Inspecting Informing Improving

Annual report 2008/09

Healthcare Commission

Our work to improve healthcare for patients and the public

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Annual report and accounts 2008/09

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A copy of the report has also been provided to the Secretary of State for Wales and the Minister for Health and Social Services, Welsh Assembly Government, pursuant to paragraph 11(4) of the Health and Social Care Act 2008 (Commencement No.9, Consequential Amendments and Transitory, Transitional and Savings Provisions) Order 2009.

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About the Healthcare Commission

The Healthcare Commission worked to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assessed and reported on the performance of healthcare organisations in the NHS and independent sector, to ensure that they provided a high standard of care. We also encouraged providers to continually improve their services and the way in which they work.

In Wales, the Healthcare Commission's role was more limited. It related mainly to national reviews that include Wales and to our yearly report on the state of healthcare in England and Wales.

What we did

Inspecting
Inspected the quality and value for money of healthcare and public health

Informing
Equipped patients with the best possible information about the provision of healthcare

Improving
Promoted improvements in healthcare and public health

How we worked

- We worked closely with patients, carers and the public to maintain our focus on improving their experiences of healthcare.
- We promoted the rights of everyone to have opportunities to improve their health and to receive good healthcare.
- Our approach to assessing healthcare was based on the best available evidence and aims to encourage improvement.
- We worked in partnership to ensure a targeted and proportionate approach to audit and inspection.
- We worked locally to build relationships and intelligence about the quality of services throughout England.
- We were independent and fair in our decision-making and reported on what we find fairly and impartially.
- We were accountable for our actions and for what we achieved in relation to our costs.

On 1 April 2009, the Care Quality Commission, the new independent regulator of health, mental health and adult social care, took over the Healthcare Commission's work in England.

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Making a difference for patients and the public

On 31 March 2009, the Healthcare Commission reached the end of an exciting and challenging five-year journey. During this time, all of our work has been unified by one overriding aim – to bring about improvements in the quality of healthcare and the experience of patients. Here are some examples of how we have made a difference for patients and the public in 2008/09:

Making safety a priority

The safety of care continued to be our highest priority. We carried out two investigations into serious concerns about patients' safety, one triggered by intelligence picked up through a major development in how we use data for surveillance. We have now completed 17 investigations since 2004.

We helped to reduce rates of healthcare-associated infection by inspecting every acute hospital trust in England for compliance with the Government's hygiene code.

Continuous improvement

Our annual health check of the NHS has stimulated continuous improvement. In our 2005/06 assessment, we scored only two NHS trusts "excellent" for both the quality of their services and the quality of their financial management. By 2008/09, 42 trusts had achieved this rating. And whereas 60% of trusts were rated either "weak" or "fair" in 2005/06, 60% were either "good" or "excellent" this year.

Improving care for more vulnerable groups

We again demonstrated our commitment to "equal citizenship" for everyone, through our reviews and studies of services for those who are less able to assert their rights. In 2008/09 these included services for children in hospital, adults and young people with learning disabilities, young offenders and adult prisoners, and people using mental health services in hospital and the community. And following our review of England's maternity services in 2007, we worked with the Royal College of Obstetricians and Gynaecologists, the Royal College of Nursing and the Royal College of Midwives to draw up clear standards for maternity care. These will make it easier to check that services are measuring up to what mothers need.

Helping patients get complaints resolved

After building a system for reviewing patients' unresolved complaints from scratch in 2005/06, by 2008/09 we were completing 95% of cases within six months and published our third annual report on lessons to be learned by the NHS.

Making sure the public has a say about healthcare

We took an in-depth look at how well NHS trusts engage patients and the public when they plan and develop their services, and published a national report on our findings and recommendations.

Our year in brief

A selection of our achievements during the year from April 2008 to March 2009

April 2007

- Launched investigation into services provided by West London Mental Health NHS Trust
- Published second annual report of our work reviewing patients' unresolved complaints about the NHS
- Published report of our investigation into Staffordshire Ambulance Service NHS Trust
- Published results of the 2007 national survey of NHS staff
- Launched inspection programme to check infection control in 170 NHS hospitals

May 2008

- Published review of services for treating substance misuse, with the National Treatment Agency
- Published results of the 2007 national survey of in-patients in NHS acute hospitals
- Published report on quality of NHS maternity services throughout England
- Published report on the effectiveness of public health services with the Audit Commission
- Reported on largest ever review of acute inpatient mental health services
- Published results of 2008 national survey of patients of local health services

August 2008

- Published our first annual report on regulating the management of controlled drugs in England
- Launched follow-up of our 2007 audit of services for people with learning disabilities and published the results of our review of specialist services for adolescents
- Reported that Great Western Ambulance Service NHS Trust has made improvements to emergency response times since our intervention

November 2008

- Published an analysis of our unannounced inspections of infection control practices at 51 NHS hospitals
- Reported the results of the 2008 Count Me In census of inpatients in mental health and learning disability services

December 2008

- Published results of joint area review of Haringey's arrangements for safeguarding children and young people, following the death of a 17-month-old baby boy known as "Baby P"
- Launched our yearly report to Parliament on the state of healthcare in England and Wales
- Published the results of our intervention at Milton Keynes Hospital NHS Foundation Trust's maternity unit

March 2009

- Published findings of our review of the Defence Medical Services
- Published report on managing possible risks to patients' safety
- Reported on follow-up of our 2005/06 review of children's services in hospitals
- Reported on our review of commissioning of services for people with learning disabilities, with the Commission For Social Care Inspection and Mental Health Act Commission
- Reported on our investigation into Mid Staffordshire NHS Foundation Trust

June 2008

- Reported improvement at Sutton and Merton Primary Care Trust following our investigation into its services for people with learning disabilities
- Published results of our review of the progress of reform of the NHS with the Audit Commission
- Published NHS trusts' annual self-assessments of compliance with the Government's core standards for healthcare
- Published latest survival rates at heart surgery units across the UK, on website run with Society for Cardiothoracic Surgery in Great Britain and Ireland

July 2008

- Published third joint chief inspectors' report on how well children are safeguarded in England
- Secured the conviction of the Orthopaedic and Spine Specialty Clinic Ltd for breaching its conditions of registration with the Healthcare Commission

September 2008

- Launched findings of 2008 national survey of users of community mental health services
- Announced that Milton Park Independent Hospital had made significant improvements to the safety of patients since our previous inspections
- Report that Mid Staffordshire NHS Foundation Trust had addressed concerns we raised about the safety of patients in Stafford Hospital's A&E department
- Published findings of our review of how well England's urgent and emergency services work together as a system

October 2008

- Published performance ratings for all NHS trusts in the third annual health check, with improved accessibility on our website
- Reported significant progress by Oxford Radcliffe Hospitals NHS Trust in improving the care and treatment of patients who need cardiac surgery, following our investigation in 2006

January 2009

- Reported significant improvements at Maidstone and Tunbridge Wells NHS Trust, following our investigation into infection control at the trust
- Published results of national survey of users of accident and emergency services
- Published results of our third review of services for substance misuse, with the National Treatment Agency

February 2009

- Published third annual report of our work reviewing patients' unresolved complaints about the NHS
- Published report with HM Inspectorate of Probation on healthcare for young offenders, and the results of our study of the commissioning of healthcare for adult prisoners

- Published report on regulating healthcare since 2004
- Published report on our intervention at Birmingham Children's Hospital
- Launched the results of the 2008 national surveys of NHS staff
- Published findings of a study of how well trusts engage with patients and the public
- Published findings of review of mental health services for older people
- Reported on follow-up of our 2005/06 review of community mental health services
- Published the results of our review of race equality practices in NHS trusts

Foreword

Throughout the Healthcare Commission's final year, we maintained the momentum of our programme of work and successfully balanced these core activities with the demands of preparing for transition to the new regulator, the Care Quality Commission. During this exceptionally busy time, we reported on a wider range of healthcare topics than in any other year.

The third year of our annual health check of the NHS showed significant improvement in performance. For example, we scored 100 trusts (26%) "excellent", 139 (36%) "good", 132 (34%) "fair" and 20 (5%) "weak" for the quality of their services. Two years ago, only 41% achieved a score of excellent or good, while 59% were scored fair or weak.

Since 2004 the Healthcare Commission has completed 16 in-depth, forensically exacting investigations into serious failures of NHS services. This year we reported on our investigations at Staffordshire Ambulance Service NHS Trust, and Mid Staffordshire NHS Foundation Trust, and reviewed heart transplant services at Harefield Hospital. One other investigation, at West London Mental Health Trust, will be reported on by the Care Quality Commission later in 2009.

Another major achievement in the area of patients' safety was our inspection of all 172 acute trusts in England on standards for infection control, at the request of the Secretary of State for Health. This inspection programme – our largest ever – has played a part in reducing rates of infection.

The needs of children and young people was an important theme this year. Our review of services for children in hospital trusts showed some improvement since 2005/06, but more is needed, particularly in staff training on child protection. Following the "Baby P" trial, we have carried out a Joint Area Review of safeguarding arrangements in Haringey with Ofsted and the Inspectorate of Constabulary. The findings led to our review of arrangements for safeguarding children at NHS trusts throughout England. In our joint annual report with Her Majesty's Inspectorate of Probation, we called for primary care trusts to provide better healthcare for young offenders.

In March 2009, we published the results of the first ever independent review of the Defence Medical Services, which we carried out at the request of the Surgeon General.

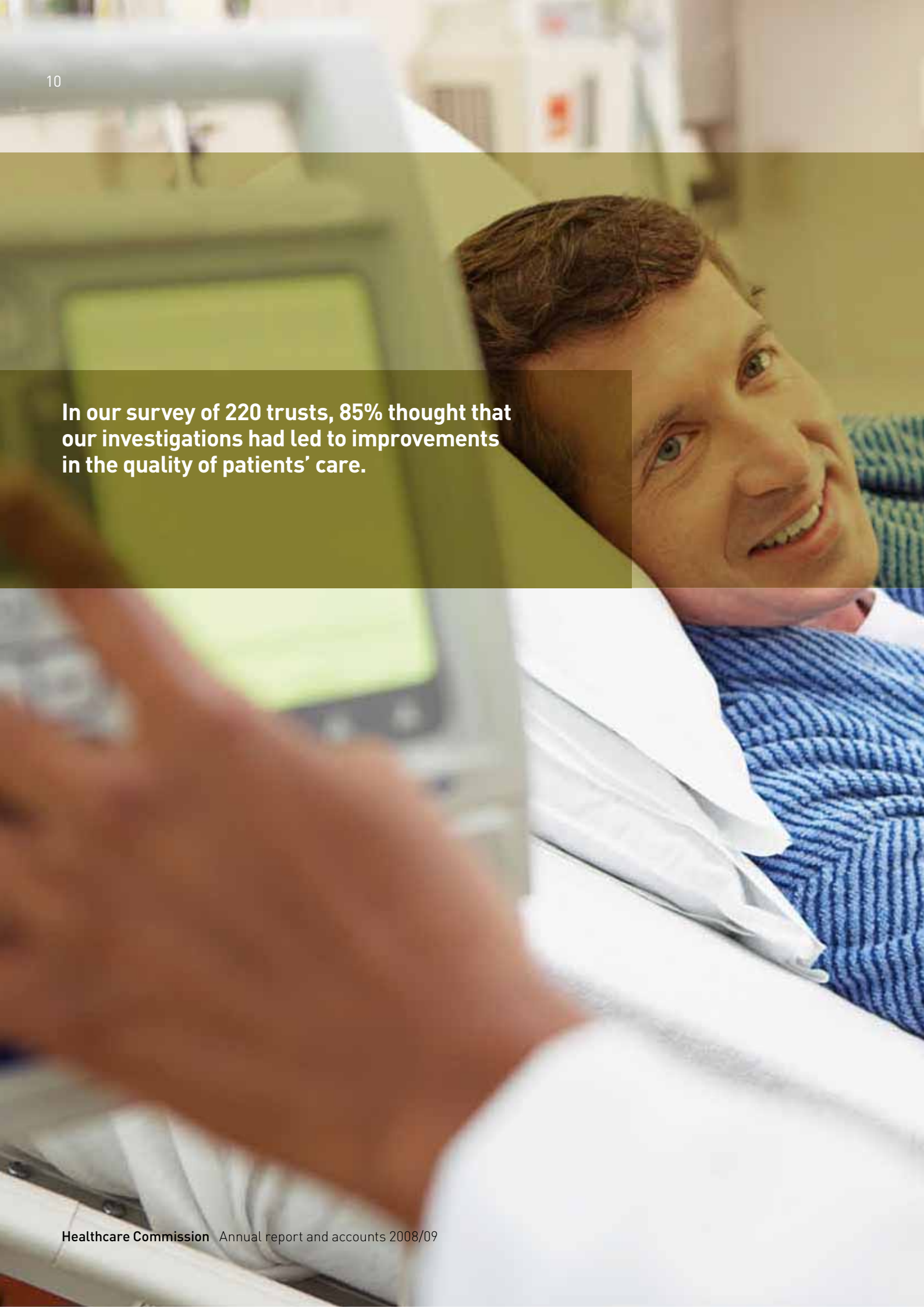
Our third annual report on our work reviewing patients' unresolved complaints showed that some trusts are still not responding to complaints effectively or learning from them. We called for the NHS to focus on addressing these issues. On 1 April 2009 the Government is introducing a simpler process for handling complaints about the NHS, which will not involve our successor, the Care Quality Commission. We worked closely with the Parliamentary and Health Service Ombudsman and the Department of Health to make sure that the changeover to the new system is as smooth as possible for complainants.

The Healthcare Commission's work has demonstrated the value to patients of independent regulation of healthcare. While the new regulator will inevitably develop new methods of its own, we hope that it will benefit from the legacy of our lessons and experience. We wish the Care Quality Commission every success in its regulation of healthcare and social care – both are sectors of vital importance to the nation.

We would both like to thank the staff and the Commissioners of the Healthcare Commission. Through their commitment, skills and tireless determination, we have ended 2008/09 with a fully delivered work programme. They have enabled the Healthcare Commission to continue making a difference for patients until the very end of its final year.

Professor
Sir Ian Kennedy,
Chair

Anna Walker CB,
Chief Executive



In our survey of 220 trusts, 85% thought that our investigations had led to improvements in the quality of patients' care.

Promoting a better experience of health and healthcare

The Healthcare Commission launched the annual health check, our pioneering risk-based system for assessing performance in the NHS, in 2005. It has stimulated improvement in services for patients and the public ever since.

Now, three years later, the positive impact can be seen very clearly. For example, we scored 42 NHS trusts "excellent" for both the quality of their services and the quality of their financial management. Only two trusts achieved this level of performance in 2005/06.

The annual health check is complemented by our national reviews and studies that focus in detail on the quality of different types of healthcare services. In 2008/09 we reported on our widest range of topics so far, including the first ever review of the Defence Medical Services.

These were some of our key activities in 2008/09:

The annual health check 2007/08

On 16 October 2008 we published the results of our third annual health check of the NHS in England. The results showed that overall NHS trusts are improving the quality of their services and managing their finances more effectively.

Our assessment looks at a wide range of areas that matter to patients and the public including safety, waiting times, infection control and health outcomes.

We awarded all 391 NHS trusts a performance rating consisting of two parts: a score for quality of services and a score for use of resources. The score for quality of services shows how well the trust has met the Government's core standards and a range of targets and indicators of outcomes, while the score for use of resources refers to how effectively it has managed its finances. These scores are on a scale of "excellent", "good", "fair" and "weak".

What the annual health check showed us

The NHS's overall performance for quality of services had improved again this year. More trusts scored excellent and good for both parts of the rating and fewer trusts scored fair or weak than in 2006/07. Forty-two trusts scored excellent for both use of resources and quality of services, compared to 19 in 2006/07 and two in 2005/06.

Quality of services rating
The number of trusts that achieved a rating of excellent for quality of services increased to 100 (26%), from 65 (16%) in 2006/07, while the number that were given a rating of weak decreased to 20 (5%), from 33 (8%) in 2006/07. In addition, 139 (36%) of trusts scored good and 132 (34%) of trusts scored fair, compared to 121 (31%) and 175 (44%) respectively in 2006/07.

Use of resources rating
During 2007/08, the NHS significantly improved the quality of its financial management: 24% of trusts were scored excellent for their use of financial resources, 37% were scored good, 34% were scored fair and only 5% were scored weak, compared to 14%, 23%, 36% and 26% respectively for 2006/07.

Follow-up on trusts rated "weak" for quality of services
Nationally, the proportion of trusts that were scored weak for the quality of their services fell noticeably in 2007/08. However, of these 20 trusts, 18 had also been scored weak in 2006/07 and 12 have been scored weak for the last three years.

In early 2009 the Healthcare Commission and representatives of their strategic health authorities visited the 20 trusts. Together we explored the reasons for the trusts' weak performance and the actions they needed to take to improve their performance in 2008/09.

Regulating the independent healthcare sector

Our work to align regulation of the independent and NHS sectors included introducing a framework for assessing corporate risk and escalating concerns that covers both sectors. This new framework influenced how we reviewed independent providers' self-assessments for 2007/08.

We introduced more detailed information summaries for our assessors, so that they have better data to aid decisions about whether or not to inspect a hospital. After a pilot with acute hospitals, we developed summaries for staff assessing independent mental health establishments, which include information from the Mental Health Act Commission and other partners. During the year we inspected 654 independent providers and made 346 initial registrations.

When we consulted providers about regulatory fees for 2009/10, our proposal included revising fees to keep pace with inflation and recommendations for decisions about two different approaches that we had piloted. The new Care Quality Commission, which takes over the work of the Healthcare Commission on 1 April 2009, will be responsible for launching the fees scheme for 2009/10. When doing so, it will take into account the responses to our consultation and any changes that it intends to introduce that might affect fees. The system of regulation for the independent healthcare sector, under the Care Standards Act 2000, will remain largely unchanged until October 2010.

Some of our reviews and studies focus on the needs of different groups of patients, such as people with learning disabilities or mothers, or on more general issues such as patient and public engagement.

Driving improvement through in-depth reviews and studies

Our national reviews and studies of different areas of healthcare provide valuable information and guidance for the public and the NHS. The topics we look at range from a particular type of service – for example, mental health services – to complex systems involving many different types of services and organisations, such as England's urgent and emergency care system. Some of our reviews and studies focus on the needs of different groups of patients, such as people with learning disabilities or mothers, or on more general issues such as patient and public engagement or information governance.

Acute inpatient mental health services: our review revealed marked variations in performance between trusts, and sometimes between wards within the same trust. None of the trusts scored excellent on all four of our criteria, or for the effectiveness of the care pathway from admission to discharge. We found that 39% of trusts were "weak" on involving service users and carers, and 12% scored "weak" on providing individualised care. We identified four priority areas for improvement: greater focus on personalised care; ensuring the safety of service users, staff and visitors; more appropriate and safe interventions; and increasing the effectiveness of the acute care pathway.

Defence Medical Services: at the request of the Surgeon General, Ministry of Defence, we carried out a review of healthcare for the Services in this country and overseas – an area that the Healthcare Commission had not previously assessed. This ambitious and challenging review found some exemplary healthcare provision in trauma care and rehabilitation. The training and preparation for trauma management in the Defence Medical Services is an area that the NHS could learn from when delivering emergency care. Our review also highlighted some areas in need of improvement, in relation to clinical care, patients' safety and the overall management of services.

Commissioning of services for people with learning disabilities: we worked with the Commission for Social Care Inspection and the Mental Health Act Commission to find out how well local services in nine areas of England were supporting people with learning disabilities and complex needs. We published a report on each area and a national overview report in which we recognised some signs of progress and staff trying hard to make a difference. Where services were being designed with users at the centre, we saw people's lives being transformed. But there was not yet the local leadership needed for services to be commissioned in a way that really met the needs of local communities.

Older people's mental health services: this study looked at how well NHS trusts provide and commission services for older people with mental health needs. The areas it covered included age discrimination; inpatient care, the comprehensiveness of services, and how well trusts were working with other agencies in this field. Although we found some good practice, there were also widespread problems. Users of services and their carers were finding that services that were not provided consistently, or were not

sensitive to their individual needs. Our study highlighted the need for improvement in the following areas: the quality and relevance of data; joint working between health and social care organisations; commissioning of services; leadership; and the need for services to be available regardless of age.

Patient and public engagement: in our study of how well healthcare organisations engage with patients and the public to help them plan and operate services, we found that many people did not feel that they had enough say about the health services provided in their area or how these were delivered. Those in the poorest health, in vulnerable circumstances or experiencing discrimination often found it more difficult than others to engage with health services. And where healthcare organisations were taking people's views into account, this was most likely to influence the immediate care environment and least likely to influence how they set priorities, allocated funds, or assessed the quality of clinical care. But most of the healthcare organisations recognised these problems and were working to engage people more effectively, and to make better use of their views and experiences.

Prison healthcare: this study of how effectively primary care trusts (PCTs) purchase healthcare services for prisons showed that such commissioning was variable and not always meeting the needs of individual prisoners. The PCTs we looked at had processes in place to manage serious untoward incidents and initiatives to promote better health for prisoners relating to smoking, sexual health and substance misuse. But many of them were not commissioning schemes to divert offenders with mental health problems out of the criminal justice system and into appropriate health services, or had not completed recent assessments of prisons' healthcare needs.

60%

...of PCT areas were "better" or "best performing" across a range of services in urgent and emergency care

Race equality: we used publication audits and an in-depth review of 39 trusts to assess whether NHS trusts were meeting their legal obligations to promote race equality. We found improvements and examples of good practice, but many trusts were still falling short. For example, only 35 per cent of them had provided information for all of the publishing requirements of the Race Equality Act 2000. We called for trusts to take immediate action to ensure they meet statutory duties; any breach will count against a trust's rating in the 2008/09 annual health check.

Substance misuse 2 and 3: our second review of substance misuse services with the National Treatment Agency focused on commissioning and harm reduction. No local drug partnerships scored "weak", and commissioning partnerships had developed strong performance management structures, but there was a need for better strategic

leadership of local drug partnerships. There were good systems for reducing drug-related deaths, but vaccinations for hepatitis B and testing and treatment for hepatitis C were not being provided widely enough.

The third review in our series looked at diversity and inpatient and residential rehabilitation services. Although 15% of local drug partnerships were scoring "excellent" and 72% "good", we found that diversity was not always addressed in drug treatment strategic plans. There was widespread good practice in providing and commissioning rehabilitation services, but patients discharged from detoxification need better support and monitoring.

Urgent and emergency care: in this review we looked, for the first time, across the range of services in a local authority area. We found that most (60%) of PCT areas were "better" or "best performing". Services performed best against national standards such as the time patients' spend in A&E departments. They did less well in areas such as GP out-of-hours services, where more than 30% of services failed to meet national quality requirement for answering telephone calls. Some patients were bemused by the range of services available and frustrated at being passed from one service to another. To help overcome these problems for patients, we called for services to work together better and recommended a single contact number for urgent care services (like 999 for emergency services).

Follow-up review of adult community mental health: our 2005/06 review of community mental health services showed that people who used the services were not always being cared for in a way that put them first, or involved in decisions about their care and medication. This year we found some improvements since 2006, but significant gaps still existed, particularly in access to out-of-hours support and psychological therapies for people with a diagnosis of schizophrenia.

During 2008/09 we carried out a number of other reviews and studies that will be reported on by the Care Quality Commission later in 2009. The topics include health inequalities, disabling factors in healthcare; information governance in healthcare organisations, and management of medicines.

Working with services for children and young people

A Healthcare Commission review of services for children in hospitals in 2005/06 showed that training to help staff meet children's needs was patchy and not updated often enough. When we reviewed this important area in 2008/09, we found some improvements in some aspects of staff training, such as for child protection and managing pain, although more is needed. However, there was considerable room for improvement in life support training and in ensuring that surgeons and anaesthetists carry out a sufficient number of operations on children to maintain specialist skills.

2008/09 saw the final phase of our five-year cycle of inspections with HMI Probation, looking at the contribution that health services have made to the work of youth offending teams. We found that health services' support, assessment and management of young offenders' health was patchy, and inadequate in some areas. Our report recommended that the Care Quality Commission continues the programme of joint inspections in 2009/10, focusing on the need for PCTs to meet their statutory obligations and address physical and emotional health needs as early as possible to reduce the risk of reoffending.

Public health

In July 2008, we published the report of our joint study with the Audit Commission on the impact and effectiveness of government policies for improving the health of England's population and tackling the inequalities in health and access to healthcare experienced by certain groups. We found improvement in areas such as deaths from cancer and coronary disease, and smoking and aspects of sexual health. However, more needs to be done on the increasingly challenging problems of obesity, alcohol misuse, mental health problems and unintentional injury. Our recommendations included calling for the Government to apply the learning from its most effective programmes to tackle these areas.

Cardiovascular disease (CVD) is the country's biggest killer and contributor to inequalities in health and life expectancy. In 2008/09 we carried out a study of how well PCTs are addressing inequalities in CVD within their area. This included analysing, for the first time, GPs' prescribing of cholesterol-lowering drugs and activities to reducing levels of smoking.

Surveys of patients and staff in the NHS

Our extensive national programme of surveys provides NHS trusts with valuable information about the views and experiences of patients and employees. By helping trusts to identify issues, the findings can promote improvements in the working environment and the quality of care that patients receive. The surveys are also one of our largest sources of data for the annual health check.

We provide each trust with a detailed report so that it can compare its results with those for other trusts, review any problems and take action if necessary.

In 2008/09 we published the results of the fifth annual survey of NHS staff throughout England. We also published the results of four national surveys of different groups of patients: hospital inpatients, patients of local health services, users of community mental health services, and patients attending A&E departments.

We also reported on the associations that our 2006 and 2007 surveys identified between responses from staff and inpatients in acute and specialist hospital trusts. Overall, we found significant associations between what staff and patients experienced. For example, there was a correspondence between patients' perceptions about cleanliness and those of staff.

During the year we changed how we present the results of our patient experience surveys on our website, making them more relevant and understandable to the public. We have recommended to the Care Quality Commission that they develop this work further, following positive feedback from the public.

Our work in Wales

During 2008/09 we continued to work closely with Healthcare Inspectorate Wales (HIW), the Wales Audit Office and the 15 other signatories of the Concordat between Bodies Inspecting, Regulating and Auditing Health and Social Care in Wales. This included cooperating with partners in Wales that reviewed healthcare services in similar areas to the services we have reviewed in England. As 2008/09 is the final year of the Healthcare Commission's responsibilities in Wales, we published a report on our work in Wales since 2004, and our final report on the state of healthcare in England and Wales (see page 28). Although the Care Quality Commission will not have responsibilities in Wales, it will have a statutory duty to cooperate with Welsh Ministers. To support the new regulator in this duty, we have encouraged plans for the existing cooperative arrangements to remain after the Healthcare Commission ceases to exist at the end of March 2009.

Evaluating our work as England's watchdog for healthcare

Since our first year of operation in 2004/05, we have commissioned an ongoing programme of research to ensure that our regulatory work was subject to external evaluation. In July 2008 we published *Making a Difference*, a report that brings together the findings of this independent research, based on evidence gathered from NHS and independent healthcare organisations.

After the second year of the annual health check (2006/07), the external evaluators systematically gathered the views of 220 NHS trusts. Ninety-three per cent of them thought that our new system of assessment had had a positive impact on the care of patients and 67% thought that it had improved the safety of patients. More than nine out of ten trusts had made changes because of the annual health check and thought that it was a catalyst for change. Nearly 90% of trusts thought that the self-assessment process had had a positive impact in their trust. Most trusts (70%) thought that the process of self-declaration was a good use of their time and that the benefits outweighed the costs.

When 103 trusts were asked about the topics of our national reviews of different types of healthcare services, almost all of them approved of our choice of topics. Around 70% of them thought that our reviews had a positive impact on patients.

Of the 220 trusts surveyed about our investigations into serious failures of care at individual trusts, 35% thought that they had a significant impact on improving their own standards, and 55% cent reported a smaller impact. Eighty-nine per cent of trusts thought that our investigations had improved patients' safety and 85% thought that they had led to improvements in the quality of care.

Our assessment of all trusts' compliance with the hygiene code was the largest programme of inspection we have carried out.

Safeguarding the public

A major focus of the Commission's work is to identify any risks that patients may be exposed to when receiving healthcare, and examine the underlying causes. We hold the organisations involved to account and ensure that they make improvements to safeguard the public.

Through our public reports, we share the lessons learned with the wider NHS and independent healthcare sector, to help reduce risks to patients in the future.

2008/09 was a year of intensive activity in this area. We carried out our largest ever inspection programme, which checked infection control practices at all NHS acute trusts in England. We reported on three investigations into serious concerns at NHS trusts, and carried out seven interventions, including working with Ofsted and the police on a review of children's services in Haringey following the death of "Baby P". And we launched a major innovation in our surveillance work – a programme that checks on higher than expected deaths for particular conditions in NHS hospitals, which provides an early alert of possible problems with patients' safety.

These were some of our key activities in 2008/09:

Healthcare-associated infection

In 2008/09, our dedicated team inspected all 170 acute trusts in England to assess their compliance with the hygiene code (Health Act 2006: *Code of Practice for the Prevention and Control of Health Care Associated Infection).*

This was the largest programme of inspection we have carried out. Our aim was to help to reduce the number of people who die or suffer illness as a result of healthcare-associated infection, to improve patients' experience of the care they receive, and to increase people's confidence in the safety of their local healthcare services.

Overall, we found that NHS trusts had made real progress. Most were able to demonstrate clear leadership over infection control at board level and had good systems for infection control in place. Although many of the trusts still had areas that needed attention, most had acted positively and promptly when we suggested improvements.

We served improvement notices to four NHS trusts requiring urgent improvements to their systems for infection prevention and control. Ashford and St Peter's Hospitals NHS Trust and Homerton University Hospital NHS Foundation Trust took the necessary action. We served notices to Barnet, Enfield and Haringey Mental Health NHS Trust and North Bristol NHS Trust in March 2009. Both are being followed up by the Care Quality Commission as part of the registration programme for NHS trusts.

Use of ionising radiation

Since 2007 the Healthcare Commission has been responsible for enforcing the Ionising Radiation (Medical Exposure) Regulations 2000 (amended 2006). These regulations exist to protect patients from unintended, excessive or incorrect exposure to medical ionising radiation. We continued our proactive inspection programme of radiotherapy departments throughout 2008/09. We published the summary reports of these proactive inspections, and of findings from stakeholder engagements and notifications we received of exposures "much greater than intended", on the Healthcare Commission's website. We also began inspections in some other clinical areas, such as dental and chiropractic radiology, in independent healthcare organisations.

Controlled drugs

During 2008 we published our first Annual Report on how healthcare providers and agencies involved in regulating the use of controlled drugs have been implementing

the new governance structures for the safer management of controlled drugs. We found that these organisations were collaborating effectively at both the national and local levels. This is a good foundation for developing an environment in which controlled drugs are managed safely and effectively as a matter of course, and in which information on concerns can be acted upon and shared. We made a number of recommendations to help strengthen implementation further and to promote effective management of the new arrangements.

Investigations reported on in 2008/09

The Healthcare Commission has the power to investigate if we have evidence that suggests a serious problem at an NHS trust that may be putting patients at risk.

This type of concern could be referred to us for investigation by a member of our assessment staff, a patients' organisation, a member of the public, or sometimes by the trust itself.

Staffordshire Ambulance Service NHS trust
In April 2008 we reported on an investigation that we carried out at Staffordshire Ambulance Service NHS Trust in response

"[The assessors for healthcare-associated infection] were straightforward, thorough and demanding. At all times when interviewing staff they were courteous and understanding... I can only say that our experience here was entirely satisfactory."

Chief executive of an acute NHS trust, 2009

to serious concerns raised by its staff, the West Midlands Strategic Health Authority and others. Our investigation covered the trusts' activities from April 2004 to June 2007. The problems it highlighted included poor management of controlled drugs, emergency ambulance volunteers known as "community first responders", and an out-of-hours GP service.

The trust was a good performer in terms of response times for emergency calls. It was also considered to be innovative in its introduction of new equipment and services and had good relationships with patients and the public. However, we found that these achievements were undermined by a lack of good management systems and a culture that did not prioritise patients' safety. We called for the trust to improve its practices for monitoring the quality and safety of its services, to assess its innovations carefully for any potential risk to patients before introducing them, to review how it trained and managed emergency ambulance volunteers, and to improve its management of medicines.

Mid Staffordshire NHS Foundation Trust

In March 2009, we published the findings of our investigation into Mid Staffordshire NHS Foundation Trust. This had been triggered by our alert system that identified higher than expected rates of death in people admitted to the trust in an emergency. There was also considerable local concern about the quality of care, particularly of nursing care.

Our investigation found that the trust had no effective system for the admission and management of emergency patients. Nor did it monitor outcomes for these patients in a systematic way, and so it failed to identify the high death rate. When the high rate was drawn to the attention of the trust, it mainly looked to problems with data as an explanation, rather than considering that there may have been problems in the care it provided.

We also found that the clinical management of many patients admitted as emergencies fell short of an acceptable standard in one or more aspects of basic care. At a time when the trust's strategic focus was on financial and business matters, and on becoming a foundation trust, it had decided to significantly reduce staff without adequately assessing the consequences for patients. The trust did not have an open, learning culture, and it was poor at identifying and investigating cases where patients' assessment and treatment had gone wrong. We considered that there had been significant failings in the provision of emergency healthcare, and in the leadership and management of the trust. We called for the trust to take actions at every level – from "the board to the ward" – in the areas that involved emergency healthcare.

Interventions in 2008/09

We carried out interventions where we believed that an NHS trust was not doing all that it could to protect patients, and where we wanted to identify the problem more quickly than would be possible with a full investigation.

During 2009/09 we carried out interventions at the Royal Cornwall Hospitals NHS Trust, Great Western Ambulance Service NHS Trust, Milton Keynes Hospital NHS Foundation Trust, South West London & St George's Mental Health NHS Trust and University Hospitals Leicester NHS Trust. At the request of the Secretary of State for Health, we carried out focused interventions at Birmingham Children's Hospital NHS Foundation Trust and the four trusts involved in providing care to "Baby P".

Enforcement activity in independent healthcare

Our work investigating providers of independent healthcare increased significantly in 2008/09 – by more than 63%. We also served 20 enforcement notices, twice as many as in 2007/08. At the end of the year the Healthcare Commission was considering prosecuting three unregistered providers and was investigating a further 36 cases.

In July 2008 we secured the conviction of a registered provider of an orthopaedic hospital in Peterborough. The conditions of its registration required the hospital to have an inpatient physiotherapy service provided by a suitably qualified, skilled and experienced physiotherapist, and no patients under the age of 18 were to be admitted or consulted in the outpatient department. The provider was found guilty of breaching both of these conditions. The magistrate imposed a conditional discharge for 18 months, fines of £10,000 and awarded £15,000 in costs.

Mortality outliers

This year we launched a programme that checks on higher than expected deaths for particular conditions in NHS trusts, which provides an early alert of possible problems with patients' safety. For example, it alerted us to the high mortality rate at the Mid Staffordshire Foundation NHS Trust, where we subsequently carried out an in-depth investigation (see page 21).

The information that we collected was analysed in detail and checked against the intelligence that we already held, before determining what, if any, action we needed to take.

Following the programme's success with death rates, we applied the model to other indicators of outcomes for patients.

Safeguarding children and vulnerable adults

Following the conclusion in November 2008 of the trial of three adults involved in the death of "Baby P", the Healthcare Commission conducted a focused Joint Area Review of safeguarding arrangements in Haringey, with Ofsted and the Inspectorate of Constabulary. Our findings led to an England-wide review of the safeguarding arrangements that NHS trusts' boards have in place.

In 2008/09 we streamlined and clarified our approach to safeguarding, including bringing together our policy and procedures for identifying and reporting concerns.

We established a formal reporting structure so that any safeguarding concerns can be escalated quickly and appropriately, and made sure that our processes aligned with established risk-profiling systems.

We ran mandatory e-training for all staff to raise awareness of safeguarding issues, and our assessors with level-2 training in how to act on concerns.

Reviewing complaints about the NHS

Since 2004, any patient who has complained to an NHS trust in England and not been satisfied with its response has been able to ask us to look into their case. If the patient has not been happy with our decision after reviewing their case, they could then contact the Parliamentary and Health Service Ombudsman.

In our last year as the independent reviewer of patients' complaints, we dealt with 6,783 cases. We upheld 25% of them, and asked these trusts to take steps to improve the services involved to prevent similar complaints in the future. In 20% of cases we asked the trusts to carry out more work to resolve the complaint. Sixteen per cent of cases were not upheld by the Commission, 30% of them did not fall within our jurisdiction, and the remainder were withdrawn by the patient or their representative.

In February 2009, we published our third, and final, *Spotlight on Complaints* report. Our aim in this year's report was to leave a legacy of information and learning to help NHS trusts to resolve patients' complaints at a local level as quickly as possible. The cases we reviewed in 2008/09 showed that often patients were not only concerned about the issue that gave rise to their complaint, but also the way in which the trust responded when they complained. As this was a cause of dissatisfaction for one in five complainants, our report included case histories showing good or bad practice for trusts to consider.

From 1 April 2009, when the Healthcare Commission ceased to exist, the Government introduced a simpler, two-stage process for complaints: if the trust does not respond satisfactorily, the patient has the right to go straight to the Parliamentary and Health Service Ombudsman with their case. This will increase the pressure for NHS trusts to deal more effectively with complaints about their services.

We made it easier for users of services to compare the results of different organisations in our online presentation of our annual performance ratings.

Providing authoritative, independent and relevant information

The intelligent use of information has been the cornerstone of the Healthcare Commission's work since it was established in 2004.

When we drew up our vision of a modern, information-led regulator, we identified three guiding principles: we must collect the right information about healthcare services, we must use it in the right way, and we must make it available to the right people.

This year we again made major strides in each of these areas, and received a very positive report from the Office of Government Commerce when it reviewed our strategic investment in information systems since 2004.

These were some of our key activities in 2008/09:

Using information intelligently

In 2008/09 we created a data catalogue which contains all of the vast quantity of healthcare information that we hold – more than 250 different data sets. The catalogue ensures that all the data we have collected is at our fingertips, that we know how we can use it, and that we hold the latest available versions of data sets. It also ensures that we use our data accurately and efficiently, and so reduce duplication of effort for ourselves and the organisations we regulate.

We further developed our surveillance programme, which combines use of sophisticated statistics, clinical expertise and local intelligence to identify troubling trends inside hospitals. Our aim is to intervene before these concerns become crises. Our analysis of data at a practice level – for example, the Quality and Outcome Framework – has enabled us to say more about the quality of primary care than in previous years, and to identify where local variations give us cause for concern.

The Healthcare Commission has supported these activities with substantial investment in information systems. In 2008/09, the Office of Government Commerce (OGC) reviewed this investment. The result was a very positive report, in which the OGC recognised that our investment programme had been instrumental in turning our vision of information-led regulation into a set of practical capabilities. One key example is

iCab (information cabinet), a system which has enabled us to collate information from multiple external and internal sources and categorise it to allow intelligent searches on specific issues and concepts. This year iCab has provided crucial support to our inspections of all NHS acute trusts against the hygiene code, as part of the fight to reduce healthcare-associated infection.

Making information accessible

We believe that patients and the public must have access to independent, authoritative information about the quality of healthcare services before they can make informed choices. This is why, with feedback from our users, we have continued to improve our online presentation of the results of our assessments of healthcare organisations.

70%

Amount of traffic directed to our website from the BBC news site regarding NHS performance ratings

Changes in 2008/09 included making it easier for users to search these performance ratings, including comparing results for different organisations. During the year we added details of their performance in our reviews of England's maternity services and community mental health services, and in our national surveys of NHS patients.

We raised public awareness of the information that we provide online through work with healthcare-related organisations and the national online media. For example, when we published our annual performance ratings for the NHS on 16 October 2008, more than 70% of the traffic to the site came through a link on the BBC's news site. To increase the number of people that it reaches, we also shared our data with NHS Choices, the government website that provides information about local healthcare services in England.

Improving users' experience on our website

In 2008 we carried out a comprehensive redevelopment of the Healthcare Commission's website, informed by usability testing and qualitative research with target audiences. The improvements we introduced included a more intuitive navigational structure, a more engaging 'look and feel', a simpler, more accessible editorial style, and a searchable publications library housing more than 2,000 downloadable documents. The new site was launched in October, which ensured that our annual performance ratings of the NHS were presented within a user-friendly, clearly structured framework of information about the Commission's work.

To raise awareness of our work with LINKs, we ran events across the country and developed a website to share people's experiences of healthcare.

Engaging with patients and the public

This year we again asked local stakeholders to tell us how well they think NHS trusts in their area are meeting the Government's core standards. We received comments from overview and scrutiny committees, lay members of the boards of governors of NHS foundation trusts, the children's safeguarding bodies and, for the first time, the new local involvement networks (LINks).

The Government introduced LINks in April 2008 to give people more say in the way that their local health and social care services are commissioned and provided. To raise awareness of our work with LINks, we ran events across the country and developed a website that enables LINks to send us information throughout the year about people's experiences of using healthcare services. We also continued to support Speak Out, our network of community and voluntary groups that represents those whose voices are often ignored, including homeless people, travellers, and minority ethnic groups. This year we provided training to help Speak Out groups capture their experiences of healthcare in a way that can be fed into our assessment work.

All NHS trusts in England have a statutory duty to involve patients and the public in their work (Section 242 NHS Act 2006). As England's healthcare watchdog, the Healthcare Commission is responsible for ensuring that they do so. In 2008/09 we carried out a national review of this important area, which included the views of patients and voluntary organisations (see page 14).

Our publications

During the year we published the reports of two investigations into serious failures of services at individual NHS trusts, two follow-up reports on trusts we had investigated in 2007/08, and reports of our interventions at six other trusts. We published 25 reports on national reviews and studies of healthcare services, and an annual report for each of the following areas of the Commission's work: reviewing patients' complaints about the NHS, regulating the safe management of controlled drugs, and regulating the use of ionising radiation in healthcare. We also published three consultation documents, the Healthcare Commission's report on the design of the annual health check in 2008/09 and a range of guidance on the assessment process for NHS trusts and third-party participants. In October 2008, we published *Raising the standard*, a brochure celebrating NHS achievement in the annual health check, which including the stories of ten NHS trusts. At the beginning of 2008/09 we launched an updated version of our corporate booklet, *About the Healthcare Commission*, which was awarded the Plain English Campaign's Crystal Mark for clarity.

State of Healthcare report: the Healthcare Commission has a statutory responsibility to report annually to Parliament on the provision of healthcare in England and Wales. Our *State of Healthcare* report brings together the findings of all of our assessments, surveys and studies throughout the year and data collected by other organisations. It provides a comprehensive national picture of the services available and their quality, and how easily the public can access this healthcare.

In December 2008 we published our last *State of Healthcare* report, in which we took the opportunity to review our findings for each of the previous four years. We found that the health of the nation continues to improve, and that the NHS has sustained its improvements in meeting government standards and targets, with dramatic improvements in meeting target waiting times. However, a small number of trusts are trapped at an unacceptably poor level of performance. Many services are still not as patient-centred as they should be and there are groups of patients whose needs are still not sufficiently well met. The safety of care is higher up the NHS agenda but trusts are still not doing enough to monitor and learn from incidents and ensure that they follow good practice. We also called for improvements in how healthcare services are commissioned, the measurement of outcomes, patients' experience of healthcare, and the journey people make through the system of care. We also called for more focus on assessment in primary care, which accounts for 85% of the contacts that people have with the NHS.

Working with clinicians

Much of the Healthcare Commission's work with clinicians over the last few years has foreshadowed the outcome of Lord Darzi's Next Steps review, with its emphasis on quality and a clinically led service. We ran workshops with a wide range of clinical groups, including nurses, allied health professionals and clinicians from black and ethnic minorities, as part of a project to find out how they think the quality of clinical care should be defined and measured. We continued our work with the Academy of Medical Royal Colleges and individual colleges on developing a systematic approach to the accreditation of clinical services. Following our review of maternity services in 2007/08, our joint working with the clinical community intensified in this area. The Healthcare Commission made a significant contribution to the Royal College

of Obstetricians and Gynaecologists' working party which defined standards for maternity and gynaecological care. The standards include clear, auditable measures that link where possible with our review and other data collections to provide benchmarking indicators across trusts and clarity over the service levels to be expected by those commissioning services.

We also continued to develop our relationships with the National Institute for Health and Clinical Excellence (NICE), the Postgraduate Medical Education and Training Board and the Commission for Healthcare Regulatory Excellence. In particular, we have strengthened the link between NICE guidance and our assessment of health and healthcare (see page 37).

In our work with the clinical community in 2008/09, our aim has been to provide a sound base for the Care Quality Commission to build on from April 2009.

Statutory access to information

In 2008/09, we closed 430 formal requests for information made under the Freedom of Information Act 2000 and the Data Protection Act 1998.

In our planning for inclusion process, we assessed impact against all six strands of diversity – this helped to inform our design of the 2008/09 annual health check.

Focusing on equality, diversity and human rights

Although the last 50 years has brought major improvements in people's health in England, some disadvantaged groups and communities are still not able to share the benefits of these improvements.

Ever since the Healthcare Commission was established in 2004, we have worked to help narrow the gaps between the quality of health and access to healthcare that different people experience. This includes making sure that that the principles of equality, diversity and human rights are at the heart of everything we do, including our assessments of healthcare services.

These were some of our key activities in 2008/09:

Planning for inclusion

Our equality impact assessment process, know as the planning for inclusion process (PIP), goes beyond the legal requirement for public sector bodies. We assess impact against all six strands of diversity – age, disability, gender, religion or belief, and sexual orientation – and for human rights as well. Our work in this area is vital to the delivery of the positive actions plans in our race, gender and disability equality schemes.

This year we carried out PIP assessments on all the components of the annual health check, and the results informed our design of the 2008/09 annual health check. We also used the PIP process when considering how the Care Quality Commission could incorporate equalities and human rights into its methodology and measurements of standards in the future.

Other external-facing projects we assessed using PIP included: our national surveys of NHS patients, our review of commissioning of services for people with learning disabilities, our independent reviews of patients' complaints about the NHS, a review of race equality practices in NHS trusts and a review of disabling factors in healthcare.

Development of human rights

This year we arranged for the British Institute of Human Rights to run a series of workshops to give our staff practical guidance on how the principles of human

rights can be applied to healthcare regulation. We also worked with Race for Health to develop a cultural competence framework, with the aim of it being used to improve the delivery of healthcare services. The Healthcare Commission co-sponsored the Health Services Journal's "Equality and Human Rights Forum", a two-day conference designed to give NHS trusts information and tools to help them embed equality and human rights within their organisations.

Count Me In census

The annual Count Me In census was a joint initiative between the Healthcare Commission, the Mental Health Act Commission, the Care Services Improvement Partnership and the National Institute for Mental Health in England. It aims to capture the number of inpatients in mental health and learning difficulties services in England and Wales and to encourage service providers to collect and monitor data on patients' ethnic backgrounds.

We carried out the 2008 census on 31 March, collecting information from 31,020 inpatients in mental health services and 4,107 inpatients in learning disability services in the NHS and independent healthcare sector. As well as recording the ethnicity and age of inpatients, we captured details about their stay in hospital, such as how they were referred, how long they had been an inpatient, and whether they had been detained under the Mental Health Act.

Rates of admission were lower than the national average among the white British, Indian and Chinese groups, and were average for the Pakistani and Bangladeshi groups. They were higher than average among other minority ethnic groups, and more than three times higher for black and white/black mixed groups. People in the "other black" group were eight times more likely than average to be admitted. The overall patterns that emerged were similar to those that we saw in the previous censuses.

Improving care for people with learning disabilities

In 2007 we carried out the first national audit of services for people with learning disabilities. This year we followed it up with an audit of 48 specialist inpatient services. We mainly looked at services that were not audited in 2007, but also revisited 10 services to check on their progress. We also visited two specialist adolescent services, to look at whether the care addresses the particular needs of young people with learning disabilities. We have now inspected services at all of the 89 organisations that currently provide care for people with learning disabilities in England.

As with our 2007 audit, the study was designed and carried out involving people with learning difficulties, their family carers and people working in the sector.

We concluded two major programmes of joint inspection of children's services, working in partnership with Ofsted, the Audit Commission and HMI Probation.

Taking the lead in coordinating and improving regulation

Our work as the lead coordinator of regulators of health and social care in England was aimed at preventing regulatory activities, such as inspections and reviews of services, from becoming an excessive burden for healthcare organisations.

The Concordat, a voluntary agreement between the main regulatory bodies, is key to achieving this goal.

Research this year by our providers' advisory group gave Concordat members a unique insight into how regulators are viewed by the regulated. We welcomed more than 250 people to a series of risk summit meetings. Our other work with partners included five joint reports of reviews and studies on a variety of topics, and contributing to the design of the new Comprehensive Area Assessment.

Update on the Concordat

In 2008/09, the Concordat's activities included:

- Establishing and supporting a providers' advisory group hosted by the NHS Confederation and Independent Healthcare Advisory Services. The group represents a range of healthcare organisations and advises them on the impact of existing and proposed regulatory frameworks. Its activities during the year included looking at the problem of duplication of standards across regulators, and surveying providers' perceptions of overlap and duplication. At a consultative workshop in early 2009, members of the Concordat said that they considered the advisory group to be a highly effective source of constructive challenge.
- Holding 12 collaborative risk summits across our North, Central, London, South East and South West regions between November 2008 and January 2009. These meetings involved the principal healthcare regulators and inspectorates, along with representatives of strategic health authorities. More than 250 people took part. Early evaluation of the meetings showed that they have the potential to reduce duplication of regulatory activity, improve how

trusts view regulators and enrich the intelligence we use during our assessment activities.

- Reducing the number of data collections being coordinated by the NHS Information Centre.
- Actively supporting a similar concordat in Wales, of which the Healthcare Commission is a signatory (see page 17).

Working in partnership

We also concluded two major programmes of joint inspection of children's services. We finished our three-year programme of Joint Area Reviews with Ofsted and the Audit Commission in September, and our five-year programme of youth offending team inspections with HMI Probation and Ofsted in July. Both programmes highlighted that while some areas were getting better at meeting the health needs of children and young people in vulnerable situations, overall there was not enough investment in consistent and high-quality service provision.

This year we published the following joint reports on national reviews and studies of healthcare that we carried out with partners:

- A review of the commissioning of services for people with learning disabilities, with the Commission for Social Care Inspection and the Mental Health Act Commission.
- The 2008 Count Me In Census, with the Mental Health Act Commission, the Care Services Improvement Partnership and the National Institute for Mental Health in England.
- Two reviews of substance misuse services, in partnership with the National Treatment Agency.
- A report on a study of the impact of modernisation of the NHS, with the Audit Commission.
- A report on a study of the impact of policy on health improvement, with the Audit Commission.

Comprehensive Area Assessment
For the first time in 2009, under the Comprehensive Area Assessment (CAA) system, six inspectorates will jointly assess how well local public services in England are meeting the needs of people who live in each area. Our contribution to the development of the new CAA assessment included holding two public consultations with the other inspectorates, and taking part in 10 trials of the methodology in summer 2008. The assessment framework and guidance for inspectors was published in February 2009, and the first CAA assessments will start in April 2009. The results will be reported in November 2009.

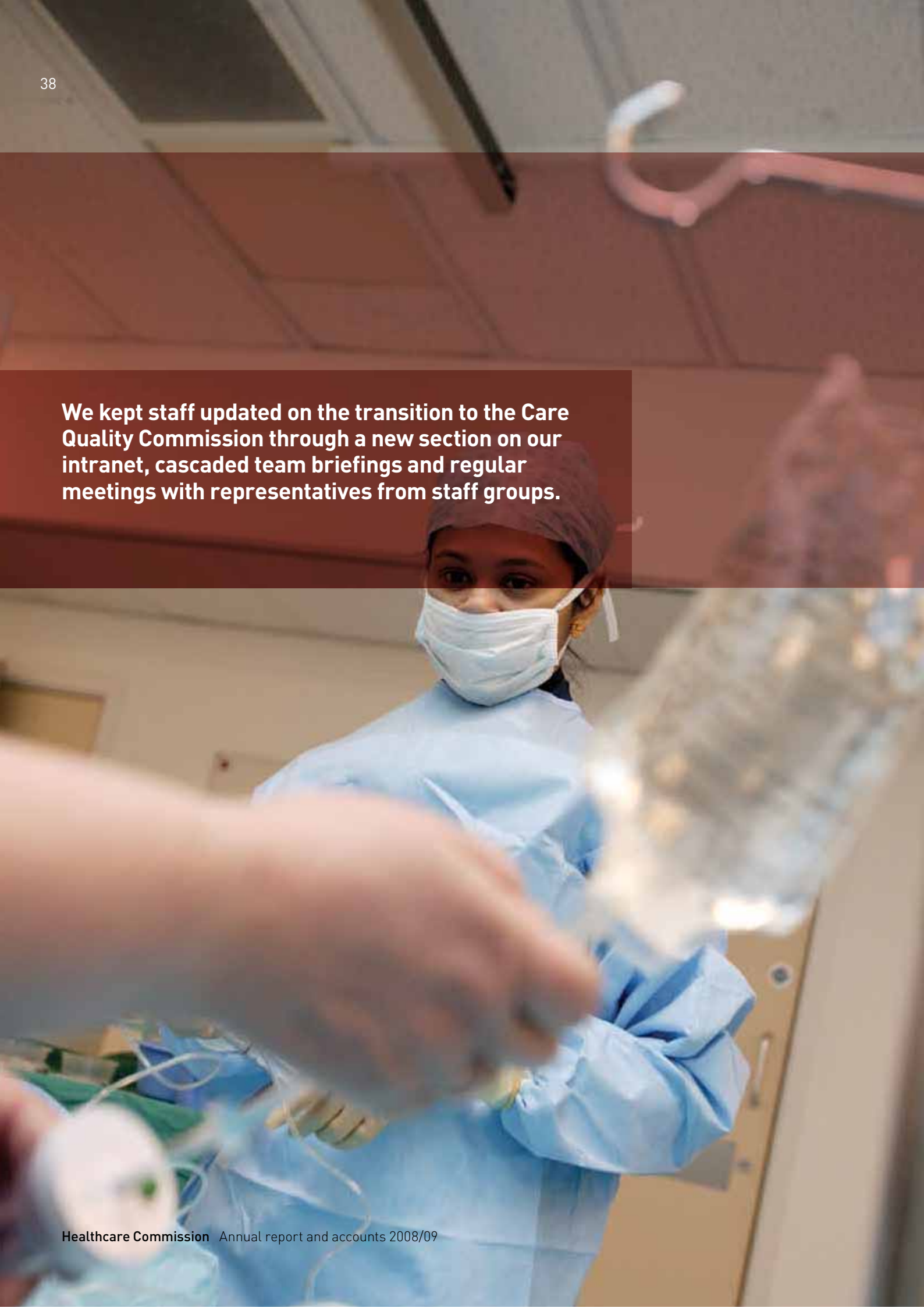
250

Number of representatives from healthcare regulators and inspectorates that took part in Concordat risk summits

Working with NICE
This year we revised our joint statement with the National Institute for Health and Clinical Excellence (NICE) that describes how the Healthcare Commission takes account of NICE guidance in our assessments. After strengthening our assessment of how well healthcare organisations implement the guidance, we put forward proposals for tracing implementation, from board level through to delivery of services, in the Care Quality Commission's 2009/10 review of NHS performance.

Memoranda of understanding
We signed memoranda of understanding with the Royal College of Psychiatrists and the General Chiropractic Council. The latter focused on the Ionising Radiation (Medical Exposure) Regulations 2000, which the Healthcare Commission is responsible for enforcing.

We revised our memorandum of understanding with the General Medical Council to broaden its scope beyond information-sharing around fitness to practise. The new agreement covers more of the Council's functions, including its approval of practice settings.



We kept staff updated on the transition to the Care Quality Commission through a new section on our intranet, cascaded team briefings and regular meetings with representatives from staff groups.

Building a world class regulatory body

Throughout 2008/09, the Healthcare Commission has remained focused on making a difference for patients and the public, despite the challenges of preparing for transition to the Care Quality Commission.

As well as handing over our regulatory responsibilities at the end of the year, we will be passing on the lessons we have learned and the experience we have developed as England's independent regulator of healthcare. This will include suggestions for how the Care Quality Commission might take forward and develop some of the Healthcare Commission's innovations, so that they yield further benefits for patients and the public.

Investing in our staff

The Healthcare Commission's corporate training programme for 2008/09 included a range of programmes designed to engage, motivate and support our staff during a year of considerable change. Our redesigned leadership and management programme helped those who were new to management to pick up a range of skills and provided a useful refresher for other staff.

We introduced a bi-monthly conversation event so that leaders could have regular discussions about the organisation's progress towards merger with the Commission for Social Care Inspection and the Mental Health Act Commission, and to facilitate learning about change management. In view of these responsibilities for managing change, our coaching programme focused on support for our leadership and management group this year.

The Commission's James Mayes award is a tribute to our colleague, James Mayes, who was killed in the London bombings of 2005. In 2008/09 the award enabled two members of staff to carry out research projects overseas. One project involved researching public health in the USA, focusing on clinical quality and programme management. The other project, which involved visits to Europe and South America, looked at the regulation of the medical use of ionising radiation and how it is enforced in other countries.

As was to be expected, the dominant theme in our communications with staff this year was the transition to the Care Quality Commission, and particularly the HR issues involved. We kept staff up to date with developments through a new dedicated section on the intranet, cascaded team briefings and regular sessions with a network of group representatives.

We attracted a wide range of speakers from the health and social care sector to speak at our 'lunchtime learning' sessions. These weekly events proved extremely popular with staff at all levels, including those in our regional offices, who were able to join in through teleconference and video streaming.

Supporting diversity in the workforce

The Healthcare Commission was fully committed to creating a supportive working environment based on mutual respect and trust, so that staff can reach their full potential regardless of race, nationality, ethnic or national origins, marital status, sexual orientation, impairment, gender, age, religion or belief.

In 2008/09 we worked with our Ethnic Diversity and Lesbian, Gay and Bisexual networks to develop or review policies and programmes of work, to monitor the implementation of equality schemes and to provide mutual support. This year a national Lesbian, Gay, Bisexual and Transgender (LGBT) network group was formed at the Healthcare Commission. Along with an equivalent group at the Commission for Social Care Inspection, it was consulted on the organisational culture for the Care Quality Commission and on the future of diversity networks. The LGBT network has liaised with organisations such as Gender Trust and Equality Southwest and attended an LGBT health summit in September 2009 on behalf of the Healthcare Commission.

We continued to provide diversity training for staff and to promote a culture that values and celebrates diversity – for example, by celebrating Black History Month, Eid and Diwali.

Figure 1 Healthcare Commission staff by location

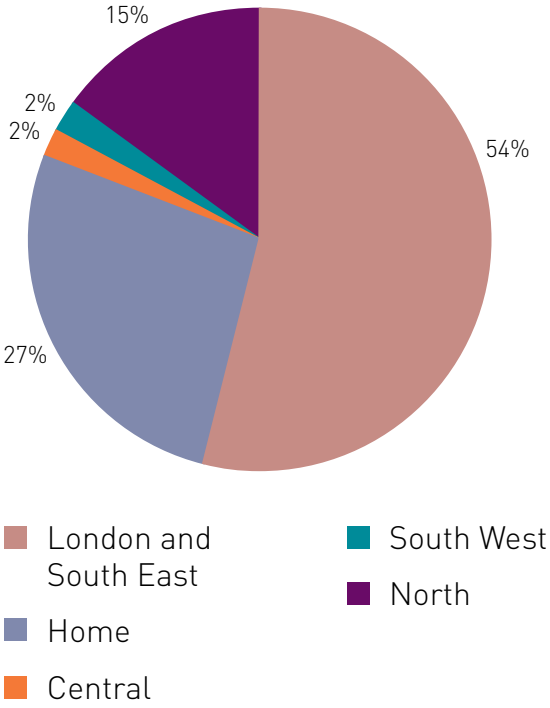


Figure 2 Healthcare Commission regional structure

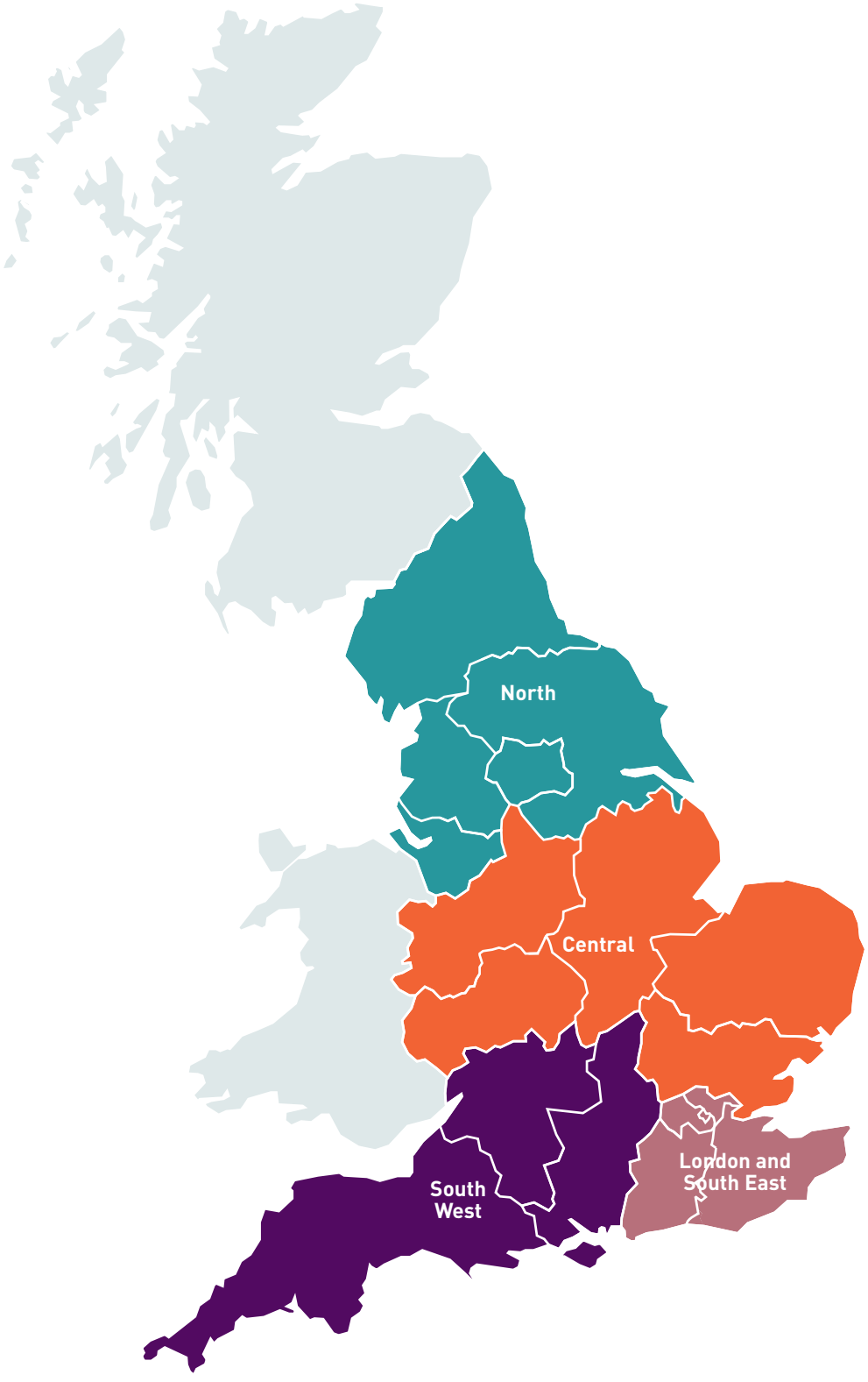
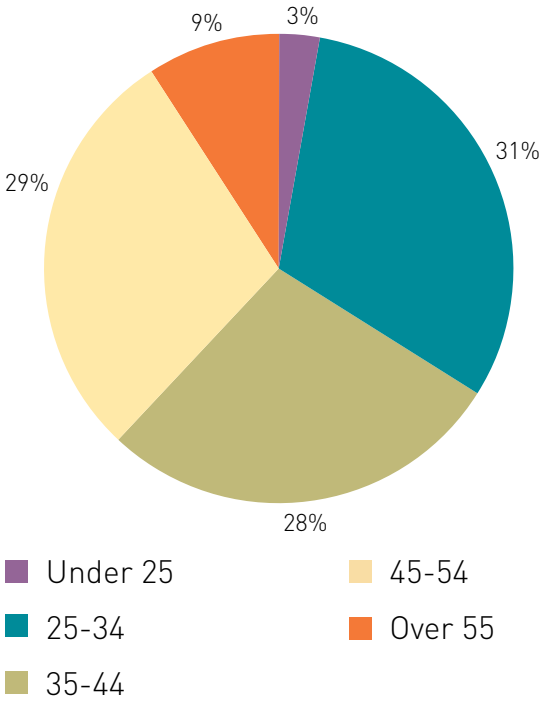


Figure 3 Healthcare Commission staff by age



Raising awareness of our work

In the final year of the Healthcare Commission we have built on the excellent relationships we have developed with stakeholders and the media since 2004/05. We have disseminated the findings of our reviews, investigations and assessments to a wide range of audiences. The media has given significant coverage to our publications, including our reports on investigations into serious concerns at three NHS trusts, the results of this country's most comprehensive review of maternity services, and the first ever review of the Defence Medical Services.

The Healthcare Commission's ability to play such an active role in promoting improvements in healthcare would not have been possible without listening to and engaging with our stakeholders at every opportunity. In 2008/09 we continued to hold seminars and gave keynote addresses at major healthcare conferences in the NHS and independent sectors. Our work with parliamentarians included a reception at the Houses of Parliament to mark the launch of the Commission's 2008 *State of Healthcare* report, our presence at the three major party political conferences, and evidence given to a number of parliamentary select committees.

Our regulatory expertise is now acknowledged worldwide and we have sought to share our experience and ideas with professionals from other countries. This year we have hosted delegations from countries as far apart as Armenia, Venezuela, China, Iraq, Japan, Sweden, Denmark and Australia, who have visited us to hear about our pioneering model of regulation and other aspects of our work. We have participated in the European Partnership for Supervisory Organisations and presented several papers at the International Forum on Quality and Safety in Paris and Berlin.

Transition to the Care Quality Commission

In 2005, the Government announced its plans to create a new regulator for health and adult social care. Established in 2008, the Care Quality Commission took over the work of the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission in April 2009.

We initiated significant reductions in budget and headcount during 2007/08 in order to enter 2008/09 at the target operating limit set by the Department of Health in preparation for the closure of the Healthcare Commission. Our restructuring process was completed by the end of April 2008, at which point 18 members of staff had been made redundant. Two members of our clinical audit team transferred to the Health Quality Improvement Partnership in November 2008.

During 2008/09, the momentum of our preparations for transition to the new regulator increased significantly, as did the organisational effort involved. This was particularly the case after the Chairman and Chief Executive were appointed in the summer and the Care Quality Commission came into existence in shadow form in October. An overarching transition board was set up, comprising representatives of the three existing commissions, the Department of Health sponsors and the Care Quality Commission.

The Healthcare Commission created an internal programme and governance structure in order to manage its response and contribution to the creation of the new regulator in a controlled and coordinated way.

In November, the Care Quality Commission launched its organisational structure. This included new roles at the levels of the executive board and their direct reports, which were filled through a competitive recruitment process. For posts below these levels, staff were either matched on the basis of their existing roles, or competed for roles through ring-fenced competitions, or transferred directly into their existing roles. By the end of the process, 120 members of staff had been made redundant, of whom 60 were employed in our complaints function that ceased to exist on 31 March 2009.

Figure 4 Healthcare Commission staff by ethnic origin

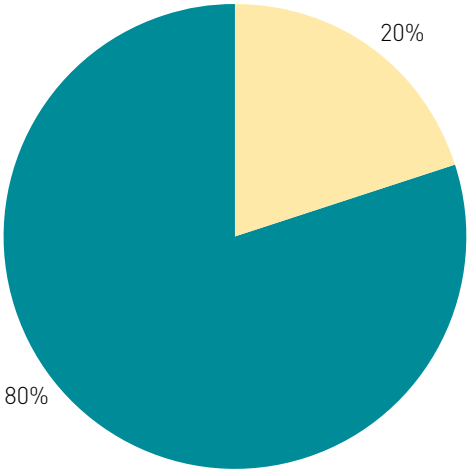
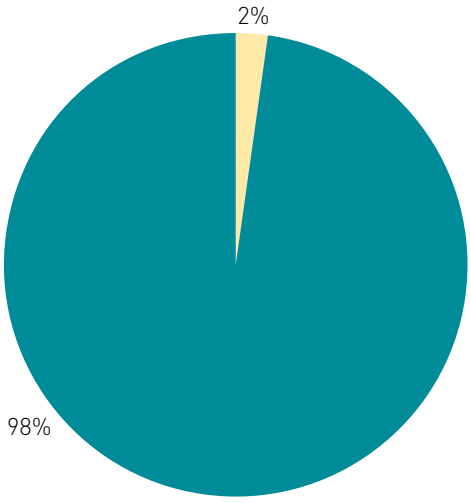


Figure 5 Healthcare Commission staff by declared disability



Corporate objectives during transition
Our objectives during the transition period were to:

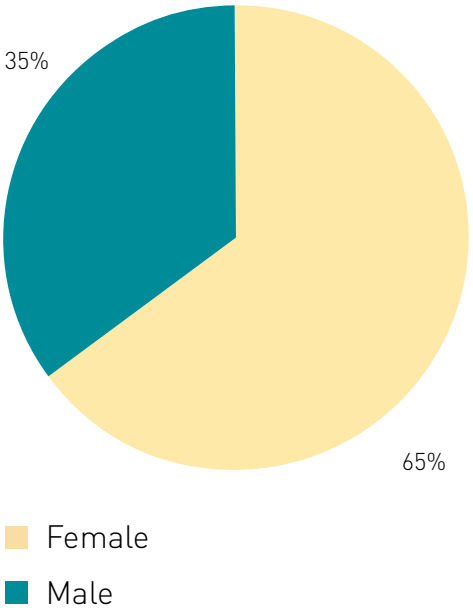
- Ensure the full delivery of our 2008/09 work programme.
- Support the new organisation's aims and objectives.
- Ensure that we provided the best possible support to our staff.
- Help ensure a smooth transition to the Care Quality Commission.

Despite the considerable change and uncertainties of the transition period, we largely succeeded in achieving these objectives. We delivered our committed work programme while contributing to the establishment of the new regulator and ensured that our staff were well-supported throughout. This involved regular, transparent internal communication, and support and services to help staff find new employment either within or outside the Care Quality Commission.

Passing on learning
To help inform the Care Quality Commission's thinking when developing its approach to regulation and associated systems, we identified and analysed the lessons we have learned as the independent regulator for healthcare since 2004.

This learning relates to a variety of our business areas – from the local-level work of our frontline assessors to the Healthcare Commission's leadership of the Concordat between regulatory bodies. We have particularly focused on supporting

Figure 6 Healthcare Commission staff by gender



the Care Quality Commission's registration of NHS trusts, which comes into effect on 1 April 2009. For example, we reviewed the conditions of registration of all of our registered providers of independent healthcare, to make sure that these conditions are suitable for transfer to the new joint registration system.

One key statutory responsibility that has not been handed over to the Care Quality Commission is our role as independent reviewer of patients' unresolved complaints about the NHS. During 2008/09 we worked closely with the Ombudsman to ensure the smooth handling of existing cases that needed to be transferred to the Ombudsman for completion after 31 March 2009, and to pass on our learning about complaints-handling in the NHS.

Corporate governance and finance

Statement of corporate governance 2008/09

Introduction

The Healthcare Commission was abolished on 31 March 2009 by the Health and Social Care Act 2008. It had been established by the Health and Social Care (Community Health and Standards) Act 2003 and launched on 1 April 2004. On 1 April 2009, the Care Quality Commission, the new independent regulator of health, mental health and adult social care, took over most of the Healthcare Commission's work in England. Healthcare Inspectorate Wales became responsible for carrying out the Healthcare Commission's activities relating to Wales.

The Healthcare Commission's legal name was the Commission for Healthcare Audit and Inspection. The Healthcare Commission had the status of a non-departmental public body.

The Statement of Corporate Governance 2008/09 covers the Healthcare Commission's fifth and final year of operation.

Principal activities

The main function of the Healthcare Commission was to encourage improvement in the provision of healthcare by and for NHS bodies. Its main statutory functions included:

- Carrying out reviews and investigations of the provision of healthcare and the arrangements to promote and protect public health, including studies aimed at improving economy, efficiency and effectiveness in the NHS.
- Promoting the coordination of reviews and assessments undertaken by other bodies.
- Publishing information about the state of healthcare across the NHS and the independent sector, including the results of national clinical audits.
- Reviewing the quality of data relating to health and healthcare

and, in England only:

- Reviewing the performance of each NHS organisation and awarding an annual rating of that organisation's performance.
- Regulating the independent healthcare sector through a programme of registration, assessment and inspection.
- Considering complaints about NHS bodies that have not been resolved through their own processes for dealing with complaints.
- Publishing the results of surveys of the views of NHS staff and patients using NHS services.

In exercising its functions, the Commission was required to be particularly concerned with:

- The availability of, and access to, healthcare.
- The quality and effectiveness of healthcare.
- The economy and efficiency of the provision of healthcare.
- The availability and quality of information provided to the public about healthcare.
- The need to safeguard and promote the rights and welfare of children, and the effectiveness of measures taken to do so.

The Commission had a duty to work in partnership with the Audit Commission, Monitor and the Commission for Social Care Inspection (CSCI). In Wales, the Healthcare Commission had a duty to cooperate with the National Assembly for Wales, and works closely with the Healthcare Inspectorate Wales.

In exercising many of its functions, and particularly those concerned with the NHS, the Healthcare Commission had to have regard to such aspects of government policy as the Secretary of State for Health directed.

Corporate governance and arrangements for accountability

The Healthcare Commission committed itself to achieving high standards of corporate governance, and chose to apply the provisions of the July 2003 Combined Code (the Code) where relevant and proportionate to the Healthcare Commission's role as a regulator and its status as a non-departmental public body. This Statement describes how, during the period 2008/09, the Healthcare Commission applied the relevant provisions of the Code.

In addition, the Healthcare Commission was subject to a number of other mechanisms for accountability.

The Chief Executive, as the Accounting Officer for the Healthcare Commission, was responsible and accountable for the management of the Healthcare Commission's funds and assets.

The Secretary of State for Health was answerable to Parliament for the policies and performance of the Commission. The Healthcare Commission had a formal agreement with the Department of Health about working arrangements, known as the Management Statement. Part 2 of this Management Statement comprised a Financial Memorandum, which specified the terms on which the Healthcare Commission received and spent its funds. During 2008/09, the Healthcare Commission and the Department of Health agreed a revised version of Part 1 of the Management Statement and a protocol relating to the exchange of information about any public announcements and publications by each party.

The Chair and Chief Executive of the Healthcare Commission met the Minister for an annual review of performance and there were regular meetings with ministers, senior policy officials of the Department and the Standards and Healthcare Commission Relations team – the branch responsible for the relationship with the Department of Health as sponsor of the

Healthcare Commission. The Senior Departmental Sponsor of the Healthcare Commission at the Department of Health for the last year and a half of the Commission was Professor Sir Bruce Keogh, NHS Medical Director, who was formally responsible to the Permanent Secretary for the performance of the Healthcare Commission.

The Commission aimed to transact as much of its business as possible in public. Meetings of the Commission were held in public and included a session during which members of the public and the press could put questions to Commissioners and members of the Executive Team. When there was business of a confidential nature to be discussed, publicity on which would be prejudicial to the public interest, the latter part of the meeting was held in private. In April 2008, the Commission held a special meeting in private in order to deal with some pressing items of business. The minutes of this meeting were later made public.

Each year, several meetings of the Commission have been held at locations other than London. During 2008/09 the Commission met in London, Cambridge and Leeds.

The Commission was committed to consulting the public on its programme of work and key strategies.

The effectiveness of corporate governance and systems of governance was kept under review.

The Commission

The role of the Commission was to:

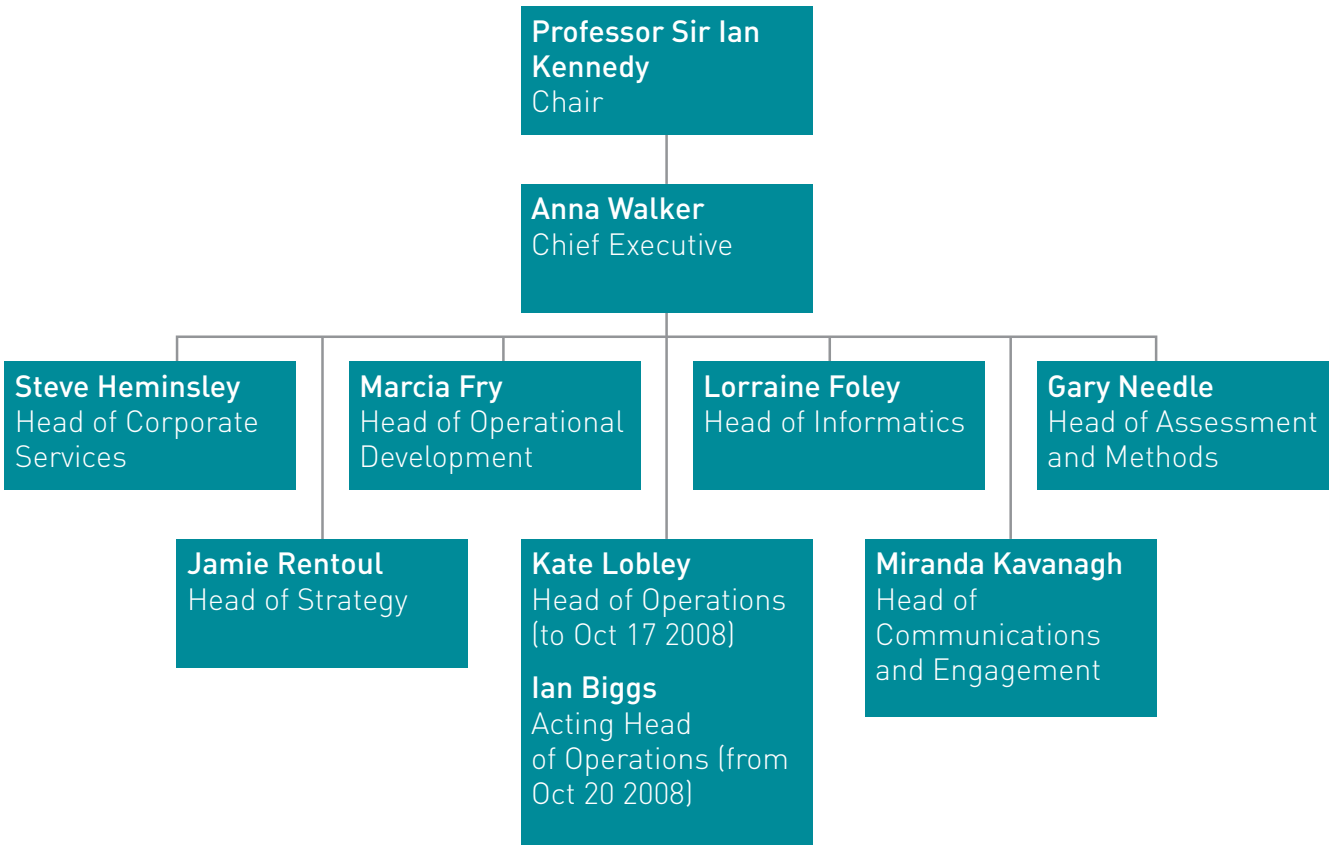
- Exercise the Healthcare Commission's statutory functions and duties.
- Make strategic decisions affecting the future operation and resources of the Healthcare Commission.
- Oversee the discharge by the executive of the management of day-to-day business.
- Set appropriate policies to manage risks to operations and the achievement of strategic objectives.
- Seek regular assurance that the system of internal control was effective in managing risks in the manner it had approved.

Leadership of the Commission

Leading the Commission's 14 Commissioners was the Chair, Professor Sir Ian Kennedy.

Anna Walker CB, Chief Executive of the Commission, led the senior management team, known as the Executive Team.

The role of the Executive Team was to take overall responsibility for the effective development and performance of the organisation and to oversee the successful delivery of the programme of work in line with the strategic goals set out in the Corporate Plan and the outcomes set out in the Balanced Scorecard, and the Operating Plan. Post-holders during 2008/09 are shown below.



Membership of the Commission

Arrangements for the membership of the Commission were set out in legislation and regulations. The Chair and the majority of the Commissioners were lay members, in other words they were not healthcare professionals or the holders of a paid appointment or office with an NHS body. One of the Commissioners made the interests of Wales his or her special care.

The Appointments Commission appointed all Commissioners including the Chair. Three new Commissioners joined the Healthcare Commission in April 2008: Patrick Boyle , Dr Fiona Campbell and Charles Goody.

During the year 2008/09, the terms of office of two Commissioners, Sir Nick Partridge and Michael Hake, came to an end. They were reappointed for a further term. The appointments of all Commissioners came to an end on 31 March 2009 with the abolition of the Healthcare Commission.

Information on the period of office of each Commissioner is given below.

Commissioners and their periods of office

Name	Period of office
Khurshid Alam	1 February 2004 to 31 March 2009
Dr Sarah Blackburn	1 February 2004 to 31 March 2009
Patrick Boyle	17 April 2008 to 31 March 2009
Dr Fiona Campbell	17 April 2008 to 31 March 2009
Dr Jennifer Dixon	26 February 2004 to 31 March 2009
Clare Dodgson	1 January 2007 to 31 March 2009
Charles Goody	17 April 2008 to 31 March 2009
Michael Hake	1 February 2004 to 31 March 2009 Reappointed from 1 February 2009
Professor Deirdre Kelly	1 January 2007 to 31 March 2009
Professor Sir Ian Kennedy (Chair)	1 February 2004 to 31 March 2009
Sir Nick Partridge (Joint Deputy Chair)	1 February 2004 to 31 March 2009 Reappointed from 1 February 2009
Cliff Prior CBE	1 January 2007 to 31 March 2009
John Scampion CBE	1 February 2004 to 31 March 2009
Professor Iqbal Singh	1 February 2004 to 31 March 2009
Paul Streets OBE (Joint Deputy Chair)	1 February 2004 to 31 March 2009

The working of the Commission and its committee structure

The Standing Orders of the Commission set out the rules by which the Commission operated. They included the Code of Practice for members of the Commission and the Standing Financial Instructions.

The Commission adopted a Schedule of Matters Reserved to it for collective decision. The following matters were reserved to the Commission:

1.	Establishing and maintaining the strategic direction of the Commission.
2.	Approval annually of plans/budgets in respect of the application of available financial resources, capital and revenue.
3.	Approval of the annual report of the Commission to be laid before Parliament with a copy sent to the Secretary of State.
4.	Receipt of the annual accounts, the audited accounts and the management letter from the external auditors.
5.	Approval of the appointment of the Chief Executive.
6.	Approval of the corporate plan of the Commission.
7.	The process for the appointment of the second tier staff of the Commission.
8.	Receipt of a regular update on policies in place to ensure the effective management of the Commission's employees.
9.	Approval of and amendments to the Healthcare Commission's Standing Orders which include the Standing Financial Instructions.
10.	Approval of the Scheme of Delegation for the Commission.
11.	Material contracts of the Commission as agreed.
12.	Approval of the risk management strategy for the Commission.
13.	Review and approval of the Commission's overall governance arrangements, taking into account the advice of the Audit Committee.
14.	The receipt of reports setting out details of any significant prosecution, defence or settlement of litigation or areas where litigation may be likely.
15.	A report on declarations of interest made by Commissioners.
16.	Consideration of the outcome of an investigation that any Commissioner has acted, or omitted to act, in a manner which constitutes a breach of the Commission's Standing Orders including its Code of Practice for Members. If appropriate, recommending to the Secretary of State that the member should be removed from office.
17.	Appointment of bankers to the Commission.
18.	Approval of arrangements for the handling of complaints about the Commission including any complaint about a member of the Commission.

The Commission also formally agreed arrangements for the discharge of its functions and the terms of reference of Committees of the Commission.

In 2008/09 the Commission had the following Committees:

- Audit Committee
- Remuneration Committee
- Nomination Committee
- Committee on the Use of Confidential Personal Information
- Investigations Committee

Members and Chairs of Committees were appointed by the Commission, on the recommendation of the Nomination Committee, with the exception of the Chair of the Audit Committee, for which the recommendation was approved by the Appointments Commission.

In addition, the Commission met for an informal discussion of strategy in April 2008, and two groups of Commissioners met regularly: the Group of Commissioners concerned with Assessment and the Chair's Small Group of Commissioners.

Roles and responsibilities of Commissioners

Commissioners had corporate responsibilities as the non-executive members of the board of a public body. In particular, Commissioners had corporate responsibility for the stewardship of public funds, and for ensuring that the Healthcare Commission complied with any statutory or administrative requirements for the use of public funds.

Other important responsibilities included:

- Ensuring that high standards of corporate governance were observed at all times.
- Establishing the overall strategic direction of the Healthcare Commission within the framework of policy and resources agreed with the Secretary of State.
- Ensuring that the Commission did not exceed its powers or functions.
- Ensuring that the Commission considers guidance issued by the Department of Health and complied with any statutory duties imposed on public bodies.

Individual Commissioners had wider responsibilities to the general public as Commissioners of the Healthcare Commission. Commissioners agreed to follow the Seven Principles of Public Life[1] and also to:

- Act in good faith and in the best interests of the Commission.
- Not misuse information gained in the course of their public service.
- Ensure they comply with the Commission's rules on the acceptance of gifts and hospitality.

Some Commissioners had additional roles. Charles Goody held the appointment as the Commissioner making the interests of Wales his special care. Sir Nick Partridge and Paul Streets were Joint Deputy Chairs during 2008/09, following an election the previous year. The Commission had two Caldicott Guardians, one a Commissioner and the other a member of the Executive Team. During 2008/09 the holders were Professor Deirdre Kelly and Steve Heminsley.

Meetings and attendance

A table showing members' attendance at meetings of the Commission and Committees during the year is shown below, with attendance shown as a proportion of the numbers of meetings that individual Commissioners were eligible to attend.

[1] As set out by the Commission on Standards in Public Life.

Membership and attendance at meetings of the Commission and Committees 2008/09

Name	Meetings of the Commission	Strategy meetings of the Commission	Audit Committee	Remuneration Committee	Nomination Committee	Committee on the Use of Confidential Personal Information	Investigations Committee
Professor Sir Ian Kennedy	**4.5/5**	**1/1**		**5/5**			
Khurshid Alam	3/5	1/1		2/5	0/2		
Dr Sarah Blackburn	3/5	1/1	4/6				4/5
Patrick Boyle	4/5	-	3/4				
Dr Fiona Campbell	5/5	-					1/2[2]
Dr Jennifer Dixon	2/5	0.5/1			**2/2**		
Clare Dodgson	3/5	1/1	4/6		2/2		
Charles Goody	5/5	-	3/4			1/2	
Michael Hake	5/5	1/1	6/6	4/5		2/2	3/3[3]
Professor Deirdre Kelly	5/5	1/1				1/2	2/5
Sir Nick Partridge	5/5	1/1					**5/5**
Cliff Prior	4.5/5	1/1		3/5	1/2		
John Scampion	5/5	1/1	**6/6**	3/5			3/5
Professor Iqbal Singh	4/5	1/1			2/2		
Paul Streets	4/5	1/1		2/5		**2/2**	

Notes: Bold text indicates Chair of the Committee.
Attendance at only one of the two sessions of a full day meeting is counted as 0.5

[2] Dr Fiona Campbell became a member of the Investigations Committee with effect from November 27th 2008.

[3] Michael Hake resigned from the Investigations Committee with effect from 16 October 2008.

Remuneration of Commissioners

The remuneration of Commissioners was determined by the Secretary of State for Health. The remuneration of the Chair was in line with that of a high court judge. During 2008/09, the level of remuneration of Commissioners was set at the rate payable to the non-executive directors of NHS trusts, which was £7,765 per annum – an increase of 2.2% from 1 April 2008. This remuneration was for two and a half days a month. The Chair of the Audit Committee received an additional £5,176 per annum – again an increase of 2.2% from April 2008.

Expertise and experience

Given the nature of the Healthcare Commission's statutory responsibilities and the breadth and complexity of the issues with which it dealt, it was essential that the Commissioners brought a broad range of experience to the Commission. This included professional and managerial expertise in health strategy and policy, public health, education and training and academic research, the NHS, and the independent and voluntary sectors. Details of the professional backgrounds and other appointments of Commissioners were published on the Commission's website.

Independence of Commissioners and declarations of interest

The Chair had no other significant commitments during the year.

The Commission was satisfied that the Commissioners were independent of Healthcare Commission's management and free from any business or other relationship which could materially interfere with the exercise of their independent judgement, notwithstanding in some instances a regulatory connection between the Healthcare Commission and the Commissioners who were employed by organisations regulated by the Healthcare Commission. The Commission recognised that conflicts of interest could arise for all Commissioners, and had arrangements in place to handle any conflicts that might arise in the consideration of the Commission's business.

Register of interests

The Commission maintained a register of interest for Commissioners and members of the Executive Team. The register was available to members of the public for inspection at Finsbury Tower and through the website.

Effectiveness of the Commission

The Chair conducted individual appraisals with all Commissioners during the winter of 2008/09.

Papers were provided for all meetings of the Commission and its committees.

During the year, the Healthcare Commission's internal auditors, South Coast Audit, undertook a review of corporate governance as part of the programme of internal audit reviews.

Committees of the Commission

Audit Committee

The main function of the Audit Committee was to advise the Commission on the adequacy and effective operation of its systems of internal controls and therefore the quality of financial and other reporting of the Healthcare Commission.

The Audit Committee carried out its work by reviewing and challenging the assurances which were available to the Accounting Officer, the way in which these assurances were developed, and the priorities and approaches on which the assurances were premised.

Specifically, the Audit Committee provided advice by:

- Review and oversight of the preparation of annual accounts for the approval of the Commission.
- Review of the Healthcare Commission's systems of internal control and risk management.
- Monitoring the effectiveness of internal audit and of the relationship with and between internal and external auditors.

The Chair of the Audit Committee was John Scampion. The Audit Committee met on five occasions during 2008/09 and made regular reports to the Commission on its activities.

The Chief Executive, Head of Finance, Head of Corporate Services, external auditors and internal auditors were invited to attend all meetings. At each meeting during 2008/09, the Committee had private meetings with the external auditors and the internal auditors without management present. In addition, the Committee met in private with the members of the Executive Team.

The external auditor of the Healthcare Commission was the National Audit Office (NAO) who conducted audits on behalf of the Comptroller and Auditor General. The Head of External Audit had the right of direct access to the Chair of the Committee. The Commission's external auditors did not provide additional services to the Healthcare Commission during 2008/09.

During 2008/09, South Coast Audit was responsible for the internal audit at the Healthcare Commission. The Committee agreed the planned programme of audits, as well as any changes to the programme, and ensured that those conducting the internal audit had the necessary access to information to enable them to fulfil their mandate. The Head of Internal Audit had the right of direct access to the Chair of the Committee. The Commission's internal auditors did not provide additional services to the Healthcare Commission during 2008/09.

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

Risks relating to key aspects of the Commission's activities were explored by the Committee throughout the year. It received reports on areas of the organisation's work that faced the greatest risks in relation to the closure of the Healthcare Commission and transition to the Care Quality Commission. These included the security of information; steps being taken to prevent fraud; novel, contentious or repercussive payments to staff, and fees for the registration of independent healthcare. The Audit Committee also considered in detail the actions being taken by the Healthcare Commission to manage the closure of its complaints on 31 March 2009 and the transition to a two-stage processing for handling complaints from 1 April 2009.

The Committee produced its own annual report, which set out its activities.

Remuneration Committee
The Remuneration Committee had responsibility for the effectiveness, integrity and compliance of the protocols and practices of the Commission relating to rewards. A key responsibility was the annual review of the remuneration of the Chief Executive and Executive (second tier) Team employed directly by the Commission. The Committee agreed the approach to the award of performance-related pay for all employees of the Commission, and during 2008/09 approved business cases being made to the Department of Health's Human Resources Governance and Assurance Committee on matters related to the transition to the Care Quality Commission.

Professor Sir Ian Kennedy chaired the Committee. The Chief Executive and Head of Corporate Services attended meetings, except when matters relating to their own remuneration were being considered. During 2008/09, the Remuneration Committee met five times.

Nomination Committee
Dr Jennifer Dixon chaired the Nomination Committee which met twice during the year. The Nomination Committee made recommendations to the Commission on arrangements for the membership and the chairs of standing committees.

Committee on the Use of Confidential Personal Information
The Health and Social Care (Community Health and Standards) Act 2003 provided the Healthcare Commission with the power to require information, including confidential personal information, from both NHS and independent healthcare providers, when it was necessary or expedient for the proper exercise of the functions of the Commission. The Act required the Healthcare Commission to prepare and publish a code of practice in relation to confidential personal information. The code of practice was published in January 2005. The Commission established a committee of Commissioners to oversee the operation of the code of practice.

During 2008/09, the Committee met twice. The Chair of the Committee was Paul Streets. Members of the Committee included the Caldicott Guardian from the Commission and Dr Peter Harrowing, an independent member.

The Committee had approved frameworks for delegated decision-making on the obtaining, handling, use and disclosure of confidential personal information. It monitored the use of the frameworks, which allowed certain staff to make decisions in specified circumstances.

Investigations Committee
The Chair of the Investigations Committee was Sir Nick Partridge. During 2008/09, the Investigations Committee met five times.

The Investigations Committee provided strategic advice and made decisions in relation to investigations into potential failures in NHS services in England and in certain cross-border Special Health Authorities (as regards Wales). The Committee ensured that appropriate policies and procedures were in place and oversaw the guiding principles for investigations, including the criteria adopted for deciding whether an investigation was required, and recommending any changes to the Commission. The Committee approved cases for investigation by the Healthcare Commission and approved the terms of reference.

The Committee received summary information about all the cases managed by the investigations team during 2008/09.

The Committee approved the draft reports of major investigations at NHS trusts and reports of significant failings to the Secretary of State for Health. The Committee also monitored the implementation of action plans put in place as a result of its recommendations.

The Committee recommended other forms of intervention where a formal investigation was not considered appropriate, and during 2008/09 received a report on the first five interventions undertaken. A number of cases arose from a programme undertaken jointly between investigators and analysts, looking for and following up statistical outliers in data on mortality.

The Committee raised concerns about the omission from the Health and Social Care Bill 2008 of powers for the new regulator similar to the Healthcare Commission's powers to recommend special measures when it had serious concerns about the safety of patients. The Committee was pleased when an amendment to the Health and Social Care Act 2008 was subsequently passed which certified that the Care Quality Commission also had this prerogative.

The Chair's Small Group of Commissioners
The membership of the Group was the Chair, the Joint Deputy Chairs and three other commissioners co-opted by the Chair. The Group had formal terms of reference but did not have any decision-making authority or powers delegated by the Commission. The views of the Group were reported to the Commission. The Chair of the Healthcare Commission chaired meetings and the Chief Executive was invited to attend. The Group met on six occasions during 2008/09.

The function of the Group was to give advice on any matters that the Chair might raise. The transition to the Care Quality Commission and the changes to the arrangements for the review of NHS complaints were the major subjects of discussion during 2008/09.

The Group of Commissioners concerned with assessment
This Group was an ad hoc group of Commissioners convened by the Chair to assist the Commission in developing its methods, delivery and reporting of the assessment of performance in the NHS and independent healthcare sectors. It proved to be a valuable means of enabling Commissioners to develop a deeper understanding of the issues arising in the assessment of performance in healthcare, and to address various issues of policy.

The Group was chaired by John Scampion at the invitation of the Chair of the Commission, and it was open to any Commissioner to attend. The Chief Executive, the Head of Assessment and Methods, and other members of the Executive Team were invited to attend meetings of the Group, together with other senior managers responsible for the matters being discussed. During 2008/09, the Group met on five occasions.

Annual report

The Healthcare Commission was required to report on the following:

- The way in which it has exercised its functions during the year.
- The provision of healthcare by or for NHS bodies.
- What it has found in the course of exercising its functions during the year in relation to persons for whom it is the registration authority under the Care Standards Act 2000.

The annual report was laid before Parliament and sent to the Secretary of State for Health and the Welsh Assembly Parliament. The accounts of the Healthcare Commission were audited by the Comptroller and Auditor General and copies were sent to the Secretary of State for Health.

Management commentary

Principal activities
The Healthcare Commission was determined to make a real difference to the delivery of healthcare and to promote continuous improvement for the benefit of patients and the public. To do this, it focused on three key areas in 2008/09. These were:

1. Ensuring that the basics are in place.
2. Assessing and encouraging improvement.
3. Making information more accessible.

Objectives and strategies for achieving goals
Strategic goals in 2008/09 were:

- To promote better and safer experiences of health and healthcare for patients and the public using fair and credible systems for assessing and rating performance across the NHS and independent sector.
- To safeguard the public by acting swiftly and appropriately on complaints, concerns and significant failings in the provision of healthcare.
- To provide authoritative, independent, relevant and accessible information about what is going on in healthcare and the opportunities for improvement.
- To use assessments and other activities to promote action to reduce inequalities in the provision of healthcare to people and to improve their experiences, and their access to services through greater respect for human rights and diversity.
- To take a lead in coordinating and improving the impact and value for money of assessments and regulation of healthcare services.
- To support people in creating an efficient, flexible and highly skilled organisation delivering world class assessments and regulation.

The annual report provides information on our non-financial achievements in 2008/09 in achieving these goals.

Financial performance
The annual accounts report on the Commission's income and expenditure during the year, with the related grant-in-aid funding being credited directly to the operating cost reserve (note 10) in accordance with HM Treasury guidance.

The financial accounts to 31 March 2009 are the Commission's fifth and final set of annual accounts. While the activities, assets and liabilities of the Healthcare Commission were transferred from 1 April 2009 to the Care Quality Commission and Department of Health, the accounts have been prepared on the basis that the Commission is a going concern. The accounts have been prepared in the form directed by the Secretary of State for Health, with the approval of Treasury, in accordance with the Health and Social Care Act 2008 (Commencement No.9, Consequential Amendments and Transitory, Transitional and Saving Provisions) Order 2009 No. 4623, and the Financial Reporting Manual (FreM) 2008-2009.

Accounting convention
The financial statements were prepared under the modified historic cost convention by the inclusion of fixed assets at their value to the business by reference to current costs.

Impact of new accounting standards
During the year, the Healthcare Commission adopted FRS 25 'Financial Instruments: Disclosure and Presentation', FRS 26 'Financial Instruments: Measurement', and FRS 29 'Financial Instruments: Disclosures'. The main impact was that FRS 26 required financial instruments to be measured in a way that reflected the fair value of the asset or liability, usually by discounting.

As permitted by the FReM, prior year adjustments were not made to the balance sheet at 31 March 2008 or to the income and expenditure account for that year.

The adoption of this standard did not have a significant impact on the financial statements.

Financial results and review
The results for the year to 31 March 2009 are set out in the financial statements on pages 96 to 119.

The Commission's financial performance is identified within the income and expenditure account. The Commission's net expenditure for the year was £63.6m. Expenditure totalled £72.9m on operational activities reduced by income of £9.3m from Independent Healthcare fees and other activities as explained in the accounts. Additionally, terminations of employment cost £4.2m. Expenditure is funded from grant-in-aid provided by the Department of Health. Government grants totalling £65.4m were received in the year, including £4.0m designated as capital grant-in-aid. Reserves at 31 March 2009 were £10.8m (£13.0m 2008).

Fixed assets
The Commission's fixed assets at 1 April 2008 comprised refurbishment costs to leased land and buildings, furniture, fittings, plant & machinery and on information technology, as reduced by depreciation and amortisation calculated to release the asset costs to the income and expenditure over their useful working lives. Asset costs are revalued under modified historic cost accounting.

During the year to 31 March 2009, the Commission acquired assets with a value of £4.4m. These assets comprised the purchase of information technology infrastructure and software.

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

Charitable payments
No charitable donations were made during the year.

Payment of creditors
The Commission's policy was to pay creditors in accordance with contractual conditions or, where no contractual conditions exist, within 10-30 days of receipt of goods and services or the presentation of a valid invoice, whichever was the later. This complied with the Better Payment Practice Code and guidance received from HM Treasury.

No interest was paid during the year under the Late Payment of Commercial Debts (Interest) Act 1998.

In 2008/09, the Commission paid 94.5% (90%) of invoices, based on volume, and 94.6% (91%) of invoices, based on value, within 30 days. These calculations were based on the date of the invoice and therefore understated the Commission's performance as payments were delayed while confirmation was obtained of satisfactory supply of goods and services.

Equality and diversity
The Healthcare Commission was fully committed to creating a supportive working environment based on trust and mutual respect. We wanted our people to reach their full potential, regardless of race, nationality, ethnic or national origins, marital status, sexual orientation, impairment, gender, age, religion or belief, working arrangements or any other factor. The Commission's policies to promote equality and diversity applied across its entire work force and were set out in its intranet. These policies underpinned all other HR policies and management processes (including performance management).

Staff consultation
Staff were consulted regularly throughout the year. This was achieved through:

- Regular meetings between staff and Executive Team members which were open to all staff.
- The involvement of staff in developing the policies and objectives set out in the corporate plan.
- More formal meetings with the joint negotiating committee for staff were management and unions.
- A staff forum on which Finsbury Tower and regionally-based staff were represented by elected delegates.
- An annual staff conference.
- Regular all-staff communications.
- Periodic confidential surveys of staff attitudes, the results of which were shared.

Auditor appointment
The Comptroller and Auditor General was the appointed auditor of the Commission under the provision of the Health and Social Care Act 2008 (Commencement No.9, the Amendments and Transitory, Transitional and Saving Provisions) Order 2009, No. 462.

The audit fee for the year was £71,000 (£59,000 2007/08). The Comptroller and Auditor General did not undertake any non-audit work during the year.

Disclosure of information to the auditors
So far as the Chief Executive Officer, CQC is aware:

- There is no relevant audit information of which the entity's auditors are unaware.
- All steps that ought to have been taken were taken to make themselves aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

Financial instruments
Because of the non-trading nature of the Healthcare Commission's activities and the way in which Government Departments are financed, the Commission was not exposed to the degree of financial risk faced by business entities.

The Healthcare Commission had no borrowings and relied on the grants from the Department of Health for its cash requirements and was therefore not exposed to liquidity risks. It had no material deposits and all material assets and liabilities were denominated in sterling so it was not exposed to interest rate risk or currency risk.

Trade debtors do not carry any interest and are stated at their nominal value less any provision for impairment.

Trade creditors are not interest bearing and are stated at their nominal value.

Longer-term debtors and creditors are discounted when the time value of money is considered material.

Financial costs of strategic goals
The detailed financial performance is shown within the operating cost statement and in the other financial statements and associated notes.

Gross operating costs of £77.0m were offset by £8.4m of income in respect of our work for the independent sector and a further £0.8m sundry income. Net operating costs of £67.8m were met from our grant funding as explained above and in the financial statements.

Revenue operating costs analysed according to strategic goals

	2008/09		2007/08
Strategic goal	**Average number of employees** (whole-time equivalent)	**Net operating cost £000**	**Net operating cost £000**
Promote a better experience of health and healthcare for patients and public	447	29,616	31,070
Safeguard the public	162	10,473	11,843
Provide authoritative, independent, relevant and accessible information	52	4,619	4,109
Take a lead in coordinating and improving the impact and value for money of assessment and regulation	32	1,596	2,285
Promote action to reduce inequalities in people's health and increase respect for human dignity	6	385	332
Create an organisation delivering world class assessment and regulation	144	21,081	17,629
Total	843	67,770	67,268

Capital grant funding: £4.4m was spent on capital expenditure

	2008/09	2007/08
Strategic goal	**Capital expenditure £000**	**Capital expenditure £000**
Create an organisation delivering world class assessment and regulation	4,439	5,409
Total	4,439	5,409

The majority of capital expenditure was in support of the creation of an intelligent information management system. This development has been agreed by the Commission and, subject to agreement with the Department of Health, funding will be through grant-in-aid in the year in which expenditure is incurred, with appropriate capitalisation of elements of the project. In the year the functionality of the client relationship management system was increased, enhancing the website that allowed trusts to interrogate the annual health check results, and a pilot of the proposed information cabinet was undertaken.

Net operating costs can also be analysed between three main business components:

			2008/09	2007/08
	Expenditure £m	**Income £m**	**Net operating cost £m**	**Net operating cost £m**
NHS	57.2	-	57.2	58.1
Complaints	10.0	-	10.0	9.6
Independent healthcare	9.0	8.4	0.6	(0.4)
Total	**76.2**	**8.4**	**67.8**	**67.3**

Expenditure is stated after allocating common overhead costs. Independent healthcare fees are set at a level intended to recover the costs arising in regulating the sector and are set following a consultation process. The net cost of £0.6m was part-funded from the unspent fee income from 2007/08. The balance will be taken into consideration when setting future fees.

Going concern

In March 2005 the Chancellor of the Exchequer announced that the Healthcare Commission's functions would be combined with the Commission for Social Care Inspection and Mental Health Act Commissions and a new social care and health body would be created. Subsequently, under the Health and Social Care Act 2008, the CSCI was dissolved on 31 March 2009 and, with effect from 1 April 2009, its functions were transferred to the Care Quality Commission.

Assets and liabilities were transferred to the Care Quality Commission on 1 April 2009 and as the transfer of activities was between the Department of Health's Arms Length Bodies, they are not considered to be "discontinued". It has accordingly been considered appropriate to adopt a "going concern" basis for the preparation of the Healthcare Commission's final financial statements.

Contractual obligations

The Healthcare Commission operated a contracts register, which showed the contracts let for the Commission.

The Commission had a number of IT service contracts in place, the major service supplier being CSC Computer Science Ltd. CSC supplied services relating to operating systems, hardware maintenance, IS infrastructure, and IT operations.

Mouchel Business Services provided the payroll service to the Healthcare Commission.

New developments to the scope of work

In September 2008 a Transition Team was created. They oversaw, managed and coordinated the Healthcare Commission's input into the creation of the new Care Quality Commission. An action plan was prepared which included all work in progress and any data, records or files. Matters relating to the legal shutdown of the Healthcare Commission, estates closure and rationalisation, Finance, IT, Comprehensive Area Assessment development and 2008/09 Commissioning assessments, procurement and contracts were also included and had closure and/or continuity plans drawn up.

The plan identified any risks for the Healthcare Commission and any emerging issues which were relevant to the Care Quality Commission. Risks for the Healthcare Commission were more associated with the possibility of any non-completion of statutory work programmes and the steps the Healthcare Commission intended to take to mitigate against this.

Key performance indicators

There are a number of key ways in which the Healthcare Commision achieved its strategic goals. These were:

- The annual health check and other assessments of the NHS.
- Regulation of the independent healthcare sector and alignment with the NHS.
- In-depth reviews of issues of concern.
- Investigations of serious service failure.
- Handling of second stage NHS complaints.
- Providing useful information based on our assessments.

Performance was monitored using a balanced scorecard, with strategic goals being divided into objectives. Each objective was 'owned' and monitored by an Executive Team member.

During 2008/09, the Commission's performance against its objectives was reported periodically up through business groups, and reviewed by the Performance Management and Risk team before being reported to the Executive Team and the Commissioners. The report March 2009 set out opposite is based the Commission's performance reporting against its strategic goals and objectives for the period 1 April 2008 to 31 March 2009:

1. Engagement	G	The Patient Public Engagement and Clinical Quality teams managed the transfer of our stakeholder relationships to the Care Quality Commission.
2. Strategic priorities & Regulation	G	The Strategy and Policy teams have finalised their work for the Healthcare Commission and are supporting business planning and strategy and policy development for the Care Quality Commission.
3. Assess & monitor compliance	A	The AHC programme is on track but work on the 2008/09 AHC was affected by concerns about staff resource availability in the Indicators and Measurement team. The Operations Group finalised their programme of Independent Healthcare Inspections by 31 March.
4. Reviews & Studies	G	The Review and Studies programme was on track and monitored weekly by the ET. An agreed limited number of reports were published by the Care Quality Commission after April 2009.
5. Investigations, Interventions, Enforcement	G	The Investigations and Interventions team are managing the continuity of their programme of work into the Care Quality Commission. The programme is on track and remains crucial to responding to patient safety concerns. This was prioritised up to handover to the Care Quality Commission.
6. Complaints function	G	The complaints team met its SLA activity levels and quality standards and managed the transition of its responsibilities to the PHSO.
7. Communicate results	G	The Communications teams finalised all reports to be published by the Healthcare Commission by the 31 March or will carry forward and be published by the Care Quality Commission after the 1 April. Both the Media team and Internal Communications team are supporting the transition to the Care Quality Commission.

Employees sickness is also monitered. Details of days lost through sickness are included in note 2 to the financial statements.

Risk management

A corporate risk register was developed early in the Commission's first year and was reviewed and revised as part of the annual business planning process. The identified risks, and the effectiveness of the agreed actions to address these risks, were monitored by the Audit Committee and the Commission regularly.

In managing risk, the Executive Team focused on the top corporate risks that had been identified and formally assessed each risk and the mitigating actions taken on a monthly basis.

Risk appetite indicates how much exposure to particular risks the Commission was willing to tolerate. It represents an informed decision to accept the likelihood and consequences of a risk as it currently stands. During the remaining life of the Commission the ability to

do anything about some risks was limited, or the cost of taking any action may have been disproportionate to the potential benefit. In cases where risk appetite is shown as Amber this means that no further action to reduce our exposure to the risk to Green was proposed.

The position at 31 March 2009 is set out below. No risks were considered to be at stage red and to require urgent action.

Risk to the effectiveness of systems for assessing risk to the public

The transition to the Care Quality Commission might reduce the effectiveness of systems for assessing risk to the public and for managing escalation processes leading to interventions to protect the public who are known to be at risk of failure.

The Healthcare Commission mitigated this risk by prioritising staff and resource commitments to the work of national and local risk panels, ensuring that the continuity of the work of its investigations team was not disrupted by the transition to the Care Quality Commission.

Net risk : **GREEN** Target risk : **GREEN**

Risk to information governance and the security of data

The Healthcare Commission cannot ensure effective information governance and the security of its data because of human error or deliberate error because staff attention is diverted by the process of recruitment and transition to the Care Quality Commission.

The Healthcare Commission mitigated this risk by implementing its data security plan and by prioritising resources to maintain and improve data security in the run-up to merger, and no losses arose.

Net risk : **AMBER** Target risk : **GREEN**

Risk to the effective our handover of information and data to Care Quality Commission

The Healthcare Commission could not handover information and data to the Care Quality Commission unless it was assured that the Care Quality Commission had in place the capacity to ensure the same standard of security. During the early part of the transition process the Care Quality Commission did not have adequate systems and processes in place, however this was addressed and the Healthcare Commission was satisfied by 31 March 2009 that data security within the Care Quality Commission met the requirements set out by the Cabinet Office.

The Healthcare Commission mitigated this risk by highlighting to the care Quality Commission the reputational risk related to not having suitable arrangements in place on April 1 2009 and by supporting the development of these arrangements within the Care Quality Commission.

Net risk : **AMBER** Target risk : **GREEN**

RED	Urgent action required to control and respond to this risk
AMBER	Risk under control but further action required to reduce the risk
GREEN	Risk under control and being routinely monitored

Remuneration report

This report for the year ended 31 March 2009 deals with the remuneration of the Chair, Commissioners, Chief Executive Officer and Executive Team who have influence over the decisions of the Healthcare Commission as a whole.

Remuneration Committee
The remuneration of the Chief Executive and Executive Team members was set by the Remuneration Committee and was reviewed annually.

The Remuneration Committee has responsibility for the effectiveness, integrity and compliance of the reward protocols and practices of the Commission. A key accountability is the annual review of the remuneration of the Chief Executive and Executive (second tier) Team employed directly by the Commission. The Remuneration Committee determines both increases in pensionable salary and a performance bonus for the Chief Executive and Executive team members.

The Remuneration Committee met five times during 2008/09 and comprised:

		Attendances
Prof Sir Ian Kennedy	Chair	5
Kurshid Alam	Commissioner	2
Michael Hake	Commissioner	4
Cliff Prior	Commissioner	3
John Scampion	Commissioner	3
Paul Streets	Joint Deputy Chair	2

In reaching its recommendations, the Remuneration & Human Resource Committee considered:

- The need to recruit, maintain and motivate suitably able and qualified people to exercise their different responsibilities.
- Regional/local variations in labour markets and their effects on the recruitment and retention of staff.
- The Government's inflation target.

Remuneration policy
The Chair is paid a salary in line with that of a high court judge. Commissioners' remuneration is determined by the Department of Health on the basis of a commitment on average of two to three days per month.

Remuneration of the Executive Team was determined after an external benchmarking exercise and consideration of the performance of individuals against objectives set for corporate and individual performance, and in accordance with guidelines for senior executive pay issued annually by the Cabinet Office.

All senior managers/directors were employed on Commission terms and conditions, with the exceptions of the Heads of Strategy and Corporate Services who were seconded from the Department of Health and HM Revenue and Customs respectively.

All senior managers received a salary and were members of a pension scheme (either PCSPS or NHSPS depending on their previous employment).

All senior managers had agreed objectives. The Chief Executive and Executive Team members' performance was reviewed annually.

The Remuneration Committee recommends to the Commission the framework or broad policy for the remuneration of staff below second tier level.

Service contracts
Professor Sir Ian Kennedy was Chair designate on the vesting date of 8 January 2004 and was appointed by the Secretary of State for Health as Chair of the Healthcare Commission from 1 February 2004 for a period of four years to 31 January 2008. The appointment has been extended to closure of the Commission on 31 March 2009.

The NHS Appointments Commission, acting on behalf of the Secretary of State for Health, appoints Commissioners for terms of three years and in accordance with the Commission of Public Appointments code.

It was the Healthcare Commission's policy to recruit senior managers on the basis of fair and open competition. The Chief Executive, Anna Walker, was appointed on a permanent contract on 1 February 2004, after an internal and external recruitment process.

All members of the executive team were full-time employees of the Commission employed directly by the Commission or on secondment from other government departments.

The Chief Executive and Executive Team members (excluding Jamie Rentoul and Steve Heminsley – both secondees to the Commission) had contracts with the Commission requiring that they give, and are entitled to receive, six months' notice of termination. In the event of early termination, contractual entitlements apply.

All service contracts were terminated with due notice effective from 31 March 2009 when the Healthcare Commission transferred its activities and assets/liabilities to the Care Quality Commission or Department of Health.

The following sections provide details of the remuneration (including any non-cash remuneration) and pension interests of Commissioners, Chief Executive, and Executive team members, as well as those amounts payable to third parties for services as a senior manager, and any compensation or significant awards paid to former senior managers. These sections are subject to audit. Remuneration is presented in bands of £5,000.

Emoluments of Chair and Commissioners
Details of the remuneration of the Chair and Commissioners for 2008/09 are contained within the two tables below.

Chair's emoluments^

	2008/09		2007/08
	Date of appointment	Total £000s	Total £000s
Prof Sir Ian Kennedy	8 Jan 04	170-175	165-170

In addition, the Chair was reimbursed with the cost of travelling to and from the Commission including for Commission meetings. These reimbursements totalled £1,699 during 2008/09 (£3,977 in 2007/08). The Commission meets the resulting tax liability under a PAYE settlement agreement.

Commissioners' emoluments^

		2008/09	2007/08
	Date of appointment	Total £000s	Total £000s
Khurshid Alam	1 Feb 04	5-10	5-10
Dr Sarah Blackburn	1 Feb 04	5-10	10-15
Patrick Boyle	17 Apl 08	5-10	-
Dr Fiona Campbell	17 Apl 08	5-10	-
Dr Jennifer Dixon	26 Feb 04	5-10	5-10
Clare Dodgson	1 Jan 07	5-10	5-10
Charles Goody	17 Apl 08	5-10	-
Michael Hake	1 Feb 04	5-10	5-10
*Dr Sharon Hopkins	1 Feb 04	-	5-10
Professor Deirdre Kelly	1 Jan 07	5-10	5-10
*Professor Bruce Keogh KBE	1 Feb 04	-	5-10
Sir Nick Partridge (Joint Deputy Chair from 1 October 2007)	1 Feb 04	5-10	5-10
*Professor Shirley Pearce	1 Feb 04	-	0-5
Clifford Prior CBE	1 Jan 07	5-10	5-10
**John Scampion CBE	1 Feb 04	10-15	5-10
Professor Iqbal Singh	1 Feb 04	5-10	5-10
Paul Streets OBE (Joint Deputy Chair)	1 Feb 04	5-10	5-10

* Term of office expired in 2007/08

** Includes remuneration as Chair of Audit Committee

In addition, Commissioners are reimbursed with the cost of travelling to and from the Commission including for Commission meetings. These reimbursements totalled £10,063 during 2008/09 (£10,861 in 2007/08). The Commission meets the resulting tax liability under a PAYE settlement agreement.

Payments to independent members^

Dr Peter Harrowing is an independent member of the Committee on the Use of Personal Information. Fees are paid on a per meeting basis and amounted to £750 in 2008/09 (£750 2007/08).

Emoluments of Chief Executive and senior managers

The Chief Executive and all other members of the senior management team were employed under permanent employment contracts. The Chief Executive and senior managers worked for the Commission on a full time basis.

Details of the remuneration of the Chief Executive and senior managers for 2008/09 are contained within the two tables below. Emoluments are presented in bands of £5,000.

Chief Executive's emoluments^

	2008/09				2007/08
	Date of appointment	Salary £000s	Bonus £000s	Total £000s	Total £000s
Anna Walker	1 Feb 04	180-185	20-25	205-210	200-205

During the year, Anna Walker was seconded on a part-time basis to DEFRA for which the Commission received £35,432.

Other senior managers' emoluments^

				2008/09	2007/08
	Date of appointment	Salary £000s	Bonus £000s	Total £000s	Total £000s
Lorraine Foley	12 Jan 04	**130-135**	**15-20**	**145-150**	140-145
Marcia Fry	1 Apl 04	**130-135**	**15-20**	**145-150**	140-145
Miranda Kavanagh	17 Jly 06	**140-145**	**0-5**	**145-150**	145-150
Mick Linsell (retired in 2007/08)	8 Jan 04	-	-	-	85-90
Kate Lobley (resigned 17 Oct. 2008)	1 Aug 06	65-70	-	**65-70**	115-120
Gary Needle	1 Feb 08	110-115	5-10	**115-120**	20-25

Gary Needle was appointed to a position with the Care Quality Commission from 1 March 2009.

Bonus payments
Bonus payments were non-consolidated and were not pensionable. These could have been in the range 0-15% of the base salary based on performance against agreed objectives.

All salary review recommendations were subject to final approval by the Remuneration Committee.

Amounts payable to a third party for services as a senior manager^
Jamie Rentoul provided services as an Executive Team member while employed by the Department of Health. Salary costs of £160,173 (including pension and employers' costs) were recharged to the Commission by the Department of Health (£168,929 in 2007/08)

Steve Heminsley provided services as an Executive Team member with effect from 4 February 2008, while employed by HM Revenue & Customs and following the retirement from service of Mick Linsell. Salary costs of £165,840 were recharged to the Commission by HM Revenue & Customs (£26,242 in 2007/08).

Recharges include gross salary, any bonus due, National Insurance and pension costs.

Non-cash remuneration
There was no non-cash remuneration during the year (nil in 2007/08).

Compensation paid, significant awards to senior managers
There were no non-contractual compensation or significant awards paid to former Executive Team members during the year (nil in 2007/08).

Payments for loss of office^
For the Chief Executive and Marcia Fry early termination was under the terms of the Principal Civil Service Pension Scheme (PCSPS) and they were not eligible for an additional redundancy payment. However they do receive an immediate compensation lump sum from the pension fund the amount of which is dependent upon their age and length of reckonable service. The compensation lump sum is additional to the lump sum paid to the individual when accessing their pension benefits.

Lorraine Foley and Miranda Kavanagh left under the NHS pension scheme and were contractually eligible for a redundancy payment. The payment terms are set out in the Commission's Organisational Change Policy.

The total compensation paid to senior managers was as follows:

	Anna Walker £000	Marcia Fry £000	Lorraine Foley £000	Miranda Kavanagh £000
Lump sum compensation payment at date of leaving	94	98	19	8
Annual compensation payment payable until the age of 60	78	61	-	4

There were no other payments for loss of office during the year (nil in 2007/08).

Pension benefits
The Chair has foregone eligibility to join the Commission's pension scheme. Commissioners are not eligible to join either of the Commission pension schemes.

The Chief Executive and Executive Team members are ordinary members of the Principal Civil Service Pension Scheme (PCSPS) or the NHS pension scheme.

Pension entitlements at 31 March 2009

Chief Executive^

The Chief Executive is an ordinary member of the PCSPS. Accrued benefits are presented in bands.Pension benefits at 31 March 2009 may include amounts transferred from previous employments.

	Accrued benefits				Cash equivalent transfer values (CETV)		
	Real increase in year		Benefits as at 31 Mar 09				
	Lump sum £000	Pension £000	Lump sum £000	Pension £000	CETV at 31 Mar 08 £000	CETV at 31 Mar 09 £000	Real increase in CETV £000
Anna Walker	5-7.5	0-2.5	220-225	70-75	1,507	1,604	98

Executive Team^

The members of the Executive Team are eligible to become ordinary members of the NHS pension scheme or the PCSPS. Accrued benefits are presented in bands.

Pension benefits at 31 March 2009 may include amounts transferred from previous employments.

	Accrued benefits				Cash equivalent transfer values (CETV)		
	Real increase in year		Benefits as at 31 Mar 09				
	Lump sum £000	Pension £000	Lump sum £000	Pension £000	CETV at 31 Mar 08 £000	CETV at 31 Mar 09 £000	Real increase in CETV £000
** Lorraine Foley	5-7.5	0-2.5	25-27.5	7.5-10	79	147	68
* Marcia Fry	0-2.5	0-2.5	165 -170	55-60	1,120	1,185	65
** Miranda Kavanagh	5-7.5	0-2.5	12.5 -15	2.5-5	35	91	56
** Kate Lobley	2.5-5	0-2.5	20 -22.5	5-7.5	76	128	52
** Gary Needle	115 -117.5	2.5-5	127.5 -130	42.5-45	497	827	330

* member of PCSPS and the Classic Scheme

** are members of NHSPS

Kate Lobley resigned 17 Oct 2008, Gary Needle transferred to the Care Quality Commission on 28 Feb 2009.

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

The CETV figures include the value of any pension benefit in another scheme or arrangement which the individual has transferred to the Civil Service Pension arrangements and for which the CS Vote has received a transfer payment commensurate to the additional pension liabilities being assumed. 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.

Due to the Cabinet Office changing the transfer factors that came into force on 1 October 2008, there is a reduction of 4.83% between the final period CETV for 2007/08 and the start of the period CETV for 2008/09.

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

Principal Civil Service Pension Scheme (PCSPS)
The scheme is an unfunded multi-employer defined benefit scheme, made under the Superannuation Act 1972. The Commission is unable to identify its share of underlying assets and liabilities. The scheme actuary valued the scheme as at 31 March 2007. Details can be found in the resource accounts of the Cabinet Office: Civil Superannuation (www.civilservice-pensions.gov.uk).

From 1 October 2002, civil servants may be in one of three statutory based "final salary" defined benefit schemes (classic, premium, and classic plus). The Schemes are unfunded with the cost of benefits met by monies voted by Parliament each year. Pensions payable under classic, premium, and classic plus are increased annually in line with changes in the Retail Prices Index. New entrants after 1 October 2002 may choose between membership of premium or joining a good quality "money purchase" stakeholder arrangement with a significant employer contribution (partnership pension account).

Employee contributions are set at the rate of 1.5% of pensionable earnings for classic and 3.5% for premium and classic plus. Benefits in classic accrue at the rate of 1/80th of

pensionable salary for each year of service. In addition, a lump sum equivalent to three years' pension is payable on retirement. For premium, benefits accrue at the rate of 1/60th of final pensionable earnings for each year of service. Unlike classic, there is no automatic lump sum (but members may give up (commute) some of their pension to provide a lump sum). Classic plus is essentially a variation of premium, but with benefits in respect of service before 1 October 2002 calculated broadly as per classic.

For 2008/09, employers' contributions were payable to the PCSPS at one of four rates in the range 17.1% to 25.5% of pensionable pay (17.1% to 25.5% in 2007/08), based on salary bands. The scheme's Actuary reviews employer contributions every four years following a full scheme valuation. The contribution rates reflect benefits as they are accrued, not when the costs are actually incurred, and reflect past experience of the scheme.

Salary bands for 2009/10 are to remain the same as those in 2008/09:

	Salary band £	Contribution %
Band 1	19,000 and under	17.1
Band 2	19,001 to 39,000	19.5
Band 3	39,001 to 66,500	23.2
Band 4	66,501 and over	25.5

Further details about the PCSPS arrangements can be found at the website **www.civilservice-pensions.gov.uk**

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 an organisation to identify their share of the underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the Commission of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period. Details of the benefits payable under these provisions can be found on the NHS Pensions website at **www.nhsbsa.nhs.uk/pensions**.

From 1 April 2008 significant changes were made to the NHS Pension Scheme contribution rates and benefits, which largely affected new members to the NHS. Commission member benefits derive from the **NHS Pension Scheme (Amended April 2008)**.

The Scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and a FRS17 accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the Scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the Scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2009, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2009, employees' contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) FRS17 Accounting valuation
In accordance with FRS17, a valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the balance sheet date by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the Scheme Actuary. At this point the assumptions regarding the composition of the Scheme membership are updated to allow the Scheme liability to be valued.

The valuation of the Scheme liability as at 31 March 2009, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2009 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

Scheme provisions as at 31 March 2008
The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last three years pensionable pay for each year of service. A lump sum normally equivalent to three years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A

death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the Scheme. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the organisation commits itself to the retirement, regardless of the method of payment.

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

Scheme provisions from 1 April 2008
From 1 April 2008 changes were made to the NHS Pension Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pension website **www.nhsbsa.nhs.uk/pensions**

Salary band	Employee contributions	Employer contributions
£19,682 and under	5.0%	14%
£19,683 to £65,002	6.5%	14%
£65,003 to £102,499	7.5%	14%
£102,500 and over	8.5%	14%

^ Remuneration and pension entitlements are covered by the certificate and report of the Comptroller and Auditor General to the Houses of Parliament set out on pages 96 to 98 of the annual report.

Signed:

Name: Cynthia Bower

Position: Chief Executive, Care Quality Commission

Date: 24 June 2009

Statement of Accounting Officer's responsibilities

Under the Health and Social Care Act 2008 (Commencement No.9, Consequential Amendments and Transitory, Transitional and Saving Provisions) Order 2009 No. 462, the Secretary of State for Health (with the consent of HM Treasury) directed the Commission to prepare for each financial year a statement of accounts in the form and on the basis that it considered appropriate. The accounts were prepared on an accruals basis and must give a true and fair view of the state of affairs of the Commission and of its income and expenditure, recognised gains and losses and cash flows for the financial year.

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

- Observe the Accounts Direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements.
- Prepare the financial statements on a going concern basis. As reported elsewhere, the Healthcare Commission transferred its assets and liabilities to the Care Quality Commission on 1 April 2009 but it has been considered appropriate to adopt a "going concern" basis for the preparation of the Healthcare Commission final financial statements.

The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the Commission's assets, are set out in *Managing public money* published by HM Treasury. The Healthcare Commission's Accounting Officer was Anna Walker to 31 March 2009. From 1 April 2009 the Care Quality Commission's Accounting Officer had responsibility for the Healthcare Commission's records.

Statement on internal control

As the Chief Executive of the Care Quality Commission I have been designated Accounting Officer for the purposes of signing the Healthcare Commission's Annual Report and Accounts for the year to 31 March 2009. The Chief Executive of the Healthcare Commission was the Accounting Officer for the Healthcare Commission during the year ending 31 March 2009.

1. Scope of responsibility

The Healthcare Commission Chief Executive as Accounting Officer for the year to 31 March 2009 had responsibility for maintaining a sound system of internal control that supported the achievement of the Commission's policies, aims and objectives, whilst safeguarding the public funds and organisation's assets for which the Accounting Officer was personally responsible, in accordance with the responsibilities assigned in Managing Public Money.

The Commission subscribed to the seven principles of conduct underpinning public life as set out by Lord Nolan in his report.

The Secretary of State for Health was answerable to Parliament for the policies and performance of the Commission. The Commission met the minister for an annual performance review and the Chair and Chief Executive had regular meetings with ministers and senior policy officials of the Department of Health.

There was a funding agreement between the Commission and the Department of Health. The Commission consulted extensively when planning its activities, including consultation with ministers and included the risks associated with different courses of action in that consultation. The Commission's systems for internal control depended upon strategic planning (including external consultation), budget setting, agreement of an annual operating plan, monitoring of performance against the annual plan and the balanced scorecard and risk assessment and assessment and monitors.

The Commission recognised its responsibilities to ensure that there were robust arrangements for managing risk and that a formal scheme for identifying, managing and reporting on risk was in place at Commission, group, programme and project levels throughout the year.

During 2008/09 the Accounting Officer reviewed documents that she considered relevant, including internal audit reports and papers presented to the Audit Committee and management information produced during the year and discussed the state of internal controls with the external and internal auditors, and with members of the Commission.

2. The purpose of the system of internal control

The system of internal control was designed to monitor performance against plan, and budgeted to manage risk to a reasonable level, rather than to eliminate all risk of failure to achieve policies, aims and objectives; it could therefore only provide sound and not absolute assurance of effectiveness. The Commission's system of internal control was based on an ongoing process designed to identify and prioritise the risks to the achievement of its policies, aims and objectives, to evaluate the likelihood of those risks being realised (and their impact should they be realised) and to manage them efficiently, effectively and economically. The

system of internal control was in place in the Healthcare Commission for the year to 31 March 2009 and in the Care Quality Commission from 1 April 2009 to ensure that internal control was maintained through to the date of approval of the annual report and accounts and accords with guidance from HM Treasury.

3. Capacity to handle risk

The Commission established an overarching governance framework to support delivery of its policies, aims and objectives. Risk management was integrated into all levels of this framework and as such, reflected in strategic and operational planning and how performance was monitored through the balanced scorecard and budget. The table below illustrates this approach:

Stage	Purpose	Approach to risk
Strategic planning	Identify appropriate strategic goals and objectives. Consultation on those externally and with Commissioners	Scenario planning of possible events and outcomes
Budget setting	Allocation of resources to support objectives	Identification of contingencies
Operational planning	Identification of activities to be undertaken to promote objectives	Development of risk register and business continuity plans
In-year monitoring	Undertaking of performance and financial monitoring using balanced scorecard and budgetary control statements	Early identification of adverse trends in performance or financial control
Risk assessment	With support from internal audit, monitoring of actions identified through in-year monitoring as essential to mitigate risk	Re-iterative approach to ensure rigour in risk management processes

The Commission's processes were designed and developed to:

- Establish a policy framework approved by Commissioners and the executive team, within which activities and their proposed outcomes and strategic risks were identified, managed and kept under review.
- Embed the management of risk and compliance by making it part of the day-to-day management processes. The executive team collectively owned the risks and, in addition, each strategic risk was also allocated to an appropriate member of the executive team to ensure that the management of risk was an integral part of overall management arrangements.
- Ensure that named managers managed each risk and actively reviewed and reported on that risk.
- Adopt a consistent approach throughout the organisation.
- Encourage staff to identify and manage risk positively in support of delivering the objectives of the Commission.
- Keep the system of risk management under regular review to ensure it is best matched to the organisation and effectively embedded.

4. The risk and control framework

Consistent with the recognition of risk at a strategic level, the Commission developed a risk register to monitor where risks might arise and how they were mitigated. In the register, risks were identified at an operational level and consolidated to identify themes arising across the organisation. The Executive Team and the Commission reviewed the risk register for completeness. The Audit Committee reviewed the application of the risk management process.

Management of risk had not been seen as the preserve of any one part of the organisation. Whilst the Commissioners and Chief Executive were ultimately responsible for any events which may not have been foreseen or which were not properly managed, all members of the organisation had a responsibility for anticipating and managing risk effectively.

The Commission continued to review and strengthen its framework for control during the year. They adopted the Treasury's framework for assessing the management of risk in public bodies. The principal features and key controls included:

- A formal system of governance comprising of standing orders and standing financial instructions which supported and regulated how the Commission conducted its business. This included a schedule of delegation showing which functions were retained for determination by the Commissioners and which were delegated to the Chief Executive.
- An organisational structure that supported clear lines of communication and accountability.
- Business strategies that were approved by the Commission and were subject to consultation with stakeholders of the Commission.

- Clear processes, so that the risks that were identified were incorporated into an overall structure for risk management.
- Embedded methods of performance measurement based on evaluation of a balanced scorecard.

The risks and issues associated with transition to the Care Quality Commission were clearly identified and managed. This included ensuring the effective handover of key processes (baton handling) and a clear identification of liabilities and assets in a Transfer Scheme.

5. Information assurance, governance and security
2008/09 saw significant changes in the way in which information assurance and governance was perceived and undertaken within the organisation. In line with the Cabinet Office Information Governance Action Plan, the Commission:

- Increased the awareness of governance and security at all levels.
- Executive Team signed a "Statement of Commitment to Information Security".
- Regular updates were sent to staff through all available channels.
- Received regular input from the Security Manager to the Audit Committee.
- Implemented hard drive encryption on all laptops.
- Restricted usage of USB devices, and implemented encryption to writeable USB devices on all laptops and desktops.
- Established a dedicated programme for the implementation and monitoring of Cabinet Office data handling requirements.
- Updated all policies to reflect the importance of security.
- Engaged with project teams from an early stage to ensure that security is built in.
- Published a security leaflet and distributed it to all staff.

It is worthy of note that the staff of the Commission embraced their involvement in the new security conscious sector and the number of questions about governance, assurance and security from within increased.

6. Serious untoward incidents
There were two serious untoward incidents connected with information:

1) In July 2008, a complaints file was requested for retrieval from archive, for return to the Commission's Manchester office. The archive company incorrectly labelled the package for delivery to the Commission's London office. This error was further compounded as the package did not arrive at the London office. The security team were notified immediately, and instigated a search to confirm that the package had not been received at any Healthcare Commission location. The Department of Health Arms Length Body Business Support Unit (ALB BSU) were then informed of the situation, as the data involved was patient level

information. The courier company involved escalated the issue, and the package was located in a depot near to the Healthcare Commission's London office. The package was then fast-tracked to Manchester, where the contents were checked, and found to be complete.

In reviewing the events, the security team concluded that the loss and subsequent recovery occurred outside of the direct control of the Healthcare Commission, and that the Commission had undertaken its role in the process of recovery appropriately. It was agreed that the procedures developed by the Security Team were fit for purpose, and that no update was required at this time. The archive contract was established by the Department of Health, and the records management team from the Commission and their counterparts at the Department of Health were subsequently involved in the process of updating the performance requirements of that contract.

2) In November 2008, a USB memory stick was used to transport presentations to be undertaken by the legal team from the Commission's London office to an off-site location. The contents of the USB device were fully encrypted. The loss of the USB stick was discovered at the end of the session. The security team were informed, and requested copies of the information that had been transported on the USB stick. Reviewing the data, the Information Governance manager and the Security Manager found the content of the three presentations to be based entirely upon information that was in the public domain.

In reviewing the events, the Head of Legal distributed further advice to the legal team with regards to the handling of USB sticks. There was one specific item that was highlighted to staff as being a risk never to be repeated, but the nature of the information in this instance controlled the risk.

7. Review of effectiveness

The Accounting Officer of the Healthcare Commission had responsibility for reviewing the effectiveness of the system of internal control. The review of the effectiveness of the system of internal control was informed by the work of the internal auditors and the executive team within the Commission who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their management letter and other reports. The Accounting Officer of the Healthcare Commission was advised on the implications of the result of her review of the effectiveness of the system of internal control by the Commission, the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system was in place.

The process that the Commission had maintained to ensure internal control during the year included both the management of risk and other sources of assurance, including internal audit monitoring against the operating plan and balance scorecard. The Commission's internal audit function had regular access to the Chief Executive, the executive team and the chair of the audit committee, and were invited to every meeting of the audit committee. The activities of the audit committee were in turn regularly reported to the full Commission.

The respective responsibilities are set out below.

Audit Committee
The Audit Committee met six times in 2008/09. Its terms of reference were:

- To review the establishment and maintenance of an effective system of internal control and risk management.
- To recommend to the Commission the appointment (and dismissal) of the head of internal audit, approve the internal audit operating plan and receive and monitor progress upon all reports which the internal auditors issue regarding the Commission.
- To review the delivery and outcome of the external audit function, including the management letter and management's progress in the implementation of external audit recommendations.
- To ensure that the Commission's financial statements complied with best accounting practice and relevant accounting standards.

The membership of the audit committee at 31 March 2009 comprised of:

- Dr Sarah Blackburn
- Claire Dodgson
- Michael Hake
- John Scampion (Chair)
- Charles Goody
- Patrick Boyle

The Commission
The Commission had responsibility for overseeing governance. It received the minutes of the audit committee at each of its meetings and invited the chair of the audit committee to comment on any issues which may have warranted further discussion. In this way, the Commission exercised its responsibility to review the accounting officer's delivery of her duties.

The Executive Team
This team had responsibility for overseeing delivery against plan and balanced scorecard and risk management within the Commission. The culture of risk management within the Commission was determined at a strategic level. The executive team reviewed all significant risks that had been identified and ensured that they have been fairly stated. It also satisfied itself that the less significant risks were being actively managed by relevant managers, with the appropriate controls in place and that these controls were working effectively.

In her regular meetings with individuals of the executive team, the Accounting Officer sought assurance from them that they were taking individual and corporate responsibility for the deliverables and the management of risk in their respective areas of work.

Internal audit reports were addressed to the appropriate member of the executive team and significant issues were brought to the team's attention.

Internal and external audit
The Commission had an internal audit service provided by South Coast Audit. The head of internal audit reported to the audit committee and accounting officer regularly to standards defined in the Government Internal Audit Standards. Those reports included the internal auditor's independent opinion on the adequacy and effectiveness of the Commission's system of internal control, together with the recommendations for improvement. The Commission also encouraged and endorsed liaison between internal and external audit to achieve a more effective audit, based on a clear understanding of respective roles and requirements.

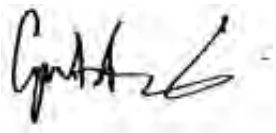
The Healthcare Commission's internal auditors expressed their opinion based on work undertaken during the year to 31 March 2009. Their overall opinion was that the Healthcare Commission had maintained a position where a satisfactory level of assurance could be given and no issues were identified or recommendations raised as part of the review. In discussion with internal auditors, they acknowledged that the Healthcare Commission had made adequate improvements to all previously identified aspects of risk, but that slight improvements would have been made to enhance the adequacy and/or effectiveness of risk management, control and governance.

Both internal and external audit were invited to all meetings of the audit committee. In recognition that the Commission worked in an increasingly complex environment, the Healthcare Commission ensured that a number of audit days within the annual audit plan were dedicated to issues around transition.

Assurance obtained by the Care Quality Commission's Accounting Officer
I have obtained assurance from the Healthcare Commission Chief Executive, who was responsible as Accounting Officer for the activities relating to the period up to 31 March 2009. I will also take into account the annual report of the Healthcare Commission's internal auditors, National Audit Office reports, an interim Statement on Internal Control signed by the Accounting Officer for the Healthcare Commission and covering the year to 31 March 2009 and any other information I become aware of in the period 1 April 2009 to the date of signing these accounts. Additionally I have instigated an independent review of these accounts to support my role as Accounting Officer from 1 April 2009.

8. Significant internal control breakdowns
No significant internal control breakdowns have been identified in the accounting year and subsequent period prior to the signing of the accounts.

Signed:



Name: Cynthia Bower

Position: Chief Executive, Care Quality Commission

Date: 24 June 2009

The certificate and report of the Comptroller and Auditor General to the Houses of Parliament

I certify that I have audited the financial statements of the Healthcare Commission for the year ended 31 March 2009 under the Health and Social Care Act 2008 (Commencement No.9, Consequential Amendments and Transitory, Transitional and Saving Provisions) Order 2009. These comprise the Operating Cost Statement, the Statement of Recognised Gains and Losses, the Balance Sheet and the Cash Flow Statement 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 Commission, Chief Executive and auditor
The Commission and Chief Executive as Accounting Officer are responsible for preparing the Annual Report, the Remuneration Report and the financial statements in accordance with The Health and Social Care Act 2008 (Commencement No.9, Consequential Amendments and Transitory, Transitional and Saving Provisions) Order 2009 and directions made by the Secretary of State with the approval of HM Treasury and for ensuring the regularity of financial transactions. These responsibilities are set out in the Statement of Accounting Officer's Responsibilities.

My responsibility is to audit the financial statements and the part of the remuneration report to be audited in accordance with relevant legal and regulatory requirements, and with International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the Health and Social Care Act 2008 (Commencement No.9, Consequential Amendments and Transitory, Transitional and Saving Provisions) Order 2009 and directions made by the Secretary of State with the approval of HM Treasury. I report to you whether, in my opinion, the information, which comprises the Statement on Corporate Governance 2008-09 and the Management Commentary included in the Annual Report is consistent with the financial statements. I also report whether in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

In addition, I report to you if the Commission has not kept proper accounting records, if I have not received all the information and explanations I require for my audit, or if information specified by HM Treasury regarding remuneration and other transactions is not disclosed.

I review whether the Statement on Internal Control reflects the Commission's compliance with HM Treasury's guidance, and I report if it does not. I am not required to consider whether this statement covers all risks and controls, or form an opinion on the effectiveness of the Commission's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and the unaudited part of the Remuneration Report and consider whether it is consistent with the audited financial statements. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinions

I conducted my audit in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. My audit includes examination, on a test basis, of evidence relevant to the amounts, disclosures and regularity of financial transactions included in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgments made by the Commission and Accounting Officer in the preparation of the financial statements, and of whether the accounting policies are most appropriate to the Commission's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that the financial statements and the part of the Remuneration Report to be audited are free from material misstatement, whether caused by fraud or error, and that in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Opinions

In my opinion:

- the financial statements give a true and fair view, in accordance with the Health and Social Care Act 2008 (Commencement No.9, Consequential Amendments and Transitory, Transitional and Saving Provisions) Order 2009 and directions made by the Secretary of State with the approval of HM Treasury, of the state of Commission's affairs as at 31 March 2009 and of its net expenditure, recognised gains and losses and cash flows for the year then ended;
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the Health and Social Care Act 2008 (Commencement No.9, Consequential Amendments and Transitory, Transitional and Saving Provisions) Order 2009 and directions made by the Secretary of State with the approval of HM Treasury; and
- information, which comprises the Statement on Corporate Governance 2008-09 and the Management Commentary, included within the Annual Report, is consistent with the financial statements.

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

Report
I have no observations to make on these financial statements.

Amyas C E Morse
Comptroller and Auditor General

National Audit Office
151 Buckingham Palace Road
Victoria
London SWIW 9SS

Date: 7 July 2009

The maintenance and integrity of the Care Quality Commission's website is the responsibility of the Accounting Officer; the work carried out by the auditors does not involve consideration of these matters and accordingly the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

Financial statements and notes

Operating cost statement

		Year to 31/03/09			Year to 31/03/08 (restated)		
		Continuing operations £000s	Discontinued operations (17) £000s	Total £000s	Continuing operations £000s	Discontinued operations (17) £000s	Total £000s
Gross operating costs	Note						
Staff costs	2	40,471	5,676	46,147	37,138	7,551	44,689
Other operating costs	3	19,255	2,451	21,706	19,397	6,994	26,391
Depreciation and amortisation	5	4,778		4,778	2,526		2,526
Notional capital charges	1v	231		231	143		143
		64,735	8,127	72,862	59,204	14,545	73,749
Less income							
Fee income	4i	8,456		8,456	7,863		7,863
Other income	4ii	813		813	858		858
		9,269	0	9,269	8,721	0	8,721
Net operating cost				**63,593**			**65,028**
Exceptional item:							
Terminations of employment				4,177			2,240
Net operating cost				**67,770**			**67,268**

The notes on pages 100 to 119 form part of these accounts

Statement of recognised gains and losses

	Note	Year to 31/03/09 £000s	Year to 31/03/08 £000s
Unrealised gains on fixed asset indexation	5	17	176

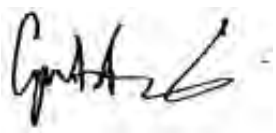
The notes on pages 100 to 119 form part of these accounts

Balance sheet

	Note	Year to 31/03/09 £000s	Year to 31/03/09 £000s	Year to 31/03/08 £000s	Year to 31/03/08 £000s
Fixed assets					
Tangible fixed assets	5		3,690		8,108
Intangible fixed assets	5		7,132		3,667
			10,822		11,775
Current assets					
Debtors: falling due within one year	6	4,649		3,362	
Cash at bank and in hand	7	4,401		6,213	
		9,050		9,575	
Current liabilities					
Creditors: falling due within one year	8	7,101		7,782	
Net current assets			1,949		1,793
Total assets less current liabilities			12,771		13,568
Creditors: falling due after one year	8		(1,055)		0
Provisions	9		(871)		(584)
Total net assets			**10,845**		**12,984**
Capital and reserves:					
Operating costs reserve	10 i)		10,604		12,555
Revaluation reserve	10 ii)		241		429
			10,845		**12,984**

The notes on pages 100 to 119 form part of these accounts

Signed:



Name: Cynthia Bower

Position: Chief Executive, Care Quality Commission

Date: 24 June 2009

Cash flow

	Note	Year to 31/03/09 £000s	Year to 31/03/09 £000s	Year to 31/03/08 £000s	Year to 31/03/08 £000s
Net cash outflow from operating activities	11		(62,016)		(67,600)
Capital expenditure and financial investment					
Payments to acquire fixed assets			(5,181)		(4,745)
Net cash outflow before financing			(67,197)		(72,345)
Financing					
Sale proceeds of Fixed Assets		2		4	
Government grant received:					
Revenue	10	61,383		65,132	
Capital	10	4,000	65,385	4,800	69,936
(Decrease) in cash at bank and in hand	**7**		**(1,812)**		**(2,409)**
Note					
Fixed Asset expenditure	5		4,439		5,409
Adjust decrease (increase) in Fixed Asset accruals	8		837		(414)
Adjust (increase) in Fixed Asset provisions	9		(95)		(250)
Payments to acquire fixed assets			5,181		4,745

The notes on pages 100 to 119 form part of these accounts

Notes to the accounts

1. Accounting policies

i) Accounting convention

The financial accounts cover the period 1 April 2008 to 31 March 2009.

These accounts have been prepared under the modified historic cost convention, in accordance with the Healthcare Commission Financial Memorandum, Accounts Direction issued by the Secretary of State with the approval of HM Treasury and in accordance with applicable accounting standards. The Income and Expenditure account has been named as the Operating Cost Statement in accordance with accounting guidance.

ii) Income

Income is made up of statutory fees from the registration of private and voluntary healthcare providers and other income arising mainly from secondments of Commission staff and recoveries of costs from other public bodies

Registration and inspection fees are payable on application and then annually in accordance with fee rates prescribed by the Secretary of State for Health. Application fees are recognised on application after initial checks and a review. Annual fee rates are set at levels that try to minimise cross-subsidy between categories of registered bodies and invoiced on the registration renewal date and recognised in full on invoice. Annual fees are refundable on de-registration in accordance with the published fee rebate policy.

iii) Value added tax (VAT)

The Commission was registered for value added tax as vat-rated income (primarily from recharging the costs of staff on secondment) exceeds the vat registration threshold. Income is reported exclusive of output vat where applicable. VAT is not charged on any of the Commission's regulation based independent healthcare fees and charges. Expenditure reported in these statements is inclusive of VAT.

iv) Fixed assets

Fixed assets are shown in the balance sheet at cost less accumulated depreciation and amortisation. Assets are revalued annually using the Office of National Statistics current price index.

Tangible fixed assets include office refurbishment, furniture, fittings, plant and machinery and IT infrastructure including IT assets in development with an expected working life of more than one year. All assets falling into these categories with a value of £5,000 or more have been capitalised together with the costs of staff and contractors working on capital projects.

Assets are capitalised as a group where the value of individual assets is less than £5,000, provided that the total value of all assets of that type exceeds £5,000. General project management costs have not been capitalised.

Intangible fixed assets include purchased computer software where expenditure of £5,000 or more has been incurred.

i) Depreciation and amortisation
Depreciation and amortisation are provided on fixed assets held at the year end on a straight-line basis, at rates calculated to write off the cost, less any residual value, over their estimated useful lives as follows:

- Office refurbishments – the unexpired period remaining on the lease up to 15 years.
- Furniture and fittings – 10 years.
- Plant and machinery – five years.
- IT infrastructure and intangible assets – three to four years.
- Depreciation and amortisation is charged on a monthly basis commencing from the month following the date on which an asset is brought into use.

ii) Indexation
RPI Indexation has been applied to building assets and for all other assets from the Office for National Statistics publication *Price index numbers for current cost accounting (MM17)*.

v) Notional cost of capital
A notional cost of capital has been calculated in accordance with HM Treasury requirements at a rate of 3.5% on the average value of capital employed during the year. The notional cost of capital for the period to 31 March 2009 was £231,000 (2008 £143, 000).

vi) Pension costs
The Commission provided two pension schemes for staff. Details of the schemes are provided in the Remuneration report and in note 2 to the financial statements.

vii) Leases
Rental payable under operating leases are charged to the income and expenditure account on a straight-line basis over the lease term.

2. Employee information

i) Staff costs

	Year to 31/03/09 £000s	Year to 31/03/08 £000s
Wages and salaries (including Commissioners)	28,544	30,319
Secondments, temporary and interim staff	10,734	7,252
* Employers national insurance	2,472	2,845
* Employers pension costs	3,773	3,805
Staff costs recharged	624	577
Provision released		(109)
	46,147	**44,689**

In addition, staff costs of £115,000 relating to 6 staff were capitalised during 2008/09 (£306,000 2007/08).

* National insurance and pension costs relate to directly employed staff only and any lay reviewers included on the Commission's payroll. Figures are not available for seconded staff paid through their "substantive" employer's payroll.

During 2008/09, a total of 3,638 days were lost due to sickness of which 70% (65% 2007/08) was due to long term illness. An average of 7 working days were lost per person (6 days in 2007/08)

Proportion lost to	2008/09	2007/08
Mental health	25.35%	22.37%
Muscular skeletal	22.78%	12.97%
Respiratory	5.98%	3.63%
All others	16.33%	21.15%
Cold/Viral/Ingestion	21.46%	35.20%
Unknown/Ill defined	8.10%	4.68%
Grand total	**100.00%**	**100.00%**

ii) Average number of employees during year

The average number of whole time equivalent employees, including secondees and agency staff by category of employment was:

	Year to 31/03/09	Year to 31/03/08
	whole time equivalents	whole time equivalents
Managerial	7	7
Support staff	655	675
Secondments, temporary and interim staff	181	139
	843	**821**

iii) Pension benefits

The principal pension scheme for staff who transferred from the Commission for Health Improvement and the National Care Standards Commission and for staff recruited directly by the Commission is the NHS pension scheme. Staff who transferred to the Commission from the Department of Health and the Audit Commission at 1 April 2004 are eligible to join the Principal Civil Service Pension Scheme. New staff were also eligible to remain within the Principal Civil Service Pension Scheme if they are already members.

(i) NHS Pension Scheme
Details of the benefits payable under the scheme provisions can be found on the NHS Pensions website at **www.pensions.nhsbsa.nhs.uk**.

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

The Scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and a FRS17 accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the Scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the Scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) FRS17 Accounting valuation
In accordance with FRS17, a valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the balance sheet date by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the Scheme Actuary. At this point the assumptions regarding the composition of the Scheme membership are updated to allow the Scheme liability to be valued.

The valuation of the Scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

Scheme provisions as at 1 April 2008

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last three years pensionable pay for each year of service. A lump sum normally equivalent to three years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the Commission commits itself to the retirement, regardless of the method of payment. The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/ member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made. From 1 April 2008 changes have been made to the NHS Pension Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pensions website **www.pensions.nhsbsa.nhs.uk**.

Contributing Healthcare Commission membership during 2008/09 was 570 (542 in 2007/08) and for 2008/09, employers contributions of £3.2m (£3.2m in 2007/08) were payable to the scheme.

(ii) Principal Civil Service Pension Scheme

From 1 October 2002, civil servants and others approved by the Cabinet Office, including certain designated staff of the Healthcare Commission, may be in one of three statutory based 'final salary' unfunded multi-employer defined benefit schemes (Classic, Premium, and Classic Plus). The schemes are unfunded, with the cost of benefits met by monies voted by Parliament each year. Entrants after 1 October 2002 may choose to join a 'money purchase' stakeholder arrangement with a significant employer contribution (partnership pension account). Pensions payable under Classic, Premium, and Classic Plus are increased annually in line with changes in the Retail Prices Index. Employee contributions are set at the rate of 1.5% of pensionable earnings for Classic and 3.5% for Premium and Classic Plus.

Benefits in classic accrue at the rate of 1/80th of pensionable salary for each year of service. In addition, a lump sum equivalent to three years' pension is payable on retirement. For Premium, benefits accrue at the rate of 1/60th of final pensionable earnings for each year of service. Unlike Classic, there is no automatic lump sum (but members may give up (commute) some of their pension to provide a lump sum). Classic Plus is essentially a variation of Premium, but with benefits in respect of service before 1 October 2002 calculated broadly as per Classic.

The partnership pension account is a stakeholder pension arrangement. The employer makes a basic contribution of between 3% and 12.5% (depending on the age of the member) into a stakeholder pension product chosen by the employee. The employee does not have to contribute but where they do make contributions, the employer will match these up to a limit of 3% of pensionable salary (in addition to the employer's basic contribution). Employers also contribute a further 0.8% of pensionable salary to cover the cost of centrally provided risk benefit cover (death in service and ill health retirement). Further details about the Civil Service Pension arrangements can be found at the website **www.civilservice-pensions.gov.uk**

Contributing membership during 2008/09 was 42 (49 in 2007/08) and for 2008/09, employers contributions of £0.6m (£0.6m in 2007/08) were payable to the scheme.

3. Other operating costs

Other operating costs include:	Year to 31/03/09 £000s	Year to 31/03/08 £000s
Communications	2,161	2,024
Consultancy and prof fees:		
Clinical audit	131	4,688
Legal fees	516	260
Other consultancy and professional fees	4,159	4,719
External audit*	71	59
IT costs, including general project management	1,935	1,726
Losses and special payments	151	17
Premises and facilities	3,159	2,773
Staff recruitment, training and development	2,059	3,264
Travel and subsistence	2,173	2,175
Operating leases:		
Equipment	2	7
Premises	4,000	4,122
Other costs	560	379
Impairment of fixed assets	576	167
Losses on disposal of fixed assets	53	11
	21,706	**26,391**

*The audit fee represents the cost for the audit of the financial statements carried out by the Comptroller and Auditor General. This amount does not include fees in respect of non-audit work and no such work was undertaken.

Notional insurance
Under the terms of its accounts direction from the Secretary of State for Health the Commission did not carry commercial insurance but met any insurance losses arising in the year up to 5% of its grant-in-aid. Losses arising from insurable claims during the year were Nil (2007-2008 below £1,000).

4. Income

Fees and charges made to the independent sector are in line with fee scales prescribed by the Secretary of State for Health under the Care Standards Act 2000. Fee levels were reviewed and in some cases increased following annual fee consultation exercises.

As detailed in Note 1 ii) annual registration fees are invoiced on the anniversary of the registration and recognised in full in the accounting year invoiced. In cases of voluntary deregistration fees are refunded to registered organisations in accordance with the fee rebate scheme detailed on the Commission's internet site. There is no provision for the cost of potential fee rebates at 31 March 2009, fee income recognised in these accounts but relating to 2009/10 registration periods was estimated at £3.2m at 31 March 2009 (£3.1m at 31 March 2008).

	Year to 31/03/09 £000s	Year to 31/03/08 £000s
i) Fee income		
Registration and inspection fees and charges to the independent sector	**8,456**	**7,863**

	Year to 31/03/09 £000s	Year to 31/03/08 £000s
ii) Other income		
Recharge of staff	624	577
Other income - speakers fees etc.	9	26
Legal costs recovered	0	0
Grants to commission research	180	255
	813	**858**

5. Fixed assets

	Office refurb. £000s	Furniture & fittings £000s	Plant & machinery £000s	Information technology £000s	Assets under construction £000s	Total tangible assets £000s	Intangible assets £000s
Cost or valuation							
Bal 1 April 2008	5,417	987	668	3,244	3,589	13,905	6,220
Additions in year	95	0	15	164		274	4,165
Transfers		(6)		234	(3,542)	(3,314)	3,314
Disposals in year	(90)	(137)	(123)	(2,014)		(2,364)	(188)
Indexation	44	(52)	(9)			(17)	
Impairment				667	(47)	620	(111)
Bal 31 March 2009	**5,466**	**792**	**551**	**2,295**	**0**	**9,104**	**13,400**
Depreciation							
Bal 1 April 2008	2,333	693	455	2,316	0	5,797	2,553
Depreciation and amortisation in year	459	106	71	596		1,232	3,546
Transfer		(6)		6		0	
Disposals in year	(83)	(134)	(97)	(1,995)		(2,309)	(188)
Indexation	14	(41)	(7)			(34)	
Impairment				728		728	357
Bal 31 March 2009	**2,723**	**618**	**422**	**1,651**	**0**	**5,414**	**6,268**
Net book value 31 March 2009	**2,743**	**174**	**129**	**644**	**0**	**3,690**	**7,132**
Net book value 31 March 2008	**3,084**	**294**	**213**	**928**	**3,589**	**8,108**	**3,667**

6. Debtors

	Year to 31/03/09 £000s	Year to 31/03/08 £000s Restated
Amounts falling due within one year		
Trade debtors	1,533	1,203
Advances - staff loans	118	134
Prepayments and accrued income	1,631	1,780
Other debtors	1,367	245
	4,649	**3,362**

Staff loans are for season tickets, bicycle purchase and gym membership.

No member of staff received loans in excess of £5,000.

Intra-governmental balances		
Balances with Central Government	1,179	275
Balances with NHS trusts	0	53
Balances with local authorities	547	521
Balances with public corporations and trading funds	0	0
Balances with bodies external to Government	2,923	2,513
	4,649	**3,362**

7. Analysis of cash and bank balances and changes during the year

	1/04/2008 £000s	Cashflow £000s	31/03/2009 £000s
Paymaster general	6,209	(1,808)	4,401
Cash balances	4	(4)	0
	6,213	**(1,812)**	**4,401**

8. Creditors

	Year to 31/03/09 £000s	Year to 31/03/08 £000s
a) Amounts falling due within one year		
Trade creditors	3,188	2,864
Taxation and national insurance	989	869
Accruals and deferred income:		
Staff & operating costs	497	2,476
Terminations of employments	1,932	273
Fixed assets	18	855
Other creditors	477	445
	7,101	**7,782**
Intra-governmental balances		
Balances with Central Government	1,599	1,048
Balances with NHS trusts	155	63
Balances with local authorities	1	0
Balances with public corporations and trading funds	2,506	437
Balances with bodies external to Government	2,840	6,234
	7,101	**7,782**
b) Amounts falling due after one year		
Accruals and deferred income:		
Terminations of employment	**1,055**	**0**
All balances with Public Corporations & Trading Funds		

9. Provisions

	Lease dilapidations £000s	Redundancy & termination costs £000s	Legal costs £000s	Total £000s
Bal 1 April 2008	250	334	0	584
Provided in year	108	481	32	621
Paid in year	0	(334)		(334)
Bal 31 March 2009	**358**	**481**	**32**	**871**

Lease dilapidations

Leases of Bristol and Leeds premises expired during 2009/10. Leases of Finsbury Tower offices expire in 2020.

The anticipated costs of Finsbury Tower dilapidations is being depreciated over the remaining lifetime of the leases.

Provisions at 31 March 2009 were:

Bristol & Leeds leases	£13k
Finsbury Tower leases	£345k

Redundancy costs

Redundany provisions are the anticipated costs arising from notices of redundancy issued prior to 31 March 2009 but where service will continue into 2009-10. The provision includes the estimated costs of payments to the pension funds where staff have been entitled to claim a pension prior to their normal retirement date.

Legal costs

Legal costs represent the anticipated costs to complete cases which were unresolved at 31 March 2009.

10. Reserves

	Year to 31/03/09 £000s		Year to 31/03/08 £000s	
i) Operating cost reserve				
Balance at 1 April 2008		12,555		9,748
Government grants received				
Revenue grant in aid	61,383		62,229	
Grant transferred to NCASP	0		2,903	
	61,383		65,132	
Capital grant in aid	4,000		4,800	
	65,383		69,932	
Less net expenditure for the period	(67,770)		(67,268)	
		(2,387)		2,664
Non Cash				
Capital charges written back		231		143
Revaluation reserve released		205		
Balance at 31 March 2009		**10,604**		**12,555**
ii) Revaluation Reserve				
Balance at 1 April 2008		429		253
Indexation increase in the year		17		176
Released to operating cost reserve		(205)		
Balance at 31 March 2009		**241**		**429**

11. Reconciliation of net operating cost to net cash outflow from operating activities

	Year to 31/03/09 £000s	Year to 31/03/08 £000s
Net operating cost for the financial year	(67,770)	(67,268)
Depreciation	4,778	2,526
Notional capital charge	231	143
Downward revaluation of fixed assets	576	167
Losses on disposal of fixed assets	53	11
(Increase) decrease in debtors	(1,287)	373
Increase (decrease) in revenue creditors	156	(3,277)
Increase in creditor's due after one year	1,055	0
Increase (reduction) in revenue provisions	192	(275)
Net cash outflow from operating activities	**(62,016)**	**(67,600)**

12. Operating leases

Commitments under operating leases to pay rentals during the year following these accounts are given in the table below, analysed according to the period in which the lease expires.

	Note	Year to 31/03/09 £000s	Year to 31/03/08 £000s
Land and buildings			
Leases which expire within one year		46	425
Leases which expire within two to five years		0	1,741
Leases which expire after five years	9	1,744	1,744
		1,790	**3,910**
Other leases			
Leases which expire within one year		0	3
Leases which expire within two to five years		0	0
Leases which expire after five years		0	0
		0	**3**

Dilapidation provisions have been created on the above leases as set out in note 9.

13. Capital commitments

The Healthcare Commission's capital expenditure was controlled by the Department of Health for the year to 31 March 2009. The Commission had the following capital commitments, based on orders in place, at 31 March 2009:

	31/03/09 £000s	31/03/08 £000s
Expenditure contracted but not provided	Nil	Nil
Expenditure authorised but not contracted	Nil	Nil

14. Contingent liabilities

The following contingent liabilities have been identified at the Balance Sheet date (£nil 2008):

Regulatory actions.
Three cases are in progress which arose from the Commission's work on regulation of the Independent Healthcare sector. The cases involve defending an application for judicial review, bringing proceedings to cancel a registration and prosecuting an unregistered provider. Costs are estimated to not exceed £100,000 in total.

Employment tribunals
One tribunal case was in progress at 31 March 2009. The case involved a complaint involving wrongful dismissal and was not expected to result in a material liability.

15. Related party transactions

All Commissioners and senior staff formally declare potential conflicts of interest each year and also during any decision making process in which a conflict arises. The individual then takes no further part in the decision making. None of the members of the Commission or senior staff or other related parties have undertaken any material transactions with the Commission during the year.

Department of Health
The Healthcare Commission is a non-departmental public body sponsored by the Department of Health. The Department of Health is regarded as a related party.

From 1 April 2009, the Healthcare Commission, CSCI and MHAC transferred activities, assets and liabilities to the Care Quality Commission. Transactions between the Healthcare Commission and these bodies during the financial year were as follows:

	Year to 31/03/09 £000s	Year to 31/03/08 £000s
Department of Health - Income		
Grant in Aid – Revenue	61,383	62,229
Grant in Aid – Capital	4,000	4,800
Commissioned work	150	10
Reimbursement of set-up costs for CQC	1,801	
	67,334	67,039
Department of Health - Expenditure:		
Staff secondments	160	190
Set-up costs for CQC	1,801	
Consultancy		60
	1,961	250
Other bodies:	CSCI	MHAC
Staff secondments – Out	41	135
Staff secondments – In	8	
Non-pay costs reimbursed	98	171

The Commission has had a small number of transactions with other Government Departments and other central government bodies. Balances at 31 March 2009 are shown in notes 6 and 8.

16. Financial instruments

FRS 25, 26 and 29 regarding Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The Healthcare Commission was not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 25, 26 and 29 mainly apply.

Derivatives and other Financial Instruments required disclosure of the role which financial instruments have had during the period in creating or changing the risks the Healthcare Commission faced in undertaking its activities.

Interest Rate Risk
Interest rate is not significant, as the Healthcare Commission has no borrowings or material interest bearing deposits.

Liquidity Risk
The Healthcare Commission had no borrowings and relied on the grants from the Department of Health for its cash requirements and was therefore not exposed to liquidity risks.

Currency Risk
All material assets and liabilities are denominated in sterling so the Healthcare Commission was not exposed to currency risk.

Credit Risk
The Healthcare Commission is not exposed to credit risk.

17. Discontinued activities

Discontinued activities comprise the NHS 2nd tier complaints function which ceased as a regulatory function on transfer to the Care Quality Commission on 31 March 2009. Clinical Audit surveys were commissioned by the Department of Health through NCASP to 31 March 2008. From 1 April 2008 the Commission ceased its supervisory role.

18. Post balance sheet events

The activities of the Healthcare Commission ceased on 31 March 2009. Most activities transferred from that date to the Care Quality Commission, the hearing of 2nd tier complaints within the NHS ceased on 31 March 2009 and the related costs are reported as discontinued activities.

The financial statements and notes were signed by Cynthia Bower as accounting officer on 24 June 2009 and authorised to be issued on 7 July 2009.

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Healthcare Commission

On 1 April 2009, the Care Quality Commission took over the Healthcare Commission's work.

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