Regulatory fees from April 2016

Final regulatory impact assessment

This final regulatory impact assessment has been published alongside *Regulatory fees from April 2016 under the Health and Social Care Act 2008 (as amended): Our response to the consultation.* We suggest that stakeholders 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 fee scheme from April 2016.

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. Like many public regulatory bodies, CQC is required by government to set fees in order to cover the costs of its functions.

3. CQC consulted on proposals to modify the current fee scheme in the consultation: *Regulatory fees – have your say*. We published an initial regulatory impact assessment alongside this consultation which provided stakeholders with 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 2016.

Background

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 to recover chargeable costs of the services we provide through fees over a reasonable time period.

8. CQC's total revenue budget for 2015/16 was £249.3 million, of which £4.9 million was allocated to Healthwatch England, so we were operating with resources of £244.4 million. The budget is derived from a combination of grant-in-aid and income from fees paid by providers (£113.5 million or 50.6% of the total). Of our operational resources, £224.4 million related to our registration functions under the 2008 Act and £20.0 million to other functions.

9. The £20.0 million covered activities that we are not able to recharge as fees and include our regulation under the Mental Health Act 1983, the Office of the National Freedom to Speak Up Guardian, our enforcement and thematic review work, and the work we are undertaking on Market Oversight. These are all funded by grant-in-aid.

10. We increased fees for 2015/16 by 9% from the previous year for all sectors, except the dental sector. This signified our intent of moving to full chargeable cost recovery within a reasonable time frame as required by HM Treasury. It was also a pragmatic decision while we were developing the methodology to identify the costs of the new regulatory approach for each sector. Appendix 3 outlines our costing methodology and the development of the costing model.

11. The increase in fees for 2016/17 builds on that foundation. The sectors vary on how close they are to full chargeable cost recovery and so the increase in

2016/17 is differentiated by sector to ensure that all sectors will reach this position at the same time. This is detailed in Appendix 1.

12. The fee increases are a reflection of the 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. In future CQC's overall budget will reduce as a result of the savings required by the Department of Health under the Spending Review. Table 1 shows CQC's total indicative budget broken down by grant-in-aid for non-recoverable services and provider fees over the four years of the Spending Review (2016/17 to 2019/20). This is in line with the indicative budget negotiated with the Department of Health. The indicative budget is further broken down by sector in Appendix 1 with actual figures shown for 2015/16 and indicative figures for 2016/17 to 2019/20.

13. Further details of the impact of the Spending Review on CQC are provided in paragraphs 23-25.

Response to increasing fees

14. We asked three questions in our consultation. The first and second, regarding options for achieving full chargeable cost recovery over two or four years respectively, impact on all providers except for the dental sector. The third question impacts only on dental providers which had already reached full chargeable cost recovery. The overwhelming majority of responses to the first two questions confined their views to these two proposals and expressed a preference for the second of these two options.

15. The responses were broadly grouped around three issues:
    - Serious concern at the scale of the increases, irrespective of the options for their implementation, and corresponding concern about their impact on quality of care and sustainability of services.
    - The timing of our fee proposals against the consultation on our five year strategy and the Department of Health's parallel consultation to extend our fee-setting powers through new regulations.
    - Positive comments and criticism about CQC's effectiveness, efficiency and value for money.

16. Greater detail is provided in the consultation response document and the detailed report analysing responses, which are available on our website.

17. The two sectors furthest from full chargeable cost recovery are NHS GPs and the community social care sector. Their fees in 20161/7 would see the steepest increase of all sectors under a two year trajectory. We had full and detailed discussions with the Department of Health about the totality of all the responses we received. The Government has recently announced additional funding to cover the expense of the required increase to fees for NHS GPs in 2016/17, and we have agreed that the impact of increases for the community social care sector

should be mitigated by setting fees for 2016/17 in the context of those proposed under a four year trajectory.

18. Therefore, on this basis, we invited the consent of the Secretary of State to allow CQC to charge fees in 2016/17 based on the two year trajectory towards cost recovery for all providers except for community social care and dental providers. Given the absolute requirement on us to achieve full chargeable cost recovery, the significant gap in funding that would result from adopting a different option for 2016/17, and the impact that would have on delivering our statutory responsibilities in regulating health and social care services, the outcome is that, from 1 April 2016, we will:
    - Set fees for all providers, except community social care and dental providers, at the levels set out in our consultation under the two year timescale option,
    - Set fees for community social care providers at the levels set out in our consultation under the four year timescale option, and
    - Hold the current fee levels for dental providers at those set out in the 2015/16 fee scheme.

19. Looking at CQC's costs within the wider context of health and social care costs more generally, the overall indicative CQC budget is around 0.19% of the total amount spent on Health and Social Care in England. While this figure is not intended to diminish the importance with which any rises in fees are regarded by individual providers, it does demonstrate that the total amount spent on regulation is proportionately small. Individual fees are, for the majority, no more than 1% of a provider's turnover and in instances where a provider pays tax, then fees are tax allowable, so the differential rate of taxation, whether for a sole trader, partnership or company, will reduce that proportion further.

20. The launch in 2015 of a payment by instalments scheme has helped providers to manage the payment of fees in a way that does not impact cash flow as severely as a one-off payment does.

Strategy, Spending Review and cost improvement

A) Introduction

21. We are required by government to move to full chargeable cost recovery and have previously avoided such significant changes to fees while we embedded our approach to regulation. A number of providers have argued that we should wait until this is embedded before looking at how we move to full cost recovery for our regulation.

    We believe that identifying the budgetary constraints at an early stage helped focus and inform the strategy.

B) Strategy

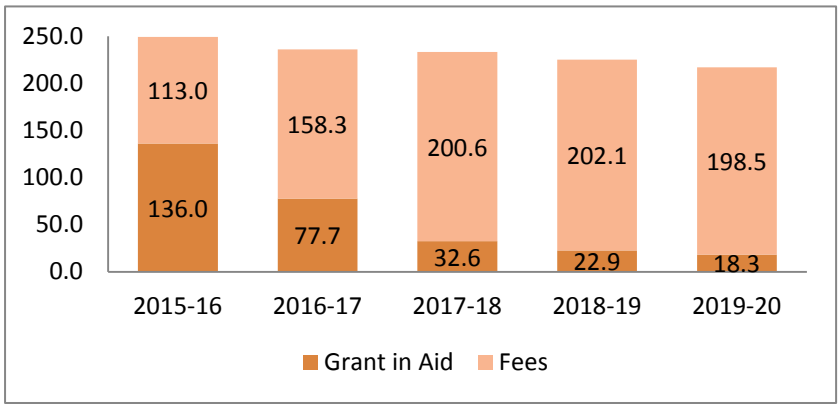
22. *CQC's strategy 2016 to 2021 shaping the future: consultation document* describes how we intend to deliver our vision with reduced resources by being more efficient and effective. We intend to improve the efficiency of our inspections and registration approach as we improve our use of intelligence, and our underlying systems and processes. As we develop our plans, we will set out what this means for the costs of inspection.

C) Spending Review

23. During 2015 the government's Spending Review resulted in significant reductions in funding to the public sector and CQC is no exception in having to make savings. CQC is required 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 next four years. We have modelled the impact of this and identified indicative budget levels for the remaining four years reducing the overall indicative budget to £217 million in 2019/20.

24. Table 1 shows graphically the impact of the Spending Review on CQC's indicative budget as submitted to the Department of Health. It also estimates the ratio of grant-in-aid and fees over each of the next four years with fees achieving full chargeable cost recovery by 2017/18 and overall indicative budgets going down to £217 million by 2019/20. Appendix 1 shows the estimated impact of the Spending Review on the sectors for the years 2015/16 to 2016/17.

Table 1: Graph showing ratio of grant-in-aid and fees for the period 2015/16 to 2019/20. Fees achieve full chargeable cost recovery by 2017/18 for all sectors and overall budgets go down to £217 million by 2019/20. Note the figures for 2016/17 and beyond are indicative only



25. The fees for 2016/17 are the same as those presented in the draft consultation document and they are in line with the indicative Spending Review budget provided to the Department of Health. 2017/18 to 2019/20 figures are lower than presented in the draft consultation document as they now reflect the settlement submitted following the Spending Review set out in table 1.

D) Cost improvement

26. The strategy identifies that although we have introduced fundamental changes to our model of regulation over the past three years, many of the supporting processes and systems we use need to be more efficient. We believe we can make significant savings over the next five years by improving these processes and systems, including greater use of new technologies to help us identify and reduce waste and duplication, and to standardise our core activities. The strategy document provides examples of these technologies such as the CQC provider portal, national resource planning tool, CQC website developments, IT infrastructure, and data analysis tools.

27. A cost improvement programme is also being introduced to CQC. This will ensure that both recurrent and non-recurrent savings are identified. The programme will focus on realising significant savings through commercial strategies, and then moving into efficiencies in the way in which we deliver inspection in years two to four of the Spending Review. Work has already begun in some areas of the organisation to modernise ways of working and, as we do so, there will be structural changes to help release costs from the organisation. We expect that we will be doing much more of this in the next period covered by the strategy.

28. Fees for years beyond 2016/17 are indicative and are based on our current understanding of costs. They will change as a result of the implementation of the CQC strategy with the various initiatives and system improvements described, as well as our improved understanding of costs. Despite this, it is important that we map out what the future is likely to look like, while acknowledging that the actual figures for future years may vary either because of changes to costs or as a result of any changes made to the fees scheme in future years.

Impact on providers

29. The consultation responses highlighted the financial difficulties that providers face, ranging from frozen or reducing income to increasing staff costs (such as the impact of the introduction of the Living Wage and increases in national insurance). The consultation response document and analysis report provides detail on this. These are available on our website.

30. Table 2 shows the actual fees for 2015/16 and the indicative increases for 2016/17.

Table 2: Indicative fees increases for 2016/17

	2015/16 actual fee (£m)	2016/17 indicative increase (£m)
NHS trusts	21.9	16.4
Independent healthcare - hospitals	4.0	0.5
Independent healthcare - single specialty	1.2	0.0

Independent healthcare - community	3.8	0.2
Adult social care - residential	60.5	7.3
Adult social care - community	7.5	5.4
NHS GPs	6.0	15.3
Dentists	8.3	0.0
	113.2	**45.1**

We considered our proposed fees against the estimated value of each market sector (Table 3). As we have stated before, our fees will represent 0.12% of overall indicative turnover of the health and social care market although this varies between sectors. We will review the impact on each sector in turn.

31. The proposed fees for the NHS trust sector corresponds to a very small part (0.04%) of typical turnover and such small comparative increases do not impact the sector disproportionately. The cost of regulation for this sector is the lowest percentage of indicative turnover but, as described in Appendix 3, fees are based on the underlying costs of regulation.

32. The independent sector is a small and varied one consisting of hospitals, community and single specialty providers, and we are conscious that because of this our modelled costs could be more sensitive to change than larger sectors. We are implementing a small overall increase for this sector and an average fee of 0.18% of turnover. Within this, we feel that 'independent healthcare - single specialty' is particularly vulnerable to the apportionment of indirect costs and overheads, as this group consists of a few smaller providers and so we have decided to leave their fees at 2015/16 values.

33. The fees for dental providers will be held at their current rate as under the current model the chargeable costs for this sector are at full cost recovery. Those costs will remain the same during 2016/17 and the costs of regulating this sector are expected to fall after that.

34. The fee for 'adult social care – residential' providers will be 0.45% of average indicative turnover. This sector has been at a higher level of recovery than all other sectors for a period of time, so the increases are in line with this position.

35. The fee for 'adult social care - community' providers will represent 0.29% of average indicative turnover of their sector. As noted in the draft regulatory impact assessment, 'adult social care - community' costs are higher than previously identified due to a flaw in the former costing model, so the sector is at a lower rate of cost recovery than previously understood. Because of this, providers asked us to consider recommending a longer trajectory than other sectors. We have introduced a lower fee increase for community social care providers by implementing fee amounts in the context of those we proposed in our consultation under a four year trajectory.

36. The NHS GPs sector fee increase represents 0.23% of average turnover of their sector and they are furthest from full chargeable cost recovery.

Table 3: Impact of 2016/17 fees on provider sectors	Value of market £m	% of FCCR	2016/17 fee	% of turnover
NHS trusts	90,300	67%	38.3	0.04%
Independent healthcare - hospitals				
Independent healthcare - single specialty				
Independent healthcare - community	5,308	98%	9.7	0.18%
Adult social care - residential	14,901	96%	67.8	0.45%
Adult social care - community	4,500	44%	12.9	0.29%
NHS GPs	9,100	56%	21.3	0.23%
Dentists	5,730		8.3	0.14%
Total indicative value of market (£m)	**129,839**		**158.3**	**0.12%**

FCCR: full chargeable cost recovery

See Appendix 2 for reference data

37. The decision is to charge fees in 2016/17 fees in the context of those we proposed under the two year trajectory towards full chargeable cost recovery for all providers except for community social care and dental providers. This option provides a balance in our funding that fulfils government policy and also allows us to safeguard our position as an independent regulator of the health and adult social care sectors by allowing us to implement our strategy and our new model of regulation in full in a timely way. This would mean greater responsiveness to providers and continued assurance to users, their carers and the general public of the quality of services provided by regulated providers.

38. We will ensure that we remain accountable to providers and the public for how we use our income, and demonstrate that our judgements are independent and we are fair, efficient, effective and proportionate. In this context we estimate that the current indicative budget for CQC is approximately 0.19% of the overall spending on health and social care in England and we estimate it will reduce to 0.17% by 2021 using the current market valuation.

Developing the fees scheme

39. 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.

40. We need to undertake a review of our fees structure for each area so 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.

41. Feedback from the consultation suggested that some of the bands were too wide or the fee increases from one band to the next too large. It was suggested that the boundaries were arbitrary or unfair, with some reasoning that practices would limit their patient numbers to remain in a more advantageous band. Fees based on a provider's number of locations were questioned as some felt that the number of locations was not synonymous to size. Some felt that it would be fairer if charges reflected providers' size measured in numbers of clients, numbers of beds or hours of care delivered. Others thought the most appropriate measure would be providers' number of employees, turnover or profit. There were a few calls for a fixed, basic fee for small providers, which could be accompanied by additional fee bands for medium-sized and large providers. A few respondents suggested a cap on the total fee based on a (small) percentage of a provider's turnover.

42. From next year we will undertake a systematic review taking into account the above points and provider comments.

Final decision

43. Set fees for all providers, except community social care and dental providers, at the levels set out in our consultation under the two year timescale option.

44. Set fees for community social care providers at the levels set out in our consultation under the four year timescale option.

45. Hold the current fee levels for dental providers at those set out in the 2015/16 fee scheme. The 2016/17 fee band tables can be found in the published fee scheme.

Appendix 1: Grant-in-aid and Fees by sector for 2015/16 and 2016/17

	2015-16					2016-17			
	GIA	Fees	Total	% FCCR		GIA	Fees	Total	% FCCR
	£'M	£'M	£'M			£'M	£'M	£'M	
NHS Trusts	38.1	21.9	60.0	36%		18.3	38.3	56.6	67%
Independent healthcare - hospitals	0.9	4.0	4.9	81%		0.2	4.5	4.7	96%
Independent healthcare - single specialty	0.1	1.2	1.3	90%		0.1	1.2	1.3	96%
Independent healthcare - community	0.5	3.8	4.3	88%		0.1	4.0	4.1	98%
Adult social care-residential	14.1	60.5	74.6	81%		2.6	67.8	70.3	96%
Adult social care-community	23.7	7.5	31.2	24%		16.5	12.9	29.4	44%
NHS GPs	33.8	6.0	39.8	15%		16.3	21.3	37.6	56%
Dentists	0.0	8.3	7.0	119%		0.0	8.3	8.3	119%
Total indicative budget for chargeable work	**111.2**	**113.2**	**224.4**	50%		**54.0**	**158.3**	**212.2**	75%
Non-Chargeable Work	24.9	0.0	24.9			23.8		23.8	
Total indicative budget	**136.1**	**113.2**	**249.3**	**45%**		**77.7**	**158.3**	**236.0**	**67%**

Key:
FCCR = Full chargeable cost recovery
GIA = Grant-in-aid

Note on accounting treatment of figures:
Fees in this document are shown on an invoiced basis as this reflects the actual impact on the health and social care sectors. We report fees on an accruals basis to the Department of Health. This means that we estimate reported income for next year will be £7 million lower than the invoiced total. The total indicative budget shown represents the budget that we expect to be our total cost target. Therefore grant-in-aid represents the balancing figure and will be £7 million higher than shown through the impact assessment.

Appendix 2: References

	Value of market £m	Information source
NHS trusts	90,300	http://www.health.org.uk/sites/default/files/APerfectStorm.pdf page 9: Figure 1.1: Resource spending in real terms in England, 2014/15
Independent healthcare - hospitals		Commission on the Future of Health and Social Care in England The UK private health market and https://www.laingbuisson.co.uk/MediaCentre/PressReleases/PrivateAcute.aspx
Independent healthcare - single specialty		
Independent healthcare - community	5,308	
Adult social care - residential	14,901	Laing and Buisson Care of Older People 27th Ed. (2014/15).
Adult social care-community	4,500	Laing and Buisson Domiciliary Care UK market report 2013
NHS GPs	9,100	http://www.health.org.uk/sites/default/files/APerfectStorm.pdf page 9: Figure 1.1: Resource spending in real terms in England, 2014/15
Dentists	5,730	Dentistry An OFT market study 01/05/2012
Total indicative value of market (£m)	**129,839**	

Appendix 3: Costing methodology and development of the costing model

1. Our costs are divided into direct costs, indirect costs and overheads. Direct costs result from activity directly related to our inspection activity and can be allocated at provider level (though we rarely do that). Indirect costs result from activities that can be apportioned to a particular sector, but cannot be allocated to specific providers. Overheads cannot be allocated to specific sectors and so have to be apportioned using appropriate measures (as an example, IT 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.

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

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

4. This gives us a fully absorbed cost for each of the inspection directorates. Knowledge of our model of regulation, backed up with data collected from timesheets (or the national resource planning tool, once it is implemented) provides the detail that allows us to allocate costs to each category of fees. This provides the total chargeable cost for each sector, as well as the cost of non-regulatory and non-chargeable activity.

5. The model began as a relatively simple model which provided high level sector costs and this has been used as the basis for the fees consultation. Significant further work and development has been undertaken in the last six months and a more detailed granular model has evolved. The assumptions and outputs from the model have been rigorously tested, and continue to be reviewed by directorates on a quarterly basis in line with the refreshing of the data and the approach refined in order to ensure that the model is as accurate a representation of the underlying costs as possible. This process ensures we have a good model that is able to monitor both our performance and value for money. With improved efficiencies and predicted changes in CQC strategy, future years' budgets and forecasts will be used in a version of the model to monitor expected activity costs for future years. This will assist in modelling future years' fee projections as well as business planning. Additional development will include reporting costs regionally, allowing Directorates to identify high performing regions and benchmark performance within other regions.

6. There are various methods that could be have been used to calculate fees using these fully absorbed costs. We have positioned fees as a charge for entering and remaining in a regulated market. There is a range of ways we could have charged providers, from the simplest where every provider pays the same fee, to the most complicated and bureaucratic approach which could be a fee based on

the exact resources utilised by each provider. We have taken a more nuanced approach where we have characterised providers and grouped them into sectors which are of similar size and complexity and which are regulated in similar ways. Within these sectors we have tried to band providers for fee charging purposes in ways that reflect the characteristics of that particular market combined with ease of collecting the required data. We have tried to charge appropriately to their size. We believe that this balances fairness with ease of implementation. It recognises that different methodologies, and hence different costs, do apply to different sectors.