The Council for Healthcare Regulatory Excellence

Annual report and accounts

2010/11

Annual report volume I

council for healthcare regulatory excellence

The Council for Healthcare Regulatory Excellence

Annual report volume I: Annual report and accounts 2010/11

(Associated with this document is the Annual report volume II: Performance review of 2010/11.)

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1. Chair's introduction

This has been a challenging year for most public bodies and CHRE is no exception. Not only is the financial climate the toughest most of us have ever faced but there has been a huge upheaval in the shape of the public sector through various legislative proposals and government plans. Unlike many other organisations we are not facing abolition or merger but we are facing considerable change when the proposals in the Health and Social Care Bill reach the statute book.

For a large part of this year therefore CHRE staff and Council have been planning and preparing for the challenges of 2012 and beyond as well as for a period of transition. In circumstances like these it is easy to forget that the current business has also to be carried out to the highest standards and that there can be no faltering in the present even when so much energy has to be devoted to the future. I want to place on record my most grateful thanks and warmest congratulations to all CHRE staff for the way they have dealt with this stressful situation, facing it with commitment, skill, hard work, good humour and positive attitudes. Even moving into new premises, that notorious test of patience and goodwill, was managed effectively and efficiently.

Subject to Parliamentary approval, 2012 will see the establishment of a transformed CHRE, with a different legal structure, different accountability and different funding arrangements. As the Professional Standards Authority for Health and Social Care we shall be responsible to Parliament through the Privy Council, receive most of our income from a levy on the regulators and have the power to accredit voluntary registers, as well as taking on other responsibilities. The fact that these proposals have been made and introduced into legislation is a clear indication that the government believes that we can be trusted to deliver this challenging agenda and that we can maintain the good relationships we have established with regulators as we do so. That we are so trusted is due in no small measure to the ability of our CEO Harry Cayton, who is indefatigable in his promotion of the principles of what is fast becoming established as 'right-touch regulation' and whose passionate commitment to putting patient and public safety at the heart of good regulation continues to be so important in the work of the organisation.

At a time when we shall be facing so much change, it is a great relief to me personally that our governance structure will remain the same since no one could wish for a more able, well-informed or committed Council than the one I chair. I am grateful for their wisdom and foresight, for their hard work and for the principles we share. I look forward to working with staff and Council colleagues in the exciting year ahead.

Baroness Jill Pitkeathley
Chair

2. Council report

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 12.)

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.

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.

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

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.

[1] Available at http://www.opsi.gov.uk/acts/acts2002/ukpga_20020017_en_1
[2] Available at http://www.opsi.gov.uk/acts/acts2008/ukpga_20080014_en_1

In addition, we monitor policy in the UK and Europe.

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

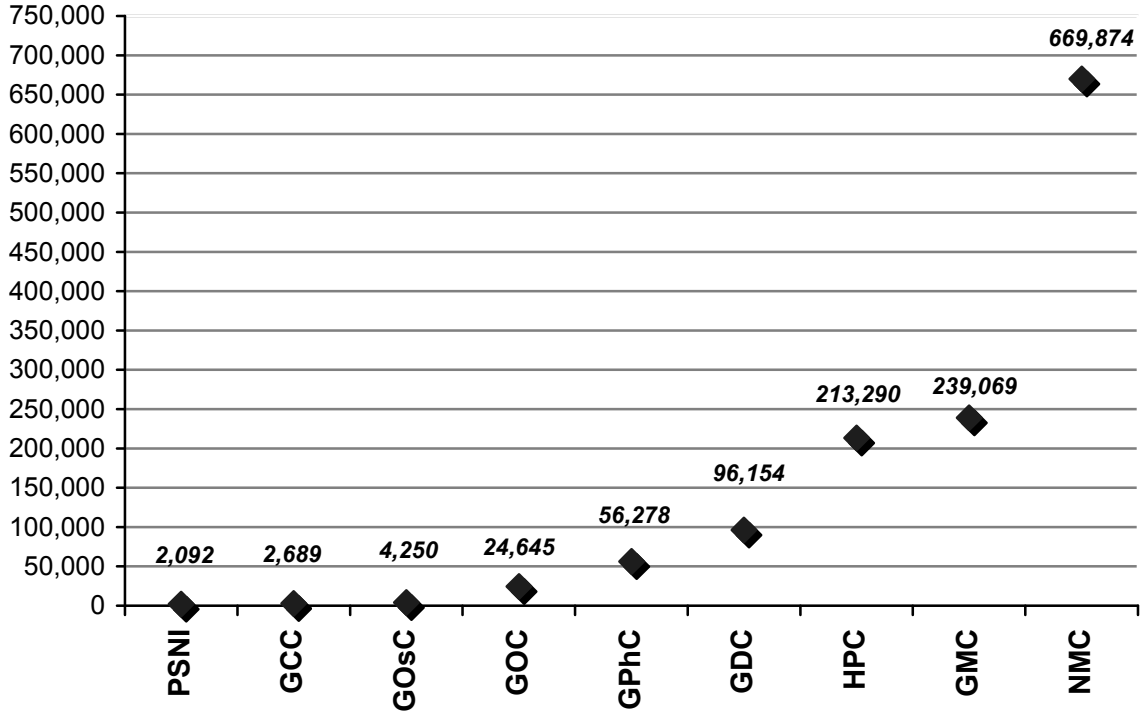
1. We monitor the performance of the regulatory bodies annually to identify good practice and areas for improvement
2. We audit initial stages of the regulatory bodies' fitness to practise procedures and examine final decisions made by them about whether healthcare professionals are fit to practise. 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 2011 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 2011/12

The aims and objectives of CHRE are set out below.

For 2011/12 we have two overarching priorities:

- To fulfil our current and continuing statutory obligations
- To prepare to implement our new roles and responsibilities during 2012.

Our aim

CHRE aims to promote the health, safety and well-being of patients and other members of the public and to be a strong, independent voice for patients in the regulation of health professionals throughout the UK.

Our mission

We protect the public by:

- Helping the regulatory bodies to improve their performance
- Setting and driving up standards for health professional regulation
- Encouraging greater consistency of regulatory practice and outcomes
- Shaping future developments in the regulation of health professionals.

We aim to promote and support 'right-touch' regulation. This is regulation that is based on a careful assessment of risk, which is targeted and proportionate, which provides a framework in which professionalism can flourish and organisational excellence can be achieved - that is the consistent performance of good practice combined with continuous improvement.

Our strategic plan also takes into account views from patients, the public, regulatory bodies and other key stakeholders.

As reviewed and agreed by our Council in October 2010, CHRE's strategic priorities for the next three years are:

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

We will do this by:

- Working with the regulatory bodies to deliver reliable assessment and robust oversight of their performance
- Using our statutory powers to audit and review fitness to practise cases appropriately, including the statutory right of appeal
- Being proportionate and focused on outcomes
- Enabling good practice and learning to be shared
- Transparent, robust and fair public reporting.

We will know we have succeeded because:

- There is a continuing overall reduction in concerns identified in our performance review and audits
- We refer fewer cases to court
- We see more good practice and improvement in the regulators
- We will have identified innovative opportunities for sharing learning and good practice.

Building evidence and promoting debate in order to identify excellence in health professional regulation and to contribute to the wider field of regulatory policy

We will do this by:

- Research and analysis of policy in regulation and healthcare
- 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 suggesting solutions
- Publishing advice, guidance and research
- Promoting discussion, debate and learning through seminars and conferences
- Understanding the wider context of regulation in the UK and internationally.

We will know we have succeeded because:

- There is continuing and sustained demand for our policy advice
- We will have played an active role in delivering the reforms arising from the 2007 White Paper, including revalidation
- An evidence base will be established around excellence in professionalism and regulation, including work completed by the regulation observatory
- Other organisations, including the Department of Health and regulatory bodies, take action to deliver our recommendations
- Our insight and experience is sought by the wider regulatory sector
- Right-touch regulation is applied and there is continuing improvement in the quality of professional regulation.

Promoting and applying right- touch regulation in the development of our standards and processes and in our work to improve the quality of professional regulation

We will do this through:

- Consistent application of our values and principles and the elements of right-touch regulation
- Strong relationships and partnership with the regulatory bodies
- Dialogue with patients, the public and their representative organisations
- Our commitment to inclusion, equality and diversity
- Promoting regulation's role in patient safety

- Being clear and positive in our relationships with regulatory bodies
- Active engagement across regulation both within and outside the health sector
- Independent and constructive relationships with sponsor departments and recognition of our value across the UK.

We will know we have succeeded because:

- There is greater public awareness about the role of professional regulation
- The right-touch regulation approach is widely understood and supported
- The views, expectations and experiences of patients and the public run throughout our work
- There is greater consistency in the outcomes of activities of the regulatory bodies we oversee
- We are invited to contribute to seminars, conferences and other events
- Our work continues to be recognised and valued internationally.

To further these strategic aims we have undertaken the work described below during the year.

Work in 2010/11

Quality and scrutiny

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 too lenient 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. This report shows clearly that although the number of fitness to practise cases being managed by the regulators has risen significantly, the number we have serious concerns about has dropped to two during 2010/11.

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 do this in writing and through holding feedback meetings with the regulatory bodies. These meetings have resulted in agreed actions, often involving additional training for the regulators' fitness to practise panel members. We have continued to contribute to many of the regulators' training sessions for panel members and legal assessors on matters such as the writing of determinations.

This year we have again seen an increase in the number of fitness to practise cases notified to us by the regulators, from 1,370 in 2008/09; 1,835 in 2009/10 to 2,192 in 2010/11.

Of the 2,192 cases we received between 1 April 2010 and 31 March 2011, 1,898 were closed with no requirement for more information. We sought and considered additional information in 264 cases. In 425 of all cases received we identified learning points to feed back to the regulators.

During the year we considered eight cases at case meetings, and we referred three cases to court. All of the referrals were NMC cases. We expect an outcome from these later in 2011. We also reached settlement in two NMC cases which we referred to court in 2009/10.

All five of the cases considered at case meetings that did not result in court referrals resulted in us feeding back comments to the regulators. Our feedback proposed improvements to their handling of future cases.

This year we carried out our second audit of cases closed at the initial stages of the fitness to practise process. We audited a selection of cases that each of the regulators had closed without referral to a final panel hearing. This included cases closed by the GPhC during its first three months of operation.

We found that the audits of all but two of the regulators demonstrated a continuation of good practice or improvements in practice compared to our findings during last year's audit. We made a number of recommendations. The Regulators responses to these can be found in Volume II of this report and on our website at www.chre.org.uk/satellite/387/.

We found that the regulators had casework systems that meant that they generally achieved good standards of record keeping and decision making. Most of the regulators demonstrated good communication with the public and adequately explained why they had reached decisions to close individual cases without referral to a final panel hearing.

Performance review

We have carried out our annual performance review of the nine regulators for 2010/11 using the revised standards and process which we referred to in our 2009/10 report.

The revised standards have enabled us to focus our reporting more closely on the outcomes achieved by the regulators in terms of improving public protection and patient safety. Our 2010 performance review report only refers to individual regulators' processes where we consider that will assist other regulators to improve their own processes, or where we consider that the processes have impacted negatively on the regulator's performance.

We have also improved the way in which we set out the information in the performance review report for 2010 (for example by reducing our use of technical language) as a result of comments we received from members of the public, groups representing patient interests, employers and others about last year's report.

Our stakeholder engagement has also resulted in us receiving a record amount of feedback from third parties during this year's performance review process, which has been very useful.

For further information on our performance review of the health professional regulators in 2010/11, please refer to volume II of this annual report.

NMC progress review

In June 2010 the NMC invited us to carry out a progress review of its fitness to practise function. We were asked to look at the organisation's progress since we published our special report to the Minister of State in 2008, and following the results of our first initial stages audit (carried out in June 2009). We had expressed our concern about the standards of casework and the general performance of the fitness to practise department in those two reports.

As a result of our progress review, we found that the NMC had made some significant improvements to its fitness to practise work, such as the introduction of a new case management system and the use of fit-for-purpose premises for fitness to practise hearings. However, we remained concerned about the number and seriousness of the improvements that the NMC still had to make, particularly around its customer care, its management of serious cases and the timeliness of its case progression. We were satisfied that the NMC had developed a good understanding of the areas in which it still needed to improve, and that it recognised that its failings potentially impacted on both public protection/patient safety and the public's confidence in the NMC as an effective regulator. We agreed with the NMC that we would work together over the months following publication of the report to ensure that improvements continued to be made. The report of our 2010 progress review is available on our website at www.chre.org.uk/satellite/320/

Review of 11 General Teaching Council (England) cases involving allegations of racism

Our expertise and advice has been sought outside the health sector. In June 2010 the General Teaching Council for England (GTCE) invited CHRE to undertake a review of its handling of 11 cases which involved allegations of racism. We welcomed the invitation to use our expertise in a new regulatory setting which also afforded us the opportunity to gather good practice. From the information we reviewed, we considered that the GTCE had generally handled these cases well, and that it had appropriate procedures and processes in place. We saw examples of good case handling and decision making. We also identified areas for improvement in relation to the GTCE's procedural manuals, the quality of its investigations and the sanctions imposed on registrants. The GTCE met the cost of our review.

As a result of the review we also identified areas of concern resulting from the GTCE's underpinning legislation. While these concerns had only a limited impact on the 11 cases we reviewed (and only in relation to sanctioning) we considered they should be taken into account in any future model of regulation for the teaching profession in England.

As a result of our report, the Department for Education asked for our input to the development of its proposals for the future regulation of teachers in England.

The full report is available at www.chre.org.uk/satellite/318/.

Advice on right-touch regulation

This year we have continued to develop our body of knowledge regarding effective health professional regulation and published our paper, *Right-touch Regulation,* which has been well received. Right-touch regulation is an approach to proportionate, targeted and risk-based regulation which we use as a guide in our own work and as a means of judging the work of others.

We have responded to commissions from the Departments of Health to provide advice to ministers.

This year commissions from the UK government were affected by the general election which meant that we received commissions late in the year. Specifically, during 2010/11, we published policy recommendations on managing extended practice; and are on track to deliver our advice on modern and efficient fitness to practise adjudication. We have held preliminary discussions with the Department for Health on a commission linked to the Command paper entitled *Enabling Excellence; Autonomy and Accountability for Health and Social Care Staff.*

We have also been working on developing the performance review to include more quantitative data from the regulators to help us – and the public – to assess their performance.

We introduced fortnightly *Viewpoint* articles on the CHRE website in which we comment on topical issues and proactively disseminate our advice and expertise on regulatory matters in the UK and in Europe.

We actively engage with members of the public to ensure that their views and opinions influence our work. We have published guidance for patients on what to expect from health professionals and have piloted complaints guidance.

A key part of our work is providing input into policy reviews and consultations undertaken by other organisations. We have responded to 17 consultations from the regulators and others, including the Law Commission where we suggested the introduction of a single act for the regulation of health professionals to unify health professional regulation and improve consistency.

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 are crucial to inform and direct our work.

We have worked to improve the ways that we engage with the public to ensure that our work better reflects the views of the public.

We have sought to widen our engagement to reach more diverse groups and have again increased the membership of our Public Stakeholder Network. Network members' input continues to influence and improve the quality of our external communications.

We keep network members involved in our work through our electronic newsletter, email updates, invitations to participate in our events and requests for their input into our consultations and discussions. We have extended the use of our newsletter, inviting members of the public and regulators to submit articles to encourage dialogue.

In order to develop further our relationship with the members of the Public Stakeholder Network, we held a series of five meetings with the public in October 2010, which we called 'Four Country Conversations'. These were held across England, Northern Ireland, Scotland and Wales. Attendees participated in workshops which enabled them to make suggestions for possible improvements in our work. As was our aim, attendees learned about CHRE and current regulatory issues. We in turn gained valuable insight into the public's perception of our work and how it may impact on the lives of patients and the public. We also held a meeting with a small number of minority groups to discuss ways to increase our engagement with a more diverse public.

Promoting discussion and debate

CHRE endeavours to be proactive in the field of health professional regulation, learning from others and sharing that knowledge.

We are actively raising the profile of health professional regulation, encouraging greater synergies and learning between system and professional regulation and have held joint staff seminars with the Office of Fair Trading and the Legal Services Board.

During 2010/11 we continued to host discussion seminars on the future of regulation, identifying areas of interest across regulatory and other sectors, and bringing people together to discuss them. We held four seminars in London and Edinburgh where we discussed:

- Regulating for compassion
- Patient safety
- Devolution – regulation in the four UK countries
- Employers – regulation and the workplace.

Approximately 35 organisations were represented at the seminars, including patient and public organisations, regulatory bodies from across the UK from the health sector and other sectors, government departments, think tanks, professional associations, charities and colleges.

In January 2011 we held a third high-level symposium to discuss the extent to which regulation is value for money. The symposium involved amongst others the health professional regulatory bodies, representatives from the Departments of Health for each of the UK Countries, the Office for Fair Trading, the General Social Care Council, the Care Quality Commission and National Voices. The regulators are considering plans to take forward the ideas and proposals that arose.

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. We continue to monitor relevant developments in Europe through our membership of European-level organisations and groups.

Work is continuing to establish the CHRE International Observatory on the Regulation of Health Professionals. The Observatory will be a repository of information on how health professional regulation works internationally, with the aim of supporting cross-country learning on good practice. We have contracted with the London School of Economics to work with us to establish this facility.

To date, 81 organisations from 31 countries have become members of the Observatory, with the longer term aim of expanding its scope to cover a still wider range of countries and professions. The Observatory website is on track to go live by summer 2011.

Who we are and how we work

Council

CHRE's Council comprises seven non-executive members and up to two executive members. All non-executive members of our new Council have been appointed from the public, so that we are completely independent of the healthcare professional regulators.

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

Council members

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

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

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.[3]

Attendance at Council meetings held in public

There were six Council meetings held in public between 1 April 2010 and 31 March 2011.

Council member	Number attended
Jill Pitkeathley (Chair)	6
Ann Curno	5
Ian Hamer	6
Andrew Hind	6
Sally Irvine	6
Stuart MacDonnell	5
Jayne Scott	6
Harry Cayton	6

Committees and working groups of the Council

Audit and Risk Committee

Role

The Council established an Audit and Risk Committee to support them in their 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 2010 and 31 March 2011. Members' attendance is shown below.

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

[3] Available at: http://www.opsi.gov.uk/acts/acts2002/ukpga_20020017_en_15#sch7

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. In particular, this includes work in the following areas:

- Consideration of final fitness to practise decisions
- The audit of initial fitness to practise decisions
- Reviewing the performance of the regulators
- Consideration of complaints about the regulatory bodies.

There were three Scrutiny Committee meetings held between 1 April 2010 and 31 March 2011. Members' attendance is shown below.

Committee member	Number attended
Sally Irvine (Chair)	3
Ann Curno	3
Ian Hamer	3

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 were two Remuneration Committee meetings held between 1 April 2010 and 31 March 2011. Members' attendance is shown below.

Committee member	Number attended
Jill Pitkeathley (Chair)	2
Ian Hamer (in the absence of Andrew Hind)	1
Andrew Hind	1
Harry Cayton	2

4. Chief Executive's report

The change of government, the subsequent changes in policy, the review of 'arm's length bodies' and the financial pressures on the public sector have all meant that the last year has seen considerable pressure and additional work for CHRE.

I am pleased that we have maintained our statutory roles throughout the year, including the production of an important statement of our position on professional regulation, *Right-touch Regulation,* while contributing constructively to the arm's length bodies review undertaken by the Department of Health.

We have carried out a second annual audit of the initial stages of fitness to practise while continuing to review all cases which reach a final determination and to exercise our power of appeal if and when we judge it necessary for the protection of the public. The number of such cases has risen significantly during the year but our small scrutiny and quality team has managed to review all cases within the statutory deadline.

We have worked closely with the regulators and others in promoting good practice in regulation and in encouraging learning, discussion and debate. We continue to respond to commissions from the Secretary of State for Health for policy advice and to make sure our advice is responsive to developments in Scotland, Wales and Northern Ireland.

We have managed our budget within the cuts required by the government and have complied with all the restrictions placed on us including a pay freeze for all staff. We have reduced our office costs by moving to new premises and by sharing space with other organisations.

Operationally we are structured to reflect the key areas of our work:

- Scrutiny and quality
- Policy, research and external relations
- Governance and operations.

The directors of each area with the chief executive form the Management Team, which meets on a regular, formal basis to review and discuss a range of issues. These include reviews of the budget, risk management, policy development and the recruitment of staff. To further our statutory duties, we continued to research and develop regulatory thinking and advice and built upon our reputation as a forum for open and challenging debate about regulation in health and social care.

During 2010/11 the Management Team was strengthened by the appointment of new directors in each area. They have each brought considerable experience and expertise. Each of them has ably led their own team and provided valuable support to both me and the Council.

Our performance is monitored internally by Council through its oversight of the strategic and operational functions of the organisation. Reports to the Council and its committees include financial updates, risk assessments, details of progress against business plan objectives and regular reports from internal and external auditors.

In addition, quarterly meetings are held between our executive and the Department of Health. In addition this year we have worked with the Department of Health Arm's Length Bodies Transition Team.

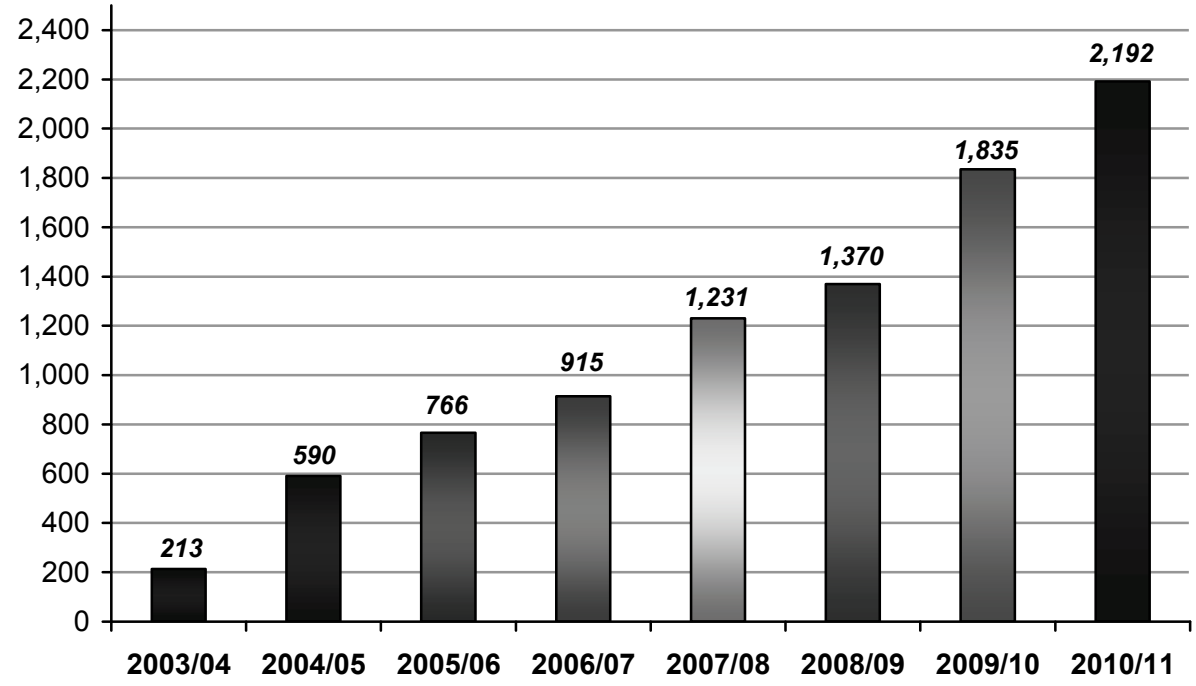
Performance

There has been a 19 per cent increase in the number of fitness to practise cases notified to us by the nine regulators, compared to the previous year. We have continued to review all cases within our statutory deadline.

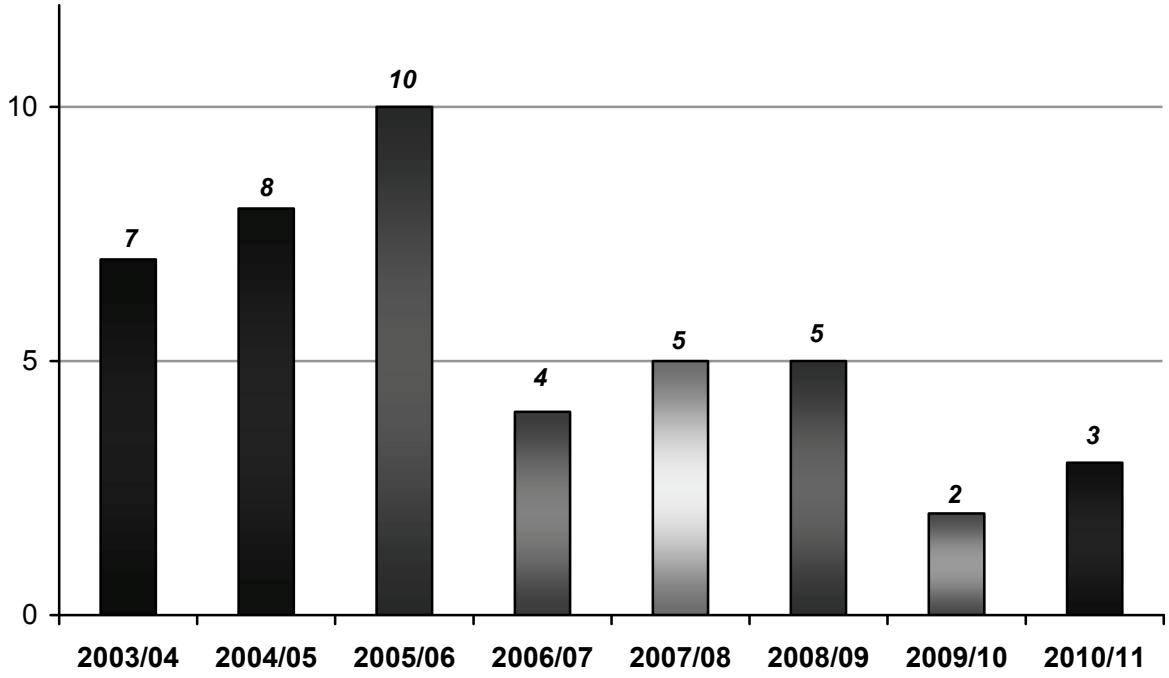
The possible reasons behind the upward trend in the number of fitness to practise cases notified to us were explained in last year's annual report. The increase is likely to be a direct consequence of the increasing number of serious fitness to practise complaints dealt with by the regulators each year, as well as of the extension of our remit in 2008 to include decisions in cases about ill-health. For example, the GMC's annual report for 2009 reported that the number of enquiries it had considered had increased by 11 per cent compared to 2008. During 2010/11 we have received a far higher than usual number of fitness to practise decisions from the GCC, which has contributed to the overall increase.

Despite the increase in the number of cases reviewed there has continued to be a decrease in case meetings and court referrals this year. This reflects the general downward trend over the last five years. We think that this is the result of an overall improvement in the quality of the decision making at the regulators' final panel hearings. There are several factors that we believe have influenced this overall improvement, including the impact of learning points that we have fed back to the regulators, as well as significant court decisions.

Number of fitness to practise cases reviewed by CHRE annually



Number of fitness to practise cases referred to court each year



Office accommodation

In December 2010 we left the premises at 11 Strand London WC2 and moved to 157-197 Buckingham Palace Road London SW1. By making this move we have reduced our office costs while improving the working environment for our staff. We aim to make effective use of the space available and are sharing with the Independent Reconfiguration Panel. We have also offered accommodation to the NHS Institute for Innovation and Improvement, and on a temporary basis to displaced members of staff from the Appointments Commission.

Future developments

We will continue to concentrate on the delivery of our principal activities in order to ensure that we continue to promote the interests of patients and the public within health professional regulation. We will continue to focus on right-touch regulation, promoting 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.

Information governance

Information governance describes the policies and proceedures by which we use, share, store and keep safe the information that we need to carry out our work. Over the last 12 months we have built on our successful implementation of the Cabinet Office's minimum mandatory requirements. We continue to thoroughly assess the risks to information we hold and have put in place suitable safeguards to minimise and manage risks. This year, to strengthen our systems of internal control, all staff have undergone training in how to value and safeguard the information that we hold. We have changed the way in which we record incoming case files in response to a data loss which is reported in more detail on page 28 of this report. We have also carried out penetration testing of our systems to ensure that they are secure.

Website

Our website is an important communication tool. We use it to publish:

- Our key annual reports – the annual report, performance review and the audit of the initial stages report
- All information and updates on the range of our work to target patients and the public, professionals and parliamentarians
- Regular policy updates
- Our interactive online newsletter, which in 2010/11 features our projects, articles from patients and the public, and professionals. It has facilitated discursive debates as we receive feedback on a perspective proposed in an article and deliver this feedback securely to authors
- Press releases and our news coverage (including archived information and reports). This has been reported to be useful to journalists.
- Consultation and exchange, enabling us to conduct formal consultations and informal discussions with a variety of partners and groups.

Our users report that the website is friendly, active (as it is regularly updated) and attractive. We received an independent 70 per cent rating on accessibility in December 2009, but not being satisfied with that, in March 2010 we invited the public to tell us how we could better communicate with them through the website. As a result, in 2010/11, we implemented enhanced colour and navigation schemes. Our accessibility rating has improved for those with colour blindness. We also improved navigation by making information available in easy-read formats, after which viewers could elect to access more detailed reports through website links. To aid continued improvement, we regularly review sources of traffic, special interest areas and pages with the most hits.

In collaboration with the Welsh Language Board, our website displays essential patient and public information in English and Welsh.

Environment

We seek to minimise the impact of our activities on the environment. We use recycled materials where such alternatives are available and provide value for money. We seek to reduce the use of paper by maximising the use of our intranet and website for the dissemination of information. Our new office was refurbished to the BREEAM environmental assessment standard, which looks at heating, lighting, recycling and other matters, and has an 'excellent' rating. When travel is necessary we use public transport as much as possible and have increased our use of telephone conferencing to avoid travel.

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 (pages 39-55).

This report has been prepared in accordance with the Accounting Standards Board's *Reporting Statement: Operating and financial review*.

Our external auditor is the Comptroller and Auditor General. South Coast Audit provides the internal audit function.

Financial summary

Grant in aid funding for 2010/11 comprised £2.1m from the Department of Health and £0.435m from the devolved administrations. At 31 March 2011, we had reserves carried forward of £0.47m (2009/10: £0.29m) after net operating costs of £2.36m (2009/10: £2.6m).

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

Our creditor payment policy changed in 2009/10 in accordance with the introduction of the government's Better Payment Policy when we aimed to pay all creditors within 10 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. This target was changed to five days in 2010/11. This target could only be achieved if we employed more staff. Accordingly we aim to pay 60 per cent of undisputed invoices in five days and 100 per cent in 10 days.

During 2010/11 financial year, payments were made to suppliers as follows:

Period	No of invoices paid within 5 working days	Total No of invoices paid within period	% of invoices paid within 5 working days	Amount paid within 5 working days	Total amount paid within period	% of total amount paid within 5 working days
Apr-Jun 10	66	154	43%	£109,647	£208,648	53%
Jul-Sep 10	94	186	51%	£108,801	£267,108	41%
Oct-Dec 10	139	282	49%	£66,130	£294,877	22%
Jan-Mar 11	146	267	55%	£364,866	£620,022	59%
Total	**445**	**889**	**50%**	**£649,444**	**£1,390,655**	**47%**

Period	No of invoices paid within 10 working days	Total No of invoices paid within period	% of invoices paid within 10 working days	Amount paid within 10 working days	Total amount paid within period	% of total amount paid within 10 working days
Apr - Jun 10	154	154	100%	£208,648	£208,648	100%
Jul - Sep 10	186	186	100%	£267,108	£267,108	100%
Oct - Dec 10	282	282	100%	£294,877	£294,877	100%
Jan - Mar 11	267	267	100%	£620,022	£620,022	100%
Total	**889**	**889**	**100%**	**£1,390,655**	**£1,390,655**	**100%**

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

The balance owed to trade creditors as at 31 March 2011 was £67,626 (2009-10: £37,485). As a proportion of the total amount invoiced by suppliers in the year, this is equivalent to 18 days (2009/10: nine days).

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.

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

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

Each year the Remuneration Committee also considers an annual uplift to reflect a cost of living increase payable from October. We were instructed by the Department of Health that no cost of living increase could be paid in line with the pay guidance for government employees issued by Cabinet Office.

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. We treat termination payments and provisions for compensation for termination on a case-by-case basis in consultation with our advisors.

A total of 55.0 days (2009/10: 58.5 days) were lost due to sickness absence in the year. This equates to 2.9 days (2009/10: 3.2 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
Michael Andrews	Director of Scrutiny and Quality	19 January 2004 (left 14 May 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) 2010-11	Salary (£'000) 2009-10	Real increase/ (decrease) in pension at age 60 (£'000)	Total accrued pension at 31 March 2011 (£'000)
Linda Allan	80-85	0-5 (full year equivalent 80-85)	0-2.5	0-2.5
Michael Andrews	5-10 (full year equivalent 70-75)	65-70	0-2.5	5-7.5
Christine Braithwaite	70-75 (full year equivalent 80-85)	-	0-2.5	7.5-10
Harry Cayton	135-140	135-140	0-2.5	10-12.5
Rosalyn Hayles	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.

Note: the following were not provided: benefits in kind; performance bonuses; expenses allowance; compensation for loss of office or termination of service (2009/10: £nil).

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 2010 (to nearest £1,000)	Cash Equivalent Transfer Value as at 31 March 2011 (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	0-2.5	N/A	N/A	1	19	18
Michael Andrews	Director of Scrutiny and Quality	5-7.5	15-17.5	0-2.5	86	79	(9)
Christine Braithwaite	Director of Policy and External Relations	7.5-10	27.5-30	2.5-5	159	169	5
Harry Cayton	Chief Executive	10-12.5	32.5-35	2.5-5	236	N/A*	N/A*
Rosalyn Hayles	Director of Scrutiny and Quality	0-2.5	N/A	N/A	-	6	6

* Member over 60 not applicable

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

Council members' remuneration

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

The Chair receives remuneration of £33,688 pa (2009/10: £33,688), members receive annual remuneration of £7,881 (2009/10: £7,881) and the Audit and Risk Committee Chair receives annual remuneration of £13,135 (2009/10: £13,135). Members' remuneration during the year amounted to £92,134 (2009/10: £92,154) including social security costs.

In addition, expenses amounting to £13,196 (2009/10: £15,947) were reimbursed to Council members.

Members' remuneration is subject to tax and national insurance through PAYE. HMRC has notified us that they are seeking to collect tax and national insurance in relation to travel expenses for the current and previous years. An estimated provision has been made for this in the accounts.

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

Payments to individual members are disclosed in the following ranges:

CHRE Council during 2010/11

	2010/11	2009/10
	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

14 June 2011

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 recognised gains and losses 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.

- 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.

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. Statement on internal control

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 2011 and up to the date of approval of the annual report and accounts, and accords with HM Treasury guidance.

Capacity to handle risk

Council meetings, which are attended by Council members and the executive Management Team, are our main decision-making forum. The Council formally meets six times a year. In addition, it has an annual away day at which developing issues, the strategy for the organisation and matters of concern are discussed.

The Council has established committees to support its work.

The Audit and Risk Committee's main aims are to ensure the proper stewardship of CHRE's resources and assets, to oversee financial reporting and to monitor the effectiveness of audit arrangements (internal and external), internal controls and the management of risk throughout the organisation.

The Scrutiny Committee, which was established in 2009, monitors, quality assures and reports on the operation of our scrutiny and oversight of the nine health professional regulatory bodies. During each year its programme includes a review of decisions in accordance with our powers under Section 29, of our audit of the initial stages of fitness to practice decisions and of our performance reviews.

Both the Scrutiny and Audit and Risk Committees report to the Council. The Council and its Audit and Risk Committee oversee the risk management process and receive regular updates on CHRE's performance in relation to its business plan.

The Management Team comprising the Chief Executive, Director of Governance and Operations, Director of Scrutiny and Quality, and the Director of Policy, Research and External Relations meets regularly, usually at least twice a month. It considers the management accounts and finances of the organisation and issues relating to the management of CHRE, including the risk register.

The risk and control framework

During the year the Council, Audit and Risk Committee and Management Team continued to review and update CHRE's strategy for handling risk and the risk register.

Our risk management policy seeks to identify the risks facing the organisation and treat them according to established guidelines. Managers make sound decisions on the risks the organisation retains, those it reduces through strategic or operational change and those it may transfer.

The risk register defines the risks associated with achieving our objectives as well as the operational risks in the day-to-day running of the organisation. These are identified through consultation with Council and staff members. Evaluation and control of risks is undertaken by defining the risk event and consequences and then assessing the controls.

During 2010/11 the risk register presented to the Audit and Risk Committee has been updated regularly. In particular in 2010/11 we have updated the risk register to take account of the changes to financial control arising from the changes in government policy and reporting requirements, the review of Department of Health arm's length bodies, the end of our lease at 11 Strand and the implications of the changes proposed to CHRE's legislation in the Health and Social Care Bill, currently before Parliament. The executive continues to provide evidence regarding the process for identifying risks and placing them on the register and the Audit and Risk Committee robustly tests those presumptions.

The register is structured to reflect our key objectives; protecting the public, improving regulation and managing our business effectively. In identifying and scoring risks, the Management Team considers the strategic objectives of the organisation, the individual team objectives and any changes since the last review. Each member of the Management Team identifies and responds to the risks associated with their particular area of responsibility; maintaining statutory responsibilities, quality assurance, financial management and so on. In addition, each strand of the business plan is linked to the relevant strand of the risk register, again with an identified senior manager who is responsible for delivering that area of work.

We pay considerable attention to managing significant risks. In the interest of protecting patients, we are prepared to take controversial decisions, which may increase the risk of reputational harm. Managers review risk on an ongoing basis and will tolerate, treat or avoid risks according to the nature of each risk. During the last year, we have had to consider how to manage the risks associated with our effective oversight of regulatory bodies; the risks arising from the expiration of the lease and move to new offices; and the risks that arise from the proposed extension to our remit and new funding arrangements.

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 processes are in place to mitigate risks to our information.

There was a regrettable failure of data security in November 2010 which we reported to the Department of Health and to the Information Commissioner. Three files containing personal data relating to fitness to practise decisions by regulators were unable to be found when needed. Following our investigation it is our belief that there was in fact no data loss and that these files were inadvertently securely disposed of. However we have implemented a comprehensive new process for receiving and handling such data and have agreed an undertaking with the Information Commissioners Office. We have also taken advice from the Department of Health.

Transition risks

This year we have paid particular attention to the risks that CHRE as an organisation is exposed to as we prepare for our new role with its new responsibilities, legal status and financial arrangements as (subject to Parliamentary approval) the Professional Standards Authority for Health and Social Care.

We have discussed and identified risks relating to the transition across the entire staff group. We have established a Change Team including the directors and representatives of each staff team. Each key area of transition has a named responsible person and progress and risks are reported and monitored at regular meetings.

Some risks which may affect us are beyond our control, for example those relating to the parliamentary progress of the legislation. However we have plans we can put in place depending on the Parliamentary timetable. As well as preparing for change we are fully aware of our need to maintain our existing statutory responsibilities and remain attentive to those responsibilities.

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

- The Council, which met six times
- CHRE's Audit and Risk Committee which consisted of three members of Council. I also attended the Audit and Risk Committee meetings together with the Director of Governance and Operations, the Accounting Manger 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, South Coast Audit, 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.

South Coast Audit (SCA) were our internal auditors during 2010/11. SCA's work was informed by the analysis of the risk and the internal audit plans are approved by the Audit and Risk Committee and are made known to Council. Each year SCA provides me with a report on its internal audit activity at CHRE. The report includes SCA's independent opinion on the adequacy and effectiveness of our system of internal controls, together with recommendations for improvements. In their 2010/11 report, SCA stated that the level of assurance was 'good', which is defined as there being an adequate and effective system of risk management, control and governance to address the risks that objectives are not fully achieved.

As part of our regular programme of reviewing suppliers we agreed during the year to reconsider our internal audit needs to take account of the particular transition risks we are facing as an organisation. Because of government restrictions on arm's length bodies and its move towards shared services we were not able to go out to tender for internal auditors. We have appointed Grant Thornton who undertake internal audit work for the Department of Health as CHRE's internal auditors for the 2011/12 financial year.

I do not consider that we have any significant weaknesses in our system of internal controls, apart from those relating to the handling of case files reported above and since corrected. 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.

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.

Disclosure of relevant audit information

As Accounting Officer I have taken all steps to make myself aware of any relevant audit information and to establish that CHRE's auditors are aware of that information. I have advised the auditors of all relevant information. For 2010/11, I am able to report that there were no material weaknesses in CHRE's system of internal controls that affected the achievement of the organisation's aims and objectives.

Harry Cayton
Accounting Officer

14 June 2011

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 2011 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.

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

Opinion on regularity

In my opinion, in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions 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 2011 and of its net operating cost, changes in taxpayers' equity and cash flows for the year then ended
- The financial statements have been properly prepared in accordance with the National Health Service Reform and Health Care 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 council report, the strategic objectives 2011/12 and 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 statement on internal control 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

16 June 2011

9. Statement of comprehensive net expenditure for the year ended 31 March 2011

	Note		Year ended 31 March 2011 £		Year ended 31 March 2010 (restated) £
Expenditure					
Staff costs	3		1,169,085		1,118,594
Other expenditure	4		1,228,058		1,487,381
Income					
Operating income	5		(37,541)		-
Net operating cost before tax			2,359,602		2,605,975
Corporation tax			-		86
Net operating cost	2		**2,359,602**		**2,606,061**

Other comprehensive expenditure

There was no other comprehensive net expenditure in the year ended 31 March 2011.

The notes on pages 39 to 55 form part of these accounts.

10. Statement of financial position as at 31 March 2011

		31 March 2011		31 March 2010	
	Note	**£**	**£**	**£**	**£**
Property, plant and equipment	6	106,607		95,567	
Total non-current assets			***106,607***		***95,567***
Trade and other receivables	7	179,714		220,109	
Cash and cash equivalents	8	352,985		302,162	
Total current assets			***532,699***		***522,271***
Trade and other payables	9	(165,246)		(160,934)	
Provisions	10	(8,300)		(166,161)	
Total current liabilities			***(173,546)***		***(327,095)***
Non-current assets plus net current assets			**465,760**		**290,743**
Assets less liabilities			**465,760**		**290,743**
Reserves					
General reserves			465,760		289,797
Revaluation reserve			-		946
Total reserves			**465,760**		**290,743**

The notes on pages 39 to 55 form part of these accounts.

Harry Cayton
Accounting Officer

14 June 2011

11. Statement of cash flows for the year ended 31 March 2011

	Note	Year ended 31 March 2011	Year ended 31 March 2010 (restated)
		£	£
Cash flows from operating activities			
Net operating costs for the year		(2,359,602)	(2,605,975)
Adjustment for non-cash transactions:	4	82,484	105,274
Decrease in trade and other receivables	7	40,395	12,593
Increase in trade and other payables	9	4,312	3,297
(Decrease)/increase in provisions	10	(157,861)	20,822
Movements in provisions not passing through the statement of comprehensive net expenditure	10	(2,451)	(20,822)
Less: Corporation tax		-	(86)
Net cash outflow from operating activities		***(2,392,723)***	***(2,484,897)***
Cash flow from investment activities			
Purchase of property, plant and equipment	6	(91,073)	(24,242)
Net cash outflow from investment activities		***(91,073)***	***(24,242)***
Cash flow from financing activities			
Grant in aid from the Department of Health:			
Revenue		2,008,927	2,229,000
Capital		91,073	25,000
Devolved administration funding:			
Scotland		242,180	237,815
Wales		138,891	136,390
Northern Ireland		53,548	95,450
Net cash flow from financing activities		***2,534,619***	***2,723,655***
Net financing			
Net increase in cash and cash equivalents	8	50,823	214,516
Cash and cash equivalents at the beginning of the financial year	8	302,162	87,646
Cash and cash equivalents at the end of the financial period/year	8	**352,985**	**302,162**

The notes on pages 39 to 55 form part of these accounts.

12. Statement of changes in taxpayer's equity for the year ended 31 March 2011

	General reserve	Revaluation reserve	Total
	£	£	£
Balance as at 31 March 2009	**170,939**	**2,210**	**173,149**
Changes in reserves in the year ended 31 March 2010			
Transfers between reserves	1,264	(1,264)	-
Net operating costs	(2,606,061)		(2,606,061)
Total recognised income and expenditure in 2009/10	**(2,604,797)**	**(1,264)**	**(2,606,061)**
Grant in aid from the Department of Health:			
Revenue	2,229,000	-	2,229,000
Capital	25,000	-	25,000
Funding from the devolved administrations:			
Scotland	237,815	-	237,815
Wales	136,390	-	136,390
N Ireland	95,450	-	95,450
Balance as at 31 March 2010	**289,797**	**946**	**290,743**
Changes in reserves in the year ended 31 March 2011			
Transfers between reserves	946	(946)	-
Net operating costs	(2,359,602)	-	(2,359,602)
Total recognised income and expense in 2010/11	**(2,358,656)**	**(946)**	**(2,359,602)**
Grant in aid from the Department of Health:			
Revenue	2,008,927	-	2,008,927
Capital	91,073	-	91,073
Funding from the devolved administrations:			
Scotland	242,180	-	242,180
Wales	138,891	-	138,891
N Ireland	53,548	-	53,548
Balance as at 31 March 2011	**465,760**	**-**	**465,760**

The notes on pages 39 to 55 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 2010/11 *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.

Accounting convention

The financial statements have been prepared under the historical cost convention as modified to account for the revaluation of property, plant and equipment at their value to the business by reference to their current cost. This is in accordance with directions issued by the Secretary of State for Health and approved by HM Treasury. CHRE is not required to provide reconciliation between current cost and historical cost surpluses and deficits.

Without limiting the information given, the financial statements meet the accounting and disclosure requirements of the Companies Acts and accounting standards issued by the Accounting Standards Board so far as those requirements are appropriate.

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.

Any surplus on revaluation is credited to the revaluation reserve. A deficit on revaluation is charged to the operating cost statement, unless the downward revaluation is solely due to fluctuations in market value in which case the amount is debited to the revaluation reserve until the carrying value reaches the level of depreciated historic cost.

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

Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the statement of cash flows, cash and cash equivalents are 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.

Provisions

CHRE provides for legal or constructive obligations that are of uncertain timing or amount at the statement of financial position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2 per cent in real terms.

Contingencies

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

A contingent liability is disclosed unless the possibility of a payment is remote. A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust. A contingent asset is disclosed where an inflow of economic benefits is probable. Where the time value of money is material, contingencies are disclosed at their present value.

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 and in respect of work carried out for the General Teaching Council for England during this period.

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 regarding 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.

Capital charge

In accordance with the FReM published by HM Treasury, a notional charge for the cost of capital employed during the year is not included in the operating cost statement. This is a change in accounting policy and more details are included in note 4.

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). The CHRE does not generally hold insurance but had specific cover in respect of its lease obligations at 11 Strand, and for 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.

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

The following standards and interpretations have been adopted by the European Union but are not required to be followed until after March 2011. None of them are expected to impact upon CHRE's financial statements.

- IFRS1 First Time adoption of IFRS
- IFRS 7 Financial Instruments Disclosure
- IAS 24 Related Parties
- IAS 12 Deferred Tax
- IFRS 9 Financial Instruments.

Accounting standards issued that have been adopted early

No accounting standards have been adopted early by the Council.

2. Analysis of net operating costs by segment

Segmental analysis

Net operating costs were incurred by the three CHRE teams as follows. CHRE does not maintain separate statement of financial position accounting for these teams. There were no inter-segment transactions in the year.

Year ended 31 March 2011	Policy and External Relations	Scrutiny and Quality (S29)	Scrutiny and Quality (Other)	Operations	Total
	£	£	£	£	£
Operating costs	623,521	392,581	217,350	1,163,691	**2,397,143**
Operating income	-	(22,688)	-	(14,853)	**(37,541)**
Net operating costs	623,521	369,893	217,350	1,148,838	**2,359,602**

Year ended 31 March 2010	Policy Research and External Relations	Scrutiny and Quality (S29)	Scrutiny and Quality (Other)	Operations	Total
	£	£	£	£	£
Operating costs	762,908	329,559	237,696	1,275,812	**2,605,975**
Interest receivable after corporation tax	-	-	-	86	**86**
Net operating costs	762,908	329,559	237,696	1,275,898	**2,606,061**

3. Staff numbers and related costs

	Permanently employed	Other	Total year ended 31 March 2011	Permanently employed	Other	Total year ended 31 March 2010
	£	£	£	£	£	£
Salaries	959,867	-	959,867	886,210	-	886,210
Social security costs	83,913	-	83,913	74,362	-	74,362
Superannuation costs	118,482	-	118,482	110,639	-	110,639
Agency/ temporary costs	-	6,823	6,823	-	47,383	47,383
	1,162,262	**6,823**	**1,169,085**	**1,071,211**	**47,383**	**1,118,594**

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 2011	Permanently employed	Other	Total year ended 31 March 2010
Total	**18.7**	**0.18**	**18.9**	**18.1**	**0.6**	**18.7**

There were no staff engaged on capital projects during 2010/11 or during 2009/10.

4. Other expenditure

	Notes	Total year ended 31 March 2011	Total year ended March 2010 (restated)
		£	£
Council Members' remuneration		92,134	92,154
Legal and professional fees		457,482	451,377
Consultancy		7,746	49,275
Premises and fixed plant		465,951	484,749
Training and recruitment		46,322	105,774
PR, communications and conferences		30,059	58,008
Establishment expenses		64,412	90,528
External audit fee †		24,000	24,000
Other costs		71,080	26,242
Non cash expenditure‡:			
Unused provision	10	(113,612)	-
(Profit)/loss on disposal of fixed assets		928	-
Depreciation	6	81,556	105,274
Total expenditure		**1,228,058**	**1,487,381**

† CHRE made payments of £159,964 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.

‡ The notional cost of capital charge of £3,018 has been removed from 2009/10 comparative information as referred to in the accounting policy note. The related reversal has also been removed from the statement of comprehensive net expenditure comparatives.

Had a charge been included in the period, there would have been a charge of £2,689 in this note to the accounts and reversed in the statement of comprehensive net expenditure. The statement of financial position as at 1 April 2010 is not affected by this change in accounting policy as shown on page 36.

5. Operating income

	Total year ended 31 March 2011	Total year ended 31 March 2010
	£	£
Other operating income	14,853	-
Section 29 cost recoveries	22,688	-
Total operating income	**37,541**	**-**

6. Non current assets

Intangible assets

CHRE held no intangible assets as at 31 March 2011 and 31 March 2010.

Property, plant and equipment

31 March 2011	Furniture, fixtures & fittings – conversion costs	IT equipment	Decommissioning costs	Total
	£	£	£	£
Valuation				
At 1 April 2010	167,682	147,560	166,161	481,403
Additions	64,774	26,299	-	91,073
Revaluation	-	-	2,451	2,451
Disposals	(121,599)	(1,190)	(168,612)	(291,401)
At 31 March 2011	110,857	172,669	-	283,526
Depreciation				
At 1 April 2010	146,002	98,270	141,564	385,836
Charge in year	25,598	28,910	27,048	81,556
Disposals	(121,597)	(264)	(168,612)	(290,473)
At 31 March 2011	50,003	126,916	-	176,919
Net book value				
At 31 March 2011	**60,854**	**45,753**	**-**	**106,607**
At 31 March 2010	21,680	49,290	24,597	95,567

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

The valuation of decommissioning assets as at 31 March 2011 and 31 March 2010 is referred to in note 10 to the accounts.

31 March 2010	Furniture, fixtures and fittings – conversion costs	IT equipment	Decommissioning costs	Total
	£	£	£	£
Valuation				
At 1 April 2009	167,682	123,318	145,339	436,339
Additions	-	24,242	-	24,242
Revaluation	-	-	20,822	20,822
At 31 March 2010	167,682	147,560	166,161	481,403
Depreciation				
At 1 April 2009	117,100	65,069	98,393	280,562
Charge in year	28,902	33,201	43,171	105,274
At 31 March 2010	146,002	98,270	141,564	385,836
Net book value				
At 31 March 2010	**21,680**	**49,290**	**24,597**	**95,567**
At 31 March 2009	50,582	58,249	46,946	155,777

7. Trade receivables and other current assets

Amounts falling due within one year:

	31 March 2011	31 March 2010
	£	£
Trade and other receivables	17,349	25,706
Prepayments	162,365	194,403
Total trade and other receivables	***179,714***	***220,109***

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 2011	31 March 2010
	£	£
Balances with other central government bodies	4,083	6,601
Balances with local authorities	122,769	91,517
Total intra government balances	126,852	98,118
Balances with bodies external to government	52,862	121,991
Total trade and other receivables	***179,714***	***220,109***

8. Cash and cash equivalents

	31 March 2011	31 March 2010
	£	£
Balance at 1 April 2010	302,162	87,646
Net changes in cash and cash equivalent balances	50,823	214,516
Balance at 31 March 2011	**352,985**	**302,162**
The following balances were held at:		
Government Banking Service	221,485	290,548
Commercial banks and cash in hand	131,500	11,614
Balance at 31 March 2011	**352,985**	**302,162**

9. Trade payables and other current liabilities

Amounts falling due with one year:

	31 March 2011	31 March 2010
	£	£
Trade and other payables	67,626	37,485
Taxation and social security	30,731	27,193
Accruals	66,889	96,256
Total trade and other payables	***165,246***	***160,934***

There were no trade payables or 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 2011	31 March 2010
	£	£
Balances with other central government bodies	74,931	35,557
Balances with NHS trusts	1,021	-
Total intra government balances	75,952	35,557
Balances with bodies external to government	89,294	125,377
Total trade and other payables	***165,246***	***160,934***

10. Provisions for liabilities and charges

	Dilapidations provision	HMRC provision	Total
	£	£	£
Balance at 1 April 2010	166,161	-	166,161
Arising during the year	2,451	8,300	10,751
Provision used	(55,000)	-	(55,000)
Reversed unused	(113,612)	-	(113,612)
Balance at 31 March 2011	**-**	**8,300**	**8,300**

Dilapidation costs for former office accommodation at 11 Strand, London, WC2N 5HR were settled by CHRE on 11 February 2011 to fully discharge all CHRE liabilities arising from the lease for this accommodation which expired on 22 December 2010. The unused provision has been written off in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets.

The HMRC provision 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

As at 31 March 2011 two cases that CHRE will potentially refer to the High Court under its Section 29 powers were under settlement discussions with the regulatory body.

Liabilities

One High Court case, under CHRE's Section 29 powers, was undecided as at 31 March 2011. There was therefore uncertainty on the related financial consequences pending a final judgement.

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

12. Capital commitments

The Council has no capital commitments as at the statement of financial position date.

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 2011**	**31 March 2010**
	£'000	**£'000**
Not later than one year	278	168
Later than one year and not later than five years	995	-
Total commitments under operating leases	***1,273***	***168***

Finance leases

CHRE had no finance leases as at the statement of financial position dates.

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 2011 the Department of Health provided total grant in aid of £2.1m (2009/10: £2.254m).

CHRE received funding contributions towards its activities in the year from the devolved administrations in Northern Ireland (£0.054m), Scotland (£0.242m), and Wales (£0.139m). In 2009/10 CHRE received £0.095m from Northern Ireland, £0.238m from Scotland and £0.136m 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 2011 no Council member undertook any related party transactions with CHRE.

The senior management team is also asked to disclose any related party transactions. During 2010/11 there were no disclosures.

15. Losses and special payments

There were no material losses and special payments in the period (2009/10: none).

16. Post statement of financial position events

There are no material post statement of financial position events.

The accounts have been authorised for issue on 16 June 2011 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 the 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

The Council 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 2011 CHRE had a non-interest bearing cash balance of £352,957.

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

The Council 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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