Care Quality Commission

Annual report and accounts 2012/13

Raising standards, Putting people first

Care Quality Commission

Annual report and accounts 2012/13

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Contents

Raising standards, Putting people first: CQC at a glance

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

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

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

In April 2013 we announced **our strategy to transform CQC** so that it can fulfil its purpose and carry out its role effectively, focusing on six strategic priorities:

1	2	3	4	5	6
Better use of information and inspection	Working better with our partners in the health and social care system	Building better relationships with the public	Building relationships with those we regulate	Strengthening how we deliver our responsibilities in terms of mental health and mental capacity	Building a high-performing organisation

How we carry out our role

- We set standards of quality and safety that people have a right to expect whenever they receive care.
- We register care services that meet our standards.
- We monitor, inspect and regulate care services to make sure that they continue to meet the standards.
- We protect the rights of vulnerable people, including those whose rights are restricted under the Mental Health Act.
- We listen to and act on people's views and experiences of the care they receive.
- We challenge all providers, with the worst performers getting the greatest attention.
- We make fair and authoritative judgements, supported by the best information, evidence and data.

- We take appropriate action if care services are failing to meet the standards.
- We carry out in-depth investigations to look at care across the system.
- We report on the quality of care services, publishing clear and comprehensive information, including performance ratings to help people choose care.
- We involve people who use care services in our work, working with local groups, our partners in the health and social care system, and the public to make sure that people's views and experiences are at the centre of what we do.

Our principles

- We put **people who use services** at the centre of our work.
- We are **independent, rigorous, fair and consistent**.
- We have an **open and accessible** culture.
- We work **in partnership** across the health and social care system.
- We are committed to being a **high-performing organisation** and apply the same standards of continuous improvement to ourselves that we expect of others.
- We promote **equality, diversity and human rights**.

Funding in 2012/13

£92.7m	Annual fee income paid by care providers
£68.1m	Grant-in-aid received from the Department of Health

Sectors we regulate*

	Registered providers	Registered locations
NHS trusts	256	2,156
Independent health care	1,402	3,033
Independent ambulance	243	304
Primary dental care	8,057	10,102
Adult social care	12,669	25,275
GP and primary medical services**	7,634	8,658
Total	**30,261**	**49,528**

*Figures as at 31 March 2013

**From 1 April 2013; includes GP out-of-hours services registered from 1 April 2012.

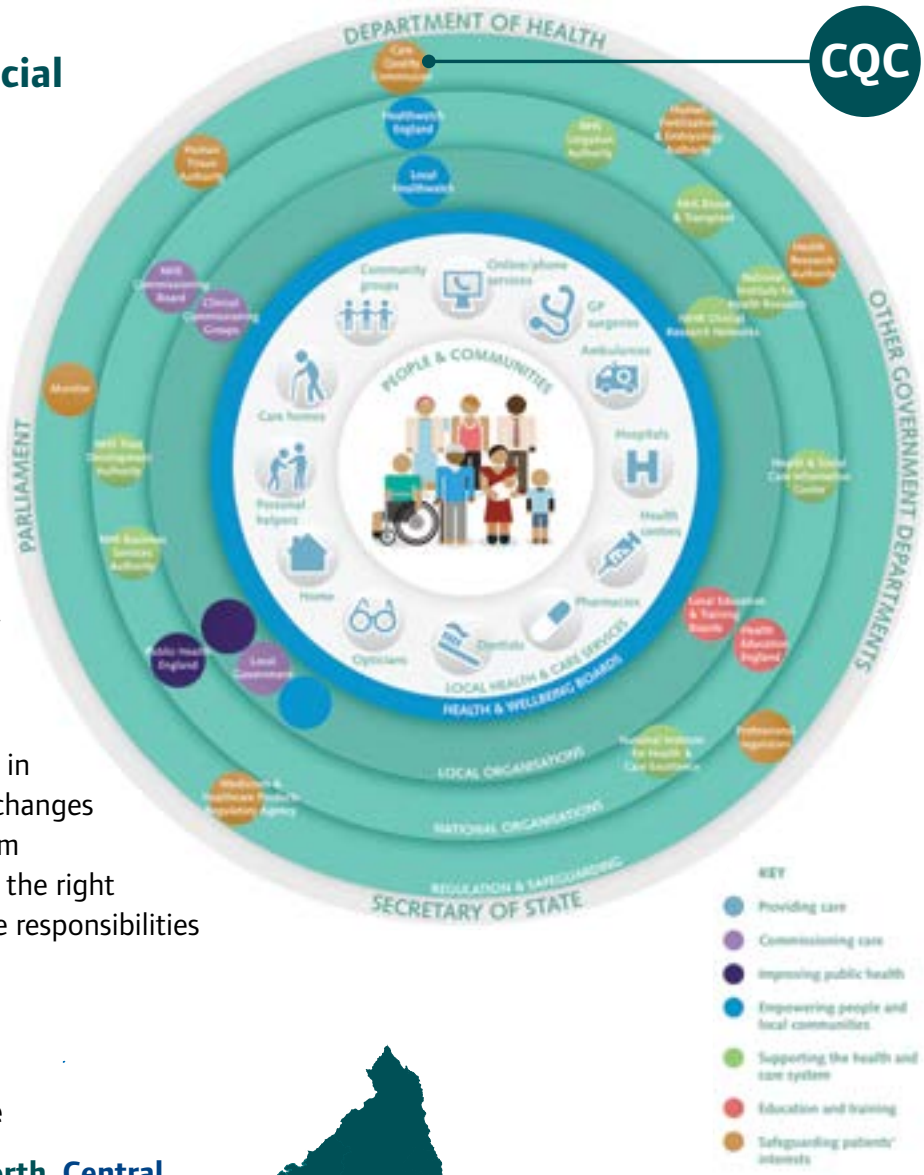
Key highlights 2012/13

35,371	Total inspections carried out
1,408	Inspections that included Experts by Experience (people from outside CQC with experience of receiving care)
8,634	Whistleblowing contacts received
910	Warning notices to providers
83%	Percentage of warning notices issued within 14 days of identifying one is required
1,090	Visits by Mental Health Act Commissioners
94%	Safeguarding calls answered in 30 seconds by National Customer Service Centre

How we fit into the wider health and social care system

The Care Quality Commission is a non-departmental public body, overseen by the Department of Health. We were established under the Health and Social Care Act 2008. We are accountable to the Secretary of State for Health for discharging our functions, duties and powers effectively, efficiently and economically.

We are one part of a larger health and social care system in England that has seen huge changes in the way it is structured from 1 April 2013. The diagram on the right gives a global overview of the responsibilities under the new system.



Facts and figures

Structure and workforce

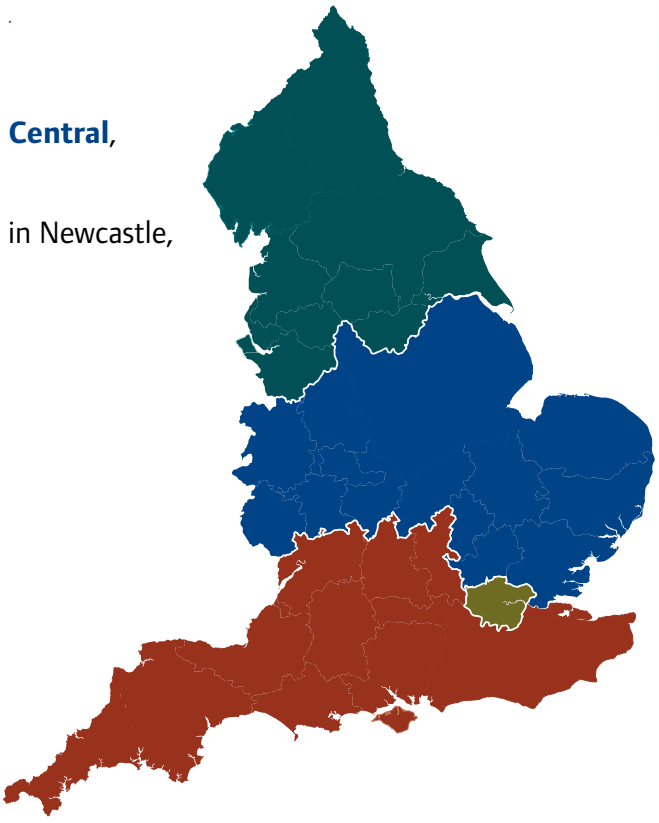
Four operational regions: **North**, **Central**, **South** and **London**

National Customer Service Centre in Newcastle, HQ in London

Permanent staff **2,148***

Of which:
955 frontline inspectors

*Average whole-time equivalent staff during the year



Strategy review

In 2012/13 CQC carried out a fundamental review of its purpose and role. The review resulted in a new strategy for the organisation. In developing it we looked closely at how we carry out our role, listening to what people who use health and social care services, providers of those services and others told us about what matters to them.

We took into account the transformation of the health and social care system, which makes it even more important that existing and new organisations work together efficiently and effectively. And we reflected the Secretary of State's initial response to the landmark Francis Report into the failings at Mid Staffordshire NHS Foundation Trust, which set out important new responsibilities for us.

As a result, we are making major changes to what we do and how we do it, and we will deliver these changes between 2013 and 2016.

In developing our strategy, we engaged and consulted at length with our staff, members of the public, people who use services, providers, stakeholders, and our partners in the health and social care system.

How we engaged and listened during our strategy review

The strategy sets out CQC's direction for the next three years. It states the changes we intend to make and demonstrates our commitment to make sure people receive safe, effective, compassionate, high-quality care.

As the outputs from the consultation were so significant, it was important that we carried out an extensive engagement programme to hear the views and opinions of as many people as we could.

We held national and regional events across England for people who use services, providers, commissioners, regulators and other key stakeholders. We ran an extensive programme of briefings and meetings with staff to make sure colleagues across the organisation had the opportunity to discuss and contribute to the strategy as it developed.

We held events specifically for people who use services, involving Experts by Experience, Local Involvement Network representatives and CQC's eQuality Voices group. We also targeted seldom heard groups to get a view from diverse communities such as travellers and Jewish women. In addition there were public focus groups, online discussions, and e-bulletins to key audiences as well as submissions online to the consultation questions.

Overall we engaged with more than 1,500 people, and used their views and opinions to inform our strategic direction for the next three years. Chris Hopson, Foundation Trust Network's Chief Executive, commented: "We would particularly commend the recent stakeholder engagement exercise on CQC's strategy, which was a model of its kind."

We are clear that our purpose is to make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve. To deliver our purpose, our strategy has six strategic priorities:

1. **Better use of information and inspection**
2. **Working better with our partners in the health and social care system**
3. **Building better relationships with the public**
4. **Building better relationships with those we regulate**
5. **Strengthening how we deliver our responsibilities in terms of mental health and mental capacity**
6. **Building a high-performing organisation**

We will continue to carry out our programme of unannounced inspection and enforcement across the sectors we regulate. We will also continue to publish our inspection reports, national reviews and other information about the quality and safety of services. However, to achieve our strategic aims, we will do the following things differently:

- We will appoint a Chief Inspector of Hospitals, a Chief Inspector of Social Care, and a Chief Inspector of General Practice.
- We will change what we look at when we inspect so that we tackle the following five questions about services.
  - Are they safe?
  - Are they effective?
  - Are they caring?
  - Are they responsive to people's needs?
  - Are they well-led?
- We will develop new fundamental standards that focus on these five areas, working with the public, people who use services, providers and professionals, and our partners to do so.
- We will make sure our inspectors specialise in particular areas of care and lead teams that include clinical and other experts, and people with experience of care who we call Experts by Experience.
- In NHS hospitals, we will introduce national teams with specialist expertise to carry out in-depth reviews of hospitals, particularly those with significant or long-standing problems and trusts applying to be foundation trusts.
- In NHS hospitals, we will introduce a clear programme for failing trusts that makes sure that immediate action is taken to protect people and deal with the failure.

- We will predict, identify and respond more quickly to services that are failing, or are likely to fail, by using information and evidence in a more focused and open way. This includes listening better to people's views and experiences of care and to care staff who tell us about their concerns.
- We will improve our understanding of how well different care services work together by listening to people's experiences of care when they move between different care services.
- We will work more closely with our partners in the health and social care system to improve the quality and safety of care and coordinate our work better.
- We will publish better information for the public, helping them to easily find and understand our reports on their care services. This will include ratings of services.

The changes set out above will apply to most services and will be developed with our staff, providers, the public, our partners and others. They will come into effect in NHS hospitals and mental health trusts first because we recognise there is an urgent need for more effective inspection and regulation of these services. We will extend and adapt our approach to other sectors in 2014 and 2015.

We will make sure that above all else our judgements are completely independent of the health and social care system and that we are always on the side of people who use care services.

We will continue to involve people who use services and their families and carers in our work. We will maintain our focus on human rights, equality and diversity.

The Business Review in this annual report is structured around our six strategic priorities and shows how the work we carried out in 2012/13 aligns with the future direction of CQC.

Chair's Foreword

When I started as CQC's Chair in February 2013, CQC had been consulting on its strategy for a number of months. The strategy review was in response to a number of criticisms about the way we regulate care services and to failures in preventing poor care – in particular from the Winterbourne View Serious Case Review and the Francis Report into the catastrophic collapse of care at Mid Staffordshire NHS Foundation Trust.

The Grant Thornton review of our registration and regulatory oversight of University Hospitals of Morecambe Bay NHS Foundation Trust, commissioned in July 2012 and published in June 2013, shows the scale of the task ahead of us. David Behan, our Chief Executive, commissioned the review because he was determined that CQC will be an open and transparent organisation.

The report showed that CQC at that time was slow to identify failings at the trust, and slow to take action. This confirmed my view that CQC's model for inspecting hospitals was totally flawed. It also highlighted serious cultural and behavioural failures within CQC that included a dysfunctional leadership team. It was evidence of a failure in leadership and a defensive and insular culture. It is not the way things will happen in the future.

We are changing the culture and leadership of CQC. We have already significantly changed our Executive Team and made substantial changes to the Board. We have appointed Professor Sir Mike Richards as Chief Inspector of Hospitals and Paul Bate as Executive Director of Strategy and Intelligence, and we are actively recruiting Chief Inspectors of Social Care and General Practice. We have also appointed five new non-executive directors.

We have also completed the strategy review. We engaged widely and listened throughout the consultation to what people who use services, CQC staff, providers, professionals, commissioners and representatives bodies told us. We listened hard to people's diverse views – shown by the fact that the draft document we set out initially changed considerably as we moved through the consultation process.

We are now very clear about our purpose – to make sure health and social care services are well-led and provide people with safe, effective, responsive, compassionate, high-quality care; and to encourage services to improve. Above all else, we will always be on the side of people who use services and make sure that our judgements are completely independent of the health and social care system.

There are many care services and hospitals in England that provide excellent care, and we should never forget that. However, two names in particular – Mid Staffordshire NHS Foundation Trust and Winterbourne View hospital – have provided levels of care that were completely unacceptable. To this list must now be added Morecambe Bay.

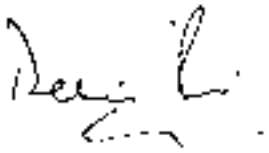
The task ahead of all of us is to entrench quality and safety at the heart of care. Lord Darzi pointed the way in 2008, setting out his measures of quality in *High Quality Care for All*. Robert Francis in his report on the appalling care suffered by patients at Mid Staffordshire gave the overwhelming and compelling argument for change. The Secretary of State has now given us the support and resources to put quality and safety at the top of the health and care agenda.

So going forward, we are developing new fundamental standards of care that will set a clear bar below which providers of care must not fall – there will be immediate and serious consequences for those that do, including prosecution. Powerful and respected Chief Inspectors of Hospitals, Social Care and General Practice will lead national teams of expert inspectors and make sure we, and our partners in the health and social care system, focus on the things that matter to people. We will improve how we listen to and act on people's views and experiences of care, and involve more people in our work. We will make sure that directors and leaders of organisations make a legal commitment to provide safe, high-quality care and are personally held accountable for it.

We will also introduce ratings of services in line with the review by the Nuffield Trust, so that people have better information about services and so that there is greater accountability for poor care. This will be a real spur to improving care.

I know that the vast majority of all those that work for CQC do so because they want to make a difference and to give real quality assurance to the people in our society who are most vulnerable. We all know that we are going to have to change fundamentally the way we regulate health and social care.

I want to thank CQC staff for the immense hard work they have put into the last 12 months. While we are focused on a new strategy, this Annual Report is a reflection of their continued commitment and effort, all the while putting the thought and building blocks in place for the changes that must come.



David Prior
Chair

Chief Executive's Review

As Chief Executive my role is to work with the Board, staff and stakeholders to achieve two objectives. Firstly, the transformation of the way CQC registers, inspects and monitors the quality and safety of health and care services. Secondly, to deliver the programmes of inspection, registration and monitoring of health and care services.

We do this for the purpose of making sure health and social care services provide people with safe, effective, compassionate, high-quality care and encouraging care services to improve.

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

I regard it as an immense privilege to lead CQC. When I took up the role in July 2012 I set out four priorities:

1. To develop the strategy for the next three years.
2. To maintain CQC's values of effective delivery, accountability, integrity, inclusiveness and pride in our work.
3. To support staff in their jobs.
4. To develop CQC as a well-led high-performing organisation that seeks to constantly improve.

A fifth priority was to ensure we delivered the 2012/13 programme of registration, inspection and monitoring. All priorities are key to establishing CQC as a credible organisation.

The strategy *Raising standards, putting people first* was developed during 2012/13 and as David Prior, our Chair sets out, now provides clarity on the purpose, role and priorities for CQC over the next three years. The process of engagement with stakeholders and staff in developing the consultation draft and the final draft all helped and added real value.

As a public organisation we need to uphold the highest standards of openness and transparency. If we are to hold others to account for this, we need to demonstrate it ourselves.

I commissioned an independent review from Grant Thornton to examine CQC's regulatory action at University Hospitals of Morecambe Bay NHS Foundation Trust. I extended the terms of reference of the investigation to cover complaints made by a member of the public, James Titcombe, whose baby son Joshua died shortly after being born at Furness General Hospital. Grant Thornton published their report in June 2013.

The report revealed just how deficient CQC's oversight of the trust was in 2010.

In commissioning and publishing the report, we have shown the open and transparent approach that CQC will continue to take. The report also redoubles my determination to create a culture in CQC that puts patients and people who use services at the heart of what we do, and values the views of the public.

We will use the report to inform the changes we are making to how we inspect and regulate and how we are run. We have completely rewritten the strategy with input from the public, from providers and from our own staff. We are now putting that strategy into practice and first of all will radically change the way we inspect hospitals, starting in autumn 2013.

In summer 2012, the CQC staff survey reported an overall staff engagement score that went up from 41% in 2010 to 55% in 2012 – good news and showing we were moving in the right direction. However there were some scores such as morale and communication that were still too low. A pulse survey published in February 2013 showed some further progress. From September 2012 the CQC quarterly performance board meetings have been broadcast live on our website, reaching an average about 800 people with each broadcast. Feedback has been positive.

When I arrived as Chief Executive, staff told me that they were concerned about a culture of bullying and harassment. I am clear there should be a zero tolerance towards bullying, harassment and any sort of discrimination. Two initiatives followed as a result: a network of dignity champions who staff can approach in complete confidence for support and advice is now in place, and I appointed an independent consultant to listen to any member of staff who wished to share their experience. I am waiting for a final report that will set out a number of recommendations. These will help us in building a strong and supportive culture.

I have reflected on the challenge of communicating effectively with a workforce that is predominantly home-based, but which also includes a significant proportion of office-based colleagues.

Since I took up the role I have written directly to each member of staff every Friday setting out the priorities for our work, explaining the changes we are planning and, importantly, celebrating the successes and achievements of the organisation. It is a personal note reflecting my role and priorities. The feedback has been positive and encouraging.

Engagement of staff has been, and will continue to be, one of my top priorities.

Supporting staff through development and training opportunities is key. We have made some progress on this, through the development of a partnership with the Alzheimer's Society to roll out dementia awareness training for each member of CQC staff.

The plans for next year include an Academy that will support staff in making the transition to a new way of registering, inspecting and monitoring services.

David Prior in his Foreword has talked about the way CQC will transform over the next three years to put quality and safety at the heart of the way CQC regulates. But CQC has not stood still while we consulted on our strategy. Our achievements in 2012/13 laid foundations for the future.

We introduced more clinical and professional expertise in our regulatory activity and inspections, by using specialist advisors on secondment from a wide range of health and care backgrounds, including doctors, nurses, midwives, dentists, allied health professionals and social care experts. We also improved our ability to tap into the knowledge of people who use care services, using Experts by Experience in more than 1,400 inspections in 2012/13, almost three times the number from the previous year. These trends will continue over the next three years.

We worked closely with our partners in the new health and social care system, and in particular with the other regulators and professional bodies to share information at an early stage. For example, in May 2012, we expanded the assurances that CQC provides to Monitor and the Department of Health in relation to NHS trusts seeking foundation trust status by creating a dedicated FT Assurance team. The team reviews our evidence on these organisations and builds up a more detailed picture of the quality of care, before initiating three-way discussions with Monitor and CQC inspection staff to look in detail at issues and concerns.

We made it easier for people to contact us and tell us about their experiences through the 'Tell us about your care' programme, working with organisations like the Patients Association and the Relatives and Residents Association, and through the whistleblowing helpline. We established communication partnerships with 20 leading charities to encourage direct feedback from the public to CQC, and most of these have links from their websites to the 'Share your experience' form on our website.

We also made it easier for people to find out about what we say about care services through email alerts when we publish an inspection report, and through the widget which is embedded in provider websites and allows people to access our latest report on a service.

We fully completed CQC's inspection programme of health and adult social care services, carrying out more than 35,000 inspections in the year, and followed through with enforcement action where it was necessary – we served a total of 910 warning notices on providers in respect of unacceptable care. At the same time, we registered more than 7,500 GP practices and other primary medical services through our dedicated online services system. Most importantly we were able to register these services without compromising inspection activity in the other sectors we regulate.

In order to achieve this, we increased our capacity by increasing our frontline inspectors to 955 full-time equivalents. We did this while keeping a strong grip on our finances, making savings in areas such as our estates strategies in the year, and ensuring we kept within our budget.

Alongside our ongoing inspections, we published a number of reviews that focused on specific care issues. We looked at care provided to older patients in 50 NHS hospitals (following a similar review in 2011) and in 500 care homes, in relation to dignity and nutrition. We carried out a review of 250 home care services providing care to more than 26,000 people. And we published our review into 150 disability services, following the commitment CQC made in light of the abuse that had taken place at Winterbourne View.

All of these in-depth programmes showed that many services provide an excellent standard of care, and we reported what was working well, to share good practice and encourage providers to improve. But each programme also found some services where care was unacceptably poor. This information is invaluable in helping us understand where the greatest risks to people lie in each sector, and where we need to direct our efforts in the future.

David Behan
Chief Executive

Highlights of 2012/13

Work carried out in 2012/13 that underpinned our forward strategy for 2013 to 2016

1 Better use of information and inspection

Highlights

Fully **completed our inspection programme** across all sectors

Extended **clinical and professional expertise** in inspections

Experts by Experience used in 1,408 inspections

Whistleblowing contacts more than **doubled**

Provider performance against standards **improved** in all sectors

2 Working better with our partners in the health and social care system

Highlights

Closer working with **Monitor** on assessing prospective foundation trusts

Healthwatch England established as a committee of CQC

3 Building better relationships with the public

Highlights

Broadened the **Tell Us About Your Care** programme

Communication partnerships with **20 leading charities**

Clearer inspection reports

Launched **email alerts**

Large take up of information **'widget'**

68,000 downloads of publications in **alternative formats**

Customer Service Centre one of **UK top 50 call centres**

4 Building relationships with those we regulate

Highlights

Registered more than **7,500 GP practices**

Embedded **online accounts** in GP registration

Further developed **online communities**

94% providers agree the way CQC regulates is **beneficial to people's quality of care**

5 Strengthening how we deliver our responsibilities in terms of mental health and mental capacity

Highlights

Further developed **joint inspections** with MHA monitoring teams

1,090 visits to MHA patients

87% of complaints about the use of MHA triaged **within three days**

Thematic focus on **restrictive practices**

6 Building a high-performing organisation

Highlights

Improved **staff survey** results

Anti-bullying campaign

Started **Investors in People** process

Dementia training for all staff

Full complement of inspectors recruited

Business Plan priorities for 2013/14

- Improve assessment and judgement of all the services we regulate by appointing a Chief Inspector of Hospitals, a Chief Inspector of Social Care, and a Chief Inspector of General Practice.
- Improve the safety and quality of care in NHS acute hospitals and mental health trusts by changing the way we inspect them.
- Identify, predict and respond more quickly to services that are failing, or are likely to fail, by using data, intelligence and evidence in a more sophisticated and transparent way.
- Improve our understanding of how well different care services work together by introducing specific reviews of people's experiences of care when they move between services.
- Work better with other regulators and partners to improve the quality and safety of care focusing on Monitor, the NHS Trust Development Authority, NHS England, the Healthwatch network and local councils.
- Publish better information for the public – including organisation ratings – to improve transparency.
- Introduce a more rigorous test for organisations applying to provide care services, which includes ensuring that named directors and managers commit to meeting the standards and tests their ability to do so.
- Build a high-performing organisation that is well run, has an open culture that supports and enables its staff, and is focused on its customers.

Business review

1

Using information and inspection

In 2012/13, we laid the groundwork for regulating different services in different ways, making better use of tailored information and increasing our access to specialist expertise. We will use the learning going forward to develop new fundamental standards of care that for each sector will have a tailored approach to safety, effectiveness, how caring services are, how well they are led, and how responsive they are to what people tell them.

In this section: Inspection programme ■ Building our specialist expertise ■ Experts by Experience ■ Themed inspections and reviews ■ Outliers ■ Using the voice of people who use services ■ Whistleblowing and safeguarding ■ Equality and human rights ■ Sector reviews ■ NHS trusts ■ Independent health care ■ Dental care ■ Adult social care

Inspection programme

We carry out regular, unannounced inspections to make sure that providers continue to meet standards of quality and safety that people have a right to expect. We track inspections according to whether they are:

- Scheduled – planned by CQC in advance and carried out at any time
- Responsive – carried out at any time in response to concerns
- Follow-up – a follow-up of a previous inspection to check that improvements have been made.

In 2012/13, we completed our comprehensive programme for carrying out scheduled inspections of locations, with a very small number of exceptions.

Table 1 shows the number of locations inspected against the original business plan for 2012/13. In total, 28,583 locations received a scheduled inspection in the year. There were 3,530 locations that were not inspected for a variety of reasons: mostly because they de-registered in the year, were not providing services when we went to inspect them, or are lower risk services that we inspect every other year.

Table 1: Number of locations inspected against target for 2012/13

	NHS trusts		Adult social care	Independent health care	Primary dental care	Independent ambulance (annual inspection)**	Independent ambulance (inspection every two years)***	Total
	Acute hospitals	Non-acute trusts						
Business plan target	**350**		**25,008**	**2,764**	**3,546**	**230**	**87**	**31,985**
Total locations not requiring an inspection*	(9)	(23)	(2,753)	(644)	(0)	(77)	(24)	(3,530)
Number of locations to be inspected	224	94	22,255	2,120	3,546	153	63	28,455
Total locations inspected	**224**	**94**	**22,250**	**2,117**	**3,682**	**153**	**63**	**28,583**
Variance against Business Plan	0		(5)	(3)	136	0	0	128

*Due to locations that de-registered during the year, locations that were not providing services when we went to inspect them, lower risk services that we inspect every other year, and in a few other minor exceptions.

**These are independent ambulance locations that carry out the regulated activity of 'Treatment of disease, disorder or injury' and as a result are scheduled for inspection every year.

***These are 'non-urgent' independent ambulance locations that are scheduled for inspection every other year.

Overall in 2012/13, our inspectors carried out 35,371 inspections. This number included 1,760 responsive and 4,489 follow-up inspections as well as scheduled inspections. Table 2 shows the total number of inspections in each sector.

Table 2: Total number of inspections in 2012/13 by sector

	NHS	Adult social care	Independent health care	Primary dental care	Independent ambulance (annual inspection)	Independent ambulance (inspection every two years)	Total
Total number of inspections (all types)	845	27,678	2,434	4,161	180	73	35,371

Building our specialist expertise

In 2012/13, we began to extend the clinical and professional expertise in our regulatory activity and inspections. We created a bank of specialist advisors – consisting of experienced health and social care professionals – in July 2012 to support our staff. These were mostly secured on secondment contracts with employing organisations, and had a wide range of specialist expertise.

Table 3: Number of specialist advisors by specialism

Specialism	Number of advisors*
Nurses – general/children	79
Nurses – mental health/learning disabilities/social care	17
Midwives	14
Doctors	22
GPs	4
Dentists	27
Clinical scientists	3
Allied health professionals	20
Social care specialists	21
Executive and senior management – with governance and quality expertise	21
Those involved in the dignity and nutrition inspection programme	40
Those involved in the home care inspection programme	5
Those involved in the learning disability inspection programme	30
Total	**303**

* Data as at 28 February 2013

Figure 1 shows the different types of requests made by each regional Operations team (up to

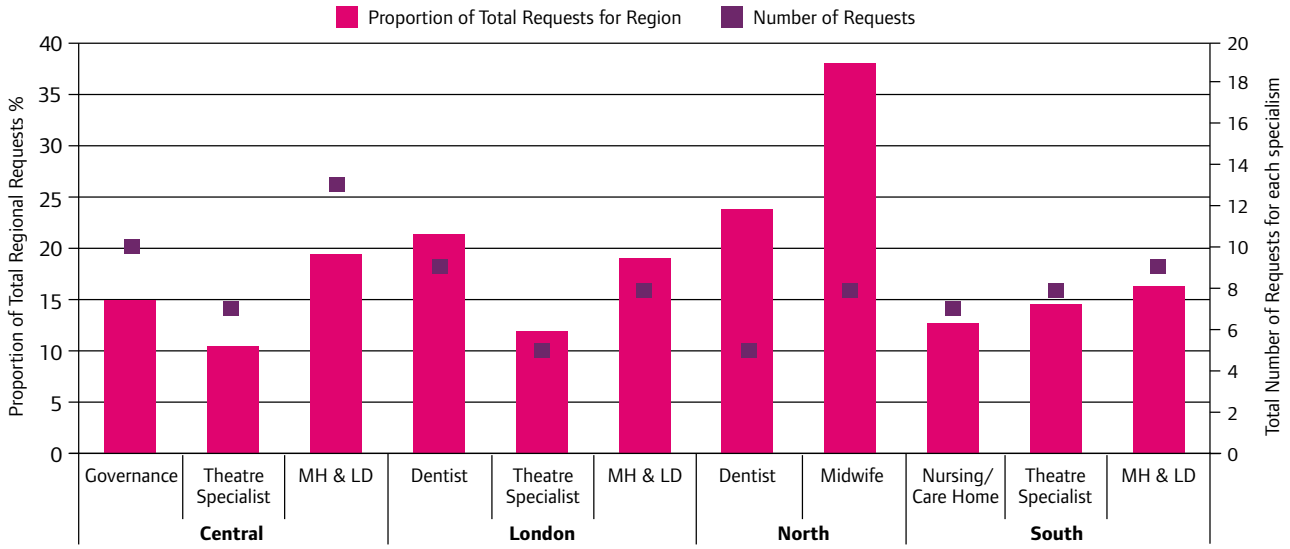
28 February). The highest number of requests overall were for theatre specialists and experts in caring for people with mental ill-health and learning disabilities. In total, there were 281 requests to use the bank by the end of the year.

Many inspectors said that using the specialist advisors has helped increase their knowledge and understanding of the sectors and services they inspect, increased their confidence in making judgements and helped them identify evidence they would not otherwise have considered.

Likewise, the specialist advisors said that their experience had been positive, that their input was valued and made a difference, and that they provided evidence that would not otherwise have been considered. Sector understanding of CQC also improved when the advisors took learning back to their organisations.

> *"The advisor was a specialist in their field and was able to provide up-to-date information on standards that was expected in the speciality. This meant CQC were able to clearly identify what improvements were needed to achieve compliance and our findings were not challenged. I learnt a lot from the advisor which I have used in further inspections of this type."*
>
> **CQC inspector**

Figure 1: Main specialisms requested by region



I enjoyed working with the inspector immensely; I think we learned from each other. I certainly gained a lot of knowledge of CQC inspection that I can take back to my own organisation and I hope the inspector felt I added value. I believe I helped the inspector make a judgement based on the evidence of what service should be provided if the provider is compliant with the standards.

Specialist advisor

We also employ nine National Professional Advisors who give us advice on best practice and act as ambassadors for us. They include a GP, a cardiac surgeon, a radiologist, a nurse, a dentist, a senior social care manager, a psychiatrist and an ambulance and emergency care manager. In March 2013 Professor Rona McCandlish joined us as our National Professional Advisor for midwifery.

Experts by Experience

We improved our ability to use the knowledge of people who use care services. We used Experts by Experience, who are people who have experience of using or caring for people who use health, social care and mental health services, in 1,408 inspections (compared with 506 in 2011/12) and in 57 Mental Health Act visits in 2012/13.

For the programme, we worked in partnership with support organisations which included Age UK, the Choice Support consortium of smaller and user-led organisations, the Challenging Behaviour Foundation, Oxfordshire User Team and Addiction Dependency Solutions.

Of the inspections, more than 800 were part of the dignity and nutrition and home care themed inspections (see below). As part of our evaluation programme, we asked the inspectors to rate the effectiveness of using the Experts by Experience.

They generally said that their advice was of high quality: 50-64% of the inspectors involved in the themed inspections completely agreed or mostly agreed; 7-19% did not agree. There were broadly similar levels of agreement that Experts by Experience were effective in increasing inspectors' confidence in making a judgement. However, there were significant minorities of inspectors who did not agree.

"I enjoyed this [Mental Health Act] visit and felt accepted by the team. I knew what was expected of me and what my role was within the team. I found I was respected for my views."

Expert by Experience

"I enjoyed the user involvement [training] session and especially enjoyed the Expert by Experience slot – it made me want to take [an Expert] with me on each visit.... I thought the session was well delivered and the way the Expert by Experience was involved in the training showed him he was a valued member of the team. His insight was very useful."

Compliance inspector

The evaluation suggests that inspectors are confident in their own abilities, but Experts by Experience add some value in these areas, and development work in guidance and training would help improve their effectiveness.

Case study – the work of an Expert by Experience

Laura Broughton, who has learning disabilities, has been an Expert by Experience since 2010. She was involved in CQC's themed inspections of 150 learning disability services – the findings of which, published in June 2012, revealed that almost half the services failed to meet standards.

She said, "One of the things that comes up a lot on inspections is that staff are doing things for individuals rather than them being able to doing things for themselves." For example, in one care home, Laura noticed that the stairs only had handrails on one side. The weakness in her right side means she needs rails on both sides, so she was able to draw the home's attention to this, as a way of helping people get around better and be more independent.

Another example of something she spotted was that people had drinks only at meal times. "There are no drinks for them [at other times], considering heating is higher than usual," she said. "Some people using the service need to be offered drinks regularly because they can't verbally ask for one and are not able to get up and get one when they want one."

Themed inspections and reviews

Our themed inspections help us to take a targeted and in-depth examination of a particular type of care. They spread learning both outside and within CQC to understand the root causes of poor care and drive up standards. We completed three intensive programmes in 2012/13, and the details are reported later in this section.

We evaluated the themed inspections to understand their effectiveness, efficiency and economy. There was strong support from inspectors across all three programmes for

the appropriateness of the themes selected, the likelihood of the inspections driving improvement across the sector, and the overall approach enabling inspectors to get at the issues that really mattered.

Aspects that inspectors found more challenging were being able to identify equality and diversity issues, timelines being realistic, the significant impact on their other inspection work, and ambivalence around whether the programmes delivered value for money.

We also carried out four thematic reviews in 2012/13. These examine existing intelligence gathered by CQC or other organisations around a particular topic or issue and help our inspectors assess the risk of poor care within providers. The topics covered hospital admissions from care homes, access to NHS secondary care, dementia and the physical health needs of people with a learning disability.

Outliers

Our surveillance programme uses sophisticated statistical methods to spot data that shows unexpected performance (known as 'outliers'), for example unusually high death rates. We generate most of the outlier data within CQC. We also pull in outlier data from organisations such as the Dr Foster Unit at Imperial College and the National Joint Registry.

A CQC expert panel reviews each case and decides whether the outlier merits being followed up. We pursue a case until one of two outcomes has been achieved:

- The trust has provided sufficient evidence that the alert is not, or no longer, a quality of care issue.
- The trust has put in place an appropriate plan to improve care.

In our 2012/13 acute programme, we processed 139 cases: 104 for mortality, 27 for maternity and eight for hip or knee revisions. We pursued 85% of these cases with the trust concerned; 62% resulted in an action plan to improve the care.

We also examine high and low reporting of patient safety incidents in NHS trusts, which are reported by the National Reporting and Learning System, and clusters of 'never events', which are reported to the Strategic Executive Information System. These are sent straight to our regional inspection teams for follow-up.

In social care, the Surveillance Team analyses notifications from care homes of deaths, serious incidents and abuse in order to identify homes with potential concerns. Unusually high or low reporting for this type of home are reported to inspection teams.

We also check emergency admissions to hospitals from care homes for a range of conditions that may reflect poor care in the care home. These include dehydration, pressure sores, urinary tract infections, pneumonitis, pneumonia and lower respiratory tract infections.

Case study – Higher than expected deaths of people with irregular heartbeats

We were informed by the Dr Foster Intelligence Unit at Imperial College (DFU) that a trust had a significantly high number of deaths of people with irregular or abnormal heartbeats (cardiac dysrhythmias) over a recent 12-month period. We asked the trust to explain the higher than expected number and to review the case notes of the patients identified in the DFU analysis.

The trust supplied individual patient summaries, and followed up with detailed areas for improvement and an accompanying action plan. An extract is shown in table 4.

The trust's response came before our outliers panel again and we closed the case, making sure that the local CQC inspector followed up on the implementation of the action plan.

Table 4: Extract of case study action plan

Problem	Action	Lead
Fluid balance management	Nursing documentation audit Implement electronic fluid balance management	Chief Nurse
Management of anticoagulation in the elderly	Use evidence-based risk scores to inform the decision to begin anticoagulation with warfarin, particularly in the elderly.	Divisional Directors
Delays in decisions regarding DNAR	Raise awareness of making timely DNAR decisions and complete documentation.	Divisional Directors, Medical Director

Using the voice of people who use services

Our Quality and Risk Profiles (QRP) gather key information about care providers that helps our inspectors to see where risks lie and prompt them to take a closer look.

In 2012/13, we ran a project to increase the volume and coverage of information submitted to CQC by people who use services. The volume of 'people's voice' data items increased – by 39% in NHS QRPs, 209% in adult social care and 33% in independent health care. People's voice data now represents 20% of all observations in the NHS QRP, 1.5% of the adult social care QRP and 3% of the independent health care QRP.

The project specifically focused on encouraging the public to complete the 'Your experience' forms on CQC's website. There was a sharp increase in the volume of these in all sectors of the QRP during the year: a 230% increase in the NHS, 224% in adult social care and 167% in independent health care.

In February 2013, we launched a redesign of the QRP for adult social care and independent healthcare, incorporating new pages that clearly set out the regulatory history, correspondence and data relating to 'people's voice'. Inspectors fed back very positively about the new QRPs, and we will continue to evaluate their use to identify any further enhancements.

At the end of the year we began to review QRPs for NHS acute trusts, and more generally the use of information to assess risk in these trusts. The aim is to develop a focused set of measures to identify NHS trusts that will receive more in-depth inspection in 2013/14.

Whistleblowing and safeguarding

Following the appalling abuse at Winterbourne View hospital in 2011, we continued to improve our safeguarding procedures and our capacity to deal with whistleblowing by care staff, in line with our Winterbourne View Internal Management Review. We also contributed to the Winterbourne View Serious Case Review, which was published in August 2012.

In April 2012, we established the Safety Escalation Team (SET) to make sure that all high-risk information received into our National Customer Service Centre is triaged and processed efficiently, consistently and quickly. The team handles all telephone calls, emails and post relating to whistleblowing, safeguarding and mental health calls. The team 'tracks and traces' all whistleblowing information through the appropriate inspection teams and follows up each of these to make sure they are being progressed to a resolution.

The SET consists of 46 members of staff; this includes 14 dedicated call handlers and four

members of staff who do the 'track and trace' element.

Whistleblowing increased consistently throughout the year. In total we received 8,634 whistleblowing contacts in 2012/13, more than double the number of contacts in 2011/12. Table 5 below shows the sources of whistleblowing and the method people used to contact us.

In September 2012 we analysed a sample of 350 whistleblowing cases received by CQC between April and September 2012 – around 10% of the total. In October our Quality and Risk Assurance Managers carried out an in-depth review of 40 whistleblowing cases across our four regions (6% of the concerns sent to us in September 2012).

Both audits sought assurance that the actions, decisions and judgements in response to whistleblowing concerns were appropriately recorded and actioned. We are using these audits to help us identify recommendations about the key improvements we need to make, and these will link into our new surveillance and inspection model.

In October, CQC joined with other regulators, professional bodies and trade unions to launch the Speaking Up charter, a commitment to work together to support people who raise concerns in the public interest. It sets out a commitment to work more effectively together to create a just, open and transparent culture – one that ensures people are fully supported to report concerns and safety issues and are treated fairly and with empathy.

We continued during 2012/13 to improve our safeguarding systems and processes in response to lessons learned from high-profile cases, especially the Serious Case Review into the events at Winterbourne View.

In May 2012, we published a revised Safeguarding Protocol, which took into account a number of the recommendations of our Winterbourne View Internal Management Review. Actions completed over the last 12 months include:

- Strengthening our links with local safeguarding teams and boards.

Table 5: Sources and methods of whistleblowing contacts in 2012/13

Source	Method of contact						Total
	Phone	Email	Letter	Website	In person	Fax	
Social care	3,433	2,931	746	325	11	10	**7,456**
NHS trust	169	295	97	38	1	1	**601**
Independent health care	105	152	35	16	1		**309**
Primary dental care	40	71	4	7			**122**
Independent ambulance	26	75	3	12			**116**
Primary medical services	10	6	2	1			**19**
Government department	1	4	1				**6**
Local authority			1				**1**
Other and unspecified	3	1					**4**
Total	**3,787**	**3,535**	**889**	**399**	**13**	**11**	**8,634**

Case study – Rapid follow-up of whistleblowing concerns

A whistleblower contacted us about a residential care home for men and women who have a learning disability. Many of the people living there could display behaviour which was challenging to manage, and many did not use verbal speech to communicate.

The concerns were very serious, about physical and sexual abuse of people living at the service by one of the people living at the home. The whistleblower had told the manager of the home, but no action had been taken to refer the matter to safeguarding, inform the alleged victims' relatives, notify CQC or take action to protect vulnerable people.

We informed the local safeguarding team immediately and they contacted the manager to ask her to carry out an investigation into the allegations. The safeguarding team pronounced themselves happy with the conclusion of the investigation several weeks later.

We were not. We inspected the home straightaway and uncovered a number of problems with the manager's investigation – for example, asking for opinions from staff who were not present during the incidents. We also discovered that a previous incident had not been referred to safeguarding or CQC, and therefore only investigated when a member of staff blew the whistle.

We issued a warning notice to both the provider and the manager and reported concerns about the safeguarding response. The safeguarding team launched a full safeguarding investigation and the home's commissioning contract was suspended.

We then received more whistleblowing information about other incidents that had been reported to the manager but no action taken. We inspected again and found evidence of a number of cases where nothing had been done to make sure people were protected from harm.

We contacted the safeguarding team and commissioners immediately to report our serious concerns about the service. An urgent teleconference was held with the local authority directors, directors from the local NHS trust and the safeguarding team, and we held an urgent meeting with the commissioners and the provider. The manager was suspended the following day and shortly afterwards tendered her resignation.

Temporary managers were put into place who started identifying and reporting a wide range of new safeguarding issues. The providers advertised for a permanent manager and asked for some time to implement changes. Health and social care professionals were reviewing placements and needs on a very regular basis and there was a high level of professional support, training and auditing, so we felt it was safe to allow this space.

We inspected again three months later and still had serious concerns that the home was not delivering a safe service that treated people with dignity and respect.

We asked the provider to come in and tell us explicitly how they would assure themselves that the service was being delivered safely, appropriately and to a suitable standard. We fed back our findings to the commissioning and safeguarding teams.

Finally, after a fourth inspection, we saw that there were significant improvements in the appearance and emotional wellbeing of people at the home. Staff were more respectful and engaged well. The commissioners reported similar improvements.

- Developing a management protocol regarding data exchange between our MHA Operations staff and compliance teams.
- Providing clearer guidance to our staff on managing safeguarding alerts and concerns.
- Developing and implementing safeguarding quality assurance systems, including management information reports.
- Completing a safeguarding case file audit to help us assure that we are managing safeguarding information appropriately.
- Developing a tool that allows us to systematically interrogate safeguarding information we hold on providers.

Equality and human rights

Equality and human rights are threaded through the regulations that we use – including issues such as dignity, respect, independence and requirements for providers to avoid unlawful discrimination and meet people's needs on equality grounds.

In 2012/13, we carried out an evaluation of equality and human rights in our inspection work. We analysed the regulatory action taken in a sample of 200 inspections to find out how often it related to different aspects of equality and human rights. We surveyed CQC staff and Experts by Experience on the reasons for any variations in regulatory action and ideas for improvement. Some of the key issues raised by the evaluation show that we need to:

- Build a more rights-based approach, enabling our staff to use 'the lens of human rights' for their day-to-day work.
- Focus more on the 'risk to rights' for people who use services, especially some of the positive rights such as independence and choice, participation in the local community and rights to equality.

- Develop our ability to identify and judge different outcomes for people using the same service.
- Developing our ability to act as a 'system player' around equality and human rights – for example working with service commissioners where we find breaches of the Equality Act that do not breach the Health and Social Care Act.
- Use the evaluation to improve CQC functions beyond inspection – particularly registration and enforcement.

A number of actions were agreed as a result of the evaluation and are included in the 2013/14 business plan.

Our evaluation has also informed our equality objective to improve the information that we hold around risks to equality in organisations that we regulate. We are using some new sources of information around equality risks, such as county court discrimination cases, and we are testing how to make better use of existing data, such as the 2011 Census and Hospital Episode Statistics, to identify potential risks to equality.

Progress on our equality objectives is monitored both by the CQC Board and by people who use services through our eQuality Voices group (see page 51).

Sector reviews

On 31 March 2013, of those that had been inspected under the Health and Social Care Act, 23,479 locations (82%) were meeting all the essential standards of quality and safety, and 5,281 locations (18%) were not meeting at least one of the standards.

Figures 2 to 4 show the frequency of inspections and rates of compliance for each type of inspection in 2012/13. As expected, compliance rates for responsive reviews are considerably lower than scheduled reviews. Rates of compliance for follow-up reviews are higher than responsive reviews, but not up to the levels of compliance seen in scheduled reviews.

In the year we published a total of 910 warning notices in response to unacceptable care we found. This compared with 638 warning notices in 2011/12. We issued 83% of warning notices within 14 days of identifying the need for one, against a business plan target of 90%.

A total of 75 providers de-registered due to intervention by CQC, and in six cases we used our enforcement powers to either urgently suspend provider registrations or urgently impose conditions or variation of conditions. There was one successful prosecution of a provider in the year (see page 32 below).

The number of enforcement actions and the corresponding conversion rates from a finding of non-compliance to enforcement activity showed a consistent increase throughout the year (see figure 5). Analysis of all enforcement actions since October 2010 based on type of inspection shows that the majority of enforcement actions (48%) are as a result of follow-up inspections, with 27% resulting from responsive inspections and 23% from scheduled inspections.

Figure 2: Rates of compliance and frequency – scheduled inspections

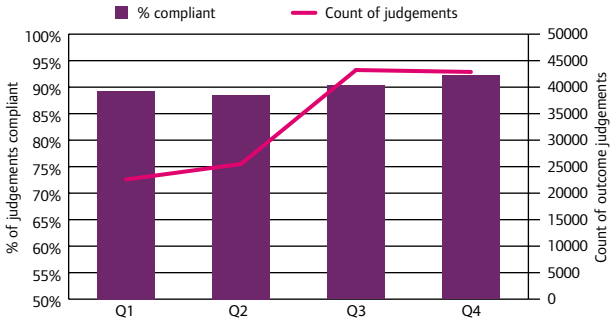


Figure 3: Rates of compliance and frequency – responsive inspections

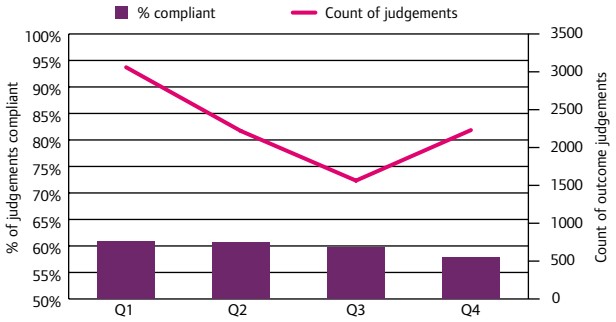


Figure 4: Rates of compliance and frequency – follow-up inspections

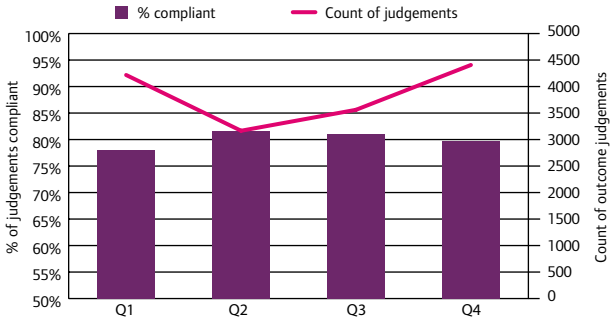
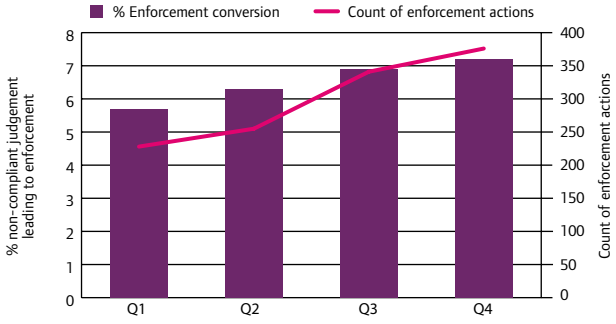


Figure 5: Conversion rates of non-compliance to enforcement by quarter – all types of inspection

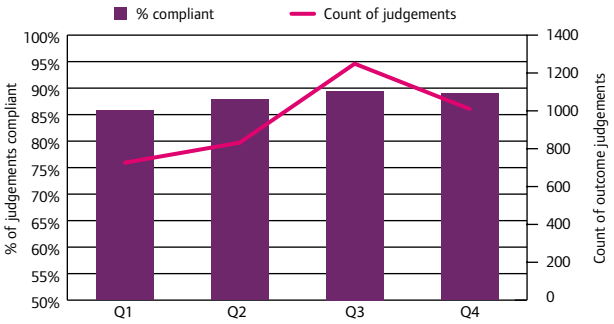


NHS trusts

- 256 NHS trusts registered with CQC on 31 March 2013.
- Net decrease of 35 trusts (12%) since 1 April 2012.
- 2,156 NHS locations on 31 March 2013.
- Net decrease of 240 (10%) since the start of the year.
- 20 warning notices published.
- Most common failures in: planning and delivery of patient care; monitoring the quality of care.
- There was one occasion where we had to take action quickly to protect patients from a high-risk situation: we imposed conditions at Dewsbury Hospital to prevent patients spending more than 23 hours in a day-case unit that was not properly equipped for privacy, dignity and patient hygiene.
- 398 compliance actions issued.
- Most common areas for improvement: planning and delivery of patient care; monitoring the quality of the care delivery; keeping accurate records; making sure there were enough staff with the right qualifications; and supporting those staff with training and development.

In February 2013, following the publication of the Francis Report, the Prime Minister asked Professor Sir Bruce Keogh to review the quality of care and treatment provided by 14 NHS trusts and NHS foundation trusts that were persistent outliers on mortality indicators. CQC is a key partner in the review of these 14 trusts and a report is expected in summer 2013.

Figure 6: Rates of compliance and inspection frequency – NHS trusts



Average enforcement rate (escalation from non-compliance to enforcement action)

2011/12	3.0%
2012/13	6.5%

Dignity and nutrition in NHS hospitals

A themed inspection programme looked at the care provided to older patients at 50 NHS trust hospitals during 2012, focusing on dignity and nutrition. It followed similar inspections of 100 hospitals in 2011.

We were pleased to see that broadly more hospitals were meeting people's nutritional needs. In 44 out of 50 hospitals (88%), patients were given a choice of food and drink to meet their nutritional needs and given help to eat and drink when they needed it. The corresponding figure in 2011 was 83%.

On the other hand, there were fewer hospitals where we saw that patients were always treated with dignity and their privacy and independence respected. Out of 50 hospitals, 41 (82%) were meeting the standards for respecting patients' privacy and dignity and involving them in decisions about their care. This compared with 88% of hospitals in the 2011 review. It is clearly unacceptable that this position, poor to begin with, deteriorated further.

Of the nine hospitals we inspected in both 2011 and 2012, seven had either improved or were continuing to meet the standards. We published an overview report in March 2013, bringing together the findings, identifying what works well, what hospitals need to do better, and recommendations for providers and commissioners.

Dementia care in hospitals

We carried out a review of hospital data to look at how the outcomes for people with dementia in hospital differ from those for similar people without dementia. This showed that the health and social care system is struggling to care adequately for people with dementia. This is having an impact on hospital capacity and resources. Once in hospital, people with dementia are more likely to stay there longer, to be readmitted, and to die there.

Knowing and recognising the signs of dementia is the first step to improving the quality of care that people receive. Yet CQC found that almost a third of hospital admissions involving people with dementia did not include a record of their dementia, despite the fact that it had

Case study – Local press highlighting NHS trust improvement between CQC inspections

Our inspections of local services gain a lot of press attention – often highlighting poor performance, but also celebrating improvement. One article this year told how staff said lessons had been learned since their NHS trust failed an inspection following "worrying" staff shortages and patient waiting times in 2011. After that inspection, CQC asked the trust to improve its food and the way it was served to patients. Our next routine inspection in February 2013 involved speaking to 29 inpatients, five relatives and 38 staff, including doctors, nurses, midwives and managers. We found that the hospital's care of patients, cleanliness, staff levels and support for workers all met the standards patients should be able to expect. A spokesman from the trust said: "We take the valuable feedback we gain from internal and external reviews, such as the CQC, and take the lessons learned into improving our training for staff, reviewing the quality and variety of food provided for patients as well as looking at appropriate staffing levels across the services."

Feedback from the staff about the hospital's food:

2011: The meals are "terrible" and "awful".

2013: "The food is very good, there's a good selection and plenty of it."

been identified in the past. This reinforces the need for better identification of dementia and comprehensive training for care staff.

Morecambe Bay investigation

In July, we published the report of our investigation into emergency care at Royal Lancaster Infirmary and Furness General Hospital, part of University Hospitals of Morecambe Bay NHS Foundation Trust.

We interviewed more than 200 hospital staff and spoke to staff from eight different external stakeholders. We received information from more than 100 people who had used the trust's services, through interviews and written submissions. MPs and local councillors submitted their views and the views of their constituents.

We found that:

- Patients were waiting too long to be seen.
- Patients were accommodated in mixed sex wards.
- Both hospitals were not meeting the national target to admit, discharge or transfer 95 per cent of patients within four hours of their admission.
- Both hospitals were not working together and had limited plans for cross-site working.
- Staffing levels were inadequate.

Although patients were still at risk of receiving poor care, changes to the management of the trust resulted in positive actions to address many of the issues highlighted in our report.

Termination of pregnancy inspections

In July, we published 249 individual inspection reports into providers offering terminations of pregnancy. This followed an inspection of a private health clinic in January 2012, where we identified evidence that HSA1 forms were being pre-signed by one doctor. This is in breach of the Abortion Act, and allows a second doctor to effectively take a solo decision to allow a termination. The Secretary of State for Health asked us to investigate whether this practice was widespread. Targeted, unannounced inspections identified clear evidence of pre-signing at 14 locations, all of which were NHS trusts.

We required the trusts that were found to be pre-signing HSA1 forms to stop this practice and take steps including internal audits and staff training to ensure continued compliance.

Termination of pregnancy inspections – Evaluation

This was a unique set of inspections and staff faced a range of challenges in their delivery. Our Operational Improvement Team (see page 72) is evaluating the work carried out, to explore the learning points and make sure the organisation is well prepared to respond to any such requests in the future. Using online surveys, workshops and reviews of evidence the evaluation is looking at ideas about the way we approach such inspections, the information that needs to be available to our inspectors and how we assure the quality of our findings. We will publish the evaluation later in 2013.

A&E survey

The results of our fourth national survey of NHS accident and emergency (A&E) departments showed that waiting times were getting longer. However most people surveyed said that they still had confidence and trust in the health professionals who treated them. Perceptions of the cleanliness of A&E units also substantially improved from previous surveys. Almost 46,000 people who attended A&E departments during January to March 2012 completed the survey.

Ionising radiation

CQC is the enforcement authority for the Ionising Radiation (Medical Exposure) Regulations 2000 in England, known as IR(ME)R. The regulations concern the use of medical exposures using nuclear medicine pharmaceuticals and diagnostic and therapeutic uses of radiation on patients. The regulations require organisations, such as NHS trusts, to protect patients from unnecessary and un-optimised radiation. Organisations must tell us when there has been an exposure 'much greater than intended', each of which we investigate.

We received 669 notifications in 2012 and conducted more than 20 inspections, most of them in clinical radiology departments. We served two improvement notices on NHS trusts and published these on our website in a register alongside our enforcement policy.

Pharmacy and controlled drugs inspections

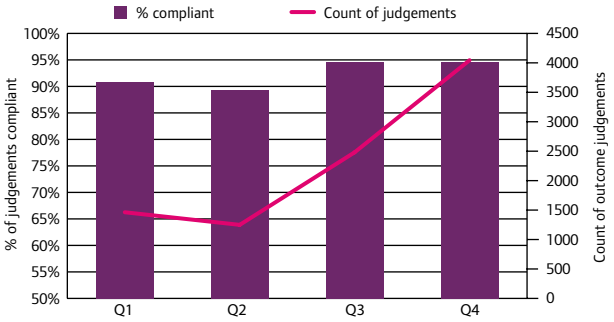
Our specialist Pharmacy and Controlled Drugs Team carried out 85 inspections in NHS trusts in 2012/13. Thirty-nine of these inspections uncovered problems with the management of medicines. Key themes we have found included:

- Poor storage of medicines: intravenous fluids not being stored securely; medicine room doors and cupboards being left open and unlocked when no staff are present; poor arrangements for keeping medicines refrigerated.
- A lack of arrangements for people to manage their own medicines where appropriate, including situations where people were managing some of their medicines without the staff on the ward being aware they had them.

Independent healthcare

- 1,402 independent healthcare providers registered with CQC on 31 March 2013.
- Net increase of 175 providers (14%) since 1 April 2012.
- 3,033 independent healthcare locations on 31 March 2013.
- Net increase of 269 (10%) since the start of the year.
- One cancellation of a service in independent health care: this was a hospital for people with learning disabilities, some of whom were liable to be detained under the Mental Health Act.
- 41 warning notices published, mainly in mental health and learning disability services.
- Most common failures in: assessing and planning care for people; keeping people safe.
- There were no trends identified in the few warning notices issued in acute health settings.
- 664 compliance actions issued.
- Markedly different levels of compliance in different independent health care settings. Mental health and learning disability services performed less well than acute and community healthcare services.

Figure 7: Rates of compliance and inspection frequency – independent healthcare



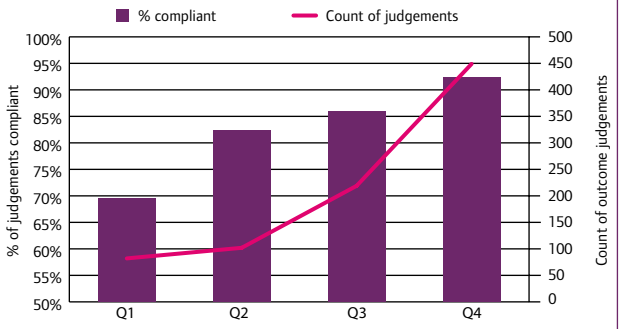
Average enforcement rate (escalation from non-compliance to enforcement action)

2011/12	4.1%
2012/13	6.5%

Independent ambulances

- 243 independent ambulance providers registered with CQC on 31 March 2013.
- A zero net change in the number of providers since 1 April 2012.
- 304 independent ambulance locations on 31 March 2013.
- Net decrease of 19 (6%) since the start of the year.
- We cancelled the registration of one ambulance provider.
- 5 warning notices published.
- Most common failures in: keeping proper records; monitoring the quality of care.
- 123 compliance actions issued.
- Most commons areas for improvement: keeping proper records about the service and patient care; recruiting staff safely; monitoring the quality of care.

Figure 8: Rates of compliance and inspection frequency – independent ambulances



Average enforcement rate (escalation from non-compliance to enforcement action)

2011/12	3.3%
2012/13	5.4%

Case study – Private ambulance service turns things around

We received concerns about the way a private ambulance service that supplies ambulances and paramedics to sporting events in Gloucester managed its controlled drugs. During our resulting inspection, we found a number of other concerns, relating to cleanliness and infection control, safety and suitability of the ambulances, and maintaining records. We issued two warning notices.

Not long afterwards, we received a call from a major sporting event, concerned that they had been using the provider for years, and whether that could continue. We were able to confirm that the provider had done everything that was needed and was now compliant.

As a result of our inspection, competitors attending these events could be reassured that they would be treated in clean and fit-for-purpose ambulances with fully working equipment.

Pharmacy and controlled drugs inspections

Our Pharmacy and Controlled Drugs Team carried out 87 inspections in independent healthcare services in 2012/13. Forty-eight of these uncovered problems with the management of medicines. The issues uncovered were broadly the same as in NHS trusts. The corresponding inspection figures for independent ambulance services were 11 and seven respectively.

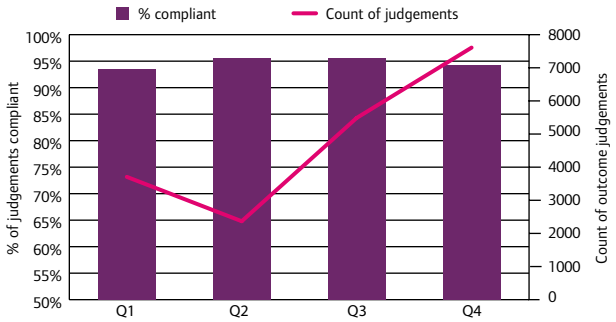
Cosmetic surgery

In May 2012 CQC prosecuted a cosmetic surgery company for failure to register. The company was providing liposuction treatment at independent clinics in Wakefield and London without being properly registered. It was fined £40,000. This was the first prosecution of this kind under current legislation. The result of the case sent out a clear message to providers that CQC will act on information about unregistered providers, and will not hesitate to take tough enforcement action wherever necessary to ensure the safety of patients.

Dental care

- 8,057 primary dental care providers registered with CQC on 31 March 2013.
- 55 fewer providers in total (0.7%) than when the sector came into regulation on 1 April 2012.
- 10,102 dental locations on 31 March 2013.
- 28 fewer (0.3%) than the start of the year.
- In February 2013, we served our first Prohibition Notice on a dentist under the Ionising Radiation (Medical Exposure) Regulations.
- 26 warning notices published.
- There related to shortfalls in: cleanliness and infection control; keeping vulnerable people safe; safe recruitment of staff; safety and suitability of the premises.
- 975 compliance actions issued.
- Most common area for improvement: ensuring effective cleanliness and infection control.

Figure 9: Rates of compliance and inspection frequency – dental care



Average enforcement rate (escalation from non-compliance to enforcement action)

2011/12	2.3%
2012/13	3.9%

Building on the initial inspections started in 2011/12, out inspectors focused on four main areas when checking the quality of dental care provided: the respect and involvement of patients, the care and welfare of patients, safeguarding patients from abuse, and cleanliness and infection control.

They found that the performance of the sector was very good compared to other parts of the health and social care system. In our early inspections, we had identified safeguarding of vulnerable adults as the area where we has the most issues. The dental sector responded to this quickly, and the level of training, support and understanding in the sector improved. More recent inspections have shown that effective checks when recruiting staff and keeping patient records up to date, safe and confidential are areas we need to keep an eye on going forward.

Case study – Problems under the surface at a dental surgery

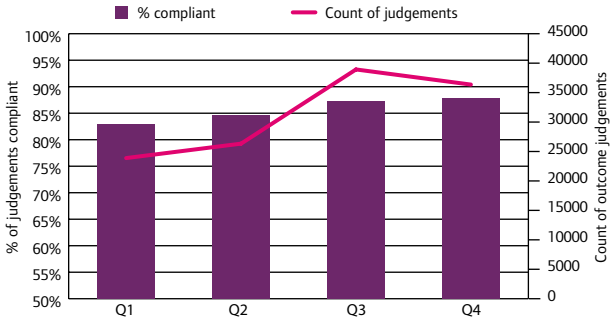
When we visited a dental surgery on the Somerset coast, the patients told us it was clean and well-maintained. However, that's not what our inspectors found. There were no systems in place to monitor the quality of its infection control and the dentist was not following current guidance on preventing the spread of infections, dealing with common dental emergencies, or ensuring that dental instruments were sterilised properly.

We issued a warning notice. A few weeks later when we went back to check progress, and found the practice had made vast improvements to the way it monitored its service. They now had regular audits and had made adjustments to their decontamination room to ensure they were up to date with current guidance. Staff now followed procedures to protect themselves and other people from the risk of infections.

Adult social care

- 12,669 adult social care providers registered with CQC on 31 March 2013.
- Net increase of 240 providers (2%) since 1 April 2012.
- 25,275 adult social care locations on 31 March 2013.
- Net rise of 267 (1%) since the start of the year.
- We took 15 enforcement actions during the year where we restricted the provider's scope of service, including cases where individual locations were closed.
- A further 18 occasions when we prevented a provider from delivering a service at all.
- 818 warning notices published.
- Most common failures in: providing medicines safely; identifying and planning the delivery of care; monitoring the quality of care.
- 16,399 compliance actions issued.
- Most common areas for improvement included: identifying and planning the delivery of care; support for staff training and development; monitoring the quality of care; keeping accurate records.

Figure 10: Rates of compliance and inspection frequency – adult social care



Average enforcement rate (escalation from non-compliance to enforcement action)

2011/12	4.2%
2012/13	7.1%

Dignity and nutrition in care homes

Mirroring our themed inspections on dignity and nutrition in hospitals, in 2012 we also looked at the care provided to older people across 500 care homes.

We found that almost two-thirds (316) of the homes we inspected met all the standards we checked. This meant that staff were respecting and involving people and that people's nutritional needs were being met. To support this, homes had enough skilled and knowledgeable staff, they had taken steps to protect people from the risk of abuse, and they kept accurate records to support people's care.

However, people living in one in six of the care homes (80 homes) we inspected did not always have their privacy and dignity respected or were not involved in their own care. Staff and managers in some homes:

- Talked to people using inappropriate words or manners.
- Did not use doors and screens when providing personal care, or did not give people somewhere to keep their possessions securely.
- Did not find out how people preferred to be cared for or spend their time.
- Failed to provide choices of activities and options for people to support their independence – particularly for people with dementia.

People living in one in six care homes (87 homes) were not always supported to eat and drink sufficient amounts. Staff and managers in some homes:

- Did not always give people a choice of food or support them to make a choice.
- Failed to identify or provide the support that people who were at risk of malnutrition needed.
- Did not ensure that there were enough staff available to support people who needed help to eat and drink: 14% of homes failed to have enough staff to meet people's needs.

We published an overview report in March 2013, bringing together the findings, identifying what works well, what homes need to do better, and recommendations for providers, commissioners and other professional bodies.

Case study – How inspections can improve an individual's experience of care

Over lunchtime at a care home for people with dementia we used our 'Short Observational Framework for Inspections' recording tool to check how residents were being cared for. We were concerned to see the way that one woman was being supported to eat. The staff said she couldn't recognise food, so they had to press the spoon to her lips for her to taste the food so she would then open her mouth. No member of staff explained to her what they were doing; they were unable to tell when she was full, or even if she liked the food or not. We could not accept this explanation, and despite objections from the provider, found them non-compliant with the outcome on respecting and involving people.

On our follow-up visit, we found that the woman no longer needed help to eat, because she was able to do it herself. The manager had taken our inspection feedback seriously and had made a speech and language referral. The staff were told she had not been able to recognise the pureed food, so they were advised to stop the spoon feeding. All they had to do was present her food in the usual way, and encourage her to eat. This change not only changed the experience for one person, but brought about a significant change in people's assumptions about the abilities that people with dementia still have.

Dementia care in care homes

As mentioned above, we carried out a review of hospital data to look at how the outcomes for people with dementia in hospital differ from those for similar people without dementia. The review also compared patterns of admissions to hospital of similar people with and without dementia living in care homes.

We found that, in more than half of PCT areas in the country, people with dementia living in a care home are more likely to go into hospital with avoidable conditions (such as urinary infections, dehydration and pressure sores) than similar people without dementia. Once in hospital, people with dementia are more likely to stay there longer, to be readmitted, and to die there.

The review showed clearly that the combined health and social care system is struggling to care adequately for people with dementia. The findings highlight a system-wide challenge of integrating care across hospitals and care homes.

Home care themed inspections

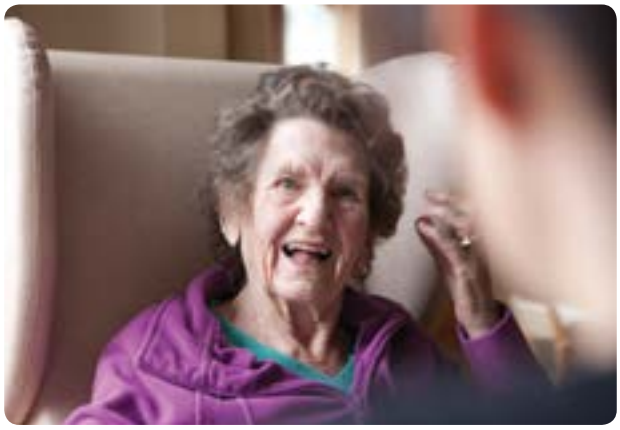
Home care was another focus of our themed inspections in 2012/13. We inspected 250 home care services that provided care to more than 26,000 people, gathered the views of more than 4,600 people and visited 738 people in their own homes. We found that 74% of the services were meeting all five of the standards that our inspectors checked. However, we had concerns around the following areas.

- On many occasions, people received no prior notice that they would be visited by a care worker they didn't know.
- Visits were often delayed or sometimes cancelled without prior notice.
- Risks associated with a person's care or medical conditions had not been assessed and care plans had not been updated for several years.
- Some services did not have clear systems to monitor the quality and information in care plans.

Home care services – evaluation

One of the objectives of the home care inspections was to improve the way we regulate these services. Our review made recommendations which we have already incorporated into our methodology for inspectors from April 2013. These include:

- We will inspect home care agencies with short notice unless we have concerns about the service.
- Using questionnaires gave us additional views about a service that we wouldn't otherwise have. Most of the inspectors who took part found the information from the questionnaires useful for inspecting and reporting. We are therefore making questionnaires available for inspectors to gather views and experiences of people receiving care from large home care agencies.
- When home visits were successful, inspectors felt they were able to listen to the experience of the person and have feedback from their relative. Inspectors said that home visits were especially important where people were in vulnerable circumstances and where they also had a relative there to contribute.
- We will continue to involve Experts by Experience in carrying out telephone interviews with people using services.



We recorded a great deal of feedback from people using home care services, including recurring themes about choice and preferences:

> *"The chopping and changing of hours and people is a real issue. I'm never sure who is coming. The girls may all be very nice but I feel more consistency would be so much better, I spend so much time explaining things. I would like to know who is coming, maybe not the same girl every time but several who come regularly. But I have all sorts coming. I don't seem to have much choice about that."*
>
> **Person using home care services**

Case study – Our enforcement action starts a ripple effect at a home care service

When we inspected the services provided to people by a home care service, every person we spoke with told us that the agency had missed visits. Staff were turning up late, or not at all, or failing to visit people at their preferred time. One person's bedtime visit was at 10pm, when they always wanted to go to bed at 7pm.

On following up, the service had made huge improvements, and when we inspected another agency run by the same provider we were pleased to hear that 'lessons learned' from previously failing service had been disseminated to other branches.

Pharmacy and controlled drugs

Our Pharmacy and Controlled Drugs Team carried out 34 inspections of home care services in 2012/13. Twenty-two of these uncovered problems with the management of medicines. We found poor arrangements for the recording of administration of medicines, confusion around whether or not the provider was providing support to the person for the safe management of medicines, and a lack of training for care workers in medicines management.

2

Working with our partners

We worked hard in 2012/13 to work better and more closely with other regulators and organisations that provide supervision and oversee the health and social care system to improve the quality of care for people. We focused on the importance of sharing information quickly and widely to make sure people receive safe and acceptable standards of care.

In this section: Working with system partners, professional associations and other regulators ▪ Healthwatch England ▪ Engaging with national stakeholders, Parliament and Government ▪ Joint inspections

Working with system partners, professional associations and other regulators

A key priority in our strategy review, CQC focused in 2012/13 on building stronger working relationships with other regulators, professional associations and partners in the health and social care system.

Local and regional partnership working

At a local and regional level, our compliance inspectors and managers meet on a regular basis with social services and healthcare commissioners to share information on providers. We meet with organisations representing people who use services, as well as the providers themselves.

In any community, there is a lot of information and intelligence gathered about the providers of services. At times, the information held by one organisation will not cause concern, but when combined with other intelligence may point to a potential problem that should be investigated further.

CQC has a statutory duty to share information on its enforcement activity with local authorities, NHS commissioners and Monitor. Inspectors ensure that this information is passed on at the appropriate time. We routinely share

the outcomes of our inspections or other intelligence as it arises.

The new NHS has established a network of 27 quality surveillance groups including CQC, Monitor, NHS Trust Development Authority, local Healthwatch and local authorities. The aim is to ensure that a watch is kept on quality at a local level by those closest to the detail and most aware of concerns. They pool information and intelligence, and work together to take coordinated action in case of service failure.

Compliance teams continue to meet with local authorities that act as both the commissioners of services and the local safeguarding authorities. There are formal meetings and unscheduled discussions when more urgent issues arise.

Monitor

CQC informs Monitor of any concerns about the quality and safety of care at an NHS foundation trust. We then agree with Monitor what regulatory activity needs to be carried out. We take joined up regulatory action with them where it brings about the greatest benefits for people who use services.

We updated our memorandum of understanding and operational protocols to support effective collaboration between our frontline staff. We are also working together on operational and strategic issues so that our approaches are aligned and duplication is minimised.

In 2012/13, we began developing a single application form to enable providers to register with CQC and obtain a Monitor licence in the same transaction.

NHS Trust Development Authority

CQC and the NHS Trust Development Authority (NHS TDA) created a partnership agreement that sets out our commitment to early and proactive information sharing and our intention to support and oversee partnership working. CQC and the NHS TDA will work closely together operationally, at a national and local level to monitor, assess and address concerns about the quality of care in NHS trusts.

NHS England

CQC and NHS England have a statutory duty to cooperate and work to a common purpose to

CQC and Monitor: joint working in action

In May 2012, we expanded the assurances that CQC provides to Monitor and the Department of Health in relation to NHS trusts seeking foundation trust status.

We created a dedicated FT Assurance team to review our evidence on these organisations. The team also considers other data to build up a more detailed picture of the quality of care provided.

Since July 2012, the team has developed a framework for information. This includes an in-depth retrospective review of the trust, providing a picture of the regulatory status of the organisation and showing specific risks, which areas should be focused on in the future, and CQC's overall view of quality.

The team established three-way discussions with Monitor and CQC operations staff to look in detail at issues and concerns.

The development of the FT Assurance team and subsequent work has enabled CQC to provide more detailed commentary on NHS trusts, covering a greater scope than was in place before. While this has contributed to some delays in the authorisation of some trusts, the overriding purpose has been to make sure that these trusts show that they meet the national standards.

improve outcomes for patients. Our agreement with NHS England cements joint working at a national level and sets out the values and behaviours we want to demonstrate through effective joint working. It embeds a shared commitment to work together on three priorities to improve outcomes for patients:

- Agree a protocol to share information about the quality of care in order to spot potential problems early, and manage risk.
- Implement the proposals in the National Quality Board's document, *Quality in the new health system: Maintaining and improving quality from April 2013*, which describes how the health care system should prevent, identify and respond to serious failures in quality.
- Set the tone for ways of working nationally, locally and in the wider landscape of our organisations and strategic partners in health and care.

National Institute for Health and Care Excellence (NICE)

CQC has worked for several years with the National Institute for Health and Care Excellence (NICE), which currently makes reference to clinical guidelines in our national standards. With a greater focus on standards, we are working closely with NICE to ensure there is a clear link between fundamental standards (which will form the basis of CQC regulation going forward) and their Quality Standards. Although Quality Standards are predominantly about driving excellence, it is important that they align so that CQC supports the improvement of care beyond fundamental standards.

Association of Directors of Adult Social Services

We formally engage and work with the Association of Directors of Adult Social Services (ADASS) at a number of levels. In 2012/13, our Chief Executive met every quarter with the ADASS executive team to discuss CQC's work and gain their views. This included engaging with the wider ADASS membership on key issues of joint interest such as our strategy review.

We also engaged with the relevant ADASS policy committees including the Standards and Performance Committee, Safeguarding Adults Committee, Learning Disability and Mental Health committees. Working with these committees allowed us to provide updates on our relevant work programmes.

ADASS is responsible for leading the work on sector-led improvement for councils' adult social care performance. We are members of the programme board and the outputs of our regulatory work helped to shape the work programme. Our operational teams across the regions also contributed to the peer review and challenge work that forms part of the sector-led improvement approach.

Local Government Association

We formally engaged with the Local Government Association (LGA) through Chief Executive and political leadership membership meetings throughout the year. We also worked with the LGA through the ADASS sector-led improvement programme.

The LGA and NHS England are sponsoring the work of a joint improvement team to oversee the system transformation of learning disability services for people in England. There is a programme board overseeing this work and we are vital to that membership, providing the data and information that will help make the changes needed to the system.

Safeguarding

In our revised safeguarding protocol we strengthened our commitment to develop working relationships with local safeguarding partnerships. We are committed to attend appropriate safeguarding strategy meetings and local safeguarding boards at least once a year to share information, promote the role of CQC in safeguarding, and discuss local or regional safeguarding matters.

Last year CQC met with the safeguarding leads from ADASS every quarter to share information and discuss safeguarding issues. We also attended the Department of Health Safeguarding Advisory Board which is a cross-sector strategic forum on safeguarding. CQC regularly attends national safeguarding conferences to promote our role in safeguarding and share information on changes to our inspection processes.

Sharing information about health care

We received many of our alerts for high death rates from the Dr Foster Unit at Imperial College (see page 20).

We also followed up revision rate outliers (that identify potentially poor quality of care in hip and knee replacement surgery) in partnership

CQC and the General Medical Council

CQC and the General Medical Council (GMC) have had a formal memorandum of understanding in place for some time in recognition of the need for joined-up working. In 2012/13 we worked together to develop a framework that gives day-to-day definition to this cooperation and how this joint working can be maximised.

The framework consists of a revised memorandum, an information sharing agreement (covering routine data sharing), and a joint working protocol. The protocol is a practical guide for staff that sets out how CQC and the GMC will work together effectively in our respective roles to protect the public.

We agreed that the framework should be built with an emphasis on our frontline staff, keeping the approach and content meaningful to them in their day-to-day activities. We are rolling this out across our organisations and will be closely reviewing it with a view to extending it to all strategic partnership work.

with the National Joint Registry and Bristol University. This was a pilot for how we might work in closer collaboration with other organisations who are identifying outliers.

All our correspondence with trusts is shared with local commissioning bodies and Monitor or the NHS TDA as appropriate. These bodies use our information to help with their risk assessments. As part of our agreement for receiving Strategic Executive Information System 'never event' data, we provide NHS England with regular analysis reports.

Parliamentary and Health Service Ombudsman

We have a good working relationship with the Parliamentary and Health Service Ombudsman (PHSO), which investigates complaints about government departments, other public organisations and the NHS. However, we have recognised the need to strengthen this and ensure information of concern is shared quickly and used effectively in our inspections of services. We are therefore involved in a number of joint working projects with the PHSO, and senior managers meet regularly to ensure that our information sharing meets the expectations of both Francis Report about Mid Staffordshire NHS Foundation Trust and the Fritchie Report about complaints in the NHS.

Equality and Human Rights Commission

Our Memorandum of Understanding with the Equality and Human Rights Commission (EHRC) has ensured regular information sharing between CQC and EHRC on our thematic work, such as our inspections of home care for older people in 2012/13. We have also carried out joint work with EHRC on developing our information on risks to equality in the providers that we regulate.

Joint working with HFEA and HTA

Since 2010 CQC has been working with the Human Fertilisation and Embryology Authority (HFEA) and the Human Tissue Authority (HTA) exploring ways to increase effective and efficient partnership working to promote quality and safety.

The Department of Health announced in January 2013 that it will not pursue a transfer of functions from the HFEA and the HTA to CQC. We welcomed this announcement and continue to cooperate with the Department, the HFEA and the HTA to improve efficiencies and reduce duplication.

We have made particular progress in our work to reduce the regulatory overlap with the HFEA for some IVF clinics. From October 2013, the HFEA will extend its inspection activity to include fertility treatment procedures involving use of anaesthesia or sedation; this will have the effect of removing many of these services from the scope of CQC registration and will therefore remove the current duplication that exists.

Healthwatch England

Healthwatch England, the independent champion for consumers of health and social care services, was launched on 1 October 2012 as a statutory committee of CQC. Anna Bradley was appointed by the Secretary of State as Chair of the Healthwatch England and as a Commissioner on the CQC Board.

Anna oversaw the recruitment of her Committee members and the Healthwatch England Committee met in November for the first time. Healthwatch England and CQC agreed to work together as strategic partners, enabling Healthwatch England to be operationally and editorially independent of CQC.

Dr Katherine Rake was appointed as Chief Executive and took up her post in January 2013. Healthwatch England staff, based in London and Leeds, have been working with Anna and

Katherine to launch Healthwatch England. Key activities included developing links with local Healthwatch organisations, creating the Healthwatch England website, and establishing how it will work with other bodies such as NHS England, Monitor and the Local Government Association.

Healthwatch England published its first business plan in March 2013. Its priorities for 2013/14 are to:

- Ensure consumers of health and social care can exercise their right to be heard.
- Ensure consumers of health and social care can exercise their right to redress.
- Support local Healthwatch at this key stage of development.
- Establish Healthwatch as an effective organisation that makes a difference for consumers in a changing health and social care landscape.

Engaging with national stakeholders, Parliament and Government

In 2012/13 we continued to build strong links with national stakeholders, Parliament and Government.

We worked with stakeholders to inform our strategy review and build advocates for CQC who can speak positively on our behalf. Channels included:

- **Stakeholder Committee** – developed to support our statutory obligation to consult and engage with stakeholders. Chaired by Board member, John Harwood, the Committee is made up of 23 representatives of the care professionals, people who use services, care providers, campaign groups and policy shapers that reflect CQC's regulated sectors.
- **Stakeholder Advisory groups** – these allow CQC to source feedback from a range of experts and leading organisations on key areas of work, such as our themed inspection programmes and our strategy, at the same time as ensuring this form of contact is used as a key relationship builder.
- **Stakeholder database and contact programme** – allowing us to identify opportunities in stakeholder relationships. Results included better relationships with think tanks and other regulators.

We introduced an integrated approach to stakeholders and Parliament, aligning channels so that our communication is clearer and more consistent, including:

- **Parliamentary contact programme –** our constituency engagement programme plays a pivotal role in building relationships between MPs and regional teams so that there is ongoing dialogue on local issues and an opportunity to communicate our policies and strategy. Following its launch in August 2012 there was a significant increase in supportive comments from MPs and peers, via the press and social media.
- **Westminster events** – CQC arranged a series of events to keep Parliamentarians informed, including roundtable discussions, speaking at All Party Parliamentary Group meetings, arranging 1:1 briefings and launching reports in Parliament with support from MPs, covering subjects including the Mental Health Act and home care.

- **MP e-newsletter –** we produced a bi-monthly CQC newsletter to provide MPs with regular updates on our work.
- **Parliamentary committees –** we engaged with members of key committees throughout the year, including the Health Select Committee and Public Accounts Committee, to improve our relationships with these MPs.
- **Constituency updates for MPs –** we developed a constituency-wide email alert for MPs (see page 52). Around 10% of MPs have signed up for the service.

We have been developing a more strategic and proactive approach to our relationship with the Department of Health, which includes working with our sponsor team to improve understanding of, and support for, our new strategy and the changes it will introduce. We have also started to develop closer engagement with other Government departments including the Cabinet Office and the Department for Business, Innovation and Skills, particularly with regard to our role in the work of these departments on better regulation.

Joint inspections

Children's safeguarding

In July 2012, we completed a three-year programme of safeguarding and looked after children's inspections that we conducted jointly with Ofsted.

In 2012/13 we worked with Ofsted, HMI Constabulary, HMI Probation and HMI Prisons to develop a multi-agency approach to the inspection of child protection and conducted five pilot inspections. The plans for implementation have been deferred to allow for further development. In the meantime, we will inspect child safeguarding in health, including services for looked after children, as a separate programme during 2013/14 and share our findings with the other inspectorates.

In March 2013, in a joint report called *What about the children?*, Ofsted and CQC together called on the Government to make it a mandatory requirement for mental health services to collect data on children whose parents or carers have mental health difficulties and report on such data nationally. The report highlighted how a failure to spot children whose parents have mental ill-health means that they do not get the help they need. Some are left at risk of harm.

Secure training centres

During the year, CQC was a full partner with Ofsted and HMI Prisons in developing a new framework for inspecting Secure Training Centres (STCs). These are purpose-built centres for young offenders up to the age of 17.

Following two pilot inspections, a full programme of inspections are underway with each of the four STCs being inspected annually.

Research in secure environments (and more generally in the youth justice system) has consistently highlighted the wide range and very high incidence of complex health needs that young people have in these settings. Our inclusion in these inspections means we will have a much better oversight of all health services linked to youth justice since we already inspect youth offending teams and young offender institutions (see below).

HMI Prisons and HMI Constabulary

Health services provided in prisons, young offender institutions (YOIs), immigration removal centres (IRCs) and police custody must register with CQC and meet the same standards of quality and safety as other services.

A CQC inspector joins the HMI Prisons team for two days of a week-long inspection of the whole of an establishment. Each organisation covers its own standards and regulations but the

inspectors work closely together and the activity is coordinated on site.

In 2012/13 CQC and HMIP inspected together on 48 occasions, including 10 inspections of police custody. Police custody inspections involve elements of the Mental Health Act because, for example, police custody may be used as a place of safety under section 136 of the Mental Health Act. In 2012/13 CQC's Mental Health Act Commissioners worked with HMI Constabulary and HMI Prisons on a joint review of the use of police custody in nine police areas. The findings will be published in a joint national report.

HMI Probation

We worked with HMI Probation to complete a three-year programme of inspections of youth offending teams (YOTs) and plan a new risk-proportionate programme for 2013.

We have been generally reassured by our findings over this inspection period. Recommendations from the individual inspections and previous reviews have led to clear action plans and constructive developments in the vast majority of YOTs and the delivery of health services to them. Feedback from YOT managers about the contribution of CQC to the inspection cycle has generally been positive and they have highlighted the good progress that has been made with associated health services.

We continued to work alongside HMI Probation on full joint inspections, and completed five of these through the year. We also worked with them on a thematic inspection examining multi-agency responses to children and young people who sexually offend.

3

Building relationships with the public

A positive, trusting relationship with the public is key to being a successful regulator. To build that relationship, we increased our efforts to ensure the public are aware of and understand the work we do, make sure our information tells them what they need to know, listen and respond to what people are telling us about the quality of care services, and involve people in our work.

In this section: Improving our access to people's views ■ Involving the public and raising awareness ■ Better information for the public ■ The work of our National Customer Service Centre

Improving our access to people's views

Tell Us About Your Care programme

During 2012 we ran a number of Tell Us About Your Care pilots to better understand the information we get from the public and increase our access to it. The pilots tested new systems for tracking and evaluating that information so we can report on it more routinely.

In two of the pilots we worked with the Relatives and Residents Association and the Patients Association to gather feedback from people contacting their national help lines.

In another, in the North West, we tested different methods of encouraging people to tell us directly about their experiences of care. We put leaflets in GP practices and advertised on local radio, handed out leaflets on our inspections and attended local carers' and older people's community groups.

Our inspectors said that most (89%) of the information we received was valuable and they used it in their inspection planning. Two per cent of the information prompted an urgent inspection and 2% a safeguarding referral. Three per cent brought forward the date of a planned inspection. Overall 10% of the information prompted contact with the provider. A quarter of

Case study – Information from the public leads to urgent inspection and improvements in care

When a member of the public had concerns about the care their relative had received at a care home in Swindon, they were able to tell us in confidence by completing our online feedback form, which they had heard about through our partnership project with the Patients Association.

The person reported long delays between their relative pressing an emergency call button and a member of staff coming to help. They told us they didn't think there were enough staff on duty, and that the staff who were available were not always treating their relative with dignity and respect. Our inspector already had some concerns about the home and this extra information prompted them to carry out an urgent unannounced inspection.

On our inspection we talked to people living in the home, talked to staff and checked records. Most people who we talked to told us they were happy with the care they received, but we saw people were sitting for a long time over lunch as there were not enough staff to support them. When we asked residents about calls bells, some made comments such as, "if you ring your call bell you might have to be patient" or "sometimes you may have to wait if someone needs help more urgently".

At the end of our inspection we judged that the home was not always providing people with care that met national standards of quality and safety, so we asked them to send us a plan detailing what they would do, and by when, to make sure care improved.

When we returned to the home for a follow-up inspection we saw staff being attentive and kind to residents. We saw staff enabling people to maintain their independence and encouraging them to eat their lunch with minimum assistance. As a result we judged the home was now providing care that was safe, effective and compassionate and we published our report on our website so people could see the improvements made by the home.

the information consisted of positive comments about care.

We are committed to continuing our working relationship with the Patients Association and the Relatives and Residents Association. We are looking to establish similar projects with other national charities.

In 2013/14 we will implement the internal system changes that will allow us to routinely report on the volume and value of information we get from members of the public.

Improving how we gather people's views on inspections

In 2012/13 we developed a new dashboard to monitor how often our inspectors talk to people who use services and carers during inspections, observe and track people's care, and use other tools to gather their experiences. This has helped our local teams to monitor where they need to provide more support and training to inspectors.

We are using the information to improve how we involve community groups in inspections. We also strengthened the way we gather people's experiences of home care services, including the use of telephone interviews by Experts by Experience.

Involving the public and raising awareness

Forging links with the community and voluntary sector

We made much greater use of charities' communications channels in 2012/13 to get our message direct to users and carers at the point of need. We established communication partnerships with 20 leading charities including Mind, British Heart Foundation, Age UK, Terrence Higgins Trust, Mental Health Foundation, Epilepsy Society, Choice Support and Carers Trust.

Most of the charities have included links from their websites to our 'Share your experience' form. Several asked CQC to brief their helpline teams so that they can better handle callers complaining about care and encourage them to feed back their views to CQC.

We began partnership work with Regional Voices, a national network of nine regional networks of community and voluntary groups. This includes testing better ways of communicating with diverse communities and exploring how we can better gather their feedback. This will roll out in 2013/14.

Voluntary and community organisations have been part of our Stakeholder Committee and played a significant role in our strategy review.

Work with local representative groups

We continued to build relationships with local involvement networks (LINks), scrutiny committees, foundation trust councils of governors and patient participation groups. These have led to greater information sharing. For example, we made increasing use of LINks' 'enter and view' reports and scrutiny reviews.

Charities help CQC to raise awareness

Mind hosted a blog called 'An inspector calls', in which one of our compliance inspectors recalled a series of inspections she carried out in direct response to an anonymous member of the public. Mind said: "The response was excellent and we would always be keen to host more blogs from CQC".

A compliance manager hosted **Carers Trust's** monthly webchat, resulting in a lively discussion that all participating 'chatters' said they found very useful. The charity has invited CQC to host further chats.

Age UK's online radio station, The Wireless, broadcast a series of programmes co-produced with CQC. They included an interview with our Chief Executive, David Behan. The broadcasts have also been made available through the Hospital Broadcasting Association to all of its 217 member stations serving 421 hospitals.

Case study – Devon LINk

Devon LINk has been developing its use of enter and view, working closely with the local CQC manager and the local authority. A training session delivered by the Devon safeguarding team on the local authority's safeguarding procedures now forms part of the training package for LINk authorised representatives.

The LINk was alerted to a safeguarding concern by a participant. The concern related to a care home for people with dementia. The front door of the care home was being left open and on at least one occasion a resident had wandered out of the home without staff knowledge. The local authority was alerted to the issue and the LINk shared the information with CQC. As part of the response, CQC undertook a responsive inspection and the information was used in the CQC inspection report of the service and informed CQC action.

Our LINks advisory group met quarterly to advise on CQC's plans and inspection programmes. We wrote briefings for LINks and Healthwatch and 10 case studies of foundation trust councils of governors' work with CQC. Further guides for scrutiny committees and district councillors will be available in 2013.

We sent a monthly LINks bulletin and local press releases to all LINks and scrutiny committees. CQC staff presented our work at a number of local and regional meetings of LINks, governors and scrutiny councillors. We established a regular communication out to local councils, sending them short articles for their residents' magazines, community newsletters and websites.

We directly involved governors, councillors and LINks in developing our new strategy. All our work has been supported through partnership working with national bodies including the Centre for Public Scrutiny and the Foundation Trust Governors Association. We have built on our work with LINks to begin to establish effective local relationships with all Healthwatch organisations.

To support our registration of primary medical care from April 2013, we explored the best ways of getting information from GPs' patients. Working with the National Association for Patient Participation, we met around 60 patient participation groups (PPGs) to explain CQC's role in regulation, talk about what information we could use from PPGs, and discuss how our inspectors could work with them. We have since created a 'sounding board' of PPG members.

Involving the public in CQC's work

As well as using Experts by Experience in inspections (see page 18), we continued to involve people who use services and their relatives and carers in planning and developing our work.

People who use services sat on a range of advisory groups, such as the learning disability advisory group and the domiciliary care inspection programme group. Members of the

public helped us develop our inspection reports and new aspects of our website.

We continued to develop the involvement of SpeakOut in informing our national work and our strategy. SpeakOut is a network of more than 80 diverse community groups managed by the School of Social Work at the University of Central Lancashire. It is an example of how we engage with seldom heard community groups. We provide training and support for the groups so that they can take part in our consultations and staff training, review our policy documents and provide direct feedback on their community's views and experiences of care services.

In 2012 we established a public reference group. This contains more than 100 people, and is refreshed every three months to make sure it remains representative of the wider public. We used the group to test our public messaging and materials, including our draft strategy. We showed them one version and, based on the feedback they gave us, developed a further version which they told us was "much clearer and easy to understand". We also tested our leaflet that tells people what standards they can expect from their GP practice, as well as posters for placing in GP practices. The group told us which messages they felt were most important to communicate and what design style they liked best. Smaller public focus groups helped us understand public views on our proposed purpose and role under our strategy review.

eQuality Voices

eQuality Voices, a group of people who use services, helps to shape and monitor CQC's equality objectives and ensure a diverse range of people are involved in CQC's work. During the year, eQuality Voices carried out in-depth monitoring of our equality and human rights priorities. This resulted in a number of actions – for example our customer service centre providing a better service to people who do

Case study – Young Expert by Experience

Maria Ostoja-Starzewski, Involvement Team Leader, and Aileen Hamdan, Involvement Officer, held a workshop with young people and subsequently set up a children and young people advisory group to help involve them as young Experts by Experience.

Maria said: "Most of the children and young people we speak to do not initially know anything about CQC, but once they understand what we do they are very enthusiastic about helping us. They also come up with useful and interesting suggestions such as talking more about our work in schools and colleges, through student magazines for example."

At one session, a 13-year-old boy said: "I think you should talk to lots of patients, not only to doctors… you should send surveys to parents with clever questions… Undercover would be really good because no one knows you are there!"

Aileen added: "We also set up a focus group with children in year 6 and 7, aged 10 to 12. The outputs will also help us devise 'prompt' questions that will help future young Experts by Experience and help CQC inspectors to get information from children and young people. We are currently focusing on services that are most relevant to children such as dentists, GPs and children's hospitals."

Maria said: "We will be carrying out further focus groups and expanding the age ranges we speak to and the subjects we cover over the coming months. We will share our key findings from all of our activities."

not speak English as a first language and CQC monitoring whether disabled staff use the Access to Work Scheme. eQuality Voices were also closely involved in CQC's strategy review.

Better information for the public

Improving our inspection reports

It is vital that our inspection reports continue to improve as a tool for helping people make choices about care services. We asked the public, providers, other stakeholders and our staff for their thoughts on the content and layout of the reports. We made the following improvements:

- A summary of our judgements on the front page, using the same ticks and crosses as our website.
- A clearer summary section called 'What people told us and what we found'.
- A more balanced view of the evidence for each of the standards inspected.
- A clearer explanation of why a particular regulation is not being met and why we are taking action.

We also gave our inspectors a simpler recording tool to cut the amount of time it took to write and publish a report. The percentage of draft reports issued by inspectors within 10 days of a site visit improved from 65% in the first quarter of 2012/13 to 71% in the final quarter. However, this fell short of our business plan target of 90% for the year as a whole.

Email alerts

We launched an email alert service in November 2012. People can receive an email when we inspect a service, and again when the inspection report is published.

More than 12,000 subscriptions to services were made in the first three months. The service has proved popular with the public, the media and commissioners of services. Other groups have found it useful too – for example, those working in the financial sector who want to keep up to date with their clients' reports.

In early 2013 we added constituency-wide alerts for MPs. All English MPs can receive weekly alerts about the services in their area. In 2013/14, the public will be able to get alerts based on search filters, for example "all care homes within 10 miles of Leeds that provide care for people with dementia".

Website improvements

In November 2012, responding to feedback from website users, we enabled people to search for services no longer registered with us. This helps the public to find out about the history of particular places, and read the reports of services that previously operated at the same address.

The use of our website grew steadily throughout 2012/13. More than 600,000 people visited the site in January 2013, compared to 350,000 in January 2012. Also, the number of followers to CQC's corporate Twitter account (@carequalitycomm) doubled in 2012/13, from 7,550 in April 2012 to 15,847 at the end of March 2013.

An increasing proportion of people visiting our website did so to find information about care services. In January 2013, almost a third of all the pages viewed on the site were people looking at care services in our online directory.

- In 2012/13 there were 6 million visits to our website (up from 4.8 million in 2011/12)
- 3 million of these were unique visits

Syndication of information

The CQC 'widget' was a big innovation this year. A care provider can embed a summary view of CQC judgements into their own website. This

links to the full profile on CQC's website and updates as soon as the information changes.

We launched the widget in October 2012, following a pilot period during which a small group of providers helped us develop it. Providers welcomed the widget. Karen Willey, Corporate Assurance Manager for Lincolnshire Community Health Services NHS Trust told us, "This is a very useful tool as it allows direct access to the CQC website to find out about the provider and access to reports about the location". Use of the widget has grown quickly. In the last week of March 2013, it was viewed on more than 1,300 websites, generating around 200,000 page views.

Figure 10: A CQC widget on Lincolnshire Community Health Services NHS Trust's website (see above)

Online directories, such as the Social Care Institute for Excellence's Find Me Good Care website, are using the widget to build our judgements into their own data and therefore provide better information to the public.

We also worked with local and national government and the commercial and charitable sectors to increase access to our information. Our data is now driving the new Provider Quality Profiles on NHS Choices and we are also working with a number of third party websites to gather the views of people who use services.

Transparency

As a public body we are keen to be transparent and show our progress against our business plan. We created a scorecard on our website that shows how we are performing against our key targets and commitments. This is split into information on registration, inspection, enforcement and customer service.

In September 2012 we started streaming our board meetings live to our YouTube channel. We simultaneously lead discussions on Twitter to help people follow the issues and find out more about the agenda items.

Making our information accessible

We work hard to make sure that the way we communicate with people is accessible. In their learning report on involving people, the General Social Care Council said in 2012 that CQC's accessible communications policy "is an excellent example of how the work of regulators can be made accessible to people who use services and their carers".

We further developed the policy by consulting with people who use services, Experts by Experience, CQC staff and accessible communication specialists. We worked with our Learning Disability Advisory Group and organisations like the Challenging Behaviour Foundation to consult on our easy read material. Our eQuality Voices group also did a spot-check on access to publications and information on our website.

We publish summaries of our corporate publications in easy read, large print, audio, British Sign Language video and six community languages. We promote these using social media, at events, with internal staff, with key stakeholders and through e-bulletins. In total there were 68,577 downloads of our key publications in alternative formats.

This year, we added a link to each provider's profile page that invites people to ask for an alternative format of an inspection report.

The work of our National Customer Service Centre

Our National Customer Service Centre (NCSC) has a vital role in building better relationships with the public. That is why we have a continuous programme of improvement which sees us regularly engage with both our internal and external customers.

Our customer group is diverse and their needs are broad. We take pride in delivering a good customer experience, and we listen when we get it wrong. We expect high standards of quality and commitment from our staff and in return we invest in our staff through training, career development and people investment.

In placing the public as a central customer of NCSC, we give service promises that are clear and unambiguous and offer to resolve enquiries at the first contact wherever possible.

We created a single Safety Escalation Team to ensure that all concerns received from people using services, carers and families, as well as staff working in health and care settings are handled swiftly and effectively to safeguard individuals. And we further strengthened our handling of enquiries received from patients detained under the Mental Health Act.

In 2012/13, we answered 94% of safeguarding calls within 30 seconds, against a business plan target of 90%.

NCSC one of the UK's top 50 call centres

NCSC handles 5,600 calls, emails and items of post every week and is the first point of contact for CQC's many different customers.

In the NCSC we work with our customers to continually check our performance, seek out feedback, and understand where we can improve people's experience and deliver what they need. This year, we established partnerships with bodies such as the Medical Regulators Network, Mencap and the Department of Health to benchmark our service delivery.

In 2012, we entered a national customer insight programme: the Top 50 Companies for Customer Service. We have benefited from it by working with similar organisations to continually review best practice and share thinking. The assessments from the Top 50 help us see how other organisations deliver customer service, identify best practice and understand how we measure against industry standards. During our first year of membership we were awarded 36th place in the UK Top 50. We will continue with the programme in 2013/14 to further improve our customer service.

4

Building relationships with those we regulate

Providers of services have a duty to meet the standards of care set out in legislation. It is important for us to strike the right balance between taking action against poor performance and working with providers to make sure that people receive the right care. In the year we worked to build a relationship with care providers based on trust, openness and mutual respect.

In this section: Engagement with providers ■ Provider and professional feedback ■ Primary medical services ■ Reducing the regulatory burden ■ Registration services and customer support ■ Provider fees

Our strategy review confirmed that CQC's approach should be towards regulating different sectors differently. In 2012/13 we set out to improve our relationships with providers, and put in place the foundations for differentiated regulation, through more tailored communications, and by improving our links with individual care staff and stakeholder groups.

Engagement with providers

Our provider reference groups (PRGs) consist of two online communities of providers. One is for GPs and has 949 members. The other is for all registered providers and has 3,807 members.

We use the communities to engage providers in our work and consult them on potential changes to our approach. We do this through discussions on the PRG online forums, live question and answer sessions, sharing of materials, and asking for comment in the review sections.

We ran 11 separate reviews in 2012/13 which generated 299 responses to detailed questions. There were 29 forums opened during that period, containing 133 contributions. The feedback we receive from these communities helps us to develop our policies, guidance and reports, and is also a useful tool in communicating messages about CQC's work.

Case study – Tailoring our communications with providers through our reference groups

One of the projects we asked our provider reference groups to help us with was a new inspection poster. Based on feedback from our inspectors, we planned to use the poster to notify people in a service when an inspection was taking place. We asked the group whether they'd have any objections to putting up such a poster in their service, if there was any information missing, and whether they had any other comments on the draft version we showed them. We were pleased to get 93 responses and used the valuable feedback to develop the poster before issuing it to inspectors.

In February 2013 we replaced our monthly e-newsletter to all providers with sector-specific bulletins. We now send out four separate e-newsletters to all adult social care, dental care, health care and primary medical care providers.

We also send out an e-newsletter to health and social care professionals, featuring case studies, articles from our National Professional Advisors and inspector blogs. The number subscribing to this increased every month and as of March 2013, there were 8,055 subscribers.

The 'what works well' articles, such as the case studies and blogs that appear in all our e-newsletters, aim to share good practice with providers. Readership statistics show that these features are regularly in the top two or three most read categories.

Provider and professional feedback

We surveyed providers twice in 2012 – in March and September – to find out their views and experience of our regulation and inspection, and whether they thought CQC helps to achieve good quality care for people. We received 3,708 responses to the March survey, and 3,589 to the one in September, a 10% response rate. Both surveys generated a good spread of views across all sectors.

The results were broadly positive in both surveys. For example, 95.6% of providers said they felt well informed about CQC and had all the information they need to be regulated by us.

Figure 11: How clear are you about what you as a provider or manager need to do to operate under our regulatory model?

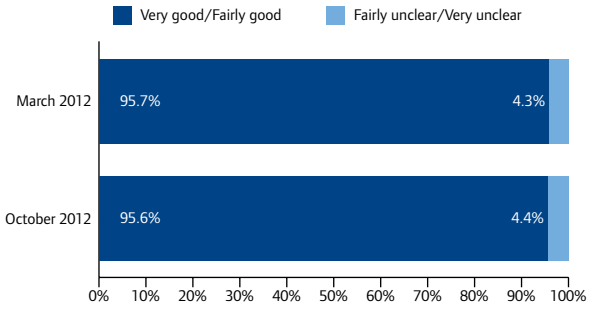
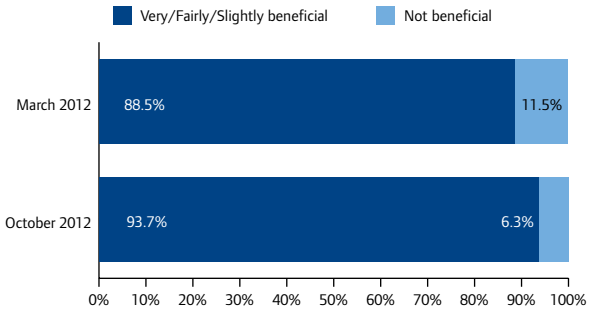


Figure 12: To what extent do you believe the way CQC inspects and regulates is beneficial to the quality of care received by people?



We also ran our first survey of frontline health and social professionals in October 2012, asking some of the same questions as the provider survey. There were more than 2,300 responses and it allowed us to compare the level of understanding that frontline staff have, and what they think about CQC.

We worked in collaboration with a number of stakeholder groups, including professional bodies and the royal colleges, to publicise this

Figure 13: How would you rate the inspector's understanding of the type of care you provide?

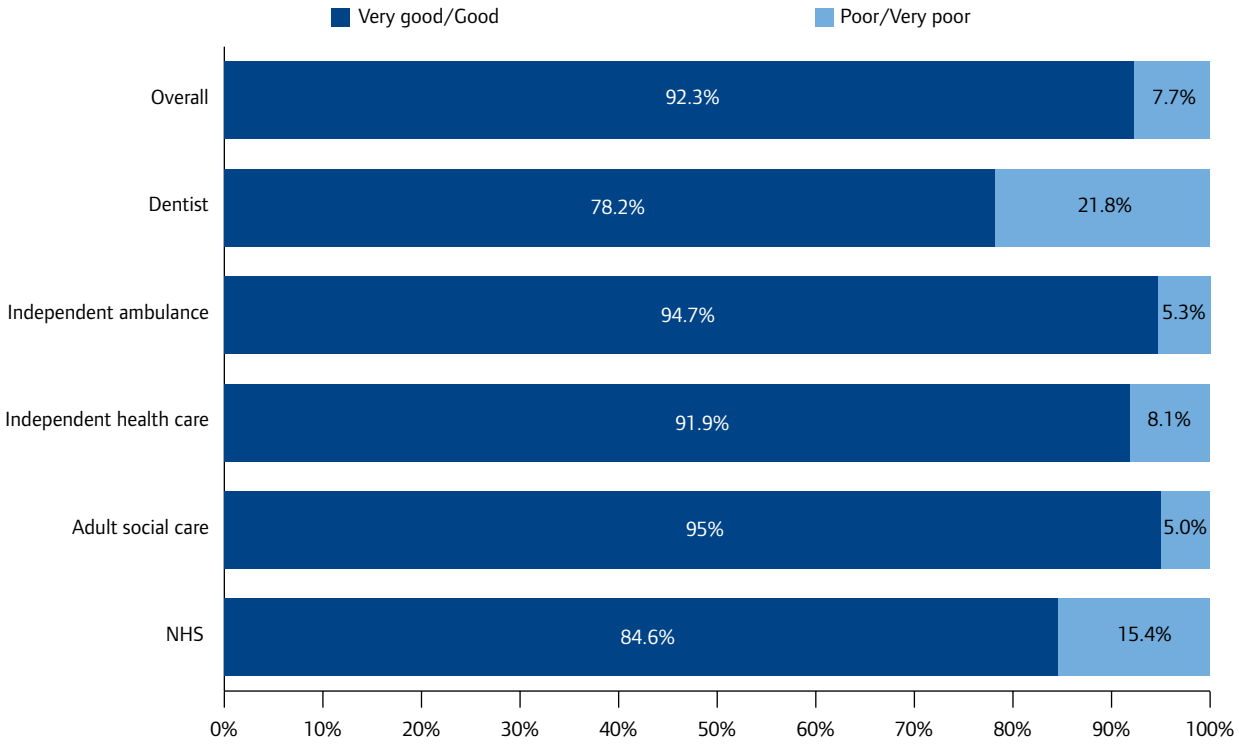


Figure 14: How is CQC doing at ensuring that all providers meet the essential standards of quality and safety?

	Very well	Fairly well	Satisfactory	Fairly poor	Very poor	Don't know
Ensuring that all providers meet the essential standards of quality and safety	**28.1**	**34.5**	**22.8**	**7.4**	**2.4**	**4.8**

survey and feed back the results. Although generally positive, the findings showed that professionals did not have the same level of understanding of CQC as providers' management roles – for example 73% understood the way we inspect compared to 96% of providers – and we therefore have work to do to bridge this gap.

Primary medical services

The end of March 2013 marked the end of bringing the fifth care sector – primary medical services (mainly GP practices) – into regulation. These providers have been a focus of intensive engagement since 2011.

We listened to the feedback we received from the sector through our primary medical service provider reference group and our stakeholder advisory group. This includes the British Medical Association, the National Association of Primary Care and the General Medical Council. We used the learning from the transition of previous sectors and the extra time we were given to register the sector to significantly improve the experience for primary medical services.

Case study – Our pilot of primary medical service inspections

We visited Sturminster Newton Medical Centre, which is a GP practice in Dorset, in July 2012 on a pilot unannounced inspection and spent a full day at the service. We found the centre to be compliant with all of the outcomes we assessed: 'consent to care and treatment', 'cooperating with other providers', 'safeguarding people who use services from abuse', 'supporting workers' and 'complaints'.

Our inspector, Alison Giles, who inspected the practice said: "All of the practice staff and lots of patients were happy to talk to me and give me their views. Patients said they felt staff supported one another and "you get the impression of a happy and professional team here".

"We met and talked with staff about being trained and supported to carry out their roles. They told us about mandatory training sessions and we looked at some training records. Staff were able to demonstrate they knew about whistleblowing, and told us the culture at the practice was open and supportive to all staff."

When asked about the inspection, Jane Dawes, Practice Manager at the medical centre, said: "I think it is important that CQC should be able to turn up at any time to do an inspection and receive a consistent response to the questions asked."

"Through the course of the day, the inspector asked to see some examples of paperwork and policies including training records, our consent policy and the minutes from some of our meetings. Most of the day was taken up with talking to people though – both staff and patients. Staff weren't just asked the usual things, but open questions so they could describe events and situations that had occurred in the practice and how they were dealt with. The inspector also spoke to five patients who were in the centre that afternoon waiting for appointments."

"At the end of the day we had a very helpful feedback session where the inspector talked us through areas where we could improve. She also picked up on minor things we had not noticed. After our experience, I would advise other practices not to worry too much. All of our staff were pleasantly surprised at just how straightforward it all was. As long as you are realistically complying with relevant guidance and your staff are aware and work within these guidelines you should have nothing to worry about from a CQC inspection."

Through their feedback, we were able to identify concerns they had about the process, and how best to reach and engage with them. As a result we published guidance for them much earlier in the process, using language that was more meaningful to them, and addressed issues immediately as they arose.

Online accounts

A key element to the positive relationship was the development of online GP accounts. This was the first major release of a key programme that will eventually mean CQC is 'digital by

default' – that wherever possible, all our services will be online. CQC's Digital First Strategy will help drive the development of high-quality digital services for all our key audiences.

The accounts meant that providers could apply for registration using an easy-to-use online form. This was developed with input from the provider reference group and stakeholder advisory group. It gave providers more flexibility and control over the completion of the form and gave them more options for the timing of their application. The form itself was simplified and made easier to use – for example, a provider that declared they were not meeting a number of standards could include a single composite action plan.

We completed the programme of registering GP practices. In total, there were 7,634 primary medical services registered with CQC on 1 April 2013. This number includes GP practices as well as GP out-of-hours services that were required to be registered from 1 April 2012.

Reducing the regulatory burden

Partnership changes

All previous health and social care regulators have struggled with responding to changes to the legal composition of a partnership registered as provider. Until now, we have managed this by requiring a fresh application when a new partner joins the partnership or an existing partner leaves. While this process was legally robust, it created a significant extra burden for providers and additional work for CQC.

Following extensive research and specialist legal opinion, we changed the way we register partnerships. New partnership applications, including those for all primary medical service providers, will result in a partnership condition being added to its registration. When there are changes to the partnership, an application to vary the condition can be made rather than a new application. This has benefits for providers,

but also for people who use their services, as there will be continuity of the providers and information about them.

Red Tape Challenge

The Cabinet Office launched the Healthy Living and Social Care theme of the Red Tape Challenge in November 2012, covering more than 500 regulations relating to public health, quality of care/mental health, the NHS and professional standards. The quality of care/mental health section covered regulations relating to CQC, health and social care and mental health.

The purpose of the Challenge was to identify which regulations should be scrapped or improved to boost growth and jobs and give health professionals more time to care for patients, without weakening public health safeguards. The Government response has been published, and we are looking at their recommendations.

Focus on Enforcement

At the same time, the Department for Business Innovation and Skills' Better Regulation

Executive launched the Focus on Enforcement review of adult care homes. This asked the care homes sector to say how the enforcement of regulation could be improved. CQC worked with the review team and the findings from it will contribute to the development of our strategy.

Registration services and customer support

The first point of contact for providers is our National Customer Service Centre. We have a dedicated team that has access to detailed information about registration, legislation, guidance and policy.

The team has, over time, developed expertise across a range of areas to enable the majority of queries to be answered at the first point of contact. In addition the team has ready access to a number of key policy, legal and strategy experts to whom complex, or out of the ordinary, queries can be escalated.

The team works from the premise that timely responses are essential to allow providers to progress applications. Eight-six per cent of registrations were completed by regional assessors within our business plan target of eight weeks, against a target of 90%. The figure for completing applications to change a registration within a target of four weeks was 74%, against a target of 90%. This was mostly driven by the inability of our systems to differentiate between those applications that were within our control and those that were the responsibility of the provider to complete. The two figures compared with 73% of all registration applications that were completed within target in 2011/12.

In 2012/13, we answered 96% of calls about mental health within 30 seconds (against a business plan target of 90%) and 84% of registration calls within 30 seconds (target 80%).

Provider fees

CQC has powers to set fees for providers under section 85 of the Health and Social Care Act 2008. Like all public bodies, we are required by Government to set fees in order to cover costs. We have progressively increased fees towards full cost, as activity and cost data has improved, while harmonising the fees schemes that we inherited.

We consulted on our proposals for the 2013/14 fees scheme in September 2012. In particular this addressed:

- Our strategic approach to the development of the scheme.
- Primary medical care providers, who are the last major group to come in to regulation.

In total 508 providers responded to the consultation and there was strong support for our strategic approach. We aim to achieve full cost recovery in all sectors by 2015/16. To engage providers more closely in the process, we have set up a fees advisory panel consisting of the major representative bodies and trade associations from each sector. This group has already begun to consider how these costs are put together and how we should approach incentives.

5

Our responsibilities in mental health and mental capacity

We strengthened our focus around the Mental Health Act and Mental Capacity Act Deprivation of Liberty Safeguards to protect the human rights of some of the most vulnerable people in society. People with a learning disability, whether they are detained or not, are a highly vulnerable group to whom CQC is committed to strengthening its protection.

In this section: Developing our regulatory model ■ Mental Health Act visits ■ Mental Capacity Act Deprivation of Liberty Safeguards ■ Restrictive practices

Our responsibilities in mental health are unique, but complex. They are set out in the following:

- Health and Social Care Act – where we inspect services and where our enforcement powers lie.
- Mental Health Act (MHA) – where we visit detained patients to protect their human rights.
- Mental Capacity Act (MCA) – including our regulatory work concerning people with a learning disability, dementia, etc.

We have made strides this year to make the way we work in mental health more efficient and effective.

Developing our operating model

Following feedback from the strategic review, we have worked hard to coordinate inspections between our compliance inspectors and MHA Commissioners. In November, we published a working agreement that outlined how inspection, registration and Mental Health Act monitoring teams will work together, especially relating to risk, information sharing and joint working.

The agreement states that, where possible, we carry out joint inspections. Also, staff may share information both during registration and ongoing monitoring, through formal channels such as the Quality and Risk Profile, Operations Intelligence provider reports and

MHA Operations managers' input on regional risk panels.

In the mental health sector, the Surveillance Team has started to analyse notifications of deaths of detained patients and are identifying establishments where there may be concerns about clusters of deaths.

Our Service User Reference Panel (SURP) is made up of people who are, or have been, detained under the Act. The panel gives us helpful information on conducting visits and helps to steer different projects in the right direction. Consultation with SURP members was a key factor that strongly influenced the revision of our MHA complaints policy in the year.

Case study – Working with the Service User Reference Panel

SURP members felt CQC's Mental Health Act complaints policy needed to be more user friendly, with less jargon and clearer messages on what CQC could do. Sarah Markham, one of the SURP members who helped with the revisions, said of the new policy, "Overall, it is a clear, concise, comprehensive and instructive document. It is evident that the SURP suggestions have been taken into account."

The SURP's suggestion that CQC produce a poster for hospital wards about Mental Health Act complaints was also taken up, and the poster is now available on our website.

Sarah said of her involvement with CQC, "I have found being a member of SURP empowering and positively challenging. It's good to be involved with similar minded people in trying to improve everyone's experience of mental health services."

We triaged 87% of MHA complaints within three working days (against a business plan target of 90%) and responded within 25 days to 71% of requests (target 90%).

As part of the consultation on our strategy review, we commissioned research into international models of monitoring mental health legislation to inform planning and development of its MHA monitoring. The research was undertaken in late 2012 and published by CQC in 2013.

NHS community mental health survey

In September 2012, we published our survey of more than 15,000 people who use NHS mental health services outside hospital, such as those offered by outpatient clinics, local teams providing crisis home treatment, assertive outreach, early intervention for psychosis, and generic community mental health services. It showed that there are still some people whose experience of care needs to improve, especially around areas such as help with physical health and day-to-day living.

Mental Health Act visits

The Mental Health Act (MHA) 1983 is the law for England and Wales under which a person can be admitted, detained and treated for mental disorder in hospital against their wishes. The MHA covers the processes of detention, rights of people while they are detained, how they can

be discharged from hospital and what aftercare they can expect to receive.

CQC's main duties under the MHA include:

- Visiting and interviewing in private people who are subject to the MHA to ensure their rights are upheld. This duty is carried out by our Mental Health Act Commissioners.
- Appointing Second Opinion Appointed Doctors (SOADs) and managing the SOAD service.
- Investigating or facilitating the resolution of complaints made by detained patients.
- Adjudicating decisions to withhold mail in high secure hospitals.

There were 96 MHA Commissioners as at 31 March 2013. They work a minimum of two days a month and come from a variety of clinical and non-clinical backgrounds. Their visits comprise the following areas:

Interviews with detained patients – These focus on whether the patient's rights are protected under the Act and whether there are concerns about their human rights, involvement, equity, and participation in their treatment. Individual concerns and issues are raised with the ward on the patient's behalf. Commissioners find out whether patients consider their treatment satisfactory or not. They will only interview those patients who wish to be interviewed, but they are not restricted in their ability to observe the care of any detained patient on the ward.

Document review – This addresses a patient's legal issues and looks at the arrangements made under care plans, risk management plans and whether the person is aware of the rights afforded to them under the Act. It helps us to work out whether a patient is detained legally and also whether they are aware of their legal rights. The patient is under no obligation to consent to their notes being reviewed.

Ward inspection – We aim to make sure that the wards provide the best environment and care for patients that are detained. As part of a ward inspection visit, the MHA Commissioner will also assess the environment and culture on a ward.

Second Opinion Appointed Doctor Service
The Mental Health Act introduced the Second Opinion Appointed Doctor Service to safeguard the rights of patients, detained under the Act, who either refuse the treatment prescribed by the approved clinician or are deemed incapable of consenting.

The 2008 amendments to the Act introduced additional safeguards relating to community treatment orders and electroconvulsive therapy.

The role of the Second Opinion Appointed Doctor (SOAD) is not to give a second clinical opinion; it is to decide whether the treatment recommended is clinically defensible and whether proper consideration has been given to the views and rights of the patient.

SOADs are independent consultant psychiatrists. CQC is responsible for appointing them and managing the service.

In 2012/13:

- 1,090 MHA Commissioner visits carried out
- 57 joint visits with Experts by Experience – an increase this year
- 5 visits in connection with 11 Section 134 adjudications (concerning withheld mail).
- 132 SOADS
- 13,522 requests for a second opinion; 2,815 of these visits resulted in a change of treatment plan
- 712 (70%) SOAD medicine visits carried out within 10 working days of receipt of request

Case study – The work of our Mental Health Act Commissioners

In line with the Mental Health Act Code of Practice, our Mental Health Act Commissioners look for evidence that patients' care plans and risk assessments have considered the minimum restrictions on patients' liberty, their diverse needs, and their own views about their treatment.

On a visit to an acute psychiatric admission ward in March 2013, we had significant concerns about the wording in one patient's care plan, which stated that:

"The following behaviours are not acceptable… 'no singing in the day areas in my own language… when I want something to be dealt with I won't keep asking the same thing either of one member of staff or of different members of staff… nursing staff may speak to (Patient A) with regards to his behavior… the instructions he receives from nursing staff should be adhered to.'"

The patient told us that his care plan was "nonsense"; but that he had to sign it: "I had no choice. They said that it is going to look good for you if you are abiding."

We raised the following concerns in our feedback to the NHS trust:

- Although the care plan was largely written in the first person, it appeared to have been written by staff for the patient rather than with him.
- The reasons for making the behaviours unacceptable were not given (nor was there any route for appeal). We struggled to understand, for example, why he should not sing in the day areas in his own language.
- The care plan seemed to make an assumption that nursing staff are always right. It may be, for example, that the patient had good reason to ask staff for something repeatedly.
- The statement that he was to adhere to instructions from nursing staff appeared both dangerous practice and oppressive. Patients should be able to talk with their care team, and patient feedback should be valued and encouraged.

We continue to monitor the application of the Code of Practice principles in this unit, but expect practice to improve.

Mental Health Act annual report

CQC publishes an annual report on our monitoring of the Mental Health Act. CQC has now produced three such reports, the most recent at a Parliamentary launch in January 2013. During 2012 CQC established an advisory group of external experts, including Experts by Experience, to support the development of this report.

The group informed CQC's work on the objectives, priorities and impact of its MHA monitoring more broadly as well as in relation to its reporting. We also strengthened the involvement and contributions of people with direct experience of detention under the MHA.

The overarching theme of the most recent report was how to embed dignity, recovery and participation in practice when people are subject to compulsory care and treatment. We found that some hospitals and wards were doing a very good job in treating patients with dignity and respect. But most of the concerns highlighted in previous reports remain, particularly in respect of care planning, patient involvement and consent to treatment.

In particular we remain concerned that cultures may persist where control and containment are prioritised over the treatment and support of individuals. In this kind of culture, 'blanket rules' can become institutionalised.

Mental Capacity Act Deprivation of Liberty Safeguards

CQC has a duty to monitor the operation of the MCA Deprivation of Liberty Safeguards in England. We do this as part of our normal inspections of care homes and hospitals.

The MCA is a very important mechanism for protecting the rights of people who do not have the ability (mental capacity) to make certain decisions for themselves. It provides guidance to people who need to make decisions on behalf of someone else. It sets out the principles that should guide such decisions, including the need to act in the person's best interests and to achieve the desired outcome in ways that put the least restriction on the person's rights and freedom of action.

We have taken a number of steps to strengthen the relevant skills and knowledge of compliance inspectors in this area.

We devised an e-learning package for inspectors, and related learning has been included as an important and integral part of inspectors' induction. We also worked to improve the awareness of the staff who assess applications for registration.

We published our third annual report on the Safeguards in March 2013. We found that the umbrella legislation of the Mental Capacity Act is not well understood or implemented in practice, and that the implications of the Safeguards in practice are not easy to understand. The use of restraint is not always recognised or recorded as such. Because of this it is not easy to monitor. Also there is wide variation in how local authorities carry out their functions as supervisory bodies.

We said that the highest priority, therefore, for health and social care in operating the Deprivation of Liberty Safeguards system is to improve understanding and practice of the Mental Capacity Act. This is also true for CQC both in its role as regulator and in monitoring the use of the Safeguards.

Supported living

CQC is aware through its registration processes that a number of settings that were previously registered as care homes have changed their legal status to become supported living settings. Together with new schemes, they offer an alternative to care homes which at their best offer a highly personalised approach to delivering housing, care and support.

However, some schemes offer a service to people whose capacity to take relevant decisions can be compromised, and who can lead highly directed lives. Sometimes the level of direction and associated restriction of liberty approaches and even surpasses the characteristics commonly associated with deprivation of liberty.

CQC's deprivation of liberty monitoring duties do not extend to supported living settings, and information about the extent of restrictive practices and deprivation of liberty,

whether appropriate or not, is hard to gather and understand. In the context of CQC's responsibilities under the OPCAT National Preventative Mechanism to monitor deprivation of liberty in all health and social care settings, there is therefore a gap in CQC's current ability to undertake this function equitably across all relevant settings.

Restrictive practices

MHA Commissioners used CQC's first thematic probe to gather information on restrictive practices in inpatient mental health wards and promote positive practice by care staff. Running between 3 December 2012 and 31 March 2013, MHA Commissioners and providers completed short surveys during routine MHA visits to inpatient wards. The probe looked at

- The right of non-detained patients to leave the ward
- The use of blanket rules and restrictions
- Appropriate security arrangements
- Staffing
- Police presence on the ward.

We will publish the findings in our 2012/13 MHA Report.

6

Building a high-performing organisation

We keep striving to be a higher-performing organisation. We made significant improvements in the year to ensure CQC is well run and well led, has an open culture that supports its staff, and is focused on its customers.

In this section: Open culture and good leadership ■ Investing in our people ■ Meeting our equality duties ■ Recruitment and operational improvement ■ Costing corporate governance ■ Complaints ■ Information requests

Open culture and good leadership

Staff survey and action plans

We carried out CQC's second staff survey in summer 2012. It showed improvements in many areas: employees said they were more likely to be proud to work for CQC (positive score up 16%) and recommend CQC as a good place to work (positive score up 17%). The biggest improvements were in staff saying that they have the opportunity to learn, develop and grow their skills.

The balance of results was positive, with the overall employee engagement score improving from 41 in 2010 to 55 in 2012. This compares with an average score in the public sector of 56.

However, perceptions of morale in CQC had fallen. Some of the least positive scores were around communication and managing change. The results were aired at the September 2012 public Board meeting and a corporate action plan developed. The staff forum, diversity groups, home workers forum, Executive Team, the Board, communications, HR and Operations were all involved to ensure maximum engagement across CQC.

Action plans were also developed at directorate and team level using local scorecards, supported by a network of staff survey champions and HR.

We checked progress with a pulse check in February 2013. A quarter of staff were selected at random to take part. The top results were 'My line manager is open to my ideas and suggestions' with a 76% positive score and 'I have a clear understanding of my contribution to achieving CQC's objectives' also 76% positive. The question with the largest increase was 'I understand the reasons why organisational changes are made', up to 65% from 41%.

Perceptions of morale in CQC stayed the same, at 16% positive. However there has been a significant shift in the number of staff scoring neutral rather than negative. The new question in the pulse check 'My personal morale is good' scored significantly higher at 55% positive.

Other development areas include 'I believe changes are effectively implemented in CQC' at 19% positive (up from 18%) and 'I feel communications across different parts of CQC are effective' 28% positive (up from 24%).

These scores show that we are continuing to make progress in a range of areas but that there is still scope for significant improvement. We will have a continued focus on improving organisational morale.

Action on bullying

CQC is committed to zero tolerance of bullying and harassment – an issue raised in the 2010 staff survey. We launched two new initiatives in 2012/13 to help tackle this issue.

In March 2013, we introduced a dignity at work scheme. Anyone with concerns about bullying and harassment can talk informally to one of 25 members of staff who are specially trained, dignity at work advisers. The advisers provide confidential support and advice, regardless of whether the employee is making a complaint, being accused, or is a witness to bullying.

We also appointed an independent consultant, Sarah Hunter, to look in depth at bullying and harassment in CQC and see how we can build a strong anti-bullying culture.

Internal communications

We made significant efforts to improve communication and work with all staff to develop our plans and ensure staff understand how we will change in the future. We continued to improve our intranet and have launched discussion forums so that staff can join debates and discussions. We also set up a reference group of staff from across CQC to provide feedback and challenge on our internal communications arrangements.

In 2012 we carried out a major engagement exercise with our staff to get their views on our strategy and our development plans. We will continue this level of engagement and discussion with staff as we move forward to implement our strategy.

Staff forum

CQC's staff forum continued to provide a foundation for a constructive relationship between all staff (including temporary and seconded staff) and CQC's management.

The forum enables staff to express their opinions and influence thinking on issues that affect them. Agenda items can be raised by staff or management, covering a broad range of topics including operational effectiveness, working conduct and training. Alongside the trade unions' Joint Negotiating and Consultation Committee, the forum acts as a formal representative body for staff consultation in CQC.

Leadership development

During 2012/13, we strengthened initiatives to promote better leadership across the organisation. Monthly leadership events

focus on key themes, for example on business planning and skills development for the leadership group. In addition, leadership principles were introduced in the performance development review (PDR) process for all line managers.

In 2013, all leaders within CQC will attend our Management Development module focused on effective two-way performance and development dialogue with staff.

CQC managers have also been invited to take part in the 2013 Hubbub leadership and talent development programme. CQC joined this collaborative leadership and talent development programme in 2012. Hubbub aims to create a culture of collaboration across arm's length bodies in developing the skills and behaviours of middle and senior managers.

Investing in our people

In 2013, we embarked on the Investors in People (IIP) process, focusing initially on the Core Standard and Health and Well-Being awards. A diagnostic has also been undertaken against the Diversity in Business Accreditation (DiBA) award. We are now focused on driving forward the actions needed for full IIP and DiBA accreditation.

Frontline training

We provided staff with a range of learning and development opportunities during 2012/13 to underpin and support the work they do. This training was developed and delivered with the support of key stakeholders across CQC and aligned to the significant changes to methodology, systems and processes. The training, which was mandatory to frontline staff, included:

- Induction for new inspectors
- Introduction to CQC's registration processes
- Mental Capacity Act and Deprivation of Liberty Safeguards library.

We continued to ensure that our staff receive effective training in safeguarding. In 2012/13 all staff new to CQC received training in basic awareness and all new inspectors received a dedicated day of safeguarding training.

Decision-making evaluation

As part of our internal programme of evaluation, we carried out an evaluation of decision making in our compliance process. We held focus groups with inspectors, and used a panel, consisting of National Professional Advisors, compliance managers and peer inspectors to review decisions made during inspections. The evaluation highlighted a number of areas where we can work better to support our frontline staff, and continue to improve how we test and assure the quality and reliability of our regulatory judgements. This work will be a priority in our 2013/14 evaluation programme.

Dementia awareness

As dementia becomes more common in our ageing population, we are keen to make sure that CQC staff have the knowledge, skills and support to understand the impact of dementia on people's experience of care. We also want to support our staff, on a personal level, in raising

awareness of a condition which is likely to affect the lives of many of us.

We put together a development programme for staff in conjunction with the Alzheimer's Society. It started in March 2013 with a basic awareness course, with further specialised training to follow that is tailored to the needs of inspectors and registration assessors. In addition, staff were given information on how to become a Dementia Friend through the Alzheimer's Society.

Staff excellence awards

Our staff excellence awards continued to thrive, identifying role models for our inclusive values and behaviours. From April 2013, the scheme is being enhanced with a staff selection panel to recommend winners to the Executive Team and a range of new categories, for example leadership, engagement, self-development and growth. We are also introducing a team category as part of our drive for a high-performing team culture.

Meeting our equality duties

We have a duty under the Equality Act 2010 to set and publish equality objectives every four years. To ensure progress is made in achieving the objectives, in 2012/13 we improved our processes to make sure that equality objectives are embedded in organisational planning and reporting – including ensuring that ownership for the objectives is clear in business plans and that progress is reported to the Board every three months. Progress on specific equality objectives is covered in relevant sections of this report.

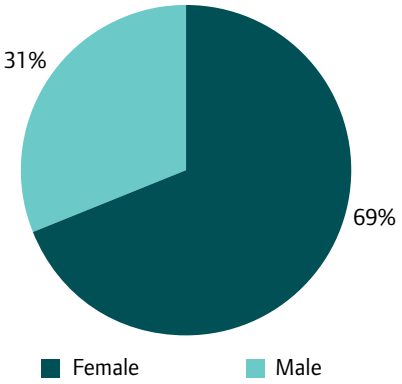
We also have a duty to provide equality information about CQC staff and about equality in our functions. In December 2012, the Equality and Human Rights Commission published a national review of the equality information provided by all public sector bodies. The review report used CQC as the good practice example for all national bodies, saying:

"CQC has published extensive equality information, including equality objectives, information about its workforce and about the people affected by NHS policies and practices. It has several ways to ensure that people can access documents, including equality information, in alternative formats or languages."

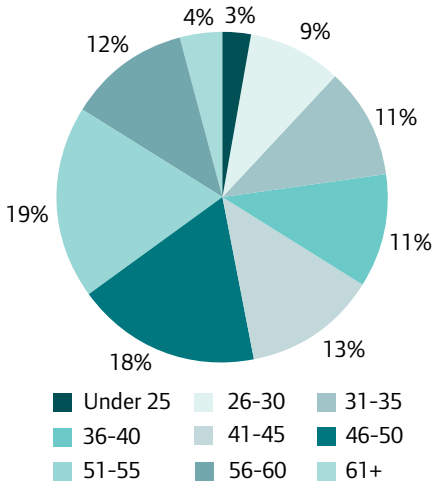
The report concluded that "CQC is a good example of a national organisation displaying good practice and acting as a role model towards the organisations that it regulates." We built on our reporting last year with an updated equality information report, called Equality Matters, in January 2013.

CQC staff profile as at 30 September 2012

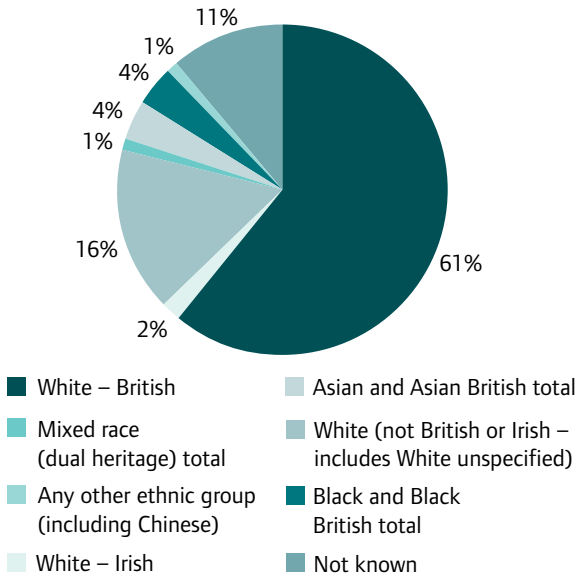
Gender



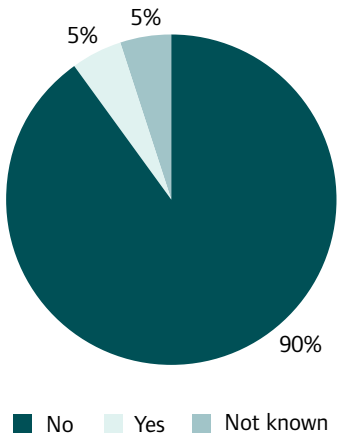
Age



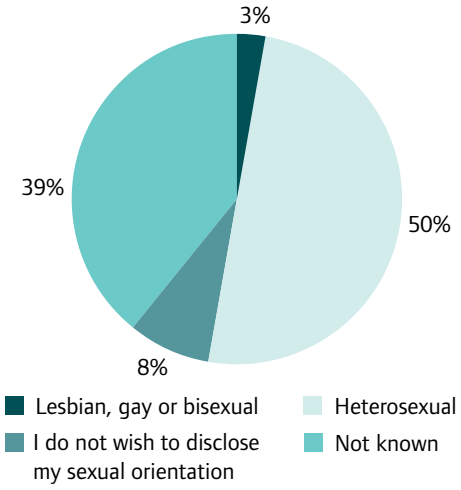
Ethnicity



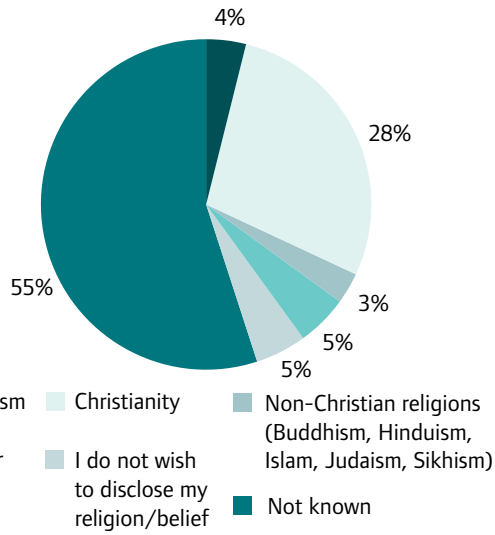
Disability



Sexual orientation



Religion and belief



Action to promote equality

We have three equality objectives relating to our staff – concerned with ensuring a diverse workforce at CQC, eliminating harassment and treating staff equally, and staff learning around equality and human rights. The Equality Matters report set out our progress on these objectives. In addition to the work described above on the Diversity in Business Award and on tackling bullying, we:

- Continued support for the CQC staff Disability Equality Network; the Lesbian, Gay, Bisexual and Transgender staff network; and the Race Equality Network.
- Analysed the staff survey by equality characteristics and carer status, and engaged with the networks and other staff to build an action plan based on the results.
- Signed up to the 'Charter for employers who are positive about mental health', part of the Mindful Employer initiative. This aims to increase awareness of mental health at work and provide support for employers in recruiting and retaining staff.
- Worked to improve the staff equality monitoring data that we hold, including a request to all staff to update their monitoring information.

- Worked with the Race Equality Network on career progression for Black and minority ethnic staff to help address the under-representation of Black and minority ethnic staff at higher grades.
- Supported 55 disabled staff who require reasonable adjustments on an ongoing basis through Personal Enabling Plans.

Stonewall's Equality Index

CQC jumped 23 places to 133rd in the Stonewall Workplace Equality Index. We got a score of 125, just 12 points outside the top 100 employers. The index is a tool for employers to measure their efforts to tackle discrimination and create inclusive workplaces for lesbian, gay and bisexual employees. CQC entered the index two years ago in 278th and was placed 157th last year. This year's rise means we have jumped 145 places in just two years. This is a significant achievement, especially as the number of employers in the index is growing and every year the competition gets more challenging.

Recruitment and operational improvement

Recruitment to the additional inspector posts needed to deliver the 2012/13 inspection programme did not progress as quickly as we expected. However, by the end of the year, the average vacancy rate for inspectors had reduced to zero and a full complement of 955 inspectors was in place. The vacancy rate for the organisation as a whole reduced from 14.8% at the end of quarter 1 to 2.2% at the end of the year.

To address the temporary gap in frontline resources, we brought in extra capacity through overtime for existing staff and by employing a cohort of temporary inspectors. These consisted of more than 150 care professionals who had extensive experience in care services and brought a range of expertise for inspection teams to draw on.

The programme was in line with CQC's intentions to tailor the way we regulate different types of organisations and making greater use of clinical experts on inspections. The temporary inspectors were thoroughly inducted, worked in teams led by CQC staff and generally carried out inspections of low risk services.

Operational Improvement Team

In a high-performing organisation, striving for continuous improvement is key. We established an Operational Improvement Team to focus on the essential work of our operational staff and drive forward improvements and efficiency. The team works with frontline staff to identify inefficiency and suggest improvement, and then implement changes in partnership with other directorates.

In August 2012, the team implemented a new approach to planning and reporting on inspection activity. Through ongoing engagement with inspectors, we built a process that has saved inspectors, on average, a day on each inspection. These system changes, supported by a fully integrated induction programme, have also reduced the time it takes new inspectors to familiarise themselves with the process.

Deployment of resources and workforce effectiveness

During the year, inspectors started recording their time through a timesheet system. We have used this information to set benchmarks for how long inspections in each sector should take. It also helps ensure that we have appropriate capacity, that individual inspectors have manageable portfolio sizes, and that they have sufficient time for important activities such as following up safeguarding alerts and training.

Costing corporate governance

A costing exercise was carried out through the Audit and Risk Assurance Committee to work out the cost of corporate governance as a percentage of total budget. The purpose was to enable CQC to track its governance costs over time and help it demonstrate value for money.

There are a number of practical challenges in costing corporate governance, particularly in a public sector organisation where there is no agreed costing model to use. Some costs, such as the cost of disclosures to Parliament, are difficult to derive because they are spread across a number of Directorates.

As a percentage of total expenditure at 2011/12 levels, we calculated that corporate governance activity during 2012/13 including one-off costs amounted to 1.89%; excluding one-off costs it was 1.38%. The exercise will be repeated from year to year to track costs and benchmark against other organisations when possible.

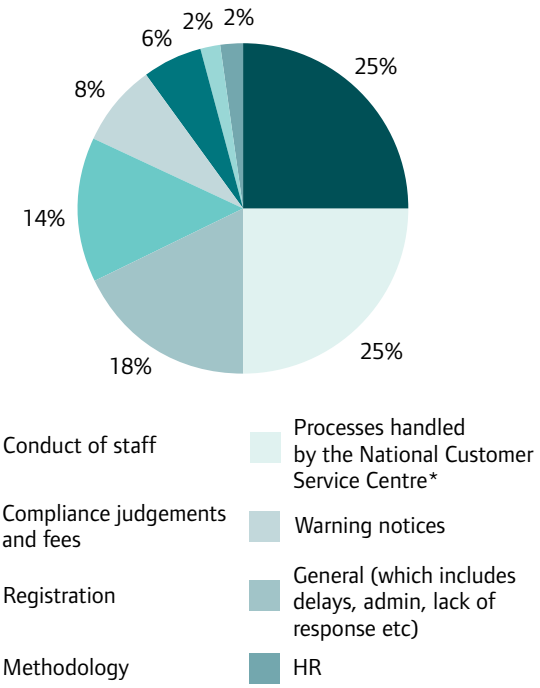
Complaints

We see complaints as an important way for us to learn and improve. We are committed to providing the best possible service; however sometimes things can go wrong.

Our complaints procedure is in two easy-to-follow stages. In Stage 1, CQC line managers should resolve the problem. In a complainant is not satisfied with a Stage 1 response, they can ask for a Stage 2 review by the specialist CQC Corporate Complaints Team (CCT). If still not satisfied, the complainant can approach the Parliamentary and Health Service Ombudsman (PHSO).

Complaints are recorded and tracked and the National Complaints Manager provides feedback to the Executive Team and the Board at regular intervals. There were 414 Stage 1 complaints in 2012/13, a reduction from the 495 complaints received the previous year, and 20 of these were upheld. The table below shows a breakdown of these complaints by topic. Of the total, 83 (20%) went to Stage 2 and eight were upheld.

Stage 1 complaints in 2012/13



*Note: complaints handled by NCSC are not exclusively complaints about the NCSC, as the Stage 1 team will respond directly to complainant if they can.

In 2012/13, we saw an increase in the number of providers making complaints. Many of these including complaints about:

- The content of their inspection reports; in particular the judgements made by individual inspectors.

- Being issued with a warning notice; they were often unhappy that the notice was accompanied by a press release.
- Having to deal with several members of staff about the same issue; due to the nature of inspection work, inspectors are not always available to provide a quick response.

There was a marked increase in complaints made about CQC following the Panorama programme about Winterbourne View hospital. Appearances by senior managers at the Francis public inquiry, the Health Select Committee and publicity surrounding the Department of Health capability review as well as the publication of the Francis report also sparked an increase in complaints.

CQC commissioned an independent review from Grant Thornton to examine CQC's regulatory action at University Hospitals of Morecambe Bay NHS Foundation Trust, following a specific complaint, and their report was published in June 2013.

Lessons learned and improvements made

Our communication with complainants has improved and handling of complaints now has a higher profile within the organisation. The quality of our responses has improved. However work is continuing with all staff groups to ensure that responses are factual, sympathetic and informative.

Several areas of the business are working together to look for a solution to the issue of complaints about judgements made during inspections. We are looking to simplify the system for providers so that they will not have to make representations and a complaint when they are unhappy with the outcome of their inspection. We have communicated with providers on this matter and we have seen a fall in numbers this year compared with last year.

Unnecessary and unjustified delays in our actions result in inconvenience to others.

The importance of responding to complaints in a timely and robust manner has now been recognised across the organisation. Appropriate and measurable standards for the timelines of responses to all correspondence including phone calls, emails, letters, have been agreed and improvement in this area is becoming apparent.

Training on managing complaints has been added to induction and management training across the organisation. The training includes responding to and learning from complaints.

We have simplified our messaging and provided more information for members of the public about how they can pursue a complaint about the services registered with us. This has resulted in a decrease in the number of people who make these types of complaints.

Information requests

For the first time since the formation of CQC, the number of requests for information received and handled by our Information Access Team declined. These are requests made under the Freedom of Information Act 2000 (FOIA) and section 7 of the Data Protection Act 1998 (DPA). The team also handles aspects of information sharing with other public bodies where those issues are particularly complex or fall outside of the scope of existing policies and agreements.

This decline in numbers appeared, at least in part, to be as a result of significant improvements in the quality and amount of information that we proactively publish on our website and elsewhere. However, the Information Access team reported a general increase in the complexity of the requests received, as understanding of CQC's work increases and public interest in how we perform our functions – and the information that we hold – also rises, resulting in more detailed and searching requests for information.

Of the 1,144 requests received, 96.9% were responded to within deadline in 2012/13 (compared with 98.7% of 1,403 in 2011/12). The proportion of FOIA and DPA requests where the applicants requested an internal review (reconsideration of CQC's decision on disclosure) was 2.7%, and in 1.3% of cases the complaint was fully or partially upheld. One DPA request and no FOIA requests were subject to a complaint investigation by the Information Commissioners Office.

The number of requests that related to the sharing of information with other regulators and public bodies was also reduced by improved guidance and training for our inspection staff, and through detailed policies and information sharing agreements that allow front line staff to make autonomous decisions on sharing information (with access to specialist advice as required). We are reviewing our agreements on information sharing with other bodies to make sure they reflect the rapidly changing sector and remain robust and useful.

Our Board

David Prior, Chair

After graduating from Cambridge University with an Exhibition and MA in Law, David qualified as a Barrister in 1976, and for the following four years worked as an Associate with Lehman Brothers and Lazard Frères in London and New York.

David spent the next 15 years working as a Senior Executive within British Steel and a number of private companies. In 1997, he was elected as a Member of Parliament for North Norfolk and went on to be Vice-Chairman and Deputy Chairman and CEO of the Conservative Party. He was also on the Select Committee for Trade and Industry.

In 2002, David became Chairman of the Norfolk and Norwich University Hospital and a Director of Aurelian Oil and Gas Plc. He is also Chairman of the Governors of Ormiston Victory Academy and Chairman of the proposed Sir Isaac Newton Free School.

David Behan, Chief Executive

David was born and brought up in Blackburn in Lancashire and graduated from Bradford University in 1978. He was awarded a CBE in 2003, and, in 2004, was awarded an Honorary Doctorate in Law by Greenwich University.

He was previously the Director General of Social Care, Local Government and Care Partnerships at the Department of Health, the President of the Association of Directors of Social Services, and the first Chief Inspector of the Commission for Social Care Inspection.

From 1996 to 2003, David was Director of Social Services at London Borough of Greenwich as well as a member of the Greenwich Primary Care Trust Board and the Professional Executive Committee.

David Behan is a member of the CQC Board.

Anna Bradley, Healthwatch England Chair

Anna is a long-standing consumer advocate, having worked at Which? for many years, and was formerly Chief Executive of The National Consumer Council.

She has long experience as a regulator, having been a director at the Financial Services Authority and the Chair of two professional regulators – an organic certification body and the Ofcom Consumer Panel.

She is Chair of Healthwatch England, an independent committee of CQC.

John Harwood

John Harwood is a former senior civil servant and local authority chief executive. He retired in 2008 from the Food Standards Agency where he was the Chief Executive. He served for almost twenty years as the Chief Executive of Lewisham Borough Council and of Oxfordshire County Council.

In 2000, he moved to central government to be the founding Chief Executive of the Learning and Skills Council. He spent 2004 as the interim Chief Executive of Cumbria County Council before later moving to the FSA.

John Harwood is Chair of the Stakeholder Committee and the Audit and Risk Assurance Committee. He also sits on the Remuneration Committee (board sub-committees).

Steve Hitchins

Steve has worked in both private and public sectors, running a manufacturing engineering company, leading Islington Council and holding the role of Vice-Chair at Islington PCT.

He also served as a board member of the London Development Agency, assembling the land for the 2012 Olympic sites.

He is now Vice-Chair of Newlon Housing Trust and Chair of Juvenile Diabetes Research Foundation, a charity which raises money to find a cure for type 1 diabetes. Steve contracted type 1 diabetes over 40 years ago.

Kay Sheldon

Kay Sheldon was a Mental Health Act Commissioner for 11 years and a member of the Mental Health Act Commission Board for five years.

She brings personal experience as a user of mental health services to CQC and she has been involved with a variety of user-led initiatives in both the statutory and voluntary sectors.

Kay was a Trustee of Mind for five years and prior to that she was Co-Chair of Mind Link, Mind's service user network.

Kay Sheldon is also a member of the Remuneration Committee (a board sub-committee).

In addition to the Board members above, the following non-executive directors were appointed in June 2013.

Professor Louis Appleby

Professor Louis Appleby is currently National Clinical Director for offender health, having been National Director for Mental Health from 2000-2010. He is Professor of Psychiatry at the University of Manchester. He developed the national suicide prevention strategy for England.

Camilla Cavendish

Camilla Cavendish is an award-winning journalist, Associate Editor of the Sunday Times and is currently leading the Cavendish Review, an independent review into the training and support of healthcare assistants. She has been an analyst at McKinsey & Co, Chief Executive of the South Bank Employers' Group and assistant to the Chief Executive at Pearson Plc.

Paul Corrigan

Paul Corrigan is a former health policy advisor to Tony Blair and former special advisor to Alan Milburn and John Reid. He is Adjunct Professor at Imperial College Institute of Global Health.

Dr Jennifer Dixon

Dr Jennifer Dixon is Chief Executive of the Nuffield Trust and has just completed a review into ratings for health and social care. She is a former member of the Healthcare Commission board, a former advisor to the NHS chief executive, and the former Director of Policy at the Kings Fund. She is also a fellow of the Royal College of Physicians.

Michael Mire

Michael Mire is currently a senior partner at McKinsey & Company, where he has over 30 years of experience. He has focused on retailing, financial services and transformation. He is retiring from McKinsey this year.

Our Executive Team

Paul Bate, Executive Director of Strategy and Intelligence

Dr Bate has worked at the centre of policy and delivery on health for more than 10 years. He joined CQC from Downing Street, where he was the senior policy adviser on health and adult social care to both the Prime Minister and the Deputy Prime Minister.

Allison Beal, Director of Human Resources

Allison has worked in the public sector for over 20 years, after initially joining Customs & Excise on their Management Development Programme.

Before joining CQC, she held a number of senior posts in government departments and agencies including an Executive Director post with responsibility for Finance and HR in another Health Sector ALB.

Allison has extensive experience of delivering major and complex change programmes.

Nick Blankley, Interim Director of Intelligence

Nick Blankley has had an NHS career spanning over 20 years in informatics and general management. More recently he has delivered independent consultancy and advice to enable organisational change and improvement.

During his time in the NHS, he worked across all care sectors at organisations in London, the South West and the Midlands. Over half of Nick's NHS career was spent as an executive director.

Since leaving for the world of consultancy in 2004 he has completed a wide range of testing assignments in both the public and commercial sectors.

Louise Guss, Director of Governance and Legal Services

Louise is a solicitor who commenced her career in private practice firm Dickinson Dees before moving into the public sector within the legal departments in Sunderland City and Durham County Councils. She has been in practice for 19 years.

She specialises in the law in relation to social and health care and in the provision of corporate advice and risk. She retains an active interest in mental health, human rights, child protection, education law and practice and alternative dispute resolution.

Louise is a member of the Chartered Management Institute and the Women's Solicitor Association. She also has a MBA and Post Graduate Diploma in Management and is a qualified Counsellor.

Philip King, Director of Regulatory Development

Philip has over 20 years of experience of working in the health care sector and other associated fields. He has a twin professional background as a nurse and a barrister and has worked for the NHS in a number of senior posts in provider and commissioner roles.

Immediately before joining CQC, he was Director of Nursing and Governance in a NHS Foundation Trust. Philip also has experience of working in policy and representation in the British Medical Association, the Royal College of Nursing and the Law Society where he was a policy advisor on law reform related to mental health, mental capacity and disability issues.

Philip was one of the team of lawyers at the European Court of Human Rights who successfully represented a person with a learning disability. This case contributed to the call for legislation that resulted in the implementation of the Mental Capacity Act 2005.

John Lappin, Director of Finance and Corporate Services

John has previously held a number of senior finance roles in both private and public sectors including PricewaterhouseCoopers, Ladbroke Group, Rexel and Parcelforce, and he was Finance Director at Royal Mail Letters. Most recently he was Group Finance Director of social housing provider Genesis Housing Group. He qualified as a Chartered Accountant at Pricewaterhouse Coopers.

He has extensive experience of major change management programmes in organisations, efficiency reviews and transformation programmes and has been engaged with the Department of Health in moving non-core activities to shared service providers.

Hilary Reynolds, Director of Change

Hilary has joined CQC on secondment from the Department for Work and Pensions, where she has been responsible for benefit delivery and welfare reform implementation, and will have a crucial role in leading and shaping our change programme.

Amanda Sherlock, Director of Operations

Amanda joined CQC from one of the predecessor organisations, the Commission for Social Care Inspection, where she was Regional Director for the South East. With a professional background as an Occupational Therapist, her career to date has included senior management roles in health, regulation and the NHS Executive, including leading the transition programme to establish national regulatory bodies.

Management commentary

1. Review of activities

In 2012/13 our key achievements were:

- Delivering our programme of scheduled, responsive and follow-up inspections of providers of health and adult social care services. In total, 35,371 inspections were carried out across:
  - **NHS services** (including hospitals, NHS trusts and foundation trusts, ambulance services, and community services etc).
  - **Independent health care services** (including hospitals, clinics and private ambulance services).
  - **Adult social care services** (such as care homes, nursing homes, and home-care agencies).
  - **Primary dental care services**.
  - **Independent out-of-hours medical services**.
- Registering primary medical care services. By end of March 2013, CQC had registered approximately 7,600 primary medical care providers (about 8,600 locations) that will be regulated from 1 April 2013.
- Consulting on a new strategy for CQC, engaging across the sector and with people using services, considering their responses and planning for the new strategy which was published in April 2013.
- Delivering a number of changes and improvements within a scrutiny review action plan, incorporated in our 2012/13 business plan.

2. Our priorities for 2013/14

The CQC Business Plan for 2013/14 sets out CQC's eight key priorities:

- Improve assessment and judgement of all the services we regulate by appointing a Chief Inspector of Hospitals, a Chief Inspector of Social Care and Support and considering the appointment of a chief inspector for primary and integrated care.
- Improve the safety and quality of care in NHS acute hospitals and mental health trusts by changing the way we inspect them.
- Identify, predict and respond more quickly to services that are failing or are likely to fail by using data, intelligence and evidence in a more sophisticated and transparent way.
- Improve our understanding of how well different care services work together.
- Work better with other regulators and partners to improve the quality and safety of care.
- Publish better information for the public – including organisation ratings – to improve transparency.

- Introduce a more rigorous test for organisations applying to provide care services, which includes ensuring that named directors and managers commit to meeting the standards and tests their ability to do so.
- Build a high-performing organisation that is well run, has an open culture that supports and enables its staff and is focused on its customers.

We will continue to carry out our programme of unannounced inspections in all the sectors we regulate as we make these changes.

3. Financial performance and position

The following table summarises CQC's financial performance, with further detail shown in the section on financial statements:

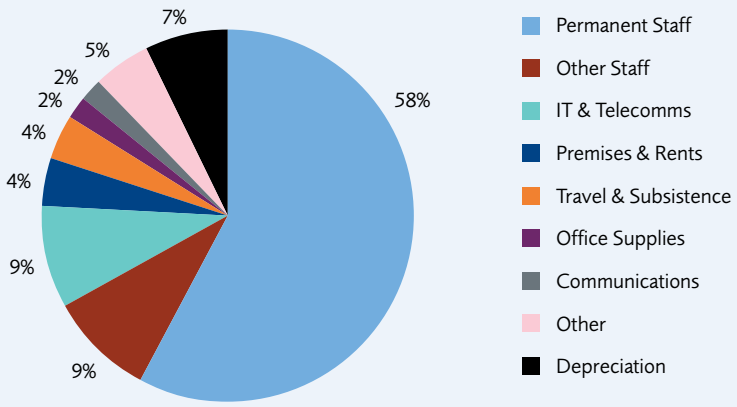
	2012/13 £m	2011/12 £m	Change £m	Change %
Expenditure	166	149	17	11
Income	(93)	(88)	(5)	(6)
Net expenditure	**73**	**61**	**12**	**20**
Capital expenditure	11	12	(1)	(8)

Revenue expenditure: £166m

Our revenue expenditure has increased £17m year on year. The main component of this was staff cost which has increased by £16m.

- This is mainly due to CQC increasing frontline inspectors to 955 full-time equivalents.
- This however took longer than expected and CQC brought in extra capacity through overtime for existing staff and by employing a cohort of temporary inspectors. Total staff costs were however within budget for the financial year.
- Within staff costs CQC incurred an increase of £1m in relation to the annual valuation of Local Government Pension Deficits, as explained in note 3.

CQC Expenditure 2012/13



The remaining £1m increase is the net result of the following:

- Engagement and consultancy costs following CQC's Strategic Review.
- Transitional costs leading up to a new IT managed service contract from April 2013.
- Additional travel and subsistence and office equipment costs due to the increased number of compliance inspectors.
- CQC achieved savings both internally and for the Department of Health, via estates strategies in the year, which are noted in section 9 of the management commentary.
- Year on year impairment of assets decreased by £7m, due to an impairment of IT intangible assets carried out at the 2011/12 year end.

Capital expenditure: £11m

The main focus of expenditure has been the development of online accounts ensuring that GPs could apply for registration using an online form. This was the first major release of a key programme that will eventually mean CQC is 'digital by default' so that wherever possible, all our services will be online.

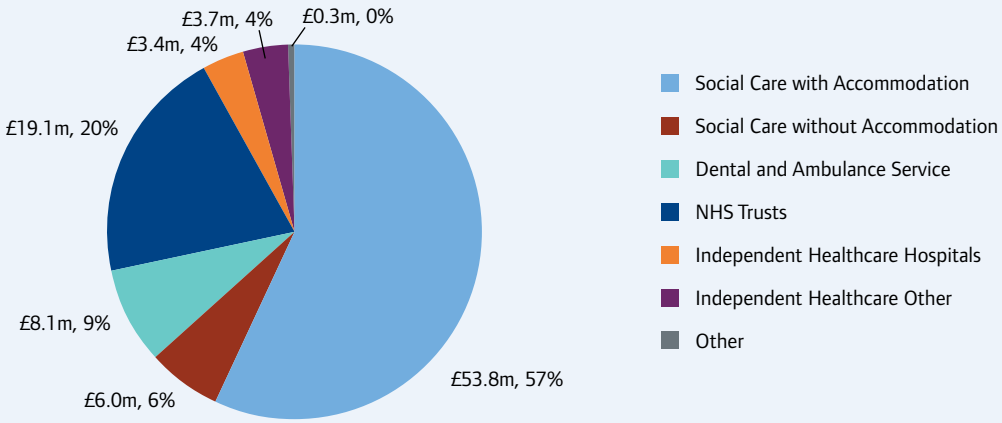
In addition to this, CQC has implemented process changes to our operating information systems to ensure that the system supports inspectors by focusing on the key decisions that they need to take to ensure robust and consistent judgements.

Income: £93m

Income has increased due to the following:

- In 2011/12 due to a new billing scheme, CQC carried forward 'income in advance' at a higher amount than previously, thus reducing income in that year.
- In 2012/13 there is not such a significant movement between the income in advance brought forward to that carried forward at March 2012 as can be seen under the statement of financial position.
- In addition to this in 2011/12 the valuation of CQC's pension schemes at year end resulted in a non-cash financial adjustment increasing income by £3m (2012/13:Nil).

Income by Sector



(The graph excludes income in advance and Department of Health funding)

Grant-in-aid

CQC's net expenditure is funded from grant-in-aid provided by the Department of Health. Grant-in-aid totalled £68.1m (2011/12: £45.3m) in the year including £11.4m designated as capital grant-in-aid.

4. Key performance indicators

The key performance indicators set out below were monitored throughout the year by management and the Board, and measured against targets.

	2012/13 target	2012/13 outturn	2011/12 outturn
Registration			
% of applications completed within target (less than 8 weeks)	N/A	Indicator changed from 2012/13	72.80%
New provider and new manager registrations completed within 8 weeks[1]	90%	86%	Reported from 2012/13
Percentage of applications to change a registration completed within 4 weeks. Manager/variation registration applications completed within 4 weeks[1]	90%	74%[7]	Reported from 2012/13
Compliance inspections			
NHS trusts with at least one scheduled inspection undertaken[2]	100% of plan[5]	318 (100% of plan)	109
Adult social care and independent healthcare locations with at least one scheduled inspection undertaken	N/A	Indicator changed from 2012/13	9,818
ASC locations with at least one scheduled inspection[2]	100% of plan[5]	22,250 (100% of plan)	Reported with IHC in 2011/12
IHC locations with at least one scheduled inspection[2]	100% of plan[5]	2,117 (100% of plan)	Reported with ASC in 2011/12
Dentist locations with at least one scheduled inspection undertaken	100% of plan[6]	3,682 (104% of plan)	1,432
Independent ambulance locations with at least one scheduled inspection[2]	100% of plan	216	Reported from 2012/13
Enforcement action			
Number of warning notices served	N/A	910	638
Number of prosecutions	N/A	1	1
Locations de-registered following CQC intervention	N/A	75	Reported from 2012/13
Urgent suspensions of registration or urgent variation or imposition of conditions using section 31 powers	N/A	6	Reported from 2012/13
Percentage of warning notices issued within 14 days of identifying one is required	90%	83%	Reported from 2012/13
Mental Health Act function			
Number of MHA Commissioner visits to Mental Health Service locations	N/A	1,090	1,502
Complaints, governance information and call handling			
Number of requests under Freedom of Information, Data Protection and Information sharing legislation	N/A	1,144	1,403

	2012/13 target	2012/13 outturn	2011/12 outturn
Compliance rate in responding fully to applicants within the statutory time limits (20 working days for freedom of information and 40 calendar days for Data Protection Act requests)	N/A	See text below	97.80%
FOI responsiveness rate – % responded to within 20 working days	95%	97.2%	Reported from 2012/13
DPA responsiveness rate – % responded to within 40 calendar days	95%	96.0%	Reported from 2012/13
Number of calls received at the National Customer Services Centre		201,862	213,536
(%) answered within 30 seconds[3]			
a. Safeguarding calls	90%	94%	94%
b. Mental Health	90%	96%	94%
c. Registration	80%	84%	84%
The number of whistle blowing contacts CQC received	N/A	8,634	4,147
The number Stage 1 corporate complaints received proceeding to Stage 2	N/A	83	47
Year end outturn vacancies of frontline staff (compliance inspectors)[4]	<2%	0%	Reported from 2012/13

1 Assesses the efficiency of applications when they are received by the regional registration assessors. Applications are first processed by our customer service centre. 97% of applications at the centre are processed within 5 days.
2 Where we inspect a minimum of five outcomes of our essential standards.
3 Target was revised in 2012/13 to calls answered within 30 seconds. Target was 20 seconds in 2011/12.
4 Frontline staff are compliance inspectors.
5 Of locations registered as at 1st April 2012 (and active at time of inspection).
6 100% of planned inspections represents 35% of all locations required as at 1st April 2012.
7 This indicator was under target. It applies to all applications to change a registration and these range in complexity. Many require significant scrutiny and some providers ask for a delay in registration. We continue to monitor performance and identify action to improve performance.

5. Risks and uncertainties going forward

The CQC Board has identified the following risks to meeting its strategic objectives:

- CQC's regulatory model fails to protect and promote the health, safety and welfare of people who use health and social care services – both now and in the future.
- CQC fails to anticipate, understand and adapt to a changing political, legislative, policy, social, technological and economic environment.
- CQC does not effectively work with or communicate its purpose to its key internal and external stakeholders, and fails to respond rapidly or effectively to restore confidence when it is criticised or challenged.
- CQC fails to deliver its purpose and role of:
  - Making sure health and social care services provide people with safe, effective, compassionate high-quality care and we encourage care services to improve.

  - Monitoring, inspecting and regulating services to make sure they meet fundamental standards of quality and safety, and publishing what we find, including performance ratings to help people choose care.
- CQC does not have the capability and capacity (workforce, resources and systems) to deliver the organisation's change and delivery objectives. The cumulative demands of considerable external and internal change increase this risk.
- CQC fails to establish and maintain an open, reflective and responsive culture, where employees are encouraged to learn from each other's successes and challenges. The governance and leadership of CQC is distracted by considerable change and instability.

Our Board has identified these as the strategic risks and has agreed the relevant mitigation. During the year the Board kept these under review.

6. Information security

During 2012/13, we have developed our Information Security and Governance Strategy in line with ISO27001 and completed or enhanced the following work areas. We:

- Completed the management actions in respect of recommendations from the 2012 internal audit of information security.
- Produced and implemented a revised Information Security and Governance Policy document, including the associated strategy and framework.
- Updated and improved our security incident reporting procedure, including root cause analysis, links to the risk management process and provided monthly analysis reports to the Information Governance Group.
- Introduced and implemented a new information security and training awareness package as a mandatory annual requirement for all staff.
- Completed an information security audit of our Mental Health Operations area and the wider organisation, achieving an overall Substantial Assurance.
- Revised the asset management process to streamline and link the process more closely with the risk management function.
- Liaised and worked closely with the Department of Health and NHS Commissioning Board on improvements to the security of the IT infrastructure as part of the migration to the IMS3 environment. This has included a number of tests by an external testing provider approved by the government's Communications-Electronics Security Group. The findings of this testing are examined by the joint working group and are mitigated as appropriate.
- Improved the assessment score on the Information Governance Toolkit submission as at 31 March 2013, based on the work carried out during the year.

7. Freedom of information

We published a wide range of information about our activities, as specified in our freedom of information publication scheme. Our Information Access Team also handles requests, such as those

made under the Freedom of Information Act 2000 and the provisions of the Data Protection Act 1998. The team also responds to formal information sharing requests from other public bodies.

8. Employment, health and safety and environment policies

8.1 Employee consultation and engagement

CQC recognises UNISON, RCN, PCS, Unite and Prospect for the purposes of collective bargaining and consultation. Although the number of union members has increased this year, unions continue to represent less than half of CQC's employees and we therefore also have an active and engaged Staff Forum.

We have continued to work to improve the engagement of colleagues within the organisation. We believe that engaging all our employees is fundamental to our success and have actively sought their views on how we can improve the work we do.

Our relationship with the unions has again improved this year and our pay negotiations took place in a positive, open and transparent environment with both sides working together to achieve the best possible outcomes. This resulted in the union membership returning a ballot result strongly in favour of the pay proposals.

Our conversations with the Joint National Consultative Committee (JNCC) of the unions and the Staff Forum continue to be based around a strategic, forward-looking agenda, which allows them to clearly understand and contribute to our strategic objectives. The unions and staff forum have worked in partnership with CQC on a number of strategic initiatives, including the preparation and analysis of the staff survey and production of staff survey action plans, the future strategic direction of CQC and improvements to the performance development review process and how it is applied.

The local JCCs continue to meet regularly to review local staff survey action plans, health and safety issues and to discuss local matters of local concern to staff.

Our Staff Forum also plays a valuable role in representing the voice of our employees. As well as raising colleagues' concerns and informing us of where our communications need to be more effective, they have decided to spend this year focusing on the areas of improving morale, continuing to reduce bullying and harassment and improving communications within CQC.

We have three diversity networks: the Lesbian, Gay, Bisexual and Trans Equality Network; the Race Equality Network; and the Disability Network. These networks aim to promote equality in CQC, to challenge views and to strive to ensure more positive outcomes for these employees within CQC. Each network has a sponsor from our Executive Team and the chairs of the Diversity Networks have regular meetings with the Chief Executive.

8.2 Employment and policies

Over the past 12 months we have reviewed a number of policies in line with updates in employment legislation. By 1 April 2013, we have introduced a whole suite of new policies in consultation with our trade unions, staff forum and diversity network groups to ensure they are meeting the needs of all staff within CQC. All managers are provided with guidance and support when new policies are introduced and workshops are delivered to senior managers to cascade the policy and its contents to

their staff. We also ensure that the policies are introduced through intranet banners and through our regular briefings for teams.

8.3 Home-working

Home-working forms the contractual arrangement for around 1,200 members of staff and is one of the flexible working options available to staff as part of CQC's commitment to help improve the work-life balance of our employees.

Home-working is integral to CQC's commitment to improving our effectiveness, both in terms of cost and in the way that we carry out our work. CQC provides the tools and equipment required to enable our home-working employees to undertake their role safely and effectively. The home-workers' reference group represents the needs of these employees, and their ideas have already been actioned, or channelled into the review of tools for the next financial year.

It is recognised that CQC home-working employees regularly handle personal information as part of their role. This has been considered with specific requirements included in the formulation of information and IT security policies, training and awareness. Recent audit sampling has indicated a good level of security awareness and compliance among home-working employees.

8.4 Health and safety

Our summary in last year's annual report identified the work done to develop and deliver a health and safety policy, action planning, organisational structure, risk management and training functions, focusing on health and safety for our employees and contractors across our business.

In this year we have focused on embedding our health and safety activities and further enhanced our skill base, and risk profile ratings for health and safety.

This year we have developed a range of policies, activities and skills to support health and wellbeing. This has included being a signatory to the Mindful Employer Charter, commitment to the Department of Health Responsibility Deals, and commitment to the Investor in People Health and Wellbeing Accreditation. This work culminated in a Strategic Commitment on Health, Safety and Wellbeing proposal to our Executive Team with a three-year vision for health, safety and wellbeing as a high-performing organisation.

During the year, 44 accidents occurred of which 36 were work related. Two of the accidents were road traffic related incidents and were reported to the Health and Safety Executive. All accidents were investigated. This included interviews with the employee, line manager and the relevant Deputy Director. Investigations were aimed to identify root causes and remedial actions, and were reported to the national health and safety committee. Remedial actions relating to the two accidents reported to the Health and Safety Executive were reported to the relevant Deputy Directors and were discussed in the wider context across CQC.

2013/14 will see our strategy take shape, and action plans to bring to life our commitments and meet our targets on accreditation for Safety Standards and Health and Wellbeing Standards.

8.5 Sickness absence data

During 2012/13 the average number of long-term days sickness per employee was 10 (2011/12: 12 days) and the average number of short-term days sickness was 4 (2011/12: 4 days). The reduction in long-term sickness is in part due to improved staff morale as a result of the implementation of a new pay and grading framework and grade structure, and also to the launch of the new attendance management policy which has enabled CQC to manage attendance more effectively.

8.6 Sustainability duty

Our sustainability aim is to reduce the impact of our business on the environment. Our priority is to reduce our carbon dioxide (CO2) emissions. Managing efficient use of our IT systems and accommodation is an important strand of this work. Sustainability should be a key driver for our work on flexible working, as well as consolidating our accommodation through the continual review of the CQC estates strategy.

We have an ongoing dialogue with our suppliers of goods and services to ensure they have sustainable working practices with supporting policies.

Original sustainability reporting was against the Sustainable Operations on the Government Estate targets (SOGE), as required by the Cabinet Office. On 1 April 2011, these targets were replaced by the Greening Government Commitments Operations and Procurement (GGCOPS).

About our data

As all but one of our offices is supplied via landlord service charge, with bills presented on a pro rata m^2 basis rather than actual consumption data, there may be some limitations to the accuracy of our financial and non-financial sustainability data. However, we are looking at how we can improve the quality of data. We are also continuing to talk with our landlords about installing check meters. This year landlords have agreed to be more proactive with their reporting and therefore figures for this financial year are more accurate than in previous years.

Carbon dioxide emissions

Area	CO2 emissions (tonnes)	Units 2012/13	Cost 2012/13 (£)	Performance against 2011/12
Building energy	1,560	3,736,528 (kwh)	355,421	Improving
Travel (rail)	305	5,075,004 (m)	2,510,503	Increasing
Travel (road)	1,286	3,830,311 (m)	1,885,305	Improving
Total	**3,151**	**N/A**	**N/A**	

Non-financial indicators (CO2)	2011/12	2012/13
Gross emissions (buildings)	1,760	1,560
Gross emissions (business travel)	1,556	1,591
Total greenhouse gas emissions	3,326	3,151

Financial indicators (£)	2011/12	2012/13
Expenditure on official business travel	3,435,815	4,451,340

Performance

50% of our reported CO2 emissions are from electricity and gas used in the buildings. The emissions are falling from the 2009/10 baseline figure due to investment in energy saving initiatives, tighter controls, and the consolidation of the estate and the closure of offices.

CO2 emissions from rail travel have increased. This is mainly because of the influx of new inspectors who attended induction and training meetings. There has been an increase in the cost of rail travel mainly due to fare increases imposed by rail companies in 2012.

The increase in CO2 emissions related to road travel is largely due to our refining of the portfolio of work carried out by inspectors.

Targets

From 1 April 2011, new targets (GGCOPS) require CQC to reduce greenhouse gas emissions from a baseline set in 2009/10 for the whole estate and business related travel, and to cut domestic business travel flights by 20% by 2015 from a 2009/10 baseline.

Managing energy use from buildings

Performance

Energy consumed in our buildings is falling against the 2009/10 baseline. This is because we have invested in energy initiatives, and tighter controls on heating, cooling and lighting. Estate consolidation and office closures have also contributed to the energy reduction.

Non-financial indicators – energy consumption (KWH)	2009/10	2010/11	2011/12	2012/13
Electricity: Non-renewable	N/A	N/A	N/A	N/A
Electricity: Renewable	3,641,075	3,521,309	2,962,050	2,580,978
Gas	2,004,344	2,028,220	1,127,011	1,155,550
Total KWH	5,645,419	5,549,529	4,089,061	3,736,528

Financial indicators (£)	2009/10	2010/11	2011/12	2012/13
Total energy expenditure	525,935	473,785	372,654	355,421

Managing water usage

Performance

CQC's water usage is almost exclusively from washrooms, showers, kitchen preparation areas, cleaning and the restaurant facility in our Finsbury Tower head office in London. The water usage has decreased by 14%, the costs are similar to 2011/12. This is due to increases in supplier cost.

Targets

From 1 April 2011, new targets (GGCOPS) will require us to reduce water consumption from a 2009/10 baseline and report on office water use against best practice benchmarks.

Non-financial indicators	2009/10	2010/11	2011/12	2012/13
Water consumption (m^3) supplied	16,388	15,561	16,418	14,164

Financial indicators (£)	2009/10	2010/11	2011/12	2012/13
Total energy expenditure	N/A	14,713	15,732	15,498

Managing office waste

Performance

Our office waste typically comprises: paper, cardboard, food and drink waste and its packaging. Recycling has increased following the consolidation of the estate and closure of offices. This has allowed us to develop better waste management procedures.

The figures for 2009/10 and 2010/11 were incomplete as landlords did not supply enough information to confirm the landfill/recycling data.

Targets

From 1 April 2011, new targets require us to reduce the amount of waste we generate by 25% from a 2009/10 baseline. We will also need to:

- Cut our paper use by 10% year-on-year.
- Ensure that we use 100% recycled paper.
- Ensure that redundant IT equipment is re-used (within the public sector or wider society) or responsibly recycled.
- Ensure that surplus furniture is re-used (within the public sector or wider society) or responsibly recycled.

Waste management is now controlled by CQC with one central contract. The increased waste figures now give a more accurate reflection of the waste produced and indicate that the previous details supplied by landlords were incomplete.

Non-financial indicators (tonnes)	2009/10	2010/11	2011/2012	2012/2013
Non-hazardous waste – landfill	27	60	130	159
Non-hazardous waste – reused/recycled	143	272	152	212
Total waste	**170**	**332**	**282**	**371**

Financial indicators (£)	2009/10	2010/11	2011/2012	2012/2013
Total disposal costs	N/A	48,021	32,000	58,206

Sustainable procurement

CQC is committed to ensuring that sustainable procurement principles are considered in every procurement project.

To enable this, our governance and procurement procedures ensure sustainability is considered at every stage of the process, from the initial completion of a business case, the creation of a specification to the exit strategy of contracts.

Central contracts managed by the procurement team are also considered for their use of recycled contents, ability to monitor CO2 emissions and adherence to the equality and diversity act.

9. Estates strategy

The CQC estates strategy has been updated to reflect the Government Property Controls, which were implemented in June 2010. The main implication of these controls is that all lease events will be reviewed and taken at every opportunity.

The 6th floor Finsbury Tower break option was taken in November 2012 and the floor was cleared and handed back to the landlord. This reduced the occupied floor space in Finsbury Tower by 525m^2, with savings of £317,000 per year.

The Human Fertilisation & Embryology Authority continue to occupy the 13th floor in Finsbury Tower, using 9.42% of the floor space resulting in 9.42% saving in the running costs.

In October 2012, Healthwatch England became part of CQC and occupied an area of the Leeds office and an area in Finsbury Tower.

The lease of the Nottingham office expires at the end of December 2013 which means that CQC will have to find alternative premises. Searches are currently underway to find a new location within the Government Estate. Due to the low occupancy costs associated with the Nottingham office it is unlikely that there will be any major cost savings linked to this move.

Birmingham City Council is in the process of serving a Compulsory Purchase Order in the area that includes our Birmingham office. The timescale for this is still uncertain but is likely to be during 2013/14. Negotiations are ongoing with the City Council to gain a full understanding of what the implications are for CQC. This will result in CQC moving out of the current office and seeking accommodation in other civil estate premises.

There are also lease breaks due in 2014 in our Newcastle Citygate office. This office is deemed as being outside the Government Property Controls as the head lease is in the name of the Department of Communities and Local Government.

The initiatives that have been taken will lead to significant savings for both CQC and the Department of Health. They also contribute to the Government's property savings targets.

10. Contractual obligations

CQC operates a contracts register, and we now publish details of all new contracts with a value over £10,000 on the Government Contracts Finder website (www.contractsfinder.business.gov.uk). Our largest contracts are with information communication technology (ICT) service suppliers: CSC Computer Science Ltd, Computacenter UK Limited, Sapient Corporation and Cable & Wireless

Worldwide PLC. Services supplied under these arrangements included ICT support services, ICT development, operating systems, hardware maintenance, information systems infrastructure, IT operations, and the CQC operating system, which is used to organise, integrate, record and coordinate our relationships with the bodies that we regulate.

11. Better payment practice code

CQC's policy was to pay creditors in accordance with contractual conditions or, where there were no specific contractual conditions, within 5-30 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 as published by HM Treasury.

In 2012/13, CQC processed 98.4% (2011/12: 99.9%) based on volume, and 99.6% (2011/12: 99.4%) of invoices based on value within 30 days.

Following new guidance from Central Government in August 2010, CQC aimed to pay 80% of all undisputed invoices from our suppliers within five working days. In 2012/13, CQC paid 76.8% (2011/12: 85.3%) based on volume, and 78.9% (2011/12: 82.9%) based on value within five days.

12. Pension costs

The treatment of pension liabilities and the relevant pension scheme details are set out in note 1.3 on page 140 and in the Remuneration Report on page 95.

13. Political and charitable donations

We made no political or charitable donations during the year.

14. Research and development

No research and development activities were charged to the financial statements during the year.

15. Form of account

Our 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 Government Financial Reporting Manual (FReM) (2012/13) and the HM Treasury Managing Public Money (2007). The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context.

16. Going concern

Our financial accounts have been prepared on the basis that CQC is a going concern. Grants for 2013/14, which cover the amounts required to meet CQC's liabilities falling due that year, have been included in Department of Health estimates which were approved by Parliament.

17. Post statement of financial position events

There are no significant post statement of financial position events.

18. Auditor

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 total amount due for audit work is £145,000 (2011/12: £145,000). There was no remuneration paid for non-audit work during the year.

19. Availability of information for audit

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

Remuneration report

The following sections provide details of the remuneration (including any non-cash remuneration) and pension interests of Board Members, Independent Members, the Chief Executive and the Executive Team. 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 with the exception of John Harwood. His remuneration is based on a commitment of three and a half days per month.

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 and to and from events at which they represent CQC. CQC meets the resulting tax liability under a settlement agreement with HM Revenue and Customs. For 2012/13 the total amounts were £27k (2011/12: £18k).

Chairman and Board Members' emoluments

	Date appointed	2012/13 total salary £000	2011/12 total salary £000
David Prior (Chair, from 28 Jan 2013)	28 Jan 2013	10 – 15[1]	–
Dame Jo Williams (Chair, resigned 27 Jan 2013)	01 Oct 2008	45 – 50[1]	60 – 65
Kay Sheldon OBE	01 Dec 2008	5 – 10	5 – 10
John Harwood	04 Mar 2010	5 – 10	5 – 10
Steve Hitchins	09 Jul 2012	5 – 10[2]	–
Anna Bradley	16 Jul 2012	30 – 35[3]	–
Professor Deirdre Kelly (resigned 31 Jan 2013)	01 Oct 2008	10 – 15[4]	10 – 15
Professor Martin Marshall (appointment expired 31 Dec 2012)	01 Jan 2009	5 – 10[2]	5 – 10
Olu Olasode (appointment expired 30 Oct 2011)	01 Nov 2008	–	5 – 10[4]

1 Full year equivalent salary £60-65k.
2 Full year equivalent salary £5-10k.
3 Full year equivalent salary £45-50k.
4 Full year equivalent salary £10-15k.

In 2012 Kay Sheldon, CQC Board member, commenced a claim in the Employment Tribunal against CQC. On 22 March 2013 a formal agreement was reached between the parties. Without admission of liability, it was agreed that CQC would pay Ms Sheldon £60,000 and in return, Ms Sheldon agreed to withdraw her Employment Tribunal claim. The payment was made in April 2013.

Payments to independent members

Julian Duxfield was an independent member of CQC's Remuneration Committee. Fees and expenses are paid on a per meeting basis and amounted to £3k for 2012/13 (2011/12: £nil).

John Butler and David Prince were independent members of CQC's Audit and Risk Assurance Committee. Fees and expenses are paid on a per meeting basis and amounted to £12k for John Butler (2011/12: £6k) and £5k for David Prince (2011/12: £nil).

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.

The remuneration of the Chief Executive and Executive Team members was set by the Remuneration Committee and reviewed annually within the scope of the national pay and grading scale applicable to Arm's Length Bodies. Following the end of a two year pay freeze, in line with many other public sector bodies, a 1% pay award was applied from 1 September 2012. In March 2013 the Government announced that public sector pay would be capped at 1% for three years, rather than the two years which was stated in the original announcement in November 2011.

The Executive Team had a contractual entitlement to be considered for a bonus of up to 10% of salary for performance in the year 2012/13. However both the Remuneration Committee and the Executive Team were of the view that it would not be appropriate for the Executive Team to accept individual bonuses in the current circumstances.

For the Chief Executive and Executive Team, early termination other than for gross misconduct, (in which no termination payments are made), is covered by their contractual entitlement under CQC's Redundancy Policy (or their previous legacy Commission's redundancy policy if they transferred). The Executive Team has three months' notice of termination in their contracts. Termination payments are made only in appropriate circumstances and may arise when staff are not required to work their period of notice. 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, overtime, recruitment and retention allowances and any other allowance to the extent that it is subject to UK taxation. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Executive team		2012/13			2011/12		
	Date Appointed	Salary £000	Bonus £000	Benefits in Kind £00	Salary £000	Bonus £000	Benefits in Kind £00
David Behan	30 Jul 2012	125–130[2]	–	–	–	–	–
Cynthia Bower (resigned 21 Aug 2012)	1 Aug 2008	75–80[4]	–	–	195–200	–	–
John Lappin	1 May 2009	140–145	–	–	140–145	–	–
Amanda Sherlock	1 Jul 2010[1]	140–145	–	–	130–135[5]	–	–
Louise Guss	1 Jul 2010[1]	110–115	–	–	110–115	–	–
Allison Beal	2 Aug 2010[1]	110–115	–	–	110–115	–	–
Philip King	1 Oct 2011	110–115	–	–	55–60	–	–
Christopher Day (interim appointment)	18 Feb 2013	10–15[3]	–	–	–	–	–
Jill Finney (resigned 21 Feb 2013)	24 Feb 2009	125–130	–	–	140–145	–	–
Amanda Hutchinson (interim appointment to 30 Sep 2011)	18 Apr 2011[1]	–	–	–	45–50	–	–
Richard Hamblin (resigned 31 Dec 2011)	1 Mar 2009	–	–	–	80–85	–	–
Linda Hutchinson (resigned 30 Apr 2011)	1 Apr 2009	–	–	–	10–15	–	–

1 Date appointed to the Executive Team for reporting purposes.
2 Full-year equivalent salary £185-190k.
3 Full-year equivalent salary £110-115k.
4 Full-year equivalent salary £195-200k.
5 Full-year equivalent salary £140-145k.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. This is outlined in the table below.

Band of highest paid director's total	2012/13	2011/12
Remuneration (£000)	195–200	195–200
Median remuneration total	37,658	37,174
Ratio	5.2	5.3

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The median remuneration total has increased in 2012/13 due to the impact of the pay award which was applied from 1 September 2012.

Payments made for loss of office

There were no payments during the year for loss of office. During the year CQC restructured its Senior Executive Management team. A provision of £0.8m has been made to cover the costs of senior management redundancies that were agreed by 31 March 2013.

Amounts payable to third party for services as a senior executive

Nick Blankley provided services as an interim Director of Intelligence, employed through Concept IT Ltd from 4 October 2012. Total employment costs of £97k for 2012/13 were recharged to the Commission by Concept IT Ltd.

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

Pension benefits were provided through the NHS Pension scheme for most members of the Executive Team, with the exception of Amanda Sherlock and Louise Guss whose pensions were provided through Teesside Pension Fund. Pension benefits at 31 March 2013 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 2013 (bands of £5,000) £000	Total accrued pension at 31 March 2013 (bands of £5,000) £000	CETV at 31 March 2012 £000	CETV at 31 March 2013 £000	Real Increase in CETV £000
David Behan (appointed 30 Jul 2012)	–	0 – 2.5	–	0 – 5	– [2]	30	20
Cynthia Bower (resigned 21 Aug 2012)	0 – 2.5	0 – 2.5	215 – 220	70 – 75	1,480	– [1]	N/A [1]
John Lappin	–	0 – 2.5	–	5 – 10	107	148	39
Amanda Sherlock	2.5 – 5	0 – 2.5	105 – 110	80 – 85	693	770	62
Louise Guss	(0 – 2.5)	(2.5 – 5)	45 – 50	60 – 65	318	336	12
Christopher Day (interim appointment 18 Feb 2013)	5 – 7.5	0 – 2.5	45 – 50	15 – 20	– [2]	230	27
Jill Finney (resigned 21 Feb 2013)	–	0 – 2.5	–	5 – 10	95	126	26

1 CETV is nil as Cynthia Bower was in receipt of benefits from August 2012.
2 No comparative data is available from NHS Pension Agency.

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 2004/05, 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 10.9% of their pensionable pay depending on total earnings.

In 2012/13 CQC employer's contribution for staff to the NHS pension fund was £5,785k (2011/12: £4,258k) at a rate of 14% (2011/12: 14%). For early retirements, other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs charged to expenditure was £379k (2011/12: £177k).

The latest assessment of the liabilities of the scheme is contained within the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

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.

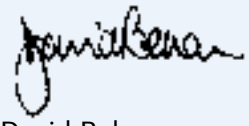
Due to legacy arrangements, CQC inherited 17 Local Government Schemes. All schemes are closed schemes. Under the projected unit method the current service cost will increase as the members of the scheme approach retirement.

Employer contributions, based on a percentage of payroll costs only, for 2012/13 were £4,263k in total (2011/12: £4,192k), at rates ranging between 15.1% and 32.3% (2011/12: 14.4% and 32.3%).

Employer contributions relating to the largest scheme, Teesside Pension Fund were £3,694k (2011/12: £3,575k) at a rate of 15.1% (2011/12: 14.4%).

From 2012/13, an indexed cash sum was levied in addition to a percentage of payroll costs in an effort to reduce the pension fund deficits. £653k in total was paid to 11 of the 17 pension funds with amounts ranging from £13k to £134k. No additional sums were paid to Teesside as it currently has sufficient staff members to enable the deficit to be recovered solely by a percentage of payroll as well as having members who are of an age that allows the deficit to be recovered over a longer period of time.

Contribution rates for 2013/14 range between 15.1% and 32.3% (15.8% for Teesside Pension Fund) with annual cash sums ranging from £14.6k to £139.7k (£nil for Teesside).



David Behan
Chief Executive, CQC

26 June 2013

Statement of Accounting Officer's Responsibilities

Under the Health and Social Care Act 2008 the Secretary of State for Health has directed the Care Quality Commission to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of CQC and of its net resource outturn, application of resources, changes in taxpayers' equity and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *Government Financial Reporting Manual* and in particular to:

- observe the Accounts Direction issued by HM Treasury, including the relevant accounting and disclosure requirements, and apply suitable 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; and
- prepare the financial statements on a going concern basis.

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

Governance statement

Introduction and context

This year has been marked by significant change for CQC. We have been subject to, and subjected ourselves to, considerable scrutiny; there have been important structural changes in the health and social care system affecting CQC and other partners; in response we have engaged in a major engagement and consultation exercise to conduct the first major review of CQC's strategy since its inception; we have received and carefully considered, along with Government and our partners, the Robert Francis Inquiry report into the failings at Mid-Staffordshire Foundation Trust; we have taken on new statutory duties, including establishing Healthwatch England; managed the transition from one Chief Executive to another; welcomed a new Chair and seen the departure of a number of Board members and executive Directors; completed a significant programme of inspections and further expanded the range and number of providers regulated by CQC through the successful registration of GPs.

CQC exists to protect and promote the health safety and welfare of people who use health and social care services. The external environment continues to be characterised by system change and a challenging economic environment for providers, in both health and social care. This, along with other drivers has prompted a thorough review of CQC's strategy which has included a major engagement exercise with stakeholders and CQC staff.

To achieve its purpose CQC must be well governed. Therefore CQC has also been addressing during the year the governance findings arising from external scrutiny, including from the NAO and Public Accounts Committee. During 2012/13 we have reviewed for ourselves our governance mechanisms to make sure that they can generate the necessary assurances that CQC is discharging its governance responsibilities effectively, efficiently and economically.

That this was necessary and important has been emphasised by the findings of the Grant Thornton review, published in June 2013, which highlighted some serious governance failures by CQC. These failures were twofold; firstly the failures in regulatory judgement, in part due to the quality of the information upon which judgements were based but mainly due to the inadequate regulatory model for hospital inspections used by CQC from 2010 (when NHS hospitals were registered for the first time) through to 2012/13, which had consequences also for the reliability of information and judgements provided to other regulators in the health and social care system, which they intended to use to support their own judgements. These systemic problems had been highlighted in the Robert Francis Inquiry report. Secondly the Grant Thornton review revealed the cultural and behavioural governance failures in CQC, including the nature of the relationship among the Board and between the Board and the Executive Team, which led to the suppression of the CQC internal report into its regulatory decision making at UHMBT. The suppression of this report and the withholding of it from the CQC Board were completely unacceptable. These failures would not have been revealed without the Grant Thornton report which was commissioned by the incoming Chief Executive.

This Statement has been drafted in line with HM Treasury Corporate Governance Code and in line with that Code where there has been non-compliance with that Code there has been explanation of actions taken.

CQC statutory background

The CQC is a non-departmental public body (NDPB) established under the Health and Social Care Act 2008. It is accountable to the Secretary of State for discharging its functions, duties and powers effectively, efficiently and economically.

CQC took over the Mental Health Act 1983 responsibilities to monitor services which provide mental health care to people detained under the Act. CQC has a legal duty under the Mental Capacity Act 2005 to monitor and report on activity under the deprivation of liberty safeguards.

The Health and Social Care Act 2012 provided for the establishment of Healthwatch England, the national consumer champion for users of health and social care services, as a statutory committee of CQC. The 2012 Act also provided for CQC to take on a monitoring role in relation to information governance and create a National Information Governance Committee.

Our purpose and role

The CQC in its new strategy has explained its purpose: "We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage services to improve." It also sets out our role: "We do this by monitoring, inspecting and regulating services to make sure they meet fundamental standards of quality and safety and by publishing ratings to help people choose and fund care".

More specifically our role is to monitor, inspect and regulate 50,000 health and adult social care services in England. These include hospitals, care homes, home-care agencies, community and treatment services, GP practices and dental practices. We will carry out our role by:

- Setting standards of quality and safety that people have a right to expect whenever they receive care.
- Registering services that meet our standards.
- Monitoring, inspecting and regulating services to make sure that they continue to meet the standards.
- Protecting the rights of vulnerable people, including those governed by the powers of the Mental Health Act.
- Listening to and acting on people's views and experiences of the care they receive.
- Taking action if services are failing to meet the standards.
- Carrying out in-depth investigations to look at care across the system.
- Reporting on the quality of care services, publishing clear, accurate, timely information.
- Involving people who use services in our work, working with local groups, our partners in the health and social care system, and the public to make sure that people's views and experiences are at the centre of what we do.

- Challenging all providers, with the worst performers getting the greatest attention.
- Making fair and authoritative judgements, supported by the best information, evidence and data.

The Governance Framework

The CQC Corporate Governance Framework sets out the elements which together facilitate effective leadership, direction and control in CQC. It explains:

- The legislative context in which CQC operates.
- CQC's accountability.
- CQC's purpose and values.
- The key elements of good governance.
- The roles and structures which support good governance at Board level and in the Executive.
- Expected Board behaviours.
- The key processes in CQC which deliver good governance.
- The Assurance Framework.
- External scrutiny and oversight.
- Disclosures and statements required in support of accountability.

Governance is not an end in itself: the framework is designed to ensure that CQC meets its purpose. The CQC Board agreed in September 2012 a vision for corporate governance to capture its intentions:

"Demonstrable excellence in corporate governance to support and enable a successful organisation."

To deliver this vision, CQC has adopted the following principles:

- Effective leadership and clear direction.
- Clear roles, responsibilities and authority.
- Clear accountability.
- Efficient and effective use of resources to sustain and improve the organisation.
- Appropriate scrutiny, oversight and supervision.
- Effective management of risk and performance.
- Integrity.

The vision is proving important and helpful in guiding the development of the governance framework and embedding it in CQC.

Framework Agreement with the Department of Health (DH) and supporting protocols

An important element of the governance framework is the CQC's accountability arrangements with the DH. These are additional to and complement the Accounting Officer's responsibilities to Parliament. The current arrangements have been in place since CQC's inception and include quarterly

accountability meetings with the Department's senior sponsor. The CQC Accounting Officer has attended all these meetings across the year and provided the performance and risk information requested by the Department. All actions required of CQC arising from these meetings have been discharged.

CQC has been working closely with DH to revise the Framework to ensure that it properly reflects CQC's revised responsibilities and accurately reflects accountability and sponsorship relationships, including those for Healthwatch England. It is expected that the revised Framework will be signed-off in the first quarter of 2013/14. In the meantime CQC has worked with DH to agree a revised protocol for Public and Parliamentary Accountability.

While signing off a revised Agreement is important, the fact that this has not been achieved during the year has not impacted adversely on the governance of CQC.

Corporate Governance Project

CQC is a relatively young organisation. It will take time to mature fully, and that includes the maturity of governance. The first phase was completed during the year in which CQC finalised the development of its suite of governance documentation and processes. The emphasis in the coming phase will be on implementing these in ways that engage with staff to help ensure they understand the importance and value of governance to CQC in meeting its purpose and objectives and thereby embed them in the CQC management culture.

A number of governance initiatives were progressed during the year through the Corporate Governance Project Board, which included an independent member of the Audit and Risk Assurance Committee, to monitor progress. The project, which is nearing its end, has several streams of activity, including accountability, risk management, management assurance and regulatory risk. A corporate governance map was published on the CQC intranet to assist staff in understanding better which decisions are made where in CQC; significant progress has been made in ensuring that line managers – particularly in CQC regulatory operations – are clear about the assurances that they should be seeking from their staff, and providing to their managers, about the quality and timeliness of work and the effective management of risk controls and mitigations.

The project has developed an Engagement Plan, including both Learning and Development and Staff Communications, to enhance understanding by staff of how corporate governance works and how it impacts on them. This will focus firstly on the identification and handling of risk and during the coming year there will be mandatory risk training for CQC staff.

The Project Board will ensure that its work is carried forward in 2013 to continue to embed improvements in corporate governance as one of the strategy work-streams to create a high performing organisation. A process to evaluate the governance framework and its component parts has been agreed to ensure that it remains fit for purpose.

There has been a follow-up audit conducted during the year. This has focused upon the effectiveness of the Project Board's delivery and has confirmed the areas which require further improvement, in particular rolling out learning and development plans for staff and effective communications to help embed governance processes in CQC.

The Project Board has been helpful in providing corporate focus on the governance improvements required. The Project Board will be disestablished later in 2013 and any remaining governance

improvements requiring cross-organisational work formally will be handed over to a Transformation Programme which has been established to implement the organisational changes required to support CQC to deliver the strategic purpose and business plan objectives.

The Grant Thornton review

In July 2012 the incoming Chief Executive commissioned an independent review by Grant Thornton UK LLP to investigate the documented concerns and questions in relation to CQC's regulatory action at University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT). During the course of the review, the Chief Executive received an additional but related complaint from James Titcombe, the father of a baby who died after treatment at UHMBT, and as a result of that meeting the Chief Executive asked Grant Thornton to extend the terms of reference for the review, so that there could be a single report covering both the original concerns and the subsequent complaint.

In commissioning and publishing this report we have demonstrated the open and transparent approach that CQC will continue to take. That approach included a wide consultation and programme of engagement (including with CQC staff) to develop the new CQC Strategy. The findings of the review support our 2013-2016 Strategy and the consultation we launched on 17 June, including the plans we have to radically change the way we register and inspect NHS hospitals. We are determined to create a culture that puts the views of the public at the heart of what we do.

The findings of the report have some important implications in relation to the internal governance of CQC. Changes have been made already during 2012/13, to improve the clarity about levels of authority in the CQC's Scheme of Delegation to make decisions in CQC, especially regulatory decisions. This work resulted in a revised and fully comprehensive Scheme of Delegation being approved by the CQC Board in May 2013 which leaves no room for doubt about authority for taking decisions, how such decisions can be escalated, and to specify who has authority to make disclosures of regulatory information. This is important because as the Grant Thornton report reveals not only was CQC's decision-making flawed in the case of UHMBT, this decision was relied upon by others in the health and social care system, including Monitor. The failure in this instance also serves to cast doubt upon the robustness of other CQC regulatory decisions. The new approach to the inspection of hospitals, which had begun to change during 2012/13, will develop further during 2013/14 so that every scheduled inspection of an NHS acute hospital will include in the inspection team a clinical expert and an expert by experience. This approach will be extended beyond 2014 to all hospital inspections.

The Scheme of Delegation will be revised further to ensure that the authority and role of the Chief Inspector(s) posts is recognised. The Scheme will be reviewed also to ensure that there is appropriate oversight of CQC's disclosure of regulatory information more widely to help build trust in CQC as a partner in the single failure regime being developed.

The fact that it was necessary to commission a review by an independent third party to get at the facts surrounding CQC's decision-making in relation to UHMBT, and that concerns had been raised and questions asked by a Board member which had not been addressed, was indicative of a culture – at least in parts of CQC and at senior level, at the start of 2012/13 – that was not supportive of good governance. Among other things this will require that CQC looks again at the operation of its internal whistle-blowing arrangements for CQC staff. These had been reviewed during the year and the policy and processes were found to be sound. However the fact asserted in the report that a member of CQC staff was given an instruction about which they had serious reservations – to delete a report – but

nevertheless did not blow the whistle needs to be examined further. We will therefore commission an independent external review of these arrangements to be carried out in the current year.

More generally, the Grant Thornton report findings reinforce that good governance is not achieved solely (or even largely) by governance process and documentation. This reiterates previous findings from CQC's own internal audit: good governance requires the necessary supportive culture and behaviours and those must be set from the top of the organisation.

The report confirms that 'a less than harmonious and probably dysfunctional working relationship may have developed between the Board and the Executive.' Since the events outlined in the report, we have significantly changed the executive team and made substantial changes to the Board. The need to strengthen and clarify the role of the Board had previously been identified and is the focus of a number of initiatives already underway, including a programme of Board development and the appointment of one of the Board members as a Senior Independent Director.

CQC's Board

CQC is led by a Board of Commissioners. In May 2012, the DH laid Regulations to increase the membership of the CQC from a minimum of six to a maximum of 12 Members plus the Chair. Currently all Board Members are appointed by the Secretary of State. There are clauses in the Care Bill presently before Parliament which – if passed – will delegate appointment of the Executive members of the Board to the CQC. The Board meets both in public and private session throughout the year. Figures 1 and 6 in the annex to this Statement detail the Board membership and the coverage of the Board's work in 2012/13.

Roles and responsibilities of the Board

The Board of Commissioners is the senior decision-making structure in CQC. It provides strategic leadership to CQC. In support of that, the Board:

- Sets the CQC strategy and approves the CQC strategic plan containing the strategic objectives.
- Sets and addresses the culture, values and behaviours of the organisation.
- Approves the CQC business plan which is designed to achieve CQC's strategic objectives.
- Monitors the performance of CQC against the business plan and holds the CQC Executive to account for that performance and for the proper running of CQC (that is, in accordance with legal and cross-Government requirements).
- Sets the risk appetite for CQC, approves the risk management processes, and owns the strategic risk register, identifying and escalating to the Secretary of State where there are risks which may threaten CQC's ability to meet its objectives or ability to discharge its regulatory responsibilities.
- Determines which decisions it will make and which it will delegate to the Executive Team via the Scheme of Delegation.
- Approves all CQC statutory publications, including the Annual Report and Accounts, the State of Care report, the report on the operation of the Mental Health Act, and the report on the operation of Deprivation of Liberty Standards.

- Takes high level policy and organisational design decisions where these will characterise the type of regulator and monitoring body CQC will be or will be perceived to be. So, for example, the CQC Board will approve the CQC regulatory model and enforcement policy.

All Commissioners have equal and joint responsibility for governing the activities of the Commission and in being accountable to Parliament, Secretary of State, DH and the public for how it has discharged its functions. Together with the Chair, all Board Members share the corporate responsibility for the decisions of the Board and for the performance of CQC.

All Board Members are required to record annually any interests relevant to their role on the Board. The register of interests is a public document which is open to public scrutiny at CQC's offices in London and is also available on the CQC's website. The Chair will form a view as to whether an interest is such that it requires the Member to withdraw from discussion or any vote on an issue.

The Board can appoint Independent Members to its Committees. The Board can also co-opt Members on to its Committees.

Strengthening and clarifying the role of the Board

During 2012/13, the CQC Board welcomed a new Chairman and two new non-executive Board Members and the Chief Executive as the first Executive Director of the Board. Paul Bate, Executive Director of Strategy and Intelligence, was also appointed to the Board by the Secretary of State in April 2013.

In June 2013 five new non-executive directors were appointed. They are Professor Louis Appleby, Camilla Cavendish, Professor Paul Corrigan, Dr Jennifer Dixon and Michael Mire.

The Chief Inspector of Hospitals is a Board position. Consideration will be given to whether the Chief Inspectors of Social Care and General Practice will also sit on the Board.

These appointments reflect CQC's commitment to strengthening its Board, widening the skills and experience available to help govern and lead the organisation. While work on the development of the Board has paused awaiting the arrival of new appointees nevertheless work has progressed on clarifying the role of the Board by:

- Establishing the CQC Board as a unitary Board, in which the Chief Executive is a full Member of the Board and a Commissioner.
- Revising and updating the role description of Board members.
- Developing a Board Operating Model which explains what issues the Board routinely considers, the criteria for deciding what issues it will consider in private, how the Board's agenda is set, and the arrangements for the conduct of its meetings. This now is being further reviewed by the new Chair.
- Revising the induction programme for new Board Members to ensure they can be effective as Board Members as quickly as possible.
- Developing an outline Learning and Development programme for new Board Members.

The Board asked for a social media policy and a policy on how Board Members should raise concerns to be drafted, both of which have been adopted and added to the Board's Code of Conduct in January 2013. These will be reviewed further in light of the findings of the Grant Thornton review to make

sure they are adequate to ensure that in future should a Board member have concerns these will be addressed internally. In support of that the Chair will be appointing one of the Board members as a senior independent director who, among other things, will play a formal role in such arrangements.

The respective responsibilities of the Board and the Executive Team have been clarified further through the development of an Accountability Framework showing how the Board and the Chief Executive are held to account and by whom, and what assurances they seek in order to discharge their responsibilities. In addition a series of Board risk management workshops held during 2012 served to focus attention on and clarify the respective roles of the Board and the Executive in risk management.

Several Board Members, including the previous Chair, Dame Jo Williams, stood down during 2012/13 or decided not to put themselves forward for reappointment. Two new members were appointed during the reporting year, including the Chair of Healthwatch England.

Board performance

An evaluation template has been developed to enable the Board and Audit and Risk Assurance Committee (ARAC) to assess their effectiveness. ARAC undertook an evaluation exercise in January 2013.

No formal evaluation of the Board was conducted during the year. The performance of the Board during the year needs to be considered in light of some important factors which affected its continuity:

- The resignation of the Chair and the appointment of a new Chair.
- The departure of two long-standing Board Members.
- The appointment to the Board of the Chair of Healthwatch England.
- The move to a unitary Board through the appointment of the Chief Executive to the Board, and subsequently the newly appointed Director of Strategy and Intelligence.

One member of the Board made a claim to an Employment Tribunal under the Equality Act. That claim was settled by agreement and the withdrawal of the Employment Tribunal proceedings very near the end of the year. As part of the agreement a financial payment was made with no acceptance of liability. However this issue impacted adversely on the performance of the Board because of the time absorbed in coming to a resolution, and the impact upon intra-Board relationships.

Nevertheless the Board undertook a full programme of work (see figure 6 in the annex to this Statement) and addressed its duties in line with the requirements of its Scheme of Delegation.

However, the proposed change of structure to become a unitary Board, the expansion in its size and the change of personnel are indicative of a Board that recognises that its performance requires improvement. The strategy of CQC has been fundamentally changed by moving from a universal, generic inspection and regulation model based on compliance with minimum or essential standards to a risk based, specialist model based on judgement and compliance with both minimum standards and the introduction of quality ratings. The executive and non-executive membership of the Board is being very substantially changed and the way the Board operates, exercises leadership and contributes to CQC's broader development will be reviewed later in 2013. This will include examining the findings

of the Grant Thornton report and considering the type and range of assurances the Board will require from the Executive. This is a priority for the Chairman in the coming year.

Committees of the Board

Statutory Advisory Committees

CQC is required by Schedule 1 Section 6 (1) of the Health & Social Care Act 2008 to have at least one Advisory Committee and as many as it sees fit, to provide advice or information about the discharge of its functions. The Board agrees the terms of reference of the Committee and has also agreed that they should be chaired by a non-executive member of the CQC Board.

The Stakeholder Committee

The Stakeholder Committee was set-up in 2011 – replacing the Provider Advisory Group – to fulfil the statutory obligation and to ensure that CQC was delivering better and more effective results as an organisation through a focused engagement with representative stakeholder groups at a Board level. It meets twice yearly and has the power to set up subcommittees to look at specific themes or issues and offer advice on these to CQC. Membership is reviewed on a yearly basis.

The Committee comprises 23 representatives of the care professionals, people who use services, care providers, campaign groups and policy shapers that reflect all of CQC's regulated sectors. Chaired by John Harwood, the Committee has been a valuable forum for discussing matters of strategic priority to the organisation. Its principal focus during the year has been on responding to CQC's consultation on its strategic priorities for the coming three years and providing policy advice to the Board and the Executive Team over the delivery of CQC's strategy.

In line with the delivery of a revised strategy, it is an appropriate time to review the operation of the Stakeholder Committee to ensure it remains aligned with the vision of the organisation. The incoming Chairman has sought feedback from current members to gather their perspective, particularly on the effectiveness of its operation and whether it reflects the relevant organisations within the changing health and social care landscape, to assist in reviewing the role of the Committee during 2013.

Healthwatch England

The Health and Social Care Act 2012 made provision for the establishment of a new statutory Committee within CQC, Healthwatch England. The primary purpose of Healthwatch England is to be the national consumer champion for users of health and social care services and to provide the Commission and other bodies with advice, information or other assistance. The Chair of Healthwatch England is Anna Bradley, who is also a CQC Commissioner.

The Healthwatch England Committee considered and accepted governance arrangements and policies approved by the CQC Board designed to ensure effective governance of Healthwatch and to provide appropriate and necessary assurances to both the CQC Board and CQC Chief Executive as the Accounting Officer.

These arrangements will be tested during the coming year as Healthwatch begins to operate to its full remit as local Healthwatch organisations are established. The governance arrangements therefore will be kept under review to ensure that they remain fit for purpose in ensuring the appropriate balance

between preserving the appropriate measure of independence for Healthwatch to be effective while also retaining the appropriate controls and assurances to support the Accounting Officer.

Dr Katherine Rake OBE took up the role as Director of Healthwatch England at the beginning of January 2013. (The title of this post was then amended by the CQC Chief Executive to 'Healthwatch Chief Executive'). The Healthwatch Chief Executive is accountable to the CQC Chief Executive in his role as Accounting Officer for operating within the financial and legal framework of CQC. The provision of support by CQC to Healthwatch England to assist its effective operation will be reflected in Service Level Agreements, for which both the CQC Chief Executive and the Healthwatch Chief Executive will be responsible for delivering. The Healthwatch Chief Executive will report to the Healthwatch Chair for the operational delivery of the Committee's business plan and day-to-day priorities.

The Healthwatch Chief Executive is required to provide assurances to the CQC Chief Executive that Healthwatch England is operating effectively, efficiently and economically; specifically that appropriate controls are in place for information governance (including information security), the handling of complaints about Healthwatch England, adhering to Standing Financial Instructions (including procurement controls); adhering to Government recruitment controls and the Service Level Agreement between CQC and Healthwatch. This post does not however form part of the CQC Executive Team.

The National Information Governance Committee

Under the Health and Social Care Act 2012, CQC has been given responsibility to monitor and report on how well registered providers handle and manage information, including confidential care records. The Act further requires CQC to establish by 1 April 2013 a National Information Governance Committee to advise and assist in the exercise of this new function.

Five independent members have been recruited and representatives obtained from NHS England, the Health and Social Care Information Centre, and Healthwatch England. The Information Commissioner's Office will be invited as an observer.

The CQC Board will approve a plan of the work for the Committee during 2013/14 which best supports CQC meeting its strategic objectives. The Committee held its inaugural meeting in June 2013.

Remuneration Committee

The Remuneration Committee has responsibility for determining the remuneration of the Chief Executive and selected senior members of staff, within the guidelines laid down by DH on Very Senior Pay. The Committee also reviews CQC's pay policy and has taken on responsibility during the year for reviewing arrangements for succession planning.

The Committee has discharged its responsibilities. It has met four times during 2012/13 and considered the executive reward strategy including revised arrangements by DH with regards to Very Senior Managers' pay; received an update on the CQC pay and grading review; and determined the pay remit for CQC for 2012/13; approved proposals for negotiation regarding the revised pay award for 2013/14; and approved the role description for a new Executive Director of Strategy. It also considered the Chief Executive and very senior manager pay awards for 2011/12. The Chief Executive and the Director of Human Resources regularly attend meetings of the Committee.

Audit and Risk Assurance Committee (ARAC)

ARAC's role is to provide independent assurance to the Board and to the Chief Executive as Accounting Officer on the effectiveness of CQC's risk management and internal control and governance systems. Its terms of reference are in line with the principles of good governance and guidance laid down by Treasury and the National Audit Office.

Professor Deirdre Kelly, who was Committee Chair, stood down from the Board at the end of January. John Harwood, who was Deputy Chair of the Committee, took over the role of Chair at the beginning of February 2013. The Committee is attended also by the NAO as external auditor, the Head of Internal Audit, the Chief Executive, the Director of Finance and Corporate Services and the Director of Governance and Legal Services.

The Committee met formally five times during 2012/13 and also held a number of workshops with the Executive Team to discuss how to improve the identification and management of strategic risks. It reported to the Board following each meeting. The DH provides an observer at meetings and receives the agenda, papers and minutes of all meetings.

During the year, the remit of the Committee expanded to take on responsibility for scrutiny of Healthwatch England's internal control and risk management, providing assurance to the Accounting Officer that its affairs have been conducted with probity and propriety. Jane Mordue, a member of the Healthwatch England Committee, was co-opted on to the Audit and Risk Assurance Committee to enable the Committee to draw on her expertise in relation to Healthwatch.

The Committee led work to review the CQC strategic risks, to align them with its new strategic objectives and to identify the supporting processes and analyses which the CQC Board will require to discharge its responsibilities. (See Risk management below.)

Specifically the Committee provided advice and assurance to the Board through:

- Review and oversight of the preparation of the annual report and accounts for the approval by the Board, including the audit completion report.
- Review of CQC's systems of internal control and risk management, including its treatment of strategic risks, monitoring the analysis of regulatory risks within and across the health and social care sectors.
- Requiring improvement in the systems to analyse patterns, themes and trends in compliance which informs the design of CQC's regulatory model and deployment of regulatory resources.
- Commissioning the Deloitte review of CQC's use of its section 48 powers under the Health & Social Care Act.
- Reviewing the overseeing improvements in CQC's counter-fraud arrangements.
- Approving a programme of risk based internal audits, and monitoring the effectiveness and timeliness of the completion of management actions.
- Receiving a report on CQC's internal whistle-blowing arrangements.
- Considering a report about the temporary loss of access to information held on a computer drive.

- Overseeing progress in the development of CQC's information governance and information security arrangements.
- Amending the ARAC Terms of Reference to include oversight of Healthwatch England.
- Approving the proposal for recharging Healthwatch England costs for the financial year to the end of March 2013.
- Receiving regular reports from the Corporate Governance Framework Project Board, (established to deliver improvements in CQC's corporate governance arrangements – see below).
- Scrutinising the Government intention to centralise internal audit provision in a departmental shared service hub from which CQC would obtain internal audit services. Recognising that such a service will need time to be established ARAC has put in place a contingency arrangement to ensure an effective and suitable resources internal audit programme in the coming year.

The Committee therefore was effective in assisting the Board to hold the Executive to account and in supporting the Accounting Officer in securing effective sources of assurance.

The Committee agreed to complete the self-assessment of its effectiveness in January. It concluded that while CQC had made a number of steps to improve its management of risk and provision of assurances, there was still work to do to ensure these were understood and embedded across the organisation. In support of that the Committee plans to adopt an assurance mapping approach to its work in the coming year to strengthen the assurances it provides to the Board and Accounting Officer. This will be important in helping to reveal early on whether there are weaknesses in controls or gaps in assurance and allow these to be addressed. Such an approach is intended to ensure that CQC has the means to identify for itself where improvement is required and to keep under constant review the adequacy of its assurance mechanisms.

Risk management, risk assessment and risk profile

Considerable work has been undertaken to refine CQC's approach to risk, including a number of workshops with the Board. As a consequence the risk management framework has been further revised and work is well advanced in installing software to empower line management's active management of business delivery risks and to provide real time assurances over risks, controls, mitigating actions and the assessment of their effectiveness. The software will also allow ready profiling of risks by type, owner, rating etc. Identifying and 'tagging' risks by type will address the previous criticism that CQC's various different registers of risks (eg, strategic, corporate, directorate etc) were confusing and a barrier to effective risk control and reporting.

Important governance changes were made during the year to place greater emphasis upon the scrutiny of regulatory risk processes and the effectiveness of the CQC regulatory model. The Regulatory Risk Committee was established to receive regular analytical reports of the volumes, patterns and trends in non-compliance and to report their conclusion about the effectiveness for the CQC regulatory model.

As a result of the reports from the Regulatory Risk Committee to ARAC, and the CQC programme of evaluation, two important pieces of work were commissioned and which have reported in year:

Review of CQC s48 powers

Deloitte was commissioned by ARAC to conduct an independent review[1] to examine how CQC has deployed its powers to conduct investigations and special reviews under Section 48 of the Health & Social Care Act. The report of this review contained a number of important recommendations which were accepted and an action plan to address these was implemented. The findings of the review included that the Section 48 power was created to be used by CQC as a strategic tool rather than merely a regulatory tool in relation to specific providers. The Board thereafter considered whether the power should be reserved to themselves and agreed that it should result in the requirement to amend the Scheme of Delegation to give effect to this, which has been done.

The Walshe review

Professor Kieran Walshe of the Manchester Business School was commissioned to conduct an evaluation of CQC's regulatory model. This concluded that there were doubts about:

- The generic nature of CQC's regulatory model across all sectors regulated by CQC and whether differentiation would be more effective.
- Whether the existing standards against which providers are regulated are sufficiently differentiated and demanding.
- Whether CQC had or would have the necessary predictive database to drive reliably a risk based model of inspection.
- Whether a generic workforce could possess the necessary skills and therefore command the respect of the provider they regulate.

The conclusions of this report – endorsed by the Board – were an important input to the shaping of the new CQC strategy, which together with the Government's response to the Francis Inquiry report, have resulted in planned fundamental changes in CQC regulatory approach.

Key risks managed in year

The Board has kept its strategic risks under regular review as part of its quarterly performance discussions. As noted elsewhere considerable work has been undertake to revise those risks and to determine the Board's risk appetite. In addition the executive has managed effectively a number of key risks in year which, had they crystallised, had the potential to have adversely impacted delivery of the business plan and/ or CQC meeting its statutory obligations:

- The lack of adequate resource planning tools, particularly in deploying regulatory resource effectively and efficiently.
- Ensuring effective continuity in the hand-over from an outgoing to an incoming Chief Executive.
- Failing to deliver the promised inspection programme due to lack of operational capacity or efficiency.
- The risk to the quality of CQC regulatory work when seeking to complete the inspection programme.
- Registering primary medical care providers more effectively than previous tranches and to deadline.

1 Deloitte are the NAO's external audit partners for CQC. This review was conducted separately from their audit service to CQC.

- The lack of an effective, system-wide failure regime for NHS providers.
- The capacity and capability to deliver against mental health statutory duties.
- The risk of developing a new CQC strategy while being uncertain of the outcome of the Mid-Staffordshire Public Inquiry.

All these risks were identified and reported to the Board and the ARAC via written Chief Executive reports.

Addressing new and emerging risks

The purpose behind the full review of the CQC strategy was to amend what CQC does, and how it does it, to better address new and emergent issues, risks and challenges in the health and social care system including the transformation of the health and social care system, which came into effect on 1 April 2013. The shaping of the strategy has also reflected the Secretary of State's initial response to the landmark Francis Report into the failings at Mid-Staffordshire NHS Foundation Trust, which set out recommendations for changes and new responsibilities for CQC.

Drawing upon the lessons from the reviews conducted during the year the new strategy sets out what CQC aims to achieve in the next three years. We are planning to make major changes to the way we regulate services in different ways based on what has the most impact on improving the things that matter to people.

We will improve assessment and judgement of all the services we regulate by appointing chief inspectors of hospitals, adult social care and support, and primary and integrated care. These new roles will be central to the better management of regulatory risk by CQC in future. Work has commenced to review thoroughly the Scheme of Delegation to incorporate the Chief Inspector roles in decision-making, and to make clear the Board's role in relation to decisions about providers posing the highest risk to service users.

We will change what we look at when we inspect so that we tackle the following five questions:

- Are services safe?
- Are they effective?
- Are they caring?
- Are they well-led?
- Do they respond to what people are telling them?

Therefore we will be revising our regulatory model to ensure that we can answer these questions. The changes will come into effect in NHS acute hospitals and mental health trusts first because we recognise there is an urgent need for more effective inspection and regulation of these services. We will extend and adapt our approach to other sectors in 2014 to 2015.

However it may take a number of months for CQC and the system as a whole to consider and implement improvements aimed at meeting the requirements of the Francis report. A number of recommendations and themes are likely to have implications for CQC's governance. These include:

- How patient user group representation is integrated into the structure of CQC.

- Consideration of the introduction of a category for nominated board members from representatives of the professions.
- Where in CQC decisions are made when there are requests for CQC to participate in joint inspections.
- Where and how in CQC judgements are made to escalate regulatory decisions.
- Where in CQC the decision is made to take temporary protective action even though an investigation (or similar) has not yet concluded.
- Who in CQC decides to require other agencies (Monitor or TDA) to take action.
- Devising and determining who will sign off aggregated assessments (ratings).

We will continue to carry out our programme of unannounced inspections and enforcement across the sectors we regulate, continue to publish our findings, and continue to deliver our responsibilities under the Mental Health Act.

CQC's strategic and business plans have been accompanied by a process for the review of associated risks. The process of transition in structures, processes personnel and regulatory methods will generate its own risks. However these have been identified and will be controlled and mitigated.

The Executive Team

The responsibility for implementing the Board's strategy belongs to the Chief Executive and his team. The Chief Executive, David Behan, took up office at the end of July 2012 and has reviewed the structure of the Executive Team. (See figure 3 in the annex to this Statement.)

A new Executive Director of Strategy and Intelligence, Dr Paul Bate, has been appointed and commenced work with CQC in May 2013. A Director of Change, Hilary Reynolds, joined CQC in May 2013 for a fixed term appointment of two years. John Lappin announced his retirement in November 2012 and that he would be leaving CQC in July 2013 following completion of the annual report and accounts. Recruitment is under way to appoint a Director of Corporate Services. In addition there are key changes to the operational structure.

An interim executive team structure will be established between April and October 2013 and the final structure established between October 2013 and October 2014 (See figures 4 and 5 in the annex to this Statement). Central to these changes will be the appointment of three Chief Inspectors, for Hospitals, Social Care, and General Practice. These changes relate directly to the changes in strategy and to the Government response to the Robert Francis public inquiry report which established the post of Chief Inspector of Hospitals. This change in structures is intended to ensure that CQC is best equipped and organised to deliver its strategic and business plan objectives.

Executive Team committees

The purpose of Executive Team committees (see figure 3) is to support the team and the Chief Executive in running the organisation. There have been changes in year and further reviews are planned. In particular:

- The Corporate Change Committee has been replaced with a Transformation Programme Board reporting to the Executive Team because future corporate changes will be driven by the need to make improvements to deliver the strategic and business plans objectives.
- The need for the Corporate Delivery Committee has been reviewed and, having been assured that its functions were either being carried out already by the Executive Team or could be better discharged by officials within the authority of their roles, has been disestablished. Its subcommittees also will be reviewed to ensure that they remain fit for purpose and necessary. In the meantime they now report directly to the Executive Team. The Establishment and Recruitment Controls Committee is the mechanism through which the Government recruitment controls have been applied to CQC. If disestablished an alternative mechanism of control will be required. The Health & Safety Committee is a statutory requirement to monitor CQC's duty to discharge its health, safety and welfare obligations to its staff. The Investment Committee has supported the CDC effectively by examining and approving formal business cases and pending review, will continue to provide this support directly to the Executive Team.
- The Regulatory Risk Committee's purpose is to keep the CQC regulatory model under review. It has reported both to the Executive Team and to the ARAC. This Committee also will be reviewed during the year as the Executive roles and responsibilities change, in particular to consider its role in light of the creation of the Chief Inspector posts.

Performance, Risk and Assurance data quality

Work has continued during the year to improve the quality of CQC's data systems and data quality. The performance reporting mechanisms and the format of the reporting within the Executive and to the Board have been further reviewed and refined; these will be refined further during the coming year to ensure that the necessary management information is available, reliable and timely to allow CQC to manage performance and risk optimally. For the coming year each Directorate's business plan will be required to make clear how it will identify and manage risk and have these captured in the personal objectives of staff.

These improvements will include improvements in the quality and timeliness of data and analysis provided to regulatory staff to support regulatory decision making, and improvements in systems to record and provide timely report of regulatory action taken, including enforcement action.

However further work is required to ensure the robustness and reliability of performance and risk data quality in the coming year.

Openness and transparency

During the year CQC made several important changes to enhance its openness and transparency:

- The CQC website section on CQC's governance was reviewed in line with best practice guidelines.
- The Board commenced live webcasting – and subsequently available video-on-demand – of its quarterly meetings in public to improve access to Board proceedings.
- CQC joined with other regulators, professional bodies and trade unions to launch the Speaking Up charter, a commitment to work together to support people who raise concerns in the public interest through a just, open and transparent culture. As a result, the Code of Conduct for Board members

has been revised to include a supporting protocol; and the whistle-blowing policy also has been amended to make it clear that there is a specific mechanism for Board members to raise concerns. This will be further reviewed in light of the findings of the Grant Thornton review.

- Following the publication of the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, CQC undertook a review of its contracts/policies to ensure that this documentation was in line with the Report's recommendations. CQC will no longer use contracts which contain non-disparagement provisions, commonly referred to as gagging clauses. (No such clauses have been used by CQC since June 2012). Additionally, relevant CQC contracts will contain specific provisions confirming the rights of staff to make protected disclosures (whistle-blow) in line with the Public Interest Disclosure Act 1998. This should ensure, insofar as possible, that staff understand they are not prevented from making disclosures in relation to public interest issues including in relation to the safety and care of health and adult social care service users.

However openness and transparency require not just policies and processes but also supportive leadership, culture and behaviours that ensure that these principles inform all of CQC's work and decision-making. This will form a key element of the work of the Transformation Programme.

Other sources of assurance

In addition to the above, as Accounting Officer I have relied upon the following additional sources of assurance during the year:

- The process of handover from the outgoing Chief Executive.
- The regular reports and assurances provided by Directors.
- The Head of Internal Audit's opinion – below.
- The SIRO's opinion – below.
- The Fraud lead's opinion – below.

The opinion of the Senior Information Risk Owner (SIRO)

I have relied upon the following annual opinion of the SIRO when preparing this Governance Statement:

"The Commission has undertaken a significant amount of work in the areas of information governance, information security and information risk management over 2012/13. This has been overseen by the Information Governance Group (IGG) which is chaired by the SIRO.

An Information Governance and Security Strategy has been put in place to address previously identified weaknesses. A key element has been the development and implementation of an Information Security and Governance Policy in October 2012, which brings together all aspects of information governance into a single policy focussed upon the international standard for information security (ISO27001) and the requirements of the government Security Policy Framework.

An Information Security internal audit in March 2012 produced a number of recommendations for development across the whole range of the information security management spectrum. A further internal audit completed in March 2013 resulted in an overall rating of Substantial Assurance.

An information governance training programme (which is mandatory for all staff) has been revised; a series of physical security reviews at the Commission's offices and data centres, and improved processes for security incident reporting and management.

Although a number of minor security incidents have occurred during the year there have been no major information security incidents and none have necessitated reporting to the ICO. The Commission has agreed to a voluntary audit of data protection compliance by the Information Commissioner's Office (ICO) early in 2013/14, and the findings of this audit will feed into the work plan for the coming year.

The Commission has put in place memoranda of understanding (MOUs) and information sharing agreements (ISAs) with key strategic partners. These documents – which guide staff and set a common understanding for how shared information will be used and handled – will be reviewed throughout 2013/14 to ensure that our information sharing processes develop to help ensure the welfare and safety of people who use care services.

CQC's Code of Practice on Confidential Personal Information sets out how it meets our legal and moral responsibilities to use information effectively whilst protecting personal privacy. This Code and supporting guidance remains under review to ensure that it remains robust and effective.

Requests under the Freedom of Information Act 2000 (FOIA) and the subject access provisions of the Data Protection Act 1998 are managed and responded to by a specialist CQC team. Over 95% are responded to within statutory deadlines.

The Commission takes on a new function in 2013 of monitoring the information governance practices of the providers we regulate. A National Information Governance Committee is being established to guide this work and the Commission intends to create a specialist team to ensure the effective delivery of this function. Work has been ongoing throughout 2012/13 to put in place the governance arrangements to support this new function.

The Commission hosts Healthwatch England, which provides an independent voice for people who use care services. Formal agreements are being developed to manage the information sharing aspects of this relationship and the relationship with local Healthwatch organisations.

The Commission completes and publishes an assessment against the NHS Connecting for Health Information Governance Toolkit. Our assessment in 2011/12 showed 50% compliance which rose to 69% for 2012/13. CQC therefore has made steady progress on information governance over the last year, but has scope for further improvement.

During the year the authority to exercise exemption under Section 36 of the Freedom of Information Act was delegated from the Secretary of State to the Chief Executive of CQC.

Overall, the above work has significantly improved the information risk assurance for CQC. Whilst overall assurance is good, as confirmed by the recent information security audit, the SIRO and Information Governance Group will lead on further work over the coming year towards CQC's aspirations for excellence in this area. Key aspects of this work will include further development of our training programme, cross-directorate work towards improved information sharing with strategic partners, and additional monitoring and checking of compliance with our internal information governance policies. The Information Governance Group considers that these measures will be key to ensuring that the Commission's information security and governance processes support our

corporate strategy and provide robust information risk management through a period of significant change."

Louise Guss – Director of Governance & Legal Services and SIRO

Additionally I have relied upon the following assurance from the Information Security Manager when preparing this Governance Statement:

"Additionally, a significant amount of work has been carried out, in conjunction with colleagues from the Department of Health and NHS England, to ensure that the technical and procedural controls for the new IMS3 infrastructure meet or exceed the requirements of the HMG Security Policy Framework. This work has been completed resulting in the formal approval of the risk management accreditation document set (RMADS) by the joint Security Working Group (SWG). A notable element of this work was assurance of the system resilience including dual live data centres and on-site inspections of their compliance with standard required by each of the IMS3 partners and contained within the IMS3 supplier contract. A risk register for the transfer of the IT service was compiled and has been monitored during the weekly meetings of the SWG. CQC specific risks have been discussed and addressed via the internal Information Governance Group meetings."

Derek Wilkinson – Information Security Manager

Head of Internal Audit opinion

I have relied upon the following annual opinion of the Head of Internal Audit when preparing this Governance Statement:

"I do not report any specific significant weaknesses that would impact on the proper discharge of CQC obligations. The frameworks for governance, risk management and control have continued to develop in line with good practice and in a more integrated and mutually reinforcing way. This is producing higher levels of assurance that risks to CQC's objectives being achieved are being better managed. There has been improvement in the governance, risk management and control of discrete processes, however the speed of maturation towards being embedded across the whole organisation is slow and has been constrained by management's capacity for handling change. CQC has recognised this in its governance vision and supporting principles, but now needs to harness the current significant change of structure, personnel and culture as a fillip to accelerate governance maturity to become a high performing, successful and sustainable organisation."

Nigel Freeman: Head of Internal Audit

Fraud lead opinion

I have relied upon the following annual opinion of the Fraud lead when preparing this Governance Statement:

"The counter fraud policy and fraud response capability were significantly updated last year and have been put into full effect during the current year. A follow-up audit on counter fraud in CQC provided substantial assurance concluding that counter fraud arrangements in CQC are satisfactory in design and operation and have been enhanced through lessons learned from recent investigations/cases.

19 potential fraud cases have been reported in the year covering a broad range. After rigorous preliminary research and consideration by the fraud response group none of these have progressed into fraud, bribery or corruption investigations.

During this year we also identified actions which amounted to fraud and gross misconduct on the part of a member of staff (a Compliance Inspector). Late in 2011/12 CQC received information from an anonymous external source which made a range of allegations regarding this individual which were fully investigated and led to the dismissal of the individual and referral of the evidence to the Police for their consideration. The Police referred the file of evidence to the Crown Prosecution Service, who determined that the evidence was adequate to commence a criminal prosecution of the individual, but concluded that a prosecution was not in the public interest. We have made strong representations regarding this decision to the Crown Prosecution Service, and have kept the Department of Health informed."

Louise Guss – Director of Governance & Legal Services and lead Director for counter fraud

Accounting Officer letters

All Accounting Officer letters received have been actioned including the guidance for arm's length bodies (ALBs) on the business planning framework for 2013/14, the CQC budget allocation for 2012/13 and the changes to efficiency controls applying to ALBs.

Ministerial directions

We have received no formal Ministerial Directions during the year. CQC however has received a Ministerial request to undertake specific inspection activity for the coming year looking at the quality of the induction of care staff, which CQC has agreed to undertake.

Conclusion

As the incoming Chief Executive I examined the available assurances, including an audit of corporate governance which found that there were deficiencies related to culture and behaviours. The Grant Thornton report – which although containing conclusions which some dispute – confirmed that there remained significant cultural and behavioural issues undermining good governance at the start of the year adversely affecting senior management and the operation of the Board.

I conclude that whilst good progress has been made in establishing good governance in CQC during the year, CQC's governance processes need to mature further; they are not as yet generating consistently the necessary positive assurances that a fully mature and embedded governance framework would provide. The governance processes will be redesigned further in the coming year alongside the organisational restructure and implementation of the strategy to ensure they support CQC in achieving its purpose.

It will be important however that CQC can demonstrate that those regulatory weaknesses and cultural deficiencies revealed by the Grant Thornton report which served to undermine good governance do not persist. As CQC moves at pace to introduce new a regulatory model it will be essential that it does not allow these processes to become operational without the necessary accompanying governance arrangements, including appropriate scepticism and challenge. Regulatory decisions must be based upon a systematic capture of evidence, sound analysis of that evidence and decision-making at a level

in the organisation which aligns with the authority provided in the governance arrangements. This is important not only in the discharge of CQC's own statutory responsibilities but also to ensure that CQC's decisions can be relied upon so that CQC is an effective and trusted partner in the health and social care system. I am confident that the commitment of a new Executive Team and a new Board to the implementation of the new CQC strategy will ensure that is the case.

Despite the issues revealed by external and internal scrutiny nevertheless the governance processes are now sufficiently established to prompt the appropriate questions and demands for assurances. In those instances where the expected positive assurances have not been forthcoming further work has been commissioned by CQC – including the Grant Thornton and other external reviews – to provide assurances and answers. CQC's governance mechanisms therefore, whilst requiring further improvement, have been sufficiently effective during 2012/13 to support the Accounting Officer in the discharge of his duties.

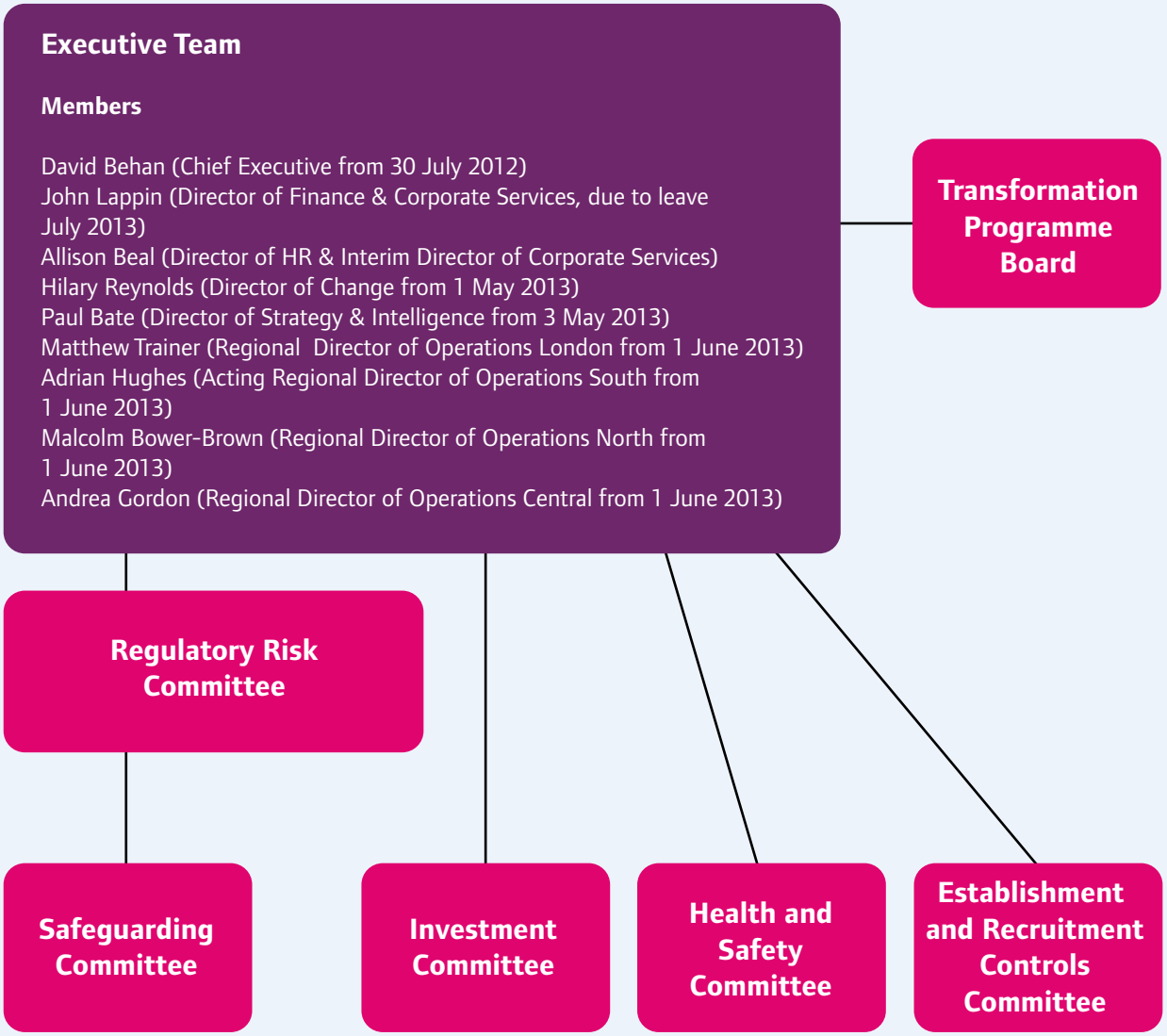
Annex

Figure 1: Board and Committee structure

Figure 2: Summary of Board attendance

	18/4/12	16/5/12	18/7/12	19/9/12	17/10/12	20/11/12	20/12/12	16/1/13	7/2/13	20/3/13
David Prior									Y	Y
Jo Williams	Y	Y	Y	Y	Y	Y	Y	Y		
David Behan			Y	Y	Y	Y	Y	Y	Y	Y
Anna Bradley			Y	Y	Y	Y	Y	Y	X	Y
John Harwood	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Stephen Hitchins			Y	Y	Y	Y	Y	Y	Y	Y
Deirdre Kelly	X	Y	Y	Y	Y	Y	Y	Y		
Martin Marshall	Y	Y	X	Y	Y	Y	Y			
Kay Sheldon	Y	X	X	Y	Y	Y	Y	Y	Y	Y

Figure 3: Executive Team Committee structure



Past Executive Team Members

Cynthia Bower (Chief Executive left CQC end July 2012)
Jill Finney (Director of Strategic Marketing & Communications left CQC 24 February 2013)
Chris Day (Interim Director of Strategic Marketing & Communications from 25 February 2013. Executive Team member until 31 May 2013)
Louise Guss (Director of Governance & Corporate Services left CQC 31 May 2013)
Nick Blankley (Interim Director of Intelligence from 5 October 2012. Executive Team member until 31 May)
Amanda Sherlock (Director of Operations left CQC 31 May 2013)
Philip King (Director of Regulatory Development. Executive Team member until 31 May 2013)

Figure 4: CQC's interim structure until October 2013

The interim structure for CQC senior structure for October 2013 will be as follows:

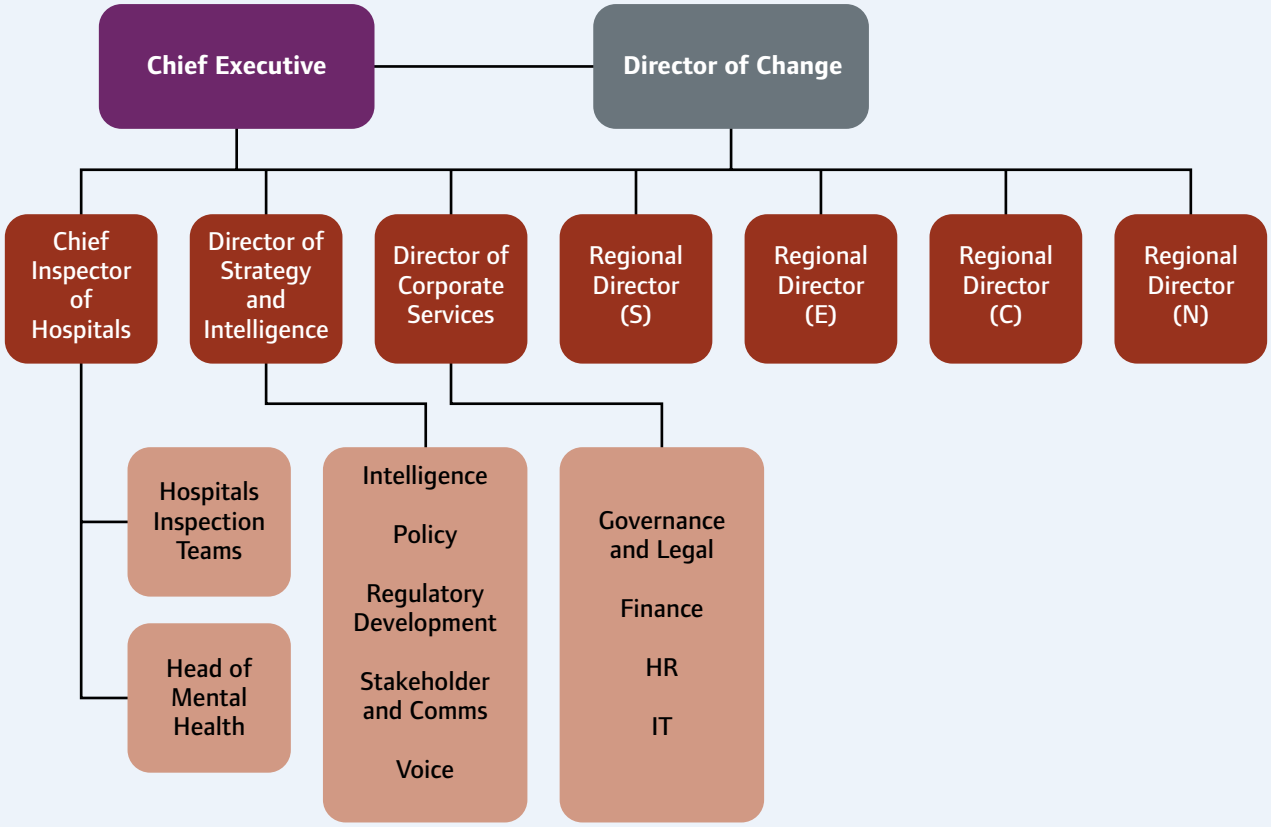


Figure 5: CQC's final structure by October 2014

The final structure for CQC will be as follows:

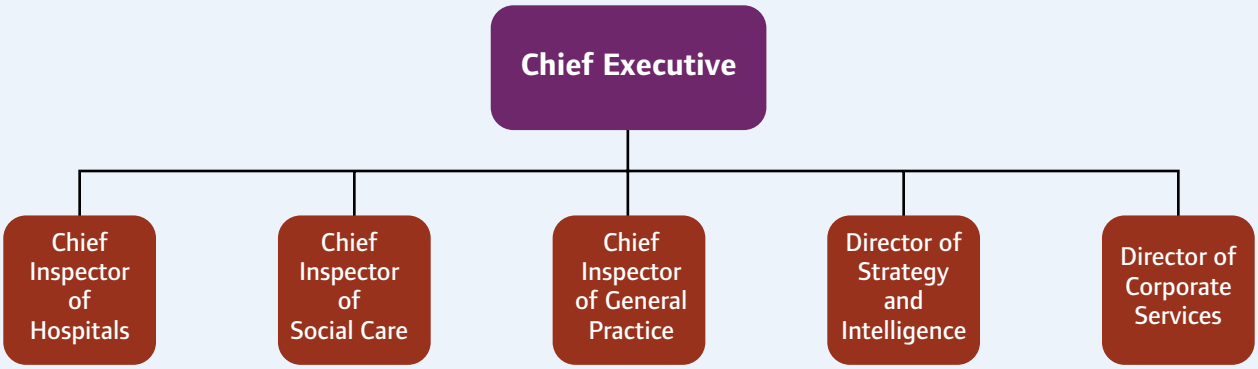
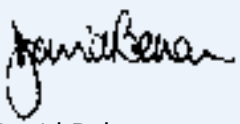


Figure 6: Board coverage

CQC Board – coverage of topics 1 April 2012 to 31 March 2013	
Agenda items	
Chairs and Commissioners' reports	Enforcement Activity – Annual report
Chief Executive reports	The CQC Regulatory Model – Evaluation project findings
Review of CQC Strategy including consultation responses	The CQC Regulatory Model – review of CQC's use of its regulatory powers
CQC Business Planning and Budget	The CQC Regulatory Model in light of consultation responses
Recruitment of the Chief Executive	Registration of Partnerships
Annual Report to Parliament – Themes and approach	Safeguarding Annual Report
Annual Reports and Accounts and Finance Report for year ended 31 March 2013	Themed Inspection update
Quarterly Risk and Performance Reports, including financial reports and review of strategic risks	Healthwatch England accountability and governance arrangements
Reports from Audit and Risk Assurance Committee – including review of the Committee's effectiveness	Healthwatch England Business Plan for 2013/14
Reports from the Remuneration Committee	State of Care report – content, approach and intended impact
Approval of Stakeholder Committee Terms of Reference and membership	Mental Health Act Annual Report
Re-appointment of Chairs of Board Committees and Review of membership of Board sub-committees	Deprivation of Liberty Safeguards – Annual Submission
Approval of the schedule of Board meetings	Working with people who use services
Approval of the Corporate Governance Framework	Report on terms of reference for National Information Governance Committee
Approval of the CQC Accountability Framework	Fees Strategy and Scheme
Review of the Board's Standing Orders and Code of Conduct, including a social media policy and how Board members should raise concerns	Fees consultation
Approval of a revised Role Description for Board Members	Working with partners including Monitor, The NHS Trust Development Authority and NHS Commissioning Board
Complaints Annual Report	Consideration of the Francis recommendations following public inquiry into Mid Staffordshire
Registration of Dentists	Responses to consultations (various including transfer of functions of HTA and HFEA to CQC; Nuffield work on Aggregated Assessments; and Strengthening the NHS Constitution)
Registration of other Primary Medical Services	Health Select Committee Report
Delivery of 2012/13 inspection programmes	



David Behan,
Chief Executive, Care Quality Commission
26 June 2013

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 2013 under the Health and Social Care Act 2008. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, 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 Board, Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities**,** the Board and the Accounting Officer are 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, certify and report on the financial statements in accordance with the Health and Social Care Act 2008. I conducted my audit in accordance with 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 read all the financial and non-financial information in the CQC Annual Report and Accounts 2012/13 to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

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 recorded in the financial statements conform to the authorities which govern them.

Opinion on regularity

In my opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements 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 2013 and of the net expenditure 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 given in the Management Commentary for the financial year for which the financial statements are prepared 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 and the part of the Remuneration Report to be audited 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 Governance Statement 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

1 July 2013

Financial statements

Statement of comprehensive net expenditure

for the year ended 31 March 2013

	Note	2012/13 £000	2011/12 £000
Expenditure			
Staff costs	2&3	110,349	94,153
Depreciation	4	11,383	11,340
Other expenditure	2&4	44,067	37,544
Impairment of assets	4	(229)	6,403
		165,570	149,440
Less income			
Income from Activities	6	(93,008)	(85,987)
Other income	6	(17)	(2,504)
		(93,025)	(88,491)
Net expenditure for the financial year		**72,545**	**60,949**

Comprehensive expenditure

	Note	2012/13 £000	2011/12 £000
Net (gain) on revaluation of intangibles		(2,188)	(10)
Net (gain) on revaluation of property, plant and equipment		(428)	(14)
Change in the discount rate on long term creditors		–	(7)
Actuarial (gain)/loss in pension schemes	3	(8,979)	55,412
		(11,595)	55,381
Total comprehensive expenditure for the year ended 31 March 2013		**60,950**	**116,330**

All income is derived from continuing operations.

Healthwatch England is a new activity during the financial year and expenditure relating to that activity is noted in note 2.

Healthwatch England is a Committee of CQC.

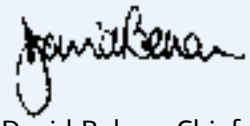
Notes 1 to 23 form part of these financial statements.

Statement of financial position

as at 31 March 2013

	Note	31 March 2013 £000	31 March 2013 £000	31 March 2012 £000	31 March 2012 £000
Non-current assets:					
Intangible assets	7	19,267		14,059	
Property, plant and equipment	8	2,306		4,540	
Total non-current assets			**21,573**		**18,599**
Current Assets:					
Trade receivables	12	3,903		7,802	
Other current assets	12	2,366		2,381	
Cash and cash equivalents	13	20,187		15,766	
Total current assets			**26,456**		**25,949**
Total assets			**48,029**		**44,548**
Current liabilities:					
Trade and other payables	14	(15,798)		(14,488)	
Current pension liabilities	14	(316)		(487)	
Provisions	15	(1,618)		(702)	
Total current liabilities excluding Fee Income in Advance		**(17,732)**		**(15,677)**	
Non-current assets plus net current assets excluding Fee Income in Advance		**30,297**		**28,871**	
Fee Income in Advance	14	(36,576)		(35,224)	
Total current liabilities			**(54,308)**		**(50,901)**
Non-current assets plus net current assets			**(6,279)**		**(6,353)**
Non-current liabilities					
Provisions	15	(1,132)		(1,439)	
Pension liabilities	14	(788)		(1,022)	
Total non-current liabilities excluding pension deficit provision			(1,920)		(2,461)
Assets less liabilities excluding pension deficit provision			**(8,199)**		**(8,814)**
Pension deficit provision	3		(61,233)		(67,768)
Assets less liabilities			**(69,432)**		**(76,582)**
Taxpayers' equity					
General reserve			(71,266)		(76,811)
Revaluation reserve			1,834		229
Total taxpayers' equity			**(69,432)**		**(76,582)**

The financial statements on pages 132 to 163 were approved by the Board on 26 June 2013 and were signed on its behalf by:



David Behan, Chief Executive, CQC

Notes 1 to 23 form part of these financial statements.

Statement of cash flows

for the year ended 31 March 2013

	Note	2012/13 £000	2012/13 £000	2011/12 £000	2011/12 £000
Cash flows from operating activities					
Total net expenditure		(72,545)		(60,949)	
Adjustment for depreciation charge	4	11,383		11,340	
Impairment of intangible assets	4	(229)		6,399	
Impairment of property, plant & equipment	4	–		4	
Net (gain)/loss on indexation of intangible assets	4	(40)		24	
Net (gain)/loss on indexation of property, plant and equipment	4	(9)		5	
Loss on disposal of intangible assets	4	–		585	
Loss on disposal of property, plant and equipment	4	3		437	
Cost of PCSPS long term creditor recognised as an expense	4&14	159		136	
Net expense on pension scheme assets and liabilities	4	425		–	
Decrease/(Increase) in trade and other receivables	12	3,914		(1,581)	
Increase in trade payables	14	2,577		3,009	
(Decrease) in current pension liabilities	14	(171)		(192)	
Increase in deferred income	14	1,352		10,227	
Increase/(Decrease) in provisions	15	184		(1,189)	
Non cash pension charge	3	2,444		(1,601)	
(Decrease) in non-current pension liabilities	14	(393)		(563)	
Net cash outflow from operating activities			(50,946)		(33,909)
Cash flows from investing activities					
Purchase of intangible assets	7&14	(11,455)		(11,310)	
Purchase of property, plant and equipment	8&14	(1,278)		(681)	
Net cash outflow from investing activities			(12,733)		(11,991)
Cash flows from financing activities					
Grants from Department of Health		68,100		45,300	
Net financing			68,100		45,300
Net increase/(decrease) in cash and cash equivalents in the year			4,421		(600)
Cash and cash equivalents at the beginning of the period	13		15,766		16,366
Cash and cash equivalents at the end of the period	13		**20,187**		**15,766**

Notes 1 to 23 form part of these financial statements.

Statement of changes in taxpayers' equity

for the year ended 31 March 2013

	Note	Revaluation reserve £000	General reserve £000	Total reserves £000
Balance at 31 March 2011		1,191	(6,743)	(5,552)
Changes in taxpayers' equity for 2011/12				
Net gain on indexation of intangible assets		10	–	10
Net gain on indexation of property, plant and equipment		14	–	14
Transfers between reserves for intangible assets		(511)	511	–
Transfers between reserves for property, plant and equipment		(475)	475	–
Net expenditure for the year		–	(60,949)	(60,949)
Change in the discount rate on long term creditors		–	7	7
Actuarial (loss) in pension schemes	3	–	(55,412)	(55,412)
Total recognised income and expense for 2011/12		**(962)**	**(115,368)**	**(116,330)**
Grant from Department of Health		–	45,300	45,300
Balance at 31 March 2012		**229**	**(76,811)**	**(76,582)**
Changes in taxpayers' equity for 2012/13				
Net gain on indexation of intangible assets		2,188	–	2,188
Net gain on indexation of property, plant and equipment		428	–	428
Transfers between reserves for intangible assets		(734)	734	–
Transfers between reserves for property, plant and equipment		(277)	277	–
Net expenditure for the year		–	(72,545)	(72,545)
Change in the discount rate on long term creditors		–	–	–
Actuarial gain in pension schemes	3	–	8,979	8,979
Total recognised income and expense for 2012/13		**1,605**	**(62,555)**	**(60,950)**
Grant from Department of Health		–	68,100	68,100
Balance at 31 March 2013		**1,834**	**(71,266)**	**(69,432)**

Notes 1 to 23 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 2012/13 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.

Early adoption of IFRS amendments and interpretations

No IFRS changes were adopted early in 2012/13.

IFRS amendments in issue that are effective for the financial year beginning 1 April 2012 but which are not expected to have an impact on the CQC's accounts

Amendments to IFRS7 Financial instruments: disclosures (annual improvements)

Amendments to IAS12 Deferred Tax: Recovery of Underlying Assets

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

IFRS9 Financial Instruments	A new standard intended to replace IAS39. The effective date is for accounting periods beginning on, or after 1 January 2015.
IFRS10 Consolidated Financial Statements	This replaces the consolidation guidance in IAS27 *Consolidated and Separate Financial Statements* and SIC 12 *Consolidation – Special Purpose Entities*. It introduces a single consolidation model for all entities based on control. The effective date is for accounting periods beginning on, or after 1 January 2013.
IFRS11 Joint Arrangements	This introduces new accounting arrangements for joint arrangements, replacing IAS31 *Interests in Joint Ventures*. The effective date is for accounting periods beginning on, or after 1 January 2013.

IFRS12 Disclosure of Interests in Other Entities	Additional disclosures are required so that financial statement users may evaluate the basis of the control, any restrictions on consolidated assets and liabilities and any risk exposures. The effective date is for accounting periods beginning on, or after 1 January 2013.
IFRS13 Fair Value Measurement	This defines "fair value", provides guidance on how to determine fair value, and requires disclosure about fair value measurements. The effective date is for accounting periods beginning on, or after 1 January 2013.
IAS 27 Separate Financial Statements	Contains the unchanged residual accounting and disclosure requirements for investments in subsidiaries, joint ventures and associates when an entity prepares separate financial statements. The effective date is for accounting periods beginning on, or after 1 January 2013.
IAS 28 Investments in Associates and Joint Ventures	Outlines the accounting arrangements for investments in associates and joint ventures using equity arrangements. The effective date is for accounting periods beginning on, or after 1 January 2013.
Amendments to IAS1	Presentation of items of Other Comprehensive Income. Items disclosed in the OCI need to be grouped into items that might be reclassified to profit and loss in subsequent periods and those that will not. The effective date is for accounting periods beginning on, or after 1 April 2013.
Amendments to IAS 16	The change relates to the classification of servicing equipment. The effective date is for accounting periods beginning on, or after 1 April 2013.
Amendments to IAS19	This affects the Pension disclosures and transactions. The effective date is for accounting periods beginning on, or after 1 January 2013.
Amendments to IAS32	The change relates to the tax effect of distribution to holders of equity instruments. The effective date is for accounting periods beginning on, or after 1 January 2014.

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 are 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 three years. The estimate of expected life is regularly reviewed to ensure that depreciation and amortisation is charged in the statement of comprehensive net expenditure is materially accurate.

Impairment of intangible and property, plant and equipment assets

At each statement of financial position date the management review 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 providers, voluntary healthcare providers, dentists, ambulance services and other income arising mainly from secondments of Commission staff and recoveries of costs from other public bodies. Annual registration fees are invoiced on the anniversary of the registration and recognised as income over the following 12 months. Statutory fees relating to future accounting periods are treated as income in advance at the end of each accounting period (Note 14). 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.

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. Consequently the liability for additional pension contributions resulting from the early termination of staff in previous years is discounted by 2.35% (2011/12: 2.8%). This is the rate for market yields on AA corporate bonds as published by HM Treasury.

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. Provisions falling due up to five years are increased by a discount factor of 1.8% and provisions falling due between five to 10 years are increased by a discount factor of 1.0% (2011/12: 2.2%) in accordance with HM Treasury guidance.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when CQC has developed a detailed plan for the restructuring and has formally informed those affected by the plan either by starting to implement the plan or announcing its main features to those affected by it. The amount of the provision is only the direct expenditures arising from the restructuring and is not associated with ongoing activities.

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 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

CQC employees are covered by the provisions of 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 the note 3 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 and reported in the statement of other comprehensive expenditure.

1.4 Administration and programme expenditure classification

A new requirement outlined in the FReM for 2011/12 is an analysis of expenditure between administration and programme costs. The analysis for non-departmental public bodies is only required to be consistent with returns made for the purposes of the Departmental Group consolidation. The expenditure identified in the statement of comprehensive net expenditure was split between programme of £46m (2011/12: £40m) and administration of £27m (2011/12: £21m) in the Spending Review of the Care Quality Commission's sponsoring department, the Department of Health.

1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of CQC's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

There are no critical judgements made by management in the application of the accounting policies that has a significant effect on the amounts recognised in the financial statements other than:

a) Impairment of intangible assets (see accounting policy note 1.2 and note 10)

b) Bad debt provision (see accounting policy note 1.2 and note 12.2)

2. Analysis of net expenditure by segment

IFRS8 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 by two segments; continuing operations and Healthwatch England. Healthwatch England is the independent champion for consumers of health and social care services.

The balance sheet by segment is not included as a segmental balance sheet was not reported to the Board. The comprehensive net expenditure for continuing operations and Healthwatch England for 2012/13 were £70.6m and £1.9m respectively. An analysis of the net expenditure by segment is below.

	Continuing operations £000	Healthwatch England £000	Total CQC £000
Expenditure			
Staff costs	109,188	1,161	110,349
Depreciation	11,383	–	11,383
Other expenditure	43,323	744	44,067
Impairment of assets	(229)	–	(229)
	163,665	1,905	165,570
Less income			
Income from activities	(93,008)	–	(93,008)
Other income	(17)	–	(17)
	(93,025)	–	(93,025)

Healthwatch England came into existence on 1 October 2012 and therefore no prior year comparatives included.

The Healthwatch England costs above include an amount of £36.9k recharged from CQC which related to overhead costs incurred by CQC.

Healthwatch England overhead of around £200k has been absorbed by CQC and not recharged in this financial year.

2.1 Revenues from major products and services: Income from fees

CQC has been operating a revised fees scheme from 1 April 2011. This introduced an annual fee for each service provider, and separate fees for registration and variations were no longer required.

	2012/13 £000	2011/12 £000
Annual Fees	(92,694)	(85,562)
Annual Fees - rebate scheme	–	–
Initial Registration Fees	–	(170)
Variation Fees	–	(31)
Chargeable inspections etc	–	–
Fee Income (Note 6)	**(92,694)**	**(85,763)**

3. Staff numbers and related costs

3.1 Staff costs comprise:

	2012/13			2011/12
	Permanently employed staff £000	Others £000	Total £000	Total £000
Wages and salaries	76,293	14,525	90,818	78,424
Social security costs	6,821	301	7,122	6,015
Other pension costs	10,701	–	10,701	9,059
	93,815	**14,826**	**108,641**	**93,498**
Less recoveries in respect of outward secondments	(311)	–	(311)	(238)
Increase in provision for pension fund deficits (See note 3.4)	2,019	–	2,019	893
Staff Costs	**95,523**	**14,826**	**110,349**	**94,153**

Other wages and salaries costs consist of:	2012/13 £000	2011/12 £000
Agency	11,602	8,063
Secondments from other organisations	166	178
Commissioner Fees	672	684
Second Opinion Doctor's Fees and Expenses	2,085	2,301
Total	**14,525**	**11,226**

Agency staff costs of £9.1m relating to IT software developments were capitalised during the year (£7.4m 2011/12).

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

	2012/13 number wte	2011/12 number wte
Directly employed	1,945	1,692
Other**	161	149
Agency Staff engaged on capital projects	42	44
	2,148	**1,885**

The actual number of directly employed whole time equivalents as at 31 March 2013 was 2,142 (2012: 1,792).

**Other – excludes the Commissioners and Second Opinion doctors who are paid per session

During 2012/13 the average number of disabled persons employed by CQC was 110 (2011/12: 99).

3.3 Exit packages

Cost band	2012/13 number	2011/12 number
<£10,000	10	20
£10,000 – £25,000	*	10
£25,000 – £50,000	*	10
£50,000 – £100,000	*	10
£100,000 – £150,000	*	*
£150,000 – £200,000	0	0
>£200,000	*	*
Total number of exit packages	**20**	**53**
Total cost	**£1,147,000**	**£722,000**

Numbers are rounded to the nearest ten, and numbers less than five are represented by *.

All redundancies were compulsory for both years.

Redundancy and other departure costs have been paid in accordance with CQC terms and conditions. Exit costs are accounted for in full in the year of departure. Where the redundancy has resulted in an early retirement, the additional pension costs are met by CQC and not by the individual pension scheme and are included in the bands above.

3.4 Pension arrangements

CQC currently offers its employees membership to the NHS pension scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. 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 run 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. The total cost charged to expenditure of £5,785k (2011/12: £4,258k) represents the contribution payable to the scheme by the Commission at rates specified in the rules of the plan. As at 31 March 2013, contributions of £698k (31 March 2012: £564k) due in respect of the current reporting period had not been paid over to the scheme.

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. 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. This means that the current service cost will increase as the members of the scheme approach retirement.

The 2010/11 triennial actuarial valuation resulted in a change to the way the deficit recovery is managed. From 2011/12 some funds have levied an indexed cash sum in addition to a percentage of payroll costs. Furthermore, from 1 April 2011, increases to local government pensions in payment and deferred pensions have been linked to annual increases in the consumer prices index (CPI), rather than the retail prices index (RPI).

Contribution rates for 2013/14 range between 15.1% and 32.3% (15.8% for Teesside Pension Fund) with annual cash sums ranging from £14.6k to £139.7k (£nil for Teesside).

The present value of the defined benefit obligations were carried out at 31 March 2013 by:

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

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

Pension fund	Assets 12/13 £000	Liabilities 12/13 £000	Surplus/ (Deficit) 12/13 £000	Surplus/ (Deficit) 11/12 £000	Surplus/ (Deficit) 10/11 £000	Surplus/ (Deficit) 09/10 £000	Surplus/ (Deficit) 08/09 £000
Avon	3,923	(5,213)	(1,290)	(1,065)	(788)	(1,096)	(719)
Cambridgeshire	2,191	(2,960)	(769)	(699)	(470)	(1,169)	(322)
Cheshire	3,210	(3,454)	(244)	(102)	138	(2,159)	(912)
Cumbria	2,674	(3,626)	(952)	(853)	(786)	(1,203)	(793)
Derbyshire	2,589	(3,078)	(489)	(315)	(123)	(417)	(385)
Dorset	1,737	(3,073)	(1,336)	(1,172)	(878)	(1,199)	(772)
East Sussex	5,079	(5,138)	(59)	(26)	288	(1,227)	(345)
Essex	4,233	(6,101)	(1,868)	(1,611)	(1,089)	(1,473)	(1,017)
Greater Manchester	11,877	(14,594)	(2,717)	(2,222)	(936)	(4,673)	(1,339)
Hampshire	3,890	(6,170)	(2,280)	(2,120)	(1,630)	(2,360)	(1,690)
Merseyside	5,751	(6,979)	(1,228)	(969)	(640)	(1,241)	(772)
Shropshire	1,785	(2,386)	(601)	(492)	(389)	(850)	(543)
Suffolk	2,676	(3,889)	(1,213)	(1,005)	(671)	(1,636)	(589)
Surrey	4,566	(5,401)	(835)	(757)	(441)	(1,928)	(768)
Teesside	228,766	(271,800)	(43,034)	(52,141)	(4,556)	(28,107)	5,811
West Sussex	2,845	(2,910)	(65)	(160)	(25)	(695)	(517)
West Yorkshire	8,616	(10,869)	(2,253)	(2,059)	(961)	(3,135)	(1,641)
Total	**296,408**	**(357,641)**	**(61,233)**	**(67,768)**	**(13,957)**	**(54,568)**	**(7,313)**

Asset values are at bid value whereas prior to 2008, the value of assets may have been reported as mid value in accordance with the accounting requirement that was in force at that time.

In 2012/13 the deficit reduced slightly due predominantly to:

- Better than expected asset returns over the year.

Three employees (2011/12: 1) retired early on ill-health grounds during the year. An additional pension cost of £51k was levied on CQC.

A summary of the IAS19 disclosure information is as follows:

The ranges of major assumptions used by the actuaries are stated below:

	Teesside Pension Fund % per annum			Other pension funds % per annum		
Key assumptions used:	**2012/13**	**2011/12**	**2010/11**	**2012/13**	**2011/12**	**2010/11**
Discount rate	4.4	4.6	5.5	3.7–4.5	4.6–4.9	5.4–5.9
Expected rate of salary increases	4.4	4.7	5.0	3.9–5.1	4.0–5.0	4.3–5.2
Expected return on scheme assets	7.0	5.7	6.8	4.5–6.7	4.6–7.1	5.3–7.7
Future pension increases	2.5	2.5	2.7	2.4–2.8	2.3–2.5	2.7–2.9
Inflation	2.5	2.5	2.7	2.4–2.8	2.3–2.5	2.7–2.9

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		
	2012/13	**2011/12**	**2010/11**	**2012/13**	**2011/12**	**2010/11**
Retiring today:						
Males	19.2	19.0	18.9	*20.1–24.0*	*20.0–23.9*	*19.8–23.8*
Females	23.2	23.1	23.0	*22.9–25.9*	*22.9–25.7*	*22.9–25.7*
Retiring in 20 years:						
Males	21.1	21.0	20.9	*22.1–25.7*	*22.0–25.6*	*21.9–25.6*
Females	25.1	25.0	24.9	*25.0–28.2*	*25.0–28.1*	*25.0–26.8*

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

	2012/13 £000	**2011/12 £000**
Gross current service cost	6,949	5,739
less employer contributions	(5,049)	(4,952)
Past service cost	–	–
Curtailments and settlements	119	106
	2,019	**893**
Expected return on pension scheme assets	(14,767)	(17,619)
Interest on pension scheme liabilities	15,192	15,125
	425	**(2,494)**
Total operating charge	**2,444**	**(1,601)**

Of the expense for the year, £2.0m debit (2011/12: £0.9m debit) has been included in the net expenditure statement as staff expenditure and £0.4m has been included in other expenditure whereas in previous year (2011/12: £2.4m credit) has been included in other income. Actuarial gains and losses have been reported in other comprehensive expenditure.

The actual return on scheme assets was a gain of £38m (2011/12: £2m loss).

The cumulative amount of actuarial gains and losses recognised in reserves since the date of transition to IFRS on 1 April 2008 is £85m (2011: £94m).

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:

	2012/13 £000	2011/12 £000	2010/11 £000
Present value of defined benefit obligations	(357,556)	(327,159)	(274,254)
Fair value of scheme assets	296,408	259,470	260,370
Deficit in scheme	**(61,148)**	**(67,689)**	**(13,884)**
Past service cost not yet recognised in balance sheet	(85)	(79)	(73)
Liability recognised in the balance sheet	**(61,233)**	**(67,768)**	**(13,957)**

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

	2012/13 £000	2011/12 £000
At 1 April	(327,238)	(274,327)
Service cost	(6,949)	(5,739)
Interest cost	(15,192)	(15,125)
Contributions from scheme members	(1,920)	(2,126)
Actuarial gains and (losses)	(14,771)	(36,308)
(Losses) on curtailments	(119)	(106)
Benefits paid	8,548	6,493
Past service cost	–	–
At 31 March	**(357,641)**	**(327,238)**

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

	2012/13 £000	2011/12 £000
At 1 April	259,470	260,370
Expected return on scheme assets	14,767	17,619
Actuarial (gains) and losses	23,750	(19,104)
Contributions by employer	5,049	4,952
Contributions from scheme members	1,920	2,126
Benefits paid	(8,548)	(6,493)
At 31 March	**296,408**	**259,470**

The actuarial (gain)/loss calculation was as follows:

	2012/13 £000	2011/12 £000
Movements in the fair value of scheme assets	(23,750)	19,104
Less movements in the present value of defined benefit obligations	14,771	36,308
	(8,979)	**55,412**

The analysis of the scheme assets and the expected rate of return at the statement of financial position date was as follows:

	Expected return			Fair value of assets		
	2012/13 %	2011/12 %	2010/11 %	2012/13 £000	2011/12 £000	2010/11 £000
Equity instruments	4.5–7.8	6.1–8.1	7.2–8.4	231,933	207,820	211,419
Debt instruments	3.3–5.8	3.3–4.4	4.8–5.0	33,422	26,418	26,127
Property	4.5–7.3	4.3–7.6	5.4–7.9	16,523	12,971	11,796
Cash	0.5–5.8	0.5–3.5	0.5–4.6	14,530	12,261	11,028
Total				**296,408**	**259,470**	**260,370**

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

	2012/13 £000	2011/12 £000	2010/11 £000	2009/10 £000	2008/09 £000
Present value of defined benefit obligations	(357,641)	(327,238)	(274,327)	(306,167)	(192,756)
Fair value of scheme assets	296,408	259,470	260,370	251,599	185,443
Surplus/(deficit) in the scheme	(61,233)	(67,768)	(13,957)	(54,568)	(7,313)
Experience adjustments on scheme liabilities	435	(625)	(3,252)	70	(616)
Percentage of scheme liabilities (%)	0%	0%	1%	0%	0%
Experience adjustments on scheme assets	23,750	(19,158)	(5,210)	57,390	(50,645)
Percentage of scheme assets (%)	8%	7%	2%	23%	27%

4. Other expenditure

	£000	2012/13 £000	£000	2011/12 £000
IT costs, including general project management	13,383		11,028	
Travel and subsistence	6,308		5,149	
Other Premises Costs	3,742		4,130	
General Office Supplies	3,611		2,941	
Rentals under operating leases	3,458		3,658	
Communications	3,363		2,055	
Telecoms	2,232		2,306	
Recruitment, Training & Development Costs	2,132		2,033	
Consultancy	1,752		71	
Redundancy	1,147		722	
Professional fees & project costs	1,146		1,310	
Printing & Publishing	595		612	
Other costs	266		(2)	
External Audit Fees – Statutory Work	145		145	
Losses and Special Payments (Bad Debt)	128		131	
Operating Leases (Equipment)	61		63	
Losses and Special Payments (Other)	60		–	
Bank Charges	–		5	
		43,529		36,357
Non-cash items				
Loss on disposal of intangible assets	–		585	
Loss on disposal of property, plant and equipment	3		437	
Net (gain)/loss on revaluation of intangibles	(40)		24	
Net (gain)/loss on revaluation of property, plant and equipment	(9)		5	
Cost of PCSPS Long Term Creditor recognised as an expense	159		136	
Net expenses on pension scheme assets and liabilities	425		–	
		538		1,187
Other Expenditure		**44,067**		**37,544**
Depreciation – intangible assets	8,274		7,225	
– property, plant and equipment	3,109		4,115	
Depreciation		**11,383**		**11,340**
Impairment of intangible assets	(229)		6,399	
Impairment of property, plant and equipment assets	–		4	
Impairment		**(229)**		**6,403**

5. Auditors' remuneration

	2012/13 £000	2011/12 £000
Fees payable to the Commission's auditors for the audit of the Commission's annual accounts	**145**	**145**

6. Income

	£000	2012/13 £000	£000	2011/12 £000
Income from activities:				
Income from fees	(92,694)		(85,763)	
Other income	(314)		(224)	
		(93,008)		(85,987)
Other income:				
Other non trading Income	(17)		(10)	
Net return on pension scheme assets and liabilities	–		(2,494)	
		(17)		(2,504)
Total		**(93,025)**		**(88,491)**

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. While the same Act, also prescribed that all NHS trusts had to be registered with CQC from 1 April 2010, dentists from 1 April 2011, GP "out of hours" services from 1 April 2012 and general practitioners from 1 April 2013.

Annual registration fees are invoiced on the anniversary of the registration and recognised as income over the following 12 months. Statutory fees relating to future accounting periods are treated as income in advance at the end of each accounting period (Note 14). 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.

7. Intangible assets

	IT Software development £000	Software licences £000	Website £000	Total £000
Cost or valuation				
At 1 April 2012	16,829	2,160	1,862	20,851
Additions	9,107	112	1,806	11,025
Disposals	(63)	(32)	–	(95)
Impairments	(233)	(240)	–	(473)
Indexation	2,526	273	276	3,075
At 31 March 2013	**28,166**	**2,273**	**3,944**	**34,383**
Amortisation				
At 1 April 2012	(4,294)	(2,110)	(388)	(6,792)
Charged in year	(6,899)	(518)	(857)	(8,274)
Disposals	63	32	–	95
Impairments	47	655	–	702
Indexation	(580)	(207)	(60)	(847)
At 31 March 2013	**(11,663)**	**(2,148)**	**(1,305)**	**(15,116)**
Net Book value at 31 March 2013	**16,503**	**125**	**2,639**	**19,267**
Net Book value at 1 April 2012	**12,535**	**50**	**1,474**	**14,059**
Cost or valuation				
At 1 April 2011	20,441	2,230	2,749	25,420
Additions	9,848	35	1,358	11,241
Disposals	(1,133)	(101)	(467)	(1,701)
Impairments	(12,289)	–	(1,777)	(14,066)
Indexation	(38)	(4)	(1)	(43)
At 31 March 2012	**16,829**	**2,160**	**1,862**	**20,851**
Amortisation				
At 1 April 2011	(6,255)	(1,173)	(951)	(8,379)
Charged in year	(5,346)	(1,014)	(865)	(7,225)
Disposals	766	101	249	1,116
Impairments	6,493	–	1,174	7,667
Indexation	48	(24)	5	29
At 31 March 2012	**(4,294)**	**(2,110)**	**(388)**	**(6,792)**
Net Book value at 31 March 2012	**12,535**	**50**	**1,474**	**14,059**
Net Book value at 1 April 2011	**14,186**	**1,057**	**1,798**	**17,041**

Intangible asset comprise software licences, software development costs, including related contractor and staff costs, and website development costs. These are valued using indices issued by the Office for National Statistics. Related general project management and overhead costs are not capitalised.

The opening and closing element of the revaluation reserve is shown below.

Revaluation reserve – intangible assets	31 March 2013 £000	31 March 2012 £000
Balance at 31 March	98	599
Net gain on indexation of intangible assets	2,188	10
Transfers between reserves for intangible assets	(734)	(511)
Balance at 31 March	1,552	98

8. Property, plant and equipment

	Information Technology £000	Furniture & Fittings £000	Total £000
Cost or valuation			
At 1 April 2012	8,676	6,834	15,510
Additions	436	5	441
Disposals	(3,457)	(123)	(3,580)
Impairments	–	–	–
Indexation	756	117	873
At 31 March 2013	**6,411**	**6,833**	**13,244**
Depreciation			
At 1 April 2012	(5,255)	(5,715)	(10,970)
Charged in year	(2,653)	(456)	(3,109)
Disposals	3,451	126	3,577
Impairments	–	–	–
Indexation	(359)	(77)	(436)
At 31 March 2013	**(4,816)**	**(6,122)**	**(10,938)**
Net Book value at 31 March 2013	**1,595**	**711**	**2,306**
Net Book value at 1 April 2012	**3,421**	**1,119**	**4,540**
Cost or valuation			
At 1 April 2011	14,016	7,480	21,496
Additions	1,050	133	1,183
Disposals	(6,378)	(829)	(7,207)
Impairments	–	(19)	(19)
Indexation	(12)	69	57
At 31 March 2012	**8,676**	**6,834**	**15,510**
Depreciation			
At 1 April 2011	(7,776)	(5,816)	(13,592)
Charged in year	(3,537)	(578)	(4,115)
Disposals	5,994	776	6,770
Impairments	–	15	15
Indexation	64	(112)	(48)
At 31 March 2012	**(5,255)**	**(5,715)**	**(10,970)**
Net Book value at 31 March 2012	**3,421**	**1,119**	**4,540**
Net Book value at 1 April 2011	**6,240**	**1,664**	**7,904**

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

The opening and closing element of the revaluation reserve is shown below.

Revaluation reserve – property, plant and equipment	31 March 2013 £000	31 March 2012 £000
Balance at 31 March	131	592
Net gain on indexation of property, plant and equipment	428	14
Transfers between reserves for property, plant and equipment	(277)	(475)
Balance at 31 March	282	131

Asset financing

All assets are owned by CQC.

9. 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 where internal recovery processes were exhausted 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.

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 which have not been provided for 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 2013	41	1,376	141
At 31 March 2012	1,437	3,122	2,760

The decrease in trade debtors was due to the improvement in debt recovery processes carried out throughout the year.

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 2013 £000	31 March 2012 £000
Current liabilities	(15,798)	(14,488)

d) Capital risk management

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.

10. Impairments

During December 2012, CQC carried out an impairment review of IT intangible assets. The review resulted in an impairment of software developments amounting to £186k and a reversal of an impairment of software licences of £415k. The impairment relates to old compliance and registration systems which were updated due to the development of new compliance and registration systems.

Impairments for the previous year related to old compliance and registration systems which were updated due to the development of new compliance and registration systems.

	31 March 2013 £000	31 March 2012 £000
Software Licences	(415)	–
Office Equipment	–	4
Developed Software	186	5,796
Website	–	603
	(229)	**6,403**

11. 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.

12. Trade receivables and other current assets

Amounts falling due within one year	31 March 2013 £000	31 March 2012 £000
Deposits and advances	127	118
Other receivables	170	34
Prepayments and accrued income	2,069	2,229
Subtotal: Other current assets	**2,366**	**2,381**
Trade receivables	3,903	7,802
Total	**6,269**	**10,183**

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

Deposits and advances include advance payments on salary and staff loans total £7k and £120k respectively (2011/12: £4k and £114k). Staff could apply for advance payments on salary and loans up to a maximum of £5k for rail season tickets.

12.1 Intra-government debtor balances

	Amounts falling due within one year	
	31 March 2013 £000	31 March 2012 £000
Intra-governmental balances:		
Balances with Central Government	126	131
Balances with NHS trusts	194	183
Balances with Local Authorities	104	671
Balances with Public Corporations & Trading Funds	–	–
Subtotal: intra-government balances	424	985
Balances with bodies external to Government	5,845	9,198
	6,269	**10,183**

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

12.2 Movement in the allowance for doubtful debts

	31 March 2013 £000	31 March 2012 £000
Balance at the beginning of the period	422	410
Additional Losses recognised during the year	283	413
Impairment Losses recognised	(174)	(11)
Amounts written off during the year as uncollectible	(75)	(45)
Amounts recovered during the year	(138)	(345)
Balance at the end of the period	**318**	**422**

13. Cash and cash equivalents

	£000
Balance at 1 April 2012	15,766
Net change in cash and cash equivalent balances	4,421
Balance at 31 March 2013	**20,187**

	31 March 2013 £000	31 March 2012 £000
The following balances were held at:		
HM Paymaster General	20,185	15,764
Commercial banks and cash in hand	2	2
	20,187	**15,766**

14. Trade payables and other current liabilities

	31 March 2013 £000	31 March 2012 £000
Amounts falling due within one year		
VAT	(39)	(9)
Other taxation and social security	(3,384)	(1,944)
Trade payables	(2,258)	(2,889)
Other Payables	(1,939)	(1,307)
Accruals and deferred income	(7,092)	(5,986)
Capital creditors – intangible assets	(842)	(1,272)
Capital creditors – property, plant and equipment	(244)	(1,081)
	(15,798)	(14,488)
Current pension liabilities	(316)	(487)
Fee income in advance	(36,576)	(35,224)
	(52,690)	**(50,199)**
Amounts falling due after more than one year		
Pension Liabilities	(788)	(1,022)
	(788)	**(1,022)**

Trade payables at 31 March 2013 were equivalent to 15 days (2011/12: 21 days) purchases, based on the average daily amount invoiced by suppliers during the year. For most suppliers no interest is charged on the trade payables for the first 30 days from the date of the invoice. Thereafter interest is charged on the outstanding balances at various interest rates. While CQC has financial risk policies in place to ensure that all payables are paid within the pre-agreed credit terms, no amounts (2011/12: nil) were paid under the provisions of the Late Payment of Commercial Debts (Interest) Act 1998.

Trade payables falling due after more than one year have been reduced by a discount factor of 2.35% pa (2011/12: 2.8%) in accordance with HM Treasury guidance.

14.1 Intra-government creditor balances

	Amounts falling due within one year		Amounts falling due after more than one year	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Balances with Central Government	(4,751)	(4,012)	–	–
Balances with NHS trusts	(113)	(177)	–	–
Balances with Local Authorities	(2,169)	(638)	–	–
Balances with Public Corporations & Trading Funds	–	–	–	–
Subtotal: intra-government balances	(7,033)	(4,827)	–	–
Balances with bodies external to Government	(45,657)	(45,372)	(788)	(1,022)
	(52,690)	**(50,199)**	**(788)**	**(1,022)**

15. Provisions for liabilities and charges

	Employment termination and other costs		Leased property dilapidations		Total	
	2012/13 £000	2011/12 £000	2012/13 £000	2011/12 £000	2012/13 £000	2011/12 £000
Balance 1 April	(491)	(2,239)	(1,650)	(1,091)	(2,141)	(3,330)
Provided in year	(1,201)	(491)	–	(771)	(1,201)	(1,262)
Provisions not required written back	32	249	–	121	32	370
Provisions utilised in year	460	1,990	100	70	560	2,060
Unwinding of Discount	–	–	–	21	–	21
Balance 31 March	**(1,200)**	**(491)**	**(1,550)**	**(1,650)**	**(2,750)**	**(2,141)**
Analysis of expected timing of discounted flows						
In the next financial year	(1,200)	(491)	(418)	(211)	(1,618)	(702)
Current Provisions 31 March	**(1,200)**	**(491)**	**(418)**	**(211)**	**(1,618)**	**(702)**
Between 1–5 years	–	–	(894)	(1,439)	(894)	(1,439)
Between 6–10 years	–	–	(238)	–	(238)	–
After 10 years	–	–	–	–	–	–
Non-Current Provisions 31 March	**–**	**–**	**(1,132)**	**(1,439)**	**(1,132)**	**(1,439)**

CQC has restructured its senior management structure. A provision has been made to cover the cost of all redundancies that were agreed by 31 March 2013 although some staff will not leave CQC until 2013/14. This provision for all redundancies is estimated as £0.9m (2011/12: £0.3m), of which £0.8m relates to senior management.

A provision has been made to cover future legal costs for example, tribunals and judicial reviews. The provision is estimated at £0.3m (2011/12: £0.2m).

Leased property dilapidations are the costs that would become payable upon the termination of the leases.

Provisions falling due up to five years have been increased by a discount factor of 1.8% and provisions falling due between 5 to10 years have been increased by a discount factor of 1.0% (2011/12: 2.2%) in accordance with HM Treasury guidance.

16. Capital commitments

Contracted capital commitments at 31 March 2013 not otherwise included within these financial statements totalled £1,322k (2012: £2,234k) and consist, in the main, of IT hardware and software developments:

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment	8	29
Intangible assets	1,314	2,205
	1,322	**2,234**

17. Commitments under leases

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

Obligations under operating leases comprise:

	31 March 2013 £000	31 March 2012 £000
Buildings – Rent:		
Not later than one year	3,324	3,235
Later than one year and not later than 5 years	10,692	11,184
Later than 5 years	4,716	7,571
	18,732	**21,990**
Other:		
Not later than one year	44	39
Later than one year and not later than 5 years	35	74
Later than 5 years	–	–
	79	**113**

Leased payments recognised as an expense

	31 March 2013 £000	31 March 2012 £000
Operating leases – rentals	3,458	3,658
Operating leases – equipment	61	63
	3,519	**3,721**

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

18. Other financial commitments

There were no other material financial commitments at the statement date (2011-12:£nil).

19. Contingent liabilities disclosed under IAS 37

The Commission has the following contingent liabilities:

	31 March 2013 £000	31 March 2012 £000
Personal injury claim	42	–
Judicial review	3	–
Legal advice	1	–
Employment tribunals	250	132
First tier tribunals	–	35
Criminal prosecution	–	12
	296	**179**

20. Related party transactions

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. During the year 2012/13 CQC has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Department of Health	1,030	68,100	82	29
NHS Foundation Trusts	176	10,930	73	15
NHS Trusts	40	8,054	40	179
NHS PCTs	8	82	6	8
NHS SHAs	1	–	–	17
NHS Special Health Authorities	107	–	48	–

CQC received a total amount of grant-in aid of £68.1m (2011/12: £45.3m) from the Department of Health. Revenue grant-in-aid totalled £56.7m (2011/12: £33.3m) of which £1.8m related to Healthwatch England and capital grant-in-aid totalled £11.4m (2011/12: £12.0m)

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

In addition, CQC has had a number of transactions with other government departments and other central and local government bodies. Most of these transactions have been with the Department for Communities & Local Government in respect of rent for office space. CQC also has amounts owed to other government departments which are mostly owed to HMRC and the NHS pension fund.

21. Third-party assets

The Commission had no third-party assets for either 2012/13 or 2011/12.

22. Discontinued activities

There were no discontinued activities of the Commission to be reported in these financial statements (2011/12: None).

23. 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 1 July 2013.

There were no other significant post statement of financial position events.

How to contact us

Call us on: **03000 616161**

Email us at: **enquiries@cqc.org.uk**

Look at our website: **www.cqc.org.uk**

Write to us at:
Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

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

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