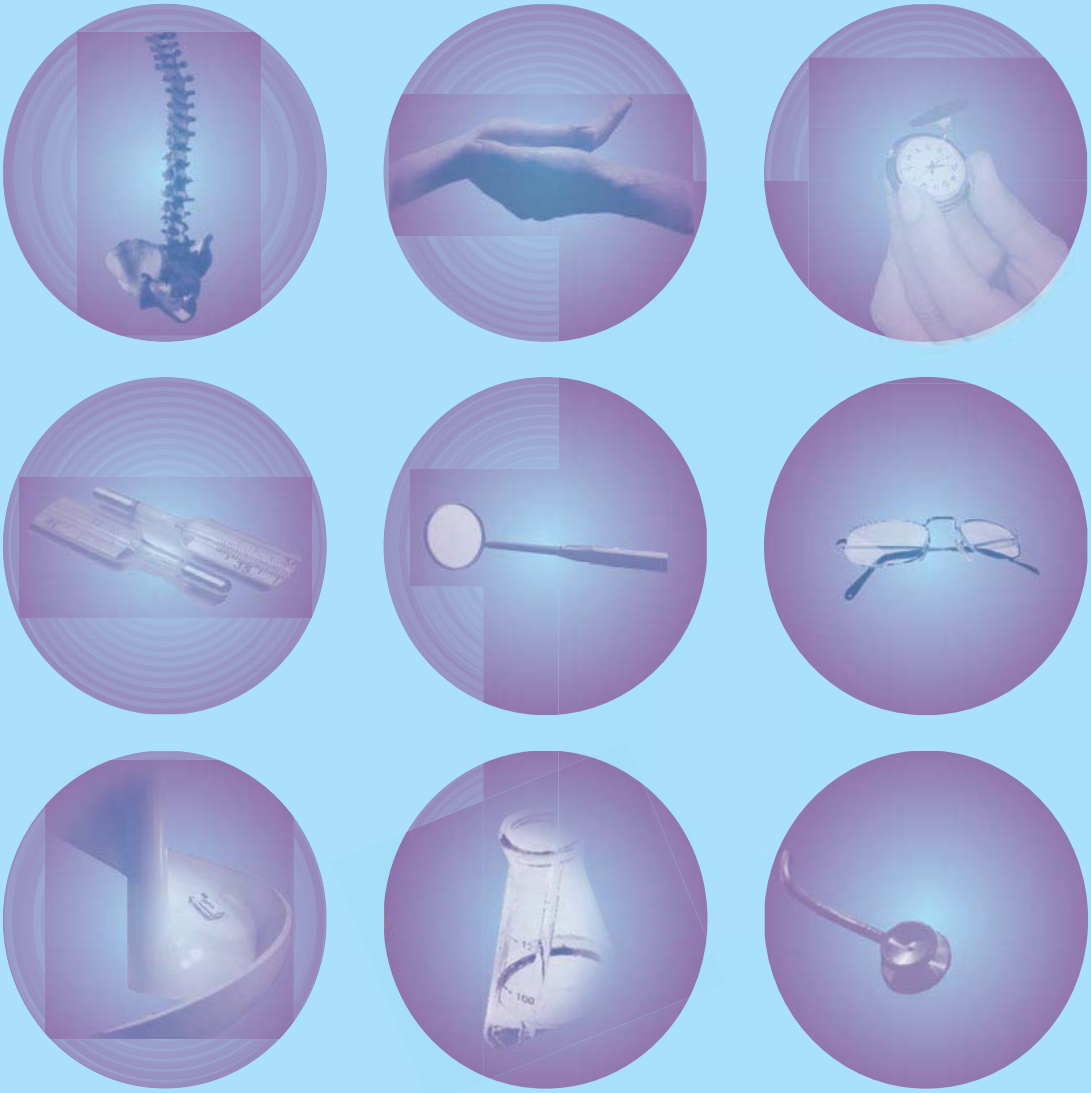

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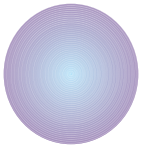

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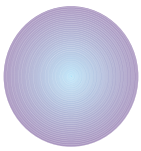

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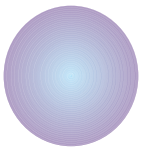

progress

Council for Healthcare Regulatory Excellence Annual Report and Accounts 2004/2005

The Council for Healthcare Regulatory Excellence is referred to in the National Health Service Reform and Health Care Professions Act 2002 as the Council for the Regulation of Healthcare Professionals.

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

Laid before the Scottish Parliament by the Scottish Ministers under the National Health Service Reform and Health Care Professions Act 2002

Laid before the Northern Ireland Assembly in accordance with the National Health Service Reform and Health Care Professions Act 2002

Laid before the National Assembly for Wales under the National Health Service Reform and Health Care Professions Act 2002

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Contents

Executive summary

In 2004/2005, we:

- **promoted good practice**
- **progressed regulatory excellence**
- **protected the public**

Promoting good practice

We have:
- built on existing communication between regulators;
- worked with regulators to promote principles of good practice;
- taken part in discussions about the future of regulation;
- hosted a major healthcare regulation conference; and
- published research about regulators' guidance on professional boundaries.

Progressing regulatory excellence

We have:
- helped regulators produce or develop Indicative Sanctions Guidance;
- worked with the Department of Health to speed up the processes for changing the law (see note below[1]); and
- consulted on section 27 of the NHS Reform and Health Care Professions Act 2002, which gives us the power to give directions to a regulator to make, or amend, certain rules.

Protecting the public interest

We have:
- shared with the regulators the 'learning points' arising out of fitness to practise cases we have reviewed;
- considered the 590 relevant fitness to practise decisions of the nine regulators (see 'About us' section) and appealed eight cases to Court where we considered that the decision was 'unduly lenient' (see 'Our achievements' section); and
- received judgments in 10 High Court cases (including some cases appealed last year).

Finally, we have also:
- carried out our second performance review of the regulators' work (see 'Regulation at Work'); and from this
- identified some of the challenges facing the regulation of healthcare professionals (see 'Challenges Ahead').

There is more information about our work on our website at www.chre.org.uk.

[1] Note: The process under section 60 of the Health Act 1999 gives the Government the power to amend the law governing the work of the regulators.

About us

'maintaining a register of professionals fit to practise in the UK'

Regulating professionals

1 Each healthcare professional must be registered with, and regulated by, one of nine statutory regulators. These organisations were created by separate Acts of Parliament so their duties and processes are not identical, but they are usually responsible for:

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

2 In general, the Councils which govern these regulators include members of that profession and a number of 'lay' members (members of the public who are not from that profession) to provide a public focus.

Our mission

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

4 We report to the UK Parliament, and consider developments in England, Scotland, Wales and Northern Ireland.

Who we are

5 Our governing Council has 19 members – one representative from each of the nine regulators (usually their president) and 10 'lay' members. Our lay members are people who do not belong to one of the regulated profession and are appointed to provide an independent view.

6 We also have an executive team of 11 staff supporting the Council.

7 We are funded through the Department of Health and must answer to the UK Parliament. Our work covers the following nine regulators currently responsible for healthcare professionals throughout the UK. The professions they regulate are listed below. Some regulators are responsible for more than one profession, for example, the HPC is responsible for 13 different professions.

- General Chiropractic Council (GCC) regulates chiropractors
- General Dental Council (GDC) regulates dentists, dental hygienists and dental therapists
- General Medical Council (GMC) regulates doctors
- General Optical Council (GOC) regulates dispensing opticians and optometrists
- General Osteopathic Council (GOsC) regulates osteopaths
- Health Professions Council (HPC) regulates 13 professions (see note below[2])
- Nursing and Midwifery Council (NMC) regulates nurses, midwives and specialist community health nurses
- Pharmaceutical Society of Northern Ireland (PSNI) regulates pharmacists
- Royal Pharmaceutical Society of Great Britain (RPSGB) regulates pharmacists

8 For more information on the regulators and the professions they regulate, please see the regulators' websites, available from the 'links' section of our website at www.chre.org.uk.

Why we have been set up

9 The idea of having one overarching body for the regulators of healthcare professionals was first suggested in the NHS plan, 'A plan for investment, a plan for reform', in 2000. We were set up on 1 April 2003, after the Government accepted a recommendation in the 'Kennedy Report' into events at Bristol Royal Infirmary. This report called for a reconnection between the regulated professions and the expectations of patients and the public. While recognising the many benefits of self-regulation, the report also identified a need for one group to make sure there is consistency and good practice among regulators. This co-ordinating function is where we think we can add most value to the work of the regulators.

What we do

10 Our responsibilities are set out in the Act, which gives us the power to:

- promote the interests of the public and patients in relation to regulating 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.

[2]Note: The Health Professions Council regulates arts therapists, biomedical scientists, chiropodists and podiatrists, clinical scientists, dietitians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers and speech and language therapists.

11 To carry out these responsibilities, we have powers to do the following:

- **Monitor how regulators carry out their functions (under section 26 of the Act)**
  We have powers to do anything that is necessary or appropriate to carry out our role, including:

  - investigating and reporting on how regulators carry out their work;
  - comparing the performance of different regulators; and
  - recommending changes in the way regulators carry out their work.

  We do this through yearly performance reviews. In our first performance review, we aimed to:

  - gather some comparative information;
  - build good relationships with the regulators;
  - find examples of good regulatory practice that already existed;
  - identify issues that might benefit from a co-ordinated approach; and
  - highlight any factors that interfere with developing good practice in professionally-led regulation.

  There is more detailed information about the performance review process and the individual reports for 2004/2005 on our website.

- **Recommend changes to regulators' rules (section 27 of the Act)**
  In the future, we may recommend that a regulator makes rules or changes its rules if we feel that it is desirable to protect the public.

- **Refer cases of 'undue leniency' to court (section 29 of the Act)**
  In some circumstances, we may refer 'fitness to practise' decisions to Court if we consider that the regulator's decision is too lenient and that a referral is necessary to protect the public.

- **Advise health ministers (section 26(7) of the Act)**
  We can also give advice to the Secretary of State or the Health Ministers of Scotland, Wales and Northern Ireland who may ask us about anything connected with a healthcare profession.

Where to find more information about us

12 You can find more information on our website at www.chre.org.uk, which includes our publications, press releases and papers discussed at Council meetings, including our 2005/2006 business plan and our 2005/2008 corporate plan. We have recently published a leaflet called 'What we do', which you can get from our website or by asking us. There is also information about us available in different languages on our website and the Welsh Language Board has approved our Welsh Language Scheme, which outlines how we will provide information to people who speak Welsh.

13 You can also find the National Health Service Reform and Health Care Professions Act 2002 on the website of Her Majesty's Stationery Office (HMSO) at www.legislation.hmso.gov.uk/acts/acts2002/20020017.htm.

Chairman's introduction

'Public protection is - and must be - at the heart of healthcare regulation.'

14 Public protection is - and must be - at the heart of healthcare regulation. Our existence is focused on the need to provide reassurance that professionally-led regulation is working effectively. We were set up following the Bristol Inquiry, when Sir Ian Kennedy called for a reconnection between the professions and the expectations of patients and the public. In our work, we are ever mindful of the overall purpose of the regulation of healthcare professionals: protecting the public by creating, and maintaining, the highest standards of competence and conduct.

15 It is by promoting good relationships, with and between regulators, and developing their current work and new ideas, that we will succeed in our mission of promoting best practice in regulation. So I was particularly pleased to be able to meet members of the regulators' governing Councils and staff at our first regulatory conference, held earlier this year. Together, we were able to exchange ideas and discuss the challenges regulators face, and everyone's enthusiasm and commitment was truly impressive. This was partnership in action, and will form a strong basis for further change.

16 I believe that our co-ordinating role is where we can add most value to the work of the regulators. We have a unique view of their work - their differences and their strengths. I want us to continue building on this privileged perspective, and making the most of our existing relationships with regulators, to make sure that best practice is shared and embedded.

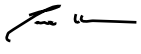
17 Change has been a constant theme in the past year. The world of regulation is changing. New roles are developing, diverse healthcare providers are emerging, and patients have higher expectations. Some regulators are still waiting for the changes in law they need to reform themselves, and all have introduced initiatives to strengthen public protection. There is, however, still much to be done in partnership with regulators to further the effectiveness, transparency and, where appropriate, consistency of the different regulators' systems.

18 Further change is also likely in the year ahead. Three major inquiries have produced reports this year, and further inquiries will publish their conclusions later in 2005. In particular, the recommendations of the Fifth Report of the Shipman Inquiry, chaired by Dame Janet Smith, will have consequences for the regulatory systems of all healthcare professionals. We contributed to the Shipman Inquiry and welcomed the publication of the report.

19 We were pleased to see that Dame Janet recognised the positive impact that we have already had in healthcare. She said: '*there is a major reason to expect that change for the better might continue, namely the CHRE. This is a new body but it has already made its mark...*' (page 45, paragraph 159). This reinforces our commitment to help the regulators embed best practice in their work.

20 Dame Janet's report and recommendations are currently being considered by two reviews, set up by the Government. We are represented on both of these reviews, which will report later in 2005. Meanwhile, we will carry on working with regulators and other stakeholders to support further improvements in regulation, and look forward to another busy year ahead.

Jane Wesson



Chairman

Director's report

'our main focus this year has been a number of initiatives to identify and share best practice in regulation, particularly in fitness to practise procedures.'

21 This is our second annual report. In the past 12 months, we have focused on building on the foundations we established last year.

22 We have targeted our work in those areas where we feel we can add most value. For example, our main focus this year has been a number of initiatives to identify and share best practice in regulation, particularly in fitness to practise procedures. We have promoted the use of Indicative Sanctions Guidance, which helps make decision-making clear and consistent. We have started work in the complicated area of handling complaints, which will continue next year.

23 Our public profile has been raised as a result of referrals to the High Court. We believe these cases have increased the protection for the public and provided invaluable learning opportunities for us and the regulators. But we feel that a lot has also been learned from the cases which were not referred. We have identified and discussed issues with the regulators and they have had the opportunity to review their fitness to practise systems in the light of these experiences. We see this as a very positive part of our role.

24 We have used our yearly performance review of the regulators to improve the effectiveness of regulation by sharing good transferable practice. Information provided by regulators highlighted many examples of good practice, as well as some areas where they could learn from one another. The performance review process showed that the regulators are willing to work with us to achieve common goals. Following this year's review, the regulators have agreed to work together to:

a make their registers more usable;
b improve the way they handle complaints; and
c prepare for new European laws to be introduced.

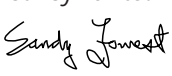
This is a very positive development, and we look forward to reviewing and reporting on progress in these areas next year.

25 This financial year was also marked by a series of events that changed the regulatory landscape. While the outcome of the Arm's Length Bodies Review did not directly affect our organisation, it has had, and will have, a significant indirect effect on us in the future.

26 The reports of the Ayling, Neale and Shipman Inquiries, and the two resulting reviews (see paragraphs 79-84), will have consequences for the regulators and us. We are part of both reviews and their outcome will affect our work programme for the year ahead.

27 Finally, I would like to thank all my staff for their hard work and commitment in carrying forward our work programme, and the people from the regulators who have worked with us.

Sandy Forrest



Director

Our achievements

Promoting good practice

Developing existing communication

28 Last year, we identified that there was an opportunity to build on existing communication between regulators to improve links and share good practice. As well as existing networks, we have created regular forums, one for fitness to practise managers and one for communications managers. In particular, the fitness to practise managers' regular forum meetings, attended also by the General Social Care Council (GSCC), resulted in discussions on a number of issues common to regulators. This forum promoted a partnership between us and the regulators which allowed us to build on current practice for further developments, such as Indicative Sanctions Guidance.

29 We have also promoted closer links between healthcare professionals' regulators and other organisations. For example, we have met the Association of Chief Police Officers to develop easier communication between regulators and the police across the UK, and will carry this work forward next year.

30 In particular, we have invited the General Social Care Council (GSCC), already an observer on our Council, to take part in some of our cross-regulatory work. We have also organised an initial meeting between the chief executives of the four national social care regulators and the nine healthcare regulators.

Promoting principles of good practice

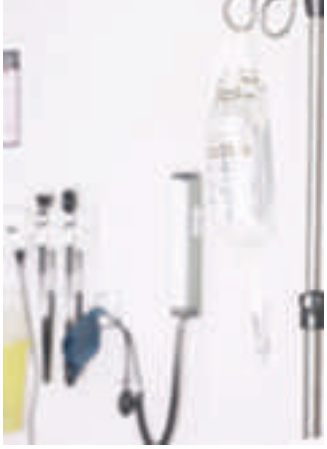
31 We have formally adopted the Better Regulation Task Force's Five Principles of Best Practice to guide our work:

- **Proportionality** - CHRE should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimised.
- **Accountability** - CHRE must be able to justify decisions, and be subject to public scrutiny.
- **Consistency** - rules and standards must be joined up and implemented fairly.
- **Transparency** - CHRE's processes should be open, simple and user-friendly.
- **Targeting** - regulation should be focused on the problem, and minimise side effects.

We have also recommended these principles to the regulators through our Council.

32 More specifically, we held a workshop with regulators and other stakeholders to identify principles of good practice when the regulators handle complaints against registrants. Our Council adopted the principles listed below and recommended them to the regulators:

- consumer-focused;
- accessible;
- transparent and open to scrutiny;



- having clear criteria for decisions that would enable consistency;
- fair to complainant and professional;
- timely;
- inquisitorial – a desire to find out what 'went wrong'; and
- used to stimulate improvement (through feedback from complaints).

'Professional regulation and excellence in healthcare' conference

33 In March 2005, we organised, for the first time, a conference for Council members of the healthcare regulators. The event was designed to:

- introduce and explain our work;
- highlight areas of common interest covering the responsibilities of the regulators; and
- encourage the Council members of regulators to get involved.

34 Part of the event was devoted to presentations from our Council members, regulators and other partner organisations. Among the main speakers, the Chair of the New Zealand Medical Council spoke about the professional and societal changes that had brought about changes to the system of healthcare regulation in New Zealand. The Health Minister for England, Lord Warner, welcomed the ongoing joint work between us and regulators, and our contribution to developing professional regulation.

Researching regulators' guidance about boundary violation

35 We commissioned the charity POPAN (the Prevention of Professional Abuse Network) to compare the regulators' guidance on professional boundaries between registrants and their patients. Maintaining boundaries is an important regulatory issue. Failing to maintain appropriate boundaries (for example, disclosing personal information, exchanging gifts, or sexual contact) leads to a significant number of complaints to regulators, and has the potential to cause patients considerable harm. Overall, the study found very little specific and detailed guidance by regulators about professional boundaries and preventing professionals taking advantage of their patients and clients. Of the nine regulators, the Nursing and Midwifery Council was found to be alone in issuing specific and separate guidance on violating professional boundaries. We will be working with the regulators next year to develop guidance and information on this issue. The full report is available on our website.

We have also promoted closer links between healthcare professionals' regulators and other organisations.

Our achievements

Progressing regulatory excellence

Taking part in discussions about the evolution of regulation

36 We have been involved in reflections about the way regulation of healthcare professionals may evolve, in particular through our involvement in the two reviews following from the publication of the Fifth Report of the Shipman Inquiry (see paragraphs 85 to 90 in 'Challenges ahead'). The recent Inquiries (Neale, Ayling and Shipman) also made recommendations involving us, and these may affect our work, depending on the Government's response to the outcomes of the two current reviews.

37 We have also been keeping up to date with developments in regulation, for example, by responding to relevant consultations, notably on the regulation of healthcare support staff, acupuncturists and herbal medicine practitioners.

Promoting Indicative Sanctions Guidance

38 At the meetings of the fitness to practise forum, we have encouraged all regulators to develop and adopt Indicative Sanctions Guidance and have identified the common values and principles upon which this guidance needs to be based. The Indicative Sanctions Guidance (ISG) has been recognised by the courts as a way to improve the consistency and openness of decisions, and to allow panels to give effect to the regulators' policies.

39 As a result of discussions at the forum, most regulators have now adopted Indicative Sanctions Guidance, and the others are all committed to, or working towards, such guidance. We hope to make further progress by producing a template document to help in this development.

Helping make legislative changes easier ('section 60')

40 Last year's annual report highlighted the delays experienced by those regulators who were making changes through a Section 60 Order (the process by which legislation governing how regulators work is generally amended). We took part in a Department of Health Working Group that was responsible for designing a project management system to make sure that section 60 orders could proceed more smoothly than in the past. In addition to project management issues, recommend-ations also include possibly using an annual 'Portmanteau' order covering minor changes to more than one regulator, or introducing a similar change to a number of regulators. The Department of Health will put the proposals into practice shortly.

Adopting our procedure to exercise our power under 'section 27'

41 In terms of section 27 of the Act, we can ask a regulator to make a rule, or change its rules, to achieve a particular end, if we 'consider that it would be desirable to do so for the protection of the public'. We have now consulted on this power, analysed the results, and adopted our policy on how we will use it. We have made it clear that this will be a last resort, following full discussion with the regulators and consultation with appropriate stakeholders. The regulations needed to introduce this power should be in place by the end of the year.

Protecting the public interest

42 Section 29 of the Act gives us important powers and responsibilities in protecting the public, and it strengthens the existing regulatory framework. If we consider that a decision made by a fitness to practise committee or panel of one of the nine regulators has been 'unduly lenient' and that a referral is necessary to protect the public, we can appeal the decision to the High Court (see note below[3]). The relevant fitness to practise committees and panels are the panels considering the conduct or performance of registrants.

43 Critically, through the section 29 process, we review all fitness to practise decisions of the regulators, and this highlights important learning points to enhance public protection. Very few cases are referred to the High Court.

Promoting excellence in fitness to practise processes

44 Referring cases to the High Court is not the main focus of our work under section 29. Our aim is to improve the quality of the regulators' fitness to practise processes and the quality of the committees' and panels' decisions. Often, we can achieve this more successfully in ways other than by referring cases to court.

45 When considering cases under the section 29 process, we have often identified issues on individual cases that do not meet the legal test needed to refer cases to court, but on which we can provide useful feedback ('learning points') to the regulator concerned to help improve their processes.

46 We have provided the 'learning points' identified to all the regulators. Issues raised have included:

a the need to give clear reasons to explain findings and sanctions imposed in fitness to practise decisions;

b the need to carry out thorough investigations in cases such as those involving child pornography;

c the need to avoid repeated adjournments and postponements of cases; and

d the circumstances when it is appropriate to accept undertakings (binding agreements) from a registrant.

47 Some of the issues raised with the individual regulators have been discussed at the fitness to practise forum, which includes representatives from all of the nine regulators. The work we are doing to share these learning points with others is very important in promoting excellence in regulation.

[3] Note: Where the registrant has a registered address in Scotland, the appropriate court is the Court of Sessions. If the registrant's registered address is in Northern Ireland, the appropriate court is the High Court of Justice.

Our achievements

48 Sometimes, even after we have referred a case to Court, we have been able to find ways, by working with the regulator, to protect the public without the need for a hearing. In one case, for example, we withdrew our appeal when the registrant agreed to give an undertaking to restrict his practice to supervised Senior House Officer posts until he had achieved full membership of the appropriate Royal College. He also agreed that this information would be given to anyone asking about his registration.

Our power under section 29 and the consideration of fitness to practise decisions

The process

49 Following consultation, our 'Process and Guidelines for Section 29 cases' document was formally adopted in November 2004 (see our website). We only have 28 days (from the last day on which a practitioner can appeal against the decision) to decide to refer a case to the High Court (see note below[4]). If a case raises concerns, we will ask the regulator for more information. The decision to refer a case is made by a case meeting of three Council members. If Council members decide that it is not necessary to refer the case to court, they can still consider whether any other action is needed, such as raising 'learning points' with the regulators. If the Court upholds the appeal, it can either substitute its decision for that of the regulator's panel, or remit the case back to the regulator.

Quality assurance and openness

50 The Section 29 Scrutiny Committee's role is to monitor our role in relation to section 29, including assessing the quality of our work. The Scrutiny Committee is made up of six members of Council and a representative from the National Consumer Council, and met three times during the year.

51 The Scrutiny Committee commissioned Professor Jonathan Montgomery, a prominent healthcare law expert, to produce two independent reports. These covered areas such as the quality of decisions made by staff on cases, the quality of our record-keeping and the consistency of decision-making by Council members at case meetings. The conclusions of the reports were generally positive, although there were areas for improvements which we will be taking forward.

52 The Scrutiny Committee also considered matters such as our arrangements for legal advice and value for money of legal services. The Scrutiny Committee have reported their findings to the Council after each of their meetings.

Cases referred to us

53 Annex A shows a breakdown of the cases we dealt with this year. From 1 April 2004 to 31 March 2005, we considered 590 cases. We closed most of these cases (476)

[4] Note: These are 28 days in a row, including non-working days such as bank holidays.

without asking for more information. We asked for information in the remaining 114 cases. Council members considered 33 of these cases at case meetings and we referred eight cases (one of which we later withdrew) to the High Court[5] under Section 29 of the Act (one of these cases was referred to the High Court in Northern Ireland). Of these eight cases, five were from the General Medical Council and one each from the Nursing and Midwifery Council, the General Dental Council and the Health Professions Council.

Outcomes of section 29 appeals

54 We received judgments from the High Court and Court of Appeal on 10 cases this year. Some of these relate to section 29 appeals made in the previous year. In six of these cases our appeal was upheld, in two they were settled by agreement and in two the appeal was dismissed. As we refer cases to Court only when we think that the decision is unduly lenient and it is necessary for the protection of the public, an appeal means that we ask for a stronger sanction.

55 There is more information about the High Court and Court of Appeal judgments on our website, including copies of the judgments. We have learnt a great deal about our powers under section 29 from these judgments, including the following (the reference to the particular case is detailed in footnotes below):

- A clarification of the meaning of undue lenience in section 29. For a decision to be unduly lenient it has to be, "*outside the range of sanctions that the relevant disciplinary panel, applying its mind to all the factors relevant to its jurisdiction, could reasonably consider appropriate*"[6]. Further explanation of undue lenience was provided by the Court of Appeal. We should consider whether the sanction is "*one which a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could reasonably have imposed*" or whether it "*is manifestly inappropriate having regard to the practitioner's conduct and the interests of the public.*"[7]

- The use of formal undertakings. In two cases, our appeals were settled by agreement prior to an uncontested hearing on the basis that the doctors agreed to give a formal undertaking to the Court not to perform certain types of work. The undertaking would be added to their registration and this information would be given to anyone asking about their registration, including employers[8].

- Under section 29, we have the power to review 'findings of fact', although the High Court would only interfere with these findings in exceptional cases[9].

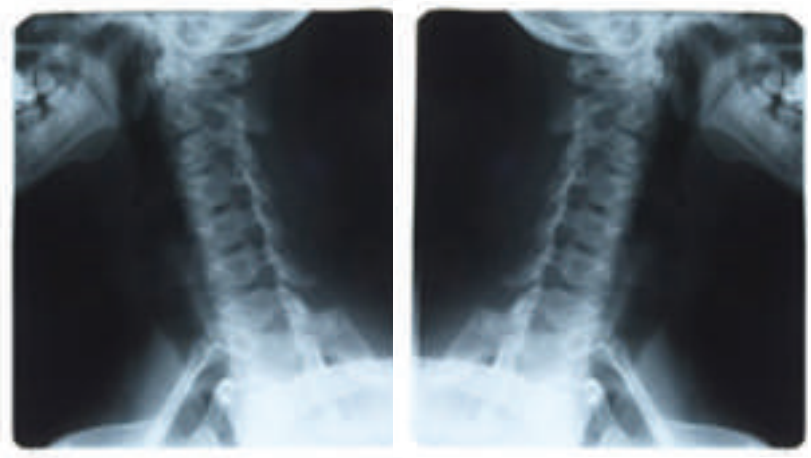
- The fitness to practise committee or panel must give reasons for its decisions[10].

[5]Note: One of the cases was referred to the High Court in Northern Ireland
[6]Note: CRHP v (1) GMC (2) Dr Solanke [2004] EWHC 944 (Admin)
[7]Note: Dr Ruscillo v (1) CRHP (2) GMC and CRHP v (1) NMC (2) Nurse Truscott [2004] EWCA Civ 1356
[8]The appeals relating to *Dr Brennan and Dr Urquhart* – terms of agreement signed before the High Court
[9]Note: CRHP v (1) GMC (2) Mr O. E. M Basiouny [2005] EWHC 68 (Admin)
[10]Note: CRHP v (1) GMC (2) Mr Basiouny [2005] EWHC 68 (Admin)

Our achievements

- Failing to ask for a resumed hearing in a case where a registrant has been suspended from the register could mean that a decision is unduly lenient .[11]
- The regulator, and not the committee or panel, is the correct first respondent in a section 29 appeal .[12]
- In cases where a registrant has been convicted of a serious criminal offence or offences, it would never be appropriate for a regulator's sanction to cease before the end of the criminal court's sanction .[13]
- Undue leniency can apply to a decision to restore a practitioner to the register .[14]
- In cases where we are offered a settlement before a hearing, we should not reject it unless we are confident that we will achieve a substantially different outcome from the one that is offered .[15]

56 At the end of March 2005, we were waiting for a judgment on one section 29 appeal and a further appeal had yet to be heard.



[11]Note: CRHP v (1) GMC (2) Mr O. E. M Basiouny [2005] EWHC 68 (Admin)
[12]Note: CRHP v (1) GMC (2) Mr O. E. M Basiouny [2005] EWHC 68 (Admin)
[13]Note: CRHP v (1) GDC (2) Mr Fleischmann [2005] EWHC 87 (Admin)
[14]Note: CRHP v (1) HPC (2) Mr Jellett [2005 EWHC 93 (Admin)
[15]Note: CRHP v (1) HPC (2) Mr Jellett [2005 EWHC 93 (Admin)

Regulation at work

The performance review process

57 Our powers include '*investigating and reporting on the performance of regulators' various functions, comparing performance between regulators and recommending changes in the way a regulator performs its functions'* (section 26 of the Act). Accordingly, every year, we carry out a performance review of the regulators.

58 The performance review process involved collecting information through a questionnaire (based loosely on the European Foundation for Quality Management (EFQM) model), followed by a face-to-face meeting with the regulators, some of whom involved their Council members.

59 The aim of the process is to highlight and share good practice through the performance review reports, the annual report, and various forums. We hope that sharing information from the performance reviews will encourage change towards good practice where appropriate.

Overview of the regulators

60 The nine regulators currently register about 1.1 million healthcare professionals across a great variety of roles and settings – for example, only around half of healthcare professionals work in the NHS. The nine regulators themselves share similar main functions but are different in many ways. Some of the main information about the regulators is given below, but there is more detail in a scoping study which is available on our website (www.chre.org.uk).

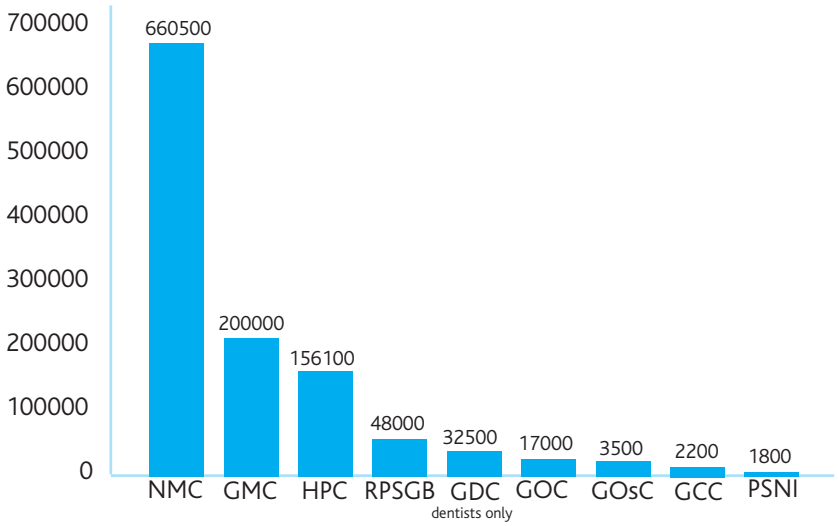
61 A number of factors affect what regulators are able to do. They have different traditions and history and, crucially, different legislative frameworks. These define their structure and roles, including their main mission and functions, and significant changes to these features often depend on amendments being made to primary legislation.

62 While all regulators share a common aim to protect the public, their legislative responsibilities often differ. Some do not have public protection as a central part of their legislation, while others have responsibility for advancing or promoting their professions.

We hope that sharing information from the performance reviews will encourage change towards good practice where appropriate.

Regulation at work

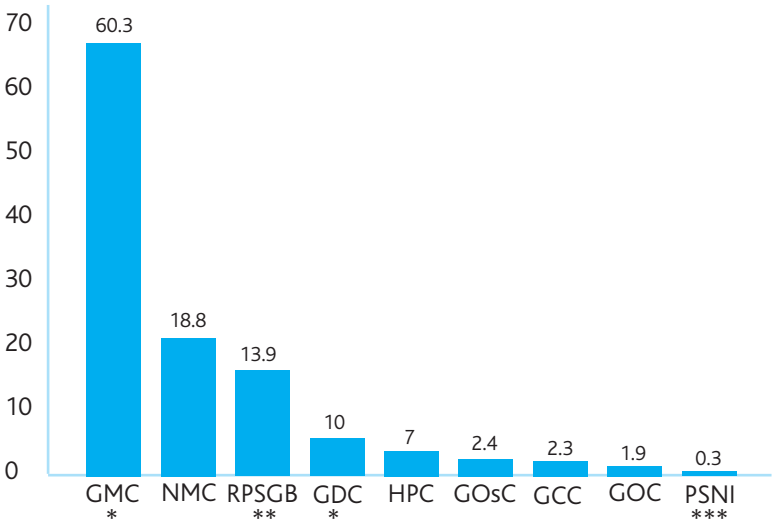
Figure 1: Number of registrants



Source: Performance review 2004/2005 and scoping study. Number of registrants at the latest available date during the performance review.

63 The number of registrants and income of regulators also affect their work. The NMC, with around 670,000 registrants, is the biggest regulator, whereas the PSNI, with around 1,800 registrants, is the smallest. Their incomes also vary greatly, with the GMC being the regulator with the most resources (see figures 1 and 2).

Figure 2: Regulators' budgets in 2003/2004 in millions (£)



* (in 2003)
** (including publications revenue) (in 2004)
***(in May 2004)

Source: Performance Review 2004/2005 and scoping study

64 One way in which the regulators make sure they have an independent view of their work is by having lay members on their governing Councils. Lay members are people appointed by the Privy Council to provide an independent opinion, and who do not belong to the profession registered by the regulator on whose governing Council they sit. At the moment, all regulators except the PSNI have lay representatives, and the proportion of lay members on regulators' governing Councils ranges from 30% to just under 50% of Council members. At the time of publication of this report, the RPSGB had increased its percentage of lay members from 13% last year to 35% this year (the new Council took office in May 2005). The PSNI is currently considering how to include lay members on their Council.

The main functions of the regulators

Assuring the quality of education and promoting professional development

65 Most of the regulators have a significant role in the education of their registrants and students. All regulators are responsible for the quality assurance of the higher or further education that students receive before they register. In this way, regulators can make sure that applicants who have passed approved courses meet the standards needed to be on the register.

66 Also, most regulators now require that their registrants carry out continuing professional development (CPD) to develop their skills. Some regulators are also looking at developing 'revalidation', a scheme to satisfy the regulator on a regular basis that registrants are up-to-date and fit to practise. This is also being considered by the current government's reviews set up after the Fifth Report of the Shipman Inquiry was published.

Example of good practice: GCC's required learning outcomes

The GCC introduced compulsory CPD in 2004. By 2006 the GCC will require specified learning outcomes to be achieved during the registrant's first year of CPD. This model aims to make sure that registrants are supported and assessed in the transition from supervised to independent practice.

Example of good practice: GOC's continuing education and training scheme

As part of the new GOC compulsory scheme for continuing education and training (CET), to be introduced with its new section 60 Order, registrants will be required to undertake, over three years, 36 general points of verified CET, which is certified by the GOC. Maintenance of a registrant's name on the speciality listing will require additional 18 CET points over the first three years to the level of competency currently required to enter the speciality listing. The GOC has also provided a software application for personal development which is accessible on–line for all registrants.

Example of good practice: PSNI's pre-registration year facilitator

PSNI has appointed a pre-registration year facilitator, whose role includes acting as the main point of contact for trainees as well as supporting tutors, who will review and update the pre-registration programme. Support for tutors includes a face-to-face training day and a support evening. Last year, the facilitator also reviewed trainees' views on their training.

Registering healthcare professionals

67 All regulators must keep a register of professionals who are allowed to practise while using the relevant protected title (for example, dentist or pharmacist). However, at the moment, the information available to the public from the registers varies, as do the documents the regulators need as proof that a professional is fit to go on the register. Some regulators have also started to register teams within a speciality, rather than one professional – for example, the GDC and the RPSGB register, or plan to register, not only dentists and pharmacists, but also other members of the team in dentistry and pharmacy, such as dental nurses and pharmacy technicians. At the moment, information on registrants' fitness to practise is not automatically exchanged between the regulators.

Example of good practice: HPC's on-line register

The HPC's register is internet-based. It is uploaded in real time and will take into account any findings of the fitness to practice panels. The HPC's fitness to practise webpage shows the name of the registrant and the final (and, if applicable, interim) decision, and this information stays on the HPC's website.

Setting standards of conduct and ethics

68 All regulators also set the standards of conduct expected of the professionals on their register. These codes of conduct or practice can be quite different, although the main values are quite similar. Some regulators also aim to develop the profession's understanding and use of the standards (see the example below).

Example of good practice: RPSGB's underpinning of its Code of Ethics

The RPSGB runs an advisory service on applying the Code of Ethics, accompanying guidance, service standards and the relevant legislation. The RPSGB also produces supplementary guidance; for example it has issued guidance on whistleblowing, and has produced guidance on internet pharmacy.

Example of good practice: GMC's use of its guidance across functions

The GMC links its regulatory activities through its guidance to doctors, *Good Medical Practice*. The values and standards described are used to inform the standards for undergraduate medical education and are contained in the standards for entry to full registration for UK graduates. *Good Medical Practice* also provides the blueprint for the structure of the PLAB test set by the Professional and Linguistic Assessments Board, the principal route by which international medical graduates obtain registration. Within the context of the GMC's fitness to practise procedures, *Good Medical Practice* is also the template against which doctors are judged.

Taking action if a professional is found unfit to practise

69 All regulators can take action on a professional's registration status if they find, through their complaints system, that a professional is unfit to practise without restrictions. At the moment, there are considerable differences in the way regulators carry out this disciplinary function, from the initial screening of complaints to the disciplinary procedures (or 'fitness to practise procedures') and the sanctions they can impose (see also paragraphs 72 to 74).

Example of good practice : GDC's Indicative Sanctions Guidance

At the end of 2004, the GDC developed for consultation its guidance for the Professional Conduct Committee. This guidance was one of the regulators' newly developed Indicative Sanctions Guidance documents. This is an easily accessible and detailed document. Some of its features include an innovative use of design and lay-out, and the recommendation that panels should consider the most serious sanction first (removing the registrant from the register) before asking the committee to consider the other sanctions in decreasing order of harshness.

Example of good practice : GOsC's fitness to practice report

The GOsC uses its fitness to practise report to inform the profession and link fitness to practise and standards. It collects statistical information on categories of complaints (and later, cases), based on the categories in the guidance, and publishes them in its report.

Communicating and working with other organisations and the public

70 Regulators have developed various ways of working with relevant partners such as devolved administrations in Scotland, Wales and Northern Ireland, education providers, professional associations, other regulators and publicly-funded organisations. Most have procedures in place to consult the public and others, and generally to communicate their aims and role. Some of them have, or are developing, strategies to involve patients and the public, and all of them have now decided to join forces to explore common initiatives in making sure that patients and the public are more involved in their work.

Example of good practice: NMC's Patient and Public Involvement strategy

The NMC is refining its patient and public involvement strategy. The original strategy, which was developed by the UKCC (its predecessor), aimed "to ensure that public involvement is central to all aspects of activity". As part of its drive to involve patients and the public, the NMC has:

- placed patient and public involvement and engagement as its first strategic aim;
- held a day of focus groups for mental health service users, nurses and carers to help the development of new standards for mental health nursing;
- organised roadshows to support the development of new standards for children's nursing, where focus groups and Question and Answer sessions provided opportunities for children, young people and their parents to have their say about what they expect from a nurse or a midwife; and
- consulted members of the public as well as members of consumer organisations in the development of a new public information leaflet.

Areas for possible development

Feedback loops and continuous improvement

71 This year, we have been particularly interested in how regulators build feedback loops between their regulatory functions – for example, how findings from the fitness to practise process are feeding into the standards of ethics and conduct. This is part of the process of continually improving procedures and policies for protecting the public. The way these feedback processes work depends on the regulator, but how much regulators use these learning opportunities also seems to vary. By sharing good practice, we are keen to encourage regulators to use links and learning to promote overall continuous improvement.

The fitness to practise procedures

72 The fitness to practise procedures (including the handling of complaints) of the regulators vary. While it is important that different processes reflect the needs of the different professions, the variations are wide-ranging, and it is questionable whether they are always justifiable. The fact that some of the regulators want to change their legislation to reflect more modern procedures suggests that some of these variations are historical.

73 Variations currently include:

- how complaints are handled and screened;
- the fitness to practise procedures;
- the type of sanctions available;
- the type of fitness to practise aspect considered (health is not currently considered by all regulators);
- the extent to which regulators use indicative sanctions and criteria at different stages of the fitness to practise process;
- the availability of emergency processes, such as interim orders;
- the composition of fitness to practise panels;
- the length of time information is kept about registrants' fitness to practise;
- the rules of evidence and the standard of proof;
- the statistical information available on the outcomes of the fitness to practise process; and
- the processes to review fitness to practise decisions to enhance consistency.

74 Many of these variations reflect the different legislative frameworks that govern regulators' work, and changing them would need changes in the law. However, some changes would not require a change in the law, for example:

- adopting guidance for decision-making at the different stages of the fitness to practise process to improve the consistency and openness of decisions;
- making more use of different ways of learning from the fitness to practise decisions; and
- the independent audit of the regulator's decisions not to proceed with complaints at the first stages of the fitness to practise procedures.

Diversity

75 Understanding the workforce and recognising the environments and circumstances in which professionals practise are both essential to the work of the regulators. In particular, knowing about registrants' ethnic backgrounds will help make sure that no discrimination takes place. More effort needs to be made to monitor the ethnic origin of registrants and how often different groups appear in fitness to practise procedures, to help avoid any possible discrimination.

Areas for joint work

76 Following discussions on the outcome of the performance review, the regulators have decided to collaborate in taking forward joint work in:

- making the register more usable;
- making complaints work better; and
- dealing with external risks by preparing for the new European Union legislation.

77 More information on our progress in these areas will be available on our website and in next year's annual report.

Challenges ahead

78 The common challenges faced by regulators are quite similar to the ones highlighted last year, with the exception of the issues identified by the recent inquiries.

The impact of recent inquiries

79 The Neale, Ayling and Shipman Inquiries have all reported in the period covered by this report. For more information on these inquiries, please see the links section of our website.

80 In particular, the Fifth Report of the Shipman Inquiry by Dame Janet Smith gave an in-depth analysis of the revalidation proposals and the fitness to practise procedure of the GMC. Only about half of the recommendations in that report focus on the GMC, and there are implications for all of the regulators, in particular in relation to their fitness to practise procedures.

81 In terms of CHRE, Dame Janet recommended that:

- CHRE should be invited to set up a panel of professionals and lay people (similar to the panel which establishes sentencing guidelines in criminal cases) to assist in the process of developing the necessary standards, criteria and thresholds for fitness to practise panels *(page 58, paragraph 56)*;
- there should be an independent review of the GMC's new fitness to practise procedures in three to four years' time, undertaken by, or on the instructions of CHRE *(page 64, paragraph 105)*; and
- there should be a review of CHRE's powers and functions to see whether these need to be extended to enable it to act effectively to ensure that patients are sufficiently protected *(page 65, paragraph 109)*.

82 The Chief Medical Officer (CMO), Sir Liam Donaldson, is currently carrying out a review following the publication of the Fifth Report of the Shipman Inquiry. The remit of this review is to identify measures to:

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

83 The second review carried out as part of the Government's consideration of the report is the review of non-medical professional regulation (by Mr Andrew Foster, the Department of Health Director of Workforce), which looks at all regulators other than the GMC. This review will consider the measures needed to:

- strengthen procedures for ensuring that the performance or conduct of non-medical health professionals and other healthcare staff does not pose a threat to patient safety or the effective functioning of services, particularly focusing on the effective and fair operation of fitness to practise procedures;

- ensure the operation of effective systems of continuing professional development and appraisal for non-medical healthcare staff and make progress towards regular revalidation where this is appropriate;
- ensure the effective regulation of healthcare staff working in new roles within the healthcare sector and of other staff in regular contact with patients; and
- in the light of the above, consider and recommend any changes needed to the role, structure, functions and number of regulators of non-medical healthcare professionals.

84 The Government response to the outcomes of these two reviews, expected towards the end of 2005, is likely to have important consequences for the regulators and their registrants, and to affect our programme of work for next year.

Section 60

85 It is noticeable that one of the main challenges the regulators faced last year has only been partly dealt with this year – the time taken to make the legislative changes the regulators need to modernise themselves (generally referred to as 'section 60 orders'(see note below[16]). These delays, sometimes of several years, restricted the modernisation plans of some of the regulators. While the Department of Health is aware of this situation, and has looked at ways of reducing the time taken to process the section 60 changes, three regulators have experienced further delays in their section 60 orders this year.

Workforce modernisation

86 Workforce modernisation is continuing. New roles are being developed that tend to blur previously clear professional boundaries – for example, some nurses and pharmacists can now prescribe medicines. Regulators have an important role in making sure that professionals on their register performing these new roles are fit to practise. Regulators also have a role in considering the entry of new professions on their register.

The movement of professionals within the European area

87 Last year, we highlighted some of the regulators' concerns relating to their ability to check whether practitioners applying to the register from outside the UK are fit to practise. Progress has been made since last year, for example, towards considering ways to improve the exchange of information between European countries on professionals' fitness to practise.

The link with criminal law

88 Regulators have at least two links with criminal law – when a registrant has a criminal conviction, or when someone continues to practise either after having been removed

[16] Note: Section 60 of the Health Act 1999 gives the Government the power to amend the legislation governing the work of the regulators.

from the register, or despite never having been registered. There is room for improving communication and flows of information with the police, and it was highlighted that it would be useful for us to support regulators in their efforts to increase co-operation with the police. So, we have held discussions with the Association of Chief Police Officers on possible issues and current practice. This process will continue next year.

The link with the corporate sector

89 In optics and pharmacy, the corporate sector is now a significant part of the market and so is a considerable employer of regulators' registrants. In optics, the GOC has adopted a corporate Code of Conduct which requires companies to promote compliance with the GOC's professional standards and code amongst their employees. In pharmacy, the RPSGB would like to strengthen corporate responsibility for delivering professionally regulated services and practice, in the public interest.

Financial summary

90 The financial accounts cover the period from 1 April 2004 to 31 March 2005. During that period, we received £2,519,472 income from grant in aid and recovery of legal costs of £239,003 achieving a retained surplus of £76,332 for the year. Our detailed financial performance during the year is identified in the income and expenditure account, which can be found in our full accounts in Annex C of this report.

Our people

Council members' biographies

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

Norma Brook. Norma was appointed as President of the Health Professions Council in May 2001. She is a qualified physiotherapist and is currently a self-employed consultant in education for physiotherapists and other professionals allied to medicine. She was Head of Divisions of Professions Allied to Medicine at the School of Health and Social Care, Sheffield Hallam University. She is a former Chair of the Physiotherapists Board of the Council for Professions Supplementary to Medicine (CPSM). Norma has extensive experience of physiotherapy education, and acts as an advisor and examiner to a number of organisations in the UK and Ireland.

Graeme Catto. Graeme has been the President of the General Medical Council since February 2002. A member of the GMC since November 1994, he has also served on the Education and Standards Committees and the Committee on Professional Performance. Graeme is Pro Vice-Chancellor, University of London, Vice-Principal at Kings College London and Dean of the Guy's, Kings' and St Thomas' Hospitals Medical and Dental School. Graeme is a member of the SE London Strategic Health Authority and Chairman of Robert Gordon's College Aberdeen.

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

Our people

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

Frances Dow. Frances is a retired academic who, until recently, was a Vice-Principal at the University of Edinburgh. Frances is a Vice-Chair of one of four Lothian Health Research Ethics Committees, and is also a trustee of the Immigration Advisory Service and a member of the Council for Assisting Refugee Academics.

Sheelagh Hillan. Sheelagh registered as a pharmacist in 1973 and owns a community pharmacy. She is Chair of the Northern Ireland Department of Health Social Services and Public Safety's Central Pharmaceutical Advisory Committee and past President of the Pharmaceutical Society of Northern Ireland. Sheelagh is a trustee and Executive Committee member of the Ulster Chemists Association, a Non-Executive Director of Homefirst Community Trust, Northern Pharmacies Ltd and a lay member of the Northern Ireland Mental Health Review Tribunal. Sheelagh holds a Theology degree from Queen's University and was awarded an MBE for services to community pharmacy. Sheelagh is a Deputy Lieutenant of County Antrim.

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

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

Hew Mathewson. Hew has been the General Dental Council President since 2003. A GDC member since 1995, Hew chaired the Professional Conduct Committee and served on the Education, Postgraduate and Ethics Committees. Hew worked as an associate in general dental practice and as a clinical assistant in oral surgery before setting up a practice in Edinburgh in 1977, in which he continues to work part-time. Previously visiting surgeon at Edinburgh Dental School, Assistant Director, Dental Studies at Edinburgh University and Regional General Dental Practice Vocational Training Adviser, Hew continues to work with vocational practitioner groups, lecturing on practice management and dento-legal matters.

Peter North. Peter is a retired RAF officer and is currently a lay assessor for the General Medical Council, a lay adviser to the National Clinical Assessment Service and a member of the Fitness to Practise Committee of the General Optical Council. Peter holds three Ministerial Appointments, on Employment Tribunals (Department of Trade and Industry), North Norfolk Primary Care Trust (Department of Health) and on the Norfolk Police Authority Appointment Panel.

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

Our people

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

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

Kieran Walshe. Kieran is Professor of Health Policy and Management, and Director of the Centre for Public Policy and Management at Manchester Business School. He has extensive experience of health policy, health management and health services research. His research interests are focused on performance, quality and regulation in healthcare. He writes regularly for a range of journals including BMJ, Health Service Journal, Health Affairs, Millbank Quarterly and Quality and Safety in Healthcare. Kieran serves on several editorial boards, acted as an expert for the Bristol Royal Infirmary Inquiry, and has advised the National Audit Office, Department of Health, Healthcare Commission and a range of other organisations on healthcare issues. His book on organisational regulation in healthcare – 'Regulating Healthcare: a Prescription for Improvement?' – was published in 2003.

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

Sally Williams. Sally is an independent health policy adviser whose clients include NHS bodies, consumer groups, charities and think-tanks. For five years, Sally was a researcher and policy adviser for the Consumers' Association. Sally is a lay visitor for the Postgraduate Medical Education and Training Board.

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.

Nicholas Wood. Nicholas is immediate past President of the Royal Pharmaceutical Society of Great Britain, his second term in office. He was first elected to the Society's Council in 1985, becoming President between 1993 and 1994 serving on the Council until 1997. He was elected to the Council again in 2003. He has been a member of all the Council's major committees, and has chaired both the Practice and Education Committees. With a background in community pharmacy, he has also worked as General Secretary of the Institute of Pharmacy Management International and is currently Deputy Chairman of the Joint Formulary Committee of the British National Formulary. He serves on the Court of Assistants of the Worshipful Society of Apothecaries, and is a governor of the School of Pharmacy, University of London.

Our people

Attendance at public Council meetings

Jonathan Asbridge	88%
Norma Brook	88%
Graeme Catto	63%
Nigel Clarke	63%
Michael Copland-Griffiths	100%
Frances Dow	100%
Sheelagh Hillan	75%
Sue Leggate	75%
Jim McCusker	88%
Hew Mathewson	100%
Peter North	75%
Hugh Ross	63%
David Smith	88%
Rosie Varley	75%
Kieran Walshe	75%
Jane Wesson	100%
Sally Williams	100%
Lois Willis	100%
Nicholas Wood	75%

Staff

Michael Andrews - Fitness to Practise Manager
Sandy Forrest - Director
Davina Mensah - Receptionist
Briony Mills - Fitness to Practise Officer
Peter Pinto de Sa - Secretary of the Council
Elisa Pruvost - Policy Manager
Voytek Rutkowski - Administrative Assistant
Eric Salem - Fitness to Practise and Policy Assistant
Kristin Smyth - Business Manager
Julie Stone - Deputy Director
Temporary member of staff - Office Manager/Executive Personal Assistant

Contact details

To contact the CHRE:

Council for Healthcare Regulatory Excellence	Kierran Cross 11 Strand London WC2N 5HR	Tel: 020-7389 8030 Fax: 020-7389 8040 E-mail: info@chre.org.uk www.chre.org.uk

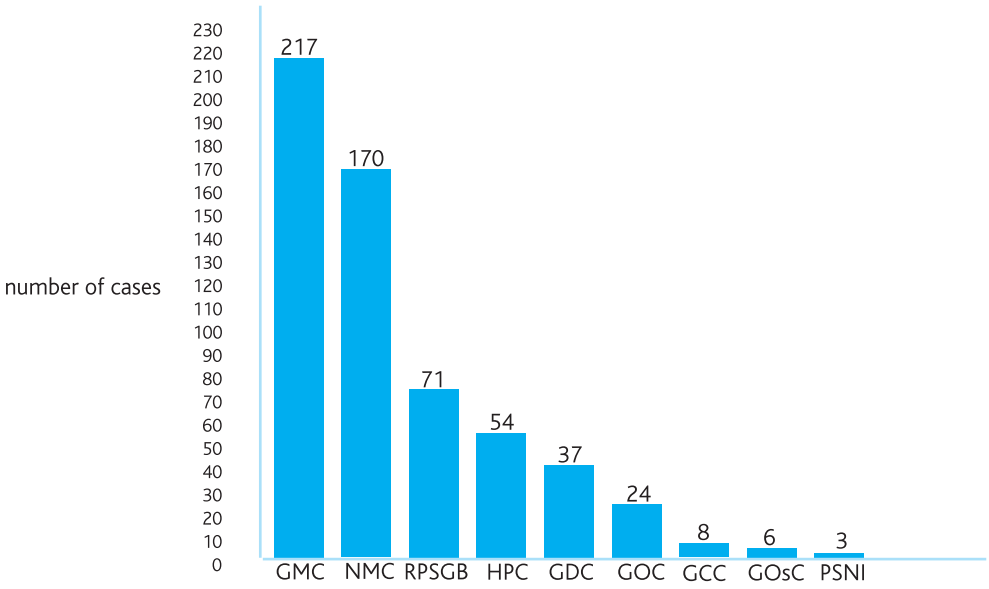
Regulatory bodies' contact details

General Chiropractic Council	44 Wicklow Street London WC1X 9HL	Tel: 020-7713 5155 Fax: 020-7713 5844 www.gcc-uk.org
General Dental Council	37 Wimpole Street London W1G 8DQ	Tel: 020-7887 3800 Fax: 020-7224 3294 www.gdc-uk.org
General Medical Council	Regent's Place 350 Euston Road London NW1 3JN	Tel: 0845 357 3456 www.gmc-uk.org
General Optical Council	41 Harley Street London W1G 8DJ	Tel: 020-7580 3898 Fax: 020-7436 3525 www.optical.org
General Osteopathic Council	176 Tower Bridge Road London SE1 3LU	Tel: 020-7357 6655 Fax: 020-7357 0011 www.osteopathy.org.uk
Health Professions Council	Park House 184 Kennington Park Road London SE11 4BU	Tel: 020-7840 9806 Fax: 020-7840 9805 www.hpc-uk.org
Nursing and Midwifery Council	23 Portland Place London W1B 1PZ	Tel: 020-7637 7181 Fax: 020-7436 2924 www.nmc-uk.org
Pharmaceutical Society of Northern Ireland	73 University Street Belfast BT7 1HL	Tel: 020-9032 6927 Fax: 020-9043 9919 www.dotpharmacy.co.uk/psni
Royal Pharmaceutical Society of Great Britain	1 Lambeth High Street London SE1 7JN	Tel: 020-7735 9141 Fax: 020-7735 7629 www.rpsgb.org.uk

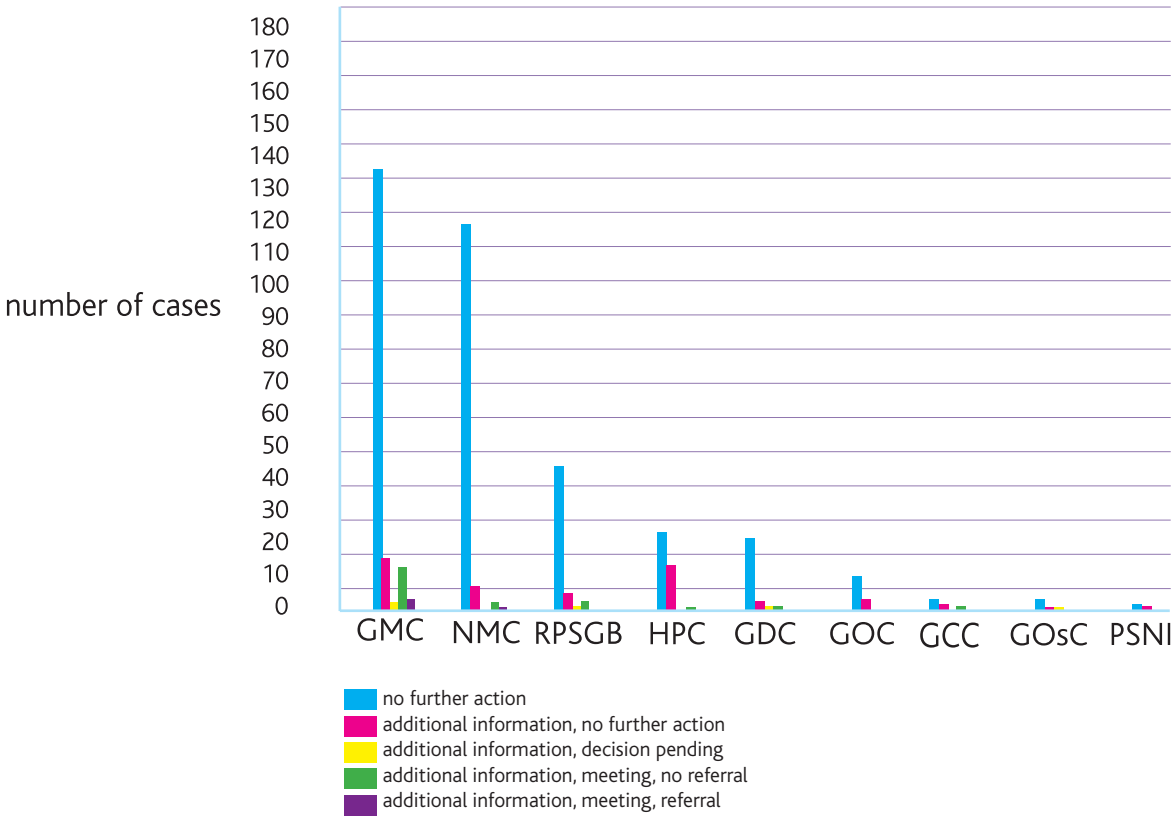
Annex A:

Figures on the cases notified to us under s29

Number of cases referred to us between 1 April 2004 and 31 March 2005



Our section 29 case decisions



Annex B:

Council committees and working groups 2004/2005

Audit Committee
Nigel Clarke (Chairman)
David Smith
Sally Williams
Lois Willis
Nicholas Wood

Communications Working Group
Nigel Clarke
Frances Dow
Peter North
Mark Oakes (General Social Care Council)
Hugh Ross
Stuart Skyte (Nursing and Midwifery Council)
Nick Stace (Consumers' Association)
Sally Williams

Scrutiny Committee
Francies Dow (Chairman)
Norma Brook
Graeme Catto
Hew Mathewson
Hugh Ross
Saranjit Sihota (National Consumer Council)
Kieran Walshe

Remuneration Committee
Jane Wesson (Chairman)
Michael Copland Griffiths
Jim McCusker
Peter North
Rosie Varley

Section 29 Working Group
Sally Williams (Chairman)
Jonathan Asbridge
Peter Coe (General Optical Council)
Hew Mathewson
Finlay Scott (General Medical Council)
Marc Seale (Health Professions Council)
Kieran Walshe

Annex C: Annual Accounts

Annex C:

FOREWORD TO ACCOUNTS

Introduction

In September 2004 the organisation changed its name to the Council for Healthcare Regulatory Excellence (CHRE). The statutory name of the organisation remains 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 2004-2005 were brought under this name.

This is a foreword to the Council for Healthcare Regulatory Excellence's (CHRE's) annual accounts for the second full year of operation until March 31st 2005.

In 2004-2005 CHRE consolidated the establishment of the organisation and worked closely with regulatory bodies to enhance and develop healthcare regulation. The organisation continues to develop the processes around Section 29 of the Act.

Accounts have been prepared in a form directed by the Secretary of State with the consent of HM Treasury. The Comptroller and Auditor General is the auditor of the Council under the National Health Service Reform and Health Care Professions Act 2002.

History and principal activities

CHRE was established in December 2003 by the National Health Service Reform and Health Care Professions Act 2002 (the Act) and has a statutory remit to:

- Promote the interests of the public and patients in relation to regulation of the health care professions;
- Promote best practice in the regulation of the healthcare professions;
- Develop principles for good professionally-led regulation of healthcare professions; and
- Promote co-operation between regulatory bodies and other organisations.

The statutory powers of the Council are:

- Performance reviews and recommendations (section 26 of the Act);
- Co-operation: Each regulator must in the exercise of its functions co-operate with the Council;
- Changes in regulators' rules (section 27): If the Council considers that it would be desirable to do so for the protection of members of the public, it may give directions requiring a regulatory body to make rules to achieve an effect which must be specified in the directions; and
- Reference of regulators' decisions to court for undue leniency (section 29).

The Secretaries of State of the four UK nations may ask the CHRE for advice on any matter connected with a profession appearing to him or them to be a healthcare profession.

Annex C:

The Council and its members

CHRE is funded through the Department of Health but accountable to the UK Parliament. CHRE's remit encompasses the nine regulatory bodies responsible for healthcare professionals, and the Council consists of the presidents of these organisations together with 10 lay members.

The nine regulatory bodies responsible for healthcare professionals are the General Chiropractic Council, the General Dental Council, the General Medical Council, the General Optical Council, the General Osteopathic Council, the Health Professions Council, the Nursing and Midwifery Council, the Pharmaceutical Society of Northern Ireland and the Royal Pharmaceutical Society of Great Britain.

The following Council members were in post during the year;

Mrs Jane Wesson (Chairman)
Mr Jonathan Asbridge
Professor Norma Brook
Sir Graeme Catto
Mr Nigel Clarke
Dr Michael Copland-Griffiths
Mr PL Marshall Davies (until 31 August 2004)
Dr Frances Dow
Mrs Sheelagh Hillan
Mrs Sue Leggate
Mr Hew Mathewson
Mr James McCusker
Mr Peter North
Mr Hugh Ross
Mr David Smith
Mrs Rosemary Varley
Dr Kieran Walshe
Mr Nicholas Wood (from 1 September 2004)
Ms Sally Williams
Ms Lois Willis

Financial results for the year ending 31st March 2005

The financial accounts cover the period 1st April 2004 to 31st March 2005, and are the third set of accounts.

The Council's accounts are presented on an accruals basis and show a true and fair view of the state of affairs at the year-end. They are the income and expenditure account, balance sheet, and cash flow statement for the financial year. They reflect the need for propriety and regularity in public finances and for the keeping of proper records, as set out in the **Non-Departmental Public Bodies' Accounting Officers' Memorandum** issued by the Treasury and published in **Government Accounting.**

The Council's financial performance during the year is identified within the income and expenditure account. It shows that the Council received £2,519,472 income, via grant in aid and recovery of legal costs of £239,003 associated with Section 29 cases taken to Court where the Council were successful in proceedings. The Council incurred expenditure of £2,716,927. After allowing for the write back of capital charges, the Council achieved a surplus of £76,332.

Fixed assets

The Council continued to acquire fixed assets necessary to carry out its functions during the year. It occupies 11 Strand under a memorandum agreement with the tenant of the building, the Department of Health, which is due to expire in December 2010. It spent £82,230 in the final conversion and set up of offices. Movements on fixed assets are shown in note 7.

Compliance with public sector payment policy

Liberata UK continues to provide accounting and financial services to the Council under the three year contract due to expire on 1 July 2006. The Council's target is to make all payments not in dispute within 30 days or less of acceptance of the relevant goods and services, or the receipt of a legitimate invoice if that is later. Processes have been set up during the year to this end and all invoice payments are made by BACS. CHRE complied with this policy in full during the financial year.

Terms of employment, employee relations and communications

At the end of the period there were eleven directly employed staff.

HR policies and procedures are now fully developed and implemented across the organisation. These provide an environment in which all employees can give of their best and contribute to the Council and their own success. Secondees in this period remained subject to their parent organisations' terms and conditions of employment and temporary staff to those of their employing organisations.

Governance

This statement of accounts includes on pages 42 to 43 a Statement on Internal Control in accordance with the Treasury's requirement that public bodies implement the Combined Code and the Turnbull Report.

Annex C:

The Council's systems of internal control are designed to manage the risks the Council faces, to safeguard its assets against unauthorised use or disposition, to maintain proper accounting records and to communicate reliable information for internal use or publication. These systems have continued to be implemented during the year ended March 2005.

Audit Committee

The Audit Committee is chaired by Nigel Clarke. There are four other members: David Smith, Sally Williams, Lois Willis and Nicholas Wood.

Remuneration Committee

The Remuneration Committee is chaired by Jane Wesson. There are four other members: Michael Copland-Griffiths, James McCusker, Peter North and Rosemary Varley.

Scrutiny Committee

The Scrutiny Committee is chaired by Frances Dow. There are six other members: Norma Brook, Graeme Catto, Hew Mathewson, Hugh Ross, Saranjit Sihota (National Consumer Council) and Kieran Walshe.

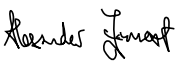
Section 29 cases

CHRE referred eight cases to the High Court in 2004-05, one of which was withdrawn. At the end of the financial year outcomes were awaited on two Section 29 appeals.

Auditors

The external auditor of the CHRE is the Comptroller & Auditor General. A fee of £17,500 has been included within note 5 to the accounts in respect of the audit of these financial statements. No non-audit services were provided.

Significant further progress has been made by the office team in the year. The Council is grateful for their efforts.



Alexander Forrest
Accounting Officer
5 July 2005

STATEMENT OF THE COUNCIL'S AND THE ACCOUNTING OFFICER'S RESPONSIBILITIES

The Council's Responsibilities

Under the Cabinet Office's Guidance on Codes of Best Practice for Board Members of Public Bodies, the Council is responsible for ensuring propriety in its use of public funds and for the proper accounting of their use. Under Schedule 17 paragraph 15 of the National Health Service Reform and Health Care Professions Act 2002, the Council is required to prepare a statement of accounts in respect of each financial year in the form and on the basis directed by the Secretary of State for the Department of Health, with the consent of the Treasury. The accounts are to be prepared on an accruals basis and must give a true and fair view of the Council's state of affairs at the year-end and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

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

Annex C:

STATEMENT ON INTERNAL CONTROL

Scope of responsibility

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

CHRE reports directly to the UK Parliament and works closely with the Department of Health 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

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 priorities, 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 2005 and up to the date of approval of the annual report and accounts, and accords with Treasury guidance.

Capacity to handle risk

A risk register was introduced and refined in 2004-05 as the organisation has developed its various functions. The format and structure of the Risk Register was reviewed and a new model developed using Treasury guidance ('The Orange Book') and is structured to reflect the strategic priorities and operational functions of the organisation.

The risk management process will be reviewed in quarterly meetings by key senior executives. It will then be referred to the Audit Committee and Council who will have oversight of the risk management process.

An annual seminar on risk management hosted by CHRE will address key risk issues for CHRE and its stakeholders. The first such event held in October 2004 provided valuable insight to the risk management process. The seminar was addressed by CHRE's internal auditors and government representatives, and was attended by CHRE staff and Council, as well as representatives from regulatory bodies and other health care organisations.

CHRE participates in a risk management forum comprising representatives from the nine regulatory bodies. This forum provides the opportunity to discuss risk issues in the healthcare regulatory field as well as the process for managing risk.

Business planning and staff objectives continue to include reference to the management of risk in their performance which is related to agreed workstreams.

The risk and control framework

The key elements of the risk management strategy are addressed by assessing the controls in place to identify and evaluate performance. The direct feedback and assurance on risk management is gained from responsible managers and professional outsourced services.

Council and its Audit Committee receive regular updates on business and finance performance. Members are encouraged to join working groups that are active in the development and implementation of policy. The risk management process is overseen by the Audit Committee and Council who provide guidance to the CHRE executive team and scan the horizon for issues that may impact on the organisation, providing CHRE with the ability to respond to issues that may impact on the organisation in the future.

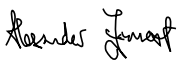
The risk appetite is assessed and managed according to principles laid out in the Treasury guidance where the organisation may elect to tolerate the risk, treat the risk in an appropriate way, transfer the risk or terminate the activity giving rise to the risk.

The risk priority for the organisation in the period 2004-2005 was in relation to cases referred to the High Court under Section 29 of the Act. Expenditure is difficult to forecast due to the nature of the legal process. Where possible, controls are in place over this expenditure and these are reviewed regularly by the Council, the Scrutiny Committee and staff, and by internal and external auditors.

Review of effectiveness

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

Continuous assessment and improvement of CHRE's systems is overseen by Council and its Audit Committee, and implemented by the executive team. Further assurance is provided by external and internal auditors whose required annual opinions confirm the adequacy of arrangements.



Alexander Forrest
Accounting Officer
5 July 2005

Annex C:

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE HOUSES OF PARLIAMENT, THE SCOTTISH PARLIAMENT AND THE MEMBERS OF THE NATIONAL ASSEMBLY FOR WALES

I certify that I have audited the financial statements on pages 46 to 59 under the National Health Service Reform and Health Care Professions Act 2002. These financial statements have been prepared under the historical cost convention as modified by the revaluation of certain fixed assets and the accounting policies set out on pages 49 to 51.

Respective responsibilities of the Council, the Director and Auditor

As described on page 41, the Council and Director are responsible for the preparation of the financial statements in accordance with the National Health Service Reform and Health Care Professions Act 2002 and directions made thereunder by the Secretary of State with the consent of Treasury and for ensuring the regularity of financial transactions. The Council and Director are also responsible for the preparation of the other contents of the Annual Report. My responsibilities, as independent auditor, are established by statute and I have regard to the standards and guidance issued by the Auditing Practices Board and the ethical guidance applicable to the auditing profession.

I report my opinion as to whether the financial statements give a true and fair view and are properly prepared in accordance with the National Health Service Reform and Health Care Professions Act 2002 and directions made thereunder by the Secretary of State with the consent of Treasury, and whether in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. I also report if, in my opinion, the Foreword is not consistent with the financial statements, if the Council has not kept proper accounting records, or if I have not received all the information and explanations I require for my audit.

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 certificate if I become aware of any apparent misstatements or material inconsistencies with the financial statements.

I review whether the statement on pages 42 to 43 reflects the Council's compliance with Treasury's guidance on the Statement on Internal Control. I report if it does not meet the requirements specified by Treasury, or if the statement is misleading or inconsistent with other information I am aware of from my audit of the financial statements. I am not required to consider, nor have I considered whether the Accounting Officer's Statement on Internal Control covers all risks and controls. I am also not required to form an opinion on the effectiveness of the Council's corporate governance procedures or its risk and control procedures.

Basis of audit opinion

I conducted my audit in accordance with United Kingdom Auditing Standards issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts, disclosures and regularity of financial transactions included in the financial statements. It also includes an assessment of the significant estimates and judgements made by the Council and Director 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 are free from material misstatement, whether caused by error, or by fraud or other irregularity 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 have also evaluated the overall adequacy of the presentation of information in the financial statements.

Opinion

In my opinion:

- the financial statements give a true and fair view of the state of affairs of the Council for the Regulation of Healthcare Professionals at 31 March 2005 and of the surplus, total recognised gains and losses and cash flows for the year then ended and have been properly prepared in accordance with the National Health Service Reform and Health Care Professions Act 2002 and directions made thereunder by the Secretary of State with the consent of Treasury; and
- in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

I have no observations to make on these financial statements.

John Bourn
Comptroller and Auditor General
12 July 2005

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

Annex C:

INCOME AND EXPENDITURE ACCOUNT
For the year ended 31 March 2005

	Note	£	Year ended 31 March 2005 £	£	Year ended 31 March 2004 £
Income					
Grant in Aid	2	2,519,472		1,450,000	
Transfer from Deferred Government Grant Reserve	12	31,792		20,453	
Other Operating Income		239,003		-	
			2,790,267		1,470,453
Expenditure					
Staff Costs	3	568,854		377,949	
Members' Remuneration	4	160,079		127,262	
Other Operating Costs	5	1,958,544		936,315	
Depreciation	7	26,458		18,336	
Notional cost of capital	6	2,992		97	
			2,716,927		1,459,959
Operating surplus/(deficit)			73,340		10,494
Notional cost of capital reversal	6		2,992		97
Retained surplus /(deficit) for the year	12		76,332		10,591

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

The notes on pages 49 to 59 form part of these accounts.

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES
For the year ended 31 March 2005

	Year ended 31 March 2005 £	Year ended 31 March 2004 £
Retained surplus/(deficit) for the year	76,332	10,591
Net unrelealised (loss)/gain on revaluation of fixed assets	4,697	-
Total recognised gains/(losses) for the year	81,029	10,591

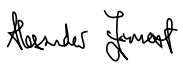
BALANCE SHEET AS AT 31 MARCH 2005

	Note	2005 £	2005 £	2004 £	2004 £
Fixed assets					
Tangible fixed assets	7		121,669		48,813
Current Assets					
Debtors	8	249,848		194,869	
Cash at bank and in hand	9	43,294		20,787	
		293,142		215,656	
Creditors : amounts falling due within one year	10	(153,529)		(221,615)	
Net current assets/(liabilities)			139,613		(5,959)
Provisions for liabilities and charges	11		(69,240)		-
Net Assets/(liabilities)			192,042		42,854
Reserves					
Income and Expenditure Account	12		70,373		(5,959)
Government Grant Reserve	12		121,669		48,813
			192,042		42,854

The notes on pages 49 to 59 form part of these accounts

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

Alexander Forrest



Accounting Officer
5 July 2005

Annex C:

CASH FLOW STATEMENT
For the year ended 31 March 2005

	Note	Year ended 31 March 2005 £	Year ended 31 March 2004 £
Net cash inflow from operating activities	13	11,686	20,787
Capital expenditure			
Payments to acquire tangible fixed assets		(89,130)	(69,266)
Net cash inflow before financing		(77,444)	(48,479)
Financing			
Grant in aid for capital expenditure		99,951	69,266
Increase in cash	9	22,507	20,787

The notes on pages 49 to 59 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 HM Treasury's guidance **Executive Non-Departmental Public Bodies Annual Reports and Accounts Guidance**. The particular accounting policies adopted by the Council are described below. They have been applied consistently in dealing with items considered material in relation to these financial statements.

b. Accounting convention

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

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

c. Grant in aid and government grant reserve

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

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

d. Tangible fixed assets

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

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

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

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

Annex C:

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	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.

Further to a review of the useful economic lives of CHRE assets during the year, the useful economic life of computer equipment was extended from two to three years as this better reflects the period over which this class of asset is used. The effect on the depreciation charge for 2004/05 of this change in accounting policy was to reduce the depreciation charge by £6,275.

The Council will remain at Kierran Cross, 11 Strand, London, WC2N 5HR until December 2010 and refurbishment costs have been depreciated over the remaining lease term to this date. (In 2003/04 it was anticipated that the Council's use of these premises would cease in December 2005). The depreciation charge for 2004/05 for refurbishment costs reflects this change reducing the depreciation charge by £10,177.

f. Section 29 costs and recoveries

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

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

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

In the case of costs awarded against the Council, expenditure is recognised in the income and expenditure where there is a final uncontested judgment against the Council. In addition, where a case has been lost, but the final outcome is still subject to appeal, and it is probable that costs will be awarded against the Council, a provision is recognised in the accounts. Where it is possible but not probable that the case will be lost on appeal and that costs may be incurred by the Council, or where a sufficiently reliable estimate of the amount payable cannot be made, a contingent liability is disclosed (see note 14).

g. Notional charges

In accordance with the **Executive Non-Departmental Public Bodies Annual Reports and Accounts Guidance** published by HM Treasury, a notional charge for the cost of capital employed during the year is included in the income and expenditure account along with an equivalent notional income to finance the charge. The cost of capital charge is calculated at 3.5 per cent, applied to the mean value of capital employed during the year, excluding non-interest bearing cash balances held with the Office of the Paymaster General.

h. Value Added Tax

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

i. Pension costs

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

This is a statutory defined pension scheme, the provisions of which are contained in the NHS Pension Scheme Regulation (SI 1995 No. 300). Under these regulations the Council is required to pay an employer's contribution, currently 14% of pensionable pay, as specified by the Secretary of State. For 2004/2005, employer's contributions of £47,762 (2003/2004: £6,851 – calculated at 7%) were payable to the NHS Pension Scheme. These contributions are charged to the income and expenditure account as and when they become due. The Government Actuary reviews the employer contributions every four years following a full scheme valuation and sets contributions rates to reflect past experience and benefits when they are accrued, not when costs are actually incurred.

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

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

j. Operating leases

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

An operating lease for Kierran Cross, 11 Strand, London, WC2N 5HR is in force with the Department of Health until 31 December 2010. As the Council are only deemed as occupiers at these premises, there are no longer term future lease commitments.

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

Annex C:

2. Income

	Note	Year ended 31 March 2005 £	Year ended 31 March 2004 £
Grant in Aid received from the Department of Health		2,619,423	1,519,266
Transfer to government grant reserve in respect of fixed asset additions	12	(99,951)	(69,266)
		2,519,472	1,450,000

3. Staff Costs

Salaries	409,059	139,788
Seconded staff costs	25,543	187,518
Social security costs	41,038	14,574
Superannuation costs	47,762	6,851
Agency/ Temporary costs	45,452	29,218
	568,854	377,949

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

	Year ended 31 March 2005 WTE	Year ended 31 March 2004 WTE
Management and Administrative	9.5	3
	9.5	3

a) Director's emoluments:

The salary and pension entitlements of the Director were as follows:

Name	Salary(£)	Real increase in pension and related lump sum at age 60 (£'000)	Total accrued pension and related lump sum at 31 March 2005 (£'000)
Alexander Forrest (*)	121,800	5-7.5	5-7.5

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

There were no benefits in kind paid this year.

b) Other senior managers' remuneration

Treasury guidance (DAO3/00) requires the Council to provide information on the salary of named individuals who are "the most senior managers" of the Council.

The salary for the senior manager of the Council was:-

Name	Salary (£'000)	Real increase in pension and related lump sum at age 60 (£'000)	Total accrued pension and related lump sum at 31 March 2005 (£'000)
Frances J Stone (Deputy Director)	50-60	2.5-5	2.5-5

c) Cash equivalent transfer values

	Cash Equivalent Transfer Value as at 1 April 2004 (£'000)	Cash Equivalent Transfer Value as at 31March 2005 (£'000)	Real increase in the cash equivalent transfer value during the reporting year (£'000)
Alexander Forrest	7	26	19
Frances Stone	2	10	9

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.

Annex C:

The CETV figure, and from 2004-05 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.

4. Members' Remuneration

The Chairman, Jane Wesson, received total remuneration of £49,078 (2003-04: £26,509) which comprised gross salary of £31,365 and a second home allowance of £17,713 (£12,000 net). Council members' remuneration and the Chairman's salary are not subject to superannuation. Members receive an annual remuneration of £5,673 (2003-04: £5,426).

Members' remuneration during the year amounted to £160,079 (2003-04: £127,262) including social security costs. Payments to individual members are disclosed in the following ranges:

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

In addition, expenses amounting to £54,132 (2003-04: £42,000) were reimbursed to the members (note 5).

5. Other Operating Costs

Other operating costs include:

	Year ended 31 March 2005 £	Year ended 31 March 2004 £ Restated
Professional fees	1,162,536	415,937
Consultancy fees	8,473	103,089
Rent and office accommodation	207,206	122,646
Accountancy services	27,208	34,690
Training and recruitment	49,403	35,231
Computer consumables and web site development costs	106,321	81,585
Impairment of fixed assets	5,334	2,117
Printing and stationery	13,051	17,000
Council members expenses	54,132	42,000
External audit fee (*)	17,500	17,000
Repairs and maintenance	56,985	17,280
Publicity	133,183	20,530
Other costs	117,212	27,210
Total other operating costs	1,958,544	936,315

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

6. Notional Cost of Capital

In accordance with the **Executive Non-Departmental Public Bodies Annual Reports and Accounts Guidance** published by HM Treasury, a notional charge for the cost of capital employed during the year is included in the income and expenditure account along with an equivalent notional income to finance the charge. The cost of capital charge of 3.5 percent 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 2005 £	Year ended 31 March 2004 £
Capital employed as at beginning of period	22,119	(16,550)
Capital employed as at 31 March	148,848	22,119
Mean capital employed	85,484	2,785
Notional charge	2,992	97

Annex C:

7. Tangible Fixed Assets

	Furniture, Fixtures & Fittings- Conversion Costs	IT Equipment	Total
	£	£	£
Valuation			
At 1 April 2004	27,648	37,556	65,204
Additions	82,230	17,721	99,951
Revaluations	4,697	(5,334)	(637)
At 31 March 2005	114,575	49,943	164,518
Depreciation			
At 1 April 2004	10,054	6,337	16,391
Charge for year	13,908	12,550	26,458
At 31 March 2005	23,962	18,887	42,849
Net Book Value			
At 31 March 2005	90,613	31,056	121,669
At 31 March 2004	17,594	31,219	48,813

8. Debtors

	31 March 2005	31 March 2004
	£	£
Debtors	166,321	124,916
Prepayments	83,527	69,953
	249,848	194,869

Included within debtors is a balance for £19,472 which the CHRE holds with another central government body (Department of Health).

9. Cash at Bank and in Hand

	31 March 2005 £	31 March 2004 £
At 1 April	20,787	-
Increase in cash in year	22,507	20,787
At 31 March	43,294	20,787
Bank account at Office of Paymaster General	43,194	20,735
Cash in hand	100	52
	43,294	20,787

10. Creditors: Amounts falling due within one year

	31 March 2005 £	31 March 2004 £
Trade Creditors	17,900	153,706
Capital Creditors	10,821	-
Other Creditors	28,610	17,368
Accruals	96,198	50,541
	153,529	221,615

The total of £28,610 for other creditors comprises balances owed to two central government departments.

11. Provisions for Liabilities and Charges

	£
Balance at 1 April 2004	-
Provision in year	69,240
Amounts used in year	-
Balance at 31 March 2005	69,240

The value of the provision relates to two Section 29 cases where it is probable at the balance sheet date that costs will be payable by the Council.

Annex C:

12. Reserves

	Government Grant Reserve £	Income and expenditure account £	Total £
At 1 April 2004	48,813	(5,959)	42,854
Surplus for the year	-	76,332	76,332
Grant for Fixed Asset Additions (note 2)	99,951	-	99,951
Depreciation transferred to income and expenditure account	(26,458)	-	(26,458)
Release to income and expenditure account for impairment	(5,334)	-	(5,334)
Surplus on revaluation of fixed assets	4,697	-	4,697
Balance as at 31 March 2005	121,669	70,373	192,042

13. Reconciliation of Operating Surplus to Net Cash Inflow from Operating Activities

	Year ended 31 March 2005 £	Year ended 31 March 2004 £
Operating surplus	73,340	10,494
Adjustment for non-cash transactions:		
Depreciation	26,458	18,336
Cost of capital	2,992	97
Deficit on revaluation of fixed assets	5,334	2,117
Release from government grant reserve	(31,792)	(20,453)
Adjustment for movements in working capital other than cash:		
(Decrease)/increase in creditors	(78,907)	205,065
Decrease/(increase) in debtors	(54,979)	(194,869)
Increase in provisions	69,240	-
Net cash inflow from operating activities	11,686	20,787

14.Contingent Liabilities

The Council referred eight cases (one case subsequently withdrawn) to the High Court in the financial year ended 31 March 2005 under its Section 29 powers. Each decision incurs legal costs for such an appeal of a regulatory body's disciplinary decision. Two High Court cases 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.

15.Capital Commitments

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

16. Related Party Transactions

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

The Department of Health is regarded as a related party. During the year to 31 March 2005 the Department of Health provided total grant in aid of £2,619,423 (2003-04: £1,519,266). 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 2005 no Council member undertook any transactions with the Council.

17.Losses and special payments

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

18.Post Balance Sheet Events

The government's response to the outcome of the Review of Non-Medical Professional Regulation and the Chief Medical Officer's Advisory Group in to Patient Safety, following on from the Report from the Shipman Inquiry, may impact on the structure and functions of CHRE.

19. Financial Instruments

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

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