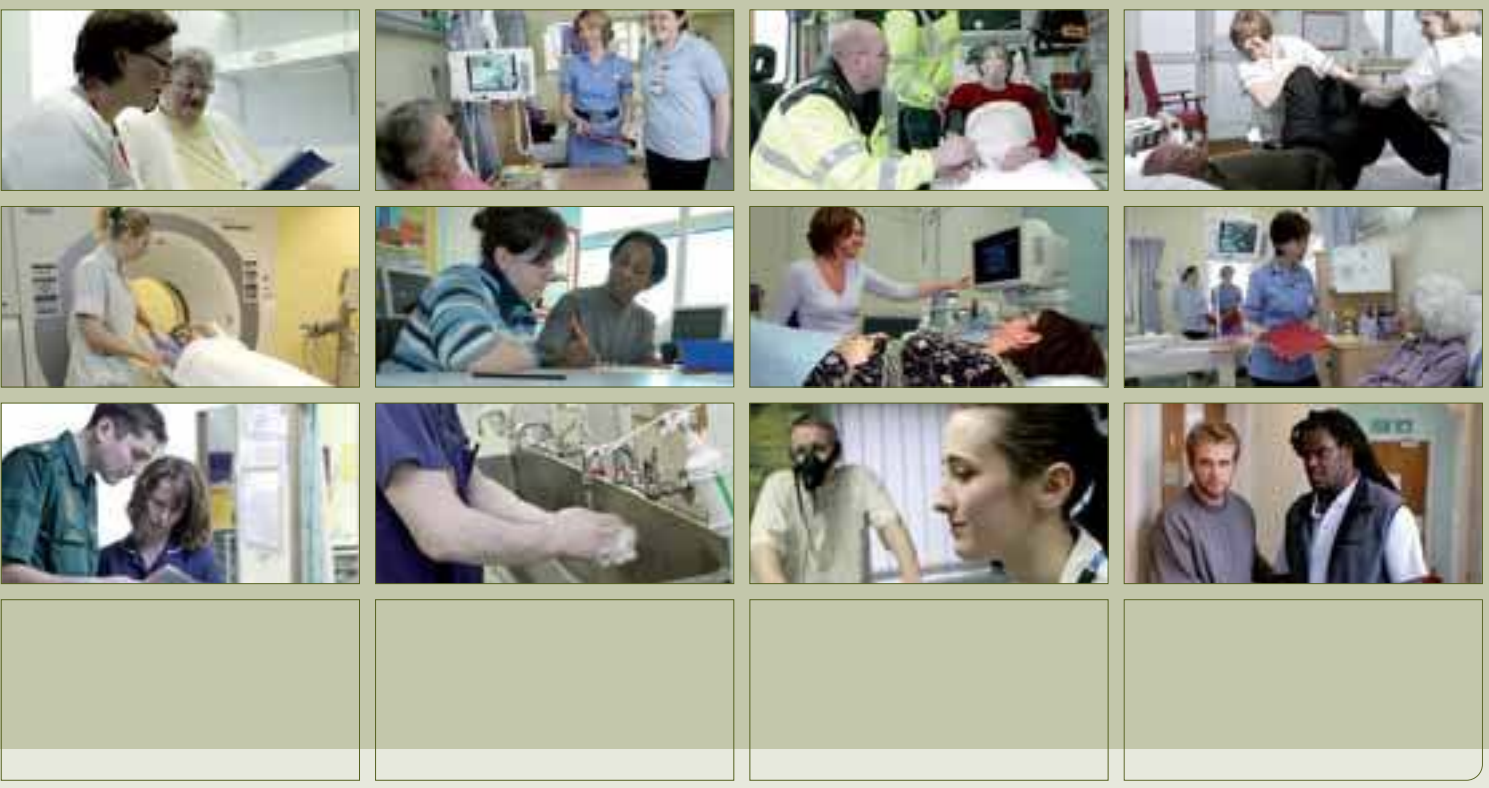
Inspecting Informing Improving

Healthcare Commission



Annual report 2005/2006

Putting patients first: a better experience of health and healthcare

First published in July 2006

ISBN: 0-10-294148-3

Healthcare Commission

Annual report 2005/2006
Putting patients first: a better experience of health and healthcare

Ordered by the House of Commons to be printed July 24th 2006.

Presented to Parliament by the Secretary of State and by the Comptroller and Auditor General in pursuance of Section 128(2) and paragraph 10(4) of Schedule 6 of the Health and Social Care (Community Health and Standards) Act 2003.

A copy of the report has also been provided to the Secretary of State for Wales and the Minister for Health and Social Services, National Assembly for Wales, pursuant to section 128(3) of the Health and Social Care (Community Health and Standards) Act 2003.

HC 1381 London: The Stationery Office £19.25

Healthcare Commission

Annual report 2005/2006

Contents

Foreword

We are pleased to be able to report a successful second year for the Healthcare Commission, one in which we believe that we have made a major contribution to encouraging improvement in health and healthcare.

In 2005/2006, we fulfilled our statutory responsibilities to Parliament and moved forward with our commitment to place patients and the public at the centre of what we do.

Over the last year we have firmly established ourselves as a regulator that means business: a regulator that does not hesitate to take action to protect patients and the public. We have also earned a reputation as an organisation that listens, is independent and fair. Above all, we are seen to be an organisation that is making a difference to health and healthcare in this country.

We have achieved this standing by delivering a challenging programme of work. We have introduced the annual health check – our new system for assessing and encouraging improvements in the performance of healthcare organisations in England. The annual health check assesses for the first time whether general core standards (in areas such as safety and focus on patients) are being met on behalf of patients across the NHS. The feedback that we have already received from the NHS is most encouraging. At the same time, we have successfully delivered a challenging programme of registering and inspecting providers of independent healthcare, under an entirely separate statutory framework. And, we have undertaken a successful programme of consultation to seek views on our proposals for developing the way in which we will work during 2006/2007.

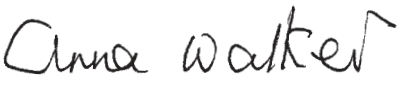
At the same time, we have carried out several major investigations and published a wide range of reports, including the State of Healthcare report and the findings of our reviews of cleanliness in hospitals, obesity in children and the care of older people. A growing number of our reports were produced jointly with our partners, including the Commission for Social Care Inspection and the Audit Commission.

We now face the challenges of another year. Within the NHS, there will continue to be reforms, with policies such as payment by results and choice for patients alongside major structural change. Financial pressures on the NHS are also likely to grow and we can expect to see the independent healthcare sector providing more services on behalf of the NHS. In this environment, it will become increasingly important for us to align our approaches to regulating the NHS and the independent sector, as through the exercise of choice more NHS patients are treated in the independent sector.

As an organisation, the Healthcare Commission must continue to deliver our work efficiently, offering value for money while operating within a constrained budget. And we must meet the challenges and seize the opportunities that emerge from the government's current review of regulation in health and social care.

As always we will remain committed to promoting improvements in the quality of health and healthcare.

Professor Sir Ian Kennedy
Chair



Anna Walker CB
Chief Executive

About the Healthcare Commission

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

In England, we are responsible for assessing and reporting on the performance of NHS and independent healthcare organisations 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, our role is more limited and relates mainly to working on national reviews that cover both England and Wales, as well as our annual report on the state of healthcare. In this role, we work closely with the Health Inspectorate Wales and the Care Standards Inspectorate Wales. We are required to pay particular attention to:

Why we exist

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, those who use and provide services, and with the public to maintain our focus on improving their experiences of healthcare.

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

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

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

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

We are independent and fair in our decision-making and report what we find without fear or favour.

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

About this report

One of our statutory responsibilities is to present an annual report to Parliament setting out how we carried out our functions.

Our *Strategic plan 2005/2008* sets out what we aim to achieve, in the form of six strategic goals. They are:

1. promoting a better experience of health and healthcare for patients and the public

2. safeguarding the public

3. providing authoritative, independent, relevant and accessible information

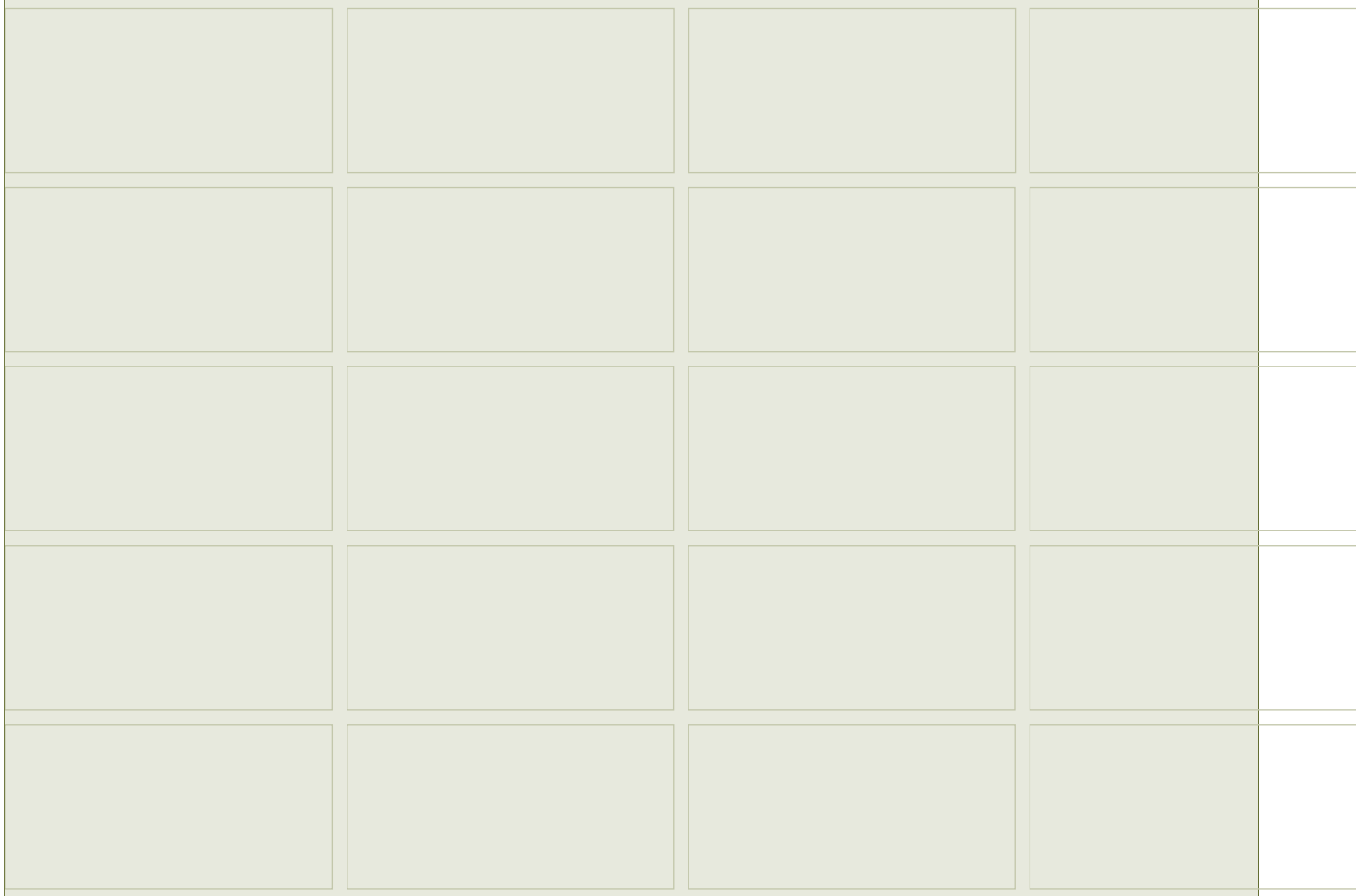
4. taking a lead in coordinating and improving the value for money of assessment of performance and regulation

5. promoting action to reduce inequalities in people's health and increasing respect for human rights and diversity

6. creating an organisation delivering world class assessment and regulation

This report sets out the progress we have made in delivering these six strategic goals. It outlines how we have carried out our functions in 2005/2006 and the changes and developments that have taken place since our last annual report. It provides a monthly summary of our key activities and achievements and contains our full financial accounts for 2005/2006.

More information about the activities covered in this report, as well as other elements of our work, can be found on our website **www.healthcarecommission.org.uk**.



Our year in brief

Some of our achievements over the last year
April 2005 – March 2006

April 2005

- called on the Secretary of State to introduce special measures to safeguard patients using the maternity unit at Northwick Park Hospital
- published the findings of our last clinical governance reviews
- promoted the Healthcare Commission at the Royal College of Nursing conference
- completed the pilot inspections of joint area reviews with the Commission for Social Care Inspection, Ofsted and the Audit Commission

May 2005

- published the findings from our investigation at Bolton, Salford and Trafford Mental Health Trust
- held events for registered providers of independent healthcare
- published the results of a clinical audit of violence in mental health settings
- attended guidance on the annual health check for providers, overview and scrutiny committees and patient and public engagement forums
- published our *Strategic plan 2005/2008*
- signed the Welsh concordat
- attended the Primary Care 2005 conference

June 2005

- Healthcare Commission's regional structure became operational
- published our acute hospital portfolio report and statistics on ward staffing
- launched our regional teams, at the NHS Confederation conference

July 2005

- published NHS performance ratings under the old system (star ratings) for the last time
- launched an investigation at Stoke Mandeville Hospital
- published the findings from our investigation at Northwick Park Hospital
- published guidance to the NHS on resolving complaints better locally
- published the *State of healthcare 2005* report and held a high profile event
- published findings from the safeguarding children reviews
- published our acute hospital portfolio report and statistics on day surgery
- published the findings from our survey of patients who had suffered a stroke
- published the findings from our review of NHS foundation trusts
- held 17 regional events to launch our new regional structure and provide guidance on the annual health check
- published findings from the *Second joint chief inspectors' report on arrangements to safeguard children* in collaboration with a number of partner organisations

August 2005

- launched our programme of improvement with the start of three improvement reviews looking into substance misuse, tobacco control, and services for children in hospital
- published our acute hospital portfolio report and statistics on accident and emergency services

September 2005

- published a leaflet to help people wanting cosmetic treatment to make informed and safe choices
- published the results of an audit of services for people with diabetes
- held 18 events in conjunction with the Commission for Patient and Public Involvement in Health to give patient and public involvement forums guidance on how to play their part in the annual health check
- attended the Labour Party Conference in Brighton and the Liberal Democrat Party Conference in Blackpool.
- published the results from our survey of patients of primary care trusts

October 2005

- launched an investigation at Cornwall Partnership NHS Trust
- appointed a team of experts to deliver our new responsibilities for the regulation of controlled drugs
- 100% trusts lodged their draft declaration as part of the annual health check by the final date for submission
- held the Healthcare Commission staff conference
- gave evidence in the House of Lords with CSCI in response to the second joint chief inspectors report on safeguarding children (July 2005)
- attended the Conservative Party Conference in Blackpool. This included a meeting with the whole of the Conservative health team

November 2005

- hosted a seminar on the future of health and social care regulation
- launched a consultation on our Three year strategy for adults with learning disabilities
- carried out 120 visits and spot checks as part of our assessment of how NHS organisations were meeting core standards

December 2005

- launched a consultation on our strategy for engaging with patients and the public
- launched a consultation on our proposals for *Regulatory fees for independent healthcare sector* and *Aligning our assessment of the NHS and independent healthcare sectors*
- published interim findings on *Management and surveillance of Clostridium difficile*, working in partnership with the Health Protection Agency
- published our *Snapshot of hospital cleanliness in England* report
- published our findings from the first census of inpatients in mental health hospitals and facilities, working in partnership with the Mental Health Act Commission and the National Institute for Mental Health in England
- attended the National Institute of Health and Clinical Excellence (NICE) conference and NHS Live
- published the first set of joint area reviews of services for children

January 2006

- launched an investigation at Oxford Radcliffe Hospitals NHS Trust
- published findings from an investigation and a review into alleged bullying and harassment at Devon Partnership NHS Trust and East Sussex Hospitals NHS Trust
- published our revised race equality scheme
- held five events with providers of independent healthcare
- publishing findings from our investigation at Mid Cheshire Hospitals NHS Trust

February 2006

- launched an investigation into services for people with learning disabilities at Sutton and Merton Primary Care Trust
- issued a statement on the latest MRSA figures
- published *Tackling child obesity – first steps*, a joint piece of work with the Audit Commission and National Audit Office

March 2006

- launched the *Count me in census 2006*, which includes learning disabilities for the first time
- published the results of our head and neck cancer audit
- published *Living well in later life* – a report on services for older people
- published our findings of the care and treatment of Christopher Alder – a joint investigation with the Independent Police Complaints Commission
- launched our consultation on *Developing the annual health check 2006/2007*
- published our report, *Findings relating to the independent healthcare sector in England 2004/2005*
- launched phase 2 of the Concordat with new signatories, a website and a scheduling tool
- held eight events with trusts and local partners to provide them with the latest information on the annual health check

Promoting a better experience of health and healthcare

Our new system of assessing the performance of NHS organisations was implemented last year and our programme of improvement reviews is helping to ensure that trusts continue to improve.

The journey a patient takes through the healthcare system is not as straightforward as it once was. Many more patients are receiving care and treatment from a combination of NHS and providers of independent healthcare. Our work must ensure that standards are met, regardless of who provides the service.

Our key activities in 2005/2006

Engaging patients and the public

Our vision for services in healthcare is shaped by the needs and views of patients and the public. In December 2005, the Commission launched a consultation on our national strategy for engaging patients and the public. The strategy set out our proposals for putting what matters most to patients and the public at the heart of our work.

During 2005/2006, we also established a network of people (champions), based in the regions, to help deliver this strategy. We trained our own staff on why it is important to engage patients and public, as well as the most effective ways to do it. We worked closely with patient and public involvement forums and overview and scrutiny committees, to help them understand and get involved in the annual health check. We ran a series of workshops, which brought together clinicians, patients and the public, to consider how best to develop the system in the future.

We have established two test sites, in the south west and Bradford areas, to work with local patient-led and community based groups to develop and test local models for effectively engaging patients and the public. Working with the University of Central Lancashire, we have established our arrangements for reaching 'seldom heard' groups.

These activities are having an impact on our work in many ways. Feedback from events and forums are shaping the ongoing development of the annual health check – particularly our approach for 2006/2007.

"The Government has set itself the aim of a 'patient-led NHS'. But our health services still have a long way to go before we can say that they are really putting patients first. Being an NHS patient is too often a frustrating experience. Services can seem fragmented and seem to be designed more to suit the needs of those providing them than those using them. People want better access to services. They also want to understand what doctors tell them and to be treated, and spoken to, in a caring manner. They need more comprehensive information about their health, appropriate involvement in the decisions about their care and advice on how to look after themselves when they leave hospital."

Professor Sir Ian Kennedy
Chair, Healthcare Commission

They are helping us to increase the involvement of public and patient engagement forums, overview and scrutiny committees and the voluntary sector, in the annual health check as well as our other improvement work. We are also using the feedback to develop new and more accessible information products, particularly about the Healthcare Commission and the performance of local healthcare organisations. And we are monitoring the effectiveness of all our engagement activity, to help us to improve the way we engage with patients and the public in the future.

Assessing the performance of healthcare organisations

In July 2005, we awarded performance ratings to all NHS trusts in England, using the star ratings system. It was the final time that we will rate performance using this system.

The ratings for the 2004/2005 financial year assessed performance in meeting targets that have become progressively tougher each year. The ratings showed an overall improvement in the performance of the NHS. There was a rise in the overall number of trusts with the maximum three stars, up from 146 in 2003/2004 to 165. There was also a fall in the number of trusts with zero stars, down from 35 to 24. However, almost a quarter of all the trusts failed to achieve financial balance for the year.

From 2005/2006, we will assess performance using our new system – the annual health check.

The annual health check

On March 31st 2005, we launched our new system of assessment – the annual health check. During 2005/2006, we focussed on embedding this new system.

The annual health check measures performance by reference to standards set by the Government as well as targets. The standards describe the overall level of quality that healthcare organisations are expected to meet across a range of areas. They are more broadly based than the targets previously used in assessments, providing a richer picture of how healthcare organisations are performing as well as the experiences of patients when they move between different healthcare organisations.

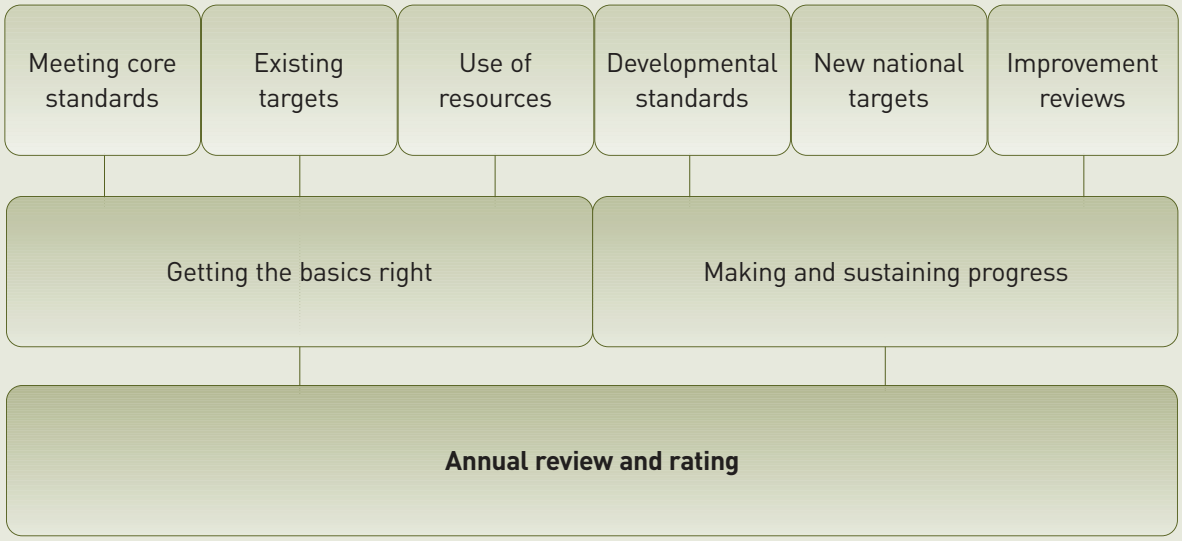
The annual health check is designed to help us answer two questions:

- is the organisation getting the basics right?
- is it making and sustaining progress?

To answer these questions, our new system has several components that are assessed and reported on separately. These components will be brought together to produce an annual rating of performance for each trust (see figure 1).

For some of the components, we are asking trusts to make a public declaration each year on how well they consider they are meeting the core standards. We will then check the declarations against a wide range of information we have gathered through surveillance, including the views of patients and the public, and follow up where there are concerns.

Figure 1: The framework of assessment



Our aim is that assessment of performance – and the information that is provided by the process – will promote improvements in healthcare in a range of ways. It will help people to make informed decisions about their care, promote the sharing of information and provide organisations with clearer expectations on standards of performance.

The draft declaration process

In October 2005, we asked trusts to make a draft declaration of how far they were meeting core standards. This draft process provided an opportunity for us to develop a common understanding with healthcare managers, clinicians and patients, of what constitutes 'satisfactorily meeting' the standards.

All trusts made their draft declaration on time. We checked the declarations against other sources of information, and carried out spot checks at almost 120 NHS trusts.

In the future, trusts will only make a declaration once each year – in May. Performance ratings will be awarded in October 2006.

The annual health check provides an important assurance that providers of healthcare in the NHS are meeting a minimum standard of performance. In addition to providing this safeguard against poor performance, we believe that we should promote improvement by stretching even trusts that are performing at the highest standard.

In March 2006, we launched a consultation exercise, setting out our proposed approach to measuring improvement in NHS organisations. This approach is based on the developmental standards set by the Government, which are designed to drive up the quality of care that patients receive.

In March, we also announced our plans to change the annual performance rating given to NHS trusts as a result of the annual health check. Instead of summarising performance in a single score, we will give trusts a rating in two parts: quality of care and use of resources. NHS trusts will be given a score for each of these areas on a four-point scale that ranges from 'excellent' to 'weak'. This new approach will enable us to provide people with a clear picture on quality, while being tough on issues of resources where necessary.

We have commissioned an independent evaluation of the annual health check. Initial results are very encouraging, and suggest that NHS trusts rate the new system positively. In particular, trusts reported that the annual health check gives them greater 'ownership' of improvements in quality and will improve the care of patients. Some trusts mentioned that the annual health check has raised the priority of quality and governance within their trust, and in particular, how they are linked to performance.

We intend to commission a second stage evaluation to assess whether the costs associated with the annual health check have settled down and the benefits realised after a year in operation.

"We have developed a completely new way of assessing the performance of healthcare organisations. This is an important step in reassuring patients and the public that general standards are met across the NHS. This is a new way of working and the early signs have been encouraging. Every trust in the country made a declaration on time and we attracted good contributions from representatives of patients and the public.

Experience shows that when organisations have a problem you normally pick up the signs in several places, which is why it is important to use different sources of information. Working this way also means we can be targeted and proportionate in our inspection, going in only where necessary."

Anna Walker
Chief Executive, Healthcare Commission

Our programme of improvement

We are committed to promoting improvement in health and the quality of healthcare, and have developed a wide programme of work to achieve this. We have carried out a small number of reviews, which will provide assessments of performance and outcomes that are more in-depth and patient centred in a small number of priority areas. There are two types of review – improvement reviews and the acute hospital portfolio.

Improvement reviews assess the progress made by healthcare organisations in ensuring continuous improvement in a small number of areas of national priority. The reviews focus on aspects of health, such as a particular service, group of the population or condition, concentrating on areas. Each organisation assessed in an improvement review is given an assessment score that feeds into their annual performance rating. In 2005/2006, we undertook three improvement reviews: substance misuse, tobacco control and services for children in hospital. We also began two additional reviews: heart failure and adults' community mental health services.

Improvement reviews carried out in 2005/2006

Substance misuse
The improvement review into substance misuse was undertaken in partnership with the National Treatment Agency (NTA). It focused on two related substance misuse themes: provision of specialist community prescribing services, and planning and coordination of care.

Tobacco control
The improvement review into tobacco control was carried out to assess the contribution primary care trusts make to reducing the prevalence of smoking in the local population and to reduce exposure to second hand smoke. The improvement review is part of a wider piece of work to improve the health of the public.

Services for children in hospital
The improvement review into services for children in hospital was carried out to assess the quality of healthcare provided to children in hospital. It was based on elements of the hospital standard in the National Service Framework for Children, Young People and Maternity.

The Kennedy report into failings in the heart services for children at Bristol found that children were inappropriately regarded as 'mini adults', many staff had not received child specific training, services were disparate and unconnected and that none took overall responsibility for children. These themes were taken up in this improvement review.

We will publish the results of these improvement reviews during 2006/2007. They will be available on our website **www.healthcarecommission.org.uk**.

The acute hospital portfolio focuses on our responsibilities to monitor value for money in the NHS. It consists of in-depth reviews covering the experience of patients, quality of care, clinical effectiveness and overall efficiency. This year, we carried out three acute hospital portfolio reviews: ward staffing, day surgery and accident and emergency, and published our results throughout the summer. We also began reviews into the management of medicines, management of admissions and diagnostic services. We will report on these in 2006/2007.

Inspecting and registering providers of independent healthcare

We are responsible for registering and carrying out annual inspections of independent healthcare services in England. Registration confirms that a service is fit for its purpose. Our inspections ensure that providers of services continue to comply with the relevant regulations and standards.

On March 31st 2006, there were 1,819 independent healthcare establishments registered with us. During the year, we undertook inspections at 1,370 establishments. The difference in these numbers is because establishments that were registered for the first time during 2005/2006 will not be inspected until 2006/2007. This illustrates the continuing growth in registrations.

When we have concerns about the safety of patients and the public, we have the power to issue an enforcement notice.

Following concerns about the treatment and welfare of adolescents with learning disabilities and mental health problems at an independent sector hospital, we made an application to seek an emergency order to close the unit. As a result, the unit was voluntarily closed.

Government policy now enables providers of independent healthcare to compete for contracts and provide services on behalf of the NHS. By 2008, one in seven non-emergency NHS patients may be treated in hospitals and clinics that are run by the independent sector. As a result, it is no longer appropriate to regulate services in the independent sector by different standards from those used in the NHS.

In December 2005, we launched a consultation on our proposals to modernise the way we regulate independent healthcare, in particular how we could align this with our system of assessment in the NHS. We also consulted on our proposed regulatory fees for the independent sector, as we move towards full cost recovery by 2008.

Throughout January and February we held consultation events across the country. We received 89 responses to our consultation on alignment and 127 responses to our consultation on fees.

There was strong support for the principle of alignment and for deciding the frequency of inspection according to risk, rather than a 'one size fits all' approach. As a result, towards the end of 2005/2006 we worked with the Department of Health to revise regulations and finalised the rules for triggering inspection visits. These came into effect on April 1st 2006.

There was also strong support for the principles of our new scheme on fees, particularly the idea of making the level of fee proportionate to the actual costs of the interventions required. However, there was uncertainty over the calculation of charges per overnight beds. The final proposals that we submitted to Ministers included phasing in some changes in shadow form only in 2006/2007.

Surveys of patients and NHS staff

Our national programme of surveys provides insights into the experiences of people who provide and use NHS services. They help to inform our local assessments, visits and reviews, and continue to be a key measure of our work.

Our annual survey of NHS staff is the world's largest annual survey of the healthcare workforce. It provides employers, policy makers and national regulators with information about the attitudes and experiences of staff in the NHS. This information is used to assess the performance of NHS organisations as employers, and to monitor the implementation of national policies designed to improve the working lives of staff and provide better care for patients. In 2005/2006, all 570 NHS trusts took part in the survey and responses were received from more than 209,000 employees. As part of the annual health check, we will use the results of this survey in our assessment of the performance of NHS organisations in relation to core standards.

In 2005/2006, we completed repeat surveys of people who use local health services, people who use community mental health services, and emergency and elective hospital inpatients. We also undertook a follow-up to the survey last year of people who have had a stroke. More than 225,000 people took part in these surveys. Detailed findings are available on our website **www.healthcarecommission.org.uk**.

Our health

With an aging population and increasing financial deficits, action to prevent disease and reduce ill health is a necessity. We have a role in ensuring that healthcare organisations develop and deliver effective public health programmes, including preventing ill health, reducing inequalities in health and protecting the population from infectious diseases.

The focus of our work in 2005/2006 has been to ensure that we are assessing the delivery of key public health issues. These include tobacco control, childhood obesity, sexual health and accidental injury in those aged under five.

Tobacco control is the single most important public health issue in the UK. We have undertaken an improvement review to assess how well primary care trusts were managing and delivering tobacco control programmes and helping people quit smoking. The results of this review will form part of the overall performance ratings awarded in October 2006.

Another major public health problem is the rise in childhood obesity. In partnership with the Audit Commission and the National Audit Office, we produced *Tackling child obesity: first steps*. This study found that a lack of coordination and strong evidence of what works at a national, regional and local level jeopardises the achievement of important national targets to reduce childhood obesity.

We have also carried out a pilot study of sexual health services. The findings of this will contribute towards the drive for improvement in the collection of data and the delivery of sexual health services within the NHS. We also began work on a national study into preventing accidental injury for children, especially those aged under five, which will report later in 2006.

"The best services involve the people they are there to serve. They must be responsive to their needs and assist hem to lead independent, fulfilling lives. The evidence from this study is that older people are not involved in the design of services and consequently services are not tailored to their needs and aspirations. It is vital to understand and respond to the specific needs of older people."

David Behan
Chief Inspector of the Commission for Social Care Inspection

Older people

The Healthcare Commission, the Commission for Social Care Inspection and the Audit Commission have worked together to assess the progress of the NHS and local authorities in meeting the standards set out in the National Service Framework (NSF) for Older People.

Our joint report *Living well in later life* found that services have improved since the March 2001 publication of the national service framework. But this progress was not consistent across the country and improvement in some areas had been slow. Some particular areas for concern were the lack of joint vision, strategy and commissioning for older people across health and local government, and the fact that older people are not involved systematically in planning and shaping services. The report also found that dignity, respect and privacy on wards can be poor and that there is a lack of attention to assistance with eating and drinking on hospital wards.

Living with long term conditions

There are an estimated 17 million people who live with one or more long term condition, including heart disease, epilepsy, arthritis, diabetes and multiple sclerosis. Living with these conditions can place enormous pressures on individuals and their carers. Providing care for those with long term conditions accounts for a large volume of NHS resources, including as many as 80% of all GP consultations and 60% of all hospital bed days.

For many individuals, there will be times when their condition deteriorates and they require medical intervention. However, it is recognised that there is now an opportunity to provide more

care in settings other than hospitals, and to provide more structured care, which seeks to prevent admissions to hospital in an emergency. This has been reflected in the recent White paper published by the Department of Health – *Our health our care our say*.

This year we began to develop our work to contribute to promoting improvements in the care of people with long term conditions. In recognition of the shift away from care in hospital, and towards more routine and regular care in primary care settings for those with long term conditions, we launched an improvement review of services for those with heart failure (see page 17). This review examines how local health services are able to accurately and promptly diagnose heart failure, and offer effective clinical care, which helps to prevent emergency admissions into hospital.

We also carried out a national review of chronic obstructive pulmonary disease (COPD), which is due to publish in 2006/2007. This review examines patterns of care provision for those with COPD and draws upon examples of where services have been developed to reduce emergency admissions into hospital. We also began to develop an improvement review of diabetes, which will assess the extent to which those with diabetes are supported to manage their own condition.

We have also run a series of focus groups, where we have met with individuals who have these long term conditions to ask them where there is greatest scope for improvement in the healthcare they receive and what aspects of their healthcare are most important to them. We have then used this information to help us shape the development of our reviews.

Children

Over the last year, our work on safeguarding the welfare of children has developed and expanded. We have been working closely with nine other inspectorates, including Ofsted, the Commission for Social Care Inspection and the Audit Commission, on a programme of joint area reviews of services for children. We provided inspection support to 31 reviews during the year. The programme will continue to roll out across the 150 local authorities and we will remain involved in the management and future development of the joint inspection programme.

Early findings from the reviews indicate that the inspections are generally valued by local authorities and raise the profile of services for children within primary care trusts. They also show that children and young people generally enjoy good health. They are also identifying innovative joint agency models for health promotion and opportunities to expand joint working on issues such as reducing teenage pregnancy.

We have also been working with Her Majesty's probation service to carry out inspections of youth offending teams. We have jointly published 60 reports. Since the YOT inspection program began in September 2003, there has been some improvement in the availability of healthcare services for children and young people who offend. However, there is still much work to do. In particular, services need to be made more accessible for those aged 16 and 17, who are in the age group that are responsible for the majority of youth crime and the more serious crimes.

In February 2006, we published the second joint chief inspectors' report into safeguarding children and young people, which was a joint piece of work with the Commission for Social Care Inspection, Ofsted and Her Majesty's probation service. Following the publication of this report, we gave evidence in the House of Lords. We also ensured that safeguarding children featured in the assessment of core standards in the annual health check, and we have trained our regional staff in safeguarding children.

Maternity services

Following the publication of standard 11 (maternity services) of the National Service Framework for Children, Young People and Maternity Services, there have been a number of initiatives and increased interest in provision of maternity care. As a result of three investigations into maternity services in three years, we have developed a programme of work to identify those maternity units in need of support or review. We are also building strong links with key organisations involved in setting standards, monitoring and improving maternity services across England.

Mental health

Over the past year, we have undertaken several pieces of work on mental health. We published our results of the first national census of ethnicity among inpatients in mental health hospitals and facilities in England and Wales (see page 42). On March 31st, the census was repeated, and extended to include 5000 people with learning disabilities.

We also

- piloted a joint review with the Commission for Social Care Inspection on community mental health services
- provided policy guidance through project boards and working groups to the Department of Health on key standards for services for mental health inpatients and the development of measurable outcomes for people with mental health needs
- worked with other regulatory bodies through the Concordat (see page 37) to ensure that our respective work programmes complement each other and do not duplicate
- gave evidence to the Disability Rights Commission inquiry into access to primary care services by people with a mental health need or learning disability

Our work in Wales

The responsibility for the local inspection of, and investigations into, the provision of healthcare by NHS bodies in Wales rests with the Healthcare Inspectorate Wales. However, we do have certain responsibilities, which cover England and Wales, relating mainly to national reviews and our annual state of healthcare report.

We provide a significant programme of national clinical audits, and during 2005/2006 we funded 27 projects covering a wide range of different types of healthcare including cancer, coronary heart disease, long term conditions, mental health and children and maternity services. The NHS in Wales has participated in a large number of these audits and will continue to participate in the programme of clinical audits.

We are also working closely with the Welsh Assembly Government, Healthcare Inspectorate Wales and the Wales Audit Office and other bodies in Wales to share learning through our national work in England. A public health workshop was held in Wales in November 2005 to discuss issues of shared learning from the improvement review of tobacco control and the pilot improvement review of sexual health. In addition, we have also shared learning arising from our investigations in England, in particular in maternity services. As a result the Healthcare Inspectorate Wales will be undertaking a thematic review of maternity services in Wales through 2006/2007.

In December 2005 we published our findings from the national census of inpatients in mental health hospitals and facilities, which covered England and Wales (see page 42). We also met our obligations under our Welsh Language Scheme, which sets out how we will implement the Welsh Language Act.

In May 2005 the main external review bodies inspecting, regulating and auditing health and social care in Wales published a Concordat (agreement). The Concordat will support the improvement of services for patients, service users and their carers and to eliminate unnecessary burdens of external review. The Healthcare Commission is a signatory and, during the year, we have been working closely with the Healthcare Inspectorate and partners to implement the Concordat.

Safeguarding the public

We have used our legislative powers to take appropriate action to safeguard patients in the NHS and independent healthcare sector. We are delivering our independent system for reviewing complaints about the NHS. And our reports on cleanliness and the control of infections in hospitals were key features of our programme to safeguard the public.

The annual health check is playing an important role in ensuring that healthcare services are safe and that healthcare organisations are taking steps to minimise risk.

When things do go wrong, our role is two-fold: to assure the public that we can identify problems and hold healthcare organisations to account, and to reduce further risks by ensuring that lessons are learned by the wider healthcare service.

Our key activities in 2005/2006

Investigations and interventions

In 2005/2006, the investigations team received 85 referrals, which were reviewed and followed up in a range of different ways. In some instances, we announced formal investigations. In others, visits were made to trusts, some unannounced, to gather further information and a number of specific recommendations were made to improve services – all of which are monitored to ensure compliance.

During 2005/2006 we published the findings of five investigations, carried out one follow-up investigation and began another five.

In May 2005, we published the results of our investigation at Bolton, Salford and Trafford Mental Health NHS Trust. The investigation resulted from allegations of errors in prescribing, dispensing and administering controlled medication within the in-patient service at Kenyon House, Manchester. The investigation found that Kenyon House relied on an out of date policy for handling drugs, record books were often incomplete and illegible and the unit operated with low staffing levels and a high use of bank and agency staff. We also made a range of recommendations including that the trust take immediate action to ensure that the correct amounts of medication are measured by a qualified nurse and checked by a trained witness and the amount of medication left on the ward at the end of the day is correctly measured and recorded.

In 2005/2006, we published the results of our investigation at North West London Hospitals NHS Trust following a number of adverse events in maternity services at Northwick Park Hospital. Our concern increased following a further maternal death at the trust in April 2005 and special measures, recommended by the Healthcare Commission, were put in place at the trust as a matter of urgency. Special measures are designed to generate improvements where other methods have failed, or are considered likely to do so.

In June 2004, a nurse was convicted of two separate charges of attempted murder of patients at the Mid Cheshire Hospitals NHS Trust. In January 2006, we published the results of our investigation into the trust's systems and procedures at the time of the incidents and subsequently to establish whether these were appropriate to protect the safety of patients. The investigation found that poor leadership and management, staff shortages and a lack of learning from complaints, resulted in the safety of patients being compromised.

In January 2006, we published the results of one investigation and one review into allegations of bullying and harassment by trust staff at East Sussex Hospitals NHS Trust and Devon Partnerships NHS Trust. These identified significant weaknesses in human resources policies, procedures and advice, and the lack of a formal structure for dealing with complaints made by staff.

As a result of all of our investigations we highlight a wide range of recommendations, both at a national and local level, and work with the organisations involved to develop an action plan detailing how they will meet these recommendations.

Care and treatment given to Christopher Alder

In December 2004 the Independent Police Complaints Commission (IPCC) requested the Healthcare Commission's assistance in investigating the circumstances leading up to the death of Christopher Alder, who died in police custody on April 1st 1998. The IPCC asked us to assess the healthcare provided to Mr Alder and the interface between the acute trust, ambulance service and police.

In March 2006 we published our findings, alongside the full IPCC report. We found that while staff tried to provide appropriate care, crucial information was not obtained or passed on which would have helped make appropriate decisions about his care and treatment. We called on the NHS and police to introduce new safeguards at a national level for handling patients in accident and emergency units when the police are involved.

The full 400 page IPPC report, described the behaviour of the officers present at the time as "disgraceful". Nick Hardwick, Chairman of the IPCC, said: "I believe the failure of the police officers concerned to assist Mr Alder effectively on the night he died were largely due to assumptions they made about him based on negative racial stereotypes."

We are continuing to work with all the parties involved in this investigation to drive forward the improvements and recommendations outlined in the report.

Management, prevention and surveillance of Clostridium Difficile

The Healthcare Commission and the Health Protection Agency jointly undertook a survey into the management, prevention and surveillance of *Clostridium difficile* – a healthcare-associated infection that can cause diarrhoea, which in severe cases, leads to more serious conditions and occasionally death. The survey was a self-assessment by trusts.

The interim findings of the trust self-assessment survey were published in December 2005, and revealed that over one third of trusts surveyed said they were not routinely following best practice with regards to minimising the risk of this infection, and were unable to routinely isolate these patients.

The survey was part of our investigation into Buckinghamshire Hospitals NHS Trust, following earlier outbreaks at Stoke Mandeville Hospital, and provided an important national context. The findings will also be incorporated into our future programme of work.

As a result of the report the chief medical officer, Professor Sir Liam Donaldson and chief nursing officer Christine Beasley warned hospitals to review procedures for handling cases following checks by the Healthcare Commission, the NHS inspectorate and the Health Protection Agency, who said it was "deeply worrying" that hospitals were not following guidance.

Dealing with complaints

The Healthcare Commission is responsible for dealing with complaints about the NHS in England that cannot be resolved locally.

From August 2004 to end of March 2006, 13,412 requests for independent review were received and 8,205 cases were resolved. In 2005/2006, the number of incoming cases (7577) and the number of completed case (7374) was broadly similar. However, the Commission is also carrying a backlog of cases that currently stands at 2,500 cases over six months old.

Who and what were the complaints about?

Of the complaints we received, 34% were in relation to acute trusts, 18% were complaints about PCTs and 9% were related to mental health trusts. The key themes raised were poor communication, the quality of how complaints are handled locally, clinical practice and the experience patients have of the care they receive.

During the year we met with trusts who had a high level of referrals of complaints and issued a protocol setting out our expectations for good handling of complaints. We have worked with the Parliamentary and Health Service Ombudsman and a range of other interested parties to create a new standard on managing complaints for the NHS that focuses on resolution rather than process.

Throughout the year we have increased budget and staffing levels, and processes have been streamlined, in an attempt to increase the efficiency of the work and provide more timely resolution. In 2004/2005, we allocated £3.1 million to this work and ended the year with a staff of 43. In 2005/2006, we increased the budget to £7.9 million and ended the year with a staff of 95. We will publish a full report on our handling of NHS complaints in the autumn. To fulfil our function of ensuring that registered providers meet the applicable standards, we also deal with complaints made to us in relation to the independent sector. As with the NHS, the complaint must first have gone through the establishment's own complaints process.

Complaints about independent healthcare providers

We have no statutory role in reviewing second stage complaints for independent healthcare providers and have no powers to direct providers towards a particular remedy for a complainant. Our approach in dealing with complaints about providers is to focus on ensuring they have followed their own complaints policy fully. Where possible breaches of regulations are highlighted by complaints we will follow this up, by inspection where necessary, to make sure improvements are put in place. In 2005/2006, we received 464 complaints about independent providers, and we investigated 327. The majority of complaints were related to the treatment and care of a patient.

Safety

Surveys consistently tell us that patients and the public are concerned that healthcare is not as safe, and our hospitals not as clean, as they would expect.

In late 2004, the Chief Medical Officer asked us to carry out a review of cleanliness and control of infection in hospitals in England. In response to this request, we decided to undertake a number of related pieces of work including a longer term national study of healthcare associated infection.

In December 2005 we published the findings from our 'snapshot' inspection of cleanliness in hospitals in England. We undertook unannounced visits at 98 hospitals and found that about a third of hospitals visited had high standards. However, we found much lower standards in around 20% of establishments, with some NHS mental health hospitals scoring very poorly. For these establishments, we requested significant improvement action to be undertaken.

Mental Health charity Mind called for an improvement in the "shocking condition" of mental health hospitals in light of the report. "There must be a change of culture within mental health services to raise standards of hospital cleanliness. Only then will service users' basic dignity be ensured."

In early 2006 we piloted a major review of the prevention and control of healthcare associated infection (including MRSA). This has been taken forward as a national study starting in April 2006, with the objective of identifying how patients can be better protected from avoidable infections. We also contributed to the development of the statutory code of practice on healthcare associated infections and have started preparing for our new duties in relation to assuring compliance by healthcare organisations.

Safe management of controlled drugs

In October 2005, we appointed a team to regulate the management of controlled drugs in England. This was to deliver the new regulatory responsibility we were given following the recommendations from the Fourth Shipman Inquiry Report.

The role of the team is to provide external assurance of both new and current arrangements for the monitoring and inspection of controlled drugs in healthcare organisations.

The team has already established a national group of regulatory partners, which includes the Commission for Social Care Inspection, Royal Pharmaceutical Society, Association of Chief Police Officers, Home Office and the Department of Health. The group first met in October 2005 and is meeting quarterly to analyse themes and trends in the management of controlled drugs.

We are also assessing information on controlled drugs in the annual self-declaration forms obtained from NHS trusts, as well as continuing to monitor the management of controlled drugs in the independent sector.

Our regulatory responsibility in this area is limited to England, however we have forged strong links with partners in Scotland, Wales and Northern Ireland to ensure sharing of themes and trends. Representatives from these countries are attending the national group meeting.

Providing authoritative, independent and relevant information

As an information-driven regulator whose remit covers both the public and private sectors, we are uniquely placed to offer an authoritative view of the quality and efficiency of healthcare organisations. We collect, use and publish information for healthcare organisations, other inspectorates, patients and the public. We have begun an ambitious programme to make our information accessible, to enable it to be used in many ways.

We aim to be an authoritative and trusted source of unbiased information on healthcare quality that will enable people to make informed healthcare decisions and be used to drive improvement.

Our information strategy is helping us realise our vision of becoming a risk-based regulator. The screening methods we devised have helped us analyse the information we collected for the annual health check so that we can direct our inspection staff where they are most needed. Increasingly it will allow us to respond promptly when things go wrong.

Over the year we have developed our information systems – notably our customer relationship management information system that will allow us to integrate all the information we hold on organisations or individuals – from complaints to inspection reports – so that we hold a single view of each.

Our key activities in 2005/2006

Making information accessible and available

The Healthcare Commission holds, and has access to, vast amounts of information relating to health, healthcare organisations, patients and the public. Our aim is to develop more effective ways of compiling and sharing this information, so that we can provide a richer picture of healthcare, support staff in their work in providing care, enable patients and the public to make positive choices about healthcare, and promote improvement.

In December 2005, the Department of Health launched a new patient leaflet, *Choosing your hospital*, which explains how patients can choose where they are treated from a list of hospitals and clinics in their local area. We worked closely with the Department of Health on this leaflet, providing information about how each hospital performs against some of the Government's main targets. The indicators in the leaflet are the ones that we and the Department of Health felt mattered most to patients, such as waiting times, cancelled operations, cleanliness and the results of surveys of patients. The leaflet has been provided to patients through their GPs.

During 2005/2006, we worked with the Society of Cardiothoracic Surgeons of Great Britain and Ireland to develop a website that provides information on outcomes of heart surgery. The site is designed to help patients who need cardiac surgery to make informed decisions about their care and treatment. It provides, for the first time, information about the rates of survival for different types of heart surgery at different units across the UK. It also provides general information about different operations, and tells people what to expect after an operation. The site was launched in April 2006.

The British Heart Foundation said the website "should enable patients to make more informed decisions."

We also continue to explore other ways in which we can make our information more accessible to everyone with an interest in our work. This aim is also linked to our commitment to reduce inequalities in health and healthcare. We provide all our information and reports in other formats and languages on request. This includes Braille, audiotape, easy read and minority ethnic languages. In 2005/2006, we revised our Welsh Language Scheme to ensure that we are appropriately and effectively meeting the needs of people in Wales.

Publishing our findings

We share information in a variety of ways – in publications or reports, through the media, online or by e-mail, or through our obligations under the Freedom of Information Act. Sometimes we use just one channel of information. Often we employ a number of approaches, depending on the audience that we are trying to reach.

Our website
Our website is the one of our most valuable means of providing up to date information about the Commission and our work. Updated regularly, it contains a wide range of information about the organisation and our work programme, access to all of our reports and publications, and links to a number of other sites.

The number of visitors to our website has increased from 95,596 in March 2005 to 142,285 in March 2006.

Our monthly electronic newsletter
Our monthly electronic newsletter (known as the e-bulletin) is another important tool that we use to keep people informed about our work. It is aimed at those working in healthcare organisations, and provides updates to subscribers about all aspects of our work. The number of people subscribing to our monthly electronic newsletter has increased over the year – from 11,000 in March 2005 to more than 15,000 in March 2006.

We have also launched new regional updates for NHS organisations, providing regular information about our work in their area. And we are developing regular bulletins for other stakeholders – such as a clinicians and MPs.

Our reports
Our findings are often published in national and local reports. In 2005/2006, many of our major publications received widespread coverage by the media. Other publications, such as local reports of inspections and action plans, were distributed directly to providers of healthcare and communities to help drive improvements in local healthcare services.

Throughout the year, we published a range of national reports, covering topics as diverse as older people, foundation trusts, mental health and ethnicity, and hospital cleanliness.

Printed copies of our reports are available free of charge by calling our helpline on 0845 601 3012. Electronic versions are available on our website.

State of Healthcare 2005
In July 2005 we published our second report on the state of healthcare in England and Wales. It focused on the experience of patients.

The report asked three questions: do people receive effective healthcare services, do they have enough control over the care that they receive and do some get a better deal from healthcare services than others? While we strongly praised the improvements that had taken place in some services, we also said that the NHS had a long way to go to achieve a 'patient-led' service.

Freedom of Information

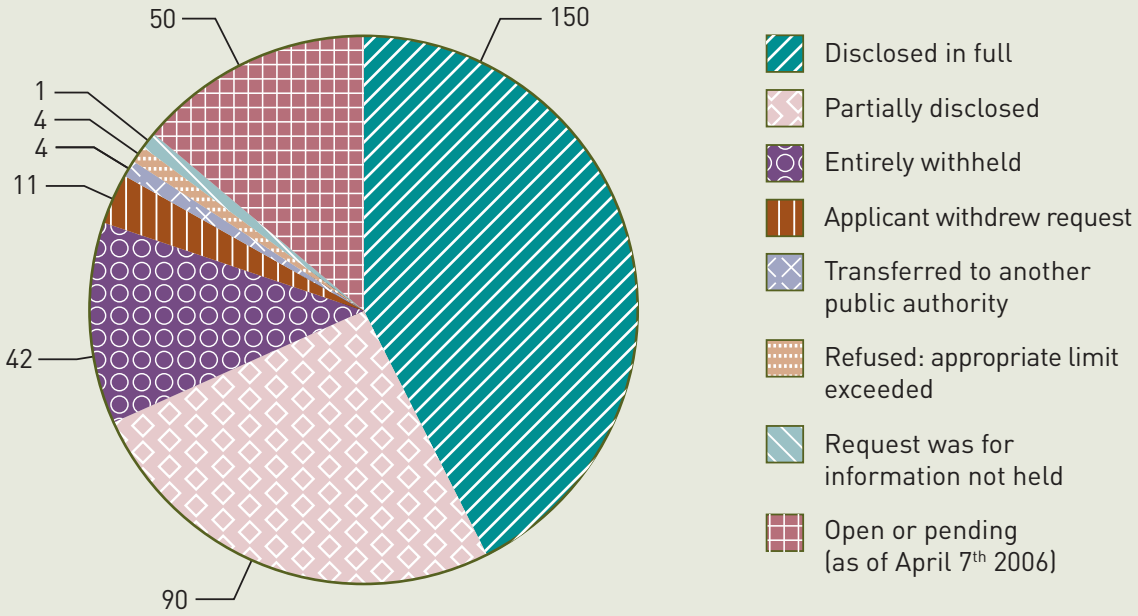
The Freedom of Information Act 2000 came into Force on January 1st 2005, giving people the right to request information held by public authorities (subject to some exemptions). The implications for organisations like the Healthcare Commission were significant.

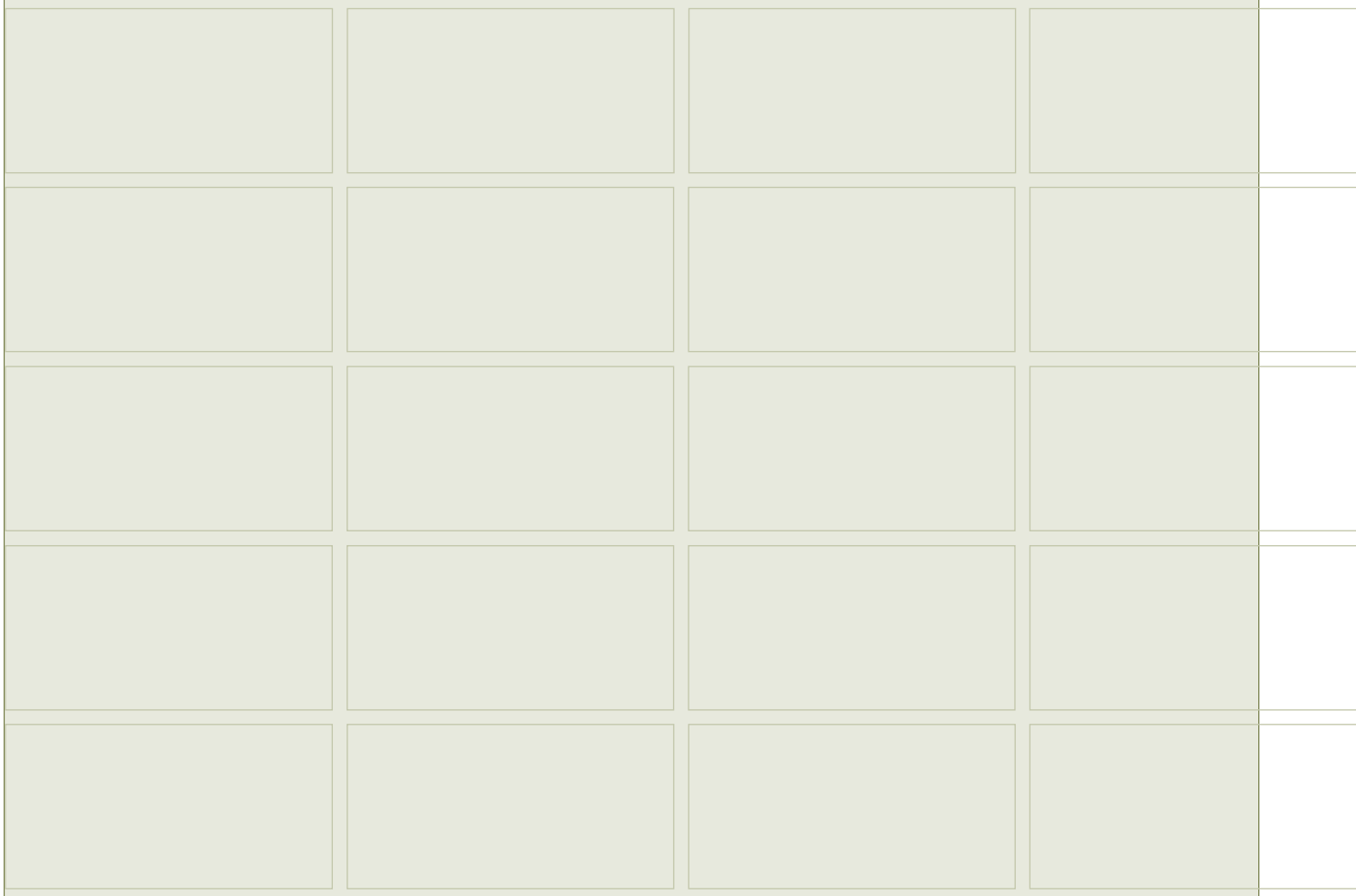
In carrying out our responsibilities under the Act, we aim to comply with two codes of practice – one on handling requests and the other on managing records. Our policy, in common with many other public authorities, is to provide information – however, we refuse requests that are over the cost limit of £450. Instead, we focus on listening to what information patients and the public want, and providing this in an accessible and meaningful way.

In 2005/2006, we received 352 statutory requests for information. Sixty seven per cent of these were made under the Freedom of Information Act, 7% were subject access requests under the Data Protection Act 1998, and 26% were requests involving a mixture of the two regimes.

For 43% of the requests we received, we disclosed the information in full. We partially disclosed the information for 26% of requests. Where we didn't disclose information, the most common reasons were section 40: personal information, section 31: law enforcement and section 22: information intended for future publication. The Freedom of Information Act sets out 23 exemptions to disclosing information. These range from national security to personal information. There is also an upper limit of work which public authorities are obliged to do when responding to a request.

Figure 2: How we dealt with requests under the Freedom of Information Act





Taking the lead in coordinating and improving regulation

We have taken major steps to work more closely in partnership with other organisations and to reduce the burden on healthcare providers.

The Department of Health estimates that more than 50 bodies can inspect or audit the NHS through requests for information. And many more make visits. The Healthcare Commission is taking the lead in coordinating the activities of the different bodies in reviewing health and healthcare services, and this underpins the way we work.

Our key activities in 2005/2006

The Concordat

The Concordat is a voluntary agreement between organisations that regulate, audit, inspect or review elements of health and healthcare in England. These organisations are working together to streamline their activities in order to support the improvement of healthcare services for the public. Following on from the launch of the Concordat last year, we have continued to work with other bodies to implement and develop the principles of the agreement.

In March 2006, we announced the addition of ten new signatories to the Concordat and launched a new website and web-based tool to allow inspectors to share information on their visiting schedules. The aim of the tool is to enable inspection bodies to plan and coordinate activity and prevent unintended clashes of visits. It also allows providers of healthcare to see when visits are planned and to hold bodies that carry out inspection to account. The website is available at **www.concordat.org.uk**. Our regional teams are also developing ways of working with other regulators to maximise efficiency.

We have also been working with organisations signed up to the Concordat and Ofsted, HMI Probation plus some charities for children in drawing up a memorandum of understanding. The Healthcare Commission's children's team also provided inspection support in Wales under our Concordat arrangements.

Signatories to the Concordat

Full signatories

Academy of Medical Royal Colleges
Audit Commission
Conference of Postgraduate Deans
Commission for Social Care Inspection
General Medical Council
Health and Safety Executive
Healthcare Commission
Human Fertilisation and Embryology Authority
Mental Health Act Commission
National Audit Office
NHS Counter Fraud and Security
NHS Litigation Authority
Postgraduate Medical Education and Training Board
Skills for Health

Associate signatories

NHS Confederation
Council for Healthcare Regulatory Excellence
Department of Health
Healthcare Inspectorate Wales
NHS Health and Social Care Information Centre
Quality Assurance Agency for Higher Education

Working in partnership

In 2005/2006, we collaborated with partner organisations on a series of joint reviews and national studies. We:

- published a joint report on obesity in children with the National Audit Office and the Audit Commission
- published a national report on services for older people with the Commission for Social Care Inspection and the Audit Commission
- carried out an improvement review of substance misuse with the National Treatment Agency and launched an improvement review of adult community mental health services with the Commission for Social Care Inspection
- published our findings from the Count me in census in December 2005, which detailed the results from a national census of ethnicity of inpatients in mental health hospitals and facilities in England and Wales and launched the 2006 census in partnership with the Mental Health Act Commission and the National Institute for Mental Health (in England)
- have been working closely with nine other inspectorates, including Ofsted, the Commission for Social Care Inspection and the Audit Commission, on a programme of joint area reviews of services for children
- have been working with Her Majesty's probation service to carry out inspections of youth offending teams
- are working with Monitor and the Audit Commission to use their information to provide a rating for the use of resources element of the annual health check

The Healthcare Commission is working collaboratively on our national studies of health and social care, to avoid duplication and provide a valuable and joined-up response on national priorities. We published a report outlining our combined programme of national studies for 2006/2007 and our approach for 2007/2008. It is proof of our commitment to work together to implement coordinated and complementary programmes.

The Department of Health's white paper, *Our health, our care, our say: A new direction for community services*, confirmed its intention to merge the Healthcare Commission and Commission for Social Care Inspection as part of an ongoing wider review of regulation. To prepare for this, we have begun a challenging programme to align our approaches. The Department of Health has also confirmed that the Healthcare Commission and the Mental Health Act Commission will merge. We already work closely with both the Commission for Social Care Inspection (CSCI) and the Mental Health Act Commission, and will continue to do so throughout 2006/2007.

In order to prepare for the merger a joint partnership board has been created by the three bodies. It meets every month to discuss strategic issues affecting the three partner organisations. An integrated performance assessment group has also been formed between the Commission for Social Care Inspection and the Healthcare Commission, to manage projects that examine the experience of users who receive a combination of health and social care services. This includes groups such as older people, users of mental health services and those with learning disabilities. Other activities include the development of common methods of review, approaches to joint planning of work programmes and consideration as to how to develop methods to assess jointly the commissioning of health and social care.

Focusing on inequalities, human rights and diversity

We have continued to ensure that the principles of equality, diversity and human rights are embedded in all our activities and the activities of those organisations we inspect and regulate.

There are still significant inequalities in the health sector. When the Healthcare Commission was established, we said that we would work to make sure that every person receives healthcare according to their needs, regardless of their circumstances and background.

Our key activities in 2005/2006

During 2005/2006 we set ourselves a challenging agenda to meet our commitments with respect to equality, diversity and human rights. We appointed a dedicated senior post and a small team to provide expertise and strategic direction to the Healthcare Commission on equality, diversity and human rights. We began by publishing our revised Race equality scheme in November 2005. The scheme outlines how we will promote race equality across all our activities. It incorporates a detailed action plan based on our corporate priorities. Major activities in the plan are:

- undertaking a project to check trusts' compliance under the Race Relations Amendment Act 2000 to inform core standards screening and establish a baseline to enable the development of an improvement review
- leading on an improvement review on race equality in partnership with the Commission for Racial Equality
- developing a race equality impact assessment system across the organisation, including training for all senior staff
- establishing a Committee on Equality and Human Rights to monitor progress against the actions in our race equality scheme action plan and wider equality work

We also began to ensure that all our work streams addressed equality, diversity and human rights. For example, the inspection guides developed for our core standard based assessments included specific reference to guidance relevant to equality, diversity and human rights, our survey of patients for 2004/2005 included analysis by disability, our review of the National Service Framework for Older People included diverse groups and focused on dignity and respect and our accessible information project took into account different abilities, disability and the needs of those people for whom English is not their first language.

We have also established relationships with the Disability Rights Commission and Equal Opportunities Commission, and begun developing a memorandum of understanding with the Commission for Racial Equality. This will enable them to feed their information into our process for assessing core standards, which will enable us to become better at highlighting poorly performing trusts in relation to discrimination.

Count me in

In December 2005, we published the results of the first national census of ethnicity among inpatients in mental health hospitals and facilities in England and Wales.

The census, which we carried out jointly with the Mental Health Act Commission and National Institute for Mental Health (in England), has provided a baseline against which we can measure changes in the provision of mental health services in the future. It is part of the Government's wider action plan aimed at improving services for people with mental health problems from black and minority ethnic communities.

Key findings from the census show that Black African and Caribbean people are three times more likely to be admitted to hospital and up to 44% more likely to be detained under the Mental Health Act. They are also more likely to experience seclusion or physical restraint. We need to understand the reasons for this and then act on them.

The census was repeated on March 31st 2006, but was extended to include an estimated 5,000 inpatients with learning disabilities and to collect information on sexual orientation.

Variations in the experiences of patients

In our race equality scheme, we made a commitment to monitor the experiences of black and minority ethnic people using services in the NHS. The Department of Health's *National Standards*, *Local Action* requires the experiences of black and minority ethnic groups to be monitored by independently validated surveys. The Healthcare Commission conducts a number of national surveys of the experiences of patients.

In October 2005, we published a report on variations in the experiences of patients, as reported in the surveys we conducted during 2003/2004. The report echoed previous findings that black and minority ethnic groups respond more negatively in some surveys. For example, in the primary care trust survey, South Asian groups responded more negatively than white responders to access, environment, relationship and information issues.

The variations we have collected from the experiences of patients from our 2004/2005 surveys is due to be published later in 2006. It will focus on the effects of ethnicity and, for the first time, disability on the experience of patients.

Safeguarding the welfare of people with learning disabilities

We are committed to ensuring that the health and healthcare of people with learning disabilities improves, that they have equal access and rights to health services and that the views of people with learning disabilities are heard.

We have developed a strategy to address the inequalities faced by people with learning disabilities. In November 2005, we published a draft strategy for consultation, and liaised with people with learning disabilities, those who use services, families and carers. We published the strategy in an easy-to-read format, on audio tape and on CD Rom. We received over 800 responses to the consultation, most of which were positive about our approach. We are now incorporating comments into the strategy, and the final version will be published in mid 2006.

In 2005, we commenced an investigation at Cornwall Partnership NHS Trust in response to serious concerns about the care and treatment of people with learning disabilities and the urgent need to bring about improvements in the quality of care provided to them. We began to plan a programme of work as a result of the early findings from the investigation. A number of special measures have been recommended after the investigation revealed widespread institutional abuse of people with learning disabilities. The full report has now been published.

In March 2005 we announced that we would be carrying out another investigation into services for people with learning disabilities, at Sutton and Merton Primary Care Trust.

Building a world class regulatory body

Over the year we have changed the way the Healthcare Commission works, making it a regionally-based organisation with strong links to trusts and other healthcare organisations.

We have continued to build a strong organisation, which is capable of delivering a challenging and demanding programme of work, at a time of considerable internal and external change.

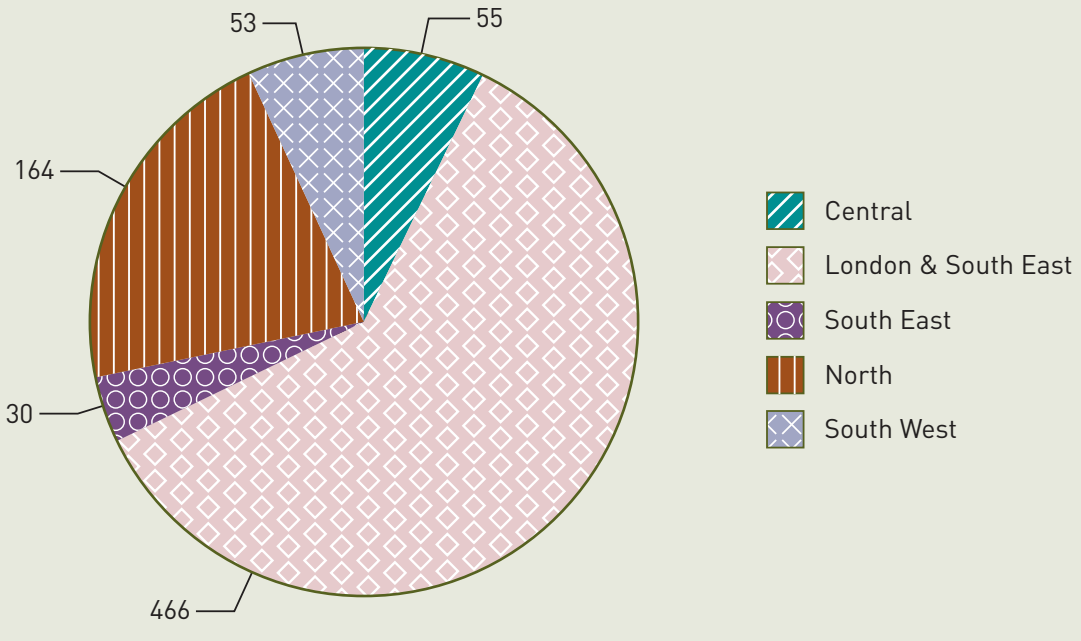
Our key activities in 2005/2006

During 2005/2006, the structure of the Healthcare Commission changed from being centrally based in London to becoming a regionally-based organisation. This has enabled us to develop local relationships with trusts and organisations. For the first time, it has also seen us using our powers to assist providers of healthcare services outside of the United Kingdom for example on the Isle of Man.

Working locally

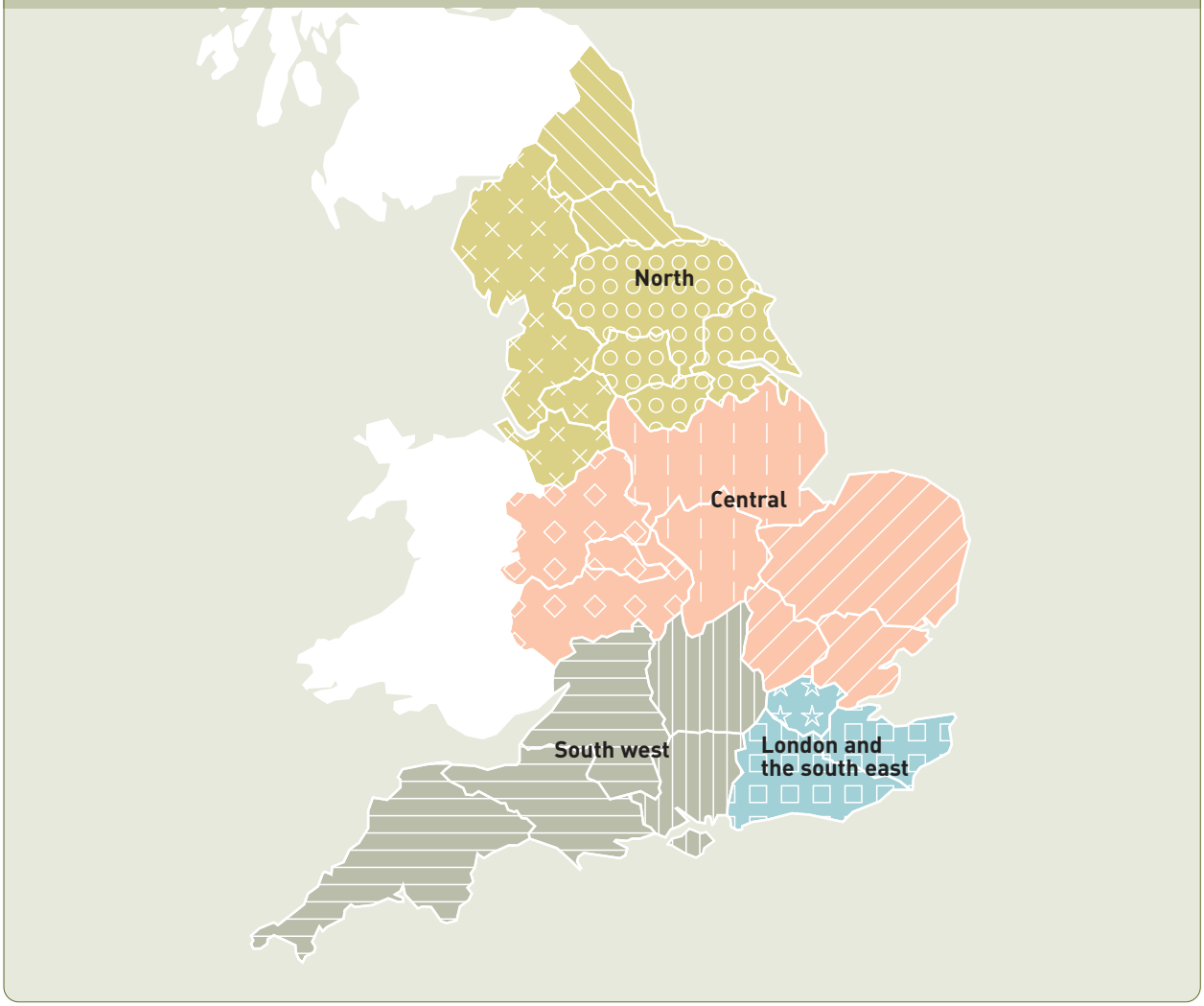
We developed a new regional structure, consisting of four regions (north, central, south west, and London and the south east) and offices in London, Nottingham, Bristol, Leeds, Manchester and Solihull. This regional structure has allowed us to implement and consult widely about the annual health check. It enables us to understand the local health economy (both NHS and independent), develop relationships with providers and respond swiftly when there are issues of patient safety. Trusts and providers benefit from a consistent named contact and a team that has considerable local expertise.

Figure 3: Healthcare Commission staff by region



During 2005/2006, operational staff in the regions established processes and structures to improve ways of working. We have developed a business plan, based on corporate objectives, which allows detailed regional planning and prioritisation.

Figure 4: Healthcare Commission regional offices



Investing in our staff

We have moved forward with our vision of learning and development, to ensure that our staff continue to "be the best at what they do and aspire to be the best that they can be." This has included introducing a system of pay and performance for staff and announcing our commitment to achieving Investors in People accreditation.

We have focused on building leadership capability. A leadership development programme – 'Leading Improvement' – was designed to support our senior leadership team. The programme included 360-degree feedback, which gave leaders an insight into how their individual behaviour directly affects peers, direct reports and managers. Each senior leader received coaching to guide them through the results of the questionnaire, and learning sets were established to ensure continual development. An emerging leaders programme was piloted, with the aim of recognising and developing high potential at all levels throughout the organisation.

A competency framework was introduced outlining core behaviours, skills, knowledge and attitudes that lead to effective job performance at the Healthcare Commission. Linked to the performance development review, the competencies have provided a constructive model for staff to discuss how they have achieved their objectives and to help identify areas for personal development. The competencies also underpin our extensive programme of training (for example, presentation skills, project management, coaching skills) offered to support individuals in meeting their objectives.

Staff engagement has also been a priority for investing in our people. A staff conference in October provided a unique opportunity for all Commission staff to come together. Throughout the year, we have provided opportunities for staff to have their opinions heard and we are committed to responding to their concerns.

Figure 5a: Healthcare Commission staff by ethnic origin

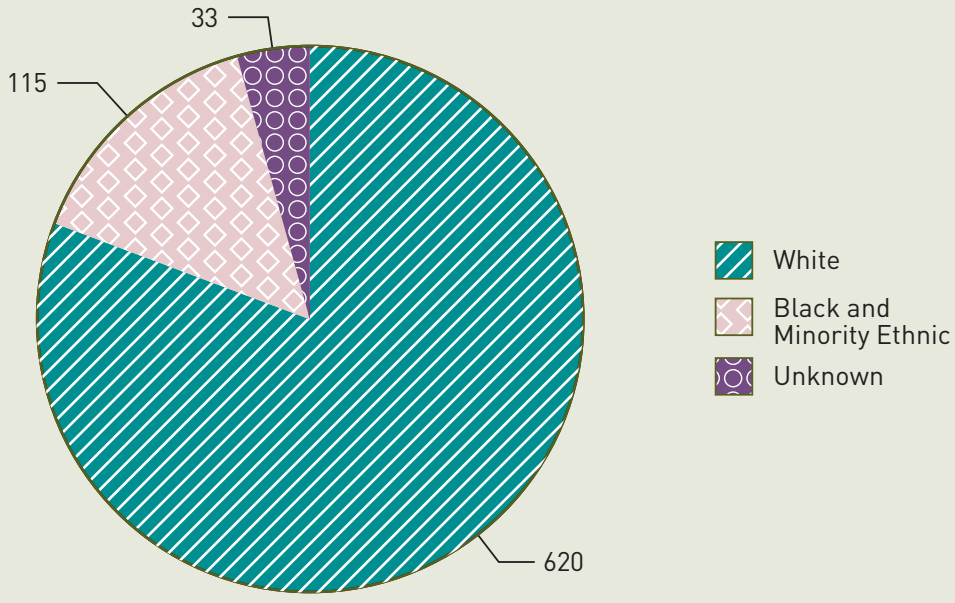


Figure 5b: Healthcare Commission staff by gender

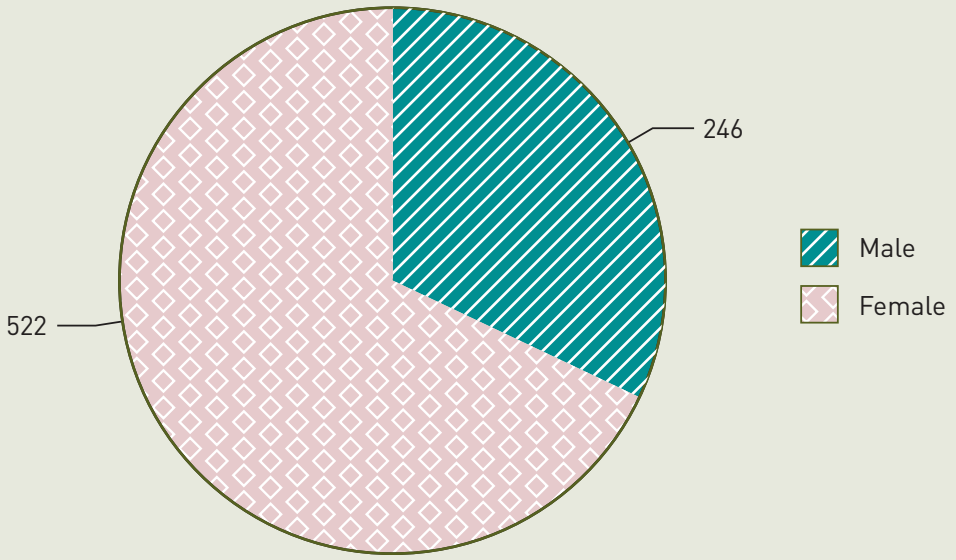
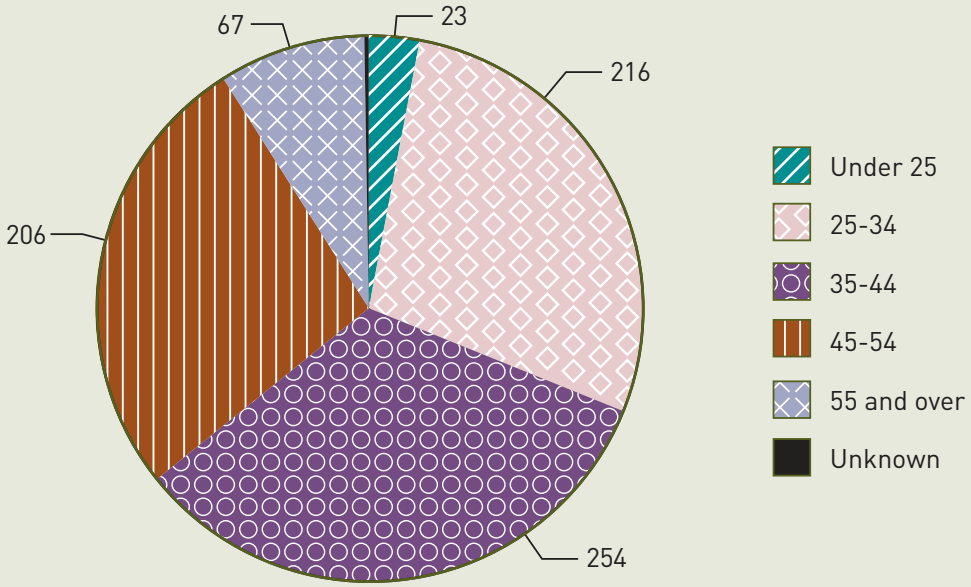


Figure 5c: Healthcare Commission staff by age



Race equality

Figure 5a shows the differences between the number of employees we have from white backgrounds and those from black and minority ethnic backgrounds. We are developing a comprehensive equality and diversity strategy. This will involve consultation across the organisation and will be finalised by August 2006.

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

- ensure support in the development and delivery of the equality and human rights internal objectives
- ensure visible leadership commitment and accountability to diversity
- ensure that diversity is mainstreamed and on the agenda at all levels in every part of the Commission in order to succeed
- ensure effective internal communication channels and facilitation of diversity through the staff forum and support networks
- oversee and contribute to the development of the strategy, action plan and targets

We will issue our next human resources monitoring report by the end of August 2006. It will compare 2004/2005 data with 2005/2006 where it is possible to do so, and will highlight any changes or opportunities for data improvement.

Finance

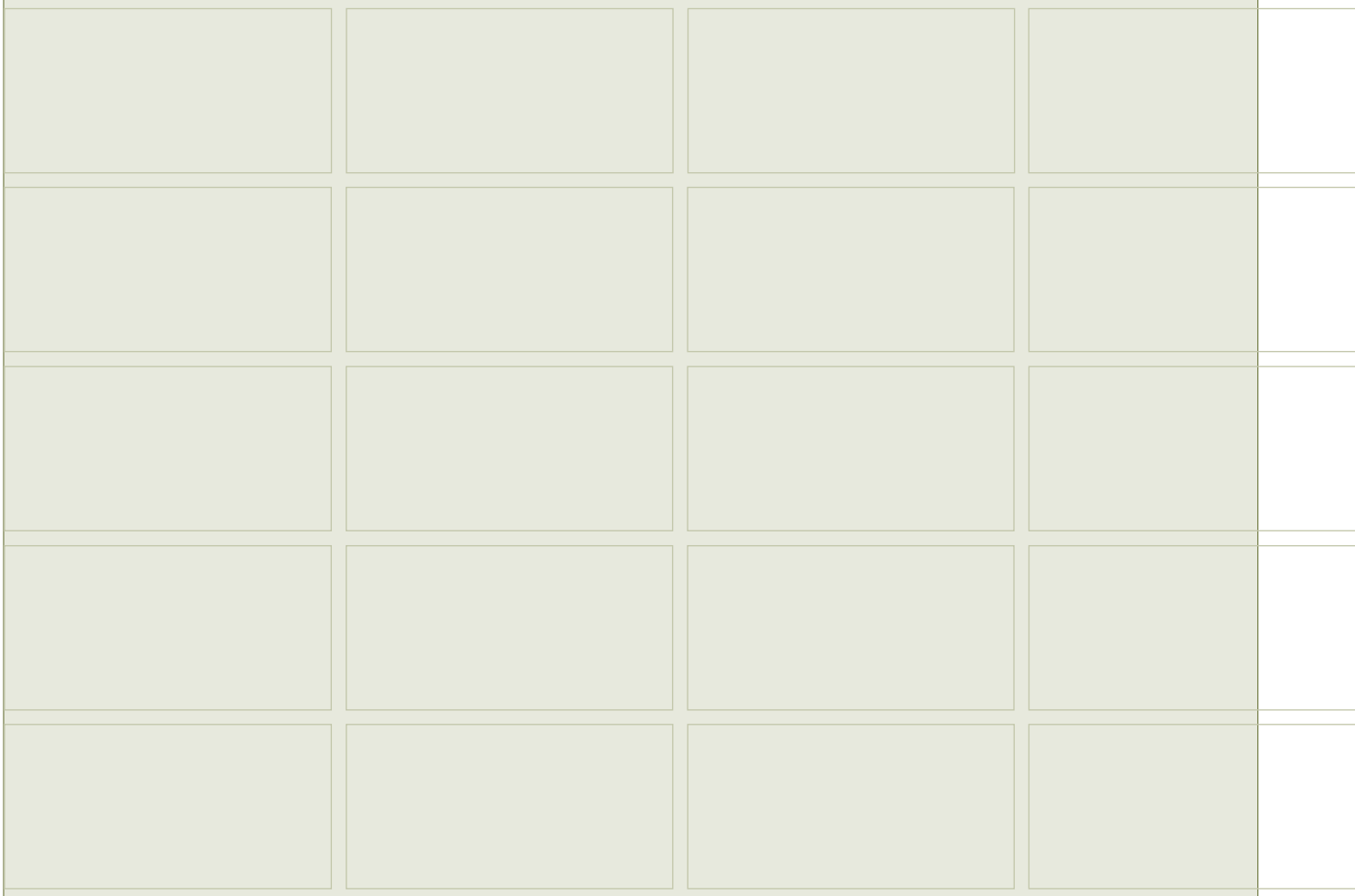
Figure 6 shows the Healthcare Commission's income and expenditure against each of our six strategic goals.

The Healthcare Commission's income is derived from fees from providers of independent healthcare, recharges of staff and other costs and grant-in-aid from the Department of Health.

Our full annual accounts begin on page 69.

Figure 6: Healthcare Commission finance against our strategic goals

	Activity	Gross income £000's	Expenditure £000's	Net £000's
Promote a better experience of health and healthcare for patients and public	Engaging patients and the public The annual health check Inspecting independent providers Surveys of patients and NHS staff Our work in Wales	(7,022)	36,838	29,816
Safeguard the public	Investigations and interventions Dealing with complaints Safety Safe management of controlled drugs	(778)	9,251	8,473
Provide authoritative, independent, relevant and accessible information	Making information available and accessible Freedom of Information and Data Protection		3,503	3,503
Take a lead in coordinating and improving the impact and value for money of assessment and regulation	Concordat Working in partnership	(290)	2,592	2,302
Promote action to reduce inequalities in peoples' health and increase respect for human dignity	Count me in census Variations analysis Safeguarding people with learning disabilities		832	832
Create an organisation delivering world class assessment and regulation	Regional work HR Staffing		25,321	25,321
Grant in aid		(70,332)	-	(70,332)
Total		**(78,422)**	**78,337**	**85**



Looking ahead

In our second year of operation we have achieved what we set out to achieve and more, firmly establishing ourselves as a regulator that is making a difference to health and healthcare in this country. In our third year, we will work towards achieving three key objectives.

Our *Corporate plan 2006/2007* sets out what we plan to do in our third year as the Healthcare Commission. 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 will be focusing our programme of work on three key areas:

- ensuring the basics are in place
- focusing on improvement
- making information more accessible

The climate that we will be working in will continue to be a challenging and ever changing one. Next year will see us move further along the path of aligning our assessment of the independent healthcare sector and the NHS. We will implement new schemes on the regulation of controlled drugs, take responsibility for regulating certain cosmetic procedures in the independent healthcare sector and monitor compliance with the hygiene code.

The current direction of reform in health and social care will affect us in different ways. There will be a growing need for us to work with other assessment bodies, a greater focus on commissioning, greater emphasis on assessment of practice in primary care and a more flexible, less organisation-focused system of assessment. In addition we expect to build on our work in assessing 'pathways of care'.

We will continue to support the Government's wider review of regulation. We will also continue to work closely with the Commission for Social Care Inspection, preparing both organisations for the proposed merger in 2008, undertaking joint projects and aligning services wherever possible.

Meanwhile, we remain strongly committed to the principles and priorities of the programme of work outlined in our *Strategic plan 2005/2008* and the updated *Corporate plan 2006/2007*, which will be published in the summer. In this, we will seek to promote real improvements in the quality of health and healthcare for the millions of people who rely on healthcare services.

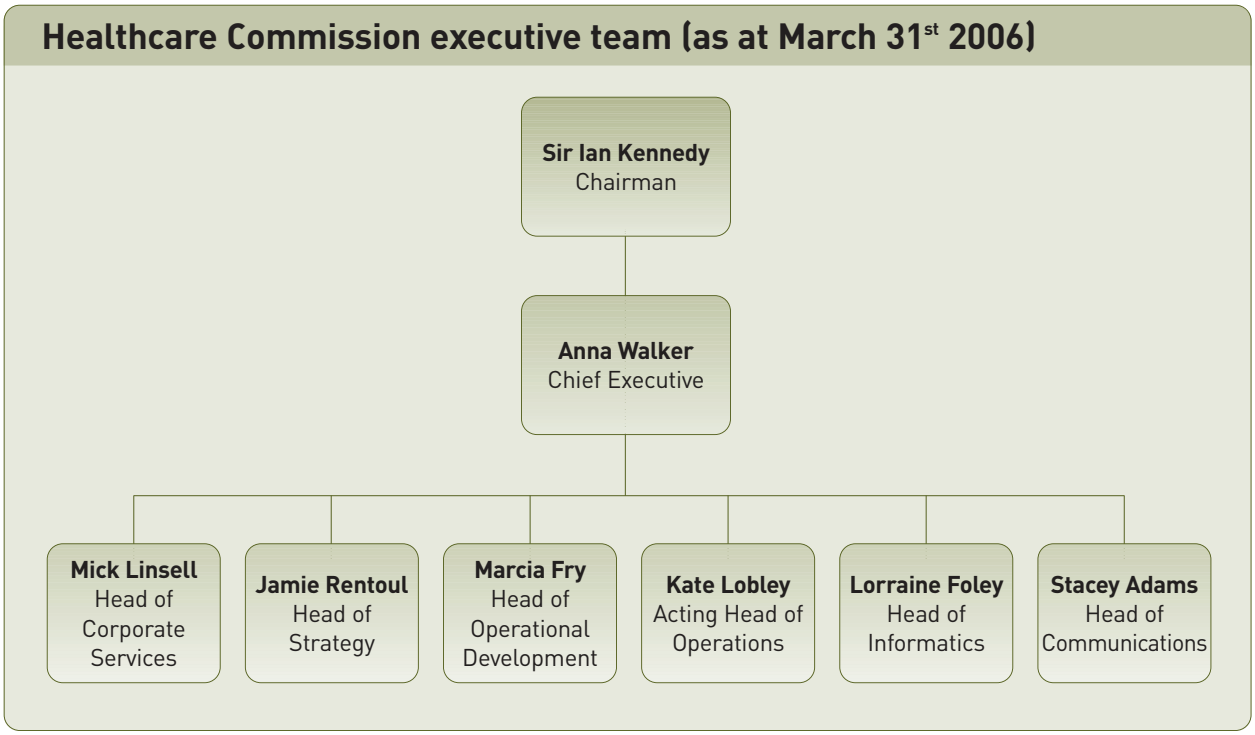
Our staffing and financial arrangements

This section of the annual report covers the following:

- Leading the Commission
- Statement of corporate governance and accountability arrangements
- Remuneration report
- Annual accounts

Leading the Commission

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



Responsibilities of the chair and commissioners

The chair and commissioners are appointed under the Health and Social Care (Community Health and Standards) Act 2003 and have the overall function of establishing and maintaining the strategic direction of the Commission.

The Commission's management statement and standing orders require the Commission to agree those matters that it does not delegate. The matters reserved for determination by the board of the Healthcare Commission are:

- the Commission may decide on any matter it wishes in full session within its legal powers
- establishing and maintaining the strategic direction of the Commission and approval of the corporate plan of the Commission
- approval annually of plans/budgets and any significant variances thereto in respect of the application of available financial resources, capital and revenues and the annual report of the Commission to be laid before Parliament
- receipt of a regular update on policies in place to ensure the effective management of the Commission's employees
- approval of and amendments to standing orders, which include the standing financial instructions
- approval of the strategy for risk management for the Commission
- receiving a report on declarations of interest made by commissioners

Figure 7: Commissioners for the Healthcare Commission

Name
Professor Sir Ian Kennedy (Chair)
Khurshid Alam[1]
Dr Sarah Blackburn[2]
Jennifer Dixon
Michael Hake[1,2]
Sharon Hopkins
Professor Bruce Keogh KBE
Nick Partridge OBE[2]
Professor Kamlesh Patel OBE (until January 2006)
Professor Shirley Pearce (Joint Deputy Chair)
John Scampion[1,2]
Professor Iqbal Singh[2]
Paul Streets OBE (Joint Deputy Chair)[1]
Stephen Thornton CBE[1,2]

1. Member of remuneration committee at March 31st 2006
2. Member of audit committee at March 31st 2006

More information about our commissioners is available on the Healthcare Commission website **www.healthcarecommission.org.uk**.

Register of interests

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

Statement of corporate governance and accountability arrangements

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

This statement describes how, during the period 2005/2006, the Healthcare Commission has applied the relevant provisions of the Code. In addition to the Code, the Healthcare Commission is subject to a number of other accountability mechanisms.

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

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

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

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

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

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

The 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

Membership of the Commission

Arrangements for the membership of the Commission are set out in legislation and regulations. In addition to the chair, the Commission has fourteen other commissioners. 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.

All commissioners including the chair are appointed by the NHS Appointments Commission. In relation to the Commissioner making the interests of Wales his or her special care, the NHS Appointments Commission appoints in consultation with the National Assembly of Wales. In relation to other commissioners, it appoints in consultation with the Secretary of State for Health.

Commissioners are appointed for a term of not longer than five years.

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

During the year 2005/2006 the term of office of three commissioners came to an end. Michael Hake and Nick Partridge were reappointed for a further three year term and Professor Kamlesh Patel did not seek reappointment. During 2005/2006 Dr Sharon Hopkins held the appointment as the Commissioner making the interests of Wales her special care. There was one vacancy throughout the year. A recruitment exercise was not successful in finding a suitable candidate. Information on the term of office of each commissioner is given below.

Figure 8: Commissioners and terms of office 2005/2006

Name	Period of appointment
Khurshid Alam	February 1st 2004 – January 31st 2007
Dr Sarah Blackburn	February 1st 2004 – January 31st 2008
Jennifer Dixon	February 26th 2004 – January 31st 2008 Reappointed March 1st 2005
Michael Hake	February 1st 2004 – January 31st 2009 Reappointed 1st February 2006
Sharon Hopkins	February 1st 2004 – January 31st 2008
Professor Sir Ian Kennedy (Chair)	February 1st 2004 – January 31st 2008
Professor Bruce Keogh KBE	February 1st 2004 – January 31st 2007
Nick Partridge OBE	February 1st 2004 – January 31st 2009 Reappointed 1st February 2006
Professor Kamlesh Patel OBE	February 1st 2004 – January 31st 2006 Did not seek reappointment
Professor Shirley Pearce (Joint Deputy Chair)	February 1st 2004 – January 31st 2008
John Scampion CBE	February 1st 2004 – January 31st 2007
Professor Iqbal Singh	February 1st 2004 – January 31st 2008
Paul Streets OBE (Joint Deputy Chair)	February 1st 2004 – January 31st 2008
Stephen Thornton CBE	February 1st 2004 – January 31st 2007

The working of the Commission and its committee structure

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

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

In 2005/2006 the Commission had the following committees:

- Audit committee
- Remuneration committee
- Nomination committee
- Committee on the use of confidential personal information
- Investigations committee
- Advisory group on clinical strategy
- Complaints (quality assurance) committee

Meetings and attendance

During 2005/2006 the Commission met formally in public on seven occasions. On one other occasion it held a meeting in private and during the year also held two separate informal discussions of strategy.

Figure 9 shows the attendance of members at Commission and committee meetings during the year, with attendance shown as a proportion of the numbers of meetings individual commissioners were eligible to attend.

The chair meets the two deputy chairs between meetings of the Commission. Other commissioners are informed in order that they may raise matters either via the secretary or via the deputy chairs.

Figure 9: Membership and attendance at meetings of the Commission and Committees 2005/2006

	Meetings of the Commission	Strategy meetings of the Commission	Audit Committee	Remuneration Committee	Nomination Committee	Committee on the Use of Confidential Personal Information	Investigations Committee	Complaints (Quality Assurance) Committee
Professor Sir Ian Kennedy	**8/8**	2/2		**3/3**				
Khurshid Alam	5/8	2/2		3/3	2/2	1/3		
Dr Sarah Blackburn	6/8	2/2	**6/6**				7/9	2/3
Dr Jennifer Dixon	5/8	2/2						
Michael Hake	8/8	2/2	4/5	3/3		3/3	9/9	3/3
Dr Sharon Hopkins	6/8	1/2			1/2	2/3		
Professor Sir Bruce Keogh	6/8	1/2						
Nick Partridge	7/8	2/2	6/6				5/9	2/3
Professor Kamlesh Patel	2.5/6	1/2				1/3		
Professor Shirley Pearce	5/8	0/2			**2/2**			
John Scampion	6.5/8	2/2	5/6	2/3			**8/9**	**3/3**
Professor Iqbal Singh	5/8	2/2	0/1		2/2		3/9	1/3
Paul Streets	7/8	2/2		3/3		**2/3**		
Stephen Thornton	6/8	2/2	3/6	2/3	1/2			

Note: Bold typeface indicates that the Commissioner was the Chair of the Committee.

Independent of commissioners and declarations of interest

The chair had no other significant commitments during the year.

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

Declarations of interests of commissioners are available on the website of the Healthcare Commission.

Effectiveness of the Commission

The Chair conducted individual appraisals with all commissioners during the course of winter 2005/2006. The Commission instituted in early 2005 a review of its effectiveness, led by an external consultant. The review reported in May 2005. A programme of action was undertaken to introduce changes to the schedule of meetings of the Commission, the structure of agendas and arrangements for ensuring the timeliness of papers.

Committees of the Commission

All committee members are appointed by the Commission. Membership and attendance at meetings of Committees are shown in figure 9. During the year, one new committee was established. In November 2005 the Commission agreed to establish the equality and human rights committee but this did not meet during the year. The complaints (quality assurance) committee met for the first time in August 2005.

Audit committee

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

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

Specifically, the audit committee provides advice by:

- review and oversight of the preparation of annual accounts for the approval of the Commission
- review of the Healthcare Commission's systems of internal control and risk management
- monitoring 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 since February 6th 2004 has been Dr Sarah Blackburn.

The chief executive, head of finance, head of corporate services, external auditors and internal auditors are invited to attend all meetings. At each meeting during 2005/2006 the Committee had private meetings with the external auditors and the internal auditors without management present. In addition, the Committee met in private with the senior executives only.

The audit committee met on six occasions during 2005/2006 and made regular reports to the Commission on its activities.

Financial statements

The audit committee formally approved the Healthcare Commission's accounts for 2005/2006. It considered reports on the Commission's funding and budget, and monitored month-by-month expenditure against budget.

Internal control and risk management systems

The audit committee commented and advised on the statement of internal control, which was signed by the chief executive, and approved the standing financial instructions.

Risks related to key aspects of the Commission's activities, such as the intelligent information management system (IIMS) were explored and continue to be monitored.

External audit
The external auditor of the Healthcare Commission is the Comptroller and Auditor General.

During the year the audit committee received reports on the interim and final audits from the external auditor and sought assurance from the executive that issues raised would be handled in an appropriate and timely way.

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

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

The Commission's external auditors did not provide additional services to the Healthcare Commission during 2005/2006.

Internal audit
The Committee recommends to the Commission the appointment of the head of the internal audit function or the appointment of suitably qualified contractors. During 2005/2006 South Coast Audit delivered this function at the Healthcare Commission, following its success in a competitive tendering exercise the previous year.

The Committee considers and approves the terms of reference and remit of the internal audit function, and agrees the planned programme of audits and any additions to the programme. In 2005/2006, the focus for internal audit work was the areas of principal risk agreed with senior management.

The Committee ensures that internal audit has the necessary access to information to enable it to fulfil its mandate. The head of internal audit has the right of direct access to the chair of the committee.

The Commission's internal auditors did not provide additional services to the Healthcare Commission during 2005/2006.

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 committee is chaired by Professor Sir Ian Kennedy.

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

In 2005/2006 the services of Towers Perrin were retained to advise on the benchmarking of salaries against the market and the introduction of performance related pay for all employees. The chief executive and four members of the second tier executive team are employed by the Commission on continuous employment contracts with a contractual right to receive notice within the guidelines of best corporate governance. A fifth member of the second tier of executives is seconded to the Commission from a government department.

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

The Commission established a committee of commissioners to oversee the operation of the code of practice. The Committee was established at a meeting of the Commission on November 25th 2004. During 2005/2006, the committee met on three occasions.

The chair of the committee on the use of confidential personal information is Paul Streets. Members of the committee include the Caldicott Guardian from the Commission. In February 2006, the Commission approved the appointment of an independent member to the committee. The independent member is not a commissioner nor an employee of the Healthcare Commission.

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

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

Nomination committee
The nomination committee was established at a meeting of the Commission on January 27th 2005. The chair of the nomination committee is Professor Shirley Pearce. During 2005/2006 the nomination committee met on two occasions.

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

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

During 2005/2006 the investigations committee met on nine occasions.

The investigations committee provides strategic advice and makes decisions in relation to investigations into potential failures in NHS services in England and in certain cross-border special health authorities. The committee ensures that appropriate policies and procedures are in place and oversees the guiding principles for investigations, including the criteria adopted for

deciding whether an investigation is required, recommending any changes to the Commission. The committee approves cases for investigation by the Healthcare Commission and approves the terms of reference. The committee may recommend other forms of review where a formal investigation is not considered appropriate.

During 2005/2006 the committee has, after consulting the chair, approved the reporting of significant failings within two NHS trusts to the Secretary of State for Health. One of the reported significant failings was accompanied by a recommendation for special measures. The committee also monitored the implementation of action plans put in place as a result of its recommendations.

Complaints (quality assurance) committee
It was agreed by the Commission in February 2005 to establish a committee to monitor the quality of decisions taken in the 'second (independent) stage' review process for complaints against the NHS. The membership of the committee is comprised of 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 also reviews, on behalf of the Commission, the management and performance of the complaints function.

During 2005/2006 the complaints (quality assurance) committee met on three occasions.

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.

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

Remuneration report

Recruitment policy

All vacancies are advertised internally and externally in the press and on the Commissions e-recruitment website, which allows application forms and equal opportunities monitoring forms to be submitted electronically.

Commitment to diversity and equality

The Healthcare Commission aims to become an exemplary organisation that promotes diversity and values difference. A key part of its overall strategy is to create an open and honest working environment, promoting diversity and encouraging all employees to reach their full potential.

The Healthcare Commission believes that equality of opportunity and freedom from unfair discrimination are fundamental human rights.

The Healthcare Commission's long term aim is that the composition of its workforce should reflect that of the communities it serves.

Equal opportunities monitoring

The Healthcare Commission is committed to equal opportunities. Our policy is to appoint the best candidate for any post irrespective of gender, ethnic or national origin, race, disability, religion, sexual orientation, marital status, age or HIV status. To find out if our policies are working we require details about those who apply to join the Healthcare Commission as part of the application form. The information given is confidential and enables us to ensure that there is no unfair discrimination or adverse impact on any group at any stage. Equal Opportunities monitoring data is separated from application forms on receipt and is not be seen by those involved in the selection process. The data is used for statistical purposes only and is not reproduced in a way that enables individuals to be identified. However, for successful applicants, the information provided is stored on manual and/or computerised files.

Data Protection Act

The Healthcare Commission holds and processes all data in compliance with the Data Protection Act 1998. The (recruitment) information provided is "sensitive personal data" and requires explicit consent before the Healthcare Commission can process it. Application forms of unsuccessful candidates are destroyed/deleted six months after the closing date for the job.

Chief executive

The Chief Executive, Anna Walker, was appointed on a permanent contract on February 1st 2004, after an internal and external recruitment process. Termination of the contract is by notice of six months on either side.

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

Membership of the remuneration committee is disclosed on page 62 of the *annual report*.

Chief executive remuneration

Chief executive remuneration		
	Remuneration for year to 31/03/06 £	**Remuneration for year to 31/03/05 £**
Chief executive	183,370	170,513

Chief executive pension entitlements at March 31st 2006
The chief executive is an ordinary member of the principal civil service pension scheme.

Pension benefits at March 31st 2006 may include amounts transferred from previous employments.

Chairman

Professor Sir Ian Kennedy was chair designate on the vesting date of January 8th 2004 and was appointed by the Secretary of State for Health as chair of the Commission from February 1st 2004 for a period of four years to January 31st 2008. The Chair is paid a salary in line with that of a High Court Judge.

Chairman's remuneration

In addition, the chairman was re-imbursed with the cost of travelling to Commission meetings. These re-imbursements totalled £ 2,743 during 2005/2006 (£4,200 2004/2005). The Healthcare Commission meets the resulting tax liability under a PAYE settlement agreement. The Chairman has foregone eligibility to join the Commission pension scheme.

Chairman's remuneration		
	Remuneration for year to 31/03/06 £	**Remuneration for year to 31/03/05 £**
Chairman	155,404	150,842

Commissioners

Commissioners are appointed for terms of three years following a selection process held by the Appointments Commission. Remuneration is determined by the Department of Health on the basis of a two to three day per month commitment.

Commissioner's remuneration

Commissioner's remuneration		
	Remuneration for year to 31/03/06 £	Remuneration for year to 31/03/05 £
Khurshid Alam	5,855	5,696
Dr Sarah Blackburn	5,855	5,696
Jennifer Dixon	5,855	5,684
Michael Hake	5,673	5,696
Sharon Hopkins	5,855	5,696
Professor Bruce Keogh KBE	5,855	5,696
Nick Partridge OBE	5,855	5,696
Professor Kamlesh Patel OBE	4,879	5,696
Professor Shirley Pearce (Joint Deputy Chair)	5,855	5,696
John Scampion CBE	5,855	5,696
Professor Iqbal Singh	5,855	5,696
Paul Streets OBE (Joint Deputy Chair)	5,855	5,696
Stephen Thornton CBE	5,855	5,696

Commissioners are not eligible to join the Commission Pension Scheme.

In addition, commissioners are re-imbursed with the cost of travelling to Commission meetings. These re-imbursements totalled £2,373 during 2005/2006 (£7,890 2004/2005). The Healthcare Commission meets the resulting tax liability under a PAYE settlement agreement.

Executive managers

Treasury guidance (DAO3/00) requires the Commission to provide information on the salary and pension rights of named individuals who are 'the most senior managers' of the Commission. The term 'senior manager' has been taken to mean members of the executive team.

All executive team members were appointed after an internal and external recruitment process and (excluding J Rentoul) are permanent and full time employees of the Commission. They have contracts of employment 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 remuneration committee determines performance bonus. Membership of the remuneration committee is disclosed on page 62 of the *annual report*.

Executive team remuneration

Executive team remuneration		
	Remuneration for year to 31/03/06 £	**Remuneration for year to 31/03/05 £**
Stacey Adams	91,200	91,722
Lorraine Foley	130,680	122,000
Marcia Fry	132,500	130,000
Simon Gillespie*	156,301	51,805
Mick Linsell	110,450	104,000

* Appointed October 4th 2004, resigned February 8th 2006. Remuneration includes all payments due to the end of his contract. A permanent appointment to replace S Gillespie had not been made at March 31st 2006.

In addition, Jamie Rentoul provided services as an executive team member whilst employed by the Department of Health. Salary costs of £145,529 (including pension and employers costs) were recharged to the Commission by the Department of Health (£71,218 2004/2005).

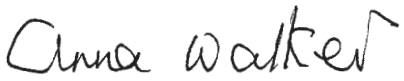
Executive team pension entitlements at March 31st 2006

Executive team pension entitlements at March 31st 2006							
	* Accrued benefits				Cash equivalent transfer values (CETV)		
	Increase in year		Benefits at March 31st 2006		CETV at March 31st 2006	CETV at March 31st 2005	Real increase in CETV
	Lump sum	Pension	Lump sum	Pension			
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Stacey Adams	0-2.5	0-2.5	17.5-20	5-7.5	97	75	20
Lorraine Foley	0-2.5	0-2.5	7.5-10	2.5-5	38	20	18
Marcia Fry	0-2.5	0-2.5	145-147.5	47.5-50	982	780	4
Simon Gillespie**	-	0-2.5	-	7.5-10	136	78	29
Mick Linsell	0-2.5	0-2.5	7.5-10	2.5-5	53	28	24

*Accrued benefits are presented in bands

** Resigned February 8th 2006

Pension benefits at March 31st 2006 may include amounts transferred from previous employments.



Anna Walker CB
Chief Executive

Date: June 30th 2006

Annual accounts

Form of accounts
These accounts have been prepared in the form directed by the Secretary of State for Health, in accordance with paragraph 10 of Schedule 6 of the Health and Social Care (Community Health and Standards) Act 2003. These accounts cover the year to March 31st 2006.

Financial results
The financial accounts to March 31st 2006 are the Commission's second full set of annual accounts and have been prepared on the basis that the Commission is a going concern.

The Commission's financial performance for the year is identified within the income and expenditure account. The Commission's total income for the year was £78.4m. Expenditure totalled £78.3m on operational activities and £2.6m on acquiring fixed assets. Income equivalent to the fixed asset expenditure has been transferred to Government Grant Reserve for release, as the assets are written off, to the income and expenditure account. The surplus for the year was £85,000, which has been added to reserves.

Fixed assets
The Commission's fixed assets at April 1st 2005 comprised refurbishment costs to leased land and buildings, office furniture and equipment and computer hardware and software, as reduced by depreciation calculated to release the asset costs to the income and expenditure over their useful working lives. Asset costs are revalued under modified historic cost accounting.

During the year to March 31st 2006, the Commission acquired assets with a value of £2.6m. These assets include refurbishment costs at Finsbury Tower and the Commission's regional offices and the purchase of office equipment and information technology infrastructure and software.

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

Charitable payments
No charitable donations were made during the year.

Implementation of the Euro
The Commission has identified the potential impact of the United Kingdom changing currency to the Euro. The relevant key systems have been identified and an action plan has been drawn up.

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 2005/2006, the Commission paid 87% (91%) of invoices, based on volume, and 87% (87%) 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.

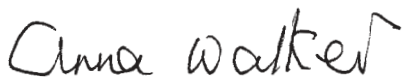
Auditor appointment
The Comptroller and Auditor General is the appointed auditor of the Commission under the provision of the 2003 Act, Schedule 6, paragraph 10 (4).

The audit fee for the year was £60,000. (£79,200 2004/2005). The Comptroller and Auditor General did not undertake any non-audit work during the year.

Post balance sheet events
As a non-departmental public body, the Healthcare Commission is classed as an arms length body. In October 2003, the Secretary of State for Health announced his intention to review the Department of Health's 'arms length bodies'. On May 20th 2004, the Secretary of State for Health outlined the first stage of this review. There are 42 separate arms length bodies that employ 22,000 staff, with a combined budget of £2.5bn. The Secretary of State for Health announced that, by 2007/2008, there would be a 50% reduction in the number of arms length bodies reducing total expenditure by £0.5bn and staff posts by 25%.

The Chancellor of the Exchequer announced in March 2005 that the Secretary of State for Health had agreed in principle to come forward with plans to merge the Commission for Social Care Inspection (CSCI) and the Healthcare Commission into a single body by 2008. This reflects the increasing joint working between health and adult social care services and is part of a wider review of regulation in health and social care. Subsequent discussions with the Department of Health have confirmed this timetable and the Healthcare Commission is meeting regularly with CSCI to ensure an orderly transition. No further information regarding this merger was available at the date of signing these financial statements and no financial implications from the merger have been anticipated in these financial statements

There have been no significant events since March 31st 2006 that would have a material effect on these financial statements.



Anna Walker CB
Chief Executive

Date: June 30th 2006

Statement of accounting officer's responsibilities

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

In preparing these accounts, the Commission has:

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

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

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 in government accounting. The system of internal control supports the achievement of the Commission's policies, aims and objectives, while safeguarding the public funds and assets for which I am personally responsible.

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

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.

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 also monitors progress against both the activities and risks.

During 2005/2006, I have reviewed documents I considered relevant, including internal audit reports and papers presented to the audit committee and management information produced during that period and I have discussed the state of internal controls with the external and internal auditors, members of the Commission and independent consultants.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level, rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness. The Commission's system of internal control is being developed 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 March 31st 2006 and up to the date of approval of the annual report and accounts and it accords with Treasury guidance.

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, as illustrated in the table below:

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

The Commission's processes are being designed and developed to:

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

4. The risk and control framework

Consistent with the recognition of risk at a strategic level, the Commission has developed a risk register to monitor where risks may arise and how they are mitigated. In the register, risks are identified at an operational level and consolidated to identify themes arising across the organisation. The executive team and the Commission review the risk register for completeness. The audit committee reviews the application of the risk management processes.

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 either may not have been foreseen or which were not properly managed, all members of the organisation must see themselves as responsible for anticipating and managing risk effectively.

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

- a formal system of governance comprising 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

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 his management letter and other reports and work commissioned from other external review agencies.

The process that the Commission has maintained to ensure internal control during the year includes both the management of risk and other sources of assurance, including internal audit. 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 respective responsibilities are set out below.

Audit committee
The audit committee met six times in 2005/2006. Its terms of reference are:

- to oversee production of the Commission's annual accounts and to recommend them to the Commission for approval
- to scrutinise and review:
  - the Commission's financial and accounting policies, practices and processes, including information and communication technology
  - the internal control systems including internal audit, in particular to appoint the internal auditors, approve their work plan and review their reports and the responses of management. The committee receives the annual report from the internal auditor summarising the work done in the period, including a review of ongoing work implementing recommendations from audit
  - the Commission's assessment and management of risk. It considers issues of risk in the course of its meetings, but formally reviews the significant risks that have been identified twice a year
  - the results of the external audit by the Comptroller and Auditor General including their management letter and the response by management
  - any aspect of the work of the organisation and to report as appropriate

The membership of the Audit Committee at March 31st 2006 was:

Dr Sarah Blackburn (Chair)
Michael Hake
John Scampion
Stephen Thornton

Nick Partridge was also a member until February 2006. There is currently one vacancy being recruited from among the commissioners under the remit of the Commission's nominations committee.

The executive team
This team has responsibility for overseeing 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 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 relevant manager 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.

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

Internal audit opinion
Our internal auditors expressed an opinion in June 2006 based on work undertaken during the year to March 31st 2006. Their overall opinion was that a satisfactory level of assurance could be given, as there is some risk that objectives may not be fully achieved. Slight improvements are required to enhance the adequacy and/or effectiveness of risk management, control and governance.

In reaching this opinion, they have considered the work undertaken during the year and have confirmed that whilst there were no significant breakdowns in internal control highlighted, a number of weaknesses were identified. The following factors outlined below were taken into particular consideration.

There are several developments that were still required to refine risk management and enhance the risk maturity of the organisation. These include consideration of having in place a risk management strategy that succinctly defines how risks will be managed and detailing how risks will be identified, evaluated etc to facilitate a consistent approach organisation wide.

A detailed review of the purchase order processing system was undertaken during the year, following concerns from management as to the adequacy of the control environment. This identified an ongoing risk of potential breaches of EU regulations, particularly in relation to consultancy contracts by repeated renewal.

Based on the work done, they were satisfied that the processes for drawing down funding from the Department of Health were robust, adequate and effective. However, an issue did arise regarding the confirmation of overall grant-in-aid funding during the year, which highlighted the need for clarity and evidence.

While investigations and complaints are followed up, they noted that the Commission currently does not have in place a structured mechanism/system to identify trends and learning from outcomes of investigations and complaints and action is in hand to deal with all of these issues fully and disseminating these to the NHS. This is fundamental to the achievement of the Commission's objective of safeguarding the public.

A review of the customer relationship management system, using the OGC3 methodology, concluded that this project was at Amber at this point in the OGC gateway cycle, and the procurement of the Seibel product was appropriate to support the Commission's business needs. The customer relationship management system is, in our opinion, a significant IM&T support system for the Commission who are committed to a fully effective implementation so that the full benefits of the system can be realised across the Commission.

Other review agencies

To support the development and improvement of the Commission's system for identifying the costs of its independent sector healthcare work, KPMG were retained to review current arrangements and recommend an approach. This work was completed during 2005/2006 and the recommended approach was utilised in the fee consultation paper issued in December 2005.

In June 2005 the Inland Revenue commenced reviewing the Commission's compliance with Inland Revenue regulations regarding payments to self-employed contractors since April 1st 2004. The review was substantially completed by March 31st 2006 with the Inland Revenue satisfied on the arrangements in place to ensure full compliance. A small number of PAYE and NIC under-payments identified during the review are being recovered from the contractors concerned under the terms of their contractual arrangements with the Commission.

In order to assess the adequacy of the Commission's financial systems, a review was commissioned in 2004/2005 from PriceWaterhouseCoopers. The audit committee and the executive team considered the report and a plan was developed to achieve the recommended improvements to the system, primarily to allow the provision of additional financial information during 2005/2006. Further improvements in the financial information systems will be achieved in 2006/2007.

Grant Thornton LLP are engaged to provide ongoing support to the development of risk recording and management across the Commission.

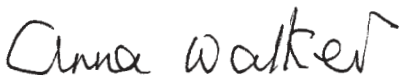
Future developments

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 2005/2006 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 a position as a 'risk enabled' organisation over the course of 2006/2007. 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. We will also work increasingly closely with CSCI to ensure that our systems are as aligned as possible in preparation for our anticipated merger in 2008.

6. Significant internal control problems

No significant internal control problems have been identified in the accounting year.

Signed by:



Anna Walker CB
Chief Executive

Date: June 30th 2006

The Certificate and Report of the Comptroller and Auditor General to the Houses of Parliament

I certify that I have audited the financial statements of the Commission for Healthcare Audit and Inspection for the year ended March 31st 2006 under the Health and Social Care (Community Health and Standards) Act 2003. These comprise the Income and Expenditure Account, the Balance Sheet, the Cashflow Statement and Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them.

Respective responsibilities of the Commission, chief executive and auditor
The Commission and chief executive 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 there under by the Secretary of State for Health with the consent of Treasury, and for ensuring the regularity of financial transactions. These responsibilities are set out in the statement of the Commission and chief executive's responsibilities.

My responsibility is to audit the financial statements 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 there under by the Secretary of State for Health with the consent of Treasury. 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. I also report to you if, in my opinion, the *Annual Report* is not consistent with the financial statements, 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 relevant authorities regarding remuneration and other transactions is not disclosed.

I review whether the statement on pages 72-77 reflects the Commission's compliance with HM Treasury's guidance on the Statement on Internal Control, and I report if it does not. I am not required to consider whether the accounting officer's statements on internal control cover all risks and controls, or form an opinion on the effectiveness of Commission's corporate governance

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.

Opinion
In my opinion:

- the financial statements give a true and fair view, in accordance with the Health and Social Care (Community Health and Standards) Act 2003 and directions made thereunder by the Secretary of State for Health with the consent of Treasury, of the state of Commission's affairs as at March 31st 2006 and of its surplus total recognised gains and losses and cashflows 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 the consent of Treasury and
- in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities, which govern them

I have no observations to make on these financial statements.

John Bourn
Comptroller and Auditor General
Date: July 12th 2006

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

Income and expenditure account year to March 31st 2006					
	NOTE	Year to 31/03/06		Year to 31/03/05	
		£'000	£'000	£'000	£'000
Gross income					
Government grant-in-aid	2		68,851		56,443
Fee income	3		7,384		4,676
Other income	3		706		396
Transfers from Government grant reserve	11		1,481		1,168
			78,422		**62,683**
Expenditure					
Staff costs	4	44,815		31,308	
Other operating costs	5	32,064		30,652	
Depreciation	6	1,394		903	
Notional capital charges	1e	64	**78,337**	48	**62,911**
Operating surplus/(deficit) for the year			**85**		**(228)**
Write back of capital charges	1e		64		48
Retained surplus/(deficit) for the financial year			**149**		**(180)**
Retained surplus brought forward			884		1,064
Retained surplus carried forward for the financial year			**1,033**		**884**

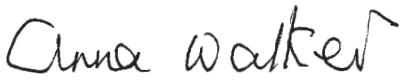
Statement of total recognised gains and losses			
	NOTE	Year to 31/03/06 £'000s	Year to 31/03/05 £'000s
Retained surplus/(deficit) for the financial year		**149**	**(180)**
Unrealised gains on fixed asset indexation	6	45	101
Total recognised gains and losses for the financial year		**194**	**(79)**

The notes on pages 83 to 95 form part of these accounts

Balance sheet					
	NOTE	Year to 31/03/06		Year to 31/03/05	
		£'000	£'000	£'000	£'000
Fixed assets					
Tangible assets	6		4,913		4,752
Intangible assets	6		1,467		483
			6,380		**5,235**
Current assets					
Debtors: falling due within one year	7a	3,278		2,425	
Cash at bank and in hand	8	5,034		4,837	
		8,312		7,262	
Creditors					
Amounts falling due within one year	9	(7,237)		(5,678)	
Net current assets			**1,075**		**1,584**
Total assets less current liabilities			**7,455**		**6,819**
Debtors: falling due after one year	7b		**208**		**-**
Provision	10		**(250)**		**(700)**
Total net assets			**7,413**		**6,119**
Financed by:					
Income and expenditure account	11		1,033		884
Government grant reserve	11		6,380		5,235
Capital and reserves			**7,413**		**6,119**

The notes on pages 83 to 95 form part of these accounts

Signed by:



Anna Walker
Accounting officer

Date: June 30th 2006

Cash flow statement			
	NOTE	Year to 31/03/06 £'000s	Year to 31/03/05 £'000s
Net cash inflow from operating activities	12	**197**	**528**
Capital expenditure			
Payments to acquire fixed assets	6	(2,581)	(1,591)
Net cash outflow before financing		**(2,384)**	**(1,063)**
Financing			
Government grant reserve	2	2,581	1,591
Increase in cash at bank and in hand	8	**197**	**528**

The notes on pages 83 to 95 form part of these accounts

Notes to the accounts

1. Accounting policies

a) Accounting convention

These accounts have been prepared under the modified historic cost convention modified to include the revaluation of fixed assets.

Without limiting the information given, the accounts have been prepared in accordance with the Accounts Direction issued by the Secretary of State for Health with the approval of HM Treasury. The accounts comply with applicable accounting standards.

b) Income

Income is made up of grant-in-aid received from the Department of Health to fund both the operating and capital costs of the Commission, 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.

Grant-in-aid relating to the purchase of capital assets is credited to the Government grant reserve. A proportion is released to the income and expenditure account to match depreciation charged on those assets.

Registration and inspection fees are payable on application and then annually in accordance with fee rates prescribed by the Secretary of State for Health. Application fees are recognised on completion of initial checks and acceptance of the application. Annual fee rates are set at levels that 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 non-refundable on de-registration during a year.

c) Fixed assets

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

Fixed assets, other than computer software, are capitalised as a tangible asset as follows:

- equipment with an individual value of £5,000 or more
- grouped assets which are interdependent with a total value of £5,000 or more, and a minimum expected life as set out in paragraph d(i) below
- building and refurbishment costs valued at £5,000 or more

Purchased computer software is capitalised as an intangible asset where expenditure of £5,000 or more is incurred. Project management costs have not been capitalised.

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

- office refurbishment – 15 years
- office furniture – 10 years
- office equipment – five years
- computer equipment – three to four years
- computer software – three to four years

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

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

e) Notional costs
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. The cost in 2005/2006 was £64,000 (£48,000 2004/2005).

f) Pension costs
The Commission provides two pension schemes for staff:

(i) NHS Pension Scheme
The NHS Pension Scheme is an unfunded multi-employer defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State for Health, in England and Wales. As a consequence it is not possible for the Commission to identify its share of the underlying scheme liabilities. Therefore the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period.

In accordance with the requirements to produce a full actuarial valuation every four years, the Government Actuary Department has been commissioned to produce a valuation as at March 31st 2003. However, the results of this valuation are not yet available. The notional surplus of the scheme at March 31st 1999 was £1.1 billion, as per the last scheme valuation by the Government Actuary Department when the conclusion of the valuation was that the scheme continued to operate on a sound financial basis. It was recommended that employers' contributions be increased to 14% of pensionable pay with effect from April 1st 2003. Subsequent to the 1999 valuation, the Government Actuary Department compared the scheme's contribution income and actuarially assessed growth in scheme liabilities and interest charges. This assessment has declared a net deficiency of £6.2m at March 31st 2004 as detailed in the scheme accounts which can be viewed on the NHS Pensions Agency website at **www.nhspa.gov.uk**. Copies can also be obtained from The Stationery Office.

The Commission is directed by the Secretary of State for Health to charge employers' pension costs contributions to operating expenses as and when they become due. On advice from the Government Actuary Department the contribution may be varied from time to time to reflect changes in the scheme's liabilities.

The total employer contribution payable in 2005/2006 was 14%. Employees pay contributions of 6% of their pensionable pay. For 2005/2006, employers' contributions of £2.7m were payable to the scheme.

(ii) Principal civil service pension scheme
The principal civil service pension scheme is an unfunded multi-employer defined benefit scheme. Consequently, the Commission is unable to identify its share of the underlying assets and liabilities. A quadrennial review of the accruing superannuation liability charges at March 31st 2003 can be found on the Principal Civil Service Pension Scheme website (**www.civilservice-pensions.gov.uk**).

Although the scheme is unfunded, employer contributions are set at the level of contributions that would be paid by private sector employers to pension schemes for their employees. For 2005/2006, employers' contributions of £ 0.6m were payable to the principal civil service pension scheme at four rates in the range 16.2-24.6% of pensionable pay, based on salary bands. Rates will increase for 2006/2007 within a range 17.1 – 25.5%.

g) Leases
Rentals payable under operating leases are charged to the income and expenditure account on a straight line basis.

h) Value added tax (VAT)
The Commission registered for value added tax (VAT) from January 3rd 2006 when its vatable turnover from cost recharges exceeded the registration threshold. Income is reported exclusive of output VAT where applicable. All expenditure reported in these statements includes VAT other than when the VAT was directly related to output VAT and reclaimable. VAT is not charged on any of the Commission's independent healthcare fees and charges.

2. Government grant

Government grant		
	Year to 31/03/06 £'000s	**Year to 31/03/05 £'000s**
Department of Health resource account	68,388	55,300
Department of Health – assets transferred	-	34
Grant transferred to HSCIC*	2,844	2,700
Grant designated to Neonatal and Intensive care	200	-
TOTAL grant-in-aid	**71,432**	**58,034**
Grant-in-aid transferred to Government grant reserve	2,581	1,591
Income reported in income and expenditure account	**68,851**	**56,443**

* Funding for the service level agreement with the HSCIC was paid directly by the Department of Health to the HSCIC.

3. Non-grant-in-aid income

Non-grant-in-aid income		
	Year to 31/03/06 £'000s	**Year to 31/03/05 £'000s**
Registration and inspection fees and charges to the independent sector	7,384	4,676

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. The fee levels were increased by 50% from April 1st 2005.

As detailed in Note 1 b) annual registration fees are invoiced on the anniversary of the registration and recognised in full in the accounting year invoiced. Fee income recognised in these accounts but relating to 2006/2007 registration periods was estimated at £2.5m at March 31st 2006 (£1.7m 2005).

Other income		
	Year to 31/03/06 £'000s	**Year to 31/03/05 £'000s**
Recharge of staff	317	362
Grants to commission research	359	-
Other income – speakers' fees etc	30	34
	706	**396**

4. Employee information

a) Staff costs

Employee information: Staff costs		
	Year to 31/03/06 £'000s	**Year to 31/03/05 £'000s**
Wages and salaries (including commissioners)	24,521	22,389
Secondments, temporary and interim staff	14,760	4,595
*Employers' national insurance	2,430	1,808
*Employers' pension costs	3,237	2,154
Staff costs recharged	317	362
Pension provision released	(450)	
TOTAL	**44,815**	**31,308**

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

b) Average number of employees during year

Average number of employees during year		
The average number of wholetime equivalent employees, including secondee and agency staff for the year ended March 31st 2006 by category of employment was:		
	Year to 31/03/06 WTE	**Year to 31/03/05 WTE**
Managerial	7	7
Support staff	620	507
Secondments, temporary and interim staff	153	95
TOTAL	**780**	**609**

c) Pension benefits

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

(i) NHS pension scheme

The scheme is a 'final salary' unfunded multi-employer defined benefit scheme. Annual pensions are normally based on 1/80th of the best of the last three years pensionable pay for each year of service. A lump sum, normally equivalent to three years' pension, is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending September 30th 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 up to five times their annual pension for death after retirement is payable.

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

Additional pension liabilities arising from early retirements are not funded by the scheme, except where the retirement is due to ill health. For early retirements not funded by the scheme, the full amount of the liability for the additional costs is charged to the income and expenditure account at the time the Commission commits itself to the retirement, regardless of the method of payment.

Contributing membership during 2005/2006 was 643, (2004/2005 507). Total employer contributions payable in 2005/2006 were £2.7m, (£1.9m 2004/2005).

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

(ii) Principal civil service pension scheme

From October 1st 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 October 1st 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.

Contributing membership during 2005/2006 was 65 (45). Total employer contributions payable in 2005/2006 were £0.6m, (£0.3m 2004/2005).

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 October 1st 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**.

5. Other operating costs

Other operating costs		
	Year to 31/03/06 £'000s	Year to 31/03/05 £'000s
Other operating costs include:		
Communication costs	2,483	2,600
Consultancy, prof fees, etc	15,648	16,569
*External audit	60	79
IT costs	1,112	632
**Losses and special payments	45	27
Premises costs and facilities costs	2,520	1,570
Recruitment and training	2,355	2,971
Travel and subsistence	3,030	2,612
Operating leases	3,423	2,249
Other costs	1,301	1,078
Impairment of fixed assets	65	186
Losses on disposal of fixed assets	22	79
	32,064	**30,652**

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

**Losses and special payments:
Losses in the year ending March 31st 2006 amounted to £45,000. (£27,000 2004//2005), comprised of:

Cash losses	3	4
Bad debts written off	37	8
Special payment on termination of employment	-	15
Fruitless payments	5	-

6. Fixed assets

Fixed assets							
	Office refurbishment	**Office furniture**	**Office equipment**	**Computer hardware**	**Total tangible assets**	**Intangible assets**	**Total fixed assets**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Cost or valuation							
Balance 01/04/05	4,148	869	558	2,242	7,817	901	8,718
Additions in year	65	75	142	855	1,137	1,444	2,581
Disposals in year				(142)	(142)	(46)	(188)
Indexation	55	7	4	(71)	(5)	(34)	(39)
Balance at 31/03/06	**4,268**	**951**	**704**	**2,884**	**8,807**	**2,265**	**11,072**
Depreciation							
Balance 01/04/05	1,087	411	334	1,233	3,065	418	3,483
Depreciation in year	269	100	78	526	973	421	1,394
Disposals in year				(138)	(138)	(28)	(166)
Indexation	16	3	2	(27)	(6)	(13)	(19)
Balance at 31/03/06	**1,372**	**514**	**414**	**1,594**	**3,894**	**798**	**4,692**
Net Book Value							
At 31/03/06	**2,896**	**437**	**290**	**1,290**	**4,913**	**1,467**	**6,380**
At 31/03/05	**3,061**	**458**	**224**	**1,009**	**4,752**	**483**	**5,235**

7. Debtors

Debtors		
	As at 31/03/06 £'000s	**As at 31/03/05 £'000s**
a) Amounts falling due within one year:		
Trade debtors	795	751
Advances – staff loans	121	86
Prepayments and accrued income	1,996	1,504
Other debtors	366	84
Total	**3,278**	**2,425**
Staff loans are for season tickets, bicycle purchase and gym membership. No member of staff received loans in excess of £5,000.		
Intra-government balances:		
Balances with central Government bodies	632	40
Balances with NHS trusts	74	95
Balances with public corporations	153	53
Balances with bodies external to Government	2,419	2,237
Total	**3,278**	**2,425**
b) Amounts falling due after one year:		
Prepayments and accrued income	208	-
All balances with bodies external to Government		

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

Analysis of cash and bank balances and changes during the year			
	As at 01/04/05 £'000s	**Cashflow £'000s**	**As at 31/03/05 £'000s**
Paymaster general	4,828	202	5,030
Other banks	5	(5)	-
Cash balances	4	-	4
Total	**4,837**	**197**	**5,034**

9. Creditors

Creditors		
	As at 31/03/06 £'000s	**As at 31/03/05 £'000s**
Amounts falling due within one year		
Trade creditors	1,429	1,086
Taxation and national insurance	884	645
Accruals and deferred income	4,481	3,619
Other creditors	443	328
Total	**7,237**	**5,678**
Intra-government balances:		
Balances with central Government bodies	1,186	1,481
Balances with NHS trusts	378	457
Balances with public corporations	908	555
Balances with bodies external to Government	4,765	3,185
Total	**7,237**	**5,678**

10. Provision

Provision		
	As at 31/03/06 £'000s	**As at 31/03/05 £'000s**
Pension fund deficit	250	700

An actuarial shortfall on pension entitlements arose from the transfer of staff from National Care Standards Commission at April 1st 2004. The pension shortfall is considered to be part of the set up costs of the Commission and at the time of the transfer of staff on April 1st 2004 the estimated liability was assessed at £700,000.
The actual liability will not be known until conclusion of the actuarial review at which point the timing of payments to meet the shortfall will be determined.

At March 31st 2006 the estimated liability assessment was reduced by the actuary to £250,000. The reduction in the provision has been credited to staff costs as shown in Note 4 a).

11. Reserves

Reserves		
	Year to 31/03/06 £'000s	**Year to 31/03/05 £'000s**
i) Income and expenditure account		
Balance at 01/04/05	884	1,064
Surplus (deficit) for the year	149	(180)
Balance at 31/03/06	**1,033**	**884**
ii) Government grant reserve		
Balance at start of period	5,235	4,711
Transfer Capital Grant	2,581	1,591
Indexation of fixed assets	45	101
Downward valuation of IT equipment, software and refurbishment charged to the I & E account	(65)	(186)
Depreciation charged to the I & E account	(1,394)	(903)
Loss on Disposals charged to I & E account	(22)	(79)
Balance at March 31st 2006	**6,380**	**5,235**

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

Reconciliation of operating surplus to net cash inflow from operating activities		
	Year to 31/03/06 £'000s	**Year to 31/03/05 £'000s**
Retained surplus/(deficit)	85	(228)
Depreciation	1,394	903
Cost of capital	64	48
Downward revaluation of fixed assets	65	186
Loss on disposal of fixed assets	22	79
Transfer from Government grant reserve	(1,481)	(1,168)
(Increase) in debtors	(1,061)	(1,336)
Increase in creditors	1,559	2,044
Reduction in provisions	(450)	-
TOTAL	**197**	**528**

13. Operating leases

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.		
	As at 31/03/06 £'000s	**As at 31/03/05 £'000s**
Land and buildings		
One year	1,025	429
Two-five years	875	608
Over five years	1,754	1,744
TOTAL	**3,654**	**2,781**
Other leases		
One year	5	88
Two-five years	7	73
Over five years	-	-
TOTAL	**12**	**161**

14. Capital commitments

The Commission had the following capital commitments at the balance sheet date:		
	As at 31/03/06 £'000s	**As at 31/03/05 £'000s**
Expenditure contracted but not provided	Nil	Nil
Expenditure authorised but not contracted	Nil	67

In addition, a major development by the Commission relates to the creation of an intelligent information management system (IIMS). This development will include a material IT development project that is subject to the gateway process and has been subject to the Gateway review. The project 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 expenditure is incurred, with appropriate capitalisation of elements of the project. Total project capital costs are estimated at £12m of which £3.2m had been expended by March 31st 2006.

15. Contingent liabilities

There are no contingent liabilities at March 31st 2006 (Nil 2005).

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 of Health and other entities for which the Department of Health 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 March 31st 2006 are shown in notes 7 and 9.

Staff costs (Note 4) include the reimbursement of employment costs for staff seconded to the Healthcare Commission from the Department of Health, Audit Commission and other Government departments. Other material transactions were:

Grant-in-aid transfer £2.8m (Note 2)
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 (£2.7m 2004/2005). This agreement ended on March 31st 2006.

Audit Commission delegated work £497,000.
The Commission has delegated certain work relating to economy, efficiency and effectiveness to the Audit Commission under section 57 (6) of the 2003 Act. In respect of this work, the Commission transferred £497,000 of its funding to the Audit Commission (£417,000 2004/2005).

Costs are included within Other operating costs (Note 5).

None of the Commission members or Executive Team or other related parties has undertaken any material transactions with the Commission during the year.

17. Financial instruments

As permitted by FRS13, 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.

Printed in the UK for The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office
07/06,5386945

આ માહિતી વિનંતી કરવાથી અન્ય રૂપે અને ભાષાઓમાં મળી શકે છે. મહેરબાની કરી ટેલિફોન નંબર 0845 601 3012 પર ફોન કરો.

GUJARATI

ਇਹ ਜਾਣਕਾਰੀ ਬੈਨਤੀ ਕਰਨ 'ਤੇ ਹੋਰਨਾਂ ਰੂਪ 'ਚ ਅਤੇ ਜ਼ਬਾਨਾਂ 'ਚ ਮਿਲ ਸਕਦੀ ਹੈ। ਕ੍ਰਿਪਾ ਕਰਕੇ ਟੈਲਿਫ਼ੋਨ ਨੰਬਰ 0845 601 3012 'ਤੇ ਫ਼ੋਨ ਕਰੋ।

PUNJABI

यह जानकारी बिनती करने पर अन्य रूप में और भाषाओं में मिल सकती है। कृपया टैलिफ़ोन नम्बर 0845 601 3012 पर फ़ोन करें।

HINDI

Akhbaartan waxaa lagu helaa iyadoo siyaabo iyo luqado kale ku qoran haddii la codsado. Fadlan soo wac lambarka telefoon ee ah 0845 601 3012.

SOMALI

Οι παρούσες πληροφορίες διατίθενται και σε άλλες μορφές ή γλώσσες εάν ζητηθεί. Τηλεφωνήστε στο 0845 601 3012

GREEK

المعلومات متاحة أيضاً لدى طلبها بعدد من الأشكال واللغات الأخرى. الرجاء الإتصال بهاتف رقم 0845 601 3012.

ARABIC

یہ معلومات درخواست کرنے پر دوسرے فارمیٹ یعنی شکلوں میں بھی دستیاب کی جاسکتی ہے۔
برائے مہربانی فون کیجئے 0845 601 3012

URDU

如有需要，本信息还有其他格式和语言的版本。
请致电 **0845 601 3012**。

CHINESE-SIMPLIFIED

如有需要，本信息還有其他格式和語言的版本。
請致電 **0845 601 3012**。

CHINESE-TRADITIONAL

অনুরোধ করলে এই তথ্যগুলি অন্য ভাষা ও আকৃতিতে পাওয়া যাবে। অনুগ্রহ করে এই নাম্বারে ফোন করুন 0845 601 3012

BENGALI

Arzu edildiği takdirde bu bilgi değişik formatlarda ve dillerde verilebilir. Lütfen 0845 601 3012 numaralı telefonu arayınız.

TURKISH

Tin tức này có bằng những hình thức và ngôn ngữ khác theo yêu cầu.
Hãy gọi phôn số 0845 601 3012

VIETNAMESE

È possibile richiedere le presenti informazioni su altri supporti o in altre lingue. A tal fine, telefonare allo 0845 6013012.

ITALIAN

Informacje te są dostępne na życzenie w innych formatach i językach.
Prosimy zadzwonić pod numer 0845 601 3012

POLISH

Healthcare Commission

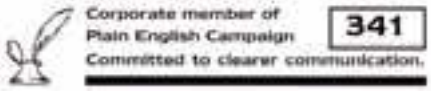
Finsbury Tower
103-105 Bunhill Row
London
EC1Y 8TG

Telephone 020 7448 9200
Facsimile 020 7448 9222
Helpline 0845 601 3012

E-mail feedback@healthcarecommission.org.uk
Website www.healthcarecommission.org.uk

This information is available in other formats and languages on request.
Please telephone 0845 601 3012.

This publication is printed on paper made from a minimum of 75% recycled fibre



Published by TSO (The Stationery Office) and available from:

Online
www.tso.co.uk/bookshop

Mail, Telephone, Fax & E-mail
TSO
PO Box 29, Norwich NR3 1GN
Telephone orders/General enquiries 0870 600 5522
Fax orders 0870 600 5533
Order through the Parliamentary Hotline *Lo-call* 0845 7 023474
E-mail book.orders@tso.co.uk
Textphone 0870 240 3701

TSO Shops
123 Kingsway, London WC2B 6PQ
020 7242 6393 Fax 020 7242 6394
68-69 Bull Street, Birmingham B4 6AD
0121 236 9696 Fax 0121 236 9699
9-21 Princess Street, Manchester M60 8AS
0161 834 7201 Fax 0161 833 0634
16 Arthur Street, Belfast BT1 4GD
028 9023 8451 Fax 028 9023 5401
18-19 High Street, Cardiff CF10 1PT
029 2039 5548 Fax 029 2038 4347
71 Lothian Road, Edinburgh EH3 9AZ
0870 606 5566 Fax 0870 606 5588

The Parliamentary Bookshop
12 Bridge Street, Parliament Square,
London SW1A 2JX
Telephone orders/General enquiries 020 7219 3890
Fax orders 020 7219 3866

TSO Accredited Agents
(see Yellow Pages)

and through good booksellers

ISBN 0-10-294148-3

9 780102 941487