Care Quality Commission-Annual report and accounts for the period 1 April 2010 to 31 March 2011

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CORRECTION

Page 50, Key performance indicators table under the heading Compliance and enforcement activity – Number of inspections and reviews of NHS, independent healthcare and adult social care providers (Care Standards Act and Health and Social Care Act) - 15,220. The correct figure should be 7,368

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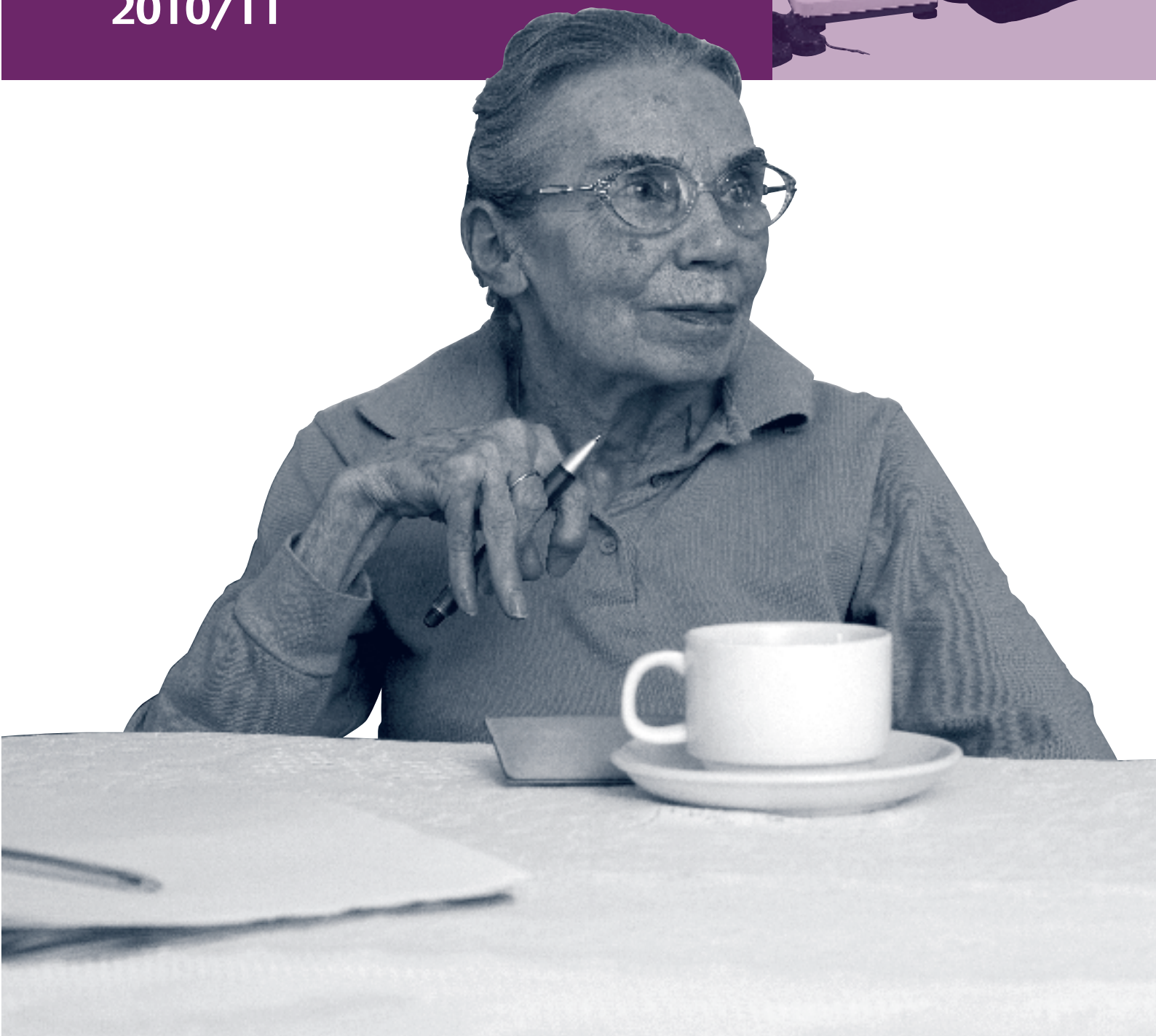
Care Quality Commission

Annual report and accounts 2010/11



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of Schedule 1 of the Health and Social Care Act 2008.

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Foreword

In our second year as England's regulator of health care and adult social care, we continued to embed the new system of regulation and the essential standards of quality and safety – the standards people have a right to expect whenever or wherever they receive care. Our job is to license services if they meet the standards, to check whether or not they continue to do so, and to take action when the standards are not being met.

It was a year of immense challenges, amid a changing landscape of regulation. The Health and Social Care Bill and arm's length body review reinforced our role as the quality regulator for health and social care, and set out proposals to take on new functions in the near future.

Our initial task in the year was to move almost 12,000 adult social care and independent healthcare providers from regulation under the Care Standards Act 2000 to the new system – joining NHS trusts who had been registered in our first year. We then began to introduce a further 9,000 primary dental care and independent ambulance providers to the regulatory system for the first time.

The task requires us to register providers if they meet the new standards, to check that they continue to do so, and to take action if they do not. It was a huge challenge for us to introduce this new system across several sectors in the same year, while at the same time bedding in a newly merged organisation. Although the programme took longer to complete than we expected, the vast majority of providers were registered in the required timescales, and we are grateful for the patience and support of providers alongside the determination and enthusiasm of CQC staff in delivering the programme.

At the same time, we began to monitor NHS trusts, and later adult social care and independent healthcare providers, to make sure they continued to meet the essential standards of quality and care. We focus our resources on acting quickly to check services whenever there are concerns that people may be getting poor care and, when we find failure, we do not hesitate to take appropriate and proportionate action. Barely a week now goes by without us issuing urgent requirements to a provider to improve the quality of their care.

We also continued our important role of monitoring the use of the Mental Health Act (MHA), to check that the rights of people detained under the Act or on community treatment orders are being protected. Our MHA Commissioners made 1,565 visits and talked to more than 4,700 patients during the year.

Central to our work are the voices of people – the people who receive care, their families and carers, and the staff who deliver the care. From the start, we have worked hard to make sure that people's direct experiences of care are at the centre of what we do, and that we listen to what people have to tell us. When our inspectors visit providers, their main job is to listen and observe, not just to look at paperwork.

CQC is a young organisation that is learning and adapting its approach to address the different risks encountered by people. We are committed to tackling poor care wherever we find it, and we will continue to build on our systems to do this effectively.

Jo Williams
Chair

Cynthia Bower
Chief Executive

Jo Williams

Cynthia Bower

"We focus our resources on acting quickly to check services whenever there are concerns that people may be getting poor care and, when we find failure, we do not hesitate to take appropriate and proportionate action"

About the Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. We make sure that the care provided by hospitals, dentists, private ambulances, care homes, in people's own homes and elsewhere, meets Government standards of quality and safety. We also protect the interests of people whose rights are restricted under the Mental Health Act.

We have two strategic priorities:

- **We focus on quality and act swiftly to eliminate poor quality care.**
- **We make sure care is centred on people's needs and protects their rights.**

All health and adult social care services are legally required to meet essential standards of quality and safety. We license providers if they meet essential standards, we assess whether or not they continue to do so and we have a range of powers we can use to make sure the standards are met. We respond quickly if there are concerns that people may be getting poor care. We do this by sharing information with a wide variety of organisations, by monitoring data from a range of sources, and by listening to concerns from the public, care staff and whistleblowers.

Our Board

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

- Dame Jo Williams, Chair.
- Professor Deirdre Kelly, Professor of Paediatric Hepatology, Birmingham Children's Hospital.
- John Harwood, former Chief Executive of the Food Standards Agency.
- Martin Marshall, Director of Clinical Quality at the Health Foundation.
- Olu Olasode, a chartered accountant, a transformation consultant and Chief Executive of TL First Consulting.
- Kay Sheldon, a trustee of Mind, the national mental health charity, for five years and a Mental Health Act Commissioner for 11 years.

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

Our structure

CQC has nine operating regions and a headquarters in London. We have a customer service centre in Newcastle that processes the information collected by our regional operations staff when they review care services. This enables us to provide a complete, up-to-date picture of the quality of health care and adult social care in England.

Implementing the same standards of care for all

In our first year of operation, 2009/10, we had focused on developing the new system of registration across health care and adult social care for which we were created, and we had started to put it into place by registering all NHS trusts in England.

In our second year, 2010/11, we continued putting the building blocks in place – addressing our primary task of moving almost 12,000 adult social care and independent healthcare providers from regulation under the Care Standards Act 2000 to the Health and Social Care Act 2008, and registering a further 9,000 primary dental care and independent ambulance providers under the new Act for the first time. And all of this to a tight legislative timescale set by Government.

A huge increase in scope

By March 2011, the regulation of multiple sectors under the same system and to the same standards was now in place. And two years on from the merger of our predecessor commissions – the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission – we had replaced three quite different organisations with one multi-functional organisation that licenses and monitors providers across a wide spectrum of health and adult social care.

In delivering this new system of regulation, the scale of our operations has increased hugely. We now regulate more than 21,000 care providers operating services from more than 36,000 locations. And this is before we include primary medical services in due course, which is expected to add a further 8,000 providers and locations.

In addition, the legal requirements of the Health and Social Care Act mean that providers must be registered and accountable for each separate regulated activity they provide. Also, we require providers to be very clear about the different locations from which they deliver care, so that we can quickly target our resources at those services where local information suggests they may be at risk of non-compliance.

The result of all this is that we now deal with a hugely increased number of applications under the new registration system every week, compared with the old regime.

And the range of services we now regulate as one body is much more complex in scope – from small care homes with a handful of beds, to sole practitioner dental surgeries, to medium-sized private hospitals, and through to large NHS trusts with three or four hospitals and hugely complex healthcare services.

Now that our fundamental structures are in place, we are looking to develop and improve our business processes to deal with this ever more complex care landscape. We will work with people who use services, providers, partners and staff to ensure we streamline and target our activity to help eliminate poor care.

A common set of standards

The cornerstone of our work is the system of registration for health care and adult social care that was introduced by the Health and Social Care Act. All providers of 'regulated activities' must be registered by CQC. Before we will give a provider this licence to operate, they must show that their services meet essential standards of quality and safety.

The essential standards are set out in two key pieces of legislation: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. There are 28 standards in all, but we focus primarily on 16 standards that most directly relate to quality and safety. Most importantly, the same standards apply to all care sectors.

> "The scale of our operations has increased hugely: we now regulate more than 21,000 care providers operating services from more than 36,000 locations"

Our standards cover the following six broad areas:

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

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

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

The NHS register goes live

On 1 April 2010, we successfully completed the first programme of registration – to license all 378 NHS provider trusts in England. We launched the register on our website, setting out the status of each trust and the regulated activities it was registered for. There were 22 trusts whose registrations were subject to conditions – actions they had to take to ensure they were meeting the essential standards.

This immediately showed the traction of CQC's strengthened regulatory powers. These 22 trusts were challenged to make swift improvements to aspects of the care they provided, or face further sanctions. By April 2011, all but two of them had made the improvements needed and the conditions on their registrations were lifted.

During the year, changes were announced to the way in which NHS primary care trusts (PCTs) operate. Under the Transforming Community Services programme, all PCTs are separating their provider and commissioning functions by transferring the community services they provide to other organisations. These transfers mean both the PCTs and the 'receiving' providers have to make changes to their registrations or apply for new ones, and we provided all the information these organisations needed to comply with the legal regulations.

There were **22 NHS trusts** whose registrations were **subject to conditions**

By April 2011, **all but two** of them had **made the improvements needed**

Rolling out across social care and independent health care

Our next major task was to register adult social care and independent health care providers by October 2010. This was a different scale altogether to the NHS – whereas that involved fewer than 400 organisations, for this tranche we had to communicate with some 12,000 providers about the detailed registration process and deal with their applications, all in six short months.

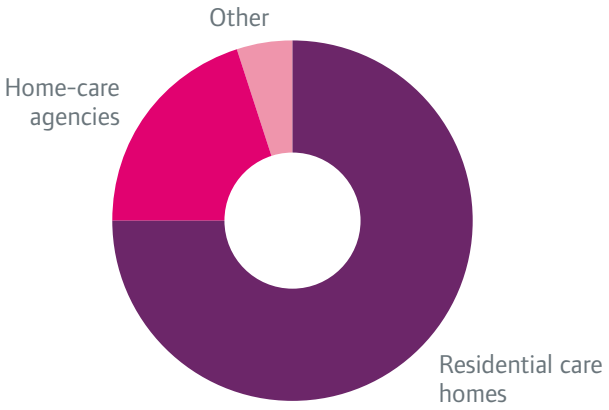
And whereas most NHS trusts are organised and structured in the same way, these providers range from very small care homes to large providers of care services operating across the country – with correspondingly different business models, management structures and ways of working.

In contrast to the NHS, applying to be registered was something the adult social care and independent healthcare sectors were used to, as most providers were already registered under the Care Standards Act regime. So here again the challenge was very different – to explain the ways the new Act differed from the old and to shift providers' minds away from concepts with which they were familiar and comfortable.

We took a new approach to communicating with these sectors. Alongside events, workshops and regular e-bulletins, we built a number of online communities to share early versions of guidance documents. Called our Provider Reference Groups, they meant we could test different approaches directly with providers and use their feedback to tailor our communications.

The result was that, overall, almost 12,000 adult social care and independent healthcare providers were successfully registered under the new Act. The adult social care providers operate in excess of 23,000 locations in England – around three quarters of these are residential care homes and about a fifth are home-care agencies.

The proportions of adult social care locations in England



Given the size of the sector and the number of providers involved, there were notably few that needed to have specific conditions placed on their registration on day one. The exception to this was a significant minority of services that did not have an appropriately experienced and qualified registered manager in place at the time they were transferring to the new registration system under the Health and Social Care Act. In October 2010, we announced that we had placed conditions on the providers of almost 1,000 care homes, requiring them to put managers in place as soon as possible.

A time to look back as well as forward

The transition of social care and independent healthcare providers to the Health and Social Care Act 2008 naturally marked the end of their regulation under the Care Standards Act 2000 (CSA).

Closing the CSA

Between April and September 2010, we registered 1,000 providers and more than 2,300 managers under the CSA. In the months running up to the end of registration under the Care Standards Act 2000 for private and voluntary healthcare and adult social care providers in England, teams from across CQC worked hard to complete our responsibilities under that Act.

For the seventh successive year, **no councils** were rated as **poor** for their adult social care services

The programme involved collaborative teamwork between CQC's many different directorates and functions. An important objective was to feed the outstanding work into our ICAP and CAiRE databases. We had to ensure that all relevant information on providers' registrations, variations and inspections was uploaded so that it could be transferred into our Customer Relationship Management tool.

The state of care

Our second annual State of Care report, published in March 2011, was a good opportunity to assess the progress made by health and social care services in the years leading up to the implementation of the new Act. Mostly they had improved. People now have greater control over their care due to more choice of who provides their care, where they receive that care and appointment times.

However, while more people have access to personalised services through direct payments or personal budgets, there is still wide variation in progress across the country. We also found that the quality of private sector care services was generally lower than those provided by councils or voluntary organisations.

Earlier, in November 2010, we published our detailed assessment of the adult social care market since 2004, using data on council commissioning patterns, national minimum standards and Care Standards Act registrations. We noted the significant improvement made by adult social care services in recent years, but highlighted the further growth needed in the market to meet future demand, due to demographic forces and people with complex needs living longer. We have also seen people increasingly being supported to live in their own homes, and self-directed support has enabled people to design their own home care in new ways.

Last year also saw a change to the system for assessing councils' commissioning that had been in place since 2002. The Government announced that CQC would no longer carry out the annual performance assessment – instead, councils themselves will take more responsibility for driving and monitoring improvement locally. We have assisted in the design of a new system working with the Department of Health, the Local Government Group and the Association of Directors of Adult Social Services.

We published our final assessment of councils' performance in November 2010. We reported that they had kept up the high quality of their adult social care services – of the 152 councils concerned, 95% were assessed as performing well or excellently. For the seventh consecutive year, no councils were rated as poor.

Dental care and private ambulance providers

In the third major tranche of registration, we were required to bring primary dental care providers and independent ambulance providers into registration under the Health and Social Care Act. Once again, the challenge was different. While used to regulation at an individual professional level, dentists had no experience of regulation at a provider level and they had to quickly get to grips with new concepts and, in particular, the essential standards of quality and safety. These standards were deliberately written so that they could apply equally to different sectors and different settings, and there was a steep learning curve for dentists and independent ambulance services to understand from us just how they applied in practice.

By the end of March 2011, we had received applications from more than 9,000 dental care and independent ambulance providers. We completed 1,107 registrations by the end of March, and a further 8,167 by the end of June 2011.

Getting ready for GPs

We also began to prepare for the registration of primary medical services – covering mainly GP practices, out-of-hours GP services and walk-in centres – in 2012 and 2013. We have been able to learn a lot from previous tranches of registration, and we will be working closely with the British Medical Association, the Royal College of General Practitioners and other bodies to test the application process and communicate to the primary medical sector.

Improving services for providers

Our first two years of operation have focused on meeting the tight timetable for registration. It has been an enormous task, and we have been grateful for the hard work and support of providers alongside the determination and enthusiasm of CQC staff in delivering the programme.

It was a huge challenge for us to introduce new legislation across several sectors in the same year, while at the same time bedding in a newly merged organisation and still maintaining a focus on monitoring the quality of care.

At times we did struggle with the sheer amount of processing and recording of data involved, and as backlogs of applications built up, we were unable to issue notices and certificates for the new registrations as quickly as we had hoped. This also had a knock-on effect on our ability to update providers' registration details on our website. We were finally able to clear our backlogs by the spring of 2011, and we are grateful to all our providers for their patience in bearing with us during that time.

With the fundamental business processes now in place, we are looking at ways we can improve these, and in particular make it easier for registered providers and managers to do business with us. We have been working with providers and staff to see where we can improve our service delivery and streamline our processes. The fruits of this work will start to come through in 2011/12.

Monitoring the quality of care

A provider's registration is just the first step in our new regulatory system. Our focus then shifts to making sure that the provider continues to meet the essential standards. This is where we will start to make a real difference to the quality of care in England. Indeed we have already started, with a full year of checking NHS trusts' compliance with the standards under our belt as well as our first reviews of adult social care and independent healthcare in the second half of the year.

How we check compliance

We aim to carry out assessments of providers at least once every two years. However, we focus our resources on assessing services at any time where there are concerns that people may be getting poor care. We identify these concerns by monitoring data from a range of sources, sharing information with a wide variety of organisations, and listening to members of the public, care staff and whistleblowers.

We gather this information into a unique overview of a service – the quality and risk profile – that is updated when new data arrives. This helps alert our analysts and inspectors to judge where people may be at risk of poor care because one or more standards are not being met.

We carry out our assessments by checking the information we have, by asking the provider to send us information, and, if we think it is necessary, by visiting the service to talk to people who use it and staff, to observe how care is delivered, and to check the provider's records. Our assessments are based on people's experiences of care and the impact it has on their health and wellbeing, as well as on whether the right systems and processes are in place. They focus on whether there is evidence that care is not meeting one or more essential standards.

In our assessments, we decide whether or not the service is meeting the standards. If it is but we have concerns that it may not continue to do so, we suggest it make some improvements.

If it is not, we insist that it must improve. The service must tell us how and by when it is going to do this. If it fails to improve, or we have serious concerns about people's health and safety, we take swift and strong action to protect people using the service. We have a range of powers we can use – these include fines, warnings, restrictions on the numbers of people that can be admitted, and suspension of a service. In extreme cases, we can cancel its licence to operate.

Throughout all this process, it is important to remember that the people who run and work in hospitals and care homes – senior management, boards of governors, medical professionals and frontline staff – all have a duty to challenge unacceptable behaviour and stop or report poor care whenever they see it.

Quality and risk profiles

The quality and risk profile (QRP) collates what we know about a care provider. QRPs are an essential tool in monitoring compliance. They highlight where risks and issues may lie by pulling together information from a variety of sources – both qualitative and quantitative – and providing an estimate of risk of non-compliance against each of the 16 key essential standards of quality and safety.

“Our assessments are based on people's experiences of care and the impact it has on their health and wellbeing, as well as on whether the right systems and processes are in place”

Crucially, QRPs are not a judgement in themselves. They are primarily a prompt or guide to assist our operations staff in their day-to-day work.

Because new information is regularly added to the QRPs, we are able to see an increasingly rich picture over time. There were more than 182,000 items of data across the QRPs for all registered NHS providers at the end of March 2011, an increase from 147,000 in September 2010, and we are adding to them all the time. Future items being explored include breaches of the mixed sex accommodation standard, and data from a range of national clinical audits.

Similarly, the data items across all adult social care and independent healthcare locations grew from around 830,000 in January 2011 to more than one million by the end of March. Many of these new items come from our links and information sharing agreements with other bodies. For example, to social care QRPs we added indicators on staffing from Skills for Care – including staff turnover and vacancy rates, and proportions of temporary and professional staff to all staff.

Since autumn 2010, we have been sharing QRPs with NHS providers and commissioners through a password-protected website. We have also provided other key stakeholders, such as the Department of Health, Monitor, and strategic health authorities, with access to the relevant QRPs.

As part of our ongoing development of the QRP programme, we held a series of workshops earlier in the year to engage with clinicians and other professionals in the NHS. This provided us with useful feedback regarding the information that we are currently using within the QRPs.

There were **more than 182,000 items of data** across the QRPs for **all registered NHS providers** at the end of March 2011, **an increase from 147,000** in September 2010

Our monitoring activity

Our initial focus in the NHS sector was firmly on the 22 trusts that were registered on 1 April 2010 with conditions. Fifteen of these were in the acute sector, four were in mental health, two were PCTs and there was one ambulance trust. Twelve of the 22 were foundation trusts.

Most of the conditions related to the care and welfare of people who use services. We made it clear that some trusts had to do more to make sure people experience effective, safe and appropriate care.

Staffing issues were also a cause of concern in some hospitals and led to a number of conditions. Having enough staff on duty with the right training and experience has a direct impact on the quality of care people experience. The trust boards involved had to ensure staff in hospitals are well trained and properly supported.

By the end of 2010/11, only five of these trusts still had conditions (and three more had their conditions lifted in April 2011). Since then, we have continued to monitor NHS trusts' compliance with the standards.

For adult social care and independent healthcare, the year was split into continuing out monitoring of providers under the Care Standards Act 2000 in the first part of the year, and then beginning our monitoring under the Health and Social Care Act from October 2010.

Overall, we completed 986 compliance reviews under the Health and Social Care Act in 2010/11. The following are just two examples of the checks we made under the new Act, showing how we approach reviews under the new system.

Since autumn 2010, we have been **sharing QRPs with NHS providers** and commissioners through a **password-protected website**

Example 1: NHS services

We carried out a routine review of a trust based in London to check whether it was meeting 16 key essential standards. The trust provides a full range of medical services for inpatients and outpatients including maternity and paediatric services.

Although patients were positive about the care and treatment they had received and complimentary about the attitude and helpfulness of staff, we found that the trust was not meeting all the essential standards.

We had two concerns in particular. Community maternity staff were either working excessive hours or had unsustainable caseloads in their attempts to balance all demands on the service. And there were issues with the record management systems being used – it was unclear whether maternity staff worked to the same system or if staff understood existing systems.

We also had five minor concerns relating to respecting and involving people, cleanliness, the safety and suitability of premises, support for staff and complaints.

We gave the trust 14 days to tell us how they were going to fix these problems, and we are following up to make sure that the improvements have been made.

Example 2: Social care services

We told the owners of a care home in Devon that they were not meeting six of the essential standards and had to make improvements to comply. Our inspectors found that the home had failed to protect the safety and welfare of its residents.

This followed an earlier visit, some months previously, in response to concerns raised by a previous manager. At the time, the owners agreed not to admit further people until they had a suitably qualified person working at the home to assess their needs. We visited the home again in January to follow up that report and found that, while there had been some improvement since then, the care provided was still falling short of standards people should be able to expect. Areas of concern included staffing levels, the way medicines were managed and arrangements for obtaining the consent to treatment of people who use the service.

We were subsequently informed that the owners were planning to close the home and our focus is to make sure that improvements are sustained until then.

Overall we carried out more than 500 enforcement actions in the year, and prosecuted three charges relating to breaches in the regulations.

Gearing up to monitor dental care services

With dental care services moving into compliance monitoring from April 2011, we were keen to pilot our monitoring tools and guidance with representatives from the sector. Between November 2010 and January 2011, 15 providers based in Hampshire and Stoke-on-Trent took part in the pilot and completed assessments for one or two of the16 essential standards of quality and safety. Overall, it showed that our existing methods and tools for monitoring were suitable for dental care providers

Giving people the information they need

Underlying our monitoring work is the need to provide people who use services and the general public more widely with easy-to-understand information on care services – to help them make choices about their own care and treatment.

Our website is central to giving information to people about the quality of care services – it received more than 5.2 million visitors in 2010/11. However, we knew that the website we built at the start of CQC in 2009 was limited in its ability to give people information on the quality of individual care services, and the delays in processing providers' registration applications only added to the lack of information on the site.

To address this, we are building an online profile of every provider that is registered with us. When this goes live later in 2011, as part of a brand new CQC website, it will show clear, up-to-date information for the public about our checks on standards of care at each service we regulate, updated weekly.

Our **website is central** to **giving information** to people about the **quality of care services** – it received more than **5.2 million visitors** in 2001/11

It will tell people at a glance whether each service is meeting the essential standards. If they are not, it will state what improvements we require to make sure they do meet the standards involved. People will also be able to see when we have carried out a formal check of a service, whether it was directly in response to concerns or a routine check.

Most importantly, each profile will include information about what people told us during our last formal check.

Excellence in adult social care

When the old system of adult social care regulation under the Care Standards Act came to an end, so did the system of performance assessment using quality ratings. While the new online profiles will give a snapshot of whether a provider is meeting the essential standards, many people told us that they had valued quality (or 'star') ratings and they wanted us to find a new way to recognise excellence in adult social care.

In November 2010, the Department of Health published its vision for adult social care. As part of this, it outlined proposals for a new voluntary excellence award, to be developed by CQC in partnership with other interested parties. Towards the end of the year, we asked for expressions of interest from organisations to deliver an excellence award on our behalf under licence from April 2012. The award would be based on a definition of 'excellence' and we have begun a wide-ranging consultation on the definition of excellence and how the award should be structured.

Looking at particular areas of care

On top of our ongoing monitoring work, CQC has the power to carry out special reviews and investigations of particular aspects of care, or look in detail at particular issues.

In line with our determination and focus to eliminate poor quality care, we decided in 2010 to change the way we carry out these reviews. With our regulatory model building knowledge about compliance with the essential standards, we can start to identify where the information we hold about providers is limited and look much more quickly at themes or issues that raise concern.

To do this, we are using the knowledge and experience of our staff – in particular, our frontline assessors and inspectors who deal with care services every day – to suggest topics for review, based on where there are gaps in our information about risk. The initial programme for 2011/12 includes maternity services, staffing, and physical healthcare for people with a learning disability.

Dignity and nutrition inspection programme

Our recent inspection programme looking at dignity and nutrition for older people in NHS acute hospitals is an example of how staff input has helped to shape the work of the inspection. It is also an example of how we can start to use the power of the different outcomes in the essential standards to build up a picture of particular aspects of care in one or more sectors.

We inspected selected wards in 100 NHS hospitals. Each of our unannounced inspection teams was led by one of our professional inspectors and included a practising, experienced NHS nurse. These professionals were joined by an 'expert by experience', an older person who had received hospital care and who could give their perspective from a patient's point of view.

We were able to use our existing methods and systems to look at specific parts of the new essential standards of quality and safety – in this case, aspects of Outcome 1 (respecting and involving people) and Outcome 5 (meeting nutritional needs) – as well as an observation tool for Outcome 5 that we developed in conjunction with the Royal College of Nursing.

We are using our powers to require hospitals that are failing to meet the essential standards to make improvements. The overall results will help us to gauge the general quality of care in these areas, and give us valuable information when looking at the same issues in other sectors.

Support for people who have suffered a stroke

We also carried out a major review of the support and care given to help people cope with life after they have suffered a stroke. Stroke is the third largest cause of death in England and is the biggest single cause of disability in adults. There are more than 900,000 people living in England who have had a stroke, and around 300,000 of these live with moderate to severe disability as a result.

As part of the review, we spoke to a wide range of people who had experience of stroke, as well as to many groups that represent and support

people who have had a stroke. A clear message from this work was that stroke can have a devastating effect on people's lives.

The review looked at the 'pathway' of care experienced by people, starting from the point people prepare to leave hospital to the long-term care and support they may need to cope with stroke-related disabilities. It looked at both health and adult social care, as well as links to other relevant services such as local support groups and services to help people participate in community life.

We published local assessment reports corresponding to the 151 PCT areas in England, and found that there are some good services built around the individual, their family and carers – the North East and South West of England were particularly good in this regard.

However, this approach is far from universal. Stroke is the single largest cause of disability in adults and our evidence shows that early access to rehabilitation is beneficial to people's recovery. We found that rehabilitation services after transfer home were inconsistent across the country and people in some areas had little or no access to specialist community-based rehabilitation.

We **published local assessment reports** corresponding to the **151 PCT areas in England** – the North East and South West of England were particularly **good in this regard**

Monitoring the operation of the Mental Health Act

Protecting the rights of people whose rights are restricted under the Mental Health Act is another vital part of our work. We published CQC's first annual report on the use of the Mental Health Act in October, raising important concerns about how some providers, in both the NHS and the private sector, were keeping to the principles of the Act and its Code of Practice.

Our Mental Health Act Commissioners visit services where people are detained under the Act, or on community treatment orders, to check that their rights are being protected. This includes private, confidential meetings with any detained patient who may request a meeting or agree to discuss their care and treatment. Our Commissioners made 1,565 visits and talked to more than 4,700 patients during the year to 31 March 2011. We identified three priority areas where services needed to do much better:

- Involving patients in decisions about their care and treatment.
- Assessing and recording patients' consent to treatment.
- Minimising restrictions on patients and avoiding 'blanket' security measures.

CQC now has the regulatory powers, not available to its predecessor, to raise standards of care in mental health services. For example, when NHS trusts had to register from April 2010, we placed conditions on four mental health trusts – three of them because patients were not being cared for in accordance with their rights. These trusts have since made improvements and we will continue to monitor them.

We also analysed how community treatment orders (CTOs) were working. CTOs were introduced in November 2008 and were particularly intended for patients who, on being discharged from hospital, may not adhere to their treatment. The order is meant to ensure that patients maintain stable mental health outside hospital and to promote recovery, while allowing for them to be recalled if necessary.

Our Commissioners made **1,565 visits** and **talked to** more than **4,700 patients during the year** to 31 March 2011

In 2009/10, more than 4,000 people were made subject to a CTO when they left hospital – at least 10 times more than the numbers predicted by the Department of Health at the time the orders were introduced. One in five patients was recalled to hospital.

We also looked at a sample of 200 reports about people on CTOs compiled by our Second Opinion Appointed Doctors (SOADs), who have to authorise the medication prescribed for patients on CTOs. Thirty per cent of the patients in the sample did not have a history of refusing to take their medication or cooperating with community services. This suggests that some hospitals are playing safe by putting patients on a CTO as a preventative measure, and it could be one of the reasons for the higher than expected number of orders.

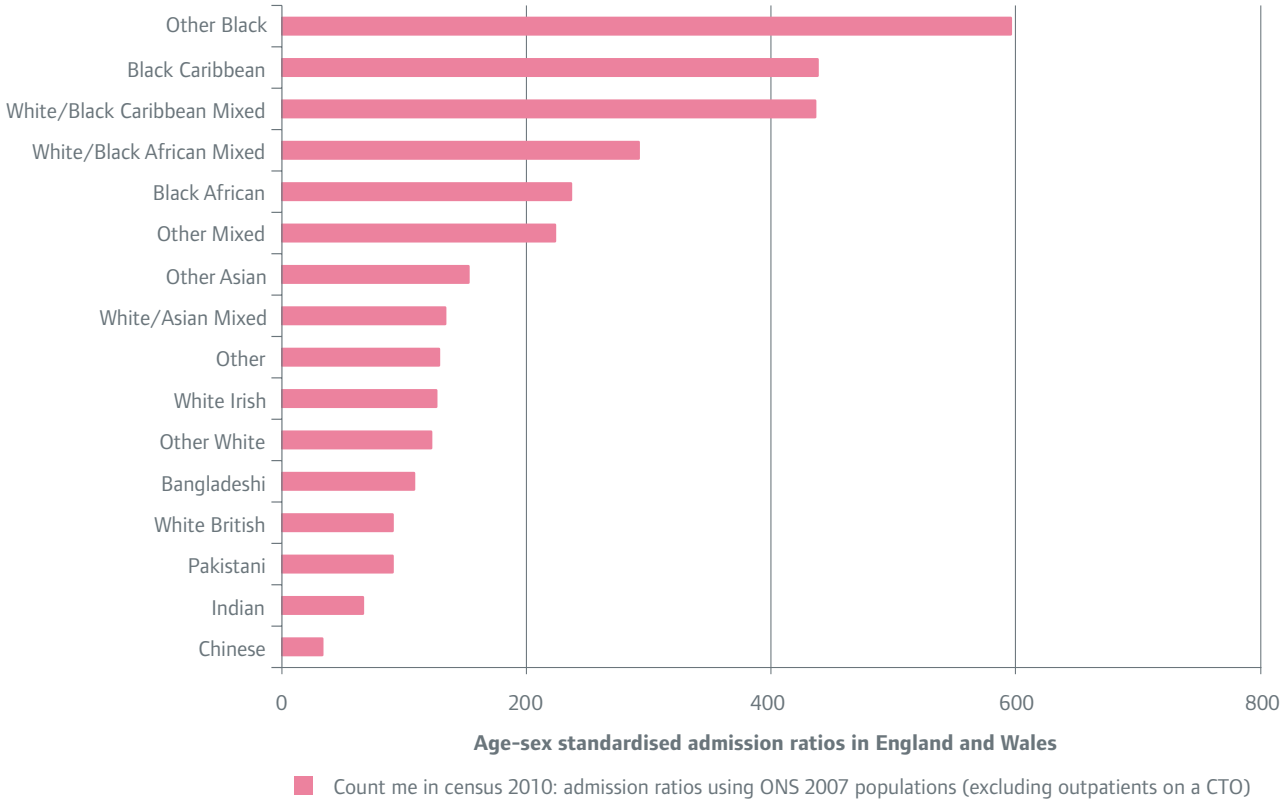
We were also concerned that there were more patients from some of the Black and minority ethnic groups (BME) placed on a CTO compared to the proportions among detained patients – where there is already over-representation of BME groups in relation to the wider community.

Inequalities in mental health

This last finding was echoed in the results of the Count me in census of the ethnicity of mental health inpatients, which we published at the end of 2010/11. The census was started in 2005 to support the Department of Health's five-year action plan for improving mental health services for people from BME communities. The 2010 census was the last one and overall showed little change from previous years:

- Rates of admission to mental health services are higher than average among some BME groups, especially Black and White/Black Mixed groups.
- Rates of detention under the Mental Health Act are higher than average among the Black, White/Black Caribbean Mixed and Other White groups.

Comparison of admissions to mental health services by ethnic group



- Rates of seclusion (the supervised confinement of a patient in a room) have generally been higher than average for the Black, White/Black Mixed and Other White groups.

In our report, we stressed that these statistics are now well known. What is needed is greater understanding about the factors that lead to the variations between the proportions of some ethnic groups on mental health wards. Early intervention is vital to reduce the need to admit people to hospital in the first place. While the Count me in census has provided a useful one-day snapshot of services, going forward providers and commissioners must make full use of the Mental Health Minimum Data Set to get a much richer, year-round understanding of levels of need and the patterns of care.

Other inspection programmes

In addition to our main activities in monitoring the compliance of all registered care providers and also the use of the Mental Health Act, we carry out other inspection programmes and analysis.

Deprivation of Liberty Safeguards

We published our first report on how the Deprivation of Liberty Safeguards, which became law in April 2009, were being implemented by care homes, hospitals, councils and primary care trusts. These safeguards protect the rights of people who lack the mental capacity to consent to their care or treatment – they include people with dementia or a learning disability.

As it was the first year of operation, we found that some councils and PCTs had not progressed as well as others in setting up the mechanisms needed to deal properly with applications. And in care homes and hospitals, the most notable finding was a lack of awareness and training among some managers and staff. We will continue to monitor these issues as everyone involved gets fully up to speed with the Safeguards.

Analysing hospital outliers

We continued our ongoing analysis of the number of people who have died in NHS hospitals in England after being admitted for a particular condition or procedure, as well as some emergency readmission rates and a selection of maternity indicators. This alerts us to those hospitals where the number is significantly higher than expected and prompts us to follow up any concerns we may have. It also encourages NHS trusts to carefully monitor their data in these areas.

We reviewed 115 mortality alerts in 2010/11, and either passed them on to our local teams for ongoing monitoring, or closed them as no further action was required. We published details of all of them on our website and all information on outliers adds to the provider's quality and risk profile.

We reviewed **115 mortality alerts** in 2010/11, and either passed them on to our local teams **for ongoing monitoring**, or closed them as no **further action was required**

Controlled drugs

In our annual report on how well healthcare organisations are implementing the safer management of controlled drugs regulations (introduced following the Harold Shipman inquiry), we found that the role of the accountable officer, responsible for monitoring these drugs, is now embedded in healthcare organisations. With this in mind, we urged chief executives and accountable officers to now keep the issue a high priority on their organisation's agenda. We also highlighted good practice among local intelligence networks. For example, one network had developed a real-time online tool for accountable officers to report any concerns directly to the other members of the network.

Ionising radiation

In the year to 31 December 2010, we received a total of 494 notifications of patients having exposures to ionising radiation that were "much greater than intended" – reflecting a continuing upward trend in the number of monthly notifications. We inspected four cardiology departments and two radiotherapy departments, and continued our pilot inspection programme in chiropractic and dental services.

Investigations

During the year, we completed the large-scale investigations started the previous year into the two care providers below. Enquiries of this type have now largely been replaced by our new system for monitoring providers' compliance with the essential standards, although we still retain the ability to carry them out if necessary. It is worth noting that most of the attributes of an investigation have been incorporated into our new dynamic monitoring system.

In June 2010, we reported on older people's mental health services at Devon Partnership NHS Trust. After a thorough investigation, we found that the trust's failure to supervise and appraise staff had led to serious concerns about the inappropriate administration of medicines in one unit. Although this problem was restricted to one site, we did find that other units providing older people's mental healthcare were isolated, with insufficient supervision of staff. Under the new registration system, we put a condition on the trust to improve its system for supervising and appraising staff, and we lifted this in March 2011 once we were satisfied with the trust's new arrangements.

In July 2010, we published the findings of our enquiry into Take Care Now (TCN), an independent healthcare organisation. It was triggered by the death of a patient after he was administered 100mg of diamorphine by an out-of-hours doctor from Germany employed by the company.

We found that TCN did not act on previous warnings about the use of diamorphine, and systemic failings were not addressed. Staffing levels were potentially unsafe and unfilled shifts and lack of clinical cover could have compromised the care of patients. TCN also failed to investigate and learn from serious incidents. It was also notable that local GPs were not confident in the service provided by TCN.

In a survey of these local GPs, half said the ability of the organisation to provide clinical care in people's home was "poor" or "very poor".

We also looked at the role of the five primary care trusts that had commissioned services from TCN. We found that they had limited understanding of the service and did not monitor TCN's performance adequately.

The PCTs have since taken action to improve commissioning and monitoring of their out-of-hours services, and we made national recommendations to all PCTs and out-of-hours providers across the country. The doctor involved was struck off the General Medical Council register and can no longer practise in the UK.

The forthcoming registration of primary care medical providers will include out-of-hours services. For the first time, the regulator will have enforcement powers to hold poor care providers to account in this sector.

In addition to these investigations, we followed up on the NHS trusts that had provided care to Peter Connelly (Baby P). In the aftermath of his dreadful death in 2008, we had found systemic failings and, despite some progress immediately following his death, more work that needed to be done to make sure adequate systems were in place to safeguard children. We were able to report in June 2010 that the four trusts involved had made significant progress and were demonstrating the leadership necessary to drive the remaining improvements needed. We continue to monitor these trusts' standards of care through our new system of monitoring compliance.

Putting people at the centre

Health care and social care have a direct impact on the quality of millions of people's lives in England every day. People's views and experience of care are at the heart of how we go about our work.

Listening to people's voices

We have made significant progress to involve people who use services in our work and embed people's voices in our regulatory activity since publishing our statement on involvement, *Voices into action*, in June 2009. We have gained recognition for our focus on involving people, reflected in the Government's decision to create HealthWatch England, the national consumer champion for health and social care as part of CQC.

We involved people directly in designing and running all the published reviews and studies in 2010/11, including the study about stroke services. We also developed new ways to gather people's views, including new surveys and observation tools (such as our methodology for understanding the quality of the experiences of people who use services who are unable to provide feedback due to their cognitive or communication impairments).

We established a series of advisory groups, including a public reference group, a voluntary sector policy forum, eQuality Voices and the LINks advisory group, a sounding board of local authority officers and members, and the SpeakOut Community Group Network to inform CQC methods and developments.

And we established a working group with Monitor, the Foundation Trust Network and the Foundation Trust Governors' Association, to develop a coordinated approach to working with foundation trust councils of governors. Progress has included a joint letter for new councils of governors from CQC and Monitor; CQC support at national governor development events; and work underway to formalise the involvement by councils of governors in our monitoring of services.

We also talk regularly to charities, representative groups and voluntary organisations, and listen to the issues that are of most concern to them. For example, our inspections into nutrition and dignity for older people followed reports from both the Patients Association and Age UK into how older people are treated in hospital, and we received support and help from both organisations in developing the programme.

> In 2010/11, we continued to establish relationships with 150 local involvement networks (LINks), as well as overview and scrutiny committees for health and social care

Local networks

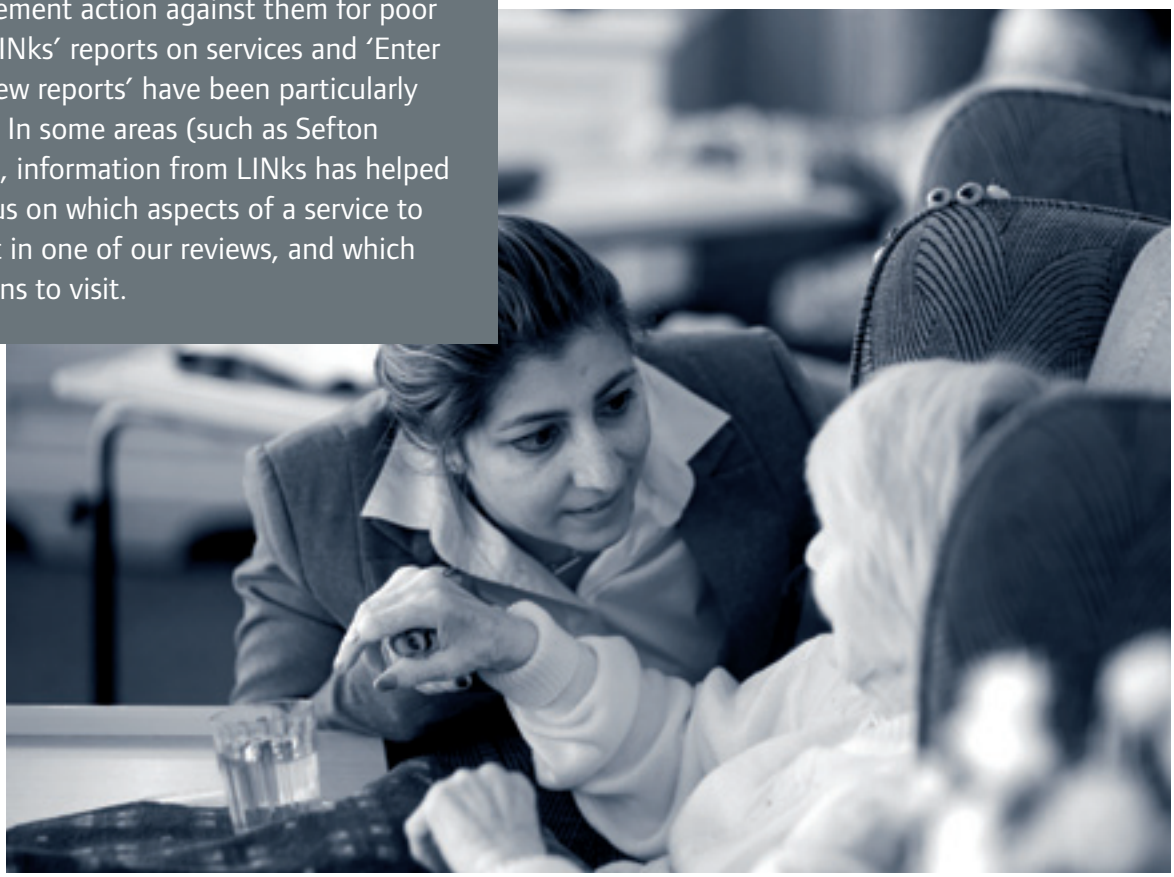
In 2010/11, we continued to establish relationships with 150 local involvement networks (LINks), as well as overview and scrutiny committees for health and social care. The information that our local teams receive from these local groups is an important source of people's voices, and has influenced our regulatory action in a number of reviews across the country.

Example: How CQC and the local involvement networks have worked together

Information from LINks has helped CQC check on a wide range of health and social care services, and is helping us prepare for registering primary medical services from 2012. In some cases, it has contributed to our decisions to take actions to require services to make improvements or to take enforcement action against them for poor care. LINks' reports on services and 'Enter and View reports' have been particularly useful. In some areas (such as Sefton below), information from LINks has helped us focus on which aspects of a service to look at in one of our reviews, and which locations to visit.

Sefton LINk:

"It has become an important aim of Sefton LINk to share information with the CQC to help them in their role of monitoring services using the web form and local compliance manager. Partnership working is the key to getting local quality services delivered in safe environments. For example, findings from an 'Enter and View' visit prompted CQC to undertake a follow up inspection as there were major concerns with a residential care home in Sefton. If the LINk had not shared this information then local concerns would not have been picked up by the national monitoring body and local services would not have been improved. The local compliance manager stated how useful the LINk's template had been for them in identifying common concerns."



In the Health and Social Care Bill, the Government announced that the role of existing LINks is to be developed and strengthened as Local HealthWatch, working with the new consumer champion for health and social care, HealthWatch England. For more details on HealthWatch, see Section 4.

Involving people in our checks on providers

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

A key part of this is working with Experts by Experience, who are people of all ages, with different impairments, from diverse cultural backgrounds who have used a range of care services. They take part in our compliance visits and talk to the people who use the care service and help our inspectors write their report. Not only do they bring their own distinctive perspective to the inspection, but their presence also helps people using the service to feel more relaxed and confident about talking about their care.

In 2010/11, we laid down plans to evolve the Experts by Experience programme into a broader, central resource for staff across CQC who need to involve people who use services in their work. Called 'Acting Together', staff will continue to be able to ask for Experts by Experience to help with visits to providers, and will now also be able to ask for people who use services to take part in other activities such as consultations, reviews and developing new methodologies. We have evaluated tenders from a number of experienced organisations to recruit, train and support people to take part in Acting Together, and we will announce more details later in 2011.

Table 1: CQC public consultations in 2010/11

Topic	Dates
Assessments of quality	February – April 2010
Interim registration fees for adult social care and independent healthcare	April – September 2010
Revisions to CQC's enforcement policy	June – August 2010
Guidance for CQC's inspectors and assessors to ensure robust scrutiny of equality and human rights issues (carried out jointly with the Equality and Human Rights Commission)	August – November 2010
Single fee scheme covering all registered providers from 2011/12	October 2010 – January 2011

CQC public consultations in 2010/11

We are committed to hearing a wide range of views on issues that are central to our regulatory role and responsibilities. In the year, we launched a number of public consultations (see table 1 on previous page).

Children and young people

We also carried out work to explore how we can involve children and young people between the ages of two to 25. In January and February 2011, we ran eight workshops where we gathered the views and experiences of around 120 children and young people on going to their GP and dentist. Much of the feedback was positive, but some of the comments highlighted areas for improvement:

"What I dislike about the doctors is they sometimes don't listen, and they are always rushing."

"The doctor always asks my mum and mostly listens to her too."

"Poor wheelchair access [at a GP surgery]."

"They don't have toys for children to play, they used to have them. It should be more welcoming for children [at a GP surgery]."

Embedding equality and human rights

It is vital that we continue to embed equality and human rights in our regulatory work. We worked in the year with the Equality and Human Rights Commission to develop joint guidance for our inspectors and assessors, to ensure they scrutinise equality and human rights issues when reviewing providers' standards of care.

We designed tools for inspectors to enable them to assess equality and human rights issues – including observational and interview tools. We developed our Short Observational Framework for Inspection (SOFI 2) for inspectors to use in services where they cannot gain people's views through verbal communication because people have communication and cognitive impairments.

As part of our work, we started two projects to improve data on equality and human rights in our quality and risk profiles for providers, in partnership with the Macmillan Human Rights project and the Equality and Human Rights Commission. We also started to evaluate the impact of equality and human rights in our new regulatory system, through workshops and feedback from frontline staff and others.

Upholding the NHS Constitution

The NHS is founded on a common set of principles and values, set out in the NHS Constitution, that bind together the communities and people it serves. In building our system for regulating the quality of care across health and adult social care – including the NHS – we upheld the Constitution and its core principles.

We have defined each of the essential standards of quality and safety according to the outcomes that we expect people to experience. In this, we put people who use services first.

The principle that the NHS respects people's human rights and has a duty to promote equality underpins all the essential standards. Also, when providers register with us they must specifically tell us how they actively promote people's equality, diversity and human rights in their services and take their views into account.

The Constitution states that the NHS must deliver high-quality care that is safe and effective, which is wholly reflected in Outcome 4 of the essential standards. It also says that NHS services must involve patients, families and carers in decisions about their care and treatment – the basis for Outcome 1.

Another principle of the Constitution is that the NHS works across boundaries and cooperates with national and local organisations in the interests of patients – which is central to Outcome 6.

Finally, in our guidance to providers on a number of the standards, we make it clear to them that they should take account of the NHS Constitution when deciding whether they comply with the standard.

Making our information accessible

We have made great efforts to make the information we produce as accessible as possible. During 2010/11, we produced booklets for members of the public to explain in plain English just what standards they should expect – there were three booklets to begin with covering care in NHS hospitals, in care homes and in people's own homes. We grouped the outcomes into five main sections and made them easy to understand:

1. People, as well as those acting on their behalf, can expect to be respected, involved in their care and support, and told what's happening at every stage.
2. People can expect care, treatment and support that meets their needs.
3. People can expect to be safe when using a service.
4. People can expect to be cared for by staff with the right skills to do their jobs properly.
5. People can expect the service to routinely check the quality of its services.

These groupings are reflected in the online profile of providers that will be launched in 2011.

Much of our public information we now test first on a new public online community. This has 150 members, all people who use care services or carers, and really helps to make sure we write our information in a way that is easier for everyone to understand.

During 2010/11, **we produced booklets** for **members of the public** to explain in plain English **just what standards they should expect**

Getting a national picture

Surveys of NHS patients

Our national surveys collect the views and experiences of people using NHS healthcare services in every area of the country. The results feed into the quality and risk profiles of each trust, therefore adding to the store of knowledge that helps us identify where providers may be at risk of not meeting essential standards, and they also help the trusts to identify where they need to improve. They also help to populate the NHS Choices website.

This year we again reported on our survey of people who were admitted to hospital. Around 69,000 adults took part in summer 2009, across 162 hospital trusts in England. There were big improvements in hospital cleanliness – 64% of patients rated their hospital as very clean, up from 56% two years' previously – and a reduction in the need for patients to share sleeping areas with the opposite sex. However, progress was disappointing in some areas: most notably, more people said they were not given enough information about medicines.

We also carried out a major survey asking women about their experiences of maternity services. More than 25,000 mothers took part. Overall, women were positive about their care, with 73% definitely having confidence in the staff caring for them during labour and birth. But while there were obvious improvements in antenatal care, this was not mirrored in women's experiences of labour and postnatal care – too many still felt that they were left alone at a time when it worried them and were leaving hospital without the information and support they needed.

A further survey captured the views of more than 17,000 people aged 16 and over who had contact with specialist community health services, covering 66 NHS trusts. Generally, people were very positive about the health and social care staff they had seen most recently for their mental health condition – the vast majority said that workers listened carefully to them, treated them with respect and took their views into account. But many said that they had not been involved as much as they would have liked in some aspects of their care, and some would have liked more help with their day-to-day living.

We carried out a major survey asking women about their experiences of maternity services. **More than 25,000 mothers took part**

Giving a voice to people with mental health problems

Another survey formed the basis of a ground-breaking exercise we conducted to hear the views of patients who had appealed to a tribunal against their detention under the Mental Health Act. This type of information had never been gathered to such an extent before, because of the practical difficulties in gaining access to mental health patients at the time of their tribunals.

We worked in partnership with the Administrative Justice and Tribunals Council, interviewing more than 150 volunteer patients. We found that patients' experiences were diverse, ranging from positive to strongly negative. Not surprisingly, those whose appeals were successful were much more positive about the process than others. But overall:

- Patients are not always well placed to ensure their lawyers are providing a good standard of advice and representation.
- Delays are a substantial factor in many patients' negative experiences of the tribunal process.
- A large part of the distress caused by delays was due to a lack of information about how long the process would take.
- A significant minority said they were not given enough time to be heard by the tribunal.
- Nearly all said they received a very rapid decision. However, follow-up information was lacking and patients felt poorly informed of any further right to appeal.

Listening to complaints

We welcome comments and suggestions about our performance and the conduct of our staff, and this includes complaints.

During 2010/11, we received 165 complaints about CQC. Of these, 114 were successfully resolved at the first stage of our complaints procedure. In the other 51 cases, the complainant requested a review by our Complaints Review Service. Seventeen complainants then asked the Parliamentary and Health Service Ombudsman to review their cases. At the time this report went to print, the Ombudsman had not taken any of these complaints forward for investigation.

The number of complaints was higher than the previous year because we received a number about the delays incurred in the registration process. Most of the other complaints were from providers who felt that we had not communicated with them efficiently, or because they had concerns about the behaviour or actions of a CQC inspector or another member of our staff.

We investigate all complaints we receive and use the feedback to help develop and improve how we go about our work.

Contributing to the landscape of care

Following the general election in May 2010, the new Government published its Health and Social Care Bill in July 2010. We made significant contributions to its wide-ranging proposals in the Bill and the arm's length bodies (ALB) review. These included significant new functions being assigned to CQC and confirmed CQC's role as the quality regulator for health and adult social care.

The Department of Health proposed to reduce the number of its ALBs, and put forward a number of changes to the remit of the remaining ALBs through the review. Three bodies – the Human Fertilisation and Embryology Authority, the Human Tissue Authority and the National Information Governance Board for Health and Social Care – are going to have relevant functions integrated into CQC. Also, providers are due to have a joint licence overseen by CQC and Monitor, the independent regulator of NHS foundation trusts.

HealthWatch

The Bill also set out plans for HealthWatch to be established as a new independent consumer champion for health and social care. A national body, HealthWatch England, will strengthen the collective voice of patients. It will be a statutory, distinctive part of CQC:

- Providing leadership, advice and support to Local HealthWatch.
- Providing advice to the NHS Commissioning Board, Monitor and the Secretary of State.
- Having powers to propose a CQC investigation of poor services.

Local HealthWatch is being created by developing the role of existing Local Involvement Networks. It will:

- Ensure that the views of people who use services, carers and members of the public are integral to local commissioning.
- Provide advocacy and support to people and help them to make choices about services.
- Provide intelligence for HealthWatch England about the quality of providers.

We are working with the Department of Health to set up the structures and systems needed for the launch of HealthWatch, which is expected to be in the second half of 2012, and assessing what resources are needed to do this effectively.

Transparency and efficiency

We have delivered on our priorities in a year that has seen the introduction of strict controls on recruitment and procurement across Government and ALBs, as part of the Government's efficiency initiatives. The measures have presented us with particular challenges, since they have coincided with an expansion of our remit.

Our overall expenditure for the year was £139 million, a reduction of £51 million on the previous year. Staff costs were reduced by £8 million, due mainly to the number of vacancies we carried throughout the year. Total income for the year increased by £15 million to £80 million.

We have also met the Government's new commitments that aim to make public expenditure more transparent, and are playing a full part in the work to streamline 'back office' functions across Government.

We published a wide range of information about our activities through our freedom of information publication scheme on our website, and our Information Access team received 1,219 requests for information during the year, up from 776 in 2009/10. We responded fully within the statutory time limits in 96% of cases (compared with 72% in the previous year).

"The Bill also set out plans for HealthWatch to be established as a new independent consumer champion for health and social care"

The **fees scheme** in operation from April 2011 **standardises** the way providers are charged. Everyone receives a **single annual invoice**

Mid-Staffordshire public inquiry

We contributed fully to the public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust. This was as a result of the report into appalling standards of care found at the trust, published in March 2009 by the Healthcare Commission, one of our predecessor bodies.

In our submissions, we explained how our new system of regulation under the Health and Social Care Act works, and how our methods for monitoring compliance with the essential standards are aimed at intervening early when the first warning signs of poor care are detected. The inquiry was ongoing at the time this annual report was published and we await its conclusions and recommendations.

Ensuring better regulation

We are committed to being a modern and effective regulator, and ensuring that our regulatory model aligns with the five principles of good regulation: transparent, accountable, proportionate, consistent and targeted.

With a clear focus on maximising the efficiency and value for money of regulation, the Government has indicated to us that we must aim to recover the costs of regulation from providers. From October 2010 to January 2011, we consulted widely with health and social care providers to determine the fees that those providers would have to pay in future.

The fees scheme in operation from April 2011 standardises the way providers are charged. Everyone receives a single annual invoice – there is no charge for any changes that providers want or need to make to their registration, and provider and manager fees are rolled into one. Providers are charged depending on where they sit within a number of bands – for example, NHS bands are determined by the organisation's turnover; bands for care homes relate to the number of registered places in the home; and bands for dental providers relate to the number of surgeries they run.

We listened carefully to the feedback we received in the consultation and made a number of changes as a result – most notably, we reduced the fees for small dental providers and independent ambulance providers by around 50%, and we phased the increases in fees for small care homes over several years.

Working with partners

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

We have a number of formal agreements with our partners on how we will effectively regulate together – these take the form of memoranda of understanding, joint working protocols and information sharing agreements. Our partners include the General Social Care Council, Monitor, the General Dental Council, the General Medical Council, the Nursing and Midwifery Council, the Equality and Human Rights Commission, and the National Treatment Agency for Substance Misuse.

One of our most important partners is the Association of Directors of Adult Social Services (ADASS). Building on our information sharing protocol and with input from a number of councils, we began working with ADASS to develop an interactive portal for exchanging data and information on social care services. The intention is that councils will be able to provide qualitative and some quantitative data to CQC, and CQC in return would supply its own information to councils, including links to providers' most recent quality and risk profiles. The development of the portal continues in 2011/12.

We also work with different partners on specific regulatory responsibilities:

Healthcare in prisons – in a joint report in May 2010, we joined with Her Majesty's Inspectorate of Prisons in calling for improvements in NHS healthcare provided for adults in the prison system.

Youth offending – we carried out 13 inspections of health services for young offenders with Youth Offending Teams. In June, we worked with HM Inspectorate of Probation, Healthcare Inspectorate Wales and Estyn to investigate whether youth offending and health services are sufficiently engaged in efforts to reduce the impact of alcohol misuse by young people who offend. Our report re-emphasised the known link between alcohol misuse and health problems, underachievement in school and offending behaviour, but suggested that children and young people who misuse alcohol are going without the appropriate help at times.

And in September, we again teamed up with HM Inspectorate of Probation and Healthcare Inspectorate Wales, as well as HM Inspectorate of Constabulary, to look at approaches to preventing child crime. We found that the work to turn children away from crime needs to be more focused and to be evaluated better.

Children and young people – we carried out 49 joint inspections of children's services with Ofsted during the year.

Working with providers

During the year, we underlined our determination to work closely with the sectors we regulate by creating a number of online communities. Called the Provider Reference Groups, they are exclusively for providers and commissioners and a way for us to gain feedback on our ideas and draft documents, and to collect opinions on our plans and projects.

We currently have communities set up covering NHS services, adult social care, independent healthcare, dental services, independent ambulance services and primary medical services. Typically we will make a document available to the group for two weeks and collate the diverse responses we receive. We have used them throughout the year to help us with registration guidance, compliance tools and approaches to fees, to name a few.

We also send out a monthly e-newsletter to stakeholders and this now has more than 35,000 subscribers. This is an important communication channel for us – in a survey of subscribers we ran in January and February 2011, 81% of recipients said that they always open and read the e-newsletter each month.

Our Provider Advisory Group – consisting of representative organisations for both providers and commissioners – also provided valuable feedback and suggestions as we developed our regulatory approach and methods.

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Our goals for the year ahead

Towards the end of the year, we reviewed our strategic aims in the light of our developing role and guidance from the Government on what it expects CQC to achieve. We decided to re-shape CQC's strategic priorities from five to two:

- **We focus on quality and act swiftly to eliminate poor quality care** – if a service falls below the essential standards, we aim to identify and act on it quickly.
- **We make sure care is centred on people's needs and protects their rights** – we aim to ensure that people have a voice in shaping their own care. And to help them make informed choices, we focus on providing up-to-date, relevant and accurate information about services.

These two aims better reflect CQC's focus for 2011 onwards and put CQC in a position to focus more fully on monitoring providers' compliance with standards – the regulatory activity we were set up to carry out.

To achieve these aims, we have identified eight delivery priorities for 2011/12 and beyond. These are to:

1. **Register 'new in scope' providers** – dental care providers, private ambulance services and GP practices.
2. **Deliver and evaluate our new regulatory model** – ensure it is focused on quality and eliminating poor quality care, and is centred on people's needs and protects their rights.
3. **Embed, improve and refine our regulatory model** – continuously improve our model, and equip our staff with the tools, competences and skills to apply consistent and effective judgements.
4. **Deliver our other statutory and related regulatory duties** – ensure that the rights of people who are subject to the powers of the Mental Health Act are upheld, carry out our statutory and other inspection functions, and modernise our mental health operations.
5. **Provide public-facing, accessible, accurate and up-to-date information** about care services to help the public and commissioners make choices and to ensure transparency around CQC's operations.
6. **Prepare for future developments** – plan for changes arising from the Health and Social Care Bill, the Public Bodies Bill, and the wider changes in health and adult social care.
7. **Improve our efficiency and performance** through effective internal working and efficient processes. Measure and manage our performance through robust management information.
8. **Value our staff** – implement a programme of leadership development, job evaluation and a new reward strategy for CQC employees.

Developing our staff capabilities

As we went into 2010/11, and with our regulatory responsibilities becoming much clearer after our first full year of operation, it quickly became clear that we needed to change some of our organisational structures – to make sure we could deliver the new regulatory model efficiently and effectively, and to maximise value for money.

Getting our structure right

We carried out three major structural changes during the year, starting with a new model for our field force. Each of our nine regions was split into registration teams that look after registration applications from providers and compliance teams that review and inspect services to make sure they are complying with the essential standards. The registration managers and compliance managers that lead the teams report directly to each regional director.

This was closely followed by a reorganisation of our customer services centre in Newcastle, again to better support the regulatory model and to align with the field force changes. Known as Shared Services and with around 370 staff, it was formed by combining the National Processing Centre and the National Contact Centre.

Shared Services now has four sections:

Customer services, the first point of contact for internal and external customers by telephone, email, post and fax, managing basic calls and correspondence and passing on more complex issues.

Compliance and performance assessment, which receives and processes compliance documents such as letters, provider assessments, surveys and correspondence from other organisations or people who use services. This team also triages and processes notifications and safeguarding alerts.

Registrations, which receives and validates applications and associated documents, sends out notices, certificates and letters following an application, and liaises with our Finance department about registration fees.

Support services, which supports the field force and the rest of Shared Services, organises and delivers training courses to Shared Services staff, and produces performance reporting and management information.

Not long afterwards, Shared Services came fully together when staff moved from our St Nicholas building in Newcastle to the Citygate office nearby. During this time of upheaval, Shared Services continued to provide an efficient service to all of CQC's customers. We saw a 13% increase in call volumes in 2010/11 – more than 345,000 calls in the year, which included 4,799 safeguarding calls.

Lastly, it was the turn of our headquarters directorates to be reviewed, in the light of the other changes already made and our changing regulatory focus. This was implemented by March 2011 and, alongside the other changes already made, allowed us to respond better to the changing regulatory focus and support our two strategic priorities.

“We saw a 13% increase in call volumes in 2010/11 – more than 345,000 calls in the year, which included 4,799 safeguarding calls”

Listening to our staff

CQC takes employee relations seriously, and recognises the following unions for the purposes of collective bargaining, consultation and employee relations:

- UNISON
- Royal College of Nursing (RCN)
- Prospect
- Unite
- PCS

Our Joint Negotiating and Consultation Committee (JNCC), which includes members of CQC management, the Trade Union Side Secretary and full-time officers and the Chair of our staff forum, has met monthly, following a meeting of Staff Side (union representatives only). Negotiations have dealt with issues such as salary review and structure, and employment policies and terms and conditions.

We also have a staff forum to help us build constructive relationships with all our staff, including the large number who are not represented by unions, and those who are temporary or seconded from other organisations.

The forum meets every six weeks, offering staff the chance to raise issues and concerns with senior management, who in turn can communicate their plans. An Executive Team member attends each meeting along with our head of HR, and senior managers attend on an ad hoc basis to discuss specific issues.

Topics for discussion at the staff forum cover issues like organisational changes, operational effectiveness, redeployment of staff, people management policies, and working conditions and training. So far, the most important items have included field force reorganisation and the HQ review.

Other issues discussed in the year were our customer relationship management tool, our staff survey and job evaluation. At times of change – such as during the field force restructure and the HQ review during the year – the forum has proved itself to be a solid bridge between staff and senior managers.

Equality, diversity and human rights

This is the first year of our Equality and Human Rights Scheme covering 2010-2013, and we have made good progress.

Equality, diversity and human rights are integral to our work at CQC. Our scheme seeks to put equality at the forefront of all that we do and ensures we fulfil our social, moral and regulatory objectives.

We started our new regulatory regime using the essential standards of quality and safety. We developed guidance for our inspectors in partnership with the Equality and Human Rights Commission. This includes support for staff to examine equality aspects of the essential standards. It also advises staff of links between the standards and providers' responsibilities under equality and human rights law.

'Equally Yours' is a training toolkit developed for all our staff on equality, which involves individual learning and group discussion. The discussion can be tailored around the learning needs of each team in relation to their understanding of equality law. We have also developed a toolkit for use by our Commissioners who visit people with learning disabilities detained under the Mental Health Act.

'eQuality Voices', a group made up of people with experience of equality issues, helps us in monitoring the implementation of our Equality and Human Rights Scheme. The group met four times during the year and dealt with the set-up, running and governance of the group, providing opportunities to input into some key CQC projects. Group members will spend more time looking at some of the action points in our Equality and Human Rights Scheme in 2011/12.

We have three staff equality networks: the race equality network, the disability equality network, and the lesbian, gay, bisexual and transgender equality network. These groups provide a useful forum for staff to influence our equality and diversity framework, as well as supporting our equality agenda and corporate priorities. In addition to these specific projects, the EDHR specialist staff at CQC provide advice to others to ensure that equality and human rights is embedded in all our work.

Data about our staff is shown in the charts opposite. Information about sexual orientation and religion or belief is not available, because response rates from staff were too low. We are working to improve these next year. Where staff did complete sexual orientation monitoring, 5.2% said that they were lesbian, gay or bisexual.

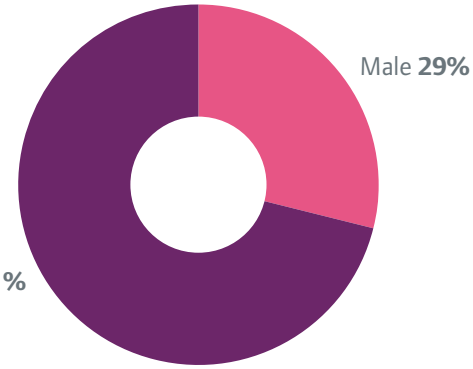
Training and development

We carried out a number of training courses in 2010/11 to increase the skills of a large proportion of our staff. Our focus on providing a robust training and development programme for our frontline staff continues to be a major priority for us.

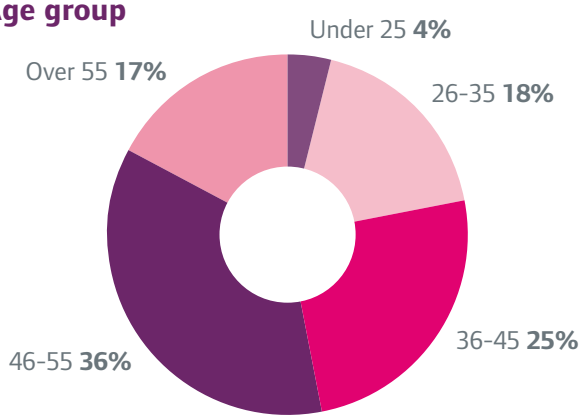
We carried out a full review of the staff performance management process in the year, and completed a programme of training on the new process for both managers and staff.

CQC staff by:

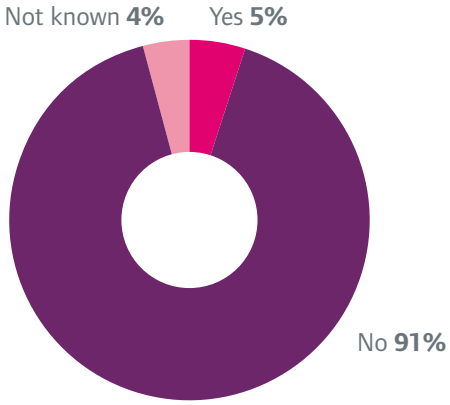
Gender



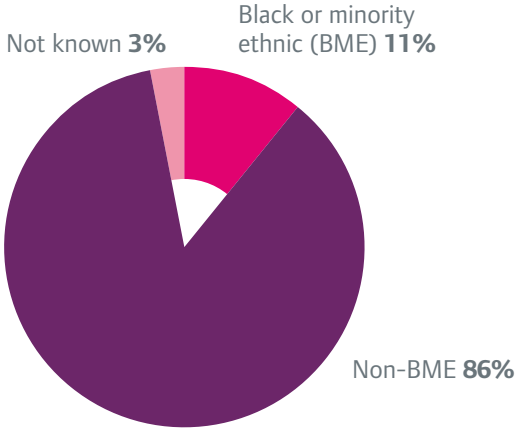
Age group



Declared disability



Ethnic origin



Corporate governance and financial statements

Corporate governance

Statutory background

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

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

Principal activities

CQC is responsible for the regulation of health, adult social care and mental health services provided in England. In carrying out this role, it contributes to the delivery of safe, quality health and social care that supports people to live healthy and independent lives, empowers individuals, families and carers in making informed decisions about their care, and is responsive to individual needs.

Organisational structure and governance

Board membership

	Date appointed	Term of office
Dame Jo Williams	Appointed Chair 24 Sep 2010 to 23 Sep 2014 (Acting Chair from 1 Jan 2010)	4 years
Professor Deirdre Kelly	Re-appointed from 15 Oct 2010 to 14 Oct 2013	3 years
Olu Olasode	1 Nov 2008 to 31 Oct 2011	3 years
Kay Sheldon OBE	Re-appointed from 1 Dec 2010 to 30 Nov 2013	3 years
Professor Martin Marshall	1 Jan 2009 to 31 Dec 2012	4 years
John Harwood	4 Mar 2010 to 3 Mar 2014	4 years

Roles and responsibilities of the Board

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

Board members must also:

- Ensure that high standards of corporate governance are observed at all times.
- Set the overall strategic direction of the Commission within the policy and resources framework agreed with the Secretary of State.

- Ensure that the Commission operates within the limits of its legal framework and any delegated framework agreed with the Secretary of State and the Department of Health and in line with any other conditions relating to the use of public funds.
- Ensure that the Commission, in reaching decisions, engages fully in collective consideration of the issues, taking account of the full range of relevant factors, including any guidance issued by the Secretary of State and other relevant central Government departments.

Register of interests

A register exists for Board members to record any interests relevant to their role on the Board. This register is a document that is open to public scrutiny at CQC's headquarters, Finsbury Tower, 103 – 105 Bunhill Row, London and is available on CQC's website. Where any decisions could give rise to a possible or perceived conflict of interest, the member concerned would declare this and the Chair would form a view about whether the interest is such, as to require the member to withdraw from discussion and any vote on any given item on the agenda. At the Chairman's discretion he or she may be asked to withdraw from the meeting for the duration of any discussion of the item.

Independent members

	Date appointed	Term of office
Julian Duxfield (Remuneration Committee)	17 Nov 2009	2 years
John Butler (Audit and Risk Committee)	1 Dec 2010	1 year

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

Committees, meetings and attendance

Remuneration Committee

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

Membership

- Dame Jo Williams (Chair)
- John Harwood
- Kay Sheldon OBE
- Julian Duxfield (independent member)

In addition, the Chief Executive and the Director of Human Resources regularly attended meetings.

The Committee met five times during the year and approved the Directors' remuneration (following the restructuring of the Executive Team and re-appointment of Directors during the year). It has also overseen and approved the programme to review CQC's reward and recognition arrangements for staff.

The Committee presented a report to the CQC Board on its work during the year and its planned programme of work for the forthcoming year.

Audit and Risk Committee

This Committee has been formed as a sub-Committee of the Board to independently provide assurance on CQC's risk management, governance and internal control. During the year, in line with best practice, the Committee augmented its membership with an external independent member.

Membership

- Olu Olasode (Chair)
- Professor Deirdre Kelly
- Professor Martin Marshall
- John Butler (independent member)

In addition, the Chief Executive, the Director of Governance and Legal Services, and the Director of Finance and Corporate Services regularly attended meetings of the Committee together with the external and internal auditors.

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

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

Specifically, the Audit and Risk Committee provided advice and support to the Board through:

- Review and oversight of the preparation of annual accounts for the approval of the Commission.
- Review of the Commission's systems of internal control and risk management.
- Approving an internal audit plan and monitoring the effectiveness of internal audit.
- Reviewing the adequacy of management actions in response to audit recommendations and that satisfactory progress is made on implementation.

The Committee met six times during 2010/11 and made regular reports to the Board on its activities.

The Comptroller and Auditor General (C&AG) is appointed by statute to audit CQC. As external auditor, he had the right of direct access to the Chair of the Committee. The Commission's external auditor did not provide any additional services to the Commission during 2010/11.

During 2010/11, KPMG was responsible for the internal audit function at the Commission until 30 September when their contract expired. During the six months KPMG did not provide any additional services to the Commission. From 1 October an in-house internal audit team has been established headed by a Head of Internal Audit who holds all the requisite professional internal audit qualifications.

The Committee oversaw the arrangements for the handover of responsibility for the provision of internal audit services.

The Committee approved an internal audit charter and audit strategy for the in-house internal audit team. It also agreed the planned programme of audits as well as any changes to the programme and ensured that those conducting the internal audit had the necessary access to information to enable them to fulfil their mandate. The Head of Internal Audit had the right of direct access to the Chair of the Committee.

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

Processes to manage key risks relating to key aspects of the Commission's activities were examined and reviewed by the Committee throughout the year. These included processes to manage risks associated with the security of information and steps being taken to prevent fraud.

The Committee presented a report to CQC's Board on its work during the year and its planned programme of work for the forthcoming year.

Executive Team

The Executive Team is responsible for CQC's development and performance. It is accountable to CQC's Board for the delivery of CQC's business plan to meet CQC's strategic objectives and is measured against indicators and targets set out in the performance assessment framework as agreed by the Board.

Following a restructuring of the Executive Team during 2010/11 a number of Directors were confirmed in post and re-appointed:

Executive Team		Date appointed
Chief Executive	Cynthia Bower	1 Aug 2008
Director of Strategic Marketing and Communications	Jill Finney	24 Feb 2009
Director of Intelligence	Richard Hamblin	1 Mar 2009
Director of Regulatory Development	Linda Hutchinson	1 Apr 2009
Director of Finance and Corporate Services	John Lappin	1 May 2009
Director of Operations Delivery	Amanda Sherlock	1 Jul 2010
Director of Governance and Legal Services	Louise Guss	1 Jul 2010
Director of Human Resources	Allison Beal	2 Aug 2010

Directors leaving the organisation during the year were:

Former Executive Team members		Date appointed
Director of Methods	Gary Needle	1 Mar 2009 to 8 Jun 2010
Director of Regulation and Strategy (seconded from the Department of Health)	Jamie Rentoul	1 Mar 2009 to 6 Aug 2010
Chief Operating Officer	Kylie Kendrick	5 May 2009 to 31 Jan 2011

Linda Hutchinson, Director of Regulatory Development resigned on 30 April 2011.

Management commentary

Review of activities

The functions for which CQC is responsible are:

- **Registering health and adult social care services** provided by the NHS, local authorities, independent and voluntary sectors. We grant them a 'licence to operate'.
- **Monitoring compliance of these services** to ensure that they continue to meet essential standards of quality and safety. This is based on an ongoing assessment of risk, through which we target our resources appropriately. This is the largest area of our activity.
- **Powers of escalation and enforcement** where concerns about breaches in essential standards of quality and safety are identified. Our powers are significant and include imposing requirements, fines, and cancelling registration of a service.
- **Delivering other statutory, joint or other inspection activity** of ionising radiation, pharmacy and controlled drugs, children's services with Ofsted, youth offending services with HMI Probation, prison healthcare with HMI Prisons, and service inspections of councils when requested by the sector or the Department of Health.
- **Providing information on the quality of health and social care services** to help people who use those services and their carers to make informed decisions about their care.
- **Visiting people whose rights are restricted under the Mental Health Act** to identify where the Act is not being used correctly and where detained patients have concerns about their care and treatment.

During 2010/11, CQC's functions changed with the Government announcement that we would no longer carry out the annual performance assessment of councils' commissioning and the assessment of NHS commissioning.

We set out in our 2009/10 annual report our five key delivery priorities for 2010/11:

- Delivering an effective programme of work on monitoring compliance with essential standards of quality and safety.
- Re-registering around 27,000 adult social care and independent healthcare providers by October 2010.
- Implementing a significant programme of organisational development.
- Reinforcing the local delivery focus of CQC's activities.
- Engaging effectively with our wide range of stakeholders and appropriately involving people who use services.

During 2010/11 we completed the registration of NHS and adult social care providers and have made significant progress in the registration of dental and private ambulance providers. We have also carried out compliance activities and enforcement actions on a number of occasions where care was of poor quality.

We introduced significant changes to our field force roles and re-organised our headquarters structure and roles within it in order to align our frontline and supporting functions with our new regulatory model.

We have made significant contributions to the wide-ranging proposals in the NHS White Paper and the arm's length bodies (ALB) review. The Department of Health proposed to both reduce the number of its ALBs and change the remit of the remaining ALBs. These include significant new functions being assigned to CQC in the Public Bodies Bill which aim to achieve

the Government's objective of reinforcing our role as the quality regulator for health and social care. The functions include the creation of Healthwatch England within CQC by 2012, and the integration of certain functions of the Human Fertilisation and Embryology Authority, Human Tissue Authority, and National Information Governance Board for Health and Social Care into CQC.

We have delivered our activities in a year that has seen the introduction of strict controls on recruitment and procurement across Government and ALBs as part of the Government's economy measures. The measures have presented us with particular challenges, since they have coincided with an expansion of our remit. We have also met the Government's new commitments that aim to make public expenditure more transparent, and are playing a full part in the work to streamline 'back office' functions across Government.

We continue to review, refine and embed our regulatory model and to work to increase our efficiency and our future priorities reflect this.

Future developments

We have reviewed our strategic priorities in the light of our developing role. We now have two priorities – which are not new but are developed from our previous five priorities:

- We focus on quality and act swiftly to eliminate poor quality care.
- We make sure care is centred on people's needs and protects their rights.

To achieve these, we have identified eight delivery priorities for the coming year and beyond. These are noted in Section 4 of this report, page 37, 'Contributing to the landscape of care'.

Financial performance and position

Details of our financial performance are shown in the section on 'Financial statements' in this report and show that the Commission's net expenditure for the year excluding finance costs was £59.0m and was within our approved budget.

During the financial year, the Government introduced additional controls over spending, in order to reduce its overall budget deficit. CQC was subject to these controls, but was able to both deliver the savings required of it and achieve its objectives for 2010/11.

This had an impact on CQC's overall expenditure for the year, which amounted to £139.1m, a reduction of £50.8m on the previous year.

The reasons for the reductions in operating costs are:

- Staff costs were reduced by £8.5m due mainly to the number of vacancies CQC carried throughout the year. Furthermore, CQC re-organised its head office structure during the year and this in turn led to delays in the recruitment of certain categories of staff.
- Other expenditure reduced by £17.0m as a result of a £10.3m reduction in transitional expenditure following evidence that CQC was bedding down after its first year of operation. CQC also reduced its spend on consultancy services following the Government freeze on external consultancy spend.

- Further, there was a significant accounting gain on the Local Government Pension deficit in 2010/11 due mainly to the change from RPI to CPI in providing for future pension benefits and in fluctuations in the investment markets. The net impact on expenditure was to reduce staff costs by £26.0m. The gain is more evident when compared to the 2009/10 reduction of £2.7m. This is a non cash accounting credit that does not impact cash operating costs in the current year.

Capital expenditure within the year was £14m. This enabled significant systems development for the registration programme and preparing CQC to operate under a new fee and billing scheme from 1 April 2011. Capital expenditure was also incurred on the development of Quality and Risk Profiles (QRP), the tool that we use to gather all data about a provider in one place enabling CQC to assess where risks lie and prompt and inform front line regulatory activity, such as reviews of compliance.

During the year, CQC exercised the lease break opportunity at St Nicholas Building in Newcastle in order to co-locate all Newcastle based staff in one office (Citygate) in the city centre.

Total income for the year was £80.1m, an increase of £15.3m on the previous year. The main reason for the increased income is the annual billing of NHS trusts in England who were required to register with CQC from 1 April 2010.

CQC's Net expenditure is funded from grant-in-aid provided by the Department of Health. Grant-in-aid totalled £92.3m (2009/10: £127m) in the year including £15.0m designated as capital grant-in-aid.

Key performance indicators

Key performance indicators used by the Commission to monitor performance throughout the year against the Care Standards Act (CSA) (2000) and the Health and Social Care Act (HSCA) (2008) are as follows:

	2010/11	2009/10
Care Standard Act Registrations		
Number of independent healthcare and social care provider registrations completed under the CSA	1,002	2,240
Number of independent healthcare and social care manager registrations completed under the CSA	2,360	4,754
Transition applications		
Number of NHS provider registrations completed under the Health and Social Care Act	0	378
Number of independent healthcare and social care provider re-registrations completed under the Health and Social Care Act	11,573	n/a
Number of dentist and private ambulance service registrations completed under the Health and Social Care Act. (A further 8,167 registered by 30 June 2011).	1,107	n/a
Business as usual registrations under HSCA		
Number of provider registrations completed under the Health and Social Care Act	493	n/a
Compliance and enforcement activity		
Number of inspections and reviews of NHS, independent healthcare and adult social care providers (Care Standards Act and Health and Social Care Act)	15,220	12,218
Number of prosecutions	3	11 (10 unregistered)
Number of enforcement actions	510	Not recorded
Mental Health Act function		
Number of visits completed to mental health service providers	1,565	1,504
Number of Second Opinion requests handled	13,763	15,288
Number of complaints received about mental health service providers	666	Not recorded
Complaints, governance, information and call handling		
Number of corporate complaints received	165	107
Number of information requests dealt with under both the Freedom of Information Act and the Data Protection Act	1,219	776
Total number of calls received at the National Contact Centre	345,218	305,354
Of the total number of calls received, number of which related to safeguarding issues	4,799	3,733
Number of visitors to the CQC website	5,227,873	4,789,826

Risks and uncertainties going forward

The Audit and Risk Committee recently approved, on behalf of the Board, a revised risk management framework for CQC. The strategic risks identified by the Board going forward are:

1. CQC fails persistently and effectively to identify or deal with non-compliance leading to poor quality care for users and damage to CQC's reputation.
2. CQC lacks adequate or appropriate resource required to meet the demands placed upon it leading to unacceptable levels of performance.
3. CQC structures and processes do not permit effective governance and accountability leading to undetected or unmanaged risks.
4. CQC's independence as a regulator is undermined leading to loss of confidence in its judgements or its ability to safeguard users.
5. CQC fails to operate in line with required standards of probity and value for money in relation to use of public funds.

Through the risk management and internal control frameworks noted in the Statement on Internal Control, the Board is satisfied that appropriate mitigating action is being taken by the Executive Team to reduce these risks to manageable and controllable levels.

Information security

In 2010/11 a new Information Security strategy was developed and implemented to ensure:

- Adherence to statutory and regulatory requirements.
- Adoption of best practice in Information Security.
- Alignment of Information Security to support CQC's organisational objectives.

In order to facilitate these aims and build upon the foundation established over the previous year, CQC has:

- Established an Information Security Steering Group to provide direction, leadership and a focus for Information Security within the Commission and where appropriate, to escalate risk to the relevant Executive body.
- Developed a new Information Security Policy Framework to complement the existing information assurance policies.
- Implemented a comprehensive set of IT Security Standards for project implementation, development and data sharing.
- Become a member of the Criminal Justice Secure Mail community to ensure that safeguarding alerts are safely and securely delivered to local authorities and the Police.
- Become a participating member of the National School of Government to ensure compliance to HMG Security Policy Framework education and awareness requirements.

In the year ended 31 March 2011, there were no incidents reported to the Information Commissioner's Office.

Freedom of information

The Commission published a wide range of information about its activities via its freedom of information publication scheme on its website: www.cqc.org.uk. It also has an Information Access Team that handles access to information requests, such as those made under the Freedom of Information Act 2000 and the subject access provisions of the Data Protection Act 1998. The Information Access Team also responds to formal information sharing requests from other public bodies.

Employment, health and safety and environment policies

Employee consultation and engagement

CQC continues to base its employee relations environment on the principles of full and equal access, engagement and involvement for all employees. CQC recognises UNISON, RCN, Prospect, Unite and PCS for the purposes of collective bargaining, consultation and employee relations and over the last year has been developing a closer and more cooperative working relationship. The Joint National Consultative Committee (JNCC) has met monthly and a number of Joint Consultative Committees have been introduced for the purposes of consultation on matters relating to local conditions and specific groups of staff.

CQC's Staff Forum has been heavily involved in the change processes that have been introduced by the organisation. They have played a valuable part in engaging employees and providing feedback on their questions and concerns to enable CQC to use these to inform its organisational planning. This has allowed us to establish a constructive relationship with all staff including those not represented by unions and secondees and temporary staff who are employed by CQC.

As part of the strategy to identify and prioritise areas for improvement for employees under the provisions of the Equality Act 2010, CQC is engaging with key personnel to develop an action plan for implementation during the forthcoming year.

In 2010/11 we introduced new employee values and behaviours. These focus on effective delivery and accountability with an inclusive approach. A new competency model has also been introduced outlining employee competencies in support of the new values.

Learning and development

CQC has been working closely with staff, external providers and the trade unions to build a coherent vision and framework for Learning and Development. Training courses were designed to increase the skills of a large proportion of staff. The focus on providing a robust training and development programme to the Operations-based workforce will continue to be a major priority for the Learning and Development function in 2011 and beyond.

A full review of the performance management process was undertaken during the year and a programme of training managers and staff on the new process was completed. To support the roll out of the new process to staff we established common, measurable and relevant objectives for core roles.

Employment and policies

It is our ongoing policy to actively support all employees to enable them to perform their work to assist in meeting our aims. This involves attracting staff from all sectors of the community, valuing their different skills and abilities and responding flexibly to their needs in achieving our goals. All employees are given the same consideration irrespective of any protected characteristics, and enjoy the same training and development opportunities and career prospects as other staff. During 2010/11 the average number of disabled persons employed by CQC was 92 (2009/10: 106).

We ensure that our employment terms are fair and free from bias and Equality Impact Assessments were undertaken on key policies and procedures affecting employment. Our employment procedures set out formal policies on key issues such as bullying and harassment, disciplinary and grievance procedures, capability and home working. These procedures will be reviewed again in 2011/12 to ensure they remain inclusive and relevant. Our staff diversity

networks and Staff Forum enables open discussion and consultation on key policies, and kept employees' representatives informed of developments impacting on employment matters. All agreed policies are published on CQC's Intranet, to ensure wide accessibility and availability to all employees.

Home-working

Home-working forms the contractual arrangement for over 1,000 members of staff and is one of the flexible working options which is available to staff as part of the CQC commitment to improving the working lives of its employees to help them achieve a healthy work-life balance. Home-working is integral to CQC's commitment to improving effectiveness, both in cost and in the way that it carries out its work. CQC provides the tools and equipment required to enable its home-working employees to undertake their role safely and effectively. The home-workers' reference group represents the needs of this community and the ideas generated have either already been actioned, or channelled into the review of tools for the next financial year.

Health and safety

In 2010/11 CQC has raised awareness of Health and Safety matters for all staff. A Health and Safety intranet section is kept up to date and we have launched a CQC bespoke e-learning Health and Safety course for all staff to ensure they are well informed on health, safety requirements and matters. We have an established team of Health & Safety champions, who work collaboratively across CQC to ensure appropriate monitoring, and that resolutions to Health and Safety issues are identified and actioned.

On a quarterly basis, the Health and Safety Officer reports to the National Health and Safety Committee, which includes Trade Union representation. The National Health and Safety Action Plan drawn up in 2009 has been completed and an audit took place in March 2010 to identify strengths and weakness. As a result a revised plan for 2011–2013 has been approved.

The on-line Display Screen Equipment (DSE) risk assessment has been a significant success and is now in its second year. The increasingly high profile of health and safety matters has resulted in a more robust health and safety culture being embedded across CQC.

Sickness absence data

During 2010/11 a total of 20,874 days (2009/10: 14,387 days) were lost due to sickness of which 14,664 days (2009/10: 11,331 days) were due to long term illness. The average number of days sickness per employee during 2010/11 was 11, (2009/10: 8 days). The main reason for long term absence in CQC is mental health associated problems. As this is the first year of operation of a new sickness reporting system, the reported increase in days lost in comparison to the previous year is largely due to improved recording processes.

Sustainability duty

CQC is conforming to new 'Greening Government' guidance introduced by DEFRA to reduce waste generation, water use, greenhouse gas emissions, and making our procurement more sustainable. Sustainable building management practices are in place across the CQC estate.

Our sustainable performance in 2010/11 against the agreed 'Greening Government' targets is as follows:

- Water use is 10m^3 per Full Time Equivalent (FTE), a decrease of 3.4m^3/FTE since 2009/10 and on track to meet the Government target of 6m^3 per FTE by 2015.

- Carbon emissions usage is 2,323 tonnes, a reduction of 13.5% since 2009/10 and better than the Government target to reduce CO_2 by 10% over 2010/11.
- Waste to landfill is 55 tonnes. The landfill waste is 0.04 tonnes per FTE and meets the Government Benchmark of 0.04 landfill waste tonnes per FTE. Figures are not available for 2009/10.
- Waste to recycling is 218 tonnes, an increase of 52.5% since 2009/10 and better than the Government target to increase recycling figures to 40% of waste by 2010.

Estates strategy

The CQC Estates strategy has been updated to reflect the new Government Property Controls, which were implemented in June 2010. As a result we have closed the St Nicholas Building office in Newcastle and will close the Belgrave Centre office in Nottingham in 2011/12 and relocate members of staff to surplus civil estate premises. We have also reduced the Birmingham office space by 50% and the Preston office space by 30% during the year. These initiatives have led to significant savings for both CQC and the Department of Health.

Contractual obligations

CQC operates a contracts register, which shows the contracts let and we now publish details of all new contracts with a value over £10,000 on the Government Contracts Finder website. CQC's largest contracts are with Information Communication Technology (ICT) service suppliers: CSC Computer Science Ltd., Computacenter, Sapient and Cable & Wireless. Services supplied under these arrangements included ICT support services, ICT development, operating systems, hardware maintenance, IS infrastructure, IT operations, and the CQC CRM system used to organise, integrate, record and coordinate CQC's relationships with the bodies that we regulate.

Better payment practice code

CQC's policy was to pay creditors in accordance with contractual conditions or, where no contractual conditions exist, 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 2010/11, CQC paid 90.7% (2009/10: 79.1%) based on volume and 94.5% (2009/10: 87.8%) of invoices based on value within 30 days.

Following new guidance from Central Government in August 2010, CQC aspired to pay 80% of all undisputed invoices from our suppliers within 5 working days. Our performance for the period August to March 2011 was 83.5% based on volume and 82.5% based on value within 5 days.

Pension costs

The treatment of pension liabilities and the relevant pension scheme details are set out in the Pensions note on page 75 and in the Remuneration Report on page 56.

Political and charitable donations

No political or charitable donations were made during the year.

Research and development

No research and development activities were carried out in 2010/11.

Form of account

The financial statements have been prepared in the form directed by the Secretary of State for Health, in accordance with the Health and Social Care Act (2008), the Government Financial Reporting Manual (FReM) (2010/11) 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.

Going concern

The financial accounts have been prepared on the basis that CQC is a going concern. Grants for 2011/12, taking into account the amounts required to meet CQC's liabilities falling due that year, have been included in Department of Health (DH) estimates which were approved by Parliament.

Post Statement of Financial Position Events

There are no significant post Statement of Financial Position events.

Auditors

The Comptroller and Auditor General (C&AG) is appointed by statute to audit CQC and report to Parliament on the truth and fairness of the annual financial statements and regularity of income and expenditure. The total amount due for audit work is £125k (2009/10: £130k plus £20k for IFRS work). There was no remuneration paid for non-audit work during the year.

Availability of information for audit

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

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 as well as those amounts payable to third parties for services as a Senior Executive. The content of the tables is subject to audit.

Remuneration of the Chair and Board Members

Board members' remuneration is determined by the Department of Health on the basis of a commitment of two days per month. The exception is Olu Olasode who is contracted for four days per month for his role as Chairman of CQC's Audit and Risk Committee.

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. For 2010/11 this amounted to £7k (2009/10: £7k). CQC meets the resulting tax liability under a settlement agreement with HM Revenue and Customs.

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

In reaching its recommendations, the Remuneration Committee considered:

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

Payments to Independent Members

Julian Duxfield was an independent member of CQC's Remuneration Committee. Fees and expenses are paid on a per meeting basis and amounted to £4k for 2010/11 (2009/10: £2k).

Chairman and Board Members' Emoluments

		2010/11	2009/10	
	Date appointed	Total salary £000	Total salary £000	
Dame Jo Williams (Chair from 24 Sep 2010) (Acting Chair from 1 Jan 2010)	1 Oct 2008	60-65	20-25	(60-65 full year equivalent)
Baroness Barbara Young (Chair) resigned 31 Dec 2009	1 Oct 2008	–	70-75	(75-80 full year equivalent)
Professor Deirdre Kelly	1 Oct 2008	5-10	5-10	
Olu Olasode	1 Nov 2008	10-15	10-15	
Kay Sheldon OBE	1 Dec 2008	5-10	10-15	
Professor Martin Marshall	1 Jan 2009	5-10	5-10	
John Harwood	4 Mar 2010	5-10	–	

John Butler was appointed an independent member of CQC's Audit and Risk Committee in 2010. Fees and expenses are paid on a per meeting basis and amounted to £2k for 2010/11.

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 Arms Length Bodies.

Remuneration of the Executive Team

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

The Executive Team had a contractual entitlement to be considered for a bonus of up to 10% of salary for performance in the year 2010/11. 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, particularly given the difficult economic and financial climate.

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 have 3 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.

Payments made for loss of office

Gary Needle received a contractual redundancy payment of £90-95k at the date of leaving.

Amounts payable to third party for services as a senior executive

Jamie Rentoul provided services as a Director of Regulation and Strategy, while employed by the Department of Health. He returned to the Department of Health on 6 August 2010. Total employment costs of £62k for 2010/11 (2009/10: £192k) comprising pension and employer's costs were recharged to the Commission by the Department of Health.

Linda Hutchinson provided services as a Director of Registration, while employed by London Strategic Health Authority. Total employment costs of £42k for 2010/11 (2009/10: £167k) comprising pension and employer's costs were recharged to the Commission by London SHA. On 1 July 2010, Linda Hutchinson became an employee of CQC.

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.

		2010/11		
Executive team	Date Appointed	Salary £000	Bonus £000	Benefits in kind £000
Cynthia Bower	1 Aug 2008	195-200	–	–
Jill Finney	24 Feb 2009	140-145	–	–
Richard Hamblin	1 Mar 2009	110-115	–	–
Linda Hutchinson (seconded from London SHA prior to 1 Jul 2010)	1 Apr 2009	95-100[2]	–	–
John Lappin	1 May 2009	140-145	–	–
Amanda Sherlock	1 Jul 2010[1]	125-130[2]	–	–
Louise Guss	1 Jul 2010[1]	105-110[3]	–	–
Allison Beal (seconded from the Department of Health prior to 2 Aug 2010)	2 Aug 2010[1]	70-75[3]	–	–
Gary Needle (redundant 8 Jun 2010)	1 Mar 2009	70-75	–	–
Kylie Kendrick (resigned 31 Jan 2011)	5 May 2009	140-145	–	–

[1] Date appointed to the Executive Team for reporting purposes
[2] Full-year equivalent salary £130-135k.
[3] Full-year equivalent salary £110-115k.

	2009/10				
Executive team	Salary £000	Bonus £000	Benefits in kind £000	Total £000	Full year equivalent salary £000
Cynthia Bower	195-200	5-10*	10-15**	210-215	195-200
Jill Finney	140-145	–	–	140-145	140-145
Richard Hamblin	110-115	–	–	110-115	110-115
John Lappin	130-135	–	–	130-135	140-145
David Johnstone (resigned 30 Nov 2009)	100-105	–	–	100-105	155-160
Gary Needle (redundant 8 Jun 2010)	140-145	–	–	140-145	140-145
Kylie Kendrick (resigned 31 Jan 2011)	120-125	–	–	120-125	145-150

2009/10 was the first year of operation for CQC, therefore the full year equivalent gross salaries are shown.

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

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

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 2011 may include amounts transferred from previous NHS employments whilst the real increase reflects only the proportion for the time in post, if the employee was not employed by CQC for the whole year.

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

	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 2011 (bands of £5,000) £000	Total accrued pension at 31 March 2011 (bands of £5,000) £000	CETV at 31 March 2010 £000	CETV at 31 March 2011 £000	Real Increase in CETV £000
Cynthia Bower	47.5 – 50	15 – 17.5	195 – 200	65 – 70	1,081	1,350	240
Jill Finney	–	0 – 2.5	–	5 – 10	33	55	21
Richard Hamblin	0 – 2.5	0 – 2.5	65 – 70	20 – 25	302	267	(43)
Linda Hutchinson	0 – 2.5	0 – 2.5	100 – 105	30 – 35	616	582	(38)
John Lappin	–	0 – 2.5	–	0 – 5	35	65	30
Amanda Sherlock	2.5 – 5	2.5 – 5	100 – 105	75 – 80	552	560	8
Louise Guss	0 – 2.5	0 – 2.5	45 – 50	60 – 65	246	240	(6)
Gary Needle (redundant 8 Jun 2010)	–	–	100 – 105	30 – 35	945	–	–
Kylie Kendrick (resigned 31 Jan 2011)	–	2.5 – 5	–	5 – 10	17	33	13

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 8.5% of their pensionable pay depending on total earnings.

In 2010/11 CQC employer's contribution for staff to the NHS pension fund was £4,408k (2009/10: £4,574k) at a rate of 14% (2009/10: 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 £723k (2009/10: £1,043k).

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 2010/11 were £4,544k in total (2009/10: £5,245k), at rates ranging between 6.2% and 39.6% (2009/10: 6.2% and 39.6%). Employer contributions relating to the largest scheme, Teesside Pension Fund were £3,790k (2009/10: £4,360k) at a rate of 13.7% (2009/10: 13.7%).

The 2010/11 triennial actuarial valuation results from Local Government Pension Funds, largely reported increased deficits in the CQC schemes. Only 3 of the 17 funds reported a surplus. All the schemes are closed resulting in the very real prospect of declining payroll numbers in the next few years. This has led to a change to the way the deficit recovery is managed. From 2011/12, an indexed cash sum will be levied in addition to a percentage of payroll costs. Teesside Pension Fund is an exception to this change, 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 2011/12 range between 14.4% and 32.3% (14.4% for Teesside Pension Fund) with annual cash sums ranging from £11k to £127.9k (nil for Teesside).

The impact of the change in accounting for future pension costs arising from the indexation changing from the Retail Price Index (RPI) to the Consumer Price Index (CPI) is noted in Note 4 of the financial statements.

Cynthia Bower
Chief Executive, CQC
6 July 2011

Statement of Accounting Officer's Responsibilities

Under the Health and Social Care Act 2008 the Secretary of State for Health has directed CQC to prepare for 2010/11 a statement of accounts in the form and on the basis set out in the 'Accounts Direction'. This direction instructed CQC to prepare accounts in compliance with the accounting principles and disclosure requirements of the edition of the Government Financial Reporting Manual issued by H M Treasury ("the FReM") which is in force for 2010/11.

The accounts shall be prepared so as to:

- Give a true and fair view of the state of affairs at 31 March 2011 and of the net resource outturn, the application of resources, changes in taxpayers' equity and cash flows for the financial year then ended.
- Provide disclosure of any material expenditure or income that has not been applied to the purposes intended by Parliament or material transactions that have not conformed to the authorities which govern them.

In preparing the accounts, CQC has to:

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

The Secretary of State for Health has designated the Chief Executive as the Accounting Officer for CQC. The responsibilities of an Accounting Officer include responsibility for ensuring propriety, and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding CQC's assets, are set out in *Managing Public Money* issued by HM Treasury (2007).

Statement on internal control

Scope of responsibility

As Accounting Officer (AO), I have responsibility for maintaining a sound system of internal control that supports the achievement of the Care Quality Commission's aims and objectives, whilst safeguarding the public funds and departmental assets; in accordance with the responsibilities assigned to me in *Managing Public Money*.

CQC is a non-departmental public body (NDPB) of the sponsoring Department for Health (DH). The Secretary of State for Health is answerable to Parliament for the performance of the Commission. The DH monitors CQC's activity through formal quarterly reviews of progress against objectives, quarterly meetings with me, and regular meetings between the Chair of CQC with the DH Permanent Secretary. In addition, I have regular meetings with Ministers and meetings with other senior DH officials.

The Commission meets regularly, including quarterly public meetings, where the performance of the Executive in achieving objectives is reviewed by the non-executive CQC Board.

The purpose of the system of internal control

The system of internal control is designed to manage the risks to the achievement of CQC's aims and objectives efficiently, effectively and economically; and to manage risks to a reasonable level rather than to eliminate all risk. It can therefore only provide reasonable and not absolute assurance of effectiveness.

Capacity to handle risk

The CQC Board, through the Audit & Risk Committee (ARC), provide leadership for risk management and sets the risk appetite for the organisation. We have improved our risk management capability, to ensure that key risks are identified, and appropriate mitigating measures are implemented.

A review of the CQC organisational structure established the Governance and Legal Services Directorate to ensure that governance issues are represented and led at Director level. The internal governance arrangements were revised during the year to clarify and strengthen accountability and provide clear routes to report and escalate both business delivery and regulatory risks. An audit of corporate governance reviewed the effectiveness of these new governance structures.

The CQC Board has reviewed and refreshed the register of strategic risks owned by it, assigning mitigating actions to the Board, individual Board members and myself. I maintain a register of corporate risks owned by me, with mitigating actions assigned to named Directors. All the Executive Team (ET) members have reviewed the risks to the delivery of their business plans and accountability for risk management, business planning and performance, and regulatory risk has been delegated to Heads of Function.

Line management responsibility for risk has been further embedded and the business planning and performance reporting systems have also been reviewed, revised and strengthened; examining the robustness of associated business risk assessment is a measure of the quality of planning.

To support the implementation of the revised risk management framework Directors and other senior managers attended workshops to embed knowledge and share understanding of the process. Revised risk management guidance has been published. Directors submit a monthly return outlining the changes to their risk profiles, to evidence that risks have been subject to regular and systematic review.

The Internal audit (IA) function was brought 'in-house' in order to support the improvement of governance and the risk management culture and capability. The role of IA and their relationship to risk management framework were reviewed. IA findings now directly inform both risk assessment and the effectiveness of risk mitigation at strategic, corporate, directorate and system level. IA annual report and opinion has been submitted to the ARC, and taken into account in the preparation of this statement. The IA function remained independent from Finance.

As a regulator, CQC has systems to manage both business delivery risks and regulatory risks. Regulatory risk management is the identification and quantification of the risk of non-compliance with the legislation regulated by CQC; and the targeting of resources to address these risks. CQC's regional compliance teams have applied a risk based approach to the review of compliance of providers. Review findings and the risk status of providers is reviewed on a monthly basis. Providers identified as minor and moderate risks are reviewed by Regional Risk Panels. Providers identified as a major risk are escalated to the Risk and Escalation Committee (REC). The REC, chaired by the Director of Operations Delivery, is responsible for the oversight of the management of regulatory risk. The Regulatory Risk Register is a standing item on the REC agenda and regional directors provide assurance on the effectiveness of actions to mitigate compliance risk and on the application of CQC's enforcement powers. Regulatory matters, where appropriate, are escalated from the REC to the ARC and the Board.

A number of significant risks were identified and managed during the year, including the registration of social care and independent healthcare providers and dentists under the Health & Social Care Act 2008; managing the ongoing compliance of the NHS and social care and independent healthcare providers; and adapting CQC's approaches to meet the requirements of the Government whilst maintaining its independence as a regulator. It is the appropriate time for the CQC regulatory model to be reviewed and this is under way and will take into account any incidents that have occurred.

The risk and control framework

CQC's risk management strategy aims to identify, assess and manage both regulatory and business delivery risks consistently across the organisation. The framework has been designed in accordance with HM Treasury guidelines. The CQC Board's Scheme of Delegation defines the authority for business and regulatory decision-making.

The revised risk management framework and processes aim to ensure that there is a regular assessment of the degree to which business risk might impact upon the regulatory risk profile and vice versa.

The CQC Board and I regularly consider the tolerable threshold for risk and will discuss with the Department of Health officials and Ministers if and when we consider that risks have moved beyond an acceptable level.

Management of information risk is a key element of the risk management framework and managers are required to report any near misses and incidents relating to the security of information. Within the governance structure the Information Security Committee, chaired by CQC's Senior Information Risk Owner, has oversight of information risks and issues. Actions to mitigate information risks included acquisition of Criminal Justice Secure eMail, development of information security policies, and organisation-wide training in information. CQC's Caldicott Guardian reviewed CQC's Code of Practice on its use of Confidential Personal Information for regulatory purposes. The Code was also reviewed by the independent National Information Governance Board and their comments taken into account.

CQC staff members are entitled to membership of the NHS Pension Scheme, therefore control measures are in place to ensure that all employer obligations contained within the Scheme regulations are complied with, including: ensuring deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules; and member Pension Scheme records are accurately updated in accordance with the required timescales.

Review of effectiveness

I have responsibility for reviewing the effectiveness of the system of internal control. This review is informed by the work of the IA and those executive managers who have responsibility for the development and maintenance of the internal control framework, and the comments made by the external auditors in their management letter and other reports.

I have sought assurance from CQC's Directors and the Heads of Function that they are taking individual and corporate responsibility for the management of risk in their respective areas of work. IA has provided me with additional independent and objective assurance and ARC provides me with a valuable overview.

The IA assurance and consultancy programme was risk based, and designed to cover sufficient audit work to enable the Head of Internal Audit (HIA) to formulate an overall opinion for the current year on the CQC's risk management, control and governance, and to support the preparation of this Statement on Internal Control.

A total of 15 assurance audits were completed; for 11 audits partial assurance was given, for three audits, substantial assurance was given and for one audit full assurance was given; therefore no audits were allocated limited or no assurance. Two audit consultancy assignments were also conducted covering the risk management framework; and aspects of operational and regulatory activity. Where IA has identified areas where controls were not in place or were not operating effectively, the appropriate ET member has responded with management actions to address the excess residual risk. Implementation of these management actions is monitored and reported to the ARC and ET. IA has acknowledged that much progress has been made, particularly in the latter part of the year, in developing governance, risk management and internal control frameworks. However these have not been fully effective across the whole year and internal control has been weak. The mitigating actions taken and planned by management should form a sound basis for governance, risk management and internal control going forward.

There have not been any specific significant weaknesses that would impact on the proper discharge of CQC obligations. However, there is a thread of weaknesses in control identified by IA and this includes some blurring of accountability with consequential gaps in management checking, insufficient breadth and depth of management information and has resulted in issues around assurance to inform and support effective oversight.

In summary, the internal control framework, although showing signs of increasing maturity especially in the later part of the year, is still considered generally weak and in need of ongoing enhancement. The culture of control is not yet well established or embedded although I do consider that the relatively recent impetus in risk management will help drive this forward.

Cynthia Bower
Chief Executive, CQC
6 July 2011

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 2011 under the Health and Social Care Act 2008. These comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, 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 Annual Report 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.

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

Opinion on regularity

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

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of Care Quality Commission's affairs as at 31 March 2011 and of its 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 'Corporate Governance' and 'Management Commentary' sections of the Annual Report 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
- 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 Statement on Internal Control does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

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

8 July 2011

Financial statements

Statement of comprehensive net expenditure for the year ended 31 March 2011

	Note	2010/11 £000	2009/10 as restated (Note 2) £000
Expenditure			
Staff costs	4	70,241	102,099
Depreciation	5	12,473	12,850
Other Expenditure	5	56,308	73,311
Impairment of Assets	5	67	1,681
		139,089	**189,941**
Less income			
Income from Activities	7	(80,062)	(64,752)
Other income	7	(22)	(32)
		(80,084)	**(64,784)**
Net expenditure excluding finance costs		**59,005**	**125,157**
Interest receivable	7	**–**	(3)
Net expenditure for the financial year		**59,005**	**125,154**

Other comprehensive expenditure

	Note	2010/11 £000	2009/10 £000
Net loss/(gain) on revaluation of intangibles		671	(3,362)
Net loss/(gain) on revaluation of property, plant and equipment		407	(1,755)
Actuarial (gain)/loss in pension schemes	4	(15,354)	48,634
		(14,276)	**43,517**
Total comprehensive expenditure for the year ended 31 March 2011		**44,729**	**168,671**

All income is derived from continuing operations.

The notes 1 to 25 form part of these financial statements.

Statement of financial position as at 31 March 2011

	Note	31 March 2011 £000	31 March 2011 £000	31 March 2010 £000	31 March 2010 £000
Non-current assets:					
Intangible assets	8	17,041		14,894	
Property, plant and equipment	9	7,904		12,353	
Total non-current assets			**24,945**		**27,247**
Current assets:					
Trade receivables	13	5,594		3,085	
Other current assets	13	3,008		3,424	
Cash and cash equivalents	14	16,366		14,919	
Total current assets			**24,968**		**21,428**
Total assets			**49,913**		**48,675**
Current liabilities:					
Trade and other payables	15	(11,046)		(16,150)	
Current pension liabilities	15	(679)		(865)	
Fee Income in Advance	15	(24,997)		(26,393)	
Provisions	16	(2,432)		(356)	
Total current liabilities			**(39,154)**		**(43,764)**
Non-current assets plus net current assets			**10,759**		**4,911**
Non-current liabilities					
Provisions	16	(898)		(1,232)	
Pension liabilities	15	(1,456)		(2,234)	
Total non-current liabilities excluding pension deficit provision			**(2,354)**		**(3,466)**
Assets less liabilities excluding pension deficit provision			**8,405**		**1,445**
Pension deficit provision	4		(13,957)		(54,568)
Assets less liabilities			**(5,552)**		**(53,123)**
Taxpayers' equity					
General reserve			(6,743)		(57,195)
Revaluation reserve			1,191		4,072
Total taxpayers' equity			**(5,552)**		**(53,123)**

The financial statements on pages 68 to 95 were approved by the Board on 6 July 2011 and were signed on its behalf by:

Cynthia Bower,
Chief Executive, CQC

The notes 1 to 25 form part of these financial statements.

Statement of cash flows for the year ended 31 March 2011

	Note	£000	2010/11 £000	£000	2009/10 as restated (Note 2) £000
Cash flows from operating activities					
Total net expenditure		(59,005)		(125,154)	
Adjustment for depreciation charge	5	12,473		12,850	
Impairment of intangible assets	5	–		1,681	
Impairment of property, plant & equipment	5	67		–	
Net loss on indexation of intangible assets	5	1,048		794	
Net loss on indexation of property, plant and equipment	5	659		456	
Loss on disposal of intangible assets	5	791		155	
Loss on disposal of property, plant and equipment	5	197		701	
(Increase)/Decrease in trade and other receivables	13	(2,093)		3,351	
(Decrease) in trade payables	15	(5,104)		(8,532)	
(Decrease) in current pension liabilities	15	(186)		-	
(Decrease)/Increase in deferred income	15	(1,396)		370	
Increase/(Decrease) in provisions	16	1,742		(2,855)	
(Decrease) in pension deficit provision	4	(25,257)		(1,379)	
(Decrease)/Increase in non-current pension liabilities	15	(778)		1,943	
Net cash outflow from operating activities			**(76,842)**		**(115,619)**
Cash flows from investing activities					
Purchase of intangible assets	8	(11,412)		(8,640)	
Purchase of property, plant and equipment	9	(2,599)		(6,982)	
Net cash outflow from investing activities			**(14,011)**		**(15,622)**
Cash flows from financing activities					
Grants from Department of Health	21	92,300		127,000	
(Increase) in cash in hand	14	–		(3)	
Net financing			**92,300**		**126,997**
Net Increase/(Decrease) in cash and cash equivalents in the year			1,447		(4,244)
Cash and cash equivalents at the beginning of the period	14		14,919		19,163
Cash and cash equivalents at the end of the period	14		16,366		14,919

The notes 1 to 25 form part of these financial statements.

Statement of changes in taxpayers' equity for the year ended 31 March 2011

	Note	Revaluation Reserve £000	General Reserve as restated (Note 2) £000	Total Reserves £000
Balance at 31 March 2009		**313**	**(11,762)**	**(11,449)**
Changes in taxpayers' equity for 2009/10				
Net gain on indexation of intangible assets	8	3,362	-	3,362
Net gain on indexation of property, plant and equipment	9	1,755	-	1,755
Transfers between reserves		(1,358)	1,358	–
Cash in hand	14	–	(3)	(3)
Net expenditure for the year		–	(125,154)	(125,154)
Actuarial (loss) in pension schemes			(48,634)	(48,634)
Total recognised income and expense for 2009/10		**3,759**	**(172,433)**	**(168,674)**
Grant from Department of Health		–	127,000	127,000
Balance at 31 March 2010		**4,072**	**(57,195)**	**(53,123)**
Changes in taxpayers' equity for 2010/11				
Net (loss) on indexation of intangible assets	8	(671)	–	(671)
Net (loss) on indexation of property, plant and equipment	9	(407)	–	(407)
Transfers between reserves for intangible assets		(1,299)	1,299	–
Transfers between reserves for property, plant and equipment		(504)	504	–
Net expenditure for the year		–	(59,005)	(59,005)
Actuarial gain in pension schemes		–	15,354	15,354
Total recognised income and expense for 2010/11		**(2,881)**	**(41,848)**	**(44,729)**
Grant from Department of Health	21	–	92,300	92,300
Balance at 31 March 2011		**1,191**	**(6,743)**	**(5,552)**

The opening and closing element of the revaluation reserve split between intangible and property, plant and equipment is shown below.

Revaluation reserve	31 March 2011 £000	31 March 2010 £000
Intangible assets	599	2,569
Property, plant and equipment	592	1,503
	1,191	**4,072**

The notes 1 to 25 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 2010/11 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 accounting policy in relation to the notional cost of capital charge has been changed during the year and is explained more fully in note 2.

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 2010/11.

IFRS amendments in issue that are effective for the financial year beginning 1 April 2010 but which are not expected to have an impact on the CQC's accounts

Amendments to IFRS5 Non-current Assets Held for Sale and Discontinued Operations

Amendments to IAS1 Presentation of Financial Statements

Amendments to IAS7 Statements of Cash Flow

Amendments to IAS17 Leases

Amendments to IAS24 Related Party Disclosures

Amendments to IAS36 Impairment of Assets

Amendments to IAS38 Intangible Assets

Amendments to IAS39 Financial Instruments: Recognition and Measurement

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 2013.
IFRS7 Financial Instruments: Disclosure	More disclosure on transfer transactions following the credit crisis. The effective date is for accounting periods on or after 1 July 2011. A second set of amendments concerns the disclosure of qualitative and quantitative disclosures on risks. The effective date is for accounting periods on or after 1 January 2011.

IAS1 Presentation of Financial Statements	Allows equity items to be disclosed in the notes rather than in the Statement of Comprehensive Expenditure. The effective date is for accounting periods on or after 1 January 2011.
IFRIC14 Prepayments of a Minimum Funding Requirement	In certain circumstances, the prepayment of future contributions to a pension scheme can be treated as an asset providing a minimum funding requirement exists. The effective date is for accounting periods on or after 1 January 2011.

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 whilst 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 3 years. The estimate of working life is regularly reviewed to ensure that depreciation charged in the expenditure account is materially accurate.

Impairment of intangible and property, plant and equipment assets

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

Research and development expenditure

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

Operating income

Income is made up of statutory fees from the registration of social care 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. Statutory fees relating to following accounting periods are treated as income in advance at the end of each accounting period (Note 15).

Leases

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

Financial instruments

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

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

Financial liabilities are recognised on the Statement of Financial Position when the Commission becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged, that is, the liability has

been paid or has expired. The Commission has no financial liabilities other than trade payables. Trade payables are not interest bearing and are stated at their nominal value.

Longer term debtors and creditors are discounted when the time value of money is considered material. Consequently the liability for additional pension contributions resulting from the early termination of staff in previous years is discounted by 2.9%. 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 currently 2.2% (2009/10: 2.2%).

A restructuring provision is recognised when the 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 Pensions

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 4 and in the Remuneration Report. Actuarial valuations are carried out at each Statement of Financial Position date with actuarial gains and losses recognised in full in the period in which they occur and reported in the Statement of Other Comprehensive Expenditure.

1.4 Administration and programme expenditure classification

The expenditure identified in the Statement of Comprehensive Net Expenditure was all classified as programme expenditure in the Spending Review of the Care Quality Commission's sponsoring department, the Department of Health.

2. Capital charge

In accordance with the 2010/11 FReM, capital charges have been excluded from the annual accounts. Prior year accounts have been restated due to this accounting policy change and the statement of financial position and accompanying notes amended accordingly. A second comparative year has been omitted. This is a departure from the requirements of IAS1. A direction has been issued by HM Treasury permitting NDPBs and other public bodies to omit a third balance sheet where there is no impact on the Statement of Financial Position and it goes in and out of the Statement of Comprehensive Net Expenditure.

A prior year adjustment note is disclosed below:

Net expenditure account	**2009/10 £000**
At beginning of year as previously stated	123,664
Prior year adjustment re cost of capital	1,490
Net Expenditure for the financial year restated	**125,154**

Statement of changes in taxpayers' equity	**General Reserve £000**
Prior year adjustment re cost of capital	1,490
Remove previously stated net expenditure for the year	123,664
	125,154

Replace	
Net expenditure for 2009/10 restated	(125,154)
	(125,154)

3. 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 as a whole since the Commission's net expenditure for the year related to its principal duties and functions as set out in the Health and Social Care Act 2008.

3.1 Revenues from major products and services: Income from Fees

	2010/11 £000	**2009/10 £000**
Annual Fees	(75,976)	(59,306)
Annual Fees – rebate scheme	1,009	538
Initial Registration Fees	(4,078)	(4,658)
Variation Fees	(1,014)	(1,111)
Chargeable inspections etc	(2)	(15)
Fee Income	**(80,061)**	**(64,552)**

4. Staff numbers and related costs

4.1 Staff costs comprise:

	2010/11			2009/10
	Permanently employed staff £000	Others £000	Total £000	Total £000
Wages and salaries	68,944	12,566	81,510	88,852
Social security costs	6,173	–	6,173	6,556
Other pension costs	9,249	–	9,249	9,811
	84,366	**12,566**	**96,932**	**105,219**
Less recoveries in respect of outward secondments	(618)	–	(618)	(425)
Increase (decrease) in provision for pension fund deficits (See note 4.4 page 78)	(26,073)	–	(26,073)	(2,695)
Staff costs	**57,675**	**12,566**	**70,241**	**102,099**

Other Staff costs consist of:	2010/11 £000	2009/10 £000
Agency	8,654	10,965
Secondments from other organisations	454	1,210
Commissioner Fees	857	803
Second Opinion Doctor's Fees and Expenses	2,601	2,399
Total	**12,566**	**15,377**

Agency staff costs of £7.1m relating to IT software developments were capitalised during the year (£3.7m 2009/10).

Other Pension costs include lump sum payments of £56k and £228k to Essex and Derbyshire Pension Funds respectively, in addition to the percentage of payroll costs sums and costs for early retirements. These amounts were paid with a view to reducing part of the overall pension fund deficit.

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

	2010/11 Number wte	2009/10 Number wte
Directly employed	1,776	1,903
Other **	176	312
Agency Staff engaged on capital projects	55	22
	2,007	**2,237**

The actual number of directly employed whole time equivalents as at 31 March 2011 was 1,915 (2010: 2,098).

**Other – excludes the Commissioners and Second Opinion doctors who are paid per session

4.3 Exit packages

Cost Band	2010/11 Number	2009/10 Number
<£10,000	30	10
£10,000 – £25,000	20	10
£25,000 – £50,000	20	20
£50,000 – £100,000	40	40
£100,000 – £150,000	20	10
£150,000 – £200,000	10	10
>£200,000	*	*
Total number of exit packages	**140**	**100**
Total cost	**£9,181,000**	**£6,829,000**

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.

4.4 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 £4,408k represents the contribution payable to the scheme by the Commission at rates specified in the rules of the plan. As at 31 March 2011, contributions of £521k 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 will levy an indexed cash sum in addition to a percentage of payroll costs. Furthermore, with effect from 1 April 2011, increases to local government pensions in payment and deferred pensions will be linked to annual increases in the Consumer Prices Index (CPI), rather than the Retail Prices Index (RPI).

Contribution rates for 2011/12 will range between 14.4% and 32.3% (14.4% for Teesside Pension Fund) with annual cash sums ranging from £11k to £127.9k (nil for Teesside).

The present value of the defined benefit obligations were carried out at 31 March 2011 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	Mercer Ltd.
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 10/11 £000	Liabilities 10/11 £000	Surplus/ (Deficit) 10/11 £000	Surplus/ (Deficit) 09/10 £000	Surplus/ (Deficit) 08/09 £000	Surplus/ (Deficit) 07/08 £000	Surplus/ (Deficit) 06/07 £000
Avon	4,148	(4,936)	(788)	(1,096)	(719)	(766)	(312)
Cambridgeshire	2,002	(2,472)	(470)	(1,169)	(322)	(20)	(115)
Cheshire	2,867	(2,729)	138	(2,159)	(912)	(492)	(150)
Cumbria	2,178	(2,964)	(786)	(1,203)	(793)	(819)	(640)
Derbyshire	2,531	(2,654)	(123)	(417)	(385)	(225)	74
Dorset	1,649	(2,527)	(878)	(1,199)	(772)	(386)	(254)
East Sussex	4,607	(4,319)	288	(1,227)	(345)	134	(260)
Essex	3,575	(4,664)	(1,089)	(1,473)	(1,017)	(1,020)	(923)
Greater Manchester	10,348	(11,284)	(936)	(4,673)	(1,339)	173	(789)
Hampshire	3,330	(4,960)	(1,630)	(2,360)	(1,690)	(500)	(1,010)
Merseyside	4,995	(5,635)	(640)	(1,241)	(772)	(632)	(12)
Shropshire	1,471	(1,860)	(389)	(850)	(543)	(494)	(502)
Suffolk	2,353	(3,024)	(671)	(1,636)	(589)	(62)	(314)
Surrey	3,827	(4,268)	(441)	(1,928)	(768)	(34)	(582)
Teesside	200,494	(205,050)	(4,556)	(28,107)	5,811	7,206	(14,180)
West Sussex	2,423	(2,448)	(25)	(695)	(517)	(101)	(189)
West Yorkshire	7,572	(8,533)	(961)	(3,135)	(1,641)	(1,684)	(282)
Total	**260,370**	**(274,327)**	**(13,957)**	**(54,568)**	**(7,313)**	**278**	***(20,440)**

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

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

In 2010/11 the deficit decreased significantly due predominantly to:

- The pension increase change from RPI to CPI. In the long term, it is expected that CPI increases will be lower than RPI increases and so this gives rise to a reduction in the defined benefit obligation on the Statement of Financial Position. The change also reduces this (and future) periods' current service cost and interest cost.
- Fluctuations in investment markets. The majority of assets in Local Government Pension Funds are invested in equities or other real assets. This leads to volatility in the funded status of the Funds and so to volatility in the amounts charged to Other Comprehensive Income and to the Statement of Financial Position from one year to the next.

Two employees retired early on ill-health grounds during the year. No additional pension liabilities were levied on CQC.

A summary of the IAS19 disclosure information is as follows:

The range of major assumptions used by the actuaries are stated below:

	Teesside Pension Fund % per annum			Other Pension Funds % per annum		
Key assumptions used:	**10/11**	**09/10**	**08/09**	**10/11**	**09/10**	**08/09**
Discount Rate	5.5	5.5	6.7	*5.4 to 5.9*	*5.5 to 5.6*	*6.6 to 7.1*
Expected rate of salary increases	5.0	5.4	4.5	*4.3 to 5.2*	*3.8 to 5.6*	*4.5 to 5.1*
Expected return on scheme assets	6.8	6.8	5.3	*5.3 to 7.7*	*5.3 to 7.2*	*4.9 to 6.5*
Future pension increases	2.7	3.9	3.0	*2.7 to 2.9*	*3.3 to 3.9*	*3.0 to 3.6*
Inflation	2.7	3.9	3.0	*2.7 to 2.9*	*3.3 to 3.9*	*3.0 to 3.6*

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		
	10/11	**09/10**	**08/09**	**10/11**	**09/10**	**08/09**
Retiring today:						
Males	18.9	19.5	19.5	*19.8 to 23.8*	*20.4 to 22.7*	*19.6 to 22.2*
Females	23.0	22.6	22.6	*22.9 to 25.2*	*23.2 to 26.1*	*22.5 to 24.9*
Retiring in 20 years:						
Males	20.9	20.4	20.4	*21.9 to 25.6*	*21.3 to 25.4*	*20.7 to 24.5*
Females	24.9	23.4	23.4	*25.0 to 26.8*	*24.1 to 28.3*	*23.6 to 26.4*

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

	2010/11 £000	**2009/10 £000**
Gross current service cost	7,939	5,535
less employer contributions	(5,683)	(8,979)
Past service cost	(29,086)	361
Curtailments and settlements	757	388
	(26,073)	**(2,695)**
Expected return on pension scheme assets	(16,591)	(11,556)
Interest on pension scheme liabilities	17,407	12,872
	816	**1,316**
Total Operating Charge	**(25,257)**	**(1,379)**

Of the expense for the year, £26.0m credit (2010: £2.7 m credit) has been included in the net expenditure statement as staff expenditure and £0.8m debit (2010: £1.3m debit) has been included in other expenditure. Actuarial gains and losses have been reported in Other Comprehensive Expenditure.

The actual return on scheme assets was a gain of £20m (2010: £69m gain).

The cumulative amount of actuarial gains and losses recognised in reserves since the date of transition to IFRS on 1 April 2008 is £39m (2010: £55m).

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:

	2010/11 £000	2009/10 £000	2008/09 £000
Present value of defined benefit obligations	(274,254)	(306,080)	(192,692)
Fair value of scheme assets	260,370	251,599	185,443
Deficit in scheme	**(13,884)**	**(54,481)**	**(7,249)**
Past service cost not yet recognised in balance sheet	(73)	(87)	(64)
Liability recognised in the balance sheet	**(13,957)**	**(54,568)**	**(7,313)**

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

	2010/11 £000	2009/10 £000
At 1 April	(306,167)	(192,756)
Service cost	(7,939)	(5,535)
Interest cost	(17,407)	(12,872)
Contributions from scheme members	(2,333)	(2,694)
Actuarial gains and (losses)	20,588	(106,024)
(Losses) on curtailments	(205)	(388)
Benefits paid	10,602	14,463
Past service cost	28,534	(361)
At 31 March	**(274,327)**	**(306,167)**

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

	2010/11 £000	2009/10 £000
At 1 April	251,599	185,443
Expected Return on Scheme Assets	16,591	11,556
Actuarial gains and (losses)	(5,234)	57,390
Contributions by employer	5,683	8,979
Contributions from scheme members	2,333	2,694
Benefits paid	(10,602)	(14,463)
At 31 March	**260,370**	**251,599**

The actuarial gain calculation was as follows:

	2010/11 £000	2009/10 £000
Movements in the fair value of scheme assets	5,234	(57,390)
Less movements in the present value of defined benefit obligations	(20,588)	106,024
	(15,354)	**48,634**

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		
	10/11 %	09/10 %	08/09 %	10/11 £000	09/10 £000	08/09 £000
Equity instruments	7.2 to 8.4	7.3 to 8.0	6.8 to 7.5	211,419	199,550	130,278
Debt instruments	4.8 to 5.0	5.0 to 5.5	5.4 to 6.5	26,127	25,693	26,631
Property	5.4 to 7.9	5.5 to 8.5	4.9 to 6.6	11,796	11,206	10,369
Cash	0.5 to 4.6	0.5 to 4.8	0.5 to 4.0	11,028	15,150	18,165
Total				**260,370**	**251,599**	**185,443**

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

	2010/11 £000	2009/10 £000	2008/09 £000	2007/08 £000	2006/07 £000
Present value of defined benefit obligations	(274,327)	(306,167)	(192,756)	(222,826)	(254,782)
Fair value of scheme assets	260,370	251,599	185,443	223,104	234,342
Surplus / (deficit) in the scheme	**(13,957)**	**(54,568)**	**(7,313)**	**278**	**(20,440)**
Experience adjustments on scheme liabilities	(3,252)	70	(616)	704	21
Percentage of scheme liabilities (%)	1%	0%	0%	0%	0%
Experience adjustments on scheme assets	(5,210)	57,390	(50,645)	(27,038)	709
Percentage of scheme assets (%)	2%	23%	27%	12%	0%

5. Other expenditure

	2010/11		2009/10	
	£000	£000	£000	£000
IT costs, including general project management	13,915		19,231	
Redundancy	9,181		6,829	
Travel and subsistence	4,965		5,728	
Rentals under operating leases	4,296		4,564	
Other consultancy, professional fees & project costs	4,210		13,550	
Other Premises Costs	3,979		5,501	
Recruitment, Training & Development Costs	3,159		3,818	
Telecoms	2,678		2,465	
General Office Supplies	2,617		3,181	
Communications	1,614		1,573	
Printing & Publishing	1,266		1,131	
Net expenses on pension scheme assets and liabilities	816		1,316	
Marketing	417		517	
Losses and Special Payments (Bad Debt)	344		76	
External Audit Fees –Statutory Work	125		150	
Losses and Special Payments (Other)	65		17	
Operating Leases (Equipment)	31		39	
Other costs	16		431	
Bank Charges	6		15	
		53,700		**70,132**
Non-cash items				
Loss on disposal of intangible assets	791		155	
Loss on disposal of property, plant and equipment	197		701	
Revenue provision for dilapidations w/back	(87)		1,073	
Net gain(loss) on revaluation of intangibles	1,048		794	
Net gain(loss) on revaluation of property, plant and equipment	659	2,608	456	3,179
Other Expenditure		**56,308**		**73,311**
Depreciation - intangible assets	6,756		7,305	
- property, plant and equipment	5,717		5,545	
Depreciation		**12,473**		**12,850**
Impairment of intangible assets	–		1,681	
Impairment of property, plant and equipment assets	67		–	
Impairment		**67**		**1,681**

6. Auditors' remuneration

	2010/11 £000	2009/10 £000
Fees payable to the Commission's auditors for the 2010/11 audit of the Commission's annual accounts	125	150

The charge for 2009/10 consists of £130k for the 2009/10 audit plus an additional charge of £20k in respect of the IFRS opening Statement of Financial Position work.

7. Income

	2010/11		2009/10	
	£000	£000	£000	£000
Income from activities:				
Income from fees	(80,061)		(64,552)	
Other income	(1)		(200)	
		(80,062)		**(64,752)**
Other income:				
Surplus on disposal of assets	–		(12)	
Other non trading income	(22)	**(22)**	(20)	**(32)**
Total		**(80,084)**		**(64,784)**
Interest receivable:				
Bank Interest Receivable	–	–	(3)	(3)

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.

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

8. Intangible assets

	IT Software development £000	Software licences £000	Website £000	Total £000
Cost or valuation				
At 1 April 2010	21,821	4,729	1,615	28,165
Additions	10,016	78	1,318	11,412
Disposals	(10,033)	(2,409)	(19)	(12,461)
Indexation	(1,363)	(168)	(165)	(1,696)
At 31 March 2011	**20,441**	**2,230**	**2,749**	**25,420**
Amortisation				
At 1 April 2010	(9,986)	(2,892)	(393)	(13,271)
Charged in year	(5,510)	(685)	(561)	(6,756)
Disposals	9,252	2,407	12	11,671
Indexation	(11)	(3)	(9)	(23)
At 31 March 2011	**(6,255)**	**(1,173)**	**(951)**	**(8,379)**
Net Book value at 31 March 2011	**14,186**	**1,057**	**1,798**	**17,041**
Net Book value at 1 April 2010	**11,835**	**1,837**	**1,222**	**14,894**
Cost or valuation				
At 1 April 2009	20,184	2,227	922	23,333
Additions	6,074	1,709	857	8,640
Disposals	(4,611)	–	–	(4,611)
Impairments	(3,566)	–	(413)	(3,979)
Indexation	3,740	793	249	4,782
At 31 March 2010	**21,821**	**4,729**	**1,615**	**28,165**
Amortisation				
At 1 April 2009	(8,666)	(1,840)	–	(10,506)
Charged in year	(6,384)	(556)	(365)	(7,305)
Disposals	4,456	–	–	4,456
Impairments	2,248	–	50	2,298
Indexation	(1,640)	(496)	(78)	(2,214)
At 31 March 2010	**(9,986)**	**(2,892)**	**(393)**	**(13,271)**
Net Book value at 31 March 2010	**11,835**	**1,837**	**1,222**	**14,894**
Net Book value at 1 April 2009	**11,518**	**387**	**922**	**12,827**

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.

9. Property, plant and equipment

	Information Technology £000	Furniture & Fittings £000	Total £000
Cost or valuation			
At 1 April 2010	16,386	9,852	26,238
Additions	2,291	308	2,599
Disposals	(2,207)	(933)	(3,140)
Impairments	(1,431)	(1,741)	(3,172)
Indexation	(1,023)	(6)	(1,029)
At 31 March 2011	**14,016**	**7,480**	**21,496**
Depreciation			
At 1 April 2010	(7,351)	(6,534)	(13,885)
Charged in year	(3,864)	(1,853)	(5,717)
Disposals	2,024	918	2,942
Impairments	1,431	1,674	3,105
Indexation	(16)	(21)	(37)
At 31 March 2011	**(7,776)**	**(5,816)**	**(13,592)**
Net Book value at 31 March 2011	**6,240**	**1,664**	**7,904**
Net Book value at 1 April 2010	**9,035**	**3,318**	**12,353**
Cost or valuation			
At 1 April 2009	8,396	11,626	20,022
Additions	6,216	766	6,982
Disposals	(839)	(2,521)	(3,360)
Indexation	2,613	(19)	2,594
At 31 March 2010	**16,386**	**9,852**	**26,238**
Depreciation			
At 1 April 2009	(3,535)	(6,169)	(9,704)
Charged in year	(3,439)	(2,106)	(5,545)
Disposals	804	1,855	2,659
Indexation	(1,181)	(114)	(1,295)
At 31 March 2010	**(7,351)**	**(6,534)**	**(13,885)**
Net Book value at 31 March 2010	**9,035**	**3,318**	**12,353**
Net Book value at 1 April 2009	**4,861**	**5,457**	**10,318**

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

Asset financing:

All assets are owned by CQC.

10. Financial instruments

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

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

a) Market risk

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

b) Credit risk

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

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

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

	Less than 30 days past due £000	31 – 60 days past due £000	61 and over days past due £000
At 31 March 2011	2	489	285
At 31 March 2010	1,769	164	312

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 2011 £000	31 March 2010 £000
Current liabilities	(11,046)	(16,150)

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.

11. Impairments

During 2010/11, CQC, in accordance with the new Government Property Controls, closed its office in the St. Nicholas building in Newcastle and staff transferred to the Citygate building also in Newcastle. The move resulted in an impairment value of £67k being made to the fittings left in the St. Nicholas building. Impairments for the previous year concerned the de-commissioning of the ICAP software development and the Annual Health Check system.

	2010/11 £000	2009/10 £000
St.Nicholas office closure - fittings	67	–
IT Core Application Project (ICAP)	–	367
Annual Health Check software developments	–	1,314
Total	**67**	**1,681**

12. Inventories

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

13. Trade receivables and other current assets

	31 March 2011 £000	31 March 2010 £000
Amounts falling due within one year:		
Deposits and advances	109	126
Other receivables	160	510
Prepayments and accrued income	2,739	2,788
Subtotal: Other current assets	**3,008**	**3,424**
Trade receivables	5,594	3,085
Total	**8,602**	**6,509**

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

13.1 Intra-government debtor balances

	Amounts falling due within one year	
Intra-governmental balances:	**31 March 2011 £000**	**31 March 2010 £000**
Balances with Central Government	54	463
Balances with NHS trusts	114	31
Balances with Local Authorities	346	299
Balances with Public Corporations & Trading Funds	14	3
Subtotal: intra-government balances	**528**	**796**
Balances with bodies external to Government	8,074	5,713
	8,602	**6,509**

Other receivables include advance payments on salary and staff loans total £16k and £93k respectively (2009/10: £13k and £113k). Staff could apply for advance payments on salary and loans up to a maximum of £5k for rail season tickets.

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

13.2 Movement in the allowance for doubtful debts

	31 March 2011 £000	**31 March 2010 £000**
Balance at the beginning of the period	210	275
Additional Losses recognised during the year	379	127
Impairment Losses recognised	(20)	–
Amounts written off during the year as uncollectible	(70)	(29)
Amounts recovered during the year	(89)	(163)
Balance at the end of the period	**410**	**210**

14. Cash and cash equivalents

	£000
Balance at 31 March 2010	14,919
Net change in cash and cash equivalent balances	1,447
Balance at 31 March 2011	**16,366**

	31 March 2011 £000	31 March 2010 £000
The following balances were held at:		
HM Paymaster General	16,363	14,916
Commercial banks and cash in hand	3	3
	16,366	**14,919**

15. Trade payables and other current liabilities

	31 March 2011 £000	31 March 2010 £000
Amounts falling due within one year		
Vat	(15)	(13)
Other taxation and social security	(1,832)	(2,174)
Trade payables	(3,617)	(5,979)
Other Payables	(1,091)	(1,199)
Accruals and deferred income	(4,491)	(6,785)
	(11,046)	**(16,150)**
Current pension liabilities	(679)	(865)
Fee income in advance	(24,997)	(26,393)
	(36,722)	**(43,408)**
Amounts falling due after more than one year		
Pension Liabilities	(1,456)	(2,234)
	(1,456)	**(2,234)**

Trade payables at 31 March 2011 were equivalent to 15 days (2009/10: 22 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. Whilst CQC has financial risk policies in place to ensure that all payables are paid within the pre-agreed credit terms, £1.3k (2009/10: £0.2k) was 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 2.9% pa (2009/10: 0%) in accordance with HM Treasury guidance.

15.1 Intra-government creditor balances

	Amounts falling due within one year		Amounts falling due after more than one year	
	31 March 2011 £000	31 March 2010 £000	31 March 2011 £000	31 March 2010 £000
Balances with Central Government	(2,912)	(2,549)	–	–
Balances with NHS trusts	(36)	(865)	–	–
Balances with Local Authorities	(751)	(1,150)	–	–
Balances with Public Corporations & Trading Funds	(1)	–	–	–
Subtotal: intra-government balances	**(3,700)**	**(4,564)**	**–**	**–**
Balances with bodies external to Government	(33,022)	(38,844)	(1,456)	(2,234)
	(36,722)	**(43,408)**	**(1,456)**	**(2,234)**

16. Provisions for liabilities and charges

	Employment termination and other costs		Leased property dilapidations		Total	
	2010/11 £000	2009/10 £000	2010/11 £000	2009/10 £000	2010/11 £000	2009/10 £000
Balance 1 April 2010	(167)	(4,085)	(1,421)	(358)	(1,588)	(4,443)
Provided in year	(2,175)	(166)	(76)	(1,076)	(2,251)	(1,242)
Provisions not required written back	73	436	132	7	205	443
Provisions utilised in year	30	3,648	243	6	273	3,654
Unwinding of Discount	–	–	31	–	31	–
Balance 31 March 2011	**(2,239)**	**(167)**	**(1,091)**	**(1,421)**	**(3,330)**	**(1,588)**
Analysis of expected timing of discounted flows						
In the next financial year	(2,239)	(167)	(193)	(189)	(2,432)	(356)
Current provisions 31 March 2011	**(2,239)**	**(167)**	**(193)**	**(189)**	**(2,432)**	**(356)**
Between 1 – 5 years	–	–	(898)	(789)	(898)	(789)
Between 6 – 10 years	–	–	–	(443)	–	(443)
After 10 years	–	–	–	–	–	–
Non-current provisions 31 March 2011	**–**	**–**	**(898)**	**(1,232)**	**(898)**	**(1,232)**

Following the first full year of operation for CQC, a restructure of the headquarters directorates took place throughout 2010/11. The new structure was designed to ensure that CQC could better deliver the new regulatory model and be able to withstand the increased financial scrutiny arising from the poor economic climate. Whilst most of the staff movements had been completed by the end of the financial year, a provision has been made to cover the cost of all redundancies that were agreed by 31 March 2011, although some staff will not actually leave CQC until 2011/12. This provision is estimated as £1.3m.

A provision has been made to cover future legal costs incurred as a result of a public inquiry involving CQC. The provision is estimated at £0.6m.

Leased property dilapidations are payable upon the termination of the leases.

Provisions falling due after more than one year have been reduced by a discount factor of 2.2% pa (2009/10: 2.2%) in accordance with HM Treasury guidance.

17. Capital commitments

Contracted capital commitments at 31 March 2011 not otherwise included within these financial statements totalled £1,382k (2010: £417k) and consist, in the main, of IT hardware and software developments:

	31 March 2011 £000	31 March 2010 £000
Property, plant and equipment	196	166
Intangible assets	1,186	251
	1,382	**417**

18. 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 2011 £000	31 March 2010 £000
Buildings:		
Not later than one year	3,288	3,757
Later than one year and not later than 5 years	12,242	14,766
Later than 5 years	10,156	12,135
	25,686	**30,658**
Other:		
Not later than one year	27	38
Later than one year and not later than 5 years	104	150
Later than 5 years	-	2
	131	**190**

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

19. Other financial commitments

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

20. Contingent liabilities disclosed under IAS 37

The Commission has the following contingent liabilities:

	31 March 2011 £000	31 March 2010 £000
First Tier Tribunals:	62	270
Employment Tribunals:	31	200
Personal Injury Claims:	–	100
Public Enquiry	489	–
Implementation of Integrated Grading Structure	1,532	–
Criminal Prosecution	4	–
	2,118	**570**

The cost relating to the implementation of integrated grading structure relates to the implementation of new salary bands in 2011/12.

21. Related party transactions

21.1 Transactions with the Department of Health.

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

	31 March 2011 £000	31 March 2010 £000
Transactions with Department of Health:		
Department of Health – Income		
Grant in Aid – Revenue	77,300	110,000
Grant in Aid – Capital	15,000	17,000
Commissioned work	226	–
Secondments	212	202
Set-up costs for CQC reimbursed	–	276
Reimbursement of costs on properties transferred to DH on 1 April 2009	1	611
Reimbursement of annual fee to West Sussex Pension fund for 09/10 and 10/11	320	–
	93,059	**128,089**
Department of Health – Expenditure		
Secondments	161	773
Implementation of payroll services	396	–
Recharge of property payments	39	373
	596	**1,146**
Department of Health balances at 31 March 2011 were:		
Amounts due to the DH from CQC	252	339
Amounts due from the DH to CQC	23	431

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

21.3 Fee income of £16.2m was received from NHS Trusts which are not regarded as related parties.

22. Third-party assets

The Commission has no third-party assets.

23. Discontinued activities

There were no discontinued activities of the Commission to be reported in these financial statements (2009/10: None).

24. 'Subsequent event' disclosure of judicial review

As outlined in note 4.4, the decision to uprate public service pensions using the Consumer Prices Index rather than the Retail Prices Index has been recognised in these accounts. This decision is currently before the courts in judicial review proceedings. The Government is robustly defending the case and therefore no adjustment has been made to the accounts for this matter. The financial implications consequent on the review finding against the Government have not been assessed.

25. 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 8 July 2011.

There were no other significant post Statement of Financial Position events.

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