Inspecting Informing Improving

Healthcare Commission

Annual report 2006/2007

Improving healthcare for patients through the annual health check

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The Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way in which they work.

In Wales, the Healthcare Commission's role is more limited. It relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare. In this work, we collaborate closely with the Healthcare Inspectorate Wales and the Wales Audit Office.

What we do

Inspecting
To inspect the quality and value for money of healthcare and public health.

Informing
To equip patients with the best possible information about the provision of healthcare.

Improving
To promote improvements in healthcare and public health.

How we work

We work closely with patients, carers and the public to maintain our focus on improving their experiences of healthcare.

We promote the right of everyone to have opportunities to improve their health and to receive good healthcare.

Our approach to assessing healthcare is based on the best available evidence and aims to encourage improvement.

We work in partnership to ensure a targeted and proportionate approach to audit and inspection.

We work locally, to build relationships and gain intelligence about the quality of services throughout England.

We are independent and fair in our decision-making and report what we find impartially and honestly.

We are accountable for our actions and for what we achieve in relation to our costs.

Making a difference for patients and the public

Highlights of 2006/2007

• We delivered the first results of a brand new system of assessment for the NHS, the annual health check – a far more comprehensive, tougher approach than the 'star ratings' system it replaced.

• We launched a website giving the results of cardiac surgery throughout England and in some areas of Wales.

• Our investigations into healthcare associated infections helped lead to stronger implementation of a statutory code on hygiene for trusts; our investigation into services for those with learning disabilities led to the first national audit of such services; and another of our investigations led to a national audit and survey of maternity services, with the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists.

• We closed 10,000 cases of second-stage complaints about NHS healthcare, and used what we learned from them to foster better complaints-handling by trusts and to tackle the common themes of patients' concerns.

• We published our assessments of the NHS and independent healthcare sectors in a way that was accessible to patients for the first time.

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Foreword

Patients, the public and policy-makers expect an independent regulator of healthcare to play a leading part in ensuring that such care is safe and of the appropriate quality. They also expect it to carry out this work efficiently and cost-effectively. So how did we measure up in 2006/2007?

In October 2006, we delivered the first results of a brand new system of assessment of the NHS, the annual health check. It is a tougher, more comprehensive approach than our old system of 'star ratings'. We found there was much to celebrate in the performance of many trusts, but also room for improvement. In the next annual health check we will be looking for progress and we are sure that trusts share this aim.

Where there are serious failures in a service, we investigate. During the year, we published reports of our investigations into the services provided for people with learning disabilities by two trusts. The lessons learned through our investigation of outbreaks of *Clostridium difficile* at a trust in Buckinghamshire were among the factors leading to stronger implementation of a statutory code on hygiene in the NHS. These investigations will have a significant impact on the care of patients in England by prompting action nationwide.

Our responsibilities for the safety of patients were extended in 2006/2007. We are now required by law to enforce regulations relating to the hygiene code, controlled drugs and ionising radiation. We put safety at the centre of our assessments for the annual health check, and launched a charter to make it the first priority of everyone involved in delivering or commissioning healthcare.

The annual health check relies on the smart use of information about healthcare rather than visits and inspections. We now place the onus on trusts' boards to tell us how they are performing, then check what they say against a range of other information, including patients' views. We only inspect trusts that are at the greatest risk of not meeting core standards, plus a random selection of all other trusts. We believe that our new system is 'light touch' and proportionate, and welcome feedback from all those affected by it so that we can continue to improve it.

Our publication of information based on our assessments is vital to promote improvements in healthcare services and to give patients and the public comparative data in an accessible form. For example, in April 2006, we launched a website showing patients' survival rates at cardiac surgery units throughout England and in some areas of Wales, in conjunction with the Society for Cardiothoracic Surgery. We made sure that we involved patients and the public in the design of our website for the annual health check. In December, we launched online information for the public about the performance of individual independent healthcare organisations.

We look forward to the opportunities the coming year holds for building on our achievements in 2006/2007, and to being able to report further significant progress in promoting improvements in healthcare in a year's time.

Professor Sir Ian Kennedy
Chair

Anna Walker CB
Chief Executive

Our year in brief

Here is a selection of the Healthcare Commission's achievements during the year from April 2006 to March 2007.

April 2006

- launched a website on outcomes of cardiac surgery with the Society for Cardiothoracic Surgery in Great Britain and Ireland

May 2006

- held regional workshops on the 2005 survey of NHS staff to help employers interpret local results
- published NHS trusts' declarations against core standards, as part of the first annual health check
- published results of 2005 survey of adult inpatients in NHS acute hospitals
- held events exploring ways of engaging patients and the public at our test sites in Leeds and Plymouth

June 2006

- published a national study of chronic obstructive pulmonary disease
- launched @ *the frontline*, an e-mail bulletin for clinicians

July 2006

- published report of our joint investigation with the CSCI into services for people with learning disabilities at Cornwall Partnership NHS Trust
- published report of our investigation into outbreaks of *C. difficile* infection at Stoke Mandeville Hospital

August 2006

- published investigation into the deaths of 10 women during or soon after maternity care at a hospital in west London
- published results of web-based audit of whether NHS trusts are promoting race equality
- published findings of the National Sentinel Organisational Audit for Stroke 2006, funded by the Healthcare Commission

September 2006

- published details of the design of the second annual health check
- launched investigation into outbreaks of *C. difficile* at Maidstone and Tunbridge Wells NHS Trust
- published results of review of adult community mental health services with the CSCI
- published results of survey of users of community mental health services
- staged 10 regional events briefing trusts on how their annual health check ratings would be published online, and six regional events to share learning on handling patients' complaints

October 2006

- published NHS trusts' performance ratings in the first annual health check on a dedicated website
- published report of national review of NHS hospitals' management of admissions
- published the *State of Healthcare* report for 2006
- launched a national poster and leaflet campaign about our work to raise awareness among patients and the public
- hosted annual conference of International Society for Quality in Health Care, in London

November 2006

- published report of national review of healthcare in the community for young offenders, with Her Majesty's Inspectorate of Probation
- published report on variations in patients' experiences of healthcare, as influenced by age, ethnicity and disabilities

December 2006

- launched detailed online information for the public about the quality of care provided by independent healthcare providers
- launched our Disability Equality Scheme and positive action plan
- published national report on review of substance misuse services in England with the National Treatment Agency for Substance Misuse
- launched consultation on our proposed fees for inspecting independent healthcare providers for 2007/2008
- published guidance for trusts on assessing progress with developmental standards as part of the annual health check in 2006/2007

January 2007

- published two reports on medicines management in acute and mental health trusts
- published report of investigation into services for people with learning disabilities provided by Sutton and Merton Primary Care Trust
- launched an investigation into services provided by Staffordshire Ambulance Service NHS Trust
- published a report of a national review of tobacco control services in England
- launched the first national audit of services for people with learning disabilities

February 2007

- published report on recurring themes in 16,000 complaints about NHS healthcare sent to us for independent review
- published report of a review of children's hospital services in England
- published report on preventing unintentional injury to children with the Audit Commission
- launched a national service review looking at 'dignity in care' in acute trusts
- held briefing events for third-party organisations due to comment on their local trusts' performance for the 2006/2007 annual health check
- launched survey of 50,000 women who gave birth in an NHS trust in England during February 2007
- hosted a conference with the National Patient Safety Agency, inviting partners to sign the joint 'Safety First' pledge

March 2007

- launched consultation on our proposals for the annual health check in 2007/2008
- published results of Count Me In Census covering England and Wales – a joint initiative with the Mental Health Act Commission and the National Institute for Mental Health in England
- published report of investigation into rates of mortality for heart surgery at Oxford Radcliffe Hospitals NHS Trust
- published results of the 2006 survey of NHS staff in England, and of a survey of the experiences of adult inpatients with benchmark reports for every acute hospital trust in England
- published reports of our reviews of imaging, endoscopy and pathology services in acute hospitals
- launched major review of maternity care in England in response to concerns raised during our earlier investigations

This year we published the performance ratings we awarded to each NHS trust in the country in the first annual health check. Our radical new system of assessment looks at what matters most to patients and takes account of their views when rating their local trust's performance.

Promoting a better experience of health and healthcare

Each year sees an increase in the number of patients receiving healthcare from a combination of NHS and independent providers. In 2006/2007 we made major advances in our work to ensure that the treatment and care provided by both sectors meet the required standards of quality.

The highlight of our year was on 12 October 2006, when we released the results of our first year of assessing the NHS using a radical new system called the annual health check. It is based on measuring what matters most to patients and provides a more comprehensive picture than ever before of how well each trust is performing. This achievement was made possible through the combined efforts of our staff, the boards and staff of NHS trusts, clinicians and groups representing patients and the public.

These were some of our key activities in 2006/2007:

The results of the first annual health check

The annual health check scores NHS trusts on many aspects of their performance and produces an overall annual rating for each organisation. This rating is made up of two parts – quality of services and use of resources. Unlike our previous 'star ratings' system, an annual health check rating is on a four-point scale of "excellent", "good", "fair" or "weak". On 12 October 2006, we released the first set of ratings under the new system, covering trusts' performance from 1 April 2005 to 31 March 2006.

The basis of our system is compliance with the Department of Health's 24 core standards, which describe a minimum level of performance that NHS trusts must meet. We asked the boards of all trusts in England to assess and declare their performance against the core standards. Patients and local authorities were asked for their views as well. We then cross-checked this local intelligence with the trusts' declarations, to make sure that our new approach was robust in practice.

To help minimise its impact on NHS front-line staff, the new system is risk-based. It gives us the information we need to be able to target trusts that are at risk of not meeting the core standards, rather than inspecting every trust in England. In the first annual health check, we found that around 12% of trusts needed risk-based inspections. We also visited another 12% – selected at random – to check that the system was working as intended.

> *"Patients will want the NHS to raise its game still further. They need a universal guarantee that trusts are meeting general standards. These are things that really matter to patients. We expect these standards will be met next year."*
>
> **Professor Sir Ian Kennedy**
> Chair, Healthcare Commission

What the annual health check showed us

The results showed that of the 570 NHS trusts in existence during 2005/2006, many had performed well. On the new four-point scale, 36% were rated "good" and 4% were rated "excellent" for their quality of services. In addition, 15% of all trusts were rated "excellent" or "good" for their use of resources. We commend the success of these trusts in the first year of our tougher, more comprehensive approach to assessment.

Just over half of the trusts (51%) received a score of "fair" for quality of services, showing a need to improve in some areas. About 9% of trusts received a score of "weak", indicating more serious problems.

Nearly half of all trusts (47%) were rated "fair" for use of resources. Over a third of trusts (37%) were rated "weak" – almost all of whom failed to meet their financial targets for 2005/2006.

We were encouraged by the number of trust boards (43%) that acknowledged that they had a problem by declaring that they had not complied with one or more core standards. These standards tended to be:

- challenging discrimination, promoting equality and respecting human rights – 9% declared non-compliance
- keeping patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely – 7% declared non-compliance
- having a systematic and planned approach to the management of records – 20% declared non-compliance

An important aim of the annual health check is to make the results useful and accessible to everyone who uses or works in NHS services. We launched the results through a dedicated website which allows patients and the public to search for their local trust, see how we rated it, and view a range of supporting information, including comparisons with other NHS trusts nationwide.

> *"We have shone a bright light on trusts' declarations of compliance with core standards. The results suggest that it has been a good first year for a risk-based, proportionate approach to regulation."*
>
> **Anna Walker**
> Chief Executive, Healthcare Commission

The way forward

In January 2007, we received the results of an independent evaluation that we had commissioned to find out how well trusts thought the annual health check compared with the 'star ratings' system it replaced. The study focused on the need for trusts to assess and declare their compliance with core standards – a requirement that did not exist under the old system but forms a major part of the annual health check.

Starting in November 2005, the research followed trusts' experiences through each stage of the assessment cycle, from a pilot draft declaration at the end of October 2005 to the final declaration in May 2006 and our release of their performance ratings in October 2006. The researchers interviewed 132 trusts, invited 227 to complete a two-stage questionnaire, and carried out 12 in-depth case studies among different types of trusts.

Among the 58 trusts that responded to the final questionnaire, the general view was that the annual health check was an improvement on the previous 'star ratings' system. Thirty-four of them said that the new system was either "better" or "much better". Many trusts reported that the assessment had triggered activity to improve their governance systems, prioritise and address areas of poor performance and renew their focus on quality and safety. However, 60% of trusts thought that the assessment of core standards was more time-consuming than the previous system of 'star ratings'.

This independent evaluation provided us with valuable learning, which we drew on – together with the results of our own evaluation and consultation – when developing the assessment framework for the next annual health check.

"For us it gives a sense of achievement in looking at how far we have come; people were starting to say 'this is quite good for us because we've never had to look at it in terms of quality'. We just looked at it in terms of performance or financial standing or whatever."

Primary care trust, South West Region

Driving improvements in the NHS

During 2006/2007, we published the results of seven service reviews. These reviews looked at particular areas of healthcare and public health, to assess trusts' current performance and indicate ways they can improve the quality and value for money of their services.

Services for substance misuse: this joint national review was carried out with the National Treatment Agency for Substance Misuse (NTA). We found that drug treatment services are getting better and most people in treatment believe services are improving, but highlighted variations in the quality of care across England.

Services for children in hospital: this review showed that 25% of trusts were providing "good" or "excellent" care and making progress on providing child-friendly environments. However, only 70% of trusts achieved an overall score of "fair". Many were not providing sufficient training for staff about children's needs in areas such as life support, assessing pain, child protection, communication and play.

Services for specialist adult community mental health: this joint review with the Commission for Social Care Inspection (CSCI) showed generally good performance, although there was room for improvement in access to talking therapies, availability of out-of-hours crisis care, race equality, better information for people who use services, how medicines are managed and physical health checks for patients with schizophrenia.

Services for tobacco control: this review showed that primary care trusts in the more deprived areas of England are providing the best approach to reducing smoking levels, working in partnership with the public and local agencies.

Management of admissions: our findings included a marked reduction in the number of patients requiring admission who spent more than four hours in A&E departments and in waits for admission from waiting lists, but 20% of patients had to share facilities with patients of the opposite sex.

Medicines management: compared with 2001, pharmacists are more actively involved in caring for patients as well as dispensing medicines. However, only 14% of wards in mental health trusts received more than five hours of time from clinical pharmacy staff per week, compared to 64% in acute and specialist trusts.

Diagnostic services: this review covered imaging, endoscopy and pathology services. It showed substantial reductions in waiting times for tests despite growth in demand for all three services. But for services such as imaging, the speed of reporting results had not improved and many endoscopy services were not being monitored for effectiveness, whereas in pathology services the length of opening hours and speed of reporting results had improved.

During the year, we funded a survey on women's experiences in maternity care with the Department of Health and the Information Centre for Health and Social Care. The survey was carried out by the National Perinatal Epidemiology Unit.

We also started preliminary work on a survey of every woman in England who gave birth during February 2007 in an NHS trust. This is the largest survey of its kind, asking up to 50,000 women about their experiences of NHS maternity care.

In 2007 we began a major review of maternity care services in England, in response to concerns raised by two investigations we conducted in 2005/2006.

It will build on the findings of the two surveys and learning from our investigations to improve outcomes for mothers, their babies and their families.

Working with services for children

Joint area reviews (JARs) assess the contribution made by local authorities and their partners towards improving outcomes for children and young people, against the key outcomes for childhood and later life set out in the Government's Every Child Matters: Change for Children programme. These outcomes are that children are healthy, safe, enjoy and achieve; make a positive contribution, and experience economic wellbeing.

We carried out around 70 JARs with nine partners. We found that organisations are striving to plan and deliver services in a more coordinated way, and many have initiated joint projects to improve the health of children and young people. However, inequalities still exist. We have therefore changed the way in which we carry out JARs, to focus more closely on the experiences of children who have the poorest outcomes, including those with disabilities and those looked after by local authorities. Safeguarding children remains a priority.

Public health and long-term conditions

In 2006/2007 we developed an action plan setting out how the Healthcare Commission will promote the prevention of ill health and the reduction of inequalities in health and healthcare. We also produced reports for every regional director of public health in England on their region's performance in these areas and as regards response to incidents and emergency situations.

We ran a series of conferences aimed at chief executives of acute and mental health trusts, primary care trusts and ambulance trusts; directors of public health; directors of commissioning and performance, and senior clinicians. The aim was to assist NHS trusts in understanding their role in delivering the public health agenda and sharing good practice. Representatives of over 100 organisations attended the conferences.

In July 2006 we published a national study of chronic obstructive pulmonary disease (COPD), the first in our series of reviews of services for major long-term conditions. COPD is the term used to describe a range of chronic chest conditions, including chronic bronchitis and emphysema. It is an incurable but largely preventable long-term condition. COPD is now the fifth most common cause of death in the UK, killing more than 27,000 people a year. Around 85% of these deaths are smoking-related.

Our report concluded that more accurate diagnosis and a more structured approach to care for those suffering from COPD would improve their quality of life and be more financially effective for the NHS.

Given the link between smoking and a wide range of public health concerns, we chose tobacco control as the subject of one of our first service reviews in 2006/2007 (see page 14).

Surveys of patients and staff in the NHS

Our national programme of surveys is the largest project of its kind in the world and the single largest source of evidence for the annual health check. It provides a third of the data that we use to cross-check trusts' declared performances.

Surveys during 2006/2007 included those of people using community mental health services, emergency and elective hospital inpatients, and patients using independent sector treatment centres. We also commissioned the largest-ever national survey of people with diabetes, and co-funded with the Department of Health and the Information Centre a national survey of women using maternity services – the first in 10 years. Overall, more than 180,000 people took part in these surveys.

In addition, we asked people who had been inpatients to rate the importance of different aspects of the care they received. The findings will directly influence the approach we take when designing surveys in the future.

In October 2006, we undertook a fourth national survey of NHS staff. The response rate was 53% – more than 128,000 staff in 326 trusts gave their views and experiences of working for the NHS in England. This series of surveys provides trusts with information they can use to improve working conditions and practices, resulting in higher quality of care for patients.

The Healthcare Commission runs its programme of surveys with the help of four independent centres: the acute coordination centre (Picker Institute Europe), the mental health and long-term conditions survey co-ordination centres (National Centre for Social Research) and the NHS staff survey advice centre (Aston University). This year we have been looking at how we can encourage more people from black and minority ethnic groups to participate, and ways of helping NHS trusts make better use of the findings of our surveys of their patients.

> *Independent research shows that the NHS values the information they gain through our survey programme, particularly the regular repetition of the research and its usefulness for external benchmarking. As one trust told us in 2006/2007: "We have nothing else that is so sophisticated and would give us such useful data."*

Regulating the independent healthcare sector

This year we asked providers, for the first time, to assess whether they were meeting the Government's core minimum standards and declare the results to us. Our regional teams then carried out a risk assessment of each declaration to determine whether the organisation needed to be inspected in 2006.

Overall, performance against the core national minimum standards was strong. The results for acute and mental health services combined showed that more than 90% demonstrated that they were meeting the majority of the 32 standards for the independent sector. However, 16% of mental health services failed to show compliance with five or more of the standards, particularly those relating to safety, such as having robust processes for recruiting and training staff. Where significant problems were found, our regional teams asked the providers to develop an action plan for improving their performance.

Reduced costs through regulatory changes

Our statutory responsibilities for regulating the independent sector are determined by the Care Standards Act 2000 and associated regulations. Until 2006 we were required to inspect all registered providers each year. Since 1 April 2006, however, we have the discretion to decide how often each provider needs to be inspected, up to a minimum of once every five years.

At the beginning of the financial year, 2,041 independent healthcare establishments were registered with us. We inspected 1,183 of them – selected because we had concerns about them or not enough information to be able to decide not to inspect. The associated reduction in our costs has enabled us to develop and consult providers on a new fees scheme for 2007/2008 which involves lower annual fees for most categories of provider.

In December 2006, we launched a web information service about the performance of independent acute hospitals, mental health units and independent sector treatment centres, aimed at patients and the general public.

Engaging with patients and the public

We constantly seek to engage with patients and the public to achieve a better understanding of what matters to them, and gather more sensitive information about how they experience healthcare services. This helps us to drive improvements in healthcare for the benefit of everyone.

Here are some of the ways we have worked with patients and the public in 2006/2007:

Focusing on what matters to patients
We ran a series of workshops with national voluntary organisations that represent patients, inviting feedback on our proposed design for the annual health check in 2007/2008. The focus was on NHS trusts' performance against the core standards that relate to the safety of patients and how information about their services is presented to the public. Other discussions with the public highlighted four areas of particular interest to them: the safety of patients; reducing inequalities in health; the quality of, and access to, services; and how well trusts use their resources and provide value for money.

Healthcare associated infection and acute inpatient mental health services were among the topics we brought patients and NHS staff together to discuss at other events. In our engagement work we make sure to include those whose voices are least likely to be heard and who often have difficulty gaining access to good healthcare. For example, when carrying out an audit of services for people with learning disabilities in early 2007, we provided training for service users so that they could take part as peer reviewers.

Learning about patients' experiences
We continuously gather intelligence about people's experiences of healthcare services, to feed into our assessments and ratings of the service providers. Patient and public involvement forums, overview and scrutiny committees, and lay members of the boards of foundation trusts all commented on their trusts' compliance with core standards in our first annual health check.

During the year we worked with community-based groups in our test site areas in the north and south west of England, so that we can be sure our engagement work meets the needs of the public. And to ensure that our corporate communications give people the information they want, in a style and format that they find accessible and engaging, we set up a consultative panel including patients and members of the public, clinicians and NHS managers. We held the first focus groups with the panel in late March, at which they provided valuable feedback to help us improve our corporate and annual health check websites.

Assessing how NHS trusts engage with the community
Our assessment activities include looking at how well NHS trusts involve patients, carers and the public in their work. In 2006/2007 we developed some principles to guide trusts in this increasingly important area.

Developing relationships with clinicians

In 2006/2007 we replaced our high-level advisory group on clinical strategy with a range of flexible mechanisms for two-way communication with clinicians. These include a 'virtual' panel of clinicians whom we consulted on a range of issues including ambulance services and psychotherapy, and a consultative panel set up to provide feedback on our print and web communications.

The National Clinical Audit and Patients' Outcomes Programme funded more than 20 projects in a wide range of disciplines, including cancer, heart disease, mental health, older people and long-term conditions. Defined and led by clinicians, the projects are managed under contract by bodies such as the Royal Colleges. They look at what happens to individual patients, with the focus on quality of clinical care. We reported on nine audits this year, some of which showed improvements for patients over time. For example, the number of specialist stroke units, associated with better survival and rehabilitation, is increasing and more heart attack patients are receiving care more quickly.

Our work in Wales

In Wales, responsibility for inspecting and investigating NHS organisations and the independent sector rests with the Healthcare Inspectorate Wales (HIW). Our statutory functions in Wales include:

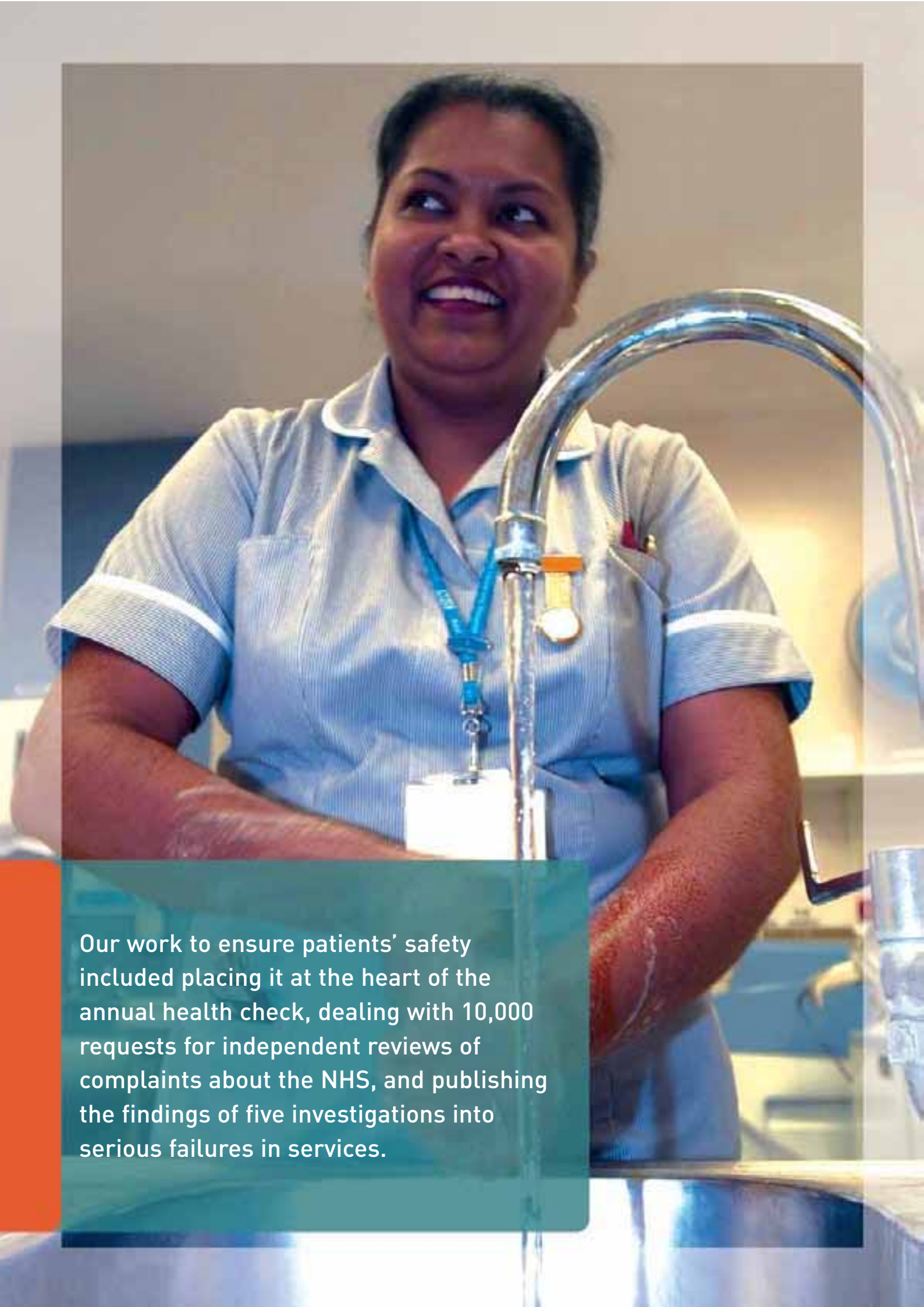
- including relevant information about Wales in our yearly report on the state of healthcare
- national reviews in England and Wales
- working with the HIW to ensure that relevant cross-border issues are managed effectively

In 2006/2007, NHS trusts in Wales continued to take part in our programme of national clinical audit. We have also worked closely with the Wales Audit Office, who maintain the acute hospital portfolio in Wales.

During the year we shared learning from our work in England with the HIW, other Welsh reviewing bodies and the Welsh Assembly Government. Topics include public health (substance misuse and control of tobacco), learning disabilities, maternity services, safeguarding (learning from serious case reviews) and ambulance services. This shared learning has informed a review of maternity services carried out by the HIW, and the development of policy on substance misuse in Wales.

The Healthcare Commission is a signatory of the Concordat between the bodies that inspect, regulate and audit health and social care in Wales. The HIW led the implementation of the Concordat and, as we led the implementation of the equivalent concordat for England, we provided our experience and expertise during the process. We also provided support for the development of an online facility for scheduling signatories' reviews, which was launched in November 2006.

We completed a consultation on our Welsh Language Scheme, which sets out how we will treat the English and Welsh languages on a basis of equality when providing services to the public in Wales. The Welsh Language Board approved the scheme in March 2007.



Our work to ensure patients' safety included placing it at the heart of the annual health check, dealing with 10,000 requests for independent reviews of complaints about the NHS, and publishing the findings of five investigations into serious failures in services.

Safeguarding the public

The safety of patients and the public, in hospitals and other healthcare settings, is a major priority for the Healthcare Commission. Through the annual health check, we monitor policies and practices in all NHS trusts to minimise risks to patients. If serious failures occur, we take action to identify the cause of the problem and to ensure that the organisation involved makes the necessary improvements.

Healthcare associated infections are now an issue of particular concern and were the subject of two of the investigations and a study that we carried out during the year. As with all our work, we aim to highlight lessons from which other providers can learn to help ensure patients' safety in the future.

These were some of our key activities in 2006/2007:

Investigations and interventions

During 2006/2007, our investigations team received 102 requests to investigate from a wide range of sources, including patients, NHS staff and other organisations.

Trusts are usually quick to cooperate and to accept the need for improvement. In these cases we intervene to verify that agreed improvements are carried through. However, if we believe that a trust is not going to take action as required, we may decide to carry out a full investigation.

During the past year we have published five reports following major investigations. At the end of each investigation we ensure that the trust prepares an action plan showing how they will carry out our recommendations. We then return to the trust periodically to review its progress until we are satisfied that the necessary improvements have been made.

Investigations we reported on in 2006/2007
In 2005, the Secretary of State for Health asked us to investigate two outbreaks of *Clostridium difficile* at Stoke Mandeville Hospital, part of Buckinghamshire Hospitals NHS Trust. Overall, 334 patients contracted the infection while in the hospital, and at least 33 people died in the outbreaks which took place between October 2003 and June 2005.

We found serious failings on the part of senior managers at the trust, who had failed to follow advice from their own infection control staff, clinicians, nurses and the Health Protection Agency. Our report also noted shortcomings in the way that other NHS trusts in England control healthcare associated infections and manage significant outbreaks. We called for all hospitals to review their procedures urgently and ensure their effectiveness in this vitally important area.

In September 2006 we began another investigation into two outbreaks of *C. difficile*, at Maidstone and Tunbridge Wells NHS Trust in Kent. We will publish our report in autumn 2007.

At the end of March 2007 we reported on our investigation into mortality rates for heart surgery at the Oxford Radcliffe Hospitals Trust, following doubts raised about the trusts' performance over a number of years. We found that the mortality rates were within acceptable statistical limits, but that the cardiothoracic surgical unit lacked the key components of a high-quality service and needed to make improvements if it were to regain its reputation as a centre of excellence.

In August 2006, we published the report of our investigation into the deaths of 10 women who died in pregnancy or within 42 days of giving birth at Northwick Park Hospital, west London, between April 2002 and April 2005. Our report, which aimed to identify if there were common factors between the deaths, showed what can happen when a maternity unit has inadequate systems to protect the women it cares for. Our findings have prompted the inspectorate to renew its call for NHS trusts to check that they have robust systems for monitoring the safety of maternity units.

We also published reports on investigations at two trusts into the quality of care provided to people with learning disabilities. The first of these, carried out with the Commission for Social Care Inspection, was at the Cornwall Partnership NHS Trust. We found many years of abusive practices and the failure of senior executives to act appropriately. Although a number of staff were found to be caring and well intended, they were not working in accordance with best practice.

There was also an over-reliance on medication to control people's behaviour, as well as illegal and prolonged use of restraint. Concerns were also raised about the legal basis for the provision of care, the management of the service, its governance arrangements and the lack of positive engagement of families and carers.

Our report after our investigation of the Sutton and Merton Primary Care NHS Trust highlighted how outmoded, institutionalised care led to the neglect of people with learning disabilities and the impoverished, completely unsatisfactory environments in which some of them lived. There were failures in management and leadership at all levels, from managers to the trust's board. We recommended an action plan that included increasing the volume and range of activities for people with learning disabilities, reviewing skills and training in the workforce, and developing plans that were centred on the individual.

Following these investigations, the Healthcare Commission decided to carry out a national audit of services for people with learning disabilities and to involve service users in the audit process (see page 33).

Our work in the independent sector

The majority of independent healthcare providers ensure that their governance and managerial systems are robust and work with us to achieve high standards of care and treatment for their patients and the public. Should we require a provider to improve their services and they do not do so, we have a number of options for ensuring their compliance, including serving a statutory notice, prosecution or cancelling their registration with us.

In October 2006 we successfully prosecuted the owners and manager of an unregistered laser service. Inspectors from our London and south-east region found that laser treatments, including hair removal, skin peeling and tattoo removal, were being provided using a class 3B or 4 laser without registration and safety checks, which is an offence under the Care Standards Act 2000.

We also found that services had been delivered by staff who had no proper training and in the absence of a laser protection advisor and expert medical advisor.

The owners pleaded guilty to carrying on and/or managing an establishment that is required to be registered. They were fined £21,000 and ordered to pay the Healthcare Commission's costs of £9,000, making a total in fines and costs of £30,000.

Reviewing complaints about the NHS

If a patient makes a complaint to a trust about its services and is not satisfied with the trust's response, the Healthcare Commission is responsible for carrying out an independent review of the complaint. This happens in about 8% of the 95,000 formal complaints made each year about NHS healthcare.

When we first took on this role in 2004, we received an unexpected number of these 'second-stage' complaints to review. To cope with the high volume of work created, we increased the number of staff in our complaints team to more than 150 in 2006/2007. During the year the team completed almost 10,000 reviews of complaints. It reduced the number of reviews that take longer than 12 months to complete, from 767 in April 2006 to 424 at the end of March 2007. By the end of summer 2007, we expect to meet routinely our target of closing 95% of cases within 12 months.

We found that around half of the cases we reviewed had merit and that in around one-third of cases the trusts could have done more to help resolve the complaint.

In February 2006, we published *Spotlight on Complaints*, a report on the recurring themes in the 16,000 complaints sent to the Commission between July 2004 and July 2006. We found that 22% of them concerned safety issues raised by patients or their families.

Our report showed that many trusts were not dealing with patient's complaints effectively. We therefore launched a national audit of complaints-handling by NHS trusts in early 2007. Their performance in the audit will be reflected in the annual health check for 2006/2007.

Handling concerns about independent healthcare providers

The Healthcare Commission has no statutory remit for handling second-stage complaints about independent healthcare providers. However, if we are sent an adverse comment or concern about a registered provider, we use the information to support our role of assessing whether Government regulations are being breached. If we consider that a provider may be breaching regulations, we ask them to provide explanatory information or we conduct an inspection visit. If serious safety or quality issues are brought to our attention, we act promptly to safeguard patients and the public.

During 2006/2007 we received 312 adverse comments or concerns about registered providers.

> *"Complaints represent the raw feelings of patients, and the NHS must listen and learn from them. At the centre of each one is an individual who often has genuinely suffered. Too often, this was not just because of what went wrong but because of the way people have been dealt with."*
>
> **Anna Walker**
> Chief Executive, Healthcare Commission

Healthcare associated infection

Healthcare associated infection continued to be an area of particular concern for patients and the public in 2006/2007.

This is a particularly challenging area for trusts, and one in which many need to make major improvements if they are to meet the Government's target of halving the MRSA infection rate by 2008. Trusts' performance against this target – and against the Government's other targets for health – is part of the annual health check.

In October 2006, the Health Act 2006, Code of Practice for the Prevention and Control of Health Care Associated Infection – the hygiene code – came into force in England. We have both a duty to assess compliance and the power to issue improvement notices and to recommend sanctions for trusts who do not meet the code's requirements.

In February 2007 we introduced a new inspection programme, in which trusts' compliance with the hygiene code will be assessed not only as part of the annual health check, but also throughout the year. Our regulation of the independent sector in this area will also change, as the Government proposes to amend the national minimum standards to reflect the requirements of the hygiene code.

Safer management of controlled drugs

The Healthcare Commission works with healthcare providers and regulatory bodies to share information and concerns relating to the misuse or diversion of controlled drugs.

Since 1 January 2007, healthcare providers are required to appoint an accountable officer for controlled drugs, whose details we publish on our website. During the past year we have worked with the Department of Health to deliver training for these accountable officers. Our staff have also been engaging actively at a local level to support the development of the new Local Intelligence Networks led by primary care trusts.

In 2006/2007 we further developed the terms of reference of the National Group for Controlled Drugs Regulation, whose members include the Healthcare Commission, the Commission for Social Care Inspection, the Home Office, the Royal Pharmaceutical Society of Great Britain, the police service, and the NHS Counter Fraud Security Management Service. The aim of the group is to enable the member organisations to work collaboratively to ensure that the Government's new procedures for regulating controlled drugs are introduced effectively.

Ionising Radiation (Medical Exposure) Regulations 2000

In November 2006, the Ionising Radiation (Medical Exposure) (Amendment) Regulations transferred responsibility for the enforcement and inspection – both of compliance and in response to reported incidents – from the Department of Health to the Healthcare Commission. The regulations cover the NHS and independent sector, and lay down measures to protect individuals against the dangers of ionising radiation in "doses greater than intended". We received 113 notifications of incidents up to 31 March 2007 – 80 of which related to diagnostic procedures – and will be using the information to inform and improve services.

We have developed a web-based notification form for reporting and collecting data about incidents. Our dedicated radiation team has established a clear methodology for triage of notifications and carrying out reactive inspections. Next year we plan to carry out a risk-based programme of proactive inspections to test healthcare providers' compliance with the regulations, led by our specialist inspector and involving trained regional staff.

Information of the right type, in the right format, is the key to enabling people to make informed decisions about healthcare and to driving improvements in services. This year we published a wider range of information than ever before, consulting patients and the public to make sure we presented it in ways they found accessible.

Providing authoritative, independent and relevant information

Our work generates a huge amount of authoritative and unbiased information about healthcare. One of our most important tasks is to ensure that this material is made available so that people can use it to make informed decisions about their own healthcare, and healthcare organisations can use it to make improvements in their services.

We place great emphasis on presenting this large volume of diverse information in ways that can be accessed and readily understood by a range of audiences. Our reputation as a trustworthy, independent source of useful information is crucial to turning our vision of risk-based regulation into a reality.

These were some of our key activities in 2006/2007:

Making useful information accessible

We are committed to publishing truly accessible information. This includes the physical format of the information, and the style and tone of language used. We are corporate members of the Plain English Campaign, and provide our publications in a range of alternative formats including Braille, audio, large print or different languages.

In 2006/2007, we set up a nationwide consultative panel comprising members of the public, clinicians and NHS managers, to review the accessibility and usefulness of our information products. The panel monitors our website and publications for general readability, ease of use and relevance, and is helping us to develop good practice in producing and communicating information.

Our publications

During 2006/2007 we published five reports on our investigations into serious failures of healthcare and 18 reports on national reviews, surveys and studies. We also published three consultation documents and a range of guidance for NHS trusts and 'third-party' participants on the annual health check process. This year we produced four public information leaflets – a brief snapshot of our work, information on requesting a review of a complaint about NHS healthcare, and two booklets on making safe choices about cosmetic surgery.

Everything we publish is available on our website, both to increase accessibility and to help reduce the number of paper copies that we need to produce. Our publications can be obtained in print and alternative formats free of charge by calling the Healthcare Commission helpline on 0845 601 3012.

State of Healthcare report

One of the Healthcare Commission's statutory duties is to report annually to Parliament and the National Assembly for Wales on the provision of healthcare in England and Wales. Our *State of Healthcare* report brings together the results of all our assessments, surveys and audits throughout the year, to form a national picture of how healthcare is made available to patients and the public, and the quality of care they are receiving.

In October 2006 we published our third *State of Healthcare* report. Its main message was that healthcare is improving and that most patients are positive about their experiences. However, there are still some major challenges, including the need for consistent action on safety and the provision of healthcare to those least able to look after themselves, such as people with learning disabilities and mental health conditions. We called for more action to ensure that people are treated with dignity and respect, and receive better quality information about their care. This year, for the first time, we included a review of how well independent healthcare providers performed against the Government's minimum standards for the sector in England.

Providing information online

Our website carries comprehensive information generated by our assessment work, surveys, investigations and reviews of complaints about NHS healthcare. Our challenge is to make this data available and easy to navigate for site visitors, who total more than 140,000 per month. We carried out extensive consultation with different audiences before launching a new website presenting the results of the annual health check in October 2006. We also introduced a new web service providing information to patients and the public about the performance of independent acute hospitals, mental health units and independent sector treatment centres.

> Another groundbreaking advance in online information has been the launch of our cardiac surgery website, in collaboration with the Society for Cardiothoracic Surgery in Great Britain and Ireland. The first of its kind, the site provides information for patients and the public about the quality of services in the NHS, and shows survival rates for each cardiac unit or surgeon in England and in some areas of Wales. It also presents helpful information about different types of cardiac surgery and what to expect after the operation. The presentation format was developed in consultation with patients and their representatives through the British Heart Foundation.

e-bulletins
Throughout the year we sent out a monthly e-mail bulletin to over 17,000 people who have asked to be kept informed of Healthcare Commission activities. We also sent monthly e-bulletins to the chief executives of all NHS trusts in England, keeping them in touch with our activities in their region and reminding them about the different stages of the annual health check process.

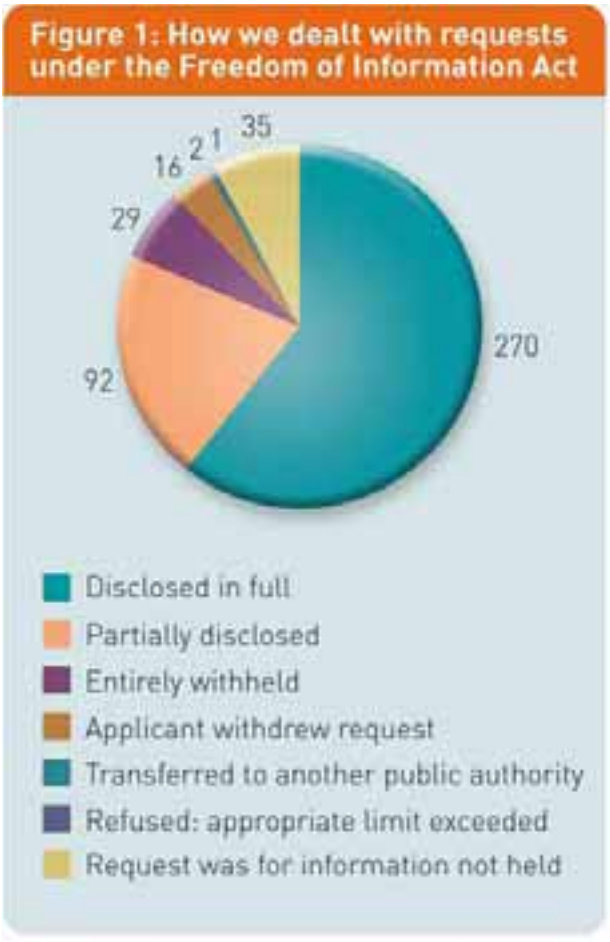
To keep parliamentarians and members of the Welsh Assembly informed about our work and key developments in healthcare regulation, we launched a quarterly bulletin for MPs. Another innovation during the year was @ *the frontline*, a quarterly bulletin for clinicians which is sent to over 1,000 subscribers. It keeps clinicians up to date with our work, gives information relevant for clinical practice and invites feedback and suggestions.

Statutory access to information

As a public sector body, we respect the right of people to request information about our activities that will give a better understanding of how we operate and the decisions we make. We welcome the opportunity to show that we work in an open and accountable way.

In 2006/2007 we dealt with and closed a total of 445 requests for specific information. Of these, 38% were made under the Freedom of Information Act 2000, 8% were subject access requests made under the Data Protection Act 1998, 47% were requests involving a mixture of the two regimes, and 8% were discretionary disclosures.

Figure 1: How we dealt with requests under the Freedom of Information Act



We continued our work to help ensure that everyone receives the healthcare they need, regardless of their circumstances or background. Not only do we embed the principles of equality, diversity and human rights in all our activities, but we also check that the organisations we regulate do so as well.

Focusing on inequalities, human rights and diversity

There are still inequalities in the healthcare that people have access to in this country. As part of our work to help reduce these, we make sure that all our activities reflect the principles of equality, diversity and human rights. Here are some examples of our work to promote awareness and implementation of these important principles in 2006/2007:

- an audit of 570 NHS trusts to check whether they had published a race equality scheme and other information required under the Race Relations (Amendment) Act 2000. The results of this audit contributed to our cross-checking of trusts' declared compliance with the core standards
- training for all our senior staff to implement a system of assessing the impact of our work on race equality
- we set up an equality schemes monitoring group, to track our progress against the positive action plans in our equality schemes

These were some of our other key activities in 2006/2007:

Our equality schemes

Race: In January 2006 we published our race equality scheme and an action plan setting out what we will do to further race equality in health and healthcare.

In addition to training senior staff in assessing the impact of our work in race equality during the year, we trained our regional assessment staff in the equality and diversity aspects of the Government's developmental standards.

Disability: The Disability Equality Duty came into force in December 2006, with the aim of promoting disability equality across the public sector. To fulfil our legal obligations as a regulator and an employer, we published a disability equality scheme and action plan. The plan sets out clear milestones, developed in partnership with disabled people and other key stakeholders.

Our public consultation about the scheme involved people who use NHS and independent healthcare services, healthcare professionals and providers, groups involved in promoting disability equality, and other inspectorate bodies.

Gender: During the year we developed our gender equality scheme and action plan, which was informed by several stakeholder events with women's groups, men's groups, transgender groups and users of mental health services. We published the scheme and action plan in April 2007.

During 2007/2008 we will be bringing together our race, gender and disability equality schemes into a single equality scheme, which will also encompass our responsibilities under legislation relating to age discrimination, sexual orientation and religion and belief.

Count Me In Census

The Count Me In Census 2006 was a joint initiative by the Healthcare Commission, the Mental Health Act Commission and the National Institute for Mental Health in England. The census is one of the three key building blocks of the Government's five-year action plan, *Delivering Race Equality in Mental Health Care*. It aims to provide accurate figures on the number of inpatients using mental health and learning disability services in England and Wales, captured on one day, and to encourage service providers to collect and monitor data on the ethnic groups of patients.

The census was conducted on 31 March 2006 and gathered information on 32,000 inpatients using mental health services and, for the first time, on those using learning disability services (4,600 inpatients).

Rates of admission in mental health services were lower than average among the white British, Indian and Chinese groups, but three or more times above average for black and white/black mixed groups. In the "other black" group, patients were overall 14 times more likely than average to be admitted (for men this increased to 18 times more likely).

Unlike mental health inpatients, no ethnic differences were observed for those detained on admission under the Mental Health Act 1983 in learning disability services.

Improving care for people with learning disabilities

During the year, we published reports of two investigations into the quality of care provided to people with learning disabilities at two trusts (see page 22). As a result of our findings from the first investigation, we decided to launch a national audit of such services. It looked at adult and specialist adolescent learning disability services, provided by the NHS and by independent service providers not registered with the CSCI.

The first stage of the audit involved collecting data by questionnaire from managers of individual units and senior management teams or boards. We used this data to select 160 individual services that included the best performing services, those that need most improvement and a random sample. In the second stage of the audit, which started in April 2007, small peer review teams visit these services. The teams include one person with a learning disability or a family carer, along with clinicians and managers who have been recruited and trained specifically for this role. We will report the audit findings in October 2007.

Dignity in care

During 2006, we responded to concerns about the treatment of older people in hospital by developing a project for assessing how well trusts are meeting the core standards that relate to 'dignity in care'. In addition to ensuring that these patients receive the right type and quality of food and help with basic needs such as eating or going to the toilet, 'dignity in care' refers to the attitudes and behaviours that staff adopt when interacting with them.

Using a risk-based approach, we selected 23 trusts for inspection, after which we notified nine of them about lapses in their compliance with core standards.

During this national study, we conducted workshops with older people and NHS staff and consulted with a number of partner organisations, including the British Geriatric Society, Royal College of Nursing, Age Concern and Help the Aged. The study report will be published in summer 2007.

We made further advances in our work to coordinate the activities of the many different bodies involved in reviewing healthcare. Together we aim to make regulatory processes as efficient and cost-effective as possible, and to minimise their impact on frontline NHS staff.

Taking the lead in coordinating and improving regulation

Although the Healthcare Commission carries a central, statutory responsibility for assessing and reporting on healthcare services, a number of other bodies are engaged in related activities. In 2004, we took the lead in trying to reduce the burden of regulation for frontline NHS staff by setting up a concordat between the different regulatory bodies that regulate, audit or review healthcare in England. In 2006, we made further progress in our joint efforts to reduce duplication of data collection and share information as effectively as possible.

These were some of our key activities in 2006/2007:

Expanding the Concordat

During 2006/2007 the UK Accreditation Forum joined the Concordat, bringing the number of signatories to 21. All of the signatories have developed detailed action plans, which have been published on the Concordat website (**www.concordat.org.uk**) along with information about their inspection activities and findings.

This year we agreed five measures of success for the Concordat and will report progress against them in next year's annual report:

- the Concordat will demonstrate increased coordination and collaboration
- signatories will adopt a risk-based approach to assessment
- the Concordat will demonstrate increased sharing of information and removal of duplication of information requests
- there will be an increased understanding among providers of healthcare that the Concordat has improved coordination and effectiveness of regulation
- signatories will demonstrate compliance with the Concordat objectives

Our regional teams are now developing ways of working with other regulators to maximise efficiency. During the year they brought key regulators together at a series of summit meetings on risk held around the country.

Working in partnership

Sharing information more effectively with other inspection bodies and healthcare organisations will improve our assessments and make our work more effective, resulting in huge benefits for patients – regardless of the type of organisation or sector they are treated in.

We have worked closely with the Commission for Social Care Inspection (CSCI), the Audit Commission and the National Audit Office in planning and implementing our national reviews and studies. This enables us to develop a collective view on the major risks and issues in health and social care, understand the challenges in supporting improvement, and work collaboratively on future national studies.

In response to the high number of recommendations made to healthcare organisations, we published a joint report that looked at youth offending teams (YOTs) in England and Wales with Her Majesty's Inspectorate of Probation and the Healthcare Inspectorate Wales. We led the healthcare element of the review, which highlighted a lack of adequate provision for young offenders.

Another joint publication reported on a review of services for substance misuse that we carried out with the National Treatment Agency for Substance Misuse (NTA). We have also been working with the NTA to establish a process to review services. We hope to deliver independent assessments of the quality of services to treat substance misuse in each drug action team area and facilitate improvements in key aspects of these services.

In June 2006, we ran a series of regional consultation events with the CSCI, to promote and support the delivery of palliative/end of life care. They were attended by more than 200 representatives of strategic health authorities, primary care trusts, local authorities and providers of specialist palliative care and care homes.

Other work with CSCI included publishing the report of the joint review of adult community mental health services, which assessed key services in local implementation team areas.

During early 2007, we worked with CSCI on five joint inspections of services for disabled and older people provided by councils and primary care trusts. The inspections looked at how well organisations were working together, including assessments of intermediate care services and progress towards the national service framework for long-term neurological conditions.

Working together with our colleagues in the Mental Health Act Commission (MHAC), we have begun to see real improvements for patients in specialist clinics. Having identified significant concerns at a clinic for eating disorders in Maidenhead, we organised a joint inspection that led to a change of leadership and a transformation in the clinic's culture. Similarly, after years of problems with absconders and non-compliance at an independent mental health medium secure unit in Milton Keynes, we have worked with police, social workers and MHAC to help the unit become a model for managing absconders.

We will continue to collect key information from trusts through the child health mapping project at Durham University. This is an example of using processes led by others to make regulation efficient and cost effective.

National Institute for Health and Clinical Excellence

This year saw us strengthen our strategic partnership with the National Institute for Health and Clinical Excellence (NICE). We are now represented on their topic consideration panels and have published a joint web statement about how Healthcare Commission assessments reflect implementation of NICE guidance. In February 2007, the Ministerial Industry Group recommended that the Healthcare Commission and NICE explore with the pharmaceutical industry how its information and insights can assist our monitoring of compliance with standards of quality.

Memoranda of understanding

During the year we concluded memoranda of understanding to underpin our working relationships with: the British Cardiac Society, the Commission for Racial Equality, the General Medical Council, Her Majesty's Inspectorate of Prisons, Her Majesty's Inspectorate of Probation, the Independent Police Complaints Commission, Monitor, the National Clinical Assessment Service, the National Patient Safety Agency and Ofsted. We also reviewed and refreshed our memorandum with the Healthcare Inspectorate Wales.

In February 2007, we published a joint study with the Audit Commission on preventing accidental injuries to children. This is a leading cause of death and illness among one to 14 year olds, and the most common reason for children to be admitted to hospital. The study looked at how partnerships across the NHS and local government are working to prevent unintentional injury, in order to share best practice with local bodies and influence policymakers.

This year we experienced the benefits of our new regional structure, including strengthened local relationships with NHS trusts and independent healthcare providers, and with organisations that represent patients at the local level.

Building a world-class regulatory body

In just three years, the Healthcare Commission has established a reputation as a leader in the development of rigorous regulatory systems that support better healthcare and public health. We continue to build a world-class organisation, capable of delivering on a challenging range of activity through a period of significant change.

These were some of our key activities in 2006/2007:

Working locally

Our new regional structure has made an enormous contribution to our effectiveness. Local inspectors and assessors have worked closely with trusts to help them understand our systems, while at the same time learning from them to improve the way we work. The structure has four regions (North, Central, South West, and London and the South East) and offices in London, Nottingham, Bristol, Leeds, Manchester and Solihull.

Figure 2: Healthcare Commission regional offices

Investing in our staff

In addition to training in core skills for all staff, our training agenda for the year focused on developing our managers through a modular training programme spanning a range of key areas. The programme culminated in a people management conference at the end of the year.

Our regional staff received specialist training relating to their work assessing NHS trusts' performance against core standards, including the requirements of the hygiene code. We also provided training in equality and diversity for all staff, and launched an extremely popular coaching and mentoring programme.

In June 2006 we introduced the James Mayes Award, a lasting tribute to our colleague James Mayes, who was tragically killed in the London bombings in July 2005. It offers a member of staff an external placement to work on using information better to improve healthcare. This year two members of staff were awarded placements, in the USA and Germany.

Engaging with staff continued to be a major priority for us. Our internal communications programme during the year ensured that staff were kept fully informed and had opportunities to have their opinions heard. In October 2006, we brought everyone in the Commission together at a staff conference to celebrate the successes of our first two years as an organisation.

Figure 3: Healthcare Commission staff by region

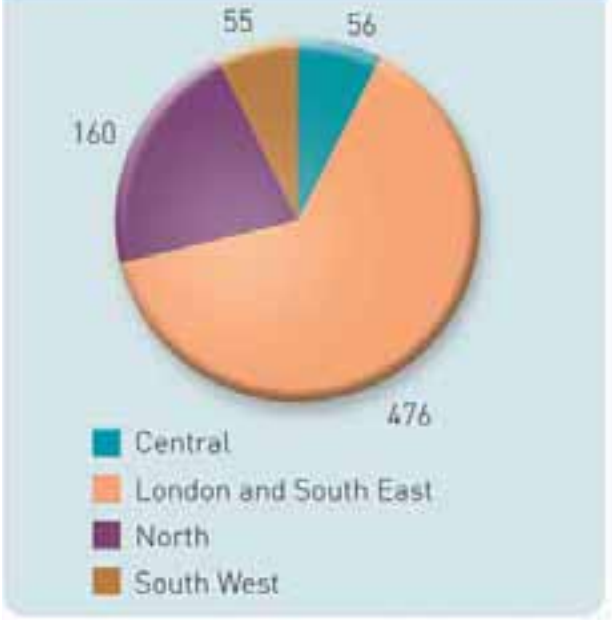
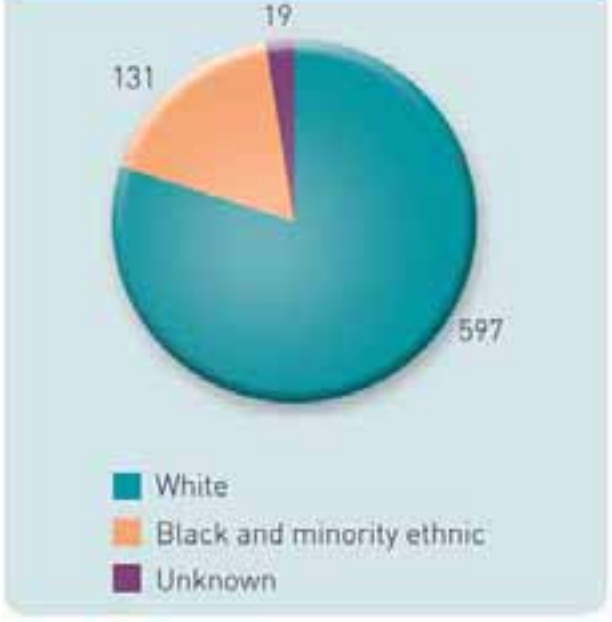


Figure 4a: Healthcare Commission staff by ethnic origin



Supporting diversity in our workforce

Action on diversity forms an integral part of our vision for the Healthcare Commission, not only in helping us to reflect the society and communities of which we are a part, but also in improving the Healthcare Commission's ability to deliver, through valuing and making the best use of the diversity of talent in our teams and organisation. In early 2006 we set up an action on diversity group, chaired by our head of operational development, who is a member of the executive team.

Figure 4a shows the number of our employees who are from white backgrounds and from black and minority ethnic backgrounds. Figures 4b and 4c show the number of employees broken down by gender and by age.

We will issue our next human resources monitoring report by October 2007, comparing data for 2005/2006 with that of 2006/2007 where possible, and highlighting any changes or opportunities for data improvement.

Figure 4b: Healthcare Commission staff by gender

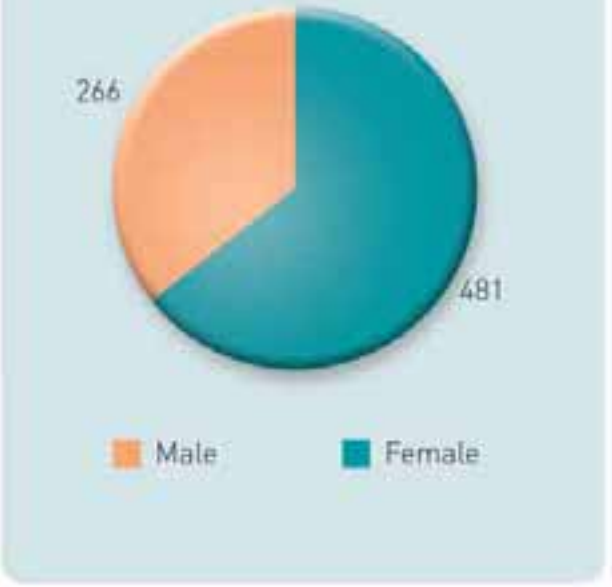
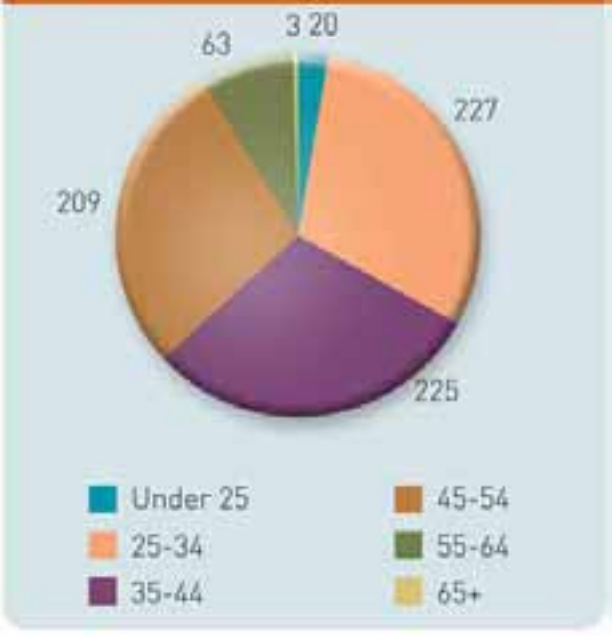


Figure 4c: Healthcare Commission staff by age



Embedding clinical knowledge and experience

Clinicians work for and with the Healthcare Commission at all levels – providing valuable expertise on clinical issues and an insight into the impact of our work in a clinical environment. Our clinical engagement team ensures that we develop a coherent strategic approach to these issues in England and Wales – and with our counterparts elsewhere in Britain – and maximise our knowledge and experience.

External advice

During the year we called on a variety of sources, including our pool of associates, to obtain formal advice on our work. These contributions are usually from clinicians and other healthcare professionals. For example, around 2,000 episodes of external advice were provided to help reconcile complaints about the NHS that had been referred to us for independent review. More than 400 associates supported our inspection and regulation of independent healthcare and 56 associates were involved in our investigations. Around 150 professionals, carers and service users were recruited to participate in our national audit of learning disability services.

We also obtain external advice through a programme of contact with Royal Colleges and other professional organisations and societies. During the year we piloted the use of 'virtual' advisory panels to assist with our future thinking about methods of assessment and inspection.

Information management

This year, we developed an online customer relationship management (CRM) system that provides a comprehensive record of our interactions with other organisations and enables us to target our communications to them. The system also allows our regional staff to enter healthcare intelligence collected locally for transfer to our analysts at head office. The first phase of roll-out took place across our regional offices and our helpline in July.

Our records management team produced a retention and disposal policy to help staff to comply with applicable legal and regulatory requirements, including the Freedom of Information Act and its Records Management Code, the Data Protection Act 1998 and the Public Records Act 1958. The policy will make useful information more readily available, support accountability through retention of records, and avoid the cost and potential liabilities of retaining information that we do not need.

Evaluation

In January 2007 we carried out a survey of chief executives in acute trusts who had taken part in our acute hospital portfolio series of service reviews to find out about its overall value to them. The results were extremely positive and supportive of our policy of continuing service reviews, with some helpful pointers for improvement.

During the year we also commissioned research into views about our complaints function, our investigation function, the second year of the annual health check, our adult community mental health review, the Concordat and a review of the impact of regulation.

Developing our reputation

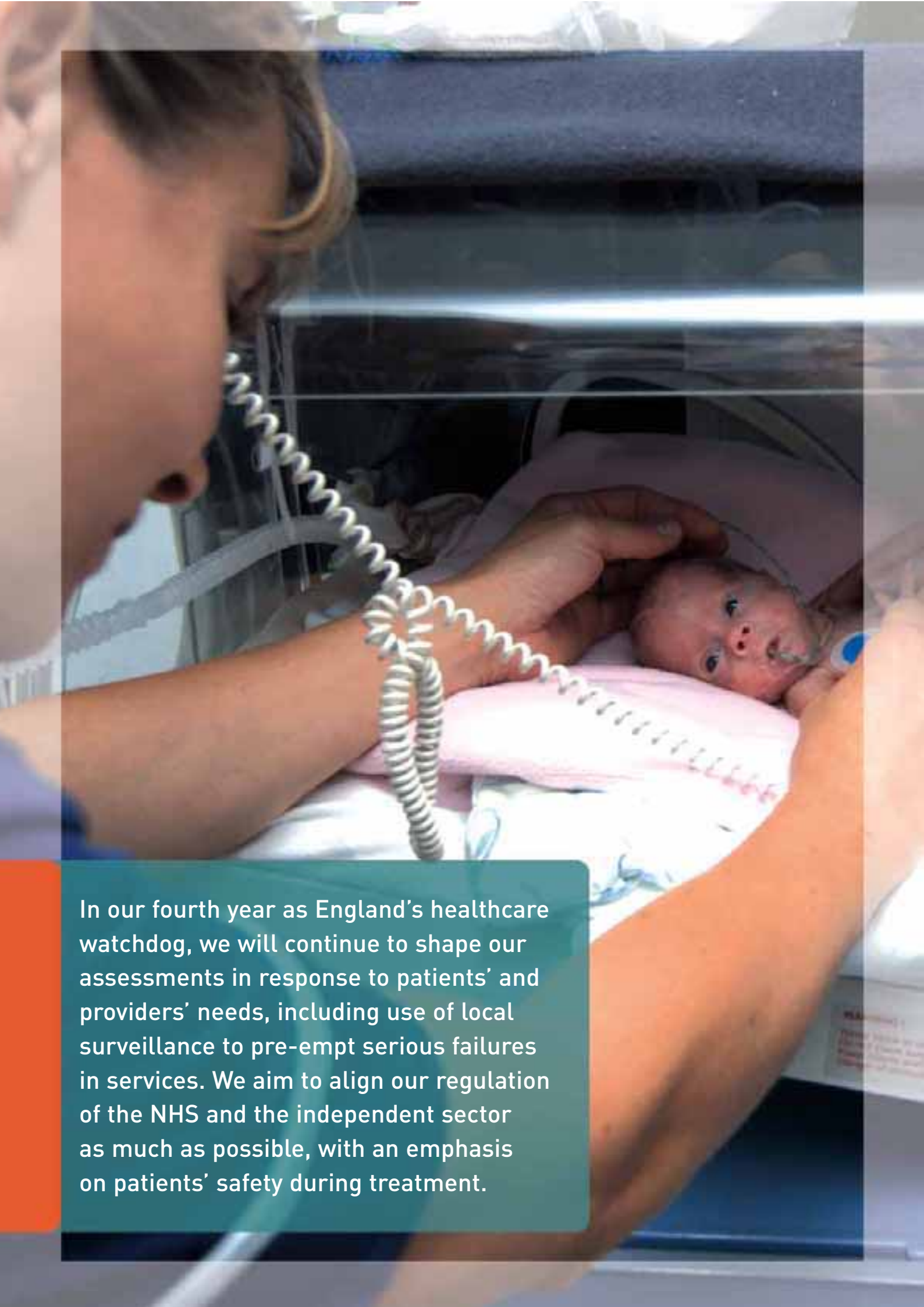
Our corporate communications activities are vital to raising public awareness and understanding of our work to safeguard patients and drive improvements in the healthcare they receive. When we publish information about healthcare providers' performance, our media and external affairs work ensures that it receives attention at a national and local level, informing and stimulating debate about the quality of healthcare services in this country.

Public interest in our work continued to rise with coverage in national newspapers growing by 8% in 2006. We also reached out to healthcare professionals, increasing our coverage in the specialist media by around a third. Since we launched a new annual health check section on our website in October 2006, the number of visitors has increased by 70%, to an average of 140,000 per month.

This work was backed by engagement with those affected by, or with an interest in, our assessments of healthcare services.

During the year, we ran events, gave talks and offered briefings on our work to representatives of patients and the public, parliamentarians, clinicians, healthcare managers and decision-makers across government.

Event highlights included our hosting of the annual conference of the International Society for Quality in Healthcare in London, which enabled us to showcase our work and develop our reputation for being at the forefront of debate about regulation and quality. With the theme of *Improving healthcare: the challenge of continuous change*, the conference played host to some of the UK's leading thinkers in healthcare, including The Rt Hon Patricia Hewitt MP, Secretary of State for Health; Professor Sir Liam Donaldson, Chief Medical Officer; Sir Brian Jarman, emeritus professor at Imperial College School of Medicine, and Sir John Oldham, creator and head of the UK National Primary Care Development Team. Our Chair, Chief Executive and senior staff gave keynote presentations and led discussion, and we organised a series of seminars.



In our fourth year as England's healthcare watchdog, we will continue to shape our assessments in response to patients' and providers' needs, including use of local surveillance to pre-empt serious failures in services. We aim to align our regulation of the NHS and the independent sector as much as possible, with an emphasis on patients' safety during treatment.

Looking ahead

This year, our priorities in health and healthcare could be grouped into the following areas:

- safety of patients
- reducing health inequalities and promoting wellbeing
- quality of and access to healthcare
- value for money and financial health

In our *Corporate Plan 2007/2008* we describe our programme of work for the coming year and identify the challenges we face over the next two years. The plan sets out our priorities, what we aim to achieve and how we will resource it. All our work moves us closer to achieving the strategic goals that we outlined in our *Strategic Plan 2005–2008*.

Our systems of regulation will develop to take account of changes in how healthcare organisations commission and provide services to patients and the public. Against the background of the Government's commitment to making regulation more efficient and cost-effective, we will continue to focus our resources and expertise in assessing the important risks, and ensuring we measure what really matters to patients and the public.

Use of independent sector healthcare by the NHS will continue to increase. This means that our assessments must assure the public that the required standards are met, or any problems identified, whatever the setting. Where appropriate, we will assess performance in both sectors against a single set of standards, and publish comparable information.

We will continue to develop our techniques of surveillance and the way that we use information in our assessments, so that we can identify problems early and ensure that action is taken swiftly by the healthcare organisation concerned.

Local commissioning, where primary care trusts purchase services, is being strengthened to encourage more competition between different service providers. As a result, we will examine closely the value for money offered by services bought on patients' behalf. We will develop new methods of assessing the ability of commissioners to achieve value for money, and provide them with independent and trusted information to help with future decisions.

We will put an even greater emphasis on safety in 2007/2008. As part of this aim, we will follow up the outcomes of a summit meeting on safety that we held in early 2007 with representatives from 25 national organisations, bringing together our regulatory work and pooling information to put in the public domain.

Looking further ahead, the Department of Health has confirmed the intention to combine the activities of the Healthcare Commission with the Commission for Social Care Inspection and the Mental Health Act Commission. We are already working to develop our assessments in a way that takes these plans into account, and will continue to do so over the coming year.

Corporate governance and finance

Statement of corporate governance 2006/2007

The Healthcare Commission's legal name is the Commission for Healthcare Audit and Inspection. It was established by the Health and Social Care (Community Health and Standards) Act 2003 and launched on 1 April 2004.

This Statement of Corporate Governance covers the Healthcare Commission's third year of operation. It forms part of the annual report and accounts 2006/2007, which are being published and laid before Parliament.

Principal activities

The Healthcare Commission has the status of a non-departmental public body.

The main aim of the Healthcare Commission is to encourage improvement in the provision of healthcare by and for NHS organisations. Its main statutory functions in England and Wales include:

- carrying out reviews and investigations of the provision of healthcare and the arrangements to promote and protect public health, including studies aimed at improving economy, efficiency and effectiveness in the NHS
- promoting the coordination of reviews and assessments undertaken by other bodies
- publishing information about the state of healthcare across the NHS and the independent sector, including the results of national clinical audits
- reviewing the quality of data relating to health and healthcare

and, in England only:

- reviewing the performance of each local NHS organisation and awarding an annual rating of that organisation's performance
- regulating the independent healthcare sector through annual registration and inspection
- considering complaints about NHS bodies that have not been resolved through their own complaints processes
- publishing surveys of the views of patients and staff

In exercising its functions, the Commission is required to be particularly concerned with:

- the availability of, and access to, healthcare
- the quality and effectiveness of healthcare
- the economy and efficiency of the provision of healthcare
- the availability and quality of information provided to the public about healthcare
- the need to safeguard and promote the rights and welfare of children, and the effectiveness of measures taken to do so

The Commission has a duty to work in partnership with the Audit Commission and the Commission for Social Care Inspection (CSCI). The Healthcare Commission's role is complemented by arrangements for the inspection of healthcare in Wales that also began on 1 April 2004.

In exercising many of its functions, and particularly those concerned with the NHS, the Healthcare Commission must have regard to such aspects of Government policy as the Secretary of State for Health may direct.

Other parts of the annual report describe how the Healthcare Commission exercised its functions in the course of 2006/2007.

Corporate governance and accountability arrangements

The Healthcare Commission is committed to achieving high standards of corporate governance, and applies the provisions of the July 2003 Combined Code (the Code) where relevant and proportionate to its role as a regulator and its status as a non-departmental public body.

This Statement describes how, during the period 2006/2007, the Healthcare Commission has applied the relevant provisions of the Code. In addition to the Code, the Commission is subject to a number of other accountability mechanisms.

The Chief Executive is the accounting officer for the Healthcare Commission, responsible and accountable for the management of the Commission's funds and assets.

The Secretary of State for Health is answerable to Parliament for the policies and performance of the Commission. The Healthcare Commission has a formal agreement with the Department of Health about working arrangements, known as the management statement. Part 2 of the management statement comprises a financial memorandum specifying the terms on which the Healthcare Commission receives and spends its funds.

The Healthcare Commission meets the minister for an annual performance review and the Chair and Chief Executive have regular meetings with ministers, senior policy officials of the Department and the branch responsible for the relationship with the Department of Health as sponsor of the Healthcare Commission.

The Commission aims to transact as much of its business as possible in public. Meetings of the Commission are held in public and include a session during which members of the public and press can put questions to commissioners and members of the executive team. When there is business of a confidential nature to be transacted, publicity on which would be prejudicial to the public interest, the latter part of the meeting is held in private.

Several meetings of the Commission each year are held at locations other than London. The schedule of forthcoming meetings of the Commission is published on the Commission's website, together with agendas and papers for meetings.

The Commission is committed to public consultation on its work programme and key strategies.

The effectiveness of corporate governance and governance systems are reviewed regularly. During the year, the Healthcare Commission's internal auditors, South Coast Audit, undertook a review of corporate governance against *The Good Governance Standard for Public Services**. Systems are also reviewed as part of the programme of internal audit reviews agreed each year. A workshop took place in October 2006, led by the National Audit Office, to review the effectiveness of the audit committee.

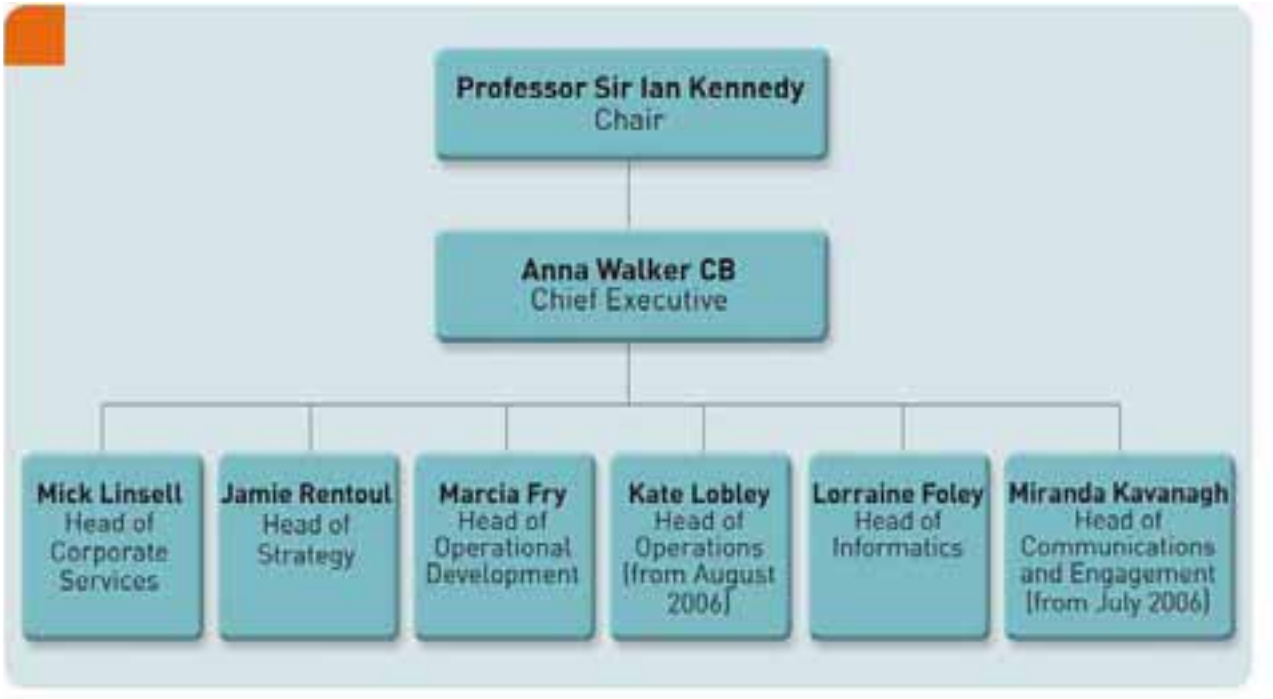
The Commission

The role of the Commission is to:

- exercise the Healthcare Commission's statutory functions and duties
- make strategic decisions affecting the future operating and resourcing of the Healthcare Commission
- oversee the discharge by the executive management of day-to-day business
- set appropriate policies to manage risks to operations and the achievement of strategic objectives
- seek regular assurance that the system of internal control is effective in managing risks in the manner it has approved

Leadership of the Commission

Leading the Commission's 14 commissioners is the Chair, Professor Sir Ian Kennedy. Anna Walker CB, Chief Executive of the Commission, leads a senior management team of six.



* *The Good Governance Standard for Public Services*, the Independent Commission for Good Governance in Public Services, (2004).

Membership of the Commission

Arrangements for the membership of the Commission are set out in legislation and regulations. The Chair and the majority of the commissioners must be lay members, in other words they must not be a healthcare professional or the holder of a paid appointment or office with an NHS body.

One of the commissioners makes the interests of Wales his or her special care.

The Appointments Commission appoints all commissioners including the Chair. In relation to the commissioner making the interests of Wales his or her special care, the Appointments Commission appoints in consultation with the National Assembly of Wales; in relation to other commissioners, it appoints in consultation with the Secretary of State for Health.

Commissioners are appointed for a term of not longer than five years, but may be re-appointed as long as their total term of office does not exceed 10 years.

Professor Sir Ian Kennedy was appointed to be Chair of the Healthcare Commission with effect from 1 February 2004. His term of office ends on 31 January 2008.

During the year 2006/2007, the term of office of three commissioners came to an end. John Scampion, Professor Sir Bruce Keogh and Khurshid Alam were re-appointed for a further three-year term. One commissioner, Stephen Thornton, left the Commission in July 2006. During 2006/2007, Dr Sharon Hopkins held the appointment as the commissioner making the interests of Wales her special care. A recruitment exercise was held in 2006 and was successful in filling the three vacancies for commissioner appointments. Clare Dodgson, Professor Deirdre Kelly and Cliff Prior took up their appointments on 1 January 2007.

Information on the term of office of each commissioner is given in Table 1.

More information about our commissioners and executive team is available on our website: **www.healthcarecommission.org.uk/aboutus/whoarewe.cfm**

Table 1: Commissioners and terms of office 2006/2007	
Name	**Period of appointment**
Khurshid Alam	1 February 2004 to 31 January 2010 Re-appointed 1 February 2007
Dr Sarah Blackburn	1 February 2004 to 31 January 2008
Dr Jennifer Dixon	26 February 2004 to 31 January 2008
Clare Dodgson	1 January 2007 to 31 December 2010
Michael Hake	1 February 2004 to 31 January 2009
Dr Sharon Hopkins	1 February 2004 to 31 January 2008
Professor Deirdre Kelly	1 January 2007 to 31 December 2010
Professor Sir Ian Kennedy (Chair)	1 February 2004 to 31 January 2008
Professor Sir Bruce Keogh KBE	1 February 2004 to 31 January 2010 Re-appointed 1 February 2007
Nick Partridge OBE	1 February 2004 to 31 January 2009
Professor Shirley Pearce (Joint Deputy Chair)	1 February 2004 to 31 January 2008
Cliff Prior CBE	1 January 2007 to 31 December 2010
John Scampion CBE	1 February 2004 to 31 January 2010 Re-appointed 1 February 2007
Professor Iqbal Singh	1 February 2004 to 31 January 2008
Paul Streets OBE (Joint Deputy Chair)	1 February 2004 to 31 January 2008
Stephen Thornton CBE	1 February 2004 to 31 January 2007 Resigned 31 July 2006

The working of the Commission and its committee structure

The Standing Orders of the Commission set out the rules by which the Commission operates. They include the Code of Practice for members of the Commission and the standing financial instructions.

The Commission has adopted a schedule of matters reserved to it for collective decision. It has also formally agreed arrangements for the discharge of its functions and the terms of reference of committees of the Commission, which are reviewed from time to time. Copies of these documents are available on the Commission's website.

In 2006/2007, the Commission had the following committees:

- audit committee
- remuneration committee
- nomination committee
- committee on the use of confidential personal information
- investigations committee
- complaints (quality assurance) committee
- equality and human rights committee

Meetings and attendance

During 2006/2007, the Commission met formally in public on five occasions. It also held two separate informal discussions of strategy.

Table 2 shows members' attendance at meetings of the Commission and committees during the year, with attendance shown as a proportion of the number of meetings individual commissioners were eligible to attend.

Table 2: Membership and attendance at meetings of the Commission and committees 2006/2007

Name	Meetings of the Commission	Strategy meetings of the Commission	Audit committee	Remuneration committee	Nomination committee	Committee on the use of confidential personal information	Investigations committee	Complaints (quality assurance) committee	Equalities and human rights committee
Professor Sir Ian Kennedy	**6/6**	2/2		**3/3**					
Khurshid Alam	4.5/6	1/2		2/3	1/1				3/4
Dr Sarah Blackburn	4/6	2/2	**4/4**				7/9	6/7	
Dr Jennifer Dixon	3/3	1/1							
Clare Dodgson*	2/2	–	1/1						1/1
Michael Hake	6/6	2/2	4/4	3/3		3/3	7/9	7/7	
Dr Sharon Hopkins	4/6	1/2			1/1	2/3			0/4
Professor Deirdre Kelly*	0/2	–				0/1			
Professor Sir Bruce Keogh	3/6	1/2							
Nick Partridge	6/6	2/2					6/9	3/7	**4/4**
Professor Shirley Pearce	4/6	2/2			**1/1**				
Cliff Prior*	1/2	–							
John Scampion	4/6	2/2	2/4	1/3			**8/9**	**6/7**	
Professor Iqbal Singh	5.5/6	2/2			1/1		1/9	1/7	3/4
Paul Streets	5/6	1/2		1/3		**3/3**			
Stephen Thornton**	1/2	0/1	2/2	2/3	–				

Note: bold text indicates Chair of the committee

* Appointed to committee 1 January 2007

** Resigned from committee 31 July 2006

The Chair meets the two deputy chairs between meetings of the Commission. Other commissioners are informed in order that they may raise matters either via the secretary or via the deputy chairs. Other commissioners are on occasion invited to join meetings.

Remuneration of commissioners

The remuneration of commissioners is determined by the Secretary of State for Health. During 2006/2007, the level of remuneration of commissioners other than the Chair was set at the rate payable to the non-executive directors of NHS hospital trusts, which was £7,500 per annum. The Chair of the audit committee also received an additional £5,000 per annum. This remuneration is for two and a half days a month.

Expertise and experience

Given the nature of the Healthcare Commission's statutory responsibilities and the breadth and complexity of the issues with which it deals, it is essential that the commissioners bring a broad range of experience to the Healthcare Commission. This includes professional and management expertise, health strategy and policy, public health, education and training and academic research, the NHS, independent and voluntary sectors. The range of experience provides for an appropriate balance of expertise and views to be brought to the deliberations on the range of issues affecting the strategic direction of the Healthcare Commission.

Details of the professional backgrounds and other appointments of commissioners can be found on the Commission's website.

Independence of commissioners and declarations of interest

The Chair had no other significant commitments during the year.

The Commission is satisfied that the commissioners are independent of Healthcare Commission management and free from any business or other relationship which could materially interfere with the exercise of their independent judgement, notwithstanding in some instances a regulatory connection between the Healthcare Commission and the commissioners who are employed by organisations regulated by the Healthcare Commission. The Commission recognises that conflicts of interest can arise for all commissioners, and has arrangements in place to handle any conflicts that might arise in the consideration of Commission business.

Register of interests

The Commission maintains a register of interest for commissioners and members of the executive team. Where any decisions are taken which could give rise to a conflict of interest, the chair of the meeting ensures at the outset that disclosure is made and the committee member withdraws for the duration of any discussion of the relevant item. The register is available to members of the public for inspection at Finsbury Tower and may be accessed through the Commission's website.

Secretariat

The secretary to the Healthcare Commission and other members of the secretariat attended and took minutes of meetings. The secretary to the Healthcare Commission and members of the secretariat provided advice to commissioners on matters of governance and support on other relevant issues. Minutes of the Commission's meetings and copies of Commission papers may be found on the Commission's website.

Effectiveness of the Commission

The Chair conducted individual appraisals with all commissioners during winter 2006/2007. Commission and committee papers were provided for all meetings. During the year, the Healthcare Commission's internal auditors, South Coast Audit, undertook a review of corporate governance against *The Good Governance Standard for Public Services**. A workshop took place in October 2006, led by the National Audit Office, to review the effectiveness of the audit committee.

Committees of the Commission

All committee members are appointed by the nomination committee. Membership and attendance at meetings of committees are shown in Table 2.

Audit committee

The key functions of the audit committee are to advise the Commission on the adequacy and effective operation of its systems of internal controls and hence the quality of financial and other reporting of the Healthcare Commission.

The audit committee carries out its work by reviewing and challenging the assurances which are available to the accounting officer, the way in which these assurances are developed, and the management priorities and approaches on which the assurances are premised.

Specifically, the audit committee provides advice by:

- review and oversight of the preparation of annual accounts for the approval of the Commission
- review of the Healthcare Commission's systems of internal control and risk management
- monitoring the effectiveness of the internal audit function and of the relationship with and between internal and external auditors

The Chair of the audit committee, since 6 February 2004, has been Dr Sarah Blackburn.

The Chief Executive, head of finance, head of corporate services, external auditors and internal auditors are invited to attend all meetings. At each meeting during 2006/2007, the committee had private meetings with the external auditors and the internal auditors without management present. In addition, the committee met in private with the senior executives only.

The audit committee met on four occasions during 2006/2007 and made regular reports to the Commission on its activities.

Financial statements

The audit committee formally approved the Healthcare Commission's accounts for 2006/2007. It considered reports on the Commission's funding and budget, and monitored month-by-month expenditure against budget.

Internal control and risk management systems

The audit committee commented and advised on the Statement of Internal Control, which was signed by the Chief Executive, and approved the Standing Financial Instructions.

* *The Good Governance Standard for Public Services*, the Independent Commission for Good Governance in Public Services, (2004).

Risks related to key aspects of the Commission's activities, such as quality assurance of the data used within the Commission, were explored and continue to be monitored.

External audit

The external auditor of the Healthcare Commission is the National Audit Office (NAO) who conducts audits on behalf of the Comptroller and Auditor General.

During the year, the audit committee received reports on the interim and final audits from the external auditors and sought assurance from the executive that issues raised in the memorandum of significant findings would be handled in an appropriate and timely way. The committee also considered the issues raised by the external auditor's management letter and the mitigation strategies proposed by the executive.

The external auditors also ran a very informative audit workshop for the members of the audit committee.

The head of external audit has the right of direct access to the Chair of the committee.

The committee ensures that the Commission's financial statements comply with best accounting practice and relevant accounting standards, Department of Health and HM Treasury regulations and requirements, and reviews the consistency of accounting policies both on a year-to-year basis and across the organisation.

The Commission's external auditors did not provide additional services to the Healthcare Commission during 2006/2007.

Internal audit

The committee recommends to the Commission the appointment of the head of the internal audit function or the appointment of suitably qualified contractors. During 2006/2007, South Coast Audit delivered this function at the Healthcare Commission.

The committee considers and approves the terms of reference and remit of the internal audit function, and agrees the planned programme of audits and any additions to the programme. As in the previous year, the focus for internal audit work for 2006/2007 was the areas of principal risk agreed with senior management.

The committee ensures that internal audit has the necessary access to information to enable it to fulfil its mandate. The Head of Internal Audit has the right of direct access to the Chair of the committee.

The Commission's internal auditors did not provide additional services to the Healthcare Commission during 2006/2007.

The committee also produces its own annual report which sets out details of its activities.

A workshop was held in October 2006, led by the National Audit Office, to review the effectiveness of the audit committee. A programme of actions has been put in place in response to the recommendations made at the workshop.

Remuneration committee
The remuneration committee has responsibility for the effectiveness, integrity and compliance of the reward protocols and practices of the Commission. A key accountability is the annual review of the remuneration of the Chief Executive and executive (second tier) team employed directly by the Commission.

Professor Sir Ian Kennedy chairs the committee.

The Chief Executive and head of corporate services attend meetings, except when matters relating to their own remuneration are being considered. The committee is advised by a member of the human resources team, and as appropriate, by independent external remuneration advisors.

During 2006/2007, the remuneration committee met four times. It agreed the introduction of performance-related pay for all employees of the Commission and determined the pay award that applied for the Chief Executive and those of the second tier senior executives directly employed by the Commission effective for the 12-month period from 1 April 2006.

Additionally, the senior executive team have a contractual entitlement to a variable annual incentive bonus award, which was paid with effect from April 2007. The variable annual incentive award is paid as a cash lump sum of between 0% to 15% of the base salary. It is determined on the basis of individual performance at the committee's discretion and on the recommendation of the Chair (for the Chief Executive) and the Chief Executive (for members of the second tier executive).

The Chief Executive and four members of the second tier executive team are employed by the Commission on continuous employment contracts with a contractual right to receive notice within the guidelines of best corporate governance. A fifth member of the team is on a fixed-term contract of employment and a sixth is seconded to the Commission from a Government department.

Committee on the use of confidential personal information
The Health and Social Care (Community Health and Standards) Act 2003 provides the Healthcare Commission with the power to require information, including confidential personal information, from both NHS and independent healthcare providers, when it is necessary or expedient for the proper exercise of the functions of the Commission. The Act requires the Healthcare Commission to prepare and publish a code of practice in relation to confidential personal information. The code of practice was produced and approved by the Commission following a public consultation exercise. It was published in January 2005.

The Commission established a committee of commissioners to oversee the operation of the code of practice. The committee was established at a meeting of the Commission on 25 November 2004. During 2006/2007, the committee met on three occasions.

The Chair of the committee on the use of confidential personal information is Paul Streets. Members of the committee include the Caldicott Guardian from the Commission. Since February 2006, the membership of the committee has included an independent member, Dr Peter Harrowing. Dr Harrowing is not a commissioner or an employee of the Healthcare Commission.

The committee has approved frameworks for delegated decision-making on the obtaining, handling, use and disclosure of confidential personal information. These frameworks allow certain staff to make decisions in specified circumstances. All other decisions must be referred to the committee.

Further information on the committee, its activities and the code of practice can be found on the Commission's website.

Nomination committee
The nomination committee was established at a meeting of the Commission on 27 January 2005. The Chair of the nomination committee is Professor Shirley Pearce. During 2006/2007, the nomination committee met on one occasion.

The nomination committee provides a clear and transparent process for assisting in the appointment and re-appointment of commissioners and for evaluating the range of skills and experience of commissioners. The committee also considers proposals for succession planning for the Commission and makes recommendations on arrangements for membership of standing committees.

Investigations committee
The Chair of the investigations committee is John Scampion.

During 2006/2007, the investigations committee met on nine occasions.

The investigations committee provides strategic advice and makes decisions in relation to investigations into potential failures in NHS services in England and in certain cross-border special health authorities. The committee ensures that appropriate policies and procedures are in place and oversees the guiding principles for investigations, including the criteria adopted for deciding whether an investigation is required, recommending any changes to the Commission. The committee approves cases for investigation by the Healthcare Commission and approves the terms of reference. The committee may recommend other forms of review where a formal investigation is not considered appropriate.

The committee has also considered ways to improve the dissemination of the learning gained through the investigative process into the wider health community.

The committee received summary information about all 69 initial consideration cases managed by the investigations team during 2006/2007. The committee approved the draft reports of major investigations at five NHS trusts and, after consulting the Chair, approved the reporting of significant failings within two NHS trusts to the Secretary of State for Health. One of the reported significant failings was accompanied by a recommendation for special measures.

The committee also monitored the implementation of action plans put in place as a result of its recommendations, and has agreed in all cases that sufficient progress has been made by the trusts concerned.

Complaints (quality assurance) committee
The committee first met on 18 May 2005. It provides an overview, on behalf of the Commission, of the management processes of 'second (independent) stage' reviews of complaints against the NHS.

Membership of the committee comprises the membership of the investigations committee, and is chaired by the Chair of the investigations committee. The head of complaints, the senior complaints and policy manager and the Healthcare Commission's legal advisor also attend.

During 2006/2007, the complaints (quality assurance) committee met on seven occasions.

The committee provided advice on the performance improvement plan and monitored its implementation and success in reducing the number of unallocated cases and cutting the time taken to complete reviews. The committee received monthly reports of management information, and considered a number of randomly-selected reports each quarter in order to review the quality of the responses sent to complainants. The Chair of the committee has supported the Chief Executive in discussions with the Department of Health, and with the Parliamentary and Health Service Ombudsman who provides the third stage in the review process.

Equality and human rights committee
The committee met for the first time on 6 April 2006. The committee, chaired by Nick Partridge, has now met on four occasions.

The committee's purpose is to ensure that the Commission:

- maximises its contribution to reducing inequalities in people's health and promoting equality of access to, experience and outcomes of healthcare
- becomes a model employer in respect of equality in employment
- meets its statutory duties and complies fully with all current and future legislation on equality and human rights

The committee has monitored the implementation of the race equality scheme, disability equality scheme and gender equality scheme. It order to streamline the process, the committee will oversee the development of a single equality scheme.

Annual reporting

The Healthcare Commission is required to report on the following:

- the way in which it has exercised its functions during the year
- the provision of healthcare by or for NHS bodies
- what it has found in the course of exercising its functions during the year in relation to persons for whom it is the registration authority under the Care Standards Act 2000

The annual report is laid before Parliament and sent to the Secretary of State for Health and the Welsh Assembly Parliament. The accounts of the Healthcare Commission are audited by the Comptroller and Auditor General and copies are sent to the Secretary of State for Health.

Management commentary

Principal activities

We are determined to make a real difference to the delivery of healthcare and to promote continuous improvement for the benefit of patients and the public. To do this we focused on three key areas in 2006/2007. These were:

1. Ensuring that the basics are in place
2. Assessing and encouraging improvement
3. Making information more accessible

Objectives and strategies for achieving activities
Our current strategic goals for 2005/2008 are:

1. To promote better and safer experiences of health and healthcare for patients and the public using fair and credible systems for assessing and rating performance across the NHS and independent sector.
2. To safeguard the public by acting swiftly and appropriately on complaints, concerns and significant failings in the provision of healthcare.
3. To provide authoritative, independent, relevant and accessible information about what is going on in healthcare and the opportunities for improvement.
4. To use our assessments and other activities to promote action to reduce inequalities in the provision of healthcare to people and to improve their experiences, and their access to services through greater respect for human rights and diversity.
5. To take a lead in coordinating and improving the impact and value for money of assessments and regulation of healthcare services.
6. To support our people in creating an efficient, flexible and highly skilled organisation delivering world class assessments and regulation.

The annual report provides information on our non-financial achievements in 2006/2007 in achieving these goals.

Financial costs of achieving our strategic goals

The detail of our financial performance is shown within the operating cost statement and in the other financial statements and associated notes.

Gross operating costs of £79.0m were offset by £8.5m of income in respect of our work for the independent sector and a further £0.7m sundry income. Net operating costs of £69.8m were in line with our grant funding as explained in the financial statements.

Figure 5a: Net expenditure by strategic goal 2006/2007 £69.8m

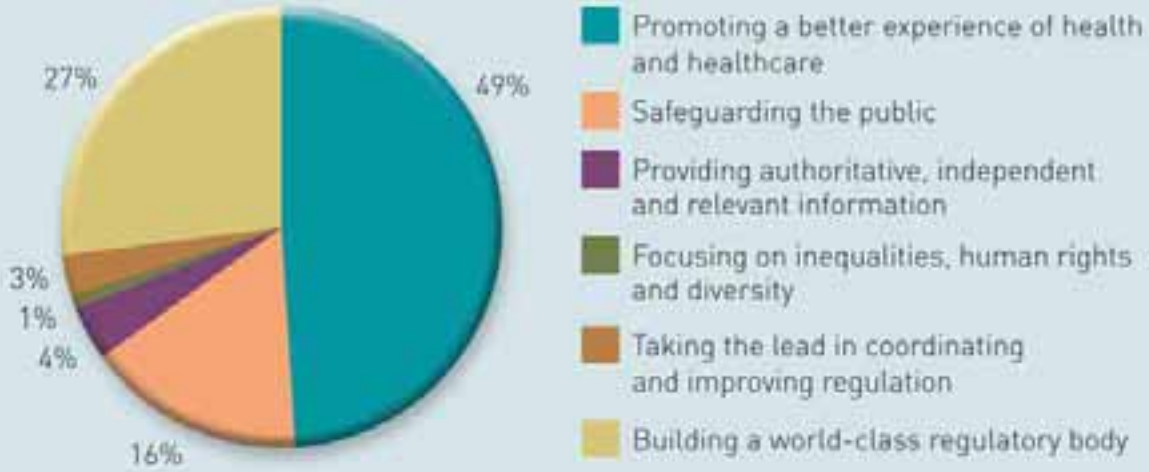


Figure 5b: Net expenditure by strategic goal 2005/2006 £70.0m

Table 3: Revenue operating costs analysed according to our strategic goals			
	2006/2007		2005/2006
Strategic goal	Average number of employees (whole time equivalent)	Net expenditure £'000	Net expenditure £'000
Promoting a better experience of health and healthcare	490	34,301	29,816
Safeguarding the public	172	11,026	8,473
Providing authoritative, independent and relevant information	31	3,000	3,303
Focusing on inequalities, human rights and diversity	8	614	832
Taking the lead in coordinating and improving regulation	21	2,054	2,302
Building a world class regulatory body	136	18,756	25,321
Total	**858**	**69,751**	**70,047**

Capital grant funding
£4.4m was spent on capital expenditure.

The majority of our capital expenditure (£3.771m) is in support of the creation of an intelligent information management system (IIMS). This development has been agreed by the Commission and, subject to agreement with the Department of Health, funding will be through grant-in-aid in the year in which the expenditure is incurred, with appropriate capitalisation of elements of the project. Two major components were completed during the year. The first involved the release of a package of products representing the information cabinet including the relevant staff training and business change elements. The second was the release of functionality associated with CRM Release 2, for independent healthcare – again including the relevant staff training and business change elements. As noted in the financial statements, £1m of capital expenditure on the IIMS project had been authorised at 31 March 2007 but not contracted.

Table 4: Capital expenditure		
	2006/2007	2005/2006
Strategic goal	Net expenditure £'000	Net expenditure £'000
Building a world class regulatory body	**4,401**	**2,581**

Net operating costs can also be analysed between three main business areas:

Table 5: Net operating costs for main business areas

	2006/2007			2005/2006
	Expenditure £m	**Income £m**	**Net expenditure £m**	**Net expenditure £m**
NHS	60.5	(0.7)	59.8	61.7
Complaints	9.8	–	9.8	7.9
Independent healthcare	8.7	(8.5)	0.2	0.4
Total	**79.0**	**(9.2)**	**69.8**	**70.0**

Key performance indicators

There are four key ways in which we will achieve our strategic goals. These are:

- the annual health check and other assessments of the NHS
- regulation of the independent healthcare sector and alignment with the NHS
- handling of second stage NHS complaints
- providing useful information based on our assessments

The Healthcare Commission monitors its strategic objectives via a series of work streams; each work stream has a lead and is owned by a member of the executive team. Performance is monitored using a balanced scorecard. Table 6 reflects the summary provided to the commissioners at the end of the year.

Ratings of 'green' signify that the outcome is on target; ratings of 'amber' receive increased attention from senior management; there were no 'red' (or critical) assessment ratings at 31 March 2007.

Table 6: Critical outcomes of the balanced scorecard at 31 March 2007

1 The annual health check and other assessments of the NHS

Critical outcomes	Measure/ current progress	Current rating	Comment/next steps	Forecast rating
The activities associated with the annual health check provide a rounded assessment of performance, including whether core standards are being met (for example, on the safety and clinical effectiveness of care).	Successful delivery of 2005/2006 annual health check. On track for 2006/2007.		Planning of 2006/2007 annual health check programme underway with current 2006/2007 delivery activities broadly on track. Detailed delivery/publication plan is subject to prioritisation and allocation of scarce resources as part of the 2007/2008 corporate planning.	
The annual health check measures what matters to patients and the public and can be shown to encourage improvement by assessing core and developmental standards, progress against targets, use of resources and through reviews of particular services and national studies.	Successful delivery of 2005/2006 annual health check. On track for 2006/2007.		Planning of 2006/2007 annual health check programme underway with current 2006/2007 delivery activities broadly on track. Detailed delivery/publication plan is subject to prioritisation and allocation of scarce resources as part of the 2007/2008 corporate planning.	
The annual health check is delivered in a proportionate, cost-effective way so that the benefits merit the costs.	Evaluation project proceeding as scheduled.		Learning to be built into 2006/2007 plan.	

Green rating: outcome is on target

Amber rating: outcome receives increased attention from senior management

2 Regulation of the independent healthcare sector and alignment with the NHS				
Critical outcomes	**Measure/ current progress**	**Current rating**	**Comment/next steps**	**Forecast rating**
Patients and the public are assured that standards are met in registered services.	All registered providers are risk assessed over the year.		On track.	
	Methods, tools and guidance are available in advance of new services entering regulation.		No new services have been brought into regulation.	
Our approach to assessment is responsive and proportionate to risk and providers.	Costs reduce compared to 2005/ 2006 as activity is increasingly targeted to risk.		This year, 25% to 30% of eligible providers did not receive an inspection visit. Activity-based costing work still underway.	
Our approach to assessment of the independent healthcare sector is broadly aligned with that of the NHS.	Read across between National Minimum Standards and Standards for Better Health (subject to review of standards by DH).		Review of Private and Voluntary Healthcare Regulations and National Minimum Standards are now not expected. Work towards alignment will run on into 2007/2008 plan.	

Green rating: outcome is on target

Amber rating: outcome receives increased attention from senior management

3 Handling of second stage NHS complaints				
Critical outcomes	**Measure/ current progress**	**Current rating**	**Comment/next steps**	**Forecast rating**
We handle and resolve effectively up to 9,600 complaints during the year, encourage trusts to improve complaints-handling at a local level, and increasingly take note of and apply the lessons learned from complaints.	9,600 case closures to be achieved.		9,932 cases closed to 31 March 2007 and 1,258 closed in March – best ever month. 3,070 cases open at year-end, 155 ahead of plan and 2,000 less than in April 2006.	
	An increase in the number of cases resolved with 'no further action' taken.		On average, 16% of cases closed in this way in 2006/2007 – similar to 2005.	
	Profile of new work is increasingly made up of more complex (categories 5 and 6) cases.		On average, 40% of further review cases are complex (categories 5 and 6) – no change from 2005.	
	There is a marginal reduction in the number of cases referred back for local resolution.		On average, 30% of cases were closed in this way in 2006, compared to 35% in 2005.	

4 Providing useful information based on our assessments				
Critical outcomes	**Measure/ current progress**	**Current rating**	**Comment/next steps**	**Forecast rating**
Patients and the public are getting significant information about the performance of healthcare organisations and local services across the NHS and independent healthcare sector. The information reflects their needs and experiences, and helps them to make informed decisions about health and healthcare.	Stakeholder survey.		Plans to gather feedback to be systematically included in our strategy update and forward plan, linking in to the work on evaluation. Very positive feedback on initial launch of annual health check results, with patient questions on 12 October. Proposal submitted to National Information Task Force to evaluate impact of cardiac surgery website.	
Providing our information to clinicians, managers and the Government prompts further improvements in healthcare.	Further measures to be defined in year.		Plans being formed to address this in communications plan.	

Green rating: outcome is on target

Amber rating: outcome receives increased attention from senior management

Remuneration report

This report for the year ended 31 March 2007 deals with the remuneration of the Chair, commissioners, Chief Executive officer and executive team who have influence over the decisions of the Healthcare Commission as a whole.

Remuneration committee

The remuneration committee determines both increases in pensionable salary determined by reference to a relevant market, and a performance bonus paid on the basis of performance against agreed objectives in the range of 0% to 15% of the base salary as at 31 March in the performance year.

Membership of the remuneration committee is shown on page 52 of the annual report.

Remuneration policy

The Chair is paid a salary in line with that of a high court judge. Commissioners' remuneration is determined by the Department of Health on the basis of a commitment of two to three days per month. Remuneration of the executive team was determined after an external benchmarking exercise.

The remuneration committee advises commissioners on all pay and remuneration issues affecting staff, and determines performance bonuses.

Service contracts

Professor Sir Ian Kennedy was Chair designate on the vesting date of 8 January 2004 and was appointed by the Secretary of State for Health as Chair of the Commission from 1 February 2004 for a period of four years to 31 January 2008.

The NHS Appointments Commission, acting on behalf of the Secretary of State for Health, appoints commissioners for terms of three years and in accordance with the Commission of Public Appointments code.

The Chief Executive, Anna Walker CB, was appointed on a permanent contract on 1 February 2004, after an internal and external recruitment process.

All executive team members were appointed after an internal and external recruitment process and are full-time employees of the Commission.

The Chief Executive and executive team members (excluding Jamie Rentoul) have contracts with the Commission requiring that they give, and are entitled to receive, six months' notice of termination. In the event of early termination, contractual entitlements apply.

The following sections provide details of the remuneration and pension interests of commissioners, the Chief Executive and executive team members.

Remuneration of the Chair and commissioners

Table 7: Chair's remuneration		
	Remuneration for year to 31/3/07 (£)	**Remuneration for year to 31/3/06 (£)**
Chair	159,059	155,404

In addition, the Chair was reimbursed with the cost of travelling to Commission meetings. These reimbursements totalled £2,594 during 2006/2007 (£2,743 in 2005/2006). The Healthcare Commission meets the resulting tax liability under a PAYE settlement agreement.

Table 8: Commissioners' remuneration			
		Remuneration for year to 31/3/07 (£)	**Remuneration for year to 31/3/06 (£)**
	Khurshid Alam	7,500	5,855
*	Dr Sarah Blackburn	12,500	5,855
	Dr Jennifer Dixon	7,500	5,855
	Michael Hake	7,500	5,673
**	Clare Dodgson	1,875	–
	Dr Sharon Hopkins	7,500	5,855
**	Professor Deirdre Kelly	1,875	–
	Professor Sir Bruce Keogh KBE	7,500	5,855
	Nick Partridge OBE	7,500	5,855
	Professor Kamlesh Patel OBE	–	4,879
	Professor Shirley Pearce (Joint Deputy Chair)	7,500	5,855
**	Cliff Prior CBE	1,875	–
	John Scampion CBE	7,500	5,855
	Professor Iqbal Singh	7,500	5,855
	Paul Streets OBE (Joint Deputy Chair)	7,500	5,855
***	Stephen Thornton CBE	1,952	5,855

* Includes remuneration as Chair of audit committee
** Appointed 1 January 2007
*** Resigned as a commissioner on 31 July 2006

In addition, commissioners were reimbursed with the cost of travelling to Commission meetings. These reimbursements totalled £3,981 during 2006/2007 (£2,373 in 2005/2006). The Healthcare Commission meets the resulting tax liability under a PAYE settlement agreement.

Remuneration of Chief Executive and executive team

Table 9: Chief Executive's remuneration	Remuneration for year to 31/3/07 (£)	Remuneration for year to 31/3/06 (£)
Chief Executive	192,324	183,370

Table 10: Executive team's remuneration		Remuneration for year to 31/3/07 (£)	Remuneration for year to 31/3/06 (£)
*	Stacey Adams	91,386	91,200
	Lorraine Foley	137,600	130,680
	Marcia Fry	137,700	132,500
**	Simon Gillespie	–	156,301
	Mick Linsell	114,750	110,450
***	Kate Lobley	71,417	–
****	Miranda Kavanagh	110,179	–

* Resigned 15 August 2006 (remuneration includes all payments due to the end of contracts)
** Resigned 8 February 2006 (remuneration includes all payments due to the end of contracts)
*** Appointed 1 August 2006
**** Appointed 17 July 2006 on a fixed-term contract expiring 31 March 2008

In addition, Jamie Rentoul provided services as an executive team member while employed by the Department of Health. Salary costs of £154,060 (including pension and employers costs) were recharged to the Commission by the Department of Health (£145,519 in 2005/2006).

Non-cash remuneration
There was no non-cash remuneration during the year (nil in 2005/2006).

Compensation paid, significant awards to senior managers
There were no non-contractual compensation or significant awards paid to former executive team members during the year (nil in 2005/2006).

Payments for loss of office
There were no payments for loss of office during the year (nil in 2005/2006).

Pension benefits
The Chair has foregone eligibility to join the Commission's pension scheme. Commissioners are not eligible to join either of the Commission's pension schemes.

The Chief Executive and executive team members are ordinary members of the NHS pension scheme or Principal Civil Service Pension Scheme (PCSPS).

Pension entitlements at 31 March 2007

Chief Executive
The Chief Executive is an ordinary member of the PCSPS.

Table 11: Chief Executive's pension entitlements at 31 March 2007

	* Accrued benefits				Cash equivalent transfer values (CETV)		
	Increase in year		Benefits at 31/3/07		CETV at 31/3/07	CETV at 31/3/06	Real increase in CETV
	Lump sum	Pension	Lump sum	Pension			
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Chief Executive	0-2.5	2.5-5	192.5-195	62.5-65	1,358	1,290	21

* Accrued benefits are presented in bands

Pension benefits at 31 March 2007 may include amounts transferred from previous employments.

Executive team
The executive team members are eligible to become ordinary members of the NHS or PCSPS pension schemes.

Table 12: Executive team pension entitlements at 31 March 2007

	* Accrued benefits				Cash equivalent transfer values (CETV)		
	Increase in year		Benefits at 31/3/07		CETV at 31/3/07	CETV at 31/3/06	Real increase in CETV
	Lump sum	Pension	Lump sum	Pension			
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
** Stacey Adams	0-2.5	0-2.5	20-22.5	5-7.5	106	97	6
Lorraine Foley	2.5-5	0-2.5	12.5-15	2.5-5	59	38	20
Marcia Fry	0-2.5	0-2.5	152.5-155	50-52.5	1,030	982	14
Mick Linsell	2.5-5	0-2.5	12.5-15	2.5-5	80	53	25
*** Kate Lobley	–	–	10-12.5	2.5-5	52	N/a	–
*** Miranda Kavanagh	–	–	2.5-5	0-2.5	14	N/a	–

* Accrued benefits are presented in bands
** Resigned 15 August 2006
*** Appointed during 2006/2007, benefits at 31 March 2007 may include benefits from previous employments

Pension benefits at 31 March 2007 may include amounts transferred from previous employments.

NHS pension scheme
The NHS pension scheme is an unfunded multi-employer-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. As a consequence, it is not possible for the Commission to identify its share of the underlying scheme liabilities. Therefore the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full valuation for FRS17 purposes every four years. The last valuation on this basis took place as at 31 March 2003. The scheme is also subject to a full valuation by the Government Actuary to assess the scheme's assets and liabilities to allow a review of the employers' contribution rates. This valuation took place as at 31 March 2004 and has yet to be finalised.

The last published valuations on which contributions were based covered the period 1 April 1994 to 31 March 1999. The notional surplus of the scheme at 31 March 1999 was £1.1 billion, as per the last scheme valuation by the Government Actuary Department when the conclusion of the valuation was that the scheme continued to operate on a sound financial basis. It was recommended that employers' contributions be increased to 14% of pensionable pay with effect from 1 April 2003. Subsequent to the 1999 valuation, the Government Actuary Department compared the scheme's contribution income and actuarially assessed growth in scheme liabilities and interest charges. This assessment has declared a net deficiency of £6.2m at 31 March 2004 as detailed in the scheme accounts which can be viewed on the NHS Pensions Agency website at **www.nhspa.gov.uk**. Copies can also be obtained from The Stationery Office.

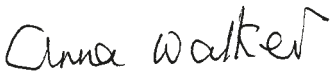
Principal Civil Service Pension Scheme
The Principal Civil Service Pension Scheme (PCSPS) is an unfunded, multi-employer public service-defined benefit scheme, made under the Superannuation Act 1972. Participating employers make contributions which are calculated on a basis consistent with those that might have applied had the scheme been funded, making allowance for amortised surpluses or deficits that would have arisen in a funded scheme based on an assumed notional investment return. The most recent assessment was carried out by Hewitt Bacon & Woodrow Limited, as at 31 March 2003, and included recommendations for the contribution rates applicable from 1 April 2005.

The Commission is unable to identify its share of the underlying assets and liabilities.
A quadrennial review of the accruing superannuation liability charges at 31 March 2003 can be found on the Principal Civil Service Pension Scheme website (**www.civilservice-pensions.gov.uk**).

Although the scheme is unfunded, employers' contributions are set at the level of contributions that would be paid by private sector employers to pension schemes for their employees. For 2006/2007, employers' contributions were payable to the PCSPS at four rates in the range 17.1% to 25.5% of pensionable pay, based on new salary bands as follows:

Table 13: Salary bands used in PCSPS

Band	New salary band (£)	Rate of charge (from 01/04/2006)
Band 1	18,500 and under	17.1%
Band 2	18,501 to 38,000	19.5%
Band 3	38,001 to 65,000	23.2%
Band 4	65,001 and over	25.5%



Signed by:
Anna Walker CB
Chief Executive
Healthcare Commission

Date: 28 June 2007

Annual accounts for the year to 31 March 2007

Introduction to annual accounts

The Healthcare Commission (Commission for Healthcare Audit and Inspection) presents the annual report and accounts for the year ended 31 March 2007. The financial accounts to 31 March 2007 are the Commission's third set of annual accounts and have been prepared on the basis that the Commission is a going concern.

These accounts have been prepared in the form directed by the Secretary of State for Health, with the approval of the Treasury, in accordance with paragraph 10 of Schedule 6 of the Health and Social Care (Community Health and Standards) Act 2003, and the Financial Reporting Manual (FreM) 2006-2007.

Financial results and review

The results for the year to 31 March 2007 are set out in the financial statements on pages 82 to 84.

The Commission's financial performance is identified within the operating cost statement. The Commission's net expenditure for the year was £69.8m. Expenditure totalled £79m on operational activities reduced by income of £9.2m from independent healthcare fees and other activities as explained in the accounts. Expenditure is funded from grant-in-aid provided by the Department of Health. Government grants totalling £72.1m were received in the period, including £4.4m designated as capital grant-in-aid. Reserves carried forward at 31 March 2007 were £10m (£7.4m in 2005/2006).

Fixed assets
The Commission's fixed assets at 1 April 2006 comprised refurbishment costs to leased land and buildings, office furniture and equipment and computer hardware and software, as reduced by depreciation calculated to release the asset costs to the income and expenditure over their useful working lives. Asset costs are revalued under modified historic cost accounting.

During the year to 31 March 2007, the Commission acquired assets with a value of £4.4m. These assets include refurbishment costs at Finsbury Tower and the Commission's regional offices and the purchase of office equipment and information technology infrastructure and software.

Research and development
There was no expenditure on research and development during the year.

Charitable payments
No charitable donations were made during the year.

Payment of creditors
The Commission's policy is to pay creditors in accordance with contractual conditions or, where no contractual conditions exist, within 30 days of receipt of goods and services or the presentation of a valid invoice, whichever is the later. This complies with the Better Payment Practice Code. No interest was paid during the year under the Late Payment of Commercial Debts (Interest) Act 1998.

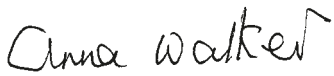
In 2006/2007, the Commission paid 93% of invoices, based on volume (87% in 2005/2006), and 91% of invoices, based on value (87% in 2005/2006), within 30 days. These calculations are based on the date of the invoice and will therefore understate the Commission's performance as payments are delayed while confirmation is obtained of satisfactory supply of goods and services.

Staff consultation
Staff were consulted regularly throughout the year. This was achieved through:

- regular meetings between staff and members of the executive team, which are open to all staff
- the involvement of staff in developing the policies and objectives set out in the corporate plan
- a staff forum on which Finsbury Tower and regionally-based staff are represented by elected delegates and union representatives
- an annual staff conference
- regular communications to all staff
- periodic confidential surveys of staff attitudes, the results of which are made available to all staff

Auditor appointment
The Comptroller and Auditor General is the appointed auditor of the Commission under the provision of the 2003 Act, schedule 6, paragraph 10 (4).

The audit fee for the year was £60,000 (£60,000 in 2005/2006). The Comptroller and Auditor General did not undertake any non-audit work during the year.



Anna Walker CB
Chief Executive
Healthcare Commission

Date: 28 June 2007

Statement of accounting officer's responsibilities

Under schedule 6, paragraph 10 of the Health and Social Care (Community Health and Standards) Act 2003, the Commission is required to prepare annual statements in respect of each financial year in such form as the Secretary of State may determine. The accounts are prepared on an accruals basis, and must show a true and fair view of the Commission's state of affairs at the year-end and of its income and expenditure, total recognised gains and losses and cash flow for the financial year.

In preparing these accounts, the Commission has:

- observed the accounts direction issued by the Secretary of State, including the relevant accounting and disclosure requirements and applied suitable accounting policies on a consistent basis
- made judgements and estimates on a reasonable basis
- stated whether applicable accounting standards have been followed and disclosed and explained any material departures in the financial statements
- prepared the financial statements on a going concern basis

The accounting officer for the Department of Health has designated me as the accounting officer for the Commission. My responsibilities as accounting officer, including responsibility for the propriety and regularity of public finances and for the keeping of proper records, are set out in the Non-Departmental Public Accounting Officer Memorandum issued by HM Treasury and published in Government Accounting.

Disclosure of information to the auditors
So far as I am aware:

- there is no relevant audit information of which the entity's auditors are unaware
- I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

Anna Walker CB
Chief Executive
Healthcare Commission

Statement on internal control

1. Scope of responsibility

As accounting officer, I have personal responsibility for maintaining a sound system of internal control, in accordance with the responsibilities assigned to me by the Department of Health in accordance with the published principles that underpin public sector accounting. The system of internal control supports the achievement of the Commission's policies, aims and objectives, while safeguarding the public funds and assets for which I am personally responsible.

The Commission subscribes to the seven principles of conduct underpinning public life as sent out by Lord Nolan in his report.

There is a funding agreement between the Commission and the Department of Health. The Commission consults extensively when planning its activities, including consultation with ministers and includes the risks associated with different courses of action in that consultation. The Commission's systems for internal control depend upon strategic planning (including external consultation), budget setting, agreement of an annual operating plan, monitoring of performance against the annual plan and the balanced scorecard and risk assessment.

The Commission recognises its responsibilities to ensure that there are robust arrangements for managing risk and that a formal scheme for identifying, managing and reporting on risk is in place at Commission, group, programme, and project levels.

During 2006/2007, I have reviewed documents I considered relevant, including internal audit reports and papers presented to the audit committee and management information produced during the year and I have discussed the state of internal controls with the external and internal auditors, and with members of the Commission.

2. The purpose of the system of internal control

The system of internal control is designed to monitor performance against plan, and budgets 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 sound and not absolute assurance of effectiveness. The Commission's system of internal control is being developed to understand and allocate costs against activities better, to monitor performance against plan and to identify and prioritise the risks to the achievement of its policies, aims and objectives, to evaluate the likelihood of those risks being realised (and their impact should they be realised) and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Healthcare Commission for the year to 31 March 2007 and up to the date of approval of the annual report and accounts, and it accords with guidance from HM Treasury.

3. Capacity to handle risk

The Commission has established an overarching governance framework to support delivery of its policies, aims and objectives. Risk management is integrated into all levels of this framework and, as such, is reflected in our strategic and operational planning and how performance is monitored through the balanced scorecard and budget. Table 14 illustrates this approach.

Table 14: Risk management approach

Stage	Purpose	Approach to risk
Strategic planning	Identify appropriate strategic goals and objectives. Consultation on those externally and with commissioners	Scenario planning of possible events and outcomes
Budget setting	Allocation of resources to support objectives	Identification of contingencies
Operational planning	Identification of activities to be undertaken to promote objectives	Development of risk register and business continuity plans
In-year monitoring	Undertaking of performance and financial monitoring using balanced scorecard and budgetary control statements	Early identification of adverse trends in performance or financial control
Risk assessment	With support from internal audit, monitoring of actions identified through in-year monitoring as essential to mitigate risk	Reiterative approach to ensure rigour in risk management processes

The Commission's processes have been designed and developed to:

- establish a policy framework approved by commissioners and the executive team, within which activities and their proposed outcomes and strategic risks are identified, managed and kept under review
- embed the management of risk and compliance by making it part of the day-to-day management processes. Although the executive team collectively own the risks, each strategic risk is also allocated to an appropriate member of the executive team to ensure that the management of risk is an integral part of overall management arrangements
- ensure that named managers manage each risk and actively review and report on that risk
- adopt a consistent approach throughout the organisation
- encourage staff to identify and manage risk positively in support of delivering the objectives of the Commission
- keep the system of risk management under regular review to ensure it is best matched to the organisation and effectively embedded

4. The risk and control framework

Consistent with the recognition of risk at a strategic level, the Commission has developed a risk register to monitor where risks may arise and how they are mitigated. In the register, risks are identified at an operational level and consolidated to identify themes arising across the organisation. The executive team and the Commission review the risk register for completeness. The audit committee reviews the application of the risk management processes. In addition, we have appointed a short-term post of risk advisor to enhance the degree of rigour behind our approach to the management of risk.

Management of risk is not seen as the preserve of any one part of the organisation. While the commissioners and Chief Executive are ultimately responsible for any events which may not have been foreseen or which were not properly managed, all members of the organisation must see themselves as responsible for anticipating and managing risk effectively.

The Commission has continued to review and strengthen its framework for control during the year. We have adopted the Treasury's framework for assessing the management of risk in public bodies. The principal features and key controls now include:

- a formal system of governance comprising standing orders and standing financial instructions which support and regulate how the Commission conducts its business. This includes a schedule of delegation showing which functions are retained for determination by the commissioners and which are delegated to the Chief Executive
- an organisational structure that supports clear lines of communication and accountability
- business strategies that are approved by the Commission and are subject to consultation with stakeholders of the Commission
- clear processes, so that the risks that are identified fit into an overall structure for risk management
- the introduction of management and reporting of key indicators of performance against a balanced scorecard

5. Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. The audit committee advise me on the implications of the result of my review of the effectiveness of the system of internal control and comment on the plans to address weaknesses and ensure continuous improvement of the systems. My review of the effectiveness of the system of internal control is informed by the work of members of the executive team within the Commission who have responsibility for the development and maintenance of the internal control framework, the internal auditors, comments made by the external auditors in their management letter and other reports and work commissioned from other external review agencies.

The process that the Commission has maintained to ensure internal control during the year includes both the management of risk and other sources of assurance, including internal audit monitoring against the operating plan and balance scorecard. The Commission's internal audit function has regular access to myself, the executive team and the Chair of the audit committee, and is invited to every meeting of the audit committee. The activities of the audit committee are in turn regularly reported to the full Commission.

The respective responsibilities are set out below.

Audit committee

The audit committee met four times in 2006/2007. Its terms of reference are:

- to review the establishment and maintenance of an effective system of internal control and risk management
- to recommend to the Commission the appointment (and dismissal) of the head of internal audit, approve the internal audit operating plan and receive and monitor progress upon all reports which the internal auditors issue regarding the Commission

- to review the delivery and outcome of the external audit function, including the management letter and management's progress in the implementation of external audit recommendations
- to ensure that the Commission's financial statements comply with best accounting practice and relevant accounting standards

The membership of the audit committee at 31 March 2007 included:

- Dr Sarah Blackburn (Chair)
- Clare Dodgson (commissioner from 1 January 2007)
- Michael Hake
- John Scampion

Stephen Thornton was also a member until May 2006. There is currently one vacancy being recruited from amongst the commissioners under the remit of the Commission's nominations committee. To increase the financial expertise of the committee, the Commission is seeking to appoint an independent member from outside of the Commission.

The Commission

The Commission has responsibility for overseeing governance. It receives the minutes of the audit committee at each of its meetings and invites the Chair of the audit committee to comment on any issues which may warrant further discussion. In this way, the Commission can exercise its responsibility to review the accounting officer's delivery of her duties.

The executive team

This team has responsibility for overseeing delivery against plan and balanced scorecard and risk management within the Commission. The culture of risk management within the Commission is determined at a strategic level. The executive team reviews all significant risks that have been identified and ensures that they have been fairly stated. It also satisfies itself that the less significant risks are being actively managed by relevant managers, with the appropriate controls in place and that these controls are working effectively.

In my regular meetings with individuals of the executive team, I seek assurance from them that they are taking individual and corporate responsibility for the deliverables and the management of risk in their respective areas of work.

Internal audit reports are addressed to the appropriate member of the executive team and significant issues are brought to the team's attention.

Internal and external audit

The Commission has an internal audit service provided by South Coast Audit. The head of internal audit reports to the audit committee and accounting officer regularly to standards defined in the Government Internal Audit Standards. Those reports include the internal auditor's independent opinion on the adequacy and effectiveness of the Commission's system of internal control, together with the recommendations for improvement. The Commission also encourages and endorses liaison between internal and external audit to achieve a more effective audit, based on a clear understanding of respective roles and requirements.

Our internal auditors expressed their opinion based on work undertaken during the year to 31 March 2007. Their overall opinion was that we had maintained a position where a satisfactory level of assurance could be given, recognising that there is some risk that our objectives may not be achieved. In discussion with our auditors, they acknowledge that we have made adequate improvements to all previously identified aspects of risk, but that as an organisation operating in a rapidly changing environment, a range of fresh risks will continue to emerge as we continue to refine our activities.

The external auditor, the Comptroller and Auditor General, is appointed under the 2003 Act and the National Audit Office regularly comments on governance.

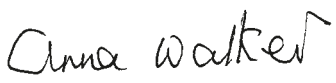
Both internal and external audit are invited to all meetings of the audit committee. In recognition that the Commission works in an increasingly complex environment, we have increased the number of audit days within the annual audit plan in successive years.

Future developments
The Commission has taken steps to ensure that the essential elements of effective control and risk management are in place. The systems have been developed and reviewed during 2006/2007 and while the controls and risk management in place have, in my view, been adequate, further improvements are required to support the Commission as it delivers the full range of its functions. Our aim is to establish ourselves as an organisation recognised for good practice in strategic planning, monitoring of performance and risk management.

We will continue to work towards improving the quality and coverage of our management information, both financial and non-financial, to further embed the management of risk at all levels, to link our corporate and individual objectives more closely and develop a fuller understanding of how we undertake our activities and how the associated costs arise. In particular, we are more closely defining how risks associated with our most critical outcomes are reflected in the balanced scorecard.

We are also focusing on externally facing aspects of our approach to risk as a regulator, to ensure that our interventions are targeted and proportionate with the criteria around risk published and shared with those bodies that we regulate. Further, we will also work increasingly closely with CSCI to ensure that our systems are as aligned as closely as possible.

6. Significant internal control breakdowns
No significant internal control breakdowns have been identified in the accounting year and subsequent period prior to the signing of the accounts.



Signed by:
Anna Walker CB
Chief Executive
Healthcare Commission

Date: 28 June 2007

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 Commission for Healthcare Audit and Inspection for the year ended 31 March 2007 under the Health and Social Care (Community Health and Standards) Act 2003. These comprise the operating cost statement, the balance sheet, the cashflow statement and statement of recognised gains and losses 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 being audited.

Respective responsibilities of the Commission, Chief Executive and auditor
The Commission and Chief Executive as accounting officer are responsible for preparing the annual report, which includes the remuneration report and the financial statements in accordance with the Health and Social Care (Community Health and Standards) Act 2003 and Treasury directions made thereunder, and for ensuring the regularity of financial transactions. These responsibilities are set out in the Statement of the Commission and Chief Executive's Responsibilities.

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

I report to you my opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the remuneration report to be audited have been properly prepared in accordance with the Health and Social Care (Community Health and Standards) Act 2003 and Treasury directions made thereunder. I report to you whether, in my opinion, certain information given in the annual report, which comprises the foreword, 'our year in brief', the management commentary and the remuneration report, is consistent with the financial statements. I also report whether in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities, which govern them.

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

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

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

Basis of audit opinion

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

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

Opinions

Audit opinion

In my opinion:

- the financial statements give a true and fair view, in accordance with the Health and Social Care (Community Health and Standards) Act 2003 and directions made thereunder by Treasury, of the state of the Commission's affairs as at 31 March 2007 and of its net operating cost for the year then ended
- the financial statements and the part of the remuneration report to be audited have been properly prepared in accordance with the Health and Social Care (Community Health and Standards) Act 2003 and Treasury directions made thereunder and
- information given within the annual report, which comprises the foreword, 'our year in brief', the management commentary and the remuneration report, is consistent with the financial statements

Audit opinion on regularity

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

Report

I have no observations to make on these financial statements.

John Bourn
Comptroller and Auditor General

Date: 11 July 2007

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

The maintenance and integrity of the Commission's website is the responsibility of the Accounting Officer; the work carried out by the auditors does not involve consideration of these matters and accordingly the auditors accept no responsibility for any changes that may have occured to the financial statement since they were initially presented on the web site.

Table 15: Operating cost statement for the year to 31 March 2007					
	Note	Year to 31/3/07		Year to 31/3/06 (Restated)	
		£'000	£'000	£'000	£'000
Gross operating costs					
Staff costs	2	47,239		44,815	
Other operating costs	3	29,790		32,064	
Depreciation	5	1,875		1,394	
Notional capital charges	1e	66		64	
			78,970		78,337
Less income					
Fee income	4(i)	8,519		7,384	
Other income	4(ii)	700		906	
			9,219		8,290
Net operating costs	11		**69,751**		**70,047**

The notes on pages 85 to 99 form part of these accounts.

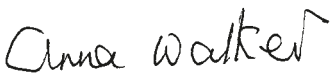
Table 16: Statement of recognised gains and losses			
	Note	Year to 31/3/07 £'000	Year to 31/3/06 £'000
Unrealised gains on fixed asset indexation	5	206	45

The notes on pages 85 to 99 form part of these accounts.

Table 17: Balance sheet					
	Note	Year to 31/3/07		Year to 31/3/06 (Restated)	
		£'000	£'000	£'000	£'000
Fixed assets					
Tangible fixed assets	5		7,142		4,913
Intangible fixed assets	5		1,756		1,467
			8,898		6,380
Current assets					
Debtors: falling due within one year	6(i)	3,735		3,278	
Cash at bank and in hand	7	8,622		5,034	
		12,357		8,312	
Current liabilities					
Creditors: falling due within one year	8	10,645		7,237	
Net current assets			1,712		1,075
Total assets less current liabilities			10,610		7,455
Debtors: falling due after one year	6(ii)		0		208
Provisions	9		(609)		(250)
Total net assets			**10,001**		**7,413**
Financed by:					
Operating cost reserve	10(i)		9,748		7,366
Revaluation reserve	10(ii)		253		47
			10,001		**7,413**

The notes on pages 85 to 99 form part of these accounts.

Signed by:



Anna Walker CB
Accounting Officer

Date: 28 June 2007

Table 18: Cash flow					
	Note	Year to 31/3/07		Year to 31/3/06 (Restated)	
		£'000	£'000	£'000	£'000
Net cash outflow from operating activities	12		(64,079)		(68,454)
Capital expenditure					
Payments to acquire fixed assets	5		(4,401)		(2,581)
Net cash outflow before financing			(68,480)		(71,035)
Financing					
Sale proceeds of fixed assets		1		0	
Government grant received:					
Revenue	10	67,667		68,651	
Capital	10	4,400	72,068	2,581	71,232
Increase in cash at bank and in hand	7		**3,588**		**197**

The notes on pages 85 to 99 form part of these accounts.

Notes to the accounts

1. Accounting policies

a) Accounting convention

The financial accounts cover the year 1 April 2006 to 31 March 2007.

These accounts have been prepared under the modified historic cost convention, in accordance with the Healthcare Commission Financial Memorandum, Accounts Direction issued by the Secretary of State with the approval of HM Treasury and in accordance with applicable accounting standards. The income and expenditure account has been renamed as the operating cost statement in accordance with changes in accounting guidance. A reconciliation between net operating costs and financing received has been included and comparative figures restated.

b) Change of accounting policy

With effect from the 2006/2007 reporting period, the FreM requires non-departmental public bodies to account for grants and grants-in-aid received for revenue purposes as financing because they are regarded as contributions from a controlling party which gives rise to a financial interest in the residual interest of NDPBs. This is a change in accounting policy from earlier periods when such items were regarded as income. The effect of this change on the certified 2005/2006 accounts and the impact of the change on the results of the current year is shown below. There is no impact on the net asset position of the Healthcare Commission as a result of this change in policy.

Table 19: Change of accounting policy 2005/2006

	Year to 31/3/06 (as previously stated) £'000	Impact of adopting new policy £'000	Year to 31/3/06 (Restated) £'000
Net operating surplus (costs) for the year	85	(70,132)	(70,047)
Operating cost reserve	1,033	6,333	7,366
Government grant reserve	6,380	(6,380)	0
Revaluation reserve	0	47	47

Table 20: Change of accounting policy 2006/2007

	Year to 31/3/07 (as previously stated) £'000	Impact of adopting new policy £'000	Year to 31/3/07 (Restated) £'000
Net operating surplus (costs) for the year	3	(69,754)	(69,751)
Operating cost reserve	1,103	8,645	9,748
Government grant reserve	8,898	(8,898)	0
Revaluation reserve	0	253	253

c) Income

Income is made up of statutory fees from the registration of private and voluntary healthcare providers and other income arising mainly from secondments of Commission staff and recoveries of costs from other public bodies.

Registration and inspection fees are payable on application and then annually in accordance with fee rates prescribed by the Secretary of State for Health. Application fees are recognised on completion of initial checks and acceptance of the application. Annual fee rates are set at levels that minimise cross-subsidy between categories of registered bodies and are invoiced on the registration renewal date and recognised in full on invoice. Annual fees are refundable on de-registration in accordance with the published fee rebate policy.

d) Fixed assets

Fixed assets are shown in the balance sheet at cost less accumulated depreciation. Assets are revalued annually using the Office of National Statistics current price index.

Tangible fixed assets include office refurbishment, office equipment and furniture, computer equipment and IT projects with an expected working life of more than one year. All assets falling into these categories with a value of £5,000 or more have been capitalised.

Assets are capitalised as a group where the value of individual assets is less than £5,000, provided that the total value of all assets of that type exceeds £5,000. General project management costs have not been capitalised.

Intangible fixed assets include purchased computer software where expenditure of £5,000 or more has been incurred.

(i) Depreciation

Depreciation is provided on fixed assets held at the year-end on a straight-line basis, at rates calculated to write off the cost, less any residual value, over their estimated useful lives as follows:

- office refurbishment – 15 years
- office furniture – 10 years
- office equipment – five years
- computer equipment, IT projects and software – three to four years

Depreciation is charged on a monthly basis commencing from the month following the date on which an asset is brought into use.

(ii) Indexation

RPI Indexation has been applied to building assets and for all other assets from the Office for National Statistics publication *Price index numbers for current cost accounting* (MM17).

e) Notional cost of capital

A notional cost of capital has been calculated in accordance with HM Treasury requirements at a rate of 3.5% on the average value of capital employed during the year. The notional cost of capital for the year to 31 March 2007 was £66,000 (£64,000 in 2006).

f) Pension costs
The Commission provides two pension schemes for staff. Details of the schemes are provided in the remuneration report and in note 2 to the financial statements.

g) Leases
Rental payable under operating leases is charged to the operating cost statement on a straight-line basis over the lease term.

h) Value added tax (VAT)
The Commission registered for value added tax during 2005/2006 when its VAT-rated income (primarily from recharging the costs of staff on secondment) exceeded the VAT registration threshold. Income is reported exclusive of output VAT where applicable. VAT is not charged on any of the Commission's regulation-based independent healthcare fees and charges. Expenditure reported in these statements is inclusive of VAT.

2. Employee information

a) Staff costs

Table 21: Staff costs		
	Year to 31/3/07 £'000	**Year to 31/3/06 £'000**
Wages and salaries (including commissioners)	28,668	24,521
Secondments, temporary and interim staff	11,384	14,760
* Employers national insurance	2,784	2,430
* Employers pension costs	3,856	3,237
Staff costs recharged	337	317
Pension provision released	(141)	(450)
Redundancy costs	351	0
	47,239	**44,815**

* National insurance and pension costs relate to directly employed staff only and any lay reviewers included on the Commission's payroll. Figures are not available for seconded staff paid through their 'substantive' employer's payroll.

b) Average number of employees during year
The average number of whole time equivalent employees, including secondees and agency staff by category of employment was 858.

Table 22: Number of employees in 2006/2007		
	Year to 31/3/07 whole time equivalents	**Year to 31/3/06 whole time equivalents**
Managerial	7	7
Support staff	697	620
Secondments, temporary and interim staff	154	153
	858	**780**

c) Pension benefits

The principal pension scheme for staff who transferred from the Commission for Health Improvement and the National Care Standards Commission and for staff recruited directly by the Commission is the NHS pension scheme. Staff who transferred to the Commission from the Department of Health and the Audit Commission at 1 April 2004 are eligible to join the Principal Civil Service Pension Scheme. New staff are also eligible to remain within the Principal Civil Service Pension Scheme if they are already members.

(i) NHS pension scheme

The scheme is a 'final salary' unfunded multi-employer-defined benefit scheme. Annual pensions are normally based on 1/80th of the best of the last three years' pensionable pay for each year of service. A lump sum, normally equivalent to three years' pension, is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the 12 months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. Additional pension liabilities arising from early retirement are not funded by the scheme except where the retirement is due to ill health. For retirements not funded by the scheme, the full amount of the liability for the additional costs is charged to the operating cost statement at the time the Commission commits itself to the retirement, regardless of the method of payment.

A death gratuity is payable for those who die in retirement, of twice final year's pensionable pay for death in service, and up to five times their annual pension for death after retirement, less pensions already paid, subject to a maximum equal to twice the member's final year's pensionable pay less their retirement lump sum.

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

Further details about the NHS pension scheme arrangements can be found at the website **www.nhspa.gov.uk**.

Contributing membership during 2006/2007 was 598 (643 in 2005/2006) and for 2006/2007, employers' contributions of £3.2m (£2.7m in 2005/2006) were payable to the scheme.

(ii) Principal Civil Service Pension Scheme

From 1 October 2002, civil servants and others approved by the Cabinet Office, including certain designated staff of the Healthcare Commission, may be in one of three statutory-based 'final salary' unfunded multi-employer-defined benefit schemes (Classic, Premium and Classic Plus). The schemes are unfunded, with the cost of benefits met by monies voted by Parliament each year. Entrants after 1 October 2002 may choose to join a 'money purchase' stakeholder arrangement with a significant employer contribution (partnership pension account). Pensions payable under Classic, Premium and Classic Plus are increased annually in line with changes in the Retail Prices Index. Employee contributions are set at the rate of 1.5% of pensionable earnings for Classic and 3.5% for Premium and Classic Plus.

Benefits in Classic accrue at the rate of 1/80th of pensionable salary for each year of service. In addition, a lump sum equivalent to three years' pension is payable on retirement. For Premium, benefits accrue at the rate of 1/60th of final pensionable earnings for each year of service. Unlike Classic, there is no automatic lump sum (but members may give up (commute) some of their pension to provide a lump sum). Classic Plus is essentially a variation of Premium, but with benefits in respect of service before 1 October 2002 calculated broadly as per Classic.

The partnership pension account is a stakeholder pension arrangement. The employer makes a basic contribution of between 3% and 12.5% (depending on the age of the member) into a stakeholder pension product chosen by the employee. The employee does not have to contribute but where they do make contributions, the employer will match these up to a limit of 3% of pensionable salary (in addition to the employer's basic contribution). Employers also contribute a further 0.8% of pensionable salary to cover the cost of centrally provided risk benefit cover (death in service and ill health retirement). Further details about the Civil Service Pension arrangements can be found at the website **www.civilservice-pensions.gov.uk**.

Contributing membership during 2006/2007 was 54 (65 in 2005/2006) and for 2006/2007, employers' contributions of £0.6m (£0.6m in 2005/2006) were payable to the scheme.

3. Other operating costs

Table 23: (i) Other operating costs		
	Year to 31/3/07 £'000	**Year to 31/3/06 (Restated) £'000**
Other operating costs include:		
Communications	2,507	2,483
Consultancy and professional fees:		
Clinical audit	4,900	4,426
Deregulated work	0	497
Legal fees	293	471
Other consultancy and professional fees	7,160	9,215
* External audit	60	60
IT costs, including general project management	2,297	2,151
** Losses and special payments	9	45
Premises and facilities	2,757	2,520
Staff recruitment, training and development	2,814	2,355
Travel and subsistence	2,323	3,030
Operating leases:		
Equipment	8	50
Premises	3,775	3,373
Other costs	674	1,301
Impairment of fixed assets	210	65
Losses on disposal of fixed assets	3	22

* The audit fee represents the cost for the audit of the financial statements carried out by the Comptroller and Auditor General. This amount does not include fees in respect of non-audit work and no such work was undertaken.

**Losses and special payments:
Losses in the year ended 31 March 2007 amounted to £9,000 (£45,000 in 2005/2006) and comprised:

	Year to 31/3/07 £'000	**Year to 31/3/06 £'000**
Cash losses	0	3
Bad debts written off	3	37
Special payments on termination of employment	0	0
Fruitless payments	6	5
	9	**45**

(ii) Notional insurance

Under the terms of its accounts direction from the Secretary of State for Health, the Commission does not carry commercial insurance but meets any insurance losses arising in the year up to 5% of its grant-in-aid. Losses arising from insurable claims during the year were below £1,000 (below £1,000 in 2005/2006) and these are included within losses and special payments.

4. Income

Fees and charges made to the independent sector are in line with fee scales prescribed by the Secretary of State for Health under the Care Standards Act 2000. Fee levels were reviewed and in some cases increased from 1 August 2006 following a fee consultation exercise in 2005/2006.

As detailed in note 1 (c), annual registration fees are invoiced on the anniversary of the registration and recognised in full in the accounting year invoiced. Fee income recognised in these accounts but relating to 2007/2008 registration periods was estimated at £3.0m at 31 March 2007 (£2.5m at 31 March 2006).

Table 24: (i) Fee income

	Year to 31/3/07 £'000	Year to 31/3/06 £'000
Registration and inspection fees and charges to the independent sector	**8,519**	**7,384**

Table 25: (ii) Other income

	Year to 31/3/07 £'000	Year to 31/3/06 £'000
Recharge of staff	337	317
Other income – speakers fees etc.	8	30
Legal costs recovered	9	0
Grants to commission research	346	559
	700	**906**

5. Fixed assets

Table 26: Fixed assets							
	Office refurbish-ment £'000	**Office furn-iture £'000**	**Office equip-ment £'000**	**Comp equip-ment £'000**	**Assets in develop-ment £'000**	**Total tangible assets £'000**	**Intangible assets £'000**
Cost or valuation							
Balance 1 April 2006	4,268	951	704	2,884	0	8,807	2,265
Additions in year	287	6	45	292	2,570	3,200	1,201
Disposals in year		(7)	(127)	(96)		(230)	
Indexation	294	15	8	(156)		161	(206)
Balance 31 March 2007	**4,849**	**965**	**630**	**2,924**	**2,570**	**11,938**	**3,260**
Depreciation							
Balance 1 April 2006	1,372	514	414	1,594	0	3,894	798
Depreciation in year	296	88	78	636		1,098	777
Disposals in year		(4)	(128)	(94)		(226)	
Indexation	99	8	4	(81)		30	(71)
Balance 31 March 2007	**1,767**	**606**	**368**	**2,055**	**0**	**4,796**	**1,504**
Net book value							
At 31 March 2007	**3,082**	**359**	**262**	**869**	**2,570**	**7,142**	**1,756**
At 31 March 2006	**2,896**	**437**	**290**	**1,290**	**0**	**4,913**	**1,467**

6. Debtors

Table 27: Debtors		
	Year to 31/3/07 £'000	**Year to 31/3/06 £'000**
(i) Amounts falling due within one year		
Trade debtors	1,359	795
Advances – staff loans	141	121
Prepayments and accrued income	2,068	1,996
Other debtors	167	366
	3,735	**3,278**
Staff loans are for season tickets, bicycle purchase and gym membership. No member of staff received loans in excess of £5,000.		
Intra-governmental balances		
Balances with central government bodies	116	632
Balances with NHS trusts	19	74
Balances with public corporations	602	153
Balances with bodies external to Government	2,998	2,419
	3,735	**3,278**
(ii) Amounts falling due after one year		
Prepayments and accrued income	**0**	**208**

7. Analysis of cash and bank balances and changes during the year

Table 28: Analysis of cash and bank balances and changes during the year			
	01/4/2006 £'000	**Cashflow £'000**	**31/3/2007 £'000**
Paymaster general	5,030	3,588	8,618
Cash balances	4	0	4
	5,034	**3,588**	**8,622**

8. Creditors

Table 29: Creditors		
	Year to 31/3/07 £'000	**Year to 31/3/06 £'000**
Amounts falling due within one year		
Trade creditors	4,692	1,429
Taxation and national insurance	928	884
Accruals and deferred income	4,567	4,481
Other creditors	458	443
	10,645	**7,237**
Intra-governmental balances		
Balances with central government bodies	1,594	1,186
Balances with NHS trusts	482	378
Balances with public corporations	446	908
Balances with bodies external to Government	8,123	4,765
	10,645	**7,237**

9. Provisions

Table 30: Provisions			
	Pension fund deficit £'000	**Other provisions £'000**	**Total £'000**
Balance 1 April 2006	250	0	250
Provided in year	0	500	500
Paid in year	0	0	0
Released in year	(141)	0	(141)
Balance 31 March 2007	**109**	**500**	**609**
Expected timing of cash flows:			
Less than one year	109	500	609

Pension fund deficit
An actuarial shortfall on pension entitlements arose from the transfer of staff from the National Care Standards Commission in 2004. At the time of transfer of staff on 1 April 2004 the estimated liability was £700,000. During 2006/2007, the estimated liability was reduced by the actuary to £109,000, from the £250,000 estimated at 31 March 2006. The actual liability will not be known until conclusion of the actuarial review which is expected to be during 2007/2008. The reduction of £141,000 in the provision has been credited to staff costs as shown in note 2.

Other provisions
Other provisions reflect the estimated likely additional costs which may become due to contractors.

10. Reserves

Table 31: Reserves				
	Year to 31/3/07		Year to 31/3/06 (Restated)	
	£'000	£'000	£'000	£'000
(i) Operating cost reserve				
Opening balance:				
Income and expenditure account		7,366		884
Government grant reserve		–		5,233
		7,366		6,117
Government grants received				
Revenue grant-in-aid	64,824		65,807	
Grant transferred to National Clinical Audit Support Programme	2,843		2,844	
	67,667		68,651	
Capital grant-in-aid	4,400		2,581	
	72,067		71,232	
Less net expenditure for the period	(69,751)		(70,047)	
		2,316		1,185
Non-cash				
Capital charges written back		66		64
Closing balance		**9,748**		**7,366**
(ii) Revaluation reserve				
Balance at 1 April 2006		47		2
Indexation increase in the year		206		45
Balance at 31 March 2007		**253**		**47**

11. Reconciliation of net operating costs and gross capital expenditure to grant-in-aid

Table 32: (i) Reconciliation of net operating costs to revenue grant-in-aid					
	Note	**Year to 31/3/07**		**Year to 31/3/06 (Restated)**	
		£'000	**£'000**	**£'000**	**£'000**
Net operating costs			69,751		70,047
Less non grant-in-aid charges					
Depreciation	5	1,875		1,394	
Impairment and losses on disposal of fixed assets	3	213		87	
Capital charges	1e	66		64	
			2,154		1,545
			67,597		68,502
Revenue grant-in-aid	10(i)		67,667		68,651
Underspend of grant-in-aid			**70**		**149**

Table 33: (ii) Reconciliation of net operating costs to capital grant-in-aid					
	Note	**Year to 31/3/07**		**Year to 31/3/06 (Restated)**	
		£'000	**£'000**	**£'000**	**£'000**
Gross capital expenditure	5		4,401		2,581
NBV of assets disposed of	5	4		22	
Less loss on disposal	3	3		22	
			1		0
			4,400		2,581
Capital grant-in-aid	10(i)		4,400		2,581
Underspend of grant-in-aid			**0**		**0**

12. Reconciliation of net expenditure to net cash outflow from operating activities

Table 34: Reconciliation of net expenditure to net cash outflow from operating activities		
	Year to 31/3/07 £'000	**Year to 31/3/06 (Restated) £'000**
Net expenditure for the financial year	(69,751)	(70,047)
Depreciation	1,875	1,394
Notional capital charge	66	64
Downward revaluation of fixed assets	210	65
Losses on disposal of fixed assets	3	22
(Increase)/decrease in debtors	(249)	(1,061)
Increase in creditors	3,408	1,559
Increase/(reduction) in provisions	359	(450)
Net cash outflow from operating activities	**(64,079)**	**(68,454)**

13. Operating leases

Commitments under operating leases to pay rentals during the year following these accounts are given in the table below, analysed according to the period in which the lease expires.

Table 35: Operating leases		
	Year to 31/3/07 £'000	**Year to 31/3/06 £'000**
Land and buildings		
Leases which expire within one year	672	1,025
Leases which expire within two to five years	1,419	875
Leases which expire after five years	1,752	1,754
	3,843	**3,654**
Other leases		
Leases which expire within one year	0	5
Leases which expire within two to five years	9	7
Leases which expire after five years	0	0
	9	**12**

14. Capital commitments

The Healthcare Commission's capital expenditure was controlled by the Department of Health for the year to 31 March 2007. The Commission had the following capital commitments, based on orders in place, at 31 March 2007:

Table 36: Capital commitments

	31/3/07 £'000	31/3/06 £'000
Expenditure contracted but not provided	Nil	Nil
Expenditure authorised but not contracted		
IIMS project	£1m	Nil

15. Contingent liabilities

There are no contingent liabilities at 31 March 2007 (nil in 2006).

16. Related party transactions

All commissioners and senior staff formally declare potential conflicts of interest each year and also during any decision-making process in which a conflict arises. The individual then takes no further part in the decision-making. None of the members of the Commission or senior staff or other related parties have undertaken any material transactions with the Commission during the year.

The Healthcare Commission is a non-departmental public body sponsored by the Department of Health. The Department of Health is regarded as a related party. During the year, the Commission has made a number of material transactions with the Department and other entities for which the Department is regarded as the parent Department. In addition, the Commission has had a small number of transactions with other Government departments and other central government bodies. Balances at 31 March 2007 are shown in notes 6 and 8.

Staff costs (note 2) include the reimbursement of employment costs for staff seconded to the Healthcare Commission from the Department of Health, Audit Commission and other Government Departments. Other material transactions were:

Grant-in-aid transfer £2.8m (note 10)

Some of the clinical audit costs were incurred under a service level agreement between the Commission and the Health and Social Care Information Centre and paid directly by the Department of Health to the HSCIC National Clinical Audit Support Programme (£2.8m in 2005/2006).

17. Financial instruments

FRS 13

Derivatives and other financial instruments require disclosure of the role which financial instruments have had during the period, increasing or changing the risks the Healthcare Commission faces in undertaking its activities. This disclosure excludes short-term debtors and creditors.

The Healthcare Commission has no borrowings and relies primarily on departmental grants for its cash requirements and is therefore not exposed to any risk of liquidity. It also has no material deposits, and all material assets and liabilities are denominated in sterling, so it is not exposed to interest rate or currency risk.

18. Post balance sheet events

There have been no significant events since 31 March 2007 that would have a material effect on these financial statements.

The financial statements and notes were signed by the Chief Executive as accounting officer on 28 June 2007 and authorised to be issued on 24 July 2007.

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