Care Quality Commission

Annual report and accounts
2015/16

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Who we are and what we do

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

Our purpose

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

Our role

Register

We register health and adult social care providers.

Monitor, inspect and rate

We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.

Enforce

We use our legal powers to take action where we identify poor care.

Independent voice

We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values underpin everything we do

EXCELLENCE – being a high-performing organisation.
CARING – treating everyone with dignity and respect.
INTEGRITY – doing the right thing.
TEAMWORK – learning from each other to be the best we can.

How we work

We are independent, but we report to Parliament through the Department of Health. We work with other regulators, local authorities and commissioning groups, health and social care organisations, and organisations that represent people who use services as part of the overall health and social care system.

Performance report

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Foreword

Peter Wyman
Chair

David Behan
Chief Executive

The past year was a landmark period for CQC. Since 2013, we have radically changed our regulation of health and social care services, and we have now firmly established a new approach to inspection, backed by ratings, that aims to improve the quality of care people receive. We completed our first full ratings inspection programme of all acute NHS trusts in England by the end of March 2016, and we will complete the comprehensive inspection programme for adult social care, GP practices and out-of-hours services, trusts and independent hospitals before the end of financial year 2016/17.

This will provide a baseline understanding of quality across health and social care that is unique not just in England, but in any country. In the autumn we will report to Parliament with the most complete picture yet of the state of care in England. That picture will show, among other things, that despite the considerable challenges facing each care sector, improvements in the quality of care have been achieved and will continue to be possible.

The evidence shows that inspection is encouraging improvements in care. Almost two-thirds of services and providers originally rated inadequate and re-inspected in 2015/16 were able to improve their rating. These improved ratings are a testament to the time, effort and determination of providers, their managers and their staff. It is also testament to the effectiveness of robust and efficient regulation. Providers and partners tell us that they use CQC's inspection reports and ratings to address areas of poor quality and inform improvement priorities, and that our findings often act as a trigger to tackle difficult issues.

During the year we improved our performance in a number of areas, including our productivity, our response times for safeguarding alerts, and our recording of performance information. Most importantly, we met our recruitment targets for inspection staff, helping to ensure we could meet our inspection programme commitments.

Encouragingly, we have begun to see a number of NHS trusts and large corporate care providers present their monthly finance and performance monitoring reports to their boards organised around our five key questions: are services safe, effective, caring, responsive and well-led? It is an example of our methodology becoming embedded in the way organisations operate and view quality.

However, we know that we cannot stand still. This report is published as we enter the first months of our new strategy. Over the next five years, the health and social care sector will need to adapt to the strong challenges they face, and CQC needs to do the same. Our ambition is to be a more targeted, responsive and collaborative regulator so more people get high-quality care.

The sectors we regulate are changing. There are new models of care and some are offering excellent services. In some places, providers are exploring new ways of providing care to people.

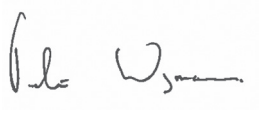
CQC must be agile in this more dynamic and radically changing sector and market. We have to be alert to risks and be able to react quickly when there are individual cases of poor care or if there is a problem in a market that could affect a group of people or a population. Technology and better use of information will be critical, and this dominates the innovative ways in which we intend to improve our overall engagement with providers and the public.

We consulted and worked hard with stakeholders and the public over the whole of last year to build the new strategy. It has been strongly supported by the vast majority of organisations and people who have provided feedback.

We will continue to work closely with stakeholders and system partners to develop our regulatory approach. We are focused on improving the efficiency and effectiveness of our operating model, systems and processes. On the ground, this includes improving the quality of our inspection reports, and publishing them more quickly.

We need to demonstrate the impact we make in encouraging services to improve. We also need to demonstrate that we are efficient in the way we operate. Over the next few years we will have less money with which to discharge our responsibilities – becoming more efficient is key to sustainability.

Finally, we will continue to always act independently and on the side of people who use services, their families and carers, in our determination to pursue equal access to high-quality care for everyone.



Peter Wyman
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Performance summary

In 2015/16 we completed the final year of a three-year journey, started in 2013, to transform the way the quality of health and social care in England is regulated. This involved radical changes to bring in a new, rigorous and expert-led inspection approach, and quality ratings to encourage improvements in care and give the public more information about the care they receive.

We are making good progress towards completing comprehensive inspections of all the services we rate, and we are building a powerful baseline understanding of the quality of care in England across health and social care.

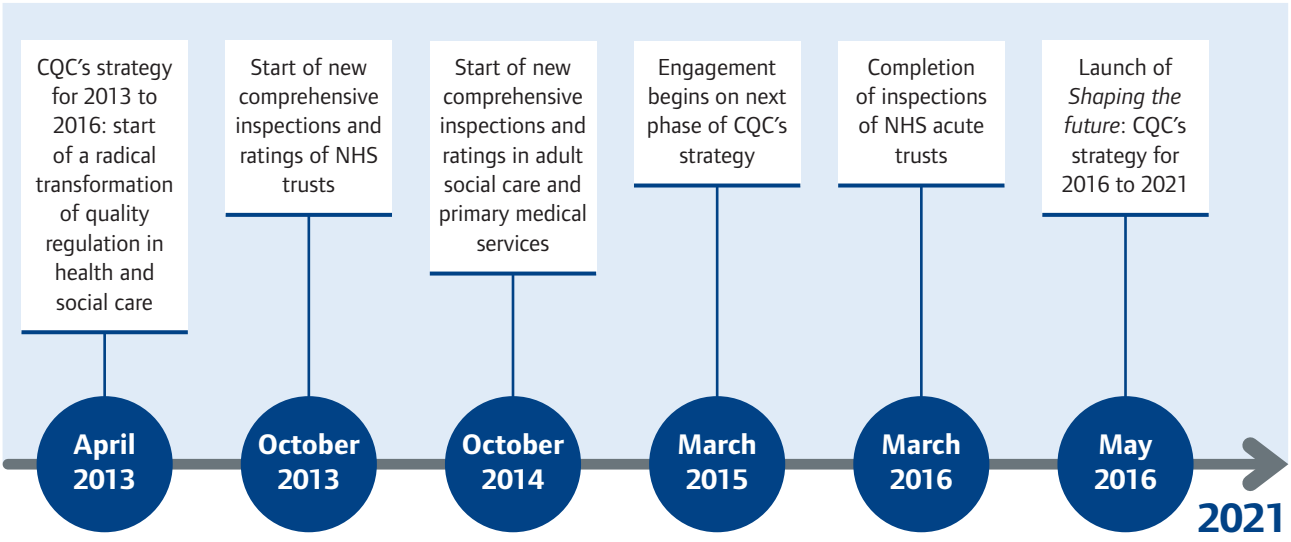
We are seeing some evidence that this work is leading to better care – there are already many providers who have improved their rating when we have gone back to re-inspect, and some providers tell us that our inspections and reports help identify areas for improvement and bring about change.

At the same time, in 2015/16 we have put a lot of focus into strengthening our own systems and processes, making sure we use our resources as efficiently and effectively as possible, and looking to reduce the requirements we put on those we regulate. We have made progress, but still have more to do. The health and social care sector is working in a challenging context, with increased demand for care and strong pressure to control costs. Over the next five years, services will need to adapt, and our regulation must do the same. We spent a lot of time and energy in the year to develop our new strategy for 2016 to 2021, *Shaping the future*. This sets out an ambitious vision for a more targeted, responsive and collaborative approach to regulation.

Progress towards completing our inspections and ratings programme

A central focus in 2015/16 was to progress our comprehensive ratings inspection programme, as well as continue to respond to concerns as they arose through focused inspections.

Figure 1: CQC timeline 2013 to 2021



We completed our programme of first ratings inspections of NHS acute non-specialist hospital trusts by the end of March 2016, and we are on track to complete planned inspections of other NHS trusts early in 2016/17. We made substantial progress in our programme of first ratings inspections for adult social care and for primary medical services, which will conclude in 2016/17.

This progress was made possible by meeting our recruitment target of 600 new inspectors. As these staff members have been trained and established in their roles, we have seen a gradual increase in inspection team productivity. Part of this was cutting the time taken to write and publish inspection reports; we will continue to focus on reducing this during 2016/17.

Our survey feedback showed that most of the providers who responded thought our inspections were a thorough review of whether their service is safe, effective, caring, responsive and well-led – 89% of adult social care providers, 78% of primary medical services providers and 20 out of 29 hospitals.

Bringing about improvements in care

Encouraging providers to improve their quality of care is at the centre of our purpose. Almost two-thirds (63%) of services and providers originally rated inadequate improved their rating following a re-inspection in 2015/16. Of the 362 (out of 578) that improved, 75% went from inadequate to requires improvement and 25% went from inadequate to good.

We re-inspected a further 1,244 services that were rated as requires improvement. Of these 36% (451) achieved a rating of good.

We found that the majority of GP practices (74% of those re-inspected) had improved their overall rating. Of the 23 hospitals re-inspected, six achieved an improved rating, and 43% of adult social care services re-inspected saw an improved rating.

This demonstrates the role that regulation plays in improving care and that, despite the significant challenges facing all the care sectors, improvement is possible. Providers tell us they use our inspection findings to address areas of poor quality – our survey feedback so far showed that the majority of providers who responded thought that our inspection reports and visits helped them improve. Our inspection teams have noted that high numbers of services make immediate improvements as a result of inspection, for example around reviewing policies and procedures, improving the safety of the care environment, enhancing person-centred care, recruitment, supervision and staff training.

At the end of 2015/16, a total of 449 providers were in special measures. This regime, which ensures there is a framework in which services can be supported to improve or signposted to organisations that can help them improve, has been an impetus for improvement, with 164 locations exiting special measures during the year. Of these, 102 had improved sufficiently to exit. The remaining were providers that either de-registered or had their registration cancelled.

We also began to see a number of NHS trusts and large corporate care providers present their monthly finance and performance monitoring reports to their boards, organised around our five key questions of: safety, effectiveness, caring, responsiveness and leadership. It is an example of our methodology becoming embedded in the way organisations operate and view quality – we believe this will in turn support these providers to improve further.

Operational efficiency and improvements

We are focused on continuous improvement of our operating model. We launched online registration for providers to improve the speed and accuracy of this important process. New health and care providers need to be registered thoroughly but also quickly so that we can make sure people have access to high-quality care.

We also completed our plans to restructure our registration teams as sector specialists, ensuring they are much more closely aligned to our inspection team structure. We expect to see the benefit of these initiatives in 2016/17.

In looking at our impact during registration, our survey feedback showed that most new providers and new registered managers who responded to our survey were positive about the impact of the registration process in helping them to deliver high-quality care. We found that the standards and guidance at registration helped providers to recognise and address areas for improvement – most commonly around recruitment, training and supervision of staff.

We made progress during the year towards many of our commitments to longer-term improvement projects. As well as successfully meeting our recruitment targets, we improved our timeliness in responding to safeguarding alerts and concerns, implemented our market oversight scheme for difficult to replace providers of adult social care, and improved in a number of areas of management assurance.

We continued to listen closely to people who use care services and the public and their representatives, including those who seldom have their voices heard (such as those in the criminal justice system or people with a learning disability). We increased our use of Experts by Experience to support our inspections, and we expanded our 'Tell us about your care' partnerships with voluntary organisations that represent and hear from people who use services the most.

However there is still more to do and a number of improvement projects started in 2015/16 are continuing into 2016/17. Full details of these are reported to our public Board meetings through our quarterly performance reports. They include:

- Improving our information management and technology – this programme aims to ensure that our data and information systems work together effectively so that our staff can do their jobs efficiently. It reached the end of its initiation phase in March 2016. We are now focused on completing the roadmaps needed for each part of the programme, and developing and prioritising the capital programme that will guide it.
- Developing our new insight model, which will bring together all the information we have on a service and enable us to more effectively target our resources where the risk to quality of care is greatest or where quality is improving. The concept model for the acute sector has progressed well, and further development of data and statistical methodology is ongoing.
- Responding to concerns about the quality of care – the development of an integrated triaging tool has been approved, and the focus is now on streamlining the routes of contact into CQC, to create a more efficient process.
- Implementing our new approach to enforcement – improved IT systems for handling enforcement went live in April 2016, and we are now ensuring all operational staff are trained in the new system.
- Embedding a quality framework into our operating model – work is ongoing to ensure quality standards are fully integrated into all parts of our operating model.
- Embedding our values – there were notable improvements in our staff survey results, but there is more to do to improve communication, change processes and staff morale, to further reduce bullying and harassment, and to improve the experience of disabled staff.

CQC manages a range of strategic and operational risks to the delivery of its purpose, and we report on these in our public Board meetings, setting out a risk rating for each risk

and the mitigating actions being carried out to manage them. We reviewed these risks in May 2016 and added new ones associated with our new strategy, capacity and budget. Strategic risks include those relating to encouraging improvement, budget, capacity, skills and capability of staff, and the information we collect and use. Operational risks include the ability to make timely regulatory decisions, responding effectively to public concerns, and the design and functionality of our systems and processes. A full list of risks and mitigating actions is published on our website. See also the risk management section on page 72.

Financial performance and economy

Our revenue expenditure in 2015/16 was £236 million, which was £13 million under our budget for the year of £249 million. Expenditure was higher than last year, however, largely driven by an increase in staff costs as we achieved our recruitment targets; ensuring that Experts by Experience were supporting a higher number of inspections; and dual running of our London estate as we transitioned to a new main office in Victoria.

During the year we laid the groundwork for the future savings required of us. This included introducing greater controls around vacancies, driving value for money out of our third party contracts and investing in systems to ensure that efficiencies are realised in our processes.

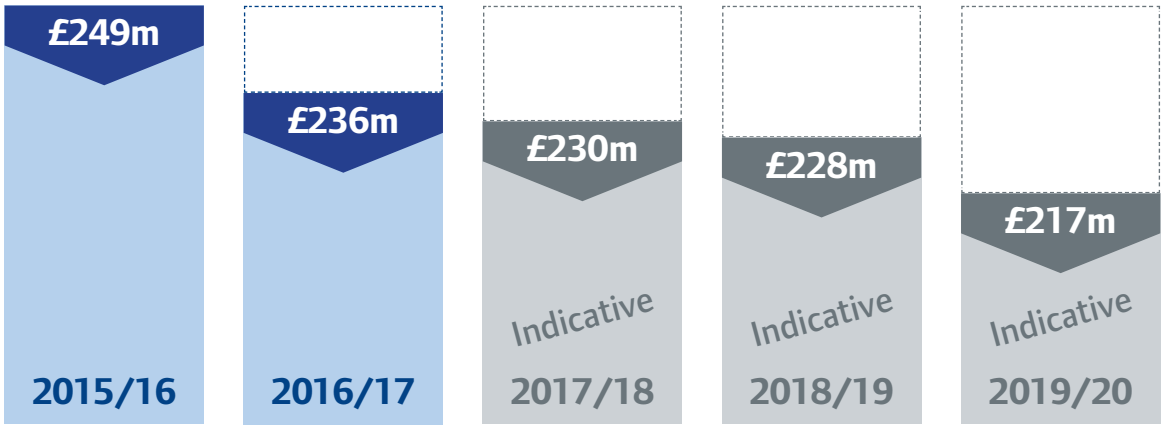
For 2016/17 our operating budget is £236 million, and by 2019/20 it will be £217 million (figure 2). At the same time, the main source of our funding will switch from grant-in-aid from the Department of Health to fees paid by providers.

We are aiming to work more efficiently, deliver savings each year and be a more effective regulator with a lower cost base by 2019/20. To support this, we continued to develop a costing model – we will use this as the baseline on which we will build our impact and value for money reporting in the future. We will publish the first of these reports in autumn 2016. See page 46 for more detail on our costing model.

Shaping the future through our new strategy

Over the next five years the health and social care sector will need to adapt, and we do not underestimate the challenges that services face. Demand for care has increased as more people live for longer with complex care needs, and there is strong pressure on services to control costs. To help meet these challenges, services are changing the way they organise and deliver care, and our approach needs to evolve too.

Figure 2: CQC budget levels, 2015/16 to 2019/20



We engaged in a year-long conversation with our partners, providers, stakeholders and the public to develop our new five-year strategy for 2016 to 2021, which we published in May 2016.

This sets out our ambition to be a more targeted, responsive and collaborative regulator so that more people get high-quality care. It was strongly supported by the vast majority of organisations and people who provided feedback during our consultation. We made sure that we engaged closely with people who use services, including people with protected equality characteristics and the organisations that represent them. Of those who took part, 86% said they agreed or strongly agreed with CQC's vision.

Our purpose, role and operating model will not change – inspections will continue to be central to our assessments of quality, and we will continue our work with the public to understand and focus on what matters to people.

But we will put more of our resources into assessing the quality of care for services with poor ratings and those whose rating is likely to change, and less on those where care quality is good. We will better monitor changes in quality by bringing together what people who use services are telling us, knowledge from our inspections, and data from our partners. We will make more use of unannounced inspections, focused on the areas where this insight suggests risk is greatest or quality is improving.

We will learn alongside providers who offer new care models or use new technologies, to encourage innovation by flexibly and effectively registering and inspecting such new models. And we will make it easier for everyone to work with our systems – developing a shared data set with partners, other regulators and commissioners, so providers are only asked for information about care quality once, and using online processes as the default to make interactions with providers and the public easy and efficient.

Performance analysis

1. How we measure our performance, impact and value for money

We measure how successful we have been each year in achieving our purpose by looking at how we have performed in four areas:

- impact and outcomes
- quality and effectiveness
- internal capability
- costing model.

We use a range of strategic measures and key performance indicators to track our performance in these areas. We report on our performance to CQC's Board, the public, partners and stakeholders, the Department of Health and the Parliamentary committees that scrutinise our work and to whom we are accountable.

We started work to understand better our impact and value for money and we began to develop robust measures to assess this. We measure our value for money by asking questions on economy, efficiency and effectiveness.

Now that we have been delivering our new inspection approach and ratings system for long enough, we are able to look more closely at our impact, using a broad range of evidence. This includes data and information when we rate again, surveys about our regulatory model, and case studies of providers that show our impact in action.

We look for progress under the following outcomes:

- That providers are being encouraged to improve.
- That people are receiving safe, effective, caring, responsive and well-led care.
- That our information helps the public in their choice of care service.

We have early evidence of our impact in this report. We have analysed the results of our post-registration and post-inspection surveys of providers that had an inspection report published between January and June 2015, our October 2015 inspection team survey, and our 2016 public awareness survey. We are assessing the costs of the different elements of our operating model, calculated through our developing costing model. We will explore using the costing model to identify how efficient we are and we are undertaking work to ensure we can be more economical.

We will report on our impact and value for money on an annual basis and we will publish our first detailed report in October 2016. This will draw together all of our information and provide a fuller picture. It will include assessments of our costs, the burden of regulation on providers and the benefits that result from our work.

Our key performance indicators

We report on the following key performance indicators (KPIs) for 2015/16 in this performance analysis:

Figure 3: Key performance indicators 2015/16

KPI	2015/16 target	2015/16 actual	Page
Registration processes completed within 50 days (new, variation, cancellation)	90%	77%	15
Inspections (first comprehensive rating) undertaken versus plan	100%	Performance is against overall inspection programme. See figure 8.	20
Inspection reports published within 50 working days	Tracked through the year, but no specific target	62%	20
Safeguarding alerts referred to a safeguarding authority within 0-1 days	95% (target from quarter 3)	96% (Quarters 3 and 4 combined)	35
Safeguarding alerts and concerns had one of four possible mandatory actions taken in 0-5 days	90% (target from quarter 3) 100% (target from quarter 4)	Quarter 3: 79% Quarter 4: 83%	35
Mental Health Act visits planned each quarter completed	90%	93%	24
SOAD requests undertaken (visits) within target time – medicine, ECT, CTO	95% all	86%	24
Complaints about CQC: upheld at stage 1; progressing to stage 2; upheld at stage 2	<20% all	Upheld at stage 1 – 17% Progressed to stage 2 – 21% Stage 2 upheld – 26%	23
Calls answered in 30 seconds – general	80%	78%	14
Safeguarding/mental health calls answered in 30 seconds	90%	91%	14
Correspondence answered in 10 days	90%	91%	14
Frontline vacancies – recruitment plan achieved	100%	100%	39
Turnover	<5%	11.2%	39
Sickness	<5%	3.5%	39
Variance from revenue and capital budget	£0	Revenue – £15.7m (6%) under budget (actual £248.1m) Capital – £6.5m (38%) under budget (actual £10.5m)	44

We also draw on additional management information – on enforcement actions taken, and on special measures, and a number of strategic measures of impact and quality which are described in CQC's business plan for 2015/16. Where these are used in the performance report they are referenced in the relevant section.

Ensuring high-quality customer service

In support of all our functions, our National Customer Service Centre (NCSC) deals with enquiries relating to registration, safeguarding, mental health and online services, as well as general calls about CQC, and complaints about providers. Correspondence (emails, letters, online contacts) are also dealt with.

There was a small increase in the number of calls – we received 259,735 calls, compared with 258,151 in 2014/15. Call-handling (the number of calls answered within agreed targets) improved by 2% for both safeguarding and mental health. General call-handling performance slightly decreased. However, this was due to prioritising the more serious calls and is not a concern.

Our performance in responding to correspondence within 10 days also improved, from 89% of correspondence to 91%.

Figure 4: National Customer Service Centre (NCSC) call-handling and correspondence performance, 2015/16 and 2014/15

	2015/16	2014/15	Target
Safeguarding calls answered within 30 seconds	91%	89%	90%
Mental health calls answered within 30 seconds	92%	90%	90%
General calls answered within 30 seconds	78%	79%	80%
Correspondence replied to in less than 10 days	91%	89%	90%

2. Registering health and care services

We register health and care services to ensure that people receive high-quality care. Registration is a very important quality check and providers must show that they are capable of meeting the fundamental standards before we can register them. It is important that our registration requirements are clear and transparent so that providers are clear on the legal basis on which they are able to provide services.

Performance

In *A fresh start for registration* in August 2015, we set out our plans for continuous improvement of registration as we adapt to meet the needs of new and more complex models of care. As part of this, we launched online registration through our provider portal, which will improve accuracy and save time in the registration process. We updated our guidance for providers and inspectors (for example, guidance on registering care models for people with a learning disability), and we developed new interview prompts to make registration more tailored to each type of service. These changes are expected to help us improve performance on the registration KPI.

During 2015/16, we set out plans to move to sector specialist teams in registration, to build the expertise of the team and to encourage better joint working between inspection and registration. These changes were introduced in April 2016.

During 2015/16 we completed a total of 34,998 registration processes. This compares with 36,269 processes last year. Registration processes include new registrations, cancellations and variations in registration.

We have a target that 90% of registration processes are completed within 50 working days. In the year we achieved 77% overall within this plan (80% for the Adult Social Care directorate and 74% for the Hospitals and Primary Medical Services directorates). This is in line with the end of 2014/15 when 82% had been completed against the same timeframe. Our analysis of the average number of days to complete a registration shows they ranged between 40 and 62 days, between October 2015 and March 2016. We believe this range may reflect the varying complexity of registration applications, but we need to do further analysis to make sure this is the case. Improvements are required and changes to the registration team structure, put in place in April 2016, will improve performance as resource is allocated more effectively.

Figure 5: Registration processes 2015/16 and 2014/15

	Total all directorates 2015/16	Total all directorates 2014/15
Registration processes	34,998	36,269
Within 50-day target	77%	82%

The KPI data includes registrations where CQC's decision to refuse an application was challenged. This means that those applications could not be completed within the 50-day target.

Impact

Most new providers and new registered managers who responded to our January to June 2015 post-registration survey were positive about the impact of the registration process in helping them to deliver high-quality care. Primary medical services providers were

slightly less positive about how registration helps them improve.

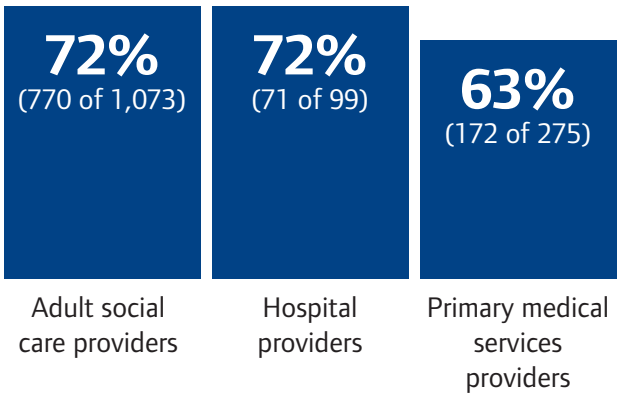
Seventy-four per cent of adult social care providers, 70% of primary medical services and 10 hospitals responding to our survey told us that the standards and guidance they received before registering helped them to improve their systems and plans for providing care.

Figure 6: 'Before registering, the standards and guidance helped us to improve our systems and plans for providing care' (newly registered providers)

Adult social care providers	Hospital providers	Primary medical services providers
74% (68 of 92)	10 providers (out of 12)	70% (42 of 60)

Across all sectors, the majority of new providers and registered managers responding to the survey said that the application form helped them to think about how they would deliver care.

Figure 7: 'The registration application form helped us think about our plans to deliver care' (newly registered providers and registered managers)



Providers told us in the survey that our registration guidance had helped them to view their own processes in a new light, allowing them to recognise and address areas that needed to improve based on CQC expectations.

> *I am currently working through each of the outcomes relevant to our registration status with all of my service clinical leads. We are using this as a framework to ensure we are providing safe, effective, caring, responsive and well-led services. We can then prioritise any specific areas requiring improvement or further development together as a team, in the best interest of the overall quality we provide for patients and their families.*
> **(Hospice)**

They also reported areas where completing the application forms had helped them to improve. The predominant theme across all sectors was that registration helped them improve training, recruitment and supervision of staff.

Adult social care providers referred to monitoring the quality of their service, improvements in record keeping, improving communication with people who use their services and involving people in decisions relating to their care and treatment.

> *We have introduced resident participation in the recruitment of staff. Residents' feedback after meeting candidates has been invaluable in helping us to appoint the right people. The residents have appointed a committee who consider the way we run the service and they make suggestions for where we could improve.*
> **(Residential adult social care service)**

Within primary medical services, there were improvements in staff appraisal, training and supervision, making the care environment safe, incident reporting and management, and risk management. Hospitals also reported improvements in staff appraisal, training and supervision, and making the environment safe, as well as staffing levels and caseloads, and learning lessons from complaints and feedback.

Rated primary medical services and adult social care services noted how their documentation and audit systems were becoming reflective of CQC's requirements.

> *Our internal audit system is being updated to ensure that quality of the services we provide are with the five headings from CQC.*
> **(Community adult social care service)**

Also mentioned in all sectors were improved procedures to gather feedback from people who use services and their families.

Another theme in adult social care was improvements to person-centred care planning.

3. Monitoring quality

We gather and analyse data about services to help us decide when, where and what to inspect. This gives our inspectors a picture of areas that may need to be followed up during an inspection. It also helps us to make better use of resources by targeting activity where it's most needed.

We look at different data in different sectors, and compare the information to help us pinpoint differences from national averages. When we find variation, the action we take depends on what kind of variation we have identified. It might involve carrying out an inspection or we may contact the service to find out more.

Performance

Using data and information

During the year, we felt increasingly confident that our data and information collection is supporting our findings on inspections. This in turn is helping us to plan our resources in advance for an inspection. We found that the majority of GP practices rated good or outstanding were flagged as having low-risk scores, whereas most rated requires improvement or inadequate had higher-risk scores. Similarly in adult social care services, the majority of locations rated good or outstanding had low-risk scores, whereas most rated requires improvement or inadequate had higher-risk scores.

In the hospitals sector we finished our programme of publishing monitoring information for acute NHS trusts and for mental health NHS services, with final reporting in May 2015 and February 2016 respectively. We have turned our attention to developing our new insight model, which will monitor changes in indicators of quality to support our new targeted, responsive and collaborative approach to regulation. We have completed a statistical evaluation of the acute NHS trust Intelligent Monitoring to identify the sets of indicators with stronger relationships to our inspection findings. We are using these findings to inform how we will design the insight model. Data and information from the views of people who use services and their families will continue to be a critical component of our monitoring approach.

Market oversight

The market oversight scheme was a new regulatory duty for 2015/16. We are required to monitor the financial sustainability of the most difficult to replace providers of adult social care (Parliament defines difficult to replace in regulations). CQC is required to notify relevant local authorities if a provider is likely to experience business failure, and services are likely to cease as a result. Local authorities have a duty to ensure people continue to receive care.

Over the course of 2015/16, we have recruited a new in-house team with relevant expertise in finance, restructuring and lending. While the team was being recruited, the analysis of financial returns was outsourced and this was moved back in-house at the end of 2015/16.

All providers in the scheme have routinely been submitting quarterly financial information. This is then combined with what we know about quality to make an assessment on the sustainability of providers and drives our risk-assessed engagement with providers. Our operating model for market oversight is set out in published guidance. We met providers in March 2016 to seek their feedback on our operation of the scheme to date. This was positive about the expertise CQC has built and the proportionate approach taken to date.

Impact

We began to see a number of NHS trusts and large corporate care providers presenting their monthly finance and performance monitoring reports to their boards organised around CQC's five key questions of: safety, effectiveness, caring, responsiveness and leadership. Examples include Central Manchester NHS Foundation Trust, Frimley Health NHS Trust, and South West London and St Georges Mental Health NHS Trust. It is an example of our methodology becoming embedded in the way some organisations operate and view quality.

Our monitoring of data and information is an integral part of our regulatory process, although it is not specifically focused on encouraging improvement. Our January to June 2015 post-inspection survey found that the information we request from providers can help to encourage improvement in some providers.

Of those providers who responded to our survey, 45% (313) of adult social care providers, 49% (80) of primary medical services providers and 10 (of 29) hospitals providers said that completing the information request form helped them to identify areas for improvement – for example, processes for gaining feedback from people who use services, such as review cards.

There was a clear emphasis on not just receiving feedback, but using it to inform areas for service improvement.

> *"We are implementing a low level complaint system, which should improve the service by encouraging patients to voice their opinion if they are not happy and simply wish to mention it rather than make a formal complaint."*
> **(Primary medical service)**

Improvement in auditing was another common development. CQC's request for information in itself appears to act as a prompt for services to prepare for inspections and critically examine how they are performing.

> *"While we were carrying out good levels of appraisals, training and risk management, having a more auditable process allowed for better tracking and identifying gaps."*
> **(Primary medical service)**

4. Inspecting and rating

Our inspections are the main way we understand the quality of health and social care, and our ratings aim to help people choose services and encourage providers to improve. We also have a statutory role to monitor the use of specific Acts of Parliament and regulations.

When we inspect, we ask the same five questions of every service: is it safe, effective, caring, responsive and well-led? We then rate each service on a four-point scale of outstanding, good, requires improvement or inadequate. We ensure that equality and human rights are embedded in the questions we ask.

We have a specialist approach to inspection which means that each inspection team includes inspectors with sector-specific knowledge, as well as external sector experts (such as senior NHS doctors), where required. We also include Experts by Experience (people who have personal experience of using a service or caring for someone who has) on many of our inspections.

Performance

Inspection programme

We started delivering our new approach to inspection in 2013, starting with NHS acute trust inspections, followed by adult social care services, GP practices and mental health services in 2014. During 2015/16 we continued to roll out our new approach to other types of service, including dental practices, independent hospitals, NHS 111, independent doctors and substance misuse services.

The figures in this section relate to inspections 'against plan' in each sector and are based on the 2015/16 business plan commitments to complete the programme during 2016/17 – in adult social care and primary medical services by the end of September 2016. These commitments have been revised in the light of experience and will now complete by the end of March 2017. The percentage of plan completed in 2015/16 therefore needs to be seen in the context of this new delivery plan.

At the end of 2015/16 we had completed our programme of first ratings inspections of acute non-specialist NHS hospital trusts, with a total of 136 inspections since we started inspecting under our new approach. We were on track to complete the rest of our planned ratings inspections for other hospital trusts (acute specialist, mental health, community and ambulance and acute independent).

Our first ratings inspections for adult social care locations and primary medical services providers were 88% and 80% complete respectively against plan at the end of the year (see figure 8).

Our productivity has been increasing gradually during the year as new inspectors are trained and established in their roles. We have also supported inspectors with temporary assistant inspectors and flexible use of overtime.

A key focus during the year was to reduce the time between the inspection and the publication of the inspection report. During 2015/16, 62% of reports were published within our agreed limit of 50 working days. This compares well with 2014/15 when only 26% of new approach inspection reports were published within 50 days.

There is a general improvement in the average number of days taken to complete a report in the Adult Social Care directorate and the Primary Medical Services directorate. While we need to improve further, the target for certain hospital trust inspections will be 65 working days in 2016/17.

Figure 8: Number of programme inspections undertaken up to 31 March 2016*

	Number of programme inspections undertaken to 31 March 2016**	Progress against plan at the end of 2015/16
Adult social care locations (since October 2014)	15,293	88%
Primary medical services providers (GP practices, dental practices and out-of-hours care) (since October 2014)	5,098 (4,110 GP practices and 988 dental practices)	80%
Hospitals programme (commenced October 2013)		
Hospitals (acute non-specialist trusts)	136	100%
Hospitals (acute specialist trusts)	9	50%
Hospitals (mental health trusts)	47	84%
Hospitals (community trusts)	15	83%
Hospitals (ambulance trusts)	3	30%
Hospitals (independent)	306	n/a***

* The table above shows the categories of inspection that were reported to the Board on a quarterly basis throughout the year.

** 'Programme inspections undertaken to date' refers to progress against the programme (first ratings, with the exception of dentists and some independent hospital locations) that started in the Hospitals directorate in October 2013, and in the Adult Social Care and Primary Medical Services directorates from October 2014. Note that these numbers will include some inspections where reports have not yet been published by the year end.

*** Independent hospital inspections were undertaken on a risk basis in 2015/16. Our target for this sector is for 2016/17 when we will complete the programme (by March 2017).

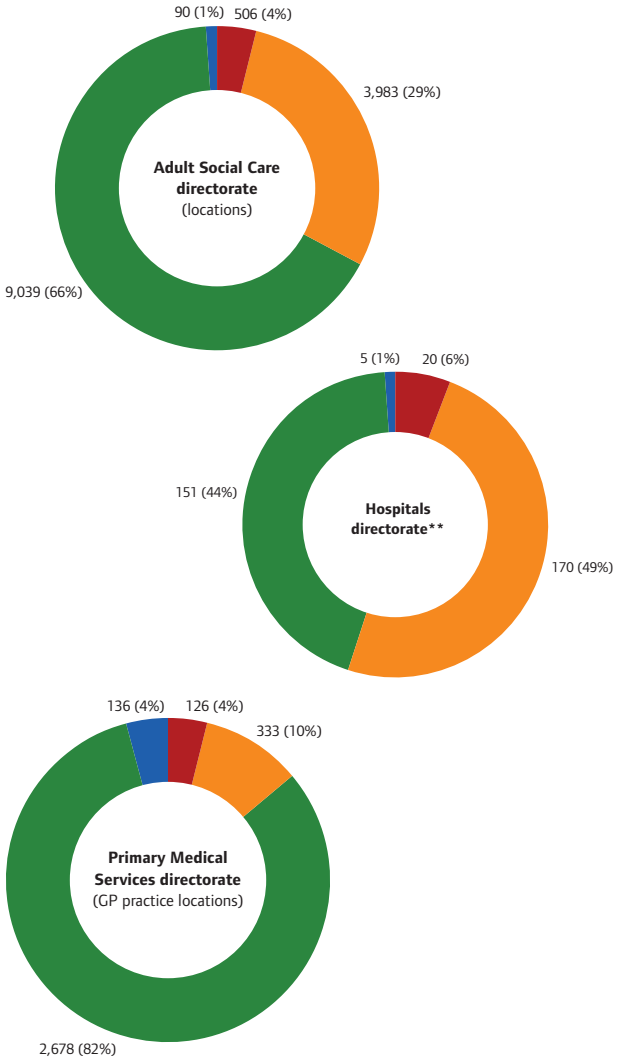
In the same period, CQC carried out the following additional re-inspections and focused inspections:

Figure 9: Re-inspections and focused inspections 2015/16 and 2014/15

	Re-inspections and focused inspections 2015/16	Follow-up, focused and responsive inspections 2014/15
Adult Social Care directorate	2,547	2,438
Primary Medical Services directorate	358	887
Hospitals directorate	57	178

Note that in 2014/15 we were still undertaking inspections under our old approach and so figures for 2015/16 are not comparable. We have also simplified our terminology for the different types of inspection we carry out.

Figure 10: Ratings as at 31 March 2016*



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

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

Note: The ratings shown have been aggregated to an overall level. Due to differences between the size and type of organisations rated in each sector, different levels of aggregation of ratings are used to derive the overall ratings. More aggregation will lead to a greater dominance of requires improvement ratings. Additionally, as the ratings programme is not yet complete, the ratings distribution is affected by the decision to inspect higher risk locations or providers first.

Ratings

We started rating services in October 2013. At the end of 2015/16 we had more than a year of published ratings data in all of the main sectors we regulate. Since we started rating, 13,618 adult social care locations, 346 hospital locations and trusts, and 3,273 GP practices have been rated.

We continue to see an ongoing trend with the highest proportion of good and outstanding ratings under the caring key question, and the highest proportion of requires improvement and inadequate under the safe key question, followed by well-led. We look in detail at ratings by key question and identify trends in our annual *State of Care* report.

It has been a full year since the requirement for providers to display their ratings started. It is now much easier for people using services to see exactly what rating their local service has been given and make an informed choice about which services to use. Ratings posters appear in reception areas, entrances, on websites and on social media. In February 2016, we launched our new care home ratings map which is a simple tool to help people quickly find their nearest care home and check the rating.

Engaging people who use services and care staff

In 2015/16 we increased our use of Experts by Experience and secured two new contracts to provide Experts by Experience services. Through these, we have significantly increased our financial investment in the Experts by Experience programme. For 2016/17 this will be around £5.8 million, up from £4.8 million in 2015/16. The contracts will see an increase in the number of inspections and activities involving them. During the year we received some criticism regarding levels of pay offered under the new contracts. Although CQC does not set rates of pay offered by contractors we sought to protect the pay rates, for a period of time, of Experts by Experience who wished to

transfer from their old employers to the new contractor, Remploy Ltd. However, CQC has a duty to deliver value for money for taxpayers and our decision to award these new contracts was focused on expanding the numbers of Experts by Experience involved in our inspections. This was to ensure that the high-quality contribution Experts by Experience have provided so far is maintained and delivering that value for money.

We continued to develop our 'Tell us about your care' programme, working with our established partners and beginning two new partnerships with ChildLine (through the NSPCC) and Age UK, to add to the existing partnerships with MIND, AvMA, Patients Association, Relatives and Residents Association, and Carers UK. We promoted each of our NHS trust inspections to the public, local Healthwatch, scrutiny committees and other statutory, voluntary and community groups that represent the public, including people from marginalised and disadvantaged community groups; held 85 public listening events to encourage people to share their experiences directly with inspectors to help inform the inspection; and held focus groups and meetings with user groups before mental health trust inspections. We worked closely with voluntary sector networks including Regional Voices and Healthwatch England. We established a mechanism for encouraging prisoners and their families to share their experiences of care. We also engaged with a wide range of people and representative groups, including people from equality groups, to co-produce and develop the way we do our work.

During the year, we consulted on and established the role of the National Guardian responsible for encouraging staff in the NHS to feel confident about speaking up about concerns or issues. The role is independent but hosted by CQC on behalf of NHS England, NHS Improvement and CQC. A person was appointed to the role in January 2016 and began the process of establishing the National Guardian's office and functions, but then resigned from the post in early March 2016. A replacement is expected to be appointed by the end of July 2016. Despite this, the National Guardian's office opened in April 2016 to continue developing the principles and functions of the role.

Complaints about CQC

We value feedback to help us continuously improve. Providers and people who use services use our complaints procedure when they believe we have not taken sufficient action to address a concern or feel that our processes and methodologies have not been used satisfactorily. This can include our inspection processes.

During the year we received 441 stage 1 complaints and of these 58 were upheld. The number of stage 1 complaints has decreased from 2014/15, when we received 485. There are a number of reasons for this reduction, including early triage to ensure that we only accept those complaints that qualify and we are clear about the alternative processes that complainants can follow in order to achieve resolution. We also received 70 stage two complaints, of which 19 were upheld.

We share learning from each individual complaint as this helps to inform improvements in both policy and practice. In addition to individual behaviour change, some examples of wider improvements include: putting in place a system for monitoring the publication of inspection reports; clear processes for recording of complaints correspondence; updated guidance; and operational updates for all CQC staff on record keeping.

Other inspections, visits and monitoring

People detained under the Mental Health Act

We are responsible for keeping the Mental Health Act 1983 (MHA) under review. The MHA helps to protect detained people and ensure they understand their rights and can challenge poor care.

During the year we carried out 1,252 Mental Health Act Reviewer visits, which is 93% of our planned visits and above our target of 90%. This is similar to 2014/15.

Second Opinion Appointed Doctors (SOADs) have an important role in protecting patients who either refuse treatment or who lack capacity to consent. We have set ourselves timescales for a SOAD visit based on the type of treatment and the clinical situation. During the year our SOAD performance was below plan, and unchanged from 2014/15 in percentage terms, although there was a substantial increase in medicine visits. An online facility being rolled out in 2016/17 will eliminate manual processes and make SOADs' interactions with CQC more streamlined. We will also be looking at the SOAD visits financial package for the more intensive activities, and whether some activities need to be done as home visits in order to improve performance by the end of the business planning year.

Children's services

We continued to conduct reviews into the effectiveness of healthcare arrangements for safeguarding children and young people, as well as the quality of healthcare services for looked after children.

In addition we worked closely with Ofsted, HMI Constabulary and HMI Probation to develop a joint targeted area inspection programme. This looks at how agencies in a local area work together to safeguard children, and the first inspection started at the end of February 2016.

We also worked with Ofsted on the Special Educational Needs and Disability programme. This started in May 2016. It focuses on how well health, social care, and educational organisations work together to identify children with special educational needs and disabilities, and how well they work together to assess and meet those needs.

Health and justice settings

We continued to inspect healthcare services in a variety of secure settings. For most of these we started using our new inspection approach.

We developed a joint inspection programme with HMI Probation to inspect youth offending services and adult probation services, and started inspecting adult services. We continued to inspect youth offending services under our previous inspection approach and carried out six inspections during the year. Inspections under

Figure 11: MHA Reviewer and SOAD visits 2015/16 and 2014/15

Performance indicator	Plan	2015/16 visits	2014/15 visits
MHA Reviewer visits	90%	1,252 (93%)	1,253 (93%)
SOAD visits – medicine	95%	3,572 (89%)	3,141 (88%)
SOAD visits – electroconvulsive therapy (ECT)	95%	390 (65%)	382 (65%)
SOAD visits – community treatment orders	95%	244 (74%)	316 (74%)

our new approach will begin later in 2016. We worked with Ofsted and HMI Prisons to inspect the three secure training centres for young people using our new approach.

We continued our scheduled programme for inspecting all prisons, immigration removal centres and police custody with HMI Prisons. We now inspect jointly with HMI Prisons and produce a joint report detailing the findings; previously HMI Prisons would lead the inspection. We continued to inspect police custody jointly with HMI Constabulary and HMI Prisons.

Over the course of the year we carried out 41 inspections of prisons, three inspections of immigration removal centres and five inspections of police custody. We issued a Warning Notice to one prison provider, and requirement notices were issues to a number of providers, with follow-up inspections planned.

Medical ionising radiation

We are responsible for enforcing the Ionising Radiation (Medical Exposure) Regulations 2000 (known as IR(ME)R) across the NHS and in independent hospitals across primary care, including dentistry and chiropractic care in England. These regulations protect patients from unintended, excessive or incorrect exposure to medical radiation including radiology, radiotherapy and nuclear medicine exposures. Specialist inspectors do this work and also provide support to colleagues at other inspections.

During 2015, we received a total of 1,277 notifications where radiation exposure was much greater than intended. This was an increase of 15.7% compared with 2014 and a continuation of the year-on-year increase we have seen over the last 10 years. This is positive, as it indicates a stronger reporting culture and the confidence of clinical departments in our enforcement methodology. The number should also be viewed in the context of the estimated 45 million medical exposures that take place each year.

We also engaged with healthcare professionals to provide support and share learning, and discussed, for example, the new duty of candour requirements for providers as they might relate to the IR(ME)R regulations.

Controlled drugs

We are responsible for making sure that health and social care providers, and other regulators, maintain a safe environment for managing controlled drugs in England. During the year we maintained oversight over how controlled drug local intelligence networks are working, and ensured they were effectively reporting and investigating trends and concerns. We maintained and updated the register of controlled drug accountable officers, who are responsible for controlled drug handling and governance in their organisations, and led the National Group on Controlled Drugs. This group of regulators and agencies met four times during 2015.

Impact

We see the impact of our inspections and ratings in two main ways:

- improvements to individual service and provider ratings on re-inspection
- the changes that providers make to the way they provide care, as a direct result of our inspections.

Re-inspections

During the year we re-inspected a total of 1,822 services following a requires improvement or inadequate rating – 1,690 adult social care locations, 23 hospital trusts and 109 GP practices.

Almost two-thirds (63%) of services and providers originally rated inadequate improved their rating following a re-inspection in 2015/16. Of the 362 (out of 578) that improved, 75% went from inadequate to requires improvement and 25% went from inadequate to good (figure 12).

Figure 12: Services and providers originally rated inadequate that improved their rating when re-inspected in 2015/16

Directorate	Number re-inspected	Number improved		Of which: Improved to requires improvement	Improved to good
Adult Social Care	529	331	↑ 63%	256	75
Hospitals (trusts)*	8	4	↑ 50%	4	0
Primary Medical Services (GP practices)	41	27	↑ 66%	10	17
Overall	578	362	↑ 63%	270	92

* This table does not include the Wexham Park Hospital example below, which improved from inadequate to good. This is because the Hospitals figures in this table are based on trust level change, not individual locations.

Of the 1,244 services originally rated as requires improvement, 36% (451) achieved a rating of good on re-inspection.

The majority of GP practices (74% of those re-inspected following a rating of inadequate or requires improvement) had improved their overall rating. Of the 23 hospital trusts inspected, six improved from inadequate or requires improvement. And 43% of adult social care services re-inspected following a rating of inadequate or requires improvement were able to improve their rating.

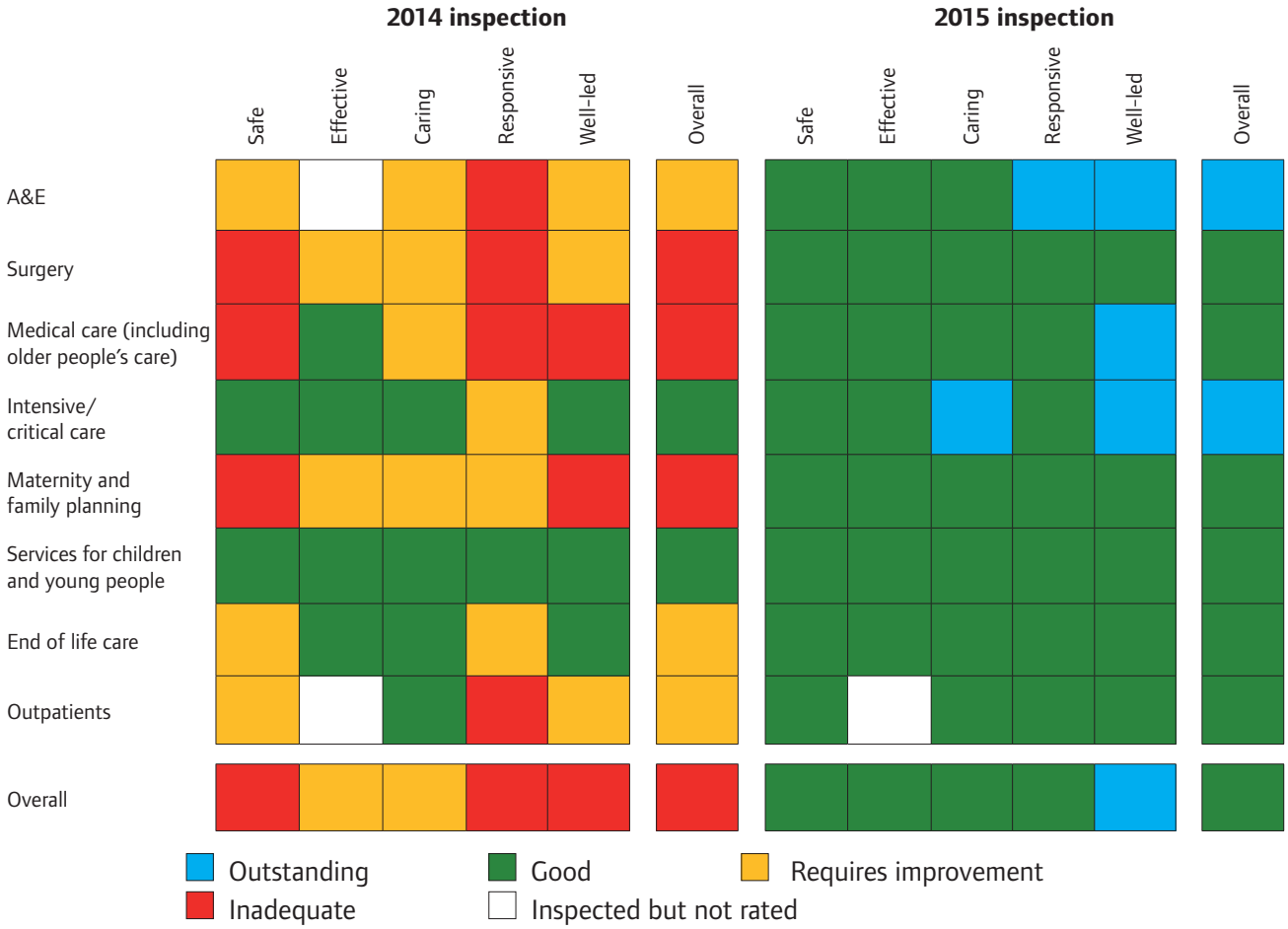
This demonstrates the role that regulation plays in improving care and that, despite the significant challenges facing all the care sectors, improvement is often possible. Providers tell us they use our inspection findings to address areas of poor quality – our survey feedback so far showed that the majority of providers who responded thought that our inspection reports and visits helped them improve. Our inspection teams have noted that high numbers of services make immediate improvements as a result of inspection, for example around reviewing policies and procedures, improving the safety of the care environment, enhancing person-centred care, recruitment, supervision and staff training.

Wexham Park Hospital – from inadequate to good

Rated inadequate by CQC in May 2014, Wexham Park Hospital was taken over by Frimley Health NHS Foundation Trust in October 2014. Just over a year later, our re-inspection showed remarkable improvements in the quality of care, alongside improvements to the hospital's finances. Now rated as good, Wexham Park has been the most impressive example of turning around the quality of care since CQC's new inspection approach began.

Since the takeover, Wexham Park has reduced its deficit (saving £22 million in 2015/16) by running on less money and reducing total staff numbers by about 120 (mostly non-clinical staff), alongside a financial improvement programme that focused on improving facilities and buildings. The chief executive noted that equally important to the financial package was the huge effort invested in changing the culture. This was leadership at all levels – the executive team setting out the vision and supporting the clinical leaders and their teams to do the right thing for their patients. There are still some remaining issues and improvements to be made to achieve the ongoing savings that are needed to be financially sustainable. However, this example demonstrates that quality can be improved without driving up staffing costs.

Figure 13: Ratings for Wexham Park Hospital, 2014 and 2015



Changes made by providers as a result of our inspections

Overall, most providers who had an inspection report published between January and June 2015 and who responded to our survey said that our inspection was a thorough review of whether their service was safe, effective, caring, responsive and well-led. In adult social care, 89% were positive and in primary medical services the response was 78%. In hospitals 20 out of 29 providers were positive.

The majority also agreed that the visit helped them improve and that the report provided information to help them improve, although the numbers for primary medical services reports were a little lower (figure 14). Our inspection team survey supported the positive findings and reported that high numbers of services make immediate improvements as a result of inspection.

We found that the inspection report is more effective in encouraging improvement in providers rated less positively (requires improvement or inadequate). The inspection visit had a relatively equal positive impact in helping providers to improve, regardless of the rating.

In our post-inspection survey, providers from all sectors commented that they had made improvements by reviewing policies and procedures – most notably medicines management, such as training, processes for 'as needed' medicines and securing drugs in locked cabinets.

Some providers commented in general that their audit processes had improved, in particular for medicines management, that more audits now take place and that they are now using audits for staff learning. Some providers also reported improvements in leaving clearer audit trails and

improvements being made to their quality assurance policies.

Some respondents commented on how the inspection report meant that they made improvements to the care environment, so that it was safe for people. Some also said that where the environment needed updating, the report prompted them to get capital investment for these changes, and the inspection brought forward maintenance work.

> *The air conditioning in the maternity department had been broken for over six months. Staff and patients were subject to extreme temperatures of over 35 degrees. Nothing had been done and it wasn't on the risk register. During inspection we brought to the trust's attention that this was unacceptable for both patients and staff and remedial action had taken place by the end of the week.*
> **(CQC inspection staff, acute NHS trust)**

Another theme common to all sectors was improvements around person-centred care.

Changes to care plans, particularly to make them more person-centred or adding more detail, was highlighted by adult social care providers. CQC inspectors reported reviews in care planning, with a drive towards personalisation among the immediate improvements made by providers after the inspection.

> *I have addressed care plans and risk assessments by reviewing all of these and I have ensured that they have been re-written completely, with much more information and more person-centred, taking into account mental capacity assessments/needs.*
> **(Residential adult social care service)**

Finally, some primary medical services and adult social care services provided specific examples of changes they made relating to staff training, supervision and recruitment. CQC inspectors reported that addressing the training needs of staff were among the immediate improvements made by providers after the inspection. These ranged from first aid training to Mental Capacity Act training.

Figure 14: 'The inspection visit helped us to reflect on how we could improve our service' and 'The inspection report provided information that will help us to take action to improve our service' (providers with reports published, January to June 2015)

	Adult social care providers	Hospital providers	Primary medical services providers	Total
Visit helped us improve	86% (1,110)	85% (35)	68% (231)	82% (1,376)
Report helped us improve	78% (1,013)	76% (31)	60% (203)	74% (1,247)

Note: Numbers in brackets refer to the total respondents.

Care home (part of a group of care homes) rated outstanding

A care home inspected in 2015 and rated outstanding received feedback at the end of its inspection that medical administration records were not consistent. The registered manager and deputy manager acted straightaway to improve the situation.

As soon as CQC left, the two managers discussed the issue and came up with an action plan. The day after the inspection, the managers looked at their current procedure for the administration of medicines and asked the nursing team to conduct an audit and suggest ideas for how it could be improved.

The team spent the day updating the procedure and the details of the action plan and emailed them to CQC within 24 hours of the inspection. As a result of the inspection and the changes made to this procedure, the care home reports that it now holds a monthly medication audit to ensure the safe management of medicines. The inspection was seen positively as it made staff tighten their procedures.

Residential care home rated inadequate

A care home that was rated inadequate during an unannounced inspection has made a variety of changes, prompted by a CQC inspection.

For example, one resident told the inspector that the patio doors in her bedroom were being left open at night to allow air to circulate, even though this was a security risk. The care home responded by fitting an air vent in the bedroom so the doors did not need to be kept open.

Another resident complained that the care home doors were difficult to open and had caused bruising to the resident's arms. As a result, the home started the process of changing the closing mechanism in 25 doors.

Personalised care was also an area that was being addressed. Training had been provided to staff about writing a personalised care plan, and new initiatives such as keep fit classes in residents' rooms were being offered to less mobile residents.

Another major impact of the inspection was an update of auditing procedures, for example for medicines management, cleaning, recording falls and injuries, and fire procedures.

Some staff could see that some of the changes made following the inspection had led to the care home being a more ordered, efficient and transparent place to work. They could also see that the residents had benefited from being in a better environment.

Hospital and community trust rated outstanding

Staff at an NHS hospital and community trust, that was rated outstanding, still felt they could improve further and used CQC's inspection report to sort out minor issues after the inspection.

The deputy director of nursing said, "We got the preliminary report and pored over it. We forgot it said we were good and outstanding, we went straight to the negative and tried to triangulate it ourselves – is it a true reflection of the service?"

An example of one of the changes made after the inspection was improving storage facilities at one of the trusts' community sites. The focus for staff was on improving quality.

Care home (part of a group of care homes) rated requires improvement

CQC inspected a care home and rated it requires improvement, issuing four Warning Notices. This prompted the organisation that runs the home to replace the registered manager.

Before the inspection, the organisation already had some concerns about the registered manager. The local authority monitoring officer was also aware of some issues relating to the home.

Soon after the inspection, the care home created an action plan that is now updated and reviewed each week by the new registered manager, and checked by the managing director.

The change in management has had positive benefits, including improved staff morale and motivation, and more positive relationships with managers. The residents appear happier, and clinical indicators such as weight gain and readmission to hospital suggest that care has improved. There have also been positive comments from relatives and professionals who visit the home.

Using the inspection report as a quality tool

Our post-inspection survey showed that providers use the inspection report to discuss and feed back findings with commissioners, staff, and people who use services and their families. Some providers proactively use our inspection reports in a number of ways:

- as a means to gain feedback in areas of improvement from people who use services
- providing people who use services with a better understanding of the service

- aiding commissioners in their commissioning decisions and as part of their contract monitoring.

Within primary medical services, there was particular mention from some providers of using our inspection reports in patient participation groups and discussion forums.

> *Patients and carers have obviously read the information from the report online and used the information to provide constructive advice on practice improvements.*
> **(Primary medical service)**

A popular theme among a number of subsectors was that commissioners had often read the inspection reports, and used them as a quality monitoring tool and as a method of increasing their understanding of service performance, thereby increasing oversight of service delivery. This has been reported as a means of performance monitoring and assessing a service's suitability for their clients.

> *The local commissioners used the inspection report in deciding future placements of their clients. We receive new enquiries on a regular basis due to achieving a rating of a 'good provider'.*
> **(Residential adult social care service)**

Before and after inspection

Although the inspection visit clearly helps providers improve, preparation for the visit can interrupt day-to-day activities. Most providers (88%) felt the inspection team did their best not to disrupt care and adult social care providers (81%) generally felt that the time spent preparing was about right. However 45% of primary medical services providers felt it was too much. Our first full impact and value for money report in October 2016 will include an assessment of the burden of regulation on providers.

After the inspection, it is important that providers receive good and clear feedback so they can improve. The majority (93%) of those rated good or outstanding who responded to our survey agreed that, 'The inspection team provided clear feedback at the end of, or after, the inspection visit' and 72% of those rated requires improvement or inadequate agreed.

Our survey also found that where specialist advisors had been involved in an inspection, they had taken back learning to help improve the services where they work. There was a clear value in both learning the successes and failures of services and how those problems had been addressed.

Equality and human rights

We have also looked at how inspection staff, Experts by Experience and specialist advisors view inspections in relation to equality and human rights. In our October 2015 inspection team survey, the majority (61%) of those who responded felt that our inspections ensured that people using the service had the following human rights upheld: fairness, dignity, respect, autonomy and right to life. Further work is needed though in advancing equality for people through inspections as, although a significant minority (41%) felt this was happening, the majority were less positive.

Public awareness of CQC

Every year we ask the public about their understanding of our role and whether they trust us to help them make choices in health and social care. Our 2016 public awareness survey showed that:

- 17% of people could name CQC as the regulator of health and social care services in

England without being prompted. This is an increase from 9% last year. The number of people who have seen a CQC report or rating is increasing, but overall awareness remains low.

- Levels of trust, confidence and overall opinion have decreased, but this is largely due to a sharp increase in the 'undecided' category rather than an increase in negative views.
- There is a strong correlation between exposure to CQC ratings or reports and high levels of trust and confidence.
- 89% of people using our website to choose care services for themselves or a loved one said they found our reports somewhat or very useful.
- Although our survey showed an increase in awareness from the previous year, awareness of CQC inspection reports and ratings is still fairly low, and they have limited influence so far on people's choice of care service.

A slightly different perspective emerged from our post-inspection survey of providers. We found of those who responded, some providers thought that the publication of reports has helped inform choice, recognise good care and increased the popularity of certain services. Some said that a poor rating can lead to negative press coverage, loss of business, staff demotivation and increased workload. This difference in perception between providers who responded to our post-inspection survey and the results from our public awareness survey may be that providers come in to contact with those who are actually using services, whereas our public survey is of the whole population, including those who may rarely use such services.

5. Enforcement and protecting people from poor care

Ensuring that we protect people from poor care and the risk of harm is fundamental to our regulatory work. We do this by taking enforcement action when we need to; encouraging an open and honest culture so that people can report concerns easily; and by responding as quickly as possible to concerns.

Performance

Enforcement action

Where necessary, we use our enforcement powers to protect people from poor care.

During 2015/16 we took 1,090 enforcement actions and at the year-end we also were in the process of taking another 777 actions. In 2014/15 we took 1,179. The most common action during 2015/16 was a Warning Notice (informing a provider that we will take action if they do not improve by a set time), which accounted for 76% of all enforcement actions during the year.

While we have made less use of Warning Notices in 2015/16, 828 as opposed to 1,037 in 2014/15, we have undertaken more urgent actions – suspensions, variations or imposition of conditions, and cancellations. We have also issued 55 fixed penalty notices, compared with 10 in 2014/15. As a percentage of all inspections undertaken, enforcement represented 6% of all the inspections undertaken, compared with 6.5% of the inspections in 2014/15, although as noted above, this year was characterised by greater use of urgent actions.

During the year we have worked hard on increasing skills and knowledge of enforcement and embedding our new enforcement powers,

Figure 15: Enforcement action in 2015/16

Enforcement action	Adult Social Care directorate	Hospitals directorate	Primary Medical Services directorate	Total actions
Warning Notices served	711	36	81	828
Non-urgent cancellations of registration	65	3	12	80
Urgent procedure for suspension, variation or imposition or removal of conditions	30	17	21	68
Non-urgent variation or imposition or removal of conditions	38	2	9	49
Fixed penalty notices issued	51	0	4	55
Number of prosecutions	1	0	3	4
Urgent cancellations	5	0	1	6
2015/16 overall enforcement actions	**901**	**58**	**131**	**1,090**
2014/15 overall enforcement actions	1,057	40	82	1,179

which have been active for a year. The majority of staff members involved in inspection and registration completed detailed enforcement training and it is a core part of our inductions. We have also made improvements to our enforcement reporting system to make it easier to log enforcement action. New management information measuring timeliness of enforcement action and the outcome of enforcement activity is being developed for reporting during 2016/17.

Special measures

When we find serious failures of care and providers do not appear to be improving, we recommend that they are put into special measures. This ensures that there is a framework in which services can be supported to improve, or signposted to organisations that can help them to improve. Providers are given a clear timeframe to improve, and if that does not happen we can take further action.

At the end of 2015/16, a total of 449 providers were in special measures. During the year we put 581 providers or locations into special measures – 438 adult social care providers, eight hospital providers and 135 GP practices. However we have seen improvement and 164 locations exited special measures: 102 of these had improved sufficiently to exit special measures, 30 were de-registered and 32 had their registration cancelled.

An open and honest culture

Making sure the culture of an organisation is open and honest at all levels is an important way that we protect people from poor care. As part of our inspection methodology we look at the duty of candour requirement for providers and the fit and proper person requirement for directors.

The duty of candour requires providers to be open with people using services when they experience harm. It contains a number of clear steps that must be followed when a notifiable safety incident occurs. During 2015/16 we started to check on our inspections that providers are meeting the duty of candour and

Figure 16: Special measures activity 2015/16

	Adult Social Care directorate	Hospitals directorate (trusts)	Hospitals directorate (independent)	Primary Medical Services directorate (GP practices)
In special measures at start of year	0	14	0	18
Entrants	438	6	2	135
Exits	117	4	0	43
Of which: De-registered	21	0	0	9
Sufficient improvements	71	4	0	27
Registration cancelled	25	0	0	7
In special measures at end of year	321	16	2	110
De-registered before formally entering special measures (report being published)	10	0	0	3

that they have systems and processes in place to do so. We responded to a number of questions during the year and we agreed more clarity and guidance for providers and the public would be helpful. The Department of Health is consulting on the duty of candour regulations, and we will update our guidance when the outcome of the consultation is known.

The fit and proper person requirement states that providers need to have the right systems and processes to ensure their directors are of the right character, physically and mentally fit, and have the necessary skills, qualifications and experience.

Between December 2014 (when the requirement came into force) and the end of March 2016, CQC received 45 referrals about individuals relating to the fit and proper person requirement regulation. Review of the information received is ongoing in many cases. Many of those individuals were not eligible to be considered under the regulation because they were not current directors.

Responding to concerns

One of the main ways people contact CQC when they have a concern or issue is through our National Customer Service Centre (NCSC). During the year we received 80,567 contacts (calls, emails and other correspondence) about information of concern. This was similar to 2014/15 when we received 80,530 contacts. Of the concerns received in 2015/16, 46% were safeguarding concerns, 41% were complaints about providers, 11% were whistleblowing and 1% were safeguarding alerts.

During the year we developed our approach to responding to concerns by making our role in this clearer to the public, improving how we respond, and working towards improving people's experiences when they contact us.

We have recorded a significant rise in the number of complaints about providers – an increase of 54% between 2014/15 (21,664 complaints) and 2015/16 (33,362 complaints). This is mostly explained by the introduction of our improved electronic triage tool, which means safeguarding concerns are now clearly identified and information that was previously logged as safeguarding now forms part of the complaints process.

We have had a particular focus on safeguarding during the year under the auspices of an improvement programme led by the Safeguarding Committee. We have an important role to play in ensuring providers keep children and adults who are at risk, safe from abuse or neglect. From October 2015 we started reporting against new and more specific targets and we can now report that we are improving our timeliness in responding to safeguarding alerts and concerns.

Between October 2015 and March 2016 we received 44,342 safeguarding concerns and 523 safeguarding alerts. Alerts are when we are the first statutory agency to be informed and so the most urgent, as we must ensure the local authority, which is the lead local statutory body for safeguarding, is aware. Looking at the final quarter of the year, NCSC had referred 99% of safeguarding alerts to inspectors within one day (exceeding the target of 95%). The target for referring concerns was narrowly missed (93% against a target of 95%). Over the year, NCSC has developed a decision-making tool to help better collect and triage information of concern at the point it is received by CQC. This tool was tested and rolled out fully by March 2016.

Across CQC, in quarter 4 we met our target of 95% for referring alerts to local authorities within one day. However, we are behind in our target for completing one of four mandatory actions for alerts and concerns within 0 to 5 days, at 83% (against a target of 100%). We have seen an improvement in this performance throughout the year, improving by 4% between quarter 3 and quarter 4 but we

remain below our target. The Safeguarding Committee has established a new performance sub-group to increase scrutiny of performance and improvement plans. This performance is mostly based on figures from the Adult Social Care directorate. In hospitals and primary medical services, the numbers of alerts and concerns are too low to demonstrate a trend.

Impact

Our survey methodology does not currently cover feedback from providers on the impact of our enforcement work in terms of how it encourages sustained improvements in care. We do have some feedback from inspectors that Warning Notices encourage improvements after an inspection, for example improved staffing in adult social care services and hospitals.

As our inspection activity continues and we get closer to inspecting all providers, we are finding more locations that are still not meeting the fundamental standards. We are particularly concerned to track all services that have been in breach of regulations for more than 12 months.

As at 2 May 2016, there were 1,727 adult social care locations (out of more than 25,000) in breach for more than one year. Actions are underway aimed at reducing the numbers of locations in breach of standards and prioritising inspection activity on areas of breach where the risk is likely to be greater.

As at 2 May 2016, there were 164 primary medical services (out of 20,000) that had been in breach for more than a year. These consisted of 22 dental practices and 142 GP practices and other primary medical services.

We continue to ensure that these locations are monitored, that they receive follow-up inspections and enforcement action where appropriate. For the Hospitals directorate, we currently do not collect data on the larger providers that enables this analysis, but we monitor improvement and take enforcement action as appropriate.

Figure 17: Safeguarding alerts and concerns 2015/16: first actions taken

Safeguarding action	Quarter 3 (2015/2016)	Quarter 4 (2015/16)
Alerts triaged to inspector within 0-1 days	97 (98%)	69 (99%)
Concerns triaged to inspector within 0-1 days	8,364 (96%)	7,809 (93%)
Alerts referred to a safeguarding authority within 0-1 days	209 (97%)	187 (95%)
Time taken for one of four mandatory actions for alerts and concerns to be taken in 0-5 days	21,841 (79%)	21,579 (83%)

6. Using our independent voice

We have a unique overview of quality across the health and adult social care sector and we use our independent voice to publish reports and information for the public, care providers, commissioners, our partners and our own staff about a range of health and social care issues. Our aim is that our reports support high-quality care, encourage improvement, show what standards the public can expect from services, demonstrate how poor providers are held to account, and influence commissioners and others in the health and social care system.

Performance

We published our major, annual *State of Care* report in October 2015. This is our report to Parliament setting out the quality of health and social care across the whole of England. The report showed that health and social care providers are operating in an increasingly challenging environment with many financial pressures, and nationally there is variation in care quality, particularly in safety. However improvement is possible and many providers are doing well. We showed how the quality of leadership, driving strong and positive organisational cultures, is critical for high performing services.

We also published a number of other reports:

- *Monitoring the Mental Health Act* – the report found that people detained under the Act are still receiving too much variation in standards of care. One of the biggest issues was a lack of support for patients to be involved in their care and treatment. Training and support for staff was also found to be not good enough.
- *Monitoring the Deprivation of Liberty Safeguards* – the report found a 10-fold increase in Deprivation of Liberty Safeguards applications, due to the March 2014 Supreme Court ruling which clarified the test for when people are deprived of their liberty.
- *Right here, right now* – this report found that the quality of care experienced by a person experiencing a mental health crisis can vary greatly depending on where they are and what help they require.
- *Quality of care in a place* – we launched this pilot in August 2015 and published prototype reports on our findings in North Lincolnshire and Salford and data reports on Tameside and Greater Manchester. The reports looked at how services are coordinated and whether this information is useful in addition to our existing regulation of individual care providers.

We started work on a number of new themed reviews during 2015/16 and we will report on these in 2016/17. The topics are: data security in health care (which aims to help improve the information governance practices of health and social care providers); neonatal care; integrated care for older people; end of life care; people's involvement in their own care; investigation and learning from deaths in NHS hospitals; and diabetes care in the community.

During the year we created two new online tools for general practice: one bringing together examples of innovative and outstanding GP care that providers can learn from, the other showing examples of the main features of the inadequate practice we find.

Impact

Initial analysis is starting to show evidence about our influence on improvement in the quality of care of providers. In our annual provider survey in 2015, some respondents in each sector, who had read our major quality of care and thematic reports, told us that they had taken action to make changes as a result. Details of this analysis will be included in our first annual impact and value for money report to be published in autumn 2016.

The way we engage is important and among the factors considered in analysing our impact we look at the ways in which we reach providers, the public and other stakeholders. In 2015/16, we directly and indirectly engaged with people in a number of ways:

- CQC's website attracted 58 million page visits from 28 million users.
- CQC was represented at 272 events, reaching an audience of more than 45,000 people.
- In 2015, we gave 285 national broadcast media interviews, dealing with 1,500 national media enquiries in total. We issued 118 press releases and CQC was mentioned in more than 6,000 news articles nationally.

7. Our capacity, capabilities and culture

To successfully deliver our purpose, we need to have a strong and well-trained workforce as well as a positive organisational culture that encourages the best from each member of staff.

Recruiting the right people

During the year we met and exceeded our inspector recruitment target of 600 new inspectors over two years, and we continued to focus on ensuring that new members of our inspection teams were trained and ready to inspect.

We still have work to do on filling posts where team members have left. Staff turnover during 2015/16 was 11.2% and this was higher than in 2014/15 when turnover was 7.5%. However this rate is not out of line with public and private sector norms.

Some of this turnover was due to high levels of retirement, but there were a range of other reasons. There is a particular focus needed on inspection staff who leave in a short space of time: of the 126 inspection staff who left in 2015/16, 24% left after less than one year. This compares with 41% who left after 10 or more years of service. Work is being done to investigate this rate and to improve the experience of staff when they leave, so we can better analyse their reasons for doing so.

Time lost to sickness remained well below our target of 5%.

Learning and development

During the year we continued to invest in training and development for our staff, building skills, supporting performance development, and ensuring all staff were up to date with new legislation.

We ran a range of other training courses for staff over the year through the CQC Academy. CQC staff have attended multiple online learning events or taken online courses since the system launched in November 2014. The total participant figure for training events and courses was approximately 10,000. Examples include enforcement training, protecting information training and training on the Mental Capacity Act. We also started a new leadership training programme in partnership with Ashridge Business School. This intensive training for CQC managers and leaders will continue throughout 2016/17.

We launched our new online performance development system, which has streamlined the process of performance reviews and embedded CQC's values in the system. Staff and their managers can now assess how they use CQC's values in their work, alongside their objectives and performance targets.

Figure 18: Turnover and sickness, 2015/16

	Plan	2015/16	2014/15
Headcount	n/a*	3,387 (3,272 FTE**)	2,777 (2,681 FTE)
Turnover (rolling 12-month average)	<5%	11.2%	7.5%
Time lost to sickness (rolling 12-month average)	<5%	3.5%	3.6%

* We manage headcount based on a clear need and recruit only when we can demonstrate value for money – for this reason we have no fixed headcount plan figures.

** Full-time equivalent (FTE).

Of particular importance was a major partnership with the Equality and Human Rights Commission and the British Institute of Human Rights. Making sure equality and human rights are embedded across inspections is fundamental to our approach and so 1,078 inspection staff and 878 other staff attended an equality and human rights face-to-face training event, which also included learning on unconscious bias. Before the training, 23% of staff who took part agreed that they knew about mitigating unconscious bias in their work, but after the training this rose to 98%. In addition, 47 people attended a six-day course of additional training to become equality and human rights leads to help promote sustained organisational development in embedding equality and human rights in our work.

As a result of the learning programme, more than 180 staff have joined our new equality and human rights network. This brings together staff from across the organisation to build equality and human rights into everything that we do through opportunities for peer support and reflective practice. Our established staff organisations that promote equality and inclusiveness for particular groups of staff – the disability equality network, the Lesbian, Gay, Bisexual and Transgender (LGBT) equality network and the race equality network – also gained momentum during the year.

We started a new CQC mentoring scheme in February 2016 to encourage staff to learn from each other and develop CQC's values of excellence, caring, integrity and teamwork. Examples of the benefits include gaining new connections across the organisation, building confidence, and learning from the management experience of others. The scheme will run for 12 months and includes introductory training, webinars and follow-up support.

Open, transparent and supportive culture

We know from our inspections that an open and transparent culture is an important factor behind services rated good or outstanding and this is also the case for CQC's performance.

The views of our staff are very important. Every year our staff survey provides feedback on how staff feel about working for CQC. Our September 2015 survey showed the highest level of staff engagement yet at 65%, which is well ahead of the public sector benchmark. In total, 2,444 staff responded.

We saw big increases of positive responses in certain areas, for example those feeling positive that CQC supports the health and wellbeing of staff rose by 9% from 2014 to 56% of staff in 2015. When asked if the work CQC does with providers improves standards of care, 90% responded positively, a 9% increase from 2014. And 85% of staff (an increase of 9% from 2014) felt that they had a clear understanding of their contribution to achieving CQC's objectives.

However results around communication, change processes and morale were less positive. Only 33% of respondents felt that morale is good across CQC, and 37% responded negatively. Results for personal morale were better, with 59% responding positively. Only 31% of staff felt that communications across CQC were effective and understanding of why organisational changes are made dropped to 53% of staff responding positively (an 8% decrease from 2014).

The results for most equality groups were similar across the majority of questions. However, the feedback from disabled staff was less positive, particularly around perceptions and morale, values, role, inclusion, wellbeing and behaviour. During the year we have interrogated these results further to find out how we can improve them. We have also committed to taking part in the NHS Workforce Race Equality Standard

(WRES). The WRES results can be found in the 'Staff report' (pages 93-94).

The results in the staff survey for bullying and harassment were 1% better than 2014, but they were still not good enough at 11% of staff having experienced bullying and harassment from colleagues in the past 12 months. For lesbian, gay and bisexual (LGB) staff the percentage experiencing bullying and harassment was higher (at 18%) and for disabled staff even higher (at 21%).

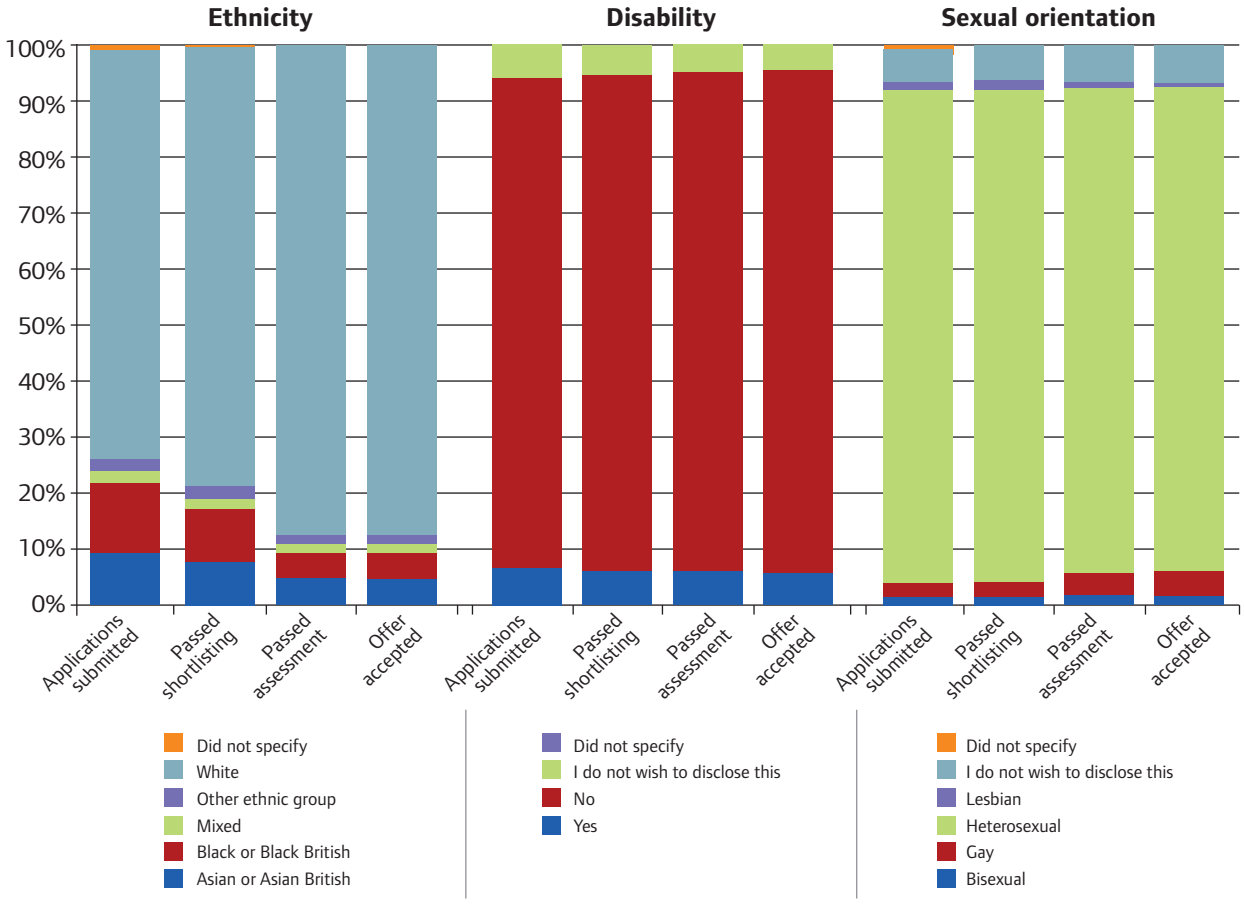
We focused on staff wellbeing during 2015/16 and started developing a number of events and initiatives, for example our new leadership programme builds personal and team resilience. Our new staff recognition scheme allows outstanding performance to be celebrated more frequently for a mix of everyday tasks and bigger achievements. The scheme has replaced our staff excellence awards.

Staff equality

It is very important that we promote and protect equality, diversity and basic human rights and it is an integral part of the way we work. For people who use services, we work towards the ambition of equal access, outcomes and experiences when using health and social care services. We have a legal duty under the Equality Act 2010 to show information on CQC's employees who share a protected characteristic under the Act. We use this annual report to fulfil this duty.

We are required to report on people who use health and care services or work in those services, and who share a protected equality characteristic who may be affected by our activities, and on the use of the Deprivation of Liberty Safeguards under the Mental Capacity Act 2005. We report on these in our *State of Care* report every year. We also have a legal duty to report on the use of the Mental Health Act

Figure 19: Diversity during the recruitment process – inspection and analyst staff, 2015/16



(MHA) 1983 – we do this through our separate annual MHA report.

In terms of whether equality groups are proportionately represented in management grades (CQC grade A and above), we found that there were no significant differences in relation to gender, and that, as expected, younger staff (35 and below) were under-represented in management grades. We did however find that staff from the Asian/Asian British and Mixed groups are under-represented in management grades and that this is a statistically significant difference.

We also found lower numbers of Black/Black British staff and disabled staff in management grades than would be expected, but these differences are not statistically significant. In fact there has been an improvement compared with last year – the percentage of BME staff in management roles has increased from 10.4% to 11.6% – representing 17 more BME staff, though this still lags some way behind the percentage of White staff in management roles (18.7%, down 0.1% from the previous year).

We have done work during the year to examine the success rates for people in different equality groups when they apply for jobs at CQC. We looked at inspection team and analysis team roles, as these form 70% of our recruitment activity and found that BME people are less likely to be successful at the shortlisting and assessment stages. The majority (three quarters) of all applications during the year were from White candidates. Of the applications from BME candidates, only 2.8% of candidates were offered posts, compared with 6.9% of White candidates. We are looking at the reasons for these differences and if we need to amend our selection processes.

We found no significant difference in recruitment outcomes for people with a disability, who made up 6.3% of all applications during the year.

Applications from LGB candidates made up 4.7% of all applications, and the outcome was strong with 7.1% of LGB candidates being offered posts. However this did differ within the overall LGB grouping, with 11.6% of gay men being successful, compared with only 4.6% of lesbians, despite the overall success rate for women (6.1%) being slightly higher than for men (5.4%).

Figure 20: Progress on meeting our equality objectives (end date March 2017)

Objective	Progress*
1. Deliver learning and development for all CQC staff by March 2016 to address unconscious bias.	• Online or face-to-face learning on unconscious bias has been completed by 2,203 staff. This included reflection on unconscious bias and strategies for mitigating this. See section on learning and development, page 39.
2. Include race equality for staff (through the NHS Workforce Race Equality Standard) as a factor in our judgements about whether hospitals are well-led.	• Developed our approach to integrating the WRES into hospital inspections, working closely with the NHS England WRES team and other experts. • Piloted our approach in 19 inspections. • Recruited around 20 equality specialist advisors to assist where concerns around staff race equality are identified before inspection. • From April 2016, we will roll out our approach to all NHS trust inspections and to independent hospitals that participate in WRES.
3. Improve our regulatory insight and action about the safety and quality of mainstream health services for people with a learning disability or dementia, or those experiencing mental ill-health.	• Showed a video on all acute hospital inspection briefing days covering important issues for people with a learning disability in acute services, and used a linked set of key questions on each inspection. • Focused on people with dementia in inspections of A&E departments and older people's wards • Developed guidance for GP practices on what we expect for care of people with a learning disability.
4. Help our inspectors to pursue key lines of enquiry and to make consistent and robust judgements about particular aspects of equality.	• Developed guidance to help inspectors follow up equality questions in adult social care provider information returns. • Produced two short films about the importance of meeting the needs of LGB people using adult social care services. • Sexual orientation, sensory impairment, and transition of young disabled people into adult services have been incorporated as case studies into our staff equality and human rights learning.
5. Work towards having no difference in the employment outcomes for our staff or potential recruits because of age, disability, ethnicity, gender, gender reassignment, religion or belief, or sexual orientation.	• Developed 'real time equality monitoring' of our major recruitment exercises so that we can pick up where staff with particular equality characteristics are faring less well in the recruitment process. • Developed a mentoring scheme including positive action to establish mentoring for BME and disabled staff; 29 BME and disabled staff are receiving mentoring support so far. • Commissioned in-depth engagement with disabled staff and staff in our Strategy and Intelligence directorate to understand the root causes of some staff survey results around equality. • Signed up to the WRES as an organisation and published our first WRES report. • Continued to consider equality and human rights in the development of our work programmes and policies. This year we have carried out equality and human rights impact analyses for CQC's strategy consultation; display of ratings; market oversight function; regulatory fees 2016/17 consultation; CQC's mentoring scheme; counter fraud policy. Externally facing analyses can be found on our website.

*All objectives are partly met, except objective 2 which is fully met.

8. Financial performance and costing model

Financial performance

In 2015/16 CQC had a total revenue budget of £249 million. This was funded through £120 million grant-in-aid provided by the Department of Health, £113 million from fees charged to providers in respect of their annual registration fees, and a further £16 million risk share from the Department of Health to support our inspection programme. CQC also had a capital expenditure budget of £17 million, funded by the Department of Health and other non-cash budgets set by the Department of Health.

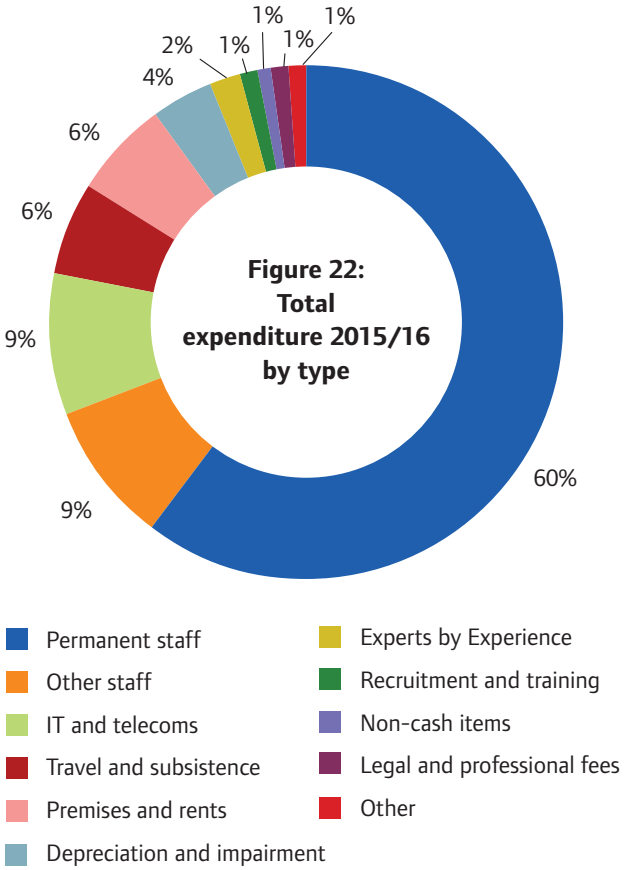
Figure 21: Expenditure 2015/16 and 2014/15

	2015/16			2014/15		
	Actual £m	Budget £m	Under/ (over) spend £m	Actual £m	Budget £m	Under/ (over) spend £m
Expenditure made up of:						
Pay	170.0	179.4	9.4	148.8	162.1	13.3
Non-pay	66.1	70.1	4.0	57.8	61.9	4.1
Sub-total	236.1	249.5	13.4	206.6	224.0	17.4
Depreciation	9.7	12.0	2.3	11.2	12.0	0.8
Annually managed expenditure (AME)	2.3	2.3	0.0	3.9	3.9	0.0
Total expenditure	**248.1**	**263.8**	**15.7**	**221.7**	**239.9**	**18.2**
Funded by:						
Fee income	(109.3)	(113.0)	(3.7)	(103.4)	(103.4)	0.0
Net expenditure	**138.8**	**150.8**	**12.0**	**118.2**	**136.5**	**18.3**

Net expenditure

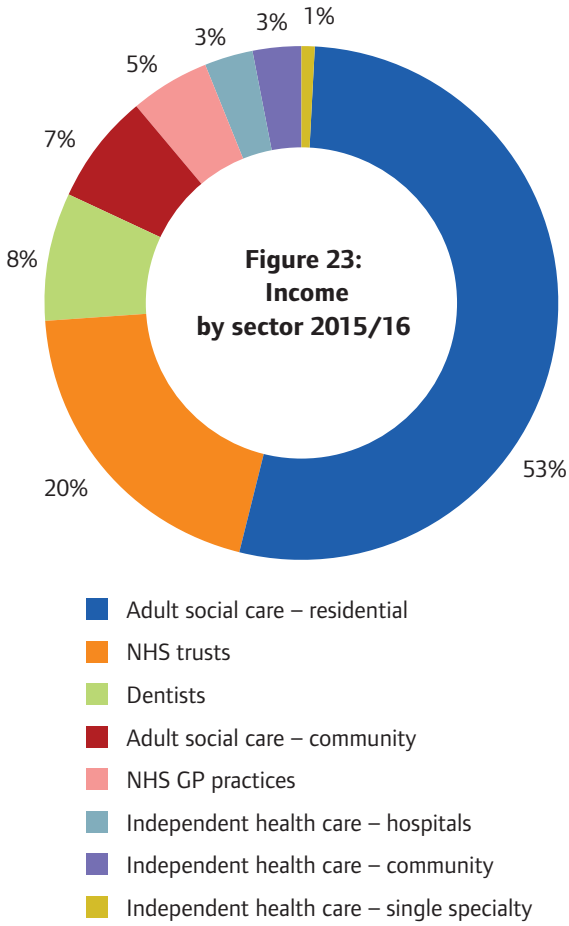
Total expenditure increased by £26 million compared with 2014/15. The significant movements were in relation to:

- An increase in staff costs as we achieved our recruitment targets. The associated costs of a larger workforce have increased spend in training, recruitment, and travel and subsistence, with the latter also impacted by a higher volume of comprehensive inspections completed.
- CQC has invested in ensuring that Experts by Experience are supporting a higher number of inspections in year and this investment will continue to increase into 2016/17.
- Dual running of our London estate as we transitioned to a new office and exited our Finsbury Tower office.



Income

Income increased by £6 million compared with 2014/15, following a 9% increase in fees applied to all sectors except independent community health care and dentists.



In accordance with HM Treasury guidance, *Managing Public Money*, CQC is required to set fees in order to recover all the costs of its functions. Our latest consultation strategy sets a path that will take us to full cost recovery and the approach will continue during 2016/17.

Capital expenditure

Capital expenditure totalled £10 million during 2015/16. The majority of this was on IT projects (£8.6 million), which are designed to improve efficiency going forward and economies in our revenue budget. The remainder was on estates.

Major areas of IT capital expenditure for 2015/16 included:

- Specific developments related mainly to the national resource planning system, intelligence tools, end-to-end inspection processes and registration improvement.
- Infrastructure that was largely for the provision of IT equipment for new starters and replacement of obsolete equipment.
- Developments that added capacity and those that allowed us to maintain our current capabilities. Most of this was spent on our Customer Relationship Management (CRM) system, which underpins our statutory functions.

Estates included the move to Buckingham Palace Road and improvements across our estate.

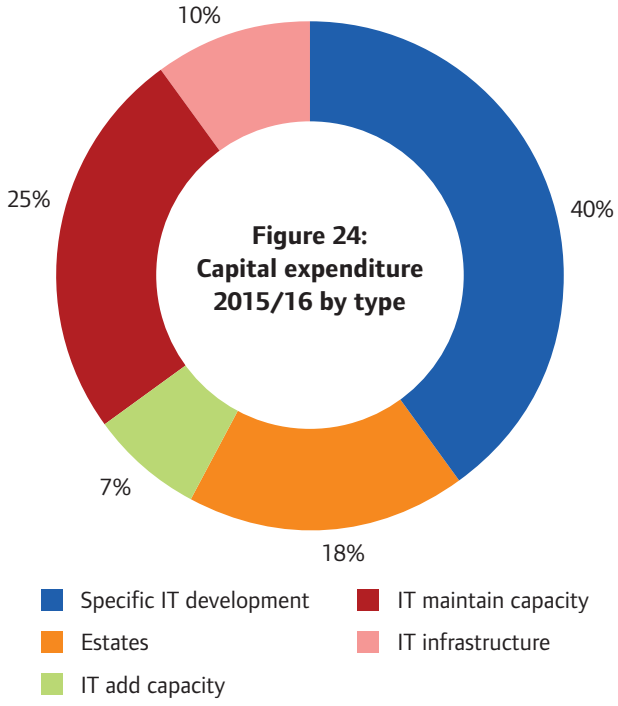


Figure 24: Capital expenditure 2015/16 by type

Costing model

In 2015/16 we developed a costing model to a greater level of detail than in previous years. We will use it as the baseline on which we will build our impact and value for money reporting in the future. More detailed analysis will be conducted in 2016/17 after the baseline for 2015/16 has been completed. The model helps us to:

- calculate our costs in our core functions
- understand what is driving our costs and where we could be more economical and efficient
- benchmark our progress over time
- inform discussions on the fees we charge to providers.

Cost of our core functions

Our total costs in 2015/16 for our operating model activities were £222.1 million, with a further £12.7 million representing statutory activities that we are required to support, but which lie outside our operating model. Inspection incurred the highest cost at £134.0 million, followed by monitoring at £46.4 million.

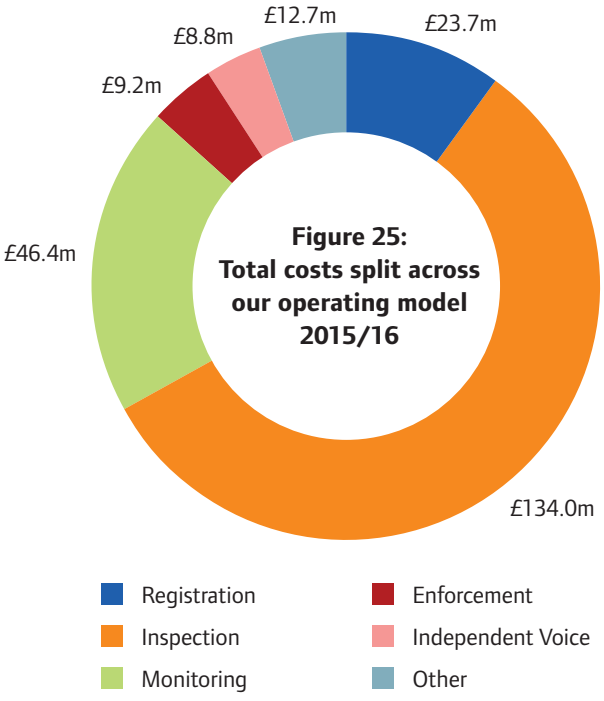


Figure 25: Total costs split across our operating model 2015/16

Note: This excludes £1.4 million relating to accounting adjustments, which are not part of CQC's operating costs.

Value for money self-assessment

The largest area of our expenditure relates to inspection activity. As part of our work to explore our value for money, we calculated an average cost for inspections across the year. This is a very initial analysis, but it is a broad measure of efficiency. It will require further monitoring as the costing model develops.

We found that our total cost of inspection gradually increased across the year in all sectors, due to our focus on reaching an appropriate staffing establishment to enable delivery of our comprehensive inspection and ratings programme. During this time we delivered a higher proportion of inspections for this additional cost, and at a reducing average cost per inspection for all three inspection directorates. This is shown in the charts on the next page.

The average cost for inspections for the Hospitals directorate fell from £182,068 in quarter 1 to £74,759 in quarter 4. The cost increased slightly between quarter 2 and quarter 3, but not significantly. A part of this was undoubtedly a result of efficiencies but other facts need to be taken into account. This directorate saw a large influx of staff in quarter 1, who needed training and so the quarter 1 figure includes a large element of this training cost. Quarter 4 included inspection of a larger number of independent hospitals, which are significantly smaller than NHS trusts. The average for the Hospitals directorate across the year was £108,581. This gives a better overall idea of the cost and will be a more robust figure for comparing with future years.

The average cost for inspections for the Primary Medical Services directorate fell from £9,341 in quarter 1 to £5,286 in quarter 4.

The average cost for inspections for the Adult Social Care directorate fell from £5,276 in quarter 1 to £3,149 in quarter 4.

The downward trend in the Adult Social Care and Primary Medical Services directorates was as a result of staff becoming more familiar with our inspection methodology, settling into their roles and so becoming more efficient.

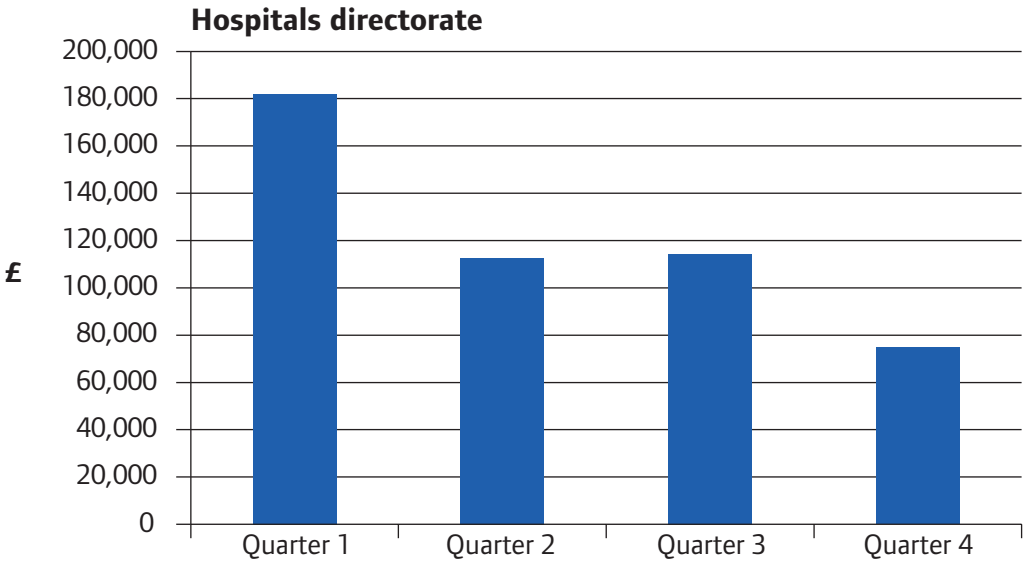
Also, in relation to primary medical services, our inspections of dental practices use fewer specialist staff than NHS GP practices, which results in a lower cost of inspection. The Primary Medical Services directorate inspected more dental providers in quarters 3 and 4 than in quarters 1 and 2, so this different mix also contributed to the reducing cost of inspection.

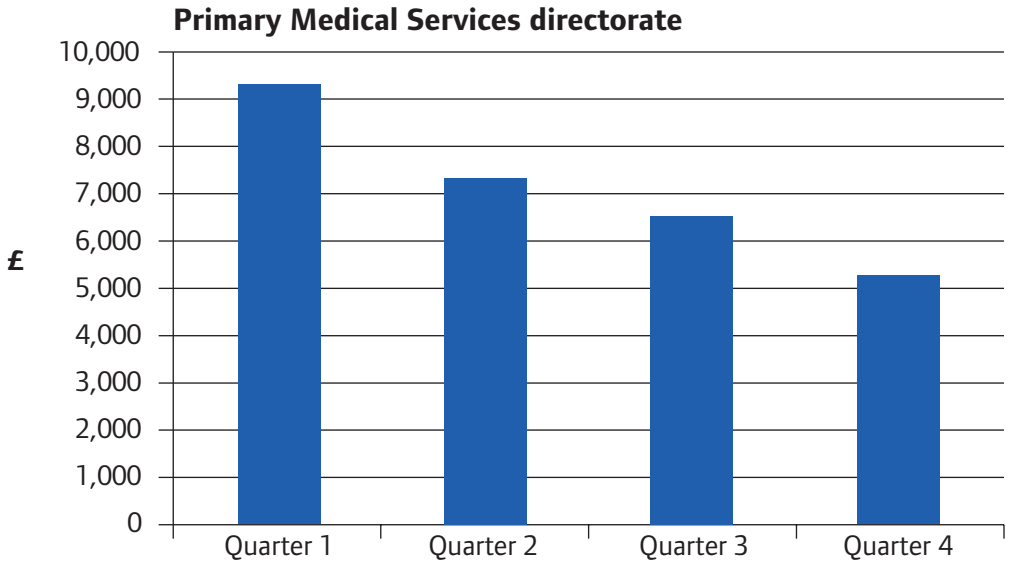
We continue to monitor and benchmark our cost per inspection activity. As the new inspection methodology moves into a steady state, the expectation is that the average cost per inspection will continue to reduce, demonstrating efficiencies due to increased productivity from staff and natural economies of scale from the familiarity of the new methodology. For any areas showing an increase in cost, inspection directorates will be expected to explain and take corrective action.

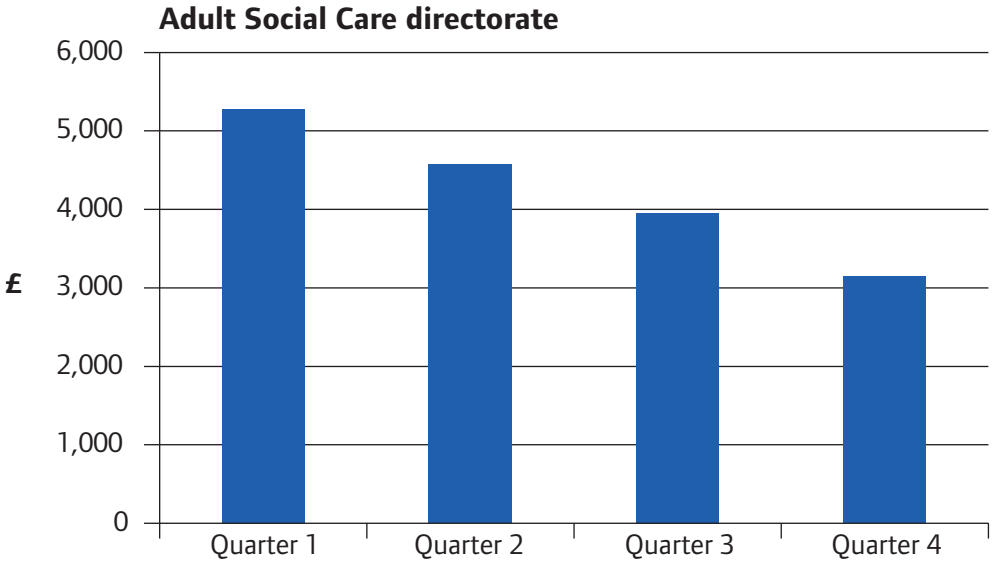
This monitoring and benchmarking has already led to a review of the allocation of staff and resource to inspections to ensure they remain cost-effective, while still delivering an effective inspection.

Savings can also be evidenced from work carried out to reduce costs, such as rationalising CQC's estate, stricter controls over recruitment, and monitoring and controls for travel, subsistence and hire of meeting rooms.

Figure 26: Average cost per inspection for 2015/16 by inspection directorate







9. Performance on other matters

Requests for information

We published a wide range of information about our activities, as specified in our freedom of information publication scheme.

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

In the 2015/16 financial year, the Information Access team responded to 937 requests for information. Of these:

- 728 were under the Freedom of Information Act 2000. Of these, 94.4% were responded to within the legal deadline of 20 working days.
- 164 were under the Data Protection Act 1988. Of these, 97% were responded to within the legal deadline of 40 calendar days.
- 45 were responded to under our information sharing procedures. Of these, 97.8% were responded to within our internal deadline of 20 working days.

The number of unique individuals who made requests in 2015/16 was 674.

Feedback received from requesters remains high, with 80% of the applicants who provide feedback saying they are satisfied with our responses.

Of the total requests for information, 34 (3.8%) resulted in the applicant requesting an internal review (asking CQC to reconsider the original decision). One request (0.1%) was subsequently referred to the Information Commissioner's Office (ICO) by the applicant for independent review; the appeal was not upheld by the ICO.

Sustainability

Our sustainability aim is to reduce the impact of our business on the environment. Our priority is to reduce our carbon dioxide (CO_2) emissions. Efficient use of our IT systems and accommodation is an important strand of this work. Sustainability is a key driver for flexible working, as well as for consolidating our accommodation. We regularly review our estates strategy to consider sustainability.

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

About our data

All but one of our offices is supplied via landlord service charge, which includes utility costs presented on a pro rata m^2 basis rather than actual consumption data. Therefore, there may be some limitations to the accuracy of our financial and non-financial sustainability data. In 2015/16, landlords' details have been more difficult to obtain for energy consumption, water use and costings. We have been in the process of relocating our London offices in two phases. This has incurred costs for both offices as staff were moved to one location, 151 Buckingham Palace Road. The move was finalised in May 2016. Note that the energy data shown below does not include staff occupation at 151 Buckingham Palace Road.

Between 2009/10 and 2014/15, we were guided by the Greening Government Commitments as the main sustainability driver for government and arms' length bodies. New targets are in the process of being established to cover 2016/17 to 2019/20.

Carbon dioxide emissions

Performance

CO_2 emissions from rail and car travel increased by 20% from 2014/15 as staffing numbers increased following changes to CQC's regulatory model. Costs increased by 13.5% for the same period. CO_2 emissions from domestic business travel flights increased by 18%.

Figure 27: Carbon dioxide emissions 2015/16

Area	CO_2 emissions (tonnes)	2015/16 units	2015/16 cost £	Performance against 2014/15
Building energy	1,262	3,246,083(kWh)	354,629	See note
Travel (rail)	943	12,859,004 (m)	4,964,731	Increasing
Travel (road)	1,942	6,375,193 (m)	3,257,128	Increasing
Total	**4,147**	**n/a**	**n/a**	

Note: Unable to state performance as the energy data does not include staff occupation at Buckingham Palace Road.

Figure 28: Carbon dioxide emissions indicators 2013/14 to 2015/16

Non-financial indicators (CO_2)	2015/16 (tonnes)	2014/15 (tonnes)	2013/14 (tonnes)
Gross emissions (buildings)	1,262	1,390	1,364
Gross emissions (business travel)	2,885	2,303	2,072
Total	**4,147**	**3,693**	**3,436**

Financial indicators (£)	2015/16	2014/15	2013/14
Expenditure on official business travel	8,221,589	7,116,621	5,327,697

Managing energy use from buildings

Performance

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

Figure 29: Energy use indicators, 2009/10 and 2013/14 to 2015/16

Non-financial indicators – energy consumption (kWh)	**2015/16**	**2014/15**	**2013/14**	**2009/10**
Electricity	2,138,184	2,553,712	2,463,736	3,641,075
Gas	1,107,899	1,369,641	1,452,699	2,004,344
Total (kWh)	**3,246,083**	**3,923,353**	**3,916,435**	**5,645,419**

Financial indicators (£)	**2015/16**	**2014/15**	**2013/14**	**2009/10**
Total energy expenditure	354,629	309,887	322,423	525,935

Note: Energy figure for 2015/16 does not include staff occupation at Buckingham Palace Road.

Managing water use

Performance

CQC's water use is almost exclusively from washrooms, kitchen preparation areas and showers.

Figure 30: Water use indicators, 2009/10 and 2012/13 to 2015/16

Non-financial indicators	**2015/16**	**2014/15**	**2013/14**	**2012/13**	**2009/10**
Water consumption (m^3) supplied	11,282	10,108	13,717	14,164	16,388

Financial indicators (£)	**2015/16**	**2014/15**	**2013/14**	**2012/13**	**2009/10**
Total water expenditure	14,075	19,106	15,860	15,498	n/a

Managing office waste

Performance

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

Waste management at most of our buildings has been controlled by CQC with one central contract from May 2011. However, from April 2015 waste management in our new London office has not been managed by this contract. Data for this office is not included in the figures shown, and is difficult to obtain from the landlord.

Figure 31: Office waste indicators 2009/10 and 2012/13 to 2015/16

Non-financial indicators (tonnes)	2015/16	2014/15	2013/14	2012/13	2009/10
Non-hazardous waste (landfill)	89	119	115	159	27
Non-hazardous waste (re-used/ recycled)	160	294	217	212	143
Total waste	**249**	**413**	**332**	**371**	**170**

Financial indicators (£)	2015/16	2014/15	2013/14	2012/13	2009/10
Total disposal costs	28,332	54,709	59,583	58,206	n/a

Sustainable procurement

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

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

Central contracts managed by the Procurement team are also considered for their use of recycled materials, ability to monitor CO_2 emissions, and adherence to equality and diversity under the Equality Act 2010.

Estates strategy

CQC's estates strategy aims to have an estate that best supports our approach to regulation, within constraints of cost, and is of fundamental importance to the success of our organisation. The strategy considers the practical aspects (where we locate our increased numbers of staff) and the cultural (how our buildings reflect how we want people to connect with and 'belong' to CQC).

Our estates ambition is two-fold: to ensure we maintain our resilience as we develop as an organisation and the end points of our existing leases demand us to make decisions; and to ensure we make the long-term strategic decisions that will result in us having a permanent estate in place to cater appropriately and proportionately for all of our staff's needs.

Our estate is spread across seven buildings, providing us with 1,350 desks. We have 1,332 members of staff who are permanently office-based, and 2,076 who are home workers.

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

- Head office (single location) – functions that are required to be office-based and in a single central location close to Westminster; for example, the Chief Executive's private office, the Chief Inspectors, the Executive Directors and the Board Secretariat.
- Regional offices (small number of locations of variable size) – functions that are required to be office-based, but not located centrally; for example, the National Customer Service Centre (NCSC), Finance, HR and Intelligence functions.
- Hubs (larger number of locations of small size) – functions that are home-based, providing a community space for meetings and occasional office-based working.

Over the past year we have:

- Fully relocated our London head office from Finsbury Tower to new, modern space at 151 Buckingham Palace Road. Finsbury Tower has now closed.
- Commenced modernisation and improvement works to our existing Newcastle and Leeds offices that will complete by August 2016.

During 2015/16 our estates strategy has resulted in annual exchequer savings of £3.9 million recurring, following the relocation from commercial space at Finsbury Tower to government space at Buckingham Palace Road.

David Behan
Chief Executive, Care Quality Commission
23 June 2016

Accountability report

2

Corporate governance report

Directors' report

Introduction

The Accounting Officer for CQC has responsibility for working with the CQC Board to ensure that CQC is well governed and that the organisation has a sound system of internal control that allows us to deliver our purpose and role. This corporate governance report sets out a comprehensive explanation of the organisational governance of CQC in accordance with HM Treasury's and other governance standards, and the level of assurance that can be provided during 2015/16.

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

Statutory functions

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

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

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

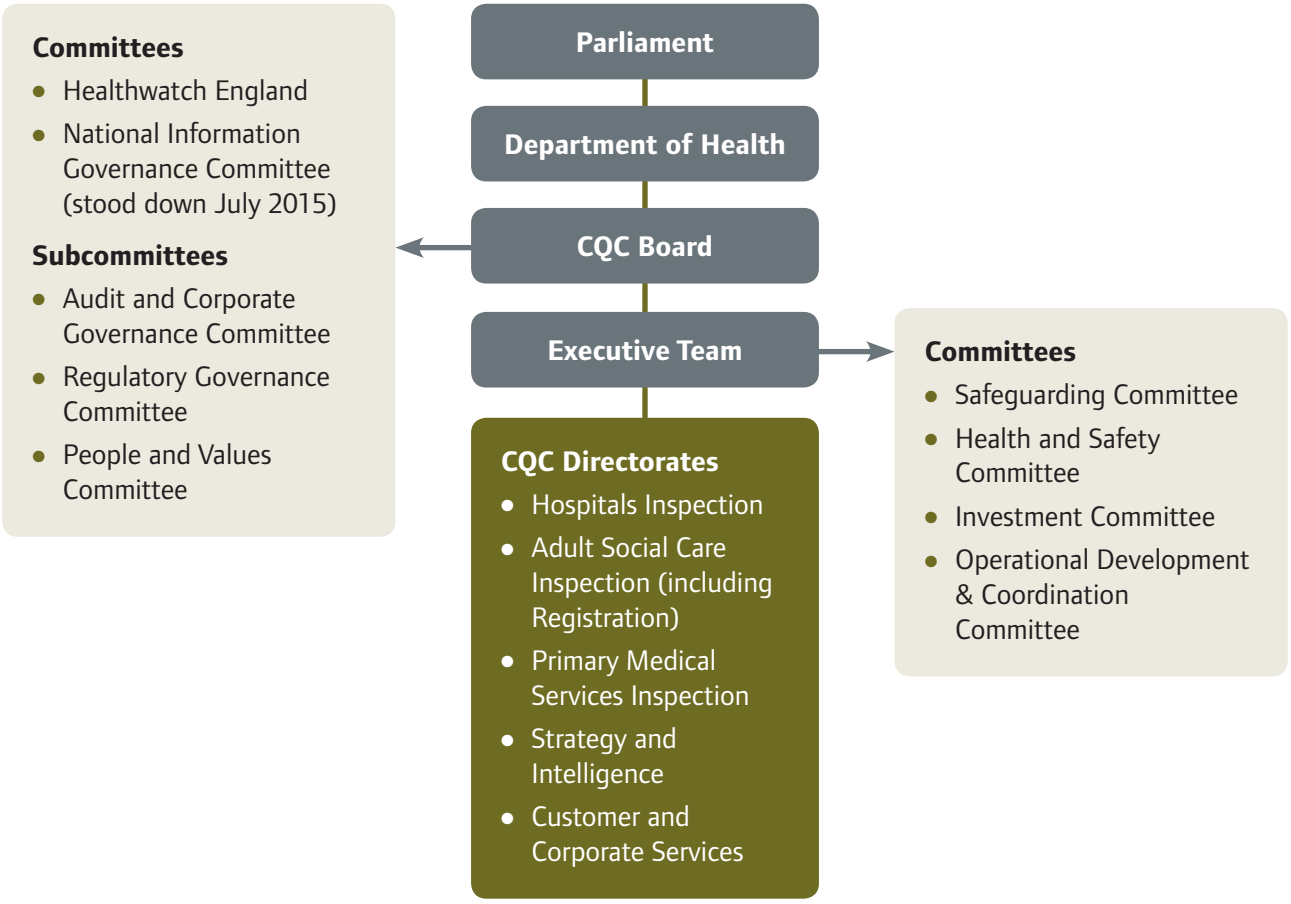
CQC's statutory functions are set out in the Health and Social Care Act 2008 as amended, the Care Act 2014 and related regulations. Specifically, CQC's statutory functions in relation to health and social care providers include registration of providers and managers; review and investigation of provider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

CQC governance framework and structures

CQC has a corporate governance framework which sets out the governance arrangements for the organisation. A process of reviewing CQC's governance arrangements was started in 2015 and is ongoing. The diagram on page 56 sets out current arrangements.

Parliament and the Department of Health

As an NDPB, CQC aims to have a good working relationship with its sponsor department, the Department of Health. The Department of Health and CQC have a framework document in



place which sets out CQC's purpose, its governance and accountability, management and financial responsibilities and reporting procedures.

The Accounting Officer is held accountable to Parliament and the Department of Health through the Health Select Committee and quarterly accountability review meetings with the Department. The Accounting Officer attended all these meetings in 2015/16 and actions required of CQC arising from these meetings have been discharged.

CQC's Board

The main responsibilities of CQC's Board are to:

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

CQC's Board is committed to achieving outstanding levels of governance, as CQC would expect of providers when assessing whether they are well-led.

CQC's unitary Board is made up of the Chair (Peter Wyman), eight non-executive Board members, myself as Chief Executive and Accounting Officer, our three Chief Inspectors and the Executive Director of Strategy and Intelligence. The Executive Director of Customer and Corporate Services also attends Board meetings. One of the non-executive directors (Michael Mire) acts as the Senior Independent Director. Peter Wyman was appointed as the new Chair of CQC by the Secretary of State for Health from 4 January 2016. His term of appointment is for four years. He replaces David Prior who stood down in May 2015. Michael Mire acted as Interim Chair of CQC from June 2015 to December 2015.

Board member Camilla Cavendish also stood down in May 2015. Anna Bradley, Board member and Chair of Healthwatch England stood down in December 2015 and was replaced on the Board by the Interim Chair of Healthwatch England, Jane Mordue.

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

The Board meets both in public and private session throughout the year. Public sessions of the Board are webcast live and are subsequently available to view as recordings. The Board's default position is to take decisions and hold discussions in public. However, where there are draft reports to consider that need to be considered in private before publication, or where matters relating to individuals and employment are being discussed, they are dealt with in a private session.

All Board members are required to record annually any interests relevant to their role on the Board. The register of interests is a public document that is open to public scrutiny at CQC's offices in London. It is also available on CQC's website. The Chair will form a view as to whether an interest is such that it requires the member to withdraw from discussion or any vote on an issue. Our policy on Board member interests has been revised during the year. The Board membership is at annex 1; the record of Board attendance at annex 4 and the coverage of Board business at annex 5. The Board has discharged its duties as set out in the Scheme of Delegation during the year.

Non-statutory committees of the Board

Audit and Corporate Governance Committee

The Audit and Corporate Governance Committee (ACGC) provides assurance to the CQC Board on CQC's risk management, governance and internal control. The ACGC also engages with our internal auditors (Health Group Audit) and our external auditor, the National Audit Office, to determine the priorities for audit work during the year. The committee has one independent member, Linda Farrant, who was appointed in July 2015. David Prince, the other independent member, stood down in June 2015. Paul Rew is chair of the ACGC.

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

The Regulatory Governance Committee (RGC) provides assurance to the CQC Board that systems, processes and accountabilities are in place for identifying and managing risks associated with delivering the regulatory programme. The committee also ensures that the surveillance model is robust and makes possible an effective inspection programme (including rating) that provides public confidence in the work of CQC. The committee is chaired by Michael Mire and has three non-executive Board members. While Michael Mire was acting as Interim Chair of CQC, Board member Louis Appleby chaired the RGC. The Chair of the RGC sits on the ACGC.

People and Values Committee (formerly the Remuneration Committee)

The People and Values Committee (PVC) has responsibility for determining the remuneration of the Chief Executive and selected senior members of staff, within guidelines laid down by the Department of Health on Very Senior Pay.

The committee, which is chaired by Peter Wyman, has up to three non-executive Board members. It also reviews CQC's pay policy and its arrangements for succession planning. The committee oversees how the organisation is embedding our values of excellence, caring, integrity and teamwork.

Statutory committees of the Board

Healthwatch England

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

The Accounting Officer meets quarterly with the Chair and Chief Executive of Healthwatch England to gain assurances that the organisation is operating effectively, efficiently and economically. Following the departure of the Chair and Chief Executive of Healthwatch England during the year, the opportunity has been taken to review some of the operational arrangements between CQC and Healthwatch England.

The National Information Governance Committee

The Health and Social Care Act 2012 gave CQC new legal responsibilities from 1 April 2013 for monitoring and seeking to improve registered providers' information governance practices. This was done through a National Information Governance Committee (NIGC), which stood until July 2015. Between March 2014 and July 2015 the committee was chaired by Paul Bate, the Executive Director of Strategy and Intelligence, who is also CQC's Senior Information Risk Owner. The committee reported to the Board in July 2015, setting out its findings since its establishment and making 10 recommendations, all of which were accepted by the Board.

Stakeholder Committee

The Stakeholder Committee was originally set up to provide advice to CQC's Board. However, the Stakeholder Committee did not meet in 2015/16, as CQC has taken a co-production approach to the development of new policies and methodologies. This approach has proven to be successful, with positive feedback from those involved, and is kept under review.

Governance processes

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

CQC's Executive Team

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

Committees of the Executive Team

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

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

The following committees report directly to the Executive Team:

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

Annex 1: Board and Committee membership

CQC Board

Board member	Term of office
David Prior (Chair) (left May 2015) Peter Wyman CBE DL (Chair)	28 January 2013 – 27 January 2017 4 January 2016 – 3 January 2020
David Behan CBE (Chief Executive)	5 November 2012
Anna Bradley (left 18 December 2015) Jane Mordue – Interim Board member	16 July 2012 – 15 July 2015 19 December 2015 – until appointment of new Healthwatch England Chair
Kay Sheldon OBE	1 December 2008 – 30 November 2016
Dr Paul Bate	3 May 2013
Prof. Paul Corrigan CBE	1 July 2013 – 30 June 2016
Prof. Louis Appleby CBE	1 July 2013 – 30 June 2016
Dr Jennifer Dixon CBE	1 July 2013 – 30 June 2016
Michael Mire (Interim Chair: 9 June 2015 – 31 December 2015)	1 July 2013 – 30 June 2017
Camilla Cavendish (left May 2015)	1 July 2013 – 30 June 2017
Prof. Sir Mike Richards	16 July 2013
Prof. Steve Field CBE	30 September 2013
Andrea Sutcliffe	7 October 2013
Paul Rew	1 July 2014 – 30 June 2017
Sir Robert Francis QC	1 July 2014 – 30 June 2017

Audit and Corporate Governance Committee

Committee member
Paul Rew (Chair)
Michael Mire
Sir Robert Francis QC
Co-opted member
Jane Mordue (co-opted from Healthwatch England)
Independent members
Linda Farrant
David Prince (left committee 30 June 2015)

People and Values Committee (formerly the Remuneration Committee)

Committee member
Peter Wyman CBE DL (Chair)
Kay Sheldon OBE
David Behan CBE
Prof. Louis Appleby CBE (left committee 29 February 2016)
Dr. Jennifer Dixon CBE

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

Committee member
Michael Mire (Chair)
Kay Sheldon OBE
Anna Bradley (left committee 31 December 2015)
Camilla Cavendish (left 31 May 2015)
Prof. Paul Corrigan CBE
Paul Rew
Prof. Louis Appleby CBE (joined committee 1 March 2016)

Annex 2: Executive Team membership

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

Annex 3: Board and Executive Team biographies

Peter Wyman CBE DL, Chair

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

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

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

He was awarded a CBE in 2006.

David Behan CBE, Chief Executive

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

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

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

Professor Louis Appleby CBE, Non-executive director

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

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

Professor Appleby developed the National Suicide Prevention Strategy for England, re-launched in 2012. It focuses on support for families and prevention of suicide among at-risk groups.

Dr Paul Bate, Executive Director of Strategy and Intelligence

Dr Paul Bate has worked at the centre of health policy and delivery for more than 10 years. He joined CQC from Downing Street, where he was the senior policy adviser on health and adult social care to both the Prime Minister and the Deputy Prime Minister. He also worked for the Prime Minister's Delivery Unit under the previous government, where he led the health standards team and ran national reviews on cancer, elective waiting times, long-term conditions and healthcare-associated infections.

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

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

Dr Paul Bate leaves CQC and the CQC Board in July 2016.

Professor Paul Corrigan CBE, Non-executive director

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

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

Dr Jennifer Dixon CBE, Non-executive director

Dr Jennifer Dixon is Chief Executive of the Health Foundation. Between 2008 and 2013 she was Chief Executive of the Nuffield Trust. She is also currently a trustee of NatCen Social Research.

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

She is a visiting professor at the London School of Economics and Political Sciences, Imperial College and the London School of Hygiene and Tropical Medicine. She is also a member of the editorial board of the Office of Health Economics.

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

Dr Jennifer Dixon leaves the CQC Board in July 2016.

Professor Steve Field CBE, Chief Inspector of General Practice

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

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

He was Chair of council of the Royal College of General Practitioners between 2007 and 2010. For the past 12 years he has been a Member of Faculty at the Harvard Macy Institute, Harvard University in Boston, Massachusetts. He is a non-executive director of University College London Partners, Honorary Professor at the University of Birmingham and Honorary Professor at the University of Warwick.

Steve received a CBE for his services to medicine in the Queen's 2010 New Year's Honours List. He continues to practise as a GP at Bellevue Medical Centre in Birmingham, a large academic training practice involved in research and healthcare education at undergraduate and postgraduate levels.

Sir Robert Francis QC, Non-executive director

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

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

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

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

Michael Mire, Non-executive director

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

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

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

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

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

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

Paul Rew, Non-executive director

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

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

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

Professor Sir Mike Richards, Chief Inspector of Hospitals

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

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

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

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

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

Kay Sheldon OBE, Non-executive director

Kay Sheldon was a Mental Health Act commissioner for 11 years and a member of the Mental Health Act Commission Board for five years. She brings personal experience as a user of mental health services to CQC, and she has been involved with a variety of user-led initiatives in both the statutory and voluntary sectors.

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

Kay is also a member of the People and Values Committee (a Board subcommittee).

Andrea Sutcliffe, Chief Inspector of Adult Social Care

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

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

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

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

Our Executive Team

CQC's Executive Team consists of:

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

and

Eileen Milner, Executive Director of Customer and Corporate Services

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

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

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

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

Annex 4: Summary of Board attendance

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
David Prior (Chair)	✓											
Peter Wyman CBE DL (Chair)										✓	✓	✓
David Behan CBE (Chief Executive)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Anna Bradley	✓	✓	✓	✗		✓	✗	✓	✓			
Kay Sheldon OBE	✗	✓	✓	✓		✓	✓	✗	✓	✓	✓	✓
Dr Paul Bate	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Prof. Paul Corrigan CBE	✓	✗	✓	✗		✗	✓	✓	✓	✓	✓	✓
Prof. Louis Appleby CBE	✓	✓	✓	✓		✓	✓	✗	✓	✓	✓	✓
Dr Jennifer Dixon CBE	✗	✓	✓	✓		✓	✓	✗	✓	✓	✓	✓
Michael Mire	✓	✓	✓	✗		✓	✓	✓	✓	✓	✓	✓
Camilla Cavendish	✓	✗										
Prof. Sir Mike Richards	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Prof. Steve Field CBE	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Andrea Sutcliffe	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Paul Rew	✗	✗	✓	✓		✓	✓	✗	✓	✓	✓	✗
Sir Robert Francis QC	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Jane Mordue										✓	✓	✓

Annex 5: Board business 2015/16

CQC Board – coverage of topics 1 April 2015 to 31 March 2016
Agenda items
2015 staff survey results
ACGC annual report to Board
Acute and mental health NHS trusts Intelligent Monitoring banding proposals
Annual provider surveys report
Adult social care market update and role of CQC
Board discussion on strategy scenario(s) (including NHS trusts' use of resources)
Board pad demonstration
Board seminar – future inspection approach
Brainstorming session on CQC's future strategic direction, facilitated by Paul Corrigan
Business plan priorities for 2016/17
Capital programme
Chief Executive's report
Controlled drugs annual report 2014
Corporate governance framework
Counter fraud, bribery and corruption policy
CQC draft business plan and budget 2016/17
CQC draft inspection programme for 2016/17
Customer Relationship Management (CRM) procurement project
Data security review report – including policy statement on information security and governance
Declaration of interests policy
Deprivation of Liberty Safeguards report
Draft handbook and key lines of enquiry for independent doctors
Duty of candour
Experts by Experience
Fees for 2016/17 – CQC response to fees consultation
Fees strategy consultation
Finance/spending review update
Fit and proper person
Five-year structural and financial outlook for health and social care sectors
Freedom to Speak Up Guardian consultation
Fresh start for registration
Gifts and hospitality policy
GP Intelligent Monitoring review and outcomes
Health and justice handbook
Healthwatch England – presentation of draft high-level business plan 2016/17

CQC Board – coverage of topics 1 April 2015 to 31 March 2016
Healthwatch update
Hospital investigation thematic
Healthwatch England six-month update to CQC Board
Integration, pathways and place 2015/16 programme – report to Board
Intelligence inspections analytical services procurement support for independent health inspections
IT services and systems for communications
Julie Mellor and Executive Team, Parliamentary and Health Service Ombudsman (PHSO) (complaints/ ombudsman/memorandum of understanding)
Leadership and management development programme
Mental Health Act report
Mental health crisis care national report
Morecambe Bay investigation
National resource planning system
New strategy 2016: learning from last two years and future trends
NHS 111 handbooks
National Information Governance Committee final report to Board
Overview on PHSO investigations
Patient experience survey programme
Performance and finance report
Performance report
Procurement
Quality of care in a place – North Lincolnshire report
Regulation of dental services report
Responding to concerns
Responsive analysis call-down contract
Regulatory Governance Committee annual report to Board
Speak up policy
Special measures – next steps
State of Care report
Strategy – board discussion
Strategy 2016 to 2021 – Board discussion and to approve
Substance misuse services draft handbook
Topics for Board development away day
Values-based organisation and leadership
Workforce Race Equality Standard report

Statement of Accounting Officer's responsibilities

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

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the government financial reporting manual (FReM) 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 FReM have been followed, and disclose and explain any material departures in the financial statements
- prepare the financial statements on a going concern basis.

The Secretary of State for Health has appointed the Chief Executive as Accounting Officer of the Care Quality Commission (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 CQC's assets, are set out in *Managing Public Money* published by HM Treasury.

Governance statement

Management assurance

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

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

Each of our directorates provides a self-assessment against a clear set of expectations of performance in these eight core management disciplines. These assessments are then put through a collective challenge by the Executive Team, before being presented to the ACGC. The main findings from our assessments in October 2015 and February 2016 are summarised below, together with some of the improvement actions we have underway.

Key points are:

- Across our directorates our work on performance and risk management had improved most.
- Planning and continuous improvement were the areas that scored most highly.
- We need to do more to improve our work on quality management and information and evidence management as these are rated as 'requires improvement'.
- We need to do more to ensure that areas we self-assess as 'requires improvement' do actually improve – as some of these areas have remained in this category for some time.
- Internal audit, performance reporting and other evidence sources show that we cannot be complacent and need to continue to improve – particularly in people management, information and evidence management, financial management systems and control, and governance and decision making.

The organisation put in place its management assurance framework in 2014 with the aim of it increasingly becoming a central tool to support change and improvement. It has enabled CQC to underpin delivery of its purpose and role with a clear framework for how we manage ourselves. The framework itself has been improved over time – including setting out characteristics of the four levels of performance for self-assessment. And as we have developed the guidance and approaches to the eight management disciplines, then the assurance framework has evolved to include these – most recently with the finalisation of the quality framework.

Firstly, we recognise, that while we are confident we have embedded the assurance process, there is still more to do to make sure the requirements and standards are understood at all the critical levels in the organisation. Secondly, we have had a number of audit recommendations that highlight where further improvement is required, and we have made a number of significant changes and are working on action plans to deliver further improvements. Thirdly, we know

that in certain areas of assurance, such as information and evidence management, all our directorates feel that there is more to be done, and we are intending to use the assurance framework to highlight where cross cutting action is needed. And finally, we want to continue to make the assurance process stronger by comparing self-assessment with other sources of evidence.

These improvements have been set out in business plans for 2016/17 and progress will be tracked during the year ahead.

We continue to develop our self-assessment process and in 2016/17 we want to compare these assessments more closely to data on outcomes and performance in assurance areas, and to look at our corporate performance more closely rather than each directorate's contribution. We will look at whether we can develop an aggregated rating at CQC level for each assurance area.

Planning

A number of improvements were made in our planning approach in 2016/17. At the beginning of the year our plans set out a challenging inspection programme and significant recruitment was required. Through close tracking of performance, it became clear that a re-profiling of inspection plans was needed and this was carried out in quarter 2. The re-profiling was undertaken alongside the planning for 2016/17, which began in October 2015. The 2016/17 planning round was conducted within the context of a new strategy being developed and a reduced budget for 2016/17.

Directorates engaged with each other about their planning proposals and there were a number of discussions and responses to the requirements of each directorate. A number of directorates held planning discussions with staff, and reflected comments in their plans. Planning discussions involving the wider leadership team enabled 2016/17 plans to be considered in the context of the year being the first of the new five-year strategy and, although the development of the strategy and the business plan had parallel timelines, there was good engagement by senior leaders in long term as well as shorter term planning.

An extensive set of budget discussions have resulted in a corporate plan and directorate plans agreed by the Board and the Department of Health in April 2016. Our strategy for 2016 to 2021 was published at the end of May 2016.

Performance and risk management

A continued strengthening of the quality of performance information and focus on performance reporting in directorates has resulted in increased performance – particularly in the timeliness of our response to safeguarding alerts and concerns, which was an issue before we established a Safeguarding project and delivered a number of improvements. We were also able to highlight the backlog of inspections that needed to be completed and, as a result a re-profiling of the inspection programme took place in quarter 2, which informed a more realistic business plan commitment for the inspection directorates in 2016/17.

There have been improvements in frontline staff recording performance information during the year, as a result of tracking timeliness of reporting and management focus on the issue.

As part of business planning for 2016/17, all our key performance indicators (KPIs) have been reviewed, with targets assigned for all the KPIs – including the timely publication of inspection reports, which was recommended by the National Audit Office review.

Our risk management framework provides for a Strategic and Operational Risk Register to be considered by the Board at quarterly intervals, and the Executive Team more frequently.

The register identifies the strategic level risks that the Board will oversee, and the higher level operational risks, which by their nature require cross cutting action to mitigate, or are of significant importance that they need to be highlighted and managed at a corporate level. The risk register sets out the mitigations that are being carried out to manage the level of each risk, and these mitigations are built into the business plans of directorates. Progress with delivering mitigating actions is monitored by the Executive Team, the Audit and Corporate Governance Committee and the Board. Directorates have risk registers associated with their business plans, and these will also reflect strategic or high level operational risks that they are managing. Directorates monitor their risks and mitigations on an ongoing basis. Directorates continue to update risk registers as required during the year. A risk management audit has made a number of recommendations for improvements. Work on these is progressing within an action plan and relevant directorate business plans, and progress is good.

As set out earlier in the Annual Report, the Board and Executive Team have agreed a set of risks for 2016/17. Mitigating actions have been set out and work is ongoing to ensure these are robust, and incorporated in business plans and are clearly owned so they can be monitored.

Quality management

During 2015/16, a CQC quality framework was approved by the Executive Team. The main emphasis of our approach to quality during the year has been on ensuring we are making high-quality and consistent inspection judgements under our new approach. Clear quality standards that link to our operating model are now in place. Controls are set out and the measurement through quality sampling reports is now in place; the outcomes are being reported to inspection directorates. Other directorates are in the process of embedding the quality framework in their areas, and have further work to do on this in the coming year.

The Hospitals directorate has introduced quality of delivery officers who are now in post, and has employed report writing coaches. In the Adult Social Care directorate, a wide ranging series of improvements have been brought in to quality arrangements, including those focused on specific themes such as inadequate services and enforcement, and service specific reviews following concerns have provided useful learning. The Primary Medical Services directorate communicates with staff following national quality panels, to feedback and pass on lessons learned.

The Intelligence team has strengthened its quality arrangements following an internal audit of their quality assurance arrangements for external analyses. A quality assurance policy was put in place in August 2015 and there is a programme of quality audits across the team, which is reported on in a monthly scorecard.

People management and development

While recruitment of inspectors progressed well in the year, and overall inspector numbers are now at 94% of establishment, the Hospitals directorate has more vacancies than the other sectors; inspector numbers were at 80% of establishment at the end of quarter 4. Our directorates have agreed their business plans and budgets for 2016/17, and will keep their establishment numbers under review as part of ongoing business planning and budget monitoring activity.

A programme to modernise our customer support services is underway and it includes how we deliver business support. It will be completed in 2016/17. Business support was centralised in April 2015 and since then a better understanding has developed around work processes. We recognise the recommendations of external consultants who found regional

variations in service delivery of business support; that some business support staff skills were not fully used; and that transactional activity made up a large part of some teams' work. Our plans going forward as part of the modernisation programme include examining centralising all repeatable processes as much as possible, and returning specialist business support functions to directorates.

A new performance review and development framework was launched in April 2015 and this helped to inform objective setting for the year. We are confident that the majority of staff are clear on the objectives they are working to. However, directorates are highlighting the difficulty they are experiencing with loading information relating to staff performance management onto the automated people and development system 'ED'. This can be time consuming, and as a result is acting as a barrier to managers engaging with ED. However, improvements have been made to the system for the 2016/17 reporting year.

There is evidence that directorates are focusing on poor performance and applying our HR policy to dealing with capability issues.

The Academy is now delivering training that is more specific to the individual inspection directorates. The amount of e-learning available, with a focus on mandatory training, has increased significantly in the year. In the last quarter, we have launched the development programme for Leadership and Management – 'Inspire'.

The 2015 staff survey results indicated improvement in some key areas and a percentage increase in the level of employee engagement. However, there are concerns about our ability to manage change, communicate effectively and take action in response to what the survey is saying. A number of actions have been put in place to address these issues, including more discussion with staff about concerns. We have a number of actions in our corporate business plan for 2016/17 that focus on the themes that were of concern to staff. CQC has set itself the target of increasing its scores in the areas of concern, and in the overall engagement score, in 2016.

Financial management, systems and control

A new structure and senior roles in the Finance and Commercial teams has enabled greater engagement with managers, ensuring they are aware of good financial management and financial accountability, and that responsibility rests with those making decisions and committing resources. A training module on financial awareness will be rolled out in 2016/17. Our Investment Committee is provided with routine capital reporting, as well as a commercial report on contract areas for concern and procurement savings achieved as a result of action taken by the Commercial team. A new Finance subcommittee of the Board has been formed and will operate from 2016/17.

We will institute strengthened processes for expenditure monitoring and controls and approvals for filling vacancies, as well as implementing a process to recover underspends from directorates in-year as a contribution to our savings target.

We will implement a cost improvement programme, identifying areas of financial opportunity, risk assessing the impact and implementing and reporting on the required changes on an ongoing basis.

Alongside this, Finance will be working to ensure that forecasting in CQC is more robust and that the implication of current expenditure or potential savings initiatives is identified on a rolling basis beyond the current financial year. The appointment of a capital investment manager has ensured greater rigour in assessing business cases and understanding and analysing CQC's capital programme and

underpins the governance and oversight of the Investment Committee.

In 2016/17, CQC will receive 75% of its chargeable costs from providers. This will rise to nearly 100% in the following year. Being funded by providers presents CQC with several challenges. These include our continued understanding, now more than ever, that all resource must show value for money and that we need to be effective in debt recovery and in forecasting. A fees manager and a costing manager have been recruited to strengthen this work.

Information and evidence management

Directorate self-assessments scored this area lowest. Some of the key cross cutting improvements being put in place to address this are as follows.

Evidence management

We are aware that we need to improve how data and evidence are used consistently to inform inspection planning, decisions and judgements. In CQC's knowledge and information strategy, we stated that we will build on our previous work and products to produce a comprehensive insight model (a tool to collect, analyse and report data about services). This will enable CQC to better protect people who use services by using information to trigger action where concerns are raised. If an inspection is considered the necessary response, then the intelligence in the insight model will drive that inspection.

Development work has also been carried out to change the structure and format of our inspection reports and outputs. A key aspect of this is our plan to introduce evidence tables, in which data and evidence will be structured against our key lines of enquiry and published alongside our reports. The information in the evidence tables will be tested on inspection and corroborated with the evidence that our inspectors collect while on site.

Information management

We believe there is a strong understanding of the importance of good information governance across CQC. However, the complex and difficult to understand legal framework of responsibilities hampers how effectively the responsibilities are discharged across CQC.

To address these issues, CQC has undertaken significant work to design and implement a new information asset register. Information asset management helps to identify risks associated with specific information assets, and ensures those risks are managed effectively.

Information asset owners across the organisation have been identified, engaged and supported to understand their responsibilities. They are supported by a network of knowledge and information management champions. This work has been supported by a review of information management policies and a new web page to create a one-stop shop for all information policies.

Governance and decision making

We have a Scheme of Delegation to ensure all significant decisions are made by those who are authorised to make them. To the best of our knowledge, during the year CQC has not assumed duties beyond its statutory powers, nor has it improperly delegated any duties. We made a number of significant improvements to the scheme in the year to make it clearer. An internal audit report during the year made further recommendations to ensure the scheme is well understood across CQC; the way information is recorded in our systems reflects how the delegations apply; updates are regular; and training and support is available. An action plan will be taken forward to deliver on these during 2016/17.

During the year we have reviewed our:

- code of practice.
- complaints end-to-end process to improve the quality of complaints handling and customer experience.
- ratings review end-to-end process – a new process aimed at speeding up the triage and review process has been agreed.
- corporate governance framework.

Actions and improvements in these areas are underway.

Continuous improvement

The majority of our directorates report that they have strengthened their capability in continuous improvement, although much of our current improvement activity is focused on discharging our regulatory functions. This has included making improvements to inspection reports and quality assurance of inspections. Directorates and teams are working well in partnership to deliver improvements in efficiency, effectiveness and economy. It has included lessons learned from inspections and in particular significant instances of poor care, including where urgent action has to be taken by CQC. As noted earlier, a focus on safeguarding performance has produced improvements in the timeliness and consistency of our work, and a reduction in a backlog of cases.

We are confident that our audit programmes are focusing on areas of greatest risk, and we continue to learn lessons from these, and identify improvement actions. While we have dedicated improvement resources and are looking at building capability, we are yet to define a continuous improvement approach for CQC and recognise the cultural and behavioural shift required to make the desired progress. We have gathered key learning from other organisations, and we will take forward the development of an approach in 2016/17. This is important as we begin to implement the changes set out in our new strategy.

Other assurance areas

Information security and governance

Information security remains a high priority in support of CQC's purpose of ensuring that health and social care services provide people with safe, effective, compassionate, high-quality care and encouraging care services to improve.

This area has been given additional impetus and priority during the year due to the proliferation and increase in the threat around cyber security, as well as a review of data security in the NHS by CQC.

The knowledge and information strategy and information security continue to be supported through CQC investment in systems, software and technology – ensuring that staff have timely access to accurate information that is appropriately secured and is managed in line with legislation, compliance requirements and related guidance.

Assurance of information security controls continues to be obtained from a wide range of sources, to ensure that the security systems in place are appropriate and operating correctly. We continue to measure our internal security arrangements against existing and emerging standards including ISO27001 and Cyber Essentials

Security incident analysis and response has been carried out during the year and is reported to the CQC Senior Information Risk Officer and the Audit and Corporate Governance Committee. We have continued to liaise with the Department of Health, NHS England and the Information Commissioner's Office on matters of information security and privacy.

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

CQC completes the annual Information Governance Toolkit return, coordinated by NHS Digital. Improvements this year in our information governance practices and information systems have resulted in a score of 89% compared with the previous year's score of 85%. Our overall rating is classed as 'satisfactory', which indicates that we have achieved level 2 or above compliance (on a three-level rating system) in each of the applicable requirements. Work will continue to further improve on this score during the forthcoming year. There have been no information security incidents during 2015/16 that CQC has had a requirement to report externally.

Counter fraud

The Director of Governance and Legal Services leads the CQC counter fraud function. The number of allegations of fraud received during 2015/16 has shown a continued downward trend, with only nine cases reported and investigated; none of these have been found to be substantiated. This downward trend has been attributed to the relaunch of the counter fraud training and the newly launched conflicts of interest policy and associated declaration of interest returns from all staff. These, in turn, have significantly enhanced internal awareness of policies and procedures. There is an ongoing commitment to thorough and robust investigation of all reported fraud, bribery or corruption.

Head of Internal Audit Opinion

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

My opinion is based on the outcomes of the work that Internal Audit has conducted throughout the course of the reporting year and on the follow-up action from audits conducted in the previous reporting year. There have been no undue limitations on the scope of Internal Audit work and the appropriate level of resource has been in place to enable the function to satisfactorily complete the work planned. Internal Audit is fully independent and remains free from interference in determining the scope of internal auditing, performing work and communicating the results.

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

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

  Management's focus since April 2014 has been on ensuring that CQC has the right strategic risks recorded on its risk register and that the Executive Team, the Audit and Corporate Governance Committee and the Board are regularly reviewing the relevant risks. In 2015/16, the corporate risk and assurance manager has been working with the business managers in each directorate to deliver a programme of understanding, knowledge transfer and support to enable each of them to deliver on their risk management responsibilities. Our review of risk management provided moderate assurance over these processes. We observed strong visible commitment at the senior level, with the majority of business units using systematic approaches. There is some variation in risk management practice between

directorates that will require some future focus, as well as helping staff understand how the corporate risk appetite should inform decision making.

From 1 April 2015, CQC took on responsibility for the market oversight of larger social care providers from the Department of Health. We reviewed the arrangements established by management, which have included securing external support for the process while the internal team has been established. The team will take on full responsibility for financial appraisals from 1 April 2016. We concluded that risks in taking on this service appear to have been identified and managed reasonably.

We have also noted through our work and engagement with directors and managers that there is self-awareness of the areas where systems, processes and controls can be improved to mitigate risk. In a number of cases, management has invited Internal Audit to help identify actions to assist them in making those improvements.

- In the case of **governance**:

  A number of audits have assessed different aspects of governance during the year. We reviewed the corporate governance structures and information flows, and also the application of the Scheme of Delegation, and concluded that while there was moderate assurance over governance structures and information, assurance was limited in relation to the Scheme of Delegation. The Scheme itself is fit for purpose but there is a need to review the systems in place by which evidence of compliance is captured.

  We provided moderate assurance over the review of the new operating model that was implemented for 2015/16, and noted that management are continuing to take steps to strengthen the control environment. The introduction of the model appears to have a number of benefits, namely: the provision of a framework on which other activity can be developed; greater clarity on how all areas of CQC work together; and a common language for the organisation. The speed, quality and consistency of implementation still varies across the organisation and in the accountability for, functionality and use of supporting IT systems and data management to deliver CQC's overall objectives.

  In the area of health and safety, progress has been made in giving the Health, Safety and Wellbeing Committee visibility of the operation of controls, and in improving controls at a detailed level. The results of the external specialist review have shown that there remains scope to improve governance of health and safety, and management is developing an action plan in response to this to be delivered in 2016/17. We performed a follow-up of our 2014/15 audit of business continuity planning. This has shown that while some limited progress has been achieved, a lead officer has only recently been recruited to take responsibility for this area, so there remains more to do in terms of strengthening the governance of the business continuity programme.

  Management has continued to develop and embed the management assurance self-assessment process that involves six-monthly self-assessment by Chief Inspectors, Executive Directors and Heads of Department of the planning, operational, financial and performance management processes across CQC. Commendable progress has been made in developing and implementing the framework and engaging the organisation in the process. The outputs from the latest exercise in March 2016 show a number of areas of improvement, most notably performance and risk management and also help to highlight areas where there is a recognised need for improvement in controls, in particular the area of information and evidence management. Building on the

assessment framework developed, the next steps should include clarifying the expectations of supporting evidence for the assessments and how this will be incorporated into the corporate review.

- In the case of **control**:

  We have issued 20 audit reports from the 2015/16 programme and four to complete the 2014/15 programme. Excluding the reports on risk management and corporate governance, the other 22 address key aspects of the systems of internal control. Fifteen of these reports were rated moderate, seven limited and two were not formally rated. This represents a positive direction of travel on the prior year when seven moderate and eight limited assurance reports were issued. While recognising that in areas such as business continuity and expenses payments, some action has been taken to address prior year recommendations, assurance remains limited while changes are embedded to deliver the expected outcomes. This demonstrates the learning culture operating within CQC, where audit findings are used to drive continuous improvement.

  The overarching theme arising from the audits is that while progress has been made in enhancing systems and processes, there remains a challenge with the IT systems used. Our reports on Scheme of Delegation compliance and registration, which both concluded limited assurance, drew attention to reliance on the Customer Relationship Management (CRM) system for recording processes. CRM is not bespoke to the tasks involved and staff have identified it as difficult to use. The audits identified issues with the recording of evidence and ability to locate it within the system. We therefore believe there is a need to review the IT systems in use and scope to develop those for the future, as well as a need for additional training, guidance, support and/or compliance checking of recorded evidence in CRM.

  Our report on registration noted the efficiency challenge that management is responding to in organising that function to meet its key performance targets. Similarly, our report on the new Flexible Working Office identified that all recruitment and engagement data is stored on MS Excel spreadsheets, which is manually intensive and inherently more risky, although we identified no issues with controls over recruitment. A new process has been implemented for expense payments to staff and, as that is more widely used by staff, should reduce difficulties in collating and storing supporting documentation.

  The remaining audits have provided moderate assurance over the controls in place covering a wide range of financial and operational systems and processes. In particular, this includes all areas of the core financial systems reviewed in the year. We found that tendering for the new Experts by Experience contracts had built on learning from the previous arrangements and that the new quality framework, which was still being rolled out, had improved quality assurance over externally facing analyses. We also identified a number of positive aspects to general IT controls including staff training, change controls, back-up and security arrangements.

  Management is aware of the areas within the organisation requiring improvement, and has been open in seeking support in a number of these, asking Internal Audit to focus on such areas to help them in embedding a robust control framework. Generally, good progress has been made in implementing prior year audit recommendations, with our 2016/17 review of financial management demonstrating significant improvement to core processes. Strengthening the processes and controls around expense payments, business continuity and the governance arrangements for health and safety remain work in progress, with detailed action plans being worked through.

Therefore, in summary, my overall opinion that I can give to the Accounting Officer of the Care Quality Commission for the reporting year 2015/16 is **MODERATE** assurance that there are adequate and effective systems of governance, risk management and control, noting that the IT systems warrant further management consideration.

Jane Forbes
Head of Internal Audit

Accounting Officer's conclusion

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

Greatest progress has been made across the organisation in introducing performance and risk management across all directorates. However, we know that in some areas, in particular information and evidence management, there is more to be done. The Executive Team also recognises that there is more to do to make sure the requirements and standards are understood at all levels in the organisation. These improvements are set out in the business plans for 2016/17 and progress will be tracked in the year ahead.

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

I agree with their conclusion.

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

I conclude that the CQC governance and assurance processes have supported me in discharging my role as Accounting Officer. I am not aware of any significant internal control problems in 2015/16. Improvements will continue in 2016/17 to strengthen the assurance that can be provided and the overall internal control environment within CQC.

Remuneration and staff 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 are subject to audit.

Remuneration of the Chair and non-executive Board members

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

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

CQC reimburses its Chair, non-executive Board and independent members for the cost of travelling to and from CQC, including for Board meetings and for other events at which they represent CQC. CQC meets the resultant tax liability under a settlement agreement with HM Revenue and Customs. For 2015/16 the total liability amounted to £1k (2014/15: £6k).

Chair and non-executive Board members' emoluments

	Date appointed	2015/16 total salary £000	2014/15 total salary £000
Peter Wyman CBE DL (Chair)	4 Jan 2016	15 – 20[1]	–
Michael Mire (Interim Chair from 9 Jun 2015)[2]	1 Jul 2013	35 – 40[3]	5 – 10
David Prior (Chair, resigned 15 May 2015)	28 Jan 2013	5 – 10[1]	60 – 65
Kay Sheldon OBE	1 Dec 2008	5 – 10	5 – 10
Prof. Louis Appleby CBE	1 Jul 2013	5 – 10	5 – 10
Prof. Paul Corrigan CBE	1 Jul 2013	5 – 10	5 – 10
Dr Jennifer Dixon CBE	1 Jul 2013	5 – 10	5 – 10
Sir Robert Francis QC	1 Jul 2014	5 – 10	5 – 10[7]
Paul Rew	1 Jul 2014	10 – 15[4]	5 – 10[8]
Jane Mordue	19 Dec 2015	10 – 15[5]	–
Anna Bradley (resigned 18 Dec 2015)	16 Jul 2012	30 – 35[6]	45 – 50
Camilla Cavendish (resigned 21 May 2015)	1 Jul 2013	0 – 5[7]	5 – 10

[1] Full year equivalent salary would be £60–65k.
[2] Michael Mire was appointed as Interim Chair with effect from 9 June 2015, which extended to 3 January 2016 before the new Chair took up his post.
[3] During the period as Interim Chair the full year equivalent salary would be £60–65k. The full year equivalent salary for the remainder of the year would be £5–10k.
[4] Paul Rew received enhanced remuneration as chair of the Audit and Corporate Governance Committee
[5] Jane Mordue was appointed as Interim Chair of Healthwatch England and received enhanced remuneration as a result. Full year equivalent salary would be £45–50k.
[6] Anna Bradley received enhanced remuneration as a result of her role as Chair of Healthwatch England. Full year equivalent salary would be £45–50k.
[7] Full year equivalent salary would be £5–10k.
[8] Full year equivalent salary would be £10–15k.

Payments to independent members

David Prince and Linda Farrant were independent members of CQC's Audit and Corporate Governance Committee. Fees and expenses are paid on a per meeting basis and during 2015/16 amounted to £1k for David Prince (2014/15: £4k) and £5k for Linda Farrant (2014/15: £nil).

Christopher Fincken, Alan Gillies, Dilys Jones and Christine Munns were independent members of CQC's National Information Governance Committee. Fees and expenses are paid on a per meeting basis and during 2015/16 amounted to £5.3k for Christopher Fincken (2014/15: £0.6k), £3k for Alan Gillies (2014/15: £3k), £nil for Dilys Jones (2014/15: £nil) and £4k for Christine Munns (2014/15: £4k).

Remuneration of the Chief Executive

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

Remuneration of the Executive Team

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

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

For the Chief Executive and Executive Team, early termination other than for gross misconduct (in which no termination payments are made) is covered by their contractual entitlement under CQC's redundancy policy (or their previous legacy Commission's redundancy policy if they transferred). The Executive Team has three months' notice of termination in their contracts. Termination payments are only made in appropriate circumstances and may arise when the member of staff is not required to work their period of notice. They may also be able to access the NHS Pension Scheme arrangements for early retirement depending on age and scheme membership. Any amounts disclosed as compensation for loss of office are also included in the 'Staff report', page 95.

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

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

2015/16	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long-term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits[1] (bands of £2,500) £000	Compensation for loss of office (bands of £5,000) £000	Total (bands of £5,000) £000
David Behan CBE Chief Executive	185–190	–	–	–	37.5-40	–	225–230
Dr. Paul Bate Executive Director of Strategy & Intelligence	140–145	–	–	–	20–22.5	–	160–165
Prof. Sir Mike Richards Chief Inspector of Hospitals	235–240	–	–	–	–[2]	–	235–240
Prof. Steve Field CBE Chief Inspector of General Practice	170–175	–	–	–	–	–	170–175
Andrea Sutcliffe Chief Inspector of Adult Social Care	140–145	–	–	–	5–7.5	–	150–155
Eileen Milner Executive Director of Customer & Corporate Services	140–145	–	–	–	27.5–30	–	165–170

[1] All pension-related benefits calculated as the real increase in pension multiplied by 20 plus the real increase in any lump sum less the contributions made by the individual. The real increase excludes increases due to inflation or any increases or decreases due to a transfer of pension rights.
[2] Pension-related benefits for Prof. Sir Mike Richards is £nil as in receipt of benefits.

2014/15	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long-term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits[1] (bands of £2,500) £000	Compensation for loss of office (bands of £5,000) £000	Total (bands of £5,000) £000
David Behan CBE Chief Executive	185–190	–	–	–	32.5–35	–	220–225
Dr. Paul Bate Executive Director of Strategy & Intelligence	140–145	–	–	–	60–62.5	–	200–205
Prof. Sir Mike Richards Chief Inspector of Hospitals	235–240	–	–	–	–[2]	–	235–240
Prof. Steve Field CBE Chief Inspector of General Practice	170–175	–	–	–	0–2.5	–	175–180
Andrea Sutcliffe Chief Inspector of Adult Social Care	140–145	–	–	–	35–37.5	–	180–185
Eileen Milner Executive Director of Customer & Corporate Services	140–145	–	–	–	25–27.5	–	165–170

[1] All pension-related benefits calculated as the real increase in pension multiplied by 20 plus the real increase in any lump sum less the contributions made by the individual. The real increase excludes increases due to inflation or any increases or decreases due to a transfer of pension rights.
[2] Pension-related benefits for Prof. Sir Mike Richards is £nil as in receipt of benefits.

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

The banded remuneration of the highest paid director in CQC during 2015/16 was £235-240k (2014/15: £235-240k). This was 6.2 times (2014/15: 6.3) the median remuneration of the workforce, which was £38,071 (2014/15: £37,976).

In 2015/16 no employees (2014/15: eight employees) received annualised remuneration in excess of the highest paid director. The calculation is based on the full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis. Remuneration ranged from £7,881 to £237,350 (2014/15: £7,881 to £316,791).

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

In 2015/16, 18 senior executives were paid in excess of £100k (2014/15: 18).

Payments made for loss of office

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

Amounts payable to third party for services as a senior executive

No amounts were paid to third parties for services as a senior executive during 2015/16 (2014/15: £165k employment costs including employer's pension and national insurance costs). Hilary Reynolds, Director of Change, was seconded from the Department of Work and Pensions, from 1 May 2013 to 28 February 2015.

Pension benefits

Pension benefits of non-executive board members

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

Pension benefits of the Chief Executive and Executive Team

Pension benefits were provided through the NHS Pension Scheme for all members of the Executive Team. Pension benefits at 31 March 2016 may include amounts transferred from previous NHS employment, while the real increase reflects only the proportion of the time in post if the employee was not employed by CQC for the whole year.

	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2016 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000) £000	Cash equivalent transfer value at 1 April 2015 £000	Cash equivalent transfer value at 31 March 2016 £000	Real increase in cash equivalent transfer value £000	Employers contribution to stakeholder pensions £000
David Behan CBE Chief Executive	2.5–5	–	10–15	–[3]	130	185	52	–
Dr. Paul Bate Executive Director of Strategy & Intelligence	0–2.5	–	20–25	–[3]	172	196	20	–
Prof. Sir Mike Richards Chief Inspector of Hospitals	–[1]	–[1]	–[1]	–[1]	–[1]	–[1]	–[1]	–[1]
Prof. Steve Field CBE[2] Chief Inspector of General Practice	0–2.5	0–2.5	50–55	160–165	1,078	1,126	25	–
Andrea Sutcliffe Chief Inspector of Adult Social Care	0–2.5	2.5–5.0	25–30	75–80	436	472	26	–
Eileen Milner Executive Director of Customer & Corporate Services	2.5–5.0	–	5–10	–[3]	36	65	29	–

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

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

[3] Lump sum is zero as member is in the 2008 section of the scheme.

Cash equivalent transfer values

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

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

Real increase in CETV

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

Automatic enrolment

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

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

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

NHS pension scheme

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

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016 is based on valuation data at 31 March 2015, updated to 31 March 2016 with summary global member and accounting data.

In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

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

In 2015/16 CQC employer's contributions for staff to the NHS pension fund was £12,449k (2014/15: £8,786k) at a rate of 14.3% (2014/15: 14%). For early retirements, other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs charged to expenditure was £nil (2014/15: £nil).

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

Local government pension schemes

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

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

Employer contributions for 2015/16 based on a percentage of payroll costs only, were £4,057k in total (2014/15: £4,401k), at rates ranging between 14.4% and 36.8% (2014/15: 14.4% and 34.6%). Employer contributions relating to the largest scheme, Teesside Pension Fund, were £3,546k (2014/15: £3,842k) at a rate of 17.0% (2014/15: 17.0%).

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

well as having members who are of an age that allows the deficit to be recovered over a longer period of time.

Contribution rates for 2016/17 range between 14.4% and 39.1% (17.0% for Teesside Pension Fund), with annual cash sums ranging from £1.6k to £206.0k (£nil for Teesside).

National Employment Savings Trust

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

Employer contributions based on a percentage of payroll costs total £23k for 2015/16 (2014/15: £20k), at a rate of 0.98% (2014/15: 0.99%).

Staff report

The information presented in this section is subject to audit. Staff costs are presented in the notes to the financial statements, page 112.

1. Staff numbers

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

	2015/16 Number	2014/15 Number
Directly employed	**3,091**	2,384
Other	**58**	281
Staff engaged on capital projects	**1**	4
Total	**3,150**	2,669

'Other' does not include commissioners or Second Opinion Appointed Doctors who are paid per session.

The actual number of directly employed whole-time equivalents as at 31 March 2016 was 3,295 (31 March 2015; 2,681).

2. Staff composition

Number of staff employed as at 31 March 2016:

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

Number of staff employed as at 31 March 2015:

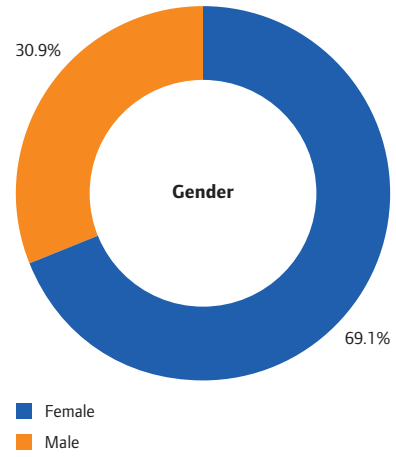
	Board members	Directors	Total employees
Male	6	9	875
Female	3	14	1,895

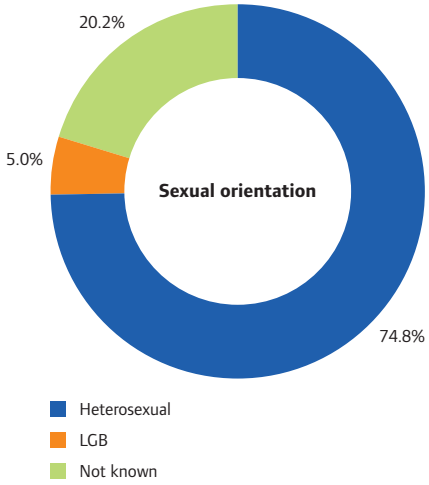
Board members include the Chair and non-executive Board members.

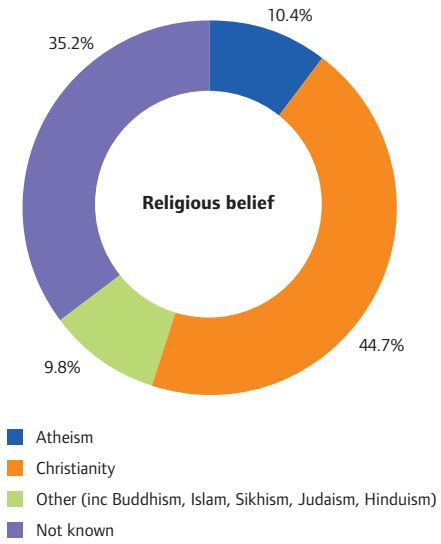
The Chief Executive, an Executive Director and the Chief Inspectors, who are included as Directors in the table above, are also members of the Board (four males, one female).

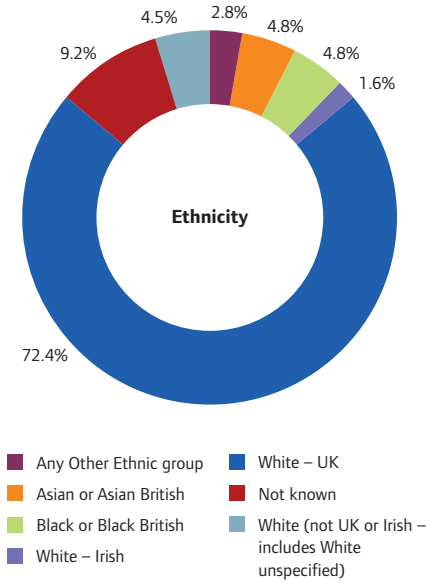
Staff equality profiles at 31 March 2016

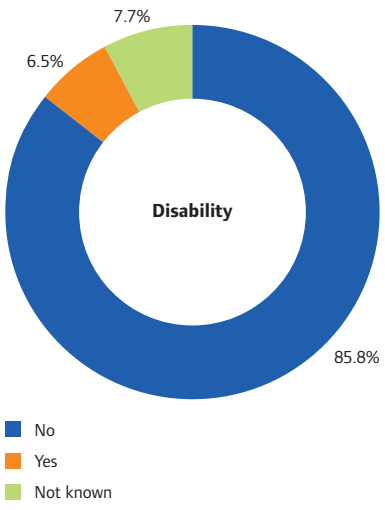
Section 5 below (page 93) provides a commentary on CQC's staff equality profiles.

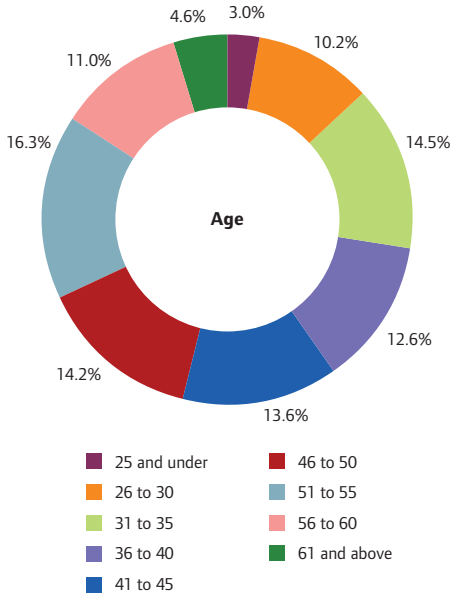












3. Sickness absence data

During 2015/16 the average number of long-term days sickness per absent employee was nine (2014/15: 10 days) and the average number of short-term days sickness was five (2015/16: four days).

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

4. Staff policies

4.1 Employment consultation and engagement

CQC recognises UNISON, the Royal College of Nurses, the Public and Commercial Services Union (PCS), Unite and Prospect for the purposes of collective bargaining and consultation. All of our staff are represented by the staff forum.

We have jointly reviewed our ongoing conversations with the Joint Negotiation and Consultation Committee (JNCC) and implemented a more strategic forward-looking approach. We continue to work with the staff forum, and again continue to base these discussions around a strategic, forward-looking agenda, which allows clarity to understand and contribute to our strategic objectives. The unions and staff forum have worked in partnership with CQC on a number of strategic initiatives, such as the future direction of CQC and the impact of the government spending review.

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

The local joint consultative committees meet on a regular basis to address local issues for staff. Matters that have a potentially wider scope are referred to the JNCC. Topics typically discussed include the review of local staff survey action plans; health, safety and wellbeing; facilities and office management; and other matters that could improve the local working environment.

Our staff forum plays a valuable role in representing the voice of all our employees and has representatives from across the country. The forum provides management with information on how CQC staff are responding to what is happening within the organisation.

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

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

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

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

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

4.2 Employment and policies

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

Three new polices have been drafted, approved and shared with all staff within CQC. The new policies are Critical Illness policy, Speak Up policy (previously entitled Whistleblowing) and a new Code of Conduct policy.

4.3 Home working

Home working forms the contractual arrangement for 2,008 members of staff and is the principal working arrangement for our inspectors, who make up 50% of our workforce. It is also one of a number of flexible working options that form part of CQC's commitment to help improve the work-life balance of our employees.

Home working is integral to CQC's commitment to improving our effectiveness, both in terms of cost and in the way that we carry out our work. CQC provides the tools and equipment required to enable our home working employees to undertake their role safely and effectively.

5. Staff equality

Our staff equality profiles are shown in section 2 above (page 91). At the end of March 2016, the profiles were very similar to the previous year, with some small increases and decreases. The number of Black and minority ethnic (BME staff) increased slightly from 11.1% to 12.4% and lesbian, gay and bisexual (LGB) staff increased from 4.6% to 5.0%. However, during the year, the percentage of men decreased from 31.5% to 31.0% and the percentage of disabled people decreased from 6.8% to 6.5%. Further details of staff composition and numbers are in our 'CQC staff workforce statistics' (available on our website).

We have committed to taking part in the NHS Workforce Race Equality Standard (WRES) and published our first WRES report in July 2015. In order to benchmark ourselves, we have also compared the 2015 CQC staff survey indicators included in the WRES against the results for the national NHS staff survey in England.

While both White and BME staff in CQC are less likely to say that they have experienced harassment, bullying or abuse compared with the NHS average, we still have an ambition to reduce this further in line with our zero tolerance of harassment policy. We are concerned that the percentage of both BME and White staff believing that they have equal opportunities within CQC for career progression and promotion is significantly lower than the NHS average. Though the gap between BME and White staff is slightly smaller in CQC than in the NHS, BME staff are still less likely to say that CQC provides equal opportunities for progression. We are also concerned that only 44% of disabled staff think CQC provides equal opportunities for career progression. We are undertaking a range of work to address this, see 'Progress on our equality objectives' on page 43.

CQC 2015 staff survey results compared with NHS nationally, for WRES indicators (national NHS staff survey in brackets)

	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Percentage of staff experiencing discrimination from manager/team leader or other colleagues in the last 12 months	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
Percentage rounded to nearest whole %				
White staff	8 (24)	5 (6)	10 (22)	61 (89)
BME staff	5 (25)	7 (12)	11 (25)	52 (76)

6. Expenditure on consultancy

CQC spent a total of £2k on consultancy services during 2015/16 (2014/15: £1,318k). Spend during 2014/15 related to the design of inspection packs to assist the delivery of our new approach to inspection.

7. Off-payroll engagements

For all off-payroll engagements as at 31 March 2016, for more than £220 per day and that last for longer than six months:

	Number
Number of existing engagements as at 31 March 2016	8
Of which:	
Number that have existed for less than one year at the time of reporting	1
Number that have existed for between one and two years at the time of reporting	2
Number that have existed for between two and three years at the time of reporting	4
Number that have existed for between three and four years at the time of reporting	1
Number that have existed for four or more years at the time of reporting	–

All existing arrangements as at 31 March 2016 have received approval from the Department of Health.

Assurance that the right amount of income tax and national insurance is being paid has been received from seven of the individuals engaged off-payroll at 31 March 2016.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016, for more than £220 per day and that lasted for longer than six months:

	Number
Number of new engagements, or those that reach six months in duration between 1 April 2015 and 31 March 2016	2
Number of the above which include contractual clauses giving CQC the right to request assurance in relation to income tax and national insurance obligations	2
Number for whom assurance has been requested	2
Of which:	
Number of whom assurance has been received	1
Number of whom assurance has not been received	1
Number that have been terminated as a result of assurance not being received	–

The engagement for whom assurance has not been received left CQC on 31 March 2016; details of the individual have been passed to HMRC.

	Number
Number of off-payroll engagements of board members and/or senior officials with significant financial responsibility during the year	–
Number of individuals on payroll and off-payroll that have been deemed board members and/or senior officials with significant financial responsibilities during the financial year.	26

8. Exit packages

There were no exit costs incurred during 2015/16.

Parliamentary accountability and audit report

1. Losses and special payments

During 2015/16 CQC recognised 547 losses totalling £189k (2014/15: 466 cases totalling £295k), which all related to unpaid annual provider registration invoices, and no special payments (2014/15: one case totalling £10k).

There were no individual losses or special payments that exceeded £300k (2014/15: none).

2. Remote contingent liabilities

There were no remote contingent liabilities as at 31 March 2016 (31 March 2015: none).

3. Better payment practice code

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

	2015/16	2014/15
Number of invoices paid within 30 days	97.0%	96.8%
Value of invoices paid within 30 days	97.8%	96.4%

In line with guidance from the government published in August 2010, CQC aims to pay 80% of all undisputed invoices from suppliers within five working days. During 2015/16 CQC exceeded this target based on both volumes and value:

	Target	2015/16	2014/15
Number of invoices paid within five working days	80.0%	83.0%	81.2%
Value of invoices paid within five working days	80.0%	86.2%	84.7%

4. Fees and charges

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

	Income £000	Full cost £000	Deficit £000
Regulatory fees for chargeable activities	108,966	220,527	(111,561)

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

David Behan
Chief Executive, Care Quality Commission
23 June 2016

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 2016 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 Chief Executive as Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Social Care Act 2008. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the Care Quality Commission's affairs as at 31 March 2016 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 Performance Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

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

Report

I have no observations to make on these financial statements.

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

5 July 2016

Financial statements

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Statement of Comprehensive Net Expenditure

for the year ended 31 March 2016

	Note	2015/16 £000	2014/15[1] £000
Income from fees	6	(108,966)	(103,171)
Other operating income	6	(350)	(226)
Total operating income		**(109,316)**	**(103,397)**
Staff costs	3	171,523	149,903
Purchase of goods and services	4	57,938	52,937
Depreciation, amortisation and impairment charges	4	9,478	10,778
Provision expense	4	(153)	1,020
Other operating expenditure	4	9,259	7,099
Total operating expenditure		**248,045**	**221,737**
Net operating expenditure		**138,729**	**118,340**
Finance expense	4	(18)	(31)
Net expenditure for the year		**138,711**	**118,309**
Other comprehensive net expenditure			
Items that will not be reclassified to net operating costs:			
– Net gain on revaluation of intangible assets		(167)	(78)
– Net gain on revaluation of property, plant and equipment		(28)	(9)
– Actuarial (gain)/loss in pension schemes		(4,459)	15,331
Comprehensive net expenditure for the year		**134,057**	**133,553**

All income is derived from continuing operations.
Expenditure is derived from continuing operations and Healthwatch England activity which is shown in note 2.
CQC received grant-in-aid totalling £135.0m (2014/15: £126.0m) from the Department of Health.
Notes 1 to 19 form part of these financial statements.

[1] The presentation of comparative 2014/15 figures have been revised in line with the format prescribed by the government financial reporting manual (FReM).

Statement of Financial Position

as at 31 March 2016

	Note	31 March 2016 £000	31 March 2015[1] £000
Non-current assets			
Intangible assets	7	14,641	13,934
Property, plant and equipment	8	3,018	2,673
Total non-current assets		**17,659**	**16,607**
Current assets			
Trade receivables	11	2,301	1,639
Other current assets	11	1,633	2,766
Cash and cash equivalents	12	38,901	39,187
Total current assets		**42,835**	**43,592**
Total assets		**60,494**	**60,199**
Current liabilities			
Trade and other payables	13	(35,110)	(25,150)
Current pension liabilities	13	(236)	(205)
Provisions	14	(121)	(1,661)
Fee income in advance	13	(24,262)	(32,606)
Total current liabilities		**(59,729)**	**(59,622)**
Non-current assets plus net current assets		**765**	**577**
Non-current liabilities			
Provisions	14	(1,418)	(1,219)
Pension liabilities	13	(230)	(355)
Total non-current liabilities excluding pension deficit		**(1,648)**	**(1,574)**
Assets less liabilities excluding pension deficit provision		**(883)**	**(997)**
Pension deficit provision	4	(69,589)	(70,418)
Assets less liabilities		**(70,472)**	**(71,415)**
Taxpayers' equity			
General reserve		(70,698)	(71,694)
Revaluation reserve		226	279
Total taxpayers' equity		**(70,472)**	**(71,415)**

[1] Balances as at 31 March 2015 have been revised to present trade receivables as net of any fee income relating to future periods. Previously trade receivables presented as £7,382k and fee income in advance as (£38,349k).

The financial statements on pages 102 to 131 were approved by the Board on 23 June 2016 and were signed on its behalf by:

David Behan
Chief Executive, Care Quality Commission

Statement of Cash Flows

for the year ended 31 March 2016

	Note	2015/16 £000	2014/15[1] £000
Cash flows from operating activities			
Net expenditure for the year		(138,711)	(118,309)
Adjustment for non-cash transactions	4	12,993	14,864
Decrease in trade and other receivables	11	471	3,148
Increase in trade and other payables	13	8,374	5,039
Decrease in pension liabilities	13	(94)	(306)
Decrease in fee income in advance	13	(8,344)	(4,521)
Use of provisions	14	(1,170)	(57)
Net cash outflow from operating activities		**(126,481)**	**(100,142)**
Cash flows from investing activities			
Purchase of intangible assets	7&13	(7,348)	(8,117)
Purchase of property, plant and equipment	8&13	(1,457)	(1,800)
Net cash outflow from investing activities		**(8,805)**	**(9,917)**
Cash flows from financing activities			
Grants from Department of Health		135,000	126,013
Net financing		**135,000**	**126,013**
Net increase in cash and cash equivalents in the year		**(286)**	**15,954**
Cash and cash equivalents at 1 April		39,187	23,233
Cash and cash equivalents at 31 March		**38,901**	**39,187**

[1] The presentation of comparative 2014/15 figures have been revised in line with the format prescribed by the FReM.

Statement of Changes in Taxpayers' Equity

for the year ended 31 March 2016

	Note	General reserve £000	Revaluation reserve £000	Total reserves £000
Balance at 1 April 2014		**(64,429)**	**554**	**(63,875)**
Changes in taxpayers' equity for 2014/15:				
Grants from Department of Health		126,013	–	126,013
Net expenditure for the year		(118,309)	–	(118,309)
Revaluation gains		–	87	87
Transfer between reserves		362	(362)	–
Actuarial loss in pension schemes	5	(15,331)	–	(15,331)
Balance at 31 March 2015		**(71,694)**	**279**	**(71,415)**
Changes in taxpayers' equity for 2015/16:				
Grants from Department of Health		135,000	–	135,000
Net expenditure for the year		(138,711)	–	(138,711)
Revaluation gains		–	195	195
Transfer between reserves		248	(248)	–
Actuarial gain in pension schemes	5	4,459	–	4,459
Balance at 31 March 2016		**(70,698)**	**226**	**(70,472)**

Notes to the financial statements

1. Statement of accounting policies

The financial statements have been prepared on the basis that the Care Quality Commission (CQC) is a going concern. Grant-in-aid which is required to fund CQC's net expenditure during 2016/17 has been included in the Department of Health estimates, which have been approved by HM Treasury.

1.1 Basis of accounting

The financial statements have been prepared in accordance with a Direction issued by the Secretary of State for Health (with the consent of HM Treasury) to prepare for each financial year a statement of accounts in the form and on the basis that it considers appropriate. These financial statements have been prepared in accordance with the 2015/16 government financial reporting manual (FReM) as determined by the Department of Health with the approval of HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of CQC for the purposes of giving a true and fair view has been selected. The particular policies adopted by CQC are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

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

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

The FReM did not require the following Standards and Interpretations to be applied in 2015/16. These Standards are still subject to FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 *Financial Instruments* – application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 15 *Revenue for Contracts with Customers* – application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 16 *Leases* – application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.2 Accounting convention

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

Intangible assets

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

All assets are revalued annually using the appropriate Office for National Statistics price index. Increases in value are credited to the revaluation reserve while the asset is in use. Reductions below cost are charged to the Statement of Comprehensive Net Expenditure.

Property, plant and equipment

Expenditure on office refurbishments, office furniture and fittings, office equipment, IT equipment and infrastructure is capitalised if it has a value of £5,000 or more and a useful 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. General IT project management costs are not capitalised. The assets are recorded at cost and are restated at current value each year using the appropriate Office for National Statistics price index.

Depreciation

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

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

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

The estimated useful lives and residual values are reviewed annually.

Impairment of intangible and property, plant and equipment assets

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

Research and development expenditure

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

Operating income

Income is made up of statutory fees from the registration of social care providers, voluntary healthcare providers, NHS trusts, dentists and ambulance services. Annual registration fees are invoiced on the anniversary of the registration and recognised as income over the following 12 months. Statutory fees which have been paid relating to future accounting periods are treated as income in advance at the end of each accounting period (note 13). In cases of voluntary deregistration, fees are refunded to registered organisations in accordance with the fee rebate scheme detailed on CQC's website.

Leases

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

Financial instruments

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

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

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

Non-current receivables and payables are discounted when the time value of money is considered material. Consequently the liability for additional pension contributions resulting from the early termination of staff in previous years is discounted by 1.37% (2014/15: 1.3%). This is the rate for market yields on AA corporate bonds as published by HM Treasury.

Grants receivable

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

Provisions

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

The amount recognised as a provision is the best estimate of the consideration required to settle the present obligation at the Statement of Financial Position date, taking into account the risks and uncertainties surrounding the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the real rate set by HM Treasury. Provisions falling due up to five years are increased by a discount factor of 1.55% (2014/15: 1.5%) and provisions falling due between 5 to 10 years are increased by a discount factor of 1.00% (2014/15: 1.05%) in accordance with HM Treasury guidance.

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

Value added tax

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

1.3 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable CQC to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to CQC of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

Charged to staff costs:

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

Charged to other expenditure:

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

Charged to other comprehensive expenditure:

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

1.4 Critical accounting judgements and key sources of estimation uncertainty

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

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

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

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

c. Indexation of non-current assets (see accounting policy note 1.2, note 7 and note 8)

d. Assumptions used to determine the IAS 19 pension liability for funded pension schemes (note 5)

2. Analysis of net expenditure by segment

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

Healthwatch England came into existence on 1 October 2012 and is the independent champion for consumers of health and social care services.

The transformation programme through which CQC changed the way it inspects health and social care services commenced during 2013/14 and ended during 2014/15.

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

An analysis of the net expenditure by segment is below:

	2015/16			2014/15			
	Continuing operations £000	**Healthwatch England £000**	**Total CQC £000**	**Continuing operations £000**	**Healthwatch England £000**	**Trans-formation £000**	**Total CQC £000**
Gross expenditure	244,306	3,721	**248,027**	209,177	4,363	8,166	**221,706**
Income	(109,316)	–	**(109,316)**	(103,397)	–	–	**(103,397)**
Net expenditure	**134,990**	**3,721**	**138,711**	**105,780**	**4,363**	**8,166**	**118,309**

The Healthwatch England costs above include £129k (2014/15: £138k) which was recharged from continuing operations in relation to overhead costs incurred by CQC.

Healthwatch England overheads of approximately £414k (2014/15: £108k) have been absorbed by CQC and not recharged in this financial year.

3. Staff costs

Staff costs comprise:

	Permanently employed £000	Others £000	2015/16 Total £000	2014/15 Total £000
Wages and salaries	120,327	21,768	142,095	126,269
Social security costs	10,266	991	11,257	8,999
Other pension costs	16,713	551	17,264	13,853
Termination benefits	–	–	–	182
Subtotal	**147,306**	**23,310**	**170,616**	**149,303**
Less recoveries in respect of outward secondments	(549)	–	(549)	(258)
Increase in provision for pension fund deficits	1,456	–	1,456	858
Total net cost	**148,213**	**23,310**	**171,523**	**149,903**

Other wages and salary costs consist of:

	2015/16 Total £000	2014/15 Total £000
Bank inspectors	13,341	9,911
Second Opinion Appointed Doctors	2,905	2,631
Agency	2,554	16,577
Inward secondments from other organisations	2,287	1,814
Commissioners	681	901
Total	**21,768**	**31,834**

Agency staff costs of £0.1m relating to IT software developments were capitalised during the year (2014/15: £0.6m).

4. Operating expenditure

	£000	2015/16 £000	£000	2014/15[1] £000
Staff costs		171,523		149,903
Purchase of goods and services:				
Establishment	23,316		23,411	
Travel and subsistence	15,588		12,703	
Premises	7,279		6,656	
Rentals under operating leases	5,492		3,899	
Training and development	2,596		2,334	
Professional fees	1,993		1,035	
Supplies and services	1,433		1,377	
External audit fee (statutory work)	145		145	
Insurance	94		59	
Consultancy	2		1,318	
		57,938		52,937
Depreciation and impairment charges:				
Amortisation of intangible assets	8,162		9,644	
Depreciation of property, plant and equipment	1,323		1,229	
Impairment of intangible assets	(13)		(87)	
Impairment of property, plant and equipment	6		(8)	
		9,478		10,778
Provision expense		(153)		1,020
Other operating expenditure:				
Experts by Experience	4,849		3,384	
Net expense on pension scheme assets and liabilities	2,174		2,140	
Business rates paid to local authorities	1,585		678	
Other	280		364	
Losses and special payments (irrecoverable debts)	189		295	
Clinical negligence insurance	126		139	
Loss on disposal of fixed assets	56		99	
		9,259		7,099
Finance expense		(18)		(31)
Total operating expenditure		**248,027**		**221,706**

[1] The presentation of comparative 2014/15 figures have been revised in line with the format prescribed by the FReM.

5. Pension costs

Due to legacy arrangements made by a predecessor organisation, CQC makes contributions to defined benefit pension schemes for the former employees of CSCI. These schemes are closed to new employees. The present value, the related current service cost and past service cost were measured using the projected unit credit method. This means that the current service cost will increase as the members of the scheme approach retirement.

The latest triennial actuarial valuation was completed as at 31 March 2013 which set the employer contribution rates for three years from 1 April 2014. Some of the funds have also levied a cash sum in addition to a percentage of payroll costs as part of the deficit recovery plan. Increases to local government pensions in payment and deferred pensions have been linked to annual increases in the consumer price index (CPI), rather than the retail prices index (RPI).

Contribution rates for 2016/17 range between 14.4% and 39.1% (17.0% for Teesside Pension Fund) with annual cash sums ranging from £2k to £206k (£nil for Teesside Pension Fund).

The Statement of Financial Position shows an overall deficit provision of £69.6m (31 March 2015: £70.4m). The Department of Health has provided a guarantee to meet the pension deficit liability should they fall due.

The present value of the defined benefit obligations were carried out at 31 March 2016 by:

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

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

Pension fund	Assets 31 March 2016 £000	Liabilities 31 March 2016 £000	Surplus/ (deficit) 31 March 2016 £000	Surplus/ (deficit) 31 March 2015 £000
Avon	4,862	(6,178)	**(1,316)**	(1,392)
Cambridgeshire	2,684	(3,307)	**(623)**	(681)
Cheshire	3,997	(3,602)	**395**	55
Cumbria	3,376	(3,431)	**(55)**	(255)
Dorset	2,326	(3,628)	**(1,302)**	(1,452)
East Sussex	5,356	(5,499)	**(143)**	(406)
Essex	4,947	(5,780)	**(833)**	(1,188)
Greater Manchester	14,509	(17,029)	**(2,520)**	(3,023)
Hampshire	4,190	(5,980)	**(1,790)**	(1,930)
Merseyside	6,376	(7,645)	**(1,269)**	(1,498)
Shropshire	2,183	(2,804)	**(621)**	(694)
Suffolk	3,319	(4,161)	**(842)**	(1,287)
Surrey	5,097	(5,480)	**(383)**	(736)
Teesside	247,187	(304,398)	**(57,211)**	(54,211)
West Sussex	3,942	(3,382)	**560**	314
West Yorkshire	9,239	(10,875)	**(1,636)**	(2,034)
Total	**323,590**	**(393,179)**	**(69,589)**	**(70,418)**

All assets are held at bid value.

No employees (2014/15: nil) retired early on ill-health grounds during the year, as a result additional pension costs of £nil (2014/15: £nil) were levied on CQC.

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

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

	Teesside Pension Fund % per annum		Other pension funds % per annum	
Key assumptions used:	**2015/16**	**2014/15**	**2015/16**	**2014/15**
Discount rate	3.4	3.2	3.2 – 3.7	3.1 – 3.2
Expected rate of salary increases	3.3	3.3	3.1 – 4.2	3.0 – 4.3
Expected return on scheme assets	3.4	3.2	3.2 – 3.7	3.1 – 3.2
Future pension increases	1.8	1.8	1.7 – 2.2	1.8 – 2.4
Inflation	1.8	1.8	1.7 – 2.2	1.8 – 2.4

Mortality assumptions

Investigations have been carried out into the mortality experience of CQC's defined benefit schemes and concluded that the current mortality assumptions include sufficient allowance for future improvements in mortality rates. The assumed life expectancy of those retiring at age 65 are:

	Teesside Pension Fund		Other pension funds	
Key assumptions used:	**2015/16**	**2014/15**	**2015/16**	**2014/15**
Retiring today:				
Males	23.1	23.0	21.4 – 24.6	21.4 – 24.5
Females	25.6	25.5	24.0 – 26.4	24.0 – 26.3
Retiring in 20 years:				
Males	25.3	25.2	24.0 – 26.9	24.0 – 26.9
Females	28.0	27.8	26.6 – 29.2	26.6 – 29.1

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

	2015/16 £000	**2014/15 £000**
Service cost:		
Current service cost	6,279	5,942
Past service cost	–	–
Net interest expense	2,174	2,140
Amount recognised in net expenditure	**8,453**	**8,082**

Of the expense for the year, the total service cost of £6.3m (2014/15: £5.9m) has been included in the Statement of Comprehensive Net Expenditure as staff expenditure, note 3. £4.8m (2014/15: £5.0m) is included within other pension costs and £1.5m (2014/15: £0.9m) is included as an increase in provision for pension fund deficits. The net interest expense of £2.2m (2014/15: £2.1m) has been included in other expenditure, note 3. The re-measurement of the net defined benefit obligation is included in the Statement of Comprehensive Net Expenditure.

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

	2015/16 £000	**2014/15 £000**
The return on plan assets (excluding amounts included in net interest expense)	15,063	(17,790)
Other re-measurement gains on plan assets	–	(25)
Actuarial gains arising from changes in demographic assumptions	–	–
Actuarial (losses) and gains arising from changes in financial assumptions	(15,749)	35,414
Actuarial losses arising from experience adjustments	(3,773)	(2,268)
Re-measurement of the net defined benefit obligations	**(4,459)**	**15,331**

The cumulative amount of actuarial gains and losses recognised in reserves since the date of transition to IFRS on 1 April 2008 to 31 March 2016 is £85m (31 March 2015: £89m).

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

	31 March 2016 £000	31 March 2015 £000
Present value of defined benefit obligation	(393,092)	(402,914)
Fair value of scheme assets	323,590	332,589
Deficit in scheme	**(69,502)**	**(70,325)**
Past service cost not yet recognised	(87)	(93)
Liability recognised in the Statement of Financial Position	**(69,589)**	**(70,418)**

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

	2015/16 £000	2014/15 £000
At 1 April	**(403,007)**	**(357,637)**
Current service cost	(6,279)	(5,942)
Interest cost	(12,692)	(15,149)
Contributions from scheme members	(1,764)	(1,863)
Past service costs	–	–
Re-measurement gains/(losses)		
Actuarial gains arising from changes in demographic assumptions	–	–
Actuarial gains and (losses) arising from changes in financial assumptions	15,749	(35,414)
Actuarial gains arising from experience adjustments	3,773	2,268
Benefits paid	11,041	10,730
Scheme cessation	–	–
At 31 March	**(393,179)**	**(403,007)**

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

	2015/16 £000	2014/15 £000
At 1 April	**332,589**	**305,548**
Interest income	10,518	13,009
Re-measurement gain/(loss):		
The return on plan assets (excluding amounts included in net interest expense)	(15,063)	17,790
Other	–	25
Employer contributions	4,831	5,094
Member contributions	1,764	1,863
Benefits paid	(11,041)	(10,730)
Administration expenses	(8)	(10)
Scheme cessation	–	–
At 31 March	**323,590**	**332,589**

The actual return on scheme assets was a loss of £4.5m (2014/15: gain of £30.8m).

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

	Expected return		Fair value of assets	
	2015/16 %	2014/15 %	2015/16 £000	2014/15 £000
Equities	3.2 – 3.7	3.1 – 3.2	256,811	264,186
Property	3.2 – 3.7	3.1 – 3.2	22,948	21,141
Government bonds	3.2 – 3.7	3.1 – 3.2	7,446	8,657
Other bonds	3.2 – 3.7	3.1 – 3.2	12,198	19,126
Cash	3.2 – 3.7	3.1 – 3.2	14,460	8,443
Other	3.2 – 3.7	3.1 – 3.2	9,727	11,036
Total			**323,590**	**332,589**

6. Income

	2015/16 £000	2014/15 £000
Income from fees	(108,966)	(103,171)
Other operating income	(350)	(226)
	(109,316)	**(103,397)**

Fees and charges are made in accordance with section 85(1) of the Health and Social Care Act 2008. Consent was obtained from the Secretary of State for Health for the Fees Scheme for 2015/16 which gives rise to the fees scales used.

Annual registration fees are invoiced on the anniversary of the registration and recognised as income over the following 12 months. Statutory fees relating to future accounting periods which have been paid are treated as income in advance at the end of each accounting period (note 13). In cases of voluntary deregistration, registered organisations can apply for a refund in accordance with the fee rebate scheme detailed on CQC's website.

During 2015/16 CQC recovered 45.4% (2014/15: 43.6%) of its costs in fees. CQC has the power to recover costs associated with its registration functions under Section 85 of the Health and Social Care Act 2008. In accordance with HM Treasury guidance, *Managing Public Money*, CQC is required to set fees in order to recover all the costs of its functions. Our latest consultation strategy sets a path that will take us to full cost recovery. This formed the basis of CQC's consultation in 2015/16 and the approach will continue during 2016/17.

7. Intangible assets

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

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

Intangible assets comprise software licences, software development costs, including related contractor and staff costs, and website development costs. These are revalued 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	2015/16 £000	2014/15 £000
Balance at 1 April	233	453
Net gain on indexation of intangible assets	167	78
Transfers between reserves for intangible assets	(228)	(298)
Balance at 31 March	**172**	**233**

8. Property, plant and equipment

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

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

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

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

Revaluation reserve: property, plant and equipment	**2015/16 £000**	**2014/15 £000**
Balance at 1 April	46	101
Net gain on indexation	28	9
Transfers between reserves	(20)	(64)
Balance at 31 March	**54**	**46**

9. Impairments

At 31 March 2016 CQC carried out an impairment review of all assets. The review resulted in no impairments being recognised.

All assets are revalued annually using the appropriate Office for National Statistics price index. The application of the index has resulted in both upward and downward movements in value. For websites, developed expenditure and information technology overall upward movements in value were recognised which initially reserved previous impairments charged to operating expenditure with the remainder increasing the revaluation reserve. Net downward movements were recognised for both software licences and furniture and fittings resulting in amounts being charged to operating expenditure.

	31 March 2016 £000	31 March 2015 £000
Impairments and (reversals) charged to Statement of Comprehensive Net Expenditure		
Intangible assets		
– Websites	(9)	(14)
– Software licences	14	(1)
– Developed expenditure	(18)	(72)
Property, plant and equipment		
– Information technology	(5)	(8)
– Furniture and fittings	11	–
Total impairments and (reversals) charged to the Statement of Comprehensive Net Expenditure	**(7)**	**(95)**
Total impairments and (reversals) charged to the Revaluation Reserve	**–**	**–**
Total impairments and (reversals) charged in year	**(7)**	**(95)**

10. Financial instruments

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

Credit risk

Credit risk arises from cash and cash equivalents, as well as the credit exposures derived from care home operators. Management monitors this closely and all undisputed debts over 61 days where internal recovery processes have been exhausted are sent to an external debt collection company. While ultimate recovery is still pursued, such debts are provided for as a matter of course.

CQC had a large number of small receivable balances therefore disclosure of the largest balances was not considered in the evaluation of overall credit risk.

The table below shows the aging of the overdue analysis of trade receivables 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	Total £000
At 31 March 2016	139	349	546	**1,034**
At 31 March 2015	590	2,525	485	**3,600**

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

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

Liquidity risk

CQC manage liquidity risk through regular cash flow forecasting to ensure that sufficient funds are available to cover working capital requirements. CQC has no borrowings and relies on grant-in-aid from the Department of Health to cover cash requirements and is therefore not significantly exposed to liquidity risks.

Market risk

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

10.1 Financial assets

	31 March 2016 £000	31 March 2015[1] £000
NHS receivables	78	139
Non–NHS receivables	3,856	4,266
Cash at bank and in hand	38,901	39,187
Total	**42,835**	**43,592**

10.2 Financial liabilities

	31 March 2016 £000	31 March 2015[1] £000
NHS payables	3,091	3,581
Non–NHS payables	56,747	54,735
Total	**59,838**	**58,316**

11. Trade receivables and other current assets

	31 March 2016 £000	31 March 2015[1] £000
Amounts falling due within one year:		
Trade receivables	2,301	1,639
Other current assets:		
Deposits and advances	162	144
Other receivables	224	292
Prepayments and accrued income	1,247	2,330
Other current assets	1,633	2,766
Total	**3,934**	**4,405**

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

Deposits and advances include payments on salary and staff loans which total £18k and £144k (31 March 2015: £17k and £127k). Staff can apply for advance payments on salary and loans up to a maximum of £5k for rail season tickets.

[1] Balances as at 31 March 2015 have been revised to present trade receivables as net of any income relating to future periods. Trade receivables previously presented as £7,382k. An adjustment has also been made to trade payables and other current liabilities (note 13).

11.1 Movement in the provision for impairment of receivables

	2015/16 £000	2014/15 £000
Balance at 1 April	**555**	**331**
Additional losses recognised during the year	529	632
Provisions reversed as unused	(160)	(126)
Amounts written off during the year as uncollectable	(92)	(75)
Amounts recovered during the year	(178)	(207)
Balance at 31 March	**654**	**555**

12. Cash and cash equivalents

	2015/16 £000	2014/15 £000
Balance at 1 April	**39,187**	**23,233**
Net change in cash and cash equivalent balances	(286)	15,954
Balance at 31 March	**38,901**	**39,187**
The following balances at 31 March were held at:		
Government banking service and cash in hand	38,901	39,187
Total balance at 31 March	**38,901**	**39,187**

13. Trade payables and other current liabilities

	31 March 2016 £000	31 March 2015[1] £000
Amounts falling due within one year:		
VAT	(52)	(55)
Other taxation and social security	(3,690)	(3,115)
Trade payables	(4,615)	(3,211)
Other payables	(3,903)	(3,680)
Accruals	(19,580)	(13,405)
Capital creditors – intangible assets	(2,772)	(1,370)
Capital creditors – property, plant and equipment	(498)	(314)
	(35,110)	**(25,150)**
Current pension liabilities	(236)	(205)
Fee income in advance	(24,262)	(32,606)
Total current trade payables and other current liabilities	**(59,608)**	**(57,961)**
Amounts falling after more than one year:		
Pension liabilities	(230)	(355)
Total non-current trade payables and other non-current liabilities	**(230)**	**(355)**

Trade payables at 31 March 2016 were equivalent to 35 days (31 March 2015: 17 days) purchases, based on the daily average amount invoiced by suppliers during the year. For most suppliers no interest is charged on the trade payables for the first 30 days from the date of the invoice. Thereafter interest is charged on the outstanding balance at various interest rates.

Trade payables falling due after more than one year have been reduced by a discount factor of 1.37% per annum (2014/15: 1.30%) in accordance with HM Treasury guidance.

[1] Balances as at 31 March 2015 have been revised to present fee income in advance as net of any amounts not yet received. Fee income in advance previously presented as (£38,348k). An adjustment has also been made to trade receivables and other current assets (note 11).

14. Provisions for liabilities and charges

	2015/16			2014/15		
	Employment termination and other costs £000	Leased property dilapidations £000	Total £000	Employment termination and other costs £000	Leased property dilapidations £000	Total £000
Balance at 1 April	**561**	**2,319**	**2,880**	**325**	**1,622**	**1,947**
Provided in year	121	215	**336**	414	803	**1,217**
Provisions not required written back	(491)	–	**(491)**	(121)	(57)	**(178)**
Provisions utilised in year	(70)	(1,100)	**(1,170)**	(57)	–	**(57)**
Change in discount Rate	–	2	**2**	–	(18)	**(18)**
Unwinding of discount	–	(18)	**(18)**	–	(31)	**(31)**
Balance at 31 March	**121**	**1,418**	**1,539**	**561**	**2,319**	**2,880**

14.1 Analysis of expected timings of discounted cash flows

	2015/16			2014/15		
	Employment termination and other costs £000	Leased property dilapidations £000	Total £000	Employment termination and other costs £000	Leased property dilapidations £000	Total £000
Not later than one year	121	–	**121**	561	1,100	**1,661**
Later than one year and not later than five years	–	1,418	**1,418**	–	1,219	**1,219**
Later than five years	–	–	**–**	–	–	**–**
Balance at 31 March	**121**	**1,418**	**1,539**	**561**	**2,319**	**2,880**

A provision has been made to cover future legal costs, for example tribunals and judicial review. The provision is estimated at £0.1m (31 March 2015: £0.1m).

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

Provisions falling due up to five years have been increased by a discount factor of 1.55% (2014/15: 1.50%) and provisions falling due between five and 10 years have been increased by a discount factor of 1.00% (2014/15: 1.05%) in accordance with HM Treasury guidance.

15. Capital commitments

Contracted capital commitments at 31 March 2016, not otherwise included within these financial statements:

	31 March 2016 £000	31 March 2015 £000
Intangible assets	6,639	3,140
Property, plant and equipment	198	124
Total	**6,837**	**3,264**

16. Commitments under leases

16.1 Obligations under operating leases

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

Obligations under operating leases comprise:

	31 March 2016 £000	31 March 2015 £000
Buildings:		
Not later than one year	4,745	3,645
Later than one year and not later than 5 years	14,860	13,056
Later than 5 years	360	1,081
	19,965	**17,782**
Other:		
Not later than one year	17	27
Later than one year and not later than 5 years	15	–
Later than 5 years	–	–
	32	**27**

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

17. Contingent liabilities disclosed under IAS37

CQC has the following contingent liabilities:

	31 March 2016 £000	31 March 2015 £000
Employment tribunals and legal advice	200	139
Total	**200**	**139**

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

18. Related party transactions

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

	Payments to related party £000	Receipts from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Department of Health	6,161	135,004	1,896	-
NHS foundation trusts	1,551	13,900	439	19
NHS trusts	641	8,028	368	40
NHS England	199	–	48	17
NHS special health authorities	123	–	1	2
Other non-departmental public bodies	316	173	339	–

CQC received a total amount of grant-in aid of £135.0m (2014/15: £126.0m) from the Department of Health.

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

In addition, CQC has had a number of transactions with other government departments and other central and local government bodies. Most of these transactions have been with the Department for Communities and local government in respect of rent for office space. CQC also had amounts owed to the NHS Pension Fund and other government departments; these amounts are mostly owed to HM Revenue and Customs.

19. Events after the reporting period date

There were no significant events after the Statement of Financial Position date. The Accounts were authorised for issue on 5 July 2016 by the CQC Chief Executive.

Care Quality Commission

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