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Council for Healthcare Regulatory Excellence

Annual report and accounts 2005/2006

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- protect
- promote
- progress

Council for Healthcare Regulatory Excellence (CHRE)

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Presented to Parliament pursuant to schedule 7, section 16(2) of the National Health Service Reform and Health Care Professions Act 2002

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345211_HC1302_Text / Sig: 1 / Plate A

Contents

Contents

1	Chair's introduction	3
2	Director's report	5
3	Executive summary	7
4	About us	9
5	Our achievements	13
6	Regulation at work	23
7	Challenges ahead	32
8	Our people	36
9	Financial summary	44
Annex A: Section 29 statistics		45
Annex B: Our committees		47
Annex C: Annual Accounts		48

345211_HC1302_Text / Sig: 1 / Plate B

1 Chair's introduction

1.1 The regulation of healthcare professionals exists to protect the public by creating, and maintaining, the highest standards of conduct and competence. This may involve wider considerations of promoting health or increasing public awareness of the services available from various professions, but protecting the public is always at the heart of regulation.

1.2 At this time of regulatory change and uncertainty it is very important that we keep this overall objective in mind. Healthcare regulation is likely to be affected by the outcomes of the reviews into the regulation of healthcare professionals undertaken by Professor Sir Liam Donaldson, Chief Medical Officer (CMO), and Mr Andrew Foster, Director of Workforce, from the Department of Health in England.[1] This could well include strengthening fitness to practise processes, with stronger links, and better defined boundaries, between the roles of employers and regulators.

1.3 Regulators recognise that, in fulfilling their role, they need to harmonise the outcomes of their processes. Standardising their process or practice is not an objective in itself, but will help deliver outcomes which make public protection proportionate, fair and easily understood both by the public and professionals.

1.4 Together with the regulators, we are committed to the ideals of the Better Regulation Task Force[2] for a regulatory process that is proportionate, accountable, consistent, transparent and targeted. Regulators should continue to boost the confidence of the public in the effectiveness and 'fitness for purpose' of regulation and work in partnership with CHRE, each other and their key partners. This is by no means a new responsibility, and in monitoring recent developments we have seen clear evidence of the shared desire of regulators for continuous improvement and to learn from one another.

1.5 Regulators are actively exploring the concept of 'risk-based regulation' put forward in the Hampton Report,[3] for instance in relation to revalidation or the quality assurance of education provision. This means focusing regulatory activity on the areas of greatest risk.

1 More information is available from paragraphs 3.2, 3.3, 7.3 and 7.4.

2 The Better Regulation Task Force (BRTF) has now become the Better Regulation Commission (BRC). The BRTF developed the principles of good regulation of proportionality, accountability, consistency, transparency and targeting. For more information see http://www.brc.gov.uk/downloads/pdf/principlesleaflet.pdf.

3 Reducing administrative burdens: effective inspections and enforcement, Philip Hampton, March 2005, available on http://www.hm-treasury.gov.uk/hampton.

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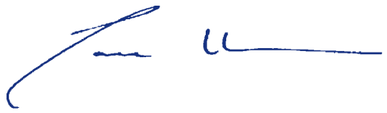
1.6 Next year, we will focus on collaborative work in three specific areas: professional boundaries between registrants and patients, the range of sanctions available to regulators, and student fitness to practise; three topics identified as particularly important in conjunction with the regulators.

1.7 The work of regulators, and the environment in which they operate, continues to evolve and change. They are facing increased and more complex regulatory challenges, and a wider scope as regulation is extended to encompass other members of healthcare teams. At the same time, they face external challenges, which include ensuring the consistency of regulation across the UK and, of course, responding to the outcome of the two reviews.

1.8 It is in CHRE's co-ordinating role that we can add most value to the work of the regulators. In the current challenging environment, I expect that we will continue to strengthen our partnerships, and build on the Council's considerable achievements. I thank all those across the UK who have worked closely with us over the past year and who share in our success, particularly my fellow Council members. I look forward to my Council playing a key role in the future development of healthcare regulation across the UK.



Jane Wesson
Chair

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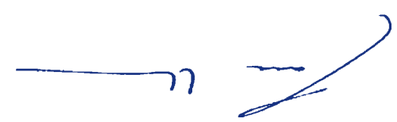

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4

2 Director's report

2.1 CHRE's third year of operation has seen a period of significant reflection on regulation, in which we have been particularly active. We have played a key role in the reviews of the regulation of healthcare professionals undertaken by Professor Sir Liam Donaldson and Mr Andrew Foster following the Shipman Inquiry Fifth Report in December 2004 (see Section 7, paragraphs 7.1 to 7.6). Our Chair was part of both reviews. I served on the latter and along with the Department of Health we organised two major conferences bringing together the wide variety of stakeholders who comprised the Foster Review Reference Group.

2.2 We have enhanced our relationships with the devolved administrations and other stakeholders in Scotland, Wales and Northern Ireland. They are key partners, given both our UK-wide remit and the evolving nature of healthcare systems in the four nations. In particular, Scotland and Northern Ireland are responsible for the regulation of new groups and this has presented some challenges over the year, particularly for the GDC and the RPSGB, who have been working to expand regulation to their wider teams. We have also strengthened our links with our colleagues from the regulators of social care staff (social care regulation is structured on a four-nation basis), and with organisations responsible for monitoring healthcare provision.

2.3 We have initiated a project-based approach to identify and disseminate best practice in regulation, fulfilling one of our core functions of promoting good practice. We are particularly pleased that the Department of Health has contributed to the funding of one of our major projects on maintaining effective boundaries between patients and practitioners. Through regular meetings with regulators at various forums (including practitioner groups) we have continued to share current practice and promote collaboration between regulators and others.

2.4 We have faced a significant increase (over 30%) in the volume of fitness to practise cases, decided by the regulatory bodies, that we review. Despite this rise, the proportion of cases we referred to the High Court continues to be very small (about 1.3% of cases received). To keep things in perspective, with a similar proportion of appeals by registrants that the decision was unduly harsh, the regulatory bodies are clearly achieving a very high success rate in returning defensible decisions – and most importantly the 764 fitness to practise decisions which we reviewed relate to a registrant base of over 1.16 million professionals.

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2.5 Much can be learned from reviewing fitness to practise cases, including those which we have not referred to the High Court. To promote best practice and share knowledge, we have identified 'learning points', disseminated them to regulators and made them available to the public on our website. We have also organised briefing seminars for lawyers from regulators and professional defence associations on the implications of recent Court decisions on regulatory processes.

2.6 We have used the third year of our performance review (see Section 6) to build on the information base gathered last year, and identify key challenges for regulation. A significant challenge over the course of the next year will be implementing the Safeguarding Vulnerable Groups Act (see Section 7, paragraphs 7.11 and 7.12) which will create a vetting and barring scheme, founded on the recommendations of the Bichard Inquiry[2]. As most healthcare registrants have frequent contact with children and vulnerable adults, and therefore require to be 'monitored' to permit this, there will be significant practical issues, and related cost implications, to be addressed in developing the interface between regulation and the proposed Independent Barring Board.

2.7 Internally, our funding and accountability arrangements underwent a process of change during the course of the year. Our budget is now the responsibility of the government's Arms Length Body Change Programme team, while other aspects of our accountability to Parliament remain the province of the relevant parts of the Department of Health. While this continues to present certain challenges, we recognise that the size and nature of the organisation may be affected by the recommendations of the two reviews.

2.8 It has, therefore, been another busy year for us. I would like to thank all my staff for their hard work and commitment in carrying forward our work programme, and colleagues from the regulators who have helped us towards our shared goal of improved public protection.

Sandy Forrest
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4 The Protection of Vulnerable Groups Bill, which is expected to become law late in 2006, creates a vetting and barring scheme for those who work with children and vulnerable adults – it was recommended in the Bichard Inquiry Report into the Soham murders.

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3 Executive summary

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3.1 Throughout 2005/2006, our goals were to:

- promote good practice
- progress regulatory excellence
- protect the public.

3.2 In the early part of 2005, the Government established two major reviews on the regulation of healthcare professionals in response to the Shipman Inquiry Report; one led by Professor Sir Liam Donaldson focusing on medical regulation, and the other by Mr Andrew Foster, looking at regulatory issues affecting the non-medical workforce.[5]

3.3 The reviews, which focus on the nature and scope of regulation, have accounted for a substantial proportion of our work this year. The UK Government's response to the recommendations of the reviews is expected in the next financial year, and we anticipate that this will recommend some significant changes to regulation, which will no doubt require careful consideration by us, the regulators and other stakeholders.

Promoting good practice

3.4 We have:

- adopted a best practice approach to establishing collaborative projects with regulators which will be further developed over the next year
- identified important 'fitness to practise' issues from the section 29 process[6] and shared the learning points with the regulators
- continued to debate and share good practice in meetings with regulatory body staff
- developed our existing partnerships, forged closer links with the social care sector, and promoted further collaboration between regulators and other partners and stakeholders.

5 Professor Sir Liam Donaldson, Chief Medical Officer for England, and Mr Andrew Foster, Director of Workforce, Department of Health for England. The reviews were announced in January and March 2005. For the terms of reference, see paragraphs 7.3-7.4 of our report.

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Progressing regulatory excellence

3.5 We have:

- contributed fully to the 'Foster' and 'Donaldson' reviews
- used the annual performance review process to encourage collaborative working
- improved contacts with government departments and relevant organisations in Scotland, Wales and Northern Ireland.

Protecting the public

3.6 We have:

- reviewed 764 relevant fitness to practise decisions of the nine regulators (see 'About us' section 4) and appealed 10 decisions to the High Court where we considered that the outcome was 'unduly lenient' (see 'Our achievements' section 5)
- received judgment in eight High Court cases, all of which resulted in our appeals being upheld. While five cases were the subject of full hearings, three were resolved by way of a consent order, using our Alternative Disputes Resolution policy. This ensured that our public protection concerns were met without the need for a full Court hearing
- closely monitored key developments in regulatory law arising from High Court cases brought by us and registrants
- refined section 29 procedures in the light of such developments.

3.7 Finally, we have also:

- carried out our third performance review of the regulators' work, identifying some key trends (see 'Regulation at work' section). The process has highlighted a clear appetite among the regulators to work together to harmonise further regulatory outcomes across the professions. This will be particularly important for the future as existing roles develop and new ones are created, eroding traditional professional boundaries
- identified some of the challenges facing the regulation of healthcare professionals (see 'Challenges ahead' section).

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Executive summary

345211_HC1302_Text / Sig: 4 / Plate B

4 About us

Regulating professionals

4.1 Each healthcare professional working in the UK must be registered with, and regulated by, one of nine statutory regulators. These organisations were created by separate Acts of Parliament, at different times, so their duties and processes are not identical, but they have generally similar functions:

- maintaining a register of those fit to practise in the UK (in some cases this includes companies or organisations)
- setting the standards of behaviour and ethics registrants must meet
- setting educational standards and creating systems to maintain registrants' skills
- dealing with concerns about those who are unfit to practise because of poor health, misconduct or poor performance.

4.2 In general, the Councils which govern these regulators include members of that profession and a number of 'lay' members (members of the public who are not from that profession) to provide a public focus. While the proportion of lay members varies from Council to Council, all currently have a professional majority.

Our mission

4.3 CHRE was set up in April 2003 by the National Health Service Reform and Health Care Professions Act 2002 (the Act). Our mission is to protect the public interest, promote best practice and achieve excellence in the regulation of healthcare professionals.

4.4 We report to the UK Parliament, and take account of developments in England, Scotland, Wales and Northern Ireland – an increasingly important dimension of our work. While professions regulated prior to devolution remain the 'reserved' responsibility of the UK Parliament, responsibility for groups joining after that date is 'devolved' to the Scottish Parliament and the Northern Ireland Assembly. We see a clear advantage, and a need, for regulation to remain fundamentally UK-based, although regulatory schemes will have to adapt and be flexible to take account of the diverse developmental needs of the devolved countries, where health policy and health provision are devolved functions.

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Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

345211_HC1302_Text / Sig: 5 / Plate A

Who we are

4.5 Our governing Council has 19 members – one representative from each of the nine regulators (usually the president) and 10 'lay' members. Our lay members are people who do not belong to any of the regulated professions and are appointed to provide an independent view. The lay members include one from each of Scotland, Wales and Northern Ireland.

4.6 We have an executive team of 12 staff supporting the Council, although much of the work we undertake is in partnership with the regulatory bodies who often provide assistance. For example, the RPSGB seconded a staff member to us for six months to help us establish our project-based approach and the NMC seconded a senior staff member, who has assisted in building up our links with the devolved nations and Europe. Future projects are likely to include the support of either seconded or temporary staff.

4.7 We are funded through the Department of Health and answerable to the UK Parliament. Our work covers the nine regulators and the range of professionals listed below:

- General Chiropractic Council (GCC) regulates chiropractors
- General Dental Council (GDC) regulates dentists, dental hygienists and dental therapists
- General Medical Council (GMC) regulates doctors
- General Optical Council (GOC) regulates dispensing opticians and optometrists
- General Osteopathic Council (GOsC) regulates osteopaths
- Health Professions Council (HPC) regulates 13 professions (see list below)[7]
- Nursing and Midwifery Council (NMC) regulates nurses, midwives and specialist community public health nurses
- Pharmaceutical Society of Northern Ireland (PSNI) regulates pharmacists
- Royal Pharmaceutical Society of Great Britain (RPSGB) regulates pharmacists.

7 The Health Professions Council currently regulates arts therapists, biomedical scientists, chiropodists and podiatrists, clinical scientists, dieticians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers, speech and language therapists.

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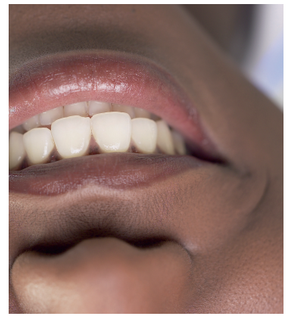

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4.6 We have an executive team of 12 staff supporting the Council, although much of the work we undertake is in partnership with the regulatory bodies who often provide assistance. For example, the RPSGB seconded a staff member to us for six months to help us establish our project-based approach and the NMC seconded a senior staff member, who has assisted in building up our links with the devolved nations and Europe. Future projects are likely to include the support of either seconded or temporary staff.

4.7 We are funded through the Department of Health and answerable to the UK Parliament. Our work covers the nine regulators and the range of professionals listed below:

4.8 For more information on the regulators check the links to their websites on www.chre.org.uk.

Why we were set up

4.9 The idea of having one overarching body for the regulators of healthcare professionals was first suggested in 2000 in the NHS plan, 'A plan for investment, a plan for reform'. We were set up after the Government accepted a recommendation in the 'Kennedy Report' into events at Bristol Royal Infirmary. This report called for a reconnection between the regulated professions and the expectations of patients and the public. While recognising the many benefits of self-regulation, the report also identified a need for one body to make sure there is consistency and good practice among regulators. It is through this co-ordinating function that we believe we can add most value to the work of the regulators.

What we do

4.10 Our responsibilities are set out in the Act, which tasks us to:

- promote the interests of the public and patients in relation to regulated healthcare professions
- promote best practice in regulating healthcare professions
- develop principles for good, professionally-led regulation of healthcare professions
- promote co-operation between regulators and other organisations.

4.11 To carry out these responsibilities, we can:

- *Monitor how regulators operate*, which includes:
  - investigating and reporting on how they function
  - comparing their performance
  - recommending changes in how they carry out their work.

  We do this through an annual performance review process (see 'Regulation at work' Section 6). More information about this, including overall and individual reports for this year and last year, is on our website. (Section 26 of the Act)

345211_HC1302_Text / Sig: 6 / Plate A

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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345211_HC1302_Text / Sig: 6 / Plate A

- *Recommend changes to regulators' rules*
  In the future, we may recommend that a regulator makes rules or changes existing rules if we feel that this is desirable to protect the public. (Section 27)
- *Refer cases of 'undue leniency' to Court*
  In some circumstances, we may refer 'fitness to practise' decisions to Court if we consider that the regulator's decision is too lenient and that a referral is necessary to protect the public. (Section 29)
- *Advise health ministers*
  We have a statutory responsibility to give advice to the Secretary of State or the Health Ministers of England, Scotland, Wales and Northern Ireland, who may ask us about anything connected with a healthcare profession. (Section 26(7))

Where to find more information about us

4.12 You can find more information on our website at www.chre.org.uk. This includes our publications, press releases and Council papers, and our business and corporate plans. We published a leaflet called 'What we do', which you can get from our website or by asking us. Information about us is also available in different languages, and we have an approved Welsh Language Scheme.

4.13 The Act itself is on the HMSO website at:
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5 Our achievements

Promoting good practice

Adopting a best practice approach

5.1 While our Act makes specific reference to the promotion of best practice, this is given a pragmatic interpretation to mean spreading transferable good practice. This is because, to be useful, good ideas or processes must be capable of working in the context of the nine different regulatory schemes. We have decided to implement a project-based approach to identify and disseminate best practice across all aspects of regulatory activity. The Better Regulation Task Force's five principles of good regulation (adopted by our Council in November 2004)[9] provide a framework for this:

- proportionality
- consistency
- targeting
- accountability
- transparency.

Photo by Kampfner Photgraphy

5.2 In the next year:

- we will be working with regulators and other key stakeholders to take forward recommendations arising from the Ayling and Kerr/Haslam Inquiries.[10] This project will strengthen boundary maintenance (i.e. maintaining acceptable interpersonal relationships) between professionals and patients, by formulating guidance and training materials for use by regulators and within the NHS.
- we will review, with regulators, the sanctions available to them in their fitness to practise processes, to ensure that they have the flexibility derived from having a full range of appropriate sanctions at their disposal.
- in co-operation with regulators, we will also consider the issue of the suitability of students or equivalent to practise a specific profession during education and/or training (i.e. student fitness to practise).

9 For more information on the principles underpinning best practice work, see http://www.chre.org.uk/Website/about/Meetings/CouncilMeeting.2004-09-03.1861358266/papers/Item%206%20Identifying%20Best%20Practice%20FINAL.pdf

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Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

345211_HC1302_Text / Sig: 7 / Plate A

Disseminating good practice

5.3 We only refer cases to Court under our section 29 jurisdiction when there is no other effective means of protecting the public. More commonly, cases we look at give rise to learning points that we feed back to regulators to improve their fitness to practise processes. Sometimes, the point is relevant to a specific regulator, but the bulk of issues are of generic importance. The collective learning has been collated into a 'learning points' document which also includes information and decisions from registrant Appeals. The learning points document has been disseminated to the regulators and is available on our website. This paper will be updated regularly as new issues arise and in line with developing practice.

5.4 Sharing these learning points has been an effective way of promoting excellence in regulation. Regulators have considered this information and in some cases used it to inform members and associates involved in the fitness to practise process.

5.5 We have continued to debate and share good practice through the regular forums attended by regulators' staff. Our fitness to practise forum, for example, has facilitated the sharing of experience on training for panel members. We also held a joint meeting with staff from the fitness to practise, registration and education functions on the subject of 'good character and health' (the requirement for prospective registrants to show that they are not unfit to enter the register of the regulator for reasons of conduct or health).

Promoting collaboration

5.6 Collaboration with other organisations continues to be a key aspect of our work. We have become an associate member of the 'Concordat' developed by the Healthcare Commission, the independent inspection body for both the NHS and independent healthcare. This initiative is designed to minimise regulatory burden by helping inspectorates to coordinate regulatory activity. We have continued to meet with important stakeholders across the UK (see paragraph 5.12), and have developed links in other parts of Europe. Much of the activity there has focused on sharing information, and we have established links with CEPLIS[11], a European organisation for the self-regulating professions.

5.7 We have also engaged with the Association of Chief Police Officers (ACPO) through the fitness to practise forum, to develop understanding and sharing of information between regulators and the police. It seems

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345211_HC1302_Text / Sig: 7 / Plate B

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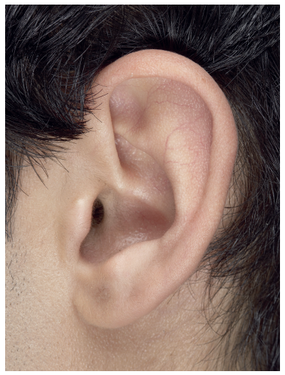
Partnership in health and social care

5.8 The interface between health and social care differs from country to country within the UK, and separate social care regulatory structures have developed. The Chair of the General Social Care Council in England has been an observer on our Council since its inception, and provides a link between CHRE and the four social care regulators (by agreement between them, when our Council meets out of England, the 'local' regulatory chair will attend).

5.9 To improve dialogue and sharing of good practice, we have organised meetings between the Chief Executives of the health and social care regulators. Areas of common concern and current practice have been explored, for example how the concept of 'good health' in terms of registrants can be dealt with.

Progressing regulatory excellence



Contributing to the reviews in the regulation of healthcare professionals

5.10 The two reviews have provided a focus of attention throughout the year, and we have played a key role in contributing to them. Our Chair was part of the CMO's group and both she and our Director were part of the Advisory Group to the Foster Review. We responded to the 'call for ideas', issued by the two reviews and our responses can be found on our website. Additional comment on the process and importance of these reviews is given in paragraphs 7.1 – 7.6.

Encouraging collaborative working through the performance review

5.11 We use our annual performance review process to promote tangible improvements in healthcare regulation. To achieve greater consistency in regulation, we have concentrated on areas that would particularly benefit from

345211_HC1302_Text / Sig: 8 / Plate A

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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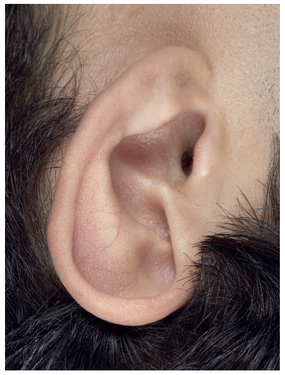

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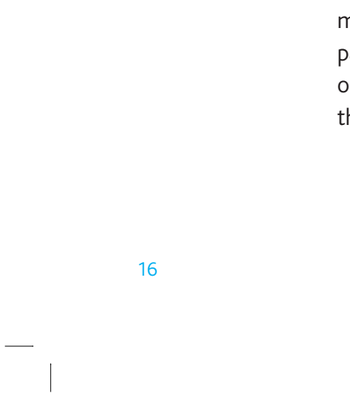

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- a joint report on the content and public accessibility of information on their registers. The UK Health and Social Care Regulators' Public and Patient Involvement Group (see good practice example, paragraph 6.27) has been tasked to commission research into how to make registers more accessible and meaningful to the public
- further development work on their complaints systems, and the establishment of joint training on child protection for fitness to practise panellists
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Building links across the UK

5.12 As our remit is UK-wide, working with key stakeholders in the four nations of the UK is crucial. This year, we worked to develop further active networks, particularly with the health departments of the devolved administrations and the slightly different stakeholder groups operating there. We entered into a Memorandum of Understanding with the new Northern Ireland Regulation and Improvement Authority, whose role is to monitor the quality of health and social care across Northern Ireland, and with NHS Quality Improvement Scotland, whose role is to act as the leading organisation in improving the quality of healthcare delivered by NHS Scotland. The Department of Health in England, together with the Arms Length Body Change Programme Team, has begun discussions with the devolved nations to decide an appropriate financial contribution to CHRE's budget.

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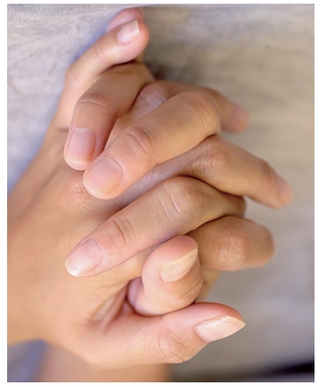

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Protecting the public

5.14 Section 29 of the Act gives us important powers and responsibilities in protecting the public. Under section 29, in some circumstances, we may refer 'fitness to practise' decisions to Court[12] if we consider that the regulator's decision is too lenient and that a referral is necessary to protect the public. We have continued to use these responsibilities to strengthen the regulatory framework, and in doing so, to enhance public protection.

Section 29 Statistics

5.15 Annex A shows a breakdown of the cases we dealt with this year. We considered 764 cases from 1 April 2005 to 31 March 2006; 600 were closed with no requirement for more information. We sought and considered additional information in the remaining 164 cases. Council members considered 27 of these cases and we appealed to the High Court in ten cases (one of which we later withdrew). Of these ten cases, seven were from the General Medical Council, two from the General Dental Council and one from the Health Professions Council.

5.16 The aim of the section 29 process is to improve the quality of the fitness to practise procedures and the standard of the decisions made by panels and committees. This can often be achieved successfully without needing to refer a case to the High Court. In many cases we identified important learning points to enhance public protection, which we have disseminated to the regulators (see paragraph 5.3).

5.17 Since January 2005, the database set up to manage the section 29 process has allowed us to gain better insight into the types of cases considered by regulators. We found that charges most frequently relate to poor performance or competence, dishonesty, record keeping and criminal convictions.

12 Where the registrant has a registered address in Scotland, the appropriate court is the Court of Sessions in Edinburgh. If the registered address is in Northern Ireland, the appropriate court is the High Court of Justice in Belfast; those with English and Welsh registered addresses are dealt with in the High Court in London.

345211_HC1302_Text / Sig: 9 / Plate A

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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5.19 As part of our process, a case meeting of our Council members decides whether to refer a case to Court. Case meetings normally consist of three members. A breakdown of the number of case meetings attended by each Council member is given below. It should be noted that regulatory members are not permitted to sit on cases involving their own registrants, and most cases have come from the GMC and the NMC.

Attendance at case meetings

1 April 05 to 31 March 06

Regulatory members	
Jonathan Asbridge (NMC)	6
Norma Brook (HPC)	1
Graeme Catto (GMC)	0
Nigel Clarke (GOsC)	5
Michael Copland-Griffiths (GCC)	2
Hew Mathewson (GDC)	7
Kate McClelland* (PSNI)	0
Hemant Patel* (RPSGB)	0
Rosie Varley (GOC)	3
Lay members	
Frances Dow	7
Sue Leggate	2
Jim McCusker	1
Peter North	12
Hugh Ross	0
David Smith	3
Kieran Walshe	1
Jane Wesson	8
Sally Williams	3
Lois Willis	2

*Council members who joined the Council in the latter part of the year and who had to undergo training before being able to sit in meetings. Previous Council members Nicholas Wood (RPSGB) and Sheelagh Hillan (PSNI) attended 2 and 1 case meetings respectively.

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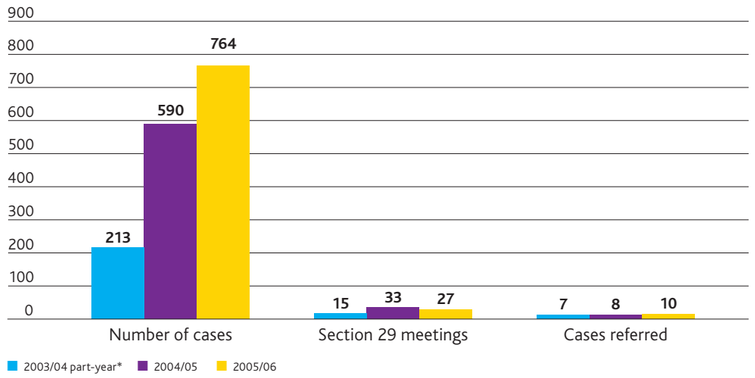
Figure 1: section 29 cases from 2003/04 to 2005/06



*we did not start considering cases until September 2003.

5.20 Over the last year there has been an increase in the number of fitness to practise cases dealt with by the regulatory bodies, and consequently in the volume of decisions which we reviewed. This rise is accounted for to some extent by an increase in complaints received by some of the regulators, and by others taking action to reduce the time taken to complete cases. This trend is likely to continue, as more professional groups become registered, and regulators are enabled to operate more flexibly due to changes in their legislation. Despite this rise, the proportion of cases we referred to the High Court continues to be very small (about 1.3% of cases received) and the total number of referrals this year is similar to previous years (figure 1).

5.21 We received judgments from the High Court on eight cases this year. Some of these relate to section 29 appeals made in the previous year. In all of these cases our appeal was upheld, and in three, this was following a settlement of the case by agreement of all of the parties. There is more information about the High Court judgments, including copies of the Court judgments and orders, on our website.

Developments in regulatory law

5.22 Only a small number of cases are referred to Court under section 29 and referral to Court is by no means our main focus. However, there have been some important judgments arising both from section 29 appeals, and from

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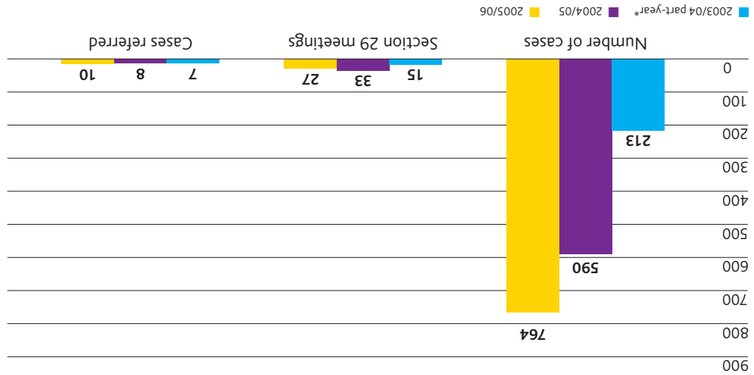
Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

Figure 1: section 29 cases from 2003/04 to 2005/06



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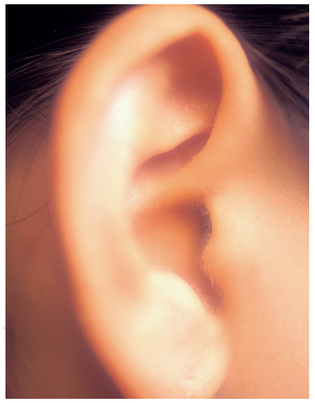
appeals by registrants against decisions made by their regulatory body. The most notable judgments have been those in the cases of *Southall, Giele* and *Meadow*.[13] The main issues raised in these judgments are summarised below, and more details are available on our website:



- *Deference to the committee* – while account is generally given to the expertise of the original panel (i.e. "deference"), this carries less weight on issues where the Court may feel it is able to assess for itself what is needed to protect the public.
- *Insight/Remorse* – while absence of remorse may indicate lack of insight or the maintenance of unreasonable views (which are relevant factors as regards risk and therefore the appropriate sanction), it should not in itself result in a higher sanction as a means of punishment.
- *Public interest in allowing continuation of practice* – a competent registrant about whom patients and colleagues have nothing but praise, should not be precluded from practice altogether, if that can be achieved with no danger to the public, and with no damage to the reputation of the profession.
- *The weight to be attached to testimonials* – these can be afforded significant weight, and might be considered in assessing the risk posed to the public, however these are aspects that affect sanction rather than culpability.
- *The purpose of sanctions* – in terms of sanction, the public interest includes protection of patients, maintenance of public confidence in the profession and declaring and upholding proper standards of conduct. This can extend, in appropriate cases, beyond patients to those who are directly adversely affected by the doctor's actions.
- *The weight to be given to the Indicative Sanctions Guidance (ISG)* – Indicative Sanctions Guidance is just guidance and must take into account certain overarching principles. This includes a recognition that the public interest might, despite a finding that a practitioner has been guilty of serious professional misconduct, indicate that they should be able to return to safe work.

13 Southall – [2005] EWHC 579 (Admin)
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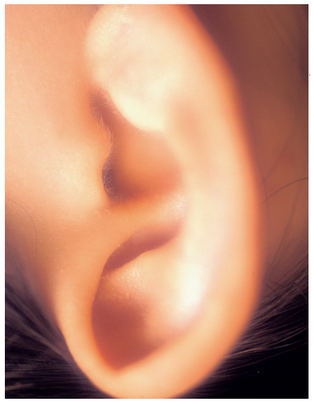

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- *Erasure only if essential* – erasure[14] should only be applied if it is "essential" i.e. the conduct must be 'fundamentally incompatible' with being on the register.
- **Immunity from disciplinary action for expert witnesses* – immunity from legal action for expert witnesses should extend to disciplinary action by regulatory bodies. However it was still open for a judge to refer the expert to the relevant disciplinary body "if his conduct has fallen so far below what is expected of him as to merit some disciplinary action". *(this aspect is the subject of an Appeal by the Regulatory Body).

Alternatives to Court action

5.23 The Courts have made it clear that resolving public protection concerns by way of a Court hearing may not always be necessary, if alternative ways that adequately protect the public can be agreed. During the year, we implemented our Alternative Disputes Resolution Policy, which requires us to engage in discussions (through their legal representatives) with the regulatory body and the registrant to agree an alternative outcome which rectifies the situation. Of the cases we considered to be unduly lenient, about a third were resolved by agreement, although most of these then required to be endorsed by the Court and given effect through a 'consent order', as only the Court has the power to change or set aside the original decision. However, this is generally an administrative process avoiding the need for a full Court hearing.

Example: In one case, we withdrew our appeal when the registrant agreed to give an undertaking to restrict his practice to supervised Senior House Officer posts until he had achieved full membership of the appropriate Royal College. He also agreed that this information would be given to anyone asking about his registration. It has to be recognised, though, that we cannot compromise on our public protection concerns and not all cases can be resolved in this way.

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Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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345211_HC1302_Text / Sig: 11 / Plate A

Other developments in section 29

The process

5.24 Following consultation, we revised our 'Process and Guidelines for Section 29 cases' document and our Council formally adopted the updated version in November 2005. We have also produced a document detailing risk factors to be taken into account when members consider whether we need to refer cases to Court. This document, our Alternative Dispute Resolution Policy, guidance for members, copies of all Court judgments and copies of the notes of all section 29 case meetings are available on our website.[15]

Quality assurance and openness

5.25 The section 29 Scrutiny Committee has continued to monitor our work on section 29, including assessing the quality of our decisions. The Scrutiny Committee is made up of six members of Council and a senior policy representative from Which?[16], and met three times during the year.

5.26 During the course of the year, the Committee commissioned a third report which will focus on whether the staff are referring the appropriate cases to Council members for consideration at case meetings.

5.27 The Scrutiny Committee also considered matters such as our arrangements for legal advice, value for money of legal services and diversity issues. The Committee reports its findings to the Council following each meeting.

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6 Regulation at work

6.1 Part of our statutory remit involves conducting an annual performance review of the functions of the regulatory bodies. This section presents some of the outcomes of this review.

6.2 Last year we asked the regulators to provide detailed information, in a standardised format, on their organisational structure, functions and outcomes. This provided a baseline against which changes could be tracked. This year the exercise was repeated, but on an 'updating' basis. Following this a face-to-face meeting was held with each of the regulators. More information on the questionnaire, the process and the detailed outcomes of the performance review can be found on our website.[17]

Overview

The nine regulators

6.3 The nine regulators currently register about 1.16 million healthcare professionals (see figure 2), across the independent and the NHS sectors, in a great variety of settings. Although the regulators are responsible for broadly similar functions, they also differ in many ways. They regulate different healthcare roles, have different legislative frameworks and traditions, and varying numbers of registrants and incomes (see figure 3).

6.4 This year, it is apparent that regulators have been working particularly on two aspects of their functions: education and standards. In education the focus has been particularly on the undergraduate level and quality assurance systems. In a number of healthcare courses, students can be subject to more extensive discipline provisions than apply to the wider student population, and this year the GOC introduced an initiative involving the creation of a register of students.

6.5 Standards and guidance need to be 'living' documents, responsive to developments. This approach is exemplified by the GDC's move towards supplementary guidance (see good practice example on page 24). The RPSGB has developed additional guidance on child protection and on raising concerns about the fitness to practise of another health professional. This year has also seen some important consultations or preparatory work on standards by a number of regulators.

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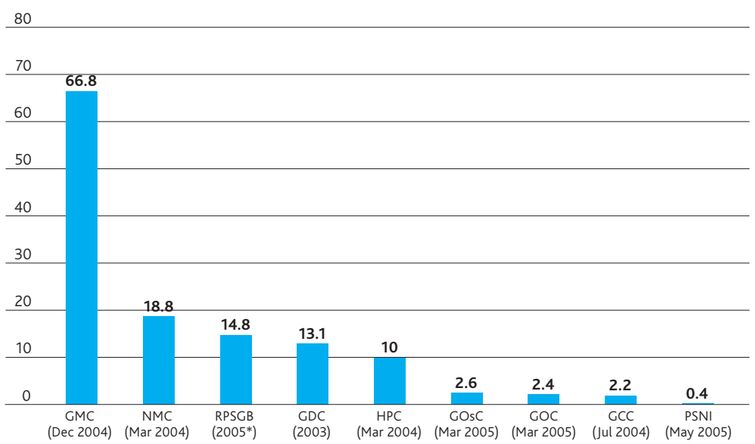
Figure 2: income - regulators, 2004/05 (£million)



*This represents the sum of RPSGB's income from registration and net income from publications.

Source: performance review 2005/06.

Trends in regulation

Increasing volume

6.6 The volume of work undertaken by regulators appears to have increased compared with last year. Overall, the nine regulators have more professionals on their registers (about 3% more[18] – see figure 3) and heard more fitness to practise (FTP) cases (see Annex A, which shows cases we received under section 29). The overall 1%[19] rise in the number of complaints disguises higher rises for some of the regulators.

GOOD PRACTICE EXAMPLE

The GDC revised its core guidance to dental professionals, which is supported by supplementary guidance targeted to particular issues. Supplementary guidance has been published on patient consent, confidentiality of patient information and team working. Further guidance on complaints handling and raising matters of concern is due to be published in May 2006.

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Regulation at work

345211_HC1302_Text / Sig: 12 / Plate B

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80 70 60 50 40 30 20 10 0
66.8 18.8 14.8 13.1 10 2.6 2.4 2.2 0.4
GMC (Dec 2004) NMC (Mar 2004) RPSGB (2005*) GDC (2003) HPC (Mar 2004) GOsC (Mar 2005) GOC (Mar 2005) GCC (Jul 2004) PSNI (May 2005)

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Regulation at work

345211_HC1302_Text / Sig: 12 / Plate B

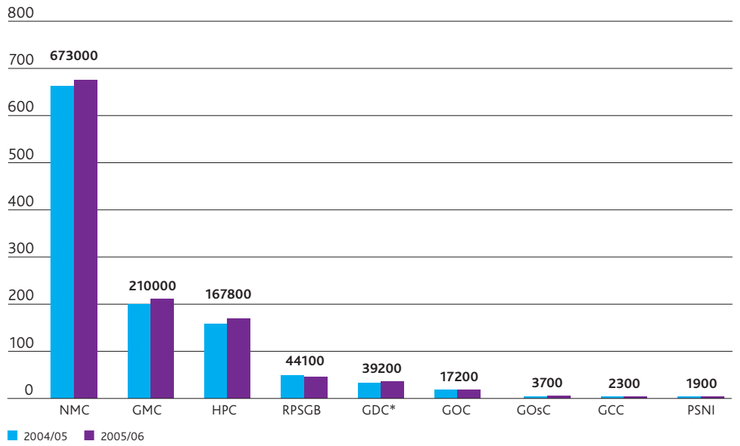
Widening scope

6.7 Regulation is extending to cover more professions or members of the healthcare team. Some regulatory bodies are about to regulate new categories of registrants. These include:

- the GOC registering students from this year
- the RPSGB and PSNI regulating, in future, pharmacy technicians (currently regulated on a voluntary basis)
- the GDC regulating further members of the dental team
- consultation on the regulation, by the HPC, of applied psychologists, and further consultation expected on the regulation by the HPC of clinical perfusion scientists, clinical physiologists and clinical technologists.

6.8 A number of aspirant groups are also looking towards, or preparing for, regulation. The Foster Review has considered the regulation of healthcare assistants and how the new roles that have emerged within the health service should best be regulated.

Figure 3: Number of registrants (in thousands)



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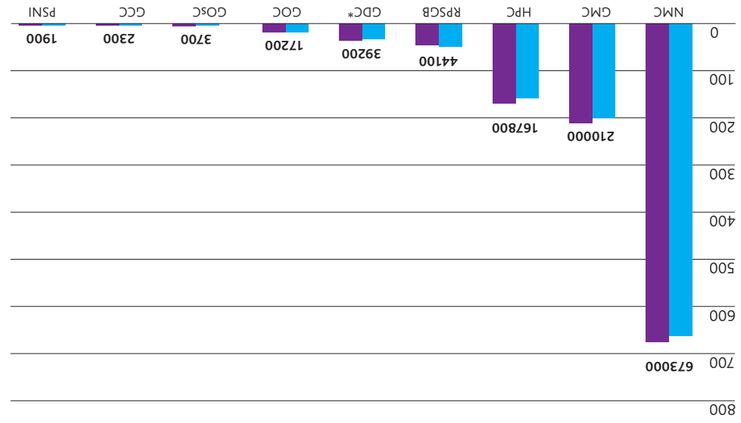

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6.9 Regulation has also expanded the scope of its functions to include Continuing Professional Development (CPD) schemes, and potentially, revalidation.[20] All non-medical regulators have developed a CPD scheme for their registrants, and the GMC has continued its work to devise a robust system of revalidation. Some of the other regulators have also considered this concept in depth, with the GDC adopting an incremental approach towards revalidation by strengthening CPD first. Further work on revalidation by some other regulators is currently on hold, awaiting the Government's response to the two reviews.

Growing complexity

6.10 The work of regulators is becoming more complex. Regulators liaise with a wide range of stakeholders and are striving to improve internal processes. They are also developing a more 'risk-based' approach to their work and are seeking to enhance the evidence-base for their policy developments (see paragraph 6.24). We expect this to be an ongoing trend.

6.11 Regulators are working hard to ensure they have efficient organisational structures. All now have a business plan and the majority have adopted corporate plans. Some regulators also have a dedicated strategy or planning function within their organisations. The HPC has ISO accreditation and uses ISO standards[21].

Key developments

Promoting public confidence

6.12 Public confidence in healthcare professions remains high,[22] but recent public inquiries have highlighted that this could be further strengthened. We welcome the increased lay and public input and greater transparency in regulation, but more could be done to increase the accountability of regulators and provide reassurance that regulation works to protect the public.

6.13 The discussions during the course of the Foster Review provide an indication of how topical the question of public confidence remains. As well as discussing the continuing concerns about the fragmentation of the complaints systems, consideration was also given to possible mechanisms for reinforcing public confidence. These included:

20 The Medical Act 1983 defines revalidation as a set of procedures operated by the GMC to secure the evaluation of a medical practitioner's fitness to practise as a condition of continuing to hold a licence to practise (i.e. an evaluation at the point of revalidation). See *Developing medical regulation: a vision for the future*, GMC, April 2005.

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345211_HC1302_Text / Sig: 13 / Plate B

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- increasing the number of appointed members of regulators' Councils
- establishing independent adjudication separate from regulators.

Public and Patient Involvement (PPI) strategies

6.14 In this context, we welcomed the drive by more regulators to develop a patient and public involvement (PPI) strategy and the move to work more closely through the UK Health and Social Care Regulators' Public and Patient Involvement Group. We are also pleased to see regulators using different, and often innovative, means to gather public views. Open events held by the GMC and communication exercises such as those undertaken by the HPC also raise understanding of the functions of regulators.

GOOD PRACTICE EXAMPLE

The GMC organised a citizens' jury which considered the issue of children's rights when receiving medical care, and the information from this exercise will be taken into account in developing guidance on the treatment and care of children. Following the successful piloting of its tracking survey last year (to ask the public and registrants their views on a range of subjects), the GMC has decided to undertake a tracking survey every year.

GOOD PRACTICE EXAMPLE

The NMC held focus groups to encourage more direct engagement on some key NMC policies: for instance overseas-trained midwives applying for registration, fitness for practice at the point of registration and standards for assessment and learning in practice. It also organised a pilot programme to find out what different types of service users expect from nurses and midwives. Children and young people were the focus of the first of their pilot roadshows.

Separation of functions

6.15 There seems to be an evolution towards the separation of policy making and the fitness to practise process. The GDC, the GMC and the HPC already have fitness to practise panels independent from their governing Councils. The RPSGB's statutory committee also has non-Council members, and the GOsC has increased the number of co-optees to its fitness to practice committees. Following the implementation of its recent section 60 order[23], the GOC will have external members hearing cases in a new fitness to practice committee, and the RPSGB will have external members sitting on its new fitness to practise panels when its legislation is updated through a new section 60 order.

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345211_HC1302_Text / Sig: 14 / Plate A

6.16 This development also brings with it the challenge of retaining the link between a regulator's policy and its translation into its fitness to practise processes.

Transparency

6.17 Transparency and consistency of the fitness to practise process, from complaints handling to case outcomes, can be seen as a way to increase public confidence in regulation. Indicative sanctions guidance, which is used by panel members when considering fitness to practise cases, but is also available to other stakeholders, provides a means of further developing transparency and consistency. We have been keen to emphasise the importance of the development and use of indicative sanctions guidance, already adopted by some regulators, and have developed a template building on current best practice.[24] All regulators have now adopted, or in the case of the GOC and the GOsC are developing, indicative sanctions guidance. This is a significant step forward from last year.

6.18 During last year's performance review, we highlighted the importance of quality assurance at the preliminary stages of the fitness to practise process, which includes the stage where regulators handle complaints. Several regulators have moved further towards internal or external audit of their decisions at the preliminary stage of the fitness to practise process. Last year we also developed a template for a complaints leaflet,[25] and those regulators that have subsequently changed their leaflets have taken this template into account.

GOOD PRACTICE EXAMPLE

The GDC is consulting on its guidance to the Investigating Committee which will be established mid-2006 as part of reforms to the Fitness to Practise system. This follows enabling legislation that was passed during 2005. The GDC has also consulted on, and adopted, guidance on the impact of criminal convictions and proven misconduct on applications for professional registration/restoration.

6.19 It is also important that regulators have effective systems so that members of the public, registrants and other stakeholders can make complaints about the organisation (and/or staff). We are pleased to note that all regulators have now adopted such systems, or are further developing existing ones.

6.20 We were also pleased to see that most regulators have now made efforts to collect information on the ethnic background of registrants, or are planning to do so. We believe this will assist them to fulfil their duties to avoid discrimination.

24 http://www.chre.org.uk/Website/about/Meetings/CouncilMeeting.2004-09-03.1845773097/papers/Item%208%20Indicative%20Sanctions%20Guidance%20FINAL.pdf

25 http://www.chre.org.uk/Website/about/Meetings/CouncilMeeting.2004-09-03.1845773097/papers/Item%207%20Complaints%20Handling%20FINAL.pdf

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6.21 The move towards publishing more information on websites is a positive trend and most regulators now publish their fitness to practise decisions electronically. Some have included indicative sanctions guidance on their websites, or reviewed the printed information provided on their complaints system. Finally, most regulators have adopted clear objectives and/or performance indicators as part of their business plans.

Ensuring the effectiveness and fitness for purpose of regulation

6.22 The drive to make regulation 'fit for purpose', enabling it to protect the public in all contexts, maintain standards and respond to the modernisation of healthcare, can be supported by a number of concepts: risk-based regulation, evidence-based approach to policy and decision-making, and sharing of learning.

The concept of risk-based regulation

6.23 Generally, regulators are committed to the Better Regulation Task Force's principles of proportionality, accountability, consistency, transparency and targeting. Following the Hampton Report,[26] the concept of 'risk-based regulation' (regulatory activity focused on the areas of greatest risk) has gathered momentum and is being actively considered by many regulators. The challenge is how to apply this concept to the regulation of healthcare professionals.

GOOD PRACTICE EXAMPLE

The GMC has adopted a risk-based approach to the regulation of doctors, particularly in terms of revalidation: where there is a low regulatory risk, the level of scrutiny and intervention by the GMC should be similarly low. Risks can be divided into two aspects: the context in which the doctor works, and personal indicators of impairment. Where the risk is higher and the potential for harm to patients is greater, a correspondingly greater level of scrutiny is required. A key element of this approach will be the collection of information on the scope of practice of doctors.

An evidence-based approach

6.24 The majority of regulators are continuing to develop an evidence-based approach to policy and decision-making, through discussions and meetings with stakeholders, wide-ranging consultation, the experience of other sectors or countries, and the commissioning of research.

26 See paragraph 1.5. Reducing administrative burdens: effective inspections and enforcement, Philip Hampton, March 2005, available on http://www.hm-treasury.gov.uk/hampton

345211_HC1302_Text / Sig: 15 / Plate A

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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345211_HC1302_Text / Sig: 15 / Plate A

GOOD PRACTICE EXAMPLE

The RPSGB has a five-year research strategy. For example, during 2005 it completed research into the teaching, learning and assessment methods used in Schools of Pharmacy, a project which has now been followed up with a number of mini-projects in different schools looking at innovative approaches.

Shared learning

6.25 One use of evidence to improve regulatory functions is the dissemination of learning across regulatory bodies, as well as across regulatory functions within regulators, for instance through the use of the learning points derived from our section 29 process (see paragraph 5.3). Some regulators, such as the GOsC, have also used 'feedback loops' across their functions by identifying key learning points from their fitness to practise cases and circulating these to registrants. We consider sharing of learning as an important part of organisational development and other examples are available from our performance review reports for last year and the responses by regulators to our questionnaire.

Working in partnership

6.26 We believe that regulators must continue to work collaboratively among themselves and with other organisations to enhance further the overall effectiveness of regulation. This seems increasingly relevant with the emergence of new and extended roles within the healthcare systems, such as surgical care practitioners, and closer and evolving team working, including that between health and social care.

Collaborative working and harmonisation

6.27 Regulators have worked positively together for a number of years on a range of issues. This collaboration has been reinforced by CHRE's existence - through our Council, forums, workshops, the performance review process, and joint projects.

GOOD PRACTICE EXAMPLE

Regulators decided to work together in the UK Health and Social Care Regulators' Public and Patient Involvement Group. This group, supported by the GCC, aims to identify and develop effective ways in which partner organisations can work together to enhance PPI by means of informing, consulting and partnership, within health and social care regulation.

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Regulation at work

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345211_HC1302_Text / Sig: 15 / Plate B

6.28 We anticipate that harmonisation of best practice will be spurred on as a result of decisions by the Government in relation to the recommendations of the Donaldson and Foster reviews. The regulators have identified during the performance review areas appropriate for harmonisation. They will meet together, and with us, to discuss joint projects. The outcomes of these discussions will be included in our future Council papers.

Strategic partnership

6.29 We recognise that regulators assure the competence of the practitioners on their registers in partnership with other organisations. Ensuring public protection therefore requires a multi-agency approach which recognises the appropriate contribution of higher education institutions, the Royal Colleges, employers and other stakeholders such as patients and the public. Respective roles need clarifying to avoid duplication or gaps in the process. In the case of employers or equivalent, this could include the levels of intervention in complaints, or the degree of involvement of employers in revalidation.

6.30 Professionally-led regulation crucially relies on professional 'buy-in', and all regulators face the challenge of retaining this. They continue to do so through a variety of means, such as consultation, involvement in the development of standards, and feedback.

GOOD PRACTICE EXAMPLE

Nine regional conferences have been held by the GOsC, to continue to involve the osteopathic profession. These have been used in particular to promote a better understanding of the new GOsC's Code of Practice, which came into effect on 1 May 2005, and have sought to engage osteopaths proactively. The films presented to osteopaths to stimulate debate and understanding used examples of actual complaints.

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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7 Challenges ahead

7.1 The regulation of healthcare professionals operates within an active policy and legislative environment. In the course of the year, new external challenges common to all regulators have emerged.

Reviews into the regulation of healthcare professionals

7.2 The Government set up two reviews into the regulation of healthcare professionals. The remits of the two reviews were as follows.

7.3 The Donaldson review aimed to:

- strengthen procedures for assuring the safety of patients in situations where a doctor's performance or conduct poses a risk to patient safety or the effective functioning of services
- ensure the operation of an effective system of revalidation
- modify the role, structure and functions of the General Medical Council.

7.4 The Foster review sought to identify the measures needed to:

- strengthen procedures for ensuring that the performance or conduct of non-medical health professionals and other healthcare staff does not pose a threat to patient safety or the effective functioning of services, particularly focusing on the effective and fair operation of fitness to practise procedures
- ensure the operation of effective systems of continuing professional development and appraisal for non-medical healthcare staff and make progress towards regular revalidation where this is appropriate
- ensure the effective regulation of healthcare staff working in new roles within the healthcare sector and of other staff in regular contact with patients.

7.5 The review also sought to consider whether any changes were needed to the role, structure, functions and number of regulators of non-medical healthcare professional staff.

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7 Challenges ahead

Prof Sir Liam Donaldson

7.6 We regard the Foster and the Donaldson reviews as two linked exercises, designed to ensure that healthcare regulation is fit for purpose and able to support patient-centred, modern healthcare delivery. We believe very strongly that the two reviews should have a read-across of their recommendations, so that their outcome is consistent across the whole regulation of healthcare professionals.

Kerr-Haslam Inquiry

7.7 The Kerr-Haslam Inquiry (July 2005) reported on the abuse of vulnerable psychiatric patients, during the 1970s and 1980s, by two consultant psychiatrists, William Kerr and Michael Haslam. The report contained many recommendations, some of them relevant to our work.[27] The work on boundary maintenance we commissioned, and the report, were a spur for our current project on professional boundaries (see paragraph 5.2).

The evolving nature of healthcare systems in the UK

7.8 Health provision in the four countries is evolving and is becoming increasingly diverse. For instance, in England, the Government published a White Paper on primary care, and new contracts have been introduced for some of the professions. In Scotland, the Scottish Executive proceeded with the implementation of the report 'Delivering for Health', which sets out a programme of action for the NHS in Scotland.[28] Roles within healthcare are changing and expanding. This modernisation has led to discussions as part of the Foster review on the regulation of new and extended healthcare roles.

7.9 In addition, while regulation of existing professional groups is reserved to the Westminster Parliament, the regulation of new groups in Scotland and Northern Ireland is the responsibility of the devolved administrations. This has presented challenges over the year for the RPSGB and the GDC, with some faltering in the regulation of the other members of the team in pharmacy and dentistry as a result of constitutional issues in Scotland.

27 http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4115349&chk=XN1BBZ

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Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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33

345211_HC1302_Text / Sig: 17 / Plate A

7.10 We believe that it is crucial that levels of public protection are similar across the UK. The key challenge is to ensure a system of regulation which is integrated and has consistent outcomes UK-wide, so that anomalies and loopholes are not created, and staff can easily move from one nation to another without public protection issues arising.

Safeguarding Vulnerable Groups Bill

7.11 After the publication of the Bichard Inquiry Report into the failings in information sharing around the Soham murder Inquiry, the Government established a consultation process and created a 'regulators' group' where policy papers were developed, with representatives from CHRE, GMC, HPC and NMC. We subsequently commented on draft clauses included in the Safeguarding Vulnerable Groups Bill.[29]

7.12 This legislation is due to be enacted in 2006 and will bring with it substantial changes in the way regulated professionals are vetted for roles which involve dealing with children and vulnerable adults. The regulators convened a seminar, organised by the RPSGB, at the end of this financial year, at which practical implications of the Bill were discussed and observations shared with the team who are working on the Bill.

Making Section 60 Orders[30] more effective

7.13 Section 60 orders are the main mechanism for legislative change. We consider that the streamlining of legislative changes through the section 60 process should be addressed as a matter of priority to ensure greater public protection. All regulators recognise the need for rationalisation in some areas across regulation, but have urged that necessary change through section 60 orders is not delayed as a result of the CMO and Foster Reviews.

29 The Safeguarding Vulnerable Groups Bill was introduced in the House of Lords on 1 March 2006 and can be accessed at: http://www.publications.parliament.uk/pa/ld200506/ldbills/079/2006079.htm

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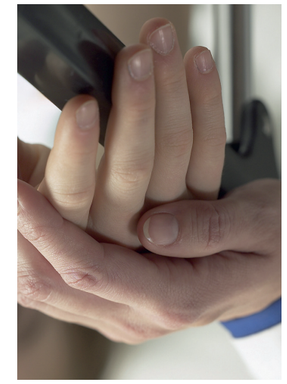
Challenges ahead



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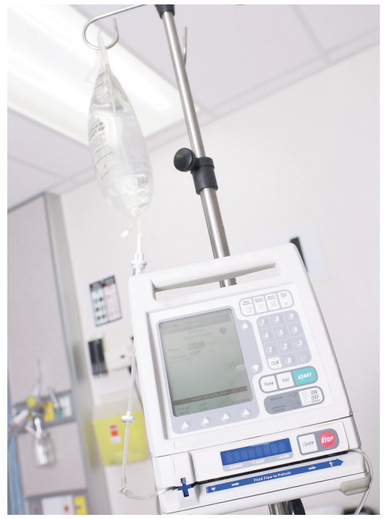
Mobility of healthcare professionals

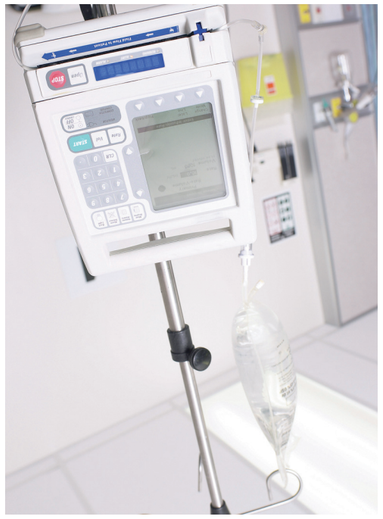
7.14 In 2005/2006, the European Union (EU) passed into legislation the directive on the Mutual Recognition of Professional Qualifications. This has been given two years for translation into domestic law and will be enshrined in UK law by 20 October 2007. In relation to healthcare, recent judgments in the European Court of Justice (ECJ) have required the European Commission to consider health as a 'Service of General Economic Interest', and therefore potentially for inclusion in the 'Services in the Internal Market' Directive. In February 2006, after careful consideration, the European Commission agreed to remove health from the directive. However, the legal uncertaintities created by ECJ jurisprudence, that challenged the Treaty principle that health is reserved to member state legislation, suggest that some aspects of health could be remitted to the European Union (EU). Proposals are being developed regarding a legislative framework for health at EU level. Discussions are expected to commence by autumn 2006.

7.15 Exchange of information between regulators in Europe, on professionals' fitness to practise, was considered under the 'Health Care Professionals Crossing Borders' project. This project has made real progress, as it now has European Commission support.



345211_HC1302_Text / Sig: 18 / Plate A

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006



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Biographies

Jonathan Asbridge. Jonathan is the President of the Nursing and Midwifery Council and National Clinical Director for patient experience in emergency care. Jonathan was Chief Nurse at Barts and the London NHS Trust, a post he held for seven years. His clinical background is in critical care. Jonathan was previously Director of Nursing at the Oxford Radcliffe Hospital and Addenbrooks Hospital Cambridge and chaired the review of adult critical care nursing in 1999, which made a significant contribution to 'Comprehensive Critical Care', which has formed the modernisation of critical care services throughout the country.

Norma Brook. Norma was appointed President of the HPC in May 2001. She is a qualified physiotherapist and is currently a self-employed consultant in education for physiotherapists and other professionals allied to medicine. She was Head of Divisions of Professions Allied to Medicine at the School of Health and Social Care, Sheffield Hallam University. She is a former Chair of the Physiotherapists Board of the Council for Professions Supplementary to Medicine (CPSM). Norma, who has extensive experience of physiotherapy, acts as an advisor and examiner to a number of bodies nationally and internationally. She is a Fellow of the Chartered Society of Physiotherapy and has received Honorary Doctorates from the University of East Anglia, Robert Gordon University, the University of Central England, University of Brighton and Sheffield Hallam University.

Graeme Catto. Graeme has been the President of the General Medical Council since February 2002. A member of the GMC since November 1994, he has also served on the Education and Standards Committees and the Committee on Professional Performance. Graeme is a Professor of Medicine, University of Aberdeen, Governor of the Qatar Science and Technology Park, Patron of the Medical Council on Alcoholism and Member of the Council of Brighton & Sussex Medical School.

Nigel Clarke. Nigel has been Chairman of the General Osteopathic Council since 2001, having served as Treasurer and lay member since the Council's inception. Following a career in public policy, including work at the CBI and the Commons, Nigel became finance director of GJW, a company offering public policy-related services. It was in connection with this work that he became interested in the regulation of osteopathy. Nigel runs a small consultancy and serves as a director of Advanced Transport Systems Ltd and PulsCare Inc. Nigel is a trustee of the Prince of Wales' Foundation for Integrated Health and works with the 'Changing Faces' charity.

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Nigel Clarke. Nigel has been Chairman of the General Osteopathic Council since 2001, having served as Treasurer and lay member since the Council's inception. Following a career in public policy, including work at the CBI and the Commons, Nigel became finance director of GJW, a company offering public policy-related services. It was in connection with this work that he became interested in the regulation of osteopathy. Nigel runs a small consultancy and serves as a director of Advanced Transport Systems Ltd and PulsCare Inc. Nigel is a trustee of the Prince of Wales' Foundation for Integrated Health and works with the 'Changing Faces' charity.

Michael Copland-Griffiths. Michael has been General Chiropractic Council Chairman since 2002, having been a member since its inception. After working overseas, Michael studied chiropractic at the Anglo-European College. Until his appointment to the GCC, he played an active role in the profession's efforts to secure statutory regulation serving as past president of the British Chiropractic Association. Prior to the GCC's establishment, as Steering Group Chairman, he helped unite the profession, gaining consensus for a code of conduct, standards of proficiency and competence and raised funds to ensure financial independence. Michael is the author of Dynamic Chiropractic today: the complete and authoritative guide.

Frances Dow. Frances is a retired academic who until recently was Vice-Principal at the University of Edinburgh. She has been a Vice Chair of one of four Lothian Health Research Ethics Committees. Currently she chairs a Scottish Executive Health Department steering group concerned with registration and training for healthcare support workers, as well as being a member of a SEHD strategy group on new medical support roles. She is also a Trustee of the Immigration Advisory Service and a member of the Council for Assisting Refugee Academics.

Sue Leggate. Sue started her career as an economist but spent most of her career working for the Consumers' Association (CA). From 1969 to 1995, Sue worked for the CA in a variety of research and editorial roles, culminating in several years as editor of 'Which?' magazine. Since then, Sue has worked freelance, providing consumer consultancy and concentrating on working as a lay member within the health sphere. Sue was Vice-Chair of North Essex Health Authority and Chair of Epping Forest PCT, and spent five years as a lay member of the GMC, including serving on its Governance Working Group. Sue is a trustee of the Consumers' Association.

Jim McCusker. Jim had over 40 years' experience of public services, including the health service, before he retired in 2003. Jim spent most of this time working for the Northern Ireland Public Service Alliance (NIPSA) and held the position of General Secretary from 1977 until his retirement. Jim currently holds two other public appointments – Member of the European Economic and Social Committee and Member of the Board of the Labour Regulations Agency for Northern Ireland – as well as being associated with various other organisations.

345211_HC1302_Text / Sig: 19 / Plate A

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

345211_HC1302_Text / Sig: 19 / Plate A

Hew Mathewson. Hew has been the General Dental Council President since 2003. A GDC member since 1995, Hew chaired the Professional Conduct Committee and served on the Education, Postgraduate and Ethics Committees. Hew worked as an associate in general dental practice and as a clinical assistant in oral surgery before setting up a practice in Edinburgh in 1977, in which he continues to work part time. Previously visiting surgeon at Edinburgh Dental School, Assistant Director, Dental Studies at Edinburgh University and Regional General Dental Practice Vocational Training Adviser, Hew continues to work with vocational practitioner groups, lecturing on practice management and dento-legal matters. He is President elect of the Conference des Ordres et organismes assimiles des praticiens de l'art Dentaire Europeens – the organisation which brings together all the European dental regulators.

Kate McClelland. Kate McClelland is a current member of the Pharmaceutical Society of Northern Ireland (PSNI). Between 2003 and 2005, she was President of the PSNI, having served as its Vice-President between 2001 and 2003. A graduate of the Queen's University of Belfast School of Pharmacy, Kate has been a contractor pharmacist in Maghberry since 1993, having served for a number of years as a locum community pharmacist.

Peter North. Peter North is a retired RAF officer who now holds three ministerial appointments with Employment Tribunals, North Norfolk Primary Care Trust (until September 2006) and the Home Office. He is a Lay Associate at the Healthcare Commission and works as a Lay Assessor for the GMC. He is also a member of the Fitness to Practise committees of the GDC and GOC and a Lay Visitor for the Postgraduate Medical Education and Training Board.

Hemant Patel. Hemant Patel has been President of the Royal Pharmaceutical Society of Great Britain since June 2005, his second term in office. He has served continuously on the Society's Council since 1993, first becoming President between 1998-99. With a background in community pharmacy, he also works as Secretary of the North-East London Local Pharmaceutical Committee and as a Board Member of the National Pharmaceutical Association. He is currently Vice President of the Commonwealth Pharmaceutical Association and a delegation member of the Pharmaceutical Group of the European Union.

345211_HC1302_Text / Sig: 19 / Plate B

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345211_HC1302_Text / Sig: 19 / Plate B

Hugh Ross. Hugh is Chief Executive of Cardiff and Vale NHS Trust. He was formerly Programme Director of Bristol Health Services Plan and Chief Executive of the United Bristol Healthcare Trust. Hugh joined the NHS in 1976, where he worked in the Wessex Region. This was followed by a series of posts in London at Westminster and St Bartholomew's Hospitals. This led to his appointment as Unit General Manager of the City Unit, Coventry. Hugh later became the Unit General Manager of Leicester General Hospital and then, after the granting of Trust status, its first Chief Executive.

David Smith. Educated at Ruskin College, University College Cardiff, and with a Masters degree in European Industrial Relations and Human Resource Management, David is currently a food policy consultant. He is a former Further Education lecturer and initiator and Director of Adamsdown Community & Law Centre Cardiff, and the first EC funded anti-poverty programme in Wales, pioneering the development of public engagement and participation in health inequalities. Until recently he was a member of the Food Standards Agency Welsh Advisory Committee. David is also Vice-Chair of Public Health Alliance Cymru and represents the Wales Council for Voluntary Action on the NICE Partners Council and the Reference Group for the implementation project of the Wales Concordat for inspection, regulation and audit.

Rosie Varley. Rosie is Chairman of the General Optical Council, an NHS Appointments Commissioner and a member of the Mental Health Review and Disability Tribunals. Rosie has held a number of non-executive roles in the NHS, chaired a Mental Health and Community Trust, and served as Regional Chairman of the Anglia and Oxford and Eastern NHS regions. Rosie continues to have a particular interest in mental health and substance misuse and is involved with organisations working in these areas. Through the GOC, Rosie has maintained an interest in the role of professional regulation in promoting clinical quality and patient benefit.

345211_HC1302_Text / Sig: 20 / Plate A

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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39

345211_HC1302_Text / Sig: 20 / Plate A

Kieran Walshe. Kieran is Professor of Health Policy and Management and Co-Director of the Centre for Public Policy and Management at Manchester Business School. He has extensive experience of health policy, health management and health services research. His research interests are focused on performance, quality and regulation in healthcare. He writes regularly for a range of journals including BMJ, Health Service Journal, Health Affairs, Millbank Quarterly and Quality and Safety in Healthcare. Kieran serves on several editorial boards, acted as an expert for the Bristol Royal Infirmary Inquiry, and has advised the National Audit Office, Department of Health, Healthcare Commission and a range of other bodies on healthcare issues. He is also research director of the NHS service delivery and organisations (SDO) research programme. His books include "Regulating healthcare: a prescription for improvement?" (2003);"Patient safety: research into practice" (2005); and "Healthcare management" (forthcoming, 2006).

Jane Wesson. Jane Wesson has chaired CHRE since it was set up in April 2003. Previously, Jane set up and chaired the NCAA (now NCAS) after eight years as Chair of the Harrogate NHS Trust. She has worked in the NHS as a non-executive director since 1990, combining this with roles with the NHS Confederation, DH and various investigations and enquiries within the NHS. Jane is a solicitor with a background in commercial litigation and has experience in chairing social security and child support tribunals. Her work now includes independent assessment for the Office for the Commissioner for Public Appointments, and she is a Trustee Director with Anchor Trust.

Sally Williams. Sally is an independent health policy adviser whose clients include NHS bodies, consumer groups, charities and think-tanks. Sally was previously a researcher and policy adviser for the Consumers' Association and Which?. Sally has a particular interest in the regulation, training and supervision of healthcare professionals, and represents the public interest on a range of bodies involved with professional standards. For example, as a lay visitor for the PMETB (Postgraduate Medical Education and Training Board), Sally inspects standards of medical training. She also provides advice when concerns are raised about an individual surgeon's clinical performance or the delivery of a surgical service, as a Lay Reviewer for the Royal College of Surgeons' Invited Review Mechanism. Sally is also a lay member of the Cosmetic Surgery Interspecialty Committee.

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Attendance

Attendance at Public Meetings between April 2005/March 2006 (in percentage terms)

Jonathan Asbridge	83
Norma Brook	67
Graeme Catto	100
Nigel Clarke	100
Michael Copland Griffiths	100
Frances Dow	100
Sheelagh Hillan*	33.3
Sue Leggate	83
Hew Mathewson	100
Jim McCusker	83
Kate McClelland**	100
Peter North	100
Hemant Patel***	100
Hugh Ross	67
David Smith	100
Rosie Varley	83
Kieran Walshe	67
Jane Wesson	100
Nicholas Wood****	66
Sally Williams	100
Lois Willis	100

* Between April and October 2005.
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David Smith	100
Rosie Varley	83
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Nicholas Wood****	66
Sally Williams	100
Lois Willis	100

* Between April and October 2005.
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Our details

Our staff

Michael Andrews	Fitness to Practise Manager
Francesca Compton	Office Manager/Executive Personal Assistant
Sandy Forrest	Director
Rosemary Macalister-Smith	Head of International Regulation
Rachael Martin	Fitness to Practise Assistant
Davina Mensah	Receptionist
Briony Mills	Fitness to Practise Officer
Peter Pinto de Sa	Secretary of the Council
Elisa Pruvost	Policy Manager
Voytek Rutkowski	Administrative Assistant
Kristin Smyth	Business Manager
Julie Stone	Deputy Director

Contact details

Contact us

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WC2N 5HR
Phone: 020 7389 8030
Fax: 020 7389 8040
E-mail: info@chre.org.uk
Website: www.chre.org.uk

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345211_HC1302_Text / Sig: 21 / Plate B

Regulators' contact details

General Chiropractic Council	44 Wicklow Street London WC1X 9HL	Phone: 020 7713 5155 Fax: 020 7713 5844 Website: www.gcc-uk.org
General Dental Council	37 Wimpole Street London W1G 8DQ	Phone: 020 7887 3800 Fax: 020 7224 3294 Website: www.gdc-uk.org
General Medical Council (London office)	Regent's Place 350 Euston Road London NW1 3JN	Phone: 0845 357 8001 Fax: Website: www.gmc-uk.org
General Optical Council	41 Harley Street London W1G 8DJ	Phone: 020 7580 3898 Fax: 020 7436 3525 Website: www.optical.org
General Osteopathic Council	176 Tower Bridge Road London SE1 3LU	Phone: 020 7357 6655 Fax: 020 7357 0011 Website: www.osteopathy.org.uk
Health Professions Council	Park House 184 Kennington Park Road London SE11 4BU	Phone: 020 7840 9806 Fax: 020 7840 9805 Website: www.hpc-uk.org
Nursing and Midwifery Council	23 Portland Place London W1B 1PZ	Phone: 020 7637 7181 Fax: 020 7436 2924 Website: www.nmc-uk.org
Pharmaceutical Society of Northern Ireland	73 University Street Belfast BT7 1HL	Phone: 028 9032 6927 Fax: 028 9043 9919 Website: www.psni.org.uk
Royal Pharmaceutical Society of Great Britain	1 Lambeth High Street London SE1 7JN	Phone: 020 7735 9141 Fax: 020 7735 7629 Website: www.rpsgb.org.uk

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General Osteopathic Council	176 Tower Bridge Road London SE1 3LU	Phone: 020 7357 6655 Fax: 020 7357 0011 Website: www.osteopathy.org.uk
Health Professions Council	Park House 184 Kennington Park Road London SE11 4BU	Phone: 020 7840 9806 Fax: 020 7840 9805 Website: www.hpc-uk.org
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9 Financial summary

9.1 Our financial performance during the year, and position as at 31 March 2006, is identified within the income and expenditure account and balance sheet respectively, which can be found in our full accounts. During the year we received £2,379,479 income through grant in aid. We also recovered legal costs of £237,177 associated with Section 29 cases taken to the High Court where we were successful in proceedings.

9.2 We incurred expenditure of £2,462,090, including £805,218 Section 29 non pay costs. After allowing for the write back of capital charges, we achieved a surplus of £56,469. Our full accounts were laid before Parliament in July 2006 and can be found at Annex C. The Comptroller and Auditor General qualified the Council's accounts and details of this can be found on pages 64-65 (Annex C).

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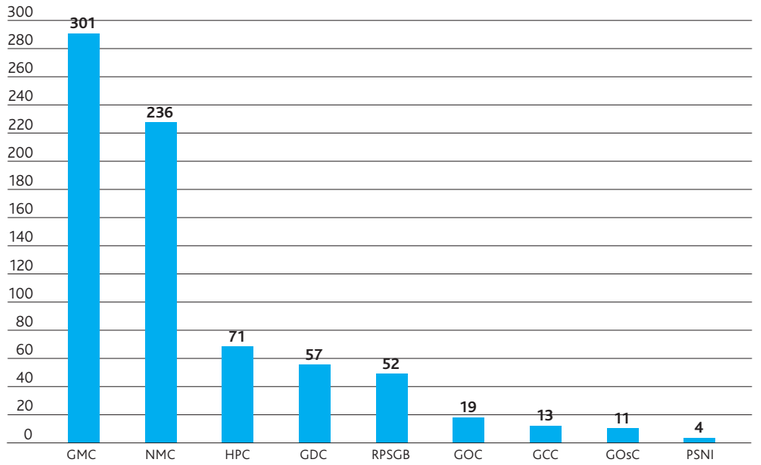
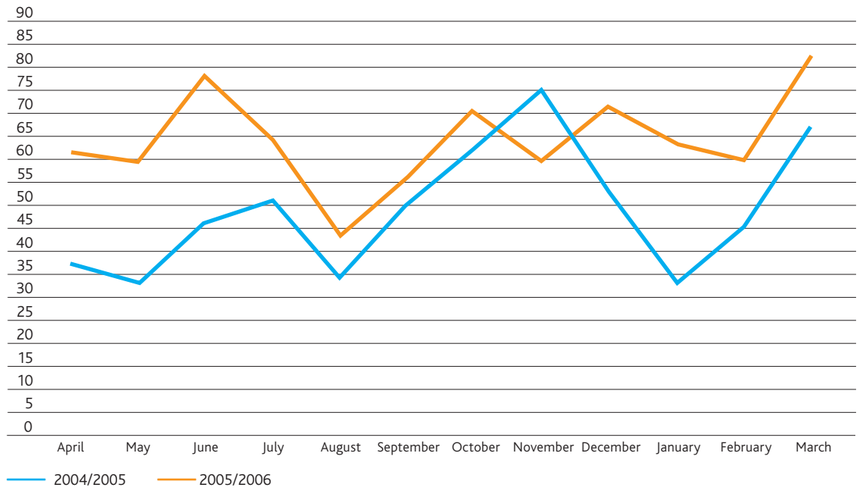
Annex A

*Section 29 statistics**

Number of cases notified to CHRE 1 April 2005 to 31 March 2006 per regulatory body



Number of cases received by month by year



* For more information on the section 29 process, please see paragraphs 5.15–5.16

345211_HC1302_Text / Sig: 23 / Plate A

Annex A

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Number of cases received by month by year

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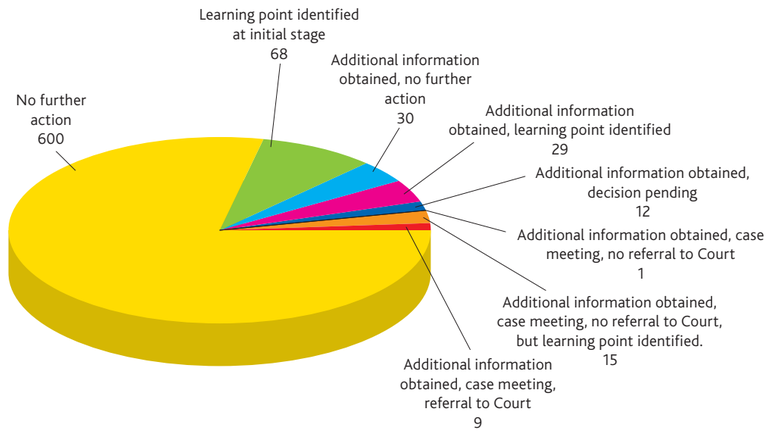
Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

45

Case outcomes 1 April 2005 to 31 March 2006 across all regulatory bodies (number of cases received)



Number of cases referred to Court by month per year

	2004/2005	2005/2006
April	0	1*
May	0	0
June	0	2
July	3	1
August	0	5
September	3	0
October	0	0
November	0	0
December	1	0
January	0	0
February	0	1
March	0	0
Total	7	10
% of cases referred out of all cases considered	1.2	1.4

* case received in previous financial year.

345211_HC1302_Text / Sig: 23 / Plate B

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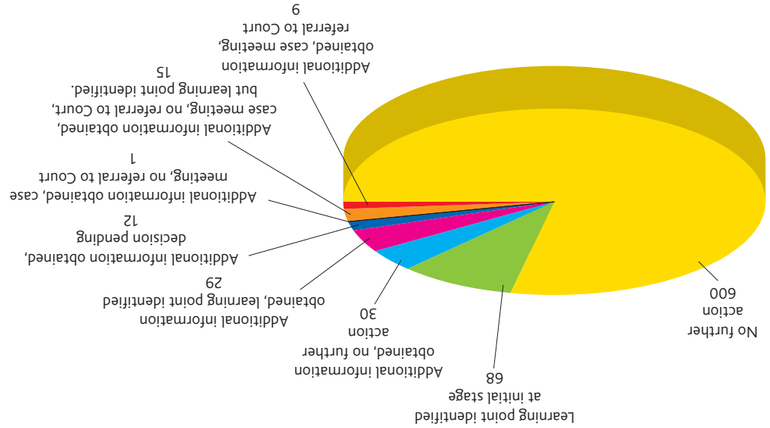
Case outcomes 1 April 2005 to 31 March 2006 across all regulatory bodies (number of cases received)



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February	0	1
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Total	7	10
% of cases referred out of all cases considered	1.2	1.4

* case received in previous financial year.

46

Annex B

Our committees

Audit Committee

Hugh Ross, Chair
David Smith
Sally Williams
Lois Willis

Finance Committee

Nigel Clarke, Chair
Hew Mathewson
Jane Wesson

Remuneration Committee

Jane Wesson, Chair
Nigel Clarke
Michael Copland Griffiths
Jim McCusker
Peter North
Hugh Ross (as Audit Chair)
Rosie Varley

Scrutiny Committee

Frances Dow, Chair
Frances Blunden (non-CHRE member)
Norma Brook
Graeme Catto
Sue Leggate
Hew Mathewson
Kieran Walshe

Annex B

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Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

47

345211_HC1302_Text / Sig: 24 / Plate A

Annex C

Annual Accounts

Contents

In September 2004 the organisation changed its name to the Council for Healthcare Regulatory Excellence (CHRE). The statutory name of the organisation remains the Council for the Regulation of Healthcare Professionals (CRHP) and cases referred to Court under Section 29 of the National Health Service Reform and Health Care Professions Act 2002 in 2005-06 were brought under this name.

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Contents

Annual Accounts

Annex C

345211_HC1302_Text / Sig: 24 / Plate B

Council Report

1 There were changes in Council membership[1] during the year as a result of some regulatory bodies appointing new Presidents. The Chair of the Council was appointed to the Council by the NHS Appointments Commission and elected as Chair by Council members. Jane Wesson's term of office as the elected Chair of the Council for Healthcare Regulatory Excellence (CHRE) commenced on 23 January 2006 and will continue until the end of her current period as a CHRE member (28 February 2007). Subject to her reappointment as a member at this time, Jane Wesson's term of office as Chair will continue until 22 January 2009.

2 Schedule 7 of the National Health Service Reform and Health Care Professions Act 2002 provides directions for the appointment of members to the Council.

3 The Chair is evaluated annually by the NHS Appointments Commission, and Council members are evaluated on an annual basis by the Chair. Training is provided for members participating in Section 29 Panel meetings and for any other matters deemed relevant and necessary by Council.

4 Each member's register of interests is available on the CHRE website at www.chre.org.uk.

5 A Finance Committee[2] was established and met for the first time in January 2006. Its remit includes: ensuring the Council is adequately resourced to achieve its aims; scrutinising the income, expenditure and budgets for the Council; monitoring CHRE's relationship with its principal funding bodies, the Department of Health (DH) and Arms Length Body Change Programme Team (ALB Team); scrutinising and advising on CHRE's business plan and its implementation; and supporting the Director in his role as Accounting Officer.

6 Post balance sheet events are provided in note 19 to the accounts.

7 Related party transactions are provided in note 17 to the accounts.

8 CHRE's 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.

2005-06	Number	£
Total invoices paid	859	1,879,252
Total invoices paid within target	850	1,863,678
Percentage of invoices paid within target	99%	99%

1 8 Our People

2 Annex B: Our Committees

Council Report

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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49

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

10 During the year there was a review of all existing employment policies. Some policies were amended to reflect changes in policy and/or guidance and additional policies were introduced to the organisation.

11 The external auditor for CHRE is the Comptroller and Auditor General and South Coast Audit provides the internal audit function.

12 As far as the Accounting Officer (AO) is aware, there is no relevant audit information of which CHRE's auditors are unaware, and the AO has taken all steps he ought to have taken to make himself aware of any relevant audit information and to establish that CHRE's auditors are aware of that information.

13 The office team continues to make significant progress and the Council is grateful for their efforts.

14 CHRE's accounts have been prepared in accordance with the Accounts Direction given by the Secretary of State pursuant to Paragraph 15 of Schedule 7 of the National Health Service Reform and Health Care Professions Act 2002.

15 Council members are aware that the qualification of CHRE's Accounts by the Comptroller and Auditor General[3] this year results from a genuine error on the part of the executive, and that management integrity has not been compromised.

3 Certificate and Report of the Comptroller and Auditor General

345211_HC1302_Text / Sig: 25 / Plate B

Annex C

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3 Certificate and Report of the Comptroller and Auditor General

50

Management Commentary

16 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 (the Act). It is funded through the Department of Health (DH) and answerable to the UK Parliament.

17 Our mission is to protect the public interest, promote best practice and achieve excellence in the regulation of healthcare professionals.[4]

18 In 2005-06 CHRE continued successfully to develop its business both internally, through further establishment of appropriate guidelines and procedures, and externally, through various aspects of its work including the dissemination of best practice learning points, the consolidation of the performance review process and participation in two major reviews of healthcare regulation.[5]

19 Funding of £2.4 million was provided as Grant-in-Aid through the Department of Health in 2005-06. Funding of £2 million for 2006/07 has been confirmed by the DH Arm's Length Bodies Business Support Unit, which has taken over responsibility for this function for 2006-07 onwards. Indicative budgets have also been set for 2007/08 and 2008/09.

20 CHRE is waiting on the outcomes of the two healthcare regulation reviews which are expected to include information about their likely impact on the organisation. The budget notification for 2006/07 – 2008/09 acknowledges this by stating that there is 'the strong possibility of CHRE's current remit expanding as a result of the Non-Medical Professional Regulation and CMO reviews' and that 'we will discuss the position when the outcomes and recommendations of the reviews are known, alongside the potential impact on the budgetary and headcount positions.' Budgets for 2006/07 – 2008-09 may also be subject to change in light of the demands of the ALB Change programme.

21 A significant area of concern to Council has been, and continues to be, the lack of clarity around funding for CHRE with particular reference to the activities associated with Section 29 (S29) of the Act[6]. The nature of S29 is such that it is not possible to predict precisely the scale of work that the organisation may be required to undertake each year, or the outcome of cases taken to the High Court. Any individual case has the potential for significant financial exposure if the appeal is unsuccessful.

22 CHRE maintains stringent controls around S29 work which is overseen by Council, the Scrutiny Committee and the Fitness to Practise team. In 2005-06 this work was subject to a detailed audit by the National Audit Office which concluded that 'It is clear that the Council have performed a great deal of work not just in the selection of legal firms, but in the entire way that the S29 process, has been, and continues to be managed and monitored.' and 'We have been impressed by the measures taken by the Council in introducing robust controls to help in the monitoring of S29 legal costs.'

4 4 About Us/5 Our Achievements

5 2 Director's Report/Paragraph 5.10 Progressing Regulatory Excellence/7 Challenges Ahead

6 Protecting the Public: Paragraph 5.14

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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51

345211_HC1302_Text / Sig: 26 / Plate A

23 The financial cost of S29 work to the organisation each year is not known in advance and while the DH has provided additional funding to support this work in 2004-05 and 2005-06, this has to date been the result of separate negotiations each year rather than a formal acknowledgement of the possible requirement for additional funding for S29 each year.

24 For 2006-07 onwards however there has been formal written advice provided from the DH to CHRE stating that the DH is committed to underwriting any overspend caused by S29 exigencies and that CHRE will be expected to maintain its stringent internal controls around the costs of the S29 process.

25 CHRE's funding and remit has been discussed with the DH and ALB Team over a period of several months. This has included the potential for support from the Scottish Parliament, Welsh Assembly and Northern Ireland Assembly under the Barnett Formula. Initial approaches have commenced from the DH and it is understood these will be taken forward by the ALB Team in 2006-07.

26 Funding arrangements for CHRE, for its current work and potentially expanded role in future, remain a high priority in all discussions and negotiations with the DH and ALB Team.

27 CHRE is in a strong financial position at year end as shown on the Balance Sheet (page 68) and the objective is to maintain this position with positive cash balances at all times together with positive net working capital. The financial performance and cash flow of CHRE for the year ended 31 March 2006 is shown on the Income and Expenditure Account (page 66) and Cash Flow Statement (page 69) respectively and supporting notes.

28 An analysis of accounting policies is shown in note 1 to the accounts; there have been no changes to these in the year.

29 Since its establishment in April 2003, and consistent with the ALB Review framework, CHRE's back-office functions have been outsourced to a range of organisations. The functions supported in this way include: financial services; payroll; human resources; information technology support and maintenance; website support and maintenance; and, building and office services.

30 In 2005-06 the lease for CHRE's premises was assigned by the DH to CHRE. This represents an on-going financial commitment until December 2010.

31 A new member of the senior management team was appointed on a fixed-term basis from December for one year bringing the number of employees to 12 with the possibility that this may increase following the outcome of the two reviews referred to above in paragraph 20.

32 CHRE's 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

345211_HC1302_Text / Sig: 26 / Plate B

Annex C

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objectives and regular reports from internal and external auditors. In addition formal quarterly reviews are held between CHRE executive, the DH and ALB Team, and an annual formal review is held between the Chair, Director and DH.

33 This report has been prepared in accordance with Reporting Statement: Operating and Financial Review.

Alexander Forrest
Accounting Officer
14 July 2006

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Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

345211_HC1302_Text / Sig: 27 / Plate A

Remuneration Report

34 The Remuneration Committee ensures that CHRE has remuneration policies that are fit for purpose and applied consistently. The policy on remuneration for senior managers,[7] commissioned by the Remuneration Committee[8] in June 2004, states that they should be based on a spot rate pay value dependent on market value. A review of the grade takes place each year to ensure the pay level remains competitive for retention purposes. In addition to the review the salary levels are uplifted to incorporate a cost of living increase each October. Full consideration is given to the average earnings index, retail prices index, the level of increase for other regulatory bodies and the organisations within the same geographical area, and data from the Government's Office of Manpower Economics report.

35 Assessment of whether or not performance conditions were met is undertaken according to the CHRE Performance Appraisal Policy and Procedure. Remuneration is not subject to performance conditions although progression on the payband (which applies to staff on Levels 1 through to 5) is subject to satisfactory appraisal.

36 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 4 there is a one-month notice period. For level 5 staff, the Deputy Director and Head of International Regulation there is a three-month notice period and for the Director 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. CHRE treats termination payments on a case-by-case basis in consultation with our legal advisors.

37 Senior Managers' contracts

Name	Title	Date of contract	Unexpired term	Notice period
Alexander Forrest	Director	17/11/2003	Permanent contract	6 months

CHRE treats provisions for compensation for termination on a case-by-case basis in consultation with our legal advisors.

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

7 Council for the Regulation of Healthcare Professionals Job Evaluation Exercise, Liberata UK Ltd.

8 Annex B: Our Committees

Annex C

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54

345211_HC1302_Text / Sig: 27 / Plate B

39 Senior Managers' salaries

Name	Salary (£)	Real increase in pension at age 60 (£'000)	Total accrued pension at 31 March 2006 (£'000)
Alexander Forrest (*)	125,454	0-2.5	2.5-5
	(2004/05: 121,800)		

(*) The Director is a member of the NHS Pension Scheme.

Note: the following were not provided: allowances; bonuses; expenses allowance; compensation for loss of office or termination of service (2004/2005: £Nil).

40 Pensions

Name	Title	Value of accrued pension (£'000)	Related lump sum (£'000)	Real increase in related lump sum (£'000)	Cash Equivalent Transfer Value as at 1 April 2005 (£'000)	Cash Equivalent Transfer as at 31 March 2006 (£'000)	Real increase in the cash equivalent transfer value during the reporting year (£'000)
Alexander Forrest	Director	2.5-5	5-10	2.5-5	26	48	22

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

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

Note: Julie Stone is not included in the Remuneration Report for 2005-06 as her position within CHRE does not meet the criteria outlined in the Financial Reporting Manual 7.2.23: 'This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or sections within the entity'.

345211_HC1302_Text / Sig: 28 / Plate A

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55

345211_HC1302_Text / Sig: 28 / Plate A

42 Members' Remuneration

The Chair, Jane Wesson, received total remuneration of £52,607 (2004-05: £49,078) which comprised gross salary of £31,365, a second home allowance of £20,417 (£12,000 net) and Section 29 panel meeting attendance fees of £825. Council members' remuneration and the Chair's salary are not subject to superannuation. Members receive an annual remuneration of £5,673 (2004-05: £5,673).

Members' remuneration during the year amounted to £165,291 (2004-05: £160,079) including social security costs and Section 29 panel attendance fees of £3,850. Payments to individual members are disclosed in the following ranges:

	Year ended 31 March 2006 £'000	Year ended 31 March 2005 £'000
Mr Jonathan Asbridge	5-10	5-10
Professor Norma Brook	5-10	5-10
Sir Graeme Catto	5-10	5-10
Mr Nigel Clarke	5-10	5-10
Dr Michael Copland-Griffiths	5-10	5-10
Mr Marshall Davies (until 31 August 2004)	–	0-5
Dr Frances Dow	5-10	5-10
Mrs Sheelagh Hillan (until 31 October 2005)	0-5	5-10
Mrs Sue Leggate	5-10	5-10
Dr Hew Mathewson	5-10	5-10
Mr James McCusker	5-10	5-10
Mr Peter North	5-10	5-10
Mr Hugh Ross	5-10	5-10
Mr David Smith	5-10	5-10
Mrs Rosemary Varley	5-10	5-10
Dr Kieran Walshe	5-10	5-10
Ms Sally Williams	5-10	5-10
Ms Lois Willis	5-10	5-10
Mr Nicholas Wood (until 3 August 2005)	0-5	0-5
Dr K McClelland (from 2 November 2005)	0-5	–
Mr HR Patel (from 1 October 2005)	0-5	–

In addition, expenses amounting to £54,642 (2004-05: £54,132) were reimbursed to the members.

56

Annex C

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345211_HC1302_Text / Sig: 28 / Plate B

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

The Council's Responsibilities

43 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 17 paragraph 15 of the National Health Service Reform and Health Care Professions Act 2002, 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.

44 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; and
- 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

45 The Accounting Officer for the Department of Health has appointed the Director 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 Government Accounting.

345211_HC1302_Text / Sig: 29 / Plate A

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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

The Council's Responsibilities

43 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 17 paragraph 15 of the National Health Service Reform and Health Care Professions Act 2002, 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.

44 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;
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Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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57

345211_HC1302_Text / Sig: 29 / Plate A

Statement on Internal Control

Scope of responsibility

46 As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Council for Healthcare Regulatory Excellence (CHRE) 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 Government Accounting.

47 CHRE reports directly to the UK Parliament and works closely with the Department of Health and the ALB Team in delivering its statutory obligations as well as the key objectives of the business plan. This includes identifying and responding appropriately to both internal and external risks.

The purpose of the system of internal control

48 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. The system of internal control has been in place in CHRE for the year ended March 2006 and up to the date of approval of the annual report and accounts, and accords with Treasury guidance.

Capacity to handle risk

49 The risk register structure continues to reflect the strategic priorities and operational functions of the organisation. The strategic priorities of CHRE are outlined in the business plan.

50 Each strand of the business plan links to the relevant strand of the risk register and the senior manager responsible for delivering a strand of the business plan identifies and responds to the risks associated with that particular area of work. This is an ongoing process which is reviewed regularly by all senior managers and the Audit Committee, and is supported by relevant guidance.[9]

9 HM Treasury 'Orange Book' and the Australian/New Zealand Standard for Risk Management 4360:2004

345211_HC1302_Text / Sig: 29 / Plate B

Annex C

Statement on Internal Control

Scope of responsibility

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58

51 CHRE continues to participate in the Risk Management Forum which comprises representatives from the nine regulatory bodies. This forum provides the opportunity to discuss risk issues in the healthcare regulatory field as well as the process for managing risk. In 2005-06 the Forum decided that rather than CHRE produce a risk management seminar, as it had done in 2004, it would be preferable to invite speakers to address the group on specific subjects of interest. This program has been deferred to 2006-07 due to scheduling issues with some members.

52 Staff training in managing risk focussed on health and safety-related matters. A programme of fraud risk management training was commenced and is on-going.

The risk and control framework

53 CHRE's risk management policy seeks to identify the risks facing the organisation and treat them according to established guidelines. The risk appetite is low and managers make sound decisions on the risks the organisation retains, those it reduces through strategic or operational change, and those it transfers.

54 The risk register clearly defines the risks associated with each of the strategic business plan priorities as well as the operational risks in day-to-day running of the organisation. These are identified through consultation with Council, key staff members and other parties such as the external auditors. Evaluation and control of risks is undertaken by defining the risk event and consequences, and then assessing the controls.

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

56 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.

57 The Head of Internal Audit Opinion has provided full assurance on the effectiveness of the system of internal control for 2005-06, on the basis of the work they had undertaken.

58 CHRE obtains assurance from Liberata UK regarding their provision of outsourced financial services through evidence of risk control systems, disaster recovery plans and its accreditation with the British Standards Institute.

59 CHRE has re-examined its systems of internal control following the qualification by the Comptroller and Auditor General with regard to advance payment of £55,000 made to a firm of solicitors involved in ongoing Section 29 case work. Given the exceptional nature of this payment, amendment to the existing controls is not considered necessary.

345211_HC1302_Text / Sig: 30 / Plate A

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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59

345211_HC1302_Text / Sig: 30 / Plate A

Review of effectiveness

60 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.

Alexander Forrest
Accounting Officer
14 July 2006

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Accounting Officer
14 July 2006

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The Certificate of the Comptroller and Auditor General to the Houses of Parliament

I certify that I have audited the financial statements of Council for the Regulation of Healthcare Professionals for the year ended 31st March 2006 under the National Health Service Reform and Healthcare Professions Act 2002. These comprise the Income and Expenditure Account, the Balance Sheet, the Cashflow Statement and Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them.

Respective responsibilities of the Council, Accounting Officer and Auditor

The Council and 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 Healthcare Professions Act 2002 and directions made thereunder by the Secretary of State with the approval of the Treasury and for ensuring the regularity of financial transactions. These responsibilities are set out in the Statement of Council's and Accounting Officer's Responsibilities.

My responsibility is to audit the financial statements 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 has been properly prepared in accordance with the National Health Service Reform and Healthcare Professions Act 2002 and directions made thereunder by the Secretary of State with the approval of the Treasury. 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. I also report to you if, in my opinion, the Foreword is not consistent with the financial statements, if the Authority 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 relevant authorities regarding remuneration and other transactions is not disclosed.

I review whether the statement on pages 58-60 reflects the Council's compliance with HM Treasury's guidance on the Statement on Internal Control, and I report if it does not. I am not required to consider whether the Accounting Officer's statements on internal control cover all risks and controls, or form an opinion on the effectiveness of the Council's corporate governance procedures or its risk and control procedures.

The Certificate of the Comptroller and Auditor General to the Houses of Parliament

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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 only the Council Report, the unaudited part of the Remuneration Report and the Management Commentary. 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 opinion

I conducted my audit in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. An 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 judgements made by the Council and Accounting Officer in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Council'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.

Qualified opinion in respect of payment in advance of need

HM Treasury's Government Accounting sets out the financial framework within which central government sector entities are required to operate. Government Accounting states that, as a general rule, entities should only make payments in arrears, that is, after the specified goods or services have been satisfactorily provided. In principle, therefore, entities should make advance payments only on an exceptional basis, and even then, only where they are able to demonstrate an appropriate value for money case for doing so.

The Council's balance sheet includes a prepayment of £55,000 that, under Government Accounting, was not properly due in 2005-2006 and did not meet Government Accounting's requirements for making advance payments. Accordingly, I have concluded that the payment did not conform with the authorities which govern them.

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 only the Council Report, the unaudited part of the Remuneration Report and the Management Commentary. 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.

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In my opinion:

- the financial statements give a true and fair view, in accordance with the National Health Service Reform and Healthcare Professions Act 2002 and directions made thereunder by the Secretary of State with the approval of the Treasury, of the state of the Council's affairs as at 31 March 2006, and of its surplus, total recognised gains and losses and cashflows 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 Healthcare Professions Act 2002 and directions made thereunder by the Secretary of State with the approval of the Treasury; and
- except for the advance payment referred to above, 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.

My report setting out the reasons for my qualification is at pages 64 to 65.

John Bourn
Comptroller and Auditor General
21 July 2006

National Audit Office
157-197 Buckingham Palace Road
Victoria
LONDON SW1W 9SP

63

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Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

345211_HC1302_Text / Sig: 32 / Plate A

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

Introduction

1. The Council for the Regulation of Healthcare Professionals was established on 1 April 2003 by the National Health Service Reform and Health Care Professions Act 2002. The Council's objectives are to protect the public interest, promote best practice and achieve excellence in the regulation of healthcare professionals.

2. This report explains the circumstances surrounding qualification of my audit opinion on the Council financial statements for 2005-2006.

Basis for the qualified audit certificate

3. I am required, under Auditing Standards, to satisfy myself that in all material respects the expenditure and income shown in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. In determining whether expenditure and income conform to the authorities which govern them, I have regard to:

- the legislation authorising each financial transaction;
- relevant regulations issued under the governing legislation;
- Parliamentary authorities;
- appropriate Treasury authorities; and
- HM Treasury's Government Accounting, which sets out the financial framework within which government entities are required to operate.

Advance payment to a supplier

4. On 30 March 2006, the Council made an advance payment of £55,000 to one of its solicitors in respect of future services for ongoing section 29 case work. The Council received 2006-07 project funding from the Department of Health of £97,000 on 29 March 2006 and made the decision to make the advance payment to comply with Department of Health guidance to minimise cash balances. Government Accounting, however, states that advance payments should be the exception and that, where such payments may be desirable, the value for money case should be established. Additionally, Government Accounting normally requires entities making advance payments to seek Treasury approval, as appropriate. I found no evidence that the Council had achieved value for money by making such a payment, neither had they sought or obtained Treasury approval.

64

Annex C

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

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345211_HC1302_Text / Sig: 32 / Plate B

5. I have therefore concluded that the payment does not conform to the authorities which govern them and I have qualified my opinion on the Council's financial statements for 2005-06 in this respect.

John Bourn
Comptroller and Auditor General
21 July 2006

National Audit Office
157-197 Buckingham Palace Road
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John Bourn
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21 July 2006

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Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

345211_HC1302_Text / Sig: 33 / Plate A

Income and Expenditure Account

For the year ended 31 March 2006

	Note	Year ended 31 March 2006 £	£	£	Year ended 31 March 2005 £	£	£
Income:							
Grant in Aid	2		2,232,330			2,519,472	
Transfer from Deferred Government Grant Reserve	3		36,003			31,792	
S29 Cost Recoveries			237,177			239,003	
Other Operating Income			6,190			–	
				2,511,700			2,790,267
Expenditure:							
Staff Costs	4		651,112			568,854	
Members' Remuneration[10]			161,441			160,079	
Other operating costs:							
S29 Costs		805,218		1,225,907			
Other Operating Costs		781,307		732,637			
Total Other Operating Costs	6		1,586,525			1,958,544	
Depreciation	8		56,153			26,458	
Notional cost of capital	7		6,859			2,992	
			2,462,090			2,716,927	
Operating surplus			49,610			73,340	
Notional cost of capital reversal	7		6,859			2,992	
Retained surplus for the year	13		56,469			76,332	

All operations are continuing. There were no material acquisitions or disposals in the year.

The notes on pages 70 to 80 form part of these accounts.

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			2,462,090			2,716,927	
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Retained surplus for the year	13		56,469			76,332	

Income and Expenditure Account

For the year ended 31 March 2006

Statement of Total Recognised Gains and Losses

For the year ended 31 March 2006

	Year ended 31 March 2006 £	Year ended 31 March 2005 £
Retained surplus for the year	56,469	76,332
Net unrealised gain on revaluation of fixed assets	744	4,697
Total recognised gains for the year	57,213	81,029

The notes on pages 70 to 80 form part of these accounts.

67

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

Statement of Total Recognised Gains and Losses

For the year ended 31 March 2006

	Year ended 31 March 2006 £	Year ended 31 March 2005 £
Retained surplus for the year	56,469	76,332
Net unrealised gain on revaluation of fixed assets	744	4,697
Total recognised gains for the year	57,213	81,029

The notes on pages 70 to 80 form part of these accounts.

Annex C

Balance Sheet

as at 31 March 2006

	Note	£	2006 £	£	2005 £
Fixed assets					
Tangible fixed assets	8		232,098		121,669
Current Assets					
Debtors	9	342,154		249,848	
Cash at bank and in hand	10	20,419		43,294	
		362,573		293,142	
Creditors: amounts falling due within one year	11	(173,770)		(153,529)	
Net current assets			188,803		139,613
Provisions for liabilities and charges	12		(157,500)		(69,240)
Net Assets			263,401		192,042
Reserves					
Income and Expenditure Account	13		126,842		70,373
Government Grant Reserve	13		136,559		121,669
			263,401		192,042

The notes on pages 70 to 80 form part of these accounts

Signed on behalf of the Council for Healthcare Regulatory Excellence

Alexander Forrest
Accounting Officer
14 July 2006

Signed on behalf of the Council for Healthcare Regulatory Excellence

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The notes on pages 70 to 80 form part of these accounts

	Note	£	2006 £	£	2005 £
Fixed assets					
Tangible fixed assets	8		232,098		121,669
Current Assets					
Debtors	9	342,154		249,848	
Cash at bank and in hand	10	20,419		43,294	
		362,573		293,142	
Creditors: amounts falling due within one year	11	(173,770)		(153,529)	
Net current assets			188,803		139,613
Provisions for liabilities and charges	12		(157,500)		(69,240)
Net Assets			263,401		192,042
Reserves					
Income and Expenditure Account	13		126,842		70,373
Government Grant Reserve	13		136,559		121,669
			263,401		192,042

Annex C

Balance Sheet

as at 31 March 2006

Cash Flow Statement

For the year ended 31 March 2006

	Note	Year ended 31 March 2006 £	Year ended 31 March 2005 £
Net cash (outflow)/inflow from operating activities	14	(12,651)	11,686
Capital expenditure			
Payments to acquire tangible fixed assets	8, 11	(60,373)	(89,130)
Net cash outflow before financing		(73,024)	(77,444)
Financing			
Grant in aid for capital expenditure		50,149	99,951
(Decrease)/Increase in cash	10	(22,875)	22,507

The notes on pages 70 to 80 form part of these accounts

69

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

345211_HC1302_Text / Sig: 35 / Plate A

Cash Flow Statement

For the year ended 31 March 2006

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Net cash (outflow)/inflow from operating activities	14	(12,651)	11,686
Capital expenditure			
Payments to acquire tangible fixed assets	8, 11	(60,373)	(89,130)
Net cash outflow before financing		(73,024)	(77,444)
Financing			
Grant in aid for capital expenditure		50,149	99,951
(Decrease)/Increase in cash	10	(22,875)	22,507

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 HM Treasury's guidance *Financial Reporting Manual*. 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.

Grant in aid applied to revenue is accounted for on a cash receivable basis. A proportion of the grant in aid received, equal to expenditure on fixed asset acquisitions in the year, is taken to the government grant reserve at the end of the financial year. Each year, an amount equal to the depreciation charge on the fixed assets acquired through grant in aid is released from the government grant reserve to the income and expenditure account.

d Tangible fixed assets

Fixed assets are valued in the balance sheet at their modified historic cost less depreciation. Assets are revalued at current replacement cost by using price index numbers for current cost accounting published by the Office of National Statistics.

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.

Annex C

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345211_HC1302_Text / Sig: 35 / Plate B

Any surplus on revaluation is credited to the government grant reserve. A deficit on revaluation is debited to the income and expenditure account, unless the downward revaluation is solely due to fluctuations in market value in which case the amount is debited to the government grant 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 income and expenditure account on an accruals basis.

As a result of judgments 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 judgment in the Council's favour. 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 judgment 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 (see note 15).

345211_HC1302_Text / Sig: 36 / Plate A

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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g Notional charges

In accordance with the *Financial Reporting Manual* published by HM Treasury, a notional charge for the cost of capital employed during the year is included in the income and expenditure account along with an equivalent notional income to finance the charge. The cost of capital charge is calculated at 3.5 per cent (2004/05: 3.5%), 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 income and expenditure account and included under the heading relevant to the type of expenditure.

i Pension costs

The Council participates in the NHS Pension Scheme which is an unfunded multi-employer defined benefit scheme, and the Council is unable to identify its share of the underlying assets and liabilities. A full actuarial valuation of the NHS Pension Scheme was carried out at 31 March 2003. Details of this valuation and the benefits provided by the scheme is provided in the scheme's account which is available on the NHS Pensions Agency website www.nhspa.gov.uk.

This is a statutory defined benefit scheme, the provisions of which are contained in the NHS Pension Scheme Regulation (SI 1995 No. 300). Under these regulations the Council is required to pay an employer's contribution, currently 14% of pensionable pay, as specified by the Secretary of State. For 2005/2006, employer's contributions of £65,278 (2004/2005: £47,762) were payable to the NHS Pension Scheme. These contributions are charged to the income and expenditure account as and when they become due. The Government Actuary reviews the employer contributions every four years following a full scheme valuation and sets contributions rates to reflect past experience and benefits when they are accrued, not when costs are actually incurred.

Employees pay 6% of pensionable pay. Employer and employee contributions are used to defray the cost of providing the scheme benefits. These are guaranteed by the Exchequer, with the liability falling to the Secretary of State, not to the Council. Index linking costs under the Pensions (Increase) Act 1971 are met directly by the Exchequer.

The scheme is notionally funded. Scheme accounts are prepared annually by the Department of Health and are examined by the Comptroller and Auditor General.

72

Annex C

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345211_HC1302_Text / Sig: 36 / Plate B

j Operating leases

Rentals payable under operating leases are charged to the income and expenditure account on an accruals basis.

An operating lease for Kierran Cross, 11 Strand, London, WC2N 5HR is in force until 24 December 2010.

The Council has agreed with the Department of Health to remain at the above address until the date referred to above.

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% in real terms.

73

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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345211_HC1302_Text / Sig: 37 / Plate A

2 Income

	Note	Year ended 31 March 2006 £	Year ended 31 March 2005 £
Grant in Aid received from the Department of Health		2,281,882	2,619,423
Transfer to government grant reserve in respect of fixed asset additions	13	(49,552)	(99,951)
		2,232,330	2,519,472

3 Government Grant Reserve

	Note	Year ended 31 March 2006 £	Year ended 31 March 2005 £
Transfer from Government grant reserve in respect of the annual depreciation charge	13	34,789	26,458
Transfer from Government grant reserve in respect of fixed asset impairment	13	1,214	5,334
		36,003	31,792

4 Staff Costs

	Year ended 31 March 2006 £	Year ended 31 March 2005 £
Salaries	520,663	409,059
Seconded staff costs	–	25,543
Social security costs	52,528	41,038
Superannuation costs	65,278	47,762
Agency/Temporary costs	12,643	45,452
	651,112	568,854

The increase in staff costs in 2005-06 includes: an annual cost of living rise to salaries of 3% from October 2005, agreed by the Remuneration Committee; the fixed-term employment of an additional senior member of staff for part of the year; and the re-grading of one position from Level 1 to Level 2 on the payband.

Annex C

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Annex C

345211_HC1302_Text / Sig: 37 / Plate B

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 2006 WTE	Year ended 31 March 2005 WTE
Management and Administrative	*11.6	9.5
	11.6	9.5

*Include 0.60 temporary staff members

6 Other Operating Costs

Other operating costs include:

	Note Below	Year ended 31 March 2006 £	Year ended 31 March 2005 £
Professional fees	a	760,638	1,162,536
Consultancy fees		9,724	8,473
Rent and office accommodation	b	309,729	207,206
Accountancy & HR services	c	72,355	27,208
Training and recruitment		46,370	49,403
Computer consumables and web site development costs	d	58,620	106,321
Impairment of fixed assets		1,214	5,334
Printing and stationery		17,101	13,051
Council members' expenses		54,642	54,132
External audit fee (*)		18,990	17,500
Repairs and maintenance	e	90,999	56,985
PR and communications	f	68,965	133,183
Other costs	g	77,178	117,212
Total other operating costs		1,586,525	1,958,544

a. Costs associated with undertaking the Section 29 process.

b. In 2005-06 CHRE increased its level of occupancy at 1st Floor, Kierran Cross, 11 Strand, London from 64% to 90.65%. Rent, rates and service charges increased accordingly (see note g).

c. Accountancy costs include payments to Parfitt & Co Chartered Accountants. This service was provided to CHRE by salaried employees in 2004/05. Liberata outsourced accounting service costs also increased in 2005/06. Also included is £8,559 in respect of outsourced HR provision received from NHS Counter Fraud and Security Management Service.

d. Costs in 2004-05 were mostly for set-up of a new online data management system. Cost efficiencies have been achieved in 2005-06 in the management of outsourced web and IT contracts.

e. In June 2005, the Department of Health assigned to CHRE the lease for its office space at 1st Floor, Kierran Cross, 11 Strand, London and provision has been made for dilapidation obligations of CHRE under the assigned lease (see note b).

f. The restructure of an outsourced PR contract and separate press cutting service achieved savings in 2005/06.

g. Holding Council meetings in CHRE's offices achieved significant savings in 2005/06 (see note c).

345211_HC1302_Text / Sig: 38 / Plate A

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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75

7 Notional Cost of Capital

In accordance with the *Financial Reporting Manual* published by HM Treasury, a notional charge for the cost of capital employed during the year is included in the income and expenditure account 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 2006 £	Year ended 31 March 2005 £
Capital employed as at beginning of period	148,848	22,119
Capital employed as at 31 March	243,082	148,848
Mean capital employed	195,965	85,484
Notional charge	6,859	2,992

8 Tangible Fixed Assets

	Furniture, Fixtures & Fittings – conversion costs £	Decommissioning Costs £	IT Equipment £	Total £
Valuation				
At 1 April 2005	114,575	–	49,943	164,518
Additions	30,460	117,500	19,092	167,052
Revaluations	941	–	–	941
Impairments	–	–	(1,949)	(1,949)
At 31 March 2006	145,976	117,500	67,086	330,562
Depreciation				
At 1 April 2005	23,962	–	18,887	42,849
Charge for year	17,639	21,364	17,150	56,153
Revaluations	197	–	(735)	(538)
At 31 March 2006	41,798	21,364	35,302	98,464
Net Book Value				
At 31 March 2006	104,178	96,136	31,784	232,098
At 31 March 2005	90,613	–	31,056	121,669

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Valuation				
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9 Debtors

	31 March 2006 £	31 March 2005 £
Debtors	131,328	166,321
Prepayments	210,826	83,527
	342,154	249,848

10 Cash at Bank and in Hand

	31 March 2006 £	31 March 2005 £
At 1 April	43,294	20,787
(Decrease)/Increase in cash in year	(22,875)	22,507
At 31 March	20,419	43,294
Bank account at Office of Paymaster General	20,319	43,194
Cash in hand	100	100
	20,419	43,294

11 Creditors: Amounts falling due within one year

	31 March 2006 £	31 March 2005 £
Trade Creditors	20,829	17,900
Capital Creditors	–	10,821
Other Creditors	8,552	28,610
Deferred income	88,070	–
Accruals	56,319	96,198
	173,770	153,529

Other creditors include an intra government balance of £8,552 due to NHS Pensions Agency

12 Provisions for Liabilities and Charges

	£
Balance at 1 April 2005	69,240
Arising during the year	157,500
Utilised during the year	(59,061)
Reversed unused in the year	(10,179)
Balance at 31 March 2006	157,500

The provisions arising during the year relate to obligations under the lease for office accommodation at Kierran Cross, 11 Strand, London, WC2N 5HR which was assigned to CHRE, from the Department of Health, with effect from 22 June 2005. £117,500 relates to estimated decommissioning costs which will fall due at the end of the lease term in 2010 and £40,000 for accommodation repairs estimated to have fallen due at the balance sheet date.

345211_HC1302_Text / Sig: 39 / Plate A

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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	31 March 2006 £	31 March 2005 £
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13 Reserves

	Government Grant Reserve	Income and expenditure account	Total
	£	£	£
At 1 April 2005	121,669	70,373	192,042
Surplus for the year	–	56,469	56,469
Grant for Fixed Asset Additions (note 2)	49,552	–	49,552
Grant for Fixed Asset Additions carried forward	597	–	597
Depreciation transferred to income and expenditure account	(34,789)	–	(34,789)
Release to income and expenditure account for impairment	(1,214)	–	(1,214)
Surplus on revaluation of fixed assets	744	–	744
Balance as at 31 March 2006	136,559	126,842	263,401

14 Reconciliation of Operating Surplus to Net Cash Inflow from Operating Activities

	Year ended 31 March 2006	Year ended 31 March 2005
	£	£
Operating surplus	49,610	73,340
Adjustment for non-cash transactions:		
Depreciation	56,153	26,458
Cost of capital	6,859	2,992
Deficit on revaluation of fixed assets	1,214	5,334
Release from government grant reserve	(36,003)	(31,792)
Adjustment for movements in working capital other than cash:		
(Decrease)/increase in creditors	31,062	(78,907)
Decrease/(increase) in debtors	(92,306)	(54,979)
(Decrease)/increase in provisions	(29,240)	69,240
Net cash (outflow)/inflow from operating activities	(12,651)	11,686

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	£	£
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(Decrease)/increase in provisions	(29,240)	69,240
Net cash (outflow)/inflow from operating activities	(12,651)	11,686

13 Reserves

	Government Grant Reserve	Income and expenditure account	Total
	£	£	£
At 1 April 2005	121,669	70,373	192,042
Surplus for the year	–	56,469	56,469
Grant for Fixed Asset Additions (note 2)	49,552	–	49,552
Grant for Fixed Asset Additions carried forward	597	–	597
Depreciation transferred to income and expenditure account	(34,789)	–	(34,789)
Release to income and expenditure account for impairment	(1,214)	–	(1,214)
Surplus on revaluation of fixed assets	744	–	744
Balance as at 31 March 2006	136,559	126,842	263,401

15 Contingent Liabilities

Three High Court cases, under CHRE S29 powers, were undecided as at the year end. There is thus uncertainty on the financial consequences until a final judgment is made.

Judgment by the High Court may permit recovery of these Council costs or alternatively a charge to the Council of the costs of the regulatory body and its registrant. At the balance sheet date, it is not possible to forecast the level of probability of any potential liability.

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 2006 the Department of Health provided total grant in aid of £2,379,479 (2004-05: £2,619,423).

Apart from this there were no related party transactions entered into.

The Council maintains a register of interest for the Chairman and Council members. On a periodic basis the register is updated by the Council Secretary to reflect any change in Council members' interests. During the period ending 31 March 2006 no Council member undertook any transactions with the Council.

18 Losses and special payments

There were no material losses or special payments made during the financial year.

19 Post Balance Sheet Events

As referred to in the CHRE 2004/05 accounts, the government's response to the outcome of the Review of Non-Medical Professional Regulation and the Chief Medical Officer's Advisory Group into Patient Safety, following on from the Report from the Shipman Inquiry, may impact on the future structure and functions of CHRE.

20 Financial Instruments

The Council has no borrowings and relies primarily on grant in aid from the Department of Health for its cash requirements, and therefore it is not exposed to any risk of liquidity. It also has no material deposits, and all material assets and liabilities are denominated in sterling, so it is not exposed to interest rate or currency risk.

345211_HC1302_Text / Sig: 40 / Plate A

Council for Healthcare Regulatory Excellence Annual report and accounts 2005/2006

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79

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21 Commitments Under Operating Leases

Expenses of the CHRE include rent and service charge payments under operating lease rentals in the sum of £259k.

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

	31 March 2006 £'000	31 March 2005 £'000
Expiring between 1 and 5 years	322	–
	322	–

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80

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Annex C

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	31 March 2006 £'000	31 March 2005 £'000
Expiring between 1 and 5 years	322	–
	322	–

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