Monitor

Making the health sector work for patients

Annual report and accounts 2013/14

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Monitor

Annual report and accounts
1 April 2013 - 31 March 2014

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Monitor

Wellington House, 133-155 Waterloo Road, London SE1 8UG

Telephone: 020 3747 0000

Email: enquiries@monitor.gov.uk

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About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and procurement, choice and competition operate in the best interests of patients.

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Monitor's role

Our responsibilities to help improve the health sector for patients and other service users grew last year with our new broader remit under the Health and Social Care Act 2012. We need, above all, to help the sector close the gap over the coming years between quality expectations and current performance, and the gap between the growth in revenues and the trend growth in costs.

In April 2014 we published our new strategy for 2014-17. It influenced our actions throughout the previous 12 months while we were developing it. We are therefore reporting under its headings for 2013/14. There are six elements. The first four of these mirror our core responsibilities, and so are closely related to our four main organisational functions: provider appraisal, provider regulation, pricing, and co-operation and competition. The last two elements are designed to support our overall success in making sure the health sector works for patients.

1. Making sure public providers are well led. From its inception, Monitor has been tasked with making sure public providers of NHS care are well led, delivering quality care on a sustainable basis. We do this in two ways, first by setting a required standard that all NHS providers must meet (our foundation trust authorisation standard or 'bar') and by working, most recently with the NHS Trust Development Authority, to ensure that, in due course, all NHS providers meet this standard. Second, we seek to control the risk that foundation trusts, once authorised, fall back below the required standard. If they do, we take remedial action. We also work with others to support the ongoing development of foundation trust capabilities so that they are better able to deal with the challenges they face.

2. Making sure essential NHS services are maintained. If a provider of essential NHS services, whether an NHS foundation trust or an independent sector provider, gets into such serious difficulty that it is unlikely to be able to continue providing its essential services for much longer, we are responsible for making sure those services are maintained and protected for local patients. The services may continue to be provided by the failing provider while it restructures, or by alternative providers.

3. Making sure the NHS payment system promotes quality and efficiency. One of our new duties is to work with NHS England to design and operate the payment system for all NHS services. NHS England specifies how services should be grouped for payment purposes (known as currencies), and Monitor sets the rules for how the level of any payment should be determined.

4. Making sure procurement, choice and competition operate in the best interests of patients. The purpose of promoting good procurement and, where appropriate, enabling patients and commissioners to choose between competing service providers is to support improvements in the quality of care and the efficiency with which it is provided. Our role is to help commissioners and providers make sure patients do not lose out through poor commissioning, restrictions on their rights to

make choices or inappropriate anti-competitive behaviour by commissioners or providers.

5. Promoting change through high quality analysis and debate, and by encouraging innovation. The change required to improve patient care needs to happen in frontline organisations. Monitor can only fulfil its mission if, in conjunction with our partners, we can influence what people in those frontline organisations do. In addition to our formal powers, as the sector regulator we also have an opportunity to promote change by undertaking high quality analysis and using it to stimulate debate on critical issues, and by encouraging innovation.

6. Making sure Monitor is a high performing organisation. In order to deliver our strategy we must ourselves strive to be a high performing and effective organisation. We must do this against the backdrop of the very significant expansion in scope of our responsibilities and the corresponding growth in our organisation. We also have to shape our culture so patients are at the heart of all we do.

Interim Chairman's foreword

As the new Interim Chairman of Monitor, I am pleased to introduce our annual report and accounts at the end of our first year as health sector regulator. My determination for the future is to ensure that, in line with our new primary duty, we put patients and quality of care at the centre of our work.

As former Chairman of an NHS trust, I know that there is a wealth of success stories within the NHS, that the overall level of professionalism is high and that new treatments are offering hope to many patients. But some tragic lapses in the quality of care, and sometimes a lack of compassion as well, mean there is simply no room for complacency. Our aim as one of the organisations that lead the NHS system must be to make sure all hospital and other foundation trusts give patients, carers and other users the consistent quality of services they deserve, and that this is extended to integrated care in the community.

The new architecture of the NHS means that responsibilities are divided among many bodies. To be an effective organisation we must work closely with organisations such as the Care Quality Commission, the Competition and Markets Authority, the Department of Health, the NHS Trust Development Authority, and NHS England in its commissioning role. Monitor itself does not deliver care. It is our job to support those who do, giving them as much freedom as possible to do what they are good at: to innovate at a local level.

One of our specific tasks is to help and encourage the creation of new models of care. We have a duty to enable these models to be delivered in an integrated way. For me, this is one of the most fundamental approaches to improving care. Too often services are fragmented, and it is the most vulnerable patients, such as those with long-term conditions, who suffer most. My years in the NHS and in local government have shown me how vital it is for all aspects of care to be joined up.

In Monitor we work as one team. We have had some changes to the Board team this year. Stephen Thornton's term of appointment concluded at the end of May. He has made a valuable contribution for over seven years. Iain Osborne joined the Board in May. Dr David Bennett has until recently held the roles of chairman and chief executive. The Board and David, who lead Monitor, have long wanted to separate these roles, thereby complying with best governance practice. I look forward to working closely with David in his role as chief executive. I would like to thank David and the Board for all their efforts in helping to build Monitor into a highly capable organisation. While holding the roles of both chairman and chief executive, David successfully led the organisation as it made the challenging transition to become sector regulator.

Finally, it is a very real achievement for us that the National Audit Office found earlier this year that Monitor has achieved value for money in regulating NHS foundation trusts, has rigorous processes and standards, and has generally been effective in helping trusts in difficulty to improve. This is a tribute to our staff's professionalism and I would like to thank them for all their hard work during the year. I hope this report will bring to life the important work that Monitor is doing.

The Baroness Joan Hanham CBE
Interim Chairman
2 July 2014

Chief Executive's review of the year

Following months of preparation by our staff, Monitor made a smooth transition on 1 April 2013 to our new role of sector regulator for health services in England, with a duty to protect and promote the interests of patients. During the year, our work to make sure NHS foundation trusts are well led (our original role) reflected growing pressure on the NHS to improve the quality of services in a difficult financial climate. Most of the 147 NHS foundation trusts that we oversee managed well on our performance measures. However, some were in special measures for quality reasons and 40 ended 2013/14 in financial deficit, more than double the number of the previous year.

Our expanded role means we can do more to help frontline NHS staff meet these pressures. Where public providers have got into difficulties we have looked for sustainable solutions that work for the whole local health economy, in line with our new responsibility for making sure essential NHS services are maintained for patients. We have taken this approach at the troubled Mid Staffordshire NHS Foundation Trust. The trust special administrators that we appointed there concluded that the trust should be dissolved, and that other organisations should take over the running of the services it previously provided. This solution is now being implemented.

Monitor has acknowledged that it was a mistake to grant Mid Staffordshire foundation trust status in 2008 because we didn't have a full picture of the state of care at the trust at the time. We have learned many lessons, in particular the importance of listening closely to patients and engaging with them more. In that regard, we are particularly pleased that Professor Hugo Mascie-Taylor has joined Monitor as Medical Director and Executive Director of Patient and Clinical Engagement, with responsibility for this priority. Professor Mascie-Taylor has a strong clinical background and extensive NHS leadership experience. He is also one of the trust special administrators at Mid Staffordshire NHS Foundation Trust, working to ensure that its services serve patients' needs into the future.

With NHS England and the NHS Trust Development Authority we have funded strategic planning support for 11 local health economies struggling with financial problems. Experts are helping local commissioners and providers draw up integrated five-year plans that should put them on a firm footing and support the delivery of quality care in the long term.

Supporting more co-ordinated strategic planning by local commissioners and providers has been a theme throughout the year. In December, our planning guidance for NHS foundation trusts asked them to produce five-year strategic plans for the first time. Our guidance complements the planning guidance issued to commissioners by NHS England and to NHS trusts by TDA.

Closer working with the other bodies leading the NHS, notably NHS England, the NHS Trust Development Authority, the Care Quality Commission and the Department of Health, has also been a theme. We collaborated with the Care Quality Commission and the Department of Health on special measures for helping hospitals with serious quality failings to improve. In February, with the NHS Trust Development Authority, we found the 14 NHS trusts and NHS foundation trusts placed in special measures last year were using this additional support, which includes providing expert oversight and support on the ground through 'improvement directors' and partnering with 'buddy trusts', to deliver tangible quality improvements for their patients. On 9 June 2014 Basildon and Thurrock University Hospitals NHS Foundation Trust came out of special measures.

Since the beginning of the year we have been responsible, with NHS England, for making sure the NHS payment system promotes good-quality and efficient care across the health service. In December 2013 we introduced rules for agreeing payments where local commissioners and providers have found new ways to improve patient services that are not covered by the existing tariff. We have also developed, with input from the sector, a strategy for reforming the NHS payment architecture in the long term so that it consistently encourages providers and commissioners to meet the needs of patients. This work continues in 2014/15.

Our new responsibility for making sure the NHS uses procurement, choice and competition in the best interests of patients is perhaps the most controversial and the least well understood. Over the year, we sought to tackle misunderstandings by producing guidance for commissioners, meeting many of them in person, and publishing the details of our decisions – what we decide and why – for every case in this area we consider.

In all our work, we pursued our duty to enable integrated care for patients. In November 2013 we were delighted to launch, with a number of partners, the integration pioneer scheme. This provides tailored support to pioneers selected for their imagination and success in making sure health and social services work together to provide better support at home and earlier treatment in the community. Their patients should be less likely to need emergency care in hospital or care homes. In return, we ask the pioneers to inform us and the rest of the sector how they integrate their local health, public health, social care and voluntary systems. This exercise should inform the joint plans that all localities must produce for sharing the £3.8 billion Better Care Fund between health and social care in 2014/15.

We also undertook a range of research projects, as a complement to our sector regulator responsibilities, to find out how well different aspects of the NHS work for patients and to identify how they could be improved. We published two reports on NHS walk-in centres. The first reported on our concerns about the closure of centres that had delivered a good service to patients; the second set out for commissioners the questions they should ask themselves before closing a walk-in centre in order to

ensure the potential impact on service users is properly taken into account. Other projects, some ongoing, looked at GP services, the economics of smaller acute general hospitals, and what the future ‘provider landscape’ could look like.

We closed the year by completing our three-year strategy for helping commissioners and providers redesign healthcare in England, with patients’ needs for quality and compassionate care at its centre. For this and all else that we have done I am immensely grateful to all our staff for their energy and professionalism in taking on our expanded responsibilities this year. We look forward to continuing to help the people who deliver health services in making the NHS work better for patients over the coming year.

Dr David Bennett
Chief Executive
2 July 2014

Making sure public providers are well led

Monitor has always been more than a financial or economic regulator. We make sure trusts are well led so that they can deliver high quality care for patients. The new powers we received in April 2013 gave further impetus to the emphasis on quality which has become so important across the NHS following the Francis Inquiry. After publication of the Francis Report, the government published its initial response, entitled 'Patients First and Foremost', which set out a collective commitment for the whole healthcare system. In June we set out our commitment to improve how we work in a comprehensive action plan to address the Francis recommendations, which built on the improvements we had made previously. We work closely with the Care Quality Commission (CQC), having adopted a seamless approach to safeguarding patients through quality regulation, with the aim of preventing problems arising in the first place.

Working towards all NHS providers achieving the foundation trust standard

Working with the NHS Trust Development Authority and the Care Quality Commission to streamline the assessment approach

One of our principal roles is to assess applications by NHS trusts for NHS foundation trust status. During 2013/14 we worked with NHS Trust Development Authority (TDA) and CQC to streamline the end-to-end assessment process. Our key objectives were the need to act on the recommendations from the Francis Inquiry, remove unnecessary duplication, minimise the burden on trusts and align with CQC's new inspection approach.

We have completed the first phase of this project with the following changes:

Revised Care Quality Commission threshold

NHS trusts who apply for foundation trust status will now need to be inspected under the new CQC inspection approach.

These trusts will be inspected alongside other organisations as part of the routine inspections that the Chief Inspector of Hospitals conducts. An overall rating of 'good' or 'outstanding' will be required to pass through to the next stage of the assessment. If the TDA Board is satisfied that a trust is ready to proceed, then it will offer its support (on behalf of the Secretary of State for Health) for the organisation to move on to Monitor for assessment.

Early review of quality governance

We have agreed to undertake our review of an applicant's quality governance during the TDA stage of the assessment process, where this has not already been performed externally as was done previously. We piloted this approach with two NHS trusts in 2013/14 and it will be implemented during 2014/15. Once these trusts are referred on to the Monitor stage of the assessment process we will adopt a risk-based approach to update our conclusions on quality governance prior to an authorisation decision.

Alignment of governance frameworks with the Care Quality Commission inspection approach

We have worked with CQC and TDA to align the current quality governance framework and board governance framework used in developing and assessing NHS foundation trust applicants into one overarching well-led framework. We have also mapped CQCs five key lines of enquiry (which support their inspection approach to well led) to the 10 questions in our well-led framework. This well-led framework, combining the existing approaches, will then be used by TDA to develop and oversee applicants and by Monitor to test applicants for foundation trust status, while existing foundation trusts will be encouraged to use it to conduct governance reviews every three years. Between now and October 2014 CQC, Monitor and TDA will develop and test proposals to take forward more detailed alignment of the framework.

During 2014/15 we will continue to work with TDA to identify ways to further streamline the assessment process with the aim of minimising the burden on trusts.

Assessment in 2013/14

During 2013/14, five NHS trusts were referred to us for assessment, prior to the introduction of the Chief Inspector of Hospital's new inspection regime. Since 1 April 2014 only St George's Healthcare NHS Trust has been referred to us from TDA.

During the year we: completed assessments of 15 NHS trusts; we authorised two and deferred applications from nine (of which six are awaiting inspection under the new inspection regime); two trusts requested a postponement; and four trusts withdrew (see table below).

By the end of March 2014, of the total 246 NHS trusts in England, 147 had achieved NHS foundation trust status.

Assessment summary 2009-14

Year	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Referred	7	11	5	12	5
Assessed	20	14	10	10	15
Authorised	14	7	7	2	2
Deferred (2013/14 includes six trusts assessed but awaiting CQC inspection under the new regime)	1	1	1	5	9
Postponed	4	6	1	3	2
Withdrew	1	0	3	0	4
Rejected	0	0	0	0	0
Total number of foundation trusts	129	136	143	145	147

Significant transactions

We assessed a number of capital investments and early transaction reviews during the year, including one significant transaction – the acquisition of the Princess Royal University Hospital by King's College Hospital NHS Foundation Trust. We have begun to assess the Royal Free London NHS Foundation Trust's proposed acquisition of Barnet and Chase Farm Hospitals NHS Trust.

Regulating providers

Our approach minimises the impact on patients of poorly performing providers by identifying problems early and acting quickly.

We continue to make sure that NHS foundation trusts are well led and well run so they provide patients with quality care on a sustainable basis. But since the Health and Social Care Act 2012 we no longer ensure they comply with their terms of authorisation. Instead from 1 April 2013 NHS foundation trusts must now meet the conditions of the NHS provider licence, issued by Monitor.

To ensure a smooth transition, the 19 foundation trusts that were in significant breach of their terms of authorisation under our old regime remained subject to robust regulatory action under the new licence. We use the licence conditions as our principal tool for carrying out our new functions as well as continuing our oversight of NHS foundation trust governance. The licence conditions include requirements concerning pricing, choice and competition, integrated care and continuity of services, as well as specific conditions for foundation trusts relating to governance.

We have also continued to develop our regulatory approach in response to the Francis Report into the breakdown of care at Mid Staffordshire NHS Foundation Trust, the Keogh Review into trusts with high mortality rates and the Berwick Review of patient safety in the NHS.

Foundation trust risk assessment framework

NHS providers of services operate in a very challenging financial and clinical environment. Two of our most important roles for patients are overseeing the governance and financial sustainability of NHS foundation trusts, which provide £36.2 billion of NHS services. We developed the 'Risk assessment framework' (RAF) after consulting with the sector and launched this in August. We use the RAF to forecast which trusts are in greatest financial difficulty, or where we have concerns with how those trusts are run, including poor quality of care or failure to meet national waiting times standards. Where the RAF indicates a concern with either the finances or the governance of a trust, it may trigger an investigation and regulatory action to safeguard the quality and sustainability of services for patients.

NHS foundation trusts in breach of their licence

In addition to the 19 foundation trusts which had been in significant breach of their terms of authorisation in 2012/13, we found eight more foundation trusts in breach of their licence, taking the total to 27 at 31 March 2014.

During 2013/14	**Breach**	**Action taken**
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	Governance	Following the Keogh Review, which highlighted problems with leadership and staffing, we placed the trust in special measures. We made a legally binding agreement with the trust to strengthen clinical leadership and improve quality governance.
Aintree University Hospitals NHS Foundation Trust	Governance	We made a legally binding agreement with the trust to deliver improvements in leadership and to meet their C. difficile target.
Colchester Hospital University NHS Foundation Trust	Governance	Following the Keogh Review, a whistleblower came forward with concerns about the trust's implementation of their cancer pathway. We stepped in and placed the trust in special measures.
Heart of England NHS Foundation Trust	Governance	We made a legally binding agreement with this trust to deliver improvements in its urgent care.
Dorset Healthcare University NHS Foundation Trust	Governance	Following the decision of the trust chair to stand down, we required the trust to appoint an interim chair and made a legally binding agreement for urgent improvements to be made to the way in which the trust is run.
Calderstones Partnership NHS Foundation Trust	Governance	We made a legally binding agreement with the trust to carry out a package of care improvements including weekly reviews for patients at specialist NHS learning disability centres in Lancashire with their case manager.
Cumbria Partnership NHS Foundation Trust	Governance	We made a legally binding agreement with this trust to ensure they comply with clinical quality standards, offer good quality care to patients and improve their leadership.
The Christie NHS Foundation Trust	Governance	Following concerns that this trust has not adhered to corporate governance standards, they have agreed to appoint an interim chair chosen by Monitor.
Since 31 March 2014	**Breach**	**Action taken**
Southern Health NHS Foundation Trust	Governance	We made a legally binding agreement with this trust to improve the quality of care in Oxfordshire and the way it manages its services.
University Hospital of South Manchester NHS Foundation Trust	Finance and governance	We made a legally binding agreement with this trust that they would appoint a turnaround director to help them deal with short-term financial problems and undertake a review of their leadership and how they are run.

Current investigations	Breach	Action taken
South Tees Hospitals NHS Foundation Trust	Finance and governance	We launched an investigation into why some patients were waiting too long for treatment. The investigation has been expanded to look at the trust's deteriorating financial position.
Lancashire Teaching Hospitals NHS Foundation Trust	Governance	We are investigating why some patients are waiting too long for treatment.
Barnsley Hospital NHS Foundation Trust	Finance and governance	We launched an investigation into why patients are waiting too long for A&E treatment and why the trust's finances are deteriorating.
Central and North West London NHS Foundation Trust	Governance	We are investigating governance concerns at the trust triggered by CQC warning notices.

Special measures

When we consider that an NHS foundation trust with quality problems is unable to make sufficient improvements in a reasonable timeframe without extra support, we place it in special measures – a set of specific interventions designed to improve the quality of care within 12 months. This is usually based on a recommendation from CQC. We work with CQC, who focus on identifying failures in the quality of care and judging whether improvements have been made, and TDA, who work with NHS trusts.

Although the range of actions will vary, trusts subject to special measures must have:

- a regularly updated improvement plan, published on their own website and NHS Choices
- an assigned 'improvement director'
- in most cases, an assigned partner from a high-performing trust to provide support to make improvements.

We will only take a trust out of special measures once CQC has re-inspected and the trust is no longer rated 'inadequate' in the 'well-led' domain and has made progress across the other four domains. We also have to be confident that improvements will be sustained.

Following the Keogh Review, in July 2013 we initially placed six of the nine foundation trusts investigated in special measures.

Trusts placed in special measures in 2013/14	Reason
Basildon and Thurrock University Hospitals NHS Foundation Trust (July 2013)	Problems with patient care and hospital governance
Medway NHS Foundation Trust (July 2013)	Problems with patient care and hospital governance but Monitor later escalated its regulatory action after uncovering broader problems with A&E performance and deteriorating financial position
Burton Hospitals NHS Foundation Trust (July 2013)	Problems with patient care, hospital governance and clinical leadership
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (July 2013)	Problems with patient care, hospital governance and clinical leadership
Sherwood Forest Hospitals NHS Foundation Trust (July 2013)	Problems with patient care and hospital governance
Tameside Hospital NHS Foundation Trust (July 2013)	Problems with patient care, hospital governance and clinical leadership
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (October 2013)	Problems with poor care and weak leadership
Colchester Hospital University NHS Foundation Trust (November 2013)	Concerns about management of the cancer care pathway

Since 31 March 2014 one further trust, Heatherwood and Wexham Park Hospitals NHS Foundation Trust, has also been placed in special measures.

On 9 June 2014 Basildon and Thurrock University Hospitals NHS Foundation Trust exited special measures.

Performance

We track the performance of NHS foundation trusts to help them prevent operational issues becoming quality problems and adversely affecting patient care.

We review NHS foundation trusts' annual plans each spring and then report on performance against the plan and operational performance at each quarter. During the year we reported that overall the foundation trust sector met most key operational targets (such as A&E) although there is increasing pressure on the achievement of most waiting time targets. Financial performance across the sector remained positive, but the level of surplus across the system has declined compared to the previous year.

Accident and emergency

Each winter NHS accident and emergency (A&E) departments face pressures to cope with the peak demands on them due to seasonal illnesses and injuries. In 2012/13 the NHS as a whole failed the A&E target for January to March (Q4), so last year funding of £400 million was allocated to help local health systems during this period.

We set up a special Monitor unit to support the foundation trusts most likely to miss their targets. We also shared information at regular meetings with TDA, NHS England and the Association of Directors of Adult Social Services. Although the NHS foundation trust sector missed the Q4 target (94.7%) they improved significantly compared with the same period the previous year (93.4%), despite 78,771 (3.2%) more attendances and 49,451 (3.8%) more emergency admissions. In a survey of foundation trusts with A&E departments, 17 out of 20 respondents rated the involvement of the Monitor team as 'very' or 'somewhat' helpful.

Infection control

Across NHS foundation trusts the incidence in C. difficile cases continues to decline but the number of trusts breaching their individual target continues to rise, partly because individual targets are reduced every year. Fifteen trusts who failed the target had not declared a risk. This suggests that the number of trusts breaching the target will continue to rise.

NHS England recognises that some trust targets were too ambitious and the calculation methodology for 2014/15 is therefore being reviewed.

Referral to treatment

Overall, foundation trusts achieved all three elective waiting time standards in October to December (Q3) of 2013/14 and continued to perform better collectively than NHS trusts. However, more foundation trusts breached all three target standards in Q3 than in Q2 (July to September). Of the 80 foundation trusts with growing waiting lists, 75% cited a significant increase in referrals and only 20% a reduction in capacity, data quality issues or other factors. The biggest contributors to waiting list growth are not the specialties that perform worst against the targets, so larger waiting lists will not necessarily result in future deterioration of target performance.

A recent National Audit Office report found that some trusts are not interpreting the waiting time rules correctly, so Monitor is working with NHS England, the Department of Health and TDA to improve the reporting and audit of waiting time data.

Financial reporting

We compiled the consolidated accounts for the foundation trust sector, providing an audited public record of financial performance in the year. As in previous years, the accounts were laid before Parliament before the summer recess on 11 July 2014.

The majority of foundation trusts are breaking even or are in surplus but the number of trusts in deficit has almost doubled from the equivalent time last year. The sector surplus before impairments and transfers was £134 million in 2013/14, which compares to £500 million in 2012/13. Overall, the performance of the sector reflects the tough financial climate and foundation trusts' responses.

Development work

Improving strategic planning in the sector

The financial challenges of the coming years will require Monitor and our national partners to support the sector in improving its planning and mitigating the impact on patients. NHS England, Monitor and TDA have therefore worked together to ensure that timetables, planning horizons, expectations and guidance are aligned and co-ordinated for the 2014/15 planning round.

We are moving away from incremental one-year planning: clinical commissioning groups (CCGs), foundation trusts and NHS trusts are now required to develop robust but ambitious plans that cover the next five years. We will focus more heavily on strategic and local health economy issues as part of our annual review of foundation trusts' plans as we believe it is crucial that these medium- and long-term plan components are strategically consistent and aligned with those of commissioners and partners. The three partner organisations have embarked on a joint programme of support for 11 particularly challenged local health economies to help them deliver improved joined-up five-year strategic plans.

Helping to strengthen individuals and institutions

Induction days for chairs, chief executives and non-executive directors:
To support the chairs and chief executives of NHS foundation trusts, we held three induction sessions on core regulatory procedures. There were a total of 31 attendees. Working together with the Foundation Trust Network, we also ran two programmes for new non-executive directors. This programme includes sessions on NHS finance, quality, competition, and pricing and helps to prepare non-executive directors for their role in holding executive directors to account.

Medical directors: Insights into the day-to-day work of medical directors – and what support they need – have significantly improved our understanding of the sector. We conducted a survey of more than 250 medical directors at a range of trusts; the findings, published in May 2014, were of particular interest to clinicians aspiring to take on leadership roles and others with an interest in advancing clinical leadership.

Code of governance: We updated the 'NHS Foundation Trust Code of Governance' in December 2013 to reflect the new regulatory and policy landscape. This is designed to be a useful, practical tool for foundation trusts that covers effective corporate governance and improved organisational performance and which supports them to discharge their duties.

Panel for Advising Governors**:** We established the independent Panel for Advising Governors in June 2013. Now any council of governors can be better informed, with the option of asking the Panel whether their trust has breached or is at risk of breaching its constitution or Chapter 5 of the National Health Service Act 2006 (the main legislation on NHS foundation trusts).

Morecambe Bay Investigation

In September 2013 the Secretary of State for Health announced an independent investigation into maternity and neonatal services at University Hospitals of Morecambe Bay NHS Foundation Trust in response to a series of deaths of mothers and newborn babies between January 2004 and June 2013. The investigation, chaired by Dr Bill Kirkup, is focusing on the trust's actions, as well as the actions of regulators and commissioners. The terms of reference provide full details of the scope of the investigation, which will report to the Secretary of State for Health by autumn 2014. We continue to co-operate constructively with the investigation.

Making sure essential NHS services are maintained

Patients rightly expect timely access to essential NHS services. If a provider gets into such serious difficulty that it is unlikely to be able to continue providing its essential services for much longer, we are responsible for making sure those services are maintained and protected for the people who need them. From April 2014, certain independent sector providers needed to hold a licence for the first time, offering even greater safeguards for patients.

Establishing a single continuity of services regime

The Care Act 2014 establishes a single continuity of services regime covering providers that fail on quality grounds as well as those that fail financially. We will work with our partners across the system to ensure its successful implementation.

Supporting clinical commissioning groups to designate commissioner requested services

The most essential healthcare services are now designated 'commissioner requested services' (CRS). These are services commissioners believe would be hard to replace should a provider fail financially. We have a duty to safeguard these and took steps to help commissioners make the designations, including publishing guidance. We will work with NHS England to update the guidance and to build CRS designation into future annual planning rounds.

Regulating independent sector NHS providers

On 1 April 2014 we licensed 86 independent providers of NHS-funded healthcare that are required to hold the licence. This was the culmination of our work to engage with independent providers and develop infrastructure to handle licence applications. Bringing independent providers formally under our regulation is a milestone in our transition from being purely a foundation trust regulator. Licensing independent providers will be important in promoting choice, sustainability of essential services and joined-up care for patients.

Licensed independent providers are subject to the licence provisions on pricing, competition, choice and integrated care. In particular, we oversee financial risk at these independent sector providers and published the 'Risk assessment framework for independent sector providers of NHS services' in April 2014.

A specialist team will make initial assessments of licensed providers during 2014/15 and will strengthen relationships with the independent sector, especially third sector providers.

Taking action to protect services

Mid Staffordshire NHS Foundation Trust

Based on the report of the contingency planning team (CPT) we appointed, we put the trust into special administration in April 2013. The trust's board and governors were automatically suspended as required under the Health and Social Care Act 2012 and the trust special administrators (TSAs) took over responsibility for running the trust.

The TSAs, who included an experienced clinician, ran an extensive public consultation on their draft recommendations and produced a final report which set out recommendations for the dissolution of the trust and for the future configuration of health services currently provided by it.

Following our approval of the TSAs' final recommendations, the Secretary of State for Health considered the plans. On 26 February 2014 he accepted the TSAs' recommendations.

After the Secretary of State's decision, the TSAs began implementing their recommendations, to prepare the trust for formal dissolution later this year while continuing to run the trust in the meantime.

The special administration has now moved into the implementation phase, which will see the TSAs prepare for the transfer of management and some services at Stafford Hospital to University Hospital of North Staffordshire NHS Trust, and at Cannock Chase Hospital to the Royal Wolverhampton Hospitals NHS Trust.

Peterborough and Stamford Hospitals NHS Foundation Trust

We appointed a multi-disciplinary CPT in February 2013 to look at the sustainability of the services provided by Peterborough and Stamford Hospitals NHS Foundation Trust. The team's sustainability review, published in early June 2013, found the trust to be clinically and operationally sustainable, but financially unsustainable, highlighting a risk to the ongoing delivery of services for patients. The CPT's recommendations included driving efficiencies within the trust; developing a regional steering group to ensure joined-up working across the local health economy and maximising the benefits from use of the trust's assets, particularly the use of existing and potential clinical space at Peterborough City Hospital.

In September 2013, we accepted binding enforcement undertakings from the trust to address the CPT's recommendations to reduce its deficit. Then, in February 2014, Monitor and the trust agreed to revise these to give the trust more time to look at similar schemes and consider commissioners' plans to find the best party to maximise the opportunity provided by the trust's assets. This could result in bids for the use of clinical space made available through converting the existing non-clinical space, and may extend to bids which both do this and offer to run the trust's existing

services more efficiently. Our enforcement team will continue to check the trust meets the enforcement undertakings.

Milton Keynes Hospital NHS Foundation Trust and Bedford Hospital NHS Trust

Our enforcement team is leading a strategic review of both in- and out-of-hospital NHS services across the Milton Keynes and Bedfordshire area, in order to support NHS England and local CCGs to make decisions about future services for patients. Both Milton Keynes Hospital NHS Foundation Trust and neighbouring Bedford Hospital NHS Trust are experiencing financial and clinical challenges. As part of the review, we are working with TDA to consider the issues facing the trusts in the context of the wider health economy.

Given the scale of the financial challenge faced by the health sector in the coming years and emerging clinical best practice guidelines from the Royal Colleges and others, we expect an increase in complex regulatory action of this kind in the future and we are planning staffing levels within the enforcement team accordingly.

Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust was placed in special measures by Monitor in October 2013, due to our concerns about poor quality care and weak leadership. This followed warnings from CQC that patient care was inadequate and a report from NHS England that highlighted insufficient nurse staffing levels. As part of our action, Monitor appointed a new interim chair of the board and new interim chief executive.

Despite progress in several areas during winter 2013, particularly A&E, the trust forecast that it would make a significant deficit in 2013/14. In March 2014, we decided to send in a team of experts to come up with a plan to secure the future of services for patients at the trust. This contingency planning team will work with local commissioners and the trust to identify options for sustainable patient services and will make a clear recommendation to Monitor later this year.

Understanding local health economies

To support our work with trusts in financially challenged health economies, our economics team is doing research to help us understand the interactions that take place across local health economies and the impact these have on the challenges providers face. We have started by studying three main areas: our approach to defining a local health economy for a particular area; how to provide data analysis; and interviews with stakeholders including providers and commissioners.

Making sure the NHS payment system promotes quality and efficiency

The belief of Monitor and NHS England that the NHS payment system could do more to promote higher quality patient care within the budget is now widely accepted among healthcare commissioners and providers. Monitor and NHS England are jointly responsible for the design of the NHS payment system, and we are approaching this shared responsibility as a significant opportunity to promote patients' interests.

Our work on the design of the payment system can make a substantial difference to quality of care that will really be felt by patients, for example by:

- enabling better co-ordinated out-of-hospital care
- giving providers incentives to meet best practice standards.

In May 2013, Monitor and NHS England published 'How can the NHS payment system do more for patients', setting out for discussion our early thoughts on options for redesigning the payment system over the long term.

Our approach to national prices for the 2014/15 tariff was broadly similar to that of the Department of Health in 2013/14, as we sought to ensure predictability of income for providers while we gathered and consulted with the sector on the evidence on new payment options that must underpin any longer term design changes. However, the rules for use and variation of the prices are now more clear and explicit than they have been in the past. During the year, we proposed, consulted extensively with the sector and published jointly with NHS England the '2014/15 National Tariff Payment System', our first collection of payment rules and national standard prices. These make up the NHS payment system. The price list and rules in this document came into effect at the start of the 2014/15 financial year. Clinical commissioning groups and providers of NHS care use these rules and the price list (or tariff) to agree the prices for the care that NHS patients receive. NHS England decides what services to group within a national price while Monitor leads on the method and rules for setting prices.

The rules also allow local commissioners and care providers to experiment with alternative payment approaches for new patterns of care, as long as they do so transparently and have considered constructively the options available with patients' interests in mind. We were especially concerned to make sure that the payment system is not blocking innovations that could lead to better integrated care for frail and elderly patients.

Putting the building blocks in place for a sustainable payment system

We have commissioned a study that looks at costings at the level of the individual patient. Due for publication in 2014, this will inform our vision of how healthcare should be costed, thereby helping providers and commissioners access better data to inform decisions to improve care for patients. We will also work with our partner NHS England to enable delivery of integrated care and urgent and emergency care.

Monitor has established a team to help ensure that the payment rules are applied effectively, that dealings are transparent, and that examples of successful local pricing are shared within the sector.

Mental health trust funding

Several mental health campaign organisations, including the Mental Health Network, criticised Monitor and NHS England over the '2014/15 National Tariff Payment System'.

An additional £150 million was allocated to national prices to fund service improvements in acute health services. Monitor and NHS England have stated that the national tariff rules for 2014/15 allow commissioners and providers to negotiate local prices as appropriate where there is no national price. We have clarified that for mental health services, for which there is no national price, commissioners and providers are allowed to agree local prices.

As we develop the '2015/16 National Tariff Payment System', both Monitor and NHS England are engaging with all parts of the NHS, including mental health, community services and independent providers, to understand the cost pressures they face and to continue to develop an evidence-based approach to pricing.

Supporting integrated care

We are actively pursuing our duty to enable the delivery of person-centred, co-ordinated care because, in many cases, an integrated approach can improve the quality or efficiency of care patients receive. Integration also has the potential to improve people's NHS experiences by reducing inequalities of access or outcomes. Integrated care can have system-wide benefits: joining up clinical care, social care and other types of care, it is one of the best-known examples of the new patterns of service delivery so important for the future of the NHS.

Enabling integrated care through regulatory levers

In most cases, it is for commissioners to design, develop and fund better and more integrated patterns of care with local providers. Our role as the sector regulator is to work with other organisations, remove barriers and consider how to enable them to do this.

Across Monitor we work to provide the regulatory incentives that allow new models to emerge and to encourage integrated care. This involves a number of our functions including policy, provider appraisal, provider regulation, enforcement and licensing, choice and competition, and pricing. For example, our provider licence includes a specific condition requiring licence holders not to take actions that could reasonably be regarded as detrimental to delivering care in an integrated way.

Working with national partners

We are one of the national partners that make up the Integrated Care and Support Collaborative, along with organisations such as the Department of Health, NHS England and the Local Government Association. Together, the Collaborative set a clear direction through 'Integrated Care and Support: Our Shared Commitment', which was published in May 2013. This described what good person-centred, co-ordinated care looks and feels like and how we work together to achieve it. Following this, 14 integrated care 'pioneers' were chosen – for their innovative approaches and commitment to continuous improvement – to exemplify existing good practice.

Making integrated care the norm

The pioneers' experiences should also provide reliable evidence for understanding the improvements that come from delivering integrated care. As part of the Collaborative, the Department of Health and NHS Improving Quality will evaluate the impact of the pioneers programme on the sector, in addition to the local evaluation that pioneers carry out. This should help us gauge what changes, in terms of outcomes or efficiencies, have resulted.

Making sure procurement, choice and competition operate in the best interests of patients

We assumed our new responsibilities on procurement, patient choice and competition in the health sector on 1 April 2013. This was one of the most significant changes to our remit. For providers, patient and commissioner choice represents an incentive to deliver high quality services that are tailored to the needs of patients.

To meet our new duties, we created the Co-operation and Competition team on 31 March 2012 when the staff of the former Co-operation and Competition Panel transferred to become part of Monitor and the panel itself became an advisory body. (All senior roles were subject to open competition.) Then in April 2014 we appointed two experts to provide advice on competition to our senior team and board, replacing the stand-alone advisory panel, the Co-operation and Competition Panel. This will help make sure that the right advice is available to senior decision-makers.

The team has two strategic priorities both aimed at making sure choice and competition operate in the best interests of patients: education and focused action. To take each in turn, we realise that we need to help the sector understand the new patient choice rules and how they can benefit patients. Our focus is on helping people do the right thing for patients rather than waiting for them to do the wrong thing.

Helping the sector understand how the rules benefit patients

A key feature of our work in 2013/14, which continues this year, is a structured programme of engagement with commissioners and providers. This includes:

- speaking engagements at conferences and other events run by organisations including NHS Clinical Commissioners, the Healthcare Financial Management Association, the Commissioning Support Unit Network and the Foundation Trust Network; we also stage interactive sessions for groups, particularly CCGs, on request
- regional roadshows to help commissioners understand the regulations]: in March and early April 2014, we ran 10 workshops around the country – nearly 90% of attendees reported afterwards that their knowledge about the regulations was ‘fairly or very high’
- a new dedicated sector involvement team to engage with the system to improve knowledge and understanding of the regulations.

The Procurement, Patient Choice and Competition Regulations guidance

One of the principal areas of our oversight of choice and competition is through the Procurement, Patient Choice and Competition Regulations (also known as the Section 75 regulations). Commissioners are responsible for meeting the needs of patients in a way that improves services; these regulations build on previous rules

and provide a framework for doing this. We published our guidance in December 2013 to help commissioners understand how the rules should be interpreted and applied in practice.

We published the guidance alongside some hypothetical scenarios, designed to explain our approach. We also issued a short, accessible briefing note setting out the main points of the full guidance and followed this up with engagement activity, described above.

Formal cases

We resolve many issues without ever intervening formally, but we do open formal investigations where it is likely that only this can provide the best outcome for patients. We have powers to intervene to protect choice, enable integration of care and prevent anti-competitive behaviour that is not in the interests of patients. In particular, we can apply and enforce the sections of the provider licence on integrated care and choice and competition and also the Competition Act 1998. We can also make market investigation references to the new Competition and Markets Authority (CMA).

If there is a need to investigate (for example, where there is evidence of anti-competitive behaviour that is not in the interests of patients) we will do so, and we will take action to ensure that the system works as intended for patients.

We opened investigations following three complaints on the commissioning and provision of NHS services. As a result of these:

- We are investigating whether patients are disadvantaged by the way non-emergency hospital services were purchased in the Blackpool, Fylde and Wyre area of Lancashire.
- We concluded an investigation following a complaint from the Thornbury Radiosurgery Centre Limited about the conduct and procurement practices of the North of England Specialised Commissioning Group in the Yorkshire and Humber area and its successor, NHS England, in relation to the commissioning of radiosurgery services which are specialised services. We published guidance for commissioners based on the lessons learned from the investigation.
- We concluded an investigation into the commissioning of cancer surgery services in Greater Manchester by NHS England (formerly NHS Greater Manchester) following complaints from University Hospital of South Manchester NHS Foundation Trust and Stockport NHS Foundation Trust. We published guidance for commissioners based on the lessons learned from the investigation.

Informal advice

As our approach is to help guide people do the right thing in securing quality services for patients, we consider it important to offer an informal advice service; commissioners, providers and patient groups can contact us with queries on procurement, choice and competition issues. Typically, these range from factual questions about aspects of the relevant rules to complex questions relating to a major service reconfiguration. We work with the people and organisations who contact us to understand the issues involved and offer tailored advice so that decisions made are good for patients.

There has been a significant rise in both the volume and complexity of queries. We have responded by allocating additional resources to this important area of our work.

Mergers

We have a statutory role to advise the new CMA on the patient benefits of proposed mergers involving NHS foundation trusts. Among the proposals we have advised on are: a pathology joint venture between University College London Hospitals NHS Foundation Trust, Royal Free London NHS Foundation Trust and The Doctors Laboratory Limited; the mergers of Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust; and the transfer of neurosurgery services from the Royal Free London NHS Foundation Trust to University College London Hospitals NHS Foundation Trust.

We have recently agreed with CMA and the wider health system that Monitor should play a fuller role in the merger process: our aim is to create a smoother and swifter path for mergers and acquisitions that work well for patients. We will engage with NHS foundation trusts contemplating a merger at an early stage to ensure the proposal works well for patients from the perspectives of good governance and competition. We will explain how likely we believe it is that the transaction might raise competition issues and we will independently assess how the merger may deliver benefits for patients.

We have been working with CMA and its predecessor bodies to develop a shared understanding of how it will approach future mergers in the NHS. And we have produced a joint guide on how statutory merger control rules apply to NHS mergers.

Understanding whether aspects of the system are working well for patients

We have published our first in-depth studies designed to show how well certain parts of the health sector are working for patients.

We issued a call for evidence in June 2013 to better understand the challenges facing the GP sector in England and to identify what we and others can do to help address them. We published Discussion document following Monitor's call for evidence on GP services explaining what people had told us in February 2014. Among the issues for patients were: variations in access and quality; the ability of

new or existing providers of GP services to develop the scope of their offer to the NHS; and providers' ability and incentives to work together to benefit patients.

In February 2014 we published Walk-in centre review: final report and recommendations in England as well as advice and recommendations for commissioners when deciding the future of walk-in centres. In this report we examined how the closure of walk-in centres had limited people's ability to choose where and when they access routine or urgent primary care without an appointment.

Promoting change through high quality analysis and debate, and by encouraging innovation

The changes required to improve patient care – and help close the funding gap that is opening up over the coming years – need to happen in frontline organisations. We can only fulfil our mission if, in conjunction with our partners, we can support and influence what people in those organisations do. As sector regulator, we have an excellent opportunity to encourage truly transformational change through high quality analysis and debate and by encouraging innovation.

One particularly important area of this work is supporting the development of the new service or care models that will meet changing patient needs by:

- undertaking or promoting research and analysis on critical issues, such as economies of scale among providers
- working with clinicians and patient groups to promote a national debate on alternative service or care models with a focus on developing new, higher value models that meet the public's desire to maintain or improve access.

Another area is working with clinicians, commissioners, patient groups and providers to secure public support for the required changes by:

- building a coalition of opinion leaders in support of necessary changes
- developing partnerships with national and local stakeholders to inform and engage the public.

Closing the gap

In October 2013 we published a major study into the challenges facing the NHS in our report 'Closing the NHS funding gap: how to get better value healthcare for patients'. This set out how improving productivity could help close the funding gap and informed our new 2014-17 strategy. Historically, productivity growth in the NHS has lagged behind that in the economy as a whole. If the NHS is to have a chance of closing the expected gap – estimated at £30 billion a year by 2021 – it will need to achieve 'more for less' at a higher rate than it ever has done before. Steps to meet the challenge include:

- improving productivity within existing services
- delivering the right care in the right settings, including increasing care in the community
- developing new, innovative ways of delivering care
- making 'one-off' reductions in capital expenditure and staffing costs
- changing the way health spending is allocated, which is currently based on historic demand.

These opportunities won't be easily realised, but have the potential to close the financial gap and improve the way services are delivered.

Monitor's 2014-17 strategy

We published our new corporate strategy for 2014-17 in April 2014 after engaging with our partners and national stakeholder organisations.

'Monitor's strategy 2014-17' sets out how we intend to help the front line redesign how care is delivered. In simple terms, our job is to work with the other system leaders and those who work on the front line to make the health sector work better for patients. Our strategy describes what we plan to do to achieve this, focusing on the critical priorities for the next three years against each of our core responsibilities.

The strategy has four cross-cutting themes:

1. **Paying more attention to provider capability:** The capabilities of provider organisations and their leaders will be more important than ever if they are to sustain the provision of high quality services in the face of a highly challenging and fast-changing environment.

2. **Balancing freedom to change and risk of failure:** Change and innovation require that local decision-makers are granted the freedom to get on and do their jobs. However, at a time when increasing attention is being paid to the quality of care and resources are scarce we must actively play our part in reducing the risk that failings go uncorrected for any significant period.

3. **Making sure rules operate in the best interests of patients:** Monitor has responsibility for two sets of rules that are central to how the health sector operates: those governing the payment system and those governing procurement, patient choice and competition.

4. **Joining up nationally and locally:** The new architecture of the NHS means that responsibilities are divided among many bodies. At Monitor we will reach out to and seek to work closely with our partner organisations, nationally and locally. This means, in particular, NHS England, TDA, CQC, CMA, and the Department of Health.

NHS Futures Summit

Our NHS Futures Summit event, run jointly with NHS England and TDA, brought together over 100 senior leaders and innovators from across the system to debate new models of care, the barriers that prevent them from emerging and enablers necessary to support their adoption. The report that followed the summit, 'A call to action: transformative ideas for the future of the NHS', disseminated thinking and evidence around some of the new care models that can produce fundamental change.

Making sure Monitor is a high performing organisation

To deliver our best work for patients we must ourselves strive to be a high performing and effective organisation. We are seeking to achieve this against the backdrop of the very significant expansion in the scope of our responsibilities and the corresponding growth in our organisation.

National Audit Office report on Monitor's regulation

The National Audit Office (NAO) published its report 'Regulating Foundation Trusts' in February 2014. This assessed our role as a regulator of NHS foundation trusts, our assessment process and our preparedness for our new role as sector regulator.

Sir Amyas Morse, Head of the NAO, stated that: "Monitor has done a good job in regulating NHS foundation trusts. Its processes for assessing NHS trusts are robust and its judgments have mostly been sound. It has helped NHS foundation trusts in difficulty to improve and trusts have regularly taken radical action, such as changing their chair or chief executive, in response to Monitor's interventions. However, bigger challenges lie ahead for Monitor, as it takes on its significant new responsibilities that stretch across the whole health sector. In addition, as Monitor itself recognises, it needs to adapt how it works with other bodies to tackle underlying local weaknesses that increase the risk of individual trusts failing, either clinically or financially."

In July the House of Commons Committee of Public Accounts (PAC) published its own report 'Monitor: regulating NHS Foundation Trusts'. The PAC agreed with many of the NAO's findings and recommendations but commented adversely on several aspects of our performance, including the level of clinical experience within Monitor. We are already taking action along many of the lines recommended by the PAC and the NAO.

Investment in a new information system

Access to high quality data is essential to our regulatory decision-making. We are developing a new information store to capture for the first time a comprehensive range of healthcare and population data that permits us to do new types of more complex economic and financial analysis. Examples include modelling new pricing methodologies and building models of local health economies to analyse the risks faced by providers and understand the long-term sustainability of small acute hospitals.

Chairman and other leadership developments

There have been significant developments in Monitor's Board and Executive Committee. Baroness Joan Hanham was appointed Interim Chairman of Monitor on 20 January 2014. Dr David Bennett, who had been Chairman since March 2011 alongside his role as Chief Executive, is now solely Chief Executive.

Stephen Thornton's term as a non-executive director and Deputy Chairman was extended until 31 May 2014. The Board agreed that Keith Palmer should take on the

role of Deputy Chairman and Senior Independent Director from 1 April 2014, for a period of one year.

Fiona Knight joined as Executive Director of Organisation Transformation on 1 July 2013.

Culture and values, in particular patient and clinical focus

Our new role as regulator of the healthcare sector requires our staff to have a broad perspective, understanding the needs of patients and the challenges faced by those delivering care on the front line. The health sector is distinctive: those in the caring professions need to deliver specific outcomes, in an often challenging economic context, and must also show compassion for individual patients, friends and families. Similarly, only those on the front line are able to implement innovation successfully. We recognise that, as a regulator, we will not be able to promote a stronger focus on quality or encourage the sector to innovate and change unless we truly understand the viewpoints of those who actually deliver care.

Our previous corporate values emphasised internal attributes, in particular, the importance of analytical rigour and professionalism. We believe that these are firmly rooted in the organisation's culture and the need now is for more outward-looking values that ensure staff are always working with our partners to consider the impact of their work on patients, in support of the front line.

Using the move to our new offices in Wellington House, we asked all our staff to celebrate the best of Monitor's first 10 years and consider how we could strengthen our ways of working to make an even bigger difference for patients. In December we ran an event called 'Making a Difference for Patients'. Over 90% of our staff attended and, led by members of the Executive Committee, were invited to make the connection between their work and individual patient stories. We encouraged staff to think about how their work can contribute directly to benefiting patients and asked them to help shape our new set of values. We followed up with team exercises tied into NHS Change Day with values ambassadors appointed in each directorate.

Our new values, agreed in March, are:

- Putting patients first
- Working with partners
- Supporting the front line
- Working as one team
- Being professional

It is essential patients remain at the heart of everything Monitor does. This year we have worked hard to put in place the foundations on which Monitor can build for the future, with a firm patient focus at the centre. Our economics team, working with the stakeholder engagement team, has undertaken research and held patient group

roundtables on how best to engage with patients and their representatives. Monitor is now using that feedback to embed a new patient-engagement focused function.

Equality and diversity

We are committed to promoting equality and diversity both as an employer and in carrying out our statutory functions. In line with the NHS Constitution, we aim to be an inclusive organisation that treats everyone with dignity and respect. Last year we improved the way we gather workforce diversity data and published 'Equality in our workforce' to comply with our duty under the Equality Act 2010. We will be launching a fairness and inclusion programme during 2014/15, including training for managers to counter unconscious biases.

Recruitment and induction

We continued a major recruitment programme last year to build capacity across Monitor in our new functions. We have made significant progress in recruiting and inducting people into the organisation. The appointment of more staff with a clinical background, including Professor Hugo Mascie-Taylor as our new Medical Director and Executive Director of Patient and Clinical Engagement from May 2014, will increase our connection with clinicians and patients.

Monitor staff in post

	March 2011	March 2012	March 2013	March 2014	March 2015 (projected)
No. of staff in post	148	181	299	424	494

Monitor's staff profile by year

	Female	Male	Average age	Staff turnover	Black and ethnic minority
2009/10	57%	43%	36 years	12.4%	15%
2010/11	61%	39%	36.6 years	11.3%	16%
2011/12	55%	45%	36.6 years	21%	20.3%
2012/13	56%	44%	36.2 years	12%	18%
2013/14	54%	46%	36.2 years	12.7%	21.4%

Staff development

Investing in the development of our staff remains a priority. Following our well-received induction programme, we introduced a core learning and development programme for all staff in October 2013, seeking to enhance communication skills, coaching, people management and the delivery of results. We also launched a series of 'Monitor Talks' in lunchtimes. This is a joint venture between the economics and policy teams to share insights from work that is being done across Monitor and from relevant external experts. In addition, we refreshed our monthly 'all staff' briefings and ensured a comprehensive staff cascade process to get input into our new strategy as it developed.

Staff engagement

We conducted a full staff survey in February 2014 and had a response rate of 71%. The results were very positive in a number of areas with 81% of staff saying they are proud to work for the organisation. We scored well in staff recommending Monitor as a great place to work (74%), feeling safe to speak up and question the way things are done (69%), and confidence in the leadership (67%). All of these were at least 16% above benchmark comparisons. People also enjoy their jobs, are clear on what they need to do, and feel they are kept informed. Staff were also positive about the changes introduced by the leadership. Among the pointers for action to ensure even higher levels of engagement were greater cross-team working, ensuring alignment of day-to-day working with our new strategy, and enhanced performance development. The Executive Committee has agreed that the full survey will be run annually in February with a short 'pulse' survey in September or October to monitor progress.

Whistleblowers and complaints

We recognise that listening and responding effectively to feedback is vital. We have a dedicated enquiries and complaints team providing a point for all our contact with patients, their families, whistleblowers and other members of the public. Complaints can provide a valuable warning sign about problems at an individual trust and we take them seriously. We immediately share details of healthcare complaints with CQC and provide any other relevant help to ensure that complaints are received by the right bodies. We also use the valuable information that complaints provide to inform our regulatory approach.

In 2013/14 we received 438 complaints in total, 342 of which were about NHS foundation trusts. We received four complaints about Monitor, one of which we have partially upheld. This related to delay and poor communication in dealing with a whistleblowing case. The Parliamentary and Health Service Ombudsman investigated one complaint about Monitor, which also related to a whistleblowing case; the Ombudsman found no evidence that Monitor was at fault and did not uphold the complaint. In 2013/14 we received and considered 39 separate whistleblowing concerns about foundation trusts.

Business plan for 2013/14

In our business plan for 2013/14 we set ourselves 75 actions to achieve and added another eight projects during the course of the year. We successfully completed 59 actions, 10 of which then became activities categorised as 'business as usual'. This amounts to 79% of our target number, in addition to the 8 completed projects. Where actions were only partially completed, due mainly to resource constraints or external dependencies, they were reprioritised into the 2014/15 financial year.

Monitor's financial position

Our non-capital outturn for the financial year 2013/14 was £64 million, including £46.1 million core running costs, £16.4 million for contingency planning teams

(CPTs) and trust special administration (TSA) and £1.6 million relating to reviews of special measures trusts. Our non-capital allocation for the financial year 2014/15 is £82.3 million in total, the increase reflecting: our ongoing work regulating NHS foundation trusts and assessing applicant trusts; recruitment of staff to the new functions in our sector regulator role; and an expected increase in CPT and trust special administration activity.

Annual governance statement 2013/14

Introduction

In managing the affairs of the organisation, the Board of Monitor is committed to achieving high standards of integrity, ethics and professionalism across all of our areas of activity. As a fundamental part of this commitment, we aim to support and adopt the highest standards of corporate governance within the statutory framework. This annual governance statement sets out how Monitor's resources have been managed and controlled in 2013/14 to enable this.

Monitor's governance framework

Our Board

The role of the Board is to lead the organisation, by setting its strategy (including Monitor's vision, mission and values) and agreeing the framework within which operational decisions will be taken.

Board composition

The Health and Social Care Act 2012 (the 2012 Act) stipulates that Monitor's Board is to consist of a chair and at least four non-executive directors appointed by the Secretary of State for Health. The chief executive and other executive directors who are Board members are appointed by the non-executive directors, subject to the consent of the Secretary of State for Health. The number of executive directors on Monitor's Board must not exceed the number of non-executive directors.

Monitor's Board is made up of four non-executive directors (Heather Lawrence, Iain Osborne, Keith Palmer, who is also Monitor's Deputy Chairman, and Sigurd Reinton) and three executive directors. Stephen Thornton, who was Non-Executive Director and also Monitor's Deputy Chairman, left the Board on 30 May 2014. David Bennett occupied the roles of both Chairman and Chief Executive until 20 January 2014, when he resigned from the position of Chairman. Baroness Joan Hanham was appointed by the Secretary of State for Health as Monitor's Interim Chairman with effect from 20 January 2014 until 31 December 2014. David Bennett continues in his role as Chief Executive. Stephen Hay and Adrian Masters also continue in their executive roles as Managing Director of Provider Regulation and Managing Director of Sector Development, respectively.

No individual or group of individuals dominates the Board's decision-making. Collectively, the non-executive directors bring a valuable range of experience and expertise as they all currently occupy, or have occupied, senior positions in the healthcare sector, in the commercial sector and in public life. With the exception of the Chief Executive, Managing Director of Provider Regulation and Managing Director of Sector Development, members of Monitor's Executive Committee are not members of the Board but they attend Board meetings as a matter of routine and make presentations on pertinent matters arising from their respective directorates.

The non-executive directors

Monitor's non-executive directors are independent of management and have no cross directorships or significant links which could materially interfere with the exercise of their independent judgements. Arrangements for the handling of any possible conflicts of personal interest are set out in Monitor's Rules of Procedure.

Sigurd Reinton, Heather Lawrence and Keith Palmer continue in their positions as non-executive directors following their four-year appointments in 2012. Stephen Thornton's second four-year term of appointment was due to conclude on 30 September 2013. In light of the Secretary of State for Health's decision to appoint a new chairman, Stephen Thornton's appointment was extended to ensure that Monitor continued to have a majority of non-executive directors on its Board. He left Monitor on 30 May 2014. Stephen was replaced on Monitor's Board by Iain Osborne, who was appointed as Non-Executive Director (for three years) with effect from 19 May 2014.

Board members' terms and conditions of appointment are available on request from the Secretary to the Board.

Deputy Chair and Senior Independent Director

Stephen Thornton occupied the positions of deputy chair and senior independent director from 1 April 2012 until 30 May 2014 when he left Monitor and Keith Palmer took on these positions. The principal responsibilities of Monitor's senior independent director are to:

1. work closely with the chairman, act as a sounding board and provide support
2. make themselves available for confidential discussions with other Board members who may have concerns that they believe have not been properly considered by the Board as a whole
3. act as a point of contact for stakeholders with concerns that contact through the normal channels has failed to resolve, or for which such contact is inappropriate
4. relay to the non-executive directors their observations and any views they may have received from stakeholders.

Chairman and Chief Executive

Baroness Joan Hanham was appointed Monitor's Interim Chairman with effect from 20 January 2014 until 31 December 2014. Prior to this David Bennett had been Monitor's Chairman since 1 March 2011. The Secretary of State for Health decided to appoint an interim chairman in light of the Health Select Committee's decision not to endorse his candidate for the substantive appointment in October 2013.

The role of Chairman is to:

1. provide effective leadership and management of Monitor's Board
2. ensure that Monitor's Board, as a whole, plays a full and constructive part in the development and determination of Monitor's strategy and overall objectives
3. act as the guardian of Monitor's Board decision-making processes
4. ensure that Monitor's Board has the information and advice needed to discharge its statutory duties, and
5. ensure that there is effective communication by Monitor with its stakeholders, including by the Chief Executive and other Executive Committee members, and that members of Monitor's Board develop an understanding of Monitor's major stakeholders.

David Bennett has been Chief Executive since 1 November 2012. The role of Chief Executive is to:

1. lead and manage Monitor as an organisation, including its staff and work programmes
2. propose and develop Monitor's strategy and overall objectives, in close consultation with the Chairman and the rest of the Board
3. be responsible, with the Executive Committee, for implementing the decisions of the Board and its committees
4. promote and conduct the affairs of Monitor with the highest standards of integrity, probity and corporate governance
5. lead the communications programme with stakeholders, jointly with the Chairman.

How the Board operates

The 2012 Act established that the body corporate known as the Independent Regulator of NHS Foundation Trusts was to continue to exist and to be known as Monitor. The 2012 Act also established Monitor as the sector regulator for health, with a primary duty to protect and promote the interests of people who use healthcare services by promoting provision of healthcare services that:

(a) is economic, efficient and effective

(b) maintains or improves the quality of services.

In the exercise of powers under paragraph 10(1) of Schedule 8 to the 2012 Act, Monitor has made the Rules of Procedure to establish a Board and to regulate its procedures and those of its committees. The Rules of Procedure are published on Monitor's website.

To discharge its duties effectively, the Board must determine the scope of its activities and the areas of the organisation to which it will assign high priority. This 'job description' for the Board is set out in the Matters Reserved to the Board (Annex C to Monitor's Rules of Procedure), which reflect the Board's priorities and determine the extent of its intended direct involvement in particular areas of the organisation.

The Matters Reserved to the Board include:

- establishing and maintaining Monitor's strategic direction – reviewing, contributing to and approving Monitor's vision, mission and values
- approving Monitor's corporate and business plans, including distributing Monitor's financial allocation as set out in the annual business plan and any subsequent material change to this
- approving Monitor's risk management strategy/framework, including determining Monitor's risk appetite
- approving all of Monitor's significant regulatory policies prior to consultation with stakeholders and any material amendments following responses received in response to consultation
- determining any operational decision considered to be policy-determining (ie having strategic implications) and/or very high risk.

While the Matters Reserved to the Board reflect the Board's priorities and the matters in which it intends to be actively involved, they also delineate the areas in which the Board considers it appropriate to delegate authority to others, including Board committees, the Chief Executive and other executives. To ensure clear lines of accountability between the Board and the Executive, Monitor has a Scheme of Delegation (Annex D to the Rules of Procedure). The Scheme of Delegation reflects the job descriptions of Monitor's Executive Committee members and follows from the Matters Reserved to the Board.

Monitor's Board has agreed a code of ethical practice (Annex B to the Rules of Procedure), which provides a high level statement of the standards of practice expected of Monitor's Board and staff. The code explicitly reflects the Statement of Common Purpose agreed in light of the findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry and recognises the importance of the principles and values identified within the NHS Constitution. Monitor is committed to taking account of these in all of its decisions and actions.

Information required for the Board to operate

The Board has agreed a classification of the information it requires to carry out its duties and having given specific consideration to the nature and quality of information required in each of these categories, is content that the information it receives is appropriate to ensure that it is kept fully up to date on the issues arising which affect Monitor.

The Rules of Procedure govern the information to be submitted to formal Board meetings. In addition to these formal meetings, Executive Committee members maintain regular contact with all the non-executive directors and hold informal meetings with them to discuss issues affecting Monitor.

In addition to advice from Monitor's in-house legal and regulatory directorates, the Board may request independent and external professional advice on any matter relating to the discharge of its duties. The costs of any such advice are met by Monitor, subject to the agreement between Monitor and the Department of Health as to funding for unforeseen circumstances that may arise during a financial year.

Secretary to the Board

The Secretary to the Board is responsible for:

1. advising the Board on all corporate governance matters
2. ensuring that Board procedures are followed
3. ensuring good information flow between the Board and its committees, and
4. facilitating induction programmes for non-executive directors.

Any questions that stakeholders may have on corporate governance matters should be addressed to the Secretary to the Board at Monitor's office address.

Board effectiveness

Board meetings and attendance

Attendance of the Chairman, individual non-executive directors and Executive Committee members at Board and committee meetings during 2013/14

Name	Board Max. 15 mtgs	A&R Committee Max. 5 mtgs	Nomination Committee Max. 1 mtg	Remuneration Committee Max. 4 mtgs
Joan Hanham*	2	N/A	N/A	N/A
Keith Palmer	15	5	N/A	4
Sigurd Reinton	15	5	N/A	N/A
Stephen Thornton	14	N/A	1	4
Heather Lawrence	15	N/A	1	4
David Bennett	15	5	1	3
Stephen Hay	14	3	N/A	2
Adrian Masters	15	2	N/A	N/A
Miranda Carter	15	N/A	N/A	N/A
Catherine Davies	15	N/A	N/A	N/A
Fiona Knight **	7	N/A	0	3
Kate Moore	15	N/A	N/A	N/A
Sue Meeson	14	N/A	N/A	N/A

* Joan Hanham joined Monitor in January 2014 ** Fiona Knight joined Monitor in July 2013
Iain Osborne and Hugo Mascie-Taylor joined Monitor in 2014/15 and so are not listed in this table.

Induction

All non-executive directors who join the Board receive detailed induction information about Monitor, its structure, operations and corporate governance. Meetings are arranged with members of the Executive Committee and other key senior members of staff. Visits to NHS foundation trusts are also arranged. The Interim Chairman received all of this information and undertook a full programme of induction meetings on her appointment in January 2014.

Performance evaluation

The Board sets objectives for both the Chairman and the Chief Executive. The Chairman sets objectives for individual Board members. As Chief Executive, David Bennett sets objectives for the Executive Committee against the objectives set for the Board and in relation to the delivery of the organisation's business plan. Upon being appointed Chief Executive, David Bennett agreed with the non-executive members of the Board that it would not be appropriate for him to appraise them. The Interim Chairman will be pursuing this as a priority in 2014/15.

The Board agreed to postpone an evaluation of its performance until the expected appointment of a new Chairman in October 2013. As this did not take place and the Interim Chairman was appointed in January 2014, it has been agreed that a full external evaluation will take place in June 2014.

Compliance with corporate governance codes of good practice

Monitor reviews its compliance against the 'Code of Good Practice for Corporate Governance in Central Government Departments', the 'UK Corporate Governance Code' and the 'NHS Foundation Trust Code of Governance'. Where they are applicable to Monitor, Monitor has complied with the main principles of each of these codes during the period 1 April 2013 to 31 March 2014, except for the following:

Cabinet Office Code of Good Practice	NHS Foundation Trust Code of Governance	UK Corporate Governance Code	Monitor position
N/A	**A.2.2** *The roles of chairperson and chief executive must not be undertaken by the same individual.* **A.3.1** *A chief executive should not go on to be the chairperson of the same NHS foundation trust.*	**A.2.1** *The roles of chairman and chief executive should not be exercised by the same individual. The division of responsibilities between the chairman and chief executive should be clearly established, set out in writing and agreed by the Board.*	David Bennett acted as both Chief Executive and Chairman from 1 March 2011 until 20 January 2014. His appointment to the role of Chairman was not a matter for Monitor's Board, as it is the responsibility of the Secretary of State for Health. On David Bennett's resignation as Chairman, Baroness Joan Hanham was appointed as

Cabinet Office Code of Good Practice	NHS Foundation Trust Code of Governance	UK Corporate Governance Code	Monitor position
			Monitor's Interim Chairman with effect from 20 January 2014 until 31 December 2014.
N/A	**B.2.11** *It is a requirement of the 2012 Act that the chairperson, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive, are responsible for deciding the appointment of executive directors.*	**B.7.1** *All directors of FTSE 350 companies should be subject to annual election by shareholders.* **B.7.2** *The Board should set out to shareholders in the papers accompanying a resolution to elect a non-executive director why they believe an individual should be elected.*	Monitor's executive directors were appointed by the Board, rather than its Nomination Committee, as part of the determination of Monitor's organisation design and the appointments approved by the Secretary of State for Health.
5.9 *The Board and accounting officer should be supported by an audit and risk assurance committee, comprising at least three members.*	**C.3.1** *The Board must establish an audit committee composed of at least three members who are all non-executive directors.*	**C.3.1** *The Board should establish an audit committee of at least three, or in the case of smaller companies two, independent non-executive directors*	During 2013/14, Monitor's Audit and Risk Committee comprised two non-executive directors. Efforts were made to appoint an independent member but this was not possible. However, on his appointment as a non-executive director, Iain Osborne joined the committee.
N/A	**C.3.6** *The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the organisation.*	**C.3.6** *The audit committee should have primary responsibility for making a recommendation on the appointment, reappointment and removal of the external auditor*	Given the statutory composition of Monitor, the National Audit Office acts as its external auditor.
4.12 *The lead non-*	**B.6.2** *Evaluation of the*	**B.6.2** *Evaluation of the Board*	It is planned that an externally facilitated

Cabinet Office Code of Good Practice	NHS Foundation Trust Code of Governance	UK Corporate Governance Code	Monitor position
executive Board member should support the Chair to ensure a Board effectiveness evaluation is carried out annually, and with independent input at least every three years.	*Board of NHS foundation trusts should be externally facilitated at least every three years.*	*of FTSE 350 companies should be externally facilitated at least every three years.*	evaluation of the effectiveness of Monitor's Board will take place in June 2014. This has been delayed as a result of uncertainties about the appointment of Monitor's Chairman.

Conflicts of interest

There are three main types of conflict faced by Monitor: (i) conflict of personal interest; (ii) conflict between bodies and (iii) conflict between operational directorates/functions. Arrangements for the handling of any possible personal conflicts of interest are set out in Monitor's Rules of Procedure. Monitor has agreed joint partnership arrangements with other healthcare regulatory bodies to manage any possible conflicts that might occur with them.

With regard to operational/ functional conflicts of interest, section 67 of the 2012 Act imposes specific legal duties on Monitor. Monitor is required to act to ensure that there is neither an actual nor a perceived conflict between the exercise of any of its functions in respect of: (i) regulating foundation trusts; or (ii) imposing additional licence conditions on NHS foundation trusts; or (iii) the accounts of NHS foundation trusts; and the exercise of any of its other functions. Further, Monitor must ignore its functions to issue additional licence conditions to NHS foundation trusts when exercising its competition and pricing functions. Where Monitor has resolved a conflict of interest, Monitor must publish a statement which sets out the nature of the conflict, the manner in which it was resolved and the reasons for deciding to resolve it in that manner. No such conflict was identified in 2013/14 and, consequently, no such statement required publication.

Further information about how Monitor manages operational conflicts of interest can be found in its Operational or Functional Conflicts of Interest Policy, which is published on Monitor's website.

Board committees

The terms of reference of all the committees are reviewed on a regular basis (at least annually) by the Secretary to the Board and by the Board as appropriate.

Audit and Risk Committee

Members: Keith Palmer (Chair), Sigurd Reinton, Iain Osborne (from 19 May 2014)

At the invitation of the committee, the Chief Executive (in his capacity as Monitor's Accounting Officer), the Managing Director of Provider Regulation, the Managing Director of Sector Development, the Director of Strategy and Policy, the Director of Financial Reporting and Risk Director, the Head of Internal Finance, the Head of Internal Audit (KPMG in 2013/14) and the external auditor (NAO) attend meetings. The Secretary to the Board attends Audit and Risk Committee meetings and acts as secretary to the committee.

The committee met five times in the 2013/14 financial year, as well as holding a self-assessment workshop. There have been no occasions on which either the internal auditor or the external auditor has requested a private session with the committee. All non-executive directors have access to the minutes of all of the committee's meetings. A report is presented to the Board by the chair of the committee following each Audit and Risk Committee meeting.

Key duties of the committee include:

1. appointing internal auditors and managing the relationship with them
2. commissioning and receiving reports from the internal auditors on the adequacy of Monitor's internal control systems
3. considering all relevant reports from the Comptroller and Auditor General, Monitor's external auditor, including reports on Monitor's accounts, achievement of value for money and the responses to any management letters issued by them
4. in-depth reviewing Monitor's risk profile and reporting to the Board on managing and mitigating current and emerging risks.

The Audit and Risk Committee undertook a self-assessment workshop in March 2014, which was facilitated by the NAO. This workshop informed the content of the committee's annual report to the Board, which was presented to the Board in May 2014 and is available on Monitor's website.

Highlights of the Audit and Risk Committee's reports to the Board in 2013/14:

- review and oversight of the preparation of Monitor's annual reports and accounts
- review and oversight of the preparation of the NHS foundation trust consolidated account
- approval of a programme of risk-based internal audits and monitoring of the outcomes of these internal audit reviews
- review of Monitor's systems of internal control and risk management, including its treatment of strategic risks

- agreeing Monitor's banking arrangements
- appointment of an Independent Member to the Audit and Risk Committee
- appointment of Monitor's Head of Internal Audit

Nominations Committee

Members: Heather Lawrence (Chair), Stephen Thornton (until 30 May 2014), David Bennett, Iain Osborne (from 19 May 2014)

At the invitation of the committee, the Executive Director of Organisation Transformation attends meetings. The Secretary to the Board attends Nominations Committee meetings and acts as secretary to the committee.

The Nominations Committee leads the process for Board appointments, by evaluating the balance of skills, knowledge and experience among existing Board members and agreeing, for submission to ministers, a description of the role and capabilities required for particular appointments. The Nominations Committee also takes the lead on succession planning for the Board. The committee met once in the 2013/14 financial year, to consider the progress being made on the recruitment of Monitor's Chairman and non executive directors..

Remuneration Committee

Members: Stephen Thornton (Chair) (until 30 May 2014), Iain Osborne (Chair) (from 19 May 2014), Keith Palmer, Heather Lawrence

At the invitation of the committee, the Chief Executive and the Executive Director of Organisation Transformation attend meetings. The Secretary to the Board attends Remuneration Committee meetings and acts as secretary to the committee. Details of the Remuneration Committee and its policies can be found in the Remuneration report (on page 66).

Highlights of the Remuneration Committee's reports to the Board in 2013/14:

- considering the application of the Very Senior Manager (VSM) Pay Framework at Monitor
- Monitor's pay strategy
- Long service awards

Technology Assurance Committee

Members: Sigurd Reinton (Chair), Stuart Jobbins (Independent Member), Paul Willer (Independent Member), Ted Woodhouse (Independent Member)

The committee, which first met formally in May 2014, supports the Board by providing independent assurance on information strategy and associated project proposals. On the basis of the information provided to it, the committee will provide

assurance on key decisions or recommendations which have critical strategic significance or that would materially impact risk.

Independent members of the committee have significant experience in senior leadership roles in large IT organisations and/or experience of leading large complex IT systems in multi-functional organisations. They use this experience to test and challenge Monitor's Information and IT Strategy and assure the Board that it is on track and meeting its objectives.

Executive committees

The Executive Committee is made up of the executive Board members and other direct reports to the Chief Executive, who chairs the Committee. Alongside the Executive Committee are other executive committees mirroring Monitor's regulatory functions. Each of these is chaired by the Chief Executive, with membership consisting of the relevant Executive Committee members. The Controls Committee approves expenditure within the framework of delegated efficiency controls set out by the Department of Health. The committee also approves expenditure on external recruitment activities for Monitor's activities relating to both its business-as-usual and its transition activities.

The Provider Regulation Executive focuses on the operation of a rigorous fit-for-purpose regulatory regime through monitoring the performance of all licensed providers of NHS-funded services (to 31 March 2013 NHS foundation trusts only) of their obligations under the provider licence. It takes decisions on provider-related interventions and enforcement.

The Provider Appraisal Executive (known until April 2014 as the Assessment Executive) focuses on decisions relating to NHS trust applications to become NHS foundation trusts. Should a decision on an application be considered to be policy-determining and/or high risk, the Provider Appraisal Executive will refer it to the Board. It also takes decisions on the risk ratings of significant transactions proposed by NHS foundation trusts.

The Pricing Executive focuses on the development and implementation of a coherent, long-term pricing strategy to deliver appropriate benefits to patients, including production of the annual national tariff. Joint design with NHS England is managed through the Joint Pricing Executive, which has membership from both organisations.

The Co-operation and Competition Executive focuses on establishing and maintaining transparent, effective principles and procedures for managing competition complaints and investigating cases.

Attendance of the Chairman, individual non-executive directors and Executive Committee members at Board and committee meetings during 2013/14

Name	Executive Committee Max. 29 mtgs	Controls Committee Max. 61 mtgs	Provider Appraisal Executive Max. 11 mtgs	Provider Regulation Executive Max. 17 mtgs	Pricing Executive Max. 9 mtgs	Co-operation and Competition Executive Max. 13 mtgs
David Bennett	29	46	8	13	8	13
Stephen Hay	25	47	11	16	N/A	N/A
Adrian Masters	25	49	10	14	9	11
Miranda Carter	26	N/A	11	16	7	N/A
Catherine Davies	24	N/A	N/A	N/A	N/A	12
Fiona Knight *	20	15	N/A	N/A	N/A	N/A
Kate Moore	28	N/A	10	15	N/A	8
Sue Meeson	28	N/A	N/A	N/A	5	N/A

* Fiona Knight joined Monitor in July 2013
** Sue Meeson started attending meetings of the Pricing Executive from November 2013
*** Hugo Mascie-Taylor joined Monitor in May 2014

External directorships for Executive Committee members

Subject to certain conditions, and unless otherwise determined by the Board, Executive Committee members are permitted to accept one appointment as a non-executive director. With effect from 1 May 2009 Stephen Hay was appointed non-executive director and Chair of the Audit and Risk Committee at the Department for Communities and Local Government, for which the remuneration is £10,000 per annum. Kate Moore is Chair of Governors at a primary school. The position is unpaid. Adrian Masters is the Treasurer of PACT (Prisoner Advice and Care Trust), a national charity which supports people affected by imprisonment. The position is unpaid.

Relationships with stakeholders

Stakeholder engagement

Monitor meets key stakeholders on a regular basis to discuss matters relating to NHS foundation trust policy and broader questions on health reform.

During 2013/14, regular meetings were held with a number of organisations and individuals, including ministers, special advisers and senior officials from the

Department of Health, the Foundation Trust Network, chairs, chief executives and finance directors of NHS foundation trusts, the Care Quality Commission, the NHS Trust Development Authority, NHS England and the National Audit Office.

Monitor's website

The website www.gov.uk/monitor is the primary source of information on Monitor. It includes an archive of publications, information on NHS foundation trust performance and information on our corporate practices. Stakeholders can register for notifications of when any news releases are posted, consultations are launched, documents published and new events publicised.

Monitor's duties as a regulator

Duty to review regulatory burdens

Under the 2012 Act, Monitor is required to keep the exercise of its functions under review to ensure it does not maintain or impose regulatory burdens which it considers to be unnecessary.

During 2013/14 Monitor sought to reduce the data collection burden on providers of NHS-funded services. While it is essential that Monitor gathers data from providers of NHS-funded services in England to exercise its functions to the benefits of patients, it is estimated that the current annual cost to NHS trusts and NHS foundation trusts of responding to Monitor's mandatory requests for data was just over £6.2 million. According to the Health and Social Care Information Centre (HSCIC), Monitor's current requests account for just over 12% of a total annual burden of over £51 million from approved central data collections from the NHS. Of this £51 million, around £28 million (or just under 55%) results from requests for data currently coming from the Department of Health.

Monitor has always seen it as important to minimise the burden of data collection on providers of NHS-funded health services. To this end we:

- comply with the principles of the HSCIC Review of Central Returns (ROCR) process to make sure that our demands on NHS providers are minimised, fit with current national health policies and are carried out in the most efficient way without duplication
- make extensive use of other central collections, notably Hospital Episode Statistics (for calculating prices) and other activity data (for judging performance against patient access targets)
- are working with HSCIC on an audit of the burdens that the Department of Health and its arm's length bodies place on the NHS
- have already implemented a number of small measures to simplify and reduce data requirements.

There is currently no scope to eliminate data collections required by law or in support of our statutory functions. In addition, we and the other healthcare oversight bodies in England are committed to making more data available to the public and patients about the performance of different providers to help inform their choices. This implies that the burden on providers of responding to requests for information will rise unless we collectively become smarter and more efficient at collecting, reporting, using and sharing data. In future, reducing the burden of data collections will need to focus on:

- redesigning and refocusing collections
- merging collections to reduce duplication
- working collaboratively with other national bodies to develop and adopt a more systematic approach to data collections across the health and social care system.

Impact assessments

Monitor should undertake an impact assessment when it is proposing to do something that could have a significant impact on those who provide healthcare services for the purposes of the NHS, those who use these services, the general public or the activities of Monitor itself. In 2013/14 Monitor undertook an impact assessment of proposals for the 2014/15 National Tariff Payment System, the outcome of which is available on Monitor's website.

Macpherson recommendations on quality assurance of models

The Macpherson Report, published in March 2013, made a number of recommendations relating to the processes, culture and environment within which business critical analytical models are quality assured. As a result of this review, Monitor has identified what it considers to be three business critical models, two of which are new, in 2013/4. Information about these models and the systems Monitor has in place to provide assurance that they are appropriate can be found below.

Monitor's models and systems for their quality assurance

Description	Quality assurance processes in place
The Long Term Financial Model (known as the LTFM) is used by Monitor's Assessment directorate to understand the financial history, current position, and financial forecasts of foundation trust applicants. It is the tool Monitor uses to stress-test the applicant trusts' forward assumptions to assess whether the applicants are financially viable (a key criterion of authorisation); we also consider whether they are well governed and legally constituted. The model is business critical because a key government priority is the authorisation of all NHS trusts as foundation trusts. The	The LTFM was developed internally by a modelling expert and has been externally audited by modelling experts on a number of occasions as it has been further developed over the years. Where minor simple fixes are required to the LTFM in-year the issue would be considered and addressed by one member of Monitor's model team and reviewed by another member before release. Where major reworks to the balance sheet calculation engine are required (such as for the introduction of International Financial Reporting

Description	Quality assurance processes in place
LTFM is a key tool in assessing the financial viability of the applicant trusts.	Standards) we have commissioned a modelling expert from an independent accounting firm to undertake these changes, which are checked by the firm, Monitor's model team, and through piloting with applicant trusts. Annual updates or larger changes (which require major rework of the balance sheet) to the LTFM are undertaken by members of Monitor's model team and the changes required are written up by one person (on a cell-by-cell or line-by-line basis), input by a second person, and tested by a third person. It will not be released until a senior manger and director have reviewed the changes. The LTFM has been extensively tested. Versions of the LTFM have been used more than 200 times and the inputs and outputs scrutinised by internal and external experts.
The Monitor Tariff Calculation Model will be used to calculate the prices and related data points Monitor sets in its national tariff document. The model is business critical because its outputs are used in the calculation of what a provider of NHS services gets paid for performing these services. It covers approximately £29 billion of expenditure.	The Model is based on the Payment by Results model that was produced by the Department of Health until 2013/14. All changes to this model go through a documented model change process. The model change process requires the tariff calculation team to explain and evidence the reasons for any model change and any resulting coding changes are checked by an independent member of Monitor's Information Systems team. Furthermore, Monitor is planning to procure an external audit of the Model before publishing its outputs.
The Impact Assessment Model is primarily used to assess the expected impact of proposed changes to national prices in the National Tariff Payment System. It is used to calculate the effect on income and expenditure for providers and commissioners as a result of changes to national prices or pricing rules. The key outputs of the model set out the expected financial position of providers and commissioners, including various charts, metrics, and tables, which are included in the published national tariff impact assessment. The model is business critical because Monitor has a statutory duty to perform impact assessment for changes to prices and pricing rules in the national tariff. This model is our principal tool for evaluating those proposals; it is used during policy	This documents the quality assurance process for Version 2.0 of the Impact Assessment Model, which was used for Monitor and NHS England's proposals for the payment system in 2014/15. We are currently introducing a number of updates to the Impact Assessment Model and plan to review our quality assurance processes for the next version, which will be used to assess our joint proposals for the payment system in 2015/16. Version 2.0 was built in structured query language by specialist developers who were managed by business users from the pricing team under a defined project mandate. The model was subject to peer review with specific outputs reconciled against published financial statements to validate the financial data used in the model. A written audit report was produced for the model based on the tests conducted. The

Description	Quality assurance processes in place
development and forms an important part of our formal impact assessment of changes to prices or pricing rules in the national tariff. The policies in the national tariff govern the majority of expenditure by CCGs. In the event of a referral to the competition commission or judicial review of the national tariff this model may be reviewed by third parties. The integrity of the model is also important to our credibility and reputation as an evidenced based regulator.	output of the model was shared with NHS England and the final outputs were published as part of our internal audit report. The outputs are consistent with our expectations and vary depending on changes in input variables as we expected. The model is reviewed annually to assess whether it is fit for purpose.

Harris recommendations on assurance regarding statutory arrangements

The Harris Report, published in 2013, recommended that there should be greater assurance at board and departmental level that all statutory functions within the health and social care landscape established by the 2012 Act are being exercised appropriately. Monitor's Board is content that it understands the fundamental principle of public law that, where a function has been conferred by statute on a public authority, the public authority may not, unless expressly permitted to do so, further delegate the performance of that function to another body.

Internal control – statement from David Bennett, Monitor's Chief Executive

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Monitor's policies, aims and objectives. These are set out in the National Health Service Act 2006, the Health and Social Care Act 2012 and Monitor's Corporate Strategy and Business Plan. In doing so, I must safeguard the public funds and assets in accordance with the responsibilities assigned to me in 'Managing Public Money and the Accounts Direction' from the Department of Health dated 14 June 2007.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of Monitor's policies, aims and objectives
- evaluate the likelihood of those risks being realised and the impact should they be realised
- manage risks efficiently, effectively and economically.

The system of internal control has been in place in Monitor for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts, and accords with HM Treasury guidance.

Risk and control framework

As Monitor experienced significant growth, development and change during 2013/14, the organisation's risk-management framework, systems, processes and resources were subjected to incremental changes and reviews. Monitor reviewed and progressed its corporate risk profile both from a top-down and bottom-up perspective through the Directorates' risk profiles. An updated risk matrix was presented to the Audit and Risk Committee and has been adopted from Q4 (January to March 2014) onwards for assessing and prioritising risks across the organisation. A network of risk champions has been successfully set up to share good practice, and to co-ordinate and support embedding of an appropriate risk-management culture in the organisation. Risk and performance reporting continued as regular agenda items at Executive Committee meetings to enhance discussion of risks and formalise risk escalation for the attention of senior management.

The principal risks facing Monitor during 2013/14 as identified by the business plan

Risk	**Mitigation – what did Monitor do to manage the risk?**
Recruitment and retention: not attracting, recruiting or retaining people with the right skills to work at Monitor.	• Targeted people with NHS, clinical or financial experience as appropriate. • Reviewed the effectiveness of recruitment strategy to date and refreshed as necessary. • Ensured staff engagement and development strategy in place.
Leadership and management: not demonstrating strong leadership and management at all levels of the organisation.	• Understood leadership capability across the organisation. • Supported development of leadership and management capability. • Active role modelling by senior leaders.
Technical competence: making mistakes and getting big decisions wrong.	• Regularly reviewed key regulatory functions and processes to ensure they were fit for purpose. • Undertook 'lessons learnt' evaluation from big decisions. • Ensured we were as transparent as possible in our decision-making processes.
Reputation: Monitor is seen as not adding sufficient value to patients and the taxpayer.	• Assessed and responded to stakeholder views on the impact of our work. • Communicated what we do to stakeholders and used a variety of mechanisms to understand if our work had made a difference.
Partnership working: Monitor fails to work well with partners and fails to form strong relationships with CQC, TDA, NHS England, OFT and DH.	• Held regular meetings with partners to check on what was working well and what could be improved to foster a more collaborative relationship.

Risk	Mitigation – what did Monitor do to manage the risk?
Stakeholder support: Monitor fails to get the support of stakeholders for its role and work.	• Built relationships with the government, Parliament and other key stakeholders. • Promoted a long-term strategy and consensus on the future direction of the NHS.

Capacity to handle risk

Monitor's Board has overall responsibility for ensuring delivery of Monitor's strategies and goals as outlined in the 2013/14 Business Plan. When setting these strategies and goals, the Board considers Monitor's specific statutory functions as outlined in legislation and Board members' wider understanding of the healthcare system (the latter being informed, amongst other things, by Board workshops).

When the strategies and goals have been established, detailed plans are drawn up for each strategy area with input from all staff. Risks against achievement of goals and strategies are reported to the Board on a quarterly basis. Monitor's Internal Audit strategy categorises Monitor's business into three systems (operational systems, support systems and the governance framework). Internal Audit considers the risks to Monitor in terms of these systems and this directs Internal Audit's priorities, which are reflected in the Annual Internal Audit Plan.

Monitor's Audit and Risk Committee gives consideration to risks faced by the organisation on a quarterly basis and reports its conclusions directly to the Monitor Board. Internal Audit makes regular reports to the Audit and Risk Committee based on its own work programme. The Board discusses the most significant risks and the actions identified to mitigate the likelihood and impact of those risks. On an annual basis, the Audit and Risk Committee evaluates the effectiveness of the risk management framework and approves the Annual Internal Audit Plan for the following year.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. This review is informed by the work of the internal auditors and Executive Committee members who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports.

Monitor continues to enhance its internal controls environment above and beyond the minimum levels required. Monitor's management team continues to ensure that appropriate and relevant controls are embedded in all areas of Monitor's work.

Internal audit work covering compliance and intervention processes continues to provide me with adequate assurance that effective controls are either in place or being developed to a high degree of sophistication. Monitor's Board has maintained strategic oversight and review of internal control and risk management arrangements through regular reports by directors on their areas of responsibility, and through specific papers for discussion at Audit and Risk Committee and Board meetings.

The Audit and Risk Committee, which meets on a quarterly basis, has considered:

- individual internal audit reports and management responses
- the internal auditor's annual report and opinion on the adequacy of our internal control system
- National Audit Office audit reports and recommendations, and
- regular reports on Monitor's corporate risk register, including the identification of risks to the organisation's system of internal control and information about the controls that have been put in place to mitigate these risks.

Any data losses experienced by Monitor would be reported to the Audit and Risk Committee. There have been no such incidents in 2013/14.

To my knowledge, and based on the advice I have received from those managers with designated responsibilities for managing risks and the risk management system, I am not aware of any significant internal control problems for 2013/14. As Monitor's Accounting Officer, I have gained assurance over the adequacy of Monitor's internal control environment from individual assurances given to me by each member of the Executive Committee as to the adequacy of the internal control environment within their own directorate.

Dr David Bennett
Chief Executive
2 July 2014

Our Board

Baroness Joan Hanham CBE (Interim Chairman)

Baroness Hanham is a Conservative member of the House of Lords, becoming a Life Peer as Baroness Hanham of Kensington in the Royal Borough of Kensington and Chelsea in 1999. Her previous roles include: Parliamentary Under Secretary of State at the Department for Communities and Local Government (DCLG) (2010 to 2013), Leader of Kensington and Chelsea Council (1989 to 2000) and Chairman of St Mary's Hospital NHS Trust (2000 to 2007). She became a Freeman of the City of London in 1984 and was awarded a CBE in 1997.

Heather Lawrence OBE (Non-Executive Director from 1 July 2012)

Heather Lawrence was appointed as Non-Executive Director at Monitor on 1 July 2012. She is also a non-executive director of NMC Healthcare, a FTSE 250 company. Her previous roles include: Chief Executive of Chelsea and Westminster Hospital, Chair of the national negotiations for the SAS Doctors contract and Agenda for Change 3-year pay deal for non-medical staff, Commissioner for the Prime Minister's Commission on the Future of Nursing and Midwifery, member of the Dr Foster Global Comparators Founders Board and nurse at St Mary's Hospital Paddington.

Iain Osborne (Non-Executive Director from 19 May 2014)

Iain Osborne was appointed as Non-Executive Director from 19 May 2014. He is also Group Director for regulatory policy at the Civil Aviation Authority, and is an experienced regulatory expert having led the work between UK economic regulators before the formation of the current UK Regulators Network. His previous roles include Chief Executive of Northern Ireland's utility regulator and secondment to the European Commission's competition directorate.

Keith Palmer OBE (Non-Executive Director from 1 April 2012, Deputy Chair and Senior Independent Director from 1 June 2014)

Keith Palmer was appointed to Monitor's board as a Non-Executive Director on 1 April 2012. Keith is founder and non-executive chairman of InfraCo, a not-for-profit public private partnership that develops infrastructure in developing countries, and of AgDevCo, a not-for-profit public private partnership that supports agricultural development in sub-Saharan Africa. He is also currently a senior associate of the Nuffield Trust. His previous roles include: non-executive director of Guy's and St Thomas' NHS Foundation Trust, Chairman of Barts and the London NHS Trust, senior associate of the King's Fund, Treasurer and Trustee of Cancer Research UK and Vice-Chairman of NM Rothschild merchant bank.

Sigurd Reinton CBE (Non-Executive Director from 1 January 2012)

Sigurd Reinton was appointed as Non-Executive Director at Monitor on 1 January 2012. He holds an additional ministerial appointment with the National Air Traffic Services Ltd. His previous roles include: Director of NATS Holdings, which provides

the air traffic control services for the UK and North Atlantic airspace, and for the main UK airports, Chairman of the London Ambulance Service NHS Trust, Chairman of Mayday University Hospitals NHS Trust, member of the board of the Ambulance Services Network, member of the advisory board of The Foundation, member of the Council of the NHS Confederation, Director (senior partner) at McKinsey.

Stephen Thornton CBE (Non-Executive Director, Deputy Chair from 1 April 2012, and Senior Independent Director until 30 May 2014)

Stephen Thornton was appointed as Non-Executive Director at Monitor on 1 October 2006. He was re-appointed on 1 October 2009 for four years but had his term of appointment extended twice while Monitor was without a non-executive chairman. He left Monitor on 30 May 2014. Stephen is a member of the Department of Health's National Quality Board, an Honorary Fellow of the Royal College of Physicians, Vice Chair of the Eastern Academic Health Science Network, a non-executive director of The Pathology Partnership and a member of the Nursing and Midwifery Council. Stephen's previous roles have included: Chief Executive of the Health Foundation, various senior executive NHS management and board positions, Chief Executive of Cambridge & Huntingdon Health Authority, Chief Executive of the NHS Confederation and Commissioner on the board of the Healthcare Commission.

Dr David Bennett (Chief Executive)

David Bennett was appointed as Chief Executive of Monitor on 1 March 2010. His previous roles have included: non-political Chief Policy Adviser to Prime Minister Tony Blair, Head of the Policy Directorate and the Strategy Unit in 10 Downing Street, independent adviser to various NHS bodies, and senior partner at McKinsey, where he focused on regulated, technology-intensive industries. David was Chairman of Monitor from 1 March 2011 to 19 January 2014. He is also a member of the Executive Committee.

Stephen Hay (Managing Director, Provider Regulation)

Stephen Hay is Managing Director of Provider Regulation at Monitor, responsible for the monitoring, enforcement and failure regimes for NHS foundation trusts. His portfolio of financial experience is wide ranging and includes mergers and acquisitions, turnaround, due diligence, initial public offerings and risk assessment. He is also a non executive director on the DCLG board since May 2009, where he chairs the audit and risk committee. A qualified chartered accountant, Stephen previously worked as a director at KPMG, where he advised boards of corporates and private equity houses. He is also a member of the Executive Committee.

Adrian Masters (Managing Director, Sector Development)

Adrian Masters joined Monitor in September 2005. His previous roles include: Director of the Health Team in the Prime Minister's Delivery Unit and roles at McKinsey, IBM and PwC. He is a qualified accountant and has an MBA from Stanford University. Adrian is also a member of the Executive Committee.

Executive Committee

Dr David Bennett (Chief Executive) See Board biographies

Miranda Carter (Executive Director, Provider Appraisal)

Miranda Carter joined Monitor in August 2004. A qualified chartered accountant, she started her career at Deloitte and then moved to PwC in London. She has advised the boards of corporate and private equity houses and her financial experience includes mergers and acquisitions, due diligence and initial public offerings.

Catherine Davies (Executive Director, Co-operation and Competition)

Catherine Davies joined Monitor in October 2012 from the Co-operation and Competition Panel (CCP). Catherine is a competition law specialist with experience in all aspects of EU and UK competition law. Before joining CCP in 2009 she worked at the Competition Commission and a large City law firm.

Stephen Hay (Managing Director, Provider Regulation) See Board biographies

Fiona Knight (Executive Director, Organisation Transformation)

Fiona Knight joined Monitor on 1 July 2013. Fiona has worked in human resources for more than 20 years, including 13 years at KPMG where she was an HR director. Her experience includes supporting teams and businesses through change and transition and managing HR integration.

Hugo Mascie-Taylor (Medical Director and Executive Director of Patient and Clinical Engagement from May 2014)

Hugo Mascie-Taylor joined Monitor on 1 May 2014. He has a strong clinical background, having worked in the NHS as a clinical director, medical director and a director of commissioning. He is currently a trust special administrator at Mid Staffordshire NHS Foundation Trust.

Adrian Masters (Managing Director, Sector Development) See Board biographies

Sue Meeson (Executive Director, Strategic Communications)

Sue Meeson joined Monitor in January 2010. She was previously Director of Communications for the Legal Services Commission and held a variety of corporate communications roles with Unilever. Her experience covers all aspects of internal and external communications.

Kate Moore (Executive Director, Legal Services)

Kate Moore, a solicitor, joined Monitor in September 2004. Kate has extensive experience of regulatory, litigation and public law gained through her previous roles at City law firms, as Director of Legal at the Investors Compensation Scheme and as a principal consultant with KPMG.

Directors' report

These accounts reflect the operations of Monitor. Monitor was originally established in January 2004 under the Health and Social Care (Community Health and Standards) Act 2003 and it continues under the Health and Social Care Act 2012. Monitor has responsibility for authorising, monitoring and regulating NHS foundation trusts and, in addition, it has been assigned the role of sector regulator for healthcare services under the Health and Social Care Act 2012. Monitor is accountable to Parliament and independent of government.

Further information on Monitor's role can be found on page 7 of this report.

In accordance with the provisions of Schedule 8 of the Health and Social Care Act 2012, these accounts have been prepared in a form directed by the Secretary of State. These accounts cover the year ended 31 March 2014.

Employment

A number of employment policies have been developed and Monitor will continue to enhance and develop all aspects of staff employment arrangements. Further details on equality and diversity can be found in the main body of the annual report.

Staff engagement

Monitor conducted a full staff survey in February 2014 and had a response rate of 71%, above that typical in the public sector. The results were extremely positive in a number of areas with 81% of staff saying they are proud to work for the organisation. People enjoy their jobs, are clear on what they need to do and feel they are kept informed. Staff were also positive about the changes introduced by the leadership.

As with all surveys, it has given pointers for action to ensure even higher levels of engagement such as greater cross-team working, better alignment of day-to-day working with Monitor's strategy, and enhanced performance development. The Executive Committee has agreed that the full survey will be run annually in February with a short 'pulse' survey in September or October.

Sickness absence

The average time taken as sick leave by Monitor employees in 2013/14 was 2.4 days (2012/13: 3.0 days).

Environmental impact

Monitor remains committed to improving its environmental efficiency. We have an Environmental Management Policy to ensure our operations have a minimum impact on the environment.

Pension liabilities

The treatment of pension liabilities is disclosed in note 1 to the financial statements.

Health and safety

Monitor complies with all relevant legislation concerning health and safety at work and is committed to ensuring that safe working conditions are provided for employees, contract staff and visitors.

Statement of payment practices

Unless the amounts charged are considered to be incorrect, Monitor has adhered to its policy to pay suppliers in accordance with the Better Payments Practice Code for the year ended 31 March 2014. Monitor aims to meet a 10-day payment target with out-turn against this target as follows.

	Number		Value	
	2013/14	2012/13	2013/14	2012/13
Total number of invoices	7,603	5,355	£43.9m	£26.8m
Invoices meeting target	6,986	4,963	£31.1m	£19.3m
Percentage meeting target	92%	93%	72%	72%

Register of interests

A register of interests of Board members is maintained by the Secretary to the Board and is available on Monitor's website.

Management of information risk and personal data related incidents

Monitor seeks to minimise the risk of a serious untoward incident arising from the misuse of personal or sensitive data. To this end, Monitor has an Information Risk Policy and Information Charter to identify and manage Monitor's exposure to risk in relation to any information it compiles or stores. There were no incidents of personal data being lost or stolen in 2013/14, reportable to the Information Commissioner's Office or otherwise.

Audit

The auditor of Monitor is the Comptroller and Auditor General. Details of the audit fee for the year ended 31 March 2014 are disclosed in note 5 to the Financial Statements. In addition to the statutory audit of the financial statements, the Comptroller and Auditor General will be auditing the consolidation of the accounts of NHS foundation trusts for the year ended 31 March 2014.

Accounting Officer's disclosure to the Auditors

So far as the Accounting Officer is aware, there is no relevant audit information of which Monitor's auditors are unaware. The Accounting Officer has taken all steps necessary to make himself aware of any relevant audit information and to establish that Monitor's auditors are aware of this information.

Sustainability report

Greenhouse gas emissions			
		2013/14	**2012/13**
Non-financial indicators (tCO_2e)	Total gross emissions for Scope 2	204	261
	Total net emissions for Scope 2	204	261
	Total gross emissions for Scope 3	31*	33*
Related energy consumption (KWh)	Electricity: non-renewable	295,068	376,945
	Gas	232,628	304,713
Financial indicators (£'000s)	Expenditure on energy	41	50
	Expenditure on official business travel	186	179

*This is the total of all measurable emissions for which data is available. Monitor staff may claim for taxis, or train journeys booked personally when travelling on business but identifying the emissions from these has not been possible due to data limitations.

Monitor occupied up to three floors of a multi-tenanted building at Matthew Parker Street until December 2013, and now occupies three floors of Wellington House. The energy figures (including Scope 2) contained in these tables just represent the Matthew Parker Street site; Wellington House is a Department of Health owned property and as such the sustainability figures for the space Monitor occupies will be reported in the Department's annual report.

The gas meter in Matthew Parker Street is for the whole building, so Monitor has taken a proportion of total usage based on our percentage floor area, which is how we were charged. As such, we had little direct control over our gas usage figures. However, we worked closely with the managing agent to minimise heating costs and, thereby, gas consumption. The building was only heated during core office hours and not at all during weekends.

Monitor continues to promote staff awareness in terms of switching off computers and lights when not in use, and has invested in more energy efficient IT, such as thin client computers for users and 'virtualised' servers rather than physical servers.

Waste				
			2013/14	**2012/13**
Non-financial indicators (t)	**Total waste**		**23.8**	**23.5**
	Non hazardous waste	Landfill	6.4	9.0
		Reused/recycled	17.4	14.5
Financial indicators (£'000s)	**Total disposal cost**		**11**	**12**
	Non hazardous waste	Landfill	5	7
		Reused/recycled	6	5

Landfill waste costs were paid by the landlord and Monitor has taken a proportion of the total based on our percentage floor area, which is how we were charged. Monitor cannot control these costs directly but has its own initiatives in place to reduce landfill waste, such as recycling schemes for the following items: printer toners, mobile phones, paper, cardboard, light bulbs, plastics, batteries and tin cans.

Water				
			2013/14	**2012/13**
Non-financial indicators (m^3)	Water consumption	Supplied	791	1,013
Financial indicators (£'000s)	Water supply costs		2	2

The water meter is for the whole Matthew Parker Street building, so Monitor has taken a proportion of total usage based on our percentage floor area, which is how we were charged. As such we had little direct control over how much water we consumed whilst at Matthew Parker Street, however we had schemes in place to minimise staff water consumption, such as low volume flush toilets, and high levels of maintenance which meant that leaking pipes or dripping taps were attended to quickly.

Dr David Bennett
Chief Executive
2 July 2014

Remuneration report

Remuneration policy

The remuneration of Monitor employees, including the Chief Executive, is agreed by the Remuneration Committee, while the Chairman's salary is determined by the Secretary of State for Health. The membership of the Remuneration Committee comprises the Deputy Chairman of Monitor, a non-executive director and other members as from time to time agreed by the chairman of the Committee. Other non-executive directors attend by invitation. No member is involved in any decisions or discussion as to their own remuneration. In reaching its recommendations, the Committee has regard for the following considerations:

- the Department of Health pay remit guidance
- the need to recruit, retain and motivate suitably able and qualified staff
- the funds available from the Department of Health and
- the requirement to deliver performance targets.

Service contracts

Appointments are made on merit on the basis of fair and open competition. Unless otherwise stated, the Executive Committee covered by this report holds appointments which are open-ended.

On 1 November 2012 David Bennett was appointed as Chief Executive of Monitor. He continued to hold the position of Chair from that date until 19 January 2014. Baroness Joan Hanham's appointment as Interim Chairman came into effect on 20 January 2014.

Notice periods and termination costs

The required notice periods for the Executive Committee are given in the table below. Under the terms of their contract, after one continuous year of service, members of the Executive Committee are eligible for the same severance payment as any other Monitor employee, which is determined by the Civil Service severance compensation scheme.

	Notice period
David Bennett Chief Executive	3 months
Stephen Hay Managing Director of Provider Regulation	6 months
Adrian Masters Managing Director of Sector Development	6 months
Miranda Carter Executive Director of Assessment	3 months

Catherine Davies Executive Director of Co-operation and Competition	3 months
Fiona Knight Executive Director of Organisational Transformation	3 months
Sue Meeson Executive Director of Strategic Communications	3 months
Kate Moore Executive Director of Legal Services	3 months

Salary and pension entitlements

The following sections provide details of the remuneration and pension interests of Monitor's Executive Committee and Board. These figures have been audited. Senior managers are salaried and are entitled to annual pay progression subject to individual performance against objectives.

	Salary (£,000)		**Benefits in kind (to nearest £100)**		**Pension benefits (£'000)**		**Total (£'000)**	
	2013/14	2012/13	2013/14	2012/13	2013/14	2012/13	2013/14	2012/13
David Bennett Chief Executive*	230-235	220-225 *(235-240 full time equivalent)*	100	100	N/A	N/A	230-235	220-225 *(235-240 full time equivalent)*
Stephen Hay Managing Director, Provider Regulation**	190-195	190-195*	100	0	33	42	220-225	235-240
Adrian Masters Managing Director, Sector Development	160-165	150-155	100	0	39	54	200-205	205-210
Miranda Carter Executive Director, Assessment (appointed with effect from 1 November 2012)	130-135	50-55	0	0	32	11	160-165	60-65
Catherine Davies Executive Director, Co-operation and Competition (appointed with effect from 1 October 2012)	125-130	60-65	0	0	N/A	N/A	125-130	60-65
Fiona Knight Executive Director, Organisational Transformation (from 1 July 2013)	90-95	N/A	0	N/A	0	N/A	90-95	N/A
Sue Meeson Executive Director, Strategic Communications	105-110	95-100	0	0	45	42	150-155	135-140

Kate Moore Executive Director, Legal Services	130-135	125-130	0	0	26	47	155-160	170-175
Janet Polson Director, HR and Corporate Services (until 31 October 2012)***	N/A	50-55	N/A	0	N/A	N/A	N/A	50-55

* David Bennett did not receive an additional salary as Chair while also serving as Chief Executive. David Bennett also does not receive a pension.
** Stephen Hay's remuneration in 2012/13 includes a payment for untaken annual leave of £0-5k which was non-pensionable. Stephen Hay has Board level responsibility for Finance.
*** The Director of HR and Corporate Services role ceased to be an Executive position from 1 November 2012.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in Monitor as at 31 March 2014 was £230-235k (31 March 2013, £225-230k). This was 3.9 times (31 March 2013, 3.8) the median remuneration of the workforce as at 31 March 2014, which was £60,000 (31 March 2013, £60,000).

The median remuneration figures only include permanent staff on payroll. Agency staff costs have not been included as such staff generally occupy short-term, project related positions and so their inclusion would artificially skew the overall figure.

In 2013/14 no employees received remuneration in excess of the highest-paid director (2012/13: zero). Remuneration ranged from £20-25k to £230-235k (2012/13 £20-25k to £220-225k).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Chairman and other non-executive directors	**Salary (£,000)**		**Benefits in kind (to nearest £100)**		**Total (£'000)**	
	2013/14	2012/13	2013/14	2012/13	2013/14	2012/13
Baroness Joan Hanham Interim Chair (from 20 January 2014)	10-15 (20-25 full time equivalent)	N/A	0	N/A	10-15 (20-25 full time equivalent)	N/A
Jude Goffe Non-executive director (term ended 8 May 2012)	N/A	0-5	N/A	300	N/A	0-5

Stephen Thornton Non-executive director	10-15	20-25	2,300	3,500	15-20	25-30
Sigurd Reinton Non-executive director	10-15	15-20	1,200	1,400	10-15	15-20
Keith Palmer Non-executive director	5-10	5-10	0	100	5-10	5-10
Heather Lawrence Non-executive director (appointed with effect from 1 July 2012)	5-10	5-10	900	400	5-10	5-10

David Bennett held the post of Chair until 19 January 2014. He did not receive a salary as Chair in addition to that which he received as Chief Executive.

All remuneration paid to the Chairman and non-executive directors is non-pensionable. The benefits in kind given to executive and non-executive directors are disclosed below. The monetary value of benefits in kind covers any payments (for business expenses or otherwise) or other benefits provided by Monitor which are treated by HM Revenue & Customs as a taxable emolument.

	Accrued pension at pension age as at 31/3/14 and related lump sum	**Real increase in pension and related lump sum at pension age**	**CETV* at 31/3/14**	**CETV at 31/3/13**	**Real increase in CETV**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Stephen Hay Managing Director. Provider Regulation**	20-25	2-2.5	321	272	20
Adrian Masters Managing Director, Sector Development	25-30	3-3.5	404	340	21
Miranda Carter Executive Director, Assessment	20-25	2-2.5	262	223	16
Fiona Knight Executive Director, Organisational Transformation	0-5	0-0.5	28	27	-7
Sue Meeson Executive Director, Strategic Communications	10-15	3-3.5	178	127	27
Kate Moore Executive	20-25	2-2.5	333	286	17

Director, Legal Services					

* Cash equivalent transfer value

David Bennett does not receive a pension on his salary as Chief Executive.

Catherine Davies, Executive Director of Co-operation and Competition, is a member of a partnership pension scheme. During 2013/14 she has made contributions to the scheme of £3,100 and Monitor made contributions of £16,800 on her behalf (figures given to the nearest £100).

None of the Executive Committee are members of a scheme which automatically pays a lump sum on retirement.

Details of off-payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees in 2012, arm's length bodies are required to publish information on highly paid and/or senior off-payroll engagements, comprising:

- all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last for longer than six months and
- any new off-payroll engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014, for more than £220 per day and that last for longer than six months.

As at 31 March 2014 Monitor has one off-payroll engagement at a cost of over £58,200 per annum (at 31 March 2013: nil).

The appropriate assurance has been sought that the individual is paying the right amount of tax.

None of the Board or Executive Committee members are engaged through off-payroll arrangements.

Civil Service pensions

Pension benefits are provided through the Civil Service pension arrangements. Existing staff may be in one of four defined benefit schemes; either a 'final salary scheme' (Classic, Premium and Classic Plus) or a 'whole career scheme' (Nuvos). The schemes are unfunded with the cost of benefits met by monies voted by Parliament each year.

Pensions payable under Classic, Premium, Classic Plus and Nuvos are increased annually in line with Pensions Increase legislation. Employee contributions are salary-related and ranged between 1.5% and 6.25% of pensionable earnings for classic and 3.5% and 8.25% for Premium, Classic Plus and Nuvos. 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. Classic Plus is essentially a variation of Premium but with benefits in respect of service before 1 October 2002 calculated broadly in the same way as Classic.

The Nuvos scheme was introduced on 30 July 2007 for all new staff unless they are already members of or eligible to rejoin the other schemes. Members of Nuvos build up pension based on their pensionable earnings during their period of scheme membership. At the end of the scheme year (31 March) the member's earned pension account is credited with 2.3% of their pensionable earnings in that scheme year and the accrued pension is uprated in line with the Consumer Price Index (CPI). In all cases members may opt to give up (commute) pension for lump sum up to the limits set by the Finance Act 2004.

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 from a selection of approved products. 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 on the website www.civilservice-pensions.gov.uk.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. The CETV is the amount paid by one pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when a pension scheme member leaves and chooses to transfer the benefits accrued from their previous scheme.

The pension figure shown relates to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details, include the value of any pension benefit in another scheme or arrangement which the individual has transferred to the Civil Service pension arrangements and for which the Civil Service Vote has received a transfer payment commensurate with the additional pension liabilities being assumed. They also include any additional pension benefit accrued to the

member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries and do not take account of any actual or potential reduction to benefits resulting from Lifetime Allowance Tax which may be due when pension benefits are drawn.

Real increase in CETV

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

Dr David Bennett
Chief Executive
2 July 2014

Strategic report

Monitor's net expenditure for the year was £64,048k (2012/13: £42,703k). Staff costs represent 52% of net expenditure at £33,313k (2012/13: 54%; £22,861k). Other operating costs include property, consulting and office expenses.

The increase in net expenditure in 2013/14 is mainly due to Monitor continuing to expand as a consequence of taking on new powers from 1 April 2013. As responsibilities of core teams have grown, staff numbers have increased resulting in an increase in staff costs of £10,452k. In addition, £16,372k was spent on examining viable long-term solutions for a number of providers in financial distress through Monitor's role in contingency planning and trust special administration.

In 2013/14 expenditure on professional services was £22,324k (2012/13: £14,034k), with the main reason for the increase the £12,300k spent on trust special administration work. More detail of how money has been spent in 2013/14 can be found in the main accounts.

Property and office costs have also increased as Monitor has taken on more staff and completed the move to a new office location in 2013/14.

Grant-in-aid of £69,654k was received during the year of which £4,318k was applied to the purchase of fixed assets. Net assets at 31 March 2014 were £11,082k (31 March 2013: £5,476k).

A review of Monitor's activities and performance against business objectives during the year is set out on pages 35 to 39 of this report, with a summary of Monitor's future strategy on page 34.

Dr David Bennett
Chief Executive
2 July 2014

Statement of Accounting Officer's responsibilities

The Secretary of State for Health has directed Monitor to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Monitor and of its net resource outturn, application of resources, changes in taxpayers' equity and cash flows for the financial year.

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

- observe the Accounts Direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgments and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in Monitor's financial statements and
- prepare the accounts on a going concern basis.

The Accounting Officer for the Department of Health has designated the Chief Executive, David Bennett, as Accounting Officer of Monitor. The responsibilities of an accounting officer, including responsibility for the propriety and regularity of the public finances for which the accounting officer is answerable, for keeping proper records and for safeguarding Monitor's assets, are set out in 'Managing Public Money' published by HM Treasury.

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 Monitor for the year ended 31 March 2014 under the Health and Social Care Act 2012. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration report that is described in that report as having been audited.

Respective responsibilities of the Board, Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Board and the Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Social Care Act 2012. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to Monitor's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by Monitor; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on regularity

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

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of Monitor's affairs as at 31 March 2014 and of the net expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the Health and Social Care Act 2012 and Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion:

- the part of the Remuneration report to be audited has been properly prepared in accordance with Secretary of State directions made under the Health and Social Care Act 2012; and
- the information given in the Directors' report, Sustainability report, and Strategic report sections included within the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the part of the Remuneration report to be audited are not in agreement with the accounting records and returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

Sir Amyas C E Morse
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
Victoria, London SW1W 9SP

8 July 2014

Statement of comprehensive net expenditure
for the year ended 31 March 2014

	Note	year ended 31/03/14 £000's	£000's	year ended 31/03/13 £000's	£000's
Expenditure					
Staff costs	3	(33,313)		(22,861)	
Amortisation/Depreciation	4	(885)		(436)	
Other expenditure	4	(30,095)		(19,646)	
Total expenditure			(64,293)		(42,943)
Income					
Miscellaneous income	5		245		240
Net expenditure			(64,048)		(42,703)
Comprehensive net expenditure for the year			(64,048)		(42,703)

All operations are continuing.

There were no other recognised gains or losses for the financial year.

The notes on pages 81 to 92 form part of these accounts.

Statement of financial position
as at 31 March 2014

	Note	31/03/14 £000's	31/03/14 £000's	31/03/13 £000's	31/03/13 £000's
Non-current assets					
Intangible assets	7a		1,959		102
Property, plant and equipment	7b		2,443		1,119
Total non-current assets			4,402		1,221
Current assets					
Trade and other receivables	8	926		966	
Cash and cash equivalents	9	18,638		11,977	
Total current assets			19,564		12,943
Total assets			23,966		14,164
Current liabilities					
Trade and other payables	10	(12,884)		(8,366)	
Provisions for liabilities and charges	12	0		(309)	
Total current liabilities			(12,884)		(8,675)
Non-current assets plus net current assets			11,082		5,489
Non-current liabilities					
Financial liabilities	11	0		(13)	
Total non-current liabilities			0		(13)
Assets less liabilities			11,082		5,476
General reserve			11,082		5,476

The notes on pages 81 to 92 form part of these accounts.

Dr David Bennett
Chief Executive
2 July 2014

Statement of cash flows
for the year ended 31 March 2014

	Note	year ended 31/03/2014 £000's	year ended 31/03/13 £000's
Cash flows from operating activities			
Net expenditure on ordinary activities		(64,048)	(42,703)
Adjustments for non-cash items			
Depreciation charge	4	698	322
Amortisation charge	4	187	114
Loss on disposals	4	240	0
Reversal of unused provision	12	(20)	0
Release of long term rent accrual	11	(13)	(59)
Adjustments for movements on working capital			
(Increase) in trade and other receivables falling due within one year	8	(264)	(207)
Increase in trade and other payables falling due within one year	10	3,899	670
Use of provision	11	(289)	0
Net cash outflow from operating activities		(59,610)	(41,863)
Cash flows from investing activities			
Payments to acquire intangible non-current assets	7	(1,306)	(98)
Payments to acquire property, plant and equipment	7	(2,089)	(718)
Proceeds of disposal of plant, property and equipment		12	0
Cash flows from financing activities			
Grant-in-aid received		69,654	46,600
Net increase in cash and cash equivalents		**6,661**	**3,921**
Cash and cash equivalents at the beginning of the year	9	11,977	8,056
Cash and cash equivalents at the end of the the year	9	18,638	11,977

The notes on pages 81 to 92 form part of these accounts.

Statement of changes in taxpayers' equity
for the year ended 31 March 2014

	General Reserve 2013/14 £000's	General Reserve 2012/13 £000's
Balance at 1 April	**5,476**	**1,579**
Comprehensive net expenditure for the year	(64,048)	(42,703)
Grant-in-aid received towards revenue expenditure	65,336	45,873
Grant-in-aid received towards purchase of non-current assets	4,318	727
Balance at 31 March	**11,082**	**5,476**

Notes to the Accounts

1. Accounting policies

The financial statements have been prepared in accordance with the 2013/14 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of Monitor for the purpose of giving a true and fair view has been selected. The particular policies adopted Monitor are described below. They have been applied consistently in dealing with items that are considered material to the accounts

Accounting convention

This account is prepared under the historical cost convention, in accordance with directions issued by the Secretary of State for Health with the approval of HM Treasury.

Non-current assets

The *FReM* permits revaluation of property, plant and equipment, and intangible assets to their value to the business at current costs. Monitor has determined that current value is not materially different from historical cost and has therefore chosen to value property, plant and equipment, and intangible assets at historical cost.

Intangible assets comprise purchased licences to use third party software systems. All assets falling into this category with a value of £5,000 or more have been capitalised. Intangible assets are valued at historical cost less amortisation.

Assets under construction comprises assets currently being built and not yet in use. Assets under construction are not amortised.

Property, plant and equipment comprises IT hardware, furniture, fixtures, office equipment and leasehold improvements which individually or grouped cost more than £5,000. Tangible assets are valued at historical cost less depreciation.

Assets of the same or similar type acquired around the same time and scheduled for disposal around the same time, or assets which are purchased at the same time and are to be used together, are grouped together as if they were individual assets.

All non-current assets have been funded by Government grant-in-aid.

Amortisation and depreciation

Amortisation and depreciation is provided from the month following purchase on all non-current assets at rates calculated to write off the cost or valuation of each asset evenly over its expected life as follows:

IT Software and IT Equipment - 3 years
Furniture, fixtures and office equipment - 5 years
Leasehold improvements - over life of lease

Income

The main source of funding for Monitor is Government grant-in-aid from the Department of Health. This is credited to the general reserve as it is received. In addition, Monitor receives income as a result of its operating activities. Miscellaneous operating income is recognised on the face of the *Statement of comprehensive net expenditure* and is accrued for using the accruals convention.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term.

1. Accounting policies continued

Value Added Tax
Monitor is registered for VAT in respect of the supply of staff seconded to other organisations. HM Revenue & Customs have determined that only a very limited amount of input VAT can be reclaimed, therefore most of the expenditure in these accounts is shown inclusive of irrecoverable VAT.

Pensions
Monitor participates in the Principal Civil Service Pension Scheme. The scheme is an unfunded defined benefit scheme. Monitor contributes annual premiums and retains no further liability except in the case of employees who take early retirement. Employers pension cost contributions are charged to operating expenses as and when they become due. Details are included in note 14 to the Accounts.

Special measures buddy trust reimbursements and incentive payments

Partnership organisations that have been appointed to provide support to trusts in special measures ("buddy trusts") are eligible to receive reimbursement of expenses in delivering an agreed programme of support. These reimbursement payments are recognised as an expense on a straight-line basis over the period of time that buddy trusts work with their corresponding special measures trusts.

Buddy trusts are also potentially eligible for an incentive payment up to twice the reimbursement cost total; this is subject to criteria based on the benefits delivered by each programme of work. Incentive payments are recognised as an expense in the accounts when it becomes probable that the eligibility criteria have been met.

1. Accounting policies continued

Early adoption of IFRSs, amendments and interpretations
Monitor has not adopted any IFRSs, amendments or interpretations early.

IFRSs, amendments and interpretations in issue but not yet effective, or adopted

IAS 8, accounting policies, changes in accounting estimates and errors, require disclosures in respect of new IFRSs, amendments and interpretations that are, or will be applicable after the accounting period. There are a number of IFRSs, amendments and interpretations issued by the International Accounting Standards Board that are effective for financial statements after this accounting period and have not been adopted early by Monitor:

• IFRS 10 Consolidated Financial Statements: Effective date 1 January 2014 under EU adoption; to be adopted by HM Treasury in 2014/15.
• IFRS 11 Joint Arrangements: Effective date 1 January 2014 under EU adoption; to be adopted by HM Treasury in 2014/15.
• IFRS 12 Disclosures of Interests in Other Entities: Effective date 1 January 2014 under EU adoption; to be adopted by HM Treasury in 2014/15.
• IAS 17 Leases: the timing for EU adoption is uncertain.
• IAS 18 Revenue Recognition: effective no earlier than 1 January 2015
• IFRS 13 Fair Value Measurement: Effective date 1 January 2013 under EU adoption; to be adopted by HM Treasury in 2015/16.
• IAS 27 Separate Financial Statements: Effective date 1 January 2014 under EU adoption; to be adopted by HM Treasury in 2014/15.
• IAS 28 Associates and joint ventures: Effective date 1 January 2014 under EU adoption; to be adopted by HM Treasury in 2014/15.
• IFRS 9 Financial Instruments: The timing for EU adoption is uncertain.

None of these new or amended standards and interpretations are likely to be applicable or are anticipated to have future material impact on the financial statements of Monitor.

2. Analysis of net expenditure by segment

Monitor has chosen to divide its activities into four reportable segments. These segments are used by Monitor's executive to manage and report expenditure throughout the year.

Segment 1: Monitor's core running costs. Monitor's core responsibilities are to make sure:
- foundation hospitals, ambulance trusts and mental health and community care organisations are well led and are run efficiently;
- essential NHS services continue if a provider gets into difficulty;
- the NHS payment system rewards quality and efficiency;
- choice and competition operate in the best interests of patients; and
- to enable better integration of care.

Segment 2: Contingency planning work (CPT). During 2013/14 contingency planning activity was undertaken at two foundation trusts to examine viable long term solutions for the local health economies in question.

Segment 3: Trust Special Administration work (TSA). In 2013/14 Monitor used powers to appoint Trust Special Administrators to failing trusts for the first time. The costs reported here relate to the Mid Staffs Administration.

Segment 4: Special Measures. As a result of the Keogh Review several trusts were placed into Special Measures during 2013/14. More detail on the this work is given elsewhere in this report.

	Core running costs £000's	CPT £000's	TSA £000's	Special measures £000's	Total £000's
Gross expenditure	46,346	4,072	12,300	1,575	64,293
Income	(245)	0	0	0	(245)
Net expenditure	**46,101**	**4,072**	**12,300**	**1,575**	**64,048**

Prior year

	Core running costs £000's	CPT £000's	Segments no longer reported £000's	Total £000's
Gross expenditure	18,132	4,092	20,719	42,943
Income	(133)	0	(107)	(240)
Net expenditure	**17,999**	**4,092**	**20,612**	**42,703**

Prior year segments no longer reported:

Transition expenditure: Net expenditure of £18,324k was reported for Transition in 2012/13 to prepare to become sector regulator for health care services under the Health and Social Care Act 2012. Transition activities incorporate either set up costs which have ceased or ongoing costs which are reported within Monitor's core running cost segment.

Cooperation and Competition Panel (CCP): £2,288k was reported in 2012/13 on CCP, for which Monitor recieved ring-fenced funding. From 1 April 2013 the CCP was integrated into Monitor to become the Cooperation and Compeitition Directorate, and their funding is no longer ring-fenced and is therefore included within Monitor's core running cost segment.

3. Staff costs

a) Staff costs comprise the following

	Permanently employed staff £000's	Others £000's	Total £000's
Salaries and wages	19,238	8,040	27,278
Social security costs	2,041	0	2,041
Employer's pension costs	4,131	0	4,131
Total cost of staff employed	**25,410**	**8,040**	**33,450**
Less recoveries in respect of outward secondments	(137)	0	(137)
Total cost of staff	**25,273**	**8,040**	**33,313**

Prior Year

	Permanently employed staff £000's	Others £000's	Total £000's
Salaries and wages	11,537	7,853	19,390
Social security costs	1,230	0	1,230
Employer's pension costs	2,442	0	2,442
Total cost of staff employed	**15,209**	**7,853**	**23,062**
Less recoveries in respect of outward secondments	(201)	0	(201)
Total cost of staff	**15,008**	**7,853**	**22,861**

Other staff costs consist of agency, interim and seconded staff.

b) Analysis of full time equivalent employees during the year:

As at 31 March 2014, there were 365 salaried staff members (31 March 2013: 226), 319 of whom are members of the Principal Civil Service Pension Scheme, 39 of whom are members of the Partnership Civil Service Pension Scheme, and 7 of whom are not members of a pension scheme.

Monitor engages staff on various agency, secondment, temporary and interim arrangements for variable time periods. As at 31 March 2014 there were 59 staff working at Monitor on this basis (31 March 2013: 73).

The average number of full time equivalent employees during the year ended 31 March 2014 was 303 (year ended 31 March 2013: 181). The average number of whole-time equivalent agency, secondment, temporary and interim staff was 53 (year ended 31 March 2013: 50).

c) Reporting of Civil Service and other compensation schemes - exit pacakges

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	0	0
£10,000 - £25,000	0	0	0
£25,000 - £50,000	0	1	1
£50,000 - £100,000	0	1	1
£100,000- £150,000	0	0	0
£150,000- £200,000	0	0	0
Total number of exit packages by type	**-**	**2**	**2**

	£000's
Total resource cost	106

Redundancy and other departure costs have been paid in accordance with employment contracts and the provisions of the Civil Service Compensation Scheme, a statutory scheme made under the Superannuation Act 1972. Exit costs are accounted for in full in the year of departure.

d) The salaries of executives and NEDs are disclosed in the Remuneration Report on page 66.

4. Other operating expenditure

	year ended 31/03/2014 £000's	year ended 31/03/13 £000's
Property expenses *	2,307	2,070
Office expenses *	3,260	2,630
Professional services **	22,324	14,034
Special measures reimbursements	742	0
Audit fee for Monitor	40	40
Audit fee for consolidated accounts	68	73
Depreciation	698	322
Amortisation	187	114
Loss on disposals	240	0
Travel and subsistence	281	220
Communication expenses	603	349
General expenses	230	230
Total other operating expenditure	**30,980**	**20,082**

* Property expenses relate to the cost of leasing and running Monitor's offices. This has increased as Monitor has taken on more space in Wellington House during 2013/14.

Office expenses include items needed to operate in the office, such as stationery and photocopying, which has risen over the year as a result of increased staff numbers and the need to fit out more desks.

Also included in office expenses are external recruitment fees and associated advertising costs (£1,240k) as Monitor continues to recruit new posts to enable Monitor to perform its new functions

** Spend on professional services has increased in 2013/14 mainly due to Monitor's work on Trust Special Administration. An analysis of the 2013/14 consultancy spend compared to the previous year is provided below:

	year ended 31/03/2014 £000's	year ended 31/03/13 £000's
Trust Special Administration	12,300	0
Contingency planning work	4,072	4,092
Pricing development spend	1,798	885
Licencing development spend	0	1,217
Organisation design and build	341	3,354
Other policy, provider regulation and assessment spend	3,813	4,486
Professional services total	**22,324**	**14,034**

5. Miscellaneous income

	year ended 31/03/2014 £000's	year ended 31/03/2013 £000's
Rental income	79	160
Other miscellanenous income	166	80
	245	**240**

Monitor sublet part of its office space at Matthew Parker Street until December 2013, when Monitor relocated fully to Wellington House. Monitor no longer sublets any of its office space.

Other miscellaneous income mainly comprises contributions from NHS England to work undertaken by Monitor during 2013/14.

6. Analysis of net expenditure by Programme and Administration budget

Programme spend in 2013/14 comprises costs of Trust Special Administration and special measures reviews. In 2012/13 Programme spend consisted of contingency planning team work however this has been reclassified as Administration spend by the Department of Health in 2013/14.

	year ended 31/03/2014 £000's	year ended 31/03/13 £000's
Administration	50,552	38,611
Programme	13,496	4,092
	64,048	**42,703**

7. Non-current assets

a) Intangible assets

	Software licences £000's	Information technology £000's	IT assets under construction £000's	Total £000's
Cost or valuation				
As at 1 April 2013	449	41	0	490
Additions	357	539	1,148	2,044
Disposals	0	0	0	0
At 31 March 2014	**806**	**580**	**1,148**	**2,534**
Amortisation				
As at 1 April 2013	347	41	0	388
Charge for year	157	30	0	187
Disposals	0	0	0	0
At 31 March 2014	**504**	**71**	**0**	**575**
Net Book Value at 31 March 2013	102	0	0	102
Net Book Value at 31 March 2014	**302**	**509**	**1,148**	**1,959**

Prior Year

	Software licences £000's	Information technology £000's	IT assets under construction £000's	Total £000's
Cost or valuation				
As at 1 April 2012	359	41	0	400
Additions	98	0	0	98
Disposals	(8)	0	0	(8)
At 31 March 2013	**449**	**41**	**0**	**490**
Amortisation				
As at 1 April 2012	254	28	0	282
Charge for year	101	13	0	114
Disposals	(8)	0	0	(8)
At 31 March 2013	**347**	**41**	**0**	**388**
Net Book Value at 31 March 2012	105	13	0	118
Net Book Value at 31 March 2013	**102**	**0**	**0**	**102**

Spend on IT assets under construction in 2013/14 relates to development of two IT systems: an online licensing system for independent providers, and a strategic information platform to address Monitor's increased demands for data analysis across a number of functions.

7. Non-current assets continued

b) Property, plant and equipment

	IT equipment £000's	Furniture, fixtures and office equipment £000's	Leasehold improvements £000's	Total £000's
Cost or valuation				
As at 1 April 2013	1,253	607	923	2,783
Additions	989	1,285	0	2,274
Disposals	(10)	(116)	(923)	(1,049)
At 31 March 2014	**2,232**	**1,776**	**0**	**4,008**
Depreciation				
As at 1 April 2013	532	471	661	1,664
Charge for year	506	133	59	698
Reverse Disposals	(4)	(73)	(720)	(797)
At 31 March 2014	**1,034**	**531**	**0**	**1,565**
Net Book Value at 31 March 2013	721	136	262	1,119
Net Book Value at 31 March 2014	**1,198**	**1,245**	**0**	**2,443**

Prior Year

	IT equipment £000's	Furniture, fixtures and office equipment £000's	Leasehold improvements £000's	Total £000's
Cost or valuation				
As at 1 April 2012	756	553	923	2,232
Additions	560	69	0	629
Disposals	(63)	(15)	0	(78)
At 31 March 2013	**1,253**	**607**	**923**	**2,783**
Depreciation				
As at 1 April 2012	416	437	567	1,420
Charge for year	179	49	94	322
Reverse Disposals	(63)	(15)	0	(78)
At 31 March 2013	**532**	**471**	**661**	**1,664**
Net Book Value at 31 March 2012	340	116	356	812
Net Book Value at 31 March 2013	**721**	**136**	**262**	**1,119**

All non-current assets listed above are owned by Monitor.

8. Trade receivables and other current assets - amounts falling due within one year

	31/03/2014 £000's	31/03/13 £000's
Prepayments	600	445
Capital prepayments	0	304
Other receivables	326	217
	926	966

8a. Trade receivables and other current assets - intra-government balances

	31/03/2014 £000's	31/03/13 £000's
Balances with central government bodies	187	104
Balances with NHS Bodies	0	55
Subtotal: Intra-government balances	**187**	**159**
Balances with bodies external to government	739	807
Total receivables	**926**	**966**

9. Cash and cash equivalents

The following balances at 31 March were held at:	31/03/2014 £000's	31/03/13 £000's
Government Banking Service	18,623	11,957
Commercial banks and cash in hand	15	20
	18,638	11,977

10. Trade payables and other current liabilities

Amounts falling due within one year:	31/03/2014 £000's	31/03/13 £000's
VAT payable	9	6
Tax and national insurance contributions	750	428
Trade payables	3,934	3,992
Capital payables	275	0
Pensions payable	548	322
Liability relating to rent-free period	0	59
Accruals and deferred income	7,024	3,559
Capital accruals	344	0
	12,884	8,366

10a. Payables - intra-government balances

	31/03/2014 £000's	31/03/13 £000's
Balances with central government bodies	2,344	1,133
Balances with NHS Bodies	798	111
Subtotal: Intra-government balances	3,142	1,244
Balances with bodies external to government	9,742	7,122
Total payables	**12,884**	**8,366**

11. Financial liabilities

	31/03/2014 £000's	31/03/13 £000's
Liability relating to rent free period	0	13

12. Provisions for liabilities and charges

	Dilapidation provision £000's
Provision as at 1 April 2013	309
Provided in year	0
Provisions not required written back	(20)
Provisions utilised in year	(289)
Provision as at 31 March 2014	**0**

Monitor held a provision for dilapidation for its office space at 4 Matthew Parker Street. On vacation of this property in December 2013, the provision was utilised with a small amount reversed unused.

There is no delapidation provision required for Wellington House.

13. Operating leases

Total minimum lease payments under operating leases are given in the table below, analysed according to the period in which the payments fall due.

	31/03/2014 £000's	31/03/13 £000's
Within 1 year	1,102	1,964
Within 2 to 5 years	1,102	5,572
After more than 5 years	0	0
	2,204	**7,536**

14. Pension scheme

Monitor participates in the Principal Civil Service Pension Scheme (PCSPS). The Scheme is an unfunded, multi-employer defined benefit scheme but Monitor is unable to identify its share of the underlying assets and liabilities. A full actuarial valuation was carried out as at 31 March 2007. Details can be found in the resource accounts of the Cabinet Office: Civil Superannuation (www.civilservice-pensions.gov.uk).

For 2013/14, employer's contributions of £3,928,190 were payable to the PCSPS (2012/13: £2,357,758) at one of four rates in the range of 16.7% and 24.3% of pensionable pay, based on salary bands. The Scheme Actuary reviews employer contributions every four years following a full scheme valuation.

The contribution rates are set to meet the cost of benefits accruing during 2013/14 to be paid when a member retires, and not the benefits paid during this period to existing pensioners.

Employees can opt to open a partnership pension account, a stakeholder pension with an employer contribution. Employer's contributions of £158,254 (2012/13: £76,924) were paid into one or more of a panel of three appointed stakeholder pension providers. Employer contributions are age-related and range from 3% to 12.5% of pensionable pay. Employers also match employee contributions up to 3% of pensionable pay. In addition, employer contributions of £13,309 (2012/13: £6,892), 0.8% of pensionable pay, were payable to the PCSPS to cover the cost of the future provision of lump sum benefits on death in service and ill health retirement of these employees.

Contributions due to the partnership pension providers at 31 March 2014 were £15,549 (31 March 2013: £6,535).

15. Capital commitments

There were no capital commitments at 31 March 2014 that require disclosure.

16. Related parties

Monitor is a non-departmental public body of the Department of Health, which is regarded as a related party. During the year, Monitor has had a number of material transactions with the Department.

In addition, Monitor has had a small number of transactions with other government departments and other central government bodies.

No Board or Executive team member or other related party has undertaken any material transactions with Monitor during the year.

17. Financial instruments

IFRS 7, Financial Instruments Disclosure, requires the disclosure of the role that financial instruments have had during the period in creating or changing the risk an entity faces in undertaking its activities. Financial instruments play a much more limited role in creating or changing risk for Monitor than would be typical of the listed companies to which IFRS 7 mainly applies, as described below.

Liquidity risk

The main source of funding for Monitor is government grant-in-aid received from the Department of Health. This is paid to Monitor monthly on the basis of a payment schedule agreed annually with the Department of Health. By ensuring that expenditure is maintained within the budgetary allocation, Monitor faces minimal liquidity risk.

Interest rate risk

Throughout the year ended 31 March 2014, Monitor held no interest bearing assets or liabilities and, therefore, was not subject to any interest rate risk.

Credit risk

As can be seen in note 8a, at 31 March 2014, only £739,000 (31 March 2013: £807,000) of Monitor's receivables were with bodies external to government. Of these, £596,000 were prepayments and £79,000 were season ticket loans, which are recoverable through payroll. Given that intra government balances are not subject to credit risk, Monitor faced very little credit risk at 31 March 2014.

Most of Monitor's cash balance is held with the Government Banking Service. Monitor also maintains a commercial bank account with HSBC but the balance on this account is automatically reduced if it ever rises above £25,000. Given the limit on the amount held in it, Monitor faces minimal credit risk as a result of maintaining this account.

18. Contingent liabilities

On appointment of the Mid Staffordshire NHS Foundation Trust special administrators during 2013/14, Monitor issued an indemnity to cover additional liabilities arising following the issue of the administrators' recommendations. Monitor has a separate agreement with the Department of Health to cover any resulting liabilities arising.

19. Events after the reporting date

In May 2014, two applications for judicial review of the Secretary of State's decision relating to the trust special administrators' recommendations were made (Monitor is not a party to either application). As explained in note 18, Monitor has issued an indemnity to the trust special administrators which would cover costs incurred as a result of the judicial reviews. The full costs are uncertain at this stage, however the Department of Health has agreed to fund any resulting costs. No adjustments have been made to the accounts in respect of this.

The Accounting Officer authorised these financial statements for issue on 8 July 2014.

There are no other events after the reporting date which require disclosure.

Monitor

Making the health sector work for patients

Contact us

Monitor, Wellington House,
133-155 Waterloo Road,
London, SE1 8UG

Telephone: 020 3747 0000
Email: enquiries@monitor.gov.uk
Website: www.GOV.UK/monitor

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