

Council, 4 December 2014

Response to Department of Health consultation on the Professional Standards Authority (PSA) fee.

Executive summary and recommendations

Introduction

The Department of Health recently consulted on draft regulations to change the way in which the Professional Standards Authority for Health and Social Care (PSA) is funded.

The proposal, if implemented, would mean that the nine regulators overseen by the PSA would fund the statutory functions of the PSA. This was announced in 2010 as part of the review of the Arm's length bodies overseen by the Department of Health. The fee would be apportioned between the regulators on the basis of registrant numbers.

The consultation closed on 28 November 2014. The HCPC's response to the consultation and a copy of the consultation document are appended.

In 2011, CHRE (now the PSA) sent to the regulators a discussion paper which set out the possible methods for apportioning the fee. This is referred to in our consultation response and is also appended for information.

Decision

This paper is to note; no decision is required.

Background information

None

Resource implications

None

Financial implications

There are no financial implications as a result of this paper. However, the proposals made in the consultation, if implemented, would have financial implications for the HCPC (as set out in the response).

Appendices

- HCPC response to Department of Health consultation on 'Professional Standards Authority for Health and Social Care - Draft fees regulations'.
- Department of Health (2014). Professional Standards Authority for Health and Social Care – Drafts fees regulations.
- Council for Healthcare Regulatory Excellence (2011). Proposals for calculating the statutory levy.

Date of paper

26 November 2014

25 November 2014

Health and Care Professions Council response to Department of Health consultation on ‘Professional Standards Authority for Health and Social Care – Draft fees regulations’

The Health and Care Professions Council welcomes the opportunity to respond to this consultation.

The Health and Care Professions Council (HCPC) is a statutory regulator of health, social work and psychological professions governed by the Health and Social Work Professions Order 2001. We regulate the members of 16 professions. We maintain a register of professionals, set standards for entry to our register, approve education and training programmes for registration and deal with concerns where a professional may not be fit to practise. Our main role is to protect the health and wellbeing of those who use or need to use our registrants’ services.

1. Overall comments

- 1.1 We have set out our response to the individual consultation questions below.
- 1.2 Overall, we disagree with the method put forward in the consultation for apportioning the Professional Standards Authority (PSA) fee, on the basis that it would unfairly and perversely penalise us for keeping registration fees low, and because other options to that proposed appear not to have been considered fully or at all.
- 1.3 We would observe more generally that the consultation document does not address the methodology that will be used in ensuring that the nine regulators of health and care professionals will only pay for those functions of the PSA which directly relate to them. Having a clear understanding of this methodology is important for ensuring confidence in the new arrangements, particularly in relation to those functions to be funded by the fees paid by the regulators, but only ‘in so far as such work related to regulatory bodies’ (pages 11 and 12).
- 1.4 We would expect as a minimum that in its annual report and accounts the PSA will need to provide detailed information about the methodology used in apportioning the fee, for example, how it has allocated employee costs and overheads to each of its functions.
- 1.5 We would further note that the consultation document is silent on what accountability arrangements would be put in place to ensure that, with the change from Department of Health funding, the PSA’s budget continues to be set at a proportionate level necessary to achieve its statutory functions, and that the PSA continues to provide ‘value for money’. The impact assessment uses a range of £3.9m to £8.5m as the annual savings achieved by changing the basis

of funding, suggesting perhaps that the PSA's spending is expected to increase, with the lower end estimate higher than the PSA's reported expenditure for 2013-2014. Any increase in the PSA budget will have an impact on the regulators and the fees charged to registrants.

2. Specific questions

Question 1: Do you agree that the functions listed in Table 1 should be covered by the fee? Please provide the rationale behind your response and any amendments to the included functions you would suggest.

Yes, we agree.

We are content that the consultation document has identified those functions of the PSA which relate to its statutory role in overseeing the nine statutory regulators of health and care professionals.

However, please see our comments in section one about a lack of information in the consultation document as to the methodology which will be used to ensure that the PSA's costs are apportioned correctly.

Question 2: Do you agree the functions listed in Table 2 should be excluded from the fee?

Yes, we agree.

We are content that the consultation document has identified those functions of the PSA which do not relate to its statutory role in overseeing the nine statutory regulators of health and care professionals.

However, please see our comments in section one about a lack of information in the consultation document as to the methodology which will be used to ensure that the PSA's costs are apportioned correctly.

Question 3: Do you agree that method 1 – apportionment of the fee according to the number of registrants - is currently the only viable option available for determining the fees? Please explain the rationale for your response.

We disagree. We have set out our rationale below.

Options appraisal

We are surprised that the consultation document and supporting impact assessment appears to fail to consider all the reasonable alternative options for determining the fee, or to explain why other potential alternatives have not been put forward for detailed consideration.

The consultation document and impact assessment fails to consider the following options.

- A method for apportioning the fee based on the income of the regulatory bodies. This method would be equally easy to understand and equally simple to calculate, based on equally available and reliable information, as method 1.
- A method for apportioning the fee based on some combination of registrant numbers and the income of the regulatory bodies. This method would be equally easy to understand and equally simple to calculate, based on equally available and reliable information, as method 1.
- A method for apportioning the fee based on operational metrics which would more fairly reflect the regulators' actual costs to the PSA, for example, the number of Section 29 referrals made to the High Court by the PSA for each regulator. Whilst we do not advance this option at this stage, as it may fail the 'easy to understand' consideration, there is no indication that the feasibility of this has even been considered, bar vague references in the consultation document to the (absence of sufficient) 'management information' (pages 13 and 14). We note that the Authority has 'committed to explore whether other management information may be used for determining the fees in the future' (page 13). However, there is no time period given for this commitment or for review of the regulations.

With respect to the first two options outlined in the bullet points above, these were previously considered in March 2011 as potential methods for determining the fee by the then Council for Healthcare Regulatory Excellence (CHRE; now the PSA).¹ We are therefore surprised that these options are not reflected in any way in the consultation document or in the impact assessment.

We further consider that those options that are put forward in the consultation have not been fully appraised. The consultation document and impact assessment justifies the Government's preferred method on the basis that it would meet the policy objective of reducing the cost to the taxpayer, whilst 'ensuring the fee structure would be easily understood and the smaller regulators would not be disproportionately impacted' (page 14). We do not dispute that these are valid considerations, but, as outlined above, the impact assessment fails to consider other options which would also achieve these aims. It further fails to consider the importance of the overall fairness of the proposals across all of the regulators, regardless of their size, and whether these proposals are consistent with the policy outlined in 'Enabling Excellence: Autonomy and accountability for healthcare workers, social workers and social care workers' (2011) and its challenge to the regulators to contain the cost of registration fees.

¹ Council for Healthcare Regulatory Excellence (2011). Proposals for calculating the statutory levy.

The consultation document says that method 1 is ‘compliant with HM Treasury Managing Public Money guidance’ (page 14). However, neither the consultation document nor the impact assessment provide any information about this guidance or how far other alternative options would also be compliant. Respondents are therefore provided with insufficient information to be able to reach an informed view about the preferred method.

We agree with the assessment in the consultation document that method two – whereby the fee would be determined through a combination of a fixed fee and a fee based on registrant numbers – is not a viable option because it would have a disproportionate impact on the smallest regulators.

Apportioning the fee based solely on registrant numbers

We consider that method 1, the preferred option, would have the effect of unfairly and perversely penalising the HCPC and our registrants.

We have been able to harness the benefits of economies of scale to achieve significant operational efficiencies. ‘Enabling Excellence’ set out the Government’s expectation that the regulators should ‘identify and secure significant cost reductions...and contain registration fees’ (page 11, paragraph 2.7). We have kept any increases in our registration fee to below inflation and the current registration fee of £80 per year is the lowest of all the nine regulators overseen by the PSA and 25% lower than the next lowest fee.

The proposed method for apportioning the fee is inconsistent with Enabling Excellence because it does not provide any reward for economies of scale already achieved, or any incentive to achieve further economies of scale in future. It would have a disproportionate impact on the HCPC compared to other regulators with smaller registrant numbers, but higher registration fees and therefore larger incomes. The CHRE has previously noted the ‘significant impact’ of this option on regulators such as the HCPC ‘with high numbers of registrants and low registration fees’ (CHRE 2011, page 6).

To illustrate this point, the impact assessment estimates that in year one the costs to the HCPC would be £0.8m and to the General Medical Council (GMC), with smaller registrant numbers, £0.6m. However, based on the most recent available data, the HCPC’s income to the nearest million was £25m and the GMC’s £95m.² To give another comparison, we calculate based on available data that the HCPC accounts for approximately 22% of the total number of registrants across all nine regulators but only approximately 10% of the total income from registration fees.

² Figures are based on HCPC reported income in the period 1 April 2013 to 31 March 2014 and GMC reported income for the year ending 31 December 2013.

Source: HCPC Annual report 2014 and GMC Annual report 2013
<http://www.hcpc-uk.org/publications/reports/index.asp?id=882>
http://www.gmc-uk.org/Annual_report_2013.pdf_57177544.pdf

The HCPC would therefore be in the unfair position of paying more despite having less income with which to meet the cost. We would therefore have less ability to absorb some or all of the costs as we might wish, without the need to pass this directly on to our registrants. Put simply – the proposed method means that regulators with less registrants, but with much higher fees and therefore higher income, will be in a much better position to absorb the cost without increasing pressure on existing fee levels.

Our preferred method – apportioning the fee based on income or on a combination of income and registrant numbers

We therefore propose that consideration should be given to apportioning the fee instead based on income or, alternatively, on some combination of income and registrant numbers. The latter would take account of both the need that the smaller regulators should not be disproportionately impacted, whilst ameliorating the perverse impact on regulators such as the HCPC with larger registrant numbers, but with lower incomes relative to those numbers. The CHRE previously concluded that a hybrid model would produce ‘a more distributive and proportionate outcome’, accommodating the ‘conflicting interests’ of a method based solely on registrant numbers or one based solely on income (CHRE 2011, page 6).

In our view income would provide a feasible proxy on which to base some or all of the fee and would meet the need set out in the consultation document to ensure that the fee structure was easily understood. It would also be relatively simple to administer.

Impact on the HCPC

If the Department of Health decides to progress the proposals as they currently stand, we would be forced to seek to make changes to our registration fees in order to pay the PSA fee. The impact on the HCPC of method 1 and of a fee based solely on income is estimated below. This is based on the lower estimate of £3.9m given in the impact assessment.

Number of registrants	Approximate income (£)	Estimated PSA fee based on registrant numbers (£)	% of income	Estimated PSA fee based on income (£)	% of income
322,021*	26,000,000**	860,000	3.3%	400,000	1.5%

* Figure from 2013-2014 PSA performance review report
 ** Approximate 2014-2015 forecasted figure
 N.B. Figures have been rounded

We have always sought to run the organisation on an efficient basis so do not have significant reserves from surplus budgets in previous years to draw on to absorb the cost of the PSA fee. We would have to pass on the cost to our registrants.

Each profession renews its registration every two years, staggered over a two year registration cycle. This means that it is a full two years before the HCPC realises the benefit of an increase in its fees. Therefore, if the current proposal was progressed, we may need to contemplate a more significant initial increase in order to ensure that we have sufficient funds to pay the PSA fee.

If the current proposal was progressed, we would request that Department of Health resources are allocated to supporting us in urgently progressing changes to our Rules which, by allowing us to reduce unnecessary costs, would ensure that we have sufficient income to pay the PSA fee, whilst minimising the impact, where possible, on registration fees.

Question 4: Do you agree that the regulations should specify that the demand for payment should include a period of notice?

Yes, we agree.

Question 4a: If so, do you agree that this period should be 15 days?

No.

Question 4b: If not please specify a different period and explain why it is preferred

We would suggest that 30 days would be a more appropriate period and more consistent with normal invoicing practice.

Question 5: Do you agree that interest due on late payment should be set as drafted?

Yes, we agree.

Question 6: Do you agree with the Department's assessment that the implementation of this policy will not have an adverse impact on equality?

No.

We consider that there will some impact on the basis of equality that is not considered in the impact assessment. There will be differences in the demographic and socio-economic profile of the different professions that each regulator regulates.

A large majority of our registrants are female and a significant proportion will work part time hours and will accordingly be lower paid. The proposed method of apportioning the

PSA fee is very likely to necessitate an increase in the registration fee and would therefore adversely impact upon this group of registrants with less ability to pay.

Question 7: Do you have any comments on the draft regulations?

No.



Department
of Health

Professional Standards Authority for Health and Social Care

Draft Fees Regulations

October 2014

Title: Professional Standards Authority for Health and Social Care - Draft Fees Regulations

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Consultation

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Regulatory Bodies
GPs
Nurses
Doctors
Pharmacists
Midwives
Chiropodists/Podiatrists
Dieticians
Royal Colleges
Social care providers
General Public
Patients

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Professional Standards Authority for Health and Social Care

Draft Fees Regulations

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Executive summary

- In 2010, the Department of Health (DH) conducted a review of its Arm's Length Bodies (ALBs) as part of the wider changes envisaged for the NHS and the drive to increase accountability and transparency across Government, while reducing the number and associated costs of public bodies.
- ***The Liberating the NHS: Report of the arm's-length bodies***¹ review found no compelling reason for the then Council for Healthcare Regulatory Excellence (CHRE), the body responsible for the oversight of the health professions regulators, to continue to be funded by the Government and Devolved Administrations.
- Instead, the review recommended that the CHRE be funded through a compulsory levy (or fee) on the regulatory bodies it oversees.
- The Health and Social Care Act 2012 provided for the CHRE to be renamed the Professional Standards Authority for Health and Social Care ("the Authority" or the PSA) and for the Authority to be funded in the main by the regulatory bodies.
- Subject to the approval of Parliament, the Privy Council must make regulations requiring each regulatory body to pay periodic fees to the Authority. The regulations must also set out the functions of the Authority to be included in the fee and the methodology for determining the level of fees to be paid by each regulatory body.
- This consultation seeks views on a proposed draft of these regulations, attached at Annex A.
- Subject to the response to this consultation and Parliamentary approval, we are aiming for the regulations to be laid in late 2014, to commence in early 2015 to facilitate the collection of fees relevant to the period from 1 April 2015 by the Authority.
- The consultation exercise will run for 8 weeks. The closing date for comments is 28 November 2014.
- Once the consultation has closed, we will analyse responses, finalise the proposals and (if required) draft amendments to the regulations. The regulations will then be laid before both the UK and Scottish Parliaments.
- This document is published alongside a consultation stage Impact Assessment that assesses the costs and benefits of the options (including a Small and Micro-sized Business Assessment and an assessment of the impact on equality).

¹ <https://www.gov.uk/government/publications/liberating-the-nhs-report-of-the-arms-length-bodies-review>

1. Background

- 1 The Professional Standards Authority is an Arm's Length Body (ALB) of the Department of Health (DH), currently funded by DH and the Devolved Administrations, with responsibility for the scrutiny and assurance of the activities undertaken by the nine health professions regulators:
 - General Chiropractic Council
 - General Dental Council
 - General Medical Council
 - General Optical Council
 - General Osteopathic Council
 - General Pharmaceutical Council
 - Health and Care Professions Council
 - Nursing and Midwifery Council
 - Pharmaceutical Society of Northern Ireland
- 2 In 2010, the Department of Health conducted a review of its ALBs, as part of the wider changes envisaged for the health care sector, and the drive to increase accountability and transparency across government while reducing the number and costs of public bodies.
- 3 The aim of the review was to simplify the national landscape, remove duplication and better align the ALB sector with the rest of the health and social care system by:
 - ensuring that functions related to quality and safety improvement are devolved closer to the frontline;
 - integrating and streamlining existing national health improvement and protection bodies and functions within a new Public Health Service;
 - creating a more coherent and resilient regulatory system with clarity of responsibilities and reduced bureaucracy around licensing and inspection;
 - centralising data returns in the Health and Social Care Information Centre;
 - maximising opportunities for outsourcing of functions and shared business support functions across the sector to reduce overall costs and seek to realise assets through the commercialisation of activities.
- 4 The report (see box 1) recognised that the CHRE fulfilled an ongoing need, but found no reason why it should continue to be funded through DH and the Devolved Administrations. Instead, the report recommended that CHRE should be renamed and funded through a fee on the regulatory bodies it oversees. The proposal to make the Council self-funding also

reflects the long-standing principle that the system of professional regulation in healthcare is funded by the professionals themselves.

Box 1

Extract from *Liberating the NHS: Report of the arm's length bodies review*

“Council for Healthcare Regulatory Excellence (CHRE)

The Council for Healthcare Regulatory Excellence is an Executive Non-Departmental Public Body responsible for scrutiny and quality assurance of the nine health care professions regulators in the UK. We have considered whether it is essential that there continues to be a regulator of the professional regulators. We concluded that the Council for Healthcare Regulatory Excellence does currently fulfil an ongoing need to quality assure professional regulation, but we will keep this under review.

Going forward, we see no compelling reason why the Council for Healthcare Regulatory Excellence should remain as an Executive Non-Departmental Public Body in the arm's-length bodies sector. Therefore, we propose to make it self-funding through a levy on those it regulates. We also propose to extend the Council for Healthcare Regulatory Excellence's remit to set standards for and to quality assure, voluntary registers held by existing statutory health and care professions regulators and others such as professional bodies. We intend to include provisions in the Health Bill to make these and associated changes.”

Health and Social Care Act 2012

5 The proposals and recommendations relating to CHRE made through this review were taken forward within the Health and Social Care Act 2012. This Act provided for CHRE to be renamed the Professional Standards Authority for Health and Social Care (“the Authority”) and for the Authority to be funded in the main by a fee imposed on the health professions regulatory bodies. The Act confers a duty on the Privy Council to enact legislation requiring the nine healthcare professional regulatory bodies to pay periodic fees to the Authority. The Act also makes other provisions in relation to the content of the regulations as detailed below: -

- Impose a duty on the regulatory bodies overseen by the Authority to pay fees to the Authority.
- Stipulate which functions are to be funded by the fee.
- Set out the method by which Privy Council must determine the level of fees paid by each regulatory body (see below).
- Allow the Authority to recoup its costs from the regulators in advance of expenditure (i.e. to charge fees in April 2015 for services to be rendered in 2015/2016).

- Require payment of the fees within a given time.
- Provide that when some or all of a fee is not paid on time, the outstanding amount is subject to interest.
- Allow Privy Council to re-determine the fee at the request of the Authority, the regulatory bodies, or on its own initiative.

2. The Draft Regulations

Functions to be funded by the fee

- 6 Under the provisions of section 25A of the National Health Service Reform and Health Care Professions Act 2002 (as inserted by section 223 of the Health and Social Care Act 2012), the Privy Council must make regulations that require each regulatory body to pay the Authority periodic fees in respect of the Authority's functions in relation to that body as specified in the regulations.
- 7 The draft regulations attached to this consultation provide for the functions in Table 1 to be covered by the fee.

Table 1: Functions to be Covered by the Fee

Section*	Title
25 (2)	<p>The Professional Standards Authority for Health and Social Care</p> <p>i) promote the interest of patients and other members of the public in relation to the performance of the regulatory bodies</p> <p>ii) promote best practice in the performance of professional regulation functions</p> <p>iii) formulate principles of good professional self-regulation and encourage regulatory bodies to conform</p> <p>iv) promote co-operation between regulatory bodies</p>
25A (5)	<p>Funding of the Authority</p> <p>Process for determining the periodic fees to be paid by the regulatory bodies</p>
25B	<p>Power of the Authority to advise regulatory bodies etc.</p> <p>Advice to the regulatory bodies in relation to their statutory functions</p> <p>This excludes advice provided by the Authority for which a separate fee may be charged</p>
25C (2)(a)	<p>Appointments to regulatory bodies</p> <p>The Authority may assist the Privy Council with any of its appointments functions in relation to a regulatory body.</p>

<p>26 (1) and (2)</p>	<p>Powers and duties of the Authority: General</p> <p>The Authority may do anything which appears to it to be necessary or expedient for the purpose of or in connection with the performance of its functions to the extent that such functions are exercised in relation to the regulatory bodies. It may:</p> <ul style="list-style-type: none"> i) investigate and report on the performance of each regulatory body ii) where a regulatory body performs functions corresponding to those of another, investigate and report how the performance of those functions compares ii) make recommendations to a regulatory body to change the way it performs its functions
<p>26B (1) and (4)</p>	<p>Duty to inform and consult the public</p> <ul style="list-style-type: none"> i) publication of information about the authority and the exercise of its functions ii) seek views of members of the public and organisations which appear to represent the interests of service users on matters relevant to the functions of the Authority
<p>27 (2) and (4)</p>	<p>Power to make directions requiring regulatory body to make rules.</p>
<p>28</p>	<p>Complaints about regulatory bodies</p> <p>Regulations may make provision as to the investigation of complaints about regulatory bodies. (Note this section has not yet been commenced)</p>
<p>29 (4)</p>	<p>Reference of disciplinary cases by Authority to court</p> <p>The Authority may refer a case to the relevant court if it considers certain decision about a practitioners fitness to practise are unduly lenient or should not have been made</p>
<p>Schedule 7, paragraphs 15(1)-(4), 16(1), (1B) & (2)*</p>	<p>Governance functions</p> <p>Accounting, reporting and planning requirements imposed on the Authority.</p> <p><i>*These functions are only included to the extent to which they relate to the regulatory bodies.</i></p>

Schedule 7, paragraphs 16(3) and (4)*	<p>Parliamentary accountability</p> <p>If required to do so, the Authority must lay a report on any matter as requested by the UK Parliament, the Northern Ireland Assembly, or the Scottish Parliament.</p> <p><i>*These apply only in so far as such work related to regulatory bodies.</i></p>
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* Note: Section numbers relate to those in the NHS Reform and Health Professions Act 2002 (as amended)

- 8 Provisions in the Act also prevent certain other functions of the Authority being funded through the fee. These are set out in Table 2.

Table 2: Functions Excluded from the Fee

Section	Title
25G	Power of the Authority to accredit voluntary registers
25H	Accreditation of voluntary register: impact assessment
25I	Functions of the Authority in relation to accredited voluntary registers
26A	Powers of Secretary of State and devolved administrations (to request advice etc.)

Section 25B empowers the Authority to provide advice or auditing services to the regulatory bodies, or to bodies with functions that correspond to those of the regulatory bodies, whether or not these relate to health or social care. Where it does so, a compulsory fee, determined by the Authority, will be paid by the bodies to which it provides advice or auditing services. However, the Authority may only provide advice or auditing services under this section if doing so would assist it in the performance of its functions (apart from its function of providing advice, reports or investigations to the Secretary of State or the devolved administrations under section 26A).

Question 1: Do you agree that the functions listed in Table 1 should be covered by the fee? Please provide the rationale behind your response and any amendments to the included functions you would suggest

Question 2: Do you agree the functions listed in Table 2 should be excluded from the fee?

Methodology for determining the fee

- 9 The Department of Health asked the Authority to provide advice on the method for apportioning the fee between the regulatory bodies it oversees. In reaching a recommendation, the Authority adhered to the principle that the fee structure should be transparent, simple and not likely to add unduly to administrative costs.
- 10 The Health and Social Care Act 2012 requires the fee to be imposed on the regulatory bodies. However, it will be for each regulator to decide whether to absorb this cost, or to meet it through increasing the registration fees it charges its registrants.
- 11 The Department of Health considered three potential fee structures in depth²:
- **Method 0:** Do nothing
 - **Method 1:** Apportion fees between the healthcare professional regulators according to the number of registrants
 - **Method 2:** Fixed equal fee charged to each regulator, with the remainder of the total apportioned according to the number of registrants the regulators oversees.

Method 0: Do nothing

- 12 This is not considered a viable option as secondary legislation is necessary to realise the policy intention set out in the Health and Social Care Act 2012. The Authority's fees need to be compulsory (i.e. set out in legislation), to prevent any actual or perceived compromise of the Authority's independence from the regulators and from Government.

Method 1: number of registrants

- 13 Under Method 1, secondary legislation would be introduced to give the Authority the power to become self-funding via raising fees from the nine regulatory bodies it oversees, based on the number of registrants each regulator oversees.
- 14 At present, the number of registrants per regulator is the only feasible proxy available for the Authority to use to apportion the fee between the regulatory bodies it oversees and this is consequently the preferred method. However, the Authority has committed to explore whether other Management Information may be used for determining the fees in the future.

² A wide variety of options were initially considered by the PSA, with the majority deemed unsuitable at an early stage and therefore not assessed in detail by the Department of Health.

Method 2: Fixed equal fee charged to each regulator, with the remainder of the total apportioned according to the number of registrants the regulators oversees.

15 Under Method 2, secondary legislation would again be introduced to give the Authority the power to become self-funding via raising fees from the nine regulatory bodies it oversees. However, under this option the fee would be comprised of an equal fixed charge to all regulators to cover the Authority's activities from which they benefit equally, with the remainder of the costs apportioned according to the number of registrants overseen by each regulator. Although this option was considered, there is currently not enough management information available that can be used as a suitable proxy for this scenario and this is therefore not currently a viable option.

Preferred Option

16 The Government has considered the advice provided by the Authority and HM Treasury and considers that Method 1 would be the best option. Under this option, the fee structure is simple and easily understood, the smaller regulatory bodies would not be disproportionately impacted and it is compliant with HM Treasury Managing Public Money guidance.

The draft regulations attached to this consultation are therefore based on using method 1 to determine the fee.

Question 3: Do you agree that method 1 – apportionment of the fee according to the number of registrants – is currently the only viable option available for determining the fees? Please explain the rationale for your response.

Timetable for payment and interest payments

17 The Privy Council will determine the fee to be paid by each regulatory body in accordance with the method for determining the fee as set out above. The Privy Council, or more usually, the Authority on its behalf will send a written fee demand to the regulatory bodies setting out the amount of the periodic fee, the period to which that fee relates, and the date by which payment must be made.

18 The draft regulations currently require a “notice period” of 15 days for payment of the fee.

Question 4: Do you agree that the regulations should specify that the demand for payment should include a period of notice?

Question 4a: If so do you agree that this period should be 15 days?

Question 4b: If not, please specify a different period and explain why it is preferred.

19 In the event of late payment of fees, the regulations provide for interest to be payable. This is based on the HMRC interest penalties and is designed to ensure that the Authority is financially sound and able to focus on its primary function of public protection.

Question 5: Do you agree that interest due on late payment should be set as drafted?

Question 6: Do you agree with the Department's assessment that the implementation of this policy will not have an adverse impact on equality?

Question 7: Do you have any comments on the draft Regulations?

3. Summary of Consultation Questions

Question 1: Do you agree that the functions listed in Table 1 should be covered by the fee? Please also provide the rationale behind your response and any amendments to the included functions you would suggest.

Question 2: Do you agree the functions listed in Table 2 should be excluded from the fee?

Question 3: Do you agree that method 1 – apportionment of the fee according to the number of registrants – is currently the only viable option available for determining the fees? Please explain the rationale for your response.

Question 4: Do you agree that the regulations should specify that the demand for payment should include a period of notice?

Question 4a: If so, do you agree that this period should be 15 days?

Question 4b: If not, please specify a different period and explain why this is preferred.

Question 5: Do you agree that the interest due on late payment should be set as drafted?

Question 6: Do you agree with Department's assessment that the implementation of this policy will not have an adverse impact on equality?

Question 7: Do you have any comments on the draft Regulations?

4. Responding to this Consultation

Consultation Process

- 20 This document launches a consultation on regulations setting out the funding arrangements for the Professional Standards Authority for Health and Social Care. It is being run in accordance with the Cabinet Office Code of Practice on Consultations (reproduced below). The closing date for the consultation is 28 November 2014.
- 21 There is a full list of the questions we are asking on page 14 of this consultation and there is a questionnaire on the Department's website which can be printed and sent by post to: Professional Standards Authority Fees Consultation Room, 2N11 Quarry House, Quarry Hill, Leeds LS2 7UE
- 22 Alternatively, comments can be sent by e-mail to: hrdlistening@dh.gsi.gov.uk
- 23 It will help us to analyse the responses if respondents fill in the questionnaire but responses that do not follow the structure of the questionnaire will be considered equally. It would also help if responses were sent in Word format, rather than pdf.

Comments on the consultation process itself

- 24 If you have any concerns or comments which you would like to make relating specifically to the consultation process itself please contact:
- Consultations Coordinator, Department of Health 3E48, Quarry House, Quarry Hill,
Leeds LS2 7UE
- 25 Please do not send consultation responses to this address.

Confidentiality of information

- 26 We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter (www.dh.gov.uk/en/FreedomOfInformation/DH_088010).
- 27 Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).
- 28 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, amongst 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 on the Department.

29 The Department 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.

Summary of the consultation responses

30 A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Gov.UK website (www.gov.uk)

Annex A – Draft Fee Regulations

STATUTORY INSTRUMENTS

2014 No. 000

HEALTH CARE AND ASSOCIATED PROFESSIONS

[*****]

The Professional Standards Authority for Health and Social Care (Fees) Regulations 2014

<i>Made</i> - - - -	***2014
<i>Laid before Parliament</i>	***2014
<i>Laid before the Scottish Parliament</i>	***2014
<i>Coming into force</i> - -	***2014

The Privy Council makes the following Regulations in exercise of the powers conferred by sections 25A(1), (3), (10) and (11) and 38(5) and (7) of the National Health Service Reform and Health Care Professions Act 2002(3).

In accordance with section 25A(12) of that Act, the Privy Council has consulted the Professional Standards Authority for Health and Social Care, the bodies referred to in that section and those other persons which it considers appropriate to consult.

Citation, commencement and interpretation

1.—(1) These Regulations—

- (a) may be cited as the Professional Standards Authority for Health and Social Care (Fees) Regulations 2014;
- (b) come into force on *** ** 2014.

(2) In these Regulations—

“amended fee notice” means a fee notice amended to reflect a periodic fee re-determined pursuant to regulation 7;

“Bank of England base rate” means—

⁽³⁾ c. 17. Section 25A was inserted by section 223 of the Health and Social Care Act 2012 (c. 7). Section 25A(3) provides that regulations must, in particular, provide for the method of determining the amount of a fee under the regulations. Section 38 was also amended by section 223 of the Health and Social Care Act 2012 by, *inter alia*, insertion of sub-section (3A).

(a) the rate announced from time to time by the Monetary Policy Committee of the Bank of England as the official dealing rate, being the rate at which the Bank is willing to enter into transactions for providing short term liquidity in the money markets; or

(b) where an order under section 19 of the Bank of England Act 1998⁽⁴⁾ is in force, any equivalent rate determined by the Treasury under that section;

“chargeable period” is to be construed in accordance with regulation 2;

“due date” is to be construed in accordance with regulation 6;

“fee notice” has the meaning given in regulation 6(1);

“periodic fee” refers to a fee which is payable by a regulatory body by virtue of regulation 2.

(3) References in these Regulations to sections and parts of sections refer to sections and parts of sections of the National Health Service Reform and Health Care Professions Act 2002.

Obligation on regulatory bodies to pay fees

2.—(1) Each regulatory body⁽⁵⁾ must pay the Authority⁽⁶⁾ a periodic fee of an amount determined or, as the case may be, re-determined, by the Privy Council in respect of the Authority’s functions in relation to it.

(2) A periodic fee is to be determined or re-determined in respect of such period (“the chargeable period”) as the Privy Council chooses, and the chargeable period may occur after the fee becomes payable.

Functions in respect of which a periodic fee is payable

3. The functions of the Authority in respect of which the each regulatory body must pay a periodic fee to it are—

(a) those under—

(i) subsection (2) of section 25 (The Professional Standards Authority for Health and Social Care);

(ii) subsection (5) of section 25A (funding of the Authority)⁽⁷⁾;

(iii) subsection (1)(a) of section 25B (power of the Authority to advise regulatory bodies etc)⁽⁸⁾, but only to the extent that such fees are not recovered in respect of the performance of such functions under subsection (2) of that section;

(iv) subsection (2)(a) of section 25C (appointments to regulatory bodies)⁽⁹⁾;

(v) subsections (1) and, to the extent that paragraph (2A) does not apply, (2) of section 26 (powers and duties of the Authority: general)⁽¹⁰⁾;

⁽⁴⁾ 1998, c. 11.

⁽⁵⁾ “the regulatory bodies” means the bodies described in section 25(3) of the enabling Act, as amended by section 127 and paragraph 17(1) to (3) of Schedule 10 to the Health and Social Care Act 2008; by article 68 of and paragraph 10(1) and (2) of Part 1 of Schedule 4 to SI 2010/231, and by section [212(7)(j)] of the [Health and Social Care Act 2012].

⁽⁶⁾ Section 25(1) of the enabling Act was amended by section [221(2)] of the [Health and Social Care Act 2012] and sections 25, 26, 26A, 26B, 27 to 29 of, and Schedule 7 to, the enabling Act were amended by paragraph [62] of Schedule [16] to the [Health and Social Care Act 2012] so that in those sections of and in Schedule 7 to the enabling Act, “the Authority” means the Professional Standards Authority for Health and Social Care. Other uses of the term “the authority” elsewhere in the enabling Act refer to the defined term “the appropriate authority”.

⁽⁷⁾ Section 25A was inserted by section [223(1)] of the [Health and Social Care Act 2012].

⁽⁸⁾ Section 25B was inserted by section [224(1)] of the [Health and Social Care Act 2012].

⁽⁹⁾ Section 25C was inserted by section [226] of the [Health and Social Care Act 2012].

⁽¹⁰⁾ Section 26 was amended by section [227(2)] of the [Health and Social Care Act 2012].

- (vi) subsection (1) and (4) of section 26B (duty to inform and consult the public)⁽¹¹⁾, to the extent to which the functions relate to regulatory bodies;
- (vii) subsections (2) and (4) of section 27 (regulatory bodies and the Authority);
- (viii) subsection (4) of section 29 (references of disciplinary cases by Authority to court)⁽¹²⁾;
- (b) such functions as may be performed by the Authority pursuant to any regulations made under section 28 (complaints about regulatory bodies)⁽¹³⁾;
- (c) those functions in paragraphs 15(1) to (4) and 16(1), (1B) and (2) of Schedule 7⁽¹⁴⁾ to the extent to which they relate to regulatory bodies; and
- (d) such functions as may be performed by the Authority pursuant to paragraph 16(3) or (4) of Schedule 7⁽¹⁵⁾ to the extent to which they relate to regulatory bodies.

Privy Council powers to require information from regulatory bodies

4.—(1) In order to determine a periodic fee, the Privy Council may, in writing, require a regulatory body to provide it with information it considers necessary for that purpose.

(2) That information may include information about past, current and anticipated numbers of persons whose names appear on a register maintained by the regulatory body concerned pursuant to statute: this does not include registers established and maintained pursuant to section 25D.

(3) The Privy Council must specify in writing the time by when the information requested must be received.

(4) The Privy Council may, in writing, extend the time so specified to such later time as it thinks reasonable in all the circumstances.

Method for determining the amount of a fee

5. The amount of the periodic fee payable by a regulatory body is determined in accordance with the formula—

$$\text{TFR} \times n\%$$

where—

“TFR” is the total funding requirement of the Authority as determined by the Privy Council under section 25A(9)(a);

“n%” is the proportion which the number of registrants registered with the regulatory body in question bears to the aggregate of all registrants registered with all the regulatory bodies.

⁽¹¹⁾ Section 26B was amended by section [228(7)] of the [Health and Social Care Act 2012].

⁽¹²⁾ Section 29 was amended by SI 2002/3135, SI 2004/1771, SI 2005/848 and 2011, and SI 2010/231. Other amendments made by section 118 of the Health and Social Care Act 2008, which were not commenced, were revoked by paragraph [73(2)(b)] of Schedule [16] to the [Health and Social Care Act 2012]. Paragraph [73(2)(a)] of that Schedule also amended section 29.

⁽¹³⁾ Section 28 is in force in so far as it confers any power to make an order or regulation, but not otherwise.

⁽¹⁴⁾ Paragraph 15 was amended by section [225(6)] of the [Health and Social Care Act 2012].

⁽¹⁵⁾ Paragraph 16 was amended by section 114(1) and (6) of the Health and Social Care Act 2008, and by section [225(7)] of the [Health and Social Care Act 2012].

Time for payment and interest payable

6.—(1) The Privy Council must send a written notice to the regulatory body (the “fee notice”) stating the amount of the periodic fee which is payable by that regulatory body and specifying the chargeable period to which it relates.

(2) A periodic fee must be paid by the due date.

(3) The due date is that specified in the fee notice or, in the case of a re-determined periodic fee pursuant to regulation 7, in the amended fee notice.

(4) The date specified by the Privy Council in a fee notice or an amended fee notice must not be earlier than 15 clear days after the date of the notice.

(5) Where that a regulatory body does not pay the full amount of the periodic fee by the due date, it must pay interest to the Authority on the outstanding amount of that fee.

(6) Interest is to accrue daily from the day immediately following the due date at the annual rate of 1.5% above the Bank of England base rate.

Re-determination of a fee

7. On a request by the Authority or by a regulatory body, or on the Privy Council’s own initiative, the Privy Council may re-determine the amount of a periodic fee payable by a regulatory body.

Judith Simpson

** **** 2014

Clerk of the Privy Council

EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations provide for fees to be paid by the regulatory bodies mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002 (“the 2002 Act”), as amended by the Health and Social Care Act 2012 (c. 7). Section 25A of the 2002 Act, inserted by the 2012 Act, provides for the costs of the Professional Standards Authority for Health and Social Care (“the Authority”) (formerly the Council for Healthcare Regulatory Excellence) incurred in respect of its functions in relation to the regulatory bodies to be funded by fees imposed on those regulatory bodies by virtue of regulations under that section. Fees are determined by the Privy Council and paid to the Authority. Section 25A provides for a process of consultation and determination by the Privy Council of the Authority’s costs and the fees which each regulatory body should be required towards those costs. It also provides that the method for determining the amount of a fee is to be set out in regulations.

Regulation 2 requires each regulatory body to pay to the Authority fees determined periodically by the Privy Council, and provides for the Privy Council to choose the “chargeable period” in respect of which such a fee (“a periodic fee”) is to be paid.

Regulation 3 lists the functions in respect of which periodic fees are.

Regulation 4 gives the Privy Council powers to require information from the regulatory bodies for the purpose of assessing the periodic fee payable.

Regulation 5 sets out the formula by which the amount of a periodic fee is to be determined.

Regulation 6 provides for the time for payment of a periodic fee to be set out in a written fee notice sent by the Privy Council, which must not be sooner than 15 clear days after the date of the notice. Provision is also made for the accrual of interest daily on fees not paid by the due date, at the annual rate of 1.5% above the Bank of England base rate.

Regulation 7 provides for the re-determination of periodic fees on the request of the Authority, a regulatory body, or on its own initiative.

An impact assessment has been prepared in relation to these Regulations and is available from Professional Standards Team, Department of Health, 2N11, Quarry House, Leeds, LS2 7UE.

Proposals for calculating the statutory levy

March 2011

1. Introduction

- 1.1 CHRE has considered a number of different approaches to apportioning the statutory levy which will be paid by the regulatory bodies from 2012 (subject to parliamentary approval)
- 1.2 This paper sets out three options, one of which is preferred by the CHRE, and invites comments and views from the regulators.
- 1.3 Ultimately the decision as to how the levy is raised and apportioned as well as the involvement of the regulatory bodies in this process is a matter for the government and will be set out in regulations following the passage of the Health and Social Care Bill however both CHRE and Department of Health officials are keen to understand the perspectives of the regulators on the advantages, disadvantages and fairness of different approaches.
- 1.4 The CHRE Director of Governance and Operations is currently engaged in a programme of visits and discussions with the finance directors of all the regulators in order to understand the financial basis of each regulator and its financial cycle.
- 1.5 Regulators are invited to respond to these proposals in this paper by **31 May 2011**.

2. Government proposals for the levy

- 2.1 Proposals for the levy are set out in the Command Paper *Enabling Excellence*¹ and in Clause 208 of the Health and Social Care Bill.

3. Principles for the establishment of the levy

- 3.1 The following principles should apply:
 - The levy is to cover the expenditure that the Authority advises the Privy Council that it needs to make and has agreed with the Privy Council
 - The expenditure should reflect the cost of the Authority's work.
 - The process for determining the levy should be, so far as is practicable, equitable and transparent
 - The methodology should be easy to explain

¹ *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers* February 2011

- The regulations should not be setting the precise levy thus there should be no need to undertake annual consultation on the methodology.
- As a statutory fee the levy will not be subject to VAT

3.2 In addition it is proposed that:

- The levy will be collected annually
- The Authority will when ever possible determine its costs (and therefore they levy) for a three year period
- The levy is on the regulatory bodies not the registrants.
- The levy will be payable by the regulators to the Authority on receipt of invoices. (This could be annually or quarterly)

4. Three methods of calculating the levy

4.1 The methodology needs to be cost effective in that it, of itself, must not unduly add to the costs of the Authority and consequently to the levy to be raised from the RBs, either directly or indirectly..

4.2 The options for consideration are based on

- The number of registrants (a)
- The fee income due from the registrants (b)
- A combination of (a) and (b), (c)

4.3 The method of calculating the levy will, when decided, be set out in regulations

4.4 For each option for the methodology for the apportionment of the levy the following should apply:

- The total cost of the Authority² will have been determined as per the Act and Regulations
- The levy will be collected in respect of the relevant financial year; 1 April to 31 March
- The relevant date for the determination of the data required for apportionment will be 1 January.
- The number of registrants will be the number of registrants (by differing classes if relevant) on the register of the RB on the relevant date

² Excluded from the levy on the regulators is the cost of the accreditation scheme for voluntary registers and any consultancy work agreed with third parties. The additional cost of any of advice commissioned by the Secretary of State or the Health Departments will also be paid for separately.

- The fees will be the fees charged by the Regulator to registrants at the relevant date
 - The fee income will be the fees arising as of 1 January in respect of the number of registrants on the roll on the relevant date based on the fees in force at that time
- 4.5 Within a given time period, for example 14 days, of 1 January the RBs must provide to the Privy Council/Authority the following information:
- The number of registrants on the register (by class if relevant)
 - The fees in force
 - The fee income due as a consequence of a) and b)
- 4.6 There should be penalties for the late provision of data since any delay on the part of one regulator delay the speed with which the Privy Council /Authority can confirm the levy cost to all regulators.
- 4.7 There should be a stated timescale for the Privy Council /Authority to adhere to for the notification of the individual costs to the RBS.
- 4.8 While the methodology will be in the regulations the precise costs in relation to each RB will not be. These will change each year. Since even if the Authority's costs i.e. the total levy cost to be recovered is set for three years the apportionment across the RBs may change as the number of registrants or total fee income changes.

Method A

- The total number of registrants will be determined following the submissions from the RBs.
- The respective percentage share of the total number of registrants will be determined for each RB.
- Each RB will contribute that percentage of the total levy cost.

Method B

- The total fee income due to the RBs will be determined following the provision of data by the RBs.
- The respective percentage share of the total fee income will be determined for each RB.
- Each RB will contribute that percentage of the total levy cost.

Method C

- The two calculations to determine the costs payable for both Method A and Method B will be undertaken and the individual costs determined
- The two figures will be aggregated.
- The aggregated figure will be halved and the resultant figure will be the levy that is payable.

5. The notional effects of different methods of calculating the levy

- 5.1 All examples have been worked using a notional figure of £2.8million as the Authority's annual operating costs.
- 5.2 The number of registrants has been based on the figures published in the most recent CHRE Annual Report, (with the inclusion of an additional 85,000 members for HPC to reflect the prospective inclusion of social workers) giving a combined membership figure of 1,373,041.
- 5.3 The income is based on registrant fees (the number of registrants times the fee to be paid) is also taken from annual accounts, and from the figures published in the CHRE's own Annual Report.

Table 1: Impact on regulators of levy calculated on number of registrants (method A)

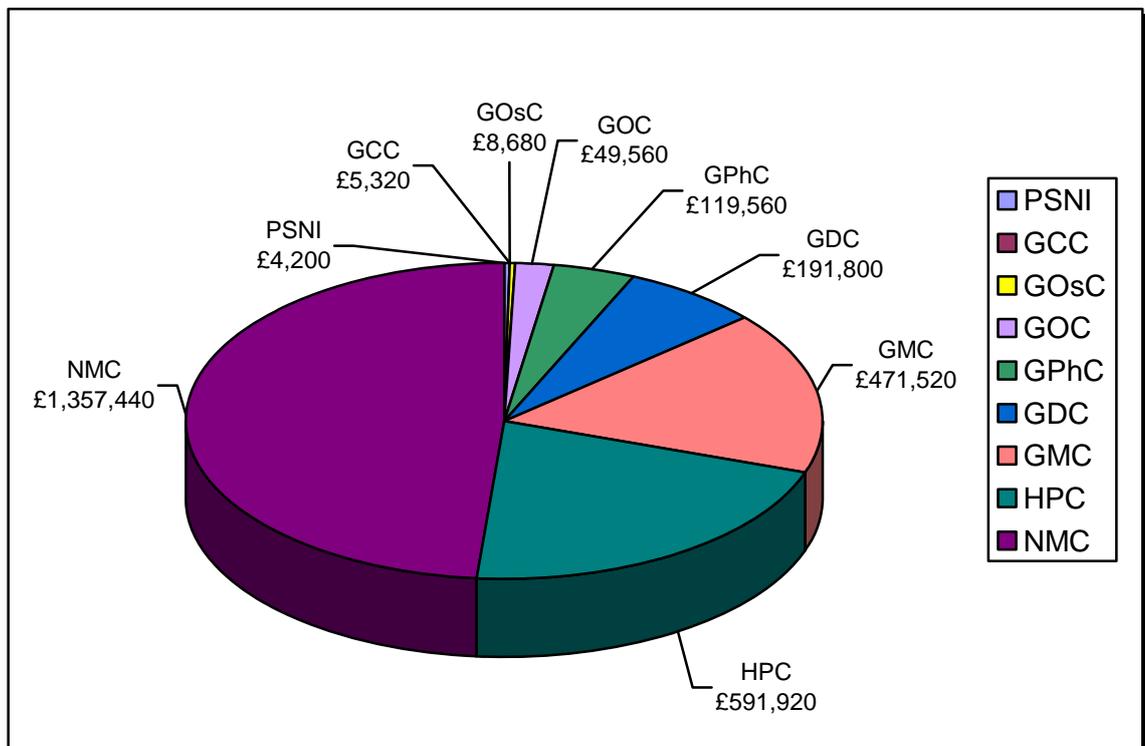


Table 2: Impact on regulators of levy calculated on income (method B)

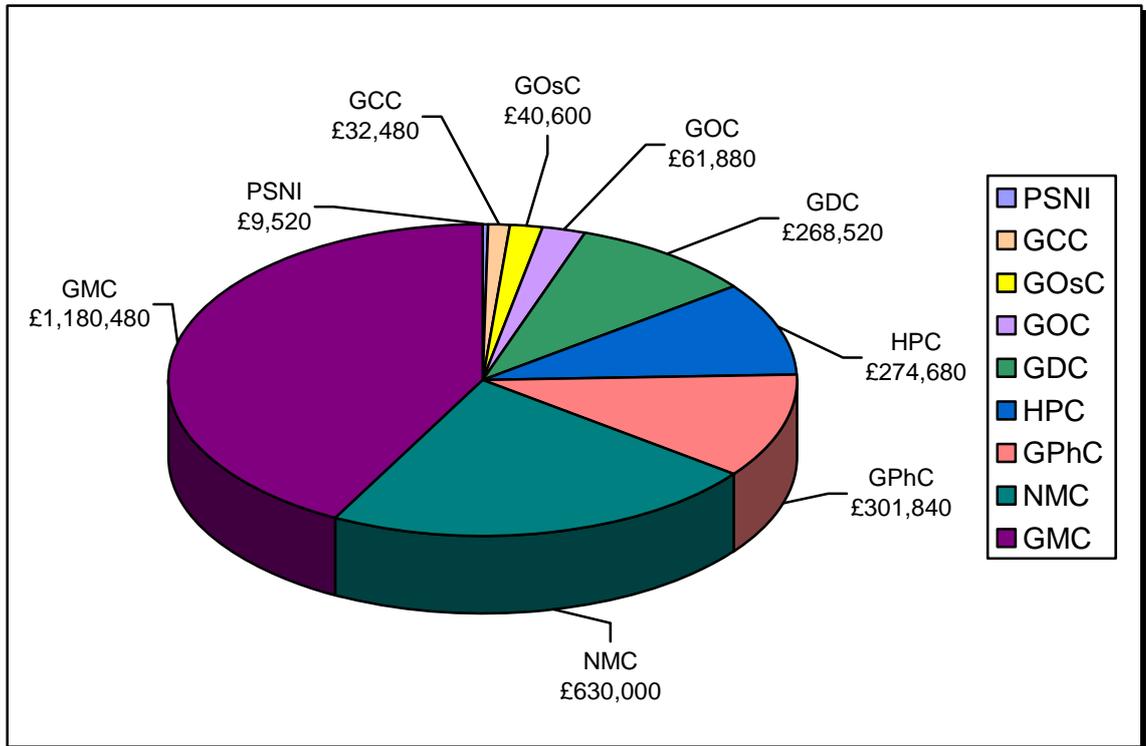


Table 3: Impact on regulators of levy calculated on combination of number of registrants and income (method C)

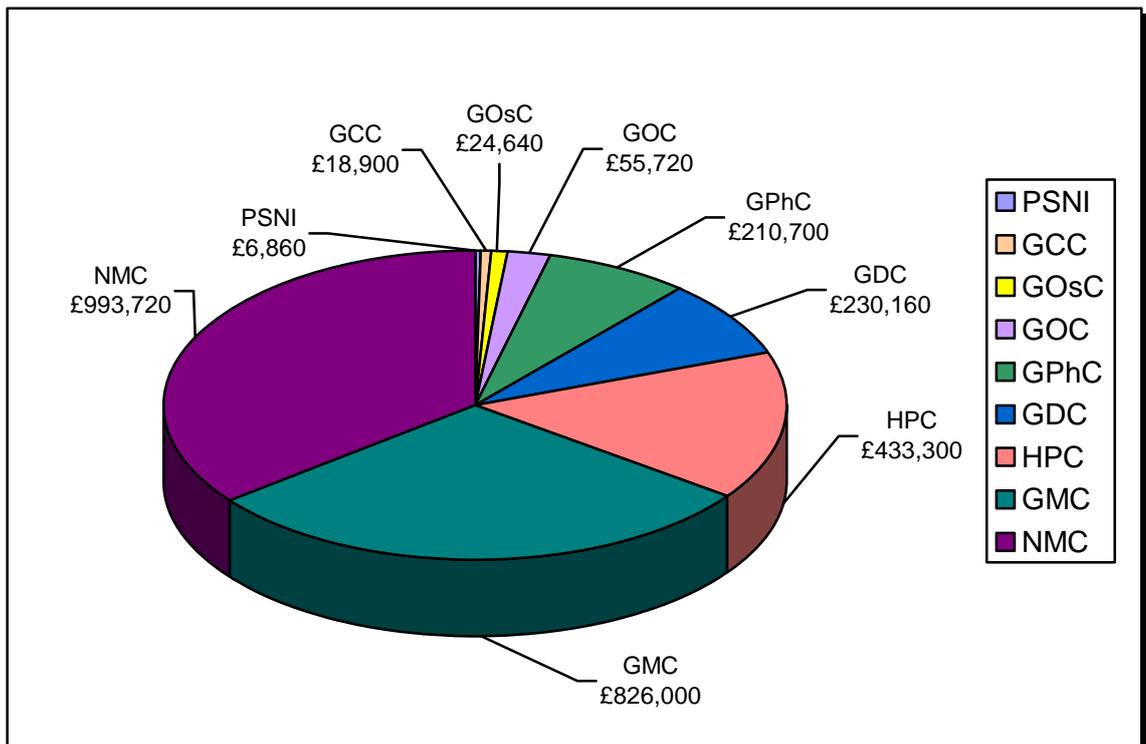
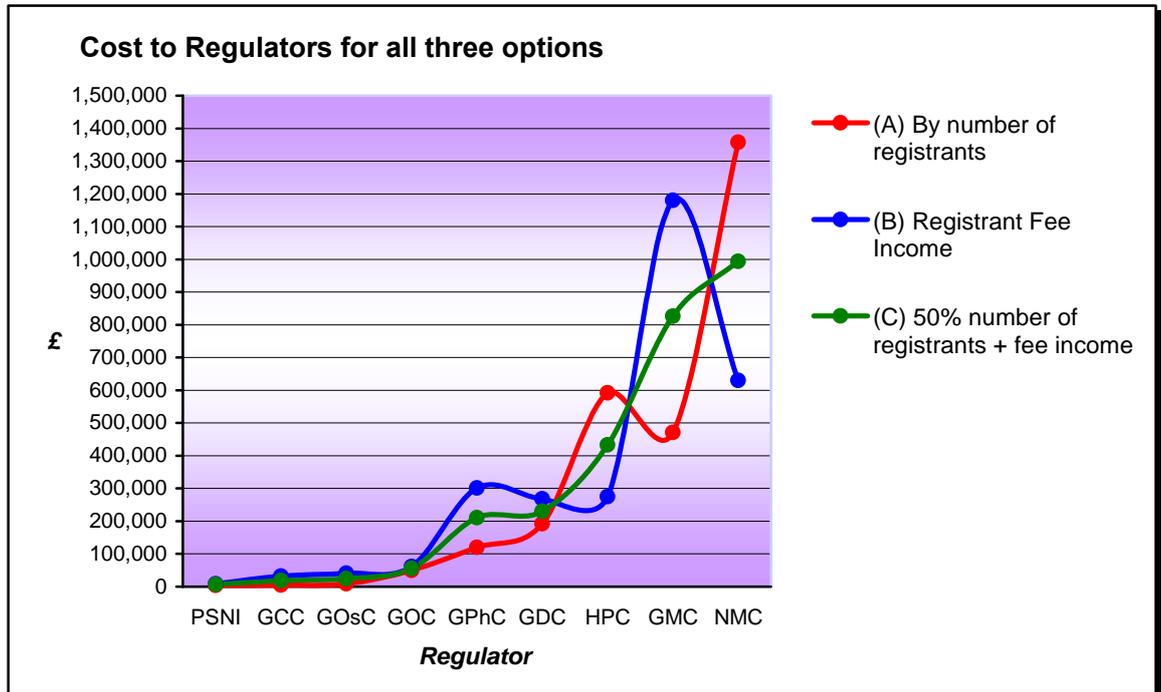


Table 4: Comparison of all three options



6. Conclusion

- 6.1 It is apparent that each of the methods, while raising the same sum of money through the levy, has a different impact on the regulators individually.
- 6.2 CHRE was initially attracted to method A as being simple to explain and calculate and having precedent in the approach taken by the Legal Services Board. However method A has a significant impact on regulators with high numbers of registrants and low registration fees.
- 6.3 Method B was then considered. This is more proportionate but increases costs on the smallest regulators and changes the balance between larger ones.
- 6.4 Method C, although somewhat more complicated to explain and to calculate produces a more distributive and proportionate outcome. To some extent it recognises and accommodates the conflicting interests in models A and B.
- 6.5 The Council of CHRE having considered all the options at some length is now seeking views from the regulatory bodies. The Council's preferred methodology is option C which, in its view, achieves the most proportionate allocation while meeting our principles of ease of calculation, clarity and ease of administration. However the Council is keen to seek views and representations from the regulatory bodies to shape its thinking further.