Care Quality Commission

Annual report and accounts
2016/17

HC 200

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Annual report and accounts 2016/17

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 18 July 2017.

HC 200

Any enquiries related to this publication should be sent to us at enquiries@cqc.org.uk.

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

Print ISBN 9781474144971

Web ISBN 9781474144988

ID 15051708 07/17

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

Who we are...

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

Our values underpin everything we do

- **EXCELLENCE**
- **CARING**
- **INTEGRITY**
- **TEAMWORK**

How we are organised

We are organised under five directorates:

- **ADULT SOCIAL CARE**
- **HOSPITALS**
- **PRIMARY MEDICAL SERVICES AND INTEGRATED CARE**
- **STRATEGY AND INTELLIGENCE**
- **CUSTOMER AND CORPORATE SERVICES**

...and what we do

Our role

Register	Monitor, inspect and rate	Enforce	Independent voice
We register health and adult social care providers.	We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.	We use our legal powers to take action where we identify poor care.	We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

We are focused on four strategic priorities

1	2	3	4
Encourage improvement, innovation and sustainability in care	Deliver an intelligence-driven approach to regulation	Promote a single shared view of quality	Improve our efficiency and effectiveness

Who we work with

- We are independent, but we report to Parliament through the Department of Health.
- We work with other regulators, local authorities and commissioning groups, health and social care organisations, and organisations that represent people who use services, including the Healthwatch network.
- Healthwatch England, the national consumer champion for users of health and social care services, is a statutory committee of CQC's Board.
- The National Guardian's Freedom to Speak Up Office (NGO) is jointly funded by CQC, NHS Improvement and NHS England. CQC's Chief Executive has responsibility as Accounting Officer for the NGO.

Performance report

1

The performance report consists of four sections:

Foreword

Peter Wyman
Chair

Sir David Behan
Chief Executive

Four years ago, we set out on the first phase of an ambitious journey to radically change the way health and adult social care in England is regulated. The past year has been a successful one for CQC, having delivered on our business plan, including completing our comprehensive inspection and ratings programme. As a result, we now have a robust baseline of quality across health and social care. We are the only country in the world to have an independent assessment of the quality of health and social care by a single regulator.

Always at the centre of our work is our clear purpose: to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage services to improve. With our programme now complete for NHS trusts, adult social care services, GP practices, out-of-hours care, urgent care, NHS 111 and the independent healthcare sector (as well as our annual inspections of 10% of dental services), we can now see the fruits of our commitment to delivering on that purpose. It has provided a strong foundation on which to build our next phase of regulation.

We want to thank our staff for the immense hard work they have put into the last 12 months and for their commitment and dedication to our purpose and values.

We want to be a catalyst for changes that improve the quality of care that people receive. Our ratings allow us to highlight improvements in care and identify excellence, as well as to see where care might not be improving. They show that when we re-inspect, most providers do improve, particularly those rated inadequate or requires improvement. If providers do not improve, we take enforcement action to protect people from poor care.

Our performance during the year has been strong and sustained in most areas. With our inspector recruitment programme now complete, our inspector workforce is in line with our plans and we have robust recruitment and retention policies in place. We also saw an increase in enforcement actions taken compared with last year, including our first four prosecutions using our new powers.

While we have made good progress in many areas, there are some areas where we need to improve. We still took too long to publish our inspection reports – we are continuing to examine how we can streamline our systems and simplify our reports to make sure people can access a report as quickly as possible after an inspection. Also, although our registration performance improved from last year and we were close to achieving our targets, we still need to do better.

Our achievements have been in the context of a reducing budget – from £249 million in 2015/16 to £236 million in 2016/17. At the same time, the main source of our funding has moved from the Department of Health to fees paid by providers.

Our budget will continue to reduce and we need to deliver our purpose with fewer resources. This year we have focused on strengthening our systems and processes to become more efficient and effective, and to ensure we can deliver value for money to the public, people who use services and their carers, and providers. We have managed to significantly reduce the cost of our inspections for the first time since 2010/11 and we will look to achieve further reductions.

We appointed a Chief Digital Officer to oversee delivery of our information management and technology strategy, setting out to overhaul our systems over the next few years. This will include putting far more of our transactions with providers online, helping to improve the information we collect and rationalising the burden, particularly in data collection and processing. Public accessibility to our data will also be enhanced.

Our annual report to Parliament, *State of Care*, signalled the changing health and social care landscape in a context of increasing demand for services and financial challenge. Our unique view across all the different types of care enabled us to highlight our concerns that adult social care services were approaching a 'tipping point'. This led to national and high-profile debates, including in Parliament, about how quality can be improved in adult social care and, in this case, discussions about additional funding for the sector.

New ways of providing care, such as online GP services and innovative solutions to managing hospital discharge processes, present us with important challenges and considerations for the way we regulate. We wish to encourage innovation while ensuring that all care, however provided, is safe and effective.

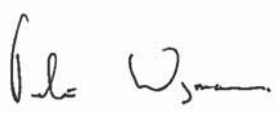
Building on our strong foundation, we have started the evolution to the next phase of our work in line with our strategy for 2016 to 2021, *Shaping the future*, which set out our vision for a more targeted, responsive and collaborative approach to regulation. We spent a large part of the year talking to members of the public, people who use services, providers and our stakeholders to help shape and develop our plans.

Our next phase of regulation of NHS trusts, alongside simpler and consolidated assessment frameworks, is being rolled out early in 2017/18 after formal consultation. Later in the year, we will begin to implement similar improvements for adult social care and primary medical services, and consult on assessing leadership and use of resources in NHS trusts in partnership with NHS Improvement. A core part of our next phase is our new CQC Insight model, which will better assess risk to the quality of care and also see where improvement has taken place, by using increased and more detailed information about providers and from people who use services.

We also took steps to work with our partners to develop a shared understanding of the quality of care, with the aim of streamlining what is required of providers. We worked with the National Quality Board to develop a shared view of quality for health care, and in adult social care we worked with partners to develop a shared framework for quality, called *Quality matters*.

The coming year will be one where we need to adapt and develop to meet the new and continued challenges in the health and social care system, while still making important organisational cost savings. Our inspection directorates will work more closely with each other during 2017/18, to look at how health and care systems work together to better serve the needs of local people.

At all times, we remain committed to acting independently and being on the side of people who use services, their families and their carers.



Peter Wyman CBE DL
Chair

David Behan CBE
Chief Executive

Progress against our strategy for 2016 to 2021

PRIORITY 1:

Encourage improvement, innovation and sustainability in care

- Continued to engage with members of the public, providers and our partners on our **next phase of regulation**, including consulting on our approach to regulating NHS trusts and our new assessment frameworks for health care and adult social care.
- Published and consulted on our principles for regulating **new models of care** and complex providers; worked with NHS England and NHS Improvement to align our approaches to new models of care; and set up named leads for each Vanguard area (including Greater Manchester).
- Developed our plans with NHS Improvement to **assess NHS trusts' use of resources**.
- Continued to **strengthen our work at a local level** to share information on how the quality of care is changing, including the Healthwatch network, complaints advocacy services and overview and scrutiny committees.
- Published reports looking at **how care is integrated across organisations**, to support improvement, including: *Building bridges, breaking barriers* – a report on care for older people; *Learning, candour and accountability* – a review of the way NHS trusts review and investigate deaths; and *A different ending* – a review of end of life care.
- Started to **strengthen how we assess how well-led providers are**, including learning from deaths.
- Developed **plans and methodology for carrying out 20 reviews of how well local health and social care services work together**, with a focus on delayed transfers of care. The reviews form part of a package of support measures to identify and support local systems that are challenged, and to ensure more joined-up working between adult social care and the NHS. We will make recommendations for how improvements could be made in each local authority area.

PRIORITY 2:

Deliver an intelligence-driven approach to regulation

- Started to trial **CQC Insight dashboards** for acute NHS hospital, mental health, GP practice and adult social care inspections, and started to consider how we could develop them to support regulating new care models.
- Worked towards a streamlined registration process by phasing out paper applications and **encouraging new providers to register using our online system**.
- Established **new partnerships to encourage people to tell us about their care** with a focus on people using adult social care, people with a learning disability and people with mental health needs.

PRIORITY 3:

Promote a single shared view of quality

- As part of the National Quality Board we published our **shared commitment to quality framework** – a nationally agreed definition of quality in health care, and guide for clinical and managerial leaders.
- Helped to facilitate, with our partners, the development of **a framework for quality in adult social care**, *Quality matters*.
- Worked with NHS Improvement and NHS England to establish **a single, shared data set**.
- Continued to work with providers to encourage them to **develop their own quality assurance frameworks based on CQC's five key questions.**

PRIORITY 4:

Improve our efficiency and effectiveness

- Introduced our **national resource planning system, Cygnum,** to help improve our efficiency by bringing together all the information inspectors need to plan their inspections.
- Reduced the **average cost** of our inspections.
- Started to develop a **user-needs approach to digital development** to engage better with the public.
- **Published our innovation plan,** which sets out how we will innovate and encourage others.
- Worked towards meeting our **equality objectives** for **2015 to 2017**, including considering the Workforce Race Equality Standard (WRES) in all NHS trust inspections under the well-led key question.

Performance summary

2016/17 was a successful year in which we achieved a number of important milestones in line with an ambitious business plan. We:

- completed our comprehensive inspections and ratings programme
- improved efficiency in our systems and processes to achieve financial savings and better value for money
- identified improvements to speed up the publication of inspection reports – we are taking action on this in 2017/18
- improved our registration efficiency in the context of an increased demand for registration
- sustained a strong inspector workforce and established a robust assessment and recruitment process
- took more enforcement action to protect people from poor care
- launched our new strategy for 2016 to 2021 and started to consult on our next phase of regulation.

Comprehensive inspections and ratings programme

During the year we reached a significant milestone when we completed our comprehensive inspections and ratings programme. This achievement means that, for the first time, we have a baseline of the quality of health and social care in England, drawn from more than 45,000 inspections since the start of our new approach.

We completed first ratings inspections across all our main sectors – NHS trusts, adult social care services, GP practices, out-of-hours care, urgent care, NHS 111, and the independent healthcare sector – of all services registered at the start of the programme. We also completed our annual programme of dental inspections.

Our ratings enable us to measure improvement in the quality of care and to highlight where services may not be improving or where care is deteriorating. When we go back to re-inspect we find that most providers do improve, particularly those rated inadequate or requires improvement. During the year we re-inspected a total of 4,864 services following an inadequate or requires improvement rating. The majority (53%) improved their rating. This compares with 44% in 2015/16.

The breadth and depth of information that we now have about the quality of care means we are increasingly able to speak confidently with our independent voice. Our *State of Care* report for 2016/17 highlighted how adult social care was approaching a 'tipping point' and how this was impacting on the rest of the system. This led to national and high-profile debates (including in Parliament) about how quality can be improved in adult social care and its funding arrangements. We have also published a number of important thematic reviews, such as our investigation of deaths and our end of life care review.

Engaging with providers, the public and other stakeholders is an important part of how we encourage improvement. In 2016/17 our website attracted 64 million page visits from 9.3 million users, we spoke at 334 events and we issued more than 1,000 press releases to support the publication of inspection reports, corporate reviews and other major announcements.

Efficiency in our systems and processes to achieve financial savings and better value for money

We have successfully delivered savings through our cost improvement programme, and with a reduced budget. At the same time, our funding has moved from grant-in-aid from the Department of Health to fees paid by providers.

Our revenue expenditure in 2016/17 was £226.2 million (excluding depreciation), which was £12.4 million less than the £238.6 million we spent last year. This is the first year since 2011 where we have spent less than the previous year. We also achieved a lower average cost for inspections during the year compared with 2015/16.

These expenditure and cost savings have been possible with a continued focus on strengthening and improving our systems and processes to be more efficient and achieve better value for money. We focused on good budget management, driving out better value from supplier contracts, and completing an infrastructure strategy in 2015/16.

We have invested in new digital systems that will help drive efficiencies in the future – for example our new national resource planning tool, Cygnum, which will improve the way we manage and schedule our inspection activities. However, there is a lot more to do in our digital transformation.

We also improved our customer service centre to create a better experience for customers. We developed new tools and training for staff to help us listen and respond better.

We aim to continue making savings year-on-year, becoming a more effective regulator with as low a cost base as possible by 2019/20 in line with our spending review target of £217 million.

Improvements needed to the speed with which we publish inspection reports

It is very important that inspection reports are published to a high quality, and as quickly as possible to ensure members of the public can make decisions about care, and providers understand what they need to do to if they have to improve. However, publishing inspection reports within agreed timescales remained a significant challenge during the year.

We have, however, seen some notable improvement when compared with last year. In the Adult Social Care directorate there was a consistent upwards trend in most months. Although the number of published reports increased from the previous year by 16% (from 13,368 to 15,519), we improved performance from 67% published within 50 days in 2015/16 to 80% in 2016/17. In the Primary Medical Services directorate, 60% were published on time, an improvement from 2015/16 when 50% were published on time. This performance was in a context of a 41% increase in the volume of reports, from 3,759 in 2015/16 to 5,301 in 2016/17. In the Hospitals directorate there was some improvement in most teams in the average time taken to publish reports.

We acknowledge this is an area for continued improvement and are committed to taking action on this in 2017/18.

We commissioned an external review of our systems and processes. This took place towards the end of 2016/17 and identified a range of efficiency recommendations that we will deliver on during the year ahead. These focused on:

- making improvements to our post-inspection processes, particularly around quality control and assurance
- training and developing our staff and addressing skills gaps
- exploring longer-term transformation of our supporting systems to enable full digital delivery of report publishing.

Improved our registration efficiency in the context of an increased demand for registration

In the context of an increase in demand for registration, we continued to strengthen our registration function to ensure providers are clear what they need to do to meet standards of care, and to make registration an even more effective barrier to poor care. We saw sustained efficiency over the year, moving from 74% of registration processes completed in quarter 1 to 86% in quarter 4. We came close to completing 90% of registration processes within 50 days. However, we still have more improvements to make to meet our target. We are continuing to develop better approaches to improve registration and to measure its effectiveness.

Sustained a strong inspector workforce and established a robust assessment and recruitment process

After meeting our inspector recruitment target last year, our inspection staff numbers have remained strong throughout the year. We have established robust assessment and recruitment processes, and the number of inspection staff in post has been consistently above 90% establishment.

Took more enforcement action to protect people from poor care

When we find poor care, we act quickly and effectively to protect people. We took more enforcement action this year than last year (1,910 compared with 1,090 actions) and, since receiving new powers to prosecute in April 2015, we strengthened the capacity of our staff and improved our enforcement recording processes. We also took our first enforcement action against two online providers of primary care, protecting the public regardless of how they access care.

When we find serious failings in care, we recommend that providers are put in special measures – 740 providers were placed in special measures and 657 exited special measures. Of those that exited, 470 did so because they had made substantial improvement.

Our new strategy for 2016 to 2021 and our next phase of regulation

In May 2016 we launched our new five-year strategy, signalling the evolution of our approach to regulation. It set out an ambitious vision for a more targeted, responsive and collaborative approach, so that more people get high-quality care.

We worked closely with people who use services, providers and stakeholders to shape this next phase, which will be more intelligence-driven. We developed and started to test data dashboards as part of our new CQC Insight model. CQC Insight will make better use of information from people who use services by better analysing comments and concerns, and integrating feedback from local partners and stakeholders.

We began collaborating with providers and partners to develop a single shared view of quality, which aims to help reduce the burden of regulation on providers. This included publishing our shared commitment to quality framework as part of our work with the National Quality Board – a nationally agreed definition of quality in health care, and guide for clinical and managerial leaders. And, with our partners, we helped to facilitate the development of a framework for quality in adult social care, *Quality matters*, which will publish in summer 2017.

We worked with partners on our plans for aligning our approach to regulating new models of care. We consulted on the principles of our new approach to these providers, with plans to test these next year.

Performance analysis

1 How we measure our performance

We measure our performance using a range of key performance indicators (figure 1) and strategic measures to track our efficiency, effectiveness and impact. We then report to CQC's Board, the public, partners and stakeholders, the Department of Health and the Parliamentary committees who scrutinise our work and to whom we are accountable.

Much of our reporting is aligned to our operating model which forms the structure of the work we do.

Register	Monitor, inspect and rate	Enforce	Independent voice
We register health and adult social care providers.	We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.	We use our legal powers to take action where we identify poor care.	We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our key performance indicators

Figure 1: Key performance indicators 2016/17

KPI	2016/17 target	2016/17 actual	2015/16 actual	Pg
Registration				
Registration processes completed within 50 days (new, variation, cancellation)	90%	79%	77%	20
Inspection				
Inspections (first comprehensive rating) undertaken versus plan	100%	All targets met. See figure 6	n/a	31
Inspection report publishing time – Adult Social Care directorate within 50 days	90%	80%	67%	33
Inspection report publishing time – Primary Medical Services directorate within 50 days	70% from Q1 90% by Q4	60%	50%	33
Inspection report publishing time – Hospitals within 50 days (independent health and focused NHS inspections of less than 3 core services)	70% from Q2 90% by Q3	16%	n/a	33
Inspection report publishing time – Hospitals within 65 days (NHS inspections of 3 or more core services)	70% from Q2 90% by Q3	12%	n/a	33
Mental Health Act Reviewer visits – planned visits completed each quarter	90%	93%	93%	38
Second Opinion Appointed Doctor (SOAD) visits undertaken within target time:				38
Medicine	95%	88%	89%	
Electroconvulsive therapy	95%	53%	65%	
Community treatment orders	95%	71%	74%	
Responding to information				
Safeguarding alerts referred to a safeguarding authority within 0-1 days	95%	98%	n/a	28
Safeguarding alerts and concerns had one of four possible mandatory actions taken in 0-5 days	95%	85%	n/a	28
Q1-Q3: Complaints about CQC (old process, 1 April to 31 October 2016):				37
% upheld at stage 1	<20%	24%	17%	
% progressed to stage 2	<20%	27%	21%	
% upheld at stage 2	<20%	15%	26%	

KPI	2016/17 target	2016/17 actual	2015/16 actual	Pg
Q3-Q4: Complaints about CQC first line resolutions and investigations (new process, 1 November 2016 to 31 March 2017):				37
Personal acknowledgements sent within 3 days	90%	79%	n/a	
First line resolutions (actions agreed) within 7 days	85%	80%	n/a	
Investigations completed within 30 days	80%	82%	n/a	
CQC complaints upheld/partially upheld by the Parliamentary and Health Service Ombudsman (PHSO)	<3%	1%	n/a	
General calls answered in 30 seconds	80%	81%	78%	29
Safeguarding calls answered in 30 seconds	90%	90%	91%	29
Mental health calls answered in 30 seconds	90%	90%	92%	29
Correspondence answered in 10 days	90%	95%	91%	29
Our people				
Sickness	<5%	3.8%	3.5%	53
Staff survey engagement index score	>1% increase	63%	65%	52
Finance and business plan				
Variance from revenue and capital budget (includes achieving efficiency savings by directorate)	0%			
Revenue*		£14.1m (6%) under budget (actual £221.8m)	£13.4m (5%) under budget (actual £236.1m)	63
Capital		£6.7m (52%) under budget (actual £6.3m)	£6.5m (38%) under budget (actual £10.5m)	65
Business plan milestones (key deliverables published in our business plan) with significant issues (that is, rated red or amber-red)	<25% each quarter	9%	n/a	

*Note: Actual revenue figures in both years are stated prior to adjustments required for the financial statements (see Statement of Comprehensive Net Expenditure, page 128).

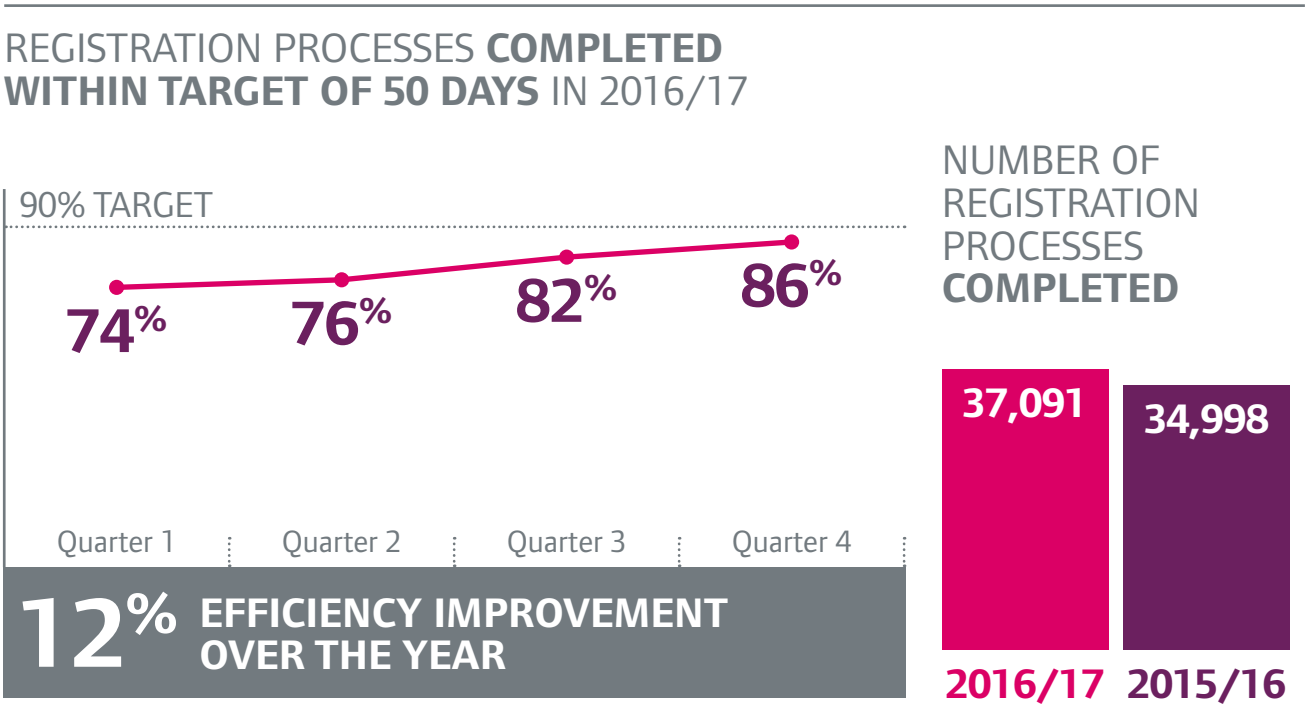
Risk management

CQC manages a range of strategic and operational risks to the delivery of its purpose. We report on these in our public Board meetings, setting out a risk rating for each risk and the mitigating actions being carried out to manage them. In April 2017 we reviewed these risks, our mitigations and our risk tolerance statement with the Board. We added new risks as part of our business plan for 2017/18 and we re-rated our risks, ensuring we have plans in place to manage them. Our risks cover the following areas:

- **Encouraging improvement** – risk that we do not have impact in encouraging improvement, innovation and sustainability in care.
- **Quality** – risk that we do not implement our operating model effectively because we do not encourage people who use services, their relatives and carers to engage with CQC; or we do not respond quickly and effectively to public concerns; or we do not make accurate, insightful, reliable, timely, cost-effective and legal regulatory decisions.
- **Implementing our strategy** – risk that we do not effectively collect and process the information we need to be an effective, intelligence-driven regulator and accurately predict quality; or that we fail to implement an agile approach to emerging and new models of care.
- **Information management and technology** – risk that we are unable to deliver our strategy because we are not well supported by IT technologies and systems; or there is a cyber security incident/attack causing service disruption or a major data security alert.
- **Our people** – risk that we fail to respond adequately where our people feel we are not developing a high-performing culture and embedding our values.
- **Financial** – risk that we are unable to reduce our costs in line with our reduced budget and that fees from providers are not received in a timely way.

A full list of risks and mitigating actions is published on our website and the references to risk management are in the Governance statement on page 96.

2 Registering health and care services



Providers that want to register with CQC need to assure us that the services they provide are of high quality and are safe for the people who use them. All providers of health and social care that carry out regulated activities must register with CQC.

Registration efficiency

Our registration performance was below target during 2016/17. However, there was a sustained improvement in efficiency over the year, in the context of an overall increase in registration activity. The improvement can be linked with our continued work to strengthen our registration function to make registration a more effective barrier to poor providers.

Our registration work involves three types of process – new registrations, cancellations and variations. During 2016/17 we completed a total of 37,091 registration processes. This is a 5% increase in activity from 2015/16, when we completed 34,998 processes.

Our target is that 90% of registration processes are completed within 50 days. We saw sustained improvement every quarter across all directorates, moving from 74% in quarter 1 to 86% in quarter 4. The average time for a new registration process reduced from 50 to 44 days between quarters 1 and 4 – an efficiency improvement of 12%.

Despite this improvement, we still have further work to do to improve our registration approach to meet our target. Across the year as a whole, the Adult Social Care registration team was at 79% of target, and the Hospitals and Primary Medical Services registration teams were both at 80%.

We aligned our registration teams by sector in April 2016 to encourage better joint working between registration and inspection teams, and to develop staff expertise in each sector. We have improved our ways of working to respond more effectively to alerts about unregistered providers. We are also reducing the time taken to complete registration by phasing out paper applications for new registrations and encouraging new providers to use our online system. These changes have helped to drive the improvements we have seen. We are continuing to develop better approaches to improve the process of registration and to measure the effectiveness of registration as well as our performance.

Importantly, our registration application form is being developed to make it more straightforward for providers. Of those providers and newly registered managers who responded to our January to December 2016 post-registration survey, 85% (2,900), found the application form easy to use.

In June 2017, following consultation with providers, members of the public and stakeholders, we published our updated *Registering the right support* policy. The policy sets out our expectation that the underpinning principles of choice, promotion of independence and inclusion for individuals are fundamental to what a good service looks like for every person with a learning disability and/or autism. It explains how providers should register or vary the registration of their service in line with the national plan and agreed model of care. We launched a consultation on our next phase of registration improvement in June 2017. We asked for feedback on our intentions to register providers who are ultimately responsible for the quality and safety of services and to improve the information we use to describe services that carry on a regulated activity.

Shared view of quality

We began collaborating with providers and partners to develop a single shared view of quality which should help reduce the burden of regulation on providers. For example, we:

- Published, as part of the National Quality Board, our shared commitment to quality framework – a nationally agreed definition of quality in health care, and guide for clinical and managerial leaders.
- Helped to facilitate, with our partners, the development of a framework for quality in adult social care – *Quality matters* – a single definition of quality and a shared set of quality priorities in adult social care. It will publish in summer 2017. It sets out a commitment to high-quality, person-centred adult social care and, building on the partnerships and commitments that we have made before, sets out a clear action plan. As part of this, CQC with Skills for Care, will engage with

other organisations, and lead work to agree a common dataset for quality in adult social care.

- Worked with the General Medical Council, the Nursing and Midwifery Council, the Health and Care Professions Council and other professional regulators to improve information sharing. This was supported by a workshop with professional regulators which resulted in two key workstreams on data sharing and an escalation protocol. This work will continue in 2017/18.
- Worked with NHS Improvement and NHS England to establish a single, shared data set. We also worked on patient safety issues; reviewed how NHS trusts investigate and learn from deaths; and agreed a joint well-led framework and a joint 'use of resources' approach with NHS Improvement.
- Continued to work with providers to encourage them to develop their own quality assurance frameworks based on CQC's five key questions, and to share this information with us regularly. We have seen examples of this happening in some NHS trusts and large corporate care providers.

New models of care

We established a CQC cross-sector working group and a CQC Insight working group to focus on new models of care, and we explored how we could assess the quality of care of those providers. We have:

- Worked with NHS Improvement and NHS England to learn from their work on new models, and to find ways to work together and align our approach.
- Co-produced and consulted on the principles for our approach to regulating new models as part of our next phase of regulation, and started to plan how to test our approach next year.
- Started to consider how we could develop CQC Insight to support regulating new care models.
- Engaged with Vanguard areas and other providers developing new models of care to learn about their work. This has helped to inform our next phase approach, and to think through the implications across CQC's operating model.
- Worked with Greater Manchester on their plans for devolution.

We have also published updated guidance for providers on how to register new models of care and we are updating our registration processes to be flexible to registering new models of care, such as digital providers.

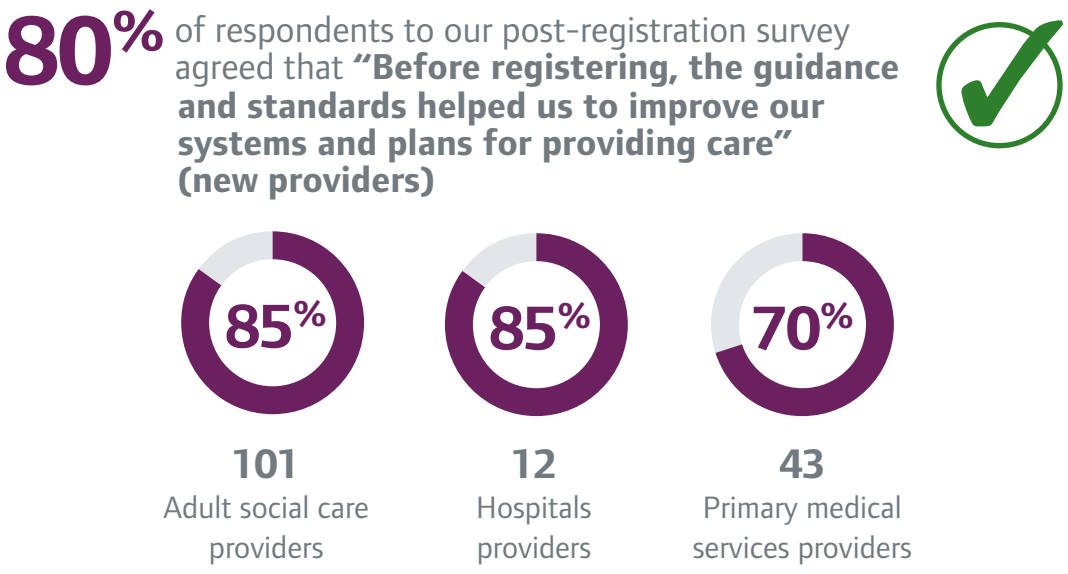
Impact

The guidance we provide at registration is making it clear to providers what they can do to improve care to meet our quality standards. In our January to December 2016 post-registration survey, the majority (80%) of new providers who responded, agreed that CQC guidance and standards helped them to improve their systems and plans for providing care (figure 2). Hospitals and adult social care providers were particularly positive, with 85% of respondents agreeing. For primary medical services providers, 70% of those who responded to the survey agreed, although when looking at only GP practices this dropped to 54% (7 out of 13 respondents). Improvements around systems and plans for openness and transparency, and recruitment checks were commonly mentioned.

"Our organisation has developed a 'Duty of Candour' policy to help with this. We have organised more relatives and residents meetings to facilitate open discussion."

(Adult social care provider)

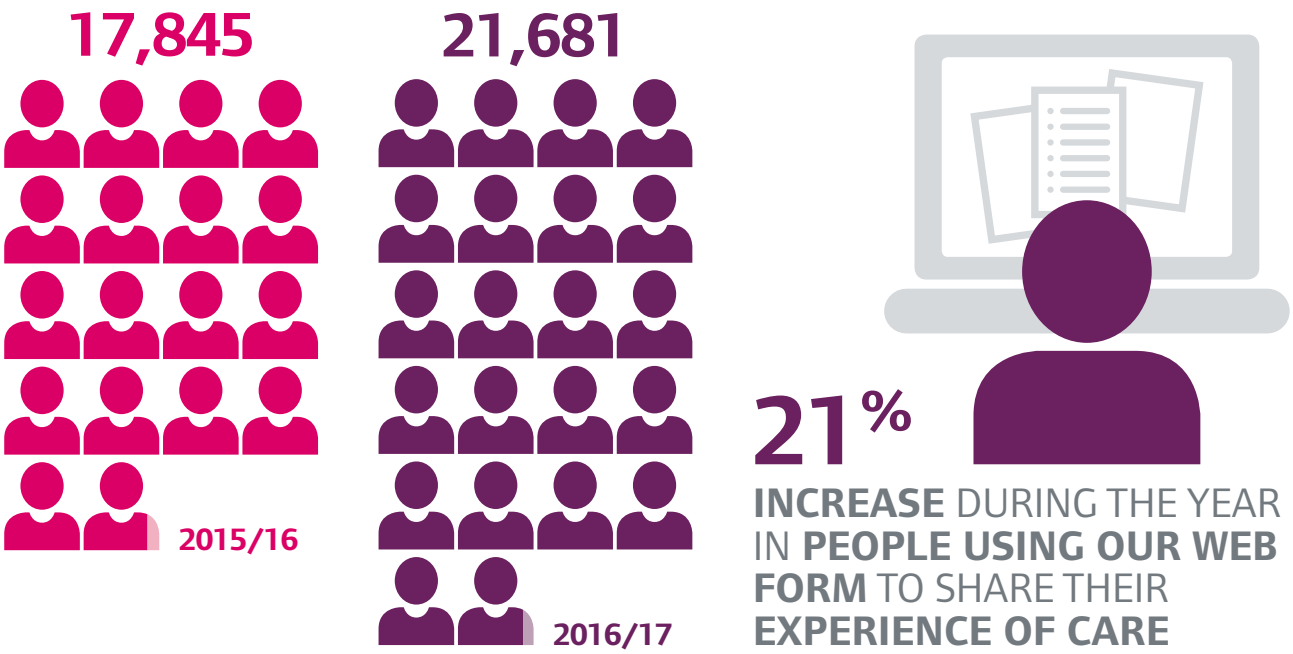
Figure 2: Preparing to register



Source: Respondents to post-registration survey (January to December 2016)

Completing the application is helping providers to think through how they deliver care. Most providers and newly registered managers (75%) who responded to our survey agreed that the application helped them to think about their plans to deliver care. By sector, this was 77% (1,207) of adult social care respondents, 66% (76) of hospitals respondents and 71% (248) of primary medical services respondents.

3 Monitoring quality



We monitor, gather and analyse data and insight from a wide range of sources to help give us a clear picture of where to inspect, and how to target and tailor our inspections appropriately. The information includes data from providers, feedback or concerns about care from the public and people who use services, and information from staff working in services.

Performance

CQC Insight

We started to develop our new CQC Insight model that will better highlight information of concern, so that we know what specific areas to target during our inspections. Part of this will be an even greater focus on information that we receive from people who use services.

We developed and trialled CQC Insight data dashboards for acute NHS trusts, mental health, GP practices and adult social care inspections, as well as for registration. These dashboards are a source of data and information for inspectors and contain information from providers, the public, and a range of other sources so that they can monitor services. We are continuing to refine, test and develop the dashboards further as we receive feedback from users. We developed an 'intelligence hub' – a central system that draws together multiple data sources from the dashboards. The hub provides efficiency benefits for managing data and allows much more flexible access for our analysts.

We also invested in a new IT system for analysing qualitative (text-based) data from the public and people who use services. Once this automated system is in use, it will enable us to analyse a much larger amount of qualitative data and get more quickly to a picture of people's views of care.

In December 2016 we appointed a Chief Digital Officer in a new role working across CQC and NHS Improvement to develop and streamline our information technology. An important focus for this role is to prioritise strategic projects and improve the range of information and data we collect, while also finding ways to reduce the burden of data collection on providers.

Focus on CQC Insight

CQC Insight is grounded in our learning from our previous Intelligent Monitoring work and from our baseline of information from our ratings inspections. It is designed to have a much greater focus on information that links with our ratings, including predicting areas where there may be problems. It will make better use of information from people who use services by analysing qualitative text-based comments and concerns, and integrating feedback from local partners and stakeholders. The result will be a more detailed understanding of specific services and groups of people that use them, along with better analysis of trends over time.

Market oversight

We continued to monitor the financial sustainability of large, hard-to-replace adult social care providers through our market oversight scheme. We are required to notify relevant local authorities if a provider is likely to experience business failure, and services are likely to cease as a result. As at 31 March 2017, there were 51 providers in the scheme.

From the financial information submitted by each provider, we have found that care at home (domiciliary care) has the most financial challenges. We have seen a sustained level of large, corporate providers handing back contracts as they have been unable to continue operating with limited finances.

Care homes appear to be more resilient to financial pressure, but they still experienced an overall decline in profit margins. For both sectors, the main pressures are from increased staff costs, and the National Living Wage increases continue to add additional pressure to certain providers.

Listening to people

Listening to the views of people using services and care staff providing those services is an integral part of our approach to monitoring the quality of care.

We heard directly from people who shared an experience of care with us – both positive experiences and concerns. People share experiences by email, by phone or through our dedicated web form. During the year we saw an increase in people using the web form, with 21,681 sharing their experience in this way. This was a 21% increase from 2015/16 when the figure was 17,845.

In response to the share your experience forms submitted, 485 scheduled inspections were brought forward and 112 urgent responsive inspections were carried out.

We worked with a wide range of partners – commissioners, the Healthwatch network, complaints advocacy services, overview and scrutiny committees, foundation trust councils of governors, patient participation groups, and the voluntary and community sectors – to learn more about people's views of care.

Our 'Tell us about your care' programme, where we invest in partnerships with organisations that work with and represent people using services and carers, increases our access to people's experiences of care on an ongoing basis. During the year we worked with Age UK, Carers UK, Mind, NSPCC, Patients Association and the Relatives and Residents Association. We established new contracts with Disability Rights UK and the National Autistic Society to hear more from people using adult social care, people with a learning disability and/or autism and people with mental health needs. We also consulted on and co-produced our new public engagement strategy for 2017 to 2021, which sets out our plans to continue and strengthen our public engagement.

Responsive inspection of an adult social care provider

A member of the public shared their experience with CQC about a residential social care provider in the north east of the country in January 2017. The caller had urgent concerns about someone they cared for who had received care or treatment at the service. A CQC inspector used the evidence to contact the provider and seek a response. They also raised a safeguarding alert with the local authority. The evidence resulted in CQC carrying out a responsive inspection.

Inspection brought forward of a dental provider

A member of the public complained to CQC about a Hampshire-based dental provider in January 2017. The caller wanted CQC to share their experiences with the service and with any other organisation, and was also planning to complain direct to the provider. A CQC inspector used the evidence to bring the scheduled inspection forward and contacted the caller for further information.

We made significant investment in our Experts by Experience programme. In 2016/17 we invested approximately £5 million in the programme, compared with £2 million in 2013/14. This reflects the value we place on the individual expertise that Experts by Experience bring to our inspections, policies, strategies and training of our own staff.

During the year we used our research into the needs of our website users to design tailored content and social media campaigns. We ran four unique campaigns inviting older people, carers, people with invisible long-term conditions and people with a mental health illness to share their experiences. We also worked closely with voluntary and community organisations to reach out to groups of people whose voices are often not heard. For example, we ran a project to hear from people with a learning disability, and another project to engage with people in the criminal justice system.

It is very important that staff who work in health and care services feel able to share information or concerns about the care they see and deliver. The new National Guardian, Dr Henrietta Hughes, started work in October 2016. She is responsible for leading cultural change and building a network of Freedom to Speak Up Guardians across NHS secondary care providers to enable staff to speak up and raise concerns. The role is independent, but we host it on behalf of NHS England, NHS Improvement and CQC.

Responding to concerns

Responding to information of concern is a high priority. We received 76,634 contacts in 2016/17 relating to information of concern, compared with 80,567 in 2015/16. Of the contacts received, 42% (31,826) were safeguarding concerns, 0.2% (158) were safeguarding alerts, 49% (37,217) were complaints about providers and 10% (7,433) were whistleblowing.

We exceeded our target of referring 95% of safeguarding alerts (alerts are the most urgent issues where we are the first statutory agency to be informed) to the safeguarding authority within one day. However, our target for taking mandatory action on all safeguarding allegations (alerts and concerns) after referral within five days was not met and was at 85% at the end of the year (figure 3).

Figure 3: Safeguarding alerts and concerns 2016/17 – first actions taken

Safeguarding action	Target	2016/17 actual
Alerts triaged to inspector within 0-1 days	95%	99% (143)
Concerns triaged to inspector within 0-1 days	95%	95% (31,730)
Alerts referred to a safeguarding authority within 0-1 days	95%	98% (589)
One of four mandatory actions for alerts and concerns to be taken in 0-5 days	95%	85% (95,684)

Note: A new KPI for safeguarding alerts and concerns was introduced part-way through 2015/16 so previous year figures are not comparable.

We also review all complaints made to us about the way providers exercise their powers and duties under the Mental Health Act (MHA). During 2016/17 we received 2,353 MHA complaints, and total contacts (consisting of new complaints, enquiries and follow-ups to complaints) were 7,413. We will report fully on these in autumn 2017 in our annual *Monitoring the Mental Health Act* report.

A better experience for customers

We improved our customer service centre to ensure a better experience for customers. We developed a range of new customer service tools and associated training for staff. We are improving how we listen, explain and respond to the views of people who use services and those who represent them, providers and stakeholders.

In 2015 we surveyed 230 people who had been in contact with CQC before this improvement work, and then again in 2017 after the work had been completed. The second survey saw a range of improvements, with highlights being an increase in respondents who said the professionalism of the person they spoke to was excellent (56% in 2015 to 71% in 2017) and an increase in respondents who said that CQC explained their role and helped them to understand it completely (8% increase from 2015, up to 60% saying they understood it completely) (figure 4).

Customer service performance was consistent during this period of change. We received 213,527 calls and we met our targets for answering calls within 30 seconds. Our general call performance improved from 2015/16, as did our performance in responding to correspondence (emails and letters) (figure 5).

Figure 4: Did CQC explain their role to you and did you understand it?

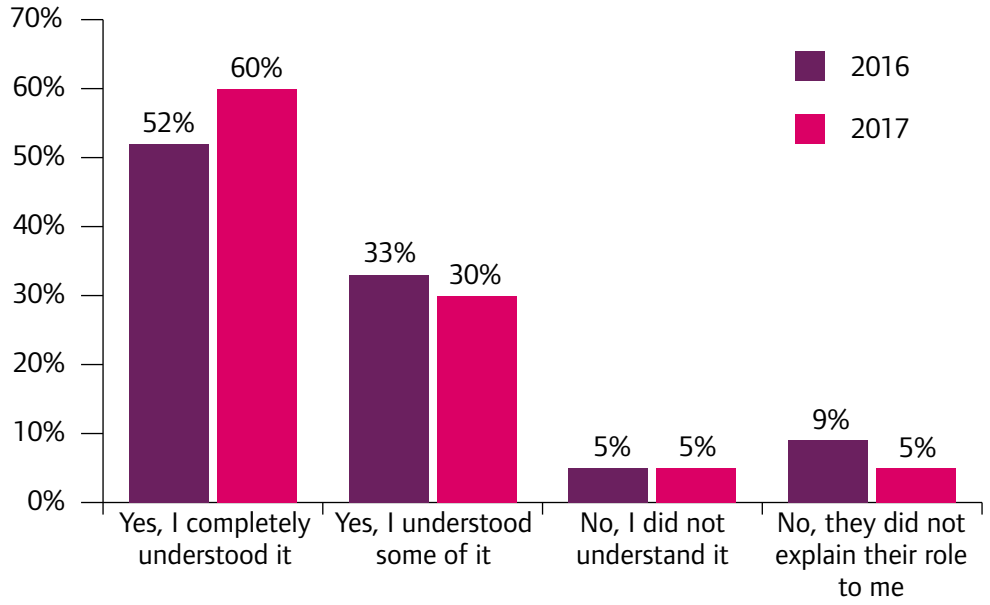


Figure 5: National customer service centre call handling and correspondence

	Target	2016/17	2015/16
General calls answered in 30 seconds	80%	81%	78%
Safeguarding calls answered in 30 seconds	90%	90%	91%
Mental health calls answered in 30 seconds	90%	90%	92%
Correspondence answered in 10 days	90%	95%	91%

Impact

The primary aims of our monitoring work are to ensure that people who use services are not at risk of poor quality care and are protected from harm, and to help us to promote and encourage improvement. In our July to September 2016 survey of CQC's inspection staff, we asked if staff felt they had enough good quality information to assess the risk of a service before inspection. The majority (76%) of CQC inspectors and inspection managers who responded across the sectors agreed completely, or to a large or moderate extent, that they had enough good quality information.

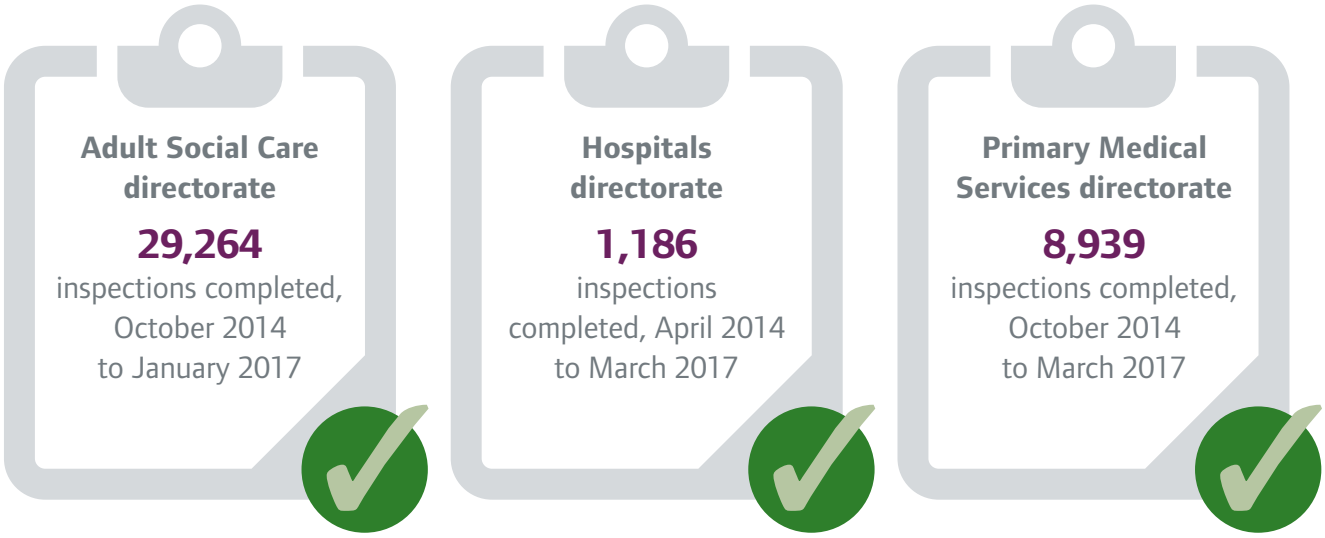
Our provider information request (PIR) is an important way for us to gather information about a service and decide which areas to prioritise during our inspections. It also helps to encourage improvement. In our January to December 2016 post-inspection survey, 67% of providers who responded agreed that the process of gathering information for the PIR helped them to identify areas for improvement.

"The PIR provides me with a good springboard for self-reflection and thinking about the service that is provided."

(Adult social care provider)

4 Inspecting and rating

OUR BASELINE OF CARE QUALITY – COMPLETION OF OUR FIRST RATINGS INSPECTION PROGRAMME



We inspect health and care services to understand the quality of care that people are receiving. We check to make sure services are providing safe, effective, caring, responsive and well-led care, and we monitor the use of specific Acts of Parliament and regulations.

We then publish what we find, including quality ratings, so that people can clearly understand the quality of care of a particular service, and can choose the right one for them. Our ratings of outstanding, good, requires improvement or inadequate help to encourage providers to improve.

Performance

Inspection programme

We have reached an important milestone in our inspection programme which started in 2013. We completed our programme of first ratings inspections across all of our main sectors – NHS trusts, adult social care services, GP practices, out-of-hours care, urgent care, NHS 111 and the independent healthcare sector by the end of the year – of all services registered at the start of the programme. Since we started our new approach to inspection, we have carried out more than 45,000 inspections (including comprehensive inspections, re-inspections and focused inspections when we have specific concerns, and our annual programme of dental inspections where we inspect 10% of registered dental locations) (figure 6). We are the only country in the world to have an independent assessment of the quality of health and social care by a single regulator.

This means that for the first time we have a baseline of the quality of health and social care in England. As we continue to inspect new providers and return to re-inspect providers, we can now do so against a robust benchmark.

Figure 6: Completion of our inspections and ratings programme, as at 31 March 2017*

	Comprehensive programme inspections completed*	Programme started and completed	Total inspections completed (incl. focused and re-inspections)
Adult Social Care directorate	**29,264**	**Oct 14 to Jan 17**	**33,413**
Residential adult social care	21,518	Oct 14 to Jan 17	24,846
Community-based adult social care	7,530	Oct 14 to Jan 17	8,340
Hospice services	216	Oct 14 to Jan 17	227
Hospitals directorate	**1,186**	**April 14 to March 17**	**1,707**
Acute hospital (NHS non-specialist)	175	April 14 to March 16	303
Acute hospital (NHS specialist)	19	Jan 15 to March 16	25
Acute hospital (independent)	219	April 15 to March 17	284
Ambulance service providers (NHS)	14	Jan 15 to June 16	18
Community health providers (NHS)	21	Oct 14 to June 16	30
Community health providers (independent)	137	Oct 14 to March 17	149
Community substance misuse providers	105	April 15 to Dec 16	131
Mental health – community and residential providers (NHS)	85	Oct 14 to June 16	132
Mental health – community and residential providers (independent)	210	Oct 14 to Dec 16	379
Residential substance misuse providers	151	April 15 to Dec 16	178
Termination of pregnancy (independent)	50	April 16 to June 16	78

Figure 6 continues on next page.

	Comprehensive programme inspections completed*	Programme started and completed	Total inspections completed (incl. focused and re-inspections)
Primary Medical Services and Integrated Care directorate	**8,939**	**Oct 14 to March 17**	**9,885**
Dental care locations (2016/17 only)**	1,116	Annual programme	1,116
GP practices	7,705	Oct 14 to Jan 17	8,644
GP out-of-hours services	65	Oct 14 to March 17	67
Remote clinical advice services	4	April 15 to March 17	4
Urgent care services and mobile doctors	49	April 15 to March 17	54

Note:

*These numbers will include some inspections where reports were not published by the end of the financial year 2016/17. The numbers cover inspections of all services registered at the start of the programme; some are services that have had an inspection but have since de-registered. For the Hospitals directorate, the numbers include some inspections that were 'pilot' inspections where we tested our new regulatory models before the start of our new approach.

**We inspect but do not rate dental practices – this figure is our annual commitment to inspect 10% of all dental practices.

We have continued to involve people who use or have used services in our inspections. During 2016/17, there were 7,580 instances of Experts by Experience supporting CQC inspections. We acknowledge there have been some difficulties with this contract during the year. Our current contracts will come to an end next year and during 2017/18 we will undertake the procurement for new contracts to deliver this important service. We will ensure that appropriate time is allowed to develop our requirements, engage with stakeholders and for public procurement compliance. Although improvements have been made this year, we acknowledge further improvements are needed if CQC is to learn the lessons from the previous contracts as it procures new contracts. We will engage with people who use services and their carers, CQC staff and stakeholder organisations to ensure our Experts by Experience programme continues to support our inspection activity.

Inspection report publishing time

It is very important that inspection reports are published to a high-quality, and as quickly as possible to ensure members of the public can make decisions about care, and providers understand what they have to do to if they need to improve. However, publishing inspection reports within agreed timescales remained a significant challenge during the year.

We have, however, seen some notable improvement when compared with last year (figure 7). In the Adult Social Care directorate, there was a consistent upwards trend in most months. Although the number of published reports increased from the previous year by 16% (from 13,368 to 15,519), we improved performance from 67% published within 50 days in 2015/16 to 80% in 2016/17. The average days to publish reports fell in each quarter this year, from 42 days in quarter 4 of 2015/16

to 39 days in quarter 4 of 2016/17. In the Primary Medical Services directorate, 60% were published on time, an improvement from 2015/16 when 50% were published on time. This performance was in a context of a 41% increase in the volume of reports, from 3,759 in 2015/16 to 5,301 in 2016/17. In the Hospitals directorate there was some improvement in most teams in the average time taken to publish reports.

We acknowledge this is an area for continued improvement and are committed to taking action on this in 2017/18. We commissioned an external review of our systems and processes, which took place towards the end of 2016/17, and identified a range of efficiency recommendations that we will deliver on during the year ahead. These focused on:

- making improvements to our post-inspection processes, particularly around quality control and assurance
- training and developing our staff and addressing skills gaps
- exploring longer-term transformation of our supporting systems to enable full digital delivery of report publishing.

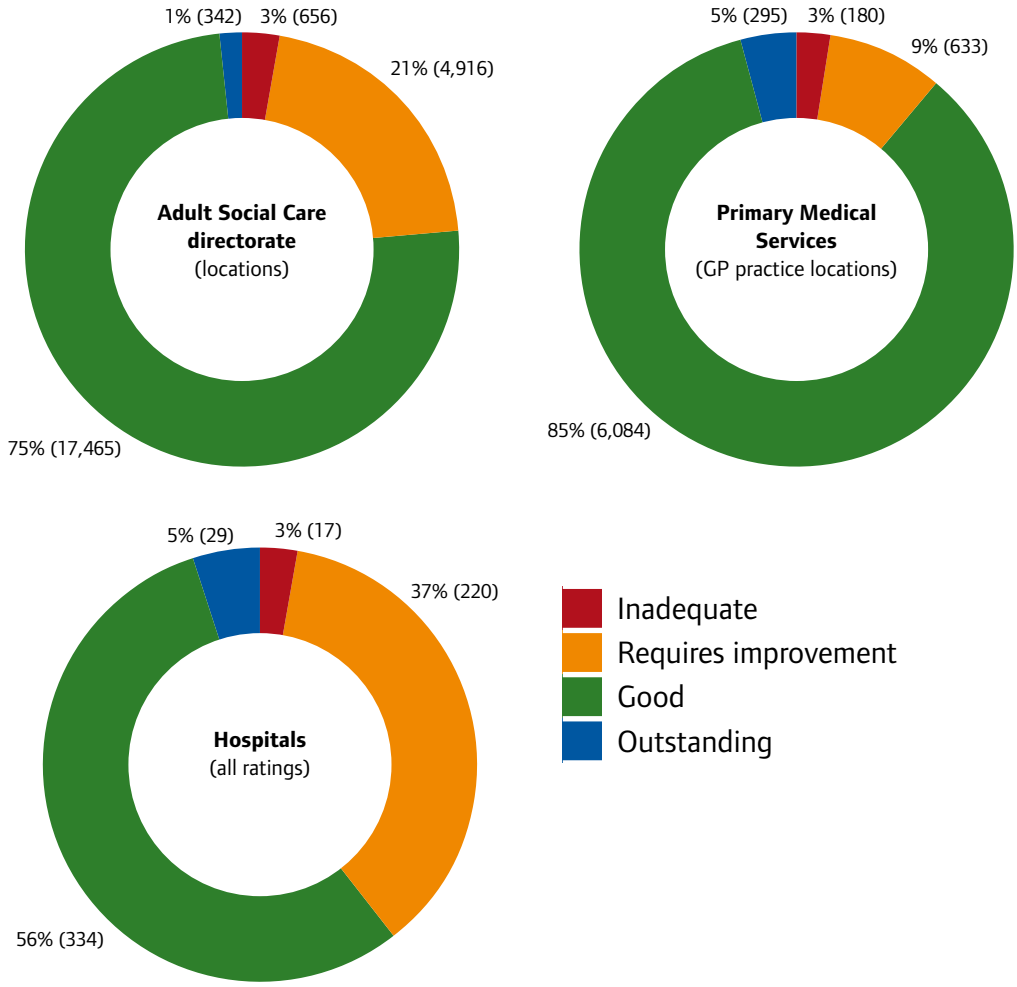
Figure 7: Inspection reports publishing time 2016/17

	Percentage of inspection reports published within 50 days 2016/17 – target of 90% (for hospitals with 3 or more core services, target is 65 days)	Percentage of inspection reports published within 50 days 2015/16 – target of 90%
Adult Social Care directorate	80% (15,519)	67% (13,368)
Hospitals directorate (independent health and focused NHS inspections of less than 3 core services)	16% (746)	n/a – 2015/16 measure not comparable
Hospitals directorate (NHS inspections of 3 or more core services)	12% (41)	n/a – 2015/16 measure not comparable
Primary Medical Services directorate	60% (5,301)	50% (3,759)

Ratings

Since we started rating, as at 31 March 2017 we have rated a total of 23,379 adult social care locations, 600 NHS and independent healthcare locations and trusts (including mental health) and 7,192 GP practices (figure 8). Overall, most services are providing good care. Although we have now met our inspection programme commitments, we continue to rate newly registered services.

Figure 8: Ratings as at 31 March 2017



Notes:

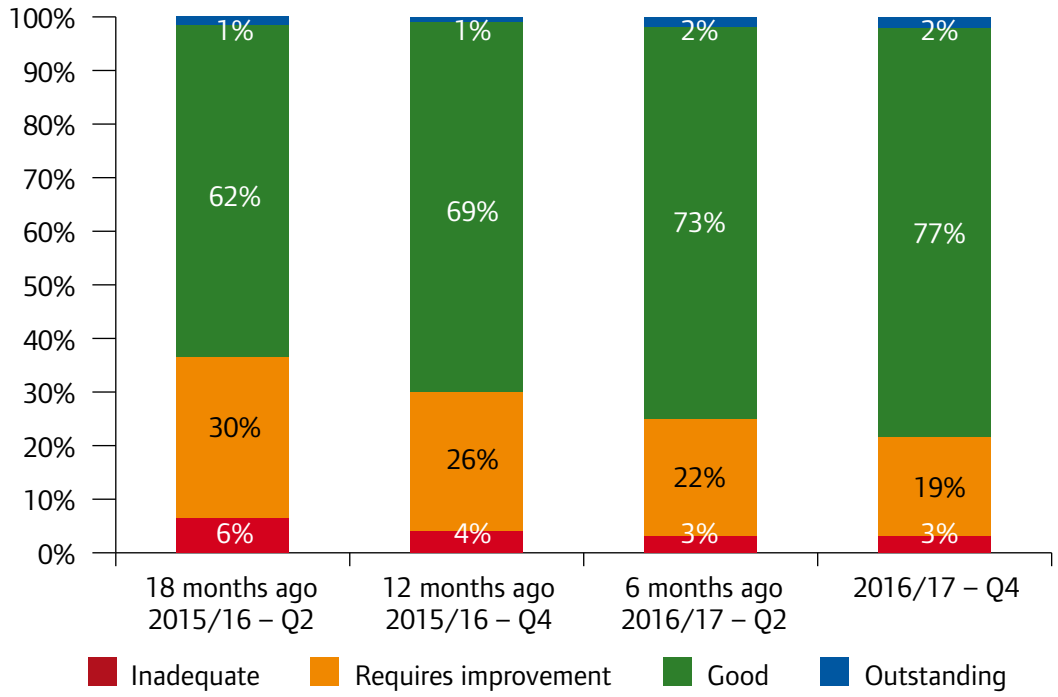
1 These ratings figures include providers and locations where we inspected and then published an inspection report. During the year, small numbers may merge or close; as a result, not all of the providers and locations included in these ratings figures will still be providing services.

2 The ratings shown have been aggregated to an overall level. Due to the differences between the size and type of organisations in each sector, different levels of aggregation of ratings are used to derive the overall ratings. More aggregation will lead to a greater dominance of requires improvement ratings.

3 Hospitals directorate ratings include: NHS and independent acute healthcare locations, and NHS mental health and community trusts.

During the course of the ratings programme, the proportion of good and outstanding ratings across all directorates has increased – in quarter 2 of 2015/16 the overall proportion was 63% and this had increased to 79% by the end of 2016/17. The proportion of requires improvement ratings also decreased from 30% to 19% over the same period. The proportion of inadequate ratings had a slight decrease from 6% to 3% (figure 9). There are two main reasons for this improvement – risk-based inspection (we inspected poorer services first) and also the fact that services do generally tend to improve their rating when they are re-inspected.

Figure 9: Distribution of overall ratings over 18 months, 2015/16 quarter 2 to 2016/17 quarter 4



Note: These ratings figures include providers and locations where we inspected and then published an inspection report. During the year, small numbers may merge or close; as a result, not all of the providers and locations included in these ratings figures will still be providing services.

We rate at a number of different levels depending on the sector, as it is important for us to look at quality in different ways. In adult social care we rate just at location level (such as the care home or care service). We rate GP practices at location level (the GP practice) and by population group (such as the quality of services for older people or for people living with long-term conditions). We rate hospitals at provider level (usually NHS trust), at location level (hospital) and at core service level (such as maternity and gynaecology services, or outpatient services). We calculate an acute trust rating by aggregating the ratings of each hospital or service in a trust. To get to that hospital location rating, we aggregate the ratings of the core services within that hospital. As a result, the ratings picture in the hospitals sector can look different depending on the level of the rating. For example, if there are a few core services that are rated requires improvement or inadequate, this will have the effect of lowering the overall hospital trust rating.

Our next phase of regulation

With our first ratings and inspections programme complete, we are already underway with developing our next phase of regulation, as set out in our five-year strategy that started in May 2016.

We developed and co-produced our next phase proposals in partnership with the public, people who use services, providers and stakeholders. We then asked for views on the first of three consultations, and we also consulted jointly with NHS

Improvement on our approach to assessing leadership and use of resources in NHS trusts.

In June 2017 we published:

- two new streamlined assessment frameworks for health care and adult social care, which have been consolidated from 11 separate assessment frameworks
- updated guidance for NHS trust providers
- strengthened guidance for registering services for people with a learning disability and/or autism
- our principles for new models of care.

Our second consultation, launched in June 2017, focuses on changes to our regulation of adult social care and primary medical services, among other areas of regulation. Our third consultation will launch later in 2017/18 and will focus on independent health care.

Complaints about CQC

Every complaint raised with CQC provides an opportunity to learn and improve. This year, the highest category of complaints that we received related to inspector performance and conduct issues. Examples included the tone and attitude of inspection staff during visits; the general competency of the inspection team around evidence collection; and potential bias and pre-conceived ideas of the service or looking for the negatives. Other themes included administration and how we handled information about registered services. We encourage staff to learn from complaints, and in some cases we offer additional training and guidance.

In November 2016, we implemented a new single end-to-end process to improve the quality and speed of investigations of complaints about CQC. We created a new national complaints team to provide a greater level of personal customer contact. The process is clearer and more transparent and aims for a more efficient approach to the consistency and quality of investigations and follow-up of actions.

During 2016/17, we received fewer complaints than last year: 413 compared with 441 and 15% fewer than in 2014/15. The performance indicators between the old and new processes have changed, and are not directly comparable.

Under the new process, more complaints have been fully or partially upheld, which reflects greater independence in the review of cases, as well as a changing culture across teams to acknowledge and respond to mistakes as they seek to continuously improve. Teams also improved their handling of complaints using CQC's responding to concerns principles, and there was more effective triaging and early resolution of complaints by the National Complaints team. For example, in 80% of cases we agreed a set of actions with the customer against a target of 85% under first line resolution.

We saw good performance in completing investigations within 30 days under the new process. Since November, 82% of all investigations have been completed within that timeframe; this is above our target of 80%. Additionally, only 1% of all cases progressed to the Parliamentary and Health Service Ombudsman in this reporting year. Two cases were partially upheld in quarter 4.

We also continued to report using our previous complaints process up to the end of October 2016. During this time we received a total of 263 stage 1 complaints. Of these, 58 were upheld.

Improving as a result of a complaint

We received a complaint about the provider information return (PIR) form – the person who complained said that while the form was now online, it was still not easy to work through.

We added this feedback to other feedback received along similar lines and this has been fed into the requirements for our new PIR system. We are addressing it as part of the technical improvements to the system, and we are carrying out further testing with providers.

Other inspections, visits and monitoring

People detained under the Mental Health Act

We are responsible for keeping the Mental Health Act 1983 (MHA) under review. The MHA protects people who are detained and ensures they have the right to challenge poor care.

In 2016/17 we carried out 1,264 MHA Reviewer visits. This was 93% of planned visits and above our target of 90% (figure 10).

We also carry out Second Opinion Appointed Doctor (SOAD) visits to review treatments that have been recommended to patients who lack the capacity to consent or are refusing that treatment. They ensure the rights and choices of those patients are protected.

At the end of the year, the number of SOAD visits carried out within agreed timescales was below target, particularly visits relating to electroconvulsive therapy which can rely heavily on external logistical factors. We are working to better manage visit requests from providers using our new online portal. We also continue to work on recruitment and retention of SOADs to increase their availability across the country to carry out visits.

Figure 10: MHA Reviewer and SOAD visits 2016/17

Type of visit	2016/17 target	2016/17 visits	2015/16 visits
MHA Reviewer visits	90% within timescale	1,264 (93%)	1,348 (93%)
SOAD visits – medicine	95% within timescale	3,575 (88%)	3,181 (89%)
SOAD visits – electroconvulsive therapy	95% within timescale	380 (53%)	390 (65%)
SOAD visits – community treatment orders	95% within timescale	154 (71%)	244 (74%)

Multi-agency inspections

Children and young people have the right to be protected from abuse and exploitation and to have their health and welfare safeguarded. We continued to review the effectiveness of healthcare services for safeguarding children and young people, and the quality of healthcare services for looked after children, carrying out 22 inspections in 2016/17.

In 2016/17, we carried out eight joint targeted area inspections with our partner inspectorates Ofsted, HMI Prisons, HMI Constabulary and HMI Probation, evaluating the effectiveness of multi-agency safeguarding arrangements, as well as conducting thematic reviews into child sexual exploitation and domestic violence. We completed more than 30 joint inspections with Ofsted, evaluating how well health, education and social care were working together to meet the needs of children and young people with special educational needs and disability. Our July 2016 *Not seen, not heard* review looked at child safeguarding and health care for looked after children. It identified that more needs to be done to identify children at risk, and that children must have good access to emotional and mental health support as they transition from child to adult services. It also emphasised the importance of the child's voice in care planning, and that the overall focus should be on better outcomes for children.

Inspection of health and social care services within criminal justice and immigration detention settings is an important aspect of regulation. It ensures that disadvantaged and vulnerable people receive care that meets their needs and is equal in quality to that available to the wider population. We inspected 39 prisons and two immigration removal centres; 40% of these inspections resulted in requirement notices, which are being followed up through re-inspections to ensure improvements are made. We completed the national inspection programme of youth offending services, led by HMI Probation. We inspected five services and continue to support adult probation service inspections. With Ofsted and HMI Prisons we inspected the three secure training centres for young people. We supported six inspections of police custody, jointly with HMI Constabulary and HMI Prisons.

Medical ionising radiation

We are responsible for enforcing the Ionising Radiation (Medical Exposure) Regulations 2000 in England, across NHS and independent hospitals and primary care (including dental and chiropractic care). These regulations protect patients from unintended, excessive or incorrect exposure to medical radiation, including radiology, radiotherapy and nuclear medicine.

During 2016, we received a total of 1,319 notifications where radiation exposure was 'much greater than intended'. This was an increase of 3% since 2015 and continues the trend for a year-on-year increase. This indicates better awareness and a stronger reporting culture among clinical departments. The number should be viewed in the context of the millions of medical exposures that take place each year.

Controlled drugs

We are responsible for making sure that health and social care providers, and other regulators, maintain a safe environment for managing controlled drugs in England. We continued to maintain oversight over how controlled drug local intelligence networks are working, and ensured they were effectively reporting and investigating trends and concerns. We kept the register of controlled drug accountable officers up-to-date and led the National Group on Controlled Drugs, meeting with the group three times.

Impact

Re-inspections

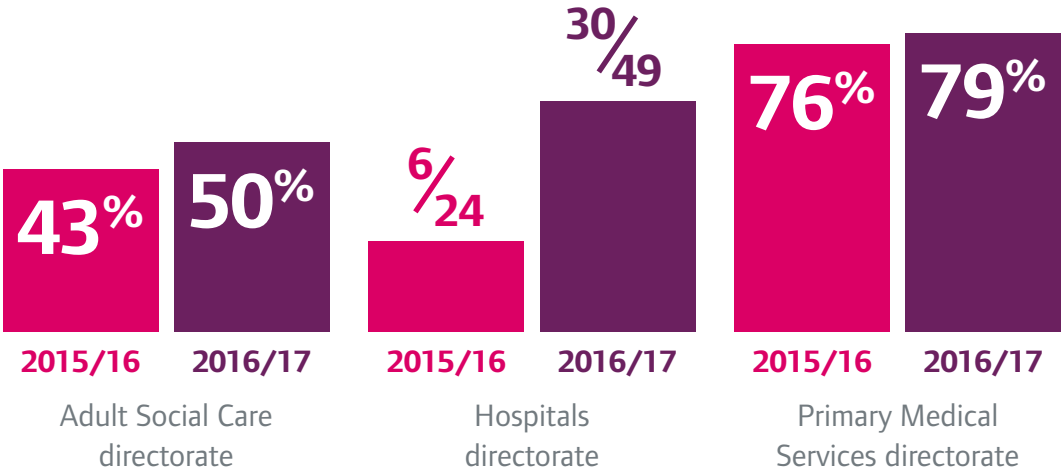
When we go back to re-inspect providers and find changes that result in an improved rating, this is a good indication that our inspections are having an impact on the quality of care.

During 2016/17, we re-inspected a total of 4,864 services following a rating of inadequate or requires improvement. The majority (53%) improved their rating. This compares with 44% in 2015/16.

Looking at all services and providers re-inspected in 2016/17 after an inadequate rating (758), 58% improved their rating to requires improvement, 13% improved to good and 29% stayed the same. Of those rated requires improvement and re-inspected (4,106), 49% improved to good and six services improved to outstanding, but a substantial minority (42%) remained the same.

Looking at the sectors, 4,358 adult social care locations were re-inspected; of these, 50% improved their rating. We re-inspected 457 GP practices and the majority of these (79%) improved their rating. We also re-inspected 49 hospital trusts and 30 (61%) improved their ratings (figure 11). The majority of services that did not improve their rating stayed the same, although a minority (8% of adult social care locations and 5% of GP practices) did receive a lower rating.

Figure 11: Providers that improved their rating on re-inspection, 2016/17



Changes made by providers as a result of our inspections process

Our inspection process is designed to encourage providers to improve. We have found that inspection is most likely to drive improvement among providers rated inadequate or requires improvement (figure 12). In our post-inspection survey for January to December 2016, we found that common changes made by providers as a result of the inspection process included changes to record-keeping, medicines management and staff recruitment checks, many of which we would expect to have a strong impact on safety.

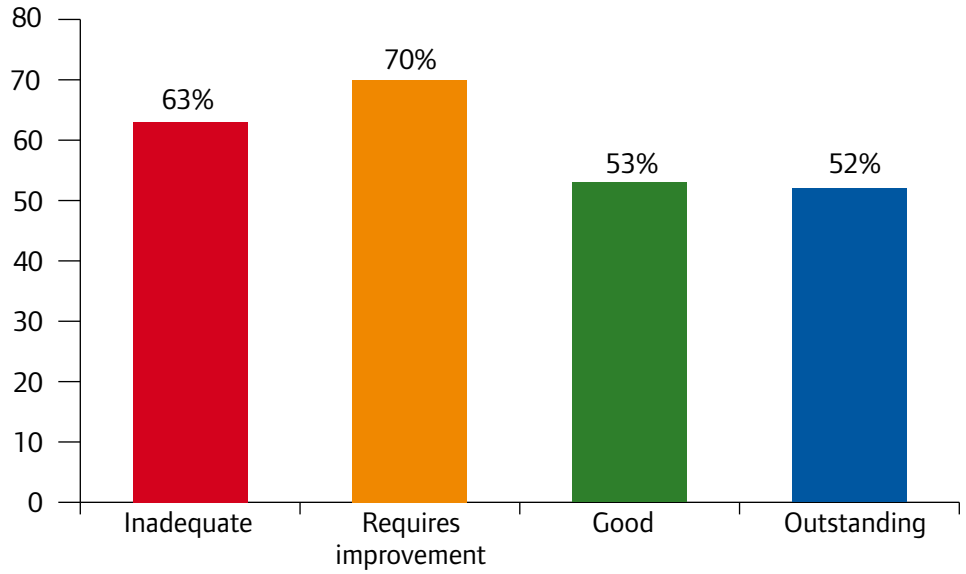
"A new falls risk assessment has been introduced. A paper-light pressure ulcer risk assessment has been developed and is set to be introduced as part of a new electronic nursing record system later this year."

(NHS trust)

"We have implemented a new system of medication following inspection. Following advice we have consulted with our chemist suppliers, installed new medication cabinets and methods of dispensing as well as medicine administration record sheets being formulated by the chemist."

(Adult social care provider)

Figure 12: Percentage of providers telling us they have made changes as a result of inspection, by rating



Source: Respondents to post-inspection survey (January to December 2016)

Guidance and standards

Most providers who responded to our post-inspection survey felt the guidance and standards from CQC helped them to improve quality in their services, with 81% agreeing. By sector, this was 87% (3,405) of adult social care respondents, 63% (927) of primary medical services respondents and 86% (147) of hospitals respondents.

"Publications available from CQC give the staff clear guidelines of what is expected during the inspection, the five key questions and what we are doing to evidence this. The factual information is detailed clearly and its importance has helped me to explain to my staff what is expected of them and why we do what we do, and the way we do it."

(Adult social care provider)

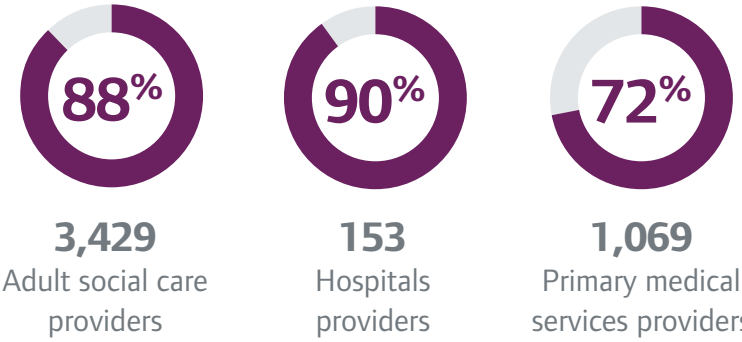
Inspection visit

Most providers who responded to our post-inspection survey also felt the inspection visit helped them to reflect on how they could improve (84%). By sector, this was 88% (3,429) of adult social care providers, 90% (153) of hospitals providers and 73% (1,069) of primary medical services providers (figure 13).

The majority of respondents (71%, 2,838) said that, after the inspection, they made immediate changes as a result of feedback.

Figure 13: Improving after inspection

84% of respondents to our post-inspection survey agreed that **"The inspection visit helped us to reflect on how we could improve our service"**



Source: Respondents to post-inspection survey (January to December 2016)

The ratings

We have seen that our ratings encourage providers to improve. In our post-inspection survey, 72% (2,837) of providers who responded, who had been rated good or outstanding, said the rating had motivated staff, compared with 33% (362) of providers rated requires improvement or inadequate. Providers who felt ratings motivated their staff mentioned various reasons for this. Some said they were given a good understanding of what they were doing well, what still needed to be done to improve, and a clear benchmark of quality.

"The 'good' overall rating has provided us with a benchmark about the standard of our performance and has become our prompt for pursuing excellence. Our staff have been highly motivated to learn that they are doing the right thing and their hard work is appreciated."

(Adult social care provider)

"The ratings gave a true reflection of the areas we had identified to improve and also where we were working well."

(Primary medical services provider)

In our post-inspection survey, we asked 388 providers who had received an improved rating (since their previous inspection) what had encouraged or enabled their improvement. They cited the rating they received, the inspection report and the inspection visit as three of the main reasons. For those in special measures, this was also found to be a key factor in encouraging or enabling their improvement.

"The whole CQC process has been positive. The visit identified areas that we were non-compliant with and required improvement. We were very disappointed with the result and immediately put measures in place to improve the areas in which we failed."

(Primary medical services provider)

Inspection report

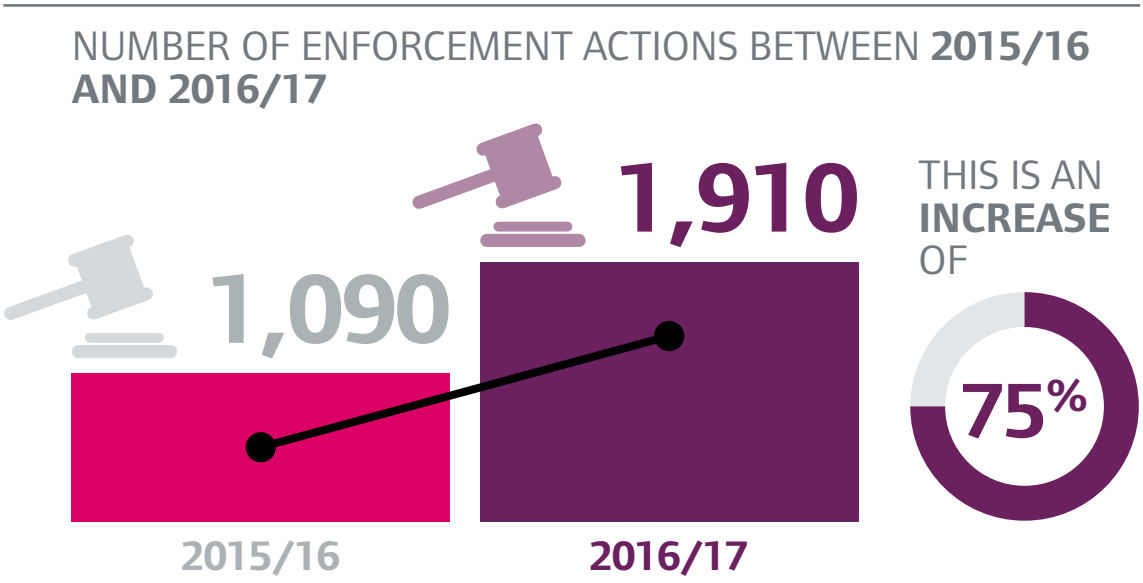
The majority of providers who responded to our post-inspection survey said that the inspection report helped them to take action to improve their service (76%). By sector, this was 80% (3,140) of adult social care respondents, 87% (148) of hospitals respondents and 64% (934) of primary medical services respondents.

We check to find out if people accessing inspection reports on our website can find them easily, can understand them, and find them useful. In 2016/17 our website survey results showed similar results for all three questions compared with 2015/16. We found that:

- 84% of people looking at an inspection report on our website said that it was easy or very easy to find
- 84% of people looking at an inspection report on our website said that the information in it was easy or very easy to understand
- 91% of people looking at an inspection report on our website reported that it was very or somewhat useful.

We continue to work to improve our website, including making it more accessible to navigate and for people to find the information they need.

5 Enforcement and protecting people



A core part of our role is to protect people from poor care. We do this by taking enforcement action when needed, and also by encouraging an open and transparent culture so people can report concerns easily.

Performance

Enforcement action

We have taken much more enforcement action this year compared with the previous year, and we have been strengthening the capacity of our staff since receiving new powers in April 2015.

We took 1,910 enforcement actions in 2016/17, compared with 1,090 in the previous year (figure 14). This is a 75% increase and follows significant work to improve and streamline our enforcement processes and build a more intuitive system that is better able to record enforcement activity. This shows we are using the powers given to us by Parliament. We have also invested in more training for enforcement staff to develop confidence and capability. As at 31 March 2017, there were 1,271 enforcement actions in progress but not yet concluded.

Of the actions taken, the majority were Warning Notices (1,352). We brought our first four successful prosecutions against adult social care providers following new enforcement powers given to us in April 2015. It is important that we are able to use these powers to hold providers to account when they put people at risk of poor care.

Sometimes our interventions can also lead to providers cancelling their registration voluntarily.

We also took our first urgent enforcement action against providers of digital primary care to protect people using those services. We published guidance to clarify how we will regulate digital health care and reminded providers that the same safeguards should be in place for patients whether they attend a physical consultation with their GP or seek medical advice and treatment online.

Figure 14: Enforcement action in 2016/17

Action	Adult Social Care directorate	Hospitals directorate	Primary Medical Services directorate	Total actions
Warning Notices	1,095	116	141	1,352
Non-urgent cancellations of registration	99	4	22	125
Urgent procedure for suspension, variation or imposition or removal of conditions	87	13	59	159
Non-urgent variation or imposition or removal of conditions	174	0	37	211
Fixed penalty notices	50	2	3	55
Prosecutions	4	0	1	5
Urgent cancellations	3	0	0	3
2016/17 overall enforcement actions	**1,512**	**135**	**263**	**1,910**
2015/16 overall enforcement actions	901	58	131	1,090
2014/15 overall enforcement actions	1,057	40	82	1,179

Special measures

We recommend that providers are put in special measures when we find serious failings in care, and it is an important part of our framework to make sure services improve.

At the start of the year there were 464 providers or locations in special measures. During the year we put 740 providers or locations into special measures: 575 adult social care locations, four NHS trusts, six independent hospital locations and 155 GP practices. At the end of the year, there were 547 providers/locations remaining in special measures. Note that some of those exiting had entered special measures in the previous year.

Of the 657 that exited special measures, 470 did so because they had made substantial improvement (figure 15).

Figure 15: Special measures activity 2016/17

2016/17 activity	Adult Social Care directorate	Hospitals directorate (trusts)	Hospitals directorate (independent health)	Primary Medical Services (GP practices) directorate
Providers/locations in special measures at the start of the year = 464				
Entrants	575	4	6	155
In special measures (at year end)	395	15	7	130
Exits	519	5	0	133
Of which: De-registered	74	0	0	30
Sufficient improvements	376	5	0	89
Registration cancelled	69	0	0	14
Providers/locations in special measures at the end of the year = 547				

Fit and proper person and duty of candour

We review the fit and proper person requirement (FPPR) Regulation 5 during our inspections to ensure that providers have the right systems and processes in place for recruiting directors of appropriate character, physical ability, skill and experience. We started to consult on some changes to our approach to FPPR in June 2017. These proposed changes consider the way we share information with providers when we receive information of concern about a director. We are also consulting on a more detailed interpretation of serious mismanagement and serious misconduct. This will be included in future guidance.

We also review FPPR Regulation 19 to ensure that providers have the right systems and processes in place for recruiting all staff employed in the organisation.

We check that providers are meeting the duty of candour (Regulation 20), which means being open and honest with people using services when something goes wrong and they experience harm. They should have the right systems and processes in place to make sure this happens.

Management review records are created when we believe that there is a risk to the quality of care or there has been an incident. The records capture the information we have, and we then undertake management review meetings to consider the information and decide what steps to take. These meetings look at the overall picture of a provider and as part of those meetings we look at FPPR and duty of candour – these are just one element of a much broader discussion (figure 16). In 2016/17 there were 688 management review records created that then led to 901 meetings. FPPR was included in 645 records and duty of candour was included in 73.

Figure 16: Fit and proper person requirement and duty of candour discussed as part of management review records, 2016/17

Directorate or team	% FPPR: employed and FPPR: directors, discussed	% duty of candour, discussed
Adult Social Care directorate	66%	64%
Hospitals directorate	9%	26%
Primary Medical Services directorate	20%	3%
Registration teams	5%	7%

Impact

We asked providers if enforcement is an effective deterrent and if it can help to encourage compliance. Of those who responded to our January 2017 annual provider survey (sent to all providers), 61% thought it was an effective deterrent to poor care. By sector, 74% of adult social care providers and 72% of hospitals providers thought it was a deterrent. In primary medical services the figure was lower at 42% (figure 17). Although most respondents felt it could be an effective deterrent, some also emphasised the importance of taking a proportionate approach.

Figure 17: Impact of enforcement

61% of respondents to our annual provider survey agreed that **"the prospect of enforcement action is an effective deterrent to encourage compliance?"**

2,180
Adult social care providers

659
Hospitals providers

1,098
Primary medical services providers

Source: Annual provider survey, January 2017

Of all the services we inspect, there are a number that struggle to improve quickly and remain in breach of the regulations under the Health and Social Care Act 2008 for longer periods. At the end of the year, there were 4,337 adult social locations that were in breach of the regulations. Of these, 1,666 (38%) had been in breach for more than a year. There were also 1,025 primary medical services locations in breach. Of these, 295 (29%) had been in breach for more than a year (note that this figure may also include some providers that are waiting for re-inspection). There is ongoing work to ensure that actions plans are in place for all those in breach and for the majority there are planned re-inspections. Those in breach for more than a year are prioritised for inspection. If after this they receive an overall rating of inadequate, they will go into special measures.

6 Using our independent voice

INFLUENCE OF SELECTED CQC REPORTS

Better care in my hands

1,212
respondents said they took action to make changes after reading

A different ending

1,083
respondents said they took action to make changes after reading

State of Care 2015/16

774
respondents said they took action to make changes after reading

Source: Annual provider survey 2017

As we have developed our comprehensive baseline understanding of the quality of care in England, we are increasingly able to speak with confidence using our independent voice across a range of issues.

Performance

We published a range of reports reflecting our findings and deeper understanding of health and social care. We also developed a robust internal process and working group for assessing new thematic reviews and reports.

In October 2016, we published our *State of Care* report – our major review of the quality of health and social care in England, which we present every year to Parliament. The report highlighted particularly how adult social care was approaching a 'tipping point' and how this was impacting on the rest of the system. This led to national and high-profile debates (including in Parliament) about how quality can be improved in adult social care and its funding arrangements. The report also emphasised the need for strong leadership and collaboration to ensure quality is maintained and services improve. Included in the report this year was our annual equality information relating to health and social care services that we regulate, and our annual report on our monitoring of the use of the Deprivation of Liberty Safeguards.

We also published a number of other thematic reports:

- *Learning, candour and accountability* – our report on the way NHS trusts review and investigate the deaths of patients.
- *My diabetes, my care* – a report on people's experiences of diabetes care and the support they are given to self-manage their condition.
- Report on neonatal care – a review of how risks for newborn babies are identified and managed, and of the care for infants in the community who need respiratory support.
- *Not seen, not heard* – a review of the arrangements for child safeguarding and health care for looked after children in England.
- *Safe data, safe care* – a review of whether personal health and care information is being used safely and is appropriately protected in the NHS.
- *Building bridges, breaking barriers* – a report on how well care for older people is integrated across health and social care, and the impact of this on older people who use services and their families and carers.
- *Better care in my hands* – a review of how people are involved in their care and what better involvement looks like.
- *A different ending* – a review looking at inequalities in end of life care for specific groups of people.

Impact

Many providers do make changes to services as a result of reading our publications. In our January 2017 annual provider survey, we found that providers mentioned some reports more frequently than others when we asked if a list of our reports were of interest to their organisation. The three reports of most interest were: *Better care in my hands*, 41% (2,418) of respondents found it of interest; *State of Care 2015/16* (39%, 2,250); and *A different ending* (38%, 2,263).

We also found that some providers had taken action to make changes as a result of reading our reports. Of those who found *Better care in my hands* of interest, 52% (1,212) took action to make changes. For *State of Care* it was 36% (774) and for *A different ending* it was 49% (1,083).*

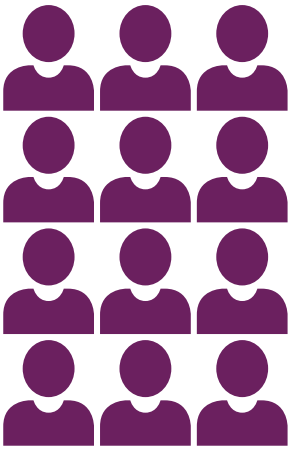
Of those that took action as a result of these three reports, more than 80% said they had seen improvements in care as a result: 86% (1,012) for *Better care in my hands*, 80% (594) for *State of Care* and 86% (900) for *A different ending*.*

* Not all respondents who answered the first question went on to answer each subsequent question.

The way we engage with providers, the public and other stakeholders is an important part of how we can make an impact. In 2016/17, we directly and indirectly engaged with people in a number of ways:

- CQC's website attracted 64 million page visits from 9.3 million users.
- CQC was represented at 334 speaking events and 24 exhibitions, reaching an audience of more than 50,000 people.
- In 2016/17, we logged 1,207 enquiries from the media and 245 confirmed broadcast interviews. We issued 1,055 press releases, which supported the publication of inspection reports, corporate publications and other major announcements, and we featured in 5,702 pieces of coverage.

7 Our people, capabilities and culture



OUR STAFF SURVEY

- **HIGHER RESPONSE RATE** THAN LAST YEAR
- **STAFF ENGAGEMENT SCORE OF 63%**
- **87% OF RESPONDENTS** AGREED THAT THEIR LINE MANAGER TRUSTS THEM TO DO THEIR JOB
- **75% OF RESPONDENTS** AGREED THAT THEY FEEL FULLY INVOLVED IN THEIR PERFORMANCE AND DEVELOPMENT REVIEWS

Promoting a positive organisational culture and ensuring our people feel supported and well-equipped to do their jobs is very important.

Engaging with staff

Our annual staff survey enables all CQC employees to share how they feel about working for CQC. The results for 2016 reflect an organisation that has created a solid foundation and started to build a strong platform for the future. The survey had a higher response rate than last year and we had a staff engagement score of 63%. This compares with a score of 65% in 2015/16, but remains above the public sector benchmark.

Our staff survey tells us that people who work at CQC believe we make a positive difference and we are aligned to our purpose. There were positive responses around line management and performance management – 87% of respondents agreed that their line manager trusts them to do their job and 75% agreed that they feel fully involved in their performance and development reviews (up 6% from last year). Other areas, including communications, managing change and access to learning, were clear areas for improvement – for instance just 28% agreed that changes are effectively implemented. There was also a sense that there should be clearer direction and leadership.

To respond to the results, we have carried out a series of around 120 in-depth interviews to listen to staff and learn more about what we can do to better shape the future of CQC. These are being followed up by a series of staff events and team meetings to discuss what we have learned from the interviews. We are focused on three main areas:

- Culture and leadership – providing ownership of the organisational culture at all levels through an engaging review of how we do things at CQC.
- Learning and development – enabling access to learning opportunities that support people to adapt to the changes in the way CQC works.
- Processes and systems – making it easier for staff to do their job.

Focusing on these areas will ensure we are creating systemic and long-lasting change across CQC for the benefit of people that access health and social care services.

Recruiting and retaining the right people

After meeting our inspector recruitment target last year, our inspector workforce is in line with our planning expectations – we have the right number of staff to judge risk and to carry out inspection visits frequently. We have established robust assessment and recruitment processes, and the number of inspection staff in post has been consistently above 90% establishment.

Our average turnover figure for the year was 12.5%, which is slightly higher than in 2015/16 when it was 11.2%, but in line with public sector norms. We are looking at different ways in which we can nurture the talent within CQC to ensure we make the most of the skills and experience of our people.

Over the year, staff time lost to sickness has remained consistent at around 3.8%, which is below our target of 5% and similar to last year.

Learning and development

The development of our people continues to be a major priority for us. Our learning and development opportunities for staff have continued to expand with new courses added to our education and development (ED) system, such as the equality and human rights programme and the enforcement programme. Over the year there was a total of 37,652 separate learning sessions. This comprised 7,397 places at classroom-based activities, 11,769 instances of learning materials completed, 13,719 instances of online courses completed and 4,767 instances of video learning completed.

We have found from our inspections that good leadership has a strong link with the quality of care and we believe this also applies to the quality of our work as a regulator. We have continued to focus on building a sound core of leadership capability and continue to develop leadership skills within CQC in a number of ways. In 2016/17, we:

- Delivered our leadership and management development programme (Inspire) in partnership with Ashridge Business School to ensure all leaders in CQC have the necessary capability to be successful in implementing our new strategy. The programme is designed to enable professional and personal development founded on effective feedback, personal development plans and learning. It covers areas such as change, complexity, performance management, development and appreciative enquiry. To date, all of our senior leaders have undertaken the programme and it is currently being rolled out to other levels of management.
- Launched a new introduction to management programme for new and existing staff to build confidence and expertise in our policies and procedures and in their roles as managers.
- Made a wealth of resources available to support continual, self-guided learning.

We also continued to implement our successful mentoring programme, which is designed to increase access to leadership roles for under-represented groups. Our first programme started in February 2016 and completed in January 2017 with 39 participants. A second programme, also with 39 participants, started in November 2016 and will complete in October 2017.

8 Equality, diversity and human rights

'FOCUS ON ABILITY' – HIGHLIGHTS

- **MENTAL HEALTH TRAINING** FOR CQC MANAGERS
- **'TIME TO TALK'** MENTAL HEALTH AWARENESS EVENTS
- **BETTER** REASONABLE ADJUSTMENT PROCESSES FOR STAFF
- **32% OF MENTEES** IN OUR MENTORSHIP PROGRAMME IDENTIFY AS DISABLED PEOPLE

We protect and promote equality, diversity and human rights as an integral part of our work. We continued to monitor the equality and diversity of our staff, and we completed a range of activities under our equality objectives.

Our equality objectives

We have a wide work programme looking at how we protect and promote equality and human rights to enable us to deliver our human rights approach to regulation. Part of this is the delivery of our equality objectives that we set out in 2015:

1. unconscious bias learning for all staff
2. race equality for staff in our well-led assessment of NHS trusts
3. improve our regulation of health services for people with a learning disability, dementia or mental ill-health
4. help inspectors improve how they inspect key lines of enquiry (KLOEs) on specific equality issues
5. equality of outcome in CQC employment.

We have successfully met or partially met all of these objectives, and we have set out a new and stretching set of objectives for 2017 to 2019 (page 58).

Unconscious bias learning for all staff

At the end of May 2017, unconscious bias learning had been completed by 2,768 staff, often as part of a wider programme of learning about equality and human rights. Unconscious bias is now part of the induction programme for all new staff.

Race equality for staff in our well-led assessment of NHS trusts

We now consider the Workforce Race Equality Standard (WRES) in all NHS trust and relevant independent healthcare inspections. We look at work the provider has carried out to close any gaps in experience or outcomes for Black and minority ethnic (BME) staff, compared with White staff. To do this, we have developed evidence-gathering methods and learning for inspectors. We also support a network of hospital inspection equality champions and we use external equality specialist advisors on a flexible basis on our inspections. Feedback from stakeholders has confirmed that including WRES in our inspections has been very positive for highlighting the importance of workforce race equality in NHS trusts.

Improve our regulation of health services for people with a learning disability, dementia or mental ill-health

Before we started working on this objective in 2014/15, the quality of care for people with a learning disability was mentioned in 54% of our NHS acute hospital inspection reports. By 2016 this had increased to at least one mention in 97% of trust-wide reports and 95% of reports on individual hospitals. The care for people with a learning disability, dementia or a mental health condition is always considered in our inspection reports of GP practices.

Help inspectors improve how they inspect key lines of enquiry on specific equality issues

Our learning programmes for inspectors now include specific equality issues in adult social care and primary medical services, with a focus on lesbian, gay and bisexual (LGB) people, people with sensory impairment and young, disabled people. We also ask providers about these groups in our provider information request (PIR). We have worked to increase the understanding and confidence of inspectors around these issues through sharing good practice and running advice sessions, and we have started to see more coverage of the issues in our inspection reports through our key lines of enquiry. Our Lesbian, Gay, Bisexual and Transgender (LGBT) Equality Network has been involved with our work around LGB people using adult social care. We will continue this work through our new equality objectives on person-centred care and on accessible information.

Equality of outcome in CQC employment

A CQC staff equality and inclusion journey was developed in 2016/17 in partnership with all of the staff equality networks. Our September 2016 staff survey results indicated that diversity and inclusion continues to be a strong scoring area:

- I am treated with respect by the people I work with across CQC – 79% positive.
- I think that CQC respects individual differences (such as culture, working styles, backgrounds or ideas) – 73% positive.

We have focused on those parts of the survey where we felt we could, and should, see an improvement. We commissioned a review during 2016 looking at why disabled staff consistently had the least positive scores in the staff survey. An organisational commitment was made and our 'Focus on Ability' programme was launched to improve the experience and outcomes for disabled staff with active involvement from our Disability Equality Network. Improvements have included: better reasonable adjustment processes and assistive technology; mental health training for managers; 'Time to talk' mental health awareness events including CQC signing the 'Time to talk' pledge; and awareness-raising for staff around disability equality issues. Additionally, of those who have taken part in our mentoring scheme up to the end of March 2017, 32% of mentees (and 12% of mentors) identified as disabled people.

The staff survey also highlighted some issues for staff with caring responsibilities, including workload, work-life balance and equal opportunities for career progression and promotion. CQC has since committed to developing a new network for staff with caring responsibilities to help tackle these issues.

Workforce Race Equality Standard

We are committed to using the WRES to improve race equality for CQC's workforce. One of the key indicators we want to improve is equal opportunities for career progression or promotion. Our mentoring programme over the last two years has seen high representation from our BME staff: 54% of mentees and 21% of mentors. We have also looked at recruitment processes for specific roles to see if we need to alter these to improve race equality.

There were positive messages in the 2015/16 WRES indicators for BME staff:[1]

- The indicator, "In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?" was the most improved indicator for BME staff at 7% for 2015/16, compared with 13% for 2014/15.
- As at 31 March 2016, the percentage of BME staff in CQC was 12.4%. This represented an increase of 1.3% on the previous year.
- The indicator, "In the last 12 months, I have experienced harassment, bullying or abuse at work from people other than CQC staff" was 5% for BME staff and 8% for White staff.

1 Note that our WRES report was published in July 2016 and so indicators are based on 2015/16 figures.

Equality objectives for 2017 to 2019

We have new equality objectives for 2017 to 2019, which started in April 2017:

- person-centred care and equality
- accessible information and communication
- equality and the well-led provider
- equal access to pathways of care
- continue to improve equality of opportunity for our staff and those seeking to join CQC.

Further details about the new objectives can be found on our website.

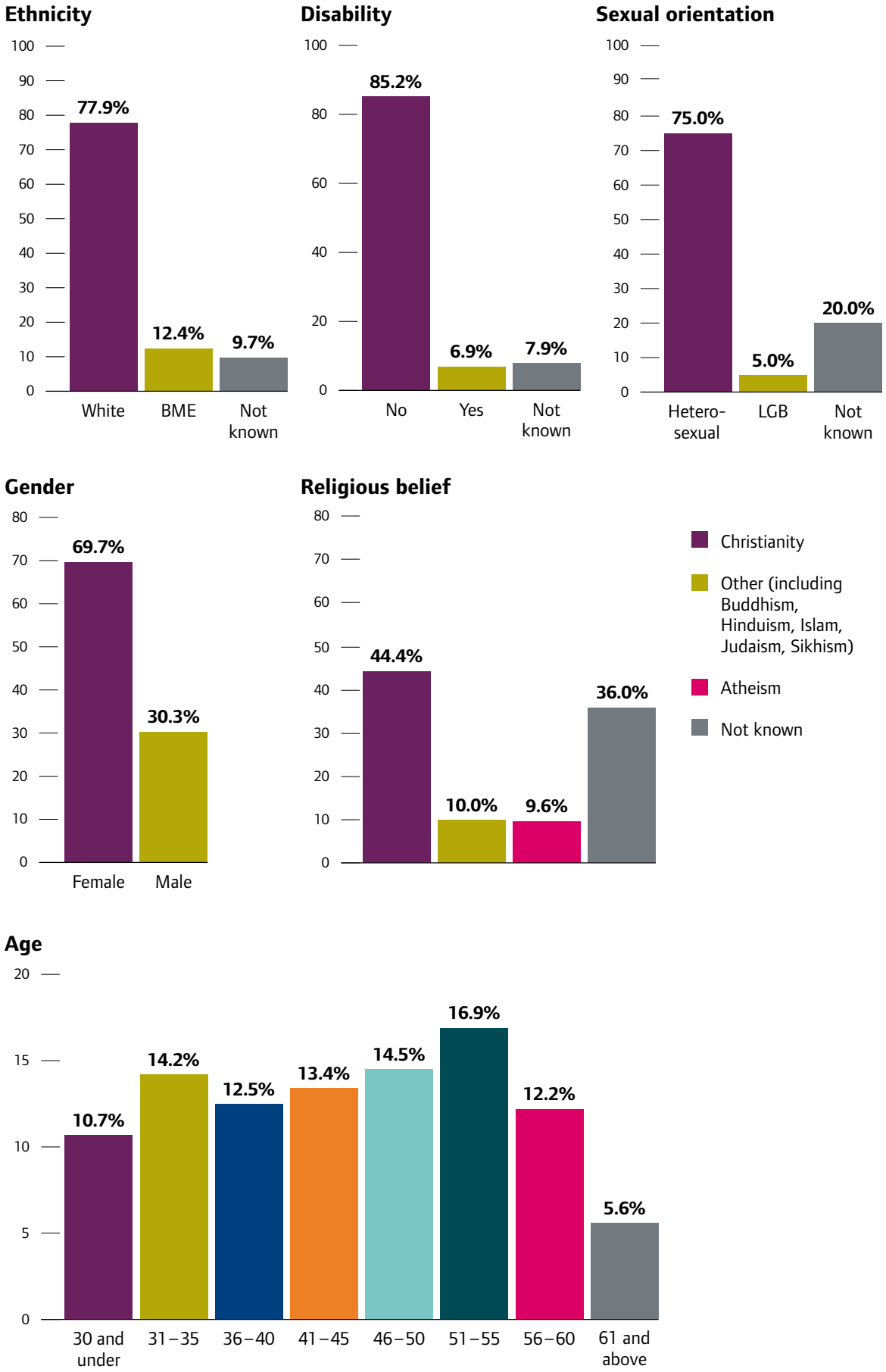
Staff equality profiles and networks

We have a legal duty under the Equality Act 2010 to show information on CQC's employees who share a protected characteristic under the Act. We use this annual report to fulfil this duty.

At 31 March 2017, our staff equality profiles were very similar to the previous year (figure 18). The biggest change was within the age profile of staff where there was a noticeable decline in the percentage of employees aged 30 and under, from 13.1% last year to 10.7% in 2016/17.

In terms of whether equality groups are proportionately represented in management grades (CQC pay grade A and above), in line with last year we found there were no significant differences in relation to gender. Also similar to last year, we found a significantly lower number of BME staff, disabled staff or those with religions or beliefs other than Christianity or atheism, than would be expected in management grades. In contrast, we found significantly more LGB staff in management grades than would be expected. Given this, it shows the importance of our internal mentoring programme aimed at people from under-represented groups.

Figure 18: Staff equality profiles as at 31 March 2017



Ensuring equality and increasing diversity through recruitment

We are committed to continue working towards full equality of opportunity for existing and potential staff, to ensure we have access to the broadest possible diversity of talent.

During the year, 5.3% of all shortlisted candidates were LGB people. They were more successful overall in our selection process, as 8.2% of all new starters were LGB people.

Additionally, 8.3% of shortlisted candidates declared a disability. There was broad parity of opportunity through our selection process, as 7.3% of all new starters were disabled people.

In terms of ethnicity, 19.7% of all shortlisted candidates and 14.1% of new starters were from BME backgrounds.

Our staff networks

We have four established staff equality networks that promote equality and inclusiveness for different groups of staff:

- the Disability Equality Network
- the Lesbian, Gay, Bisexual and Transgender (LGBT) Equality Network
- the Race Equality Network
- the Equality and Human Rights Network.

All the networks have had successful years. In particular, the Race Equality Network won an award for outstanding network at the 2016 Health and Social Care BME network (EMBRACE) awards; and thanks to the work of our Disability Equality Network, our Focus on Ability project has been shortlisted for the Employers Network for Equality and Inclusion 'team of the year' award.

The Equality and Human Rights Network of over 250 staff brings together all aspects of equality and human rights and aims to integrate this into everything we do. The network celebrated two years in existence this year. Our second equality and human rights network conference was a real success for driving change in the organisation.

We make proactive use of the resources available to us through our corporate membership of organisations such as the Business Disability Forum, Employers network for equality and inclusion, Disability Confident Committed employer, Employers for Carers and Stonewall.

Impact

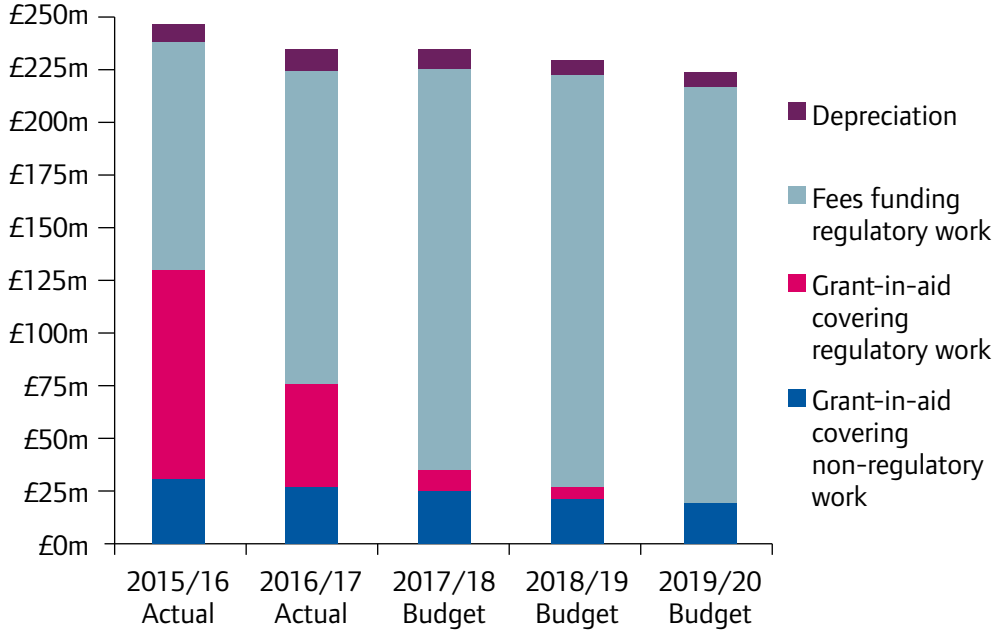
We continued to monitor the potential equality and human rights impact of our work on people who use services and providers. We conducted a number of equality and human rights impact analyses, including on our strategy for 2016 to 2021 and our investigation of deaths review. Actions arising from the strategy analysis are being actively supported and monitored.

In our January to December 2016 post-inspection survey of providers, 62% of respondents agreed that the inspection was effective in advancing equality for people using services.

We also carried out 16 equality impact analyses relating to internal policies or organisational changes – most of these related to staff employment policies.

9 Financial performance and costing model

MOVE FROM GRANT-IN-AID TO FUNDING FROM PROVIDERS (FIGURE 19)



Financial performance

In 2016/17 CQC's revenue expenditure was £226.2 million, excluding depreciation. This was funded through £76.6 million grant-in-aid provided by the Department of Health and £149.6 million from fees charged to providers in respect of their annual registration fees. The depreciation charge came to £9.4 million, making a total spend of £235.6 million.

CQC also spent £6.3 million on capital investments, funded by the Department of Health.

We drove down our costs against both 2015/16 actual figures and the 2016/17 budget with a combination of strong budget management; a contract management strategy that has improved the value achieved from contracts; and our infrastructure strategy. This approach has improved mobile and flexible working, resulting in significantly lower costs for travel, accommodation and external meeting rooms. Overall staff costs were slightly down on 2015/16 and any increases in costs for permanent staff were offset by the reduced use of associates and agency staff.

The operating budget for 2017/18 (which excludes depreciation) is £227.6 million. We have a spending review target of £217.0 million for 2019/20. The reductions we

have achieved this year will continue through the next few years. By the end of the spending review in 2020, we aim to operate from as low a cost base as possible, while still being as effective as a regulator. Over the same period, we are moving to being fully funded by providers for most of our regulatory functions.

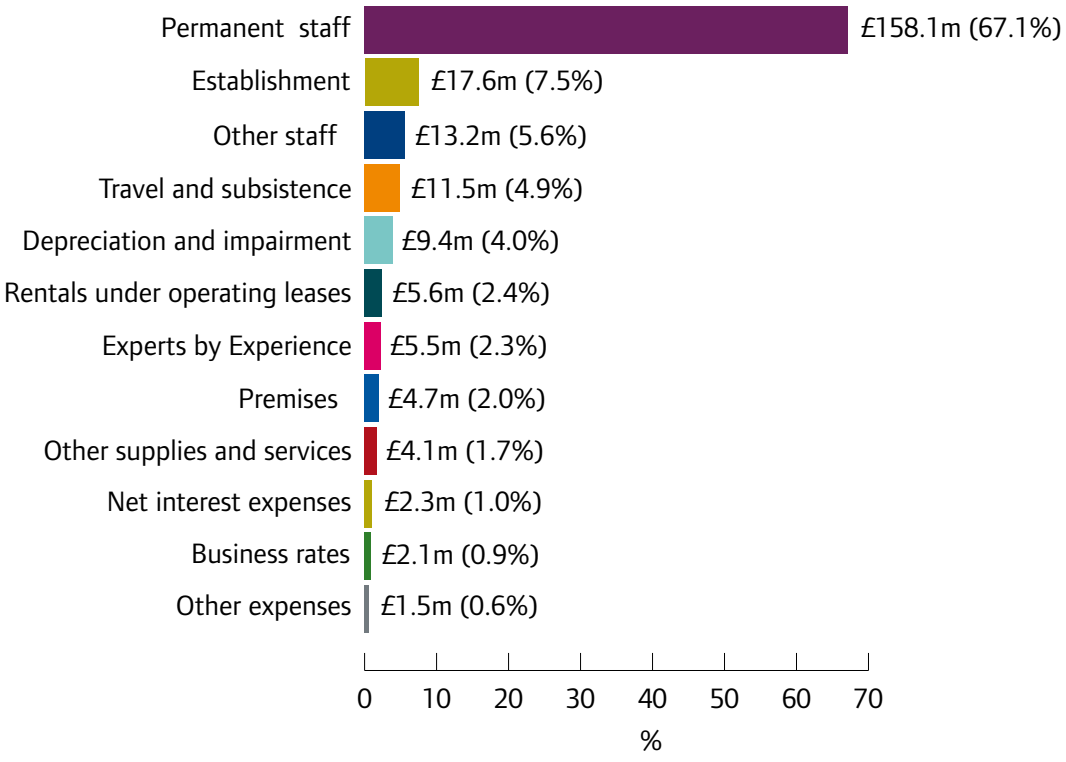
Figure 19 at the start of this chapter shows that our total cost base is projected to decrease over the same time that there is a switch in funding from the Department of Health to providers. The effect of these two changes over that period means that providers will benefit from the reduction in our cost base by seeing lower increases than would otherwise have been the case.

Net expenditure

For 2016/17 our revenue expenditure was £226.2 million (figure 20). This compares with a figure of £238.6 million in 2015/16. This is a decrease of £12.4 million. The significant movements were in relation to:

- Non-pay: Managing third party contracts and driving value for money through them, particularly in the areas of travel and subsistence. The completion of an infrastructure strategy in 2015/16 that has improved mobile and flexible working, resulting in significantly lower costs on travel, accommodation and external meeting rooms.
- Pay: Staff costs decreased slightly overall (£0.2 million). This is the net result of two opposite but related trends. The full year effect of recruitment in 2015/16 led to an increase in the cost of our permanent workforce. However, this was countered by a linked reduction in the use of specialist advisors and bank inspectors.

Figure 20: Total revenue expenditure by type, 2016/17



Income

As discussed, we have reduced our costs compared with 2015/16. However, our fee income increased by £40.6 million to £149.6 million (figure 21) compared with 2015/16, following a fees consultation that will see most providers paying the full costs of regulation to CQC (known as full-cost recovery). Our strategy for increasing fees is in line with HM Treasury guidance as outlined in *Managing Public Money*. CQC is required to set fees in order to recover all the costs of its regulatory functions. This includes depreciation, which has been charged as part of fees for the first time. Our grant-in-aid has fallen during the same period. This explains why providers have seen increases in fees while our overall cost base is reducing.

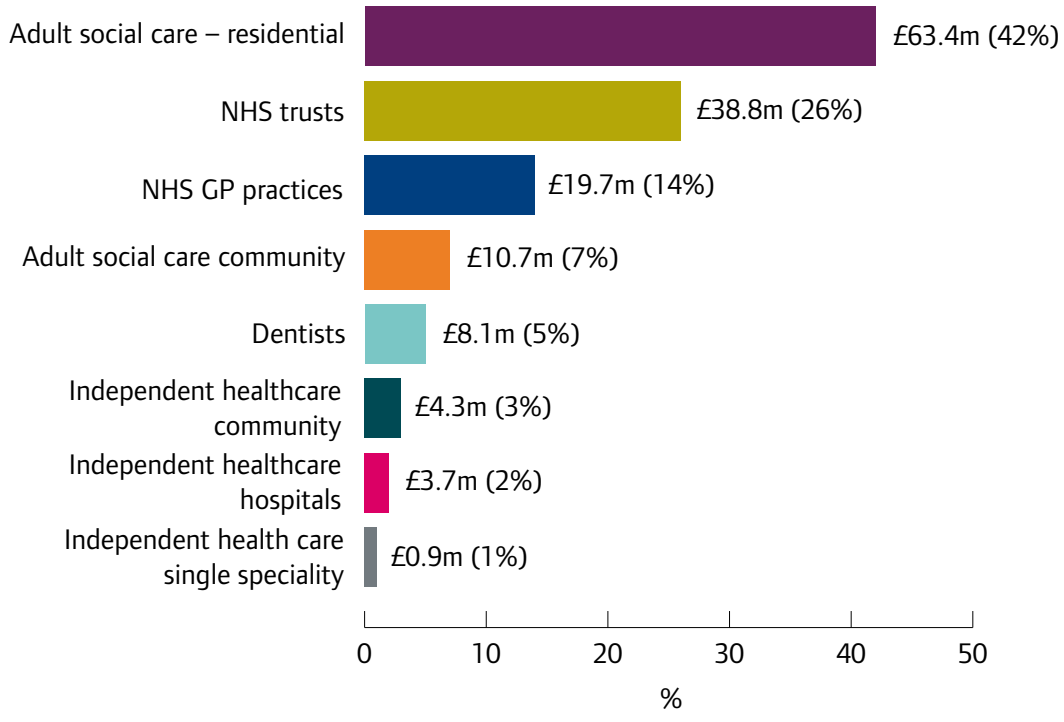
The fees payable by most providers have increased. Providers are on a two-year trajectory to full-cost recovery with two exceptions:

- Fees for dental providers remain unchanged because they are already at full-cost recovery.
- Community adult social care providers are on a four-year trajectory.

Our latest fees consultation outlines that all sectors, except community adult social care services, will be at full-cost recovery in 2017/18 when we will collect £192.0 million in fees against a total possible figure of £203.0 million. We will receive £34.0 million from grant-in-aid, £11.0 million of which will cover the remaining gap in fees funding. This will leave £23.0 million to cover areas specifically excluded from fee charging, which includes Healthwatch England, the National Guardian's Office, market oversight, enforcement and thematic reviews.

As our costs fall we will continue to review our fee levels and structure, and we will consult appropriately.

Figure 21: Total income by sector, 2016/17

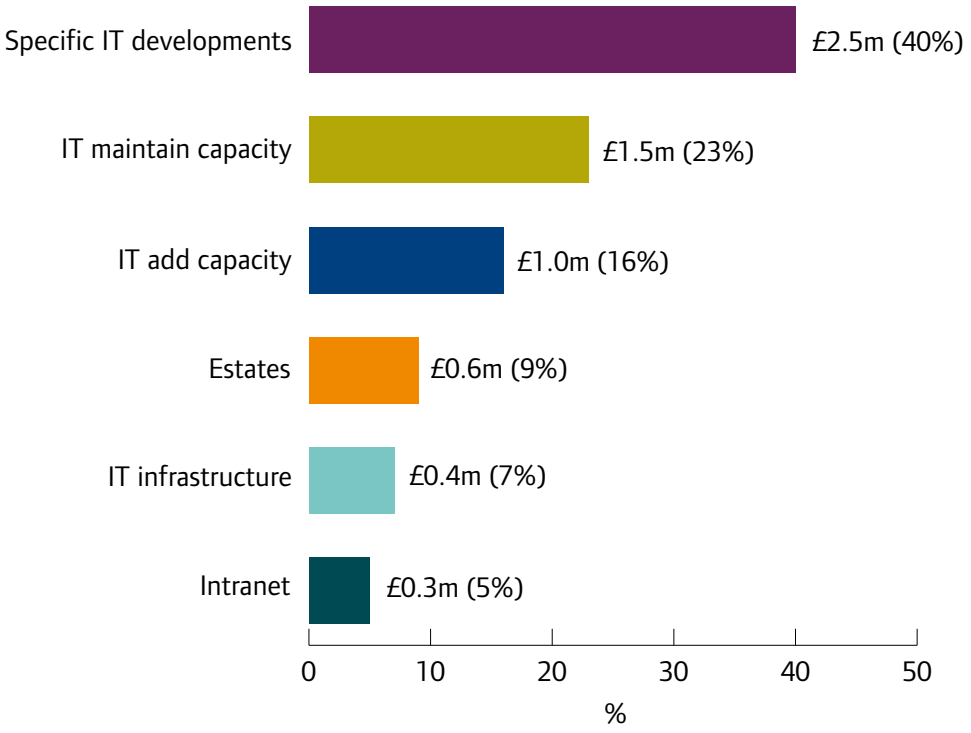


Capital expenditure

CQC started 2016/17 with a capital budget of £13.0 million and we spent £6.3 million of that during the course of the year. Key projects included the national resource planning system (Cygnum), intelligence tools and maintenance and improvement of the customer relationship management (CRM) system.

Figure 22 splits the spend for 2016/17 into the key areas in which we invest our capital funds. However, overall capital expenditure was lower than in previous years because we have spent time re-shaping our programme, particularly around new digital projects. The appointment of the Chief Digital Officer has allowed us the opportunity to restructure how we deliver our investment programme and reassess it to ensure that we receive maximum value for money.

Figure 22: Capital expenditure by type, 2016/17



Costing model

Cost of our core functions

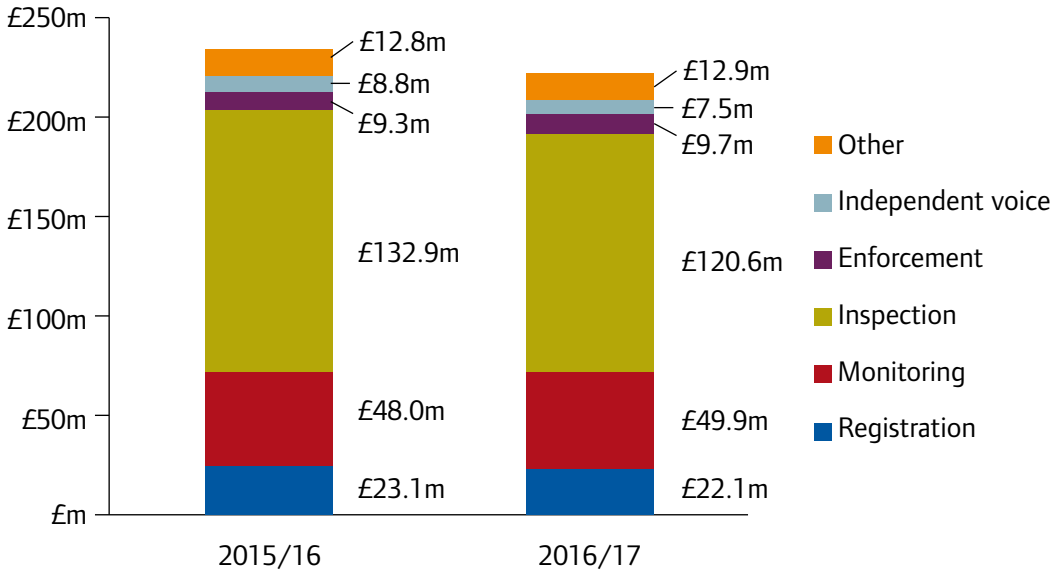
We use our costing model to assess the fully allocated costs of our core functions. The total costs in 2016/17 of our operating model activities were £209.7 million. A further £12.9 million represented statutory activities that we are required to support, but which lie outside of our operating model. Note that this excludes £3.6 million relating to accounting adjustments, such as the revaluation on intangible and tangible assets and the actuarial revaluation on pensions, that are not part of CQC's operating costs. Inspection incurred the highest cost at £120.6 million, followed by monitoring at £49.9 million.

Value for money self-assessment

We have seen efficiency savings in our inspection, registration and independent voice activity, with costs decreasing by a total of £14.6 million, from £164.7 million in 2015/16 to £150.2 million in 2016/17. Inspection activity accounted for the largest saving of £12.2 million. This was largely due to a focus on ensuring our inspections were efficient by being fully and appropriately staffed, particularly in terms of external specialist staff, and that inspection timescales were met. However, it was also as a result of efforts to reduce non-staff costs, specifically travel and subsistence. The decrease of £1.0 million from £23.1 million to £22.1 million in the cost of our registration activity occurred despite an increase in the number of registration processes from 2015/16 to 2016/17. Figure 23 demonstrates how our efficiency savings have shown reductions in our costs from 2015/16.

The cost of our monitoring activity increased by £1.9 million, from £48.0 million in 2015/16 to £49.9 million in 2016/17, and is attributed to the start of our next phase of regulation and increasing investment in our intelligence tools and functions. There were minimal increases in cost of £0.4 million and £0.2 million respectively in our enforcement and statutory activities and these relate to the increase in enforcement activity and the creation of the National Guardian's Office.

Figure 23: Cost by operating model activity, 2016/17 and 2015/16



As part of our continued work to explore our value for money, we focus on the largest area of our expenditure, inspection activity. We model the average cost for inspections across the year as a broad measure of efficiency. We found that during 2016/17 the average cost for inspections in all three directorates was lower than in 2015/16.

The average cost of inspections for the Hospitals directorate fell from £107,490 in 2015/16 to £43,119 in 2016/17 (figure 24). This was partly due to efficiency savings, but other factors need to be taken into account. The first round of comprehensive inspections of NHS trusts was concluded in 2015/16. These inspections were considerably larger and more resource intensive than the inspections of independent hospitals that took place in 2016/17 and so, as expected, the overall average decreased. The different types of inspections carried out in the Hospitals directorate all showed a decrease from 2015/16 to 2016/17, due in part to reducing costs but also due to variations in the size and nature of inspections in the Hospitals directorate, which covers a wide range of provider types from small independent and single specialty providers to large multi-site, multi-specialty NHS trusts.

The average cost of inspections for the Primary Medical Services directorate fell from £6,641 in 2015/16 to £4,902 in 2016/17. The average cost for inspections for the Adult Social Care directorate fell from £4,051 in 2015/16 to £3,283 in 2016/17 (figure 25).

This downward trend in both those directorates was a result of our inspection methodology being fully embedded in 2016/17 and staff being more efficient as a result of improved processes. Our inspections also used fewer external specialist staff during 2016/17, as a result of a greater understanding of what we expect on inspection and of proactively managing this pool of staff. Our overhead costs also reduced significantly from 2015/16 due to savings achieved in our support directorates.

Figure 24: Average cost per inspection for 2016/17, Hospitals directorate

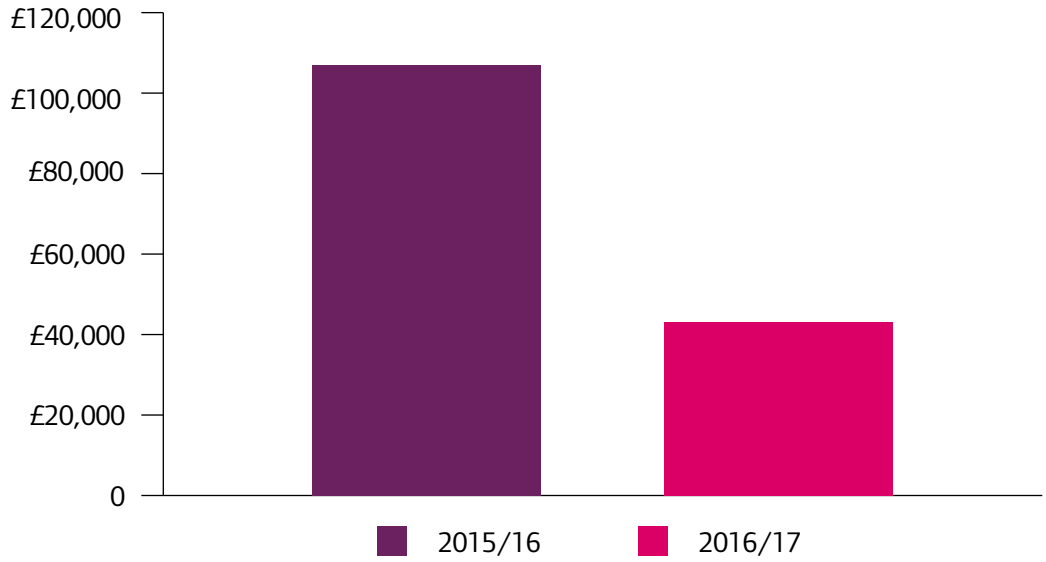
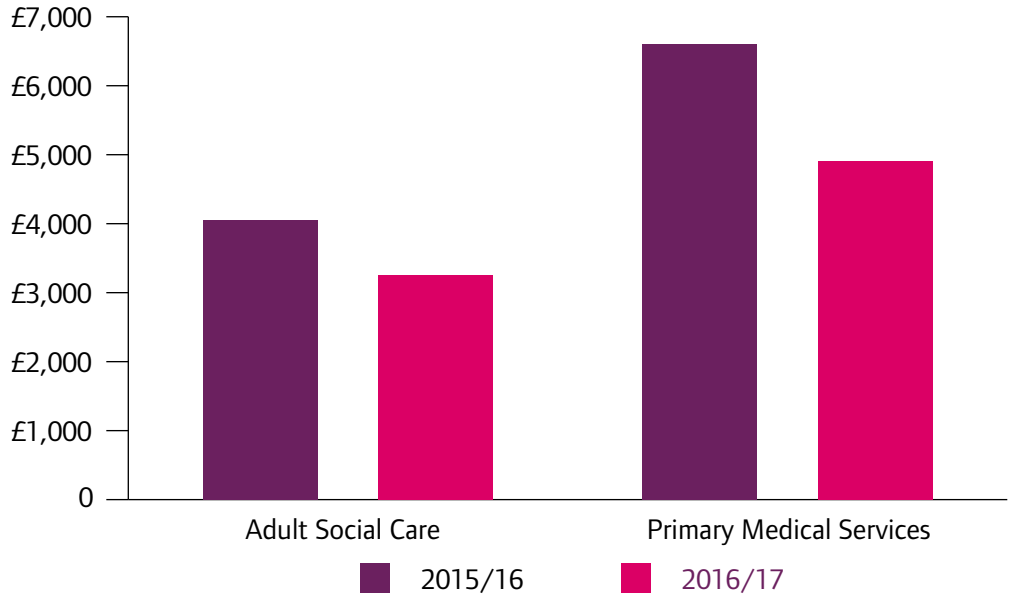


Figure 25: Average cost per inspection for 2016/17 Adult Social Care and Primary Medical Services directorates



Cygnum – our new resource planning tool

As we enter our next phase of regulation and focus increasingly on being as efficient as possible, inspection teams will have the support of our new national resource planning system, Cygnum, which was introduced during the year and rolled out across our inspection directorates.

This digital tool will be embedded in the coming year and will improve our efficiency by bringing together a range of different information in one place to help inspectors plan their inspections and ensure we have the right people in the right place at the right time.

The tool will also support registration from 2017/18.

10 Performance on other matters

Requests for 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 2016/17, the Information Access team responded to 860 requests for information:

- 669 were under the Freedom of Information Act 2000. Of these, 97% were responded to within the legal deadline of 20 working days.
- 167 were under the Data Protection Act 1988. Of these, 96% were responded to within the legal deadline of 40 calendar days.
- 24 were responded to under our information sharing procedures. Of these, 100% were responded to within our internal deadline of 20 working days.

The number of unique individuals who made requests in 2016/17 was 616.

Feedback received from requesters remains high, with 79% of the applicants who provide feedback saying they were happy with our responses and have gained a better understanding of CQC.

Of the total requests for information, 37 (4%) resulted in the applicant requesting an internal review (asking CQC to reconsider the original decision). Three requests (0.3%) were subsequently referred to the Information Commissioner's Office by the applicant for independent review; one complaint was withdrawn by the applicant, the other two are still pending.

Innovation plan

We published our innovation plan in March 2017. The plan sits alongside our strategy for 2016 to 2021 and sets out how we are supporting innovation within the health and social care sector, as well as how well we innovate ourselves as an organisation. We do this in many ways, referenced throughout the performance report.

Business Impact Target

The Business Impact Target is part of the government's deregulation agenda. Its aim is to reduce the regulatory burden on business. CQC and other regulators have been brought into the scope of the target, meaning we need to assess the impact on businesses of all eligible changes to the way we regulate since 8 May 2015.

This means we plan to reduce our burden on providers who are businesses by carrying out two types of assessments on the changes we make in our regulatory approach. The first is that we must produce Business Impact Target Assessments that set out our estimate of the impact of changes we make in our regulatory approach on business, monetised as far as possible. The second is that we must submit a list of all the other changes we have made in our regulatory approach whether they have affected businesses or not, to assure the Regulatory Policy Committee (which works with the Better Regulation Executive) that we are assessing all the changes that impact on businesses. We have published a table detailing the changes on our website – the Qualifying Regulatory Provisions are those changes affecting businesses, the Non-Qualifying Regulatory Provisions are the other changes we have made that we do not believe impact on businesses, for instance because they are only changes that affect what CQC does.

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.

Targets

From 1 April 2011, new Greening Government Commitment (GGC) Operations and Procurement targets 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. In July 2016, GGC provided updated operational targets and guidance:

"Compared to a 2009/10 baseline, by 2019/20, the government will:

- Cut greenhouse gas emissions by 32% from the whole estate and UK business transport, with bespoke targets applying to each department.
- Reduce the number of domestic business flights taken by 30% (excluding Ministry of Defence front line command flights).
- Reduce waste sent to landfill to less than 10% of overall waste; continue to reduce the amount of waste generated and increase the proportion of waste which is recycled.
- Reduce paper consumption by 50%.
- Continue to further reduce water consumption. Each department will set internal targets and continue to improve on the reductions they had made by 2014/15."

Carbon dioxide emissions

Performance

CO_2 emissions from rail and car travel have decreased by 21% from 2015/16. Costs have decreased by 14% for the same period. CO_2 emissions from domestic business travel flights have decreased by 39%.

Figure 26: Carbon dioxide emissions 2016/17

Area	CO_2 emissions (tonnes)	2016/17 Units	2016/17 Cost £	Performance against 2015/16
Building energy	1,295	3,368,718 (kWh)	289,242	Reducing
Travel (rail)	678	8,881,821 (m)	3,546,813	Improving
Travel (road)	1,802	6,183,672 (m)	2,962,298	Improving
Total	**3,775**	**n/a**	**n/a**	

Figure 27: Carbon dioxide emissions indicators 2013/14 to 2016/17

Non-financial indicators (CO_2)	2016/17 (tonnes)	2015/16 (tonnes)	2014/15 (tonnes)	2013/14 (tonnes)
Gross emissions (buildings)	1,295	1,262	1,390	1,364
Gross emissions (business travel)	2,480	2,885	2,303	2,072
Total	**3,775**	**4,147**	**3,693**	**3,436**
Financial indicators (£)	**2016/17**	**2015/16**	**2014/15**	**2013/14**
Expenditure on official business travel	6,509,111	8,221,589	7,116,621	5,327,697

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 we have tighter controls on heating, cooling and lighting. Our 2016/17 data includes our London office, 151 Buckingham Palace Road.

Figure 28: Energy use indicators 2014/15 to 2016/17 against baseline

Non-financial indicators – energy consumption (kWh)	2016/17	2015/16	2014/15	2009/10
Electricity	2,681,974	2,138,184	2,553,712	3,641,075
Gas	1,030,109	1,107,899	1,369,641	2,004,344
Total (kWh)	**3,712,083**	**3,246,083**	**3,923,353**	**5,645,419**

Financial indicators (£)	2016/17	2015/16	2014/15	2009/10
Total energy expenditure	289,242	354,629	309,887	525,935

Managing water use

Performance

CQC's water use is almost exclusively from washrooms and showers. Water use data for 2016/17 has not been supplied to CQC by all landlords; therefore we must estimate some use. Costs provided relate to only two offices but show a large reduction due to renewal of the water services contract.

From 1 April 2011, the targets (GGCOPs) have required us to reduce water consumption from a 2009/10 baseline and report on office water use against best practice benchmarks.

Figure 29: Water use indicators 2013/14 to 2016/17 against baseline

Non-financial indicators	2016/17	2015/16	2014/15	2013/14	2009/10
Water consumption (m^3) supplied	10,950	11,282	10,108	13,717	16,388

Financial indicators (£)	2016/17	2015/16	2014/15	2013/14	2009/10
Total water expenditure	6,727	14,075	19,106	15,860	n/a

Managing office waste

Performance

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

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 since May 2011. Waste management data for 151 Buckingham Place Road is provided by the landlord's contractors who report that all waste is recycled. This has resulted in a significant reduction in the waste sent to landfill.

Figure 30: Office waste indicators 2013/14 to 2016/17 against baseline

Non-financial indicators (tonnes)	2016/17	2015/16	2014/15	2013/14	2009/10
Non-hazardous waste (landfill)	22	89	119	115	27
Non-hazardous waste (re-used/recycled)	163	160	294	217	143
Total waste	**185**	**249**	**413**	**332**	**170**

Financial indicators (£)	2016/17	2015/16	2014/15	2013/14	2009/10
Total disposal costs	27,701	28,332	54,709	59,583	n/a

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.

Estates strategy

CQC's estates strategy aims to provide an estate that best supports our approach to regulation, meets our constraints regarding cost, and supports Government Property Agency guidance. The strategy considers where we locate our staff as well as the cultural aspects of our buildings and how they can best reflect how we want to work and connect with people. CQC's baseline data includes the fact that over 60% of our staff are home-based. We want to reduce our estate to what is required to support the efficiency savings outlined in our organisational strategy. Part of this will be through supporting the Cabinet Office's four principles of HQ, Home, Host and Hub. We work closely with the Department of Health to ensure we maximise opportunities and align our efforts wherever possible.

Our estate is spread across seven buildings. These are located in Birmingham, Bristol, Leeds, London, Newcastle, Nottingham and Preston. We also have access to five smaller satellite offices giving us a good geographic reach. Overall we have 1,170 members of staff who are permanently office-based, and 2,057 who are permanent home workers.

Over the past year we:

- Reviewed our estate requirements for the next five years. Building on this review, we plan to engage with staff about what the drivers for change are regarding our estate and what options there will be over this period.
- Moved to an agile working model in most of our offices. Staff now use laptops at un-allocated desks and small lockers for storage, rather than traditional desk-based equipment such as PCs and pedestals. The model has resulted in changing work patterns for many staff, with people adopting more flexible working across our estate.
- Carried out an extensive estate health and safety audit.

Sir David Behan CBE
Chief Executive, Care Quality Commission
22 June 2017

Accountability report

2

The accountability report consists of four sections:

Corporate governance report

Directors' report

Introduction

The Accounting Officer for CQC (the Chief Executive) has responsibility for working with CQC's Board to ensure that CQC is well governed and that the organisation has a sound system of internal control that allows us to deliver our purpose and role. This Corporate governance report sets out a comprehensive explanation of the organisational governance of CQC in accordance with HM Treasury and other governance standards, and the level of assurance that can be provided during 2016/17.

Following significant changes that have focused on transforming our approach to regulating health and social care services, our priority going forward is to ensure that CQC is an efficient, effective and well managed organisation.

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 and as the regulator of all health and adult social care services in England.

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

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

CQC's statutory functions are set out in the Health and Social Care Act 2008 as amended, 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

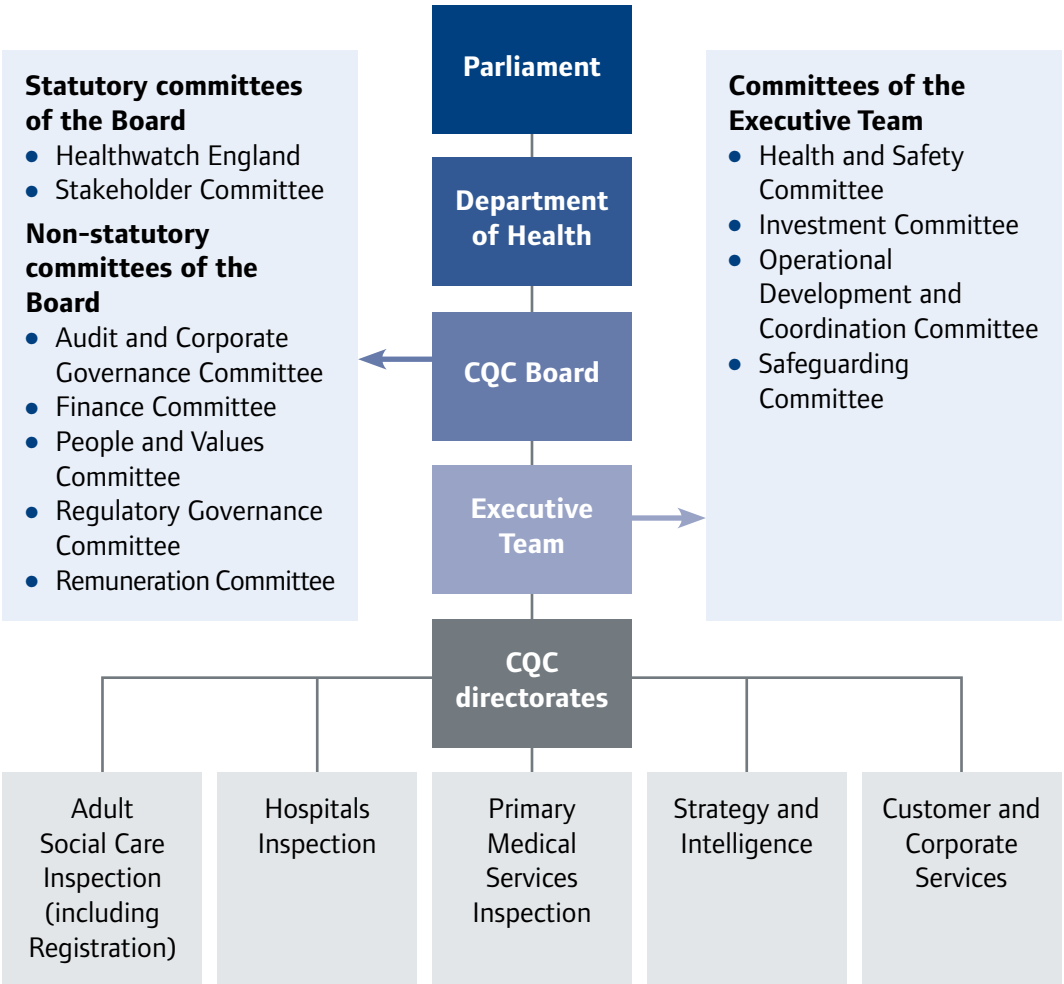
CQC has a corporate governance framework that sets out the governance arrangements for the organisation. It was fully updated this year. Figure 31 sets out current arrangements.

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. The Department of Health 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.

The Accounting Officer is held accountable to CQC's Board and to Parliament, as well as to the Department of Health. This accountability is discharged through quarterly accountability review meetings with the Department of Health. The Accounting Officer attended all these meetings in 2016/17 and actions required of CQC arising from these meetings have been discharged. Other ways that the Accounting Officer upholds CQC's accountability is through CQC's *State of Care* report and *Monitoring the Mental Health Act* report, through CQC's inspection reports, and through hearings with the Health Select Committee, and the Public Accounts Committee.

Figure 31: CQC's governance arrangements



CQC's Board

The main responsibilities of CQC's Board are 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, as CQC would expect of providers when assessing whether they are well-led.

CQC's unitary Board is made up of the Chair (Peter Wyman), eight non-executive Board members, myself as Chief Executive and Accounting Officer, our three Chief Inspectors and the Executive Director of Strategy and Intelligence. The Executive Director of Customer and Corporate Services also attends Board meetings. One of the non-executive directors (Michael Mire) acts as the Senior Independent Director. Peter Wyman was appointed as the new Chair of CQC by the Secretary of State for Health from 4 January 2016. His term of appointment is for four years.

Membership of the Board has changed since April 2016:

- Jennifer Dixon completed her term of office on 30 June 2016.
- Jora Gill was appointed to the Board from 1 November 2016.
- Kay Sheldon completed her term of office on 30 November 2016.
- Jane Mordue was confirmed as the Chair of Healthwatch England and member of CQC's Board from 1 December 2016, having been interim Chair of Healthwatch since December 2015. Her term of appointment is for two years.
- Paul Bate, Executive Director of Strategy and Intelligence and Executive Board member left CQC on 18 July 2016. This role was fulfilled on an interim basis by Malte Gerhold, who was confirmed in the role on 6 February 2017. Malte Gerhold also replaces Paul Bate as CQC's Senior Information Risk Owner.
- Michael Mire completed his term of office on 30 June 2017.
- Mike Richards will complete his term of office on 11 August 2017.

The full revised Board and Committee Membership is set out in annex 1 and a summary of Board attendance up to 31 March 2017 is set out in annex 4.

Collectively the members of CQC's Board bring a wide range of experience and expertise, which informs the decisions that the Board makes. All Board members have equal and joint responsibility for governing the activities of CQC and in being accountable to Parliament, the Secretary of State for Health, the Department of Health and the public, for how it has discharged its functions.

The Board meets both in public and private session throughout the year. Public sessions of the Board are recorded and are available to view on CQC's website thereafter. The Board's default position is to take decisions and hold discussions in

public. However, where there are draft reports to consider that need to be considered in private before publication, or, for example, where matters relating to individuals and employment are being discussed, they are dealt with in a private session.

An independent Board effectiveness review was conducted in January 2017 to appraise the purpose, ways of working, competence, performance and reporting of CQC's Board. The review was conducted by Deloitte and completed in March 2017 with the findings published in April 2017. The report found CQC's Board to be effective, but made some recommendations for further improvement. These will be taken forward during 2017/18.

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 that is open to public scrutiny at CQC's offices in London. It is also available on CQC's website. The Chair will form a view as to whether an interest is such that it requires the member to withdraw from discussion or any vote on an issue. The Board has discharged its duties as set out in the Scheme of Delegation during the year.

Statutory committees of the 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 users of health and social care services and to provide CQC and other bodies with advice, information or other assistance.

The Accounting Officer meets quarterly with the Chair and Chief Executive of Healthwatch England to gain assurances that the organisation is operating effectively, efficiently and economically.

Stakeholder Committee

The Stakeholder Committee was originally set up to provide advice or information to CQC's Board on matters connected with its functions. The Stakeholder Committee did not meet in 2016/17. However, a Cross-sector Provider Advisory Group was set up in May 2016 and has met quarterly during the year. This group provides the role of the Stakeholder Committee by giving advice to CQC on the implementation of its strategy in the context of the changing way that regulated services are used and delivered, and the requirement for CQC to deliver its purpose more efficiently and effectively. The group is chaired by CQC and includes representatives from provider trade associations and membership bodies across all sectors.

Non-statutory committees of the Board

Audit and Corporate Governance Committee

The Audit and Corporate Governance Committee (ACGC) provides assurance to CQC's Board on CQC's risk management, governance and internal control. The ACGC

also engages with our internal auditors (Health Group Audit) and our external auditor, the National Audit Office, to determine the priorities for audit work during the year.

Finance Committee

Terms of reference for a Finance Committee were approved by the Board on 27 July 2016. The Finance Committee's responsibility is to make recommendations and provide advice on financial management, to ensure that CQC operates within its budget and that sufficient resources are available for investment.

People and Values Committee

The establishment of the Finance Committee and re-establishment of the Remuneration Committee provided an opportunity to review the terms of reference of the People and Values Committee (PVC). The PVC will have oversight of succession planning, staff development and talent management, and oversee the understanding and application of CQC's values. Revised terms of reference for the PVC were approved by the Board on 27 July 2016.

Regulatory Governance Committee

The Regulatory Governance Committee provides assurance to CQC's Board that systems, processes and accountabilities are in place for identifying and managing risks associated with delivering the regulatory programme.

Remuneration Committee

The Remuneration Committee was re-established to determine the remuneration of selected senior executives and consider overall pay policy for the organisation. The function was previously carried out as part of the role and responsibilities of the PVC. Terms of reference for the Remuneration Committee were approved by the Board on 22 June 2016.

National Guardian (Freedom to Speak Up) Office

The National Guardian's (Freedom to Speak Up) Office (NGO) was established with the support of CQC in April 2016. Its purpose is to lead on culture change in the NHS. It was created as a result of recommendations made by Sir Robert Francis QC's *Freedom to speak up review* (2015) that identified issues of concern and where improvements are needed.

The NGO has been established with operational independence from CQC and is jointly funded by CQC, NHS Improvement and NHS England. A memorandum of understanding between the NGO and these bodies sets out the agreed oversight arrangements. CQC's Chief Executive has responsibility as Accounting Officer for the NGO. The NGO will also report to CQC's Board at least once a year on its strategy, plans and the discharge of its public funds.

Governance processes

The Accounting Officer has responsibility for maintaining a sound system of internal control that supports the achievement of CQC's purpose, aims and objectives. The Accounting Officer must safeguard the public funds and assets that are allocated and managed by CQC. These responsibilities are discharged with and through the Executive Team.

CQC's Executive Team

There are clear divisions between the responsibilities of CQC's Board and the Executive Team. The responsibility for implementing the Board's strategy belongs to the Chief Executive and his team. The Chief Executive, three Chief Inspectors, the Executive Director of Strategy and Intelligence and the Executive Director of Customer and Corporate Services make up the Executive Team. The current membership and structure is detailed in annex 2.

Committees of the Executive Team

The Executive Team meets twice a month. Since the revision of its terms of reference, the Executive Team takes items both for decision and discussion in separate sections of its agenda. The discussion section of the meeting considers items about approaches and emergent thinking, and Executive Directors give a formal steer to work as it develops.

The decision section of the meeting takes decisions, or recommends a decision to CQC's Board as appropriate, on policy, publications, corporate planning and performance monitoring.

The following committees report directly to the Executive Team:

- The **Health and Safety Committee** is a statutory requirement to monitor CQC's duty to discharge its health, safety and welfare obligations to its staff.
- The **Investment Committee** supports the Executive Team by examining and approving formal cases and having oversight of the capital programme.
- The **Operational Development and Coordination Committee** provides coordination of operational activity within and across directorates.
- The **Safeguarding Committee** provides oversight of our safeguarding processes and assesses our responsiveness to safeguarding information.

Annex 1: Board and Committee membership

CQC Board

Board member	Term of office
Peter Wyman CBE DL (Chair)	4 January 2016 – 3 January 2020
Sir David Behan CBE (Chief Executive)	From 5 November 2012
Prof. Louis Appleby CBE	1 July 2013 – 30 June 2019
Dr Paul Bate	3 May 2013 – 18 July 2016
Prof. Paul Corrigan CBE	1 July 2013 – 30 June 2019
Dr Jennifer Dixon CBE	1 July 2013 – 30 June 2016
Prof. Steve Field CBE	From 30 September 2013
Sir Robert Francis QC	1 July 2014 – 30 June 2020
Dr Malte Gerhold	From 19 July 2016
Jora Gill	1 November 2016 – 31 October 2019
Michael Mire	1 July 2013 – 30 June 2017
Jane Mordue	19 December 2015 – 30 November 2018
Paul Rew	1 July 2014 – 30 June 2020
Prof. Sir Mike Richards	From 16 July 2013 – 11 August 2017
Kay Sheldon OBE	1 December 2008 – 30 November 2016
Andrea Sutcliffe	From 7 October 2013

Audit and Corporate Governance Committee

Committee members
Paul Rew (Chair)
Sir Robert Francis QC
Michael Mire (to 30 June 2017)
Independent Member
Linda Farrant

Finance Committee

Committee members
Sir David Behan CBE (Chair)
Michael Mire (to 30 June 2017)
Paul Rew
Peter Wyman CBE DL

People and Values Committee

Committee members
Peter Wyman CBE DL (Chair)
Prof. Louis Appleby CBE
Sir David Behan CBE
Prof. Paul Corrigan CBE
Dr Jennifer Dixon CBE (to 30 June 2016)
Sir Robert Francis QC
Michael Mire (to 30 June 2017)
Jane Mordue
Paul Rew
Kay Sheldon OBE (to 30 November 2016)

Regulatory Governance Committee

Committee members
Michael Mire (Chair) (to 30 June 2017)
Prof. Louis Appleby CBE
Prof. Paul Corrigan CBE
Paul Rew

Remuneration Committee

Committee members
Peter Wyman CBE DL (Chair)
Prof. Louis Appleby CBE
Prof. Paul Corrigan CBE
Sir Robert Francis QC
Michael Mire (to 30 June 2017)
Jane Mordue
Paul Rew

Annex 2: Executive Team membership

Executive Team member	Role	Start of membership
Sir David Behan CBE	Chief Executive	30 July 2012
Dr Paul Bate	Executive Director of Strategy and Intelligence	3 May 2013 – 18 July 2016
Prof. Steve Field CBE	Chief Inspector of General Practice	30 September 2013
Dr Malte Gerhold	Executive Director of Strategy and Intelligence	19 July 2016
Eileen Milner	Executive Director of Customer and Corporate Services	13 January 2014
Prof. Sir Mike Richards	Chief Inspector of Hospitals	16 July 2013 – 11 August 2017
Andrea Sutcliffe	Chief Inspector of Adult Social Care	7 October 2013

Annex 3: Board and Executive Team biographies

Peter Wyman CBE DL, Chair

Peter Wyman is the Chair of the Care Quality Commission. He took up the position in January 2016.

Peter Wyman served as Chair of the Yeovil District Hospital NHS Foundation Trust for five years and has held a range of senior posts in the private, public and voluntary sectors across his career.

He was a partner in PricewaterhouseCoopers LLP, and was President of the Institute of Chartered Accountants in England and Wales from 2002 to 2003.

Peter Wyman was awarded a CBE in 2006.

Sir 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 presented with a City and Guilds fellowship in October 2016.

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 Adult Social Services, and the first Chief Inspector of the Commission for Social Care Inspection.

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

David Behan was awarded a knighthood in the 2017 New Year's Honours list.

Professor Louis Appleby CBE, 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.

Louis 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.

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.

Professor Steve Field CBE, Chief Inspector of General Practice

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

Steve Field 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 Field 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 healthcare 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.

Dr Malte Gerhold, Executive Director of Strategy and Intelligence

Dr Malte Gerhold joined CQC in 2013 as Director of Policy and Strategy, when he was responsible for setting out CQC's new five-year strategy through to 2021.

Malte started his career as a strategy consultant, before working as an advisor at the Prime Minister's Delivery Unit, from where he was appointed Deputy Director of the Strategy Unit at the Department of Health. Before joining CQC, he lived and worked in Sierra Leone for just under three years, leading a team advising the president on the implementation of the government's priorities in health care, energy, agriculture and investment.

Malte has a BSc from the London School of Economics and a PhD from Oxford. He has a particular interest in improvement, new technologies and innovation, and better use of data.

Jora Gill, Non-executive director

Jora is The Economist Group's Chief Digital Officer. Since he joined the Group in 2014, he has overseen the Group's infrastructure change to the Cloud and led a transformation of its products and services. This includes a new economist.com, and also a fundamental overhaul of its customer service systems to enhance subscriber satisfaction, retention and profitability.

He was previously Chief Technology Officer at Elsevier and also at Standard & Poors.

Jora Gill is recognised as one of the Top 100 Global Digital Change Agents.

Eileen Milner, Executive 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.

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.

Michael Mire, Non-executive director

Michael Mire was a partner of McKinsey & Company, the management consulting firm, for more than 20 years. He worked predominantly on strategy for retailing and financial services clients until his retirement in 2013.

After leaving university he joined the banking firm N M Rothschild. He then went to Harvard Business School where he gained an MBA degree. On his return, he was seconded to the then equivalent of the Number 10 Policy Unit before he joined McKinsey.

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

Jane Mordue, Non-executive director and Chair of Healthwatch England

Jane Mordue was formerly Deputy Chair of Citizens Advice, having worked within the Citizens Advice service since 2000 when she became Chairman of the Buckingham Winslow and District Citizen's Advice Bureau.

She was also Vice Chair of the Gangmasters' Licensing Authority and a Chartered Director of the Institute of Directors. Her previous career included 15 years at the University of London, four years as Secretary General at the Law Society, as well as four years as Chair of Thames Valley Strategic Health Authority.

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 and at Northumbrian Water. He is also a member of the advisory board of Exeter University Business School.

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

In July 2012 he 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 Richards was appointed CBE in 2001 and was awarded a knighthood in 2010.

Andrea Sutcliffe, Chief Inspector of Adult Social Care

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

She has more than 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, where she was Chief Executive from April 2012.

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

Annex 4: Summary of Board attendance 2016/17

	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Peter Wyman CBE DL (Chair)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Sir David Behan CBE (Chief Executive)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Prof. Louis Appleby CBE	✓	✗	✓	✗		✓	✓	✓	✓	✗	✓	✓
Dr Paul Bate	✓	✓	✓									
Prof. Paul Corrigan CBE	✓	✓	✓	✗		✗	✓	✓	✓	✓	✓	✓
Dr Jennifer Dixon CBE	✓	✓	✓									
Prof. Steve Field CBE	✗	✓	✓	✓		✗	✓	✓	✓	✓	✓	✗
Sir Robert Francis QC	✓	✓	✓	✓		✓	✗	✗	✓	✓	✓	✓
Dr Malte Gerhold				✓		✓	✓	✓	✓	✓	✓	✓
Jora Gill								✗	✗	✓	✓	✓
Michael Mire	✗	✓	✓	✓		✓	✓	✓	✓	✗	✓	✓
Jane Mordue	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Kay Sheldon OBE	✓	✓	✓	✗		✓	✓	✓				
Paul Rew	✓	✓	✓	✓		✓	✓	✗	✓	✓	✓	✓
Prof. Sir Mike Richards	✗	✓	✓	✗		✓	✓	✓	✓	✓	✓	✓
Andrea Sutcliffe	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✗

Annex 5: Board business 2016/17

Annual report and accounts
Audit and Corporate Governance Committee report
Board sub-committees and update
Business plan and budget 2016/17
Business plan and budget 2017/18
Capital programme review
Code of Practice on Confidential Personal Information
CQC Insight strategy
CQC staff survey 2016
CQC Strategy 2016 to 2021
Estates strategy
Experts by Experience contract and lessons learned
Fees consultation
Fees scheme 2017/18
Finance Committee report
Fit and proper person requirement
Healthwatch England report
Horizon scanning for future strategy development
Impact of CQC and value for money
Information management and technology programme
Internal commercial strategy
Laptop replacement programme
Learning from current inspection programme in adult social care
Medium-term strategy group – strategic implementation plan
Medium-term plan
Mental Health Act report
National Audit Office/Public Accounts Committee action plan and narrative
Next phase of regulation and use of resources consultation
Performance report
Primary medical services seminar
Public engagement strategy – key themes
Registering the right support – learning disability service registration
Regulatory Governance Committee report
Renewal of Oracle support and maintenance agreements
Responsible Officer annual report
Social media policy
State of Care report
Strategic risk report
Terms of reference for Finance and People and Values Committees
Workforce Race Equality Standard report

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 (CQC) to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of CQC and of its net resource outturn, application of resources, changes in taxpayers' equity and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the government financial reporting manual (FReM) and in particular to:

- observe the Accounts Direction issued by the Secretary of State for Health, 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 FReM have been followed, and disclose and explain any material departures in the financial statements
- prepare the financial statements on a going concern basis.

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

As Accounting Officer I can confirm that:

- There is no relevant audit information of which CQC's auditors are unaware.
- I have taken all steps that I ought to have taken to make myself aware of any relevant audit information and to establish that CQC's auditors are aware of that information.
- The annual report and accounts as a whole are fair, balanced and understandable.
- I take personal responsibility for the annual report and accounts and the judgements required for determining that it is fair, balanced and understandable.

Governance statement

Management assurance

CQC has a management assurance framework that has been designed to seek assurance from all parts of the organisation that internal controls are working effectively and to identify areas of concern. The assurance framework looks at eight areas of management responsibility:

- planning
- performance and risk management
- quality management
- people management and development
- financial management, systems and control
- information and evidence management
- governance and decision making
- continuous improvement.

Each of our directorates provides a self-assessment against a clear set of expectations of performance in these eight core management disciplines. These assessments are peer reviewed, then put through a collective challenge by the Executive Team, before being presented to the Audit and Corporate Governance Committee (ACGC). The main findings from our assessments in October 2016 and February 2017 are summarised below, together with some of the improvement actions we have underway. Key points are:

- Across our directorates, our work on planning, financial management, systems and control, and continuous improvement are the areas that scored most highly.
- We need to do more work on quality management, people management and development, and information and evidence management. These areas are highlighted as priorities in our business plan for 2017/18.
- We will review our management assurance standards and processes in 2017/18. This will include introducing a key performance indicator (KPI) for directorates to achieve a rating of good in all eight areas, and tightening our processes to ensure consistency in self-assessments.

The organisation put in place its management assurance framework in 2014 with the aim of it increasingly becoming a central tool to support change and improvement. It has enabled CQC to underpin delivery of its purpose and role with a clear framework for how we manage ourselves. The framework itself has been improved during 2016/17 and we have started a process of reviewing the standards, which

we will conclude in 2017/18. We will look at how management information and KPIs can be used as contextual evidence of improvement in management assurance. We are already comparing internal audit recommendations with our self-assessments to ensure the conclusions are compatible. To ensure consistency we have involved our internal auditors in sampling the assessments, and we will ensure that ratings are peer reviewed across directorates. Finally, we are ensuring that we build improvement actions into our business plans and tracking that they are delivered.

Planning

We made significant improvements to our planning process in the year. We created a medium-term strategy group of senior managers to oversee the development of a medium-term plan (2016 to 2019), for delivery of our strategic priorities over three years. Our workforce planning was improved and this function worked well with our financial planning function to develop the agreed 2017/18 business plan. More directorates are tracking, reviewing and communicating business plans – and there has been greater stakeholder input to our plans. An internal audit of our medium-term plan was carried out and we believe that work since the audit on our annual plans, risk register and programme planning put us in a good position to quickly meet the recommendations of the audit. A future area of focus for directorates will be improving our project planning and resource planning. We will introduce our new resource planning system in 2017/18, Cygnum, which will enable us to plan our inspection resources more effectively. The system was rolled out across the three inspection directorates towards the end of the 2016/17 and will be embedded over the coming year. During this time we will see increased benefits, particularly by bringing multiple processes and information into one place to help teams schedule and manage resources more effectively.

Performance and risk management

A continued strengthening of the quality of performance information and a focus on performance reporting in directorates has enabled us to deliver key performance targets, in particular to meet our inspection commitments. In 2016/17 we completed our commitment to rate those services registered at October 2014 and where we had the power to rate them. The conclusion of our comprehensive ratings programme means for the first time there is a benchmark of the quality of care for the public in England across adult social care, hospitals and GP practices. We were unable to meet our targets for inspection report publication times. However, as set out in the performance report, we carried out a review of the inspection reports process towards the end of 2016/17. We will consider recommendations for how we improve our performance in this area early in 2017/18. As part of business planning for 2017/18, all of our KPIs have been reviewed, with targets assigned.

Our risk management framework provides a strategic and high-level risk register to be considered by the Board at quarterly intervals, and the Executive Team more frequently.

The register identifies the strategic and higher level operational risks that the Board will oversee. These by their nature require cross-cutting action to mitigate, or are of significant importance that they need to be highlighted and managed at a corporate level. The risk register sets out the mitigations that are being carried out to manage the level of each risk, and these mitigations are built into the business plans of directorates. Progress with delivering mitigating actions is monitored by the Executive Team, the ACGC and the Board. Directorates have risk registers associated with their business plans and these will also reflect strategic or high-level operational risks that they are managing. Directorates monitor their risks and mitigations on an ongoing basis. Directorates continue to update risk registers as required during the year. We have introduced a new training module for managers, including a video in which the Chair of the ACGC explains our risk management approach, including risk tolerances.

As set out in the Performance report, the Board has agreed our risk register for 2017/18. Mitigating actions have been set out in the register, and these are part of our directorate business plans that we agreed in March 2017. We reviewed our risk tolerance statement and agreed that the stated tolerances should remain unchanged. Our target risk levels for the 2017/18 risk register are in line with our tolerance statement. Following a recommendation from our internal auditors, we made risk tolerance a prominent feature in a risk training package we developed in 2016/17.

We engaged with a number of other arm's length bodies involved in health commissioning, oversight and regulation to discuss risk interdependencies, and we shared details of our risks, and considered other organisations' risks to inform our risk planning for 2017/18.

Quality management

Across our inspection directorates, we have strengthened our quality management arrangements. Quality activities feature strongly in the majority of our directorates with many excellent examples of quality management, particularly in the Intelligence team, and the Adult Social Care directorate. However, directorates have more to do. This is in line with an audit of our quality framework, which recognised that significant work had been carried out to define the framework, but that it has taken some time to roll the framework out and it is not yet embedded across the whole organisation. However, this does not include the inspection directorates or the Intelligence team. In response we have made quality management a priority in our business plan for 2017/18 and in the business plans of directorates. There will be a focus on the supporting quality processes, controls and assurances and putting these in place. We would expect to see more use of quality evidence in management assurance assessments in 2017/18.

People management and development

During the year we focused on improving our performance management frameworks, ensuring we managed recruitment and vacancies with a stable inspector workforce; rolling out the 'Inspire' management development programme; and monitoring mandatory training. We also completed a significant modernisation programme for customer and business support services.

Our 2016 staff survey had a higher response rate than last year, and a staff engagement score of 63%. This compares with a score of 65% in 2015/16, but remains above the public sector benchmark. We saw positive results around people saying that CQC's work makes a difference, encourages improvement and is in line with our values. Staff also gave positive responses around their teams being supportive and about their line management. However, there is more for us to do to improve the results for communication, managing change, access to learning and clarity of leadership. In the management assurance assessment process, directorates and units recognised their need to make improvements to some staff management processes and the majority have good examples of work they have planned or that is underway. We will continue to make improvements over the coming year.

Financial management, systems and control

We have improved the way in which our Finance team engages with directorates, and this has been recognised by the majority of directorates. The advice and quality of management information is improving. This has been important as we engaged in a planning round for 2017/18 which involved considering complex financial information and significant budget savings to meet the requirements of the government's spending review. These savings are now embedded in plans for directorates in 2017/18.

An internal audit of the governance of the capital investment planning approach noted that the introduction of the change management framework had added structure and formalised change management processes since the previous audit in March 2015. The audit recognised that the change management process had yet to be fully embedded across the organisation, as well as there being further action to take around investment planning, approval and the management of benefits realisation. We will take forward the necessary improvements in 2017/18.

Information and evidence management

Information management

Information security and governance is dealt with in greater detail in a dedicated section below. We are reviewing our management assurance standards for information and evidence management to ensure they adequately cover the latest information security and governance standards. Our directorates have carried out work on information assets and security during the year and we focused on ensuring that mandatory training on information security is completed by all staff.

Evidence management

Across our directorates, while the majority report that they are meeting standards for being rated good on evidence management, inspection directorates highlight key dependencies between performance in this area and the information management and technology programme. A number of key improvements have been made to our technology systems in the last year, including appointing a Chief Digital Officer in January 2017. This has given CQC the opportunity to plan and deliver further improvements to how our operating model is supported by technology; to ensure that technologies are adapted to our new strategic priorities; and to ensure CQC is accessible to providers online. This is a key priority of our business plan for 2017/18.

Governance and decision making

We have a Scheme of Delegation to ensure that all significant decisions are made by those who are authorised to make them. We have no information or evidence to suggest that during the year CQC assumed duties beyond its statutory powers, or improperly delegated any duties. We updated the scheme twice in the year and have made improvements to make it clearer. In line with an internal audit report recommendation to ensure the scheme is well understood across CQC, we produced a training module on the scheme and improved how we communicate changes to the scheme. This has led to greater staff awareness of the scheme and recording of decisions.

During the year, we also streamlined our process for handling complaints about CQC to reflect strong benchmark standards. The process is now more customer-focused and a greater number of complaints are being resolved through first line resolution within seven working days. We also introduced improvements to our ratings review process so that providers receive a quicker response to their request for reviews and those that meet the criteria are mainly determined within 50 working days.

Continuous improvement

Directorates in corporate functions point to a number of improvements that have been made to the guidance, processes or policies they provide for the organisation.

We are also confident that our audit programmes are focusing on the areas of greatest risk, and we continue to learn lessons from these and identify improvement actions. These areas are mentioned earlier in the Governance statement.

The ACGC places a lot of focus on implementation of audit recommendations and receives a report on progress at each of its meetings. During 2016/17, of 186 internal audit recommendations, 103 were completed by the end of the year, 54 were on track to complete by the planned date, and 29 were in progress but behind schedule.

We have dedicated resources to continue to improve and build CQC's capability, and we have begun to set out a common approach to our quality improvement in 2017/18, drawing on learning from other organisations.

Other assurance areas

Information security and governance

Information security and governance are integral elements that support CQC's purpose of ensuring that health and social care services provide people with safe, effective, compassionate, high-quality care and encouraging care services to improve.

This area has been the subject of additional scrutiny and work during the year following the loss of disclosure and barring service (DBS) certificates relating to provider staff in July 2016. The incident was reported promptly both internally and to the Information Commissioner's Office (ICO), and the details were published on our website. The ICO have informed us that they do not intend to take regulatory action in response to this incident.

We have, as a result, conducted internal and external reviews of our security and governance framework, and examined our associated procedures and processes. A major 18-month work programme has been put in place with the aim of addressing the recommendations of the external review, which included enhancing and updating security and governance policies, procedures and practices where necessary. An additional recommendation to improve the security culture in CQC has been included in the work programme. This aims to increase staff awareness of the importance of information security; the assurance of our processes against relevant standards and benchmarks; and the planning and management of the new regulations, systems and processes.

Security incident analysis and response has been carried out during the year and is reported to CQCs Senior Information Risk Officer and the ACGC. We have continued to liaise with the Department of Health, NHS England, NHS Digital and the ICO on matters of information security and privacy. Our communication with these organisations, and others, was exercised most recently both during and after the recent global cyber attack which impacted parts of the NHS. Urgent checks on CQC's own infrastructure revealed that it was not vulnerable to this particular attack as relevant security patching and updates to software packages had been applied in a timely manner. CQC's risk register includes the risk that there is a cyber security incident or attack causing service disruption or a major data security alert. We continue to monitor this risk and our actions to manage it.

Our internal information governance group has held monthly meetings to monitor and manage work and progress in the area of information governance and security. This has ensured that CQC continues to comply with relevant legislation and guidance.

CQC completes the annual Information Governance Toolkit return, coordinated by NHS Digital. Improvements this year in our information governance practices and information systems have resulted in a score of 94%, compared with the previous year's score of 89%. Our overall rating is classed as 'satisfactory', which indicates that we have achieved level 2 or above compliance (on a three-level ratings system) in each of the applicable requirements. We will continue work to further improve on our security and information governance during the forthcoming year.

Counter fraud

The Director of Governance and Legal Services leads CQC's counter fraud function. The number of allegations of fraud received during 2016/17 has continued to be very low, with only 16 cases reported and investigated. All cases have contained allegations of corruption or conflict of interest but, following thorough investigation, none have been found to be substantiated.

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. Internal Audit is fully independent and remains free from interference in determining the scope of internal auditing, performing work and communicating the results.

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

- In the case of **risk management**:

  CQC has a clear focus on the identification and management of risk, with risks being subject to regular review through the Board and the Audit and Corporate Governance Committee (ACGC). Our work on Market Oversight concluded that the key risks associated with CQC taking on the oversight function and development of its operating model have been identified and appropriately managed.

  Through our work and engagement with directors and managers, we have observed a good self-awareness of the areas where systems, processes and controls can be improved to mitigate risk. In a number of cases, management has invited Internal Audit to help identify actions to assist them in making those improvements. We have also observed the embedding of risk management within the change cycle, including for example the project management of the Cygnum implementation project.

  There is a strong focus on improvement and taking action to mitigate the risks identified through the audit work. This is evidenced by a positive and constructive approach to agreeing audit recommendations and action plans. While there is an appropriate framework to oversee implementation of agreed actions, there is scope to improve on the timeliness of completion.

- In the case of **governance:**

  A number of audits have assessed different aspects of governance during the year. We reviewed the governance of cost improvement programmes which, as a new challenge facing CQC, was an area that management recognised required further development, and we also considered procurement and contract management where significant improvements have been made. Our work on investment appraisal, benefits realisation and change management identified that improvements had been made to the structures for governing those processes, but we concluded that the assurance remained limited while those changes became embedded. Notably, at the time of our review, no projects had fully progressed through the new arrangements. Management also recognises a need to focus more on benefits identification and assessing realisation.

  In the area of health and safety, progress has been made in revising the role and operation of the Health, Safety and Wellbeing Committee, restructuring the management resource in that area and developing a comprehensive action plan for improvement of underlying controls. We similarly observed progress with the change programme for Registration, although in both areas we concluded that assurance remains limited pending further completion of actions.

  Management has continued to develop and maintain the management assurance self-assessment process that involves six-monthly self-assessment by Chief Inspectors, Executive Directors and Heads of Department of the planning, operational, financial and performance management processes across CQC. We have previously commented on the commendable progress made in developing and implementing the framework, and it remains an important component of maintaining a focus on governance, risk and controls across the organisation, as a support to continuous improvement.

- In the case of **control:**

  We have issued 23 (2015/16: 24) audit reports since our last annual report, performing further work to conclude in some areas carried forward from the 2015/16 programme and in completing the 2016/17 programme. All of these reports have addressed key aspects of the systems of internal control. One (2015/16: none) of these reports was rated substantial, 11 (2015/16: 15) of these reports were rated moderate, six (2015/16: 7) limited and five (2015/16: two) were not formally rated. Generally, our programme has focused on areas under development and where management has recognised a need for improvement, with a smaller number of reviews covering core areas, such as financial controls which are key to forming the annual opinion but where generally reviews in prior periods have not identified any significant need for improvement. We carried out reviews of the core systems of payroll and cash forecasting in the year, which both concluded with moderate assurance. Accordingly, while the number of limited conclusions has fallen by only one, in the context of a focus on areas known to require improvement, this represents a positive outcome. In addition, although work remains in progress in some areas, there is evidence of

improvement through our follow-up work which, together with development of the operating model, change management and quality framework, shows the learning and improvement culture operating within CQC.

In 2015/16 we drew attention to the theme of IT systems emerging from our reviews, which had indicated a need to assess CQC's requirements for technology in the future. We are therefore pleased to note the appointment of a Chief Digital Officer and ongoing work to develop a new digital strategy. The importance of completing and delivering this strategy was highlighted in our report on the implementation plan for CQC's overall strategy, which noted that the implementation plan would need to be reviewed and potentially updated to align to the development of the digital strategy in due course.

Excluding both Health and Safety and Registration, which were follow-up reviews where significant programmes of change are underway, the only 2016/17 reviews rated as limited assurance were Home worker Arrangements which was added to the audit plan mid-year at the request of management, and Investment Appraisal and Benefits Realisation. The home workers audit confirmed a need for systems and processes to be brought into line with latest regulations and for further work to be carried out to determine whether there may be any exposure to liabilities. Investment Appraisal, Benefits Realisation and Change Management is an area that management had recognised that required improvement. Revised structures and processes had been put in place as part of change management, but no projects had yet gone through those processes at the time of our review so we could not take account of their impact on business cases and projects.

The remaining audits have provided moderate assurance over the controls in place covering a wide range of financial and operational systems and processes. In particular, we noted improvement in procurement, tendering and contract management procedures.

Therefore, in summary, my overall opinion that I can give to the Accounting Officer of the Care Quality Commission for the reporting year 2016/17 is **MODERATE** assurance that there are adequate and effective systems of governance, risk management and control.

Jane Forbes
Head of Internal Audit

Accounting Officer's conclusion

The management assurance framework is a central tool to support change and improvement. It has enabled CQC to underpin delivery of its purpose with a clear framework. We have continued to embed this management assurance process, alongside a quality framework and a framework for managing change. The internal auditors noted the progress in implementing these frameworks and in engaging the organisation in the process.

CQC has made significant change and improvement, and focus on our operating model and internal systems and processes mean that there are now more robust mechanisms for assessing risk and compliance. We will continue to pay close attention to the effectiveness of our internal governance processes, noting the particular need to ensure that some changes we have made need to be monitored. In addition, some areas are still undergoing substantial change. For example, the registration function is undergoing a programme of transformation and improvement, and it is recognised that a continued focus is needed on the development and implementation of the new approach to inspection, and the development of CQC Insight.

The Head of Internal Audit has provided an annual opinion providing moderate assurance that there are adequate and effective systems of governance, risk management and control, noting that the IT systems warrant further management consideration.

I agree with their conclusion.

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

I conclude that CQC's governance and assurance processes have supported me in discharging my role as Accounting Officer. I am not aware of any significant internal control problems in 2016/17. Improvements will continue in 2017/18 to strengthen the assurance and the overall internal control environment within CQC.

Remuneration report

The following sections provide details of the remuneration (including any non-cash remuneration) and pension interests of Board members, independent members, the Chief Executive and the Executive Team. The content of the tables 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 per 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.

The Chair, non-executive Board and independent members are reimbursed for the cost of travelling to Board meetings and to other events at which they represent CQC. The resultant tax liability is met by CQC under a settlement agreement with HM Revenue & Customs. For 2016/17 the total liability amounted to £7k (2015/16: £1k).

Chair and non-executive Board members' emoluments

	Date appointed	2016/17 total salary £000	2015/16 total salary £000
Peter Wyman CBE DL (Chair)	4 Jan 2016	60–65	15–20[5]
Michael Mire (Interim Chair)[1]	1 Jul 2013	5–10	35–40[6]
Prof. Louis Appleby CBE	1 Jul 2013	5–10	5–10
Prof. Paul Corrigan CBE	1 Jul 2013	5–10	5–10
Sir Robert Francis QC	1 Jul 2014	5–10	5–10
Paul Rew	1 Jul 2014	10–15[2]	10–15[2]
Jane Mordue	19 Dec 2015	35–40[3]	10–15[7]
Jora Gill	1 Nov 2016	0–5[4]	–
Kay Sheldon OBE (appointment expired 30 November 2016)	1 Dec 2008	5–10[4]	5–10
Dr Jennifer Dixon CBE (appointment expired 30 June 2016)	1 Jul 2013	0–5[4]	5–10
Anna Bradley (resigned 18 Dec 2015)	16 Jul 2012	–	30–35[8]
David Prior (Chair, resigned 15 May 2015)	28 Jan 2013	–	5–10[5]
Camilla Cavendish (resigned 21 May 2015)	1 Jul 2013	–	0–5[4]

[1] Michael Mire was appointed as Interim Chair with effect from 9 June 2015 to 3 January 2016 before the new Chair, Peter Wyman, took up his post.

[2] Paul Rew received enhanced remuneration through his role as Chair of the ACGC.

[3] Jane Mordue was initially appointed as Interim Chair Of Healthwatch England, full-year equivalent salary £45–50k. This appointment was made permanent with effect from 1 December 2016, full-year equivalent salary £30–35k.

[4] Full-year equivalent salary would be £5–10k.

[5] Full-year equivalent salary would be £60– 65k.

[6] During the period as Interim Chair the full-year equivalent salary would be £60– 65k. The full-year equivalent salary for the remainder of the year would be £5–10k.

[7] Full-year equivalent salary would be £45–50k.

[8] Anna Bradley's enhanced remuneration is as a result of her role as Chair of Healthwatch England.

Payments to independent members

Linda Farrant was an independent member of CQC's Audit and Corporate Governance Committee. Fees and expenses are paid on a per meeting basis and during 2016/17 amounted to £5k (2015/16: £5k). Payments were also made to David Prince during 2015/16 totalling £1k.

Remuneration of the Chief Executive

The Chief Executive's remuneration is agreed by the Board via the People and Values Committee (PVC) 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 terms and conditions under permanent employment contracts.

The remuneration of the Chief Executive and the Executive Team members was set by the PVC and is reviewed annually within the scope of the national pay and grading scale applicable to arm's length bodies.

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 Staff report (page 120).

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.

2016/17	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000) £000	Long-term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits[1] (bands of £2,500) £000	Compensation for loss of office (bands of £5,000) £000	Total (bands of £5,000) £000
Sir David Behan CBE Chief Executive	185–190	–	–	–	42.5–45	–	**230–235**
Prof. Sir Mike Richards Chief Inspector of Hospitals	235–240	–	–	–	–[2]	–	**235–240**
Prof. Steve Field CBE Chief Inspector of General Practice	170–175	–	–	–	22.5–25	–	**195–200**
Andrea Sutcliffe Chief Inspector of Adult Social Care	140–145	–	–	–	20–22.5	–	**165–170**
Eileen Milner Executive Director of Customer & Corporate Services	140–145	–	–	–	30–32.5	–	**170–175**
Dr Malte Gerhold Executive Director of Strategy & Intelligence	95–100[3]	–	–	–	27.5–30	–	**120–125**
Dr Paul Bate Executive Director of Strategy & Intelligence	40–45[4]	–	–	–	(0–2.5)	–	**40–45**

[1] All pension–related benefits calculated as the real increase in pension multiplied by 20 plus the real increase in any lump sum less the contributions made by the individual. The real increase exclude increases due to inflation or any increase or decreases due to a transfer of pension rights.

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

[3] Dr Malte Gerhold was appointed as Acting Executive Director of Strategy and Intelligence on 19 July 2016. This appointment was made permanent on 6 February 2017.

[4] Dr Paul Bate resigned as Executive Director of Strategy and Intelligence on 18 July 2016.

2015/16	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000) £000	Long-term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits[1] (bands of £2,500) £000	Compensation for loss of office (bands of £5,000) £000	Total (bands of £5,000) £000
Sir David Behan CBE Chief Executive	185–190	–	–	–	37.5–40	–	**225–230**
Dr Paul Bate Executive Director of Strategy & Intelligence	140–145	–	–	–	20–22.5	–	**160–165**
Prof. Sir Mike Richards Chief Inspector of Hospitals	235–240	–	–	–	–[2]	–	**235–240**
Prof. Steve Field CBE Chief Inspector of General Practice	170–175	–	–	–	–	–	**170–175**
Andrea Sutcliffe Chief Inspector of Adult Social Care	140–145	–	–	–	5–7.5	–	**150–155**
Eileen Milner Executive Director of Customer & Corporate Services	140–145	–	–	–	27.5–30	–	**165–170**

[1] All pension-related benefits calculated as the real increase in pension multiplied by 20 plus the real increase in any lump sum less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decreases due to a transfer of pension rights.

[2] Pension-related benefits for Prof. Sir Mike Richards is £nil as in receipt of benefits.

Fair pay (subject to audit)

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 2016/17 was £235–240k (2015/16: £235–240k). This was 6.1 times (2015/16: 6.2) the median remuneration of the workforce which was £38,837 (2015/16: £38,071).

In 2016/17 no employees (2015/16: no employees) 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 £5–10k to £235–240k (2015/16: £5–10k to £235–240k).

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

In 2016/17, 16 senior executives were paid in excess of £100k (2015/16: 18).

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

No amounts were paid to third parties for services as a senior executive during 2016/17 (2015/16: £nil).

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 2017 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 2017 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2017 (bands of £5,000) £000	Cash equivalent transfer value at 1 April 2016 £000	Cash equivalent transfer value at 31 March 2017 £000	Real increase in cash equivalent transfer value £000	Employers contribution to stakeholder pensions £000
Sir David Behan CBE Chief Executive	2.5–5	–	15–20	–[5]	185	244	59	–
Prof. Sir Mike Richards Chief Inspector of Hospitals	–[1]	–[1]	–[1]	–[1]	–[1]	–[1]	–[1]	–[1]
Prof. Steve Field CBE[2] Chief Inspector of General Practice	0–2.5	5–7.5	55–60	165–170	1,126	1,231	105	–
Andrea Sutcliffe Chief Inspector of Adult Social Care	0–2.5	5–7.5	25–30	80–85	472	520	48	–
Eileen Milner Executive Director of Customer & Corporate Services	2.5–5	–	5–10	–[5]	65	97	32	–
Dr Malte Gerhold[3] Executive Director of Strategy & Intelligence	0–2.5	–	5–10	–[5]	41	67	18	–
Dr Paul Bate[4] Executive Director of Strategy & Intelligence	0–2.5	–	20–25	–[5]	196	208	4	–

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

[2] Figures for Prof. Steve Field are in respect of officer employment only. No practitioner employment is included.

[3] Dr Malte Gerhold was appointed on 19 July 2016.

[4] Dr Paul Bate resigned on 18 July 2016.

[5] 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 which 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 which may be due when pension benefits are drawn.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the 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 Reviewers, 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.

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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 scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This uses an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017 is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

In 2016/17, CQC employer's contributions for staff to the NHS pension fund was £13,519k (2015/16: £12,449k) at a rate of 14.3% (2015/16: 14.3%). 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 (2015/16: £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 Stationary 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 2016/17, based on a percentage of payroll costs only, were £4,606k in total (2015/16: £4,057k), at rates ranging between 14.4% and 39.1% (2015/16: 14.4% and 36.8%). Employer contributions relating to the largest scheme, Teesside Pension Fund, were £3,299k (2015/16: £3,546k) at a rate of 17.0% (2015/16: 17.0%).

During 2016/17, an indexed cash sum was levied in addition to a percentage of payroll costs in an effort to reduce the pension fund deficits. In total £831k was paid to 13 of the 16 remaining pension funds, with amounts ranging from £1.6k to £206.0k. 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 2017/18 range between 0.0% and 41.6% (17.9% for Teesside Pension Fund), with annual cash sums ranging from £26k to £612k (£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 totalled £26k for 2016/17 (2015/16: £23k), at a rate of 0.98% (2015/16: 0.98%).

Staff report

The information in sections 1 and 7 is subject to audit. Staff costs are presented in the Notes to the financial statements on page 138.

1. Staff numbers

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

	2016/17 number	2015/16 number
Directly employed	3,200	3,091
Other	31	58
Staff engaged on capital projects	–	1
Total	**3,231**	**3,150**

'Other' does not include non-executive Board members or Second Opinion Appointed Doctors who are paid per session.

The actual number of directly employed whole-time equivalents as at 31 March 2017 was 3,097 (31 March 2016; 3,295).

2. Staff composition

Number of staff employed as at 31 March 2017:

	Board members	Directors	Total employees
Male	7	11	1,225
Female	2	22	2,640

Number of staff employed as at 31 March 2016:

	Board members	Directors	Total employees
Male	6	11	1,054
Female	2	18	2,352

Board Members include the Chair, non-executive Board members and the independent member of the ACGC.

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).

3. Sickness absence data

During 2016/17, the average number of long-term days sickness per absent employee was 11 (2015/16: nine days) and the average number of short-term days sickness was four (2015/16: five days).

Sickness absence is managed through the wellbeing programme, which encompasses ways to support attendance at work.

4. Staff policies

4.1 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. Our staff are represented by the staff forum.

We have jointly reviewed our ongoing conversations with the Joint Negotiation and Consultation Committee (JNCC) and implemented a more strategic forward-looking approach. We continue to work with the staff forum and to base these discussions around a strategic, forward-looking agenda, which allows us to 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 future direction of CQC and the impact of the government spending review.

Throughout the year, both the unions and the forum have been actively engaged in the review and launch of our people policies, including the management of change policy. CQC has engaged with union colleagues in formal consultation processes and encouraged contribution to the various change programme boards, ensuring the views of colleagues within CQC have been represented.

The local joint consultative committees 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.

CQC's 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.

CQC's three equality networks – the Lesbian, Gay, Bisexual and Trans (LGBT) Equality Network, the Race Equality Network, and the Disability Equality Network – work to promote diversity and equality in CQC, challenge views and strive to ensure dignity for all CQC employee groups. Each network is sponsored by a member of our Executive Team and the Chief Executive meets with the chairs of all the networks.

The Disability Equality Network is focused on challenging societal attitudes through campaigning for effective disability awareness training, and promoting positive images of disabled people. It supports members, promotes best practice and provides networking opportunities for staff. During the year, the network supported CQC's 'Focus on Ability' programme which was launched to improve the experience and outcomes for disabled staff. It has resulted in a number of improvements as well as raising awareness for staff of disability equality issues.

The Race Equality Network works strategically with CQC's 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 holding regular meetings, attending events and communication with members and CQC staff on LGBT issues.

CQC consults all of the networks on issues affecting the wider organisation, such as policy development to ensure that all staff views are taken into account. A notable initiative this year has been the development and launch of a new mentoring programme, designed to actively build and retain a diverse organisation by supporting and valuing the contribution of all individuals, and in particular engaging those who are under-represented in the organisation.

4.2 Employment and policies

All of our people management policies were reviewed in 2015, to ensure legal compliance, best practice and that they were the right fit for the changing culture of CQC. All our policies have been through consultation with the unions, staff forum, diversity network groups and managers across CQC. Towards the end of 2015 and in early 2016, all revised polices were rolled out to managers to ensure they have a good understanding of the policies and how they should be applied.

4.3 Home working

Home working forms the contractual arrangement for 2,057 members of staff and is the principal working arrangement for our inspection staff, who make up more than 50% 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 carry out their role safely and effectively.

5. Expenditure on consultancy

CQC spent a total of £14k on consultancy services during 2016/17 (2015/16: £2k).

6. Off-payroll engagements

For all off-payroll engagements as at 31 March 2017, for more than £220 per day and that last for longer than six months:

	Number
Number of existing engagements as at 31 March 2017	1
Of which:	
Number that have existed for less than one year at the time of reporting	–
Number that have existed for between one and two years at the time of reporting	–
Number that have existed for between two and three years at the time of reporting	1
Number that have existed for between three and four years at the time of reporting	–
Number that have existed for four or more years at the time of reporting	–

All existing arrangements as at 31 March 2017 have received approval from the Department of Health.

At 31 March 2017, we had received assurance that the right amount of income tax and national insurance had been paid by the one individual who is engaged off-payroll.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, for more than £220 per day and that lasted for longer than six months:

	Number
Number of new engagements, or those that reach six months in duration between 1 April 2016 and 31 March 2017	–
Number of the above which include contractual clauses giving CQC the right to request assurance in relation to income tax and national insurance obligations	–
Number for whom assurance has been requested	–
Of which:	
Number of whom assurance has been received	–
Number of whom assurance has not been received	–
Number that have been terminated as a result of assurance not being received	–

	Number
Number of off-payroll engagements of Board members and/or senior officials with significant financial responsibility during the year	–
Number of individuals on payroll and off-payroll that have been deemed Board members, and/or senior officials with significant financial responsibilities during the financial year.	18

7. Exit packages

Exit package cost band	Number of compulsory redund-ancies Number	Cost of compulsory redund-ancies £s	Number of other departures agreed Number	Cost of other departures agreed £	Total number of exit packages Number	Total cost of exit packages £	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £
Less than £10,000	16	65,885	–	–	**16**	**65,885**	1	247
£10,000 to £25,000	11	164,055	–	–	**11**	**164,055**	–	–
£25,001 to £50,000	12	458,364	–	–	**12**	**458,364**	–	–
£50,001 to £100,000	5	414,393	–	–	**5**	**414,393**	–	–
£100,001 to £150,000	1	122,403	–	–	**1**	**122,403**	–	–
£150,001 to £200,000	–	–	–	–	**–**	**–**	–	–
More than £200,000	–	–	–	–	**–**	**–**	–	–
Total	**45**	**1,225,100**	**–**	**–**	45	1,225,100	1	247

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.

	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.

Parliamentary accountability and audit report

The contents of notes 1 to 3 below are subject to audit.

1. Losses and special payments

During 2016/17, CQC recognised 815 losses totalling £713k (2015/16: 547 cases totalling £189k), which mainly related to unpaid annual provider registration invoices, and two special payments totalling £11k (2015/16: nil).

There were no individual losses or special payments that exceeded £300k (2015/16: none).

2. Remote contingent liabilities

There were no remote contingent liabilities as at 31 March 2017 (31 March 2016: none).

3. Fees and charges

The following table provides an analysis of the services for which a fee is charged. These figures are subject to audit and regularity.

	Income £000	Full cost £000	Deficit £000
Regulatory fees for chargeable activities	(149,585)	197,010	47,425

Our regulatory fees are charged for the cost of our registration functions. These functions cover all our activities associated with registering providers, making changes to their registration and carrying out inspections. Other existing responsibilities, such as our work under the Mental Health Act, are not included within our registration functions, and their costs are covered instead by grant-in-aid from the Department of Health.

4. Better payment practice code

CQC's policy is to pay creditors in accordance with contractual conditions or, where no specific conditions exist, within five to 30 days of the receipt of goods or services or the presentation of a valid invoice, whichever is later. This complied with the Better Payment Practice Code and guidance as published by HM Treasury.

	2016/17	2015/16
Number of invoices paid within 30 days	98.9%	97.0%
Value of invoices paid within 30 days	98.9%	97.8%

In line with guidance from the government published in August 2010, CQC aims to pay 80% of all undisputed invoices from suppliers within five days. During 2016/17, CQC exceeded this target based on both volumes and value:

	Target	2016/17	2015/16
Number of invoices paid within five days	80.0%	84.1%	83.0%
Value of invoices paid within five days	80.0%	88.7%	86.2%

Sir David Behan CBE
Chief Executive, Care Quality Commission
22 June 2017

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 2017 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 and staff report and the Parliamentary Accountability disclosures that are described 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 Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Social Care Act 2008. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Care Quality Commission's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Care Quality Commission; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements 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 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 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 the Care Quality Commission's affairs as at 31 March 2017 and of 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 Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion:

- the parts of the Remuneration and staff report and the Parliamentary Accountability disclosures to be audited have been properly prepared in accordance with Secretary of State directions made under the Health and Social Care Act 2008; and
- the information given in the Performance report and the Accountability 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 parts of the Remuneration and staff report and the Parliamentary Accountability disclosures to be audited are not in agreement with the accounting records and 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

5 July 2017

Financial statements

3

The financial statements are prepared in accordance with the Financial Reporting Manual 2016/17, published by HM Treasury, and comprise:

Statement of Comprehensive Net Expenditure

for the year ended 31 March 2017

	Note	2016/17 £000	2015/16 £000
Income from fees	6	(149,585)	(108,966)
Other operating income	6	–	(350)
Total operating income		**(149,585)**	**(109,316)**
Staff costs	3	171,292	171,523
Purchase of goods and services	4	43,509	57,938
Depreciation, amortisation and impairment charges	4	9,449	9,478
Provision expense	4	388	(153)
Other operating expenditure	4	11,010	9,259
Total operating expenditure		**235,648**	**248,045**
Net operating expenditure		**86,063**	**138,729**
Finance expense		(21)	(18)
Net expenditure for the year		**86,042**	**138,711**
Other comprehensive net expenditure			
Items that will not be reclassified to net operating costs:			
– Net gain on revaluation of intangible assets		(1,004)	(167)
– Net gain on revaluation of property, plant and equipment		(143)	(28)
– Actuarial gain in pension schemes		(774)	(4,459)
Comprehensive net expenditure for the year		**84,121**	**134,057**

The income and expenditure disclosed in the Statement of Comprehensive Net Expenditure relates to activities that are continuing.

Grant-in-aid totalling £81.7m was drawn down from the Department of Health during the year (2015/16: £135.0m) as shown in the Statement of Cash Flows.

Notes 1 to 20 form part of these financial statements.

Statement of Financial Position

as at 31 March 2017

	Note	31 March 2017 £000	31 March 2016 £000
Non-current assets			
Intangible assets	7	12,727	14,641
Property, plant and equipment	8	2,695	3,018
Total non-current assets		**15,422**	**17,659**
Current assets			
Trade receivables	11	3,361	2,301
Other current assets	11	1,896	1,633
Cash and cash equivalents	12	27,559	38,901
Total current assets		**32,816**	**42,835**
Total assets		**48,238**	**60,494**
Current liabilities			
Trade and other payables	13	(22,971)	(35,110)
Current pension liabilities	13	(81)	(236)
Provisions	14	(475)	(121)
Fee income in advance	13	(24,055)	(24,262)
Total current liabilities		**(47,582)**	**(59,729)**
Total assets less current liabilities		**656**	**765**
Non-current liabilities			
Provisions	14	(1,363)	(1,418)
Pension liabilities	13	(102)	(230)
Total non-current liabilities excluding pension deficit		**(1,465)**	**(1,648)**
Assets less liabilities excluding pension deficit provision		**(809)**	**(883)**
Pension deficit provision	5	(72,084)	(69,589)
Assets less liabilities		**(72,893)**	**(70,472)**
Taxpayers' equity			
General reserve		(81,649)	(70,698)
Revaluation reserve		756	226
Retained earnings		8,000	–
Total taxpayers' equity		**(72,893)**	**(70,472)**

The financial statements on pages 128 to 159 were approved by the Board on 22 June 2017 and were signed on its behalf by:

Sir David Behan CBE
Chief Executive, Care Quality Commission

Statement of Cash Flows

for the year ended 31 March 2017

	Note	2016/17 £000	2015/16 £000
Cash flows from operating activities			
Net expenditure for the year		(86,042)	(138,711)
Adjustment for non-cash transactions	15.1	13,247	12,993
(Increase)/decrease in trade and other receivables	11	(1,323)	471
(Decrease)/increase in trade and other payables	15.2	(10,021)	8,374
Decrease in pension liabilities	13	(283)	(94)
Decrease in fee income in advance	13	(207)	(8,344)
Use of provisions	14	(67)	(1,170)
Net cash outflow from operating activities		**(84,696)**	**(126,481)**
Cash flows from investing activities			
Purchase of intangible assets	15.3	(7,491)	(7,348)
Purchase of property, plant and equipment	15.4	(855)	(1,457)
Net cash outflow from investing activities		**(8,346)**	**(8,805)**
Cash flows from financing activities			
Grant-in-aid from Department of Health: cash drawn down in year		81,700	135,000
Net financing		**81,700**	**135,000**
Net decrease in cash and cash equivalents in the year		**(11,342)**	**(286)**
Cash and cash equivalents at 1 April		38,901	39,187
Cash and cash equivalents at 31 March		**27,559**	**38,901**

Statement of Changes in Taxpayers' Equity

for the year ended 31 March 2017

	Note	General reserve £000	Revaluation reserve £000	Retained earnings £000	Total reserves £000
Balance at 1 April 2015		**(71,694)**	**279**	**–**	**(71,415)**
Changes in taxpayers' equity for 2015/16:					
Grant-in-aid from Department of Health: cash drawn down in year		135,000	–	–	135,000
Net expenditure for the year		(138,711)	–	–	(138,711)
Revaluation gains – intangible assets		–	167	–	167
Revaluation gains – property, plant and equipment		–	28	–	28
Transfer between reserves		248	(248)	–	–
Actuarial gain in pension schemes	5	4,459	–	–	4,459
Balance at 31 March 2016		**(70,698)**	**226**	**–**	**(70,472)**
Changes in taxpayers' equity for 2016/17:					
Grant-in-aid from Department of Health: cash drawn down in year		81,700	–	–	81,700
Net expenditure for the year		(86,042)	–	–	(86,042)
Revaluation gains – intangible assets		–	1,004	–	1,004
Revaluation gains – property, plant and equipment			143	–	143
Transfer between reserves		617	(617)	–	–
Actuarial gain in pension schemes	5	774	–	–	774
Retained fee income		(8,000)	–	8,000	–
Balance at 31 March 2017		**(81,649)**	**756**	**8,000**	**(72,893)**

A retained earnings reserve has been created to reflect the recovery of depreciation as an element of the fees charged to providers, in line with HM Treasury's Managing Public Money. Depreciation is a non-cash movement, so recovery of depreciation by fees generates a cash balance. Through agreement with the Department of Health (DH) this can only be used in future years to fund appropriate capitalised expenditure in the year not separately financed by DH, improvements to the regulatory regime or returned to fee payers through lower future fees. Given the ring-fenced nature of this cash balance it is appropriate to separate it from the general reserve which reflects taxpayer's investment. This is most appropriately achieved by creating a retained earnings reserve.

The transfer of £8m reflects the proportion of CQC's assets that supports the regulatory functions where costs can be recovered under Section 85 of the Health and Social Care Act 2008 (see note 6).

Notes to the financial statements

1. Statement of accounting policies

The financial statements have been prepared on the basis that the Care Quality Commission (CQC) is a going concern. Grant-in aid which is required to fund CQC's net expenditure during 2017/18 has been included in the Department of Health estimates which have been approved by HM Treasury.

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 2016/17 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 CQC 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.

Accounting Standards that have been issued but have not yet been adopted

The following list presents the recently issued Accounting Standards and Amendments which have not yet been adopted with the FReM, and are therefore not applicable to CQC's accounts in 2016/17.

- IFRS 9 *Financial Instruments* – application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 14 *Regulatory Deferral Accounts* – only applies to first time adopters of IFRS after 1 January 2016 and is therefore not applicable to CQC.
- IFRS 15 *Revenue for Contracts with Customers* – application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 16 *Leases* – application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment and intangible assets. Revaluations are performed annually so that they are stated in the Statement of Financial Position at fair value. Any revaluation or indexation increase is credited to the revaluation reserve, except to the extent that it reverses an impairment for the same asset previously recognised as an expense, in which case the increase is credited to the Statement of Comprehensive Net Expenditure 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

Expenditure relating to IT software and software developments, including CQC's website, is capitalised if the asset has a cost of at least £5,000 or considered part of a collective group of interdependent assets with a total cost exceeding £5,000. General IT software project management costs are not capitalised.

All assets are revalued annually using the appropriate producer price index (PPI) as published by the Office for National Statistics. Increases in value are credited to the revaluation reserve whilst the asset is in use. Reductions below cost are charged to the Statement of Comprehensive Net Expenditure.

Property, plant and equipment

Expenditure on office refurbishments, office furniture and fittings, office equipment, IT equipment and infrastructure is capitalised if the asset has a value of at least £5,000 with a useful life of more than one year. Individual assets costing less than £5,000 are capitalised when considered part of a group if the total cost exceeds £5,000. General IT project management costs are not capitalised. The assets are recorded at cost and are restated at current value each year using the appropriate producer price index (PPI) as published by the Office for National Statistics.

Depreciation

Non-current assets are depreciated on a monthly basis from the date at which the asset is brought into use. Depreciation and amortisation is charged on a straight line basis to write off the costs or valuation of non-current assets, less any residual value, over their estimated useful lives as follows:

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

Office refurbishments and furniture is written-off over the remaining life of the lease (the date of the first lease break) if below 10 years. IT software, including developed software is written-off over the expected life if less than three years.

The estimated useful lives and residual values are reviewed annually.

Impairment of intangible and property, plant and equipment assets

At each Statement of Financial Position date, 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 annual statutory fees charged to all registered providers. Fees are invoiced on the anniversary of the registration and recognised as income over the following 12 months. Statutory fees which have been paid relating to future accounting periods are treated as income in advance at the end of each accounting period (note 13). 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 Statement of Comprehensive Net Expenditure on a straight-line basis over the lease term. There are no finance leases.

Financial instruments

Due to the non-trading nature of CQC'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 and all material assets and liabilities are denominated in sterling so it is not exposed to interest rate risk or currency risk.

Financial assets are recognised on the Statement of Financial Position when 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 receivables. Trade receivables 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 have no financial liabilities other than trade payables. Trade payables are not interest bearing and are stated at their nominal value.

Non-current receivables and payables 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 0.24% (2015/16: 1.37%). This is the rate for market yields on AA corporate bonds as published by HM Treasury.

Grants receivable

Grants received, including 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; and
- 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 2.70% (2015/16: 1.55%) and provisions falling due between five to 10 years are increased by a discount factor of 1.95% (2015/16: 1.00%) 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.

Value added tax

CQC 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 annual 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

Most past and present employees of CQC are covered by the provisions of the NHS Pensions 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 run in a way that would enable CQC 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 CQC of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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). Staff who were members of the Principal Civil Service Pension Scheme (PCSPS) were offered membership of the NHS pension scheme. Other staff, who were members of the Local Government Pension Scheme (LGPS), were allowed to keep their legacy arrangements. Details of the NHS pension scheme and the LGPS are provided in the 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 Comprehensive Net Expenditure. Charges to the Statement of Comprehensive Net Expenditure 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:

- net interest cost – the expected increase in the present value of liabilities during the year as they move one year closer to being paid.

Charged to other comprehensive expenditure:

- actuarial gain or loss on assets and liabilities – the extent to which investment returns achieved in year are different from interest rates used at the start of the year.

1.4 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.

The following are critical judgements that have been made by management in the process of applying CQC's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

a) Impairment of intangible assets (see accounting policy note 1.2 and note 7)

b) Provision for impairment of receivables (see note 11.1)

c) Indexation of non-current 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 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 two segments: continuing operations and Healthwatch England.

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:

	2016/17			2015/16		
	Continuing operations £000	**Healthwatch England £000**	**Total CQC £000**	**Continuing operations £000**	**Healthwatch England £000**	**Total CQC £000**
Gross expenditure	232,979	2,648	**235,627**	244,306	3,721	**248,027**
Income	(149,585)	–	**(149,585)**	(109,316)	–	**(109,316)**
Net expenditure	**83,394**	**2,648**	**86,042**	**134,990**	**3,721**	**138,711**

Overheads in relation to Healthwatch England totalling £642k (2015/16: £414k) were absorbed by CQC and are included in continuing operations above.

During 2016/17 no overheads were recharged from continuing operations (2015/16: £129k) to Healthwatch England.

3. Staff costs

Staff costs comprise:

	Permanently employed £000	Others £000	2016/17 Total £000	2015/16 Total £000
Wages and salaries	125,129	11,691	**136,820**	142,095
Social security costs	13,755	1,073	**14,828**	11,257
Other pension costs	17,697	454	**18,151**	17,264
Termination benefits	1,033	–	**1,033**	–
Subtotal	**157,614**	**13,218**	**170,832**	**170,616**
Less recoveries in respect of outward secondments	(510)	–	**(510)**	(549)
Increase in provision for pension fund deficits	970	–	**970**	1,456
Total net cost	**158,074**	**13,218**	**171,292**	**171,523**

Other staff costs consist of:

	2016/17 Total £000	2015/16 Total £000
Bank inspectors and specialist advisors	7,111	13,341
Second Opinion Appointed Doctors	3,257	2,905
Inward secondments from other organisations	2,029	2,287
Commissioners	444	681
Agency	377	2,554
Total	**13,218**	**21,768**

No staff costs were capitalised during the year (2015/16: £0.1m relating to agency staff engaged on software development).

4. Operating expenditure

	£000	2016/17 £000	£000	2015/16 £000
Staff costs		171,292		171,523
Purchase of goods and services:				
Establishment	17,564		23,316	
Travel and subsistence	11,504		15,588	
Rentals under operating leases	5,552		5,492	
Premises	4,749		7,279	
Supplies and services	1,665		1,433	
Training and development	1,456		2,596	
Professional fees	762		1,993	
External audit fee (statutory work)	145		145	
Insurance	98		94	
Consultancy	14		2	
Subtotal: Purchase of goods and services		43,509		57,938
Depreciation, amortisation, and impairment charges:				
Amortisation of intangible assets	8,053		8,162	
Depreciation of property, plant and equipment	1,420		1,323	
(Reversal of) impairment of intangible assets	(22)		(13)	
(Reversal of) impairment of property, plant and equipment	(2)		6	
Subtotal: Depreciation, amortisation, and impairment charges		9,449		9,478
Provision expense		388		(153)
Other operating expenditure:				
Experts by experience	5,502		4,849	
Net interest expense on pension scheme assets and liabilities	2,299		2,174	
Business rates paid to local authorities	2,099		1,585	
Losses and special payments (irrecoverable debts)	713		189	
Clinical negligence insurance	146		126	
Loss on disposal of fixed assets	163		56	
Other	88		280	
Subtotal: Other operating expenditure		11,010		9,259
Total operating expenditure		**235,648**		**248,045**

5. Pension costs

Due to legacy arrangements made by a predecessor organisation, CQC makes contributions to 16 defined benefit schemes on behalf of the former employees of the Commission for Social Care Inspection (CSCI). All of these schemes are closed to new employees.

The Statement of Financial Position shows an overall deficit provision of £72.1m (31 March 2016: £69.6m). The Department of Health has provided a guarantee to meet the pension deficit liability should they fall due.

The present value, the related current service cost and past service costs 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 actuarial assessment of each obligation was carried out at 31 March 2017 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

5.1 Pension assets and liabilities

The pension assets and liabilities attributable to CQC for each local government pension benefit scheme are as follows:

Pension fund	Assets 31 March 2017 £000	Liabilities 31 March 2017 £000	Surplus/ (deficit) 31 March 2017 £000	Surplus/ (deficit) 31 March 2016 £000
Avon	5,206	(7,155)	**(1,949)**	**(1,316)**
Cambridgeshire	3,565	(3,238)	**327**	**(623)**
Cheshire	4,166	(4,335)	**(169)**	**395**
Cumbria	3,984	(3,984)	**–**	**(55)**
Dorset	2,777	(4,270)	**(1,493)**	**(1,302)**
East Sussex	6,278	(6,151)	**127**	**(143)**
Essex	5,842	(6,831)	**(989)**	**(833)**
Greater Manchester	17,061	(18,307)	**(1,246)**	**(2,520)**
Hampshire	5,560	(7,810)	**(2,250)**	**(1,790)**
Merseyside	7,121	(8,443)	**(1,322)**	**(1,269)**
Shropshire	2,806	(3,724)	**(918)**	**(621)**
Suffolk	3,697	(4,849)	**(1,152)**	**(842)**
Surrey	5,733	(5,481)	**252**	**(383)**
Teesside	299,514	(360,187)	**(60,673)**	**(57,211)**
West Sussex	4,847	(3,647)	**1,200**	**560**
West Yorkshire	10,713	(12,542)	**(1,829)**	**(1,636)**
Total	**388,870**	**(460,954)**	**(72,084)**	**(69,589)**

All assets are held at bid value.

Two employees (2015/16: nil) retired early on ill-health grounds during the year, as a result additional pension costs of £nil (2015/16: £nil) were levied on CQC.

5.2 Actuarial assumptions

5.2.1 Financial Assumptions

A summary of the key assumptions used by the actuaries of the pension schemes are as follows:

	Teesside Pension Fund % per annum		Other pension funds % per annum	
Key assumptions used:	**2016/17**	**2015/16**	**2016/17**	**2015/16**
Discount rate	2.5	3.4	2.5 – 2.6	3.2 – 3.7
Expected rate of salary increases	3.0	3.3	2.7 – 4.0	3.1 – 4.2
Expected return on scheme assets	2.5	3.4	2.5 – 2.6	3.2 – 3.7
Future pension increases	2.0	1.8	2.0 – 2.5	1.7 – 2.2
Inflation	2.0	1.8	2.0 – 2.5	1.7 – 2.2

5.2.2 Mortality assumptions

Based on actuarial mortality tables, the average future life expectancies at age 65 are summarised below:

	Teesside Pension Fund		Other pension funds	
Key assumptions used:	**2016/17**	**2015/16**	**2016/17**	**2015/16**
Retiring today:				
Males	22.8	23.1	21.5 – 24.0	21.4 – 24.6
Females	24.9	25.6	24.1 – 27.0	24.0 – 26.4
Retiring in 20 years:				
Males	25.0	25.3	23.0 – 26.1	24.0 – 26.9
Females	27.2	28.0	26.2 – 29.3	26.6 – 29.2

5.3 Charges to net expenditure

Amounts recognised in the Statement of Comprehensive Net Expenditure in respect of these defined benefit pension schemes are as follows:

	2016/17 £000	2015/16[1] £000
Service cost:		
Current service cost	5,518	6,189
Past service cost	–	–
Administration expenses	89	98
Net interest expense	2,299	2,174
Amount recognised in net expenditure	**7,906**	**8,461**

[1] The prior year comparative for 2015/16 has been restated to separately show administrative expenses which were previously disclosed as part of current service cost.

Of the expense for the year, the total service cost of £5.6m (2015/16: £6.3m) has been included in the Statement of Comprehensive Net Expenditure as staff expenditure, note 3. £4.6m (2015/16: £4.8m) is included within other pension costs and £1.0m (2015/16: £1.5m) is included as an increase in provision for pension fund deficits. The net interest expense of £2.3m (2015/16: £2.2m) has been included in other expenditure, note 4. The re-measurement of the net defined benefit obligation is included in the Statement of Comprehensive Net Expenditure.

5.4 Charges to other comprehensive net expenditure

Amounts recognised in the Statement of Comprehensive Net Expenditure are as follows:

	2016/17 £000	2015/16 £000
The return on plan assets (excluding amounts included in net interest expense)	(62,392)	15,063
Other remeasurement gains on plan assets	(205)	–
Actuarial losses arising from changes in demographic assumptions	(7,638)	–
Actuarial gains and (losses) arising from changes in financial assumptions	74,922	(15,749)
Actuarial losses arising from experience adjustments	(5,461)	(3,773)
Remeasurement of the net defined benefit obligations	**(774)**	**(4,459)**

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 2017 is £84m (31 March 2016: £85m).

5.5 Amount recognised in the Statement of Financial Position

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

	31 March 2017 £000	31 March 2016 £000
Present value of defined benefit obligation	(460,853)	(393,092)
Fair value of scheme assets	388,870	323,590
Deficit in scheme	**(71,983)**	**(69,502)**
Past service cost not yet recognised	(101)	(87)
Liability recognised in the Statement of Financial Position	**(72,084)**	**(69,589)**

5.6 Reconciliation of fair value of scheme liabilities

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

	2016/17 £000	2015/16[2] £000
At 1 April	**(393,179)**	**(403,007)**
Current service cost	(5,518)	(6,189)
Administration expenses	(81)	(90)
Interest cost	(13,187)	(12,692)
Contributions from scheme members	(1,638)	(1,764)
Past service costs	–	–
Re-measurement gains/(losses)		
Actuarial gains arising from changes in demographic assumptions	7,638	–
Actuarial gains and (losses) arising from changes in financial assumptions	(74,922)	15,749
Actuarial gains arising from experience adjustments	5,461	3,773
Benefits paid	14,472	11,041
At 31 March	**(460,954)**	**(393,179)**

[2] The prior year comparative for 2015/16 has been restated to separately show administrative expenses which were previously disclosed as part of current service cost.

5.7 Reconciliation of fair value of employer assets

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

	2016/17 £000	2015/16 £000
At 1 April	**323,590**	**332,589**
Interest income	10,888	10,518
Re-measurement gain/(loss):		
The return on plan assets (excluding amounts included in net interest expense)	62,392	(15,063)
Other	205	–
Employer contributions	4,637	4,831
Member contributions	1,638	1,764
Benefits paid	(14,472)	(11,041)
Administration expenses	(8)	(8)
At 31 March	**388,870**	**323,590**

5.8 Fair value of employer assets

The fair value of scheme assets and the expected rate of return at the Statement of Financial Position date were as follows:

	Expected return		Fair value of assets	
	2016/17 %	2015/16 %	2016/17 £000	2015/16 £000
Equities	2.5 – 2.6	3.2 – 3.7	296,447	256,811
Property	2.5 – 2.6	3.2 – 3.7	26,251	22,948
Government bonds	2.5 – 2.6	3.2 – 3.7	5,522	7,446
Other bonds	2.5 – 2.6	3.2 – 3.7	12,011	12,198
Cash	2.5 – 2.6	3.2 – 3.7	36,375	14,460
Other	2.5 – 2.6	3.2 – 3.7	12,264	9,727
Total			**388,870**	**323,590**

5.9 Sensitivity analysis

Pension liabilities are calculated using actuarial estimates as shown in note 5.2 above. If the major assumptions were to change, the impact on the defined benefit obligation would be as follows:

	Teesside Pension Fund			Other pension funds		
	£000	£000	£000	£000	£000	£000
Adjustment to discount rate	**+ 0.1%**	**Current**	**- 0.1%**	**+ 0.1%**	**Current**	**- 0.1%**
Present value of total obligation	354,189	360,187	366,286	99,260	100,767	102,280
Movement	(5,998)	–	6,099	(1,507)	–	1,513
Adjustment to inflation	**+ 0.1%**	**Current**	**- 0.1%**	**+ 0.1%**	**Current**	**- 0.1%**
Present value of total obligation	361,233	360,187	359,149	100,875	100,767	100,659
Movement	1,046	–	(1,038)	108	–	(108)
Adjustment to future pension increases	**+ 0.1%**	**Current**	**- 0.1%**	**+ 0.1%**	**Current**	**- 0.1%**
Present value of total obligation	365,231	360,187	355,218	102,200	100,767	99,338
Movement	5,044	–	(4,969)	1,433	–	(1,429)
Adjustment to life expectancy	**+ 1 year**	**Current**	**- 1 year**	**+ 1 year**	**Current**	**- 1 year**
Present value of total obligation	371,050	360,187	349,398	104,037	100,767	97,401
Movement	10,863	–	(10,789)	3,270	–	(3,366)

5.10 Funding arrangements

The funded nature of the LGPS requires participating employers and employees to pay contributions into the fund, calculated at a level intended to balance the pension liabilities with investment assets. Information on the framework for calculating contributions to be paid is set out in LGPS Regulations 2013 and the Funding Strategy Statement of each fund.

The last triennial actuarial valuation was completed as at 31 March 2016 which set the employer contribution rates for three years from 1 April 2017 to 31 March 2020. Some of the funds have also levied a 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 price index (CPI), rather than the retail prices index (RPI).

Contribution rates for 2017/18 range between 0% and 41.6% (17.9% for Teesside Pension Fund) with annual cash sums ranging from £26k to £612k (£nil for Teesside Pension Fund).

6. Income

	2016/17 £000	2015/16 £000
Income from fees	(149,585)	(108,966)
Other operating income	–	(350)
	(149,585)	**(109,316)**

Fees and charges are made in accordance with section 85(1) of the Health and Social Care Act 2008. Consent was obtained from the Secretary of State for Health for the Fees Scheme for 2016/17 which gives rise to the fees scales used.

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 which have been paid are treated as income in advance at the end of each accounting period (note 13). In cases of voluntary deregistration, registered organisations can apply for a refund in accordance with the fee rebate scheme detailed on CQC's website.

During 2016/17 CQC recovered 66.3% (2015/16: 45.4%) 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 means that all but one of our sectors will be charged fees at full cost recovery in 2017/18.

7. Intangible assets

	IT software development £000	Software licences £000	Website £000	Total £000
Cost or valuation				
At 1 April 2016	29,288	3,046	5,655	**37,989**
Additions	4,384	609	275	**5,268**
Disposals	(878)	–	–	**(878)**
Indexation gains/(losses) charged to other operating expenditure	35	14	6	**55**
Indexation gains to revaluation reserve	1,872	191	355	**2,418**
At 31 March 2017	**34,701**	**3,860**	**6,291**	**44,852**
Amortisation				
At 1 April 2016	18,008	1,302	4,038	**23,348**
Charged in year	5,806	1,036	1,211	**8,053**
Disposals	(723)	–	–	**(723)**
Indexation gains charged to other operating expenditure	27	–	6	**33**
Indexation gains to revaluation reserve	1,083	82	249	**1,414**
At 31 March 2017	**24,201**	**2,420**	**5,504**	**32,125**
Net book value at 1 April 2016	**11,280**	**1,744**	**1,617**	**14,641**
Net book value at 31 March 2017	**10,500**	**1,440**	**787**	**12,727**
Asset financing:				
Owned	10,500	1,440	787	**12,727**
At 31 March 2017	**10,500**	**1,440**	**787**	**12,727**

	IT software development £000	Software licences £000	Website £000	Total £000
Cost or valuation				
At 1 April 2015	30,757	1,833	5,287	**37,877**
Additions	7,216	1,218	316	**8,750**
Disposals	(8,983)	(14)	(16)	**(9,013)**
Indexation gains charged to other operating expenditure	83	(12)	25	**96**
Indexation gains to revaluation reserve	215	21	43	**279**
At 31 March 2016	**29,288**	**3,046**	**5,655**	**37,989**
Amortisation				
At 1 April 2015	20,739	756	2,448	**23,943**
Charged in year	6,036	550	1,576	**8,162**
Disposals	(8,922)	(14)	(16)	**(8,952)**
Indexation gains charged to other operating expenditure	65	2	16	**83**
Indexation gains to revaluation reserve	90	8	14	**112**
At 31 March 2016	**18,008**	**1,302**	**4,038**	**23,348**
Net book value at 1 April 2015	**10,018**	**1,077**	**2,839**	**13,934**
Net book value at 31 March 2016	**11,280**	**1,744**	**1,617**	**14,641**
Asset financing:				
Owned	11,280	1,744	1,617	**14,641**
At 31 March 2016	**11,280**	**1,744**	**1,617**	**14,641**

Intangible assets comprise software licences, software development costs, including related contractor and staff costs, and website development costs. These are revalued using the appropriate producer price index (PPI) published 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	2016/17 £000	2015/16 £000
Balance at 1 April	172	233
Net gain on indexation of intangible assets	1,004	167
Transfers between reserves for intangible assets	(532)	(228)
Balance at 31 March	**644**	**172**

8. Property, plant and equipment

	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation			
At 1 April 2016	6,738	5,923	**12,661**
Additions	480	480	**960**
Disposals	(144)	(3,667)	**(3,811)**
Indexation gains/(losses) charged to other operating expenditure	9	–	**9**
Indexation gains to revaluation reserve	397	21	**418**
At 31 March 2017	**7,480**	**2,757**	**10,237**
Depreciation			
At 1 April 2016	4,911	4,732	**9,643**
Charged in year	1,048	372	**1,420**
Disposals	(141)	(3,662)	**(3,803)**
Indexation gains charged to other operating expenditure	7	–	**7**
Indexation gains to revaluation reserve	275	–	**275**
At 31 March 2017	**6,100**	**1,442**	**7,542**
Net book value at 1 April 2016	**1,827**	**1,191**	**3,018**
Net book value at 31 March 2017	**1,380**	**1,315**	**2,695**
Asset financing:			
Owned	1,380	1,315	**2,695**
At 31 March 2017	**1,380**	**1,315**	**2,695**

	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation			
At 1 April 2015	5,805	6,951	**12,756**
Additions	903	738	**1,641**
Disposals	(48)	(1,757)	**(1,805)**
Indexation gains charged to other operating expenditure	14	(11)	**3**
Indexation gains to revaluation reserve	64	2	**66**
At 31 March 2016	**6,738**	**5,923**	**12,661**
Depreciation			
At 1 April 2015	3,867	6,216	**10,083**
Charged in year	1,057	266	**1,323**
Disposals	(60)	(1,750)	**(1,810)**
Indexation gains charged to other operating expenditure	9	–	**9**
Indexation gains to revaluation reserve	38	–	**38**
At 31 March 2016	**4,911**	**4,732**	**9,643**
Net book value at 1 April 2015	**1,938**	**735**	**2,673**
Net book value at 31 March 2016	**1,827**	**1,191**	**3,018**
Asset financing:			
Owned	1,827	1,191	**3,018**
At 31 March 2016	**1,827**	**1,191**	**3,018**

Property, plant and equipment are valued using the appropriate producer price index (PPI) published by the Office for National Statistics.

The opening and closing element of the revaluation reserve is shown below:

Revaluation reserve: property, plant and equipment	**2016/17 £000**	**2015/16 £000**
Balance at 1 April	54	46
Net gain on indexation	143	28
Transfers between reserves	(85)	(20)
Balance at 31 March	**112**	**54**

9. Impairments

At 31 March 2017 CQC carried out an impairment review of all assets. The review resulted in no impairments being recognised.

All assets are revalued annually using indices published by the Office for National Statistics. The application of the index has resulted in both upward and downward movements in value. Overall upward movements in value were recognised which initially reserved previous impairments charged to operating expenditure with the remainder increasing the revaluation reserve.

	31 March 2017 £000	31 March 2016 £000
Impairments and (reversals) charged to Statement of Comprehensive Net Expenditure		
Intangible assets		
– Websites	–	(9)
– Software licences	(14)	14
– Developed expenditure	(8)	(18)
Property, plant and equipment		
– Information technology	(2)	(5)
– Furniture and fittings	–	11
Total impairments and (reversals) charged to the Statement of Comprehensive Net Expenditure	**(24)**	**(7)**
Total impairments and (reversals) charged to the Revaluation Reserve	**–**	**–**
Total impairments and (reversals) charged in year	**(24)**	**(7)**

10. Financial instruments

Liquidity risk

The cash requirements of CQC are met through annual registration fees charged to providers and grant-in-aid from the Department of Health. The Fees Scheme published in April 2016 set a trajectory to full chargeable cost recovery which will result in the fees paid by providers becoming the main source of funding for CQC.

CQC manages liquidity risk through regular cash flow forecasting to ensure that sufficient funds are available to cover working capital requirements. CQC has no borrowings relying on the collection of fees and grand-in-aid from the Department of Health to cover cash requirements.

Credit risk

Credit risk arises from cash and cash equivalents and accounts receivable. Management monitors the collection of fees closely and all undisputed debts that have reached 61 days past due and where internal recovery processes have been exhausted are sent to an external debt collection company. In this case such debts are provided for as irrecoverable as a matter of course whilst ultimate recovery is pursued.

Of the trade receivables balance recognised at 31 March 2017, see note 11, there were no material balances with individual organisations. Therefore disclosure of the largest balances was not considered in the evaluation of overall credit risk.

CQC issued annual fee invoices to registered providers totalling £170.0m during 2016/17. Of this amount £39.0m relates to transactions with NHS trusts and a further £23.1m was invoiced to GPs, the majority of which are publicly funded. Invoices relating to providers of adult social care services totalled £88.7m during the year, of which those overseen by the statutory Market Oversight scheme accounted for £23.3m.

The table below shows the value of overdue trade receivables which have not been provided for as irrecoverable 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	Total £000
At 31 March 2017	631	220	385	**1,236**
At 31 March 2016	139	349	546	**1,034**

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 the receivables mentioned above. CQC does not hold any collateral as security.

Market risk

CQC is not exposed to currency or commodity risk. All material assets and liabilities are denominated in sterling. With the exception of cash and cash equivalents, CQC has no interest bearing assets or borrowing subject to variable interest rates. Income and cash flows are largely independent of changes in market interest rates.

10.1 Financial assets

	31 March 2017 £000	31 March 2016 £000
NHS receivables	294	78
Non-NHS receivables	4,963	3,856
Cash at bank and in hand	27,559	38,901
Total	**32,816**	**42,835**

10.2 Financial liabilities

	31 March 2017 £000	31 March 2016 £000
NHS payables	2,720	3,091
Non-NHS payables	44,489	56,747
Total	**47,209**	**59,838**

11. Trade receivables and other current assets

	31 March 2017 £000	31 March 2016 £000
Amounts falling due within one year:		
Trade receivables	3,361	2,301
Other current assets:		
Deposits and advances	163	162
Other receivables	588	224
Prepayments and accrued income	1,145	1,247
Subtotal: Other current assets	1,896	1,633
Total	**5,257**	**3,934**

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

Deposits and advances include payments on salary and staff loans which total £16k and £147k (31 March 2016: £18k and £144k). Staff can apply for advance payments on salary and loans up to a maximum of £5k for rail season tickets.

11.1 Movement in the provision for impairment of receivables

	2016/17 £000	2015/16 £000
Balance at 1 April	**654**	**555**
New provisions recognised during the year	1,087	529
Provisions reversed as unused	(179)	(160)
Amounts written off during the year as uncollectable	(281)	(92)
Amounts recovered during the year	(195)	(178)
Balance at 31 March	**1,086**	**654**

12. Cash and cash equivalents

	2016/17 £000	2015/16 £000
Balance at 1 April	**38,901**	**39,187**
Net change in cash and cash equivalent balances	(11,342)	(286)
Balance at 31 March	**27,559**	**38,901**
The following balances at 31 March were held at:		
Government banking service and cash in hand	27,559	38,901
Total balance at 31 March	**27,559**	**38,901**

13. Trade payables and other current liabilities

	31 March 2017 £000	31 March 2016 £000
Amounts falling due within one year:		
VAT	(140)	(52)
Other taxation and social security	(3,699)	(3,690)
Trade payables	(2,372)	(4,615)
Other payables	(4,980)	(3,903)
Accruals	(10,628)	(19,580)
Capital creditors – intangible assets	(549)	(2,772)
Capital creditors – property, plant and equipment	(603)	(498)
Total trade and other payables	**(22,971)**	**(35,110)**
Current pension liabilities	(81)	(236)
Fee income in advance	(24,055)	(24,262)
Total current trade payables and other current liabilities	**(47,107)**	**(59,608)**
Amounts falling after more than one year:		
Pension liabilities	(102)	(230)
Total non-current trade payables and other non-current liabilities	**(102)**	**(230)**

Trade payables at 31 March 2017 were equivalent to 10 days (31 March 2016: 35 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.

Trade payables falling due after more than one year have been reduced by a discount factor of 0.24% per annum (2015/16: 1.37%) in accordance with HM Treasury guidance.

14. Provisions for liabilities and charges

	2016/17			2015/16		
	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	**121**	**1,418**	**1,539**	**561**	**2,319**	**2,880**
Provided in year	406	5	**411**	121	215	**336**
Provisions not required written back	(54)	–	**(54)**	(491)	–	**(491)**
Provisions utilised in year	(67)	–	**(67)**	(70)	(1,100)	**(1,170)**
Change in discount Rate	–	31	**31**	–	2	**2**
Unwinding of discount	–	(22)	**(22)**	–	(18)	**(18)**
Balance at 31 March	**406**	**1,432**	**1,838**	**121**	**1,418**	**1,539**

14.1 Analysis of expected timings of discounted cash flows

	2016/17			2015/16		
	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	406	69	**475**	121	–	**121**
Later than one year and not later than five years	–	1,363	**1,363**	–	1,418	**1,418**
Later than five years	–	–	**–**	–	–	**–**
Balance at 31 March	**406**	**1,432**	**1,838**	**121**	**1,418**	**1,539**

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 2016: £0.1m).

Employment termination costs relate to the restructuring which formed part of the modernisation of our national customer service centre. The provision covers the cost of redundancies that were agreed by 31 March 2017, although some staff will not leave CQC until 2017/18, and is estimated as £0.2m (31 March 2016: £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 2.70% (2015/16: 1.55%) and provisions falling due between five and 10 years have been increased by a discount factor of 1.95% (2015/16: 1.00%) in accordance with HM Treasury guidance.

15. Reconciliation of movements in the Statement of Cash Flows

15.1 Adjustment for non-cash transactions

	Note	2016/17 £000	2015/16 £000
Depreciation and impairment charges	4	9,449	9,478
Increase in provision for pension fund deficit	3	970	1,456
Net interest expenses on pension scheme assets and liabilities	4	2,299	2,174
Loss on disposal of fixed assets	4	163	56
Provisions expense	4	388	(153)
Finance expense: unwinding of discount on provisions	14	(22)	(18)
Total adjustment for non-cash transactions		**13,247**	**12,993**

15.2 Movement in trade and other payables

	Note	2016/17 £000	2015/16 £000
(Decrease)/increase in trade and other payables	13	(12,139)	9,960
Less (decrease)/increase in capital creditors – intangible assets	13	2,223	(1,402)
Less (increase)/decrease in capital creditors – property, plant and equipment	13	(105)	(184)
Total movement in trade and other payables		**(10,021)**	**8,374**

15.3 Purchase of intangible assets

	Note	2016/17 £000	2015/16 £000
Additions	7	(5,268)	(8,750)
(Decrease)/increase in capital creditors – intangible assets	13	(2,223)	1,402
Total purchase of intangible assets		**(7,491)**	**(7,348)**

15.4 Purchase of property, plant and equipment

	Note	2016/17 £000	2015/16 £000
Additions	8	(960)	(1,641)
Increase in capital creditors – property, plant and equipment	13	105	184
Total purchase of property, plant and equipment		**(855)**	**(1,457)**

16. Capital commitments

Contracted capital commitments at 31 March 2017, not otherwise included within these financial statements:

	31 March 2017 £000	31 March 2016 £000
Intangible assets	4,946	6,639
Property, plant and equipment	–	198
Total	**4,946**	**6,837**

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 2017 £000	31 March 2016 £000
Buildings:		
Not later than one year	5,574	4,745
Later than one year and not later than five years	13,414	14,860
Later than five years	265	360
Total	**19,253**	**19,965**
Other:		
Not later than one year	62	17
Later than one year and not later than five years	29	15
Later than five years	–	–
Total	**91**	**32**

There were no future minimum lease payments due under finance leases at the Statement of Financial Position date.

18. Contingent liabilities disclosed under IAS37

CQC has the following contingent liabilities:

	31 March 2017 £000	31 March 2016 £000
Employment tribunals and legal advice	918	200
Total	**918**	**200**

Due to the nature of the contingent liabilities it is difficult to accurately determine the final amounts due and when they will crystallise.

19. Related party transactions

CQC 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	5,953	81,700	1,956	–
NHS foundation trusts	8	25,244	513	47
NHS trusts	6	13,498	167	9
NHS England	90	–	69	–
NHS special health authorities	143	–	–	89
Other non-departmental public bodies	13	–	15	149

CQC received a total amount of grant-in aid of £81.7m (2015/16: £135.0m) 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 Business, Energy & Industrial Strategy 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.

20. Events after the reporting period date

There were no significant events after the Statement of Financial Position date.

The financial statements were authorised for issue on 5 July 2017 by the Chief Executive as Accounting Officer.

Care Quality Commission

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CQC-379-60-WL-072017

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ISBN 978-1-4741-4497-1