Care Quality Commission

Annual report and accounts **2014/15**

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Presented to Parliament pursuant to paragraph 10(4) of Schedule 1 of the Health and Social Care Act 2008.

Ordered by the House of Commons to be printed on 21 July 2015.

HC 256

This publication is available at https://www.gov.uk/government/publications

Print ISBN 9781474120616

Web ISBN 9781474120623

ID 2904026 07/15

Printed on paper containing 75% recycled fibre content minimum

Printed in the UK by the Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office

Contents

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

OUR PURPOSE

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

OUR ROLE

We **register** care providers.

We **monitor, inspect and rate** services.

We **take action to protect people** who use services.

We **speak with our independent voice**, publishing regional and national views of the major quality issues in health and social care.

OUR VALUES

Excellence – being a high-performing organisation.

Caring – treating everyone with dignity and respect.

Integrity – doing the right thing.

Teamwork – learning from each other to be the best we can.

Foreword

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

To achieve this clear purpose, CQC has been on a journey for the last two years – to radically transform the way we regulate and inspect health and social care providers in England, and bring in new, rigorous and expert-led inspections and ratings. In 2014/15, we moved from designing this new approach to delivering it.

Together with providers, people who use services and stakeholders, we worked hard during the year to implement our new approach. There have been inevitable challenges in introducing a new methodology, but it is beginning to show results. We have celebrated examples of outstanding care, and we have found and tackled inadequate care.

Although it is still too early to fully demonstrate the impact of the change, we firmly believe we are heading in the right direction. We are proving our ability to deliver effective assessments of the organisations we regulate. Compared to the past, when there was no shared view of what good quality looked like, we are now able to provide a comprehensive description of the quality of care delivered by health and adult social care providers.

We now know that around 65% of the services we have rated deliver good or outstanding care, with the remainder either requiring improvement or delivering inadequate care – we have never had this kind of information before.

We have moved from being a regulator that focuses on whether providers are passing a legal threshold – to one that encourages improvement by all services through highlighting good and outstanding practice while ensuring improvements are made to unsafe and poor quality services. Over 70% of providers say that CQC inspections gave them information that helped them to improve their service.

In 2015/16, we are continuing to embed and improve this new approach, and addressing the challenge of making sure we have the right people, capacity, capability, systems and processes to successfully deliver our purpose.

We want to continue to build public confidence in our work, empower people to understand the quality of care they should expect, and help them to choose between services if they want to. In a health and care system under significant financial pressure, it is even more important to have an independent regulator to provide clear and trusted information on quality.

With a strong model underpinning our work, we know we can work together on a sound basis to make sure health and social care services are safe, effective, caring, responsive and well-led. As Dr Bill Kirkup CBE, chairman of the investigation into maternity care at Morecambe Bay Hospital Trust said in his March 2015 report, "It is clear to us that the biggest change has been in the CQC. From an organisation that manifestly had significant problems in its first few years, which greatly hampered it, it has become, we believe, capable of effectively carrying out its role as principal quality regulator."

A real sense of progress

During 2014/15, we saw rapid progress. At the start of the year we were focused on testing and evaluating our new approach, and were only just beginning to inspect and rate the first few services. By the end of the year, we had fully implemented our new inspections approach and ratings system for three key sectors: NHS acute, mental health and community trusts; adult social care; and GP practices. We were well underway with developing our approach for other sectors.

We inspected a total of 7,038 providers/locations under our new approach and, of these, we had published the ratings of 3,180 by 31 March 2015. Our ratings of outstanding, good, requires improvement and inadequate are giving people choice and encouraging providers not just to meet standards, but to improve. They are also showing the wide variation in quality that exists within the different care sectors. During 2015/16 and 2016/17 we will continue to inspect and rate the rest of our providers.

We launched our Intelligent Monitoring system for GP practices and mental health services during 2014/15, building on the system we already had in place for acute hospitals. Intelligent Monitoring is an important tool that uses data to flag potential concerns about the quality of care of providers and helps to prioritise our inspections. We did not get GP Intelligent Monitoring right to begin with, due to data errors which we quickly corrected, and we decided after considering feedback from GPs that the system of risk banding was not appropriate for GP practices.

We prepared providers and our staff for the new fundamental standards of care that launched on 1 April 2015. These standards include important new enforcement powers for CQC that allow us to go straight to prosecution when we find the most serious failings in care, without issuing a Warning Notice first. They also include new requirements, the 'duty of candour' and 'fit and proper person' for directors, that will help us to hold leadership to account for poor care.

Where we identify serious failures in care we will place a provider in special measures. We developed special measures regimes for NHS trusts in 2013/14 and for GP practices in 2014/15. There were 14 trusts and 10 GP practices in special measures at the end of the year. They were introduced for adult social care from April 2015.

Special measures can be a turning point in care for a service. Almost all of the 11 NHS trusts that were put into special measures in 2013 had demonstrated significant improvement when we inspected them eight to 10 months later. Some had improved so much that we were able to rate them as good and they exited special measures. Others needed further support to continue their progress.

The positive impact of special measures was also shown in a report by Dr Foster in February 2015, *Is special measures working?* This looked at a study of the 11 trusts and concluded that special measures had had an impact on reducing mortality rates across the trusts.

Strengthening our systems and processes

Although we have seen good progress, there have been challenges during the year in getting our systems and processes right and able to fully support the new approach. Our more detailed approach to inspection with larger, specialist teams means we are able to better identify poor care. However, inspections are taking longer and they require more staff.

During 2014/15, we focused on building our capacity by recruiting a strong workforce under each of our five directorates, and we designed a new recruitment approach to help us find high calibre candidates. This extensive recruitment programme continued throughout the year, and we made progress in recruiting for some key

roles. However, recruiting enough new inspectors and analysts with the right skills was a significant challenge and we had to reset our expectations of how quickly we could recruit. Our revised goal for the end of April 2015 was to hire 300 additional inspectors and we met that target. By the end of December 2015 we hope to have achieved our overall target of 600 new inspectors.

We have continued to focus on improving our registration function. We have introduced a more thorough test for those applying to provide care services from April 2015. To help streamline processes, we will be starting to roll out online accounts to all providers.

We previously had a key performance indicator on the timeliness of our responses to safeguarding information. This was to respond to safeguarding alerts within one day, and concerns within two days. Extensive investigation of the data underpinning this target showed that the data was not appropriate and not accurately reporting the actions of our inspectors in responding to information of concern. In recognition of this, we changed our way of reporting our safeguarding activity during the course of 2014/15, and we now report on the time taken for a variety of different possible actions.

In 2015/16, we will make sure our operating model, and the systems and processes that go alongside it, are robust and strong enough to cope with the increased detail of inspections, while ensuring quality and consistency. We will particularly focus on: improving the cost, quality and timeliness of inspection and inspection reports; improving the management of staff; identifying and managing provider risk systematically; improving the use of data and evidence across the inspection process; reducing reliance on manual processes; and embedding quality standards, controls and assurance.

Rooted in our values

Our values are fundamental to the way we work at CQC, and are the bedrock on which we build our progress. In October we formally launched our new values – excellence, caring, integrity and teamwork. Excellence helps us to become a high-performing organisation; caring underlines the importance of treating everyone with dignity and respect; integrity helps us to always do the right thing; and teamwork is about learning from each other to be the best we can be.

As a regulator our task is to look at providers and ensure they are providing a high-quality service. However, to do this successfully we must also look inwards at our own capabilities and capacity as an organisation.

Taking action on equality – for people using health and social care services and for our own staff – is important for us. We know that there is still too much variation in people's access, experience and outcomes when they use services, and that this affects the quality of services for many people. To play our part in addressing this, we have developed our human rights approach to regulation which embeds equality into the way that we regulate services. Turning to our own staff, we know that diverse organisations are effective organisations. We need to focus both on addressing specific staff equality issues and promoting a culture of inclusivity at CQC. During 2014/2015 we developed five new equality objectives for 2015-2017 supporting both our regulatory and human resources ambitions for equality.

Our 2014 staff survey, which took place in August, had the biggest response rate yet, and the overall level of engagement achieved a composite score of 64 (six points above the public sector benchmark of 58). However, this highlighted that the sheer pace of changes we are implementing has a huge impact on staff. Only 27% were positive that morale was good in general across CQC, albeit this was a rise of 4% since 2013. However, 53% of individuals said

that their own personal morale was good. This shows that meeting the recruitment challenge and embedding robust systems and processes in 2015/16 are so important.

During 2014/15, the CQC Academy really took off. The Academy supports the development of individuals, teams and the organisation itself, so that CQC is a learning organisation seeking feedback continuously to improve its performance. Staff were trained on the new quality regulations and fundamental standards, and on our stronger enforcement powers. We will look to develop our Academy further this year with training for all staff on equality and human rights. In 2014/15 we also started our comprehensive induction programme for all new staff. The programme explains right from the start how we at CQC can all work together to improve quality of care and strive for excellence, integrating the values in our everyday work.

A very important part of building our capabilities is to keep listening to others and acting on feedback from members of the public telling us about their care, and from our providers and stakeholders who work with us every day. Only by listening and learning will we develop towards excellence.

Across the health and social care sector, one of the key learnings from mistakes in the past has been around the importance of openness and transparency in ensuring quality and driving improvement. Recommendations from the 2015 *Hard Truths* report into the Mid Staffordshire public inquiry, Sir Robert Francis's *Freedom to Speak Up* review, and Kate Lampard's 'lessons learned' report into Jimmy Savile, all agree on this. It is essential that health and social care services foster an environment where care professionals and people who use services feel safe to raise concerns and complaints, and feel confident that these will be listened to and acted on. CQC is committed to developing and supporting this culture and during 2014/15 we continued to support and promote the different ways in which care professionals can raise whistleblowing concerns with CQC. In 2015/16 we will support those appointed to new roles as 'freedom to speak up' guardians in each NHS trust, along with the proposal for an Independent National Guardian.

Our 2014 themed review on complaints, *Complaints matter*, found that responses to complaints from people who use services vary greatly across the health and social care sectors, and there is a need to take complaints more seriously. Our new inspection approach has complaints embedded in the process to make sure that each complaint is being handled correctly.

Importantly, we also look carefully at ourselves and learn from the complaints we receive about CQC, both from inside and outside the organisation. Our staff surveys and regular provider surveys help us to understand where and how we need to improve.

Working to improve quality and safety

There is an increasing recognition that improvement requires the whole local health and care system to work together to make the transformations needed. We will play our part in enabling this.

But quality regulation cannot do this alone – a coordinated strategy for improvement is needed. There are five major influences on quality – care staff and professionals, providers, commissioners and funders of care, regulators and the voice of people who use services – and all need to work effectively together to drive improvements in care. Through our inspections and our findings, CQC can add value to the other drivers of quality.

CQC's expenditure in 2014/15 was £221 million. While this only represents 0.15% of £148 billion of total spending on health and adult social care, we are nevertheless taking action to improve our efficiency and the consistency of our actions to ensure we have maximum impact and deliver value for money.

We will continue to work closely with providers, commissioners and other regulators, and take action to encourage improvement across the spectrum of quality – by removing inadequate care through improvement or forcing those providers concerned to close, and by encouraging improvement by giving providers the target of a good or outstanding rating.

We will also review and share learning from the implementation of the fundamental standards, especially the duty of candour. We will work to understand how this is helping to improve quality and safety, alongside an increased focus on learning from complaints and concerns.

There are a number of areas where we will do more to support services to improve following an inspection, including signposting to external resources such as guidance and improvement agencies, and making it easier to access examples of excellence and share learning from organisations that have improved.

We will also be looking in future at the efficient use of resources – increasingly recognised as a key element of quality – as part of our inspections of NHS hospitals. This work will focus on organisations' ability to deliver high-quality patient care that is also efficient and sustainable. We will be working with partners, patient organisations, stakeholders, providers, commissioners and our staff to develop a common, comparable measure of the use of resources in the NHS.

Shaping the future

There is commitment throughout the health and care system to transform the way we care for people. CQC has a critical role here, being a catalyst for change that can improve the quality of care people receive. Regulation should not be a barrier to innovation. Now that we have our new approach in place, we want to go further and look at new models of care and how we can play our part in the changing health and social care landscape.

We want to help find solutions to the challenges facing the sector, which is why we focus on sharing good performance to enable learning and improvement, as well as identifying where services need to improve.

NHS England's *Five Year Forward View* signals a need for radical change in care delivery. It outlines a new vision of care designed around individual needs in order to get the best outcomes for people using services. Currently, care can be fragmented and based on old ways of delivery with services separated from each other and hard to navigate. It is clear that this will change in the future.

We have a unique overview across health and social care and we are an independent voice on the quality of care. In 2015/16 we will be looking at three main areas. We will work with those developing new models of care, including the vanguard sites, to ensure that our approach is adaptable and supports innovation. We will use our thematic reviews to better understand care pathways and how these could be more joined up. And we will look closely at the quality of care in local areas and bring our inspection findings from across sectors together to see how well people in particular communities are served by their local health and care system.

Most importantly we will always act independently and remain on the side of people who use services, their families and their carers. We are passionate about high-quality care and restless in our desire to encourage improvement and see better care.

David Behan
Chief Executive

Business review

1

Introduction

1.1 Who we are

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. Our purpose is to make sure these services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve.

Our regulation of care is important because we make judgements on quality and safety. We have a trusted position in telling the public about that quality. Good quality care can be distilled down to the following question: would you entrust a friend or relative to the care of that hospital, care home or GP practice? People depend on us to make this clear.

We are an independent regulator, reporting to Parliament through the Department of Health. We work with others who regulate and oversee performance in the health and social care system to align processes and reduce the regulatory burden on providers. In particular we have close working relationships with Monitor and the NHS Trust Development Authority (who regulate NHS foundation trusts and NHS trusts respectively), NHS England (who commission [purchase] health services nationally), local authorities and commissioning groups (who purchase care services locally on behalf of people), and with organisations such as the Association of Directors of Adult Social Services, Skills for Care, the Social Care Institute for Excellence, Healthwatch England and the Parliamentary and Health Service Ombudsman – all of which have important roles in ensuring high-quality care.

1.2 Our new approach to regulating care services

In the last two years we have transformed our approach to regulation and inspection. We have introduced radical changes and brought in a new, rigorous and expert-led inspection approach and ratings system that puts people at the heart of everything we do. In 2014/15 we began to deliver this.

Although it is still very early to show the full impact, and there is much to be done in terms of embedding and refining our systems and processes, we believe that our new approach is the right one. More comprehensive and more rigorous inspections are both uncovering problems that may have been missed previously and are identifying those providers giving outstanding care. The new ratings will give the public a better and more transparent understanding of the quality of different services, while also encouraging providers to improve.

Our new approach was formed in the wake of concerns that our inspections were not finding serious failings in care. Criticisms from the Winterbourne View Serious Case Review, the Orchid View Serious Case Review, the catastrophic collapse of care at Mid Staffordshire NHS Foundation Trust, and the serious shortcomings in regulatory oversight at University Hospitals of Morecambe Bay NHS Foundation Trust, led to a thorough reform of CQC and our inspection methods.

We have designed our new approach to be much more detailed and intensive than before. There has been an important shift in focus from judging only whether providers meet legal standards, to increased professional judgement and encouraging providers to improve. Our new approach is different in the following ways:

- We use a sector-specific, team approach to inspection, including specialist advisors (who bring current, expert knowledge from across health and social care, for example, senior NHS doctors on a hospital inspection) and Experts by Experience (people with personal experience of using or caring for someone using the type of service). This means teams have specialist knowledge of their sector and practical experience of using services.
- We request and use an increased amount of data to inform each inspection, so we can build a complete picture of the service. This includes evidence from local voluntary and community groups and public representatives.
- We ask the same five key questions of every service: is it safe, effective, caring, responsive and well-led? This means we have comparable data and we can encourage improvement in specific areas.
- Inspection teams use a detailed set of supporting questions, known as key lines of enquiry, to direct the inspection and ensure consistency.
- We rate services on a four-point scale of outstanding, good, requires improvement or inadequate, and we have set out the characteristics of the ratings. This both encourages improvement by providers and helps to promote choice for people who use services.
- We have ensured that equality and human rights are embedded in our new approach and are part of our key questions and key lines of enquiry. During 2014/15 we developed five new equality objectives for 2015 to 2017 (see page 71).

Our approach has been developed in close partnership (what we call 'co-production') with people using services, their relatives and carers, the public, providers, our staff, Experts by Experience, partners and stakeholders. It has also been informed by formal consultation, frequent testing and a programme of evaluation. We have been open and transparent at every stage in the development of our new approach. We believe that with specialist inspection teams, increased data gathering requirements and a new ratings system, we are going in the right direction to drive improvement.

1.3 How we organise our work

We have four core functions that combine together to form our new operating model:

1. We **register** those who apply to CQC to provide health and adult social care services.
2. We use feedback and data to **monitor** services, and then carry out expert **inspections**, making a judgement of each service and giving an overall **rating**.
3. Where we find poor care (inadequate or requires improvement) we ask providers to improve and we can **enforce** this if necessary.
4. We provide an **independent voice** on the state of health and adult social care in England, helping to share learning and encourage continuous improvement across the sector.

Our model is underpinned by the new fundamental standards for health and social care, which were introduced for all providers in April 2015. We have also been given new enforcement powers, and the requirement to make sure that those in leadership positions and responsible for poor care are held accountable for it (the 'fit and proper person' requirement). At all times our priority is to keep people safe and protect them from poor care.

Ensuring equality in care services and protecting the rights of those who use services is an integral part of our work and also extends to our own staff. This *Annual report and accounts* fulfils our legal duty under the Equality Act 2010 to show information on CQC's employees who share a protected characteristic as defined by the Act. The requirement to report on information relating to people other than employees who share a relevant protected characteristic and who are affected by our policies and practices will be fulfilled through our annual *State of Care* report.

Our directorates

Our work is organised under five directorates:

Andrea Sutcliffe

Adult Social Care – residential and community services including care homes, nursing homes, home care services and hospices, and our registration, safeguarding and market oversight functions.

Professor Sir Mike Richards

Hospitals – acute, community, mental health and substance misuse services, both NHS and independent.

Professor Steve Field

Primary Medical Services and Integrated Care – GP practices and GP out-of-hours services, dental practices, integrated care services, prisons and criminal justice, child safeguarding, medicines optimisation, and 111 services.

Dr Paul Bate

Strategy and Intelligence – Engagement, Intelligence, Planning, Performance & Programmes, and Policy & Strategy.

Eileen Milner

Customer and Corporate Services – HR, Customer Support Services, Governance & Legal, Finance, Commercial & Infrastructure, and Academy teams.

Figure 1: CQC's four core functions

Driving improvement and celebrating outstanding care – our new approach in action

Excellence in primary medical services

Dr PJP Holden & Partners

This GP practice in Derbyshire was rated outstanding overall by CQC – our inspectors noted the high quality of the practice's leadership and the way it tracks its own performance.

We recognised Dr PJP Holden & Partners for the way clinical staff received regular updates about best practice; there were also weekly staff discussions about clinical issues and changes in practice.

The practice was able to show work programmes that ensured everyone was aware of accountability – and who was doing what, and by when. Rated outstanding for its effectiveness, it was also clear to our inspectors that the practice had strong community connections in a rural area. There was frequent contact with patients, face-to-face or through surveys and group meetings, to make sure the practice could adapt to changing needs.

CQC was able to see clear examples of patients' improved health outcomes as a result of action taken by the practice.

We also rated leadership at Dr PJP Holden & Partners as outstanding. We noted their use of a national measurement tool for performance monitoring and peer reviews. The inspection report described a practice that "enables staff to drive continuous improvement" and with "innovative ways of working to meet patients' needs."

Improving primary medical services

Branston and Heighington family practice

This family GP practice was rated good overall by CQC and it is an example of a care provider that has demonstrated improvement in the quality of its care.

Branston and Heighington was found to be good in all the key questions asked by a CQC inspection team – this is a service that is good at being safe, effective, caring and responsive, and it is well-led.

This practice was the subject of concern in August 2014 when we issued a Warning Notice. Inspectors noted that the practice did not have effective systems to monitor the quality of its service.

However, a comprehensive inspection under our new approach in January 2015 found many positive aspects about the practice's quality of care, as it had taken action to address problems identified by CQC's inspectors. We found that risks to patients were assessed and well-managed, including those relating to recruitment checks. Care was planned according to best practice guidance and there was appropriate training for staff.

As part of our inspections, CQC also considers patients' views about care providers. At this practice, inspectors saw that information was freely available for anyone who wanted to complain – seven written complaints to the practice had been handled satisfactorily, and in a timely and transparent way. Issues raised in complaints had been examined for themes and learning was cascaded to staff.

Excellence in adult social care

Resolve, Bishop Auckland

Resolve care home in Bishop Auckland, County Durham provides care and support for up to seven people who have a forensic learning disability and complex needs. It was one of the first adult social care services to receive an outstanding rating from CQC.

On the day of the unannounced inspection in November 2014, CQC's inspection team found the home to be calm and relaxed, with friendly and supportive interactions between staff and residents.

CQC observed that the staff at the home were actively encouraging residents to be as independent as possible and to challenge themselves, while also remaining safe.

All residents had opportunities for training, education and personal development, including work placements in the community, and the chance to enrol on courses in community conservation and employment skills.

People living at the service told inspectors that staff understood their needs, listened to them and made them feel valued. Care plans were detailed, and people were directly involved in making decisions about the support they were receiving. People also said they felt comfortable raising concerns if they needed to.

Debbie Westhead, CQC's Deputy Chief Inspector, said, "We found that Resolve was providing an outstanding service to the people it supported and the team there should be extremely proud of the work they do. What really struck us about this service was the level of personalised support that people received, from staff who had the right skills and who treated people with great kindness."

Improving adult social care

Werrington Lodge Care Home

CQC's inspections of Werrington Lodge care home in Peterborough during 2014 revealed failings in care and risks to health and wellbeing. The care home took on board the concerns, made real improvements, and was subsequently rated as good.

The home, which provides accommodation and nursing for up to 82 people living with dementia or mental ill-health was visited by a CQC inspection team in May 2014.

Significant concerns were raised around cleanliness and infection, lack of care and compassion for residents, and weak leadership and systems to guide staff. CQC also found that people were not protected from the risk of abuse, and their rights under the Mental Capacity Act 2005 were not taken into account.

CQC took immediate action to safeguard the residents, including contacting the local authority, speaking with the provider about an action plan, and issuing eight Warning Notices. Follow-up inspections in June showed steady improvement, and in November a comprehensive inspection revealed the home had addressed the concerns.

CQC found that among other improvements, people were now getting good support in terms of eating and drinking, people's rights were being valued and acted on, and recruitment, training and leadership of staff had improved. The home received a rating of good in its inspection report, published in January 2015.

The inspection team said, "People were treated well by respectful and attentive staff and they and their relatives were involved in the review of people's individual care plans."

Excellence in hospital care

Frimley Park Hospital

Frimley Park Hospital in Surrey was the first acute hospital provider to be rated outstanding overall by CQC – and among its top ratings was its standard of leadership. It was pointed out to our 22-strong inspection team that the staff "wanted to work for Frimley Park". We noted that a clear vision and values had been developed with staff to ensure they were aligned.

Our comprehensive inspection highlighted the work that had been done to promote staff engagement. An open-door policy with the chief executive and executive team, and their high visibility, was clear to inspectors.

While the hospital was found to be outstanding, it was evident that the trust was also good at assessing its own performance. The hospital's A&E service, for example, was redesigned with patients' views in mind – inspectors noted the "exceptional patient care", including dementia-friendly areas.

Of the key questions asked by CQC inspectors, this hospital was found to be outstanding for its responsiveness and its caring staff. CQC praised Frimley Park's "strong patient-centred culture", noting its evident strength and depth of leadership at board and ward level.

Improving hospital care

George Eliot Hospital NHS Trust

George Eliot Hospital is a 352-bed acute hospital in Nuneaton, Warwickshire. The provider trust was one of 14 hospital trusts placed in special measures in 2013, following the Keogh Review of trusts with high mortality rates.

A comprehensive inspection at George Eliot in April and May 2014 involved a team of 31 – there were CQC inspectors, analysts, doctors, nurses, patients, Experts by Experience and senior NHS managers.

We found that the trust had made many significant improvements. Inspectors found that staff were caring and compassionate, and were positive about working for the trust and the changes made. Emergency care had been improved. The trust had opened a new acute medical admissions unit which, along with the ambulatory care unit, was to improve the flow of emergency patients through the hospital by speeding up assessment, treatment and discharge. Seven-day services were developing well, and new ways of working had been developed to standardise care for people who were acutely ill.

We rated the trust as good overall, and George Eliot Hospital was rated as requires improvement. We also highlighted some areas of outstanding care in the hospital. Services including medical care, critical care, maternity and family planning were all rated good. As a result, in July 2014 CQC's Chief Inspector of Hospitals, Sir Mike Richards, recommended that George Eliot trust be taken out of special measures.

Although CQC's new approach to inspection showed that significant improvements had been made, there remained room for improvement. "The trust cannot be complacent," said the Chief Inspector. "But as the trust has moved forward and made improvements across its services, CQC has developed confidence in the trust's leadership to continue to work to make further changes for the good of its patients."

CQC will continue to check that the trust continues to improve.

1.4 Facts and figures 2014/15

7,038
were planned inspections under our new approach

Inspections undertaken in 2014/15
17,889

3,503
were inspections to follow up a previous problem or to directly respond to new concerns

7,348
were planned inspections under the old approach

£221 million
CQC's expenditure for 2014/15

which is **0.15%** of the **£148 billion** public spend on health and social care

9.2%
of all organisations have been rated under our new inspection regime (ratings published on our website as at 31 March 2015)

1.4 million
transactions dealt with by our National Customer Service Centre

1,179
enforcement actions carried out by CQC

90,606
pieces of **safeguarding information were received** in 2014/15

1,253
Mental Health Act Reviewer visits to locations

36,269
registration processes completed

2

Ensuring what we do makes a difference

In 2014/15, we moved from developing our new approach, to delivering it. We inspected a significant number of providers for the first time under our new approach, and we introduced our new ratings system. We completed the development of our special measures regimes and produced guidance on how we will apply our new enforcement powers. We also continued to talk about important issues in health and social care and encourage improvement by care providers.

We are receiving positive feedback on our new approach. When we asked adult social care providers in quarter 3 (October to December 2014), "Does the inspection report provide information that helps you to take action to improve your service?", 78% of providers who responded to our survey agreed or strongly agreed. In the Hospitals directorate, our most recent figures are from quarter 2, when 88% of providers who responded were positive about this question (a 20% increase on quarter 1). The Primary Medical Services directorate results were less positive, with 58% of providers who responded in quarter 3 agreeing that the information helped them to improve.

These initial responses are useful, although we need to complete more new-style inspections before we can provide real evidence that the

changes have made a substantial impact. We are going much wider and achieving more depth with our inspections than previously, and this is the first time we have had so much data on quality. This does mean it will take longer to see the full impact of our work.

However, we are beginning to see early indications of a positive impact and improved quality of care. We are highlighting where care is excellent – during the year we rated 41 providers as outstanding. We are homing in on inadequate care – we rated 268 providers as inadequate. And our new inspections and ratings are already helping providers to improve.

We are an organisation striving for excellence. We want to see more and better change, and to deliver results for people using health and social care services.

2.1 How we developed our new approach

The journey to our new approach started in 2012 when we consulted on a new strategy *Raising Standards, Putting People First*. In early 2013 we received the important recommendations from the Francis report of the Mid Staffordshire NHS Foundation Trust public inquiry, and we used these to further refine our plans. In April 2013 we set out our new strategy for 2013 to 2016 and our plans to completely transform the way we inspect and regulate health and adult social care services.

New chief inspectors

By October 2013 we had appointed our full team of chief inspectors to lead our three new inspection directorates: Professor Sir Mike Richards as Chief Inspector of Hospitals, Professor Steve Field as Chief Inspector of General Practice, and Andrea Sutcliffe as Chief Inspector of Adult Social Care.

Working in partnership

From 2013, and continuing into 2014/15, we used engagement, consultation and our co-production approach to make sure everyone's views were heard and incorporated into our development work. By co-production, we mean working in true partnership with providers, people who use services, and other stakeholders to listen, reflect and develop our methods together.

The development phase included sector co-production meetings, formal consultations, face-to-face events, focus groups, online surveys, activity on our online communities for providers and the public, commissioned research and social media. By engaging with our audiences in this open and transparent way, we generated a wealth of insight that helped us to focus on what matters to them most, which in turn helped to build their trust and confidence in our work, and helped us to develop a better system of regulation.

We also ran pilot inspections and followed up each phase of testing with an evaluation of activity. Suggestions and feedback from this evaluation were then incorporated into our next testing phase.

Co-production in particular has made the process of developing our new approach open and transparent and continues to be a part of our work as we embed the approach, and test it for all the sectors we regulate. During 2015/16, we will make improvements to how we measure the effectiveness of our audience engagement.

Intelligent Monitoring

In October 2013, we published our first Intelligent Monitoring reports for NHS trusts based on 150 indicators. Intelligent Monitoring is CQC's bespoke, intelligence-driven model that assesses potential concerns about the quality of care of providers and helps to guide when and

Co-production, participation and consultation

In October 2014, we published our handbooks for providers of adult social care – the results of extensive collaborative working and genuine co-production, participation and consultation.

We worked together with the public, Experts by Experience, key stakeholders, partner organisations, our staff and providers themselves to co-produce the handbooks. This co-production took place during face-to-face meetings, often followed by online discussions, and was directly influenced by everyone involved. All discussions were two-way and consultations took place during formal consultation periods, and outside of them. We communicated regularly throughout all stages of the development of the handbooks to ensure everyone felt involved and engaged.

The activities used to develop the handbooks included:

- External co-production group events (18 in total with an average of 30 people at each event), which included five roundtable events to discuss complex issues.
- Consultation events across England for providers, members of the public and CQC staff with more than 650 people attending. We also had a meeting with our children and young person's advisory group.
- Online debate and discussion including our public and provider community groups (39 and 92 responses), our consultation web form, two Q&As on Twitter, and a social media campaign (#tellCQC) where members of the public held up signs telling us what good care means to them.
- Focus groups with a range of people who are rarely heard from, which were carried out by our SpeakOut network.
- Research interviews with 40 members of the public.
- Monthly telephone calls and quarterly meetings with local Healthwatch representatives.

These activities helped us to fully understand the needs of our target audiences and to develop the handbooks to make them as useful as possible to everyone. We collected feedback about our co-production approach to development and we found that people did feel very engaged in the process and in the work of CQC. On average, 86% of people who took part in the co-production groups were positive (agreed or strongly agreed) that their views had been taken on board by us in the development of our new approach to inspection. And on average, 92% of people were positive that they felt informed about the changes that CQC was making.

where we inspect. We collect information from a wide range of data sources, group it together, and analyse key data and feedback to help us prioritise which services to inspect. In November 2014 we published our Intelligent Monitoring indicators for GP practices and mental health services. See page 44 for more information on Intelligent Monitoring.

Launch of our new approach

In April 2014, one year after publishing our plans to reform, we started formally inspecting and rating NHS trusts under our new approach. The new inspections of adult social care services and GP practices began in October 2014.

Our new approach to inspecting primary dental care services (which does not involve rating services) began in April 2015, after close consultation and co-production with the sector.

New fundamental standards and enforcement powers

A new set of fundamental standards of care came into effect on 1 April 2015 and apply to all health and adult social care providers (see box below). These were recommended by Sir Robert Francis (a CQC Board member from 1 July 2014) in his Mid Staffordshire inquiry report, and they replace the old 'essential standards of quality and safety'. They give a clearer picture of the standards below which people's care must never fall. They include the new regulations about 'duty of candour' for providers and the 'fit and proper person' requirements for directors.

A NEW SET OF FUNDAMENTAL STANDARDS OF CARE CAME INTO EFFECT ON 1 APRIL 2015 AND APPLY TO ALL HEALTH AND ADULT SOCIAL CARE PROVIDERS.

CQC has also been given new enforcement powers, in particular an ability to prosecute providers for failures in care without first having to issue a Warning Notice. See page 27 for more information.

New fundamental standards

The new fundamental standards state that everyone must:

- Receive person-centred care.
- Be treated with dignity and respect.
- Give consent to treatment or arrange for another person to do so on their behalf.
- Not be given unsafe care or treatment.
- Not suffer any form of abuse or improper treatment while receiving care.
- Have enough to eat and drink to keep them in good health.
- Receive care and treatment in a place that is clean and where the equipment is clean, suitable and looked after properly.
- Be able to complain about their care and treatment.

And that the provider of care must:

- Have effective governance and systems to check the quality and safety of the care they provide.
- Have enough suitably qualified, competent and experienced staff to make sure they can meet these standards, and give their staff the support, training and supervision they need to help them do their job.
- Only employ people who can provide care and treatment appropriate to their role. They must have strong recruitment procedures in place and carry out relevant checks such as on applicants' criminal records and work history.
- Be open and transparent with people about their care and treatment. If something goes wrong, they must explain what has happened, provide support and apologise.
- Display their CQC rating in a place where it can be easily seen. They must also include this information on their website.

Continual refinement

Although our new approach is in place for most areas in our three sectors, and in development for the others, we still have a long way to go until it is fully embedded. We want to continuously improve and learn from everything we do and we will keep listening to, and working with, providers of services, the public and our own staff to help us do this.

Three of our equality objectives for 2015-2017 relate to refining our regulatory approach. We will develop how we consider race equality for staff in our assessments of whether NHS trusts are well-led, in line with the new NHS Workforce Race Equality Standard. We will also look at how we can factor into our inspections service quality for particular groups of people, including people with a learning disability using acute hospital services and lesbian, gay and bisexual people living in care homes.

2.2 How we inspect

Our new inspection process is much more rigorous and in-depth than our previous approach. It is designed to be thorough in both finding poor care and identifying excellent care. Central to this is the gathering of information from a wide range of sources in advance of the inspection, and the use of a specialist inspection team with input from specialist advisors and people who have used services (Experts by Experience).

Planning the inspection and gathering information

Before we inspect, we invest significant time in planning and gathering background information about a service. This is an important change introduced by our new approach and ensures our inspection teams are as fully prepared as possible before the inspection begins.

By the time an inspection starts, the inspection team will have a variety of information from different sources, which builds up a picture of the service they are about to inspect. The information can include:

- A data pack about the provider compiled by CQC.
- Advance information from providers.
- Feedback from the public through the 'Share your experience' online form.
- Feedback from people who use the service gained through talking to groups such as local Healthwatch, and organising listening events (for announced inspections), where the public meet with the inspection team.
- In some cases, information from local stakeholders (such as the local clinical commissioning group or local authority), including useful equality and demographic information.

This information helps the inspection team to prioritise specific areas of a service during the inspection.

The feedback we have received shows that there is a real potential value in this pre-inspection information and in the data packs. However, inspection teams would benefit from further improvements to ensure they get the right information in the right format. There is also potential to improve efficiency and effectiveness by taking further action to help inspection teams use and interpret data pack information, so that it has a clearer impact on planning what is looked at on inspection, and on judgements.

Inspection teams

The introduction of specialist inspection teams was a significant change under our new approach. We now have specialist advisors who are clinical professionals with expertise in a particular area (for example, diabetes care or maternal health). This means that expert knowledge of the sectors is much stronger and each team member has a more specific role.

Andrea Sutcliffe, Chief Inspector of Adult Social Care

My team and I have a passion for social care. We are committed to ensuring everyone gets the person-centred, high-quality care and support they have every right to expect in a range of services including care homes, nursing homes, care at home, hospices, supported living services and shared lives.

My aim is simple: for each of us to ask, when we look at a service, is this good enough for my mum, dad, partner, brother, sister or indeed anyone we love and care for?

We have a lot to be proud of in 2014/15. We worked with a vast range of people using services, their carers and families, providers, commissioners and partners to co-produce our new approach. We launched the new, more rigorous inspections of adult social care services, and started to issue ratings. We laid the groundwork for applying the new fundamental standards and using our stronger enforcement powers. And we established the framework to deliver our new responsibilities for the market oversight of difficult-to-replace providers.

There is much that adult social care providers and staff can be proud of – as any of the outstanding and good inspection reports demonstrate. But sadly we also continue to find poor and unacceptable care and we have rated some services as inadequate. By highlighting poor care in this way, we can help services and those around them to make necessary changes.

We still have a lot to do in the coming year. In 2015/16 we will recruit the full numbers of staff we need, so that inspectors have smaller portfolios and can respond appropriately to any concerns they receive, and registration inspectors have the capacity to deliver a timely and robust service. We are also putting in a lot of work to speed up our report writing.

We will be focusing on completing all comprehensive rating inspections by September 2016, as well as implementing our new role overseeing the financial health of difficult-to-replace providers. Throughout, our values of excellence, caring, integrity and teamwork will guide the way we work, as individuals and as teams.

Professor Sir Mike Richards, Chief Inspector of Hospitals

My role as Chief Inspector is to lead the Hospitals directorate in delivering a robust, fair and transparent inspection programme. Through carrying out good inspections, I believe we can help to drive improvement in services for patients.

Since the creation of the directorate on 1 April 2014, we have been implementing our new approach to the way we regulate and inspect acute hospitals, community health services and mental health services.

Our new inspections allow us to have more clinical involvement working alongside CQC inspectors. We listen carefully to what patients and the public are telling us, and use our Intelligent Monitoring system to give us information about services. We carry out rigorous, in-depth inspections, following the patient's pathway through a number of core services.

I want the public to be able to trust us to find out what is good and what is less good in our hospitals, and I want them to be able to trust us to work with our partners to make services better. We have been very pleased to give outstanding ratings to two trusts: Salford Royal and Frimley Park. But equally we have been determined to uncover inadequate care – there were 21 NHS trusts in special measures at some point in 2014/15, and 14 trusts were still receiving support through special measures at the end of the year.

Looking ahead, we will assess and judge how well hospital services put the quality of care and the interests of patients at the heart of everything that they do, including their responsibilities under the Mental Health Act, the Mental Capacity Act, and the Deprivation of Liberty Safeguards. We will continue to implement the new ratings system, championing the interests of people using services and making critical judgements about the quality of care provided.

Professor Steve Field, Chief Inspector of General Practice

I passionately believe that everyone in our society deserves high-quality primary care. Whether you're a rich person or someone who is poor and perhaps homeless, you should have access to the same high-quality care no matter what your circumstances are or where you live.

CQC's Primary Medical Services directorate is responsible for regulating a broad spectrum of service providers that includes GP practices, GP out-of-hours services, dental practices, independent consulting doctors, health and social care provided in criminal justice settings, children's safeguarding in health and services provided to looked after children, urgent care, and 111 services. We also lead on medicines optimisation, integrated health and social care, and developing and delivering themed inspections, such as how services deliver end of life care or support people living with diabetes.

We want to help build a system that ensures that primary health care in England becomes the very best in the world. We have a unique opportunity not just to get poor or inadequate services to improve but also to celebrate great primary care services.

In 2014/15, we began our new, more comprehensive approach to inspecting GP practices and issuing ratings. This has already found truly outstanding care, as well as those at the other end of the spectrum – inadequate services that in many cases are now getting support to improve through the special measures regime.

Looking ahead to 2015/16, we will continue this work, and we have identified six success factors to ensure we are the trusted voice of quality in primary health care:

- Effective and efficient systems and tools for our inspection teams.
- Continuous improvement and clear evidence to demonstrate our impact.
- Recruiting staff with the right values, skills and capacity to do their jobs.
- Making sure our teams feel valued, supported, empowered and listened to.
- Making sure everyone understands the scope of our responsibility and buys into our ambition.
- Building collaborative relationships that support and influence improvement.

The feedback from providers suggests that the inclusion of this expertise adds credibility to the inspections and their use is widely supported.

During the year we also significantly increased the use of Experts by Experience as part of our inspection teams. Experts by Experience are members of the public who are using services or have used them, or who care for somebody who uses them, and who bring the voice of practical experience to the inspection. As we grow the numbers of Experts by Experience and specialist advisors, we are also working towards clearer role definitions, guidance and training, and more targeted deployment.

In 2015/16 we will develop and start to roll out a new national resource planning tool to make the process of inspection planning simpler and more joined up. The new tool will bring together all the key people (inspectors, analysts, bank colleagues, specialist advisors and Experts by Experience) to deliver our new approach in the most timely, fair, efficient and effective way.

2.3 Our inspection programmes

Inspections

At 31 March 2015, we were making good progress in inspecting all of the health and adult social care services in England under our new approach. In October 2014, we set targets for our new approach inspection programme. By the target date of 31 March we were doing well but slightly below our projected numbers for the year. The Adult Social Care directorate completed 99% of its target, the Hospitals directorate completed 84%, and the Primary Medical Services directorate completed 83%. Particular challenges in achieving the targets included recruiting the larger numbers of inspectors that we need, and the total time that inspections take due to the increased rigour of the approach.

Table 1 shows the total inspections carried out in 2014/15. We inspected 7,038 providers/locations under our new, more rigorous, comprehensive and in-depth approach. In total, we carried out 17,889 inspections (old and new) in the year. This compares with 39,567 old-approach inspections in 2013/14.

We expect our inspection numbers to grow at a more rapid pace as the approach is embedded and the efficiency of systems and processes improves. We have also been working hard on recruitment to make sure our inspection teams are at full capacity and trained in the new approach. For 2015/16, we have re-calculated our inspection projections. We have done this based on the number of inspections required to complete our ratings and inspections programme, and to reflect when our newly recruited inspectors will be trained and ready to inspect.

Ratings

Ratings by providers/locations

One of the significant changes introduced by our new approach is the requirement on providers to display ratings. The new ratings are of real benefit to people using services as they help people to choose between different services if they want to. They also encourage providers to improve. In 2014/15, we published the ratings for 3,180 providers/locations (see figure 2). This is 9.2% of the total number of providers/locations that will be rated.

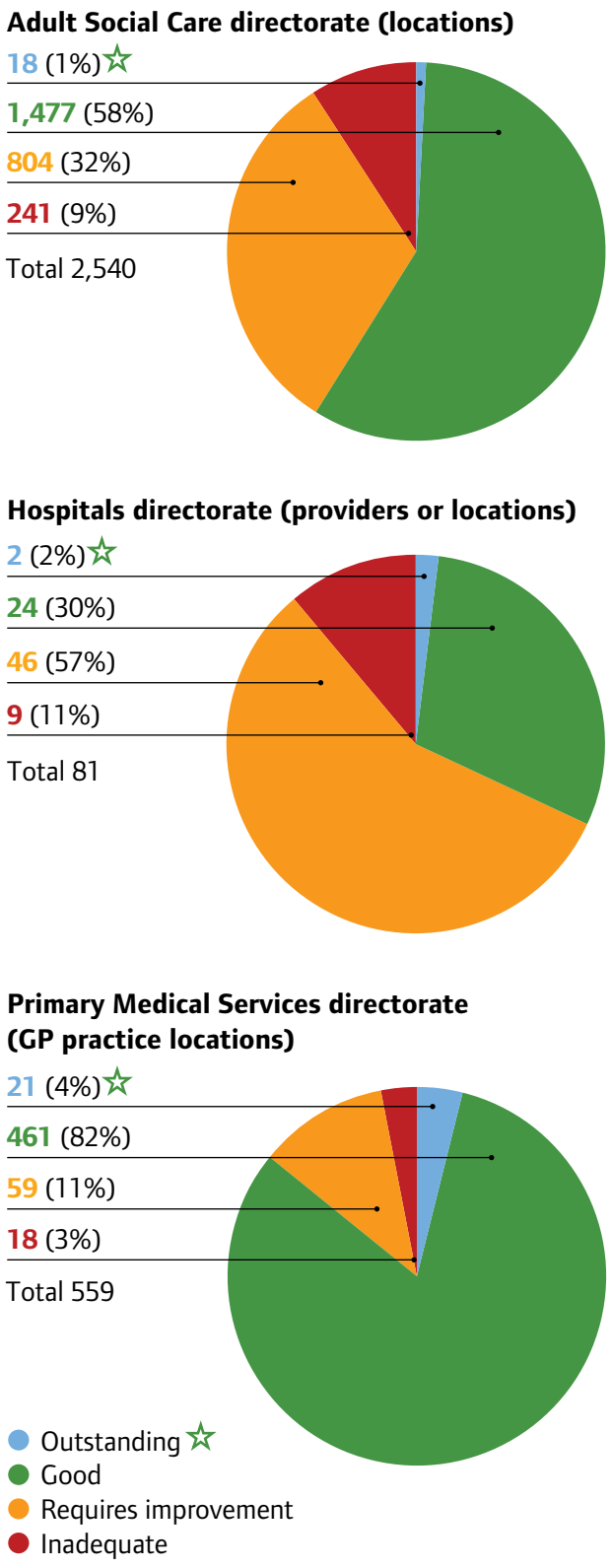
Of the providers/locations rated, the majority (1,962) were good. There were 909 requires improvement, 268 inadequate and 41 outstanding ratings.

Table 1: Total inspections carried out in 2014/15

Inspection type	Adult Social Care directorate	Hospitals directorate	Primary Medical Services directorate	Total
Old approach	6,979	90	279	**7,348**
New approach	5,230	131	1,677	**7,038**
Responsive (old approach)*	744	58	124	**926**
Follow-ups (old approach)	1,580	118	749	**2,447**
Focused (new approach)**	114	2	14	**130**
Total	**14,647**	**399**	**2,843**	**17,889**

* Responsive inspections respond to specific information that has come to our attention.
** Focused inspections under our new approach cover both responsive and follow-up inspections.

Figure 2: Total ratings published in 2014/15



Note: Figure 2 shows fewer rated providers than those inspected under the new approach in table 1, as reports take some time after the inspection to be published. This includes time to check the quality of inspection judgements and reports.

It is important to note that, in acute hospitals, we rate each location on its eight core services (urgent and emergency services; medical care including older people's care; surgery; critical care; maternity and gynaecology; services for children and young people; end of life care; outpatients and diagnostic imaging). We then aggregate all the ratings to get an overall score for the location. As a result these detailed ratings can have the effect of lowering the overall location rating, which may well be good or outstanding in some areas.

Ratings by the five key questions

In terms of the five key questions we ask of all services, all types of providers/locations tend to perform best for being caring (see figure 3). In the Adult Social Care directorate, 2,131 of 2,539 locations were rated as outstanding or good under this question. In the Hospitals directorate, 76 of 81 providers/locations were rated as good or outstanding for caring. For GP practices, it was 539 of 556 providers.

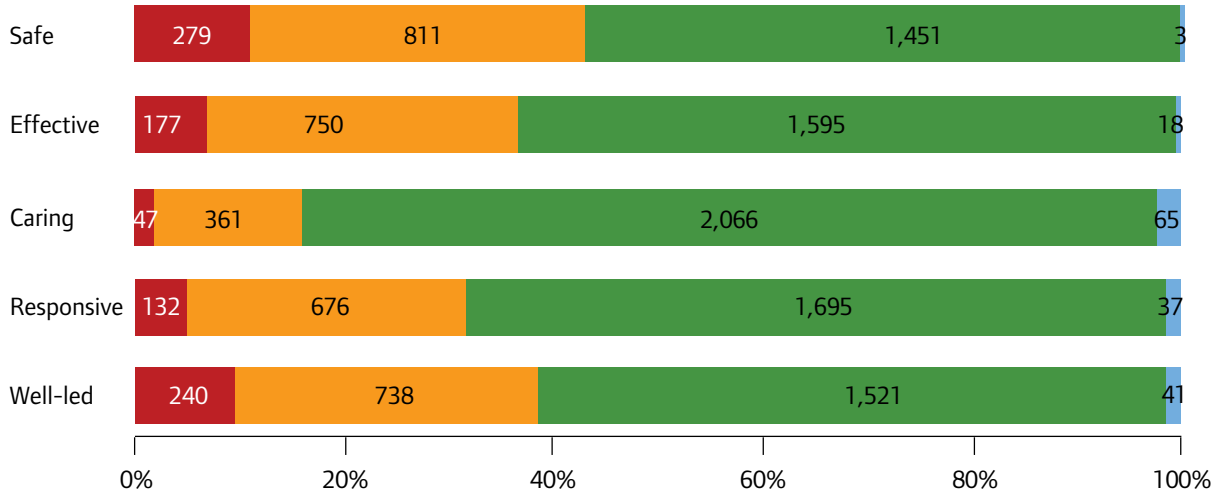
In all sectors the biggest problem was safety. In the Adult Social Care directorate, 1,090 out of 2,544 (43%) locations were rated as inadequate or requires improvement for safety. In the Hospitals directorate, 67 out of 81 (83%) providers/locations were rated as inadequate or requires improvement. Among GP practices, it was 173 out of 556 (31%).

It is still very early to see definitive trends in our ratings, particularly in relation to the key questions. We will explore these ratings fully in our *State of Care* report in October 2015. By the end of 2015/16 we should be able to see trends in more depth. We will also by then have ratings for other types of service, including independent hospitals and ambulance trusts.

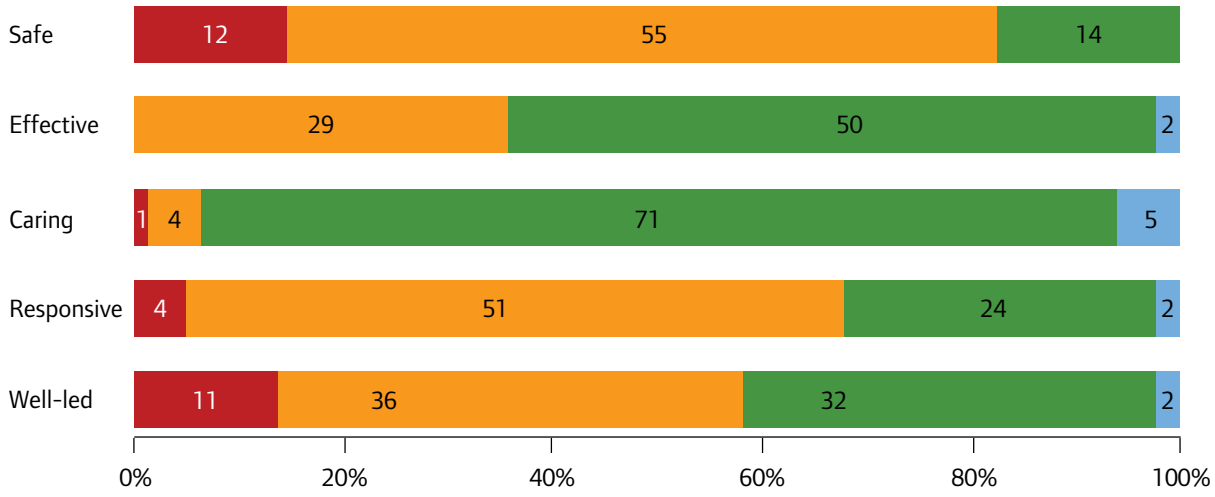
For all inspection directorates, the proportion of locations not meeting one or more of the essential standards of quality and safety for over a year has increased. All inspection directorates monitor their inspection activity in relation to these locations through directorate performance

Figure 3: Ratings by key question published in 2014/15

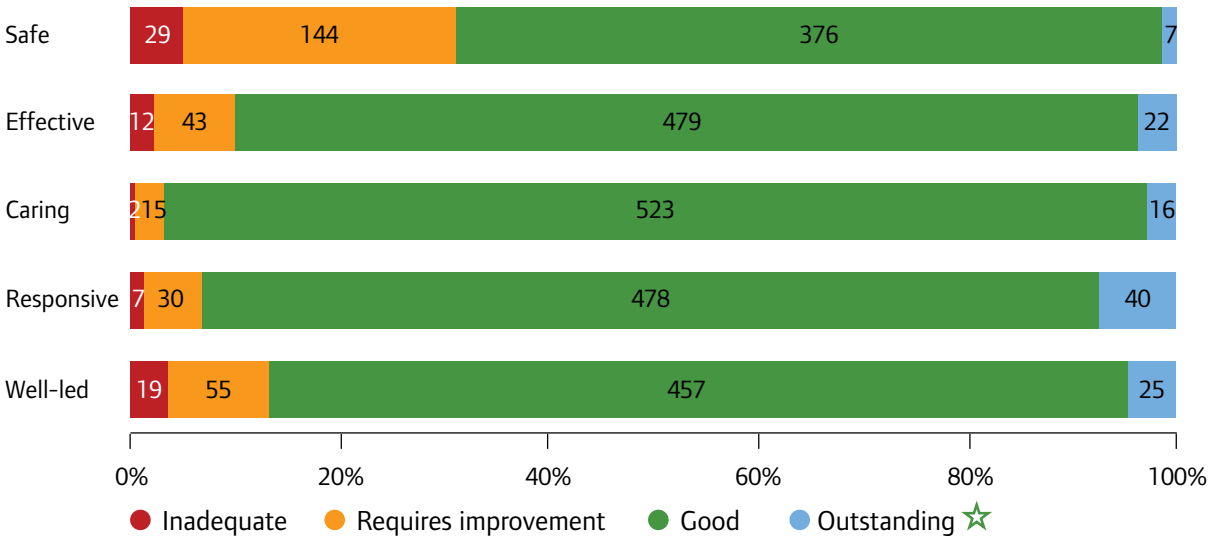
Adult Social Care directorate (locations)



Hospitals directorate (providers or locations)



Primary Medical Services directorate (GP practice locations)



Note: The number of key question ratings above will always not match the total ratings published, shown in figure 2. This is because the key question data includes inspections carried out under wave (test) inspections when the key areas were rated, but no overall rating was given. The data also includes focused inspections when key areas were re-rated.

meetings, supported by regular management information.

In the Adult Social Care directorate, this shows by team when locations were last inspected, how long they have not met standards and whether a registered manager is in post. This has enabled the directorate to focus on inspecting locations without a manager more quickly. The Hospitals directorate is focusing on organisations that have been non-compliant for over one year to examine what action is being taken, when the last inspection took place, and when the next inspection is scheduled, in order to be assured that non-compliance is being dealt with in a timely way. The Primary Medical Services directorate also looks at regular reports that identify long-term non-compliant organisations and ensuring that these are being prioritised for inspection.

All services rated inadequate are usually in some form of enforcement. For those rated inadequate, we are now also able to use special measures to drive improvement. We are prioritising those still to be rated using a risk-based approach.

Multi-agency inspections

During the year, the children's inspection team continued their reviews of the contributions made by health services to safeguarding children and services to looked after children, based on local authority areas. We also continued to work with Ofsted, HMI Constabulary, HMI Prisons and HMI Probation to plan the future delivery of multi-agency inspections of services for vulnerable children and young people. The new approach will include a comprehensive picture of how local authorities, health, police, probation and other services work together.

In October 2014 we started consulting on our new approach to inspection in secure settings. Healthcare services in prisons, youth offender institutions and immigration removal centres will all be subject to CQC's new style of regulation during 2015.

2.4 Protecting people from poor care

Protection is a fundamental part of our regulation. We can make a big impact on the lives of people who use services if we quickly identify and act when poor care is taking place, and we have enforcement powers that we can use when we find serious failings in care. We also protect people's rights through our monitoring of the Mental Health Act 1983 and the Deprivation of Liberty Safeguards under the Mental Capacity Act 2005.

Driving a culture of openness and honesty

An important part of our work is encouraging a culture of openness at all levels. In November 2014, the duty of candour for providers and the fit and proper person requirement for directors came into force for NHS bodies, and for all other services in April 2015. They require health and social care providers to be open and honest when things go wrong, and to hold directors (or their equivalents) to account when care fails.

As part of our new approach, we ask whether lessons are learned and improvements made when things go wrong. We check if providers are admitting their mistakes to patients and families, and writing truthful reports of the incidents. Where this is not happening and we find a provider is not delivering good quality care, we check if a regulation has been breached and take appropriate action.

Under the fit and proper person requirement for directors, we check that providers have assured themselves that their senior leaders are fit for their role. We are still learning and testing how this will work in practice: we have added additional questions at the registration stage to make sure providers have robust systems in place to carry out appropriate checks on recruitment of directors or equivalent, and on an ongoing basis. We also assess these checks during our comprehensive inspections of NHS

hospitals and are working on introducing these into our inspections of other providers. We have put arrangements in place to consider matters of potential concern that come to our attention. Providers are responsible for making sure that a person is of good character, is physically and mentally fit, and has the necessary qualifications, skills and experience.

Warning Notices and other enforcement action

Throughout the year we have helped to protect people by continuing to issue providers with Warning Notices and taking enforcement action where necessary. Warning Notices are where we put providers on notice that we will take legal action if they do not improve by a set deadline.

During 2014/15, we took 1,179 enforcement actions, 90% of which related to regulated activities in adult social care (the sector with by far the most inspections). This is a decrease compared with 1,523 over the same period in 2013/14. However, we took more enforcement actions as a proportion of inspections carried out: 6.6% for 2014/15 compared with 3.8% the previous year. The majority of our enforcement actions were Warning Notices (1,037); 63 locations had their registration cancelled; and there were 10 fixed penalty notices issued as well as five prosecutions (table 2). We also introduced the special measures regimes in 2014/15 – see page 32 for details.

WARNING NOTICES ARE WHERE WE PUT PROVIDERS ON NOTICE THAT WE WILL TAKE LEGAL ACTION IF THEY DO NOT IMPROVE BY A SET DEADLINE.

Stronger enforcement powers

In April 2015, we gained important new enforcement powers. These powers will help us to better protect people from harm and hold providers and individuals to account for failings in their services. In the most serious cases we can now go straight to prosecution without first

Table 2: Enforcement action in 2014/15 (related to regulated activities)

Enforcement action	Adult Social Care directorate	Hospitals directorate	Primary Medical Services directorate
Special measures total	n/a*	21	10
Warning Notices published	937	33	67
Non-urgent cancellations of registration	53	0	10
Urgent procedure for suspension, variation or conditions of registration**	17	7	3
Non-urgent variation or imposition or removal of conditions	37	0	0
Fixed penalty notices issued	10	0	0
Number of prosecutions	3	0	2
2014/15 overall enforcement actions	**1,057**	**40**	**82**
2013/14 overall enforcement actions	1,314	147	62

* Special measures for adult social care only started on 1 April 2015.
** This means urgent suspensions of registration, or urgent variation or imposition or removal of conditions.

Acting on complaints and safeguarding concerns

Vista Healthcare Independent Hospital in Hampshire was registered to provide care and treatment for 67 people. All of the residents had mental health problems or a learning disability and many were in extremely vulnerable circumstances.

CQC had been concerned about the quality of care provided by Vista for some time. After receiving further complaints, safeguarding concerns and reports from whistleblowers, CQC inspected in November 2014 and served two Warning Notices that identified the improvements that Vista needed to make. We then inspected again to check that improvements had been made, and found they had not.

"The standard of care we saw was shocking," said Karen Bennett-Wilson, CQC Head of Inspection, who attended the visit. "Many patients felt angry and frustrated by the way they were treated. They told us that many staff did not listen to them and did not treat them with respect."

Among many problems at the hospital, there was a culture of bullying, particularly on one ward, and a large number of violent incidents; there were no curtains in 11 out 12 people's rooms on one ward; there was serious risk of infection on three wards; under-floor pipes and pumps were visible and posed a risk; patients were deprived of privacy and dignity; and incident reports reflected that staff had locked patients in their rooms, without using appropriate seclusion procedures.

CQC acted promptly to take enforcement action. The operation that followed involved NHS England, local authority safeguarding teams, clinical commissioning groups, the police and the Ministry of Justice. CQC closed the ward that was of most concern and the patients at greatest risk were moved to different hospitals for their safety.

Karen Bennett-Wilson said that doing the right thing for the residents at Vista was her team's priority. "We made a real difference to people's lives. We protected people from harm and abuse and we have helped changed the culture and environment at that home."

Vista is now managed by a new care provider and the hospital has a new name.

having to issue a Warning Notice. Previously we always had to follow a staged process, which took time. Now we can act quickly if there is an urgent situation and stop poor care as soon as possible. Other new powers include the ability to ask Monitor and the NHS Trust Development Authority to place a trust in administration.

In April 2015, CQC took over the role of deciding whether regulatory action needs to be taken in response to health and safety incidents that involve people who use care services regulated by CQC. Responsibility for this used to be with the Health and Safety Executive (HSE). HSE will continue to regulate providers not registered with CQC, and health and safety involving workers, visitors and contractors. We will be able to draw on our new enforcement powers if we feel cases are particularly serious, but we hope that our new approach will identify risks early on so we can help providers to improve and ensure serious situations are infrequent.

Market oversight

During 2014/15, we developed our approach to our new regulatory duty to oversee the financial sustainability of difficult-to-replace providers of adult social care services. The duty came into force in April 2015 and CQC published guidance for providers in March 2015. Market oversight aims to protect people from the effects of a

provider failing and services needing to close, by giving local authorities (who have the legal duty to ensure people's needs continue to be met) the chance to prepare and plan. The criteria for being part of the scheme is set by Parliament and is based on factors such as size, geographical concentration and/or the specialist nature of the care provided. There is no judgement that these providers are more likely to fail, only that they would be difficult to replace should they fail. As of May 2015, 43 providers are subject to the scheme, delivering services from 4,000 locations, and we have started to receive financial information from them which allows us to assess the likelihood of failure.

Protecting people who lack mental capacity

Since 2009, we have had a legal duty to report on the use of the Deprivation of Liberty Safeguards under the Mental Capacity Act 2005. The safeguards are used to protect the rights of people who lack the ability to make certain decisions for themselves and ensure that their freedom is not inappropriately restricted. We made it a priority to embed the Mental Capacity Act firmly in our new approach as this was something lacking before. We have incorporated the Act into our key lines of enquiry and our inspectors are asked to routinely check that people are being treated with dignity and not being unnecessarily deprived of their freedom.

In March 2014, the Supreme Court made an important clarification that a person lacking mental capacity to consent is deprived of their liberty if they are both not free to leave and under continuous supervision and control. Our annual monitoring report on the use of the Deprivation of Liberty Safeguards, published in early 2015 (for 2013/14), highlighted that in the six months following this judgement, requests for authorisations to use the safeguards increased at a rate that was likely to be at least eight times that of 2013/14. As a result there has been a backlog of requests for local authorities. We also found that there is variation in the correct use of the safeguards by region and we are concerned that this could indicate a lack of understanding of the Act.

Acting when people are at risk of harm

CQC takes decisive action where we finds inadequate care and we work with other local organisations to help improve the way people are cared for.

At Royd Hill Nursing Home in Keighley, West Yorkshire, we found a catalogue of issues described by the inspector as "unhygienic and potentially harmful". Providing nursing and residential care for older people and people with dementia, the home was found to be inadequate in all of CQC's key questions about quality of care.

Among concerns set out in the inspection report in February 2015, we described inadequate cleaning, dirty pull-cords in toilets, wheelchairs covered in food waste and spilled drinks, and a strong and unpleasant smell of urine – particularly in a communal area.

Residents looked unkempt and dishevelled with stains on clothing, and some people had long fingernails, dried food around their mouths and food on their hands. People's dignity was compromised, basic care was not given and there was risk of infection. Inspectors also found that people were not given adequate fluids and their nutritional needs were not met.

Visiting inspectors were not satisfied with care standards at Royd Hill and found people with more complex nursing needs were at immediate risk of receiving unsafe and inappropriate care. As a result, CQC took urgent action to prevent the provider from carrying out nursing care at the home and with the help of the local authority and clinical commissioning group the residents were safely relocated to alternative accommodation.

CQC inspector Karen Westhead said that although it was not easy taking the action to remove people from their home, the risk of them coming to harm was too high, the evidence was compelling and we did not have confidence that the provider could put things right.

Shortly after the people were moved to a new home, the clinical commissioning group's head of clinical quality and governance told CQC that, "The action we took was without doubt the correct thing to do and it is fantastic to hear how well these people are doing… one resident was so hungry in the first few days in the new home that he was eating two or three portions of food at every meal."

Our report described people's individual experiences under the Deprivation of Liberty Safeguards and drew from evidence gathered from local independent mental health advocacy services and other support organisations working with people who may lack capacity. In 2014/15, we provided mandatory training for our staff on the Mental Capacity Act and our inspectors will continue to make sure that providers are informed about the requirements of the Act so that we can try to reduce regional differences.

Monitoring the use of the Mental Health Act

CQC has been responsible for keeping the Mental Health Act 1983 (MHA) under review for the last five years. The importance of monitoring the Act to protect detained people cannot be underestimated, and we are committed to helping people understand their rights and challenge poor care. On 1 April 2015, the revised MHA Code of Practice came into force. The last revision of the Code was in 2008, and this new revision reflects CQC's experience and learning in

monitoring the MHA and our recommendations from our annual MHA reports.

During 2014/15, we carried out 1,253 MHA Reviewer visits to mental health service locations, which was 93% of our total planned visits and above our target of 90%. This compares with 2013/14 when we made 1,227 visits (97% of our planned visits against a target of 95%).

Our MHA monitoring work has continued to be informed by our service user reference panel and an extended advisory group made up of a wide range of organisations supporting people with experience of the MHA.

Our inspections highlighted the variation in care provided to detained patients. Too often we found services that are not routinely involving patients in their treatment; issues of bed availability; and an increasing number of patients being detained far away from home. Our new inspection approach looks closely at how providers are delivering care under the Act and assesses their governance systems and how they work to inform local needs assessments.

We saw an improvement in our Second Opinion Appointed Doctor (SOAD) visits during 2014/15. SOADs provide a safeguard for patients who either refuse treatment or are deemed incapable of consenting. They decide whether the treatment recommended is clinically defensible and whether patients' rights have been considered properly. Eighty eight per cent of visits were completed against our target in the medicine category (87% in 2013/14), 65% in electroconvulsive therapy (ECT) (49% in 2013/14) and 74% in community treatment orders (CTOs) (70% in 2013/14). This increased performance has been driven by better administrative processes. Despite this progress we were below our targets for ECTs and CTOs. In 2015/16, a new portal will launch to improve the process even further.

2.5 Helping providers to improve care

We want to help providers to improve and to build a positive learning culture where they keep striving for excellence. This in turn will lead to better care for people using services. We support improvement in a number of ways, including listening to and acting on feedback from providers on our new inspection process and how it supports their improvement; continuing to develop our special measures programme; sharing information with our key stakeholders to support a joined-up system; and conducting thematic reviews of important healthcare issues, which can promote learning across the health and social care sector.

After every inspection we ask providers to give us feedback on how they found the experience. With the implementation of our new approach we are looking to build confidence in our new inspections. Although it is still early to get a clear understanding, the results from the 2014/15 surveys appear to be fairly positive but with areas for improvement. We report our survey information one quarter in arrears and so our results include responses only up to December 2014.

For example, 86% of adult social care providers who responded agreed or strongly agreed with the statement, "The inspection visit helps us to reflect on how we could improve" (this has remained stable from quarters 1 to 3, April to December 2014). For hospitals providers, our most recent figures are for quarter 2 when providers who responded were 100% positive (an increase of 21% from quarter 1). Primary medical services providers who responded were 58% positive in quarter 3.

Feedback on the statement, "The inspection report provided information that helps us take action to improve our service" was also positive for adult social care providers, with 78% of those who responded agreeing or strongly agreeing in

quarter 3. For hospitals providers the most recent figures we have available are for quarter 2 when 88% of those who responded were positive, an increase of 20% from quarter 1. Primary medical services providers who responded were 58% positive in quarter 3, a slight decrease of 3% from the previous quarter.

We are pleased to see some positive results from providers around the inspections assisting with improvement. We believe that the embedding of our new approach will address some of the negative trends. During 2015/16, we will look at improving the response rates from providers so that we can gain a clearer idea of our impact on helping providers to improve.

Effectiveness of special measures in improving care

Although we want providers to take responsibility for their own improvement, we also need to be ready to invoke our special measures powers when we find very serious failings in care.

Special measures can drive improvement and be a turning point for many providers. They help protect people who are not receiving the care they deserve and in some cases they save lives. The Dr Foster report (February 2015), *Is special measures working?*, looked at a study of 11 trusts with high mortality rates that were put into special measures in July 2013. It concluded that special measures did have an impact on reducing mortality overall across the trusts.

The special measures programme was first introduced for NHS trusts in July 2013. During 2014/15, we informally consulted on special measures for GP practices, independent healthcare and adult social care services and our approach has been produced and refined in response to feedback from the public, providers,

Special measures for a GP practice

Priory Avenue Surgery in Caversham, Reading was one of the first GP practices to be put into special measures by CQC. In November 2014, a specialist team carried out a comprehensive inspection at the surgery and identified concerns, particularly around poor leadership and clinical governance, staff numbers, recent staff changes, and poor updating of patient records and test results.

CQC worked closely with North and West Reading Clinical Commissioning Group (CCG) and NHS England before the inspection and received advance notice of their concerns around the leadership of the practice.

Following the inspection, CQC rated the surgery inadequate for being safe, effective and well-led, and inadequate overall. It was placed into special measures in January 2015, opening the way for a package of support.

Ruth Rankine, Deputy Chief Inspector, said of the decision to place the service in special measures, "It is important that the 7,600 people who are registered with the Priory Avenue Surgery can rely on getting the high-quality care that everyone is entitled to receive. I am hopeful that the practice will do what is required for the sake of its patients."

Since the inspection, close partnership working has continued and NHS England, the Royal College of GPs and the CCG have worked with the surgery and CQC to ensure services to patients are safe and effective. This led to the service being taken over and on 1 June 2015, Berkshire Healthcare NHS Foundation Trust took on interim management of the surgery for one year.

and stakeholders. Special measures for GP practices were introduced during 2014/15, and for independent healthcare and adult social care from April 2015. There were 21 trusts in special measures at some point during 2014/15, and 14 were in special measures at the end of year, along with 10 GP practices.

When we put a provider or service into special measures, they have six months to improve. There is support available for NHS trusts and primary medical services. After that there will be a re-inspection to check improvements are being made. If there is no improvement we will start the process of varying or cancelling the provider's registration. A second visit will be made at the 12-month point where the provider will either exit special measures or the necessary action will be taken.

For NHS trusts we provide a slightly different approach. Trusts receive a package of support to improve from Monitor, NHS England and the NHS Trust Development Authority. The period for improvement is 12 months, with a likely extension to 18 months.

In August 2014, we published our own progress report, *Special measures: one year on*, which looked at the same 11 NHS trusts as the recent Dr Foster report. The report found that almost all of the trusts that were put into special measures in July 2013 had demonstrated significant improvement by the time of our inspections eight to 10 months later. Two of the trusts had made so much progress that we rated them as good. Three more were able to leave special measures with a rating of requires improvement. Learning from this report on what helps a trust move out of special measures included: the strength of leadership within the trust; acceptance of the scale of challenge by the trust; engagement between managers and clinical staff; and willingness to be open to support from other trusts. This learning is being used to ensure that other trusts in special measures improve just as quickly.

Sharing information with other organisations

We share our information and data openly with our partners and stakeholders and, in doing so, promote improvement and joined-up thinking, reducing the negative impact of disjointed services on those who use them. We also learn from our partners and work together to make sure our new approach is continuously informed by that learning.

In May 2014, we started a new arrangement with the Local Government Ombudsman to make sure that any concerns raised by people about adult social care services are transferred between the two organisations. This means that the concern should not have to be raised twice and worried relatives or people using services can be assured of a joined-up approach to the problem.

Similarly in December 2014, CQC and the General Medical Council signed a new agreement around sharing information relevant to both organisations, particularly in relation to patient safety concerns. And in March 2015, an agreement was finalised between CQC and Monitor, which outlines how the organisations will strengthen their working practices and share information, including being more open and transparent and working together on best practice. A joint operating protocol has also been launched with the Nursing and Midwifery Council, and there is ongoing work to operationalise this through joint learning events. Information sharing with Health Education England has also been addressed through a memorandum of understanding, which should be finalised in summer 2015.

In May 2015, a memorandum of understanding was finalised between CQC and the Equality and Human Rights Commission setting out how we will work together. We have also set out this information for the NHS Equality and Diversity Council.

In developing our new approach we have worked closely with stakeholders to set out clear responsibilities for regulation. For example in 2014/15 we worked with the General Dental Council and NHS England to set out responsibilities for our approach to regulating dental practices.

During 2014/15, we worked closely with the Health and Safety Executive (HSE) to prepare for the new fundamental standards and our new enforcement policy. This included extensive sharing of information and the creation of a new system that means from April 2015, CQC routinely receives immediate notification of RIDDORs (HSE's system of statutory notification of safety incidents).

Partnerships with local stakeholders, including those with responsibilities to hold services to account on behalf of the public, are also key to our new approach – and another important way in which we can encourage service improvements locally. We have published joint guidance with Healthwatch England for all local Healthwatch on how we can work together. We have also published joint guidance with the Centre for Public Scrutiny for all local health and social care scrutiny committees, and elected councillors in England, including specific guidance for councillors in district councils. These partnerships are also an important source of information about people's views and experiences of care.

2.6 Supporting choice for people who use services

Finding the right care for a relative or friend can be hugely stressful. A CQC survey conducted with the online forums Mumsnet and Gransnet found that choosing care is one of life's most stressful moments (84% of respondents). Dubbed the 'sandwich generation', family members are often in the difficult position of choosing care for elderly relatives at the same time as looking after their own children. During 2014/15 we launched our new ratings system, which helps members of the public to choose between services. We also continued to build public awareness of CQC so that people using services understand that they have a right to choose and that we can support them.

Public engagement

In January 2015, we launched our new public engagement strategy for 2015/16. This strategy sets our four programmes of work: raising public awareness and understanding of CQC's role and purpose; listening to and acting on people's views and experiences of care; engaging the public in how we do our job; and providing high-quality information to help them choose care services.

A CQC SURVEY CONDUCTED WITH THE ONLINE FORUMS MUMSNET AND GRANSNET FOUND THAT CHOOSING CARE IS ONE OF LIFE'S MOST STRESSFUL MOMENTS.

During the last year we used various methods to increase public awareness of our role and the services we offer that support people when choosing or using health and adult social care services. For example we:

- Made our public information leaflets and other hard copy materials available to care providers; ran CQC video content in 1,780 GP practices across England, giving us a potential reach of five million people a year; and trialled making video content about CQC available in 150 pharmacies across the country.
- Developed a partnership with Mumsnet and Gransnet to promote the information and services we offer that can support women when choosing and using health services.
- Worked with voluntary and community sector partners nationally and regionally to reach out to people using services and their carers

through their trusted networks – including through social media and member magazines.

- Explored ways of promoting CQC and the standards of care, and encouraged feedback about services from key groups in local communities.
- Increased membership of our public online community by 48% from 1,898 members (September 2014) to 2,748 (March 2015). We use our online community to share proposals and draft materials to get public feedback on our work.
- Supported National Care Home Open Day. Our Chief Inspector of Adult Social Care joined over 250 inspectors and staff from CQC to visit care homes on 20 June 2014 as part of our support for the open day. The day was a valuable opportunity for us to meet with residents, carers, friends and visitors to care homes and to spread the word about our role in regulating homes; the standards of quality and safety people have a right to expect; and the information we provide that can support choice.

WE WORKED WITH VOLUNTARY AND COMMUNITY SECTOR PARTNERS NATIONALLY AND REGIONALLY TO REACH OUT TO PEOPLE USING SERVICES AND THEIR CARERS THROUGH THEIR TRUSTED NETWORKS.

We run an annual survey to look at the public's awareness of CQC, how well they understand our role and whether they have trust in us to do our job. At the beginning of 2014/15, this survey showed:

9% of people could name CQC as the regulator of health and social care services in England without being prompted ('unprompted awareness').

55% said they had heard of CQC when prompted.

60% said they trusted that CQC was on the side of people who use services.

10% had seen, read or used one of our inspection reports, with around two-thirds of those relating to care homes.

We also asked people using our website (a mix of members of the public, care professionals and other stakeholders) to tell us how easily they found the inspection report they were looking for, how easily they understood the information it contained and how useful they found it. In 2014/15, the results of this survey showed:

72% of people said the report was easy to find (31% "very easy", 41% "quite easy").

73% said the report was easy to understand (28% "very easy", 45% "quite easy").

71% said the report was useful in helping to choose care for themselves or a friend or relative (28% "very useful", 43% "quite useful").

We recognise that there is work to be done in improving the ease with which people find information on our website and how useful they find the content of our inspection reports.

In 2015/16, we are making improvements to both these surveys to help us measure our impact more effectively. This will include identifying how different groups use our reports so we can assess their value to them.

WE ALSO ASKED PEOPLE USING OUR WEBSITE TO TELL US HOW EASILY THEY FOUND THE INSPECTION REPORT THEY WERE LOOKING FOR.

Ensuring providers display their ratings

The introduction of ratings was a key step forward in helping members of the public to choose services. Ratings provide an easy reference point for understanding what good care looks like and help build public awareness of CQC's rigorous inspection process.

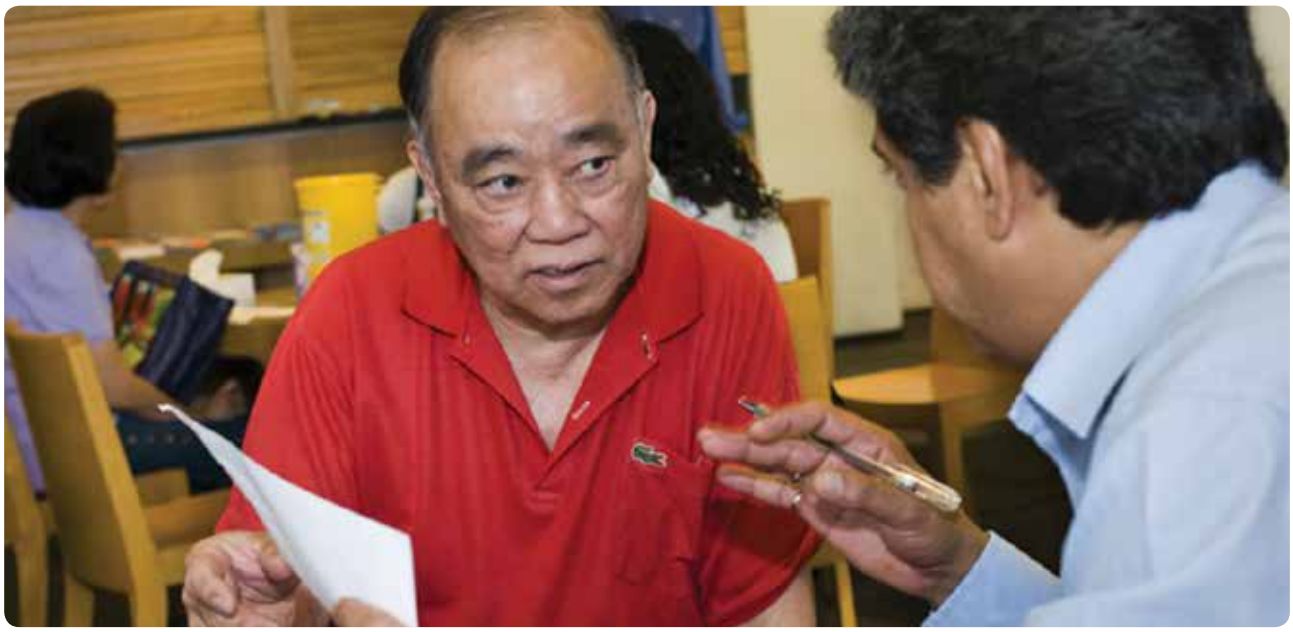
The compulsory display of ratings for providers was introduced in April 2015. It is part of the new fundamental standards. The public have a right to know how the care services they are using are performing. Our ratings tell the public whether we think the care a service provides is outstanding, good, requires improvement or inadequate. Providers need to display their rating on posters placed in prominent areas such as waiting rooms, where they are clearly visible to the public, and on their websites. We engaged the public and providers in a period of consultation, and through testing on our public and provider online communities, to make sure the rating display materials we developed were clear and easy to understand.

2.7 Improvements across different types of care

Our unique position as a regulator and inspector of services means we can present an independent voice on health and social care issues that helps the sector to improve, and helps us to improve our own inspections. During 2014/15, we conducted a number of themed inspections and reviews, which are now having an impact on our inspection approach, and we published our annual *State of Care* report.

Our review of **dementia care** looked at the whole care system and its impact on people with dementia. We found an unacceptable gap in the quality of care, meaning that someone living with dementia is highly likely to experience poor care as they move between different services. We published a report on the review, *Cracks in the pathway*, in October 2014. CQC made a number of commitments following the review.

Our thematic review of **mental health crisis care** has continued throughout 2014/15 and completed in early 2015. It explores the experiences and outcomes of people when they have a mental health crisis. As part of this work, in October 2014 we published a local area analysis on the CQC website. We used available mental health crisis care data from across sectors, and broke it down by local authority area to build a shared understanding of the help, care and support available to people in crisis across England. We also commissioned research with the Race Equality Foundation to gather and learn from the experiences of 80 people from Black and minority ethnic communities with direct experience of crisis care. We published an online map of all health-based places of safety



in England, and we published detailed findings in our report, *A safer place to be*. This report showed that some health-based places of safety are very good, but others are less responsive and sometimes turn people away.

We published a national report in June 2015, which includes actions for CQC and other key health and social care partners. We will use our findings to continue developing the way we inspect mental health services and our approach to our monitoring responsibilities under the Mental Health Act.

Our themed review of **complaints** culminated in the publication of our report, *Complaints matter*, in December 2014. The review looked at the state of complaints across health and adult social care services and found that, although most providers have complaints systems in place, people's experiences of these systems are not consistently good. CQC strongly believes complaints need to be taken more seriously and our new approach highlights the importance of managing and learning from complaints. To do this, we have a mandatory key line of enquiry for inspectors to use to ask about complaints processes when they visit providers. We will continue to review our inspection findings and refine our methods if necessary for continuous improvement, openness and transparency, including working closely with NHS complaints advocacy services.

We conducted a short data review of the **diabetes care pathway** looking at likelihoods of emergency admission in relation to demographic group. From this we have created an indicator for clinical commissioning groups to use.

We also had a number of thematic reviews underway during the year, which will complete in 2015/16. Our end of life care review is looking at inequalities and barriers to receiving good quality, joined-up care at the end of life. It is focusing on geographic variations, and the experiences of different groups (including people with non-cancer diagnoses, people with multiple co-morbidities, and people with dementia). We have also begun a review of how hospitals investigate serious incidents. We will publish the findings of both of these reviews later this year.

3

Quality, consistency and providing value for money in what we do

As a regulatory organisation we strive for quality and consistency, both in the way in which we do things and in the providers we inspect. If we want to see providers improve the quality of care, then we also need to look at our own processes. Our new approach to inspection is much more robust than the previous approach, but we need to ensure it is fair, consistent and evidence-based, and that it provides good value for money.

3.1 Listening to people

Listening to and acting on people's experiences of care is vital to our work. It helps us to decide when, where and what to inspect; supports better registration, inspection, judgements and ratings; and results in better information.

We have a number of systems in place to listen to the views (positive and negative) of people who are receiving care and using services, as well as their families, friends and carers.

We also listen closely to care staff, and encourage a culture that enables them to speak out if something is not right and if they feel people are receiving poor care. We take our responsibilities in terms of safeguarding seriously and carefully consider our approach to each safeguarding alert or concern and how best to act.

Listening to people who use services and acting on people's views and experiences of care

Our overall ambition is to make sure that people from a wide range of population groups feel that CQC is on their side, and to empower people to encourage improvements to care. Our approach to date has focused on making sure people are aware of and understand CQC's purpose and role, particularly when we are of most use to them, such as when they are using or choosing care. In 2014/15 we:

- Continued to run our **'Tell us about your care'** service in partnership with a number of organisations (see box).
- Held 80 **public listening events** across the country for people to speak directly to the CQC inspection team about their local hospital before each comprehensive inspection. Usually attended by 30 to 70 people, their feedback is important for planning the inspection.

'Tell us about your care' – partnerships with the community and voluntary sector

To increase our access to people's experiences of care (both good and bad) we have established partnerships with a number of national health and social care charities. We take a range of actions in response to the information we receive through these partnerships.

We currently work with the Patients Association, the Relatives & Residents Association, Carers UK, Mind, Action against Medical Accidents and most recently, The Silver Line (a free and confidential 24-hour helpline offering information, friendship and advice for older people who may live alone).

For our *Complaints Matter* report (published in November 2014) we analysed a specific sample of the feedback received as follows:

- We received an average of 280 items of feedback each month across all of our partners. Of these, 42 (15%) were positive comments and 238 (85%) were concerns about care.
- Of the 238 concerns, on average 24 a month (10%) were serious enough to prompt us to make a safeguarding referral to the local council because someone may have been at risk of, or experiencing, abuse. Fourteen concerns each month (6%) prompted us to carry out a responsive inspection or to bring forward the date of a planned inspection.
- On average, 57 concerns each month (24%) prompted us to raise the issues with the service provider and seek a response from them. This ranged from a discussion with the provider and verbal assurances, or a request for evidence (such as staff rotas), to requesting an investigation to be carried out by the registered manager and a report submitted to CQC. It also included requesting a copy of the provider's response to the complaint, where an individual had indicated they were intending to make a complaint to the service.
- For around 103 concerns (43%), the relevant inspector advised that no immediate action was required, but the information would be used to inform the next scheduled inspection. Sixteen concerns (7%) required no action because the issues raised had been covered at a recent CQC inspection. And 22 concerns (9%) did not provide enough information or did not prompt any action because the concern was about an experience that took place too long ago and/or there had been changes to the service in the meantime.

- Worked on a campaign to specifically target **foundation trusts** being inspected, promoting the inspection, listening event and 'Share your experience' form with a bespoke website page for each inspection. We emailed more than 65,000 people and received over 1,000 experiences of care in return.
- Continued our work with the **SpeakOut network**, a national network of more than 100 marginalised and disadvantaged community groups supported by CQC and the University of Central Lancashire. This helps groups to have a stronger voice about health and social care matters affecting their communities.
- Increased contact with **local community and voluntary groups** and public representatives across the country prior to inspections and routinely, to encourage feedback to inform inspections.
- Worked in **partnership** with organisations such as Regional Voices and other national consortia of voluntary organisations, to encourage local groups to share their experiences about the quality of care for the people they support, and encourage individuals to share feedback.

Listening to health and social care professionals

We listen closely to what those providing health and social care services tell us about quality of care. We are interested in the views of everyone, from frontline health and care professionals through to senior management and leaders.

As part of our new inspection approach we look closely at the leadership of organisations and consider how easy it is for staff to raise concerns and have these taken seriously and acted on. We believe that encouraging staff to raise concerns is a crucial part of a well-led organisation and we look at this in relation to the rating we give organisations for the well-led key question. We also use information from staff to help better plan our inspections and understand the areas needing the greatest attention. In our post-inspection survey we ask providers if their staff were given an opportunity to share their views and experiences with the inspection team. In quarter 3 (October to December 2014) 94% of adult social care providers and 87% of primary medical services providers who responded, agreed positively with this. For hospital providers our most recent figures are from quarter 2, when 100% of providers who responded were positive about this statement.

The *Freedom to Speak Up* review led by Sir Robert Francis QC was published on 11 February 2015. This looked at creating an honest and transparent reporting culture in the NHS so that healthcare professionals feel safe raising concerns about poor care and patient safety (these concerns are sometimes known as 'whistleblowing'). The report showed that although some services report routinely on issues of concern, others do not, and there can be a culture of fear around speaking up in the workplace.

The report gave a series of recommendations and CQC is committed to supporting these. The appointing of local 'freedom to speak up' guardians in every NHS trust was a key recommendation, along with the proposal for an Independent National Guardian to support the new local roles and review the handling of concerns against best practice. The Department

of Health has just finished consulting on whether this role should be based in CQC. At CQC our National Customer Service Centre receives all concerns (including whistleblowing concerns) and ensures each one is tracked and traced until it is resolved. Any healthcare professional with a whistleblowing concern can call, visit, email, fax or write to us, or fill in our online 'Share your experience' form.

Responding to information of concern: our role in safeguarding adults and children

Safeguarding adults or children who are at risk of abuse, neglect or harm is everybody's business in health and social care, and CQC has an important role to play to ensure providers keep children and adults safe.

Our three primary roles for safeguarding are to:

- Monitor, inspect and regulate services under our new approach to make sure providers have effective systems and processes in place to help keep children and adults safe from abuse and neglect, and that they meet the fundamental standards for safeguarding. We take appropriate regulatory action to ensure that shortfalls in providers' safeguarding arrangements are rectified and that improvements are maintained.
- Act promptly on safeguarding issues when we are made aware.
- Work in partnership with the local authority and the police, co-operating with them and sharing information where appropriate to help them conduct inquiries or investigations. In May 2014 we joined forces with NHS England, the Association of Directors of Adult Social Services, the Local Government Association and the Association of Chief Police Officers to put together the *Safeguarding Adults – Roles and Responsibilities in Health and Care Services* document, which sets out how individuals and organisations should work together to prevent abuse and neglect.

CQC receives a significant amount of information from people who are concerned that someone is at risk of being abused, harmed or neglected. In 2014/15, CQC received 90,606 pieces of safeguarding information. Our first priority is to ensure that the right people are aware so they can take the right action to protect the individual. This is particularly important for the 2,567 pieces of information where we are the first statutory agency to be informed (known as a safeguarding alert). We then consider, alongside all the other areas of concern, what regulatory response is necessary and appropriate.

We previously had a key performance indicator on timeliness of responding to safeguarding information. This was to respond to safeguarding alerts within one day, and to concerns within two days. Extensive investigation of the data underpinning this target throughout 2014/15 demonstrated that the data was not appropriate and not accurately reporting the actions of our inspectors in responding to information of concern. In recognition of this, we changed the way we report our safeguarding activity during the course of 2014/15, and we now report on the time taken for a variety of different possible actions.

Table 3 shows our reporting data in this new format for safeguarding alerts during 2014/15. Performance improved towards the end of 2014/15. At the end of quarter 4, 58% of all safeguarding alerts had been responded to within one day (compared with 47% at the end of quarter 3). For safeguarding concerns responded to within two days, the corresponding figures were 41% and 22%. Given that performance reporting for safeguarding has recently changed, we will be able to provide a clearer picture of our performance across all safeguarding information in 2015/16.

Table 3: Safeguarding alerts 2014/15: first actions taken

Safeguarding alerts first actions	0-1 days	2 days	3-10 days	11-30 days	31+ days	Date disparity	Total
Referred to safeguarding authority as an alert by CQC	1,054	78	135	21	12	4	1,304
Discussed with local safeguarding team	138	6	42	30	58	5	279
There was other contact with the provider	132	18	40	64	57	6	317
Noted for next planned inspection	110	10	63	50	93		326
No further CQC action required*	23	8	22	22	25		100
No action taken*	7		4	2	14		27
CQC staff attended a strategy meeting	1		1		2	1	5
A management review was held	2		1		1	1	5
A planned inspection was brought forward	8		4	4	9	3	28
A responsive inspection took place	4		7	2	14	3	30
CQC has begun or has taken enforcement action	3		1		5	1	10
No action specified*			19	24	93		136
	58%	**5%**	**13%**	**9%**	**15%**	**1%**	**100%**
Total	**1,482**	**120**	**339**	**219**	**383**	**24**	**2,567**

*Note: 'No action taken' means that someone has looked at the record and decided that no action at all is required. 'No further CQC action required' means there is no further action required from CQC. 'No action specified' means that the record is still open and no action has been identified on our system.

We refreshed the membership and terms of reference of the CQC safeguarding committee in 2014/15 to ensure it provides effective leadership across CQC. We established a safeguarding improvement project, and this is driving improvements in our policy, use of information and data, our systems and processes, as well as supporting our staff with better training and improved management of safeguarding. This will lead to improved performance during 2015/16 in timeliness of response.

During 2015/16, we will be piloting a new decision-making tool that will help us triage all concerns received. This will include a further improved system for reporting on safeguarding alerts and concerns.

Ensuring high-quality customer service

Our dedicated National Customer Service Centre (NCSC) in Newcastle upon Tyne is the first point of contact with CQC for most people. It deals with general queries about CQC, as well as specific calls relating to registration, safeguarding, mental health, and online services. The centre has a programme of continuous improvement to ensure the best possible service. For the third year running, the NCSC was in the UK Top 50 Customer Service Awards, achieving 28th place for call handling and 30th place for email handling.

The centre works to agreed targets to ensure calls and emails are answered as quickly as possible. During 2014/15 there was a notable increase of 8% in calls to NCSC: 258,151 calls compared with 238,621 in 2013/14. This had a downward effect on call performance, but the effect was slight when compared with the increased call volume. For mental health and safeguarding, the target was 90% of calls answered within 30 seconds, and for general calls, 80% within 30 seconds. In 2014/15 the centre nearly met the target for safeguarding calls with 89% responded to in the target time, although this was a slight drop-off from 2013/14 when the performance was 91%.

In mental health the target of 90% was met but with a decrease from the 93% in 2013/14. General calls nearly reached the target of 80% and performed better than last year (78%). Our correspondence target was to reply to 90% of emails and letters within 10 days; during 2014/15 we achieved an 89% response rate.

3.2 Registering care services

The national registration team are the first point of contact with CQC for new health and social care providers. Their work gives assurance to the public that providers are able to deliver services that are safe and of the right quality.

Registration is an important part of CQC's role in helping to improve the quality of health and social care. It is the first step to protect people from poor care. If a provider or manager cannot satisfy us that they have the capacity and capability to provide safe, effective, caring, responsive and well-led care, we refuse to register them.

We have introduced a more thorough test for individuals, partnerships and organisations applying to provide care services. It means that, from 1 April 2015, providers have had to declare that they can meet the new fundamental standards. This includes making sure that directors of a service commit to meeting the new fit and proper person requirement for directors.

The registration team also plays an important role in responding to allegations that providers are operating unregistered, and will take enforcement action where necessary, including prosecution.

During the year we had good feedback from providers that our registration process is robust. In our survey of providers we found that, from April to December 2014, 95% of providers felt that the registration interview was a thorough

assessment and 93% felt that the site visit was thorough.

In 2014/15, we completed 36,269 separate registration processes. These were a mix of new registrations, variations in registration, and cancellations. This compared with 48,472 registration processes the previous year, when GP practices had to register for the first time.

Across the sectors, we focused on improving the time in which we register new providers or registered managers. Against a target of 90%, 82% of registration processes were completed in 50 working days. Over the same period last year 78.5% were completed against a shorter timeframe of 40 days.

Returned applications (usually due to wrong or incomplete information on forms) have remained a problem. We are improving our systems and making the application process more streamlined through the use of online accounts. Where these are already in place, evidence is showing that we have significantly reduced the number of returned applications. In 2015/16, we will be starting to roll out online accounts to all providers. We also work with providers on complex or large registrations and on new models of care.

Through our registration improvement project we are also changing the structure and content on our website to ensure providers have clear guidance and a better understanding of the standards they need to meet. We will continue to build on this over time so that, as well as improving the user experience, we can improve the quality of applications we receive.

We are developing our approach to specialisms to strengthen our assessments in line with the various sectors we work with. We are also building our methodology to respond to the specific needs of people with a learning disability, in the light of the Winterbourne Concordat and the Bubb report published in November 2014.

3.3 Intelligent Monitoring

Intelligent Monitoring is CQC's bespoke intelligence-driven model that flags up concerns about the quality of care of providers and helps guide our new approach to inspection. We collect information from a wide range of data sources (for example, medication errors, staff turnover, safeguarding alerts and complaints). These are then combined to give a clear picture of which areas of care to focus on and which providers to prioritise. Intelligent Monitoring is crucial for making sure we continuously improve our predictions and monitoring of potential concerns about quality. Intelligent Monitoring is not a static process. We are always refining our model, looking for ways to ensure consistency and quality control.

Intelligent Monitoring started in October 2013 and has run for over a year for hospital trusts. We therefore have results from both testing of our new approach and actual inspections that we can use to gauge its effectiveness. Note that there are many factors that affect ratings other than the nationally comparable data used in the Intelligent Monitoring bands, and Intelligent Monitoring only flags concerns in trusts that are performing very significantly below the average for a given indicator.

INTELLIGENT MONITORING IS NOT A STATIC PROCESS. WE ARE ALWAYS REFINING OUR MODEL, LOOKING FOR WAYS TO ENSURE CONSISTENCY AND QUALITY CONTROL.

Table 4 sets out the ratings of 65 hospital trusts published between April 2014 and March 2015. This shows that 16% of trusts in bands 1-3 (six out of 38) were rated inadequate. This is twice as high as the 7% of trusts in bands 4-6 (two out of 27) rated inadequate. However, as the number of trusts with an overall inadequate rating is small, it is too early to draw definitive conclusions.

Dr Paul Bate, Director of Strategy and Intelligence

The role of Strategy & Intelligence (S&I) is to enable CQC to deliver its purpose. We do this by setting the strategy frameworks and operating model for our inspection and registration teams and ensuring that, by looking ahead, we make the most of the opportunities to assess care quality and encourage improvement. We also deliver a wide variety of products and services, from data packs to inform inspections, public and staff engagement including our website and intranet, and management information to help prioritise inspections.

Our four units – Engagement, Intelligence, Planning, Performance & Programmes, and Policy & Strategy – come together in teams to focus on different elements of our work and solve business problems in a cohesive way. We achieved a great deal in 2014/15 to transform the way CQC regulates and inspects. This included developing the new inspection methodology for all the different sectors, building our Intelligent Monitoring systems, creating tools for CQC staff and guidance for providers, engaging with many different audiences to co-produce the new approach, laying the foundations for CQC's new strategy in 2016, and launching our knowledge and information strategy to completely re-model and improve the way we collect, use and store data.

In 2015/16, we will do two main things. We will embed CQC's operating model and ensure it is underpinned by robust quality standards, activities and processes. And we will shape the future of CQC and of quality regulation as we develop CQC's strategy for 2016 onwards.

Underpinning this will be a focus on our own capacity and capabilities, by growing our workforce, building on the professional and technical skills of S&I staff, and strengthening our diversity. We will also be clear and transparent in providing performance information and management assurance about how we are improving the way CQC is managed and providing value for money.

WE LAUNCHED INTELLIGENT MONITORING FOR GP PRACTICES AND MENTAL HEALTH SERVICES IN NOVEMBER 2014, BUT IT IS TOO EARLY TO ASSESS THE IMPACT.

We are continuing to evaluate Intelligent Monitoring to understand how we can continue to develop it, particularly around a smaller set of indicators that are most likely to indicate poor care.

We launched Intelligent Monitoring for GP practices and mental health services in November 2014, but it is too early to assess the impact. We have, however, refined and corrected the data indicators for our GP practice monitoring. In December 2014 we apologised and re-banded 60 GP practices that were previously in the GP bands 1 or 2. We also removed the banding system for GP practices in March 2015, agreed to change the language around "risk", and made further corrections to improve the analysis we carry out.

Table 4: Intelligent Monitoring risk banding and ratings results for hospital trusts 2014/15

Banding	Inadequate	Requires improvement	Good	Outstanding	Banding total
Band 1	4	16	4	0	24
Band 2	1	4	3	0	8
Band 3	1	4	1	0	6
Band 4	0	6	1	0	7
Band 5	1	7	1	0	9
Band 6	1	5	3	2	11
Rating total	**8**	**42**	**13**	**2**	**65**

3.4 Evaluating our new inspection programme

Our new approach has been tested and evaluated at every stage to ensure we are getting it right for providers, the public, partners, and our own inspection teams. In continuing to introduce the new inspections, we conduct test inspection phases (known as 'waves') and then evaluate them in order to gather feedback and refine and improve the quality of our approach. Our external and internal evaluations combine a range of research methods including: direct observations of inspections; interviews with providers, partners, CQC staff and the public; online surveys of inspectors; document reviews; and attendance at strategic meetings. Evaluation is very important for making sure our new approach is robust, consistent and high quality.

During 2014/15, testing and evaluating continued as we gradually rolled out inspections for different sectors. We noticed a number of positive common themes emerging as we evaluated each sector, including that providers and inspection teams found our approach to be much more comprehensive than the previous approach. The use of an inspection team including Experts by Experience and specialist advisors was also welcomed, as was the much more thorough collection of evidence.

There was a generally good response to the statement, "The inspection team had good knowledge of the type of care we provide", with positive responses from adult social care providers (91% in quarter 3) and primary medical services providers (74% in quarter 3). For hospital providers, our most recent figures are from quarter 2 when those providers who responded were 63% positive about this statement.

Less positive was feedback on the inspections taking much longer than before and requiring a higher level of capacity and time than was available. In addition, a clear need for further training was identified during the evaluations, particularly on report writing and on how to use the key questions effectively on an inspection visit.

We integrated the learning from all of our evaluations into the development of our new approach and we continue to follow up on the recommendations and suggestions made.

3.5 High-quality and consistent inspection judgements and reports

It is important that the public, as well as providers and staff, feel confident in CQC's inspections and view our judgements and reports as robust and reliable. Our new approach strives for consistency throughout and we have a number of quality control measures in place to ensure we reach fair judgements. These include peer reviewing of inspection reports and national panels that look at inspection judgements. We also provide continuous training and development for our inspectors. However, our evaluation work has suggested that more needs to be done to establish and improve quality standards, controls and assurances, and the quality of inspection report writing.

As we are continuing to develop and refine our new approach inspection processes, we did not set a time target for publishing inspection reports in 2014/15. However, we expected a period of up to 50 working days between the date of the final site visit and the publication of the final report. Only 26% of new approach reports were published within 50 days across the three inspection directorates.

There are ongoing projects to reduce publication timescales for future inspections, and all directorates were showing an improving trend in the last two quarters of the year. We will continue to improve our processes and look to agree targets in the year ahead.

We have a number of ways to check how consistent our judgements and reports are, including feedback from providers on the inspection process and team; ratings and aggregation challenges; and providers who receive inadequate ratings saying that our inspection judgements are fair.

In quarter 3, we found that 64% of adult social care providers who responded to our survey of those who did not meet the essential standards agreed that our rating was fair and evidence-based. This was a decrease from 77% in the previous quarter. For hospital and GP providers the response numbers for quarters 2 and 3 were too low to be analysed.

We had 27 challenges to ratings during 2014/15. Two of these were upheld, nine were not upheld, and 16 were pending review at 31 March 2015. We are collating the learning from these as we move through 2015/16.

3.6 Speaking with our independent voice

CQC uses its independent voice to inform a wide range of audiences about issues of quality in health and social care. We reach the public, care providers and professionals, commissioners and those governing services, CQC staff, stakeholders and opinion formers with timely, relevant and authoritative reports and information.

In doing this, our aim is always to:

- Support the delivery of safe, effective, caring, responsive and well-led services.
- Encourage improvement by care providers.
- Tell the public what standards they have a right to expect, and help them to make informed decisions as consumers of care services.

- Influence commissioners, national and local politicians, and others in the health and care system, so they can make better purchasing, governance and oversight decisions.
- Demonstrate how providers of poor care are held to account.

We published our annual *State of Care* report in October 2014, highlighting the wide and unacceptable variation in the quality and safety of care across England, and the detrimental impact this has on people who use health and care services and their families.

In our report on our Mental Health Act monitoring, published in February 2015, we raised our deep concerns that one in five records of mental health patients lacked evidence that their rights had been explained to them after being detained.

We also published a number of reports on specific health and social care issues during the year. See page 36 for more details.

3.7 Assessing our value for money

In 2014/15, we began to collate evidence of CQC's activity, performance and impact to derive a baseline assessment of our value for money following the radical transformation of our regulatory approach. We drew on a range of sources, including performance information, in-house and external evaluation, management assurance and internal audit. At the same time, the National Audit Office has been making an external assessment of our value for money.

During the coming year, we will continue to develop and report on our value for money, concentrating on achieving:

- Economy – through improved procurement and tight budgetary control.
- Efficiency – through the development and monitoring of our operating model.
- Effectiveness – through continued evaluation of our approach and engagement with those that we regulate.

4

Developing our values, capacity and capabilities

Our new approach to inspection has needed an increased focus on staff and skills inside CQC. We spent significant time in 2014/15 building the capacity and capability of our workforce to be ready for the new approach. We have invested in creating a positive and values-driven staff culture that promotes openness, transparency, inclusiveness, and an acceptance of complaints and challenge. We have had some positive feedback from staff in our annual survey. But we still have a number of areas to monitor, including staff morale – which has been affected by the speed of implementing the new approach – recruitment challenges and high workloads.

4.1 Building a culture based on our values

CQC can only achieve its goals and drive improvements in care if all staff support the changes and the direction of the organisation. During 2014/15 all our staff were actively engaged in a project to develop a new set of values that accurately reflect our organisational culture. These values of excellence, caring, integrity and teamwork were launched in October 2014. We will measure the impact of the values so far in our next staff survey.

We are proud of our values and feel they reflect our desire to provide high levels of support to our staff combined with high levels of challenge. They remind staff that at the core of their work is the commitment to listen to and act on what people using services and staff working in services tell us.

Our values are closely linked with equality and human rights, which helps us to integrate these principles in our everyday work. For example, our desire for excellence means that we strive to improve health and care outcomes for people who experience inequality when accessing services. Our caring value links directly with making sure everyone using care services is treated with dignity and respect.

Our values in action

CQC's new values are now integrated into our ways of working, helping us to work better together and to do the right thing in order to improve quality of care. Since they launched, there have been a wide range of activities to energise and inspire staff.

The values were officially revealed at CQC's leadership conference in October 2014 and broadcast by livestream across the whole organisation. Staff unveiled the new values, then talked about what they mean for us as an organisation. Further leadership conferences in January and April 2015 took excellence and caring as their themes.

November 2014 was named 'values month' and, during special themed weeks, guest speakers inspired staff; a live Question Time-style session with the Board encouraged debate and focused on our integrity value; staff discussed mental health awareness, through our social network tool Yammer; and there was the Great CQC Bake-Off which raised money for charity and encouraged our teamwork and caring values.

But the values focus did not stop with these events. They continue to be integrated into our everyday work. For example at our customer service centre in Newcastle there is a values tree where people can pin ideas about how to make a difference; in April 2015 we launched a wellbeing project to help us care for ourselves and others at work; and we re-developed our longstanding staff excellence awards to incorporate our values.

So what next? Every staff member will now measure the 'how' as well as the 'what' of their work through our new performance management system and will be encouraged to rate themselves against each value and behaviour. We will also provide values training, encourage role modelling, and ensure our recruitment is values-based. We will continue to evaluate our success through the staff and provider surveys to make sure our values are helping us to have an impact and become a high-performing organisation.

Integrity means that we are constantly looking to do the right thing for people who use services, and our teamwork value links very closely to our new team approach to inspection.

In January 2015, we celebrated a real success for the values at CQC when for the first time we ranked in the top 100 UK employers in the Stonewall Equality Workplace index. Stonewall is the UK's leading lesbian, gay, bisexual and transgender rights charity.

4.2 Recruiting the right people

During 2014/15, we focused on recruiting a strong workforce under each of our five directorates, capable of taking on the challenge of implementing our new inspection approach. Due to the increased depth and rigour of our new approach, we have invested in significantly increasing our staff capacity. Our extensive recruitment programme has continued throughout the year and we have made progress in recruiting to the key roles needed to deliver our inspection programme including inspectors, inspection managers, registration inspectors, registration managers, senior analysts and analyst team leaders.

We have developed a new approach to recruitment to help us find the high calibre of candidate we need. We have tailored our recruitment campaigns to be flexible and to adjust to our specialist requirements.

However, recruiting enough new inspectors, inspection managers and analysts with the right skills has been a significant challenge. We have

Eileen Milner, Director of Customer and Corporate Services

The Customer and Corporate Services (CCS) directorate incorporates many different functions of CQC: Customer Support Services (including our National Customer Service Centre); Finance, Commercial and Infrastructure; Governance and Legal Services; Human Resources and the Academy.

CCS is often the first point of contact for care providers and members of the public. We also offer high levels of support to CQC staff, helping colleagues across CQC to achieve our organisational goals. With such a wide range of disciplines, we have worked hard in 2014/15 to create a shared team ethic and core purpose. This is to provide a consistently high standard of support to our diverse customer base, both internal and external.

We have been busy. Our customer support teams are the front door to CQC – in 2014/15, we dealt with 1.4 million transactions, many of them complex queries, and we began a major review of how CQC handles concerns from the public and care staff. Our governance and legal teams redesigned CQC's governance processes to be more robust, and oversaw the introduction of our new and stronger legal powers. Our finance teams intensified their focus on CQC's value for money and high value procurements, while the infrastructure team gave better support for our non-office workers. HR has supported all of CQC in a phenomenal rate of recruitment activity, and the Academy has led significant investment in learning and development, giving our staff the confidence they need to do their jobs, which includes the application of the new legislation.

Our focus going forward is to embed the twin pillars of excellence and value for money. The challenges for 2015/16 are to ensure CQC's financial and staff resources are aligned to the external environment, and to continue to review our IT infrastructure so that CQC can regulate effectively using the best possible technical support.

therefore been under-staffed during the year. This has affected the speed with which we can deliver our inspection programme, and it had an impact on staff morale. Our goal for the end of April 2015 was to hire 300 additional inspectors and we met that target. By the end of December 2015 we hope to have achieved our overall target of 600 new inspectors.

During the year we have been growing our team of national professional advisors and clinical advisors to guide the continued development of our new approach in specialist areas. These senior clinical appointments are integral to ensuring the highest quality in our assessments of clinical practice, fine-tuning our approach, and tackling the complexities of integrated care. In December 2015, our Senior National GP Advisor and Responsible Officer, Nigel Sparrow, was awarded an OBE for services to primary care.

4.3 Training and development

Growing staff skills and expertise through training and development is important to CQC. The CQC Academy has now been running since 2013 and is gradually growing and adding more courses to its portfolio. In November 2014 we launched our e-learning portal, the Education and Development (ED) system, which allows staff to manage their own learning and development online. The Academy is important for developing staff and supporting them in CQC and in their future careers.

EQUALITY AND HUMAN RIGHTS ARE EMBEDDED ACROSS OUR INSPECTION APPROACH AND THEY ARE FUNDAMENTAL TO TREATING PEOPLE WHO USE SERVICES WITH FAIRNESS, DIGNITY AND RESPECT.

We developed the welcome process to make sure every new staff member receives a positive introduction to CQC and a seamless transition from the interview stages to their new role.

The corporate induction is a chance to introduce CQC's purpose, values and role and to encourage commitment and enthusiasm from the very start. The Chief Executive speaks to all new starters on their first day.

Training in new and updated legislation, including the new fundamental standards, is crucial to ensure we carry out our regulatory role correctly and legally. For example, during 2014/15 all staff were trained on the important changes to our enforcement powers and how this will impact on providers who do not meet their legal obligations. Staff were trained on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Towards the end of 2014/15, staff started being trained on the new fit and proper person and duty of candour requirements.

In April 2015, we launched our new equality and human rights learning programme in partnership with the Equality and Human Rights Commission. This will run until March 2016. Equality and human rights are embedded across our inspection approach and they are fundamental to treating people who use services with fairness, dignity and respect. The programme is tailored for different staff groups and meets one of our equality objectives through exploring key issues around unconscious bias, beliefs, and our human rights approach. The programme also trains inspection staff to look out for instances where a person's human rights could be violated, as this affects decisions about enforcement action we could take.

4.4 Continuous improvement and transparency

We are constantly looking ahead to see how we can improve and be effective in meeting the challenges of the future. In particular we strive to be a transparent organisation that recognises and admits its mistakes as well as celebrates its successes.

Responding to complaints about CQC

As a regulator we need to be open to complaints about our work. We view complaints as a chance to learn and improve. Our aim is to respond quickly to complaints, with most being resolved at stage 1 (the first time a person complains about CQC) and as few as possible requiring further investigation at stage 2 (when CQC responds and the complainant does not accept our response).

In 2014/15 we received 485 stage 1 complaints. This was a 9% reduction from the 534 complaints received in 2013/14. Sixteen per cent (78) were upheld; this compared with 8% in the previous year. We have improved the way we investigate complaints and how we collect information.

AS A REGULATOR WE NEED TO BE OPEN TO COMPLAINTS ABOUT OUR WORK. WE VIEW COMPLAINTS AS A CHANCE TO LEARN AND IMPROVE.

We received 58 stage 2 complaints (which compared with 86 in 2013/14). Of these, 17 were upheld.

The Adult Social Care and Customer and Corporate Services directorates accounted for 72% of the complaints, and recorded 229 and 123 complaints respectively during the year. For the Adult Social Care directorate the high figure can be explained by the large number of providers (and therefore inspections) within the sector. The Customer and Corporate Services directorate is often the first point of contact for people speaking to CQC, and so complaint figures tend to be higher.

The three most common complaints across CQC were about our performance and conduct (26%), our policies and procedures (26%), and delays in replying to queries (9%).

We continually strive to ensure our complaints process is fit for purpose. We are in the process of reviewing how we handle people's first point of contact with CQC to ensure that complaints are resolved as soon as possible. With increased knowledge and skills we should be better able to resolve issues before they escalate.

Learning from a complaint

We received a complaint by someone acting on behalf of a person using a care service. It was about the conduct of one of the supporting members of our inspection team. The person had become upset about being questioned. As a result of this complaint, we apologised to the person for the conduct of the supporting member of staff, and also updated our inspection methodology. We reiterated guidance for supporting staff about how to speak sensitively to people receiving care. We are now working in collaboration with supporting organisations to implement some new training around managing complaints.

What our staff say

We conduct a staff survey every year to understand how staff feel about working for CQC. Our 2014 survey took place in August. The overall level of engagement achieved a composite score of 64 (six points above the public sector benchmark of 58). More employees than before across all equality groups said they would recommend CQC as a good place to work, which is good progress in terms of our equality commitments.

There were a number of good scores. For example, 91% of staff were positive (meaning they agreed or strongly agreed) that their team was committed to producing high-quality work (1% less than in 2013). Eighty four per cent of staff were positive that in their team they all respect and value each other (up 1% from 2013). Eighty six per cent of staff felt that

CQC is fulfilling its role effectively (an increase of 12%).

However, there were less positive results relating to change at CQC, training, morale and equality of opportunity. Only 38% were positive that the training and development they receive is effective and just 34% of people were positive that changes are effectively implemented in CQC. Only 27% were positive that morale is good in general across CQC, although this was a rise of 4% since 2013, and 53% of individuals answered that their own personal morale was good. In terms of equality and diversity, Black and minority ethnic (BME) staff and disabled staff were still less likely to consider CQC as an equal opportunities employer, compared with other groups, and disabled staff were also less positive than their non-disabled colleagues across nearly all of the staff survey questions.

It should be noted though that, at the time of the survey, CQC was still in the early stages of transformation to our new approach, and so staff opinion may have been influenced by a time of rapid change. As a result of the feedback in the survey, we have been focusing on improving communication; change management; staff resourcing; systems, tools and processes; and learning and development. We are also developing a new people strategy to help create a more inclusive organisation.

DURING 2015/16 WE HAVE PLANS IN PLACE TO FOCUS ON STAFF WELLBEING AND WE WILL PROVIDE FURTHER TRAINING ON WORKPLACE VALUES AND BEHAVIOURS.

Another key area to highlight is around bullying and harassment. In our 2014 staff survey 12% of staff said they had personally been bullied or harassed at work in the previous year. Disabled staff were still more likely to say that they had personally experienced bullying, harassment or discrimination (27%), compared with other staff.

Results for other equality groups were closer to the overall figure; for example 13% of BME staff said they had experienced bullying or harassment in the previous year.

The overall figure has gradually decreased since 2012 when it was 21% and, of those who report bullying and harassment, 27% said they felt satisfied with how it was dealt with (a rise of 6% since 2013). However we need to reduce this further and work hard to make sure the culture and management at CQC is supportive and caring, with no place for bullying. The recent Francis report identified bullying and harassment as an issue across the whole of the NHS and so we need to play a part in carefully monitoring this in relation to our own staff. During 2015/16 we have plans in place to focus on staff wellbeing and we will provide further training on workplace values and behaviours.

Staff equality profiles

At CQC we believe that diverse organisations mean healthy and effective organisations. We are committed to promoting a culture of inclusivity within our own workforce and making

sure we are in line with our organisational values. Every year we monitor staff equality and diversity at CQC to make sure we identify any inequalities and find ways to address them. For example we have used staff data, alongside conversations across CQC, to inform our new equality objectives for 2015-2017 relating to equal outcomes for staff.

We have three established staff organisations that work to promote equality for particular groups – the Disability Equality Network; the Lesbian, Gay, Bisexual, Transgender (LGBT) Equality Network; and the Race Equality Network. In April 2015 we launched our new equality objectives which will run until March 2017. These apply to all aspects of our work, but include specific commitments to improving equality for CQC staff.

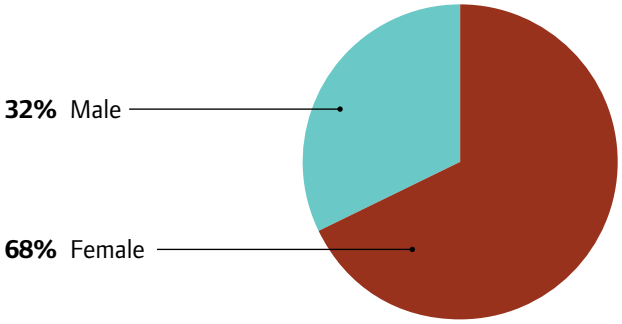
Figure 4 shows our staff equality profiles at the end of March 2015. During the previous year, our diversity profiles in certain areas improved, while others remained the same. We are also performing well in some areas by comparison with the general workforce in the country at large. Our *Equal measures* report showed that staff identifying as heterosexual, lesbian, gay or bisexual were all proportionally represented across pay bands (as at the end of September 2014). However, we still need to do more to achieve our ambition of having no difference in employment outcomes for staff based on their equality characteristics (age, disability, ethnicity, gender, gender reassignment, religion or belief, or sexual orientation).

- **Age:** As of March 2015, 3% of CQC's workforce was under 25 compared with 14% in the general workforce. However, when we compare the figure with the previous year, the proportion of under-25s had increased from 2% to 3%. There was still low representation of younger staff on higher pay bands (Band A and above) but this is to be expected as more experienced staff are likely to be in the higher pay bands.
- **Disability:** The number of disabled staff in CQC remained low as of March 2015 at 7% when compared with the general workforce figure of 14%. There was no improvement on this since last year. Only 5% of staff in management and leadership positions were disabled people.
- **Ethnicity:** There have been no major changes between this year and last. Eleven per cent of CQC staff were from BME backgrounds, which is the same as the general workforce figure. The representation of BME staff in management grades was still proportionally low at 7%.
- **Religion:** The number of Christian staff was lower than in the general workforce (44% at CQC compared with 59% in the general workforce). In September 2014, all religions were proportionally represented across all pay bands.
- **Sexual orientation:** Five per cent of CQC staff identified as lesbian, gay or bisexual at the end of March 2015. There was no significant change in the proportion of heterosexual, lesbian, gay and bisexual, and 'unknown' sexual orientations across CQC. In September 2014 they were all proportionately represented across pay bands.
- **Gender:** Comparing CQC gender patterns to the general workforce, males were under-represented and females were over-represented (68% of staff at CQC were female, compared with 46% in the general workforce). This is due to the nature of our work as women tend to be over-represented in the health and social care sector.

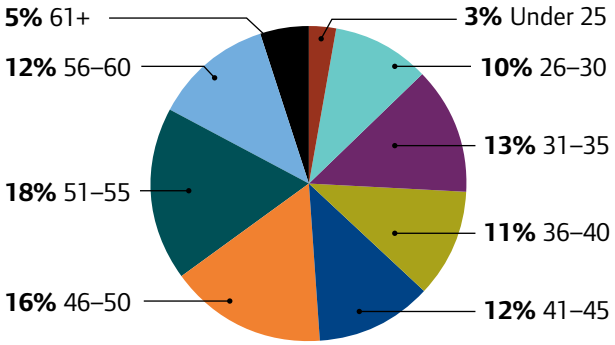
Sources: General workforce gender, age, disability and ethnicity data are respectively from the Office for National Statistics (ONS) website, Tables A03: Labour Force Survey Summary Aged 16-59/64 (by gender); A05: Labour Market Status by Age Group; A08: Economic Activity of People with Disabilities Aged 16-59/64; and A09: Labour Market Status by Ethnicity. Religion data are from the 2011 census, Table KS209EW.

Figure 4: Staff equality profiles at 31 March 2015

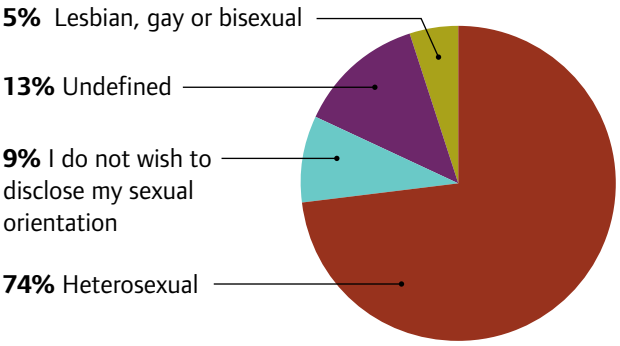
Gender



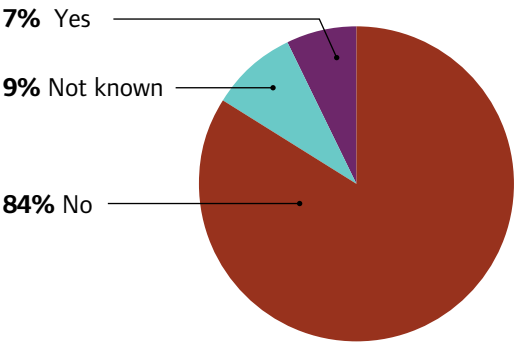
Age



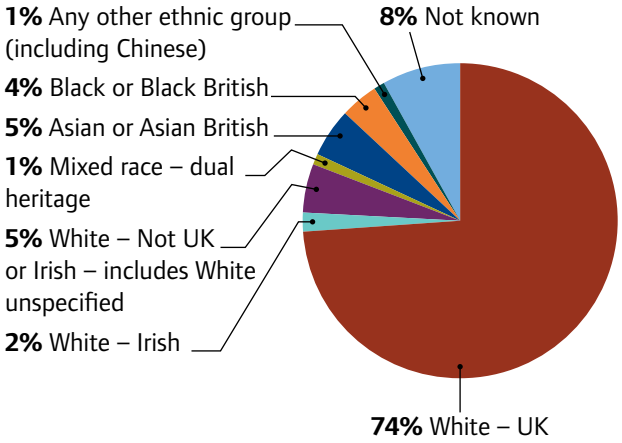
Sexual orientation



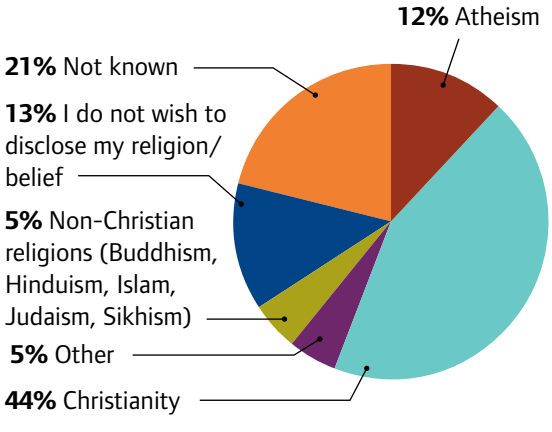
Disability



Ethnicity



Religion and belief



Total staff headcount at 31 March 2015 was 2,763.

Our Board and Executive Team

5

Board members

Michael Mire

Acting Chair

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 until his retirement in 2013.

After leaving university Michael 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. Michael 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.

David Behan CBE

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, was awarded an Honorary Doctorate in Law by Greenwich University.

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

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

Professor Louis Appleby

Non-executive director

Professor Louis Appleby is Professor of Psychiatry at the University of Manchester, where he leads a group of more than 30 researchers in the Centre for Mental Health and Safety.

He was National Clinical Director for Health and Justice between 2010 and 2014, and National Director for Mental Health between 2000 and 2010.

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

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

He received his doctorate in particle physics from the University of Manchester in 1999.

Anna Bradley

Non-executive director

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

She also 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.

Professor Paul Corrigan CBE

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 CBE

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. She is also currently a trustee of NatCen Social Research.

Jennifer originally trained in medicine. She practised mainly paediatric medicine before a career in policy analysis. She has researched and written widely on healthcare reform in the UK and internationally and has an MA in public health and a PhD in health services research from the London School of Hygiene and Tropical Medicine. Until January 2008, Jennifer was director of policy at The King's Fund. She was the policy adviser to the Chief Executive of the National Health Service between 1998 and 2000, and a Harkness Fellow in New York in 1990.

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 CBE

Chief Inspector of General Practice

Professor Steve Field became Chief Inspector of General Practice in October 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.

Steve is also Chair of the National Inclusion Health Board, improving the health of the most vulnerable. He was Chair of the NHS Future Forum, which was launched in April 2011. He presented the final reports to the full UK Cabinet in June 2011, which led to key changes in the Bill that became the Health and Social Care Act. After successfully leading two phases of this project, he led the review of the NHS Constitution.

He was Chair of council of the Royal College of General Practitioners between 2007 and 2010. For the past 12 years he has been a Member of Faculty at the Harvard Macy Institute, Harvard University in Boston, Massachusetts. 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.

Steve 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, a large academic training practice involved in research and health care education at undergraduate and postgraduate levels.

Sir Robert Francis QC

Non-executive director

Sir Robert Francis QC has been a barrister since 1973 and became a Queen's Counsel in 1992.

He is a Recorder (part time Crown Court judge) and authorised to sit as a Deputy High Court Judge. He is a governing Bencher of the Honourable Society of the Inner Temple, where he has chaired its Education and Training Committee.

Sir Robert Francis specialises in medical law, including medical and mental health treatment and capacity issues, clinical negligence and professional discipline. He has appeared in a number of healthcare-related inquiries and chaired the Independent Inquiry into the care provided by the Mid Staffordshire NHS Foundation Trust, and subsequently the Mid Staffordshire NHS Foundation Trust Public Inquiry.

He is the honorary President of the Patients Association and a trustee of the Point of Care Foundation and the Prostate Cancer Research Centre. He has also been elected to an Honorary Fellowship of the Royal College of Anaesthetists.

Paul Rew

Non-executive director

Paul Rew is an experienced non-executive director in both the private and public sectors and Fellow of the Institute of Chartered Accountants in England and Wales.

He is currently non-executive director and chair of the Audit and Risk Committee at the Department for the Environment, Food and Rural Affairs, The Met Office and Northumbrian Water. He is also a member of the advisory board of Exeter University Business School.

Paul is a former Partner with PricewaterhouseCoopers, during which he was responsible for audits and other services for a wide range of clients, led areas of the business, developed new services, and advised on strategy, change, planning and risk management.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Professor Sir Mike Richards became Chief Inspector of Hospitals in July 2013.

He was a hospital physician for more than 20 years. After a variety of training posts he was a consultant medical oncologist between 1986 and 1995, and Professor of Palliative Medicine at Guy's and St. Thomas' Hospitals between 1995 and 1999.

In 1999 Sir Mike 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.

In July 2012 Sir Mike was appointed as Director for Reducing Premature Mortality on the NHS Commissioning Board (now NHS England). In this role he led the development of a cardiovascular outcomes strategy.

Sir Mike was appointed CBE in 2001 and was awarded a Knighthood in 2010.

Kay Sheldon OBE

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 CQC, and she has been involved with a variety of user-led initiatives in both the statutory and voluntary sectors.

Kay was a trustee of Mind for five years. Prior to that, she was co-chair of Mind Link, Mind's service user network.

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

Andrea Sutcliffe

Chief Inspector of Adult Social Care

Andrea Sutcliffe became Chief Inspector of Adult Social Care in October 2013.

She has nearly 30 years' experience in health and social care, managing a range of services including those for children and older people.

She joined CQC from the Social Care Institute for Excellence (SCIE) where she was Chief Executive from April 2012.

Previously Andrea was Chief Executive of the Appointments Commission and was an executive director at the National Institute for Health and Clinical Excellence for seven years.

Our Executive Team

CQC's Executive Team consists of:

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

and

Eileen Milner

Director of Customer and Corporate Services

Eileen'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 of Business Strategy.

Northgate Information Solutions provides a range of services to the public sector including health information and screening services, business support, transformation services and tailored software.

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.

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

Corporate governance and financial statements

- Strategic report
- Directors' report
- Remuneration report
- Statement of Accounting Officer's Responsibilities
- Governance statement
- The Certificate and Report of the Comptroller and Auditor General to the Houses of Parliament
- Financial statements
- Notes to the financial statements

Strategic report

1. Our strategy

CQC's new approach to regulation is set out in our strategy for 2013 to 2016, *Raising standards, putting people first* – our radical agenda to change the way that health and care services in England are regulated. Since it was published, we are able to take earlier and more effective enforcement action against providers of poor care, and to recognise and encourage those who deliver good and outstanding care. We have also responded to challenges about our old inspection model and completely changed the way we assess services. These significant changes to the way we regulate NHS trusts, adult social care services and primary medical services are now in place. Inspections and Intelligent Monitoring of reliable data now deliver a deeper insight into the quality and safety of services and provide challenge and clarity about providers' performance. To meet the demands of our new approach, we have re-shaped our organisation and we are working hard to recruit the additional staff we need by the end of 2015/16. To support staff, we have established our CQC Academy to provide training and development. We have also consulted on and agreed CQC's organisational values and we are working to embed these.

2. Strategic priorities for 2015/16

CQC's business plan for 2015/16 sets out the priorities for our work in the third and final year of *Raising standards, putting people first*. The business plan is important as it sets out what we will deliver to achieve our purpose, the money we will spend as a result, and how we will measure our progress and achievements.

In the business plan we set out four priorities:

- Deliver the new approach to regulation – we will continue to implement and improve the new approach to regulation. 2015/16 will be the first year that we will inspect using the new regulations approved by Parliament as a result of the Government's response to Sir Robert Francis QC's report into Mid Staffordshire NHS Foundation Trust.
- Shaping the future – we will continue to develop our approach to inspection so that we can respond to the new models of care that will emerge over the next few years, such as those set out in the *Five Year Forward View*, in the proposals for Greater Manchester, in the vanguard projects, and the new models developing in primary medical services and adult social care. We are clear that regulation must not act as a barrier to innovation.
- Build an effective CQC – we will ensure that we have the right people, capacity, capability, systems and processes in place so that we can successfully deliver our purpose; and that we continuously improve – not least by listening to those who use and those who provide services. In 2015/16 we will undertake to recruit the full number of permanent staff, professional advisors and Experts by Experience that we need. We will develop the skills and knowledge of staff through our Academy; foster a culture that promotes the health and wellbeing of our workforce; and embed our values of

excellence, caring, integrity, and teamwork. We will embed our operating model, and we will implement our knowledge and information strategy.

- Demonstrate the difference we make – we will ensure that we are well-run; efficient and effective; and demonstrate that we make a positive impact and deliver value for money.

We will develop a strategy for the next phase of our work and we describe in *Shaping the future*, our high level ambitions for the development of health and care quality regulation in England. We will work on three key areas in 2015/16:

- Developing how we will regulate new models of care.
- Developing a programme of work to look at pathways of care to understand better the outcomes they achieve for people.
- Analysing how health and care services can work in a community or a segment of the population, and how well people are served by that health and care system. The focus will be the system and outcomes, not just the performance of a single organisation.

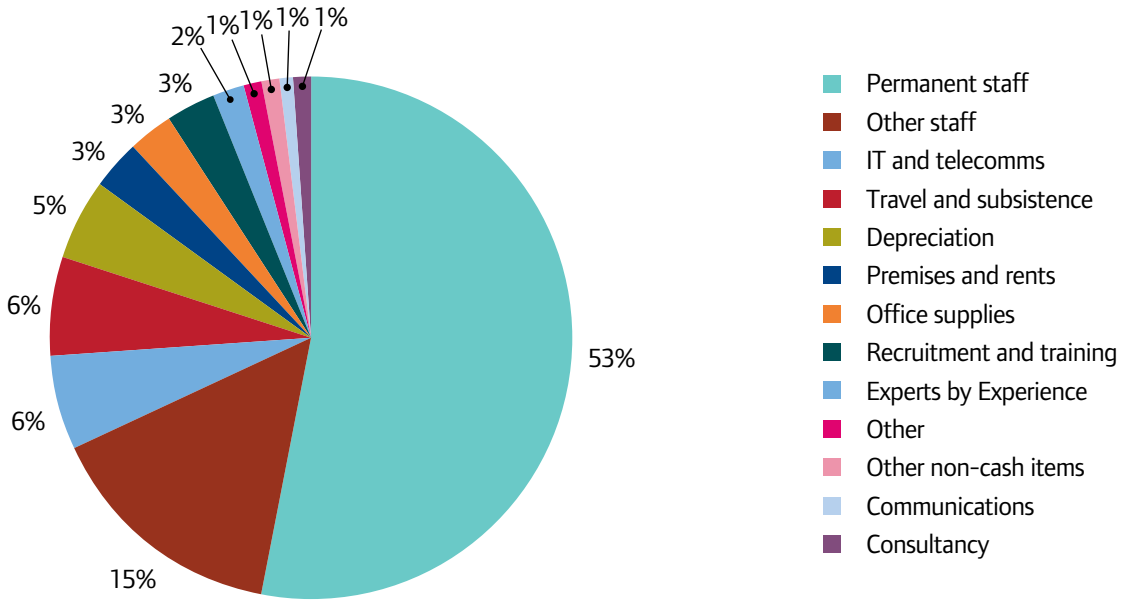
3. Financial performance and position

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

	2014/15 £m	2013/14 £m	Change £m	Change %
Recurring expenditure	221	194	27	14
Income	(103)	(101)	(2)	2
Net expenditure	**118**	**93**	**25**	**27**
Capital expenditure	10	9	1	11

Overall expenditure in CQC is broken down as follows:

CQC expenditure 2014/15



Revenue expenditure: £221m

Our revenue expenditure has increased by £27m compared to last year. The significant movements in relation to this are:

- In order to deliver a new, more comprehensive approach to inspection, CQC has implemented a new structure and revised the make-up of inspection teams; this has required a significant investment in our frontline workforce, a new management structure within each of our Chief Inspector structures and an increase in specialist roles such as analysts. The impact of this was increased expenditure on permanent staff of £11m, when compared to 2013/14.
- CQC continued its commitment to use more 'Specialist Advisors' and 'Experts by Experience' as part of our inspection teams. This represents an additional £8m expenditure for specialist advisors included under 'other staff' and £1m for Experts by Experience when compared to 2013/14.
- Interim staff have been used to fill vacant posts while recruitment is carried out against an increased establishment. Specialist interims have also been used to provide expertise to the organisation. This has resulted in increased expenditure of £3m compared to last year. However, this is anticipated to drop significantly moving into 2015/16.
- CQC's increased establishment and additional use of specialist advisors, together with a new approach to inspection, has resulted in additional travel and subsistence costs of £5m and general office expenses of £1m compared to last year. However, this is anticipated to fall as we have better staff coverage across the country and have invested in our infrastructure to allow for better mobile working.
- The cost of recruiting and training has risen by £2m, which is due to the increase in CQC's establishment. By ensuring that staff investment is applied in a managed way the newly-established Academy has minimised this increase, by providing effective in-house training.
- Premises costs appear £3m higher in 2014/15 when compared to 2013/14. Following an external forensic audit of our building rates, a rebate of £3m was received in 2013/14 therefore lowering our costs.
- In 2013/14, CQC incurred additional costs for the dual running of IT managed service contracts during a period of handover. This, together with savings achieved from our telecommunications contract and usage, resulted in a decreased expenditure of £2m compared to last year.
- Expenditure on consultancy dropped by £5m compared to last year. This is a direct result of CQC's transformation programme moving from design to delivery. In 2013/14 most of CQC's consultancy expenditure consisted of expert advice on designing our new approach to inspection and regulation, ensuring continuity from the 'Keogh review' and transferring skills and expertise to CQC staff for future inspections and finally helping frame a new structure including three new Chief Inspectors.

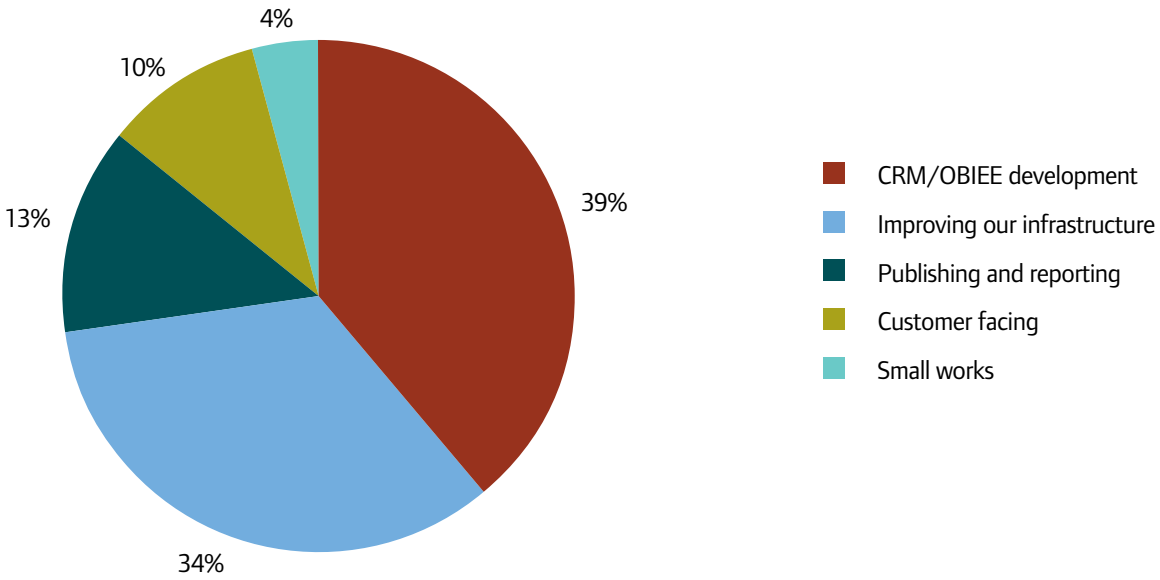
Capital expenditure: £10m

CQC's capital expenditure has been themed around delivering change that supports our transforming organisation. Overall expenditure has increased by £1m compared to last year and relates to the following areas:

- Customer relationship management (CRM) / Oracle business intelligence enterprise edition (OBIEE): these are the main systems that underpin our inspection methodology and are used to record and report on our inspection activity. Expenditure has enabled the system to meet the current demands of our revised methodology.
- Infrastructure: this is about providing IT equipment to the additional staff we have recruited, refreshing existing IT equipment that is at the end of its life cycle and improving our premises, including the introduction of regional hubs for our field staff.
- Publishing and reporting: investment in our digital systems has ensured that CQC is able to communicate effectively to ensure we maintain our voice in the health and social care system. It has also ensured that data and information is drawn from corporate systems rather than being entered numerous times into individual systems.
- Customer facing: this ensured that our online capabilities were developed achieving a change from manual to electronic processes and enabling increased customer engagement.

These areas of expenditure are designed to deliver efficiencies in our revenue budget.

Capital programme 2014/15



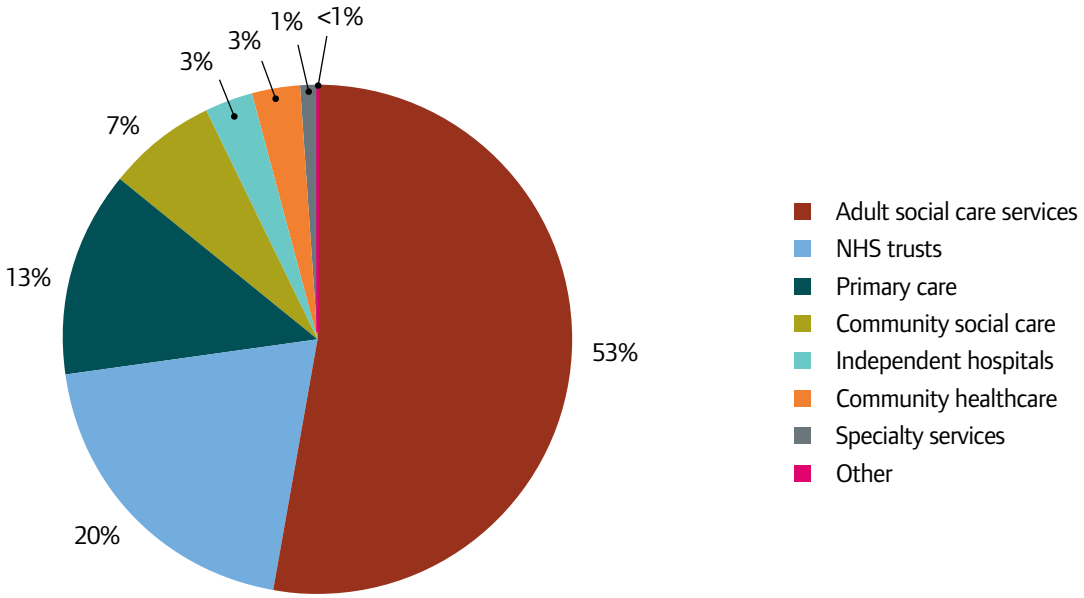
Income: £103m

Income increased by £2m compared to last year. A change to the fee scheme for 2014/15 increased fees for certain sectors that CQC regulates as follows:

- Care services: 1.5%
- Community social care: 1.5%
- Dentists: 0%
- All other providers: 2.5%

This has increased fee income by £3m; however this was partially offset by a £1m increase in deferred income compared to 2013/14, which can be seen under the statement of cash flows.

Income by sector



Grant-in-aid

CQC's net expenditure is funded from grant-in-aid provided by the Department of Health. Grant-in-aid totalled £126.0m (2013/14: £87.3m).

4. Key performance indicators

The key performance indicators (KPIs) set out below were monitored throughout the year by the Executive Team, the Board and management within CQC.

		2014/15 outturn	2013/14 outturn
Registration			
Number of registration processes completed[1]		36,269	48,472
% completed within KPI[2] – target 90%		81.5%	78.5%
Inspections			
Scheduled inspection programme (old approach)[3]			
Locations with at least one inspection (2013/14 KPI)		Not reported from 2014/15	30,334
Subsequent scheduled inspections (2013/14)			1,645
Themed inspections (2013/14)			185
Adult Social Care – number of inspections (2014/15)		6,979	Reported from 2014/15
Hospitals – number of inspections (2014/15)		90	
Primary Medical Services – number of inspections (2014/15)		279	
Sub-Total		7,348	32,164
Comprehensive inspection programme (new approach inc. waves)[3,4]			
Adult Social Care – number of inspections		5,230	Reported from 2014/15
Hospitals – number of inspections		131	
Primary Medical Services – number of inspections		1,677	
Sub-total		7,038	
Responsive and follow-up inspections			
Adult Social Care – number of inspections	Responsive[4]	744	Reported from 2014/15
	Follow-up	1,694	
	Total	2,438	
Hospitals – number of inspections	Responsive[4]	58	
	Follow-up	120	
	Total	178	
Primary Medical Services – number of inspections	Responsive[4]	124	
	Follow-up	763	
	Total	887	
All sectors	Responsive[4]	926	1,654
	Follow-up	2,577	5,749[5]
Total – of responsive and follow up, all sectors		3,503	7,403
Total inspections – All sectors/directorates and all types		17,889	39,567[5]
Enforcement action			
Number of Warning Notices served[6]		1,037	1,456
Number of prosecutions		5	0
Urgent suspensions of registration or urgent variation or imposition of conditions using Section 31 powers		27	4
Mental Health Act Function			
Number of Mental Health Act (MHA) Reviewer visits to mental health service locations – target 90% of plan[7]		1,253 (93% of plan)	1,227 (97% of plan)

	2014/15 outturn	2013/14 outturn
Complaints, governance information and call handling		
Number of requests under		
a) Freedom of Information (FOI)	758	845
b) Data Protection (DP)	158	192
c) Information Sharing (IS)	73	109
FOI responsiveness rate – % responded to within 20 working days – target 95%	94%	93%
DP responsiveness rate – % responded to within 40 calendar days – target 95%	93%	94%
IS responsiveness rate – % responded to within 20 working days – target 95%	97%	96%
Number of calls received at the National Customer Service Centre (NCSC)	258,151	238,621
(%) answered within 30 seconds		
a) Safeguarding calls – target 90%	88.8%	91.1%
b) Mental health – target 90%	89.9%	92.6%
c) Registration – target 80%	86.6%	83.1%
Numbers of correspondence (letters and emails) received at NCSC	29,346	Reported from 2014/15
(%) correspondence replied to within 10 days – Target 90%	89.4%	
The number of whistleblowing contacts CQC received	Not reported in 2014/15[8]	9,473
The number of stage 1 corporate complaints received proceeding to stage 2 – target <20%	58 (12%)	86 (16%)

[1] Registration processes include: producing a registration recommendation report; issuing a Notice of Decision; closing a refused application; issuing a registration certificate; completing process without a certificate; and terminating an application. A single registration application can lead to more than one registration process.

[2] KPI for 2013/14 applies to processes completed in less than 8 weeks and in 2014/15 less than 10 weeks.

[3] In 2014/15 we implemented our new approach to regulation in all the sectors CQC regulates, as set out in the CQC Strategy – *Raising standards, putting people first, 2013-16*. This entailed completing a number of inspections under the 'old approach' and then fully introducing the new approach from the middle of the year. At the same time we were recruiting new inspectors. In our 2015/16 business plan we set out the dates by which we will complete the ratings inspections of all providers or locations we regulate, a programme that extends to December 2016. The dates for each sector's ratings inspections to be completed vary depending on service type, with the earliest being in March 2016. In order to ensure we achieve our plan we will monitor inspections that lead to ratings against inspection trajectories, fully introducing this monitoring in 2015/16.
Our new approach inspections differ fundamentally from the old approach inspections we undertook in 2013/14. They are carried out under different methodologies, the inspections are more in depth, more time is spent on the inspection, and inspection teams are larger and often involve Experts by Experience and specialist advisors.

[4] In 2014/15 an inspection carried out in response to, for instance, information of concern could be recorded in one of two ways. 1) As a responsive inspection, if the inspection was undertaken and solely looked at the issue of concern. 2) As a comprehensive or scheduled inspection if a programme inspection (scheduled or comprehensive) already planned in the future was brought forward and carried out. Therefore the number of inspections carried out in response to information in 2014/15 is higher than the figure shown for 'responsive inspections'.

[5] Total inspections activity of 39,567 includes subsequent scheduled inspections of 1,645; themed inspections of 185; and follow-up inspections of 5,749. These were not included in the key performance indicators' table in our *Annual report and accounts* for 2013/14 as they were not part of the KPI. They were reported in our public performance report for quarter 4 in May 2014. They are included in 2013/14 figures for comparison with 2014/15 reporting which includes all inspections.

[6] The proportion of Warning Notices to inspections carried out in 2013/14 was 3.7% (1,456/39,567) and 5.8% (1,037/17,889) in 2014/15.

[7] Target for 2013/14 was 95% of plan.

[8] In 2013/14 we reported on the number of whistleblowing contacts we received. At present we are undertaking a programme of work to improve the way we deal with concerns, which will include the experience of people giving us feedback, how we capture and record information, and how we use the information. This information includes safeguarding alerts and concerns, and information from whistleblowers. While this work is underway we have not reported information on whistleblowing separately in our corporate performance reporting.

5. 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 handles requests for information made under the Freedom of Information Act 2000, the Environmental Information Regulations 2004, and the subject access provision of the Data Protection Act 1998. The team also responds to formal information sharing requests from other public bodies, where these fall outside of the agreements we have in place with those organisations.

In the 2014/15 financial year, the Information Access team responded to 989 requests for information. Of these:

- 758 were under the Freedom of Information Act 2000, and of these, 94.3% were responded to within the legal deadline of 20 working days.
- 158 were under the Data Protection Act 1988, and of these, 93% were responded to within the legal deadline of 40 calendar days.
- 73 were responded to under our information sharing procedures, and of these 97.3% were responded to within our internal deadline of 20 working days.

Whilst overall numbers of requests have fallen compared with previous years, the requests actually handled by the Information Access team are increasing in complexity. We believe that this is a result of work undertaken by CQC to proactively publish information, meaning that people have not needed to make formal requests on some of the more straightforward issues that have generated requests in previous years. The Information Access team's resource is therefore being focused on more difficult and contentious issues.

Feedback received from requesters remains high with 87.5% of the applicants who provide feedback saying they are satisfied with our responses.

Of the total requests for information, 64 (6.5%) resulted in the applicant requesting an internal review (asking CQC to reconsider the original decision). Two requests (0.2%) were subsequently referred to the Information Commissioner's Office (ICO) by the applicant for independent review, and in one of these cases the appeal against CQC's original decision was upheld by the ICO.

6. Employment, health and safety, and environment

6.1 Employment and policies

All of our policies now supersede those of our predecessor organisations. On 27 April 2015, we launched the Declaration of Interests policy and this will be rolled out to all managers during 2015/16 to ensure they have a good understanding of how it will work in principle for the different roles in CQC.

During 2015/16 we will review and update a number of key policies. A project plan is in place and we started the first phase of consultation with the unions and Staff Forum at the end of April 2015.

6.2 Home working

Home working forms the contractual arrangement for 1,600 members of staff and is the principal working arrangement for our inspectors who make up 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 Forum (HWF) represents the needs of these employees, and their ideas have already been actioned, or channelled into the review of tools for 2015/16.

6.3 Health, safety and wellbeing

This year we had a focus on ensuring effective health and safety arrangements for our new organisational structures and new ways of working. We have also re-launched the National Health, Safety and Wellbeing Committee.

We continue to embed health, safety and wellbeing across all our functions and activities with the focus this year on reviewing the impact of our new inspection methodologies, including the introduction of Experts by Experience and specialist advisors to our inspection teams.

We seek to proactively monitor all our offices, activities and services to ensure robust health and safety management. This has included moves to new offices offering a more flexible working environment in line with Government policy.

Ongoing challenges are being addressed through new management structures and we are planning an in-depth review during 2015/16 to ensure that we continue to meet our commitments in this area.

This year we have worked with our colleagues in the 10 health bodies following our pledge to improve the health and wellbeing of our staff, under NHS England's 'Healthier staff, higher quality care' commitments. Our Chief Executive, David Behan, has this year joined the same 10 Department of Health bodies in signing a new pledge to enhance the engagement of employees working in care settings.

During this year we had 48 work-related accidents/near misses, with three considered serious (ie reportable to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). These were made up of one slip/trip and two road traffic accidents.

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

2015/16 will see us review and re-launch all our health and safety policies, supported by appropriate training. We are also planning a major programme of activities to support employee wellbeing and resilience underpinned by our caring value. Importantly, we will commission an in-depth review of our health and safety management arrangements alongside a compliance audit.

6.4 Equality and human rights

Ensuring equality in care services and protecting the rights of those who use services is an integral part of our work and also extends to our own staff. This *Annual report and accounts* fulfils our legal duty under the Equality Act 2010 to show information on CQC's employees who share a protected characteristic as defined by the Act. The requirement to report on information relating to people other than employees who share a relevant protected characteristic and who are affected by our policies and practices will be fulfilled through our annual *State of Care* report.

In early May 2015, a memorandum of understanding was finalised between CQC and the Equality and Human Rights Commission setting out how we will work together. We have also set this information out for the NHS Equality and Diversity Council.

During 2014/15 we developed five new equality objectives for 2015 to 2017:

1. Deliver learning and development for all CQC staff by March 2016 to address unconscious bias.
2. Include race equality for staff as a factor in our judgements about whether hospitals are well-led.
3. Improve our regulatory insight and action about the equality and safety of mainstream health services for people with a learning disability or dementia, or those experiencing mental ill-health.
4. Help our inspectors to pursue key lines of enquiry and make consistent and robust judgements about particular aspects of equality.
5. Work towards having no difference in the employment outcomes for our staff or potential recruits because of age, disability, ethnicity, gender, gender reassignment, religion or belief, or sexual orientation.

We also have an important legal requirement to monitor the use of the Mental Health Act 1983 during inspections as well as to protect people's rights by monitoring the use of the Deprivation of Liberty Safeguards under the Mental Capacity Act 2005.

6.5 Employee gender data

No of staff as at 31 March 2015	Board members	Directors	Total employees
Male	6	9	875
Female	3	14	1,895

No of staff as at 31 March 2014	Board members	Directors	Total employees
Male	5	7	722
Female	4	4	1,592

Board Members include the Chair, Commissioners, Non-Executive Board Members and the Independent Member of the Audit and Corporate Governance Committee.

The Chief Executive, an Executive Director and the Chief Inspectors, who are included as Directors in the table above, are also members of the Board (four males, one female).

6.6 Sustainability

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. Efficient use of our IT systems and accommodation is an important strand of this work. Sustainability is a key driver for flexible working, as well as for consolidating our accommodation. We continually review our estates strategy to consider sustainability.

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

All but one of our offices is supplied via landlord service charge, which includes utility costs presented on a pro rata m^2 basis rather than using actual consumption data. Therefore there may be some limitations to the accuracy of our financial and non-financial sustainability data. This year landlords continued the positive trend from 2013/14, being more accurate with their reporting, and therefore figures for 2014/15 are more accurate than in previous years.

Carbon dioxide emissions

Area	CO_2 emissions (tonnes)	2014/15 Units	2014/15 Cost £	Performance against 2013/14
Building energy	1,390	3,923,353(kWh)	309,887	Improving
Travel (rail)	712	9,112,532 (m)	4,387,892	Increasing
Travel (road)	1,591	5,196,826 (m)	2,728,729	Increasing
Total	**3,693**	**N/A**	**N/A**	

Non-financial indicators (CO_2)	2013/14 (tonnes)	2014/15 (tonnes)
Gross emissions (buildings)	1,364	1,390
Gross emissions (business travel)	2,072	2,303
Total	**3,436**	**3,693**

Financial indicators (£)	2013/14	2014/15
Expenditure on official business travel	5,327,697	7,116,621

Performance

Of our reported CO_2 emissions, 38% are from electricity and gas used in the buildings. The emissions are falling from the 2009/10 baseline figure primarily due to the reduction in the number of buildings occupied by CQC.

CO_2 emissions from rail and car travel have increased because we have a bigger workforce and more activity following changes to CQC's regulatory model. This has also resulted in cost increases due to more journeys undertaken.

CO_2 emissions from domestic business travel flights have reduced by 76% due to a reduction in the number of flights.

Targets

From 1 April 2011, new Greening Government Commitment Operations and Procurement targets (GGCOPs) required CQC to reduce greenhouse gas emissions from a baseline set in 2009/10 for the whole estate and business related travel by 25% and to cut domestic business travel flights by 20% by March 2015 from a 2009/10 baseline.

Managing energy use from buildings

Performance

Energy consumed in our buildings continues to fall 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**	**2012/13**	**2013/14**	**2014/15**
Electricity	3,641,075	2,580,978	2,463,736	2,553,712
Gas	2,004,344	1,155,550	1,452,699	1,369,641
Total (kWh)	**5,645,419**	**3,736,528**	**3,916,435**	**3,923,353**

Financial indicators (£)	**2009/10**	**2012/13**	**2013/14**	**2014/15**
Total energy expenditure	525,935	355,421	322,423	309,887

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 26% this year; the costs are higher than 2013/14 due to better accuracy of data received from landlords and increases in maintenance charges which are included in the expenditure figures.

Targets

From 1 April 2011, the target (GGCOPs) have required 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**	**2014/15**
Water consumption (m^3) supplied	16,388	16,418	14,164	13,717	10,108

Financial indicators (£)	**2009/10**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Total energy expenditure	N/A	15,732	15,498	15,860	19,106

Managing office waste

Performance

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

Targets

From 1 April 2011, the targets have required us to reduce the amount of waste we generate by 25% from a 2009/10 baseline. We 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 at most of our buildings has been controlled by CQC with one central contract from May 2011. The increased waste figures from 2011/12 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**	**2014/15**
Non-hazardous waste (landfill)	27	130	159	115	119
Non-hazardous waste (re-used/ recycled)	143	152	212	217	294
Total waste	**170**	**282**	**371**	**332**	**413**

Financial indicators (£)	**2009/10**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Total disposal costs	N/A	48,021	58,206	59,583	54,709

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, to 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 materials, ability to monitor CO_2 emissions, and adherence to equality and diversity under the Equality Act 2010.

7. Estates strategy

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

Our ambition is two-fold – to ensure that we maintain organisational resilience as we expand as an organisation and the end points of our existing leases demand us to make decisions; and to ensure that 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 1,305 desks. We have 1,094 members of staff who are permanently office based, and 1,600 who are officially home workers. By April 2016 we will have 3,200 staff. Our aim is to have eight desks for every 10 office based members of staff.

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

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

b) Regional offices (small number of locations of variable size) – functions that are required to be office based, but not located centrally. For example, the National Customer Service Centre (NCSC), Finance, HR, and Intelligence functions.

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

The development of 'hubs' is a new element of our current estates approach, which is unable to offer a local office to all our staff.

Over the past year we have:

- Opened hub offices in Plymouth, Cambridge, Penrith and Southampton.
- Relocated to a new Birmingham office.
- Secured new London head office premises. The first wave of 300 staff will move from Finsbury Tower to the new London head office premises by September 2015.

During 2014/15 our estates strategy has resulted in exchequer savings of £40,000 recurring following the relocation to a new Birmingham office.

8. 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 2014/15, CQC processed 96.8% (2013/14: 99.3%) of invoices based on volume and 96.4% (2013/14: 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 suppliers within five working days. In 2014/15, CQC paid 81.2% (2013/14: 83.9%) based on volume, and 84.7% (2013/14: 91.1%) based on value within five days.

9. Form of accounts

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) (2014/15) 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.

10. Going concern

Our financial accounts have been prepared on the basis that CQC is a going concern. Grants for 2015/16, which cover the amounts required to meet CQC's liabilities falling due that year, have been included in Department of Health estimates that were approved by Parliament.

David Behan
Chief Executive, Care Quality Commission
26 June 2015

Directors' report

1. Employment 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. 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 change process. By participating in the formal consultation process and contributing to the various change programme boards, both these bodies ensured that the views of colleagues within CQC have been represented, and that the decision-making process has been open and transparent.

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 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 unions met with management regularly to receive updates on progress and worked collaboratively to identify and solve staff queries.

During April and May 2015 the Board engaged with the Joint National Consultative Committee (JNCC) on the activities that had been underway within CQC to support staff morale and promote wellbeing. The Board discussed the important issues raised by the JNCC with the Executive Team and were confident actions being taken would support staff morale and wellbeing.

The local joint consultative committee was re-launched in May 2015 and will 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 include the review of local staff survey action plans; health, safety and wellbeing; facilities and office management; and other matters that could improve the local working environment.

Our Staff Forum plays a valuable role in representing the voice of all our employees and has representatives from across the country. The forum provides management with information on how CQC staff are responding to what is happening within the organisation. In addition to raising their colleagues' concerns through monthly meetings and the sharing of written questions and answers, the forum provides an informed view on where policies could be updated for the benefit of CQC or where our communications could be more effective.

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 meets regularly with the chairs of the equality networks.

The Disability Network is focused on challenging societal attitudes through campaigning for effective disability awareness training, both internally and externally, and to promote positive images of disabled people. It supports members, promotes best practices and provides networking opportunities for staff.

The Race Equality Network works strategically with the CQC leadership team to implement its equality and human rights approach to regulation. It promotes and influences race equality within CQC and supports members and individuals in their work and development.

The role of the LGBT Network is primarily to provide a safe and supportive working environment to its members by sharing experiences and best practice through regular meetings, attending events and communicating with members and CQC staff on LGBT issues.

CQC consults with all the networks on issues affecting the wider organisation, such as policy development, to ensure that the views of all staff are taken into account.

2. Sickness absence data

During 2014/15 the average number of long-term days sickness per absent employee was 10 (2013/14 was seven days) and the average number of short-term days sickness was four (2013/14 was three days).

Absence reporting was identified as an area of development and work has been undertaken to improve the accuracy of our reporting. This improvement in reporting ensures that we can accurately manage and support sickness absence. To aid this we launched our wellbeing programme which encompasses ways to support attendance at work.

3. Contractual obligations

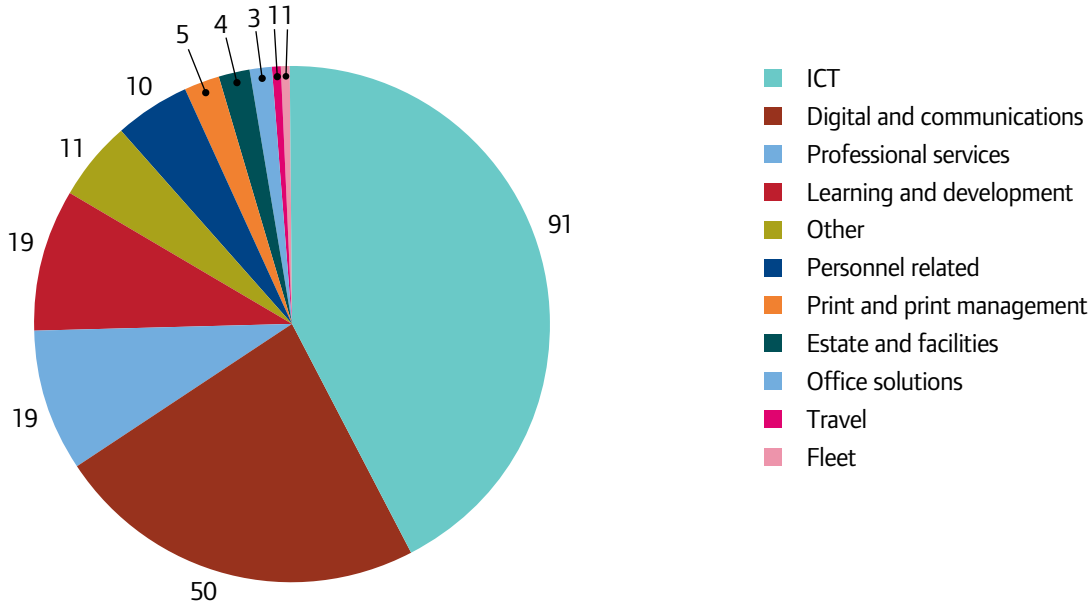
CQC procures from Government frameworks wherever possible and records all contracts on a centrally held register. All contracts over £10,000 are published on the Government Contracts Finder website. We also publish tenders on the same website when there are no suitable frameworks available, as part of any approach to market. This also ensures that we address broader Government procurement policy in respect of SMEs who are directed by the crown to this website.

Our largest used contracts for 2014/15 were with Redfern Travel Ltd, Computacentre UK Ltd, Calder Conferences Ltd and Atos Ltd. CQC also had a large spend associated with contingent labour in 2014/15. Recruitment of permanent employees to the fixed establishment has since been underway and expenditure in 2015/16 will be much reduced. CQC is in the process of transferring any residual requirements for contingent labour to the mandated Capita contract for these services.

The Government's Crown Commercial Service owns the contracts for Redfern Travel Ltd and Calder Conferencing Ltd although CQC has a bespoke agreement under this contract for volume of usage and value. Atos Ltd provides an information communications technology (ICT) service under an umbrella contract owned by the Department of Health; therefore there are standard rates for agreed service. However, CQC can negotiate separate variations within the overarching boundaries of the contract terms.

CQC awarded over 200 contracts in 2014/15 as categorised in the chart below:

Contract volume 2014/15



4. Off-payroll engagements

For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2015	95
Of which, the number that have existed:	
for less than one year at the time of reporting	52
for between one and two years at the time of reporting	33
for between two and three years at the time of reporting	5
for between three and four years at the time of reporting	2
for four or more years at the time of reporting	3

All existing arrangements that have existed for two years or more at the time of reporting have received approval from the Department of Health.

For all new off-payroll engagements between 1 April 2014 and 31 March 2015, 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 2014 and 31 March 2015	142
Number of new engagements that include contractual clauses giving the right to request assurance in relation to income tax and National Insurance obligations	142
Number for whom assurance has been requested	142
Of which:	
assurance has been received	41
assurance has not been received	101
engagements terminated as a result of assurance not being received	0

Of the 101 engagements where no assurance has been received, 94 are either no longer employed or are now on CQC's payroll.

	Number
Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year.	1
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.	23

One senior official, employed as a Director of Change was seconded from the Department for Work and Pensions from 1 May 2013 to 28 February 2015. This was an interim role responsible for the delivery of the transformation programme.

5. Pension costs

The treatment of pension liabilities and the relevant pension scheme details are set out in note 1.3 on page 125 and in the remuneration report on page 82.

6. Political and charitable donations

We made no political or charitable donations during the year.

7. Research and development

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

8. Post statement of financial position events

There are no significant post statement of financial position events.

9. 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.

10. Availability of information for audit

As far as the Accounting Officer is aware there was no relevant information of which CQC's auditor was not aware. The Accounting Officer took all reasonable and required steps to make himself aware of any relevant audit information and he established that 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
26 June 2015

Remuneration report

The following sections provide details of the remuneration report (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 are subject to audit.

Remuneration of the Chair and Non-Executive Board members

Non-Executive Board members' remuneration is determined by the Department of Health on the basis of a commitment of two to three days a month.

There are no provisions in place to compensate for Non-Executive Board members' early termination of appointment or for the payment of a bonus.

CQC reimburses its Chairman, Non-Executive Board and independent members for the cost of travelling to and from CQC including for Board meetings and for other events at which they represent CQC. CQC meets the resultant tax liability under a settlement agreement with HM Revenue & Customs. For 2014/15 the total liability amounted to £6k (2013/14: £10k).

Chairman and Non-executive Board members' emoluments

	Date appointed	2014/15 total salary £000	2013/14 total salary £000
David Prior (Chair)	28 Jan 2013	60 – 65	60 – 65
Kay Sheldon OBE	1 Dec 2008	5 – 10	5 – 10
Anna Bradley	16 Jul 2012	45 – 50[1]	45 – 50[1]
Prof. Louis Appleby	1 Jul 2013	5 – 10	5 – 10[2]
Camilla Cavendish	1 Jul 2013	5 – 10	5 – 10[2]
Prof. Paul Corrigan CBE	1 Jul 2013	5 – 10	5 – 10[2]
Dr Jennifer Dixon CBE	1 Jul 2013	5 – 10	5 – 10[2]
Michael Mire	1 Jul 2013	5 – 10	5 – 10[2]
Sir Robert Francis QC	1 Jul 2014	5 – 10[2]	–
Paul Rew	1 Jul 2014	5 – 10[3]	–
John Harwood (appointment expired 3 Mar 2014)	4 Mar 2010	–	10 – 15[3]
Steve Hitchins (resigned 18 Dec 2013)	9 Jul 2012	–	5 – 10[2]

[1] Anna Bradley's enhanced remuneration is a result of her role as Chair of Healthwatch England.
[2] Full year equivalent salary would be £5 – 10k.
[3] Full year equivalent salary would be £10 – 15k. Both Paul Rew and John Harwood received enhanced remuneration as chair of the Audit & Corporate Governance Committee.

Payments to independent members

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 2014/15 amounted to £8k for John Butler (2013/14: £8k) and £4k for David Prince (2013/14: £5k).

Christopher Fincken, 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 2014/15 amounted to £0.6k for Christopher Fincken (2013/14: £0.4k), £3k for Alan Gillies (2013/14: £2k), £nil for Dilys Jones (2013/14: £0.3k) and £4k for Christine Munns (2013/14: £3k).

Remuneration of the Chief Executive

The Chief Executive's remuneration is agreed by the Board through 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 for the year 2014/15. However, both the Remuneration Committee and 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 only made in appropriate circumstances and may arise when the member of staff is 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.

2014/15	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 CBE Chief Executive	185-190	-	-	-	60-65	-	**250-255**
Dr Paul Bate Director of Strategy & Intelligence	140-145	-	-	-	80-85	-	**220-225**
Prof. Sir Michael Richards Chief Inspector of Hospitals	235-240	-	-	-	- [1]	-	**235-240**
Prof. Stephen Field CBE Chief Inspector of General Practice	170-175	-	-	-	25-30	-	**200-205**
Andrea Sutcliffe Chief Inspector of Adult Social Care	140-145	-	-	-	55-60	-	**200-205**
Eileen Milner Director of Customer & Corporate Services	140-145	-	-	-	45-50	-	**185-190**

[1] Pension related benefits for Prof. Sir Michael Richards is £nil as in receipt of benefits.

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 CBE Chief Executive	185-190	-	-	-	60-62.5	-	**250-255**
Dr Paul Bate Director of Strategy & Intelligence	120-125[1]	-	-	-	-[15]	-	**120-125**
Prof. Sir Michael Richards Chief Inspector of Hospitals	150-155[2]	-	-	-	-[15]	-	**150-155**
Prof. Stephen Field CBE 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 Customer & 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	30-40[7]	-	-	-	85-87.5	-	**120-125**

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
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**
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] Dr Paul Bate, appointed 13 May 2013, full year equivalent salary £140-145k.
[2] Prof. Sir Michael Richards, appointed 16 July 2013, full year equivalent salary £235-240k.
[3] Prof. 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 structure for the period 1 June 2013 to 31 October 2013, full year equivalent salary £105-110k.
[7] Adrian Hughes, member of the interim structure for the period 1 June 2013 to 31 October 2013, full year equivalent salary £90-95k.
[8] Matthew Trainer, member of the interim 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 relating 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 for during the previous financial year.

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 during 2014/15 was £235-240k (2013/14: £235-240k). This was 6.3 times (2013/14: 6.3) the median remuneration of the workforce which was £37,976 (2013/14: £37,414).

In 2014/15, eight employees (2013/14: 11) received annualised 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 £316,791 (2013/14: £7,881 to £304,836).

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 2014/15, 18 senior executives were paid in excess of £100k (2013/14: 14).

Payments made for loss of office

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

Amounts payable to third party for services as a senior executive

Hilary Reynolds, Director of Change, was seconded from the Department for Work and Pensions, from 1 May 2013 to 28 Feb 2015. Employment costs totalling £165k, including employer pension and national insurance contributions, were recharged to CQC during 2014/15 (2013/14: £159k).

Pension benefits

Pension benefits of non-executive board members

Non-executive 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 all members of the Executive Team. Pension benefits at 31 March 2015 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 2015 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000) £000	Cash equivalent transfer value at 1 April 2014 £000	Cash equivalent transfer value at 31 March 2015 £000	Real increase in cash equivalent transfer value £000	Employers contribution to stakeholder pensions £000
David Behan CBE Chief Executive	2.5–5	–	5–10	–[3]	78	130	50	–
Dr Paul Bate Director of Strategy & Intelligence	2.5–5	–	15–20	–[3]	128	172	41	–
Prof. Sir Michael Richards Chief Inspector of Hospitals	–[1]	–[1]	–[1]	–[1]	–[1]	–[1]	–[1]	–[1]
Prof. Stephen Field CBE[2] Chief Inspector of General Practice	0–2.5	2.5–5	50–55	155–160	1,022	1,078	54	–
Andrea Sutcliffe Chief Inspector of Adult Social Care	0–2.5	5–7.5	20–25	70–75	372	436	56	–
Eileen Milner Director of Customer & Corporate Services	0–2.5	–	0–5	–[3]	6	36	29	–

[1] Pension benefits for Prof. Sir Michael Richards is £nil as member is in receipt of benefits.
[2] Figures for Prof. Stephen Field are in respect of officer employment only, no practitioner employment is included.
[3] Lump sum is zero as member is in the 2008 section of the scheme.

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 the disclosures apply.

The CETV figures, and from 2004/05, the other pension details, include the value of any pension benefit in another scheme or arrangement that the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their

Pension benefits of the Chief Executive and Executive Team

Pension benefits were provided through the NHS Pension Scheme for all members of the Executive Team. Pension benefits at 31 March 2015 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 2015 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000) £000	Cash equivalent transfer value at 1 April 2014 £000	Cash equivalent transfer value at 31 March 2015 £000	Real increase in cash equivalent transfer value £000	Employers contribution to stakeholder pensions £000
David Behan CBE Chief Executive	2.5–5	–	5–10	–[3]	78	130	50	–
Dr Paul Bate Director of Strategy & Intelligence	2.5–5	–	15–20	–[3]	128	172	41	–
Prof. Sir Michael Richards Chief Inspector of Hospitals	–[1]	–[1]	–[1]	–[1]	–[1]	–[1]	–[1]	–[1]
Prof. Stephen Field CBE[2] Chief Inspector of General Practice	0–2.5	2.5–5	50–55	155–160	1,022	1,078	54	–
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The CETV figures, and from 2004/05, the other pension details, include the value of any pension benefit in another scheme or arrangement that the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their

purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries and do not take account of any potential reduction to benefits resulting from Lifetime Allowance Tax that 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 employer (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 into 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 hour 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 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 Pension 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015 is based on valuation data as at 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking the actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury has 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 or copies can 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 ended 31 March 2012.

The Scheme Regulations 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.

In 2014/15 CQC's employer contributions for staff to the NHS pension fund was £8,786k (2013/14: £7,388k) at a rate of 14% (2013/14: 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 (2013/14: £nil).

The latest assessment of 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 initially inherited 17 Local Government Schemes. On 31 March 2014 the staff membership of CQC in the Derbyshire pension fund fell to zero and as a result a cessation charge was payable by CQC equal to the actuary assessed pension deficit as at that date. All of these schemes are closed to new CQC employees. Under the projected unit method the current service cost will increase as the members of the scheme approach retirement.

Employer contributions for 2014/15, based on a percentage of payroll costs only, were £4,401k in total (2013/14: £4,119k), at rates ranging between 14.4% and 34.6% (2013/14: 15.1% and 32.3%). Employer contributions relating to the largest scheme, Teesside Pension Fund, were £3,842k (2013/14: £3,598k) at a rate of 17.0% (2013/14: 15.8%).

During 2014/15 an indexed cash sum was levied in addition to a percentage of payroll costs in an effort to reduce the pension fund deficits. £696k in total was paid to 13 of the 16 remaining pension funds with amounts ranging from £1.5k to £104.0k. No additional sums were paid to Teesside as it currently has sufficient staff members to enable the deficit to be recovered solely by a percentage of payroll as well as having members who are of an age that allows the deficit to be recovered over a longer period of time.

Contribution rates for 2015/16 range between 14.4% and 36.8% (17.0% for Teesside Pension Fund) with annual cash sums ranging from £1.5k to £149.0k (£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 2014/15 totalled £20k (2013/14: £10k) at a rate of 0.99% (2013/14: 0.96%).

David Behan
Chief Executive, Care Quality Commission
26 June 2015

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 the Care Quality Commission 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 the Care Quality Commission. 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 Care Quality Commission's assets, are set out in *Managing Public Money* published by the HM Treasury.

Governance statement

As Accounting Officer I have responsibility for working with the CQC Board to ensure that CQC is well governed and that the organisation has a sound system of internal control that allows it to deliver its purpose and role. This governance statement sets out a comprehensive explanation of the organisational governance of CQC in accordance with HM Treasury guidance, other governance standards, and the level of assurance that has been provided during 2014/15.

CQC has completed the second year (2014/15) of a three year transformation. These first two years have focused on changing the way health and care services in England are regulated. Significant changes have included the introduction of a new model for inspection, use of Intelligent Monitoring to prioritise where we inspect, recruitment of specialist inspectors and changes to the way CQC takes enforcement action. The way in which CQC is organised to deliver the new approach to regulation has also changed with a move to sector specialist teams. These changes were introduced through a transformation programme which has now closed, although the journey to excellence for CQC is not yet complete. The focus for 2015/16 is on delivering our approach to regulation consistently and on internal systems and operational arrangements to ensure that the organisation has the governance structures, systems and resources to demonstrate that it is operating efficiently and effectively.

Statutory functions

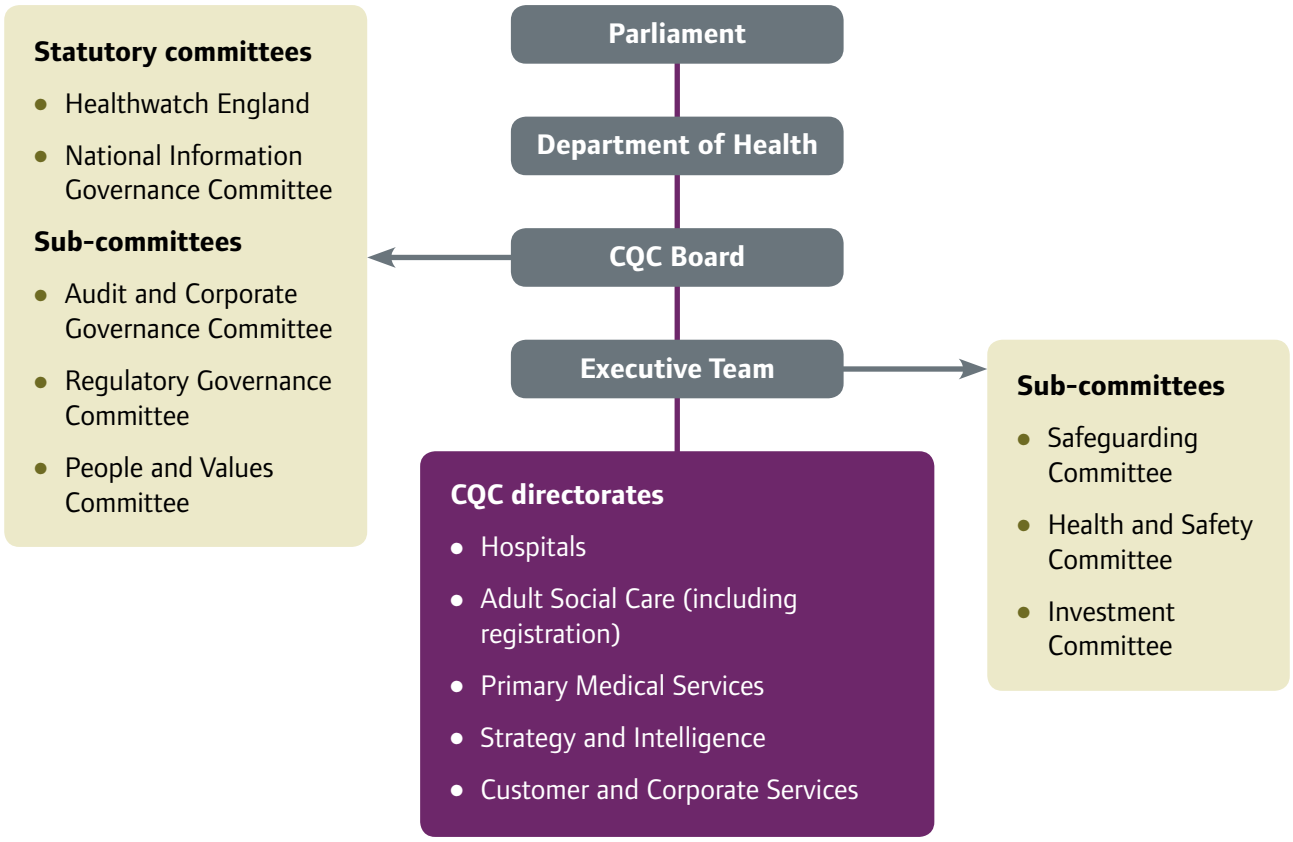
CQC is an executive non-departmental public body (NDPB) established by legislation to protect and promote the health, safety and welfare of people who use health and social care services. CQC is the regulator of all health and adult social care services in England.

Its purpose is to make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve. Its role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, and to publish what it finds, including performance ratings to help people choose care.

CQC's statutory functions are set out in the Health and Social Care Act 2008, the Health and Social Care Act 2012, the Care Act 2014 and related regulations. Specifically, CQC's statutory functions in relation to health and social care providers include registration of providers and managers; review and investigation of provider services; and Mental Health Act functions in relation to persons detained under that Act.

CQC governance framework and structures

CQC has a corporate governance framework that sets out the governance arrangements for the organisation. The following diagram sets out current arrangements.



Parliament and the Department of Health

As an NDPB, CQC aims to have a good working relationship with its sponsor department, the Department of Health (DH). DH and CQC have a framework document in place which sets out CQC's purpose, its governance and accountability, management and financial responsibilities and reporting procedures.

CQC has been established to be operationally independent of DH, in that it is responsible for delivering its own objectives; determining how it inspects and how it makes judgements about the quality and safety of services provided by individual health and social care providers. As Accounting Officer for CQC, I am accountable to DH for the discharge of its duties and I am examined by the Health Select Committee in Parliament on an annual basis. CQC attends quarterly accountability review meetings with DH. I have attended all these meetings in 2014/15 and actions required of CQC arising from these meetings have been discharged.

CQC's Board

The main responsibilities of CQC's Board is to:

- Provide strategic leadership to CQC and approve the organisation's strategic direction.
- Set and address the culture, values and behaviours of the organisation.
- Assess how CQC is performing against its stated objectives and public commitments.

CQC's Board is committed to achieving outstanding levels of governance in the same way as would be expected of providers.

CQC's unitary Board comprises David Prior, the Chair, nine non-executive Board members, myself as Chief Executive and Accounting Officer, three Chief Inspectors and the Executive Director of Strategy and Intelligence. David Prior stood down as Chair on 14 May 2015. One of the non-executive directors (Michael Mire) will act as interim Chair and is also the Senior Independent Director. In 2014/15, Sir Robert Francis QC and Paul Rew were appointed to the Board by the Secretary of State for Health. Their terms of office are three years. They replaced Steve Hitchins and John Harwood, who stood down from CQC's Board in December 2013 and March 2014 respectively.

Collectively, the members of CQC's Board bring a wide range of experience and expertise which inform the decisions the Board makes. All commissioners also have equal and joint responsibility for governing the activities of CQC.

The Board meets in public and private sessions 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, where there are draft reports to consider which need to be considered in private before publication, or where matters relating to individuals and employment are being discussed, they are dealt with in private session.

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 CQC's website. The Chair will form a view as to whether an interest is such that it requires the Board member to withdraw from discussion or any vote on an issue. The policy on member interests was revised during the year.

The Board attended a Board effectiveness and development day on 15 July 2014. Non-executive Board members, with the exception of two which are yet to be completed, have had an annual appraisal with the Chair.

The Board membership is in annex 1; the record of Board attendance in annex 2 and the coverage of Board business in annex 4 to this statement. The Board has discharged its duties during the year as set out in the Scheme of Delegation.

Non-statutory committees of the Board

Since the appointment of a Board Secretary in January, a review of the Board's non-statutory committees has been undertaken and CQC's Board approved new terms of reference and changes to the names of two of the committees.

Audit and Corporate Governance Committee

The Audit and Corporate Governance Committee (ACGC) provides support and advice to the CQC Board on CQC's risk management, governance and internal control. The Committee's key areas of focus during the year are reflected in this governance statement. ACGC also engages with the internal auditors (Health Group Audit) and the external auditors (the National Audit Office in partnership with Deloitte) to determine the priorities for audit work during the year. The Committee has had two independent members who provide valuable challenge; one member (John Butler) stepped down on 29 January 2015 at the end of his term of appointment. Paul Rew is the chair of the ACGC.

Regulatory Governance Committee (formerly the Regulatory Governance and Values Committee)

The Regulatory Governance Committee (RGC) provides support and advice to the CQC Board that systems, processes and accountabilities are in place for identifying and managing risks associated with delivering the regulatory programme. The Committee also reviews whether the approach to Intelligent Monitoring is robust and makes possible an effective inspection programme (including ratings) that provides public confidence in the work of CQC. The Committee is chaired by Michael Mire and has five non-executive Board members.

People and Values Committee (formerly the Remuneration Committee)

The People and Values Committee (PVC) has responsibility for determining the remuneration of the Chief Executive and selected senior members of staff, within guidelines laid down by the Department of Health on Very Senior Pay. The Committee which is chaired by the Board Chair and includes three non-executive Board members, also reviews CQC pay policy and its arrangements for succession planning. This committee will also oversee how the organisation is embedding the new values of excellence, caring, integrity and teamwork which were approved by the Board in November 2014.

The terms of reference for the above three committees, and for the Executive Team (see below) were revised and updated in February 2015. The ACGC and PVC fulfil the role of a Nominations and Governance Committee, as referred to in HM Treasury's Code of Good Practice.

Statutory committees of the Board

CQC is required by Schedule 1 Section 6 (1) of the Health and 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 any committee and its Chair. Ordinarily, the statutory committees will be chaired by a non-executive member of the CQC Board.

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 people who use health and social care services and to provide CQC and other bodies with advice, information or other assistance. It does this through the Healthwatch network which is made up of local Healthwatch across each of the 152 local authority areas, and Healthwatch England which is the national body.

The Accounting Officer meets quarterly with the Chair and Chief Executive of Healthwatch England to seek assurances that the organisation is operating effectively, efficiently and economically. During 2014/15, a review of the governance arrangements between CQC and Healthwatch identified some areas where oversight could be strengthened. The two organisations are currently in the process of revising and reviewing their memorandum of understanding and service level agreement. During 2014/15 I have determined that Katharine Rake, Chief Executive of Healthwatch England, is the Accountable Officer for Healthwatch England.

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 the National Information Governance Committee (NIGC). This committee has met four times during 2014/15 and has been chaired by Dr Paul Bate, the Executive Director of Strategy and Intelligence, who is also CQC's Senior Information Risk Owner. The NIGC has four independent members, three representative members representing key relevant partners, and one observer. In 2015/16, the structure of this committee will be reviewed as agreed by the Board in March 2015.

Stakeholder Committee

The Stakeholder Committee was set up to meet twice a year to provide advice to CQC's Board and Executive Team. The committee is made up of approximately 20 invited representative bodies (umbrella organisations where appropriate) representing the user voice, care providers and professionals, and campaign groups and policy shapers in all CQC-regulated sectors. It is no longer possible to manage the relationship with stakeholders through one meeting or committee. During 2014/15, the function of this committee was undertaken through a co-production approach to the development of new policies and methodologies which required the establishment of a large number of separate stakeholder groups. This approach has proven to be successful and builds on CQC's specialist approach to regulation. Feedback from providers and partners about the level of engagement has been positive.

The CQC governance framework will be updated during 2015/16 and will include looking at any committees that were not reviewed during 2014/15.

Governance processes

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of CQC's purpose, aims and objectives. In doing so, I must safeguard the public funds and assets which are allocated to and managed by CQC. The main mechanism for doing this is through delegated authority to the Executive Team.

CQC's Executive Team

There are clear divisions between the responsibility of CQC's Board and the Executive Team. The responsibility for implementing the Board's strategy belongs to the Chief Executive and the Executive Team. The Chief Executive, three Chief Inspectors and the Executive Directors of Strategy and Intelligence and Customer and Corporate Services make up the Executive Team. Hilary Reynolds, the Executive Director of Change, left CQC at the end of February 2015. The current membership and structure is detailed in annex 3.

The Executive Team meets on a weekly basis. These meetings take items both for discussion and decision each week. The decision section of the meeting takes decisions, or recommends to the CQC Board as appropriate on strategy and policy, planning and performance monitoring and publications. The discussion section of the meeting considers items about approaches and emergent thinking, and the Executive Team gives a formal steer to work as it develops.

Sub-committees of the Executive Team

Transformation Programme Board

The Transformation Programme Board operated throughout 2014/15 and has now been disbanded, effective with the end of the transformation programme and Hilary Reynolds' departure. The Board oversaw all of the work to develop new business and regulatory processes and the reorganisation of CQC to align structure and resources.

The Executive Team also has other committees:

- The *Investment Committee* has supported the Executive Team by examining and approving investment business cases and having oversight of the capital programme.
- 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 *Safeguarding Committee* provides oversight of CQC's safeguarding policies and processes, and assesses performance in responding to safeguarding information.

Financial control

Controls are in place in CQC to ensure the appropriate use and stewardship of funds and assets. Internal audits during the year confirmed that improvements have been made and will continue to be made to core financial controls, financial governance and financial reporting which strengthen the oversight of financial expenditure. Further improvements will be made in 2015/16. The key controls in place are:

- Financial reporting to the Executive Team and Board. This has improved through changes to the financial performance report they receive which has strengthened financial governance.
- Investment Committee oversight of all significant business cases and procurements. The Investment Committee's remit is to ensure that the necessary business case and procurement approvals are in place for programme and project investment and that these align with CQC's investment strategy and priorities.
- Financial delegations clearly set out in the Scheme of Delegation with defined limits for financial expenditure and contract award. The Scheme of Delegation is subject to annual review and changes are communicated to all staff.
- A system of budgetary control which is in place with budget managers involved in the budget setting and forecasting processes. Budgets are subject to challenge by the finance team as well as the Executive Team before being presented to CQC's Board for approval. Budget variations are analysed, investigated and explained.
- Financial controls through CQC's use of the NHS Shared Service to access the Oracle financial management system. This system has inbuilt controls and reconciliation to manage our finances and the capability to produce up-to-date financial reporting.
- A dedicated procurement team who provide professional procurement advice to budget holders on issues such as UK and European Union procurement legislation and the development of commercial contracts. Management information on all procurement contracts has improved over the last 12 months.

- Asset management and control procedures, including the appropriate segregation of duties and processes to ensure accurate recording, accounting and safeguarding of CQC assets.
- Independent assurance, through internal and external auditors, that management controls are working as intended.

Data quality

CQC publishes a range of reports and documents. During 2014/15 there have been some concerns with the quality of internal and external data.

The new organisation structure was introduced from April 2014. It took the first six months of the year to implement all necessary amendments to corporate systems to ensure that internal reporting was aligned to this new structure. Three concerns became evident during the year.

Completion of corporate systems

Firstly, there were data completeness and data quality issues associated with the recording of inspections during 2014/15. Updating our core systems to support the new approach meant that there was a change to the process for recording inspections and as a result, inspectors were under-reporting the number of inspections carried out. Also the increase in activity delivered as part of the inspection process meant that actions were being completed on our core systems at the end of the process rather than during it.

To help address this problem, we introduced better management information to support managers to work with individual inspectors to improve recording, arranged 'Make Your Inspections Count' training to explain how to record the inspection activity, and improved our regular reporting to help inspection managers ensure their teams were recording their inspections correctly.

Quality of external analyses

Secondly, there have been quality problems with the Intelligent Monitoring information for GP providers, which was published initially in November 2014. This resulted in 60 practices (less than 1%) previously in higher priority bands 1 and 2 being moved to lower priority bands. An apology was provided to these practices for this error and in March 2015 CQC withdrew the banding system for GP practices. An internal review of the quality assurance that is applied to all published data has been undertaken and the lessons learned were reported to the Regulatory Governance Committee in February 2015. The main finding was that quality controls and assurance vary and need to be strengthened to a consistent level across all the analyses CQC produces. A full internal review of GP Intelligent Monitoring has been carried out. This has led to further improvements in the way CQC analyses and presents the information, particularly the way in which variation between general practices is analysed.

Safeguarding information

Thirdly, over the course of the year it became apparent that the data being used to record performance in responding to safeguarding information was not appropriate. The organisation uses the Customer Relationship Management (CRM) system for safeguarding which delivers information allowing a clear audit trail of actions, but it is not a suitable data source to measure the key

performance indicator (KPI) which is about real time responsiveness to information. So although audits showed inspectors were responding to information, the KPI data did not always demonstrate this. The approach to the KPI has been amended.

Management assurance

During 2014/15, CQC developed and introduced a new management assurance framework which has been designed to seek assurance from all parts of the organisation. It seeks assurance that internal controls are working effectively and if not, identifies areas of concern. The assurance framework looks at the following eight areas of management responsibility:

- Planning
- Performance and risk management
- Quality management
- Financial management, systems and control
- Information and evidence management
- People management
- Learning and continuous improvement
- Governance and decision making.

Directorates provide a self-assessment against a clear set of expectations of performance in these eight core management disciplines. These assessments are then put through a collective challenge by the Executive Team, before being presented to the ACGC. The main findings from the assessments in October 2014 and February 2015 are summarised in the next section.

The management assurance approach has helped directorates to be clear on the improvements they need to make. These improvements have been set out in business plans for 2015/16 and progress will be tracked during the year.

1. Planning

There have been improvements in the approach to planning during the year following review of our plans which were developed at the beginning of the year. These initial plans proved to be too optimistic in terms of the number of staff we could recruit and the number of inspections that could be delivered. There was a significant focus on operational workforce planning during the last quarter of 2014/15 to ensure clarity on the resources needed to be able to deliver inspection programmes and ratings in 2015/16. Recruitment plans have been revised to reflect a new strategy for recruiting operational staff. This has involved close working between the inspection directorates and support functions to agree revised completion dates for the inspection and ratings programme.

CQC's business plan for 2015/16 reflects the outcome of the planning across the organisation and is underpinned by business plans for the directorates. The Transformation Programme is now closed and any residual activity is reflected in directorate business plans. These directorate plans are of better quality than in previous years, largely as a result of better working across the organisation to identify

and agree key dependencies. Greater staff engagement in the planning process for 2015/16 was evident through the number of directorate planning events which were held.

A review of the business continuity planning by the internal auditors has identified that this is an area where plans need to be more robust with greater staff awareness. Work has begun and will continue into 2015/16.

2. Performance and risk management

In 2014/15, a new corporate performance report for the CQC Board was introduced based around the strategic measures and KPIs which were set out in CQC's business plan. Feedback from CQC Board members has been positive, and the process for producing this report, with individual directorates providing information, works well. The Board performance report is available to the public on the CQC website.

For some of the measures in the report data has been available during the year, but others were dependent on the introduction of new approaches before their effectiveness could be assessed. There have also been some concerns with data completeness, and consequently operational staff have been encouraged to ensure all corporate systems are updated in a timely manner to ensure there is an accurate view of performance.

From April 2015, each directorate is now expected to have a performance scorecard in place and these will support the review of performance in a more integrated way. These scorecards will cover: milestone delivery, performance indicators, risks, financial performance and achievement of improvement priorities to strengthen the assurance that the directorates can provide. The inspection directorates receive weekly reports that help them to track delivery of their inspection programmes and recruitment plans. Governance arrangements have been established in the inspection directorates to ensure that the escalation route for performance issues and concerns about providers is much clearer.

The ACGC have confirmed in their annual report to the Board that they have seen improvements in the organisation's risk management processes during 2014/15. There is more confidence that the organisation is managing the right risks at both a strategic and an operational level. An internal audit during the year provided assurance that these processes were effective but some improvements were needed to make roles and responsibilities for risk management clearer below director level. Since the audit, a Board-approved risk tolerance statement has been developed and approved, providing greater clarity on Board expectations of how different types of risk should be managed.

Inspectors continue to focus on the providers that present the greatest risk to the public. This information and the approach to Intelligent Monitoring help to prioritise inspections. However, following the re-structure of the inspection directorates there is a need to ensure a consistent approach to how risk is identified within inspection teams and how concerns are escalated. This is one of the business improvement priorities for 2015/16.

3. Quality management

The main emphasis of the approach to quality has been to ensure that high quality and consistent inspection judgements are being made. Regional and national quality assurance panels have been in place to review inspection reports before they are published. There have been some issues with the quality of reports but these are being addressed through training and coaching. These quality

assurance arrangements have resulted in it taking longer to finalise and publish these reports. As inspectors become more experienced through completing a larger number of inspections, report writing is expected to become more efficient and to achieve greater consistency.

During 2014/15 a quality framework for the whole of CQC was developed, working with each part of the organisation to identify and agree the quality standards they will work to and how CQC will assess whether these are being achieved. Quality management is an integral part of the CQC's operating model.

4. Financial management, systems and control

The internal audit of financial management during the year confirmed that aspects of basic financial controls and reporting were robust, but also identified concerns about how embedded this key discipline is across the organisation. An action plan to implement the audit findings is in place. A new Director of Finance, Commercial and Infrastructure has been appointed, providing stronger financial leadership and re-structuring of the support provided to budget holders. Budget holders have provided assurance that they are managing finances effectively. There has been closer alignment between business and financial planning this year.

A new approach to procurement has been adopted to ensure that budget holders are provided with procurement expertise which relates to the goods or services being purchased. Greater awareness of the procurement process and the controls that apply is required within the organisation.

An internal audit report for the Department of Health was published on 5 June 2015 which reviewed previous practice on two procurements in February 2013. The report noted some procedural errors in the procurements; recognised that the capacity and capability of the CQC procurement team has improved since the time of those procurements; and recommended that CQC took a number of actions. Those actions are either in train or already implemented and progress will be reported to ACGC in 2015/16.

A significant proportion of the underspend on revenue and capital in 2014/15 was as a result of it taking longer to complete contracts and delays in recruiting staff. There is now better oversight, through the Investment Committee, of the business cases which are put forward for consideration. However, more work is required around processes to ensure that business cases are of a consistently high standard before they come to the Investment Committee.

Internal controls to detect fraud are working as intended with no significant issues to report from the year. Financial delegations are reviewed during the year to ensure they reflect any changes made to governance arrangements.

5. Information and evidence management

As a regulator, making highly effective, evidence-based decisions is critical. Processes are in place for ensuring that all significant regulatory decisions are made by those who are qualified and authorised to make them. The new enforcement policy was published in February 2015. Dedicated, expert inspectors will focus on enforcement activity to ensure that the right enforcement action, based on the appropriate evidence, is taken. All staff are required to undertake mandatory enforcement training to ensure they understand how CQC takes action against providers and to ensure evidence is gathered appropriately.

In November 2014, the Board approved a new knowledge and information strategy which, when delivered, will ensure that current barriers which prevent staff being able to easily access knowledge and information are removed. Existing systems will be more integrated, new systems procured, and more information will be publicly available. Protection of information in corporate systems is not a significant concern as security is generally good. We are also developing a secure information system specifically for our market oversight scheme because of the sensitive data we will hold about providers. An internal audit has identified work needed to strengthen mitigation of cyber risks, although exposure to these types of risks is low. Greater clarity is needed on all information assets and the roles within the organisation which are responsible for managing these assets are being reviewed.

Despite CQC having a largely mobile workforce, security incidents are relatively infrequent. This is largely as a result of the training and awareness raising which is included at induction and through other interventions.

6. People management

Sickness absence levels are within the 5% target which performance is measured against. This is a strong achievement as some staff groups have felt under pressure as changes have been introduced and the inspection directorates have not had the required numbers of inspectors in post. The Executive Team has been concerned about the wellbeing of staff. Recruitment was made a priority, particularly to increase the number of inspectors and analysts. There was also a focus to ensure staff are motivated to stay with the organisation. The main ways of doing this are through keeping staff engaged, effectively managing people in line with HR policies and processes, and providing staff with learning and development opportunities.

The annual staff survey was completed in August 2014. The engagement index improved to a score of 64, a one point improvement on the previous year. This is above the public sector benchmark of 58. Teams across CQC have been reflecting on their results and agreeing the local action needed to address the issues raised by staff. A new performance review and development framework has been introduced for 2015/16 to strengthen how managers assess individual staff performance and understand the development needs of their staff.

Further work is needed to provide all managers with the people management information needed to manage staff effectively. Understanding of HR policies also needs to improve, especially among staff new to the organisation. In March 2015 the Board approved a revised and clearer conflicts of interest policy for staff which was informed by an internal audit and has been communicated to staff who are in the process of making declarations of interest. Improvements are being made to how temporary staff (contractors, bank inspectors, specialist advisors and Experts by Experience) are supported and managed. A central team will manage those who work for CQC on a flexible basis.

7. Learning and continuous improvement

The importance of learning and continually improving is emphasised across CQC. An ongoing evaluation programme enables the organisation to learn about the impact it is making and to identify improvements which can be made. Understanding value for money (VFM) was a key work area during 2014/15 and a VFM self-assessment has been undertaken in preparation for a review by the National Audit Office which will report in July. We are also taking forward work to develop a robust and sustainable approach to assessing the costs and benefit of our regulation.

Work has been undertaken to understand the key components of the CQC operating model which are: register; monitor, inspect and rate; enforcement; and independent voice, and to be able to articulate supporting systems and processes. This work has identified that there is some variation in approach. Some of this variation is necessary to account for sector or provider differences but some result in inefficiency. Improvement priorities have been identified and agreed by the Executive Team to be addressed in 2015/16.

During 2014/15, the CQC Academy was fully operational, ensuring that staff are supported in developing the skills and knowledge to undertake their roles. As new approaches to inspection have been rolled out, the priority during the year has been to train inspection teams in the methodologies they now apply. A new corporate induction programme helps new staff members to understand the organisation quickly and become productive from an early stage. In November 2014, a new Education and Development (ED) system was introduced which allows individuals to manage their learning and development and help the Academy to more effectively plan the training interventions needed.

8. Governance and decision making

The main changes to governance arrangements are explained earlier in the governance statement. The inspection directorates developed their governance arrangements during the year as their senior management teams were recruited. These will be fully operational in 2015/16. New staff are made aware of the organisation's governance arrangements during their induction.

Other assurance areas

Information security and governance

CQC's knowledge and information strategy is supported through investment in systems, software and technology to enable staff to have timely access to accurate information which is appropriately secured and is managed in line with legislation, compliance requirements and related guidance.

Information security has continued to be a high priority. Assurance of the information security controls in place comes from a wide range of sources, both technical and procedural. CQC has an Information Governance Group which meets monthly to monitor and manage work and progress in the area of information governance and security. This has ensured that CQC continues to comply appropriately with relevant legislation and guidance.

Internal audits of information governance and security and cyber security during 2014/15 both gave moderate assurance that controls were effective.

Security incident analysis and response has been carried out during the year and is reported to the Senior Information Risk Owner (Dr Paul Bate) and the ACGC. CQC has also continued to liaise with DH, NHS England and the Information Commissioner's Office. A potential security breach occurred early in the year when a small number of patient records were left in an insecure location for a short period. This incident was reported to the Information Commissioner's Office who subsequently decided that no actual breach of personal information had taken place and no further action was necessary.

CQC completes the annual Information Governance Toolkit return, coordinated by the Health and Social Care Information Centre. Improvements this year in information governance practices and information systems have resulted in a score of 85%. The overall rating is classed as satisfactory and planning is in place to further improve on this score during 2015/16.

Counter fraud and legal

The Director of Legal Services and Information Rights leads our legal services and also acts as the organisation's fraud lead. The number of allegations of fraud received during 2014/15 has shown a downward trend on the previous year; 18 cases were reported and investigated with none of them found to be substantiated. There is an ongoing commitment to thorough and robust investigation of all reported fraud, bribery or corruption. An internal audit of counter fraud during 2014/15 provided moderate assurance and confirmed that CQC takes fraud and corruption seriously. To my knowledge during the year CQC has not assumed duties beyond its statutory powers, nor has it improperly delegated any duties.

Risks and challenges

The CQC Board has responsibility for setting the organisation's risk tolerance and oversight of the strategic risk register which is reviewed on a quarterly basis by both the ACGC and the Executive Team. Risks are escalated to the Board from across the organisation once they have been discussed by the Executive Team and issues are reported through the corporate performance report or the Chief Executive's report to the Board. The strategic risk register is published on the CQC website.

The key strategic risks faced and managed during 2014/15 were:

Recruitment and training

The most significant risk the organisation faced related to recruiting and training the numbers of additional staff needed to deliver inspections. Inspectors to deliver hospital and mental health inspections have been particularly difficult to recruit. Delays in recruiting more staff meant that the workloads of current inspectors increased and CQC has not delivered the volume of inspections it originally intended. This risk has largely been managed through targeted recruitment campaigns, changing the deadlines for completing inspections, induction training and communicating recruitment progress to staff.

Enforcement action

A core role of CQC is to ensure that action is taken, when required, in order to protect the public. CQC's powers of enforcement allow inspectors to take this action but if it is not taken swiftly or effectively, the risk of harm will still exist. A new enforcement policy, published in February 2015, helps ensure the most appropriate action is taken and with additional staff CQC will have the capacity to respond quickly.

Failure of new approaches

The approaches to Intelligent Monitoring and inspection will never be completely perfect. However, both need to be highly effective at serving their purpose and identifying risk. Intelligent Monitoring helps us to prioritise inspection programmes by ensuring inspectors visit providers that Chief Inspectors and Deputy Chief Inspectors are most concerned about. When CQC inspects, the approach is informed by data to ensure the focus of the inspection is on the right things. Quality control and assurance are the main mechanisms for ensuring consistency and rigour.

Market oversight

Over the last nine months, CQC's new approach to market oversight of 'difficult to replace providers' in the adult social care sector has been developed. Failure of provision on a large scale can be distressing for residents and their families. Financial oversight of organisations is a new area of regulation for CQC and there has been reliance on external expertise to help develop a scheme with clear entry and exit criteria. Developers have worked with providers to ensure that they are confident CQC will hold their data securely. A small team with the required expertise and experience will oversee the scheme, but is not yet at full complement.

Managing change

CQC has been through a significant amount of change in the last two years. Feedback from a range of stakeholders, including staff, indicates that this change has been for the better. Change has been difficult at times, but successful, largely as a result of the hard work and dedication of staff and a structured approach to programme management. The final Gateway review of the transformation programme gave amber green status recognising the improvements that have been made throughout the lifecycle of the two year programme.

Head of Internal Audit opinion

In accordance with the requirements of the UK Public Sector Internal Audit Standards, I am required to provide the Accounting Officer with my annual opinion of the overall adequacy and effectiveness of the organisation's risk management, control and governance processes.

My opinion is based on the outcomes of the work that Internal Audit has conducted throughout the course of the reporting year and on the follow-up action from audits conducted in the previous reporting year. There have been no undue limitations on the scope of Internal Audit work and the appropriate level of resource has been in place to enable the function to satisfactorily complete the work planned.

For the three areas on which I must report, I have concluded the following:

In the case of **risk management**:

Management's focus since April 2014 has been on ensuring that CQC has the right strategic risks recorded on its risk register and that the Executive Team, Audit and Corporate Governance Committee (ACGC), Regulatory Governance Committee (RGC) and the Board, are reviewing the relevant risks on a regular basis. Simultaneously, the Corporate Risk and Assurance Manager has been working with the Business Managers in each directorate to deliver a programme of understanding, knowledge transfer and support to enable each of them to deliver on their risk management responsibilities. The outcome of this has been an improvement in the systems and processes in place that are designed to drive risk management across the organisation.

From our audit of risk management undertaken in the first half of the year, we concluded that some improvements were required to enhance the adequacy and effectiveness of the current arrangements. We noted strong visible commitment at the top level and most business units using systematic approaches. But while some good practice was in place, risk was not being consistently managed across the whole organisation. We recommended that CQC defines its risk appetite, which has since been done and approved by the Board, and that there is increased focus on challenging the content of

directorate risk registers and improving the understanding of responsibilities below director level with a view to driving a 'bottom-up' approach to risk management. Good progress has been made in what remains an area of continued focus.

In the case of **governance:**

A number of audits have assessed different aspects of governance during the year. We performed initial reviews of two areas where management recognised the opportunity to improve current arrangements, those being business continuity planning and CQC's arrangements for governance and oversight of Healthwatch England. Both reviews identified recommended areas for attention, which have fed into management's ongoing action plans.

Reviews of cyber security, information governance and counter-fraud arrangements indicated that management has, in general, recognised the potential issues in these areas and implemented reasonable governance arrangements. However, we also identified areas where governance arrangements could be improved, most notably around financial management, capital accounting and health and safety compliance monitoring. Prior to our review, management had already identified financial governance and management as being an area for improvement and an appointment to the role of Director of Finance was made shortly after our audit work completed. The National Health, Safety and Wellbeing Committee had been re-launched shortly before our work, which identified a number of areas that management is now taking forward.

In the case of **control:**

We have issued 21 audit reports. Excluding Risk Management, the other 20 address key aspects of the systems of internal control. Seven of these reports were rated 'moderate', eight 'limited', and the other five were not formally rated as these provided position statements and action plans on known areas for improvement. There were no audit reports rated as 'unsatisfactory'. There has been a broader and more extensive coverage of internal audit reviews in 2014/15 compared to the previous year.

The overarching theme arising from these reviews is that, progress has been made to strengthen the control environment but there is still further work to do to both develop and align systems and controls to the operating model and to ensure continued compliance as CQC completes its transformation journey. The reviews around core financial processes generally showed a sound internal control environment with 'moderate' assurance concluded in the areas of Payroll and Accounts Receivable.

Notably, on several occasions, management have proactively invited Internal Audit to look into areas where either they have concerns or where they have sought independent assurance that systems are robust. This has included financial management, business continuity, recruitment processes, procurement and expenses. By the end of the year, we have seen some evidence of improved controls and greater visibility and engagement across the organisation in the areas of financial management and procurement.

The reviews around key operational processes identified the continuing need to develop internal control processes to address the following areas of risk where only 'limited' assurance could be given: health and safety of the workforce, managing conflicts of interest around inspections, reimbursement of expenses, capital accounting and contract management. Detailed action plans are being worked through with good progress made at the year-end, with remaining actions incorporated into the 2015/16 business plan.

Finally, following some public commentary on Intelligent Monitoring data released for GP practices, Internal Audit was commissioned to review the quality assurance arrangement in place around all external facing analyses produced by CQC. A core theme from this review was the need to formalise existing controls and to evidence that controls and processes are operating consistently in practice. An action plan is currently being worked through to fully embed an organisation-wide quality assurance framework.

Therefore, in summary, my overall opinion is that I can give to the Accounting Officer of the Care Quality Commission for the reporting year 2014/15:

MODERATE assurance that there are adequate and effective systems of governance and risk management; and

LIMITED assurance that there is an adequate and effective system of control.

Jane Forbes – Head of Internal Audit

Accounting Officer letters

All Accounting Officer letters received have been actioned.

Ministerial directions

CQC has not received any Ministerial directions during the year.

Accounting Officer's conclusion

The new management assurance approach has helped increase awareness of the internal controls in place and the areas for improvement. It has also informed the views expressed in this statement. The assessments which directorates have undertaken have been honest and reflective. These assessments have also been tested against the views of others within the organisation and from outside.

I accept the opinion of the Head of Internal Audit. The findings from internal audit are consistent with our own view of the organisation. We have made some improvements during 2014/15 but there is further work to do to ensure controls, systems and processes are operating effectively. The ACGC have also formed their views on the adequacy of CQC's corporate risk management, financial controls and corporate governance systems based on all the information which has been reported to them during the year. The committee have reported any concerns to the Board.

The past year has focused on ensuring that the new approach to regulating health and care is being rolled out. The focus is now turning to ensuring that systems and processes are in place to support staff to deliver the new approach to regulation consistently and effectively. Capacity is being built for learning and implementing improvements in a controlled but responsive way.

CQC has complied with HM Treasury's *Corporate Governance in Central Government Department's Code of Good Practice* to the extent that it applies to a non-departmental public body.

I conclude that the CQC governance and assurance processes have supported me in discharging my responsibilities as Accounting Officer. I am not aware of any significant internal control problems in

2014/15. Improvements are being made to strengthen the assurance that can be provided and the overall internal control environment within CQC during 2015/16.

Annex 1: Board and committee membership

CQC Board

Board member	Term of office
David Prior (Chair)[1]	28 January 2013 – 27 January 2017
David Behan CBE (Chief Executive)	5 November 2012 – 4 November 2016
Anna Bradley	16 July 2012 – 31 March 2016
Kay Sheldon OBE	30 November 2010 – 30 November 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[2]	1 July 2013 – 30 June 2017
Prof. Sir Mike Richards	16 July 2013
Prof. Steve Field CBE	30 September 2013
Andrea Sutcliffe	7 October 2013
Paul Rew	1 July 2014 – 30 June 2017
Sir Robert Francis QC	1 July 2014 – 30 June 2017

[1] – David Prior stood down as Chair on 14 May 2015.

[2] – Camilla Cavendish stood down as a Board member on 21 May 2015.

Audit and Corporate Governance Committee

Committee member

Paul Rew (Chair)

Michael Mire

Sir Robert Francis QC

Co-opted member

Jane Mordue (co-opted from Healthwatch England)

Independent members

John Butler (left 29 January 2015)

David Prince

People and Values Committee (formerly the Remuneration Committee)

Committee member

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

Regulatory Governance Committee (formerly the Regulatory Governance and Values Committee)

Committee member

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

Annex 2: Summary of Board attendance

	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
David Prior (Chair)	✗	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
David Behan CBE (Chief Executive)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Anna Bradley	✓	✗	✓	✓		✓	✗	✓	✓	✗	✓	✓
Kay Sheldon OBE	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Dr Paul Bate	✗	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Prof. Paul Corrigan CBE	✓	✓	✓	✗		✓	✓	✓	✓	✓	✓	✓
Prof. Louis Appleby	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Dr Jennifer Dixon CBE	✗	✗	✓	✓		✓	✗	✗	✓	✓	✓	✓
Michael Mire	✓	✓	✗	✓		✓	✗	✗	✓	✗	✓	✓
Camilla Cavendish	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✗
Prof. Sir Mike Richards	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Prof. Steve Field CBE	✓	✓	✗	✓		✓	✗	✓	✗	✓	✓	✓
Andrea Sutcliffe	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Paul Rew				✓		✓	✓	✓	✓	✓	✓	✓
Sir Robert Francis QC				✓		✗	✓	✓	✓	✓	✓	✓

Annex 3: Executive Team and committee structure and membership

Executive Team member	Role	Start of membership
David Behan CBE	Chief Executive	30 July 2012
Hilary Reynolds[1]	Director of Change	1 May 2013
Dr Paul Bate	Executive Director of Strategy and Intelligence	3 May 2013
Prof. Sir Mike Richards	Chief Inspector of Hospitals	16 July 2013
Prof. Steve Field CBE	Chief Inspector of General Practice	30 September 2013
Andrea Sutcliffe	Chief Inspector of Adult Social Care	7 October 2013
Eileen Milner	Executive Director of Customer and Corporate Services	13 January 2014

[1] – Hilary Reynolds left CQC at the end of February 2015.

Previous Executive Team members

Executive Team member	Role	End of Membership
Matthew Trainer	Regional Director of Operations, London	31 March 2014
Adrian Hughes	Acting Regional Director of Operations, South	31 March 2014
Malcolm Bower-Brown	Regional Director of Operations, North	31 March 2014
Andrea Gordon	Regional Director of Operations, Central	31 March 2014

Annex 4: Board business 2014/15

CQC Board – coverage of topics 1 April 2014 to 31 March 2015

Agenda items

Academy update

ACGC Annual Report to the Board

Acute hospital inspection evaluation report

Adult social care system information strategy

Annual Report and Accounts

Business and budget planning

Business plan

Capital programme

Chief Executive report

Child safeguarding consultation

Committees' terms of references

Covert surveillance

Cross-sector special measures

Culture and values

Declaration of interests policy

Dementia-themed inspection national report

Directorate updates

Enforcement policy

Equality annual report

Estates strategy

Executive Team and Board expenses

Experts by Experience

Fees and fees consultation

Finance report

Forward View (NHS England)

Fundamental standards

Governance statement

GP Intelligent Monitoring

Healthwatch England update

Evaluation of CQC acute hospital inspection model

Intelligent Monitoring

Knowledge and information strategy

Market oversight

Mental Health Act annual report

National survey programme

New approach to urgent care

NHS GP out-of-hours services

National Information Governance Committee report to the Board

Orchid View investigation report

Performance report

Provider guidance

Provider handbooks – including new approach to independent healthcare, dentists, ambulances, and health and justice

Public engagement strategy

Recruitment services

Registration project

Regulation and enforcement powers

Regulations guidance

Review of ratings

Regulatory Governance and Values Committee report to the Board

Safety quality

Shaping the future

Signposting statement

State of Care report

State of complaints report

David Behan
Chief Executive and Accounting Officer,
Care Quality Commission
26 June 2015

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 2015 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 2014/15 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 2015 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

8 July 2015

Financial statements

Statement of Comprehensive Net Expenditure

for the year ended 31 March 2015

	Note	2014/15 £000	2013/14 £000
Expenditure			
Staff costs	2&3	149,903	128,757
Depreciation and amortisation	2&4	10,873	11,047
Other expenditure	2&4	61,025	54,363
Impairment of assets	2&4	(95)	420
		221,706	**194,587**
Less income			
Income from activities	5	(103,171)	(101,181)
Other income	5	(226)	(223)
		(103,397)	**(101,404)**
Net expenditure for the year		**118,309**	**93,183**

Other comprehensive expenditure

	Note	2014/15 £000	2013/14 £000
Items that will not be reclassified to net operating costs:			
Net (gain)/loss on revaluation of intangible assets	7	(78)	412
Net (gain)/loss on revaluation of property, plant and equipment	8	(9)	34
Actuarial loss/(gain) in pension schemes	3	15,331	(11,861)
		15,244	**(11,415)**
Total comprehensive expenditure for the year ended 31 March 2015		**133,553**	**81,768**

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 shown in note 2.

CQC received grant-in-aid totalling £126.0m (2013/14: £87.3m) from the Department of Health.

Notes 1 to 22 form part of these financial statements.

Statement of Financial Position

as at 31 March 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets			
Intangible assets	7	13,934	15,586
Property, plant and equipment	8	2,673	1,790
Total non-current assets		**16,607**	**17,376**
Current assets			
Trade receivables	12	7,382	4,894
Other current assets	12	2,766	2,659
Cash and cash equivalents	13	39,187	23,233
Total current assets		**49,335**	**30,786**
Total assets		**65,942**	**48,162**
Current liabilities			
Trade and other payables	14	(25,150)	(20,008)
Current pension liabilities	14	(205)	(333)
Provisions	15	(1,661)	(383)
Total current liabilities excluding fee income in advance		**(27,016)**	**(20,724)**
Non-current assets plus net current assets excluding fee income in advance		**38,926**	**27,438**
Fee income in advance	14	(38,349)	(37,127)
Total current liabilities		**(65,365)**	**(57,851)**
Non-current assets plus net current assets		**577**	**(9,689)**
Non-current liabilities			
Provisions	15	(1,219)	(1,564)
Pension liabilities	14	(355)	(533)
Total non-current liabilities excluding pension Deficit		**(1,574)**	**(2,097)**
Assets less liabilities excluding pension deficit provision		**(977)**	**(11,786)**
Pension deficit provision	3	(70,418)	(52,089)
Assets less liabilities		**(71,415)**	**(63,875)**
Taxpayers' equity			
General reserve		(71,694)	(64,429)
Revaluation reserve		279	554
Total taxpayers' equity		**(71,415)**	**(63,875)**

The financial statements on pages 117 to 150 were approved and authorised for issue by the Board on 26 June 2015 and were signed on its behalf by:

David Behan
Chief Executive, Care Quality Commission

Notes 1 to 22 form part of these financial statements.

Statement of Cash Flows

for the year ended 31 March 2015

	Note	2014/15 £000	2013/14 £000
Cash flows from operating activities			
Total net expenditure		(118,309)	(93,183)
Adjustment for depreciation and amortisation	4	10,873	11,047
Impairment of intangible assets	4	(87)	380
Impairment of property, plant and equipment	4	(8)	40
Loss on disposal of intangible assets	4	98	769
Loss on disposal of property, plant and equipment	4	–	39
Cost of PCSPS long term creditor recognised as an expense	4&14	57	85
Net expense on pension scheme assets and liabilities	4	2,140	2,577
(Increase) in trade and other receivables	12	(2,595)	(1,284)
Increase in trade payables	14	5,039	3,717
(Decrease)/increase in current pension liabilities	14	(128)	17
Increase in deferred income	14	1,222	551
(Decrease) in provisions	15	(1,207)	(3,382)
Non-cash pension charge	3	2,998	2,717
(Decrease) in non-current pension liabilities	14	(235)	(340)
Net cash outflow from operating activities		**(100,142)**	**(76,250)**
Cash flows from investing activities			
Purchase of intangible assets	7&14	(8,117)	(6,798)
Purchase of property, plant and equipment	8&14	(1,800)	(1,231)
Net cash outflow from investing activities		**(9,917)**	**(8,029)**
Cash flows from financing activities			
Grants from Department of Health		126,013	87,325
Net financing		**126,013**	**87,325**
Net increase in cash and cash equivalents in the year		**15,954**	**3,046**
Cash and cash equivalents at 1 April	13	23,233	20,187
Cash and cash equivalents at 31 March	13	39,187	23,233

Notes 1 to 22 form part of these financial statements.

Statement of Changes in Taxpayers' Equity

for the year ended 31 March 2015

	Note	Revaluation reserve £000	General reserve £000	Total reserves £000
Balance at 1 April 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)**
Change in taxpayers' equity for 2014/15				
Net gain on indexation of intangible assets		78	-	78
Net gain on indexation of property, plant and equipment		9	-	9
Transfer between reserves for intangible assets		(298)	298	-
Transfer between reserves for property, plant and equipment		(64)	64	-
Net expenditure for the year		-	(118,309)	(118,309)
Actuarial (loss) in pension schemes	3	-	(15,331)	(15,331)
Total recognised income and expense for 2014/15		**(275)**	**(133,278)**	**(133,553)**
Grants from Department of Health		-	126,013	126,013
Balance at 31 March 2015		**279**	**(71,694)**	**(71,415)**

Notes 1 to 22 form part of these financial statements.

Notes to the financial statements

1.1 Basis of accounting

The financial statements have been prepared in accordance with a Direction issued by the Secretary of State for Health (with the consent of HM Treasury) to prepare for each financial year a statement of accounts in the form and on the basis that it considers appropriate. These financial statements have been prepared in accordance with the 2014/15 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 Care Quality Commission for the purposes of giving a true and fair view has been selected. The particular policies adopted by CQC 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 2014/15.

IFRS amendments in issue that are effective for the financial year beginning 1 April 2014 but do not have an impact on CQC's accounts

- IFRS 10 *Consolidated Financial Statements*
- IFRS 11 *Joint Arrangements*
- IFRS 12 *Disclosures of Interests in Other Entities*
- IAS 27 *Separate Financial Statements*
- IAS 28 *Investments in Associates and Joint Ventures.*

IFRS amendments and interpretations in issue but not yet effective, or adopted, and are expected to have an impact on CQC's accounts

IFRS 13 *Fair Value Measurement*	A new standard prepared to provide consistent guidance on fair value measurement which will take effect in the 2015/16 financial year.
IAS 36 *Impairment of Assets on recoverable amount disclosures*	The amendment modifies some of the disclosure requirements of IFRS 13 regarding the measurement of the recoverable amount of impaired assets. The application is subject to further review by HM Treasury and is expected to take effect in the 2015/16 financial year.
IFRS 14 *Regulatory Deferral Accounts*	This is a limited scope standard providing an interim solution for rate-regulated entities that have not yet adopted IFRS and is effective for accounting periods beginning on, or after, 1 January 2016.
IFRS 15 *Revenue from Contracts with Customers*	A single comprehensive model is established for entities to use in accounting for revenue arising from contracts with customers. It supersedes the following revenue standards and interpretations upon its effective date; IAS 18 *Revenue* and IFRIC 18 *Transfers of Assets from Customers*. The effective date is for accounting periods beginning on, or after, 1 January 2017.
IFRS 9 *Financial Instruments*	This supersedes IAS 39 *Financial Instruments: Recognition and Measurement* in its entirety. It contains the requirements for the classification of financial assets and financial liabilities. The effective date is for accounting periods beginning on, or after 1 January 2018.

IFRS amendments and interpretations in issue but not yet effective, or adopted, and are not expected to have an impact on CQC's accounts

- IAS 1 *Disclosure initiative*
- IAS 27 *Equity Method in Separate Financial Statements*
- IAS 16 and IAS 41 *Bearer Plants*
- IAS 16 and IAS 38 *Clarification of acceptable methods of depreciation and amortisation*
- IFRS 11 *Accounting for acquisitions of interests in joint operations*
- IFRS 10 and IAS 28 *Sale or contribution of assets between an investor and its associates or joint ventures*
- IFRS 10, IFRS 12 and IAS 28 *Investment entities: applying the consolidation exception.*

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 included in the Statement of Financial Position 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 CQC'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 for 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 for National Statistics price index.

Depreciation

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

Estimated useful lives:

Property, plant and equipment:

Furniture and fittings:

- Office refurbishment 10 years
- Furniture 10 years
- Office equipment 5 years

Information technology:

- IT equipment 3 years
- IT infrastructure 3 years

Intangible assets:

Software licences 3 years

Developed software and website 3 years

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

Office refurbishments and furniture are written-off over the remaining life of the lease (the date of the first lease break) if below 10 years. Computer software, including developed software is written-off over the expected life of the software if less than three years. The estimate of expected life is regularly reviewed to ensure that depreciation and amortisation 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, NHS trusts, dentists, ambulance services and other income arising mainly from secondments of Care Quality 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 CQC's website.

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 Care Quality Commission's activities and the way in which Government departments are financed, CQC was not exposed to the degree of financial risk faced by business entities. CQC has no borrowings and relies on the grants from the Department of Health for its cash requirements. CQC is therefore not exposed to liquidity risks. It has no material deposits, other than with the government banking service, 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 in the Statement of Financial Position when CQC 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. CQC 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 in the Statement of Financial Position when CQC 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. CQC 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 1.3% (2013/14: 1.8%). This is the rate for market yields on AA corporate bonds as published by HM Treasury.

Grants receivable

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

Provisions

Provisions are recognised when CQC has a present obligation (legal or constructive) as a result of a past event. It is probable CQC 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 1.5% (2013/14: 1.9%) and provisions falling due between 5 to 10 years are increased by a discount factor of 1.05% (2013/14: 0.65%) in accordance with HM Treasury guidance.

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

A restructuring provision is recognised when CQC has developed a detailed plan for the restructuring and has formally informed those affected by the plan either by starting to implement the plan or announcing its main features to those affected by it. The amount of the provision is only the direct expenditures arising from the restructuring and is not associated with ongoing activities.

Value added tax

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

1.3 Employee benefits

Short–term employee benefits

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

Retirement benefit costs

CQC employees are covered by the provisions of National Health Service (NHS) pension scheme. The NHS pension scheme is a defined benefit scheme and CQC'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 CQC.

On 1 April 2009 staff transferred to CQC from three other commissions – the Commission for Social Care Inspection (CSCI), the Healthcare Commission (HC) and the Mental Health Act Commission (MHAC). Existing members of the Principal Civil Service Pension Scheme (PCSPS) were offered membership of the NHS pension scheme but other transferring staff, who were members of the Local Government Pension Scheme (LGPS), were allowed to keep their legacy arrangements. Details of the NHS pension scheme and the LGPS are provided in note 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 CQC, 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 £92m (2013/14: £61m) and administration of £26m (2013/14: £32m) 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 have 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)

d) Assumptions used to determine the IAS 19 pension liability for funded pension schemes (note 3.5).

2. Analysis of net expenditure by segment

IFRS 8 requires operating segments to be identified on the basis of internal reports that are regularly reviewed by the Chief Executive. CQC's Board monitored the performance and resources of the organisation 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:

				2014/15				2013/14
	Continuing operations £000	Healthwatch England £000	Trans-formation £000	Total CQC £000	Continuing operations £000	Healthwatch England £000	Trans-formation £000	Total CQC £000
Expenditure								
Staff costs	140,079	2,698	7,126	**149,903**	117,231	2,081	9,445	**128,757**
Depreciation and amortisation	10,873	-	-	**10,873**	11,047	-	-	**11,047**
Other expenditure	58,320	1,665	1,040	**61,025**	42,354	2,088	9,921	**54,363**
Impairments of assets	(95)	-	-	**(95)**	420	-	-	**420**
	209,177	4,363	8,166	**221,706**	171,052	4,169	19,366	**194,587**
Income								
Income from activities	(103,171)	-	-	**(103,171)**	(101,181)	-	-	**(101,181)**
Other income	(226)	-	-	**(226)**	(198)	(25)	-	**(223)**
	(103,397)	-	-	**(103,397)**	(101,379)	(25)	-	**(101,404)**
Net expenditure	**105,780**	**4,363**	**8,166**	**118,309**	**69,673**	**4,144**	**19,366**	**93,183**

The CQC transformation programme commenced during 2013/14.

Healthwatch England came into existence on 1 October 2012 as a statutory Committee within CQC. The costs included within these financial statements only relate to the head office function and do not include those incurred by the local Healthwatch branches across its network.

The Healthwatch England costs above include £138k (2013/14: £120k) which was recharged from continuing operations in relation to overhead costs incurred by CQC.

Healthwatch England overheads of approximately £108k (2013/14: £288k) has been absorbed by CQC and not recharged in this financial year.

2.1 Revenues from major products and services: income from fees

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

	2014/15 £000	2013/14 £000
Annual fees	(103,171)	(101,181)
Total fee income (note 6)	**(103,171)**	**(101,181)**

3. Staff numbers and related costs

3.1 Staff costs comprise

	Permanently employed £000	Others £000	2014/15 Total £000	2013/14 Total £000
Wages and salaries	94,435	31,834	**126,269**	106,700
Social security costs	8,117	882	**8,999**	8,095
Other pension costs	13,408	445	**13,853**	12,883
Termination benefits	182	–	**182**	31
	116,142	**33,161**	**149,303**	**127,709**
Less recoveries in respect of outward secondments	(258)	–	**(258)**	(259)
Increase in provision for pension fund deficits (see note 3.5)	858	–	**858**	1,307
Net costs	**116,742**	**33,161**	**149,903**	**128,757**

Other wages and salary costs consist of:	2014/15 £000	2013/14 £000
Agency	16,577	13,582
Bank	9,911	4,476
Secondments from other organisations	1,814	776
Commissioner fees	901	989
Second Opinion Appointed Doctors' fees and expenses	2,631	2,503
Total	**31,834**	**22,326**

Agency staff costs of £0.6m relating to IT software developments were capitalised during the year (2013/14: £3.2m).

3.2 Average number of persons employed

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

	2014/15 Number	2013/14 Number
Directly employed	2,384	2,172
Other *	281	352
Agency staff engaged on capital projects	4	34
Total	**2,669**	**2,558**

* This does not include commissioners and Second Opinion Appointed Doctors who are paid per session.

The actual number of directly employed whole-time equivalents as at 31 March 2015 was 2,622 (31 March 2014: 2,237).

3.3 Exit packages

Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Cost of compulsory redundancies £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	–	–	–	–	–	–	–	–
£10,000-£25,000	–	–	–	–	–	–	–	–
£25,000-£50,000	–	–	–	–	–	–	–	–
£50,000-£100,000	–	–	–	–	–	–	–	–
£100,000-£150,000	–	–	–	–	–	–	–	–
£150,000-£200,000	1	181,590	–	–	1	181,590	–	–
>£200,000	–	–	–	–	–	–	–	–
Total	**1**	**181,590**	**–**	**–**	**1**	**181,590**	**–**	**–**

Redundancy and other departure costs have been paid in accordance with CQC terms and conditions following approval by the Department of Health's Governance and Assurance Committee. 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	–	–
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	**–**	**–**

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 discloses that no exit payments were 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. Past and present employees are covered by the provisions of 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. It is not possible for the Care Quality Commission to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due. Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to operating expenses at the time CQC commits itself to the retirement, regardless of the method of payment.

The total cost charged to expenditure of £8,786k (2013/14: £7,338k) represents the contribution payable to the scheme by the Care Quality Commission at rates specified in the rules of the plan. As at 31 March 2015, contributions of £829k (31 March 2014: £674k) 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 Non-executive 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 £20k (2013/14: £10k) represents the contribution payable by CQC to the National Employment Savings Trust at the specific rates of the scheme. As at 31 March 2015, contributions of £2k (31 March 2014: £2k) 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. These schemes are closed to new employees. 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 latest triennial actuarial valuation was completed as at 31 March 2013 which set the employer contribution rates for three years from 1 April 2014. Some funds have also levied an indexed cash sum in addition to a percentage of payroll costs as part of the deficit recovery plan. 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 2015/16 range between 14.4% and 36.8% (17% for Teesside Pension Fund) with annual cash sums ranging from £1.5k to £149k (£nil for Teesside).

In June 2011 the International Accounting Standards Board (IASB) issued a new version of IAS 19 *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.

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.

Although the statement of financial position shows a deficit provision of £70.4m which results in an overall net liability position of £71.4m 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 2015 by:

Pension fund	**Actuary**
Avon	Mercers Ltd.
Cambridgeshire	Hymans Robertson LLP
Cheshire	Hymans Robertson LLP
Cumbria	Mercers Ltd.
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 2015 £000	Liabilities 31 March 2015 £000	Surplus/ (deficit) 31 March 2015 £000	Surplus/ (deficit) 31 March 2014 £000
Avon	4,969	(6,361)	**(1,392)**	(998)
Cambridgeshire	2,763	(3,444)	**(681)**	(608)
Cheshire	3,839	(3,784)	**55**	(62)
Cumbria	3,365	(3,620)	**(255)**	(241)
Derbyshire	–	–	**–**	– [1]
Dorset	2,478	(3,930)	**(1,452)**	(1,029)
East Sussex	5,429	(5,835)	**(406)**	(498)
Essex	5,001	(6,189)	**(1,188)**	(806)
Greater Manchester	14,512	(17,535)	**(3,023)**	(2,648)
Hampshire	4,210	(6,140)	**(1,930)**	(1,790)
Merseyside	6,311	(7,809)	**(1,498)**	(1,028)
Shropshire	2,220	(2,914)	**(694)**	(466)
Suffolk	3,242	(4,529)	**(1,287)**	(1,086)
Surrey	5,106	(5,842)	**(736)**	(825)
Teesside	255,853	(310,064)	**(54,211)**	(38,427)
West Sussex	3,921	(3,607)	**314**	38
West Yorkshire	9,370	(11,404)	**(2,034)**	(1,615)
Total	**332,589**	**(403,007)**	**(70,418)**	**(52,089)**

[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 paid equal to the scheme deficit at 31 March 2014 of £1,167k (assets £2,508k, liabilities £3,675).

Asset values are at bid value.

No employees (2013/14: 2) retired early on ill-health grounds during the year, as a result additional pension costs of £nil (2013/14: £57k) were 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:	**2014/15**	**2013/14**	**2014/15**	**2013/14**
Discount rate	3.2	4.3	3.1 – 3.2	3.5 – 4.4
Expected rate of salary increases	3.3	3.9	3.0 – 4.3	3.4 – 4.6
Expected return on scheme assets	3.2	4.3	3.1 – 3.2	3.5 – 4.4
Future pension increases	1.8	2.4	1.8 – 2.4	2.3 – 2.8
Inflation	1.8	2.4	1.8 – 2.4	2.3 – 2.8

Mortality assumptions

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

	Teesside Pension Fund		Other pension funds	
Key assumptions used:	**2014/15**	**2013/14**	**2014/15**	**2013/14**
Retiring today:				
Males	23.0	22.9	21.4–24.5	21.4–24.4
Females	25.5	25.1	24.0–26.3	24.0–26.2
Retiring in 20 years:				
Males	25.2	25.4	24.0–26.9	24.0–26.9
Females	27.8	27.7	26.6–29.1	26.6–29.0

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

	2014/15 £000	**2013/14 £000**
Service cost:		
Current service cost	5,942	6,025
Past service cost	–	11
Net interest expense	2,140	2,577
Amount recognised in net expenditure	**8,082**	**8,613**

Of the expense for the year, the total service cost of £5.9m (2013/14: £6.0m) has been included in the net expenditure statement as staff expenditure, note 3.1. £5.0m (2013/14: £4.7m) is included within other pension costs and £0.9m (2013/14: £1.3m) is included as an increase in provision for pension fund deficits. The net interest expense of £2.1m (2013/14: £2.6m) has been included in other expenditure, note 4. The remeasurement of the net defined benefit obligation is included in the statement of comprehensive net expenditure.

Amounts recognised in the statement of comprehensive expenditure are as follows:

	2014/15 £000	2013/14 £000
The return on plan assets (excluding amounts included in net interest expense)	(17,790)	(2,817)
Other remeasurement gains on plan assets	(25)	–
Actuarial gains and losses arising from changes in demographic assumptions	–	11,135
Actuarial gains and losses arising from changes in financial assumptions	35,414	(4,492)
Actuarial gains and losses arising from experience adjustments	(2,268)	(15,687)
Remeasurement of the net defined benefit obligations	**15,331**	**(11,861)**

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 2015 is £89m (31 March 2014: £74m).

The amount included in the statement of financial position arising from the Care Quality Commission's obligations in respect of its defined benefit retirement benefit schemes is as follows:

	31 March 2015 £000	31 March 2014 £000
Present value of defined benefit obligation	(402,914)	(357,548)
Fair value of scheme assets	332,589	305,548
Deficit in scheme	**(70,325)**	**(52,000)**
Past service cost not yet recognised	(93)	(89)
Liability recognised in the Statement of Financial Position	**(70,418)**	**(52,089)**

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

	2014/15 £000	2013/14 £000
At 1 April	**(357,637)**	**(357,641)**
Current service cost	(5,942)	(6,025)
Interest cost	(15,149)	(15,483)
Contributions from scheme members	(1,863)	(1,815)
Past service costs	–	(11)
Remeasurement (gains)/losses		
Actuarial gains and losses arising from changes in demographic assumptions	–	(11,135)
Actuarial gains and losses arising from changes in financial assumptions	(35,414)	4,492
Actuarial gains and losses arising from experience adjustments	2,268	15,687
Benefits paid	10,730	10,619
Scheme cessation	–	3,675
At 31 March	**(403,007)**	**(357,637)**

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

	2014/15 £000	2013/14 £000
At 1 April	**305,548**	**296,408**
Interest income	13,009	12,906
Remeasurement gain/(loss)		
The return on plan assets (excluding amounts included in net interest expense)	17,790	2,817
Other	25	–
Employer contributions	5,094	4,735
Member contributions	1,863	1,815
Benefits paid	(10,730)	(10,619)
Administration expenses	(10)	(6)
Scheme cessation	–	(2,508)
At 31 March	**332,589**	**305,548**

The actual return on scheme assets was a gain of £30.8m (2013/14: £14.8m 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	
	2014/15 %	2013/14 %	2014/15 £000	2013/14 £000
Equities	3.1–3.2	3.5–4.4	264,186	239,239
Property	3.1–3.2	3.5–4.4	21,141	16,612
Government bonds	3.1–3.2	3.5–4.4	8,657	9,321
Other bonds	3.1–3.2	3.5–4.4	19,126	17,526
Cash	3.1–3.2	3.5–4.4	8,443	14,382
Other	3.1–3.2	3.5–4.4	11,036	10,976
Total			**332,589**	**308,056**

4. Other expenditure

	2014/15 £000		2013/14 £000	
Travel and subsistence	12,703		7,322	
IT costs, including general project management	11,954		13,850	
General office supplies	7,090		6,487	
Recruitment, training and development costs	5,626		3,395	
Other premises costs	4,387		958	
Rentals under operating leases	3,899		3,527	
Experts by Experience	3,384		–	
Communications	2,838		4,899	
Telecoms	2,343		2,034	
Professional fees and project costs	1,555		1,185	
Consultancy	1,318		5,881	
Printing and publishing	932		697	
Losses and special payments (bad debts)	295		141	
Other costs	226		267	
External audit fees – statutory work	145		145	
Operating leases (equipment)	69		84	
Losses and special payments (other)	10		60	
Grants to other bodies	5		–	
		58,779		50,932
Non-cash items:				
Loss on disposal of intangible assets	98		769	
Loss on disposal of property, plant and equipment	–		39	
Cost of PCSPS long term creditor recognised as an expense	57		85	
Unwinding of discount on provisions	(31)		(12)	
Change in discount rate on provisions	(18)		(27)	
Net expenses on pension scheme assets and liabilities	2,140		2,577	
		2,246		3,431
Other expenditure		**61,025**		**54,363**
Amortisation of intangible assets	9,644		9,638	
Depreciation of property, plant and equipment	1,229		1,409	
Depreciation and amortisation		**10,873**		**11,047**
Impairment of intangible assets	(87)		380	
Impairment of property, plant and equipment	(8)		40	
Impairments		**(95)**		**420**

During 2014/15, 466 cases were recognised by CQC with a total value of £295k (2013/14: 329 cases totalling £201k) and also one special payment was made totalling £10k (2013/14: 4 cases totalling £60k).

There were no individual losses or special payments that exceeded £300k (2013/14: none).

4.1 Auditors' remuneration

	2014/15 £000	2013/14 £000
Fees payable for the audit of CQC's annual accounts	145	145
Total	**145**	**145**

5. Income

	2014/15 £000	2013/14 £000
Income from activities:		
Income from fees	(103,171)	(101,181)
Other income	–	–
	(103,171)	**(101,181)**
Other income:		
Other non-trading income	(226)	(223)
Net return on pension scheme assets and liabilities	–	–
	(226)	**(223)**
Total	**(103,397)**	**(101,404)**

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.

During 2014/15 CQC recovered 43.6% (2013/14: 55.4%) of its costs in fees. CQC has the power to recover costs associated with its registration functions under Section 85 of the Health and Social Care Act 2008. In accordance with HM Treasury guidance, 'Managing Public Money', CQC is required to set fees in order to recover all the costs of its functions. Our latest consultation strategy sets a path that will take us to full cost recovery. CQC will consult on this during 2015/16.

6. Analysis of net expenditure by admin and programme budget

	2014/15			2013/14		
	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000
Expenditure						
Staff costs	18,162	131,741	**149,903**	14,143	114,614	**128,757**
Travel and subsistence	1,329	11,374	**12,703**	1,963	5,359	**7,322**
IT costs, including general project management	1,354	10,600	**11,954**	3,755	10,095	**13,850**
General office supplies	1,179	5,911	**7,090**	2,199	4,288	**6,487**
Recruitment, training and development costs	764	4,862	**5,626**	953	2,442	**3,395**
Other premises costs	408	3,979	**4,387**	266	692	**958**
Rentals under operating leases	549	3,350	**3,899**	955	2,572	**3,527**
Experts by Experience	–	3,384	**3,384**	–	–	**–**
Communications	356	2,482	**2,838**	1,474	3,425	**4,899**
Telecoms	218	2,125	**2,343**	534	1,500	**2,034**
Professional fees and project costs	181	1,374	**1,555**	323	862	**1,185**
Consultancy	118	1,200	**1,318**	966	4,915	**5,881**
Printing and publishing	134	798	**932**	227	470	**697**
Losses and special payments (bad debts)	17	278	**295**	37	104	**141**
Other costs	21	205	**226**	178	89	**267**
External audit fees – statutory work	13	132	**145**	38	107	**145**
Operating leases (equipment)	6	63	**69**	22	62	**84**
Losses and special payments (other)	1	9	**10**	16	44	**60**
Grants to other bodies	–	5	**5**	–	–	**–**
Non-cash items:						
Loss on disposal of intangible assets	9	89	**98**	200	569	**769**
Loss on disposal of property, plant and equipment	–	–	**–**	10	29	**39**
Cost of PCSPS long term creditor recognised as an expense	5	52	**57**	22	63	**85**
Unwinding of discount on provisions	–	(31)	**(31)**	–	(12)	**(12)**
Change in discount rate on provisions	–	(18)	**(18)**	–	(27)	**(27)**
Net expenses on pension scheme assets and liabilities	199	1,941	**2,140**	670	1,907	**2,577**
Amortisation of intangible assets	897	8,747	**9,644**	2,506	7,132	**9,638**
Depreciation of property, plant and equipment	114	1,115	**1,229**	366	1,043	**1,409**
Impairment of intangible assets	–	(87)	**(87)**	–	380	**380**
Impairment of property, plant and equipment	–	(8)	**(8)**	–	40	**40**
Income						
Income from activities	–	(103,171)	**(103,171)**	–	(101,181)	**(101,181)**
Other income	–	(226)	**(226)**	(25)	(198)	**(223)**
Net Expenditure after interest	**26,034**	**92,275**	**118,309**	**31,798**	**61,385**	**93,183**

7. Intangible Assets

	IT software Development £000	Software Licences £000	Website £000	Total £000
Cost or valuation				
At 1 April 2014	28,472	2,224	4,773	**35,469**
Additions	5,218	1,433	1,274	**7,925**
Disposals	(3,180)	(1,838)	(801)	**(5,819)**
Impairments	113	3	20	**136**
Indexation	134	11	21	**166**
At 31 March 2015	**30,757**	**1,833**	**5,287**	**37,877**
Amortisation				
At 1 April 2014	(16,112)	(2,105)	(1,666)	**(19,883)**
Charged in year	(7,627)	(487)	(1,530)	**(9,644)**
Disposals	3,125	1,838	758	**5,721**
Impairments	(41)	(2)	(6)	**(49)**
Indexation	(84)	–	(4)	**(88)**
At 31 March 2015	**(20,739)**	**(756)**	**(2,448)**	**(23,943)**
Net book value at 31 March 2015	**10,018**	**1,077**	**2,839**	**13,934**
Net book value at 1 April 2014	**12,360**	**119**	**3,107**	**15,586**
Asset financing:				
Owned	10,018	1,077	2,839	**13,934**
At 31 March 2015	**10,018**	**1,077**	**2,839**	**13,934**
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**

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	**2014/15 £000**	**2013/14 £000**
Balance at 1 April	453	1,552
Net gain/(loss) on indexation of intangible assets	78	(412)
Transfers between reserves for intangible assets	(298)	(687)
Balance at 31 March	**233**	**453**

8. Property, plant and equipment

	Information Technology £000	Furniture & Fittings £000	Total £000
Cost or valuation			
At 1 April 2014	4,662	6,878	**11,540**
Additions	1,538	557	**2,095**
Disposals	(435)	(516)	**(951)**
Impairments	11	–	**11**
Indexation	29	32	**61**
At 31 March 2015	**5,805**	**6,951**	**12,756**
Depreciation			
At 1 April 2014	(3,356)	(6,394)	**(9,750)**
Charged in year	(919)	(310)	**(1,229)**
Disposals	435	516	**951**
Impairments	(3)	–	**(3)**
Indexation	(24)	(28)	**(52)**
At 31 March 2015	**(3,867)**	**(6,216)**	**(10,083)**
Net book value at 31 March 2015	**1,938**	**735**	**2,673**
Net book value at 1 April 2014	**1,306**	**484**	**1,790**
Asset financing:			
Owned	1,938	735	**2,673**
At 31 March 2015	**1,938**	**735**	**2,673**
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**

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	2014/15 £000	2013/14 £000
Balance at 1 April	101	282
Net gain/(loss) on indexation of property, plant and equipment	9	(34)
Transfers between reserves for property, plant and equipment	(64)	(147)
Balance at 31 March	**46**	**101**

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

CQC 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, CQC 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.

CQC 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 £000	31-60 days past due £000	61 and over days past due £000
At 31 March 2015	590	2,525	485
At 31 March 2014	438	1,504	57

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. CQC did not hold any collateral as security.

c) Liquidity risk

Management aimed to manage liquidity risk through regular cash flow forecasting to ensure CQC had sufficient available funds for operations. CQC 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 CQC'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 2015 £000	31 March 2014 £000
Balance at 31 March	(25,150)	(20,008)

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 2015 CQC carried out an impairment review of all assets. The review resulted in no impairments being recognised.

All assets are revalued annually using the appropriate Office for National Statistics price index. This has resulted in upward movements in value which initially reversed previous impairments charged to expenditure with the remainder increasing the revaluation reserve.

Impairments recognised in the previous year related to the impact of applying the price index which resulted in downward movements.

	31 March 2015 £000	31 March 2014 £000
Developed software	(72)	309
Website	(14)	66
Information technology	(8)	40
Software licences	(1)	5
Total Impairments	**(95)**	**420**

11. Inventories

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

12. Trade receivables and other current assets

	31 March 2015 £000	31 March 2014 £000
Amounts falling due within one year:		
Deposits and advances	144	132
Other receivables	292	521
Prepayments and accrued income	2,330	2,006
Subtotal: Other current assets	**2,766**	**2,659**
Trade receivables	7,382	4,894
Total	**10,148**	**7,553**

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

Deposits and advances include payments on salary and staff loans which total £17k and £127k (2013/14: £2k and £130k). Staff can 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 2015 £000	31 March 2014 £000
Intra-government balances:		
Balances with central government	4	130
Balances with NHS bodies inside the Departmental Group	139	77
Balances with local authorities	281	312
Balances with public corporations and trading funds	–	48
Subtotal: intra-government balances	**424**	**567**
Balances with bodies external to government	9,724	6,986
Total	**10,148**	**7,553**

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

12.2 Movement in the allowance for doubtful debts

	2014/15 £000	2013/14 £000
Balance at 1 April	**331**	**318**
Additional losses recognised during the year	632	323
Impairment losses recognised	(126)	(58)
Amounts written off during the year as uncollectable	(75)	(88)
Amounts recovered during the year	(207)	(164)
Balance at 31 March	**555**	**331**

13. Cash and cash equivalents

	2014/15 £000	2013/14 £000
Balance at 1 April	**23,233**	**20,187**
Net change in cash and cash equivalent balances	15,954	3,046
Balance at 31 March	**39,187**	**23,233**
The following balances at 31 March were held at:		
Government banking service and cash in hand	39,187	23,233
Total balance at 31 March	**39,187**	**23,233**

14. Trade payables and other current liabilities

	31 March 2015 £000	31 March 2014 £000
Amounts falling due within one year:		
VAT	(55)	–
Other taxation and social security	(3,115)	(2,655)
Trade payables	(3,211)	(1,432)
Other payables	(3,680)	(2,877)
Accruals and deferred income	(13,405)	(11,463)
Capital creditors – intangible assets	(1,370)	(1,562)
Capital creditors – property, plant and equipment	(314)	(19)
	(25,150)	**(20,008)**
Current pension liabilities	(205)	(333)
Fee income in advance	(38,349)	(37,127)
Total current trade payables and other current liabilities	**(63,704)**	**(57,468)**
Amounts falling due after more than one year:		
Pension liabilities	(355)	(533)
Total non-current trade payables and other non-current liabilities	**(355)**	**(533)**

Trade payables at 31 March 2015 were equivalent to 17 days (31 March 2014: 14 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. CQC has financial risk policies in place to ensure that all payables are paid within the pre-agreed credit terms, and no amounts (2013/14: £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 1.30% per annum (2013/14: 1.80%) 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 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000
Intra-government balances:				
Balances with central government	(5,075)	(6,171)	–	–
Balances with NHS bodies inside the Departmental Group	(3,581)	(327)	–	–
Balances with local authorities	(1,389)	(2,572)	–	–
Balances with public corporations and trading funds	(87)	(4)	–	–
Subtotal: intra-government balances	**(10,132)**	**(9,074)**	**–**	**–**
Balances with bodies external to government	(53,572)	(48,394)	(355)	(533)
Total	**(63,704)**	**(57,468)**	**(355)**	**(533)**

15. Provisions for liabilities and charges

	2014/15			2013/14		
	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	**325**	**1,622**	**1,947**	**1,200**	**1,550**	**2,750**
Provided in year	414	803	**1,217**	179	178	**357**
Provisions not required written back	(121)	(57)	**(178)**	(254)	(19)	**(273)**
Provisions utilised in year	(57)	–	**(57)**	(800)	(48)	**(848)**
Change in discount rate	–	(18)	**(18)**	–	(27)	**(27)**
Unwinding of discount	–	(31)	**(31)**	–	(12)	**(12)**
Balance at 31 March	**561**	**2,319**	**2,880**	**325**	**1,622**	**1,947**

15.1 Analysis of expected timings of discounted cash flows

	2014/15			2013/14		
	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	561	1,100	**1,661**	325	58	**383**
Later than one year and not later than five years	-	1,219	**1,219**	-	805	**805**
Later than five years	-	-	**-**	-	759	**759**
Balance at 31 March	**561**	**2,319**	**2,880**	**325**	**1,622**	**1,947**

CQC restructured its senior management structure in 2013/14. A provision was made to cover the cost of redundancies. This provision is estimated as £0.1m (31 March 2014: £0.1m).

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 2014: £0.2m).

A provision of £0.3m has arisen in relation to an onerous contract on a property lease (31 March 2014: £nil).

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 1.5% (2013/14: 1.9%) and provisions falling due between 5 and 10 years have been increased by a discount factor of 1.05% (2013/14: 0.65%) in accordance with HM Treasury guidance.

16. Capital commitments

Contracted capital commitments at 31 March 2015, not otherwise included within these financial statements, totalled £3,264k (31 March 2014: £1,793k) and consist, in the main, of IT hardware and software developments.

	31 March 2015 £000	31 March 2014 £000
Intangible assets	3,140	1,783
Property, plant and equipment	124	10
Total	**3,264**	**1,793**

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 2015 £000	31 March 2014 £000
Buildings:		
Not later than one year	3,645	3,331
Later than one year and not later than 5 years	13,056	12,570
Later than 5 years	1,081	2,446
	17,782	**18,347**
Other:		
Not later than one year	27	46
Later than one year and not later than 5 years	–	4
Later than 5 years	–	–
	27	**50**

There were no future minimum lease payments due under finance leases at the statement of financial position date.

17.2 Lease payments recognised as an expense

	2014/15 £000	2013/14 £000
Buildings	3,899	3,527
Other	69	84
	3,968	**3,611**

18. Other financial commitments

There were no other material financial commitments at the statement of financial position date (31 March 2014: £nil).

19. Contingent liabilities disclosed under IAS 37

CQC has the following contingent liabilities:

	31 March 2015 £000	31 March 2014 £000
Civil Litigation	–	376
Employment tribunals	139	308
Prosecution	–	150
First-tier tribunal	–	85
Legal advice	–	10
Total	**139**	**929**

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, and 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	6,271	126,013	2,470	–
NHS foundation trusts	539	12,230	425	–
NHS trusts	512	8,008	514	108
NHS England	115	2	105	13
NHS special health authorities	144	–	19	2
Other non-departmental public bodies	32	233	32	16

CQC received a total amount of grant-in-aid of £126.0m (2013/14: £87.3m) 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

CQC held no third-party assets at the reporting date (31 March 2014: £nil).

22. Events after the reporting period date

There were no significant post statement of financial position events.

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CQC-285-265-WL-072015

ISBN 978-1-4741-2061-6