The Council for Healthcare Regulatory Excellence

Annual report and accounts

2011/12

Annual report volume I

council for healthcare regulatory excellence

The Council for Healthcare Regulatory Excellence

Annual report volume I: Annual report and accounts 2011/12

(Associated with this document is the Annual report volume II: Performance review of 2011/12.)

Presented to Parliament pursuant to schedule 7, paragraph 16 (2) of the National Health Service Reform and Health Care Professions Act 2002, as amended by the Health and Social Care Act 2008.

Laid before the Scottish Parliament by the Scottish Ministers under the National Health Service Reform and Health Care Professions Act 2002, as amended by the Health and Social Care Act 2008.

Laid before the Northern Ireland Assembly in accordance with the National Health Service Reform and Health Care Professions Act 2002, as amended by the Health and Social Care Act 2008.

Laid before the National Assembly for Wales in accordance with the National Health Service Reform and Health Care Professions Act 2002, as amended by the Health and Social Care Act 2008.

Ordered by the House of Commons to be printed 28 June 2012.

council for healthcare regulatory excellence

HC 200-1
SG /2012/9-1
London: The Stationery Office

£38.50
2 volumes not sold separately

Any enquiries regarding this publication should be sent to us at **CHRE, 157-197 Buckingham Palace Road, London SW1W 9SP.**

This publication is also available from our website at **www.chre.org.uk**

ISBN: 9780102976038

Printed in the UK by The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office

ID 2478742 06/12

Printed on paper containing 75% recycled fibre content minimum

Contents

1. Chair's introduction

This annual report looks back over a period of both maintenance and planning and forward to a period of transition.

We have continued to deliver our statutory responsibilities to a high standard. The second volume of this annual report covers the performance review of the health professional regulators. We have also audited the early decisions on fitness to practise cases and reviewed a record 2,528 final determinations.

We have also, at the request of the Secretary of State for Health, undertaken two special reviews; an investigation into allegations made by the former chair of the General Dental Council, and a strategic review of the Nursing and Midwifery Council.

Our policy work has included commissions regarding the cost-effectiveness and efficiency of the professional regulators and to develop standards for members of NHS boards and governing bodies in England.

Our reviews and policy work continue to be shaped by the approach we set out in *Right-touch Regulation* and we are pleased that this way of approaching regulation is becoming widely accepted and indeed is attracting international interest.

The Health and Social Care Act 2012 has received royal assent. We have been planning for the implementation of our new roles for over a year. We are consulting on standards for the new scheme of assured voluntary registers of health and care occupations and on standards for appointments to the regulators' councils.

The timetable for implementation of our new responsibilities is becoming clearer as we complete this report. In this context I particularly want to thank the Council members and the work of the Audit and Risk Committee and Scrutiny Committee for overseeing our management of risk and maintenance of quality in uncertain times.

The Council could not do its work without the input of our excellent staff who have met deadlines, taken on extra work without complaint, managed uncertainty and consistently produced reports and policy papers of the highest quality. I am grateful to them all. In particular I wish warmly to acknowledge the contribution of our Chief Executive, Harry Cayton, whose skill, wisdom and sheer hard work have enabled CHRE to maintain its excellent performance in this challenging year.

Baroness Jill Pitkeathley
Chair

2. Council for Healthcare Regulatory Excellence

About CHRE

CHRE was set up in April 2003, by the National Health Service Reform and Health Care Professions Act 2002.[1]

The Health and Social Care Act 2008[2] created a new, smaller Council from 1 January 2009, comprising seven non-executive members and up to two executive members. (Details of Council membership are given on page 30.)

When the changes in the Health and Social Care Act 2012[3] have been fully implemented the Council will change to seven non-executive members and one executive member. The non-executive members will be appointed by the Privy Council, the Scottish and Welsh ministers and the Department of Health, Social Services and Public Safety in Northern Ireland.

CHRE has powers to:

- Audit the initial stages of fitness to practise cases and report on our findings in relation to each regulator
- Review the outcome of final fitness to practise cases and to refer them to court if we consider that the outcome is unduly lenient and fails to protect the public
- Investigate, compare and report on the performance of each regulatory body. We are specifically required to report to Parliament on how far each regulatory body has complied with any duty imposed on it to promote the health, safety and well-being of patients and members of the public
- Give directions requiring a regulatory body to make rules under any power the body has to do so
- Provide advice to the Secretary of State, the National Assembly for Wales, Scottish ministers or the Department of Health, Social Services and Public Safety in Northern Ireland on any matter connected with a health profession.

The 2008 Act gave us additional powers of scrutiny. We audit the processes used by the regulators to receive and screen complaints against individual health professionals.

We are funded by the Department of Health in England and by the devolved administrations in Northern Ireland, Scotland and Wales.

[1] Available at www.opsi.gov.uk/acts/acts2002/ukpga_20020017_en_1
[2] Available at www.opsi.gov.uk/acts/acts2008/ukpga_20080014_en_1
[3] Available at http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

What we do

We promote the health and well-being of patients and the public in the regulation of healthcare professionals. We scrutinise and oversee the work of the nine regulatory bodies that set standards for the training and conduct of healthcare professionals.

We share good practice and knowledge with the regulatory bodies, conduct research and introduce new ideas about regulation to the sector. We work closely with, and advise, the four UK government health departments on issues relating to the regulation of healthcare professionals. In addition, we monitor policy in the UK and Europe.

We promote good practice in the regulation of healthcare professionals in five main ways:

1. We monitor the performance of the regulatory bodies annually to identify good practice and areas for improvement
2. We audit initial stages of the regulatory bodies' fitness to practise procedures and examine final decisions made by them about whether healthcare professionals are fit to practise. In some cases we will refer decisions to court where we believe that such decisions are unduly lenient
3. We promote good practice in regulation, conduct research, share learning with regulatory bodies and hold events to explore better ways to manage new challenges
4. We advise the Secretary of State for Health and health ministers in Northern Ireland, Scotland and Wales on matters relating to the regulation of healthcare professionals
5. We keep abreast of European and international practice to improve policy decisions on UK regulation of healthcare professionals. Through our networks, we advise colleagues in other countries of the methods we have adopted for better regulation of UK healthcare professionals.

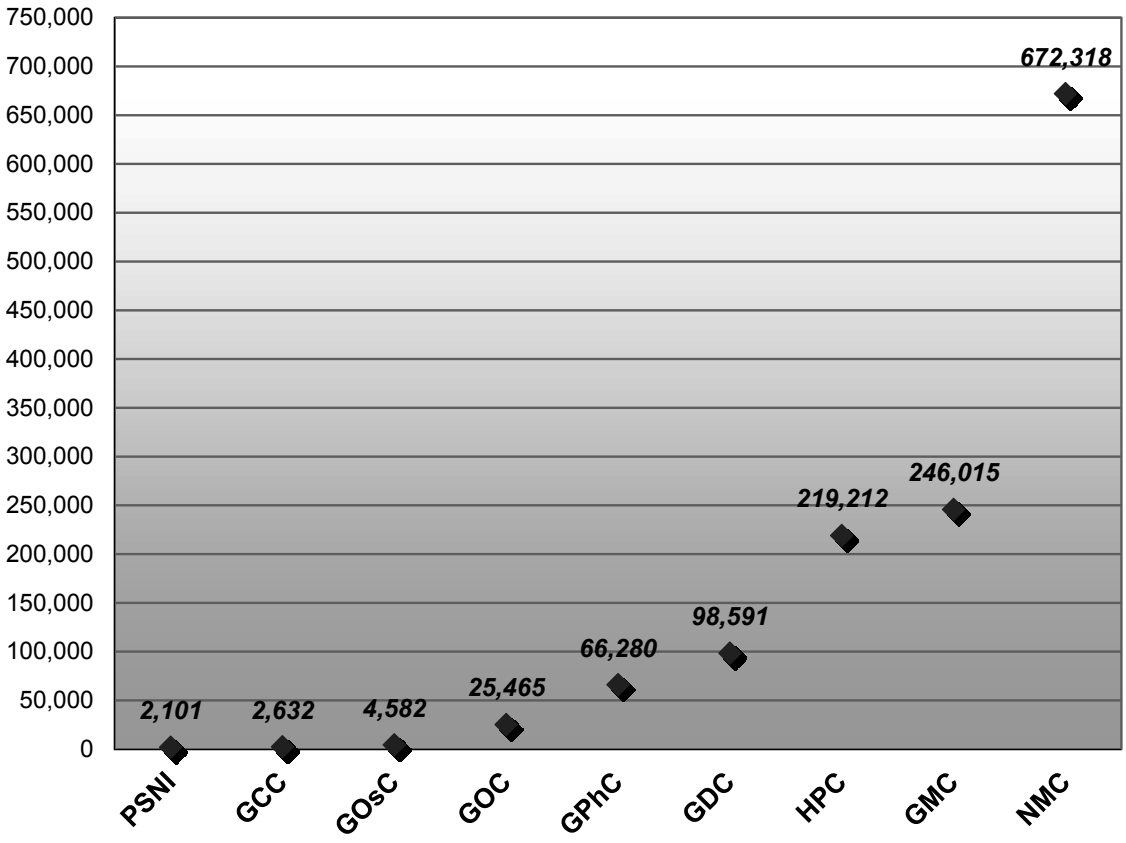
The nine regulators of healthcare professionals that we oversee are:

- The **General Chiropractic Council (GCC)**, which regulates chiropractors
- The **General Dental Council (GDC)**, which regulates dentists, dental hygienists, dental therapists, clinical dental technicians, orthodontic therapists, dental nurses and dental technicians
- The **General Medical Council (GMC)**, which regulates doctors
- The **General Optical Council (GOC)**, which regulates dispensing opticians and optometrists
- The **General Osteopathic Council (GOsC)**, which regulates osteopaths
- The **General Pharmaceutical Council (GPhC)**, which regulates pharmacists in Great Britain

- The **Health Professions Council (HPC)**, which regulates arts therapists, biomedical scientists, chiropodists and podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists and orthotists, radiographers, and speech and language therapists
- The **Nursing and Midwifery Council (NMC)**, which regulates nurses and midwives
- The **Pharmaceutical Society of Northern Ireland (PSNI)**, which regulates pharmacists in Northern Ireland.

Details of the number of registrants per health professional regulator at 31 March 2012 are shown below.

Number of registrants per health professional regulator



Contact details and web addresses for each of the regulators can be found on our website, www.chre.org.uk.

3. Strategic objectives 2012/13

In December 2011 we reviewed our strategic objectives in preparation for our transition to the Professional Standards Authority for Health and Social Care.

Our aims and objectives as we move forward to become the Professional Standards Authority are set out below.

For 2012/13 we have two overarching priorities:

- To fulfil our current and continuing statutory obligations
- To prepare and implement our new roles and responsibilities.

Our aim

We work to raise standards and encourage improvements in the registration and regulation of people who work in health and social care. We do this in order to promote the health, safety and well-being of patients, service users and other members of the public.

Our values

Our values act as a framework for our decision-making. They are at the heart of who we are and how we would like to be seen by our partners. We are committed to being:

- Focused on the public interest
- Independent
- Fair
- Transparent
- Proportionate.

Our values will be explicit in the way that we work; how we approach our oversight of the registration and regulation of those who work in health and social care, how we develop policy advice and how we engage with all our partners. We will be consistent in the application of our values in what we do.

We are independent but hold ourselves accountable to the public and to the parliaments and assemblies of the United Kingdom for what we do and how we do it.

We listen to the views of people who receive care. We seek to ensure that their views are acted upon in the registration and regulation of people who work in health and social care.

We promote and support right-touch regulation[4]. This is regulation that is based on an assessment of risk, which is targeted and proportionate, which provides a framework in which professionalism can flourish and organisational excellence can be achieved.[5] We will apply the principles of right-touch regulation to our own work.

Our strategic objectives are that we will be:

Contributing to the improvement of occupational standards and practice in health and social care by establishing the Professional Standards Authority as an independent, authoritative, effective, value for money organisation acting in the public interest.

We will do this through:

- Consistent application of our values
- Dialogue with patients and service users, the public and their representative organisations
- Being committed to inclusion, equality, diversity and human rights
- Promoting regulation's proper role in public safety
- Being clear and positive in our relationships with regulatory bodies and organisations holding voluntary occupational registers
- Active engagement with regulators and others both within and outside the health and social care sector
- Efficient business practices and cost-effective working
- Publishing annually our business plan and annual report and accounts.

We will know we have succeeded because:

- The regulatory bodies and others respect our advice and act on it
- We receive commissions from governments and others
- We have facilitated co-operation across regulatory bodies and between them and others
- The public, patients and service users have greater confidence in the regulation of health and social care
- Our financial basis is sound.

[4] *Right-Touch Regulation* http://www.chre.org.uk/policyandresearch/336/

[5] Organisational excellence is the consistent performance of good practise with continuous improvement.

Reporting clearly and openly on the effectiveness of regulatory bodies in the regulation of health and social care professionals in the interests of patients and the public.

We will do this by:

- Working with the health and social care professional regulators to deliver evidence-based, reliable assessment and robust oversight of their performance
- Reporting annually on the regulators' responses to our performance reviews and audits and on their implementation of our recommendations
- Using our statutory powers to audit and review fitness to practise cases appropriately, including the statutory right of appeal
- Responding appropriately to concerns and complaints raised with us and investigating and reporting openly when necessary
- Being proportionate and focused on outcomes
- Enabling good practice and learning to be shared
- Transparent, resolute and fair public reporting.

We will know we have succeeded because:

- We see good practice and improvement in the regulators
- Regulators respond to and act on our recommendations
- There is a continuing overall reduction in the concerns identified in our performance review and audits
- Our internal quality assurance demonstrates that we make the right decisions about possible appeals
- We have facilitated innovative and effective opportunities for sharing learning and good practice.

Enhancing public confidence in unregulated health and care occupations by creating a reliable and effective accreditation scheme for voluntary occupational registers, promoting quality in education and training, registration and standards of conduct.

We will do this by:

- Having clearly defined standards of entry to our voluntary registers accreditation scheme
- Ensuring that all holders of voluntary registers which we accredit continue to meet our standards
- Supporting and encouraging the holders of voluntary registers to meet the standards of the accreditation scheme and enabling them to join
- Promoting communication and co-operation between the holders of voluntary registers to share best practice
- Clarifying for, and communicating to, the public the difference between statutory regulation and voluntary registration

- Enabling the public and patients to make informed choices about the provision of health and social care
- Taking action against those holders of voluntary registers which fail to meet our standards
- Reviewing the effectiveness and efficiency of the scheme
- Ensuring that the scheme is value for money.

We will know we have succeeded because:

- Organisations which hold voluntary occupational registers will seek accreditation
- Unregulated workers in health and social care occupations will seek to join an accredited register
- Public, employers, providers and commissioners will seek services from people on a register that we have accredited
- The public and service users are generally clear about the difference between statutory regulation and accredited voluntary registration
- There is public recognition of our accreditation scheme for voluntary registers as a mark of quality in which they have confidence.

Building evidence and promoting debate in order to identify excellence in health and care professional regulation and registration, and to influence the wider field of regulatory policy.

We will do this by:

- Research and analysis of policy in regulation, health, and social care both in the UK and overseas
- Responding to commissions for advice from the Secretary of State for Health and the ministers in devolved administrations
- Identifying problems from our performance reviews and recommending solutions
- Publishing research, advice and guidance
- Promoting discussion, debate and learning through seminars and conferences
- Understanding the wider context of regulation including internationally
- Facilitating co-operation and collaboration between regulatory bodies and others.

We will know we have succeeded because:

- There is continuing and sustained demand for our policy advice and guidance from regulators, the holders of voluntary registers and others
- We continue to be commissioned by Department of Health and the devolved administrations to provide policy advice
- We have played an active role in delivering the government's reforms to professional and occupational regulation and registration
- An evidence base will be established around excellence in professionalism and right-touch regulation
- Other organisations, including the regulators, voluntary register holders and Department of Health take action to deliver our recommendations
- Our insight and experience is sought by the wider regulatory sector
- We are invited to contribute to seminars, conferences and other events
- We are asked to facilitate joint working.

4. Chief Executive's report

This annual report covers an important period for CHRE. It reports on our last year before the passage of the Health and Social Care Act 2012 and also reflects a period of preparation and transition to becoming the Professional Standards Authority for Health and Social Care. Throughout this transition period we have remained fully commited to the maintenance and performance of our exiting statutory responsibilities, while spending a great deal of time and effort preparing for our new responsibilities.

During the year we have also undertaken several significant commissions from the Department of Heath and devolved administrations. These include advice on the size of effective councils and a major project to develop standards for NHS boards and governing bodies in England

We carried out a progress review for the Nursing and Midwifery Council (NMC) which looked at the way they had implemented improvements in their fitness to practise processes and decision-making. Following further significant difficulties at the NMC we also commenced, at the request of the Parliamentary Secretary of State for Health and with the co-operation of the NMC, a major stratgic review which is ongoing at the time of preparing this report.

We have also been conducting an investigation into allegations made by the former Chair of the General Dental Council and this is reported on in more detail below.

The Health and Social Care Act 2012, which received royal assent in April 2012 states that the CHRE will continue to exist, albeit under the new name. The Act will result in significant changes to the organisation.

The Professional Standards Authority will be a public body with statutory duties and will be accountable to Parliament through the Privy Council. The current CHRE Council members will become the members of the new Authority.

The Authority is to be financed through a levy on the regulatory bodies that it oversees. It will also be able to generate income from other activities, for example, fees from the provision of advice and advisory services to the regulatory bodies and other similar organisations in the UK and abroad. Advice and investigations that are specifically commissioned by the Secretary of State and/or the devolved administrations will also be the subject of a separate fee. The quality assurance of voluntary registers, which in the long term will operate on a cost-recovery basis, will require government funding initially.

New powers arising from the 2012 Act

Assuring voluntary professional and occupational registration

The Authority will have an additional role in strengthening patient safety by setting standards for voluntary registers and quality assuring them. The Authority will ensure that such arrangements are coherent and underpin joint working across health and social care.

The purpose of the voluntary scheme is to encourage the development of professional conduct, ethical practice and high standards of performance in groups associated with or affiliated to the delivery of health and social care, where statutory regulation is not necessary to protect the public.

The regulation of social workers

The transfer of the regulation of social workers from the General Social Care Council (GSCC) to the Health and Care Professions Council (HCPC – the renamed Health Professions Council) will occur in July 2012.

This will result in an increase in the number of professionals regulated by the HCPC which will also result in an increase in the number of complaints and fitness to practise cases they handle.

Supporting the quality of appointments to regulators' councils

Section 227 of the Health and Social Care Act 2012 enables the Privy Council to make arrangements with the regulatory bodies and the Professional Standards Authority to assist it with its appointment functions. The professional regulators will be responsible for managing the process of appointment and reappointment of council members and chairs (and any related processes) in line with the requirements of their legislative frameworks, including their Constitution Orders, and will make recommendations to the Privy Council.

The Authority's role will be to advise the Privy Council about the process adopted by the regulators in recommending an appointment. Having received the Authority's advice about the process, the Privy Council can then make a decision to appoint an individual to the council of a regulatory body.

Extension of powers in the 2002 Act

The Department of Health has asked CHRE for advice relating to the commencement of two aspects of our current legislation.

The first aspect relates to section 27(2), which allows CHRE to instruct a regulatory body to make or change rules if this is necessary to protect the public. We have been asked to provide advice about the procedure that could be followed in such circumstances. CHRE first consulted on this matter back in 2005, and we have modified the process to ensure it is up to date.

The second relates to section 28, which, once commenced, would provide us with the power to investigate concerns that are raised with us by the public or anybody else about the way a regulator has exercised its functions. We agree with the Department of Health, which suggested our role should be limited to 'administrative and policy matters', excluding consideration of matters where people simply disagree with a fitness to practise decision. The Department will consult on the draft regulations in 2012/13.

Our work in 2011/12

Scrutiny and Quality

We have a range of powers to scrutinise the regulators to ensure that patient safety and public protection are central to their work. Under Section 29 of the National Health Service Reform and Health Care Professions Act 2002 we can refer final fitness to practise decisions made by the nine regulatory bodies to court. We do this if we consider that a decision is unduly lenient (within the meaning of that phrase, as set out in case-law) and that a referral is necessary in the interest of public protection. We have continued to use these important powers where necessary for the protection of the public. While the number of fitness to practise cases being managed by the regulators has risen significantly, there continues to be only a small number of cases where the criteria for a court referral are met (four cases during 2011/12).

The principal aim of our scrutiny of final fitness to practise cases is to improve the standard of the decisions made by the regulators' panels and committees. This can usually be achieved by feeding back learning points to the regulators, rather than by referring cases to court. We usually do this in writing, or sometimes in feedback meetings. The feedback we provide to the regulators may assist them in focusing the training they provide to their fitness to practise panel members, and/or staff. During 2011/12 we have continued to contribute to such training if asked to do so by the regulators.

This year we have again seen an increase in the number of fitness to practise cases notified to us by the regulators, from 1,835 in 2009/10, to 2,192 in 2010/11 and 2,528 in 2011/12. This means that in the past two years there has been a 38 per cent increase in the number of fitness to practise cases we review.

Nevertheless, the downard trend in court referrals over the past six years continues, which we believe reflects ongoing improvement in the quality of the decision-making at most of the regulators' fitness to practise hearings. We have noticed some improvements in the quality of some regulators' determinations and are confident that the learning points we have fed back have been a significant contributor to the overall improvements made in the quality of panels' decisions.

Of the 2,528 cases we received this year, 1,841 were closed with no requirement for more information. We sought and considered additional information in 320 cases. In 563 of all cases received we identified learning points to feed back to the regulators. Compared to the previous year this

represents a small decrease in the number of learning points we fed back (we fed back learning points in 22 per cent of cases in 2011/12 compared to 26 per cent in 2010/11).

During the year we considered 16 cases at case meetings, compared to eight cases during 2010/11, and we referred four cases to court (2010/11: two cases).

> The first case referred was one in which the General Dental Council's (GDC's) Professional Conduct Committee (PCC) had found that a dentist had made 'inappropriate linked claims' by claiming for courses of treatment other than in accordance with the NHS General Dental Services Contract. It also found that the dentist had operated without indemnity insurance from 2 to 31 March 2009, and had failed (over a 15 month period) to respond to the GDC's repeated requests to demonstrate that she held the required indemnity insurance cover. The PCC found the registrant's fitness to practise impaired and imposed a three month suspension order without ordering a review hearing.

CHRE referred the case to the High Court on 19 September 2011 and the hearing took place on 24 February 2012. The judge allowed CHRE's appeal and quashed the determination of the PCC, ordering the case to be remitted for reconsideration to a freshly constituted PCC.

> The second case was one in which the Pharmaceutical Society of Northern Ireland's (PSNI's) Statutory Committee found that between January 2005 and April 2008 a pharmacist had inappropriately and excessively dispensed a prescription-only medicine to an elderly patient. The committee determined that whilst the pharmacist's actions amounted to misconduct, it did not consider he presented any risk to public safety that would merit his striking off the Register of Pharmacists.

CHRE referred the case to the High Court under its emergency procedures on the basis that the decision was unduly lenient. However, following a subsequent case meeting CHRE withdrew the appeal.

> The third case concerned a nurse who, during her shift, left the nursing home where she worked such that there was insufficient staffing. The nurse was also found to have failed to remove a chair immediately when asked to, which prevented a patient from leaving his room. She also allowed nursing staff to remain outside a patient's room, hindering any exit for the patient. The Nursing and Midwifery Council's (NMC's) Conduct and Competence Committee allowed a suspension order previously imposed for six months to lapse and determined to impose no further sanction on her registration.

CHRE referred the case to the Court of Session in Scotland on the basis that the decision of the committee was unduly lenient in making no finding of impairment. The hearing took place on 1 March 2012 and CHRE's appeal was

allowed. The judge ordered that the decision be quashed and substituted a finding of impairment of fitness to practise.

> In the fourth case, a biomedical scientist was convicted of assault by beating. The Health Professions Council's (HPC's) Conduct and Competence Committee found the regsitrant's fitness to practise not impaired.

CHRE referred the case to the High Court and a Consent Order between CHRE and the HPC was approved by the court on 5 April 2012, allowing the appeal and quashing the decision of the committee, ordering that the matter be remitted to the committee for re-determination.

In addition, the High Court upheld our appeal in an NMC case that we had referred in 2010/11. As part of its judgement[6] it made an important statement about the relevance of upholding professional standards and confidence in the profession to fitness to practise panels' decisions about whether or not a registrant's fitness to practise is impaired.

Details of case meetings and summaries of cases referred to court can be found on our website[7].

Of the 12 cases considered at case meetings that did not result in court referrals, 10 resulted in us feeding back learning points to the regulators. We also fed back comments to the PSNI in relation to the appeal that we withdrew. In September 2011 we issued a learning points bulletin aimed at helping the regulators to improve the decisions made by their fitness to practise panels, based on the learning we had identified from our scrutiny of their decisions. The bulletin can be found on our website[8].

Our feedback was also used to inform the work of our Standards and Policy team in advising the Secretary of State on modernising and improving the efficiency of fitness to practise adjudication among the health professional regulators. That advice can be found on our website[9].

During 2011/12 we carried out audits of a sample of the cases closed at the initial stages of the fitness to practise process by four of the nine regulators that we oversee. This represented a change in our previous process. In both 2009/10 and 2010/11 we carried out audits of all nine regulators' case closures. In January 2011 our Council decided that, in light of the baseline information we had gathered during the previous two years, it would be appropriate to move to a more risk-based and proportionate audit process. The revised audit process requires us to audit each regulator at least once in every three-year cycle, with the frequency of audits varying according to our assessment of the probable

[6] Details can be found at www.chre.org.uk/_img/pics/library/110414_Grant_Judgement.pdf
[7] www.chre.org.uk/overseeingregulators/306/
[8] www.chre.org.uk/_img/pics/library/1109_Learning_points_bulletin_-_Improving_Fitness_to_Practise_decisions.pdf
[9] www.chre.org.uk/_img/pics/library/1108_M_EFtPA_FINAL.pdf

risk. Our *Audit Process and Guidelines* document has been amended to reflect this new approach and is available from our website[10].

During 2011/12 we audited the cases closed by the NMC, the GDC, the GCC and the GPhC. In a further change to our previous process, we published our findings in relation to each regulator separately, as soon as possible after completion of each audit.[11] These reports are available from our website[12].

We found evidence of continuing weaknesses in the fitness to practise processes of two of the regulators (the NMC and the GDC) although we also found evidence of measures being taken to improve performance. We made a number of recommendations in our reports.

The evidence that we obtained during the audits in 2011/12 has been used to inform our assessment of risks for the purposes of deciding which regulators to audit in 2012/13.

Performance review

We have carried out our annual performance review of the nine regulators for 2011/12 using the same standards and process as in 2010/11. We have however made two key changes to our approach to conducting the performance review.

1. We used a revised approach to the evidence-gathering stage, providing a template for the regulators to use when compiling their evidence submission to us. The template included specific questions asking the regulators to report on progress they had made in the activities that were highlighted in the 2010/11 performance review report. The template also asked the regulators for evidence of their responses to specific external events, including the reports published during 2011/12 by various system regulators concerning issues that impact upon the health professions regulators. The aim of this revision to our approach was to ensure that the regulators targeted their evidence submissions appropriately, and to ensure that we received consistent information from all of them.

2. We have used a different reporting structure in the 2011/12 performance review report. The individual regulators' reports are briefer and more focused, setting out clearly the areas where, in our view, a regulator has failed to meet the standards of good regulation, as well as explaining the reasons for our conclusions. The purpose of this revised reporting structure is to improve the clarity of our report, so that it is easier for readers to understand our evaluation of each regulator's performance. In making this change we were responding to comments from the regulators themselves and from other readers that the level of detail in our reports and the narrative style made it difficult to identify the key points.

[10] www.chre.org.uk/_img/pics/library/110831_Audit_Process_and_Guidelines_Revised.pdf

[11] Changes to the process are discussed with and approved by the Scrutiny Committee and/or Council.

[12] www.chre.org.uk/overseeingregulators/307/

For further information about the performance review of the health professional regulators in 2011/12, please refer to volume II of this annual report.

General Dental Council (GDC) investigation

On 3 June 2011 the Department of Health asked CHRE to advise whether:

- The concerns raised by the former Chair of the GDC (Alison Lockyer) upon her resignation about the GDC's governance indicate that the GDC may be failing in any way to fulfil its statutory functions
- There are concerns about the actions of individuals on the Council which ought to be drawn to the attention of the Appointments Commission.[13]

The Department of Health's request followed concerns raised by Alison Lockyer in a letter she sent to the Secretary of State on 5 May 2011 upon her resignation from the GDC. This investigation is continuing.

Fitness to practise

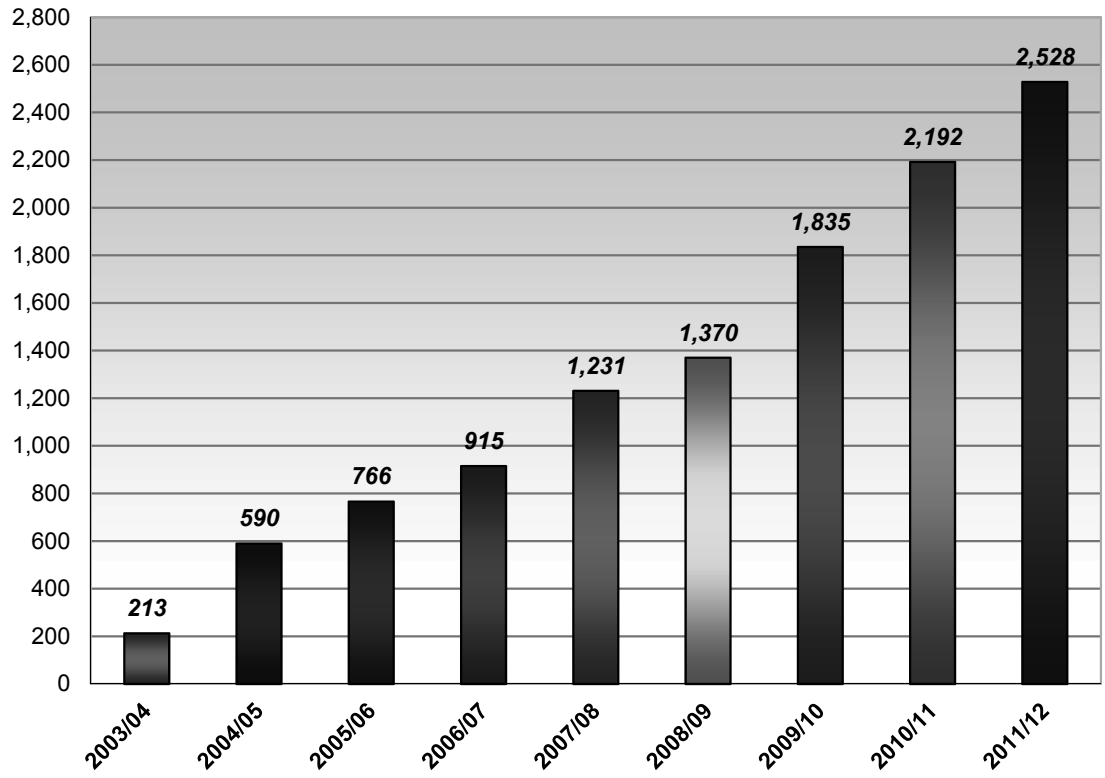
There has been a 15 per cent increase in the number of fitness to practise cases notified to us by the nine regulators compared to the previous year (and a 38 per cent increase compared to 2009/10). We have continued to review all cases within our statutory deadline.

We acknowledge that the number of fitness to practise allegations is increasing significantly each year for some regulators, and we welcome attempts being made by regulators to understand the reasons for this increase, in addition to putting more resource into the fitness to practise function to deal with referrals. Further research in this area will help us to understand, for example, whether the increase in referrals is of inappropriate cases which should properly be dealt with in other ways; or whether it is of appropriate cases, in which case it should be viewed as a positive development, possibly reflecting greater awareness of the role of the regulators and willingness to refer concerns to them.

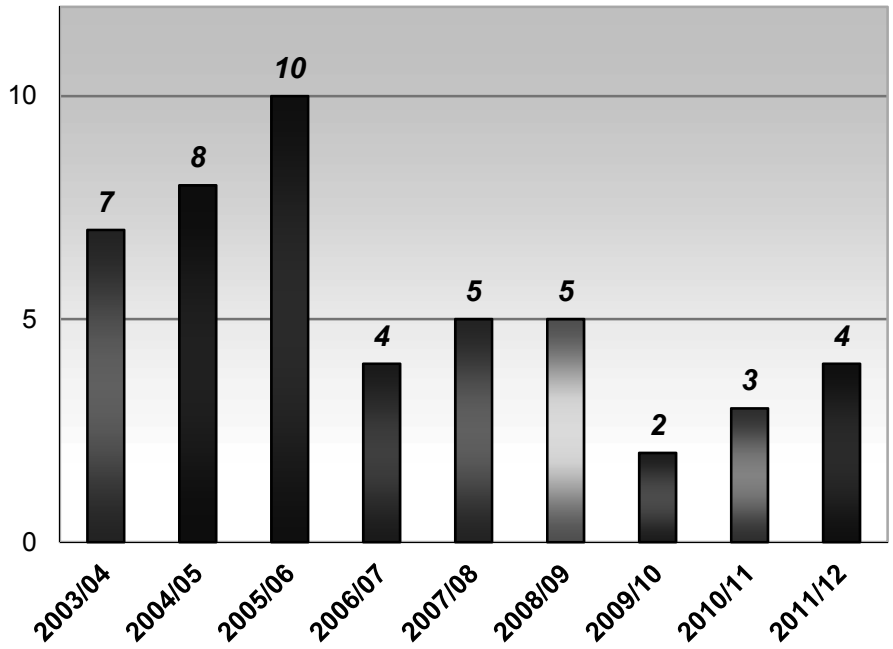
In addition to the various reasons that might underlie the upward trend in number of fitness to practise cases notified to us, which are set out in our peformance review reports for 2009/10 and 2010/11, this year has seen some regulators increasing the number of hearings they hold concurrently in order to improve the timeframes for completion of each case. This year has also seen the conclusion of the fitness to practise hearings held by the General Chirocpractic Council in relation to an unusual number of complaints that it received during 2009/10. Both these factors have had an impact on the total number of fitness to practise decisions notified to us.

[13] The Appointments Commission currently has the power on behalf of the Privy Council to remove or suspend GDC Council members. The GDC's Constitution Order sets out the grounds for removal and suspension. The Appointments Commission has been empowered to carry out the Privy Council's functions on appointments of regulators' council members - and 'appointment' has an extended definition when applied to this function according to the *Health Act 2006, s71 (2):*
(2)In this Part 'appointment' includes—(a) any process involving an appointment (whether described as re-appointment or replacement or otherwise) including a temporary appointment; and (b) nomination for appointment; and also includes removal or suspension from office.

Number of fitness to practise cases reviewed by CHRE annually



Number of fitness to practise cases referred to court each year



Standards and policy

Advice on matters related to the regulation of health professionals

During the year we completed our work on patient and public participation in the work of the regulators, fulfilling a commitment from our performance review of regulators in 2010. We highlighted good practice across the health professional regulators in the report and concluded with five principles for effective participation:

- Be clear and focused
- Use existing knowledge, networks and expertise
- Make it easy for people to participate
- Listen, act and provide feedback
- Make participation part of everyday business.

We also supported the Scrutiny and Quality team in developing indicators of regulators' performance for inclusion in the 2011 performance review report. The report included quantitative data from each regulator across education and training, registration and fitness to practise. We have to take care when interpreting this data and we should not make misleading comparisons. There are many differences across the regulators in terms of their size and the legislation, rules and processes they work within. They have different numbers of fitness to practise cases and registration applications. They also depend on information from third parties to carry out their fitness to practise role and this can affect the speed of their work.

The Department of Health commissioned us to provide it with several pieces of advice this year. In August 2011 we published our advice on modern and efficient fitness to practise adjudication. Making the right decisions in the right way about a health professional's fitness to practise is vital to public protection. Our report concluded that, whilst there has been improvement, there remains a strong sense of inconsistency in the regulators' outcomes as well as inconsistencies within regulators. Good practice in adjudication and the investigation preceding it is not consistently demonstrated. People who raise a concern to a professional regulator find the process stressful and daunting, to the extent that it may deter people from raising a concern again in the future. Finally, there remains confusion, not just amongst the public but also stakeholder organisations, about the purpose of the fitness to practise process. We made recommendations to the regulators and highlighted matters for the Law Commission to consider in its current review.

In June 2011, the Department of Health asked us for advice on the efficiency and effectiveness of health professional regulators in delivering a high quality regulatory regime. We are investigating the scope for efficiency savings within the regulators while maintaining the focus on effective public protection. We will report back in summer 2012. As part of this project we were asked specifically whether there is a case for moving to smaller councils as a way of delivering more board-like and effective governance. We concluded, in our interim report

Board Size and Effectiveness[14] (published in September 2011) that there does appear to be a correlation between smaller boards of between 8 to 12 members and effectiveness. The Department of Health has subsequently consulted on proposals to reduce the size of the General Medical Council and the General Dental Council to 8 to 12 members, and to introduce appointed chairs for these two organisations.

On 6 July 2011 the Secretary of State for Health commissioned CHRE to draw up a code of conduct and draft standards of probity, behavior and competence for executive and non-executive NHS board members in England. This work builds on existing standards and initiatives, drawing on the experience of senior managers and leaders within the NHS and the expectations of patients and service users. We consulted on draft standards in early 2012, and we will submit our advice to the Department of Health in summer 2012.

A key part of our work is providing input into policy reviews and consultations undertaken by other organisations. We have responded to 20 consultations from the regulators and others. We also met regularly with the Law Commission as they prepared their consultation paper on simplifying the legislative framework around health professional regulation.

Preparing for our new roles

As we continue our transition from CHRE to the Professional Standards Authority we remain focused on the need to ensure the delivery of our core activity; promoting the interests of patients and the public within health professional regulation. We continue to focus on right-touch regulation and the promotion of regulatory practice that balances the burden of regulation with the need for robust ways to ensure patient and public safety. In doing so we will be agile and ready to adapt when necessary.

We have made substantial progress in developing standards and criteria to support the delivery of two new functions under the Health and Social Care Act 2012. We have worked closely with the Appointments Commission to build our approach to our new role in advising the Privy Council on the appointments processes used by regulators to identify council members and chairs. We have also developed standards and criteria for the accreditation of voluntary registers held by organisations for unregulated health and social care practitioners. This scheme will be launched in November 2012.

Following the government's announcement in *Enabling Excellence*[15], we have also developed our criteria and process for handling concerns raised about the regulators under section 28 of the NHS Reform and Health Care Professions Act 2002. As part of this work we will provide advice to the Department of Health on a process to direct a regulator to make or change a rule should we deem it necessary to protect the public, under section 27(2).

[14] This can be found at: http://www.chre.org.uk/_img/pics/library/pdf_1320922005.pdf

[15] Found at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124359

In preparation for our new role overseeing social work in England, we have held learning sessions for our staff.

Our relationship with the public, regulators and other stakeholders

We aim to be transparent and accessible to all, and the views of patients and the public and other stakeholders are crucial to inform and direct our work.

We have held a number of workshops this year in connection with our work to develop the voluntary accreditation scheme, working regularly with over 40 organisations and with some members of our Public Stakeholder Network.

We piloted a new, partnership approach to engagement, supported by the Board of Community Health Councils in Wales and the Residents and Relatives Association in England. We also held engagement events in Scotland, assisted by the Scottish Health Council and in Northern Ireland, with the assistance of the General Medical Council's office in Belfast. All these were well-attended and enabled us to meet with more diverse groups. We have facilitated a Learning Circle Group for the health professional regulators' patient and public engagement since March 2011, at the request from the Chief Executives Steering Group, to share and develop good practice.

We engaged with a wide range of stakeholders on the development of the standards for members of NHS boards and governing bodies in England. This included chief executives, chairs, non-executive directors, and executive directors of NHS trusts and strategic health authorities, GPs, experts on leadership and management in health, and experts on inclusion and equality. We discussed the work with NHS Employers, the NHS Confederation, the Institute of Healthcare Management, NHS Education for Scotland and the National Leadership Council amongst others. We also presented the work to members of the public at two Local Involvement Networks (LINks) meetings, advertised it through our website and public and professional stakeholder networks, and commissioned research with patients and the public and NHS staff to get a wide range of views on the standards. In addition we received 65 responses to the formal consultation.

Promoting improvement, discussion and debate

CHRE endeavors to be active in the field of health professional regulation, learning from others, sharing that knowledge and stimulating improvement.

We are actively raising the profile of health professional regulation, encouraging greater synergies and learning between system and professional regulation. During 2011/12 we held three seminars aimed at improving collaboration between regulators on topics including investigating concerns and education.

In March we held a fourth high-level symposium to facilitate discussion of the Law Commission's review of health professional regulation. The symposium involved, amongst others, the health professional regulatory bodies, representatives from the governments of each of the UK countries, the Centre for Health Services Economics and Organisations, AVMA (Action Against

Medical Accidents), social work professional regulators, National Voices, Legal Services Board, National Audit Office and law firms we work with. We also gave a presentation on Right-Touch Regulation at the congress of the Council for Licensure, Enforcement and Regulation in July 2011.

Research

Building on the work undertaken last year, we have commissioned a further literature review on the potential of the behavioural sciences to inform our understanding of the impact of regulators on the behaviour of their registrants. This work is being undertaken by a part-time secondee from the General Social Care Council. We also commissioned research into people's perceptions of risks in health and care settings, and who people perceive to be responsible for mitigating those risks.

During the year, CHRE contributed ideas to the research being taken forward by the UK Commission for Employment and Skills and the Institute for Employment Studies into occupational regulation.

The following articles were submitted:

- 'No Good Deed Goes Unpunished' for a book to be published by London School of Economics in 2012
- 'Regulating for Compassion' for a publication by 2020 Health to be published in 2012
- 'Finding the Right Touch' for a symposium edition of the *British Journal of Guidance and Counselling* to be published in 2013.

Strengthening relationships across the UK, in Europe and worldwide

We have continued to build on our constructive relationships across the UK and in Europe and have designated staff leads for each of the devolved administrations.

We continue to monitor relevant developments in Europe through our membership of European-level organisations and groups. We have also provided opportunities and promoted learning through internships, secondments and observers.

Particular focus has been given to:

- The review of the Professional Qualifications Directive
- Submission to the House of Lords European Union Subcommittee, June 2011
- The European Commission consultation on the Green Paper, September 2011.

We received a substantial body of research from the London School of Economics (LSE) regarding the regulation of healthcare in other countries. Our contract with LSE has now ended and we have appointed a part-time researcher to summarise the work for publication.

Governance and operations

Sustainability

We continue to work to improve the sustainability of our operations. Our office was recently refurbished to the BREEAM environmental assessment standard, which looks at heating, lighting, recycling and other matters, and has an 'excellent' rating. CHRE occupies 2.58 per cent of the building, part of which is occupied by CHRE tenants.

Our gas and water consumption is calculated as 2.58 per cent of the total. Our electricity is separately monitored and the consumption for the space rented from the landlord is known. This does not however include the consumption by CHRE's tenants. We will review, and reduce where possible, our future consumption with reference to the following statistics for 2011/12.

2011/12	Gas	Electricity	Water
	5993.7 kWh	55,809 kWh	184.43 m^3

Following refurbishment, the building has communal facilities to separate waste for recycling on every floor, and to encourage staff to do this no waste is collected from bins at desks. Waste is separated into recyclable, non-recyclable and glass. A contractor separates the mixed recyclables.

The installation of compactors has reduced the frequency of collections from daily to fortnightly, reducing vehicle emissions. As of November 2011 the total waste from the building is being measured by weight and detailed figures should be available from next year.

We seek to minimise the impact of our own activities on the environment. We use recycled materials where such alternatives are available and provide value for money.

We are seeking to reduce the use of paper by maximising the use of our intranet and website for the dissemination of information. We are also using electronic versions of meeting papers where technically practical. Where paper is used we are looking to reduce its consumption through the active management of printers requiring double-sided printing. We used 338 cases of paper in 2011/12 and this will be reviewed and reduced where possible. We will report on our progress next year.

When travel is necessary we use public transport as much as possible and have increased our use of telephone and video conferencing to avoid the need to travel. When possible, journeys within the UK and Europe are made by train. We will collect data in 2012/13 to provide a baseline for future monitoring and efficiency.

We are also be working to improve our organaistional infrastructure, making it ready for our new functions.

During the year we have undertaken a strategic review of our IT, including our website and database, and work to add new functionality to both the website and our database has begun. In addition we are working to enhance the accessibility and reporting of the data we hold.

Accounts and audit

Our accounts have been prepared according to Determinations by the Secretary of State pursuant to Schedule 7, Paragraph 15 of the National Health Service Reform and Health Care Professions Act 2002, as amended by the Health and Social Care Act 2008.

Details about the NHS Pension Scheme and the treatment of pension liabilities in the accounts are set out in accounting policies within the notes to the accounts (note 1).

Our external auditor is the Comptroller and Auditor General. Grant Thornton undertakes the internal audit function.

This report has been prepared in accordance with the 2011/12 government *Financial Reporting Manual* (FReM) issued by HM Treasury.

So far as we are aware, there is no relevant audit information of which the auditors are unaware, and we have taken all the steps to make ourselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Financial summary

Grant in aid funding for 2011/12 comprised £1.87m (2010/11 £2.10m) from the Department of Health and £0.40m (2010/11 £0.44m) from the devolved administrations. At 31 March 2012, we had reserves carried forward of £0.29m (2010/11: £0.47m) after net operating costs of £2.44m (2010/11: £2.36m).

An analysis of accounting policies is shown in note 1 to the accounts. There have been no significant changes to these during the year.

Transparency

CHRE was an early adopter of transparency initiatives. Having embraced the concept of disclosure, we were already using our website to provide information on policies, operations and expenditure to the public prior to the drive to do so which commenced in 2011. We will continue to do so even if there is no formal duty to do so.

Our creditor payment policy is maintained in accordance with the Government's Better Payment Policy which currently provides for payment of suppliers within five working days of receipt of invoice, except in the instance where there may be a query or dispute regarding an invoice. This target is challenging, especially for a small organisation, and could only be achieved if we employed more staff. Accordingly we aim to pay 60 per cent of undisputed invoices within five days and 100 per cent within 10 days.

During the 2011/12 financial year, 100 per cent of invoices were paid within 10 days and 54 per cent (by number of invoices) and 46 per cent (by total invoice value) within five days.

Details of our payment record can be found on our website[16].

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

The balance owed to trade creditors as at 31 March 2012 was £142,000 (2010/11: £68,000). As a proportion of the total amount invoiced by suppliers in the year, this is equivalent to 34 days (2010/11: 18 days).

Other information that can be found in the government disclosure and transparency sections of our website includes:

- Expenditure over £25,000
- Council member expenses
- Management team expenses
- Hospitality
- Staff salaries
- Staff organogram.

[16] www.chre.org.uk/_img/pics/library/1202_Payment_stat_Apr_-_Feb_2012.pdf

5. Remuneration report

Our pay policy incorporates a band structure within which staff can progress along incremental points within a given band alongside a performance appraisal process. No performance-related pay bonuses are paid. Normal practice would be for the Remuneration Committee to consider an annual uplift to reflect a cost of living increase payable from October. In line with the pay guidance for government employees issued by the Cabinet Office in 2010, for the second year no uplift has been paid.

Progression through the pay band increments is subject to meeting certain performance standards as defined in the policy. All staff receive an annual appraisal in April and where performance has reached the agreed standard, progression within their band takes place in April.

We were instructed by the Department of Health in 2010/11 that as the annual increments were not contractual we could not pay them. Accordingly for the second year running staff have had no pay increase of any kind.

Contracts are usually offered on a permanent basis. If on occasion they are offered on a fixed-term basis,this is to reflect the nature and context of the work involved. The notice period required is determined by the position of the post holder. We treat termination payments and provisions for compensation for termination on a case-by-case basis in consultation with our advisors.

A total of 51.5 days (2010/11: 55 days) were lost due to sickness absence in the year. This equates to 2.7 days (2010/11: 2.9 days) per person.

Senior managers' contracts

Name	Title	Date of contract	Unexpired term	Notice period
Linda Allan	Director of Governance and Operations	15 March 2010	Permanent contract	3 months
Christine Braithwaite	Director of Policy and External Relations	17 May 2010	Permanent contract	3 months
Harry Cayton	Chief Executive	1 August 2007	Permanent contract	6 months
Rosalyn Hayles	Director of Scrutiny and Quality	15 August 2010	Permanent contract	3 months

Senior managers' salaries

Name	Salary (£'000) 2011/12	Salary (£'000) 2010/11	Real increase/ (decrease) in pension at age 60 (£'000)	Total accrued pension at 31 March 2011 (£'000)
Linda Allan	80-85	80-85	0-2.5	2.5-5
Christine Braithwaite	80-85	70-75 (full year equivalent 80-85)	0-2.5	10-12.5
Harry Cayton	135-140	135-140	2.5-5	15-17.5
Rosalyn Hayles	75-80	45-50 (full year equivalent 75-80)	0-2.5	0-2.5

This table has been audited by the Comptroller and Auditor General.

All senior managers in the year were members of the NHS Pension Scheme.

A register of senior managers' interests is available on our website.

Under the government's *Financial Reporting Manual*, CHRE is required to disclose the relationship between the salary of the most highly-paid director (the Chief Executive) and the median earnings of the overall CHRE workforce.

The salary of the Chief Executive in the financial year 2011/12 was £140K. This was 3.12 times the median salary of the workforce, which was £45K.

The salary of the Chief Executive in the financial year 2010/11 was £140K. This was 3.12 times the median salary of the workforce, which was £45K.

No employees received remuneration[17] in excess of the Chief Executive in 2011/12 or 2010/11. Remuneration ranged from £25K to £140K (2010/11: £24K to £140K)

[17] Total remuneration includes salary only and there were no non-consolidated performance-related pay, benefits-in-kind or severance payments in 2011/12 or 2010/11. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Pensions

Name	Title	Value of accrued pension (£'000)	Related lump sum (£'000)	Real increase/(decrease) in related lump sum (£'000)	Cash Equivalent Transfer Value as at 1 April 2011 (to nearest £1,000)	Cash Equivalent Transfer Value as at 31 March 2012 (to nearest £1,000)	Real increase in the Cash Equivalent Transfer Value during the reporting year (to nearest £1,000)
Linda Allan	Director of Governance and Operations	2.5-5	N/A	N/A	19	42	22
Christine Braithwaite	Director of Policy and External Relations	10-12.5	30-32.5	0-2.5	169	204	29
Harry Cayton	Chief Executive	15-17.5	17.5-20	(15-17.5)	N/A	288	N/A[18]
Rosalyn Hayles	Director of Scrutiny and Quality	0-2.5	N/A	N/A	6	18	11

This table has been audited by the Comptroller and Auditor General.

Cash Equivalent Transfer Value
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members' 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 scheme or arrangement when the member leaves a scheme and chooses to transfer the benefit accrued in the 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 figure, and from 2005/06 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETV are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

No compensation has been paid to former senior managers, or payments made to third parties for the services of a senior manager.

[18] Member over 60 not applicable

Council members' remuneration

Remuneration for the Chair and Council members is not subject to superannuation.

The payments made to Council are also subject to Cabinet Office guidance. The Chair receives remuneration of £33,688 pa (2010/11: £33,688); members receive annual remuneration of £7,881 (2010/11: £7,881) and the Audit and Risk Committee Chair receives annual remuneration of £13,135 (2010/11: £13,135). Members' remuneration during the year amounted to £91,296 (2010/11: £92,134) including social security costs.

Members' remuneration is subject to tax and national insurance through PAYE.

In addition, expenses amounting to £10,366 (2010/11: £13,196) were reimbursed to Council members. During 2010/11 HM Revenue and Customs (HMRC) notified us that they were seeking to collect tax and national insurance in relation to travel expenses for the current and previous years. Following discussion with HMRC, who considered members of the Council as office holders who needed to travel from home to work (to attend meetings at the CHRE's offices), it was deemed that their travel expenses should be subject to tax.

Members' remuneration has been audited by the Comptroller and Auditor General.

Payments to individual members are disclosed below.

Payments made to CHRE Council members during 2011/12

	2011/12	2010/11
	Salary (bands of £5,000)	Salary (bands of £5,000)
Chair		
Jill Pitkeathley	30-35	30-35
Members		
Ann Curno	5-10	5-10
Ian Hamer	5-10	5-10
Andrew Hind (Audit and Risk Committee Chair)	10-15	10-15
Sally Irvine	5-10	5-10
Stuart MacDonnell	5-10	5-10
Jayne Scott	5-10	5-10

Harry Cayton
Accounting Officer
13 June 2012

6. Statement of the Council's and the Accounting Officer's responsibilities

The Council's responsibilities

Under the Cabinet Office's *Guidance on Codes of Best Practice for Board Members of Public Bodies*, CHRE is responsible for ensuring propriety in its use of public funds and for the proper accounting of their use. Under Schedule 7 paragraph 15 of the National Health Service Reform and Health Care Professions Act 2002, as amended by the Heath and Social Care Act 2008, CHRE is required to prepare a statement of accounts in respect of each financial year in the form and on the basis directed by the Secretary of State for the Department of Health, with the consent of HM Treasury. The accounts are to be prepared on an accruals basis and must give a true and fair view of CHRE's state of affairs at the year end and of its income and expenditure, total changes in taxpayers' equity and cash flows for the financial year.

In preparing the accounts CHRE is required to:

- Observe the accounts direction issued by the Secretary of State, with the consent of HM Treasury, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards have been followed, and disclose and explain any material departures in the financial statements
- Prepare the statements on the going concern basis unless it is inappropriate to presume that CHRE will continue in operation.

The Accounting Officer's responsibilities

The Accounting Officer for the Department of Health has appointed the Chief Executive as the Council's Accounting Officer. His relevant responsibilities as the Accounting Officer, including his responsibility for the propriety and regularity of the public finances for which he is answerable and for the keeping of proper records, are set out in the *Non-Departmental Public Bodies' Accounting Officers' Memorandum* issued by HM Treasury and published in *Managing Public Money.*

7. Governance statement

The Council

The Council has corporate responsibility for ensuring that CHRE fulfils its statutory duties and for promoting the efficient, economic and effective use of its resources.

CHRE's Council comprises seven non-executive members and one executive member. All non-executive members of our council have been appointed from the public so that we are completely independent of the health professional regulators.

We have a small executive team covering our three areas of work: scrutiny and quality; policy and standards; and our governance and operations.

Chair of Council

The Chair is responsible to the Secretary of State for the Department of Health for England and to the devolved administrations. The Chair has a particular leadership responsibility on the following matters:

- Formulating the Council's strategy
- Ensuring that the Council, in reaching decisions, takes proper account of any relevant guidance provided by the ministers or the sponsor departments
- Promoting the efficient, economic, and effective use of resources including staff
- Encouraging high standards of propriety
- Ensuring that the Council meets at regular intervals throughout the year and that the minutes of meetings accurately record the decisions made and, where appropriate, the views of individual Council members.

Council members

Council member	Appointed by
Jill Pitkeathley (Chair)	Privy Council
Ann Curno	Secretary of State for England
Ian Hamer	Welsh ministers
Andrew Hind	Secretary of State for England
Sally Irvine	Secretary of State for England
Stuart MacDonnell	Department of Health, Social Services and Public Safety in Northern Ireland
Jayne Scott	Scottish ministers
Harry Cayton	Council

Schedule 7 of the National Health Service Reform and Health Care Professions Act 2002, as amended by the Health and Social Care Act 2008, provides directions for the appointment of members to the Council.[19]

A register of interests for each member is available on our website, www.chre.org.uk

Re-appointments

Council members are generally appointed for an initial term of four years which can be extended to a second term. When CHRE was established the Council members were appointed for varying initial terms in order to facilitate future continuity.

During 2011/12 two Councils members, Ann Curno and Sally Irvine, each completed their initial term of appointment and were re-appointed for a second term.

Attendance at Council meetings held in public

There were five Council meetings held in public between 1 April 2011 and 31 March 2012.

Council member	Number of meetings attended
Jill Pitkeathley (Chair)	5
Ann Curno	5
Ian Hamer	5
Andrew Hind	5
Sally Irvine	5
Stuart MacDonnell	5
Jayne Scott	5
Harry Cayton	5

During the year the Council has been particularly concerned to ensure that the balance between fulfilling our statutory responsibilities and preparing for our new roles as the Professional Standards Authority has been maintained. Foremost in the Council's thinking and the basis of its decision-making has been the protection of patients and the public.

In this transition period the Council has been careful to give due consideration to the change in strategic direction required for the new organisation and has reviewed and changed its three-year strategic plan.

It has also been aware of the importance of the financial, organisational and infrastructure changes that will be necessary for the future and of the need to invest in these.

[19] Available at www.opsi.gov.uk/acts/acts2002/ukpga_20020017_en_15#sch7

The Council greatly values the work of the staff team but also is certain of its role in holding the executive to account. The Chief Executive and directors and other staff members present papers to the Council in person and are challenged on their content, quality and on the underlying information. In addition, as reported below the Council's two committees pay particular attention to both audit and risk and to the scrutiny of our performance of our statutory function.

The Council is confident but not complacent in its own performance. All Council members have attended all meetings and taken an active part. In addition all serve on one committee or more. All Council members, including the Chief Executive, are appraised annually by the Chair and the Chair is appraised by the Appointments Commission. At an annual strategic planning and review session the Council discusses its own performance and how it can be improved. Council members receive regular informal feedback from the chairs and chief executives of the regulators we oversee and from the Department of Health and devolved administrations.

During a period of transition the management of risk is particularly important. During the year the Council, its committees and the executive team have been particularly attentive to the identification and mitigation of risks. Transition risks have been specifically identified and reported on and have been discussed in detail and regularly reviewed by the staff Change Team, the Council, the Audit and Risk Committee and with our internal and external auditors. The work of the Audit and Risk and Scrutiny Committees have been particularly important this year in monitoring the executive's performance in delivering the business plan against a background of considerable pressure and change.

The Council has reflected on its performance during the year. It considers it well understands its role and responsibilities as far as governance is concerned. It operates in an atmosphere of openness and trust and receives the right amount of information in accessible forms and in a timely manner.

The Council ensures that it has time for strategic discussion and planning and is always concerned to provide the right balance between challenge to the executive and support to the staff team. It has a small committee structure so that the whole Council is involved in decision-making and planning.

The Council reports that it is confident in the abilities of the Chief Executive and of the directors and is pleased that staff morale is good in spite of the uncertain times which the organisation has faced this year.

Committees and working groups of the Council

Audit and Risk Committee

The Council established an Audit and Risk Committee to support it in its responsibilities for risk control and governance. The committee reviews the comprehensiveness of assurances in meeting the Council and Accounting Officer's assurance needs and reviewing the reliability and integrity of these assurances.

There were four Audit and Risk Committee meetings held between 1 April 2011 and 31 March 2012. Members' attendance is shown below.

Grant Thornton was our internal auditor during the 2011/12 financial year.

Members' attendance at committee meetings during 2011/12 was as follows:

Committee member	Number of meetings attended
Andrew Hind (Chair)	4
Stuart MacDonnell	4
Jayne Scott	3

The minutes of meetings are formally reported to Council as are the committee's opinion on the risk register and changes made to it.

The committee reviews its terms of reference and work programme annually and reports any changes that it proposes should be made to the Council. Each year it formally reports to Council on:

- Its work during the previous financial year
- The assessment of the information governance arrangements
- The internal audit reports submitted to it
- The views and opinion of the external auditors.

The committee sets its own work programme for the coming year at its December meeting and this influences the work programme set for internal audit. The internal audit work this year was focused on supporting the transition work and ensuring that the risks associated with the changes were being identified and addressed. The following reports were considered by the Committee:

- November 2011 – Transition Arrangements (Phase1)
- November 2011 – Core Financials Controls
- November 2011 – Fee Modeling
- March 2012 – Transition Arrangements (Phase 2)
- March 2012 – Follow Up

In its internal audit annual report for 2011/12, Grant Thornton awarded CHRE the opinion of 'satisfactory', the highest level of effectiveness commenting:

"Overall, we have concluded that, in the areas examined, the risk management, corporate governance and internal controls activities and controls are suitably designed to achieve the risk management objectives required by management.

Those activities and controls that we examined were operating with sufficient effectiveness to provide reasonable but not absolute assurance that the related risk management objectives were achieved during the period under review."

The management of risk in integral to the CHRE fulfilling its objectives. The CHRE has a risk register which details clearly the key risks that may prevent it from achieving its objectives and the controls in place to mitigate those risks. Each risk has been assigned to an owner (on the management team) who is responsible for managing the risk. During 2011/12 in order to be better able to monitor the risks arising from transition and issues associated with it a separate transition risk register was established.

During the year the committee has been concerned about the number of risks that the executive had rated as red and the fact that they were remaining red; issues such as the timetable for the Act, the regulations that need to be made in terms of the Act to change the finances of the organisation, the increasing workload and the impact this was having on performance.

The committee has been attentive to the risks created by the external environment and the limited extent to which CHRE can mitigate them. The committee noted that some risks had remained red because CHRE had no direct control over them. During the year it did however see the likelihood of problems arising concerning the Section 29 cases and the audit of fitness to practise reduce as a consequence of changes to procedures and the efforts of the staff concerned.

The committee considered the *Annual Assessment of Information Risk Management* which documented CHRE's current position, along with the issues which had arisen during the year.

The committee had been made aware throughout the year of any incidents which had occurred, were satisfied that these had been dealt with seriously and presented no systematic weaknesses in CHRE's systems and were assured that no sensitive data had been compromised.

In preparation for the transition to the Professional Standards Authority the committee considered what banking arrangements the Authority should have; in particular whether it should bank with the Government Banking Service. The committee took the view that it would be advisable for the Authority to bank independently and staff have been in discussion with several banks in order to identify which would be most suitable.

Another transition issue considered by the Committee was the potential impact of value added tax on the Authority. In view of the different funding arrangements and the fact that the Authority would be earning income from its work, independent professional advice was taken on this matter. Our advisers have been in discussion with HMRC to obtain confirmation as to our understanding.

Scrutiny Committee

Role

The Scrutiny Committee reviews, monitors and reports on the operation of CHRE's scrutiny and oversight of the nine health professional regulatory bodies.

There were four Scrutiny Committee meetings held between 1 April 2011 and 31 March 2012. Members' attendance is shown below.

Committee member	Number of meetings attended
Sally Irvine (Chair)	4
Ann Curno	4
Ian Hamer	4

During 2011/12 each of the Scrutiny Committee's meetings have concentrated on one of the three principal areas of the Scrutiny and Quality team's work: the review of final fitness to practise decisions (under Section 29 of the 2002 Act), the initial stages audits and the annual performance review.

Initial stages audits

In January 2011 CHRE's Council approved recommendations that a more risk-based approach to auditing the initial stages of the regulators' fitness to practise processes should be adopted, with the effect that the frequency of each regulator's audit would vary in future according to CHRE's assessment of the relevant risks, with each regulator being audited at least once in every three-year cycle.

The Scrutiny Committee considered and approved the relevant changes to the written audit process and reporting schedule at its meeting in April 2011, as well as deciding upon the regulators that should be subject to audit during summer 2011. At that meeting the committee also confirmed it was content with the quality of the 2010/11 audit report that had been recently published and that it did not consider there was any requirement for CHRE to reconsider the size of the sample of cases audited, following the statistical advice received on this issue when the audit process was first developed.

At its meeting in December 2011 the committee agreed on the regulators to be audited during 2012 based on an assessment of the relevant risks. The potential disruption arising in summer 2012 as a result of the Olympic and Paralympic games was discussed at the meeting in March 2012, and it was agreed that any on-site auditing during these periods should be minimised, to the extent that the overall audit timetable permits.

Review of final fitness to practise decisions (CHRE's 'Section 29' jurisdiction)

At its meeting in December 2011 the Scrutiny Committee reviewed all decisions taken to appeal/not to appeal individual cases which had been taken at Section 29 case meetings during the previous 12 months, as well as reviewing a small sample of cases which had not been referred forwards for Section 29 case meetings. The committee agreed that the executive had reached appropriate decisions in each case.

At its meetings in December 2011 and March 2012, the committee was provided with statistical data relating to the size of the Section 29 caseload and were informed that the data at the end of the financial year was likely to demonstrate a further significant year on year increase in the number of cases CHRE was required to review.

Annual performance review of the regulators

At its meeting in September 2011 the committee approved changes proposed by the Scrutiny and Quality team in order to improve the efficiency of the performance review process, and in particular, changes aimed at improving the quality of the evidence submissions from the regulators and ensuring that they provide evidence related to outcomes rather than processes. Proposed changes to the format of the performance review report (following feedback received from the regulators) were also discussed and approved.

Other work

The committee has regularly reviewed CHRE's handling of complaints about the regulators (and was informed about the workshop with the regulators that was held in September 2011 with the aim of disseminating good practice in complaints handling) and has received regular updates on the progress of individual Section 29 appeals and the progress of special reviews/investigations.

The Chief Executive has also updated the committee regularly about the plans for delivery of the preparatory work relating to the government's proposed expansion of CHRE's role in two areas that ultimately the committee will be responsible for overseeing on behalf of the Professional Standards Authority's Council:

- Advising the Privy Council on appointments to the regulators' councils
- Making the regulations required to bring into effect CHRE's power to investigate complaints about the regulators.

Remuneration Committee

Role

The Remuneration Committee meets once a year, or more frequently if necessary, to agree the annual cost of living increase for staff and to deal with other remuneration issues if they arise.

There was one Remuneration Committee meeting held between 1 April 2011 and 31 March 2012. Members' attendance is shown below.

Committee member	Number of meetings attended
Jill Pitkeathley (Chair)	1
Ian Hamer	1
Andrew Hind	1
Harry Cayton (in attendance)	1

Since CHRE continued to be subject to the ongoing pay restrictions set by the Cabinet Office, the committee was not required to consider any pay award for the staff in 2011/12. It did however meet in order to begin consideration of how it would undertake its obligations in respect of pay and conditions of service when CHRE becomes the Professional Standards Authority. These early considerations will be built upon during the coming year.

Pension scheme regulations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments to the Scheme are in accordance with the rules and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Data handling

The protection of data held by us and requests for its disclosure have been important considerations for us during the year.

In 2010/11 we implemented all the relevant Cabinet Office minimum mandatory requirements to strengthen the system of internal control we already had in place.

We hold very little personal information.The main data we hold relates to our own staff. Where we require access to personal data held by others this is generally undertaken at the premises of the data holder. Our auditors are required to work through remote access to our server whenever possible. Since this is not always possible the laptops used by the auditors have been encrypted to provide another layer of security.

Staff continue to undertake the Cabinet Office's 'Protect Information' online training. The training is split into three levels and is assessment-based.

All staff are required to complete the level appropriate to their level of responsibility for data handling. All members of staff who have completed the training to date successfully passed the assessment.

The Audit and Risk Committee Chair has provided a statement that he was satisfied that we have appropriate policies for staff to adhere to, as far as they apply to CHRE, and that suitable processes are in place to mitigate risks to our information.

Scope of responsibility

As Accounting Officer I have responsibility for maintaining a sound system of internal control that supports the achievement of CHRE's policies, aims and objectives, whilst safeguarding the public funds and organisational assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money.*

CHRE reports to the UK Parliament and works closely with the devolved administrations in Northern Ireland, Scotland and Wales, and with the Department of Health in England to deliver our statutory obligations and the key objectives of our business plan. This includes identifying and responding appropriately to both internal and external risks.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is designed to identify and prioritise the risks to the achievement of organisational policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

Our system of internal control has been in place for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts, and accords with HM Treasury guidance. The key elements of the system of internal control include

- Financial procedures detailing financial controls, for responsibilities of and authorities delegated to the management team
- Business planning processes setting out the objectives of the CHRE supported by details annual income, expenditure, capital and cashflow budgets
- Regular reviews of performance along with variance reporting, scenario planning and reforecasting.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, the Management Team which has responsibility for the maintenance of the internal controls, and comments made by the external auditors in their management letter and other reports. The Audit and Risk Committee and Council have advised me on the implications of the result of my review on the system of internal control. The Scrutiny Committeee has this year considered in detail our perfomance against our own standards of our statutory functions.

The effectiveness of the system of internal control was maintained and reviewed through:

- The Council, which met five times
- CHRE's Audit and Risk Committee, which consists of three members of Council. I also attended the Audit and Risk Committee meetings together with the Director of Governance and Operations, the Accounting Manager and representatives from the National Audit Office and internal auditors
- Risk management arrangements as described, under which key risks that could affect the achievement of our objectives have been managed actively, with progress being reported to the Audit and Risk Committee and through it to Council
- Our annual assessment of information risk management undertaken in accordance with Cabinet Office guidance
- Regular reports from the internal auditors, Grant Thornton, complying with the government's Internal Audit Standards, which include an independent opinion on the adequacy and effectiveness of our internal controls together with recommendations for improvement where necessary.
- Comments made by external auditors in their management letter and other reports.

I do not consider that we have any significant weaknesses in our system of internal controls. A programme of continuous monitoring exists, in consultation with the Audit and Risk Committee, internal auditors and external auditors, to ensure that we meet best practice standards in all areas of our operations.

External and internal influences are considered and any potentially significant risks are discussed with key stakeholders as soon as they become apparent.

We continue to keep our arrangements under review in response to external developments and, as mentioned above, paying particular attention to our proposed transition to the Professional Standards Authority.

I am satisfied that this report reflects adequately the information risks we have faced, will face in the future and the actions that we take to manage the information risks effectively. I am satisfied that the information risk incidents were managed appropriately. I am confident that staff are aware of their responsibility to store, share and destroy information securely and that the

processes we implemented as a result of the previous year's incidents have successfully strengthened our procedures.

I confirm that the assessment of information risk management has been completed satisfactorily and that the information can be used for our annual governance statement.

I confirm we have complied with the Code of Corporate Governance as detailed in DAO(GEN)02/12 – Governance Statements in so far as it applicable to us.

Harry Cayton
Accounting Officer

13 June 2012

8. The Certificate and report of the Comptroller and Auditor General to the Houses of Parliament, the Scottish Parliament and the Northern Ireland Assembly

I certify that I have audited the financial statements of the Council for Healthcare Regulatory Excellence for the year ended 31 March 2012 under the National Health Service Reform and Health Care Professions Act 2002 as amended by the Health and Social Care Act 2008. These comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the remuneration report that is described in that report as having been audited.

Respective responsibilities of the Council, Accounting Officer and Auditor

As explained more fully in the Statement of the Council's and Accounting Officer's responsibilities, the Council and Chief Executive, as Accounting Officer, are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service Reform and Health Care Professions Act 2002 as amended by the Health and Social Care Act 2008. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards.

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

In my opinion:

- The financial statements give a true and fair view of the state of the Council for Healthcare Regulatory Excellence's affairs as at 31 March 2012 and of its net operating cost for the year then ended; and
- The financial statements have been properly prepared in accordance with the National Health Service Reform and Healthcare Professions Act 2002 as amended by the Health and Social Care Act 2008 and Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion:

- The part of the Remuneration Report to be audited has been properly prepared in accordance with Secretary of State directions issued under the National Health Service Reform and Health Care Professions Act 2002 as amended by the Health and Social Care Act 2008; and
- The information given in the Chief Executive's Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

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

Report

I have no observations to make on these financial statements.

Amyas C E Morse
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

15 June 2012

9. Statement of comprehensive net expenditure for the year ended 31 March 2012

	Note		Year ended 31 March 2012 £'000		Year ended 31 March 2011 (restated) £'000
Expenditure					
Staff costs	3		1,181		1,169
Other expenditure	4		1,535		1,246
Income					
Operating income	5		(275)		(55)
Net operating cost before tax			2,441		2,360
Net operating cost			**2,441**		**2,360**

The notes on pages 48-61 form part of these accounts.

Other comprehensive net expenditure

There was no other comprehensive net expenditure in the year ended 31 March 2012.

10. Statement of financial position as at 31 March 2012

		31 March 2012		31 March 2011	
	Note	£'000	£'000	£'000	£'000
Non-current assets					
Property, plant and equipment	6	162		107	
Total non-current assets			***162***		***107***
Current assets					
Trade and other receivables	7	260		180	
Cash and cash equivalents	8	155		353	
Total current assets			***415***		***533***
Current liabilities					
Trade and other payables	9	(285)		(166)	
Provisions	10	(3)		(8)	
Total current liabilities			***(288)***		***(174)***
Non-current assets plus net current assets			**289**		**466**
Assets less liabilities			**289**		**466**
Reserves					
General reserves			**289**		**466**

The notes on pages 48-61 form part of these accounts.

Harry Cayton
Accounting Officer

13 June 2012

11. Statement of cash flows for the year ended 31 March 2012

	Note	Year ended 31 March 2012	Year ended 31 March 2011
		£'000	£'000
Cash flows from operating activities			
Net operating costs for the year before cost of capital reversal		(2,441)	(2,360)
Adjustment for non-cash transactions[20]	4	42	83
(Increase)/decrease in trade and other receivables	7	(80)	40
Increase in trade and other payables	9	119	4
(Decrease) in provisions	10	(5)	(158)
Movements in provisions not passing through the statement of comprehensive net expenditure		-	(2)
Net cash outflow from operating activities		***(2,365)***	***(2,393)***
Cash flow from investment activities			
Purchase of property, plant and equipment	6	(97)	(91)
Net cash outflow from investment activities		***(97)***	***(91)***
Cash flow from financing activities			
Grant in aid from the Department of Health:			
Revenue		1,868	2,009
Capital		-	91
Devolved administration funding:			
Scotland		200	242
Wales		114	139
Northern Ireland		82	54
Net cash flow from financing activities		***2,264***	***2,535***
Net financing			
Net (decrease)/increase in cash and cash equivalents	8	(198)	51
Cash and cash equivalents at the beginning of the financial year	8	353	302
Cash and cash equivalents at the end of the financial year	8	**155**	**353**

The notes on pages 48-61 form part of these accounts.

[20] Excluding unused provision included in (decrease) in provisions

12. Statement of changes in taxpayer's equity for the year ended 31 March 2012

		General reserve	Revaluation reserve	Total
		£'000	£'000	£'000
Balance as at 31 March 2010		**290**	**1**	**291**
Changes in reserves in the year ended 31 March 2011				
Transfers between reserves		1	(1)	-
Net operating costs		(2,360)		(2,360)
Total recognised income and expenditure for the year ended 31 March 2011		**(2,359)**	**(1)**	**(2,360)**
Grant in aid from the Department of Health:				
Revenue		2,009	-	2,009
Capital		91	-	91
Funding from the devolved administrations:				
Scotland		242	-	242
Wales		139	-	139
N Ireland		54	-	54
Balance as at 31 March 2011		**466**	**-**	**466**
Changes in reserves in the year ended 31 March 2012				
Total recognised income and expenditure in the year ended 31 March 2012		(2,441)	-	(2,441)
Grant in aid from the Department of Health:				
Revenue		1,868	-	1,868
Capital		-	-	-
Funding from the devolved administrations:				
Scotland		200	-	200
Wales		114	-	114
N Ireland		82	-	82
Balance as at 31 March 2012		**289**	**-**	**289**

The notes on pages 48-61 form part of these accounts.

13. Notes to the accounts

1. Accounting policies

Basis of preparation

These financial statements have been prepared in accordance with the 2011/12 government *Financial Reporting Manual* (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the UK public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of CHRE for the purpose of giving a true and fair view has been selected. The particular policies adopted by CHRE for the reportable period are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

Critical accounting judgements and key sources of estimation uncertainty

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

Non current assets

Non current assets other than computer software are capitalised as property, plant and equipment as follows:

- Equipment with an individual value of £1,000 or more
- Grouped assets of a similar nature with a combined value of £1,000 or more
- Refurbishment costs valued at £1,000 or more.

Under the principles of modified historic cost accounting, depreciated historical cost is deemed a suitable proxy where the asset has a short useful economic life or is of low value. Indexation has not been applied since 31 March 2008 as this would not be material. Asset valuations are reviewed on an annual basis, at each statement of financial position date, to ensure that the carrying value fairly reflects current cost.

Depreciation is provided on a straight-line basis, calculated on the revalued amount to write off assets, less any estimated residual balance, over their remaining estimated useful life.

The useful lives of non current assets have been estimated as follows:

- Refurbishment costs, furniture and fittings over the remaining accommodation lease term
- Computer equipment – three years.

Depreciation is charged from the month in which the asset is acquired.

Computer software costs are charged to the operating cost statement on an accruals basis.

Cash at bank and in hand

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

In the statement of cash flows, cash is shown net of bank overdrafts held with the Government Banking Service (GBS) that form an integral part of CHRE's cash management and over which CHRE has a right of set off against other GBS accounts in credit.

Grant in aid and general reserve

CHRE is financed by grant in aid from the Department of Health.

Revenue grant in aid received from the Department of Health, used to finance activities and expenditure which support the statutory and other objectives of CHRE, is treated as contributions from a controlling party giving rise to a financial interest in the residual interest in CHRE and therefore is accounted for as financing by crediting them directly to the general reserve on a cash received basis.

Financial contributions to the activities of CHRE from the devolved administrations are also accounted for as financing by crediting them directly to the general reserve on a cash-received basis.

Operating income

Operating income includes Section 29 cost recoveries, premises income received from subtenants and income received from recycling old palmtop computers.

Comparative information and restatements

CHRE occupied offices at 157-197 Buckingham Palace Road from December 2010 under a Memorandum of Terms of Occupation (MOTO) with the National

Audit Office. CHRE has agreed MOTO's for part of this office space with the Independent Reconfiguration Panel (IRP) and the NHS Institute for Improvement and Innovation. The MOTO income in 2010/11 comprised £18k from IRP and was disclosed in other expenditure.

CHRE has reclassified MOTO income in 2011/12 as operating income and comparative amounts have therefore been reclassified in accordance with IAS1 Presentation of Financial Statements. More details are provided in note 4.

Section 29 costs and recoveries

Under its Section 29 powers, CHRE can appeal to the High Court against a regulatory body's disciplinary decisions. Costs incurred by CHRE in bringing Section 29 appeals are charged to the operating cost statement on an accruals basis.

As a result of judgements made by the courts, costs may be awarded to CHRE if the case is successful (income), or costs may be awarded against CHRE if the case is lost (expenditure). Where costs are awarded to or against CHRE, these may be subsequently revoked or reduced as a result of a successful appeal either by the defendant or by CHRE. Therefore in bringing either income or expenditure to account, CHRE considers the likely outcome of each case on a case-by-case basis.

In the case of costs awarded to CHRE, the income is not brought to account unless there is a final uncontested judgement in CHRE's favour or an agreement between parties of the proportion of costs that will be paid and submitted to the courts. When a case has been won but the final outcome is still subject to appeal, and it is highly probable that the case will be won on appeal and costs will be awarded to CHRE, a contingent asset is disclosed.

In the case of costs awarded against CHRE, expenditure is recognised in the income and expenditure where there is a final uncontested judgement against CHRE. In addition, where a case has been lost, but the final outcome is still subject to appeal, and it is probable that costs will be awarded against CHRE, a provision is recognised in the accounts. Where it is possible but not probable that the case will be lost on appeal and that costs may be incurred by CHRE, or where a sufficiently reliable estimate of the amount payable cannot be made, a contingent liability is disclosed.

Value added tax

Value added tax (VAT) on purchases is not recoverable, hence is charged to the operating cost statement and included under the heading relevant to the type of expenditure, or capitalised if it relates to an asset.

Short-term employee benefits

Salaries are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of

the year is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable 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.

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 statement at the time CHRE commits itself to the retirement, regardless of the method of payment.

Operating leases

Rentals payable under operating leases are charged to the operating cost statement on an accruals basis.

Foreign exchange

Transactions which are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the date of each transaction, except where rates do not fluctuate significantly, in which case an average rate for a period is used. Resulting exchange gains and losses are taken to the operating cost statement.

Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings including losses which would have been made good through insurance cover had CHRE not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). CHRE does not generally hold insurance but has specific cover in respect of travel and business continuity.

Financial instruments

As required by the FReM, CHRE has accounted for financial instruments and made disclosures relating to those financial instruments, in accordance with International Accounting Standards 32 and 39 and International Financial Reporting Standard 7.

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

IAS 8, accounting policies, changes in accounting estimates and errors, require disclosures in respect of new IFRS's, amendments and interpretations that are, or will be applicable after the accounting period. There are a number of IFRS's, amendments and interpretations issued by the International Accounting Standards Board that are effective for financial statements after this accounting period. The following have not been adopted early by CHRE:

- IFRS 7 Financial Instruments: Disclosures
- IFRS 9 Financial Instruments
- IFRS 13 Fair Value Measurement
- IAS 1 Presentation of Financial Statements
- IAS 19 Employee Benefits
- IAS 32 Offsetting Financial Assets and Financial Liabilities

None of these new or amended standards and interpretations are likely to be applicable or are anticipated to have future material impact on the financial statements of CHRE.

Early adoption of IFRS's, amendments and interpretations

CHRE have not adopted any IFRS's, amendments or interpretations early.

2. Analysis of net operating costs by segment

Segmental analysis

Changes have been made to the segmental analysis of CHRE's activities in 2011/12 which will endure at the point of transition to the Professional Standards Authority in 2012/13. Segmental analysis has therefore been restated for the year ended 31 March 2011 in accordance with IFRS 8.

Net operating costs were incurred by the CHRE's four main expenditure streams as detailed below. CHRE does not maintain a separate statement of financial position accounting for these segments. There were no inter-segment transactions in the year.

Year ended 31 March 2012	Standards and regulations	Observatory	Chargeable activities	Voluntary registers	Total
	£'000	£'000	£'000	£'000	£'000
Operating costs	2,368	82	247	19	**2,716**
Operating income	(275)	-	-	-	**(275)**
Net operating costs	2,093	82	247	19	**2,441**
Year ended 31 March 2011 (restated)	**Standards and regulations (restated)**	**Observatory (restated)**	**Chargeable activities (restated)**	**Voluntary registers (restated)**	**Total**
	£'000	£'000	£'000	£'000	£'000
Operating costs	2,235	158	22	-	**2,415**
Operating income	(41)		(14)	-	**(55**)
Net operating costs	2,194	158	8	-	**2,360**

3. Staff numbers and related costs

	Permanently employed	Other	Total year ended 31 March 2012	Permanently employed	Other	Total year ended 31 March 2011
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries	965	-	965	960	-	960
Social security costs	93	-	93	84	-	84
Super-annuation costs	121	-	121	118	-	118
Agency/ temporary costs	-	2	2	-	7	7
Total	**1,179**	**2**	**1,181**	**1,162**	**7**	**1,169**

Average number of persons employed

The average number of full time and part-time staff employed, including temporary staff, during the year is as follows:

	Permanently employed	Other	Total year ended 31 March 2012	Permanently employed	Other	Total year ended 31 March 2011
Total	18.83	0.10	**18.93**	18.72	0.18	**18.90**

There were no staff engaged on capital projects in the year ended 31 March 2012.

Reporting of Civil Service and other compensation schemes – exit packages

Council has not made any payments in respect of exit packages in the year ended 31 March 2012.

4. Other expenditure

	Notes	Total year ended 31 March 2012	Total year ended 31 March 2011 (restated)
		£'000	£'000
Members' remuneration		91	92
Legal and professional fees		732	457
Consultancy		-	8
Premises and fixed plant[21]		477	483
Training and recruitment		23	47
PR, communications and conferences		14	30
Establishment expenses		50	64
External audit fee[22]		23	24
Other costs		83	71
Non cash expenditure:			
Unused provision		-	(113)
(Profit)/loss on disposal of fixed assets		1	1
Depreciation	6	41	82
Total expenditure		**1,535**	**1,246**

[21] As referred to in note 1, 2010/11 MOTO payments from IRP of £18k in respect of office space at 157-197 Buckingham Palace Road have been reclassified as operating income and removed from Premises and fixed plant expenses. This reclassification has also been reflected in the statement of comprehensive net expenditure and related notes. The statement of financial position as at 1 April 2011 is not affected by this reclassification as shown in note 1.

[22] CHRE made payments of £293k to the National Audit Office for non-audit work in respect of accommodation costs of CHRE for use of office space at 157-197 Buckingham Palace Road, London.

5. Operating Income

	Total year ended 31 March 2012	Total year ended 31 March 2011 (restated)
	£'000	£'000
Section 29 cost recoveries	98	23
Other operating income	177	32
Total operating income	**275**	**55**

6. Non-current assets

Intangible assets

CHRE held no intangible assets as at 31 March 2012 and 31 March 2011.

Property, plant and equipment

31 March 2012	Furniture, fixtures & fittings – conversion costs	IT equipment	Total
	£'000	£'000	£'000
Valuation			
At 1 April 2011	111	173	284
Additions	8	89	97
Disposals	(2)	(24)	(26)
At 31 March 2012	117	238	355
Depreciation			
At 1 April 2011	50	127	177
Charge in year	14	27	41
Disposals	(2)	(23)	(25)
At 31 March 2012	62	131	193
Net book value			
At 31 March 2012	**55**	**107**	**162**
At 31 March 2011	61	46	107

All assets above are wholly owned by CHRE without any related financial liabilities.

31 March 2011	Furniture, fixtures and fittings – conversion costs	IT equipment	Decommissioning costs	Total
	£'000	£'000	£'000	£'000
Valuation				
At 1 April 2010	168	147	166	481
Additions	65	26	-	91
Revaluation	-	-	2	2
Disposals	(122)	(1)	(168)	(291)
At 31 March 2011	111	172	-	283
Depreciation				
At 1 April 2010	146	98	141	385
Charge in year	26	28	28	82
Disposals	(122)	-	(169)	(291)
At 31 March 2011	50	126	-	176
Net book value				
At 31 March 2011	**61**	**46**	**-**	**107**
At 31 March 2010	22	49	25	96

7. Trade receivables and other current assets

Amounts falling due within one year:

	31 March 2012	31 March 2011
	£'000	£'000
Trade and other receivables	83	18
Prepayments	177	162
Total trade and other receivables	**260**	**180**

There are no trade receivables and other current assets falling due after more than one year.

Intra government balances

Intra government balances within the totals for trade receivables and other current assets are as follows:

	31 March 2012	31 March 2011
	£'000	£'000
Balances with other central government bodies	24	4
Balances with local authorities	138	123
Total Intra government balances	162	127
Balances with bodies external to government	98	53
Total trade and other receivables	**260**	**180**

8. Cash and cash equivalents

	31 March 2012	31 March 2011
	£'000	£'000
Balance at 1 April 2011	353	302
Net changes in cash and cash equivalent balances	(198)	51
Balance as at 31 March 2012	**155**	**353**
The following balances were held at:		
Government Banking Service	153	221
Commercial banks and cash in hand	2	132
Balance as at 31 March 2012	**155**	**353**

9. Trade payables and other current liabilities

Amounts falling due with one year:

	31 March 2012	31 March 2011
	£'000	£'000
Trade and other payables	142	68
Taxation and social security	32	31
Accruals	111	67
Total trade and other payables	**285**	**166**

There were no trade payables and other current liabilities falling due after more than one year.

Intra government balances

Intra government balances within the totals for trade payables and other current liabilities are as follows:

	31 March 2012	31 March 2011
	£'000	£'000
Balances with other central government bodies	110	75
Balances with NHS trusts	-	1
Total intra government balances	110	76
Balances with bodies external to government	175	90
Total trade and other payables	**285**	**166**

10. Provisions for liabilities and charges

	HMRC provision	Total
	£'000	£'000
Balance at 31 March 2011	8	8
Arising during the year	3	3
Provision used	(8)	(8)
Balance at 31 March 2012	**3**	**3**

The HMRC provision as at 31 March 2011 and 2012 represents CHRE's estimated liability for income tax and National Insurance Contributions in relation to Council member travel and subsistence expenses.

11. Contingent assets and liabilities

Assets

There were no contingent assets at the year end.

Liabilities

One High Court case under CHRE's Section 29 powers was undecided as at 31 March 2012. There was therefore uncertainty, as at that date, as to the related financial consequences until a final judgement is made.

Judgement by the High Court may permit recovery of these CHRE costs or, alternatively, a charge to CHRE of the costs of the regulatory body and its registrant.

Judgement was made on the undecided case above on 5 April 2012, in favour of CHRE. On 18 May 2012, the Health Professions Council agreed to contribute £6,500 towards CHRE's costs of this case.

12. Capital commitments

The Council had no capital commitments as at the statement of financial position dates.

13. Commitments under leases

Operating leases

CHRE's expenses include rent and service charge payments under operating lease rentals.

CHRE had the following obligations under non-cancellable operating leases:

Buildings	31 March 2012	31 March 2011
	£'000	£'000
Not later than one year	278	278
Later than one year and not later than five years	718	995
Total commitments under operating leases	**996**	**1,273**

Finance leases

CHRE did not have any finance leases in the year ended 31 March 2012

14. Related parties

CHRE has ultimate accountability to the UK Parliament. It is an executive non-departmental public body sponsored by the Department of Health.

The Department of Health is regarded as a related party. During the year to 31 March 2012 the Department of Health provided total grant in aid of £1.87m (2010/11: £2.10m).

CHRE received funding contributions towards its activities in the year from the devolved administrations in Northern Ireland (£0.08m), Scotland (£0.20m), and Wales (£0.11m). In 2010/11 CHRE received £0.05m from Northern Ireland, £0.24m from Scotland and £0.14m from Wales.

Apart from the above there were no related party transactions entered into.

CHRE maintains a register of interests for the Chair and Council members which is available on the website. On a periodic basis the register is updated by the Executive Secretary to reflect any change in Council members' interests. During the period ending 31 March 2012 no Council member undertook any related party transactions with CHRE.

The senior management team is also asked to disclose any related party transactions. During 2011/12 there were no disclosures.

15. Losses and special payments

There were no material losses and special payments in the period.

16. Post statement of financial position events

There are no material post statements of financial position events. These accounts were authorised for issue on 15 June 2012 by the Accounting Officer.

17. Financial instruments

Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

The relationship that CHRE has with Department of Health, and the way it is financed, means that its exposure is reduced. In addition CHRE has limited powers to borrow or invest surplus funds and its financial assets and liabilities are generated by day-to-day operational activities, thus the effect of the financial instruments on changing the risk is again reduced.

Debtors and creditors that are due to mature or become payable within 12 months from the statement of financial position date have been omitted from all disclosures.

Currency risk

CHRE is a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. CHRE has no overseas operations. CHRE therefore has low exposure to currency rate fluctuations.

Interest rate risk

CHRE has no borrowing and relies primarily on grant in aid from the Department of Health and financial contributions from the devolved administrations. CHRE therefore has low exposure to interest rate fluctuations

As at 31 March 2012 CHRE had a non-interest bearing cash balance of £153k and a cash balance of £2k generating a floating interest rate.

Credit risk

Because the majority of CHRE funding income comes from the Department of Health, with contributions from the devolved administrations, CHRE has low exposure to credit risk.

Liquidity risk

CHRE relies primarily on grant in aid from the Department of Health, financed from resources voted annually by Parliament, and contributions from the devolved administrations and therefore has low exposure to liquidity risk.

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