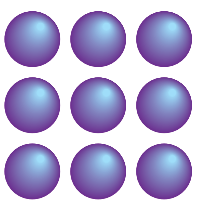
Annual report and accounts

2008/09

Annual report volume I



council for healthcare regulatory excellence

Annual report volume I: Annual report and accounts 2008/09

(Associated with this document is the Annual Report volume II: *Performance Review of Health Professional Regulators* 2008/09)

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Contents

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Chair's introduction

We report on a year of change for the Council for Healthcare Regulatory Excellence (CHRE). During 2008/09 we reformed our governance, acquired new statutory powers, strengthened our external relations, deepened our research capacity and significantly increased our productivity. We did this at reduced cost to the public purse.

Our annual report to Parliament this year comes in two parts; this volume which reports on our activities for the year and includes the accounts, and Volume II, which is our report on the performance of the healthcare professional regulators.

We are charged under our new legislation with promoting the health, safety and well-being of patients and other members of the public. We have made engagement with patients and the public one of our priorities, aiming to be transparent to facilitate this relationship. During the year we established a stakeholder network, held a series of public meetings and conferences, improved our website, introduced a customer relationship management system, revised our Welsh language policy and provided plain English training for all our staff.

In overseeing the nine healthcare professional regulators we aim for a fair, open but thorough process which is based on robust challenges to the regulators' self-assessment process. We combine information from the self-assessments with intelligence that has been gathered from our scrutiny of all final fitness to practise determinations, from the small number of complaints we receive and from patient organisations and professional associations. We are grateful to the regulators for their constructive engagement with this process, which provides assurance to Parliament and the public, but also promotes and encourages further improvement.

In promoting good practice, we have provided advice and guidance on seven topics at the request of the Secretary of State for Health in response to the White Paper, *Trust Assurance and Safety – The Regulation of Health Professions in the 21st Century*, or other identified needs. We have held a series of seminars on the future of regulation to widen debate and provide a forum for developing good practice. In March 2009 a successful conference on moving from self-regulation by professionals alone to regulation that is shared between professionals and the public, attracted a varied and interested audience including a significant representation of patients and the public.

As Chair of the reformed Council which took over in January 2009 I must acknowledge the excellent work of the previous Council in preparing for the transition and handing over an organisation that was in good order. In particular my predecessor as Chair of the Council, Rosie Varley, provided strong leadership at a time of considerable challenges.

The new members of the Council who took office with me bring a rich mix of experience and expertise. We very much look forward to the challenges ahead and to putting the health, safety and well-being of patients and the public at the very heart of our work.

Baroness Jill Pitkeathley
Chair

Council report

1 The Council for Healthcare Regulatory Excellence (CHRE) was set up in April 2003 by the National Health Service Reform and Health Care Professions Act 2002.[1]

2 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.

3 The 2008 Act also gave us additional powers of scrutiny. We will audit the processes used by the regulators to receive and screen complaints against individual health professionals. Preparation for this began in 2008/09 and the work itself will commence in early 2009/10. We will also develop a number of initiatives to encourage and inform good practice in regulation and aim to improve communication between regulators, healthcare providers and our other stakeholders.

4 Our mission is to protect the public by setting standards in healthcare professional regulation and to support the regulators to improve their processes by sharing good practice and shaping future developments in healthcare regulation.

What we do

5 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 training and conduct of healthcare professionals.

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

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

- We monitor the performance of the regulatory bodies annually to identify good practice and areas for improvement

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

- 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
- We promote good practice in regulation, conduct research, share learning with regulatory bodies and hold events to explore better ways to manage new challenges
- We advise the Secretary of State for Health and health ministers in Scotland, Wales and Northern Ireland on matters relating to the regulation of healthcare professionals
- We keep abreast of European and international policies to improve policy decisions on UK regulation of healthcare professionals. Through these networks, we advise colleagues in other countries of the methods we have adopted for better regulation of UK healthcare professionals.

8 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 Health Professions Council (HPC), which regulates arts therapists, biomedical scientists, chiropodists and podiatrists, clinical scientists, dieticians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, 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
- The Royal Pharmaceutical Society of Great Britain (RPSGB), which regulates pharmacists in England, Wales and Scotland.

There are contact details and web addresses for each of the regulators on our website, www.chre.org.uk.

9 We are funded by the Department of Health in England and in 2008/09 we also received funding from the devolved administrations in Scotland, Wales and Northern Ireland.

Our vision, mission and values

10 Our core purpose is laid out in legislation and during the year our Council and executive reaffirmed our vision, mission and values. These are described below.

Vision

11 Our vision is to be a strong and independent influence within the regulation of healthcare professionals. All of our activities are directed towards achieving this vision.

Mission

12 We exist to deliver public protection in healthcare provision by:

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

Values

13 Our values act as a framework for our decision making. They are at the heart of who we are and how we would like to be seen by our stakeholders and include:

- Patient and public focus
- Fairness
- Proportionality
- Transparency
- Agility
- Adding value to regulation.

Organisational priorities[3]

14 In December 2008 the Council reaffirmed the strategic priorities for the organisation as outlined in their plan for the period 2007/08 to 2010/11. They agreed that, with the governance change, the strategic priorities would be reviewed for the period 2009/10 to 2011/12 by the new Council.

15 The new Council will produce its strategic priorities during 2009 and has stated that they intend to renew the focus on public and patient safety.

16 An important part of our planning for 2008/09 included preparation for the transition to the anticipated new governance structure. This new structure was confirmed with the introduction of the Health and Social Care Act 2008 and has been implemented from 1 January 2009.

17 Throughout our planning for the transition to new structures and roles our Council has remained committed to ensuring that we continue to fulfil all our statutory responsibilities, particularly those of scrutinising the healthcare professional regulators.

18 Council, through the Audit Committee, worked to ensure that governance matters were not affected during this transition, in particular with reference to the anticipated change in its structure and membership. Transition governance matters became a standing item on the Audit Committee agenda from February to November 2008 and special sessions of the committee were held on 8 May and 16 September 2008 to consider this matter.

Partnership with social care regulators

19 We have continued to work closely with the four UK social care workforce regulators, particularly with regard to the Health and Social Care Act 2008. We have continued to organise regular meetings between the chief executives of the health and social care workforce regulators. At an operational level, General Social Care Council staff are involved in cross-regulatory groups and our projects.

3 Reference throughout this document to the work of Council during the period 1 April to 31 December 2008 refers to the Council and its members as it existed under the previous governance structure. For the period 1 January to 31 March 2009 it refers to the Council and its members as exist under the new governance structure. See the section 'Council members' for further information about Council structure and membership during the year.

Partnership with healthcare professions regulators

20 Following the reform of our governance, we are establishing a regulators' forum to which senior representatives of all the regulatory bodies, including the social care councils, will be invited. The first meeting is due to take place in July 2009.

Who we are

21 The structure of our governing Council changed during 2008/09.

22 From 1 April to 31 December 2008 our Council had 19 members: one representative from each of the nine regulators (usually the president) and 10 public members. The public members included one from each of the devolved administrations; Scotland, Wales and Northern Ireland. During this period, one of the public member positions was vacant.

23 From 1 January 2009 the new governance structure came into force, as a result of the Health and Social Care Act 2008. Under these new arrangements, our Council now comprises of 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 now completely independent of the healthcare professional regulators.

24 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.[4]

4 Information about CHRE's staff may be found on page 22.

Council members

25 From 1 April to 31 December 2008 our Council was made up of 19 members:[5]

Members nominated by the regulatory bodies:

Martin Astbury (from 12 June 2008), RPSGB
Graeme Catto, GMC
Nigel Clarke, GOsC
Jill Crawford (from 4 September 2008), NMC
Anna van der Gaag, HPC
Nancy Kirkland (until 3 September 2008), NMC
Hew Mathewson, GDC
Kate McClelland, PSNI
Hemant Patel (until 11 June 2008), RPSGB
Rosie Varley, GOC, Acting Chair
Judith Worthington, GCC

Public members:[6]

Frances Dow
Sue Leggate
Jim McCusker
Peter North
Hugh Ross
David Smith
Kieran Walshe
Sally Williams
Lois Willis

26 From 1 January 2009 our Council comprises the following members:

Non-executive members:

Ann Curno
Ian Hamer
Andrew Hind
Sally Irvine
Stuart MacDonnell
Jill Pitkeathley, Chair
Jayne Scott

5 Changes in Council membership prior to 31 December 2008 occurred as a result of the NMC and the RPSGB each electing a new president.
6 One position was vacant.

Executive member:[7]

Harry Cayton

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

27 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.[8]

28 Rosie Varley continued to act as Chair until 31 December 2008. This followed a decision by Council in the previous year to confirm her in this role until the new legislation allowed the appointment of a Chair from 1 January 2009.

29 The previous Council successfully managed a smooth and effective transition, handing over to its successors an organisation with a clear sense of direction, well managed, committed to protecting the public and with a legacy of knowledge and experience of improving healthcare professional regulation.

30 **Attendance at public meetings**

There were four public meetings between 1 April and 31 December 2008.

Martin Astbury[9]	3	Jim McCusker	3
Graeme Catto	4	Peter North	4
Nigel Clarke	3	Hemant Patel[10]	1
Jill Crawford[11]	2	Hugh Ross	4
Frances Dow	4	David Smith	4
Anna van der Gaag	4	Rosie Varley	4
Nancy Kirkland[12]	0	Kieran Walshe	4
Sue Leggate	3	Sally Williams[13]	2
Hew Mathewson	4	Lois Willis	4
Kate McClelland	3	Judith Worthington	4

7 Our legislation allows for two Executive members of the Council.
8 Available at: http://www.opsi.gov.uk/acts/acts2002/ukpga_20020017_en_15#sch7
9 Martin Astbury was only eligible to attend three meetings following his appointment from 12 June 2008.
10 Hemant Patel was only eligible to attend one meeting as his term on Council ended on 11 June 2008.
11 Jill Crawford was only eligible to attend two meetings following her appointment from 4 September 2008.
12 Nancy Kirkland was only eligible to attend two meetings as her term on Council ended on 3 September 2008.
13 Sally Williams was on maternity leave for part of the year.

There were two public meetings between 1 January and 31 March 2009.

Harry Cayton[14]	1
Ann Curno	1
Ian Hamer	2
Andrew Hind	2
Sally Irvine	2
Stuart MacDonnell	2
Jill Pitkeathley	2
Jayne Scott	1

Committees and working groups of the Council

Audit Committee

1 April – 31 December 2008	1 January – 31 March 2009
Hugh Ross, Chair	Andrew Hind, Chair
Graeme Catto	Stuart MacDonnell
Sue Leggate	Jayne Scott
Jim McCusker	
Lois Willis	

Finance Committee

1 April – 31 December 2008	1 January – 31 March 2009
Nigel Clarke, Chair	From 1 January 2009 the new Council and the Audit Committee took over the work undertaken by the previous Finance Committee.
Nancy Kirkland (until 3 September 2008)	
Hew Mathewson	
Sally Williams	

14 In a private session following their first meeting on 22 January 2009, Council appointed the Chief Executive, Harry Cayton, as an executive member of Council with immediate effect.

Remuneration Committee

1 April – 31 December 2008	1 January – 31 March 2009[15]
Rosie Varley, Chair	Harry Cayton
Nigel Clarke	Andrew Hind
Peter North	Jill Pitkeathley
Hugh Ross	

Scrutiny Committee

1 April – 31 December 2008	1 January – 31 March 2009
Frances Dow, Chair	Sally Irvine, Chair
Hew Mathewson	Ann Curno
Kieran Walshe	Ian Hamer
Judith Worthington	

15 The Chair of the Remuneration Committee has not yet been decided.

Operations

31 Our creditor payment policy is that all creditors are paid within 30 days of receipt of invoice except in the instance where there may be a query or dispute regarding an invoice.

2008/09	Number	£
Total invoices paid	820	1,489,156
Total invoices paid within 30-day target	820	1,489,156
Percentage of invoices paid within 30-day target	100%	100%

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

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

34 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.

35 The Council is very grateful to our staff for continuing to work effectively and without interruption to the business of the organisation during a year of considerable change. All transition risks were accurately identified and appropriate action to mitigate them was taken. The transfer of governance arrangements proceeded to our planned timetable and we continued to meet all our statutory functions whilst, at the same time, improving our performance and productivity.

Summary

36 This has been an important year of transition and change for us, with the new leadership and new roles and responsibilities. As set out in this report the Council has acted to maintain its statutory functions, to complete a range of work streams and to contribute to the future through the White Paper projects. The Council has held seminars, to strengthen our external relations and prepared for new tasks, having to balance existing work with effective transition planning. We start this year with a stronger and more focused organisation, together with a clear remit to promote the health, safety and well-being of patients and the public.

Management commentary

37 We are structured to reflect the key areas of our business :

- Scrutiny and quality
- Policy, research and external relations
- Operations.

38 The heads of each area and the Chief Executive form the Management Team, which meets on a regular, formal basis to review and discuss a range of issues which include reviews of the budget, policy development and recruitment of staff.

39 During 2008/09 we recruited additional staff members to new or expanding areas of work.[16] These areas were:

- The development of the performance review process
- Implementation of new information governance policies and procedures
- Preparation for the audit of the early stages of fitness to practise work
- Expansion of our external relations function.

Fitness to practise

40 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 and in the interest of public protection. We have continued to use these important powers where necessary for the protection of the public.

41 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.

42 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 action, 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.

16 Information about CHRE's staff may be found on page 22.

43 We have seen a further increase this year in the number of fitness to practise cases notified to us by the regulators: from 915 in 2006/07 and 1,231 in 2007/08 to 1,370 in 2008/09. There has been a significant increase in the number of cases since 1 January 2009 as from that date, we started to consider cases regarding the health of professionals as well as performance and conduct cases. This followed a change to the legislation brought about by the Health and Social Care Act 2008.

44 Of the 1,370 cases we considered between 1 April 2008 and 31 March 2009, 1,150 were closed with no requirement for more information. We sought and considered additional information in the remaining 220 cases. Ten of these cases were considered at a case meeting and we referred five cases to court. Of the cases referred, two were from the NMC, one was from the GMC, one was from the GOsC and one was from the HPC. We subsequently withdrew one of the NMC appeals and the HPC appeal from the court. Two appeals were settled by agreement and the other appeal was dismissed.

45 The White Paper, *Trust, Assurance and Safety – The Regulation of Health Professions in the 21st Century*, included a recommendation that we should audit the initial stages of the regulators' fitness to practise processes. We were given the power to do this in the Health and Social Care Act 2008. We ran a project, in liaison with the regulators and with public and patient representation, to set up a process and guidelines for carrying out this audit. We carried out a full public consultation on the draft process and took account of feedback received before finalising the process in April 2009.

46 The audit of the initial stages of regulators' fitness to practise processes starts in April 2009. We intend to publish the results of the first year's audit in spring 2010.

Performance review

47 This year we piloted the new standards-based performance review process. The new standards were compiled in consultation with the regulatory bodies. They set out the minimum requirements we believe a regulator should meet in order to carry out its functions to an acceptable standard. All of the regulators completed a self-assessment against all of the standards. We discussed these self-assessments with officials and in some cases with members of the regulators and published a report of our findings in August 2008.

48 For further information on our performance review of the healthcare regulatory bodies in 2009 please refer to Volume II of this annual report.

Special Report

49 Following an adjournment debate in Parliament, the Minister of State for Health in England asked us to report on the Nursing and Midwifery Council and to give particular consideration to issues relating to their standards for governance. Our Special Report to the Minister of State on the NMC was published in June 2008 and is available on our website at www.chre.org.uk.

White Paper

50 The White Paper, *Trust*, *Assurance and Safety – The Regulation of Healthcare Professionals in the 21st Century* was published in February 2007. We participated in the work of the national groups charged with taking forward different aspects of implementation.

51 Specifically, we provided advice on common protocols for the investigation of concerns, thresholds for referral to regulatory bodies, a single standard definition of good character, information sharing at the point of entry to the register and references.

52 The reports of the Tackling Concerns Nationally and Tackling Concerns Locally working groups were published in early 2009 and we expect further work as a result. The report of the Extending Professional Regulation group is expected imminently, and this is also expected to propose various pieces of work for us.

53 In November 2008 we provided advice to the Department of Health on aspects of the establishment of the General Pharmaceutical Council. These included existing good practice in the regulation of the pharmacy professions, likely changes to pharmacy practice over the next ten years and the need to operate in the context of devolved government.

54 We also provided policy advice to the Department of Health on harmonising the sanctions available to regulatory bodies in fitness to practise cases.

Future of regulation

55 During 2008/09 we held a number of seminars and a conference to open up discussion and debate on the future of regulation.

56 From November 2008 to January 2009 we held three seminars on a range of cross-cutting regulatory issues, inviting representatives from regulatory bodies, health organisations, other sectors and representatives of patient and public organisations. A further series of seminars is planned to commence in May 2009.

57 In February 2009 we held a high level symposium at Leeds Castle, Kent, to discuss future trends in health and regulation. Discussions included how complex regulatory systems could interact, how regulation could learn lessons from crisis, and how we can achieve an increased agility and effective horizon scanning. A report of the symposium was produced in early 2009/10.

58 A public conference in March 2009 focused on moving from self-regulation by the regulatory bodies to shared regulation between the regulatory bodies and patients and the public. It was well attended and participants included representatives of regulatory bodies from Ireland, Australia and Norway, professional associations and patient representative organisations. Others with a wider interest in professional regulation, including representatives from the General Teaching Council and the Legal Services Board, were also present. At least twenty per cent of the attendees on the day were from patient representative organisations or were members of the public.

Health and Social Care Act 2008

59 The Health and Social Care Act passed through Parliament during the 2007/08 parliamentary session, receiving Royal Assent on 21 July 2008. The Act provides the legislative background to enable many of the changes to us as an organisation, and other aspects of the legal framework for health professionals regulation, proposed by the White Paper. The Act gives us the main statutory objective of promoting the health, safety and well-being of patients and other members of the public, and establishes a duty for us to inform and consult with the public.

Strengthening relationships across the four countries of the UK, in Europe and worldwide

60 Relations with the four UK countries continue to be constructive. We held productive meetings with the Ministers in Wales and Scotland and plans are now in place for meeting the Minister in Northern Ireland.

61 In July 2008 the European Commission launched a draft Directive on patients' rights in cross-border healthcare. The purpose of the Directive is to clarify, in primary legislation, case law which has been built up by the European Court of Justice on this matter. We responded to the consultations on the draft, seeking to encourage, in particular, the statutory exchange of information between regulators on the fitness to practise of registrants seeking to work in other Member States.

62 In January 2009 the European Commission launched a Green Paper on the Healthcare Workforce and sought a wide response to the consultation. We responded directly to the Commission and via the European Union (EU) organisations to which we belong. Again, we took the opportunity to encourage the Commission to introduce a statutory requirement for regulators across the EU to share fitness to practise information on those registrants seeking to work in another Member State.

Our stakeholder involvement

63 Our strategic communications plan outlines our methods to consolidate relationships with existing stakeholders, to form new relationships with stakeholders in the four countries and to enable us to become increasingly transparent and accessible to an increased base of external audiences.

64 Initiatives during 2008/09 included the formation of our Public Stakeholder Network (which was established in spring 2009), planning for a new stakeholder newsletter to deliver quarterly updates on our current projects and public consultations, a website with increased interactive features and our programme of public events.

65 We held public meetings in the four countries in autumn 2008 to present the results of our performance review. These public events and consultations resulted in feedback from many stakeholder groups, and have served to refine our initial plans for patient and public engagement.

Information governance

66 During the year, the Cabinet Office set out mandatory measures for the identification and management of information risks and the protection of personal data.

67 In order to meet these minimum mandatory measures, we identified the personal and sensitive data we hold, how it is accessed, stored and destroyed and how it is shared with our delivery partners. We then introduced a number of processes and policies to manage the risks to our information. These policies identify our responsibilities for safeguarding personal and confidential information and reinforce that safe and effective information management is essential to good governance. Over the coming year staff will also receive information governance training.

68 We already had significant systems of internal control around personal and sensitive data that we hold. The measures we have now introduced have further formalised and reinforced these systems. Through implementing the Cabinet Office's minimum mandatory measures and by working together internally and with our delivery partners, we are confident that we have thoroughly assessed the risks to our information and have implemented suitable safeguards to minimise risks and to manage risks appropriately. We have also published our privacy policy on our website. However, we will keep this under regular review.

69 The executive team reports on management of our information risks to the Audit Committee and the Chair of this committee is asked annually for a statement on the effectiveness of this process.

Our operations

70 Since our establishment in April 2003, and consistent with the Arm's Length Body review framework, our back-office functions have been outsourced to a range of organisations. The functions supported in this way include finance, internal audit, payroll, human resources, legal services, information technology support and maintenance, technical website support and maintenance, estates and building and office services.

71 All supplier contracts are reviewed as their terms stipulate. We commenced reviews of all contracts on a six-monthly rolling basis during the year. However we decided that this process did not add sufficient value to the reviews that would occur as a matter of course, according to the terms and/or length of each contract. We have procedures in place to ensure that we receive value for money by following procurement processes that are consistent with those used by the Department of Health.

72 In 2007/08 we commissioned a comprehensive report on our potential dilapidations liability under the lease for the First Floor, 11 Strand. This report provides detailed information about the state of the building and our likely obligations. It does not, however, take into account the possibility of the landlord undertaking significant works to the building as the result of all the leases ending at the same time.

73 Our lease is due to end in December 2010 and preparations for this commenced in early 2009. We have commissioned estates specialists to assist in the development of the lease options analysis, and we will discuss this with the Department of Health during 2009/10.

74 We received capital funding of £50,000 from the Department of Health in 2008/09. This was used to purchase replacement desktop and portable IT equipment as well as a portable video communication system. Most of our desktop and laptop computers had fully depreciated and had been superseded by more efficient equipment and were therefore replaced. The videoconferencing system will enable us to minimise the need for travel to other parts of the UK to attend meetings.

75 As part of our business continuity plan a server has now been set aside for disaster recovery purposes. This runs a live connection from a secure hosted location directly into our network.

76 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 assessment, progress against business plan objectives and regular reports from internal and external auditors. In addition, quarterly meetings are held between our executives, the Department of Health and Arm's Length Body Business Support Unit.

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

78 While we are a small organisation, efforts are made wherever possible to ensure that we consider environmental matters. During 2008/09 we introduced a new system that allows us to recycle a wide range of office consumables.

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

80 As far as the Accounting Officer is aware, there is no relevant audit information of which our auditors are unaware. The Accounting Officer has taken all steps he ought to have taken to make himself aware of any relevant audit information and to establish that our auditors are aware of that information.

Financial summary

81 Grant in aid funding for 2008/09 comprised £2,100,000 from the Department of Health and £400,295 from the Devolved Administrations. At 31 March 2009, CHRE had reserves carried forward of £173,148 (2007/08: 216,915) after net operating costs of £2,544,062 (2007/08: 2,214,218).

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

Staff

Michael Andrews	Head of Scrutiny and Quality
Timothy Bailey	Scrutiny Manager (from 3 March 2009)
Valerie Baldino	Office Manager
Douglas Bilton	Project Manager
Michael Blomfield	Policy Analyst
Harry Cayton	Chief Executive
Lisa Foley	Executive Secretary (from 6 October 2008)
Marija Hume	Finance Manager (from 6 May 2008)
Emma Kelly-Dempster	Good Practice Officer (from 21 April 2008)
Raymond Liu	Finance Manager (maternity cover from 23 March 2009)
Rosemary Macalister-Smith	Head of Policy, Research and External Relations
Rachael Martin	Fitness to Practise Assistant
Briony Mills	Fitness to Practise Officer
Beata Santa	Finance Assistant
Dan Scott	Receptionist/Administrator
Kristin Smyth	Head of Operations
Rachael De Souza	Public Affairs Manager (from 2 June 2008)
Kate Webb	Senior Policy Analyst (from 25 June 2008)

A register of interests for senior managers is available on the CHRE website.

A total of 29.5 days were lost to sickness absence in the year. This equates to an average of 1.9 days per person.

Contact details

Council for Healthcare Regulatory Excellence
11 Strand
London
WC2N 5HR

Phone: 020 7389 8030
Fax: 020 7389 8040
E-mail: info@chre.org.uk
Website: www.chre.org.uk

Remuneration report

83 During 2008/09 a new pay policy was introduced, incorporating a new band structure and process for moving up incremental points within each band. This has been aligned with the performance appraisal process and a standardised timetable for appraisals will be introduced across the organisation from 1 April 2009.

84 Progression through the pay bands by incremental points is subject to meeting certain performance standards as defined in the policy.

85 As a result of the job evaluation process that resulted in the new pay policy, adjustments were required to the salaries for some members of staff. Some of these adjustments were backdated to October 2007.

86 Each year the Remuneration Committee also considers an annual uplift to reflect a cost of living increase from October.

87 Previously the Remuneration Committee considered detailed pay data on inflation, settlements and earnings from published sources to inform the annual uplift however in 2008/09 the committee decided that the uplift should reflect the government's inflation target of two per cent.

88 The policy on termination of contracts is determined by the level of responsibility of the position. For all staff up to and including pay band level D there is a one-month notice period. For pay band level E and F staff there is a three-month notice period and for the Chief Executive a six-month notice period. Contracts are offered on a permanent basis, subject to certain requirements being met and successful completion of a probationary period. Contracts are occasionally offered on a fixed-term basis, generally to reflect the nature of, and context for, the work involved. We treat termination payments and provisions for compensation for termination on a case-by-case basis in consultation with our advisors.

89 Senior managers' contracts

Name	Title	Date of contract	Unexpired term	Notice period
Michael Andrews	Head of Scrutiny and Quality	19 January 2004	Permanent contract	3 months
Harry Cayton	Chief Executive	1 August 2007	Permanent contract	6 months
Rosemary Macalister-Smith	Head of Policy, Research and External Relations	1 December 2005	Permanent contract	3 months
Kristin Smyth	Head of Operations	27 October 2003	Permanent[17] contract	3 Months

90 There have been no awards made in respect of early termination to past senior managers.

91 Senior managers' salaries

Name	Salary (£'000) 2008/09	Salary (£'000) 2007/08	Real increase/ (decrease) in pension at age 60 (£'000)	Total accrued pension at 31 March 2009 (£'000)
Michael Andrews	65-70	55-60	0-2.5	2.5-5
Harry Cayton	130-135	80-85 (full year equivalent £120-125)	0-2.5	5-7.5
Rosemary Macalister-Smith	75-80	80-85	(2.5-5)	35-37.5
Kristin Smyth	65-70	55-60	0-2.5	2.5-5

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

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

Note: the following were not provided: allowances; benefits in kind; bonuses; expenses allowance; compensation for loss of office or termination of service (2007/08: £Nil).

17 Fixed-term contract from 27 October 2003. Permanent contract from 1 October 2004.

92 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 2008 (to nearest £1,000)	Cash Equivalent Transfer as at 31 March 2009 (to nearest £1,000)	Real increase in the cash equivalent transfer value during the reporting year (to nearest £1,000)
Michael Andrews	Head of Scrutiny and Quality	2.5-5	12.5-15	2.5-5	37	70	22
Harry Cayton	Chief Executive	5-7.5	20-22.5	5-7.5	91	182	62
Rosemary Macalister-Smith	Head of Policy, Research and External Relations	35-37.5	110-112.5	(5-7.5)	661	883	144
Kristin Smyth	Head of Operations	2.5-5	12.5-15	2.5-5	42	75	23

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

93 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

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

95 The Chair position attracts remuneration of £33,190 pa (2007/08: £32,059), members attract annual remuneration of £7,765 (2007/08: £7,500) and the Audit Committee Chair position attracts annual remuneration of £12,941 (2007/08: £12,500). An adjustment was made during the year for back payments due to members from 1 April 2007 (1.3 per cent) and 1 April 2008 (2.2 per cent).

96 Members' remuneration during the year amounted to £170,773 (2007/08: £184,292) including social security costs and Section 29 panel attendance fees of £10,525 (2007: £10,938) which were distributed between 10 members of Council who sat on panels during the year.

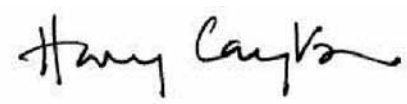
97 Payments to individual members are disclosed in the following ranges:

	2008-09		2007-08	
	Salary (bands of £5,000)*	S29 panel attendance fees[18]	Salary (bands of £5,000)*	S29 panel attendance fees
	£'000	£	£'000	£
Chair:				
Jane Wesson ** (until 12 April 2007)	0–5	–	0–5	275
Rosie Varley (Acting Chair from 13 April 2007)	25–30	2,800	30–35	2,150
Jill Pitkeathley (from 1 January 2009)	5–10	–	–	–
Members:				
to 31 December 2008:				
Martin Astbury (from 12 June 2008)	0–5	–	–	–
Graeme Catto	5–10	–	5–10	825
Nigel Clarke	5–10	625	5–10	413
Jill Crawford (from 4 September 2008)	0–5	–	–	–
Frances Dow 10[19] (from 2 July 2007)	5–10	1,250	5–10	350
Anna van der Gaag	5–10	550	5–10	550
Sue Leggate	5–10	1,100	5–10	550
Hew Mathewson	5–10	1,375	5–10	2,025
Kate McClelland	5–10	–	5–10	550
James McCusker	5–10	–	5–10	625
Peter North	5–10	1,175	5–10	1,525
Hemant R Patel	0–5	–	5–10	–
Hugh Ross (Audit Committee Chair)	5–10	–	10–15	–
David Smith	5–10	–	5–10	275
Kieran Walshe	5–10	550	5–10	–
Sally Williams	5–10	–	5–10	275

	2008-09		2007-08	
	Salary (bands of £5,000)*	S29 panel attendance fees[18]	Salary (bands of £5,000)*	S29 panel attendance fees
	£'000	£	£'000	£
Lois Willis	5–10	825	5–10	550
Judith Worthington	5–10	275	5–10	–
Sandra Arthur ** (until 19 October 2007)	0–5	–	0–5	–
Nancy Kirkland (from 22 October 2007)	0–5	–		–
from 1 January 2009:				
Ann Curno	0–5	–	–	–
Ian Hamer	0–5	–	–	–
Andrew Hind (Audit Committee Chair)	0–5	–	–	–
Sally Irvine	0–5	–	–	–
Stuart MacDonnell	0–5	–	–	–
Jayne Scott	0–5	–	–	–
* Includes S29 Panel Attendance Fees. ** 2007/08 and 2008/09 back pay settled in 2008/09				

In addition, expenses amounting to £18,307 (2007/08: £30,196) were reimbursed to the members.

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



Harry Cayton
Accounting Officer
10 June 2009

18 Panel attendance fees are paid according to the Determination by the Secretary of State for Health for the Remuneration and Allowances payable by the Council for Healthcare Regulatory Excellence, as amended from time-to-time.

19 Frances Dow's initial period of appointment to the Council ended on 31 March 2007. The Scottish government was unable to confirm her re-appointment until 2 July 2007 due to protocols relating to the Scottish parliamentary election in May 2007.

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

The Council's responsibilities

98 Under the Cabinet Office's *Guidance on Codes of Best Practice for Board Members of Public Bodies*, the Council 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, the Council 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 the Treasury. The accounts are to be prepared on an accruals basis and must give a true and fair view of the Council'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.

99 In preparing the accounts the Council is required to:

- Observe the accounts direction issued by the Secretary of State, with the consent of the 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 the Council will continue in operation.

The Accounting Officer's responsibilities

100 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 the Treasury and published in *Managing Public Money*.

Statement on internal control

Scope of responsibility

101 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*.

102 We report to the UK Parliament and work closely with the devolved administrations in Scotland, Wales and Northern Ireland; and, the Department of Health in England in delivering our statutory obligations as well as 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

103 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 based on an ongoing process 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 2009 and up to the date of approval of the annual report and accounts, and accords with Treasury guidance.

Capacity to handle risk

104 The Audit Committee has oversight of our risk management and this is a regular item on their meeting agendas.

105 The Management Team comprising the Chief Executive, Head of Operations, Head of Scrutiny and Quality, and the Head of Policy, Research and External Relations, meets regularly to consider a number of matters including risk management.

106 We have continued to make progress in developing and implementing our systems of internal control and embedding risk management in the organisation. The Management Team recognises that this is an important part of continuous development and review. During the coming year it will continue to ensure that the organisation is fully engaged with risk management.

The risk and control framework

107 During the year the Management Team undertook a comprehensive review of the risk register. This resulted in a more focused document that consolidates many of the risks identified in the previous register, in order to ensure a more transparent and relevant list of risks.

108 In addition, a new risk matrix was produced to provide a visual representation of inherent and residual risks in terms of their impact and likelihood.

109 The register is still structured to reflect the organisation's operational structure: scrutiny and quality; policy, research and external relations and operations. In identifying the risks, the Management Team considered the strategic objectives of the organisation, each team's objectives, the previous risk register and the implications of the Health and Social Care Act 2008, including the new governance structure.

110 The revised risk register was brought to the Audit Committee who endorsed the new format and process.

111 Each strand of the business plan continues to link to the relevant strand of the risk register and the senior manager responsible for delivering that area of work.

112 The members of the Management Team identify and respond to the risks associated with their particular area of work. This is an ongoing process which is reviewed regularly by them and by the Audit Committee, and is supported by relevant guidance.[20]

20 HM Treasury, *The Orange Book*, Oct 2004 Australian/New Zealand Standard, *Risk Management 4360*, Aug 2004

113 We pay considerable attention to managing risks and are prepared to take higher organisational risks to improve protection of patients and the public. Managers review risk on an ongoing basis and will tolerate, treat or avoid risks according to the nature of each risk. Significant risks that have had to be considered in 2008/09 include the White Paper work streams (as much of this work was outside our control, yet the organisation played a central role in its delivery) and the introduction of the Health and Social Care Act 2008 which changed our governance structure and significantly enhanced our role in the healthcare regulatory environment.

114 We hold very little personal information and, where we do, the processes for managing this information have been reviewed and improved. We introduced a privacy policy in March 2008 which is published on our website and covers our processes for maintaining any personal electronic data records. While no amendments to our current systems of control over risk to information were considered necessary, during 2008/09 we nevertheless introduced a range of policies and procedures[21] in order to conform with Cabinet Office requirements, and to reinforce throughout the organisation the management of information in appropriate and consistent ways.

115 An assessment of the effectiveness of the implementation of these new policies was undertaken in December 2008 and again in March 2009, to coincide with the change in governance structure. This was carried out in accordance with the Cabinet Office's guidance on the annual assessment of information risk management.

116 There were no material information risk incidents to report for 2008/09.

117 The Audit Committee Chairs for each period have provided statements that they were satisfied we now have the required range of policies for staff to adhere to, as far as they apply to CHRE, the processes in place to mitigate risks to our information and that this and staff's personal responsibility to safeguard information will be reinforced through information security training.[22] In order to ensure that we continue to manage our risks appropriately and to remain compliant with best practice, it was strongly recommended that the executive regularly reviews our compliance with the Cabinet Office's minimum mandatory requirements.

21 These are available on the CHRE website, www.chre.org.uk
22 This training is taking place early in 2009/10.

Review of effectiveness

118 As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Council and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

120 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.

121 The risk register clearly 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 key staff members. Evaluation and control of risks is undertaken by defining the risk event and consequences and then assessing the controls.

122 Council and its Audit Committee oversee the risk management process and receive regular updates on business performance.

123 During 2008/09 the risk register was presented in detail to the Audit Committee and the executive will continue to provide evidence regarding the process for identifying risks and placing them on the register. They will also provide any updates regarding the prioritisation of risks and ongoing management of the top risks as appropriate.

124 Horizon scanning remains a part of regular review and this involves consideration and contribution from the Council, Audit Committee and the executive team. External and internal influences are considered and any potentially significant risks are discussed with key stakeholders as soon as they become apparent.

125 In 2008/09 the Head of Internal Audit Opinion provided their highest opinion which was that a 'Good' level of assurance could be given as 'there is an adequate and effective system of risk management, control and governance to address the risk that objectives are not fully achieved'.

126 Throughout 2008/09 we obtained assurance from Moorepay regarding their provision of outsourced payroll services through evidence of risk control systems, disaster recovery plans and accreditation of each organisation with the British Standards Institute.

127 All our staff are entitled to membership of the NHS Pension Scheme and control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with.

Harry Cayton
Accounting Officer
10 June 2009

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

I certify that I have audited the financial statements of the Council for Healthcare Regulatory Excellence for the year ended 31 March 2009 under the National Health Service Reform and Health Care Professions Act 2002. These comprise the operating cost statement, the balance sheet, the cash flow statement, and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the remuneration report that is described in that report as having been audited.

Respective responsibilities of the Council, Accounting Officer and Auditor

The Council and Chief Executive as Accounting Officer are responsible for preparing the annual report, the remuneration report and the financial statements in accordance with the National Health Service Reform and Health Care Professions Act 2002 and directions made thereunder by the Secretary of State with the approval of Treasury and for ensuring the regularity of financial transactions. These responsibilities are set out in the Statement of the Council's and Accounting Officer's Responsibilities.

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

I report to you my opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the remuneration report to be audited have been properly prepared in accordance with the National Health Service Reform and Health Care Professions Act 2002 and directions made thereunder by the Secretary of State with the approval of Treasury. I report to you whether, in my opinion, the information, which comprises the management commentary and Council report included in the annual report is consistent with the financial statements. I also report whether in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

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

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

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

Basis of audit opinions

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

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

Opinions

In my opinion:

- The financial statements give a true and fair view, in accordance with the National Health Service Reform and Health Care Professions Act 2002 and directions made thereunder by the Secretary of State with the approval of the Treasury, of the state of the Council for Healthcare Regulatory Excellence's affairs as at 31 March 2009 and of its net operating costs for the year then ended
- The financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Reform and Health Care Professions Act 2002 and directions made thereunder by the Secretary of State with the approval of the Treasury, and
- Information, which comprises the management commentary and Council report, included within the Annual Report, is consistent with the financial statements.

Opinion on Regularity

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

Report

I have no observations to make on these financial statements.

Amyas C E Morse
Comptroller and Auditor General
National Audit Office
151 Buckingham Palace Road
Victoria
London SWIW 9SS
18 June 2009

Operating cost statement for the year ended 31 March 2009

	Notes		Year ended 31 March 2009 £	Year ended 31 March 2008 £
Operating costs	2		2,610,882	2,280,820
Operating income	3		(59,872)	(59,630)
Net operating cost before capital charges reversal			2,551,010	2,221,190
Capital charges reversal	7		(6,535)	(6,972)
Net operating cost before interest			2,544,475	2,214,218
Interest receivable		(523)		–
Corporation tax[23]		110		
			(413)	–
Net operating cost			**2,544,062**	**2,214,218**

Net operating costs were incurred by the three constituent CHRE teams as follows. CHRE does not maintain separate balance sheet accounting for these teams.

	Net operating costs
	£
Policy, research and external relations	696,612
Scrutiny and quality – S29	357,854
Scrutiny and quality – other	213,750
Operations	1,275,846
	2,544,062

All operations are continuing. There were no material acquisitions or disposals in the year. There were no recognised gains or losses in the year (2007/08: none) other than the net operating costs above.

The notes on pages 41 to 54 form part of these accounts

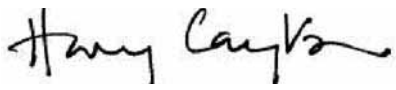
23 Corporation tax at 21% on interest receivable

Balance sheet
as at 31 March 2009

	Notes	£	2009 £	£	2008 £
Fixed assets					
Tangible fixed assets	8		155,777		182,538
Current assets					
Debtors	9	232,702		204,932	
Cash at bank and in hand	10	87,646		142,886	
		320,348		347,818	
Creditors: amounts falling due within one year	11	(157,637)		(171,231)	
Net current assets			162,711		176,587
Provisions for liabilities and charges	12		(145,339)		(142,210)
Net assets			173,149		216,915
Reserves					
General reserve	13		170,939		213,441
Revaluation reserve	13		2,210		3,474
			173,149		216,915

The notes on pages 41 to 54 form part of these accounts

Signed on behalf of the Council for Healthcare Regulatory Excellence



Harry Cayton
Accounting Officer
10 June 2009

Cash flow statement
for the year ended 31 March 2009

	Notes	Year ended 31 March 2009 £	Year ended 31 March 2008 £
Net cash outflow from operating activities	14	(2,506,427)	(2,070,848)
Interest received		523	–
Capital expenditure			
Payments to acquire tangible fixed assets	8	(49,937)	(38,387)
Fixed asset disposal proceeds		305	–
Net cash outflow before financing		(2,555,536)	(2,109,235)
Financing			
Grant in aid from the Department of Health for revenue expenditure	13	2,050,000	1,778,500
Devolved Administration funding:			
Scotland		218,002	245,000
Wales		125,024	127,000
N Ireland		57,270	–
Grant in aid from the Department of Health for capital expenditure	13	50,000	33,000
(Decrease)/increase in cash	10	(55,240)	74,265

The notes on pages 41 to 54 form part of these accounts

Notes to the accounts

1. Accounting policies

a. Basis of preparation

These financial statements have been prepared in accordance with the Accounts Direction given by the Secretary of State with the consent of Treasury and in accordance with HM Treasury's *Financial Reporting Manual* (FReM). The particular accounting policies adopted by the Council are described below. They have been applied consistently in dealing with items considered material in relation to these financial statements.

b. Accounting convention

The financial statements have been prepared under the historical cost convention as modified to account for the revaluation of tangible fixed assets at their value to the business by reference to their current cost.

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.

c. Grant in aid and government grant reserve

The Council 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 is also accounted for as financing by crediting them directly to the general reserve on a cash received basis.

d. Tangible fixed assets

Under the principles of modified historic cost accounting depreciated replacement cost is deemed a suitable proxy where the asset has a short useful economic life or is of low value. On this basis indexation has not been applied this year. Asset valuations are to be reviewed on an annual basis at each balance sheet date to ensure that the carrying value fairly reflects current cost. Depreciation is still charged on the remaining useful economic life of the brought forward re-valued asset base.

Fixed assets other than computer software are capitalised as tangible fixed assets 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.

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

Any surplus on revaluation is credited to the government grant 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.

e. Depreciation

Depreciation is provided on a straight-line basis, calculated on the revalued amount to write off assets, less any estimated residual balance, over their estimated useful life. The useful lives of tangible fixed assets have been estimated as follows:

Refurbishment costs, furniture and fittings	From 1 April 2003 to the end of the lease in December 2010
Computer equipment	3 years

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

f. Section 29 costs and recoveries

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

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

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

In the case of costs awarded against the Council, expenditure is recognised in the income and expenditure where there is a final uncontested judgement against the Council. 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 the Council, 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 the Council, or where a sufficiently reliable estimate of the amount payable cannot be made, a contingent liability is disclosed.

g. Notional charges

In accordance with the FReM published by HM Treasury, a notional charge for the cost of capital employed during the year is included in the operating cost statement along with an equivalent notional income to finance the charge. The cost of capital charge is calculated at 3.5 per cent (2007/08: 3.5 per cent), applied to the mean value of capital employed during the year, excluding non-interest bearing cash balances held with the Office of the Paymaster General.

h. 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.

i. Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.pensions.nhsbsa.nhs.uk. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable 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 body of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

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

a) Full actuarial (funding) valuation

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

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

b) FRS17 accounting valuation

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

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

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

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

Scheme provisions as at 31 March 2008

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

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

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

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

Scheme provisions from 1 April 2008

From 1 April 2008 changes have been made to the NHS Pension Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pensions website www.pensions.nhsbsa.nhs.uk.

j. Operating leases

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

An operating lease for the First Floor, 11 Strand, London, WC2N 5HR is in force until 22 December 2010.[24]

k. Provisions

CHRE provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet 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 the Treasury's discount rate of 2.2 per cent in real terms.

l. Operating income

The majority of CHRE's operating income relates to section 29 recoveries (see note 1 f.).

m. 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).

24 In 2008/09 the lease end date was amended by the Landlord from 24 December 2010 to 22 December 2010. This was done to correct a drafting error in tenants' leases for 11 Strand.

2. Operating costs

	Notes	Year ended 31 March 2009			Year ended 31 March 2008		
		£	£	£	£	£	£
Staff costs	4		946,122			904,265	
Members' remuneration[25]			160,248			173,354	
Other operating costs:							
S29 costs		306,211			239,120		
Other operating costs		1,111,939			871,571		
Total other operating costs	6		1,418,150			1,110,691	
Depreciation	8		79,827			85,538	
Notional cost of capital	7		6,535			6,972	
Total operating costs				2,610,882			2,280,820

3. Operating income

	Year ended 31 March 2009 £	Year ended 31 March 2008 £
S29 cost recoveries	59,622	59,630
Other operating income	250	–
Total operating income	59,872	59,630

4. Staff costs

	Year ended 31 March 2009 £	Year ended 31 March 2008 £
Salaries	746,240	570,373
Social security costs	66,677	56,916
Superannuation costs	101,907	72,532
Agency/temporary costs	31,298	204,444
Total staff costs	946,122	904,265

The increase in salaries in 2008/09 resulted from the recruitment of additional staff members to new or expanding areas of work including: Good Practice Officer, Finance Manager, Public Affairs Manager, Scrutiny Manager and a Scrutiny Officer who joins CHRE early in 2009/10.

25 Further information may be found in the Remuneration Report

5. Average number of staff

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

	Year ended 31 March 2009 WTE (whole time equivalent)	Year ended 31 March 2009 WTE (whole time equivalent)
Management and administrative	*15.49	*13.07
	15.49	13.07

* Includes 0.76 WTE temporary staff members (2007/08: 1.63)

6. Other operating costs

Other operating costs include:

	Year ended 31 March 2009 £	£	Year ended 31 March 2008 £	£
Professional and consultancy fees		348,553		224,318
Rent and office accommodation		302,316		345,437
Non cash expenditure:				
Provision for doubtful debts	–		5,000	
(Profit)/loss on disposal of fixed assets	(305)		–	
(Decrease)/increase in provisions	–		(76,268)	
		(305)		(71,268)
Council members' expenses		18,307		30,196
External audit fee (*)		21,800		19,000
Other costs		727,479		563,008
Total other operating costs		1,418,150		1,110,691

* CHRE did not make any payments to the National Audit Office for non audit work.

7. Notional cost of capital

In accordance with the FReM published by HM Treasury, a notional charge for the cost of capital employed during the year is included in the operating cost statement along with an equivalent notional income to finance the charge. The cost of capital charge of 3.5 per cent was applied to the mean value of capital employed during the year, excluding non-interest bearing cash balances held with the Office of the Paymaster General.

	Year ended 31 March 2009 £	Year ended 31 March 2008 £
Capital employed as at 1 April	201,215	197,176
Capital employed as at 31 March	172,241	201,215
Mean capital employed	186,728	199,196
Notional charge	6,535	6,972

8. Tangible fixed assets

	Furniture, fixtures & fittings – conversion costs £	Decom-missioning costs £	IT equipment £	Total £
Valuation				
At 1 April 2008	156,702	142,210	115,136	414,048
Additions	10,980		38,957	49,937
Revaluation		3,129		3,129
Disposals			(30,775)	(30,775)
At 31 March 2009	167,682	145,339	123,318	436,339
Depreciation				
At 1 April 2008	90,637	72,166	68,707	231,510
Charge for year	26,463	26,227	27,137	79,827
Eliminated on disposals			(30,775)	(30,775)
At 31 March 2009	117,100	98,393	65,069	280,562
Net book value				
At 31 March 2009	**50,582**	**46,946**	**58,249**	**155,777**
At 31 March 2008	66,065	70,044	46,429	182,538

9. Debtors

	31 March 2009 £	31 March 2008 £
Debtors	69,655	44,204
Prepayments	163,047	160,728
Total debtors	232,702	204,932

Intra government balances
Intra government balances within the totals for debtors are as follows:

	31 March 2009 £	31 March 2008 £
Balances with other central government bodies	25,895	4,062
Balances with local authorities	77,358	73,689
Total intra government balances	103,253	77,751
Balances with bodies external to government	129,449	127,181
Total debtors	232,702	204,932

10. Cash at bank and in hand

	31 March 2009 £	31 March 2008 £
At 1 April	142,886	68,621
(Decrease)/increase in cash in year	(55,240)	74,265
At 31 March	87,646	142,886
Bank account at Office of Paymaster General	907	15,696
Commercial bank account	86,639	127,090
Cash in hand	100	100
Total cash at bank and in hand	87,646	142,886

11. Creditors: amounts falling due within one year

	31 March 2009 £	31 March 2008 £
Trade creditors	4,489	69,584
Taxation and social security	28,667	24,404
Corporation tax	110	-
Accruals	124,371	77,243
Total creditors: amounts falling due within one year	157,637	171,231

Intra government balances

Intra government balances within the totals for creditors are as follows:

	31 March 2009 £	31 March 2008 £
Balances with other central Government bodies	76,948	87,263
Total intra government balances	76,948	87,263
Balances with bodies external to government	80,689	83,968
Total creditors: amounts falling due within one year	157,637	171,231

12. Provisions for liabilities and charges

	£
Balance at 1 April 2008	142,210
Arising during the year	3,129
Balance at 31 March 2009	145,339

The provisions arising during the year relate to repair and maintenance obligations under the lease for office accommodation at First Floor, 11 Strand, London, WC2N 5HR.

The cost of decommissioning the accommodation at the conclusion of the lease term in 2010 was reviewed in detail by GVA Grimley Chartered Surveyors in January 2008. This dilapidations report was reviewed by Drivers Jonas, CHRE's new estates advisors, in March 2009. Their view on the report was that the figures given for the dilapidations are correct and do not require updating.

All of the closing balance relate to estimated decommissioning costs, after unwinding adjustment, which are expected to fall due at the conclusion of the lease term in 2010.

13. Reserves

	General reserve £	Revaluation reserve £	Total £
Brought forward as at 1 April 2008	213,441	3,474	216,915
Funding – Department of Health	2,100,000		2,100,000
Funding – devolved administrations			
Scotland	218,002		218,002
Wales	125,024		125,024
N Ireland	57,270		57,270
Realised revaluation	1,264	(1,264)	–
Net operating costs	(2,544,062)		(2,544,062)
Carried forward as at 31 March 2009	170,939	2,210	173,149

14. Reconciliation of operating surplus to net cash inflow from operating activities

	Year ended 31 March 2009 £	Year ended 31 March 2008 £
Net operating costs for the year before cost of capital reversal	(2,551,010)	(2,221,190)
Adjustment for non-cash transactions:		
Depreciation	79,827	85,538
Deficit on indexation revaluation of fixed assets	–	–
Capital charges	6,535	6,972
Revaluation/loss on disposal of fixed assets	(305)	–
Adjustment for movements in working capital other than cash:		
Increase/(decrease) in creditors	(13,594)	41,906
Less: capital creditor	–	6,535
Less: corporation tax creditor	(110)	–
Decrease/(increase) in debtors	(27,770)	85,659
(Decrease)/increase in provisions	–	(76,268)
Net cash (outflow) from operating activities	(2,506,427)	(2,070,848)

15. Contingent liabilities

There were no cases at the High Court, under CHRE S29 powers, that were undecided as at the year end.

CHRE has a possible liability under the lease for 11 Strand, London, WC2N 5HR, in respect of extraordinary service charge works that might be necessary to the building during the lease term.

There is potentially a legal claim against CHRE which may result in a judgment against CHRE although at year end this was considered unlikely.

16. Capital commitments

The Council has no capital commitments as at the balance sheet date.

17. Related party transactions

The Council is a non-Departmental Public Body sponsored by the Department of Health.

The Department of Health is regarded as a related party. During the year to 31 March 2009 the Department of Health provided total grant in aid of £2,100,000 (2007/08: £1,811,500).

CHRE received funding contributions to its activities in the year from the devolved administrations in Scotland (£218,002), Wales (£125,024) and Northern Ireland (£57,270). In 2007/08 CHRE received £245,000 from Scotland, £127,000 from Wales and no funding from Northern Ireland however they indicated that a proportionate contribution would be provided in 2008/09 and this was duly received.

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

The Council maintains a register of interests for the Chair and Council members. 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 2009 no Council member undertook any transactions with the Council.

The following disclosure relates to Council members who were in a position of influence up until 31 December 2008 resulting from their appointment to the CHRE Council by virtue of their nomination by the nine regulatory bodies.[26]

Sandra Arthur – past President, Nursing and Midwifery Council
Martin Astbury – Vice-President, Royal Pharmaceutical Society of Great Britain
Graeme Catto – President, General Medical Council
Nigel Clarke – Chairman, General Osteopathic Council
Jill Crawford – President, Nursing and Midwifery Council
Hew Mathewson – President, General Dental Council
Rosie Varley – Chairman, General Optical Council
Hemant Patel – President, Royal Pharmaceutical Society of Great Britain
Kate McClelland – member, Pharmaceutical Society of Northern Ireland
Anna van der Gaag – President, Health Professions Council
Judith Worthington – Vice-Chair, General Chiropractic Council and Chair, Deputy Chair, Investigating Committee – Royal Pharmaceutical Society of Great Britain
Chair, Fitness to Practise panels – General Medical Council, Member of Appointments Board – Nursing and Midwifery Council
Nancy Kirkland – immediate past President, Nursing and Midwifery Council

26 Further information about the period that each member served on Council is available in the section 'Council members'.

Up until 31 December 2008, all of the regulators overseen by CHRE appointed a member to the Council for Healthcare Regulatory Excellence. In relation to Section 29, no member could have any involvement in CHRE's consideration of any case which originates from the regulatory body which they represent. CHRE has had transactions with some of these bodies in 2008/09 in relation to appeals made under Section 29 in which costs have been awarded by the High Court.

18. Losses and special payments

Losses and special payments amounted to £1,708 for the year. This consisted of unavoidable travel adjustments, losses and special payments due to cancellation of a forum in Belfast as well as presentation and communication training cancellation.

19. Post balance sheet events

There were no material post balance sheet events.

The accounts have been authorised for issue on 18 June 2009 by the Accounting Officer.

20. Financial instruments

Financial risk management

Financial reporting standard 29 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. Because of the continuing service provider relationship that the CHRE has with Department of Health and the way it is financed, CHRE is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. CHRE has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing CHRE in undertaking its activities.

Debtors and creditors that are due to mature or become payable within 12 months from the balance sheet 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. The Trust has no overseas operations. The Trust 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 2009 CHRE had a non-interest bearing cash balance of £1,007 (2007/08: £142,886) and a cash balance of £86,639 (2007/08: £nil) generating a floating interest rate.

Credit risk

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

Liquidity risk

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.

21. Commitments under operating leases

Expenses of the CHRE include rent and service charge payments under operating lease rentals in the sum of £248,210 (2007/08: £280,705).

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

	31 March 2009 £'000	31 March 2008 £'000
Expiring between 1 and 5 years	255	259
Total commitments under operating leases	255	259

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