The Council for Healthcare Regulatory Excellence

Annual report and accounts
2009/10

Annual report volume I

council for healthcare regulatory excellence

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Annual report volume I: Annual report and accounts 2009/2010

(Associated with this document is the *Annual report volume II: Performance review of report 2009/2010)*

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Contents

1. Chair's introduction

During the last year the Council for Healthcare Regulatory Excellence (CHRE) has continued to put the health, safety and well-being of patients and other members of the public at the forefront of its work. This report covers the first full year of CHRE's reformed governance and new responsibilities. It shows, I believe, an organisation increasingly focused on the quality of health professional regulation, on using the statutory and other means available to us to promote patient safety, on high quality policy advice and on being transparent and accountable and using our resources efficiently.

In 2009/10 we carried out our first audit of the initial stages of the regulators' fitness to practise processes. This is the part of the process where regulators receive concerns or complaints and decide whether or not to proceed with them. We published our audit report in February 2010. We found that the vast majority of decisions were reasonable and did not present any potential risk to the public. We were also able to identify areas of good practice and some inconsistent or inadequate processes which we have asked the regulators to consider. We believe that the audit has been a valuable exercise and is a useful addition to our work in helping the regulators to improve.

During the year the Council has developed and consulted on a clear strategic plan. This sets out our values and principles and three key objectives:

1. Reporting clearly and openly on the effectiveness of health professional regulators in the interests of patients and the public
2. Building evidence and promoting debate in order to identify excellence in health professional regulation and to contribute to regulatory policy
3. Building confident relationships to create right touch regulation.

We report in more detail on our objectives and business planning elsewhere in this report.

We have continued to build relationships with organisations with interests in this area; the Care Quality Commission, the Legal Services Board, the General Teaching Councils and the Social Care Councils, the Institute for Government, the Royal Colleges and professional associations and the unions. We work closely with colleagues in the four health departments. We value all these partnerships and have been encouraged by the positive support we have received from them and the regulators for our programme of policy and good practice seminars. These relationships have also helped in ensuring our policy advice is well-founded and useful.

I should like to thank my Council members for their vision and commitment to CHRE and for the way we have worked together to create an effective governance structure and strategic vision for the future. I should also like to thank our staff who have managed many changes over the last year and continued to deliver high quality work and ensure our statutory functions are met.

Baroness Jill Pitkeathley

Chair

2. Council report

About CHRE

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

The Health and Social Care Act 2008[2] created a new, smaller Council from 1 January 2009, comprising seven non-executive members and up to two executive members. (Details of Council membership are given on page 13).

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

CHRE has powers to:

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

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

What we do

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

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

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

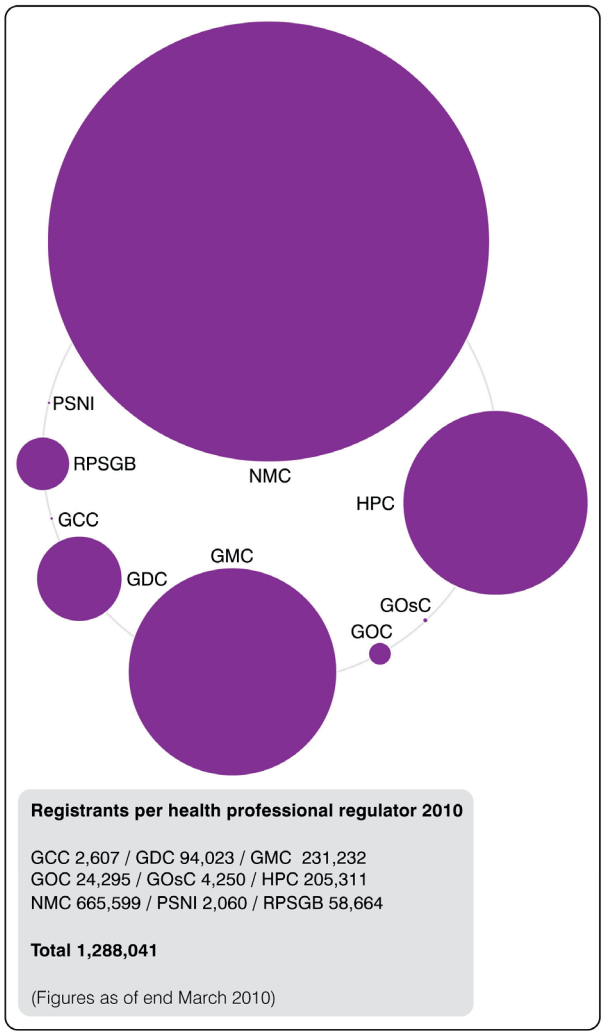
We promote good practice in the regulation of healthcare professionals in five main ways:

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

The nine regulators of healthcare professionals that we oversee are:

- The **General Chiropractic Council (GCC)**, which regulates chiropractors
- The **General Dental Council (GDC)**, which regulates dentists, dental hygienists, dental therapists, clinical dental technicians, orthodontic therapists, dental nurses and dental technicians
- The **General Medical Council (GMC)**, which regulates doctors
- The **General Optical Council (GOC)**, which regulates dispensing opticians and optometrists
- The **General Osteopathic Council (GOsC)**, which regulates osteopaths
- The **Health Professions Council (HPC)**, which regulates arts therapists, biomedical scientists, chiropodists and podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists and orthotists, radiographers, and speech and language therapists
- The **Nursing and Midwifery Council (NMC)**, which regulates nurses and midwives
- The **Pharmaceutical Society of Northern Ireland (PSNI)**, which regulates pharmacists in Northern Ireland
- The **Royal Pharmaceutical Society of Great Britain (RPSGB)**, which regulates pharmacists in England, Scotland and Wales.

Details of the number of registrants per health professional regulator are shown below.



Registrants per health professional regulator 2010

GCC 2,607 / GDC 94,023 / GMC 231,232
GOC 24,295 / GOsC 4,250 / HPC 205,311
NMC 665,599 / PSNI 2,060 / RPSGB 58,664

Total 1,288,041

(Figures as of end March 2010)

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

Our aim

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

Our values and principles

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

Our values are:

- Patient and public centred
- Independent
- Fair

- Transparent
- Proportionate
- Outcome focused.

Our values will be explicit in the way that we work; how we approach our oversight of health professional regulation, how we develop policy advice, how we engage with all our stakeholders and how we behave.

We have adopted the following six principles of good regulation. We aim to apply these to our own work as well as using them in our oversight and policy work.

- Proportionality
- Accountability
- Consistency
- Targeting
- Transparency
- Agility.

We aim to promote and support 'right touch' regulation. This is regulation that is based on a careful assessment of risk, which is targeted and proportionate, which provides a framework in which professionalism can flourish and organisational excellence can be achieved.

Our strategic objectives

In September 2009 the Council discussed a three year strategic plan to set the direction of CHRE. The Council invited comments on this draft strategic plan from regulatory bodies at the Regulators' Forum in July 2009 and invited comments from patients, the public and other stakeholders.

The strategic objectives agreed were:

- Reporting clearly and openly on the effectiveness of regulatory bodies in the regulation of health professionals in the interests of patients and the public
- Building evidence and promoting debate in order to identify excellence in health professional regulation and to contribute to the wider field of regulatory policy
- Building confident relationships to create right touch regulation.

To further these three strategic aims we have undertaken the following main areas of work during the year:

Quality and scrutiny

We have a range of powers to scrutinise the regulators to ensure that patient safety and public protection are central to their work. Under Section 29 of the National Health Service Reform and Health Care Professions Act 2002 we can refer final fitness to practise decisions made by the nine regulatory bodies to court. We do this if we consider that a decision is too lenient and that a referral is necessary in the interest of public protection. We have continued to use these important powers where necessary for the

protection of the public. This report shows clearly that although the number of fitness to practise cases being managed by the regulators has risen significantly, the number we have serious concerns about has dropped to only two this last year.

The principal aim of our scrutiny of final fitness to practise cases is to improve the standard of the decisions made by the regulators' panels and committees. This can usually be achieved by feeding back learning points to the regulators, rather than by referring cases to court. We do this in writing and through holding feedback meetings with the regulatory bodies. These meetings have resulted in agreed action, often involving additional training for the regulators' fitness to practise panel members. We have continued to contribute to many of the regulators' training sessions for panel members and legal assessors on matters such as the writing of determinations.

This year we have again seen an increase in the number of fitness to practise cases notified to us by the regulators, from 1,231 in 2007/08 and 1,370 in 2008/09, to 1,835 in 2009/10.

Of the 1,835 cases we received between 1 April 2009 and 31 March 2010, 1,634 were closed with no requirement for more information. We sought and considered additional information in the remaining 201 cases. In 171 of all cases received, we identified learning points to feed back to the regulators.

During the year we considered nine cases at case meetings, and we referred two cases to court. Both of these were NMC cases. We expect an outcome from these referrals later in 2010.

Six of the cases considered at case meetings resulted in us feeding back comments to the regulators proposing improvements to their handling of future cases.

We were given the power to audit the early stages of fitness to practise processes in the Health and Social Care Act 2008. Between April and December 2009, we carried out our first audit.

In March 2010 we published *Fitness to Practise Audit Report – Audit of Health Professional Regulatory Bodies' Initial Decisions*, providing details of our findings at each regulator. We described areas of good practice and areas of risk, and we made a number of recommendations to help regulators enhance their performance. The report can be found on our website, www.chre.org.uk.

During the course of the audit work we invited all of the regulators to take part in a pilot 'mystery shopping' project. This was designed to assess how they handle initial telephone queries about fitness to practise issues. The GDC, GOC, GOsC and PSNI agreed to take part in the project. CHRE also took part, so that our own response to telephone queries across the

organisation could be tested. In addition to being able to provide feedback to the participants we learnt a great deal about the practicalities and value of running such a project. We are likely to repeat the project on a larger scale in future and we will draw upon the lessons we learnt.

Performance review

We again carried out our annual performance review of the nine health professional regulators. This year, our review has benefitted from more extensive feedback from third parties which we have found useful during our considerations of the regulators' performance. For further information on our performance review of the health professional regulators in 2009/10, please refer to volume II of this annual report.

In the spirit of continuous improvement, we reviewed the performance review standards and process this year. We wanted to ensure that they were proportionate, risk based and focused on regulatory outcomes. We also wanted to be sure that they enabled us to check whether the regulators are protecting the public as well as help the regulators in carrying out their functions. Our aim is to reduce the number of standards and requirements on the regulators while improving our insight into their effectiveness.

As part of the revision process, we met with members of the public, professional representative organisations and the regulators to discuss suggestions and ideas. We also held a 12-week consultation on our proposed revisions to the process and standards and received 31 responses.

The revised performance review process and standards will be used from 2010/11. The new documents can be found on our website.

Special report

In June 2009, the Secretary of State for Health commissioned CHRE to carry out a review of the conduct function of the General Social Care Council (GSCC), the social care regulator for England.

We submitted a report to the Secretary of State in September 2009. The publication, *Report and Recommendations to the Secretary of State for Health on the Conduct Function of the General Social Care Council*, identified a number of failings in the processes and procedures of the conduct function at the GSCC and in its management and oversight. The report made several recommendations to the GSCC and to the Department of Health for the correction of weaknesses in the conduct function, the improvement of quality and the enhancement of public protection. The report can be found on our website, www.chre.org.uk. The government published its response to our report in November 2009.[3]

[3] Department of Health, 2009. Response to the *Report and Recommendations of the Review of the Conduct Function of the General Social Care Council.* London: DH.

Regulatory policy development

We have increased our policy work, and in doing so have developed a body of knowledge regarding excellence in health professional regulation. We have responded to commissions from the Departments of Health to provide advice to ministers. Specifically, during 2009/10, we published policy recommendations in the following areas:

- Priorities for 'Section 60' orders to update regulatory bodies' legislation
- Quality assurance of education
- How regulatory bodies approach the problem of data misuse
- Advanced practice
- Scope for sharing functions amongst the regulators
- Healthcare for people with disabilities
- Sharing the registrant's response with the complainant
- Protecting the public from unregistered practitioners
- Whether regulators should receive the outcomes of student fitness to practise committees
- Maximising the contribution of regulatory bodies' registers to public protection.

We have worked to improve the way that we engage with the public in our policy work, using market research to inform specific areas of research to ensure that our work better reflects the views of the public.

Building on our work during 2008/09 on clear sexual boundaries between health professionals and patients, we published guidance for patients on this issue in May 2009.

From October 2009 to January 2010 we hosted an online consultation on the General Pharmaceutical Council's (GPhC's) draft standards, prior to the GPhC becoming a legal entity.

The advice that we developed for the GPhC was that regulation should seek to be 'agile', that is, forward looking, responsive to change and adaptable. When we subsequently submitted evidence to the House of Commons Regulatory Reform Committee, which reported in July 2009, we suggested that the concept of agility should be adopted by regulators in all sectors, not just health professional regulation. The committee's report commended this idea.[4]

A key part of our work is providing input into policy reviews and consultations undertaken by other organisations. During 2009/10, we responded to 13 consultations on a wide range of subjects. Our responses contributed to good practice in regulation, including the following:

- In line with a recommendation in our report on health requirements for registrants, the HPC consulted on removing the requirement for 'good health' from their registration requirements

[4] House of Commons Regulatory Reform Committee, 2009. *Themes and Trends in Regulatory Reform, Ninth Report of Session 2008-09*. London: TSO.

- The NMC and GOsC both committed to sharing the registrant's response with complainants in line with the recommendation in our report on this matter
- Following our response to her consultation in March 2010, we received an assurance from the Parliamentary and Health Service Ombudsman that she would share details of complaints she received about the fitness to practise of health professionals with the health professional regulators,
- Both the GDC and GOC took recommendations made in our report on registers and included them in ongoing projects to improve their registers for patients and the public
- The Calman Commission report on Scottish devolution agreed with our recommendation that the regulation of health professionals should be reserved and managed at a UK level, to facilitate mobility of professionals in the UK and allow a common approach to standards and guidance for the benefit of patients and the public.

Our relationship with the public, regulators and other stakeholders

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

The membership of our Public Stakeholder and Professional Stakeholder Networks continues to grow, with membership including representatives of country-wide patient organisations and major charities. Network members' input is increasingly influencing and improving the quality of our external communications.

We keep network members involved in our work through our electronic newsletter, email updates, invitations to participate in our events and requests for their input into our consultations and discussions.

In order to develop further our relationship with the members of the Public Stakeholder Network, we held a series of six meetings with the public in March 2010, which we called 'I Learn - U Learn'. These were held across England, Northern Ireland, Scotland and Wales. Attendees participated in case study discussions and workshops which enabled them to make suggestions for possible improvements in our work. As was our aim, attendees learned about CHRE and current regulatory issues. We in turn gained valuable insight into the public's perception of our work and how it may impact on the lives of patients and the public.

Promoting discussion and debate

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

During 2009/10 we continued to host discussion seminars on the future of regulation, identifying areas of interest across regulatory and other sectors, and bringing people together to discuss them. We held two series of three seminars. In the first series, which ran from May to July 2009, we discussed:

- Sexual boundaries between health professionals and patients
- Child protection
- Whistleblowing.

In the second series of seminars, which took place between October and December 2009, we discussed:

- Professional leadership and regulation
- How information systems would support revalidation decisions
- The boundary between registrants' personal and professional lives.

The second series of seminars were held jointly with organisations in the devolved administrations – the Northern Ireland Social Care Council, NHS Quality Improvement Scotland, and the General Teaching Council for Wales. The seminars took place in Belfast, Edinburgh and Cardiff, strengthening our relationships across the UK and across regulatory sectors.

Approximately 70 organisations were represented at the seminars, including patient and public organisations, regulatory bodies from across the UK from the health sector and other sectors, government departments, think tanks, professional associations, charities and colleges. A further series of seminars will begin in May 2010.

In February 2010 we held a second high-level symposium to discuss how regulation should react to likely future changes in health, the economy and society more generally. The symposium involved amongst others the health professional regulatory bodies, representatives from the Departments of Health, the General Social Care Council, the Office of the Health Professions Adjudicator, the Care Quality Commission, the National Audit Office and National Voices. We are currently drawing up plans to take forward the ideas and proposals that arose.

Strengthening relationships across the UK, in Europe and worldwide

We have continued to build on our constructive relationships across the UK. As mentioned above, one way in which we have done this has been by co-hosting seminars with partner organisations in the devolved administrations.

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

Initially we will invite organisations from 22 countries to become members of the Observatory, with the longer term aim of expanding its scope to cover a wider range of countries and professions.

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

Who we are and how we work

Council

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

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

Council members

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

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

Schedule 7 of the National Health Service Reform and Health Care Professions Act 2002, as amended by the Health and Social Care Act 2008, provides directions for the appointment of members to the Council.[5]

Attendance at Council meetings held in public

There were six Council meetings held in public between 1 April 2009 and 31 March 2010.

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

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

Committees and working groups of the Council

Audit and Risk Committee

Role

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

There were five meetings of the committee during the year.

Membership

Committee members from 1 April 2009 to 31 March 2010 were:

- Andrew Hind, Chair
- Stuart MacDonnell
- Jayne Scott.

Scrutiny Committee

Role

The Scrutiny Committee reviews, monitors and reports on the operation of CHRE's scrutiny and oversight of the nine health professional regulatory bodies. In particular, this includes work in the following areas:

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

There were four meetings of the committee during the year.

Membership

Committee members from 1 April 2009 to 31 March 2010 were:

- Sally Irvine, Chair
- Ann Curno
- Ian Hamer.

Remuneration Committee

Role

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

Membership

Committee members from 1 April 2009 to 31 March 2010 were:

- Jill Pitkeathley, Chair
- Andrew Hind
- Harry Cayton.

3. Chief Executive's report

This last year has been an important one for the development of CHRE as an organisation and for the improvement of its work to promote excellence in health professional regulation.

This has been the first full year in which the reformed governance structures have operated. The Council works effectively as a board, it has a clear strategic plan and business planning process and though its Audit and Risk and Scrutiny committees it ensures effective oversight of the executive team and the agreed work programme.

We have successfully implemented our new statutory power of audit of the initial stages of fitness to practise while continuing to review all cases which reach a final determination and to exercise our power of appeal if and when we judge it necessary for the protection of the public.

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

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

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

The directors of each area and the Chief Executive form the Management Team, which meets on a regular, formal basis to review and discuss a range of issues. These include reviews of the budget, policy development and the recruitment of staff. In furtherance of our statutory duties, we continued to research and develop public policy and advice and built upon our reputation as a forum for open and challenging debate about regulation in health and social care.

During 2009/10 the Management Team gave particular attention to supporting the Council in strategic planning, improving our assessment and management of risk, ensuring the quality of our performance and to securing the continuity of our work by preparing for a move to new premises.

Performance

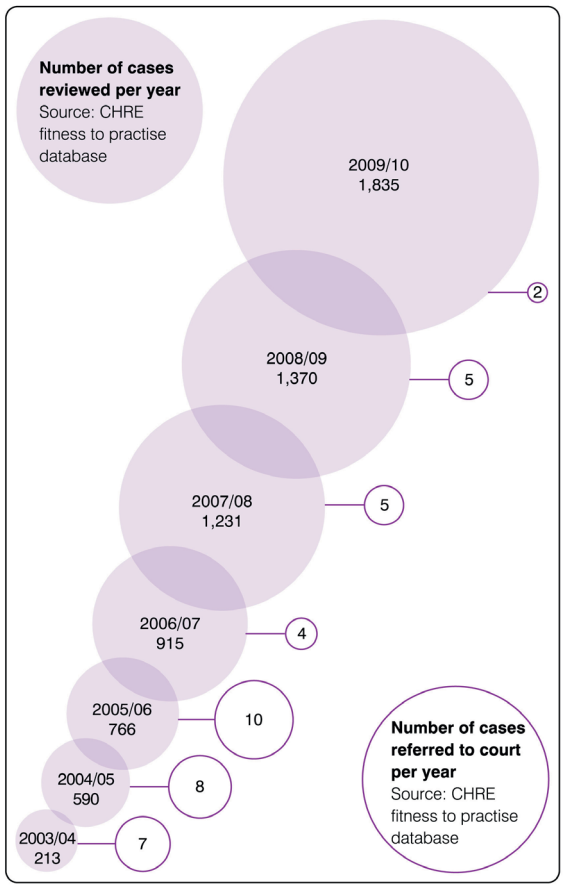
Our performance is monitored internally by Council through its oversight of the strategic and operational functions of the organisation. Reports to the Council and its committees include financial updates, risk assessments, details of progress against business plan objectives and regular reports from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

In addition, quarterly meetings are held between our executive and the Department of Health and Arm's Length Bodies Business Support Unit.

As mentioned earlier, this year there has been a 32 per cent increase in the number of fitness to practise cases notified to us by the nine regulatory bodies.

There are several possible reasons for this. The changes introduced by the 2008 legislation widened our remit to enable us to review cases relating to the health of a professional as well as their conduct. The number of professions regulated has also continued to increase, while some of the regulators have been working to address historical backlogs resulting in more cases coming through in recent times. In addition, the number of complaints made to the regulatory bodies may have increased.

Number of fitness to practise cases and cases referred to court per year



Future developments

We will continue to concentrate on delivery of our principal activities in order to ensure that we continue to promote the interests of patients and the public within health professional regulation. We will continue to focus on right touch regulation, promoting regulatory practice that balances the burden of regulation with the need for robust ways to ensure patient and public safety. In doing do so we will be agile and ready to adapt when necessary.

Information governance

Over the last 12 months we have built on our successful implementation of the Cabinet Office's minimum mandatory requirements. We continue to thoroughly assess the risks to our information and have put in place suitable safeguards to minimise and manage risks. This year, to strengthen our systems of internal control all staff have undergone training in how to value and safeguard the information that we hold. We have also carried out penetration testing of our systems to ensure that they are secure.

Website

Work to improve the accessibility of our website is ongoing. In 2009/10 we commissioned an independent audit on its accessibility. Implementation of the audit's recommendations is due to be completed by June 2010.

In collaboration with the Welsh Language Board, we launched our Welsh Language Scheme and now have a bilingual English and Welsh website.

Environment

We seek to minimise the impact of our activities on the environment. We use recycled materials where such alternatives are available and provide value for money. We seek to reduce the use of paper by maximising the use of our intranet and website for the dissemination of information.

During 2008/09 we introduced a new system that allows us to recycle a wide range of office consumables and this continues. While the use of taxis is not encouraged, they are on occasion necessary, and in 2009 we changed our corporate contractor to an eco-friendly taxi service which uses low emission vehicles.

Accounts and audit

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

Details about the NHS Pension Scheme and the treatment of pension liabilities in the accounts are set out in accounting policies within the notes to the accounts (page 39).

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

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

Financial summary

Grant in aid funding for 2009/10 comprised £2.25m from the Department of Health and £0.47m from the devolved administrations. At 31 March 2010, we had reserves carried forward of £0.29m (2008/09: £0.17m) after net operating costs of £2.61m (2008/09: £2.54m).

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

Our creditor payment policy has changed in accordance with the introduction of the government's Better Payment Policy. We aim to pay all creditors within 10 rather than 30 days of receipt of invoice, except in the instance where there may be a query or dispute regarding an invoice. This target is challenging, especially for a small organisation.

During 2009/10 financial year, payments were made to suppliers as follows:

Period	Percentage of suppliers' invoices paid within 10 working days	Percentage of suppliers' invoices paid within 30 days
01/04/09 – 30/06/09	99.50%	100%
01/07/09 – 31/09/09	100%	100%
01/10/09 – 31/12/09	100%	100%
01/01/10 – 31/03/10	100%	100%

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

The balance owed to trade creditors as at 31 March 2010 was £37,485 (2008/09: £4,489). As a proportion of the total amount invoiced by suppliers in the year, this is equivalent to nine days (2008/09: one day).

4. Remuneration report

Our pay policy incorporates a band structure within which staff can progress along incremental points within a given band alongside a performance appraisal process. No bonuses are paid.

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

Each year the Remuneration Committee also considers an annual uplift to reflect a cost of living increase payable from October. At its meeting in July 2009, the committee recommended a two per cent increase in pay with effect from October 2009.

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

A total of 58.5 days (2008/09: 29.5 days) were lost due to sickness absence in the year. This equates to 3.2 days (2008/09: 1.9 days) per person.

Senior managers' contracts

Name	Title	Date of contract	Unexpired term	Notice period
Linda Allan	Director of Governance and Operations	15 March 2010	Permanent contract	3 months
Michael Andrews	Director of Scrutiny and Quality	19 January 2004 (left 14 May 2010)	Permanent contract	3 months
Harry Cayton	Chief Executive	1 August 2007	Permanent contract	6 months
Rosemary Macalister-Smith	Director of Policy and External Relations	1 December 2005 – 28 February 2010	Not applicable	Not applicable
Kristin Smyth	Director of Governance and Operations	27 October 2003 – 29 December 2009	Not applicable	Not applicable

Senior managers' salaries

Name	Salary (£'000) 2009/10	Salary (£'000) 2008/09	Real increase/ (decrease) in pension at age 60 (£'000)	Total accrued pension at 31 March 2010 (£'000)
Linda Allan	0–5 (full year equivalent £80-85)	–	0–2.5	0–2.5
Michael Andrews	65–70	65–70	0–2.5	5–7.5
Harry Cayton	135–140	130–135	0–2.5	7.5–10
Rosemary Macalister-Smith	70–75 (full year equivalent £75–80)	75–80	2.5–5	40–42.5
Kristin Smyth	50–55 (full year equivalent £65–70)	65–70	0–2.5	5–7.5

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

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

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

Note: the following were not provided: allowances; benefits in kind; bonuses; expenses allowance; compensation for loss of office or termination of service (2008/09: £Nil).

Pensions

Name	Title	Value of accrued pension (£'000)	Related lump sum (£'000)	Real increase/(decrease) in related lump sum (£'000)	Cash Equivalent Transfer Value as at 1 April 2009 (to nearest £1,000)	Cash Equivalent Transfer as at 31 March 2010 (to nearest £1,000)	Real increase in the cash equivalent transfer value during the reporting year (to nearest £1,000)
Linda Allan	Director of Governance and Operations	0–2.5	N/A	N/A	–	1	1
Michael Andrews	Director of Scrutiny and Quality	5–7.5	15–17.5	0–2.5	70	86	12
Harry Cayton	Chief Executive	7.5–10	27.5–30	5–7.5	182	236	44
Rosemary Macalister-Smith[6]	Director of Policy and External Relations	40–42.5	125–127.5	7.5–10	883	–	–
Kristin Smyth	Director of Governance and Operations	5–7.5	15–17.5	0–2.5	75	89	10

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

Cash Equivalent Transfer Value

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

The CETV figure, and from 2005/06 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETV are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase/(decrease) in CETV

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

[6] Retired 28 February 2010.

No compensation has been paid to former senior managers, or payments made to third parties for the services of a senior manager. This statement has been audited by the Comptroller and Auditor General.

Council members' remuneration

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

The Chair receives remuneration of £33,688 pa (2008/09: £33,190), members receive annual remuneration of £7,881 (2008/09: £7,765) and the Audit and Risk Committee Chair receives annual remuneration of £13,135 (2008/09: £12,941).

Members' remuneration during the year amounted to £92,154 (2008/09: £170,773) including social security costs and Section 29 panel attendance fees of £1,650 (2008/09 £10,525) which were distributed between four members of Council who sat on panels during the period to 30 June 2009. This was a transitional arrangement and no further payments were made after this date.

In addition, expenses amounting to £15,947 (2008/09: £18,307) were reimbursed to Council members.

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

Payments to individual members are disclosed in the following ranges:

CHRE Council as of 1 January 2009

	2009/10	2008/09
	Salary (bands of £5,000)	Salary (bands of £5,000)*
Chair:		
Jill Pitkeathley	30–35	5–10
Members:		
Ann Curno	5–10	0–5
Ian Hamer	5–10	0–5
Andrew Hind (Audit and Risk Committee Chair)	10–15	0–5
Sally Irvine	5–10	0–5
Stuart MacDonnell	5–10	0–5
Jayne Scott	5–10	0–5

CHRE Council to 31 December 2008

	2009/10	2008/09	
	Salary (bands of £5,000)	Salary (bands of £5,000)*	S29 Panel attendance fees
	£'000	£'000	£
Chair:			
Jane Wesson** (until 12 April 2007)	–	0–5	–
Rosie Varley (Acting Chair from 13 April 2007)	–	25–30	2,800
Members:			
Martin Astbury (from 12 June 2008)	–	0–5	–
Graeme Catto	–	5–10	–
Nigel Clarke	–	5–10	625
Jill Crawford (from 4 September 2008)	–	0–5	–
Frances Dow (from 2 July 2007)	–	5–10	1,250
Anna van der Gaag	–	5–10	550
Sue Leggate	–	5–10	1,100
Hew Mathewson	–	5–10	1,375
Kate McClelland	–	5–10	–
James McCusker	–	5–10	–
Peter North	–	5–10	1,175
Hemant R Patel	–	0–5	–
Hugh Ross (Audit Committee Chair)	–	5–10	–
David Smith	–	5–10	–
Kieran Walshe	–	5–10	550
Sally Williams	–	5–10	–
Lois Willis	–	5–10	825
Judith Worthington	–	5–10	275
Sandra Arthur** (until 19 October 2007)	–	0–5	–
Nancy Kirkland (from 22 October 2007)	–	0–5	–

* Includes S29 panel attendance fees
** 2007/08 and 2008/09 back pay settled in 2008/09

Harry Cayton
Accounting Officer

24 June 2010

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

The Council's responsibilities

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

In preparing the accounts CHRE is required to:

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

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

The Accounting Officer's responsibilities

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

6. Statement on internal control

Scope of responsibility

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

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of organisational policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. Our system of internal control has been in place for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts, and accords with HM Treasury guidance.

Capacity to handle risk

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

The Council has established committees to support its work.

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

The Audit and Risk Committee terms of reference were received in December 2009.

In January 2009 the Council agreed to restructure the Scrutiny Committee. The first meeting of the new committee was held in April 2009. It reviews, monitors and reports on the operation of our scrutiny and oversight of the

nine health professional regulatory bodies. It has oversight of the final fitness to practise decisions in accordance with our powers under Section 29.

Both committees report to the Council. The Council and its Audit and Risk Committee oversee the risk management process and receive regular updates on business performance.

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

The risk and control framework

During the year the Council, Audit and Risk Committee and Management Team worked to review and update CHRE's strategy for handling risk and the risk register. This resulted in a new format for the risk register that ranks the risks, provides more information and differentiates more effectively between inherent and residual risks.

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

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

During 2009/10 the risk register presented in detail to the Audit and Risk Committee has been updated regularly. Transient but nevertheless important risks arising from changing circumstances, such as staff changes, have been incorporated into it. The executive continues to provide evidence regarding the process for identifying risks and placing them on the register. They also provide, as appropriate, updates regarding the prioritisation of risks and ongoing management of the top risks.

The register is structured to reflect our operational structure: scrutiny and quality; policy, research and external relations; and governance and operations. In identifying and scoring risks, the Management Team considers the strategic objectives of the organisation, the individual team objectives and any changes since the last review. The Management Team identifies and responds to the risks associated with their particular area of work.

This is an ongoing process which is reviewed regularly by them and by the Audit and Risk Committee, and is supported by relevant guidance. In addition, each strand of the business plan is linked to the relevant strand of the risk register, again with an identified senior manager who is responsible for delivering that area of work.

We pay considerable attention to managing significant risks. In the interest of protecting patients, we are prepared to take difficult decisions, which may increase the risk of reputational harm. Managers review risk on an ongoing basis and will tolerate, treat or avoid risks according to the nature of each risk. During the year, we have had to consider how to manage the risks associated with the need to access data held by the regulatory bodies; the risks arising from the expiration of the lease of our office accommodation; and the risks that might arise from any extension in the scope of our remit.

Data handling

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

In 2008/09 we implemented the majority of the Cabinet Office's minimum mandatory requirements to strengthen the system of internal control we already had in place. In 2009/10 we are confident that we have further enhanced the security of our information.

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

All but two members of staff attended an in-house training session on the requirements of our information governance policies as well as the relevant legislation.

Following this, all staff undertook the Cabinet Office's 'Protect Information' online training (other than one member of staff who was on maternity leave). The training was split into two levels and was assessment based. The Information Asset Owners and the Senior Information Risk Owner had to complete level two and the remaining staff level one. All members of staff successfully passed the assessment.

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

There have been no material losses of information during the year, including any losses of personal data, which would require to be reported to the Information Commissioner's Office. We are continuing to develop policies and procedures for information management which are in accordance with government requirements but are proportionate to an organisation of our size.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors 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. The Audit and Risk Committee and Council have advised me on the implications of the result of my review on the system of internal control.

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

- The Council, which met six times to consider strategic issues
- CHRE's Audit and Risk Committee which consisted of three members of Council one of whom was the Chair. I also attended the Audit and Risk Committee meetings together with the Director of Governance and Operations, the Contracted Accounting Manger and representatives from the National Audit Office and South Coast Audit
- Risk management arrangements as described, under which key risks that could affect the achievement of our objectives have been managed actively, with progress being reported to the Audit and Risk Committee and through them to Council
- Our annual assessment of information risk management undertaken in accordance with Cabinet Office guidance
- Regular reports from the internal auditors, South Coast Audit, complying with the government's Internal Audit Standards, which include an independent opinion on the adequacy and effectiveness of our internal controls together with recommendations for improvement where necessary.

We have appointed South Coast Audit (SCA) as our internal auditors. SCA's work is informed by the analysis of the risk to which we are exposed and the internal audit plans are approved by the Audit and Risk Committee and are made known to Council. Each year SCA provides me with a report on its internal audit activity at CHRE. The report includes SCA's independent opinion on the adequacy and effectiveness of our system of internal controls, together with recommendations for improvements. In their 2009/10 report, SCA stated that the level of assurance was 'satisfactory'. They stated that in their opinion there was some risk that objectives may not be fully achieved and that slight improvements are required to enhance the adequacy or effectiveness of risk management control and governance.

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

Horizon scanning remains a part of our regular review and this involves consideration and contributions from the Council, our Audit and Risk 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.

We continue to keep our arrangements under review in response to external developments, including changes in our operational environment.

Disclosure of relevant audit information

As Accounting Officer I have taken all steps to make myself aware of any relevant audit information and to establish that CHRE's auditors are aware of that information. I have advised the auditors of all relevant information.

For 2009/10, I am able to report that there were no material weaknesses in CHRE's system of internal controls that affected the achievement of the organisation's aims and objectives.

Harry Cayton
Accounting Officer

24 June 2010

7. The Certificate and report of the Comptroller and Auditor General to the Houses of Parliament

I certify that I have audited the financial statements of the Council for Healthcare Regulatory Excellence for the year ended 31 March 2010 under the National Health Service Reform and Healthcare Professions Act 2002 as amended by the Health and Social Care Act 2008. These comprise the operating cost statement, the statement of financial position, the statement of cash flows, the statement of changes in taxpayers' equity and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the remuneration report that is described in that report as having been audited.

Respective responsibilities of the Council, Accounting Officer and auditor

As explained more fully in the statement of the Council's and Accounting Officer's responsibilities, the Council and Chief Executive, as Accounting Officer, are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Council for Healthcare Regulatory Excellence's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Council for Healthcare Regulatory Excellence; and the overall presentation of the financial statements.

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

Opinion on regularity

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

Opinion on financial statements

In my opinion:

- The financial statements give a true and fair view of the state of the Council for Healthcare Regulatory Excellence's affairs as at 31 March 2010 and of its net operating costs, changes in taxpayers' equity and cash flows for the year then ended
- The financial statements have been properly prepared in accordance with the National Health Service Reform and Healthcare Professions Act 2002 as amended by the Health and Social Care Act 2008 and Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion:

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

Matters on which I report by exception

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

- Adequate accounting records have not been kept
- The financial statements are not in agreement with the accounting records or returns
- I have not received all of the information and explanations I require for my audit
- The Statement on Internal Control does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

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

28 June 2010

Operating cost statement for the year ended 31 March 2010

	Note	2009/10 £		2008/09 £
Staff costs	4	1,118,594		946,122
Operating costs	5	1,490,399		1,664,760
Operating income	6	–		(59,872)
Net operating cost before capital charges reversal		2,608,993		2,551,010
Capital charges reversal	7	(3,018)		(6,535)
Net operating cost before interest		2,605,975		2,544,475
Interest receivable		–	(523)	
Corporation tax[7]		86	110	
		86		(413)
Net operating cost		**2,606,061**		**2,544,062**

The notes on pages 36-50 form part of these accounts.

[7] Corporation tax at 21% on interest receivable.

Statement of financial position as at 31 March 2010

	Note	31 March 2010		31 March 2009		1 April 2008	
		£	£	£	£	£	£
Non-current assets							
Property, plant and equipment	8	95,567		155,777		182,538	
Total non-current assets			***95,567***		***155,777***		***182,538***
Current assets							
Trade and other receivables	9	220,109		232,702		204,932	
Cash and cash equivalents	10	302,162		87,646		142,886	
Total current assets			***522,271***		***320,348***		***347,818***
Current liabilities							
Trade and other payables	11	(160,934)		(157,637)		(171,231)	
Provisions	12	(166,161)		–		–	
Total current liabilities			***(327,095)***		***(157,637)***		***(171,231)***
Non-current assets plus net current assets			**290,743**		**318,488**		**359,125**
Non current liabilities							
Provisions	12	–		(145,339)		(142,210)	
Total non current liabilities			***–***		***(145,339)***		***(142,210)***
Assets less liabilities			**290,743**		**173,149**		**216,915**
Reserves							
General reserve			289,797		170,939		213,441
Revaluation reserve			946		2,210		3,474
			290,743		***173,149***		***216,915***

The notes on pages 36-50 form part of these accounts.

Harry Cayton
Accounting Officer

24 June 2010

Statement of cash flows for the year ended 31 March 2010

	Note	2009/10	2008/09
		£	£
Cash flows from operating activities			
Net operating costs for the year before cost of capital reversal		(2,608,993)	(2,551,010)
Interest received		–	523
Adjustment for non-cash transactions:	5	108,292	86,057
Decrease/(increase) in trade and other receivables	9	12,593	(27,770)
Increase/(decrease) in trade and other payables	11	3,297	(13,594)
Less: corporation tax		(86)	(110)
Net cash (outflow) from operating activities		***(2,484,897)***	***(2,505,904)***
Cash flow from investment activities			
Purchase of property, plant and equipment	8	(24,242)	(49,937)
Proceeds of disposal of property, plant and equipment		–	305
Net cash (outflow) from investment activities		***(24,242)***	***(49,632)***
Cash flow from financing activities			
Grant in aid from the Department of Health:			
Revenue		2,229,000	2,050,000
Capital		25,000	50,000
Devolved administration funding:			
Scotland		237,815	218,002
Wales		136,390	125,024
Northern Ireland		95,450	57,270
Net cash flow from financing activities		***2,723,655***	***2,500,296***
Net financing			
Net increase/(decrease) in cash and cash equivalents	**10**	214,516	(55,240)
Cash and cash equivalents at the beginning of the financial year	10	87,646	142,886
Cash and cash equivalents at the end of the financial year	**10**	**302,162**	**87,646**

The notes on pages 36-50 form part of these accounts.

Statement of changes in taxpayers' equity for the year ended 31 March 2010

	Note	General reserve	Revaluation reserve	Total
		£	£	£
Balance as at 31 March 2008		**213,441**	**3,474**	**216,915**
Changes in reserves in the year ended 31 March 2009				
Transfers between reserves		1,264	(1,264)	–
Net operating costs		(2,544,062)	–	(2,544,062)
Total recognised income and expenditure for 2008/09		***(2,542,798)***	***(1,264)***	***(2,544,062)***
Grant in aid from the Department of Health:				
Revenue		2,050,000	–	2,050,000
Capital		50,000	–	50,000
Funding from the devolved administrations:				
Scotland		218,002	–	218,002
Wales		125,024	–	125,024
N Ireland		57,270	–	57,270
Balance as at 31 March 2009		**170,939**	**2,210**	**173,149**
Changes in reserves in the year ended 31 March 2010				
Transfers between reserves		1,264	(1,264)	–
Net operating costs		(2,606,061)		(2,606,061)
Total recognised income and expenditure in 2009/10		**(2,604,797)**	**(1,264)**	**(2,606,061)**
Grant in aid from the Department of Health:				
Revenue		2,229,000	–	2,229,000
Capital		25,000	–	25,000
Funding from the devolved administrations:				
Scotland		237,815	–	237,815
Wales		136,390	–	136,390
N Ireland		95,450	–	95,450
Balance as at 31 March 2010		**289,797**	**946**	**290,743**

The notes on pages 36-50 form part of these accounts.

Notes to the accounts

1. Accounting policies

Basis of preparation

These financial statements have been prepared in accordance with the 2009/10 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the UK public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of CHRE for the purpose of giving a true and fair view has been selected. The particular policies adopted by CHRE for the reportable period are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

Accounting convention

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

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

Critical accounting judgements and key sources of estimation uncertainty

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

Non current assets

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

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

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

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

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

- Refurbishment costs, furniture and fittings – from 1 April 2003 to the end of the lease on 22 December 2010
- Computer equipment – three years.

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

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

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

Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the statement of cash flows, cash and cash equivalents are shown net of bank overdrafts held with the Government Banking Service (GBS) that form an integral part of CHRE's cash management and over which CHRE has a right of set off against other GBS accounts in credit.

Provisions

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

Contingencies

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

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

Grant in aid and general reserve

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

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

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

Operating income

The majority of CHRE's operating income relates to section 29 recoveries (see note 6).

Section 29 costs and recoveries

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

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

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

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

Capital charge

In accordance with the FReM published by HM Treasury, a notional charge for the cost of capital employed during the year is included in the operating cost statement along with an equivalent notional income to finance the charge. The cost of capital charge is calculated at 3.5 per cent (2008/09: 3.5 per cent) applied to the mean value of capital employed during the year, excluding non-interest bearing cash balances held with the Office of the Paymaster General.

Value added tax

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

Short-term employee benefits

Salaries are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the year is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed

under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

Operating leases

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

An operating lease for the First Floor, 11 Strand, London, WC2N 5HR is in force until 22 December 2010.[8]

Foreign exchange

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

Losses and special payments

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

Losses and special payments are charged to the relevant functional headings including losses which would have been made good through insurance cover had CHRE not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). The CHRE does not generally hold insurance but does have specific cover in respect of its lease obligation at 11 Strand, travel and business continuity.

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

Financial instruments

As required by the *Government Financial Reporting Manual,* CHRE has accounted for financial instruments in accordance with financial reporting standards 25 and 26 and has made disclosures relating to those financial instruments in accordance with financial reporting standards 25 and 29.

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

The following standards and interpretations have been adopted by the European Union but are not required to be followed until after March 2010. None of them are expected to impact upon CHRE's financial statements.

- IAS 24 Related Party Disclosures
- IFRS 1 Limited Exemptions
- IFRS 9 Financial Instruments
- FReM Chapter 8 Impairments
- FReM Chapter 11 Income and Expenditure.

Accounting standards issued that have been adopted early

No accounting standards have been adopted early by the Council.

2. First time adoption of International Financial Reporting Standards (IFRS)

Taxpayers' equity

There were no adjustments to taxpayers' equity as at 31 March 2008 of £216,915 arising from the first time adoption of IFRS by CHRE.

Net operating costs

There were no adjustments to net operating costs for 2008/09 of £2,544,062, arising from the first time adoption of IFRS by CHRE.

There were also no adjustments identified as necessary under UK GAAP further to the first time adoption of IFRS by CHRE.

3. Analysis of net operating costs by segment

Segmental analysis

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

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

Year ended 31 March 2009	Policy Research and External Relations	Scrutiny and Quality (S29)	Scrutiny and Quality (Other)	Operations	Total
	£	£	£	£	£
Operating costs after capital charges reversal	696,612	417,476	213,750	1,276,509	**2,604,347**
Operating income	–	(59,622)	–	(250)	**(59,872)**
Interest receivable after corporation tax	–	–	–	(413)	**(413)**
Net operating costs	696,612	357,854	213,750	1,275,846	**2,544,062**

4. Staff numbers and related costs

	Permanently employed	Other	Total year ended 31 March 2010	Permanently employed	Other	Total ended 31 March 2009
	£	£	£	£	£	£
Salaries	886,210	–	886,210	746,240	–	746,240
Social security costs	74,362	–	74,362	66,677	–	66,677
Superannuation costs	110,639	–	110,639	101,907	–	101,907
Agency/ temporary costs	–	47,383	47,383	–	31,298	31,298
	1,071,211	**47,383**	**1,118,594**	**914,824**	**31,298**	**946,122**

Average number of persons employed

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

Permanently employed	Other	Total 2009/10	Permanently employed	Other	Total 2008/09
18.1	**0.6**	**18.7**	**14.7**	**0.8**	**15.5**

There were no staff engaged on capital projects in 2009/10 and 2008/09.

5. Operating costs

	Notes	Total year ended 31 March 2010	Total year ended 31 March 2009
		£	£
Members' remuneration		92,154	160,248
Legal and professional fees		451,377	506,623
Consultancy		49,275	20,085
Premises and fixed plant		484,749	436,100
Training and recruitment		105,774	146,713
PR, communications and conferences		58,008	168,232
Establishment expenses		90,528	70,390
External audit fee (*)		24,000	21,800
Other costs		26,242	48,512
Non cash expenditure:			
(Profit)/loss on disposal of fixed assets		–	(305)
Depreciation	8	105,274	79,827
Cost of capital charge	7	3,018	6,535
Total operating costs		**1,490,399**	**1,664,760**

** CHRE paid £2,800 to the National Audit Office for non audit work in relation to IFRS trigger point work.*

6. Operating income

	Total year ended 31 March 2010	Total year ended 31 March 2009
	£	£
S29 Cost recoveries	–	59,622
Other operating income	–	250
Total operating income	–	**59,872**

7. Notional cost of capital

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

	Total year ended 31 March 2010	Total year ended 31 March 2009
	£	£
Capital employed as at 1 April	172,242	201,215
Capital employed as at 31 March	195	172,242
Mean capital employed	86,219	186,728
Notional charge	3,018	6,535

8. Non current assets

Intangible assets

CHRE held no intangible assets as at 31 March 2010, 31 March 2009 and 2008.

Property, plant and equipment

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

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

The valuation of decommissioning assets as at 31 March 2009 is referred to in note 12 to the accounts.

2008/09	Furniture, fixtures and fittings – conversion costs	IT equipment	Decommissioning costs	Total
	£	£	£	£
Valuation				
At 1 April 2008	156,702	115,136	142,210	414,048
Additions	10,980	38,957	–	49,937
Revaluation	–	–	3,129	3,129
Disposals	–	(30,775)	–	(30,775)
At 31 March 2009	167,682	123,318	145,339	436,339
Depreciation				
At 1 April 2008	90,637	68,707	72,166	231,510
Charge in year	26,463	27,137	26,227	79,827
Disposals	–	(30,775)	–	(30,775)
At 31 March 2009	117,100	65,069	98,393	280,562
Net book value				
At 31 March 2009	**50,582**	**58,249**	**46,946**	**155,777**
At 31 March 2008	66,065	46,429	70,044	182,538

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

The valuation of decommissioning assets as at 31 March 2009 is referred to in note 12 to the accounts.

9. Trade receivables and other current assets

Amounts falling due within one year:

	31 March 2010	31 March 2009	1 April 2008
	£	£	£
Trade and other receivables	25,706	69,655	44,204
Prepayments	194,403	163,047	160,728
Total trade and other receivables	***220,109***	***232,702***	***204,932***

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

Intra government balances

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

	31 March 2010	31 March 2009	1 April 2008
	£	£	£
Balances with other central government bodies	6,601	25,895	4,062
Balances with local authorities (business rates)	91,517	77,358	73,689
Total intra government balances	98,118	103,253	77,751
Balances with bodies external to government	121,991	129,449	127,181
Total trade and other receivables	***220,109***	***232,702***	***204,932***

10. Cash and cash equivalents

	31 March 2010	31 March 2009	1 April 2008
	£	£	£
Balance at 1 April	87,646	142,886	68,621
Net changes in cash and cash equivalent balances	214,516	(55,240)	74,265
Balance at 31 March	302,162	87,646	142,886
The following balances at 31 March were held at:			
Government Banking Service	290,548	907	15,696
Commercial banks and cash in hand	11,614	86,739	127,190
Balance at 31 March	302,162	87,646	142,886

11. Trade payables and other current liabilities

Amounts falling due with one year:

	31 March 2010	31 March 2009	1 April 2008
	£	£	£
Trade and other payables	37,485	4,489	69,584
Taxation and social security	27,193	28,667	24,404
Corporation tax	–	110	–
Accruals	96,256	124,371	77,243
Total trade and other payables	***160,934***	***157,637***	***171,231***

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

Intra government balances

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

	31 March 2010	31 March 2009	1 April 2008
	£	£	£
Balances with other central government bodies	35,557	55,148	68,263
Total intra government balances	35,557	55,148	68,263
Balances with bodies external to government	125,377	102,489	102,968
Total trade and other payables	***160,934***	***157,637***	***171,231***

12. Provisions for liabilities and charges

	£
Balance at 1 April 2008	142,210
Arising during the year	3,129
Balance at 31 March 2009	145,339
Arising during the year	20,822
Balance at 31 March 2010	**166,161**

The closing balance relates to estimated decommissioning costs which are expected to fall due at the conclusion of the lease for office accommodation at First Floor, 11 Strand, London, WC2N 5HR. This lease expires in December 2010.

The cost of decommissioning the accommodation at the conclusion of the lease was independently reviewed by GVA Grimley Chartered Surveyors in January 2008. This dilapidations report was reviewed by Drivers Jonas, CHRE's new estates advisors, in March 2009. Further to this subsequent review, no change was made to the provision as at 31 March 2009, other than an inflationary uplift.

A further review by Drivers Jonas was concluded in February 2010 resulting in an additional decommissioning provision of £17,625 and a further inflationary uplift of £3,197.

The provision as at 31 March 2010 is at the higher end of a range of estimated potential liabilities identified by Drivers Jonas in their February 2010 report ie £141,000 to £176,000, excluding any potential landlord claim for loss of rent. The negotiation of any dilapidation liability is inherently complex and the ultimate settlement value cannot be determined in advance with certainty.

13. Contingent liabilities

Two High Court cases, under CHRE Section 29 powers, were undecided at the year end. There was therefore uncertainty on the financial consequences until a final judgement is made. Judgement 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.

14. Capital commitments

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

15. Commitments under leases

Operating leases

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

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

Buildings	31 March 2010	31 March 2009
	£'000	£'000
Not later than one year	168	255
Later than one year and not later than five years	–	168
Total commitments under operating leases	***168***	***423***

Finance leases

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

16. Losses and special payments

There were no material losses and special payments in the year (2008/09: none).

17. Related party transactions

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

The Department of Health is regarded as a related party. During the year to 31 March 2010 the Department of Health provided total grant in aid of £2.254m (2008-09: £2.1m).

CHRE received funding contributions towards its activities in the year from the devolved administrations in Northern Ireland (£0.095m), Scotland (£0.238m), and Wales (£0.136m). In 2008/09 CHRE received £0.057m from Northern Ireland, £0.218m from Scotland and £0.125m from Wales.

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

CHRE maintains a register of interests for the Chair and Council members which is available on the website. On a periodic basis the register is updated by the Executive Secretary to reflect any change in Council members' interests. During the period ending 31 March 2010 no Council member undertook any related party transactions with CHRE.

The senior management team is also asked to disclose any related party transactions. During 2009/10 there were no disclosures.

18. Events after the reporting period

There are no material post statement of financial position events.

The accounts have been authorised for issue on 28 June 2010 by the Accounting Officer.

19. Financial instruments

Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had in creating or changing the risks CHRE has faced in undertaking its activities.

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

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

Currency risk

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

Interest rate risk

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

As at 31 March 2010 CHRE had a non-interest bearing cash balance of £290,648 (2008/09: £1,007) and a cash balance of £11,514 (2008/09: £86,639) generating a floating interest rate.

Credit risk

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

Liquidity risk

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

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