council for healthcare regulatory excellence

Annual Report and Accounts
2006/2007

HC 699

protect
promote
progress

Council for Healthcare Regulatory Excellence (CHRE)
Annual report and accounts 2006/2007

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1 Executive summary

1.1 Introduction

Throughout 2006/2007, our goals remained:

- promoting good practice;
- progressing regulatory excellence; and
- protecting the public.

In the summer of 2006 the Government published two reports on healthcare regulation in response to the Fifth Report of the Shipman Inquiry. The Chief Medical Officer's review (CMO review) related to the regulation of doctors, while the Department of Health review (DH review) was concerned with the regulation of the non-medical healthcare professions. Contributing to these reviews has continued to constitute a significant portion of our work.

Following a period of consultation the Government published the White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*, recommending far-reaching changes to regulation. Our Council and role are also set to change, with more focus on providing "an authoritative independent voice for patients on the regulation of professionals". The White Paper proposes that CHRE should undertake a number of projects which will be a large component of our work in the coming year.

1.2 Promoting good practice

We have:

- undertaken projects on sexual boundaries between patients and professionals, and student fitness to practise;
- contributed to the reviews of healthcare regulation (see above) and provided advice to ministers;
- identified important issues related to fitness to practise from our Section 29 process, and shared the feedback points with the regulators;

- participated in cross-regulatory groups to share good practice; and
- carried out our fourth annual performance review of the regulators' work, identifying key trends of the past year and key challenges for the year ahead.

1.3 Progressing regulatory excellence

We have:

- built links with other organisations in the UK, in Europe and worldwide;
- strengthened our partnerships with the four UK social care regulators;
- disseminated good practice through our annual performance review process; and
- promoted further collaboration between the regulators.

1.4 Protecting the public

We have:

- reviewed 915 fitness to practise decisions across the nine regulators and appealed four that we considered unduly lenient to the High Court;
- received judgments from the High Court in two cases, both of which upheld our appeals;
- continued to resolve many cases outside of court, by means of our Alternative Dispute Resolution Policy;
- monitored the developments in regulatory law arising from High Court cases brought both by us and by registrants; and
- had our work monitored by the Section 29 Scrutiny Committee, including an assessment of the quality of our decisions.

More information about our work can be found on our website at www.chre.org.uk.

2 Chair's introduction

As we close a year of debate about the future shape of the regulation of healthcare professionals, it is clear that the key challenge ahead will be delivering the reforms identified in the past year.

Reviews by the Chief Medical Officer, on the regulation of doctors, and the Department of Health, on the regulation of non-medical healthcare professionals, concluded with the White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* in February 2007. This White Paper sets out the future direction of the regulation of healthcare professionals over the years to come.

A number of the reforms contained in the White Paper directly affect CHRE: "The Government expects that the reforms (...) will provide greater room for CHRE's Council to balance its work on scrutiny with enhanced and extended work on best practice and common regulatory issues. In doing so, it needs to be an authoritative independent voice for patients on the regulation of professionals, providing expert advice on policy. To do so, it also needs to be independent of the professional regulators themselves."

Crucially, the Council itself will change, becoming smaller and more board-like. All its members will be appointed, and it will no longer include the presidents of the national healthcare regulators. We welcome this development and relish the challenge of becoming a more strategic council that is instrumental in delivering improvements in regulation. The White Paper also sets out key tasks for CHRE in researching and advising on regulation-related issues.

We believe that the proposals in the White Paper are positive for patients, the public and professionals. From a public perspective, CHRE will be responsible for monitoring the preliminary stages of the fitness to practise procedures of the regulators, in which complaints about registrants are received and screened. This will enhance public confidence in regulation by providing added transparency and accountability to the fitness to practise system, and will support the regulators in learning from their current functions.

Most important, though, is the overall vision and the key purpose of the reforms: to strengthen public protection by increasing accountability for continuing fitness to practise, creating more consistency across regulators, and fostering collaboration between regulators and the organisations delivering health and social care at a local level.

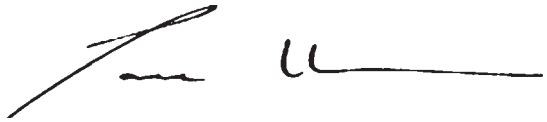
The White Paper will also change the relationships between regulators and organisations delivering health and social care, patients, the public and professionals. The development of a revalidation process will allow individual professionals to demonstrate that they remain up-to-date and fit to practise their profession. An independent body is to be formed to adjudicate on fitness to practise cases involving doctors. Other regulators will be able to use a central list of fitness to practise panel members and, over time, join the new independent adjudication body. All regulators will have more strategic councils, with increased public input.

We welcome these developments, for which the White Paper consultation paved the way in the past year. The challenges of implementing the reforms should not, however, be underestimated. For us and for the regulators, there is an ever-greater need to work together in partnership, and with patients and the public, professionals, health departments, our social care partners, and other stakeholders.

It is important to set these overall reforms in the context of a changing healthcare and regulatory environment. Whilst we and the regulators will spend time and energy on the White Paper reforms, we will also need to keep focused on the wider trends of greater patient choice, diversification of providers, customised healthcare systems in England, Wales, Scotland and Northern Ireland, mobility of professionals worldwide, and greater information sharing in cases involving children and vulnerable adults.

CHRE has always seen its role as adding value to the work of the regulators through co-ordination and the sharing of learning. Helping to deliver a wide programme of reforms will require us to concentrate on this core function, and we are ready for this challenge.

I would like to thank all those who have worked with us in the past year for their support, in particular my fellow council members, who have helped shape the White Paper's ambitious agenda, and we look forward to working with our partners to see through a more consistent, proportionate and effective regulatory system.



Jane Wesson
Chair

3 Director's report

The fourth year of CHRE was dominated by the discussions arising from the UK-wide reviews of the regulation of healthcare professionals, resulting in the White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*. We were actively involved in the reviews and the subsequent consultation. We provided the Secretary of State, at her request, with advice on revalidation, good character, outstanding legislative issues, student registration, and protocols for local investigation.

The White Paper sets out a wide-ranging programme of work for CHRE, the regulators, healthcare providers and other stakeholders. This will require CHRE to implement a number of strands of work. We have already started revising our internal processes to prepare for new responsibilities, bespoke projects and proposed legislative changes. We need to continue building on this work, and on the consultative approach we adopted for the Clear Boundaries project, to be fit for purpose.

From the Clear Boundaries project, on defining and maintaining clear sexual boundaries between patients and professionals, we have produced draft guidance for employers, professionals and patients, which we will launch in 2007. This guidance will help raise awareness of this issue to minimise incidences of abuse, and ensure that complaints are dealt with sympathetically and effectively. We are particularly grateful to the large number of individuals and organisations who contributed to the project and hope to build on this work over the next couple of years.

We also completed the first phase of our student fitness to practise project, in partnership with the regulators. The White Paper asked regulators to report back on the issue of whether they should have closer relationships with students and trainees. We now aim to facilitate the regulators' work on student fitness to practise, by holding a workshop to discuss the issues to be addressed and share information.

The main purpose of the Section 29 process is to improve the quality of the regulators' fitness to practise procedures and the standard of decisions made by panels and committees. In many cases we have identified important learning to enhance public protection. We have compiled this learning into a document, which will enable us to share good practice across the regulators and other organisations. This learning has also been fed back individually to the regulators, which have taken it into account. We have also organised a seminar for staff and lawyers from the regulators on the subject of writing charges.

It is to the credit of the regulators that there has been a substantial improvement in the quality of outcomes from their fitness to practise panels. We are confident that our Section 29 work has been a major factor in generating these improvements. Although the number of cases notified to CHRE has increased by 151, there has been a reduction in the number referred to court, from ten last year to four this year. Many of the panels' decisions show that they have learned from the outcomes of Section 29 appeals and the feedback we have given to the regulators.

We have undertaken our fourth performance review, with a specific theme of partnership working. Regulators have worked together in a number of ways, notably by jointly commissioning research on making their registers more usable for patients and the public. Regulators have also worked to involve patients and the public more in their work – an area which needs to be developed further – and with employers, for example by running events or producing publications.

The publication of the White Paper concluded a year of some uncertainty for CHRE, as well as a year of change, with both Jane Wesson and myself leaving the organisation to take up new roles[1]. But it was also a year of great achievement: the fundamental and positive reforms to regulation, as outlined in the White Paper, that arose from the many debates between the Government, CHRE, regulators and other stakeholders.

I would particularly like to thank my staff, and all those who have helped us, for their hard work in carrying forward this demanding work programme.

Sandy Forrest
Director

1 Jane Wesson resigned as Chair and lay member of Council with effect from 12 April 2007 and Sandy Forrest resigned as Director with effect from 30 April 2007. A process is currently underway to replace Sandy Forrest as Director and Jane Wesson as a lay member and then to elect a new Chair.

4 About us

4.1 Regulating professionals

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

- to maintain a register of those fit to practise in the UK (in some cases, companies or organisations as well as individuals);
- to set standards of behaviour and ethical guidelines for registrants;
- to set educational standards and create systems to maintain registrants' skills; and
- to deal with concerns about fitness to practise because of registrants' poor health, misconduct or poor performance.

In general, the councils that govern these regulators include members of that profession and a number of lay members (members of the public) to provide a public focus. The proportion of lay members varies from council to council, but all currently have a majority of professionals.

4.2 Our mission

CHRE was set up in April 2003 by the National Health Service Reform and Health Care Professions Act 2002 (the Act)[2]. Our mission is to protect the public interest, promote best practice and achieve excellence in the regulation of healthcare professionals.

We report to the UK Parliament, and take account of developments in England, Scotland, Wales and Northern Ireland. While professions regulated prior to devolution remain the 'reserved' responsibility of the UK Parliament, responsibility for groups joining after that date is devolved to the Scottish Parliament and the Northern Ireland Assembly. The National Assembly for Wales could seek similar powers in the future. We see a clear advantage and need for regulation to remain fundamentally UK-based, although regulatory schemes will have to adapt and be flexible to take account of the diverse developmental needs of the devolved nations, where health policy and health provision are devolved functions.

2 Available at: www.opsi.gov.uk/acts/acts2002/20020017.htm.

CHRE Council meeting, March 2007

4.3 Who we are

Our governing Council has 19 members: one representative from each of the nine regulators (usually the president) and 10 lay members. The lay members include one from each of Scotland, Wales and Northern Ireland.

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

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

- General Chiropractic Council (GCC), which regulates chiropractors;
- General Dental Council (GDC), which regulates dentists, dental hygienists and dental therapists;
- General Medical Council (GMC), which regulates doctors;
- General Optical Council (GOC), which regulates dispensing opticians and optometrists;
- General Osteopathic Council (GOsC), which regulates osteopaths;
- Health Professions Council (HPC), which regulates arts therapists, biomedical scientists, chiropodists and podiatrists, clinical scientists, dieticians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers, and speech and language therapists;
- Nursing and Midwifery Council (NMC), which regulates nurses and midwives[3];
- Pharmaceutical Society of Northern Ireland (PSNI), which regulates pharmacists; and

3 The NMC currently has three parts to its register: nurses, midwives, and specialist community public health nurses.

- Royal Pharmaceutical Society of Great Britain (RPSGB), which also regulates pharmacists.

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

4.4 Why CHRE was set up

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

4.5 What we do

Our responsibilities, as set out in the Act, are to:

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

We can carry out these responsibilities in four main ways.

4.5.1 Monitoring how regulators operate (Section 26 of the Act)

Monitoring includes:

- investigating and reporting on how regulators function;
- comparing their performance; and
- recommending changes in how they carry out their work.

We do this through an annual performance review process (see 6). More information about this, including overall and individual reports for this year and last year, is on our website.

Student fitness to practise seminar, October 2006

4.5.2 Recommending changes to regulators' rules (Section 27)

In the future, we may recommend that a regulator makes rules or changes existing rules if we feel that this is necessary to protect the public.

4.5.3 Referring cases of 'undue leniency' to court (Section 29)

In some circumstances, we may refer fitness to practise (FTP) decisions to court if we consider the regulator's decision to be unduly lenient and that a referral is necessary to protect the public.

4.5.4 Advising health ministers (Section 26 (7 and 8))

We have a statutory responsibility to give advice to the Secretary of State/health ministers of England, Scotland, Wales and Northern Ireland, who may ask us about anything connected with a healthcare profession.

4.6 Developments within CHRE during the year

We have redesigned our website to make it more accessible. The website is now easier to navigate, so that the information being published and updated can be found more quickly. We aim to be an open and transparent organisation and our website enables us to communicate information effectively to our stakeholders, such as patients and the public, regulators, registrants, employers, education providers and statutory organisations. We have also created an extranet to support regular communication with Council members.

For more information about CHRE, including our publications, press releases and Council papers, and our business and corporate plans, see our website at www.chre.org.uk. Information about us is also available in different languages, and we have an approved Welsh Language Scheme.

5 Our achievements

5.1 Promoting good practice

5.1.1 Clear Boundaries project

Our Clear Boundaries project focuses on promoting and maintaining clear sexual boundaries between patients and professionals. This project, funded by the Department of Health, was set up in response to the Ayling and Kerr/Haslam Inquiries[4]. It forms a significant part of the Government's response to the inquiries, as set out in its recent *Safeguarding Patients* document[5], which accompanies the White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*. The project aims to minimise inappropriate sexual behaviour in professionals, improve the processes for detecting and dealing with such behaviour, and inform patients about the standards of conduct they are entitled to expect from professionals.

In the past year, we completed a literature review on the subject, spanning 1970 to 2006[6]. Guidance for professionals and NHS employers has been drafted and tested with focus groups, as has a patient information leaflet. Work is underway on how the issue of professional boundaries can be incorporated into pre- and post-registration education and training, and into the training of fitness to practise (FTP) panel members. A further success of this project has been to create a national network of around 450 interested individuals and organisations, which will serve as a useful basis for the consultation stages of other projects. The Clear Boundaries project will continue in the coming year.

5.1.2 Student fitness to practise project

Last year we also completed the first phase of our student fitness to practise project, in collaboration with regulators. Student fitness to practise can be defined as the suitability of students or trainees to practise a particular profession during education and training. The objectives of this phase of the project were to:

- share learning on regulators' current practice in promoting professional values among students and ensuring that students are fit to practise at the point of registration;
- discuss professional values for students; and
- identify next steps, if necessary.

4 *Committee of Inquiry – independent investigation into how the NHS handled allegations about the conduct of Clifford Ayling*, September 2005, Department of Health, Cm 6298, The Kerr/Haslam Inquiry, HM Government, Cm 6640, July 2005.

5 *Safeguarding Patients*, Cm 7015, Department of Health, February 2007.

6 Halter, M, Brown, H and Stone, J. *Sexual Boundary Violations by Health Employees: An Overview of the Published Empirical Literature* (2007), Council for Healthcare Regulatory Excellence.

Student fitness to practise seminar, October 2006

The project included a scoping exercise, a cross-regulatory seminar in October 2006, and an overall report setting out specific areas for further consideration. The project identified the main challenges in student fitness to practise, allowed the regulators to share good practice and raise common concerns, and suggested next steps. The White Paper (see 6.3) subsequently recommended that regulators should report back in January 2008 on this issue. We now plan to work with regulators to revisit the recommendations for the next phase of the project in 2008.

5.1.3 Contributing to the regulatory reviews and advice to ministers

In 2005, the Government set up two reviews of the regulation of healthcare professionals, following the publication of the Fifth Report of the Shipman Inquiry (*Safeguarding Patients: Lessons from the Past – Proposals for the Future*[7]). The first review, by Sir Liam Donaldson, Chief Medical Officer (CMO) for England, considered the regulation of doctors, and the second, by the Department of Health (DH), considered the regulation of other healthcare professionals. We were involved in both reviews, and contributed to the debate throughout the year, in particular by responding to the consultation on the reports produced by the reviews.

In addition, under Section 26 (7 and 8) of the *National Health Service Reform and Health Care Professions 2002* (the Act), we are required to respond to ministers' requests for advice (see 4.5.4). This year, the Secretary of State for Health asked for our advice on five topics:

- protocols for local investigation;
- good character;
- student registration;
- revalidation; and
- priorities for legislative reforms outside of the scope of the reviews.

We have now adopted a formal procedure for responding to requests under Section 26 (7 and 8).

7 For more information see http://www.the-shipman-inquiry.org.uk/fifthreport.asp.

5.2 Working in partnership to progress regulatory excellence

5.2.1 Building links within the UK, in Europe and worldwide

We have contributed to national discussions on and responses to the White Paper in the differing healthcare environments of the three devolved nations. We have worked closely with partners in the devolved nations on specific initiatives.

- In **Scotland** we contributed to projects on the regulation of support workers and the development of a "physician's assistant" role. Discussions with the Scottish Executive Health Department (SEHD) led to the establishment of regular meetings between SEHD, regulatory body chief executives and CHRE, where the role of regulation and the particular healthcare agenda for Scotland will be discussed. We consolidated our memorandum of understanding with NHS Quality Improvement Scotland[8] and established a relationship with Scottish social services.
- A four-country meeting, proposed by CHRE, was held in **Wales**. This meeting gave an opportunity for civil servants from the devolved nations to discuss the implications of the CMO and DH reviews. We also held our September 2006 retreat in Cardiff, which was attended by the Welsh Minister for Health and chief and senior officers. As in Scotland, we have contributed to the discussion of emergent roles.
- In a year of change and uncertainty for healthcare regulation in **Northern Ireland**, we provided advice to the health department in its development of a patient and public involvement (PPI) strategy. We met with the PSNI quarterly to support and advise it as it prepares for substantial change.

In Europe, we joined and have been active members of CEEP (the European Centre of Enterprises with Public Participation and of Enterprises of General Economic Interest) and CEPLIS (the European Council of the Liberal Professions), and have discussed with organisations in the UK and Europe the implications of new directives. In particular relation to the new directive on the mutual recognition of qualifications, we attended European meetings and reported to stakeholders in the UK on a new electronic information-sharing initiative (the Internal Market Information (IMI) project). We regularly review European Union case law for healthcare registrant cases to ensure that there is no conflict with UK law, and contribute to the Department of Health's transposition of European directives into national law.

8 NHS Quality Improvement Scotland is a special health board responsible for improving care across NHS Scotland. For more information see www.nhshealthquality.org.

Clear Boundaries conference, June 2006

Worldwide, we attended the Conference of the International Association of Medical Regulatory Authorities (IAMRA) in Wellington, New Zealand, in November 2006. While in New Zealand, we also had the opportunity to share good practice and key issues with colleagues from New Zealand and Australia.

5.2.2 Partnership with the social care regulators

We have continued to build on our partnership with the four UK social care regulators, to enable us to exchange experience and ideas and to reflect the increased integration of health and social care policy. The chair of the General Social Care Council (GSCC) in England has always been an observer on our Council, and when our Council meets out of England, the chair of the relevant regulator for social care staff in Scotland, Wales or Northern Ireland attends. We have continued to organise regular meetings between the chief executives of the health and social care regulators. At operational level, GSCC staff are involved in cross-regulatory groups and our projects.

5.2.3 Section 29 feedback points

From our role under Section 29 of the Act, we have identified important learning about the FTP processes of the regulators to enhance public protection. This has been disseminated to the regulators through frequent feedback meetings. These meetings have resulted in agreed action, often involving additional training for the panel members. We have contributed to many of the regulators' training sessions for panel members and legal assessors on matters such as the writing of determinations. The issues we have raised with the regulators, and progress on the agreed action points, have been reviewed during the performance reviews of the regulators (see 6).

We are in the process of developing a summary of all of the learning arising from our consideration of FTP cases under Section 29 which will shortly be made available on our website to all FTP panel members. This will be updated regularly as new issues emerge. One issue that we have noted as a part of this process has been an increasing number of cases in which the charges or allegations have been incorrectly or imprecisely framed. In response to this we ran a seminar for staff and lawyers from the regulators on the writing of charges.

5.2.4 Cross-regulatory groups

We have set up a short-term working group to consider the development of a standardised set of information that all regulators would record for FTP cases. This would allow comparison of FTP decisions across the regulators. The information gathered would also enable regulators and CHRE to highlight questions to explore and overall trends across regulators.

There are a number of cross-regulatory groups sharing information and good practice, and two groups working on joint initiatives:

- the UK Health and Social Care Regulators' Public and Patient Involvement Group (PPI Group); and
- the Alliance of UK Health Regulators on Europe (AURE).

The chief executives and registrars of the regulators also meet regularly. These meetings are invaluable in facilitating the exchange of ideas, as well as cross-regulatory working. For example, our cross-regulatory group of FTP managers received a presentation by a representative of the Association of Chief Police Officers (ACPO), and regular updates from the GMC and the NMC about the development of a protocol to exchange information with the police. This has had a positive impact on the dialogue of regulators with the police.

5.2.5 Promoting cross-regulatory collaboration

Two years ago, through the performance review process, CHRE and regulators identified important cross-regulatory areas of work:

- making complaints work better;
- preparing for the European directive on the recognition of qualifications; and
- making registers more accessible to the general public.

This year, as part of the performance review process, regulators have given an update on progress in these areas.

Most of the regulators have revised their complaints leaflets, using the common template produced by CHRE. All regulators have been working with the Government to prepare for a new European directive on the recognition of qualifications. This will become part of UK legislation on 20 October 2007, and will present challenges for regulation, particularly in relation to temporary and occasional work.

Student fitness to practise seminar, October 2006

The PPI Group (see 5.2.4), to which the regulators and CHRE all contribute, commissioned research into how registers could be made more usable. Regulators have begun to consider and implement these recommendations. The GOC, for example, has changed its search function and included a guide to using the register.

5.3 Protecting the public

Under Section 29 of the Act, we can, in some circumstances, refer FTP decisions to court[9] if we consider that a decision is too lenient and that a referral is necessary to protect the public. A case meeting of our Council members decides whether to refer each case. We have continued to use these powers responsibly to strengthen the regulatory framework and, in doing so, to enhance public protection.

The principal aim of the Section 29 process is to improve the quality of the regulators' fitness to practise procedures, and the standard of the decisions made by panels and committees. This can often be achieved without referring cases to court.

5.3.1 The positive impact of Section 29

There is no doubt that there have been substantial improvements in the quality of outcomes from the regulators' fitness to practise panels. We are confident that our work in Section 29 has been a major factor in generating these improvements. Although the number of cases notified to CHRE has increased, there has been a reduction in the number referred to court. Many of the panels' decisions show that they have learned from the outcomes of Section 29 appeals and the feedback we have given the regulators. In many cases they have referred in their determinations to relevant judgments in Section 29 cases.

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

9 Where the registrant has a registered address in Scotland, the appropriate court is the Court of Sessions in Edinburgh. If the registered address is in Northern Ireland, the appropriate court is the High Court of Justice in Belfast. Where the registered address is in England or Wales, the appropriate court is the High Court in London.

We believe that by tracking the types of cases, and encouraging regulators to categorise them (see 5.2.4), it will be easier to identify areas where education and training or guidance may need to be strengthened or good practice shared. This is important if more general lessons are to be learned when things have gone wrong.

5.3.2 Developments in regulatory law

Only a small number of cases are referred to court under Section 29, and referral to court is by no means our main focus. However, there have been some important judgments arising both from Section 29 appeals, and from appeals by registrants against decisions made by their regulatory body. The most notable judgments have been those in the cases of *Marshall, Phipps, Meadow* and *Saluja*. The main issues raised in these judgments are summarised below – more details are available on our website.

- *Giving reasons in determinations*
  Panels need to give reasons to explain their findings of fact, although the amount of detail will vary according to the matter under consideration. There is also a duty on panels to explain how the sanction they have imposed protects the public.
- *Immunity from disciplinary action for expert witnesses*
  A Court of Appeal judgment overturned last year's High Court judgment which said that immunity from legal action for expert witnesses should extend to disciplinary action by regulators.
- *Application of Section 29 to a decision to stay proceedings*
  Any decision which effectively ends the panel's jurisdiction in a case becomes a decision for the purposes of Section 29.

5.3.3 Developments in the Section 29 process

Following consultation with the regulators, we revised our *Process and Guidelines for Section 29 cases* document, and CHRE's Council formally adopted the updated version in January 2007. This document is available on our website, together with other guidance we use when assessing FTP cases, including:

- our Alternative Dispute Resolution Policy;
- guidance for members on the exercise of the Section 29 discretionary power;
- copies of all court judgments; and
- copies of the notes of all Section 29 case meetings.

Student fitness to practise seminar, October 2006

5.3.4 Alternative dispute resolution

The courts have made it clear that resolving public protection concerns by way of a court hearing may not always be necessary if alternative ways that adequately protect the public can be agreed. During the year we have continued to implement our Alternative Dispute Resolution Policy, which requires us to engage in discussions with the regulatory body and the registrant (through legal representatives) to agree an outcome which rectifies the situation.

5.3.5 Quality assurance and openness

The Section 29 Scrutiny Committee has continued to monitor our work on Section 29. The Scrutiny Committee is made up of six members of Council and a senior policy representative from Which?, the independent consumer organisation. The Committee met twice during the year.

The Committee considered a third research report which it had commissioned to assess whether the staff are referring the right cases to Council members for consideration at case meetings. The report, by Professor Vivienne Harpwood of Cardiff University, concluded that the staff have been referring the right cases to case meetings. The report showed no bias in respect of the regulator, the registrant's gender or, as far as it was possible to ascertain, ethnicity, and that good practice was the norm. The Scrutiny Committee was pleased to note Professor Harpwood's comments on the consistency, professionalism, depth of knowledge and excellent team working of the Section 29 staff.

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

5.3.6 Tendering for legal advice

To ensure that we are achieving value for money in relation to the legal advice we receive, we have undertaken a retendering exercise for legal advice, with support from the NHS Purchasing and Supply Agency (NHS PASA). The tender was advertised widely, including in the Official Journal of the European Union. We expect to have completed this process by the end of May 2007.

5.3.7 Numbers of Section 29 cases

We have continued to see an increase in the number of FTP cases dealt with by the regulators (from 764 to 915). This rise is to some degree due to an increase in the number of complaints received by some of the regulators. It is also due to the fact that some regulators have been taking action to reduce the time taken to complete cases, in order to clear backlogs of cases.

The trend of increasing numbers of FTP cases is likely to continue as more professional groups become registered, and as changes in legislation allow regulators to operate more flexibly.

Annex A shows a breakdown of the cases we dealt with this year. Of the 915 cases we considered between 1 April 2006 and 31 March 2007, 732 were closed with no requirement for more information, and we sought and considered additional information in the remaining 183 cases. Council members considered ten of these cases and we appealed to the High Court in four cases (one of which we later withdrew). Of these four cases, two were from the HPC, including the one which was withdrawn. The other two were from the NMC.

We received judgments from the High Court on two cases this year. In both cases our appeals were upheld. There is more information about the High Court judgments, including copies of the court judgments and orders, on our website.

Student fitness to practise seminar, October 2006

6 Developments in regulation

As part of our statutory remit we conduct an annual performance review of the functions of the regulators.

This year, as last year, we asked the regulators to update the information held from previous years on their organisational structure, functions and activities. Following this, we held face-to-face meetings with each of the regulators. More information on the questionnaire, the process and the detailed outcomes of the performance review can be found on our website.

The nine regulators currently register about 1.19m healthcare professionals (see figure 1), across the independent and NHS sectors and in a great variety of settings. Although the responsibilities of the regulators are broadly similar, each has a different legislative framework and established practices. They also vary in many ways because of differences in their sizes and incomes, and because different professions have different regulatory challenges.

6.1 Overview: trends and information

6.1.1 Chief Medical Officer and Department of Health reviews

For most of the regulators, this year was dominated by work relating to the Chief Medical Officer (CMO) and Department of Health (DH) reviews. The reports arising from these reviews were published in summer 2006, and a period of consultation followed, to which all regulators contributed. The resulting White Paper, *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century,* was published in February 2007.

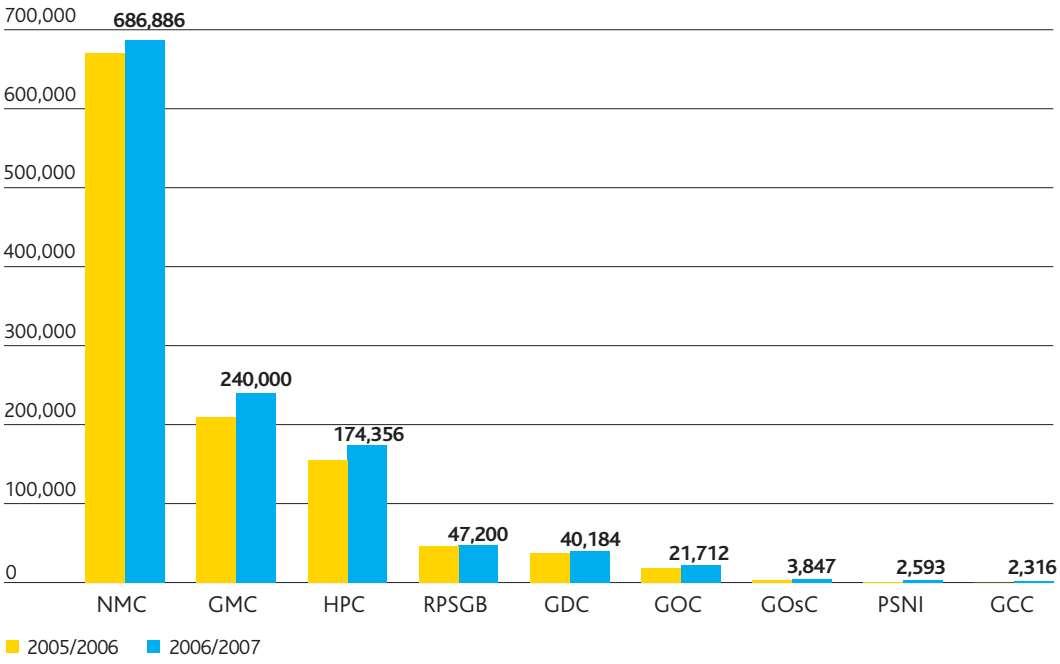
The implications of the CMO and DH reviews are far-reaching, and recommendations were made for the development of many areas of regulation. The reviews focused on:

- the governance arrangements of regulators;

- adjudication in fitness to practise (FTP) cases;
- a move towards a system of revalidation of healthcare professionals; and
- whether the number of regulators should be reduced.

For more information on the reviews see 5.1.3.

Figure 1: number of registrants



Numbers above the columns relate to 2006/2007

6.1.2 New legislation

Regulators have faced the challenge of implementing new legislation, in the form of Section 60 Orders[10]. The GDC, GOC and RPSGB have all been working to implement the changes brought in by recent legislation, covering issues such as changing FTP processes or making continuing professional development (CPD) compulsory.

6.1.3 Volume of work

As last year, the volume of work undertaken by the regulators has increased. The total number of professionals registered has risen by approximately 4% (see figure 1). The total number of complaints against registrants received by the regulators has remained broadly the same, although individual regulators have seen changes (see figure 2).

10 The process under Section 60 of the Health Act 1999 gives the Government the power to amend the law governing the work of the regulator.

Council dinner, March 2007

The number of FTP cases dealt with by regulators, and thus the number of cases notified to our Section 29 department, has risen this year (see 5.3.7).

6.1.4 Regulating more healthcare staff

The need for a wider range of healthcare staff to be regulated has been discussed this year, with some regulators obtaining legislation to do so. The GDC began regulating dental nurses, dental technicians, clinical dental technicians and orthodontic therapists. The RPSGB's recent Section 60 Order has allowed for the statutory registration of pharmacy technicians in England and Wales, which will be implemented across Great Britain when equivalent legislation is introduced in Scotland. More healthcare professionals and professions may be regulated in the future (see 6.3.4).

6.1.5 Revalidation of registrants

Revalidation (see 6.3.2) was proposed some years ago by the GMC as a means of ensuring that professionals remain fit to practise. The CMO report proposed and consulted on a model of revalidation for doctors, while the DH report considered whether the general principle of revalidation should be introduced for other healthcare professionals. Regulators have identified revalidation as a priority area of work for the coming year. If introduced, it will have implications for the relationship between regulators, employers, commissioners and the professionals themselves.

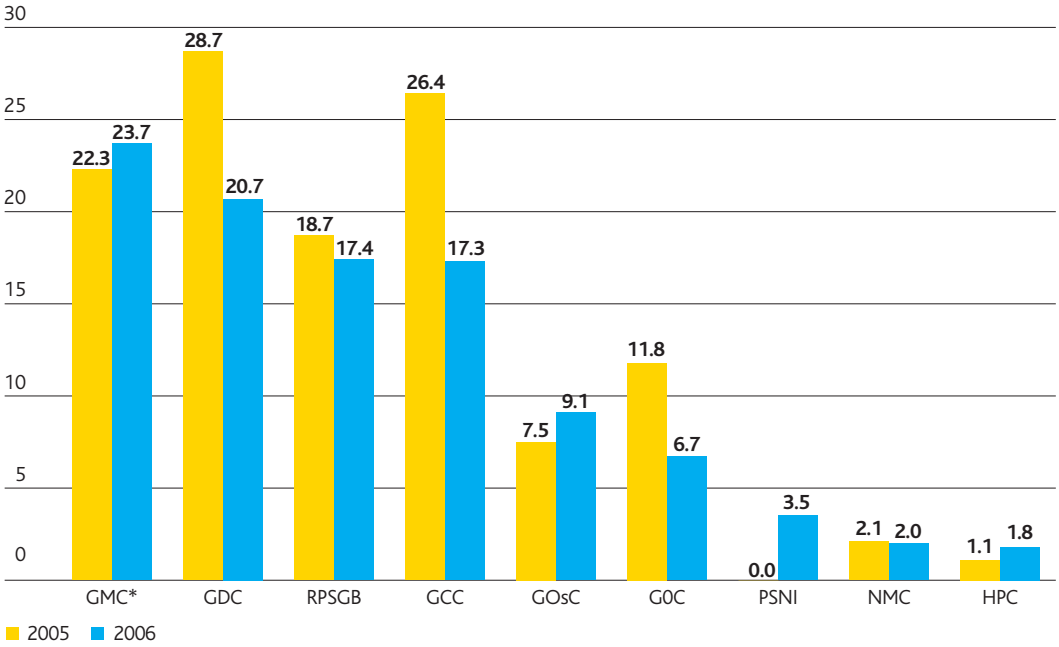
6.1.6 Strengthening key activities

Education has, as last year, been an important area of work for the regulators. Some have started to review their educational standards, while others have introduced changes to their quality assurance systems, worked with educational providers or

Good practice example

*The GMC has reviewed its core guidance, **Good Medical Practice**, and produced four pieces of supplementary guidance to support it. It also published guidance on the role and responsibilities of doctors when working with young people.*

Figure 2: complaints received per thousand registrants



*2004 and 2005 data used for the GMC as 2006 data is not yet available

Complaints refer to complaints made to regulators against their registrants.
Differences in the number of complaints received need to be seen in the context of differences between regulators' complaints processes and the environments in which registrants work.

worked on standards for CPD. The GDC, GMC, HPC, NMC and RPSGB all published additional guidance or reviewed existing guidance for registrants on a variety of issues. The GOC has commissioned legal advice on the sale and supply of optical appliances, and had significant input into guidance developed by the professional bodies.

The GDC, HPC and RPSGB have all made changes to their processes for dealing with complaints about their registrants (FTP cases). The GDC and RPSGB both received Section 60 Orders reforming their FTP processes and the GDC, having received its order earlier in the year, is well advanced in the implementation of the changes.

6.2 Performance review: key developments and challenges

6.2.1 Accountability

Good governance is a key component of good regulation. The CMO and DH reviews highlighted this, and the regulators, in their responses to the reviews, recognised the need for changes to their governance arrangements in order to strengthen public confidence. This year some regulators have examined their governance arrangements, for instance the GDC has consulted on constitutional reform.

Student fitness to practise seminar, October 2006

The CMO and DH reviews suggested that for those regulators whose legislation or a Royal Charter provides for professional leadership and promoting the profession, these should explicitly and exclusively be exercised for the benefit of the public. The PSNI and RPSGB both recognise this challenge, and the GOsC is keen to amend its statutory objectives to clarify that its role is to promote the standards expected of an osteopath, not to promote the profession.

6.2.2 Transparency and consistency

The general move by regulators towards separating policy-making and adjudication has continued this year, with most now either having or seeking to have FTP panels independent of their councils.

Good practice example

The RPSGB used an independent appointments group when choosing members for its new FTP committees. These committee members have received training that includes CHRE feedback points and the issue of boundaries between professionals and patients, the latter provided by WITNESS.[11]

The improvement in FTP processes is quantifiable through our Section 29 power (see 5.3). This year we made four referrals to court, compared with ten in the previous year. Feedback given to regulators on the amount of detail required in their determinations has resulted in improvements, in particular from the GMC and HPC.

6.2.3 Proportionality and targeting

'Feedback loops' – sharing information between a regulator's different departments – have allowed the regulators to learn from their activities. The GDC intends to implement a new system of categorising and analysing FTP cases to facilitate better feedback on education and standards issues, and the HPC's Policy and Standards department is working with its FTP department to ensure consistency and best practice in answering standards and ethics queries.

11 The charity, formerly known as Popan, that deals with abuse by health and care workers – see www.witnessagainstabuse.org.uk.

Good practice example

The GOsC organised workshops to improve registrants' continuing professional development (CPD). These workshops fed back key points from the FTP process to the profession in order to foster best practice and to help osteopaths avoid situations which are likely to lead to complaints. Their objective is to improve the patient experience.

Regulators have continued to work towards an evidence-based approach to policy- and decision-making. The GMC has established a research partnership with the Economic and Social Research Council, with projects on a range of issues expected to run from 2007 until 2009.

Last year, the performance review revealed that a number of regulators were actively considering the concept of risk-based regulation. There has been further progress this year. The NMC adopted a new UK-wide quality assurance framework for nursing and midwifery education that aims to provide a risk-based approach to monitoring NMC standards. The RPSGB commissioned a scoping study on assessing risks and risk-based regulation in relation to advanced and specialist registration and annotations to the register.

Good practice example

In May 2006 the GDC opened its Dental Complaints Service (DCS) to assist dental patients and professionals in resolving complaints about private dental services. Following the closure of a complaint, feedback forms are sent out to both the dental professional and the patient and used to inform process improvements. A review of its first hundred days of operation showed that the DCS was able to facilitate the resolution of the majority of complaints within two and a half days. The DCS focuses on encouraging the dental professional and patient to resolve complaints quickly and informally, as an alternative to the courts. As an operationally independent service, the DCS is entirely separate from the GDC's FTP procedures.

6.2.4 Working with others

The regulators continued to be involved in a number of cross-regulatory groups, such as the PPI Group and AURE (see 5.2.4). Regulators have also participated in CHRE-led projects on sexual boundaries and student fitness to practise, the GMC seconding a member of staff to the latter, as well as working with each other on projects relating to education, training and guidance.

Clear Boundaries conference, June 2006

Good practice example

In continuing work on its 'HPCheck' campaign, which aims to raise awareness of protected titles, the HPC ran a regional campaign in Birmingham to publicise the importance of checking that a health professional is registered. An 'e-kit' has been developed for registrants, with logos and information that they can use to help display their registration clearly, to encourage members of the public to check the register.

Good practice example

The GOsC is working with the NMC to develop joint guidance for osteopath's caring for pregnant women. The GOsC also plans to work with the RPSGB on the training of FTP staff in drafting complaints statements. The PSNI and the RPSGB have worked jointly on the quality assurance of undergraduate education.

All regulators are involved in the PPI Group. In addition to its work on making registers more usable (see 5.2.5), the group has undertaken projects on a joint UK health and social care regulators' patient information leaflet, as well as a patient and public involvement (PPI) practice handbook, a standard page on all regulators' sites with links to the joint information leaflet, and a series of seminars on PPI issues. In addition to this group, each regulator is at a different stage in the development of its own full PPI scheme. The RPSGB has adopted a comprehensive PPI strategy while the GDC hosted conferences with Action against Medical Accidents (AvMA).

Good practice example

The GMC has expanded its Patient and Public Reference Group by recruiting seven further lay members. An external readers' panel has been established to ensure that the GMC's communications are accessible and easy to understand.

Good practice example

The NMC has used focus groups to inform several areas of its policy development and has taken feedback from individuals and patients' groups, which indicated a preference for this form of engagement.

The regulators have been involved in specific initiatives in England, Scotland, Wales and Northern Ireland, and some of the larger regulators have considered the issue of devolving powers within their organisations. The GMC this year opened its Belfast office, and already has offices in Cardiff and Edinburgh. The RPSGB has implemented its decision to devolve powers to develop and improve pharmacy practice, forming new national pharmacy boards, operational from February 2007.

Employers are key stakeholders for most of the regulators, which have continued to work in partnership with them. The GMC's Employers' Reference Group is working to improve complaints handling, and the NMC has hosted regular Employers' Summits and seminars on the *NMC Code of professional conduct: standards for conduct, performance and ethics*.

6.2.5 Challenges for the future

In addition to the challenges posed by the publication of the White Paper (see 6.3), further challenges remain, including:

- the changing healthcare landscape across the devolved nations of the UK;
- the increased mobility of the international workforce, particularly within Europe;
- a greater focus on patient involvement and, specifically in England, patient choice; and
- the implementation of new legislation relating to the protection of children and vulnerable adults.

To implement the recommendations in the White Paper, regulators will need further legislation, including Section 60 Orders. A need has been identified to streamline the process by which such orders are passed, an issue highlighted by the delays experienced by the RPSGB in receiving its recent order. We will continue to discuss this issue with the Government.

Lord Hunt, Minister of State for Quality, Department of Health

Dr. Brian Gibbons, Minister of Health and Social Services, Welsh Assembly Government (until May 2007)

6.3 The White Paper

In February 2007 the Government published the White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*[12]. It follows the Chief Medical Officer's report on the regulation of doctors and the Department of Health consultation on non-medical professions (CMO and DH reports), which in turn followed the Fifth Report of the Shipman Inquiry, and sets out the Government's proposals for reforming the regulation of healthcare professions.

Its proposals reflect the principles that the Government believes should underpin statutory professional regulation:

- prioritising public protection and quality of care;
- sustaining public confidence in regulation by ensuring the regulators' independence;
- maintaining standards;
- proportionality; and
- the flexibility to serve differing needs such as those of the devolved regions.

Key themes of the White Paper are outlined below. Implementation of some of the recommendations may require both primary and secondary legislation.

6.3.1 Governance

Regulators' councils are to be smaller and more accountable to Parliament. Members will be independently appointed, and at least half will be lay people. The Government will work with the pharmacy profession to establish a new General Pharmaceutical Council responsible for the regulation of pharmacists and pharmacy technicians, and the registration of pharmacy premises. As a first step a working party will be established to take forward detailed proposals, and its work will help to inform decisions about the regulation and leadership of pharmacy in Northern Ireland.

12 For more information see: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065946

As with the healthcare regulators, CHRE's Council is to become smaller and more board-like. The regulators will no longer nominate members, who will instead be selected by the Appointments Commission. The Chair will also be appointed rather than elected. The Government intends CHRE to be "an authoritative independent voice for patients on the regulation of professionals", and this will be considered by our Council.

6.3.2 Revalidation

The CMO report's proposed system of revalidation for doctors was endorsed by the White Paper. Under this system, all doctors will have a licence to practise which must be renewed every five years. The Government will seek to establish a network of GMC Affiliates, which will facilitate revalidation and strengthen the relationship between national and workplace regulation. Revalidation for other professions is necessary, but the details (for example, frequency) for each need to be proportionate to the risks inherent in the work in which each practitioner is involved.

6.3.3 Adjudication

A civil standard of proof, flexibly applied, is to be used in FTP cases for all healthcare professions (previously some professions have applied a criminal standard). This means that impaired fitness to practise will be established on the balance of probabilities, rather than beyond reasonable doubt. In addition, the civil standard can be flexibly applied to take into account the circumstances and gravity of individual cases, with more serious matters requiring a greater degree of probability of the evidence being true.

An independent body is to be formed to adjudicate on FTP cases involving doctors, with doctors and the GMC having the right to appeal its decisions. This independent body will be charged with establishing a central pool of approved panellists, chosen by the Appointments Commission. Other regulators will be able to draw on this pool to conduct independent adjudication panels within their own organisations. Ultimately the other regulators may wish to adopt the independent body for the adjudication of their FTP cases to provide further assurance of impartiality.

Under CHRE's Section 29 power, we currently review all cases that reach the adjudication stage of regulators' FTP processes. We welcome the fact that, under the proposals of the White Paper, we will be asked to audit a sample of cases that the regulators have closed at earlier stages. We will report annually to Parliament on whether patient safety has been properly considered. There is also a proposal that we will monitor the GMC's use of its power to appeal decisions of the new independent adjudication body (see above).

Andy Kerr, Scottish Minister for Health and Community Care (until May 2007)

Paul Goggins, Minister with responsibility for Health, Social Services and Public Safety, Northern Ireland Office (until May 2007)

6.3.4 Professions not currently regulated

Statutory regulation is to be introduced for a range of healthcare professionals:

- applied psychologists;
- several groups of healthcare scientists; and
- psychotherapists, counsellors and other psychological therapists.

For emerging professions, a UK-wide working party will develop criteria to determine which roles also need statutory regulation. These professions are to be regulated either by existing regulators or by the new General Pharmaceutical Council, with no new regulators being created.

6.3.5 Developments in CHRE's role

Promoting consistency and developing common principles among regulators will be an increasingly important aspect of our work. It is proposed that we will be charged with supporting the development of common standards for revalidation and systems for its implementation, as well as recommending a standard definition of 'good character'.

Other projects proposed by the Government include:

- producing guidance for employers on when to refer FTP cases to a regulator; and
- continuing work on sexual boundaries between professionals and their patients.

For a full list of recommendations involving CHRE see our website at www.chre.org.uk.

7 Our people

7.1 Council Members

7.1.1 Biographies

Sandra Arthur. Sandra is currently the elected President of the Nursing and Midwifery Council. She has spent 31 years working with the NHS. She has been a midwife lecturer at Cardiff University since 1998. Sandra Arthur was editor of "Midwifery Matters", the Association of Radical Midwives (ARM) journal, and was the local ARM contact for members of the public for six years. Her multicultural interests are reflected in the two years she spent working for the Workers Education Association running Asian and Somali women's health workshops. Sandra was elected to the Royal College of Midwives Council for six years, five of which were as Vice Chair.

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

Nigel Clarke. Nigel has been Chairman of the GOsC since 2001, having served as Treasurer and lay member since the Council's inception. Following a career in public policy, including work at the Confederation of British Industry and the House of Commons, Nigel became finance director of GJW, a company offering public policy-related services. He now runs a small consultancy and serves as a director of Advanced Transport Systems Ltd, Vidapulse Ltd, and as Chairman of Newscounter Ltd. Nigel is a trustee of the Prince of Wales' Foundation for Integrated Health and works with the Changing Faces charity.

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

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

Hew Mathewson. Hew has been President of the GDC since 2003, and has been a member since 1996. Hew chaired the GDC's Professional Conduct Committee and served on the Education, Postgraduate and Ethics Committees. Hew works part-time in the dental practice he set up in Edinburgh in 1977. He was previously visiting surgeon at Edinburgh Dental School; Assistant Director, Dental Studies at Edinburgh University; and Regional General Dental Practice Vocational Training Adviser. He is also currently President of the Conférence des Ordres et organismes assimilés des praticiens de l'art Dentaire Européens – the organisation that brings together European dental regulators.

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

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

Peter North. Peter is a retired RAF officer who now holds ministerial appointments with the Department of Constitutional Affairs and the Home Office. He works as an independent Lay Assessor for the GMC. Peter is also a member of the fitness to practise committees of the GDC and GOC, and a Lay Visitor for the Postgraduate Medical Education and Training Board (PMETB).

Hemant Patel. Hemant has been President of the RPSGB since June 2005. He has served continuously on the Society's Council since 1993, first becoming President from 1998 to 1999. With a background in community pharmacy, he also works as Secretary of the North-East London Local Pharmaceutical Committee. He is currently Vice President of the Commonwealth Pharmaceutical Association and a delegation member of the Pharmaceutical Group of the European Union.

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

David Smith. David is currently a part-time food policy consultant and carer. He is a former further education lecturer and initiator and Director of Adamsdown Community & Law Centre Cardiff, and the first EC-funded anti-poverty programme in Wales, pioneering the development of public engagement and participation in health inequalities. David represents the Wales Council for Voluntary Action on the NICE Partners Council, the Wales Concordat Reference Group for inspection, regulation and audit, and the Skills for Health Sector Qualifications Strategy Group (Wales).

Anna Van der Gaag. Anna is President of the HPC and Honorary Research Fellow in the Faculty of Medicine, University of Glasgow. She has been involved in research and development initiatives in speech and language therapy for more than two decades. Her current research work includes user involvement in decision-making, e-learning in post-graduate education, and improving communication between primary care practitioners and people with communication disabilities. Anna has been a member of various advisory groups for the Medical Research Council, Department of Health, King's Fund, and the Royal College of Speech and Language Therapists.

Rosie Varley. Rosie is Chairman of the GOC, Chairman of The Public Guardian Board, Chairman of East of England Skills for Health, and a member of the Mental Health Review and Disability Tribunals. Until March 2007 Rosie was one of the NHS Appointments Commissioners. She has held a number of non-executive roles in the NHS, chaired a Mental Health and Community Trust, and served as Regional Chairman of the Anglia and Oxford and Eastern NHS regions. Rosie has a particular interest in mental health and substance misuse and is involved with organisations working in these areas. Rosie was awarded the OBE for services to the NHS and healthcare in the 2007 New Year Honours List.

Kieran Walshe. Kieran is Co-Director of the Centre for Public Policy and Management, and Professor of Health Policy and Management at Manchester Business School. He has previously worked at the University of Birmingham, the University of California at Berkeley, and the King's Fund in London. He has particular interests and expertise in public services regulation; the governance, accountability and performance of public services; and policy evaluation and learning. He is the Research Director of the Department of Health's NIHR service delivery and organisation research programme. His books include *Regulating Healthcare: A Prescription for Improvement* (2003); *Patient Safety: Research into Practice* (2005); and *Healthcare Management* (2006).

Jane Wesson. Jane has chaired CHRE since its inception in April 2003. Previously, she set up and chaired the National Clinical Assessment Authority (now the National Clinical Assessment Service) after eight years as Chair of the Harrogate NHS Trust. She has worked in the NHS as a non-executive director since 1990, combining this with roles within the NHS Confederation, Department of Health and various investigations and enquiries within the NHS. Jane is a solicitor with a background in commercial litigation and has experience in chairing social security and child support tribunals. Her work also includes independent assessment for the Office for the Commissioner for Public Appointments, and various non-executive roles.

Sally Williams. Sally is an independent health policy adviser whose clients include NHS bodies, consumer groups, charities and think-tanks. Sally previously worked as health policy adviser for the Consumers' Association and Which?. She has a particular interest in the regulation, training and supervision of healthcare professionals, and represents the public interest on a range of bodies involved with professional standards. This includes serving as a Lay Visitor for the Postgraduate Medical Education and Training Board (PMETB) and lay reviewer for the Royal College of Surgeons' Invited Review Mechanism.

Lois Willis. Lois is an independent management consultant working with a range of organisations and individuals within the public and independent sectors. Her particular interest is the effective development of partnerships to deliver policy intent. Lois is Chair of Trustees of the Storey Gallery in Lancaster. She was previously a Health Authority Chief Executive in the North West.

Judith Worthington. Judith has been a lay member of the GCC since June 2004, and chairs its Resource Management and Audit committees. Previously a lay member of the GMC, she now chairs GMC fitness to practise panels. She is non-executive Vice Chairman, University Hospitals of Leicester NHS Trust. She has participated as the lay member in Healthcare Commission's investigations into service failures in the NHS trusts. She has chaired the Leicester Warwick Medical School's fitness to practise (FTP) committee since 2000. She has made lay contributions in other areas, including as a lay magistrate, chairing the family proceedings panel, and as a member of the Lord Chancellor's panel of lay interviewers for judicial appointments.

To see each member's register of interest, visit our website at www.chre.org.uk.

7.1.2 Attendance

Figure 1: Percentage attendance at public meetings April 2006 – March 2007

Sandra Arthur*	100	Hemant Patel	66
Graeme Catto	66	Hugh Ross	50
Nigel Clarke	100	David Smith	100
Frances Dow	66	Rosie Varley	66
Anna van der Gaag**	50	Kieran Walshe	100
Sue Leggate	66	Jane Wesson	100
Hew Mathewson	83	Sally Williams***	66
Kate McClelland	83	Lois Willis	100
Jim McCusker	100	Judith Worthington****	80
Peter North	100		

* Replaced Jonathan Asbridge
** Replaced Norma Brook
*** Sally Williams was on maternity leave for part of the year
**** Replaced Michael Copland-Griffiths

7.2 Our staff

Michael Andrews
Head of Fitness to Practise
Valerie Baldino
Office Manager
Francesca Compton
Council Secretary
Sandy Forrest
Director
Rosemary Macalister-Smith
Head of International Regulation
Rachael Martin
Fitness to Practise Assistant
Briony Mills
Fitness to Practise Officer
Unnati Patel
Administrative Assistant
Elisa Pruvost
Policy Manager
Kristin Smyth
Head of Business Governance

There are also currently two temporary members of staff.

7.3 Contact details

Council for Healthcare Regulatory Excellence
Kierran Cross
11 Strand
London
WC2N 5HR

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

Council dinner, March 2007

8 Financial summary

Our financial performance during the year, and position as at 31 March 2007, is identified in the Operating Cost Statement, Balance Sheet and supporting notes in the full accounts of the Council. During the year we received grant in aid funding from the Department of Health in the sum of £2.033m. We also recovered £185k associated with Section 29 cases taken to the High Court where we were successful in proceedings.

Our net operating costs were £2,139k including £329k Section 29 non pay costs. Our full accounts were laid before Parliament in July 2007 and can be found at Annex C. The Comptroller and Auditor General gave an unqualified opinion on the Council's accounts and details of this can be found on pages 62 to 64 (Annex C).

Annex A: Section 29 statistics

For information about our Section 29 power, see 5.3.

Figure 1: cases notified to CHRE 1 April 2006 – 28 February 2007

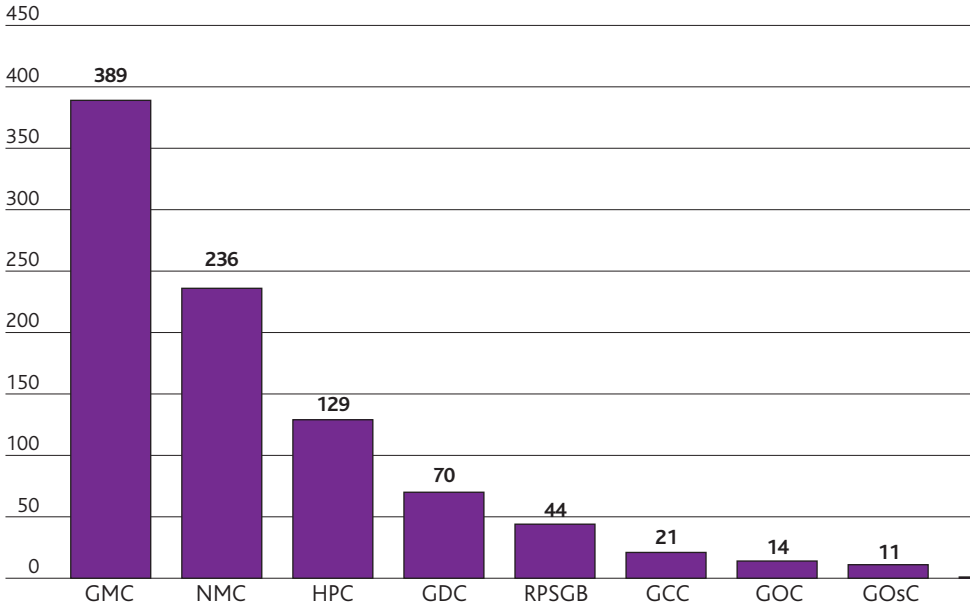


Figure 2: cases notified to CHRE by month

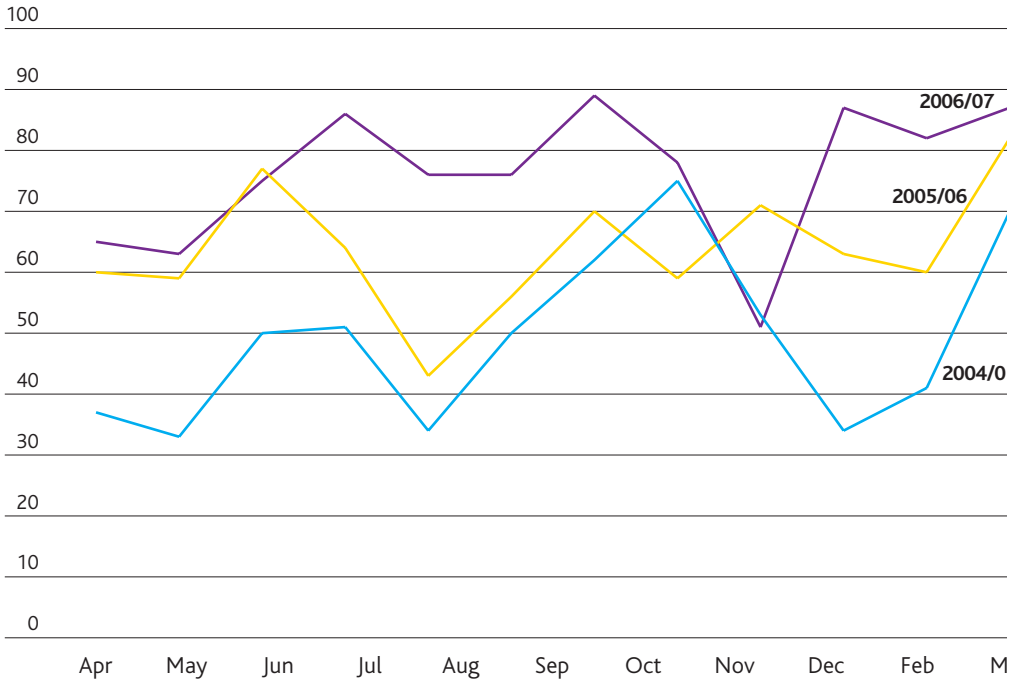


Figure 3: case outcomes across all regulators 1 April 2006 to 31 March 2007

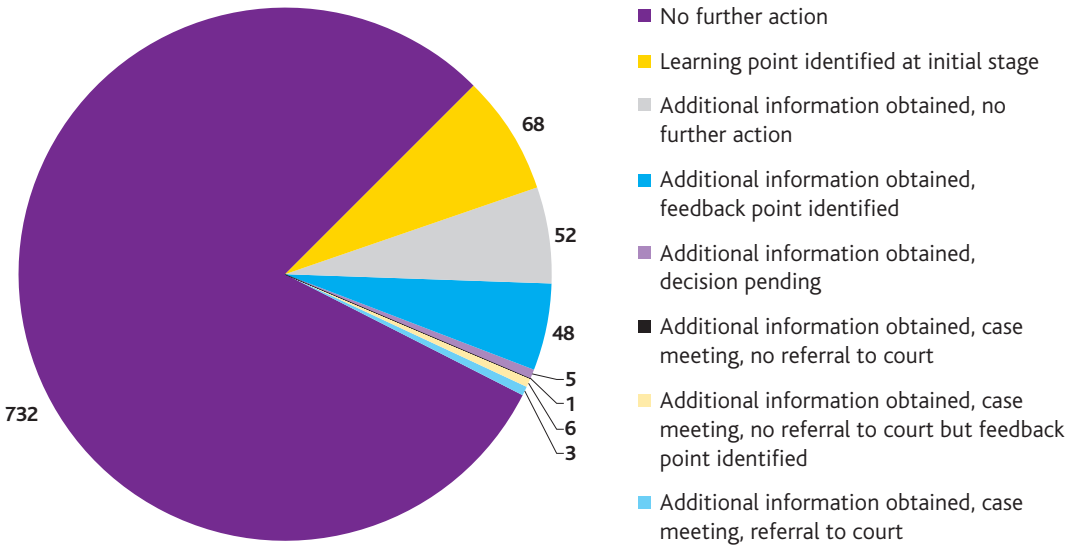


Figure 4: cases referred by month

	2004/2005	2005/2006	2006/2007
April	0	1*	1*
May	0	0	0
June	0	2	0
July	3	1	0
August	0	5	0
September	3	0	2
October	0	0	0
November	0	0	0
December	1	0	0
January	0	0	0
February	0	1	0
March	0	0	1
Total	**7**	**10**	**4**
% of cases referred out of all cases considered	**1.20%**	**1.30%**	**0.4%**

*case received in previous financial year

Figure 5: distribution of incoming cases, excluding those resulting in erasure, by regulator (total 521)

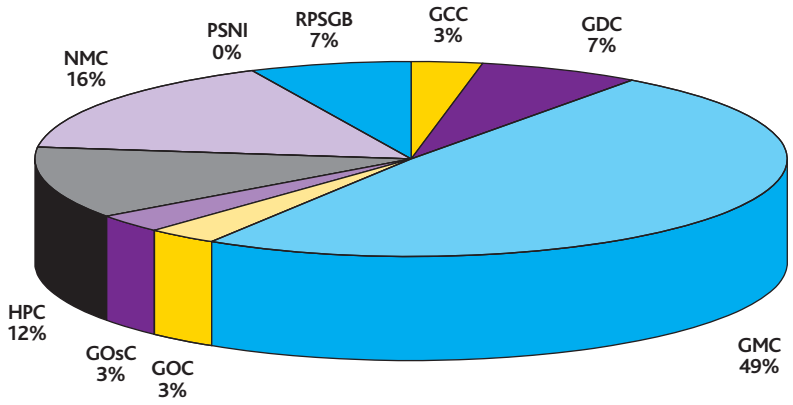
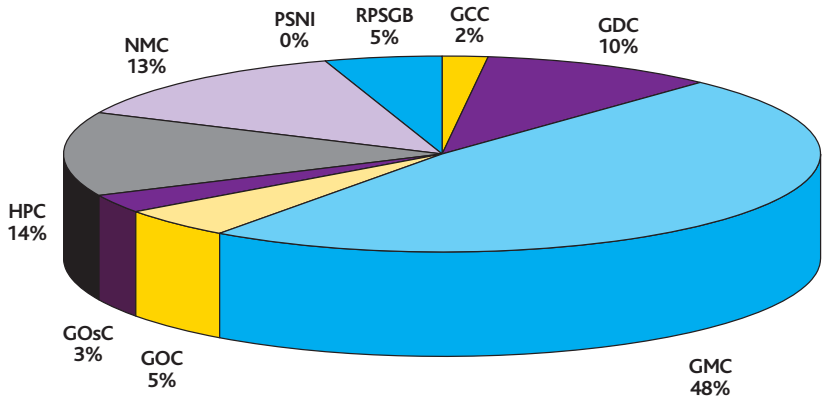


Figure 6: distribution of transcripts requested, by regulator (total 88)



The two charts above, resulting from Professor Harpwood's research report, show there is no evidence of bias in relation to the decisions made between outcomes of the different regulators. The number of referrals to Court, requests for transcripts of hearings, and of feedback points, are all in line with the proportion of cases received from each regulator.

Annex B: Committees and working groups of the Council

Membership indicated below is for the financial year 2006/2007[13].

Audit Committee
Hugh Ross, Chair
David Smith
Sally Williams
Lois Willis

Finance Committee
Nigel Clarke, Chair
Hew Mathewson
Jane Wesson

Remuneration Committee
Jane Wesson, Chair
Nigel Clarke
Jim McCusker
Peter North
Hugh Ross as Audit Committee Chair
Rosie Varley

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

13 On 14 March 2007 Council approved new committees for the financial year 2007/2008.

Annex C: Annual accounts

Contents

In September 2004 the organisation changed its name to the Council for Healthcare Regulatory Excellence (CHRE). The statutory name of the organisation remains the Council for the Regulation of Healthcare Professionals (CRHP) and cases referred to court under Section 29 of the National Health Service Reform and Health Care Professions Act 2002 in 2006-2007 were brought under this name.

Council report

1. There were changes in Council membership during the year as a result of some regulatory bodies appointing new Presidents. Further information about the Council may be found in the Annual Report in section 7 'Our People'.

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

3. The Chair is evaluated annually by the Appointments Commission, and lay Council members are evaluated on an annual basis by the Chair. Training is provided for members participating in Section 29 panel meetings and for any other matters deemed relevant and necessary by Council. The Audit Committee has instigated an annual review of training needs for its members and undertook its first training day in February 2007.

4. The Chair of CHRE resigned as Chair and lay member of Council in April 2007 and a process is currently underway to replace her on Council as a lay member and then to elect a new Chair. Council is working closely with the Appointments Commission and the Department of Health to appoint a new lay member. The Director resigned with effect from 30 April 2007. As the result of the Director's departure the Annual Accounts for 2006-2007 will be signed by the Acting Director who is currently the Accounting Officer.

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

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

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

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

2006-2007	**Number**	**£**
Total invoices paid	938	1,302,567
Total invoices paid within 30-day target	929	1,263,119
Percentage of invoices paid within 30-day target	99%	97%

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

10. During the year there was a review of existing employment policies. Some policies were amended to reflect changes in policy and/or guidance and additional policies were introduced to the organisation including an Anti-Fraud and Corruption Strategy and a Race Equality Scheme.

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

12. At the request of the Audit Committee a one-day training programme was devised by the National Audit Office and South Coast Audit to consider the role of the Committee, the role of the auditors and the relationship between the Committee, auditors and executive. The executive were also invited to participate in the latter part of the training day.

13. The training day assisted in taking several items, such as risk management, forward considerably.

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

15. CHRE's accounts have been prepared according to Determinations by the Secretary of State pursuant to Paragraph 15 of Schedule 7 of the National Health Service Reform and Health Care Professions Act 2002.

Management commentary

16. The Council for Healthcare Regulatory Excellence (CHRE) was set up in April 2003 by the National Health Service Reform and Health Care Professions Act 2002 (the Act). It is funded through the Department of Health (DH) and answerable to the UK Parliament.

17. Further information about CHRE may be found in the Annual Report in section 4 'About Us', section 5 'Our Achievements and section 6 'Developments in Regulation'.

18. Our mission is to protect the public interest, promote best practice and achieve excellence in the regulation of healthcare professionals. Information about CHRE's mission may be found in the Annual Report in section 4 'About Us' and section 5 'Our Achievements'.

19. In 2006-2007 CHRE continued successfully to develop its business both internally, through further establishment of appropriate guidelines and procedures, and externally, through various aspects of its work including the Clear Boundaries project, student fitness to practise project, contributing to the reviews by the Chief Medical Officer and the Department of Health, and providing advice to ministers.[1]

20. Funding of £2.033 million was provided as grant in aid through the DH in 2006-2007. Additional funding for 2007/2008 is being discussed with the DH and the DH Arms' Length Bodies Business Support Unit (ALB BSU) which includes support for work arising from the White Paper. Further information about the White Paper may be found in the Annual Report in section 6.3 'The White Paper'.

21. Costs for our work on Section 29 have fallen in 2006-2007 as the result of CHRE referring fewer cases and the timing of court orders associated with cases in the previous year. Costs in this area remain unpredictable as they are dependent entirely on the number of cases referred, the progression and outcomes of these cases, and the timings of the court orders.

22. Increasingly CHRE is able to settle cases by agreement thereby avoiding the need for costly contested hearings[2].

23. Funding arrangements for CHRE remain a high priority in all discussions and negotiations with the DH and ALB BSU. It is anticipated that the DH will seek support for CHRE in 2007-2008 from the Scottish Parliament, Welsh Assembly and Northern Ireland Assembly under the Barnett formula.

1 Chair's Introduction/Director's Report/5 Our Achievements/6.2.5 Challenges for the future

2 5.3 Protecting the Public

24. CHRE has maintained a strong financial position at year end, as shown on the Balance Sheet (page 66), and has maintained positive cash balances and net working capital at all times during the year.

25. The financial performance and cash flow of CHRE for the year ended 31 March 2007 is shown in the Operating Cost Statement (page 65), Cash Flow Statement (page 67), and supporting notes (pages 68 to 81).

26. An analysis of accounting policies is shown in note 1 to the accounts. There have been no changes to these in the year other than the changes referred to in note 1 Accounting Policies c. Grant in aid and government grant reserve.

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

28. In 2006-2007 the financial management structure was reviewed. Previously financial and payroll services had been provided through a combination of a bureau service (Liberata UK) and a Contracted Accounting Manager. The contract with the bureau service was terminated at a break point and outsourced services retained with the Contracted Accounting Manager. A contract for the provision of payroll services has now been established with a new supplier (Moorepay).

29. The transition from the previous structure went smoothly and internal audit has confirmed that strong controls were maintained throughout the changeover period. In some cases they have been enhanced.

30. One of the benefits of changing the financial management structure has been that CHRE now holds all its financial data in-house and is able to exercise greater control over the management of this information.

31. In 2006-2007 a scheduled rent review of the lease for CHRE's premises was undertaken by the landlord and resulted in a nil increase for the term of the lease until December 2010.

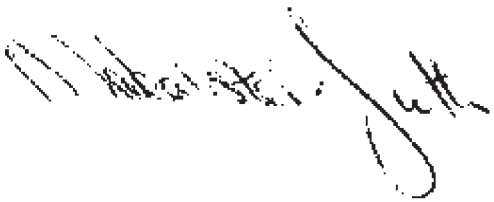
32. Four members of staff, including the Director, resigned and two other members of staff, previously engaged on a fixed-term basis, were confirmed in a permanent position during the year. Details of our employees and temporary workers may be found in note 5 to the Accounts. There is the possibility that the numbers of employees may increase in 2007-2008 as the result of additional work resulting from the White Paper[3].

3 6.3 The White Paper

33. CHRE's performance is monitored internally by Council through its oversight of the strategic and operational functions of the organisation. Reports to the Council and its committees include financial updates, risk assessment, progress against business plan objectives and regular reports from internal and external auditors. In addition formal quarterly reviews are held between CHRE executive, the DH and ALB BSU, and an annual formal review is held between the Chair, Director and DH.

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

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



Rosemary Macalister-Smith
Accounting Officer

20 June 2007

Remuneration report

36. The policy on remuneration for senior managers[4] commissioned by the Remuneration Committee[5] in June 2004, states that they should be based on a spot rate pay value dependent on market value. A review of the grade takes place each year to ensure the pay level remains competitive for retention purposes. In addition to the review the salary levels are uplifted to incorporate a cost of living increase each October. Full consideration is given to the average earnings index, retail prices index, the level of increase for other regulatory bodies and organisations within the same geographical area, and data from the Police Negotiating Board's report *A Survey of Pay awards for Non-Manual Employees outside the Public Services Sector*. The same information was previously provided to CHRE via the Government's Office of Manpower Economics report.

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

38. The policy on termination of contracts is determined by the level of responsibility of the position. For all staff up to and including pay band level 4 there is a one-month notice period. For level 5 staff, the Deputy Director and Head of International Regulation there is a three-month notice period and for the Director a six-month notice period. Contracts are offered on a permanent basis, subject to certain requirements being met, and successful completion of a probationary period. Contracts are occasionally offered on a fixed-term basis, generally to reflect the nature of, and context for, the work involved. CHRE treats termination payments on a case-by-case basis in consultation with our legal advisors.

39. Senior managers' contracts.

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

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

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

4 CRHP Job Evaluation Exercise, Liberata UK Ltd

5 Annex B: Committees and Working Groups of the Council

41. Senior managers' salaries

Name	Salary (£)	Real increase in pension at age 60 (£'000)	Total accrued pension at 31 March 2007 (£'000)
Alexander Forrest (*)	129,218 (2005-2006: £125,454)	0-2.5	2.5-5

This table is subject to audit by the Comptroller and Auditor General.

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

Note: the following were not provided: allowances; bonuses; expenses allowance; compensation for loss of office or termination of service (2005-2006: £Nil).

42. Pensions

Name	Title	Value of accrued pension (£'000)	Related lump sum (£'000)	Real increase in related lump sum (£'000)	Cash equivalent transfer value as at 1 April 2006 (£'000)	Cash equivalent transfer as at 31 March 2007 (£'000)	Real increase in the cash equivalent transfer value during the reporting year (£'000)
Alexander Forrest	Director	2.5-5	12.5-15	2.5-5	48	72	16

This table is subject to audit by the Comptroller and Auditor General.

Cash Equivalent Transfer Value

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

The CETV figure, and from 2005-2006 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETV are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

43. There has been no compensation paid to former senior managers, or payments made to third parties for the services of a senior manager. This statement is subject to audit by the Comptroller and Auditor General.

44. Members' remuneration

The Chair, Jane Wesson, received total remuneration of £53,576 (2005-2006: £52,607) which comprised gross salary of £31,837, a second home allowance of £20,414 (£12,000 net) and Section 29 panel meeting attendance fees of £1,325 (2005-2006: £825).

Council members' remuneration and the Chair's salary are not subject to superannuation.

Members received annual remuneration of £7,500 p.a. (2005-2006: £5,673) and the Audit Committee Chair received additional remuneration of £5,000 p.a. with effect from 1 April 2006. The Chair's remuneration was increased by 1% from 1 April 2006 and a further 1.2% from 1 November 2006.[6]

6 The increase in members' remuneration was awarded by the Secretary of State for Health

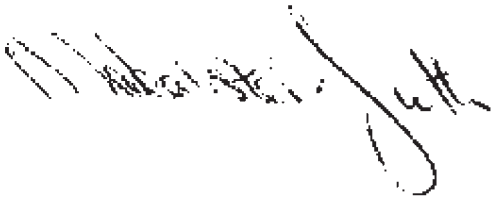
Members' remuneration during the year amounted to £216,222 (2005-2006: £165,291) including social security costs and Section 29 panel attendance fees of £11,188 which were distributed between 14 members of Council who sat on panels during the year. Payments to individual members are disclosed in the following ranges:

	Year ended 31 March 2007 * £'000	S29 Panel Attendance Fees[7] 2006-2007 £	Year ended 31 March 2006 * £'000	S29 Panel Attendance Fees 2005-2006 £
Mrs S Arthur (from 7 August 06)	0-5		–	
Sir Jonathan Asbridge (until 4 August 06)	0-5	700	5-10	275
Professor Norma Brook CBE (until 7 July 06)	0-5	550	5-10	
Professor Sir Graeme Catto	5-10		5-10	
Mr Nigel Clarke	5-10	1,463	5-10	
Dr Michael Copland-Griffiths (until 31 May 06)	0-5		5-10	
Dr Frances Dow	5-10	975	5-10	550
Mrs Sheelagh Hillan (until 31 October 2005)	–		5-10	
Mrs Sue Leggate	5-10	550	5-10	
Dr Hew Mathewson	5-10	175	5-10	550
Dr Kate McClelland (from 2 November 2005)	5-10	825	0-5	
Mr James McCusker	5-10	825	5-10	
Mr Peter North	5-10	1,738	5-10	1,650
Mr Hemant Patel (from 1 October 2005)	5-10		0-5	
Mr Hugh Ross (Audit Committee Chair)	10-15		5-10	
Mr David Smith	5-10	412	5-10	
Dr Anna Van der Gaag (from 22 August 06)	0-5		–	
Mrs Rosemary Varley OBE	5-10	275	5-10	
Dr Kieran Walshe	5-10	550	5-10	
Ms Sally Williams	5-10		5-10	
Ms Lois Willis	5-10	825	5-10	
Mr Nicholas Wood (until 3 August 2005)	–		0-5	
Mrs Judith Worthington (from 1 June 06)	5-10		–	

* Includes S29 Panel Attendance Fees

In addition, expenses amounting to £52,156 (2005-2006: £54,642) were reimbursed to the members.

Members' remuneration is subject to audit by the Comptroller and Auditor General.



Rosemary Macalister-Smith
Accounting Officer

20 June 2007

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

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

The Council's responsibilities

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

46. In preparing the accounts the Council is required to:

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

The Accounting Officer's responsibilities

47. The Accounting Officer for the Department of Health has appointed the Acting Director as the Council's Accounting Officer. Her relevant responsibilities as the Accounting Officer, including her responsibility for the propriety and regularity of the public finances for which she is answerable and for the keeping of proper records, are set out in the *Non-Departmental Public Bodies' Accounting Officers' Memorandum* issued by the Treasury and published in *Government Accounting*.

Statement on internal control

Scope of responsibility

48. As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Council for Healthcare Regulatory Excellence (CHRE) policies, aims and objectives, whilst safeguarding the public funds and organisational assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Government Accounting*.

49. CHRE reports directly to the UK Parliament and works closely with the Department of Health and its Arms' Length Body Business Support Unit team in delivering its statutory obligations as well as the key objectives of the business plan. This includes identifying and responding appropriately to both internal and external risks.

The purpose of the system of internal control

50. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of organisational policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in CHRE for the year ended March 2007 and up to the date of approval of the annual report and accounts, and accords with Treasury guidance.

Capacity to handle risk

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

52. Each strand of the business plan links to the relevant strand of the risk register and the senior manager responsible for delivering a strand of the business plan identifies and responds to the risks associated with that particular area of work. This is an ongoing process which is reviewed regularly by all senior managers and the Audit Committee, and is supported by relevant guidance[8].

53. CHRE has previously participated in a Risk Management Forum with representatives from the regulatory bodies. In 2005-2006 it was proposed that speakers would be invited to address the group on specific subjects of interest in 2006-2007. The group has not met in 2006-2007 and therefore this program was not undertaken.

54. Staff training in managing risk continued to focus on health and safety-related matters. A programme of fraud risk management training was completed with the Counter Fraud & Security Management Service, a Division of the NHS Business Services Authority, resulting in a member of staff becoming an Accredited Counter Fraud Specialist.

The risk and control framework

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

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

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

58. The risk register was developed further in 2006-2007 with the addition of a risk management strategy and implementation document, providing a framework for the risk register.

59. During 2006-2007 the risk register was presented in detail to the Audit Committee. At its meeting in February 2007 the Committee agreed to refine the process for considering risk and in future will receive the top 6-10 risks, as identified by the executive, with 2-3 of these risks analysed in detail at each meeting.

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

60. The executive will provide evidence as to the process for identifying risks and placing them on the register, and continue to provide any updates regarding the prioritisation of risks and ongoing management of these top 6-10 risks as appropriate. The detailed risk register will remain available to the Committee.

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

62. In 2006-2007 the Audit Committee approved a change to the financial management structure at CHRE. This involved terminating the agreement with Liberata UK who had previously provided outsourced financial and payroll services, bringing all the data in-house, and retaining the services of Contracted Accounting Manager on renegotiated terms. In addition CHRE procured a new payroll provider: Moorepay. This change in the provision of financial and payroll services was effective from 1 October 2006.

63. CHRE has received assurance from its internal auditors, South Coast Audit, that this process was managed effectively with all relevant controls maintained throughout. In some instances the level of control has been enhanced.

64. In 2005-2006 the Head of Internal Audit Opinion provided full assurance on the effectiveness of the system of internal control on the basis of work they had undertaken. In 2006-2007 this Opinion has been revised to 'Satisfactory' and also states that 'Slight improvements are required to enhance the adequacy and/or effectiveness of risk management, control and governance.'

65. Throughout 2006-2007 CHRE obtained assurance from Liberata UK and Moorepay regarding their provision of outsourced financial and payroll services through evidence of risk control systems, disaster recovery plans and accreditation of each organisation with the British Standards Institute.

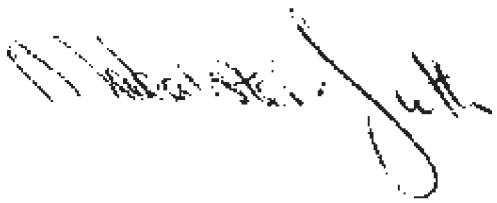
66. All CHRE staff are entitled to membership of the NHS Pension Scheme and control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with.

Review of effectiveness

67. As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the organisation who have responsibility for the development and maintenance

of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the former Accounting Officer, the Council and the Audit Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

68. While I do not consider that CHRE has any significant weaknesses in its system of internal controls a programme of continuous improvement exists, in consultation with the Audit Committee, internal auditors and external auditors, to ensure that CHRE meets best practice standards in all areas of its operations.



Rosemary Macalister-Smith
Accounting Officer

20 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 Council for the Regulation of Healthcare Professionals for the year ended 31st March 2007 under the National Health Service Reform and Healthcare Professions Act 2002. 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 been audited.

Respective responsibilities of the Council, Accounting Officer and Auditor

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

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

I report to you my opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Reform and Healthcare Professions Act 2002 and directions made thereunder by the Secretary of State with the approval of the Treasury. I report to you whether, in my opinion, certain information given in the Annual Report which comprises sections titled "About us", "Our achievements", "Developments in regulation", "Our people", "Financial Summary", "Committees and working groups of the Council", the Council Report and Management Commentary is consistent with the financial statements. I also report whether in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

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

I review whether the Statement on Internal Control reflects the Council's compliance with HM Treasury's guidance, and I report if it does not. I am not required to consider whether this statement covers all risks and controls, or form an opinion on the effectiveness of the Council'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 Council and Accounting Officer in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Council's circumstances, consistently applied and adequately disclosed.

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

Audit Opinion

In my opinion:

- the financial statements give a true and fair view, in accordance with the National Health Service Reform and Healthcare Professions Act 2002 and directions made thereunder by the Secretary of State with the approval of the Treasury, of the state of the Council's affairs as at 31 March 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 National Health Service Reform and Healthcare Professions Act 2002 and directions made thereunder by the Secretary of State with the approval of the Treasury; and
- information given within the Annual Report, sections titled "About us", "Our achievements", "Developments in regulation", "Our people", "Financial Summary", "Committees and working groups of the Council", the Council Report and Management Commentary 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
5 July 2007

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

OPERATING COST STATEMENT

For the year ended 31 March 2007

	Note	Year ended 31 March 2007 £	Year ended 31 March 2006 – Restated £
Operating costs	2	2,343,031	2,463,631
Operating income	3	194,944	243,367
Net operating cost before capital charges reversal		2,148,087	2,220,264
Capital charges reversal	7	(9,246)	(8,400)
Net operating cost		**2,138,841**	**2,211,864**

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

STATEMENT OF RECOGNISED GAINS AND LOSSES

For the year ended 31 March 2007

	Year ended 31 March 2007 £	Year ended 31 March 2006 – Restated £
Net unrealised gain on revaluation of fixed assets	2,003	744
Recognised gains for the year	**2,003**	**744**

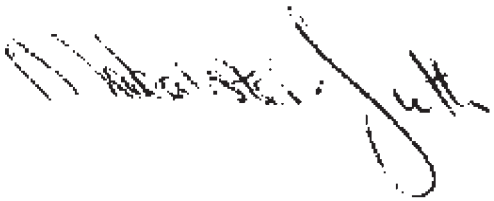
The notes on pages 68 to 81 form part of these accounts.

BALANCE SHEET AS AT 31 MARCH 2007

	Note	2007 £	2007 £	2006 – Restated £	2006 – Restated £
Fixed assets					
Tangible fixed assets	8		211,514		232,098
Current Assets					
Debtors	9	290,591		342,154	
Cash at bank and in hand	10	68,621		20,419	
		359,212		362,573	
Creditors: amounts falling due within one year	11	(129,325)		(85,700)	
Net current assets			229,887		276,873
Provisions for liabilities and charges	12		(193,768)		(157,500)
Net Assets			247,633		351,471
Reserves					
General Reserve	13		242,675		347,363
Revaluation Reserve	13		4,958		4,108
			247,633		351,471

The notes on pages 68 to 81 form part of these accounts.

Signed on behalf of the Council for the Regulation of Healthcare Professionals



Rosemary Macalister-Smith
Accounting Officer

20 June 2007

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 MARCH 2007

	Note	Year ended 31 March 2007 £	Year ended 31 March 2006 – Restated £
Net cash outflow from operating activities	14	(1,960,259)	(2,333,051)
Capital expenditure			
Payments to acquire tangible fixed assets	8,11	(25,827)	(60,373)
Fixed asset disposal proceeds		1,288	
Net cash outflow before financing		(1,984,798)	(2,393,424)
Financing			
Grant in aid from the Department of Health for revenue expenditure	13	2,000,000	2,320,400
Grant in aid from the Department of Health for capital expenditure	13	33,000	50,149
Increase/(Decrease) in cash	10	48,202	(22,875)

The notes on pages 68 to 81 form part of these accounts.

Notes to the Accounts

1. Accounting policies

a. Basis of preparation

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

b. Accounting convention

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

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

c. Grant in aid and government grant reserve

In 2005-2006 Grant in Aid received from the Department of Health was accounted for as income in the Income and Expenditure Account under 2005-2006 FReM guidance.

The 2005-2006 accounting policy of CHRE was as follows:

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

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

Further to *Financial Reporting Advisory Board Paper* (FRAB) (80) 08 dated 29 June 2006, the updated 2006-2007 FReM guidance (4.2.15) requires a different accounting treatment and necessitates a change in accounting policy for CHRE in 2006-2007.

The 2006-2007 accounting policy of CHRE is as follows:

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

Revenue grant in aid received from the Department of Health used to finance activities and expenditure which support the statutory and other objectives of CHRE is treated as contributions from a controlling party giving rise to a financial interest in the residual interest in CHRE and therefore is accounted for as financing by crediting them directly to the General Reserve on a cash receivable basis. The effect of this change on the certified 2005-2006 accounts and the impact of the change on the results for the current year is shown below.

Impact of revised accounting policy 2005-2006

	At 31 March 2006 (as previously stated) £	Impact of adopting the revised accounting policy £	At 31 March 2006 Restated £
Net income/(expenditure) for 2005-2006	56,469	(2,268,333)	(2,211,864)
General Reserve	126,842	220,521	347,363
Government Grant Reserve	136,559	(136,559)	–
Revaluation Reserve	–	4108	4,108
Deferred Income	88,070	(88,070)	–
		(220,521)	

Impact of revised accounting policy 2006-2007

	At 31 March 2007 (without applying the new policy) £	Impact of adopting the revised accounting policy £	At 31 March 2007 (applying the new policy) £
Net income/(expenditure) for 2006-2007	4,177	(2,143,018)	(2,138,841)
General Reserve	131,019	111,656	242,675
Government Grant Reserve	116,614	(116,614)	–
Revaluation Reserve	–	4,958	4,958

d. Tangible fixed assets

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

Fixed assets other than computer software are capitalised as tangible fixed assets as follows:

- equipment with an individual value of £1,000, or more;
- grouped assets of a similar nature with a combined value of £1,000 or more; and
- refurbishment costs valued at £1,000 or more.

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

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

e. Depreciation

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

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

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

f. Section 29 costs and recoveries

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

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

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

In the case of costs awarded against the Council, expenditure is recognised in the income and expenditure where there is a final uncontested judgment against the Council. In addition, where a case has been lost, but the final outcome is still subject to appeal, and it is probable that costs will be awarded against the Council, a provision is

recognised in the accounts. Where it is possible but not probable that the case will be lost on appeal and that costs may be incurred by the Council, or where a sufficiently reliable estimate of the amount payable cannot be made, a contingent liability is disclosed (see note 15).

g. Notional charges

In accordance with the FReM published by HM Treasury, a notional charge for the cost of capital employed during the year is included in the operating cost statement along with an equivalent notional income to finance the charge. The cost of capital charge is calculated at 3.5 per cent (2005-2006: 3.5%), applied to the mean value of capital employed during the year, excluding non-interest bearing cash balances held with the Office of the Paymaster General.

h. Value added tax

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

i. Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. As a consequence it is not possible for CHRE 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 asses 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 valuation on which contributions are based covered the period 1 April 1994 to 31 March 1999. Between valuations the Government Actuary provides an update of the scheme liabilities on an annual basis. The latest assessment of the liabilities of the scheme is contained in the Scheme Actuary Report, which forms part of the NHS Pension Scheme (England and Wales) Resource Accounts, published annually. These accounts can be viewed on the NHS Pensions Agency website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.

The conclusion from the 1999 valuation was that the scheme continues to operate on a sound financial basis and the notional surplus of the scheme is £1.1billion. It was recommended that employers' contributions are set at 14% of pensionable pay from 1 April 2003. On advice from the actuary the contribution may be varied from time to time to reflect changes in the scheme's liabilities. Employees pay contributions of 6% (manual staff 5%) of their pensionable pay.

NHS Bodies are directed by the Secretary of State to charge employers pension cost contributions to operating expenses as and when they become due.

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% 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 retirements are not funded by the scheme except where the retirement is due to ill-health. For early 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 Authority commits itself to the retirement, regardless of the method of payment.

A death gratuity of twice final year 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 amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

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

j. Operating leases

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

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

k. Provisions

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

l. Operating income

Operating income is recognised on an accruals basis and includes re-charges made to other tenants occupying First Floor, Kierran Cross in relation to rates and other accommodation costs.

2. Operating costs

	Note	£	Year ended 31 March 2007 £	£	£	Year ended 31 March 2006 – Restated £	£
Staff costs	4		735,166			651,112	
Members' remuneration[9]			205,034			161,441	
Other operating costs:							
S29 costs		328,707			805,218		
Other operating costs		1,014,096			781,307		
Total other operating costs	6		1,342,803			1,586,525	
Depreciation	8		50,782			56,153	
Notional cost of capital	7		9,246			8,400	
Total operating costs				2,343,031			2,463,631

3 Operating income

	Year ended 31 March 2007 £	Year ended 31 March 2006 – Restated £
S29 cost recoveries	185,214	237,177
Other operating income	9,730	6,190
Total operating income	194,944	243,367

9 Renumeration Report

4. Staff costs

	Year ended 31 March 2007 £	Year ended 31 March 2006 £
Salaries	585,958	520,663
Social security costs	54,041	52,528
Superannuation costs	65,165	65,278
Agency/temporary costs	30,002	12,643
Total staff costs	735,166	651,112

The increase in staff costs in 2006-2007 includes: an annual cost of living rise to salaries of 3% from October 2006, agreed by the Remuneration Committee and the Department of Health. Also, 2005-2006 included a portion of the salary costs for a senior member of staff whereas 2006-2007 includes the full costs for this member of staff. The increase in agency costs was the result of the employment of a temporary policy officer and receptionist prior to the appointment of permanent employees.

5. Average number of staff

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

	Year ended 31 March 2007 WTE (whole time equivalent)	Year ended 31 March 2006 WTE (whole time equivalent)
Management and administrative	* 12.44	11.6
	12.44	11.6

* Includes 0.99 WTE temporary staff members (2005-2006 0.60)

6 Other operating costs

Other operating costs include:

	Note Below	Year ended 31 March 2007 £	Year ended 31 March 2007 £	Year ended 31 March 2006 – Restated £	Year ended 31 March 2006 – Restated £
Professional fees	a.		300,267		760,638
Consultancy fees	b.		31,131		9,724
Rent and office accommodation	c.		389,304		309,729
Accountancy & HR services	d.		80,680		72,355
Training and recruitment			43,604		46,370
Staff expenses	e.		38,145		24,293
Computer consumables and web site development costs			50,861		58,620
Non cash expenditure:					
Impairment of fixed assets		2,438		1,214	
Loss on disposal of fixed assets		441		–	
Increase in provisions		36,268		40,000	
			39,147		41,214
Council members' expenses			52,156		54,642
External audit fee (*)			19,010		18,990
Repairs and maintenance			60,101		50,999
PR and communications	f.		10,776		68,965
Project costs	g.		147,894		–
Other costs	h.		79,727		69,986
Total other operating costs			1,342,803		1,586,525

a. Costs associated with undertaking the Section 29 process.

b. Consultancy fees increased as the result of the engagement of consultants including: facilitators to assist in meetings with the Chief Executives of the regulatory bodies; representatives to negotiate the rent review process with the Landlords on behalf of CHRE, and Health and Safety advisors who undertook risk assessments of CHRE's premises.

c. In 2005-2006 CHRE increased its level of occupancy at 1st Floor, Kierran Cross, 11 Strand, London from 64% to 90.65%. Rent, rates and service charges increased accordingly. 2006-2007 was the first full year CHRE has been at 90.65% occupancy.

d. Accountancy costs include payments to Liberata (for 6 months only), Parfitt & Co Chartered Accountants and Moorepay for payroll (for 7 months only). Also included is £4,027 in respect of outsourced HR provision received from NHS CFSMS. The costs for production of the CHRE annual report for 2005-2006 are included in this figure.

e. Additional staff expenses were incurred as the result of a higher level of activity at a national and international level, including attendance at the International Association of Medical Regulatory Authorities' conference in New Zealand.

f. The restructure of an outsourced PR contract and separate press cutting service achieved savings in 2005-2006. 2006-2007 was the first full year on the renegotiated PR contract.

g. This includes the Clear Boundaries Project (£117,894) and Project Initiation Documents created in response to the publication of the White Paper in February 2007 (£30k).

h. Additional costs incurred during the year included an increase in building telecoms costs as the result of taking on the lease, also the upgrade to CHRE's broadband internet contract.

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

7. Notional cost of capital

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

	Year ended 31 March 2007 £	Year ended 31 March 2006 – Restated £
Capital employed as at beginning of period	331,152	148,848
Capital employed as at 31 March	197,176	331,152
Mean capital employed	264,164	240,000
Notional charge	9,246	8,400

8. Tangible fixed assets

	Furniture, fixtures & fittings – conversion costs £	Decommissioning costs £	IT equipment £	Total £
Valuation				
At 1 April 2006	145,976	117,500	67,086	330,562
Additions	7,929		24,433	32,362
Disposals			(2,977)	(2,977)
Indexation revaluation	2,797			2,797
Indexation impairment			(4,986)	(4,986)
At 31 March 2007	156,702	117,500	83,556	357,758
Depreciation				
At 1 April 2006	41,798	21,364	35,302	98,464
Charge for year	24,022	10,682	16,078	50,782
Eliminated on disposals			(1,248)	(1,248)
Indexation revaluation	794			794
Indexation impairment			(2,548)	(2,548)
At 31 March 2007	66,614	32,046	47,584	146,244
Net book value				
At 31 March 2007	90,088	85,454	35,972	211,514
At 31 March 2006	104,178	96,136	31,784	232,098

9. Debtors

	31 March 2007 £	31 March 2006 £
Debtors	132,781	131,328
Prepayments	157,810	210,826
Total debtors	290,591	342,154

Intra-Government balances

Intra-Government balances within the totals for debtors are as follows:

	31 March 2007 £	31 March 2006 £
Balances with other central Government bodies	19,565	–
Balances with Local Authorities	70,818	69,064
Total Intra-Government balances	90,383	69,064
Balances with bodies external to Government	200,208	273,090
Total debtors	290,591	342,154

10. Cash at bank and in hand

	31 March 2007 £	31 March 2006 £
At 1 April 2006	20,419	43,294
Increase/(decrease) in cash in year	48,202	(22,875)
At 31 March 2007	68,621	20,419
Bank account at Office of Paymaster General	50,460	20,319
Commercial bank account	18,061	–
Cash in hand	100	100
Total cash at bank and in hand	68,621	20,419

11. Creditors: amounts falling due within one year

	31 March 2007 £	31 March 2006 Restated £
Trade creditors	43,928	20,829
Capital creditors	6,535	–
Taxation and social security	29,519	–
Other creditors	3,616	8,552
Accruals	45,727	56,319
Total creditors: amounts falling due within one year	129,325	85,700

Intra-Government balances

Intra-Government balances within the totals for creditors are as follows:

	31 March 2007 £	31 March 2006 Restated £
Balances with other central Government bodies	70,080	37,319
Total Intra-Government balances	70,080	37,319
Balances with bodies external to Government	59,245	48,381
Total creditors: amounts falling due within one year	129,325	85,700

12. Provisions for liabilities and charges

	£
Balance at 1 April 2006	157,500
Arising during the year	36,268
Utilised during the year	–
Reversed unused in the year	–
Balance at 31 March 2007	193,768

The provisions arising during the year relate to obligations under the lease for office accommodation at Kierran Cross, 11 Strand, London, WC2N 5HR. £117,500 of this balance relates to estimated decommissioning costs which will fall due at the conclusion of the lease term in 2010 and £76,268 for accommodation repairs estimated to have fallen due at the balance sheet date.

13. Reserves

	General Reserve (formerly Income and Expenditure Account) £	Revaluation Reserve £	Total £
Brought forward as at 1 April 2006 – restated	347,363	4,108	351,471
Revaluation		2,003	2,003
Transfer to General Reserve – realised revaluation	1,153	(1,153)	–
Funding	2,033,000		2,033,000
Net operating costs	(2,138,841)		(2,138,841)
Carried forward as at 31 March 2007	242,675	4,958	247,633

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

	Note	Year ended 31 March 2007 £	Year ended 31 March 2006 – Restated £
Net operating costs for the year		(2,148,087)	(2,220,264)
Adjustment for non-cash transactions:			
Depreciation	8	50,782	56,153
Deficit on indexation revaluation of fixed assets	8	2,438	1,214
Capital charges	7	9,246	8,400
Loss on disposal of fixed assets		441	–
Adjustment for movements in working capital other than cash:			
Increase/(decrease) in creditors		43,625	(57,008)
Less: Capital creditor		(6,535)	–
Decrease/(increase) in debtors		51,563	(92,306)
Increase/(decrease) in provisions		36,268	(29,240)
Net cash (outflow) from operating activities		(1,960,259)	(2,333,051)

15. Contingent liabilities

Three High Court cases, under CHRE's Section 29 power, were undecided as at the year end. There is thus uncertainty on the financial consequences until a final judgment is made.

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

16. Capital commitments

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

17. Related party transactions

The Council is an independent public body sponsored by the Department of Health.

The Department of Health is regarded as a related party. During the year to 31 March 2007 the Department of Health provided total grant in aid of £2,033,000 (2005-2006: £2,282,479). Apart from this there were no related party transactions entered into.

The Council maintains a register of interest for the Chairman and Council members. On a periodic basis the register is updated by the Council Secretary to reflect any change in Council members' interests. During the period ending 31 March 2007 no Council member undertook any transactions with the Council.

The following disclosure relates to Council members who are in a position of influence resulting from their appointment to the CHRE Council by virtue of their nomination by the nine regulatory bodies.

Professor Sir Graeme Catto – President, General Medical Council

Mr Nigel Clarke – Chairman, General Osteopathic Council

Dr Hew Mathewson – President, General Dental Council

Mrs Rosie Varley OBE – Chairman, General Optical Council

Mr Hemant Patel – President, Royal Pharmaceutical Society of Great Britain

Dr Kate McClelland – past President, Pharmaceutical Society of Northern Ireland

Dr Anna van der Gaag – President, Health Professions Council

Professor Norma Brook CBE – immediate past President, Health Professions Council

Mrs Judith Worthington – Council member, General Chiropractic Council and Chair, GMC fitness to practise panels

Dr Michael Copland-Griffiths – immediate past President, General Chiropractic Council

Mrs Sandra Arthur – President, Nursing and Midwifery Council

Sir Jonathan Asbridge – immediate past President, Nursing and Midwifery Council

All of the regulators overseen by CHRE appoint a member to the Council for Healthcare Regulatory Excellence.

In relation to Section 29, no member can have any involvement in CHRE's consideration of any case which originates from the regulatory body which they represent. CHRE has had transactions with some of these bodies in 2006-2007 in relation to appeals made under Section 29 in which costs have been awarded by the High Court.

18. Losses and special payments

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

19. Post balance sheet events

There are no material post balance sheet events. The accounts have been authorised for issue on 19 July 2007 by the Accounting Officer.

20. Financial instruments

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

21. Commitments under operating leases

Expenses of the CHRE include rent and service charge payments under operating lease rentals in the sum of £320,242 (2005-2006: £258,777).

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

	31 March 2007 £'000	31 March 2006 £'000
Expiring between 1 and 5 years	322	322
Total commitments under operating leases	322	322

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