Care Quality Commission

Consultation

Regulatory fees – have your say

Proposals for fees from April 2016 for all providers that are registered under the Health and Social Care Act 2008

November 2015

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

Our purpose

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

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

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 with more than 40,000 locations and set clear expectations of what good care looks like and when improvements need to be made. Under our 2013-2016 strategy, *Raising Standards, Putting People First*, we have introduced tougher registration checks, specialist and expert-led inspections, and ratings based on what matters most to the people using services. We use Intelligent Monitoring – our sources of information about providers – to help us to decide when, where and what to inspect, and report on our judgements in a fair, consistent and robust way. Our strategy for 2016-2021, which we are currently developing, will include refining our model to make it more efficient and effective. To continue to carry out our work effectively we must be a strong, independent and impartial regulator, and have sufficient resources to do the job well. We must use those resources effectively to encourage the highest standards of quality and safety and ensure that we can act quickly when we find inadequate care.

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. As we do not yet fully recover the costs of our chargeable activities, we need to be increasingly funded by the providers we regulate through the fees we charge them. This means that we have to account to both providers and taxpayers for how we use our budget. This year there is additional detailed scrutiny on the costs of public spending under the government's Spending Review 2015.

We have already put in place significant changes to the way we regulate and inspect services. Our comprehensive, more specialist and expert-led inspections, implemented across all the sectors we regulate, have increased the costs of regulation. Our fee consultation last year set out proposals for how we would start to change the balance in the amount funded by central government and by providers' fees to pay for those costs. This consultation sets out the further changes we propose to make to fees for providers in 2016/17 and beyond, to meet our obligation to achieve full chargeable cost recovery.

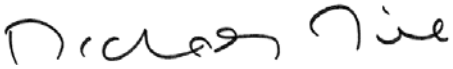
We have always consulted widely on our proposed changes to fees, and will continue to do so, as the effect on costs of our inspection approach becomes clearer in the light of our developing wider strategy. Alongside formal consultation though, we remain committed to involving providers directly in developing our fees strategy and work closely with the members of the Fees Advisory Panel to help us do that. The final decision on fees for 2016/17 rests

[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.

with the Secretary of State, and we expect this decision to be made in March 2016.

We do not underestimate the impact on providers of paying fees, and we will continue to look carefully at our costs relating to regulation. We have a responsibility to cover our costs by charging fees, but we are also accountable for demonstrating that we are fair, efficient, effective and proportionate. 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 is 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.



Michael Mire
Interim Chair

David Behan
Chief Executive

1. Summary

Background

The Health and Social Care Act 2008 includes powers for the CQC to set regulatory fees, subject to consultation.[2] Following this consultation, we will prepare the fees scheme and our Board will seek the Secretary of State's approval of our recommendations. The fee scheme cannot take effect until he has consented to it.

CQC is funded through both grant-in-aid from the Department of Health and fee income. We are required by government policy to set fees that cover our chargeable costs, and in doing so reduce our reliance on grant-in-aid. We must therefore take account of that obligation when developing our consultation proposals.

Summary of proposals

This paper sets out our proposals in relation to fees for the 2016/17 fee scheme. We know that providers also want clarity about our intention for fee increases over future years. This paper therefore sets out our proposals for the pace at which we achieve full chargeable cost recovery. We also set out our proposals for the dental sector.

Proposal 1

Our first, and main, proposal is to achieve full chargeable cost recovery over a defined timescale. This applies to all registered providers, except for the dental sector. We are seeking views on two options for the timetable to move to a position where CQC recovers full chargeable costs:

- Option 1 – recovery over **two years** between 2016-2018
- Option 2 – recovery over **four years** between 2016-2020

Because we are offering two options for the timescale to achieve full chargeable cost recovery, the annual fees we are proposing for 2016/17 will be different under each option. In tables 1 and 2 below, we have shown examples of the fees we are proposing for 2016/17, and the estimated fee charges for future years for each option. At this stage, we can only estimate fees for the years beyond 2016/17, as they will depend on many variables, including budgetary agreements and potential changes to our methodology. We have, therefore, only shown these as indicative charges in this consultation document.

We welcome respondents to this consultation making any other suggestions about how we may raise sufficient fees so that, combined with grant-in-aid, we are able to perform our statutory functions. Please see page 29.

[2] See annexes E and F in this document for more information about our powers to set fees.

Full details for all fee category bands for both options are shown in Annexes A and B.

Table 1

Proposal 1: Option 1 – Examples of proposed annual fees for 2016/17 and estimated annual fees for 2017/18 under a two-year timescale for each fee category (for full details, please see Annex A)

		Actual fee	Proposed fee	Estimated fee
Fee category	**Example band size**	**2015/16**	**2016/17**	**2017/18**
NHS trusts*	Turnover from £125,000,001 to £225,000,000	£78,208	£136,864	£215,835
Independent hospitals	4 to 6 locations	£37,987	£42,545	£46,800
Single specialty services	4 to 6 locations	£6,704	£6,704	£7,441
Community healthcare services	4 to 6 locations	£6,704	£7,039	£7,391
Independent ambulance services	4 to 10 locations	£4,469	£4,692	£4,927
Single location GPs	5,001 up to 10,000 registered patients	£725	£2,574	£4,839
Multiple location GPs	5 locations	£2,681	£9,518	£17,893
Care home providers	From 26 to 30 service users at a location	£3,761	£4,212	£4,661
Hospice services	4 to 6 locations	£6,638	£7,435	£8,226
Community social care	Single location	£796	£2,229	£3,287

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

Table 2

Proposal 1: Option 2 – Examples of proposed annual fees for 2016/17 and estimated annual fees from 2017/20 under a four-year timescale for each fee category (for full details, please see Annex B)

		Actual fee	Proposed fee	Estimated fee		
Fee category	**Example band size**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
NHS trusts	Turnover from £125,000,001 to £225,000,000	£78,208	£109,491	£144,200	£180,250	£215,835
Independent hospitals	4 to 6 locations	£37,987	£40,266	£42,682	£44,603	£46,800
Single specialty services	4 to 6 locations	£6,704	£6,704	£7,441	£7,441	£7,441
Community healthcare services	4 to 6 locations	£6,704	£6,905	£7,112	£7,255	£7,391
Independent ambulance services	4 to 10 locations	£4,469	£4,603	£4,741	£4,836	£4,927
Single location GPs	5,001 up to 10,000 registered patients	£725	£1,341	£2,146	£3,219	£4,839
Multiple location GPs	5 locations	£2,681	£4,960	£7,936	£11,904	£17,893
Care home providers	From 26 to 30 service users at a location	£3,761	£4,062	£4,306	£4,486	£4,661
Hospice services	4 to 6 locations	£6,638	£7,169	£7,599	£7,918	£8,226
Community social care	Single location	£796	£1,369	£2,054	£2,772	£3,287

Proposal 2

Our second proposal relates to fees for dental providers. The chargeable costs for this sector are fully recovered under the current fee levels, and those costs will remain the same during 2016/17. After that time, the costs of regulating this sector are expected to fall. On this basis, we will hold dental fees charges at current levels for 2016/17, and propose to then decrease them in 2017/18, maintaining them at that level until 2019/20 so as to reflect the reduction in costs and maintain full chargeable cost recovery levels, as illustrated in Table 3 below. Whether a two or a four year option is decided for other sectors under Proposal 1 will have no material impact on the dental sector, as the decrease in their fees under this proposal will take effect in the second year, 2017/18, and be maintained until 2019/20.

Table 3
Proposal 2 – Examples of estimated annual fees for 2017/18
(for full details, please see Annex C)

		Actual fee		Estimated fee
Fee category	**Example band size**	**2015/16**	**2016/17**	**2017/18**
Single location dentist	5 dental chairs	£1,100	£1,100	£935
Multiple location dentist	5 locations	£4,000	£4,000	£3,400

Full details of both our proposals are in section 3.

We do not propose to make any other changes to the fees scheme for 2016/17.

Summary of our strategic direction and its relationship to setting fees

We are currently developing a new strategy to be launched in spring 2016. This will be a five-year strategy that will set out our vision for health and adult social care quality regulation in the future.

It will include the measures we will take to refine our established regulatory model to make it more efficient and effective. This will undoubtedly influence the costs of regulation, which we will continue to monitor closely, as the changes we make to our approach become embedded over time.

Our fee consultation is being published in advance of our five-year strategy, so does not yet take full account of the vision we will launch in the Spring. This is unavoidable given that, in order to meet the Department of Health's anticipated reduction in our grant-in-aid, which is designed to move CQC towards compliance with the government's policy of achieving full chargeable cost recovery, we need to consult now on proposed fee increases so that we can publish the fee scheme in time to take effect on 1 April 2016.

As part of our overall strategic direction, we are positioning fees as the charge providers pay to be able to enter and remain in a regulated market. 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. It also enables us to encourage improvement in care services. This is our fundamental purpose, and will not change, even though our strategic direction will develop.

We have included more information about our strategy in section 4 of this document.

Summary of proposed changes to other regulations and their relationship to fees

The Department of Health will be publishing two consultations which have a bearing on fees; one that will propose making minor changes to the scope of

providers who need to be registered with CQC, and a second which will propose extending CQC's fee-setting powers.

We have included more information about the relationship and potential effect of these two consultations on CQC's fees in section 4 of this document.

Other information

Following on from proposals we first set out in 2013, our latest key document – *A Fresh Start for Registration*[3] – sets out the improvements we are making to further strengthen our approach to registration, which is the first legal step of our regulatory process. We have included more information about our registration strategy and its impact on fees in section 4 of this document.

We have also recently published a number of documents on our website (www.cqc.org.uk) that explain our new approaches in some of the different sectors we regulate, such as independent doctors, substance misuse services and health and care provision in secure settings. You may find it helpful to read those relevant to you alongside this consultation.

Please also 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.

We carried out an Equality and Human Rights impact assessment (EQIA) of our proposals, 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 EQIA, please include any feedback in your responses to questions 2 or 3 on page 29.

Responding to the consultation

We will take your responses to this consultation into account to finalise these proposals.

See section 5 for how to send us your comments. Please make sure that your comments reach us by noon on **15 January 2016.**

When we have analysed the feedback from this consultation in January 2016, we will prepare a response and a final fees scheme, which CQC's Board will recommend to the Secretary of State, who is responsible for making the final decision about fees charges, and whose consent is required in order for the scheme to come into effect. We expect to publish our response and our final fees scheme in March 2016, for implementation on 1 April 2016.

This means that we will not be able to confirm exactly what fees providers will be paying in 2016/17 until relatively close to when the scheme takes effect.

[3] www.cqc.org.uk/content/cqc-welcomes-fresh-start-registration

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 2016 and estimates of those that may apply in subsequent years. CQC will not make any decisions about fees for 2016/17 until we have reviewed the responses to this consultation. However, fees for 2016/17 are unlikely to be set at a level that is higher than the amounts we have set out in this document.

2. Our budget

Context

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 costs of the services we provide under statute.

The document *Managing Public Money*[4] 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)

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

CQC reached the end of its formal transformation programme in March 2015. This involved the development of a new approach to inspection, and substantial organisational restructuring. The costs of this meant that between 2012 and 2015, CQC received additional grant-in-aid as a proportion of its budget. Some of those costs were specific to the transformation work and so were not expected to be repeated; other costs were to fund the requirement for CQC to be an effective regulator on a continuing basis. So during that time, the rise in costs out-stripped increases in fees, and cost recovery levels fell. With the establishment of a steady-state environment, CQC is expected by the Department of Health to return to compliance with government policy to achieve full recovery of its chargeable costs from fees income.

As set out in *Managing Public Money*, certain elements of our registration functions are exempt from being included as recoverable costs from fee charges, such as the costs of our enforcement activity. This means that we will not be required to recover 100% of our costs through fees. Instead, we have set a fee policy that moves us to a full chargeable cost recovery position, so that providers ultimately bear all the chargeable costs, reducing our reliance on grant-in-aid.

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

In 2014/15, our fee income recovered just under 54% of chargeable costs. We increased fee charges in 2015/16 by 9% for all sectors, except for dentists, as the first stage in making incremental fee increases to reduce reliance on grant-in-aid for funding our chargeable activities.

CQC's budget is at its current level as part of a series of negotiations with the Department of Health, which has assessed the resources it considers are required to discharge our statutory functions. We are not currently considering substantial changes to the way we discharge these functions and so have made a starting assumption that our current budget will remain static for 2016/17. We have then calculated the level of fees that CQC will need to charge, taking account of the anticipated reduction to our grant-in-aid.

CQC's budget in future years, and the level of fees we will be required to charge, will be affected by factors such as the current spending review and on our own drive to be more efficient. To meet its targets, the government is demanding significant focus on cost reduction from many government organisations and CQC is not exempt from this. Given these variable factors, we are setting out proposals for the fee levels for 2016/17, within a two or a four year timetable for achieving full chargeable cost recovery, and can only show indicative figures for likely fee levels in subsequent years.

Our budget – 2015/16

Our budget for 2015/16 is £249.3 million, of which £4.9 million is separately allocated to Healthwatch England. This means that we are operating with resources of £244.4 million, from a combination of grant-in-aid and income from fees paid by providers. Of this overall resource, £224.4 million is being used to regulate providers and £20 million for other functions. The £224.4 million is an increase of £20 million from 2014/15 and from £180 million in 2013/14. These increases were necessary to fund the significant changes we made to our regulatory approaches, including the recruitment of additional staff to carry them out.

The £224.4 million allocation of the budget is used to resource our registration 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, monitoring and inspecting services and taking action to address any shortfalls in meeting regulations. As detailed below in section 4, our legal powers enable us to charge fees to providers to cover the cost of regulating them under our registration functions. At the moment, a higher proportion of these costs is met by grant-in-aid than from fee income. We are proposing that this should change in order to bring us into compliance with government policy.

The £20 million allocation of our budget that relates to our other functions includes visiting people detained under the Mental Health Act, monitoring arrangements for the use of controlled drugs and enforcing regulations on the safe use of x-rays. We cannot recover the costs of these functions by charging fees to providers as our legal powers do not enable us to do so. Therefore these costs are fully covered by grant-in-aid.

In 2015/16, we expect our fee income from registered providers to be £113.5 million (50.6% of £224.4 million). The balance of our budget is funded as grant-in-aid from the Department of Health. If our final fees income is above the estimated figure, then our grant-in-aid is reduced. The changes we applied to fee charges in 2014/15 and 2015/16 did not have the effect of significantly increasing our overall cost recovery levels, as our budget increased to a greater extent than the increases in fee charges were able to keep pace with. This, together with anticipated reductions in our grant-in-aid for 2016/17 means that, unless CQC is to make substantial reductions to its operating budget, we need to recover additional sums in fees from registered providers.

Our budget in relation to fees proposals for 2016/17

At the time of publishing this consultation, CQC's total revenue budget for 2016/17 is still under negotiation with the Department of Health so, for the purposes of this consultation, we are assuming the budget to be around the same as for 2015/16.

In 2016/17, we propose to generate an increased proportion of income from fees in order to bring us in line with wider government policy as follows.

If the two-year recovery proposal is decided on by the Secretary of State after the consultation, our estimated income from fees and grant-in-aid (GIA) would be:

Year	GIA	Fees	Absolute increase on previous year	% of cost recovery
	£'M	£'M	£'M	%
2016/17	83.0	166.3	52.8	74.3
2017/18	24.9	224.4	58.1	100.0

In this scenario we propose that this increase is achieved through a differentiated increase to existing fee charges for all providers except for the dental sector, which is already at full chargeable cost recovery.

If the four-year recovery proposal is decided on by the Secretary of State after the consultation, our estimated income from fees and grant-in-aid would be:

Year	GIA	Fees	Absolute increase on previous year	% of cost recovery
	£'M	£'M	£'M	%
2016/17	111.6	137.7	24.1	61.5
2017/18	85.8	163.5	25.9	73.1
2018/19	56.7	192.6	29.1	86.1
2019/20	24.9	224.4	31.8	100.0

In this scenario, again we propose this increase is achieved through a differentiated increase to existing fee charges for all providers except for the dental sector, which is already at full chargeable cost recovery.

We are seeking your views on these scenarios, and your suggestions if you wish to recommend other options – please refer to page 29.

While we accept that any increase in fees will not be welcomed because it will result in higher charges for the individuals and organisations we regulate, the total CQC budget of £224.4 million makes up only 0.16% of the overall value of the sectors. Further details are available in our *Draft regulatory impact assessment*, published on our website.

3. Fee proposals from April 2016

Our proposed changes below are subject to the outcome of this consultation and the final decision of the Secretary of State. We are not planning to make any other changes to our fees scheme for this year.

Annexes A to C at the end of this document show the detailed fees levels for our proposals (see the table below). Options 1 and 2, which are set out in Proposal 1, are both intended as alternatives to achieve full chargeable cost recovery, over two or four years, by differentially increasing fees for all providers, except the dental sector. Proposal 2 is intended to maintain the dental sector at full chargeable cost recovery by decreasing fees in 2017/18.

Proposals
1. To move to compliance with government policy on setting fee levels, through either: • Option 1 – full chargeable cost recovery over two years, or • Option 2 – full chargeable cost recovery over four years
2. To maintain full chargeable cost recovery levels for the dental sector by decreasing their fees charges in 2017/18

Government policy for fee setting

We explained in the section 'Our budget – 2015/16' above that if our grant-in-aid from the Department of Health is reduced because we are expected to move to compliance with the government policy of setting fees that fully cover our chargeable costs, we will be required to increase our income from provider fees.

In our last fee consultation in October 2014, we said that the proposed 9% across-the-board fee increase represented the first stage of making further incremental increases to achieve full chargeable cost recovery, and that we would consider differentiating those increases by sector to fairly apportion the actual costs of regulation. These proposals for the fee levels for 2016/17 represent the next step in achieving a greater level of cost recovery. In considering the options that we have, we have had to consider government policy in conjunction with the economic state of the health and social care sector. As part of this process we have reviewed the model that we use to understand our costs for each sector.

Methodology we have used for calculating fee levels

Within the proposals for 2016/17 described in this document, we have set out proposals for fee levels for the different sectors that we regulate. Unlike last year, these are not set out as a flat rate. Instead, they are differentiated so

that each sector reaches full chargeable cost recovery at the same time, but with different percentage increases applying to them, depending on how far that sector currently is from reaching full chargeable cost recovery.

Our costs are divided in to 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. Further detail is provided in the *Draft regulatory impact assessment* in paragraphs 23 to 27.

These costs are then proposed to be distributed among providers in each sector using the structure of the fees scheme to ensure that smaller providers are protected and that providers are charged appropriate to their size.

How we developed our proposals for the period over which we should move to achieve full chargeable cost recovery

We considered a number of options for the period over which we should move to compliance with government policy on full chargeable cost recovery. We sought advice from the Department of Health about what would be considered an acceptable maximum period, and have had discussions about the likely level of grant-in-aid from the Department of Health for 2016/17 and future years.

We were advised that moving to full cost recovery over a four-year period was the longest time we could reasonably expect to be permitted before complying with the policy in full. Two years was the shortest timescale that could reasonably be considered without destabilising individual sectors. Three years did not seem to be sufficiently different from these two periods to be considered as a separate option.

Offering variable timescales to different sectors did not seem fair to a number of sectors so, other than the specific case of dental providers, where full cost recovery has already been achieved, we decided to offer options for two defined timescales for all sectors.

Invitation to comment on our proposals for fee levels for 2016/17

We have explained that we expect our grant-in-aid to reduce in 2016/17, and have set out the context of the government's policy in relation to fee income generally. We have also explained that the final decision on the level of both grant-in-aid and fees rests with the Secretary of State for Health.

We are well aware of the impact of increases on providers and that the increases are significantly higher than anything we have proposed in previous years.

The sectors are currently at different distances from reaching full chargeable cost recovery. For example, the NHS GP sector overall is currently at 15% chargeable cost recovery, compared to 81% for the residential adult social care sector. Therefore fees for NHS GPs in this consultation show relatively larger increases than other sectors over the same timescales. The charts in section 4 illustrate the percentage of full chargeable cost recovery that each sector is currently at in 2015/16. They also show the progression to full chargeable cost recovery in percentage terms for each year under the two-year and four-year trajectories.

We believe we continue to have clear support from providers, the public and our partners for the direction we are taking to change, embed and evaluate our regulatory approach, and for the impact it is making. Our *State of care* report[5] shows how our inspections so far are providing clear evidence to the public that many providers are delivering high quality care, but also demonstrate that care can be inadequate, variable and unsafe. We rate the majority of providers through our judgements, and those ratings enable people, including commissioners of services, to make comparative, informed decisions about care services.

The majority of providers we have inspected confirm that our inspections have helped them to identify where improvements need to be made, and that outcomes for people who use their services had been improved as a result of our inspection activity. We are also seeing evidence that, where we have re-inspected providers to follow up concerns about quality of care, half had improved their original rating, showing the positive impact of inspection on encouraging improvement. We have also increasingly used our enforcement powers to drive out poor quality provision through measures such as cancelling or suspending a provider's registration, ensuring that people using those services are protected from harm.

The CQC Board's policy is that the organisation should continue to be properly resourced for it to be effective. In order to pursue this policy, we are obliged to ensure that funding comes increasingly from fee income from the providers we regulate, while actively seeking ways to improve our efficiency, including making improvements to our operating model.

» Proposal 1: The 2016/17 fee scheme

For 2016/17, we are proposing two alternative fee schemes, designed to move CQC to compliance with government policy over either two or four years, the details of which are set out below.

[5] www.cqc.org.uk/content/state-care-201415

As part of this proposal we also provide indicative figures for the increases in future years to 2019/20. As already described, figures for the years beyond 2016/17 are only estimates, but they provide some idea of the effect of the progression of both trajectories.

Option 1 – Recovery over two years between 2016-2018

Under this option, we propose to achieve full chargeable cost recovery over two years, between 2016-2018.

Rationale

A two-year timetable achieves full chargeable cost recovery across all sectors by the 2017/18 financial year and means larger percentage fee increases would be made relatively quickly. These increases will impact variably on the sectors, depending on their current levels of chargeable cost recovery, and are set against our existing budget figures and the current costs of our regulatory model.

If this option were implemented, we would satisfy HM Treasury policy requirements for achieving full chargeable cost recovery, and would significantly reduce our reliance on grant-in-aid. Providers would also have some information about likely fee charges for the next two financial years, and could plan their financial forecasts using these assumptions.

If this policy is adopted, our estimates for fee charges in the second year may need to be adjusted should our budget or costs significantly change. This might be due to factors such as the outcomes of our budget negotiations and the Spending Review, the future scope of our activity, the developments we plan to make within our new five-year strategy, and the efficiencies we are committed to making.

Advantages and disadvantages of this option are further described in our *Draft regulatory impact assessment*.

The full details of the estimated fee amounts are set out in Annex A. Examples of estimated annual fees and the estimated differential impact by fee category under a two-year timescale, have already been shown in the Summary section on page 7.

Option 2 – Recovery over four years between 2016-2020

Under this option we propose to achieve full chargeable cost recovery over four years, between 2016-2020.

Rationale

A four-year timetable achieves full chargeable cost recovery across all sectors by the 2019/20 financial year. Fee increases would impact variably on the sectors, depending on their current levels of chargeable cost recovery, and are set against our existing budget figures and the current costs of our regulatory model.

If this option were implemented, it would take us longer to satisfy HM Treasury policy requirements for achieving full chargeable cost recovery. It would prolong the period we would have to continue to rely on grant-in-aid to fund a significant amount of our expenditure. However, providers would have lower fee increases than under the two-year model. They will also have some indication of likely fee levels for the next four financial years.

If this policy is adopted, our estimates for fee charges in the second, third and fourth years may need to be adjusted should our budget or costs significantly change in any year during this period. This might be due to factors such as the outcome of our budget negotiations, the future scope of our activity, the developments we plan to make within our new five-year strategy, and the efficiencies we are committed to making.

Advantages and disadvantages of this option are further described in our *Draft regulatory impact assessment*.

The full details of the estimated fee amounts are set out in Annex B. Examples of estimated annual fees and the estimated differential impact by fee category under a four-year timescale, have already been shown in the Summary section on page 8.

We ask respondents to consider both timescale options and indicate their preference for which one should be implemented by responding to the question below (repeated on page 29). In considering their preferred option, we also ask respondents to set out their views about other ways in which fee levels might be set in 2016/17 to those proposed in this consultation document. We will not make any decisions about what we will be recommending to the Secretary of State for his decision until we have reviewed all the responses to this consultation, so your views and comments are welcome.

Readers might also find it helpful to refer to Section 4, 'CQC's strategic direction for fees', before responding to this question.

Consultation questions

1. In setting fees for 2016/17, which of the two options for achieving full chargeable cost recovery would you prefer CQC to adopt (please select one option):

   Option 1 ❑ – recovery of the fees amount over two years between 2016-2018, as set out in Annex A, or

   Option 2 ❑ – recovery of the fees amount over four years between 2016-2020, as set out in Annex B?

2. Would you prefer CQC to adopt another option for setting fees for 2016/17? For example:
   - A different option for how and when CQC should achieve full chargeable cost recovery.
   - A different option on how we divide fees between different types of provider.

   Please explain what option you recommend to CQC and your reasons for proposing this.

Proposal 2: To maintain full chargeable cost recovery levels for the dental sector by decreasing their fees in 2017/18

Proposal

We propose to maintain full chargeable cost recovery levels for the dental sector by decreasing their fees in 2017/18.

Rationale

We have significantly remodelled the regulatory approach we take to inspecting and monitoring dental providers. This means that we plan to physically inspect 10% of dental locations every year, using our comprehensive methodology, with selection based on a balance between risk profiling and random selection. We will also carry out focused follow-up activity and take enforcement action where it is necessary to do so. At the same time, we will continue to monitor every year the remainder of the sector's locations that we have not physically inspected.

Our cost analysis for regulation of the dental sector shows that the sector is already at full chargeable cost recovery. While we have reduced the number of locations we schedule for inspection, we are continuing to develop the information base we expect to use to enable us to effectively monitor those providers who are not inspected. The costs of regulation include a proportion for physical inspection activity, but also include the costs of our ongoing monitoring activities including, in the case of the dental sector, the costs of establishing an effective intelligence base during 2016/17.

The fees for regulating dental providers will be held at their current rate in 2016/17, while we continue to develop the information base to effectively monitor the sector's performance. We expect costs to fall in 2017/18, as the full regulatory model of inspection and monitoring will have embedded by that time. Therefore, our second proposal is to decrease dental fee charges in 2017/18, maintaining that level until 2019/20 to maintain full chargeable cost recovery levels, as illustrated in the examples table below. Whether a two or a four year option is decided on under Proposal 1, this will have no material impact on the dental sector, as the decrease in their fees under Proposal 2 will take effect in the second year, 2017/18, and be maintained until 2019/20.

The full details of the estimated fee amounts are set out in Annex C. The table below illustrates as examples what the increase would mean in actual £ charges to individual providers in various/average fee bands in 2017/18.

Proposal 2 – Examples of estimated annual fees for 2017/18 (for full details, please see Annex C)

Fee category	2017/18		
	Example band size	**Effect of proposed decrease (from 2016/17)**	**Estimated annual fee**
Single location dentist	5 dental chairs	-£165	£935
Multiple location dentist	5 locations	-£600	£3,400

Consultation question

3. Do you agree with our proposal to maintain full chargeable cost recovery levels for the dental sector by decreasing their fees in 2017/18?

   Yes ❑

   No ❑

   Not applicable ❑

   If there are aspects of this proposal that you do not agree with, please explain why.

4. CQC's strategic direction for fees

This section covers:

- Our strategic approach to regulation, and fees
- Measuring our costs and resourcing our regulatory approach
- Flexible payments
- Fee charges for making applications to register or to vary conditions, and
- Associated Department of Health consultations

1. Our strategic approach to regulation and fees

In 2013, we launched *Raising Standards, Putting People First* – a three-year strategy introducing our new approach to regulation, which saw unprecedented changes in the way we carry out our role. We are now developing our new five-year strategy, which will set out our vision for health and adult social care quality regulation in the future and which will be published in Spring 2016. Our new strategy will focus on how we can refine our approach to be even more efficient and effective, as well as flexible and responsive to new models of care. We intend that it will be a vision for the future of quality regulation, more than just an organisational strategy.

As the new strategy develops and throughout its implementation, we will consider fully the impact on the costs of regulation of these areas above, and will continue to monitor costs closely as the changes we make to our approach become embedded over time. We will continue to use our costing, performance and evaluation evidence to ensure that we make the best use of the information that is available to us. This will help us to deploy our teams as efficiently as possible, and make sure that we are effective and can demonstrate our value for money.

Our strategic direction for fees will continue in parallel with our five-year strategy. We are positioning fees as a charge to enter and remain in a regulated market. The main rationale for positioning fees in this way is to avoid complexity. While fees charges will remain differentiated between sectors, certain core principles, such as fairness and simplicity, will be consistent in each. Our fees will continue to be linked directly to the total cost of regulation, with the cost primarily at sector, or sub-sector, level rather than at provider level. We will continue to identify the provider characteristics that are the major drivers of cost, such as size, in order to apportion fees fairly among providers.

We are required to change the current balance of our reliance on grant-in-aid to fund a large percentage of our chargeable activities to one where the income for these is recovered from providers, and have set out in this consultation the timescale options to achieve that change. While the balance will change in relation to funding our chargeable costs, our overall income will always be sourced partly from grant-in-aid and partly from provider fees.

Our new strategy will reinforce our role in a changing health and adult social care environment and our fees strategy will play a fundamental part in ensuring our resources are balanced appropriately between income from fees and grant-in-aid.

2. Measuring our costs and resourcing our regulatory approach

We have set out in this document that the current levels of chargeable cost recovery are not sustainable as they are not in line with government policy for regulators to meet the full chargeable costs of their activities through fees.

We described in our last consultation how we were strengthening our methods to collect activity information and measure the costs of the new regulatory approach – these are an important part of our evaluation programme, and how we assess our value for money. We are continuing to embed collection methods for our direct costs, review our indirect costs and overheads, and develop better procedures for managing our costs.

This programme is helping us to improve our understanding of the costs of our approach, and to forecast our resource requirements more accurately. It is also helping us underpin the shift we are required to make from our current reliance on grant-in-aid funding to our chargeable income being funded by fees from providers.

We also continue to actively engage with the members of our Fees Advisory Panel, who represent all the sectors we regulate, in discussions about how we measure and evaluate our costs and translate those into proposals for fee charges.

3. Presenting the increases – absolute values or percentages

This consultation document presents information about the proposed and estimated increases in fees in absolute values rather than in percentage terms. We have only used percentages when we are comparing changes year on year at the fee category level. Responses to previous consultations suggest that providers will judge increases on what they mean to them in percentage terms. Given this, it is important to address why we have predominantly used absolute values in this consultation.

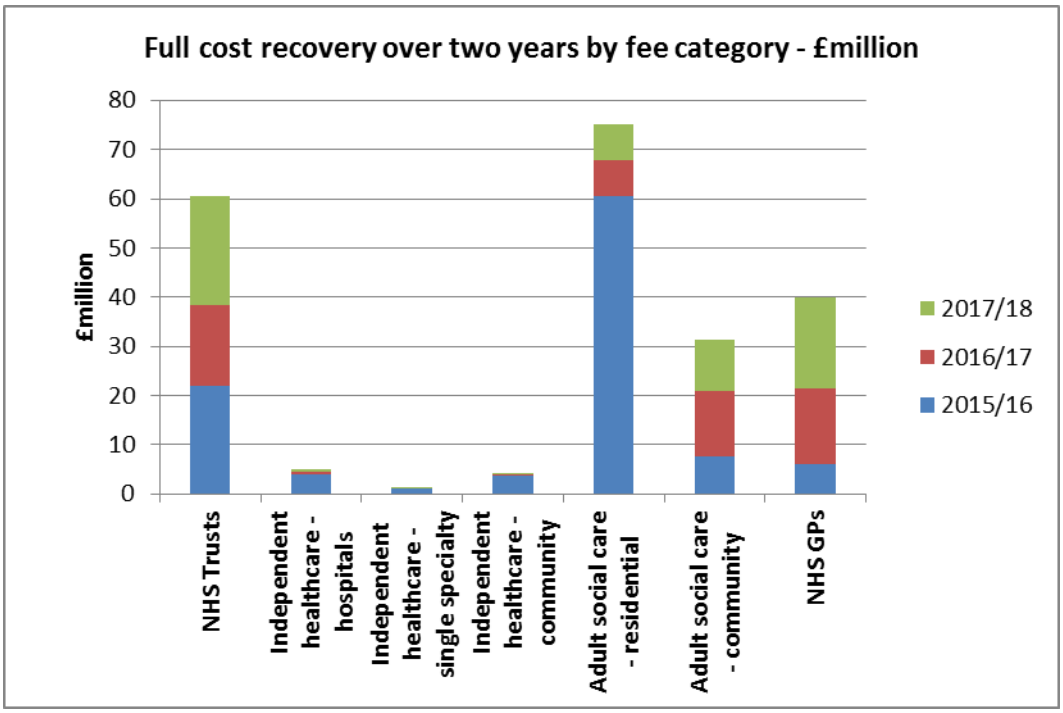
We consider that absolute values more clearly show the actual £ impact of increases, whereas percentages are relative and can give a misleading perspective. This is particularly important in the current situation of the individual sectors being at very different distances from reaching full chargeable cost recovery. We give an example to illustrate this below.

The NHS GP sector overall is currently at 15% cost recovery, compared to 81% for the adult social care residential (ASCR) sector. NHS GPs are the most recent provider group to come in to regulation (in April 2013). The fee charges for the sector that year were set at an estimated 50% of what we expected the cost of regulating the sector to be. As costs have risen, the sector has fallen further back in cost recovery terms. ASCR providers, in contrast, have been

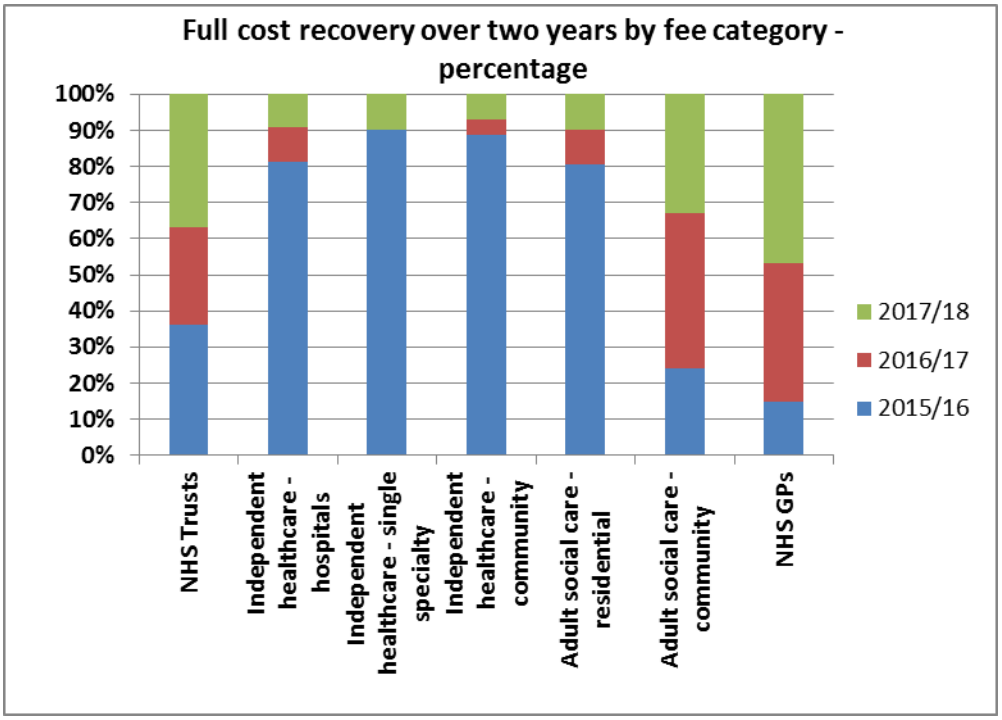
regulated and paying fee charges for over a decade and, having been subject to fee increases over time, are much closer to cost recovery than other sectors. So, moving NHS GPs to full recovery over a two or four year period requires relatively larger percentage increases than in ASCR over the same timescales. Using percentages as a value can make this look unfair for NHS GPs, as their percentage increases over two years (2016/17 and 2017/18) are 255% and 85% compared to 12% and 11% respectively for ASCR providers. We can only make sense of this when looking at the starting point for both sectors, so percentages do not help here.

We have decided not to present both percentages and absolute values in all the illustrative tables as this would swamp the consultation document with too much detail. However, we have set out below what the increases look like in both absolute and percentage terms for each category, for both options.

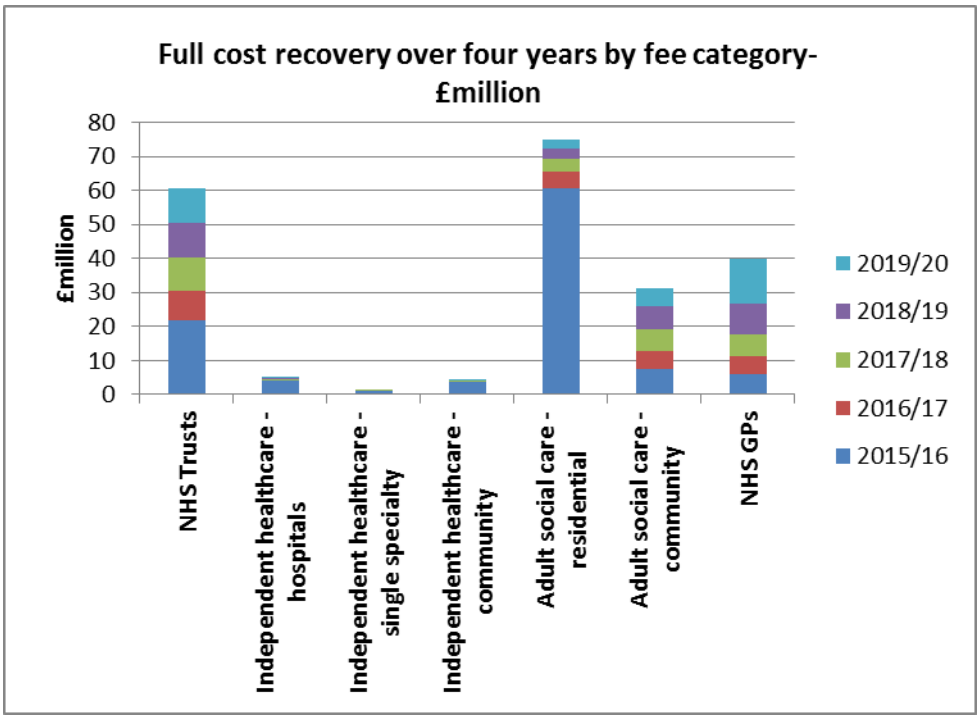
The chart below shows the current levels of fees income in £ from each of the fees categories, and the estimated amount of income that would be required to meet full chargeable cost recovery under a two year timescale:



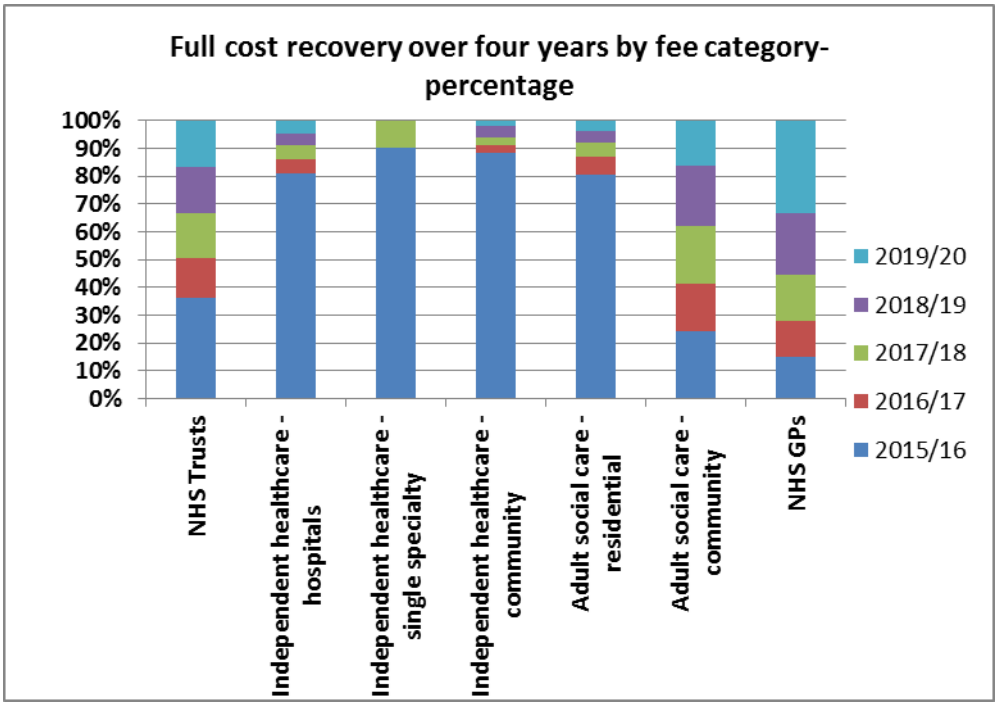
The chart below shows the current level of cost recovery in per cent from each of the fees categories, and the estimated percentage increases that would be required to meet full chargeable cost recovery under a two year timescale:



The chart below shows the current levels of fees income in £ from each of the fees categories, and the estimated amount of income that would be required to meet full chargeable cost recovery under a four year timescale:



The chart below shows the current level of cost recovery in per cent from each of the fees categories, and the estimated percentage increases that would be required to meet full chargeable cost recovery under a four year timescale:



The charts illustrate that it is difficult to make both absolute increases and percentage increases uniform year on year. We have modelled our fee proposals for 2016/17 and the estimated charges for subsequent years to ensure that neither absolute nor percentage increases are extreme, resulting in small variations in the size of increases year on year.

4. Flexible payments

We introduced a facility for paying fees by instalments starting with providers who were invoiced in June 2015. This had been a longstanding request from providers to help them balance their cash-flow. This is being rolled out to providers as their invoices are raised and all providers will have been offered this option by May 2016. At the time of preparing this consultation, 30% of providers, where the offer of this facility has been made, have signed up to take advantage of it. Further information about how to register for flexible payments is available on our website at:
www.cqc.org.uk/content/payment-instalment

5. Fee charges for making applications to register or to vary conditions

Our strategic approach to regulation over the last three years included the development of our model for controlling entry to the health and adult social care market. This included having tougher, more rigorous checks on new providers who want to register for the first time, as well as for existing providers who want to vary their conditions of registration.

Following on from proposals we first set out in 2013, our latest key document – *A Fresh Start for Registration* – sets out the improvements we are making to further strengthen our approach to registration, which is the first legal step of our regulatory process. Our document sets out how we determine who is able to enter the regulated health and adult social care market, and the steps we will take when cancelling or placing conditions on a provider's registration when required. Our vision for the future of registration as part of our approach to regulation will be embedded within our new five-year strategy from 2016.

In our last fee consultation we said that we intended in future to re-introduce separate charges for applications to register and vary conditions of registration. This was partly to provide an incentive for applicants to provide high quality applications that demonstrate that they will be able to meet fundamental standards of care.

However, given that we are embarking on an improvement programme for our registration model, and this is at early stages of development, we are not yet in a position to develop firm proposals for consultation, but will do so in due course.

6. Associated Department of Health consultations

The Department of Health will be publishing two consultations during the autumn which have a bearing on fees, one which will propose making minor changes to the scope of providers who need to be registered with CQC, and a second, which will propose extending CQC's fee-setting powers.

Review of Regulations
The Department's Review of Regulations consultation, to be published in autumn 2015, will propose a number of amendments to existing regulations so that certain providers would be exempted from the need to register with CQC, while others would come into the scope of regulation. Several new exemptions will be proposed, some will be removed and some regulations will be amended to provide a clearer definition about which providers must register. Subject to regulations coming into effect, there may be an impact on fee charges for affected providers which we will review at the appropriate time.

Regulations to clarify the scope of CQC's fee setting powers
Our current powers to set fees extend only to our registration functions under Chapter 2 of the 2008 Act, where our activities fall into the scope of cost recovery through fees. Our registration functions include our comprehensive inspections which are used for a number of purposes, including assessing whether providers are breaching their registration requirements, rating the quality of providers' performance and gathering evidence for potential enforcement activity. However, there are parts of our regulatory work that are not recoverable through fees, such as charging for ratings, as these fall into Chapter 3 of the 2008 Act.

In order to provide clarity about the scope of our fee-setting powers, the Department of Health will be consulting on making changes to regulations. We advise providers to look out for both of these consultations on the Department of Health's website:
www.gov.uk/government/organisations/department-of-health

5. How to give us your views

The questions we have asked about fees from April 2016 for providers that are registered under the Health and Social Care Act 2008 are:

1. In setting fees for 2016/17, which of the two options for achieving full chargeable cost recovery would you prefer CQC to adopt (please select one option):

   Option 1 ❑ – recovery of the fees amount over two years between 2016-2018, as set out in Annex A, or

   Option 2 ❑ – recovery of the fees amount over four years between 2016-2020, as set out in Annex B?

2. Would you prefer CQC to adopt another option for setting fees for 2016/17? For example:

   - A different option for how and when CQC should achieve full chargeable cost recovery.
   - A different option on how we divide fees between different types of provider.

   Please explain what option you recommend to CQC and your reasons for proposing this.

3. Do you agree with our proposal to maintain full chargeable cost recovery levels for the dental sector by decreasing their fees in 2017/18?
   - Yes ☐
   - No ☐
   - Not applicable ☐

   If there are aspects of this proposal that you do not agree with, please explain why.

Please send us your response by noon on 15 January 2016

You can respond to our consultation in three ways:

Online
Use our online form at **www.cqc.org.uk/FeesConsultation2015**

By email
Email your response to **feesconsultation2015@cqc.org.uk**

By post – write to us at:
Freepost RLYL-HLLY-ZTJS
Fees Consultation 2015
Care Quality Commission
Finsbury Tower
103/105 Bunhill Row
London
EC1B 1QW

Annex A – Table of estimated fee charges by fee category over two years

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 Schedule 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

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 B – Table of estimated fee charges by fee category over four years

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

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.

Annex C – Table of estimated fee charges for dental providers

Fees trajectory over two financial years

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		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 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

Fees trajectory over four financial years

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		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 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

Annex D – Key principles for setting fees

We work to key principles to guide how we set fees. These reflect the principles for managing public resources and the standards expected of public service bodies, set out in HM Treasury's guide to Managing Public Money.

	Guiding principles	Key actions
1	**Demonstrate fairness and proportionality**	• Involve stakeholders in advising on how to distribute charges and grant-in-aid, and on reasonableness of charges. • Balance providers' different situations, including their size, complexity and inherent risk, with our income requirements and the government requirement for full recovery of chargeable costs.
2	**Reflect costs**	• Ensure we use an evidence-based approach that is derived from a better monitoring of costs, so that our charges increasingly reflect in more detail the costs of our activity.
3	**Make fees simple**	• Make the structure of fees as intuitive as possible, so they are seen to relate to costs.
4	**Be transparent**	• Build the approach from an open discussion about CQC's actual costs. • Involve stakeholders openly and on an ongoing basis.

Annex E – Our fee-setting powers

Our powers for setting fees[6] 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 only 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.

We do not currently have powers to set fees for any of our activity associated with our functions other than registration, as these fall under different parts of the 2008 Act. We could not include charges for these functions within our annual fee unless the Secretary of State agrees to make regulations to extend our fee-setting powers. The Department of Health is consulting on proposals which will clarify our legal powers to include a fee for other charges within our fees scheme, should we choose to exercise that power. See also section 4 (6) – Associated Department of Health consultations.

[6] See Annex F.

Annex F – 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 G – Protecting your rights

Following the Code of Practice
This consultation follows the Cabinet Office Consultation Principles. In particular we aim to:

- Consult widely throughout the process, allowing sufficient time for written consultation at least once during the development of the policy.
- Be clear about what our proposals are, who may be affected, what questions we want to ask and the timescale for responses.
- Ensure that our consultation is clear, concise and widely accessible.
- Ensure that we provide feedback regarding the responses received and how the consultation process influenced the development of the policy.
- Monitor our effectiveness at consultation, including through the use of a designated consultation coordinator.
- Ensure our consultation follows better regulation best practice, including carrying out a regulatory impact assessment if appropriate.

Confidentiality of information
Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), 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/FeesConsultation2015

By email

Email your response to:
feesconsultation2015@cqc.org.uk

By post

Write to us at:
Freepost RLYL-HLLY-ZTJS
Fees Consultation 2015
Care Quality Commission
Finsbury Tower
103/105 Bunhill Row
London
EC1B 1QW

Please contact us if you would like a summary of this document in another language or format.

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Phone us on: 03000 616161

Email us at: enquiries@cqc.org.uk

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