

# Monitor

Making the health sector  
work for patients

## Annual report and accounts 2014/15



Monitor

Annual report and accounts

1 April 2014 to 31 March 2015

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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 patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

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## Monitor's role

In April 2014 we published our [strategy for 2014-17](#) which has framed our actions throughout these past 12 months. There are six elements. The first four mirror our core responsibilities and are closely related to our 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. We can only fulfil our 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.

## Chairman's foreword

I am pleased to introduce our annual report and accounts for 2014/15, my first full year with Monitor. When I joined, I expressed my determination that we should put patients and quality of care at the centre of our work, in line with our primary regulatory duty. I believe we are doing that, and this is being reinforced by our new Patient and Clinical Engagement Directorate.

The NHS is the subject of much criticism but we should never lose sight of its many successes. While emphasis is rightly placed on achieving targets, we need to remember that the service sees over a million patients every 36 hours – patients who have high expectations of the NHS in terms of the quality of care they receive. We are indebted to the professionalism and hard work of those at the front line.

However, there is no escaping the fact that there are huge challenges ahead as the NHS manages rising demand and flat budgets. This is alongside the imperative to maintain high quality, compassionate care for patients and the fact that there will also be a need to change the way services are planned and provided.

The 'NHS Five Year Forward View' (published in October by the Care Quality Commission, Health Education England, Monitor, NHS England, NHS Trust Development Authority and Public Health England) is a plan to bring about patient-centred, co-ordinated, integrated care. This joint vision focuses on prevention, out-of-hospital care and the integration of primary, secondary and community care.

As someone whose background covers both the NHS and local government, I am encouraged to see that integrated care has emerged as a principal theme. Integrating care better is crucial to lowering the pressure on hospitals; we need to ensure that only patients who really need to go there do so and that others are treated elsewhere in their community. It seems clear that the quality of the care patients receive will benefit from health, social and community care being joined up. There are already radical and innovative ideas about how to bring this about, particularly from the pilot schemes across the country. Monitor is supporting both the Integrated Care Pioneers and the Vanguard sites which are testing new care models set out in the Five Year Forward View.

Over the last year, I and other Monitor Board members have been visiting local trusts and other parts of local health economies. I am confident from these visits that we are beginning to see concrete progress. One foundation trust I visited during the year shows what can be done: it now provides acute, community and social care to urban and rural populations. It is to open state-of-the-art emergency care facilities and, having acquired two GP practices, it is looking to grow further in primary care.

Supporting the health sector is at the forefront of all we do. Our experience suggests that providers struggling with operational and financial challenges have too little support available to them. Our new Provider Sustainability Directorate will be an important new element in our ability to address that.

During the year we have welcomed two new non-executive directors to the Board. Iain Osborne joined us in May 2014, bringing a wealth of regulatory expertise from the utility and aviation sectors. Dr Timothy Heymann, who joined in February 2015, contributes distinguished clinical experience as well as a knowledge of health regulation and business.

I am most grateful to all our Board members for the support they give to Monitor, the interest they take in our work and the challenge and expertise they bring to their roles.

Working as a team is essential to all that we do, and so I want to thank the staff for their commitment to the organisation. It is their loyalty and team work which ensures that everything is done to the highest standard and reflects the values to which we subscribe. I hope this report offers an insight into the important work they do.

We also enjoy good relationships and co-operation with our other principal partners, which contribute greatly to the individual responsibilities we each have to the NHS.

Finally, the Board is very sad that David Bennett will be stepping down later this year after five years at Monitor: he has shown outstanding leadership and we consider him to be the best of the best of chief executives. It has been a privilege working with him and he is highly regarded both in Monitor itself and externally. As Monitor and the Trust Development Authority begin to work closely under a new single chief executive, we will maintain David's single-minded focus on what is important, particularly to patients.

Baroness Joan Hanham CBE  
Chairman  
2 July 2015

## Chief Executive's review of the year

The NHS faces a severe challenge to simultaneously improve care quality, meet access targets and drive up productivity. To achieve this there can be no let-up in the speed or scale of change in provider organisations. That is why over the past year, our second as regulator for health services in England, our priority has been to help local commissioners and providers redesign the way they deliver healthcare for longer-term sustainability while continuing to maintain their operational performance.

All this has had to be done by the sector in the face of increasing demand and constrained funding. For example, GP referrals to hospital and ambulance calls were up by 6.5% and 7.5% respectively. Meanwhile, the rise in NHS funding has not kept pace with the growth in activity. By the end of March 2015, 29 NHS foundation trusts (or 19% of the total) were in breach of their licence and subject to regulatory action by Monitor as we worked to help them deal with their challenges.

Last year was the first that the foundation trust sector as a whole ended the year in deficit, with 77 out of 153 trusts losing money. Although the plans of individual trusts are more realistic this year, they would result in a worse financial performance for the sector. Put simply, this is unaffordable.

The level of public support for the NHS remains as high as it is because of the efforts of the clinicians, managers and others on the front line who deliver patient care. We are always determined to find better ways to help them.

Experience has taught us that struggling trusts cannot resolve their difficulties alone: they need a concerted, long-term response from the various providers, commissioners and users of services who make up their local health economy. Our enforcement team now seeks to co-ordinate such responses, working with our national partners, particularly NHS England and the NHS Trust Development Authority (TDA).

As this is now an integral part of what we do, we have set up a new Provider Sustainability Directorate. This team will help hospitals and other providers improve their performance and how they innovate so that organisations can get back onto a sustainable footing before their difficulties become overwhelming. For trusts already in special measures, we are working with the Care Quality Commission (CQC) and TDA to help them step up their improvements.

Publishing the 'NHS Five Year Forward View' in October 2014 was an important step in helping the sector become sustainable in the longer term. Jointly produced by six national NHS bodies including Monitor, this set out a coherent direction for the sector with a vision of patients guiding the development of new care models.

Individual trusts, however, each need a reliable plan for the future and many are falling short on this. A review of trusts' five-year strategic plans showed that only

30% would secure a sustainable future. In response to this need for stronger planning skills, we created a detailed toolkit to help those on the front line work out sound organisational strategies. And, to help foundation trusts co-ordinate their long-term plans with NHS trusts and with commissioners, we worked with TDA and NHS England to align our planning guidance and assumptions better.

There is a widespread emphasis now on promoting improved, integrated, joined-up services for patients. At Monitor we have advised organisations how they can collaborate to integrate care; we have revised our regulatory approach to mergers and other major transactions to support those that are clearly in patients' interests. We have also reviewed the commissioning of services, such as GP services, to make sure that it works well for patients. I am encouraged that there is now broad support across the NHS for our efforts to have all organisations adopt the same approach to costing. Among other benefits, this will make providing effective integrated care much more feasible.

During the year we encountered objections from commissioners and providers to Monitor's and NHS England's joint proposals for the next national tariff. In our view, this showed the difficulty of balancing interests within the sector at a time when funding and other pressures are so significant. We believe we devised a pragmatic way forward for the majority of providers while we work with everyone to address the most immediate concerns regarding the payment system and reshape it in the longer term. New payment approaches, for example capitation-based payments, can help dissolve traditional boundaries between primary, secondary, community and social care and give providers incentives to deliver better integrated care.

We were particularly pleased to see the flow of applications for foundation trust status reinvigorated: six new organisations – including the first mental health trust – have become foundation trusts. Also highly positive has been the development of our new Patient and Clinical Engagement Directorate under Professor Hugo Mascie-Taylor. Monitor is being joined as well by Ruth May, our first Nurse Director, Stan Silverman as Deputy Medical Director, and four additional senior clinicians.

After more than five years leading Monitor, I shall be stepping down as chief executive later this year. I am immensely proud of the hard work and commitment of all our staff. As the organisation begins a new era of working more closely with TDA, I wish Monitor's staff and the new chief executive every success in supporting the NHS in the future.

Dr David Bennett  
Chief Executive  
2 July 2015

## Strategic report

### Making sure public providers are well led

In the two years since we received new powers, Monitor has continued to be more than a financial or economic regulator. We make sure trusts are well led so that they can deliver high quality care for patients, working closely with CQC to safeguard patients through quality regulation, with the aim of preventing problems arising in trusts in the first place. We continue to act on the recommendations of the Francis Inquiry and we are working actively with other organisations which also lead the sector on operational performance targets such as accident and emergency waiting times and sustainability risks at trusts.

We do this through two core teams:

- Our provider appraisal team defines the foundation trust authorisation standard that all NHS providers must meet and assesses applicants against it. It also evaluates the major transactions, such as mergers and acquisitions, considered by NHS foundation trusts to ensure that they benefit patients and do not undermine the organisations' sustainability.
- Our provider regulation team monitors individual NHS foundation trusts' performance and steps in where there are problems.

We also develop capability in the foundation trust sector to help trusts deal with the challenges they face and evaluate individual complaints we receive about them to see if there are grounds for wider governance concerns.

### Working towards all NHS providers achieving the foundation trust standard

#### Continued development of regulatory processes

We continued to work with our national partners, CQC and TDA, to define a common understanding of what a good organisation looks like and what it should be able to demonstrate. This makes our regulatory activities more coherent, consistent and transparent, and easier for trusts and foundation trusts to work with.

Our [updated 'Well-led framework for governance reviews'](#) supports this work and we are updating our 'Guide for applicants' to reflect these changes.

#### Revising our approach to transactions

In April 2014, after consulting the sector, we published our risk assessment framework with an updated appendix on NHS foundation trust transactions and followed this in July with new guidance. We now urge NHS providers considering transactions to contact us early in their planning to make sure proposals work well for patients. We can help them determine whether a particular transaction makes

sense from care quality, operational, financial and (where relevant) choice and competition perspectives.

Our new approach will help make sure that:

- mergers and acquisitions are based on sound analysis of the expected patient benefits supported by robust action plans
- statutory review of a proposed merger or acquisition can take place quickly and without undue costs.

## **Provider appraisal activity in 2014/15**

### *Assessments*

During 2014/15, we achieved a milestone by authorising our first three community foundation trusts and the first foundation trust providing high security psychiatric services. Six NHS trusts were referred to us for assessment, and we reactivated the assessments of eight NHS trusts (four previously deferred and four previously paused while awaiting inspection under the new CQC inspection regime) (see Table 1). We completed eight assessments, of which we authorised six, deferred one and paused one awaiting CQC inspection. TDA withdrew two NHS trusts' applications (one deferred and one postponed) (see Table 2).

“ We achieved a milestone by authorising our first three community foundation trusts and the first foundation trust providing high security psychiatric services ”

We also reviewed the quality governance procedures to ensure the quality of care of four NHS trusts during the TDA stage of assessment.

By the end of March 2015, 151 of the 241 NHS trusts in England had achieved NHS foundation trust status.

**Table 1: Assessments summary 2009-15**

Year	2009/ 10	2010/ 11	2011/ 12	2012/ 13	2013/ 14	2014/ 15
Referred	7	11	5	12	5	6
Reactivated	-	-	-	-	1	8
Assessed	20	14	10	10	15	8
Authorised	14	7	7	2	2	6
Deferred	1	1	1	5	3	1
Paused (pending CQC outcome)	-	-	-	-	6	1
Postponed	4	6	1	3	2	-
Withdrew	1	0	3	0	4	2
Rejected	0	0	0	0	0	0
Total no. of foundation trusts	129	136	143	145	147	151*

\* This total includes Mid Staffordshire NHS Foundation Trust, now a shell organisation under special administration following the transfer of its services to the management of two neighbouring trusts in November 2014. It also reflects the takeover of two foundation trusts by other foundation trusts.

**Table 2: Monitor's applications pipeline 2014/15**

	In progress	Deferred/ postponed	Paused pending CQC outcome	Total Monitor pipeline
Pipeline at 31 March 2014	1	8	6	15
Paused	(1)		1	-
Referred from TDA	6			6
Reactivated	8	(4)	(4)	-
Withdrawn		(2)		(2)
Deferred	(1)	1		-
Authorised	(6)			(6)
Pipeline at 31 March 2015	7	3	3	13

### *Significant transactions*

We assessed several significant transactions during the year, including:

- Royal Free London NHS Foundation Trust's acquisition of Barnet and Chase Farm Hospitals NHS Trust
- Frimley Park Hospital NHS Foundation Trust's acquisition of Heatherwood and Wexham Park Hospitals NHS Foundation Trust
- Papworth Hospital NHS Foundation Trust's proposed new buildings funded through the private finance initiative.

## Regulating providers

Our provider regulation team monitors NHS foundation trusts' performance and takes remedial action where they fall below the required standard. Our approach is to identify problems early and act quickly to minimise the impact on patients. Our principal tool for doing this is the NHS provider licence, which includes requirements on pricing, choice and competition, integrated care and continuity of services, as well as specific conditions for foundation trusts relating to governance. All foundation trusts and non-exempt independent providers of NHS services must meet the conditions of the licence.

### **Developing our regulatory action to respond to challenge**

During the past 12 months, more providers than ever have struggled to meet significant operational and financial challenges, in part because of rising demand for NHS services combined with flat real-terms funding growth. At 31 March 2015, we were taking formal action at 29 foundation trusts in breach of their provider licence, representing 19% of the sector.

To help the sector meet these challenges we have revised our approach to regulation and are working more closely with our national partners. With CQC's Chief Inspector of Hospitals and TDA we are finding ways to maximise improvements to patient services in hospitals in the greatest need through the special measures programme. We are also working with NHS England and TDA on specific national and local priorities, including A&E, waiting times and strategic planning. In a growing number of cases, problems at individual hospitals require long-term response across the whole local health economy and we need to co-ordinate our response with NHS England and TDA to address these.

In the past 12 months, we found 10 more foundation trusts in breach of their licence and took formal action (see Table 3 below); 8 foundation trusts demonstrated sufficient improvements for us to remove all the formal action to which they had been subject (see Table 4 below); several others have partially addressed the issues they have been facing and are currently on track to have their formal action removed.

Since 31 March 2015, we have taken further action at Norfolk and Norwich University Hospitals NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust, making legally binding agreements with them to take the necessary steps to ensure they are able to deliver high quality services on a sustainable basis for their patients.

We also took enforcement action at King's College Hospital NHS Foundation Trust in early April 2015 after the trust was unable to resolve longstanding operational and financial problems at the Princess Royal University Hospital, which it took over in October 2013. We have agreed with the trust that it develop and implement an

effective turnaround plan and a longer-term strategic plan to ensure patient services are improved and continue to be provided in a sustainable way.

We are also currently investigating nine trusts (see Table 5 below).

We launched an investigation into St George’s University Hospitals NHS Foundation Trust in April 2015 due to a sudden deterioration in finances shortly after its authorisation. We have asked the trust to commission an external review to determine why financial performance has deteriorated so sharply and to inform the turnaround programme that is being developed.

**Table 3: NHS foundation trusts found in breach of their licence during 2014/15**

Trust	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 to undertake an external review of the leadership and how it is run, and appoint a turnaround director to help it deal with short-term financial problems.
Barnsley Hospital NHS Foundation Trust	Finance and governance	We have made a legally binding agreement with the trust to seek expert help to fix its financial issues, put plans in place to cut waiting times and strengthen the trust’s leadership.
South Tees Hospitals NHS Foundation Trust	Finance and governance	We have made a legally binding agreement with the trust to implement a financial recovery and an infection control plan, appoint a transformation director and commission an external review of its leadership.
East Kent Hospitals University NHS Foundation Trust	Governance	After CQC identified care quality issues, we placed the trust in special measures. We made a legally binding agreement with the trust to take steps to address CQC’s concerns and strengthen its governance and leadership.
Royal Berkshire NHS Foundation Trust	Finance and governance	We have made a legally binding agreement with the trust to take specific steps to address its governance and financial issues and ensure it continues to deliver

Trust	Breach	Action taken
		high quality services.
Calderdale and Huddersfield NHS Foundation Trust	Finance and governance	We have made a legally binding agreement that the trust will appoint a turnaround director, develop a plan to improve its finances and commission a review of board leadership.
The Dudley Group NHS Foundation Trust	Finance	We have made a legally binding agreement with the trust to develop and implement an effective financial turnaround and a robust strategic plan to address its financial decline.
Norfolk and Suffolk NHS Foundation Trust	Governance	After CQC identified care quality issues, we placed the trust in special measures. It has agreed to put an action plan in place to address the issues identified by CQC.
Basildon and Thurrock University Hospitals NHS Foundation Trust*	Finance	We made a legally binding agreement that the trust will implement a financial recovery plan and commission an external review of its sustainability to identify how services for patients can be secured in the long term.

\* Basildon and Thurrock University Hospitals NHS Foundation Trust was subject to formal action in relation to its governance until August 2014 (see Table 4 below), when Monitor concluded that it had improved and was again compliant with its licence. In February 2015, Monitor took further regulatory action in relation to the trust's short and long-term financial challenges.

**Table 4: NHS foundation trusts ceasing to be subject to formal regulatory action in the year to 31 March 2015**

Trust	Type of breach of licence	Date
Cambridge University Hospitals NHS Foundation Trust	Finance and governance	May 2014
Dorset HealthCare University NHS Foundation Trust	Governance	June 2014
Aintree University Hospital NHS Foundation Trust	Governance	July 2014
Basildon and Thurrock University Hospitals NHS Foundation Trust	Governance	August 2014
Heatherwood and Wexham Park Hospitals NHS Foundation Trust*	Finance and governance	October 2014
Mid Staffordshire NHS Foundation Trust**	Finance and governance	November 2014
The Christie NHS Foundation Trust	Governance	November 2014
Royal National Hospital for Rheumatic Diseases NHS Foundation Trust***	Finance	February 2015

\* Heatherwood and Wexham Park Hospitals NHS Foundation Trust was acquired by Frimley Park Hospital NHS Foundation Trust on 1 October 2014.

\*\* The services and assets of Mid Staffordshire NHS Foundation Trust were transferred to University Hospitals of North Midlands NHS Trust and the Royal Wolverhampton NHS Trust on 1 November 2014.

\*\*\* The Royal National Hospital for Rheumatic Diseases NHS Foundation Trust was acquired by the Royal United Hospitals Bath NHS Foundation Trust on 1 February 2015.

**Table 5: NHS foundation trusts currently under investigation**

Trust	Reason for investigation
Taunton and Somerset NHS Foundation Trust	We are investigating governance concerns at the trust following multiple breaches of the referral to treatment (admitted) target.
Yeovil District Hospital NHS Foundation Trust	We are investigating financial sustainability concerns at the trust, triggered by a deterioration in its financial position.
City Hospitals Sunderland NHS Foundation Trust	We are investigating financial sustainability concerns at the trust, triggered by a continuity of services risk rating of 2.
Gateshead Health NHS Foundation Trust	We are investigating financial sustainability concerns at the trust, triggered by a continuity of services risk rating of 2.
Lancashire Teaching Hospitals NHS Foundation Trust	We are investigating financial sustainability concerns at the trust, triggered by a deterioration in its forecast financial position.
Warrington and Halton	We are investigating financial sustainability concerns at the

Trust	Reason for investigation
Hospitals NHS Foundation Trust	trust, triggered by a continuity of services risk rating of 2.
Wirral University Teaching Hospital NHS Foundation Trust	We are investigating financial stability and governance concerns at the trust, triggered by a continuity of services risk rating of 2.
Cambridgeshire and Peterborough NHS Foundation Trust	We are investigating financial sustainability concerns at the trust, triggered by a continuity of services risk rating of 2.
St George's University Hospitals NHS Foundation Trust	We are investigating financial sustainability concerns at the trust, triggered by a deterioration in the trust's financial position.

### *Special measures*

Where we identify serious failures in the quality of care and are concerned that a foundation trust's management cannot make the necessary improvements without support, we will place a foundation trust in special measures. This is a set of specific interventions designed to improve care quality and leadership within 12 months, and is usually based on a recommendation from CQC's Chief Inspector of Hospitals. Such interventions typically include assigning a 'buddy' organisation and an improvement director to the trust. During this year, we have continued to work with CQC's Chief Inspector of Hospitals and TDA to make the special measures regime more effective.

Twelve foundation trusts are in special measures or have been during last year while three have exited (see Table 6 below). Basildon and Thurrock University Hospitals NHS Foundation Trust and Northern Lincolnshire and Goole NHS Foundation Trust were removed from special measures after the Chief Inspector of Hospitals found significant improvements in the quality of care and leadership. Heatherwood and Wexham Park Hospitals NHS Foundation Trust was acquired by Frimley Park Hospital NHS Foundation Trust, the first trust to be rated 'outstanding' by CQC.

**Table 6: Foundation trusts in special measures in the year to 31 March 2015**

Trust	Date entering special measures	Reason for entering special measures	Date of leaving special measures	Reason for remaining in or leaving special measures
Burton Hospitals NHS Foundation Trust	July 2013	Keogh review*: concerns about skill mix, junior doctor support and board information	N/A	Recommendation by Chief Inspector of Hospitals after CQC inspection in April 2014
Medway NHS Foundation Trust	July 2013	Keogh review: concerns about clinical supervision and urgent care	N/A	Recommendation by Chief Inspector of Hospitals after CQC inspection in April 2014
Tameside Hospital NHS Foundation Trust	July 2013	Keogh review: concerns about infection control and out-of-hours cover	N/A	Recommendation by Chief Inspector of Hospitals after CQC inspection in May 2014
Sherwood Forest Hospitals NHS Foundation Trust	July 2013	Keogh review: concerns about a large backlog of complaints and appointments	N/A	Recommendation by Chief Inspector of Hospitals after CQC inspection in April 2014
Basildon and Thurrock University Hospitals NHS Foundation Trust	July 2013	Keogh review: concerns about governance, infection control, A&E, workforce and patient experience	June 2014	Recommendation by Chief Inspector of Hospitals. The trust made improvements in A&E, paediatrics, mortality rates and hospital governance
Northern Lincolnshire and Goole NHS Foundation Trust	July 2013	Keogh review: concerns about clinical leadership and priority of quality of care. There were also concerns with A&E, out-of-hours stroke services, staffing levels, poor skill mix, lack of basic patient care and poor experience in some areas	July 2014	Recommendation from Chief Inspector of Hospitals. The trust improved its medical staffing and strengthened its clinical leadership by appointing a new medical director. The trust will continue to receive support from other NHS organisations to provide expert advice and support to ensure that improvements continue

\* In 2013 Sir Bruce Keogh, NHS Medical Director for England, reviewed the quality of care and treatment provided by 14 trusts and foundation trusts that had mortality rates persistently higher than expected.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	October 2013	CQC inspection, which raised concerns about staffing levels and dementia care	N/A	Recommendation by Chief Inspector of Hospitals after CQC inspection in July 2014
Colchester Hospital University NHS Foundation Trust	November 2013	Concerns about management of the cancer care pathway	N/A	Recommendation by Chief Inspector of Hospitals after CQC inspection in May 2014
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	May 2014	Recommendation following CQC's Chief Inspector of Hospitals inspection, which highlighted concerns about patient care, nurse staffing levels, bullying, harassment and cultural problems	October 2014	Acquisition of the trust by Frimley Park NHS Foundation Trust
University Hospitals of Morecambe Bay NHS Foundation Trust	June 2014	Concerns about the safety of services (in particular, medical and nursing staff levels) and a lack of clarity about the trust's future strategy	N/A	Yet to be re-inspected by CQC
East Kent Hospitals University NHS Foundation Trust	August 2014	Problems with patient care, hospital governance and clinical leadership (identified by CQC inspection). Monitor has also taken additional enforcement action at the trust following breach of the four-hour A&E target	N/A	Yet to be re-inspected by CQC
Norfolk and Suffolk NHS Foundation Trust	February 2015	CQC inspection raised concerns about safety of services, staffing levels and leadership at the trust	N/A	Yet to be re-inspected by CQC

“ Every troubled organisation faces a different set of challenges, often complex and inter-related ”

Our experience this last year has shown that every troubled organisation faces a different set of challenges, often complex and inter-related. Identifying the right support

for trusts in special measures is critical to turning around a trust, but it has proved difficult to find high-performing ‘buddy’ organisations and individual NHS leaders with the skills, experience and determination to tackle such challenging and varied situations. To address this, we have made significant progress during the year in setting up a network of highly qualified and skilled leaders who are available to support foundation trusts in difficulties.

## 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 their annual plans each spring then report on performance against the plan and operational performance at each quarter.

During the year, many foundation trusts did not meet key operational performance standards such as the accident and emergency (A&E) four-hour maximum waiting time. This is likely to reflect the increasing pressures faced by the sector. NHS leaders, for example, often cite the growth in demand for urgent care services as a significant contributory issue. There are further pressures across the system to deliver waiting time targets while improving efficiency and quality of care for patients.

### *Accident and emergency*

We have been working closely with TDA, NHS England and the Association of Directors of Adult Social Services to share information and provide additional support where needed. This year £688 million was allocated to help local health systems and providers during winter, and the Emergency Care Intensive Support Team has also provided expert help. The funding was used for initiatives such as strengthening weekend discharges, increasing radiology capacity in A&E and enhancing weekend pharmacy services.

However, foundation trusts missed the A&E target in every quarter in 2014/15. An annual performance of 93.5% was significantly below the 95% target and the 95.4% achieved in 2013/14.

With our national partners we are reviewing the reasons for this drop in performance to identify the actions we can take and support we can offer to help foundation trusts improve performance in 2015/16.

### *Infection control*

Across foundation trusts the total number of reported Clostridium difficile (C. difficile) cases saw an increase in 2014/15 compared to 2013/14 (806 compared to 676). However, there has been a sharp decline in the number of foundation trusts breaching C. difficile targets during the last quarter of the year. This is a direct result of changes in 2014/15 to NHS England's methodology for measuring C. difficile target performance, which emphasises cases caused by providers' 'lapses in care' rather than the total number of cases reported.

### *Referral to treatment*

Foundation trusts achieved the 92% standard for incomplete pathways (92.73%) at the end of 2014/15. They also achieved the elective waiting time standard for non-admitted pathways with a performance of 95.5%, but failed the standard for admitted pathways with a performance of 88.2%.

The number of trusts breaching at least one of the three standards at the end of 2014/15 has increased when compared to the same period last year from 24 to 53. This is likely to have been due to the policy of relaxing penalties on breaches so that fewer people waited for prolonged periods. However, in 2014/15 the number of patients treated did not keep pace with a higher than expected growth in referrals. Data from December 2014 showed that, between 2013/14 and 2014/15, GP referrals for a first outpatient appointment grew between 5.5% and 6.5%.

We worked this year with NHS England and TDA to run initiatives to improve referral to treatment performance and will continue this in 2015/16, with a particular focus on improving the reporting and audit of waiting time data.

### *Cancer performance*

The number of foundation trusts achieving the 62-day standard for cancer treatment has been declining since 2013/14. The main contributing factors cited by trusts for underperformance were mostly related to complex diagnostic pathways. In particular, the average wait for patients referred for gastrointestinal, head and neck, sarcoma and urological treatments was approximately 50 days. These patients make up over 50% of the total referrals.

### *Financial performance*

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 will be laid before Parliament before the summer recess.

During the year we also track the financial performance of foundation trusts on a quarterly basis. Our quarterly monitoring information revealed an exceptionally challenging year for foundation trusts. For the first time, they reported an overall

deficit before impairments and transfers. The size of the deficit was £345 million, including consolidated charities. This was £479 million worse than 2013/14. Over 50% of foundation trusts were in deficit at the end of the year, and most of them were acute trusts.

The deterioration in financial performance was largely driven by the growth in expenditure during the year exceeding the growth in revenue. Expenditure increased as a result of excessive use of agency staff in response to both activity and quality pressures. This was exacerbated by failure to achieve all the cost savings planned. Although revenue increased, this was not proportional to the growth in activity. Foundation trusts saw a significant rise in their emergency activity which displaced planned elective work. The unplanned emergency activity led to the reduced tariff paid, thus not fully compensating the costs of delivering the work. The earnings before interest, tax, depreciation and amortisation (EBITDA) margin also saw a significant decline in 2014/15. The overall margin at 3.8% was below the 5.2% achieved in 2013/14. This was also below the 5% threshold that we use to assess foundation trusts' long-term financial sustainability.

Although the sector's deficit affected the amount of cash foundation trusts held at the end of 2014/15, it was higher than the sector planned at the start of the year.

In addition, foundation trusts continued to invest in improving patient care infrastructure. The spend on capital schemes in 2014/15 was similar to the year before.

### **Improving annual planning**

In the last 12 months our annual planning process has responded to the sector's weaknesses in strategic planning and addressing sustainability concerns.

For the 2014/15 planning round:

- we required trusts to submit both a five-year strategic plan that included a self-assessment of their sustainability and a detailed two-year operational plan
- with NHS England and TDA we supported 11 challenged health economies during their strategic planning phase, comparing the providers' and commissioners' submissions to test they were aligned and cross-checking to identify any gaps in their planned contracted income.

We focused our strategic reviews on foundation trusts and their local health economies where we identified sustainability problems.

We concluded that only 30% of foundation trusts had a plan setting out a sustainable future for themselves in the medium term; 70% of plans suggested their trusts' sustainability was at risk to varying degrees. Without fundamental change – for

example, integrating and redesigning patient services – the sector is likely to face increasing financial distress.

During 2014/15 we have continued to improve the annual planning process by:

- creating a comprehensive strategy development toolkit for foundation trusts and trusts
- matching our guidance and assumptions with our national partners, including jointly releasing planning guidance, developing a joint risk assessment process and cross-checking activity plans for the first time
- introducing a draft plan phase to help trusts by identifying risks earlier and feeding back before submitting their final annual plans.

### **Creating our Provider Sustainability Directorate**

Our experience of providers that are struggling with operational and financial challenges suggests that they do not get enough support. By setting up a Provider Sustainability Directorate we will offer providers help on operational performance and developing their ability to introduce new care models.

All foundation trusts will be able to draw on the Provider Sustainability Directorate's support but they will not have to use it unless they are in breach of their licence. Like our development team, which is now part of the new directorate, this support directorate will help the NHS to help itself. The Provider Sustainability Directorate's work will be kept separate from the regulatory oversight of foundation trusts, which remains the Provider Regulation Directorate's responsibility.

The new directorate will bring in-house much of the contingency planning work previously outsourced to external consultants. This comprises analysis of providers' long-term clinical, operational and financial sustainability, as well as development of restructuring options where providers are unsustainable in their current form. By bringing this in-house we hope not only to reduce the cost of contingency planning teams but to develop and retain within the NHS the intellectual capital that flows from the work.

### **Supporting the sector's development**

Our development team is led by an experienced NHS service improvement director from a large acute and community foundation trust. It helps organisations develop their leadership, board, strategy and care quality so they can respond better and faster to changing patient needs and local challenges. We undertake the work with a range of national partners including TDA, NHS England, CQC and the Department of Health, and collaborate with a range of other national organisations including NHS Providers.

Our recent work includes:

- the strategy development toolkit, which was piloted by five foundation trusts
- working with partners on a new talent programme to foster potential chief executives and support them once in post
- topic-specific events for executive directors
- good practice webinars on the emergency care pathway, service line management and strategy development.

We are committed to the drive to improve quality and patient safety and are active partners in the national campaign 'Sign up to Safety', learning with seven trailblazer foundation trusts. The campaign aims to reduce avoidable harm to patients by 50% and save 6,000 lives.

### **Complaints and whistleblowing: encouraging an open and honest culture**

Responding effectively to feedback from concerns is vital to the NHS's future. Monitor is a member of the Complaints Programme Board, set up to improve complaint handling as part of the Department of Health's response to Sir Robert Francis's report on Mid Staffordshire NHS Foundation Trust. We have raised awareness of the board's work and reminded foundation trusts of the importance of good complaints handling. We also contributed to the 'Freedom to Speak Up' review led by Sir Robert to encourage an open and honest reporting culture in the NHS (see next page), and wrote to all foundation trusts to emphasise the importance of this issue. We will work with our national partners to deliver the review's national recommendations.

We created a section on our website specifically for patients and the public. This includes a video on how to complain about health services and how we use information from the complaints we receive (see below).

#### *Complaints about foundation trusts*

This year, we received 820 complaints about health services, 621 of which were about foundation trusts.

We always share complaints with CQC and TDA to inform their picture of individual trusts. Our memorandum of understanding with Healthwatch England describes how we share intelligence at a national level and regionally with local Healthwatch organisations.

Where we receive complaints that give us concern about a foundation trust's governance or quality governance, we consider whether we need more information from the trust and then decide whether to take formal regulatory action.

## Whistleblowing

“ We are creating a strengthened centralised team for dealing with all complaints and whistleblowing concerns ”

Whistleblowers play an important part in identifying areas of poor practice in the health sector. Our audit and risk committee identified whistleblowing as a priority for 2014/15 so we reviewed our policies, taking account

of the ‘Freedom to Speak Up’ review, and are creating a strengthened centralised team in Monitor for dealing with all complaints and whistleblowing concerns. This will further improve the service we provide people who take time to raise concerns with us, as well as improve how we use the intelligence they give us about the health sector.

We received 28 whistleblowing concerns in 2014/15. We considered them all carefully and communicated our findings to the whistleblower. Where a disclosure raised potential concerns about governance, we investigated whether the trust was complying with the terms of its provider licence.

### **Government’s response to the Mid Staffordshire public inquiry**

In February 2015, the Department of Health published ‘[Culture change in the NHS: applying the lessons of the Francis Inquiries](#)’ setting out progress in applying the lessons learned from the tragic and inexcusable failings at Mid Staffordshire NHS Foundation Trust. Progress includes a new, rigorous CQC inspection regime for hospitals, GPs and adult social care, extra clinical staff working in the NHS and the special measures regime for failing trusts in which Monitor continues to play a pivotal part.

### **‘Freedom to Speak Up’ Review**

The public inquiry into Mid Staffordshire noted that, while the culture there was particularly disturbing, it was important to recognise that other parts of the NHS were also failing to face problems and deal with them, letting down patients and staff alike. The Secretary of State therefore commissioned Sir Robert Francis to carry out an independent review called ‘Freedom to Speak Up’ to provide advice and recommendations on creating a more open and honest reporting culture in the NHS. We have supported in principle all the review’s recommendations and are working with our national partners to implement them. This is alongside the Department of Health’s consultation on the impact of some of the recommendations on the sector.

### **Savile Inquiry**

Following the allegations of Jimmy Savile’s wrongdoing at NHS organisations, the Department of Health launched an inquiry into his activities. Although many of the actions took place a long time ago and, in some cases, at institutions that no longer exist, it was readily acknowledged that everyone in the NHS has a responsibility to

make sure nothing like this can happen again. The lessons learned report published on 26 February included 14 recommendations for the NHS, Department of Health and wider government.

With a focus on protection of patients, staff, visitors and volunteers, we requested all foundation trusts to check their safeguarding arrangements, take any action necessary and let us know what they are doing or plan to do.

### **Morecambe Bay Investigation**

The Secretary of State for Health established the investigation into University Hospitals of Morecambe Bay NHS Foundation Trust in September 2013 following concerns over serious incidents in Furness General Hospital's maternity department. Covering January 2004 to June 2013, the report, published in March 2015, concludes that the maternity unit was dysfunctional and that serious failures of clinical care led to avoidable and tragic deaths of mothers and babies.

The report makes 44 recommendations for the trust and the wider NHS, aimed at ensuring the failings are properly recognised and acted on. We have already actioned one of the recommendations – publication of a memorandum of understanding with CQC, which sets out how we work together and share information effectively – and are working on the others that are relevant.

## Making sure essential NHS services are maintained

If a provider gets into serious difficulty that threatens its ability to offer essential services, we must intervene to maintain and protect those services for the people who need them. In April 2014, our responsibility was extended from foundation trusts to the independent sector, and some independent sector providers now need to hold a licence from us.

## Dealing with an increased caseload

There has been a noticeable increase in the number of trusts with severe problems. Our enforcement team works intensively with them to diagnose and resolve their issues. One approach we use is to send in contingency planning teams that review whether a trust is clinically, operationally and financially sustainable, and recommend options for further action. These may include taking the further step of appointing Trust Special Administrators (TSAs) to take control of a provider's affairs and recommend to us and, ultimately, the Secretary of State for Health, how services can be provided sustainably and to a good standard.

“ We have recruited staff with clinical, NHS operations and strategy experience ”

We have recruited staff with clinical, NHS operations and strategy experience to our enforcement team during the year, broadening our skill mix to reflect the increasing

complexity of issues. Our first permanent senior enforcement director was an experienced foundation trust director and foundation trust interim chair.

## Solutions for the most troubled trusts and local health economies

We increasingly find that problems at foundation trusts cannot be resolved by or in the trust alone, but require a long-term response across the local health economy. This calls for powers beyond those that the trust's licence gives us, so we work with NHS England and TDA when seeking solutions across whole health economies. As national partners we are able to ensure that within their financial constraints all parts of a local system are focused on achieving the best outcomes for patients.

Solutions across local health economies often involve reconfiguring services between individual acute providers or between acute and non-acute settings. This can be unpopular with local stakeholders. Our focus is on finding the best solution for patients, agreeing it with local stakeholders and ensuring it is implemented. Commissioners are integral to this process.

## Trust special administration of Mid Staffordshire NHS Foundation Trust

In October 2012 we appointed an independent contingency planning team (CPT) to Mid Staffordshire NHS Foundation Trust to assess the trust's clinical, financial and operational sustainability. On the basis of the CPT's conclusions, we appointed

TSA's from April 2013 (Mid Staffordshire was the first foundation trust to be placed into trust special administration). In January 2014, we approved the recommendations in the TSA's' final report, which was then submitted to the Secretary of State. In February 2014 the Secretary of State accepted the TSA's' recommendations. Following the completion of the trust special administration process, from 1 November 2014 services formerly provided by Mid Staffordshire at County Hospital (formerly Stafford Hospital) and Cannock Chase Hospital have been provided by University Hospitals of North Midlands NHS Trust and the Royal Wolverhampton Hospital NHS Trust respectively.

We learned many lessons through our first trust special administration that we can apply to future TSA's and to developing solutions for other challenged health economies.

### **The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust**

We appointed a multidisciplinary CPT in September 2014 to set out the options for sustaining services at the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. The CPT, which is set to report in mid-2015, has made extensive progress, establishing the extent of the clinical and financial challenges facing the trust and its local health economy, as well as exploring possible solutions to those challenges. These include making significant operational improvements at the trust, achieving commissioner-led demand management initiatives and examining the impact of different care models and innovative ways of working.

The CPT has also considered governance arrangements and milestones that must be passed to ensure the local health system implements the CPT's final recommendations promptly.

### **Tameside Hospital NHS Foundation Trust**

A multidisciplinary CPT is helping Tameside Hospital NHS Foundation Trust, its clinical commissioning group and the council develop and test a locally generated idea to fully integrate health and social care services. The team will build on work already done locally and work with the trust, commissioners, clinicians and patients to confirm that this is the best solution for Tameside.

We appointed this CPT in November 2014 because the trust is clinically and financially unsustainable in its current form. The trust has been in breach of its licence since February 2011 and we placed it in special measures in July 2013.

### **Peterborough and Stamford Hospitals NHS Foundation Trust**

We appointed a multidisciplinary CPT in February 2013 to look at the sustainability of the services provided by Peterborough and Stamford Hospitals NHS Foundation Trust. The team's review in early June 2013 found the trust to be clinically and

operationally sustainable but financially unsustainable, highlighting a risk to patient services.

During 2014 and 2015 we worked closely with NHS England and TDA to oversee a systems transformation project by Cambridge and Peterborough Clinical Commissioning Group. This aims to make strategic changes to the local system that will improve outcomes for patients and ensure medium-term financial sustainability. It will also help implement the CPT's findings, not least maximising benefits from use of the trust's assets. Separately we have continued to take regulatory action to make efficiency savings at the trust, and in 2014/15 it completed a cost improvement programme totalling £13 million, 5.5% of controllable costs.

### **Milton Keynes Hospital NHS Foundation Trust**

During 2014/15, our enforcement team led a strategic review of healthcare services for populations served by Milton Keynes and Bedfordshire CCGs. On its completion in October 2014, the two local CCGs identified two preferred options for hospital services at Milton Keynes Hospital NHS Foundation Trust and neighbouring Bedford Hospital NHS Trust. They also said they intended to do further work before consulting the public. Our enforcement team, with NHS England and TDA, has been supporting this work over the last six months.

### **Medway NHS Foundation Trust**

We placed the trust in special measures in July 2013 in response to the Keogh review of trusts with persistently high mortality rates. We intervened further in February 2014 to appoint an interim chair and interim chief executive as the trust was unable to demonstrate sufficient progress against its improvement plans. CQC rated the trust inadequate in its full inspection report in July 2014, recommending the trust remain in special measures, and highlighted further significant concerns over safety and clinical leadership in the emergency department following an inspection in July 2014.

Following these negative reviews the trust has worked to appoint a substantive chair and put in place a new executive team. We have worked with the trust to secure funding to develop and improve the emergency department, to bring senior clinical leadership expertise into the emergency department and to agree an enhanced 'buddy' arrangement with Guy's and St Thomas' NHS Foundation Trust, which will help the new leadership team at Medway improve the hospital's performance. Alongside the quality issues identified by the Keogh and CQC reviews, the trust faces continued financial deficits and we will be working with it in 2015/16 to ensure its long-term sustainability.

## Regulating independent providers of NHS services

Since 1 April 2014, all independent providers of NHS services have been required to hold a provider licence unless exempt under the conditions set by the Department of Health. The licence allows us to act to protect essential local services if an independent provider fails.

At 31 March 2015, 101 independent providers held licences.

This was the first year that independent providers were operating under our new licensing regime and we made progress in establishing it:

- We continued ongoing work with NHS England to ensure that commissioners consider which of their services would be at risk if a provider fails, and should therefore be designated as commissioner requested services (CRS). At 31 March 2015 there were 12 independent providers of CRS in our risk assessment and financial oversight regime.
- In April 2014, we published our 'Risk assessment framework for independent providers of NHS services', which explains how we assess risk in independent providers of commissioner requested services in much the same way as we do for foundation trusts.
- We also worked with CQC to enable providers to make joint NHS provider licensing and CQC registration applications. By 31 March 2015, we had received 14 joint licensing and registration applications.

## Making sure the NHS payment system promotes quality and efficiency

Monitor and NHS England are jointly responsible for the NHS payment system. NHS England leads on specifying how services are defined for payment purposes (in what are known as ‘currencies’) and we lead on setting prices and rules for payment levels nationally and locally.

The payment system provides a framework of rules and principles that help commissioners decide what services to purchase and support providers to deliver effective services efficiently. We believe the payment system can help them adopt the new care models outlined in the ‘NHS Five Year Forward View’.

To support this, we have three strategic objectives for payment system regulation:

- a long-term ‘clean sheet redesign’ approach
- a pragmatic approach to short-term priorities
- pursuing a step change in the quality and use of data on cost, activity and outcomes that underpin the payment system.

### Pricing development: taking a long-term ‘clean sheet redesign’ approach to the payment system

#### New payment approaches

Monitor and NHS England published ‘[Reforming the payment system for NHS services: supporting the Five Year Forward View](#)’ in December 2014 after reviewing payment approaches and incentives from around the world. We also tested several payment approaches with the sector.

“ We have focused on approaches that support new models of integrated care ”

We have focused on approaches that support new models of integrated care (including mental health and primary care) and enable the development of networks of providers

for urgent and emergency care, maternity and specialised services.

To help commissioners and providers adopt new payment designs in their local health economies, we published two examples of how to develop local payment arrangements and are developing more. We are also continuing to work on using linked sets of information about patients to promote integrated care.

## **Pricing delivery: our approach to the national tariff**

### **Sector response to the national tariff 2015/16**

Monitor is responsible for publishing the national tariff. During 2014 we engaged with the sector on proposals for 2015/16.

We used a range of data, much of it provided by the sector, to inform the development of proposals for the national tariff. We published independent research to support how we set the 'efficiency factor', our expectation of the extent to which providers can deliver the same services, to the same level of quality (or better), at a lower cost than previous years. We also created expert advisory groups to further test and gain feedback on our proposals. We held workshops with over 160 organisations and a series of webinars that engaged with 500 individuals.

We engaged with the sector ahead of the statutory consultation on our proposals for 2015/16, including those on the method for setting national prices.

Nevertheless, at the close of the statutory consultation, 75% of relevant providers, weighted by share of supply, objected to the proposed method. As a result, we were unable to publish the proposed tariff.

In response we have developed, with NHS England, interim payment arrangements. Providers were asked to select either an Enhanced Tariff Offer (ETO) or a Default Tariff Rollover; 87% of providers have accepted the ETO.

We are continuing to work on arrangements for 2015/16 and in the meantime we have started developing proposals for the 2016/17 National Tariff Payment System, which will address feedback on the 2015/16 tariff proposals.

### **Locally determined prices**

During 2014/15 we focused on improving the sector's understanding and awareness of the rules for locally determined prices and the benefits they can bring for local health economies.

Local modifications of prices are intended to ensure healthcare services can be provided where they are needed, even if the cost is higher than the national price. We received 18 submissions for these in 2014/15: 6 were rejected because they did not comply with rules and principles, 4 were withdrawn, 8 are outstanding.

Local variations of prices are the main mechanism for designing alternative payment approaches. Commissioners and providers can use them to agree adjustments to national prices or related currencies to better support services for patients. We received 321 submissions for local variations in 2014/15 and have published them as a resource for the sector.

We will maintain our work to improve the sector's capability relating to these rules as we continue to encourage commissioners and providers to vary the national tariff where this supports new local care models that better meet patients' needs.

### **Pursuing a step change in the quality and use of data on cost**

#### **Costing transformation programme**

We consulted the sector on '[Improving the costing of NHS services: proposals for 2015-21](#)' in December 2014 and, following feedback, we published our changes to the costing transformation programme in March 2015. The programme will support the use of patient level costing systems – computerised information systems in hospitals that track and analyse the costs of care incurred by individual patients - as well as improvements in the quality and use of costing data. Together these changes will secure some of the building blocks underpinning new payment approaches and new care models.

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

### **Strategic priorities**

Our Co-operation and Competition Directorate ensures that procurement, patient choice and competition operate in patients' best interests. Our strategy for 2014-17 sets out two priorities:

- educating and informing patients, commissioners, providers and the wider health system about how the rules on procurement, choice and competition affect them and why they benefit patients
- focusing our action where we will most benefit patients.

### **Making sure the sector understands how to use the rules to benefit patients**

Over the past year, we have worked closely with the sector to increase understanding of how the procurement, choice and competition rules help improve patient care and value for money.

We published:

- guidance for NHS providers considering a merger (July 2014), including an explanation of how we advise the Competition and Markets Authority (CMA) on the benefits of mergers involving NHS foundation trusts and a practical guide for foundation trust managers considering a merger
- guidance for providers on choice and competition (September 2014), including how we use the powers we share with the CMA; how we approach our powers to make market investigation references under the Enterprise Act 2002
- case studies of how the choice and competition conditions of the provider licence and competition law work.

Commissioners and providers continue to contact us for advice and support that involves specialist input from clinicians, lawyers and economists. In 2014/15 we received 224 requests from clinical commissioning groups (CCGs), NHS providers, charities, social enterprises and other independent sector providers plus a significant number of queries from patients and patient organisations such as local Healthwatch.

We are also exploring ways to help the wider sector on issues such as managing conflicts of interest and what can be done to ensure new care models work well for patients.

We have run 22 workshops across the country for commissioners, which were also attended by NHS England area teams and commissioning support units plus

sessions targeted at CCG accountable officers and governing bodies. We have also spent time on secondment at CCGs and working with NHS Clinical Commissioners and others to host webinars on the Procurement, Patient Choice and Competition regulations.

On mergers, we consulted providers to develop our guidance, worked with the CMA to offer advice and ran a session to help trust chairs and chief executives better understand merger control and how to develop a patient benefits case.

### **Focusing our investigations where they will most benefit patients**

In the past year we have undertaken two formal investigations into complaints:

- from Spire Healthcare about the commissioning of elective services in the Blackpool area: our analysis did not support the complaint that patients were directed away from Spire Fylde Coast Hospital towards Blackpool Teaching Hospitals NHS Foundation Trust. We did, however, find that CCGs in Blackpool and in Fylde and Wyre had not ensured patients were offered choice and that patient choice was publicised and promoted. Local commissioners have agreed to take steps to ensure that patients are aware of their rights and able to exercise them effectively
- from Northern Devon Healthcare NHS Trust about NHS Northern, Eastern and Western Devon CCG's decision to name the Royal Devon and Exeter NHS Foundation Trust as its preferred provider of community services for the eastern part of the CCG's area: we are reviewing the decisions taken to ensure they are in patients' best interests, in accordance with the rules on procurement, choice and competition.

We continue to investigate whether aspects of the sector are working well for patients, particularly to help commissioners secure quality services for patients. This has included a focus on making sure patients can exercise their rights to choose their provider of care. For example:

- in August 2014 we published joint research with NHS England into the extent to which patients exercise choice over where to have their first outpatient appointment; we found that only 38% of patients recalled being offered a choice of provider when they were referred by their GP, and have committed to further work to support and enable patients to make choices about their care
- in January 2015 we published a report on commissioning community services to support more co-ordinated care for patients, outlining opportunities for commissioners to move to new ways of working or new care models and test which providers are most likely to achieve the changes that commissioners want for patients

- in March 2015, working closely with Action on Hearing Loss, we published a report examining how well patient choice works in the commissioning of adult hearing services. We found that patients valued having a choice as it put them in control of their care. We also found that choice, where offered, had helped improve access to services but that very few patients were in fact being offered choices.

“ We found that patients valued having a choice as it put them in control of their care. We also found that choice, where offered, had helped improve access to services ”

Monitor’s new approach to mergers is to engage with providers early in the process to offer informal advice on how they can understand and articulate how patients would benefit from a proposed merger and to assess any competition implications.

This is intended to ensure that any statutory review of a proposed merger can happen swiftly and without excessive cost.

This is helping mergers that work well for patients to go ahead. These include the acquisition by Frimley Park NHS Foundation Trust of Heatherwood and Wexham NHS Foundation Trust, and Chelsea and Westminster Hospital NHS Foundation Trust’s acquisition of West Middlesex University Hospital NHS Trust on which we advised the CMA, and a pathology merger between NHS trusts in south east England, on which we advised the NHS Trust Development Authority. Other trusts are benefiting from tailored advice on proposed mergers and we will continue this approach.

## Supporting integrated care

We are working to make integrated care a reality through a range of activities, thereby fulfilling our duty to enable integrated care. We support innovation among providers and encourage approaches that are adapted to local circumstances. We work with national partners on integrating care, including the new care models set out in the 'NHS Five Year Forward View'.

## Ensuring the sector does not stand in the way of integrated care

We have produced guidance to help licensees and NHS trusts understand what is expected of them in relation to the integrated care licence condition. This includes high level principles alongside examples of behaviour that might lead them to breach this licence condition, and potentially lead to regulatory action.

We continue to raise awareness that person-centred, co-ordinated care is not at odds with competition. We have done this by running roadshows, offering informal advice to commissioners and providers and regularly updating frequently asked questions on our website.

## Providing flexibility for new care models

“ We ensure that regulation allows new care models to emerge within the NHS ”

Across Monitor, we ensure that regulation allows new care models to emerge within the NHS. We are developing a payment system that will reward the efficient provision of

good quality, patient-centred, co-ordinated care. This includes payment approaches, such as capitation, that would align individual providers' incentives to system-wide outcomes. We are working with 'co-development' sites to test these from 2015/16, and have published guidance and local payment examples. We have also worked with 12 local areas that are developing patient-level linked datasets, and have published a modelling tool to help commissioners estimate health and social care spend across their locality.

We are reviewing transactions between health providers to support those that are aiming to create integrated care organisations, such as those in Torbay, Cambridge and Salford. We have also been working with challenged providers and local health economies, such as Tameside, on whether integrated care can help sustain essential services in the long term.

## Supporting local areas to make integrated care the norm

Our aim is to support local innovation in integrated services and gather evidence for integrated care. We have continued to directly support the Integrated Care Pioneers, including the second wave announced in January 2015, and we intend to support the Forward View Vanguard sites.

Support we have provided so far includes:

- advice to help localities with their integrated care plans – for example, on payment approaches and competition issues
- in-depth sessions and ‘surgeries’ on topics such as population segmentation
- a payment forum with local areas to enable shared learning
- a workshop on patient-level linked datasets to help the wider sector with information governance concerns
- webinars exploring strategy development across local care economies.

We have committed to more of this support in the future and are determined that our regulatory approach enables care to be delivered in a more integrated way.

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

Supporting redesign of the NHS is central to our work, and many of our powers are critical to achieving this. We collaborate with other national bodies to help those who run the NHS locally transform patient services, and have carried out our own programme of research to explore ways of improving care.

### Joint work to help introduce new care models

In June 2014 NHS England, TDA and Monitor launched a national programme, called NHS Accelerate, to prototype new care models. It worked with Airedale, Wharfedale and Craven, Blackpool and Fylde Coast, Hull, North Tyneside, South Somerset and Vale of York local health economies. A national team from the partners supported them to adopt new care models and communicate what they had learned. Specifically, they helped design the care models, provide access to leading experts and research, and resolve national issues holding up service transformation. The team provided each area with an account manager and senior sponsor.

The programme provided useful lessons on what sort of national support local areas would find helpful. Alongside the Integrated Care Pioneers programme, it inspired the new care models programme in the Five Year Forward View and some of the sites subsequently became Vanguards. In particular, it brought to the fore the need to learn on the ground what might work rather than creating a national blueprint for transformation.

### Contributing to the ‘NHS Five Year Forward View’

“ We made a significant contribution to the analysis and narrative of the ‘NHS Five Year Forward View’ ”

We and our national partners committed to developing a truly combined vision for tackling the challenges facing the NHS. The ‘NHS Five Year Forward View’ was published jointly by CQC, Health

Education England, Monitor, NHS England, Public Health England and TDA in October 2014. It was well received and has helped inform debate on health policy since its publication. It identifies how the NHS needs to change over the next five years to address problems in health inequalities, quality of care and funding of services. The report crystallises the consensus that national support is needed to transform services and looks at how it might best be done.

We made a significant contribution to the analysis and narrative of the ‘NHS Five Year Forward View’, drawing on our 2013 report ‘[Closing the NHS funding gap: how to get better value healthcare for patients](#)’, our work in identifying high value new care models and our understanding of NHS provider finances. We also contributed content for specific sections and suggestions for addressing the issues identified.

Since the Forward View launch we have helped spread its messages, often speaking at events with our national partners.

### **Implementing the ‘NHS Five Year Forward View’**

Monitor, NHS England and TDA published joint guidance in December 2014 inviting interest from local areas wishing to become Vanguard sites testing the new care models. Over 260 expressions of interest were assessed, and in March 2015 an initial 29 localities were selected to develop one of the three models: multispecialty community providers, integrated primary and acute care systems and models of enhanced health in care homes.

We are also leading work to support:

- *the new care models programme*: chairing the board, designing the programme, helping research further care models and advising Vanguard sites on payment, contracting and procurement
- *whole system intervention*: working with TDA to establish how we can combine our roles working with commissioners, and where appropriate, new care models, to make challenged local health economies more sustainable
- *the Forward View’s national cross-system governance arrangements*: leading the design and implementation of new governance arrangements supported by a joint secretariat to enable national bodies to collaborate more effectively.

### **Improving understanding of the issues facing smaller acute providers**

In June 2014 we published research into the effect of size on the clinical and financial performance of smaller acute NHS trusts and foundation trusts. We tested whether being small makes it difficult for smaller providers to perform well.

Our analysis found no systematic evidence of poorer clinical quality in small hospitals and only a limited effect of size on financial performance. However, we concluded that size is likely to become a more important influence on performance in future because of developments such as:

- guidance to increase numbers of permanent staff in the acute sector
- further consolidation of specialist care
- moves to improve care out of hospital.

In response to these findings, we did more research looking at international models of critical care, stroke, accident and emergency services, paediatrics, emergency surgery and maternity services in seven countries that have a similar cultural approach to healthcare to England. We found models abroad that could support

quality or efficiency improvements if they are more consistently used in the NHS. These are:

- 'risk tiering' for maternity and paediatric services
- greater use of technology, particularly to deliver care remotely
- increased use of GPs for out-of-hours urgent care.

We published our findings in December 2014 and launched an online discussion on using these models in the NHS. We heard from a range of people including providers, commissioners, Royal Colleges, charities and national bodies, and published a summary of the ideas and feedback we received in March 2015.

### **The future provider landscape for elective surgery**

As part of our work to help develop new care models, we have started research on the changes required across the NHS in elective surgery. We have so far examined national clinical models alongside international models. Our initial impressions suggest there is significant scope in many local health economies for developing new care models for elective surgery, and we are working to identify optimum or high value models in several specialties.

## Making sure Monitor is a high performing organisation

We must be a high performing and effective organisation to fulfil our mission to make the health sector work better for patients. To improve our own performance, we have concentrated this year on two activities: recruiting and retaining high quality staff, particularly those with frontline clinical and NHS management experience, and embedding our values to ensure that staff are aligned with our overall mission, as set out in the Health and Social Care Act 2012.

### Public Accounts Committee's report on Monitor's regulation

Following the National Audit Office (NAO) report in February 2014, '[Regulating foundation trusts](#)', which praised our approach to regulation, the House of Commons Committee of Public Accounts (PAC) published its own report, '[Monitor: regulating NHS foundation trusts](#)' in July 2014. Though the PAC agreed with many of NAO's findings, it commented adversely on some aspects of our performance, particularly the level of clinical experience within the organisation. During the last year we have taken action along the lines the PAC recommended, increasing our clinical expertise, and have continued to make this a priority.

### Patient and clinical engagement

In 2014 we strengthened our senior team by appointing Professor Hugo Mascie-Taylor as Medical Director and Executive Director of Patient and Clinical Engagement. The Patient and Clinical Engagement Directorate helps ensure that we have input from patients and clinicians through outreach and engagement programmes so that our decisions are in patients' best interests. The directorate provides in-house advice and helps other teams access external clinical expertise.

“ We have input from clinicians and patients through outreach and other engagement programmes so that our decisions are in patients' best interests ”

In 2014/15 work has progressed in two key areas. First, by increasing our internal clinical expertise with the appointment of a nurse director and deputy medical director, as well as four more senior clinicians who are expected to be appointed soon on a

part-time basis as experts in areas including urgent and emergency care and mental health. Second, we have strengthened links with the wider clinical community, including national professional bodies, and engaged them earlier and more readily in our work. A new Clinical Advisory Forum, comprising foundation trust medical directors and chief nurses, will work closely with the directorate and act as an external sounding board for the clinical advice provided internally. The Patient and Clinical Engagement Directorate's priorities include ensuring the right support is available to medical directors across the sector and supporting the clinical aspects of implementing the Forward View.

## Culture and values

We need to ensure that our staff thoroughly understand our role and strategy, and that everything they do is aligned to this strategy of making the health sector work for patients. All five of our values reflect our collective ambition to make a difference for patients:

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

After a series of activities during the year to encourage staff to think about our values, we held a 'values week' in September. Our 'values ambassadors', based in each directorate, organised activities designed to emphasise how relevant and important our values are to the way employees perform their roles every day. To continue to embed our values in everything we do, we have also updated the core competencies our staff work to. This will help us integrate the values into the way we recruit, manage performance and develop our employees. We have also updated the 'Working for Monitor' section of our website, linking the 'deal we offer' explicitly to our values.

During February and March 2015 we commissioned Ipsos MORI to undertake research among our stakeholders to help us understand how we are performing and the progress we've made since we took on our sector regulator role in April 2013. We conducted a quantitative survey with 264 stakeholders and carried out longer qualitative interviews with a further 50 stakeholders. The results show that our stakeholders generally say they have a good understanding of what we do, and the majority (80%) feel we carry out our role well. There was also confidence that we put patients first (61%) but less confidence about how we support the front line – with only 29% saying we do this well. We are feeding the results into how we develop our communications and establish benchmarking for our future work, especially on implementing the Five Year Forward View.

Our health and wellbeing programme for staff has proved outstandingly popular and demonstrates our commitment, as a leader of the NHS system, to the health and wellbeing of our own people. Our autumn staff survey found that 58% of employees were satisfied with the support available if they experienced stress or pressure. While there is still progress to be made here this marks a 14% increase on earlier in the year. Dame Carol Black, the Department of Health's expert adviser on work and health, launched our 2015 programme in January with a talk on wellbeing in the workplace.

## Equality and diversity

We recognise that individuals and their different cultures, perspectives and experiences add real value to the way Monitor works. We aim to recruit, develop and retain the most talented people, regardless of their background, and help exploit their talents to the full. At the end of 2014/15, 22% of staff had declared their ethnicity as Black, Asian and minority ethnic, an increase of 2% from our August 2014 report 'Equality in our workforce'. During the year, 98 people attended training on inclusive leadership, including nearly 70% of our wider leadership team. More than 95% of the organisation has completed diversity and equality training. In addition, a number of people across Monitor have been trained to use the Equally Yours board game, which has been tailored for us and stimulates lively discussion at team meetings on equality themes.

## Recruitment

Recent growth in staff numbers reflects the work of establishing the regulatory framework required by statute and supporting a growing number of challenged foundation trusts and local health economies. Our recruitment efforts aim to strengthen our provider sustainability and provider regulation capability.

We recognise our organisational need for staff with clinical and NHS operational backgrounds. Currently we have 15 roles filled by people with a clinical background, while 115 employees (25%) have previous professional experience of the healthcare sector, of whom, over half (54%) have direct experience of working in the NHS. To expand this skill base, we now advertise all roles on the NHS Jobs website. We are also exploring with the Department of Health the potential to recognise continuity of service from NHS organisations, which we believe will make it easier to attract staff with an NHS background.

### *Monitor staff in post*

**Table 7: Monitor staff in post 2011-15**

	March 2011	March 2012	March 2013	March 2014	March 2015
Staff in post	148	181	299	424	532

**Table 8: Monitor 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%
2014/15	52%	48%	36.3 years	17.1%	22.4%

At 31 March 2015 Monitor's Board was made up of two women and seven men; the Executive Committee comprised a further four women and two men. Biographies of members of the Board and Executive Committee members can be found on page 56.

As an organisation we are undertaking a significant amount of structural change to ensure we evolve to better regulate the NHS foundation trusts under our remit, and ultimately the patients they serve. During such periods of change we would expect higher than average levels of staff turnover (in 2014/15 this was 17.1% compared to an average of 13.9% over the previous five years).

### **Staff development**

We remain fully committed to our staff's personal and professional development. Our core learning programme is designed to strengthen skills in key areas including leading and managing people, influencing and communicating, and fostering individual and team development. We have refocused our performance management approach towards performance development. Staff and managers across the organisation are now tasked not just with setting stretching and challenging goals aligned to department objectives, but with considering and implementing the development they need now and in future to enhance their performance.

During 2014/15, to help develop our line managers' effectiveness, we targeted coaching on improving team performance. Employees can also now access support from more experienced colleagues in other directorates who have had training in coaching and communicating while teams are encouraged to develop local professional development initiatives. For example, our Legal Services team is now accredited to offer in-house training for legal trainees.

During the year we organised 118 training events for more than 1,200 delegates. Our most popular learning events centred on improving business writing skills, inclusivity training for leaders and developing communication skills.

### **Monitor's employee engagement**

“ 76% of staff recommend Monitor as a great place to work ”

We ran a short staff survey in the autumn to monitor progress since our full survey in February 2014. It attracted a response rate of 86%, a

15% increase on the full survey. We again scored well in staff being proud to work for Monitor (81%) as well as recommending Monitor as a great place to work: 76% do so, a 2% increase since February. We also scored well on employees believing strongly in Monitor's purpose and objectives (81%) and understanding how their role contributes to our corporate strategy (71%). The proportion of staff understanding how the strategy makes a difference for patients grew to 68%, a rise of 20% on the previous survey after team and all staff briefings on our strategy and business plan. We will continue our engagement and alignment programme in 2015/16.

## Corporate social responsibility

Our staff undertook activities to ensure we are a positive influence in our local area while reinforcing our values. Our sponsored charity for 2014 was St Mungo's Broadway, which helps people recover from the issues that create homelessness. We supported it with an array of fundraising events organised by our social committee. Our sponsored charity for 2015 is CCHF All About Kids, which provides severely disadvantaged children in London with residential activity and respite breaks. We continued our mentoring programme with a local school to improve students' confidence, personal effectiveness and employability while developing our own staff's communication, leadership and teamwork skills.

Our major event was a volunteering day at a local children's centre and Waterloo Millennium Green Park, with the Department of Health and Public Health England, cleaning up the children's centre's playground and the park. During the winter we collected warm clothes for local homeless charities and worked with Lambeth Council to donate Christmas presents to local underprivileged children.

## Complaints about Monitor

When we make mistakes we are committed to being open and honest, and learning from them. This year we received six complaints about Monitor, which mainly related to decisions not to take regulatory action against different foundation trusts. Although we identified no concerns with these decisions, we partially upheld half of these complaints as a result of delay and/or poor communication on our part, which we are committed to addressing to avoid a recurrence. One of these complaints contributed to our review of how Monitor deals with whistleblowing concerns and our decision to create a strengthened, centralised team for complaints and whistleblowing.

## Business plan for 2014/15

At the end of 2014/15, Monitor had completed 59 (83%) out of 71 business plan actions. Of the remaining 12 actions, one was deprioritised and 11 were partially completed (due to external dependencies and/or operational factors) and will continue into 2015/16. This represents an improvement on last year, when Monitor completed 79% of the 2013/14 business plan actions.

The 11 actions to be continued in 2015/16 were delayed due to:

- external dependencies (six actions)
- resource availability (three actions)
- scope change (two actions).

These partially completed actions spread across five of our strategic objectives, confirming that we are not underachieving in one particular area of our strategy.

## Sustainability report

**Table 9: Monitor greenhouse gas emissions**

Greenhouse gas emissions			
		2014/15	2013/14
Non-financial indicators (tCO <sub>2</sub> e)	Total emissions for Scope 2 (Energy Indirect) Emissions	N/A	204
	Total gross emissions for Scope 3 Official Business Travel Emissions	45	31*
Related energy consumption (KWh)	Electricity: non-renewable	N/A	295,068
	Gas	N/A	232,628
	Expenditure on energy	N/A	41
Financial indicators (£000s)	Expenditure on official business travel	292	186

\*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 for 2013/14 (including Scope 2) represented the Matthew Parker Street site; the space at Wellington House is leased from the Department of Health and as such the sustainability figures (including Scope 2, waste management and finite resource consumption) for the space Monitor occupies will be reported in the Department's annual report.

## Financial commentary

Monitor's accounts have been prepared on a going concern basis. More detail can be found in Note 1 to the accounts. Monitor's net expenditure for the year was £72.3 million (2013/14: £64 million). The main categories of spend are broken down as follows:

**Table 10: Main categories of spend**

	2014/15 £m	2013/14 £m	Reference to accounts
Staff	39.5	33.3	Note 3
Contingency planning teams	8.6	4.0	Note 4
Trust special administration	7.4	12.3	Note 4
Other professional services	7.1	6.0	Note 4
Property and office expenses	5.0	5.6	Note 4
Special measures reimbursements	2.1	0.7	Note 4
Depreciation and amortisation	1.4	0.9	Notes 7
Other	1.2	1.2	Note 4
<b>Total</b>	<b>72.3</b>	<b>64.0</b>	

The largest area of spend is staff costs, which represent 55% of net expenditure in 2014/15 (2013/14: 52%). The increase in staff costs is mainly due to Monitor continuing to expand after taking on new powers as a result of the Health and Social Care Act 2012. As the responsibilities of core teams have grown, staff numbers have increased.

In 2014/15 the largest area of professional spend relates to examining and implementing viable long-term solutions for providers in financial distress through Monitor's role in contingency planning and trust special administration. In 2014/15, £16.0 million was spent on these activities (2013/14: £16.3 million).

Other professional services spend relates to development of Monitor's other functions, including taking on responsibility from the Department of Health for the programme of costing and coding assurance work, which has cost £1.3 million in 2014/15. This is partially offset by a reduction in professional services spend in other areas. More detail can be found in Note 4 to the accounts.

Special measures reimbursements are costs of buddy agreements set up to support foundation trusts that have been placed in special measures. This initiative was put in place in September 2013, so 2014/15 is the first full year of its operation. Costs have increased in 2014/15 to £2.1 million (2013/14: £0.7 million).

In 2014/15 property and office expenses decreased from £5.6 million to £5.0 million. This is due to Monitor consolidating into one office during 2013/14.

Grant-in-aid of £63.7 million was received during the year of which £4.0 million was applied to the purchase of non-current assets. Net assets at 31 March 2015 were £2.5 million (31 March 2014: £11.1 million). The decrease in net assets is primarily due to a reduction in year-end cash balance following 'Managing Public Money' principles of not drawing down cash in advance of need.

### 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 2015. Monitor aims to meet a 10-day payment target with outturn against this target as follows.

**Table 11: Payment practices**

	Number		Value	
	2014/15	2013/14	2014/15	2013/14
Total number of invoices	7762	7603	£45.1m	£43.9m
Invoices meeting target	7251	6986	£26.5m	£31.1m
Percentage meeting target	93%	92%	60%	72%

The percentage of invoices by value meeting the target has decreased due to a significant increase in higher value invoices which are subject to increased scrutiny and more detailed authorisation procedures.

More detail of how money has been spent in 2014/15 can be found in the main accounts.

You can find a review of our activities and performance against business objectives during the year on pages 13 to 49. Our strategy for 2014 to 2017 is published [here](#) and sets out how we intend to help the front line redesign how care is delivered. It has four cross-cutting themes:

- paying more attention to provider capability
- balancing freedom to change and risk of failure
- making sure rules operate in the best interests of patients
- joining up nationally and locally, particularly with partner organisations such as NHS England, TDA, CQC, the CMA, and the Department of Health.

Our performance against our business plan for 2014/15 is set out on page 49. Our business plan for 2015/16 is published [here](#) and focuses on our role in helping the NHS address its two main priorities – short-term operational improvement and longer-term sustainability.

Dr David Bennett  
Chief Executive  
2 July 2015

## Directors' report

The annual report and accounts have been reviewed in detail by Monitor's Executive Committee, Audit and Risk Committee and Board. At each point it has been confirmed that the annual report and accounts, taken as a whole, are considered to be fair, balanced and understandable. They provide the information necessary for Monitor's stakeholders to assess Monitor's business model, performance and strategy.

### Our Board

Baroness Joan Hanham CBE (Chair)  
Keith Palmer (Non-Executive Director)  
Iain Osborne (Non-Executive Director)  
Sigurd Reinton CBE (Non-Executive Director)  
Heather Lawrence OBE (Non-Executive Director)  
Dr Timothy Heymann (Non-Executive Director)  
Dr David Bennett (Chief Executive)  
Stephen Hay (Managing Director, Provider Regulation)  
Adrian Masters (Managing Director, Sector Development)

### Executive Committee

Dr David Bennett (Chief Executive)  
Miranda Carter (Executive Director, Provider Appraisal)  
Catherine Davies (Executive Director, Co-operation and Competition)  
Stephen Hay (Managing Director, Provider Regulation)  
Adrian Masters (Managing Director, Sector Development)  
Kate Moore (Executive Director, Legal Services)  
Jeremy Mooney (Executive Director, Strategic Communications)  
Fiona Knight (Executive Director, Organisation Transformation)  
Professor Hugo Mascie-Taylor (Medical Director/Executive Director, Patient and Clinical Engagement)  
Adam Sewell-Jones (Executive Director, Provider Sustainability)

Board and Executive Committee biographies can be found on page 56.

## **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.

## **Employment**

Monitor continues to enhance and develop all aspects of staff employment arrangements. As well as compliance with applicable legislation, we have continued to strive to be an employer of choice for candidates. This has been a particular focus given the need to expand in response to changing demands. We have stepped up our pace of recruitment without reducing the quality of candidate experience for those with disabilities. Details of the gender split in the Board and Executive Committee can be found in the Strategic report on page 48. Further details on equality and diversity can be found in the Strategic report, page 47, and the Governance statement, page 70.

## **Staff engagement**

To provide an update on staff engagement from the full February 2014 survey, a shorter 'pulse' survey was conducted in October 2014. Staff response rates increased from 71% to 86% respectively. Following the work to embed Monitor's values during the year, the results of the pulse survey clearly showed that staff felt a stronger link between their work and providing benefits to patients. The perception among staff of career development opportunities and personal wellbeing also improved following the introduction of additional training and supporting guidance.

The next full survey has been scheduled for September/October 2015.

## **Sickness absence**

The average time taken as sick leave by Monitor employees in 2014/15 was 3.7 days (2013/14: 2.4 days).

## **Pension liabilities**

The treatment of pension liabilities is disclosed in note 3 to the financial statements.

## **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 2014/15, 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 2015 are disclosed in note 4 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 2015.

## **Disclosure to the Auditors**

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

Dr David Bennett  
Chief Executive  
2 July 2015

## **Our Board**

### **Baroness Joan Hanham CBE (Chairman from September 2014 and previously Interim Chairman from January 2014)**

Baroness Hanham CBE is a Conservative member of the House of Lords, having become a life peer in 1999. From 2010 to 2013, she was Parliamentary Under Secretary of State at the Department for Communities and Local Government (DCLG), and its Minister in the House of Lords. She has extensive experience in local government, having been Leader of the Royal Borough of Kensington and Chelsea from 1989 to 2000. She also has experience of the health service, having been a member of the North West Thames Regional Health Authority and of the Board of the Chelsea and Westminster Hospital, a Mental Health Act Commissioner and Chairman of St Mary's NHS Trust.

Baroness Hanham is a strong supporter of the voluntary sector, a former Chairman of the English Volunteering Development Council and immediate past President of Volunteering England (now part of National Council for Voluntary Organisations).

### **Keith Palmer (Non-Executive Director from April 2012)**

Keith Palmer is founder and Non-Executive Chairman of AgDevCo, a not-for-profit public-private partnership that supports agricultural development in sub-Saharan Africa. His previous involvement in the health sector includes Non-Executive Director of Guy's and St Thomas' NHS Foundation Trust, Chairman of Barts Health NHS Trust and Senior Associate of the King's Fund and of the Nuffield Trust.

Other positions he has held include Treasurer and Trustee of Cancer Research UK and Vice-Chairman of NM Rothschild merchant bank.

### **Iain Osborne (Non-Executive Director from May 2014)**

Iain Osborne is also Group Director for regulatory policy at the Civil Aviation Authority, and an experienced regulatory expert, having held senior roles in six regulated sectors, privately and publicly funded, at EU, national and regional levels.

His previous roles include Chief Executive of Northern Ireland's energy and water regulator; secondment to the European Commission's competition directorate; and Strategy Director to a pan-European telecoms company.

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

Sigurd Reinton was until 2013 a director of NATS Holdings, which provides the air traffic control services for UK and North Atlantic airspace, and for the main UK airports. At NATS, he served on the Audit and Nominations committees and chaired the Stakeholder Council.

He was Chairman of the London Ambulance Service NHS Trust for 10 years until 2009 and before that of Mayday University Hospitals NHS Trust. He was a member of the Board of the Ambulance Services Network and of the advisory board of The Foundation. He was a member of the Council of the NHS Confederation from 1998 to 2007 and was the lead for London. He was previously a director (senior partner) at McKinsey & Company.

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

Heather Lawrence has 23 years' experience as a chief executive including 12 years at Chelsea and Westminster Hospital (2000 to 2012), which gained NHS Foundation Trust status in 2006. Heather also hosted the North West London (NWL) Collaborative Leadership in Applied Health Research Care, set up the NWL Health Innovation Cluster and co-designed the NWL Learning and Education Board.

As a chief executive, Heather has developed organisations where the relationship between managers and clinicians is pivotal to achievements both for the patient and in delivering targets. She chaired the national negotiations for the SAS Doctors contract and Agenda for Change three-year pay deal for non-medical staff. She was a Commissioner for the Prime Minister's Commission for the Future of Nursing and Midwifery, and a member of the Dr Foster Global Comparators Founders Board.

Heather originally trained as a nurse before qualifying as a teacher and becoming a nurse tutor. She is a Chartered Fellow of the Institute of Personnel Management.

### **Dr Timothy Heymann (Non-Executive Director from February 2015)**

Timothy Heymann is a consultant gastroenterologist at Kingston Hospital and Reader in Health Management with the Centre for Health Economics and Management at Imperial College Business School. He is a fellow of the Higher Education Academy and of the Royal College of Physicians of London for whom he is a host examiner.

His previous experience includes: Non-Executive Director, NHS Direct; member, Risk and Regulation Advisory Council; Chair, Information Group of the British Society of Gastroenterology; healthcare consultancy and teaching in Europe, India, the Commonwealth of Independent States, Latin America and Australasia; work in teaching hospitals across London; and management consultancy with McKinsey & Company.

### **Dr David Bennett (Chief Executive)**

David Bennett's 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 & Company, where he focused on regulated, technology-intensive industries.

### **Stephen Hay (Managing Director, Provider Regulation)**

Stephen Hay is Managing Director of Provider Regulation at Monitor, responsible for the monitoring, compliance and intervention regime for NHS foundation trusts. A qualified chartered accountant, he previously worked with KPMG, latterly as a director within the Transaction Services Department. His financial experience is wide ranging and includes mergers and acquisitions, due diligence for initial public offerings and risk assessment.

He joined the DCLG Board as a non-executive director, in May 2009 and was Chairman of DCLG's Audit and Risk Committee until December 2014. He continues to be a member of the Audit and Risk 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 & Company, IBM and PwC. He is a qualified accountant with an MBA from Stanford University.

## **Executive Committee**

### **Dr David Bennett (Chief Executive) See Board biographies**

### **Miranda Carter (Executive Director, Provider Appraisal)**

Miranda joined Monitor in 2004. Her current role as Executive Director of Provider Appraisal covers the assessment and authorisation of applicants for NHS foundation trust status, risk assessing significant transactions undertaken by NHS foundation trusts, and developing assessment and transaction policy.

A qualified chartered accountant, Miranda started her career at Deloitte. She joined PwC in 1997 and spent four years in the Transaction Services Department. Her financial experience is wide ranging and includes mergers and acquisitions, due diligence and initial public offerings.

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

Catherine Davies joined Monitor on 1 October 2012. She has worked in health since 2009 and came to Monitor from the Co-operation and Competition Panel.

She is a competition law specialist with experience in all aspects of EU and UK competition law, having advised on mergers and acquisitions, joint ventures, distribution arrangements and market investigations across a wide range of sectors, including consumer goods, energy, media and healthcare. Before working in the healthcare sector she worked at the Competition Commission and a large City law firm.

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

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

**Kate Moore (Executive Director, Legal Services)**

Kate Moore, a solicitor, joined Monitor in September 2004. She 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.

**Jeremy Mooney (Executive Director, Strategic Communications)**

Jeremy Mooney joined Monitor in January 2015. His career has included extensive experience of corporate communications in both the civil service and in business. As well as working in the telecommunications and IT industry and the outsourced public services sector, he previously spent over nine years as a senior civil servant in Whitehall, firstly in the NHS Modernisation Agency in the Department of Health, and then as Director of Communication at the Department for Transport.

A serving army reservist, Jeremy has completed operational tours in the Balkans and in Afghanistan.

**Fiona Knight (Executive Director, Organisation Transformation)**

Fiona Knight joined Monitor on 1 July 2013. She has worked in human resources for more than 20 years, including 13 years at KPMG where she was an HR director. Before that, she worked in HR roles within financial services. Her experience includes supporting teams and businesses through change and transition, managing HR integration, employee relations and performance management.

**Professor Hugo Mascie-Taylor (Medical Director / Executive Director, Patient and Clinical Engagement)**

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, including Executive Medical Director of Leeds Teaching Hospitals Trust (which involved periods acting as Chief Executive) and Medical Director at the NHS Confederation.

He was Trust Special Administrator at Mid Staffordshire NHS Foundation Trust, working to ensure that services at Cannock Chase and Stafford Hospitals continue to operate for patients into the future.

### **Adam Sewell-Jones (Executive Director, Provider Sustainability)**

Adam Sewell-Jones joins Monitor on 8 August 2015. He has 23 years experience within the NHS and was most recently Deputy Chief Executive at Basildon and Thurrock University Hospitals NHS Foundation Trust where he had responsibility for strategy and the transformation programme, which underpinned a wide range of service developments to improve the quality of the healthcare services provided.

A qualified accountant, Adam has held a range of roles at Basildon including Director of Finance, Chief Operating Officer and General Manager of Medicine and worked in finance roles at trusts including University College London Hospitals and Redbridge Healthcare.

# 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
- the requirement to deliver performance targets.

It should be noted that in April 2014, the Senior Salaries Review Body made certain recommendations in relation to very senior manager (VSM) salaries. This recommendation was not accepted by the government and there was no annual increment to VSM salaries in 2014/15.

## Service contracts

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

## Notice periods and termination costs

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

**Table 12: Executive team notice periods**

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

	Notice period
Catherine Davies, Executive Director, Co-operation and Competition	3 months
Fiona Knight, Executive Director, Organisational Transformation	3 months
Hugo Mascie-Taylor, Executive Director, Patient and Clinical Engagement	3 months
Jeremy Mooney, Executive Director, Strategic Communications	3 months
Kate Moore, Executive Director, Legal Services	3 months

## Salary and pension entitlements

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

**Table 13: Salary, benefits in kind and pension benefits**

	Salary (£'000)		Benefits in kind (to nearest £100)		Pension benefits (£'000)		Total (£'000)	
	2014/15	2013/14	2014/15	2013/14	2014/15	2013/14	2014/15	2013/14
David Bennett Chief Executive*	230-235	230-235	100	100	N/A	N/A	230-235	230-235
Stephen Hay** Managing Director, Provider Regulation	190-195	190-195	100	0	59	49***	250-255	240-245
Adrian Masters Managing Director, Sector Development	165-170	160-165	0	0	49	38***	210-215	200-205
Miranda Carter Executive Director, Provider Appraisal	130-135	130-135	0	0	32	32	160-165	160-165
Catherine Davies Executive Director, Co-operation and Competition	130-135	125-130	0	0	N/A	N/A	130-135	125-130
Fiona Knight Executive Director, Organisational Transformation (from 1 July 2013)	120-125	90-95	0	0	45	34***	165-170	120-125
Hugo Mascie-Taylor Executive Director,	115-120	N/A	0	N/A	N/A	N/A	115-120	N/A

	Salary (£'000)		Benefits in kind (to nearest £100)		Pension benefits (£'000)		Total (£'000)	
Patient and Clinical Engagement (appointed with effect from 1 May 2014)								
Sue Meeson Executive Director, Strategic Communications (until 19 January 2015)	85-90	105-110	0	0	43	43***	130-135	145-150
Jeremy Mooney Executive Director, Strategic Communications (from 20 January 2015)	25-30	N/A	0	N/A	10	N/A	35-40	N/A
Kate Moore Executive Director, Legal Services	130-135	130-135	0	0	45	26	175-180	155-160

\* David Bennett did not receive an additional salary as Chair while also serving as Chief Executive (until 19 January 2014). He also does not receive a pension.

\*\* Stephen Hay has Board level responsibility for Finance.

\*\*\* Adjustments to the 2013/14 pensions benefits have been made for Stephen Hay, Adrian Masters, Fiona Knight and Sue Meeson due to retrospective updates made by the Civil Service pension providers.

Total remuneration includes salary, benefits in kind and severance payments. There is no performance-related pay. It does not include employer pension contributions and the cash equivalent transfer value (CETV) of pensions.

The value of pension benefits accrued during the year is calculated as (the real increase in pension multiplied by 20) less (the contributions made by the individual). The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

## Pay multiples

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 in the financial year 2014/15 was £230-235,000 (31 March 2014, £230-235,000). This was 3.8 times (31 March 2014, 3.9) the median full-time equivalent (FTE) remuneration of the workforce at 31 March 2015, which was £60,600 (31 March 2014, £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 2014/15 no employees received remuneration in excess of the highest paid director (2013/14: zero). Remuneration ranged from £20-25,000 to £230-235,000 (2013/14 £20-25,000 to £230-235,000).

### Chairman and other non-executive directors

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.

**Table 14: Benefits in kind for executive and non-executive directors**

	Salary claimed (£'000)		Benefits in kind (to nearest £100)		Total (£'000)	
	2014/15	2013/14	2014/15	2013/14	2014/15	2013/14
Baroness Joan Hanham Chair (from 20 January 2014)	60-65 (105-110 FTE)	10-15 (20-25 FTE)	1800	0	60-65 (105-110 FTE)	10-15 (20-25 FTE)
Stephen Thornton Non-Executive Director (until 30 April 2014)	0-5	10-15	200	2300	0-5	15-20
Sigurd Reinton Non-Executive Director	15-20*	10-15	400	0	15-20*	10-15
Keith Palmer Non-Executive Director	5-10*	5-10	100	0	5-10*	5-10
Heather Lawrence Non-Executive Director	10-15	5-10	800	900	10-15	5-10
Iain Osborne Non-Executive Director (with effect from 19 May 2014)	5-10	N/A	100	N/A	5-10	N/A
Timothy Heymann Non-Executive Director (with effect from 16 February 2015)	0-5	N/A	0	N/A	0-5	N/A

\*Sigurd Reinton and Keith Palmer both received remuneration during 2014/15 in relation to previous years' unclaimed amounts. The total remuneration received by Sigurd Reinton and Keith Palmer (inclusive of amounts relating to previous financial years) is £20,000-£25,000 and £15,000-£20,000 respectively.

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

**Table 15: Executive directors' pensions and cash equivalent transfer values**

	Accrued pension at pension age as at 31/3/15 and related lump sum	Real increase in pension and related lump sum at pension age	CETV* at 31/3/15	CETV* at 31/3/14	Real increase in CETV*
	£'000	£'000	£'000	£'000	£'000
Stephen Hay Managing Director, Provider Regulation	35-40	2.5-5	533	461**	40
Adrian Masters Managing Director, Sector Development	30-35	2.5-5	472	401**	29
Miranda Carter Executive Director, Provider Appraisal	20-25	0-2.5	301	262	17
Fiona Knight Executive Director, Organisational Transformation	0-5	2.5-5	66	27**	27
Sue Meeson Executive Director, Strategic Communications (until 19 January 2015)	15-20	2.5-5	222	174**	27
Jeremy Mooney Executive Director, Strategic Communications (from 20 January 2015)	0-5	0-2.5	8	N/A	6
Kate Moore Executive Director, Legal Services	25-30	2.5-5	404	341	32

\* Cash equivalent transfer value

\*\* Adjustments to the 2013/14 CETV have been made for Stephen Hay, Adrian Masters, Fiona Knight and Sue Meeson due to retrospective updates made by the Civil Service pension providers.

David Bennett, Chief Executive, and Hugo Mascie-Taylor, Executive Director, Patient and Clinical Engagement, do not receive pensions on their salary.

Catherine Davies, Executive Director, Co-operation and Competition, is a member of a partnership pension scheme. During 2014/15 Monitor made contributions of £18,800 on her behalf (figures given to the nearest £100).

None of the Executive Team 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 published by the Chief Secretary to the Treasury on 23 May 2012, Monitor must publish information on highly paid and/or senior off-payroll engagements. The information contained in the tables below includes all off-payroll engagements as at 31 March 2015 for more than £220 per day and that last longer than six months for Monitor.

**Table 16: Off-payroll engagements at 31 March 2015**

All off-payroll engagements as at 31 March 2015 which are more than £220 per day and last for longer than six months	
Number of existing engagements as of 31 March 2015	30
Of which...	
Number that have existed for less than one year at time of reporting.	25
Number that have existed for between one and two years at time of reporting.	4
Number that have existed for between two and three years at time of reporting.	1
Number that have existed for between three and four years at time of reporting.	0
Number that have existed for four or more years at time of reporting.	0
All new off-payroll engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015, for more than £220 per day and that last for longer than six months	
Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	43
Number of the above which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	31
Number for whom assurance has been requested	43
Of which...	
Number for whom assurance has been received	0
Number for whom assurance has not been received	43
Number that have been terminated as a result of assurance not being received.	0

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

In April 2015, the Department of Health issued revised guidance regarding off-payroll engagements which expanded the definition of such engagements. As a result there has been a significant increase in the number on which Monitor must now report. Following this change in guidance all existing off-payroll engagements are now subject to a risk-based assessment as to whether assurance needs to be sought that the individual is paying the right amount of tax. Monitor is in the process of seeking the relevant assurances required; none were due to be received at the time of publication.

## **Pension liabilities**

The treatment of pension liabilities is disclosed in note 3 to the financial statements.

## **Civil Service pensions**

Pension benefits are provided through the Civil Service pension arrangements. Further details of Monitor's pension arrangements can be found in note 3 to the accounts.

## **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 cash equivalent transfer values**

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 2015

## Statement of Accounting Officer's responsibilities

Under the Health and Social Care Act 2012, the Secretary of State for Health has directed Monitor to prepare an annual report and accounts for each financial year 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 expenditure, application of resources, changes in taxpayers' equity and cash flows for the financial year.

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.

In preparing the accounts, the Accounting Officer has complied 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
- prepare the accounts on a going concern basis.

# Governance statement 2014/15

## Note

The Secretary of State announced on 11 June that Monitor and the NHS Trust Development Authority will move to appoint a single leader. The closer working between Monitor and TDA will encompass those functions and duties carried out by both organisations, with Monitor continuing to exercise its existing role. The change will mean that all NHS providers, whether they are foundation trusts or trusts, are under the oversight of one chief executive, overseeing teams working closely together. Work will be undertaken by Monitor, TDA and the Department of Health to establish the governance required to support these arrangements.

David Bennett announced at the same time that he was standing down as chief executive after more than five years, although he has agreed in principle that he will continue in post in the meantime to ensure an effective transition.

## Introduction

As Accounting Officer and working together with the Board of Monitor, I have responsibility for maintaining effective governance and a sound system of internal control to support 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 (the 2012 Act) and Monitor's Corporate Strategy and Business Plan. While doing so, I safeguard the public funds and assets for which I am personally responsible. This is 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.

In managing Monitor's affairs, the Board and I are 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 support and adopt the highest standards of corporate governance within the statutory framework. This governance statement sets out how I have managed and controlled Monitor's resources in 2014/15 to enable this.

## Monitor's governance framework

### The Board

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

## **Board composition**

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. I and the 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.

In addition to its Chairman, Monitor's Board consists of five non-executive directors (Timothy Heymann, Heather Lawrence, Iain Osborne, Sigurd Reinton and Keith Palmer, who is also Monitor's Deputy Chairman) and three executive directors. Baroness Joan Hanham was appointed as Chairman for approximately a year with effect from 20 January 2014. In September 2014, the Secretary of State extended her appointment until 31 March 2016. Alongside me, as executive directors, Stephen Hay and Adrian Masters continue 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 myself and the other executive directors, 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.

Directors' and officers' insurance cover is in place to protect the Board, Executive Committee members and others in the event of legal action taken against them as a result of their actions on behalf of Monitor.

## **The non-executive directors**

Monitor's non-executive directors are independent of management and have no cross directorships or significant links that 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.

Stephen Thornton's role as non-executive director and Deputy Chairman concluded on 30 May 2014. His second term of appointment had been extended to ensure that Monitor continued to have a majority of non-executive directors on its Board. Sigurd Reinton, Heather Lawrence and Keith Palmer continue as non-executive directors following their four-year appointments in 2012. Iain Osborne was appointed as non-executive director on 19 May 2014 for a period of three years. Timothy Heymann was appointed as non-executive director on 16 February 2015 for a period of three years.

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

The Chairman and the non-executive directors hold at least one meeting a year without the executives present. In 2014/15 this meeting took place on 3 March 2015.

### **Deputy chair and senior independent director**

Keith Palmer has occupied the positions of Deputy Chairman and Senior Independent Director since 30 May 2014. The principal responsibilities of Monitor's Senior Independent Director are to:

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

### **The Chairman and the Chief Executive**

Baroness Joan Hanham was initially appointed as Monitor's Chairman with effect from 20 January 2014 until 31 December 2014. In September 2014, the Secretary of State for Health decided to extend this appointment with effect from 1 January 2015 until 31 March 2016.

The role of the chairman is to:

- provide effective leadership and management of Monitor's Board
- 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
- act as the guardian of Monitor's Board decision-making processes
- ensure that Monitor's Board has the information and advice needed to discharge its statutory duties
- 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.

Having acted on an interim basis for some time, I took on the substantive role of Chief Executive on 1 November 2012. The role of the chief executive is to:

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

## How the Board operates

The 2012 Act 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 which is:

- economic, efficient and effective and
- 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.

Matters Reserved to the Board include:

- establishment and maintenance of Monitor's strategic direction – reviewing, contributing to and approving Monitor's vision, mission and values
- approval of Monitor's corporate and business plans, including the distribution of Monitor's financial allocation as set out in the annual business plan and any subsequent material change to this

- approval of Monitor’s risk management strategy/framework, including the determination of Monitor’s risk appetite
- approval of all of Monitor’s significant regulatory policies prior to consultation with stakeholders and any material amendments following responses received in response to consultation
- determination of 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, myself and other members of the Executive. 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 senior executives 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 members and its 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 in the NHS Constitution. Monitor is committed to taking account of these in all its decisions and actions.

### **Information required for the Board to operate**

The Board has agreed a classification of the information it requires in order 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 issues arising that 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:

- advising the Board on all corporate governance matters
- ensuring that Board procedures are followed
- ensuring good information flow between the Board and its committees
- 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

The attendance of the Chairman, individual non-executive directors and Executive Committee members at Board and committee meetings during 2014/15 was as follows:

**Table 17: Attendance at Board and committee meetings**

Name	Board Max 12 mtgs	Audit and Risk Committee Max. 5 mtgs	Nomination Committee Max 1 mtgs	Remuneration Committee Max 2 mtgs	Technology Assurance Committee Max 4 mtgs
<b>Board members</b>					
Joan Hanham	12	5	0	1	0
Stephen Thornton*	0	0	N/A	N/A	N/A
Keith Palmer	11	5	N/A	2	N/A
Timothy Heymann**	1	N/A	N/A	N/A	N/A
Heather Lawrence	12	N/A	1	2	N/A
Iain Osborne***	10	4	1	2	N/A
Sigurd Reinton	11	5	N/A	N/A	4
David Bennett	12	5	1	2	N/A
Stephen Hay	11	4	N/A	0	2
Adrian Masters	12	3	N/A	N/A	4
<b>Board attendees</b>					
Miranda Carter	10	N/A	N/A	N/A	N/A
Catherine Davies	11	N/A	N/A	N/A	N/A
Fiona Knight	7	N/A	N/A	2	N/A
Sue Meeson^	10	N/A	N/A	N/A	N/A

Name	Board Max 12 mtgs	Audit and Risk Committee Max. 5 mtgs	Nomination Committee Max 1 mtgs	Remuneration Committee Max 2 mtgs	Technology Assurance Committee Max 4 mtgs
Jeremy Mooney <sup>^^</sup>	3	N/A	N/A	N/A	N/A
Kate Moore	10	N/A	N/A	N/A	N/A
Hugo Mascie- Taylor	9	N/A	N/A	N/A	N/A

\* Stephen Thornton left Monitor on 30 May 2014    \*\*Timothy Heymann joined Monitor on 16 February 2015

\*\*\* Iain Osborne joined Monitor on 19 May 2014

<sup>^</sup>Sue Meeson left Monitor in January 2015    <sup>^^</sup>Jeremy Mooney joined Monitor in January 2015

## 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 Chairman, Iain Osborne and Timothy Heymann received all this information and undertook a full induction programme in January 2014, May 2014 and February 2015, respectively.

## Performance evaluation

The Chairman of the Board sets objectives for individual Board members. I set objectives for Executive Committee members against the objectives set for the Board and in relation to the delivery of the organisation's business plan. In June 2014 the Chairman undertook performance appraisals of those non-executive members of the Board who had been in the role for over a year. She also reviewed my performance at this time. I am responsible for the appraisal of Executive Committee members.

A full external evaluation of the Board took place in November and December 2014. The results of this were reported formally to the public session of the Board meeting in January 2015.

The formal review of the performance of Monitor's Chairman is undertaken by Monitor's senior department sponsor at the Department of Health, on behalf of the Secretary of State. In March 2015 the non-executive directors, led by the Senior Independent Director, met to evaluate the performance of the Chairman in order to feed into this review of her performance.

## 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 Cabinet Office Code of Good Practice), the ‘NHS Foundation Trust Code of Governance’ and the ‘UK Corporate Governance Code’. Monitor has complied with the main principles of each of these codes during the period 1 April 2014 to 31 March 2015, except for the following:

**Table 18: Monitor’s compliance with codes of good practice**

Cabinet Office Code of Good Practice	NHS Foundation Trust Code of Governance	UK Corporate Governance Code	Monitor position
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. (Not applicable to Monitor – it is not a FTSE 350 company)	Monitor’s executive directors were appointed by the Board, rather than its Nomination Committee, as part of Monitor’s organisation design and appointments approved by the Secretary of State for Health
		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. (Not applicable to Monitor – it does not have shareholders)	The Nomination Committee has, however, reviewed the size and composition of the Board and its committees and confirmed that it was content
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.3.7 The audit committee should have primary responsibility for making a recommendation on the appointment, reappointment and removal of the external auditor (Not applicable to Monitor – it is not a FTSE 350 company)	Given the statutory composition of Monitor, the National Audit Office acts as its external auditor

Cabinet Office Code of Good Practice	NHS Foundation Trust Code of Governance	UK Corporate Governance Code	Monitor position
N/A	N/A	D.2.4 Shareholders should be invited specifically to approve all new long-term incentive schemes. (Not applicable to Monitor – it does not have shareholders)	Monitor does not have shareholders. The remuneration of its senior executives is subject to the Department of Health's Very Senior Manager Pay Framework and reviewed by its Remuneration Committee
N/A	N/A	Section E Relations with shareholders (Not applicable to Monitor – it does not have shareholders)	Monitor does not have shareholders, but works hard to ensure an appropriate dialogue with regulatory partners and other key stakeholders as well as patients and the public

## Conflicts of interest

Arrangements for handling any possible personal conflicts of interest are set out in Monitor's Rules of Procedure. Monitor has also agreed joint partnership arrangements with other healthcare regulatory bodies to manage any possible conflicts that might occur with them in the carrying out of their statutory duties.

Furthermore, Monitor is required under section 67 of the 2012 Act to be vigilant in the exercise of its functions for the possibility of either an actual or perceived functional conflict between its NHS foundation trust-specific functions and all its other functions, and to take action to resolve any such conflict.

In light of this, Monitor draws a distinction between: (i) those situations where it has on the one hand imposed additional licence conditions on a provider and is also exercising its competition and/or pricing functions in relation to the same trust ('functional conflicts'); and (ii) those situations which while they may appear to constitute a conflict, are in reality an overlap of different Monitor functions and which are addressed by Monitor legitimately and reasonably balancing potentially competing interests ('balancing of competing regulatory interests').

Where Monitor has resolved a conflict of interest, Monitor must publish a statement that 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 2014/15 and consequently, no such statement required publication. Further information is set out in Monitor's 'Functional conflicts and balancing competing regulatory interests policy', which is available on its 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

At the invitation of the committee, I (in my 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) 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.

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:

- oversight of financial reporting
- oversight of risk management and internal controls
- interaction with Monitor's external auditor
- oversight of internal audit activities.

In order to fulfil these duties in 2014/15, the committee has undertaken the following key activities.

1. Determined that the significant issues to be considered in respect of Monitor's financial statements were:
  - a. capital expenditure – the risk that costs could be capitalised incorrectly or at the wrong value
  - b. segmental reporting of ring-fenced expenditure – the risk that ring-fenced budgets could be inappropriately applied to core expenditure

- c. management override of controls – the risk present in all entities that management override controls to perpetrate fraud.
2. Evaluated the effectiveness of Monitor’s risk management and internal controls on an ongoing basis. The committee receives risk reports at each meeting and, based on this information, evaluates risk management and instructs any improvements required. Using this information and that provided by Monitor’s internal and external auditors the committee has concluded that the control environment is adequate and effective.
3. Reviewed and commented on the audit plans presented by the National Audit Office in relation to its audit of Monitor’s financial statements and of the consolidated NHS foundation trust account. As the NAO acts as Monitor’s external auditors by statutory appointment, the committee has not formally reviewed the effectiveness of the NAO as its external auditor. The NAO did not provide Monitor with any non-audit services in 2014/15.
4. Appointed Monitor’s Head of Internal Audit in May 2014. The committee was actively involved in the arrangements made for the transfer of Monitor’s internal audit service to the Department of Health (DH) Health Group Internal Audit Service. The 2014/15 internal audit plan was approved by the committee and the committee received the reports of internal audit reviews throughout the year.

The Audit and Risk Committee presents an annual report to the Board, which is published on Monitor’s website. Further information about the activities of the committee can be found in this report.

### **Nomination Committee**

Members: Heather Lawrence (Chair), Iain Osborne, David Bennett

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

The Nomination 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 Nomination Committee also takes the lead on succession planning for the Board.

The committee met once in 2014/15, to consider the size, structure and composition of the Board and the arrangements in place for succession planning. While the non-executive director appointments made during 2014/15 were the responsibility of the Secretary of State for Health, the committee provided important input into the description of the role and the capabilities required. Monitor was not responsible for these appointments and the competitive process was managed by the Department of Health.

Monitor's Equality and Diversity Policy was reviewed and amended in 2014/15. This policy confirms Monitor's commitment to promoting equality and diversity and promoting a culture that actively values difference and recognises that people from different backgrounds and experiences can bring valuable insights to the workplace and enhance the way we work. Monitor has four main equality objectives, which it has made significant progress against in 2014/15:

**Table 19: Progress against equality objectives**

Equality objectives 2014-2016	Progress report
To attract, retain and develop high-performing people from the widest talent pool, with the right skills, experiences and competencies from a diverse range of backgrounds	
EO1 To make positive changes to the way we gather data regarding protected characteristics	<ul style="list-style-type: none"> <li>• Monitor's 'Equality in our workforce' report published (August 2014)</li> <li>• We have developed a more comprehensive system for gathering employee diversity metrics and made significant progress. Since January 2014, 96% of new joiners have declared their gender, ethnicity, sexual orientation and religion</li> <li>• We are developing an improved recruitment process to track and monitor applicants' diversity metrics (some reliance on agencies required)</li> </ul>
EO2 To continue to operate the guaranteed interview scheme for applicants who meet the minimum requirement for the role	<ul style="list-style-type: none"> <li>• Ongoing – while we operate the 'two ticks' disability scheme which guarantees disabled people an interview, we have only had one applicant this financial year</li> </ul>
To demonstrate clear leadership with senior commitment and accountability for mainstreaming diversity and inclusion into our organisation	
EO3 To establish an Equality and Diversity lead sponsor	<ul style="list-style-type: none"> <li>• Fiona Knight appointed as Executive Committee lead sponsor in June 2014</li> <li>• Became member of Employers Network for Equality and Inclusion (ENEI) in October 2014</li> </ul>
EO4 To monitor progress against our equality objectives	<ul style="list-style-type: none"> <li>• We continue to consider equality trends through our routine HR processes and procedures, such as: employee survey findings, retention rates, exit reasons, annual appraisals, disciplinary and grievance cases, bullying and harassment complaints and pay gaps</li> </ul>
To create an inclusive workplace where our people feel valued, respected, are treated fairly and have a sense of belonging; free from bullying, harassment and discrimination	
EO5 To establish networking groups for individuals to come together, share ideas and	<ul style="list-style-type: none"> <li>• An informal LGBT network meets monthly. There is an appetite for more networking groups and we will work with ENEI to establish principles and best</li> </ul>

Equality objectives 2014-2016	Progress report
provide peer support to one another	<p>practice</p> <ul style="list-style-type: none"> <li>• Monthly well-being initiatives over the last four months have helped promote a culture where our people feel valued and able to accept support offered</li> <li>• Our 'Values week' in September 2014 helped focus on respecting individual differences and treating others in fair and inclusive ways (One Team)</li> <li>• Our Employee Value Proposition was refreshed in October 2014 to reflect our values, inclusivity and fairness</li> </ul>
To ensure our people receive targeted fairness and inclusion awareness training through a structured programme of initiatives to enhance our reputation as an employer of choice	
EO6 To continue to provide equality and diversity training for all staff	<ul style="list-style-type: none"> <li>• We have raised awareness of unconscious bias, stereotyping and inappropriate behaviours in the workplace through:</li> <li>• Induction - our Welcome programme was refreshed to reflect our values and our 'One Team' behaviours</li> <li>• Diversity and inclusion eLearning – 96% of all staff completed the training by end October 2014; from November 2014, all new starts are required to complete the eLearning training</li> <li>• Inclusive leadership workshops: 73% of all Grade 2.1s and above have attended a half-day workshop</li> <li>• Recruitment and selection diversity training: all OT recruitment and HR personnel completed a half-day workshop</li> <li>• ENEI* workshop: Board and Executive Committee members explored unconscious bias and critical inclusive leadership behaviours in October 2015</li> <li>• Equally Yours board game: the interactive board game continues to be used across teams, sub-directorates and directorates.</li> </ul>

\* ENEI: Employers Network for Equality and Inclusion

In 2014/15 Monitor significantly improved its data capture of diversity metrics. Almost all new joiners in the past year declared their gender, ethnicity, sexual orientation and religion. The overall gender split is 54% female and 46% male. At Executive Committee level men and women are equally represented, but women continue to be under-represented at director level (only 29%). The average age of employees is

36 and Monitor's Black, Asian and minority ethnic (BAME) workforce has increased. Of the 96% who declared their ethnicity, 74% are white, 16% are Asian, 5% are declared 'mixed/other' and 5% are black. The Employers Network for Equality and Inclusion (ENEI) has advised that Monitor's BAME representation is a positive reflection on the organisation.

### **Remuneration Committee**

Members: Iain Osborne (Chair), Keith Palmer, Heather Lawrence

The Executive Director of Organisation Transformation and I attend meetings, at the invitation of the committee. The Secretary to the Board attends Remuneration Committee meetings and acts as secretary to the committee.

The purpose of the Remuneration Committee is to ensure that Monitor operates a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. It also has a role in ensuring that Monitor is able to recruit and retain a high performing workforce. For details see the Remuneration report (page 61).

The committee met twice in 2014/15. It considered Monitor's reward programme of work, including the organisation's reward philosophy, its grade structure, pay frameworks and pay management. The committee also reviewed the organisation's pay protection policy. A clear area of the committee's focus continues to be the application of the Very Senior Manager (VSM) Pay Framework.

### **Technology Assurance Committee**

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

The committee supports the Board by providing independent assurance on information strategy and associated project proposals. On the basis of information provided to it, the committee will provide assurance on key decisions or recommendations that have critical strategic significance or would materially impact risk. Chaired by a non-executive director and populated by independent members who have significant experience in senior leadership roles in large IT organisations and/or experience of leading large complex IT systems in multi-functional organisations, the committee tests and challenges Monitor's Information and IT Strategy to assure the Board that it is on track and meeting its objectives.

The committee met four times in 2014/15. Highlights of the business it considered include:

- Monitor's relationship with the Health and Social Care Information Centre
- the developing information governance environment

- governance, risk and the Knowledge Information Management (KIM) team's operational processes
- the architecture of Monitor's Strategic Information Programme
- Monitor's Information Strategy.

## **Executive committees**

I chair the Executive Committee, which is made up of the other executive Board members, the rest of my direct reports and other regular attendees. Alongside the Executive Committee are other executive committees mirroring Monitor's regulatory functions. I chair each of these and the rest of their membership consists 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.

The Provider Appraisal Executive focuses on decisions relating to NHS trust applications to become NHS foundation trusts. If a decision on an application is considered to be marginal (according to criteria agreed by the Board), 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 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 of their obligations under the provider licence. It takes decisions on provider-related interventions and enforcement.

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 members 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.

**Table 20: Executive committees**

Name	Executive Committee Max 30 mtgs	Controls Committee Max 44 mtgs	Provider Appraisal Executive Max 12 mtgs	Provider Regulation Executive Max 24 mtgs	Pricing Executive Max 12 mtgs	Co-operation & Competition Executive Max 10 mtgs
David Bennett	30	27	11	23	11	10
Stephen Hay	27	38	11	19	N/A	N/A
Adrian Masters	26	38	10	19	10	8
Miranda Carter	25	N/A	11	21	10	N/A
Catherine Davies	27	N/A	0	0	6	10
Fiona Knight	23	4	N/A	N/A	N/A	N/A
Hugo Mascie-Taylor*	7	N/A	0	0	0	2
Sue Meeson**	22	N/A	N/A	N/A	8	N/A
Jeremy Mooney***	5	N/A	N/A	N/A	3	N/A
Kate Moore	28	N/A	12	21	N/A	10

\*Hugo Mascie-Taylor joined Monitor in May 2014

\*\*Sue Meeson left Monitor in January 2015

\*\*\*Jeremy Mooney joined Monitor in January 2015

## 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 2014/15, Board and executive 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 NAO.

### Events

Monitor also runs regular events and webinars to keep stakeholders informed and provide opportunities to discuss specific elements of the regulatory regime.

## **Monitor's website**

The website, [www.gov.uk/monitor](http://www.gov.uk/monitor), is the primary source of information on Monitor.

It includes Monitor's publications, information on NHS foundation trust performance and information on our corporate practices.

Stakeholders can sign up to receive an email when 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 that it does not maintain or impose regulatory burdens that it considers to be unnecessary.

Whenever Monitor proposes any changes to the regulatory framework it operates it consults on these so that those whom it regulates have an opportunity to comment on possible regulatory burden. Such an opportunity was provided in 2014/15 when Monitor proposed changes to its risk assessment framework.

In 2014/15 Monitor also carried out work to understand the actual or perceived barriers to change at provider organisations, to ensure that its approaches to assessing applicant trusts and regulating existing NHS foundation trusts are flexible enough to accommodate rapid and significant changes to models of care. This work identified potential sources of regulatory barriers and then tested the sector's perceptions of these. This work will continue as part of the programme of work on new care models supporting the NHS Five Year Forward View.

### **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 2014/15 Monitor undertook an impact assessment of proposals for the 2015/16 National Tariff Payment System, the outcome of which is available on Monitor's website.

### **Quality assurance of business critical 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, in 2014/15 Monitor identified what it considers to be four business critical models. Information about these models and Monitor's quality assurance processes can be found below.

**Table 21: Monitor’s quality assurance processes**

Description	Quality assurance processes in place
<p>The Long Term Financial Model (known as the LTFM) is used to understand the financial history, current position, and financial forecasts of foundation trust applicants. It is also used to stress test applicant trusts' forward assumptions, to assess whether the applicants are financially viable</p> <p>The model is business critical because financial viability is a key criterion for foundation trust authorisation</p>	<p>The LTFM was developed internally by a modelling expert and has been externally audited by modelling experts on a number of occasions</p> <p>All changes to the model go through a documented model update process, including segregation of duties and multiple stage review processes</p> <p>Large-scale changes to complex parts of the model are typically performed and/or reviewed by external modelling experts, although such changes are rare</p>
<p>The Monitor tariff calculation model will be used to calculate the prices and related data points Monitor sets in its national tariff document.</p> <p>The model is business critical because its outputs are used in the calculation of what a provider of NHS services gets paid (by commissioners) for performing these services. It covers approximately £30 billion of NHS expenditure</p>	<p>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. It was subject to an independent review by an appropriately qualified third party</p> <p>The tariff calculation model for the 2016/17 national tariff is currently under development based on the model from the previous year. It will be subject to further internal quality assurance processes and an independent review by an appropriately qualified third party</p>
<p>The impact assessment model assesses the expected impact of proposed changes to national prices. 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</p> <p>The model is business critical because it is used to support Monitor’s statutory duty to perform an impact assessment of changes to the national tariff payment system</p>	<p>The impact assessment model for the 2015/16 national tariff was developed by modelling experts at Monitor. It was subject to an independent review by an appropriately qualified third party</p> <p>The impact assessment model for the 2016/17 national tariff is currently under development based on the model from the previous year. It will be subject to further internal quality assurance processes and an independent review by an appropriately qualified third party</p>
<p>The set of acute reconfiguration models comprises four separate (but linked) financial models, which are used to:</p>	<p>The set of acute reconfiguration models was developed jointly by internal and external modelling experts. On completion the models</p>

Description	Quality assurance processes in place
<ul style="list-style-type: none"> <li>• forecast the financial challenge in a local health economy over five or 10 years (baseline models)</li> <li>• model the impact of changes in the configuration of acute services (reconfiguration model)</li> <li>• test outputs of the reconfiguration model ('bottom-up' costing model)</li> </ul> <p>The models are business critical because they have been used to inform commissioner decisions regarding the potential future configuration of hospital services in a challenged health economy (the decision for which may be subject to judicial review). Monitor also intends to use the models in other health economies in the future</p>	<p>were subject to external audit by an independent accounting firm to confirm accuracy and logical integrity</p> <p>Going forward, any changes to the models will go through an internal quality assurance process. Changes will be included in a model change log, input by one suitably skilled member of the team and checked by at least one other</p>

In line with the recommendations of the Macpherson Review, model owners are accountable for implementing appropriate quality assurance procedures for their analytical models. In addition, Monitor has been working to ensure it has an appropriate organisational framework for reviewing and reporting on these models. It was agreed in 2014/15 that the risk and performance team would co-ordinate the Macpherson process within Monitor as part of its regular liaison with directorates. This will help to identify gaps and overlaps between the risks facing the organisation. Moreover, some of the processes and frameworks in place for Monitor's business critical models are likely to form mitigations or controls on several of the risks within its corporate risk register.

In relation to the peer review of specific models, the risk and performance team will be able to call on an existing group of analysts from across Monitor. This group has the capacity to assess and advise on the quality assurance procedures for analytical models and can interact directly with model owners as required. It can also act as an additional advisory group to help identify models. Part of the group's remit will be to advise on best practice quality assurance in line with the Macpherson recommendations. Further, the risk and performance team will liaise with the chair of this group as part of the quarterly reporting process to identify risk and assurance issues relating to the business critical models.

## **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. In 2014/15 Monitor undertook an extensive review of its various statutory powers and duties to ensure that it is fully cognisant of the duties and powers conferred on it by Parliament, or delegated to it by the Secretary of State, which provide the essential authorities for all of Monitor's decision-making and action. 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. At the executive level, each of Monitor's duties has been assigned to a senior member of the executive to ensure that the competence, capacity and infrastructure are in place to deliver them effectively and efficiently. These arrangements are tested through Monitor's internal audit work.

## **Risk management and control**

### **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 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 2015 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 2014/15, 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 top-down and bottom-up perspectives through individual directorates' risk profiles. A network of risk champions has been successfully set up to share good practice, 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. Monitor also initiated exploratory work to identify the Board's appetite for risk.

### The principal risks facing Monitor during 2014/15

Monitor's annual plan identified that the organisation faced the following significant risks in 2014/15:

**Table 22: Significant risks facing Monitor during 2014/15**

Risk	Mitigation – what did Monitor do to manage the risk?
<p>Monitor fails to turn around failing NHS foundation trusts and ensure continuity of service is maintained</p>	<ul style="list-style-type: none"> <li>• Established a dedicated enforcement team to tackle the most complex cases</li> <li>• Recruited staff with a wide range of experience into the enforcement team</li> <li>• Built a model to identify the pipeline of foundation trusts that may require intervention</li> <li>• Enhanced our five-year planning view (as part of the annual plan review) to help identify emerging problems earlier</li> <li>• Established lessons learnt from our enforcement projects</li> <li>• Established Special Measures (for quality and leadership issues) and Failure Regime (for continuity of service issues) for the most distressed trusts</li> </ul>
<p>A lack of capability and leadership in the NHS increases the likelihood that trusts will get into difficulties and be less able to recover</p>	<ul style="list-style-type: none"> <li>• Provided good practice corporate governance training to boards of foundation trusts, chief executives and senior executives</li> <li>• Ensured the new well-led framework for governance reviews looked at trusts' ability to attract new capabilities and leadership</li> <li>• Developed a network of senior leaders to place in foundation trusts requiring leadership support or change</li> <li>• Participated in the Leadership Academy programme</li> </ul>
<p>Monitor has insufficient capability and</p>	<ul style="list-style-type: none"> <li>• Recruited to further senior enforcement director</li> </ul>

Risk	Mitigation – what did Monitor do to manage the risk?
capacity to handle the increasing number of NHS foundation trusts in difficulty	<p>and enforcement director roles</p> <ul style="list-style-type: none"> <li>• Undertook organisational design project to ensure appropriate capacity and capability</li> <li>• Reviewed its intervention toolkit to identify any potential improvement areas</li> </ul>
Patient outcomes are affected if the NHS does not rise to its growing 2020 financial challenge	<ul style="list-style-type: none"> <li>• Developed Monitor's 2014-17 strategy to reflect balanced health sector requirements to manage patient demands while simultaneously increasing efficiency to reduce its cost base</li> <li>• Working with national partners, local commissioners and providers to ensure parliamentarians have an accurate understanding of this risk</li> <li>• Supported the sector-wide forward view paper which will provide options for the sector on how to address the financial challenge.</li> </ul>
Monitor fails to develop an effective strategy with our partners to address significant financial challenges in 2015/16	<ul style="list-style-type: none"> <li>• Worked closely with our partners through regular meetings and sharing intelligence on the nature of the problem and potential options</li> </ul>
Challenges associated with Monitor's significant growth and making sure that we are successful in making a positive difference to the health sector and patients' outcomes	<ul style="list-style-type: none"> <li>• Ongoing review of management processes, balance of leadership skills and health sector experience</li> <li>• External promotion through high quality analysis and debate, engagement with stakeholders and working to remove perceived barriers to change</li> </ul>

On completion of its analysis of responses to the statutory consultation on the proposed rules and prices in the national tariff for 2015/16, it became clear that around 13% of CCGs, 37% of relevant providers by number and 75% of relevant providers by share of supply objected to the proposed method for determining national prices for NHS services. Under legislation governing the NHS payment system, the proposals for 2015/16 could not be introduced because of the proportion of CCGs, or the proportion of relevant providers (by number or weighted by share of supply), who objected to the method equalled 51%, without a reference to the Competition and Markets Authority. As the share of the total tariff income received by

the objecting providers exceeded 51%, the 2015/16 National Tariff could not be introduced in its proposed form and its implementation was delayed.

Interim arrangements came into effect on 1 April 2015, consisting of the 'Enhanced Tariff Option' (which broadly reflects the proposals for the 2015/16 National Tariff, as set out in the section 118 consultation notice) and the 'Default Tariff Rollover' (the default position in which providers continue to use 2014/15 prices).

### **Capacity to handle risk**

Monitor's Board has overall responsibility for ensuring delivery of Monitor's strategies and goals as outlined in the 2014/15 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, among other things, by Board briefings and 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 the priorities 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 its own 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 take all possible steps to enhance its internal controls environment above and beyond the minimum levels required. Monitor's senior executives continue to ensure that appropriate and relevant controls are embedded in all areas of Monitor's work. These are tested by internal audit work.

Internal audit reports in 2014/15 addressed the following areas:

- risk management
- data models
- information governance
- data quality and data sources
- IT security
- pricing – programme assurance
- pricing operations
- independent provider licensing
- finance for distressed cases
- recruitment and inductions
- provider appraisal
- key financial controls
- procurement
- financial regulations
- legal services.

Having reviewed the outcomes of this work and follow-up actions from audits conducted in previous years, Monitor's Head of Internal Audit has confirmed that he can give assurance that Monitor has had adequate and effective systems of control, governance and risk management in place for 2014/15. This means that, in his opinion, some improvements are required to enhance the adequacy of Monitor's framework of governance, risk management and control.

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
- NAO audit reports and recommendations

- 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.

Three internal audit reviews were considered to indicate significant weaknesses in Monitor's framework of governance, risk management and control, such that it could be or could become inadequate and ineffective. These were:

- information services
- IT security
- pricing – programme assurance.

Monitor has accepted the recommendations made by the internal audit service in these reports. The implementation of these actions will be followed up by internal auditors in 2015/16.

Recognising the importance of public trust in data sharing, and the clarity provided by the Health and Social Care Information Centre's Code of Practice on Confidential Information, Monitor is strengthening its information governance controls under the guidance of a newly appointed Senior Information Risk Officer. This is also in line with recommendations arising from internal audit reviews throughout the year.

Any data losses experienced by the organisation would be reported to the Audit and Risk Committee. There have been no such incidents in 2014/15.

To my knowledge and based on the advice I have received from those individuals with designated responsibilities for managing risks and the risk management system, I am not aware of any significant internal control problems for 2014/15. 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 2015

# 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 2015 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 my 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.

## Overview of my audit approach

### Application of materiality

I applied the concept of materiality both in planning and performing my audit, and in evaluating the effect of misstatements on my audit and on the financial statements. This approach recognises that financial statements are rarely absolutely correct, and that an audit is designed to provide reasonable, rather than absolute, assurance that the financial statements are free from material misstatement or irregularity. A matter is material if its omission or misstatement would reasonably influence the decisions of users of the financial statements.

The choice of materiality requires professional judgement and for Monitor's financial statements was set at £1.6 million, which is approximately 2% of gross expenditure, a benchmark that I consider to be the principal consideration for users in assessing the financial performance of the entity.

As well as quantitative materiality there are certain matters that, by their very nature, would influence the decisions of users if not correct. These included, for example, the Remuneration Report and the disclosures of exit packages. My assessment of any such misstatements would take into account these qualitative aspects as well as the size of the misstatement.

I applied the same concept of materiality to my audit of regularity. In planning and performing audit work in support of my opinion on regularity, and evaluating the impact of any irregular transactions, I took into account both quantitative and qualitative aspects that I consider would reasonably influence the decisions of users of the financial statements.

I agreed with the Audit Committee that I would report to it all corrected and uncorrected misstatements identified through my audit in excess of £16,000 as well as differences below that threshold that, in my view, warranted reporting on qualitative grounds, including irregular transactions.

My audit approach is risk-based, informed by a good understanding of Monitor's operations. In designing my audit approach, I assessed and took account of the risk of material misstatement in the financial statements and the risk of material irregularity in the underlying transactions. This approach focuses effort towards higher risk areas, such as management judgements and estimates and areas that are considered significant based upon size or complexity.

In my audit, I tested and examined information, using sampling and other auditing techniques, to the extent I considered necessary to provide a reasonable basis for me to draw conclusions. I obtained audit evidence through testing the effectiveness of controls, substantive procedures or a combination of both.

## Risks significant to my audit

Those risks that had the greatest effect on my audit strategy, the allocation of resources in my audit, and the direction of the efforts of the engagement team were as follows:

- **Ring-fenced budgets:** In addition to its core revenue budget, Monitor also receives three ring-fenced budgets from the Department of Health. Unless specifically authorised by the Department of Health, Monitor may use these ring-fenced budgets only to support its work on Contingency Planning, Trust Special Administration and Special Measures “buddying” for Trusts. Monitor’s financial statements include segmental reporting disclosures, analysing transactions by its core activities and the three areas of activity relating to these ring fenced budgets. When planning my audit I assessed there was a risk that Monitor may use its ring-fenced budgets to fund other activities, without authorisation from the Department of Health.

To address this risk I assessed Monitor’s control and monitoring procedures over expenditure from ring fenced budgets. I also performed direct testing on transactions recorded in each of Monitor’s reportable segments. I carried out this work to enable me to verify whether or not amounts had been reported and classified appropriately. I also assessed whether Monitor had made any transfers from its ring fenced budgets and, if so, whether or not any such transfers had been properly authorised. I am satisfied that this risk has not materialised.

- **Capital expenditure:** Monitor has several capital IT systems projects in progress, with planned expenditure of £5 million in 2014/15. These projects relate to the development of Monitor’s Online Licensing System and its Strategic Information Platform. I assessed that there was a risk that expenditure incurred on these projects may not be accounted for in line with the requirements of ‘IAS 38: Intangible Assets’.

To address this risk I assessed Monitor’s control and monitoring procedures over the classification of expenditure as either revenue or capital on these projects. I also performed direct testing on expenditure incurred on these projects to assess whether or not it had been accounted for in line with ‘IAS 38: Intangible Assets’. I am satisfied that this risk has not materialised.

- **The risk of management override of control:** I identified a risk because ISAs (UK and Ireland) require that I consider this risk. I reviewed a sample of journals for appropriateness and considered management’s accounting estimates and significant judgements for evidence of bias. I also included an element of unpredictability in our testing plans. I am satisfied that this risk has not materialised.

## **Opinion on the 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 2015 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 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 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.

## **My duty to read other information in the Annual Report**

Under the ISAs (UK and Ireland), I am required to report to you if, in my opinion, information in the Annual Report is:

- materially inconsistent with the information in the audited financial statements;  
or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge acquired in the course of performing our audit; or
- otherwise misleading.

In particular, I am required to consider:

whether I have identified any inconsistencies between my knowledge acquired during the audit and the Board's confirmation in the Directors' Report that they consider the Annual Report is fair, balanced and understandable and

whether the Annual Report appropriately discloses those matters that we communicated to the Audit Committee which I consider should have been disclosed.

I confirm that I have not identified any such inconsistencies or misleading statements.

## **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

9 July 2015

## Accounts and notes

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 2015.

## Statement of comprehensive net expenditure for the year ended 31 March 2015

		year ended 31/03/15		year ended 31/03/14	
	Note	£000's	£000's	£000's	£000's
<b>Expenditure</b>					
Staff costs	3	(39,455)		(33,313)	
Depreciation and amortisation	4	(1,442)		(885)	
Other expenditure	4	<u>(31,356)</u>		<u>(30,095)</u>	
<b>Total expenditure</b>			(72,253)		(64,293)
<b>Income</b>					
Miscellaneous income	5		<u>1</u>		<u>245</u>
<b>Net expenditure</b>			<u>(72,252)</u>		<u>(64,048)</u>
<b>Comprehensive net expenditure for the year</b>			<u><u>(72,252)</u></u>		<u><u>(64,048)</u></u>

All operations are continuing.

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

The notes on pages 105 to 115 form part of these accounts.

## Statement of financial position as at 31 March 2015

		31/03/15		31/03/14	
	Note	£000's	£000's	£000's	£000's
<b>Non-current assets</b>					
Intangible assets	7a		4,438		1,959
Property, plant and equipment	7b		<u>2,555</u>		<u>2,443</u>
<b>Total non-current assets</b>			<u>6,993</u>		<u>4,402</u>
<b>Current assets</b>					
Trade and other receivables	8	815		926	
Cash and cash equivalents	9	<u>7,913</u>		<u>18,638</u>	
<b>Total current assets</b>			8,728		19,564
<b>Total assets</b>			<u>15,721</u>		<u>23,966</u>
<b>Current liabilities</b>					
Trade and other payables	10	(13,191)		(12,884)	
<b>Total current liabilities</b>			(13,191)		(12,884)
<b>Non-current assets plus net current assets</b>			<u>2,530</u>		<u>11,082</u>
<b>Assets less liabilities</b>			<u>2,530</u>		<u>11,082</u>
<b>General reserve</b>			<u>2,530</u>		<u>11,082</u>

The notes on pages 105 to 115 form part of these accounts.

Dr David Bennett  
Chief Executive  
2 July 2015

**Statement of cash flows**  
**for the year ended 31 March 2015**

		31/03/2015	31/03/2014
	Note	£000's	£000's
<b>Cash flows from operating activities</b>			
Net expenditure on ordinary activities		(72,252)	(64,048)
<b>Adjustments for non-cash items</b>			
Depreciation charge	4	940	698
Amortisation charge	4	502	187
Loss on disposals	4	3	240
Reversal of unused provision	11	0	(20)
Release of long term rent accrual		0	(13)
<b>Adjustments for movements on working capital</b>			
(Increase)/decrease in trade and other receivables falling due within one year	8	111	(264)
	10	757	3,899
Increase in trade and other payables falling due within one year			
Use of provision	11	0	(289)
<b>Net cash outflow from operating activities</b>		<u>(69,939)</u>	<u>(59,610)</u>
<b>Cash flows from investing activities</b>			
Payments to acquire intangible non-current assets	7a	(3,431)	(1,306)
Payments to acquire property, plant and equipment	7b	(1,055)	(2,089)
Proceeds of disposal of plant, property and equipment		0	12
<b>Cash flows from financing activities</b>			
Grant-in-aid from Department of Health		63,700	69,654
<b>Net increase in cash and cash equivalents</b>		<u>(10,725)</u>	<u>6,661</u>
Cash and cash equivalents at the beginning of the year	9	<u>18,638</u>	<u>11,977</u>
Cash and cash equivalents at the end of the year	9	<u>7,913</u>	<u>18,638</u>

The notes on pages 105 to 115 form part of these accounts.

**Statement of changes in taxpayers' equity  
for the year ended 31 March 2015**

	<b>General Reserve</b>	<b>General Reserve</b>
	<b>2014/15</b>	<b>2013/14</b>
	<b>£000's</b>	<b>£000's</b>
<b>Balance at 1 April</b>	<b>11,082</b>	<b>5,476</b>
Comprehensive net expenditure for the year	(72,252)	(64,048)
Grant-in-aid received towards revenue expenditure	59,664	65,336
Grant-in-aid received towards purchase of non-current assets	4,036	4,318
<b>Balance at 31 March</b>	<b><u>2,530</u></b>	<b><u>11,082</u></b>

## Notes to the Accounts

### 1. Accounting policies

The financial statements have been prepared in accordance with the 2014/15 Government Financial Reporting Manual (FRoM) issued by HM Treasury. The accounting policies contained in the FRoM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FRoM 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.

#### Going concern

Monitor's accounts are produced on a going concern basis. The Department of Health has approved Monitor's 2015/16 budget, and Monitor will continue to be financed by the Department through grant-in-aid.

#### Non-current assets

The FRoM 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 comprise 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.

#### Amortisation and depreciation

Amortisation and depreciation are provided from the month after the asset is brought into use 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 using the accruals convention.

#### Operating leases

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

## Notes to the Accounts continued

### 1. Accounting policies continued

#### **Value Added Tax**

Monitor is registered for VAT however HM Revenue & Customs have determined that only a very limited amount of input VAT can be reclaimed. 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 3 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 in accordance with the corresponding Memorandum of Understanding for each arrangement.

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.

## Notes to the Accounts continued

### 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 13 *Fair Value Measurement*: Effective date 1 January 2013 under EU adoption; to be adopted by HM Treasury from 2015/16.
- IFRS 15 *Revenue from contracts with customers*: Not yet EU adopted. Expected to be effective from 2017/18
- IFRS 9 *Financial Instruments*: Not yet EU adopted. Expected to be effective from 2018/19
- IAS 36 recoverable amount disclosures: To be adopted from 2015/16
- IAS 19 *employer contributions to defined benefit pension schemes*: Effective from 2015/16 but not yet EU adopted.
- IAS 17 Leases: 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.

## Notes to the Accounts continued

### 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:

- public providers are well led
- essential services are maintained
- the NHS payment system promotes quality and efficiency and
- procurement, choice and competition operate in the best interest of patients.

Segment 2: Contingency planning team (CPT) work. During 2014/15 contingency planning activity was undertaken in depth at three foundation trusts to examine viable long-term solutions for the local health economies in question. In addition, planning support was provided to a number of health economies in a joint project with NHS England and the NHS Trust Development Authority.

Segment 3: Trust special administration (TSA) work. Costs of TSA in 2014/15 represent the completion of the Mid Staffordshire NHS Foundation Trust Administration.

Segment 4: Special measures buddying. Trusts in special measures can enter into partnership ('buddy') arrangements with other providers to provide advice and support. The costs reported here reflect the reimbursement of buddy trust costs and eligible incentive payments. Note that in 2013/14, this segment included the cost of Improvement Directors (£833k); in 2014/15 these costs have been incorporated into the core budget in segment 1.

<b>2014/15</b>	<b>Core running costs</b>	<b>CPT</b>	<b>TSA</b>	<b>Special measures</b>	<b>Total</b>
	<b>£000's</b>	<b>£000's</b>	<b>£000's</b>	<b>£000's</b>	<b>£000's</b>
Gross expenditure	54,111	8,621	7,402	2,119	72,253
Income	(1)	0	0	0	(1)
<b>Net expenditure</b>	<b>54,110</b>	<b>8,621</b>	<b>7,402</b>	<b>2,119</b>	<b>72,252</b>

<b>2013/14</b>	<b>Core running costs</b>	<b>CPT</b>	<b>TSA</b>	<b>Special measures</b>	<b>Total</b>
	<b>£000's</b>	<b>£000's</b>	<b>£000's</b>	<b>£000's</b>	<b>£000's</b>
Gross expenditure	46,346	4,072	12,300	1,575	64,293
Income	(245)	0	0	0	(245)
<b>Net expenditure</b>	<b>46,101</b>	<b>4,072</b>	<b>12,300</b>	<b>1,575</b>	<b>64,048</b>

## 3. Staff costs

## a) Staff costs comprise the following

2014/15	Permanently employed staff £000's	Others £000's	Total £000's
Salaries and wages	25,940	5,308	31,248
Social security costs	2,759	0	2,759
Employer's pension costs	5,513	0	5,513
<b>Total cost of staff employed</b>	<b>34,212</b>	<b>5,308</b>	<b>39,520</b>
Less recoveries in respect of outward secondments	(65)	0	(65)
<b>Total cost of staff</b>	<b>34,147</b>	<b>5,308</b>	<b>39,455</b>
Average number of whole-time equivalent persons employed during the year	419	47	466
2013/14	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
<b>Total cost of staff employed</b>	<b>25,410</b>	<b>8,040</b>	<b>33,450</b>
Less recoveries in respect of outward secondments	(137)	0	(137)
<b>Total cost of staff</b>	<b>25,273</b>	<b>8,040</b>	<b>33,313</b>
Average number of whole-time equivalent persons employed during the year	303	53	356

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

Monitor participates in the Principal Civil Service Pension Scheme (PCSPS). The Scheme is an unfunded, multi-employer defined benefit scheme in which Monitor is unable to identify its share of the underlying assets and liabilities. A full actuarial valuation was carried out as at 31 March 2012. Details can be found in the resource accounts of the Cabinet Office: Civil Superannuation ([www.civilservice-pensions.gov.uk](http://www.civilservice-pensions.gov.uk)).

For 2014/15, employer's contributions of £5,336,240 were payable to the PCSPS (2013/14: £3,928,190) 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 the benefits accruing during 2014/15 to be paid when the member retires and not the benefits paid during this period.

Employees can opt to open a partnership pension account, a stakeholder pension with an employer contribution. Employer's contributions of £258,938 (2013/14: £158,254) 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 £20,128 (2013/14: £13,309), 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 the 31 March 2015 were £27,375 (31 March 2014: £15,549).

## b) Reporting of Civil Service and other compensation schemes - exit packages

There have been no redundancy or other departure costs in 2014/15 (2013/14: 2 other departures totalling £106k).

## c) The salaries of executives and NEDs are disclosed in the Remuneration Report on page 61

## Notes to the Accounts continued

### 4. Other operating expenditure

	31/03/2015	31/03/2014
	£000's	£000's
<i>Core running costs</i>		
Office expenses	3,648	3,260
Property expenses	1,374	2,307
Pricing development spend	2,731	1,798
Costing and coding assurance	1,262	-
Audit fee for Monitor	45	40
Audit fee for consolidated accounts	68	68
Other professional services	3,076	4,154
Travel and subsistence	442	281
Communication expenses	411	603
General expenses	221	230
<i>Non-cash items</i>		
Depreciation and amortisation	1,442	885
Loss on disposals	3	240
<i>Ring-fenced expenditure</i>		
Contingency planning teams	8,592	4,072
Trust special administration	7,364	12,300
Special measures reimbursements	2,119	742
<b>Total other operating expenditure</b>	<b>32,798</b>	<b>30,980</b>

Commentary on expenditure for the year is contained within the Strategic Report.

### 5. Miscellaneous income

	year ended	year ended
	31/03/2015	31/03/2014
	£000's	£000's
Rental income	-	79
Other miscellaneous income	1	166
	<b>1</b>	<b>245</b>

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.

## Notes to the Accounts continued

### 6. Analysis of net expenditure by Programme and Administration budget

Programme spend comprises costs of trust special administration, special measures improvement and buddying, and spend on the costing and coding assurance programme.

	31/03/2015	31/03/2014
	£000's	£000's
Administration	60,234	50,552
Programme	12,018	13,496
	<b>72,252</b>	<b>64,048</b>

### 7. Non-current assets

#### a) Intangible assets

2014/15	Software licences £000's	Information technology £000's	IT assets under construction £000's	Total £000's
<b>Cost or valuation</b>				
As at 1 April 2014	806	580	1,148	2,534
Additions	198	0	2,783	2,981
Reclassification	0	569	(569)	0
Disposals	0	0	0	0
<b>At 31 March 2015</b>	<b>1,004</b>	<b>1,149</b>	<b>3,362</b>	<b>5,515</b>
<b>Amortisation</b>				
As at 1 April 2014	504	71	0	575
Charge for year	195	307	0	502
Disposals	0	0	0	0
<b>At 31 March 2015</b>	<b>699</b>	<b>378</b>	<b>0</b>	<b>1,077</b>
Net Book Value at 31 March 2014	302	509	1,148	1,959
<b>Net Book Value at 31 March 2015</b>	<b>305</b>	<b>771</b>	<b>3,362</b>	<b>4,438</b>

2013/14	Software licences £000's	Information technology £000's	IT assets under construction £000's	Total £000's
<b>Cost or valuation</b>				
As at 1 April 2013	449	41	0	490
Additions	357	539	1,148	2,044
Disposals	0	0	0	0
<b>At 31 March 2014</b>	<b>806</b>	<b>580</b>	<b>1,148</b>	<b>2,534</b>
<b>Amortisation</b>				
As at 1 April 2013	347	41	0	388
Charge for year	157	30	0	187
Reverse Disposals	0	0	0	0
<b>At 31 March 2014</b>	<b>504</b>	<b>71</b>	<b>0</b>	<b>575</b>
Net Book Value at 31 March 2013	102	0	0	102
<b>Net Book Value at 31 March 2014</b>	<b>302</b>	<b>509</b>	<b>1,148</b>	<b>1,959</b>

Spend on IT assets under construction in 2014/15 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. Development of the online licensing system was completed during 2014/15, and it was brought into full use in year.

## Notes to the Accounts continued

### 7. Non-current assets continued

#### b) Property, plant and equipment

2014/15	IT equipment £000's	Furniture, fixtures and office equipment £000's	Leasehold improvements £000's	Total £000's
<b>Cost or valuation</b>				
As at 1 April 2014	2,232	1,776	0	4,008
Additions	910	145	0	1,055
Disposals	0	(6)	0	(6)
<b>At 31 March 2015</b>	<b>3,142</b>	<b>1,915</b>	<b>0</b>	<b>5,057</b>
<b>Depreciation</b>				
As at 1 April 2014	1,034	531	0	1,565
Charge for year	652	288	0	940
Disposals	0	(3)	0	(3)
<b>At 31 March 2015</b>	<b>1,686</b>	<b>816</b>	<b>0</b>	<b>2,502</b>
Net Book Value at 31 March 2014	1,198	1,245	0	2,443
<b>Net Book Value at 31 March 2015</b>	<b>1,456</b>	<b>1,099</b>	<b>0</b>	<b>2,555</b>

2013/14	IT equipment £000's	Furniture, fixtures and office equipment £000's	Leasehold improvements £000's	Total £000's
<b>Cost or valuation</b>				
As at 1 April 2013	1,253	607	923	2,783
Additions	989	1,285	0	2,274
Disposals	(10)	(116)	(923)	(1,049)
<b>At 31 March 2014</b>	<b>2,232</b>	<b>1,776</b>	<b>0</b>	<b>4,008</b>
<b>Depreciation</b>				
As at 1 April 2013	532	471	661	1,664
Charge for year	506	133	59	698
Reverse Disposals	(4)	(73)	(720)	(797)
<b>At 31 March 2014</b>	<b>1,034</b>	<b>531</b>	<b>0</b>	<b>1,565</b>
Net Book Value at 31 March 2013	721	136	262	1,119
<b>Net Book Value at 31 March 2014</b>	<b>1,198</b>	<b>1,245</b>	<b>0</b>	<b>2,443</b>

All non-current assets are owned by Monitor.

## Notes to the Accounts *continued*

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

	31/03/2015	31/03/2014
	£000's	£000's
Trade and Other receivables	170	326
Prepayments and accrued income	645	600
	<u>815</u>	<u>926</u>

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

	31/03/2015	31/03/2014
	£000's	£000's
Balances with central government bodies	61	187
Balances with NHS Bodies	0	0
<b>Subtotal: Intra-government balances</b>	<b>61</b>	<b>187</b>
Balances with bodies external to government	754	739
<b>Total receivables</b>	<b>815</b>	<b>926</b>

### 9. Cash and cash equivalents

	31/03/2015	31/03/2014
	£000's	£000's
Balance at 1 April	18,638	11,977
Net change in cash and cash equivalent balances	(10,725)	6,661
Balance at 31 March	<u>7,913</u>	<u>18,638</u>

#### The following balances at 31 March were held at:

Government Banking Service	7,900	18,623
Commercial banks and cash in hand	13	15
	<u>7,913</u>	<u>18,638</u>

### 10. Trade payables and other current liabilities

	31/03/2015	31/03/2014
	£000's	£000's
<b>Amounts falling due within one year:</b>		
VAT	6	9
Other taxation and social security	944	750
Trade payables	5,753	3,934
Capital payables	0	275
Pensions payable	728	548
Accruals and deferred income	5,591	7,024
Capital accruals	169	344
	<u>13,191</u>	<u>12,884</u>

#### 10a. Trade payables and other current liabilities - intra-government balances

	31/03/2015	31/03/2014
	£000's	£000's
Balances with central government bodies	1,639	2,344
Balances with NHS Bodies	2,834	798
<b>Subtotal: Intra-government balances</b>	<b>4,473</b>	<b>3,142</b>
Balances with bodies external to government	8,718	9,742
<b>Total payables</b>	<b>13,191</b>	<b>12,884</b>

## Notes to the Accounts continued

### 11. Provisions for liabilities and charges

Monitor has no provisions in 2014/15 (2013/14: nil).

### 12. Commitments under leases

Total future minimum lease payments under operating leases are given in the table below for each of the following periods:

	2014/15 £000's	2013/14 £000's
Within 1 year	1,625	1,102
Within 2 to 5 years	0	1,102
After more than 5 years	0	0
	<b>1,625</b>	<b>2,204</b>

## Notes to the Accounts *continued*

### 13. Capital commitments

There were no capital commitments at 31 March 2015 that require disclosure.

### 14. 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.

### 15. 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 Monitor holds no financial instruments that are either complex or play a significant role in Monitor's financial risk profile, Monitor's exposure to credit, liquidity or market risk is limited.

### 16. Events after the reporting date

The Secretary of State announced on 11 June 2015 that Monitor and the NHS Trust Development Authority will move to appoint a single leader. The closer working between Monitor and TDA will encompass those functions and duties carried out by both organisations, with Monitor continuing to exercise its existing role. The change will mean that all NHS providers, whether they are foundation trusts or trusts, are under the oversight of one chief executive, overseeing teams working closely together.

David Bennett announced at the same time that he was standing down as chief executive after more than five years, although he has agreed in principle that he will continue in post in the meantime to ensure an effective transition.

This has no impact on Monitor's accounts and no adjustments have been made as a result.

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

The Accounting Officer authorised these financial statements for issue on 9 July 2015



Making the health sector  
work for patients

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