Inspecting Informing Improving

Annual report 2007/08

Making healthcare safer for patients

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Healthcare Commission

Annual report and accounts 2007/08

Making healthcare safer for patients

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About the Healthcare Commission

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

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

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

What we do

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

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

Improving
To promote improvements in healthcare and public health

How we work

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

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

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

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

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

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

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

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Foreword

Our fourth annual report records a year of significant progress by the Healthcare Commission on behalf of patients and the public. We now see the efforts and innovations of our first four years bearing fruit and making a real difference to the quality of healthcare services.

In October 2007, we published the results of our second annual health check of the NHS. We were very pleased to see the positive impact that the system is having on those who provide healthcare. More trusts were rated "excellent" than in 2006, fewer were rated "weak", and there was clear improvement nationwide. For example, 19 trusts were rated excellent for both the quality of their services and the use of their resources, whereas only two achieved this in 2005/06. One in three of all trusts had improved the quality of their services. However, a small number of trusts were rated "weak" for the second year running. Improvements have also been made in the independent sector – 80% of organisations provided sufficient evidence of compliance with the national minimum standards for us not to need to inspect them.

Safety, infection control and hygiene issues were prominent during the year, particularly after we reported on our investigation into two outbreaks of *C. difficile* at Maidstone and Tunbridge Wells NHS Trust and the resulting loss of life. We inspected 120 acute hospital trusts for compliance with the Government's hygiene code (the Health Act 2006, Code of Practice for the Prevention and Control of Heath Care Associated Infection), and will be inspecting all acute hospitals in the NHS in 2008/09.

Through our reviews and studies of aspects of healthcare we again increased the depth and range of information that is publicly available, and ensured that this information was published in a user-friendly way. Topics included services for heart failure and for diabetes, community mental health services, and dignity in care. We also carried out England's most comprehensive review of maternity services to date. It highlighted marked variations in the quality of care, with trusts in London performing the most poorly. After our audit of services for people with learning difficulties, in partnership with the Commission for Social Care Inspection, we called for widespread improvement of such services.

This year saw significant progress in our work as the independent reviewer of patients' complaints about NHS services in England. We reviewed 7,500 complaints which had not been resolved locally, carried out a national audit of how well trusts handle complaints, and disseminated training and guidance to help them improve their practices in this important area.

Looking ahead to 2008/09, we will be delivering an extremely full programme of work while at the same time preparing for a smooth transition to the new regulator, the Care Quality Commission, at the end of the year. We are committed to maintaining the momentum that we have developed over the last four years, and look forward to seeing our pioneering work in risk-based, information-led regulation being continued in the new organisation.

Professor Sir Ian Kennedy
Chair

Anna Walker CB
Chief Executive

Our year in brief

A selection of our achievements during the year from April 2007 to March 2008

April 2007

- Published the results of our national survey of people with diabetes
- Launched our gender equality scheme and positive action plan
- Announced a 15% cut in our 2007/08 regulatory fees to independent healthcare organisations

May

- Published the findings of the 2007 National Sentinel stroke audit that we funded
- Published the results of our 2006 national survey of adult inpatients in NHS acute hospitals
- Launched a review looking at race equality in NHS trusts

June

- The launch of a website that we funded showing survival rates at specialist heart services for children
- Launched national programme of inspections to help tackle healthcare-associated infections

August

- Published latest survival rates for heart surgery on website run with the Society for Cardiothoracic Surgery in Great Britain and Ireland
- Reported progress at East Sussex Hospitals NHS Trust following our investigation into bullying and harassment

September

- Published results of national survey of users of community mental health services
- Published our recommendations for improvement at Newham University Hospital NHS Trust following backlog in antenatal care
- Published report of our study into dignity in care for older people

October

- Government announces that the Healthcare Commission will annually inspect all acute trusts against the hygiene code
- Published the first audit of how the NHS deals with patients' complaints
- Reported the findings of our investigation into fatal outbreaks

December

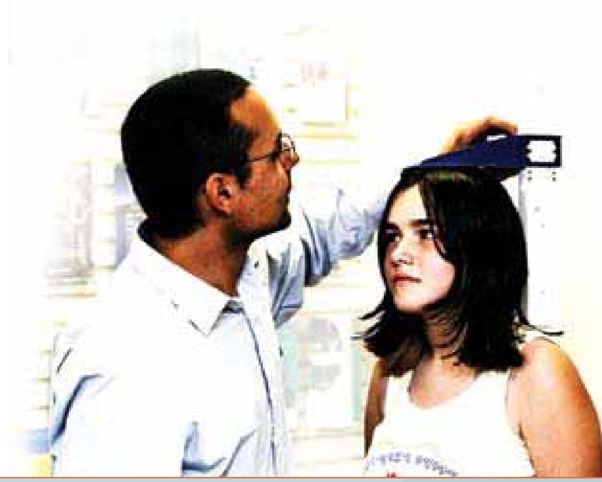
- Called for sweeping changes in the care provided for people with learning difficulties, after our national audit of these services
- Published the results of the 2007 Count Me In census of inpatients in mental health trusts and learning difficulties services and organisations
- Following our survey of ambulance trusts that use volunteers, called for national guidance on how they should manage these schemes
- Launched consultations on our proposals for next annual health check and on fees for regulating independent providers in 2008/09
- Launched a section on our website for people with learning difficulties

January 2008

- Secured conviction of unregistered provider of laser services who was not following guidelines on safety
- Published our results on national review of maternity services

February

- Issued improvement notices to Bromley



- Published NHS trusts' annual self-assessments of compliance with the Government's core standards
- Co-hosted a major conference on maternity services with the National Patient Safety Agency

July

- Published the results of our reviews of services for people with heart failure and diabetes
- Issued first improvement notice on infection control (to Barnet and Chase Farm Hospitals NHS Trust)
- Published results of our review of sexual health services

- Published report on the care provided by independent sector treatment centres
- Published report into healthcare-associated infections, with practical advice for NHS trusts
- Published review of adult community mental health services, with the Commission for Social Care Inspection

of *C. difficile* at Maidstone and Tunbridge Wells NHS Trust

- Published performance ratings for all NHS trusts in the second annual health check, in a new, accessible format
- Launched a section on our website on NHS services for people with diabetes

November

- Responded to the Department of Health's proposals for the shape of the regulation of health and social care in the future
- Carried out a rapid review of heart transplant surgery at Papworth Hospital following an increase in number of deaths after transplants

- Reported on substantial progress by Stoke Mandeville Hospital after our investigation into infection control at the trust
- Workshop on measuring clinical quality with the Academy of Medical Royal Colleges
- Published results of survey of 26,000 women who gave birth in NHS maternity units in early 2007

and Ipswich Hospitals NHS Trust, requiring immediate changes to their infection control practices

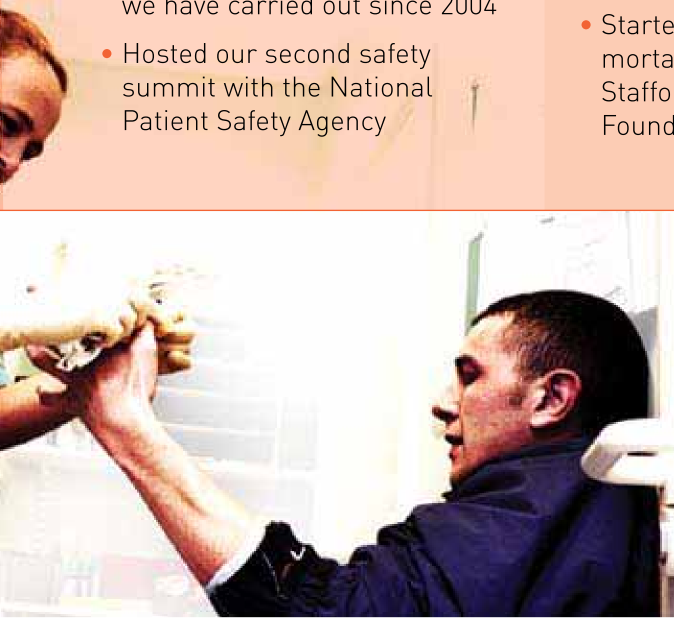
- Published report on lessons learned from the 13 investigations we have carried out since 2004
- Hosted our second safety summit with the National Patient Safety Agency

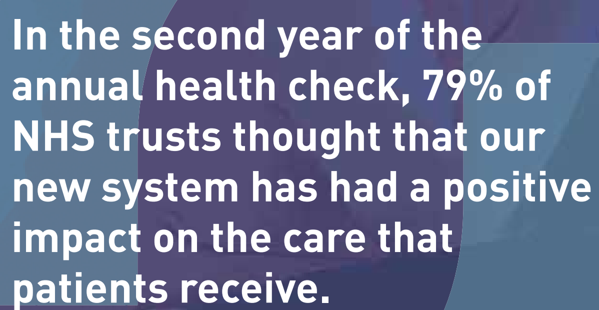
- Launched workshops on services for people with learning difficulties (with the Care Services Improvement Partnership)

March

- Started investigation into mortality rates at the Mid Staffordshire NHS Foundation Trust

- Published our first report on incidents reported to us under the Ionising Radiation (Medical Exposure) Regulations (2000)
- Reported that Cornwall Partnership NHS Trust shows substantial progress in addressing failings in its services for people with learning difficulties since our investigation in 2006





In the second year of the annual health check, 79% of NHS trusts thought that our new system has had a positive impact on the care that patients receive.

Promoting a better experience of health and healthcare

As England's healthcare watchdog, our overriding aim is to promote improvements in the healthcare that patients receive, including their experience of treatment and care. Our annual health check of the NHS plays a crucial part in this, by revealing trusts' shortcomings as well as highlighting progress and examples of excellence. This year we also promoted improvement through our in-depth reviews of specific NHS services and our work to strengthen the regulation of independent healthcare providers.

We were particularly pleased this year to hear that trusts felt that our system of assessment was having a positive impact on the care of patients and that it helped them to focus more attention on patients' safety.

These were some of our key activities in 2007/08:

The annual health check 2006/07

On 18 October 2007 we published the second set of annual performance ratings for NHS trusts under the annual health check, a pioneering, risk-based system that we introduced for our 2005/06 assessment cycle. These ratings cover trusts' performance during the year from 1 April 2006 to 31 March 2007.

We look at many aspects of treatment and care, focusing on how well NHS trusts are meeting the Department of Health's core standards. These define a level of performance that trusts must meet, particularly with regard to keeping patients safe from infection and other types of harm, providing effective treatments and care, and making sure that everyone who needs healthcare services has access to them.

We give each trust an overall performance rating that is made up of two parts: quality of services and use of resources. Quality of resources refers to how well the trust has met the Government's core standards for the NHS, and use of resources refers to how effectively it has managed its finances. We score both parts using a scale of "excellent", "good", "fair", or "weak".

Each April we ask the board of every trust in England to assess how well their organisation has complied with the core standards during the preceding year, and to publicly declare this information. We also ask patients, patient groups and other stakeholders for their views, then use this local intelligence, along with data collected during our service reviews, to cross-check the trusts' self-assessments. We then select a proportion of all the trusts in England to visit for a detailed inspection. For this year's annual health check, we visited around 10% on the basis that they were at risk of not complying with the core standards, and an additional 10% that were selected at random.

The results of our second annual health check showed that this pioneering, risk-based approach to assessment is helping to improve NHS services nationwide.

What the annual health check showed us

We saw an overall improvement for the 394 NHS trusts in existence during 2006/07. A larger proportion of them scored "excellent" and a smaller proportion scored "weak" for both parts of the rating than for 2005/06.

Quality of services: 16% of trusts were rated "excellent" and 30% were rated "good", compared to 4% and 36% respectively for 2005/06. Forty-five per cent of trusts were rated "fair" and 8% were rated "weak" – compared with 50% and 9% respectively in 2006.

Use of resources: 14% of trusts were rated "excellent" and 23% were rated "good", compared to 3% and 12% respectively in 2006. Thirty-six per cent of trusts were rated "fair" for 'use of resources', compared to 47% for 2005/06. There was an encouraging reduction in the proportion of trusts rated "weak" – 26%, down from 37% in 2005/06.

There were areas of significant improvement, including all trusts ensuring that cancer patients received treatment within a month after diagnosis, unless this was not clinically advisable. Of the 18 million patients that went to A&E, 98% received care within four hours, and more trusts met the target for reducing the number of cancelled operations than in 2005/06.

Follow-up for trusts rated "weak" for quality of services

We rated 33 trusts "weak" for the quality of their services. This was the second year running that nine of them had received this score. In addition, four of them had also been rated "weak" for their use of resources for two years running.

To ensure that these trusts improved and that some of the lessons learned were shared with the NHS as a whole, we met with them in early 2008 and also worked closely with their strategic health authorities and the Department of Health.

In the case of the Royal Cornwall Hospitals NHS Trust, its performance was particularly weak, to the extent that it had not met 70% of the Government's core standards. We therefore inspected the trust, carried out a more detailed intervention and made a range of recommendations. In April 2008 we found that the trust has made progress in implementing our recommendations and that its board was leading a process of organisational change to improve the way it delivers its services. We will review the trust's progress again in the autumn of 2008.

Evaluating the annual health check 2006/07

We commissioned the Office of Public Management to evaluate the impact of the annual health check in its second year, focusing on whether the NHS thought that our system improved the care patients received and benefited trusts. The evaluation gave us valuable feedback that has informed our thinking when developing the annual health check assessment framework for 2007/08.

Many trusts viewed the annual health check as a "catalyst for change" that had helped them to prioritise areas for action. Of the 220 trusts surveyed, 198 had made changes as a result of the new system. Seventy-nine per cent said that it had had a positive impact on patients' care, through, for example, improved hygiene and infection control, better information for patients and more attention being paid to their views. Fifty-seven per cent of the trusts surveyed agreed that including compliance with the hygiene code in their self-assessments had had a positive impact on the safety of patients, and 75% said that they had built core standards into their service-level contracts and commissioning arrangements.

Most of the trusts surveyed (70%) said that when they balanced the benefits against the costs, the annual health check assessment process was a good use of their staff time. The evaluation also showed that patient and public involvement forums saw the process as a lever for improving local healthcare, and that they were actively included in it.

Moving forward

During 2007/08 we have also consulted patients, the public, representatives of NHS trusts, and other stakeholders on the proposed design of the 2008/09 annual health check, through print and web publications and 50 stakeholder events. We published an analysis of their feedback and the final design of the assessment framework in June 2008.

Driving improvements in the NHS

During 2007/08 the Commission published the results of five in-depth reviews of the services that the NHS provides in specialist areas of healthcare. Through our service reviews, we collect, analyse and publish data about healthcare that would not otherwise be available either to the public or to the NHS. The results enable trusts to identify where they need to improve, and help us to cross-check their self-assessments against the Government's core standards.

Services for heart failure: this review showed some very positive progress over the last few years. There has been a continuing reduction in the time patients with heart failure wait to be diagnosed, and a marked increase in the numbers of patients receiving drugs to control symptoms and reduce the rate at which their condition develops. However, we had concerns that clinicians may be failing to identify heart failure in a significant number of people suffering from the condition.

We published six national reviews and studies that highlighted what needs to be done to improve different types of services. By the end of 2007/08, changes were already starting to happen – for example, following our audit of services for people with learning difficulties, 85% of the services had either made or had planned changes.

The majority (82%) of trusts' services were either "good" (53%) or "fair" (29%), and 9% of trusts were providing "excellent" services. The 10% of trusts that we rated "weak" have been required to produce an action plan showing how they will make the improvements needed.

Services for people with diabetes: in this review we assessed how well primary care trusts commissioned services that help people with diabetes to manage their condition. We found that 5% (7) of trusts were "excellent", 11% (16) were "good", 73% were "fair" and 12% (18) were "weak". In the trusts we rated "weak", people with diabetes were not receiving yearly check-ups and relevant tests. Furthermore, the trusts were not commissioning adequate services – such as education for patients and good processes for planning care – to help them to manage their diabetes. Regular check-ups, support from healthcare professionals, and the right treatment can help to prevent people with diabetes developing complications such as heart problems, blindness and kidney failure.

Specialist community mental health services for adults: our joint review with the Commission for Social Care Inspection showed that services were generally performing well, but with variation across the country. There was room for improvement in access to talking therapies, availability of crisis care out of hours, race equality, information for users of services, how medicines are managed, and physical health checks for people with schizophrenia.

Maternity services: in 2007 we carried out England's most comprehensive assessment of maternity services to date. Involving 148 trusts, the review covered the period from when a woman first contacts a maternity service to her final contact with a midwife after the birth. In addition to information from the trusts, we collected the views of 26,000 mothers who gave birth in NHS trusts in January and February 2007.

The quality of maternity care varied significantly across the country, with trusts in the north of England performing relatively well, while trusts in London performed the most poorly. We ranked 21% of services as "least well performing", 22% as "fair performing", 32% as "better performing" and 26% as "best performing". The Government has acted on our findings – in January 2008 it announced an extra £330 million funding to improve maternity services.

Services for people with learning difficulties: in 2007 we carried out an audit of specialist inpatient healthcare services for people with learning difficulties, working with the Commission for Social Care Inspection. For more information, see page 32.

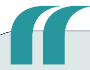
Dignity in care: in August 2007 we published the results of a national study into how well NHS trusts are meeting the Government's core standards relating to 'dignity in care'. This aspect of care involves helping patients – particularly older people – with their basic needs, making sure they receive the right kind and quantity of food, and that staff are respectful in their attitudes towards them.

After inspecting 23 trusts on the basis of risk of non-compliance, we found that five of them complied with the relevant standards. We asked 10 of the remaining trusts to make improvements such as providing adequate staff training and protecting patients' meal times from clinical activity. We warned eight of the poorer performers that they may be at risk of non-compliance in the annual health check, although we had not identified any major breaches of the standards. Our report also called for better implementation and monitoring of policies for this area, and for improvements in services for patients with dementia and those who are near the end of their lives.

Working with services for children and young people

Our joint area reviews with Ofsted, the Audit Commission and other partners showed that local authorities and PCTs are working increasingly effectively together to provide services for children. Through the best examples of such partnerships, school nurses, health visitors and midwives are able to create and monitor new systems for providing care, and to offer advice and support to children, young people, parents and carers. By prompting organisations to examine their practices more closely, the joint review process is making differences at various levels of the provision of care.

The Healthcare Commission also takes part in joint inspections of youth offending teams. In 2007 we reported that the provision of healthcare for young offenders had improved but remained inadequate. For example, health services were not well represented on the teams' management boards, young people who offend often had difficulty accessing the appropriate mental health services, and the processes for assessing and referring them for healthcare and substance misuse services were often inadequate.



PCT board members take these standards very seriously and would accord a lower priority to public health if we were not included in these standards.

Director of public health on our assessment of trusts' compliance with core standards in public health

Public health

In preparation for the 2007/08 annual health check, we developed and disseminated a set of benchmarking indicators for PCTs to use alongside their local intelligence when assessing their performance in public health. We ran regional events for provider trusts, to enable them to share good practice and further their understanding of the standards for public health and the important role they have in improving the health of people in England.

A survey of directors of public health showed that the majority of them were very positive about our assessing trusts' compliance with the core standards for public health, saying that it helped to improve delivery of public health work and increased its profile. Only 2% said that it brought no benefit.

In July 2007, we published the report of our national study of sexual health. We found that a lack of reliable or consistent data in England made it difficult to track positive progress or to identify areas that need to improve. It also affects how well services can target high-risk groups, plan resources, and monitor people's levels of sexual health and access to services.

Surveys of patients and staff in the NHS

Our national programme of surveys provides vital insights into the experiences of both patients and the people who provide their care. It is also our single largest source of data for the annual health check. These were some of our key findings in 2007/08:

Community mental health services: this survey showed that the relationships between patients and their psychiatrists continued to improve since the previous year, and more people with complex mental health needs knew who their care coordinator was and had been offered copies of their care plans. Of the people surveyed, the proportion who had the phone number of someone to contact out of hours had risen from 49% to 52%, and the vast majority who had used it said that they were able to speak to someone about their problem within an hour. However, more than one in three service users who would have liked counselling were not receiving it.

Mothers' experiences of NHS maternity services: of the 26,000 women who took part, 89% thought that their care was either "excellent", "very good" or "good" during pregnancy, 90% thought so about their care during labour and birth, and 80% thought so about their care after birth. However,

> **We called for all independent healthcare providers to collect and publish data about patients' treatment and care that is comparable to information available about NHS services. This would help patients make informed choices about healthcare and would aid regulation.**

there were some areas of concern, including postnatal care, communications with staff, food, and cleanliness, and women's responses about these areas varied widely between trusts.

Experiences of patients in NHS hospitals: in our annual survey patients' satisfaction with their overall care remained high, with 92% saying it was "good", "very good" or "excellent". But there were striking variations – for example, in the best performing trusts 77% of patients rated their care "excellent", compared to only 24% in the lowest performing trusts. Issues of concern included the standard of food and use of mixed-sex accommodation, and staff's speed of response to calls for help and assistance with eating.

Experience of NHS staff: many staff reported high levels of job satisfaction, strong support from line managers, and access to flexible working hours and to training, learning and development opportunities. But the survey also revealed relatively high levels of violence and abuse of staff compared with other working environments. In addition, respondents did not always feel that their work was valued by their employers and thought that communication with senior management was poor.

Regulating the independent sector

In 2007/08 the Commission made significant steps in aligning its approaches to regulating the independent and NHS sectors, both in terms of work towards making comparable information available about services and the use of risk-based assessment.

We assessed registered services against the Government's national minimum standards, targeting those that we considered to be at risk of non-compliance, and collected performance indicators to allow us to make a more rounded assessment of such risk. The majority of independent healthcare providers met most of the national minimum safety standards. A higher proportion of independent providers reported that they met both the core minimum standards on safety and the safety standards that apply to their specific healthcare sector. However, as in the NHS, relatively low compliance with standards on decontamination remained a concern.

We worked with the Department of Health, Connecting for Health, the Information Centre and independent providers to make sure that in the future information will be available that enables the public to compare the quality of care that different organisations provide.

After consultation with providers, we made minimal changes to our proposals for inspection fees for 2008/09, following the success of the changes we made to the scheme in 2005/06 and 2006/07.

Independent sector treatment centres (ISTCs)

Introduced as part of the Government's plan to cut NHS waiting times, ISTCs are independently managed centres that provide a limited range of planned, non-emergency surgery and diagnostic services for the NHS. This year we published the results of a study comparing the quality of care provided in the NHS and in ISTCs.

We found that overall the services provided by ISTCs were of a good standard and rated highly by patients. However, the poor quality of the data available about their services made it difficult to draw a comparison with the quality of care in the NHS.

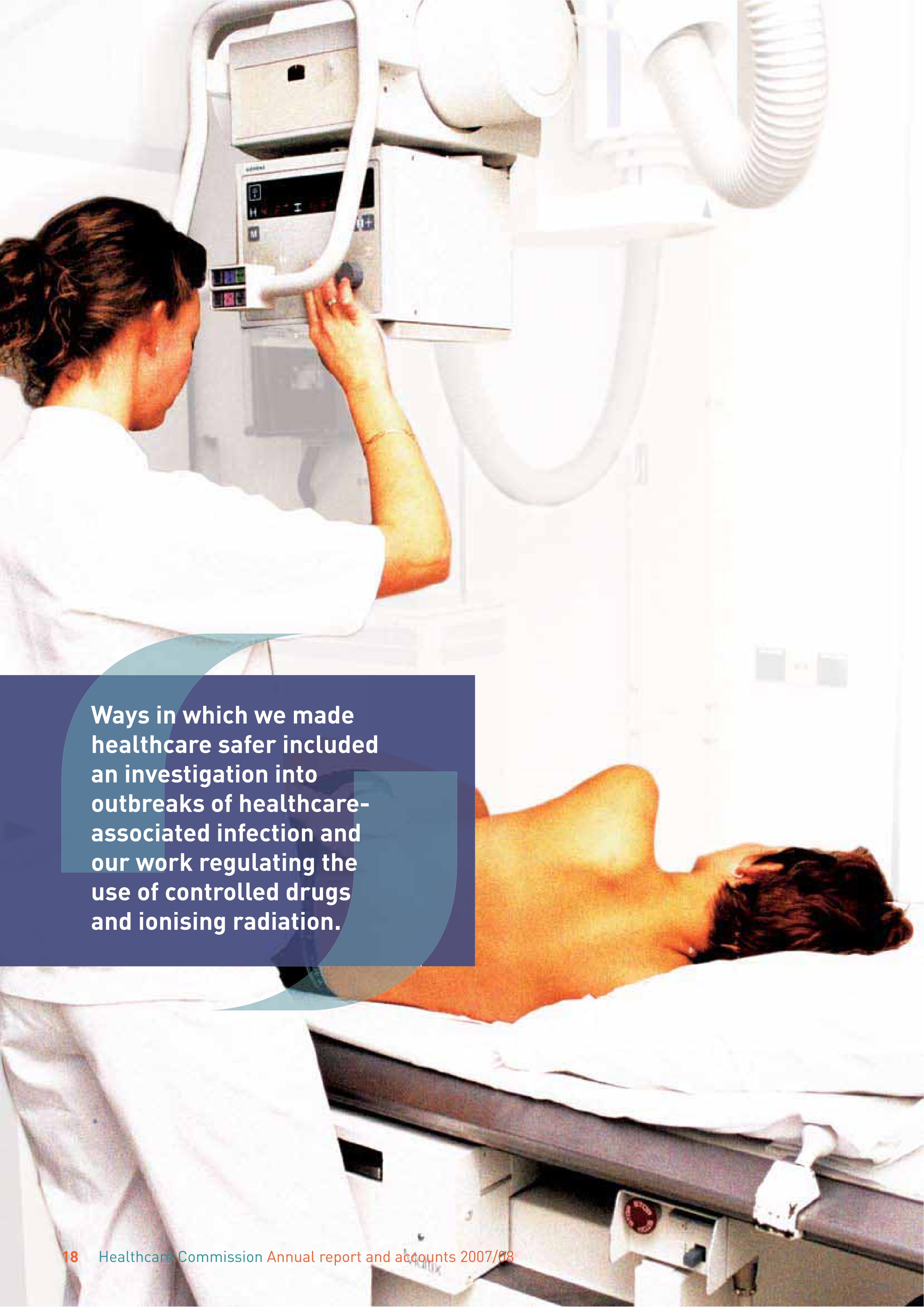
Since we published our report we have been working closely with the Department of Health, the NHS Information Centre, and independent healthcare providers on strategies to improve the quality of data. Reports by the NHS Information Centre have shown that providers have responded positively, and overall the quality of data is improving. However, the Healthcare Commission and the Information Centre have noted that the quality for key fields remains low, and was too poor for us to analyse in our update review of ISTCs.

Our work in Wales

During 2007/08, Welsh NHS trusts continued to take part in our national programme of clinical audit and patients' outcomes (see page 28). The Commission and Healthcare Inspectorate Wales kept in touch over the development and outcomes of our respective service reviews, including those on maternity services and services for people with learning difficulties. We signed a memorandum of understanding with the Welsh Audit Office to facilitate the sharing of information and liaison over areas of mutual interest.

The Healthcare Commission is a signatory of the concordat between the bodies that inspect, regulate and audit health and social care in Wales. 2007/08 saw us working with our Welsh partners to further develop the cooperative arrangements on which the concordat is based.

We produced English and Welsh versions of all of our publications that covered Wales, or would have an impact on Welsh services.



Ways in which we made healthcare safer included an investigation into outbreaks of healthcare-associated infection and our work regulating the use of controlled drugs and ionising radiation.

Safeguarding the public

People rightly expect to be safe when they are in the care of health services. Patients' safety is one of our top priorities. The annual health check is one way that we identify risks to patients, but we also carry out targeted investigations and review complaints about the NHS to spot common themes that show where things may be going wrong.

While our work on healthcare-associated infection achieved a particularly high profile this year, we also led work to help minimise the risks caused by poor management of controlled drugs, and to improve healthcare organisations' procedures when using ionising radiation.

These were some of our key activities in 2007/08:

Investigations we reported on in 2007/08

In October 2007, we reported the findings of our investigation into the control of infection and quality of care for patients with *C. difficile* at Maidstone and Tunbridge Wells NHS Trust between April 2004 and September 2006. During this period, more than 1,170 patients were infected across the trust's three hospitals. We estimated that about 90 of these patients definitely or probably died as a result, after detailed examination of the case notes of a sample of 50 patients.

The investigation revealed serious failings in how patients with *C. difficile* were cared for, particularly during two major outbreaks of the infection. We called for the board to review the trust's leadership and to make changes to improve the care of patients and the control of healthcare-associated infection. At a national level, we called for *C. difficile* to be managed as a serious medical condition in its own right, rather than as a clinical complication.

Following up after investigations

Maidstone and Tunbridge Wells NHS Trust: since we published the results of our investigation, we have revisited the trust and identified some early progress in response to our recommendations. We will be formally assessing the trust's progress, and will make a public statement on our findings in the autumn of 2008.

Stoke Mandeville Hospital: the staff of Stoke Mandeville Hospital have made substantial progress since July 2006, when our investigation report showed serious failings in the prevention and management of healthcare-associated infection by Buckinghamshire Hospitals NHS Trust. Our follow-up review, published in November 2007, found that infection control has become a top priority at the trust and that it met all requirements of the hygiene code. The rate of *C. difficile* infection was well below the national average, according to the most recent data on the trust published by the Health Protection Agency.

> **Our work this year following up on three of our investigations showed significant improvements at two of the trusts, and signs of progress at the most recently investigated trust.**

Cornwall Partnership Trust: following our investigation into widespread, long-term abuse of people with learning difficulties at this trust, it had been under 'special measures' since July 2006. In March 2008 we were pleased to report that the trust had made significant improvements in the quality of care it provided to people with learning difficulties. Its services were more focused on each individual's needs, provided a better environment for people, and encouraged them to be more independent and to have a say in planning their own care. Acting on the Commission's advice, the Health Secretary announced in March 2008 that he had lifted the trust out of special measures.

Interventions during 2007/08

During 2007/08, our investigations team received 120 requests to investigate (known as 'referrals') from a wide range of sources, including Healthcare Commission staff, organisations representing patients, members of the public or even the trusts themselves. All these referrals go through a robust process to ensure that the concerns raised are handled appropriately and the Commission responds in a proportionate way. For example, we will carry out an intervention into a trust's services instead of a full investigation if we think that it is the most effective, practical way to bring about the improvements needed.

Trusts at which we carried out interventions during 2007/08 included Bromley PCT (services for people with learning difficulties), Newham University Hospital NHS Trust (maternity services), Papworth Hospital NHS Foundation Trust (heart surgery) and Royal Cornwall Hospitals

NHS Trust (governance systems and the management of risk). Further details are available on the Healthcare Commission's website, where we now publish summary reports on our interventions in order to encourage learning across the NHS.

Learning from investigations

In February 2008, we published *Learning from investigations*, a report that highlighted recurring themes in the 14 investigations we had completed since the Healthcare Commission was established in 2004. These included poor leadership, ineffective management, poor teamwork with staff feeling unable to communicate problems, and a lack of clarity about who was responsible for what across the trust. In addition, many of the trusts' boards did not have systems for keeping them up to date with key information such as rates of infection and measures of quality of care. They were therefore unable to spot problems and take steps to fix them.

Our report on recurring themes in the investigations that we have carried out since 2004 sent an important message to the boards of all NHS trusts in England. It highlighted the importance of good leadership, effective management and systematic use of information in preventing serious failings that put patients at risk.

Reviewing complaints about the NHS

If a patient is not satisfied with the response they receive from an NHS trust after complaining about its services, they can ask the Healthcare Commission to look into the situation. In 2007/08, patients or their representatives sent us more than 7,500 complaints to review, 1,400 of which we returned to the trusts for further local work. During the year we completed 9,000 reviews, and in 3,500 of these cases we tracked the trusts' progress with making the changes that we recommended.

In 2007/08 we reduced the average time needed to a review a complaint from seven months to three months, and upheld or partially upheld almost 20% of the complaints we reviewed. We carried out a national audit to find out how well NHS trusts were meeting the core standards in this area, and, for the first time, included data on complaints handling in our assessments for the annual health check. *Spotlight on complaints*, our second report on common themes in patients' complaints, highlighted a lack of basic nursing care, poor communication between staff, hurried consultations with GPs, and insufficient help for those using mental health services.

We intensified our advisory work with NHS trusts, including developing and running 30 training sessions for complaints managers and publishing an online toolkit on how to handle patients' complaints effectively.

Concerns about independent healthcare providers

We encourage the public to tell us if they have concerns about the services they have received from an independent healthcare organisation. If a provider's services need to be improved, but do not present a high risk to patients, we work with them to achieve this rather than taking punitive action. If, on the other hand, we have reason to believe that they have committed an offence under the Care Standards Act 2000 and associated regulations, the Commission is empowered to take civil and/or criminal action against the provider.

In early 2008, the Commission had eight ongoing cases of enforcement action involving the independent sector. Three of these related to unregistered services where we deemed there to be a risk to patients.

In January 2008 we secured the second conviction of an unregistered provider in Feltham, Middlesex. The company had been providing laser services without being registered with the Commission, and without any evidence of training for staff or compliance with safety rules. The magistrates imposed a custodial sentence of five months, suspended for two years and 100 hours unpaid work in the community, along with £30,000 in costs.

Healthcare-associated infection

During 2007/08, we inspected 120 acute trusts as part of our programme to assess compliance with the hygiene code (the Health Act 2006, Code of Practice for the Prevention and Control of Heath Care Associated Infection). We issued improvement notices to three trusts – Barnet and Chase Farm Hospitals NHS Trust, Bromley Hospitals NHS Trust and Ipswich Hospitals NHS Trust – instructing them to improve their infection control procedures and levels of cleanliness as a matter of urgency. Each of the trusts responded by taking action to make the improvements needed.

As part of this drive to tackle the continuing problem of healthcare-associated infection, we introduced additional procedures for incorporating local intelligence from patients and the public, NHS staff and our assessors into our inspection methodology.

In 2008/09 we will be visiting all 172 acute trusts in England to assess their compliance with the hygiene code. Our aim is to help trusts to reduce the numbers of people who die or suffer illness as a result of healthcare-associated infection, to improve patients' experience of the care they receive, and to increase people's confidence in the safety of their local healthcare services. We have prepared for this nationwide activity by setting up a dedicated team of assessors who will work with expert infection control advisers on the assessments.

> **We inspected 120 acute trusts for compliance with the hygiene code, published a national study of healthcare-associated infection containing practical advice for trusts, and published reports on our work promoting the safe use of controlled drugs and ionising radiation by healthcare services.**

In July 2007, the Commission published a national study into healthcare-associated infection, which included practical advice for trusts to consider in their efforts to reduce rates of infection. The report emphasised that while the boards of trusts have to balance a range of priorities, the safety of patients is paramount. We produced the report in response to a request from the Chief Medical Officer for England, who asked the Commission to examine the factors associated with reducing rates of infection.

Safer management of controlled drugs

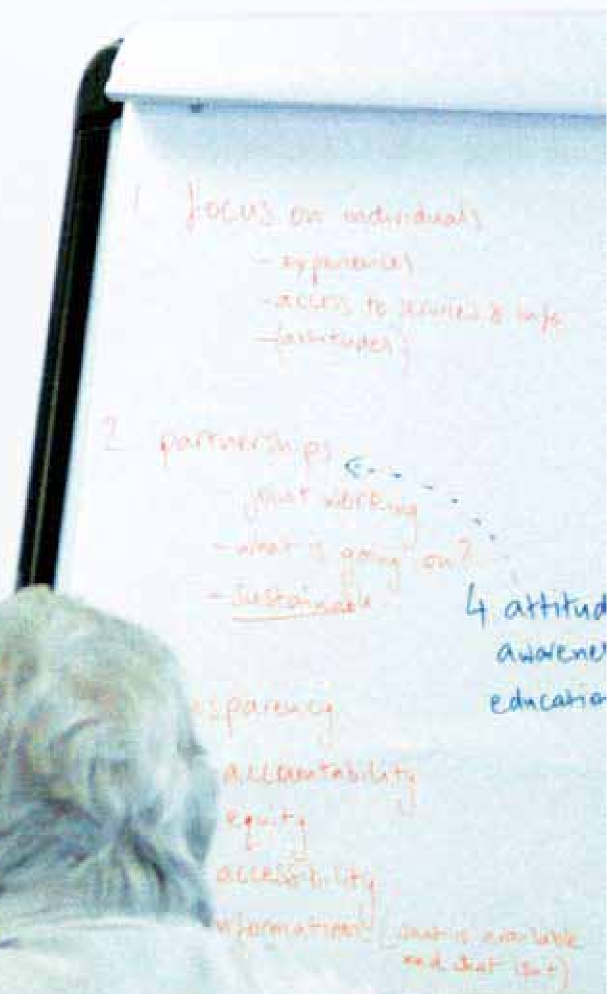
Since late 2006 the Healthcare Commission has led collaborative working between organisations involved in regulating and monitoring the management of controlled drugs in England.

During 2007/08 we added criteria for evaluating the management of controlled drugs to our assessments of NHS and independent providers. We also helped to develop national guidance and training for accountable officers in healthcare organisations. These members of staff are responsible for the handling of controlled drugs, in order to deliver safer care for patients and to help ensure that the clinicians treating them have access to vital medicines. As healthcare providers now have to inform us of the details of their accountable officers, we created a web-based facility to make it easy for them to do so.

Ionising radiation

2007/08 was the first complete year during which the Commission has been responsible for enforcing compliance with the Ionising Radiation (Medical Exposure) Regulations 2000. In March we published a report on our first 14 months of activity, during which providers reported 329 errors to us, almost double the yearly average reported to the Department of Health under the previous arrangement. We believe that this may be the result of a greater awareness of the need to notify the regulator and the fact that our online tool makes it easier for healthcare staff to do so.

Our analysis of reported incidents has enabled us to help develop guidance for providers on the safe use of ionising radiation. We launched our programme of inspections of radiotherapy departments by April 2007, and had visited 22 of them by the end of March 2008.



We placed more importance than ever on two-way sharing of information with the public. This helps people to make decisions about healthcare, and also enables them to influence how we assess those services.

Providing authoritative, independent and relevant information

Patients and the public can only exercise choice if they can make informed decisions about their healthcare. This means that they must have access to authoritative information about NHS and independent healthcare services, produced in a variety of formats. In 2007/08 we developed our website further, making it easier for people to find out about, and compare, the performance of their local healthcare organisations.

Along with having access to information they can trust, patients and the public should be able to play a fuller part in decisions about health services. For the Commission, this means getting their views on how we assess healthcare organisations and provide information – an area in which we have been particularly active this year.

These were some of our key activities in 2007/08:

Making information accessible

The Commission's website is a vital tool in our mission to make information about healthcare accessible to as many people as possible. This year we focused both on extending the range of information we provide online, and on making sure that we present it in as user-friendly a way as possible. For the launch of the results of the second annual health check on 18 October 2007, we introduced a new facility whereby users could type in their postcodes and be taken to Google maps displaying our ratings of all their local NHS organisations, with more detailed information just a click away. On launch day, the BBC featured a link to this search on their news site, which resulted in more than 48,000 people visiting our ratings section. At the end of March 2008, we extended it to include searchable information about more than 2,000 independent healthcare organisations.

During the year we launched a new 'healthcare focus' area on the site, in which we present key information from our nationwide reviews of specialist services, using the postcode search format that proved so effective for the annual health check ratings. The topics we featured this year were services for people with diabetes, and maternity services.

In 2006/07 heart surgeons throughout the UK joined forces with us to make survival rates at units available to the public on a dedicated website, along with useful general information for those facing heart surgery. Keen to be even more open and transparent in 2007/08, the units agreed to put their 2007 data through a new, tougher model before this year's update of the site. We have also upgraded the general page content to make it as user-friendly and jargon-free as possible.

We enabled members of the public to compare the quality of their local healthcare services, including changes in performance from one year to the next, at the click of a mouse.

Throughout the year we worked with our national consultative panel, comprising members of the public, clinicians and healthcare managers, to review the accessibility, ease of use and relevance of our web and print communications.

Engaging with patients and the public

As England's healthcare watchdog, we place great importance on engaging patients and the public in our work, to ensure that they have an opportunity to shape how we assess healthcare organisations and provide information. We want people from all walks of life, and especially those who are most vulnerable to illness and least likely to be heard, to be able to tell us about their experiences of healthcare services. During the year we expanded our national network of community groups that reach out to black and minority ethnic groups and disabled people, and built up our network of national voluntary organisations.

We invited comment on how well trusts are meeting core standards from a range of local groups: patient and public involvement forums, overview and scrutiny committees, and lay members of the boards of governors of NHS foundation trusts. This year, for the first time, we also asked children's safeguarding bodies for their views. We held a roadshow of regional briefings in preparation for the new local involvement networks (LINks) that replaced patient and public involvement forums in April 2008. In our test site areas in the north and south-west of England, we worked with communities to build such networks and find the best ways to communicate with them. In response to their feedback we have developed an online community in Devon and Cornwall to reach people living in more remote rural areas. We then built on this model to create an extranet for communicating with the LINks networks from 2008 onwards. As part of this year's drive towards online engagement, we developed web submission forms that enable unstructured feedback from local community groups to be integrated with analysed data from national patient groups.

Our publications

During the year we published a report on a Healthcare Commission investigation into serious failures of healthcare and 20 reports on reviews of services, national studies, and surveys. We also published three consultation documents and a range of guidance on the annual health check process for NHS trusts and 'third-party' participants. In January 2008 we re-launched two key public information booklets – one on our role in helping to resolve patients' complaints about the NHS, and the other on how we can help with concerns about independent providers' services. Both these leaflets were awarded the Plain English Campaign's crystal mark for clarity.

The Healthcare Commission has a statutory duty to report annually to Parliament on healthcare in England and Wales and to provide the National Assembly for Wales with a copy. We do this through our *State of Healthcare* report. It brings together the results of all of our assessment work throughout the year, along with data from other organisations, to provide a comprehensive picture of healthcare services, their quality and how the public are given access to them.

Working in consultation with a wide range of local community groups in the north and south-west of England, we harnessed new technology to enable us to integrate their online feedback about healthcare services with analysed data from national patient groups.

In 2007 we reported that in general the population's health is improving, but varies according to geographical area – particularly in poorer areas with fewer GPs. Most patients are positive about hospital services. The quality of NHS services overall is improving, including some dramatic improvements in waiting times, but the performance of PCTs has declined. Acute trusts are making progress towards establishing a stronger culture of safety, although many of their boards need to show stronger leadership. In the independent sector, more organisations met the national minimum standards, but we still have some concerns about mental health services in the sector.

Our report raised concerns that the particular needs of vulnerable groups are not being met – for example, children and young people, those with mental health problems, people with learning difficulties, and older people. There have been major strides in tackling the 'big killers' – cancer, circulatory disease and respiratory diseases. However, five-year survival rates for cancer and death rates for respiratory diseases are worse than in most other European countries.

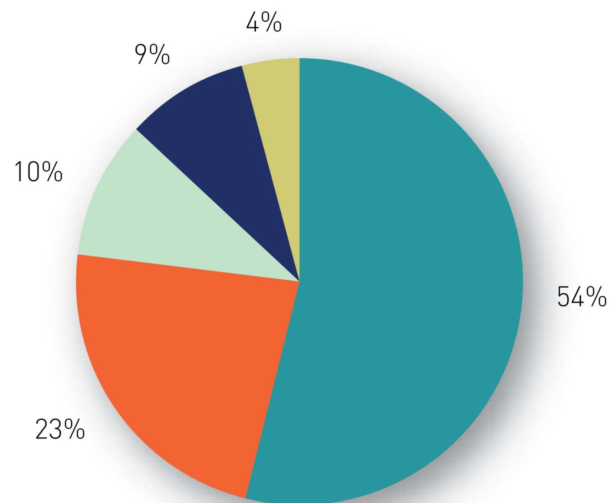
Working with clinicians

This year saw a further strengthening of our relationship with clinicians and clinical bodies, which focused on our initiative with the Academy of Medical Royal Colleges about measurement of clinical quality. Representatives of almost all of the royal colleges, the Department of Health and the National Institute for Health and Clinical Excellence attended a workshop we held in November. This was a prelude to more intensive consultation with clinicians and clinical bodies about our proposals for the 2008/09 annual health check, which include an increased focus on clinical quality.

Many stakeholders felt they had a positive working relationship with the Commission and that it was interested in its partners. Clinicians were particularly positive about the more recent attempts by the Commission to engage with them. This appears to be an area of significant achievement, particularly given the findings of research in 2005 which suggested the need for better clinical engagement.

Extract from 2007 MORI survey of the Healthcare Commission's stakeholders

Figure 1: How we dealt with statutory requests for information



- All information provided
- Information partially released
- Information withheld - exemption application
- Information not held
- Applicant cancelled request

In February, clinicians and senior NHS managers from all over the country came together in Reading at our conference on improved access to psychological therapies and our role in assessing this government-led initiative. We also held a workshop on clinical quality with the British Medical Association, and an event for acute hospital

trusts to promote sharing of good practice in public health and partnership working across health communities. In November around 300 delegates attended a congress looking at how clinicians and managers can work in partnership to improve standards, which we sponsored with NHS North West.

During the year we funded 22 clinical audits in a wide range of disciplines, including cancer, neonatal intensive care, heart disease, mental health, older people and long-term conditions.

Statutory access to information

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

In 2007/08, we closed a total of 456 re for specific information. Of these, 34% made under the Freedom of Informati Act 2000, 11% were subject access re made under the Data Protection Act 1 50% were requests involving a mixture of the two regimes, and 4% were discretionary disclosures.

Policy for accessible communications

In March 2007, we launched a new policy that formalised and extended our existing practices for making our publications accessible to people with physical impairments or learning difficulties, and to people whose first language is not English.

We have taken major steps in embedding the principles of equality, diversity and human rights in our work, including screening all key projects sing our new 'planning or inclusion' process.

Focusing on equality, diversity and human rights

One of the fundamental principles of the NHS is that everyone should have equal access to health services, yet we know that there are still serious health inequalities. Our work to help reduce these involves making sure that all our activities reflect the principles of equality, diversity and human rights. This year, for example, we assessed more than 30 of our projects to identify their impact in these areas.

We also carried out the most comprehensive study to date of services for people with learning difficulties, and a census of mental health inpatients – two groups that often suffer as a result of inequalities. We also reviewed how NHS trusts promote race equality.

These were some of our key activities in 2007/08:

Planning for inclusion

The Commission, along with all public sector bodies, has a legal requirement to assess the impact that its policies and projects have on equality, by race, disability and gender. Our equality impact assessment, known as the planning for inclusion process (PIP), goes beyond this legal requirement. We assess impact against all six strands of diversity – age, disability, ethnicity, gender, religion or belief, and sexual orientation – and for human rights as well.

The PIP allows us to identify the potential, adverse, negative or positive impact of a piece of work on different groups. It requires our staff to put in place, at the project planning stage, the actions needed to remove negative or adverse impact, and actions to promote equality.

By the end of the year we had completed more than 30 PIP assessments, including one for the components of the annual health check assessment process. We also produced an internal report on how the annual health check could have a greater impact on promoting equality, human rights and diversity.

Equality schemes

We completed and published our annual reviews of our race, disability and gender equality schemes, which evaluate their effectiveness and identify our future priorities.

During the year we reviewed how effectively NHS trusts promote race equality and will publish our findings in 2008/09. We also audited trusts' compliance with the publication requirements of race, disability and gender equality legislation.

Count Me In census

The annual Count Me in census is a joint initiative between the Healthcare Commission, the Mental Health Act Commission, the Care Services Improvement Partnership and the National Institute for Mental Health in England. It is part of the Government's five-year action plan to improve mental health services for black and minority ethnic communities. The census aims to capture the number of people using mental health and learning difficulties services in England and Wales and to encourage service providers to collect and monitor data on patients' ethnic backgrounds.

We carried out the 2007 census on 30 March, collecting information from 31,187 inpatients in mental health hospitals and 4,153 inpatients in learning disability hospitals. As well as recording the ethnicity and age of inpatients, we captured selected details concerning their stay in hospital, such as how they were referred, how long they had been an inpatient, and whether they had been detained under the Mental Health Act.

Rates of admission into mental health services were lower than the national average among the white British, Indian and Chinese groups, and were average for the Pakistani and Bangladeshi groups. They were higher than average among other minority ethnic groups for both genders, and more than three times higher for black and white/black mixed groups. People in the "other black" group were 10 times more likely than average to be admitted. These patterns are very similar to those we observed in 2006 and 2005.

> **We examined each of the components of our annual health check of the NHS, to identify ways of increasing further the system's positive impact on equality and to identify whether it had any potential adverse impact and how this could be offset.**

Improving care for people with learning difficulties

In December 2007 we published the results of the first audit of services for people with learning difficulties in England, which looked at specialist adolescent services provided by the NHS and independent organisations not registered with the Commission for Social Care Inspection

(CSCI). One of our largest ever inspection programmes, the audit looked at 72 NHS trusts and 17 independent organisations, which between them provide 638 services to more than 4,000 individuals. People with learning difficulties, family carers and those working in the sector were all involved in designing and carrying out the audit.

The audit revealed unacceptable variations in the quality of services throughout the country. Even the better examples did not meet the standard to be expected of modern services for people with learning difficulties. We did not find evidence of physical abuse, but many of the people using the services lived in poor physical environments, with few choices about how they lived their lives and were isolated from the wider community. The Commission made 2,548 recommendations for improvement.

At the end of 2007/08, 85% of the services said that as a result of the audit they had either made or had planned changes, which included improving staff training, increasing the involvement of people with learning difficulties and enhancing their physical environments.

As well as working with other regulators on reviews and studies, we led a number of initiatives to explore how we can reduce further the impact that regulatory processes have on healthcare providers.

Taking the lead in coordinating and improving regulation

Effective regulation is vital to ensure the quality and safety of healthcare services. It also prevents regulatory processes being an excessive burden on the organisations being regulated. With these aims clearly in mind, we have again been active in our role as the lead body coordinating health and social care regulators in England.

Because providers of health and social care work closely with other public sector bodies, good local coordination is also important. Our local work this year included preparing for the comprehensive area assessment, a new system for assessing councils' services that comes into effect in 2008. Other examples included working practically with partners to address a serious fall in standards at two registered independent organisations.

These were some of our key activities in 2007/08:

Update on the Concordat

The Healthcare Commission takes the lead in coordinating the activities of the main bodies involved in regulating health and social care in England. The aim is to reduce the burden of regulation for service providers, including unnecessary costs. In June 2007 one such provider, the Manchester Children's Hospital, hosted an event which enabled the concordat signatories to hear first-hand about the impact of their work. As a result, the Concordat has this year renewed its efforts to address duplication and overlap between the work of regulatory bodies in England. New activities include:

- Establishing an advisory group jointly chaired by senior representatives of the NHS and the independent healthcare sector.
- Collaborative events at which signatories share information and evidence on healthcare organisations and coordinate any follow-up action.
- Working with a pilot group of healthcare organisations, to gain a fuller understanding of the demands that regulation places on them and to identify opportunities for streamlining our practices.

Through the Concordat, we worked with a pilot group of healthcare organisations to identify ways of streamlining our processes, to lessen the impact on their core work of delivering healthcare to patients and the public.

Working in partnership

This year we published reports on joint service reviews and national studies with a range of partners:

- A review of adult community mental health services, with the CSCI.
- An audit of services for people with learning difficulties, with the CSCI.
- The 2007 Count Me in census, with the Mental Health Act Commission, the Care Services Improvement Partnership and the National Institute for Mental Health in England.

We also collaborated with the CSCI to develop a programme of work looking at commissioning of services for people with learning difficulties, and at how to assess the performance of NHS trusts which provide both health and social care (care trusts). Together we undertook five local reviews of the services that local authorities and PCTs provide for older people and disabled people.

Piloting comprehensive area assessments

In our North, and London and South East regions we took part in pilot work to consider how comprehensive area assessments might operate. This new system for assessing the public services that councils deliver in their areas comes into effect in April 2009. We prepared for it by liaising closely with other public service inspectorates such as the Audit Commission, the CSCI, Ofsted and Her Majesty's Inspectorate of Constabulary, to develop ways of coordinating our risk-based assessment activity within the new system.

Improving standards through partnerships

In the West Midlands we brought about marked improvements in the standards of care provided by two independent healthcare organisations, working in partnership with other agencies.

In the first example, one of our advanced investigative practitioners led an intervention into services for people with learning difficulties, working closely with the local authority safeguarding team, the Health and Safety Executive, the Mental Health Act Commission and the local police. Our negotiations with the organisation resulted in it suspending its registered manager and temporarily halting admissions. The organisation is now demonstrating commitment to safety and quality of services.

As a result of another intervention, an independent hospital that offered care for people with mental health problems volunteered to halt admissions for a month while it dealt with urgent issues raised by our inspection team. After we made the decision to carry out this risk-based inspection, we again worked with local partners including the local authority, the Health and Safety Executive, the Mental Health Act Commission and the police. The hospital has since made significant positive progress in the areas where we identified problems.

Working with NICE

All NHS trusts should follow guidance from the National Institute for Health and Clinical Excellence (NICE), unless they can demonstrate good reasons for not doing so. Through our close strategic partnership with NICE, we have been developing better methods of measuring how well trusts are implementing its guidance. At NICE's annual conference in December 2007 the Commission led a session on the future of regulation of healthcare and the impact of NICE guidance.

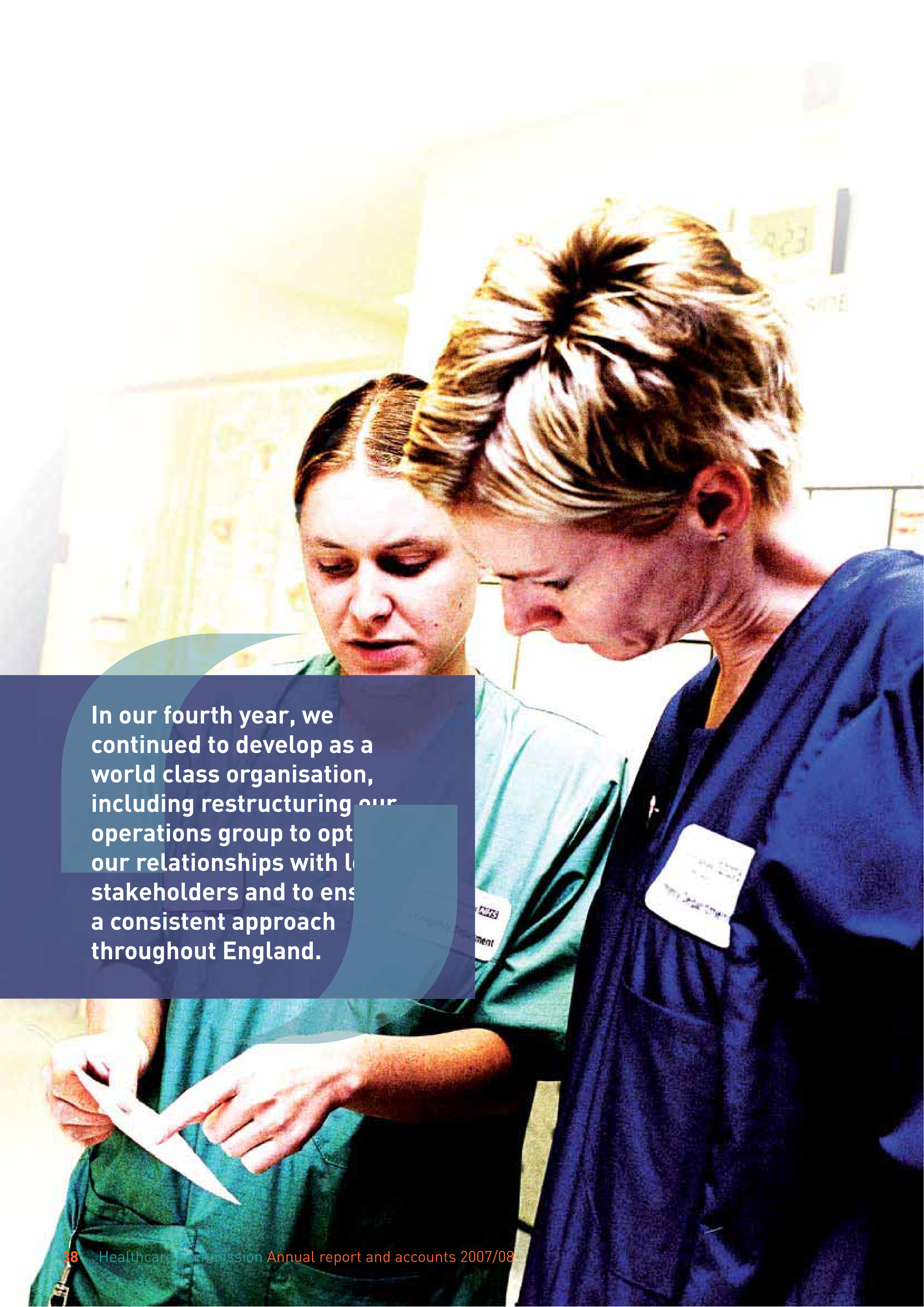
Memoranda of understanding

Many of our partner organisations value working with the Commission. To promote further joint working and sharing of information, we have this year agreed memoranda of understanding with NICE, the Wales Audit Office, the General Chiropractic Council, the Nursing and Midwifery Council, the Confidential Enquiry into Maternal and Child Health, the Disability Rights Commission, the Equal Opportunities Commission, the National Heart Improvement Team, the National Patient Safety Agency and the Postgraduate Medical Education and Training Board. We have also developed more specific arrangements with the MRSA Cleaner Hospitals Team, the Audit Commission, the Independent Healthcare Advisory Service and the National Perinatal Epidemiology Unit, to allow for joint working on reviews of services during 2007/08.

Working together towards equality

We held workshops with the Disability Rights Commission on NHS trusts' implementation of their disability equality schemes; we then worked with the Equality and Human Rights Commission to evaluate the impact of these workshops.

Other partnership activities included working with the CSCI and the Mental Health Act Commission, to identify equality issues related to the merger of the three organisations at the end of 2008/09. This work will lead to a strategic proposal for the Care Quality Commission, to ensure equality, diversity and human rights remain prominent in the regulation of health and adult social care.


In our fourth year, we
continued to develop as a
world class organisation,
including restructuring
operations group to opt
our relationships with l
stakeholders and to ens
a consistent approach
throughout England.

Building a world class regulatory body

During 2007/08 the Healthcare Commission has continued to adapt and change, both in response to our strategic priorities and in order to improve our efficiency and effectiveness. This year we have introduced new systems to help our staff work more effectively, particularly those who are not office-based, and continued to develop the skills of our staff.

As a regulator, it is important that we take account of other's views of our performances and the impact of our work. During the year we sought feedback from a wide range of organisations and individuals, and commissioned a number of formal independent evaluations.

These were some of our key activities in 2007/08:

Working locally

In October 2007 the Commission reorganised the structure and function of its operations group in line with our future strategic direction. Our newly streamlined area teams work within carefully defined boundaries to make the most of their relationships with our stakeholders, and with a focus on consistency of approach. These changes have enabled us to increase both the efficiency and cost-effectiveness with which we assess healthcare organisations throughout England.

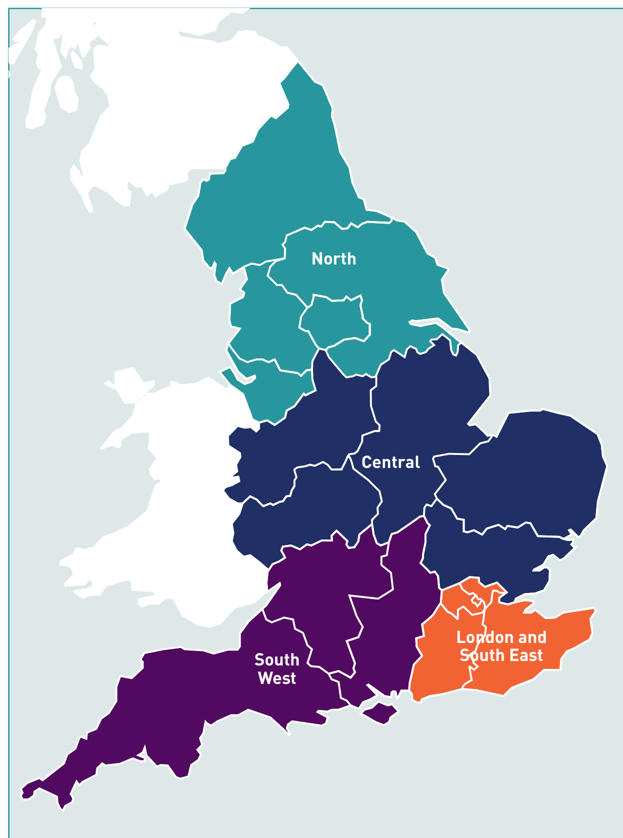
One of the challenges for a workforce that is geographically spread, with a high proportion of home-based workers, is keeping everyone up to date and well informed. At the beginning of 2007/08 we launched an online portal through which our regional staff can access the guidance, tools, templates and protocols they need to do their jobs.

Investing in our staff

In addition to training for all staff in core skills and equality and diversity, the Commission offered its staff many other opportunities for learning and development in 2007/08. Participants in our coaching programme – available to 50 middle managers leading key projects – reported an increased confidence and productivity that was also observed by their line managers.

The Commission's James Mayes award is a tribute to our colleague James Mayes, who was tragically killed in the London bombings of 2005. This year the award funded placements for three members of our staff at leading healthcare organisations in France and Italy.

Figure 2: Healthcare Commission regional structure



In response to the findings of our 2006 survey of staff, in 2007 we introduced "The Feel Good Factor", a programme of activities designed to improve staff morale across the Commission. Practical solutions to reducing stress included the Stairmaster challenge, in which staff are encouraged to improve fitness by using stairs rather than lifts, and Emailogic training in managing email correspondence effectively.

aff informed and listening to
ws was a key priority during a year
that has brought changes for many staff.
ernal communications programme
ed that staff were kept fully up to
e. It culminated in a very successful
erence in January, at which Ben
adshaw, the Minister for Health, was
e speaker.

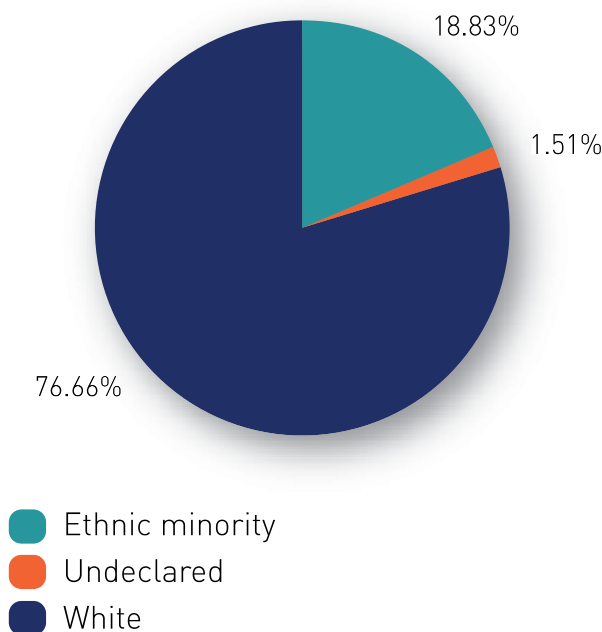
Supporting diversity in the workforce

The Commission has carried out equality
sessments on all of its new
esources policies, including our
ecruitment policy. We have also
ed our ability to capture and report
tics relating to diversity, through
ork, an online system through which
d and update their employee
ormation, and by redeveloping our
ting database. This year we also
ed diversity network groups for
aff, and developed and implemented
or line managers on valuing
es at work.

Respected and personable; credible, professional and good to work with.

How the Commission's staff were described in a survey of our stakeholders conducted by Ipsos MORI Social Research Institute

Figure 5: Healthcare Commission staff by ethnic origin



After phase one roll-out last year, we extended the use of our new customer relationship management system (CRM), making it the main operating system for our regulatory activity.

Our electronic information cabinet (iCAB) is designed to integrate all the information we hold about the organisations we regulate along with information from other key data sources such as the Department of Health. It will enable us to carry out customised searches of all our information repositories and indexed websites, with a facility for discussions around key topics and news and information feeds for designated topics. This year we started to rationalise and cleanse our documents to support the development of iCAB and in readiness for the Commission's merger with the Commission for Social Care Inspection and the Mental Health Act Commission at the end of 2008/09.

Evaluating our work

This year we commissioned the Office of Public Management to carry out a programme of work evaluating the impact of our assessment work on the NHS and the independent sector.

NHS organisations: page 9 summarises the results of the evaluation of the second year of the annual health check. In our service reviews, almost all of the 103 trusts surveyed thought that our choice of topics was good, and four out of five found the reports on our findings useful. Although 70% of them thought that the reviews had benefits for patients and for them, 40% thought that the process could be improved to reduce the time and effort involved.

Of the 220 trusts surveyed about our investigations into serious failures of care at individual trusts, 70% thought that had a significant impact on improving their own standards. Eighty-nine per cent of members of our online clinical advisory forum thought that our investigations improved the safety of patients, and 85% thought that they improved patients' care. But less than half

of the forum thought that our investigations improved patients' confidence in NHS healthcare, and 15% thought that they reduced it.

Independent healthcare organisations: virtually all 100 of the sample organisations surveyed thought that our assessments and inspections were important in driving quality in healthcare services, and that being inspected improved their reputations with the public. Four out of five thought that that the process focused on the safety of patients, and that the overall costs of self-assessment and inspection were reasonable.

Raising awareness of our work

Public interest in the Commission's work continued to rise throughout 2007/08, with national coverage in newspapers growing by 20%. During the year we have also strengthened awareness and understanding of our work among healthcare professionals by working with the specialist media on a range of in-depth features.

Figure 6: Healthcare Commission staff by declared disability

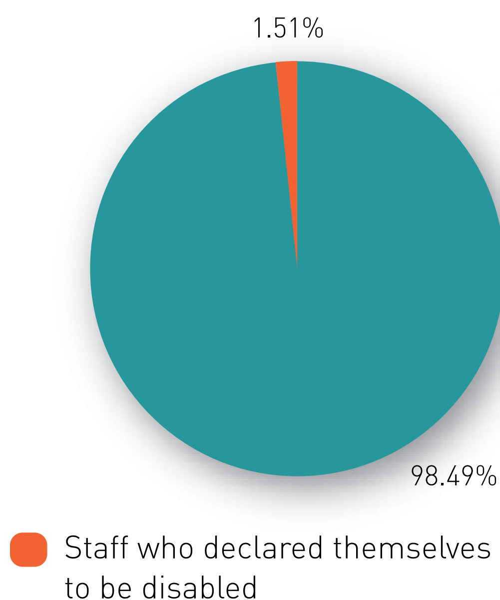
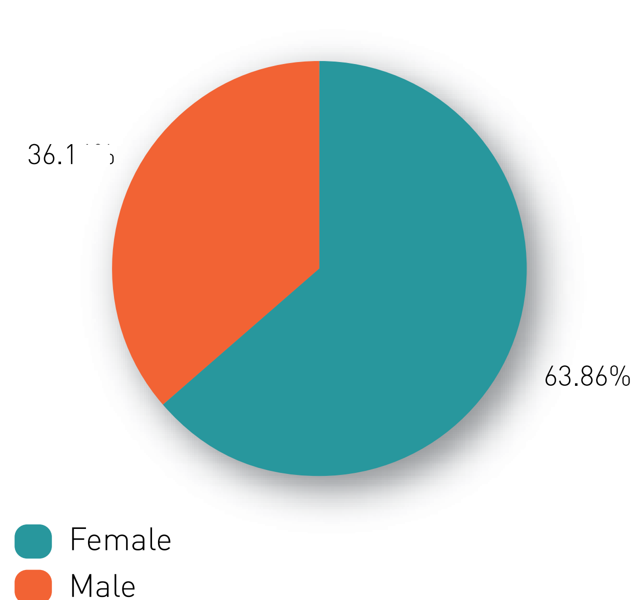


Figure 7: Healthcare Commission staff by gender



Our corporate communications played a major part in driving public debate on infection control. The key activities included a number of events, publication of the outcome of our assessors' inspection of 120 trusts against the hygiene code, and publication of the findings of our investigation into two fatal outbreaks of *C. difficile* at the Maidstone and Tunbridge Wells NHS Trust.

> **Organisers of fringe meetings at party political conferences could learn a thing or two from the Healthcare Commission.**
>
> John Carvel, Health Editor, *The Guardian*

Our 2007/08 audit of stakeholders showed that the majority were extremely positive in their views and often spontaneously praised the Healthcare Commission and its work. They consider it to be a well-run organisation that has credibility and integrity, and makes a real difference to the healthcare sector.

Event highlights this year included our hosting of "Safe Delivery", a conference that brought together health professionals and policy makers to focus on maintaining safety in maternity services as they undergo major changes. Representatives from the Department of Health, the Royal College of Midwives, the Royal College of Obstetricians and Gynaecology, the Confidential Enquiry into Maternal and Child Health and the National Epidemiology Unit shared data and examples of good practice with nearly 200 policy makers, clinicians, NHS managers and staff. We hosted visits by diplomats and healthcare professionals from countries throughout the world, including China, Denmark and Egypt, to share our experience of building a pioneering model of regulation.

Figure 3: Healthcare Commission staff by location

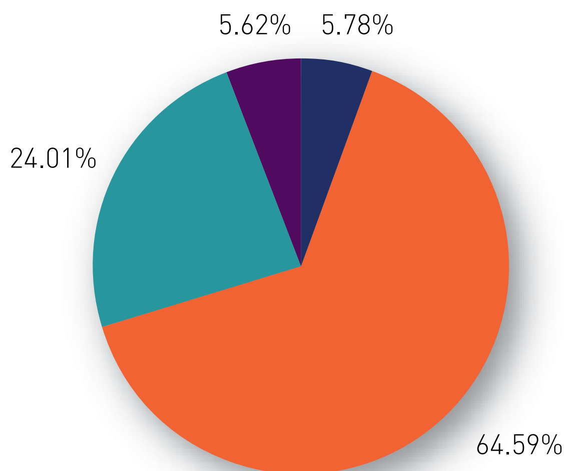
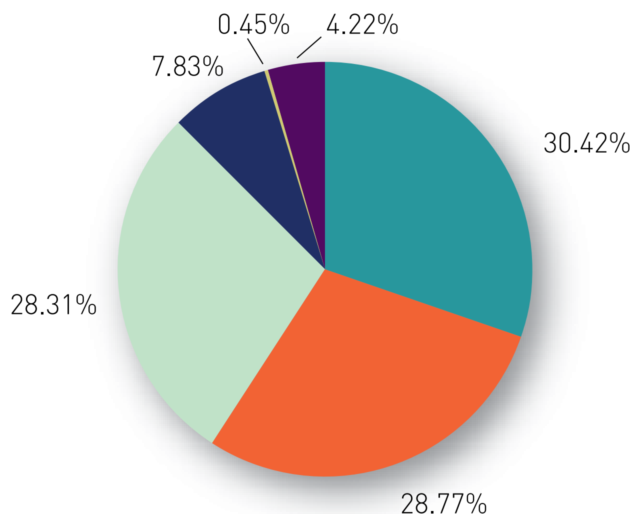


Figure 4: Healthcare Commission staff by age



Clinical knowledge and experience

Clinicians and other healthcare professionals provide the Commission with valuable expertise on clinical issues and an insight into the impact of our work in the healthcare environment. During the year we used such advice on 1,500 occasions – mainly involving complaints about the NHS, but also in areas such as learning disabilities, race equality and hygiene. Our online forum for clinicians – launched in 2006/07 and now with 3,000 members – enables us to call on their expertise speedily. Topics on which we sought broader comment in 2007/08 included the value of our investigations and how we might review psychotherapy and ambulance services.

Management of information

We introduced or refined a number of new technologies to support our regulatory activity during the year. For example, we undertook a significant overhaul of our registration system for the independent sector, which included re-defining our ways of working to improve the customer experience and to deliver a more consistent, automated and cost-effective process.

Throughout the year we have contributed to the debate about the development of the Care Quality Commission, sharing the Commission's experience of developing and implementing systems for regulating healthcare in England.

The Healthcare Commission's charter

As England's healthcare watchdog, the Commission exists to provide a service to patients and the public. This year we launched a charter that summarises our commitment to others and ourselves, and the standards of service and behaviour that the Commission expects of its staff. The charter also invites feedback from anyone who comes into contact with the Commission, so that we can continuously improve how we work. To read the charter, visit **www.healthcarecommission.org.uk**

Corporate governance and finance

Statement of corporate governance 2007/08

Introduction

The Healthcare Commission's legal name is the Commission for Healthcare Audit and Inspection. The Healthcare Commission has the status of a non-departmental public body.

The Commission was established by the Health and Social Care (Community Health and Standards) Act 2003 and launched on 1 April 2004. Subject to the passage of the Health and Social Care Bill 2008, it will be abolished and replaced from 1 April 2009 by a new regulator for health and social care, to be known as the Care Quality Commission.

The statement of corporate governance 2007/08 covers the Healthcare Commission's fourth year of operation.

Principal activities

The main function of the Healthcare Commission is to encourage improvement in the provision of healthcare by and for NHS bodies. Its main statutory functions include:

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

and, in England only:

- Reviewing the performance of each local NHS organisation and awarding an annual rating of that organisation's performance.
- Regulating the independent healthcare sector through a programme of registration, assessment and inspection.
- Considering complaints about NHS bodies that have not been able to be resolved through their own complaints processes.
- Publishing the results of surveys of the views of NHS staff and patients using NHS services.

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

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

The Commission has a duty to work in partnership with the Audit Commission, Monitor and the Commission for Social Care Inspection (CSCI). In Wales, the Healthcare Commission has a duty to cooperate with the National Assembly for Wales, and works closely with the Healthcare Inspectorate Wales.

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

Corporate governance and accountability arrangements

The Healthcare Commission is committed to achieving high standards of corporate governance, and chooses to apply the provisions of the July 2003 Combined Code (the Code) where relevant and proportionate to the Healthcare Commission's role as a regulator and its status as a non-departmental public body. This Statement describes how, during the period 2007/08, the Healthcare Commission has applied the relevant provisions of the Code.

In addition, the Healthcare Commission is subject to a number of other accountability mechanisms.

The Chief Executive, as the Accounting Officer for the Healthcare Commission, is responsible and accountable for the management of the Healthcare Commission's funds and assets.

The Healthcare Commission has a formal agreement with the Department of Health about working arrangements, known as the management statement. Part 2 of this management statement comprises a financial memorandum, which specifies the terms on which the Healthcare Commission receives and spends its funds. During 2007/08, the Healthcare Commission and the Department of Health discussed revisions to Part 1 of the management statement which were finalised early in 2008/09.

The Chair and Chief Executive of the Healthcare Commission meet the Minister for an annual performance review and there are regular meetings with ministers, senior policy officials of the Department and the Standards and Healthcare Relations team – the branch responsible for the relationship with the Department of Health as sponsor of the Healthcare Commission. The Senior Departmental Sponsor of the Healthcare Commission at the Department of Health is Professor Sir Bruce Keogh[1], NHS Medical Director, who is formally responsible to the Permanent Secretary for the performance of the Healthcare Commission.

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

Each year, several meetings of the Commission are held at locations other than London. During 2007/08 the Commission met in London, Stratford-upon-Avon and Bristol. Unfortunately, the meeting scheduled to take place in Bradford had to be cancelled because of flooding, and was replaced by a special meeting in London. The Commission is committed to public consultation on its work programme and key strategies.

The effectiveness of corporate governance and governance systems is reviewed regularly.

The Commission

The role of the Commission is to:

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

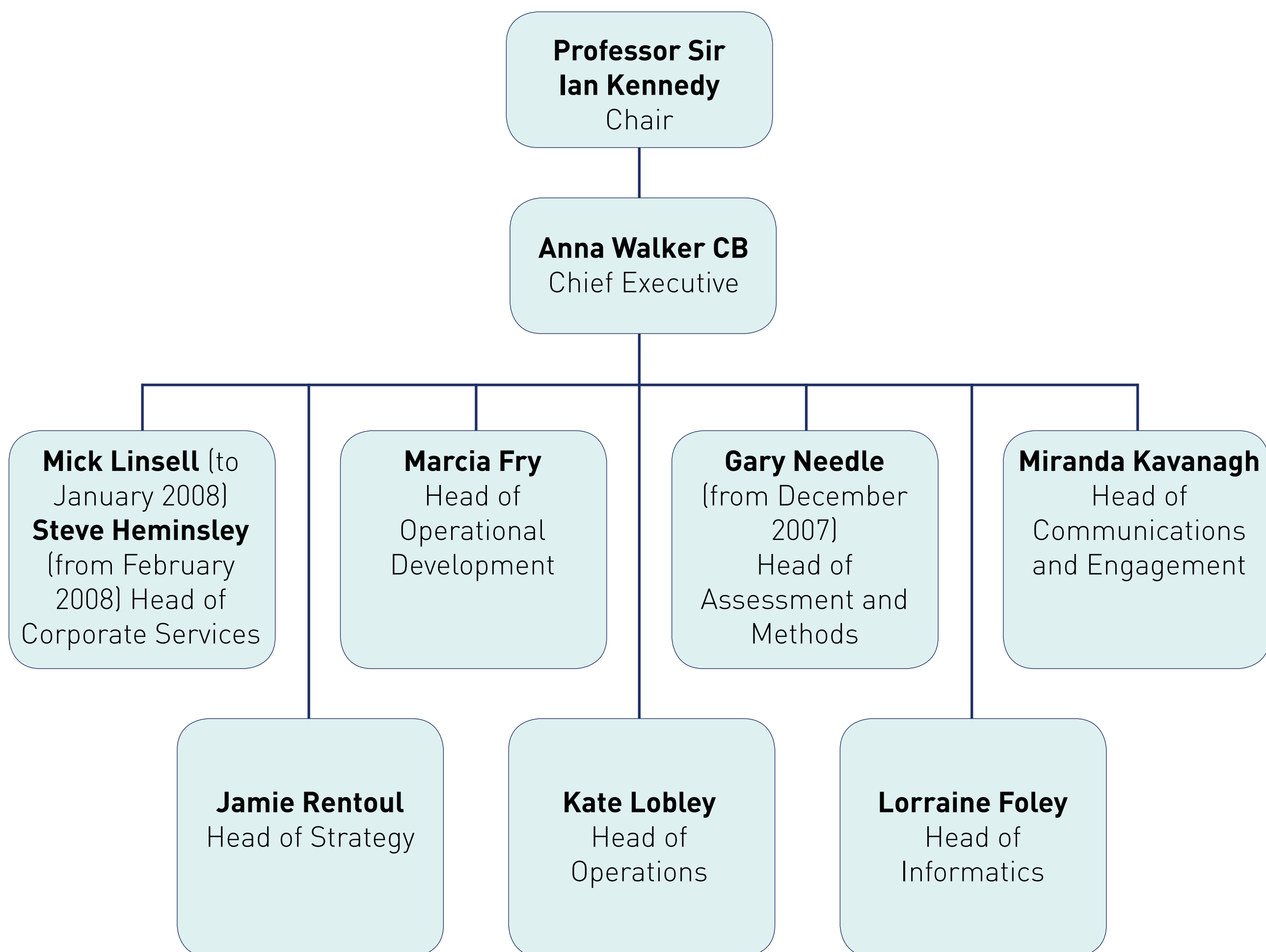
[1] From November 2007.

Leadership of the Commission

Leading the Commission's 14 Commissioners is the Chair, Professor Sir Ian Kennedy.

Anna Walker CB, Chief Executive of the Commission, leads the senior management team, known as the Executive Team.

The role of the Executive Team is to take overall responsibility for the effective development and performance of the organisation and to oversee the successful delivery of the programme of work in line with the strategic goals set out in the corporate plan and the outcomes set out in the Balanced Scorecard, and the Operating Plan. Current post-holders are shown below.



Membership of the Commission

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

The Appointments Commission appoints all commissioners including the Chair. Professor Sir Ian Kennedy was first appointed to be Chair of the Healthcare Commission with effect from 1 February 2004 and re-appointed for a further term until the end of June 2009.

During the year 2007/08, the terms of office of five commissioners came to an end. Dr Sarah Blackburn, Professor Iqbal Singh, Paul Streets and Dr Jennifer Dixon were reappointed for a further term. Dr Sharon Hopkins did not seek re-appointment. In the course of the year, Professor Shirley Pearce and Professor Sir Bruce Keogh resigned as Commissioners.

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

More information about our Commissioners and Executive Team is available on our website: **www.healthcarecommission.org.uk/aboutus/whoarewe.cfm**

Table 1: Commissioners and terms of office 2007/08	
Name	**Period of appointment**
Khurshid Alam	1 February 2004 to 31 January 2010
Dr Sarah Blackburn	1 February 2004 to 30 June 2009 Re-appointed 1 February 2008
Dr Jennifer Dixon	26 February 2004 to 30 June 2009 Re-appointed 1 March 2008
Clare Dodgson	1 January 2007 to 31 December 2010
Michael Hake	1 February 2004 to 31 January 2009
Dr Sharon Hopkins	1 February 2004 to 31 January 2008
Professor Deirdre Kelly	1 January 2007 to 31 December 2010
Professor Sir Ian Kennedy (Chair)	1 February 2004 to 30 June 2009 Re-appointed 1 February 2008
Professor Bruce Keogh KBE	1 February 2004 to 31 January 2010 Resigned 11 November 2007
Nick Partridge OBE (Joint Deputy Chair)	1 February 2004 to 31 January 2009
Professor Shirley Pearce (Joint Deputy Chair)	1 February 2004 to 31 January 2008 Resigned 30 September 2007
Cliff Prior CBE	1 January 2007 to 31 December 2010
John Scampion CBE	1 February 2004 to 31 January 2010
Professor Iqbal Singh	1 February 2004 to 30 June 2009 Re-appointed 1 February 2008
Paul Streets OBE (Joint Deputy Chair)	1 February 2004 to 30 June 2009 Re-appointed 1 February 2008

The working of the Commission and its committee structure

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

The Commission has adopted a schedule of matters reserved to it for collective decision.

The following matters are reserved to the Commission:

1. Establishing and maintaining the strategic direction of the Commission.
2. Approval annually of plans/budgets in respect of the application of available financial resources, capital and revenue.
3. Approval of the annual report of the Commission to be laid before Parliament with a copy sent to the Secretary of State.
4. Receipt of the annual accounts, the audited accounts and the management letter from the external auditors.
5. Approval of the appointment of the Chief Executive.
6. Approval of the corporate plan of the Commission.
7. The process for the appointment of the second tier staff of the Commission.
8. Receipt of a regular update on policies in place to ensure the effective management of the Commission's employees.
9. Approval of and amendments to the Healthcare Commission's Standing Orders which include the Standing Financial Instructions.
10. Approval of the Scheme of Delegation for the Commission.
11. Material contracts of the Commission as agreed.
12. Approval of the risk management strategy for the Commission.
13. Review and approval of the Commission's overall governance arrangements, taking into account the advice of the Audit Committee.
14. The receipt of reports setting out details of any significant prosecution, defence or settlement of litigation or areas where litigation may be likely.
15. A report on declarations of interest made by Commissioners.
16. Consideration of the outcome of an investigation that any Commissioner has acted, or omitted to act, in a manner which constitutes a breach of the Commission's Standing Orders including its Code of Practice for Members. If appropriate, recommending to the Secretary of State that the member should be removed from office.
17. Appointment of bankers to the Commission.
18. Approval of arrangements for the handling of complaints about the Commission including any complaint about a member of the Commission.

The Commission has also formally agreed arrangements for the discharge of its functions and the terms of reference of Committees of the Commission. Copies of these documents are available on the website.

In 2007/08 the Commission had the following committees:

- Audit Committee
- Remuneration Committee
- Nomination Committee
- Committee on the Use of Confidential Personal Information
- Investigations Committee
- Complaints (Quality Assurance) Committee[2]
- Equality and Human Rights Committee[3].

Members and chairs of committees are appointed by the Commission, on the recommendation of the Nomination Committee, with the exception of the Chair of the Audit Committee, for which the recommendation is approved by the Appointments Commission.

In addition to the formal meetings, from time to time commissioners meet informally. During 2007/08, the Commission met twice for informal discussions of strategy. In addition, two groups started to meet regularly – the group of commissioners concerned with Assessment, and the Chair's Small Group of Commissioners.

Roles and responsibilities of Commissioners

Commissioners have corporate responsibilities as the non-executive board members of a public body. In particular, commissioners have corporate responsibility for the stewardship of public funds, and ensuring that the Healthcare Commission complies with any statutory or administrative requirements for the use of public funds.

Other important responsibilities include:

- Ensuring that high standards of corporate governance are observed at all times.
- Establishing the overall strategic direction of the Healthcare Commission within the framework of policy and resources agreed with the Secretary of State.
- Ensuring that the Commission does not exceed its powers or functions.
- Ensuring that the Commission considers guidance issued by the Department of Health and complies with any statutory duties imposed on public bodies.

[2] Committee abolished 13 March 2008.

[3] Committee abolished 24 January 2008.

Individual commissioners have wider responsibilities to the general public as Commissioners of the Healthcare Commission. Commissioners agree to follow the Seven Principles of Public Life[4], and must:

- Act in good faith and in the best interests of the Commission.
- Not misuse information gained in the course of their public service.
- Ensure they comply with the Commission's rules on the acceptance of gifts and hospitality.

Some commissioners have additional roles. Until the end of her term of office, Dr Sharon Hopkins held the appointment as the Commissioner making the interests of Wales her special care.

The Commission appoints two commissioners as joint deputy chairs. These appointments were held by Paul Streets and Professor Shirley Pearce until her resignation. An election was then held, and Nick Partridge and Paul Streets were appointed.

The Commission has two Caldicott Guardians, one a commissioner and the other a member of the Executive Team. Until the end of the term of office and retirement, respectively, Dr Sharon Hopkins and Mick Linsell held these appointments in 2007/08.
The current holders are Professor Deirdre Kelly and Steve Heminsley.

Meetings and attendance

Members' attendance at Commission and committee meetings during the year is given in Table 2, with attendance shown as a proportion of the numbers of meetings that individual commissioners were eligible to attend.

[4] As set out by the Committee on Standards in Public Life.

Table 2: Membership and attendance at meetings of the Commission and committees 2007/08

	Meetings of the Commission	Strategy meetings of the Commission	Audit Committee[5]	Remuneration Committee	Nomination Committee	Committee on the Use of Confidential Personal Information	Investigations Committee	Complaints (Quality Assurance) Committee[6]	Equality and Human Rights Committee[7]
Professor Sir Ian Kennedy	**5/5**	**2/2**		**3/3**					
Khurshid Alam	3/5	2/2		3/3	0/1				2/2
Dr Sarah Blackburn	2/5	1/2	**5/5**				5/6	5/6	
Dr Jennifer Dixon	2/5	0/2			**1/1**				
Clare Dodgson	5/5	1/2	4/5						2/2
Michael Hake	5/5	2/2	5/5	3/3		3/3	5/6	5/6	
Dr Sharon Hopkins[8]	3/4	1/2			0/1	1/2			0/2
Professor Deirdre Kelly	5/5	2/2				3/3	0/1	0/1	
Professor Sir Bruce Keogh[9]	2/2	1/1							
Nick Partridge	5/5	2/2					**3/6**	**1/6**	**2/2**
Professor Shirley Pearce[10]	1/2	1/1			0/1				
Cliff Prior	4/5	2/2		0/0					
John Scampion	4/5	2/2	**5/5**	2/3			**6/6**	**5/6**	
Professor Iqbal Singh	3/5	2/2			1/1		0/5	0/5	1/2
Paul Streets	3/5	0/2		1/3		**2/3**			

Note: Bold text indicates Chair of the Committee.

[5] Attendance at the joint meeting of the Audit Committee and the Complaints (Quality Assurance) Committee on 21 November 2007 is reported as part of the Audit Committee attendance. Attendees were each members of both Committees.
[6] Committee abolished 13 March 2008
[7] Committee abolished 24 January 2008
[8] Term of office ended 31 January 2008
[9] Resigned 11 November 2007.
[10] Resigned 30 September 2007

Remuneration of commissioners

The remuneration of commissioners is determined by the Secretary of State for Health. During 2007/08, the level of remuneration of commissioners was set at the rate payable to the non-executive directors of NHS trusts, which was £7,598 per annum – an increase of 1.3% from 1 April 2007. This remuneration was for two and a half days a month. The Chair of the Audit Committee received an additional £5,065 per annum – again an increase of 1.3% from April 2007.

Expertise and experience

Given the nature of the Healthcare Commission's statutory responsibilities and the breadth and complexity of the issues with which it deals, it is essential that the commissioners bring a broad range of experience to the Commission. This includes professional and management expertise, health strategy and policy, public health, education and training and academic research, the NHS, and the independent and voluntary sectors. Details of the professional backgrounds and other appointments of Commissioners can be found on our website.

Independence of commissioners and declarations of interest

The Chair had no other significant commitments during the year.

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

Register of interests

The Commission maintains a register of interests for commissioners and members of the Executive Team. The register is available to members of the public for inspection at Finsbury Tower and may be accessed through our website.

Effectiveness of the Commission

The Chair conducted individual appraisals with all commissioners during the winter of 2007/08.

Commission and committee papers were provided for all meetings.

During the year, the Healthcare Commission's internal auditors, South Coast Audit, undertook a review of progress made on actions since the review of corporate governance against the Good Governance Standard for Public Services[11] the previous year. Systems were also reviewed as part of the programme of internal audit reviews.

Committees of the Commission

Audit Committee

The main function of the Audit Committee is to advise the Commission on the adequacy and effective operation of its systems of internal controls and therefore the quality of financial and other reporting of the Healthcare Commission.

The Audit Committee carries out its work by reviewing and challenging the assurances which are available to the Accounting Officer, the way in which these assurances are developed, and the management priorities and approaches on which the assurances are premised.

Specifically, the Audit Committee provides advice by:

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

The Chair of the Audit Committee was Dr Sarah Blackburn until February 2008, and John Scampion subsequently. In June 2007, the Committee appointed Michael Hake as Vice Chair.

The Chief Executive, Head of Finance, Head of Corporate Services, external auditors and internal auditors are invited to attend all meetings. At each meeting during 2007/08, the Committee had private meetings with the external auditors and the internal auditors without management present. In addition, the Committee met in private with the senior executives.

[11] The Good Governance Standard for Public Services, The Independent Commission for Good Governance in Public Services, 2004.

The Audit Committee met on four occasions during 2007/08 and made regular reports to the Commission on its activities. In addition, the Committee held a joint meeting with the Complaints (Quality Assurance) Committee on 21 November 2007.

The Committee produces its own annual report, which sets out its activities.

In June 2007, the Committee held a workshop on risk management, which was also attended by the internal auditors.

The Audit Committee received a report on the steps being taken to ensure the security of information within the Healthcare Commission. Following high profile losses of personal data elsewhere in the public sector, systems and processes were subject to new directives and guidance from the Cabinet Office. Assurance of information security will in future be addressed within the Statement of Internal Control.

The Audit Committee considered in detail an agreement that was reached with a supplier of services to bring about early termination of a contract.

The external auditor of the Healthcare Commission is the National Audit Office (NAO) who conducts audits on behalf of the Comptroller and Auditor General. The Head of External Audit has the right of direct access to the Chair of the Committee. The Commission's external auditors did not provide additional services to the Healthcare Commission during 2007/08.

During 2007/08, South Coast Audit delivered the internal audit function at the Healthcare Commission. The Committee ensures that internal audit has the necessary access to information to enable it to fulfil its mandate. The Head of Internal Audit has the right of direct access to the Chair of the Committee. The Commission's internal auditors did not provide additional services to the Healthcare Commission during 2007/08.

The Committee agrees the planned programme of audits and any additions to the programme.

During 2007/08, the Committee developed its programme of work for the remainder of its expected life, to March 2009. This identified a number of areas of activity drawn from the key aspects of the Healthcare Commission's programme of work and key risks, and the transfer of assets during the period of transition to the new regulatory body, and was also linked to the strategy for internal audit provision for 2008/09.

Improvements were made to the reporting of the progress in implementing internal audit recommendations, and in particular the regular and more prominent reporting to the Executive Team of the recommendations and management responses.

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

Professor Sir Ian Kennedy chairs the Committee. The Chief Executive and Head of Corporate Services attend meetings, except when matters relating to their own remuneration are being considered.

During 2007/08, the Remuneration Committee met three times. It agreed the approach to the award of performance-related pay for all employees of the Commission and that an arrangement should be imposed when a negotiated agreement with the trade unions could not be reached.

Nomination Committee
Dr Jennifer Dixon replaced Professor Shirley Pearce as the Chair of the Nomination Committee from November 2007. During 2007/08, the Nomination Committee met once.

The Nomination Committee provides a clear and transparent process for assisting in the appointment and re-appointment of commissioners and for evaluating the range of skills and experience of commissioners. The Committee also makes recommendations to the Commission on arrangements for the membership and the chairs of standing committees.

Committee on the Use of Confidential Personal Information
The Health and Social Care (Community Health and Standards) Act 2003 provides the Healthcare Commission with the power to require information, including confidential personal information, from both NHS and independent healthcare providers, when it is necessary or expedient for the proper exercise of the functions of the Commission. The Act requires the Healthcare Commission to prepare and publish a code of practice in relation to confidential personal information. The code of practice was published in January 2005. The Commission established a committee of commissioners to oversee the operation of the code of practice. During 2007/08, the Committee met on three occasions. The Chair of the Committee is Paul Streets. Members of the Committee include the Caldicott Guardian from the Commission. Since February 2006, the membership of the Committee has included an independent member, Dr Peter Harrowing.

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

Further information on the Committee, its activities and the code of practice can be found on our website.

Investigations Committee

The Chair of the Investigations Committee was John Scampion until January 2008 and Nick Partridge after that date. During 2007/08, the Investigations Committee met six times.

The Investigations Committee provides strategic advice and makes decisions in relation to investigations into potential failures in NHS services in England and in certain cross-border special health authorities. The Committee ensures that appropriate policies and procedures are in place and oversees the guiding principles for investigations, including the criteria adopted for deciding whether an investigation is required, and recommending any changes to the Commission. The Committee approves cases for investigation by the Healthcare Commission and approves the terms of reference.

The Committee received summary information about all the cases managed by the investigations team during 2007/08. The Committee approved the draft reports of major investigations at NHS trusts and reports of significant failings to the Secretary of State for Health. The Committee also monitored the implementation of action plans put in place as a result of its recommendations.

The Committee may recommend other forms of review where a formal investigation is not considered appropriate. During the year, the Committee agreed the set of conditions under which the Commission might consider an intervention to be the most appropriate course of action. The Committee approved the process for intervention or inspection when trusts are identified by the annual health check as not meeting core standards, or do not show an improvement in performance the following year.

Complaints (Quality Assurance) Committee

The Committee provided an overview, on behalf of the Commission, of the management processes of second (independent) stage reviews of complaints against the NHS.

The membership of the Committee comprises the membership of the Investigations Committee, and is chaired by the Chair of the Investigations Committee. The Head of Complaints, the Senior Complaints and Policy Manager and the Healthcare Commission's Legal Advisor also attend.

The Committee monitored the implementation of the updated performance improvement plan 2007/08 and its success in further reducing the time taken to complete reviews. The Committee received monthly reports of management information, and supported the introduction of new processes for complaints handling in May 2007, and measures for monitoring and improving the quality of service within the complaints function.

During the year, the Department of Health announced proposals to reform the arrangements for complaints about health and social care from April 2009, to create a single unified complaints procedure. The Commission's second stage function will cease. The Committee was concerned about the slow progress made in planning for the transition to the new arrangements, and the risks if a complaints service could not be delivered effectively meanwhile.

During 2007/08, the Complaints (Quality Assurance) Committee met six times. The Committee recommended in February 2008 that it be abolished and its functions passed back to the Commission. This was put into effect from March 2008.

Equality and Human Rights Committee
The Committee, chaired by Nick Partridge, met twice during 2007/08.

The Committee's purpose was to ensure that the Commission:

- Maximised its contribution to reducing inequalities in people's health and promoting equality of access to, experience and outcomes of healthcare.
- Became a model employer in respect of equality in employment.
- Met its statutory duties and complied with all current and future legislation on equality and human rights.

The Committee was set up with a fixed timespan to oversee the implementation of the Race Equality Scheme, Disability Equality Scheme and Gender Equality Scheme. Legislation to prevent age discrimination has also been enacted during the life of the Committee. It met for the first time in April 2006 and decided in November 2007 that it had completed its remit and would recommend that it be abolished and its functions passed back to the Commission.

The Chair's Small Group of Commissioners
For some years, it had been the practice of the Chair to meet the joint deputy chairs between meetings of the Commission to seek their advice and support in his leadership of the Healthcare Commission. During 2007/08, this meeting was widened to include up to three other commissioners co-opted by the Chair. The Group has formal terms of reference but does not have any decision-making authority or powers delegated by the Commission. The views of the Group are reported to the Commission. The Chair of the Healthcare Commission chairs meetings and the Chief Executive is invited to attend. The first meeting of the Group was held in February 2008.

The function of the Group is to give advice on any matters that the Chair may raise, which may include:

- The strategic direction of the Healthcare Commission.
- Key issues in the operations of the Healthcare Commission, its financial resources and staff.
- The management of the strategic relationship between the Healthcare Commission and the Department of Health, and with other government departments.
- The management of the reputation and standing of the Healthcare Commission.

The Group of Commissioners concerned with assessment
This Group is an ad hoc group of Commissioners convened by the Chair to assist the Commission in developing its methods, delivery and reporting of the assessment of performance in the NHS and independent healthcare sectors.

It has proved to be a valuable means of enabling Commissioners to develop a deeper understanding of the issues arising in the assessment of performance in healthcare, and to address various issues of policy that arise.

The functions of the Group are to give advice on the following matters:

- Ensuring that assessment is coherent with wider developments in the sector.
- Understanding best practice in how assessment promotes improvement.
- The strategic direction for assessment of performance in healthcare, including the impact of the design of systems of assessment.
- Ensuring that lessons are learned and taken into account in the development of systems of assessment.

The membership of the Group comprises at least five commissioners who have volunteered to become members, but other commissioners may also attend. The Group is currently chaired by John Scampion at the invitation of the Chair of the Commission. The Chief Executive, the Head of Assessment and Methods, and other members of the Executive Team are invited to attend meetings of the Group, together with other senior managers responsible for the matters being discussed.

During 2007/08, the Group met twice, in February and March.

Annual reporting

The Healthcare Commission is required to report on the following:

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

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

Management commentary

Principal activities
We are determined to make a real difference to the delivery of healthcare and to promote continuous improvement for the benefit of patients and the public. To do this, we focused on three key areas in 2007/08. These were:

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

Objectives and strategies for achieving goals
Our current strategic goals are:

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

The annual report provides information on our non-financial achievements in 2007/08 in achieving these goals.

Financial performance

The annual accounts report on the Commission's income and expenditure during the year, with the related grant-in-aid funding being credited directly to the operating cost reserve (note 10) in accordance with HM Treasury guidance. A financial comparison between our net costs and grant funding is provided in the following table.

Table 3: Comparison of grant funding and related expenditure		2007/08 £000	2006/07 £000
Grant funding	Revenue	65,132	67,667
	Capital	4,800	4,400
	Non-cash expenditure*	2,847	2,155
		72,779	74,222
Net costs	Net operating costs	67,264	69,751
	Capital expenditure	5,409	4,401
		72,673	74,152
Grant added to reserves		106	70

* Non-cash expenditure within net operating costs not directly funded by grant-in-aid includes depreciation, losses on disposal and impairment and notional capital charges.

Financial costs of our strategic goals
The detail of our financial performance is shown within the income and expenditure account and in the other financial statements and associated notes.

Gross operating costs of £76.0m were offset by £7.9m of income in respect of our work for the independent sector and a further £0.8 sundry income. Net operating costs of £67.3m were in line with our grant funding as explained above and in the financial statements.

Figure 8: Net expenditure by strategic goal 2007/08

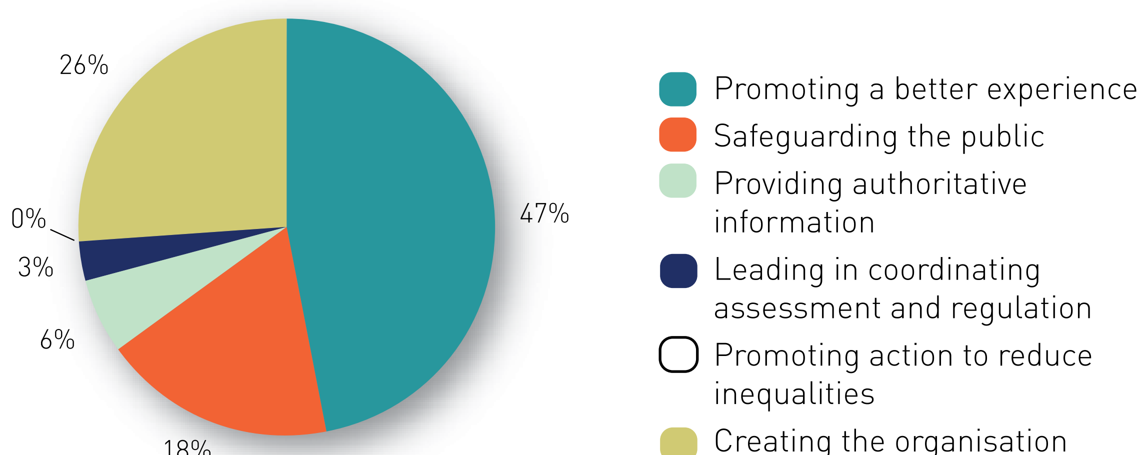


Figure 9: Net expenditure by strategic goal 2006/07

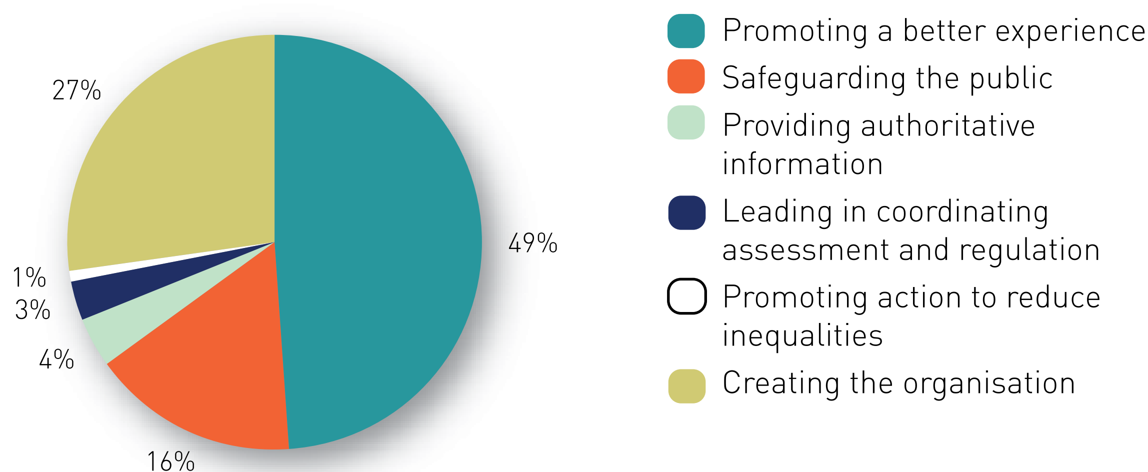


Table 4: Revenue operating costs analysed according to our strategic goals

Strategic goal	2007/08		2006/07
	Average number of employees (whole-time equivalent)	Net operating cost £'000	Net operating cost £'000
Promote a better experience of health and healthcare for patients and public	412	31,070	34,301
Safeguard the public	191	11,843	11,026
Provide authoritative, independent, relevant and accessible information	62	4,109	3,000
Take a lead in coordinating and improving the impact and value for money of assessment and regulation	28	2,285	2,054
Promote action to reduce inequalities in people's health and increase respect for human dignity	6	332	614
Create an organisation delivering world class assessment and regulation	122	17,625	18,756
Total	**821**	**67,264**	**69,751**

Table 5: Capital grant funding: *£5.4m was spent on capital expenditure*

Strategic goal	2007/08 Capital expenditure £'000	2006/07 Capital expenditure £'000
Create an organisation delivering world class assessment and regulation	5,409	4,401
Total	**5,409**	**4,401**

The majority of our capital expenditure is in support of the creation of an intelligent information management system. This development has been agreed by the Commission and, subject to agreement with the Department of Health, funding will be through grant-in-aid in the year in which expenditure is incurred, with appropriate capitalisation of elements of the project. In the year we have increased the functionality of the client relationship management system, enhanced the website that allows trusts to interrogate the annual health check results, and undertaken a pilot of the proposed information cabinet.

Net operating costs can also be analysed between three main business components.

Table 6: Net operating costs for main business areas

	2007/08			2006/07
	Expenditure £m	Income £m	Net operating cost £m	Net operating cost £m
NHS	58.9	0.8	58.1	59.8
Complaints	9.6		9.6	9.8
Independent healthcare	7.5	7.9	(0.4)	0.2
Total	**76.0**	**8.7**	**67.3**	**69.8**

Independent healthcare fees are set at a level intended to recover the costs arising in regulating the sector and are set following a consultation process. Fee income for the year was higher than expected due to increasing numbers of new registrations. The net income of £0.4m compared with a net cost of £0.2m in 2006/07. The balance of £0.2m now held will be taken into consideration when setting future fees.

Key performance indicators

There are a number of key ways in which we will achieve our strategic goals. These are:

- The annual health check and other assessments of the NHS.
- Regulation of the independent healthcare sector and alignment with the NHS.
- In-depth reviews of issues of concern.
- Investigations of serious service failure.
- Handling of second stage NHS complaints.
- Providing useful information based on our assessments.

Performance was monitored using a balanced scorecard, with strategic goals being divided into 16 objectives. Each objective was 'owned' and monitored by an Executive Team member.

During 2007/08, the Commission's performance against its objectives was reported periodically up through business groups, and reviewed by the Performance Management and Risk team before being reported to the Executive Team and the Commissioners. The balanced scorecard report at 31 March 2008 which follows is based on the Commission's performance reporting against its strategic goals and objectives for the period 1 April 2007 to 31 March 2008.

Table 7: Key balanced scorecard objectives - Performance status – March 2008

Strategic goals	16 key balanced scorecard objectives	Executive Team owner
Promote a better experience of health and the 2006/07 annual health check	1. Successful delivery of the 2006/07 annual health check	Gary Needle
	2. 2007/08 annual health check: programme reshaped to meet our principles and respond to legitimate stakeholder concerns	Gary Needle
	3. 2008/09: good strategic plan reflecting healthcare and regulatory reforms: timely consultation on annual health check programme	Jamie Rentoul
	4. Strategy teams focus on delivering agreed programme	Jamie Rentoul
	5. Effective independent healthcare regime, sector fees policy, cost recovery and successful progress towards alignment of independent healthcare and NHS regulatory approaches in 2007/08	Gary Needle
Safeguard the public	6. Improved Commission processes for handling complaints; improved trust performance and action on learning from complaints	Marcia Fry
	7. The Commission spots concerns, responds proportionately and shares learning	Marcia Fry
Provide authoritative, independent, relevant and accessible information	8. The Commission is considered to be a credible and valued organisation that safeguards the public, promotes improvement, and is seen as a trusted provider of independent information	Miranda Kavanagh
	9. Develop effective relationships and feedback from patients, public and clinical leaders	Miranda Kavanagh
	10. Our information is relevant, useful and widely accessible to our target audiences and provides a strong lever in furthering our regulatory aims	Lorraine Foley

Table 7: Key balanced scorecard objectives Performance status March 2008 *cont*		
Strategic goals	**16 key balanced scorecard objectives**	**Executive Team owner**
Take a lead in co-ordinating and improving the impact and value for money of assessments and regulation	11. Effective contribution to shaping future regulatory regime for health and social care	Jamie Rentoul
	12. Effective reorganisation and re-skilling to meet changing regulatory needs; effective contribution to planning for transition to new organisation	Lorraine Foley
Support our people in creating an efficient, flexible and highly skilled organisation	13. Internal governance systems show significant improvements over 2006/07, including balanced scorecard, operating plan and risk management	Steve Heminsley
	14. Operations staff achieve planned programme, reflecting changes in assessment policy, ensuring consistency and credibility	Kate Lobley
	15. Managing and leading our staff	Steve Heminsley
	16. Good budget management and use of resources, credible budgets developed for 2007/08 and 2008/09	Steve Heminsley
Use assessments and other activities to reduce inequalities	The Healthcare Commission's work on promoting actions to reduce inequalities underpins its assessment, inspection and engagement activities described above.	

At the end of 2007/08, the Commission had successfully achieved all of its 16 objectives. Information on the performance of areas of the Commission's work is available on the Commission's website.

Risk management

In managing risk, the Executive Team focuses on the top nine corporate risks that have been identified and formally assesses each risk and the mitigating actions taken on a monthly basis.

Risk appetite indicates how much exposure to particular risks the Commission is willing to tolerate. It represents an informed decision to accept the likelihood and consequences of a risk as it currently stands. During the remaining life of the Commission, our ability to do anything about some risks is limited, or the cost of taking any action may be disproportionate to the potential benefit. In cases where our risk appetite is shown as Amber, this means that we do not intend to take any further action to reduce our exposure to the risk to Green.

The position at 31 March 2008 is set out below. No risks were considered to be at stage red and to require urgent action.

Table 8: Executive Team top nine corporate risks

		Net risk	Risk appetite
A	Risk that support for the Commission's work erodes among the public, clinicians, the healthcare sector and Government	AMBER	AMBER
B	Risk that the Commission's systematic processes fail to protect the public who are known to be at risk of healthcare service failure	AMBER	AMBER
C	Risk that the Commission's annual health check programme is not seen as robust and credible	GREEN	GREEN
D	Risk that the Commission's regulation of independent sector providers is not seen as robust and credible	GREEN	GREEN
E	Risk of the Commission not meeting its stated targets to both improve the quality and reduce the time to handle second stage complaints	AMBER	AMBER
F	Risk that the Commission cannot sustain business as usual activities and business critical activities due to staff retention, recruitment, infrastructure and external crises in the run-up to April 2009	AMBER	AMBER
G	Risk of the Commission not achieving financial balance	GREEN	GREEN
H	Risk that the Commission's infection prevention and control programme is not seen as robust and credible	AMBER	GREEN
I	Risk that uncertainties and delays in policy decisions from Government and DH prevent the Commission from delivering professional regulation and its transition programme	GREEN	GREEN

RED Urgent action required to control and respond to this risk
AMBER Risk under control but further action required to reduce the risk
GREEN Risk under control and being routinely monitored

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

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

Anna Walker CB
Chief Executive
Healthcare Commission

Remuneration report

This report for the year ended 31 March 2008 deals with the remuneration of the Chair, Commissioners, Chief Executive Officer and Executive Team who have influence over the decisions of the Healthcare Commission as a whole.

Remuneration Committee

The Remuneration Committee has responsibility for the effectiveness, integrity and compliance of the reward protocols and practices of the Commission. A key accountability is the annual review of the remuneration of the Chief Executive and Executive (second tier) Team employed directly by the Commission. The Remuneration Committee determines both increases in pensionable salary and a performance bonus, paid on the basis of performance against agreed objectives, in the range of 0% to 15% of the base salary as at 31 March in the performance year.

Membership of the Remuneration Committee is shown on page 56 of the annual report.

Remuneration policy

The Chair is paid a salary in line with that of a high court judge. Commissioners' remuneration is determined by the Department of Health on the basis of a commitment on average of two to three days per month. Remuneration of the Executive Team was determined after an external benchmarking exercise and consideration of the performance of individuals against objectives set for corporate and individual performance, and in accordance with guidelines for senior executive pay issued annually by the Cabinet Office.

The Remuneration Committee recommends to the Commission the framework or broad policy for the remuneration of staff below second tier level.

Service contracts

Professor Sir Ian Kennedy was Chair designate on the vesting date of 8 January 2004 and was appointed by the Secretary of State for Health as Chair of the Healthcare Commission from 1 February 2004 for a period of four years to 31 January 2008. The appointment has been extended to 30 June 2009.

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

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

All members of the Executive Team were appointed after an internal and external recruitment process and are full-time employees of the Commission employed directly by the Commission or on secondment from other government departments.

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

The following sections provide details of the remuneration and pension interests of Commissioners, the Chief Executive and Executive Team members.

Remuneration of the Chair and Commissioners

Remuneration is presented in bands of £5,000.

Table 9: ^Remuneration of the Chair

	Remuneration for the year to 31/3/08 £'000	**Remuneration for the year to 31/3/07** £'000
Chair	165-170	155-160

In addition, the Chair was reimbursed with the cost of travelling to and from the Commission, including for Commission meetings. These reimbursements totalled £3,977 during 2007/08 (£2,594 in 2006/07). The Commission meets the resulting tax liability under a PAYE settlement agreement.

Table 10: ^Remuneration of Commissioners

		Remuneration for the year to 31/3/08 £'000	Remuneration for the year to 31/3/07 £'000
	Khurshid Alam	5-10	5-10
*	Dr Sarah Blackburn	10-15	10-15
	Dr Jennifer Dixon	5-10	5-10
**	Clare Dodgson	5-10	0-5
	Michael Hake	5-10	5-10
***	Dr Sharon Hopkins	5-10	5-10
**	Professor Deirdre Kelly	5-10	0-5
****	Professor Bruce Keogh KBE	5-10	5-10
	Nick Partridge OBE (Joint Deputy Chair from 1 October 2007)	5-10	5-10
****	Professor Shirley Pearce (Joint Deputy Chair to 30 September 2007)	0-5	5-10
**	Clifford Prior CBE	5-10	0-5
*****	John Scampion CBE	5-10	5-10
	Professor Iqbal Singh	5-10	5-10
	Paul Streets OBE (Joint Deputy Chair)	5-10	5-10

* Includes remuneration as Chair of Audit Committee to 31 January 2008.
** Appointed 1 January 2007.
*** Term of office expired on 31 January 2008.
**** Resigned during the year.
***** Includes remuneration as Chair of Audit Committee from 1 February 2008.

In addition, commissioners were reimbursed with the cost of travelling to and from the Commission, including for Commission meetings. These reimbursements totalled £10,861 during 2007/08 (£3,981 in 2006/07). The Commission meets the resulting tax liability under a PAYE settlement agreement.

Remuneration of Chief Executive and Executive Team

Remuneration is presented in bands of £5,000.

Table 11: ^Remuneration of the Chief Executive

	Remuneration for the year to 31/3/08 £'000	Remuneration for the year to 31/3/07 £'000
Chief Executive	200-205	190-195

Table 12: ^Remuneration of the Executive Team

		Remuneration for the year to 31/3/08 £'000	Remuneration for the year to 31/3/07 £'000
	Lorraine Foley	140-145	135-140
	Marcia Fry	140-145	135-140
*	Miranda Kavanagh	145-150	110-115
**	Mick Linsell	85-90	110-115
***	Kate Lobley	115-120	70-75
****	Gary Needle	20-25	–

* Appointed 17 July 2006.
** Retired 18 January 2008.
*** Appointed 1 August 2006.
**** Appointed 1 December 2007. Salary costs of £23,111 (including pension and employers costs) were also recharged to the Commission by Brighton & Hove Teaching PCT.

In addition: Jamie Rentoul provided services as an Executive Team member while employed by the Department of Health. Salary costs of £168,929 (including pension and employers' costs) were recharged to the Commission by the Department of Health (£154,060 in 2006/07). Steve Heminsley provided services as an Executive Team member with effect from 4 February 2008, while employed by HM Revenue & Customs and following the retirement from service of Mick Linsell. Salary costs of £26,242 were recharged to the Commission by HM Revenue & Customs (nil in 2006/07).

Non-cash remuneration
There was no non-cash remuneration during the year (nil in 2006/07).

Compensation paid, significant awards to senior managers
There were no non-contractual compensation or significant awards paid to former Executive Team members during the year (nil in 2006/07).

Payments for loss of office
There were no payments for loss of office during the year (nil in 2006/07).

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

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

Pension entitlements at 31 March 2008

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

Table 13: ^Pension entitlements – Chief Executive

	Accrued benefits*				Cash equivalent transfer values (CETV)		
	Increase in year		Benefits at 31/03/08		CETV at 31/03/08	CETV at 31/03/07	Real increase in CETV
	Lump sum £'000	Pension £'000	Lump sum £'000	Pension £'000	£'000	£'000	£'000
Chief Executive	12.5-15	2.5-5	205-210	65-70	1,583	1,358	208

* Accrued benefits are presented in bands.

Pension benefits at 31 March 2008 may include amounts transferred from previous employments.

Executive Team

Executive Team pension entitlements at 31 March 2008

The members of the Executive Team are eligible to become ordinary members of the NHS pension scheme or the PCSPS.

Table 14: ^Pension entitlements – Executive Team

	Accrued benefits*				Cash equivalent transfer values (CETV)		
	Increase in year		Benefits at 31/03/08		CETV at 31/03/08	CETV at 31/03/07	Real increase in CETV
	Lump sum £'000	Pension £'000	Lump sum £'000	Pension £'000	£'000	£'000	£'000
Lorraine Foley	5-7.5	0-2.5	15-20	5-10	83	59	23
Marcia Fry	7.5-10	0-2.5	160-165	50-55	1,176	1,030	133
** Miranda Kavanagh	2.5-5	0-2.5	5-10	0-5	37	14	23
*** Mick Linsell	2.5-5	0-2.5	15-20	5-10	N/a	80	N/a
** Kate Lobley	2.5-5	0-2.5	15-20	5-10	80	52	17
**** Gary Needle	–	–	10-15	35-40	522	106	–

* Accrued benefits are presented in bands.
** Appointed during 2006/07, benefits at 31 March 2007 may include benefits from previous employments.
*** Retired from service in January 2008.
**** Appointed 1 February 2008, benefits to 31 March 2008 may include benefits from previous employments.

Pension benefits at 31 March 2008 may include amounts transferred from previous employments.

NHS pension scheme

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

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

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

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

Scheme provisions from 1 April 2008
From 1 April 2008 changes have been made to the NHS pension scheme contribution rates and benefits. Further details of these changes can be found on the NHS pensions website **www.pensions.nhsbsa.nhs.uk.**

From 1 April 2008, a new employee and employer contribution scale will come into effect on the basis of graduated salary bandings as set out in the table below.

Table 15: Scheme provisions from 1 April 2008

Salary band	2007/08 contributions		From 1 April 2008 contributions	
	Employee	Employer	Employee	Employer
£19,682 and under	6%	14%	5%	14%
£19,683 to £65,002	6%	14%	6.5%	14%
£65,003 to £102,499	6%	14%	7.5%	14%
£102,500 and over	6%	14%	8.5%	14%

Principal Civil Service Pension Scheme
The Principal Civil Service Pension Scheme (PCSPS) is an unfunded multi-employer public service defined benefit scheme, made under the Superannuation Act 1972. Participating employers make contributions which are calculated on a basis consistent with those that might have applied had the scheme been funded, making allowance for amortised surpluses or deficits that would have arisen in a funded scheme based on an assumed notional investment return. The most recent assessment was carried out by Hewitt Associates, as at 31 March 2007, and included recommendations for the contribution rates applicable from 1 April 2008.

The Commission is unable to identify its share of the underlying assets and liabilities. A quadrennial review of the accruing superannuation liability charges at 31 March 2007 can be found on the Principal Civil Service Pension Scheme website **(www.civilservice-pensions.gov.uk)**.

It should be noted that only members of the PCSPS immediately prior to joining the Commission are entitled to continuing membership while employed by the Commission. Membership is one of a number of variants within the PCSPS scheme.

The existing schemes closed to new members in July 2007. Existing members retained membership and existing benefits. A new scheme was established for new members from that date.

Although the PCSPS is unfunded, employers' contributions are set at the level of contributions that would be paid by private sector employers to pension schemes for their employees. For 2008/09, employers' contributions were payable to the PCSPS in the range 17.1% to 25.5% of pensionable pay, based on salary bands as follows:

Table 16: Salary bands used in PCSPS

	2007/08		From 1 April 2008	
	Salary band (£)	Rate of charge	Salary band (£)	Rate of charge
Band 1	19,000 and under	17.1%	19,500 and under	17.1%
Band 2	19,001 to 39,000	19.5%	19,501 to 40,500	19.5%
Band 3	39,001 to 66,500	23.2%	40,501 to 69,000	23.2%
Band 4	66,501 and over	25.5%	69,001 and above	25.5%

^ Remuneration and pension entitlements are covered by the certificate and report of the Controller and Auditor General to the Houses of Parliament set out on pages 91 to 93 of the annual report.

Anna Walker

Anna Walker CB
Chief Executive
Healthcare Commission

Date: 23 June 2008

Annual accounts for the year to 31 March 2008

Introduction to annual accounts

The Healthcare Commission (Commission for Healthcare Audit and Inspection) presents the Annual Report and Accounts for the year ended 31 March 31 2008. The financial accounts to 31 March 2008 are the Commission's fourth set of annual accounts and have been prepared on the basis that the Commission is a going concern.

These accounts have been prepared in the form directed by the Secretary of State for Health, with the approval of Treasury, in accordance with paragraph 10 of Schedule 6 of the Health and Social Care (Community Health and Standards) Act 2003, and the Financial Reporting Manual (FReM) 2007/08.

Financial results and review

The results for the year to 31 March 2008 are set out in the financial statements on pages 94 to 96.

The Commission's financial performance is identified within the income and expenditure account. The Commission's net operating cost for the year was £67.3m. Expenditure totalled £76.0m on operational activities reduced by income of £8.7m from independent healthcare fees and other activities as explained in the accounts. Expenditure is funded from grant-in-aid provided by the Department of Health. Government grants totalling £69.9m were received in the year, including £4.8m designated as capital grant-in-aid. Reserves carried forward at 31 March 2008 were £13.0m (£10.0m 2007).

Fixed assets
The Commission's fixed assets at 1 April 2007 comprised refurbishment costs to leased land and buildings, furniture, fittings, plant and machinery and on information technology, as reduced by depreciation and amortisation calculated to release the asset costs to the income and expenditure over their useful working lives. Asset costs are revalued under modified historic cost accounting.

During the year to 31 March 2008, the Commission acquired assets with a value of £5.4m. These assets include refurbishment costs at Finsbury Tower and the Commission's regional offices and the purchase of plant and machinery and information technology infrastructure and software.

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

Charitable payments
No charitable donations were made during the year.

Payment of creditors

The Commission's policy is to pay creditors in accordance with contractual conditions or, where no contractual conditions exist, within 30 days of receipt of goods and services or the presentation of a valid invoice, whichever is the later. This complies with the Better Payment Practice Code.

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

In 2007/08, the Commission paid 90% (93% 2006/07) of invoices, based on volume, and 91% (91% 2006/07) of invoices, based on value, within 30 days. These calculations are based on the date of the invoice and will therefore understate the Commission's performance as payments are delayed while confirmation is obtained of satisfactory supply of goods and services.

Equality and diversity

The Healthcare Commission is fully committed to creating a supportive working environment based on trust and mutual respect. We want our people to reach their full potential, regardless of race, nationality, ethnic or national origins, marital status, sexual orientation, impairment, gender, age, religion or belief, working arrangements or any other factor. The Commission's policies to promote equality and diversity apply across its entire work force and are set out in its intranet. These policies underpin all other HR policies and management processes (including performance management) and also apply to social events arranged by, or under the auspices of, the Commission.

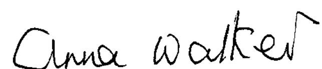
Staff consultation

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

- Regular meetings between staff and Executive Team members which are open to all staff.
- The involvement of staff in developing the policies and objectives set out in the corporate plan.
- More formal meetings with the joint negotiating committee for staff and management and unions.
- A staff forum on which Finsbury Tower and regionally-based staff are represented by elected delegates.
- An annual staff conference.
- Regular all-staff communications.
- Periodic confidential surveys of staff attitudes, the results of which are shared.

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

The audit fee for the year was £59,000 (£60,000 2006/07). The Comptroller and Auditor General did not undertake any non-audit work during the year.



Anna Walker CB
Chief Executive
Healthcare Commission

Date: 23 June 2008

Statement of Accounting Officer's responsibilities

Under paragraph 10 Schedule 6 of the Health and Social Care (Community Health and Standards) Act 2003, the Secretary of State for Health (with the consent of HM Treasury) has directed the Commission to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Commission and of its income and expenditure, recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements.
- Prepare the financial statements on a going concern basis.

The Accounting Officer of the Department of Health has designated me as Accounting Officer of the Commission. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the Commission's assets, are set out in *Managing public money* published by HM Treasury.

Anna Walker CB
Chief Executive
Healthcare Commission

Statement on internal control

1. Scope of responsibility

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

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

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

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

During 2007/08, I have reviewed documents I considered relevant, including internal audit reports and papers presented to the Audit Committee and management information produced during the year and I have discussed the state of internal controls with the external and internal auditors, and with members of the Commission.

2. The purpose of the system of internal control

The system of internal control is designed to monitor performance against plan, and budgets to manage risk to a reasonable level, rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide sound and not absolute assurance of effectiveness. The Commission's system of internal control is being developed to understand and allocate costs against activities better, to monitor performance against plan and to identify and prioritise the risks to the achievement of its policies, aims and objectives, to evaluate the likelihood of those risks being realised (and their impact should they be realised) and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Healthcare Commission for the year to 31 March 2008 and up to the date of approval of the annual report and accounts, and it accords with guidance from HM Treasury.

3. Capacity to handle risk

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

Table 17: Risk management approach

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

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

- Establish a policy framework approved by commissioners and the Executive Team, within which activities and their proposed outcomes and strategic risks are identified, managed and kept under review.
- Embed the management of risk and compliance by making it part of the day-to-day management processes. Although the Executive Team collectively owns the risks, each strategic risk is also allocated to an appropriate member of the Executive Team to ensure that the management of risk is an integral part of overall management arrangements.
- Ensure that named managers manage each risk and actively review and report on that risk.

- Adopt a consistent approach throughout the organisation.

- Encourage staff to identify and manage risk positively in support of delivering the objectives of the Commission.

- Keep the system of risk management under regular review to ensure it is best matched to the organisation and effectively embedded.

4. The risk and control framework
Consistent with the recognition of risk at a strategic level, the Commission has developed a risk register to monitor where risks may arise and how they are mitigated. In the register, risks are identified at an operational level and consolidated to identify themes arising across the organisation. The Executive Team and the Commission review the risk register for completeness. The Audit Committee reviews the application of the risk management processes. In addition, we have benefited from the observations made to us by a risk adviser seconded from an NHS trust for six months who helped us enhance the degree of rigour behind our approach to the management of risk.

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

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

- A formal system of governance comprising of standing orders and standing financial instructions which support and regulate how the Commission conducts its business. This includes a schedule of delegation showing which functions are retained for determination by the commissioners and which are delegated to the Chief Executive.

- An organisational structure that supports clear lines of communication and accountability.

- Business strategies that are approved by the Commission and are subject to consultation with stakeholders of the Commission.

- Clear processes, so that the risks that are identified fit into an overall structure for risk management.

- The introduction of management and reporting of key indicators of performance against a balanced scorecard.

We are working to ensure compliance with mandatory standards for data handling. We have reviewed policies and practices where sensitive data is concerned. We are in the course of introducing encryption to all portable computers. We have strengthened our resource by appointing a senior manager to consolidate delivery of our information governance programme.

5. Review of effectiveness

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

As an employer with staff entitled to membership of the NHS pension scheme control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer contributions and payments in to the scheme are in accordance with scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in regulations.

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

The respective responsibilities are set out overleaf.

Audit Committee

The Audit Committee met four times in 2007/08. Its terms of reference are:

- To review the establishment and maintenance of an effective system of internal control and risk management.
- To recommend to the Commission the appointment (and dismissal) of the head of internal audit, approve the internal audit operating plan and receive and monitor progress upon all reports which the internal auditors issue regarding the Commission.
- To review the delivery and outcome of the external audit function, including the management letter and management's progress in the implementation of external audit recommendations.
- To ensure that the Commission's financial statements comply with best accounting practice and relevant accounting standards.

In addition, the Committee held a half-day workshop which focused attention on all of the key risks which face the Commission.

The membership of the Audit Committee at 31 March 2008 comprised:

- Dr Sarah Blackburn (Chair to 31 January 2008)
- Clare Dodgson
- Michael Hake
- John Scampion (Chair from 1 February 2008)

The Commission

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

The Executive Team

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

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

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

Internal and external audit

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

Our internal auditors expressed their opinion based on work undertaken during the year to 31 March 2008. Their overall opinion was that we had maintained a position where a satisfactory level of assurance could be given, recognising that there is some risk that our objectives may not be achieved. In discussion with our auditors, they acknowledge that we have made adequate improvements to all previously identified aspects of risk, but that slight improvements are required to enhance the adequacy and / or effectiveness of risk management, control and governance.

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

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

Future developments

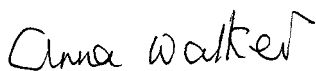
The Commission has taken steps to ensure that the essential elements of effective control and risk management are in place. The systems have been developed and reviewed during 2007/08 and while the controls and risk management in place have, in my view, been adequate, further improvements are required to support the Commission as it delivers the full range of its functions. Our aim is to establish ourselves as an organisation recognised for good practice in strategic planning, monitoring of performance and risk management.

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

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

We are actively addressing our responsibilities for compliance with tighter government guidelines on information governance. We have reviewed our internal systems and processes and have appointed an experienced security manager to oversee implementation of the requirements of the Cabinet Office's Information Governance Action Plan. To date, we are near to completion of a programme to encrypt all 300 laptop computers in issue to our staff. We have implemented new controls over other portable media. All new systems which we introduce are now subject to testing against unauthorized penetration before we accept that implementation is complete.

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



Anna Walker CB
Chief Executive
Healthcare Commission

Date: 23 June 2008

The certificate and report of the Comptroller and Auditor General to the Houses of Parliament

I certify that I have audited the financial statements of the Commission for Healthcare Audit and Inspection (the Healthcare Commission) for the year ended 31 March 2008 under the Health and Social Care (Community Health and Standards) Act 2003. These comprise the operating cost statement, the balance sheet, the cash flow statement and statement of recognised gains and losses and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the remuneration report that is described in that report as having been audited.

Respective responsibilities of the Commission, Chief Executive and auditor

The Commission and Chief Executive as Accounting Officer are responsible for preparing the annual report, the remuneration report and the financial statements in accordance with the Health and Social Care (Community Health and Standards) Act 2003 and directions made thereunder by the Secretary of State for Health with approval of HM Treasury, and for ensuring the regularity of financial transactions. These responsibilities are set out in the Statement of Accounting Officer's Responsibilities.

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

I report to you my opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the remuneration report to be audited have been properly prepared in accordance with the Health and Social Care (Community Health and Standards) Act 2003 and directions made thereunder by the Secretary of State for Health with approval of HM Treasury.

I report to you whether, in my opinion, the information, which comprises the management commentary, foreword, "our year in brief", corporate governance and finance, and remuneration report, included in the annual report is consistent with the financial statements. I also report whether in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

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

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

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

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

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

Opinions
In my opinion:

- the financial statements give a true and fair view, in accordance with the Health and Social Care (Community Health and Standards) Act 2003 and directions made there under by the Secretary of State for Health with approval of HM Treasury, of the state of the Commission's affairs as at 31 March 2008 and of its net operating cost for the year then ended;

- the financial statements and the part of the remuneration report to be audited have been properly prepared in accordance with the Health and Social Care (Community Health and Standards) Act 2003 and directions made thereunder by the Secretary of State for Health with approval of HM Treasury; and

- information, which comprises the management commentary, foreword, "our year in brief", corporate governance and finance, and remuneration report, included within the annual report, is consistent with the financial statements.

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

Report
I have no observations to make on these financial statements.

T J Burr
Comptroller and Auditor General

National Audit Office
151 Buckingham Palace Road
Victoria
London SW1W 9SS

Date: 27 June 2008

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

Table 18: Operating cost statement for the year to 31 March 2008

	Note	Year to 31/03/08		Year to 31/03/07	
		£'000	£'000	£'000	£'000
Gross operating costs					
Staff costs	2	46,929		47,239	
Other operating costs	3	26,391		29,790	
Depreciation and amortisation	5	2,526		1,875	
Notional capital charges	1v	143		66	
			75,989		78,970
Less income					
Fee income	4i	7,863		8,519	
Other income	4ii	858		700	
			8,721		9,219
Net operating costs	**11**		**67,268**		**69,751**

The notes on pages 97 to 113 form part of these accounts.

Table 19: Statement of recognised gains and losses

	Note	Year to 31/03/08	Year to 31/03/07
		£'000	£'000
Unrealised gains on fixed asset indexation	5	176	206

The notes on pages 97 to 113 form part of these accounts.

Table 20: Balance Sheet

	Note	Year to 31/03/08		Year to 31/03/07	
		£'000	£'000	£'000	£'000
Fixed assets					
Tangible fixed assets	5		8,108		7,142
Intangible fixed assets	5		3,667		1,756
			11,775		8,898
Current assets					
Debtors: falling due within one year	6	3,362		3,735	
Cash at bank and in hand	7	6,213		8,622	
		9,575		12,357	
Current liabilities					
Creditors: falling due within one year	8	7,782		10,645	
Net current assets			1,793		1,712
Total assets less current liabilities			13,568		10,610
Provisions	9		(584)		(609)
Total net assets			**12,984**		**10,001**
Capital and reserves:					
Operating cost reserve	10 i		12,555		9,748
Revaluation reserve	10 ii		429		253
			12,984		**10,001**

The notes on pages 97 to 113 form part of these accounts.

Anna Walker

Signed by:
Anna Walker CB
Accounting Officer

Date: 23 June 2008

Table 21: Cash flow

	Note	Year to 31/03/08		Year to 31/03/07	
		£'000	£'000	£'000	£'000
Net cash outflow from operating activities	12		(67,600)		(64,312)
Capital expenditure and financial investment					
Payments to acquire fixed assets			(4,745)		(4,168)
Net cash outflow before financing			(72,345)		(68,480)
Financing					
Sale proceeds of fixed assets		4		1	
Government grant received:					
Revenue	10	65,132		67,667	
Capital	10	4,800	69,936	4,400	72,068
Increase in cash at bank and in hand	7		**(2,409)**		**3,588**
Note					
Fixed asset expenditure	5		5,409		4,401
Adjust (increase) in fixed asset accruals	8		(414)		(233)
Adjust (increase) in fixed asset provisions	9		(250)		
Payments to acquire fixed assets			**4,745**		**4,168**

The notes on pages 97 to 113 form part of these accounts.

Notes to the accounts

1. Accounting policies

i) Accounting convention

The financial accounts cover the year 1 April 2007 to 31 March 2008.

These accounts are prepared in accordance with the Healthcare Commission Financial Memorandum, the Accounts Direction issued by the Secretary of State for Health, the disclosure and accounting requirements contained in HM Treasury's Managing Public Money, and the accounting and disclosure requirements given in the Government Financial Reporting Manual (FReM) insofar as these are appropriate to the Commission and are in force for the financial year for which the statements are prepared. The financial statements are prepared under the modified historic cost convention by the inclusion of fixed assets at their value to the business by reference to current costs.

ii) Income

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

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

iii) Value added tax (VAT)

The Commission is registered for Value Added Tax as vat-rated income (primarily from recharging the costs of staff on secondment) exceeds the vat registration threshold. Income is reported exclusive of output VAT where applicable. VAT is not charged on any of the Commission's regulation based independent healthcare fees and charges. Expenditure reported in these statements is inclusive of VAT.

iv) Fixed assets

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

Tangible fixed assets include office refurbishment, furniture, fittings, plant & machinery and IT infrastructure including IT assets in development with an expected working life of more than one year. All assets falling into these categories with a value of £5,000 or more have been capitalised.

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

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

(i) Depreciation and amortisation

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

- Office refurbishments – the unexpired period remaining on the lease up to 15 years.
- Furniture & fitting – 10 years.
- Plant & machinery – five years.
- IT infrastructure & intangible assets – three to four years.
- Depreciation and amortisation is charged on a monthly basis commencing from the month following the date on which an asset is brought into use.

(ii) Indexation

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

v) Notional cost of capital

A notional cost of capital has been calculated in accordance with HM Treasury requirements at a rate of 3.5% on the average value of capital employed during the year. The notional cost of capital for the year to 31 March 2008 was £143,000 (2007 £66,000).

vi) Pension costs

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

vii) Leases

Rental payable under operating leases are charged to the income and expenditure account on a straight-line basis over the lease term.

2. Employee information

i) Staff costs

Table 22: Staff costs

	Year to 31/03/08	Year to 31/03/07
	£'000	£'000
Wages and salaries (including Commissioners)	30,319	28,668
Secondments, temporary and interim staff	7,252	11,384
* Employers' national insurance	2,845	2,784
* Employers' pension costs	3,805	3,856
Staff costs recharged	577	337
Pension provision released	(109)	(141)
Redundancy costs	2,240	351
	46,929	**47,239**

In addition, staff costs of £306k relating to nine staff were capitalised during 2007/08 (nil 2006/07).

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

ii) Average number of employees during year

The average number of whole time equivalent employees, including secondees and agency staff by category of employment was:

Table 23: Average number of employees during year

	Year to 31/03/08	Year to 31/03/07
	Whole time equivalents	Whole time equivalents
Managerial	7	7
Support staff	675	697
Secondments, temporary and interim staff	139	154
	821	**858**

iii) Pension benefits

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

(i) NHS pension scheme

Details of the benefits payable under the scheme provisions can be found on the NHS pensions website at **www.pensions.nhsbsa.nhs.uk**. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and a FRS17 accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates, was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees' contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) FRS17 accounting valuation

In accordance with FRS17, a valuation of the scheme liability is carried out annually by the scheme actuary as at the balance sheet date by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2008 is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

Contributing Healthcare Commission membership during 2007/08 was 542 (598 in 2006/07); and for 2007/08 employers' contributions of £3.2m (£3.2m in 2006/07) were payable to the scheme.

(ii) Principal Civil Service Pension Scheme

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

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

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

Contributing membership during 2007/08 was 49 (54 in 2006/07) and for 2007/08, employers' contributions of £0.6m (£0.6m in 2006/07) were payable to the scheme.

3. Other operating costs

Table 24: Other operating costs	Year to 31/03/08	Year to 31/03/07
	£'000	£'000
Other operating costs include:		
Communications	2,024	2,507
Consultancy and professional fees:		
Clinical audit	4,688	4,900
Deregulated work	0	0
Legal fees	260	293
Other consultancy and professional fees	4,719	7,160
* External audit	59	60
IT costs, including general project management	1,726	2,297
Losses and special payments	17	9
Premises and facilities	2,773	2,757
Staff recruitment, training and development	3,264	2,814
Travel and subsistence	2,175	2,323
Operating leases:		
Equipment	7	8
Premises	4,122	3,775
Other costs	379	674
Impairment of fixed assets	167	210
Losses on disposal of fixed assets	11	3
	26,391	**29,790**

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

Notional insurance
Under the terms of its accounts direction from the Secretary of State for Health the Commission does not carry commercial insurance but meets any insurance losses arising in the year up to 5% of its grant-in-aid. Losses arising from insurable claims during the year were nil (2006-07 below £1,000).

4. Income

Fees and charges made to the independent sector are in line with fee scales prescribed by the Secretary of State for Health under the Care Standards Act 2000. Fee levels were reviewed and in some cases increased from 1 April 2007 following a fee consultation exercise in 2006/07.

As detailed in Note 1ii annual registration fees are invoiced on the anniversary of the registration and recognised in full in the accounting year invoiced. In cases of voluntary deregistration, fees are refunded to registered organisations in accordance with the fee rebate scheme detailed on the Commission's website. There is no provision for the cost of potential fee rebates at 31 March 2008, fee income recognised in these accounts but relating to 2008/09 registration periods was estimated at £3.1m at 31 March 2008 (2007 £3.0m).

Table 25: i) Fee income

	Year to 31/03/08	Year to 31/03/07
	£'000	£'000
Registration and inspection fees and charges to the independent sector	**7,863**	**8,519**

Table 26: ii) Other income

	Year to 31/03/08	Year to 31/03/07
	£'000	£'000
Recharge of staff	577	337
Other income - speakers fees etc	26	8
Legal costs recovered	0	9
Grants to commission research	255	346
	858	**700**

5. Fixed assets

Table 27: Fixed assets

	Office refurb. £'000's	Furn. & fittings £'000's	Plant & mach. £'000's	IT £'000's	Assets under const'n £'000's	Total tangible assets £'000's	Intan-gible assets £'000's
Cost or valuation							
Bal 1 April 2007	4,849	965	630	2,924	2,570	11,938	3,260
Additions in year	306	6	35	87	3,274	3,708	1,701
Transfers				699	(2,191)	(1,492)	1,492
Disposals in year		(10)	(14)	(385)		(409)	(116)
Indexation	262	26	17			305	
Impairment				(81)	(64)	(145)	(117)
Bal 31 March 2008	**5,417**	**987**	**668**	**3,244**	**3,589**	**13,905**	**6,220**
Depreciation							
Bal 1 April 2007	1,767	606	368	2,055		4,796	1,504
Depreciation and amortisation in year	460	81	93	692		1,326	1,200
Disposals in year		(9)	(14)	(385)		(408)	(102)
Indexation	106	15	8			129	
Impairment				(46)		(46)	(49)
Bal 31 March 2008	**2,333**	**693**	**455**	**2,316**	**0**	**5,797**	**2,553**
Net book value							
31 March 2008	**3,084**	**294**	**213**	**928**	**3,589**	**8,108**	**3,667**
31 March 2007	**3,082**	**359**	**262**	**869**	**2,570**	**7,142**	**1,756**

6. Debtors

Table 28: Debtors		
	Year to 31/03/08	Year to 31/03/07
	£'000	£'000
Amounts falling due within one year		
Trade debtors	1,203	1,359
Advances - staff loans	134	141
Prepayments and accrued income	1,780	2,068
Other debtors	245	167
	3,362	**3,735**
Staff loans are for season tickets, bicycle purchase and gym membership. No member of staff received loans in excess of £5,000.		
Intra-governmental balances		
Balances with Central Government	275	217
Balances with NHS trusts	53	19
Balances with local authorities	521	501
Balances with public corporations & trading funds	0	0
Balances with bodies external to Government	2,513	2,998
	3,362	**3,735**

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

Table 29: Analysis of cash and bank balances and changes during the year			
	1/04/2007	Cashflow	31/03/2008
	£'000	£'000	£'000
Paymaster general	8,618	(2,409)	6,209
Cash balances	4	0	4
	8,622	**(2,409)**	**6,213**

8. Creditors

Table 30: Creditors

	Year to 31/03/08	Year to 31/03/07
	£'000	£'000
Amounts falling due within one year		
Trade creditors	2,864	4,692
Taxation and national insurance	869	928
Accruals and deferred income:		
Staff & operating costs	2,749	4,126
Fixed assets	855	441
Other creditors	445	458
	7,782	**10,645**
Intra-governmental balances		
Balances with Central Government	1,048	1,594
Balances with NHS trusts	63	482
Balances with local authorities	0	0
Balances with public corporations & trading funds	437	446
Balances with bodies external to Government	6,234	8,123
	7,782	**10,645**

9. Provisions

Table 31: Provisions	Pension fund deficit £'000	Lease dilapidations £'000	Other provisions £'000	Total £'000
Bal 1 April 2007	109		500	609
Provided in year	0	250	334	584
Paid in year	0	0	(465)	(465)
Released in year	(109)		(35)	(144)
Bal 31 March 2008	**0**	**250**	**334**	**584**

Pension fund deficit

An actuarial shortfall on pension entitlements arose from the transfer of staff from the National Care Standards Commission in 2004. At the time of transfer of staff on 1 April 2004 the estimated liability was £700,000.

During 2006/07 the estimated liability was reduced by the actuary to £109,000, from £250,000 estimated at 31 March 2006.

The actual liability was nil at the conclusion of the actuarial review in 2007/08.

The reduction of £109,000 in the provision has been credited to staff costs as shown in Note 2.

Lease dilapidations

Leases of the Finsbury Tower offices include an obligation to re-instate offices on expiry in 2020. The current cost of returning offices to their original state is estimated at £250,000. This sum has been included as a fixed asset cost to be depreciated over the remaining life of the leases.

Other provisions

Other provisions at 31 March 2007 reflected the estimated likely additional costs which may become due to contractors. The additional costs were clarified at £465,000 during 2007/08. The reduction of £35,000 in the provision was credited to other costs in Note 3.

The provisions of £334,000 provided at 31 March 2008 reflect the estimated likely costs of implementing the Commission's recruitment, retention and termination policies.

10. Reserves

Table 32: Reserves

	Year to 31/03/08		Year to 31/03/07	
	£'000	£'000	£'000	£'000
i) Operating cost reserve				
Opening balance		9,748		7,366
Government grants received				
Revenue grant-in-aid	62,229		64,824	
Grant transferred to NCASP	2,903		2,843	
	65,132		67,667	
Capital grant-in-aid	4,800		4,400	
	69,932		72,067	
Less net operating cost for the financial year	(67,268)		(69,751)	
		2,664		2,316
Non-cash				
Capital charges written back		143		66
Closing balance		**12,555**		**9,748**
ii) Revaluation reserve				
Balance at 1 April 2007		253		47
Indexation increase in the year		176		206
Balance at 31 March 2008		**429**		**253**

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

Table 33: i) Reconciliation of net operating cost to revenue grant-in-aid

	Note	Year to 31/03/08		Year to 31/03/07	
		£'000	£'000	£'000	£'000
Net operating cost			67,268		69,751
Less non grant-in-aid charges					
Depreciation and amortisation	5	2,526		1,875	
Impairment and losses on disposal of fixed assets	3	178		213	
Capital charges	1v	143		66	
			2,847		2,154
			64,421		67,597
Revenue grant-in-aid	10i		65,132		67,667
Underspend of grant in aid			**711**		**70**

Table 34: ii) Reconciliation of capital expenditure to capital grant-in-aid

	Note	Year to 31/03/08		Year to 31/03/07	
		£'000	£'000	£'000	£'000
Gross capital expenditure	5		5,409		4,401
NBV of assets disposed of	5	15		4	
Less loss on disposal	3	11		3	
			4		1
			5,405		4,400
Capital grant-in-aid	10i		4,800		4,400
Overspend of grant-in-aid			**(605)**		**0**

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

Table 35: Reconciliation of net operating cost to net cash outflow from operating activities

	Year to 31/03/08	Year to 31/03/07
	£'000	£'000
Net operating cost for the financial year	(67,268)	(69,751)
Depreciation	2,526	1,875
Notional capital charge	143	66
Downward revaluation of fixed assets	167	210
Losses on disposal of fixed assets	11	3
Decrease (increase) in debtors	373	(249)
(Decrease) increase in revenue creditors	(3,277)	3,175
(Reduction) increase in revenue provisions	(275)	359
Net cash outflow from operating activities	**(67,600)**	**(64,312)**

13. Operating leases

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

Table 36: Operating leases

	Note	Year to 31/03/08	Year to 31/03/07
		£'000	£'000
Land and buildings			
Leases which expire within one year		425	672
Leases which expire within two to five years	9	1,741	1,419
Leases which expire after five years		1,744	1,752
		3,910	**3,843**
Other leases			
Leases which expire within one year		3	0
Leases which expire within two to five years		0	9
Leases which expire after five years		0	0
		3	**9**

No dilapidation costs arise on land and buildings leases expiring within one and one to five years. A provision of £250,000 has been created for dilapidation costs arising on leases that expire after five years.

14. Capital commitments

The Healthcare Commission's capital expenditure was controlled by the Department of Health for the year to 31 March 2008. The Commission had the following capital commitments, based on orders in place, at 31 March 2008:

Table 37: Capital commitments

	Year to 31/03/08	Year to 31/03/07
	£'000	£'000
Expenditure contracted but not provided	nil	nil
Expenditure authorised but not contracted	nil	£1m

15. Contingent liabilities

There are no contingent liabilities at 31 March 2008 (nil in 2007).

16. Related party transactions

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

The Healthcare Commission is a non-departmental public body sponsored by the Department of Health. The Department of Health is regarded as a related party. During the year the Commission has made a number of material transactions with the Department and other entities for which the Department is regarded as the parent Department. In addition the Commission has had a small number of transactions with other government departments and other central government bodies. Balances at 31 March 2008 are shown in notes 6 and 8.

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

Grant-in-aid transfer £2.9m (Note 10)

Some of the clinical audit costs were incurred under a service level agreement between the Commission and the Health and Social Care Information Centre and paid directly by the Department of Health to the HSCIC National Clinical Audit Support Programme (£2.8m 2006/07).

17. Financial instruments

FRS 13

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

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

18. Post balance sheet events

There have been no significant events since 31 March 2008 that would have a material effect on these financial statements.

The financial statements and notes were signed by the Chief Executive as Accounting Officer on 23 June 2008 and authorised to be issued on 27 June 2008.

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