Care Quality Commission

Annual report and accounts
2017/18

HC 1193

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Annual report and accounts 2017/18

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HC 1193

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Contents

Who we are and what we do

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

Our values

- Excellence
- Caring
- Integrity
- Teamwork

Our purpose

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

How we are organised

- Adult Social Care
- Hospitals
- Primary Medical Services and Integrated Care
- Strategy and Intelligence
- Customer and Corporate Services

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.

Strategic priorities

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

Who we work with

We are independent, but we report to Parliament through the Department of Health and Social Care.

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 CBE DL
Chair

Sir David Behan CBE
Chief Executive

The Care Quality Commission is an organisation with a clear purpose: to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care to improve. We were formed in 2009 and in 2011 we were subject to criticism from Parliament. Since that time we have made considerable progress.

Our performance today reflects the impact of the rigorous and expert-led inspection approach that we started in 2012. The approach is designed to protect people from poor care, encourage improvements in care, give the public good and timely information about the care they receive, and ensure we are efficient and effective.

Now at the mid-point of our current strategy, we should take stock and reflect on what we have achieved, and where we need to put our efforts to make sure we deliver on the priorities we have set ourselves for 2021.

At the heart of our work is our purpose and our commitment to act independently, to be on the side of people who use services, their families and carers. We want to thank all of our staff for their unremitting hard work, dedication and energy, and their commitment to our values of excellence, caring, integrity and teamwork. Our strategy for 2016 to 2021 signals our ambition for a more targeted, responsive and collaborative approach to regulation, so that more people get high-quality care. The strategy sets out four priorities:

Encourage improvement, innovation and sustainability in care

As at 31 March 2018, the overall ratings for each sector were:

- Adult social care services: 2% rated as inadequate, 17% rated as requires improvement, 79% rated as good and 2% rated as outstanding.
- Hospital services: 2% rated as inadequate, 28% rated as requires improvement, 62% rated as good and 7% rated as outstanding.
- Primary medical services: 1% rated as inadequate, 4% rated as requires improvement, 91% rated as good and 5% rated as outstanding.

We have seen an overall improvement in the distribution of ratings, with more services rated as good and outstanding compared with 2016/17. Across all sectors, 72% of services that were rated as inadequate on their previous inspection, and were re-inspected and rated in 2017/18, improved their rating. Also, 51% rated as requires improvement improved their rating. But we have also seen some services where the quality of care has deteriorated.

We have worked closely with providers that made substantial improvements, to understand what they did to improve and what others can learn. The results have been a series of case study publications that highlight the improvement journey of acute trusts, adult social care services, mental health trusts and GP practices. Our *State of Care* report and thematic reports, such as our report on children and young people's mental health, have also highlighted and supported improvement in health and care.

As health and social care services adapt to demographic change, and science and technology advances, consequently we must look ahead and be ready to change the way we regulate. We published our principles for regulating new models of care, and a report on the quality of online primary care, an area that is growing quickly. These new models of care have the potential to transform the way people access and use health and care services. It is important that people are informed and protected when accessing new types of care delivery.

Deliver an intelligence-driven approach to regulation

In 2013 we began using data and intelligence to inform our work. Building on our solid baseline understanding of the quality of health and social care, we have started our next phase of regulation and will continue to be intelligence-driven in our approach. We are confident that this will better protect people from poor care by showing us quickly and clearly where quality may have changed.

This more targeted and tailored approach to regulation is underpinned by our investment in digital technology. Over the coming years, our digital programme will transform the way that we collect, process and share our data and information. This will have substantial benefits for people who use care services, providers, partners and our staff.

We have also started to explore how data science and advanced analytics can help us to more effectively use and analyse the data that we hold, and more accurately support regulatory decision-making. We will continue this work in 2018/19.

Promote a single shared view of quality

An important aspect of our strategy is working with our system partners to agree a shared view of what good quality care looks like. We want to continue working with our key partners, such as NHS England, NHS Improvement, stakeholder organisations and professional regulators to develop better ways to coordinate and share information and processes, and in doing so also reduce the administrative burden for providers.

Our local system reviews have given us a unique understanding of the challenges of local health and care organisations working together to meet the needs of individual people. Our national report, published earlier in July, highlighted our findings in each area of what is working well, examples of good practice, and where improvement is needed for better collaboration to drive improvements in care for people.

We have made good progress in our work with partners to develop system-wide definitions of quality: our work with the adult social care sector and the Department of Health and Social Care to implement *Quality matters*, in health care with the NHS National Quality Board, and in primary care with the Regulation of General Practice Programme Board. Our next stage is to take practical steps to implement the actions outlined in each shared view.

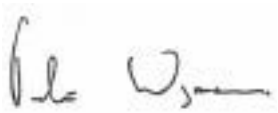
Improve our efficiency and effectiveness

Our financial performance continues to be good. Our current spending review runs from 2015/16 to 2019/20 and we have made good progress during this period. We have delivered within budget in each financial year and our operating expenditure has reduced by £16 million from the start of the spending review, primarily as a result of achieving savings on our non-pay expenditure such as travel and subsistence, and premises. We are currently forecast to achieve the required financial reductions by 2019/20.

As we move to become more intelligence-driven, we are starting to become more efficient in the way we deliver our inspection programme. Our average costs of inspection have seen an overall reduction from £7,300 per inspection to £6,400. Our funding has changed significantly during this time, with almost all chargeable activities now recovered through provider fees. This will be 100% by 2019/20, compared with 49% in 2015/16.

We set out our equality objectives for 2017 to 2019. We will have a strong focus in 2018/19 on how we make sure that equality, diversity and human rights become embedded in everyone's day-to-day work, with a particular emphasis on improving race equality. We are pleased to have no gender pay gap at CQC, and we have seen positive changes in equality of work experience for disabled staff. We want to build on these successes to become a fully inclusive organisation, as we know that this has a natural link to effectiveness.

Our Academy has a greatly enhanced learning and development programme and we have a full range of courses for all levels of staff. As we develop our methodologies and the law changes, we will continue to use the Academy to assist staff in developing their knowledge and skills. We have also invested in developing the leadership skills of our staff through a tailored programme for all CQC managers. We continue to support staff with a range of technology improvements to help them do their jobs better, and new mobile technology for inspection staff is being rolled out. A focus for the coming year will be to develop a culture of quality improvement across all levels of the organisation. We are looking to establish a partnership with a recognised quality improvement provider to assist in introducing and developing the key quality improvement skills and techniques for our staff.



Peter Wyman CBE DL
Chair

David Behan CBE
Chief Executive

Message from the Chair

This is David's final annual report and accounts as Chief Executive of CQC. I want to take this opportunity to thank David for the scale of the achievements that the organisation has delivered under his leadership. David's unique combination of passion, vision and deep understanding of the health and care system – along with his personal commitment to putting people at the heart of everything we do – have led CQC to become a catalyst for change that improves the quality of people's care.

Highlights of progress against our strategy for 2016 to 2021

Priority 1

Encourage improvement, innovation and sustainability in care

- Carried out a number of local system reviews of **how local health and care systems work together**. We published our national report with findings and recommendations earlier in July.
- Developed our **approach to regulating online primary care providers** with providers and system partners, and published our findings of our first inspections of all 52 online providers.
- Worked with NHS Improvement to consult on and develop a framework to assess the **use of resources** in NHS trusts.
- Used **our understanding of what drives improvement** to publish a range of case study reports for adult social care, acute trust, mental health trust and GP practice providers.
- Published our **principles for regulating new models of care**.
- Consulted on and developed our approach to **regulating independent health care**.
- Consulted on and developed our **changes to the structure of registration**, which included the wider set of criteria we will use to define types of providers that need to register.

Priority 2

Deliver an intelligence-driven approach to regulation

- Started using our **new methodology and intelligence-driven approach** to monitor and inspect NHS trusts, adult social care and primary medical services providers. We are making much greater use of data and insight to monitor the quality of care and be more targeted with our inspections.
- Launched **CQC Insight dashboards** to support monitoring and inspection of NHS hospitals, mental health, adult social care and GP practices, as well as to support registration, and started to develop dashboards for other sectors.
- Started to redesign **our online registration service**, starting with a focus on registered managers of domiciliary care agencies (care at home).
- Continued to build our relationships with a range of system partners to **gather people's experiences of care more effectively**, such as with the Healthwatch network, commissioners and voluntary and community sector organisations.
- Started to redesign our **online experience of care form** to make it easier for people to share their experiences and to make sure it captures structured and clear information.

Priority 3

Promote a single shared view of quality

- **Agreed *Quality matters***, the sector-wide shared commitment to quality in adult social care with system partners.
- Together with NHS Improvement, consulted on and developed our joint framework for **inspecting the well-led key question**.
- Worked to **embed our shared definition of quality in health care** with the NHS National Quality Board.
- Contributed to the national **NHS improvement and leadership development strategy**.
- Worked with partners on the Regulation of General Practice Programme Board to agree a **primary care shared view of quality**.
- Worked with partners on the Regulation of Dental Services Programme Board to update our **approach to dental regulation**.
- Developed a protocol with other system partners, including professional regulators, to **share concerns about the quality of care** and to coordinate our response.

Priority 4

Improve our efficiency and effectiveness

- **Improved our resource and inspection planning tool (Cygnum)** to make it more streamlined and efficient for staff to use.
- Started **testing our online provider information collection system** for adult social care.
- Completed our **Inspire leadership programme** for CQC managers.
- Started to **develop a culture of quality of improvement** across CQC.
- Set out our equality objectives for 2017 to 2019, with one focus being on how we **recruit a more diverse workforce**.
- **Worked to redesign our intranet,** which will launch in 2018/19 and help staff to access the information they need more easily.

Performance summary

2017/18 has been a good year for our performance and we have shown improvements in most areas, strengthening the way we monitor, inspect and regulate hospitals, care homes, general practices and other services across the country. At the same time, we have more to do – there are areas of our work that require further improvement, and where we need to do more to meet our targets.

In 2018 we received public acknowledgement of our progress from the Public Accounts Committee and the National Audit Office. While we are proud of what we have achieved, we want to continue to learn, grow and develop.

Improvement highlights

- We completed more than **17,000 inspections**. We saw improvement in the overall distribution of ratings, with more services rated as good and outstanding compared with 2016/17.
- We **used an increased range of enforcement powers to protect people**, including five criminal prosecutions.
- Our 2017 annual public awareness survey found that **65% of respondents were aware of CQC** – this is an increase from 50% in 2015.
- Nearly 80% of respondents to our provider survey agreed that **CQC encourages improvement.**
- We improved **how quickly we assess registration applications** – we assessed 85% against our target of 90% in 50 days, compared with 79% in 2016/17.
- Our staff survey results were **above the public and private sector benchmarks** on alignment to our purpose, support of team members, and visibility of leaders.
- We started to **design and develop new digital services** to help the public to share their experiences of care and to support providers to share information with us.
- Our **robust baseline of the quality of care** means we are better placed to understand changes in quality and respond quickly with our intelligence-driven approach.
- Our reviews of local health and care systems highlighted some good practice and opportunities for **improvements across organisations and sectors**.
- We **reduced our costs** against 2016/17 actual figures and the 2017/18 budget.

Protecting people from poor care

We are focused on spotting poor care and taking swift action to protect people when the quality of care they receive is unacceptable.

We refused to register providers and managers when they were not able to meet the required standards, did not have the financial resources, or were not fit to run the service.

We issued 2,283 enforcement actions, and our inspectors have increasingly used the breadth of our enforcement powers, including five criminal prosecutions in 2017/18. We also took action against unregistered providers.

We recommended that 720 providers or locations enter special measures because of serious failings in care. Of the 704 providers that exited special measures, 479 did so because they had made enough improvement.

Better understanding of changes in the quality of care

With the completion of our comprehensive ratings and inspection programme, 2017/18 has been the first year in which we have been able to build on our robust, baseline understanding of the quality of health and social care in England.

We started monitoring, inspecting and rating using our new intelligence-driven approach. We now target our inspections to where we see that the quality of care has changed – so that we can better protect people, and also acknowledge the improvement that we find.

We completed more than 17,000 inspections and met our re-inspection commitments in the Hospitals and Primary Medical Services directorates. We were close to meeting our commitments in the Adult Social Care directorate, but an increased focus on providers rated as inadequate meant that we missed our target for re-inspecting providers rated as good or outstanding.

We saw improvement in the overall distribution of ratings during 2017/18, with more services rated as good and outstanding compared with 2016/17. However, we also saw deterioration in the quality of some services, and some services failing to improve.

Across all sectors, 72% of services that were rated as inadequate on their previous inspection, and were re-inspected and rated in 2017/18, improved their rating. Also, 51% rated as requires improvement improved their rating. On the other hand, 21% of services previously rated as good and 9% of services rated as requires improvement on their previous inspection, deteriorated to a lower rating at their most recent inspection.

We inspected all 52 digital primary care providers and most independent health care providers in our programme. We continued to assess the quality of care for vulnerable groups of people, such as those living in prisons, immigration removal services and looked-after children's services.

We worked with NHS England to develop and improve our assessments of the Workforce Race Equality Standard in hospital inspections, and we took part in the pilot of the new Workforce Disability Equality Standard.

Supporting people to choose care

Our 2017 annual public awareness survey found that 65% of respondents were aware of CQC – this has increased from 50% in 2015. Of those who were aware of us, 81% said they trusted that we are on the side of people who use services.

Our inspection reports and our website are among the first points of contact for people choosing care for themselves, a relative or a friend. Our website was visited around 18 million times in 2017/18. Our survey found that the majority of people who said they had seen a CQC rating found it easy to understand, and 49% took action afterwards, such as using a service for the first time or looking at more information about the service.

We ran a number of public information campaigns to raise awareness of the health and care choices that people have, including our '#yourbirthplan' campaign to help women consider all the options for where to give birth, and our '#careaware' campaign to help people looking for a care home.

Encouraging providers to drive improvements in care

Nearly 80% of respondents to our 2018 provider survey agreed that CQC encourages improvement.

In our annual *State of Care* report, we highlighted the work that frontline staff, in challenging circumstances, have done to ensure that the majority of the care that people receive is good, and that many services had recognised our inspection findings in order to make the necessary changes to get better. We also pointed to care that still needs to improve across all sectors. The report generated substantial interest, including debates in Parliament.

We have used our understanding of what drives improvement to speak with our independent voice and to share best practice. *Are we listening?*, our review of children and young people's mental health services, showed that many children and young people experiencing mental health problems do not get the kind of care they deserve. The system is complicated, with no easy or clear way to get help or support. Although we have found areas of good practice and innovation, there is more to do. The report was used to help inform the Health and Education Committees' joint report on the children and young people's mental health Green Paper. Also, through our *Driving improvement* case study report series, we now have a clear understanding of what drives improvement in providers, and how we can encourage this. Our improvement reports have been well-received and have generated discussion and workshop learning events.

With our partners, we published *Equally outstanding* – an equality and human rights good practice resource. It uses examples from providers rated as outstanding to

explore how focusing on equality and human rights can improve the quality of care in times of financial constraint.

Quality of care in a local area

In 2017/18 we carried out a number of major reviews of local health and care systems. We looked at how the different parts of the health and social care system work together in local areas to provide care for people aged 65 and over. In our national report, published in July 2018, we highlighted some good practice, and opportunities for improvement that cross organisational and sector boundaries. We found dedicated staff who are committed to providing the best possible experiences of care for older people. However, we also found that there is variation, and in some areas, the basics are not in place. In these areas, care can be fragmented and the experience of moving between services is confusing and uncertain.

The relationships with our system partners, and how we work together to define quality, are essential for improving care in the long-term at a provider and a wider system level. We have worked with partners to agree shared definitions of quality in adult social care (known as *Quality matters*), primary medical services and NHS health care.

Some providers are aware of a shared definition of quality, but others do not experience this and we have more to do to make sure we have a positive effect on providers. In 2018/19 we will put actions from each shared definition into practice and strengthen how we work with our partners.

Investing in digital development

We have spent much of the year investing in and planning how we are going to change as an organisation to meet the ambitions of our five-year strategy. We have a large programme of digital development work to complete in 2018/19 and 2019/20. These developments will result in substantial benefits for the public, providers, our system partners and our staff.

We received 23,544 experiences of care from people through our online form in 2017/18. This compares with 21,681 in 2016/17. We have started to redesign our form to make it is easier for people to share their views and experiences.

We started to design and develop new digital services to make it easier for providers to share information with us, and to keep that information up to date. We began testing our new provider information collection tool with adult social care providers. We also started to redesign our registration service to provide a simpler interface for providers, and to register new and complex models of care more effectively.

Developing and supporting our people

Our 2017 staff survey results had positive results that were above the public and private sector benchmarks on our alignment to our purpose, the support of team members, and the visibility of leaders.

However, the results identified that we have more to do to help staff with workload, to provide the right technology to do their roles, and to improve how we manage change and communications.

To address workload pressures, we have moved to an 'always on' model of recruitment. We have also invested in mobile technology to support staff on inspection.

We are striving to achieve a culture where everyone is open to a diversity of views and experiences and where we are focused on inclusivity as a part of our day-to-day work. We have a particular focus on improving the experiences of disabled colleagues, and our work to improve race equality in recruitment. Our established staff equality networks will help us to move this forward.

More improvements needed to our inspection report publishing times

Our inspections reports and ratings help people to choose care. It is important that members of the public can see our reports as quickly as possible after inspection.

We saw significant improvement in Primary Medical Services directorate inspection report publishing times, with 85% published in the target timescale. This is a significant improvement from 60% in 2016/17. Our Adult Social Care directorate inspection report times remained strong with 84% published within timescale.

However, issues remained for our Hospitals directorate inspection reports. Although we did see some improvement from 2016/17, just 30% of hospital reports were published in the 50-day target, and 49% in the 65-day target. We are committed to building on our progress in 2018/19 and a quality improvement review of all aspects of the process is underway to drive further efficiencies.

Efficiency, effectiveness and financial performance

We have seen robust financial performance and we spent within our budget.

We reduced our costs against 2016/17 actual figures and the 2017/18 budget, continuing the trend that we started in 2015/16. We are on track to meet the target set by the government's spending review. We are now close to reaching full-cost recovery on the fees that we charge providers.

Improvements to our customer service centre mean that we are better placed to track and monitor customer experience.

We improved how quickly we assess registration applications – we assessed 85% against our target of 90% in 50 days, compared with 79% in 2016/17.

We are supporting staff to develop a culture of quality improvement – a culture that embeds systematic change and improvement into every aspect of our work and roles, and that then leads to measurable impact on performance.

Performance analysis

1 Performance measures

Our operating model forms the structure for the work that we do. We measure our performance against each part of this model. The performance analysis has a chapter on each part of our model as well as on our people, equality, diversity and human rights, financial performance and performance on other matters.

In 2017/18 we have made good progress and performed better than in 2016/17 with increases against many of our key performance indicators (KPIs). We acknowledge we have more to do to meet all of our targets.

Register

We maintain a register of who is legally able to deliver regulated activities. This register shows the public what services are available, who they are for and where to find them. All providers that want to provide regulated activities need to show they can deliver high-quality care to join this register (see chapter 2).

Monitor, inspect and rate

We gather and analyse data from people who use services, providers, and our system partners and stakeholders to help us to monitor the quality of care and to be more targeted with what we look at during our inspections. This forms the basis of our intelligence-driven approach to inspection.

We inspect services to make sure they are providing care that is safe, effective, caring, responsive and well-led. We then publish what we find, including quality ratings, so that people can understand the quality of care of a particular service and can choose the right one for them (see chapter 3 and chapter 4).

Enforce

We protect people from poor care by taking enforcement action when needed, and by holding registered providers and managers to account for failures in how a service is provided (see chapter 5).

Independent voice

We speak independently, publishing regional and national views of the major quality issues in health and social care, and we encourage improvement by highlighting good practice (see chapter 6).

Our key performance indicators

Figure 1: Key performance indicators (KPIs) 2017/18

KPI	2017/18 target	2017/18 actual	2016/17 actual	Met target	Change	Pg
Registration						
Registration processes completed within 50 days (new, variation, cancellation)	90%	85%	79%	not met	↑ improved	21
Inspection						
First inspections of newly registered locations undertaken within 12 months (services where we give ratings)	90% (100% in ASC)	ASC: 78% PMS: 100%	not comparable	ASC: not met PMS: met	not comparable	33
Re-inspections of previously rated services undertaken within the agreed maximum time periods*	90%	ASC: 82% Hospitals: 100% PMS: 96%	not comparable	ASC: not met PMS: met Hospitals: met	not comparable	33
First comprehensive inspections of Hospitals directorate (independent health care services)	100%	91%	not comparable	not met	not comparable	34
Inspection report publishing time – Adult Social Care (ASC) directorate within 50 days	90%	84%	80%	not met	↑ improved	35
Inspection report publishing time – Hospitals within 50 days (independent health and focused NHS inspections of 1 or 2 core services)	90%	30%	16%	not met	↑ improved	35
Inspection report publishing time – Hospitals within 65 days (inspections of 3 or more core services)	90%	49%	12%	not met	↑ improved	35
Inspection report publishing time – Primary Medical Services (PMS) directorate within 50 days	70% by Q1 90% by Q3	85%	60%	not met	↑ improved	35
Mental Health Act Reviewer visits – planned visits completed each quarter	90%	86%	93%	not met	↓ declined	36
Second Opinion Appointed Doctor (SOAD) visits undertaken within target time: Medicine	95%	94%	88%	not met	↑ improved	37
SOAD visits: Electroconvulsive therapy	95%	67%	53%	not met	↑ improved	37
SOAD visits: Community treatment orders	95%	78%	71%	not met	↑ improved	37
Responding to information						
Safeguarding alerts referred to a local safeguarding authority within 0-1 days	95%	96%	98%	met	↓ declined	28
Safeguarding alerts and concerns had one of 4 possible mandatory actions taken in 0-5 days	95%	90%	85%	not met	↑ improved	28
Complaints acknowledged within 3 days	95%	99.6%	79%	met	↑ improved	66
Complaints upheld by the Parliamentary and Health Service Ombudsman	<3%	1%	1%	met	↔	66
General calls (including registration) answered in 30 seconds	80%	82%	81%	met	↑ improved	30
Safeguarding calls answered in 30 seconds	90%	93%	90%	met	↑ improved	30
Mental health calls answered in 30 seconds	90%	91%	90%	met	↑ improved	30
Correspondence answered in 3 days	90%	89%	not comparable	not met	not comparable	30
Our people						
Sickness	<5%	3.8%	3.7%	met	↓ declined	50
Staff survey engagement score increased	to 64% or more	62%	64%	not met	↓ declined	49
Finance and business plan						
Management assurance areas assessed as good or outstanding**	100%	91%	not comparable	not met	not comparable	93
Variance from revenue budget	Between £0 and< £4m underspend	£8.6m (4%) under budget (actual £218.5m)	£14.1m (6%) under budget (actual £221.8m)	not met	↑ improved	62
Variance from capital budget	Between £0 and < £2m underspend	£2.3m (25%) under budget	£6.7m (52%) under budget (actual £6.3m)	not met	↑ improved	61

* We have a range of agreed time periods to return to re-inspect based on sector and type of rating on previous inspection. These are detailed in CQC's business plan for 2017/18.

** We assess ourselves against eight areas of management responsibility (see Accountability report, page 92).

How we measure our performance

We measure our performance with KPIs and strategic measures, as set out in our business plan. These allow us to track our quality, efficiency, effectiveness and impact as a regulator. Our KPIs help us to track delivery as we progress through the year, and are detailed in figure 1. Our strategic measures are designed to help us understand our impact over a longer timeframe. These measures have been tracked through our annual public awareness, provider, inspection team and staff surveys, all of which provide the basis for our improvement work. Key findings from the surveys are summarised in the relevant chapters. Some measures will be reported over future years as data becomes available and we are able to better understand our impact over time. We report the results of our performance to CQC's Board, the public, our system partners, our stakeholders, the Department of Health and Social Care, and the Parliamentary committees who scrutinise our work and to whom we are accountable.

Risk management

Our risk management framework, policies and guidance set out our approach to managing strategic and high-level risks, and directorate and team level risks across our operational and support functions.

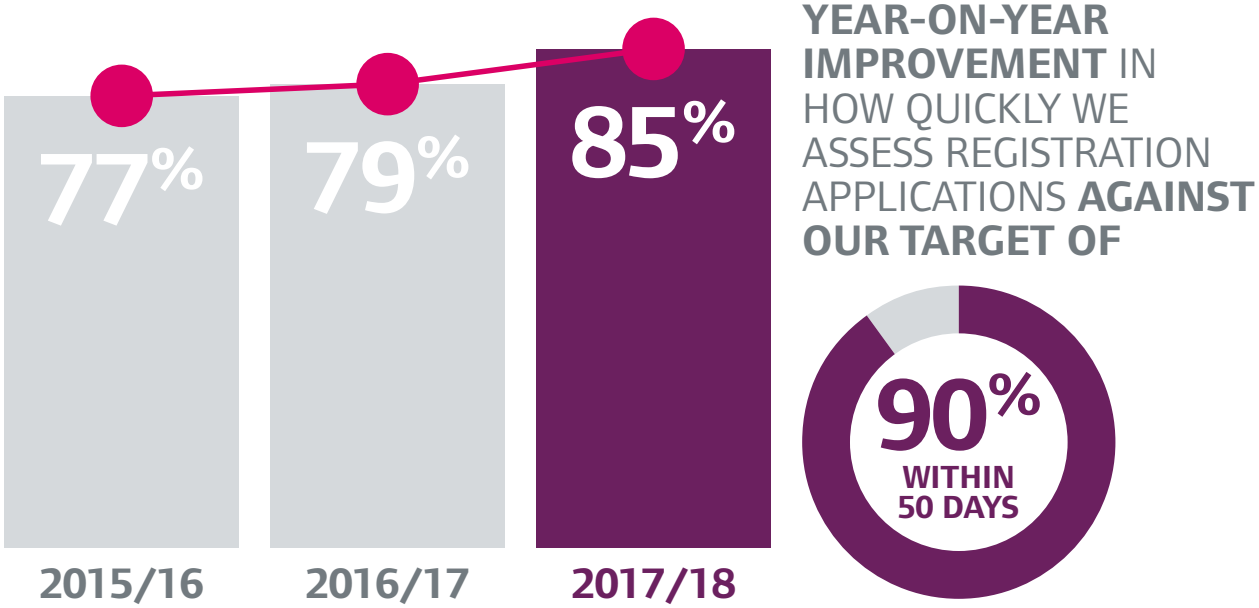
CQC manages a range of strategic and operational risks to the delivery of its purpose. We report on these in our public Board meetings, setting out a risk rating for each risk and the mitigating actions being carried out to manage them. We use a range of information to assess and manage risk – this includes tracking key performance indicators and strategic measures of success, and the progress of specific mitigation actions set out in our risk register and business plans. We assess our confidence in management of the risks, and keep ratings under review against the ratings tolerance levels set in the risk tolerance statement. On an annual basis we review our risk tolerance statement. We did this in January 2018, and made some amendments to clarify our tolerance around digital delivery.

Our assessment of the risks in our corporate risk register for quarter 4 showed that our risks are all within agreed tolerance levels. As part of our business planning for 2018/19 we have reviewed our risks for the coming year. Our risks cover the following areas:

- encouraging improvement
- external environment and implications for CQC
- quality
- information
- IT technologies and systems
- people
- financial
- market oversight.

A full list of risks and mitigating actions is published on our website.

2 Registering health and care services



Performance

We have seen a steady improvement in our registration performance over the last two years, with an improvement of eight percentage points in how quickly we assess registration applications (new registrations, variations and cancellations of registration). We completed 77% in 2015/16, 79% in 2016/17 and 85% in 2017/18 against our target of 90% within 50 days.

This improvement is in the context of a 10% increase in the volume of applications received in 2017/18 compared with the previous year, with many of these being of a higher degree of complexity. This year we received a total of 43,720 applications compared with 39,743 in 2016/17.

There has been an increase in reports of unregistered providers, with 1,517 received in 2017/18 compared with 1,206 in 2016/17. These providers may potentially be operating services without demonstrating that they are safe. We investigate them and take swift action if we find they should be on our register. For example, we encourage the service to register and take enforcement action where we find safety concerns. During the year our enforcement action for unregistered providers has included six civil actions and three criminal actions (two fixed penalty notices and a simple caution).

Continuous improvement

We have focused on making continuous, strategic improvements to registration. Our four aims are to:

- develop registration as a quality test – to act as a barrier to poor services and to drive consistency and quality improvement in services across all of our work
- develop public confidence in the register we hold about services
- support innovation in health and care services
- develop open, transparent, efficient and streamlined processes for our staff and providers.

This programme is critical to sustaining improvement in the context of increasing demand and complexity in registration, particularly the increase in new and complex providers.

Registration is a priority area for our digital transformation. We have started to design a new more efficient and cost-effective registration service that aims to:

- be a barrier to poor care
- provide an accurate register of providers
- improve the user experience for providers and reduce the burden on providers and the time taken to register.

Our first focus for the digital programme has been redesigning the registration service for registered managers of domiciliary care agencies (care at home). We will be ready to start designing and testing our processes and online products in Autumn 2018. We will continue this work across all of the sectors we regulate over the next two years.

In June 2017, we consulted on and developed our proposals for our next phase of regulation. These proposals included improvements to the structure of registration, which means we will use a wider set of criteria to describe a service. We will also improve CQC's definition of providers who need to register, so that they now include all providers that are accountable for 'directing and controlling' the delivery of regulated activities. We will start to implement the proposed changes during 2018/19.

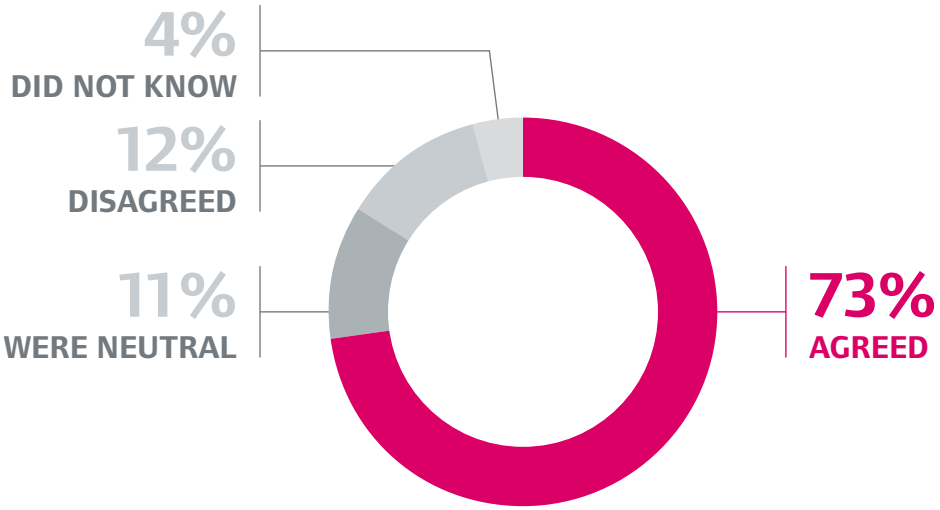
Impact

In order to protect people who use services, we can refuse to register providers and managers if we are not satisfied that they will provide high-quality care and if they do not meet the legal requirements of registration. In 2017/18 we issued almost 450 notices of proposal to refuse registration applications, an average of around 37 a month. Most of these would have been followed up with a notice of decision to refuse the application. Reasons for refusing registration applications included where the provider was not able to meet the standards to provide health and care services, or did not have the right financial resources, or where the provider or manager was

not fit to run the service. We also refused to register providers that could not comply with the requirements relating to the registration of services for people with a learning disability and/or autism.

Did the registration process provide a robust assessment of your service's ability to deliver a safe, effective, caring, responsive and well-led service?

OF THE PROVIDERS WHO RESPONDED:



Source: CQC annual provider survey 2018.
Question was asked of those who had been through registration.

In our annual survey of providers, nearly 70% of those who had been through registration said that they had a positive experience of it. There was a difference between types of provider. Seventy-seven per cent of adult social care providers, who were the majority of respondents, agreed that their overall experience of the registration process was good. This compares with 64% of hospital and 53% of primary medical services providers. When providers commented on the specifics of their experience, some they said they found the forms confusing and complex to complete. Our work to improve how we register providers, particularly our new online registration service, is designed to address these issues.

Across all sectors, 73% of respondents thought that the registration process provided a robust assessment of their service's ability to deliver a safe, effective, caring, responsive and well-led service. By sector, 83% of adult social care, 81% of hospital, and 60% of primary medical service providers agreed with this.

3 Monitoring quality

Performance

Building our capability as an increasingly intelligence-driven regulator is one of our strategic priorities. We have had a strong focus on how we collect, process, analyse and use our data and information to have a more targeted and tailored approach to monitoring the quality of care.

Digital development

We have spent much of the year investing in and planning how we are going to change as an organisation to meet the ambitions of our five-year strategy. Our digital programme underpins this work and is a fundamental part of our intelligence-driven approach. A large part of our work has involved redesigning the data collection, processing and analysis tools we use to make them more efficient. This will help improve information exchange with providers, and how we feed back what we have done with the information shared by the public.

Our ambition is that providers will have a better and more intuitive online experience to share information with us. And the public will be able to quickly see and use the information we gather before and between inspections to make decisions about care.

We have continued to regularly test and refine our digital products with users to make sure they match their needs. During 2018/19 and 2019/20 the digital

changes we make will deliver significant benefits for the public, providers, our system partners and our own staff.

Listening to people who use services

We have been improving the ways in which we engage people who use services, and how we encourage people to share their views and experiences of health and social care. Our public engagement strategy published in September 2017 and set out our priorities over the next four years. An important area is continuously encouraging and enabling the voices of people who use services, their families and carers to drive our understanding of the quality of care, making better use of their information to inform our intelligence-driven inspections, and making sure people know how we are using this information to have an impact on the quality of care.

We received 23,544 experiences of care directly from people through our online form – these were a mix of both positive experiences and concerns. This compares with 21,681 in 2016/17. In response to this, 562 inspections were brought forward to address an issue and 147 urgent inspections were carried out. We have started to redesign our online form to make sure it captures more structured, clear information and is easier to use.

We continued to build our relationships with a range of system partners to more effectively gather people's experiences, particularly the Healthwatch network, commissioners, complaints advocacy services, overview and scrutiny committees, foundation trust councils of governors, patient participation groups, and a number of community and voluntary organisations. We have partnerships with Carers UK, Disability Rights UK, Mind, The National Autistic Society, The Patients Association, and the Relatives and Residents Association. These partners make sure that if people raise concerns about care, they are shared with us. We also engage with a number of key voluntary organisations to support better partnership working and information sharing to encourage improvements in care.

Sharing experiences of care with CQC

A member of the public shared their experience of care at a GP practice in August 2017. The information was provided to CQC through the Patients Association. We used this evidence to bring forward the scheduled inspection of the practice.

A carer of a person living in a residential adult social care service made an urgent complaint about the care they were receiving in August 2017. The information was provided to CQC through the Patients Association. We raised a safeguarding alert with the local authority.

Our Experts by Experience (people with lived experience of health and care services) provide invaluable support to our inspection teams, advise on our policy and strategy, and support our training programmes. We continued to invest in and develop the programme. During 2017/18, there were 7,350 inspections that

included an Expert by Experience on the team and 197 Experts by Experience advised on our policy and methods. Experts by Experience have also supported face-to-face training for more than 200 CQC staff.

Our public online community is a forum where members of the public can get involved in our work, take part in discussions and help shape the information we provide to help people choose care. The community has around 500 members. We also run an incentivised panel of around 100 people who are representative of the general public. Every three months we introduce a new panel with a different group of people to make sure we get a wide range of perspectives. Panel members take part in surveys on areas such as inspection reporting, experiences of care, our thematic review topics and consultations. During 207/18 we sought views, for example, on our digital programme developments, the quality of maternity services and how providers display ratings.

Collecting, processing and analysing information

We have continued to invest in and develop a range of digital tools to support how we collect, analyse and process information.

We have been developing and improving how we collect information from providers. We have started testing our new online system with adult social care providers and it is in development for other sectors. The new system will be more intuitive and will make it easier for providers to submit information to us, and to keep that information up to date. It will also make it much easier for us to monitor the quality of care in between inspections to make sure we target our inspections appropriately.

Our CQC Insight tool is an integral part of how we analyse and present a range of data to support our monitoring work and our inspections. CQC Insight includes people's experiences, performance data, statutory notifications, patient surveys and safeguarding information. The system is being developed to include alerts in some sectors that will show where there may be concerns about a provider. These can then be analysed further and passed on to inspectors to decide if a re-inspection or any other action is needed. The system will also soon start to highlight where providers are improving and to look at trends over time. We have started to create a 'data hub' and when this is finalised, it will feed all of the different CQC Insight reports and products. It will automate some of our data processing and analysis to save time, and make sure we are efficient and quick to respond.

We have completed the testing of our CQC Insight dashboards to support the monitoring and inspecting of acute NHS trust, mental health, GP practice and adult social care providers, as well as to support registration. CQC Insight is now in full use, and we are starting to develop it for the ambulance, community and independent health sectors, as well as for cross-cutting services. During 2018/19 we plan to start including qualitative as well as quantitative data and information.

We have started to test and use our new data discovery tool to analyse data from providers, the public, people who use services and our own data (such as inspection reports). The tool helps us to look more quickly at larger amounts of qualitative

information (such as large volumes of detailed written feedback on a service) and also quantitative information.

We have started to explore how data science can help us to more effectively use and analyse the data that we hold, and more accurately support regulatory decision-making. Data science uses new approaches, such as machine learning, enabled by increased computing power and storage to extract knowledge or insights from structured and unstructured data.

Market oversight

We must notify relevant local authorities if a provider is likely to experience business failure, and services are likely to cease as a result. We do this through our market oversight scheme by monitoring the financial sustainability of hard-to-replace adult social care providers that meet the entry requirements of the scheme. As at 31 March 2018 there were 57 providers in the scheme. During 2017/18 there has been a continued deterioration in the risk profile of providers in the scheme. This can be attributed typically to funding and workforce pressures.

Sharing information

Working with our system partners to effectively share information and develop our view of quality together is an important aspect of our work. Our aim is to reduce workload for providers, avoid duplication of data requests, and work towards a shared view of quality. With the adult social care sector and our partners, including Skills for Care and the Department of Health and Social Care, we have made progress in implementing the sector-wide framework for quality in adult social care – *Quality matters* – a single definition of quality and a shared set of quality priorities.

We worked to agree a primary care shared view of quality with partners on the Regulation of General Practice Programme Board. We also updated our approach to dental regulation with partners on the Regulation of Dental Services Programme Board.

We worked with the national NHS Leadership Development Board to develop a set of priorities including organisational development, clinical leadership and aligning regulation.

We developed a protocol with other health and care system partners and professional regulators to share any emerging concerns about the quality of care. The protocol will help us to act on the best information and to improve how we work together and coordinate our response. It will be agreed and implemented during 2018/19.

Responding to concerns

More than half of the concerns received by our National Customer Service Centre (NCSC) related to complaints about providers, and around a third related to safeguarding concerns. The remainder comprised safeguarding alerts, whistleblowing enquiries, and unregistered providers information (see chapter 2).

Safeguarding

Safeguarding alerts are the most serious and urgent types of safeguarding information that we receive. We referred 96% (474) of safeguarding alerts to a local authority within one day and exceeded our target of 95%. This compares with 98% (589) in 2016/17. Of all the alerts and concerned received, we took 90% (96,091) of one of four mandatory actions within five days against our target of 95%. This compares with 85% (80,469) taken within five days in 2016/17.

Whistleblowing

It is very important that staff who work in health and social care feel able to speak up about anything they think is impeding their ability to do their job. The National Guardian's Office (NGO) was set up to lead a culture change to make speaking up business as usual in the NHS (see Accountability report, page 78). The NGO's broad remit is to:

- lead and develop a growing network of Freedom to Speak Up Guardians across NHS secondary care, to support staff to speak up
- review cases where there is evidence that trusts have not supported their staff to speak up in accordance with good practice, making recommendations as to how this can be improved and promoting good practice
- challenge the system to replicate and role model good speaking up practice for those organisations they oversee.

We have our own Freedom to Speak Up Guardian to support CQC staff. In 2017/18, more than 90 staff became Speak Up Ambassadors and a training programme is underway. The Ambassadors support colleagues to speak up about issues and work together in line with CQC's values. In March 2018, the NGO's national Freedom to Speak Up conference brought together more than 350 Guardians from across NHS organisations to listen, learn and network.

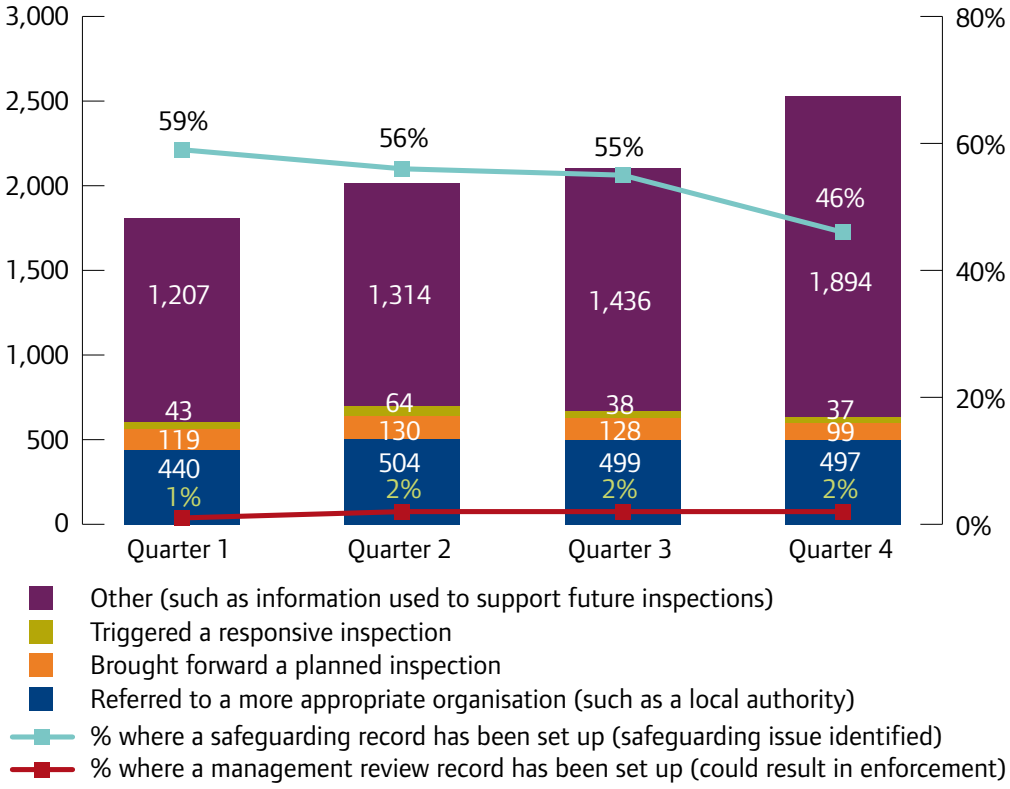
CQC received 8,449 whistleblowing enquiries in 2017/18. This was an increase from 2016/17 when we received 7,433 enquiries, and enquiries increased across each quarter of the year. The total was lower than the number of enquiries we received in 2015/16 and 2014/15.

When we receive a whistleblowing enquiry we consider the information carefully and prioritise which action to take according to the level of risk (figure 2). The most serious enquiries, for example where there is a risk of harm to an individual, will immediately trigger a safeguarding process that may include a referral to the local

authority. Other actions include bringing forward planned inspections, conducting responsive inspections, and using the information to support future inspections.

Regardless of the level of risk, all whistleblowing enquiries are important to help us build a picture of a provider and to make informed judgements about the quality of care.

Figure 2: Whistleblowing outcomes 2017/18



Complaints under the Mental Health Act (MHA)

We review all complaints about the way providers exercise their powers and duties under the Mental Health Act (MHA). In 2017/18 we received 1,341 complaints about the way the MHA was applied to patients. Including enquiries and follow-ups, there were 6,793 total contacts. We will report further on these in our annual *Monitoring the Mental Health Act* report.

Customer service

Our customer service centre underwent a period of change during the early part of the year with the aim of becoming more efficient and effective. We centralised and streamlined our systems and processes, and we invested in new telephone equipment that supports real-time reporting and immediate customer feedback after calls. The modernisation work, combined with staff training, means we are now better placed to track our performance and be more flexible to call demands and busy periods. We are now in a strong position to begin to see the benefits and positive effects on customer service and responsiveness in 2018/19.

We had a planned three-month reduction in performance after we began our new ways of working in April 2017. This had less of an overall impact than anticipated and we have exceeded most of our targets (figure 3). A recent Internal Audit report contained a number of recommendations that related to improvements in our customer services, including on handling safeguarding. We will continue to work to improve in 2018/19, including by updating our customer services standard operating procedures, and undertaking training and additional monitoring where needed.

Figure 3: National customer service centre call handling and correspondence

	Target	2017/18	2016/17
General calls (including registration) answered in 30 seconds	80%	82%	81%
Safeguarding calls answered in 30 seconds	90%	93%	90%
Mental health calls answered in 30 seconds	90%	91%	90%
Correspondence answered in 3 days	90%	89%	not comparable*

*Not comparable as the target was 'correspondence answered in 10 days' in 2016/17.

Impact

In our annual provider survey, 78% of respondents that had recently phoned or emailed NCSC felt that their query had been dealt with in a timely manner; 11% responded negatively. Eighty per cent agreed or strongly agreed that they got the information they needed. These results should be seen in the context of our target that 80% of general calls are answered in 30 seconds, and 90% of safeguarding and mental health calls are answered in 30 seconds.

An important aspect of our ongoing monitoring of the quality of care is the relationship that CQC inspectors have with providers. Of those respondents who knew who their CQC contact was, 78% agreed or strongly agreed that they have a good relationship with their named contact.

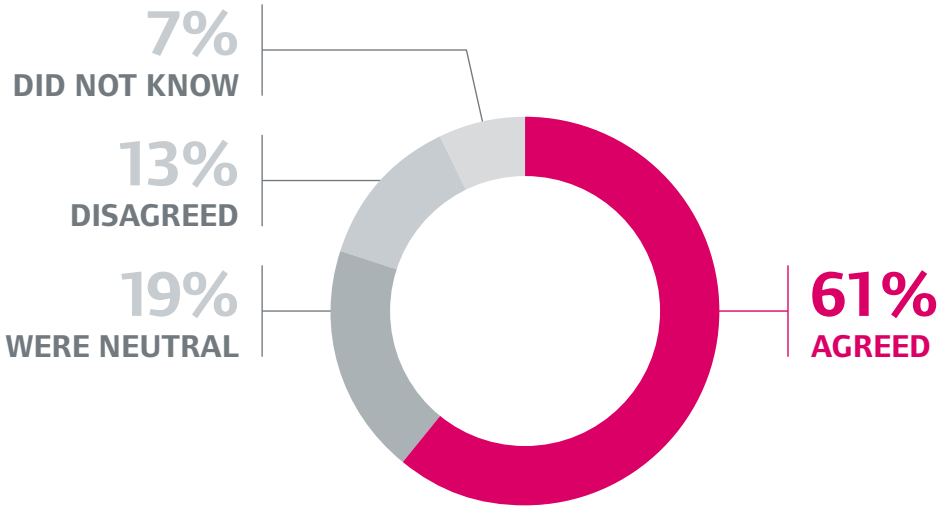
The relationships we hold with our system partners are essential for working together to define what high-quality health and social care looks like. As our approach to regulation continues to develop from sharing information and talking about risk, to more authentic collaboration with partners, strengthening our shared view of quality is an important focus.

We have made progress in developing system-wide definitions of quality: in adult social care with *Quality matters*, in health care with the NHS National Quality Board, and in primary care with the Regulation of General Practice Programme Board.

Some providers are aware of the shared definition of quality in their sector, but others are not. In our annual provider survey, 61% thought that CQC, commissioners and other regulators have a shared definition of what good quality care looks like. This was higher among adult social care providers with 71% agreeing or strongly agreeing, followed by 55% of hospitals providers and 51% of primary medical services providers.

Do you think CQC, commissioners and other regulators have a shared definition of what good quality care looks like in your service?

OF THE PROVIDERS WHO RESPONDED:



Source: CQC annual provider survey 2018.

The majority of providers indicated that they were using our assessment framework as part of their own systems and processes. Across the sectors, 86% of respondents used CQC's five key questions when communicating about their policies; 80% when assessing clinical governance; and 86% when conducting control and assurance.

We also found that 55% of providers across all sectors think that we coordinate work well with our system partners, although this was less for primary medical services providers at 41%.

During 2018/19, our next steps are to put the actions from each shared definition of quality into practice and to strengthen the ways that we work together with our partners, such as Skills for Care, NHS England and the General Medical Council, to widely embed and communicate these definitions.

4 Inspecting and rating

81%

OF PROVIDERS WHO HAD BEEN INSPECTED SAID THEY THOUGHT **CQC'S INSPECTION TEAMS WERE APPROPRIATELY SKILLED**

Performance

Our inspection activity in 2017/18 has taken place in the context of completing our first comprehensive inspection and ratings programme last year. For the first time we have been able to inspect and rate against a robust baseline of quality. This has allowed us to understand better how the quality of care is changing over time.

We have also started to explore ways of looking at the quality of care across a local area. This is important as we know there is wide variation in how health and social care systems work together to deliver care, that then affects the experiences of people.

Inspections

We have moved into our next phase of inspection and started to inspect using our new intelligence-driven approach. We are targeting our inspections towards providers where we see that the quality of care has changed. This means we can be more responsive and better at protecting people from poor care, as well as understanding where care has improved. During 2017/18 we carried out more than 17,000 inspections – this included first inspections, re-inspections and focused inspections (when we return to inspect one aspect of a service).

We published our updated inspection guidance for NHS trusts, adult social care services and primary medical services. We also published our 10 principles for regulating new models of care and complex providers and we continued to work

closely with providers to implement these. We consulted on and developed our approach to inspecting independent health care services and the related guidance will be published later in 2018/19. We also developed our approach to regulating online primary care providers with providers and system partners (such as the Medicines and Healthcare products Regulatory Agency and the General Pharmaceutical Council).

Performance against timescale targets

After we completed our comprehensive inspection programme in 2016/17, we set new timescale targets for when we inspect. This is to make sure we target our inspections based on likely risk. We aim to inspect all newly registered services within 12 months of registration to make sure the quality of care has been maintained since registration. We also return to inspect previously rated services within a range of agreed timeframes based on the level of risk. Depending on the sector, we go back to those rated as good or outstanding in a timescale of two to five years. For those rated requires improvement or inadequate we return more frequently, from between six months and two years. Our business plan for 2017/18 outlines the detailed timescales.

In the Primary Medical Services directorate, we:

- Inspected 91 newly registered locations* – 100% of these were within the target timeframe, which exceeded our target of 90%.
- Re-inspected 1,683 services* and carried out 96% of these in agreed re-inspection timeframes, which exceeded our target of 90%.
- Inspected a number of services that we do not rate – 63% (259 of 412) of independent consulting doctor and slimming clinic locations; 52 online digital providers; and our agreed 10% (1,096) of dental providers.

In the Adult Social Care directorate, we:

- Inspected 2,607 newly registered locations** – 78% of these were within the target timeframe, against our target of 100%.
- Re-inspected 8,815 services** and carried out 82% of these in agreed re-inspection timeframes, against our target of 90%.

Although we did not meet our overall re-inspection target of 90%, we met our target for re-inspecting inadequate adult social care services – we re-inspected 93% in six months. We have had a strong and important focus on returning to inspect high-risk adult social care locations where we have the greatest concern. This has needed more resource and time than initially planned and has had a small effect on our re-inspections of services rated as good and outstanding.

* Includes all services that we rate: GP practices, out-of-hours services, remote clinical advice, and urgent care services and mobile doctors.

** Includes all services that we rate but does not include the additional focused inspections we carry out where we have specific concerns.

In the Hospitals directorate we undertook 2,251 'units' of inspection. Hospital inspection units roughly equate to one core service (for example maternity care or urgent and emergency care). This was in line with our framework for agreed maximum re-inspection time periods.

We also completed first comprehensive inspections of a number of independent healthcare services that we do not yet rate. In the Hospitals directorate we inspected 38 of 40 (95%) refractive eye service locations, 168 of 195 (86%) independent ambulance services, and all 73 planned dialysis service locations.

Well-led key question inspections

There is a clear link between the leadership, management and governance of a service, and the overall quality of care. We have been working closely with NHS Improvement to focus on improving the leadership of trusts. NHS Improvement gives practical support to help NHS trusts improve, for example around their operational efficiency and financial management. We have consulted on and developed our joint framework for inspecting our key question: 'are services well-led?' We began the first of our inspections in NHS trusts in 2017/18. We aim to inspect the well-led key question at each NHS trust approximately once a year. Before we inspect a trust we take into account information received from NHS Improvement about the trust's resource and financial governance.

Use of resources assessments

We have also been working with NHS Improvement to consult on and develop a framework to assess the use of resources (such as finances, workforce, estates and facilities, and procurement) in non-specialist acute NHS trusts. Use of resources assessments started in October 2017. From 5 March 2018, each use of resources assessment results in a report and rating that is published alongside CQC's existing quality rating, as well as a combined use of resources and quality rating. During 2017/18, NHS Improvement conducted 14 use of resources assessments. The majority (12) of these were part of a pilot of the post-inspection process; a use of resources rating was given but not a combined rating.

Inspection report publishing times

Our overall performance to publish our inspection reports in agreed timescales stands at 81% against a 90% target (figure 4). The performance differs by sector. Just 30% of hospital reports (of one or two core services) were published within 50 days, and 49% (of three or more core services) published within 65 days. Members of the public need to access our inspection reports and ratings to make timely and informed choices about care and delays to publication can affect the information they have.

We acknowledge the scale and importance of the challenge and we have focused on making improvements to the processes, systems and training that support our inspection report publishing. This has resulted in consistent performance in the

Adult Social Care directorate and significant improvement in the Primary Medical Services directorate, with 84% of adult social care reports published against a 90% target, and 85% of primary medical services reports. This compares with 80% and 60% respectively across 2016/17. We have also seen gradual improvement in the average days taken to publish a report when compared with last year. This was an average of 38 days across all directorates, compared with the end of quarter 4 last year when it was an average of 44 days.

We have seen marginal improvement in the timeliness of Hospitals directorate reports, but there is much more we need to do. We have continued to send out letters to hospital providers immediately after inspection where we have serious concerns, to make sure that they can start planning improvement.

For all directorates, we have established focused projects to review barriers to performance and ways in which we can streamline the quality assurance stages. We are also providing further training and development for staff and encouraging learning from good practice. A quality improvement review of all aspects of the process is underway to look at how teams could work better together to further improve timeliness at a local level.

Figure 4: Inspection report timeliness, 2017/18

Directorate	Target	2017/18	2016/17
Adult Social Care	90% published within 50 days	84% (10,524 of 12,556)	80% (12,338 of 15,519)
Hospitals (independent health and focused NHS inspections of 1 or 2 core services)	90% published within 50 days	30% (253 of 830)*	16% (120 of 746)
Hospitals (inspections of 3 or more core services)	90% published within 65 days	49% (20 of 41)*	12% (5 of 41)
Primary Medical Services	90% published within 50 days	85% (3,370 of 3,970)	60% (3,164 of 5,301)
TOTAL**		**81% (14,657 of 18,106)**	**72% (15,627 of 21,607)**

* Where we have serious concerns, we send out letters to hospital providers immediately after inspection to make sure that they can start planning improvement.

** The total figure also includes some inspection reports that have not yet been attributed to a directorate.

Local system reviews

We carried out a number of reviews of local health and social care systems across England. The Secretaries of State for Health and Social Care and for Housing, Communities and Local Government asked us to carry out these reviews to look at how services meet the needs of older people, and how health and care providers work together. Most of the 20 reviews took place in 2017/18, although some took place in April and May 2018. The final system review report will publish shortly.

These reviews are different from our provider-focused inspections as they allow us to look at how care is provided for whole population groups and areas.

The reviews highlighted the importance of local systems working together and identified some good practice, as well as where there are opportunities for the system to improve and to collaborate better to drive improvements in care for people. Our review teams found that there are differing levels of success across systems that are focused on improving integration and person-centred care. We also found dedicated staff who are committed to providing the best possible experience of care for older people. However, for too many older people, care can be fragmented; the experience of moving between services is confusing; and people can be uncertain as to who is coordinating their care.

Our national report outlining our findings and recommendations from the reviews was published in July 2018.

Other inspections, visits and monitoring

People detained under the Mental Health Act

We are responsible for monitoring the use of the Mental Health Act 1983 (MHA). We also carry out Second Opinion Appointed Doctor (SOAD) visits to review treatments that have been recommended to people who lack the capacity to consent or who have refused treatment. The MHA protects people who are detained and makes sure they have the right to challenge poor care.

We carried out 1,133 MHA Reviewer visits, which was 86% of planned visits. This was below our target of 90% of planned visits and lower than our performance in 2016/17 when we carried out 93% of planned visits. The performance was affected by delays in recruitment.

We measure our SOAD visit timeliness performance against an agreed number of requested SOAD visits that 'qualify' in line with set criteria, not all visits undertaken in the year. We carried out 90% of all requested visits in agreed timescales compared with 85% in 2016/17, against a target of 95% (figure 5). This improvement can be linked to a faster and easier process for submitting SOAD requests through our provider portal. The increase in fees paid to SOADs has also had a positive effect on the number of visits completed and we expect this to continue in 2018/19.

Figure 5: SOAD visit performance, 2017/18

Type of visit*	2017/18 visits in remit of key performance indicator	2017/18 percentage of visits in agreed timescale (target is 95%)	2016/17 visits in remit of key performance indicator	2016/17 percentage of visits in agreed timescale (target is 95%)
SOAD visits – medicine	3,324	94% (3,110)	3,574	88% (3,160)
SOAD visits – electroconvulsive therapy	435	67% (293)	382	53% (203)
SOAD visits – community treatment orders	93	78% (73)	154	71% (110)
Total	**3,852**	**90% (3,476)**	**4,110**	**85% (3,473)**

* SOAD visits are reported a quarter in arrears.

Children and young people's healthcare services

We maintain a close focus on the quality of health care for children and young people to make sure they are protected from abuse and harm and have their rights upheld.

We carried out nine inspections of health care services for looked after children, and for children and young people who are at risk of a safeguarding issue.

We also conducted a thematic review into the system of health and care services that support children and young people's mental health. We visited 10 different areas in England to speak to staff, children and young people and their families, and also analysed our inspection reports. We found that many children and young people experiencing mental health problems do not get the kind of care they deserve. The system is complicated, with no easy or clear way to get help or support. We have seen issues around transition between child and adult services, and lack of engagement of children and young people. Although we have found areas of good practice and innovation, there is more to do. In March we published our findings and recommendations for change in our report, *Are we listening?*

With our partner inspectorates – Ofsted, HMI Prisons, HMI Constabulary and Fire and Rescue Services, and HMI Probation – we carried out eight joint targeted area inspections to look at the effectiveness of multi-agency safeguarding arrangements. With Ofsted we carried out 29 joint inspections looking at how health works with education and social care to meet the needs of children and young people with special educational needs and a disability. We jointly published a report on the findings from the first year of inspections.

Health and social care in criminal justice and immigration detention settings

In partnership with HMI Prisons we inspected 41 prisons or young offender institutions and two immigration removal centres to assess the quality of health and social care and make sure that vulnerable or disadvantaged people have their needs met. We found that registered providers had breached our regulations in 19 of these inspections and we took regulatory action. These breaches are being followed up through a programme of focused inspections, which also includes inspections triggered by concerns about services. We have supported seven inspections of police custody with HMI Constabulary and HMI Prisons.

The joint inspection of youth offending services, led by HMI Probation, was suspended during 2017/18 but started again in April 2018. With Ofsted and HMI Prisons we inspected all three secure training centres for children aged 12 to 18. We have started to support Ofsted with their inspections of secure children's homes, to make sure that the health services provided for vulnerable children are safe and effective.

In addition to our inspections, we have supported our system partners in undertaking thematic reviews of services provided to offenders. We contributed to a review led by HMI Probation looking at the community support given to adult offenders who use psychoactive substances. The report found a general lack of awareness in the sector, and the need to better assess and support people, but also highlighted some positive initiatives. A second review, led by HMI Prisons, is underway and is focused on the social care provided to adult prisoners. It is looking at the impact of the Care Act 2014 and how prisoners' personal care and equipment needs are being met to ensure their independence. It will be completed during 2018/19. These reviews enabled us to use our expertise in the regulation of substance misuse and social care, and to support partners to assess the effectiveness of services.

Medical ionising radiation

We are responsible for enforcing the Ionising Radiation (Medical Exposure) Regulations 2017 in England (known as IR(ME)R) 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.

In 2017 we received a total of 951 notifications where radiation exposure was 'much greater than intended'. This number should be viewed in the context of the millions of medical exposures that take place each year. It was a decrease from 2016, although it is not comparable as the Department of Health and Social Care published new guidance on the definition of 'much greater than intended' in January 2017.

New regulations came into effect from 6 February 2018. These replaced IR(ME)R 2000. Later in 2018/19, we will report further on our work in this area in our *IR(ME)R annual report*.

Controlled drugs

We continue to have responsibility for making sure that health and social care providers, and other regulators, maintain a safe environment for managing controlled drugs in England. However, the changes to the way health care is being delivered, including the increasing use of online primary health care and prescribing services, is adding greater complexity to governance arrangements for controlled drugs.

We carry out our responsibilities through our inspection activity and our oversight role, leading the National Group on Controlled Drugs, a cross-border group with the devolved UK administrations, and four supporting sub-groups looking at thefts, frauds, controlled drug prescribing and patient safety. We share our findings and promote best practice through our annual report and regular updates. We also contribute to controlled drug local intelligence networks led by NHS England, and we keep a national register of controlled drug accountable officers in England.

Defence medical services inspections

In April 2017 we started to inspect and rate primary care services (GP and dental services), regional rehabilitation units and mental health services at a range of defence medical facilities used by the Army, the Royal Air Force and the Royal Navy. Resourced through a contract with the Ministry of Defence, we have met our commitment to inspect an agreed number of these services. We inspected 35 GP practices (plus five follow-up inspections), 24 dental practices, two mental health services and two rehabilitation units. Most services are caring and responsive, but there is scope for improvements to make sure that care is always safe, effective and well-led.

Impact

In 2015 the Department of Health and Social Care commissioned Manchester Business School and the King's Fund to review CQC's approach to inspecting and rating, and the substantial changes we made between 2013 and 2016. The report will be published later in 2018/19. While recognising the challenges involved in rapidly changing a regulatory system, the unpublished findings suggest positive support for the progress we have made and are affirmation of the hard work of CQC staff and of health and social care providers.

The findings reflect that our inspections and ratings have encouraged providers to take a range of actions before, during and after inspection, and can be important catalysts for change and improvement. They indicate that there is greater potential for CQC to have impact by further harnessing the relationships between CQC inspectors and providers, through a greater focus on system-level regulation and through engaging and influencing other system stakeholders.

We therefore think that the findings broadly affirm many of the developments that are part of our strategy for 2016 to 2021. These include: our greater focus on

relationship management with providers to encourage improvement in care; building stronger relationships with other national bodies to ensure clarity of role, purpose and interactions, based on a shared view of quality; and greater system level regulation through our local system reviews.

Ratings

As at 31 March 2018, our current ratings profile showed that most services we have rated are providing high-quality care to people – 79% of adult social care services, 62% of hospital services and 91% of primary medical services are rated as good overall (figure 6).

We saw marginal improvement in the distribution of ratings in the first two quarters of 2017/18 with more services rated as good and outstanding compared with 2016/17 – this stabilised over the last two quarters.

A full ratings analysis will be explored in our *State of Care* report in October 2018.

Change on re-inspection

Our re-inspections of services show a mixed picture when we look at changes in ratings. We have seen improvement, but we have also seen services failing to improve or deteriorating.

Across all sectors, 72% of services that were rated as inadequate on their previous inspection, and were re-inspected and rated in 2017/18, improved their rating. Also, 51% rated as requires improvement on their previous inspection, improved. However, 21% of services previously rated as good and 9% of services previously rated as requires improvement, deteriorated to a lower rating.

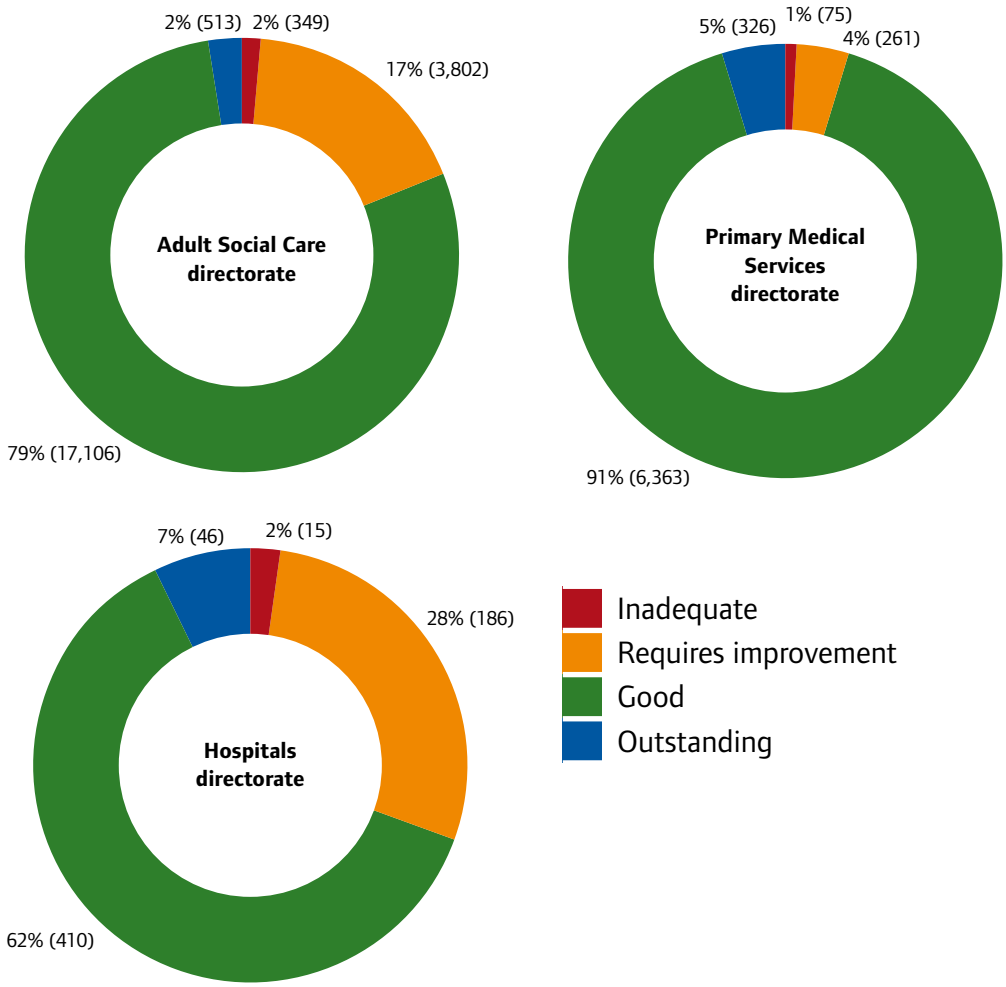
By sector, 47% of adult social care services rated as requires improvement on their previous inspection, improved to good. However, 20% previously rated as good and re-inspected deteriorated to requires improvement and 3% deteriorated to inadequate.

Most primary medical services rated as requires improvement on their previous inspection improved their rating to good (79%). However, 11% of those previously rated as good deteriorated to a lower rating.

Seven acute NHS trusts rated as inadequate on their previous inspection, improved to requires improvement. However, 29 remained at requires improvement. For independent hospitals, 13 previously rated as inadequate and re-inspected improved to either requires improvement or good.

This shows the importance of re-inspecting services at all levels of risk, while targeting the higher risk services first to best protect people.

Figure 6: Ratings profile as at 31 March 2018



Notes:

1. The ratings have been aggregated to an overall level. Due to the differences in the size and type of organisations in each sector, different levels of aggregation are used to give an overall rating. More aggregation will lead to a greater number of requires improvement ratings.
2. Adult Social Care directorate ratings are by location only. Hospitals directorate ratings comprise: NHS acute locations, independent acute and mental health locations, and NHS and mental health community trusts. Primary Medical Services directorate ratings comprise: GP practices, out-of-hours, urgent care services and mobile doctors.

Inspection approach

It is important that providers feel confident in our inspection approach and understand it. In our annual provider survey, 84% of those who had received a comprehensive inspection in the last year thought our inspection was thorough. By sector this was 87% of adult social care, 70% of hospital and 76% of primary medical services providers.

Across all sectors, 81% of providers who had been inspected said they thought CQC's inspection teams were appropriately skilled. And 86% agreed or strongly agreed that they received clear feedback after the inspection visit.

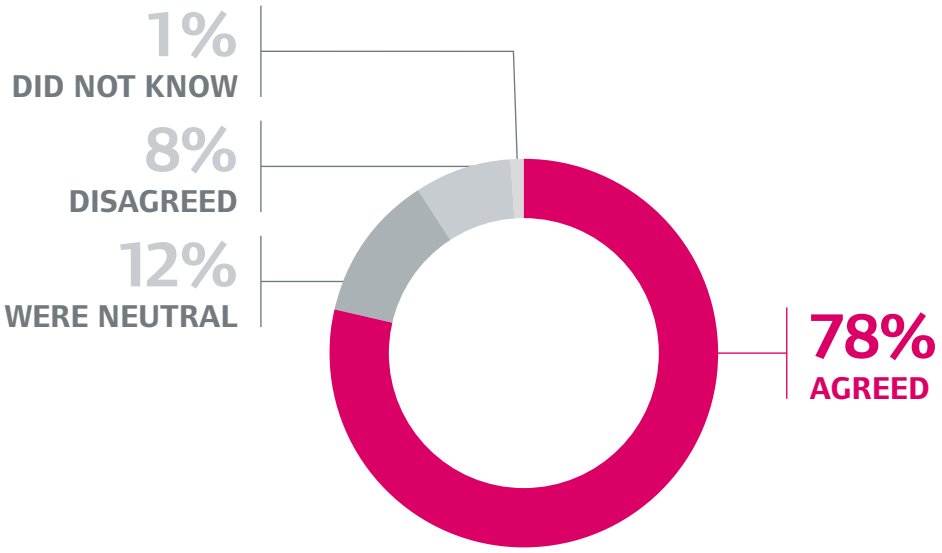
There was also positive feeling about the evidence used to make judgements. More than 70% who had been inspected in the last year said they felt CQC's judgements and ratings were fair and evidence-based.

Some providers felt there were issues around consistency in inspections, with 47% agreeing that CQC's approach is consistent from inspection to inspection. By sector this was 56% of adult social care, 36% of hospital and 37% of primary medical services providers. We are taking action to address this and have carried out a review to better understand areas of inconsistency with providers, CQC staff and other regulators. In 2018/19 we will use our learning to develop a quality improvement approach to improve consistency, which will include staff learning workshops.

Overall, providers were very positive that CQC encourages improvement with nearly 80% in agreement. By sector this was 86% of adult social care, 83% of hospital and 69% of primary medical services providers.

Do you think CQC encourages improvement?

OF THE PROVIDERS WHO RESPONDED:



Source: CQC annual provider survey 2018.

Providers told us that they were most likely to make improvements under the safety and well-led key questions. Under safety, the most common improvements were to systems, processes and practices that keep people safe, as well as to risk assessments. Under well-led, the most common improvements were to systems and processes for learning, continuous improvement, innovation and ensuring sustainability, as well as clarifying roles, responsibilities and systems of accountability to support good governance and management.

5 Enforcement and protecting people

2,283

ENFORCEMENT ACTIONS
ISSUED **IN 2017/18**

1,343

WARNING NOTICES

781

OTHER CIVIL ACTIONS

159

CRIMINAL ACTIONS

Performance

Enforcement action

A core part of our role is to protect people from poor care. Our performance is focused on taking the right action quickly when standards of care are not acceptable and people are at risk of harm.

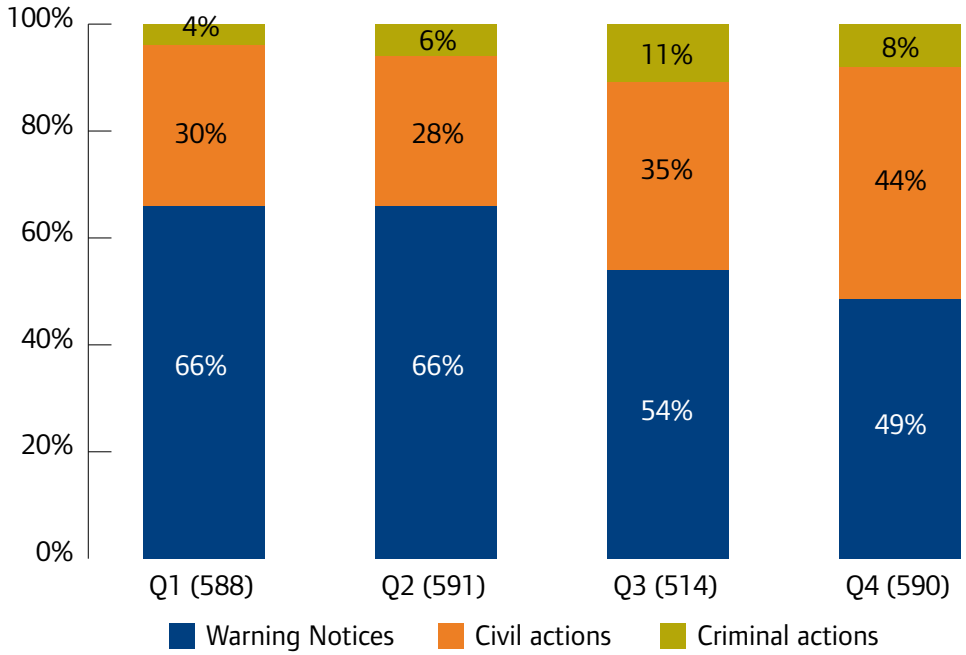
In 2017/18 we issued 2,283 enforcement actions. The majority (1,343) were Warning Notices and 781 were other civil actions. The remainder (159) were criminal actions (figure 7). Of the inspection reports published during the year, 8% included enforcement action.

Our inspectors are increasingly using the full breadth of enforcement powers and we are taking proportionally more criminal actions, such as fixed penalty notices and complex actions such as prosecution. For example, in 2017/18 we:

- enforced the closure of 141 locations (73% were adult social care services)
- successfully completed five prosecutions in relation to safe care and treatment
- issued a total of 148 fixed penalty notices (such as for failure to display a rating or to have a registered manager in place).

This range of enforcement actions shows the different steps we can take to protect the public from poor care.

Figure 7: Enforcement action, 2017/18



Note: In April 2017 we changed our reporting measures for enforcement and therefore the numbers for 2017/18 are not comparable with 2016/17.

Continuous improvement

The increase in the proportion of criminal actions compared with civil actions partially reflects our more skilled and experienced workforce, supported by our investment in training, and our focus on developing more robust systems and processes. We have started to develop how we approach quality improvement in our work, with a focus on criminal prosecution. We have also introduced a new case management system to better track and review cases using specialist legal support. It also may reflect our strong baseline of ratings history – it is easier for us to see where care is deteriorating and to return to take action.

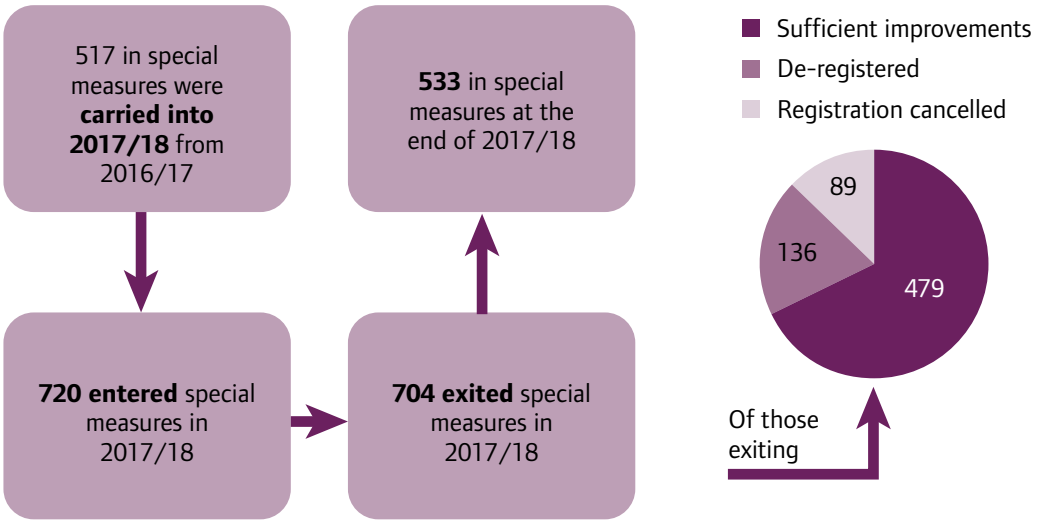
During 2017/18 we invested in a new professional regulatory skills programme that can potentially lead to a degree-level qualification. The programme will help inspectors to fulfil their regulatory responsibilities better, and support us in making use of our enforcement powers accurately and proportionately. The programme will begin in 2018/19.

Special measures

When we find serious failings in care we can recommend that providers are put in special measures. This makes sure that there is a framework in which services can be supported to improve, or signposted to organisations that can help. Providers are given a clear timeframe to improve, and if that does not happen we can take further action.

At the start of the year, there were 517 providers or locations in special measures. During 2017/18, 720 providers or locations entered special measures and 704 left. At the end of the year, 533 remained in special measures (figure 8).

Figure 8: Special measures activity, 2017/18



Impact

Providers have told us that enforcement helps to encourage compliance with the regulations. Sixty-seven per cent of providers told us in our annual provider survey that the prospect of enforcement action is a factor that encourages compliance with CQC's regulations.

Most providers or locations (479) that exited special measures during the year did so because they had made enough improvement. The remainder either de-registered (136) or had their registration cancelled (89).

From special measures to good

A GP practice in London was rated as inadequate in April 2017. It was placed in special measures for six months and Warning Notices were issued. The inspection highlighted problems such as poor storage of medicines, blood pressure monitors that had not been calibrated, and staff operating without Disclosure and Barring Service (DBS) checks.

One year on, the practice had addressed the issues raised in CQC's report and improved the quality of care substantially. In April 2018 the practice was rated as good. It was found to have a strong focus on continuous learning and improvement and had made a range of changes. These included developing clear systems to manage risk so that safety incidents were less likely to happen, and training staff to make sure they had the right skills and knowledge to deliver effective treatment.

6 Independent voice

OUR **2017 ANNUAL PUBLIC AWARENESS SURVEY** FOUND THAT

65%

OF RESPONDENTS **WERE AWARE** OF CQC

THIS HAS **INCREASED** FROM

50% **IN 2015**

Performance

Over the previous year, we have used our independent voice in many ways in the interests of people who use health and social care services. We have reported on the quality of care we have seen, and we engaged with a range of audiences to highlight specific issues.

In October 2017, we published our annual *State of Care* report. This is our in-depth report to Parliament, looking at the quality of health and social care in England. We reported that the majority of the care that people receive is good and there are providers and services that deliver outstanding care. We highlighted that many services had recognised our inspection findings and were making the necessary changes to get better. We also pointed to care that still needs to improve across all sectors. We highlighted our findings that people's quality of care is often better where the local health and social system works well together at a local level. The report led to substantial interest, including a debate in the Houses of Parliament.

Further exploring the themes we highlighted in *State of Care*, in July 2018 we published our national report on the local system reviews that we carried out during the year. The report looked at the way different services across the system work together to deliver care for older people in England (see chapter 4 for more detail).

In March 2018 we published our review of children and young people's mental health services – *Are we listening?* We reported that many children and young people experiencing mental health problems do not get the kind of care they deserve. Although we found examples of services putting children and young people at the heart of their work, overall the system is complicated and there is no easy or clear way to get help. Our phase 1 report informed the Health Select Committee's Child and Adolescent Mental Health Services Inquiry and *Are we listening?* helped inform the Health and Education Committees' joint report on the children and young people's mental health Green Paper.

In December 2017 we started work on our thematic review of serious, preventable incidents in NHS trusts. The review, commissioned by the Secretary of State for Health and Social Care, will explore the reasons why these serious events happen even where there is preventable measures guidance in place. It will look at what can be done to improve compliance with safety guidance, including working with system partners and learning lessons from other industries.

We also published a number of improvement case study reports for each sector – adult social care, general practice, hospitals and mental health. Each report looks at providers' improvement journeys, how they did it, and what helped them the most, including CQC's role. Our case study reports have been welcomed by providers and have generated discussion and workshop learning events.

During 2017/18, our website was visited around 18 million times. We have seen more people using our website, with the number of users increasing from around three million in 2012/13 to around 8.7 million in 2017/18.

We ran a number of national public information campaigns to raise awareness of the health and care choices that people have, and to promote the use of our inspection reports. These were: '#yourbirthplan' campaign to help women consider all the options for where to give birth; and our '#careaware' campaign to increase understanding of the choices available for people looking for a care home or care in the home. We also ran a targeted social media campaign to help members of the public who had recently moved home to use CQC inspection reports to find a new GP practice. We have built our social media community over the year – it grew from around 115,300 in April 2017 to around 133,000 in April 2018.

We also work closely with the media to share information and respond to queries. In 2017/18, we logged 1,047 journalist enquiries, issued 776 press releases to support the publication of our reports and other major announcements, featured in 13,310 pieces of news coverage and logged 197 confirmed interviews with broadcast media.

We continued to use opportunities to reach large and influential audiences with our findings. CQC was represented at 380 speaking events and 19 exhibitions, reaching an audience of more than 65,000 people.

Impact

National reports

We asked providers about some recent reports. Many were of interest to providers and some made changes as a result of reading them. In our annual provider survey, the three reports that were of most interest to providers all shared a similar purpose, to work together and learn from each other to improve the quality of care. These were: *Adult social care: Quality matters* (48% of these who were aware of it, found it of interest), *Equally outstanding: Equality and human rights good practice resource* (44%) and *Celebrating good care, championing outstanding care* (44%).

Of those who found *Celebrating good care, championing outstanding care* of interest, 49% took action to make changes. For *Adult social care: Quality matters* it was 45% and for *Equally outstanding* it was also 45%.

Choosing care and public awareness

It is important that people who use services understand the choices they have when they are looking for care services. Our inspection reports and quality ratings help people understand the different options for themselves or their family and friends.

In our 2017 annual public awareness survey we found that:

- 65% of respondents were aware of CQC – this has increased from 50% in 2015.
- Of those who were aware of us, 81% trust that we are on the side of people who use services – this has risen from 56% in 2015.
- When people had seen a CQC rating, the majority (85%) found it easy to understand and 49% of those people took action afterwards, such as using a service for the first time or looking at more information about the service.
- 73% of people who were aware of CQC agreed that CQC is driving improvements in the quality of health and social care services.
- Awareness was higher among respondents in population groups targeted by our campaigns (figure 9).

Figure 9: Awareness of CQC by population group targeted through our campaigns

Population group	Total awareness 2017
People choosing adult social care	80%
People accessing maternity services	70%
People over 65	71%

7 Our people, capabilities and culture

Listening to staff

Our staff survey is an important moment during the year to listen and respond to staff feedback or concerns. Our 2017 survey had the highest participation rate in three years, with 84% of CQC staff taking part. Our staff engagement score was 62%. Our ambition is to improve staff survey results year on year.

Overall, the results remained stable and we saw particularly positive responses around how staff feel about being aligned to CQC's purpose, values and how we make a difference, as well as the support they receive from team members:

- 92% of respondents agreed that our work with service providers improves standards of care and encourages improvement.
- 91% believe that CQC makes a positive difference to people's lives.
- 91% agreed that they can rely on support from their colleagues when needed.

These scores were above the public and private sector benchmarks. In addition, the score for the visibility of leaders was one of the most improved since 2016.

There were less positive results around the way we manage change and communicate with staff, workload, and the technology that supports staff to do their roles:

- 22% of respondents felt that change is effectively implemented across CQC.
- 31% thought that communications across different parts of CQC are effective.
- 50% felt they had the right tools/equipment to do their jobs.

We have plans in place to improve our change management processes and communications, as well as plans to support staff wellbeing and make sure that people have the right tools to do their jobs. Staff said that they do not always feel they have the chance to contribute their views before decisions are made or that they are involved enough during periods of change. We have trialled a new initiative where there is a focused opportunity for staff to raise issues in team meetings. These are then fed back to senior leaders to understand and respond to.

We continued our work to understand and strengthen our organisational culture. We asked staff to identify when they have felt able to work at their best and what that meant for them. Staff shared more than 600 stories that identified being autonomous, connected, curious, knowledgeable, recognised and supported as being closely aligned with working at their best. We shared and promoted these uplifting stories so that we could all learn from each other and understand our different experiences. This work will continue in 2018/19.

Recruiting and retaining the right people

To address workload pressures, we have moved to an 'always on' model of inspection staff recruitment. This makes sure that recruitment is always in line with our turnover rate, and that we are able to deploy additional staff when needed, particularly in response to our intelligence-driven approach to inspection. In 2018/19 we will invest £3.2m in additional inspection staff to support increased inspection activity and to be more flexible to respond to changes in the quality of care. Additionally, we are starting to look at ways we can strengthen how we attract people to CQC and retain them in the organisation.

We have also started to develop a talent management and succession planning strategy and we have delivered the first two phases of this. These phases have involved all of our leadership and top-level management staff. This strategy allows us to invest in CQC's future by developing our internal talent, ensuring that we support people to progress so that we have strong succession pipelines into our most critical roles.

Our staff turnover was 11.6%, which was below the turnover in 2016/17 and well in line with public and private sector norms. Time lost to staff sickness remained stable at 3.8%. This was similar to 2016/17.

Supporting staff

We are focused on supporting and caring for our staff. Our staff survey found that staff have a very positive view of the support they receive from their colleagues and their line manager. Ninety-one per cent of respondents agreed that in their team, they can rely on the support of colleagues when they need it.

Most recently we have been improving the regularity and quality of performance conversations. The staff survey highlighted that 80% of staff confirmed they had regular 1:1 performance and development discussions with their line manager, which is 8% above the public and private sector benchmarks, and 74% agreed that their line manager gives feedback on their performance that they feel helps improve their work. This score is 10% above the benchmarks.

Technology improvements have included: work to upgrade our intranet to help staff access the information they need more easily; new hybrid laptops and tablets to help staff be more mobile and connected, particularly when on inspection; and better functionality in our resource planning tool (Cygnum), making it more streamlined and efficient for staff to use.

Learning and development

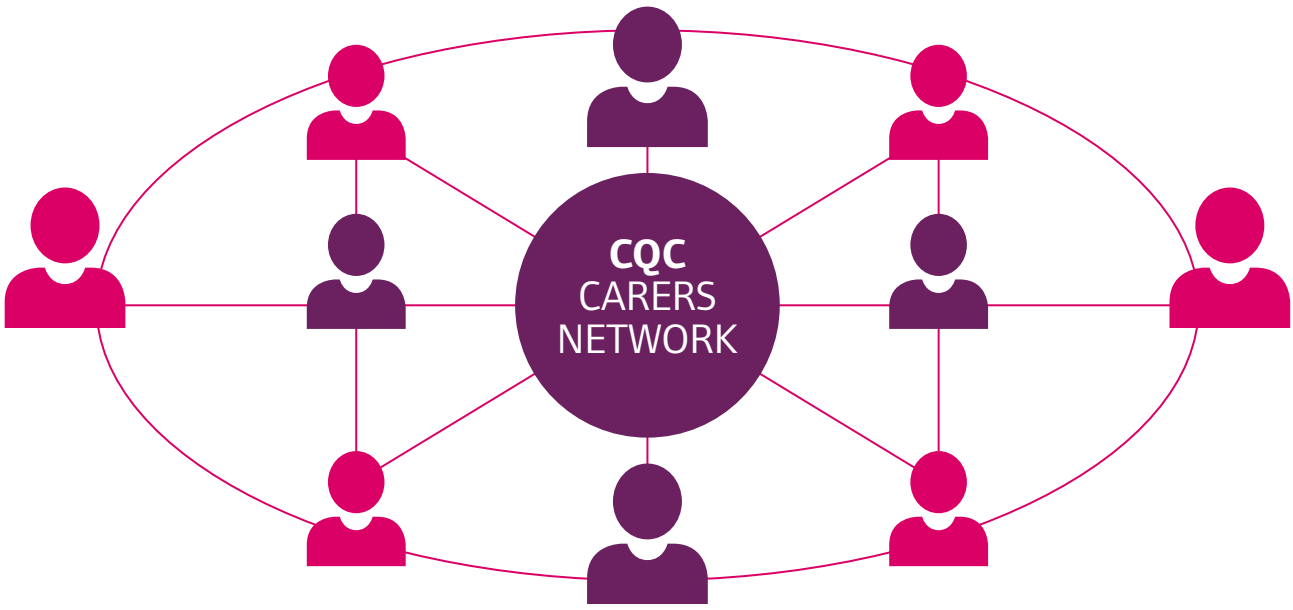
We have continued to enhance our learning and development programme with 430 new items of content added to our online education and development system, including 60 eLearning and 95 video resources. During 2017/18, more than 37,000 learning activities took place with 5,750 people attending a classroom based session, 15,500 eLearning programmes carried out, 9,000 learning resources accessed and 7,000 learning videos accessed. For example in 2017/18, 78% of staff took our course on unconscious bias, and 206 staff took our new course on mental health awareness for managers, taking the completion rate to 55%.

Our mentoring scheme is now in its second year and has supported more than 120 mentoring partnerships since it started in December 2015. The mentoring relationship helps support staff from all levels of the organisation to work towards accessing leadership roles, particularly those from under-represented groups.

We completed our Inspire leadership programme for managers across CQC. The programme has supported more than 700 managers over the previous two years to grow and develop as leaders. Feedback from staff about the course has been positive.

Our graduate analyst scheme provides the opportunity for those on it to develop their analytical skills and support CQC's work, including inspections, to drive improvement in care for people. Graduates who join each year can gain a breadth of experience by rotating through different teams and conducting analysis, writing reports and developing intelligence products. Eighteen of the 39 graduates who joined the scheme since it started have secured permanent analytical roles and three have become inspectors. As at 20 June 2018, seven graduates remain on the scheme and 11 have left CQC.

8 Equality, diversity and human rights



We protect and promote equality, diversity and human rights as an integral part of our regulation and we have made good progress against our equality objectives. Our staff survey showed some signs of improved equality of work experience for our staff, but we have more to do to be a fully inclusive and diverse working culture.

Our equality objectives

Our five equality objectives cover the period from April 2017 to March 2019. When we regulate services, we look at each equality objective for people with protected characteristics under the Equality Act 2010.

1. Person-centred care and equality

New training and support has been introduced for mental health and adult social care inspectors to help them consider and share best practice on how services acknowledge, respond to and meet the needs of lesbian, gay, bisexual and transgender (LGBT) people. Also, a group of staff members have established a good practice forum to improve how inspections look at the experience of older people from Black and minority ethnic (BME) communities who use GP practices.

2. Accessible information and communication

The Accessible Information Standard (AIS) requires public-funded health and social care services to ensure they meet the information and communication needs of disabled people who use their services.

In November 2017 we started to look at the AIS on all inspections of NHS and public-funded health and social care services. Looking at this standard through our regulation helps us to encourage improvement in the quality of care for people who have an information and communication need related to a disability, sensory loss or impairment. We will report our early findings about how providers are using the standard in our *State of Care* report.

3. Equality and the well-led provider

We worked with NHS England to develop and improve our assessments of the Workforce Race Equality Standard (WRES) in hospital inspections to support our focus on the well-led key question. We also took part in the pilot of the new Workforce Disability Equality Standard. This will help build our organisational learning before inspecting the standard when it comes into place next year.

We worked with NHS England's WRES team to look at the equality aspects of the Southport and Ormskirk Hospital NHS Trust's Freedom to Speak Up investigation.

With a number of our system partners, we published *Equally outstanding* – an equality and human rights good practice resource. It uses best practice examples from outstanding providers to explore how a focus on equality and human rights can improve the quality of care in times of financial constraint.

4. Equal access to pathways of care

We have started work to understand how access to primary care services can be improved for people in specific equality groups, including migrants, asylum seekers, Gypsies and Travellers.

5. Equality of opportunity for CQC staff and those seeking to join CQC

Embedding equality, diversity and inclusion into everything we do at CQC is core to delivering our purpose and values. We need to be representative, at all levels in CQC, of the people who use health and social care services. We should have diversity of experience and views to ensure we make the right decisions in our work. Fully considering equality and diversity also affects the whole experience of CQC staff, from recruitment to every day work to career progression. Using the results of the staff survey, we look at how we can support staff from all of the protected equality characteristics. In 2017/18 we had a particular focus on improving equality of opportunity for disabled staff and staff from BME backgrounds.

Disability

Our staff survey showed that the gap in positive sentiment between disabled staff and non-disabled staff continued to close this year, which is positive. There were generally better scores for disabled staff compared with the previous 2016 survey. For example, the score for feeling positive about work-life balance improved by 11% and for equality of opportunity by 10%.

We have also seen a number of successes. Our focus on ability programme, which delivers specific actions to improve the experience of disabled staff at CQC, was 60% complete by the end of 2017/18. Improvements from the programme have included embedding our revised tailored adjustment process and rolling out our mental health awareness training for managers. Also, 100 additional staff felt able to declare their disability for the first time in the staff survey. We saw our progress recognised when we received the Employers Network for Equality & Inclusion highly commended award.

There is more to do to improve the experiences of disabled staff. Areas from the staff survey that need further focus include personal morale and support for pursuing further learning.

Workforce Race Equality Standard (WRES)

The results from CQC's 2017 WRES found that:

- White applicants were 1.47 times as likely to be appointed as BME applicants. In 2016 this score was 1.51 times.
- BME staff were 1.33 times more likely to enter a formal disciplinary process than White colleagues. This figure improved from 2016 when it was 1.68 times.
- BME staff reported a much lower belief that CQC promotes equality, diversity and human rights in its work, and that CQC provides equal opportunities for career progression or promotion.

We are committed to using the WRES results to improve race equality for CQC's workforce. The full results can be found on our website.

Our mentoring programme over the last two years particularly encourages participation from BME staff. Over the last two years, 54% of mentees and 21% of mentors have been from BME backgrounds.

We also worked closely with a research fellow at Middlesex University, specialising in the experiences of BME staff and tackling race equality across health and social care. His focus was on how we recruit a diverse workforce, particularly how we can increase the number of BME candidates who are converted from interview through to selection for a job, and ensure equal opportunities for existing and prospective CQC employees. He consulted widely with staff and reported back to us in June 2018. We will use his recommendations to help us drive further improvement.

Sexual orientation

The survey also showed that lesbian, gay and bisexual (LGB) staff who took part feel that their experience of work is broadly equal to that of heterosexual colleagues. LGB staff are also slightly more likely to be positively connected to CQC as an employer.

Staff equality profiles and networks

Staff equality profiles

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 2018, our staff equality profiles were very similar to 2017 (figure 10). The areas to highlight from our analysis include:

- There is a higher proportion of staff identifying as LGBT at Grade A and above than would be expected.
- BME representation was significantly lower than would be expected from the overall proportion of BME staff employed in CQC, which is similar to 2016. We are currently working to assess the reasons why there are inequalities in recruitment outcomes that should support us to redress this balance in the future.
- At the most senior levels in CQC (Grade A and above), 68% of staff are female which compares with 41% in the civil service. As at 31 March 2017, our data showed that there is no gender pay gap at CQC. We report in detail on this in the Staff and remuneration report (page 113).

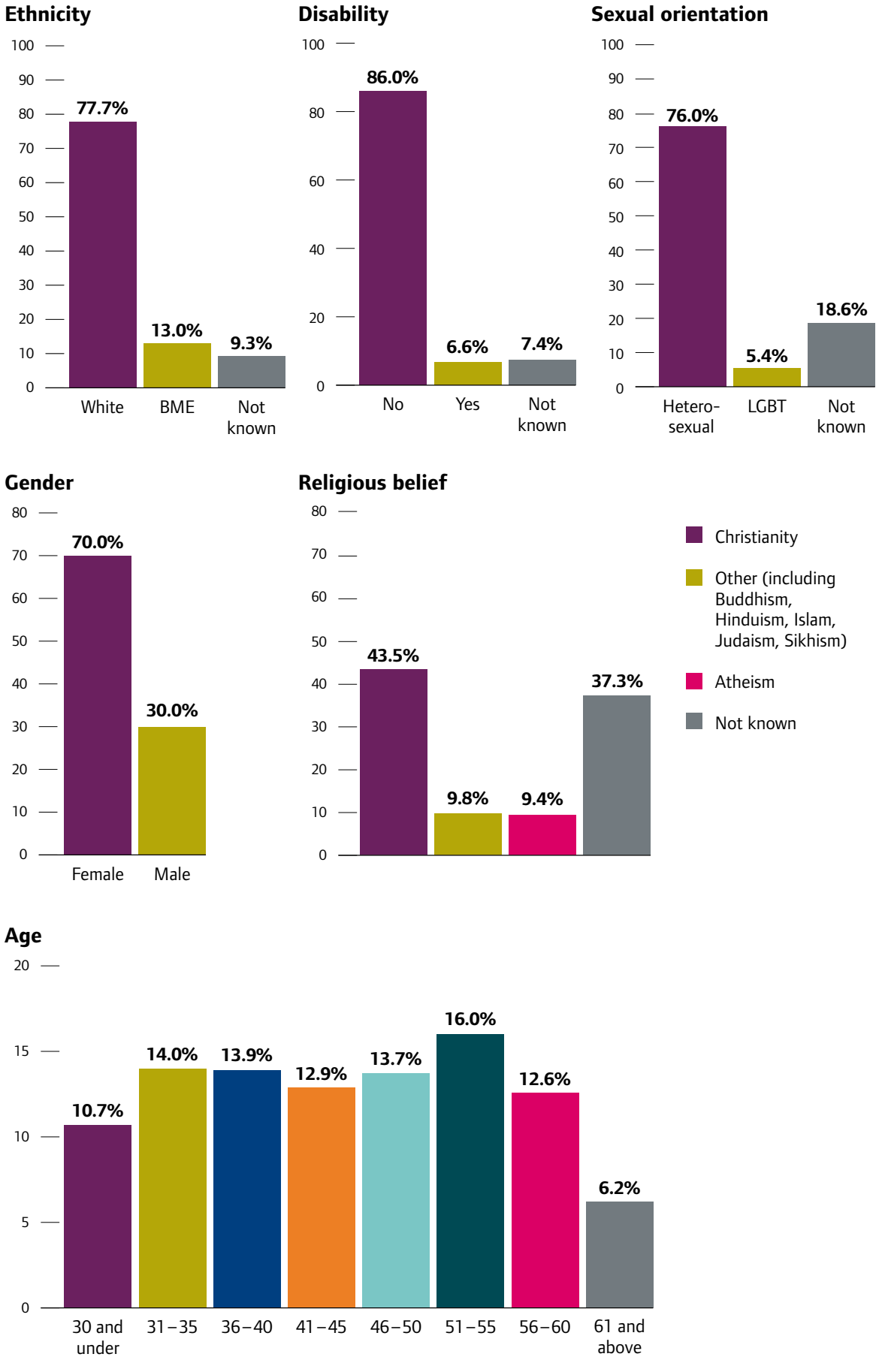
Our staff networks

Our five staff equality and diversity networks are an inspirational driver for our inclusion and diversity work across the organisation. Their dedicated work over the last few years has given us the platform to increase our focus in this area. Our ambition is that equality and diversity become a core part of each staff member's job and that they are factored into decision-making every day.

Our Equality and Human Rights Network is made up of almost 400 CQC staff and continues to grow. The network prioritises building equality and human rights into our regulatory work and improving CQC. Our third equality and human rights network conference took place in February 2018.

We also have four dedicated networks: the Disability Network, the Race Equality Network, the Lesbian Gay, Bisexual and Transgender Plus (LGBT+) Network, and our new Carer's Network that was established in 2017. Our LGBT+ network has extended its membership to transgender staff and will extend its membership in 2018/19 to other non-conforming under-represented staff, for example staff who identify as 'asexual' and 'non-binary'.

Figure 10: Staff equality profiles as at 31 March 2018



Impact

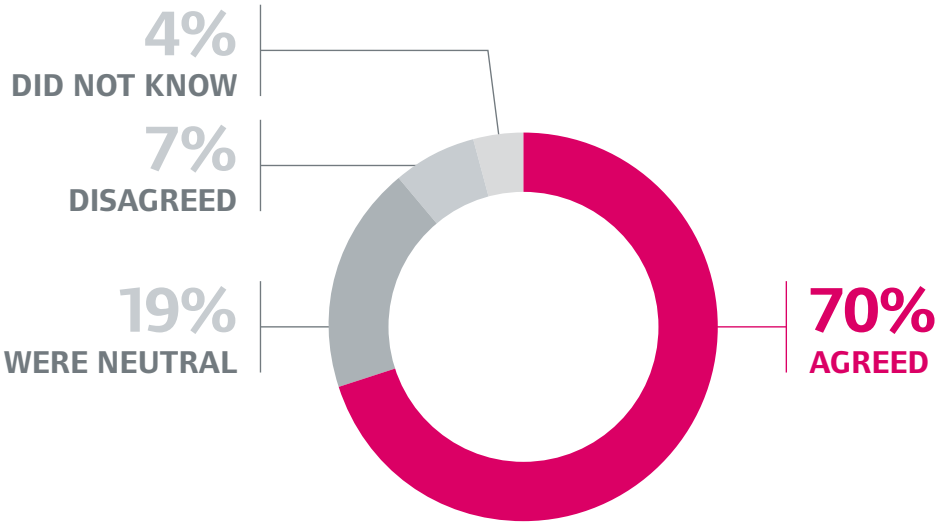
We continued to monitor the potential equality and human rights impact of our work on people who use services and providers. We conducted a number of equality and human rights impact analyses, including on CQC fees to providers, our children and young people's mental health review (*Are we listening?*) and on our public engagement strategy. We also continue to monitor actions arising from the analysis we carried out for CQC's strategy for 2016 to 2021.

In our annual provider survey, 70% of providers across all sectors agreed that CQC's work is effective in advancing equality for people using services.

We also carried out six equality impact analyses relating to internal policies or organisational changes – most of these related to staff employment policies, office changes and staff privacy.

Is CQC's work effective in advancing equality for people using services?

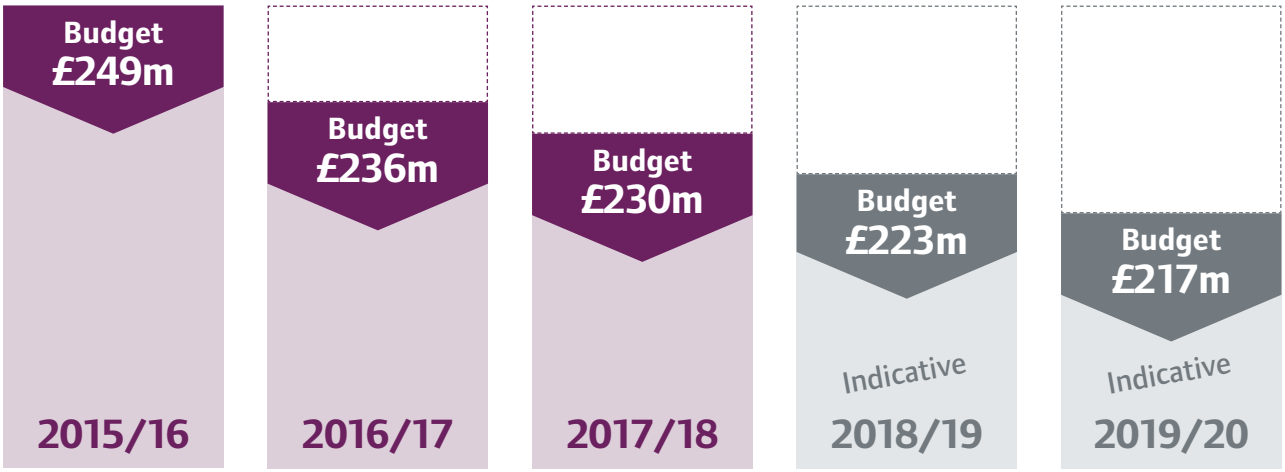
OF THE PROVIDERS WHO RESPONDED:



Source: CQC annual provider survey 2018.

9 Financial performance

GOOD PROGRESS IN REDUCING OUR BUDGET TO **MEET THE SPENDING REVIEW TARGET** IN 2019/20



In financial terms, this year has been a good year for CQC. We maintained our trajectory to achieve the 2019/20 spending review target and, in pursuit of this, the Financial statements show that our overall spend continues to fall year on year as we retain strong management controls over our expenditure.

2017/18 also saw us progress to a position where almost all of our costs for our chargeable activities are being recovered through fees. This means that these costs are being funded by providers. The Department of Health and Social Care funds activities where we are not able to charge fees – this funding has decreased during the same period. We will reach full cost recovery during 2019/20.

Our costing model has been established for three years and reflects both the decrease in expenditure and the changes in how we are regulating as a result of our strategy for 2016 to 2021.

We complete this chapter by considering the regulatory burden on providers.

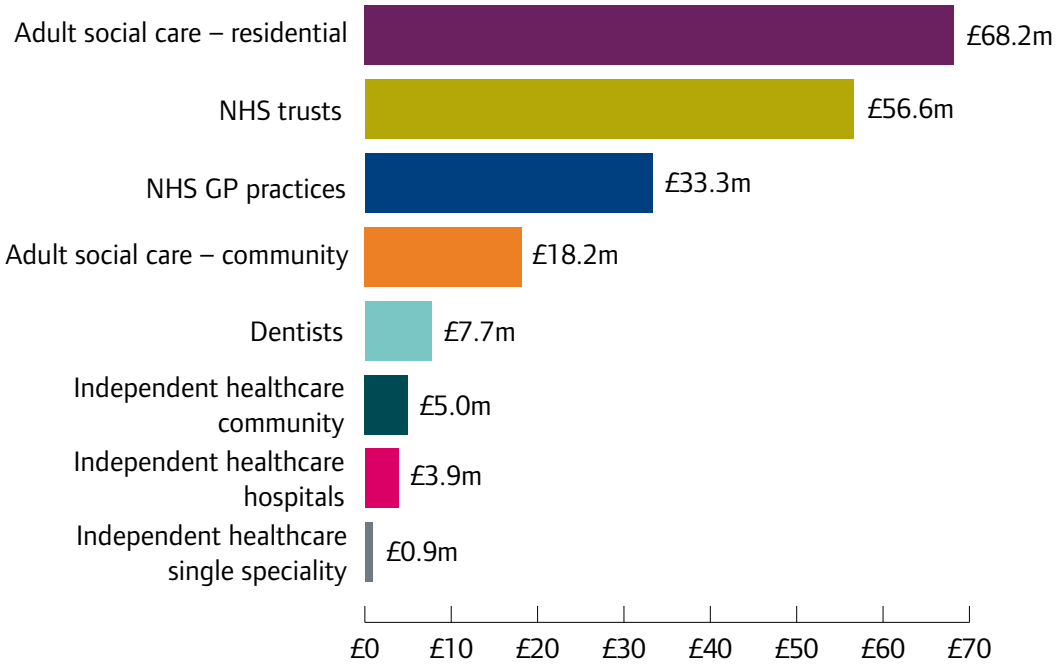
Our income

CQC is funded from two sources: fees from providers and grant-in-aid from the Department of Health and Social Care. Fees from providers fund our chargeable activities that largely relate to our regulatory work of registration, monitoring and inspection. Grant-in-aid funds our non-chargeable activities that relate to enforcement, (which is part of our regulatory activity) but not chargeable as fees, thematic reviews, market oversight, Healthwatch, the National Guardian's Office and work performed under the Mental Health Act.

During the last three years, we have carried out a strategy that moves us to full cost recovery in line with HM Treasury guidance as outlined in *Managing Public Money*. We are required to set fees in order to recover all the costs of our regulatory functions. This financial year saw us reach this position for all providers, except community social care providers which have a further two years before achieving that.

Our overall fee income has increased by £44.1 million to £193.7 million from 2016/17. Our grant-in-aid has fallen and our cost base has reduced during the same period. The contribution of fees from each sector and in relation to each other is shown in figure 11.

Figure 11: Total income by sector, 2017/18



What we spent our money on

Operating expenditure

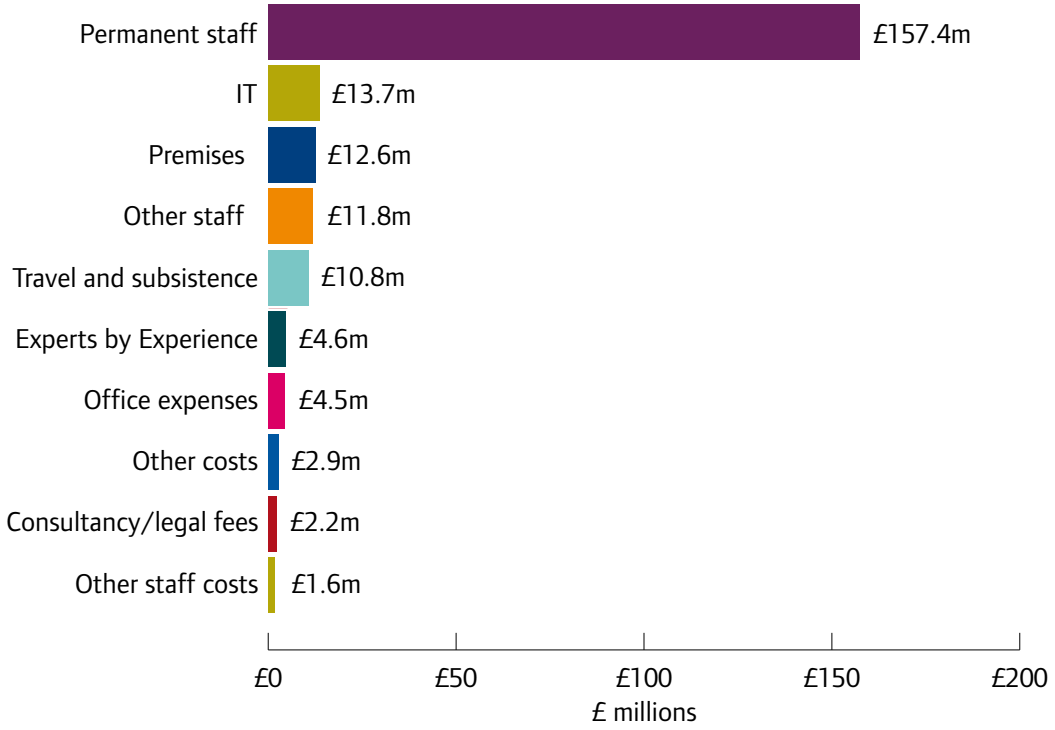
The expenditure shown in the Financial statements (the Statement of Comprehensive Net Expenditure) contains different categories of expenditure. The majority of it covers our day-to-day resources, that we monitor and control as part of our in-year budgeting. The other two elements include our depreciation charges on fixed assets and long-term provisions, which are non-cash movements that we include as part of the financial accounting preparation. The first category contains those costs that are key to managing our resources and budget, so this section concentrates on these. Note four to the Financial statements details the costs involved. They include staff costs, purchase of goods and services and other operating expenditure (excepting apprenticeship training grant, loss on disposal of fixed assets and other). Figure 12 shows the different categories of expenditure.

The figure for 2017/18 was £222.1 million and the equivalent for last year was £225.8 million, showing that costs have reduced by £3.7 million. We continue to reduce our cost base and remain on track with our spending review requirements.

The key movements in the year were:

- Most of the reduction was a result of staff costs, which were £2.1 million lower than last year. Staff (£2.0 million) and associates (£1.2 million) contributed to this reduction, offset by a £0.5 million increase for use of Bank inspectors, which were needed as a result of staff vacancies, and a £0.8 million increase in termination payments.
- We continued to ensure that we spend prudently. The main reductions in non-staff costs were in travel and subsistence, which fell by £0.7 million, supplies and services which also fell by £0.7 million and Experts by Experience which reduced by £0.9 million. This was offset by a rise of £0.6 million in professional fees.

Figure 12: Total expenditure by type, 2017/18



Capital investment

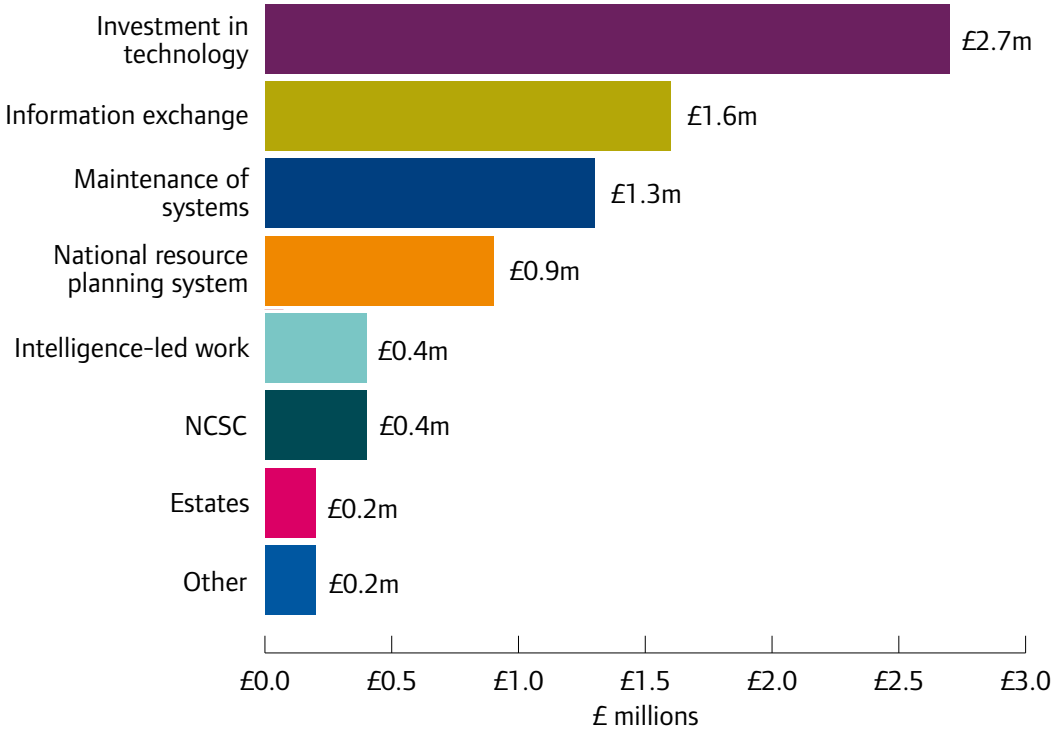
In 2017/18 we spent £7.7 million (£6.3 million in 2016/17) against an initial budget allocation of £10 million.

Most of our capital investment is concentrated in our IT function and the investment for this year and future years is vital in underpinning our strategy. Digital and intelligence work will enable us to deliver a step-change in our capability to become a more intelligence-driven, effective and efficient regulator. The ambition is to provide both the foundations for the shift to an intelligence-driven organisation, and the surrounding improvements to working practices and communications in and outside of CQC and to supporting staff with the best tools.

To achieve this, we are developing a programme to transform the way in which we build our systems, using current methodologies that will enable us to deliver the programme in the most effective way, underpinning our strategic priorities and delivering the benefits that will drive value for money. Shaping this and restructuring our IT and digital functions to be able to deliver this work has been a key focus for this year.

A key foundation of this work has been the investment of £2.7 million in the provision and upgrade of technology for staff. We have also invested an initial £0.4 million in intelligence-driven work in line with our strategy. Maintaining the systems that we have has used a further £1.3 million. Other key work has involved the national resource planning system (Cygnum), NCSC improvements and information exchange (our website and intranet). Figure 13 shows the breakdown of capital expenditure.

Figure 13: Capital expenditure by type, 2017/18



How much we spent against budget

We have shown how we spent less against the previous year (2016/17). We also spent within our budget for 2017/18. The spending review runs until 2019/20 and this shows that we are on course to reach the target of £217 million set as part of the review. We are looking beyond that to understand the optimum size we need to be an effective and efficient regulator.

Overall we underspent against budget by £6.3 million. This underspend was a combination of expenditure being £8.6 million lower than budget, reduced by a £2.3 million under-recovery on our fee income.

The underspend on expenditure was mainly on salary costs (£8.9 million); this was identified early in the financial year and enabled effective in-year planning. Some of this underspend can be attributed to efficiency savings. However it can also be linked with vacancies and a lower spend on specialist advisors and travel and subsistence in the Hospitals directorate due to the later start of our next phase of inspection programme. It has also had an adverse effect on our ability to fully deliver against our business plan for the adult social care programme. The compensating fee under-recovery was due to changes in the registration of some providers, resulting in lower fees compared with original budget expectations.

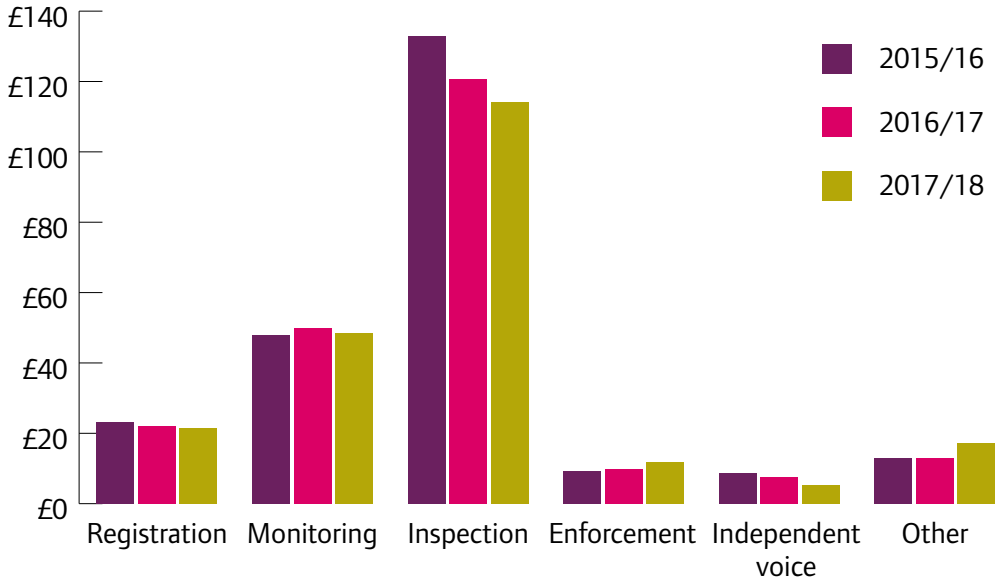
CQC has designated the net surplus of £3.2 million (as shown in the Financial statements, note 2) as a ring-fenced surplus within the general fund. We estimate that around £2.6 million of this relates to chargeable activities. Predicting future income and expense performance when budgeting is difficult and, as a result, small surpluses and deficits will occur from year to year. CQC will monitor the accumulated effect of these on chargeable costs and fees.

Our value for money

CQC's costing model was established in 2015/16 and we are now able to compare spend over a three-year period, consisting of actual expenditure for 2015/16, 2016/17 and 2017/18.

Our expenditure has reduced during this period as described above. Figure 14 shows what the change has been to the costs of our operating model.

Figure 14: Cost by operating model activity



The cost of registration, inspection and independent voice activity decreased in 2016/17 and 2017/18. The cost of monitoring activity increased from 2015/16 to 2016/17, as we began to focus on being more intelligence-driven, and reduced in 2017/18.

Both enforcement and 'other' activity increased in 2016/17 and 2017/18. These other activities relate to our non-regulatory work that is funded through grant-in-aid. The largest drivers of this increase have been the increased demand on MHA Reviewers and SOADs, as well as the local system reviews we were asked to carry out.

The average cost of inspection (figure 15) has scaled down substantially across the three financial years for Primary Medical Services and Hospitals directorates, with an increase in cost in 2017/18 for the Adult Social Care directorate. This average cost is calculated by taking the total cost of inspection for each directorate for each year and dividing by the number of inspections undertaken in each year for each directorate. The reduction in the Primary Medical Services and Hospitals directorates reflects a move to more monitoring and enforcement work. The increase in the Adult Social Care directorate reflects the increasing risk identified in the sector and that inspections in this area are becoming more complex as we move to more responsive inspections.

The reduction in the Hospitals directorate also coincides with the change from comprehensive inspections to 'units' of inspection, as well as the increase in smaller-scale inspections of independent hospitals.

This work is essential to help us understand our efficiency and the cost components of our operating model. Our focus will now be to ensure that we resource flexibly to respond to changes in the quality of care in the sectors, and the changes in demand on our operating model.

Figure 15: Average cost of inspection

Directorate	Description	2017/18	2016/17	2015/16
Adult Social Care	Inspection cost	£48.4m	£47.1m	£54.8m
	No. of inspections	12,141	14,352	13,538
	Average cost per inspection	**£4.0k**	**£3.3k**	**£4.1k**
Primary Medical Services	Inspection cost	£23.5m	£26.5m	£27.8m
	No. of inspections	3,922	5,414	4,190
	Average cost per inspection	**£6.0k**	**£4.9k**	**£6.6k**
Hospitals	Inspection cost	£42.1m	£47.0m	£50.2m
	No. of inspections	1,732*	1,089	473
	Average cost per inspection	**£24.3k**	**£43.1k**	**£106.1k**
Total	**Overall average cost per inspection**	**£6.4k**	**£5.8k**	**£7.3k**

*Figure is based on number of inspections at core service level.

Business Impact Target

The Business Impact Target aims to reduce the regulatory burden on business. We assess the impact on businesses of all eligible changes to the way we regulate and we report this to the external, independent Regulatory Policy Committee (which works with the Better Regulation Executive) by May each year.

In January 2018, we received approval from the Regulatory Policy Committee for the regulatory assessments we had produced during the last Parliament (from 2015 to 2017). We produced eight assessments during that period which showed that, on balance, we had saved businesses money by making changes to the way we regulate, and that we had contributed a £3 million saving to the government's Business Impact Target. This saving to providers was driven by introducing our digital registration service. We will continue to produce assessments for changes we make to the way we regulate during this Parliament and we will report on these on our website.

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 recorded 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. We also respond to formal information sharing requests from other public bodies, where these fall outside of the agreements we have in place with those organisations. And we provide advice to colleagues about how to share information fairly and lawfully with system partners and the providers we regulate.

In 2017/18, the Information Access team responded to 889 requests for information. There was a 96% response rate within statutory timescales, against the Information Commissioner's Office (ICO's) benchmark of 90%. These were:

- 676 requests made under the Freedom of Information Act 2000. Of these, 96.4% were responded to within the legal deadline of 20 working days.
- Six requests made under the Environmental Information Regulations 2004. All of these were responded to within the legal deadline of 20 working days.
- 196 subject access requests made under the Data Protection Act 1988. Of these, 92.9% were responded to within the legal deadline of 40 calendar days.

Eleven requests for information were responded to by the Information Access team under our information sharing procedures. Of these, 90.9% were responded to within our internal deadline of 20 working days.

The Information Access team also logged more than 900 pieces of advisory work in the financial year, where they provided advice and support to colleagues on information sharing or other information governance matters.

The number of unique individuals who made requests for information to CQC in 2017/18 was 694.

Sixty per cent of people who responded to our request for feedback said that they were happy with our responses and had gained a better understanding of CQC.

Of the total requests for information, 25 (2.8%) resulted in the applicant requesting an internal review (asking CQC to reconsider the original decision). Our review allows us to determine whether we complied with the requirements of the legislation first time round. Of the 25 internal reviews, 23 were not upheld (we did not change our original position) and two were partially upheld.

Four of the requests we responded to were referred to the ICO by the applicant for independent assessment; one complaint was partially upheld by the ICO, one complaint was not upheld, the other two are still pending a decision.

The Information Access team have supported CQC's work to prepare for the General Data Protection Regulation (GDPR) and the Data Protection Act 2018. Under these new pieces of legislation, the deadline for responding to most subject access requests (where people ask for information about themselves) will be reduced from 40 days to one month.

Complaints about CQC

We take each complaint we receive about CQC as an opportunity to learn and improve. In 2017/18 we handled 258 complaints under our formal complaints procedure.

During 2017/18 we embedded a centralised team that now manages the complete complaints process. This has helped us to more accurately categorise and triage potential complaints, as well as informally resolve concerns outside of the process. It has also improved the quality and speed of the investigation of each complaint.

We have seen the impact and benefits of our new complaints process. During 2017/18 we acknowledged 99.6% of complaints within three days. This was against a target of 95% and was a strong improvement from 2016/17 when we had an average of 79% of complaints acknowledged within three days. Of the 135 investigations carried out, 86% were completed in 30 working days against a target of 80%. Of the 123 first line resolutions completed this year, in 99% of cases we agreed the actions to be taken within seven days, against a target of 85%.

During 2017/18, seven cases progressed to the Parliamentary and Health Service Ombudsman. Two of these (1%) were partially upheld, against our target of less than 3% upheld overall.

The main themes of the complaints received in the year related to the conduct and performance of inspectors during the course of inspection activity. We have encouraged staff to learn from these complaints by reflection, discussion in meetings with line managers, or by attending additional training.

Learning from complaints

We received a complaint from a provider about technical issues submitting their registration forms. We looked into the issue and identified a system fault in updating the person's details. We acknowledged the issue and upheld the complaint. We have added this feedback to the overarching technical work underway to transform online registration to make it much easier to use.

We also received a complaint from a member of the public who wanted hard copy documentation to be returned to them. We upheld the complaint and acknowledged that there was no agreed process for returning hard copies, and apologised to the customer for any delays. As a result of the complaint, we agreed to create a process and guidance for future similar requests.

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. Flexible working has a positive effect on our sustainability. We continually review our estates strategy to consider sustainability.

We have established a Sustainability Steering Group, to coordinate our efforts and have started work on a Sustainability Development Management Plan. We have an ongoing dialogue with our suppliers of goods and services to ensure they have sustainable working practices with supporting policies. We have pledged to support the ban on single use plastics and we have started to plan a range of initiatives in this area.

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 2009/10 baseline by 25% and 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 that 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 2.4% from 2016/17 (figure 16). Costs have increased by 2% for the same period. CO_2 emissions from domestic business travel flights have decreased by 13.7% from 2016/17.

Figure 16: Carbon dioxide emissions, 2017/18

Area	CO_2 emissions (tonnes)	2017/18 Units	2017/18 Cost £	Performance against 2016/17
Building energy	1,425*	4,894,814(kWh)*	271,941*	increased
Travel (rail)	746	9,948,085 (m)	3,882,083	increased
Travel (road)	1,676	5,709,036 (m)	2,758,818	improving
Total	**3,847**	**n/a**	**6,912,842**	

*Electricity data from 151 Buckingham Palace Road is an estimate from costs incurred.

Figure 17: Carbon dioxide emissions indicators, 2014/15 to 2017/18

Non-financial indicators (CO_2)	2017/18 (tonnes)	2016/17 (tonnes)	2015/16 (tonnes)	2014/15 (tonnes)
Gross emissions (buildings)	1,425	1,295	1,262	1,390
Gross emissions (business travel)	2,422	2,480	2,885	2,303
Total	**3,847**	**3,775**	**4,147**	**3,693**

Financial indicators (£)	2017/18	2016/17	2015/16	2014/15
Expenditure on official business travel	6,640,901	6,509,111	8,221,589	7,116,621

Performance

Energy consumed in our buildings has fallen, compared with the 2009/10 baseline (figure 18). This is because we have invested in energy initiatives, and have tighter controls on heating, cooling and lighting.

Figure 18: Energy use indicators, 2015/16 to 2017/18 against baseline

Non-financial indicators – energy consumption (kWh)	2017/18	2016/17	2015/16	2009/10
Electricity	3,130,011*	2,681,974	2,138,184	3,641,075
Gas	914,872	1,030,109	1,107,899	2,004,344
Total (kWh)	**4,044,883**	**3,712,083**	**3,246,083**	**5,645,419**

Financial indicators (£)	2017/18	2016/17	2015/16	2009/10
Total energy expenditure	271,941*	289,242	354,629	525,935

*Electricity data from 151 Buckingham Palace Road is an estimate from costs incurred.

Managing water use

Performance

CQC's water use is almost exclusively from washrooms and showers. Water use data for 2017/18 has not been supplied to CQC by all landlords; therefore some estimates are used. Costs provided relate to only two offices but show a large reduction due to renewal of the water services contract (figure 19). Water use for all other offices is include in their overall service charges

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 19: Water use indicators, 2014/15 to 2017/18 against baseline

Non-financial indicators	2017/18	2016/17	2015/16	2014/15	2009/10
Water consumption (m^3) supplied	11,329	10,950	11,282	10,108	16,388

Financial indicators (£)	2017/18	2016/17	2015/16	2014/15	2009/10
Total water expenditure	6,853	6,727	14,075	19,106	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 (figure 20). 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 (in the public sector or wider society) or responsibly recycled.
- Ensure that surplus furniture is re-used (in the public sector or wider society) or responsibly recycled.
- Waste management at our buildings is largely through our landlord's contracts. All offices provide facilities for staff to recycle suitable waste and staff are encouraged to recycle wherever possible.

Figure 20: Office waste indicators, 2014/15 to 2017/18 against baseline

Non-financial indicators (tonnes)	2017/18	2016/17	2015/16	2014/15	2009/10
Non-hazardous waste (landfill)	30	22	89	119	27
Non-hazardous waste (re-used/recycled)	187	163	160	294	143
Total waste	**217**	**185**	**249**	**413**	**170**

Financial indicators (£)	2017/18	2016/17	2015/16	2014/15	2009/10
Total disposal costs	21,384	27,701	28,332	54,709	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 make sure that 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 a contract.

Sustainability is a key objective in CQC's commercial and contracts strategy and therefore its treatment in procurement and contracting reflects best practice.

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 Office of Government Property 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 needed to support the efficiency savings outlined in our organisational strategy for 2016 to 2021. Part of this will be through supporting the Cabinet Office's four principles of HQ, Home, Host and Hub. We work closely with DHSC to ensure we maximise opportunities and align our efforts wherever possible, particularly in line with the Government Hub strategy

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.

During 2017/18 we have:

- Reviewed our estate requirements for the next five years and engaged with staff around our future plans, resulting in an agreed draft strategy.
- Agreed with Cabinet Office to release 900m^2 of our London office to the Health and Safety Executive from May 2018, resulting in a reduced space that still meets our requirements but saves us money.
- Moved our Nottingham office to smaller premises that support the eight to 10 desk ratio guidance and agile working.
- Implemented an action plan derived from the 2017/18 estate health and safety audit.

Sir David Behan CBE
Chief Executive, Care Quality Commission
22 June 2018

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 2017/18.

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:

1. We register health and adult social care providers.
2. 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.
3. We use our legal powers to take action where we identify poor care.
4. 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's governance framework and structures

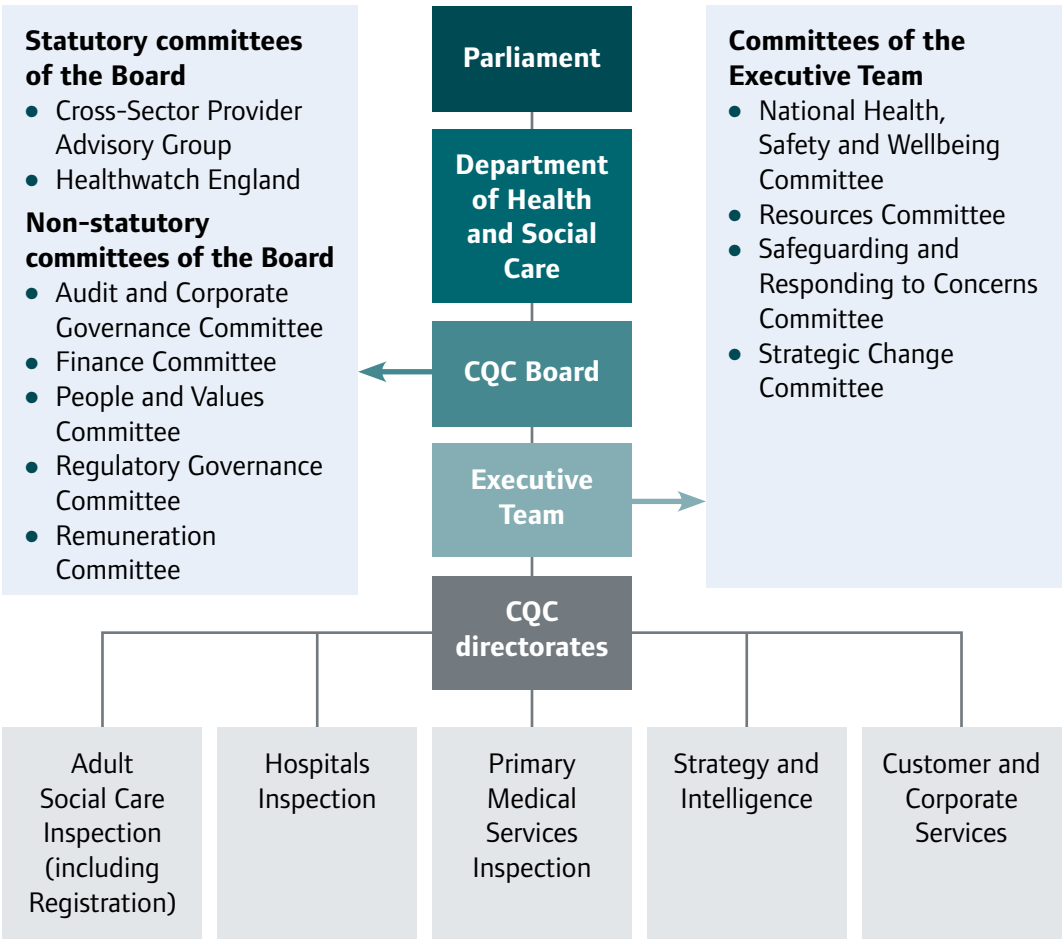
CQC has a corporate governance framework that sets out the governance arrangements for the organisation. The framework will be updated in 2018/19 to reflect changes to the governance model around Executive Team sub-committees. These changes were implemented to manage better the delivery of CQC's strategy, and medium-term and annual business plan commitments. Figure 21 sets out the current arrangements.

Parliament and the Department of Health and Social Care

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

The Accounting Officer is held accountable to Parliament through the Health and Social Care Select Committee and to the Department of Health and Social Care through quarterly accountability review meetings. The Accounting Officer attended all these meetings in 2017/18 and actions required of CQC arising from these meetings have been discharged.

Figure 21: CQC's current 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), nine non-executive Board members, myself as Chief Executive and Accounting Officer, our three Chief Inspectors and the Executive Director of Strategy and Intelligence. The Chief Operating Officer also attends Board meetings. One of the non-executive directors (Professor Paul Corrigan) acts as the Senior Independent Director.

Membership of the Board has changed since April 2017:

- Michael Mire completed his term of office on 30 June 2017.
- Professor Edward Baker was appointed as the Chief Inspector of Hospitals from 31 July 2017 following the retirement of Professor Sir Mike Richards.
- The appointment of three new non-executive Board members was announced on 5 January 2018: Sir John Oldham and Liz Sayce OBE whose appointment started on 1 January 2018, and Mark Saxton whose appointment started on 1 March 2018.

The full revised Board and Committee membership is set out at annex 1 and a summary of Board attendance up to 31 March 2018 is set out in annex 4.

Collectively the members of CQC's Board bring a wide range of experience and expertise that inform the decisions that the Board makes. All Board members also have equal and joint responsibility for governing the activities of CQC and in being accountable to Parliament, the Secretary of State for Health and Social Care, the Department of Health and Social Care 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 following each meeting. The Board's default position is to take decisions and hold discussions in public. However, there are some draft reports that need to be considered in private before publication or where discussions relate to individuals and employment issues, or commercial decisions. These matters are dealt with in a private session.

An independent Board effectiveness review was completed in March 2017 and the findings published in April 2017. Further Board development activity is planned in 2018.

All Board members are required to record annually any interests relevant to their role on the Board and these are all 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

Cross-Sector Provider Advisory Group

The Health and Social Care Act 2008 requires CQC to have an advisory committee, "for the purpose of giving advice or information to it about matters connected with its functions". The Cross-Sector Provider Advisory Group fulfils this function.

Healthwatch England

The Health and Social Care Act 2012 made provision for the establishment of a 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.

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 Internal Audit Service) and our external auditor, the National Audit Office, to determine the priorities for audit work during the year.

The committee has one independent member, Linda Farrant, who was appointed in July 2015. Paul Rew is chair of the ACGC.

Finance Committee

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.

The committee is chaired by Sir David Behan and has three non-executive Board members.

People and Values Committee

The People and Values Committee has oversight of succession planning, staff development and talent management, and oversees the understanding and application of CQC's values.

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. Professor Louis Appleby became Chair of the committee following the departure of Michael Mire on completion of his term of office on 30 June 2017. The Committee has three non-executive Board members.

Remuneration Committee

The Remuneration Committee determines the remuneration of selected senior executives and considers overall pay policy for the organisation. The committee provided advice and comment on recruitment and remuneration of the new Chief Executive and the Chief Inspector of Hospitals.

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 support a culture change in the NHS that will help staff to feel safe to speak up when they have concerns about care. It was created as a result of recommendations made by Sir Robert Francis' *Freedom to speak up review*.

The Office has been established with operational independence from the 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 also reports to CQC's Board 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. Responsibility for implementing the Board's strategy belongs to the Chief Executive and the Executive Team. The Chief Executive, three Chief Inspectors,

the Executive Director of Strategy and Intelligence and the Chief Operating Officer make up the Executive Team. They meet twice a month to consider items for decision and discussion.

Membership has changed since April 2017. Eileen Milner, Executive Director of Customer and Corporate Services, left CQC on 31 October 2017 and was replaced by Kirsty Shaw who took up the role of Chief Operating Officer on 1 March 2018. Professor Edward Baker was appointed as the Chief Inspector of Hospitals from 31 July 2017 following the retirement of Professor Sir Mike Richards. The current membership is detailed at annex 2.

Committees of the Executive Team

In January 2018, the Executive Team approved a proposal to implement a new governance model to enable it to focus on assessing CQC's overall strategic impact. Core elements of the new governance model include:

- establishing two new sub-committees of the Executive Team (the Strategic Change Committee and the Resources Committee)
- dis-establishing two existing sub-committees of the Executive Team (the Operational Development and Coordination Committee and the Investment Committee)
- dis-establishing two existing strategic working groups (the Medium-Term Strategy Group and the Workforce Planning Group).

The Executive Team considers three main areas on a monthly basis:

- operational delivery against the business plan and its key performance indicators
- delivery of strategic change and related cross-cutting changes
- effective use of resources (finance, people and commercial).

As a result of the governance model changes, the following committees now report directly to the Executive Team:

- The **National Health, Safety and Wellbeing Committee** ensures that CQC discharges its duties in relation to the health, safety and welfare of its staff.
- The **Resources Committee** oversees, monitors, and in accordance with CQC's scheme of delegation may take decisions on, the effective use of CQC's financial, people and commercial resources.
- The **Safeguarding and Responding to Concerns Committee** provides organisational assurance on the strategic direction and assurance for safeguarding and quality risks and responding to concerns.
- The **Strategic Change Committee** oversees the effective delivery of CQC's strategic changes, as defined in the strategy and rolling three-year plan.

Key governance roles

The Caldicott Guardian

Professor Edward Baker is CQC's Caldicott Guardian. In this role, Professor Baker oversees the Board's responsibility for addressing information governance at the strategic level, particularly access to identifiable patient information. This is a Board-level appointment, with the seniority and authority to exercise the necessary influence on policy and strategic planning.

Senior Information Risk Owner

The Executive Director of Strategy and Intelligence, Malte Gerhold, is CQC's Senior Information Risk Owner (SIRO). The role has been mandated by CQC's Security Policy Framework since 2009. The role is responsible for managing information risk across CQC and for making sure that data and information is identified, processed, transmitted, stored and used in line with the principles of good information governance and complies with CQC's legal, statutory and organisational requirements.

Data Protection Officer

The Head of Governance and Legal Services, Nimali de Silva, is CQC's Data Protection Officer. The role is responsible for advising on and monitoring compliance with the General Data Protection Regulation (GDPR).

CQC's Freedom to Speak Up Guardian

Mary Cridge is CQC's Freedom to Speak Up Guardian and reports to David Behan and CQC's Board. The Freedom to Speak Up Guardian promotes an open and transparent culture across the organisation, helping to make CQC a place where people can speak up with confidence.

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
Prof. Edward Baker	From 31 July 2017
Prof. Paul Corrigan CBE	1 July 2013 – 30 June 2019
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
Sir John Oldham	1 January 2018 – 31 July 2020
Paul Rew	1 July 2014 – 30 June 2020
Prof. Sir Mike Richards	16 July 2013 – 11 August 2017
Mark Saxton	1 March 2018 – 31 July 2020
Liz Sayce OBE	1 January 2018 – 31 July 2020
Andrea Sutcliffe CBE	From 7 October 2013

Audit and Corporate Governance Committee

Committee members
Paul Rew (Chair)
Sir Robert Francis QC
Sir John Oldham
Independent member
Linda Farrant

Finance Committee

Committee members
Sir David Behan CBE (Chair)
Peter Wyman CBE DL
Paul Rew
Mark Saxton

People and Values Committee

Committee members
Peter Wyman CBE DL (Chair)
Sir David Behan CBE
Prof. Louis Appleby CBE
Prof. Paul Corrigan CBE
Sir Robert Francis QC
Jora Gill
Jane Mordue
Sir John Oldham
Paul Rew
Mark Saxton
Liz Sayce OBE

Regulatory Governance Committee

Committee members
Prof. Louis Appleby CBE (Chair)
Prof. Paul Corrigan CBE
Paul Rew
Liz Sayce OBE

Remuneration Committee

Committee members
Peter Wyman CBE DL (Chair)
Prof. Louis Appleby CBE
Prof. Paul Corrigan CBE
Sir Robert Francis QC
Jora Gill
Jane Mordue
Sir John Oldham
Paul Rew
Mark Saxton
Liz Sayce OBE

Annex 2: Executive Team membership

Executive Team member	Role	Start of membership
Sir David Behan CBE	Chief Executive	30 July 2012
Prof. Edward Baker	Chief Inspector of Hospitals	31 July 2017
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 – 31 October 2017
Prof. Sir Mike Richards	Chief Inspector of Hospitals	16 July 2013 – 11 August 2017
Kirsty Shaw	Chief Operating Officer	1 March 2018
Andrea Sutcliffe CBE	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 previously the Director General of Social Care, Local Government and Care Partnerships at the Department of Health and Social Care, 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 Edward Baker, Chief Inspector of Hospitals

Professor Edward Baker became Chief Inspector of Hospitals in August 2017. He joined CQC in 2014 as Deputy Chief Inspector of Hospitals.

Before joining CQC, he worked in clinical practice for 35 years. He was Medical Director and Deputy Chief Executive of Oxford University Hospitals NHS Trust from 2010 to 2014, and Medical Director at Guy's and St Thomas' NHS Foundation Trust from 2003 to 2010. He has held numerous other clinical and academic appointments both in the UK and internationally.

While he was at Oxford University Hospitals NHS Trust, he chaired the first of CQC's new comprehensive inspections in September 2013 and led his trust through its own CQC inspection in 2014. He led major service improvements and operational and strategic change while he was at Oxford and Guy's and St Thomas' trusts.

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 in 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 2010 New Year's Honours List.

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 health care-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, and the Freedom to Speak Up review.

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 Honorary Fellowships of the Royal College of Anaesthetists, the Royal College of Surgeons (England) and the Royal College of Pathologists.

Dr Malte Gerhold, Executive Director of Strategy and Intelligence

Dr Malte Gerhold became Executive Director of Strategy and Intelligence in February 2017 after a period as Interim Executive Director. He joined CQC in 2013 as Director of Policy and Strategy and was responsible for setting out CQC's strategy for 2016 to 2021.

He started his career as a strategy consultant and 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 and Social Care. More recently he lived and worked in Sierra Leone for three years, leading a team advising the president on the implementation of the government's priorities in health care, energy, agriculture and investment.

Malte Gerhold has a BSc from the London School of Economics and a PhD from Oxford University.

Jora Gill, Non-executive director

Jora Gill 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.

Michael Mire, Non-executive director

Michael Mire left CQC's Board in June 2017.

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

Jane Mordue was formerly Deputy Chair of Citizens Advice, having worked in 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.

Sir John Oldham, Non-executive director

Sir John Oldham is a GP by background. He worked in inner city Manchester and Derbyshire before retiring from clinical practice. He is Adjunct Professor at the Institute of Global Health at Imperial College and was the Chair of the Independent Commission on Whole Person Care.

He helped pioneer quality improvement methods in health care in the UK and created a mechanism for large-scale change, replicated in a number of countries. He also worked in a Department for Education programme, successfully raising the performance of underperforming pupils in the lowest quartile of schools in England.

Previously he was a member of the National Quality Board for the NHS in England, and National Clinical Lead for Quality and Productivity at the Department of Health and Social Care.

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 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 left CQC and CQC's Board in August 2017.

Mark Saxton, Non-executive director

Mark Saxton has been a non-executive director of Yeovil Hospital NHS Foundation Trust, during which he has chaired its committees on workforce and remuneration. Before that, Mark held senior management positions in human resources and general management in FTSE and NYSE listed companies both internationally and in the UK.

Liz Sayce OBE, Non-executive director

Liz Sayce was, until May 2017, Chief Executive of Disability Rights UK. She has been a member of the Committee of Healthwatch England since 2014, is a member of the Government's Social Security Advisory Committee and is undertaking a Fellowship at the London School of Economics.

She is a member of the Disability Advisory Committee of the Equality and Human Rights Commission. Previously she was director of policy and communications at the Disability Rights Commission.

Kirsty Shaw, Chief Operating Officer

As Chief Operating Officer, Kirsty Shaw provides leadership across CQC's corporate and customer-facing functions, which include people (human resources), legal services, governance, digital, finance, commercial and the National Customer Service Centre.

Kirsty's career has focused on leading operational change and improvement programmes across a number of public bodies in the environment and food, and agricultural sectors. Before joining CQC, Kirsty was Director of Transactional Services at Natural England. Before that, she was Director of Service Delivery at the Animal Plant Health Agency and Head of Standards and Commercial Support at the Food Standards Agency.

Andrea Sutcliffe CBE, 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.

Andrea joined CQC from the Social Care Institute for Excellence where she was Chief Executive from April 2012. Previously she was Chief Executive of the Appointments Commission and was an executive director at the National Institute for Health and Care Excellence for seven years.

Andrea was awarded a CBE in the 2018 New Year's Honours list for services to adult social care in England.

Annex 4: Summary of Board attendance 2017/18

	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Peter Wyman CBE DL (Chair)	✓	✓	✓	✓	n/a	✓	✓	✓	✓	✓	✓	✓
Sir David Behan CBE (Chief Executive)	✗	✓	✓	✓	n/a	✓	✓	✗	✓	✓	✓	✓
Prof. Louis Appleby	✓	✓	✓	✗	n/a	✓	✗	✓	✗	✓	✗	✓
Prof. Edward Baker	n/a	n/a	n/a	n/a	n/a	✓	✓	✓	✓	✓	✓	✓
Prof. Paul Corrigan CBE	✓	✓	✓	✓	n/a	✓	✓	✓	✓	✓	✓	✓
Prof. Steve Field CBE	✓	✓	✓	✗	n/a	✓	✓	✓	✓	✓	✓	✓
Sir Robert Francis QC	✓	✓	✓	✓	n/a	✓	✓	✓	✓	✓	✓	✓
Dr Malte Gerhold	✓	✓	✗	✓	n/a	✓	✓	✓	✗	✓	✓	✓
Jora Gill	✓	✓	✓	✓	n/a	✓	✓	✓	✓	✓	✓	✓
Michael Mire	✓	✗	✗	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Jane Mordue	✓	✓	✓	✓	n/a	✓	✓	✓	✓	✓	✓	✓
Sir John Oldham	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	✓
Paul Rew	✓	✓	✓	✓	n/a	✓	✓	✓	✓	✗	✓	✓
Prof. Sir Mike Richards	✓	✓	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mark Saxton	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	✓
Liz Sayce OBE	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	✓
Andrea Sutcliffe CBE	✓	✓	✓	✓	n/a	✓	✓	✓	✓	✓	✓	✓

Annex 5: Board business – items considered by the Board during 2017/18

Annual report and accounts
ACGC: Quarterly reports to Board
Board effectiveness review: report from Deloitte
Business plan and budget 2018/19
Children's health and justice report
Competition and Markets Authority report
CQC's staff survey
Digital and intelligence strategy
Digital primary care providers
Equality, diversity and human rights: *Equally outstanding*
Fees scheme 2018/19
Finance Committee report: Reports to Board following each meeting
Health and safety policy
Health and safety strategy 2017 to 2019
Healthwatch England strategy and update reports to Board
Independent ambulances: First aid at events
Independent health care consultation
Local system reviews
Market oversight provider survey
Medium-term planning review 2018 to 2021
Mental Health Act report
National Audit Office/Public Accounts Committee action plan and narrative
National Guardian: Presentation of annual report and update report
National patient experience survey programme strategy
National patient survey programme
Next phase consultation
Procurement and contract approvals requiring Board consideration
Professional regulatory skills programme
Public engagement strategy 2017 to 2021
Public and national stakeholder awareness surveys
Quality improvement programme
Quality matters programme
Quarterly performance reports
Regulatory Governance Committee: Reports to Board following each committee meeting
Responsible officer annual report
State of Care report
Strategic risk report
Use of resources

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 and
- 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. My responsibilities as Accounting Officer, including responsibility for the propriety and regularity of 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 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
- continuous improvement
- people management and development
- financial management, systems and control
- information and evidence management
- governance and decision making

Each of our directorates provides a self-assessment (including a rating) against a clear set of expectations of performance in these eight core management disciplines. The assessments are peer reviewed by another directorate, then put through a collective challenge by the Executive Team, before being presented to the ACGC.

Our management assurance processes have been embedded over the last three years and have led to improvements in how we manage ourselves. Assessment ratings are challenged by a peer reviewing directorate on whether the rating appears to be reasonable in the light of the evidence presented; whether the approach to evidence is similar to that taken by other directorates; and whether there is any other evidence which contradicts an assessment, for example key performance indicators (KPIs) or other measures.

During 2017/18, Health Group Internal Audit Service also reviewed a selection of the directorate assessments, attended some peer review meetings, and reported on this to the ACGC. They commented that they saw no areas of significant concern in their analysis of the written assessments or at the meetings they attended, although they said one directorate could have set out their evidence and improvement actions more clearly.

The main findings from our assessments in 2017/18, together with some of the improvement actions we have underway, are summarised below:

- We have improved our assessment scores in seven of eight management assurance areas. Planning did not improve; however this was already a high-scoring area.

- Across our directorates our work on financial management, systems, and control and planning are the areas that have been rated most highly. These were strong areas in 2016/17 but have improved further.
- We need to do more work on quality management; and information and evidence management. These areas are highlighted as priorities in our business plan for 2018/19. They were noted as areas for improvement in 2016/17, and while some progress has been made, we need to go further.
- The most improved area was people management and development, albeit it from a low base in 2016/17. We are continuing to do work in this area, a priority in our business plan for 2018/19.
- In 2017/18 we set ourselves a KPI to be rated as good or outstanding across all the management assurance areas we assessed. Out of 88 ratings, 80 were rated as good, and eight were rated as requires improvement. This was an improvement on 2016/17 when out of 88 ratings, 78 were rated as good, although this was not a KPI in 2016/17.

The following sections provide detail under each of the eight areas of management responsibility.

Additionally, we reference the National Audit Office (NAO) action plans and the Public Accounts Committee (PAC) action plans that were published in October 2017 and December 2017 respectively. The reports followed a Health Select Committee accountability hearing on 6 December 2016.

Planning

We made further improvements to our planning process in 2017/18. This built on our work in 2016/17 when we created a Medium Term Strategy Group to oversee the development of a medium-term delivery plan for our strategic priorities from 2016 to 2019. The planning improvements have included:

- Developing a risk modelling tool that includes data on risk in health and social care services, workload, and profile of each sector and directorate (for example the profile of people who use services in each sector, staff survey indicators and turnover). We used this tool during 2017/18 to determine that we needed to allocate additional resources to the Adult Social Care directorate during 2018/19. We have agreed this on a non-recurrent basis for one year. We will continue to monitor risks in other sectors, particularly for services that we have not yet rated.
- Changes to our governance structure, including how we plan and monitor delivery. This new structure and the corresponding committees will be evaluated in 2018/19 and are detailed in the Directors' report.
- Revisions to the structure of support teams for business planning and change delivery. Both teams have been joined as one strategic planning and change team.
- Improvements to our Cygnum scheduling system that we introduced in 2016/17 to enable us to plan our inspection resources more effectively.

Health Group Internal Audit Service have scrutinised our medium-term strategy plans and our 2018/19 business plan and we are taking on board a number of their recommendations. These were broadly supportive but pointed to more work needed on detailed plans for our digital programme. The Executive Team also regularly reviews and considers models for business continuity scenarios.

There are several actions in the NAO/PAC action plan related to planning, including changes in the external environment and how they might affect how we plan for and manage change. For example, in 2018/19 and 2019/20 we will deliver a substantial digital programme and an intelligence development programme.

Performance and risk management

We have further strengthened the quality of performance information and our focus on performance reporting in directorates to help us deliver our targets.

Our KPIs showed some performance improvements in a number of areas. These included: the timeliness of assessing registration applications; Second Opinion Appointed Doctor (SOAD) performance; and customer service centre call response times.

We saw significant improvement in Primary Medical Services directorate inspection report publishing times, with 85% published within the target timescale. This has improved from 60% in 2016/17. Our Adult Social Care directorate inspection report times saw steady performance, with 84% published within timescale. We saw some improvement in the Hospitals directorate where report timeliness was furthest from the target.

However, we continued to miss our targets overall for inspection report publication times (see the Performance report, page 35). We will continue to work to improve this performance in 2018/19. Inspection report timeliness performance is a key priority for our quality improvement activity and it is embedded in our business plan for 2018/19 and in our NAO/PAC action plan. As part of business planning for 2018/19, all of our KPIs have been reviewed and targets assigned.

A recent Internal Audit report contained a number of recommendations relating to improvements in our customer services centre, including around handling safeguarding. We will continue to work to improve our customer services in 2018/19, including by updating our standard operating procedures, and undertaking training, and additional monitoring, where needed.

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

The risk register identifies the strategic-level risks and higher-level operational risks that the Board will oversee. The register sets out the mitigations that are being carried out to manage the level of each risk, and these mitigations are built into the directorate business plans. Progress in delivering mitigating actions is monitored by the Executive Team, the ACGC and the Board. Directorates have risk registers associated with their business plans.

As set out in the Performance report (page 20), the Board and Executive Team have agreed our risk register for 2018/19. Mitigating actions have been set out in the register, and these are part of our directorate business plans which were agreed in March 2018. We reviewed our risk tolerance statement to make it clearer and also to define in greater detail the risk tolerances that apply to our digital development programme, including a graduated scale of risk for projects at different stages of the agile development process.

Quality management and continuous improvement

Quality management frameworks for all directorates are in place, but are being used more proactively in some areas than others. An annual quality sampling programme is also in place, with an agreed schedule for each directorate. Quality sampling continues to be reported quarterly to inspection directorates, and a quality annual report is considered at Executive Team meetings. Our business plan for 2018/19 and our NAO/PAC action plan include actions to improve CQC's consistency in quality, performance and how it implements its approach to regulation.

We are confident that our audit programmes are focused on the areas of greatest risk, and we continue to learn lessons from these and identify improvement actions.

We appointed a new Director of Quality Improvement in 2017/18, and created a dedicated and specialist Quality Improvement team (which will be fully operational in 2018/19). The team will support the delivery of a greater number of improvement projects and make sure there is clearer strategic alignment between current performance of the organisation, strategic planning and improvement activity. The team will make better use of information and feedback on current improvement to drive greater impacts and benefits. Quality improvement is also one of the main priorities in our business plan for 2018/19. While the work to develop a culture of quality improvement is still in its early stages, there has been substantial enthusiasm and support from staff, and a number of early adopter projects have started to show positive outcomes.

People management and development

As set out in the performance report, our 2017 staff survey results remained stable and we saw positive responses around how staff feel about being aligned to CQC's purpose, the support received from team members, and the visibility of leaders. However we have more to do to address the less positive results, including to help staff manage workload, promote staff wellbeing, and make sure people have all the right technology and tools to support them in their roles.

To address workload, we have developed a more flexible approach to recruiting inspection staff that allows us to deploy additional staff when needed. We want to make sure that recruitment is always in line with our turnover rate. In 2018/19 we will invest £3.1 million in additional inspection staff to help complete our inspection activity and to be more flexible to respond to risks. We have started to develop a talent management and succession planning strategy for the organisation. Additionally, we are looking at ways to develop our attraction and retention package.

We have improved the technology available to staff. This was a key priority for 2017/18 and will continue in 2018/19 to support our digital programme. For example, we have worked to upgrade our intranet, which will be launched in 2018/19, and streamlined the functionality of our resource planning tool (Cygnum).

We have continued to enhance our learning and development programme, our mentoring scheme is now in its third year and we completed our Inspire leadership programme for managers across CQC.

In directorates, initiatives to address staff survey concerns have continued, and delivery of these plans has resulted in a number of directorates rating their people management and development assurance area as slightly higher than 2016/17.

Financial management, systems and control

Directorates have continued to improve their focus on management of resources, working closely with Finance colleagues. Budget holders have improved their financial awareness and consideration, and this has been evident in the savings achieved against budget. Additionally we are using information such as the average cost of inspection to monitor our efficiency and have developed this further to provide internal benchmarking.

There was an underspend in 2017/18 and some of this can be attributed to efficiency savings. However, around 70% related to vacancies as well as lower spend on specialist advisors and travel and subsistence in the Hospitals directorate. This was due to our hospitals next phase of inspection programme starting later than planned. This later start allowed us time to finalise and communicate the new inspection processes to staff, and to launch our new online guidance for providers, designed to be much easier to access and use.

We have presented a range of business cases to the relevant committees during 2017/18. However we would like to see improvements in how these are presented, for example better options appraisal and identifying of benefits. The quality of contract management could also be improved in parts of the organisation.

Commercial planning is an area we want to focus on and improve. We will continue to involve our Commercial and Contracts team more closely in strategic groups. The procurement code and commercial and contracts strategy have been reviewed and published internally and we have plans to publish the strategy externally.

Information and evidence management

Information management

We reviewed our management assurance standards for information and evidence management to make sure they adequately cover the latest information security and governance standards. We will implement these updated standards in 2018/19. We introduced a mandatory information security training module for staff, 'CQC values information' in 2017/18. All staff are required to repeat this training annually. As at 8 April 2018, 95% of staff had carried out the training.

Evidence management

The majority of directorates reported that they had met the standards required to be rated as good for evidence management. However two inspection directorates highlighted key dependencies between performance in this area and the information management and technology that support staff to manage evidence.

A number of important improvements continued to be made to our technology systems during 2017/18. Our business plan for 2018/19 outlines two major technology-related priorities: deliver a digital programme (priority 6) and enable CQC to become intelligence-driven (priority 7).

In October 2017, the Board agreed the main priorities for our digital programme. These include better and more mobile technology so our staff can do their jobs more effectively, particularly around collecting evidence when on inspection. Our NAO/PAC action plan also includes several actions related to digital delivery and our information collection systems.

Governance and decision making

The Framework Agreement between the Department of Health and Social Care and CQC has been updated. Updates predominantly reflect changes to CQC's oversight of Healthwatch England and the responsibilities relating to the National Guardian's Office.

We continued to work with our Department of Health and Social Care sponsor team and to maintain arrangements for regular performance reporting and review. Assurances around the efficient and effective operation of Healthwatch England were sought through CQC's governance frameworks. These comprise, regular reporting to CQC's Board and CQC's ACGC, and regular accountability meetings between the Accounting Officer and the Chair and Chief Executive of Healthwatch England.

We have a Scheme of Delegation to ensure 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 has assumed duties beyond its statutory powers, nor has it improperly delegated any duties. We updated the scheme twice in the year.

Our new governance model will provide a clear focus for where and at what level decisions are taken. It will help directorates to meet the management assurance standards better in future. The new model is designed to have a more appropriate balance between governance and delivery by focusing on operational delivery, strategic change delivery and effectiveness of resource. It is an important part of making sure we deliver change effectively, including the changes we are making to our digital systems and intelligence capability.

Other assurance areas

Information security and governance

Information security and governance are integral elements that support CQC's purpose.

This area has been the subject of ongoing improvement work throughout 2017/18 and has been a focus of our information governance working group. A follow-up independent external review of information security and governance arrangements in CQC was completed in September 2017. The first review took place following the loss of hard copy personal data in 2016. The follow-up review noted that CQC had delivered an impressive programme of work and had made very significant progress in implementing the recommendations of the 2016 external review. It also made four new recommendations which have been incorporated in our information governance improvement plan. An annual campaign, 'CQC values information month', took place in April 2017 and February 2018. The campaign is designed to address the most challenging of the recommendations, namely to continue to improve the security culture in CQC.

Security incident analysis and response has been carried out during 2017/18 and is reported to CQC's SIRO and the ACGC. The number of incidents reported and investigated during the year was consistent with that of previous years and were low-level incidents where no harm or distress was caused. There were also no significant incidents that required external reporting.

We have continued to liaise with the Department of Health and Social Care, NHS England, NHS Digital and the Information Commissioner's Office on matters of information security and privacy. Our communication with these organisations, and others, was exercised most recently both during and after the global Wannacry cyber attack in May 2017 which affected 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.

We implemented appropriate measures to comply with the General Data Protection Regulation (GDPR) which came into place on 25 May 2018. GDPR has replaced the Data Protection Act 1998 in regulating the processing of personal data by all organisations. A series of reviews were conducted by Health Group Internal Audit Service to provide assurance on this work.

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 we continue to comply with relevant legislation and guidance. A summary of the work of the group is reported to the Executive Team meetings on a regular basis.

We complete the annual information governance toolkit return, coordinated by NHS Digital. We have an ongoing programme of monitoring and development of our information governance practices and information systems. In 2017/18, our score was 92% and, following a review by NHS Digital of our proposed actions to improve staff uptake of annual information security refresher training, our overall rating is classed as 'satisfactory with improvement plan'. This indicates that we have achieved level two or above compliance (on a three-level ratings system) in all but one of the applicable requirements. Further work to improve our security and information governance culture is planned for 2018/19.

Anti-corruption and anti-fraud matters

The Director of Governance and Legal Services leads CQC's counter fraud function. The number of allegations of fraud received during 2017/18 has continued to be very low, with eight cases reported and investigated. Those cases contained allegations of corruption or conflict of interest but, following thorough investigation, none have been found to be substantiated.

Conclusion

We consider our management assurance assessment process to be an essential method for driving improvement in the eight areas of management responsibility, and for giving assurance as to how CQC manages and governs itself. Viewed alongside evidence from our KPIs, evaluation activity, strategic measures of success, and (in time) our strengthened benefits management, we have a good picture of where we need to improve and a way of evidencing progress, in order to meet our business plan commitments and deliver the changes recommended to us by NAO and PAC.

Over time there has been a demand to update and improve the definitions of our management assurance standards, and to consider better ways of improving consistency and fairness in judgements. During 2017/18 we reviewed all of the standards for management assurance in the eight areas and piloted the new standards in February 2018. We will evaluate the pilot early in 2018/19, before rolling the standards into wider use. We will also look at other ways of improving our performance under these standards, including sharing best practice, and looking at the scope to assure across new areas of our activity.

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 on 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 years. 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 ACGC. Through our work and engagement with directors and managers generally, we have observed a good self-awareness of the areas where systems, processes and controls can be improved to mitigate risk and a desire to improve. In a number of cases, management have invited Internal Audit to help identify actions to assist them in making improvements.

  There is a strong focus on delivering change, improvement and taking action to mitigate the risks identified whether through audit work or otherwise. There is a positive and constructive approach to agreeing audit recommendations and action plans. This year has seen improvement in the timeliness of completing actions and enhanced tracking and governance of changes being made to the implementation plans.

- In the case of **governance:**

  A number of audits have assessed different aspects of governance during the year. In particular, we reviewed the governance of the market oversight function, Healthwatch England and the National Guardian's Office and we were able to identify only low priority actions for improvement. From our follow-up of health and safety, we noted that the revised National Health, Safety and Wellbeing Committee has driven substantial progress in enhancing the control environment through which the safety and wellbeing of staff and visitors is assured.

  Management identified a challenge to update governance processes to accommodate projects that are following an 'agile' project delivery framework. Our recent review has identified a number of suggestions for consideration, designed to help the development of a suitable framework that could provide comfort that digital priorities will be delivered as planned. Management has proposed a series of actions in response, and is developing a more comprehensive implementation plan.

  The management assurance self-assessment process remains an important component of the focus on governance, risk and control across the organisation and we have continued to provide support around this. We note that an updated framework for the self-assessment is being piloted ahead of full use next year.

- In the case of **control:**

  We have issued 18 (2016/17: 23) audit reports since our last annual report. All of these reports have addressed key aspects of the systems of internal control. Two (2016/17: 1) of these reports were rated substantial, 10 (2016/17: 11) were rated moderate, two (2016/17: 6) limited and four (2016/17: 5) 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 undertook reviews of the core systems of payroll and fees forecasting, and grant-in-aid during the year. Payroll analytics work received a substantial conclusion, with both national professional advisors' recruitment and pay, and fees forecasting and grant-in-aid funding rated moderate.

  In 2015/16 and 2016/17 we drew attention to the theme of IT systems emerging from our reviews, which had indicated a need for CQC to assess its requirements for technology in the future. We are pleased to note the development of a digital roadmap and an ongoing restructuring of resources designed to deliver a function fit for the future. Our review of IT disaster recovery was rated limited, and identified the need to take action to improve resilience. Some of these actions are dependent on future changes to the IT infrastructure and architecture, and therefore risks need to be managed in the meantime.

  As noted previously, our recent review of the delivery of digital projects using an agile framework concluded that current practices represent a low level of agile maturity. This should be enhanced in coming months as management implement actions to strengthen the governance framework and enhance related skills in the organisation.

  We have reviewed planning for the implementation of the new GDPR and progress of the implementation plan. This identified good awareness of the requirements, what needs to be achieved, and progress with the plan. At the time there remained a number of actions to be completed and this should remain an area of focus during 2018/19 as the regulation takes effect, and related guidance and best practice emerges.

  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 would draw attention to health and safety where significant steps have been taken in strengthening the governance, risk management and compliance framework. Finally, there is evidence of continued improvement through our follow-up work.

Therefore, in summary, my overall opinion that I can give to the Accounting Officer of the Care Quality Commission for the reporting year 2017/18 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

CQC has continued to make significant change and improvement, with the internal auditors noting improved timeliness in taking action to mitigate identified risks. Robust mechanisms are in place to assess risk and compliance, with regular review at the Board and the ACGC.

Technology has been identified as an area for improvement in previous years. In response, a roadmap for improved delivery of CQC's digital function has been developed and resources are being restructured to deliver technological requirements for the present and the future. However, CQC is at the early stages of maturity in the use of an 'agile' framework for the delivery of digital projects. Action is being taken to strengthen this, and the Board will continue to maintain close oversight of CQC's digital programme.

A further area for continued improvement reported monthly to the Board is inspection report timeliness. With improvements made in some areas, work continues to address the shortfall in the performance, while maintaining the quality of reporting.

The appointment of the Data Protection Officer, and the outcome of the internal audit into CQC's implementation of the new GDPR obligations, provides a good foundation for a continued focus on this important issue as best practice with this new regulation emerges.

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 further work is needed on digital delivery.

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 2017/18. Work will continue in 2018/19 to strengthen the assurance and the overall internal control environment in CQC.

Remuneration and staff report

This section provides 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 and fair pay disclosures are subject to audit.

Remuneration report

Remuneration of the Chair and non-executive Board members

Non-executive Board members' remuneration is determined by the Department of Health and Social Care on the basis of a commitment of two to three days per month.

There are no provisions in place to compensate for the early termination or the payment of a bonus in respect of non-executive Board members.

The Chairman, 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 2017/18 the total liability amounted to £11k (2016/17: £7k).

Chairman and non-executive Board members' emoluments

	Date appointed	2017/18 total salary £000	2016/17 total salary £000
Peter Wyman CBE DL (Chair)	4 Jan 2016	60–65	60–65
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	10–15	5–10
Paul Rew	1 Jul 2014	10–15	10–15
Jane Mordue	19 Dec 2015	30–35[1]	35–40
Jora Gill	1 Nov 2016	5–10	0–5[2]
Sir John Oldham	1 Jan 2018	0–5[2]	–
Liz Sayce OBE	1 Jan 2018	0–5[2]	–
Mark Saxton	1 Mar 2018	0–5[2]	–
Michael Mire (appointment expired 30 June 2017)	1 Jul 2013	0–5[2]	5–10
Kay Sheldon OBE (appointment expired 30 November 2016)	1 Dec 2008	–	5–10[2]
Dr Jennifer Dixon (appointment expired 30 June 2016)	1 Jul 2013	–	0–5[2]

[1] Jane Mordue received enhanced remuneration as a result of her role as Chair of Healthwatch England.

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

Payments to independent members

Linda Farrant was an independent member of the ACGC. Fees and expenses are paid on a per meeting basis and during 2017/18 amounted to £3k (2016/17: £5k).

Remuneration of the Chief Executive

The Chief Executive's remuneration is agreed by the Board via the Remuneration Committee with reference to the Department of Health and Social Care's guidance on pay for its arm's length bodies.

Remuneration of the Executive Team

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

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

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 112).

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.

No benefits in kind, performance pay, bonus or compensation for loss of office were paid to any member of the Executive Team, or former members, during 2017/18.

	2017/18			2016/17		
	Salary (bands of £5,000) £000	All pension related benefits (bands of £2,500)[1] £000	Total (bands of £5,000) £000	Salary (bands of £5,000) £000	All pension related benefits (bands of £2,500)[1] £000	Total (bands of £5,000) £000
Sir David Behan CBE Chief Executive	185–190	–[6]	**185–190**	185–190	42.5–45	**230–235**
Prof. Steve Field CBE Chief Inspector of General Practice	160–165	–[7]	**160–165**	170–175	22.5–25	**195–200**
Andrea Sutcliffe CBE Chief Inspector of Adult Social Care	145–150	20–22.5	**165–170**	140–145	20–22.5	**165–170**
Dr Malte Gerhold Executive Director of Strategy & Intelligence	135–140	30–32.5	**170–175**	95–100[8]	27.5–30	**120–125**
Prof. Edward Baker Chief Inspector of Hospitals	120–125[2]	–[7]	**120–125**	–	–	**–**
Kirsty Shaw Chief Operating Officer	10–15[3]	–	**10–15**	–	–	**–**
Prof. Sir Mike Richards Chief Inspector of Hospitals	85–90[4]	–[7]	**85–90**	235–240	–[7]	**235–240**
Eileen Milner Director of Customer & Corporate Services	85–90[5]	27.5–30	**115–120**	140–145	30–32.5	**170–175**
Paul Bate Executive Director of Strategy & Intelligence	–	–	**–**	40–45[9]	–	**40–45**

[1] All pension-related benefits are 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] Prof. Edward Baker was appointed on 31 July 2017, full-year equivalent salary £180–185k.

[3] Kirsty Shaw was appointed on 1 March 2018, full-year equivalent salary £140–145k.

[4] Prof. Sir Mike Richards left CQC on 11 August 2017, full-year equivalent salary £235–240k.

[5] Eileen Milner left CQC on 31 October 2017, full-year equivalent salary £140–145k.

[6] Sir David Behan CBE chose not to be covered by the NHS Pension Scheme during the reporting year.

[7] Pension-related benefits for Prof. Steve Field CBE, Prof. Edward Baker and Prof. Sir Mike Richards are £nil as all are in receipt of benefits.

[8] Dr Malte Gerhold was appointed as Acting Director of Strategy and Intelligence on 19 July 2016. This appointment was made permanent on 6 February 2017. Full-year equivalent salary £135–140k.

[9] Dr Paul Bate left CQC on 18 July 2016. Full-year equivalent salary £140–145k.

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 2017/18 was £185–190k (2016/17: £235–240k). This was 4.9 times (2016/17: 6.1) the median remuneration of the workforce, which was £38,452 (2016/17: £38,837).

In 2017/18 no employees (2016/17: 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 £185–190k (2016/17: £5–10k to £235–240k).

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

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 2017/18 (2016/17: £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 2018 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 2018 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2018 (bands of £5,000) £000	Cash equivalent transfer value at 1 April 2017 £000	Cash equivalent transfer value at 31 March 2018 £000	Real increase in cash equivalent transfer value £000	Employers contribution to stakeholder pensions £000
Sir David Behan CBE Chief Executive	–[6]	–[6]	–[6]	–[6]	–[6]	–[6]	–[6]	–
Prof. Steve Field CBE[1] Chief Inspector of General Practice	–[7]	–[7]	–[7]	–[7]	–[7]	–[7]	–[7]	–
Andrea Sutcliffe CBE Chief Inspector of Adult Social Care	0–2.5	5–7.5	25–30	85–90	520	593	47	–
Dr Malte Gerhold Executive Director of Strategy & Intelligence	2.5–5	–	10–15	–[8]	67	93	6	–
Prof. Edward Baker[2] Chief Inspector of Hospitals	–[7]	–[7]	–[7]	–[7]	–[7]	–[7]	–[7]	–
Kirsty Shaw[3] Chief Operating Officer	0–2.5	–	0–5	–	–	2	–	–
Prof. Sir Mike Richards[4] Chief Inspector of Hospitals	–[7]	–[7]	–[7]	–[7]	–[7]	–[7]	–[7]	–
Eileen Milner[5] Director of Customer & Corporate Services	0–2.5	–	10–15	–[8]	97	141	14	–

[1] Figures for Prof. Steve Field are in respect of his officer employment only, no practitioner employment is included.

[2] Prof. Edward Baker was appointed on 31 July 2017.

[3] Kirsty Shaw was appointed on 1 March 2018.

[4] Prof. Sir Mike Richards left CQC on 11 August 2017.

[5] Eileen Milner left CQC on 31 October 2017.

[6] Sir David Behan CBE chose not to be covered by the NHS Pension Scheme during the reporting year.

[7] Pension benefits for Prof. Steve Field CBE, Prof. Edward Baker and Prof. Sir Mike Richards are £nil as all members are in receipt of benefits.

[8] 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 does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

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 for Health and Social Care 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018 is based on valuation data as at 31 March 2017, updated to 31 March 2018 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 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 employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. 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 and Social Care after consultation with the relevant stakeholders.

In 2017/18, CQC employer's contributions for staff to the NHS Pension Scheme was £13,103k (2016/17: £13,519k) at a rate of 14.4% (2016/17: 14.3%). From 1 April 2017 the Department of Health and Social Care introduced a charge to cover the cost of scheme administration. This administration charge equates to 0.08% of each active member's pensionable pay.

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 (2016/17: £nil).

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

Local government pension schemes

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

Due to legacy arrangements, CQC initially inherited 17 local government schemes. 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 2017/18, based on a percentage of payroll costs only, were £3,602k in total (2016/17: £3,775k), at rates ranging between 0% and 41.6% (2016/17: 14.4% and 39.1%). Employer contributions relating to the largest scheme, Teesside Pension Fund, were £3,137k (2016/17: £3,299k) at a rate of 17.9% (2016/17: 17.0%).

During 2017/18, 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, £1,671k (2016/17: £831k) was paid to 12 of the 16 remaining pension funds with amounts ranging from £26k to £612k. 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 2018/19 range between 0.0% and 41.6% (17.9% for Teesside Pension Fund), with annual cash sums ranging from £27k to £632k (£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 total £25k for 2017/18 (2016/17: £26k) at a rate of 1.00% (2016/17: 0.98%).

Staff report

The information presented in notes 1 and 9 are subject to audit.

1. Staff costs and numbers

1.1 Staff costs

	Permanently employed £000	Others £000	2017/18 total £000	2016/17 total £000
Wages and salaries	122,798	10,962	133,760	136,820
Social security costs	13,537	615	14,152	14,828
NHS pension costs	12,914	189	13,103	13,519
Local government pension scheme costs	5,273	–	5,273	4,606
Other pension costs	15	10	25	26
Apprenticeship levy	646	–	646	–
Termination benefits	1,801	–	1,801	1,033
Sub–total	**156,984**	**11,776**	**168,760**	**170,832**
Less recoveries in respect of outward secondments	(682)	–	(682)	(510)
Increase in provision for pension fund deficits	1,098	–	1,098	970
Total net cost	**157,400**	**11,776**	**169,176**	**171,292**

Other staff costs consist of:

	2017/18 total £000	2016/17 total £000
Bank inspectors and specialist advisors	6,602	7,111
Second Opinion Appointed Doctors	3,359	3,257
Inward secondments from other organisations	1,399	2,029
Commissioners	181	444
Agency	235	377
Total	**11,776**	**13,218**

No staff costs were capitalised during the year (2016/17: £nil) relating to CQC staff and agency staff engaged on software development.

1.2 Average number of persons employed

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

	2017/18 number	2016/17 number
Directly employed	3,091	3,200
Other	18	31
Staff engaged on capital projects	–	–
Total	**3,109**	**3,231**

'Other' does not include bank inspectors, specialist advisors or SOADs who are paid per session.

The actual number of directly employed whole-time equivalents as at 31 March 2018 was 3,193 (31 March 2017; 3,097).

2. Staff composition

Number of staff employed as at 31 March 2018:

	Board members	Directors	Total employees
Male	7	10	982
Female	2	22	2,297

Number of staff employed as at 31 March 2017:

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

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. Gender pay gap

The gender pay gap gives a snapshot of the gender balance in an organisation. It measures the difference between the average earnings of all male and female employees, irrespective of their role or seniority. In line with other employers we published our gender pay gap for the first time in 2017/18.

As at 31 March 2017, the data showed that the gender split in CQC was 69.1% female to 30.9% male and this was closely replicated across the quartile data. The data showed that there is no gender pay gap at CQC as staff are paid within salary bands and the mean and median hourly rate are virtually the same across all quartiles.

No data is included in the gender pay gap reporting for bonuses as CQC does not pay performance-related bonuses.

Pay gap			
Mean pay gap – ordinary pay			1.18%
Median pay gap – ordinary pay			-0.98%
Mean pay gap – bonus pay in the 12 months ending 31 March 2017			n/a
Median pay gap – bonus pay in the 12 month to 31 March 2017			n/a
The proportion of male and female employees paid a bonus in the 12 months to 31 March 2017		Male	n/a
		Female	n/a
Proportion of male and female employees in each quartile:			
	Quartile	Female	Male
	First (lower) quartile	63.4%	36.6%
	Second quartile	71.9%	28.1%
	Third quartile	72.6%	27.4%
	Fourth (upper) quartile	68.5%	31.5%

4. Sickness absence data

During 2017/18, the average number of long-term days sickness per absent employee was 10 (2016/17: 11 days) and the average number of short-term days sickness was five (2016/17: four days).

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

5. Trade union facility time

During 2017/18 CQC employed 21 staff who were trade union officials (21 whole-time equivalents). They all spent between 1% and 50% of their working hours on facility time (time granted by the employer to enable the representative to carry out their trade union role). The total cost of facility time totalled £94k during the year, equating to 0.08% of the total staff cost. The time spent on paid trade union activities as a percentage of total paid facility time hours was 19.32%.

6. Staff policies

6.1 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 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 initiatives, such as the future direction of CQC and the effect of the government spending review.

Throughout the year, both the unions and the forum have been actively engaged in the review 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 in 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 the management team with information on how CQC staff are responding to what is happening in the organisation.

CQC's four equality networks – the Carers Network, the Disability Equality Network, the Lesbian, Gay, Bisexual and Transgender Plus (LGBT+) Equality Network and the Race 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 Carers Network is a new network, set up in 2017 to encourage CQC employees with caring responsibilities to come together and support each other.

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 continued to support CQC's 'Focus on Ability' programme which seeks 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 role of the LGBT+ Network is 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.

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

CQC consults all of the networks on issues affecting the wider organisation, such as policy development to make sure that all staff views are taken into account. Our mentoring scheme is now in its second year and has supported more than 120

mentoring partnerships since it started in December 2015. The scheme is 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.

6.2 Employment and policies

All of our people management policies are currently being reviewed, to ensure legal compliance, best practice and that they continue to fit the changing culture of CQC. The policies will take on board feedback and lessons learned from across the organisation as well as the outcomes of consultation with the unions, staff forum and diversity network groups. We anticipate that all of our policies will be reviewed, published and rolled out to managers by the end of 2018 to make sure they have a good understanding of the policies and how they should be applied.

6.3 Home working

Home working forms the contractual arrangement for more than 2,000 members of staff and is the principal working arrangement for our inspection staff, which 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 work-life balance. 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.

7. Expenditure on consultancy

CQC spent a total of £714k on consultancy services during 2017/18 (2016/17: £14k). This increase was predominantly related to the digital programme.

8. Off-payroll engagements

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months:

	Number
Number of existing engagements as of 31 March 2018	1
Of which:	
Number that have existed for less than one year at the time of reporting	1
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	–
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 2018 have received approval from the Department of Health and Social Care.

As at March 2018, 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 2017 and 31 March 2018, for more than £245 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 2017 and 31 March 2018	1
Of which:	
Number assessed as caught by IR35	1
Number assessed as not caught by IR35	–
Number engaged directly (via a Personal Service Company contracted to the entity) and who are on the entity's payroll	–
Number of engagements reassessed for consistency or assurance purposes during the year	–
Number of engagements that saw a change to IR35 status following the consistency review	–

	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.	20

9. Exit packages

Exit package cost band	Number of compulsory redund-ancies	Cost of compulsory redund-ancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£	Number	£	Number	£
Less than £10,000	17	113,739	–	–	17	113,739	–	–
£10,000 to £25,000	23	400,358	–	–	23	400,358	–	–
£25,001 to £50,000	12	421,356	–	–	12	421,356	–	–
£50,001 to £100,000	8	474,909	–	–	8	474,909	–	–
£100,001 to £150,000	2	259,687	–	–	2	259,687	–	–
£150,001 to £200,000	–	–	–	–	–	–	–	–
More than £200,000	1	251,001	–	–	1	251,001	–	–
Total	**63**	**1,921,050**	**–**	**–**	**63**	**1,921,050**	**–**	**–**

Redundancy and other departure costs have been paid in accordance with CQC terms and conditions following approval from the Department of Health and Social Care's Governance and Assurance Committee. Exit costs are accounted for in full in the year of departure. Where early retirement has 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 content of notes 1 to 3 are subject to audit.

1. Losses and special payments

During 2017/18 CQC recognised 842 losses totalling £927k (2016/17: 815 cases totalling £714k), which mainly related to unpaid annual provider fees invoices, and no special payments (2016/17: two special payments totalling £11k).

There were no individual losses or special payments that exceeded £300k (2016/17: none).

2. Remote contingent liabilities

There were no remote contingent liabilities as at 31 March 2018 (31 March 2017: 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	(193,658)	196,880	3,222

Regulatory fees are charged in accordance with the Health and Social Care Act 2008 to cover 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. During 2017/18, CQC recovered 98.3% of its costs relating to chargeable activities through fees and also received grant-in-aid funding from the Department of Health and Social Care, see Notes to the financial statements (note 2).

Other existing responsibilities, such as our work under the Mental Health Act, are not included within our registration functions, and their costs are funded by grant-in-aid from the Department of Health and Social Care.

4. Better payment practice code

CQC's policy is to pay creditors in accordance with contractual conditions or, where no specific conditions exist, within 5-30 days of the receipt of goods or services or the presentation of a valid invoice, whichever was later. This complied with the Better Payment Practice Code and guidance as published by HM Treasury.

	2017/18	2016/17
Number of invoices paid within 30 days	99.6%	98.9%
Value of invoices paid within 30 days	99.7%	98.9%

In line with guidance from the government published in August 2010, CQC aims to pay 80% of all undisputed invoices from suppliers within five working days. During 2017/18, CQC exceeded this target based on volumes:

	Target	2017/18	2016/17
Number of invoices paid within five working days	80.0%	85.5%	84.1%
Value of invoices paid within five working days	80.0%	78.1%	88.7%

Sir David Behan CBE
Chief Executive, Care Quality Commission
22 June 2018

Certificate and report of the Comptroller and Auditor General to the Houses of Parliament

Opinion on financial statements

I certify that I have audited the financial statements of the Care Quality Commission for the year ended 31 March 2018 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, including the significant accounting policies. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Accountability report that is described in that report as having been audited.

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 2018 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 the Secretary of State directions issued thereunder.

Opinion on regularity

In my opinion, in all material respects the income and expenditure 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.

Basis of opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my certificate. Those standards require me and my staff to comply with the Financial Reporting Council's Revised Ethical Standard 2016. I am independent

of the Care Quality Commission in accordance with the ethical requirements that are relevant to my audit and the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Responsibilities of the Board and Accounting Officer for the financial statements

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.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Social Care Act 2008.

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. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISAs (UK), I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Care Quality Commission's internal control.
- evaluate the appropriateness of accounting policies used, and the reasonableness of accounting estimates and related disclosures made by management.

- conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Care Quality Commission's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern.
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the consolidated financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

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

Other information

The Accounting Officer is responsible for the other information. The other information comprises information included in the annual report, other than the parts of the Accountability report described in that report as having been audited, the financial statements and my auditor's report thereon. My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon. In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Opinion on other matters

In my opinion:

- the parts of the Accountability report to be audited have been properly prepared in accordance with Secretary of State directions made under the Health and Social Care Act 2008;
- in the light of the knowledge and understanding of the Care Quality Commission and its environment obtained in the course of the audit, I have not identified any material misstatements in the Performance report or the Accountability report; and
- the information given in the Performance report and 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 Accountability report 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

27 June 2018

Financial statements

3

The financial statements are prepared in accordance with the Financial Reporting Manual 2017/18, published by HM Treasury, and comprise:

Statement of Comprehensive Net Expenditure

for the year ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Income from fees	3	(193,658)	(149,585)
Other income	3	(53)	–
Total operating income		**(193,711)**	**(149,585)**
Staff costs	4	169,176	171,292
Purchase of goods and services	4	43,471	43,509
Depreciation, amortisation and impairment charges	4	8,767	9,449
Provision expense	4	1,085	388
Other operating expenditure	4	9,483	11,010
Total operating expenditure		**231,982**	**235,648**
Net operating expenditure		**38,271**	**86,063**
Finance expense		(37)	(21)
Net expenditure for the year		**38,234**	**86,042**
Other comprehensive net expenditure			
Items that will not be reclassified to net operating costs:			
– Net gain on revaluation of intangible assets	6.1	(200)	(1,004)
– Net gain on revaluation of property, plant and equipment	7.1	(27)	(143)
– Actuarial gain in pension schemes	5.4	(3,779)	(774)
Comprehensive net expenditure for the year		**34,228**	**84,121**

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

Notes 1 to 19 form part of these financial statements.

Statement of Financial Position

as at 31 March 2018

	Note	31 March 2018 £000	Restated 31 March 2017 £000[1]
Non-current assets			
Intangible assets	6	10,675	12,727
Property, plant and equipment	7	3,902	2,695
LGPS pension assets	5.1	2,450	1,906
Total non-current assets		**17,027**	**17,328**
Current assets			
Trade receivables	9	6,518	3,361
Other current assets	9	1,684	1,896
Cash and cash equivalents	10	36,959	27,559
Total current assets		**45,161**	**32,816**
Total assets		**62,188**	**50,144**
Current liabilities			
Trade and other payables	11	(25,375)	(22,971)
Other pension liabilities	11	(93)	(81)
Provisions	12	(751)	(475)
Fee income in advance	11	(24,312)	(24,055)
Total current liabilities		**(50,531)**	**(47,582)**
Total assets less current liabilities		**11,657**	**2,562**
Non-current liabilities			
Provisions	12	(2,021)	(1,363)
Other pension liabilities	11	(75)	(102)
Total non-current liabilities excluding pension deficit		**(2,096)**	**(1,465)**
Assets less liabilities excluding pension deficit provision		**9,561**	**1,097**
LGPS pension deficit	5.1	(73,582)	(73,990)
Assets less liabilities		**(64,021)**	**(72,893)**
Taxpayers' equity			
General reserve	14	(80,007)	(81,649)
Revaluation reserve	14	486	756
Retained earnings	14	15,500	8,000
Total taxpayers' equity		**(64,021)**	**(72,893)**

1 Comparative balances as at 31 March 2017 have been revised to separate the LGPS pension assets from the LGPS pension deficit, previously disclosed as a net deficit.

The financial statements on pages 128 to 165 were approved by the Board on 22 June 2018 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 2018

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Net expenditure for the year		(38,234)	(86,042)
Adjustment for non-cash transactions	13.1	12,664	13,247
Increase in trade and other receivables	9	(2,945)	(1,323)
Increase/(decrease) in trade and other payables	13.2	1,676	(10,021)
Decrease in pension liabilities	11	(15)	(283)
Increase/(decrease) in fee income in advance	11	257	(207)
Use of provisions	12	(114)	(67)
Net cash outflow from operating activities		**(26,711)**	**(84,696)**
Cash flows from investing activities			
Purchase of intangible assets	13.3	(4,817)	(7,491)
Purchase of property, plant and equipment	13.4	(2,172)	(855)
Net cash outflow from investing activities		**(6,989)**	**(8,346)**
Cash flows from financing activities			
Grant-in-aid from Department of Health and Social Care: cash drawn down in year		43,100	81,700
Net financing		**43,100**	**81,700**
Net increase/(decrease) in cash and cash equivalents in the year		**9,400**	**(11,342)**
Cash and cash equivalents at 1 April		27,559	38,901
Cash and cash equivalents at 31 March	10	**36,959**	**27,559**

Statement of Changes in Taxpayers' Equity

for the year ended 31 March 2018

	Note	General reserve £000	Revaluation reserve £000	Retained earnings £000	Total reserves £000
Balance at 1 April 2016		**(70,698)**	**226**	**–**	**(70,472)**
Changes in taxpayers' equity for 2016/17:					
Grant-in-aid from Department of Health and Social Care: cash drawn down in year		81,700	–	–	81,700
Net expenditure for the year		(86,042)	–	–	(86,042)
Revaluation gains:					
– intangible assets	6.1	–	1,004	–	1,004
– property, plant and equipment	7.1	–	143	–	143
Transfer between reserves:					
– Disposals and realised depreciation:					
– intangible assets	6.1	532	(532)	–	–
– property, plant and equipment	7.1	85	(85)	–	–
– Retained fee income	14	(8,000)	–	8,000	–
Actuarial gain in pension schemes	5.4	774	–	–	774
Restated balance at 31 March 2017[1]		**(81,649)**	**756**	**8,000**	**(72,893)**
Changes in taxpayers' equity for 2017/18:					
Grant-in-aid from Department of Health and Social Care: cash drawn down in year		43,100	–	–	43,100
Net expenditure for the year		(38,234)	–	–	(38,234)
Revaluation gains:					
– intangible assets	6.1	–	200	–	200
– property, plant and equipment	7.1	–	27	–	27
Transfer between reserves:					
– Disposals and realised depreciation:					
– intangible assets	6.1	467	(467)	–	–
– property, plant and equipment	7.1	30	(30)	–	–
– Retained fee income	14	(7,500)	–	7,500	–
Actuarial gain in pension schemes	5.4	3,779	–	–	3,779
Balance at 31 March 2018		**(80,007)**	**486**	**15,500**	**(64,021)**

1 Balances at 31 March 2017 have been restated to separately disclose the transfer between reserves relating to disposals and realised depreciation for intangible assets and property, plant and equipment, and also retained fee income. This was previously disclosed as a net movement.

Notes to the financial statements

1. Statement of accounting policies

These financial statements have been prepared in a form directed by the Secretary of State and in accordance with the Financial Reporting Manual (FReM) 2017/18, issued by HM Treasury, and the Department of Health and Social Care Group Accounting Manual (GAM) 2017/18. The accounting policies contained in the FReM and GAM follow International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM or GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of CQC for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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

1.1 Going concern

CQC's annual report and accounts have been prepared on a going concern basis. CQC is mainly financed by annual fees charged to registered providers; it also draws grant-in-aid funding from the Department of Health and Social Care (DHSC). Parliament has demonstrated its commitment to fund DHSC for the foreseeable future, and DHSC has demonstrated its commitment to the funding of CQC.

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.

1.3 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:

- impairment of intangible assets (see accounting policy note 1.13 and note 6)
- provision for impairment of receivables (see note 9.1)

- indexation of non-current assets (see accounting policy notes 1.11 and 1.12, note 6 and note 7)
- assumptions used to determine the IAS 19 pension liability for funded pension schemes (note 5).

1.4 Operating segments

Net expenditure is analysed by activities in note 2 and is reported in line with the management information used within CQC.

1.5 Revenue

The main source of revenue is the 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 11). In cases of voluntary deregistration, fees are refunded to registered organisations in accordance with the fee rebate scheme detailed on CQC's website.

1.6 Employee benefits

1.6.1 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.

1.6.2 Retirement benefit costs

NHS pensions

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.

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 is charged to expenditure at the time CQC commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Local government pensions

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. All of these schemes are closed to new employees.

Actuarial valuations are carried out at each Statement of Financial Position date with actuarial gains and losses recognised in full in the period in which they occur and reported in the Statement of Other Comprehensive Expenditure. Charges to the Statement of 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
- administration expense – charges representing the cost of administering the fund.
- 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.

Other pension schemes

CQC employees that are not eligible to join the NHS Pensions Scheme are enrolled in the National Employment Savings Trust (NEST). 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.

1.7 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 Grants receivable

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

1.9 Apprenticeship Levy

CQC is required to pay an apprenticeship levy amounting to 0.5% of the total pay bill, less an allowance of £15,000. The levy is recognised as an expense and included as an additional social security cost within the financial statements.

It is expected that apprenticeship funding will be passed directly to training providers. Where a CQC employee receives training funded by the levy, CQC will recognise a non-cash expense in the period in which the training occurs. An additional non-cash income amount, equal to the costs paid directly to the training provider, is also recognised.

1.10 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.

1.11 Intangible assets

1.11.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of CQC's business or which arise from contractual or other legal rights.

They are capitalised if:

- It is probable that future economic benefits will flow to, or service potential will be supplied to CQC.
- It is expected to be used for more than one financial year.
- The cost of the item can be measured reliably, and either:
  - the item has cost of at least £5,000, or
  - collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

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 and has a useful life of more than one year.

General IT software project management costs are not capitalised.

1.11.2 Measurement

Intangible assets are initially recognised at cost. The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. All assets are revalued annually using the appropriate producer price index (PPI) as published by the Office for National Statistics.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment, charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive net expenditure in the Statement of Comprehensive Net Expenditure.

1.12 Property, plant and equipment

1.12.1 Recognition

Expenditure on office refurbishments, furniture and fittings, office equipment, IT equipment and infrastructure is capitalised if:

- It is held for use in delivering services or for administrative purposes.
- It is probable that future economic benefits will flow to, or service potential will be supplied to CQC.
- It is expected to be used for more than one financial year.
- The cost of the item can be measured reliably, and either:
  - the item has cost of at least £5,000, or
  - collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

1.12.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Assets are restated at current value each year using the appropriate producer price index (PPI) as published by the Office for National Statistics.

Revaluations and impairments are treated in the same manner as for intangible assets (note 1.11.2).

1.13 Amortisation, depreciation and impairments

Non-current assets are depreciated on a monthly basis from the date at which the asset is brought into use. Assets under development are not amortised.

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. The estimated useful life is the period over which CQC expects to obtain economic benefits or service potential from the asset. Estimated useful lives and residual values are reviewed each year-end.

Estimated useful lives:

Category	Asset type	Estimated useful life
Intangible assets	IT software developments	3 years
	Software licences	3 years
	Website	3 years
Property, plant and equipment	Information technology	3 years
	Furniture and fittings	10 years (or lease break date if lower)

At each financial year-end, CQC checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are also tested for impairment annually at the financial year-end.

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

1.14 Leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. There are no finance leases.

1.15 Provisions

Provisions are recognised when CQC has a present legal or constructive obligation as a result of a past event, it is probable that CQC will be required to settle the 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 expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of 0.10% (2016/17: 0.24%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- a short-term rate of negative 2.42% (2016/17: negative 2.70%) for expected cash flows up to and including five years
- a medium-term rate of negative 1.85% (2016/17: negative 1.95%) for expected cash flows over five years up to and including 10 years
- a long-term rate of negative 1.56% (2016/17: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

1.16 Contingent liabilities and contingent assets

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of CQC, or
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of CQC. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.17 Financial assets

Financial assets are recognised 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 de-recognised 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.

1.18 Financial liabilities

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 de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

CQC has no financial liabilities other than trade payables. Trade payables are not interest bearing and are stated at their nominal value.

Non-current 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 0.10% (2016/17: 0.24%). This is the rate for market yields on AA corporate bonds as published by HM Treasury.

1.19 Early adoption of accounting standards, amendments and interpretations

No accounting standards, amendments or interpretations were adopted early in 2017/18.

1.20 Accounting standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following standards and interpretations to be applied in 2017/18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

- 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. The standard introduces a new classification and measurement requirements for financial assets, as well as a new approach for calculating and recognising impairments. The classification and measurement of financial liabilities remains largely unchanged. Material financial assets, receivables balances, are currently recognised net including a provision for irrecoverable debts. CQC do not expect the implementation of the standard to have a material impact.
- IFRS 15 Revenue for Contracts with Customers – 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. The standard establishes the principles that an entity shall apply to report the nature, amount, timing and uncertainty of revenue and cash flows arising from a contract with a customer. The majority of CQC's revenue relates to income from annual registration fees. Currently, fees are recognised equally over the 12 months from the anniversary date, with any paid amounts relating to future periods treated as income in advance. CQC have concluded that recognition will not change under the new standard.
- 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. CQC recognises that the application of this standard may have a material impact on the Financial Statements. The introduction of the standard will require CQC to assess its accounting processes and internal controls relating to the reporting of leases and this will not be complete until application guidance is issued by HMT. Therefore, the impact cannot be reasonably estimated at this time as it will be dependent on the leases that CQC holds at the time of implementation.

CQC does not believe that the application of any of the following standards and interpretations would have a material impact on the Financial Statements:

- IFRS 17 Insurance Contracts – application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted;
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – application required for accounting periods beginning on or after 1 January 2018;
- IFRIC 23 Uncertainty over Income Tax Treatments – application required for accounting periods beginning on or after 1 January 2019.

2. Analysis of net expenditure by activities

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 monitor the performance and resources of the organisation against the funding streams agreed with the Department of Health and Social Care (DHSC). The Statement of Financial Position by segment is not included as this was not reported to the Board.

	Chargeable activities £000	Non-chargeable activities £000	Non-cash items £000	2017/18 Total £000	Chargeable activities £000	Non-chargeable activities £000	Non-cash items £000	Restated 2016/17[1] Total £000
Expenditure:								
Staff costs	145,761	22,317	1,098	**169,176**	150,977	19,345	970	**171,292**
Purchases of goods and services	37,089	6,382	–	**43,471**	38,707	4,802	–	**43,509**
Depreciation, amortisation and impairment charges	7,500	1,267	–	**8,767**	8,000	1,449	–	**9,449**
Provision expense	–	–	1,085	**1,085**	–	–	388	**388**
Other operating expenditure	6,530	297	2,656	**9,483**	7,258	740	3,012	**11,010**
Subtotal: total operating expenditure	**196,880**	**30,263**	**4,839**	**231,982**	**204,942**	**26,336**	**4,370**	**235,648**
Finance expense	–	–	(37)	**(37)**	–	–	(21)	**(21)**
Total expenditure	**196,880**	**30,263**	**4,802**	**231,945**	**204,942**	**26,336**	**4,349**	**235,627**
Funding:								
Income from fees				**(193,658)**				**(149,585)**
Grant-in-aid				**(35,383)**				**(75,472)**
Non-cash income				**(53)**				**-**
Total funding				**(229,094)**				**(225,057)**
Net excess of expenditure before DHSC non-cash allowances				**2,851**				**10,570**

1 Comparative balances for 2016/17 have been restated to disclose net expenditure between chargeable activities, non-chargeable activities and non-cash items. Previously disclosed as net expenditure relating to continuing operations and Healthwatch England.

In agreeing annual budgets, DHSC allows CQC to incur certain non-cash expenses and shortfalls on grant-in-aid income against non-chargeable activities. These items amounted to expenditure of £6.1m for the year 2017/18. If these amounts are excluded from expenditure, the result would be that an adjusted net surplus of £3.2m would be shown in the table above.

Non-chargeable activities increased from last year due to a rise in enforcement activity and increased demand for Second Opinion Appointed Doctors, which is administered by the CQC under a statutory provision of the Mental Health Act 1983.

3. Income

	2017/18 £000	2016/17 £000
Income from fees	(193,658)	(149,585)
Apprenticeship training grant (non-cash)	(53)	–
	(193,711)	**(149,585)**

Fees and charges are made in accordance with the Health and Social Care Act 2008 (as amended). Consent was obtained from the Secretary of State for Health for the Fees Scheme for 2017/18 which gives rise to the fees scales used.

During 2017/18 CQC recovered 85.7% (2016/17: 66.3%) of its costs in fees. CQC has the power to recover costs associated with its registration, review and assessment functions under 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. All but one of our sectors are now charged fees at full chargeable cost recovery.

4. Operating expenditure

	£000	2017/18 £000	£000	Restated 2016/17[1] £000
Staff costs:				
Wages and salaries	133,760		136,820	
Social security costs	14,152		14,828	
NHS pension costs	13,103		13,519	
LGPS pension costs	5,273		4,606	
Other pension costs	25		26	
Apprenticeship levy	646		-	
Termination benefits	1,801		1,033	
Less recoveries in respect of outward				
Secondments	(682)		(510)	
Increase in provision for pension fund deficits	1,098		970	
Subtotal: Staff costs	169,176		171,292	
Purchase of goods and services:				
Establishment	17,196		17,564	
Travel and subsistence	10,812		11,504	
Rentals under operating leases	5,839		5,552	
Premises	4,720		4,749	
Training and development	1,620		1,456	
Professional fees	1,372		762	
Supplies and services	973		1,665	
Consultancy	715		14	
External audit fee (statutory work)	145		145	
Insurance	79		98	
Subtotal: Purchases of goods and services		43,471		43,509
Depreciation, amortisation and impairment charges:				
Amortisation of intangible assets	7,180		8,053	
Depreciation of property, plant and equipment	1,522		1,420	
Impairment/(reversal of impairment) of intangible assets	18		(22)	
Impairment/(reversal of impairment) of property, plant and equipment	47		(2)	
Subtotal: Depreciation, amortisation and impairment charges		8,767		9,449

	£000	2017/18 £000	£000	Restated 2016/17[1] £000
Provision expense		1,085		388
Other operating expenditure:				
Experts by experience	4,629		5,502	
Business rates paid to local authorities	2,060		2,099	
Net interest expense on pension scheme assets and liabilities	1,729		2,299	
Losses and special payments (irrecoverable debts)	927		713	
Apprenticeship training grant (non-cash)	53		–	
Loss on disposal of fixed assets	22		163	
Other	63		234	
Subtotal: Other operating expenditure		9,483		11,010
Total operating expenditure		**231,982**		**235,648**

1 Comparative balances for 2016/17 have been restated to disclose a breakdown of staff costs, previously disclosed as a net amount and also the other category now includes clinical negligence insurance and other, both previously disclosed separately.

5. Pension costs

The Statement of Financial Position shows net pension assets totalling £2.5m (31 March 2017: £1.9m) and net pension deficits of £73.6m (31 March 2017: £74.0m).

The present value, the related current service cost and past service cost were measured using the projected unit credit method. This means that the current service cost will increase as the members of the scheme approach retirement.

The actuarial assessment of each obligation was carried out at 31 March 2018 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 defined pension benefit scheme are as follows:

Pension fund	Assets 31 March 2018 £000	Liabilities 31 March 2018 £000	Surplus/ (deficit) 31 March 2018 £000	Restated Surplus/ (deficit) 31 March 2017[1] £000
Funds with a net deficit:				
Avon	5,269	(7,042)	**(1,773)**	**(1,949)**
Cheshire	4,210	(4,271)	**(61)**	**(169)**
Dorset	2,811	(4,164)	**(1,353)**	**(1,493)**
Essex	6,281	(6,710)	**(429)**	**(989)**
Greater Manchester	17,691	(18,172)	**(481)**	**(1,246)**
Hampshire	5,560	(7,900)	**(2,340)**	**(2,250)**
Merseyside	7,331	(8,355)	**(1,024)**	**(1,322)**
Shropshire	2,738	(3,536)	**(798)**	**(918)**
Suffolk	3,770	(4,808)	**(1,038)**	**(1,152)**
Teesside	302,935	(366,177)	**(63,242)**	**(60,673)**
West Yorkshire	11,455	(12,498)	**(1,043)**	**(1,829)**
Subtotal: funds with a net deficit	**370,051**	**(443,633)**	**(73,582)**	**(73,990)**
Funds with a net surplus:				
Cambridgeshire	3,555	(3,239)	**316**	**327**
Cumbria	4,138	(3,966)	**172**	**-**
East Sussex	6,355	(6,077)	**278**	**127**
Surrey	5,707	(5,418)	**289**	**252**
West Sussex	4,954	(3,559)	**1,395**	**1,200**
Subtotal: funds with a net surplus	**24,709**	**(22,259)**	**2,450**	**1,906**
Total	**394,760**	**(465,892)**	**(71,132)**	**(72,084)**

1 Comparative balances at 31 March 2017 have been restated to separately identify the funds with a net deficit and those with a net surplus.

All assets are held at bid value.

The impact of an asset ceiling on the recognition of assets is directed by paragraph 64 of IAS19. An asset ceiling is the limit above which further increases in net pension assets cease to be recognised for accounting purposes. At 31 March 2018, no asset ceilings were applied to any of the funds (31 March 2017: nil).

Seven employees (2016/17: two) retired early on ill-health grounds during the year. No additional pension costs (2016/17: £nil) were levied on CQC as a result.

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:	**2017/18**	**2016/17**	**2017/18**	**2016/17**
Discount rate	2.6	2.5	2.5 – 2.7	2.5 – 2.6
Expected rate of salary increases	3.1	3.0	2.7 – 3.9	2.7 – 4.0
Expected return on scheme assets	2.6	2.5	2.5 – 2.7	2.5 – 2.6
Future pension increases	2.1	2.0	2.1 – 2.4	2.0 – 2.5
Inflation	2.1	2.0	2.1 – 2.4	2.0 – 2.5

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:	**2017/18**	**2016/17**	**2017/18**	**2016/17**
Retiring today:				
Males	22.9	22.8	21.5 – 24.1	21.5 – 24.0
Females	25.0	24.9	24.1 – 27.2	24.1 – 27.0
Retiring in 20 years:				
Males	25.1	25.0	23.1 – 26.2	23.0 – 26.1
Females	27.3	27.2	26.2 – 29.4	26.2 – 29.3

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:

	2017/18 £000	2016/17 £000
Service cost:		
Current service cost	6,311	5,518
Past service cost	248	–
Administration expenses	81	89
Net interest expense	1,729	2,299
Amount recognised in net expenditure	**8,369**	**7,906**

Of the expense for the year, the total service cost of £6.6m (2016/17: £5.6m) has been included in the Statement of Comprehensive Net Expenditure as staff expenditure, note 4. Of this, £5.5m (2016/17: £4.6m) is included within other pension costs and £1.1m (2016/17: £1.0m) is included as an increase in provision for pension fund deficits. The net interest expense of £1.7m (2016/17: £2.3m) 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.

An additional £0.2m was paid to Teesside Pension Fund during 2017/18 relating to the cost of early retirements and is recognised as Termination Benefits, note 4. Of this amount £0.1m relates to charges recognised during 2016/17.

5.4 Charges to other comprehensive net expenditure

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

	2017/18 £000	2016/17 £000
The return on plan assets (excluding amounts included in net interest expense)	(4,186)	(62,392)
Other re-measurement losses on plan assets	–	(205)
Actuarial gains arising from changes in demographic assumptions	–	(7,638)
Actuarial (gains)/losses arising from changes in financial assumptions	(1,811)	74,922
Actuarial losses/(gains) arising from experience adjustments	2,218	(5,461)
Re-measurement of the net defined benefit obligations	**(3,779)**	**(774)**

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 2018 is £80m (31 March 2017: £84m).

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 2018 £000	31 March 2017 £000
Present value of funded benefit obligations	(465,799)	(460,853)
Fair value of scheme assets	394,760	388,870
Deficit in scheme	**(71,039)**	**(71,983)**
Present value of unfunded benefit obligations	(93)	(101)
Net deficit recognised in the Statement of Financial Position	**(71,132)**	**(72,084)**

5.6 Reconciliation of fair value of scheme liabilities

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

	2017/18 £000	2016/17 £000
At 1 April	**(460,954)**	**(393,179)**
Current service cost	(6,311)	(5,518)
Administration expenses	(74)	(81)
Interest cost	(11,361)	(13,187)
Contributions from scheme members	(1,474)	(1,638)
Past service costs	(248)	–
Re-measurement gains/(losses):		
Actuarial gains arising from changes in demographic assumptions	–	7,638
Actuarial gains/(losses) arising from changes in financial assumptions	1,811	(74,922)
Actuarial (losses)/gains arising from experience adjustments	(2,218)	5,461
Benefits paid	14,937	14,472
At 31 March	**(465,892)**	**(460,954)**

5.7 Reconciliation of fair value of employer assets

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

	2017/18 £000	2016/17 £000
At 1 April	**388,870**	**323,590**
Interest income	9,632	10,888
Re-measurement gains:		
The return on plan assets (excluding amounts included in net interest expense)	4,186	62,392
Other	–	205
Employer contributions	5,542	4,637
Member contributions	1,474	1,638
Benefits paid	(14,937)	(14,472)
Administration expenses	(7)	(8)
At 31 March	**394,760**	**388,870**

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	
	2017/18 %	2016/17 %	2017/18 £000	2016/17 £000
Equities	2.5 – 2.7	2.5 – 2.6	283,016	296,447
Property	2.5 – 2.7	2.5 – 2.6	28,149	26,251
Government bonds	2.5 – 2.7	2.5 – 2.6	5,041	5,522
Other bonds	2.5 – 2.7	2.5 – 2.6	5,660	12,011
Cash	2.5 – 2.7	2.5 – 2.6	36,922	36,375
Other	2.5 – 2.7	2.5 – 2.6	35,972	12,264
Total			**394,760**	**388,870**

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	360,080	366,177	372,378	98,221	99,715	101,213
Movement	(6,097)	–	6,201	(1,494)	–	1,498
Adjustment to inflation	**+ 0.1%**	**Current**	**- 0.1%**	**+ 0.1%**	**Current**	**- 0.1%**
Present value of total obligation	367,240	366,177	365,122	99,814	99,715	99,616
Movement	1,063	–	(1,055)	99	–	(99)
Adjustment to future pension increases	**+ 0.1%**	**Current**	**- 0.1%**	**+ 0.1%**	**Current**	**- 0.1%**
Present value of total obligation	371,305	366,177	361,125	101,142	99,715	98,292
Movement	5,128	–	(5,052)	1,427	–	(1,423)
Adjustment to life expectancy	**+ 1 year**	**Current**	**- 1 year**	**+ 1 year**	**Current**	**- 1 year**
Present value of total obligation	377,202	366,177	355,234	103,057	99,715	96,393
Movement	11,025	–	(10,943)	3,342	–	(3,322)

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.

Contribution rates for each of the schemes are reviewed at least every three years following a full actuarial valuation. 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 2018/19 range between 0% and 41.6% (17.9% for Teesside Pension Fund) with annual cash sums ranging from £27k to £632k (£nil for Teesside Pension Fund).

Cessation charges would become payable when membership in any of the funds falls to zero. The Department of Health and Social Care have provided a guarantee to meet the pension deficit liability should they fall due. Any surplus is retained by the fund.

6. Intangible assets

	IT software development £000	Software licences £000	Website £000	Total £000
Cost or valuation				
At 1 April 2017	34,701	3,860	6,291	**44,852**
Additions	3,628	4	1,314	**4,946**
Disposals	–	–	–	**–**
Indexation losses charged to other operating expenditure	(12)	–	(6)	**(18)**
Indexation gains to revaluation reserve	532	59	97	**688**
At 31 March 2018	**38,849**	**3,923**	**7,696**	**50,468**
Amortisation				
At 1 April 2017	24,201	2,420	5,504	**32,125**
Charged in year	5,737	717	726	**7,180**
Disposals	–	–	–	**–**
Indexation gains charged to other operating expenditure	–	–	–	**–**
Indexation gains to revaluation reserve	367	37	84	**488**
At 31 March 2018	**30,305**	**3,174**	**6,314**	**39,793**
Net book value at 1 April 2017	**10,500**	**1,440**	**787**	**12,727**
Net book value at 31 March 2018	**8,544**	**749**	**1,382**	**10,675**
Asset financing:				
Owned	8,544	749	1,382	**10,675**
At 31 March 2018	**8,544**	**749**	**1,382**	**10,675**

	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 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**

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.

6.1 Movement in revaluation reserve: intangible assets

	2017/18 £000	2016/17 £000
Balance at 1 April	644	172
Net gain on indexation	200	1,004
Transfers between reserves	(467)	(532)
Balance at 31 March	**377**	**644**

7. Property, plant and equipment

	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation			
At 1 April 2017	7,480	2,757	**10,237**
Additions	2,634	137	**2,771**
Disposals	(687)	(14)	**(701)**
Indexation (losses)/gains charged to other operating expenditure	(50)	4	**(46)**
Indexation gains to revaluation reserve	100	13	**113**
At 31 March 2018	**9,477**	**2,897**	**12,374**
Depreciation			
At 1 April 2017	6,100	1,442	**7,542**
Charged in year	1,037	485	**1,522**
Disposals	(687)	8	**(679)**
Indexation gains charged to other operating expenditure	–	1	**1**
Indexation gains to revaluation reserve	79	7	**86**
At 31 March 2018	**6,529**	**1,943**	**8,472**
Net book value at 1 April 2017	**1,380**	**1,315**	**2,695**
Net book value at 31 March 2018	**2,948**	**954**	**3,902**
Asset financing:			
Owned	2,948	954	**3,902**
At 31 March 2018	**2,948**	**954**	**3,902**

	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 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**

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

7.1 Movement in the revaluation reserve: property, plant and equipment

	2017/18 £000	2016/17 £000
Balance at 1 April	112	54
Net gain on indexation	27	143
Transfers between reserves	(30)	(85)
Balance at 31 March	**109**	**112**

8. 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 and Social Care. The Fees Scheme published in April 2017 sets fees for most sectors at full chargeable cost recovery, which results in the fees paid by providers becoming the main source of funding for CQC.

CQC manage liquidity risk through regular cash flow forecasting to ensure that sufficient funds are available to cover working capital requirements. CQC has no borrowings, relying upon the collection of fees and grant-in-aid from the Department of Health and Social Care 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 2018, note 9, there were no material balances with individual organisations.

CQC issued annual fee invoices to registered providers totalling £204.3m during 2017/18 (£170.0m during 2016/17). Of this amount £57.7m (£39.0m during 2016/17) relates to transactions with NHS trusts and a further £34.7m (£23.1m during 2016/17) was invoiced to GPs, the majority of which are publicly funded. Invoices relating to providers of adult social care services totalled £93.9m (£88.7m during 2016/17) during the year, of which those overseen by the statutory Market Oversight scheme accounted for £22.2m (£23.3m during 2016/17).

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:

	Up to 3 months past due £000	3-6 months past due £000	More than 6 months past due £000	Total £000
At 31 March 2018	1,036	1,277	1,338	**3,651**
At 31 March 2017	631	220	385	**1,236**

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 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.

8.1 Financial assets

	31 March 2018 £000	31 March 2017 £000
DHSC group receivables	669	294
Non-DHSC group receivables	7,533	4,963
Cash at bank and in hand	36,959	27,559
Total	**45,161**	**32,816**

8.2 Financial liabilities

	31 March 2018 £000	31 March 2017 £000
DHSC group payables	3,866	2,720
Non-DHSC group payables	45,989	44,489
Total	**49,855**	**47,209**

9. Trade receivables and other current assets

	31 March 2018 £000	31 March 2017 £000
Amounts falling due within one year:		
Trade receivables	6,518	3,361
Other current assets:		
Deposits and advances	120	163
Other receivables	876	588
Prepayments and accrued income	688	1,145
Subtotal: Other current assets	**1,684**	**1,896**
Total	**8,202**	**5,257**

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

Deposits and advances include advance salary payments and staff loans, these total £13k and £107k (31 March 2017: £16k and £147k). Staff can apply for advance payments on salary and loans up to a maximum of £5k for rail season tickets.

9.1 Movement in the provision for impairment of receivables

	2017/18 £000	2016/17 £000
Balance at 1 April	**1,086**	**654**
New provisions recognised during the year	1,368	1,087
Provisions reversed as unused	(160)	(179)
Amounts written off during the year as uncollectable	(306)	(281)
Amounts recovered during the year	(281)	(195)
Balance at 31 March	**1,707**	**1,086**

10. Cash and cash equivalents

	2017/18 £000	2016/17 £000
Balance at 1 April	**27,559**	**38,901**
Net change in cash and cash equivalent balances	9,400	(11,342)
Balance at 31 March	**36,959**	**27,559**
The following balances at 31 March were held at:		
Government banking service and cash in hand	36,959	27,559
Total balance at 31 March	**36,959**	**27,559**

11. Trade payables and other current liabilities

	31 March 2018 £000	31 March 2017 £000
Amounts falling due within one year:		
VAT	(178)	(140)
Other taxation and social security	(3,813)	(3,699)
Trade payables	(5,846)	(2,372)
Other payables	(4,186)	(4,980)
Accruals	(9,472)	(10,628)
Capital creditors – intangible assets	(678)	(549)
Capital creditors – property, plant and equipment	(1,202)	(603)
Total trade and other payables	**(25,375)**	**(22,971)**
Current pension liabilities	(93)	(81)
Fee income in advance	(24,312)	(24,055)
Total current trade payables and other current liabilities	**(49,780)**	**(47,107)**
Amounts falling after more than one year:		
Pension liabilities	(75)	(102)
Total non-current trade payables and other non-current liabilities	**(75)**	**(102)**

Trade payables at 31 March 2018 were equivalent to 26 days (31 March 2017: 10 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 0.10% per annum (2016/17: 0.24%) in accordance with HM Treasury guidance.

12. Provisions for liabilities and charges

	2017/18			2016/17		
	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	**406**	**1,432**	**1,838**	**121**	**1,418**	**1,539**
Provided in year	434	1,326	1,760	406	5	411
Provisions not required written back	(292)	(373)	(665)	(54)	–	(54)
Provisions utilised in year	(114)	–	(114)	(67)	–	(67)
Change in discount Rate	–	(10)	(10)	–	31	31
Unwinding of discount	–	(37)	(37)	–	(22)	(22)
Balance at 31 March	**434**	**2,338**	**2,772**	**406**	**1,432**	**1,838**

12.1 Analysis of expected timings of discounted cash flows

	2017/18			2016/17		
	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	434	317	**751**	406	69	**475**
Later than one year and not later than five years	–	2,021	**2,021**	–	1,363	**1,363**
Later than five years	–	–	**–**	–	–	**–**
Balance at 31 March	**434**	**2,338**	**2,772**	**406**	**1,432**	**1,838**

A provision has been made to cover future legal costs, for example tribunals and judicial review. The provision is estimated at £0.4m (31 March 2017: £0.2m).

Leased property dilapidations are the costs that would be payable on the termination of the leases.

No provisions were recognised in respect of employment termination costs (31 March 2017: £0.2m).

Provisions falling due up to five years have been increased by a discount factor of 2.42% (2016/17: 2.70%) and provisions falling due between five and 10 years have been increased by a discount factor of 1.85% (2016/17: 1.95%) in accordance with HM Treasury guidance.

13. Reconciliation of movements in the Statement of Cash Flows

13.1 Adjustment for non-cash transactions

	Note	2017/18 £000	2016/17 £000
Amortisation, depreciation and impairment charges	4	8,767	9,449
Increase in provision for pension fund deficit	4	1,098	970
Net interest expenses on pension scheme assets and liabilities	4	1,729	2,299
Loss on disposal of fixed assets	4	22	163
Provisions expense	4	1,085	388
Finance expense: unwinding of discount on provisions	12	(37)	(22)
Total adjustment for non-cash transactions		**12,664**	**13,247**

13.2 Movement in trade and other payables

	Note	2017/18 £000	2016/17 £000
Increase/(decrease) in trade and other payables	11	2,404	(12,139)
Less (increase)/decrease in capital creditors – intangible assets	11	(129)	2,223
Less (increase) in capital creditors – property, plant and equipment	11	(599)	(105)
Total movement in trade and other payables		**1,676**	**(10,021)**

13.3 Purchase of intangible assets

	Note	2017/18 £000	2016/17 £000
Additions	6	(4,946)	(5,268)
Increase/(decrease) in capital creditors – intangible assets	11	129	(2,223)
Total purchase of intangible assets		**(4,817)**	**(7,491)**

13.4 Purchase of property, plant and equipment

	Note	2017/18 £000	2016/17 £000
Additions	7	(2,771)	(960)
Increase in capital creditors – property, plant and equipment	11	599	105
Total purchase of property, plant and equipment		**(2,172)**	**(855)**

14. Movements on reserves

	General reserve £000	Revaluation reserve £000	Retained earnings £000	Total reserves £000
Balance at 1 April 2017:				
Main reserve	(81,649)	756	8,000	**(72,893)**
Retained fee income	–	–	–	**–**
Total balance at 1 April 2017[1]	**(81,649)**	**756**	**8,000**	**(72,893)**
Balance at 31 March 2018:				
Main reserve	(83,225)	486	15,500	**(67,239)**
Retained fee income	3,218	–	–	**3,218**
Total balance at 31 March 2018	**(80,007)**	**486**	**15,500**	**(64,021)**

1 Comparative balances as at 1 April 2017 not previously disclosed separately from the Financial Statements.

14.1 General reserve

The general reserve reflects the total assets less liabilities of CQC, which are not assigned to another special purpose reserve.

In 2017/18, CQC recovered 98.3% of expenditure relating to chargeable activities from providers via income from fees. Fees from providers totalling £7.5m has been used to fund amortisation and depreciation (see note 14.3).

In view of the adjusted net surplus for the year of £3.2 million (see note 2), CQC has determined to designate this as a ring-fenced surplus within the general reserve.

14.2 Revaluation reserve

The revaluation reserve is a capital reserve used when an asset has been revalued but for which no cash benefit is received. Revaluations are completed periodically to reflect the fair value of an asset owned by an organisation.

14.3 Retained earnings

The Retained Earnings reserve was initially created during 2016/17 to reflect the recovery of amortisation and depreciation as an element of the fees charged to providers.

A further transfer of £7.5m this year reflects the depreciation on the proportion of CQC's assets that supports the regulatory functions where costs can be recovered from providers.

In agreement with DHSC this reserve can only be used in future years to fund appropriate capital expenditure not separately financed by DHSC, to fund improvements to the regulatory regime or be returned to fee payers through lower future fees.

15. Capital commitments

Contracted capital commitments at 31 March 2018, not otherwise included within these financial statements:

	31 March 2018 £000	31 March 2017 £000
Intangible assets	1,405	4,946
Property, plant and equipment	313	–
Total	**1,718**	**4,946**

16. Commitments under leases

16.1 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 2018 £000	31 March 2017 £000
Buildings:		
Not later than one year	5,464	5,574
Later than one year and not later than five years	8,207	13,414
Later than five years	–	265
Total	**13,671**	**19,253**
Other:		
Not later than one year	63	62
Later than one year and not later than five years	139	29
Later than five years	–	–
Total	**202**	**91**

CQC lease buildings for its own use, under memorandum of term occupancy (MOTO) agreements, for use as office space. The obligations include any contingent rent implicit in the agreements.

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

17. Contingent liabilities disclosed under IAS37

CQC has the following contingent liabilities:

	31 March 2018 £000	31 March 2017 £000
Backdated VAT charges in accordance with HMRC rules	639	–
Employment tribunals and legal advice	631	918
Total	**1,270**	**918**

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

18. Related party transactions

CQC is a non-departmental public body sponsored by the Department of Health and Social Care (DHSC). DHSC is regarded as a related party. During the year CQC has had a significant number of material transactions with DHSC, and with other entities for which DHSC 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 and Social Care	4,692	43,100	2,394	19
NHS foundation trusts	4	36,957	947	10
NHS trusts	3	19,644	443	232
NHS England	41	–	39	177
NHS special health authorities	134	–	–	149
Public Health England	–	–	–	37
Other non-departmental public bodies	148	–	38	45
Other group bodies	38	–	5	–

CQC received a total amount of grant-in aid of £43.1m (2016/17: £81.7m) from DHSC.

During the year, there were no material transactions with organisations in which members of the Board, key managers or other related parties hold an interest.

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 and 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.

19. 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 27 June 2018 by the Chief Executive as Accounting Officer.

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