Regulatory fees from April 2017

Final regulatory impact assessment

This final regulatory impact assessment has been published alongside *Regulatory fees from April 2017 under the Health and Social Care Act 2008 (as amended): Our response to the consultation.* We suggest that you read that document in full before reading this impact assessment.

This document sets out our final analysis of the impact of the proposed changes to our fees scheme from April 2017.

Introduction

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

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

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

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

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

5. The Secretary of State has consented to the fees scheme and it will take legal effect from 1 April 2017.

Financial position

6. 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.

7. We can recover costs that relate to our chargeable regulatory work under the 2008 Act. 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. Providers consistently raise concerns about any fee increases, particularly when this is against an economically challenging background. We understand 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 HM Treasury, which expect us, like all public bodies with fee-setting powers, to recover chargeable costs of the services we provide through fees over a reasonable time period.

8. The Government document *Managing Public Money*[1] sets out that recovery of costs by a public body should be:

> "…designed to recover full costs. If the legislation permits, the charge can cover the costs of the statutory body, e.g. a regulator could recover the cost of registration to provide a licence and of associated supervision. It may be appropriate to charge different levies to different kinds of licensees, depending on the cost of providing different kinds of licences." (para 6.5.2)

and that the body should:

> "…always seek to control their costs so that public money is used efficiently and effectively. The impact of lower costs should normally be passed on to consumers in lower charges." (para 6.2.3)

9. We believe that these principles should also apply to how we use the fees income from providers.

[1] https://www.gov.uk/government/publications/managing-public-money

10. 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. The indicative budget negotiated with the Department of Health requires us to achieve at least £32 million in savings over the four years of the Spending Review. This equates to about 13% of the indicative CQC budget over the four years from 2015/16 to 2019/20. We have modelled the impact of this and identified budget levels reducing the overall indicative budget to £217 million in 2019/20.

11. The fee increases are a reflection of the required move to full chargeable cost recovery and not due to inflationary increases. The overall fee increase is matched by a corresponding reduction in grant-in-aid.

12. The figures in the table below show CQC's overall budget reducing as a result of the savings required by the Department of Health under the Spending Review and the effect on grant-in-aid for non-recoverable services and provider fees over the four years of the Spending Review (2016/17 to 2019/20). The indicative budget for 2017/18 is further broken down by sector in Appendix A.

Year	**2016/17 £m**	**2017/18 £m**	**2018/19 £m**	**2019/20 £m**
Grant-in-aid	85.0	34.0	27.0	18.0
Fees	151.0	196.0	201.0	199.0
Total budget	**236.0**	**230.0**	**228.0**	**217.0**

13. £34 million of the total budget for 2017/18 will be covered by grant-in-aid. Of this, £21.6 million will support the elements of our functions where we cannot recover costs by charging fees. These functions include: Healthwatch, Office of the National Guardian, Mental Health Act duties (including provision of second-opinion appointed doctors), thematic reviews and enforcement. £5.9 million will fund the element of costs for community social care providers not yet funded via fees. The remaining £6.5 million represents the accounting adjustment we have to apply for the effect of deferred income. Deferred income is further explained in Appendix C.

14. The £196 million funded by fees from providers will be used to resource our registration and review and assessment functions under the Health and Social Care Act 2008 (the 2008 Act). These functions include registering new providers and managers, making changes to existing registrations, and monitoring, inspecting and rating services. Note that the £196 million in addition to the £6.5 million deferred income represents £202.5 million invoiced to providers.

Response to consultation

15. We asked for feedback on three proposals in our consultation.

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

    - 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.

    Proposal 2: 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 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.

16. Most respondents to proposal 1 were opposed. This opposition fell into the following main areas, which reflect what we heard last year:

    - Criticism about CQC's regulatory effectiveness, inspection process, efficiency and value for money.
    - Concern about the equity and proportionality of how the fees scheme is structured, particularly for smaller providers.
    - Concern about the impact of increased fees on the sustainability of services and the quality of care.

17. A number of suggestions were also made about the consultation process itself and on how the fees scheme might be changed.

18. Our response to these areas is set out below.

CQC's regulatory effectiveness, inspection process, efficiency and value for money

19. We received a number of comments about our performance, usually as part of an argument against the proposed fee increases. A central thread in these comments was respondents' assertions that CQC is a bureaucratic and/or inefficient organisation. Value for money was considered by many respondents in terms of the inspection process itself, and their opinion that the inspections had minimal impact on improving quality of care. Our consultation response document and analysis report provide detail and comment on this.

20. We are strongly committed to our obligation under *Managing Public Money* to control our costs by being as efficient and effective as possible, and this is evidenced by the Spending Review reductions that will reduce fees overall. As described in *Shaping the future: CQC's strategy for 2016 to 2021*, investments that we will make will be targeted towards reducing costs. We believe we can make significant savings by greater use of new technologies to help us identify and reduce inefficiencies and duplication, and to standardise our core activities. The strategy provides examples of these technologies such as the CQC provider portal, national resource planning tool, CQC website developments, IT infrastructure, and data analysis tools.

21. We have carried out work to develop a mature costing model. The model analyses the costs of our operating model activities (registration, inspection, monitoring, enforcement and independent voice) and it also identifies from which sectors these costs derive. The model allows us to assess if we are delivering more activity for the costs we have incurred over time. From this, we can understand what is driving our costs and where we could be more economical and efficient. For example, this has led to a focus on reducing overhead costs, specifically non-staff expenditure such as travel, subsistence, room hire and IT, while not impacting on the delivery of our programme of work.

22. We are continuing to use the costing model to report and analyse the cost of our operating model, as it is changing from a programme of comprehensive inspections to a more targeted and intelligence-led approach as outlined in our strategy.

23. We have used our costing model to identify the fee charges by sector in this consultation. We will continue to use it to set our fees to reflect the full chargeable cost of regulation for each sector.

24. The reduction in fees for dental providers, as a result of changes to the model of regulating them, is an early demonstration of this. The cost of regulating them is lower than previously and this reduction is being passed directly on to the sector. However, it should be understood that some fees could rise if the cost of regulation for that sector rises.

How the fees scheme is structured

25. Various respondents focused on the proportion of fees paid relative to other organisations or sectors.

26. We endeavour to ensure that our fees reflect the cost of regulation by sector. Further to this we distribute fees in such a way as to spread the burden across providers within a sector, while protecting smaller providers. However, we cannot simply charge according to organisation size, since we have to include other factors such as simplicity and cost effectiveness of the charging methodology.

Impact of increased fees on the sustainability of services and the quality of care

27. We received consultation responses highlighting the direct impact that increasing fees would have on service quality; providers' ability to operate; staff recruitment, retention and morale; and ultimately the impact on service users. Our consultation response document and analysis report provide detail on this.

28. We have noted the fragility of the adult social care sector in our State of Care report, particularly in respect of the difficulty in obtaining support from funding providers, such as local authorities, and the impact of the introduction of the national minimum wage.

29. Providers have challenged us to see fee increases in this wider context. Simply put, our increased fees only add to existing financial difficulties. We operate within and across the whole health and social care sector. We are required to find our own funding within that sector as a whole. Our figures in the following paragraphs show that we are a small part of the total funding. We have to regulate over 30,000 providers. Therefore, while the need to fund ourselves directly from providers through fees does add to the burden within the sector, we do not believe that this relationship or size are responsible for the fragility in the market. We are strongly of the view that our fee increases are essential to ensuring that, as a consequence of our role in health and social care, services are providing people with safer, more effective, more compassionate and higher quality care.

30. Using information sources that show the total value of the market, our fees for 2017/18 will represent 0.16% of overall indicative turnover of the health and social care market – although this varies between sectors as can be seen in Appendix B.

31. While the figure of 0.16% is not intended to diminish the importance with which any rises in fees are regarded by individual providers, it demonstrates that the total amount spent on regulation is proportionately small. In instances where a provider pays tax, fees are tax allowable, so the differential rate of taxation, whether for a sole trader, partnership or company, will reduce that proportion further.

32. This does not remove our drive to be as efficient as we possibly can or to constantly seek better ways of working as outlined in our strategy. We expect efficient quality services from providers and so we should expect, and demonstrate, no less from ourselves.

33. A practical way in which we are helping providers manage the payment of their fee is through offering the option to pay by direct debit. This is the most secure way to pay and allows payment to be collected over 10 months in equal instalments. This option was first introduced in 2015 and approximately 37% of eligible providers now pay by direct debit. This option will be available to NHS trusts from April 2017 for the first time, and we will continue to promote this payment option with all eligible providers. Unlike other comparable schemes, there is no additional cost to providers for doing this.

34. The Government announced additional funding to cover the expense of the required increase to fees for NHS GPs in 2016/17.

Suggested changes to fees

35. Over the last few years the fees scheme has, by necessity, concentrated on two key areas: accommodating sectors new to regulation into the scheme and addressing the requirement to move to full chargeable cost recovery. During this time we have obtained a growing understanding of how sectors are structured and the factors that contribute towards determining the size of individual providers.

36. Feedback from recent consultations has suggested that some of the bands were too wide (for example, GP practices with patient list sizes of less than 5,000) or the fee increases from one band to the next too large (for example, Community social care has a band for 2-3 locations which is more than double the fee for one location). This year several respondents recommended fees linked to provider turnover. Another alternative was to link fees to the organisation size (measured in numbers of clients, numbers of beds or hours of care delivered). Provider performance was also suggested as an alternative as it was felt that such a system would provide an incentive to improve performance.

37. We are beginning a systematic review or our fee structures for each area to ensure that our bandings and measures better reflect each sector. Providers have made comments about this and we have responded in some areas where the structure has been particularly unreasonable. We will continue to do so by working with representative organisations to ensure that any proposed changes are fair for the majority of providers within that sector, as well as workable and cost effective for us. As a direct consequence of feedback we are proposing to review the fee bandings for community social care, NHS GP and dental providers as part of the 2018/19 fees scheme.

38. We will also work to ensure that any changes that we make are future proofed and are consistent with the likely changes to the provider landscape, for example reflecting the new models of care described in the Five Year Forward View.

Final CQC decision

39. The decision is to charge fees in 2017/18 as outlined in the consultation document.

40. Set fees for all providers, except community social care and dental providers, as the second year of the two-year trajectory to reach full chargeable cost recovery (FCCR).

41. Set fees for community social care providers as the second year of the four-year trajectory to reach FCCR.

42. Decrease fees for dental providers, maintaining FCCR levels for this sector.

43. Change the definition in the fees scheme to reclassify providers of substance misuse treatment services as providers of healthcare activities.

44. Change the 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.

45. Appendix A shows the budgeted grant-in-aid and fees for each sector for 2017/18 as well as the changes from the current year.

46. The proposed fees for individual providers can be found in Appendix 1 of *Regulatory fees from April 2017 under the Health and Social Care Act 2008 (as amended): Our response to the consultation.*

Appendix A: Grant-in-aid (GIA) and fees by sector for 2016/17 and 2017/18

	2016/17				2017/18				
	Per budget				Per budget			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**		

Note: £196 million plus £6.5 million deferred income represents the £202.5 million invoiced to providers. See Appendix C for more detail

Appendix B: Impact of 2017/18 fees on provider sectors

Sector	Value of market £m	2017/18 fee £m	% of turnover	Information source
NHS trusts	76,336	56.6	0.07%	https://www.gov.uk/government/publications/nhs-foundation-trust-accounts-consolidation-ftc-files-201516 https://www.gov.uk/government/publications/nhs-trusts-accounts-data-for-2015-to-2016
Independent healthcare - hospitals				LaingBuisson UK Healthcare Market Review – 28th edition
Independent healthcare - single specialty	9,100	5.9	0.06%	
Independent healthcare - community	3,900	4.2	0.11%	
Adult social care - residential	17,100	70.3	0.41%	
Adult social care - community	6,600	20.7	0.31%	
NHS GPs	7,764	37.5	0.48%	G/PMS, APMS and PCTMS expenditure from DH annual report 2015/16
Dentists	5,900	7.4	0.13%	LaingBuisson Dentistry UK Market report 2014
Total fees	**126,700**	**202.5**	**0.16%**	
Total CQC budget	**126,700**	**230.0**	**0.18%**	

Appendix C: Deferred income

Fees in this document are shown on an invoiced basis as this reflects the actual impact on the health and social care sectors. However, we report fees on an accruals basis to the Department of Health and within our financial accounts. This means that the estimated income for 2017/18 on an accruals basis is £6.5 million lower than the invoiced total. The total indicative budget for 2017/18 represents the budget that we expect to be our total cost target. Therefore grant-in-aid represents the balancing figure and is £6.5 million higher than shown through the impact assessment. The table below shows how the invoice date affects how the fee income is treated in our accounts.

The invoice in this example is always the same but the amounts that will be recognised in 2017/18 and 2018/19 accounts will differ.

Provider	2017/18 provider invoice	If the annual invoice date is:	Income recognised in CQC accounts for year ending:	
			31/03/18 (ie financial year 2017/18)	31/03/19 (ie financial year 2018/19)
Independent hospital with 4 to 6 locations	£43,836	01/04/2017	£43,836	£0
		30/09/2017	£21,918	£21,918
		01/03/2018	£3,653	£40,183