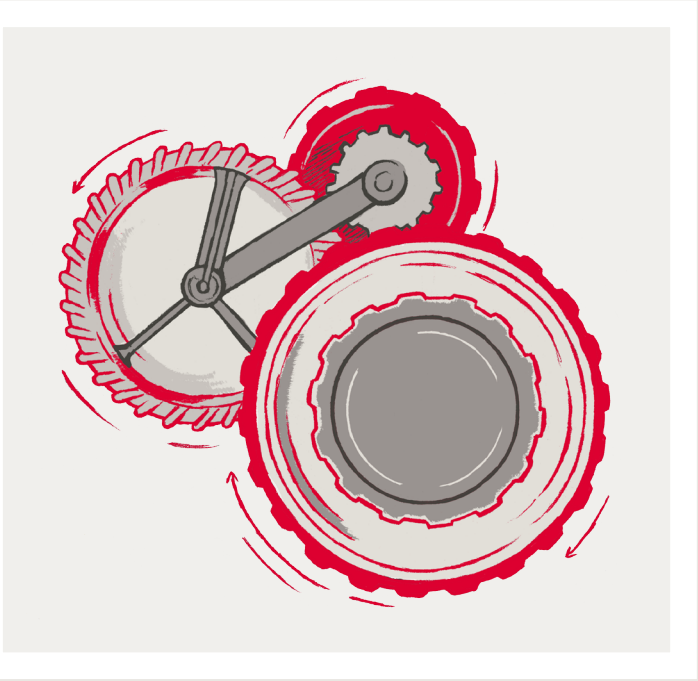
Annual report and financial statements

For the year ended 31 December 2016



2016

The Health Foundation

Introduction from the Chief Executive and Chair

The Health Foundation has a broad mission – to improve the health and health care of people living in the UK. As an independent foundation we are in the privileged position of being able to step back and try to understand why problems exist and what might help to solve them in the short, medium and longer term.

2016 was the second year of our strategic plan for 2015–18, which sets three aims: to improve health service delivery, make health policymaking more effective, and help people in the UK to become healthier. We are working to achieve these aims through:

- **testing and spreading innovations** by giving grants and practical support to front-line teams
- **building skills and knowledge** to improve the quality of care – for example, through developing leaders who can use quality improvement techniques at the front line, and building the skills needed to design, model and measure the impact of health care policies

  developing and sharing evidence on what works and why, becoming an expert centre for evaluation of interventions by 2018, monitoring the quality of health care, and researching the impact of policy reforms and how the right mix of policies can improve population health.

In both highly complex areas of health and health care, a key aim is to understand more clearly what speeds up successful change. This is a huge task and requires a continuous process of analysis and reflection, both internally with staff but also externally with a range of key stakeholder groups. It is this understanding which will help us to target future interventions and investments for maximum effect.

Major successes in 2016

This annual report shows good progress in achieving our aims in 2016, both at the level of front-line care through to national policy. For example, we funded 62 projects to allow teams to test innovative approaches to improve health care and 21 projects to help teams scale and spread successful improvement programmes. We also funded two networks – one to coach staff in hospitals to improve the flow of patients through services, the other to link NHS organisations across the UK wanting to develop front-line quality improvement activity.

As part of our work to develop evidence on what works and why, we partnered with NHS England to set up the Improvement Analytics Unit. This unit is using near real-time quantitative data to measure progress on several projects that are central to reform of the NHS, and give rapid feedback to front-line teams and NHS England to support ‘course correction’. We established two pilot sites in 2016 and will be recruiting further sites in 2017.

Throughout 2016, we published analyses on some key areas of policy. The first was on the financial health of the NHS and the funding gap. A particular success was our report highlighting the funding gap in health and social care in Wales, which resulted in the Welsh Assembly announcing a £240m funding boost for the NHS in 2017/18. The second was a major analysis of workforce policy, which is now being used to guide workforce planning at national level. The third was an analysis of the approach to improving the quality of care in the NHS in England, which resulted in shaping national policy by the National Quality Board.

During 2016, we also laid the groundwork for many of the initiatives that will get underway in 2017.

Improving health care

Several activities in 2017 aim to increase the pace of change in health care. For example, we are founding a new improvement research institute, led by the University of Cambridge. The institute will be a thriving academic hub that works with front-line staff to develop knowledge on how to improve health and care services, and translates this knowledge into practice. This is a new type of mass and applied research.

The Q initiative, co-funded by the Foundation and NHS Improvement, is bringing together a diverse and growing community of people with expertise in quality improvement. As well as expanding the initiative in 2017 to include over 1,000 people, we are piloting the first Q Lab – a dedicated space for people to work together on tackling high-priority and complex issues.

A healthier UK

Wellbeing and health are important foundations of a good life for the individual and a flourishing and prosperous society. But many factors influencing health largely sit outside of health care, for example: early life experiences, education and employment opportunities, housing, and social networks.

Following scoping work in 2016, we are implementing a long-term strategy to help people in the UK live healthier lives. We will start by researching the future health prospects of young people, exploring how society can better identify economic and other wider benefits of investment to keep people healthy, and convening a range of stakeholders to help build a culture of health within geographical communities.

Making health policymaking more effective

We know that the policy environment in which people work can help or hinder change in bringing about better health and health care for people in the UK. In 2017, we will continue to carry out policy analysis and research to provide insights on how policies might best support progress, and we will draw on the insights we gain from working with people in health and health care.

Our achievements in 2016 are due to the hard work and commitment of staff, governors and partners and we look forward to making more progress in 2017.

Dr Jennifer Dixon (Chief Executive) and Sir Alan Langlands (Chair)

The Health Foundation

Legal and administrative information

Governors	Sir Alan Langlands Sir David Dalton Martyn Hole Bridget McIntryre Andrew Morris Melloney Poole David Zahn Branwen Jeffreys Rosalind Smyth (*Appointed: 4 April 2016*) Sir Hugh Taylor (*Appointed: 13 April 2017*) Eric Gregory (*Appointed: 13 April 2017*) Loraine Hawkins (*Appointed: 13 April 2017*) Margaret Goose (*Resigned: 4 July 2016*) Deidre Kelly (*Resigned: 4 July 2016*) Murray Easton (*Resigned: 2 February 2017*)
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Governors' report (including Directors' report)

Strategic report

The governors of the Health Foundation present their annual report for the year ended 31 December 2016 under the Charities Act 2011, incorporating the strategic and Trustees' reports under the Companies Act 2006, together with the audited financial statements for the year.

The accounts have been prepared in accordance with the accounting policies set out in note 1 to the accounts and comply with the Foundation's Articles of Association, the Companies Act 2006 and 'Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2015)'.

Vision and objectives of the Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

We make links between the knowledge we gain from working with those delivering health and health care and our research and analysis. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

Our charitable objects are:

- to promote medical research, and the publication of the useful results of such research
- to promote medical education and training, including the education and training of nurses and other persons involved in the provision of health care or the management and administration of health care providers
- to promote the relief of sickness and disability and the preservation and protection of public health
- to promote the relief of the aged.

The Health Foundation's operational plans are set in the context of its charitable objects and financial resources. The plans are developed to maximise outcomes and impact as the governors are mindful of the Charity Commission's guidance on public benefit.

Activities and achievements in 2016

During 2016, we focused on ways to successfully improve the health and health care of people living in the UK, from front-line care through to changes at system level. In particular, we looked at how to improve coherence in policy initiatives. We also broadened our work

beyond health care to include population health, considering how best to develop programmes of work and grants in this area.

We built on the lessons and insights from our work in previous years and continued to work towards our three main strategic objectives:

- to improve health service delivery
- to make health policymaking more effective
- a healthier UK population.

Here we report on our work during 2016 and provide details of a selection of our activities and achievements from the year. We highlight activity included in our stated plans for 2016.

We have structured this report around the three strategic objectives above. The financial statements also reflect these objectives. Much work has been done on all three objectives, but most of our spending has been on improving health service delivery.

Improving health service delivery

Testing and spreading successful approaches through our improvement programmes
Our Innovating for Improvement programme supports teams to test innovative approaches to improve health care. To deliver the programme, we are working with an improvement agency, Haelo, which is embedded within an NHS trust. Because of the open nature of the programme, projects cover a wide range of topics and sectors. Across three rounds of applications for the programme in 2016, we chose 62 projects to fund. The final round of the year was specifically targeted at primary care and resulted in 10 projects being led by, or working closely with, primary care. Examples included a team testing a new model of care integrating primary, community and social care services within an extended primary care team, and a new collaborative approach to enhance quality of life and outcomes of care in residential homes.

In 2016 we also launched a further round of applications for our Spreading Improvement programme, which aims to spread successful improvement programmes. 14 teams were successful, including a range of individuals and projects from previous programmes supported by the Health Foundation, such as Innovating for Improvement, Realising the Value and GenerationQ.

As part of our work to identify and test new approaches to spreading and scaling improvement, we began a scoping project in partnership with the International Centre for Social Franchising. This project is examining the potential for applying social franchising and licensing within health care. We also looked at social investment, supporting the Care and Wellbeing Fund, managed by Social Finance. The Fund aims to develop and scale community-based projects to improve health and wellbeing. Its first investment was in Reconnections, a project in Worcestershire that aims to tackle loneliness among older people.

Awarding grants to take forward improvement ideas
Our Scaling Up Improvement programme supports teams to take ideas that have been successfully demonstrated on a small scale and deliver them on a larger scale. In 2016 we chose seven projects for the second round of applications for the programme. For example, a team from Northumbria Healthcare NHS Foundation Trust is scaling its intervention to

improve the care of hip fractures; the team members are working collaboratively with poorly performing organisations, which have been identified using data from the National Hip Fracture Database. RUBIS:QI, a partnership of former Health Foundation fellows, is supporting the programme.

From the first round of applications for Scaling Up Improvement, the six teams continue to progress with their projects, which are due to conclude in 2017. The PINCER project, for example, is scaling up a proven pharmacist-led IT intervention across 17 clinical commissioning groups in the Midlands and east of England, with the goal of covering 150 general practices by the end of the programme.

Catalysing longer term change through our investments
Over the past year we have developed our ambitions to make more substantial long-term investments to incubate and support initiatives that could build capability and catalyse more fundamental change in health and health care. Often these initiatives have involved working with a range of partners whose support enables us to have greater impact, and collaborating to develop skills and expertise.

Investments of this kind include the following.

- **Improvement research institute** – Since 2010 the Health Foundation has been investing in and promoting improvement science and the work we have supported has improved care and altered national policy. We are building on this investment in the field to establish an improvement research institute to develop evidence on a massive scale across the NHS about what works to improve care. In 2016 we ran a competitive process to find a host university and in 2017 appointed the University of Cambridge and their partners. The Health Foundation is committed to funding the institute in the region of £40m over 10 years with the aim that it will ultimately become self-sustaining.
- **Q** – The Q initiative is led by the Health Foundation and co-funded by NHS Improvement. It connects people skilled in improvement across the UK. In 2016 we continued to test activities with the community, including our first site visit and three community events that enabled members to share, connect and learn from one another. We piloted an approach to recruiting members and by the end of the year there were almost 500.
- **Q Labs** – The Q Improvement Lab will bring people together to explore, develop, test and spread ideas that could improve the quality of health care. The idea emerged from the co-design process used to develop the Q community and in 2016 research was undertaken to develop the Health Foundation's thinking about what a Q Improvement Lab might look like.
- **Improvement Analytics Unit** – In 2016 we set up the Improvement Analytics Unit in partnership with NHS England to build NHS capacity to examine the progress being made to improve quality as part of national transformation programmes.

Sharing valuable learning
The Shared Purpose programme ran from June 2012 until January 2016. It supported nine teams to deliver improvement projects that brought together corporate and clinical staff. The programme was predicated on the idea that collaboration in this way would lead to greater

levels of success and sustainability. Seven teams showed positive results that have been sustained, with four achieving regional spread during the lifetime of the award. It has been striking how much external recognition the programme has received, with four projects winning prestigious national awards. The Dignity in Practice project, led by Northumbria Healthcare NHS Foundation Trust, in partnership with Age UK North Tyneside, was one of the most successful: in summer 2016 Northumbria was named the best NHS trust in the country for patient experience, with the Care Quality Commission (CQC) citing its Shared Purpose programme as a contributing factor. We have continued to disseminate the learning from the programme, including at the 2016 International Forum on Quality and Safety in Healthcare in Gothenburg.

The Closing the Gap in Patient Safety programme concluded at the end of 2016. The programme supported 10 projects and findings have so far been disseminated through celebration events, academic publication, and local and national media coverage. Many of the projects have also demonstrated impact at a large scale; for instance, a project to improve safety in pharmacy in primary care across four health boards in Scotland is going to be rolled out across Scotland. Meanwhile, the Safety Measurement and Monitoring programme has enabled four leading improvement bodies across England and Scotland to develop innovative ways to measure, monitor and improve patient safety. Projects have ranged from improving ambulance safety to preventing incidents of self-harm, violence and aggression in specialist mental health services.

Engaging our audiences through digital and interactive activities
We continued to promote our *Power of people* films – an award-winning series of five short films about life-changing health care innovation and improvement. These were shown on the Community channel to mark their one-year anniversary. The campaign has been nominated for the Charted Institute of Marketing's Marketing Campaign of the Year (SME category) award and reached the final rounds of the British Independent Film Festival in April. One of the five films, Flo, won Gold at the International Independent Film Awards in spring 2016, adding to the two Haelo awards already achieved.

Overall, the *Power of People* films has amassed more than 92,000 online and offline views.

A Mile in My Shoes – an immersive audio experience telling the stories of those working in health and social care – made its debut at the NHS Confederation conference in June. It was one of the most popular exhibits at Health and Care Innovation Expo in September and was exhibited at the Houses of Parliament for a week in November.

On Twitter, we reached almost 50,000 followers of our @HealthFdn account by the end of 2016. The Q initiative (see below) also launched a Twitter account towards the end of the year – @theQcommunity – gaining 1,500 followers. The initiative's microsite also launched in 2016, generating nearly 15,000 views since launch.

Fostering collaboration through the Q initiative
Q is led by the Health Foundation and co-funded by NHS Improvement. It connects people skilled in improvement across the UK. In 2016 we continued to test activities with the community, including our first site visit and three community events that enabled members to share, connect and learn from one another. Feedback from members has been very

positive. We have now begun to commission a wider programme of face-to-face and online events, supported by an innovative approach to gathering what we learn as we go.

We piloted an approach to recruit members during the summer, and by the end of the year we had almost 500 members. We also commissioned a long-term evaluation of the programme and published a learning report – *Building Q* – summarising insights from the evaluation of the programme's design phase. We have secured public commitment from counterpart organisations in Wales and Scotland to become system-level partners for Q, alongside NHS Improvement, and we are in discussions with relevant bodies in Northern Ireland.

During 2016 we also designed the pilot Q Improvement Lab, which started in April 2017. The Improvement Lab's mission is to support ways of collaboratively designing, developing and prototyping new ideas to tackle health care challenges that the Q community has identified as a priority.

Creating an improvement research institute
Work to scope the improvement research institute got underway in January 2016. We set out to find a leading UK university to establish and run a research institute that could grow and apply credible academic knowledge to directly and positively impact on health services and benefit patients. In March 2017, the University of Cambridge was appointed to establish and run the institute, and the Health Foundation's board of governors decided to support the institute by awarding in the region of £40m over 10 years.

In 2016 we also recruited our fourth cohort of improvement science fellows for three-year post-doctoral fellowships. The pool of applicants was exceptionally strong and we appointed six fellows after interview, with research proposals covering a broad range of issues. The fellowships got underway in January 2017.

The Health Foundation at events and conferences
International Forum on Quality and Safety in Healthcare in Gothenburg: we sponsored the Improvement Science Symposium on the first day of the Forum and 15 sessions on the main programme were led by Health Foundation employees, grant holders and fellows. We distributed 9,500 items from our stands, including 7,500 publications.

NHS Confederation annual conference and exhibition: over 1,500 delegates attended the conference, where we launched our immersive audio experience, A Mile in My Shoes. About half of delegates (703) were served artisan coffees by our resident barista, and a tenth (160 delegates) signed up to our monthly newsletter.

NHS Health and Care Innovation Expo: we exhibited at the two-day event to promote the Foundation's work, distributing 4,436 items (3,466 publications and 970 pieces of other merchandise/collateral) and signing up 180 delegates to our monthly newsletter.

Using data analysis to inform improvements
In partnership with NHS England, during 2016 we established the Improvement Analytics Unit. This Unit will examine the progress being made to improve quality as part of national transformation programmes. By feeding back information to local teams on a regular basis, we hope to inform decisions about the development of services and, ultimately, to improve

outcomes for patients. During the year we established the Unit, put in place a robust approach to information governance and began the analysis for two pilot evaluations. One report has been published – *The impact of providing enhanced support for care home residents in Rushcliffe* – and the other is due to be published in July 2017.

Our in-house data analytics team is also producing insights about the quality of care from novel, linked data sets. In 2016, *BMJ Open* published an analysis of whether offering a named GP to people aged 75 years or older affects their continuity of care. We also began a more detailed analysis of the relationship between patients seeing the same GP over time and hospital admission rates. Both projects are informing national policy on improving primary care.

Making health policymaking more effective

Identifying potential improvements through research programmes

The five projects in our Informatics for Improvement research programme continued during 2016. The projects were brought together at an event to exchange learning on data linkages, during which emerging findings were shared, along with in-depth methodological discussions. During 2016 we started the scoping work for a second round of applications for the programme, identifying areas that other funders are already focused on, areas that might be of interest to the Foundation, and synergies with our in-house data analytics work. We selected national clinical audits and data registries as useful topics for the programme and held further discussions with research users, funders and academics in the field to focus on the themes. The second round of the programme launched in May 2017.

In 2016, the projects from the first round of applications for the Efficiency Research Programme shared their progress with the external advisory group. A key theme to emerge was difficulties and challenges encountered by all the teams in accessing relevant data. We have collated this feedback to better understand the issues and are now offering teams support and guidance to help them gain quicker access to the data they need. For the second round of the programme during 2016, we encouraged applications in areas that are under-researched in terms of system efficiency, and we chose three projects to support. One project is looking at efficiency in mental health and another is looking at efficiency in community services with respect to optimising home care visits. A third study is focused on end of life care and the efficiencies that may be generated when people's preferences are met for care to be provided in the home, as opposed to high-cost acute settings.

Our Behavioural Insights Research Programme focuses on interventions that have the potential to increase efficiency and reduce waste in UK health care services. Five research projects began in 2016 to design, test and evaluate work on: procurement; planning around discharging patients from emergency departments; compliance with hand hygiene protocols; cost and risk feedback for common diagnostic tests; and prescribing. The studies are expected to report findings in 2018.

Building and sharing evidence about high quality health care

To continue to build and share evidence about high quality health care, we published a range of policy analyses and commissioned research during 2016, with a particular focus on where policy initiatives could be more coherent.

We published several reports on the NHS workforce.

- *Fit for purpose?* gives an overview of the components of workforce policy in the NHS in England and the bodies that shape it. The report proposes ways in which workforce policy could be strengthened to improve the quality and productivity of care.
- In July 2016, we launched *Staffing matters; funding counts* which looked at the profile and trends of the NHS workforce, as well as several pressure points for the attention of policymakers. The main report was supplemented by a series of analyses looking at specific pressure points.

We launched the reports with a stakeholder event in Westminster, which included senior officials with responsibility for NHS workforce policy.

Our July 2016 report *A clear road ahead*, written with Professor Sheila Leatherman, set out the main elements of a national quality strategy and the need for closer working between national bodies in England. Following its publication, the frameworks we developed have been explicitly adopted by the National Quality Board, informing their aspirations for improving quality.

Throughout 2016, we published analyses on finances in health care:

- In February, we published the briefing *Acute hospital productivity*, which showed that crude productivity in acute and specialist trusts fell for the third year in a row in 2014/15.
- In March, we published *A perfect storm: an impossible climate for NHS providers' finances?* – an analysis of the pressures facing NHS trusts to help explain the reasons behind the rising number of trusts falling into financial deficit.
- Following the national referendum on the UK's membership of the EU, we published *NHS finances outside the EU*, a briefing on how the budget for the UK NHS between 2019/20 and 2030/31 might be affected by the lower GDP growth expected following the result.
- In October, we published the results of projection modelling of the demand pressures facing the NHS in Wales in 2019/20 and 2030/31. *The path to sustainability* showed that, if the NHS in Wales continues to achieve the trend rate of efficiency growth (1.0% a year) and funding were to rise in line with expected GDP growth (2.2% a year in real terms), then funding would match pressures, leading to a sustainable NHS in the long term. In response, the Welsh Assembly announced a £240m funding boost for the NHS in Wales in 2017/18 and cited the Health Foundation's research as the reason for this decision.

QualityWatch, our joint research programme with the Nuffield Trust, continued to monitor over 300 indicators of quality of care across the health and social care system. QualityWatch produced its fourth annual statement on quality of care, *Quality at a cost*, as well as an analysis of 15 key indicators of performance of the NHS in England from November 2014 to March 2015, *Winter Pressures: What's going on behind the scenes?* The programme also published *Focus on: Public health and prevention*, a report on the current state of public health services and the potential impact of recent financial and legislative developments on key health outcomes.

A healthier UK population

During 2016 we explored in depth how we could contribute to increasing action on the determinants of health. This included the following activities.

- We co-hosted a session of the Salzburg Global Seminar with the Robert Wood Johnson Foundation. Bringing together over 60 people from all over the world, the four-day event reflected on the barriers to action on the determinants of health. We contributed to a report from the event – *Hooked on health care*. The insights from the Robert Wood Johnson Foundation's Culture of Health strategy have fostered our interest in building cross-sectoral collaborations on the wider determinants of health, which will be a focus of our healthy lives work in 2017.
- We held an expert meeting to identify the points at which we could best contribute to knowledge building during a person's lifetime. As a result, we are focusing on understanding the future health prospects of young people and how these are shaped during adolescence and early adulthood.
- We also supported work at the London School of Hygiene and Tropical Medicine to better understand the evidence needed to inform policy and practice with respect to improving the health of the public. This led to an article in *The Lancet* (awaiting publication).

This work has helped us identify key themes to develop our healthy lives strategy and guide our work for 2017 and beyond. We have also grown our networks across the public health community and are supporting collaborations to build greater understanding of the determinants of health. This includes a comparative study of public health action across the four UK countries and supporting the UK Public Health Network.

Improvement over the long term

At the Health Foundation, we invest in improvement programmes of many kinds, from small-scale innovation projects to large-scale awards supporting teams to scale up proven health care interventions.

Many projects begin work that continues over several years. But whatever stage of development they are at, something we often hear from our grant holders is just how important the Health Foundation's support was in getting their work off the ground and taking it to the next level.

Below are case studies of three of these projects, past and present, which show the progress they have made by 2016 and the incredible impact their work is having.

A transformative new approach to care of patients with a cochlear implant: personalised long-term follow-up using remote care

About the project

Each year, around 1,400 people in the UK with severe to profound deafness receive a cochlear implant – an electronic medical device that replaces the function of the inner ear. These patients need lifetime follow-up, both for their implant to be adjusted and for rehabilitation, which is usually done through routine annual appointments in a clinic. However, because cochlear implant care is provided at specialist tertiary centres, these clinics may be several hours away from the patient's home, requiring significant travel and expense, including time off work.

Aware that some patients wanted to take more control over their own care, a team at the University of Southampton Auditory Implant Service – led by Dr Helen Cullington and working in partnership with Southampton Management School, the University of Nottingham and Cochlear UK – sought to redesign the service. The team wanted to enable patients to self-manage most of the time, only attending clinics when needed rather than every 12 months. By empowering patients, the project aimed to make cochlear implant care more effective and convenient – and more efficient too.

With funding from the first round of our Innovating for Improvement programme (2015–16), the team designed and tested a new long-term follow-up pathway for patients with a cochlear implant. The package offered patients remote self-monitoring (allowing them to monitor their own ability to understand speech) and self-adjustment of devices (allowing them to fine-tune the settings on their own implant). It also included a personalised online or smartphone package for people to test their own hearing at home.

The project was run as a randomised controlled trial, with 30 patients allocated to the remote-care group and 30 to a control group. Results of the project showed that empowerment and hearing stability among the remote-care group increased compared with the control group. Qualitative feedback was also positive. For some patients the effect was transformative; as one user put it, 'I must say how thrilled I was just to be able to pick up the telephone receiver without outright panic. I haven't lifted a receiver for some 40 years or so'.

As well as saving patients the trouble of travelling to appointments, the remote-care package was also cheaper for the clinic, with initial analysis from the trial sample showing net savings of around £326 per patient in clinician and administrative staff time. It is important to note that this trial ran for six months with a small sample of patients so, at this stage, it is not possible to evaluate the long-term cost implications. However, if sustained over time, this new approach would mean that the clinic has greater resources to see patients with more complex needs in person.

Learning for future work
The project uncovered many insights on the importance of working with patients to co-design new care packages, particularly in the context of remote care. The team spent a lot of time at the beginning of the project engaging with patients to understand what was important to them, including their needs, what they would and wouldn't feel comfortable doing at home, and their preferences for what remote care would involve. For example, the team found that while patients were more likely to choose remote care over usual care if the package included self-monitoring and self-adjustment of the implant, they were less likely to choose remote care if it meant they had sole responsibility for scheduling appointments. The project also highlighted that some patients need significant support to use online tools – more so than the team originally envisaged.

Another lesson was the crucial importance of working with colleagues and stakeholders to get their support.

Sustainability and spread of the new approach
Members of the project team are now seeking further patient and clinician feedback to refine the package and roll it out to a larger sample of patients. They are also using this experience to design a remote pathway for families of children with a cochlear implant.

Ultimately, this kind of service innovation is potentially relevant to all the tertiary centres in the UK and there has been substantial interest in the project. The team was careful to invite patients from some other UK services to participate in the trial, and one effect of this may be to increase interest from other providers in implementing similar pathway reforms.

Tackling health problems from club drugs: from guidance to good practice

About the project
The use of 'club drugs' and novel psychoactive substances – compounds designed to mimic established recreational drugs – is increasing. These drugs are associated with significant morbidity, but there is little clinical experience of treating the problems that can result from these drugs.

NEPTUNE (Novel Psychoactive Treatment: UK Network) was a project led by Central and North West London NHS Foundation Trust and funded from the 2012 round of our Shine innovation awards. It set out to develop the first-ever clinical guidance and care bundles to address the gap in experience and knowledge in the management of health problems resulting from the use of club drugs. The guidance has been well received from the clinical community, and tests of the care bundles in emergency departments were successful, with 100% of clinicians in these departments taking up use of the bundles.

The next phase of this project – NEPTUNE II – was funded through our Spreading Improvement programme (2015–17) and is aiming to maximise the impact of NEPTUNE by influencing the clinical practice of front-line staff across the UK. It will provide learning resources and tools across a range of health settings, which should improve access to specialist evidence-based treatment for people with drug-related harms. The team has been working to develop these resources throughout 2016.

Clinical settings targeted by the programme include specialist drug treatment services, emergency departments, primary care services, mental health services, and sexual health and HIV services.

The NEPTUNE II team will also be working to influence policymakers to embed the project's learning into national frameworks and guidance. An independent evaluation is underway and will be published once the project has been completed.

Learning for future work
The team members are discovering a great deal of unmet need through their work. They believe that their proactive response to emerging needs is strengthening their relevance and credibility among clinicians, and will support the uptake of their forthcoming educational products.

For example, they have recently developed and published guidance on synthetic cannabinoid receptor agonists (SCRAs) because use of these drugs has significantly increased among prisoners and homeless people. The SCRA guidance is to be integrated into the new edition of Public Health England's toolkit for prisons. The NEPTUNE team is also advising Public Health England on clinical issues relating to the use of SCRAs.

Sustainability and spread of the new approach
There has been a high level of interest in this work in the UK. The project lead was recently asked to chair the Home Office's review of the New Psychoactive Substances Treatment

sub-group. The NEPTUNE guidance has provided much of the evidence for this review and the review team was keen to place NEPTUNE at the centre of its treatment and intervention recommendations. Public Health England has also supported the project from its inception and is committed to further national dissemination. The NEPTUNE II work is a close partnership with the Royal College of Psychiatrists, which will promote uptake of the educational materials.

There has been international influence too. In the summer of 2016, the European Monitoring Centre for Drugs and Drug Addiction published a report on the health responses to novel psychoactive substances. In this, NEPTUNE publications were identified as essential resources for clinicians in Europe. The original NEPTUNE guidance has recently been translated for use by clinicians in Germany.

Back in 2014, the team was invited to present their work at the G8 summit. More recently the United Nations Office for Drugs and Crime asked the team to develop clinical guidance on the management of novel psychoactive substances, aimed at an international audience in developed and developing countries.

Using Formula 1 technology for a paediatric early warning system: how one of our innovation projects has developed and grown

About the project

Life-threatening events in children are often preceded by early warning signs, but these are frequently missed or not acted upon. With funding from the 2011 round of our Shine innovation programme, a team from Birmingham Children's Hospital set out to address this problem through the Young Lives project. The project involved developing a continuous monitoring system capable of detecting deterioration in very sick children. In doing so, the team called on the expertise of McLaren Applied Technologies, the company that supplies monitoring equipment to Formula 1 racing teams.* They wanted to see if the technology used to continuously monitor the performance of Formula 1 cars could be adapted to a health care setting.

The system that the team developed was able to predict clinical deterioration accurately using real-time data from all beds, including a trolley in specialist ambulances en route to hospital. A software package was installed on the hospital's computer network that allowed data to be recorded, processed and analysed in real time. As well as giving doctors and nurses immediate access to changes in patients' vital signs – such as heart rate, breathing rate, oxygen levels and blood pressure – the system made it possible to save trends in the vital signs and set patient-specific smart alarms. Compared with the previous paper-based charting system, which is labour-intensive and produces intermittent rather than continuous data, it offered a marked improvement.

Learning for future work

Young Lives was an ambitious project that involved a series of complex technical, clinical and leadership challenges. The project team recognised that translating a new technology into an NHS context was never going to be a straightforward task, even one with a pedigree as established as McLaren's Formula 1 monitoring system. However, strong support from

* The project was led by Dr Heather Duncan, an Intensive Care Consultant, with support from Dr Rajaswari Matam, an Information Engineer, as well as McLaren Applied Technologies, Isansys Lifecare Ltd, Aston University and the University of Birmingham.

McLaren and the project's sponsors at the hospital helped to get it off the ground and make sure that the team could devote sufficient time to it. The team also worked hard to get buy-in from ward staff and families, as well as the IT, medical physics and procurement departments.

Nonetheless, the length of time needed to set up and integrate the different components of the new system, and to resolve contractual and recruitment issues, was significant – more than the team originally envisaged. This reinforces evidence from many of our programmes about the importance of the design and set-up phases for innovation projects.

Sustainability and spread of the new system
By the end of the Shine pilot project in 2012, the team at Birmingham Children's Hospital had developed and implemented a viable paediatric real-time early warning system, overcoming a series of major technical challenges in the process. Moreover, they had successfully recruited over 800 patients for the pilot. But outcome data from the pilot was only beginning to emerge, and the team recognised that it had more work to do to demonstrate the clinical and performance benefits of the new system.

Subsequent funding from the UK Clinical Research Network allowed the team to recruit a total of 3,300 patients and keep the project running for a further three years. The data and partnerships generated from this work helped the team acquire the evidence needed for a further major grant – a £1.84m award from the Health Innovation Challenge Fund, run by the Wellcome Trust and the Department of Health. The RAPID (Real-Time Adaptive and Predictive Indicator of Deterioration) project, which began in 2014 and will end in late 2017, will allow the team to fulfil one of the key long-term objectives of the original Shine project – the development of a wireless monitoring system.

Isansys Lifecare Ltd has developed the wireless sensors and collection system needed to gather the data about the children. By removing the need for cables and leads, which can restrict patient movement, the aim is to generate more continuous and reliable data. The use of wireless sensors also makes it easier for parents and carers to hold their children and interact normally with them.

RAPID has also enabled a team from Aston University's applied mathematics department to develop a more reliable alert so that clinicians can identify when children's symptoms are deteriorating. A University of Birmingham team, meanwhile, is carrying out a novel, broad mixed-methods assessment of the impact of RAPID technology that will help them, among other things, understand its cost-effectiveness.

This project has attracted considerable external interest. It has received coverage in the national media and prompted a visit in 2015 from the then Minister for Life Sciences, George Freeman MP, who saw the innovative combination of the 'world class Formula 1 technology' and 'the expertise of the NHS in diagnostics' as one that could deliver significant efficiency and performance benefits for the health service. The project was also highlighted in the Care Quality Commission's report about Birmingham Children's Hospital in February 2017, which gave the trust an 'outstanding' rating.

Our plans for 2017

We believe good health and health care are key to a flourishing society. Our aim is a healthier population, supported by high quality health care that can be equitably accessed. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

In 2017 and beyond we will be organising our work around two themes: improving health care delivery and a healthier UK.

Improving health care delivery

In early 2017, we selected the University of Cambridge to establish the world's first improvement research institute and it will be launching later in the year. The institute will be a thriving academic centre that develops knowledge about how to improve health and care services and translates this into improvements in practice.

In partnership with NHS England, we are continuing to develop the Improvement Analytics Unit (IAU) for the NHS in England. The unit uses robust statistical methods to provide rapid feedback on local initiatives to improve care and efficiency. During 2017 we will recruit further pilot sites.

The Q Initiative continues to go from strength to strength. The Q community is bringing together people with improvement expertise across the UK. It is led by the Health Foundation and supported by NHS Improvement. The community already has around 500 members, and will continue to expand, region by region, over 2017.

We are piloting the first Q Improvement Lab. The Q Labs will provide space – physical space, virtual space and head space – for people to work together on high-priority challenges. They aim to bring people with improvement expertise together to make progress on complex issues to improve care. If the pilot is successful, the long-term aim is to have a small network of labs across the UK.

The Health Foundation continues to combine knowledge and insights from our grant-making with in-house analysis. This year we will focus on two major areas of policy: quality of care and finances. We are continuing to explore quality of care in a range of areas, including through QualityWatch our joint research programme with the Nuffield Trust.

In early 2017 we will publish analysis of the finances and productivity of NHS providers in England. We are also investigating the productivity of acute providers in Wales.

We will also disseminate learning from our research projects including: work with the University of Manchester on the evaluation of Greater Manchester devolution and further outputs from our NHS workforce research.

In addition to working with NHS England and NHS Improvement, we are building a range of partnerships, for example in establishing the Improvement Research Institute, working with two other European foundations to deliver a European Health Leaders Network – Sciana, launching in spring 2017 – and the Commonwealth Fund in co-sponsoring the Harkness Fellowship programme.

We will be attending key events, including the International Forum on Quality and Safety in Healthcare in April. We are also collaborating with the International Society for Quality in

Health Care (ISQua) on its annual conference in October, which is being held in London. This year's conference has as its theme, 'Learning at the system level to improve health care quality and safety'.

Last year we worked with the Empathy Museum to develop a collection of stories from people working in and using health and social care. The result, A Mile in My Shoes, is an immersive experience, using a giant shoe box and 35 pairs of shoes, each with a unique audio story. We are developing an online experience for the project and we will be taking our giant shoe box out to events, so more people can experience it.

We are scoping an exciting new programme to develop in-depth understanding of how local health and social care systems lead, implement and embed improvements, and the support they need to accelerate change.

We will run new rounds of our improvement programmes – Innovating for Improvement, Scaling up and Spreading Improvement. We will be expanding our range of approaches to support spread and scaling of successful innovation. We have commissioned the International Centre for Social Franchising (ICSF) to identify projects that might be suitable to scale-up using social franchising approaches and to provide support to a demonstration programme.

A healthier UK

As an organisation with an overall mission to improve health, we recognise that to achieve this we need to look beyond improving health care and take action that will tackle wider determinants of health, the factors that shape where we live, learn, work and play.

We have been exploring where we can best contribute to this and have identified these overarching aims: action to change the conversation from 'ill-health as a burden' to 'good health as an asset'; promoting national policies that enable everyone to have the chance of a healthy life; and supporting local action to improve health. In early 2017, we published Healthy lives for people in the UK, introducing our healthy lives strategy.

We are working with experts – and young people themselves – to explore the factors that have the greatest bearing on young people's ability to build 'healthy foundations' between the ages of 12 and 24. We want to find out about the support young people might need to ensure solid foundations for a healthy life.

Read more about our plans for 2017

- Our newsletter interview with our chief executive Jennifer Dixon.
- To find out about our healthy lives work read the blog by Jo Bibby, our Director of Strategy.
- For our latest funding programmes visit our calendar of opportunities.

Find out more
For all the latest news and developments from the Health Foundation:

- subscribe to our newsletter at health.org.uk/newsletter register for email alerts to be notified about our latest work at health.org.uk/updates visit our lively blog for opinion, conversation and debate about the latest health and health care issues at health.org.uk/blog
- follow us on Twitter, Facebook or LinkedIn.

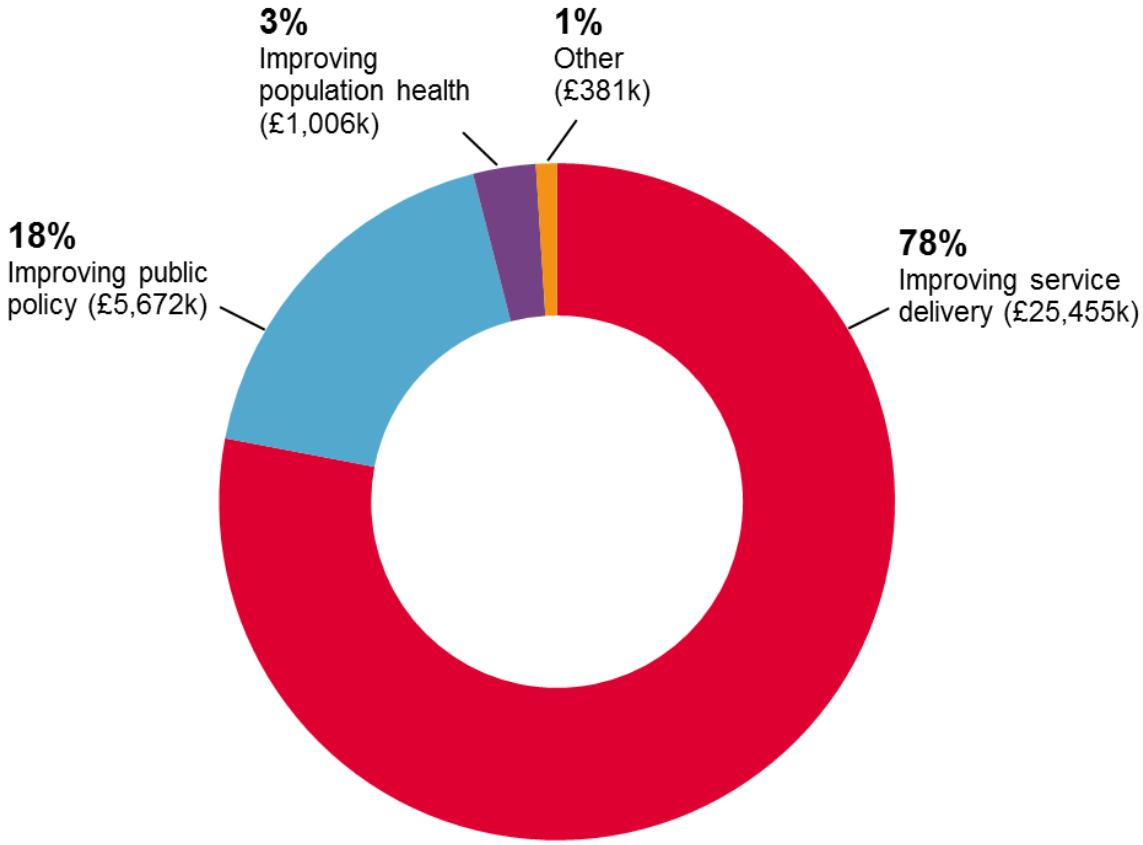
Financial review – results for 2016

Charitable activities

During 2016, the Foundation spent £32.5m (2015: £28.2m) on its charitable activities, of which £18.5m (57%) was direct grant and programme expenditure on projects related to the Foundation's key strategic priorities. Further information can be found in note 7 to the accounts. Salary costs were £7.3m (22%), and overheads were £6.7m (21%).

All expenditure is reported across our key strategic priorities; the split of expenditure for 2016 is reported in the graph below. Our overall charitable aim is to improve the health and health care of people living in the UK. By giving grants to those working at the front line and carrying out research and policy analysis, the Foundation focuses attention on how to make successful change happen; using what we know works on the ground to inform effective policymaking and vice versa.

Figure 1: Split in charitable expenditure



Restricted fund

In 2017 we received restricted income of £1,025k (2015: £975k) primarily for Q, an initiative joint-funded with NHS Improvement. The Q Initiative started in April 2015 and is continuing in 2018.

The Q Initiative is part of our substantial long-term investments to incubate and support initiatives that could build capability. This initiative will create an asset with an economic life and therefore £538k of Q expenditure is treated as an intangible asset.

Post-balance sheet event

In April 2017, we announced an award to the University of Cambridge for the development of an improvement research institute. The award committed £42,500k for 10 years, with a quinquennial review.

Subsidiary companies

The Foundation has two subsidiary undertakings.

- **Medtrust Innovations Limited** (Medtrust) is wholly owned by the Foundation as a mission related investment and is engaged in the exploitation of intellectual property rights. In March 2011, Medtrust acquired 50% of the intellectual property rights of BMJ Quality & Safety, a journal published by the BMJ Publishing Group Limited. At 31 December 2016, Medtrust had fixed assets of £526k (2015: £526k). In the year Medtrust generated an operating profit of £109k (2015: £125k).
- **The Victoria Fund LP Incorporated** (Victoria Fund) was formed in February 2010 as a vehicle to invest in a combination of hedge funds and private equity. The Health Foundation as the limited partner is entitled to all investment returns less a priority share by the general partner. As at 31 December 2016, the Victoria Fund had fixed assets of £218,367k (2015: £188,003k) and the value of its net assets was £222,026 (2015: £194,567k). Net profit in the year was £16,515k (2015: £2,562k).

Financial strategy and reserves

Investment policy and strategy

The Foundation has a structured investment process with the following primary features:

- **Investment policy** remains under the control of the board of governors; this includes investment objectives, constraints and spending rate.
- **Investment strategy** is delegated to the Investment Committee, including strategic and tactical asset allocation, rebalancing, styles and weighting within asset classes and manager arrangements.

The Foundation's investment policy and strategy are intended to provide long term stability and liquidity sufficient for the financing of the Foundation's ongoing spending and to maintain the real value of the endowment.

The governors have decided as a matter of policy that the Foundation should operate as a perpetual endowment and seek to maintain the real value of the endowment, defined as 1% above inflation. The Foundation has decided to adopt RPI+1% as a sensible proxy for expected inflation in costs to be funded.

The Governors' objective is to invest the Foundation's assets in order to maximise returns while balancing risk through a diversified asset portfolio. Within this framework the governors have agreed a number of objectives to help guide them in their strategic management of the assets and control of the various risks to which the Foundation is exposed. The Governors' primary objectives are as follows.

- **Time horizon:** the endowment shall be invested for the long term with an investment horizon of 10 years and multiple economic and market cycles.
- **Return target:** the total return target is RPI+5% per annum (net of all investment fees and costs). The objective is to maintain the real value of the Foundation's asset (RPI+1%) and provide a 4% spendable amount.
- **Spending policy:** the governors believe that the return target is consistent with sustaining a spending rate of 4% over a trailing three-year average of endowment value.
- **Risk target:** a long run volatility range of 12–14%. The governors desire to limit the possibility of a 20% fall in endowment value over one year but acknowledge that this possibility cannot be eliminated. The probability of this event is of the order of 20% or one in five.

The main features of the Foundation's investment strategy are to:

- manage the portfolio on a total return basis
- focus on 'return-generating' asset classes, which can reasonably be expected to generate attractive real returns over the long term
- have only limited exposure to 'risk-reducing' asset classes, because of their lower expected returns
- reduce risk by diversification, but accept that seeking high returns incurs volatility
- use active managers where it is reasonable to expect that the performance benefits will outweigh the additional costs.

Our approach to responsible investment

The Health Foundation is funded by an endowment that enables us to deliver an ongoing programme of work, including making significant grants to bring about better health and health care. We manage our endowment in a way that aims to generate long term income and growth to enable us to fulfil our charitable purpose, while ensuring that our assets are managed both ethically and responsibly.

We require all our fund managers to have an environmental, social and governance policy in place and recommend they adopt at least one of the following guidelines - the UK Stewardship Code or the United Nations Principles of Responsible Investment. We also ensure that environmental, social, governance and ethical factors are a standard part of our selection process when appointing new fund managers.

We do not invest directly in tobacco stocks. We also closely monitor our investment in pooled funds and if we identify any inadvertent exposure to tobacco stocks we engage with the relevant fund manager with the aim of establishing new funds.

We strive to implement responsible investment that is most aligned to the Foundation's mission and values. The Health Foundation is a member of the Charities Responsible Investment Network which is facilitated by ShareAction. We intend that this will strengthen

our approach to responsible investing where we want to use our investment portfolio to encourage businesses to behave responsibly.

Expenditure policy

The investment spending policy sets out the spending formula for the Foundation. Budgets are prepared annually alongside the business plan review. The spend targets in the budgets are modelled on the spending formula, and may be adjusted to take into account the needs of the Foundation and its operational capacity. The Foundation's support and governance spend is set by reference to the total spend level to ensure it remains reasonable and proportionate.

Grant-making policy

The Foundation sets out specific entitlement criteria for each programme at its launch. These criteria vary from programme to programme and are made available on our website. Applications are then assessed against these criteria and grants made taking into account funds available and the quality of applications. The period for which grants are awarded depends upon the programme but typically last between one and four years. Grants are monitored regularly and appropriate progress reports are required from recipients.

Reserves policy

The Foundation holds an Expendable Endowment fund which was created following the sale of PPP Healthcare Group (PPP) to Guardian Royal Exchange Group in 1998. It is the Foundation's policy to operate as a perpetual body and, in line with this policy, the governors seek to manage the Foundation's business, and in particular its investment returns and expenditure, so as to maintain the real value of this Expendable Endowment fund while providing the necessary income to fund the Foundation's ongoing charitable activities.

Within the above overall policy, governors are at any time able to use endowment capital to fund charity expenditure. Accordingly, Governors have determined that it is not necessary for the charity to hold reserves by way of separate unrestricted funds. Capital from the endowment equal to the excess of the Foundation's expenditure over its generated unrestricted income is applied as income each year such that at the year end the unrestricted fund balance is nil.

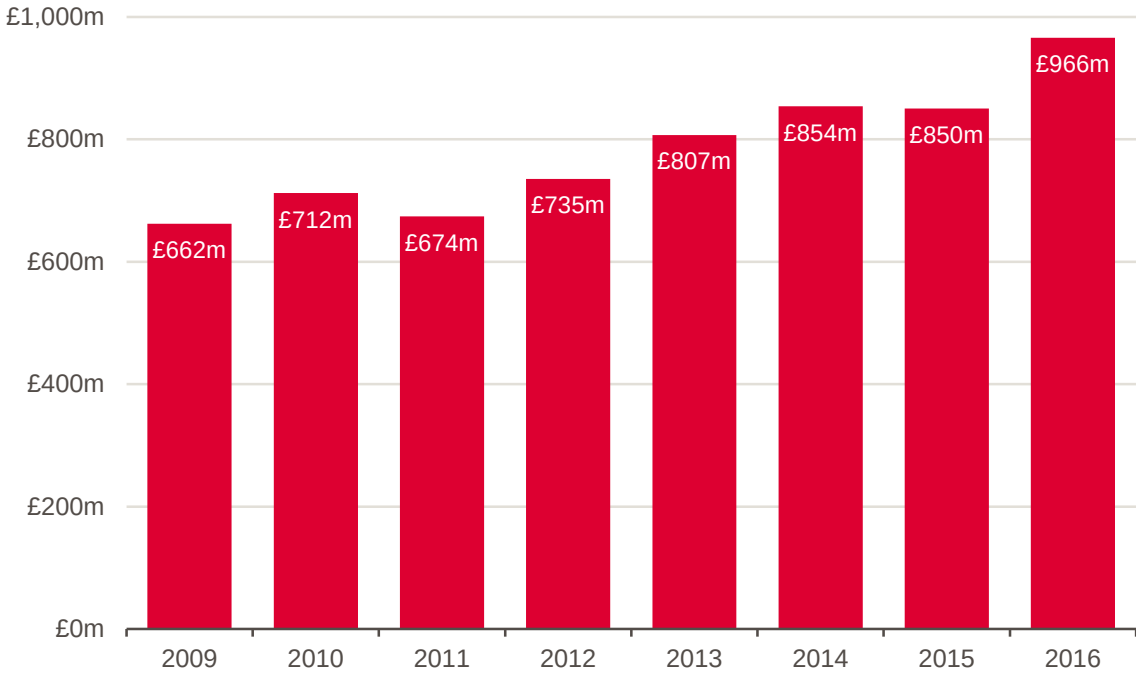
Investment returns

Our long-term goals for the management of our endowment investments are set out on pages 24–25 of this report. Based on these goals our return target is RPI+5% per annum, net of all investments fees and costs.

In 2016, the endowment fund returned a net of 18.0%, outperforming the RPI+5% target of 7.5% in that year. On a three-year annualised basis the fund returned 10.0%, exceeding the annual RPI+5% return target (10.0% per annum against 6.8% per annum), while on a five-year annualised basis the fund also exceeded the return target (10.9% per annum against 7.3% per annum.).

Figure 2 shows the change of the investments in value terms over time. In 2016, the value of the investments increased from £850m to £966m.

Figure 2: Investment values at 31 December 2016

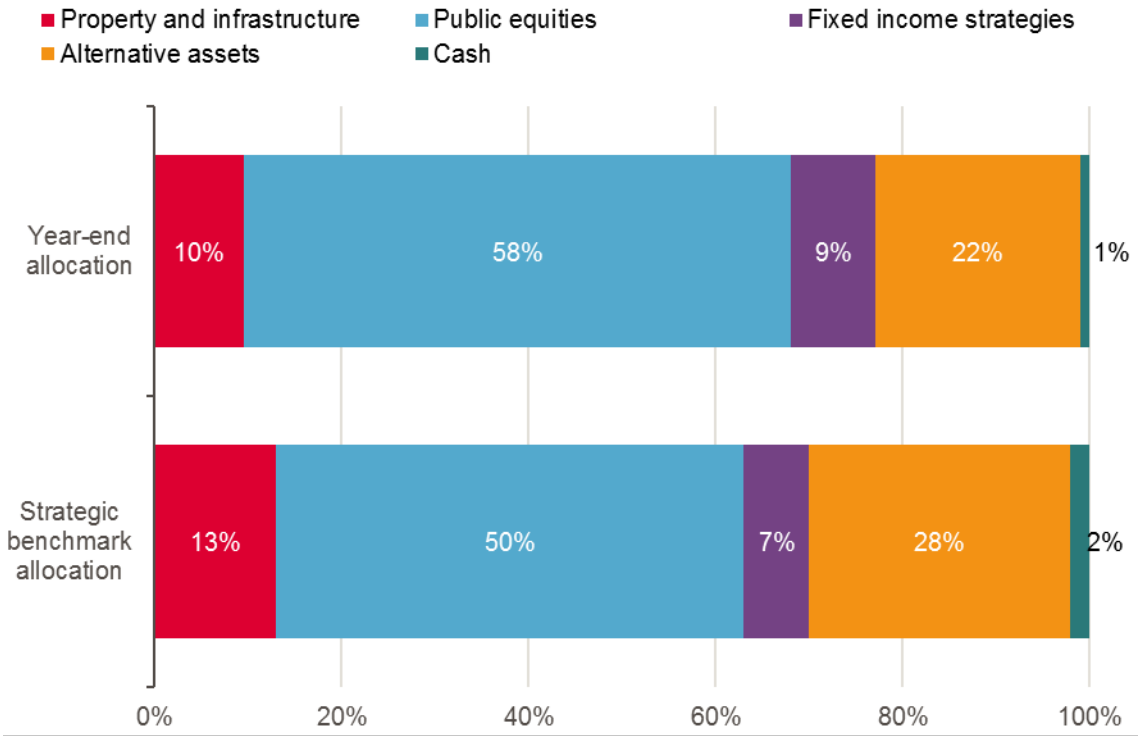


The structure of the investments is focused on global investing via a range of asset classes. The investments look to maximise returns while balancing acceptable levels of risk through a diversified asset portfolio.

The chart below shows the target strategic allocation (determined by the Investment Committee) together with the actual asset allocation at the end of 2016. The Investment Committee meet on a quarterly basis (and more frequently if required), and regularly review the long-term investment strategy and the implementation of that strategy.

The main overweight relative to the strategic benchmark allocation at the end of 2016 was in the public equity allocation. However, this was offset by an underweight in alternatives as we slowly build our private equity mandate and will source funding from overweight positions over time.

Figure 3: Asset allocation at 31 December 2016



Risk management

The Foundation's approach to managing risk, including roles and responsibilities, is set out in its risk management policy. A table of key risks owned by executive directors is reviewed by the Audit Committee and the board of governors regularly. The most important risks are detailed below.

Key risk	Nature of risk	Management of risk
Failure to achieve adequate returns on investments.	The Foundation makes poor investment decisions or suffers a sudden, major correction in market value.	The Investment Committee ensures that the Foundation's investments are suitably diversified, supported by an internal team, external advisers and external benchmarking. The committee believes that there is sufficient liquidity to meet the Foundation's cash requirements in the event of a sudden market correction.
Failure to secure the Foundation against cyber-attack	The Foundation's defences are inadequate, rendering it vulnerable to cyber-attack.	We have implemented a programme of work that strengthens our technical defences and sees people as a key part of those defences through training and maintaining awareness. Periodic penetration tests enable us to measure the success of our efforts.
Failure to secure sensitive data.	Inappropriate access to or management of sensitive data damages our reputation and prevents us from completing analytical work.	The executive team have set up a secure data environment with appropriate roles, responsibilities and data handling protocols. In addition, the underlying IT infrastructure has been strengthened.

Key risk	Nature of risk	Management of risk
Our work has insufficient impact.	The Foundation fails to address important or emerging issues or achieve a desired level of impact.	The Strategic Plan sets out our strategic priorities, which are reviewed each year. The executive team monitors the work plan and responds to changing priorities in-year. An assessment of the Foundation's impact is presented to the board of governors each year.
Our work is not of good enough quality.	We fail to ensure that our work is of the necessary quality and relevance, or our work makes use of flawed data.	We have a clear governance framework for reviewing work from the early stages through to publication. We check our work internally through peer review before it is sent externally for further peer review.
The major projects that we incubate and then release outside the organisation fail to thrive or bring us into disrepute	The projects that we release into the outside world fail to have impact proportionate to the amount we have invested in them and / or bring us reputational damage by association	We have strengthened our senior management team to oversee the relationships with stakeholders and potential stakeholders, during the period of incubation and through to release and beyond, as appropriate.

The risk management process is supported by a programme of review as part of an internal audit plan managed by BDO LLP, under the direction and approval of the Audit Committee.

Trustees' report

Structure, governance and management

The Health Foundation is a registered charity (No. 286967) and a company limited by guarantee (No. 1714937). It is governed by its memorandum and articles of association adopted on 24 July 1996 and last amended on 27 March 2012. The Foundation's endowment was first established in 1998.

The board of governors is responsible for the overall governance of the Foundation. Governors are appointed for a term of five years and may be appointed for a second term of up to four years. All governors are members and directors of the company and trustees of the registered charity. The current governors and any past governors who served during the year are listed in the table below together with the names of independent members of committees.

Name	Member/ governor	Nominations and Governance Committee	Audit Committee	Investment Committee	Remuneration Committee
Alan Langlands	Chair			✓	✓
David Dalton	✓		✓		
Murray Easton	✓	✓	✓		
Margaret Goose (stepped down	✓		✓		✓
Martyn Hole	✓		✓	✓	
Deirdre Kelly (stepped down July 2016)	✓	✓			
Bridget McIntyre	✓		Chair		
Andrew Morris	✓	✓			
Melloney Poole	✓	Chair			Chair
David Zahn	✓			Chair	✓
Branwen Jeffreys	✓	✓			
Rosalind Smyth (Appointed April 2016)	✓				✓

The following served as independent members of committees during 2016.

Name	Audit Committee	Investment Committee
Peter Mallinson		✓
Michelle McGregor Smith		✓
David Smith	✓	
Richard Williams		✓

In order to increase the effectiveness of the governors' roles and responsibilities, they are appointed to match specifications that are relevant to specific aspects of the Foundation's work. This ensures a relevant and balanced mix of skills and experience on the board.

The board meets at least four times a year. At these meetings it reviews strategy and operational/investment performance and approves operating plans and budgets. Regular performance reports are provided to the board, as well as the minutes of committee meetings, to assist it in fulfilling its role of monitoring and evaluating the organisation's performance.

All new governors receive a comprehensive induction. Refresher sessions on relevant topics are arranged for governors periodically.

Organisational structure and how decisions are made

The board of governors has set down a schedule of matters specifically reserved to it for decision. These include:

- board appointments
- the appointment and terms of reference of any committee of the board and any matters expressly reserved for the decision of the board by any such terms of reference
- approval of annual financial statements and annual business plan and budget
- changes to the Foundation's investment policy.

In addition, the following committees are established as committees of the board of the Foundation in accordance with the articles of association. Each operates in accordance with terms of reference, which ensure that the committee is properly constituted with an appropriate membership of governors, experienced independent members (in the case of the Audit and Investment Committees) and a clear set of responsibilities and authorities.

- **The Nominations and Governance Committee** is responsible for pro-actively monitoring and advising on the size and composition of the board of governors; the selection and recruitment of governors and the processes to be adopted in support of that activity; the induction and training of governors; and reviews of board performance, as requested by the board.

- **The Audit Committee** assists the board in meeting its responsibilities in respect of financial reporting; provides a channel of communication between the Foundation's external auditors and the board; provides direction and approves the implementation of the Foundation's risk management strategy and internal audit process.
- **The Investment Committee** assists the board with developing and setting an investment policy that is appropriate to the Foundation's needs. It also devises and implements an investment strategy that can be expected to meet the Foundation's investment objectives. This includes setting asset allocation, deciding and implementing manager arrangements, and monitoring performance. The chief executive and the chief investment officer are members of this committee.
- **The Remuneration Committee** approves the framework and policy determining the overall reward strategy applicable to all Foundation staff. It is also responsible for determining the reward, benefits and compensation for the individual members of the directors' team.

The board of governors delegates the exercise of certain powers in connection with the management and administration of the Foundation to the executive team managed by the chief executive.

Senior management

The chief executive is responsible for the day-to-day management of the Foundation's affairs and for implementing policies agreed by the board of governors. The chief executive is assisted by a group of staff referred to as the 'directors' and those who served during 2016 are listed below. It should be noted that although these directors are the senior executive team of the charity they are not the 'legal' directors of the charitable company.

Jennifer Dixon	Chief Executive
Jo Bibby	Director of Strategy and Innovation
Aidan Kearney	Chief Investment Officer
Anita Charlesworth	Director of Research and Economics
Cathy Irving	Director of Communications
Richard Taunt	Director of Policy (resigned May 2016)
Mike Wetherell	Chief Operating Officer (resigned July 2016)
Adam Steventon	Director of Data Analytics
Will Warburton	Director of Improvement
Paul Hackwell	Director of Finance and Operations (from January 2017)

The charity's registered office and list of key advisers can be found in the legal and administrative information at the front of these accounts.

Principal activities and development

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. It achieves this through supporting people and organisations. Further information on the charity's activities and developments are included in the strategic report on pages 9–29.

Statement of governors' responsibilities

The governors are responsible for the preparation of their annual report, including the strategic report and governors' report, and the financial statements in accordance with applicable law and UK Generally Accepted Accounting Practice. Company law requires the governors to prepare financial statements for each financial year that give a true and fair view of the state of affairs of the charitable company and the group and of the incoming resources and application of resources, including the income and expenditure, of the charitable group for that period.

In preparing these financial statements, the governors are required to:

- ensure that the most suitable accounting policies are established and applied consistently
- make judgements and estimates that are reasonable and prudent
- state whether the applicable accounting standards and statement of recommended accounting practice have been followed, subject to any material departures disclosed and explained in the financial statements
- prepare the financial statements on a going concern basis unless it is inappropriate to presume that the Foundation will continue in operation.

The governors have overall responsibility for ensuring that the Foundation has appropriate systems and controls, financial and otherwise. They are responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the Foundation and enable them to ensure that the financial statements comply with the Companies Act 2006. They are also responsible for safeguarding the assets of the Foundation and for their proper application as required by charity law, and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities and to provide reasonable assurance that:

- the Foundation is operating efficiently and effectively
- all assets are safeguarded against unauthorised use or disposition and are properly applied
- proper records are maintained and financial information used within the Foundation, or for publication, is reliable
- the Foundation complies with relevant laws and regulations.

Each of the governors has confirmed, as far as the governors are aware, there is no relevant audit information of which the Foundation's auditors are unaware. The governors have each taken all the steps that they ought to have taken as governors in order to make themselves aware of any relevant audit information and to establish that the Foundation's auditors are aware of that information.

Processes are in place to ensure that performance is monitored and that appropriate management information is prepared and reviewed regularly by both the directors' team and

the board of governors. Internal controls over all forms of commitment and expenditure continue to be refined to improve efficiency.

The systems of internal control are designed to provide reasonable but not absolute assurance against material misstatement or loss.

They include:

- a strategic plan, annual business plan and budget approved by the governors
- regular consideration by the governors of financial results, variances from budgets, non-financial performance indicators and benchmarking reviews
- delegation of day-to-day management authority and segregation of duties
- identification and management of risks
- a programme of internal audits.

Declarations and conflicts of interest policy

The Foundation has drawn up and implemented a declarations and conflicts of interest policy that explains the nature of potential conflicts of interest. It requires governors, independent members of committees, employees and other defined categories of individual with whom the Foundation works from time to time, to declare all interests and provides a framework for managing situations when conflicts arise. Governors, independent members of committees and employees are also required to notify the Head of Operations of any association with a body or organisation which is or might become an applicant for funds from the Foundation. A register of all notifications received is kept and those interests declared by governors and members of the directors' team are reviewed regularly by the directors and produced for inspection at all board meetings.

Details of transactions with related parties are set out in note 27 on pages 57–58.

The Foundation has a comprehensive whistle-blowing policy**.**

None of the governors has any beneficial interest in the company. All the governors are members of the company and guarantee to contribute £1 in the event of a winding up.

This Governors' report, prepared under the Charities Act 2011 and the Companies Act 2006, was approved by the governors on 7 July 2017, in their capacities as trustees of the charity and directors of the company. This included their approval of the Trustees' and strategic reports contained within it. The Trustees' report is signed as authorised on their behalf by:

Signed

Sir Alan Langlands 7 July 2017

Chair

Auditor's report and financial statements

Independent auditor's report to the members of the Health Foundation

We have audited the financial statements of The Health Foundation for the year ended 31 December 2016 which comprise the Consolidated Statement of Financial Activities, the Consolidated Balance Sheet, the Company Balance Sheet, the Consolidated Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice), including Financial Reporting Standard 102.

This report is made solely to the charitable company's members, as a body, in accordance with Chapter 3 of Part 16 of the Companies Act 2006. Our audit work has been undertaken so that we might state to the charitable company's members those matters we are required to state to them in an auditors' report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charitable company and its members as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of governors and auditor

As explained more fully in the statement of governors' responsibilities, the governors, who are also the directors of The Health Foundation for the purposes of company law are responsible for the preparation of the accounts and for being satisfied that they give a true and fair view.

We have been appointed auditor under the Companies Act 2006 and report in accordance with those Acts. Our responsibility is to audit and express an opinion on the accounts in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the accounts

A description of the scope of an audit of financial statements is provided on the Financial Reporting Council's website at www.frc.org.uk/auditscopeukprivate.

Opinion on accounts

In our opinion the accounts:

- give a true and fair view of the state of the group and the charitable company's affairs as at 31 December 2016 and of the group’s incoming resources and application of resources, including its income and expenditure, for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice, including Financial Reporting Standard 102; and
- have been prepared in accordance with the requirements of the Companies Act 2006.

Opinion on other matter prescribed by the Companies Act 2006

In our opinion the information given in the Governors' Report, including Strategic Report, for the financial year for which the accounts are prepared is consistent with the accounts and the Governors’ Report has been prepared in accordance with applicable legal requirements.

Matters on which we are required to report by exception

In the light of the knowledge and understanding of the company and its environment obtained in the course of the audit, we have not identified material misstatements in the Governors' Report, including Strategic Report.

We have nothing to report in respect of the following matters where the Companies Act 2006 requires us to report to you if, in our opinion:

- adequate accounting records have not been kept, or returns adequate for our audit have not been received from branches not visited by us; or
- the accounts are not in agreement with the accounting records and returns; or
- certain disclosures of trustees' remuneration specified by law are not made; or
- we have not received all the information and explanations we require for our audit.

Signed

Subarna Banerjee (Senior Statutory Auditor) 10 July 2017
for and on behalf of UHY Hacker Young

Chartered Accountants
Statutory Auditor

Consolidated statement of financial activities for the year ended 31 December 2016

	Notes	Unrestricted funds £'000	Restricted funds £'000	Endowment funds £'000	Total 2016 £'000	Total 2015 £'000
Income from:						
Charitable activities	3	124	1,025	-	1,149	1,111
Investments	4	13,790	-	-	13,790	14,401
Capital applied to income	5	17,807	-	(17,807)	-	-
Total income		31,721	1,025	(17,807)	14,939	15,512
Expenditure						
Raising funds	6	-	-	9,330	9,330	9,654
Charitable activities	7	31,721	805	-	32,526	28,195
Total resources expended		31,721	805	9,330	41,856	37,849
Net gains on investments	12	-	-	145,785	145,785	18,644
Net income / (expenditure) for the year		-	220	118,648	118,868	(3,693)
Fund balances at 1 January 2016		-	391	827,464	827,855	831,548
Fund balances at 31 December 2016		-	611	946,112	946,723	827,855

The statement of financial activities includes all gains and losses recognised in the year.

All income and expenditure derive from continuing activities.

Consolidated balance sheet for the year ended 31 December 2016

	Notes	2016 £'000	2016 £'000	2015 £'000	2015 £'000
Fixed assets					
Intangible assets	13		933		-
Tangible assets	14		1,307		1,243
Investments	15		966,088		849,691
Programme related investment	15		526		526
			968,854		851,460
Current assets					
Debtors	17	757		699	
Cash at bank and in hand		2,160		2,257	
		2,917		2,956	
Creditors: amounts falling due within one year	18	(17,763)		(17,456)	
Net current liabilities			(14,846)		(14,500)
Total assets less current liabilities			954,008		836,960
Creditors: amounts falling due after more than one year	19		(6,499)		(8,278)
Provisions for liabilities			(786)		(827)
Net assets			946,723		827,855
Capital funds					
Endowment funds – general			946,112		827,464
Income funds					
Restricted funds			611		391
Unrestricted funds			-		-
			946,723		827,855

The accounts were approved by the Governors, and authorised for issue, on 7 July 2017 and signed by:

Sir Alan Langlands

Trustee

Bridget McIntyre

Trustee

Company Registration No. 1714937

Company balance sheet for the year ended 31 December 2016

	Notes	2016 £'000	2016 £'000	2015 £'000	2015 £'000
Fixed assets					
Intangible assets	13		933		-
Tangible assets	14		1,307		1,243
Investments	15		744,347		655,369
Investments in subsidiaries	15		222,267		194,848
			968,854		851,460
Current assets					
Debtors	17	763		707	
Cash at bank and in hand		2,151		2,249	
		2,914		2,956	
Creditors: amounts falling due within one year	18	(17,760)		(17,456)	
Net current liabilities			(14,846)		(14,500)
Total assets less current liabilities			954,008		836,960
Creditors: amounts falling due after more than one year	19		(6,499)		(8,278)
Provisions for liabilities			(786)		(827)
Net assets			946,723		827,855
Capital funds					
Endowment funds – general			946,112		827,464
Income funds					
Restricted funds			611		391
Unrestricted funds			-		-
			946,723		827,855

The accounts were approved by the Governors, and authorised for issue, on 7 July 2017 and signed by:

Sir Alan Langlands

Trustee

Bridget McIntyre

Trustee

Company Registration No. 1714937

Consolidated statement of cash flows for the year ended 31 December 2016

	Notes	2016 £'000	2016 £'000	2015 £'000	2015 £'000
Cash flows from operating activities					
Cash absorbed by operations	29		(32,354)		(28,695)
Investment activities					
Cost of developing intangible assets		(933)		-	
Purchase of tangible fixed assets		(657)		(264)	
Investment proceeds re-invested		(13,776)		(14,384)	
Withdrawals from investments		43,163		36,993	
Investment management fees		(9,330)		(9,654)	
Investment income		13,790		14,401	
Net cash generated from investing activities			32,257		27,092
Net decrease in cash and cash equivalents			(97)		(1,603)
Cash and cash equivalents at beginning of year			2,257		3,860
Cash and cash equivalents at end of year			2,160		2,257

Charity information

The Health Foundation is a private company limited by guarantee incorporated in England and Wales.

The registered office is 90 Long Acre, London, WC2E 9RA.

The liability of the governors in their capacity as members of the company is limited. Each member guarantees any deficiency in the Foundation to a maximum of £1.

1.0 Accounting policies

1.1 Accounting convention

These accounts have been prepared in accordance with FRS 102 “The Financial Reporting Standard applicable in the UK and Republic of Ireland” (“FRS 102”), “Accounting and Reporting by Charities” the Statement of Recommended Practice for charities applying FRS 102, the Companies Act 2006 and UK Generally Accepted Accounting Practice as it applies from 1 January 2015. The Foundation is a Public Benefit Entity as defined by FRS 102.

The accounts are prepared in sterling, which is the functional currency of the Foundation. Monetary amounts in these financial statements are rounded to the nearest £'000.

The accounts have been prepared under the historical cost convention, modified to include certain financial instruments at fair value. The principal accounting policies adopted are set out below.

1.2 Basis of consolidation

The financial statements consolidate the charity and its wholly owned subsidiary entities, The Victoria Fund LP Incorporated and Medtrust Innovations Limited.

In accordance with section 408 of the Companies Act 2006, no separate Statement of Financial Activities has been presented for the charity. However, due to the nature of the charity’s subsidiaries, the overall net movement in funds of the charity is the same for the group.

1.3 Going concern

At the time of approving the financial statements, the governors have a reasonable expectation that the Foundation has adequate resources to continue in operational existence for the foreseeable future. Thus the governors continue to adopt the going concern basis of accounting in preparing the financial statements.

1.4 Charitable funds

The Foundation maintains three types of funds: unrestricted funds, restricted funds and expendable endowment funds. Income and expenditure on these funds are shown separately in the statement of the financial activities.

Unrestricted funds are available for use at the discretion of the governors in furtherance of their charitable objectives unless the funds have been designated for other purposes. The income is made up of investment income, other incoming resources and any capital applied as income.

Restricted funds are subject to specific conditions as to how they may be used. The purposes and uses of the restricted funds are set out in the notes to the accounts.

Expendable endowment funds represent capital gifted for the long-term benefit of the Foundation. Any income arising from the Endowment fund assets is added to the unrestricted fund. The trustees may also, at their discretion, determine to apply part or all of the endowment capital as income at which time the relevant amounts are transferred to the unrestricted fund.

1.5 Incoming resources

Income is recognised when dividends and interest are receivable, and includes recoverable taxation. Income received but not distributed by pooled funds is included as part of the net gains on investments in the statement of financial activities.

1.6 Resources expended

Expenditure is recognised on an accruals basis. Irrecoverable VAT is included within the expense items to which it relates.

Expenditure on raising funds represents amounts paid to the Foundation's external investment advisers and custodian, and an apportionment of internal support costs based on time spent. They are charged to the endowment fund, as the primary role of the investment managers and the custodian is to safeguard the investment assets of the Foundation.

Charitable activities comprise all costs incurred in the pursuit of charitable objects. These are:

- Grants including programme costs where an actual/constructive obligation exists, notwithstanding that they may be paid in future accounting periods. However, where conditions attach to the grant such that it is a performance-related grant then this is charged as the conditions are satisfied and are expensed as the related activity is performed.
- Salary costs that can be directly attributed to strategic, programme and policy work. It also includes the cost pertaining to support staff.
- Overheads such as the rent and running costs of the office space. These costs are allocated to charitable strategic priorities based on the relevant proportions of the direct costs of the charitable activities.

Governance costs comprise all costs attributable to ensuring the public accountability of the Foundation and its compliance with regulation and good practice. These costs include costs related to statutory and internal audit together with an apportionment of support costs based on time spent.

Retirement pensions and related benefits to defined contribution schemes are charged to the unrestricted fund in the accounting year in which the contributions are paid. Provision is

made for the discounted expected future costs of unfunded pension benefit commitments at each balance sheet date, based on actuarial advice.

1.7 Intangible fixed assets other than goodwill

Research expenditure is written off against profits in the year in which it is incurred. Identifiable development expenditure is capitalised to the extent that the technical, commercial and financial feasibility can be demonstrated.

Intangible assets comprise internal development costs with respect to the AIMS System and the Q Project. These assets are defined as having finite useful lives and the costs are amortised on a straight line basis over their estimated useful lives of 7 years. Intangible assets are stated at cost less amortisation and are reviewed for impairment whenever there is an indication that the carrying value may be impaired.

1.8 Tangible fixed assets

Tangible fixed assets are initially measured at cost and subsequently measured at cost or valuation, net of depreciation and any impairment losses. Tangible fixed assets with a value over £1,000 are capitalised. Depreciation is recognised so as to write off the cost or valuation of assets less their residual values over their useful lives on the following bases:

Fixtures and fittings	5 years
Computers	3 years

The gain or loss arising on the disposal of an asset is determined as the difference between the sale proceeds and the carrying value of the asset, and is recognised in net income/(expenditure) for the year.

1.9 Fixed asset investments

Fixed asset investments comprise both quoted and unquoted investments and are initially measured at transaction price excluding transaction costs, and are subsequently measured at fair value at each reporting date. Changes in fair value are recognised in net income/(expenditure) for the year. Transaction costs are expensed as incurred.

Quoted investments are listed shares, bonds and units and are stated at fair value on the basis equivalent to market value using the bid price. Asset sales and purchases are recognised at the date of trade.

Unquoted investments are stated at fair value based on professional valuations at the balance sheet date or nearest available date to it. For hedge funds, the valuations are provided by third-party hedge fund administrators. In the case of private equity funds, there is no readily identifiable market price. These funds are included at the most recent valuations by their respective managers. Investments made shortly before the balance sheet date are held at cost where the managers have yet to provide a valuation.

A subsidiary is an entity controlled by the Foundation. Control is the power to govern the financial and operating policies of the entity so as to obtain benefits from its activities. Subsidiaries are included in the Foundation's balance sheet at their net asset value which

represents the fair value of their underlying investments and other net assets. Investments in subsidiary undertakings are held at cost less any impairment.

Unrealised gains and losses are recognised at the year-end as the difference between the historical cost and the market value of the investment assets. Realised gains and losses are recognised during the year at the time the investment is sold, and include any fees incurred at source. All unrealised and realised gains and losses on investments are included within the statement of financial activities.

1.10 Impairment of fixed assets

At each reporting end date, the Foundation reviews the carrying amounts of its tangible and intangible assets to determine whether there is any indication that those assets have suffered an impairment loss. If any such indication exists, the recoverable amount of the asset is estimated in order to determine the extent of the impairment loss (if any).

Recoverable amount is the higher of fair value less costs to sell and value in use. In assessing value in use, the estimated future cash flows are discounted to their present value using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the asset for which the estimates of future cash flows have not been adjusted.

If the recoverable amount of an asset is estimated to be less than its carrying amount, the carrying amount of the asset is reduced to its recoverable amount. An impairment loss is recognised immediately in income/(expenditure) for the year, unless the relevant asset is carried at a revalued amount, in which case the impairment loss is treated as a revaluation decrease.

Recognised impairment losses are reversed if, and only if, the reasons for the impairment loss have ceased to apply. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of its recoverable amount, but so that the increased carrying amount does not exceed the carrying amount that would have been determined had no impairment loss been recognised for the asset in prior years. A reversal of an impairment loss is recognised immediately, unless the relevant asset is carried at a revalued amount, in which case the reversal of the impairment loss is treated as a revaluation increase.

1.11 Cash and cash equivalents

Cash and cash equivalents include cash in hand, deposits held at call with banks, other short-term liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts are shown within borrowings in current liabilities.

1.12 Financial instruments

The Foundation has elected to apply the provisions of Section 11 ‘Basic Financial Instruments’ and Section 12 ‘Other Financial Instruments Issues’ of FRS 102 to all of its financial instruments.

Financial instruments are recognised in the Foundation's balance sheet when the Foundation becomes party to the contractual provisions of the instrument.

Financial assets and liabilities are offset, with the net amounts presented in the financial statements, when there is a legally enforceable right to set off the recognised amounts and there is an intention to settle on a net basis or to realise the asset and settle the liability simultaneously.

Basic financial assets
Basic financial assets, which include debtors and cash and bank balances, are initially measured at transaction price including transaction costs and are subsequently carried at amortised cost using the effective interest method unless the arrangement constitutes a financing transaction, where the transaction is measured at the present value of the future receipts discounted at a market rate of interest. Financial assets classified as receivable within one year are not amortised.

Basic financial liabilities
Basic financial liabilities, including trade creditors and grants payable are initially recognised at transaction price unless the arrangement constitutes a financing transaction, where the debt instrument is measured at the present value of the future receipts discounted at a market rate of interest. Financial liabilities classified as payable within one year are not amortised.

Debt instruments are subsequently carried at amortised cost, using the effective interest rate method.

Trade creditors are obligations to pay for goods or services that have been acquired in the ordinary course of operations from suppliers. Amounts payable are classified as current liabilities if payment is due within one year or less. If not, they are presented as non-current liabilities. Trade creditors are recognised initially at transaction price and subsequently measured at amortised cost using the effective interest method.

Derecognition of financial liabilities
Financial liabilities are derecognised when the Foundation's contractual obligations expire or are discharged or cancelled.

1.13 Provisions

Provisions are recognised when the Foundation has a legal or constructive present obligation as a result of a past event, it is probable that the Foundation will be required to settle that obligation and a reliable estimate can be made of the amount of the obligation.

The amount recognised as a provision is the best estimate of the consideration required to settle the present obligation at the reporting end date, taking into account the risks and uncertainties surrounding the obligation.

Where the effect of the time value of money is material, the amount expected to be required to settle the obligation is recognised at present value. When a provision in measured at present value the unwinding of the discount is recognised as a finance cost in net income/(expenditure) in the period it arises.

1.14 Employee benefits

The cost of any unused holiday entitlement is recognised in the period in which the employee's services are received.

Termination benefits are recognised immediately as an expense when the Foundation is demonstrably committed to terminate the employment of an employee or to provide termination benefits.

1.15 Retirement benefits

Retirement pensions and related benefits to defined contribution schemes are charged to the unrestricted fund in the accounting year in which the contributions are paid.

1.16 Leases

Rentals payable under operating leases, including any lease incentives received, are charged to income on a straight line basis over the term of the relevant lease.

1.17 Foreign exchange

Transactions in currencies other than pounds sterling are recorded at the rates of exchange prevailing at the dates of the transactions. At each reporting end date, monetary assets and liabilities that are denominated in foreign currencies are retranslated at the rates prevailing on the reporting end date. Gains and losses arising on translation are included in net income/expenditure for the period.

1.18 Exemptions

The charitable company has taken advantage of the exemptions in FRS 102 not to present a company only cash flow statement and certain disclosures about the company's financial instruments. The company has taken advantage of the legal dispensation granted under S.408 of the Companies Act 2006 allowing it not to present its own statement of financial activities The company's net income for the year is £118,868k (2015: net expenditure £3,693k).

2.0 Critical accounting estimates and judgements

In the application of the Foundation's accounting policies, the governors are required to make judgements, estimates and assumptions about the carrying amount of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised where the revision affects only that period, or in the period of the revision and future periods where the revision affects both current and future periods.

The estimates and assumptions which have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities are outlined below:

Investment valuation
The Foundation's investments are stated at market value. Fixed asset investments comprise both quoted and unquoted investments and are initially measured at transaction price excluding transaction costs, and are subsequently measured at fair value at each reporting date. Changes in fair value are recognised in net income/(expenditure) for the year . Transaction costs are expensed as incurred. Valuations are obtained from the investment

managers. Directors do not believe that there is any inherent uncertainty in the presentation of these amounts, and that in their judgement, market value and fair value may be regarded as identical for the purpose of these accounts.

3.0 Charitable activities

	Share of profit in BMJ quality & safety £'000	Other income £'000	Total 2016 £'000	Total 2015 £'000
Other income	109	1,040	1,149	1,111
Analysis by fund				
Unrestricted funds	109	15	124	
Restricted funds	-	1,025	1,025	
	109	1,040	1,149	
For the year ended 31 December 2015				
Unrestricted funds	125	11		136
Restricted funds	-	975		975
	125	986		1,111

4.0 Investments

	2016 £'000	2015 £'000
Income from listed investments	7,677	8,050
Fixed interest income	2,152	2,110
Property fund income	3,961	4,241
	13,790	14,401

5.0 Capital applied to income

	Unrestricted funds £'000	Endowment funds general £'000	Total 2016 £'000	Total 2015 £'000
Released from endowment funds	17,807	(17,807)	-	-
For the year ended 31 December 2015	13,074	(13,074)		-

6.0 Raising funds

	2016 £'000	2015 £'000
Cost of raising funds		
Investment advisory costs	102	163
Staff costs	188	172
Custodian fees	82	101
Cost of raising funds	372	436
Investment managers' fees	8,958	9,218
	9,330	9,654

7.0 Charitable activities

	Improving service delivery £'000	Improving public policy £'000	Improving population health £'000	Others £'000	Total 2016 £'000	Total 2015 £'000
Grant funding of activities (see note 8)	14,448	3,219	571	216	18,454	15,797
Share of support costs (see note 9)	10,924	2,435	432	164	13,955	12,158
Share of governance costs (see note 9)	91	21	4	1	117	240
	25,463	5,675	1,007	381	32,526	28,195
Analysis by fund						
Unrestricted funds	24,799	5,561	987	374	31,721	
Restricted funds	664	114	20	7	805	
	25,463	5,675	1,007	381	32,526	
For the year ended 31 December 2015						
Unrestricted funds	21,768	4,175	1,176	492		27,611
Restricted funds	584	-	-	-		584
	22,352	4,175	1,176	492		28,195

8.0 Grant funding

	Improving service delivery £'000	Improving public policy £'000	Improving population health £'000	Others £'000	Total 2016 £'000	Total 2015 £'000
Grants to institutions (see note 30)	14,448	3,219	571	216	18,454	15,797

9.0 Support costs

		Support costs £'000	Governance costs £'000	2016 £'000	2015 £'000
Staff costs		7,266	-	7,266	6,658
Depreciation		593	-	593	477
Property costs		1,295	-	1,295	1,335
Technology costs		827	-	827	418
Other support costs		3,974	-	3,974	3,279
Audit fees	-	30	30	46	
Legal and professional		-	4	4	49
Internal audit	-	51	51	33	
Other governance costs		-	23	23	71
Governor training and recruitment	-	9	9	32	
		13,955	117	14,072	12,398

Support costs have been allocated to charitable activities in the year.

Governance costs include payments to the auditors of £30,000 (2015: £37,800) for audit fees and £6,000 (2015: £5,000) for non-audit services.

10.0 Governors

None of the governors (or any persons connected with them) received any remuneration or benefits from the Foundation during the year.

11.0 Employment costs

	2016 £'000	2015 £'000
Wages and salaries	5,911	5,698
Social security costs	653	606
Other pension costs	679	442
Other costs	211	85
	7,455	6,831

The average number of employees during the year was 117 (2015: 111) which equated to full time equivalent of 111 (2015: 109).

Employment costs include salary costs relating to fundraising of £188k (2015: £172k).

The number of employees whose annual remuneration was £60,000 or more were:

	2016 Number	2015 Number
60,001 – 70,000	6	6
70,001 – 80,000	2	2
80,001 – 90,000	3	3
90,001 – 100,000	4	4
100,001 – 110,000	2	2
110,001 – 120,000	2	2
130,001 – 140,000	1	1
160,001 – 170,000	1	1
220,001 – 230,000	1	1

12.0 Net gains on investments

	2016 £'000	2015 £'000
Revaluation of investments	145,785	18,644

13.0 Intangible fixed assets

Group and Charity	Software £'000	Q Project £'000	Total £'000
Cost			
At 1 January 2016	-	-	-
Additions – internally developed	395	538	933
At 31 December 2016	395	538	933
Amortisation and impairment			
At 1 January 2016 and 31 December 2016	-	-	-
Carrying amount			
At 31 December 2016	395	538	933
At 31 December 2015	-	-	-

The intangible asset of £395k relates to the development of grant management software (AIMS) where the benefit is expected to come through in January 2017 with a useful life of 7 years.

The Q Initiative identifies and connects people skilled in improvement across the UK, through online and events-based capabilities that promote knowledge-sharing, development and other improvement activities. This network is currently under development.

14.0 Tangible fixed assets

Group and charity	Fixtures and fittings £'000	Computer equipment £'000	Total £'000
Cost			
At 1 January 2016	1,370	1,022	2,392
Additions	140	517	657
At 31 December 2016	1,510	1,539	3,049
Depreciation and impairment			
At 1 January 2016	616	533	1,149
Depreciation charged in the year	235	358	593
	851	891	1,742
Carrying amount			
At 31 December 2016	659	648	1,307
At 31 December 2015	754	489	1,243

15.0 Fixed asset investments

Group

	Investments		
	Portfolio £'000	Other £'000	Total £'000
Valuation			
At 1 January 2016	849,691	526	850,217
Valuation changes	145,785	-	145,785
Income	13,776	-	13,776
Investment management costs included in the fund	(6,793)	-	(6,793)
Net withdrawals from portfolio	(36,371)	-	(36,371)
At 31 December 2016	966,088	526	966,614
Cost			
At 31 December 2016	729,331	526	729,857
At 31 December 2015	731,660	526	732,186

	Notes	2016 £'000	2015 £'000
Other investments comprise:			
Programme related investments	28	526	526

	2016 £'000	2015 £'000
Investments at fair value comprise:		
Property funds	92,871	92,643
Equities	559,405	462,851
Fixed interest	83,340	72,160
Alternatives	215,392	191,029
Cash	15,080	31,008
	966,088	849,691

Charity

	Investments		
	Portfolio £'000	Other £'000	Total £'000
Valuation			
At 1 January 2016	655,369	194,848	850,217
Valuation changes	125,714	20,071	145,785
Income	13,048	728	13,776
Investment management costs included in the fund	(1,913)	(4,880)	(6,793)
Net (withdrawals)/Additions from/to portfolio	(47,871)	11,500	(36,371)
At 31 December 2016	744,347	222,267	966,614
Cost			
At 31 December 2016	557,739	172,118	729,857
At 31 December 2015	562,878	169,308	732,186

	Notes	2016 £'000	2015 £'000
Other investments comprise:			
Investment in subsidiaries	28	221,741	194,322
Programme related investments	28	526	526

	2016 £'000	2015 £'000
Investments at fair value comprise:		
Property funds	92,871	92,643
Equities	559,405	462,851
Fixed interest	73,540	62,795
Alternatives	3,790	6,599
Cash	14,740	30,481
	744,347	655,369

A currency hedging programme was in place during the year to manage foreign currency exchange risk. At 31 December 2016, the group had open foreign exchange forward contracts. These contracts were entered into to mitigate any currency risk between USD and Sterling on the hedge fund mandate in the Victoria Fund. These foreign exchange forward

contracts have been revalued at the applicable year end revaluation rate and the resulting unrealised gains/(losses) are included within the overall value of the investments above. At 31 December 2016, the Victoria Fund held contracts to buy $82,731k (£65,671k at an average rate of $1.26) and £272,179k ($357,928 at an average rate of $1.32), (2015: $46,579k and £188,488k). The unrealised gain/(loss) associated with these forward currency contracts totalled (£15,525k) as at 31 December 2016 (2015: (£4,414k)).

The Victoria Fund's underlying hedge fund investments provide varying degrees of liquidity based on their own redemption terms, which typically begin with an initial lock-up period. These investments are made on an ongoing basis. As a result, the Victoria Fund may not be able to quickly liquidate all of its investments. As investment lock-up periods ease in future periods, more short-term liquidity is expected.

The following table illustrates the expected liquidity of assets and liabilities held as at 31 December 2016.

	Less than 6 months £'000	6–12 months £'000	More than 12 months £'000	Long-term lock up* £'000
Total non-current assets	-	-	7,941	56,422
Total current assets	132,865	41,650	-	-
Total current liabilities	15,839	1,014	-	-

***** This relates to underlying funds in the Victoria Fund, whose redemptions have been locked up and private equity funds which have no redemption opportunities.

At the balance sheet date, the Foundation had unfunded investment commitments of £70,310k for private equity and infrastructure from total commitments of £126,060k. These commitments form part of the planned asset allocation and will be met from within the existing investments.

16.0 Financial instruments

Group

	2016 £'000	2015 £'000
Carrying amount of financial assets		
Debt instruments measured at amortised cost	290	249
Instruments measured at fair value through profit or loss	966,088	849,691
Carrying amount of financial liabilities		
Measured at amortised cost	24,262	25,734

Charity

	2016 £'000	2015 £'000
Carrying amount of financial assets		
Debt instruments measured at amortised cost	188	132
Instruments measured at fair value through profit or loss	744,347	655,369
Carrying amount of financial liabilities		
Measured at amortised cost	24,259	25,734

17.0 Debtors: Amounts falling due within one year

	Group 2016 £'000	Group 2015 £'000	Charity 2016 £'000	Charity 2015 £'000
Amounts due from subsidiary undertakings	-	-	109	125
Other debtors	290	249	187	132
Prepayments and accrued income	467	450	467	450
	757	699	763	707

18.0 Creditors: amounts falling due within one year

	Group 2016 £'000	Group 2015 £'000	Charity 2016 £'000	Charity 2015 £'000
Other taxation and social security	2	4	2	4
Trade creditors	1,242	85	1,239	85
Grants payable	14,462	15,029	14,462	15,029
Other creditors	556	776	556	776
Accruals and deferred income	1,501	1,562	1,501	1,562
	17,763	17,456	17,760	17,456

19.0 Creditors: amounts falling due after more than one year

	2016 £'000	2015 £'000
Grants payable – in two to five years	6,499	8,278

20.0 Grants payable

Group and charity

	2016 £'000	2015 £'000
As at 1 January	23,307	25,538
Grants committed in the year	18,454	15,797
Paid during the year	(20,800)	(18,028)
As at 31 December	20,961	23,307
Split into:		
Grants payable - due within one year	14,462	15,029
Grants payable – in two to five years	6,499	8,278
As at 31 December	20,961	23,307

21.0 Provisions for liabilities

Group and charity

	2016 £'000	2015 £'000
Pension obligations	590	631
Dilapidations	196	196
	786	827

Movements on provisions:

	Pension Obligations £'000	Dilapidations £'000	Total £'000
At 1 January 2016	631	196	827
Adjustment for change in discount rate and payment in the year	(41)	-	(41)
At 31 December 2016	590	196	786

22.0 Retirement benefit schemes

a) AEGON Group Personal Pension Plan

The Health Foundation offers all current employees the opportunity to join the defined contribution Group Personal Pension Plan provided by AEGON. Contributions in the year were £467k (2015: £442k). There were no outstanding contributions at 31 December 2016.

b) The Pensions Trust – Growth Plan

In 2016 The Health Foundation withdrew from the Pension Trust Growth Plan, the total payment on withdrawal was £238k of which £124k was provided for in previous years.

c) Other retirement benefits

The Foundation has an unfunded future commitment to a former employee. The contractual commitment (as defined in each contractual arrangement) is to pay a pension equivalent to 1/60th of their pensionable salary for each year of pensionable service less any amounts of pension paid to the same members under The Pensions Trust Growth Plan. The potential pension liability at 31 December 2016, based on advice from an actuary, is estimated to be £589k, (2015: £631k). This provision will be reviewed in 2019.

23.0 Analysis of net assets between funds

Group and charity

	Unrestricted Fund	Restricted funds	Expendable endowment fund	Total
	£'000	£'000	£'000	£'000
Fund balances at 31 December 2016 are represented by:				
Intangible fixed assets	933	-	-	933
Tangible assets	1,307	-	-	1,307
Programme related investments	526	-	-	526
Investments	18,822	-	947,266	966,088
Current assets/(liabilities)	(14,303)	611	(1,154)	(14,846)
Long term liabilities	(6,499)	-	-	(6,499)
Provisions	(786)	-	-	(786)
	-	611	946,112	946,723

The Restricted Fund relates to funds from the Q initiative and PAM evaluation for the NHS in 2016 of £1,025k (2015: £975k), of which £805k (2015: £584k) was used. The balance of £611k (2015: £391k) is expected to be used in 2017.

24.0 Capital commitments

The Foundation has a number of contracts that have been entered into but which are not disclosed as liabilities as they are severable. They are recognised on a cash basis as and when the expenditure is incurred. These amounted to £3,864,680 at 31 December 2016.

25.0 Financial commitments

At 31 December 2016, the company had a property lease for its office premises, which expires in July 2019. The future minimum lease payments are as follows:

	Land and buildings 2016	2015
	£	£
Expiry date:		
Within one year	1,019	1,019
Between two and five years	2,104	2,574

26.0 Events after the reporting date

In April 2017, the Health Foundation announced an award to the University of Cambridge for the development of an improvement research institute to develop evidence on a massive scale across the NHS about what works to improve care. The award committed £42,500k for 10 years, with a quinquennial review.

27.0 Related party transactions

Due to the specialist nature of the projects funded, circumstances may occasionally arise where governors, committee members or staff are associated with organisations which apply for grants. In such cases, the Foundation has clear policies and procedures to ensure that the governor, committee member or member of staff is not involved in the assessment or

approval of the grant. All such transactions are undertaken on an arm's length basis in accordance with the normal grant assessment and arrangements. Details of governors and senior management who have interests in organisations to which the Foundation has made awards and contracted within 2016 are noted below.

Board member	**Role in associated organisation**	**Associated Organisation**
Andrew Morris	Fellow	Royal College of Physicians of Edinburgh
Alan Langlands	Honorary Professor	University of Warwick Business School
	Chair and Director	N8 (the 8 research intensive Universities in the North of England)
	Director	White Rose Universities Consortium
	Director	Russell Group of Universities
	Senior Associate Fellow	Royal Society of Medicine
	Fellow	The Academy of Medical Sciences
	Fellow	Royal College of Physicians
	Fellow	Royal College of General Practitioners
David Dalton	CEO	Salford Royal NHS Foundation Trust
Member of staff	**Role in associated organisation**	**Associated Organisation**
Jo Bibby	Non-executive	Salford Royal NHS Trust
Jennifer Dixon	Fellow	Royal College of Physicians
	Honorary Professor	Imperial College
	Honorary Professor	London School of Economics
	Honorary Professor	London School Of Hygiene and Tropical Medicine
Will Warburton	Fellow	Imperial College London

During the year, Victoria Fund LP Incorporated, a subsidiary of the Foundation, received an investment contribution of £11,500k from the charity. Medtrust Innovations Limited, a subsidiary of the Foundation donated its profit of £109k to the Foundation under gift aid.

Remuneration of key management personnel
Key management personnel are considered to be the chief executive officer and others as set out in the senior management section of the governors' annual report. The total remuneration of this group in the year, was as follows:

	2016 £'000	**2015 £'000**
Key management personnel	975	1,295

28.0 Subsidiaries

These financial statements are separate Foundation financial statements for Medtrust Innovations Limited and The Victoria Fund LP Incorporated.

Details of the Foundation's subsidiaries at 31 December 2016 are as follows:

Name of undertaking	Registered Office	Nature of business	Class of shares held	% Held Direct	% Held Indirect
Medtrust Innovations Limited	England and Wales	Intellectual property	Ordinary	100.00	
The Victoria Fund LP Incorporated	Guernsey	Investment fund vehicle	-	-	

Medtrust Innovations Limited (Medtrust)
Medtrust is wholly owned by the Foundation (initially 2 ordinary shares) and is a company registered in England and Wales. It is engaged in the exploitation of intellectual property rights.

In March 2011, the Foundation purchased a further 524,998 ordinary shares of Medtrust at £1 each to finance an investment to acquire 50% of the intellectual property rights of BMJ Quality & Safety, a journal published by the BMJ Publishing Group Limited. This social motive investment is held at cost in the charity balance sheet. Medtrust undertakes an impairment review each year.

At 31 December 2016, Medtrust had fixed assets of £526k (2015: £526k). This was also the value of its net assets, matching the value of the shareholders' funds.

During the year, Medtrust generated an operating profit of £109k (2015: £124k). The sum equivalent of its taxable profits was donated to the Foundation under gift aid as provided for in Medtrust's Articles of Association.

The Victoria Fund LP Incorporated (Victoria Fund)
The Victoria Fund was formed in February 2010 and is a limited partnership registered in Guernsey. It is a vehicle to invest in a combination of hedge funds and private equity. The limited partner is the Health Foundation and the general partner is Brook Street Limited, a Cayman Islands exempt limited company. Brook Street has delegated its powers to an investment manager, Cambridge Associates Limited.

The Health Foundation as the limited partner is entitled to all investment returns less a priority share by the general partner (Brook Street Limited) from the Victoria Fund and, for consolidation purposes, it is treated as a wholly owned subsidiary of the Foundation.

As at 31 December 2016, the Victoria Fund had fixed assets of £218,367k (2015: £188,003) and the value of its net assets was £222,025k (2015: £194,567k). Net profit in the year was £16,515k (2015: £2,562k).

29.0 Cash generated from operations

	2016 £'000	2015 £'000
Surplus/(deficit) for the year	118,868	(3,695)
Adjustments for:		
Investment income recognised in profit or loss	(13,790)	(13,876)
Cost of raising funds	9,330	4,811
Fair value gains and losses on investments	(145,785)	(14,314)
Depreciation and impairment of tangible fixed assets	593	477
Movements in working capital:		
Increase in debtors	(58)	(111)
Decrease in creditors	(1,471)	(2,094)
(Decrease)/increase in provisions	(41)	116
Cash absorbed by operations	(32,354)	(28,686)

30.0 Grant funding

The Foundation made £18,454k of grants in 2016. These grants range from small one-off awards to multi-year demonstration projects and fellowships. Integral to all our award making is direct support from the Foundation, as well as technical expertise from technical providers and consultants. This support is organised and paid for by the Foundation and delivered directly to the award holders, and can be in the form of technical development and assistance, learning events and coaching. Within this grant funding the Foundation also funds research and external evaluations to ensure programmes are evidence-based and offer value for money.

Grants made to organisations and individuals are analysed by strategic objective in the table below.

Organisations	Lead recipient	Total £
Improving Service Delivery		
Programme – Building Capacity		
Development of Association of Professional Healthcare Analysts	Association of Professional Healthcare Analysts	70,000
Dissemination of THISTLE - Plus Study findings	PROMPT Maternity Foundation	5,000
UK / Swedish collaboration on paediatric epilepsy registry - April 2015	University College London	4,636
UK Nuka Network Development	Anderson Wallace Ltd	1,200
UK Renal Registry	Renal Association: UK Renal Registry	19,500
SQUIRE writing course	Veterans Education and Research Association of Northern New England, Inc	17,200
eHealth Integration of Multidisciplinary Cancer Care in Scotland	University of Edinburgh	13,480
Programme – Evidence into Practice		
Supporting New Migrants in Primary Care	University of Sheffield	55,443
Recognition and response to eating disorders in the perinatal period	King's College London	49,921
A year in an hour: Quality improvement through interactive simulations (QIIS)	Chelsea and Westminster Hospital NHS Foundation Trust	49,690
Accelerating Systems Thinking in Healthcare Incident Investigation	Loughborough University	49,661
Learning and sharing innovation in breathlessness management (E-Breathe)	King's College London	48,000
Better tracheostomy care	National Tracheostomy Safety Project (NTSP Ltd)	47,500
REasonable adjustments to MAINstream diabetes and obesity care for adults with learning disability (REMAIN)	University of Leeds	46,981
'In Control': Awareness for adolescents with asthma and their peers	Queen Mary, University of London	45,190
Measurement Plan Assessment Tool	Imperial College London	65,551
Effective and sensitive communication: New insights and training on the associated communication challenges and skills	University of Nottingham	49,825
Safer healthcare: response and development	University of Oxford	38,984

Organisations	Lead recipient	Total £
Programme – Generation Q		
Cohort 6 – Leadership and quality improvement award	Northern Ireland Ambulance Service Health and Social Care Trust	13,500
Cohort 6 – Leadership and quality improvement award	Healthcare Improvement Scotland	13,000
Cohort 6 – Leadership and quality improvement award	NHS Dumfries and Galloway	13,000
Cohort 6 – Leadership and quality improvement award	Harrogate and District NHS Foundation Trust	11,500
Cohort 6 – Leadership and quality improvement award	NHS Vale of York CCG.	11,500
Cohort 6 – Leadership and quality improvement award	Sheffield Teaching Hospitals NHS Foundation Trust	11,500
Cohort 6 – Leadership and quality improvement award	South Yorkshire Housing Association	11,500
Cohort 6 – Leadership and quality improvement award	Airedale NHS Foundation Trust	11,500
Cohort 6 – Leadership and quality improvement award	LLR NHS Partner Alliance	11,000
Cohort 6 – Leadership and quality improvement award	University Hospitals Of Leicester NHS Trust	11,000
Cohort 6 – Leadership and quality improvement award	Nottingham University Hospitals NHS Trust	11,000
Cohort 6 – Leadership and quality improvement award	Dorset Healthcare University NHS Foundation Trust	11,000
Cohort 6 – Leadership and quality improvement award	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	11,000
Cohort 6 – Leadership and quality improvement award	University Hospital Southampton NHS Foundation Trust	10,000
Cohort 6 – Leadership and quality improvement award	East London NHS Foundation Trust	9,500
Cohort 6 – Leadership and quality improvement award	University College London Hospitals (UCLH) NHS Foundation Trust	9,500
Cohort 6 – Leadership and quality improvement award	Barking, Havering & Redbridge Hospitals NHS Trust	9,500
Cohort 6 – Leadership and quality improvement award	Family Nurse Partnership National Unit	9,500

Organisations	Lead recipient	Total £
Programme – Generation Q (continued)		
Optimising the safety of antimicrobial prescribing for patients with known penicillin allergy	University College London	287,176
System change to mitigate overdiagnosis and overtreatment: How can we ensure 'just enough medicine'?	University of Leicester	198,160
Programme – Improvement Science Fellowships		
Making the invisible visible: fairer allocation and better evaluation of critical care through real-time feedback for all at risk	London School of Hygiene and Tropical Medicine	333,126
Developing a longitudinal approach to quality and safety measurement: exploring the potential of the Electronic Patient Record	London School of Hygiene and Tropical Medicine	332,379
Multi-modality health care for self-management in sexual health and beyond	Kings College London	328,854
Developing patient created health records to improve safety in hospitals	Bangor University	304,582
Programme – Improvement Work General		
Building capability for quality improvement in general practice	Royal College of General Practitioners	71,844
Programme – Innovating for Improvement		
R4 – Embedding A Bio-Psycho Social Model Of Care In An Older Persons Inpatient Service	Leicestershire Partnership NHS Trust	75,000
R4 – Integrated structured education program for Paediatric newly diagnosed type 1 diabetes patients to empower them in self-management	University Hospitals Of Leicester NHS Trust	75,000
R3 – Supporting Shared Decision Making with Option Grids in Child Mental Health: enabling an integrated, needs based approach	Tavistock & Portman NHS Foundation Trust	75,000
R4 – Addressing urgent care demand: an avatar-based virtual nurse to facilitate self-assessment, self-care advice and signposting to NHS111 and other services	Northern Doctors Urgent Care	75,000
R3 – Harnessing the potential of patients to reduce harm using safety briefings.	Salford Royal NHS Foundation Trust	75,000
R3 – Rapid Access to complex Pulmonary Investigation Days - the RAPID Programme in Early Stage Lung Cancer	University Hospital of South Manchester NHS Foundation Trust	75,000
R3 – Developing community pharmacies to support medication monitoring in Children and Young People attending CAMHS ADHD clinic	Sussex Partnership NHS Trust	75,000

Organisations	Lead recipient	Total £
Programme – Innovating for Improvement (continued)		
R4 – Cardiologist's Kitchen initiative - targeted dietary and lifestyle interventions for hypertension combining contemporary evidence with modern marketing and media strategies	Royal United Hospital Bath NHS Trust	75,000
R4 – Managing medically unexplained symptoms in adults in primary care in Gloucestershire through screening, staff training and tailored psychological treatment	2Gether FT NHS Trust	75,000
R3 – An innovative service wide response to patients who contact the Yorkshire Ambulance Service (YAS) in an emergency following a fall.	Yorkshire Ambulance Service NHS Trust	75,000
R3 – Direct patient access to investigation for suspected upper GI malignancy. A pilot evaluation	Cowgill Medical Practice	75,000
R4 – Improving Physical health care for patients with psychosis (PHCP) through collaborative working with local community pharmacies	North East London NHS Foundation Trust	75,000
R4 – Preoperative psychological assessment and management service to improve patient's pain experience and reduce length of stay following surgery at RBH	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	74,990
R4 – Early use of admission triage score in the emergency department will prevent crowding	Queen's Medical Centre Nottingham Univ Hosp NHST	74,976
R3 – Electronic Partner Notification - ePN	Chelsea and Westminster Hospital NHS Foundation Trust	74,951
R3 – Mobile technology health solutions for patients with severe mental illness - A feasibility pilot RCT	East London NHS Foundation Trust	74,940
R3 – Improving Quality of Life in Children with Faecal Incontinence and Constipation	Barts Health NHS Trust	74,921
R4 – Piloting the use of community pharmacy to improve care for asthma patients who do not attend for yearly review: A service evaluation	Rosedale Surgery	74,898
R3 – Co-ordinated Co-response to Immediate Life Threatening Emergencies in Adults in Remote and Rural Scotland	Scottish Ambulance Service	74,898
R4 – Bridging Transitions from Hospital to Home: Collaborative Skill Sharing Intervention with Carers (iCASK)	South London and Maudsley NHS Foundation Trust	74,728
R3 – Can point of care blood tests during home visits by out-of-hours primary care clinicians improve quality of care?	Oxford Health NHS Foundation Trust	74,674

Organisations	Lead recipient	Total £
Programme – Innovating for Improvement (continued)		
R4 – Evaluating an Early Warning Tool, setting the standard of safe care for infants with complex heart conditions at home	Great Ormond Street Hospital for Children NHS Trust	74,669
R4 – Consent PLUS - Improving the Consent Process in Elective Lower Limb Arthroplasty	Abertawe Bro-Morgannwg University Health Board	74,620
R3 – Building local pathways to community capital, social capital and connectedness to improve wellbeing outcomes: A pilot project to build professional networks in local communities	Sheffield Health and Social Care NHS Foundation Trust	74,353
R4 – Integrated Health: Optimising Strength & Resilience	Royal Brompton and Harefield NHS Trust	74,341
R3 – UCLH Enhanced Recovery APP (ER-APP): Improving Perioperative Quality for Elective Surgery using Data on Pathway Compliance and Surgical Outcomes	University College London Hospitals NHS Foundation Trust	74,282
R4 – A Model for City-wide Implementation of Intensive Behavioural Intervention to Improve Sleep in Vulnerable Children.	Sheffield Children's Hospital NHS Trust	74,155
R4 – Palliative Pain Management Programme (PPMP)	St. Joseph's Hospice	74,131
R3 – Self-referral spine clinic pilot	Royal Free London NHS Foundation Trust	73,751
R3 – Using a mobile phone app to improve self-management and care of young people with arthritis	Great Ormond Street Hospital Children's Charity	73,518
R4 – Parents' Active Role & ENgagement in Their Stillbirth/perinatal death review (PARENTS): Research to inform the development of a standardised national process	North Bristol NHS Trust	73,352
R4 – NHS Health Call Undernutrition	County Durham and Darlington Acute Hospitals NHS Trust	73,337
R2 – Quality improvement and person-centredness: design and testing of the Always Event concept in healthcare settings	NHS Education for Scotland	73,000
R4 – Implementing and Evaluating Peer Supported Open Dialogue (POD) in NHS mental health services, accessing patient social networks to optimise outcomes.	Kent and Medway NHS and Social Care and Partnership Trust (KMPT)	72,659
R3 – A nurse-led innovative approach to personalised, coordinated multi-disciplinary care in new haemodialysis patients.	Royal Liverpool and Broadgreen University Hospitals NHS Trust	72,517

Organisations	Lead recipient	Total £
Programme – Innovating for Improvement (continued)		
R3 – Personalising care for patient sub-groups in general practice: 'Segmenting within general practice to achieve health improvement goals	Valentine Health Partnership	72,400
R4 – Celebrating difference: Promoting psychological well-being in children and young people living with chronic physical illness	Barts and The London University Hospital Trust	60,157
R3 – A Project to improve continence in Care Homes and reduce harm associated with incontinence.	NHS Lanarkshire	60,100
R3 – Evaluation of a wearable wireless patch for vital signs monitoring after major surgery	Leeds Teaching Hospitals NHS Trust	57,522
R4 – League of Fitness- (LoF)- Innovative Team Based Health Competition for Patient Weight Management, Healthy Lifestyle and Sustainable Community Well Being.	Social Action for Health	57,500
R4 – Development and pilot testing of an App designed to deliver Functional Strength Training to people after stroke: FeSTivAPPS	Norfolk and Norwich University Hospital NHS Trust	55,496
Developing a Carer Skills Passport for parents, paid and unpaid carers of children and young people with complex long term conditions	Alder Hey Children's Hospital	75,070
Developing a Primary Care Behaviour Change Service to improve the self-management of Long Term Conditions	First Contact Clinical	75,000
My Medical Record - UHSFT inflammatory bowel service	University Hospital Southampton	75,000
Chatter Matters: A language stimulation activity web-based application featuring music videos and activities for children with craniofacial anomalies	Oxford Craniofacial Unit	75,000
Patient Aligned Care Team (PACT) in Primary Care to support patient need in rural Wales & Shropshire	Shropshire Doctors Cooperative Ltd	75,000
Person Centred Arts & Culture for Wellbeing:	South Devon & Torbay Clinical Commissioning Group	74,990
Reaching out to fathers: using volunteers to enhance engagement in the perinatal period	Home-Start Oldham, Stockport & Tameside	74,982
A self-management support intervention (SMS) for older people living with frailty. A primary care feasibility project.	Trust Primary Care Limited	74,973
Delivering an Acute Bundle of Care for Intracerebral Haemorrhage (ABC-ICH) in Greater Manchester	Salford Royal NHS Foundation Trust	74,956

Organisations	Lead recipient	Total £
Programme – Innovating for Improvement (continued)		
Implementation and evaluation of local operative vaginal birth simulation training	North Bristol NHS Trust	74,891
Supporting primary care to offer systematic evidence based medication reviews for older people with frailty – a collaborative approach	Harrogate and Rural Districts Clinical Commissioning Group	74,551
Using Relational Coordination to improve inter-team dynamics in two pathways of care	Cumbria CCG	74,505
The Perioperative RemOte Monitoring of PaTients (PROMPT) system: an innovation in peri-operative care.	Imperial College Healthcare NHS Trust	74,469
Working Together: Creating a new model of Community Centred Care in Care Homes	South West Yorkshire Partnership NHS Foundation Trust	74,330
A nurse-led intervention to improve identification and management of patients with Alcohol-Related Brain Injury (ARBI).	Royal Liverpool & Broadgreen University Hospitals NHS Trust	74,316
Testing the use of telehealth to deliver pharmaceutical care in remote and rural locations	NHS Highland Pharmacy Team	74,300
Speech and Language Therapy for adults who stammer delivered through telemedicine.	Airedale NHS Foundation Trust	73,103
"See What I See": Delivering rapid remote clinical assessment for people in Care Homes using head-mounted technology.	Eastbourne Hailsham and Seaford CCG	72,563
Positive Reporting and Appreciative Inquiry in Sepsis (PRAISe)	Birmingham Children's Hospital	71,831
Greenwich Health and Wellbeing System: A Local Care Network population health model	Greenwich Clinical Commissioning Group	71,500
The development of a self-management and collaborative care digital platform for children and young people with ADHD and their families.	Oxleas NHS Foundation Trust	71,440
Extended Primary Care Team	Southern Health NHS Foundation Trust	64,065
Programme – International Partnership for Innovative Healthcare Delivery		
Support for innovators and entrepreneurs in scaling up innovative healthcare solutions.	Duke Global Health Institute	40,800
Programme – Original Research		
How can a successful Learning-based Maternity Safety Improvement Programme be replicated and scaled?	University of Cambridge	200,000

Organisations	Lead recipient	Total £
Programme – Person Centred Care General		
Improving whole system patient flow project	Advancing Quality Alliance	40,000
QI Task and Finish Group - award variation	Academy of Medical Royal Colleges	11,000
Programme - Safety Measurement & Monitoring		
Safety Measurement and Monitoring Phase 2	UK Improvement Alliance	460,000
Programme – Scaling Up Improvement		
R2 – Integrating mental, physical and social care in long term conditions	King's College London	500,000
R2 – A multi-centre quality improvement project to reduce the incidence of obstetric anal sphincter injury (OASI).	Croydon Health Services NHS Trust	499,997
R2 – Intensive Care Syndrome: Promoting Independence and Return to Employment (InS:PIRE)	NHS Greater Glasgow and Clyde	499,984
R2 – FREED-UP: First Episode and Rapid Early Intervention Service for Young People with Eating Disorders - Upscaled	South London and Maudsley NHS Foundation Trust	499,978
R2 – Scaling up for safety : lessons learnt from HIP QIP	Northumbria Healthcare NHS Foundation Trust	499,725
R2 – Helping Young People THRIVE: implementing a person-centred model of care for Young People's Mental Health	Tavistock & Portman NHS Foundation Trust	499,700
R2 – To Implement and Evaluate a Programme of Shared Haemodialysis Care (Dialysis Self-Management Support)	Sheffield Teaching Hospitals NHS Foundation Trust	499,606
Programme – Social Finance Ltd		
Care and Wellbeing Fund - Award variation for year 2 and 3	Social Finance Ltd	250,000
Programme – Spreading Improvement		
Sharing the success of MISSION COPD: Developing a toolkit and training pack to allow adoption across the UK.	Portsmouth Hospitals NHS Trust	30,616
Secrets of our Success: the PQIP media project	The Royal College of Anaesthetists	30,000
Expansion of our Model of Recognition and Rescue of the Deteriorating Patient Throughout the Scottish Borders Community Settings.	NHS Borders	30,000
Recovery College Training Materials: A Shared Journey Towards Hope	2gether NHS Foundation Trust	30,000

Organisations	Lead recipient	Total £
Programme – Spreading Improvement (continued)		
Extending the legacy of Realising the Value: Penny Brohn UK's dissemination of best practice in Self-Management education	Penny Brohn Cancer Care	29,999
Cochlear implant care: putting patients in charge	University of Southampton	29,991
Phase 2 of Surviving Major Surgery: distributing the H.A.P.P.Y approach	York Teaching Hospitals NHS Foundation Trust	29,975
A novel e-health resource to support patients and families in and after intensive care: Innovation spread and localisation across NHS Scotland	Edinburgh Napier	29,884
Quality trauma discharge (QTD)	North Bristol NHS Trust	29,837
Let's talk about end of life care – The Conversation Project	Royal United Hospital Bath NHS Trust	29,702
Regional spread and dissemination of TRAK eHealth intervention for musculoskeletal conditions in primary care	Cardiff and Vale University Health Board	29,666
The Peer Education Project: A classroom-based, peer-led anti-stigma intervention	Wirral Child & Adolescent Mental Health Service	28,930
Scottish Resuscitation Academy and Scottish Cardiac Arrest Symposium 2016	University of Edinburgh	28,705
Creating an interactive online coaching platform for the Quality Improvement Building Blocks Framework	Advancing Quality Alliance	13,772
Award to allow presentation of her Innovation Round 2 work at American Heart Association Scientific Sessions Conference 12th -16th November 2016	Zainab Khanbhai	1,409
Improving Public Policy		
Programme – Efficiency Research		
Efficiency, cost and quality of mental healthcare provision	University of York	551,045
WORKTECC: Workforce Operations that Realise Knowledge-based Transformational Efficiency gains in Community Care	University College London	483,720
Allocative efficiency in end of life care	Imperial College	456,391
Programme – New models of care and accountability		
Improving Quality in primary care	London School of Hygiene & Tropical Medicine	202,827
Maternity services to improve outcomes and reduce litigation costs	PROMPT Maternity Foundation	62,000

Organisations	Lead recipient	Total £
Programme – Policy Grants		
Harkness Fellowship	The Commonwealth Fund	500,000
Accountable Care Policy Gaps and Lessons from the UK and US: A Bi-Directional Study	Duke University	45,238
Improving Population Health		
Programme – Original Research / Population Health		
Putting Evidence into Policy: the mental health and wellbeing impacts of Active Labour Market Programmes in the UK	University of Cambridge	190,237
Programme – The Bromley by Bow Centre		
The Bromley by Bow Centre	The Bromley by Bow Centre	97,725
Programme - Sciana		
Sciana: The Health Leaders Network	Association of Directors of Public Health	79,964
Programme – Eating well within our means		
Eating well within our means	UK Health Forum	50,000
Programme – Building capability – 2017		
All-Party Parliamentary Health Group (APHG) public health essay series	Policy Connect	5,550
Total		14,952,524
Adjustments to awards made in previous years		(302,313)
Services provided third parties to support award holders and further the work of the foundation		3,434,620
Expenses relating to awards		152,654
Grants and donations awarded to charities by governors		216,250
Total Grants		**18,453,736**

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Registered charity number: 286967
Registered company number: 1714937