Care Quality Commission

FOCUSED ON BETTER CARE

Annual report and accounts 2009/10

Care Quality Commission

Annual report and accounts for the period 1 April 2009 to 31 March 2010

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Jo Williams
Acting Chair

Cynthia Bower
Chief Executive

The Care Quality Commission (CQC) became England's first regulator of health care and adult social care on 1 April 2009. We are pleased to be able to report a successful first year. We laid the right foundations for achieving our longer-term goals, including developing a completely new system of regulation while fulfilling our legacy responsibilities. At the same time, we successfully addressed the challenge of bringing together three very different organisations to create a distinctive CQC culture and new ways of working.

Our approach to regulation is designed to ensure that people who use services have a good experience of care and positive outcomes from their care and support. Our first corporate publication in 2009/10 was our charter for involving them in every aspect of our work, and their views and suggestions were an important influence as we developed our new, registration-based system of regulation.

After working with stakeholders across the care sector to develop the standards and tools that underpin the new system, we registered all of England's 378 NHS trusts by the time the new regulations came into force on 1 April 2010. This was a major change in healthcare regulation. For the first time in the 62-year history of the NHS, its services must be licensed to operate by the regulator.

Alongside the enormous work programme needed to develop and deliver registration, we delivered the existing regulatory system for adult social care and independent health care, including more than 12,000 inspections. Our staff tackled these twin challenges with reduced resources and during a time of rapid and unsettling organisational change, which made their achievement doubly remarkable. We would also like to thank NHS trusts for their enthusiasm and commitment during the registration process – an important factor in our success.

We have reduced our overheads and improved our productivity, while providing a structure that reflects our priorities for improving care over the next five years. With its emphasis on front-line activities, our new structure takes us closer to the communities we serve. It will enable CQC staff to forge strong links with our local stakeholders throughout the country, including providers, commissioners, people who use services and local groups that represent them. Our new approach will enable us to respond swiftly and effectively to concerns about the quality and safety of individual services.

Under the new regulations, NHS trusts had to be registered with us for control and prevention of healthcare-associated infection (HCAI) from 1 April 2009, a year before their full registration. Through our work monitoring their compliance – including 250 unannounced spot checks by our regional staff – we had already started to have a positive impact on the quality of people's care in 2009/10. The 21 trusts that had conditions attached to their HCAI registration had all made the improvements we required by December 2009. This was the first time that we used our new, extended powers of enforcement in the NHS.

In February 2010, we launched our first annual report to Parliament on the state of health care and adult social care, drawing on our 2009 performance ratings of the NHS and councils' social services to give the first truly comprehensive picture of care in England. We found continued overall improvement in both sectors. However, a small proportion of services were falling below minimum standards. Safety, safeguarding and staff training were particular concerns. We also called for more joined-up working between different types of services, and a fundamental cultural shift to enable people to shape and control their own care.

As England's first regulator of health care and social care services, we hold a large amount of information, and are committed to making it as meaningful as possible to the public and other audiences, to help people make informed choices about care and to drive improvement and promote good practice. We will start to implement our plans for this work in 2010/11.

We ended 2009/10 on a high note, with the successful launch of our new system of registration in the NHS, and the publication of our single equality and human rights scheme. Putting people at the heart of our work is driving our operation. Over the coming years as resources reduce, our role as the 'quality regulator' will become ever more significant. Our success will depend upon engaging with all communities and listening to their experiences and concerns.

Jo Williams, Acting Chair

Cynthia Bower, Chief Executive

About the Care Quality Commission

The Care Quality Commission (CQC) is a non-departmental public body that was established under the Health and Social Care Act 2008. On 1 April 2009 we began operating as England's independent regulator of health care and adult social care. As part of this role, we protect the interests of people whose rights are restricted under the Mental Health Act.

We are the first regulator to cover both health care and social care in England. From April 2010, providers of health care and social care must be registered by us to show that their services meet new, essential standards of quality and safety.

Focus on better care

Whether a service is provided by the NHS, local councils or by private or voluntary organisations, we make sure people get better care by:

- Driving improvement in health care and social care.*
- Putting people first and championing their rights.
- Acting swiftly to remedy bad practice.
- Gathering and using knowledge and expertise, and working with others.

Our Board of Commissioners

Our Commissioners have a wealth of expertise across health care and social care, including direct experience of using services. The Board members are:

- Dame Jo Williams (Acting Chair), former Chief Executive, Royal Mencap Society.
- Professor Deirdre Kelly, Professor of Paediatric Hepatology, Birmingham Children's Hospital.
- John Harwood, Former Chief Executive of the Food Standards Agency.
- Martin Marshall, Director of Clinical Quality at The Health Foundation.
- Olu Olasode, productivity and strategic finance consultant for public service, and Chief Executive of TL First Consulting.
- Kay Sheldon, Trustee of Mind, the national mental health charity.

Find out more about our Board members on our website – www.cqc.org.uk/aboutcqc/whoweare.cfm

* When we use the term "social care" in this publication, we mean adult social care for people of 18 years or more.

Compared with the combined figures for CQC's predecessor organisations, we have reduced our:

Offices:

23 to 8

Workforce:

2,900 to 2,100

Budget:

£240m* to £164m

*** in 2005/06**

Our first annual report

In our annual report for 2009/10, we report on our work in CQC's first year of operation – from 1 April 2009 to 31 March 2010. We look back on the year's achievements and challenges, including comments by some of the many people who have worked with us to help make sure that everything we do is focused on better care.

Our structure

CQC has nine operating regions and a corporate office in London. We have designed our regional structure to reflect that of the Government Offices for the Regions and NHS Strategic Health Authorities, so that we can work with these key partners as effectively as possible.

We have a shared centre in Newcastle that processes the information collected by our regional operations staff when they monitor and inspect care services. This enables us to provide a complete, up-to-date picture of the quality of health care and social care in England.

Section 1

CREATING A NEW SYSTEM OF REGULATION

378 NHS provider trusts by 1 April 2010

From 2010, providers of health care or adult social care must be registered by CQC to show that they meet new, essential standards of quality and safety. Our key task during 2009/10 was to create this completely new regulatory system, and to be ready to launch it in the NHS by April 2010, and then to other sectors later in 2010. We made sure that people who use services, as well as care providers, helped to shape how the new system would work.

"The focus of the essential standards is what matters most to people, and that's about us asking 'what should people experience if a service is meeting essential standards?'

So people should experience dignity, they should experience respect, they should experience choice, and they should experience the fact that their human rights are promoted and upheld. And I think that is a really positive and powerful message that the new essential standards bring."

Sarah Bartholomew, who led the development of our registration methods and tools, talking about the new essential standards of quality and safety and their benefits for people who use services.

"Many NHS trusts across England have really engaged with the process and I want to congratulate them for their honesty about the challenges they face. In many cases, trusts told us where they had concerns but also set out the plans they had in place to deal with them. This showed a willingness to take responsibility for patient care and to put improvements in place."

Cynthia Bower, CQC Chief Executive

1,180

people attended our consultation events on the new registration system

The cornerstone of our work as regulator is a new system of registration for health care and adult social care that was introduced by the Health and Social Care Act 2008. Under this new system, all providers of care services must be registered by CQC – including, for the first time, NHS trusts. Before we will give a provider this 'licence to operate', they must show that their services meet new, essential standards of quality and safety that respect people's dignity and rights.

A common set of standards for health care and social care

The essential standards of quality and safety are based on 28 regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. Service providers must meet all 28 standards, but we pay particular attention to the 16 standards that relate most closely to the safety and quality of people's care.

More focus on people's experience

One of the key differences about our approach to regulation is our focus on people's direct experience of care, rather than simply on whether a provider has the right processes in place.

For example, we have defined each of the essential standards according to the outcomes that we would expect people using a service to experience when the provider is meeting the standards. In this, as in all other aspects of our approach to regulation, we put people who use services first.

Our person-centred approach also gives more emphasis to 'joined-up' working – both between health care and social care services or between different services in the same sector. People who use services tell us that good partnership working can make an enormous difference to their experience of care, particularly when using more than one type of service or moving between different services.

Developing how registration would work

When designing and developing our outcomes-focused approach to regulation, we made sure that people who use services and organisations that represent them were closely involved in the process. We also worked with providers of healthcare and social care services, organisations that represent providers, and people who work in the wider health and social care system.

The most important topic for consultation was our draft guidance for providers about the outcomes they needed to achieve for people in order to meet the essential standards. Between June and August 2009, we carried out a large-scale public consultation to find out what people thought about the content and structure of the draft guidance. Our aim was to capture as much face-to-face feedback as possible, so we held 11 consultation events throughout England for people who use services and smaller-scale, regional providers of social care and health care. To gain the national perspective, we held two events in Birmingham and London for larger corporate providers, as well as people who use services and national organisations that represent them.

Engaging providers in the design process

In August and September 2009, we piloted the registration application process with providers from each sector in the north-west of England: 4 NHS trusts, 4 independent healthcare providers and 13 social care providers. Our local inspectors and assessors then reviewed the results. The test showed that our system worked, but highlighted ways in which we could make it more efficient and easier to understand before launch.

We also set up an online provider reference group, made up of more than 1,500 providers of health care and social care who review and test our regulatory tools and guidance in draft form to help us make sure that it meets their needs. During 2009/10, more than 350 NHS trusts from the group were involved in important 'co-production' work relating to registration.

Areas in the new essential standards

- **Information and involvement:** the information that providers make available to people so they can make informed decisions about their care and support.
- **Personalised care, treatment and support:** the way in which providers make sure that each person's care and treatment is effective, safe and meets his or her individual needs.
- **Safeguarding and safety:** the way in which a provider assures people that the equipment and premises used by its services are safe and suitable, and that the services manage any risks to people's safety and safeguard their dignity and human rights.
- **Suitability of staffing:** what providers do to make sure that they have suitably qualified, skilled and knowledgeable staff who can competently support people using their services.
- **Quality and management:** what providers do to manage risk so that their services maintain essential standards of safety and quality, and to notify us about deaths, unauthorised absences or other incidents involving people in their care.
- **Suitability of management:** the ways in which providers and their managers must show they are suitable to run their services, and when they need to tell us about absences of, or changes to, the provider or managers.

After reviewing our registration project in late summer 2009, The Office for Government Commerce (OGC), commended us on the progress we had made in such a short period of time. It also praised the extent to which we had involved our external stakeholders in developing the new system, calling our approach "an exemplar of best practice."

Roll-out to different care sectors

The new registration system comes into force at different points in time for different types of care. All NHS trusts had to be registered by 1 April 2010. Providers of social care and independent health care must be registered by October 2010, as this is when the Care Standards Act 2000 that currently applies to them is replaced by the Health and Social Care Act 2008. Dentists and ambulance services need to be registered by us by April 2011, and GPs by April 2012.

Communicating the new system to the NHS

Applying for registration was a new, unfamiliar process for NHS trusts. It was vital that they all knew what they needed to do, and by when, in order to be registered with CQC by 1 April 2010. We communicated the different stages of the process to them through:

- Regional workshops
- e-bulletins
- Direct mail
- A dedicated section on our website, including an e-learning module for providers
- An online 'Q&A' resource for our staff, so that they could answer trusts' questions quickly and accurately.

And to make our guidance on compliance as user-friendly as possible, we developed a dedicated microsite that automatically customised the information for each trust as soon as they entered their service types. In addition to very positive feedback from our provider reference group, the site won Communicators in Business Award of Excellence in April 2010.

Registration timeline (subject to legislation)

April 2010
NHS trusts

October 2010
Adult social care
Independent health care

April 2011
Dental practices
Independent ambulance services

April 2012
General practices

Launching the system in the NHS

The most pressing challenge of our first year was delivering the programmes of work needed to register England's 378 provider trusts by CQC by 1 April 2010. It was an enormous task, but the hard work and commitment of CQC staff, along with the enthusiasm and dedication of the NHS, ensured that every trust was registered in time.

Getting ready for roll-out across social care and independent health care

Alongside the later stages of our work to register the NHS, we developed the processes, tools and guidance needed to bring adult social care and independent health care into the new system from April 2010. There are more than 10,000 providers of social care, who deliver around 24,000 services throughout the country, and around 2,000 providers of independent health care. All of them must be registered with CQC by October 2010. Given the scale of this tranche of work, we are rolling out the application process in stages. We opened the process to the first batch of providers on 9 April 2010, and received our first application a few days later.

"An excellent solution to a complex problem. Beautifully clear and simple to use, a model for any organisation attempting to publicise complex legal/technical/policy/guidance information which needs to be tailored for specific uses/audiences/organisations/situations."

Communicators in Business, commenting on our award-winning microsite for care providers

A new approach to use of intelligence

A provider's registration is just the first step in our new regulatory system. Our focus then shifts to making sure that the provider continues to meet the essential standards required, through ongoing monitoring based on intelligent use of data. We will collate and analyse information about providers' services to build up a quality and risk profile of each provider. This information includes the views of people who use them, data from our assessments and information collected by other organisations. We will regularly update these profiles so that the information is as near 'real time' as possible. This will enable us to identify and tackle any concerns about a provider sooner than was possible under the previous, more retrospective system of regulation. If a provider's profile shows that it may be starting to fall below the essential standards, this will trigger action by our inspectors. If they find that the provider needs to make improvements, we can use our enhanced legal powers to make sure this happens.

Section 2

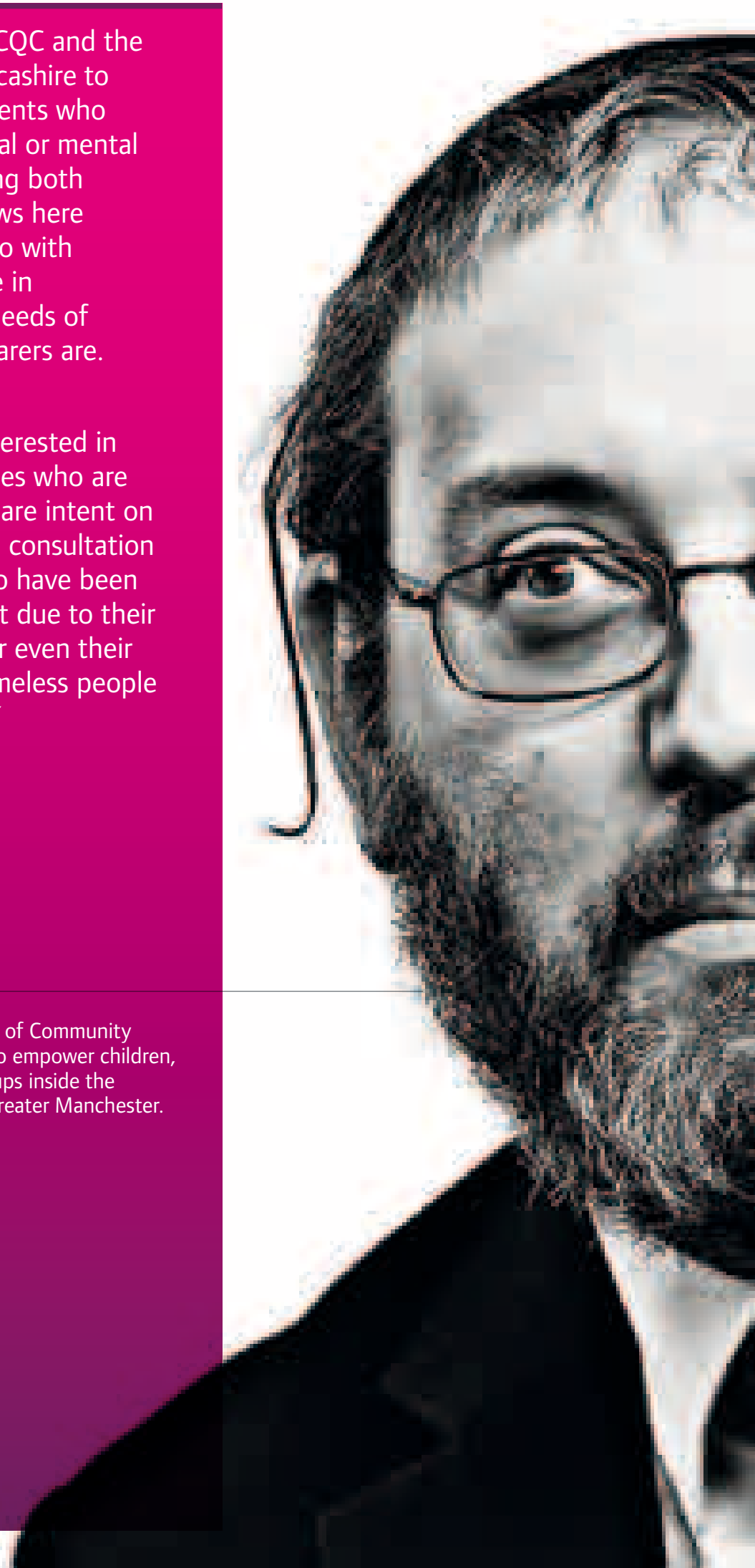
MAKING SURE EVERYONE HAS A VOICE

We put people who use services first from day 1

CQC's first corporate publication was a charter stating how we will involve people who use services in our work, and ensure that those who provide or commission care do likewise. Health care and social care have a direct impact on the quality of millions of lives in England every day. People's views and experience of care should shape how we, and providers and commissioners, go about our work.

"We're now working with CQC and the University of Central Lancashire to find out the needs of parents who have children with physical or mental disability. So we're working both with one-to-one interviews here in the community and also with an autistic support centre in Widnes to see what the needs of these families and their carers are.

CQC seem to be really interested in engaging with communities who are 'hard to reach'. And they are intent on getting the feedback and consultation from minority groups who have been excluded in the past, be it due to their religion, their sexuality, or even their way of living, such as homeless people or traveller communities."



Rabbi Simon Grant is the Director of Community Services for Binoh, which works to empower children, families and voluntary sector groups inside the Orthodox Jewish community in Greater Manchester.

> "… people who need to use health and social care services should be given the means to make their views known and to influence the way these vital services are delivered. This is particularly important for older people, and those who are disadvantaged for other reasons, who often go unheard in our society. That's why I'm giving my full support to Voices into Action."
>
> Dame Joan Bakewell, the government-appointed Voice of Older People, and guest speaker at our Voices into Action launch event on 24 June 2009

In June 2009 we launched Voices into Action, our charter on how we will involve people in our work. It explains how we will involve them in our decision-making and our assessments of care services, how we will use their feedback, and our commitment to letting them know how their views have shaped our decisions.

Our starting point was to take the best from the previous regulators' approaches to involvement, along with ideas of our own and established principles of good practice. This meant that we could use some established networks and groups while developing new ways of involving people from a wider range of backgrounds, including 'seldom heard' groups. Equally important has been our work to make sure that local care services involve their communities in their plans and decisions and respond to what people tell them.

Bringing people who use services into our work

Inspections of services

When inspecting a service, we focus on the experiences of the people who use it. For example, our inspector might talk to people during lunchtime at a care home and look out for visiting family members and friends to get their views as well. This is particularly important for people who have complex needs and may need someone to speak up for them. The inspector will also check that the staff are involving people in decisions about their care and listening to their views.

Our inspection teams sometimes take 'experts by experience' with them when visiting care services. These are people who have in-depth experience of using services, and are trained and supported in their expert role by voluntary organisations. Not only do they bring their own distinctive perspective to the inspection, but their presence also helps people using the service to feel more relaxed and confident about talking about their care. In 2009/10, experts by experience took part in 543 of our inspections of registered social care services, and in 34 inspections of how well councils organise social care for local people.

What an expert by experience does during an inspection:

- Supporting people who need help to communicate their experiences and views.
- Confirming that our inspector's rating is sound.
- Gathering specific types of evidence, if the aim of the inspection is to focus on a particular theme within care.
- Helping people to feel more relaxed talking about their care.
- Increasing the validity of our findings through their insights and expertise.

Acting together to protect people's rights

Our Mental Health Act commissioners visit services where people are detained under the Mental Health Act, or on community treatment orders, to check that their rights under the Act are being protected. This includes private, confidential meetings with any detained patient who may have a concern about their care and treatment. In 2009/10, our Mental Health Act commissioners met nearly 5,000 patients when visiting services. They also carried out eight "Acting Together" visits, in which a specially trained person with experience of being detained helps the commissioner to plan and carry out the visit.

Setting standards for care providers

In 2009/10 we started to develop ways of formally assessing how well those who provide or commission care involve people who use the services in their planning and decisions. This includes hospitals, primary care trusts, councils, care homes and home-care agencies. Both providers and the people who use their services have told us that good involvement leads to better experiences for everyone – including staff.

The first step in this important work is to define what this kind of involvement looks like when it's working well. During 2009 we invited a range of people who use services to help us draw up some 'benchmarks', based on their experiences and ideas. In February 2010 we held a workshop that brought them together with service providers, to discuss ways of grading providers' involvement activities – the first initiative of its kind.

Other ways we involve people

To make sure we put people first in everything we do – from our new system of registration to our corporate policies – we have a range of groups that enable them to shape our work.

Mental Health Improvement Board: advises us on improving outcomes for people who use mental health services and on how we monitor the use of the Mental Health Act.

People with Learning Disabilities Advisory Panel: helps us to plan and put into practice our action plan for people with learning difficulties.

Carers' Improvement Board: helps to ensure that our work takes into consideration the views and interests of England's 5 million unpaid carers.

Service User Reference Panel: represents people whose rights are restricted under the Mental Health Act.

Voices for Equality: advises and scrutinises us on our equality and human rights strategy.

Advisory Committee: a more general group that advises us on our approach to regulation. In addition to people who use services, it includes people from organisations that represent care providers, and commissioners of care (councils and primary care trusts).

CQC's work at every level benefits from input from people who use the services we regulate. Our most senior body – our Board of Commissioners – includes a member who has experience as a user of mental health services and who has been involved in a variety of user-led initiatives.

72,000

About 72,000 people took part in our survey of people admitted to hospital in summer 2008 – one of the biggest surveys of NHS inpatients ever

Linking into networks outside CQC

As well as creating our own groups, we have tapped into the knowledge, skills and experience of local networks that represent people who use services throughout the country. During 2009/10 we have been in regular contact with 800 of these groups, including local involvement networks (LINks), overview and scrutiny committees, and foundation trusts' boards of governors. We expanded Speak Out, a network of local groups which we support with the University of Central Lancaster, from 20 to 80 groups. Its members are from communities that are 'seldom heard' in the care system and we want them to have a stronger voice about the health and social care matters that affect them.

We developed an interactive online form to make it quicker and easier for groups to send us their views. After analysing this information, we add to the providers' quality and risk profiles, our key tool for monitoring compliance with the essential standards.

"Experts by experience ask questions that we may not consider, and they develop a rapport with the service users to gather lots of evidence about their experiences... Relaying this evidence in the inspection report gives very powerful messages."

CQC Inspector

Seeking people's views

Building the firm foundations we need to fulfil our regulatory responsibilities from 2010 has called for extensive consultation with those our work will affect. Among the many different types of stakeholders involved, people who use services have been a particularly important influence on our thinking. We had to be sure that our outcomes-focused approach, particularly when deciding whether to register a service, really did reflect what mattered to them.

Having a say about registration

To help us get our guidance for providers right, we organised 11 consultation events around the country. More than 1,000 people attended them, including people who use services and family carers. And to ensure that our consultation reached people whose views are not always heard, we also held 15 discussion events to reach the following groups:

- People from minority ethnic communities – including older people and those with English as a second language.
- Young asylum seekers and refugees.
- People from gypsy and traveller communities.
- Homeless people.
- People with experience of using mental health services, including patients detained under the Mental Health Act.
- Physically disabled people.
- People with learning disabilities.
- Family carers.
- People who are neurodiverse.

We made sure that our consultation document was available in easy read and other accessible versions from day one of the consultation.

Registration involvement group

As we developed how registration would work, we invited people who use the services that we would regulate through the new system to give us their insights, experiences and ideas. Our registration involvement group, made up of 30 people who use services and their carers, has reviewed our guidance and other key information for providers, and for our assessors and inspectors. Their involvement ensured that both our overall approach and the details reflect what is important to them. It was particularly valuable in helping to set the standards that providers and commissioners must meet in involving people who use services in their work.

CQC public consultations

Topic	Dates
Registration fees for providers of social care and independent health care	March – June 2010
CQC Assessments of quality	February – April 2010
Our single equality scheme	December 2009 – February 2010
Interim registration fees for NHS trusts	November 2009 – January 2010
Our strategy for 2010-2015	October 2009 – December 2010
Our position statement and five-year action plan for services for children and young people, and maternity services	August – October 2009
Our position statement and five-year action plan for mental health services	June – September 2009
Guidance for providers on compliance with the essential standards of quality and safety	June – August 2009
Voices into Action, our charter for involving people who use services	October 2008 – January 2009

Collecting views on NHS health care nationwide

Our national surveys collect the views and experiences of people using NHS healthcare services in every area of the country. The results influence the performance ratings we give their local NHS trusts, and help the trusts to identify where they need to improve.

This year we reported on our survey of people who were admitted to hospital in summer 2008. Around 72,000 people took part, making it one of the biggest surveys ever of the experiences of NHS inpatients. It highlighted that more patients rated their hospital wards and bathrooms as "very clean" compared to previous surveys, and more of them had noticed doctors and nurses washing their hands between patients. Less positive findings were that the NHS should do more to make sure that hospital food is of a consistently good quality, and that patients are sent copies of letters between hospitals and their GPs.

Our survey of people who used ambulance services for non-urgent medical problems in summer 2008 showed that 91% of our respondents "definitely" had trust and confidence in ambulance staff. Of the 4,000 people who took part, 73% rated their overall care as "excellent", and just 4% thought that help should have arrived "a lot sooner".

Section 3

DRIVING IMPROVEMENT IN CARE

13,000 inspections, mainly unannounced

Alongside creating a new system of regulation for 2010 onwards, we successfully delivered the work needed to make sure that care services met their responsibilities under the existing regulations. It ranged from inspecting more than 13,000 social care and healthcare services, and visiting nearly 5,000 people whose rights were restricted under the Mental Health Act, to prosecuting eight providers to protect people from poor-quality care.

"After the inspection, CQC went through with us what they'd found and the things we needed to improve. When they came back to re-inspect, they noticed that we'd worked really hard on our action plan. We had made a lot of improvements, including in how we communicate about HCAI within our trust.

Looking back, CQC's visit was very positive. It enabled us to focus on infection control, making sure we have the right criteria and standards in place. I believe that we're a lot further forward now than we would have been without it."

Andy Bates, Regional Head of Infection Prevention and Control for West Midlands Ambulance Services, talking about our work monitoring NHS compliance after HCAI registration.

"The CQC warning has encouraged the trust to evaluate all internal processes and standards that have the potential to impact on patient care, to ensure we can give quality assurance on all aspects – this goes much further than infection prevention and control."

Kevin Mackway-Jones, Medical Director of North West Ambulance Service NHS Trust, summing up the positive impact of CQC's inspection process

Our first year was a time of transition towards the new registration system that comes into effect in stages from 2010. To enable providers of care, councils and primary care trusts to prepare for the major changes ahead, we tried to minimise the impact of our assessments of performance under the previous system in 2009/10. Nevertheless, we made clear that we expected them to maintain the required standards throughout the year. We continued to scrutinise performance carefully and to take action if any services failed in their responsibilities to local people.

Reporting on the state of care in 2009

Because we are the first regulator to cover both social care and health care, we are the first to give a complete picture of the quality of care in England. After publishing performance ratings for the NHS in October 2009 and for councils' adult social services in December 2009, we combined this information to give a comprehensive overview in our first annual report to Parliament, *The state of health care and adult social care in England 2009*.

We found continued overall improvement in both sectors, with some services and areas of the country performing exceptionally well. However, a small proportion of healthcare and social care services were falling below minimum standards. Safety, safeguarding and staff training were particular concerns.

In view of our findings, the Department of Health asked all primary care trusts in England to make it a priority to review how they monitored out-of-hours services.

Inspection activity

During the year we carried out the following inspections to assess the quality of healthcare and social care services in England:

- Under the Care Standards Act 2000: 11,477 inspections of establishments providing adult social care services and 741 establishments providing independent health care.
- Under the Health and Social Care Act 2008: 250 inspections of NHS trusts, to check compliance with the standards for protecting people from healthcare-associated infection.
- 20 inspections of children's services with Ofsted, and 13 inspections of health services for young offenders with Youth Offending Teams.
- 1,075 inspections to check providers' arrangements for managing the use of controlled drugs.
- 5 site visits during our investigations of incidents in which people received 'greater than intended' exposures to ionising radiation.

Tackling poor performance

Enforcement

If a health care or social care service falls short of the required standards of quality and safety and continues to fail to improve, we take swift and strong action to protect people using the service.

During 2009/10 we served 536 legal notices to providers. Almost all (98%) of the problems we had identified were put right by the providers by the deadlines we gave them.

If necessary, we will take a care provider to court to protect the public from poor and unsafe care. During our first year we successfully prosecuted eight organisations:

- **May 2009:** the owners of Clarendon House, a care home in Coventry, were fined £1,666 and ordered to pay £600 court costs for repeatedly failing to address problems with how it was managing medicines – including repeated errors and not giving a resident pain-relieving medication for three days.
- **June 2009:** Pantherday Ltd was fined £2,500 and ordered to pay £12,500 court costs for offering medical services without being registered with us.
- **October 2009:** Waveriver Ltd was fined £10,000 and ordered to pay £3,000 court costs for running five services that used hair-removal lasers without being registered with us. Synergy Ltd and Anthony Mujawo were fined £2,500 and ordered to pay £1,000 court costs for operating an unregistered nurses' agency. Beautology was fined £1,000 and ordered to pay £500 court costs for operating an unregistered independent hospital.
- **February 2010:** Orchard Care Homes.Com Ltd was fined £3,200 and ordered to pay £732 court costs, for not meeting the required standards for residents' care plans and managing medicines. European Care was fined £3,400 and ordered to pay £15,300 court costs, for failings in the quality of its care services.
- **March 2010:** Care Principles Ltd was fined £5,000 and ordered to pay £12,000 court costs for failing to meet the required standards for managing medicines.

Investigations

In July 2009, we published our report on an investigation into West London Mental Health NHS Trust, which included inpatient services at the high-security units at Broadmoor Hospital. The investigation looked at how well the trust was protecting patients from harm. Since the start of the investigation in 2008, the trust had addressed some concerns, such as implementing new monitoring systems, but needed to do more to ensure that patients received the highest possible standard of care.

After we have identified serious concerns at a service, we monitor the situation through follow-up reviews. For Mid Staffordshire NHS Foundation Trust, this meant us making several unannounced visits to check the trust's progress against the action plan that it drew up in response to our original investigation. Our follow-up report in December 2009 said that the trust was taking information about its mortality rates seriously. Nevertheless, it had to continue to build public confidence by communicating better with local people, including showing them how it uses their feedback. In January 2010, our follow-up report after an investigation into maternity services at Milton Keynes Hospital NHS Foundation Trust found that although there were enough temporary midwives in place to give mothers and babies safe and effective care, the trust needed to recruit more permanent staff and plan better for emergency situations. For both of these follow-up reviews, we worked closely with Monitor, the regulator of foundation trusts, to share information and help drive improvement at the trusts.

In June 2009, we launched an enquiry into the out-of-hours services provided by Take Care Now, an independent healthcare organisation. It was triggered by the death of a patient after he was administered 100mg of diamorphine by a locum doctor from Germany. Our visits to the five primary care trusts that commission these services found that although they were monitoring Take Care Now's response times, they were not routinely looking in detail at the quality of the care it provided. In view of our findings, the Department of Health asked all primary care trusts in England to make it a priority to review how they monitored out-of-hours services.

Monitoring aspects of safety in health care

Healthcare-associated infection

Under the new regulations, NHS trusts had to be registered with us from 2009 to show that they were meeting the standards for protecting people from healthcare-associated infections – a year before their general registration. This involved 378 organisations: acute trusts, ambulance trusts, mental health trusts, primary care provider trusts, and NHS Blood and Transplant. However, we registered 21 trusts on condition that they made improvements in areas including cleaning, decontamination arrangements, staff training and infection control policies. All of them had done so by December 2009.

250

Spot checks to monitor trusts' compliance after their HCAI registration

Our work to monitor compliance after registration involved 250 unannounced spot checks. We found that 47 trusts needed to make improvements, and issued warning notices to five of them. This was the first time that we used our strengthened enforcement powers, which now extend to the NHS under the new regulations.

As part of this programme of work, we inspected England's 11 ambulance trusts – the first time the regulator has done so. Four of them were not meeting the infection-control standards and a further six needed to improve. Yet once we had identified these problems, the trusts were eager to improve as quickly as possible. When carrying out follow-up inspections, our assessors were satisfied with the changes that had been made, and some noted how staff were feeling more pride about their work because they were playing a part in these improvements.

Outliers programme

We published details of the 107 mortality alerts that we have reviewed and closed in 2009/10. This work involves analysing the number of people who have died in NHS hospitals throughout England after being admitted for a particular condition or procedure, to alert us to any hospitals where the number is significantly higher than expected. Not only does this enable us to identify where we need to carry out an investigation, but it also pushes hospital trusts to monitor their mortality data carefully and to take action where necessary. Our investigation into Mid Staffordshire NHS Foundation Trust was the result of intelligence we gained through this programme.

During the year, we expanded our outliers programme to include alerts for emergency readmissions within 30 days of discharge after elective hip replacement, knee replacement or hernia repair procedures, and a set of indicators for maternity services.

Management of controlled drugs

In December 2009 we published our annual regulatory report on how well healthcare organisations have been implementing The Controlled Drugs (Supervision of Management and Use) Regulations 2006 that were introduced in January 2007 following the Shipman Inquiry. We found that in 2008/09 most of them were complying with the regulations, and the problems experienced during the first year of the new system had been resolved. Healthcare workers were better trained and could identify problems sooner, but monitoring still needed to be more embedded into their routine practice.

Use of medical ionising radiation

In 2009 we investigated 483 notifications of patients having exposures to ionising radiation that were "much greater than intended", including five site visits to gather more evidence. We completed our inspection programme of radiotherapy departments, made four proactive inspections of cardiology departments, and piloted inspection programmes in other clinical disciplines, including dental and chiropractic radiography.

Monitoring the operation of the Mental Health Act

Our work monitoring how mental health services use their powers under the Mental Health Act is vital to protect the rights of people detained in hospital or on community treatment orders. In 2009/10 our Mental Health Commissioners visited 1,504 mental health services in the NHS and the independent sector and met with 4,934 patients.

We received 15,288 requests for second opinions about patients' care and treatment under the Act, through our second opinion appointed doctor service. This was more requests than the Department of Health's forecast, which put the service under considerable pressure. As around half of these second opinions were not completed within our target times, we commissioned a management review to explore the issues involved, including the legacy targets being used and the impact of staffing levels and of varying levels of support from providers.

We will report on the review's findings in the autumn, but in the meantime, we have:

- Increased the number of second opinion doctors on our panel from 90 to 115.
- Issued guidance to the mental health sector to make improvements in when they make requests.
- Changed our review system to make better use of second opinion doctors' time. This increases the number of patients they can see during a review visit.

107

Mortality alerts that we reviewed and closed

Looking at particular areas of care

Keeping children safe

We published two reports about child protection – both at the request of the Secretary of State for Health in response to the death of Baby Peter. The first report brought together comprehensive evidence about the 34 contacts that Peter had with health professionals after his birth, which were mainly at North Middlesex University NHS Trust, Haringey Teaching Primary Care Trust and Great Ormond Street Hospital for Children NHS Trust. We drew the information from medical notes, the results of a joint area review of safeguarding in Haringey by the Healthcare Commission, Ofsted and HM Inspector of Constabulary; and Haringey Council's serious case review report about Baby Peter's care.

We reported that the trusts had made progress in addressing the gaps in their child protection procedures. However, more needed to be done to make sure that health care staff attend multi-agency case conferences, and to improve communication between healthcare professionals and social care staff about referrals for child protection.

The second report looked at child protection throughout the NHS. Although our survey of 392 trusts showed that most of them had the right people and systems in place, there were worrying shortfalls in the numbers of staff who were up to date with mandatory training in child protection – including GPs and A&E staff.

Inequalities in people's health

Our report, *Closing the gap*, found that health services have worked hard in the last 10 years to reduce deaths from cardiovascular disease and the inequalities between deprived areas and other parts of the country. However, we called for them to increase their prescribing of statins, focus more on managing people's cholesterol levels, and make stop-smoking services available to more people living in deprived areas. Cardiovascular disease is responsible for one in three deaths in England. In our follow-up work we will look in more depth at its causes and its impact on the population's health, including commissioning data on smoking-related deaths.

Sharing information

During autumn 2009 we published three reports that urged the healthcare and social care sectors to manage and share information better in order to improve people's experience of care. *The right information, in the right place, at the right time*, looked at how healthcare organisations manage personal data. Although 80% of staff surveyed were confident that patients' information was treated confidentially, 30% of patients said that they were not given enough privacy when discussing their condition or treatment.

483

In 2009 we investigated 483 notifications of patients having exposures to ionising radiation that were greater than intended

We published two reports about child protection in 2009/10 – both at the request of the Secretary of State for Health in response to the death of Baby Peter.

Working together to prevent and control infections found that hospitals and care homes need to improve how they communicate with each other to help prevent infections. For example, almost 300 care home managers we surveyed had concerns about receiving illegible or incomplete information from hospitals that had discharged people to them. If a person has an infection that is not noted, their care may not address this need and they could pass the infection on to other people in the home.

Managing patients' medicines after discharge from hospital found evidence of good practice by GPs in this area. However, GPs and hospitals did not always share information about changes to people's medication effectively when they move between services. Eighty-one per cent of GPs said that the summaries of patients' care that hospitals sent them had insufficient detail "all of the time" or "most of the time". This could lead to GPs prescribing incompatible drugs and harm to the patient. Under our new registration system, healthcare services must show that they meet the essential standard for management of medicines before we will register them.

Special reviews and studies

In 2009/10 we created a programme of special reviews and studies that takes advantage of our unique '360 degree' perspective across both health care and social care.

To make sure that our reviews and studies ask the right questions, we set up an advisory group for each project. These groups include people who use services and their representatives, managers from organisations that provide or commission services, healthcare or social care professionals, academic experts, and representatives of national bodies and professional colleges.

We carried out planning work and field research for the following reviews in 2009/10, and aim to publish our findings between autumn 2010 and early 2011:

- Meeting the healthcare needs of people in care homes.
- Services for people who have had a stroke and their carers.
- Support for families with disabled children.
- Social services' response to people's first contact with them.

We will include findings from these reviews in the information that we use to monitor registered providers' compliance with the essential standards. If a service performs poorly in a special review, this could trigger action by our local inspection staff.

Section 4

OUR PRIORITIES

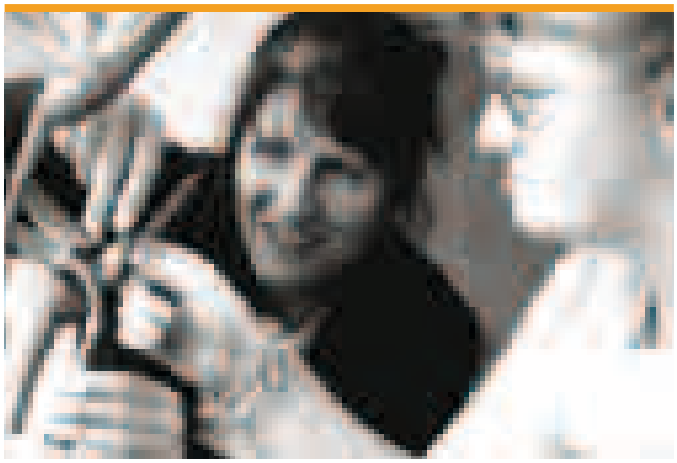
5 priority areas where CQC can make a real difference

When developing our five-year strategy, we started by identifying the most important influences on the quality of health care and social care in England. We have made them the focus of our regulatory work, and will pay particular attention to the needs and rights of more vulnerable groups. We believe that by doing so, we can help to make care better for everyone.

"Instead of carrying out a set number of inspections in a certain time period, it's now based on whether we think the people using a service are at risk, based on the information CQC continually collects, which includes people's views.

CQC is determined to put people and their views first. It's very high on the agenda – for example, with our Mental Health Advisory Group, employing people with a learning disability and building our communication with LINks and local independent networks."

Liz Palmer is a CQC Inspector in our South East Region, checking that both healthcare and social care services comply with our essential standards of quality and safety.



A crucial activity in our first year was developing the strategy that would guide CQC's work from 2010 to 2015. After consulting widely on our plans, we published our final strategy in February 2010. Driven by our vision of high-quality care for everyone, it explains what we are setting out to achieve for people who use services, how we will go about it, and how we plan to measure the impact of our work.

We will focus our work on what we believe are the most important influences on the quality of people's care and the outcomes they experience. Our unique role as the regulator of both health care and social care, coupled with our increased legal powers, gives us the opportunity to make a real difference in these priority areas:

- Making sure care is centred on people's needs and protects their rights.
- Championing joined-up care.
- Acting swiftly to help eliminate poor quality care.
- Promoting high-quality care.
- Regulating effectively, in partnership.

We have identified 10 key issues that have shaped our priorities:

1. People should be able to secure fair access to care, whether they pay for it themselves or it is publically funded.
2. Care should be centred around people, and support their independence and choice.
3. Planners and services should invest in prevention, and early intervention and support.
4. There should be real effort to reduce inequalities in health and well-being.
5. Services should tackle poor performance.
6. There should be increasing openness about the quality and safety of care.
7. Services should make sure that staff are properly trained and supported to do their jobs.

8. There should be strong and effective leadership at all levels of care.
9. Services should work together across health, social care and other public services, such as housing.
10. Care services should support people who are made vulnerable by their circumstances and make sure that their rights are protected.

All of our work over the next five years will relate directly to one or more of our priorities. And in everything that we do, we will promote equality and protect people's human rights. This will involve paying close attention to differences in people's access to services, the safety and effectiveness of the care they receive, and people's right to be treated with dignity and respect.

Protecting more vulnerable groups

We will pay particular attention to the needs of more vulnerable people, including those with mental health problems, learning disabilities, physical disabilities or long-term conditions; older people, and children and young people. During 2009 we published separate position statements and five-year action plans for promoting improvement in services for:

- Children and young people, including maternity services.
- People who use mental health services.
- People with learning disabilities.

The questions we asked our stakeholders before finalising our strategy for 2010-2015

1. Have we set the right priorities to improve the quality and safety of care?
2. Are we planning to go about our work in the right way?
3. Are we clear about our role in improving the quality of care for people in the wider system?
4. How can our regulation:
   - Strengthen the voice of people in our assessments of the quality of care?
   - Improve services and organisations where performance is poor?
   - Contribute to better integrated and joined-up care?
5. How can we streamline regulation most effectively?
6. How can you help us to achieve our plans?

To find out what we will do to deliver our priorities, download our Strategy for 2010-2015 from www.cqc.org.uk. To see our goals for the year ahead, go to page 39 of this report.

Section 5

PUTTING OUR PRINCIPLES INTO PRACTICE

CQC's new structure of 9 regions takes us closer to the communities we serve

To be sure of achieving our goals on behalf of people who use services, we first needed to build our organisation on the right foundations. This included developing a structure and business practices that will deliver our outcomes-based approach as effectively as possible, and with a strong focus on equality and human rights.

"I can't look at patients' records, but I can sit and chat with patients. And some people are much more willing to talk to me than to the Commissioner. So we always give them a choice of whether they want to see both of us, or one of us on our own. I can also sit in on their community meetings and other activities. It's good for patients' morale, and for the staff, to see someone actually inspecting the ward."

Margaret Jessop, who has bipolar disorder, talking about her 'Acting together' visits, where she accompanies our Mental Health Act Commissioners to talk to patients who are detained in mental health services.

"Against a background of major cultural change, resulting from the merger of three existing regulatory organisations, the momentum created reflects the quality and commitment of all those involved. We have been impressed by the high level of engagement of both internal and external stakeholders and their involvement in the co-production of products. The Review Team see this approach as an exemplar of best practice."

Office for Government Commerce Gateway Review Team, commenting on our registration project in summer 2009

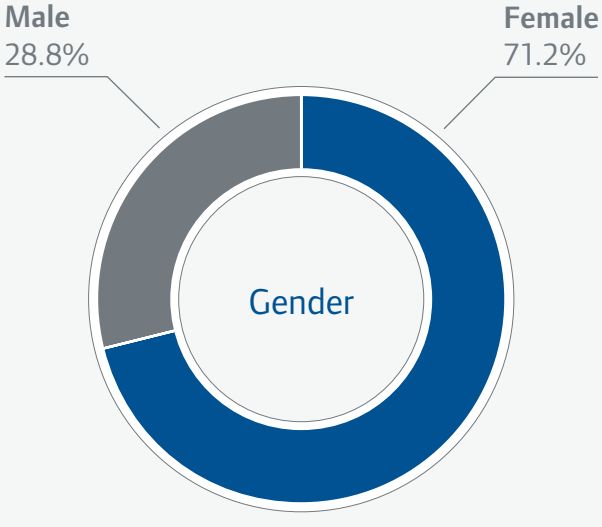
We believe in expecting the same of ourselves as we do of the organisations we regulate. This means making sure that the principles of equality and human rights, as well as those of better regulation and good business practice, are reflected in every aspect of our work.

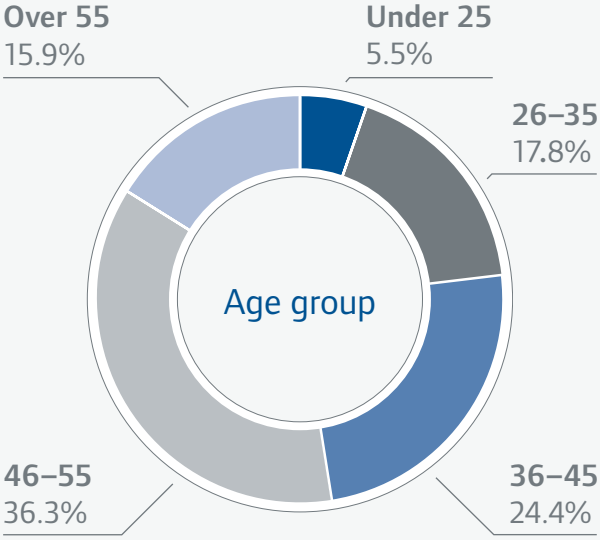
Aligning our structure with our priorities

One of our most urgent and complex tasks in our first year was to create the right organisational structure to deliver and support the new system of registration from 2010/11 onwards. Achieving this involved centralising our business services and extending home working. By the end of October 2009, we had reduced our estates from 23 offices in 13 locations to 8 regional offices and a corporate office in London, and by early 2010 had reduced our workforce from 2,900 to 2,100.

Our Shared Services centre in Newcastle was open by our first day of operation and we migrated our operational processing from regional offices to the centre during the first half of 2009/10.

CQC staff by...





As a result of these changes, we delivered the same level of assurance about the safety and quality of care as our three predecessors, but with an annual budget of £164.4 million compared to their combined budget of £240 million in 2005/06.

Promoting equality and human rights

In March 2010 we published our single equality and human rights scheme and action plans. These set out how through our work we will help to create a culture of care that puts individuals at the heart of services, and protects their human rights and promotes equality. The scheme also sets out our responsibilities for ensuring that all of our staff are valued, involved, supported and feel safe from discrimination.

During the year we set up a Voices for Equality Group and a Human Rights Steering Group, both of which will monitor CQC's progress against its action plans.

We developed a new set of tools for assessing the equality impact of our activities, with an increased focus on human rights. After consulting staff about the best approach for representing all the strands of diversity within our workforce, we set up a Disability Equality Network, a Race Equality Network and a Lesbian, Gay, Bisexual and Transgender (LGBT) Equality Network.

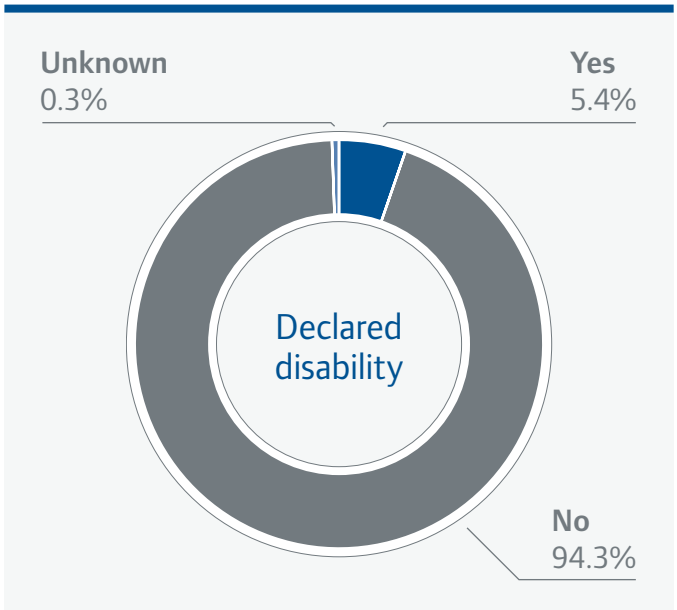
Supporting our staff

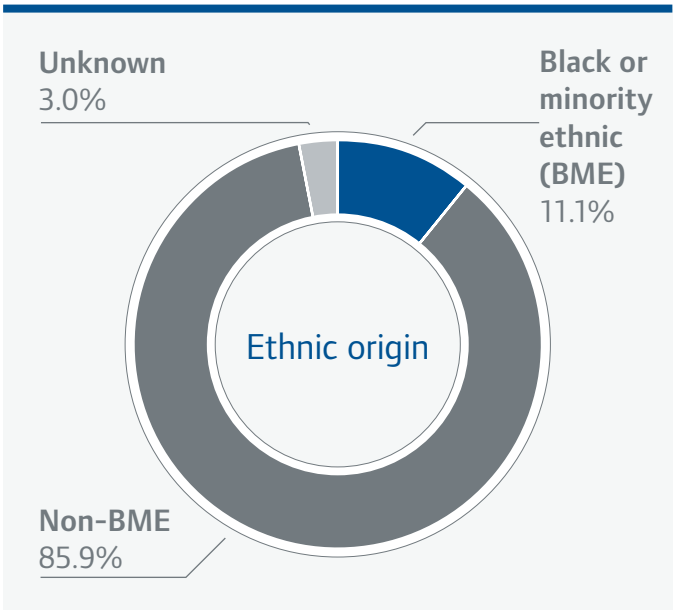
In January and early February 2010 we held regional roadshows to tell staff about the changes we proposed making to our operational model. We then entered a formal consultation period with individual members of staff from mid-February 2010 onwards.

We introduced a joint national negotiating committee for consulting and negotiating with recognised trade unions, and a staff forum to broaden our engagement with staff, particularly those who do not belong to a recognised trade union.

The launch of CQC brought together staff from three very different organisations and cultures to achieve new and challenging corporate goals. To help unite us with a clear common purpose in 2009/10, each member of staff had a set of formal performance objectives that were closely aligned to CQC's overall objectives, with progress reviews during the year.

To keep our newly home-based workforce in touch with daily developments at CQC, we worked hard at developing our digital communications with staff. This included significantly improving the CQC staff intranet, and launching a weekly e-bulletin by the Chief Executive and a monthly e-newsletter. We also held focus groups so that staff could shape the design of CQC's first staff survey, which was launched in May 2010.





Standards of service

After overcoming some challenges in early 2009/10, by the second half of the year our shared services centre was meeting its target times for processing registrations of social care and independent healthcare providers under the Care Standards Act 2000.

The centre handled 275,258 calls during the year, of which 4,400 were safeguarding calls. Call-handling improved steadily throughout the year, and by the end of 2009/10 the centre was answering 98.6% of calls within the target time.

We aim to answer 90% of safeguarding calls within 20 seconds, but by the end of the year the centre had risen well above target with 94% of these calls being answered within 20 seconds.

Working in partnership

CQC is committed to working with other regulators and performance management organisations to reduce duplication and overlap of our activities. Our joint aim is to lessen the impact of regulation on those who provide or commission health care or social care, and to improve its cost-effectiveness.

During the year we worked more closely with Monitor on the regulation of foundation trusts, and in September 2009 published a memorandum of understanding setting out our framework for working together.

275,258

The centre handled 275,258 calls during the year

98.6%

Percentage of calls answered within target time

Nearly three-quarters (120) of the 165 data sets that we used to cross-check NHS trusts' declarations of performance against the existing core standards had been collected by other organisations. In addition, we explored how we could use information collected by commissioners of services to support our regulatory activities. This led to CQC developing a joint working protocol with Directors of Adult Social Services, which was signed in May 2010.

To help reduce the variation in reporting of safety incidents by different types of NHS trusts, we worked with the National Patient Safety Agency (NPSA) to develop a new, single reporting system. From 1 April 2010, all NHS trusts must report their safety incidents to the NPSA to meet our registration requirements.

As part of our joint work on early warning systems in the NHS, we carried out collaborative reviews of NHS trusts in our nine regions with a range of other regulators and audit and review bodies. Together we drew up action plans for eighty of the trusts, and decided to hold risk summit meetings for eight of them.

Our Provider Advisory Group is made up of organisations that represent providers and commissioners. During the year the group provided valuable feedback and suggestions as we developed our regulatory approach and methods, including on proposed registration fees.

We used the data collected by 33 partner organisations when cross-checking NHS trusts' declarations of performance against existing core standards

Responding to complaints

At CQC we welcome comments and suggestions about our performance and the conduct of our staff, including complaints about CQC. We investigate every complaint that we receive, and use the feedback to help develop and improve how we go about our work.

During 2009/10, we received 110 complaints about CQC. Seventy-one of them were successfully resolved at stage 1. In the other 39 cases, the complainant requested a stage 2 review by our Complaints Review Service. Seventeen complainants then asked the Parliamentary and Health Service Ombudsman to review their cases. At the time this report went to print, the Ombudsman had not taken any of these complaints forward for investigation.

Most of the complaints we received were from providers who felt that we had not communicated with them efficiently, or because they had concerns about the behaviour or actions of a CQC inspector or another member of our staff. We received fewer complaints from members of the public, including people who use services. When we did, they were usually about the fact that we could not deal with the person's complaint about a care provider, because Parliament has not given us this responsibility.

Section 6

LOOKING FORWARD

We are now on a challenging but exciting journey towards achieving our priorities

Over the next few years, we are likely to see marked changes in the environment in which we operate, reflecting growing economic pressures and the change of Government. CQC will respond constructively to these challenges, while ensuring that care providers and commissioners continue to meet the essential standards that people have the right to expect.

"Now, as CQC is coming to the end of its first year, we have been part of an advisory group that has been helping to set policy and have discussions around what information you want from a LINk and what information the LINk would like back from CQC – it is an evolving and a learning process."

Elizabeth Mackie is the Manager for East Sussex LINk, which is a network that gathers the experiences and views of local people, organisations and groups about health and social care to feed back to services and CQC.

"Putting people at the heart of our work is driving our operation. Over the coming years as resources reduce, our role as the 'quality regulator' will become ever more significant. Our success will depend upon engaging with all communities and listening to their experiences and concerns."

Jo Williams, CQC Acting Chair

A constant presence on the horizon in 2009/10 was the growing economic pressures that may limit the public funds available for health care and social care in the future. This tightening of resources is set against a predicted increase in the need for care services, as more of the population develop ageing-related and life-style related conditions, and as people come to expect more choice and control over their care.

When responding to policy proposals in 2009/10, we focused on the need to protect the quality of care in the face of these challenges. We also looked into how we could develop our regulatory approach to increase the efficiency and effectiveness of care, through improved quality and more joined-up working between different types of services.

Helping to shape the future of care

In 2009/10 we responded to more than 50 consultations by Government and organisations that work to promote improvements in social care and health care. We included evidence gathered through our regulatory work and the views of people who use services. We gave oral evidence to a Health Select Committee Inquiry on social care, and written evidence on inquiries into patient safety and commissioning of NHS health care.

We continued to contribute to the Department of Health's review of Arm's Length Bodies, which aims to improve their effectiveness and reduce their costs.

Our goals for the year ahead

Our Business Plan 2010/11 sets out the work we will be delivering within each of our priority areas during our second year. Our key objectives will be:

- **Registering** more than 12,000 providers of adult social care and independent health care by October 2010, and working throughout the year to drive improvement by services rated 'poor' and 'adequate'.
- **Monitoring** NHS trusts, and providers of social care and independent health care from October 2010, to make sure that their services continue to meet the new essential standards.
- **Making and embedding** the major organisational changes needed to support our new system of registration, including monitoring compliance.
- **Becoming increasingly local** in our work, including supporting our inspectors and assessors to develop effective working relationships with providers and commissioners and good awareness of local issues.
- **Engaging successfully** with all of our stakeholder groups, so that they understand and value our approach to regulation, and people who use services think that we are involving them appropriately.

We successfully delivered what we set out to achieve in our first year of operation. We are now at the start of a challenging yet exciting journey towards achieving our priorities, inspired by our vision of safe, effective, high-quality care for everyone.

12,000

We aim to register more than 12,000 providers of adult social care and health care by October 2010

CORPORATE GOVERNANCE AND FINANCIAL STATEMENTS

Corporate governance

Statutory background

The Care Quality Commission (CQC) is a non-departmental public body (NDPB) established under the Health and Social Care Act 2008. It came into existence on 1 October 2008 with the appointment of Board members and a Chief Executive. As a NDPB, the Commission is accountable to the Secretary of State for discharging its functions, duties and powers effectively, efficiently and economically.

CQC became fully operational on 1 April 2009 when it took over the activities of the Commission for Social Care Inspection (CSCI), the Healthcare Commission (HC) and the Mental Health Act Commission (MHAC).

Principal activities

The CQC is responsible for the registration, review and inspection of health and adult social care services and monitors the operation of the Mental Health Act in England. In carrying out this role, it contributes to the delivery of safe, quality health and social care that supports people to live healthy and independent lives, empowers individuals, families and carers in making informed decisions about their care, and is responsive to individual needs.

Organisational structure and governance

Board membership

	Date appointed	Term of office
Dame Jo Williams (Acting Chair as of 1 Jan 2010)	1 Oct 2008	4 years
Baroness Barbara Young (Chair) (resigned with effect from 31 Dec 2009)	1 Oct 2008	4 years
Professor Deirdre Kelly	1 Oct 2008	2 years
Olu Olasode	1 Nov 2008	3 years
Kay Sheldon	1 Dec 2008	2 years
Professor Martin Marshall	1 Jan 2009	4 years
John Harwood	4 Mar 2010	4 years

Roles and responsibilities of the Board

Members of the CQC Board have a collective corporate responsibility to ensure that the Commission follows proper legal and administrative requirements on the use of public funds, including any provision of a framework document, financial memorandum or other documents governing the relationship between the Commission and the Department of Health.

Board members must also:

- Ensure that high standards of corporate governance are observed at all times.
- Set the overall strategic direction of the Commission within the policy and resources framework agreed with the Secretary of State.
- Ensure that the Commission operates within the limits of its legal framework and any delegated framework agreed with the Secretary of State and the Department of Health, and in line with any other conditions relating to the use of public funds.

- Ensure that the Commission, in reaching decisions, engages fully in collective consideration of the issues, taking account of the full range of relevant factors, including any guidance issued by the Secretary of State and other relevant central government departments.

Register of interests

A register of interests exists for Board members to record any interests affecting their role on the Board. This register is a document that is open to public scrutiny at CQC's headquarters, Finsbury Tower, 103–105 Bunhill Row, London and is available on CQC's website. Where any decisions were taken which could give rise to a possible or perceived conflict of interest, the member concerned would declare the same and would not vote on the item on the agenda. At the Chairman's discretion he or she would be asked to withdraw for the duration of any discussion of the item.

Independent members

	Date appointed	Term of office
Julian Duxfield (Remuneration Committee)	17 Nov 2009	2 years
Martin Smith (Audit and Risk Committee)	26 Oct 2009	1 year (resigned with effect from 25 Jan 2010)

The effective date of appointment is the date of the first meeting they attended.

Martin Smith resigned after accepting an executive appointment at a local authority, which gave rise to a conflict of interest.

Committees, meetings and attendance

Remuneration Committee

The work of the Remuneration Committee is detailed in the Remuneration report contained in pages 52 to 57 of this report.

Audit and Risk Committee

This committee has been formed as a sub-committee of the Board to independently provide assurance on CQC's risk management, governance and internal control. Two workshops were held during the year with the purpose of providing training to Audit and Risk Committee members in the essentials of risk management and to raise awareness of risk.

Membership

- Olu Olasode (Chair)
- Professor Deirdre Kelly
- Professor Martin Marshall
- Martin Smith (independent member) from 26 October 2009 until 25 January 2010

In addition, the Chief Executive, the Finance and Corporate Services Director, the Risk Manager and the Head of Secretariat regularly attended meetings of the Committee together with the external and internal auditors.

The main function of the Audit and Risk Committee is to advise the Board on the adequacy and effective operation of its systems of internal controls and therefore the quality of financial and other reporting of the Care Quality Commission.

The Committee carried out its work by reviewing and challenging the assurances which were available to the Accounting Officer, the way in which these assurances were developed, and the priorities and approaches on which the assurances were arrived at.

Specifically, the Audit and Risk Committee provided advice by:

- Review and oversight of the preparation of annual accounts for the approval of the Commission.
- Review of the Commission's systems of internal control and risk management.
- Monitoring the effectiveness of internal audit and of the relationship with and between internal and external auditors.

The Committee met on five occasions during 2009/10 and made regular reports to the Board on its activities.

The Comptroller and Auditor General (C&AG) is appointed by statute to audit CQC. As the external auditor they had the right of direct access to the Chair of the Committee. The Commission's external auditors did not provide any additional services to the Commission during 2009/10.

During 2009/10, KPMG was responsible for the internal audit at the Commission. The Committee agreed the planned programme of audits, as well as any changes to the programme and ensured that those conducting the internal audit had the necessary access to information to enable them to fulfil their mandate. The Head of Internal Audit had the right of direct access to the Chair of the Committee. The Commission's internal auditors did not provide any additional services to the Commission during 2009/10.

The Audit and Risk Committee considered and advised the Chief Executive, as the Commission's Accounting Officer on the organisation's annual accounts. The Committee also commented and advised on the Statement on Internal Control, which was subsequently signed by the Chief Executive.

Risks relating to key aspects of the Commission's activities were explored by the Committee throughout the year. These included the security of information and steps being taken to prevent fraud.

The Committee produced its own annual report, which set out its activities.

Executive Team

The Executive Team is responsible for CQC's development and performance. It oversees the delivery of the work programme as per the Strategic Plan, and the outcomes set out in the performance assessment framework as agreed by the Board.

Executive Team		Date appointed
Chief Executive	Cynthia Bower	1 Aug 2008
Director of Human Resources and Organisational Development, acting as Chief Operating Officer from 9 Oct 2009*	Kylie Kendrick	5 May 2009
Director of Engagement	Jill Finney	24 Feb 2009
Director of Regulation and Strategy (seconded from the Department of Health)	Jamie Rentoul	1 Mar 2009
Director of Intelligence	Richard Hamblin	1 Mar 2009
Director of Methods	Gary Needle	1 Mar 2009
Director of Finance and Corporate Services	John Lappin	1 May 2009
Director of Registration (seconded from London NHS)	Linda Hutchinson	1 Apr 2009
Director of Operations (resigned 30 Nov 2009)	David Johnstone	1 Jul 2009

* While the Director of Human Resources and Organisational Development is acting as Chief Operating Officer an Interim Director of Human Resources and Organisational Development has been appointed. The Interim Director of Human Resources and Organisational Development is not a member of the Executive Team.

Regular attendees at Executive Team meetings include the Head of the Secretariat, the Chief of Staff and the Deputy Director of Frontline Operations.

Additional changes to the Executive Team were announced in May 2010. Gary Needle left the organisation in June 2010 and Jamie Rentoul will return to the Department of Health during 2010.

Management commentary

Review of activities

With effect from 1 April 2009 and following the merger with the three previous regulators – CSCI, HC and MHAC – CQC has delivered regulatory activities for health and social care and monitored the operation of the Mental Health Act in England as well as designing and consulting on the new system of regulation we are tasked to implement.

We have been given a range of legal powers and duties. These include:

- Registering providers of health care and social care to help ensure they meet the essential standards of quality and safety. (In 2009/10 this power only related to adult social care and independent health care.)
- Monitoring how providers comply with the standards – gathering information and visiting them when we think it is needed.
- Using our enforcement powers, such as fines and public warnings, if services drop below the essential standards. If we believe that people's rights or safety are at risk, we will act quickly – including closing down a service if necessary.
- Acting to protect patients whose rights are restricted under the Mental Health Act.
- Promoting improvement in services by conducting regular reviews of how well those who arrange and provide services locally are performing.
- Carrying out special reviews of particular types of services and pathways of care or undertaking investigations on areas where we have concerns about quality.
- Supporting public accountability by assessing performance and by contributing to 'Oneplace' – the joint assessment of how well people are being served by their local public services.
- Seeking the views of people who use services, involving them in our work and publishing a statement on how we do this.
- Telling people about the quality of their local care services. This will help providers and commissioners of services to learn from each other about what works best and see where improvement is needed and help to shape national policy.

Our work in 2009/10 has included carrying out risk-based inspection and enforcement activity of some 27,000 adult social care and independent healthcare provider services, delivering assessments of local councils' adult social care commissioning, of primary care trusts' health commissioning, and of the performance of NHS health service provision. We have also carried out visits to people detained under the Mental Health Act as part of our responsibilities to help protect their rights.

We have developed and published our five-year strategy and have set out how we will ensure that the voice of people using services features at the heart of our work. In consultation with a wide range and number of stakeholders, we developed a completely new model of registration for health and adult social care to be introduced from April 2010, and have registered NHS providers in preparation for the introduction of the registration system. We have consulted on our draft equality and human rights scheme, and launched our consultation on our approach to wider assessments of quality.

We have published information on our website and in reports about the services we regulate, including a system of quality ratings for adult social care services in order to provide people with information to inform their choices. Further, we have published *The state of health care and adult social care in England*, in which we set out the key themes and quality of services in 2009, based on our regulatory work.

We published our business plan for 2010/11 in April 2010. This sets out how we are implementing our strategy, and how we aim to make care better for people through our regulatory activities and how we will measure how we are succeeding.

Future developments

Our key delivery priorities for the next year are:

- Following the introduction of full registration of NHS providers by April 2010, delivering an effective programme of work on monitoring compliance with essential standards of quality and safety.
- Effectively managing the re-registering of about 27,000 adult social care and independent healthcare providers by October 2010 with a programme of work before and after that date which particularly focuses on poor and adequate services.
- Implementation of a significant programme of organisational development, including consultation and implementation of a new operations delivery model (together with a revised approach to risk and escalation) affecting a significant proportion of our workforce.
- Reinforcing the local delivery focus of CQC's activities, with the organisation effectively supporting local staff in having an impact on the quality of care.
- Building our reputation through engaging effectively with our wide range of stakeholders so that our regulatory approach is understood and valued and people using services and other bodies consider that we are involving them appropriately.

Financial performance and position

On 1 April 2009, the assets, liabilities and activities of CSCI, HC and MHAC were transferred to CQC. The exceptions were the NHS 2nd Tier complaints function and the leases on offices that were no longer required by CQC, which transferred to the Department of Health.

Details of our financial performance are shown in the section on 'Financial statements' in this report. The Commission's net expenditure for the year excluding finance costs was £125.2m and was within our approved budget. Total expenditure amounted to £189.9m, a reduction of £58.7m on the previous year when CSCI, HC and MHAC operated as separate entities. The decrease in expenditure is a result of cost efficiencies gained from the merger, the introduction of further cost reduction initiatives and rigorous budgetary control during the year.

Staff costs reduced by £21.6m as a result of a managed reduction in the number of staff employed during the year.

Other expenditure has reduced from £91.7m in 2008/09 to £73.3m in 2009/10 mainly due to reduced charges for redundancy, loss on disposal of property, plant and equipment and intangible assets and rental costs for office space incurred in 2008/09, no longer required by CQC in 2009/10. ICT costs increased in the year due to additional project management costs arising as a result of the merger of the three legacy commissions.

Net expenditure is funded from grant-in-aid provided by the Department of Health. Grant-in-aid totalled £127.0m in the year including £17.0m designated as capital grant-in–aid.

Estates strategy

During our first year we implemented an estates strategy, which, coupled with the introduction of home working and the changes to business service arrangements, resulted in a reduction of the estate to 8 offices by the end of October 2009. This compares to 23 offices in 13 locations which the predecessor Commissions previously occupied in 2008/09.

The estates strategy focused on the closure of regional offices with a reduction of associated operating costs, the establishment of a National Processing Centre and National Call Centre in Newcastle, a new office location in Nottingham and redesign of the Corporate Office in Finsbury Tower.

Contractual obligations

CQC operates a contracts register which shows the contracts we let. CQC has a number of IT service contracts in place, the major service supplier being CSC Computer Science Ltd. CSC supplied services relating to operating systems, hardware maintenance, IS infrastructure, and IT operations during the year.

Mouchel Business Services provided the payroll service to CQC until 31 March 2010, when this function transferred to NHS Shared Business Services.

CQC also has a contract with the Office of Government Commerce in relation to the provision of telecoms services.

Ongoing contracts from the predecessor organisations which ceased operations on 31 March 2009 were transferred to CQC on 1 April 2009.

Key performance indicators

There are a number of ways in which CQC achieved its strategic goals.

- Eliminating poor quality care and promoting high quality care.
  - Regulation of the independent healthcare sector.
  - Annual assessment for commissioners (primary care trusts and councils) and NHS providers.
  - Undertook 741 independent healthcare and 11,477 social care inspections to assess and report on the quality of services.
  - Completed 1,504 mental health visits and 15,288 requests for a second opinion.
- Ensuring care is centred on people's needs and protects their rights, championing joined-up care (and involving people in our work).
  - In depth reviews of issues of concern.
  - Investigations of serious service failure.
  - Providing and publishing useful information based on our assessments.
  - Performed outpatient surveys.
- Regulating effectively, in partnership.
  - Developed a single reporting system for safety related incidents in the NHS.
  - Organised planned collaborative reviews.
  - Established a Provider Advisory Group to reduce duplication and overlap of activity.
  - Supported the Comprehensive Area Assessment programme by working with five other inspectorates to assess the quality of care in 152 local authority areas.
- Financial indicators are discussed in the 'Financial performance and position' section of this commentary.

During 2009/10, our performance was tracked in a monthly reporting cycle through which the Executive Team has kept an overview of delivery, issues and risks, to provide quarterly assurance to the Board about our effectiveness.

Any areas reported as performing below target at any time during the year have been actively managed and addressed.

Risks and uncertainties

The principal risks and uncertainties facing the Commission are set out in the Integrated Assurance and Risk Framework. The framework identifies five types of principal risk facing the Commission.

These are:

- Regulatory risks (the risks that the Commission identifies and responds to in the organisations and services, which it regulates).
- Corporate business support risks, including finance, planning, I.T. and human resources.
- Risks involving major business change, such as organisational development and the Commission's programme for implementing registration of new and existing services under the 'Health and Social Care Act 2008'.

- Corporate governance risks, such as compliance with standing orders, statutory requirements, information assurance, and business continuity.
- External and emerging risks to the work of the Commission, such as changes in government policies on the regulation of healthcare and social care sectors.

The Commission's Risk Management Policy sets out both the approach and the accountabilities and responsibilities for managing risks. These applied to all members of staff up to and including members of the Board.

Form of account

The Financial statements have been prepared in the form directed by the Secretary of State for Health, in accordance with the Health and Social Care Act 2008, the 2009/10 Government Financial Reporting Manual (FReM) and *Managing Public Money*. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Since this is the first year in which the Commission has prepared financial statements under IFRS, first time adoption rules have been applied. The prior year comparatives have been restated by merging the accounts of the predecessor organisations thereby indicating the impact of the transfer of functions to CQC.

Post Statement of Financial Position Events

There are no significant post Statement of Financial Position events.

Going concern

The financial accounts have been prepared on the basis that CQC is a going concern. Grants for 2010/11, taking into account the amounts required to meet CQC's liabilities falling due that year, have been included in Department of Health estimates which have been approved by Parliament.

Pension costs

The treatment of pension liabilities and the relevant pension scheme details are set out in the accounting policies note on page 72 and in the Remuneration report on page 52.

Political and charitable donations

No political or charitable donations were made during the year.

Research and development

No research and development activities were carried out in 2009/10.

Auditors

The Comptroller and Auditor General (C&AG) is appointed by statute to audit CQC and report to Parliament on the truth and fairness of the annual financial statements and regularity of income and expenditure. The National Audit Office (NAO), the organisation that undertakes the services on behalf of the C&AG appointed Deloitte LLP as its strategic partner firm for the audit of CQC for three years commencing from 2009/10. This meant that Deloitte completed the detailed audit of the accounts on NAO's behalf but with the NAO providing an oversight. The total amount due to the NAO is £150k (£212k in 2008/09).

There was no remuneration paid for non-audit work during the year.

Availability of information for audit

As far as the Accounting Officer is aware there was no relevant information of which CQC's auditors (Deloitte LLP) were unaware. The Accounting Officer has taken all reasonable steps that she ought to have taken to make herself aware of any relevant audit information and did establish that CQC's auditors were aware of that information. "Relevant audit information" means information needed by the entity's auditor in connection with preparing the audit report.

Better payment practice code

CQC's policy was to pay creditors in accordance with contractual conditions or, where no contractual conditions exist, within 10–30 days of receipt of goods and services or the presentation of a valid invoice, whichever was the later. This complied with the Better Payment Practice Code and guidance received from HM Treasury.

In 2009/10, CQC paid 79.12% based on volume and 87.77% of invoices based on value within 30 days. These calculations were based on the date of the invoice and therefore understated the Commission's performance as payments were delayed while confirmation was obtained of satisfactory supply of goods and services.

Trade creditors at 31 March 2010 were equivalent to 22 days purchases, based on the average daily amount invoiced by suppliers during the year.

Freedom of information

The Commission published a wide range of information about its activities via its freedom of information publication scheme on its website – www.cqc.org.uk. It also has an Information Governance Team that handles access to information requests, such as those made under the Freedom of Information Act 2000.

In 2009/10 we received 776 requests for information during the year and had a 72% compliance rate in relation to responding fully to requestors within the statutory 20 working day time limit.

Employment, health and safety and environment policies

Employee consultation and engagement

CQC's employee relations environment is based on the principles of full and equal access, engagement and involvement. CQC has signed a Recognition and Facilities agreement and UNISON, RCN, Prospect, Unite and PCS are now recognised by CQC for the purposes of collective bargaining, consultation and employee relations. A Joint National Negotiating Committee (JNNC) has been introduced for the purposes of consultation and negotiation with the recognised Trade Unions and covers topics including terms and conditions of employment, pay and benefits, policies and changes to work organisation.

CQC has also introduced a Staff Forum to broaden engagement to all employees, some of whom may not be members of a recognised trade union. This approach will ensure a strong foundation for an effective and constructive relationship with all staff, including secondees and temporary staff who are employed by CQC. The forum is intended to cover a broad range of topics including changes affecting staff, operational effectiveness, working conditions, training, policies and procedures.

As part of the strategy to facilitate employee engagement within CQC, a programme of work has been identified to promote and develop the desired culture for CQC, improve the effectiveness of communications (taking into account a diverse workforce who are predominantly home based). In addition, an annual staff survey will be introduced in 2010 to measure employee engagement with the aim of identifying and prioritising actions for improvement.

Learning and development

CQC has been working closely with staff, external providers and the trade unions to begin building a coherent vision and framework for learning and development. During 2009/10 a number of steps and interim measures were taken to accommodate the merging of the three organisations. This was important to ensure that individual objectives remained aligned to the overall corporate and team objectives and that personal development needs could continue to be managed effectively. Comprehensive guidance was communicated to encourage managers and their team members to work in partnership to establish measurable and relevant objectives that would be reviewed at regular intervals during the year. These arrangements needed to be accessible to all staff irrespective of diversity or background as was the need for delivering learning solutions to a mainly field-based workforce. The focus on providing a robust training and development programme to the field-based workforce will continue to be a major priority for the learning and development function in 2010 and beyond.

Equalities, diversity and human rights

Equalities, diversity and human rights are integral to everything we do at CQC.

During the year we developed a new set of equality impact assessment tools. Our aim was to ensure that best practice was taken from each of the predecessor Commissions but also to include a focus on human rights. A learning programme was subsequently arranged to ensure that key staff and managers were trained in undertaking equality impact assessments. This approach was to ensure that newly developed and existing policies, procedures and functions are assessed in relation to the impact on the following equality 'strands': race, gender, disability, sexual orientation, faith and belief, age, gender identity, caring responsibilities and socio-economic status.

CQC has a dedicated Equality, Diversity and Human Rights Team. The team's objective is to ensure that CQC meets its legal obligations and its corporate objectives in relation to equality and human rights both as an employer and as a regulator. The team provides support to staff across the Commission in carrying out equality impact assessments and by providing information on equality, diversity and human rights via our internal intranet.

CQC is also supported by a number of staff networks which reflect the various diversity strands. These groups initially continued in the same format as those within each predecessor Commission, and subsequently a programme was launched in July 2009 to seek staff views on how to ensure that CQC has the best format for representing all diversity strands within the Commission. New staff groups to cover the race disability and sexual orientation strands have now been established. The aim is that these groups will provide a useful forum for influencing and developing the Commission's equality and diversity framework as well as supporting the delivery of our equality and human rights agenda and corporate priorities. This will be achieved by members being involved in consultations to help CQC improve on policies and how we deliver our service, as well as working to provide mutual support for staff and identifying issues of common concern.

As a public body the Commission is subject to a range of equalities legislation including race, disability and gender duties. Over the past year, we have been developing our Equality and Human Rights Scheme. We have involved and consulted with a wide range of stakeholders, people who use services and carers, as well as our staff in the scoping, development and drafting of this scheme. Our scheme seeks to put equality at the heart of all that we do and describes how we will fulfil our social, moral, regulatory and legal obligations giving due regard to equality and human rights in all our activities.

Employment and policies

It is our ongoing policy to actively support all employees to enable them to produce the best work they can to assist us in meeting our aims. This involves attracting staff from all sectors of the community, valuing their different skills and abilities and responding flexibly to their needs in achieving our goals. People with disabilities are given the same consideration as others and will enjoy the same training and development opportunities and career prospects as other staff. During 2009/10 the average number of disabled persons employed by CQC was 106.

Employment procedures set out formal policies on key issues such as bullying and harassment, disciplinary and grievance procedures, capability and home working. We continually make sure that our employment terms are fair and free from bias, and that equality impact assessments were undertaken on the key policies and procedures affecting employment. Our staff diversity networks and staff forums enabled open discussion and consultation on key policies, and also kept employees' representatives informed of developments affecting employment within the CQC. All agreed policies were published on the CQC Intranet, to ensure wide accessibility and availability for all employees.

Home working

Home working forms the contractual arrangement for over 1,000 CQC staff and is one of the flexible working options which may be available to other staff as part of the CQC commitment to improving the working lives of its employees to help them achieve a healthy work-life balance. It also forms part of CQC's commitment to improving effectiveness, both in cost and in the way it carries out its work. CQC provides the tools and equipment required to enable home working employees to undertake their role safely and effectively while maintaining their professional and personal development. An allowance totalling £460 per annum is paid monthly on a pro-rata basis with salary.

Health and safety

CQC is committed to ensuring the health, safety and welfare of all employees, visitors, contractors and others who may be affected by the organisation's work.

A range of policy documents and guidance has been launched on the CQC Intranet system allowing staff access to up to date health and safety advice when required. We are particularly pleased with the success of moving from paper based display screen equipment and workstation risk assessments to the roll out of online training and assessment to support individual staff to maintain a healthy and safe working environment.

Comprehensive advice for home workers has been developed which covered all aspects of their work and is readily accessible both electronically and also as a reference manual.

Regular audits of all office premises were undertaken and health and safety action plans were implemented to rectify any deficiencies highlighted by formal audits such as fire risk assessments and routine workplace inspections.

The first phase of training for senior managers took place in December 2009 with 13 health and safety champions nominated and achieving Level 3 awards in Health and Safety in the Workplace from the Chartered Institute of Environmental Health.

Sickness absence data

During 2009/10, a total of 14,387 days (2008/09: 25,076 days) were lost due to sickness of which 11,331 days (2008/09: 13,935 days) were due to long-term illness. The average number of days' sickness per employee during 2009/10 was 8 (2008/09: 10 days).

Information security

There have been no new information governance requirements in the year. The requirements that were established in 2008/09 have been reviewed and the reporting mechanisms strengthened.

In line with these requirements, the Commission:

- Issued a suite of information assurance policies, and took action to ensure all staff read and understood the requirements.
- Ensured that all portable media (laptops, USB memory sticks, CD/DVD) are fully encrypted.
- Ensured that information security and governance requirements were considered from the planning stages in all projects.
- Delivered a programme of internal audit that tested information security controls, focussing particularly upon patient data handling.
- Executive Team signed a *Statement of Commitment to Information Security*.
- Ensured regular reporting on information security and governance issues to the Audit & Risk Committee.

Sustainability duty

CQC are working towards publishing a Sustainable Development Action Plan (SDAP) in 2010/11. In view of our recent formation and significant tasks in our first year, the SDAP will concentrate the initial years of the 5-year plan on a few key areas such as energy reduction and staff awareness.

A policy of recycling has been adopted in all CQC offices and we monitor our performance against the Sustainable Operations in Government Estate targets.

A questionnaire on sustainability is completed by suppliers in all tendered exercises for external procurement and is used as a management monitoring tool. In our first year we will meet level 1 of the Sustainable Procurement Framework developed by the government-sponsored, business-led Procurement Task Force and aim to reach level 3 by the end of 2010/11.

Remuneration report

The following sections provide details of the remuneration (including any non-cash remuneration) and pension interests of Board Members, Independent Members, Chief Executive and the Executive Team as well as those amounts payable to third parties for services as a Senior Executive. The content of the tables is subject to audit.

Remuneration of the Chair and Board Members

Board members' remuneration is determined by the Department of Health on the basis of a commitment of two days per month. The exceptions are Olu Olasode who is contracted for four days per month for his role as Chairman to the CQC's Audit and Risk Committee and Baroness Young who was contracted for four days per week until 1 July 2009 when she reduced to three days per week. Baroness Young resigned her post with effect from 31 December 2009 and Dame Jo Williams was appointed as Acting Chair of CQC from 1 January 2010.

Kay Sheldon worked an additional 12 days during the year for which she has been reimbursed.

There are no provisions in place for Board Members' early termination of appointment nor for the payment of a bonus.

CQC reimburses its Chairman, Board and Independent Members for the cost of travelling to and from the Commission including for Board meetings. For 2009/10 this amounted to £7k. CQC meets the resulting tax liability under a settlement agreement with HM Revenue and Customs.

Board members have been recruited throughout 2008/09 and 2009/10, therefore the full year equivalent gross salaries for the roles are shown opposite.

Chairman and Board Members' emoluments

		2009/10		2008/09	
	Date appointed	Total salary £000	Full year equivalent salary £000	Total salary £000	Full year equivalent salary £000
Baroness Barbara Young (Chair)	1 Oct 2008	70–75	75–80	50–55	105–110
Dame Jo Williams (Acting Chair as of 1 Jan 2010)	1 Oct 2008	20–25	60–65	0–5	5–10
Professor Deirdre Kelly	1 Oct 2008	5–10	5–10	0–5	5–10
Olu Olasode	1 Nov 2008	10–15	10–15	5–10	10–15
Kay Sheldon	1 Dec 2008	10–15	5–10	0–5	5–10
Professor Martin Marshall	1 Jan 2009	5–10	5–10	0–5	5–10
John Harwood	4 Mar 2010	0	5–10	0	0

Remuneration Committee

This Committee has been formed as a sub-committee of the Board to determine the remuneration of selected senior members of staff and to consider CQC's overall pay policy. The Committee is a non-executive committee and has no powers other than those specifically delegated in its terms of reference. The Committee has recruited an independent member to contribute additional expertise to its work.

Membership

- Barbara Young (Chair) until 31 December 2009, subsequently replaced by Jo Williams (Acting Chair) from 1 January 2010
- Kay Sheldon
- Julian Duxfield (independent member) from 17 November 2009
- The Chief Executive, interim Director of HR, the Head of HR Operations and the Head of Secretariat regularly attend meetings of the Committee

The main responsibility of the Committee is to ensure the effectiveness, integrity and compliance of the protocols and practices of the Commission relating to rewards. The Committee also agreed the approach to the 2009/10 pay award. This award had to meet the contractual obligations inherited from the predecessor Commissions.

The remuneration of the Chief Executive and Executive Team members was set by the Remuneration Committee and was reviewed annually within the scope of the national pay and grading scale applicable to Arm's Length Bodies.

In reaching its recommendations, the Remuneration Committee considered:

- The need to recruit, maintain and motivate suitably able and qualified people to exercise their different responsibilities.
- Regional/local variations in labour markets and their effects on the recruitment and retention of staff.
- The Government's inflation target and public sector guidelines on pay.

Payments to Independent Members

Julian Duxfield and Martin Smith were independent members of CQC. Fees and expenses are paid on a per meeting basis and amounted to £2k in 2009/10 for Mr Duxfield and £1k for Mr Smith.

Remuneration of the Chief Executive

The Chief Executive's remuneration is agreed between the Board via the Remuneration Committee with reference to the Department of Health's guidance on pay for its Arm's Length Bodies.

Remuneration of the Executive Team

The Executive Team are employed on CQC's terms and conditions under permanent employment contracts or are on secondment to CQC.

The Executive Team had a contractual entitlement to be considered for a bonus of up to 10% of salary for performance in the year 2009/10. However, both the Remuneration Committee and the Executive Team were of the view that all staff had made a significant contribution to the success of CQC in a difficult transition year and that it would not be appropriate for the Executive Team to accept individual bonuses in these circumstances, especially given a difficult financial environment.

For the Chief Executive and Executive Team, early termination other than for misconduct, is covered by their contractual entitlement under the Care Quality Commission's Redundancy Policy (or their previous legacy Commission's redundancy policy if they transferred). They may also be able to access the NHS Pension Scheme arrangements for early retirement depending on age and scheme membership.

Salary includes gross salary and any other allowance to the extent that it is subject to UK taxation. Performance pay or bonuses paid during the year are shown separately. As this is the first year of operation for CQC, certain executive roles have been recruited for part of the current year only. Therefore, the full year equivalent gross salaries for the roles are shown in the following tables.

		2009/10				
Executive team	Date appointed	Salary £000	Bonus £000	Benefits in kind £000	Total 2009/10 £000	Full year equivalent salary £000
Cynthia Bower	1 Aug 2008	195–200	5–10*	10–15**	210–215	195–200
Kylie Kendrick	5 May 2009	120–125	0	0	120–125	145–150
Jill Finney	24 Feb 2009	140–145	0	0	140–145	140–145
Richard Hamblin	1 Mar 2009	110–115	0	0	110–115	110–115
Gary Needle	1 Mar 2009	140–145	0	0	140–145	140–145
John Lappin	1 May 2009	130–135	0	0	130–135	140–145
David Johnstone (resigned 30 Nov 2009)	1 Jul 2009	100–105	0	0	100–105	155–160

*** Bonus**
The CQC Remuneration Committee recommended that the Chief Executive receive a bonus for the year 2008/09 as recognition for her high level of performance in a difficult and challenging period preparing for the launch of the new Commission. This was approved by the Department of Health and a 5% bonus which amounted to £6,000 (5% of salary from the period 1 August 2008 to 31 March 2009) was paid in November 2009.

**** Benefits in kind**
The Chief Executive received a transitional second home allowance which generated a taxable benefit of £10.3k (2008/09, £17.8k) and which terminated on 20 August 2009.

Executive team	2008/09 Salary £000	Benefits in kind £000	Total 2008/09 £000	Full year equivalent salary £000
Cynthia Bower	95–100	15–20**	115–120	195–200
Kylie Kendrick	0	0	0	0
Jill Finney	10–15	0	10–15	140–145
Richard Hamblin	5–10	0	5–10	110–115
Gary Needle	10–15	0	10–15	140–145
John Lappin	0	0	0	0
David Johnstone (resigned 30 Nov 2009)	0	0	0	0

Payments made for loss of office

There were no payments during the year for loss of office.

Amounts payable to third party for services as a senior executive

Jamie Rentoul provided services as a Director of Regulation and Strategy, while employed by the Department of Health. Total employment costs of £192k for 2009/10 (including pension, employer's costs and a bonus in respect of the previous year) were recharged to the Commission by the Department of Health.

Linda Hutchinson provided services as a Director of Registration, while employed by London Strategic Health Authority (SHA). Total employment costs of £167k for 2009/10 (including pension and employer's costs) were recharged to the Commission by London SHA.

Pension benefits

Pension benefits of Board members

Board members are not eligible for pension contributions, performance related pay or any other taxable benefit as a result of their employment with CQC.

Pension benefits of the Chief Executive and Executive Team

All are members of the NHS Pension scheme. Pension benefits at 31 March 2010 may include amounts transferred from previous NHS employments while the real increase reflects only the proportion for the time in post, if the employee was not employed by CQC for the whole year.

	Accrued Benefits				Cash Equivalent Transfer Values		
Name	Real increase in pension lump sum (bands of £2,500) £000	Real increase in pension (bands of £2,500) £000	Lump sum related to total accrued pension at 31 March 2010 (bands of £5,000) £000	Total accrued pension at 31 March 2010 (bands of £5,000) £000	CETV at 31 March 2009 £000	CETV at 31 March 2010 £000	Real increase in CETV £000
Cynthia Bower	10–12.5	2.5–5	145–150	45–50	871	1,081	181
Kylie Kendrick	0	0–2.5	0	0–5	0	17	15
Jill Finney	0	2.5–5	0	0–5	0	33	33
Richard Hamblin	17.5–20	5–7.5	65–70	20–25	196	302	99
Gary Needle	5–7.5	0–2.5	135–140	45–50	827	945	89
John Lappin	0	0–2.5	0	0–5	0	35	32
David Johnstone (resigned 30 Nov 09)	0	0–2.5	0	0–5	0	18	7

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures, and, from 2003/04, the other pension details, include the value of any pension benefit in another scheme or arrangement which the individual has transferred to the NHS pension. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries and do not take account of any potential reduction to benefits resulting from Lifetime Allowance Tax which may be due when pension benefits are drawn.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

NHS pension scheme

The principal pension scheme for staff recruited directly by CQC is the NHS pension scheme.

The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The scheme is not designed to be operated in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. Details of the benefits payable under the scheme provisions can be found on the NHS Pensions website at www.pensions.nhsbsa.nhs.uk.

Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees' contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

In 2009/10 CQC employer's contribution for staff to the NHS pension fund was £4,574k. Contribution rates for 2010/11 are as follows:

Salary band	Employee contribution	Employer contribution
£20,224 and under	5.0%	14%
£20,225 to £66,789	6.5%	14%
£66,790 to £105,318	7.5%	14%
£105,319 and over	8.5%	14%

Local Government Pension Schemes

A Local Government Pension Scheme is a guaranteed, final salary pension scheme open primarily to employees of local government but also to those who work in other organisations associated with local government. It is also a funded scheme with its pension funds being managed and invested locally within the framework of regulations provided by Government.

Due to legacy arrangements, CQC inherited 17 Local Government Schemes. All schemes are closed schemes. Under the projected unit method the current service cost will increase as the members of the scheme approach retirement.

Employer contributions for 2009/10 were £5,245k in total (£5,916k in 2008/09), at rates ranging between 6.2% and 39.6% (6.2% and 33.0% in 2008/09). Employer contributions relating to the largest scheme, Teesside Pension Fund were £4,360k (£4,903k in 2008/09) at a rate of 13.7% (13.7% in 2008/09).

The 2007/08 triennial actuarial valuation results from Local Government Pension Funds, resulted in revised employer contribution rates for 2008/09, 2009/10 and 2010/11.

Contribution rates for 2010/11 are currently expected to range between 6.2% and 39.6% (13.7% for Teesside Pension Fund).

Cynthia Bower
Chief Executive, CQC
13 July 2010

Statement of Accounting Officer's responsibilities

Under the Health and Social Care Act 2008 the Secretary of State for Health has directed CQC to prepare for 2009/10 a statement of accounts in the form and on the basis set out in the Accounts Direction. This direction instructed CQC to prepare accounts in compliance with the accounting principles and disclosure requirements of the edition of the Government Financial Reporting Manual issued by HM Treasury ("the FReM") which is in force for 2009/10.

The accounts shall be prepared so as to:

- Give a true and fair view of the state of affairs at 31 March 2010 and of the net resource outturn, resources applied to objectives, recognised gains and losses and cash flows for the financial year then ended.
- Provide disclosure of any material expenditure or income that has not been applied to the purposes intended by Parliament or material transactions that have not conformed to the authorities which govern them.

In preparing the accounts, CQC has to:

- Observe the Accounts Direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply appropriate accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements.
- Prepare the financial statements on a going concern basis.

The Secretary of State for Health has designated the Chief Executive as the Accounting Officer for CQC. The responsibilities of an Accounting Officer include responsibility for ensuring propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding CQC's assets, and are set out in *Managing Public Money* issued by HM Treasury.

Statement on internal control

Scope of responsibility

As Accounting Officer I have responsibility for maintaining a sound system of internal control that supports the achievement of CQC's policies, aims and objectives while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money*.

CQC is classified as a non-departmental public body (NDPB) of the sponsoring Department for Health. The Secretary of State for Health is answerable to Parliament for the policies and performance of the Commission. The Commission met the Minister for an annual performance review and together with the Chair, I had regular meetings with ministers and senior policy officials of the Department of Health.

Operational responsibility for monitoring CQC's activities rests with the Department of Health, which takes the form of formal quarterly reviews of progress against objectives.

Background

CQC was formed from a merger of the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission on 1 April 2009. A merger of this magnitude brings with it a number of wide ranging issues which span all activities across the organisation together with a number of inherent risks.

New management structures were put in place by 1 April 2009, and as in any new organisation these took time to become established and embedded. Consequently, management were faced with a number of challenges in that a number of policies, processes and systems had to be developed and implemented in the first half of the financial year. It is recognised that the risk management and control framework continued to be developed and improved throughout the year and any deficiencies noted at the formation of CQC have been addressed so that our key objectives have been achieved.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it could therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of departmental policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised and to manage them efficiently, effectively and economically. The system of internal control has been continuously improved throughout the year ended 31 March 2010, and, at the date of approval of the annual report and accounts, accords with Treasury guidance and has enabled our objectives to be met.

Capacity to handle risk

The Audit and Risk Committee on behalf of the Board, provides leadership of the risk management process. The Committee is supported by the Corporate Risk Manager and our internal and external auditors, KPMG and Deloitte LLP/National Audit Office.

Furthermore, the Commission has recently appointed a Regulatory Risk Manager, reporting to the Operations Delivery Director on all matters of operational and regulatory risk which are reported to the Executive Team and Audit and Risk Committee through the Risk and Escalation Committee.

Our approach is to have an overarching governance framework to support the delivery of our policies, aims and objectives. Risk management is integrated into all levels of this framework and as such reflected in strategic and operational planning and how performance is monitored through the corporate performance report and budget.

The table below illustrates this approach.

Stage	Purpose	Approach to risk
Strategic planning	Identify appropriate strategic goals and objectives	Scenario planning of possible events and outcomes
Budget setting	Allocation of resources to support objectives	Identification of contingencies
Operational planning	Identification of activities to be undertaken to promote objectives	Development of risk register and business continuity plans
In-year monitoring	Undertaking of performance and financial monitoring using the corporate performance report and budgetary control statements	Early identification of adverse trends in performance or financial control
Risk assessment	With support from internal audit, monitoring of actions identified as essential to mitigate risk	Re-iterative approach to ensure rigour in risk management processes

Our internal control and risk management processes were designed and developed throughout the year to:

- Establish a policy framework approved by the Board and the Executive Team, within which activities and their proposed outcomes and strategic risks were identified, managed and kept under review.
- Embed the management of risk and compliance by making it part of the day-to-day management processes. The Executive Team collectively owned the risks and, in addition, each strategic risk was also allocated to an appropriate member of the Executive Team to ensure its direct management.
- Ensure that named individuals managed each risk and actively reviewed and reported on that risk.
- Adopt a consistent approach throughout the organisation.
- Encourage staff to identify and manage risk positively in support of delivering the objectives of the Commission.
- Keep the system of risk management under regular review to ensure it is best matched to the organisation and effectively embedded.

The risk and control framework

Consistent with the recognition of risk at a strategic level, the Commission developed a risk register to monitor where risks might arise and how they were mitigated. In the register, risks were identified at an operational level and consolidated to identify themes arising across the organisation. The Executive Team reviewed the risk register for completeness. The Audit and Risk Committee reviewed the application of the risk management process.

The first year of the Commission's operations presented some challenges and it is recognised that in merging the three legacy Commissions into CQC it was not possible to have a risk management and control framework that was 100% fit for purpose from 1 April 2009. Senior management worked to address this challenge throughout the year and are satisfied that the control framework is now in a position to meet the needs of the organisation, while recognising that this process continues to evolve. The Commission applied the Treasury's framework for assessing the management of risk in public bodies. The principal features and key controls included:

- A formal system of governance comprising standing orders and standing financial instructions which supported and regulated how the Commission conducted its business.
- This included a schedule of delegation showing which functions were retained for determination by the Board and which were delegated to the Chief Executive.
- An organisational structure that supported clear lines of communication and accountability.

- Business strategies that were approved by the Board and were subject to consultation with stakeholders of the Commission.
- Clear processes so that the risks that were identified were incorporated into an overall structure for risk management.
- Embedded methods of performance measurement based on evaluation of a balanced scorecard.

The risks and issues associated with transition to CQC were identified and managed. This included ensuring the handover of key processes (baton handling) and a clear identification of liabilities and assets in a Transfer Scheme.

Risks around information governance and security are mitigated by control mechanisms in place, including the appointment of a Senior Information Responsibility Owner (SIRO) and a Caldicott Guardian, in line with best practice.

Furthermore, as an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure that all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from the salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the Executive Team within the Commission who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit and Risk Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board has corporate responsibility for ensuring that the Commission fulfils its aims and objectives set by the Department of Health. To this end the Board plays a major role in risk management and meets regularly to consider the strategic direction and plans.

The Board has delegated the detailed review of assurance on CQC's risk management, governance and internal control to the Audit and Risk Committee, which met five times during the year and submits regular reports to the Board.

The Executive Team has responsibility for overseeing delivery against plan and corporate performance and risk management within the Commission. They have reviewed all significant risks that had been identified and ensured that they had been fairly stated. The team also satisfied itself that the less significant risks were being actively managed by relevant managers with the appropriate controls in place and that these controls were working effectively. In my regular meetings with members of the Executive Team, I sought assurance from them that they were taking individual and corporate responsibility for the management of risk in their respective areas of work. Internal audit reports were addressed to the appropriate member of the Executive Team and significant issues were brought to the team's attention and assurances given that they were dealt with effectively.

The Commission had an internal audit service provided by KPMG, whose reports included the internal auditor's independent opinion on the adequacy and effectiveness of the Commission's system of internal control, together with the recommendations for improvement. Management have addressed all significant recommendations made by KPMG during the year. KPMG have noted the challenges faced by CQC during the early part of the year and how management responded to them in their Annual Report to the Audit and Risk Committee. Further, they recognise that the system

of internal control and risk management was not fully in place throughout the year but the Commission considered that this did not have an impact on the organisation's delivery of its key objectives.

Both internal and external audit were invited to all meetings of the Audit and Risk Committee.

Significant internal control issues

During the year KPMG identified 10 High Priority recommendations in a number of areas including policies and procedures, data handling and with inherited IT systems. In all cases a detailed action plan has been agreed to address the recommendations made.

Cabinet Office guidelines require all public sector bodies to disclose incidents of data loss which have been reported to the Information Commissioner's Office (ICO), unless specific exemptions apply. During the year, a disclosable event was reported to the ICO: some patient data under the control of a Second Opinion Appointed Doctor (SOAD) contracted by CQC was thought mislaid in an NHS trust, but it was subsequently discovered that the data had been securely locked away by a member of trust staff. CQC reviewed its data processes and guidance for SOADs. The ICO considered CQC's report and concluded that the ICO need take no action in respect of the incident.

In conclusion, during a period of significant change and restructuring for CQC, the organisation has steadily and consistently improved the control environment and taken prompt and effective action on any weaknesses identified.

Cynthia Bower
Chief Executive, CQC
13 July 2010

The certificate and report of the Comptroller and Auditor General to the Houses of Parliament

I certify that I have audited the financial statements of the Care Quality Commission for the year ended 31 March 2010 under the Health and Social Care Act 2008. These comprise the Net Expenditure Account, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the Audit of the Financial Statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Care Quality Commission's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Care Quality Commission; and the overall presentation of the financial statements.

In addition, I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament, and the financial transactions conform to the authorities which govern them.

Opinion on regularity

In my opinion, in all material respects the expenditure and income have been applied to the purposes intended by Parliament, and the financial transactions conform to the authorities which govern them.

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view, of the state of Care Quality Commission's affairs as at 31 March 2010 and of its net expenditure, changes in taxpayers' equity and cash flows for the year then ended; and
- the financial statements have been properly prepared in accordance with the Health and Social Care Act 2008 and the Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion:

- the part of the Remuneration report to be audited has been properly prepared in accordance with the Secretary of State directions issued under the Health and Social Care Act 2008; and
- the information which comprises the Corporate Governance section and the Management Commentary, included within the Annual Report, is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept; or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements are not in agreement with the accounting records or returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Statement on Internal Control does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

Amyas C E Morse
Comptroller and Auditor General
National Audit Office
157–197 Buckingham Palace Road
Victoria
London
SWIW 9SP

16 July 2010

The Care Quality Commission's report and accounts will be published on their website. The maintenance and integrity of the Care Quality Commission's website is the responsibility of the Accounting Officer; the work carried out by the auditors does not involve consideration of these matters and accordingly the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

Financial statements

Net expenditure account for the year ended 31 March 2010

	Note	2009/10 £000	2008/09 as restated (Note 2) £000
Expenditure			
Staff costs	4	102,099	123,725
Depreciation	5	12,850	17,828
Other expenditure	5	73,311	91,722
Impairment of assets	5	1,681	15,357
		189,941	248,632
Less income			
Income from activities	7	(64,752)	(66,117)
Other income	7	(12)	(2,086)
		(64,764)	(68,203)
Net expenditure excluding finance costs		**125,177**	**180,429**
Cost of capital	5	(1,490)	361
Interest receivable	7	(23)	(157)
Net expenditure for the financial year		**123,664**	180,633

All income is derived from continuing operations.

The Notes 1 to 24 form part of these financial statements.

Statement of financial position as at 31 March 2010

	Note	31 March 2010 £000	31 March 2009 as restated (Note 2) £000	1 April 2008 £000
Non-current assets:				
Intangible assets	8	14,894	12,827	25,758
Property, plant and equipment	9	12,353	10,318	20,451
Pension funds	4	–	–	278
Total non-current assets		**27,247**	**23,145**	**46,487**
Current assets:				
Trade receivables	13	3,085	4,077	3,745
Other current assets	13	3,424	5,783	5,449
Cash and cash equivalents	14	14,919	19,163	16,189
Total current assets		**21,428**	**29,023**	**25,383**
Total assets		**48,675**	**52,168**	**71,870**
Current liabilities:				
Trade and other payables	15	(16,150)	(24,682)	(19,390)
Fee income in advance	15	(26,393)	(26,023)	(25,829)
Provisions	16	(356)	(3,896)	(3,333)
Total current liabilities		**(42,899)**	**(54,601)**	**(48,552)**
Non-current assets plus net current assets		**5,776**	**(2,433)**	**23,318**
Non-current liabilities				
Provisions	16	(1,232)	(547)	(250)
Pension liabilities	15	(3,099)	(101)	(141)
Other payables	15	–	(1,055)	–
Total non-current liabilities excluding pension deficit provision		**(4,331)**	**(1,703)**	**(391)**
Assets less liabilities excluding pension deficit provision		**1,445**	**(4,136)**	**22,927**
Pension deficit provision	4	(54,568)	(7,313)	–
Assets less liabilities		**(53,123)**	**(11,449)**	**22,927**
Taxpayers' equity				
General reserve		(57,195)	(11,762)	21,042
Revaluation reserve		4,072	313	1,885
Total taxpayers' equity		**(53,123)**	**(11,449)**	**22,927**

The financial statements were approved by the Board and were signed on its behalf by:

Cynthia Bower
Chief Executive, CQC
13 July 2010

The Notes 1 to 24 form part of these financial statements.

Statement of cash flows
for the year to 31 March 2010

	Note	2009/10 £000	2008/09 £000
Cash flows from operating activities			
Net Expenditure after cost of capital charge and interest		(123,664)	(180,633)
Adjustment for cost of capital charge	5	(1,490)	361
Adjustment for depreciation charge	5	12,850	17,828
Impairment of intangible assets	5	1,681	14,958
Impairment of property, plant & equipment	5	–	399
Net/(Gain) loss on indexation of intangible assets	5	794	1,770
Net/(Gain) loss on indexation of property, plant and equipment	5	456	2,375
Loss on disposal of intangible assets	5	155	1,950
Loss on disposal of property, plant and equipment	5	701	10,493
Decrease/(Increase) in trade and other receivables	13	3,351	(666)
(Decrease)/Increase in trade payables	15	(8,532)	5,292
(Decrease)/Increase in deferred income	15	370	194
(Decrease)/Increase in provisions	16	(2,855)	860
(Decrease)/Increase in pension deficit provision	4	47,255	7,591
(Decrease)/Increase in pension liabilities	15	1,943	1,015
Net cash outflow from operating activities		**(66,985)**	**(116,213)**
Cash flows from investing activities			
Purchase of intangible assets	8	(8,640)	(17,865)
Purchase of property, plant and equipment	9	(6,982)	(8,830)
Actuarial Loss on pension funds	4	(48,634)	(6,124)
Net cash outflow from investing activities		**(64,256)**	**(32,819)**
Cash flows from financing activities			
Grants from Department of Health	21	127,000	160,133
Less Adjustment for Discontinued Activities		–	(8,127)
(Increase)/Decrease in cash in hand	14	(3)	–
Net financing outflow		**126,997**	**152,006**
		(4,244)	**2,974**
Net increase/(decrease) in cash and cash equivalents in the year			
Cash and cash equivalents at the beginning of the period	14	19,163	16,189
Cash and cash equivalents at the end of the period	14	**14,919**	**19,163**

The Notes 1 to 24 form part of these financial statements.

Statement of changes in taxpayers' equity for the year ended 31 March 2010

	Note	Revaluation reserve £000	General reserve £000	Total reserves £000
Balance at 31 March 2008		848	38,988	39,836
Holiday pay accrual for 2007/08		–	(1,098)	(1,098)
Transfers between reserves		1,037	(1,037)	–
Adjustment for property not transferred to CQC		–	10,018	10,018
Adjustment for deferred income		–	(25,829)	(25,829)
Restated balance at 1 April 2008		**1,885**	**21,042**	**22,927**
Changes in taxpayers equity for 2008/09				
Net gain/(loss) on indexation of property, plant and equipment		17	–	17
Non-cash charges – cost of capital		–	361	361
Transfers between reserves		(1,589)	1,586	(3)
Retained surplus/(deficit)		–	(180,633)	(180,633)
Actuarial gain/(loss)		–	(6,124)	(6,124)
Total recognised income and expense for 2008/09		**(1,572)**	**(184,810)**	**(186,382)**
Grant from Department of Health		–	160,133	160,133
Less grant from Department of Health re discontinued activities		–	(8,127)	(8,127)
Balance at 31 March 2009	2	**313**	**(11,762)**	**(11,449)**
Changes in taxpayers equity for 2009/10				
Net gain/(loss) on indexation of intangible assets		3,362	–	3,362
Net gain/(loss) on indexation of property, plant and equipment		1,755	–	1,755
Transfers between reserves		(1,358)	1,358	–
Non-cash charges – cost of capital	5	–	(1,490)	(1,490)
Cash in hand	14	–	(3)	(3)
Retained surplus/(deficit)		–	(123,664)	(123,664)
Actuarial gain/(loss)	4	–	(48,634)	(48,634)
Total recognised income and expense for 2009/10		**3,759**	**(172,433)**	**(168,674)**
Grant from Department of Health		–	127,000	127,000
Balance at 31 March 2010		**4,072**	**(57,195)**	**(53,123)**

The Notes 1 to 24 form part of these financial statements.

Notes to the financial statements

1.1 Basis of accounting

The financial statements have been prepared in accordance with a Direction issued by the Secretary of State for Health (with the consent of HM Treasury) to prepare for each financial year a statement of accounts in the form and on the basis that it considers appropriate. These financial statements have been prepared in accordance with the 2009/10 Government Financial Reporting Manual (FReM) as determined by the Department of Health with the approval of HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Commission for the purposes of giving a true and fair view has been selected. The particular policies adopted by the Care Quality Commission are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

The financial statements are presented in £ sterling and all values are rounded to the nearest thousand, except where indicated otherwise.

On 1 April 2009, the assets, liabilities and activities of the former Commission for Social Care Inspection (CSCI), the Healthcare Commission (HC) and the Mental Health Act Commission (MHAC) transferred to CQC. The merger has been accounted for as a machinery of government reorganisation. Although CQC was not established until 1 October 2008 and the combination did not take place until 1 April 2009, the financial information includes consolidated financial information presented as though the merged business had been a single organisation from 1 April 2008. Therefore the comparative financial statements have been presented as if the merger took place on the first day of the first financial period presented and as though the organisation as presently constituted had been in existence throughout.

IFRS has been adopted from 1 April 2008. Disclosures required under IFRS 1 concerning the financial effects of the transition from UK GAAP to IFRS are given in Note 2.

In the current year, the following new and revised Standards and Interpretations have been adopted and have affected the amounts reported in these financial statements.

Early adoption of IFRS amendments and interpretations

The Group has adopted IFRS 8, operating segments, early. The effective date of the standard was for accounting periods beginning on, or after 1 January 2010. The adoption affects disclosure requirements only. See Note 3.

IFRS amendments and interpretations in issue but not yet effective, or adopted

IAS8, accounting policies, changes in accounting estimates and errors require disclosures in respect of new IFRS amendments and interpretations that are, or will be applicable after the reporting period. There are a number of IFRS amendments and interpretations issued by the International Accounting Standards Board that are effective for financial statements after this reporting period. The following have not been adopted early by CQC:

IFRS9 Financial instruments	A new standard intended to replace IAS39. The effective date is for accounting periods beginning on, or after 1 January 2013.
IFRS1 First-time adoption of IFRS.	Three sets of amendments to the existing standard. The effective date of one set of amendments is for accounting periods beginning on, or after 1 July 2009. The effective date of the second set of amendments is for accounting periods beginning on, or after 1 January 2010. The effective date of the third set of amendments is for accounting periods beginning on, or after 1 July 2010.
IFRS5 Non-current assets held for sale & discontinued operations	Two sets of amendments to the existing standard. The effective date of one set of amendments is for accounting periods beginning on, or after 1 July 2009. The effective date of the second set of amendments is for accounting periods beginning on, or after 1 January 2010.
IFRS8 Operating segments	Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 January 2010.
IAS1 Presentation of financial statements	Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 January 2010.
IAS7 Statements of cash flow	Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 January 2010.
IAS17 Leases	Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 January 2010.
IAS24 Related party disclosures	Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 January 2010.

IAS27 Consolidated financial statements	Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 July 2009.
IAS32 Financial instruments: presentation	Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 February 2010.
IAS36 Impairment of assets	Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 January 2010.
IAS38 Intangible assets	Amendments to the existing standard. The effective date is for accounting periods beginning on, or after 1 July 2009.
IAS39 Financial instruments	Two sets of amendments to the existing standard. The effective date of one set of amendments is for accounting periods beginning on, or after 1 July 2009. The effective date of the second set of amendments is for accounting periods beginning on, or after 1 January 2010.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment and intangible assets. Revaluations are performed annually so that they are stated in the Statement of Financial Position as at fair value. Any revaluation or indexation increase is credited to the revaluation reserve, except to the extent that it reverses a revaluation decrease for the same asset previously recognised as an expense, in which case the increase is credited to the net expenditure statement to the extent of the decrease previously expensed. A decrease in carrying amount arising on the revaluation of the asset is charged as an expense to the extent that it exceeds the balance, if any, held in the revaluation reserve relating to a previous revaluation of that asset.

Intangible assets

IT software and software developments, including the Commission's website, are capitalised if having a value of £5,000 or more or considered part of a group with a total cost exceeding £5,000. General IT software project management costs are not capitalised.

All assets are revalued annually using the appropriate Office of National Statistics price index. Increases in value are credited to the revaluation reserve while the asset is in use. Reductions below cost are charged to the net expenditure account.

Property, plant and equipment

Expenditure on office refurbishments, office furniture and fittings, office equipment, IT equipment and infrastructure is capitalised if having a value of £5,000 or more and having a working life of more than one year. Assets costing below £5,000 are capitalised when considered part of a group if total costs exceed £5,000 in value. Staff and contractor costs incurred on IT infrastructure projects are capitalised. General IT project management costs are not capitalised. The assets are recorded at cost. They are restated at current value each year using the appropriate Office of National Statistics price index.

Depreciation

Depreciation and amortisation on property, plant and equipment and intangible assets is provided on a straight-line basis at rates calculated to write off the cost, less any residual value over their estimated useful lives as follows:

Estimated useful lives

Property, plant and equipment

Furniture and fittings:	
• Office refurbishment	10 years
• Furniture	10 years
• Office equipment	5 years
Information technology:	
• IT equipment	3 years
• IT infrastructure	3 years
Intangible assets:	
• Software licences	3 years
• Developed software and website	3 years

Depreciation and amortisation is calculated on a monthly basis commencing from the month following the date on which an asset is brought into use. The valuation method used is the depreciated replacement cost. This is the replacement cost of the item less accrued depreciation subject to indexation/revaluation.

Office refurbishments and furniture are written-off over the remaining life of the lease (the date of the first lease break) if below 10 years. Computer software, including developed software is written-off over the expected life of the software if less than 3 years. The estimate of working life is regularly reviewed to ensure that depreciation charged in the expenditure account is materially accurate.

Impairment of intangible and property, plant and equipment assets

At each Statement of Financial Position date the Commission reviews the carrying amounts of its property, plant and equipment and intangible assets to determine whether there is any indication that those assets have suffered an impairment loss. If any such indication exists, the recoverable amount of the asset is estimated in order to determine the extent of the impairment loss (if any).

Research and development expenditure

There was no expenditure on research and development during the year.

Operating income

Income is made up of statutory fees from the registration of social care and private and voluntary healthcare providers and other income arising mainly from secondments of Commission staff and recoveries of costs from other public bodies. Statutory fees relating to following accounting periods are treated as income in advance at the end of each accounting period (Note 15).

Leases

Rent payable under operating leases is charged to the Net Expenditure Account on a straight-line basis over the lease term. There were no finance leases.

Financial instruments

Because of the non-trading nature of the Commission's activities and the way in which government departments are financed, the Commission was not exposed to the degree of financial risk faced by business entities. The Commission has no borrowings and relies on the grants from the Department of Health for its cash requirements. The Commission is therefore not exposed to liquidity risks. It has no material deposits and all material assets and liabilities are denominated in sterling so it is not exposed to interest rate risk or currency risk.

Financial assets are recognised on the Statement of Financial Position when the Commission becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred. The Commission has no financial assets other than trade debtors. Trade debtors do not carry any interest and are stated at their nominal value less any provision for impairment.

Financial liabilities are recognised on the Statement of Financial Position when the Commission becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged, that is, the liability has been paid or has expired. The Commission has no financial liabilities other than trade payables. Trade payables are not interest bearing and are stated at their nominal value.

Longer-term debtors and creditors are discounted when the time value of money is considered material.

Grants receivable

Grants received, including Government grant-in-aid received for revenue and capital expenditure are treated as financing and credited to the Statement of Changes in Taxpayers' Equity.

Provisions

Provisions are recognised when the Commission has a present obligation (legal or constructive) as a result of a past event, it is probable the Commission will be required to settle that obligation, and a reliable estimate can be made of the amount of the obligation.

The amount recognised as a provision is the best estimate of the consideration required to settle the present obligation at the Statement of Financial Position date, taking into account the risks and uncertainties surrounding the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the real rate set by HM Treasury, currently 2.2% (2.2% in 2008/09). The exception to this rule is the provision for additional pension contributions resulting from the early termination of staff in previous years.

Value added tax

The Commission is registered for value added tax as VAT-rated income (primarily from recharging the costs of staff on secondment) exceeded the VAT registration threshold. Expenditure reported in these statements is inclusive of irrecoverable VAT.

1.3 Capital charge

A notional charge, reflecting the cost of capital utilised by CQC, is included in the Expenditure account. The charge is calculated at the real rate set by HM Treasury, currently 3.5% (3.5% in 2008/09) on the average carrying amount of all assets less liabilities, excluding cash balances with the Office of the Paymaster General.

1.4 Pensions

CQC employees are covered by the provisions of the National Health Service (NHS) pension scheme. The NHS pension scheme is a defined benefit scheme and the Commission's contributions are charged to the net expenditure account as and when they are due so as to spread the cost of pensions over the employee's working lives with the Commission.

On 1 April 2009 staff transferred to the Care Quality Commission from three other Commissions – the Commission for Social Care Inspection (CSCI), the Healthcare Commission (HC) and the Mental Health Act Commission (MHAC). Existing members of the Principal Civil Service Pension Scheme (PCSPS) were offered membership of the NHS pension scheme but other transferring staff who were members of the Local Government Pension Scheme (LGPS) were allowed to keep their legacy arrangements. Details of the NHS pension scheme and the LGPS are provided in Note 4 and in the Remuneration report. Actuarial valuations are carried out at each Statement of Financial Position date with actuarial gains and losses recognised in full in the period in which they occur.

2. Transfer of net assets (liabilities) from legacy Commissions

On 1 April 2009 the assets, net liabilities and continuing activities of CSCI, HC and MHAC were transferred to the Commission. The consolidated financial information has been presented as if the merger and conversion to IFRS took place on 1 April 2008 and therefore certain opening balances sheet adjustments have been required. These include:

- An adjustment for untaken holiday entitlement for 2007/08.
- Movements between the revaluation and general reserve resulting from the indexation of the assets.
- The removal of a provision for rental commitments on properties that were transferred from CSCI to the Department of Health.
- An adjustment for any income billed during the year that relates to the following financial period.

The adjustments described in the table below include the opening Statement of Financial Position adjustments as at 1 April 2008 together with the movement from closing the 2008/09 predecessor accounts to the balances brought forward to CQC as at 1 April 2009 in relation to both IFRS and the merger.

Net expenditure account		CSCI £000	HC £000	MHAC £000	CQC £000	All £000	Total £000
Net expenditure as per Annual Report 2008/09		123,919	67,770	5,779	2,670	–	200,138
Adjustments resulting from the merger							
Less discontinued activities	i	–	(8,127)	–	–	–	(8,127)
Provision for empty offices not transferred to CQC	vi	(10,714)	–	–	–	–	(10,714)
Provision for dilapidations on empty offices not transferred to CQC		(2,454)	–	–	–	–	(2,454)
Additional impairment of assets not transferred to CQC	vii	–	–	–	–	908	908
Increase in fee income received in advance	viii	–	–	–	–	194	194
		110,751	59,643	5,779	2,670	1,102	179,945
IFRS adjustments							
Holiday pay accrual for 08/09	ii	585	455	15	–	–	1,055
Less holiday pay accrual for 07/08	ii	(699)	(363)	(37)	–	–	(1,099)
Revaluation of assets not released to net expenditure in 08/09	iii	732					732
Restated balance at 1 April 2009		**111,369**	**59,735**	**5,757**	**2,670**	**1,102**	**180,633**

Statement of financial position		CSCI £000	HC £000	MHAC £000	CQC £000	All £000	Total £000
Non-current assets:							
Property, plant and equipment as per Annual Report 2008/09		6,313	3,690	107	6,574	–	16,684
IFRS changes							
Change arising from IFRS re-classification	iv	(1,191)	–	–	(4,892)	55	(6,028)
Merger adjustment							
Additional Impairment of assets not transferred to CQC		–	–	–	–	(338)	(338)
Restated balance at 1 April 2009		5,122	3,690	107	1,682	(283)	10,318
Intangible assets as per Annual Report 2008/09		123	7,132	114	–	–	7,369
IFRS changes							
Change arising from IFRS re-classification	iv	1,191	–	–	4,892	(55)	6,028
Merger adjustment							
Additional impairment of assets not transferred to CQC		–	–	–	–	(570)	(570)
Restated balance at 1 April 2009		**1,314**	**7,132**	**114**	**4,892**	**(625)**	**12,827**
Current assets:							
Trade receivables and other current assets as per Annual Report 2008/09		5,071	4,649	130	82	–	9,932
Merger adjustment							
Less inter company debtors	v	–	–	–	–	(72)	(72)
Restated balance at 1 April 2009		**5,071**	**4,649**	**130**	**82**	**(72)**	**9,860**
Current liabilities:							
Trade, other payables and deferred income as per Annual Report 2008/09		(14,413)	(7,101)	(1,420)	(765)	–	(23,699)
Merger adjustment							
Less inter company creditors	v	–	–	–	–	72	72
Deferred Income		(22,912)	(3,111)	–	–	–	(26,023)
IFRS changes							
Holiday pay accrual for 08/09	ii	(585)	(455)	(15)	–	–	(1,055)
Restated balance at 1 April 2009		**(37,910)**	**(10,667)**	**(1,435)**	**(765)**	**72**	**(50,705)**
Pension deficit provision							
As per Annual Report 2008/09		(7,312)	–	–	–	–	(7,312)
Prior year adjustment		(1)	–	–	–	–	(1)
Restated balance at 1 April 2009		**(7,313)**	**–**	**–**	**–**	**–**	**(7,313)**

Statement of changes in reserves		CSCI £000	HC £000	MHAC £000	CQC £000	All £000	Total £000
Reserves transferred							
As per Annual Report 2008/09		23,810	(10,846)	(174)	(6,143)	–	6,647
Holiday pay accrual for 2008/09	ii	585	455	15	–	–	1,055
Prior period adjustment re pension deficit for 2008/09		1	–	–	–	–	1
		24,396	(10,391)	(159)	(6,143)	–	7,703
Liabilities transferred to the Department of Health							
Empty offices	vi	(23,185)	–	–	–	–	(23,185)
Non-current assets							
Property, plant and equipment	vii	–	–	–	–	338	338
Intangible assets	vii	–	–	–	–	570	570
Changes arising from adoption of CQC accounting policies:							
Current liabilities							
Fee income in advance	viii	22,912	3,111	–	–	–	26,023
Restated balance at 1 April 2009		24,123	(7,280)	(159)	(6,143)	908	**11,449**

i Discontinued activities comprise the NHS 2nd Tier complaints function which ceased as a regulatory function on transfer to CQC.
ii IAS 19 states that where holiday benefit is accumulating (i.e. holiday benefit is earned over time and capable of being carried forward) a reporting entity should provide for the expected cost of the accumulated benefit.
iii Gain/loss on property, plant and equipment not released to the net expenditure account in 2008/09.
iv In accordance with IAS16 and IAS38 expenditure on developed software has been re-classified from property, plant and equipment to intangible assets.
v Debtor and creditor balances between predecessor organisations have been eliminated upon merger.
vi Empty office properties leased by CSCI were transferred to the Department of Health on 1 April 2009.
vii Those assets transferred to CQC which were deemed to be of limited application to the new organisation have been either disposed or impaired. This included fixtures and fittings and ICT infrastructure in offices CQC no longer occupy and IT hardware and ICAP software developments relating to systems and processes not used by CQC.
viii Annual registration fees are invoiced on the anniversary of the date of registration. This means that the fee can cover periods relating to the following financial year. CQC's policy recognises this and a liability was raised for any income billed during the year which relates to the following financial period.

3. Analysis of net expenditure by segment

IFRS 8 requires operating segments to be identified on the basis of internal reports that are regularly reviewed by the Chief Executive. CQC's Board monitored the performance and resources of the organisation as a whole since the Commission's net expenditure for the year related to its principal duties and functions as set out in the Health and Social Care Act 2008.

3.1 Revenues from major products and services: Income from fees.

	2009/10 £000	2008/09 £000
Annual fees	(59,306)	(58,747)
Annual fees – rebate scheme	538	728
Initial registration fees	(4,658)	(6,007)
Variation fees	(1,111)	(1,301)
Chargeable inspections etc	(15)	(17)
Fee income	**(64,552)**	**(65,344)**

4. Staff numbers and related costs

4.1 Staff costs comprise:

	2009/10			2008/09
	Permanently employed staff £000	Others £000	Total £000	Total £000
Wages and salaries	73,475	15,377	88,852	102,763
Social security costs	6,556	–	6,556	7,312
Other pension costs	9,811	–	9,811	11,133
	89,842	**15,377**	**105,219**	**121,208**
Less recoveries in respect of outward secondments	(425)	–	(425)	(1,032)
Increase (decrease) in provision for pension fund deficits	(2,695)	–	(2,695)	3,549
Staff costs	**86,722**	**15,377**	**102,099**	**123,725**

Other staff costs consist of:

	2009/10 £000	2008/09 £000
Agency	10,965	15,849
Secondments from other organisations	1,210	316
Commissioner fees	803	998
Second opinion doctors' fees and expenses	2,399	2,530
Total	**15,377**	**19,693**

Agency staff costs of £3.7m relating to IT software developments were capitalised during the year (£634k 2008/09).

4.2 The average number of whole-time equivalent persons employed during the year was as follows:

	2009/10 number wte	2008/09 number wte
Directly employed	1,903	2,208
Other**	312	348
Agency staff engaged on capital projects	22	22
	2,237	**2,578**

** Other excludes the Commissioners and Second Opinion Doctors who are paid per session.

The actual number of directly employed whole time equivalents as at 31 March 2010 was 2,098 (2009: 2,548).

4.3 Pension arrangements

Defined contribution schemes:

CQC currently offers its employees membership to the NHS pension scheme which operates as a defined contribution scheme.

The assets of the scheme are held separately from those of the Commission in funds under the control of trustees. Where there are employees who leave the scheme prior to vesting fully in the contributions, the contributions payable by the Commission are reduced by the amount of forfeited contributions. The Commission is required to contribute a specified percentage of payroll costs to the retirement benefit scheme to fund the benefits. The only obligation of the Commission with respect to the retirement benefit scheme is to make the specified contributions.

The total cost charged to expenditure of £4,574k represents the contribution payable to the scheme by the Commission at rates specified in the rules of the plan. As at 31 March 2010, contributions of £576k due in respect of the current reporting period had not been paid over to the scheme.

Defined benefit schemes:

Due to legacy arrangements made through the predecessor organisations, CQC also makes contributions to defined benefit schemes for the former employees of CSCI. All schemes are closed funded schemes. Under the projected unit method the current service cost will increase as the members of the scheme approach retirement.

Triennial actuarial valuations of plan assets were performed as at 31 March 2007 with the next formal valuation due as at 31 March 2010. The 2007/08 triennial actuarial valuation resulted in revised employer contribution rates for subsequent years.

Contribution rates for 2010/11 are currently expected to range between 6.2% and 39.6% (13.7% for Teesside Pension Fund).

The present value of the defined benefit obligations were carried out at 31 March 2010 by:

Pension fund	Actuary
Teesside	Barnett Waddingham
Essex	Mercer Ltd
Merseyside	Mercer Ltd
Greater Manchester	Hymans Robertson LLP
Derbyshire County Council	Mercer Ltd
Hampshire County Council	Hewitt Associates Ltd
West Yorkshire	Hewitt Associates Ltd
Cheshire	Hymans Robertson LLP
Avon	Mercer Ltd
Cumbria	Mercer Ltd
Cambridgeshire County Council	Hymans Robertson LLP
Suffolk County Council	Hymans Robertson LLP
East Sussex County Council	Hymans Robertson LLP
Surrey	Hymans Robertson LLP
West Sussex County Council	Hymans Robertson LLP
Dorset County Council	Barnett Waddingham
Shropshire County	Mercer Ltd

The present value of the defined benefit obligation; the related current service cost and past service cost were measured using the projected unit credit method.

The net pension asset/liability of each local government defined benefit scheme is as follows:

Pension fund	Assets 09/10 £000	Liabilities 09/10 £000	Surplus/ (deficit) 09/10 £000	Surplus/ (deficit) 08/09 restated £000	Surplus/ (deficit) 07/08 £000	Surplus/ (deficit) 06/07 £000	Surplus/ (deficit) 05/06 £000
Teesside	192,977	(221,084)	(28,107)	5,811	7,206	(14,180)	(19,268)
Essex	4,364	(5,837)	(1,473)	(1,017)	(1,020)	(923)	(1,283)
Merseyside	4,516	(5,757)	(1,241)	(772)	(632)	(12)	(285)
Greater Manchester	11,155	(15,828)	(4,673)	(1,339)	173	(789)	(1,468)
Derbyshire	2,446	(2,863)	(417)	(385)	(225)	74	(86)
Hampshire	3,760	(6,120)	(2,360)	(1,690)	(500)	(1,010)	(1,010)
West Yorkshire	6,868	(10,003)	(3,135)	(1,641)	(1,684)	(282)	(715)
Cheshire	2,361	(4,520)	(2,159)	(912)	(492)	(150)	(430)
Avon	3,703	(4,799)	(1,096)	(719)	(766)	(312)	(562)
Cumbria	2,519	(3,722)	(1,203)	(793)	(819)	(640)	(826)
Cambridgeshire	1,986	(3,155)	(1,169)	(322)	(20)	(115)	(268)
Suffolk	2,633	(4,269)	(1,636)	(589)	(62)	(314)	(549)
East Sussex	3,499	(4,726)	(1,227)	(345)	134	(260)	(480)
Surrey	3,643	(5,571)	(1,928)	(768)	(34)	(582)	(800)
West Sussex	2,376	(3,071)	(695)	(517)	(101)	(189)	(335)
Dorset	1,438	(2,637)	(1,199)	(772)	(386)	(254)	(293)
Shropshire	1,355	(2,205)	(850)	(543)	(494)	(502)	(622)
Total	**251,599**	**(306,167)**	**(54,568)**	**(7,313)**	**278**	***(20,440)**	**(29,280)**

* includes CSCI children's work which was transferred to the new Office for Standards in Education, Children's Services and Skills (Ofsted) on 1 April 2007.

Asset values are at bid value whereas prior to 2008, the value of assets may have been reported as mid value.

In 2007/08 the pension funds showed a surplus. This is reflected in the Statement of Financial Position as shown below:

	Pension fund		
Non-current assets	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Balance brought forward	–	278	278
Utilised in year	–	(278)	–
Balance carried forward	–	–	278

In 2008/09 a deficit was reported which has increased significantly in 2009/10 due predominantly to a significant reduction in corporate bond yields and rising inflation expectations, despite better than expected investment returns.

Five persons retired early on ill-health grounds during the year. The total additional accrued pension liabilities in the year amounted to £27k (pension £12k and lump sum £16k).

A summary of the IAS19 disclosure information is as follows:

The range of major assumptions used by the actuaries:

	Teesside Pension Fund % per annum			Other Pension Funds % per annum		
Key assumptions used:	**09/10**	**08/09**	**07/08**	**09/10**	**08/09**	**07/08**
Discount rate	5.5	6.7	6.6	5.5 to 5.6	6.6 to 7.1	6.1 to 6.9
Expected rate of salary increases	5.4	4.5	5.7	3.8 to 5.6	4.5 to 5.1	4.8 to 5.7
Expected return on scheme assets	6.8	5.3	5.9	5.3 to 7.2	4.9 to 6.5	5.7 to 6.3
Future pension increases	3.9	3.0	3.7	3.3 to 3.9	3 to 3.6	3.6 to 3.7
Inflation	3.9	3.0	3.7	3.3 to 3.9	3 to 3.6	3.6 to 3.7

Mortality assumptions:

Investigations have been carried out within the past three years into the mortality experience of the Commission's defined benefit schemes. These investigations concluded that the current mortality assumptions include sufficient allowance for future improvements in mortality rates. The assumed life expectations on retirement at age 65 are:

	Teesside Pension Fund			Other Pension Funds		
	09/10	**08/09**	**07/08**	**09/10**	**08/09**	**07/08**
Retiring today:						
Males	19.5	19.5	n/a	20.4 to 22.7	19.6 to 22.2	20.3 to 22.0
Females	22.6	22.6	n/a	23.2 to 26.1	22.5 to 24.9	23.1 to 26.4
Retiring in 20 years:						
Males	20.4	20.4	n/a	21.3 to 25.4	20.7 to 24.5	21.3 to 23.4
Females	23.4	23.4	n/a	24.1 to 28.3	23.6 to 26.4	24.0 to 25.9

In 2007/08 it was not a mandatory requirement for actuaries to quote the assumed mortality ages.

Amounts recognised in the net expenditure account in respect of these defined benefit schemes are as follows:

	2009/10 £000	**2008/09 £000**
Current service cost less employer contributions	(3,444)	337
Past service cost	361	1,139
Curtailments and settlements	388	2,073
Expected return on pension scheme assets	(11,556)	(14,821)
Interest on pension scheme liabilities	12,872	12,739
Total operating charge	**(1,379)**	**1,467**

Of the expense for the year, £2.7m credit (2009: £3.5m debit) has been included in the net expenditure statement as staff expenditure and £1.3m debit (2009: £2.0m credit) has been included in other expenditure. Actuarial gains and losses have been reported in reserves.

The actual return on scheme assets was a gain of £69 million (2009: £38 million loss).

The cumulative amount of actuarial gains and losses recognised in reserves since the date of transition to IFRS on 1 April 2008 is £55m (2009: £6m).

The amount included in the Statement of Financial Position arising from the Commission's obligations in respect of its defined benefit retirement benefit schemes is as follows:

	Year to 31 Mar 2010 £000	Year to 31 Mar 2009 restated £000	Year to 01 Apr 2008 £000
Present value of defined benefit obligations	(306,080)	(192,692)	(222,759)
Fair value of scheme assets	251,599	185,443	223,104
Deficit in scheme	(54,481)	(7,249)	345
Past service cost not yet recognised in balance sheet	(87)	(64)	(67)
Liability recognised in the balance sheet	**(54,568)**	**(7,313)**	**278**

Movements in the present value of defined benefit obligations were as follows:

	2009/10 £000	2008/09 £000
At 1 April	192,756	222,826
Service cost	5,535	8,912
Interest cost	12,872	12,739
Contributions from scheme members	2,694	2,963
Actuarial (gains) and losses	106,024	(46,391)
Losses (gains) on curtailments	388	2,073
Benefits paid	(14,463)	(11,505)
Past service cost	361	1,139
At 31 March	**306,167**	**192,756**

Movements in the fair value of scheme assets were as follows:

	2009/10 £000	2008/09 restated £000
At 1 April	185,443	223,104
Expected return on scheme assets	11,556	14,821
Actuarial gains and (losses)	57,390	(52,515)
Contributions by employer	8,979	8,575
Contributions from scheme members	2,694	2,963
Benefits paid	(14,463)	(11,505)
At 31 March	**251,599**	**185,443**

The actuarial loss calculation was as follows:

	2009/10 £000	2008/09 £000
Movements in the fair value of scheme assets	57,390	(52,515)
Less movements in the present value of defined benefit obligations	106,024	(46,391)
	(48,634)	**(6,124)**

The analysis of the scheme assets and the expected rate of return at the Statement of Financial Position date was as follows:

	Expected return 09/10 %	08/09 %	07/08 %	Fair value of assets 09/10 £000	08/09 restated £000	07/08 £000
Equity instruments	7.3 to 8.0	6.8 to 7.5	7.1 to 7.7	199,550	130,278	160,326
Debt instruments	5.0 to 5.5	5.4 to 6.5	5.7 to 6.8	25,693	26,631	26,178
Property	5.5 to 8.5	4.9 to 6.6	5.7 to 6.8	11,206	10,369	12,078
Cash	0.5 to 4.8	0.5 to 4.0	4.8 to 6.0	15,150	18,165	24,564
Total				**251,599**	**185,443**	**223,146**

The five-year history of experience adjustments is as follows:

	2009/10 £000	2008/09 restated £000	2007/08 £000	2006/07 £000	2005/06 £000
Present value of defined benefit obligations	(306,167)	(192,756)	(222,826)	(254,782)	(237,652)
Fair value of scheme assets	251,599	185,443	223,104	234,342	208,372
Surplus/(deficit) in the scheme	**(54,568)**	**(7,313)**	**278**	**(20,440)**	**(29,280)**
Experience adjustments on scheme liabilities	70	(616)	704	21	(18)
Percentage of scheme liabilities (%)	0%	0%	0%	0%	0%
Experience adjustments on scheme assets	57,390	(50,645)	(27,038)	709	29,400
Percentage of scheme assets (%)	23%	27%	12%	0%	14%

5. Other expenditure

	2009/10 £000	2008/09 £000
IT costs, including general project management	19,231	11,228
Other consultancy, professional fees and project costs	13,550	6,103
Redundancy	6,829	20,547
Travel and subsistence	5,728	6,713
Other premises costs	5,501	10,646
Rentals under operating leases	4,564	7,918
Recruitment, training & development costs	3,818	3,810
General office supplies	3,181	1,924
Telecoms	2,465	2,327
Communications	1,573	1,962
Net expenses on pension scheme assets and liabilities	1,316	–
Printing & publishing	1,131	635
Other costs**	578	568
Marketing	517	528
External audit fees – Statutory work	150	212
	70,132	**75,121**
Non-cash items		
Loss on disposal of intangible assets	155	1,950
Loss on disposal of property, plant and equipment	701	10,493
Loss on indexation of intangible assets	794	1,770
Loss on indexation of property, plant and equipment	456	2,375
Revenue provision for dilapidations	1,073	13
	3,179	**16,601**
Other expenditure	**73,311**	**91,722**
Impairment of intangible assets	1,681	14,958
Impairment of property, plant and equipment assets	–	399
Impairment	**1,681**	**15,357**
Depreciation – intangible assets	7,305	12,063
– property, plant and equipment	5,545	5,765
Depreciation	**12,850**	**17,828**
Cost of capital charges	**(1,490)**	**361**

** Other costs include losses and special payments of £93k for 2009/10 and £347k for 2008/09.

6. Auditors' remuneration

	2009/10 £000	2008/09 £000
Fees payable to the Commission's auditors for the 2009/10 audit of the Commission's annual accounts	150	212

The charge for 2009/10 is made up of a charge of £130k for the 2009/10 audit plus an additional charge of £20k in respect of the IFRS opening Statement of Financial Position work in relation to the predecessor organisations.

7. Income

	2009/10 £000	2008/09 £000
Income from activities:		
Income from fees	(64,552)	(65,344)
Other income	(200)	(773)
	(64,752)	**(66,117)**
Other income:		
Net return on pension scheme assets and liabilities	–	(2,082)
Surplus on disposal of assets	(12)	(4)
	(12)	(2,086)
	(64,764)	**(68,203)**
Interest receivable:		
Bank interest receivable	(3)	(145)
Other interest receivable	(20)	(12)
	(23)	(157)
Total	**(64,787)**	**(68,360)**

Fees and charges made to the independent sector are in line with fee scales prescribed by the Secretary of State for Health under the Health and Social Care Act 2008.

Annual registration fees are invoiced on the anniversary of the registration and recognised as income over the following 12 months. In cases of voluntary deregistration, fees are refunded to registered organisations in accordance with the fee rebate scheme detailed on the Commission's internet site.

8. Intangible assets

	IT software developments £000	Software licences £000	Website £000	Total £000
Cost of valuation				
At 1 April 2009	20,184	2,227	922	23,333
Additions	6,074	1,709	857	8,640
Disposals	(4,611)	–	–	(4,611)
Impairments	(3,566)	–	(413)	(3,979)
Indexation	3,740	793	249	4,782
At 31 March 2010	**21,821**	**4,729**	**1,615**	**28,165**
Amortisation				
At 1 April 2009	(8,666)	(1,840)	–	(10,506)
Charged in year	(6,384)	(556)	(365)	(7,305)
Disposals	4,456	–	–	4,456
Impairments	2,248	–	50	2,298
Indexation	(1,640)	(496)	(78)	(2,214)
At 31 March 2010	**(9,986)**	**(2,892)**	**(393)**	**(13,271)**
Net book value at 31 March 2010	**11,835**	**1,837**	**1,222**	**14,894**
Net book value at 1 April 2009 as restated (Note 2)	**11,518**	**387**	**922**	**12,827**
Cost of valuation				
At 1 April 2008	42,192	3,794	376	46,362
Additions	16,936	7	922	17,865
Disposals	(8,785)	(188)	(40)	(9,013)
Impairments	(29,041)	(91)	(341)	(29,473)
Reclassification*	1	(1,295)	–	(1,294)
Indexation	(1,119)	–	5	(1,114)
At 31 March 2009	**20,184**	**2,227**	**922**	**23,333**
Amortisation				
At 1 April 2008	(18,049)	(2,521)	(34)	(20,604)
Charged in year	(11,140)	(812)	(111)	(12,063)
Disposals	6,835	188	40	7,063
Impairments	14,334	66	115	14,515
Reclassification*	–	1,239	–	1,239
Indexation	(646)	0	(10)	(656)
At 31 March 2009	**(8,666)**	**(1,840)**	**–**	**(10,506)**
Net book value at 31 March 2009 as restated (Note 2)	**11,518**	**387**	**922**	**12,827**
Net book value at 1 April 2008	**24,143**	**1,273**	**342**	**25,758**

* The reclassification was from property, plant and equipment (Note 9).
Intangible assets comprise software licences, software development costs, including related contractor and staff costs, and website development costs. Related general project management and overhead costs are not capitalised.

9. Property, plant and equipment

	Information technology £000	Furniture and fittings £000	Assets under construction £000	Motor vehicles £000	Total £000
Cost of valuation					
At 1 April 2009	8,396	11,626	–	–	20,022
Additions	6,216	766	–	–	6,982
Disposals	(839)	(2,521)	–	–	(3,360)
Indexation	2,613	(19)			2,594
At 31 March 2010	**16,386**	**9,852**	**–**	**–**	**26,238**
Depreciation					
At 1 April 2009	(3,535)	(6,169)	–	–	(9,704)
Charged in year	(3,439)	(2,106)	–	–	(5,545)
Disposals	804	1,855	–	–	2,659
Indexation	(1,181)	(114)			(1,295)
At 31 March 2010	**(7,351)**	**(6,534)**	**–**	**–**	**(13,885)**
Net Book value at 31 March 2010	**9,035**	**3,318**	**–**	**–**	**12,353**
Net Book value at 1 April 2009 as restated (Note 2)	**4,861**	**5,457**	**–**	**–**	**10,318**
Cost of valuation					
At 1 April 2008	20,402	36,791	228	12	57,433
Additions	3,335	3,926	1,569	–	8,830
Disposals	(8,520)	(20,946)	–	(11)	(29,477)
Impairments	(10,280)	(6,952)	–	–	(17,232)
Reclassifications*	2,839	252	(1,797)	–	1,294
Indexation	620	(1,445)	–	(1)	(826)
At 31 March 2009	**8,396**	**11,626**	**–**	**–**	**20,022**
Depreciation					
At 1 April 2008	(17,107)	(19,863)	–	(12)	(36,982)
Charged in year	(2,454)	(3,311)	–	–	(5,765)
Disposals	8,498	10,472	–	11	18,981
Impairments	9,881	6,952	–	–	16,833
Reclassifications*	(1,077)	(162)	–	–	(1,239)
Indexation	(1,276)	(257)	–	1	(1,532)
At 31 March 2009	**(3,535)**	**(6,169)**	**–**	**–**	**(9,704)**
Net Book value at 31 March 2009 as restated (Note 2)	**4,861**	**5,457**	**–**	**–**	**10,318**
Net Book value at 1 April 2008	**3,295**	**16,928**	**228**	**–**	**20,451**

* The reclassification was from intangibles (Note 8).

9. Property, plant and equipment continued

Property, plant and equipment assets are valued using indices issued by the Office for National Statistics.

Asset financing:

All assets are owned by CQC.

10. Financial instruments

As the cash requirements of the Commission are met through grant-in-aid provided by the Department of Health, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with the Commission's expected purchase and usage requirements and the Commission is therefore exposed to little credit, liquidity or market risk.

Moreover financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies. The Commission had very limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities and are not held to change the risks that faced the Commission in undertaking its activities.

a) Market risk

The Commission was not exposed to currency risk or commodity risk. All material assets and liabilities were denominated in sterling. With the exception of the cash equivalents the Commission had no significant interest bearing assets or borrowings subject to variable interest rates, income and cash flows were largely independent of changes in market interest rates.

b) Credit risk

Credit risk arises from cash and cash equivalents, as well as the credit exposures derived from care home operators. Management monitored the credit closely and all undisputed debts over 61 days were sent to a debt collection company for recovery action. While ultimate recovery was still pursued, such debts were provided for as a matter of course, as were all registration or variation debts which were outstanding for more than 30 days.

The Commission had a large number of small debtors and therefore disclosure of the largest individual debt balances was not considered in the evaluation of overall credit risk.

The table below shows the ageing of the overdue analysis of trade debtors at the Statement of Financial Position date:

	Less than 30 days past due £000	31–60 days past due £000	61 and over days past due £000
At 31 March 2010	1,769	164	312
At 31 March 2009	1,650	1,062	175
At 1 April 2008	1,579	295	122

In 2009/10 the bad debt provision of £210k all related to debts over 61 days. All other debtors were considered to be current. Intra-government balances are repayable on demand and were therefore classified as current until request for payment was made.

The maximum exposure to credit risk at the reporting date is the fair value of each class of receivables mentioned above. The Commission did not hold any collateral as security.

c) Liquidity risk

Management aimed to manage liquidity risk through regular cash flow forecasting to ensure the Commission had sufficient available funds for operations. The Commission had no borrowings and relied on grant in aid from the Department of Health for its cash requirements and was therefore not significantly exposed to liquidity risks.

The table below analyses the Commission's financial liabilities which will be settled on a net basis in the period of less than one year. The carrying value of financial liabilities was not considered to differ significantly from the contractual undiscounted cash flows:

Less than one year	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Current liabilities	(16,150)	(24,682)	(19,390)

d) Capital risk management

The functions of CSCI, HC and MHAC were transferred to CQC on the 1 April 2009. Ongoing funding for CQC has been confirmed by the Department of Health. As a result the capital structure was considered low risk and it was not a requirement for management to actively monitor this on a day to day basis.

11. Impairments

Assets transferred to the Commission from CSCI, HC and MHAC on 1 April 2009 were verified and allocated a provisional working life within CQC. Assets which were not used by CQC were withdrawn and either scrapped or disposed of. This impairment to opening asset values is shown in Note 2 as a reduction in reserves transferred from other regulators.

In 2008/09 an assessment of the issues surrounding the ICAP software development resulted in an impairment value of £14.4m being made to the carrying value of the asset.

During 2009/10 CQC identified further impairments to the ICAP software development and also to the Annual Health Check system.

	2009/10 £000	2008/09 £000
IT Core Application Project (ICAP)	367	14,388
Healthcare Commission – miscellaneous items	–	61
Additional impairment of assets not transferred to CQC	–	908
Annual Health Check software developments	1,314	–
	1,681	**15,357**

12. Inventories

The Commission does not place a value on stocks of printed stationery held for use in the normal course of business. No goods are purchased for resale.

13. Trade receivables and other current assets

	31 March 2010 £000	31 March 2009 as restated (Note 2) £000	1 April 2008 £000
Amounts falling due within one year:			
Trade receivables	3,085	4,077	3,745
Deposits and advances	126	133	153
Other receivables	510	1,993	2,541
Prepayments and accrued income	2,788	3,657	2,755
Total	**6,509**	**9,860**	**9,194**

There were no amounts falling due after more than one year.

13.1 Intra-government debtor balances

	Amounts falling due within one year		
	31 March 2010 £000	31 March 2009 as restated (Note 2) £000	1 April 2008 £000
Intra-governmental balances:			
Balances with central government	463	3,098	502
Balances with NHS trusts	31	5	65
Balances with local authorities	299	831	937
Balances with public corporations & trading funds	3	–	–
Subtotal: intra-government balances	**796**	**3,934**	**1,504**
Balances with bodies external to government	5,713	5,926	7,690
	6,509	**9,860**	**9,194**

Other receivables include advance payments on salary and staff loans total £13k and £113k respectively (£41k and £173k in 2008/09). Staff could apply for advance payments on salary and loans up to a maximum of £5k for rail season tickets.

There were no intra-government debtor amounts falling due after more than one year.

13.2 Movement in the allowance for doubtful debts

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Balance at the beginning of the period	275	249	233
Additional losses recognised during the year	127	198	183
Amounts written off during the year as uncollectible	(29)	(60)	(79)
Amounts recovered during the year	(163)	(112)	(88)
Balance at the end of the period	**210**	**275**	**249**

14. Cash and cash equivalents

	£000
Balance at 1 April 2008	16,189
Net change in cash and cash equivalent balances	2,974
Balance at 31 March 2009	19,163
Net change in cash and cash equivalent balances	(4,244)
Balance at 31 March 2010	**14,919**

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
The following balances were held at:			
HM Paymaster General	14,916	5,643	6,873
Commercial banks and cash in hand	3	13,520	9,316
	14,919	**19,163**	**16,189**

15. Trade payables and other current liabilities

	31 March 2010 £000	31 March 2009 as restated (Note 2) £000	1 April 2008 £000
Amounts falling due within one year			
VAT	(13)	(13)	(23)
Other taxation and social security	(2,174)	(3,849)	(3,131)
Trade payables	(5,979)	(6,829)	(4,772)
Other payables	(1,199)	(1,409)	(2,892)
Accruals and deferred income	(6,785)	(12,582)	(8,572)
	(16,150)	(24,682)	(19,390)
Fee income in advance	(26,393)	(26,023)	(25,829)
	(42,543)	**(50,705)**	**(45,219)**
Amounts falling due after more than one year			
Pension liabilities	(3,099)	(101)	(141)
Exceptional item – terminations of employment	–	(1,055)	–
	(3,099)	**(1,156)**	**(141)**

15.1 Intra-government creditor balances

	Amounts falling due within one year			Amounts falling due after more than one year		
	31 March 2010 £000	31 March 2009 as restated (Note 2) £000	1 April 2008 £000	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Intra-governmental balances:						
Balances with central government	(2,549)	(4,656)	(3,757)	–	–	–
Balances with NHS trusts	(865)	(220)	(489)	–	–	–
Balances with local authorities	(1,150)	(787)	(1,790)	–	–	–
Balances with public corporations and trading funds	–	(2,506)	(469)	–	–	–
Subtotal: intra-government balances	**(4,564)**	**(8,169)**	**(6,505)**	**–**	**–**	**–**
Balances with bodies external to Government	(37,979)	(42,536)	(38,714)	(3,099)	(1,156)	(141)
	(42,543)	**(50,705)**	**(45,219)**	**(3,099)**	**(1,156)**	**(141)**

16. Provisions for liabilities and charges

	Employment termination and other costs £000	Leased property dilapidations £000	Total £000
Balance 1 April 2008	(3,333)	(250)	(3,583)
Provided in year	(4,085)	(108)	(4,193)
Provisions utilised in year	3,333	–	3,333
Balance 31 March 2009 as restated (Note 2)	**(4,085)**	**(358)**	**(4,443)**
Balance 1 April 2009 as restated (Note 2)	(4,085)	(358)	(4,443)
Provided in year	(166)	(1,076)	(1,242)
Provisions not required written back	436	7	443
Provisions utilised in year	3,648	6	3,654
Balance 31 March 2010	**(167)**	**(1,421)**	**(1,588)**
Analysis of expected timing of discounted flows			
In the next financial year	(167)	(189)	(356)
Current provisions 31 March 2010	**(167)**	**(189)**	**(356)**
Between 1–5 years	–	(789)	(789)
Between 6–10 years	–	(443)	(443)
After 10 years	–	–	–
Non-current provisions 31 March 2010	**–**	**(1,232)**	**(1,232)**

Provisions falling due after more than one year have been reduced by a discount factor of 2.2% pa (2.2% 2008/09) in accordance with HM Treasury guidance.

Leased property dilapidations become payable on termination of the leases.

17. Capital commitments

Contracted capital commitments at 31 March 2010 not otherwise included within these financial statements totalled £417k (2009: £111k) and consist, in the main, of IT hardware and software developments:

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Property, plant and equipment	166	12	–
Intangible assets	251	99	164
	417	**111**	**164**

18. Commitments under leases

18.1

Total future minimum lease payments under operating leases are given in the table below for each of the following periods.

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Obligations under operating leases comprise:			
Buildings:			
Not later than one year	3,757	3,218	3,218
Later than one year and not later than 5 years	14,766	12,200	12,461
Later than 5 years	12,135	14,237	15,981
	30,658	**29,655**	**31,660**
Other:			
Not later than one year	38	24	44
Later than one year and not later than 5 years	150	–	3
Later than 5 years	2	–	–
	190	**24**	**47**

18.2

There were no future minimum lease payments under finance leases at the statement date.

19. Other financial commitments

There were no other material financial commitments at the statement date.

20. Contingent liabilities disclosed under IAS 37

The Commission has the following contingent liabilities:

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
First tier tribunals:	270	300	480
Employment tribunals:	200	–	–
Personal injury claims:	100	–	–
Ongoing complex matters:	–	120	–
Prosecutions:	–	–	20
	570	**420**	**500**

21. Related party transactions

21.1 Transactions with the Department of Health

The Care Quality Commission is a non-departmental public body sponsored by the Department of Health. The Department of Health is regarded as a related party.

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Transactions with Department of Health:			
Department of Health – Income			
Grant in aid – Revenue	110,000	134,121	140,359
Grant in aid – Capital	17,000	26,012	23,582
Commissioned work	–	150	10
Secondments	202	–	–
Set-up costs for CQC reimbursed	276	1,801	–
Reimbursement of costs on properties transferred to DH on 1 April 2009	611	–	–
	128,089	**162,084**	**163,951**
Department of Health – Expenditure			
Secondments	773	160	190
Set-up costs for the Commission	–	2,845	–
Expenditure on fixed assets	–	6,574	–
Consultancy	–	–	60
Recharge of property payments	373	–	–
	1,146	**9,579**	**250**
Department of Health balances at 31 March 2010 were:			
Amounts due from the DH to CQC	339	2,152	–
Amounts due to the DH from CQC	431	199	–

21.2

From 1 April 2009, CSCI, the Healthcare Commission and MHAC transferred activities, assets and liabilities to the Care Quality Commission (CQC). Transactions between the Commission and these bodies during the financial year were as disclosed in Note 2.

21.3

There were no material transactions with the Board, key managers or other related parties during the year.

22 Third-party assets

The Commission has no third-party assets.

23 Discontinued activities

The activities transferred to the Care Quality Commission on 1 April 2009 have been treated as continuing activities in these statements. There were no discontinued activities of the Commission to be reported in these financial statements (2008/09: None).

24 Post statement of financial position events

The Commission's financial statements were laid before the Houses of Parliament by the Department of Health. The Commission is required to disclose the date on which the accounts were authorised for issue. This is the date on which the certified accounts are dispatched by CQC's management to the Department of Health. The authorised date for issue is 16 July 2010.

There were no significant post Statement of Financial Position events.

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