Care Quality Commission

Annual report and accounts 2011/12

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Foreword

This is CQC's third annual report, covering the period from 1 April 2011 to 31 March 2012. It was a year in which we put a determined and renewed focus on our core role: inspecting a wide breadth of care services – across healthcare, social care and dental care – to make sure they meet the same essential standards of quality and safety. We also continued to discharge our other main regulatory role: protecting the rights of people subject to the Mental Health Act.

We did this while under the close scrutiny of a number of different bodies, culminating in a Performance and Capability Review by the Department of Health published in February 2012. The capability review noted the growing appreciation of the scale of the challenge that CQC was set when it started in 2009, and raised a number of issues which we had already begun to tackle. In particular, we put a lot of time and effort in the year into improving the way we inspect and regulate, so that we can inspect more services more often. We now regulate more than 22,000 providers delivering over 40,000 services.

We have some important issues to address in 2012/13 and beyond – in particular to review our strategy and measure our impact and effectiveness – and we have started this work in earnest.

In May 2011, the BBC's Panorama programme highlighted appalling standards of care raised by a whistleblower at Winterbourne View, a private hospital for people with learning disabilities. We carried out immediate inspections and ensured an immediate stop on admissions to the hospital, and the hospital closed the following month.

However, we know that there were indications of problems at this hospital which should have led to us taking action sooner. We conducted a thorough internal review and improved the processes we had in place to deal with calls from whistleblowers.

As a direct result of this case, we carried out a programme of unannounced inspections covering 150 independent hospitals, NHS hospitals and care homes that care for people with learning disabilities. We found that nearly half the locations we inspected were not meeting standards and made it clear that, if the care system is to meet the needs of these vulnerable people, it is vital that authentic person-centred care is commissioned appropriately and delivered. And if this were to happen systematically, people would be much more in control and able to exercise choice about how and where care is delivered that best meets their needs.

We had already shown the effectiveness of this themed approach to inspections with our review earlier in the year of dignity and nutrition in NHS hospitals. The programme was a collaborative effort: practising nurses and experts by experience joining our inspection teams to bring a range of perspectives to the inspection process.

In evaluating this programme, we showed that there was a strong relationship between the prospect of being inspected and improvements made by providers around issues of dignity. Three-quarters of the trusts involved told us they had made changes to the way they looked at dignity and nutrition as a result of this inspection programme; and 78% of the trusts agreed that our judgements were fair, despite many of the judgements being negative – and only six per cent disagreed.

This reflects a welcome realisation that the prime responsibility for ensuring safe and good quality care lies with the provider of that care. Regulation is not, and can never be, a substitute for providers living up to that responsibility. We play our part by holding providers to account for poor care when we find it, and working with them to make sure they improve.

In this respect, our new website and directory of every care service we regulate – which we launched in October 2011 – are powerful tools to help providers take action to improve poor care, and to empower members of the public to ask questions about the standards of care they receive.

And the data that CQC holds on performance across health and social care is unique in breadth and scale. Shortly after the end of the year, we published for the first time a comprehensive assessment of services inspected under the new regulatory system up to 31 March 2012. Based on more unannounced inspections than under any previous regulatory regime, we identified themes in poor and strong performance in each sector and flagged these issues with providers.

As we go forward, these reports will help us to highlight where the risks of poor care lie, and share this information widely so that problems can be tackled early.

Jo Williams
Chair

Cynthia Bower
Chief Executive

About the Care Quality Commission

What we do

The Care Quality Commission (CQC) is the independent regulator of healthcare, adult social care and primary dental care services in England. We also protect the interests of vulnerable people, including those whose rights are restricted under the Mental Health Act.

We hold care providers to account for meeting government standards of quality and safety. We focus on care that does not meet those standards, act swiftly to tackle poor standards, and thereby drive improvement.

We put the views, experiences, health and wellbeing of people who use services at the centre of our work, and we have a range of powers we can use to take action if people are getting poor care.

How we do it

Registration

By law, all providers of care services in England are responsible for making sure that the care they provide meets essential standards of quality and safety laid down by Government.

The essential standards set out what people who use services have a right to expect about the quality and safety of care. There are 16 standards and they deal with aspects of care such as treating people with dignity and respect, providing effective and appropriate care and treatment that meets their needs and protects their rights, protecting people from abuse, having clean environments and having enough qualified and supported staff to provide the care needed.

Providers need to make a legal declaration that they are meeting these essential standards before we can register them. If they are not legally registered with us they are not able to provide services.

In total, we register more than 22,000 providers that deliver services at more than 40,000 locations. From 2013 we will also register NHS general practices.

Inspection

Once they are registered, we aim to inspect most hospitals, care homes and domiciliary care providers at least once a year, and dentists at least every two years, to check whether or not they are continuing to meet essential standards of quality and safety. We inspect any service at any time when there are concerns about poor care. Almost all our inspections are unannounced.

During our inspections we ask people about their experiences of care, talk to care staff, and check that the right systems and processes are in place.

In between inspections we continually monitor all the information we hold about a service. We do this by sharing and checking information from a range of sources, by talking to local groups, and by listening to feedback from the public, care staff and whistleblowers. We respond quickly if there are concerns that people may be getting poor care. We work with local authorities, regulators and agencies, and sometimes the police, to make sure the necessary action is taken.

People can tell us about their own, or others', experiences of care services via our website at www.cqc.org.uk, by phoning our national helpline on 03000 616161, or by writing to our National Customer Service Centre.

Enforcement

If we find that a service is not meeting the essential standards, we take action to make sure it improves. We have various powers we can use, ranging from requesting action plans, issuing warning notices – which ask for improvements in a short period of time – to suspending or cancelling the provider's registration. We also share the information we have about services with other regulators and those who have responsibility for commissioning (buying) services.

Publication

We publish the results of all of our inspections to help people make decisions about services for themselves, or those they care for. Our website uses a clear system of ticks and crosses showing whether a provider is meeting the standards. We engage with a wide range of patient and public representative groups, providers, stakeholders and partners to plan our work, hear their views and discuss our findings.

Other regulatory activities

We carry out other statutory and inspection functions, most notably visiting people who are subject to the Mental Health Act and ensuring that their rights under that Act are upheld.

Our impact

In June 2012, we launched our first quarterly Market Report, showing the results of our inspections up to 31 March 2012 and identifying for the first time themes in strong and poor performance in meeting the essential standards. Future reports will track performance in each sector and flag up issues of concern.

The majority of locations inspected as at that date were meeting all the essential standards checked: 72% in adult social care, 77% in NHS services and 82% in independent healthcare. For all locations inspected, the figure was 73%.

Separately, we looked at around 1,000 inspections, carried out in the fourth quarter of 2011/12, of locations that had already had a previous inspection. For NHS locations, 65% had either become fully compliant with the standards since the previous inspection, or had stayed compliant. The corresponding figures for adult social care and independent healthcare were 54% and 70%.

Other impact in 2011/12 included:

- Three-quarters of NHS trusts inspected in our dignity and nutrition programme said that they had made changes to the way they looked at dignity and nutrition as a result of the programme.
- In our survey of providers, 85% of respondents who had been inspected felt that our inspectors' understanding of the care setting they inspect was good or very good and 72% agreed that CQC was delivering very or fairly well on its strategic priority to act swiftly to eliminate poor quality care.

What we are

CQC is a non-departmental public body, overseen by the Department of Health. We were established under the Health and Social Care Act 2008 and began operating on 1 April 2009.

Our funding

In 2011/12, our net expenditure was £60.9 million. We are funded through a combination of registration fee income and government grant-in-aid. A total of £45.3 million was received from the Department of Health during the year by way of grant-in-aid. This included an amount of £12.0 million for capital expenditure. We are moving towards a position where all our registration costs are recovered through fees. The proportion of our expenditure covered by fees increased from 48% in 2010/11 (excluding a £26.8 million decrease in the provision for pension fund deficits) to 58% in 2011/12.

Our priorities

Our delivery priorities for 2012/13, set out in our Business Plan, are:

1. Deliver and improve our regulatory and other functions.
2. Develop a new strategy for CQC.
3. Manage and develop our organisation, people and resources.

Our people

In 2011/12, CQC employed more than 1,800 staff working in nine operating regions and a headquarters in London. Our National Customer Service Centre in Newcastle is our central processing and contact centre.

From 1 April 2012, we moved to a new organisational structure, based on four regions – South, London, Central and North – each led by a Deputy Director of Operations. These new regions align with the structure of the NHS Commissioning Board.

Our governance

We hold regular board meetings throughout the year to discuss different areas of our work. These are attended by our Board members, our Executive Team and other CQC staff. We hold board meetings that the public can attend. We put the agenda and papers on our website a few days before each meeting.

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

Biographies of our Board are presented on pages 42–43.

The Board has set up two committees to support its work: the Audit and Risk Assurance Committee and the Remuneration Committee.

The Executive Team takes overall responsibility for the effective development and performance of the organisation; oversees the successful delivery of the programme of work in line with the strategic objectives; identifies policy issues to be discussed with the Chair and/or other Board members; approves all submissions to the Board and its committees; and manages risk.

Biographies of our Executive Team are presented on pages 44–45.

Introduction

This annual report covers the work of the Care Quality Commission in the year ended 31 March 2012. At the start of the year we were still building the operational framework needed to deliver our regulatory remit set out under the Health and Social Care Act 2008.

While we had registered all NHS trusts and been able to monitor their compliance with the essential standards of quality and safety for a full year, we had only recently completed the registration of the large number of adult social care and independent healthcare services and started to inspect them. We were also still in the process of bringing primary dental care services into the same, overarching regulatory system.

We knew that this had had a significant impact on our resources and our ability to meet our principal objective of ensuring that care services are meeting the essential standards and therefore protecting people from the risk of poor care.

So from the start of 2011/12, we put a lot of time and effort into refining the way we work and operate as a regulator – refining our regulatory model that staff and providers had already told us was cumbersome and inflexible; refining the balance of information from people's experiences of care and inspections and other data to take a view on risk; and developing our resources for regulating large and diverse care sectors. In doing this, we worked hard to strengthen our operational capacity and capability and engage closely with our own staff and the sectors we regulate.

At the same time as this work was progressing, we were closely scrutinised by a number of different bodies – including the Mid Staffordshire Public Inquiry, the Health Select Committee, the National Audit Office and the Public Accounts Committee. In addition, in May 2011, the BBC's Panorama programme had highlighted serious abuse and appalling standards of care raised by a whistleblower at Winterbourne View, a private hospital for people with learning disabilities. As well as acting quickly to tackle the specific issues uncovered, we conducted a thorough internal review that informed us we needed to improve the processes we had in place to deal with calls from care workers who had concerns about where they worked.

We were also subject to a Performance and Capability Review by the Department of Health – the first of a new series of reviews of arms' length bodies to be conducted the Department and published in February 2012.

This review raised a number of issues about CQC's performance and effectiveness as the health and social care regulator which we have acknowledged and are addressing in our Action Plan published in March 2012. This response includes developing a new strategy for CQC, strengthening and improving the effectiveness and consistency of our regulatory model, strengthening our governance and developing CQC to become a high-performing, learning organisation.

The Performance and Capability Review particularly recommended that, from April 2012, we put a renewed focus on our core purpose:

- **Registering** providers of health and adult social care services, and keeping the register up to date.
- **Inspecting** services to check how they were meeting the essential standards of quality and safety.
- **Enforcing** the standards where we found they were not being met.
- **Publishing** information to the public and engaging with all the sectors we regulate.

This report sets out our activity in regulating each care sector in 2011/12, the progress we made in each of the above areas, the work we have done to develop and support our staff in delivering on our regulatory role and the operational efficiencies we have made in the year.

SECTION 1

Regulation of care sectors in 2011/12

All providers of healthcare, adult social care and dental care in England must be registered by CQC if they carry out 'regulated activities' – these correspond to the types of care usually provided by hospitals, care homes and dentists and include things such as treatment of illness or injury, nursing care, personal care and support, surgery, medical advice and care for people with mental health problems.

TABLE 1 shows the number of providers registered by CQC at the end of the year. A provider can operate in more than one sector (for example, a few NHS organisations provide adult social care services). Where this is the case, we have categorised the provider by its main area of operation. There is a wide variety of services and activities regulated by CQC within these broad categories.

Table 1

Number of providers registered with CQC

Care sector	Providers at 31 March 2012
NHS healthcare	291
Independent healthcare	1,227
Adult social care	12,429
Primary dental care	8,112
Independent ambulance	243
Total	**22,302**

A single provider can provide services from a number of different places (for example, a social care provider running several care homes, or an NHS trust operating a number of hospitals and clinics). We call these 'locations'.

Overall, on 31 March 2012, there were 40,621 registered locations in England providing health, social care and dental services. **TABLE 2** shows this split by sector and region.

Locations are important because they reflect the scale of what CQC has to monitor and inspect, as generally each location needs its own inspection. Locations can themselves vary significantly in terms of complexity: for example, a large NHS trust with a number of different hospital sites and community services will require a very different level of inspection resourcing when compared with, say, a small care home.

Overall inspection activity

We carry out regular, unannounced inspections of each location and we re-inspect those that we find are failing to meet the essential standards. We inspect at any time if we have concerns about poor care.

Our inspectors spend most of their time on inspections listening to people who use the service, watching care being delivered and talking to care staff. They look at what people are actually experiencing and the impact this has on their health and wellbeing.

We carry out three types of inspection. A responsive inspection is carried out at any time in response to concerns; a scheduled inspection is planned by CQC in advance and can be carried out at any time; and a themed inspection looks at specific themes in response to national issues or concerns.

Table 2

Registered locations as at 31 March 2012, by sector and region

Region	NHS healthcare	Independent healthcare	Adult social care	Independent ambulance	Primary dental care	Total
East	274	294	2,680	46	1,070	4,364
East Midlands	163	182	2,220	28	707	3,300
London	294	650	2,865	33	1,930	5,772
North East	139	97	1,205	13	407	1,861
North West	366	318	3,149	24	1,252	5,109
South East	381	476	4,633	76	1,900	7,466
South West	283	267	3,264	54	1,030	4,898
West Midlands	274	222	2,728	25	953	4,202
Yorkshire & Humberside	222	258	2,264	24	881	3,649
Total	**2,396**	**2,764**	**25,008**	**323**	**10,130**	**40,621**

We met our targets (see box below) for carrying out scheduled inspections between the start of the operation of the Health and Social Care Act and 31 March 2012. In 2011/12, we carried out at least one scheduled inspection of 11,359 locations. (The corresponding figure for 2010/11 for the Health and Social Care Act was 2,111 locations[1]; the total across the two years was 13,470).

We also carried out 2,589 responsive inspections in 2011/12. Overall, our inspections in 2011/12 required almost 17,000 site visits. Note that locations can be visited more than once in a year, and also a single inspection can involve more than one visit.

In June 2012, we launched our first quarterly Market Report, showing the results of our inspections up to 31 March 2012 and identifying for the first time themes in strong and poor performance across the care sectors. Future reports will track performance in each sector and flag up issues of concern.

1. In 2010/11, we also carried out inspections under the previous regulatory regime, the Care Standards Act.

The majority of locations we had inspected as at 31 March 2012 were meeting all the essential standards of quality and safety: overall 73% of all locations inspected. In total, we demanded action from 27% of providers who failed to meet all essential standards: 3,747 locations across all sectors as at that date.

The key problem areas most common across healthcare and social care were:

- **Management of medicines** – our inspectors saw a worrying number of examples where safe management of medicines is being compromised, often by a lack of information given either to those taking the medicines, or those caring for them.
- **Record keeping** – issues range from records, which include crucial information about people's care, being incomplete or not up-to-date; not kept securely or confidentially; or not showing that risks to people had been identified and were being managed.

Targets for scheduled inspections in 2010/11 and 2011/12

At the start of the new registration system, our target was to carry out at least one scheduled inspection of all NHS trusts and adult social care, independent healthcare and dental care locations within two years of their being registered under the Health and Social Care Act 2008.

Allowing for the time needed to complete transitional registrations in each sector, for gradually increasing inspector numbers and associated training throughout the year, and work to review schedules in the light of these, this translated into the following final targets for 2010/11 and 2011/12 combined:

- At least one scheduled inspection in **100%** of **NHS trusts**.
- At least one scheduled inspection in **62.5%** of **adult social care** and **independent healthcare** locations (of those that were registered by 1 February 2011).
- At least one scheduled inspection in **15%** of **dental care** locations (of those that were registered by 1 October 2011).

The above targets refer to **scheduled inspections**. Note that locations can also receive **responsive inspections** at any time where we have concerns that essential standards are not being met.

Note: On 1 April 2012, we changed to a programme of more frequent inspection. We aim to inspect all NHS trusts, independent healthcare locations and adult social care locations at least once a year, and all dental care locations at least once every two years. Therefore, new targets apply for 2012/13 – see our Business Plan 2012/13 for full details.

- **Staffing** – issues around staffing emerge as a key driving factor in many instances of non-compliance, both in terms of the numbers of staff available and in the support they are given to do their job.

These are all issues that have an impact on the other essential standard that had the lowest performance across the board – care and welfare of people and patients. The safety and suitability of premises was also an issue of concern in social care.

NHS trusts

We completed our target of inspecting 100% of NHS trusts between the start of the new regulatory system and the end of 2011/12. This equated to 288 trusts.[2]

On 31 March 2012, of the NHS locations we had inspected since the start of the new regulatory system under the Health and Social Care Act, 77% were meeting all the essential standards we had checked. In 21% of cases, we found that the service was not meeting at least one standard and we required an action plan telling us how they were going to improve. In 1% of cases, there was serious non-compliance that required us to use powers on a more urgent basis to protect people from harm or hold the trust to account.

The standards where we found the poorest performance in NHS hospitals were those dealing with care and welfare of patients; management of medicines; staffing; supporting staff; and record keeping.

The standards where we found the best performance were those dealing with the safety of equipment and having staff that are qualified and fit for the job.

Full details of how well NHS trusts are meeting the standards can be found in our quarterly Market Report.

2. Three trusts were not due for inspection by 31 March 2012, for reasons including having registered with CQC later than the majority of NHS trusts.

Dignity and nutrition in hospitals

In the NHS, we carried out a series of 100 unannounced inspections of acute hospitals between March and June 2011. This themed inspection programme looked at the whether older people in hospital are treated with dignity and respect, and whether they get food and drink that meets their needs.

The programme was a collaborative effort. More than 100 of our inspectors worked with 50 practising nurses and 40 'experts by experience' (people with direct experience of care services) in our inspection teams. An external advisory group offered us strong challenges throughout the process and helped make sure the inspection results had an impact. This group included representatives from Action on Elder Abuse, Age UK, Dignity in Care, Equality and Human Rights Commission, Local Involvement Networks (LINks), NHS Confederation, Nursing and Midwifery Council, Patients Association, Relatives and Residents Association, Royal College of Nursing and Royal College of Physicians.

We found that, while many were delivering good care, more than half of those 100 acute NHS hospitals inspected needed to make improvements and one in five was failing to meet the essential standards. Among the problems we found were:

- Patients' privacy not being respected – for example, curtains and screens not being closed properly.
- Call bells being put out of patients' reach, or not answered soon enough.
- Staff speaking to patients in a dismissive or disrespectful way.
- Patients not being given the help they needed to eat.
- Patients being interrupted during meals and having to leave their food unfinished.

We asked those trusts that failed to meet standards to tell us what they were going to do to improve, and we followed these up throughout the year.

We sent a short survey to the trusts we visited to get their views of how the programme worked and see what impact it had had on they way they worked. More than 70% agreed or strongly agreed that feedback on the day was helpful, and that the mixed team (CQC inspector, nurse and expert by experience) improved the quality of the inspection.

> [Regarding nursing standards] In some limited cases, standards have fallen below what's acceptable. You've seen it in CQC reports.... Elderly relatives not getting the care they need. And so what we need to do is make sure that doesn't happen."
>
> **David Cameron – January 2012, referencing CQC inspection reports of dignity and nutrition**

> The Care Quality Commission's report *Dignity and Nutrition for Older People* set out good examples of NHS providers treating patients with dignity and respect as well as other more worrying examples where the standards are not acceptable in a modern health service."
>
> **The Operating Framework for the NHS in England 2012/13**

In terms of our judgements, 78% agreed or strongly agreed that our decisions were a fair reflection of performance, with only 6% of those who responded disagreeing. Three-quarters of them said they had made changes to the way they looked at dignity and nutrition as a result of the programme.

Owing to the success of the programme, the Government asked us to carry out more dignity and nutrition inspections. We are inspecting 50 NHS sites, a combination of re-visits and new inspections. The programme now also covers adult social care, with inspections of 500 care homes. We will report on these 550 inspections in autumn 2012.

Learning disability services

We included NHS services in our themed inspections of services for people with a learning disability. See the section on independent healthcare below for details.

Termination of pregnancy services

At the end of the year, at the request of the Secretary of State, we started a programme of inspections into NHS and independent sector organisations that provide termination of pregnancy services. It was a huge amount of work for our inspection teams over a short period of time, and impacted our other inspection activity. We will report our findings in 2012/13.

Independent healthcare

We had a joint target of carrying out scheduled inspections of 62.5% of all independent healthcare and adult social care locations[3] between the start of the new regulatory system and the end of 2011/12. We achieved this, inspecting 11,749 locations (63.5%) by 31 March 2012 (9,818 in 2011/12 and 1,931 in 2010/11).

On 31 March 2012, of all the independent healthcare services that we had inspected since the start of the Health and Social Care Act, 82% were meeting all the essential standards we had checked. We found that, in 18% of cases, the service was not meeting at least one standard and we required an action plan telling us how they were going to improve. In 1% of cases, there was serious non-compliance that required us to use our powers on a more urgent basis to protect people from harm or hold the provider to account.

3. Of those registered on 1 February 2011.

The standards where we found the poorest performance in independent hospitals and clinics were those dealing with the management of medicines and record keeping.

The standards where we found the best performance were those dealing with meeting patients' nutritional needs and how the hospitals co-operate with other providers.

Full details of how well independent healthcare services are meeting the standards can be found in our quarterly Market Report.

Learning disability services

In May 2011, the BBC's Panorama programme highlighted serious abuse and appalling standards of care raised by a whistleblower at Winterbourne View, a private hospital for people with learning disabilities. Following an internal review, we recognised that there had been indications of problems at this hospital which should have led to us taking action sooner, and the full details of what we did to improve our processes are set out on page 25 below.

As a result of the concerns raised about this type of service, we carried out a programme of 150 inspections of independent hospitals, NHS hospitals and care homes that care for people with learning disabilities.

We looked at whether people experienced safe and appropriate care and support and whether they were protected from abuse. It was vital for us to gain the trust of patients and residents so that they could feel comfortable in giving us their views of the care they receive. Experts by experience and professional advisers joined our inspectors and helped us build a detailed picture of the care that people are receiving from learning disability services.

We published the first inspection reports in December 2011 and our national report, published in June 2012, drew together our overall findings. We found that almost half of all the services were not meeting essential standards. Many failings were a direct result of care that was not centred on the individual or tailored to their needs. Some assessment and treatment services were admitting people for long spells of time, and discharge arrangements were taking too long to arrange.

As part of our commitment to learning about the effectiveness of our processes, we commissioned an independent evaluation of the programme. We wanted to evaluate the process from the perspective of all the inspection team members: experts by experience, professional advisers and CQC inspectors. We also asked the providers for their views. The overall findings were:

- The process benefited from the broader perspective gained by involving all the different parties.
- Two-day inspections were seen to be highly effective.
- We need to give more thought to planning and preparation when bringing the groups together, and the training we offer.
- All three groups thought that their contributions were valued in the process and reports.
- CQC's inspection team leadership was highly rated.
- We need to better structure our approach to professions recruited to be part of inspection teams.
- All the groups said that they want to work in this way again.
- Providers had high praise for the courteousness and professionalism of the teams.
- Providers would like better and more prompt feedback from the inspection.

Cosmetic surgery

In January 2012, we supported the Government's initial review of data and information to determine the safety of Poly Implant Prosthése (PIP) breast implants and carried out a review of seven of the largest providers of cosmetic surgery.

In the review, we assessed the systems that the providers had in place, at a corporate level, to monitor and manage the use of equipment including medical devices, their systems for assessing and monitoring the quality of care, and how they managed complaints. We found that all of the providers were meeting these essential standards.

Adult social care

As noted above, we achieved our target for carrying our scheduled inspections of adult social care and independent healthcare locations between the start of the new regulatory system and the end of 2011/12.

On 31 March 2012, of all the adult social care services that we had inspected since the start of the Health and Social Care Act, 72% were meeting all the essential standards we had checked. We found that, in 27% of cases, the service was not meeting at least one standard and we required an action plan telling us how they were going to improve. In 1% of cases, there was serious non-compliance that required us to use our powers on a more urgent basis to protect people from harm or hold the provider to account.

In looking at social care services in detail, we split services into either nursing homes, residential homes (those without qualified nursing care), and care provided to people in their own homes.

The standards where we found the poorest performance in nursing homes were those dealing with care and welfare of people; cleanliness; management of medicines; premises; staffing and supporting staff; monitoring the quality of service provision and record keeping.

For residential homes, the poorest performance was in care and welfare of people; cleanliness; management of medicines; premises; monitoring the quality of care and record keeping.

In home care services, the poorest performance was in care and welfare of people; management of medicines; supporting staff and record keeping.

The standards where we found the best performance in nursing and residential homes were those dealing with how they co-operate with other providers and how they handle complaints. For home care services, the best performance was in meeting people's nutritional needs, co-operating with other providers, and the safety of premises and equipment.

Full details of how well adult social care services are meeting the standards can be found in our quarterly Market Report

Home care services

In 2011/12, we began the planning for a themed inspection programme to look at the care given to people in their own homes. We began inspecting 250 home care services in spring 2012, focusing on whether people are treated with dignity and respect, how people are protected from the risk of abuse, and how well supported and trained home care staff are to undertake these most important care tasks.

Reacting to our announcement, Age UK charity director Michelle Mitchell said: "We welcome CQC's decision to carry out this themed inspection of home care services. Age UK will be supporting the CQC and believe this inspection programme will help to ensure that that high quality care, dignity and respect for those needing the service will be at the heart of all domiciliary care." The programme will complete in 2012/13.

Deprivation of liberty safeguards

We have a special responsibility under the Mental Capacity Act 2005 to check how that act's 'deprivation of liberty safeguards' are used in care homes and hospitals. The safeguards protect the rights of people who lack the mental capacity to consent to their care or treatment – they include people with dementia or a learning disability. The way we fulfil this responsibility is by checking how providers operate the safeguards in our normal programme of inspections.

We published our second annual report on the operation of the safeguards in March 2012. Many providers have developed good practices, particularly in involving people and their carers in making decisions about care and treatment. However, we found that between a third and a quarter of care homes had not provided their staff with training on the safeguards, and in some cases only the manager had received training.

We found that there are still concerns among practitioners about how complicated it is to operate the safeguards in practice. We also pointed to a particular gap in information on the role of councils and PCTs that authorise applications to use the safeguards, which has hindered our ability to monitor the safeguards effectively. We continue to discuss these issues with the Department of Health.

Healthcare in care homes, and support given to families with disabled children

In addition to individual inspections and the themed inspection programmes, we published two reports looking at particular care issues.

Firstly, we looked at how older people and people with learning disabilities in care homes access health care services, whether they have choice and control over their health care and whether the care they receive is safe and respects their dignity. While the findings showed much good practice, they also showed that some homes were not arranging for proper access to healthcare for their residents.

Secondly, we looked at how long families with disabled children wait for critical services and the quality of support they have from care services. In our review, families said that they were waiting too long for mobility aids such as wheelchairs. People also felt that services were not joined up and did not work well together, while many children and their families said they had not been consulted about how their care was provided. We launched the report with the help of Whizz-Kidz, a charity that helps young people access the right mobility equipment, work placements and other life skills.

Dental care providers and private ambulances

In 2011/12, we completed the registration of dental care and private ambulance providers that had begun in the previous year. By the end of September 2011, 93% of providers had received our formal decision about their registration, and by 31 March 2012 we had a total of 8,112 dental care providers and 243 private ambulance providers on the register.

We achieved our target of carrying out scheduled inspections of 15% of dental care locations[4]: by the end of the year we had inspected 1,433 locations (16.1%) (one in 2010/11 and 1,432 in 2011/12).

So far, dentists have told us they've found our inspectors approachable and professional, and that their feedback and inspection reports are helpful. In a survey we carried out at the end of the year, 73% of respondents from dental care providers who had been inspected said that their inspector's understanding of the care they provide was good or very good, and 89% said that the feedback provided by the inspector was very helpful or fairly helpful.

4. Of those registered on 1 October 2011.

Tailoring our approach to the dental care sector

There are a number of areas where we have listened to providers, and have tailored our methodology to fit to the specific needs of the dental sector:

- Unlike other inspections, our inspectors give a short amount of notice for a planned visit to dental services, since it is disruptive to patients for us to arrive unannounced and difficult to gather the evidence we need when staff and treatment areas are fully committed to consultations.
- We have learned that dentists currently have no system for professional or clinical appraisal, and that we need to look for other evidence that providers are meeting the standard relating to the monitoring of quality of services, such as continuing professional development records and peer review.

In November, we published the first inspection of a private ambulance service. We identified major concerns in the management and storage of medicines, record keeping and monitoring of the quality of services. Our inspectors also found it was using unsafe and unsuitable equipment and didn't always have enough suitably trained staff. This was a useful reminder to all ambulance providers, especially those in the private and not-for-profit sector that were new to regulation, of the need to ensure that they are meeting the essential standards.

In the end of year survey referred to above, 21 out of 25 respondents from private ambulance services said that their inspector's understanding of the care they provide was good or very good, and 21 out of 22 said that the feedback provided by the inspector was very helpful or fairly helpful.

Primary medical services

In the initial timetable for registration, all providers of primary medical services – mostly GP practices and walk-in centres – were required to register with CQC by April 2012. However, having learned a great deal about the operational impact of registering the previous large tranches of providers, we proposed that the date be put back to give us extra time to improve the process. Following consultation, the Government confirmed that registration of the sector would be put back to 1 April 2013.

The additional time has enabled us to work closely with national organisations, including the General Medical Council, the British Medical Association and the Royal College of General Practitioners, and the various Local Medical Committees in developing our approach. Their feedback has been invaluable in talking to the sector about registration and making the process as straightforward and efficient as possible, as well as ensuring that the inspection process that will follow will be proportionate and appropriate.

One of the most important innovations for these providers is that we will be giving them much more control over the registration process through our online services (see page 22). They will have an online account through which they can submit their application, choose the time 'window' in which they want to submit, and receive our formal decision about their application. They will be able to use their online account going forward when they want to make changes to their registration, such as adding locations.

Out-of-hours providers

Although the registration of most primary medical services was moved to 2013, the exception was providers of out-of-hours services, who still had to register by 1 April 2012. Engaging with this group of providers was new to us – they have not been regulated before, or identified as a distinct group for any other purpose. We worked closely with PCTs and the NHS Alliance to help all the relevant providers in the sector enrol and then register with us by the end of April 2012 – this amounted to 49 providers.

Protecting patients' rights under the Mental Health Act

In 2011/12, we reviewed our mental health modernisation programme and in particular how our Mental Health Act operations integrate with our other functions.

We are responsible for protecting the interests of people who are subject to the Mental Health Act, by checking how mental health services in England – in both the NHS and independent sector – use their powers and fulfil their duties for patients who are detained in hospital or subject to community treatment orders or to guardianship.

Our Mental Health Act Commissioners meet patients in private to discuss their experiences and concerns, make sure they understand their rights and check that staff are using the Act correctly. In 2011/12, they made 1,502 visits and met with 4,478 patients.

We also provide 'second opinion appointed doctors', who give an independent view of whether the treatment proposed for the patient is appropriate for them. Demand for this service remained high, and there were more than 12,000 second opinion visits made in 2011/12.

Although separate to our general registration and inspection duties under the Health and Social Care Act, we made considerable progress in sharing our Mental Health Act intelligence with our inspection teams and linking the two activities more closely. Going forward, we will be using experts by experience in more visits and fully embedding joint working across our regions, including Mental Health Act Commissioners and compliance inspectors visiting services together.

We started to improve our handling of complaints from people who are subject to the restrictions of the Mental Health Act – this is the only area where we have a remit to deal with complaints from individual patients. All complaints are now given an initial assessment so that we can better decide who will review and respond to them, and we are clearer about which complaints require liaison with inspection colleagues. We were proactive in tackling cases that were still open, and we reduced a backlog of long-term complaints as a result.

We published our annual report on the use of the Mental Health Act in December 2011, with a renewed call for better care for patients. Although we found examples of good practice, considerable improvements were still needed in key areas such as lack of patient involvement, consent to treatment and the over use of restrictions placed on the movements of detained patients.

We highlighted the following:

- Lack of patient involvement in the care planning process continued to be one of the issues most frequently reported by Mental Health Act Commissioners after visits to hospitals.
- In some cases, doctors appeared to assume too readily that patients had the capacity to give their consent to treatment. The report also said that the legal powers available to providers in relation to community treatment orders were widely misunderstood, even among mental health professionals.
- On minimising restrictions imposed on patients in hospital, we still found examples of poor or questionable practice, such as denying patients regular access to the internet, locking them out of their rooms during the daytime, or listening to their telephone calls. In some cases the restrictions may seem minor, but they add to the feeling of the patient that he or she is being 'institutionalised'.
- Continuing delays in admissions to hospital due to bed availability – a longstanding problem that in some cases places the patient at great risk.
- Many patients detained under the Mental Health Act had a worrying lack of access to independent advocacy services.

SECTION 2

CQC business and operational activity in 2011/12

Registration

Under the Health and Social Care Act, all providers of care services in England are responsible for making sure that the care they provide meets essential standards of quality and safety laid down by Government.

Providers need to make a legal declaration that they are meeting these essential standards before we can register them. Therefore, registration is a legal necessity for new providers wishing to start operations and provide care services.

It is also the starting point for new providers' relationship with CQC. We significantly improved the efficiency of the registration process during the year, and streamlined the introduction of new care sectors into registration.

Registration improvements

In 2010/11, we were having to reject a high proportion of registration applications because of errors made by applicants. This led to heavy backlogs and providers having to wait unacceptable times for their applications to be processed. To help tackle this situation, we consulted our staff and our stakeholders to discuss the issues and how we could improve the registration process.

On 1 July 2011 we made changes to the application forms, made the process of submitting references easier and improved the guidance on our website. As a result of these changes, we set ourselves a new target of processing 80% of applications within eight weeks of receiving them.

Despite the very large numbers of applications received, the improvements had a big impact in the speed of turnaround. In the second quarter, 67% of applications were completed within eight weeks; in the final quarter, this had risen to 88%. Overall in the year, 30,961 applications were completed within eight weeks, 73% of the total number of 42,500.

We set a target for rejecting incorrect or incomplete applications of less than 25%. The total number rejected was higher than this, at 15,006 or 35%. However, a number of further improvements, such as the 'call back' system – providers who have a query when completing their forms can send a message from our website and we call back within 24 hours – helped to reduce the rejection rate to 31% in the final quarter.

Our National Customer Services Centre played a major role in improving the efficiency of the registration process. In a survey of providers, the proportion of people who said that our query handling was good or excellent rose from 62% in May 2011 to 85% in September 2011. Also by September, the proportion of providers who thought our speed of response was satisfactory or above was 86%, a huge rise on the May figure of 11%.

Southern Cross

After getting into financial difficulties, Southern Cross Group plc, Britain's largest care home chain, announced its intention to leave the care home sector in the summer of 2011. The organisation's plans to stay trading as a smaller entity failed and the landlords of its 740 care homes decided to seek new lessees in place of Southern Cross.

Of this number, 583 were registered with CQC. Although placing people in care homes is not CQC's role, we made it clear from the start that we would do everything in our power to ensure that the transition happened as smoothly as possible with as little disruption to the 31,000 residents in Southern Cross's care at that time.

This involved working very closely with Southern Cross itself, the new providers that were taking over the homes, local authorities, other regulators, the Association of Directors of Adult Social Services and the Department of Health. Care homes started transferring to new owners at the end of September 2011 which meant many providers registering for the first time, or existing providers having to add new details and new locations to their registration. It was a huge effort by our customer services and registration teams and we managed the transition while keeping continuity of care for the people using those services. Most importantly, we kept a record of the risk profile for each location so that we could continue to make consistent judgements about the quality of care given to the residents affected.

Online services

In line with our focus on improving the efficiency of our interaction with providers, we have been developing our online services programme since 2011. In December, we rolled out the first phase of 'Your CQC account' with a pilot involving 110 providers across a total of 695 locations.

Feedback from those taking part in the pilot has been very positive and our customer call centre has received very few support calls; satisfaction ratings have been more than 90% positive. We intend to extend online services to more processes and providers throughout 2012/13, and it forms the base for registering primary medical services by April 2013.

Inspection

Once providers have been registered, we check whether they continue to meet the essential standards of quality and safety.

We mostly carry out routine scheduled inspections, where our inspectors choose a number of areas to inspect in detail, and responsive inspections where we have been alerted to a potential problem by information that has come into us. We significantly increased our inspection activity in the year, and developed a successful themed inspection approach that explores specific types of care in detail.

Improving the way we regulate and inspect

Early in 2011, we carried out a large-scale review with our staff of how we inspect care services and monitor their compliance with the essential standards. We recognised that the existing processes were cumbersome; feedback from providers also told us that they found some of the processes difficult to follow.

More than 400 staff from across CQC attended 30 workshops to share experiences and make recommendations about how we could make this work – which is central to everything CQC does – simpler and better, and at the same time be more meaningful for the people who use care services.

With the learning we gained from this and from piloting a new approach in summer 2011, we carried out a national consultation between September and December 2011. We held a number of focus groups with our SpeakOut Network (of community groups) and with experts by experience, and invited members of LINks and a number of groups that we work with, including: Help the Aged, Challenging Behaviour Foundation, Alcohol and Drug Service (ADS)/ Oxfordshire User Team (OUT), The Daffodil Advocacy Project, and our eQuality Voices Group.

The feedback was broadly supportive of the changes we wanted to make and agreed that they would help us to be more consistent in our judgements.

The new model came into effect on 1 April 2012. Under this new model, we will inspect most services more often. We will inspect most hospitals, care homes and domiciliary care providers at least once a year, and dental services at least once every two years. The extra inspectors that we have recruited in 2011/12 and 2012/13 mean that our inspectors will be responsible for a smaller number of services than in the past. They will be able to spend more time getting to know services, checking information and responding quickly to concerns.

Our inspections are also now more targeted. They focus on a minimum of five essential standards for most services. This allows our inspections to be more tailored to take account of the type of care provided and the information we currently hold about the service. Between inspections, our inspectors have continual oversight of information about the services we regulate against all 16 essential standards to decide where there is a risk of poor care.

Following an inspection, we judge a service to be either compliant or non-compliant with the regulations. 'Improvement actions', which we imposed when we had concerns about a provider's ability to stay compliant, are no longer applied. Our inspectors are still able to make comments about where minor improvements could be made but we do not ask providers to complete action plans against these.

We hope that these changes will further improve providers' understanding of the way we regulate. We carried out a survey of all providers at the end of 2011/12 and were encouraged by the results at that time:

- 94% felt very or fairly clear about what our regulatory model required them to do.

- 92% felt that the feedback given to them after an inspection was very helpful or fairly helpful.
- 85% felt that our inspectors' understanding of the care setting they inspect was good or very good.
- 72% of respondents who had been inspected agreed that CQC was delivering very or fairly well on its strategic priority to act swiftly to eliminate poor quality care.
- 81% agreed that CQC was delivering very or fairly well on its strategic priority to make sure care is centred on people's needs and protects their rights.

We also expect that the above changes will help us meet our targets for issuing inspection reports on time. We did not achieve our overall 2011/12 target for issuing final inspection reports on time, although we did make considerable progress, rising from 36% in the first quarter to 77% in the final quarter, and we expect to continue this upward trend in 2012/13.

Acting Together

'Experts by experience' are people who have first-hand experience of care themselves, or as a family carer, and who therefore can provide the patient's perspective throughout our work.

We launched a new scheme in 2011, called "Acting Together", to help us increase our use of experts by experience in our inspections of health and social care services and visits to check the use of the Mental Health Act. In 2011/12, 506 site visits included experts by experience.

Through partnership agreements with bodies including Age UK, Challenging Behaviour Foundation and Choice Support, we are able to employ groups of people whose hands-on knowledge not only helps us with our inspections, but also how we communicate with the people they represent. Choice Support, for example, leads a group of smaller and user-led organisations that includes Voiceability, Living Options Devon, Advocacy Alliance Bedford, Skills for People, Advocacy Experience, Inclusion North, and Hersov Associates.

Before its launch the Chair of Trustees of the Challenging Behaviour Foundation commented on Acting Together: "Family carers of individuals with learning disabilities and high support needs have a wealth of experience in understanding the needs of their relatives and recognising good support and services. I am delighted that the Challenging Behaviour Foundation will be working with the CQC, supporting family carers of people with complex needs to influence and improve support and service provision."

Since the launch, Acting Together has gone from strength to strength, with experts by experience being used in increasing numbers in our inspections. They have proved particularly useful in gaining feedback from people who might find it difficult to speak for themselves. Heather Hurford, CQC's National Lead Advisor on mental health legislation said this about working with Abina Parshad Griffin, a long-term user of mental health and care services and expert by experience:

"We were talking to patients who were really quite confused about what was going to happen to them next, they'd been in the system for a very long time, and what you [Abina] said was they'd lost their own narrative of their life story... and then you went on to recommend that the hospital develop some information for them – things you need to know if you're sectioned under the Mental Health Act – and they did it."

Abina values her contribution to ensuring that people's voices are heard:

"I think it's really important that not only my voice is heard, but as many people as possible, who actually can name the services they use. When people see me on the Cowley Road, people I don't really know, they shake my hand, and they say thank you for speaking for us. I carry their voices with me. I do enjoy working for CQC, because I believe that together, with everyone involved, we can make a difference."

Involving young people

During the year, we also looked into the best ways of involving young people in inspecting care services. In February 2012, we held our first consultation event with young people who use a range of services. A mother and support worker of Lucy, a young person with Down's syndrome said:

"The whole day was pitched at the young people's level without being patronising... all young people were involved no matter what their disability and all communication methods were catered for with plenty of time allowed for individual responses. It is rare for me to walk away from such an event buzzing and feeling proud to be part of it. Lucy chatted all the way home stating that when she is an 'inspector' she will make everyone draw pictures of what they are intending to do (to children) and explain properly or they won't pass the test!!! Well done CQC. I was proud to be part of your day and look forward to working with you again."

Making use of information from the public and local groups

The information that we get from people during an inspection is central to our judgements about their experiences of care, but information we can get from people who use services and the public in between our visits is equally vital to us.

When we launched our new website in October 2011, we included a new easy-to-use online feedback form, which helps people who are using or have recently used a care service, or their friends, family and carers, to directly tell us their experiences of the service. Since October, more than 400 people a month have given us information in this way.

We also started to look at how we can improve the way we gather and use information from people who use services and their families and carers. In March 2012, we launched two pilot programmes – called 'Tell us about your care' – to better understand the value of information received from members of the public.

In these programmes, we are working on six-month pilots with the Relatives and Residents Association and the Patients Association to gather feedback from members of the public who have contacted either organisation with concerns about the quality and safety of care they or someone they care for has experienced. We will report on the pilots in 2012/13.

Our Quality and Risk Profiles (QRP) of providers draw in data from a number of sources (including directly from the feedback form on our website, or third parties such as NHS Choices) which we analyse to identify potential areas where a provider may not be meeting the essential standards. We have continued to develop the analysis tools we use to make best use of the expanding amount of information we receive from the public.

Whistleblowing information

Alongside information from people who use services and their relatives and carers, information from people who work within care services is some of the most valuable information we can get.

In May 2011, the BBC's Panorama programme highlighted serious abuse and appalling standards of care raised by a whistleblower at Winterbourne View, a private hospital for people with learning disabilities. In response to the serious issues uncovered, we:

- Carried out four unannounced inspections of the hospital.
- Ensured an immediate stop on admissions to the hospital.
- Took enforcement action to remove the registration of Winterbourne View, the legal process to close a location. The hospital closed in June 2011.
- Worked with the primary care trusts and councils who paid for the care of people at the hospital to find new accommodation for them.

We also started an immediate review of the 23 other services run by the Castlebeck Care Group, the provider that ran Winterbourne View. We found serious concerns about four of these services and took enforcement action against them – two of them subsequently closed. A further seven did not fully comply with essential standards of quality and safety – we told Castlebeck to show us how it would make improvements. We found a number of common themes across the group: a lack of training for staff, inadequate staffing levels, poor care planning, a failure to notify safeguarding incidents, and a failure to involve people in decisions about their own care.

We also carried out a targeted programme of unannounced inspections of hospitals providing care for people with learning disabilities. We inspected 150 independent hospitals, NHS hospitals and care homes that care for people with learning disabilities (see section above).

We launched a detailed internal review to establish why we did not initially take effective action in relation to the concerns that were raised by the whistleblower. This established that we needed to improve the processes we had in place to deal with calls from care workers who had concerns about where they worked.

We created a new specific whistleblowing team to make sure that no whistleblowing alerts fall through the net in future. The team receive all whistleblowing contacts by phone, email and post, assign each case to the relevant local inspector, and then 'track and chase' this to make sure that the inspection teams have received the information and confirmed they have taken whatever action is necessary, depending on who is at risk and the nature of that risk.

This focus contributed to a rise in care staff contacting us. There were more than 4,100 individual whistleblowing contacts from June 2011 to the end of the year – an average of more than 400 a month, compared with an average of around 30 communications a month previously.

As part of our new process, we undertake periodic audits of a sample of cases to analyse how whistleblowing information is being used. We conducted an audit in October 2011, using a sample of 5% of cases received between June and September 2011. This found that:

- 50% of cases resulted in the information being used to trigger or inform our inspection work.
- 61% of cases raised new concerns about a registered provider or location.
- 20% of cases resulted in us formally telling the provider to improve and supply us with an action plan.
- Just under half of the concerns raised with us were anonymous.

In December, we published a 'quick guide' on whistleblowing for health and care professionals who need to raise concerns about their workplace. It provides helpful advice on speaking out and telling CQC about poor care. We worked with partner organisations, such as the General Medical Council, the Nursing and Midwifery Council and the Academy of Medical Royal Colleges to develop this information and to promote it with their members.

Whistleblowing and warning notices result in action to protect residents at a West Country care home for adults with learning disabilities

Our new website has made it easier for staff and people who use services to tell us their experiences of care.

Ex-staff members from a home in the South West that cares for people with severe learning disabilities, including some who demonstrate challenging behaviours, used the feedback form on our website to share concerns with us about allegedly abusive practices at the home. They reported that a so-called 'quiet room' was being used for particular people in the home, some of whom were locked in the room overnight.

This information, combined with information from the local authority about an application by the home to deprive one resident of their liberty under the Mental Capacity Act (an application which the authority had turned down), led CQC inspectors to make an unannounced inspection of the care home, specifically to inspect the 'quiet room'.

Our inspectors found that a 'quiet room' did exist and three residents had been kept there overnight. The room had no heating, bedding or curtains and a surveillance camera was installed. By interviewing staff, we found that decisions over the use of the room had not involved health or social care professionals and that risk assessments over the use of the room were not in place. The room did not protect people's right to privacy, dignity, choice, autonomy, safety and representatives, relatives or advocates were not properly involved in decisions relating to the care of the people concerned.

We issued the home with two warning notices, one relating to the essential standard about respecting and involving people who use services and the second relating to the care and welfare of people who use services. We reported major concerns over five of the 16 essential standards.

A police enquiry followed our inspection report and enforcement action; both the local county council and the NHS instigated a review of the whole service and are jointly conducting safeguarding investigations at all locations managed by the provider. People at the care home we inspected were moved to new placements.

Whistleblowing as part of the NHS Constitution

The NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges that the NHS is committed to achieve.

The Constitution was updated in March 2012 as part of a series of measures intended to highlight the importance of whistleblowing in the NHS to include:

- An expectation that staff should raise concerns at the earliest opportunity.
- A pledge that NHS organisations should support staff when raising concerns by ensuring their concerns are fully investigated and that there is someone independent, outside of their team, to speak to.

Our work to promote the importance of whistleblowing and improve our processes for receiving whistleblowing information fully supports this update to the Constitution.

Information from NHS surveys

We coordinate surveys to collect feedback on the experiences of people using a range of health care services provided by the NHS.

In April 2011, we published the results of the 2010 national survey of 66,000 inpatients. The survey showed improvements in cleanliness and a reduction in the amount of mixed sex accommodation, although many other areas showed no change from the previous year.

We published the final 'Count me in' census report at the beginning of April, which looked at the ethnicity of mental health patients. The census was designed to support the Department of Health's five-year action plan for improving mental health services for Black and minority ethnic (BME) communities which ended in 2010. The report called for more collaborative work between education authorities, police authorities, the criminal justice system, voluntary organisations and BME groups to tackle the economic and social factors that contribute to higher-than-average hospital admission rates among some ethnic groups.

This was followed in August by the results of the 2011 survey of 17,000 people who use community mental health services. Eighty-six per cent of those who took part in the survey had not spent any time in hospital during the previous 12 months, underlining the importance of mental health services in the community. These findings played, and will continue to play, an important role in tracking improvement in the experience of health care for people with mental illness within the Government's new mental health outcomes strategy.

Between June and October 2011, more than 72,000 patients responded to an annual survey about their most recent visit to their outpatient department. The results showed improvements in cleanliness and people being seen on time, but treatments still require better explanation.

Information from our surveillance programme

CQC's Surveillance Team manages our 'outliers' programme, supported by major contributions from our inspection staff and professional advisors. The programme uses sophisticated statistical methods to scan the most recent health and social care information to identify unexpected performance (outliers) that may be linked to problems with the quality of care, prompting us to act.

The programme initially concentrated on higher than expected deaths (mortality alerts) – either generated ourselves from Hospital Episode Statistics or sent to us by the Dr Foster Unit. Since then, we have expanded the programme to include emergency readmission rates, some maternity indicators and controlled drugs prescribing. We plan to extend it further with work on adult social care, infections and notifications.

Over half of all cases have led to an improvement plan, many of which are taken up by our regional inspection teams for ongoing monitoring. A case can be escalated to a higher level of intervention if responses remain unsatisfactory and/or more evidence emerges about poor quality of care at the organisation.

After an initial assessment, we convene an expert panel to decide whether to follow up a case with the organisation – there have been 500 cases since 2007. Our expert panel assesses the organisation's response to the alert and decides whether the trust has provided sufficient evidence that either:

- the outlier was not related to the quality of care, or
- the concerns are no longer current, or
- they have issued a suitable improvement plan.

Examples of improvements in organisations' plans include:

- Implementing the "seven-day hospital", with no reduction in services over the weekends.
- Improved training of junior doctors.

- Better links with care homes for improving end of life care.
- Identifying and implementing best practice.
- Ensuring patients are assessed more quickly after admission.
- Patient early warning systems.
- Improved clinical diagnosis and coding.

Other regulatory responsibilities

We have a number of other specific regulatory responsibilities, most of which involve some form of inspection.

Prisons and youth offending

We carried out 27 inspections of health services with youth offending teams (YOTs), and 26 inspections of prisons.

In June, the findings of a joint programme of inspections were published, which looked at the specific interventions YOTs make regarding the health, education, training and employment of young offenders. Our inspectors joined colleagues from HM Inspectorate of Probation, Estyn, the Healthcare Inspectorate Wales and Ofsted on these inspections, which highlighted that young people were involved and supported when they were assessed on the likelihood of their reoffending. In July we published a joint report with HMI Probation which found that YOTs' management and oversight of young people's health was considerably better than it was when we last reviewed it but there was still much to be done to ensure their needs are both identified and met.

Who's looking out for the children?, a joint inspection report by CQC, HMI Constabulary, HMI Prisons, HMI Probation, the Healthcare Inspectorate Wales and the Care and Social Services Inspectorate Wales, examined young people's journeys from the point they arrive at the police station through to charge. The report found that the role of 'appropriate adult' provided to young people has evolved into being another part of the custody process, rather than safeguarding and promoting the welfare of the young person.

Children's services

We carried out 57 joint inspections of children's services with Ofsted during the year. These inspections examine the arrangements for safeguarding children, and the outcomes for children and young people who are looked after by a local authority and its partner agencies. CQC works alongside Ofsted to provide information about the contribution of health partners to improving outcomes for children and young people.

Ionising radiation

Ionising radiation, such as from x-rays or radiopharmaceuticals, is used widely in medicine, and we have a duty to enforce the Ionising Radiation (Medical Exposure) Regulations 2000 in hospitals. In the year to 31 December 2011, we received 538 notifications, reflecting a slight increase in the rate of notifications over the last three years. We made a number of inspection visits to radiology, radiotherapy and nuclear medicine departments in the acute sector and to a provider in primary care, to follow up several of the notifications we received.

Controlled drugs

In our annual report on how well healthcare organisations are implementing the safer management of controlled drugs regulations (introduced following the Harold Shipman inquiry), we found that there had been progress, with many instances of good innovative practice in the management of and sharing of concerns of controlled drugs. We reiterated the importance of ensuring that this progress is maintained and that the benefits of effective partnership working are not lost during the changes under way in primary care trusts.

Enforcement

If we find that a service is not meeting the essential standards, we take swift, targeted action to make sure it improves. The action we take is proportionate to the impact that the breach has on the people who use the service and how serious it is.

Usually, if the breach of the regulations has a minor impact on people, or the impact is moderate but it's happened for the first time, we ask the provider to send us a report setting out how they intend to address the problem and the action they will take to become compliant. Once we have agreed this, they need to tell us when they have made the necessary improvements so we can follow it up and check.

For more serious cases or where the previous action has failed, we use our stronger enforcement powers to protect people from harm or to hold the provider to account.

Types of enforcement action

We have a range of enforcement powers we can use to protect people and hold the provider to account, including placing restrictions on the service, issuing warning notices and, in the most serious cases, suspending or cancelling a provider's registration.

Warning notices were by far our most used method of enforcement in 2011/12: we served 638 warning notices on providers (an average of 12 a week).

Effective use of these enforcement tools resulted in a limited need to move to prosecution. We successfully concluded one prosecution, of a doctor operating an unregistered private hospital for cosmetic surgery. The doctor in question was found guilty of an offence under section 11 of the Care Standards Act 2000.

Investigations

In addition to our usual inspections, we have the power to carry out in-depth investigations into possible systemic failings in a care system, for example where a lack of coordination between sectors or services leads to a significant risk to the health, safety or welfare of people receiving health or social care.

During the year, we carried out three of these investigations. We began an investigation into Barking, Havering and Redbridge University Hospitals NHS Trust on 4 July 2011, focusing on maternity, elective and emergency care services provided at its two main hospital sites, as well as the governance and management systems in place at the trust.

We found problems in maternity services, including poor clinical care, abusive and unprofessional behaviour from staff, a lack of learning from maternal deaths and incidents and a lack of leadership from senior management. We made 81 recommendations to the trust, which we continue to monitor through unannounced inspections.

In November 2011, we published our investigation report into United Lincolnshire Hospitals NHS Trust's Pilgrim Hospital. Although there had been developments following feedback from two previous unannounced inspections, such as new systems to strengthen frontline management and leadership, we found more needed to be done to protect patients from the risk of poor care. Issues remained in monitoring the quality of care, the recruitment and retention of medical and nursing staff, and investigating and learning from serious incidents. We made 21 recommendations, which we checked in follow-up visits in December and found the trust had implemented actions designed to address them.

Finally, we began an investigation into emergency care services at University Hospitals of Morecambe Bay NHS Foundation Trust in January 2012, working with Monitor, the NHS foundation trust regulator.

Deterrent effect of themed inspection programmes

The initial findings from our first themed inspection programme – 100 unannounced inspections of acute hospitals looking at the issue of dignity and nutrition in wards for older people – showed that being inspected on a national issue had made providers review the way they worked. In particular, our early analysis of the impact of the programme showed that there was a strong relationship between the prospect of being inspected and improvements made by providers around issues of dignity.

We surveyed the 96 trusts that were inspected as part of this programme. Of the 74 that responded, three-quarters agreed they had made changes to the way they approach dignity and nutrition as a result of the inspection programme. And in terms of our judgments, 78% agreed or strongly agreed that our decisions were a fair reflection of performance, with only 6% of those who responded disagreeing.

Enforcement policy and judgement framework

To support the improvements we made to the way we regulate and inspect (see page 23), we consulted on changes to our Enforcement Policy and Judgement Framework. Following feedback, we published the updated documents at the end of the year.

The most significant changes, which came into effect from April 2012, were:

- Judging providers to be either compliant or non-compliant with the regulations – a change from the previous position in which a provider could be compliant but with some concerns for which we set 'improvement actions'.
- No longer making judgements about levels of concern before we judge whether a provider is compliant or non-compliant. Instead, we now consider the impact on people (which will be minor, moderate or major) after we have made a judgement of non-compliance.
- Following a clearer, more transparent enforcement process to ensuring providers achieve compliance, called the 'regulatory response escalator'.
- Publishing a summary of a warning notice and referring to this in the inspection report (unless representations about the notice are received and upheld). Previously, any warning notice was not mentioned in the inspection report – this meant that people who use services were unaware of any action being taken on a provider or manager.

Publication and engagement

Our work does not end with the inspection of a care service, and enforcement where that is appropriate. It is only done when we have published the results of the inspection on our website and updated the provider's webpages accordingly. We delivered significant improvements to giving people simple, up-to-date information about services, so that they can make decisions about their or someone else's care, and to engaging and sharing information with all our stakeholders.

Our new website

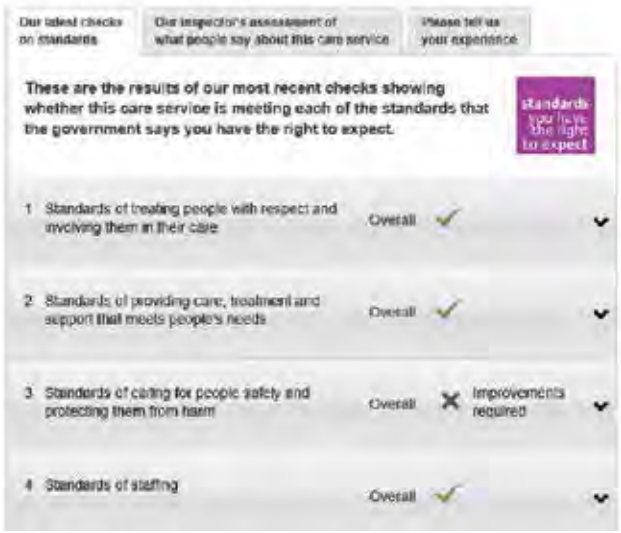
We launched a new, improved website, with a clear public focus, in October 2011. Overall in 2011/12, there were more than 1.7 million unique visitors to the website.

Groups representing the public and users of services, alongside providers and our staff, took part in workshops throughout the previous nine months to help us to develop and test both the layout and the content of the new site. To help make sure we give people the information they want and need in a way that they can understand, we carried out almost 40 one-to-one sessions with people who use services and carers to directly gather their views and see directly how they use information.

We carried out a website satisfaction survey in April 2012. Since the launch of the new site, there was a 10% increase in people who got everything they wanted when they came onto the site, a 19% rise in people who easily found information, and a 10% increase in people who thought our information was clear and easy to understand.

The new website has a page for each registered provider and each service location and uses a simple key of ticks and crosses to show whether or not a service is currently meeting the essential standards – see opposite. Visitors to the site can quickly search and compare services by name, type and location, drill down to further information about the standards and find inspection reports.

Importantly, they are also invited to directly feed back their experiences of a service through an easy-to-use online feedback form. This was developed alongside the new site and adds to the information we gather about individual services.



We publish reports on our inspections of health and social care services once a week, and collate the weekly release on a map showing all of the reports published that week – see below. We also publish a spreadsheet at the end of each month showing all the hospitals, clinics, care homes, dental practices and other health and social care services we have reported on that month.

Working with local groups

To identify where there is a risk that people could be experiencing poor care, our inspectors work with established local groups before, during and after our inspections. During 2011/12 we developed this relationship further, with separate guidance about how to work together going to:

- Local involvement networks (LINks)
- Overview and scrutiny committees for health and social care
- Local councillors
- Foundation trust councils of governors.

As well as holding regular events with LINks around the country, through our advisory group, we also ran a national development project throughout the year with 26 networks. This project is ongoing and is looking at joint working, and specifically what types of information a LINk (or a local Healthwatch body in the future) holds and may pass to Healthwatch England from October 2012.

Healthwatch

The White Paper, *Equity and excellence: Liberating the NHS* in July 2010 outlined the Government's intention to put patients and the public first by creating a new body called Healthwatch, to strengthen the collective voice of patients and the public.

Healthwatch will exist in two distinct forms – local Healthwatch and, at national level, Healthwatch England. Healthwatch England, which will be a committee of CQC, will be the new national consumer champion for patients and the public.

In preparing to launch Healthwatch in October 2012, we worked closely with the Department of Health, Local Government Association and other key stakeholders in the year. We set up a programme board and advisory group to lead and advise on the programme for Healthwatch.

To ensure that anyone who wanted to engage in Healthwatch had the opportunity, we also established an online community, which has about 800 members, to gather views and allow people to ask questions.

We also gathered the views of people who will be working with Healthwatch, including 15 regional events across the country with more than 150 people attending. The groups represented included:

- People with a range of physical and mental health issues, in Brent.
- Black and minority ethnic elders (representing local community groups), in Leicester.
- Caseworkers representing Gypsies and Travellers, in Brighton.
- Women and men of different ages from the Somali community, in Harrow.
- Men from the Pakistani community, in Halifax.
- People who use mental health services of African-Caribbean heritage, in Brent.
- Women from the Orthodox Jewish community in Salford.
- People with learning disabilities, in Tower Hamlets.
- People from the Lesbian and Gay community, in Birmingham.
- People from the Hungarian community (extended family), in Derby.
- Men from the Indian community (50+), in Derby.

Public consultations

To get feedback on our plans and activities, we regularly consult with regulated bodies, stakeholders, representative groups, as well as people who use services. **TABLE 3** shows the public consultations we carried out this year.

In particular, following the end of the previous system of adult social care quality ratings, we consulted on a new voluntary excellence award for adult social care services in England, to recognise quality over and above the essential standards.

We were clear from the outset that any award needed to be supported by the sector, and without that it should not proceed. The consultation confirmed a lack of support so, after discussion with the Department of Health, we confirmed that we would not be proceeding with the adult social care excellence award.

Since that decision, we have been working with the Association of Directors of Adult Social Services to develop a mandated dataset of adult social care performance above compliance with the essential standards, in order to influence sector-led improvement.

Table 3

CQC public consultations in 2011/12

Topic	Dates
Excellence award scheme	May – August 2011
Judgement framework and enforcement policy	September – December 2011
Fee scheme for registered providers in 2012/13	October 2011 – February 2012

Customer service

Our National Customer Services Centre (NCSC), based in Newcastle, is central to the delivery of a good and effective customer service for the sectors we regulate. Throughout 2011/12, the NCSC's focus has been on a positive customer experience, proven efficiency and effectiveness in processing high volume transactions, and delivering value for money.

The NCSC received more than 213,000 calls in 2011/12, and achieved all of its customer service targets. Most notably, the NCSC:

- Answered 94% of specific calls about mental health within 20 seconds.
- Answered 94% of safeguarding calls within 20 seconds.
- Answered 84% of registration calls within 20 seconds.

The NCSC took part in National Customer Service Week in October 2011. We are a corporate member of the Institute of Customer Service, which promotes the week, and it was an opportunity to raise awareness internally of the vital role that customer service plays and develop closer working between the NCSC and the other business areas of CQC.

Online provider communities

Engagement with the providers we regulate is a constant activity, across all the care sectors. We host several online communities that act as provider reference groups. We use these communities to post ideas, policies or documents, or ask questions, in order to inform people, create discussions and gain feedback.

In March 2012, we had communities covering the following sectors. The numbers in brackets show how many individuals had signed up in each community:

- NHS services (452)
- Adult social care (707)
- Independent healthcare (317)
- Dental services (641)
- Independent ambulance services (118)
- Primary medical services (515).

Stakeholder Committee

In 2011, we reformed our various stakeholder advisory groups, improvement boards and reference groups with the aim of delivering better and more effective results for both stakeholders and CQC.

Under the Health and Social Care Act, CQC has a statutory duty to have an advisory committee. Until 2011, this role had been fulfilled solely by the Provider Advisory Group, made up of representatives of NHS, adult social care and independent healthcare providers; it did not have representation from people who use services or from new in scope providers. A variety of other external groups also existed, with differing governance arrangements and sometimes overlapping remits. Internal and external feedback indicated that, although welcome as a way of engaging, it was not clear what the objectives of these groups were, at what level they were supposed to engage with CQC, or whether they had any positive impact on CQC's work.

We therefore created a single Stakeholder Committee to give a broader range of representative stakeholder groups the opportunity to engage with the Board and senior CQC management. Chaired by John Harwood, the Committee provides strategic and policy advice to the Board and the Executive Team about the implications of the way in which CQC carries out its functions.

The Committee is made up of around 20 invited representative bodies (umbrella organisations where appropriate) representing people who use services, care providers, campaign groups and policy shapers in all CQC-regulated sectors, and care professionals.

It is a single committee, meeting twice yearly and timed around Board meetings to allow the Board to ask the committee for advice on specific topics. The Committee can also set up sub-committees to look at specific themes or issues and offer advice on these to CQC.

Advisory groups

As part of this change, we set up external advisory groups for specific pieces of CQC work on a 'task and finish' basis. In line with good project management principles, these groups help ensure that what is being developed is effective and practical, and that those groups impacted by the work are engaged early in the process.

To support the development of these advisory groups, we drew up and maintained a 'stakeholder register' that included all members of previous stakeholder groups and boards. If a project needs stakeholder input via an advisory group, we can draw up a list of proposed members from the register to ensure a balanced representation of interests and involvement. We will add to this register over time.

External advisory groups that provided valuable advice, support and challenge on specific pieces of work in 2011/12 included the dignity and nutrition groups, the domiciliary care group and the GP advisory group.

Engaging with clinicians and professionals

We employ eight National Professional Advisors who give us advice on best practice. They include a GP, a cardiac surgeon, a radiologist, a nurse, a dentist, a senior social care manager, a psychiatrist and an ambulance and emergency care manager.

In December 2010, CQC's Board asked Professor Deirdre Kelly, a CQC Board member, to convene a group to advise how we could improve our engagement with clinicians and professionals and use their advice and support more to improve our regulatory model.

Professor Kelly created a Specialist Advice Advisory Group, made up of clinicians and professionals, as well as representatives from a variety of Royal Colleges, societies and organisations. This group made three recommendations about how CQC could engage with clinicians and professionals and access their specialist advice:

- Review the ways we deliver our regulatory model and present our findings to make them as relevant as possible to clinicians and professionals.
- Extend the use of clinical and professional 'expertise' in our regulatory activity.
- Develop a variety of mechanisms to communicate more effectively with clinicians and professionals.

Many of the actions to support these recommendations are covered elsewhere in this report. In support of the third recommendation, we began to develop regional (on top of national) relationships with a number of Royal Colleges to help with exchanging information of mutual interest about providers. Similar discussions with the professional regulators have also taken place. In addition, in February we launched a new monthly e-newsletter to communicate more directly with health and social care professionals.

We also began to develop a 'bank' of specialist advisors, and started to recruit clinicians and professionals to this bank. Staff will be able to request advice and support in the following: allied health professionals, dentistry, midwifery, medical expertise, nursing and social care services.

Working with other bodies

The Public Bodies Act 2011 and the Health and Social Care Act 2012 both had implications for CQC. The Public Bodies Act introduced the proposal that the Human Fertilisation and Embryology Authority and the Human Tissue Authority be abolished and their functions transfer to other relevant bodies, including CQC. We have been working with both bodies to streamline our inspection processes in anticipation of a consultation by the Department of Health on the transfer of functions.

The Health and Social Care Act 2012 introduced the concept of joint licensing with Monitor, and the reconfiguration of how NHS services are provided and commissioned. We have been working with Monitor and new bodies including the NHS Commissioning Board to ensure we are working together effectively in the regulation, monitoring and oversight of NHS-funded services. Under this Act, the National Information Governance Board will also become a Committee of CQC and work is progressing in anticipation of this happening in 2012/13.

Developing and supporting our staff, and making operational efficiencies

We took significant steps this year to build our capacity as a nationwide regulator that can work locally and across the whole of England. We recruited more compliance inspectors and managers, focused on leadership and performance development, and consolidated our regional structure.

Recruiting and inducting new inspectors

In line with our commitment to inspecting more services more often, we spent the year working to make sure our inspection staff were resourced to do this. In October 2011, the Department of Health authorised us to increase our staff numbers by recruiting additional compliance inspectors and managers. We carried out a large national advertising campaign and began a rigorous process of shortlisting and assessment centres that meant that we have been able to identify and recruit high calibre candidates.

Our compliance inspectors and managers are the public face of CQC, meeting with providers, people who use services, their families and others involved in care services. It is important that the people in these roles receive the best orientation and training as soon as they join us. To ensure this, we created a new, bespoke induction programme (see box) and rolled it out in the middle of the year.

Induction programme for new inspectors

To support new inspection staff, our Learning and Development team, together with members of our existing inspection teams, developed a new eight-week induction programme. This is the first time we have provided a role-specific, national scheme on this scale.

The programme is divided into corporate learning days, covering topics such as safeguarding, enforcement and engaging with people who use services, and regional days, shadowing experienced inspectors to see how they carry out their inspections, compile inspection reports and deal with other day-to-day business. Each new inspector is assigned two mentors (known as 'buddies') to support their practical development – for example, explaining what to look for when assessing services in a care home, or writing up the inspection report for an NHS trust.

The programme has been well received. Annabelle Stigwood, who began working as a compliance inspector in mid-January, commented at the end of the process: "I believe that the interrelation of the regional days and corporate days has provided a balanced and considered approach to the introduction and training. Not only have I learned best practice, but the reasoning behind this and how to implement this on inspection.

"Eight weeks have passed and now, as intended, I am up and inspecting, writing reports and dealing with notifications and enquiries. I already feel like a valuable part of the team and I am thoroughly enjoying the challenges that every day brings."

We also overhauled training for all staff to make sure it was embedded in all our work programmes. One important piece was an online tool for staff to highlight the importance of key people management policies and our employee values and behaviours. For this, our People Development team were shortlisted in the 'e-learning project team of the year' category of the prestigious 'e.learning age' magazine.

Leadership and performance development

In 2011/12, we focused on initiatives to promote better management and performance across the organisation. A new leadership group meets regularly to share progress on business planning, and promote greater joint working between different teams.

We introduced staff excellence awards in the year, to acknowledge those members of staff who display CQC's employee values and behaviours to a high degree. Any member of staff can nominate a colleague. The focus is less on what they do, and more on how they do it – for example, supportiveness shown to colleagues, integrity in their work, or their contribution to change and innovation.

The James Mayes Award is a foundation set up by James' family and sponsored by CQC. James was a Healthcare Commission analyst who was killed in the London bombings on 7 July 2005. The award provides opportunities for CQC staff to take up a research and self-development placement to help improve knowledge and thinking about improving standards of care. The 2011 recipients investigated Australia's experience of outcome measurement in mental health services, and patient survey information from a Dutch consumer index.

We are committed to creating and maintaining an environment where dignity is important and everyone treats each other with respect. We have zero tolerance for bullying in the organisations we regulate and zero tolerance within CQC. We were proud to take part in Anti-Bullying Week in November 2011, a campaign run by the Anti-Bullying Alliance. This campaign's focus was on verbal bullying, with the slogan "stop and think – words can hurt".

Job evaluation and reward review

When CQC was formed, we inherited the different grade, salary and benefits structures that existed in our predecessor commissions. Instead of one, single CQC pay and reward structure, we had four different ones. This led to inconsistency and unfairness, for example staff doing the same or similar jobs being paid quite differently simply because of the commission they used to work for.

We committed to a job evaluation and reward review programme to resolve these issues and ensure that people are rewarded fairly, in a way that is competitive with the market and that attracts and retains capable and committed people. This work continued throughout 2011/12, but the impact of the public sector pay freeze meant that we were not able to complete the programme as soon as we wanted.

Negotiations on a new pay and grading structure reached a conclusion in January 2012, and an offer was put to the various unions so that they could consult with their members. The negotiations were robust, reflecting a genuine desire on both CQC's side and the unions' side to reach a jointly agreed settlement. The first offer was rejected by a very slight majority, but a revised offer was accepted in March and the new pay and grading system came into effect from 1 April 2012.

Equality and human rights

Equality and human rights are embedded in the way we check whether providers of health and adult social care are meeting the essential standards. We also make sure that people's human rights are protected by checking that services treat them fairly, with respect and dignity and that they are given choice and control over the care they receive.

In July 2011, we published our progress in delivering our equality and human rights scheme, and followed this up at the end of the year with a set of nine equality objectives. These provide focus for our work, covering both how we regulate to ensure equality and how we ensure that our own staff have equality of opportunity. We consulted widely in developing the objectives, including our staff, our Board, our eQuality Voices group and our SpeakOut network.

In October, we joined with the Equality and Human Rights Commission to produce guidance for our compliance inspectors and registration assessors on the equality and human rights aspects of the essential standards.

Diversity in our workplace

It is fundamental that we promote equality and challenge discrimination when we see it in our work as a regulator, but this is just as important to CQC as an employer. To work effectively, we need to draw on the knowledge and skills of a diverse workforce. One of the ways we do this is through our staff networks: the Disability Network, the Lesbian, Gay, Bisexual and Trans Equality Network, and the Race Equality Network.

These groups review our actions, behaviours and policies to see how they impact people who have experienced discrimination.

Stonewall

The good work of our staff networks was highlighted in this year's workforce equality index. This is run by Stonewall, an organisation that promotes workplace equality and access to and delivery of services that are inclusive of the needs of the lesbian, gay and bisexual community. This index allows us to benchmark ourselves against other private and public sector organisations, and monitor our progress over time. This year we jumped nearly 100 places, from 252nd in 2010/11, to 157th. Ashley Thomas, from Stonewall, commented:

> "CQC's improved performance in the Stonewall Workplace Equality Index 2012 is commendable as, crucially, it has happened as a result of two processes happening at the same time: the organisation's effective investment in the equality and human rights agenda; and the vital contributions made by the well-supported LGBT network group. At CQC, gay staff generally feel able to be themselves at work, reflecting the fact that role models are visible at various levels within CQC."

Equality data

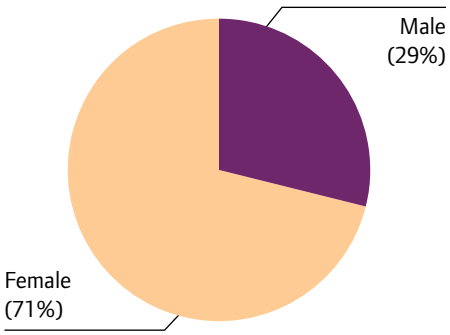
This year there was a new duty for public sector organisations to publish information about equality in their services and workforce. We published our report, *Equality in our workforce*, in January 2012, showing the profile of staff working for CQC at 30 September 2011.

Key figures included:

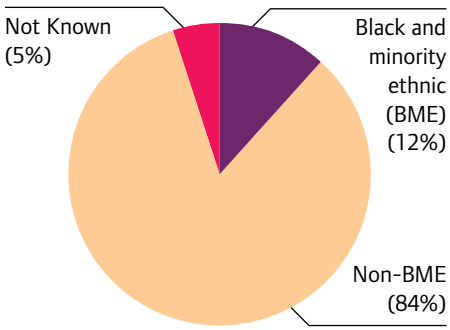
- Fewer than 5% of staff were under the age of 25.
- 5% of staff had a disability.
- Staff from Black and minority ethnic communities (nearly 12%) were under represented in higher pay grades.
- A higher percentage of new recruits were male.

CQC staff as at 30 September 2011

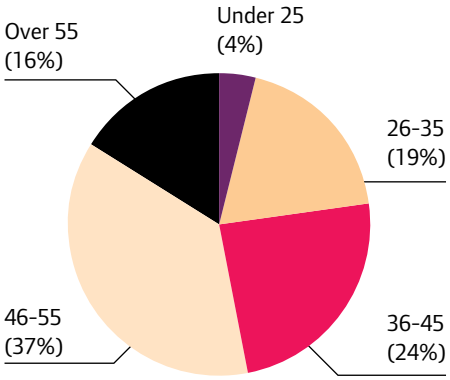
Gender



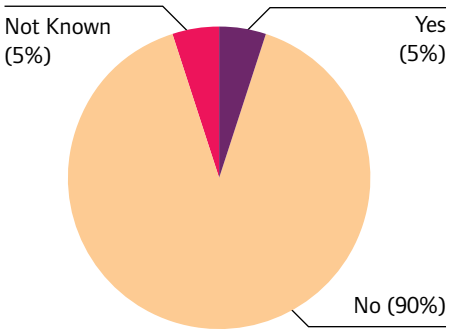
Ethnic origin



Age group



Declared disability



Religion and belief: we did not know the religion or belief of 64% of staff. We believe that this was mostly due to missing data rather than people actively choosing not to disclose their religion or belief. Encouraging staff to report their religion and belief is a key objective for CQC in 2012/13.

Sexual orientation: we do not know the sexual orientation of 50% of staff. Again, we believe this is mostly due to missing data rather than people actively choosing not to disclose their sexual orientation. Improving this data is a key objective for CQC in 2012/13.

Improving financial and operational efficiencies

We have made substantial progress in 2011/12 in improving financial and operational efficiencies, and improving our management information.

We work within Government requirements for efficiency and economy. We comply with the Centralising Category Procurement requirements and work with the Procurement Centre of Expertise. During 2011/12, our Procurement Team worked towards collaborative procurements across the Department of Health family.
The Government Procurement Service (GPS) underwent significant transformation in the year with a new remit to deliver centralised procurement. Examples of this collaboration included new travel management and office solutions contracts.

In October 2011, we moved our transactional finance operations to NHS Shared Business Services which uses a shared services business model to achieve economies of scale and demonstrate innovation and best practice.

Following new Government guidance in 2010, our aspiration has been to pay 80% of all undisputed invoices from suppliers within five working days. We exceeded the target in 2011/12.

We updated our estates strategy to reflect new Government property controls. As a result, we closed our own office in Preston and moved into the Guild Centre, an office owned by the Department for Work and Pensions. We also signed up to the Civil Service meeting rooms scheme which means our staff can access spare meeting rooms in Government buildings across England at no cost to CQC.

During the year, we awarded a new information and communication technology contract as part of a shared initiative with the Department of Health and other arms length bodies. The new contract fully supports the Government's aims for sustainable ICT services and aims to reduce the cost of the provision of back office services across government. It will provide a scaleable, robust and cost-effective ICT service and will start later in 2012.

Consolidating our regional structure

At the end of the year, we moved from nine operating regions to four. The aim was to align our boundaries with those of the NHS Commissioning Board and the way the government is organising its relationships with adult social care. The move also means that we can help our staff inspect more services closer to home, and it will also help us develop better strategic and information-sharing relationships with many of our key stakeholders.

Listening to complaints

We welcome comments and suggestions about our performance and the conduct of our staff, and this includes complaints. We investigate every one and use the feedback to help develop and improve how we go about our work.

During 2011/12, we received 495 complaints about CQC. Of these, 448 were successfully resolved at stage 1. In the other 47 cases (9%), the complainant requested a stage 2 review by our Complaints Review Service. The majority of stage 2 complaints related to staff performance and conduct, and policies, procedures and methodologies.

Twenty-nine complainants asked the Parliamentary and Health Service Ombudsman to review their cases, but none were passed to the investigation stage.

Our Board

Dame Jo Williams, Chair

Jo Williams was the former Chief Executive, Royal Mencap Society. She is also the former president of the Association of Directors of Social Services and a champion for social care services throughout a career in local government. During the year she was appointed to the Commission on the Funding of Care and Support. She is a vice chair of Everychild and the Dartington Hall Trust. Jo is also a fellow of the City & Guilds of London Institute.

Jo Williams is Chair of the Remuneration Committee (a board sub-committee).

Professor Deirdre Kelly

Deirdre Kelly is Professor of Paediatric Hepatology, Birmingham Children's Hospital and former Trust medical director.

She was the Interim Chair (until April 2012, and thereafter appointed as Chair) of the Audit and Risk Assurance Committee (a board sub-committee). She is a member of the Advisory Committee on the Safety of Blood, Tissues and Organs and the Advisory Group on Hepatitis.

She is a Governor of the Health Foundation. Deirdre Kelly was President, Chair or Past President of various national and international medical organisations and medical advisor to a number of national patient organisations.

John Harwood

John Harwood is a former senior civil servant and local authority chief executive.

He retired in 2008 from the Food Standards Agency where he was the chief executive. He served for almost 20 years as the chief executive of Lewisham Borough Council and of Oxfordshire County Council.

In 2000, he moved to central government to be the founding chief executive of the Learning and Skills Council. He spent 2004 as the interim chief executive of Cumbria County Council before later moving to the Food Standards Agency.

John Harwood is Chair of the Stakeholder Committee and also sits on the Audit and Risk Assurance Committee and the Remuneration Committee (board sub-committees).

Professor Martin Marshall CBE

Martin Marshall is the Professor of Healthcare Improvement at UCL. He is also the lead for Improvement Science London, a new initiative to promote the science of improvement across the three London Academic Health Science Centres.

Prior to his current role, he was the Clinical Director and Director of R&D at the Health Foundation. He has previously worked at the Department of Health and the National Primary Care Research and Development Centre at the University of Manchester.

Martin has been a general practitioner for over 20 years and is a fellow of the Royal College of General Practitioners, the Royal College of Physicians and the Faculty of Public Health Medicine. He was a Harkness Fellow in Health Care Policy in 1998/99 and has written over 150 publications in the field of quality of care. In 2005 he was awarded a CBE for services to health care.

Martin is a member of the Audit and Risk Assurance Committee (a Board sub-committee).

Kay Sheldon OBE

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

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

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

Kay Sheldon is a member of the Remuneration Committee (a board sub-committee).

Our Executive Team

Cynthia Bower, Chief Executive

In 1995, Cynthia became Director of Primary Care for Birmingham Health Authority, coinciding with the establishment of Primary Care Groups and the first wave of primary care trusts. In 2000, she became Chief Executive of Birmingham Specialist Community Health NHS Trust; 2002 Chief Executive of South Birmingham PCT; August 2005 Managing Director of Birmingham and the Black Country SHA; and in July 2006 she became Chief Executive of NHS West Midlands.

In July 2008, Cynthia Bower was appointed Chief Executive of CQC, which took up its duties as the regulator for health and social care on 1 April 2009.

Cynthia announced her intention to resign from CQC with effect from July 2012.

Jill Finney, Deputy Chief Executive

Jill is CQC's Deputy Chief Executive and also leads the Strategic Marketing and Communications directorate.

Jill previously worked in senior roles in marketing and communications spanning a number of industries, both in the public and private sector.

Before joining CQC, Jill was the Strategic Marketing and Communications Director for The British Library, where she led the successful opening and running of the award-winning Business and Intellectual Property Centre, which services 60,000 entrepreneurs a year. During this time, she was also a member of the Advisory Council for Libraries.

Allison Beal, Director of Human Resources

Allison has worked in the public sector for over 20 years, after initially joining Customs & Excise on their Management Development Programme.

Before joining CQC, she held a number of senior posts in government departments and agencies including an Executive Director post with responsibility for Finance and HR in another health sector arm's length body.

Allison has extensive experience of delivering major and complex change programmes.

Louise Guss, Director of Governance and Legal Services

Louise is a solicitor who commenced her career in private practice before moving into the public sector within the legal departments in a number of local authorities. She has been in practice for 18 years.

She specialises in the law in relation to social and health care and in the provision of corporate advice and risk. She retains an active interest in mental health, human rights, child protection, education law and practice and alternative dispute resolution.

Louise is a member of the Chartered Management Institute and the Women's Solicitor Association. She also has a MBA and Post Graduate Diploma in Management and is a qualified Counsellor.

Philip King, Director of Regulatory Development

Philip has over 20 years of experience of working in the health care sector and other associated fields. He has a twin professional background as a nurse and a barrister and has worked for the NHS in a number of senior posts in provider and commissioner roles.

Immediately before joining the CQC, he was Director of Nursing and Governance in a NHS Foundation Trust. Philip also has experience of working in policy and representation in the British Medical Association, the Royal College of Nursing and the Law Society where he was a policy advisor on law reform related to mental health, mental capacity and disability issues.

Philip was one of the team of lawyers at the European Court of Human Rights who successfully represented a person with a learning disability. This case contributed to the call for legislation that resulted in the implementation of the Mental Capacity Act 2005.

John Lappin, Director of Finance and Corporate Services

John has previously held a number of senior finance roles in both the private and public sectors including Ladbroke Group plc, Rexel S.A. and Parcelforce and he was Finance Director at Royal Mail Letters and Genesis Housing Group. He qualified as a Chartered Accountant at PricewaterhouseCoopers.

He has extensive experience of major change management programmes, efficiency reviews and transformation programmes and has been engaged with the Department of Health in transferring non-core activities to outsourced shared service providers.

Amanda Sherlock, Director of Operations Delivery

Amanda joined CQC from one of the predecessor organisations, the Commission for Social Care Inspection, where she was Regional Director for the South East. With a professional background as an Occupational Therapist, her career to date has included senior management roles in health, regulation and the NHS Executive, including leading the transition programme to establish national regulatory bodies.

Corporate governance and financial statements

Corporate governance

1. Statutory background

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

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

2. Principal activities

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

3. Organisational structure and governance

3.1. Board membership

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

Olu Olasode chose not to seek re-appointment when his term of appointment expired on 31 October 2011. He had been a Board member since 1 November 2008 and was chair of the Audit and Risk Committee (since re-titled the Audit and Risk Assurance Committee).

3.2. Roles and responsibilities of the Board

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

Board members must also:

- Ensure that high standards of corporate governance are observed at all times.
- Set the overall strategic direction of the Commission within the policy and resources framework agreed with the Secretary of State.
- Ensure that the Commission operates within the limits of its legal framework and any delegated framework agreed with the Secretary of State and the Department of Health and in line with any other conditions relating to the use of public funds.
- Ensure that the Commission, in reaching decisions, engages fully in collective consideration of the issues, taking account of the full range of relevant factors, including any guidance issued by the Secretary of State and other relevant central Government departments.
- Seek to discharge the Commission's functions effectively, efficiently and economically.

3.3. Register of interests

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

3.4. Independent Members

	Date appointed	Term of office
Julian Duxfield (Remuneration Committee)	First appointed 17 Nov 2009 for a period of 2 years. Renewed for a further period of 2 years	2 years
John Butler (Audit and Risk Assurance Committee)	1 December 2010	2 years

3.5. Committees, meetings and attendance

3.5.1. Remuneration Committee:

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

Membership

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

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

The Committee met five times during the year and approved the Chief Executive and Directors' remuneration taking into account the appropriate Government guidance on Very Senior Managers' pay. It has also continued to oversee the programme to review CQC's pay and grading and reward and recognition arrangements for staff.

3.5.2. Audit and Risk Assurance Committee:

This Committee has been formed as a sub-Committee of the Board to provide independent assurance on CQC's risk management, governance and internal control. During the year, the role of the Committee was reviewed and its title changed from Audit and Risk Committee, to Audit and Risk Assurance Committee (and the Terms of Reference amended accordingly). This reflects the change of emphasis in line with best practice, for the focus of the Committee's work to be upon obtaining assurances from the Executive and providing assurances to the CQC Board about the effectiveness of the arrangements, systems and processes for risk management and internal audit.

To further augment the Committee an additional independent member was recruited during the year to join the Committee from 1 April 2012.

Membership:

- Professor Deirdre Kelly (Interim Chair, from 1 November 2011 and since appointed Chair from 1 April 2012),
- Professor Martin Marshall,
- John Harwood, (appointed following the departure of Olu Olasode to fill the vacancy created by Professor Deirdre Kelly becoming interim Chair of the Committee),
- John Butler (independent member).

The previous Chair of the Committee chose not to seek re-appointment to the CQC Board at the expiry of his term of appointment. Professor Deirdre Kelly was appointed as Interim Chair of the Committee from the 1 November 2011, pending the recruitment of additional Board members to current vacancies. John Harwood was then appointed to the Committee to fill the remaining vacancy.

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

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

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

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

- Review and oversight of the preparation of the annual report and accounts for the approval of the Commission.
- Review of the Commission's systems of internal control and risk management, in particular as regards analysis of strategic regulatory risks within and across the health and social care sectors, and information governance and security risks.
- Review of the strategic risk register and providing recommendations to the Board.
- Reviewing the arrangements for detecting and investigating fraud.
- Approving an internal audit plan and monitoring the effectiveness of internal audit.
- Reviewing the adequacy of management actions in response to audit recommendations and that satisfactory progress is made on implementation.

The Committee met five times during 2011/12 and made regular reports to the Board on its activities following each meeting. The Interim Chair in addition called a review session in November to review the ways of working for the Committee and its work priorities.

The Comptroller and Auditor General (C&AG) is appointed by statute to audit CQC. As external auditor, he had the right of direct access to the Chair of the Committee. The Commission's external auditor did not provide any additional services to the Commission during 2011/12.

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

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

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

3.6. Executive Team

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

Executive Team		Date appointed
Chief Executive	Cynthia Bower	1 Aug 2008
Deputy Chief Executive and Director of Strategic Marketing and Communications	Jill Finney	24 Feb 2009
Director of Finance and Corporate Services	John Lappin	1 May 2009
Director of Operations Delivery	Amanda Sherlock	1 Jul 2010
Director of Governance and Legal Services	Louise Guss	1 Jul 2010
Director of Human Resources	Allison Beal	2 Aug 2010
Director of Regulatory Development	Philip King	1 Oct 2011

Amanda Hutchinson acted as Interim Director of Regulatory Development from 18 April to 30 September 2011.

Directors leaving the organisation during the year were:

Former Executive Team members		Date appointed
Director of Regulatory Development	Linda Hutchinson	1 Apr 2009 to 30 Apr 2011
Director of Intelligence	Richard Hamblin	1 Mar 2009 to 31 Dec 2011

Cynthia Bower has announced her resignation, and will leave CQC at the end of July 2012.

Management commentary

1. Review of activities

CQC regulates providers of:

- **Adult social care services** (such as care homes, nursing homes, and home-care agencies).
- **NHS services** (including hospitals, NHS trusts and foundation trusts, ambulance services, and community services etc).
- **Independent health care services** (including hospitals, clinics and private ambulance services).
- **Dental services**.
- **Independent out-of-hours medical services** (brought into regulation by April 2012).

In addition, by the end of March 2013, CQC will register an estimated 8,500 primary medical care providers in preparation for regulation from 1 April 2013.

Our functions are:

- **Registration**
  All service providers, which apply to register with CQC must state whether (or not) they are compliant with all the essential standards of quality and safety. CQC then decides whether to register them (usually with specific conditions that have to be met), or whether to reject their application.
- **Inspection and monitoring compliance**
  Monitoring compliance with the essential standards and regulations is an ongoing process. CQC uses inspections, information and intelligence to monitor compliance. We plan to inspect the majority of providers/locations at least once a year (dental providers every other year) both to identify poor care and to act as a deterrent. In addition, other responsive and thematic inspections are undertaken.
- **Enforcement**
  CQC uses a range of enforcement powers to take swift, targeted action where services are failing people who use them. We also share information with those who commission services and with others with responsibility for ensuring quality and safety in health and social care systems (such as other regulators).
- **Publication**
  We publish relevant, up-to-date information for the public about health and social care services and the profile pages on individual providers are placed on our website. We also publish the results of the broader thematic inspections that we undertake and present a report to Parliament describing the state of health care and adult social care services in England.
- **Additional powers and responsibilities**
  We have responsibilities for protecting the rights and interests of patients detained in England under the Mental Health Act 1983 (Section 120). We work in partnership with a number of organisations, including local groups and authorities, to share information to identify risks to people's safety and wellbeing. We also inspect children's services jointly

with Ofsted, youth offending services with HMI Probation, and prison healthcare with HMI Prisons.

In 2011/12, our delivery priorities were to:

- **Register 'new in scope' providers:** complete the registration of dental care, private ambulance and primary medical care providers (during the year, the Government delayed primary medical care registration until 2012/13).
- **Deliver and evaluate our new regulatory model:** ensure it is focused on quality and eliminating poor quality care, and is centred on people's needs and protects their rights.
- **Embed, improve and refine our regulatory model:** continuously improve our model, and equip our staff with the tools, competencies and skills to apply consistent and effective judgements, informed by user voice and responding to discrimination and inequality.
- **Deliver our other statutory and related regulatory duties:** ensure that the rights of people who are subject to the powers of the Mental Health Act are upheld, carry out our statutory and other inspection functions, and modernise our mental health operations.
- **Provide public-facing, accessible, accurate and up-to-date information** about care services to help users and commissioners make choices and to ensure transparency around CQC's operations.
- **Prepare for future developments:** plan for changes arising from the Health and Social Care Act 2012; Public Bodies Act 2011; and the wider changes in health and adult social care.
- **Improve our efficiency and performance:** through effective internal working and efficient processes, measure and manage our performance through robust management information.
- **Value our staff:** implement a programme of leadership development, job evaluation and a new reward strategy for CQC employees.

In 2011/12 we completed the registration of dental care providers and private ambulance services and 'out of hours primary medical services'. Our performance on 'business as usual' registrations has improved over the year, to a point where an average of 73% of registration applications were processed within eight weeks. In the latter part of the year our registration teams dealt effectively with a higher volume of activity related to re-registering care homes formerly owned by Southern Cross Group plc.

We achieved our targets of carrying out scheduled inspections of 100% of NHS providers; 62.5% of adult social care and independent healthcare locations (those registered by February 2011); and 15% of dentist locations by the end of March 2012. In total in 2011/12 we carried out scheduled inspections of over 11,000 locations, requiring almost 17,000 site visits. Our dignity and nutrition inspections were well received and prompted changes across the NHS. Seventy-four per cent of the trusts we inspected said they had made changes to the way they looked at dignity and nutrition as a result of the inspections. Our scheduled inspection targets are explained on page 12.

Having listened to what providers and the public told us, and building on what we have learned in the last two years, we consulted widely in September on proposed changes to the way we regulate. These changes which will ensure our inspection processes are easier to understand, more consistent and less time-consuming for providers, have been developed throughout the year, and came into effect for all inspections that start on or after 1 April 2012.

Our new website is already making a difference to how people can use the information we publish, making it easier for them to make choices about care or to raise concerns with us.

2. Our priorities for 2012/13

The CQC Business Plan for 2012/13 sets out CQC's three main priorities:

- **Deliver and improve our regulatory and other functions**
  We will be introducing a new compliance model and registering primary medical care services. Under the new compliance model we will inspect all NHS trusts, and independent health and adult social care services once a year, and all dental care locations once every two years.
- **Develop a new strategy for CQC**
  Since formulating our current strategy in 2009/10, there have been a number of changes to our responsibilities and functions, and significant changes are underway in health and social care. The first Department of Health capability review of CQC made a number of recommendations that we will also be reflecting in our strategy.

  We have made significant progress in preparing for the establishment of Healthwatch England, the proposed new national consumer champion for health and social care which is planned to be operational from October 2012.
- **Manage and develop our organisation, people and resources**
  We continue to need to recruit, maintain and develop an effective workforce ensuring we maintain frontline inspector numbers at acceptable levels and provide them with effective induction and development training. It also means managing our other resources effectively – including measuring and reporting on our performance and how we deliver value for money, and ensuring we deliver effective governance.

3. Financial performance and position

Details of our financial performance are shown in the section on 'Financial statements' in this report and show that the Commission's net expenditure for the year including finance costs was £60.9m and was within our approved budget (2010/11: £59.0m).

Whilst the net expenditure increased by approximately £1.9m from 2010/11, there are a number of factors that contributed to the movements in the year:

Staff costs increased due to a decrease in the premium of £26.1m in 2010/11 for Local Government Pension deficits as a result of a change to the calculation for future pension benefits.

Other expenditure reduced by £18.8m which was a result of the cessation of transitional expenditure, which accounted for £14.8m in 2010/11. The full year impact of previous efficiencies, such as the impact of decommissioned IT systems and the closure of St. Nicholas Building in Newcastle in 2010/11 led to further reductions.

There were further estates strategies implemented in the year which are noted in section 9 of this report which led to savings for CQC and the Department of Health.

Depreciation and impairment of assets increased by a combined total of £5.2m following a reduction to the useful asset life of IT assets which will no longer be used following the transfer to the new Department of Health IT contract and also due to impairment of old compliance and registration systems which were replaced by new software development systems.

During the year income has increased by £8.4m. The increase was due to additional income resulting from the implementation of a new fee scheme to replace legacy schemes covering social care, healthcare and NHS Trusts and included income from the registration of primary dental care providers and independent ambulances for the first time from 1 April 2011. Registration fees are now invoiced annually on the anniversary of the registration and recognised as income over the following 12 months. Statutory fees relating to future accounting periods are treated as income in advance at the end of each accounting period.

The new fee scheme reflected this amendment to billing patterns and an amount of £35.2m was billed in advance at 31 March 2012. This is shown in the "Statement of Financial Position" which notes an asset less current liabilities position of £6.4m at the year end.

The revenue budget for the financial year ending 31 March 2013 has been agreed with the Department of Health and the organisation has sufficient liquidity for the next financial year.

Capital expenditure within the year was £12.4m. This has enabled, for example, CQC to launch up to date information (Provider Profiles) for each regulated service on the CQC Internet giving the public a clear view on each provider and the associated inspection reports. Another online feature CQC has introduced in 2011/12 is the ability to submit death notifications for a registered provider or a service user online. This has reduced the volume of postal notifications received by the national customer service centre and staff processing time.

CQC's net expenditure is funded from grant-in-aid provided by the Department of Health. Grant-in-aid totalled £45.3m (2010/11: £92.3m) in the year including £12.0m designated as capital grant-in-aid.

4. Key performance indicators

Key performance indicators used by the Care Quality Commission are set out below:

	2011/12 outturn	2010/11 outturn
Business As Usual registration – new and variation applications		
Number of applications completed under HSCA Act 2008	42,500	15,699[1]
% of applications completed within target (less than 8 weeks)	72.8%	43.5%
Compliance inspections[2]		
NHS trusts with at least one scheduled inspection undertaken	109	179
Adult social care and independent healthcare locations with at least one scheduled inspection undertaken[3]	9,818	1,931
Dentist locations with at least one scheduled inspection undertaken[4]	1,432	1
Number of responsive inspections completed (responsive inspections are undertaken outside of scheduled inspections, where we have concerns about whether essential standards are being met).	2,589	791
Enforcement action		
Number of warning notices served[5]	638	Reported from 2011/12
Number of prosecutions	1	3
Mental Health Act function		
Number of MHA Commissioner visits to Mental Health Service locations	1,502	1,565

	2011/12 outturn	2010/11 outturn
Number of patients seen by MHA Commissioners	4,478	Reported from 2011/12
Number of SOAD (Second Opinion Appointed Doctor) visits	12,013	13,763
Number of Mental Health Act complaints received[6]	547	666
Complaints, governance information and call handling		
Number of requests under Freedom of Information, Data Protection and Information sharing legislation	1,403	1,219
Compliance rate in responding fully to applicants within the statutory time limits (20 working days for freedom of information and 40 calendar days for Data Protection Act requests)	97.8%	96%
Number of calls received at the National Customer Services Centre and the (%) answered within 20 seconds	See a. to d. below (new in 2011/12)	72%
	213,536	345,218
a. Safeguarding calls	94%	N/A
b. Mental Health	94%	
c. Registration	84%	
d. All other calls	85%	
The number of whistleblowing contacts CQC received	4,147	N/A started June 2011
Number of visitors to our provider profile pages on our website.	357,119[7]	N/A started October 2011
The number Stage 1 corporate complaints received proceeding to Stage 2[8]	47	51
Human resources		
Average vacancy rate (frontline staff) across the year	17.89%	Reported from 2011/12

1 Covers the period from 1 October 2010 to 31 March 2011.

2 Figures shown here for 2010/11 and 2011/12 relate to locations that had at least one inspection under the Health and Social Care Act 2008 (HSCA). Last year in our annual report we showed the total inspections under both the Care Standards Act 2000 and the HSCA. Our scheduled inspection targets are explained on page 12.

3 Of those registered before 01/02/2011.

4 Of those registered before 01/10/2011.

5 Refers to all Warning Notices served. Some may subsequently be withdrawn following successful representation from a provider.

6 These refer to complaints about providers of mental health services that CQC was asked to investigate on behalf of patients.

7 Covers the period from 1 October 2011 to 31 March 2012.

8 Stage 1 complainants have recourse to a Stage 2 complaint if they are not satisfied with the outcome of Stage 1.

5. Risks and uncertainties going forward

The CQC Board has identified the following risks to meeting its strategic objectives:

1. CQC fails to create effective regulatory systems or processes to identify or deal with non-compliance leading to persistent poor quality care for users and reputational damage for the regulatory regime.
2. CQC lacks the volume and/or type of resource required to meet the demands placed upon it (by statute or otherwise) leading to unacceptable levels of performance and/or unmet expectations.
3. CQC structures and processes (and therefore key relationships) do not permit effective governance and accountability leading to undetected and/or unmanaged risks and failure to meet objectives.
4. CQC's independence as a regulator is undermined leading to loss of confidence in its judgements and/or its ability to safeguard users.
5. CQC fails to operate in line with required standards of probity and value for money in relation to use of public funds.

The Board will be undertaking a full review of its strategic risks early in 2012/13 to ensure that they continue to reflect the risk to delivery of the strategic priorities in the revised CQC strategy which is currently undergoing review. In the meantime the Board review these risks regularly to ensure that action taken by the Executive Team has reduced these to acceptable levels or, where appropriate, that risks are escalated to CQC sponsor department in the Department of Health.

6. Information security

During 2011/12, we continued to implement our Information Security Strategy to ensure that we:

- Maintained an effective Information Governance Group to provide direction, leadership and a focus for information security.
- Established and embedded an Information Security Management Framework and associated policies and practices. Staff involved in information-related projects coordinated their work to avoid duplication and conflict.
- Implemented the management actions from the recent internal audit of information security.
- Ensured that safeguarding alerts are safely and securely delivered to local authorities and the police, through the use of the Criminal Justice Secure Mail community.
- Established an Information Asset Register, which clarifies ownership, accountabilities and assurance requirements, and integrating information risks into the general risk management framework.
- Became a member of the National School of Government to ensure compliance to HMG Security Policy Framework education and awareness requirements. All CQC employees must complete the Protecting Information Level 1 course as a minimum requirement and we are also establishing whether any additional mandatory training is required for key security roles within the Commission.
- Acted to improve our 2011/12 baseline score on the Information Governance Toolkit assessment.

During 2011/12, an incident was reported to the Information Commissioner's Office (ICO) and is still under investigation by the ICO.

7. Freedom of information

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

8. Employment, Health and Safety and Environment policies

8.1. Employee consultation and engagement

Our employee relations are based on principles of participation, involvement and effective dialogue with all staff. CQC recognises UNISON, RCN, PCS, Unite and Prospect for the purposes of collective bargaining and consultation. Membership of these unions currently represents about 33% of our established workforce. We also have an active and engaged Staff Forum.

During the last year we improved our relationship with the unions and worked closely with them throughout the complex negotiations on a new job evaluation and pay structure for all employees.

The Joint National Consultative Committee continued to meet monthly and meetings are now based on a more strategic agenda. The introduction of local joint consultative committees resulted in better engagement at a local level and issues and themes being considered at a national level more effectively.

Our Staff Forum was also involved in discussions on the organisation's strategic agenda. It played a valuable part in engaging all employees with the organisation's business agenda and ensuring the views of its employees not represented by unions are considered in organisational plans.

We have three diversity networks – the Lesbian, Gay, Bisexual and Trans Equality Network, the Race Equality Network and the Disability Network. The aim of these networks is to promote equality in CQC, challenge views and strive to ensure more positive outcomes for our employees. Each network has a sponsor from the Executive Team and the chairs of the Diversity Networks have regular meetings with the Chief Executive.

During the year we held a number of meetings with all compliance inspectors and managers to gain their views on how the inspection process can be improved and used this information to develop our new model for compliance.

8.2. Employment and policies

During the year, we continued to review our policies to ensure that they reflect current legislation and best practice, and consulted the unions, Staff Forum and Diversity Networks on them to ensure that they meet the needs of employees and apply equally and effectively to everyone. We also provided managers with support and guidance on how to apply CQC's policies.

8.3. Home-working

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

8.4. Health and safety

In 2011/12, we created a health and safety action plan based on an audit of our management strategies. We aim to achieve the British Standard – BS80001 in 2013/14. We also improved our policy and procedure and risk assessment documents, as well as our guidance, training and advice to staff.

We produce a comprehensive performance report to the National Health and Safety committee each quarter. This includes an overview of issues from around the property estate and from local Joint Consultative Councils and other consultative groups.

The work within our estate focuses on improving our risk rating, and we work closely with our contractors and landlords to improve shared health and safety management strategies.

In the year, we produced a suite of in-house and e-learning packages to meet our health and safety targets. Examples include an induction health and safety briefing; a foundation health and safety course; in-house training for manual handling; use of evacuation chairs; risk assessment and reasonable adjustments. We are also developing a package for personal safety and lone working to complement a new policy and guidance document.

In 2012/13 we will focus on embedding risk assessments in all our activities and ensuring our training packages meet all our objectives.

8.5. Sickness absence data

During 2011/12 the average number of long term days sickness per employee was 12 (2010/11: 8 days) and the average number of short term days sickness was 4 (2010/11: 3 days). We are in the process of developing a new attendance management policy and will combine its launch with a roll out designed to educate and familiarise leaders, managers and employees in the way CQC intends to manage attendance more effectively in the future.

8.6. Sustainability duty

We want to reduce the impact of our business on the environment, and our priority is to reduce our carbon dioxide (CO2) emissions. Managing our IT systems and accommodation efficiently is an important part of this work. Our focus on flexible working and consolidating our accommodation by continually reviewing our estates strategy is driven by our sustainability aims. We also work with our suppliers of goods and services to ensure they have sustainable working practices with supporting polices.

We previously reported against the Sustainable Operations on the Government Estate targets. On 1 April 2011, these targets were replaced by the Greening Government Commitments Operations and Procurement (GGCOPS).

About our data

All but one of our offices is supplied via a landlord service charge. Bills are presented on a pro rata m2 basis rather than actual consumption data. This means that there may be some limitations to the accuracy of our financial and non-financial sustainability data, but we are looking at how we can improve this. We are also talking with our landlords about the feasibility of installing check meters.

Carbon dioxide emissions

Area	CO2 emissions (tonnes)	Units 2011/12	Cost 2011/12 (£)	Performance against 2010/11
Building Energy	1,760	4,089,061(kwh)	372,654	improving
Travel (rail)	338	4,129,540 (m)	1,739,803	improving
Travel (road)	421	3,928,647 (m)	1,696,012	increased
Total	**2,519**	**N/A**	**N/A**	

Non-financial indicators (CO2)	2010/11	2011/12
Gross emissions (buildings)	2,219	1,760
Gross emissions (business travel)	786	759
Total greenhouse gas emissions	3,005	2,519
Financial indicators (£)	**2010/11**	**2011/12**
Expenditure on official business travel	3,272,845	3,435,815

Performance

43% of our reported CO2 emissions are from electricity and gas used in the buildings. The emissions are falling from the 2009/10 baseline figure due to investment in energy saving initiatives, tighter controls, and the consolidation of the estate and the closure of offices.

CO2 emissions from rail travel have fallen as we introduced further telephone and video conferencing in offices and the austerity measures brought in by the Government to further restrict business travel.

The increase in CO2 emissions from road travel is largely due to CQC carrying out more inspections and employing more inspection staff to carry out the extra inspections.

Targets

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

Managing energy use from buildings

Performance

Energy consumed in our buildings is falling against the 2009/10 baseline. This is due to investment in energy initiatives, tighter controls on heating, cooling and lighting. Estate consolidation and office closures have also contributed to the energy reduction.

Non-financial indicators – energy consumption (KWH)	2009/10	2010/11	2011/12
Electricity: Non-renewable	N/A	N/A	N/A
Electricity: Renewable	3,641,075	3,521,309	2,962,050
Gas	2,004,344	2,028,220	1,127,011
Total KWH	5,645,419	5,549,529	4,089,061
Financial indicators (£)	**2009/10**	**2010/11**	**2011/12**
Total energy expenditure	525,935	473,785	372,654

Managing water usage

Performance

CQC's water usage is almost exclusively from washrooms, showers, kitchen preparation areas, cleaning and the restaurant facility in our Finsbury Tower head office in London. The increase in spend from 2010/11 is due to the relocation of the Nottingham office to a standalone office unit; previously, the charge for water services was covered within the landlords service charge.

Targets

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

Non-financial indicators	2009/10	2010/11	2011/12
Water consumption (m3) supplied	16,388	15,561	16,418
Financial indicators (£)	**2009/10**	**2010/11**	**2011/12**
Total energy expenditure	N/A	14,713	15,732

Managing office waste

Performance

Our office waste typically comprises: paper, cardboard, food and drink waste and its packaging. Recycling has increased following the consolidation of the estate and closure of offices. This has allowed us to develop better waste management procedures. The figures for 2009/10 and 2010/11 were incomplete as landlords did not supply enough information to confirm the landfill/recycling data.

Targets

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

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

We have reviewed our waste management contracts and consolidated them to ensure that all waste is managed in a sustainable way. This will also give us consistent reporting data.

Non-financial indicators (tonnes)	2009/10	2010/11	2011/12
Non-hazardous waste- landfill	27	60	130
Non-hazardous waste- reused/recycled	143	272	152
Total waste	**170**	**332**	**282**
Financial indicators (£)	**2009/10**	**2010/11**	**2011/12**
Total disposal costs	N/A	48,021	32,000

Sustainable procurement

Our governance and procurement procedures ensure that we consider sustainability at every stage of the process, from the initial completion of a business case, the creation of a specification to the exit strategy of contracts.

Our procurement team also reviews central contracts for their use of recycled contents, ability to monitor CO2 emissions and adherence to the equality and diversity act.

9. Estates strategy

We have updated our Estates strategy to reflect the new Government Property Controls, which were implemented in June 2010. The main implication of these controls is that all lease breaks will be reviewed in a timely manner and actioned as necessary.

As a result, we closed the Tustin Court office in Preston and downsized our Birmingham office during the year.

The Human Fertilisation and Embryology Authority moved into Finsbury Tower in August 2011, taking approximately 10% of the floor space resulting in an equivalent saving in the running costs.

In October 2012, Healthwatch England (HWE) will become part of CQC and staff will be based in our offices in Finsbury Tower and St Paul's House, Leeds. HWE will contribute to the running cost of the offices.

These initiatives will lead to significant savings for both CQC and the Department of Health.

10. Contractual obligations

CQC operates a contracts register, and we now publish details of all new contracts with a value over £10,000 on the Government Contracts Finder website (www.contractsfinder.business.gov.uk). Our largest contracts are with information communication technology (ICT) service suppliers: CSC Computer Science Ltd, Computacenter UK Limited, Sapient Corporation and Cable & Wireless Worldwide PLC. Services supplied under these arrangements included ICT support services, ICT development, operating systems, hardware maintenance, information systems infrastructure, IT operations, and the CQC operating system, which is used to organise, integrate, record and coordinate our relationships with the bodies that we regulate.

11. Better payment practice code

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

In 2011/12, CQC processed 99.9% (2010/11: 90.7%) based on volume and 99.4% (2010/11: 94.5%) of invoices based on value within 30 days.

Following new guidance from Central Government in August 2010, CQC aspired to pay 80% of all undisputed invoices from our suppliers within 5 working days. In 2011/12, CQC paid 85.3% (August to March 2011: 83.5%) based on volume and 82.9% (August to March 2011: 82.5%) based on value within 5 days.

12. Pension costs

The treatment of pension liabilities and the relevant pension scheme details are set out in note 1.3 on page 94 and in the Remuneration Report on page 65.

13. Political and charitable donations

We made no political or charitable donations during the year.

14. Research and development

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

15. Form of account

The Financial Statements have been prepared in the form directed by the Secretary of State for Health, in accordance with the Health and Social Care Act (2008), the Government Financial Reporting Manual (FReM) (2011/12) and the HM Treasury Managing Public Money (2007). The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context.

16. Going concern

The financial accounts have been prepared on the basis that CQC is a going concern. Grants for 2012/13, which cover the amounts required to meet CQC's liabilities falling due that year, have been included in Department of Health estimates which were approved by Parliament.

17. Post Statement of Financial Position Events

There are no significant post Statement of Financial Position events.

18. Auditor

The Comptroller and Auditor General (C&AG) is appointed by statute to audit CQC and report to Parliament on the truth and fairness of the annual financial statements and regularity of income and expenditure. The total amount due for audit work is £145,000 (2010/11: £125,000). There was no remuneration paid for non-audit work during the year.

19. Availability of information for audit

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

Remuneration report

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

Remuneration of the Chair and Board Members

Board members' remuneration is determined by the Department of Health on the basis of a commitment of two days per month.

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

CQC reimburses its Chairman, Board and Independent Members for the cost of travelling to and from the Commission including for Board meetings and to and from events at which they represent CQC. CQC meets the resulting tax liability under a settlement agreement with HM Revenue and Customs. For 2011/12 the total amounts were £18k (2010/11: £15k).

Chairman and Board Members' Emoluments

	Date Appointed	2011/12 Total Salary £000	2010/11 Total Salary £000
Dame Jo Williams (Chair)	01-Oct-08	60-65	60-65
Professor Deirdre Kelly	01-Oct-08	10-15	5-10
Kay Sheldon OBE	01-Dec-08	5-10	5-10
Professor Martin Marshall	01-Jan-09	5-10	5-10
John Harwood	04-Mar-10	5-10	5-10
Olu Olasode (appointment expired 31 Oct 2011)	01-Nov-08	5-10	10-15

Payments to Independent Members

Julian Duxfield was an independent member of CQC's Remuneration Committee. Fees and expenses are paid on a per meeting basis. No expenses were paid for 2011/12 (2010/11: £4k).

John Butler was an independent member of CQC's Audit and Risk Assurance Committee. Fees and expenses are paid on a per meeting basis and amounted to £6k for 2011/12 (2010/11: £2k).

Remuneration of the Chief Executive

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

Remuneration of the Executive Team

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

The remuneration of the Chief Executive and Executive Team members was set by the Remuneration Committee and reviewed annually within the scope of the national pay and grading scale applicable to Arms Length Bodies. However, since CQC's pay freeze started on 1 September 2010 and will end on 31 August 2012, in line with many other public sector bodies no increase has been applied. In November 2011, the Government announced that public sector pay would be capped at 1% a year for two years following on the back of the two year pay freeze.

The Executive Team had a contractual entitlement to be considered for a bonus of up to 10% of salary for performance in the year 2011/12. However both the Remuneration Committee and the Executive Team were of the view that it would not be appropriate for the Executive Team to accept individual bonuses in the current circumstances.

For the Chief Executive and Executive Team, early termination other than for gross misconduct, (in which no termination payments are made), is covered by their contractual entitlement under CQC's Redundancy Policy (or their previous legacy Commission's redundancy policy if they transferred). The Executive Team has 3 months notice of termination in their contracts. Termination payments are made only in appropriate circumstances and may arise when staff are not required to work their period of notice. They may also be able to access the NHS Pension Scheme arrangements for early retirement depending on age and scheme membership.

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

Executive team		2011/12			2010/11		
	Date Appointed	Salary £000	Bonus £000	Benefits in kind £00	Salary £000	Bonus £000	Benefits in kind £00
Cynthia Bower	1 Aug 2008	195-200	-	-	195-200	-	-
Jill Finney	24 Feb 2009	140-145	-	-	140-145	-	-
John Lappin	1 May 2009	140-145	-	-	140-145	-	-
Amanda Sherlock	1 Jul 2010[1]	130-135[4]	-	-	125-130[3]	-	-
Louise Guss	1 Jul 2010[1]	110-115	-	-	105-110[2]	-	-
Allison Beal	2 Aug 2010[1]	110-115	-	-	70-75[2]	-	-
Philip King	1 Oct 2011	55-60[2]	-	-	-	-	-
Amanda Hutchinson (interim appointment to 30 Sep 2011)	18 Apr 2011[1]	45-50	-	-	-	-	-
Richard Hamblin (resigned 31 Dec 2011)	1 Mar 2009	80-85	-	-	110-115	-	-
Linda Hutchinson (resigned 30 April 2011)	1 Apr 2009	10-15[3]	-	-	95-100[3]	-	-

1 Date appointed to the Executive Team for reporting purposes

2 Full-year equivalent salary £110-115k.

3 Full-year equivalent salary £130-135k.

4 Full-year equivalent salary £140-145k

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. This is outlined in the table below.

Band of Highest Paid Director's Total	2011/12	2010/11
Remuneration (£'000)	195-200	195-200
Median Remuneration Total	37,174	37,174
Ratio	5.3	5.3

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

The median remuneration total and the remuneration of the highest paid director for 2011/12 has remained the same as 2010/11 due to the impact of CQC's pay freeze which started on 1 September 2010.

Payments made for loss of office

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

Pension Benefits

Pension Benefits of Board Members

Board members are not eligible for pension contributions, performance related pay or any other taxable benefit as a result of their employment with CQC.

Pension Benefits of the Chief Executive and Executive Team

Pension benefits were provided through the NHS Pension scheme for most members of the Executive Team, with the exception of Amanda Sherlock and Louise Guss whose pensions were provided through Teesside Pension Fund. Pension benefits at 31 March 2012 may include amounts transferred from previous NHS employments whilst the real increase reflects only the proportion for the time in post, if the employee was not employed by CQC for the whole year.

	Accrued Benefits				Cash Equivalent Transfer Values		
Name	Real increase in pension lump sum (bands of £2,500) £000	Real increase in pension (bands of £2,500) £000	Lump sum related to total accrued pension at 31 March 2012 (bands of £5,000) £000	Total accrued pension at 31 March 2012 (bands of £5,000) £000	CETV at 31 March 2011 £000	CETV at 31 March 2012 £000	Real Increase in CETV £000
Cynthia Bower	5 – 7.5	0 – 2.5	200 – 210	65 – 70	1,350	1,480	103
Jill Finney	–	0 – 2.5	–	5 – 10	55	95	39
John Lappin	–	0 – 2.5	–	5 – 10	65	107	41
Amanda Sherlock	2 – 2.5	0 – 2.5	100 – 105	80 – 85	560	693	116
Louise Guss	0 – 2.5	0 – 2.5	45 – 50	60 – 65	240	318	70
Richard Hamblin (resigned 31 Dec 2011)	0 – 2.5	0 – 2.5	70 – 75	20 – 25	267	332	45
Linda Hutchinson (resigned 30 Apr 2011)	0 – 2.5	0 – 2.5	105 – 110	35 – 40	582	652	5

Cash equivalent transfer values

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

The CETV figures, and from 2004/05, the other pension details, include the value of any pension benefit in another scheme or arrangement which the individual has transferred to the NHS pension. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries and do not take account of any potential reduction to benefits resulting from Lifetime Allowance Tax which may be due when pension benefits are drawn.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

NHS pension scheme

The principal pension scheme for staff recruited directly by CQC is the NHS pension scheme.

The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The scheme is not designed to be operated in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. Details of the benefits payable under the scheme provisions can be found on the NHS Pensions website at www.pensions.nhsbsa.nhs.uk.

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

In 2011/12 CQC employer's contribution for staff to the NHS pension fund was £4,258k (2010/11: £4,408k) at a rate of 14% (2010/11: 14%). For early retirements, other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs charged to expenditure was £177k (2010/11: £723k).

Local Government Pension Schemes

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

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

Employer contributions, based on a percentage of payroll costs only, for 2011/12 were £4,192k in total (2010/11: £4,544k), at rates ranging between 14.4% and 32.3% (2010/11: 6.2% and 39.6%). Employer contributions relating to the largest scheme, Teesside Pension Fund were £3,575k (2010/11: £3,790k) at a rate of 14.4% (2010/11: 13.7%).

From 2011/12, an indexed cash sum was levied in addition to a percentage of payroll costs in an effort to reduce the pension fund deficits. £610K in total was paid to 11 of the 17 pension funds with amounts ranging from £11k to £128k. 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 2012/13 range between 15.1% and 32.3% (15.1% for Teesside Pension Fund) with annual cash sums ranging from £13.2k to £133.6k (£nil for Teesside).

Cynthia Bower

Chief Executive, CQC
29 June 2012

Statement of Accounting Officer's Responsibilities

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

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

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

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

Governance statement

Introduction and context

This year has been a notable mixture of challenges and significant achievements. The external environment, including the policy environment is characterised by change and uncertainty which has impacted the CQC. Although the CQC has been operating since April 2009 there is a growing realisation that organisations need more time to develop and mature than has generally been assumed in the past. This was confirmed by our sponsor Department at the Public Accounts Committee hearing. Progress has not been as fast as had been assumed when the organisation was set up nor as swift in practice as we would have hoped. To a significant degree this has been due to the need to respond to external health and social care system changes and direct changes to the CQC's role and remit.

Nevertheless, since April 2009, we have made considerable progress in creating a single regulator of health and adult social care services spanning more than 22,000 providers in 40,000 locations. We have developed our regulatory model that uses the same standards of quality and safety across every sector based on outcomes for service users and patients.

The organisation continues to work through some legacy issues – for example in seeking to implement common employment terms for staff who were inherited from three predecessor organisations with different terms and conditions. We continue also to bring new groups of providers into the new regulatory framework to the demanding timetable set by Parliament; for example this year we completed the registration of 8,112 dental care providers and 243 private ambulance services and we expect to register an estimated 8,500 primary medical care providers by April 2013.

We have carried out nearly 17,000 site visits since April 2011 – an average of more than 1,400 a month – and served more than 600 warning notices to providers in that time. During 2011/12 we have met all targets for carrying out inspections, and in addition have carried out a number of themed inspections of dignity and nutrition, termination of pregnancy services and at the request of the Surgeon General, a review of the Defence Medical Services for the armed forces. We have also delivered a new website which provides extensive information for the public about providers and we have reduced the time taken for registration, with 73% of applications being concluded within eight weeks.

The CQC has been engaged closely during the year on a broad front of preparatory work to assume additional functions that the Health and Social Care Act 2012 (c7) requires the CQC to take on. This includes the creation of the health and social care consumer body 'Healthwatch England'.

The CQC has been subject to sustained external scrutiny during the year. The events at Winterbourne View – a private hospital in Bristol for service users with learning disabilities where there was ill-treatment of some patients by some staff – prompted much of this scrutiny. The CQC has conducted its own internal review and this has been presented to the CQC Board and action has been taken to address identified weaknesses in the CQC processes. However there are matters which remain *sub-judice* in relation to these events and because also there is an external independent case review which is yet to be published, the publication of the CQC report has been delayed.

Whilst the volume and weight of this scrutiny in a compressed period of time has been a challenge to administer, nevertheless it proved useful in confirming those areas for improvement that the CQC already had identified as well as helpfully highlighting additional priority areas for improvement. Undoubtedly however a considerable amount of senior management time and resource and Board capacity has been absorbed in addressing this weight of scrutiny and I must conclude that this impacted upon the pace of improvements in governance which otherwise would have been made.

As I stated in the Statement of Internal Control in last year's Annual Report, both the Board and I recognise that the CQC's governance arrangements are not yet fully matured in their operation, but also to some extent in their design. Therefore there has been considerable action during the year intended to improve governance arrangements and these will continue into 2012/13.

The CQC corporate governance framework

A summary of the CQC Corporate Governance Framework is set out below. This details the elements that make up the governance framework for the CQC and how it is intended to operate.

The CQC Corporate Governance Framework sets out:

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

These elements, taken together, operate to facilitate the leadership, direction and control of the CQC and to enable its long-term success.

The aim of the CQC Corporate Governance Framework is to add value to the organisation by providing the optimum governance with the lowest overhead and minimal obstruction to the day-to-day running of the CQC.

Along with line management structures, the Framework provides a mechanism to allow the CQC to be effectively led and directed. This is especially critical in a large, complex organisation with a geographically dispersed workforce. Governance processes are designed to be as user-friendly as possible consistent with their purpose. Nevertheless, one purpose of the Framework is to ensure there is effective control across the CQC; in practice this means ensuring that line management at all levels is empowered where it has authority and constrained where is does not.

The CQC also recognises that effective and mature management of risk not just reduces adverse impacts but also enables the organisation to be positive and proactive in the way it delivers its business. A systematic and consistent approach to the management of risk supports and enhances staff's ability to make decisions; provides management with a clearer understanding of potential risks, their impact, what needs to be done to manage them and the assurance that they are being managed effectively.

A key purpose of the Framework is to provide assurance – that the right things are being done in the right way and at the right time – up through the line management chain. Operating the requirements of the Framework – providing assurances and evidence as required and using assurance to identify where improvements can or must be made – forms part of the day-to-day responsibilities of line managers.

The benefits to the CQC, and in turn to the public, of effective corporate governance include:

- Adding value to the organisation by providing a sound underpinning change and modernisation.
- Clarity about what the CQC's objectives are via effective strategic and business planning.
- Clarity about levels of authority to make decisions.
- Clarity about what decisions have been made, by whom, when and why.
- The generation of reliable management information to demonstrate and track progress toward meeting targets and objectives.
- Risks to the delivery of objectives are identified and appropriate controls put in place and maintained.
- Line and audit management assurances that risks to meeting objectives are identified and that controls for those risks are being applied and are effective.
- Provision of independent assurance via audit that business processes are fit for purpose and are being operated; and that statutory requirements, for example to manage information in accordance with legal requirements are being met.
- Assurance that resources are deployed effectively and efficiently to manage risks and issues as they arise.
- Assurance that the CQC is not acting outside of its remit and authority.

The Framework exists to support and challenge the CQC in its accountability. The CQC Chief Executive is accountable as the CQC's Accounting Officer for the operation of the Corporate Governance Framework which has been mandated by the CQC Board.

A diagram of the current formal Board, Executive and associated Committee structures is shown at Appendix 1. Appendix 2 is a summary of attendance at Board meetings and a summary of the coverage of its work.

Governance relies primarily upon effective operation of the line management structure. This is supplemented as necessary with minimum additional governance processes to provide further assurance to the Board. This approach is designed to provide a proportionate response, providing adequate and sufficient governance procedures while carrying out the Commission's functions efficiently, effectively and economically.

Effective governance requires more than structures and processes –although they are vital foundations. Important too are the leadership and line management behaviours which support effective governance. The CQC recognises this and has invested in the development of the governance framework during the year. In particular:

- Articulating the Framework in a single document which seeks to explain its operation and desired outcome.
- Implementing a new risk management framework that aims to bring together strategic, business delivery and regulatory risks.
- Improving the business planning processes and associated performance reporting tools to ensure better quality management and performance information; and the continuing development of the Performance Scorecard to allow the Board better to track and assess performance against targets.
- Reviewing the operation and membership of its Audit and Risk Assurance Committee in line with the revised Corporate Governance Code to ensure that it adds value by focussing on seeking assurance from the Executive and providing assurance (or recommendations for change) to the Board.
- Strengthening the CQC's counter fraud capability and resolve.
- Preparing for the introduction of a cross-organisational process to generate appropriate line management assurance to supplement the assurance provided by internal audit and oversight by the Board.

We have conducted two internal audits of the governance framework during the year. The first focused upon structures and these – particularly the Executive structures – have been revised in line with those recommendations. In particular the committees of the Executive Team have been revised to ensure that there is a clear distinction between their governance and management functions and thereby generate more robust assurances.

The second audit reviewed both the necessary culture and behaviours to ensure that governance structures and processes operate effectively, and the newly implemented risk processes. Both these audits provided partial assurance and have helpfully focussed attention on the priorities for improvement. A corporate governance project board, including an independent non-executive member of the Audit & Risk Assurance Committee (ARAC) has been established to take forward the management actions to address all recommendations.

A key focus of the governance changes during this year has been to place even greater emphasis upon the scrutiny of regulatory risk. The lessons from the Winterbourne View incident have been central to this which has fundamentally shifted the Board's risk appetite. It has now an explicitly stated zero tolerance for any CQC regulatory risk system failures or design deficiencies. In seeking greater assurance the Board's ARAC has required from the Executive more detailed and analytical regular reports of the volumes, patterns and trends in non-compliance. Through this mechanism the ARAC, on behalf of the Board, will keep the effectiveness of the CQC regulatory model under constant review.

These arrangements also will seek to ensure that regulatory risks in the health and social care system can be better identified, managed (where this is under the CQC's control), reduced and, importantly where they cannot be adequately reduced or mitigated, escalated formally to stakeholders – including the sponsoring Department and Ministers – via the CQC Board.

An important element of the governance framework is the CQC's accountability arrangements with the Department of Health. These are additional to and complement the Accounting Officer's responsibilities to Parliament. The current arrangements have been in place since the CQC's inception and include quarterly accountability meetings with the Department's senior sponsor. As the CQC Accounting Officer, I have attended all these meetings during the year and provided the performance and risk information requested by the Department. All actions required of the CQC arising from these meetings have been discharged. These arrangements are being reviewed and we are working in collaboration with the Department on appropriate improvements.

The Department indicated that it intended to conduct a Performance and Capability review during the year. This began in October 2011 and reported in February 2012 and looked at aspects of governance arrangements including the CQC risk management and accountability arrangements. This review helpfully confirmed the conclusions which the CQC had reached about the need to improve risk management capability and supports the governance changes in hand to address that issue. The review also indicated where governance arrangements could be improved. The Department has progressed recommendations to bring about a unitary Board. The accountability arrangements, now under review will need to take account of both a move to a unitary Board but also the creation within the CQC of Healthwatch England as the health and social care consumer body. These are important changes and in making the change any adverse impacts upon the CQC's governance must be avoided or minimised. There are particular risk and issues impacting the role of the Accounting Officer arising from the creation of Healthwatch England as a consumer body within the regulator. Governance arrangements designed to mitigate these risk have been developed and how they will operate in practice will be kept under review.

As Accounting Officer I have had the benefit also of reviews by the NAO in advance of a Public Accounts Committee hearing which took place in January 2012 and the subsequent report from the Committee. The Board is overseeing the work of the Executive to ensure that all the recommendations for the various reviews are addressed, coordinated and delivered to timescale.

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

"The internal control framework, although continuing to show signs of increasing maturity, is still considered generally weak and in need of ongoing enhancement. Changes and improvement have been made but these have been focussed on changing isolated components which risk perpetuating the current situation. The purpose, priorities and strategy of the CQC are not currently clear and the impact of this is visible throughout all components of the control framework. The culture of control is, in my opinion, still not well developed or embedded although we do consider that the recent increased impetus in governance, risk management and in particular the recent initiative on management assurance will help drive this forward."

Board performance

Since inception the CQC Board has been dealing with changes and challenges of its own (the resignation of the first Chair, an extended period with an interim Chair and more recent difficulties referred to below) which has meant that there had not been an obviously suitable point at which its performance should be formally assessed.

A programme of Board development commenced in the autumn of 2011 which would have included an assessment of performance. This has been delayed after a Board member gave evidence to The Mid Staffordshire NHS Foundation Trust Inquiry. A divergence of views has arisen which had an impact on board effectiveness and performance. This led to a review commissioned by the Department of Health which commenced in December 2011 and completed in January 2012 – the formal outcome is still awaited. This situation is ongoing. In the meantime the Board has sought to discharge its responsibilities effectively.

The Department of Health Performance and Capability review already referred to has examined the effectiveness of accountability relationships in the CQC and the role of the Board. Its findings reflect that the performance of the Board – in particular in ensuring effective oversight – is in part related to the Board structure. As noted above, a recommendation from the review is that the Board should become a unitary Board containing a mix of a majority of non-executives and executives. This is being taken forward as will a related programme of Board support and development. It is my view that a unitary Board of non-executives and executives will allow for more robust oversight of the CQC, a clearer Board focus on strategic priorities and more streamlined and coordinated accountability to the CQC's sponsor Department and to Parliament. Having the Accounting Officer and other key executives as members of a unitary Board will help manage the risk of conflict in accountability that might otherwise arise from being held separately to account by a Board and a sponsor department.

Highlights of Board Committee reports

The Board has two committees: the Audit and Risk Assurance Committee which provides scrutiny, in particular, of the risk and audit arrangements for the CQC and the Remuneration Committee which oversees senior pay and the pay and reward arrangements for the CQC as a whole. There are formal reports following each meeting of the Committees presented to the Board.

A notable highlight has been the review and revision of the Audit and Risk Assurance Committee (ARAC). Its change in title – from Audit & Risk Committee – in line with best practice[5], signals the change of focus in its work, focussing now at all times upon seeking evidenced assurances in order to provide assurance to the Board. Where it cannot obtain suitably evidenced assurance it will determine whether this is a matter of performance or one of design of the governance framework and will make recommendations for action. These changes are proving effective in assisting the Board to hold the Executive to account. The Committee also has overseen the implementation and assessment of the new risk management system. It has approved and overseen the programme of internal audits, CQC's counter-fraud arrangements and updates in the CQC's information security arrangements.

5. The Revised Corporate Governance Code

The Committee has had the benefit of a new Chair and refreshed membership during the year and will commence the coming year strengthened further by a second independent non-executive member. The Committee met formally five times during the year and considered matters in correspondence and in other meetings between the formal meetings. The Department has provided an observer at 3 of the 5 meetings of the Committee during the year and received the agenda, papers and minutes of all meetings.

In addition to its role in approving the terms and condition for new Directors, the Remuneration Committee's primary focus during the year has been to oversee the CQC job evaluation and pay and grading project. The CQC inherited staff from three organisations with significantly different terms and conditions and levels of pay. It has been working since 2009 to implement a single set of terms and conditions for its staff. This proved to be a difficult and protracted issue to address in the face of public sector pay and recruitment restraints and in reaching a conclusive outcome the Committee provided valuable and helpful oversight. A settlement has been recommended to staff by the Trade Unions and will be implemented in 2012/13. This will allow implementation of a pay and grading framework that is fair and equitable for all staff.

Compliance with governance requirements

The CQC is devoting considerable attention to the quality and operation of its governance arrangements. These will also need to be revised further in the coming year to accommodate new functions – the creation of Healthwatch England, but also new ways of working – in particular the recommendation to create a unitary Board for the CQC.

Underlying the design and operation of the Corporate Governance Framework is my and the Board's commitment to adhere to the Corporate Governance Code and governance best practice both in principle and in spirit.

Performance, Risk and Assurance data quality

I have noted above the changes in hand to improve the CQC's regulatory risk arrangements and capacity following the well-publicised events surrounding the ill-treatment by some staff of patients with learning disabilities at Winterbourne View hospital which revealed some specific deficiencies in the CQC's management of regulatory information. These deficiencies have been addressed to ensure that key regulatory risk information, in particular those from whistleblowers and from those giving information about safeguarding risks, is dealt with promptly and appropriately.

The CQC previously had identified the need for improved risk management arrangements and a new process was implemented across the organisation from April 2011. This was intended to allow the CQC to coordinate and manage business delivery, strategic and regulatory risks. The discipline has been established of providing regular, monthly reports of business delivery risks and regulatory risks to the Executive team. This has included, as the year progressed, more robust assessment of the strategic risks (owned by the CQC Board) at the Board quarterly meetings in public where performance also is scrutinised.

It was recognised that improved capability for reporting and assessing regulatory risk was required. This has been addressed during the year and with the reorganisation in Operations from 9 to 4 regions capacity will be built into the regional and central Operations structures. These new regulatory risk arrangements have been audited and are subject to scrutiny by ARAC. Building this additional capacity and capability for our front-line teams is a priority for the first quarter of 2012/13. These resources will allow more agile and flexible profiling of different types of risks to help determine whether controls are effective, whether the risk profile is increasing or decreasing and to allow for a more sophisticated determination of risk appetite. This will facilitate the more efficient corporate application of resources to risks.

The Board has recognised its need to manage strategic risks effectively and has engaged strategic risk expertise from the Government Actuaries Department to assist in that work.

The quality of performance and management information has been improved significantly during the year. The CQC has delivered the programme of regulatory work to meet the targets for inspection and reviews set by the Board.

This has been the first year that the CQC has had the benefit of a full year of an in-house internal audit provision. The team has highlighted the need for the CQC to have a thorough ongoing process to generate line-management assurances. Such assurances would confirm and provide evidence that the necessary activity to meet targets and statutory obligations was being undertaken to the requisite quality and that associated risks controls (for example to protect information assets) were being applied. Work to design such a system has been undertaken during the year and will be implemented from the first quarter of 2012.

During the year the CQC has launched a new website which has transformed the quality of information the CQC is able to make available to the public to assist them in making choices about care provision. Further work is in hand to improve this further, in particular to develop the 'provider profile' snapshot of the CQC's assessment of individual providers' compliance with required standards for quality and safety of care.

During the course of the year CQC received an allegation that a member of CQC staff corruptly had accepted payment from a provider regulated by CQC. The allegations were investigated and reported to the police. The employee has been dismissed and this is now a matter being investigated by the police. CQC has conducted a 'lessons learnt' exercise in light of these events which included a review of the relevant governance controls in place, which will be strengthened as a result.

Risk assessment and risk profile

New and emerging risks

It is clear from the Winterbourne View experience that the CQC risk management processes had not operated in such a way to flag properly the risks – to the CQC and to service users – if the CQC did not identify and then act appropriately upon regulatory risk information. Actual events rather than risk analysis led to the CQC re-evaluating the effectiveness of its systems and its tolerance of this risk, which also is a strategic risk for the CQC.

Equally, it is clear that the CQC had not escalated clearly enough the wider risks to the CQC's regulatory compliance programme of activity created by the prolonged work to deliver the initial registration of providers to the timescales set by Parliament. This risk was elevated further – and this should have been flagged more strongly – by the extended period during which the CQC was carrying staffing vacancies, in particular for compliance inspectors. The Board and I have the necessary re-balancing of these risks firmly in mind as we enter 2012/13 and the programme to register all GP practices for the first time during the coming year.

Given the governance changes that the CQC has been subject to, and will need to continue to manage in the forthcoming year in relation to both the creation of a unitary Board and Healthwatch England, any proposals to add further to the CQC's remit and functions which affect governance could generate significant risks. Therefore the impact of any such changes would need to be considered carefully and will be the subject of close scrutiny.

Ministerial directions

We have received no formal Ministerial Directions during the year. The CQC however did receive Ministerial and other requests to undertake specific inspection activity, which after consideration the CQC agreed to undertake.

Significant lapses of protective security

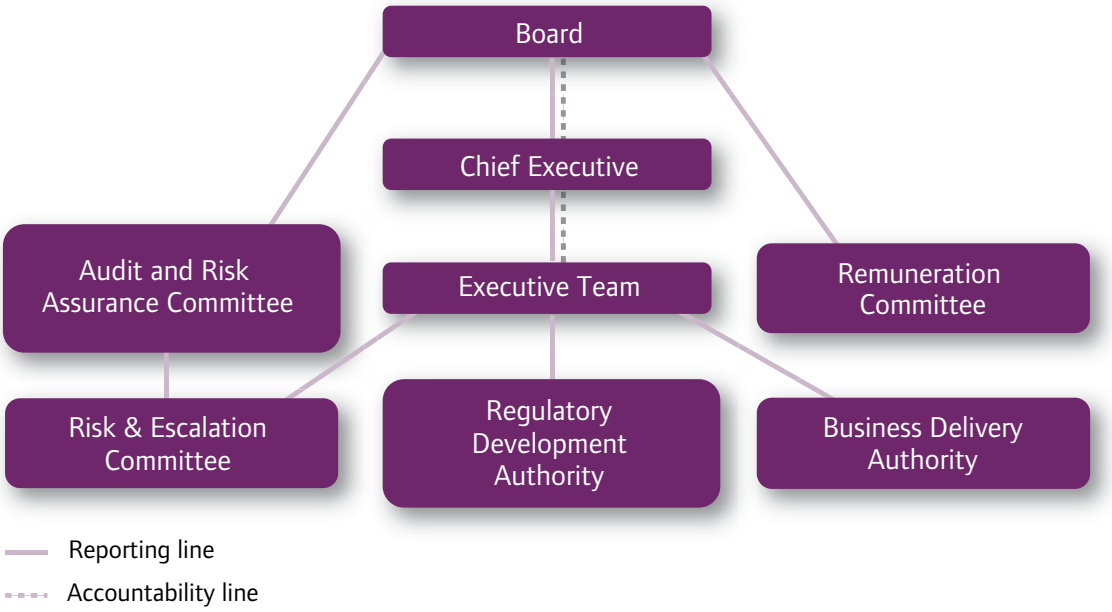
There have been no known significant lapses. The CQC adheres to the Information Commissioner (IC) requirements regarding reporting of incidents and has reported one instance to the IC in the course of the year. The IC has concluded that no enforcement action will be taken regarding this and made recommendations regarding improvements in systems.

More generally the CQC has strengthened its information security capacity across the year and has appointed a new Senior Information Risk Owner (who has undergone full training) created a central information risk asset register and conducted an information security internal audit which has generated a number of recommendations which will be implemented through a programme of work to be led by the newly appointed Information Security Manager. It has also prepared an Information Governance Strategy intended to deliver continuous improvement in the CQC's effective management of information, not only to ensure effective security to prevent breaches but also to ensure that appropriate information will be available to inform all the CQC decision-making.

Conclusion

I conclude that the CQC governance processes, though continuing to improve throughout the year and expected to improve further in the coming year, have adequately supported me in discharging my role as Accounting Officer. However the issues and challenges I have outlined above had the effect of requiring the application of significant additional Executive and other resource.

Appendix 1



Appendix 2

Table 1 Summary of Board attendance

	Private & Public Board Attendance								
Attendee names	**Dates**								
	13-Apr-11	**18-May-11**	**15-Jun-11**	**14-Sep-11**	**16-Nov-11**	**14-Dec-11**	**18-Jan-12**	**15-Feb-12**	**14-Mar-12**
Jo Williams	✓	✓	✓	✓	✓	✓	✓	✓	✓
Martin Marshall	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kay Sheldon	✓	✓	✓	✓	✓	✓	✓	✓	✓
Professor Deirdre Kelly	✓	✓	✓	✓	✓	✓	✓	✓	✓
John Harwood	✓	✓	✓	✓	✓	✓	✓	✓	✓
Olu Olasode *	x	✓	✓	x					

*Olu Olasode's term of appointment came to an end in October 2011.

Table 2 Coverage of the Board work

CQC Board – coverage of topics 1 April 2011 to 31 March 2012
Agenda Items
Quarterly Risk & Performance Reports, including financial reports and review of strategic risks
Chairs & Commissioners' reports
Chief Executive reports
Reports from Audit & Risk Assurance Committee – including review of the Committee
Reports from the Remuneration Committee
Review of CQC Strategy
CQC Business Planning and Budget
Annual Report to Parliament – Themes and approach
Annual Reports and Accounts & Finance Report for year ended 31 March 2011
Approval of Stakeholder Committee Terms of Reference and membership
Re-appointment of Chairs of Board Committees and Review of membership Board Committees
Approval of the schedule of Board meetings in private in 2012
Review of Complaints Annual Report
Registration of Dentists
Registration of other Primary Medical Services
Specialist Advisory Group Report
The CQC Regulatory Model – Evaluation Group findings
The CQC Regulatory model – refining & improving our compliance model
Mental Health Act Operations Redesign
Dignity and Nutrition Inspections Evaluation
Defence Medical Services Review
Themed Inspection update
Healthwatch England
Internal management review – Winterbourne View Hospital
State of Care report – content, approach and intended impact
Mental Health Act Annual Report
Equality & Human Rights Scheme Annual Report
CQC's Equality Objectives 2011/12
Deprivation of Liberty Safeguards Annual Submission
Emerging Issues from External Scrutiny
Managing Public Expectations of CQC
Provider Sentiment Tracking
Health Select Committee response
Improving the Customer Experience
User Engagement
User Involvement
Acting Together & Experts by Experience

CQC Board – coverage of topics 1 April 2011 to 31 March 2012
Agenda Items
Recognising Excellence in Adult Social Care
Evaluation CQC's Approach to Regulation and Developing as a Learning Organisation
Measuring CQC's impact, effectiveness and value for money
National Quality Board Early Warnings Report
Role of Advisory Groups
Fees Consultation
Fees for PCTs
Interim consultation on judgement framework and enforcement policy
Responses to consultations (various)

Cynthia Bower

Chief Executive, CQC
29 June 2012

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

I certify that I have audited the financial statements of the Care Quality Commission for the year ended 31 March 2012 under the Health and Social Care Act 2008. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Board, Accounting Officer and auditor

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Care Quality Commission's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Care Quality Commission; and the overall presentation of the financial statements. In addition, I read all the financial and non-financial information in the CQC Annual Report and Accounts 2011/12 to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

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

Opinion on regularity

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

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of Care Quality Commission's affairs as at 31 March 2012 and of the net expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the Health and Social Care Act 2008 and the Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the Secretary of State directions issued under the Health and Social Care Act 2008; and
- the information given in the Management Commentary for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records or returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

Amyas C E Morse

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

6 July 2012

Financial statements

Statement of Comprehensive Net Expenditure for the year ended 31 March 2012

	Note	2011/12 £000	2010/11 £000
Expenditure			
Staff costs	3	94,153	70,241
Depreciation	4	11,340	12,473
Other Expenditure	4	37,544	56,308
Impairment of Assets	4	6,403	67
		149,440	**139,089**
Less Income			
Income from Activities	6	(85,987)	(80,062)
Other income	6	(2,504)	(22)
		(88,491)	**(80,084)**
Net Expenditure for the financial year		**60,949**	**59,005**

Other Comprehensive Expenditure

	Note	2011/12 £000	2010/11 £000
Net (gain)/loss on revaluation of intangibles		(10)	671
Net (gain)/loss on revaluation of property, plant and equipment		(14)	407
Change in the discount rate on long term creditors		(7)	-
Actuarial loss/(gain) in pension schemes	3	55,412	(15,354)
		55,381	**(14,276)**
Total Comprehensive Expenditure for the year ended 31 March 2012		**116,330**	**44,729**

All income is derived from continuing operations.

The notes 1 to 23 form part of these financial statements.

Statement of Financial Position as at 31 March 2012

	Note	31 March 2012 £000	31 March 2012 £000	31 March 2011 £000	31 March 2011 £000
Non-current assets:					
Intangible assets	7	14,059		17,041	
Property, plant and equipment	8	4,540		7,904	
Total non-current assets			**18,599**		**24,945**
Current Assets:					
Trade receivables	12	7,802		5,594	
Other current assets	12	2,381		3,008	
Cash and cash equivalents	13	15,766		16,366	
Total current assets			**25,949**		**24,968**
Total assets			**44,548**		**49,913**
Current liabilities:					
Trade and other payables	14	(14,488)		(11,046)	
Current pension liabilities	14	(487)		(679)	
Provisions	15	(702)		(2,432)	
Total current liabilities excluding Fee Income in Advance		**(15,677)**		**(14,157)**	
Non-current assets plus net current assets excluding Fee Income in Advance		**28,871**		**35,756**	
Fee Income in Advance	14	(35,224)		(24,997)	
Total current liabilities			**(50,901)**		**(39,154)**
Non-current assets plus net current assets			**(6,353)**		**10,759**
Non-current liabilities					
Provisions	15	(1,439)		(898)	
Pension liabilities	14	(1,022)		(1,456)	
Total non-current liabilities excluding pension deficit provision			(2,461)		(2,354)
Assets less liabilities excluding pension deficit provision			**(8,814)**		**8,405**
Pension deficit provision	3		(67,768)		(13,957)
Assets less liabilities			**(76,582)**		**(5,552)**
Taxpayers' equity					
General reserve			(76,811)		(6,743)
Revaluation reserve			229		1,191
Total taxpayers' equity			**(76,582)**		**(5,552)**

The financial statements on pages 85 to 116 were approved by the Board on 29 June 2012 and were signed on its behalf by:

Cynthia Bower
Chief Executive, CQC

The notes 1 to 23 form part of these financial statements.

Statement of Cash Flows
for the year ended 31 March 2012

		2011/12		2010/11	
Cash flows from operating activities	**Note**	**£000**	**£000**	**£000**	**£000**
Total net expenditure		(60,949)		(59,005)	
Adjustment for depreciation charge	4	11,340		12,473	
Impairment of intangible assets	4	6,399		-	
Impairment of property, plant & equipment	4	4		67	
Net loss on indexation of intangible assets	4	24		1,048	
Net loss on indexation of property, plant and equipment	4	5		659	
Loss on disposal of intangible assets	4	585		790	
Loss on disposal of property, plant and equipment	4	437		198	
Cost of PCSPS Long Term Creditor recognised as an expense	4	136		–	
Net expenses on pension scheme assets and liabilities	4	–		816	
(Increase) in trade and other receivables	12	(1,581)		(2,093)	
Increase/(Decrease) in trade payables	14	3,009		(5,104)	
(Decrease) in current pension liabilities	14	(192)		(186)	
Increase/(Decrease) in deferred income	14	10,227		(1,396)	
(Decrease)/Increase in provisions	15	(1,189)		926	
Non cash pension charge	3	(1,601)		(25,257)	
(Decrease) in non-current pension liabilities	14	(563)		(778)	
Net Cash outflow from operating activities			**(33,909)**		**(76,842)**
Cash flows from investing activities					
Purchase of intangible assets	7&14	(11,310)		(11,412)	
Purchase of property, plant and equipment	8&14	(681)		(2,599)	
Net Cash outflow from investing activities			**(11,991)**		**(14,011)**
Cash flows from financing activities					
Grants from Department of Health		45,300		92,300	
Net financing			**45,300**		**92,300**
Net (Decrease)/Increase in cash and cash equivalents in the year			(600)		1,447
Cash and cash equivalents at the beginning of the period	13		16,366		14,919
Cash and cash equivalents at the end of the period	13		**15,766**		**16,366**

The notes 1 to 23 form part of these financial statements.

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2012

	Note	Revaluation Reserve £000	General Reserve £000	Total Reserves £000
Balance at 31 March 2010		4,072	(57,195)	(53,123)
Changes in taxpayers' equity for 2010/11				
Net (loss) on indexation of intangible assets		(671)	–	(671)
Net (loss) on indexation of property, plant and equipment		(407)	–	(407)
Transfers between reserves for intangible assets		(1,299)	1,299	–
Transfers between reserves for property, plant and equipment		(504)	504	–
Net expenditure for the year		–	(59,005)	(59,005)
Actuarial gain in pension schemes	3	–	15,354	15,354
Total recognised income and expense for 2010/11		**(2,881)**	**(41,848)**	**(44,729)**
Grant from Department of Health		–	92,300	92,300
Balance at 31 March 2011		**1,191**	**(6,743)**	**(5,552)**
Changes in taxpayers' equity for 2011/12				
Net gain on indexation of intangible assets		10	-	10
Net gain on indexation of property, plant and equipment		14	-	14
Transfers between reserves for intangible assets		(511)	511	–
Transfers between reserves for property, plant and equipment		(475)	475	–
Net expenditure for the year		-	(60,949)	(60,949)
Change in the discount rate on long term creditors		-	7	7
Actuarial (loss) in pension schemes	3	-	(55,412)	(55,412)
Total recognised income and expense for 2011/12		**(962)**	**(115,368)**	**(116,330)**
Grant from Department of Health		–	45,300	45,300
Balance at 31 March 2012		**229**	**(76,811)**	**(76,582)**

The notes 1 to 23 form part of these financial statements.

Notes to the financial statements

1.1 Basis of accounting

The financial statements have been prepared in accordance with a Direction issued by the Secretary of State for Health (with the consent of HM Treasury) to prepare for each financial year a statement of accounts in the form and on the basis that it considers appropriate. These financial statements have been prepared in accordance with the 2011/12 Government Financial Reporting Manual (FReM) as determined by the Department of Health with the approval of HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Commission for the purposes of giving a true and fair view has been selected. The particular policies adopted by the Care Quality Commission are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

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

Early adoption of IFRS amendments and interpretations

No IFRS changes were adopted early in 2011/12.

IFRS amendments in issue that are effective for the financial year beginning 1 April 2011 but which are not expected to have an impact on the CQC's accounts

Amendments to IFRS32 Financial instruments: presentation
Amendments to IFRS1 First Time Adoption of International Financial Reporting Standards
Amendments to IFRS7 Financial Instruments: Disclosures – Transfers of financial assets
Amendments to IAS12 Income Taxes
Amendments to IFRIC19 Extinguishing financial liabilities with equity instruments
Amendments to IFRIC14 The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their Interaction.

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

IFRS9 Financial Instruments	A new standard intended to replace IAS39. The effective date is for accounting periods beginning on, or after 1 January 2015.
IFRS10 Consolidated Financial Statements	This replaces the consolidation guidance in IAS27 *Consolidated and Separate Financial Statements* and SIC 12 *Consolidation – Special Purpose Entities*. It introduces a single consolidation model for all entities based on control. The effective date is for accounting periods beginning on, or after 1 January 2013.
IFRS11 Joint Arrangements	This introduces new accounting arrangements for joint arrangements, replacing IAS31 *Interests in Joint Ventures*. The effective date is for accounting periods beginning on, or after 1 January 2013.
IFRS12 Disclosure of Interests in Other Entities.	Additional disclosures are required so that financial statement users may evaluate the basis of the control, any restrictions on consolidated assets and liabilities and any risk exposures. The effective date is for accounting periods beginning on, or after 1 January 2013.
IFRS13 Fair Value Measurement.	This defines "fair value", provides guidance on how to determine fair value, and requires disclosure about fair value measurements. The effective date is for accounting periods beginning on, or after 1 January 2013.
IAS 27 Separate Financial Statements	Contains the unchanged residual accounting and disclosure requirements for investments in subsidiaries, joint ventures and associates when an entity prepares separate financial statements. The effective date is for accounting periods beginning on, or after 1 January 2013.
IAS 28 Investments in Associates and Joint Ventures	Outlines the accounting arrangements for investments in associates and joint ventures using equity arrangements. The effective date is for accounting periods beginning on, or after 1 January 2013.
Amendments to IAS1	Presentation of items of Other Comprehensive Income. Items disclosed in the OCI need to be grouped into items that might be reclassified to profit and loss in subsequent periods and those that will not. The effective date is for accounting periods beginning on, or after 1 July 2012.
Amendments to IAS19	This affects the Pension disclosures and transactions. The effective date is for accounting periods beginning on, or after 1 January 2013.
Amendments to IFRS7 and IAS32	The changes are intended to overcome the differences between IFRS and the US GAAP in respective offsetting requirements. The intention is to help investors better assess the effect of offsetting arrangements on a company's financial position. The effective date is for accounting periods beginning on, or after 1 January 2013 for IFRS7 and 1 January 2014 for IAS32.

1.2 Accounting convention

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

Intangible assets

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

All assets are revalued annually using the appropriate Office of National Statistics price index. Increases in value are credited to the revaluation reserve whilst the asset is in use. Reductions below cost are charged to the net expenditure account.

Property, plant and equipment

Expenditure on office refurbishments, office furniture and fittings, office equipment, IT equipment and infrastructure is capitalised if having a value of £5,000 or more and having a working life of more than one year. Assets costing below £5,000 are capitalised when considered part of a group if total costs exceed £5,000 in value. Staff and contractor costs incurred on IT infrastructure projects are capitalised. General IT project management costs are not capitalised. The assets are recorded at cost. They are restated at current value each year using the appropriate Office of National Statistics price index.

Depreciation

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

Estimated useful lives:

Property, Plant and Equipment:

Furniture and Fittings:

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

Information technology:

- IT equipment 3 years
- IT infrastructure 3 years

Intangible assets:

- Software licences 3 years
- Developed software and website 3 years

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

Office refurbishments and furniture are written-off over the remaining life of the lease (the date of the first lease break) if below 10 years. Computer software, including developed software is written-off over the expected life of the software if less than 3 years. The estimate of expected life is regularly reviewed to ensure that depreciation and amortisation is charged in the Statement of Comprehensive Net Expenditure is materially accurate.

Impairment of intangible and property, plant and equipment assets

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

Research and development expenditure

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

Operating income

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

Leases

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

Financial instruments

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

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

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

Longer term debtors and creditors are discounted when the time value of money is considered material. Consequently the liability for additional pension contributions resulting from the early termination of staff in previous years is discounted by 2.8% (2010/11: 2.9%). This is the rate for market yields on AA corporate bonds as published by HM Treasury.

Grants receivable

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

Provisions

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

The amount recognised as a provision is the best estimate of the consideration required to settle the present obligation at the Statement of Financial Position date, taking into account the risks and uncertainties surrounding the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the real rate set by HM Treasury currently 2.2% (2010/11: 2.2%).

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

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

Value added tax

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

1.3 Employee Benefits

Short –term employee benefits

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

Retirement benefit costs

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

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

1.4 Administration and programme expenditure classification

A new requirement outlined in the FReM for 2011-12 is an analysis of expenditure between Administration and Programme costs. The analysis for non-departmental public bodies is only required to be consistent with returns made for the purposes of the Departmental Group consolidation and there is no requisite to provide any comparable data for the previous year. Therefore the expenditure identified in the Statement of Comprehensive Net Expenditure was split between programme (£40m) and administration (£21m) in the Spending Review of the Care Quality Commission's sponsoring department, the Department of Health.

1.5 Critical accounting judgements and key sources of estimation uncertainty

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

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

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

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

2. Analysis of net expenditure by segment

IFRS8 requires operating segments to be identified on the basis of internal reports that are regularly reviewed by the Chief Executive. CQC's Board monitored the performance and resources of the organisation as a whole since the Commission's net expenditure for the year related to its principal duties and functions as set out in the Health and Social Care Act 2008.

2.1. Revenues from major products and services: Income from Fees

A new fees scheme came into effect on 1st April 2011. This introduced an annual fee for each service provider. Separate fees for registration and variations were no longer levied.

	2011/12 £000	2010/11 £000
Annual Fees	(85,562)	(75,976)
Annual Fees – rebate scheme	–	1,009
Initial Registration Fees	(170)	(4,078)
Variation Fees	(31)	(1,014)
Chargeable inspections etc	–	(2)
Fee Income (Note 6)	**(85,763)**	**(80,061)**

3. Staff numbers and related costs

3.1. Staff costs comprise:

	2011/12			2010/11
	Permanently employed staff	Others	Total	Total
	£000	£000	£000	£000
Wages and salaries	67,198	11,226	78,424	81,510
Social security costs	5,719	296	6,015	6,173
Other pension costs	9,059	–	9,059	9,249
	81,976	**11,522**	**93,498**	**96,932**
Less recoveries in respect of outward secondments	(238)	–	(238)	(618)
Increase (decrease) in provision for pension fund deficits (See note 3.4)	893	–	893	(26,073)
Staff Costs	**82,631**	**11,522**	**94,153**	**70,241**

Other Staff costs consist of :-	2011/12	2010/11
	£000	£000
Agency	8,063	8,654
Secondments from other organisations	178	454
Commissioner Fees	684	857
Second Opinion Doctor's Fees and Expenses	2,301	2,601
Total	**11,226**	**12,566**

Agency staff costs of £7.4m relating to IT software developments were capitalised during the year (£7.1m 2010/11). During 2011/12 the average number of disabled persons employed by CQC was 99 (2010/11: 92).

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

	2011/12	2010/11
	Number wte	Number wte
Directly employed	1,692	1,776
Other **	149	176
Agency Staff engaged on capital projects	44	55
	1,885	**2,007**

The actual number of directly employed whole time equivalents as at 31 March 2012 was 1,792 (2011: 1,685).

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

3.3. Exit packages

Cost Band	2011/12 Number	2010/11 Number
<£10,000	20	30
£10,000 – £25,000	10	20
£25,000 – £50,000	10	20
£50,000 – £100,000	10	40
£100,000 – £150,000	*	20
£150,000 – £200,000	0	10
>£200,000	*	*
Total number of exit packages	**50**	**140**
Total cost	**£722,000**	**£9,181,000**

Numbers are rounded to the nearest ten, and numbers less than five are represented by *.

All redundancies were compulsory for both years.

Redundancy and other departure costs have been paid in accordance with CQC terms and conditions. Exit costs are accounted for in full in the year of departure. Where the redundancy has resulted in an early retirement, the additional pension costs are met by CQC and not by the individual pension scheme and are included in the bands above.

3.4. Pension arrangements:

CQC currently offers its employees membership to the NHS pension scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. The total cost charged to expenditure of £4,258k (2010/11: £4,408k) represents the contribution payable to the scheme by the Commission at rates specified in the rules of the plan. As at 31 March 2012, contributions of £564k (31 March 2011: £521k) due in respect of the current reporting period had not been paid over to the scheme.

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

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

Contribution rates for 2012/13 range between 15.1% and 32.3% (15.1% for Teesside Pension Fund) with annual cash sums ranging from £13.2k to £133.6k (£nil for Teesside).

The present value of the defined benefit obligations were carried out at 31 March 2012 by:

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

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

Pension Fund	Assets 11/12 £000	Liabilities 11/12 £000	Surplus/ (Deficit) 11/12 £000	Surplus/ (Deficit) 10/11 £000	Surplus/ (Deficit) 09/10 £000	Surplus/ (Deficit) 08/09 £000	Surplus/ (Deficit) 07/08 £000
Avon	3,473	(4,538)	(1,065)	(788)	(1,096)	(719)	(766)
Cambridgeshire	1,921	(2,620)	(699)	(470)	(1,169)	(322)	(20)
Cheshire	2,869	(2,971)	(102)	138	(2,159)	(912)	(492)
Cumbria	2,322	(3,175)	(853)	(786)	(1,203)	(793)	(819)
Derbyshire	2,408	(2,723)	(315)	(123)	(417)	(385)	(225)
Dorset	1,630	(2,802)	(1,172)	(878)	(1,199)	(772)	(386)
East Sussex	4,552	(4,578)	(26)	288	(1,227)	(345)	134
Essex	3,694	(5,305)	(1,611)	(1,089)	(1,473)	(1,017)	(1,020)
Greater Manchester	10,438	(12,660)	(2,222)	(936)	(4,673)	(1,339)	173
Hampshire	3,430	(5,550)	(2,120)	(1,630)	(2,360)	(1,690)	(500)
Merseyside	5,141	(6,110)	(969)	(640)	(1,241)	(772)	(632)
Shropshire	1,538	(2,030)	(492)	(389)	(850)	(543)	(494)
Suffolk	2,354	(3,359)	(1,005)	(671)	(1,636)	(589)	(62)
Surrey	3,929	(4,686)	(757)	(441)	(1,928)	(768)	(34)
Teesside	199,639	(251,780)	(52,141)	(4,556)	(28,107)	5,811	7,206
West Sussex	2,490	(2,650)	(160)	(25)	(695)	(517)	(101)
West Yorkshire	7,642	(9,701)	(2,059)	(961)	(3,135)	(1,641)	(1,684)
Total	**259,470**	**(327,238)**	**(67,768)**	**(13,957)**	**(54,568)**	**(7,313)**	**278**

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

In 2011/12 the deficit increased significantly due predominantly to:-

- Financial assumptions at 31 March 2012 are less favourable than they were at 31 March 2011.
- Poorer than expected asset returns over the year.

One employee (2010/11: 2) retired early on ill-health grounds during the year. No additional pension liabilities were levied on CQC.

A summary of the IAS19 disclosure information is as follows:

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

	Teesside Pension Fund			Other Pension Funds		
	% per annum			% per annum		
Key assumptions used:	**2011/12**	**2010/11**	**2009/10**	**2011/12**	**2010/11**	**2009/10**
Discount Rate	4.6	5.5	5.5	*4.6 – 4.9*	*5.4 – 5.9*	*5.5 – 5.6*
Expected rate of salary increases	4.7	5.0	5.4	*4.0 – 5.0*	*4.3 – 5.2*	*3.8 – 5.6*
Expected return on scheme assets	5.7	6.8	6.8	*4.6 – 7.1*	*5.3 – 7.7*	*5.3 – 7.2*
Future pension increases	2.5	2.7	3.9	*2.3 – 2.5*	*2.7 – 2.9*	*3.3 – 3.9*
Inflation	2.5	2.7	3.9	*2.3 – 2.5*	*2.7 – 2.9*	*3.3 – 3.9*

Mortality assumptions:

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

	Teesside Pension Fund			Other Pension Funds		
	2011/12	**2010/11**	**2009/10**	**2011/12**	**2010/11**	**2009/10**
Retiring today:						
Males	19.0	18.9	19.5	*20.0 – 23.9*	*19.8 – 23.8*	*20.4 – 22.7*
Females	23.1	23.0	22.6	*22.9 – 25.7*	*22.9 – 25.7*	*23.2 – 26.1*
Retiring in 20 years:						
Males	21.0	20.9	20.41	*22.0 – 25.6*	*21.9 – 25.6*	*21.3 – 25.4*
Females	25.0	24.9	23.43	*25.0 – 28.1*	*25.0 – 26.8*	*24.1 – 28.3*

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

	2011/12	**2010/11**
	£000	**£000**
Gross current service cost	5,739	7,939
less employer contributions	(4,952)	(5,683)
Past service cost	–	(29,086)
Curtailments and settlements	106	757
	893	**(26,073)**
Expected return on pension scheme assets	(17,619)	(16,591)
Interest on pension scheme liabilities	15,125	17,407
	(2,494)	**816**
Total Operating Charge	**(1,601)**	**(25,257)**

Of the expense for the year, £0.9m debit (2011: £26.0m credit) has been included in the net expenditure statement as staff expenditure and £2.4m credit has been included in other income whereas in the previous year (2011: £0.8m debit) has been included in other expenditure. Actuarial gains and losses have been reported in Other Comprehensive Expenditure.

The actual return on scheme assets was a loss of £2m (2011: £20m gain).

The cumulative amount of actuarial gains and losses recognised in reserves since the date of transition to IFRS on 1 April 2008 is £94m (2011: £39m).

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

	2011/12 £000	2010/11 £000	2009/10 £000
Present value of defined benefit obligations	(327,159)	(274,254)	(306,080)
Fair value of scheme assets	259,470	260,370	251,599
Deficit in scheme	**(67,689)**	**(13,884)**	**(54,481)**
Past service cost not yet recognised in balance sheet	(79)	(73)	(87)
Liability recognised in the balance sheet	**(67,768)**	**(13,957)**	**(54,568)**

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

	2011/12 £000	2010/11 £000
At 1 April	(274,327)	(306,167)
Service cost	(5,739)	(7,939)
Interest cost	(15,125)	(17,407)
Contributions from scheme members	(2,126)	(2,333)
Actuarial gains and (losses)	(36,308)	20,588
(Losses) on curtailments	(106)	(205)
Benefits paid	6,493	10,602
Past service cost	–	28,534
At 31 March	**(327,238)**	**(274,327)**

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

	2011/12 £000	2010/11 £000
At 1 April	260,370	251,599
Expected Return on Scheme Assets	17,619	16,591
Actuarial gains and (losses)	(19,104)	(5,234)
Contributions by employer	4,952	5,683
Contributions from scheme members	2,126	2,333
Benefits paid	(6,493)	(10,602)
At 31 March	**259,470**	**260,370**

The actuarial loss / (gain) calculation was as follows:

	2011/12	2010/11
	£000	£000
Movements in the fair value of scheme assets	19,104	5,234
Less movements in the present value of defined benefit obligations	36,308	(20,588)
	55,412	**(15,354)**

The analysis of the scheme assets and the expected rate of return at the Statement of Financial Position date was as follows:

	Expected return			Fair value of assets		
	2011/12	2010/11	2009/10	2011/12	2010/11	2009/10
	%	%	%	£000	£000	£000
Equity instruments	6.1 – 8.1	7.2 – 8.4	7.3 – 8.0	207,820	211,419	199,550
Debt instruments	3.3 – 4.4	4.8 – 5.0	5.0 – 5.5	26,418	26,127	25,693
Property	4.3 – 7.6	5.4 – 7.9	5.5 – 8.5	12,971	11,796	11,206
Cash	0.5 – 3.5	0.5 – 4.6	0.5 – 4.8	12,261	11,028	15,150
Total				**259,470**	**260,370**	**251,598**

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

	2011/12	2010/11	2009/10	2008/09	2007/08
	£000	£000	£000	£000	£000
Present value of defined benefit obligations	(327,238)	(274,327)	(306,167)	(192,756)	(222,826)
Fair value of scheme assets	259,470	260,370	251,599	185,443	223,104
Surplus / (deficit) in the scheme	(67,768)	(13,957)	(54,568)	(7,313)	278
Experience adjustments on scheme liabilities	(625)	(3,252)	70	(616)	704
Percentage of scheme liabilities (%)	0%	1%	0%	0%	0%
Experience adjustments on scheme assets	(19,158)	(5,210)	57,390	(50,645)	(27,038)
Percentage of scheme assets (%)	7%	2%	23%	27%	12%

4. Other expenditure

	2011/12		2010/11	
	£000	£000	£000	£000
IT costs, including general project management	11,028		13,915	
Travel and subsistence	5,149		4,965	
Rentals under operating leases	3,658		4,296	
Other Premises Costs	4,130		3,892	
General Office Supplies	2,941		2,617	
Telecoms	2,306		2,678	
Communications	2,055		2,031	
Recruitment, Training & Development Costs	2,033		3,159	
Professional fees & project costs	1,310		2,378	
Redundancy	722		9,181	
Printing & Publishing	612		1,266	
External Audit Fees –Statutory Work	145		125	
Losses and Special Payments (Bad Debt)	131		344	
Consultancy	71		1,832	
Operating Leases (Equipment)	63		31	
Losses and Special Payments (Other)	–		65	
Bank Charges	5		6	
Other costs	(2)		16	
		36,357		52,797
Non-cash items				
Loss on disposal of intangible assets	585		790	
Loss on disposal of property, plant and equipment	437		198	
Net gain(loss) on revaluation of intangibles	24		1,048	
Net gain(loss) on revaluation of property, plant and equipment	5		659	
Cost of PCSPS Long Term Creditor recognised as an expense	136		–	
Net expenses on pension scheme assets and liabilities	–		816	
		1,187		3,511
Other Expenditure		**37,544**		**56,308**
Depreciation – intangible assets	7,225		6,756	
– property, plant and equipment	4,115		5,717	
Depreciation		**11,340**		**12,473**
Impairment of intangible assets	6,399		-	
Impairment of property, plant and equipment assets	4		67	
Impairment		**6,403**		**67**

5. Auditors' remuneration

	2011/12 £000	2010/11 £000
Fees payable to the Commission's auditors for the 2011/12 audit of the Commission's annual accounts	145	125

6. Income

	2011/12 £000	£000	2010/11 £000	£000
Income from activities:				
Income from fees	(85,763)		(80,061)	
Other income	(224)		(1)	
		(85,987)		**(80,062)**
Other income:				
Other non trading Income	(10)		(22)	
Net return on pension scheme assets and liabilities	(2,494)		-	
		(2,504)		(22)
Total		**(88,491)**		**(80,084)**

Fees and charges made to the independent sector are in line with fee scales prescribed by the Secretary of State for Health under the Health and Social Care Act 2008. While the same Act, also prescribed that all NHS trusts had to be registered with CQC from 1 April 2010, dentists from 1 April 2011, GP "out of hours" services from 1 April 2012 and general practitioners from 1 April 2013.

Annual registration fees are invoiced on the anniversary of the registration and recognised as income over the following 12 months. Statutory fees relating to future accounting periods are treated as income in advance at the end of each accounting period (Note 14). In cases of voluntary deregistration, fees are refunded to registered organisations in accordance with the fee rebate scheme detailed on the Commission's internet site.

Income losses – claims waived

CQC made the decision to waive its right to additional income by not invoicing those Foundation Trusts that transferred in community provider arms part way through the financial year, based upon the new turnover figure for the year. The additional income of £0.6m was waived due to the uncertainty of the information available and used to measure this income. As the Foundation Trusts are in the same departmental boundary as CQC there was no loss of income for the Department of Health or the Treasury.

7. Intangible assets

	IT Software development £000	Software licences £000	Website £000	Total £000
Cost or valuation				
At 1 April 2011	20,441	2,230	2,749	25,420
Additions	9,848	35	1,358	11,241
Disposals	(1,133)	(101)	(467)	(1,701)
Impairments	(12,289)	–	(1,777)	(14,066)
Indexation	(38)	(4)	(1)	(43)
At 31 March 2012	**16,829**	**2,160**	**1,862**	**20,851**
Amortisation				
At 1 April 2011	(6,255)	(1,173)	(951)	(8,379)
Charged in year	(5,346)	(1,014)	(865)	(7,225)
Disposals	766	101	249	1,116
Impairments	6,493	–	1,174	7,667
Indexation	48	(24)	5	29
At 31 March 2012	**(4,294)**	**(2,110)**	**(388)**	**(6,792)**
Net Book value at 31 March 2012	**12,535**	**50**	**1,474**	**14,059**
Net Book value at 1 April 2011	**14,186**	**1,057**	**1,798**	**17,041**
Cost or valuation				
At 1 April 2010	21,821	4,729	1,615	28,165
Additions	10,016	78	1,318	11,412
Disposals	(10,033)	(2,409)	(19)	(12,461)
Indexation	(1,363)	(168)	(165)	(1,696)
At 31 March 2011	**20,441**	**2,230**	**2,749**	**25,420**
Amortisation				
At 1 April 2010	(9,986)	(2,892)	(393)	(13,271)
Charged in year	(5,510)	(685)	(561)	(6,756)
Disposals	9,252	2,407	12	11,671
Indexation	(11)	(3)	(9)	(23)
At 31 March 2011	**(6,255)**	**(1,173)**	**(951)**	**(8,379)**
Net Book value at 31 March 2011	**14,186**	**1,057**	**1,798**	**17,041**
Net Book value at 1 April 2010	**11,835**	**1,837**	**1,222**	**14,894**

Intangible asset comprise software licences, software development costs, including related contractor and staff costs, and web-site development costs. These are valued using indices issued by the Office for National Statistics. Related general project management and overhead costs are not capitalised.

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

Revaluation reserve – intangible assets

	March 2012 £000	31 March 2011 £000
Balance at 31 March	599	2,569
Net gain/(loss) on indexation of intangible assets	10	(671)
Transfers between reserves for intangible assets	(511)	(1,299)
Balance at 31 March	98	599

8. Property, plant and equipment

	Information Technology £000	Furniture & Fittings £000	Total £000
Cost or valuation			
At 1 April 2011	14,016	7,480	21,496
Additions	1,050	133	1,183
Disposals	(6,378)	(829)	(7,207)
Impairments	-	(19)	(19)
Indexation	(12)	69	57
At 31 March 2012	**8,676**	**6,834**	**15,510**
Depreciation			
At 1 April 2011	(7,776)	(5,816)	(13,592)
Charged in year	(3,537)	(578)	(4,115)
Disposals	5,994	776	6,770
Impairments	-	15	15
Indexation	64	(112)	(48)
At 31 March 2012	**(5,255)**	**(5,715)**	**(10,970)**
Net Book value at 31 March 2012	**3,421**	**1,119**	**4,540**
Net Book value at 1 April 2011	**6,240**	**1,664**	**7,904**
Cost or valuation			
At 1 April 2010	16,386	9,852	26,238
Additions	2,291	308	2,599
Disposals	(2,207)	(933)	(3,140)
Impairments	(1,431)	(1,741)	(3,172)
Indexation	(1,023)	(6)	(1,029)
At 31 March 2011	**14,016**	**7,480**	**21,496**
Depreciation			
At 1 April 2010	(7,351)	(6,534)	(13,885)
Charged in year	(3,864)	(1,853)	(5,717)
Disposals	2,024	918	2,942
Impairments	1,431	1,674	3,105
Indexation	(16)	(21)	(37)
At 31 March 2011	**(7,776)**	**(5,816)**	**(13,592)**
Net Book value at 31 March 2011	**6,240**	**1,664**	**7,904**
Net Book value at 1 April 2010	**9,035**	**3,318**	**12,353**

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

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

Revaluation reserve – property, plant and equipment

	31 March 2012	31 March 2011
	£000	£000
Balance at 31 March	592	1,503
Net gain/(loss) on indexation of property, plant and equipment	14	(407)
Transfers between reserves for property, plant and equipment	(475)	(504)
Balance at 31 March	131	592

Asset Financing:

All assets are owned by CQC.

9. Financial Instruments

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

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

a) Market risk

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

b) Credit risk

Credit risk arises from cash and cash equivalents, as well as the credit exposures derived from care home operators. Management monitored the credit closely and all undisputed debts over 61 days where internal recovery processes were exhausted were sent to a debt collection company for recovery action. Whilst ultimate recovery was still pursued, such debts were provided for as a matter of course.

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

The table below shows the ageing of the overdue analysis of trade debtors which have not been provided for at the Statement of Financial Position date:

	Less than 30 days past due £000	31 – 60 days past due £000	61 and over days past due £000
At 31 March 2012	1,437	3,122	2,760
At 31 March 2011	2	489	285

The increase in trade debtors was due to the implementation of a new fee scheme and the delay in initiating debt recovery processes following the transfer of the debt collection function to an outsourced provider.

Intra-government balances are repayable on demand and were therefore classified as current until request for payment was made.

The maximum exposure to credit risk at the reporting date is the fair value of each class of receivables mentioned above. The Commission did not hold any collateral as security.

c) Liquidity risk

Management aimed to manage liquidity risk through regular cash flow forecasting to ensure the Commission had sufficient available funds for operations. The Commission had no borrowings and relied on grant in aid from the Department of Health for its cash requirements and was therefore not significantly exposed to liquidity risks.

The table below analyses the Commission's financial liabilities which will be settled on a net basis in the period of less than one year. The carrying value of financial liabilities was not considered to differ significantly from the contractual undiscounted cash flows:

Less than one year

	31 March 2012 £000	31 March 2011 £000
Current liabilities	(14,488)	(11,046)

d) Capital risk management

Ongoing funding for CQC has been confirmed by the Department of Health. As a result the capital structure was considered low risk and it was not a requirement for management to actively monitor this on a day to day basis.

10. Impairments

During October 2011, CQC carried out an impairment review of IT intangible assets. The review resulted in an impairment of software developments (£5,796k) and website developments (£603k). The impairment related to old compliance and registration systems which were updated due to the development of new compliance and registration systems.

Impairments for the previous year concerned the closure of the St. Nicholas building in Newcastle.

	31 March 2012 £000	31 March 2011 £000
St.Nicholas office closure – fittings	-	67
Office Equipment	4	-
Developed Software	5,796	-
Website	603	-
Total	**6,403**	**67**

11. Inventories

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

12. Trade receivables and other current assets

	31 March 2012 £000	31 March 2011 £000
Amounts falling due within one year:		
Deposits and advances	118	109
Other receivables	34	160
Prepayments and accrued income	2,229	2,739
Subtotal: Other current assets	2,381	3,008
Trade receivables	7,802	5,594
Total	**10,183**	**8,602**

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

Deposits and advances include advance payments on salary and staff loans total £4k and £114k respectively (2010/11: £16k and £93k). Staff could apply for advance payments on salary and loans up to a maximum of £5k for rail season tickets.

12.1. Intra-government debtor balances

	Amounts falling due within one year	
	31 March 2012	31 March 2011
	£000	£000
Intra-governmental balances:		
Balances with Central Government	131	54
Balances with NHS trusts	183	114
Balances with Local Authorities	671	346
Balances with Public Corporations & Trading Funds	–	14
Subtotal: intra-government balances	985	528
Balances with bodies external to Government	9,198	8,074
	10,183	**8,602**

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

12.2. Movement in the allowance for doubtful debts

	31 March 2012	31 March 2011
	£000	£000
Balance at the beginning of the period	410	210
Additional Losses recognised during the year	413	379
Impairment Losses recognised	(11)	(20)
Amounts written off during the year as uncollectible	(45)	(70)
Amounts recovered during the year	(345)	(89)
Balance at the end of the period	**422**	**410**

13. Cash and cash equivalents

	£000
Balance at 31 March 2011	16,366
Net change in cash and cash equivalent balances	(600)
Balance at 31 March 2012	**15,766**

	31 March 2012	31 March 2011
	£000	£000
The following balances were held at:	15,764	16,363
HM Paymaster General	2	3
Commercial banks and cash in hand	**15,766**	**16,366**

14. Trade payables and other current liabilities

	31 March 2012 £000	31 March 2011 £000
Amounts falling due within one year		
VAT	(9)	(15)
Other taxation and social security	(1,944)	(1,832)
Trade payables	(2,889)	(3,434)
Other Payables	(1,307)	(1,091)
Accruals and deferred income	(5,986)	(2,754)
Capital creditors – intangible assets	(1,272)	(1,341)
Capital creditors – property, plant and equipment	(1,081)	(579)
	(14,488)	**(11,046)**
Current pension liabilities	(487)	(679)
Fee income in advance	(35,224)	(24,997)
	(50,199)	**(36,722)**
Amounts falling due after more than one year		
Pension Liabilities	(1,022)	(1,456)
	(1,022)	**(1,456)**

Trade payables at 31 March 2012 were equivalent to 21 days (2010/11: 15 days) purchases, based on the average daily amount invoiced by suppliers during the year. For most suppliers no interest is charged on the trade payables for the first 30 days from the date of the invoice. Thereafter interest is charged on the outstanding balances at various interest rates. Whilst CQC has financial risk policies in place to ensure that all payables are paid within the pre-agreed credit terms, no amounts (2010/11: £1.3k) were paid under the provisions of the Late Payment of Commercial Debts (Interest) Act 1998.

Trade payables falling due after more than one year have been reduced by a discount factor of 2.8% pa (2010/11: 2.9%) in accordance with HM Treasury guidance.

14.1 Intra-government creditor balances

	Amounts falling due within one year		Amounts falling due after more than one year	
	31 March 2012	31 March 2011	31 March 2012	31 March 2011
	£000	£000	£000	£000
Balances with Central Government	(4,012)	(2,912)	–	–
Balances with NHS Trusts	(177)	(36)	–	–
Balances with Local Authorities	(638)	(751)	–	–
Balances with Public Corporations & Trading Funds	–	(1)	–	–
Subtotal: intra-government balances	**(4,827)**	**(3,700)**	–	–
Balances with bodies external to Government	(45,372)	(33,022)	(1,022)	(1,456)
	(50,199)	**(36,722)**	**(1,022)**	**(1,456)**

15. Provisions for liabilities and charges

	Employment termination and other costs		Leased property dilapidations		Total	
	2011/12	2010/11	2011/12	2010/11	2011/12	2010/11
	£000	£000	£000	£000	£000	£000
Balance 1 April	(2,239)	(167)	(1,091)	(1,421)	(3,330)	(1,588)
Provided in year	(491)	(2,175)	(771)	(76)	(1,262)	(2,251)
Provisions not required written back	249	73	121	132	370	205
Provisions utilised in year	1,990	30	70	243	2,060	273
Unwinding of Discount	–	–	21	31	21	31
Balance 31 March	**(491)**	**(2,239)**	**(1,650)**	**(1,091)**	**(2,141)**	**(3,330)**
Analysis of expected timing of discounted flows						
In the next financial year	(491)	(2,239)	(211)	(193)	(702)	(2,432)
Current Provisions 31 March	**(491)**	**(2,239)**	**(211)**	**(193)**	**(702)**	**(2,432)**
Between 1 – 5 years	–	–	(1,439)	(898)	(1,439)	(898)
Between 6 – 10 years	–	–	–	–	–	–
After 10 years	–	–	–	–	–	–
Non-Current Provisions 31 March	**–**	**–**	**(1,439)**	**(898)**	**(1,439)**	**(898)**

Following last year's restructuring of the headquarter directorates. CQC has restructured its regional directorates from nine to four. Our regional boundaries will mirror those of the NHS Commissioning Board and the future organisation of the Government's relationship with adult social care. This will help us develop better strategic and information-sharing relationships with many of our key stakeholders. A provision has been made to cover the cost of all redundancies that were agreed by 31 March 2012 although some staff will not leave CQC until 2012/13. This provision is estimated as £0.3m (2010/11: £1.3m).

A provision has been made to cover future legal costs for example, tribunals and judicial reviews. The provision is estimated at £0.2m (2010/11: £0.6m).

Leased property dilapidations are the costs that would become payable upon the termination of the leases.

Provisions falling due after more than one year have been reduced by a discount factor of 2.2% pa (2010/11: 2.2%) in accordance with HM Treasury guidance.

16. Capital commitments

Contracted capital commitments at 31 March 2012 not otherwise included within these financial statements totalled £2,234k (2011: £1,382k) and consist, in the main, of IT hardware and software developments:

	31 March 2012 £000	31 March 2011 £000
Property, plant and equipment	29	196
Intangible assets	2,205	1,186
	2,234	1,382

17. Commitments under leases

Total future minimum lease payments under operating leases are given in the table below for each of the following periods.

Obligations under operating leases comprise:

	31 March 2012 £000	31 March 2011 £000
Buildings – Rent:		
Not later than one year	3,235	3,288
Later than one year and not later than 5 years	11,184	11,756
Later than 5 years	7,571	10,156
	21,990	**25,200**
Other:		
Not later than one year	39	27
Later than one year and not later than 5 years	74	79
Later than 5 years	-	-
	113	**106**

Leased payments recognised as an expense

	31 March 2012	31 March 2011
	£000	£000
Operating leases – rentals	3,658	4,296
Operating leases – equipment	63	31
	3,721	4,327

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

18. Other financial commitments

There were no other material financial commitments at the statement date (2010-11:£nil).

19. Contingent liabilities disclosed under IAS 37

The Commission has the following contingent liabilities:

	31 March 2012	31 March 2011
	£000	£000
First Tier Tribunals:	35	62
Employment Tribunals:	132	31
Public Enquiry – Mid Staffordshire	–	489
Implementation of Integrated Grading Structure	–	1,532
Criminal Prosecution	12	4
	179	**2,118**

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

20. Related party transactions

The Care Quality Commission is a non-departmental public body sponsored by the Department of Health. The Department of Health is regarded as a related party. During the year 2011-12 CQC has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
Department of Health	1,299	45,376	998	68
NHS Foundation Trusts	-	10,192	36	37
NHS Trusts	-	8,863	7	16
NHS PCTs	-	944	104	130
NHS SHAs	1	-	1	-
NHS Special Health Authorities	7	-	29	-

CQC received a total amount of grant-in aid of £45.3m (2010/11: £92.3m) from the Department of Health. Revenue grant-in-aid totalled £33.3m (2010/11: £77.3m) and capital grant-in-aid totalled £12.0m (2010/11: £15.0m)

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

In addition, CQC has had a number of transactions with other government departments and other central and local government bodies. Most of these transactions have been with the Department for Communities & Local Government in respect of rent for office space. CQC also has amounts owed to other government departments which are mostly owed to HMRC and the NHS pension fund.

21. Third-party assets

The Commission had no third-party assets for either 2011-12 or 2010-11.

22. Discontinued activities

There were no discontinued activities of the Commission to be reported in these financial statements (2010/11: None).

23. Post statement of financial position events

The Commission's financial statements were laid before the Houses of Parliament by the Department of Health. The Commission is required to disclose the date on which the accounts were authorised for issue. This is the date on which the certified accounts are dispatched by CQC's management to the Department of Health. The authorised date for issue is 6 July 2012.

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

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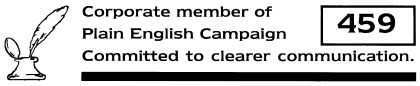

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