Care Quality Commission

Annual report and accounts

2013/14

RAISING STANDARDS, PUTTING PEOPLE FIRST

Care Quality Commission

Annual report and accounts 2013/14

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

Our purpose

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

Our role

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

Our principles

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

Foreword

David Prior, Chair (left)

David Behan,
Chief Executive (right)

CQC now has a clear purpose: to make sure health and social care services provide people with safe, effective, compassionate, high-quality care, and to encourage services to improve.

To achieve this, we have made radical changes to the way we regulate and inspect. Set out in our three-year strategy for 2013 to 2016, we are creating a model of regulation that will provide greater assurance about the safety and quality of services to the public: one that is independent and transparent; one that listens to and acts on the views and experiences of both people using services and care staff; one that drives improvement by highlighting good practice and publishing credible ratings of services based on expert inspections; and one that acts to encourage improvements not only to unsafe and poor quality services, but also to good services so they can become outstanding.

We are at the beginning of a long journey to excellence. We have already achieved a lot. There is a long way to go and it will take time to build and entrench an effective new approach.

We are aware of the scale of the changes we are making and we feel the pressure to succeed quickly. We know that in 2014/15 we are entering the period of greatest risk and challenge in what we have set out to achieve as we move from design to implementation.

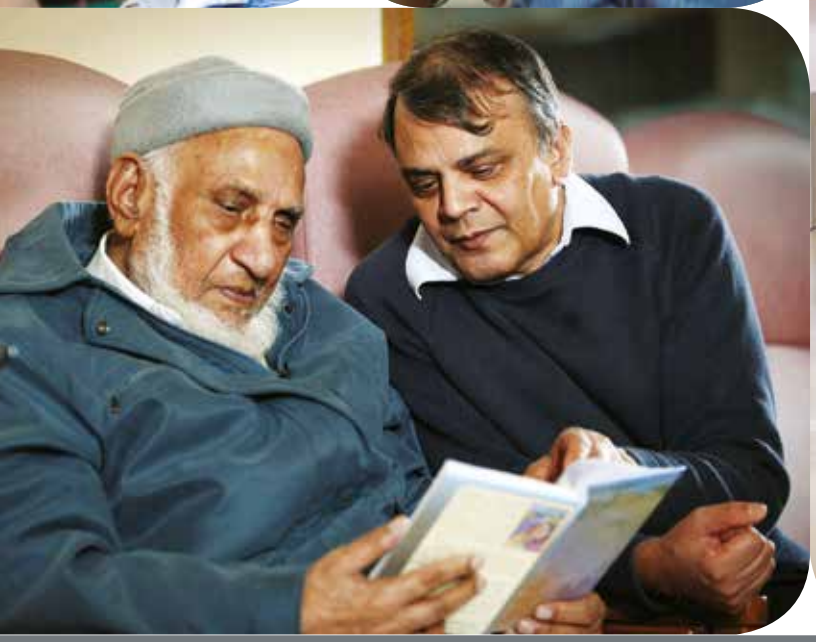
We are also mindful of the legacy of the mistakes of the past. Our new strategy was formed in the wake of severe criticism of CQC, in particular from the Winterbourne View Serious Case Review, the Francis Report into the catastrophic collapse of care at Mid Staffordshire NHS Foundation Trust, and the Grant Thornton review of our regulatory oversight of University Hospitals of Morecambe Bay NHS Foundation Trust. The overriding learning for CQC from these failures is that our priority must always be the safety and quality of care that people receive.

Looking back

In 2013/14, we completely changed CQC's leadership team, its organisation and its governance, and began to develop a fundamentally different approach to risk monitoring, inspection and regulation.

- A differentiated approach to regulation by care sector is being led by our three Chief Inspectors: Professor Steve Field, Professor Sir Mike Richards and Andrea Sutcliffe. They are leading the change to more specialist and expert inspection teams.
- This work is being informed and supported by our new Intelligent Monitoring model that assesses the risks to the quality of care in providers on an ongoing basis, and prioritises our inspection activity. The model includes how we listen and act on people's views and experiences of care.

- We began piloting our new style inspections in 18 hospital trusts in September 2013 and in mental health trusts, community health trusts and GP out-of-hours services in January 2014. By the end of the year we had inspected a total of 44 NHS trusts under the new approach, and we had begun to issue our first ratings to acute trusts.
- Our ratings are on a four-point scale: outstanding, good, requires improvement or inadequate. They will help people compare services and provide valuable information to providers and other stakeholders including commissioners by highlighting areas for improvement.
- We have made these changes while continuing to carry out fully our traditional inspections and our other regulatory activities. Our inspection teams completed the full 2013/14 inspection programme (using our existing inspection methodology) ahead of schedule. They carried out some 30,334 inspections, over 1,700 more than in 2012/13.



We want to thank CQC staff for the immense hard work they have put into the last 12 months and for their commitment and dedication in delivering the changes needed.

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Looking forward

As we look forward over the next two years and what we need to do to achieve our goals, there are a number of principles that will drive our work:

Listening to people's concerns and complaints

High-quality care can only be delivered in an environment where people are listened to and where people's views, concerns and complaints are welcomed and embraced as a way to learn and improve.

We know from our own consultations and other recent reports, such as the Clwyd/Hart Review, that the processes for raising concerns or making complaints are still confusing. Information does not always reach CQC, or it is not acted on consistently, or staff raising concerns struggle to be listened to by their employers. We are looking hard at how we can encourage people to share concerns with CQC, use this information to guide our inspections, and publish people's experiences.

In our new inspections we hold listening events with the public and focus groups with different staff groups. Listening to the stories of local people and care staff (including their concerns and complaints) helps us to target where we go on the inspection. It also helps us to highlight and showcase good practice so others can improve.

Value for money

We are committed to ensuring the value of quality of care regulation and of our own value for money, and to continuous evaluation of the impact of our work. In 2013/14 we built the foundations for a rigorous programme of evaluation and measurement to check whether we are achieving our purpose and delivering value for money. We will use four types of self-measurement across everything we do: our overall impact on care services; the expected outcomes of our work through case studies and insight; the quality of our activity; and the development of our internal capabilities.

It will be supplemented by external research on the impact of regulators operating in other sectors, and our own evaluation methods will be externally reviewed. We will also regularly evaluate ourselves against a number of strategic measures from our Business Plan, and report the results publicly.

We know from the experience of other regulators that it is difficult to separate out the contribution that regulation makes to improvement. We need to continue to think about how we measure our short and long-term impact on quality, ensure that our new methods of regulation make the best use of resources, and continuously improve the productivity of our staff and efficiency of our processes.

We will also continuously review our processes to reduce our direct costs and the regulatory burdens we place on care and health providers. We understand the issues faced by care providers and are incorporating them into our work. For example, we fed into the Focus on Enforcement review in adult social care, which highlighted issues about the impact of regulation on providers in that sector, and we are directly addressing these issues through our extensive co-production with adult social care stakeholders.

Intelligent Monitoring

In 2013/14 we developed a new intelligence driven model to assess the ongoing risks to the quality of care in providers, and to guide our inspection activity. We have done this because we want to be better at predicting and preventing risks to people who receive care. This tool helps us to prioritise which services we inspect, and when, how and what we will focus on in the inspection.

Over the next two years, we will add further information to the Intelligent Monitoring model, including feedback and concerns from people who use services and from care staff themselves. We will make it easier for people to tell us about the

care they receive, or raise concerns with us. This is because we believe that there is a strong relationship between the messages from the qualitative data collected about people's experiences and the actual quality of care delivered. Partnerships are being developed with local Healthwatch and local authorities, and voluntary organisations such as Carers UK and Mind.

Registration of care services

To provide health and care services in England, services must register with CQC and in so doing give an undertaking that they will provide safe, high-quality care. CQC's past registration approach has been criticised for doing little more than collecting information about a provider, rather than setting clear quality expectations. Over the coming year registration with CQC will become a more effective quality bar for organisations entering health and social care. We will not register services where we do not believe that their model of care is good. Where care is consistently not good, we can vary a provider's registration and place conditions on the provider with a view to improving the quality and safety of services.

Expert inspection

We have now moved from generic to specialist inspections and this will be in place for most sectors by 1 October 2014.

We have done this to make sure that the quality of care for people is the very best it can be and to build credibility among both the public and professionals. Specialist inspectors, clinical and other experts and 'Experts by Experience' allow us to understand the organisations providing services and the people who work in them, what drives their performance and their strengths and weaknesses.

In the past CQC's inspectors have been generalists, many inspecting a wide range of health and social care providers – from small care homes to large acute hospitals – and this meant that important insight was missed. Now, our inspectors will specialise on a particular care sector, and be accompanied in their work by specialist inspectors and experts – for example a midwife for maternity services or a GP for primary care – as well as people who have used services themselves as public representatives.

Our inspection reports will now be based on professional and clinical judgement not compliance. We will not tick the box and miss the point. We are also undertaking a review of the way we inspect and monitor mental health services in England. This is a priority for 2014/15.

We know that we face the challenge faced by many regulators and inspectorates in ensuring that there is consistency in our reports, ratings and judgements. We are developing a quality assurance approach to ensure that unintended variations are minimised. This is a significant challenge. It involves having to manage a complex set of issues such as applying consistent standards across different types of services and organisations as well as the training of staff carrying out inspections and ratings.

Stronger powers to protect people

The Care Act 2014 introduces new responsibilities for CQC. New legal, fundamental standards of care are planned to come into force on 1 October 2014. A crucial recommendation of the Francis Inquiry, they are clearer and more concise than current legislation. Their aim is to provide more protection for people and will include standards such as ensuring 'person-centred care', in which care and treatment must meet people's needs and reflect their preferences, treating people with dignity and respect, making sure that care is safe and with the person's consent, and that enough qualified and experienced staff are available.

Two additional new regulations will also be brought in. A new statutory duty of candour means that providers must be open and transparent when things have gone wrong. People should be given an apology, an explanation, all necessary practical and emotional support and assurances about their continuity of care. And new requirements mean that we will be able to check that providers have ensured that their board members (or their equivalents) are fit and proper persons for carrying out their responsibilities. This means that accountability will focus on individuals as well as organisations.

CQC will also gain important, new enforcement powers. These include the power to move directly to a prosecution of providers without serving a warning notice where we find the most serious breaches of fundamental standards, and the ability to require Monitor or the Trust Development Authority to place an NHS trust in administration, so that action to tackle quality problems has the same weight as those about finance.

Transparency and improvement

We encourage care services to improve; this is a vital part of CQC's purpose.

Rating the quality of providers is an important part of our new approach. Ratings will help people compare services by highlighting where care is good or outstanding and expose where care is inadequate or requires improvement. They will also be a springboard for providers to improve, and provide valuable information to other stakeholders such as commissioners. We issued our first shadow ratings for acute services in March 2014 and we will further develop, test, refine and roll out our approach to ratings across other sectors throughout 2014/15.

However, while we describe what good quality care looks like, and have powers to enforce fundamental standards, we are not accountable for providers' improvement – this is the responsibility of providers, their commissioners and, in the NHS, of Monitor and the Trust Development Authority. This means we need to think deeply about the ways in which CQC can encourage providers across the spectrum from 'inadequate' to 'outstanding' to improve.

We will publish our Intelligent Monitoring and the results of our inspection activity and our ratings on the quality and safety of care. This will enable people to understand how we have judged services so they can have some choice about the service they use. Transparency encourages services to improve, as it allows services to benchmark themselves against others.

We will look at what we can learn about our work from other industries and regulators focusing on improvement. This includes hard to assess quality factors like leadership, culture and clinical engagement, and identifing good and outstanding practice from which providers can learn.

Where there are systemic concerns, and in particular concerns which go across services beyond a single provider, we will make greater use of our power to carry out investigations. Previous regulators have found that in-depth investigations are powerful in encouraging improvement and learning across the health and social care systems.

Improving quality across all services and tackling inequality

CQC provides an annual report to Parliament on the state of health and adult social care in England. This is an important opportunity to identify emerging trends and risks in the health and social care system. CQC's remit across sectors means we are uniquely placed to do this. It includes sharing learning through describing what good care looks like and disseminating it to others.

Most people do not have needs that can be met by any one organisation. They need care from a range of organisations along a pathway of care. We will make use of our legal power to carry out themed reviews beyond our inspection activity, including health and social care commissioning. We will use this power to focus particularly on how care services work together within and across different sectors, and on the experiences of people in their journey across services.

Well-known inequalities persist in the access to and quality of services for different groups of people, including Travellers and LGBT people. CQC has a responsibility for assessing the quality of care for all people, and setting an expectation that people receive good quality care irrespective of their ethnicity or lifestyle. This means we need to think about how we can use focused reviews and inspections to shine a light on areas where inequalities in quality persist.

Independence

Our partners – the public, our own staff, care professionals and providers, and other national bodies – need to be confident in CQC at all times: that we are providing objective and fair assessments of quality free of the undue influence of vested interests, including the Government and the 'NHS system'. We can say what we think needs to improve without being swayed by financial constraints. We will always be on the side of people who use services.

The legal underpinnings for this are already in place through CQC's statutory role enshrined in law. In the Care Act 2014, the Government has given CQC more powers to inspect what it wants, when it wants – removing the need for CQC to consult and obtain approval on its programmes of work. The Secretary of State, Jeremy Hunt, said, "We will legislate to give the CQC statutory independence, rather like the Bank of England has over interest rates. The welfare of patients is too important for political meddling and our new legislation will make sure ministers always put patients first."

Public confidence in CQC's independence will, however, be determined much more through our words and actions than legal principles. We will make sure that in what we do and say our independence is clear – acting on the side of people who use care services, listening to our partners if our processes are considered to be unfair or our findings inaccurate, and explaining our approach if challenged.

A just and open culture in CQC

Our goal is to build a just culture within CQC, one that is open about what people think and believe, where we learn from mistakes to get better, and are encouraged to raise concerns that will be listened to. We are determined to become a high-performing organisation, engaging and supporting our staff and leaving behind a legacy of bullying and a defensive culture.

Our staff have responded positively. In our staff survey from early 2014, 88% of colleagues said they feel committed to CQC's future direction (a 16% increase on a year ago) and 77% of our staff said they were proud to work for CQC.

We want to do better still. For example, only 35% of staff said that morale was good, and 10% of our staff still reported they have personally been bullied or harassed at work. A broken culture and poor management have no place in CQC. We intend to become a role model in the way we ourselves handle and resolve complaints about CQC and concerns raised by our own people.

We must also ensure that CQC becomes an organisation that is constantly improving. We expect it of those we regulate, so we should expect it of ourselves. This is a priority of the new CQC Academy established to support staff through the transformation to our new way of working. This involves exploring ways to develop our skills, share our experience and expertise, and promote CQC's culture and way of working as part of our role.

These principles will underpin our work over the next two years as we move from reorganisation and redesign to execution and delivery. The journey will not be straightforward; there will be bumps in the road. We approach our work with humility and the knowledge that we will still make mistakes. The complexity and size of the health and care service makes that inevitable. We will always be open about our mistakes and learn from them to improve. However, we are making progress and we are confident that, increasingly, those who need health and care will be able to rely on our judgements, be informed by our ratings, be protected from inadequate care and benefit from a health and social care service that is continuously improving.

David Prior, Chair

David Behan, Chief Executive

CQC in numbers

There were 30,334 locations that received a scheduled inspection in 2013/14 under our existing methodology, compared with 28,583 in 2012/13. This was an increase of 1,751 year on year, equating to a 6% rise. This was driven mainly by the general practice inspections that were included in our regulatory remit for the first time. There were 1,546 inspections of GP practices carried out. Adult social care remained the largest sector in terms of the number of inspections undertaken.

Notably the programme was completed almost three weeks before the year end and during a period of significant challenge for inspection staff, continuing with the current inspection approach but also learning and preparing for involvement in the new approach.

Overall there were 39,567 inspections in the year, including follow-up and responsive inspections. Of these, 4,481 involved an Expert by Experience or specialist through either advice or as part of the visit. This was a significant increase compared with 1,405 inspections in 2012/13.

There were MHA Commissioner visits to 1,227 locations during 2013/14. This compares with 1,090 locations in 2012/13.

At the end of each financial quarter, we take a 'snapshot' of quality and safety across our inspections of care services. On 31 March 2014, 32,305 (65%) locations were meeting all standards checked but 5,089 (10%) were not meeting at least one standard. The remaining locations had not yet received an inspection by that date. Of the 1,459 responsive inspections completed by the end of the year, 904 (62%) were found to be not meeting one or more standards.

CQC took more enforcement action in 2013/14: 1,523 enforcement actions compared with 1,029 in 2012/13, a rise of 50%. Most of these were warning notices: 1,456 compared with 910 in 2012/13. Overall, 4,679 locations cancelled their registration in the year; of these 567 (12%) cancelled while not meeting one or more standards.

In our Quarter 3 post-inspection survey, 83% of adult social care services agreed or strongly agreed that the inspection visit helped them reflect how they could improve their service, and 73% of services agreed or strongly agreed that the inspection report provided information that will help them to take action to improve their service.

The figure was 90% and 86% respectively for NHS respondents. However, the corresponding figures in other sectors were lower with the lowest being primary dental care at 68% and 56% respectively.

Sectors we regulate

Hospitals, mental health and community services, including:

162 NHS trusts

276 independent acute hospitals

47 independent treatment centres

11 ambulance services

58 mental health trusts and Mental Health Act functions

353 community health care services

Adult social care, including:

17,350 residential social care homes with and without nursing

52 specialist college services

64 community-based services for people with a learning disability

109 Shared Lives services

8,110 home care services

105 Extra Care housing services

202 hospices

271 supported living services

Primary medical services and integrated care, including:

8,592 GP practices, out-of-hours services and mobile doctors

10,102 dental care locations

146 prison healthcare services

9 remote clinical advice services

35 urgent care services

Funding in 2013/14

£101.2m
Annual fee income paid by care providers

£87.3m
Grant-in-aid received from the Department of Health

Key numbers for 2013/14

30,334
Locations receiving scheduled inspections

39,567
Total inspections (including follow-up and reactive inspections)

1,456
Warning notices served

9,473
Whistleblowing contacts

1,227
Locations visited during our Mental Health Act monitoring

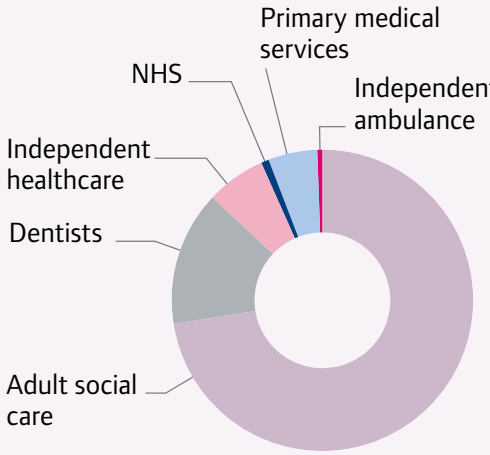
48,472
Registration applications received

238,621
Number of calls received by our National Customer Services Centre

Scheduled inspections in 2013/14

30,334 Locations receiving scheduled inspections

6% Increase from the previous year



Action taken by CQC

1,523 Enforcement action taken

50% Increase from the previous year

INDEPENDENT AMBULANCE	7 (0.5%)
PRIMARY MEDICAL SERVICES	28 (2%)
PRIMARY DENTAL CARE	34 (2%)
INDEPENDENT HEALTHCARE	67 (4%)
NHS	73 (5%)
ADULT SOCIAL CARE	1314 (86%)

Inspections by sector

NHS
280 2013/14
318 2012/13

Adult social care
22,066 2013/14
22,250 2012/13

Dentists
4,389 2013/14
3,682 2012/13

Primary medical
1,546 2013/14
0 2012/13

Independent healthcare
1,888 2013/14
2,117 2012/13

Independent ambulance
165 2013/14
216 2012/13

Experts by Experience

4,481 Involved an Expert by Experience or specialist

MHA visits

1,227 Locations visited by MHA Commissioners

13% Increase from the previous year

Business review

1. Intelligent use of information in our regulatory approach

- Intelligent Monitoring
- Outliers programme
- Using information from people who use services and the public
- Involving the public in our inspections
- Developing our approach to ratings
- Awareness building
- Thinking across health and care

Intelligent Monitoring

Our new, more comprehensive inspection approach aims to check whether there is a risk that services do not provide either safe or good quality care.

We set out during 2013/14 to develop a new 'Intelligent Monitoring' approach, to assess the risks to the quality of care in providers on an ongoing basis and guide our inspection activity. This includes how we listen and act on people's views and experiences of care.

Led by Dr Paul Bate, our Director of Strategy and Intelligence, the goal of Intelligent Monitoring is to combine information from a wide range of data sources to give our inspectors a clear picture of the areas of care that may need to be followed up within a provider or service. This information can be quantitative data, for example incidence of pressure sores, medication errors, falls, staff turnover, access times, safeguarding alerts or responses from staff surveys, or more qualitative information such as people's experiences of care shared with CQC, whistleblowing concerns, complaints and feedback from local Healthwatch and other public representative groups.

Together with local insight, this information helps us to decide when, where and what to inspect. It means that we can anticipate, identify and respond more quickly to services that are at risk of failing, and make better use of our resources by targeting activity where it is most needed.

For NHS acute and specialist trusts we published our first Intelligent Monitoring report in October 2013 based on 150 separate indicators. These look at a range of information including patient experience, staff experience and statistical measures of performance.

Where trusts perform significantly worse than the average against the selected indicators, they may be at higher risk of delivering poor quality care.

Most of the data has been publicly available but this was the first time it has been pulled together in this way and presented clearly to the public. We assigned the 161 acute NHS trusts a risk banding based on their performance against these indicators. There are six bands based on the risk that people may not be receiving safe, effective, high quality care – with band 1 being the highest risk and band 6 the lowest. We believe that our Intelligent Monitoring approach to risk identification is unique across worldwide health care.

We invited feedback from trusts, other regulators, specialist information organisations and members of the public on the indicators, and we updated the Intelligent Monitoring indicators for acute trusts in March 2014 to take account of a range of responses.

Towards the end of the year we began to develop the Intelligent Monitoring models for the other sectors and these will be implemented from October 2014. For each one, our initial scoping work identified a number of sources of possible information to give our inspectors a clear picture of when, where and what to inspect. We consulted widely on these in April and May 2014 to get people's views.

In some sectors, we know there are limitations in the coverage of national datasets, but we will start by making better use of the indicators we have, and then determine how we will improve this over time. We will be carrying out additional testing and engagement to determine the most useful indicators to inform our work.

Outliers programme

Our surveillance programme uses sophisticated statistical methods to spot data that shows unexpected performance (known as 'outliers'), for example unusually high death rates. We generate outlier data within CQC and also receive outlier data from organisations such as the Dr Foster Unit at Imperial College London and the Society for Cardiothoracic Surgery in Great Britain and Ireland.

In our 2013/14 acute programme, we processed 127 cases: 86 for mortality and 41 for maternity. We pursued 88% of these cases with the trust concerned; 68% resulted in an action plan to improve the care. Outliers for higher than expected

death rates occurred most frequently for patients admitted to hospital with heart attack, stroke, pneumonia, septicaemia, and urinary tract infections.

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

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

Using information from people who use services and the public

Information from members of the public about the care they receive is of central importance to CQC. It helps us identify where standards of care may be falling below national standards of quality and safety.

Complaints, concerns and whistleblowing

The voice of people who use services and the voice of people working in those services are at the heart of our new approach. Through our new inspections we will be considering how easy it is for people working in services to raise concerns, and have their concerns taken seriously and acted upon. We believe that a well-led organisation will encourage its staff to raise concerns, actively listen to them and take appropriate steps to address the concern, not to remove the person raising the concern, as often happens. The influence that a Board and leadership team has on the culture of the organisation is important in allowing and encouraging staff members to raise concerns.

We will also consider how well an organisation responds to complaints from people using services, again in terms of how the complaint is responded to and how the complainant is treated by the provider.

As part of our new approach to inspections, we have been working with the Patients Association to ensure the inspection model is built around what people tell us about their care and their experience of raising concerns.

We asked Dr Kim Holt, a paediatrician who formed the campaign group Patients First following her own whistleblowing experiences, to advise us on how we can best help and support employees raising concerns, drawing on her own experience as a whistleblower. We received 9,473 whistleblowing contacts is 2013/14, which is a 10% rise on the 8,634 contacts received in 2012/13.

A well-led service or organisation should have a good complaints procedure that drives improvement, and encourages its staff to raise concerns without fear of reprisal. We created a new Regulatory and Governance Values Committee as part of our Board, led by non-executive director Michael Mire. To support this work, we also appointed James Titcombe as our national advisor on patient safety, culture and quality. A former project manager in the nuclear industry, his fight for answers over the death of his baby son Joshua at University Hospitals of Morecambe Bay NHS Foundation Trust led to an independent inquiry being set up.

Tell us about your care programme

During 2013/14, we continued our 'Tell us about your care' programme by working with the Patients Association and Relatives and Residents Association, and began a partnership with Carers UK.

We are aiming through these partnerships to reach people receiving care, and their loved ones, to raise awareness of the standards of quality and safety people have a right to expect, and to encourage people to tell us about their experiences of care.

Information also comes in through our Share Your Experience web form, which is promoted in partners' websites and newsletters. We developed a 'tracking and evaluation process' so that we can analyse this information and report back on what regulatory action has been prompted by the information shared with us.

We also began to develop partnerships with local Healthwatch, local authorities, and voluntary organisations including Carers UK and MIND. We also set up a new qualitative analysis and user voice team to improve how we use information from people and staff about quality.

Local engagement during inspections

Between September 2013 and April 2014 we held more than 50 public events for members of the public to come along and talk to our inspection teams. These events are a part of our new-style inspections. The aim is to encourage people to give current and candid feedback on services prior to scheduled inspections. They have been attended by hundreds of people who use services and their carers and we have heard many individual experiences of care at the services that we inspect. These experiences, both good and bad, are used to inform our new style inspections and help us to target what we look at.

Involving the public in our inspections

Experts by Experience are people who have experience of using or caring for someone who uses health and social care services. They help us to gather the experiences of people who can find it more difficult to make their voices heard.

This year, we have sought to include more Experts by Experience in our work. We now have around 500 Experts by Experience throughout England, covering a wide variety of backgrounds, working through our partners, including Age UK, the Choice Support consortium, The Challenging Behaviour Foundation, Addiction Dependency Solutions and Oxfordshire User Team.

More and more Experts by Experience have been helping us directly regulate care services. In 2013/14, 4,481 (11.5% of all inspections) involved an Expert by Experience or specialist through either advice or as part of the visit. This was a significant increase compared with 1,405 (4.9% of inspections) in 2012/13.

In July 2013, we outlined how our new approach to inspection would include using external clinical experts and members of the public within larger, more specialised inspection teams. Our Chief Inspectors invited members of the public, as well as 3,000 health and social care professionals, to express interest in being actively involved in our work.

In response to the great deal of interest we received, we created the CQC Action Team to support members of the public and professionals wanting to be involved in our work. Since being created, the CQC Action Team has gained over 1,300 members across England. It also enabled us to recruit a further 190 Experts by Experience onto the programme.

This year we launched a new online community, enabling us to interact with Action Team members to gain their views on the common themes for inspections and to help them inform and improve our work, including the new-style hospital inspection reports. In 2014/15 we will be developing more ways for Action Team members to be involved and provide valuable input into our work.

In December 2013 we launched the CQC statement of involvement, *Putting people first*, reaffirming our commitment to involving people who use services, carers and the public in our work. It describes how we will involve people in our work over the next three years.

Healthwatch

Healthwatch England was launched in October 2012 as a national voice for patients and people who use services. We work closely with Healthwatch England to share information about concerns at a national level. Healthwatch England develops the potential of the network by supporting local Healthwatch,

facilitating peer support and learning, promoting good practice and by providing leadership.

From April 2013, local Healthwatch became the new consumer champion for health and social care at a local level, gathering the experiences that people have of care and using them to help shape local services.

Our relationship with local Healthwatch began in April 2013 with a welcome letter sent to all local Healthwatch contacts. This was followed by Healthwatch Advisory conferences around England, allowing local Healthwatch to advise us on our strategy and help build on our relationship with local Healthwatch organisations.

Developing our approach to ratings

In our strategy we set out our commitment to awarding ratings to organisations providing care. Ratings will help people compare services by highlighting where care is good or outstanding and expose where care is inadequate or requires improvement. They will also provide valuable information to providers and other stakeholders including commissioners, in particular by highlighting any areas of improvement.

During 2013/14 we worked with a wide range of stakeholders, providers, people who use services, Royal Colleges, representative bodies and other experts to design and test how our rating system will work.

In order to rate organisations, inspectors will use their professional judgement, supported by objective measures and evidence, to ask:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

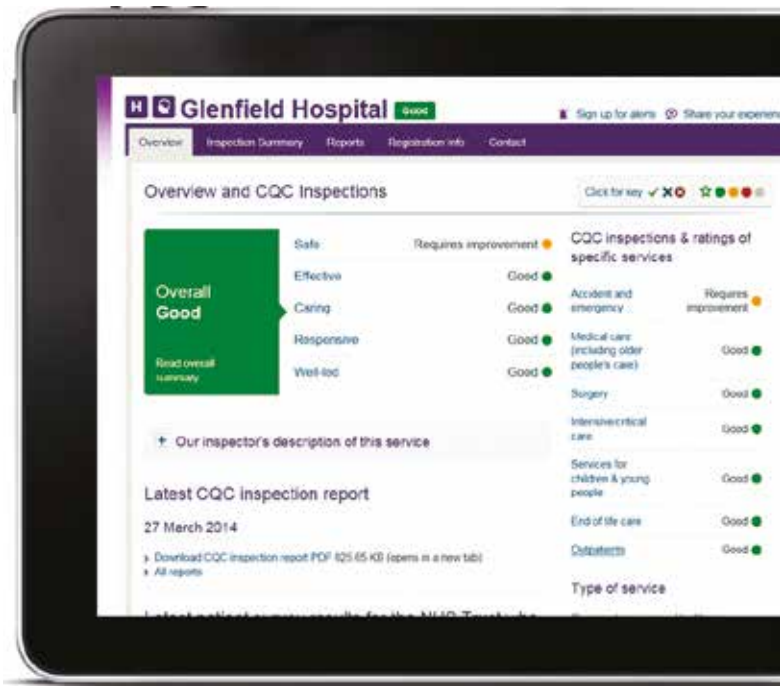
Our ratings will be based on a combination of what we find at inspection, what people tell us, Intelligent Monitoring data and local information from the provider and other organisations. We will award ratings on a four-point scale:

- Outstanding
- Good
- Requires improvement
- Inadequate

We will also provide ratings at the level which is meaningful for each sector (for example, for a care home, or A&E in a hospital).

We issued our first shadow ratings for NHS acute hospitals in March 2014 and we will further develop, test, refine and roll out our approach to ratings across other sectors in 2014/15. The legislation to enable CQC to publish ratings is expected to come into effect in the autumn of 2014.

When we inspect a provider, our starting point will be to look at whether it provides 'good' services for people; if it does we will explore whether it provides outstanding care. We will award a rating accordingly and will share what we have seen about good and outstanding care.



If a provider is not providing good care we will require it to make improvements. If a provider is in breach of a regulation, and therefore a fundamental standard, we will take appropriate, proportionate action to ensure it complies with regulations up to and including moving directly to prosecution or closing a service down – and awarding a rating to reflect this. For the NHS, we will work with Monitor and the NHS Trust Development Authority to implement a single failure regime.

Improvements to our website

Our website is an important resource for members of the public to find out information about services and make decisions about their or others' care – particularly through the reports of the almost 40,000 inspections we carried out in 2013/14.

We are constantly seeking to make improvements. In a survey on the quality of the inspection reports, people told us that they found the reports easy to find and easy to understand. Between quarter 1 and quarter 4 in 2013/14, there was a 9% increase to 77% of those that found the information very/quite helpful for those choosing care for themselves or a relative.

Awareness building

Last year 2.1 million people contacted or were referred to their local adult social care services. We think it is important that CQC reaches both these groups. To establish how best to achieve this aim, we shared some of our information with 15 local authorities to assess its value to the public, and the best ways to convey these messages.

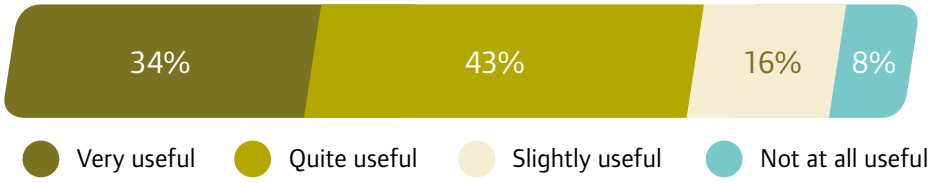
This information included leaflets about the standards people have a right to expect when receiving care, our inspection reports to help people choose care they receive, and the importance of people sharing their experiences with us to help improve care for themselves and other people. Uptake of material so far has been good, and the

Website report

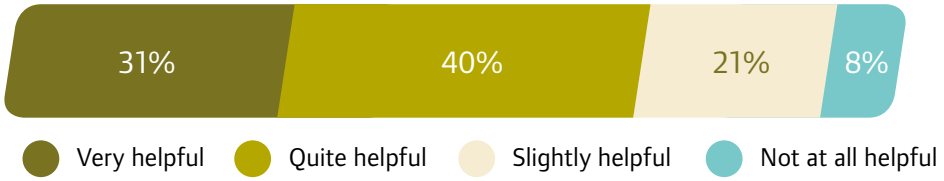
How **easy or difficult** was it to find the inspection report you were looking for today?
Sample size: 607

How **easy or difficult** was it to understand the information in the report(s)?
Sample size: 575

Did you find the information in the report(s) **useful** helping you choose care for yourself or your friend/relative?
Sample size: 167



How **helpful** did you find the inspection report(s)?
Sample size: 530



feedback from these projects will enable CQC to design and distribute a communications package to all local authority adult social care teams.

As part of our drive to increase awareness and understanding of our services to the public, we supported the first National Care Home Open Day in June 2013. One hundred and fifty of our inspectors joined a care home in their local area, providing members of the public with information, answering their questions and explaining the standards that they should be able to expect from services.

Thinking across health and care

We carried out a number of thematic activities during 2013/14 to add to our understanding of major themes affecting quality across the health and social care system.

Mental capacity

During 2013/14, we made commitments about the Mental Capacity Act (MCA) both to the House of Lords MCA Implementation scrutiny committee, and within our annual Deprivation of Liberty Safeguards report.

We have worked to ensure that the MCA is included from the start in the redesign of our new approach to regulation and inspection. We have incorporated the MCA into our key lines of enquiry and characteristics of what constitutes a 'good' service in all sectors.

We are also:

- Increasing our efforts to capture the experience of people who are, or have been, subject to authorisation, and of their families and friends.
- Making sure the MCA is embedded into the way we operate.
- Continuing to build on our collaborative relationships nationally and with local authorities and providers and to promote improvements in Mental Capacity Act compliance.

Services for people with dementia

During 2013/14 we carried out a themed inspection programme looking at dementia care. The programme examined how care homes and acute hospitals support the health, mental health and wellbeing of people with dementia, with a focus on how they work together when care is transferred between them.

We inspected 149 care homes and acute hospitals across 22 local authority areas to identify what good care look likes and how this impacts on people's experiences. We included Experts by Experience and specialist advisers as part of our inspection teams. We will publish a national report in Summer 2014.

Transition between children's and adult healthcare services

A themed programme looking at young people's transition from children's health services to adult services began in May 2013. We approached 100 clinical commissioning groups (CCGs) asking for help to identify young people with complex physical health needs between the ages of 14 and 25 to tell us about their experience of the transition process to adult services. We also consulted with our Children

and Young Person's Advisory Group to help us shape this piece of work.

We visited 19 of the CCG areas and met with young people, their families and the health and care teams. In total we spoke to 182 young people and parents, looked at 199 care records and spoke with over 500 health and care staff and commissioning teams. We found that was a significant shortfall between policy and practice around transition, and that a system-wide change is needed to achieve a much needed joined-up approach.

Induction for healthcare assistants and care assistants

In May and June 2013, CQC's inspectors carried out a survey of the induction and preparation arrangements for new care staff in social care settings and in hospitals.

The vast majority of locations reported that inductions do occur for new staff. Induction training was provided in-house in more than half of all cases. Buddying with an experienced worker and shadowing them was the most common approach, and the one cited as the most helpful. E-learning was said to be the least helpful.

However, some social care staff said they had been asked to provide care or support unsupervised where they felt unsafe (3%) or unprepared (5%). This area will be one focus for us under our new model of regulation for adult social care, in particular when we ask whether services are well-led.

Mental health crisis care

Towards the end of the year, we launched a themed programme to explore the experiences and outcomes of people experiencing a mental health crisis. This will help us improve our understanding of the care pathways that people experience when they try to access help and support during a crisis. It will enable us to build a better picture of where mental health crisis care works well and where it doesn't.

Experts by Experience are playing a vital role in the development of appropriate tools and methodology, and in guiding our understanding of how a crisis, and the care received, is experienced by the person at its centre. We will report on our findings later this year.

2. Transforming the regulation and inspection of health and care services

2.1 Hospitals, mental health care and community health services:

- Engagement and working with partners
- Testing the new approach
- Evaluation

2.2 Adult social care:

- Engagement and working with partners
- Testing the new approach
- Registration activity in 2013/14
- Market oversight

2.3 Primary medical care:

- GP practices and GP out-of-hours services
- Engagement and working with partners
- Testing the new approach
- Evaluation
- Online services for GPs
- Other inspection programmes

In 2013/14, we began the move towards a differentiated approach to regulation by care sector, led by our first Chief Inspectors: Professor Steve Field, Professor Sir Mike Richards and Andrea Sutcliffe. They are leading the change to more specialist and expert inspection teams.

In the past CQC's inspectors have not been specialised, with many looking at the whole range of health and social care providers – and this meant that sometimes important insight was missed. Now, our inspectors will specialise on a particular area of expertise and be accompanied in their work by specialist inspectors and experts – for example a midwife for maternity services or a GP for primary care – as well as Experts by Experience, who are people who have used services themselves.

Using specialists and experts in this way allows us to understand the organisations providing services, what drives their performance and their strengths and weaknesses.

The new teams have started looking at different services in different ways, based on what is most important for the quality of people's care. However, our inspection teams will always ask the same five questions:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

To direct the focus of their inspection, our inspection teams will use key lines of enquiry that directly relate to the five key questions. For each key line of enquiry we set out the characteristics of what good care looks like. Having a standard set of lines of enquiry ensures consistency of what we look at and this is vital for reaching a credible, comparable rating based on evidence.

Inspection teams will use evidence from a number of sources to answer the lines of enquiry, including information from:

- Intelligent Monitoring information
- Ongoing relationships with and previous inspections of the service or provider
- Information gathered before the inspection visit and in particular any feedback from people who use services and their representatives
- The inspection visit itself.

We will then rate services on a four-point scale: outstanding, good, requires improvement or inadequate. This is based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations.

In early April 2014, we consulted on a number of new provider handbooks, which set out the detail of how we propose to regulate and inspect different types of care service from 1 October 2014.

Initially we are focusing on inspecting specific services as that is how care is delivered to people and where problems can occur. However in future we will also look increasingly at the pathways of care that people experience as they move across services. This will allow us to consider problems in the co-ordination of care between different parts of the care system, such as those that can occur when patients are discharged from hospital to their home.

2.1 Hospitals, mental health care and community health services

Our Chief Inspector of Hospitals, Professor Sir Mike Richards, leads national teams of expert inspectors to carry out in-depth and comprehensive inspections of acute hospitals, community health services and specialist mental health services.

During the year we began the process of developing the new approach in three distinct areas:

- NHS acute hospital trusts
- NHS mental health trusts
- NHS community health services

Engagement and working with partners

Throughout the development and testing of the new approach, we engaged widely with a wide range of stakeholders, including through:

- A reference group of major stakeholders chaired by the Chief Inspector of Hospitals.
- Targeted 'task and finish groups' across different specialties and services to discuss specific areas of the new approach, such as the key lines of enquiry.
- Engagement with the relevant network groups from, among others, NHS Confederation, Foundation Trust Network and the Royal Colleges.
- Ongoing activity with our online community of providers including document reviews and live Q&A discussions.
- Regular engagement with stakeholder organisations, patient representative and consumer 'voice' organisations, and a wide range of voluntary sector groups.

As part of the initial response to the Francis report, the Government set out the need for a single failure regime to provide a simple, flexible process to enable regulators to tackle failures in quality in NHS trusts and foundation trusts. In April 2014 we published joint guidance with the NHS Trust Development Authority (TDA) and Monitor setting out how we would work together to deliver this new regime.

Our role focuses on identifying failures in the quality of care and judging whether improvements have been made. The TDA and Monitor will use their respective powers to support improvement in the quality of care provided. The guidance sets out how the TDA and Monitor make a decision to place a trust in special measures and how the three regulators work together to monitor and work with trusts when that decision is made. Only where the Chief Inspector of Hospitals recommends that a trust has sufficiently improved can it be removed from special measures.

In mental health, we continued to work with our expert Advisory Group to develop our proposals. We engaged members of this group and other colleagues in detailed discussions on quality in mental health, which services to inspect, how to involve people who use services in our new inspections, indicators for our Intelligent Monitoring for mental health and ratings for mental health services.

We also continued to collaborate with partner organisations to promote learning and consistent approaches to intervention following unexpected deaths of people subject to the Mental Health Act. This includes the Ministerial Board on Deaths in Custody, NHS England, the Department of Health, the Coroners' Society and the National Confidential Inquiry into Suicide and Homicide of People with Mental Illness. This work has led to the development of a Memorandum of Understanding with the Coroners' Society and increased sharing of our information with other agencies to promote improved understanding of risks to the safety of people in need of mental health care and treatment.

Testing the new approach

We began testing our new approach in NHS acute trusts (Wave 1 inspections) between September and December 2013. Using our new Intelligent Monitoring system, we identified 18 NHS trusts that appeared to represent a spectrum of risk across hospital care. We divided the trusts into four separate groups, so that we could pause between each group and develop and evolve the methodology through what we had learned so far.

Wave 1 included three 'shadow' ratings for trusts that volunteered to test an approach to rating different hospital services.

Our new approach, which included our learning from the 2013 reviews into NHS trusts with high mortality ratios, led by Professor Sir Bruce Keogh, was a totally new way of inspecting acute trusts:

- Gathering and analysing a large amount of hard data and soft intelligence held by many different parts of the system.
- Large multidisciplinary inspection teams consisting of senior clinicians, junior doctors, student nurses, senior health managers, Experts by Experience and patient representatives and CQC inspectors.
- The inspection team leaders were senior CQC staff experienced in hospital inspection. They led the process and the relationship with the trust's CEO. A team chair, who is usually a very senior clinician, assured trusts that leadership of the process was driven by frontline understanding of quality and of how hospitals work.
- Placing huge value on the insight from talking and listening to staff and patients.
- Convened a meeting of all local health economy parties at a Quality Summit to agree with each trust a coordinated plan of action and support needed.

But we also took it further:

- With our focus on the five key questions.
- Inspection of the same eight core services where applicable in every trust.
- Testing for the first time an approach to ratings for hospitals and trusts, so that the public can clearly understand the quality of different services on offer and so that there is a clear driver for improvement.
- Looking for the care that is good and outstanding – not just what requires improvement or is inadequate.

As a result of the learning from Wave 1, we made a number of changes to the Wave 2 test inspections. A further 19 test inspections of acute hospitals took place in Wave 2 between January and April 2014. We gave shadow ratings to all of the services inspected in Wave 2.

Work began on Wave 1 mental health pilot inspections in January, testing our new approach in four NHS trusts, and this finished in April 2014. Among other things, inspection teams tested out different ways we can integrate our monitoring of use of the MHA and all teams included MHA experts who take a lead on the MHA monitoring.

We also finished our Wave 1 testing of our new approach to community health services in April 2014, consisting of inspections of four providers.

Evaluation

Acute hospitals

We have had encouraging feedback from both trusts and our inspection teams. Our external evaluation (see below) showed that the new model had been received positively by trusts, and was seen as both more credible and more rigorous than the inspection process it replaced. Several trusts in Wave 1 commented that the new approach was a marked improvement on what CQC had done previously. Some had made a positive effort to get their staff involved in the inspection teams, both to contribute to the process and to learn about it for the benefit of their own organisation.

Jo Cubbon, Chief Executive of Taunton and Somerset NHS Foundation Trust which was inspected in Wave 1, said:

> *"Following the inspection team's visit we were able to use their comments and observations as a lever for change within a number of teams. As a direct consequence our A&E team have put forward a proposal to work in an innovative and flexible way to increase the consultant coverage for direct patient care.*
>
> *The agreement at the Quality Summit to produce a strategic commissioning plan for maternity services has created a welcomed momentum and a degree of pace to deliver future clarity. This was a direct result of the inspection team's findings.*
>
> *As a trust we recognise the importance of quality inspections, and the responsibility we have for making available staff with the skills and competence to be the very best inspectors."*

One of our inspectors summed up the learning they gained: "I now know more about this trust from one in-depth, comprehensive inspection than the last 15 put together."

The greater expertise that we've brought into the larger inspection teams – both from clinical specialists and from experts and from Experts by Experience – was invaluable. Inspection teams were able to get to heart of good care and poor care in a way that was not possible under the previous approach. We found marked variations in quality:

- There was a wide range of quality between hospitals: some were good or outstanding throughout, others had a number of poor quality services.
- In several hospitals there were marked variations between services – for example high quality maternity care but poor A&E services, and vice versa.
- In some hospitals there was variation within a service. This was particularly noticeable where one or two of the medical wards (especially in care of the elderly wards and on 'escalation' wards) were poor – what we call 'worry wards' – while others were good.

It was clear following this initial wave that there were three particular challenges for us in the new approach:

- It is important that we have a consistent approach in both how we assess services and how we make judgements about quality.
- Senior expert representation on the inspection teams is vital and we need to make sure we access the right level of expertise and ensure we have high-quality training in place for our inspection teams.
- We need to improve and refine our processes, such as doing more to prepare for the main inspection and improving the logistics of organising the inspection.

We also started to develop arrangements to monitor the cost of inspection delivery, so that we can ensure the approaches we develop are financially sustainable and provide value for money.

In addition, we commissioned an independent review of our new approach from Manchester Business School and the King's Fund, under the leadership of Professor Kieran Walshe. They broadly concluded that CQC had made rapid progress in nine months in developing and establishing a largely new acute hospital regulatory model. However they recommended that CQC make a number of improvements, including around selecting, training and deploying the performance of inspection teams, developing the skills and capacity of team members, developing a more structured framework to guide the inspection process, and reviewing our processes for arriving at judgments and ratings.

Specialist mental health services

We carried out an evaluation of the Wave 1 inspections in mental health. Overall, there was a good deal of support for the overall model, including the more in-depth approach, the integration of mental health inspection and Mental Health Act monitoring and the involvement of clinical experts. There were some concerns about:

- The intensity of the process and the lack of any time for reflection within the timetable.
- The logistics, including access to technology during an inspection.
- Some specific services (especially CAMHS and community services) not fitting comfortably into the existing key lines of enquiry.
- Obtaining the views of people who use services and carers.

We are incorporating our learning and experience from these first inspections into further testing during Wave 2, which is taking place between April and September 2014. This is including both NHS trusts and independent sector hospitals.

Second Opinion service

CQC's Second Opinion Appointed Doctors (SOAD) service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting. SOADs decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the patient's views and rights.

There were more than 13,000 requests for a SOAD review in the calendar year 2013. However, we significantly missed two of our three response targets. Although performance improved over each quarter, there is still an issue in having the right SOAD available in the right area at the right time. To improve this, we are looking to increase the panel of SOADs. We carried out significant recruitment in the year, and there are currently 131 SOADs on the national panel. We also appointed Lead SOADs to improve the quality and effectiveness of the service. However, through natural turnover there was overall a net reduction of 10 SOADs since the beginning of the year, and work to increase the number of SOADs is very much an ongoing challenge.

Improvements in 2014/15 will focus on implementing online services for providers to submit notifications, including requests.

2.2 Adult social care

Our Chief Inspector of Adult Social Care, Andrea Sutcliffe, joined CQC in October 2013 to lead the new Adult Social Care inspection directorate. This broadly covers around 17,000 residential care homes and nursing homes, 8,000 home care services, 350 hospices and smaller numbers of specialist college services, community-based services for people with a learning disability, Extra Care housing, Shared Lives and supported living services.

Engagement and working with partners

In October Andrea Sutcliffe set out her plans for working with people to develop the new approach for social care regulation.

The focus for the adult social team in the second half of 2013/14 was in engaging widely about our plans.

We used a model of 'co-production', which meant a large number of people helped to shape our thinking about the elements of the new approach, offering practical suggestions and constructive challenge. They have been critical but supportive friends; without their help and challenge we would not have got so far so quickly.

We have an external and internal co-production group. The external has around 45 members, including providers, organisations that represent providers, people who use services, family carers, local Healthwatch groups, members of the Association of Directors of Adult Social Services and national organisations.

Our internal group is mainly made up of inspectors and managers. But it also includes people from other parts of the organisation such as Legal and Intelligence.

We met with each group every six to eight weeks, looking at issues such as lines of enquiry, ratings and the use of provider information returns to give us useful information about a service before we go in to inspect.

At the end of March, participants in the co-production groups took on the role of inspector for the day and used case study material to follow through an inspection using the key lines of enquiry, ratings characteristics and the supporting tools we have developed. Both days generated lively debate about the practicalities of the new approach and gave the members of the groups not familiar with the role of the inspector a real insight into the judgements that will be required. The co-production groups have been very useful in shaping individual elements of the new approach but this was the first time they had been able to explore the end-to-end process.

The groups will continue to run until the end of 2014 and will help us to agree our response to the consultation comments and the evaluation of our Wave 1 and Wave 2 inspections in adult social care.

As well as the co-production meetings we engaged with people in other ways throughout the development period. We spoke at events and held individual meetings with a wide range of stakeholders. We held a round table to discuss how we might make use of accreditation schemes in adult social care and other round tables are planned during the consultation periods in 2014.

Testing the new approach

Much of our engagement was to inform our policies, guidance, tools and training ahead of our first group of inspections in April 2014. We selected

around 250 locations to inspect in Wave 1, to cover a geographical spread and mix of adult social care services for older people, people with a learning disability or mental health needs, and hospices. It was important to have this spread of locations and types of service so that we could fully test the new approach in different settings and circumstances.

Registration activity in 2013/14

Andrea Sutcliffe's team also leads on the registration of health and care services.

To provide health and care services in England, services must register with CQC and in so doing give an undertaking that they will provide safe, high-quality care. In response to the Winterbourne View Concordat, a system-wide programme for change following the failures of care at Winterbourne View Hospital, CQC committed to adopting a new approach to registration for all new providers of services for people with learning disabilities.

In July 2013 we introduced a new application form and associated methodology for aspirant providers of services for people with a learning disability. This included not only asking more questions in the application form about the premises, environment and quality assurance processes but also asked how the applicant would meet the individual needs of service users focused on the five questions about safe, caring, effective, responsive and well-led services.

We will be rolling out this approach to all new providers in the coming year. We are also committed to making the application process more streamlined through the use of online accounts, and are piloting how we include Experts by Experience in registration inspections.

Our Registration team have worked closely with Monitor to introduce a joint licence and registration application process. This was delivered in April 2014 and means that new providers of NHS funded healthcare services can apply for CQC registration and a provider licence via a joint application form and be issued with the registration and licence in one document.

During the year, we dealt with 48,472 registration applications, an increase of 44% on the 33,648 applications received in 2012/13.

In 2013/14 we set out an objective to complete 90% of registrations within eight weeks. For the year, 79% were within plan compared with 86% in 2012/13. The main drivers in this were the significant increase in applications and the more thorough approach to registration adopted in 2013/14. Notably the quality survey we carried out pointed to a high quality and improving service.

Overall, 4,679 locations cancelled their registration in the year; of these 567 (or 12%) cancelled while not meeting one or more standards.

We carried out a survey of new providers and managers registered with CQC between April and October 2013. Ninety per cent of providers and 93% of managers agreed that the registration assessor had good knowledge of the type of care they were applying to register or vary. In addition, 93% of those who received a site visit from an assessor agreed that the visit was a thorough assessment by CQC of the provider's or registered manager's ability to deliver or manage a quality and safe service.

The area with the lowest score (76%) was in relation to CQC's standards in helping the provider (before registering) to improve their systems and plans for providing care.

Ensuring registered managers are in place

The role of the registered manager is an important one in making a difference to people's experiences of care, and the lack of a registered manager where one is required is unacceptable. We ran a project from November 2013 to April 2014 to significantly reduce the number of locations operating without a registered manager.

We targeted 2,439 locations that had not had a registered manager for more than six months. By April 2014, 1,395 of the targeted locations had put a registered manager in place. A further 470 (20%) manager applications had been submitted for approval.

We used our enforcement powers in relation to 590 locations that failed to appoint or submit an application for a registered manager. A high proportion of these subsequently responded without the need for further action. We issued a limited number of fixed penalty notices to show the seriousness we attached to the breach of the requirement. The notice itself does not secure a registered manager, but is a way for the provider to discharge its legal liability for the offence.

We were very encouraged that providers responded to our challenge and took steps in large numbers to ensure that registered managers are in post. We will continue to work with providers to ensure all health and adult social care services that are required to have registered managers fill these positions.

Market oversight

The Care Act has introduced a requirement for a system of market oversight, whereby CQC will monitor the finances of the largest care companies to give an early warning of potential problems, and to challenge financial systems that could be unsustainable or reduce quality. The aim is to ensure that continuity of care continues in the event of the financial failure of a 'difficult to replace' provider.

We have started to explore with leaders of the adult social care sector the risk scenarios that could precipitate the failure of a large, corporate provider of services. This will help to inform the agreement of market and individual company indicators of risk that we will need to monitor. The intention is that this will come into force in April 2015.

2.3 Primary medical care

Professor Steve Field, our Chief Inspector of General Practice, joined CQC in September 2013 to lead the new Primary Medical Services and Integrated Care inspection directorate. This covers more than 7,500 GP practices, out-of-hours services and mobile doctors, more than 10,000 dental care services, and a number of prison healthcare, remote clinical advice and urgent care services.

GP practices and GP out-of-hours services

Inspections of GP practices under CQC's existing regulatory approach began in April 2013 and we had inspected around 20% of all registered providers of GP services by the end of the year. These first inspections were inspected using the same generic model that we used to regulate and inspect all providers of health and adult social care up to 2013/14.

In line with other sectors, during 2013/14 Professor Steve Field set out our plans for a new approach to monitoring, regulating and inspecting GP practices and GP out-of-hours providers. This approach has been co-produced with people who work in GP practices, people who use services and our stakeholders.

There will be new expert inspection teams, including trained specialist inspectors with clinical input led by GPs. They will be more focused on the things that matter to patients. Each practice will need to show that they have a person-centred approach where patients are able to access services when they need to. In our inspections we will also be focusing on key population groups, such as the over 75s and mothers, babies, children and young people.

There will be a rolling programme of inspections carried out systematically in each clinical commissioning group (CCG) area across England. We will inspect a number of practices in each CCG area each time we visit. We will look at how GP practices working in normal daytime hours communicate and work with out-of hours GP services. We will not be inspecting the CCG itself, but we will be maintaining a close working relationship with the CCG and

the NHS England area team to enable us to share information about the GP services in the area.

Engagement and working with partners

We created a GP Advisory Group, to advise the Chief Inspector about key aspects of the new model as it is developed. Members include the General Medical Council, NHS England, the Royal College of GPs, the Royal College of Nursing, the Nursing and Midwifery Council, the British Medical Association, Healthwatch England and Public Health England.

We also set up a GP Reference Group, through which we engage with experts from the GP sector. This group supports us by providing expert advice, opinion and challenge to the design and development of our methods. Members include NHS England area teams, CCGs, local medical committees, working GPs, the Family Doctor's Association, NHS Alliance, BMA and the Department of Health.

As well as working with the co-production group to inform our lines of enquiry and characteristics of ratings, we incorporated the existing evidence base produced by other organisations, such as the Department of Health, the Royal College of GPs and NICE.

There will be new expert inspection teams, including trained specialist inspectors with clinical input led by GPs.

We are currently in the process of developing our new approach to regulating and inspecting primary care dentistry and other urgent care services, such as 111. Our timescales for introducing these changes are slightly longer than they are for NHS GP practices.

Testing the new approach

We began testing our approach to GP out-of-hours inspections in January 2014, looking at more than 30 services. We will publish a national report on our findings from these inspections in the summer.

We started to test our proposed new approach in GP practices in our Wave 1 inspections between April and June 2014. We are inspecting 200 GP practices in 12 CCG areas.

Evaluation

As we develop our new approach we are testing it and evaluating it. This includes gathering feedback both from our staff and from those providers inspected. Our initial evaluation of these inspections showed that CQC holds limited detail about the services provided by out-of-hours services, which impacts on the resources required to gather this information and our understanding of the service before our inspectors cross the threshold.

The early inspections highlighted several areas for development, including:

- Consistency and the need to clearly define roles of inspection team members and what they should be looking at.
- Queries about how we should assess clinical effectiveness, and choosing between good and outstanding care.
- The timing of the inspection: some services have been very quiet at the time of the site visit, which raises the question of whether we are capturing typical out-of-hours service provision.
- Difficulties in gathering the views of people who use out-of-hours services; our methodology in this area needs to be improved.

Online services for GPs

The Government announced (as part of its response to the Francis Inquiry) the launch of a Reducing Burdens Concordat.

The Concordat asks the Department of Health and its Arms-Length Bodies to reduce unnecessary burden on the NHS by only collecting data that is proportionate and has a clear business purpose. Providing a positive change in customer experience is at the centre of CQC's Online Services Programme.

To date we have launched Online Services for the registration of GPs and have piloted death notifications, which providers are required to send us. Services and tools are now in place for all GPs and we have processes in place to monitor, inspect and adapt services to drive improvements in these services.

We have established how to extend Online Services for all sectors and will continue to develop it in 2014 so that the benefits we have realised for GPs can be recognised for all providers across health and social care.

Other inspection programmes

Child safeguarding and looked after children inspection programme

The Children's Services Inspection Team began their programme of reviews of child safeguarding and services for looked after children on 30 September 2013. The programme will run until April 2015. Inspections take place in local authority areas based on the identified risk within the health services in those areas.

Alongside this, we are working with Ofsted, Her Majesty's Inspectorate of Probation, Her Majesty's Inspectorate of Constabulary and Her Majesty's Inspectorate of Prisons to plan multi-agency inspections. These will jointly explore the contribution of all agencies to ensure they keep children and young people safe and promote the health and wellbeing of looked after children and care leavers. The inspections had been due to start in April 2013, but the start was deferred while the agencies jointly reviewed how they could make the joint working as effective as possible. They will now begin in April 2015.

Health and criminal justice

Over the past year CQC has carried out inspections of health care at different points within the criminal justice system. Within the community, we participated in the full joint inspection of six youth offending teams (YOTs) and published the findings from a further inspection in relation to those children and young people who sexually offend.

Further thematic inspections were undertaken to examine the way girls and young women are supported by YOTs and also how well learning difficulties and disabilities are assessed and worked with in this part of the criminal justice system.

Joint inspections have also been undertaken in relation to all four Secure Training Centres (STCs) for young people as part of an annual programme of inspections of this secure setting and seven inspections have been carried out in young offender institutions (YOIs). With adult secure settings, CQC has taken part in 47 inspections of prisons as well as five inspections of immigration removal centres and 11 inspections of police custody suites.

Business review

3. Creating a high-quality, sustainable regulatory approach

In this section:

Building a new CQC structure

To support our new regulatory approach, we carried out a substantial restructure of the organisation during 2013/14. We moved our inspection function into three inspection directorates under each of the new Chief Inspectors. We also created two new directorates – Strategy and Intelligence led by Dr Paul Bate, and Customer and Corporate Services led by Eileen Milner – to support and underpin the work of the inspection directorates. The new directorates came into effect on 1 April 2014.

This involved detailed work to build inspection teams, allocate every provider portfolio to a named inspector, and ensure that there was a safe handover of portfolios between staff, including ongoing regulatory activity, risks and complaints.

To make sure we can deliver our new regulatory commitments in all sectors in 2014/15 and beyond, we began an extensive recruitment programme towards the end of the year to increase staff capacity. The roles include inspectors, inspection managers, registration inspectors, registration managers, senior analysts and analyst team leaders. By the end of 2014/15, we aim to have increased our workforce to more than 2,500, compared with 2,237 (whole-time equivalents) at the start of the year.

In 2014/15 we will also need to grow staff capability. This reflects not only our new approach to inspection but also the introduction of new powers under the Care Act and the introduction of new regulations setting out fundamental standards of care. We will be inspecting and registering services that will be going through very significant change driven by demography, technology, expectation, and financial constraints, which we have not seen before. We will be challenged to be efficient and effective ourselves and will have to respond quickly to this changed landscape.

There is a significant risk that we do not recruit staff with the right skills and experience to operate our new approach effectively. To mitigate this, we have engaged HR specialists Penna to support us in providing professional assessment specialists (including designing and delivering a rolling programme of assessment centres). We are also developing a long-term HR and workforce strategy.

We continued to make use of 'bank' inspectors in 2013/14 to carry out inspections of social care using current methodology while inspectors were trained in the new methodology and began to pilot this during inspections.

Evaluation and sustainability

We set up a single Transformation Programme to manage the changes within CQC. This was led by Hilary Reynolds, Director of Change. The programme was assessed by the Department of Health Gateway Review in November 2013 with an amber rating. It judged delivery of our new approach as 'feasible', but highlighted areas we know we still have to address – such as capacity constraints in our HR team, information systems and estate planning, and demonstrating the effective use of additional resources.

We are aware of the scale of the changes we are making and that we have a lot to do. In 2014/15 we are entering the period of greatest risk and challenge in what we have set out to achieve as we begin to implement in full the changes to how we regulate.

We are also mindful of the legacy of the mistakes of the past. Our new strategy was formed in the wake of severe criticism of CQC, in particular from the Winterbourne View Serious Case Review, the Francis Report into the catastrophic collapse of care at Mid Staffordshire NHS Foundation Trust, and the Grant Thornton review of our regulatory oversight of University Hospitals of Morecambe Bay NHS Foundation Trust. The learning for CQC from these failures is that our over-riding priority must be the safety and quality of care that people receive.

In 2013, we began our evaluation programme by assessing each of our series of 'wave' inspections to test and refine our new approach. We also carried out post-inspection and post-registration surveys of

providers to understand their perspective and see where we could improve.

We started to develop the methods that will evaluate and measure whether we are achieving our purpose and the value-for-money of our activities. This will use four levels of measurement – our overall impact, expected outcomes of our work, the quality and effectiveness of our activity, and our internal capabilities. At each of the four levels we will evaluate, measure, analyse and use our findings to improve our own ways of working.

The challenge for CQC is to financially sustain its new approaches to regulation. To address this we are putting in place arrangements to monitor the cost of inspection delivery so that we can ensure we develop more sustainable approaches to be able to live within future financial constraints.

We also need to demonstrate that we can deliver value for the money we receive. We are building a programme of value for money measurement, including challenging budget holders on how they are achieving value for money and managing financial risks, and taking a robust approach to contract management.

Equipping our staff with the right skills

In 2013, we set up a CQC Academy to support staff through the transformation to our new way of working, to meet the demands of our new approach, and to help CQC to become an organisation that is constantly improving.

Through the Academy we will ensure that all members of staff, starting with inspectors, are appropriately trained to carry out their work. The CQC Academy aims to ensure that our staff receive the high-quality, cost-effective investment in their skills and development that we now need. We will seek to make sure that our staff have enough time and space to keep up their skills and knowledge.

The Academy's initial activities focused on conversion training for staff supporting the early

periods of our new inspection approach, and a rolling programme of skills surveys to understand the expertise people have and would like to develop. In 2014 we will roll out a Leadership and a Management Development Programme focused on the values and practical skills that our staff need to lead and manage our people well. We are working towards both being recognised by an approved professional body.

In 2014/15, we will also be focusing on making sure that a new strong corporate induction programme has been successfully launched and rolled out to all new starters. We will also need to make sure that staff performance and development reviews have been completed and that development opportunities for the Academy to deliver are identified. We will make sure that we have effective arrangements for ensuring regular feedback on performance.

Governance

Implementing the transformational changes meant that CQC needed to change the way it manages itself. The key challenge has been to simultaneously strengthen and improve the quality of our governance, addressing those weaknesses previously identified, while undertaking thorough structural reorganisation and fundamentally changing CQC's regulatory methods and approach.

CQC has completed the first year of a radical three year transformation of the organisation and its approach. There are many risks associated with such fundamental change and these will need to be managed through to completion of the programme. In the context of risk management and assurance, radical organisational change has an inevitable impact on systems and processes, and the capacity to deliver them effectively. These challenges are being addressed but they will take time to bed in to the organisation.

Our Board is now unitary, with seven non-executive and five executive directors. Meetings are held monthly and in public with a live stream online. The non-executive director membership of the Board has been greatly strengthened with the appointment in June of Louis Appleby, Camilla Cavendish, Paul Corrigan, Jennifer Dixon and Michael Mire, and Kay Sheldon has had her term extended.

The Board has three sub-committees. Notable is the creation of the Regulatory Governance and Values Committee to allow for a more detailed scrutiny and oversight of regulatory risk. It provides assurance to the Board on our systems, processes, accountabilities and values including, for example, ensuring that the surveillance and inspection model is robust, and that our whistleblowing policies are effective. The Committee will also be responsible for overseeing the operation of CQC's internal whistleblowing arrangements and how we handle concerns raised by the public.

Full details of our governance changes are set out in the Governance Statement on page 85.

Culture

We are fully committed to a just culture within CQC, one that is both open and transparent. We want to learn from mistakes to get better, make sure staff are encouraged to raise concerns that will be listened to, have a high support and high challenge culture, celebrate our successes and constantly look to improve.

Action on bullying and harassment

CQC is committed to zero tolerance of bullying and harassment – an issue raised in recent staff surveys. Towards the end of 2012/13 we appointed an independent consultant, Sarah Hunter, to look in depth at bullying and harassment in CQC and see how we can build a strong anti-bullying culture.

Her report, published in June 2013, found that there was a worrying level of perceived bullying and harassment. She also noted that it was not only staff that felt they had experienced bullying – this was also true of line managers. She made recommendations to address the issues identified. Publication of her report reflects our approach to transparency and openness.

In response to the report, staff across the organisation have been trained to support people where they feel they are being bullied or harassed. In addition to this, Michael Mire, one of the newly appointed non-executive directors, has been appointed as the Senior Independent Member to whom members of the Commission and members of staff can raise their concerns where they feel that they cannot do so through their line management or through HR.

Sarah Hunter returned to CQC in April and May 2014 for a follow-up visit, to report on both current concerns and the behaviours that staff would like to see in the future CQC.

Staff survey

Alongside the annual staff survey, we have started to carry out more frequent "pulse check" samples. The results are discussed and followed up in directorate and team meetings.

The 2014 pulse check showed that staff felt significantly more proud to work for CQC, compared to the main 2013 staff survey — from 57% positive in July 2013 to 77% positive in March 2014. A large majority of participants believed CQC has a clear future direction (86% positive) and they are committed to it (88% positive). They believed that CQC is committed to being a high performing organisation (89% positive).

However, morale across CQC was still a big concern. Only 35% of staff said that morale was good (up from 24%). The main factors that concerned staff about their ability to deliver their programmes of work were effective systems and processes (53% said this) and being equipped with the necessary skills to perform their role (49%). Many core business processes are still too bureaucratic. Only 47% of staff said that they felt valued at work.

Although the scores for bullying and harassment and experience of discrimination indicated that some progress had been made, there is further work to do in these areas. Twenty per cent of participants said they had witnessed bullying and harassment since July 2013 (down from 23%) and 10% of participants said they had been bullied or harassed at work since then (down from 14%).

Change is challenging for staff, and although staff morale and engagement has improved, we are not complacent. We will be building on staff survey results, and doing further focused work on CQC's values and behaviours, involving all staff in making sure these are what we need to carry us through the next year and into the future.

Complaints about CQC

We take all complaints very seriously, and use them as a way to improve the way we work. We aim to resolve most complaints quickly at stage 1, with CQC managers talking directly to the complainant. We received 534 stage 1 external complaints about CQC in 2013/14, compared to 414 for 2012/13, an increase of 29%.

There were 86 stage 1 complaints that progressed to stage 2 for people who were not satisfied with our first response. (This is 16% of complaints, which is within our 'ceiling' of 20%). We managed to maintain this level throughout the year, despite the increase in complaints.

Of those that progressed to Stage 2, six were upheld in 2013/14 compared to 10 in 2012/13.

Customer service

CQCs dedicated National Customer Service Centre (NCSC) is based in Newcastle upon Tyne. The centre provides advice and support to members of the public, people who use services, professionals providing registered services and other professional groups. They handle, on average, 8,000 calls, emails and items of post each week and act as the first point of contact for CQC. Total telephone calls in 2013/14 amounted to 238,621.

NCSC has a continuous programme of improvement which sees it regularly engage with both our internal and external customers, who are diverse and whose needs are broad in complexity. They take customer feedback very seriously and this year were ranked 25th (up from 36th last year) in the Top Companies for Customer Service Awards. This benchmarking provides NCSC with continuous feedback and focuses them on our improvements.

Knowledge and information strategy

In 2013/14 we began work on a knowledge and information work stream to transform the way in which the CQC values and utilises data we create, source, store and use to enable us to become truly information led.

An overarching Strategic Framework was presented to the CQC board in April 2014. This provides a structure that enables CQC to become intelligence driven. It outlines in detail how, what and who will deliver the aspirations of our corporate strategy: to deliver better information for inspections, to develop better relations with the public and develop our confident voice, and to become a high-performing organisation.

Equality and human rights

One of CQC's principles is to promote equality, diversity and human rights. Our aim is to integrate our human rights approach throughout our regulatory work. In developing this approach,

we have agreed a set of human rights principles that we can apply to our five key questions that we ask about services (whether services are safe, effective, caring, responsive and well-led) to determine key human rights topics.

We have started plans to:

- Consult publicly on our human rights approach in April 2014, so we can incorporate the views of others into the development of our approach.
- Use our human rights approach beyond individual inspections, so we can comment on equality and human rights in health and social care in order to further drive improvement for people who use services.
- Evaluate the impact of our human rights approach on the quality of care that people receive. This will be used to develop new information, tools and learning approaches for inspection staff.

Finally, we want to promote equality, diversity and human rights in everything we do and tackle inequality where we find it – both in how we regulate and as part of CQC's own culture. We have embedded an equality, diversity and human rights approach in our new approach to inspections, including a growing focus on how services comply with the Mental Capacity Act, and are exploring how we can better understand inequalities and variation in the quality of care across conditions, groups and areas.

CQC supports three staff equality networks – the Disability Equality Network, the Race Equality Network and the Lesbian, Gay, Bisexual and Transgender (LGBT) Equality Network. These networks make an extremely valuable contribution to our equality work at CQC through providing a route for consultation on staff equality matters, peer support and constructive challenge to CQC on both staff equality and equality in regulatory work. During the year we have also started to develop a network for staff with caring responsibilities.

Our equality objectives

We have made progress on our equality objectives during the year – a particular area of strength was in our accessible communications work. Progress on our objective to involve a diverse range of people of people in our work has also been strong – including the development of the SpeakOut network to reach seldom heard communities, work with Regional Voices and the development of our Experts by Experience programme to include young people.

Our equality objectives are integrated into business plans, so that they become a part of mainstream delivery and are monitored appropriately.

Staff equality profiles

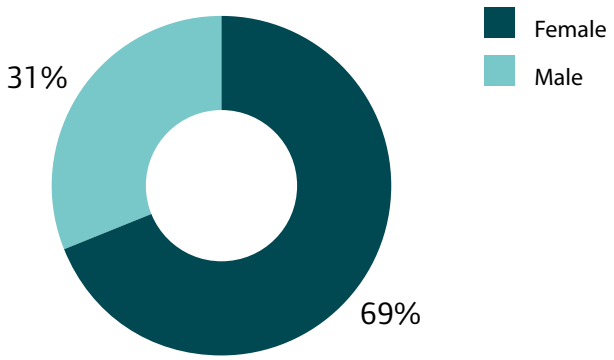
In 2013, we improved our equality monitoring data by asking each member of staff to update their personal equality information. This has expanded what we know about the profile of our staff, especially in relation to sexual orientation and religion and belief, as we have reduced the number of 'not knowns'.

Our diversity profile in a number of areas is good, in relation for example to recruiting older staff and the number of lesbian, gay and bisexual staff in middle and senior management positions. Other areas have improved slightly over the year, such as the overall percentage of disabled staff and staff from Black and minority ethnic (BME) backgrounds.

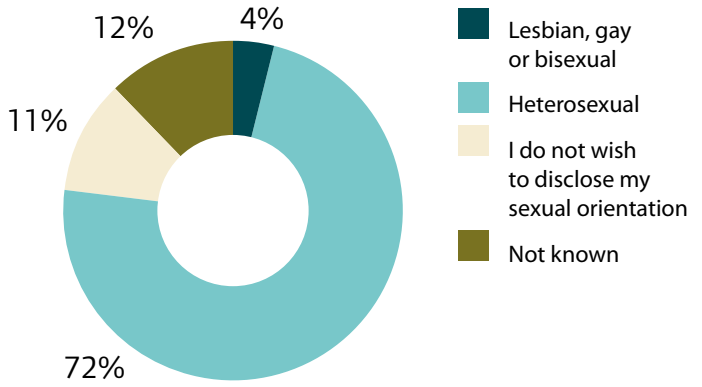
The analysis suggests some areas where we need to focus our work:

- The number of disabled staff in CQC is still low at 7.9%, compared to the overall percentage of disabled people employed in the UK workforce, which is 10.5%.
- The low percentage of BME staff in management positions; while BME people make up 12.3% of CQC staff overall, only 7.5% of Band A management positions and 3.8% of executive grade positions are filled by BME staff.
- The low percentage of staff from non-Christian religions in management positions; while 13.9% of CQC staff are in Band A or executive grade posts, only 4.9% of staff from non-Christian religions are in these posts.

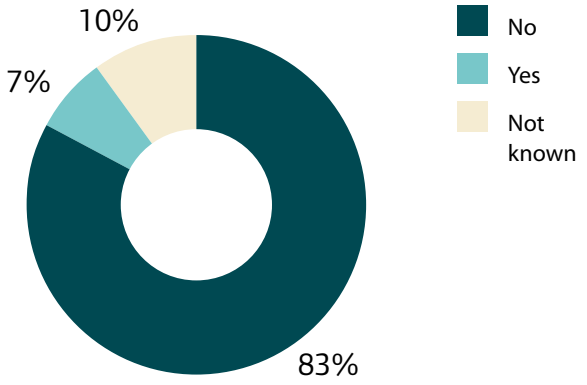
Gender – % total staff at Sept 2013



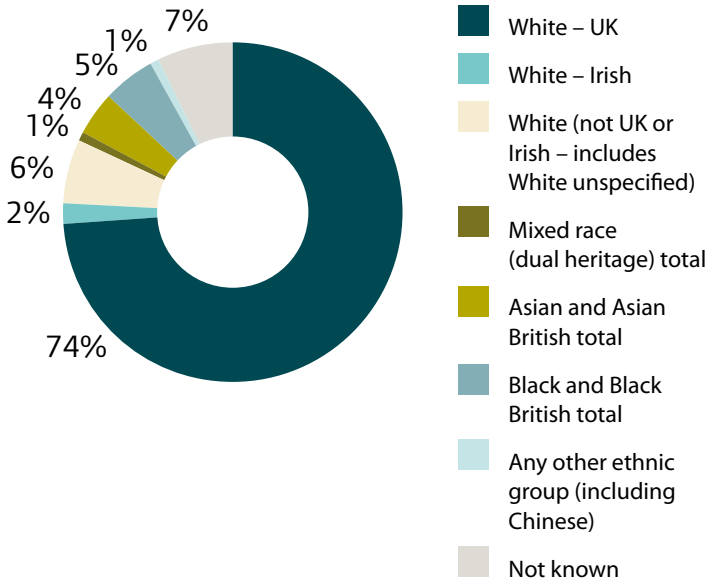
Sexual orientation – % total staff at Sept 2013



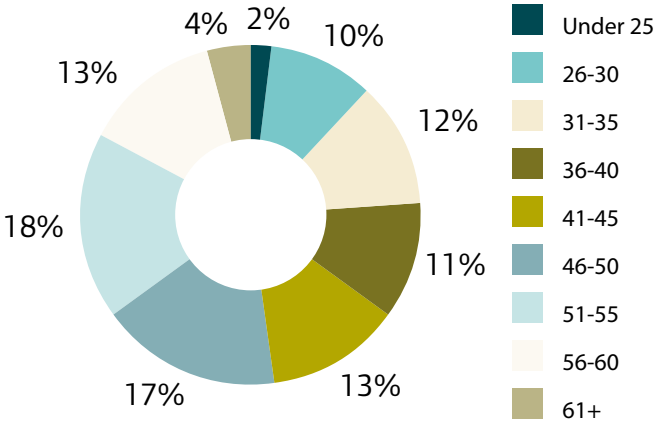
Disability – % total staff at Sept 2013



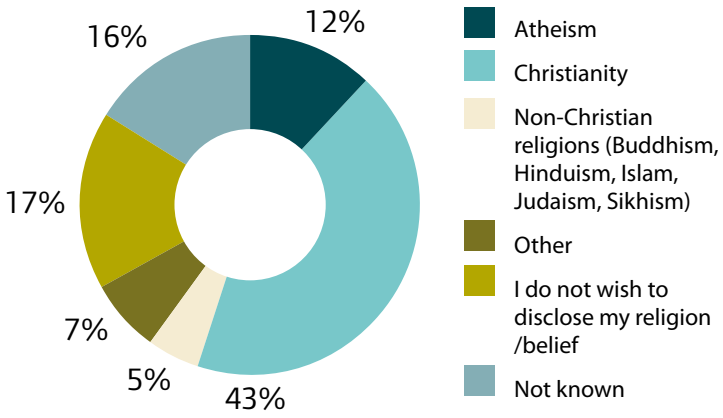
Ethnicity – % total staff at Sept 2013



Age – % total staff at Sept 2013



Religion and belief – % total staff at Sept 2013



Business review

4. Progress in 2013/14

We have started to make radical changes to the way we regulate and inspect. We are creating a model of regulation that will provide greater assurance about the safety and quality of services to the public. One that is independent and transparent. One that listens to and acts on the experiences of people using services and care staff, that drives improvement by highlighting good practice and publishing credible ratings of services based on expert inspections. One that acts to ensure improvements are made to unsafe and poor quality services.

We have already made major changes in response to what the public, people using services, providers, our staff, strategic partners and others have told us, as well as what we have learned from past weaknesses. In 2013/14, we completely changed CQC's leadership team, its organisation and governance, and began to develop a fundamentally different approach to risk monitoring, inspection and regulation.

We know there is more to do. We are aware of the scale of the changes being made and that it will take time to build an effective new approach. We know that in 2014/15 we are entering the period of greatest risk and challenge in what we have set out to achieve.

We are also looking ahead to identify the issues and opportunities that we need to manage over the next two years to make a reality of our strategy. These are discussed by David Prior and David Behan in their foreword on page 3. In doing this we are mindful of the broader developments that are happening in the wider care system and the size and complexity of the health and social care system that we work within.

In our business plan for 2014/15 and 2015/16, we have set out our key deliverables and milestones for the next two years. These come under three broad headings:

- Putting people's views at the heart of everything we do, improving how we listen to people who use services, the public, and staff providing care.
- Introducing the new approach to how we monitor, inspect, regulate and take enforcement action, and work with other regulators and partner organisations.
- Supporting all our staff to deliver our inspection, monitoring and regulation, through building a new open, transparent culture and managing our resources effectively and efficiently.

We are committed to continue working closely with our partners to build an effective and independent CQC that protects and promotes the health, safety and welfare of people who use services, that listens to the experiences of staff and people using services, and that drives improvement through publishing credible ratings based on expert inspections.

Business review

5. Our Board

David Prior
Chair

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

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

In 2002 he became Chairman of the Norfolk and Norwich University Hospital and a Director of Aurelian Oil and Gas plc. He is also Chairman of the Governors of Ormiston Victory Academy and Chairman of Sir Isaac Newton Sixth Form Free School.

David Behan
Chief Executive

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

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

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

Professor Louis Appleby
Non-executive director

Professor Louis Appleby is currently the National Clinical Director for Health and Justice. Prior to this he was the National Director for Mental Health between 2000 and 2010.

He is Professor of Psychiatry at the University of Manchester where he leads a group of over 30 researchers in the Centre for Mental Health and Risk. He developed the National Suicide Prevention Strategy for England, re-launched in 2012. It focuses on support for families and prevention of suicide among at-risk groups.

Dr Paul Bate
Director of Strategy and Intelligence

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

He also worked for the Prime Minister's Delivery Unit under the previous government, where he led the health standards team and ran national reviews on cancer, elective waiting times, long-term conditions and health care acquired infections.

He has a strong background in strategy development and organisational design, including working for consultants McKinsey & Company and 2020 Delivery.

Anna Bradley
Non-executive director

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

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

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

Camilla Cavendish
Non-executive director

Camilla Cavendish is an award-winning journalist and Associate Editor for the Sunday Times. She recently led an independent review into the training and support of health care assistants.

She has been an analyst at McKinsey & Company, Chief Executive of the South Bank Employers' Group and assistant to the Chief Executive at Pearson plc.

Professor Paul Corrigan
Non-executive director

Professor Paul Corrigan is the former health policy adviser to Tony Blair and former special adviser to Alan Milburn and John Reid.

Between 2007 and 2009, he was the Director of Strategy and Commissioning at the London Strategic Health Authority. Since then, he has been working as a consultant and a coach, helping leaders within the NHS to drive changes in their organisations.

Dr Jennifer Dixon
Non-executive director

Dr Jennifer Dixon is Chief Executive of the Health Foundation. Between 2008 and 2013 she was Chief Executive of the Nuffield Trust, and prior to that she was Director of Policy at the King's Fund.

She was previously a policy adviser to the NHS chief executive. She is a visiting professor at The London School of Economics and Political Sciences, Imperial College and the London School of Hygiene and Tropical Medicine. She is also a member of the editorial board of the Office of Health Economics.

In 2009 she was elected as a fellow of the Royal College of Physicians. In 2013 she was awarded a CBE for services to public health.

Professor Steve Field
Chief Inspector of General Practice

Professor Steve Field became Chief Inspector of General Practice in September 2013. Before this, he was NHS England's Deputy National Medical Director, with the lead responsibility for addressing health inequalities in line with the NHS Constitution.

He is Chairman of the National Inclusion Health Board Improving the health of the most vulnerable. He was the Chairman of the NHS Future Forum which was launched in April 2011, and Chairman of Council of the Royal College of General Practitioners between 2007 and 2010. He is a non-executive director of University College London Partners, Honorary Professor at the University of Birmingham and Honorary Professor at the University of Warwick.

He received a CBE for his Services to Medicine in the Queen's 2010 New Year's Honours List. He continues to practise as a GP at Bellevue Medical Centre in Birmingham.

Michael Mire
Non-executive director

Michael Mire was a partner of McKinsey & Company, the management consulting firm, for more than 20 years. He worked predominantly on strategy for retailing and financial services clients.

After leaving university, he joined the banking firm N M Rothschild. He then went to Harvard Business School where he gained an MBA degree. On his return, he was seconded to the then equivalent of the No. 10 Policy Unit before he joined McKinsey.

He is on the board of Aviva plc, where he is a non-executive director and a member of the Risk and Governance Committees, and is a Senior Advisor to Lazard, the investment bank.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Professor Sir Mike Richards became Chief Inspector of Hospitals in July 2013, joining CQC from NHS England where he was Director for Reducing Premature Mortality.

In 1999 he was appointed as the first National Cancer Director at the Department of Health. In 2007, his role was extended to include end-of-life care. He led the development and implementation of the NHS Cancer Plan in 2000, the Cancer Reform Strategy in 2008 and Improving Outcomes: A strategy for cancer in 2011.

He was a consultant medical oncologist between 1986 and 1995 and Professor of Palliative Medicine between 1995 and 1999 at Guy's and St. Thomas' Hospitals.

He was appointed CBE in 2001 and was awarded a Knighthood in 2010.

Kay Sheldon
Non-executive director

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

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

She was a trustee of Mind for five years. Prior to that, she was Co-Chair of Mind Link, Mind's service user network.

Andrea Sutcliffe
Chief Inspector of Adult Social Care

Andrea Sutcliffe became Chief Inspector of Adult Social Care in October 2013. She joined CQC from the Social Care Institute for Excellence where she was Chief Executive from April 2012.

She has nearly 30 years' experience in health and social care, managing a range of services including those for children and older people. Previously she was Chief Executive of the Appointments Commission and was an executive director at the National Institute for Health and Clinical Excellence for seven years.

She is an advocate of the use of social media to share information and learn from others. She blogs regularly for sites such as the Guardian Social Network and on the Social Care Institute for Excellence website.

6. Our Executive Team

CQC's Executive Team consists of:

- David Behan
- Dr Paul Bate
- Professor Steve Field
- Professor Sir Mike Richards
- Andrea Sutcliffe

and

Eileen Milner
Director of Corporate Services

Eileen Milner's career spans senior roles in public service advisory work in the UK and internationally, specialising in education and welfare reform. She joined CQC from Northgate Information Solutions where she was Executive Director Business Strategy.

She began her career as a graduate trainee in local government where she specialised in managing education services. From there, she became an academic specialising in public sector reform. She then worked for consultants RSM Robson Rhodes, providing advice to a range of public sector organisations.

She is a trustee of the Bell Foundation, which aims to create opportunities and change lives through language education for excluded individuals and communities.

Hilary Reynolds
Director of Change

Hilary Reynolds joined CQC on secondment from the Department for Work and Pensions, where she was responsible for benefit delivery and welfare reform implementation.

Prior to the Department for Work and Pensions, she was responsible for front line social sector services in New Zealand for three years. She has worked in public service for 27 years, mostly in the welfare sector, policy, change and operational delivery roles.

She holds a Masters degree in Business Administration from Henley Management College.

Corporate governance and financial statements

Strategic report and Directors' report

Remuneration report

Statement of Accounting Officer's Responsibilities

Governance statement

- Annex 1: Board and Committee structure and membership
- Annex 2: Summary of Board member attendance
- Annex 3: Executive team and Committee structure and membership
- Annex 4: CQC'S interim senior management structure to October 2013
- Annex 5: CQC'S current senior management structure
- Annex 6: Board business 2013/14

The Certificate and Report of the Comptroller and Auditor General to the Houses of Parliament

Financial statements

Notes to the financial statements

Strategic report and Directors' report

1. Review of activities

In April 2013 we published our strategy for 2013-16, Raising Standards, Putting People First. The strategy proposed radical changes to the way we regulate health and social care services, and followed extensive consultation with the public, our staff, providers and key organisations. The changes we set out acted on the recommendations of Robert Francis' report into the failings of Mid Staffordshire NHS Foundation Trust and the Government's response to those catastrophic failings. They also reflect the report into the abuse of people with learning disabilities at Winterbourne View hospital, Professor Kieran Walshe's evaluation of our work, Deloitte's report into how we carry out investigations and Grant Thornton's Review of our regulatory activity at Morecambe Bay NHS Foundation Trust.

In 2013/14 we began the transformation in how we monitor, inspect and regulate health and adult social care services. We appointed three new Chief Inspectors – of Hospitals, Adult Social Care, and General Practice. They have begun the work of introducing the changes in their sectors; first in the acute sector with the publication of our intelligent monitoring data, and the start of inspections with specialist and expert teams. Across the wider organisation, our new structure is in place and recruitment has commenced for vacant posts.

We also completed our inspection programme for 2013/14 in March 2014, completing inspections at 30,334 locations.

2. Our priorities for 2014/15 and 2015/16

In our business plan for 2014/15 and 2015/16, we set out the key deliverables and milestones for the introduction of these changes. These will be delivered through nine priorities under three headings:

- Putting people's views at the heart of everything we do, improving how we listen to people who use services, the public, and staff providing care (Priority 1);
- Introducing the new approach to how we monitor, inspect, regulate and take enforcement action, and work with other regulators and partner organisations (Priorities 2-6);
- Supporting all our staff to deliver our inspection, monitoring and regulation, through building a new, open, transparent culture and managing our resources effectively and efficiently (Priorities 7-9).

The business plan priorities in full are as follows:

Purpose: To make sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve:

Putting the views of people at the heart of everything we do:

1. Feedback from people who use services and from staff, including complaints, concerns and whistleblowing, is at the heart of our intelligent monitoring and our regulatory judgements.

Introducing the new approach to how we monitor, inspect, regulate and take enforcement action, and work with other regulators and partner organisations:

2. In the acute, mental health and community sectors.
3. In the adult social care sector, and develop monitoring of the finances of some adult social care providers.
4. In the primary medical care sector, and develop our approach to integrated care.
5. New registration – register organisations applying to provide care services – ensuring a commitment to deliver services that are safe, effective, responsive, caring and well-led.
6. Provide authoritative reports on major national health and social care quality issues, highlighting improvement and celebrating success.

Supporting all our staff to deliver our inspection, monitoring, regulation and other functions:

7. Build a transparent and 'just' culture; invest in training and development; assure our quality; and meet equalities, diversity and human rights commitments.
8. Implement a new knowledge and information strategy.
9. Manage our performance and resources effectively and efficiently; evaluate our impact, costs and benefits.

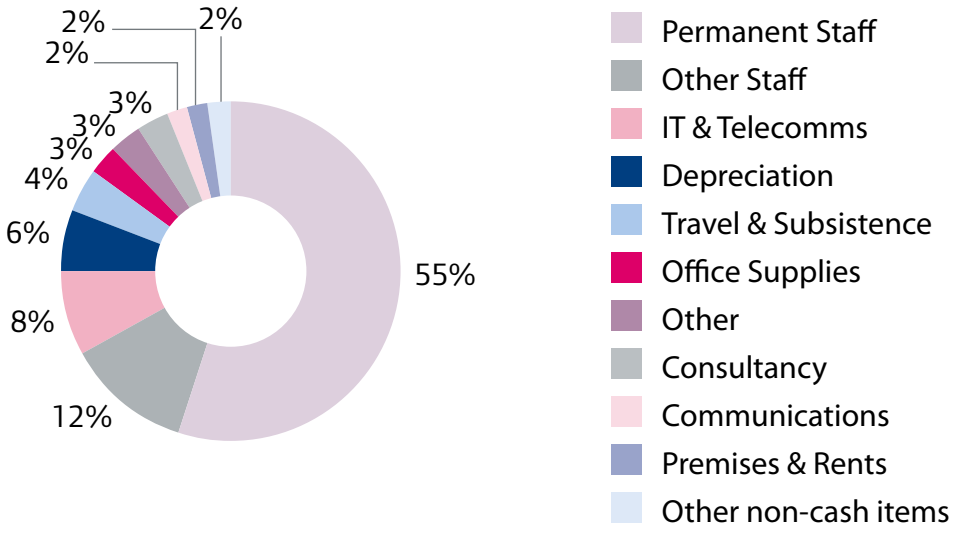
3. Financial performance and position

The following table summarises CQC's financial performance, with further detail shown in the Financial Statements:

	2013/14 £m	2012/13 £m	Change £m	Change %
Recurring expenditure	175	168	7	4
Transformation expenditure	19	–	19	100
Income	(101)	(93)	(8)	9
Net expenditure	**93**	**75**	**18**	**24**
Capital expenditure	9	11	(2)	(18)

Overall expenditure in CQC is broken down as follows:

CQC expenditure 2013/14 (Including transformation expenditure)



Recurring revenue expenditure: £175m

Our recurring revenue expenditure has increased by £7m year on year. The significant movements in relation to this budget are:

- CQC utilised a bank of temporary inspectors in year to help deliver our inspection programme in 2013/14, this also included payroll overtime costs for existing frontline staff and non-pay costs in setting up and supporting the bank programme. The cost of this was £5m in year.

- CQC followed up on a commitment to use more 'Experts by Experience' as part of our inspections. This represents an additional £1m spend from 2012/13 (this excludes acute sector inspections under the new methodology, captured under transformation funding).
- An external forensic audit of buildings' rates was carried in year for our London, Birmingham, Bristol and Nottingham offices. This resulted in CQC receiving a rebate back to 2009/10 in some cases, and a reduced rate for the remainder of 2013/14. The total saving in year was £3m.
- The cost of CQC's wage bill has increased by approximately £3m from last year (excluding the bank element mentioned above) as a result of
  - The annual cost of frontline inspectors recruited during 2012/13.
  - The impact of the pension 'opt in' directive for employees.
- Within the recurring budget there was a £1m reduction in consultancy spend. The main focus of consultancy spend in year was within the transformation programme as detailed below.
- Healthwatch England's costs have increased by £2m (£1m pay and £1m non-pay). The increase is reflective of Healthwatch England's first full year of operation.

Transformation expenditure: £19m

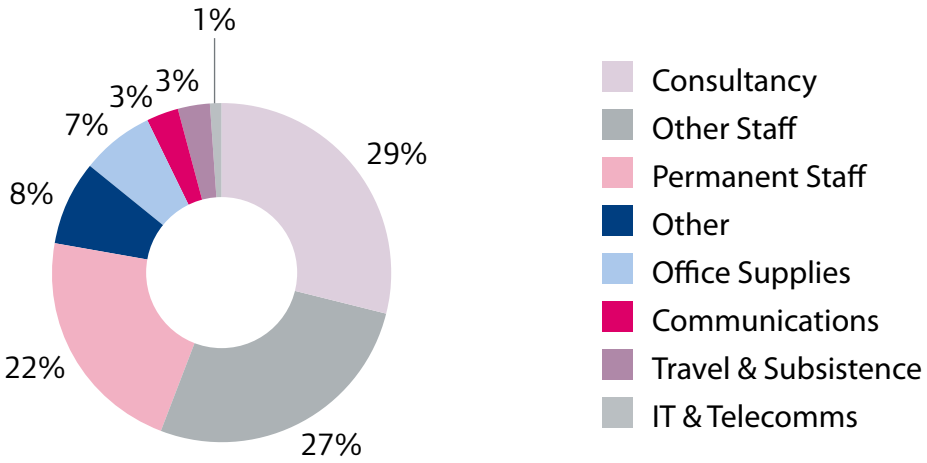
CQC is transforming how we regulate and inspect across all health and social care. To enable delivery of this work, CQC received an additional £19m funding from the Department of Health in 2013/14 which is represented by Transformation expenditure in the above table.

In 2013/14 this funding enabled CQC to build our approach to inspection across all sectors and ensure it meets the requirements of people who use care services. This work has involved:

- Designing and delivering the first waves of inspection with acute hospital services. The inspections involve a team of clinical professionals, experts by experience and CQC staff.
- Provide intelligence monitoring to help decide where and what to inspect.
- Evaluate our approach following wave inspections to improve and enhance our methodology.
- Re-design the organisational structure of CQC and begin recruiting to new executive and frontline posts.
- Engage with internal and external stakeholders over our new approach.

The table below shows how the transformation funding has been spent.

Transformation expenditure 2013/14



I. Permanent staff costs relate to internal secondments requiring backfill. It also includes the first year costs of the new executive team in CQC.

II. Other staff costs cover both additional temporary staff supporting the programme and clinical professionals assisting on wave inspections.

III. Consultancy spend covers various procurements (see Consultancy expenditure below)

IV. Other spend mainly relates to recruitment costs and training and development.

Consultancy spend: £6m

CQC spent £5.8m in 2013/14 on expert external advice. The majority of this spend (96%) was in relation to our transformation programme, the most significant being support for the delivery of waves inspections, ensuring continuity from the 'Keogh review' and to transfer skills and expertise to CQC staff for future inspections.

The below table provides details on the consultancy contracts agreed in 2013/14 over £100,000 (figures shown include VAT and expenses):

Requirement	Support for Wave 1 of Acute Hospitals Inspection		
Deliverables	Consultancy support to give continuity from the 'Keogh Review' of 14 Trusts, to ensure successful delivery of Wave 1, and to transfer skills and expertise to internal staff for future waves of inspections.		
Framework	Consultancy One Framework Competition		
Approval month	Aug-13	**Length**	6 months
Value	£1,835,971	**Supplier**	PWC

Requirement	Develop CQC's Information Function to support risk based approach		
Deliverables	Assessment of current approaches to data capture and analysis		
Framework	Multi-disciplinary Framework		
Approval month	May-13	**Length**	4 months
Value	£1,300,080	**Supplier**	McKinsey & Co

Requirement	Wave 2 Acute, Wave 1 Mental Health & Community Trust Inspections (PMO)		
Deliverables	Consultancy support to provide project management and logistics support ensuring continuity from the first wave of hospital inspections and to ensure successful delivery of the new mental health and community services inspection model.		
Framework	Consultancy One Framework Competition		
Approval month	Oct-13	**Length**	5 months
Value	£1,431,557	**Supplier**	PWC

Requirement	Organisational Design		
Deliverables	Creation of a stakeholder engagement and communications strategy plan, People Transition Policy and Approach and Competency & Skills Framework and Knowledge Transfer Plan.		
Framework	Consultancy One Framework Competition		
Approval month	Oct-13	**Length**	3 months
Value	£433,937	**Supplier**	PWC

Requirement	Development of New Intelligent Monitoring System		
Deliverables	Consultancy support required to assist in the development of the intelligent monitoring component for a) primary care services and b) community health services.		
Framework	Consultancy One Framework Competition		
Approval month	Oct-13	**Length**	5 months
Value	£297,519	**Supplier**	KPMG

Requirement	To review the CQC regulatory activity in relation to UHMB following the conclusion and publication of the Commission's investigation of the Trust		
Deliverables	Whether the CQC regulation of UHMB was proportionate transparent and timely given the legal, regulatory and geographical context of the Trust; and the organisation context of CQC during the period April 2009 to date.		
Framework	Multi-disciplinary Framework		
Approval month	Aug-12 Initially	**Length**	12 months
Value	£247,364	**Supplier**	Grant Thornton

Requirement	Logistics & Design of CQC New Regulatory Model		
Deliverables	Consultancy support required to design and populate the methods and tools CQC needs to deliver new approach inspections – across acute care, mental health services, community health services, primary care and adult social care		
Framework	Consultancy One Framework Competition		
Approval month	Oct-13	**Length**	5 months
Value	£241,468	**Supplier**	KPMG

Capital expenditure: £9m

Our capital expenditure has decreased by £2m year on year. This is reflective of our period of change, where the focus has been planning system requirements and ensuring they provide a sustainable platform in line with the strategic direction of CQC.

The majority of the expenditure incurred in year ensured that our current systems support new or changed business activity or was to improve operational efficiency, data quality or reporting capabilities.

There was further emphasis on CQC's digital capabilities, with expenditure developing our online capabilities for registration and notifications and further development of our website to publish the new inspection information, all of which aims to improve the experience and interaction the public and providers have with CQC.

Other expenditure included IT hardware to ensure that staff have the right equipment to carry out their roles effectively.

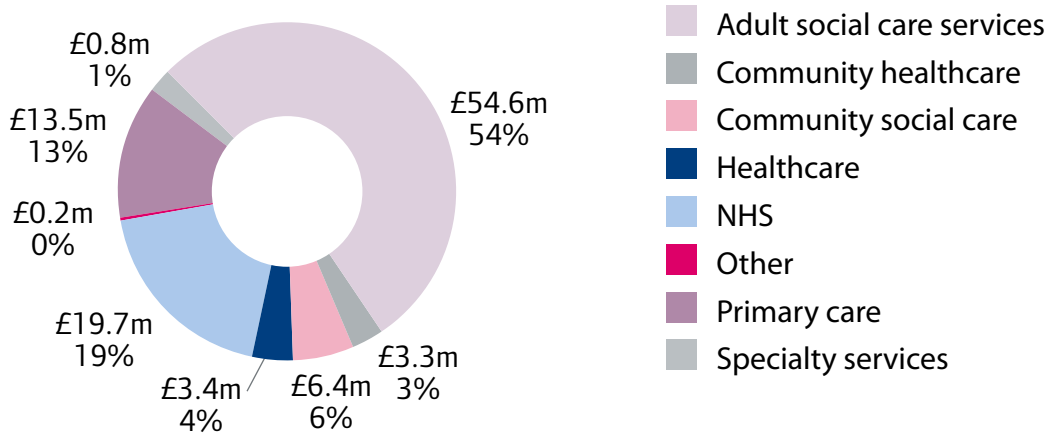
Income: £101m

Income increased by £8m year on year, this is primarily through the introduction of GPs to registration in 2013/14, accounting for £5m of the income in year.

The remaining increase in fee income is reflective of:

- Minor amendments to the annual fee scheme (£2m).
- A lower deferred income balance (£1m) compared to 2012/13, this can be seen under the Statement of Cash Flows.

Income by sector



(The graph excludes Income in advance and DH funding)

Grant-in-aid

CQC's net expenditure is funded from grant-in-aid provided by the Department of Health. Grant-in-aid totalled £87.3m (2012/13: £68.1m).

4. Key performance indicators

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

	2013/14 target	2013/14 outturn	2012/13 outturn
Registration			
Number of applications received	N/A	48,472	Reported from 2013/14
% of applications completed within target (less than 8 weeks)	90.0%	78.5%[7]	86.0%
Compliance inspections			
NHS trusts with at least one scheduled inspection undertaken	100% of plan[1]	280[1] (99.3% of plan)	318 (99.3% of plan)
Adult social care locations with at least one scheduled inspection	100% of plan[2]	22,066 (100% of plan)	22,250 (100% of plan)
Independent health care locations with at least one scheduled inspection	100% of plan[3]	1,888 (100% of plan)	2,117 (100% of plan)
Dentist locations with at least one scheduled inspection undertaken	100% of plan[4]	4,389 (100% of plan)	3,682 (104% of plan)
Independent ambulance locations with at least one scheduled inspection	100% of plan[5]	165 (100% of plan)	216
Primary medical services locations with at least one scheduled inspection	100% of plan[6]	1,546 (104% of plan[6])	Reported from 2013/14
Number of responsive inspections completed (responsive inspections are undertaken outside of scheduled inspections, where we have concerns about whether essential standards are being met)	N/A	1,654[8]	Reported from 2013/14
Enforcement action			
Number of warning notices served	N/A	1,456	910
Number of prosecutions	N/A	0	1
Urgent suspensions of registration or urgent variation or imposition of conditions using section 31 powers	N/A	4	6
Mental Health Act function			
Number of MHA Commissioner visits to mental health service locations	95% of plan	1,227 (97% of plan)	1,090

	2013/14 target	2013/14 outturn	2012/13 outturn
Complaints, governance information and call handling			
Number of requests under			
a) Freedom of Information (FOI)	N/A	845	
b) Data Protection (DP)	N/A	192	1,144
c) Information Sharing (IS)	N/A	109	
FOI responsiveness rate – % responded to within 20 working days	N/A	93%	97.2%
DPA responsiveness rate – % responded to within 40 calendar days	N/A	94%	96.0%
IS responsiveness rate – % responded to within 20 working days	N/A	96%	Reported from 2013/14
Number of calls received at the National Customer Services Centre	N/A	238,621	201,862
(%) answered within 30 seconds			
a) Safeguarding calls	90.0%	91.1%	94%
b) Mental health	90.0%	92.6%	96%
c) Registration	80.0%	83.1%	84%
The number of whistleblowing contacts CQC received	N/A	9,473	8,634
The number Stage 1 corporate complaints received proceeding to Stage 2	N/A	86	83

[1] All NHS acute hospital locations inspected that are registered during 2013/14. Non-acute hospital providers inspected on the basis of risk. The 2013/14 outturn includes the number of locations for NHS acute hospitals and the number of providers for NHS non acute hospitals.

[2] All adult social care locations registered as at 1 April 2013 (and active at time of inspection).

[3] All independent health care locations registered as at 1 April 2013 (and active at time of inspection), except locations which fall into a number of low risk categories. These are inspected at least once every 2 years.

[4] All dental services locations registered as at 1 April 2013 (and active at time of inspection) and that have not had an inspection since registration.

[5] All independent ambulance locations with the regulated activity 'Treatment of disease, disorder or injury' (TDDI) registered as at 1 April 2013 (and active at time of inspection). Non urgent ambulance services (do not provide TDDI) inspected at least once every 2 years (i.e. if they were inspected during 2012/13 one would not be required during 2013/14 unless we chose to on the basis of risk or new information).

[6] From June 2013 we undertook to inspect 20% of primary medical service providers selected on the basis of risk or random selection from those registered as at 1 April 2013 (and active at time of inspection).

[7] Assess the efficiency of applications when they are received by the regional registration assessors. Applications are first processed by our customer service centre. 92% of applications at the centre are processed within 5 days. The decrease in performance is due to a significant increase in the number of applications processed and a more thorough approach to the assessment of registration applications.

[8] The number of responsive inspections is based on the date of the first site visit.

5. Risks and uncertainties going forward

CQC's Board has identified a number of strategic risks to meeting our purpose and objectives. These risks are reviewed at each meeting of the Board and the Audit and Corporate Governance Committee provides assurance to the Board that the arrangements in place for managing these risks are robust.

Continuing risks

- Risk that inspection fails to pick up significant provider risk and failure, and that CQC does not act appropriately based on the findings of the inspection.
- Risk that the public, professionals and politicians lose confidence in CQC if we do not take appropriate action when evidence suggests it is necessary.
- Risk that intelligent monitoring fails to pick up significant provider risk and failure that CQC does not act appropriately on what our monitoring indicates.
- Risk that if we do not embed transformational change well CQC will not improve or deliver its purpose.
- Risk that CQC does not listen to the public and stakeholders, respond effectively to the support and advice given or meaningfully build user voice into our regulatory approaches.
- Risk that CQC fails to recruit and retain staff with the skills and experience required to help the organisation to improve.
- Risk that without clear information strategy, we will not support new approaches to information management and technology, or effectively manage our information and the risks associated with it.

Recently added risks

- Risk that without a sound basis for making ratings decisions, CQC could get significant volumes of appeals which absorb significant inspector and legal resource.
- Risk that if CQC does not set up a robust market oversight function we will fail to spot market failure, leaving service users at risk or in a vulnerable position.
- Risk that without a robust and clear approach to registering providers CQC will miss an opportunity to prevent potential poor quality care provision.
- Risk that if CQC does not have robust evidence management processes and controls the organisation may lose valuable evidence, make poor decisions, not fulfil its role as a regulator or be subject to external challenge by providers.
- Risk that CQC cannot financially sustain its new approaches to regulation and has to either increase fees or significantly reduce its costs.
- Risk that CQC does not, or cannot, demonstrate that it delivers value for the money it receives, which has an impact on its ability to generate future grant and fee income.

These risks are kept under review during the year through discussions with Executive Team risk owners. These risks are detailed in the governance statement.

6. Information security

Information security and associated controls have continued to be improved throughout 2013/14. We have built on the already established information security management system and have made improvements in the areas of monitoring, education and awareness as well as the implementation of new technical and procedural controls.

Information security has been obtained from a number of sources throughout the year including:

- IT infrastructure security systems reports.
- Internal and external audit reports.
- Incident reporting and management.
- Security training education completion reports.
- Information risk management.
- Staff surveys and feedback.

We have examined our responsibilities for information security and associated risk management in line with the Senior Information Risk Owner (SIRO) requirements. These ensure that we are continuing to discharge our responsibilities according to Her Majesty's Government security policy framework.

Security incident analysis and response has been carried out during the year with appropriate reporting to the SIRO and the Audit and Governance Committee. We have also continued to liaise with the Department of Health, NHS England and the Information Commissioner's Office.

The internal Information Governance group has met monthly to monitor and manage work for both information governance and security. This has ensured that CQC continues to comply appropriately with relevant legislation and guidance. It has also ensured that the correct level of support to the rest of CQC is in place to help improve the safety and care of people who use services.

CQC completes the annual Information Governance Toolkit return, coordinated by the Health and Social Care Information Centre. Improvements this year in our information governance practices and information systems have resulted in a score of 84% (rising from 69% in 2012/13). Our overall rating is now classed as 'satisfactory' as we are able to demonstrate and evidence acceptable compliance in all of the requirement areas of the Toolkit.

7. Freedom of information

We published a wide range of information about our activities, as specified in our freedom of information publication scheme. Our Information Access Team also handles requests, such as those made under the Freedom of Information Act 2000 and the provisions of the Data Protection Act 1998. The team also responds to formal information sharing requests from other public bodies.

8. Employment, health and safety and environment policies

8.1. Employee consultation and engagement

CQC recognises UNISON, the Royal College of Nurses, the Public and Commercial Services Union (PCS), Unite and Prospect for the purposes of collective bargaining and consultation. The number of union members has fallen slightly this year with 40% of our employees being union members. All of our staff are represented by the Staff Forum. Throughout the year both the unions and the Forum have been actively engaged in our organisational transformation process. By participating through the formal consultation process and contributing to the various change programme boards, both these bodies have ensured that the views of colleagues within CQC were represented and that the decision-making process was open and transparent.

CQC believes that employee engagement is fundamental to organisational success and have actively sought employee views on how we can improve the work we do. This year our staff survey showed that 82% of colleagues across CQC were positive that the organisation was changing for the better and our employee engagement score increased by 8 points over last year's score. Repeated year-on-year improvements in this score have resulted in a cumulative increase of 22 points over our first survey in 2010.

Our ongoing conversations to inform and consult with the Joint Negotiation and Consultation Committee (JNCC) of the unions and engage with the Staff Forum continue to be based around a strategic, forward-looking agenda, which allows them to clearly understand and contribute to our strategic objectives. The unions and Staff Forum have worked in partnership with CQC on a number of strategic initiatives, such work as the preparation and analysis of the staff survey and production of staff survey action plans, the future strategic direction of CQC, and improvements to the performance development review process and how it is applied. During the height of the transformation period, the joint unions met with management on an almost weekly basis to receive updates on progress and work collaboratively to identify and solve staff queries before they became issues.

The local Joint Consultative Committees have also continued to meet on a regular basis to address local issues for staff. Matters that have a potentially wider scope are referred to the JNCC. Topics typically discussed could include the review of local staff survey action plans, health, safety and well-being, plus facilities and office management and other matters that could improve the local working environment.

Our Staff Forum also plays a valuable role in representing the voice of all our employees and has representatives located throughout the country. The Forum provides management with information on how colleagues within CQC are responding to what is happening within the organisation. In addition to raising colleagues' concerns via the monthly meetings and the sharing of written questions and answers, the Forum provides an informed view on where the policy could be updated for the benefit of CQC or where our communications need to be more effective to reach all staff groups. The Forum chooses special project themes annually. For 2013/14 they decided to focus on the areas of improving morale, continuing to reduce bullying and harassment and improving communications within CQC.

Our three equality networks: the Lesbian, Gay, Bisexual and Trans Equality (LGBT) Network; the Race Equality Network; and the Disability Network, work to promote diversity and equality in CQC, to challenge views and strive to ensure dignity for all CQC employee groups. Each network is sponsored by a member of our Executive Team. The Chief Executive closed the London event marking LGBT History Month in February and meets regularly with the chairs of the Diversity Networks.

8.2 Employment and policies

Most of our policies have now superseded those of our predecessor organisations. We have developed a Code of Conduct policy which has been through the consultation process with the unions and Staff Forum. Managers have been trained on the key issues and this is now on the CQC intranet.

During the remainder of 2014 we have a number of key policies that need reviewing. We have already held workshops for the Grievance and Zero Tolerance on Bullying and Harassment policies with a group of CQC staff at all levels to gain their feedback on improvements, to ensure that the policies are more robust and easier to interpret.

8.3 Home-working

Home-working forms the contractual arrangement for 1,459 members of staff and is the principal working arrangement for our inspectors who are two-thirds of our workforce. It is also one of a number of flexible working options that form part of CQC's commitment to help improve the work-life balance of our employees.

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

8.4 Health and safety

We continue to drive improvements and enhance our range of health and safety support across our estate and all our activities with the focus this year on reviewing role specific and directorate risk assessments.

We continue to proactively monitor all our offices, activities and services to ensure robust health and safety management. We have enhanced our corporate health and safety induction, local health and safety training and reviewed our personal safety training modules.

This year we have joined 10 health bodies in pledging to improve the health and well-being of our staff, under the 'Healthier Staff – Higher Quality Care' commitments.

Our Chief Executive, David Behan, signed up to all the pledges and this has been a foundation to launch our new health and well-being strategy. We have linked all our health, safety and well-being under one function to provide a proactive advice, guidance and supportive service.

The health and well-being strategy has focused on ensuring our support for those with chronic health conditions is best practice. We have enhanced our reasonable adjustments and launched events and intranet pages to raise awareness and support with a specific focus on mental health issues in the work place.

During this year we had 35 work-related accidents/near misses, with five considered serious (i.e. reportable to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences' Regulations). The five were made up of 1 slip and trip, 3 road traffic accidents and 1 physical assault.

All accidents, incidents and near misses are fully investigated by competent health and safety professionals, and remedial actions and lessons learned and shared across the Commission through the governance of our National Health and Safety Committee.

2014/15 will see us embed and improve our health, safety and well-being strategies across our estate and continue to work to maximise our relationships with all our stakeholders, contractors and partners.

8.5 Sickness absence data

During 2013/14 the average number of long-term days sickness per employee was 7 (2012/13: 10 days) and the average number of short-term days sickness was 3 (2012/13: 4 days). The reduction in long-term sickness is in part due to improved staff morale (2013 staff survey – Satisfaction has risen from 48% positive in 2012 to 61% positive now) and also to the attendance management policy which has enabled CQC to manage attendance more effectively.

8.6 Employee gender data

Number of staff as at 31 March 2014	Board members	Directors	Total Employees
Male	5	7	722
Female	4	4	1,592

Number of staff as at 31 March 2013	Board members	Directors	Total Employees
Male	4	3	689
Female	2	3	1,519

8.7 Sustainability duty

Our sustainability aim is to reduce the impact of our business on the environment. Our priority is to reduce our carbon dioxide (CO_2) emissions. Managing efficient use of our IT systems and accommodation is an important strand of this work. Sustainability should be a key driver for our work on flexible working, as well as consolidating our accommodation by continually reviewing our estates strategy.

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

About our data

As all but one of our offices is supplied via landlord service charge, with bills presented on a pro rata m^2 basis rather than actual consumption data, there may be some limitations to the accuracy of our financial and non-financial sustainability data. This year landlords have been more proactive with their reporting, and therefore figures for this financial year are more accurate than in previous years.

Carbon dioxide emissions

Area	CO_2 emissions (tonnes)	2013/14 Units	2013/14 Cost £	Performance against 2012/13
Building energy	1,364	3,916,435 (kWh)	322,421	Improving
Travel (rail)	500	5,699,286 (m)	2,999,845	Increasing
Travel (road)	1,572	5,134,143 (m)	2,331,852	Increasing
Total	**3,436**	**N/A**	**N/A**	

Non-financial indications (CO_2)	2012/13	2013/14
Gross emissions (buildings)	1,560	1,364
Gross emissions (business travel)	1,591	2,072
Total	**3,151**	**3,436**

Financial indications (£)	2012/13	2013/14
Expenditure on official business travel	4,451,340	5,327,697

Performance

40% of our reported CO_2 emissions are from electricity and gas used in the buildings. The emissions are falling from the 2009/10 baseline figure due to investment in energy saving initiatives.

CO_2 emissions from rail and car travel have increased because we have a bigger workforce and more activity during a period of business transformation. There has been an increase in the cost of rail travel mainly due to fare increases imposed by rail companies in 2013.

Targets

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

Managing energy use from buildings

Performance

Energy consumed in our buildings is falling against the 2009/10 baseline. This is because we have invested in energy initiatives, and have tighter controls on heating, cooling and lighting.

Non-financial indicators – energy consumption (kWh)	2009/10	2011/12	2012/13	2013/14
Electricity: non-renewable	N/A	N/A	N/A	N/A
Electricity: renewable	3,641,075	2,962,050	2,580,978	2,463,736
Gas	2,004,344	1,127,011	1,155,550	1,452,699
Total (kWh)	**5,645,419**	**4,089,061**	**3,736528**	**3,916,435**

Financial indicators (£)	2009/10	2011/12	2012/13	2013/14
Total energy expenditure	525,935	372,654	355,421	322,423

Managing water usage

Performance

CQC's water usage is almost exclusively from washrooms, showers, kitchen preparation areas, cleaning and the restaurant facility in our Finsbury Tower head office in London. The water usage has decreased by 3%; the costs are slightly higher than 2012/13.

Targets

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

Non-financial indicators	2009/10	2011/12	2012/13	2013/14
Water consumption (m^3) supplied	16,388	16,418	14,164	13,717

Financial indicators (£)	2009/10	2011/12	2012/13	2013/14
Total energy expenditure	N/A	15,732	15,498	15,860

Managing office waste

Performance

Our office waste typically comprises: paper, cardboard, food and drink waste and IT packaging.

Targets

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

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

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

Non-financial indicators (tonnes)	2009/10	2011/12	2012/13	2013/14
Non-hazardous waste – landfill	27	130	159	115
Non-hazardous waste – reused/ recycled	143	152	212	217
Total waste	**170**	**282**	**371**	**332**

Financial indicators (£)	2009/10	2011/12	2012/13	2013/14
Total disposal costs	N/A	48,021	58,206	59,583

Sustainable procurement

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

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

Central contracts managed by the procurement team are also considered for their use of recycled contents, ability to monitor CO_2 emissions and adherence to the equality and diversity act.

9. Estates strategy

The CQC estates strategy aims to have an estate which best supports our new approach and is of fundamental importance to building and sustaining the success of our organisation. This is both in terms of the practical (where do we locate our extra staff?) and the cultural (how do our buildings reflect how we want people to connect with and 'belong' to CQC?).

Our ambition is twofold – to ensure we maintain organisational resilience as we expand as an organisation and end points to our existing leases demand us to make decisions; but also to ensure we make the long-term strategic decisions that will result in us having a permanent estate in place to cater appropriately and proportionately for all of our staff's needs by April 2016.

At present our estate is spread across seven buildings, providing us with 1,281 desks. We have 1,000 members of staff who are permanently office based, and 1,400 who are officially home workers. By April 2016 we will have 3,200 staff. If the current split between home/office based working continues, we will have almost 1,500 staff who are 'estate based' and 1,700 who are designated as being part of a home-based workforce.

Our broad estates strategy is based upon all CQC functions being based across three different types of estate:

a) Central HQ (single location) – functions which are required to be office-based and located in a single central location close to Westminster. For example, Chief Executive's private office, Chief Inspectors, Executive Directors and Board Secretariat.

b) Regional offices (small number of locations of variable size) – functions which are required to be office based, but not located centrally. For example, NCSC, Finance, HR, Intelligence functions.

c) Hubs (larger number of locations of small size) – functions which are home-based, providing a community space for meetings and occasional office based working.

The development of 'hubs' is a departure from our current estates approach which is unable to offer all of our staff a 'local' office (for example, we know we have at least 50 staff who live over 100 miles from their nearest CQC office).

Our property lease events take place in the following order:

1) We must exit our Birmingham office by December 2014.

2) We serve notice on the commercial lease at our Leeds office by January 2015 and exit by January 2016.

3) We must serve notice on the commercial lease at our London office by May 2015 and exit by May 2016.

4) We must exit our Nottingham office by October 2016.

5) We may have to vacate our Preston office by October 2017 depending on the Department for Work and Pensions' plans for the building.

6) We must exit our Bristol office by November 2018.

7) We must exit our Newcastle office by August 2019.

The actions being taken to address the lease break or endings are as follows:

- Birmingham – we will move to suitable alternative premises before December 2014 and are currently formally appraising our options.
- Leeds – we are discussing with the Department of Health potential sharing options with other health bodies located in central Leeds with a view to appraising options in Autumn 2014.
- London – we will move to suitable alternative premises before May 2016 and are currently formally appraising our options.
- Nottingham – we moved into new premises in October 2013, no action is currently being taken with regard to future estate.
- Preston – we regularly meet with the Department for Work and Pensions and will continue to discuss their future plans for the building.
- Bristol – we are discussing future accommodation options with South West Government Property Unit and their place-based strategy identifies government premises at 2 Temple Quay as future accommodation.
- Newcastle – no action taken at present.

The development of 'hubs' is new for CQC, and one we see as potentially a major part of our estates strategy; namely to ensure all our home-working staff have a 'local' office. This is important for the large numbers of our people who currently live very large distances from their nearest office – particularly those who live in Cornwall, Norfolk, Suffolk or Hampshire.

The functions needed at the 'hubs' do not require a new 'CQC building' in the sense of our current estate. Instead, we see the solution as being to seek accommodation within government or local authority space where our staff can access these functions for a low overhead.

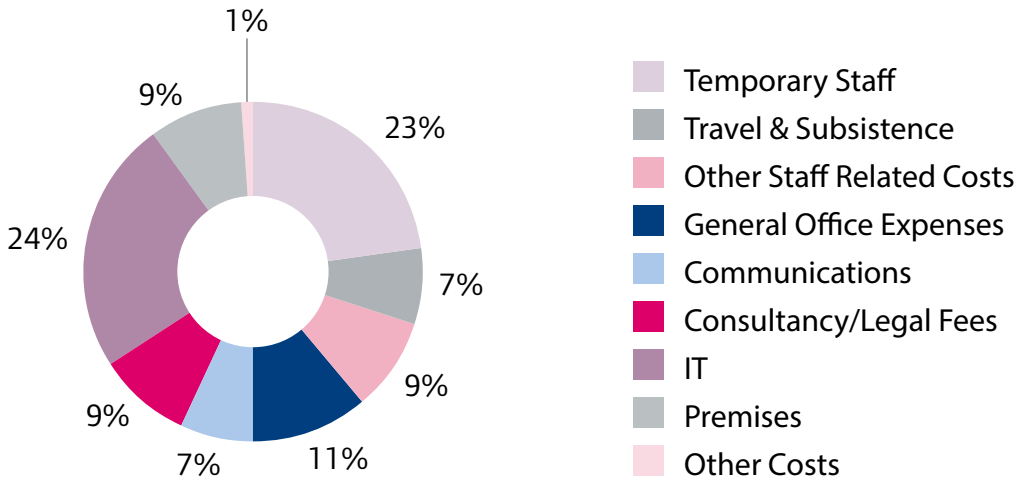
We will provide hubs in locations that best target staff currently isolated from our existing estate.

10. Contractual obligations

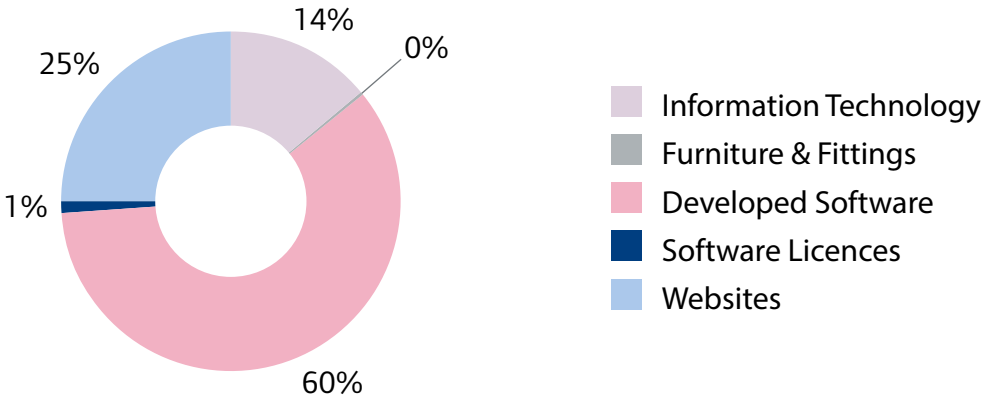
CQC uses Government frameworks wherever possible and we record all contracts on a centrally held register. All contracts over £10,000 are published on the Government Contracts Finder website. We also publish some tenders via the same website to attract the open market. Our largest contracts are with information communications technology (ICT) services suppliers: Atos Ltd, Computacentre UK Ltd, Cable & Wireless Worldwide PLC and Sapient Corporation. One of these contracts is owned by CQC (Cable & Wireless), which was procured prior to the Transparency agenda 2010. The Department of Health owns the other contracts. The recruitment contract with Hays Specialist Recruitment Ltd is also a large contract and is owned by the Government's Crown Commercial Services.

In 2013/14 CQC processed £67m (£59m revenue, £8m capital) of expenditure through existing or new contracts. The below table identifies the type of goods or services procured.

Revenue expenditure categorised by type of goods or services provided for the period Apr-13 to Mar-14



Capital expenditure categorised by type of goods or services provided for the period Apr-13 to Mar-14



Notes:

- This is based on the invoices processed in the period so may include invoices which relate to a prior period.
- The split between revenue and capital is based on the original distributions of the invoice so may have been reallocated following processing.

The top 25 suppliers for 2013/14, accounting for 81% of the procured spend, are shown in the following table:

Supplier Name	Revenue £'000	Capital £'000	Total £'000
Hays Specialist Recruitment Ltd	12,361	–	**12,361**
Department of Health	4,458	214	**4,671**
Computacenter (UK) Ltd	2,001	2,220	**4,221**
CSC Computer Sciences Ltd	3,761	193	**3,954**
Sapient Ltd	534	3,321	**3,855**
Redfern Travel Ltd	3,789	–	**3,789**
Pricewaterhouse Coopers	3,293	–	**3,293**
Calder Conferences Ltd	2,544	–	**2,544**
Communities & Local Government	2,102	–	**2,102**
McKinsey & Company	2,052	–	**2,052**
Axis12 Ltd	486	1,375	**1,861**
Atos Origin IT Services UK Ltd	1,376	–	**1,376**
Rockdell Property Management	1,034	–	**1,034**
Choice Support	894	–	**894**
Age UK	852	–	**852**
Cable & Wireless UK	842	–	**842**
Vodafone Ltd	783	–	**783**
Atos IT Services UK Ltd	754	14	**768**
Picker Institute Europe	746	–	**746**
Workman LLP	539	–	**539**
Serco Consulting	513	–	**513**
Supplies Team	404	–	**404**
Hempsons Solicitors	392	–	**392**
GVA Grimley Ltd	381	–	**381**
Brook Street (UK) Ltd	341	–	**341**
Total	**47,233**	**7,335**	**54,568**

Notes:

- This is based on the invoices processed in the period so may include invoices which relate to a prior period.
- The split between revenue and capital is based on the original distributions of the invoice so may have been reallocated following processing.

11. Off-payroll engagements

For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2014	69
Of which, the number that have existed:	
for less than one year at the time of reporting	42
for between one and two years at the time of reporting	19
for between two and three years at the time of reporting	2
for between three and four years at the time of reporting	3
for four or more years at the time of reporting	3

It is assumed that all existing off-payroll engagements were subjected to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought by the owner of the Framework contract.

For all new off-payroll engagements between 1 April 2013 and 31 March 2014, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	71
Number of new engagements which include contractual clauses giving the right to request assurance in relation to income tax and National Insurance obligations	63
Number for whom assurance has been requested	63
Of which:	
assurance has been received	63
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

Sixty-three new people were engaged under the Crown Commercial Service Non-Medical Non-Clinical Framework which included contractual clauses giving the right to request assurance in relation to income tax and National Insurance obligations. It is assumed that those assurances have been requested and received by the owner of the Framework contract. Eight new people were engaged under the Department of Health Information Services Flexible Resource Pool Framework which does not include the contractual clauses and therefore no assurances were requested.

	Number
Number of off-payroll engagements of Board Members, and/or senior officials with significant financial responsibility, during the financial year.	2
Number of individuals that have been deemed "Board Members, and/or senior officials with significant financial responsibilities" during the financial year. This figure includes both off-payroll and on-payroll engagements.	33

One senior official, employed as a Director of Change was seconded from the Department of Works and Pensions from 1 May 2013. The role is an interim role responsible for the delivery of the transformation programme.

One senior official, employed as an Interim Director of Intelligence from 5 October 2012 to 5 July 2013 was engaged off payroll due to the difficulty in recruiting permanently to a specialised role.

12. Better payment practice code

CQC's policy was to pay creditors in accordance with contractual conditions or, where no specific 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 2013/14, CQC processed 99.3% (2012/13: 98.4%) based on volume and 99.6% (2012/13: 99.6%) of invoices based on value within 30 days.

Following new guidance from the government in August 2010, CQC aimed to pay 80% of all undisputed invoices from our suppliers within five working days. In 2013/14, CQC paid 83.9% (2012/13: 76.8%) based on volume, and 91.1% (2012/13: 78.9%) based on value within five days.

13. Pension costs

The treatment of pension liabilities and the relevant pension scheme details are set out in note 1.3 on page 123 and in the Remuneration report on page 72.

14. Political and charitable donations

We made no political or charitable donations during the year.

15. Research and development

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

16. Form of account

Our financial statements have been prepared in the form directed by the Secretary of State for Health, in accordance with the Health and Social Care Act (2008), the Government Financial Reporting Manual (FReM) (2013/14) 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.

17. Going concern

Our financial accounts have been prepared on the basis that CQC is a going concern. Grants for 2014/15, which cover the amounts required to meet CQC's liabilities falling due that year, have been included in Department of Health estimates which were approved by Parliament.

18. Post statement of financial position events

There are no significant post Statement of Financial Position events.

19. Auditor

The Comptroller and Auditor General (C&AG) is appointed by statute to audit CQC and report to Parliament on the truth and fairness of the annual financial statements and regularity of income and expenditure. The total amount due for audit work is £145,000 (2013/14: £145,000). There was no remuneration paid for non-audit work during the year.

20. Availability of information for audit

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

David Behan
Chief Executive, Care Quality Commission
23 June 2014

Remuneration report

The following sections provide details of the remuneration (including any non-cash remuneration) and pension interests of Board Members, Independent Members, the Chief Executive and the Executive Team. The content of the tables is subject to audit.

Remuneration of the Chair and Board Members

Board members' remuneration is determined by the Department of Health on the basis of a commitment of two days per month, with the exception of John Harwood. His remuneration was based upon a commitment of three and a half days per month.

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

CQC reimburses its Chairman, Board and Independent Members for the cost of travelling to and from the Commission including for Board meetings and for events at which they represent CQC. CQC meets the resultant tax liability under a settlement agreement with HM Revenue & Customs. For 2013/14 the total amounts were £10k (2012/13: £27k).

Chairman and Board Members' emoluments

	Date appointed	2013/14 total salary £000	2012/13 total salary £000
David Prior (Chair)	28 Jan 2013	60 – 65	10 – 15[1]
Kay Sheldon	1 Dec 2008	5 – 10	5 – 10
Anna Bradley	16 Jul 2012	45 – 50[5]	30 – 35[3]
Camilla Cavendish	1 Jul 2013	5 – 10[2]	–
Paul Corrigan	1 Jul 2013	5 – 10[2]	–
Michael Mire	1 Jul 2013	5 – 10[2]	–
Louis Appleby	1 Jul 2013	5 – 10[2]	–
Jennifer Dixon	1 Jul 2013	5 – 10[2]	–
John Harwood (appointment expired 3 Mar 2014)	4 Mar 2010	10 – 15[4]	5 – 10
Steve Hitchins (resigned 18 Dec 2013)	9 Jul 2012	5 – 10[2]	5 – 10[2]
Jo Williams (Chair, resigned 27 Jan 2013)	1 Oct 2008	–	45 – 50[1]
Deirdre Kelly (resigned 31 Jan 2013)	1 Oct 2008	–	10 – 15[4]
Martin Marshall (appointment expired 31 Dec 2012)	1 Jan 2009	–	5 – 10[2]

[1] Full year equivalent salary £60 – 65k
[2] Full year equivalent salary £5 – 10k
[3] Full year equivalent salary £40 – 45k
[4] Full year equivalent salary £10 – 15k. John Harwood received enhanced payment as Audit Chair.
[5] Anna Bradley's enhanced remuneration is a result of her Healthwatch role.

Payments to independent members

Julian Duxfield was an independent member of CQC's Remuneration Committee. Fees and expenses are paid on a per meeting basis and amounted to £3k for 2013/14 (2012/13: £3k).

John Butler and David Prince were independent members of CQC's Audit and Corporate Governance Committee. Fees and expenses are paid on a per meeting basis and during 2013/14 amounted to £8k for John Butler (2012/13: £12k) and £5k for David Prince (2012/13: £5k).

Alan Gillies, Dilys Jones and Christine Munns were independent members of CQC's National Information Governance Committee. Fees and expenses are paid on a per meeting basis and during 2013/14 amounted to £2k for Alan Gillies (2012/13: £nil), £0.3k for Dilys Jones (2012/13: £nil) and £3k for Christine Munns (2012/13: £nil).

Remuneration of the Chief Executive

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

Remuneration of the Executive Team

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

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

The Executive Team had a contractual entitlement to be considered for a bonus up to 10% of salary for performance in the year 2013/14. However both the Remuneration Committee and the Executive Team were of the view that it would not be appropriate for the Executive Team to accept individual bonuses in the current circumstances.

For the Chief Executive and Executive Team, early termination other than for gross misconduct (in which no termination payments are made), is covered by their contractual entitlement under CQC's Redundancy Policy (or their previous legacy Commission's redundancy policy if they transferred). The Executive Team has three months' notice of termination in their contracts. Termination payments are made only in appropriate circumstances and may arise when staff are not required to work their period of notice. They may also be able to access the NHS Pension Scheme arrangements for early retirement depending on age and scheme membership. Any amounts disclosed as compensation for loss of office are also included in the notes to the financial statements, note 3.3 exit packages.

Salary includes gross salary, overtime, recruitment and retention allowances and any other allowance to the extent that it is subject to UK taxation. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Payments in kind are the estimated value of any benefits received by the person otherwise than in cash that are not disclosed elsewhere in the remuneration report.

2013/14	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits (bands of £2,500) £000	Compensation for loss of office (bands of £5,000) £000	Total (bands of £5,000) £000
David Behan Chief Executive	185-190	–	–	–	60-62.5	–	**250-255**
Paul Bate Director of Strategy & Intelligence	120-125[1]	–	–	–	–[15]	–	**120-125**
Michael Richards Chief Inspector of Hospitals	150-155[2]	–	–	–	–[15]	–	**150-155**
Stephen Field Chief Inspector of General Practice	85-90[3]	–	–	–	–[15]	–	**85-90**
Andrea Sutcliffe Chief Inspector of Adult Social Care	70-75[4]	–	–	–	–[15]	–	**70-75**
Eileen Milner Director of Corporate Services	30-35[5]	–	–	–	–[15]	–	**30-35**
Malcolm Bower-Brown Regional Director of Operations, North	40-45[6]	–	–	–	12.5-15	–	**55-60**
Andrea Gordon Regional Director of Operations, Central	40-45[6]	–	–	–	10-12.5	–	**50-55**
Adrian Hughes Acting Regional Director of Operations, South	35-40[7]	–	–	–	85-87.5	–	**120-125**
Matthew Trainer Regional Director of Operations, London	35-40[8]	–	–	–	5-7.5	–	**40-45**
Allison Beal Director of Human Resources & Interim Director of Corporate Services	110-115	–	–	–	–	–	**110-115**

2013/14	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits (bands of £2,500) £000	Compensation for loss of office (bands of £5,000) £000	Total (bands of £5,000) £000
Philip King Director of Regulatory Development	55-60[9]	–	–	–	–[15]	–[17]	**55-60**
John Lappin Director of Finance & Corporate Services	45-50[10]	–	–	–	5-7.5	–	**50-55**
Christopher Day Interim Director of Strategic Marketing & Communications	10-15[11]	–	–	–	7.5-10	–	**20-25**
Louise Guss Director of Governance & Corporate Services	15-20[12]	8[14]	–	–	–[16]	–[17]	**15-20**
Amanda Sherlock Director of Operations	20-25[13]	–	–	–	–[16]	–[17]	**20-25**

1 Paul Bate, appointed 13 May 2013, full year equivalent salary £140-145k.
2 Michael Richards, appointed 16 July 2013, full year equivalent salary £235-240k.
3 Stephen Field, appointed 30 September 2013, full year equivalent salary £175-180k.
4 Andrea Sutcliffe, appointed 7 October 2013, full year equivalent salary £145-150k.
5 Eileen Milner, appointed 13 January 2014, full year equivalent salary £140-145k.
6 Malcolm Bower-Brown and Andrea Gordon, members of the interim senior structure for the period 1 June 2013 to 31 October 2013, full year equivalent salary £105-110k.
7 Adrian Hughes, member of the interim senior structure for the period 1 June 2013 to 31 October 2013, full year equivalent salary £90-95k.
8 Matthew Trainer, member of the interim senior structure for the period 1 June 2013 to 31 October 2013, full year equivalent salary £95-100k.
9 Philip King, redundant 15 September 2013, full year equivalent salary £110-115k.
10 John Lappin, resigned 31 July 2013, full year equivalent salary £140-145k.
11 Christopher Day, interim appointment to 13 May 2013, full year equivalent salary £110-115k
12 Louise Guss, redundant 31 May 2013, full year equivalent salary £110-115k.
13 Amanda Sherlock, redundant 31 May 2013, full year equivalent salary £140-145k.
14 Louise Guss' expenses payment is a payment in kind and is non-cash and relates to a lease car.
15 No comparative data was available from NHS Pensions Agency therefore the annual increase in pension entitlement could not be calculated.
16 Only data in relation to CETV was available from Teesside Pension Fund due to both employees leaving during the period therefore the annual increase in pension entitlement could not be calculated.
17 Exit packages for redundancies were paid during 2013/14 however these amounts were accrued during the previous financial year, please see notes below.

2012/13	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits (bands of £2,500) £000	Compensation for loss of office (bands of £5,000) £000	Total (bands of £5,000) £000
David Behan Chief Executive	125-130[18]	–	–	–	–[23]	–	**125-130**
Cynthia Bower Chief Executive	75-80[19]	–	–	–	5-7.5	–	**80-85**
John Lappin Director of Finance & Corporate Services	140-145	–	–	–	42.5-45	–	**185-190**
Amanda Sherlock Director of Operations	140-145	–	–	–	35-37.5	320-325[24]	**495-500**
Louise Guss Director of Governance & Corporate Services	110-115	34[22]	–	–	–	215-220[24]	**330-335**
Allison Beal Director of Human Resources	110-115	–	–	–	–	145-150[24]	**255-260**
Philip King Director of Regulatory Development	110-115	–	–	–	–	140-145[24]	**250-255**
Christopher Day Interim Director of Strategic Marketing & Communications	15-20[20]	–	–	–	–[23]	–	**15-20**
Jill Finney Deputy Chief Executive and Director of Strategic Marketing & Communications	125-130[21]	–	–	–	35-37.5	–	**160-165**

[18] David Behan, appointed 30 July 2012, full year equivalent salary £185-190k
[19] Cynthia Bower, resigned 21 August 2012, full year equivalent salary £195-200k
[20] Christopher Day, interim appointment to Executive Team from 18 February 2013, full year equivalent salary £110-115k
[21] Jill Finney, resigned 21 February 2013, full year equivalent salary £140-145k
[22] Louise Guss' expenses payment is a payment in kind and is non-cash and relates to a lease car.
[23] No comparative data was available from NHS Pensions Agency therefore the annual increase in pension entitlement could not be calculated.
[24] Amounts were accrued to cover the cost of redundancies agreed by 31 March 2013 following a restructure of the Executive Team. Amounts were paid during 2013/14 with the exception of one payment that has not been made. A provision for this outstanding payment is included in the accounts.

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in CQC in the financial year 2013/14 was £235-240k (2012/13: £195-200k). This was 6.3 times (2012/13: 5.2) the median remuneration of the workforce, which was £37,414 (2012/13: £37,658).

In 2013/14, 11 (2012/13: 16) employees received remuneration in excess of the highest paid director. The calculation is based on the full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis. Remuneration ranged from £7,881 to £304,836 (2012/13: £7,881 to £260,031).

The ratio between the highest paid director and the median remuneration of the workforce has increased due to the introduction, and appointment to, the Chief Inspector of Hospitals post which attracts a higher banded salary than the previous highest paid director.

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

In 2013/14, 14 senior executives were paid in excess of £100k (2012/13: 11).

Payments made for loss of office

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

Amounts payable to third party for services as senior executive

Hilary Reynolds, Director of Change, was seconded from Department for Work and Pensions, from 1 May 2013. Employment costs totalling £159K for 2013/14 were recharged to CQC.

Nick Blankley provided services as an Interim Director of Intelligence, employed through Concept IT Ltd from 5 October 2012 to 5 July 2013, employment costs totalling £35k for 2013/14 (2012/13: £97k) were recharged to 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.

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 Louise Guss, Adrian Hughes and Amanda Sherlock whose pensions are provided through Teesside Pension Fund. Pension benefits at 31 March 2014 may include amounts transferred from previous NHS employment while the real increase reflects only the proportion of the time in post if the employee was not employed by CQC for the whole year.

	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2014 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000) £000	Cash equivalent transfer value at 1 April 2013 £000	Cash equivalent transfer value at 31 March 2014 £000	Real increase in cash equivalent transfer value £000	Employers contribution to stakeholder pension £000
David Behan Chief Executive	2.5-5	–	5-10	–	30	78	48	–
Paul Bate[1] Director of Strategy & Intelligence	–[12]	–[12]	10-15	–	–[12]	128	–[12]	–
Michael Richards[2] Chief Inspector of Hospitals	–[12]	–[12]	95-100	305-310	–[12]	–	–[12]	–
Stephen Field[3] Chief Inspector of General Practice	–[12]	–[12]	45-50	145-150	–[12]	1,002	–[12]	–
Andrea Sutcliffe[4] Chief Inspector of Adult Social Care	–[12]	–[12]	20-25	60-65	–[12]	372	–[12]	–
Eileen Milner[5] Director of Corporate Services	–[12]	–[12]	0-5	–	–[12]	6	–[12]	–
Malcolm Bower-Brown[6] Regional Director of Operations, North	0-2.5	–	0-5	–	15	36	9	–
Andrea Gordon[6] Regional Director of Operations, Central	0-2.5	0-2.5	20-25	70-75	363	400	12	–
Adrian Hughes[6] Acting Regional Director of Operations, South	2.5-5	5-7.5	55-60	100-105	659	854	66	–

	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2014 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000) £000	Cash equivalent transfer value at 1 April 2013 £000	Cash equivalent transfer value at 31 March 2014 £000	Real increase in cash equivalent transfer value £000	Employers contribution to stakeholder pension £000
Matthew Trainer[6] Regional Director of Operations, London	(0-2.5)	5-7.5	5-10	15-20	45	70	10	–
Philip King[7] Director of Regulatory Development	–[12]	–[12]	0-5	0-5	–[12]	44	–[12]	–
John Lappin[8] Director of Finance & Corporate Services	0-2.5	–	10-15	–	148	171	6	–
Christopher Day[9] Interim Director of Strategic Marketing & Communications	0-2.5	0-2.5	15-20	55-60	230	290	6	–
Louise Guss[10] Director of Governance & Corporate Services	–[13]	–[13]	–[13]	–[13]	336	355	–	–
Amanda Sherlock[11] Director of Operations	–[13]	–[13]	–[13]	–[13]	770	781	(5)	–

1 Paul Bate, appointed 13 May 2013
2 Michael Richards, appointed 16 July 2013
3 Stephen Field, appointed 30 September 2013
4 Andrea Sutcliffe, appointed 7 October 2013
5 Eileen Milner, appointed 13 January 2014
6 Malcolm Bower-Brown, Andrea Gordon, Adrian Hughes & Matthew Trainer, members of the interim senior structure for the period 1 June 2013 to 31 October 2013
7 Philip King, redundant 15 September 2013
8 John Lappin, resigned 31 July 2013
9 Christopher Day, interim appointment to 13 May 2013
10 Louise Guss, redundant 31 May 2013
11 Amanda Sherlock, redundant 31 May 2013
12 No comparative data is available from NHS Pensions Agency
13 Only data in relation to CETV was available from Teesside Pension Fund due to both employees leaving during the period

Cash equivalent transfer values

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

The CETV figures, and from 2004/05, the other pension details, include the value of any pension benefit in another scheme or arrangement which the individual has transferred to the NHS pension. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the Care Quality Commission Annual report and accounts 2013/14 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.

Automatic enrolment

The Pensions Act 2008 introduced measures aimed at encouraging greater private saving by making changes to workplace pensions. From 1 August 2013 all CQC staff entitled to be enrolled in a workplace pension were automatically enrolled, or from their start date if later than this date. All staff enrolled into a workplace pension retain the option to opt out at any time.

Automatic enrolment applies to all staff defined as a worker under the new legislation. This applies to all staff under a normal contract of employment with CQC as well as Mental Health Act Commissioners, Second Opinion Appointed Doctors and all staff on casual or zero hours contracts. The new rules do not apply to honorary appointments, such as the chair and board members, agency workers, experts by experience or staff seconded-in from other organisations.

CQC operates the NHS Pension Scheme for automatic enrolment, as this is the principal pension scheme for staff recruited directly by CQC. Those not eligible to join the NHS Pension Scheme are enrolled with the National Employment Savings Trust.

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.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014 is based on valuation data as at 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public services schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes was carried out as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees' contributions are on a tiered scale from 5% up to 10.9% of their pensionable pay depending on total earnings.

In 2013/14 CQC employer's contribution for staff to the NHS pension fund was £7,388k (2012/13: £5,785k) at a rate of 14% (2012/13: 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 £nil (2012/13: £379k).

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

Local Government Pension Schemes

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

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

Employer contributions, based on a percentage of payroll costs only, for 2013/14 were £4,119k in total (2012/13: £4,263k), at rates ranging between 15.1% and 32.3% (2012/13: 15.1% and 32.3%). Employer contributions relating to the largest scheme, Teesside Pension Fund were £3,598k (2012/13: £3,694k) at a rate of 15.8% (2012/13: 15.1%).

During 2013/14 an indexed cash sum was levied in addition to a percentage of payroll costs in an effort to reduce the pension fund deficits. £687k in total was paid to 11 of the 17 pension funds with amounts ranging from £15k to £140k. No additional sums were paid to Teesside as it currently has sufficient staff members to enable the deficit to be recovered solely by a percentage of payroll as well as having members who are of an age that allows the deficit to be recovered over a longer period of time.

On the 31 March 2014 the staff membership of CQC in the Derbyshire pension fund fell to zero. As a result a cessation charge totalling £1,167k was payable by CQC which was equal to the actuary assessed pension deficit at 31 March 2014.

Contribution rates for 2014/15 range between 14.4% and 34.6% (17.0% for Teesside Pension Fund) with annual cash sums ranging from £1.5k to £104.0k (£nil for Teesside).

National Employment Savings Trust

The National Employment Savings Trust is a qualifying pension scheme established by law to support the introduction of automatic enrolment from 1 August 2013.

Employer contributions, based on a percentage of payroll costs only, for 2013/14 totalled £10k, at a rate of 0.96%.

David Behan
Chief Executive, Care Quality Commission
23 June 2014

Statement of Accounting Officer's Responsibilities

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

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

- observe the Accounts Direction issued by HM Treasury, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

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

Governance statement

This governance statement is provided by David Behan as Accounting Officer. It sets out a comprehensive explanation of the organisational governance of the CQC in accordance with HM Treasury guidance.

CQC's purpose

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

The CQC purpose and role is:

- We make sure health and social-care services provide people with safe, effective, compassionate, high-quality care and we encourage services to improve.
- We do this by monitoring, inspecting and regulating services to make sure they meet fundamental standards of quality and safety and by publishing ratings to help people choose and fund care.

In April 2013 CQC published a three year strategy for 2013 to 2016. The strategy set out radical changes to the way CQC inspects and regulates health and social care services. This governance statement therefore covers the first year of CQC's transformation, and reflects the pace and scale of the changes that have already taken place. A key challenge has been to simultaneously strengthen and improve the quality of governance in CQC, addressing those governance weaknesses previously identified, whilst undertaking through-going structural reorganisation and fundamentally changing CQC's regulatory methods and approach.

CQC's role

CQC monitors, inspects and regulates 40,000 health and adult social care services in England. These include hospitals, care homes, home-care agencies, community and treatment services, GP practices and dental practices. We carry out our role by:

- Setting standards of quality and safety that people have a right to expect whenever they receive care.
- Registering services that meet our standards.
- Monitoring, inspecting and regulating services to make sure that they continue meet the standards.
- Protecting the rights of vulnerable people, including those governed by the powers of the Mental Health Act.
- Listening to and acting on people's views and experiences of the care they receive.
- Taking action if services are failing to meet the standards.

- Carrying out in-depth investigations to look at care across the system.
- Reporting on the quality of care services, publishing clear, accurate, timely information.
- Involving people who use services in our work, working with local groups, our partners in the health and social care system, and the public to make sure that people's views and experiences are at the centre of what we do.

This year has been marked by significant change in the way CQC carries out its role. We have:

- Introduced new methods of assessment of providers, beginning with a selection of acute NHS trusts and widened to include mental health and community trusts. This has involved the development of new lines of inquiry for the five questions that we ask (are services: safe; effective; caring; well-led; and responsive to people's needs?); larger multi-skilled inspection teams including a range of subject and clinical experts and experts by experience; and work to develop a system for ratings all providers.
- Created three sector specific groups of CQC inspectors – hospitals, adult social care and primary medical services & integrated care – led by three new Chief Inspectors. Our Chief Inspectors are now placed on a statutory basis and are members of the CQC Board. The new executive position of Director of Strategy & Intelligence also joined the Board.
- The Secretary of State expanded the maximum size of the CQC Board and five new non-executive Board members were appointed during the year. A new executive team has been formed during the year compromising the three Chief Inspectors, the Director of Strategy & Intelligence, the Director of Transformation and the Director of Customer and Corporate Services. There have been also significant changes to other senior operational roles including the appointment of Deputy Chief Inspectors.
- Taken note of the Care Act during its passage through Parliament and its implications for CQC's statutory responsibilities which will be reflected in CQC's governance arrangements.

Forthcoming statutory changes

The Care Act received Royal Assent on 14 May 2014. Its provisions have a number of important implications for the CQC since it:

- Introduces a regime in which the CQC oversees the financial sustainability of the most hard-to-replace social care providers and ensures that care will not be interrupted if providers in the regime fail. It gives the CQC powers to require that a provider in financial difficulty develops sustainable plans.
- Commits the Government to make regulations for a statutory duty of candour to promote a more open culture to discuss with patients and others when mistakes are made.
- Introduces a single failure regime for NHS trusts and NHS foundation trusts which

will be operated in partnership between CQC, Monitor, the NHS Trust Development Authority (TDA) and NHS England.

- Introduces a new type of Warning Notice for NHS trusts and foundation trusts which will be issued where CQC determines that the quality of health care requires "significant improvement". This can lead to intervention by Monitor or TDA.
- Enables CQC to require Monitor to make an order to authorise the appointment of a trust special administrator where it is satisfied that there is a serious failure in the quality of services provided by an NHS foundation trust.
- Places in primary legislation changes to the CQC Board that increase the total number of members and allow on the Board executive directors in addition to the Chief Executive, the Chief Inspector of Hospitals, the Chief Inspector of Adult Social Care and the Chief Inspector of General Practice. The Chief Inspector posts become statutory positions.
- Removes some of the powers of the Secretary of State to direct the actions of CQC to provide it with greater autonomy.
- Introduces a system through which the CQC will rate health and social care providers.
- Introduces a criminal offence of providing false or misleading information. The Police and the Crown Prosecution Service will investigate providers.
- Introduces a requirement that staff working in regulated activities have a minimum training qualification.

The Governance Framework and structures

The CQC Board has adopted a vision for CQC's governance: "Demonstrable excellence in corporate governance to support and enable a successful organisation". To help deliver this the CQC Corporate Governance Framework sets out the elements which together facilitate effective leadership, direction and control in CQC. It explains:

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

The Framework, approved last year, has been in operation during the year.

There were four main changes to the Governance structures during the year:

- The creation of new Board committee – the Regulatory and Governance Values Committee – with consequential changes to the Audit and Risk Assurance Committee, now the Audit and Corporate Governance Committee.
- The disestablishment of the executive Regulatory Risk Committee.
- The creation of the National Information Governance Committee as a statutory advisory committee to the CQC Board.
- The establishment of the Transformation Programme as a committee of the Executive Team.

The detail of these changes and their effect is detailed below, as are the changes to governance processes. An internal audit review has been completed and as a result, and taken along with changes in personnel, the technical aspects of governance and assurance will move to sit alongside organisational risk within CQC's Performance, Planning and Programmes directorate.

An important element of the governance framework is the CQC's accountability arrangements with the Department of Health (DH). These are additional to and complement the Accounting Officer's responsibilities to Parliament. CQC has worked closely with DH to revise the Framework to ensure that it properly reflects CQC's revised responsibilities. A revised and updated Framework Agreement was agreed, signed and published in March 2014. This details the accountability and sponsorship relationships, including those for Healthwatch England.

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

CQC's Board

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

- Sets the CQC strategy and approves the CQC strategic plan containing the strategic objectives.
- Sets and addresses the culture, values and behaviours of the organisation.
- Approves the CQC business plan which is designed to achieve CQC's strategic objectives.
- Monitors the performance of CQC against the business plan and holds the CQC Executive to account for that performance and for the proper running of CQC (that is, in accordance with legal and cross-Government requirements).
- Sets the risk appetite for CQC, approves the risk management processes, and owns the strategic risk register, identifying and escalating to the Secretary of State where there are risks which may threaten CQC's ability to meet its objectives or ability to discharge its regulatory responsibilities.

- Determines which decisions it will make and which it will delegate to the Executive Team via the Scheme of Delegation.
- Approves all CQC statutory publications, including the Annual Report & Accounts, the State of Care report, the report on the operation of the Mental Health Act, and the report on the operation of Deprivation of Liberty Standards.
- Takes high level policy and organisational design decisions where these will characterise the type of regulator and monitoring body that CQC will be.

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

In 2012, the DH laid Regulations to increase the membership of the CQC from a minimum of six to a maximum of twelve Members plus the Chair. These regulations were further amended during 2013 to increase the size further to a maximum of 14 plus the Chair. Currently all Board Members are appointed by the Secretary of State. The Care Act delegates appointment of the Executive members of the Board to the CQC.

The Board meets both in public and private session throughout the year. Public sessions of the Board are webcast live and are subsequently available to view as recordings. The Board's 'default' position is to take decisions and hold discussions in public. However, in common with other Boards, it holds some discussions in private sessions, for example where there are draft reports to consider (for example the State of Care report) which need to be considered in private before publication, or where matters relating to individuals and employment are being discussed.

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

Board performance

In June 2013 five new non-executive directors were appointed by the Secretary of State. They are Professor Louis Appleby, Camilla Cavendish, Professor Paul Corrigan CBE, Dr Jennifer Dixon CBE and Michael Mire. The three Chief Inspectors of Hospitals, (Professor Sir Mike Richards), Adult Social Care (Andrea Sutcliffe) and Integrated Care (Professor Steve Field) were appointed to the Board. Dr Paul Bate, Executive Director of Strategy & Intelligence, was also appointed to the Board by the Secretary of State in April 2013.

These appointments reflect CQC's commitment to strengthening its board, widening the skills and experience available to help govern and lead the organisation. The Board membership is at annex 1; the record of Board attendance at annex 2 and the coverage of Board business at annex 6 to this Statement.

The Chair has appointed a non-executive Board member, Michael Mire, to act as the Senior Independent Director. The role-holder will:

- Meet with other Board Members to ensure that their views are understood and that the Chair is made aware of any concerns they have. Any Board Member may request a meeting with the Senior Independent Director.
- Meet annually with the Board Members, specifically to gather input to the Chair's appraisal by the Secretary of State.
- Act as a sounding board for the Chair, providing support to the Chair in delivery of the Chair's objectives.

The Senior Independent Director (SID) is expected to work with the Chair and other Board Members to resolve significant issues. The SID will be expected to intervene to maintain stability of the Board and of CQC, including, for example, where:

- There is a dispute between the Chair and the Chief Executive.
- Board Members have expressed concerns that are not being addressed.
- The strategy being followed by the Chair and the Chief Executive is not supported by the entire board.
- Requests by Board Members for specific information to ensure they can carry out their roles effectively are not being met.

Given the Board was in transition and new members were being appointed, no formal collective evaluation of the Board was conducted during the year. A programme of Board development is due to commence and continue across the coming year.

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

Committees of the Board

Statutory Committees

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

The Stakeholder Committee

Since the publication of CQC's strategy in April 2013 and following the appointment of each of our Chief Inspectors, we undertaken wide ranging consultation on our approach and methodology. We have established a series of sector led Advisory Groups each of which is chaired by the relevant Chief Inspector. The membership of each of our Advisory Groups is composed of a range of different stakeholders including representatives from Royal Colleges, strategic partners, and professional trade associations, the voluntary and community sectors and Experts by Experience. The Advisory Groups enable CQC to engage key stakeholders in the strategic direction of the organisation and the changes we are making, support the Chief Inspectors by contributing to the design and development

of our methods and approach by providing expert advice, opinion and challenge. This activity took the place of the Stakeholder Committee, which did not meet during the year, pending decisions about how best, in light of CQC's new organisational structure and new regulatory approach, to obtain such advice via a statutory committee.

Bilateral meetings have also taken place, including with the General Medical Council with whom we launched a joint working protocol in August 2013, to review our working relationships. During the year we made concerted efforts to build relationships with a number of national charities, targeting those organisations that represent, or work on behalf of, people who use health and social care services, their families and carers. We particularly targeted national charities that represent older people, people with a learning disability, carers and people with a mental health illness as these groups form some of our key target public audiences.

This programme of engagement has widened and deepened the quality of our formal relationships with stakeholders and will inform the CQC Chair's decision during the coming year about the future of the Stakeholder Committee and its membership.

Healthwatch England

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

During the year the CQC Accounting Officer appointed Dr Katherine Rake OBE as an Accountable Officer to formalise the accountability arrangement between the Healthwatch England Chief Executive post and the CQC Accounting Officer. This is reflected in the revised Framework Agreement between CQC and the DH.

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

The National Information Governance Committee

The Health and Social Care Act 2012 gave CQC new legal responsibilities from 1 April 2013 for monitoring and seeking to improve registered providers information governance practices. To provide advice in relation to these new functions, CQC was required to set up a National Information Governance Committee (NIGC). Its role is to provide advice on development and delivery of CQC's information governance monitoring functions. CQC Board approved the Committee's terms of reference and membership at their meeting on 22 May 2013.

Five independent members were recruited and representatives confirmed from NHS England, the Health and Social Care Information Centre and Healthwatch England. The Information Commissioner's Office attends as an observer. The NIGC chair, Stephen Hitchens resigned in December. He was replaced by Dr Paul Bate, CQC's Executive Director of Strategy and Intelligence.

The Committee has agreed that the objectives of its work programme should be:

- To undertake monitoring activity which improves CQC's understanding of the quality of practice in relation to use of information to support delivery of good quality care.
- To identify and share good practice.
- To evaluate the best way to continue the monitoring function after April 2015.

The NIGC have provided CQC with advice regarding:

- Analysis of evidence held by CQC and some other publically available information on the quality of information governance within health and social care.
- Development of the information pathway which describes a user's experience of care if information is used effectively.
- The memorandum of understanding being drawn up between CQC and the Information Commissioner's Office.
- The Caldicott Review, and how CQC should implement relevant recommendations.
- Detailed consideration of the new inspection methodology, members suggested a number of specific questions that can be asked in order to demonstrate a trust's approach to information governance.
- Two specific thematic reviews:
  - 'experience and outcomes for people experiencing a mental health crisis'; and
  - 'quality of dementia care'

It is planned that two formal reports will be published as part of the programme: a succinct report in 2014 to cover 2013/14 activity, including early evidence and preliminary activity; and a fuller report covering 2013 – 15 to be published in 2015 containing evaluation of evidence, examples of good practice and recommendations.

Board committees

Remuneration Committee

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

The Committee has discharged its responsibilities during the year in line with its terms of reference.

Audit and Corporate Governance Committee

During the year a new Board subcommittee – the Regulatory Governance and Values Committee (RGVC) – was formed to oversee the executive management of regulatory risk and, more broadly, CQC's general approach to wider regulatory issues in the care system. The creation of the RGVC required an examination and review of the Audit and Risk Assurance Committee (ARAC). ARAC has been recast as the Audit and Corporate Governance Committee (ACGC) with revised terms of reference drafted to align with those of the RGVC to ensure there is clarity about the respective roles of the committees as regards oversight of risk management and line management assurance processes. The ACGC has oversight of the overarching policies and processes whilst the RGVC oversees how these are operationalised to ensure effective executive management of regulatory risks.

HM Treasury guidance allows for separate audit and risk committees. Nevertheless the views of both the Department of Health as the CQC sponsor body and the National Audit Office were sought about this proposed change and they were content with the arrangement. This new arrangement is included in the revised Framework Agreement between CQC and the DH.

To help ensure that there is no unhelpful overlap of work, or gaps in risk assurance oversight, the chairs of each committee have been members of other. This will ensure coordination of work and essential sharing of information.

The ACGC's role is to provide independent advice to the Board and to the Chief Executive as Accounting Officer on the effectiveness of CQC's risk management and internal control and governance systems. Its terms of reference are in line with the principles of good governance and guidance laid down by HM Treasury.

The Committee was chaired by John Harwood until his term of appointment to the CQC Board came to an end at the end of March 2014. Other current non-executive members are Michael Mire, who joined the Committee during the year and is acting as interim Chair of the Committee prior to the appointment of a new Chair, and Jane Mordue (from the Healthwatch England Committee) along with two independent members. Stephen Hitchins resigned from the Committee during the year when he resigned from the CQC Board. The Committee was also attended by the National Audit Office as external auditor, the Head of Internal Audit, the Chief Executive, the Director of Finance and Corporate Services and the Head of Corporate Governance.

The Committee met formally six times during 2013/14 and reported to the Board following each meeting. The Department of Health provides an observer at meetings and receives the agenda, papers and minutes of all meetings.

The Committee led work to review the CQC strategic risks, to align them with its new strategic objectives and to identify the supporting processes and analyses which the CQC Board will require to discharge its responsibilities (see risk management below).

Specifically the Committee provided advice and commented on the degree of assurance and embedding to the Board through:

- Review and oversight of the preparation of the annual report and accounts for the approval by the Board, including the audit completion report.
- Review of CQC's systems of internal control and risk management, including its treatment of strategic risks, (The monitoring and analysis of regulatory risks within and across the health and social care sectors was transferred to the RGVC during the year).
- Reviewing the overseeing improvements in CQC's counter-fraud arrangements.
- Approving a programme of risk based internal audits, and monitoring the effectiveness and timeliness of the completion of management actions.
- Overseeing progress in the development of CQC's information governance and information security arrangements.
- In its Part 2 meetings, providing oversight of Healthwatch England's governance, in particular of its management of risk and its audit programme.
- Ensuring any issues and gaps in assurance and control identified in the previous year's Governance Statement are being addressed.
- Scrutinising the Government intention to centralise internal audit provision in a departmental shared service hub from which CQC would obtain internal audit services and appointing a new Head of Internal Audit nominated by the from the shared service provider.

The Committee therefore was effective in assisting the Board to hold the Executive to account and in supporting the Accounting Officer in securing effective sources of assurance.

In the coming year, the Committee's approach to meeting its assurance responsibilities will be strengthened through the development of an assurance mapping process. The Committee has agreed the proposed approach and this is now being implemented. This will be important in helping to show early on where there are weaknesses in controls or gaps in assurance and allow these to be addressed. This approach is intended to ensure that CQC has the means to identify for itself where improvement is required and to keep under constant review the adequacy of its assurance mechanisms.

The Regulatory Governance & Values Committee

This committee was formed during the year to strengthen in particular the oversight of the management of regulatory risk and the provision of the associated assurances and to provide oversight of CQC's regulatory culture. This Committee, chaired by Michael Mire has the following Board membership: Kay Sheldon, Anna Bradley, Camilla Cavendish, John Harwood and Paul Corrigan.

The prime focus of the Committee during the year has been to examine aspects of the customer experience in bringing concerns to CQC and whether this acts as a barrier to receiving information that would be helpful to CQC as a regulator. In particular, the Committee has reviewed how CQC handles and makes use of protected disclosures

(whistle-blowing) from those who work in providers regulated by CQC. This develops further the commitments made in the Governance Statement in 2012/13, to undertake a review of CQC's policies and procedure in relation to the discharge of its role as a prescribed person under the Public Interest Disclosure Act.

CQC's Executive Team

The responsibility for implementing the Board's strategy belongs to the Chief Executive and his team. The Chief Executive, David Behan, took up office at the end of July 2012 and has reviewed the structure of the Executive Team. (See the annexes to this Statement).

A new Executive Director of Strategy and Intelligence, Dr Paul Bate, has been appointed and commenced work with CQC in May 2013. The three new Chief Inspectors have been appointed and they have joined the Executive Team. A Director of Change, Hilary Reynolds, joined CQC in May 2013 for a fixed term appointment of two years. John Lappin, Director of Finance & Corporate Services, left CQC in July 2013. Eileen Milner joined CQC in January 2014 as Director of Customer and Corporate Services. The current membership and membership across the year is detailed at annex 3.

The interim and current senior management structure are contained at annexes 4 and 5. This change in structures has been effective in ensuring that CQC is best equipped and organised to deliver its strategic and business plan objectives.

Executive Team committees

The Executive Team (ET) meets on a weekly basis taking items for discussion and items for decision on alternate weeks. The ET Discussion meeting considers items about approaches and emergent thinking, and Executive Directors will give a formal steer to work as it develops. The ET Decision meeting takes decisions, or recommends a decision to the CQC Board as appropriate, on policy, publication and corporate planning and business monitoring.

Transformation Programme Board

The Board reports directly to the Executive Team. The Board has its own formal governance arrangements following Programme governance best practice and supported by the CQC Programme and Projects office. The Board oversees and coordinates all of the work to develop new business and regulatory processes and the corporate reorganisation to align CQC structure and resources behind the delivery of the CQC strategy. The governance arrangements for the Transformation Board provide assurance to address the recommendations of the Macpherson review of Quality Assurance in Government.

The Establishment and Recruitment Controls Committee is the mechanism through which the Government recruitment controls have been applied to CQC. The Health & Safety Committee is a statutory requirement to monitor CQC's duty to discharge its health, safety and welfare obligations to its staff. The Investment Committee has supported the Executive Team and the Board CDC effectively by examining and approving formal business cases.

The Regulatory Risk Committee was disestablished during the year (its subcommittee, the Safeguarding Committee continues and reports directly to the Executive Team). Instead oversight for regulatory risk has been strengthened through the appointment of the three Chief Inspectors who have this responsibility individually and collectively and through the creation of the Board Regulatory Governance and Values Committee.

Governance processes

Risk Management

CQC has completed the first year of a radical three year transformation of the organisation and its approach. There are many risks associated with such fundamental change and these will need to be managed through to completion of the programme. In the context of risk management and assurance, radical organisational change has an inevitable impact on systems and processes, and the capacity to deliver them effectively. As a consequence, it has been difficult for CQC to implement improvements in this sphere since last year. However, work has continued to refine CQC's management of risk and ability to provide assurance, but there is more to do to ensure that it is embedded systematically and that, as staff either move within, or join, the organisation, they are supported to understand their responsibilities and implement best practice.

During 2013/14 there has been integrated performance and risk reporting to the Executive Team and the Board. The Strategic Risk Register has supported and informed regular risk discussions by the Executive Team and the Board and the document is made available on the CQC website. Appropriate systems are in place to ensure that risks are identified and reported to the Board via written Chief Executive reports. The strategic risk profile and reports include details of how CQC is mitigating high risk areas. The Gateway Review of the Transformation Programme made some positive comments about the approach to risk management across the programme but also made some recommendations for improvement which are being implemented.

The completeness and quality of risk profiling below the strategic level varies and this will be addressed in the coming year as the risk and management assurance systems further mature. This has been recognised during the year and discussed with the ACGC which has decided that risk training must be rolled out in an integrated way to CQC managers (and not seen as an isolated activity) in order to truly embed risk management and other risk processes since these are currently inconsistently applied through our internal audit process.

A notable development in relation to informing oversight of regulatory risk is the creation of the Regulatory Governance and Values Committee to allow for more detailed scrutiny. The Chief Inspectors are currently developing their arrangements for managing regulatory risk within their directorates. The Operations Transition project has ensured that risk information relating to providers has been handed over from current to new portfolio holders at 1 April 2014 when new structures came into place.

Organisational changes have been implemented so that reports on regulatory risk are now provided by the Planning, Performance and Programmes directorate to the Regulatory Governance and Values Committee.

Key risks managed in year

Continuing strategic risks

The Executive have managed significant continuing strategic risks arising out of its transformation programme and development of new inspection methodology, (including preparation for the introduction of ratings). Continuing risks identified by the Board, and on which the ACGC advises on assurance, are:

- Risk that inspection fails to pick up significant provider risk and failure, and that CQC does not act appropriately based on the findings of the inspection.
- Risk that the public, professionals and politicians lose confidence in CQC, if CQC does not take appropriate action when evidence suggests it is necessary.
- Risk that intelligent monitoring fails to pick up significant provider risk and failure that CQC does not act appropriately on what our monitoring indicates.
- Risk that if CQC does not embed transformational change effectively, CQC will not improve how it delivers its purpose and role.
- Risk that CQC does not listen to the public and stakeholders, respond effectively to the support and advice given or meaningfully build user voice into our regulatory approaches.
- Risk that CQC fails to recruit and retain staff with the skills and experience required to help the organisation to improve.
- Risk that without clear information strategy, we will not support new approaches to information management and technology, or effectively manage our information and the risks associated with it.

Historic risks

Aside from these continuing strategic risks, the Executive have managed a number of risks arising from the investigation conducted by Grant Thornton into CQC's regulatory decision making in respect of the University Hospitals Morecambe Bay Trust. The report's findings are disputed by one or more of the individuals referred to in the report, and the issue continues to be managed by the Executive.

CQC is a respondent to the Morecambe Bay Investigation, and is fully committed to providing a timely and comprehensive response to any requests for assistance from the investigation. It is not yet known what the full impact, including costs impact, of the investigation will be.

The departure of a significant number of senior staff in the last year has involved a risk of loss of corporate knowledge, and some risk to delivery. Those risks were recognised, and appointments made accordingly.

CQC undertook a review of the system of internal control around the recruitment function as it related to volume recruitment during the year. This highlighted that there had been weaknesses in systems and processes during 2012 and early 2013. In response to these findings the internal controls have been significantly strengthened in this area to ensure that the recruitment process and in particular volume recruitment is robust. For example criteria and checks for those passing through stages of the recruitment process have been significantly tightened.

Regulatory risks

Specific risks arising out of ongoing regulatory activity have also been managed, and where those risks have been significant, they have been reported to the Board. Contingent liabilities arising out of legal challenge to CQC's activities are identified and assessed. This is against a backdrop of greater emphasis on the use of intelligent monitoring information than has historically been the case. Work will continue to develop this capability, and embed it fully into CQC's inspection and enforcement activity. It is also to be seen in the wider context of a recognised current lack of a mature, system wide failure regime for NHS providers. The risk of possible failure to embed the Mental Capacity Act 2005 into regulation and monitoring is being mitigated by training plans and policy development. Nevertheless, cases in which CQC has failed to identify or deal with provider failings, as in the case of Orchid View, may continue to arise, as CQC continues to deal with its past. Such cases are also a reminder of the considerable challenge to improve and deploy intelligent monitoring and to help avoid such failures in the future.

The introduction of the Care Act provisions as they relate to CQC will involve further significant changes for CQC inspections and enforcement. It is anticipated that next year will therefore involve a similar level of risk to the year just completed.

Addressing new and emerging risks

We are improving the way we regulate services through the appointment of the Chief Inspectors. These new roles will be central to the better management of regulatory risk by CQC in future. Work has been undertaken to review thoroughly the Scheme of Delegation to incorporate the Chief Inspector roles in decision-making, and to make clear the Board's role in relation to decisions about providers posing the highest risk to service users.

Changes in our approach have come into effect in NHS acute hospitals and mental-health trusts first because we recognise there is an urgent need for more effective inspection and regulation of these services. We will extend and adapt our approach to other sectors in 2014 and early 2015.

A number of changes have been introduced aimed at meeting the requirements of the Francis report. These include:

- How patient user group representation is integrated into the structure of CQC.
- Where in CQC decisions are made when there are requests for CQC to participate in joint inspections.
- Where and how in CQC judgements are made to escalate regulatory decisions.
- Where in CQC the decision is made to take temporary protective action even though an investigation (or similar) has not yet concluded.
- Who in CQC decides to require other agencies (Monitor or the NHS Trust Development Authority) to take action.
- Devising and determining who will sign off aggregated assessments (ratings).

We will continue to carry out our programme of unannounced inspections and enforcement across the sectors we regulate, continue to publish our findings, and continue to deliver our responsibilities under the Mental Health Act.

Performance, Risk and Assurance data quality

During the year we have continued to report performance to each Board meeting. We have developed our reporting during the year to move towards being able to report under our new organisational structure, and in particular individual sectors, from April 2014. We have introduced more qualitative information from post inspection and post registration surveys as well as information about how useful our reports are to providers and the public. We have integrated information on risk with our performance reporting to ensure that performance information is used to inform our assessment of risk. An internal audit during the year of the adequacy of the audit trail and management assurance of Performance Information and Data Quality gave substantial assurance that the controls upon which the organisation relies to report corporate performance information are in place and working effectively.

Management assurance

Work has been undertaken during the year to create a management assurance system for CQC. This will form a key governance 'line of defence' and signals a move away from previous over-reliance on internal audit to provide assurance and detect weaknesses in controls. The arrangements have been devised under the oversight of the Audit and Corporate Governance Committee who approved a proposal for assurance mapping and assurance criteria on behalf of the CQC Board. The arrangements are aligned with the assurance framework required by the Department of health for its Arm's Length Bodies and also meets HM Treasury requirements.

The Executive Team have reviewed and approved detailed implementation proposals and regular assurances will be generated from the first quarter of 2014/15.

Key sources of Assurance

In addition to the above, as Accounting Officer I have relied upon the following additional sources of assurance:

- The SIRO's opinion – below;
- The Head of Internal Audit's opinion – below;
- The Fraud lead's opinion – below;
- The CQC legal Advisor's opinion;
- The regular reports and assurances provided by Directors – below.

The opinion of the Senior Information Risk Owner (SIRO)

I have relied upon the following annual opinion of the SIRO when preparing this Governance Statement:

"The Commission has undertaken work in the areas of information governance, information security and information risk management over 2013/14. This has been overseen by the Information Governance Group (IGG) which is chaired by the SIRO, Dr Paul Bate.

A focus of the IGG is to provide our staff with information so that they know how to process information in a secure and correct manner. There is also a focus on improvements to make it easy for staff to do the right thing and difficult for them to get it wrong.

The transformation programme and the Knowledge and Information work stream within it, aims to ensure that CQC becomes intelligence driven. The information governance and security work aims to support and complement this by ensuring that the information available to those who need it is accurate and reliable and has the correct levels of confidentiality applied to it. This work incorporates both tactical assurance elements such as staff feedback and incident analysis as well as strategic planning during involvement in programmes and projects where security and governance requirements are designed into systems and processes. We are able to be both reactive by learning from issues and mistakes, and proactive, ensuring that issues and mistakes are less likely in the future.

Security reports are received from the service provider on a regular basis, these include; monthly summary of infrastructure security status; urgent issue escalation process from the service provider to both head of ICT live services and the information security manager; user (including privileged user) activities; auto forward of emails; data transfer to external media; reports on the effectiveness of infrastructure security mechanisms. We are still relatively early in the lifecycle of the IT infrastructure contract with a new service provider but a major transfer of services has been successfully completed and significant progress has been made. There have been some operational and security issues with the new service which have been and continue to be addressed. As the service matures it is expected that the operational abilities and security protection delivered to CQC will continue to improve and provide significant benefits and assurance.

The security incident management process is used to encourage staff to report all actual and potential information governance and security incidents so that damage limitation, appropriate escalation and reporting can take place. All reported incidents are logged, tracked and analysed to provide an indication of where controls are not fully effective or where business processes need to be changed. The incident analysis report is considered at each IGG meeting and has shown that the majority of incidents, whilst having minor impact, have been caused by either human error or incorrect data being held on CQC systems. Both of these causes have been, and continue to be addressed by user education and awareness and the data quality improvement work stream.

Information security and governance education and awareness training is both a requirement of the HMG security policy framework for all public bodies and ALBs as well as an internal CQC requirement. The primary source of the training is a module on the CQC learning management system which all staff have been asked to complete on an annual basis. This is supplemented by a quick guide providing a high level overview of security and governance requirements and a 'top ten' good practices list. The training is also supplemented by intranet publications of security reminders to maintain awareness of the requirements.

An information risk register is maintained by the IGG and is reviewed at each meeting. This register has been reformatted during 2013 and is organised into 2 levels by collating specific risks into 6 strategic 'themes': supporting delivery; information quality; confidentiality; information sharing; transparency; compliance and governance. Work on the risk register continues with the aim of communicating information risk awareness more widely across CQC and to promote appropriate ownership of the risks at both operational and project or work stream level. The IGG are working with the Knowledge and Information work stream to ensure that information risk is coordinated across the organisation, and to ensure that new governance processes are effective in mitigating risks.

Feedback is received regularly from staff in the form requests for assistance or advice on particular security or governance issues, for example, on information sharing or the external transmission of data. These types of request provide assurance that there is a level of awareness amongst staff and that they know where to seek help on complying with requirements. Two staff surveys have been carried out to test the level of security and governance awareness and to highlight operational issues. These have provided valuable feedback on what is working well and areas which need more focus. The survey carried out in April shows a very good level of awareness in some areas but also highlights a small number of areas that require more attention: awareness of data protection and information security policy was over 90% while the requirement to protectively mark sensitive documents was just over 60%.

Requests under the Freedom of Information Act 2000 (FOIA) and the subject access provisions of the Data Protection Act 1998 are managed and responded to by a specialist CQC team. Over 95% are responded to within statutory deadlines.

The Commission completes and publishes an assessment against the NHS Connecting for Health Information Governance Toolkit. Our assessment in 2012/13 showed 69% compliance. This rose to 84% for 2013/14.

As with any operational system, ongoing monitoring and assurance gathering must adjust and continue to evolve to track changes to CQC and its requirements. This is particularly the case as we go through the transformation programme. Arrangements are in place to ensure that information governance and security are included in the transformation at each stage so that requirements can be designed in rather than being left behind or added retrospectively. Overall, the information security

and governance monitoring measures detailed in this report provide a good level of assurance as well as a good likelihood that risks and issues can be identified at an early stage so that remediation can be put in place. The SIRO and Information Governance Group will lead on further work over the coming year towards CQCs aspirations for excellence."

Dr Paul Bate – Director of Strategy and Intelligence and SIRO

Head of Internal audit opinion

I have relied upon the following annual opinion of the Head of Internal Audit when preparing this Governance Statement:

"I can report no specific, significant weaknesses that would impact on the proper discharge of CQC obligations. However the position this year does not indicate much improvement, with governance, risk and control arrangements largely in line with those we reported in previous years.

The transformation programme inevitably brings its own risks to governance, not only in its execution but also to existing controls and governance arrangements as people change and roles are revised. The frameworks for governance, risk management and control have again been updated so as to remain appropriate given the significant volume and pace of change in CQC. However, progress in implementing those frameworks has further slipped and the need remains to fully embed these across the organisation.

In particular, risk management and assurance frameworks need to be more comprehensive across CQC, which would facilitate a greater management awareness of and commitment to risk, control and assurance which should feature within the work they do. The cultural development needed to support effective, whole organisation governance, risk management and assurance is a priority but has not progressed as such. It is important that a management assurance culture is developed, supported and challenged in the coming year, and that the information systems necessary to support this are in place. This will benefit individual business areas and systems, as well as the assurance over responses to internal audit recommendations.

Considering all of the above, and based upon the internal audits undertaken and other work performed, I conclude that governance, risk management and control arrangements have not materially improved during the year and that though such arrangements have been established and kept up to date they are not operating effectively or are not being consistently applied throughout the organisation".

Nigel Freeman – Head of Internal Audit 15.4.14

Fraud Lead Opinion

I have relied upon the following an annual opinion of the Fraud Lead when preparing this Governance Statement:

> *"The number of fraud cases investigated during 2013/14 has shown a continued upward trend on previous years. In line with the commitment to zero tolerance we have promoted a greater awareness and understanding of fraud, bribery and corruption and the requirement to report it. This has led to 32 cases being reported during the year. We have thoroughly investigated the allegations, the majority proved unfounded where no further action was required. However, 2 serious cases were reported and substantiated with disciplinary action taken. The ongoing commitment to thorough and robust investigation of all reported fraud, bribery or corruption demonstrates that CQC take such allegations very seriously and will take appropriate action".*

Rebecca Lloyd Jones – Director of Governance & Legal Services and lead Director for counter fraud

Legal Adviser's Opinion

The following statement has been provided by the legal advisor:

> *"I can confirm that CQC is aware of its statutory duties and has mechanisms in place to ensure that it meets these. I can confirm that to the best of my knowledge, CQC has not assumed duties beyond its statutory powers, nor has it improperly delegated any duties".*

Rebecca Lloyd-Jones – Director of Governance & Legal Services and CQC legal advisor

Accounting Officer letters

All Accounting Officer letters received have been actioned.

Ministerial directions

We have received no formal Ministerial Directions during the year.

Accounting Officer Conclusion

CQC has complied with HM Treasury's *Corporate Governance in Central Government Department's Code of Good Practice*, to the extent that it is relevant to CQC which is an NDPB.

CQC is here to make sure that health and social care services provide people with safe, effective, compassionate, high quality care, and we encourage care services to improve. In April 2013 we published our strategy for the next 3 years, which set out radical changes to the way we regulate health and social care services. In 2013/14 we have designed the changes we will make to how we perform our functions. We have looked at how we inspect, and we have carried out a lot of activity and engagement to make sure that we get it right. This has included consultation, and pilot activity to trial our new inspection methodology. Next year we will need to increase our capacity, and grow our capability.

This reflects not only our new approach to inspection, but also the introduction of new powers under the Care Act, and the introduction of Regulations setting out "fundamental standards" of care. We will be inspecting and registering services that will be going through very significant change driven by demography, technology, expectation, and financial constraints, which we have not seen before. We will be challenged to be efficient and effective ourselves, and will have to respond quickly to this changed landscape.

Recognising the challenges ahead, senior appointments were made last year to strengthen the Executive Team, through the appointment of the Chief Inspectors and other Directors. Further work is now needed to support them in increasing capability and capacity within their teams. One way we will do this is through the new CQC Academy, which will support staff training and development, increasing our professional skills and specialisms. This will enable us to meet the demands of our new approach, and the changes to our regulatory framework. At the same time, we have begun to build up the capability of our corporate support systems, including HR and information and knowledge management. This is essential if we are to give our staff the tools they need to fulfil their role. Change is challenging for staff, and although staff morale and engagement has improved, we are not complacent. We will be building on staff survey results, and doing further focused work on CQC's values and behaviours, involving all staff in making sure these are what we need to carry us through the next year and into the future.

CQC has implemented some very significant changes in the last year – delivering our planned inspection programme alongside our development and piloting activity was an achievement we should be proud of. But we know that there is much more to do if we are to meet next year's challenges, which will include delivering the new ratings introduced by the Care Act, and regulating against the new fundamental standards signaled in the Francis report. We will continue to work closely with all our stakeholders to make sure we learn as much as possible from those who use and deliver services.

This report has highlighted the considerable risks associated with change on this scale. The transformation programme has had an inevitable impact on CQC's ability to improve its risk management and controls since last year. Governance frameworks have been updated, and risk management controls have remained appropriate given the significant pace and volume of change in CQC. However, consistent implementation has been affected, and more will need to be done next year to ensure a comprehensive awareness of risk management and assurance. Nevertheless, I conclude that the CQC governance processes, though inevitably affected by the transformation programme, and expected to improve in the coming year, have adequately supported me in discharging my role as Accounting Officer.

Annex 1: Board and Committee structure and membership

CQC's Board

Current Members

David Prior (Chair)	28 January 2013 - 27 January 2017
David Behan (Chief Executive)	5 November 2012 - 4 November 2016
Anna Bradley	16 July 2012 - 15 July 2015
John Harwood	4 March 2010 - 31 March 2014
Kay Sheldon OBE	30 November 2010 - 30 Nov 2016
Dr Paul Bate	3 May 2013
Prof. Paul Corrigan CBE	1 July 2013 - 30 June 2016
Prof. Louis Appleby	1 July 2013 - 30 June 2016
Dr Jennifer Dixon CBE	1 July 2013 - 30 June 2016
Michael Mire	1 July 2013 - 30 June 2017
Camilla Cavendish	1 July 2013 - 30 June 2017
Prof. Sir Mike Richards	16 July 2013
Prof. Steve Field	30 September 2013
Andrea Sutcliffe	7 October 2013

Members retiring or resigning through the year

Stephen Hitchins	9 July 2012 - 18 December 2013

Audit and Corporate Governance Committee

John Harwood (Chair)
Stephen Hitchins
To December 2013
Michael Mire
From 1 October 2013

Co-opted Member
Jane Mordue
(co-opted from Healthwatch England)

Independent Members
John Butler
1 February 2013 - 31 January 2015
David Prince
1 February 2013 - 31 January 2016

Remuneration Committee

David Prior (Chair)
John Harwood
Kay Sheldon OBE
Prof. Louis Appleby
Dr Jennifer Dixon CBE

Former Members
Julian Duxfield
2 November 2011 -
1 November 2013
(Independent Member}

Regulatory Governance and Values Committee

Michael Mire (Chair)
John Harwood
Kay Sheldon OBE
Anna Bradley
Camilla Cavendish
Prof. Paul Corrigan CBE

Annex 2: Summary of Board member attendance

	4/13	5/13	6/13	7/13	9/13	10/13	11/13	12/13	1/14	2/14	3/14
DP		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
DB		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
AB		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
JH		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
KS		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
SH		✓	✓	✓	✓	✓	✓	✓			
PB		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
PC				✓	✓	✓	✓	✓	✓	✓	✓
LA				X	✓	✓	✓	✓	✓	✓	✓
JD				✓	✓	✓	✓	✓	✓	X	✓
MM				✓	✓	✓	✓	✓	X	✓	✓
CC				✓	✓	✓	✓	X	✓	✓	✓
MR				✓	✓	X	✓	✓	✓	✓	✓
SF				✓	✓	✓	✓	✓	✓	✓	✓
AS				✓	✓	✓	✓	✓	✓	✓	✓

Annex 3: Executive team and Committee structure and membership

Executive Team

Members

David Behan (Chief Executive)	From 30 July 2012
Hilary Reynolds (Director of Change)	From 1 May 2013
Dr Paul Bate (Director of Strategy and Intelligence)	From 3 May 2013
Matthew Trainer (Regional Director of Operations London)	1 June 2013 - March 2014
Adrian Hughes (Acting Regional Director of Operations South)	1 June 2013 - March 2014
Malcolm Bower-Brown (Regional Director of Operations North)	1 June 2013 - March 2014
Andrea Gordon (Regional Director of Operations Central)	1 June 2013 - March 2014
Prof. Sir Mike Richards (Chief Inspector of Hospitals)	From 16 July 2013
Prof. Steve Field (Chief Inspector of General Practice)	From 30 September 2013
Andrea Sutcliffe (Chief Inspector of Adult Social Care)	From 7 October 2013
Eileen Milner (Director of Corporate Services)	From January 2014

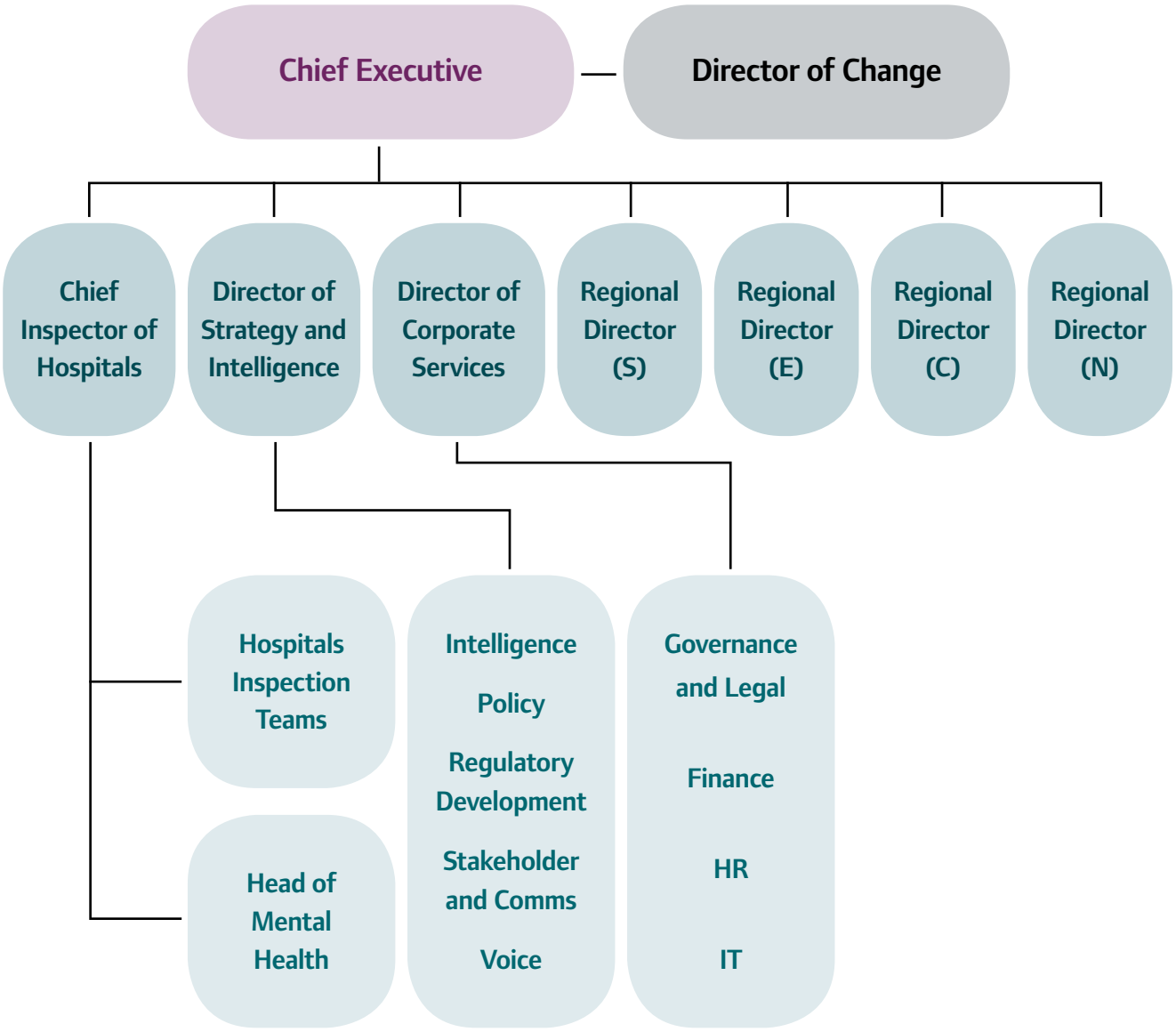
Previous Executive Team Members

Chris Day (Interim Director of Strategic Marketing & Communications)	From 25 February 2013
Executive Team member	Until 31 May 2013
Louise Guss (Director of Governance & Corporate Services)	Left CQC 31 May 2013
Nick Blankley (Interim Director of Intelligence)	From 5 October 2012
Executive Team member	Until 31 May 2013
Amanda Sherlock (Director of Operations)	Left CQC 31 May 2013
Philip King (Director of Regulatory Development)	
Executive Team member	Until 31 May 2013
John Lappin (Director of Finance & Corporate Services)	Until 31 July 2013
Allison Beal (Director of HR & Interim Director of Corporate Services)	

- **Transformation Programme Board**
- **Safeguarding Committee**
- **Establishment & Recruitment Controls Committee**
- **Health and Safety Committee**
- **Investment Committee**
- **Regulatory Risk Committee**
  Disbanded end of April 2013

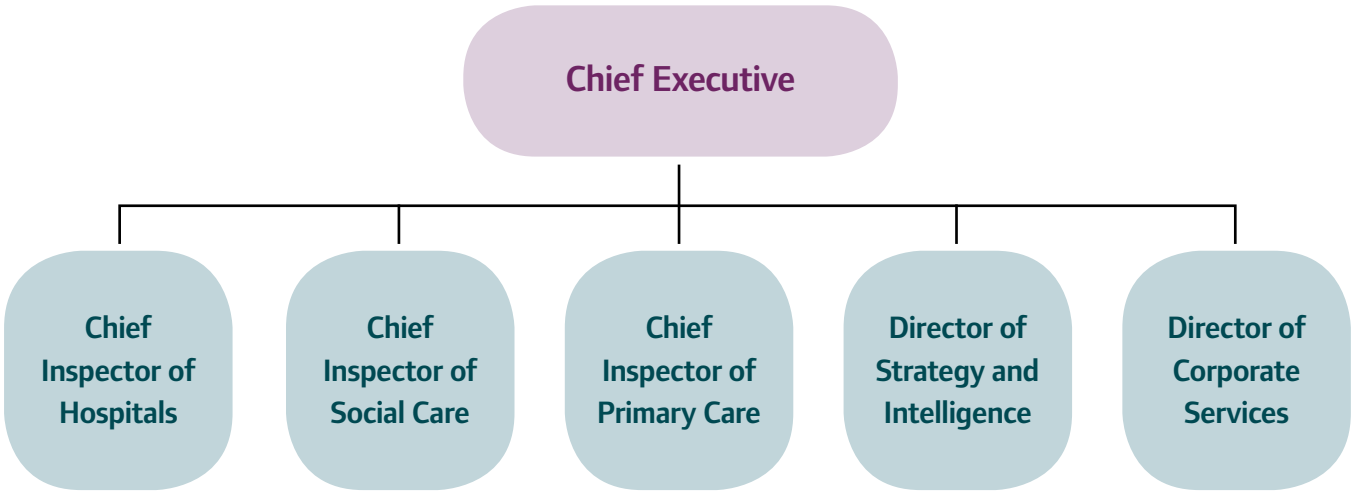
Annex 4: CQC'S interim senior management structure to October 2013

The interim structure for CQC senior management up to October 2013 was as follows:



Annex 5: CQC'S final senior management structure

The final structure for CQC is as follows:



Annex 6: Board business 2013/14

CQC Board – coverage of topics 1 April 2013 to 31 March 2014
Agenda Items
Chairs & Commissioners' reports
Chief Executive reports
Review of CQC Strategy including consultation responses
CQC Business Planning and Budget
Recruitment of the Chief Executive
Annual Report to Parliament – Themes and approach
Annual Reports and Accounts & Finance Report for year ended 31 March 2013
Quarterly Risk & Performance Reports, including financial reports and review of strategic risks
Reports from Audit & Risk Assurance Committee – including review of the Committee's effectiveness
Reports from the Remuneration Committee
Approval of Stakeholder Committee Terms of Reference and membership
Re-appointment of Chairs of Board Committees and Review of membership of board sub-committees
Approval of the schedule of Board meetings
Approval of the Corporate Governance Framework
Approval of the CQC Accountability Framework
Review of the Board's Standing Orders and Code of Conduct, including a social media policy and how Board members should raise concerns
Approval of a revised Role Description for Board Members
Complaints Annual Report
Registration of Dentists
Registration of other Primary Medical Services
Delivery of 2012/13 inspection programmes
Enforcement Activity – Annual report
The CQC Regulatory Model – Evaluation project findings
The CQC Regulatory model – review of CQC's use of its regulatory powers

The CQC Regulatory Model in light of consultation responses
Registration of Partnerships
Safeguarding Annual Report
Themed Inspection update
Healthwatch England accountability and governance arrangements
Healthwatch England Business Plan for 2013/14
State of Care report – content, approach and intended impact
Mental Health Act Annual Report
Deprivation of Liberty Safeguards – Annual Submission
Working with people who use services
Report on terms of reference for National Information Governance Committee
Fees Strategy and Scheme
Fees consultation
Working with partners including Monitor, The NHS Trust Development Authority and NHS Commissioning Board
Consideration of the Francis recommendations following public inquiry into Mid Staffordshire
Responses to consultations (various including transfer of functions of HTA and HFEA to CQC; Nuffield work on Aggregated Assessments; and Strengthening the NHS Constitution)
Health Select Committee Report

David Behan
Chief Executive and Accounting Officer, Care Quality Commission
23 June 2014

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 2014 under the Health and Social Care Act 2008. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Board, Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Board and the Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Social Care Act 2008. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Care Quality Commission's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Care Quality Commission; and the overall presentation of the financial statements. In addition, I read all the financial and non-financial information in the Annual Report and Accounts 2013/14 to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

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

Opinion on regularity

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

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of Care Quality Commission's affairs as at 31 March 2014 and of the net expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the Health and Social Care Act 2008 and the Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the Secretary of State directions issued under the Health and Social Care Act 2008; and
- the information given in the Strategic Report and Directors' 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 returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records or returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

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

25 June 2014

Financial statements

Statement of comprehensive net expenditure

for the year ended 31 March 2014

	Note	2013/14 £000	2012/13[1] £000
Expenditure			
Staff costs	2&3	128,757	111,767
Depreciation and amortisation	4	11,047	11,383
Other expenditure	2&4	54,363	45,490
Impairment of assets	4	420	(229)
		194,587	**168,411**
Less income			
Income from activities	5	(101,181)	(93,008)
Other income	5	(223)	(17)
		(101,404)	**(93,025)**
Net expenditure for the year		**93,183**	**75,386**

OTHER COMPREHENSIVE EXPENDITURE

	2013/14 £000	2012/13[1] £000
Items that will not be reclassified to net operating costs:		
Net loss/(gain) on revaluation of intangible assets	412	(2,188)
Net loss/(gain) on revaluation of property, plant and equipment	34	(428)
Actuarial (gain) in pension schemes	(11,861)	(11,820)
	(11,415)	**(14,436)**
Total comprehensive expenditure for the year ended 31 March 2014	**81,768**	**60,950**

All income is derived from continuing operations.

Expenditure is derived from continuing operations, Healthwatch England activity and transformation programme activity. Expenditure relating to those activities is noted in note 2.

CQC received grant-in-aid totalling £87.3m (2012/13: £68.1m) from the Department of Health.

Notes 1 to 23 form part of these financial statements.

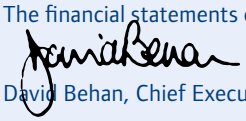
[1] Figures for 2012/13 have been restated due to the revision of IAS19 Employee Benefits and a reclassification between headings.

Statement of financial position

as at 31 March 2014

	Note	31 March 2014 £000	31 March 2014 £000	31 March 2013 £000	31 March 2013 £000
Non-current assets					
Intangible assets	7	15,586		19,267	
Property, plant and equipment	8	1,790		2,306	
Total non-current assets			**17,376**		**21,573**
Current assets					
Trade receivables	12	4,894		3,903	
Other current assets	12	2,659		2,366	
Cash and cash equivalents	13	23,233		20,187	
Total current assets			**30,786**		**26,456**
Total assets			**48,162**		**48,029**
Current liabilities					
Trade and other payables	14	(20,008)		(15,798)	
Current pension liabilities	14	(333)		(316)	
Provisions	15	(383)		(1,618)	
Total current liabilities excluding fee income in advance		**(20,724)**		**(17,732)**	
Non-current assets plus net current assets excluding fee income in advance		**27,438**		**30,297**	
Fee income in advance	14	(37,127)		(36,576)	
Total current liabilities			**(57,851)**		**(54,308)**
Non-current assets plus net current assets			**(9,689)**		**(6,279)**
Non-current liabilities					
Provisions	15	(1,564)		(1,132)	
Pension liabilities	14	(533)		(788)	
Total non-current liabilities excluding pension deficit			**(2,097)**		**(1,920)**
Assets less liabilities excluding pension deficit provision			**(11,786)**		**(8,199)**
Pension deficit provision	3		(52,089)		(61,233)
Assets less liabilities			**(63,875)**		**(69,432)**
Taxpayers' equity					
General reserve			(64,429)		(71,266)
Revaluation reserve			554		1,834
Total taxpayers' equity			**(63,875)**		**(69,432)**

The financial statements on pages 114 to 156 were approved by the Board on 23 June 2014 and were signed on its behalf by:



David Behan, Chief Executive

Notes 1 to 23 form part of these financial statements.

Statement of cash flows

for the year ended 31 March 2014

	Note	2013/14 £000	2013/14 £000	2012/13[1] £000	2012/13[1] £000
Cash flows from operating activities					
Total net expenditure		(93,183)		(75,386)	
Adjustment for depreciation and amortisation	4	11,047		11,383	
Impairment of intangible assets	4	380		(229)	
Impairment of property, plant and equipment	4	40		–	
Net (gain) on indexation of intangible assets	4	–		(40)	
Net (gain) on indexation of property, plant and equipment	4	–		(9)	
Loss on disposal of intangible assets	4	769		–	
Loss on disposal of property, plant and equipment	4	39		3	
Cost of PCSPS long term creditor recognised as an expense	4&14	85		159	
Net expense on pension scheme assets and liabilities	4	2,577		2,995	
(Increase)/decrease in trade and other receivables	12	(1,284)		3,914	
Increase in trade payables	14	3,717		2,577	
Increase/(decrease) in current pension liabilities	14	17		(171)	
Increase in deferred income	14	551		1,352	
(Decrease) in provisions	15	(3,382)		(2,386)	
Non-cash pension charge	3	2,717		5,285	
(Decrease) in non-current pension liabilities	14	(340)		(393)	
Net cash outflow from operating activities			**(76,250)**		**(50,946)**
Cash flows from investing activities					
Purchase of intangible assets	7&14	(6,798)		(11,455)	
Purchase of property, plant and equipment	8&14	(1,231)		(1,278)	
Net cash outflow from investing activities			**(8,029)**		**(12,733)**
Cash flows from financing activities					
Grants from Department of Health		87,325		68,100	
Net financing			**87,325**		**68,100**
Net increase in cash and cash equivalents in the year			**3,046**		**4,421**
Cash and cash equivalents at 1 April	13		20,187		15,766
Cash and cash equivalents at 31 March	13		23,233		20,187

Notes 1 to 23 form part of these financial statements.

[1] Figures for 2012/13 have been restated due to the revision of IAS19 Employee Benefits.

Statement of changes in taxpayers' equity

for the year ended 31 March 2014

	Note	Revaluation reserve £000	General reserve[1] £000	Total reserves[1] £000
Balance at 1 April 2012		**229**	**(76,811)**	**(76,582)**
Changes in taxpayers' equity for 2012/13				
Net gain on indexation of intangible assets		2,188	–	2,188
Net gain on indexation of property, plant and equipment		428	–	428
Transfer between reserves for intangible assets		(734)	734	–
Transfer between reserves for property, plant and equipment		(277)	277	–
Net expenditure for the year		–	(75,386)	(75,386)
Actuarial gain in pension schemes	3	–	11,820	11,820
Total recognised income and expense for 2012/13		**1,605**	**(62,555)**	**(60,950)**
Grants from Department of Health		–	68,100	68,100
Balance at 31 March 2013		**1,834**	**(71,266)**	**(69,432)**
Change in taxpayers' equity for 2013/14				
Net (loss) on indexation of intangible assets		(412)	–	(412)
Net (loss) on indexation of property, plant and equipment		(34)	–	(34)
Transfer between reserves for intangible assets		(687)	687	–
Transfer between reserves for property, plant and equipment		(147)	147	–
Net expenditure for the year		–	(93,183)	(93,183)
Actuarial gain in pension schemes	3	–	11,861	11,861
Total recognised income and expense for 2013/14		**(1,280)**	**(80,488)**	**(81,768)**
Grants from Department of Health		–	87,325	87,325
Balance at 31 March 2014		**554**	**(64,429)**	**(63,875)**

Notes 1 to 23 form part of these financial statements.

[1] Figures for 2012/13 have been restated due to the revision of IAS19 Employee Benefits.

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 2013/14 Government Financial Reporting Manual (FReM) as determined by the Department of Health with the approval of HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Commission for the purposes of giving a true and fair view has been selected. The particular policies adopted by the Care Quality Commission are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

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

Early adoption of IFRS amendments and interpretations

No IFRS changes were adopted early in 2013/14.

IFRS amendments in issue that are effective for the financial year beginning 1 April 2013 but which are not expected to have an impact on the CQC's accounts

- Amendment to IAS12 Income Taxes: Deferred tax.
- Amendment to IAS16 Property, Plant and Equipment: Classification of servicing equipment
- Amendment to IAS32 Financial Instruments: Tax effect distribution relating to equity instruments.
- IAS34 Interim Financial Reporting: Segment information.

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

IFRS10 Consolidated Financial Statements	This replaces the consolidation schedule guidance in IAS27 *Consolidated and Separate Financial Statements* and SIC 12 *Consolidation – Special Purpose Entities*. It introduces a single consolidation model for all entities based on control. The effective date is for accounting periods beginning on, or after 1 January 2014.
IFRS11 Joint Arrangements	This introduces new accounting arrangements for joint arrangements, replacing IAS31 *Interest in Joint Ventures*. The effective date is for accounting periods beginning on, or after 1 January 2014.
IFRS12 Disclosure of Interests in Other Entities	Additional disclosures are required so that financial statement users may evaluate the basis of the control, any restrictions on consolidated assets and liabilities and any risk exposures. The effective date is for accounting periods beginning on, or after 1 January 2014.
IFRS13 Fair Value Measurement	A new standard prepared to provide consistent guidance on fair value measurement. The application is subject to further review by HM Treasury and is expected to take effect in 2015/16.
IAS27 Separate Financial Statements	Contains the unchanged residual accounting and disclosure requirements for investments in subsidiaries, joint ventures and associates when an entity prepares separate financial statements. The effective date is for accounting periods beginning on, or after 1 January 2014.
IAS28 Investments in Associates and Joint Ventures	Outlines the accounting arrangements for investments in associates and joint ventures using equity arrangements. The effective date is for accounting periods beginning on, or after 1 January 2014.

1.2 Accounting convention

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

Intangible assets

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

All assets are revalued annually using the appropriate Office of National Statistics price index. Increases in value are credited to the revaluation reserve 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 expected life is regularly reviewed to ensure that depreciation and amortisation is charged in the Statement of Comprehensive Net Expenditure is materially accurate.

Impairment of intangible and property, plant and equipment assets

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

Research and development expenditure

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

Operating income

Income is made up of statutory fees from the registration of social care providers, voluntary healthcare providers; dentists, ambulance services and other income arising mainly from secondments of Commission staff and recoveries of costs from other public bodies. Annual registration fees are invoiced on the anniversary of the registration and recognised as income over the following 12 months. Statutory fees relating to future accounting periods are treated as income in advance at the end of each accounting period (note 14). In cases of voluntary deregistration, fees are refunded to registered organisations in accordance with the fee rebate scheme detailed on the Commission's internet site.

Leases

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

Financial instruments

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

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

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

Longer term debtors and creditors are discounted when the time value of money is considered material. Consequently the liability for additional pension contributions resulting from the early termination of staff in previous years is discounted by 1.8% (2012/13: 2.35%). This is the rate for market yields on AA corporate bonds as published by HM Treasury.

Grants receivable

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

Provisions

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

The amount recognised as a provision is the best estimate of the consideration required to settle the present obligation at the Statement of Financial Position date, taking into account the risks and uncertainties surrounding the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the real rate set by HM Treasury. Provisions falling due up to five years are increased by a discount factor of 1.9% (2012/13: 1.8%) and provisions falling due between 5 to 10 years are increased by a discount factor of 0.65% (2012/13: 1.0%) in accordance with HM Treasury guidance.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when 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 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

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

On 1 April 2009 staff transferred to the Care Quality Commission from three other Commissions – the Commission for Social Care Inspection (CSCI), the Healthcare Commission (HC) and the Mental Health Act Commission (MHAC). Existing members of the Principal Civil Service Pension Scheme (PCSPS) were offered membership of the NHS pension scheme but other transferring staff, who were members of the Local Government Pension Scheme (LGPS), were allowed to keep their legacy arrangements. Details of the NHS pension scheme and the LGPS are provided in the note 3 and in the Remuneration Report. Actuarial valuations are carried out at each Statement of Financial Position date with actuarial gains and losses recognised in full in the period in which they occur and reported in the Statement of Other Comprehensive Expenditure. Charges to the net expenditure account are detailed below.

Charged to staff costs:

- current service cost – the increase in liabilities as a result of additional service earned in the year.
- past service cost – the increase in liabilities arising from current year decisions whose effect relates to the years of service earned in earlier years.
- gains or losses on settlements and curtailments – the result of actions to relieve the liabilities or events that reduce the expected future service or accrual of benefits of employees.

Charged to other expenditure:

- interest cost – the expected increase in the present value of liabilities during the year as they move one year closer to being paid.
- expected return on assets – the annual investment return on the fund assets attributable to the Care Quality Commission, based on the average of the expected long-term return.

1.4 Administration and programme expenditure classification

The analysis for non-departmental public bodies is only required to be consistent with returns made for the purposes of the Departmental Group consolidation. The expenditure identified in the Statement of Comprehensive Net Expenditure was split between programme of £61m (2012/13: £48m) and administration of £32m (2012/13: £27m) in the Spending Review of the Care Quality Commission's sponsoring department, the Department of Health.

1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of CQC's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

There are no critical judgements made by management in the application of the accounting policies that has a significant effect on the amounts recognised in the financial statements other than:

a) Impairment of intangible assets (see accounting policy note 1.2 and note 10)

b) Bad debt provision (see accounting policy note 1.2 and note 12.2)

c) Indexation of fixed assets (see accounting policy note 1.2, note 7 and note 8)

2. Analysis of net expenditure by segment

IFRS8 requires operating segments to be identified on the basis of internal reports that are regularly reviewed by the Chief Executive. CQC's Board monitored the performance and resources of the organisation by three segments; continuing operations, Healthwatch England and the transformation programme. Healthwatch England is the independent champion for consumers of health and social care services. Under the transformation programme CQC is changing the way it inspects health and social care services.

The Statement of Financial Position by segment is not included as this was not reported to the Board.

An analysis of the net expenditure by segment is below:

	2013/14 Continuing operations £000	Health-watch England £000	Trans-formation £000	Total CQC £000	2012/13[1] Continuing operations £000	Health-watch England £000	Total CQC £000
Expenditure							
Staff costs	117,231	2,081	9,445	**128,757**	110,606	1,161	**111,767**
Depreciation and amortisation	11,047	–	–	**11,047**	11,383	–	**11,383**
Other expenditure	42,354	2,088	9,921	**54,363**	44,746	744	**45,490**
Impairments of assets	420	–	–	**420**	(229)	–	**(229)**
	171,052	4,169	19,366	**194,587**	166,506	1,905	**168,411**
Income							
Income from activities	(101,181)	–	–	**(101,181)**	(93,088)	–	**(93,088)**
Other income	(198)	(25)	–	**(223)**	(17)	–	**(17)**
	(101,379)	(25)	–	**(101,404)**	(93,025)	–	**(93,025)**
Net expenditure	**69,673**	**4,144**	**19,366**	**93,183**	**73,481**	**1,905**	**75,386**

The CQC transformation programme commenced during 2013/14, therefore no comparative data is presented in the table above.

Healthwatch England came into existence on 1 October 2012.

The Healthwatch England costs above include £120.0k (2012/13: £36.9k) which was recharged from continuing operations in relation to overhead costs incurred by CQC.

Healthwatch England overheads of approximately £288k (2012/13: £200k) has been absorbed by CQC and not recharged in this financial year.

[1] Figures for 2012/13 have been restated due to the revision of IAS19 Employee Benefits and a reclassification between headings.

2.1 Revenues from major products and services: income from fees

CQC has been operating a revised fees scheme from 1 April 2011; this introduced an annual fee for each service provider.

	2013/14 £000	2012/13 £000
Annual fees	(101,181)	(92,694)
Total fee income (note 6)	**(101,181)**	**(92,694)**

3. Staff numbers and related costs

3.1 Staff costs comprise

	Permanently employed £000	Others £000	2013/14 Total £000	2012/13[1] Total £000
Wages and salaries	84,374	22,326	106,700	90,818
Social security costs	7,782	313	8,095	7,122
Other pension costs	12,875	8	12,883	10,701
Termination benefits	31	–	31	1,147
	105,062	**22,647**	**127,709**	**109,788**
Less recoveries in respect of outward secondments	(259)	–	(259)	(311)
Increase in provision for pension fund deficits (see note 3.5)	1,307	–	1,307	2,290
Net costs	**106,110**	**22,647**	**128,757**	**111,767**

Other wages and salary costs consist of:	2013/14 £000	2012/13 £000
Agency	18,058	11,602
Secondments from other organisations	776	166
Commissioner fees	989	672
Second opinion doctors' fees and expenses	2,503	2,085
Total	**22,326**	**14,525**

Agency staff costs of £3.2m relating to IT software developments were capitalised during the year (2012/13: £9.1m).

[1] Figures for 2012/13 have been restated due to the revision of IAS19 Employee Benefits and termination benefits have been reclassified within staff costs having been previously included within other expenditure, note 4.

3.2 Average number of persons employed

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

	2013/14 Number	2012/13 Number
Directly employed	2,172	1,945
Other*	352	161
Agency staff engaged on capital projects	34	42
Total	**2,558**	**2,148**

The actual number of directly employed whole-time equivalents as at 31 March 2014 was 2,237 (31 March 2013: 2,142).

* This does not include commissioners and second opinion doctors who are paid per session.

3.3 Exit packages

Exit package cost band (including any special payment element)	Number of compulsory redund-ancies Number	Cost of compulsory redund-ancies £s	Number of other departures agreed Number	Cost of other departures agreed £s	Total number of exit packages Number	Total cost of exit packages £s	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £s
<£10,000	–	–	1	1,904	1	1,904	–	–
£10,000-£25,000	1	10,962	1	17,663	2	28,625	–	–
£25,000-£50,000	–	–	–	–	–	–	–	–
£50,000-£100,000	–	–	–	–	–	–	–	–
£100,000-£150,000	–	–	–	–	–	–	–	–
£150,000-£200,000	–	–	–	–	–	–	–	–
>£200,000	–	–	–	–	–	–	–	–
Total	**1**	**10,962**	**2**	**19,567**	**3**	**30,529**	**–**	**–**

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 early retirements have been agreed, the additional costs are met by CQC and not by the individual pension scheme. Ill-health retirement costs are met by the pension scheme and are not included in the table.

3.4 Non-compulsory departures

	Agreements Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	2	20
Mutually agreed resignations (MARS) contractual costs	–	–
Early retirements in the efficiency of service contractual costs	–	–
Contractual payments in lieu of notice	–	–
Exit payments following employment tribunals or court orders	–	–
Non-contractual payments requiring HM Treasury approval	–	–
Total	**2**	**20**

No non-contractual payments (£nil) were made to individuals where the payment value was more than 12 months of their annual salary.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that report.

3.5 Pension arrangements

The principal pension scheme CQC offers its employees is 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 £7,338k (2012/13: £5,785k) represents the contribution payable to the scheme by the Commission at rates specified in the rules of the plan. As at 31 March 2014, contributions of £674k (31 March 2013: £698k) due in respect of the current reporting period had not been paid over to the scheme.

The Pensions Act 2008 introduced measures to encourage greater private savings by making changes to workplace pensions. From 1 August 2013 all CQC staff entitled to be enrolled in a workplace pension were automatically enrolled, or from their start date if later than this date. All staff who are automatically enrolled retain the option to opt out at any time.

Automatic enrolment applies to all staff defined as a worker under the new legislation. This applies to all staff under a normal contract of employment with CQC as well as Mental Health Act Commissioners, Second Opinion Appointed Doctors and all staff on casual or zero hours contracts. The new rules do not apply to honorary appointments, such as the chair and board members, agency workers, experts by experience or staff seconded-in from other organisations.

CQC operates the NHS Pension Scheme for automatic enrolment, as this is the principal pension scheme for staff recruited directly by CQC. Those not eligible to join the NHS Pension Scheme are enrolled with the National Employment Savings Trust. The total cost charged to expenditure of £10k (2012/13: £nil) represents the contribution payable by CQC to the National Employment Savings Trust at the specific rates of the scheme. As at 31 March 2014, contributions of £2k (31 March 2013: £nil) due in respect of the reporting period had not been paid over to the scheme.

Due to legacy arrangements made through the predecessor organisations, CQC also makes contributions to defined benefit schemes for the former employees of CSCI. All schemes are closed funded schemes. The present value of the defined benefit obligation; the related current service cost and past service cost were measured using the projected unit credit method. This means that the current service cost will increase as the members of the scheme approach retirement.

The 2010/11 triennial actuarial valuation resulted in a change to the way the deficit recovery is managed. From 2011/12 some funds have levied an indexed cash sum in addition to a percentage of payroll costs. Furthermore, from 1 April 2011, increases to local government pensions in payment and deferred pensions have been linked to annual increases in the consumer prices index (CPI), rather than the retail prices index (RPI).

Contribution rates for 2014/15 range between 14.4% and 34.6% (17.0% for Teesside Pension Fund) with annual cash sums ranging from £1.5k to £104.0k (£nil for Teesside).

In June 2011 the International Accounting Standards Board (IASB) issued a new version of IAS19 Employee Benefits. This applies to financial years starting on or after 1 January 2013. Disclosures made within these statements have been prepared in accordance with the revised standard. As a result comparative figures relating to 2012/13 have been restated.

The key change is that the interest cost and expected return on assets component of profit are now combined into a net figure. In effect this means that the expected return has been replaced by a figure that would be applicable if the expected return on assets assumption was equal to the discount rate.

There is a requirement to include a sensitivity analysis for each significant actuarial assumption as at the end of the reporting period. This information is not included as there are 17 pension funds and therefore it is impracticable to include this sensitivity analysis.

Although the statement of financial position shows a deficit provision of £52m which results in an overall net liability position of £63.9m the Department of Health has provided a guarantee to meet the pension deficit liability should they fall due.

The present value of the defined benefit obligations were carried out at 31 March 2014 by:

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

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

Pension fund	Assets 31 March 2014 £000	Liabilities 31 March 2014 £000	Surplus/ (deficit) 31 March 2014 £000	Surplus/ (deficit) 31 March 2013 £000
Avon	4,302	(5,300)	**(998)**	(1,290)
Cambridgeshire	2,562	(3,170)	**(608)**	(769)
Cheshire	3,461	(3,523)	**(62)**	(244)
Cumbria	2,864	(3,105)	**(241)**	(952)
Derbyshire	–[1]	–[1]	**–[1]**	(489)
Dorset	2,369	(3,398)	**(1,029)**	(1,336)
East Sussex	4,925	(5,423)	**(498)**	(59)
Essex	4,591	(5,397)	**(806)**	(1,868)
Greater Manchester	13,039	(15,687)	**(2,648)**	(2,717)
Hampshire	3,730	(5,520)	**(1,790)**	(2,280)
Merseyside	5,653	(6,681)	**(1,028)**	(1,228)
Shropshire	1,953	(2,419)	**(466)**	(601)
Suffolk	2,791	(3,877)	**(1,086)**	(1,213)
Surrey	4,505	(5,330)	**(825)**	(835)
Teesside	236,698	(275,125)	**(38,427)**	(43,034)
West Sussex	3,422	(3,384)	**38**	(65)
West Yorkshire	8,683	(10,298)	**(1,615)**	(2,253)
Total	**305,548**	**(357,637)**	**(52,089)**	**(61,233)**

[1] On 31 March 2014 the staff membership of CQC in the Derbyshire County Council Pension Fund fell to zero. As a result a cessation charge was calculated as equal to the scheme deficit at 31 March 2014 of £1,167k (assets £2,508k, liabilities £3,675). This charge is now recognised in note 14, trade payables and other current liabilities.

Asset values are at bid value whereas prior to 2008, the value of assets may have been reported as mid value in accordance with the accounting requirement that was in force at that time.

In 2013/14 the deficit reduced predominantly due to better than expected asset returns over the year.

Two employees (2012/13: 3) retired early on ill-health grounds during the year. An additional pension cost of £57k (2012/13: £51k) was levied on CQC.

A summary of the IAS 19 disclosure information is as follows:

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

	Teesside Pension Fund % per annum		Other pension funds % per annum	
Key assumptions used:	2013/14	2012/13	2013/14	2012/13
Discount rate	4.3	4.4	3.5-4.4	3.7-4.5
Expected rate of salary increases	3.9	4.4	3.4-4.6	3.9-5.1
Expected return on scheme assets	4.3	4.4	3.5-4.4	3.7-4.5
Future pension increases	2.4	2.5	2.3-2.8	2.4-2.8
Inflation	2.4	2.5	2.3-2.8	2.4-2.8

Mortality assumptions

Investigations have been carried out into the mortality experience of the CQC'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	
Key assumptions used:	2013/14	2012/13	2013/14	2012/13
Retiring today:				
Males	22.9	19.2	21.4-24.4	20.1-24.0
Females	25.1	23.2	24.0-26.2	22.9-25.9
Retiring in 20 years:				
Males	25.4	21.1	24.0-26.9	22.1-25.7
Females	27.7	25.1	26.6-29.0	25.0-28.2

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

	2013/14 £000	2012/13 £000
Service cost:		
Current service cost	6,025	7,220
Past service cost (including curtailments)	11	119
Net interest expense	2,577	2,995
Amount recognised in net expenditure	**8,613**	**10,334**

Of the expense for the year, the total service cost of £6.0m (2012/13: £7.3m) has been included in the net expenditure statement as staff expenditure, note 3.1. £4.7m (2012/13: £5.0m) is included within other pension costs and £1.3m (2012/13: £2.3m) is included as an increase in provision for pension fund deficits. The net interest expense of £2.6m (2012/13: £3.0m) has been included in other expenditure, note 4. The remeasurement of the net defined benefit obligation is included in the statement of comprehensive expenditure.

Amounts recognised in the statement of comprehensive expenditure are as follows:

	2013/14 £000	2012/13 £000
The return on plan assets (excluding amounts included in net interest expense)	(2,817)	(26,590)
Actuarial gains and losses arising from changes in demographic assumptions	11,135	146
Actuarial gains and losses arising from changes in financial assumptions	(4,492)	15,059
Actuarial gains and losses arising from experience adjustments	(15,687)	(435)
Remeasurement of the net defined benefit obligations	**(11,861)**	**(11,820)**

The cumulative amount of actuarial gains and losses recognised in reserves since the date of transition to IFRS on 1 April 2008 to 31 March 2014 is £74m (31 March 2013: £85m).

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:

	31 March 2014 £000	31 March 2013 £000
Present value of defined benefit obligation	(357,548)	(357,556)
Fair value of scheme assets	305,548	296,408
Deficit in scheme	**(52,000)**	**(61,148)**
Past service cost not yet recognised	(89)	(85)
Liability recognised in the Statement of Financial Position	**(52,089)**	**(61,233)**

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

	2013/14 £000	2012/13 £000
At 1 April	**(357,641)**	**(327,238)**
Current service cost	(6,025)	(7,215)
Interest cost	(15,483)	(15,001)
Contributions from scheme members	(1,815)	(1,920)
Past service costs (including curtailments)	(11)	(119)
Remeasurement (gains)/losses		
Actuarial gains and losses arising from changes in demographic assumptions	(11,135)	(146)
Actuarial gains and losses arising from changes in financial assumptions	4,492	(15,059)
Actuarial gains and losses arising from experience adjustments	15,687	435
Benefits paid	10,619	8,622
Scheme cessation	3,675	–
At 31 March	**(357,637)**	**(357,641)**

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

	2013/14 £000	2012/13 £000
At 1 April	**296,408**	**259,470**
Interest income	12,906	12,006
Remeasurement gain/(loss)		
The return on plan assets (excluding amounts included in net interest expense)	2,817	26,590
Employer contributions	4,735	5,049
Member contributions	1,815	1,920
Benefits paid	(10,619)	(8,622)
Administration expenses	(6)	(5)
Scheme cessation	(2,508)	–
At 31 March	**305,548**	**296,408**

The actual return on scheme assets was a gain of £14.8m (2012/13: £36.2m gain).

The analysis of the scheme assets and the expected rate of return at the statement of financial position date is as follows:

	Expected return		Fair value of assets	
	2013/14 %	2012/13 %	2013/14 £000	2012/13 £000
Equities	3.5-4.4	3.7-4.5	239,239	221,926
Property	3.5-4.4	3.7-4.5	16,612	16,089
Government bonds	3.5-4.4	3.7-4.5	9,321	21,715
Other bonds	3.5-4.4	3.7-4.5	17,526	10,976
Cash	3.5-4.4	3.7-4.5	14,382	13,854
Other	3.5-4.4	3.7-4.5	10,976	11,848
Total			**308,056**	**296,408**

4. Other expenditure

	2013/14 £000	£000	2012/13[1] £000	£000
IT costs, including general project management	13,850		13,383	
Travel and subsistence	7,322		6,308	
General office supplies	6,487		3,611	
Consultancy	5,881		1,752	
Communications	4,899		3,363	
Rentals under operating leases	3,527		3,458	
Recruitment, training and development costs	3,395		2,132	
Telecoms	2,034		2,232	
Professional fees and project costs	1,185		1,146	
Other premises costs	958		3,742	
Printing and publishing	697		595	
Other costs	267		266	
External audit fees – statutory work	145		145	
Losses and special payments (bad debts)	141		128	
Operating leases (equipment)	84		61	
Special payments (other)	60		60	
		50,932		42,382
Non-cash items:				
Loss on disposal of intangible assets	769		–	
Loss on disposal of property, plant and equipment	39		3	
Net (gain) on revaluation of intangible assets	–		(40)	
Net (gain) on revaluation of property, plant and equipment	–		(9)	
Cost of PCSPS long term creditor recognised as an expense	85		159	
Unwinding of discount on provisions	(12)		–	
Change in discount rate on provisions	(27)		–	
Net expenses on pension scheme assets and liabilities	2,577		2,995	
		3,431		3,108
Other expenditure		**54,363**		**45,490**
Amortisation of intangible assets	9,638		8,274	
Depreciation of property, plant and equipment	1,409		3,109	
Depreciation and amortisation		**11,047**		**11,383**
Impairment of intangible assets	380		(229)	
Impairment of property, plant and equipment	40		–	
Impairments		**420**		**(229)**

[1] Figures for 2012/13 have been restated due to the revision of IAS19 Employee Benefits and termination benefits have been reclassified within staff costs, note 3.1, having been previously included within other expenditure.

There were no individual losses or special payments that exceeded £300k (2012/13: none).

4.1 Auditors' remuneration

	2013/14 £000	2012/13 £000
Fees payable for the audit of the Commission's annual accounts	145	145
Total	**145**	**145**

5. Income

	2013/14 £000	2012/13 £000
Income from activities:		
Income from fees	(101,181)	(92,694)
Other income	–	(314)
	(101,181)	**(93,008)**
Other income:		
Other non-trading income	(223)	(17)
Net return on pension scheme assets and liabilities	–	–
	(223)	**(17)**
Total	**(101,404)**	**(93,025)**

Fees and charges made to the independent sector are in line with fee scales prescribed by the Secretary of State for Health under the Health and Social Care Act 2008. While the same Act also prescribed that all NHS trusts had to be registered with CQC from 1 April 2010, dentists from 1 April 2011, GP "out of hours" services from 1 April 2012 and general practitioners from 1 April 2013.

Annual registration fees are invoiced on the anniversary of the registration and recognised as income over the following 12 months. Statutory fees relating to future accounting periods are treated as income in advance at the end of each accounting period (note 14). In cases of voluntary deregistration, fees are refunded to registered organisations in accordance with the fee rebate scheme detailed on the CQC website.

6. Analysis of net expenditure by admin and programme budget

	2013/14			2012/13[1]		
	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000
Expenditure						
Staff costs	14,143	114,614	128,757	11,177	100,590	111,767
IT costs, including general project management	3,755	10,095	13,850	3,774	9,609	13,383
Travel and subsistence	1,963	5,359	7,322	1,779	4,529	6,308
General office supplies	2,199	4,288	6,487	1,018	2,593	3,611
Consultancy	966	4,915	5,881	491	1,261	1,752
Communications	1,474	3,425	4,899	948	2,415	3,363
Rentals under operating leases	955	2,572	3,527	985	2,473	3,458
Recruitment, training and development costs	953	2,442	3,395	424	1,708	2,132
Telecoms	534	1,500	2,034	629	1,603	2,232
Professional fees and project costs	323	862	1,185	323	823	1,146
Other premises costs	266	692	958	1,055	2,687	3,742
Printing and publishing	227	470	697	168	427	595
Other costs	178	89	267	157	109	266
External audit fees – statutory work	38	107	145	41	104	145
Losses and special payments (bad debts)	37	104	141	36	92	128
Operating leases (equipment)	22	62	84	17	44	61
Special payments (other)	16	44	60	17	43	60

	2013/14			2012/13[1]		
	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000
Non-cash items:						
Loss on disposal of intangible assets	200	569	769	–	–	–
Loss on disposal of property, plant and equipment	10	29	39	1	2	3
Net (gain) on revaluation of intangible assets	–	–	–	(11)	(29)	(40)
Net (gain) on revaluation of property, plant and equipment	–	–	–	(3)	(6)	(9)
Cost of PCSPS long term creditor recognised as an expense	22	63	85	45	114	159
Unwinding of discount on provisions	–	(12)	(12)	–	–	–
Change in discount rate on provisions	–	(27)	(27)	–	–	–
Net expenses on pension scheme assets and liabilities	670	1,907	2,577	845	2,150	2,995
Amortisation of intangible assets	2,506	7,132	9,638	2,317	5,957	8,274
Depreciation of property, plant and equipment	366	1,043	1,409	871	2,238	3,109
Impairment of intangible assets	–	380	380	(64)	(165)	(229)
Impairment of property, plant and equipment	–	40	40	–	–	–
Income						
Income from activities	–	(101,181)	(101,181)	–	(93,008)	(93,008)
Other income	(25)	(198)	(223)	–	(17)	(17)
Net expenditure after interest	**31,798**	**61,385**	**93,183**	**27,040**	**48,346**	**75,386**

[1] Figures for 2012/13 have been restated due to the revision of IAS19 Employee Benefits

7. Intangible assets

	IT software development £000	Software licences £000	Website £000	Total £000
Cost or valuation				
At 1 April 2013	28,166	2,273	3,944	34,383
Additions	5,040	77	2,401	7,518
Disposals	(3,697)	(37)	(1,452)	(5,186)
Impairments	(391)	(83)	(68)	(542)
Indexation	(646)	(6)	(52)	(704)
At 31 March 2014	**28,472**	**2,224**	**4,773**	**35,469**
Amortisation				
At 1 April 2013	(11,663)	(2,148)	(1,305)	(15,116)
Charged in year	(8,222)	(76)	(1,340)	(9,638)
Disposals	3,428	37	952	4,417
Impairments	82	78	2	162
Indexation	263	4	25	292
At 31 March 2014	**(16,112)**	**(2,105)**	**(1,666)**	**(19,883)**
Net book value at 31 March 2014	**12,360**	**119**	**3,107**	**15,586**
Net book value at 1 April 2013	**16,503**	**125**	**2,639**	**19,267**
Asset financing:				
Owned	12,360	119	3,107	15,586
At 31 March 2014	**12,360**	**119**	**3,107**	**15,586**
Cost or valuation				
At 1 April 2012	16,829	2,160	1,862	20,851
Additions	9,107	112	1,806	11,025
Disposals	(63)	(32)	–	(95)
Impairments	(233)	(240)	–	(473)
Indexation	2,526	273	276	3,075
At 31 March 2013	**28,166**	**2,273**	**3,944**	**34,383**

	IT software development £000	Software licences £000	Website £000	Total £000
Amortisation				
At 1 April 2012	(4,294)	(2,110)	(388)	(6,792)
Charged in year	(6,899)	(518)	(857)	(8,274)
Disposals	63	32	–	95
Impairments	47	655	–	702
Indexation	(580)	(207)	(60)	(847)
At 31 March 2013	**(11,663)**	**(2,148)**	**(1,305)**	**(15,116)**
Net book value at 31 March 2013	**16,503**	**125**	**2,639**	**19,267**
Net book value at 1 April 2012	**12,535**	**50**	**1,474**	**14,059**
Asset financing:				
Owned	16,503	125	2,639	19,267
At 31 March 2013	**16,503**	**125**	**2,639**	**19,267**

Intangible assets comprise software licences, software development costs, including related contractor and staff costs, and website development costs. These are valued using indices issued by the Office for National Statistics. Related general project management and overhead costs are not capitalised.

The opening and closing element of the revaluation reserve is shown below:

Revaluation reserve: intangible assets	2013/14 £000	2012/13 £000
Balance at 1 April	1,552	98
Net (loss)/gain on indexation of intangible assets	(412)	2,188
Transfers between reserves for intangible assets	(687)	(734)
Balance at 31 March	**453**	**1,552**

8. Property, plant and equipment

	Information Technology £000	Furniture & Fittings £000	Total £000
Cost or valuation			
At 1 April 2013	6,411	6,833	13,244
Additions	932	74	1,006
Disposals	(2,502)	(100)	(2,602)
Impairments	(93)	–	(93)
Indexation	(86)	71	(15)
At 31 March 2014	**4,662**	**6,878**	**11,540**
Depreciation			
At 1 April 2013	(4,816)	(6,122)	(10,938)
Charged in year	(1,101)	(308)	(1,409)
Disposals	2,463	100	2,563
Impairments	53	–	53
Indexation	45	(64)	(19)
At 31 March 2014	**(3,356)**	**(6,394)**	**(9,750)**
Net book value at 31 March 2014	**1,306**	**484**	**1,790**
Net book value at 1 April 2013	**1,595**	**711**	**2,306**
Asset financing:			
Owned	1,306	484	1,790
At 31 March 2014	**1,306**	**484**	**1,790**
Cost or valuation			
At 1 April 2012	8,676	6,834	15,510
Additions	436	5	441
Disposals	(3,457)	(123)	(3,580)
Impairments	–	–	–
Indexation	756	117	873
At 31 March 2013	**6,411**	**6,833**	**13,244**

	Information Technology £000	Furniture & Fittings £000	Total £000
Depreciation			
At 1 April 2012	(5,255)	(5,715)	(10,970)
Charged in year	(2,653)	(456)	(3,109)
Disposals	3,451	126	3,577
Impairments	–	–	–
Indexation	(359)	(77)	(436)
At 31 March 2013	**(4,816)**	**(6,122)**	**(10,938)**
Net book value at 31 March 2013	**1,595**	**711**	**2,306**
Net book value at 1 April 2012	**3,421**	**1,119**	**4,540**
Asset financing:			
Owned	1,595	711	2,306
At 31 March 2013	**1,595**	**711**	**2,306**

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

The opening and closing element of the revaluation reserve is shown below:

Revaluation reserve: property, plant and equipment	2013/14 £000	2012/13 £000
Balance at 1 April	282	131
Net gain on indexation of property, plant and equipment	(34)	428
Transfers between reserves for property, plant and equipment	(147)	(277)
Balance at 31 March	**101**	**282**

9. Financial instruments

As the cash requirements of CQC 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 CQC's expected purchase and usage requirements and CQC is therefore exposed to little credit, liquidity or market risk.

Moreover financial instruments play a much more limited role in creating or changing risk that would be typical of listed companies. CQC 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 CQC 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 monitors the credit closely and all undisputed debts over 61 days where internal recovery processes were exhausted were sent to a debt collection company for the recovery action. While ultimate recovery was still pursued, such debts were provided for as a matter of course.

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

The table below shows the aging of the overdue analysis of trade debtors which have not been provided for at the statement of financial position date:

	Less than 30 days past due	31-60 days past due	61 and over days past due
At 31 March 2014	438	1,504	57
At 31 March 2013	41	1,376	141

Intra-government balances are payable 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 were 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 2014 £000	31 March 2013 £000
Balance at 31 March	(20,008)	(15,798)

d) Capital risk management

Ongoing funding for CQC has been confirmed by the Department of Health. As a result the capital structure was considered low risk and it was not a requirement for management to actively monitor this on a day to day basis.

10. Impairments

At 31 March 2014 CQC carried out an impairment review of IT intangible assets. The review resulted in no impairments being recognised.

All assets are revalued annually using the appropriate Office of National Statistics price index. This has resulted in downward movement in value which was initially offset against previous gains held in the revaluation reserve and the remainder was charged to expenditure as impairments.

Impairments for the previous year related to old compliance and registration systems which were updated due to the development of new systems.

	31 March 2014 £000	31 March 2013 £000
Developed software	309	186
Website	66	–
Information technology	40	–
Software licences	5	(415)
Total Impairments	**420**	**(229)**

11. Inventories

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

12. Trade receivables and other current assets

	31 March 2014 £000	31 March 2013 £000
Amounts falling due within one year:		
Deposits and advances	132	127
Other receivables	521	170
Prepayments and accrued income	2,006	2,069
Subtotal: Other current assets	**2,659**	**2,366**
Trade receivables	4,894	3,903
Total	**7,553**	**6,269**

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

Deposits and advances include payments on salary and staff loans which total £2k and £130k (2012/13: £7k and £120k). Staff could apply for advance payments on salary and loans up to a maximum of £5k for rail season tickets.

12.1 Intra-government receivable balances

	31 March 2014 £000	31 March 2013 £000
Intra-government balances:		
Balances with central government	130	126
Balances with NHS trusts and foundation trusts	77	194
Balances with local authorities	312	104
Balances with public corporations and trading funds	48	–
Subtotal: intra-government balances	**567**	**424**
Balances with bodies external to government	6,986	5,845
Total	**7,553**	**6,269**

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

12.2 Movement in the allowance for doubtful debts

	2013/14 £000	2012/13 £000
Balance at 1 April	**318**	**422**
Additional losses recognised during the year	323	283
Impairment losses recognised	(58)	(174)
Amounts written off during the year as uncollectable	(88)	(75)
Amounts recovered during the year	(164)	(138)
Balance at 31 March	**331**	**318**

13. Cash and cash equivalents

	2013/14 £000	2012/13 £000
Balance at 1 April	**20,187**	**15,766**
Net change in cash and cash equivalent balances	3,046	4,421
Balance at 31 March	**23,233**	**20,187**
The following balances at 31 March were held at:		
Government banking service and cash in hand	23,233	20,187
Total balance at 31 March	**23,233**	**20,187**

14. Trade payables and other current liabilities

	31 March 2014 £000	31 March 2013[1] £000
Amounts falling due within one year:		
VAT	–	(39)
Other taxation and social security	(2,655)	(3,384)
Trade payables	(1,432)	(1,026)
Other payables	(2,877)	(1,939)
Accruals and deferred income	(11,463)	(8,324)
Capital creditors – intangible assets	(1,562)	(842)
Capital creditors – property, plant and equipment	(19)	(244)
	(20,008)	**(15,798)**
Current pension liabilities	(333)	(316)
Fee income in advance	(37,127)	(36,576)
Total current trade payables and other current liabilities	**(57,468)**	**(52,690)**
Amounts falling after more than one year:		
Pension liabilities	(533)	(788)
Total non-current trade payables and other non-current liabilities	**(533)**	**(788)**

[1] Figures as at 31 March 2013 amended due to reclassification between headings.

Trade payables at 31 March 2014 were equivalent to 14 days (31 March 2013: 15 days) purchases, based on the daily average 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 balance at various interest rates. While CQC has financial risk policies in place to ensure that all payables are paid within the pre-agreed credit terms, no amounts (2012/13: £nil) were paid under the provisions of the Late Payment of Commercial Debts (Interest) Act 1998.

Trade payables falling due after more than one year have been reduced by a discount factor of 1.80% per annum (2012/13: 2.35%) in accordance with HM Treasury guidance.

14.1 Intra-government payable balances

	Amounts falling due within one year		Amounts falling due after more than one year	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
Intra-government balances:				
Balances with central government	(6,171)	(4,751)	–	–
Balances with NHS trusts and foundation trusts	(327)	(113)	–	–
Balances with local authorities	(2,572)	(2,169)	–	–
Balances with public corporations and trading funds	(4)	–	–	–
Subtotal: intra-government balances	**(9,074)**	**(7,033)**	**–**	**–**
Balances with bodies external to government	(48,394)	(45,657)	(533)	(788)
Total	**(57,468)**	**(52,690)**	**(533)**	**(788)**

15. Provisions for liabilities and charges

	2013/14			2012/13		
	Employment termination and other costs £000	Leased property dilapidations £000	Total £000	Employment termination and other costs £000	Leased property dilapidations £000	Total £000
Balance at 1 April	1,200	1,550	2,750	491	1,650	2,141
Provided in year	179	178	357	1,201	–	1,201
Provisions not required written back	(254)	(19)	(273)	(32)	–	(32)
Provisions utilised in year	(800)	(48)	(848)	(460)	(100)	(560)
Change in discount rate	–	(27)	(27)	–	–	–
Unwinding of discount	–	(12)	(12)	–	–	–
Balance at 31 March	**325**	**1,622**	**1,947**	**1,200**	**1,550**	**2,750**

15.1 Analysis of expected timings of discounted cash flows

	2013/14			2012/13		
	Employment termination and other costs £000	Leased property dilapidations £000	Total £000	Employment termination and other costs £000	Leased property dilapidations £000	Total £000
Not later than one year	325	58	383	1,200	418	1,618
Later than one year and not later than five years	–	805	805	–	894	894
Later than five years	–	759	759	–	238	238
Balance at 31 March	**325**	**1,622**	**1,947**	**1,200**	**1,550**	**2,750**

CQC has restructured its senior management structure. A provision has been made to cover the cost of redundancies. This provision is estimated as £0.1m (31 March 2013: £0.9m).

A provision has been made to cover future legal costs, for example tribunals and judicial review. The provision is estimated at £0.2m (31 March 2013: £0.3m).

Leased property dilapidations are the costs that would be payable on the termination of the leases.

Provisions falling due up to five years have been increased by a discount factor of 1.9% (2012/13: 1.8%) and provisions falling due between 5 and 10 years have been increased by a discount factor of 0.65% (2012/13: 1.0%) in accordance with HM Treasury guidance.

16. Capital commitments

Contracted capital commitments at 31 March 2014, not otherwise included within these financial statements, totalled £1,793k (31 March 2013: £1,322k) and consist, in the main, of IT hardware and software developments.

	31 March 2014 £000	31 March 2013 £000
Intangible assets	1,783	1,314
Property, plant and equipment	10	8
Total	**1,793**	**1,322**

17. Commitments under leases

17.1 Obligations under operating 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 2014 £000	31 March 2013 £000
Buildings:		
Not later than one year	3,331	3,324
Later than one year and not later than 5 years	12,570	10,692
Later than 5 years	2,446	4,716
	18,347	**18,732**
Other:		
Not later than one year	46	44
Later than one year and not later than 5 years	4	35
Later than 5 years	–	–
	50	**79**

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

17.2 Lease payments recognised as an expense

	2013/14 £000	2012/13 £000
Buildings	3,527	3,458
Other	84	61
	3,611	**3,519**

18. Other financial commitments

There were no other material financial commitments at the statement date (31 March 2013: £nil).

19. Contingent liabilities disclosed under IAS37

CQC has the following contingent liabilities:

	31 March 2014 £000	31 March 2013 £000
Civil Litigation	376	–
Employment tribunals	308	250
Prosecution	150	–
First Tier Tribunal	85	–
Legal advice	10	1
Personal injury claims	–	42
Judicial review	–	3
Total	**929**	**296**

Due to the nature of the contingent liabilities it is difficult to accurately determine the final amounts due and when they will crystallise.

20. Related party transactions

The Care Quality Commission is a non-departmental public body sponsored by the Department of Health. The Department of Health is regarded as a related party. During the year CQC has had a significant number of material transactions with the Department of Health, other with other entities for which the Department of Health is regarded as the parent department.

	Payments to related party £000	Receipts from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Department of Health	5,271	87,350	2,070	42
NHS Foundation Trusts	103	11,480	158	22
NHS Trusts	189	8,135	169	55
NHS England	–	–	46	5
NHS Special Health Authorities	141	–	–	–
Other non-departmental public bodies	57	54	6	82

CQC received a total amount of grant-in aid of £87.3m (2012/13: £68.1m) from the Department of Health.

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

In addition, CQC has had a number of transactions with other government departments and other central and local government bodies. Most of these transactions have been with the Department for Communities and Local Government in respect of rent for office space. CQC also had amounts owed to the NHS pension fund and other government departments; these amounts are mostly owed to HMRC.

21. Third-party assets

The Commission held no third-party assets at the reporting date (31 March 2013: £nil).

22. Prior period adjustments and changes in accounting policies

In June 2013 the International Accounting Standards Board (IASB) issued a revised version of IAS19 Employee Benefits which applied to financial years starting on or after 1 January 2013. These statements have been prepared based on the revised standard and as a result comparative figures for 2012/13 have been restated on the same basis.

The revised standard implemented a change to the expected return on asset component of pension costs. This means that the expected return on assets is calculated at the discount rate, instead of the previous method which was at an expected rate of return based on actual plan assets held.

Below is a summary of the changes made in respect of the Statement of Comprehensive Net Expenditure, Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the notes to the financial statements.

In addition termination benefits have been reclassified within staff costs, this was previously presented within other expenditure.

Where figures within the notes to the financial statements are restated this has been indicated on the note. Note 3.5 Pension Costs is prepared in accordance with the revised standard.

22.1 Statement of Comprehensive Net Expenditure

	Published Accounts 2012/13 £000	IAS 19 adjustments £000	Reclass-ification £000	Restated Accounts 2012/13 £000
Expenditure				
Staff costs	110,349	271	1,147	111,767
Other expenditure	44,067	2,570	(1,147)	45,490
Net expenditure for the year	**72,545**	**2,841**	**–**	**75,386**
Other comprehensive expenditure:				
Actuarial (gain) in pension scheme	(8,979)	(2,841)	–	(11,820)

22.2 Statement of Cash Flows

	Published Accounts 2012/13 £000	IAS 19 adjustments £000	Reclass-ification £000	Restated Accounts 2012/13 £000
Cash flows from operating activities				
Total net expenditure	(72,545)	(2,841)	–	(75,386)
Net expense on pension scheme assets and liabilities	425	2,570	–	2,995
Increase in provision	184	(2,570)	–	(2,386)
Non cash pension charge	2,444	2,841	–	5,285

22.3 Statement of Changes in Taxpayers' Equity

	Published Accounts 2012/13 £000	IAS 19 adjustments £000	Reclass-ification £000	Restated Accounts 2012/13 £000
General reserve				
Net expenditure for the year	(72,545)	(2,841)	–	(75,386)
Actuarial gain in pension schemes	8,979	2,841	–	11,820

22.4 Analysis of net expenditure by segment, note 2

	Published Accounts 2012/13 £000	IAS 19 adjustments £000	Reclass-ification £000	Restated Accounts 2012/13 £000
Continuing operations				
Staff costs	109,188	271	1,147	110,606
Other expenditure	43,323	2,570	(1,147)	44,746
Net expenditure for the year	**70,640**	**2,841**	**–**	**73,481**
Total net expenditure for the year	**72,545**	**2,841**	**–**	**75,386**

22.5 Staff costs, note 3.1

	Published Accounts 2012/13 £000	IAS 19 adjustments £000	Reclass-ification £000	Restated Accounts 2012/13 £000
Permanently employed				
Termination benefits	–	–	1,147	1,147
Increase in provision for pension fund deficits	2,019	271	–	2,290
Total staff costs	**110,349**	**271**	**1,147**	**111,767**

22.6 Other expenditure, note 4

	Published Accounts 2012/13 £000	IAS 19 adjustments £000	Reclass-ification £000	Restated Accounts 2012/13 £000
Termination benefits	1,147	–	(1,147)	–
Non-cash items:				
Net expense on pension scheme assets and liabilities	425	2,570	–	2,995
Total staff costs	**44,067**	**2,570**	**(1,147)**	**45,490**

23. Events after the reporting period date

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 25 June 2014.

There were no significant post statement of financial position events.

Care Quality Commission

How to contact us

Call us on › 03000 616161

Email us at › enquiries@cqc.org.uk

Look at our website › www.cqc.org.uk

Write to us at ›
Care Quality Commission
Citygate
Gallowgate
NE1 4PA

Follow us on Twitter › @CareQualityComm

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