Care Quality Commission

# Regulatory fees

## Consultation document

Proposals for fees from April 2017 for all providers that are registered under the Health and Social Care Act 2008

October 2016

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

### Our purpose

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

### Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

### Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

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

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# Foreword

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

We regulate over 30,000 health and adult social care providers in more than 40,000 locations and set clear expectations of what good care looks like and when improvements need to be made. We will soon complete inspections of all services we rate. This gives us a powerful baseline from which to launch our strategy for 2016-2021. We know that our work is leading to better care – providers tell us our reports help identify areas for improvement, and we regularly see improvements when we re-inspect.

Protecting the public in this way has a financial cost. We are partly funded by grant-in-aid[1] from the government. However, government policy for all fee-setting regulators is that the full costs of their chargeable activities must be recovered through fees from providers. We made significant progress in achieving this last year and the proposals in this consultation continue that progression.

We have to account to both providers and taxpayers for how we use our budget. The government's Spending Review of 2015 adds a further layer of scrutiny and challenge, as we know that we have to achieve our strategy with fewer resources. Our strategy for 2016-21 makes a clear link between the delivery of our purpose and the need to do so efficiently and effectively.

The proposals in this consultation are shaped by the trajectory to full chargeable cost recovery that was set last year. We have always consulted widely on our proposed changes to fees, and will continue to do so. The final consent on fees rests with the Secretary of State, and we expect this to be made in March 2017.

We do not underestimate the impact on providers and the market sustainability 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. In this context, it should be noted that the budget for CQC in relation to the overall spending on health and adult social care in England remains at 0.16%.

Please send us your comments and suggestions on our proposals. It is important that the fees we set are fair, and that they reinforce the priority that providers should give to delivering high-quality, compassionate and safe care.

**Peter Wyman**
Chair

**David Behan**
Chief Executive

[1] Grant-in-aid is funding from the government. See our Draft regulatory impact assessment for current levels of fees, total fee income and grant-in-aid contribution, in each sector.

# 1. Introduction

## Summary of proposals

We are consulting on the fee amounts for the 2017/18 fee scheme, in line with the requirements of the Health and Social Care Act 2008 (the HSCA). Last year, following consultation, and with the consent of the Secretary of State, we decided to meet the government requirement to achieve full chargeable cost recovery, set over a two year period for most providers and over four years for community social care providers. The fee amounts we are now consulting on are in line with that decision.

**Proposal 1:** Changes to fee amounts in the fees scheme for 2017/18:

We propose:

- To increase fees for all sectors, except community social care and dental providers, as the second year of the two-year trajectory to reach full chargeable cost recovery (FCCR).
- To increase fees for community social care providers as the second year of the four-year trajectory to reach FCCR.
- To decrease fees for dental providers maintaining FCCR levels for this sector.

Table 1 gives examples of what these changes mean for selected bands from each sector. Full details can be found at Annex A.

### Table 1

| | | Actual fee | Proposed fee |
|---|---|---|---|
| **Fee category** | **Example band size** | **2016/17** | **2017/18** |
| NHS trusts* | Turnover from £125,000,001 to £225,000,000 | £136,864 | £202,239 |
| Independent hospitals | 4 to 6 locations | £42,545 | £43,836 |
| Single specialty services | 4 to 6 locations | £6,704 | £6,958 |
| Community healthcare services | 4 to 6 locations | £7,039 | £7,456 |
| Independent ambulance services | 4 to 10 locations | £4,692 | £4,970 |
| Single location GPs | 5,001 up to 10,000 registered patients | £2,574 | £4,526 |
| Multiple location GPs | 5 locations | £9,518 | £16,736 |

| | | | |
|---|---|---|---|
| Single location dental providers | 3 chairs | £850 | £749 |
| Multiple location dental providers | 4 locations | £3,200 | £2,819 |
| Care home providers | From 26 to 30 service users at a location | £4,212 | £4,375 |
| Hospice services | 4 to 6 locations | £7,435 | £7,721 |
| Community social care providers | Single location | £1,369 | £2,192 |

* Please note, where this document refers to NHS trusts, it includes NHS trusts and NHS foundation trusts.

**Proposal 2**

We propose to change a definition in the fees scheme to reclassify providers of substance misuse treatment services as providers of healthcare activities.

**Proposal 3**

We propose to change a definition in the fees scheme to ensure that single-location providers of NHS primary medical services, where all or part of that location is a minor injuries unit or an urgent care centre, are charged on the same basis as single-location providers of NHS primary medical services where all or part of that location is a walk-in centre.

Full details of each of our proposals are in section 3.

## Other relevant reports

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

We carried out an Equality and Human Rights impact assessment (EQHRIA) of our proposals, which is also available on our website. Our assessment identified that our fee proposals would have no impact on how the organisations we regulate deliver their functions in terms of equality or human rights. If you wish to comment on our EQHRIA, please include any feedback in your responses to the questions on page 16.

## Responding to the consultation

We will take your responses to this consultation into account to finalise our provision for fees for 2017/18.

Please see section 4 for how to send us your comments. Please make sure that your comments reach us by noon on **Wednesday 11 January 2017.**

When we have analysed the feedback from this consultation in January 2017, we will prepare a response and a final fees scheme. CQC's Board will recommend the scheme to the Secretary of State, 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 2017, for implementation on 1 April 2017.

This timescale means that we will not be able to confirm exactly what fees providers will be paying in 2017/18 until relatively close to when the scheme takes effect. Providers may therefore wish to take the fee levels set out in this document as being indicative of the amounts we propose to ask the Secretary of State to approve from 1 April 2017, as a guide for setting budgets.

# 2. CQC's strategic context for fees

This section covers:

- Our budget and the Spending Review
- The relationship between our strategic approach to regulation and fees
- Our approach to setting fees
- Our approach to value for money
- Development of the fees scheme

## Our budget and the Spending Review

Our budget is made up of a combination of grant-in-aid from central government budgets and income from fees paid by providers. Like all public bodies with fee-setting powers, CQC is expected to follow government policy by setting fees that, over time, cover the chargeable costs of the services we provide under statute.

Our overall budget is monitored by the Department of Health and we are subject to the demands of the government's Spending Review of 2015. CQC is required to achieve at least £32 million in savings over the four years of the Spending Review. Our budget for 2017/18 will be £230 million, which is £6 million lower than in 2016/17.

£196 million of the 2017/18 budget will be funded by fees from providers, and used to resource our registration and review and assessment functions under the Health and Social Care Act 2008. These functions include registering new providers and managers, making changes to existing registrations, and monitoring, inspecting and rating services.

Our draft regulatory impact assessment, published on our website, sets out full details of our budget and the analysis behind our proposals.

## The relationship between our strategic approach to regulation and fees

We have published our strategy for the next five years from 2016 (see *Shaping the future: CQC's Strategy for 2016 to 2021* on our website). In this we set out our four priorities, which are:

1. Encourage improvement, innovation and sustainability in care
2. Deliver an intelligence-driven approach to regulation
3. Promote a single shared view of quality
4. Improve our efficiency and effectiveness

The fourth priority recognises the important relationship between what we do and how we do it. Our organisation needs to be properly resourced for it to be effective, but this needs to be achieved against a background of a reducing budget. We are also fully aware that we regulate providers that are operating within a demanding financial environment, and that funding for providers is increasingly challenging. Providers face pressures to control costs at a time when demand for care is increasing and care needs are becoming more complex. Not only does this mean that we have to review how we regulate effectively, but that we have to achieve this while our own resources are reducing and while responding to innovations and changes within the health and social care sectors.

In order to pursue this, we are obliged to ensure that the majority of our funding comes from fee income from the providers we regulate. Our income from fees enables us to ensure, through our regulatory work, that health and social care services provide people with safe, effective, compassionate, high-quality care. Our strategy reflects the broader financial context facing the providers we regulate, and the Spending Review. We are actively seeking ways to improve our efficiency, including making improvements to our operating model, and looking closely at its costs.

## Our approach to setting fees

We have described above what our fees fund. We define our fees as a charge for entering and remaining in a regulated market. There is a range of ways we could have charged providers, from the simplest where every provider pays the same fee, to the most complicated and bureaucratic approach which could be a fee based on the exact resources used by each provider. We recognise that there is a cost in administering a highly complex scheme, but that there is also a need to reflect the substantial variation among providers: so we have adopted an approach that calibrates fees by provider type and size. Within these sectors we have banded providers for fee charging purposes in ways that reflect the characteristics of that particular market combined with ease of collecting the required data. We then charge appropriate to their size. We believe that this balances fairness with simplicity.

The assessment of the cost of regulating each sector is measured by the data we collect from our current methodology modified by our understanding of future changes. Our new strategy will change some elements of how we approach our methodology, but others will remain unchanged. We have factored these in to setting our proposed fees for 2017/18 and will continue to do so for future years. Moving to full chargeable cost recovery does not mean that fees will stay at the same level, but will be set in response to the costs of regulating each sector. This is evident in our approach to fees for dental providers this year.

## Our approach to value for money

Like other parts of the health and care system, CQC must carry out its role with efficiency and demonstrate that it is effective. As a regulator we recognise that, while some services remain the same, the level of radical innovation and change in health and social care services means that regulation must respond by adapting its approach to a broader range of services. We have set out in our strategy document how we will continue to regulate the health and care sectors and deliver our purpose in this changing landscape, and we are taking a number of steps to ensure we do this by measuring our effectiveness and efficiency.

For each sector, we assess the activities we carry out, the costs associated with these activities and what happens as a result of regulation. We examine how efficiently and effectively we carry out our work, the administrative costs to providers to enable us to undertake regulatory activities and the costs associated with changes providers make to their approaches to care as a result of our regulatory activities.

## Development of our fees scheme

The focus on fees last year and in this consultation has been primarily to increase charges to meet the requirement for achieving full chargeable cost recovery. Once cost recovery is achieved for each sector this does not mean that fees will always stay at the same level, as we will continuously evaluate and monitor the ongoing costs of regulating each sector and set fees accordingly.

We appreciate that the health and care sectors are experiencing significant changes that will affect how care is delivered, where and in what settings, and by whom. New arrangements for how services are being developed are already emerging and CQC will need to understand and adapt to such changes in its regulatory work. We will then need to see how this affects our regulatory model and its costs. This will inevitably result in needing to evaluate the structure of the existing fees scheme to ensure that the categories, bands, range of charges and definitions set out in it remain relevant and in line with how the sectors are developing Any changes we need to make to the fees scheme in future would be subject to consultation as already described in this document. Comments provided as feedback to this consultation will be used to inform the development of proposals before we go out to consult next year on our fees scheme for 2018/19.

In the event that additional services might be brought into the scope of CQC regulation in future, we would need to consult to ensure we can charge fees to those providers. If that were to be the case, we would run a short, focused consultation, separate to this main one, and publish it on our website and inform providers that may be specifically affected.

# 3. Fee proposals from April 2017

## Government policy for fee setting

Our previous three fee consultations explained the government requirement that we are obliged to recover all costs that are related to our functions, as regards registration and reviews and performance assessment, under the Health and Social Care Act 2008 (the HSCA). We refer to these costs as our chargeable costs. Each additional pound that we charge in fees recovered from providers is matched by an equivalent decrease in the grant-in-aid received from the Department of Health. This process intentionally transfers the majority of our funding from government to providers in order to meet the requirement for achieving full chargeable cost recovery made on all fee-setting regulatory bodies. HM Treasury's document *Managing Public Money* sets out these principles. More detail can be found in our draft regulatory impact assessment.

In the 2016/17 consultation, we set out our best estimate of what the fee charges under the trajectory options would look like at that time. The fees we proposed for the 2016/17 year were specified, but figures we gave for future years were indicative, intended to give providers an idea of the financial impact of the trajectory options from 2017 onwards. Our proposal now sets out specified figures for fees in 2017/18. These are in line with the previous indicative figures, but with some adjustments informed by our costing model as a result of data received from inspections during the year and an understanding of our actual budget following the outcome of the Spending Review.

HM Treasury have been very clear that the requirement to move to full cost recovery must be achieved in as short a timescale as possible. With this in mind we do not intend to revise the timescales of the trajectory and so are not consulting on other options for the first proposal.

This consultation is inviting comments and opinions from providers and stakeholders on each of our proposals in accordance with section 85 (4) of the HSCA. With regard to our first and main proposal, described below, we are seeking comments on the fee amounts we are proposing for 2017/18. The opinions and views we receive are important as they allow us to reflect openly and honestly the views of those directly affected by this consultation to our Board and the Secretary of State.

Since our last fees consultation, our powers to set fees have been extended by Government to include our review and performance assessment functions under Chapter 3, section 46 of the HSCA. The Care Quality Commission (Fees) (Reviews and Performance Assessments) Regulations 2016, came into force on 1 April 2016 and enable us to charge fees to include all our activities associated with rating services. This means we will be making an amendment to our fees scheme to reflect the additional functions under Chapter 3 of the HSCA. This change will come in to effect on 1 April 2017.

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

Annex A at the end of this document show the detailed fees levels for our proposals.

Proposal 1 sets out our intention to make changes to fee amounts in the fees scheme for 2017/18 to achieve full chargeable cost recovery (FCCR) across all sectors, and to continue the trajectory for community social care providers to achieve FCCR by 2019/20.

Proposal 2 is intended to make a change to a definition in the fees scheme to reclassify providers of substance misuse treatment services.

Proposal 3 is intended to make a change to a definition in the fees scheme to clarify charges for providers of services in minor injuries units and urgent care centres.

## » Proposal 1: Changes to fee amounts in the fees scheme for 2017/18

We propose:

- To increase fees for all sectors, except community social care and dental providers, as the second year of the two-year trajectory to reach full chargeable cost recovery (FCCR).
- To increase fees for community social care providers as the second year of the four-year trajectory to reach FCCR.
- To decrease fees for dental providers maintaining FCCR levels for this sector.

The effect on individual fees for providers is shown in the tables at Annex A. The table in Annex B sets out what this means in overall terms for each sector.

As in the previous year, the extent to which sectors have progressed towards FCCR differs between sectors. This means that increases for each sector are not uniform, but vary by sector in order to reach FCCR. This can be seen by comparing the figures between the sectors furthest from and closest to cost recovery.

The NHS GP sector was one of two sectors furthest from FCCR. Expected total costs to regulate the sector in 2017/18 are £37.5 million and fees currently received stand at £21.3 million, so we need to raise a further £16.2 million in fees to bring the sector to full chargeable cost recovery. Their increase in 2016/17 was mitigated by the Department of Health making extra funding available.

The other sector furthest from FCCR is the community social care sector. The estimated costs for regulating this sector in 2017/18 are £26.5 million and current fees recovered stand at £12.9 million. The size of the gap we have to

cover for this sector was mitigated by giving them four years to reach FCCR. This second year will take them to £20.7 million in fees recovered. This compares to an increase of £2.5 million in 2017/18 for the residential adult social care sector, which is closer to cost recovery than other sectors.

We are proposing to decrease fees for dental providers by £0.9 million – a reduction in costs from £8.3 million to £7.4 million. As indicated last year, we expected the change in our approach to regulating this sector to decrease costs. This is the first full year when we can test this out, but current information suggests that costs are decreasing. We have reflected this in the proposed fees for 2017/18 and will continue to monitor cost data over the course of the year.

**Response to proposal 1**

What are your views on our proposals for fees for 2017/18, which take us to full chargeable cost recovery for most sectors? You may wish to comment, for example, about the impact on your service of the fees scheme as set out in this consultation.

## Proposal 2: To change a definition in the fees scheme to reclassify providers of substance misuse treatment services

We propose to change a definition in the fees scheme to reclassify providers of substance misuse treatment services as providers of healthcare activities.

The regulated activity of 'accommodation for persons who require treatment for substance misuse' is currently classified in our fees scheme as a care activity rather than a healthcare activity. For this regulated activity to be

carried on, the accommodation has to be provided to the same residents together with treatment. 'Treatment' in this regulated activity covers a range of recognised treatment interventions, such as managed withdrawal or detoxification or a structured psychosocial treatment programme. Therefore, the accommodation and the treatment must be linked so that the accommodation is provided because someone requires and accepts treatment. (This regulated activity does not apply to hospitals that provide detoxification treatments for substance misuse. In such cases, the detoxification being provided in the hospital would be covered under the regulated activity of 'Treatment of a disease, disorder or injury'.)

We have recently carried out a review of those providers that were registered for the regulated activity of 'accommodation for persons who require treatment for substance misuse'. A number of care home providers were included within this number, but although they were caring for people who have (or have had) problems with substance misuse, and were providing residential accommodation to those people, they were not providing treatment such as described above. Therefore, they did not need to be registered for the regulated activity of 'accommodation for persons who require treatment for substance misuse', and needed instead to be registered for the regulated activity of 'accommodation for persons who require nursing or personal care'.

Our review, and the subsequent revisions to individual provider's registrations, means that those providers registered for accommodation with treatment for substance misuse are regulated and inspected under CQC's healthcare (substance misuse) methodology. Those providers registered for accommodation with nursing or personal care are regulated and inspected under CQC's adult social care (care home) methodology.

These two regulated activities are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Schedule 1, paragraphs 2 and 3 – paragraph 2 referring to accommodation with nursing or personal care, and paragraph 3 to accommodation with treatment for substance misuse. Our fees scheme currently includes paragraph 3 within its definition of 'care activities', but we consider we should place this regulated activity within the fees scheme definition of 'healthcare activities', to reflect that these services are regulated as such.

If we implemented this proposal, it would mean that providers of this regulated activity would pay fees under the community health care services part of the fees scheme under Part 2, column 3 (refer to Annex A for details). This affects a small number of providers and an even smaller number (around 20) will see an increase in fees of a maximum of £200.

## Response to proposal 2

What are your views on our proposal to change a definition in the fees scheme to reclassify providers of substance misuse treatment services as providers of healthcare activities?

## » Proposal 3: To change a definition in the fees scheme to clarify charges for providers of services in minor injuries units and urgent care centres

We propose to change a definition in the fees scheme to ensure that single-location providers of NHS primary medical services, where all or part of that location is a minor injuries unit or an urgent care centre, are charged on the same basis as single-location providers of NHS primary medical services where all or part of that location is a walk-in centre.

Our fees scheme currently has a provision that charges single location providers of NHS primary medical services, where all or part of that location is a walk-in centre, the fee that is set out in the highest band under Part 4 of the fees scheme. A walk-in centre means a place where information and treatment for minor conditions is provided to the public. However, there are a number of terms used, sometime interchangeably, that reflect the way that these types of treatment services have developed over time, including minor injuries units and urgent care centres. They all provide similar services, but under different specifications, for example:

- They provide a service to patients registered at that location and/or those not registered at that location
- Some are a walk-in service and/or use an appointment system
- All or part of the service may be commissioned either by a clinical commissioning group or NHS England.

While there are numerous variations, they are regulated by CQC in the same way using the same methodology and we want to ensure that similar services, however they are titled, are charged on the same basis.

The change we are proposing to the definition of walk-in centres in the fees scheme would clarify that single location providers of NHS primary care services, where all or part of the location is a minor injuries unit or an urgent care centre, would pay the fee set out in the highest band under part 4 of the scheme. This would not apply to providers of NHS primary care where the provider of walk-in, minor injuries or urgent care services is an NHS trust, or where a provider of NHS primary care services has more than one location.

This is a clarification and does not change the fee charged or the level of the fee increase proposed for 2017/18.

**Response to proposal 3**

What are your views on our proposal to change a definition in the fees scheme to clarify charges for providers of services in minor injuries units and urgent care centres?

# 4. How to give us your views

We have asked for your views about fees from April 2017 for providers that are registered under the Health and Social Care Act 2008:

1. What are your views on our proposals for fees for 2017/18, which take us to full chargeable cost recovery for most sectors? You may wish to comment, for example, about the impact on your service of the fees scheme as set out in this consultation.

2. What are your views on our proposal to change a definition in the fees scheme to reclassify providers of substance misuse treatment services as providers of healthcare activities?

3. What are your views on our proposal to change a definition in the fees scheme to clarify charges for providers of services in minor injuries units and urgent care centres?

**Please send us your response by noon on Wednesday 11 January 2017.**

You can respond to our consultation in three ways:

**Online**
Use our online form at **www.cqc.org.uk/FeesConsultation2016**

**By email**[2]
Email your response to **feesconsultation@cqc.org.uk**

**By post** – write to us at:
**Freepost RTTE-JTBT-ZTHH**
**Fees consultation**
**Care Quality Commission**
**151 Buckingham Palace Road**
**LONDON**
**SW1W 9SZ**

[2] We cannot guarantee to consider responses sent after the closing date, or sent to alternative CQC email addresses.

# Annex A – Tables of proposed fee charges by fee category for all providers

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

| | Actual fee | Proposed fee |
|---|---|---|
| Amount of turnover | 2016/17 | 2017/18 |
| Up to £75,000,000 | £78,208 | £115,565 |
| From £75,000,001 to £125,000,000 | £107,536 | £158,902 |
| From £125,000,001 to £225,000,000 | £136,864 | £202,239 |
| From £225,000,001 to £325,000,000 | £166,243 | £245,652 |
| From £325,000,001 to £500,000,000 | £195,519 | £288,912 |
| More than £500,000,000 | £224,847 | £332,249 |

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

| | Actual fee | Proposed fee |
|---|---|---|
| Number of locations | 2016/17 | 2017/18 |
| 1 | £10,646 | £10,968 |
| 2 to 3 | £21,272 | £21,917 |
| 4 to 6 | £42,545 | £43,836 |
| 7 to 10 | £85,090 | £87,670 |
| 11 to 15 | £137,646 | £141,820 |
| More than 15 | £187,699 | £193,390 |

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

| | Actual fee | Proposed fee |
|---|---|---|
| Number of locations | 2016/17 | 2017/18 |
| 1 | £1,679 | £1,743 |
| 2 to 3 | £3,352 | £3,479 |
| 4 to 6 | £6,704 | £6,958 |
| 7 to 10 | £13,407 | £13,915 |
| 11 to 15 | £26,814 | £27,831 |
| More than 15 | £53,628 | £55,662 |

### 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 |
|---|---|---|
| Number of locations | 2016/17 | 2017/18 |
| 1 | £1,763 | £1,867 |
| 2 to 3 | £3,520 | £3,728 |
| 4 to 6 | £7,039 | £7,456 |
| 7 to 10 | £14,077 | £14,910 |
| 11 to 15 | £28,155 | £29,820 |
| More than 15 | £56,309 | £59,640 |

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

| | Actual fee | Proposed fee |
|---|---|---|
| Number of locations | 2016/17 | 2017/18 |
| 1 | £939 | £994 |
| 2 to 3 | £1,877 | £1,988 |
| 4 to 10 | £4,692 | £4,970 |
| 11 to 50 | £11,732 | £12,425 |
| 51 to 100 | £28,155 | £29,820 |
| More than 100 | £56,309 | £59,640 |

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

| | Actual fee | Proposed fee |
|---|---|---|
| Number of locations | 2016/17 | 2017/18 |
| 1 | £292 | £309 |

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

| | Actual fee | Proposed fee |
|---|---|---|
| Number of registered patients | 2016/17 | 2017/18 |
| Up to 5,000 | £2,187 | £3,845 |
| 5,001 to 10,000 | £2,574 | £4,526 |
| 10,001 to 15,000 | £2,978 | £5,237 |
| More than 15,000 | £3,365 | £5,918 |

**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 |
|---|---|---|
| Location | 2016/17 | 2017/18 |
| 1 | £3,365 | £5,918 |

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

| | Actual fee | Proposed fee |
|---|---|---|
| Number of locations | 2016/17 | 2017/18 |
| 2 | £4,761 | £8,371 |
| 3 | £6,347 | £11,161 |
| 4 | £7,934 | £13,951 |
| 5 | £9,518 | £16,736 |
| 6 to 10 | £11,900 | £20,924 |
| 11 to 40 | £23,799 | £41,848 |
| More than 40 | £59,494 | £104,614 |

**Primary care services (Dental) – One location (Part 6 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 | Proposed fee |
|---|---|---|
| Number of dental chairs | 2016/17 | 2017/18 |
| 1 | £600 | £529 |
| 2 | £750 | £661 |
| 3 | £850 | £749 |
| 4 | £950 | £837 |
| 5 | £1,100 | £969 |
| 6 | £1,100 | £969 |
| More than 6 | £1,300 | £1,145 |

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

| | Actual fee | Proposed fee |
|---|---|---|
| Number of locations | 2016/17 | 2017/18 |
| 2 | £1,600 | £1,410 |
| 3 | £2,400 | £2,114 |
| 4 | £3,200 | £2,819 |
| 5 | £4,000 | £3,524 |
| 6 to 10 | £4,800 | £4,229 |
| 11 to 40 | £10,000 | £8,810 |
| 41 to 99 | £30,000 | £26,429 |
| More than 99 | £60,000 | £52,857 |

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

| | Actual fee | Proposed fee |
|---|---|---|
| Maximum number of service users | 2016/17 | 2017/18 |
| Less than 4 | £309 | £321 |
| From 4 to 10 | £805 | £836 |
| From 11 to 15 | £1,612 | £1,674 |
| From 16 to 20 | £2,356 | £2,447 |
| From 21 to 25 | £3,223 | £3,348 |
| From 26 to 30 | £4,212 | £4,375 |
| From 31 to 35 | £4,956 | £5,147 |
| From 36 to 40 | £5,701 | £5,921 |
| From 41 to 45 | £6,446 | £6,694 |
| From 46 to 50 | £7,190 | £7,468 |
| From 51 to 55 | £7,930 | £8,235 |
| From 56 to 60 | £8,673 | £9,008 |
| From 61 to 65 | £9,913 | £10,295 |
| From 66 to 70 | £10,902 | £11,322 |
| From 71 to 75 | £11,897 | £12,355 |
| From 76 to 80 | £12,886 | £13,383 |
| From 81 to 90 | £13,880 | £14,415 |
| More than 90 | £15,499 | £16,096 |

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

| | Actual fee | Proposed fee |
|---|---|---|
| Number of locations | 2016/17 | 2017/18 |
| 1 | £1,861 | £1,933 |
| 2 to 3 | £3,717 | £3,861 |
| 4 to 6 | £7,435 | £7,721 |
| 7 to 10 | £15,639 | £16,242 |
| 11 to 15 | £29,738 | £30,885 |
| More than 15 | £59,478 | £61,771 |

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

| | Actual fee | Proposed fee |
|---|---|---|
| Number of locations | 2016/17 | 2017/18 |
| 1 | £1,369 | £2,192 |
| 2 to 3 | £3,806 | £6,093 |
| 4 to 6 | £7,611 | £12,184 |
| 7 to 12 | £15,224 | £24,370 |
| 13 to 25 | £30,447 | £48,740 |
| More than 25 | £60,893 | £97,476 |

# Annex B – Impact of move to full chargeable cost recovery by sector

| | 2016/17 | | | | 2017/18 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Per Budget | | | | Indicative costs and fees | | | | Increase against current fees | |
| | COSTS | FEES | GIA | | COSTS | FEES | GIA | | | |
| | £'M | £'M | £'M | | £'M | £'M | £'M | | £'M | % |
| NHS Trusts | 56.6 | 38.3 | 18.3 | | 56.6 | 56.6 | - | | 18.3 | 47.8% |
| Independent healthcare - hospitals | 4.7 | 4.5 | 0.2 | | 4.6 | 4.6 | - | | 0.1 | 3.0% |
| Independent healthcare - single specialty | 1.3 | 1.2 | 0.1 | | 1.2 | 1.2 | - | | 0.0 | 3.8% |
| Independent healthcare - community | 4.1 | 4.0 | 0.1 | | 4.2 | 4.2 | - | | 0.2 | 5.9% |
| Adult social care - residential | 70.3 | 67.8 | 2.6 | | 70.3 | 70.3 | - | | 2.5 | 3.7% |
| Adult social care - community | 29.4 | 12.9 | 16.5 | | 26.5 | 20.7 | 5.8 | | 7.8 | 60.1% |
| NHS GPs | 37.6 | 21.3 | 16.3 | | 37.5 | 37.5 | - | | 16.2 | 75.8% |
| Dentists | 8.3 | 8.3 | - | | 7.4 | 7.4 | - | | (0.9) | (10.8%) |
| | **212.2** | **158.3** | **54.0** | | **208.4** | **202.5** | **5.8** | | **44.2** | **28.0%** |
| | | | | | | | | | | |
| **Grant in Aid** | 23.8 | - | 23.8 | | 21.6 | - | 21.6 | | | |
| **TOTAL** | **236.0** | **158.3** | **77.8** | | **230.0** | **202.5** | **27.5** | | | |

# Annex C – 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.<br>• 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.<br>• Involve stakeholders openly and on an ongoing basis. |

# Annex D – Our fee-setting powers

Our powers for setting fees[3] 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 part 2, section 85 of the 2008 Act. These functions cover all our activities associated with registering providers, making changes to their registration and carrying out inspections. Other existing responsibilities, such as our work under the Mental Health Act, are not included within our registration functions, and their costs are covered instead by grant-in-aid from the Department of Health.

In addition, our powers to set fees extend to our review and performance assessment functions under part 3, section 46 of the 2008 Act by virtue of the Care Quality Commission (Fees) (Reviews and Performance Assessments) Regulations 2016, which came into force on 1 April 2016. These functions cover all our activities associated with rating services.

[3] 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 we want views on and the timescale for responses.
- Ensure that our consultation is clear, concise and widely accessible.
- Ensure that we provide feedback regarding the responses received and how the consultation process influenced the development of the policy.
- Monitor our effectiveness at consultation, including through the use of a designated consultation coordinator.
- Ensure our consultation follows better regulation best practice, including carrying out a regulatory impact assessment if appropriate.

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

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

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

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

Care Quality Commission
151 Buckingham Palace Road
London
SW1W 9SZ

# How to respond to this consultation

**Online**

Use our online form at:
**www.cqc.org.uk/FeesConsultation2016**

**By email**

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

**By post**

Write to us at:
**Freepost RTTE-JTBT-ZTHH**
**Fees consultation**
**Care Quality Commission**
**151 Buckingham Palace Road**
**LONDON**
**SW1W 9SZ**

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:
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www.cqc.org.uk

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Committed to clearer communication.