Annual report and financial statements

For the year ended 31 December 2015

The Health Foundation

Contents

Introduction from the Chief Executive and Chair

The Health Foundation's aim is to improve the quality of health and health care for the population of the UK. The Foundation does this through funding a range of activities, mostly testing and spreading innovations, building evidence as to what works and why, and investing in people to build skills and capacity to make improvements. Given the significant challenges to health and health care in the UK, the Foundation has a responsibility to be as effective as possible and make every penny we spend count.

In November 2014, our board approved a three-year strategy for the Foundation.

Underpinning our strategy is the view that to make improvements in the quality of health and health care across the UK, a plural set of interlocking approaches are needed, from the front line to national policy. Our focus is not just on what changes are needed, but increasingly how they can be made more quickly and effectively.

The Foundation is active across a range of areas, complementing its traditional focus on research, practice and fellowships in quality improvement, safety and person-centred care with a wider purview on quality, using other disciplines including economics, policy analysis and data analytics. The unifying theme is to use national policy levers, information and quality improvement techniques more synergistically, and (the latter two) on a far bigger scale than the NHS has ever seen. Our aim is also to gain a more rounded understanding of how needed change can happen most effectively, and thus how we can work with partners to make more progress.

2015 was a transitional year as we developed a broader set of activities to support each of our strategic aims, and recalibrated our existing work.

In 2016 we will continue this development. Our programme of work majors on ways to make successful improvements to health and health care from the front line to system level.

In health care our core offer is to make grants available to front-line teams in the health service to help them make improvements to the quality of care. We will also be focusing on spread far more this year and exploring how it can be accelerated; for example, whether social franchise and social investment models have potential to be impactful in this area.

At national level the Health Foundation will continue to be an independent source of analysis of trends and variations in quality of care and the finances of the NHS, pioneering innovative quantitative techniques to reveal new insights. We will also identify where there could be more coherence in policy initiatives – such as working with others to develop a coherent strategy to improve quality of care and ensuring the right numbers and skills for the workforce.

We will be examining how key policies can best accelerate progress to develop high quality services across areas or networks of providers.

At all levels supportive approaches, such as quality improvement techniques used by clinical staff with real-time data, are not yet universally understood and fully exploited, but their potential to accelerate change for patient benefit is huge. During 2016 we will work to boost these approaches, collaborating with a range of partners. Our Q initiative, co-funded by NHS Improvement, will also help build the quality improvement skills and knowledge of people throughout the health service. We will also continue to support research in informatics, efficiency and behavioural insights.

As part of our mission to help improve the health of the UK population, we will begin reconnaissance and debate in 2016 as to what may be the most impactful areas for us and others to invest in from 2017. We are certain it will be a creative and defining year for the Foundation, increasing our contribution and impact for public benefit.

The full programme could not have been achieved without the hard and dedicated contributions by staff, the trustees and our partners – with many thanks to all.

Dr Jennifer Dixon (Chief Executive) and Sir Alan Langlands (Chair), the Health Foundation

Trustees’ annual report

Strategic report

The governors of the Health Foundation present their annual report for the year ended 31 December 2015 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.

Vision and objectives of the Health Foundation

The Health Foundation in 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. 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 use 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 2015

Our work in 2015 was set against a challenging economic climate for the health care sector. We worked to diagnose the challenges before assessing potential solutions, which ranged from prevention initiatives to waste-reducing incremental changes on the front line, and making changes across whole health care economies. We then made firm proposals about how to implement these effectively. Any changes were monitored, and the learning about what works best has been incorporated into a continuous cycle of improvement.

We had three main objectives for 2015. These are:

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

Our key activities focused on:

- **Testing and spreading innovations:** we supported clinical and other teams to make improvements by carrying out small tests of changes that had been measured and then adapted.
- **Building capability:** we had a range of activities to equip clinical leaders and middle managers with operational skills to improve health care processes and build capability in the longer term.
- **Building the evidence supporting successful change:** we developed the evidence base for improvements to health and health care, supporting relevant groups (from patients and clinical teams to managers and policymakers) to make better and more informed decisions.

How we did it

1. Building Capability

Our improvement team is working with others to strengthen the skills needed by people working in front-line care to make improvements to services. This was done through funding fellowships, as well as providing grants to teams working directly in clinical care on projects to improve the quality of the service provided. This is the biggest continuing area of the Health Foundation's investment.

Award programmes

Through our open call and directed award programmes we give grants and practical support to front-line teams to help them test and develop innovations, and spread improvements in health care.

Innovating for Improvement and Scaling Up Improvement are our open call award programmes:

1. **The Innovating for Improvement programme** funds a variety of small-scale innovation projects across a range of health care settings and specialisms. The programme opens for applications every six months. In the first round in May 2015, 17 projects were selected, with 21 projects selected in the second round (September 2015). The majority of projects are focused on new models of care and integration, out-of-hospital care and self-care, innovations in an acute setting, and the novel identification of patients using technology.
2. **The Scaling Up Improvement programme** supports teams to take successful health care improvement interventions and deliver them on a larger scale. Participants in the

first round of the programme successfully completed their set up phase and progressed to the implementation stage in September 2015. The teams have been progressing well and are reporting on the challenges of implementing complex multi-partnership projects at scale, as well as sharing the learning from the first 10 months. We continue to support them through a number of programme-wide events and learning opportunities. Round two of the programme launched in April 2015, and after a rigorous assessment process 12 teams were invited to interview stage in February 2016. We shortlisted a diverse portfolio of applications, in terms of the scale, setting and geographical coverage.

We also made several investments in directed programmes during 2015; for example, in the Improving Patient Flow programme to test wider implementation of approaches to improve system efficiency and patient experience of urgent care.

2015 also saw the conclusion of important programmes including our Shine 2014 programme and our Shared Purpose directed programme. The focus will now be on gathering, analysing and sharing the learning, knowledge and impact of our funded programmes, so that we can promote the lessons and insights more widely.

Leadership development

GenerationQ, our part-time leadership and quality improvement development programme for senior leaders working in and with the health service, continued in 2015 with the fifth cohort starting their Fellowships in January.

This cohort have progressed well through the programme and recently launched their 'Ambition into Practice', a work-based improvement project designed to put their learning into practice. The broad themes are varied and include examples such as organisational culture change through establishing training and development programmes in quality improvement, and more traditional improvement projects focusing on processes and systems.

In 2015 we also commissioned a survey of the first four cohorts of GenerationQ to explore the organisational and personal impact of the programme. This gave us some very promising results, with a significant number of previous Fellows now in roles with increased influence and leading work that is having an impact beyond their immediate sphere.

Recruitment for the sixth cohort commenced in September 2015.

Q initiative

2015 was the founding year of 'Q', a 'national system of NHS Improvement Fellowships' developed in line with the recommendation made in the 2013 Berwick review. The programme, jointly funded with NHS England (until 1 April 2016, when NHS Improvement took over co-funding), will be publicly launched across England in 2016.

The Q initiative connects people skilled in improvement across the UK. The Q Fellows are a diverse and growing community of people with experience and understanding of improvement, committed to working collaboratively to improve the quality of health and care across the UK. The aim is to make it easier for people leading improvement to share ideas, enhance their skills and make changes that bring tangible improvements to health and care.

231 founding cohort members came together to design Q in 2015 and three design events were held across the UK. Following the third design event, we produced a proposed operating model for Q. This was received well overall by our wider stakeholders, including local, regional and national bodies and key system-level influencers.

Over 1,200 people have registered for updates on Q and we have an active social media community on Twitter which is made up of Q members and others. Approximately 2,000 tweets about Q have been sent by over 500 contributors, reaching over 350,000 accounts.

RAND Europe are undertaking a developmental evaluation of the Interim evaluation findings submitted in October 2015 show Q is progressing well.

2. Developing resources to help improve the quality of care

Guides and toolkits

We launched two new guides on evaluation and spread in March 2015 to support those working in health care improvement to evaluate and share their improvement work.

- *Evaluation: what to consider*, was inspired by people who asked us questions about how to approach evaluation of quality improvement in health care. The guide aims to help people new to evaluation by suggesting methodological and practical considerations and providing resources to support further learning.
- *Using communications approaches to spread improvement*, introduces key concepts about spreading health care improvement work and examines the evidence about the role communications can play. This resource is aimed at those who are actively engaged in health care improvement work and want to explore how to best engage the right people to spread and share their findings.

Both these publications have been extremely popular and were the most downloaded publications on our website in 2015. By the end of the year, the evaluation guide had been downloaded 3,733 times and the spreading improvement spread guide 3,312 times. Due to their immense popularity we have had to reprint both publications for our internal and external events.

We also launched a new online Communications in health care improvement toolkit in August 2015 to support health care professionals working on quality improvement projects. The toolkit helps people understand and use communications to better plan, implement and spread their improvement work. It contains guidance, resources and tips to help share learning from improvement work, engage stakeholders and spread success stories and evidence.

By the end of the year, 4,032 people have accessed and viewed the toolkit for online communications. The most popular resources are those in the 'Spreading your work' section.

Online resource centres

In 2015, we built on the success of our person-centred care and patient safety resource centres in 2014. The person-centred care site saw a year-on-year increase in user sessions of 75%, growing from 58,127 in 2014 to 101,861 in 2015. The patient safety resource centre also saw an increase in use by 61%, growing from 44,785 user sessions to 71,961 user sessions.

We have added content and functionality to our existing patient safety resource centre so that it is organised around the 22 topics addressed by the Patient Safety Collaboratives programme.

A strategic review of our resource centres was undertaken at the end of 2015 and a decision was made to maintain them until the end of 2016, when we will review them again to ensure they continue to deliver against our corporate priorities.

Webinars

In 2015 we hosted three webinars on our latest research and analysis. All three proved to be very popular with some of our highest registration and viewing figures. 40%–50% of viewers that had registered viewed the live webinars. This is above the average for engagement figures we have had to date. We ran the following webinars:

- **March 2015 – How successful change happens in the NHS and what national bodies can do to help.** This webinar outlined the findings from our *Constructive comfort* publication where 118 people registered and 54 viewed the live webinar.
- **October 2015 – The Health Foundation's review of general practice quality indicators.** This webinar reported the findings of the independent review we carried out on the indicators of the quality of care provided by general practice in England. 109 people registered and 51 people viewed the live webinar.
- **November 2015 – Getting into the improvement habit.** This webinar discussed the ideas in the thought paper entitled *Habits of an improver* where 266 people registered and 111 people viewed the live webinar.

Promoting the latest research

Through our joint ownership of the journal BMJ Quality & Safety, we continued to publish and promote the latest research on health care quality improvement. The impact factor for the journal has increased in the past year, as have circulation figures.

Throughout the year we published a monthly Research Scan, highlighting interesting research studies related to the Foundation's key areas of focus in health care improvement.

3. Building knowledge and evidence

Research activities

We invested a total of £4.6 million in new research during 2015.

Our largest programme of new research funded in the year was the Behavioural Insights Research programme, focusing on interventions that have the potential to increase efficiency and reduce waste in UK health care services. Five awards are funding research studies into: work on procurement; A&E discharge planning; hand hygiene compliance; cost and risk feedback for common diagnostic tests; and prescribing. Each of these projects will generate insight on the use and applicability of behavioural insights to drive improvement in the quality of care.

We also made new research awards for:

- informatics to support quality improvement
- efficiency research to improve the value for money of health care services
- research into regulation of health care providers and how this impacts on patient safety
- research into education for improvement, including current courses and curricula, the habits of improvers that such education should aim to cultivate, and the transfer of acquired improvement skills and knowledge into practice.

Data analytics and evaluation

Our data analytics team is testing new methods to evaluate complex service interventions – from new models of care to new payment mechanisms – with innovative approaches to using data and methods of analysis.

In 2015, a work programme was established that uses data to evaluate and accelerate changes in the health service. We published a paper that set out the latest thinking about how data can be used to support a learning health care system. The analysis itself has required some supporting infrastructure to be put in place within the Health Foundation, including a secure data processing environment to enable the team to access and analyse de-identified, person-level data consistent with the Data Protection Act and best practice in information governance.

In 2015:

- We agreed an approach with NHS England to piloting rapid-cycle evaluation methods as part of a national programme to develop new models of care (the 'Vanguards'). This will be a partnership project with NHS England, which aims to develop approaches to evaluation while embedding them within the NHS.
- We completed an evaluation of a change to service delivery that involved assigning named accountable GPs to patients over 75 years old, the findings of which have been submitted to a peer-reviewed academic journal.
- We conducted an analysis of the pathways followed by parents and carers calling NHS 111 on behalf of children.
- We began two further evaluations, looking at the effect of financial penalties on acute hospitals for readmissions and an integrated care pathway for high-risk patients.
- We funded evaluations of our improvement programmes, including a developmental evaluation of the first year of the Q initiative (see page 7).
- We also funded evaluation studies of wider quality improvement programmes such as the Wales 1000 Lives National Patient Flow programme.

In addition to this evaluative work, we scoped a programme of work to assess quality in the NHS, for example looking at continuity of care in general practice, the performance of A&E departments on waiting time targets, and trends in hospital readmission rates. We also supported an exploratory seminar of health service researchers and research funders to consider the development of appropriate evaluation approaches for complex interventions in health care. This resulted in a book published in 2016.

Together with NHS England we are jointly funding the evaluation of the use of the Patient Activation Measure (PAM) in the NHS in England. The research team from Leicester University has carried out a range of activities to understand how five CCGs and the UK Renal Registry are using the PAM to tailor individual care planning and to measure how a range of interventions are helping people to increase their knowledge, skills and motivation to manage their own health and care. The interim findings of the evaluation were jointly published with NHS England in November 2015.

QualityWatch

We continued to work jointly with the Nuffield Trust on the QualityWatch programme, providing an overview of indicators of quality of care across the health and social care system.

During the year the number of indicators tracked rose to over 300. We produced three in-depth 'Focus on' reports covering: admissions to hospital from care homes, an international comparison of health care quality, and hospital use by people with mental ill health. The latter generated media and policy interest around the greater use of emergency services for physical health by people with a mental health diagnosis, suggesting that they are not receiving high quality, timely care for physical health.

The QualityWatch annual report *Closer to critical* was launched at the annual QualityWatch conference in November.

Patient safety

We have continued to influence the policy and practice of patient safety across the UK. In 2015, we published *Continuous improvement of patient safety*, a learning report that synthesised our work in this area over the past decade. We also informed debates on the Health and Social Care (Safety and Quality) Bill, and have continued to support our Fellows

– Carl Macrae and Charles Vincent – whose work has helped lead to the establishment of an independent investigation unit in the NHS.

Developing the field of improvement science

In 2015 we made a new round of awards totalling £1.1m to four UK universities to fund PhD studies in improvement science. A report on the achievements of the first cohort of Improvement Science Fellows found that they had between them secured £23m of research funding across their institutions, and published four books and 54 peer-reviewed journal papers.

We held the first summer school for PhD students in improvement science, with input from eight supervising professors on topics such as getting published, using a range of statistical techniques and optimising the use of social media to diffuse research findings. At the end of the year the board approved work to scope the funding and establishment of an improvement research institute.

4. Contributing to the policy debate

Our policy and economics teams are attempting clearer diagnoses of the challenges at a national level and suggesting policy strategies to support change.

Policy analysis and research

In 2015 the Health Foundation undertook a number of projects aiming to improve the ability of national policy to support the delivery of high quality care. We conducted policy analysis and research on four main themes: quality and money, system analysis, implementing change, and new models of care.

In July we published *Making change happen: a Transformation Fund for the NHS*. The report draws on analysis conducted by the Health Foundation and The King's Fund – in particular six case studies of funding transformation in the health sector and beyond, along with examples of local NHS initiatives. The report was launched at an event in the Foundation's auditorium attended by David Prior and Norman Lamb. The analysis was included in our submission to the comprehensive spending review.

Our policy work resulted in a number of other reports over the year:

- *Constructive comfort: accelerating change in the NHS* (February): This report explored how national policy can best accelerate change and improvement across the NHS.
- *Glaziers and window breakers: the role of the Secretary of State for Health, in their own words* (May): This book, written with Nick Timmins, considered the role of the Secretary of State for Health and how it can support quality in health care. It was based on interviews with 10 former secretaries of state.
- *Need to nurture: outcomes-based commissioning in the NHS* (September): This report examines what outcomes-based commissioning means, the evidence to support it, and the optimum role of national policy in response to it.
- *Indicators of quality of care in general practices in England: An independent review for the Secretary of State for Health* (October): Following a request from the secretary of state, we looked at how indicators could be developed to generate meaningful information that supports improvements to care and helps the public choose which practice might best meet their needs.
- *On targets: how targets can be most effective in the English NHS* (October): This report explores how national targets can be used most effectively to improve the quality of care provided by the NHS in England. It builds on what is known about the impact of targets to identify good practice in designing and implementing new or improved targets.

A programme of work ahead of the 2015 general election

We published a wide range of briefings on key election topics (including quality and competition), as well as blogs objectively analysing the different political parties' manifestos. The Health Foundation also published *Three tests for change for a credible health policy* which set out our independent view on the priorities for the NHS. We co-hosted with the RSA the Great Health Think Off – an event bringing together an expert panel to debate the big health care issues facing politicians.

Our economics work underpinned much of the Health Foundation's work on the general election and spending review. We published briefings on NHS finances for the general election which were widely used and reported. For the spending review we submitted evidence to the Treasury and participated in numerous engagement events to discuss the options in the spending review. We did a lot of work to 'make sense' of the Spending Review and published a joint briefing with The King's Fund and Nuffield Trust. Members of the Health Foundation economics team also spoke at events with NHS and wider stakeholder audiences on the implications of the spending review.

Health economics

In 2015, the Health Foundation published a series of publications on aspects of the financial challenges facing the health and care systems. In April 2015, we published *Hospital finances and productivity: in a critical condition?,* setting out the financial and productivity performance of the English NHS. In July, as mentioned previously, we published a report jointly authored with colleagues at The King's Fund on the need for and role of a dedicated transformation fund to support the scale of change required to deliver the *NHS five year forward view*.

In October 2015, we published a report jointly authored with some economists at IPPR (the Institute for Public Policy Research) on the potential funding gap for health and social care over the next 15 years. This programme of work has been disseminated widely with high-level coverage in the media, as well as multiple opportunities to present the findings to NHS and stakeholder audiences. We have also used the analysis to support other publications. Our Director of Research and Economics, Anita Charlesworth, wrote the UK case study for the OECD's recent publication on financial sustainability in health care, plus an essay for the Smith Institute's 2015 collection on public services.

Supporting debate in public policy

In addition to our briefings and publications, the Health Foundation also supported the debate of public policy in a number of other ways, including:

- **Policy Navigator:** In 2015, we launched the Policy Navigator, an online guide to the history of health policy reform that tracks a number of themes over time. The navigator aims to help policymakers develop more informed policy, as well as provide a guide for those interested in health policy.
- **Blogs on a range of policy issues:** We published a wide range of blogs dissecting key health policy issues for the Health Foundation's website, as well as for the *Health Service Journal*, the *Guardian*, and the *BMJ*, among others.
- **Policy research projects:** A range of policy research projects were also commissioned during 2015 on topics including devolution in Manchester, international lessons on the development of competition policy, responses to organisational failure, and how to have constructive conversations with the public on service changes. All were designed to understand the promise of these activities to improve quality of care for patients.

5. Developing our work in population health

In 2015, we announced that the Health Foundation would be expanding its work to explore population health with a view to developing programmes of work and a portfolio of grants in this area. This work commenced in the latter half of the year.

We have identified that improving health will require action in the following areas:

- **Policy alignment:** Harnessing all the opportunities to maintain and improve health through alignment of cross-government and sector policy with addressing the determinants of health.
- **Leadership for health at every level:** Creating visible leaders for health across the statutory and civic structures that influence health.
- **Changing lives:** Understanding and addressing the conditions and approaches at local level needed to support individuals to lead healthy lives.

Taking effective action in these areas will be enabled by:

- **Building evidence to inform policy and action:** We need to define the concept of 'evidence-based public health' and the methods required to generate this evidence.
- **Data to provide insight and focus action:** We need to collect, collate and interpret data that can illuminate emerging trends in the determinants of health to enable early action.
- **Theory and practice of implementing change:** We need to understand the careful balance of top down and bottom up action required to create the conditions for and support choices to enable healthy lives.

There is now a broad consensus that the things which improve our health mainly sit outside of health services. Developing work programmes across the enabling factors and core components of health will be critical to be effective, and it is likely the Foundation will need to work with a diversity of other partners to make progress. The work will help the Health Foundation to develop authority and influence in this area, to achieve a longer-term objective which is to raise the profile of health and how it can be improved at a national level.

Given the breadth of the challenge, the Health Foundation will be working in partnership with others where we feel that our collective knowledge and expertise can be combined to greatest effect. For example, in 2015, we commissioned C3 Collaborating for Health, with the London School of Hygiene and Tropical Medicine and the Royal Society of Public Health, to support us to develop our knowledge base.

The wider impact of our awards

The following three case studies illustrate the long-term impact of awards received through various Health Foundation improvement programmes in recent years.

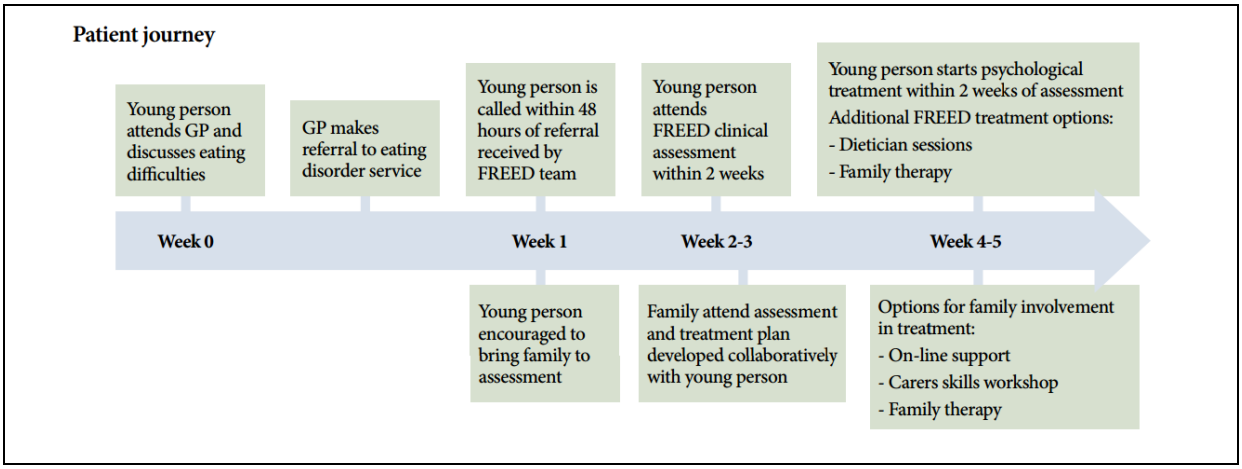
Development and evaluation of a first episode and rapid early intervention service for eating disorders (FREED)

About the project

Eating disorders tend to start in adolescence and early adulthood. Early intervention is essential to prevent the disorder becoming chronic and resistant to treatment. However, poor knowledge of how and when to access services, combined with long waiting times, can prevent young people from accessing early treatment.

FREED was set up by the South London and Maudsley NHS Foundation Trust in partnership with the Institute of Psychiatry, Psychology and Neuroscience at King's College London. The service provides an outpatient service for 18–25 year-olds, helping to ensure young people access diagnosis and treatment services at the earliest opportunity. The project was supported by the Health Foundation as part of our Shine 2014 programme.

Once referred to the service, patients were rapidly allocated to an evidence-based treatment, including therapy and guided online or manual self-help interventions.



In a cohort of 60 patients, the FREED service demonstrated a positive impact throughout the treatment journey – from referral to clinical outcomes.

- All of the FREED patients took up treatment, compared to an average of 87% from published data, and drop-out rates were reduced by 25%–35%.
- FREED patients waited almost 40% less time for an assessment and waiting times for treatment were almost halved.
- Overall clinical improvement was rapid, with patients' average eating disorder symptom score at six months being below the cut-off for a clinical eating disorder.
- Patient satisfaction was very high, with an average satisfaction for waiting times of 9.1 (score 0–10; n=17) and for the process of starting treatment of 9.2 (score 0–10; n=16).

FREED was cited as a model of good practice in a 2015 NHS England Eating Disorders Commissioning Guide and the team has been shortlisted for the Royal College of Psychiatrists' Psychiatric Team of the Year. The project is now also benefitting non-FREED patients through its social media and nutrition guides.

Learning

Engaging with and educating commissioners was key to making the intervention available to all young people with eating disorders. Getting the support of commissioners was particularly important to ensure sustained funding, given that funding delays can contribute to longer waiting times for assessment and treatment.

Patients and carers were essential to highlight the value of FREED, and the project team involved them at all stages. This included providing regular feedback, and involvement in media events and open days.

Sustainability and spread

The service has now been embedded in a large NHS specialist eating disorder service for adults, ensuring sustainability beyond the award period. South London and Maudsley NHS Foundation Trust has committed four additional staff members to sustain and expand FREED, and several local NHS commissioners are now allowing direct referrals of young people from GPs to the eating disorder unit.

To help spread and sustain this model more widely, the project team is developing a FREED service toolkit, which will make analysis and project management easier. Several other services are now interested in adopting their care pathway.

The project team has recently won a grant in the Health Foundation's Scaling Up Improvement programme, which helps deliver successful health care interventions at a larger scale. They will be completing their toolkit and spreading their innovation to other eating disorder services around the country. They have also won a small-scale grant as part of our Spreading Improvement programme, which will enable them to put together an interactive website for young adults, carers, GPs and commissioners.

Diabetes appointments via webcam in Newham (DAWN)

About the project

Set up in 2011 with funding from our Shine programme, the DAWN project provides a good example of how web-based communications can improve productivity and make services more convenient for users.

Many people with diabetes in Newham are unable or unwilling to attend hospital outpatient appointments, so the diabetes team introduced Skype-based consultations in a bid to make their service more responsive to local needs.

Early results were promising. During the first 10 months of the project almost two-thirds of eligible outpatients in Newham signed up for the web-based consultations. After some fine-tuning, the service's 'did not attend' rate fell from 30%–50% to just 16%. Service productivity also rose as Skype appointments were six minutes shorter on average than standard clinic appointments. And by re-engaging with some people who had not been coping well on their own, the new service potentially helped to avoid some emergency hospital admissions.

Feedback from service users was also positive. People from all age groups preferred the convenience of the web-based service, and felt the quality of the care they received was comparable to face-to-face appointments. The service allowed people to fit their care in around work, study and family commitments. They were also able to get answers to their questions quickly through the Skype message system, rather than wait weeks for their next clinic appointment.

Learning

The success of the Shine project led the Newham team to apply for a further Health Foundation award. This two-year follow-up project looked at the role of web-based consultations in increasing self-management and in providing a more flexible model of outpatient care. It has provided a detailed insight into people's experience of managing their diabetes with the support of Skype, as well as the technical and logistical issues involved in providing the service. It found that the key to the service's success was often the 'person behind the technology': Skype worked best, according to service users, when they were able to engage with a familiar and trusted face. The project also highlighted the value of using a technology which is well established and well known to the public such as Skype: this made it much easier to gain service user buy-in and take-up.

Another important learning point was that face-to-face consultations still have their place, even among the most enthusiastic Skype service users. Face-to-face appointments are important for building trust between clinicians and service users, and for demonstrating the use of care appliances and techniques. The project found that an effective service is one that combines face to face and web-based consultations intelligently, and is responsive to service users' changing needs over time.

Sustainability and spread

As well as being used routinely in the general diabetes and young adult clinic in Newham, a Skype-based follow-up service has now been set up for people with thyroid disease and also for the hepato-pancreato-bilary cancer service. A set of standard operating procedures for implementing Skype, together with a Skype business case, have been developed by the team to support its wider take up across Barts Health NHS Trust.

There is also growing external interest in the service. The team has had discussions with NHS England, which has published an article on DAWN on its website, and with Monitor, which has been looking at how to create the right tariff for online appointments. A number of other local providers, including South West London and St George's and University College Hospital London, are also looking at ways in which to use Skype in their services.

Meanwhile, a major National Institute for Health Research (NIHR) study, involving members of the Newham team, was set up in 2015 to examine the advantages and limitations of virtual online consultations, and also to address the policy and legal barriers to their wider use. This project will go some way towards embedding web-based consultations firmly into everyday practice in the NHS.

Implementing the Global Tracheostomy Collaborative quality improvement project

About the project

Each year, around 15,000 patients in England and Wales have a tracheostomy – a surgical procedure where a tube is inserted into the windpipe to help someone breathe.

The majority of tracheostomies are performed on critically ill patients who are dependent on external devices to support their breathing. Complications arise for a third of thracheostomy patients on wards and a quarter of patients in intensive care units. Because patients are dependent on these tubes as their artificial airway, if problems develop then significant harm can occur.

As part of the Health Foundation's Shine 2014 programme, a team at the University Hospital of South Manchester led an initiative to improve care for people undergoing a tracheostomy. This involved implementing a range of proven interventions developed by the Global Tracheostomy Collaborative (GTC), a quality improvement collaborative of doctors, nurses, allied health professionals and patients from member institutions around the globe.

The team worked with four sites, focusing on improving staff knowledge of tracheostomy care, establishing multidisciplinary teams, involving patients and families, and benchmarking local performance against international peers. Each site also had a 'patient champion' with personal experience of what it's like to have a tracheostomy.

The project saw a significant reduction in the severity of harm from tracheostomy-related incidents, and a significant reduction in total length of stay for patients – in turn generating significant cost savings.

Learning

Tracheostomy care requires input from many clinical disciplines – for example, the team performing the procedure may well be different to the team responsible for subsequent management – and the project reinforced the importance of multidisciplinary working in improving outcomes. It also highlighted the importance of collecting data on tracheostomy outcomes. Currently, few institutions collect data, which can make identifying the scale and nature of problems difficult.

Another major learning point was about the importance of patient-focused measures of quality. Patients often say that what they care most about is how a tracheostomy will affect their day-to-day life. So it was significant that the Manchester project saw big improvements in the amount of time taken to speak or eat after a tracheostomy. The project was able to reduce the average gap from tracheostomy to eating by around five days. Going forward, the team will be asking sites to capture these kinds of patient-focused metrics in addition to traditional quantitative measures like length of hospital stay.

Sustainability and spread

The new approach to tracheostomy care is now being rolled out to sites across the UK, supported by a Health Foundation Spreading Improvement grant.

This next phase of the project, led by the Royal College of Anaesthetists, will support 20 hospital sites to introduce the improvement measures. They will be working closely with each site to introduce them to the GTC resources, including educational tools, stories from exemplar projects around the world, the patient champions model and the benchmarking database. They will also be supporting the sites to embrace change where it's needed, for example by setting up multidisciplinary teams.

The project team will use the findings from this work to develop a resource pack which other hospitals can use to run their own improvement projects. The project lead, Brendan McGrath, Consultant in Anaesthesia and Intensive Care Medicine at University Hospital South Manchester and National Clinical Advisor for Tracheostomy at NHS England, says 'having the Health Foundation as a partner has helped to generate a lot of interest in what we're doing – from potential sites, the royal colleges and organisations such as the Institute for Healthcare Improvement in the US.'

Ultimately, the team's aim is to create an evidence base for what works in improving tracheostomy care – impact on quality, safety and patient experience, and the potential cost savings – and to make the case that the GTC approach should become a nationally funded model of care.

Our plans for 2016

Our organisational mission is to turn into reality ideas that improve the health and health care of people living in the UK. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

During 2016, our programme of work focuses on ways to make successful improvements to health and health care from the front line to system level. We will particularly focus on how to improve coherence in policy initiatives. We are also broadening our work beyond health care to include population health, and are considering how best to develop programmes of work and grants in this area.

We will build on the lessons and insights from our work in previous years and continue to work towards our three main strategic objectives. These are:

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

Key activities for 2016

- We will be recruiting to new round of our improvement programme Innovating for Improvement, which will open for application in the summer, as well as our Spreading Improvement programme. We will also explore the use of social franchising and social investment as ways for spreading and sustaining successful health care interventions.
- Throughout the year we will invest over £7m in grants to teams across the health service to take forward their improvement ideas as part of our Innovating for Improvement and Scaling Up Improvement programmes. This follows open recruitment calls run in 2015. We will also be thinking through how we can best support the service in future as part of a review into our existing improvement grant and fellowship programmes – ready to come back in 2017 with a renewed offer.
- Some of our improvement programmes will draw to an end during 2016, including Shared Purpose and Closing the Gap in Patient Safety. An important focus over the year will be to extract valuable learning and ensure we can share what works to improve the quality of care more widely.
- Q, an initiative led by the Health Foundation and supported and co-funded by NHS Improvement, is connecting people skilled in improvement across the UK. To ensure Q meets the needs of those doing improvement work, we have been designing it with the initiative's founding cohort, recruited in 2015. The design of Q will continue in 2016, with phased opportunities for people to apply starting in the summer of 2016.
- We will begin setting up an improvement research institute, building on the knowledge and evidence we've accumulated while developing the field over the last five years. We will also be recruiting to our Improvement Science Fellows programme in the spring.

- To continue to build and share evidence about high quality health care we will also be publishing a range of policy analysis and commissioned research, with a particular focus on where there could be more coherence in policy initiatives. Highlights include:
    - **Workforce:** A study of key trends and challenges facing the NHS.
    - **Quality strategy for England:** We are working in partnership with Professor Sheila Leatherman to review and recommend how national policy can best support improvements in health care quality.
    - **Finance:** We will publish our annual analysis of NHS providers' finances in England, as well as studies on the impact of the NHS financial crisis on hospital care, and a report looking at the potential impact of different policy decisions on the projected funding gap for the NHS in Wales.
    - **QualityWatch:** We'll continue to provide independent scrutiny into how the quality of health and social care is changing over time through QualityWatch, run in partnership with the Nuffield Trust.
- We are funding programmes of research in informatics, efficiency and behavioural insights, all of which are underway in 2016.
- Our data analytics team will be exploiting data and developing the use of quantitative analysis to assess the progress of complex service changes in near real time. We'll feed back to groups pioneering change and develop a network of existing analysts.
- We are extending our work to look more broadly at the determinants of health: the factors that shape where we live, learn, work and play. We will carry out a year of reconnaissance and discussion as to the state of population health, and what may be the most impactful innovations for us and others to invest in from 2017. We will join forces with Robert Wood Johnson Foundation and Salzburg Global Foundation, bringing together leaders and asking how governments might act differently to make a bigger positive impact on health.

For more information, visit: www.health.org.uk
You can also find more details about our current work on Twitter: www.twitter.com/HealthFdn
Sign up for our email newsletter: www.health.org.uk/enewsletter

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 governors have previously decided that it would be inappropriate for a health-related organisation to invest in tobacco companies. The Foundation has reduced investment in tobacco companies as close to zero as practically possible, and keeps this under regular review.

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.

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.

Financial review

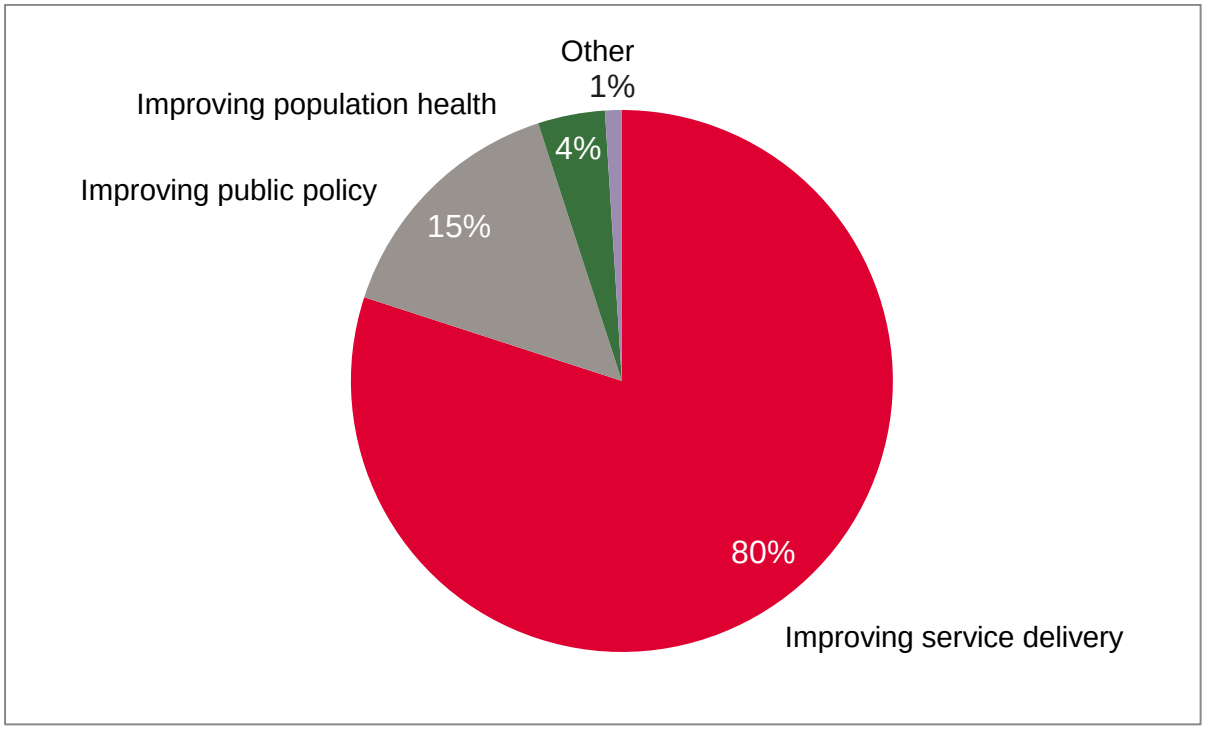
Results for 2015

Charitable activities

During 2015, the Foundation spent £28.2m (2014: £29.2m) on its charitable activities, of which over £15.8m (56%) was direct grant and programme expenditure on projects related to the Foundation's key strategic priorities. Salary costs were £6.7m (24%), which were directly related to project and policy work, and overheads were £5.7m (20%).

All expenditure is reported across our key strategic priorities; the split of expenditure for 2015 is reported in the graph below. 'Improving public policy' and 'improving population health' are new strategic priorities, being developed through 2015. 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.

Split in charitable expenditure



In 2015, the Foundation committed £1.1m to Improvement Science PhDs, just short of £3m to the Innovating for Improvement programme, £1.5m to Spreading Improvement and £1.5m to the Behavioural Insights Research programme.

Restricted fund

For the first year, the accounts reflect the receipt of restricted income. This primarily relates to £1m for Q, an initiative joint-funded with NHS Improvement (with NHS England until 1 April 2016). The Q initiative work is continuing in 2016, with additional joint funding from the Foundation and NHS England.

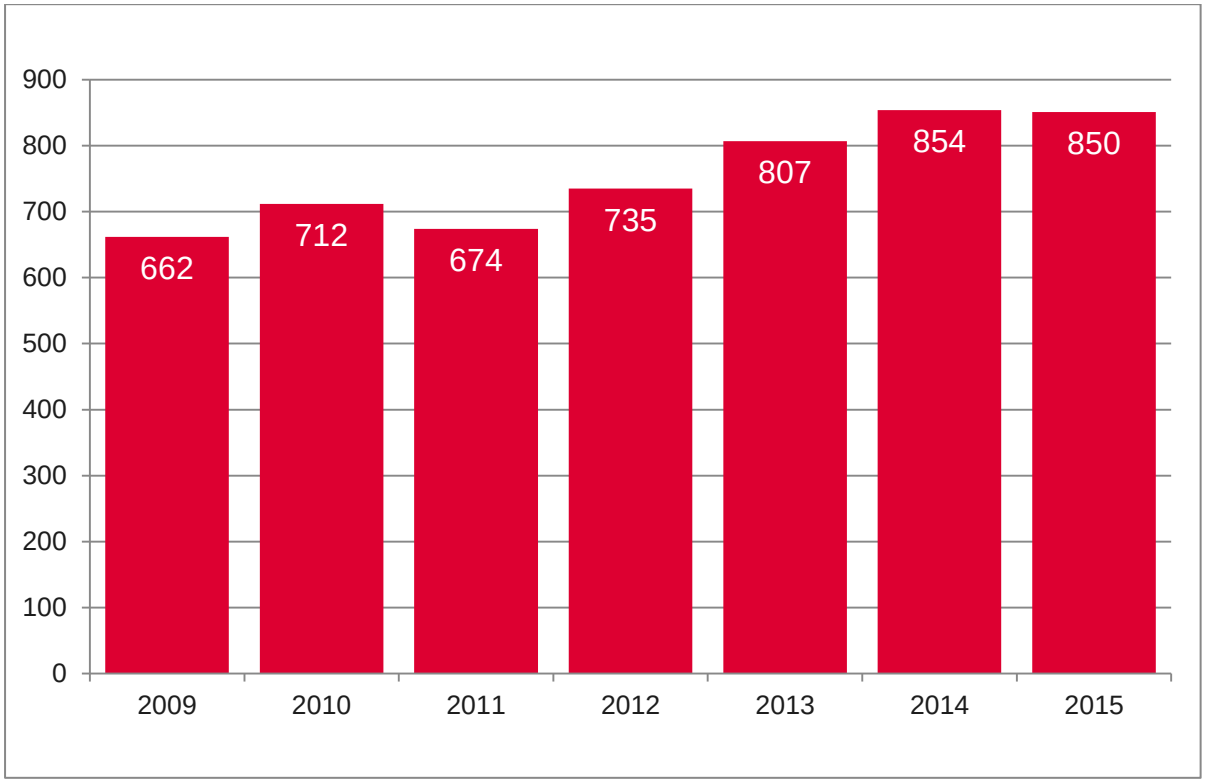
Investment returns

Our long-term goals for the management of our endowment investments are set out on page 18 of this report. Based on these goals our return target is RPI+5% per annum, net of all investments fees and costs.

In 2015, the endowment fund returned a net of 3.2%, underperforming the RPI+5% target of 6.2% in that year. On a three-year annualised basis the fund returned 8.2%, exceeding the annual RPI+5% return target (8.2% per annum against 6.9% per annum), while on a five-year annualised basis the fund was marginally behind the return target (6.6% per annum against 7.8% per annum.).

The chart shows the change of the investments in value terms over time. In 2015, the value of the investments marginally decreased from £854m to £850m.

Investment values at 31 December (£m)



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 2015. 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 equity and cash allocations were overweight relative to the strategic benchmark allocation at the end of 2015. 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.

Asset allocation at 31 December 2015

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 2015, Medtrust had fixed assets of £526k (2014: £526k). In the year Medtrust generated income of £125k (2014: £105k) and expended £0.7k (2014: £2k) resulting in an operating profit of £124k (2014: £103k).

- The Victoria Fund LP Incorporated (Victoria Fund) was formed in February 2010 and is 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 2015, the Victoria Fund had fixed assets of £188,003k (2014: £132,144k) and the value of its net assets was £194,567k (2014: £139,757k). Net profit in the year was £2,562k (2014: £8,724k).

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 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.
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 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 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	✓		✓		✓
Martyn Hole	✓		✓	✓	
Deirdre Kelly	✓	✓			
Bridget McIntyre	✓		Chair		
Andrew Morris	✓	✓			
Melloney Poole	✓	Chair			Chair
David Zahn	✓			Chair	✓
Branwen Jeffreys (Appointed May 2015)	✓	✓			
Rosalind Smyth (Appointed April 2016)	✓				

The following served as independent members of committees during 2015:

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 2015 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
Aidan Kearney	Chief Investment Officer (appointed September 2015)
Andrew Chapman	Chief Investment Officer (resigned April 2015)
Anita Charlesworth	Chief Economist
Nick Barber	Director of Research (resigned December 2015)
Cathy Irving	Director of Communications
Richard Taunt	Director of Policy
Mike Wetherell	Chief Operating Officer
Adam Steventon	Director of Data Analytics
Will Warburton	Director of Improvement

The charity's registered office and list of key advisers can be found on page 54.

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 5 to 25.

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.

So 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.

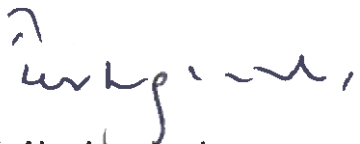
Declarations and conflicts of interest policy

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 and employees 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 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 20 on page 47.

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

This Trustees' report, prepared under the Charities Act 2011 and the Companies Act 2006, was approved by the governors on 4 July 2016, 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:



Sir Alan Langlands
Chair

4 July 2016

Auditor’s report and financial statements

For the year ended 31 December 2015

THE HEALTH FOUNDATION
INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE HEALTH FOUNDATION FOR THE YEAR ENDED 31 DECEMBER 2015

We have audited the financial statements of The Health Foundation for the year ended 31 December 2015 set out on pages 34 to 53.

The financial reporting framework that has been applied in their preparation is applicable law and FRS 102, the Financial Reporting Standard applicable in the UK and Republic of Ireland.

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 auditor's 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 the company's 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 charitable company for the purpose of company law) are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

Our responsibility is to audit and express an opinion on the financial statements 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 financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the charitable company's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the trustees; and the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the Governors' Annual Report, including the Strategic Report and the Trustees' Report, and any other surround information to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the group's and the charitable company's affairs as at 31 December 2015 and of the group's income and expenditure for the year then ended;
- have been properly prepared in accordance with FRS 102, The Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland; 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' Annual Report and the Strategic report for the financial year for which the financial statements are prepared is consistent with the financial statements.

THE HEALTH FOUNDATION
INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE HEALTH FOUNDATION FOR THE YEAR ENDED 31 DECEMBER 2015

Matters on which we are required to report by exception

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:

- the parent charitable company has not kept adequate accounting records; or
- the parent charitable company financial statements 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.

N.Ha.Ho.mi

Naziar Hashemi
Senior Statutory Auditor
For and on behalf of Crowe Clark Whitehill LLP
Statutory Auditor
London

Date: 5/7/16

THE HEALTH FOUNDATION
CONSOLIDATED STATEMENT OF FINANCIAL ACTIVITIES
FOR THE YEAR ENDED 31 DECEMBER 2015

Consolidated statement of financial activities

	Notes	Unrestricted Fund £000	Restricted Fund £000	Expendable Endowment Fund £000	**Total Funds 2015 £000**	Total Funds 2014 £000
Income and Endowments :						
Investments	6	14,401	-	-	**14,401**	16,988
Charitable Activities	7, 17	136	975	-	**1,111**	221
Capital Applied to Income		13,074	-	(13,074)	**-**	
Total Income		27,611	975	(13,074)	**15,512**	17,209
Expenditure:						
Raising Funds	8	-	-	9,654	**9,654**	9,604
Charitable Activities	9, 17	27,611	584	-	**28,195**	29,366
Total Expenditure		27,611	584	9,654	**37,849**	38,970
Operating deficit		-	391	(22,728)	**(22,337)**	(21,761)
Net gain on investments	13	-	-	18,644	**18,644**	67,370
Net Income/Expenditure for the year		-	391	(4,084)	**(3,693)**	45,609
Balances as at 1st January 2015		-	-	831,548	**831,548**	785,939
Balances as at 31st December 2015		-	391	827,464	**827,855**	831,548

Comparative figures for 2014 can be found in note 5.

THE HEALTH FOUNDATION
CHARITY AND CONSOLIDATED BALANCE SHEETS
AS AT 31 DECEMBER 2015

Charity and consolidated balance sheet

	Notes	**Group 2015 £000**	Group 2014 £000	Charity 2015 £000	Charity 2014 £000
Fixed assets:					
Tangible fixed assets	12	1,243	1,456	1,243	1,456
Financial investments	13	849,691	853,656	655,369	710,867
Programme related investment	21	526	526	-	-
Investment in subsidiaries	21	-	-	194,848	143,315
Total fixed assets		851,460	855,638	851,460	855,638
Current assets:					
Debtors	14	699	589	707	596
Cash and short term deposits		2,257	3,860	2,249	3,853
Total current assets		2,956	4,449	2,956	4,449
Current liabilities:					
Amounts falling due within one year	15	(17,456)	(16,158)	(17,456)	(16,158)
Net current liabilities		(14,500)	(11,709)	(14,500)	(11,709)
Total assets less current liabilities		836,960	843,929	836,960	843,929
Long term liabilities:					
Amounts falling due after one year	15	(8,278)	(11,670)	(8,278)	(11,670)
Provisions:					
For liabilities and charges	16	(827)	(711)	(827)	(711)
Net Assets		827,855	831,548	827,855	831,548
Funds:					
Unrestricted fund		-	-	-	-
Restricted fund	17	391	-	391	-
Expendable Endowment fund	17	827,464	831,548	827,464	831,548
Total funds		827,855	831,548	827,855	831,548

The analysis by funds can be found in Note 17.

Approved by the board on 4th of July 2016 and signed on its behalf by:

Sir Alan Langlands
Chair

Bridget McIntyre
Chair of the Audit Committee

THE HEALTH FOUNDATION
CONSOLIDATED CASHFLOW STATEMENT
FOR THE YEAR ENDED 31 DECEMBER 2015

Consolidated cashflow statement

	Notes	**2015 £'000**	2014 £'000
Net cash used in operating activities	A	**(28,695)**	(24,161)
Cash flows from investing activities			
Withdrawals from Investments		**36,993**	35,907
Investment management fees		**(9,654**	(9,604
Investment income		**14,401**	16,988
Investment proceeds re-invested		**(14,384)**	(15,501)
Purchase of tangible fixed assets		**(264)**	(1,438)
Net cash provided by investing activities		**27,092**	26,352
Change in cash and cash equivalents in the reporting period	B	**(1,603)**	2,191
Cash and cash equivalents at 1 January		**3,860**	1,669
Cash and cash equivalents at 31 December		**2,257**	3,860

A. Reconciliation of net income/(expenditure) to net cash flow from operating activities

	2015 £'000	2014 £'000
Net operating deficit for the reporting period	**(22,337)**	(21,761)
Adjustments for:		
Investment income	**(14,401)**	(16,988)
Investment management fees	**9,654**	9,604
Depreciation and amortisation charges	**477**	269
Decrease/(increase) in debtors	**(110)**	(27)
Increase/(decrease) in creditors	**(2,094)**	4,673
Increase/(decrease) in provisions	**116**	69
Net cash used in operating Activities	**(28,695)**	(24,161)

B. Movement of cash and cash equivalents

	At 1 January 2015 £'000	Movement £'000	**At 31 December 2015 £'000**
Cash at bank and in hand	3,860	(1,603)	**2,257**

Notes to the financial statements

1. Charity Information

The Health Foundation (Foundation) is a registered charity (No. 286967) and a company limited by guarantee (No. 1714937). The Health Foundation meets the definition of a public benefit entity under FRS102. The address of 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 of the Foundation to a maximum of £1.

2. Accounting Policies

a) Basis of preparation

The consolidated financial statements of the group and its subsidiary undertakings have been prepared in accordance with applicable UK GAAP including financial reporting standard 102 (FRS102). They comply with the Companies Act 2006 and the Statement of Recommended Practice (SORP) 'Accounting and Reporting by Charities' published in 2015.

b) Fund accounting

The Foundation maintains three types of funds, the Expendable Endowment fund, the Restricted Fund and the Unrestricted Fund. Income and Expenditure on these funds are shown separately within the Statement of Financial Activities.

The Expendable Endowment fund represents 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.

The Unrestricted fund represents the general funds of the charity available to be spent on the future general purposes of the Foundation. The income is made up of investment income, other incoming resources and any capital applied as income.

The Restricted fund represents the funds of the charity available solely to be used for a particular area of the Foundation's work.

c) Investments in subsidiaries

Subsidiary undertakings formed to hold investments – currently the Victoria Fund (LP) Incorporated (Victoria Fund) – are included in the charity'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.

d) Basis of consolidation

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

In accordance with section 408 of the Companies Act 2006 and 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.

e) Impact of FRS 102 Implementation

In preparing the accounts the trustees have considered whether in applying the accounting policies required by FRS 102 and the Charities SORP FRS 102 the restatement of comparative items was required. In their estimation, the impact of transitioning was not material to the financial statements and therefore the restatement of comparative items was not required. The transition date was 1 January 2015.

Victoria Fund has adopted FRS102 and this has resulted in the financial investments being restated at fair value which amounts to £3.2m. Based on the Foundation's endowment, this adjustment is less than 1% of the total endowment, which is immaterial; therefore no prior year restatement has been made.

f) Incoming resources

Income from investments is accounted for 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.

g) Resources expended

Expenditure is accounted for 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 the charitable objects. These are:
  - **Grants including programme costs** are charged to the Statement of Financial Activities 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.
- **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 appropriate actuarial advice.
- **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.

h) Foreign currencies

Foreign currency balances have been translated at the rate of exchange ruling at the balance sheet date. Income and expenditure transactions incurred in foreign currencies have been translated during the course of the year at the rate of exchange ruling at the time of the transaction.

i) Unrealised and realised gains and losses

Unrealised gains and losses are recorded 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.

j) Quoted investments

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.

k) Unquoted Investments

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 the 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.

l) Tangible and intangible fixed assets

Tangible fixed assets over a value of £1,000 are capitalised. All assets are recorded at historic cost and depreciation is provided using a straight-line basis as follows:

- Furniture & fittings over 5 years
- Computers over 3 years
- Leasehold improvements over 10 years

Intangible fixed assets are subject to review for impairment when there is an indication of a reduction in their carrying value. Any impairment is recognised in the year in which it occurs.

m) Operating Lease costs

Operating lease costs are charged to the Statement of Financial Activities on a straight line basis over the relevant lease term.

n) Financial Instruments

The Health Foundation has financial assets and financial liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at the present value of future cash flows (amortised cost). No discounting has been applied to these financial instruments on the basis that the periods over which amounts will be settled are such that any discounting would be immaterial.

Investments, including bonds and cash held as part of the investment portfolio, are held at fair value at the Balance Sheet date, with gains and losses being recognised within income and expenditure.

3. Critical accounting judgements and key sources of estimation uncertainty

In the application of the charity's accounting policies, trustees are required to make judgements, estimates and assumptions about carrying values of assets and liabilities that are not readily apparent from other sources. The estimates and underlying 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 year in which the estimate is revised if the revision affects only that year or in the year and future years if the revision affects the current and future years. The key sources of estimation uncertainty that have a significant effect on the accounts recognised in the financial statements are summarised below. The Foundation's key area of estimation is the valuation of the unlisted investments and the pension obligation provision.

4. Charity only exemptions

The charity has taken advantage of the exemptions in FRS 102 not to present a charity only cash flow statement and certain disclosures about the charity's financial instruments.

5. Prior year Consolidated Statement of Financial Activities for the Year Ended 31 December 2014

	Unrestricted Fund £000	Restricted Fund £000	Expendable Endowment Fund £000	**Total Funds £000**
Income and endowments :				
Investments	16,988	-	-	**16,988**
Charitable activities	221	-	-	**221**
Capital applied to income	7,892	-	(7,892)	-
Total income	25,101	-	(7,892)	**17,209**
Expenditure:				
Raising funds	-	-	9,604	**9,604**
Charitable activities	29,199	-	-	**29,199**
Other expenditure	167	-	-	**167**
Total expenditure	29,366	-	9,604	**38,970**
Operating deficit	(4,265)	-	(17,496)	**(21,761)**
Net gains on investments	-	-	67,370	**67,370**
Net income/expenditure for the year	(4,265)	-	49,874	**45,609**
Balances as at 1 January 2014	4,265	-	781,674	**785,939**
Balances as at 31 December 2014	-	-	831,548	**831,548**

6. Investment income

	2015 £000 Group	2014 £000 Group
Property funds	4,241	4,427
Equities	8,050	9,005
Fixed interest	2,110	3,518
Alternatives	**-**	38
	14,401	16,988

Included in fixed interest is bank interest of £17k which was not reinvested.

7. Other Income

	2015 £000 Group	2014 £000 Group
Share of profit in BMJ Quality & Safety	125	105
HREP	-	116
Other income	11	-
	136	221

8. Expenditure on raising funds

	2015 £000 Group	2014 £000 Group
Investment managers' fees	9,218	8,964
Custodian fees	101	115
Salary costs	172	182
Investment consultancy	138	216
Other investment costs	25	127
	9,654	9,604

Investment managers' fees above include manager fees of the underlying funds in the Victoria Fund.

9. Expenditure on charitable activities

	Grant £000	Salary costs £000	Overheads £000	**Total 2015 £000**	Total 2014 £000
Charitable activities					
Improving service delivery	12,576	5,300	4,467	**22,343**	27,710
Improving public policy	2,344	998	833	**4,175**	-
Improving population health	662	279	235	**1,176**	28
Others	215	81	205	**501**	1,628
Total charitable and other expenditure	**15,797**	**6,658**	**5,740**	**28,195**	29,366

The above expenditure relates to the provision of financial and other assistance in satisfaction of the objects for which the Foundation was established. Governance expenditure has been included above. Further details about grant funding for each strategic priority can be found in Note 22 on page 49.

Trustees did not received any remuneration for services as members of the Board of Trustees but a total of £6k (2014: £3k) was reimbursed to six (2014: six) members for travel to and from board meetings.

Audit fees exclusive of VAT were £32.2k (2014:£31.5k) in addition to which the auditors were paid £5k (2014:£11k) for non-audit services.

10. Staff costs

	2015 £000	2014 £000
Salaries and wages	5,698	4,274
Social security costs	606	492
Pension costs	442	348
Redundancy	71	27
Other	14	10
	6,831	**5,151**

The average number of employees during the year was 111 (2014: 83) which equated to full time equivalent of 109 (2014: 79). The total above also includes the salaries relating to investment which amount to £172k.

Employees whose employee benefits (excluding employer pension contributions) were in excess of £60,000 are shown below. The 2014 comparative figures have been restated to exclude Employers NI.

Band	2015 No	2014 No
60,001 - 70,000	6	1
70,001 - 80,000	2	1
80,001 - 90,000	3	3
90,001 - 100,000	4	4
100,001 - 110,000	2	0
110,001 - 120,000	2	1
120,001 - 130,000	0	1
130,001 - 140,000	1	1
150,001 - 160,000	0	1
160,001 - 170,000	1	0
220,001 - 230,000	1	1

Key management personnel of the Foundation are the chief executive officer and others as set out in senior management section in the governors' annual report. The total employee benefits for this group were £1,295k (2014: £1,023k). One new director (2014: two) was appointed during 2015. Trustees are not remunerated for their services.

11. Pensions

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 £442k (2014: £348k). There were no outstanding contributions at 31 December 2015.

b) The Pensions Trust – Growth Plan

The Health Foundation also participates in the Pension Trust Growth Plan ('the Plan') which was offered to employees up to 31 March 2007 before the AEGON scheme commenced. Many employees transferred to the AEGON scheme but, as at 31 December 2015, there was one active member, 13 deferred members, and three members receiving pensions participating in the Growth Plan.

The Plan is a multi-employer pension plan which in most respects is a money purchase arrangement, although it does include certain guarantee elements as described below.

The rules of the Plan give the Trustee the power to require employers to pay additional contributions in order to ensure that the statutory funding objective under the Pensions Act 2004 is met. The statutory funding objective is that a pension scheme should have sufficient assets to meet its past service liabilities, known as Technical Provisions.

The latest formal valuation of the Plan was performed at 30 September 2011 and this showed the Plan to have a funding level of 84.1% on a Technical Provisions valuation basis and a funding level of 77.3% on a buy-out basis. The Scheme Actuary prepared a funding position update at 30 September 2012 which revealed a reduction in the funding level to 80%.

The Foundation's annual deficit contribution from 1 April 2015 was £13k, and this has increased by 3% in April annually. In 2015, £13k of contributions were made by the Foundation.

The Health Foundation has recognised a provision of pension liability of £124k in 2015. Of this, £22k was paid out in 2015 resulting in a net movement of £102k.

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 2015, based on advice from an actuary, is estimated to be £508k, of which the full amount has been provided in previous years as disclosed in Note 16. This balance is reviewed every three years, with the next review in 2016.

12. Tangible fixed assets

Group and Charity

	Computer equipment £000	Furniture & fittings £000	Total £000
Cost			
At 1 January 2015	793	1,335	**2,128**
Additions	229	35	**264**
At 31 December 2015	**1,022**	**1,370**	**2,392**
Depreciation			
At 1 January 2015	272	400	**672**
Provided	261	216	**477**
At 31 December 2015	**533**	**616**	**1,149**
Net book value			
At 31 December 2015	**489**	**754**	**1,243**
At 1 January 2015	**521**	**935**	**1,456**

13. Financial Investments

a) Analysis of Charity investment holdings	2015 £000	2014 £000
Market value at 1 January	**710,867**	**690,594**
Income from investment holdings	**13,859**	**15,371**
Net withdrawals from the portfolio	**(82,561)**	**(42,319)**
Investment management costs within funds	**(2,072)**	**(1,770)**
Net gain on investments	**15,276**	**48,991**
Market value at 31 December	**655,369**	**710,867**
Cost at 31 December	**562,878**	**564,622**

b) Analysis of Group investment holdings	£000	£000
Market value at 1 January	**853,656**	**806,692**
Income from investment holdings	**14,384**	**15,501**
Net withdrawals from the portfolio	**(29,990)**	**(29,312)**
Investment management costs within funds	**(7,003)**	**(6,595)**
Net gain on investments	**18,644**	**67,370**
Market value at 31 December	**849,691**	**853,656**
Cost at 31 December	**731,660**	**683,529**

c) Market value analysis of investments

	2015 £000 Group	2014 £000 Group
Property funds	**92,643**	86,536
Equities	**462,851**	523,181
Fixed interest	**72,160**	83,104
Alternatives	**191,029**	153,464
Cash	**31,008**	7,371
Market Value at 31 December	**849,691**	**853,656**

d) A currency hedging programme was in place during the year to manage foreign currency exchange risk. At 31 December 2015 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 are included within the overall value of the investments above. At 31 December 2015, the Victoria Fund held contracts to buy $46,578,795 and £188,488,194. The unrealised gain associated with these forward currency contracts totalled £4,413,768 as at 31 December 2015.

e) 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 2015.

At 31 December 2015	**Less than 6 months**	**6-12 months**	**More than 12 months**	***Long-term lock-up**
	£'000	**£'000**	**£'000**	**£'000**
Total non-current assets	-	-	14,862	32,481
Total current assets	111,373	41,651	-	-
Total current liabilities	4,478	1,322	-	-

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

f) At the balance sheet date, the Foundation had total investment commitments of £42m for private equity and infrastructure from total commitments of £74m. These commitments form part of the planned asset allocation and will be met from within the existing investments.

14. Debtors

	Group 2015 £000	Group 2014 £000	**Charity 2015 £000**	Charity 2014 £000
Prepayments	**450**	308	**450**	308
Medtrust Ltd	**-**	-	**125**	103
Other debtors	**249**	281	**132**	185
	699	**589**	**707**	**596**

15 a) Current and long-term liabilities:

Group and charity

	Unrestricted Fund £000	**Expendable Endowment Fund £000**	**2015 £000**	**2014 £000**
Amounts falling due within one year				
Grants	15,029	-	15,029	13,868
Investment fees	-	962	962	1,000
Trade creditors and other accruals	1,465	-	1,465	1,290
	16,494	962	17,456	16,158
Amounts falling due after more than one year				
Grants – within two to five years	8,278	-	8,278	11,670
Total liabilities	**24,772**	**962**	**25,734**	**27,828**

15 b) Grants payable

Group and charity

	2015 £000	**2014 £000**
As at 1 January	25,538	20,343
Grants committed in the year	15,797	19,229
Paid during the year	(18,028)	(14,034)
As at 31 December	**23,307**	**25,538**

16 Provisions

Group and charity

	Opening balance £000	**Movement £000**	**Closing Balance £000**
Pension obligations	529	102	631
Dilapidations	182	14	196
	711	**116**	**827**

17. Allocation of assets between funds

	Expendable Endowment	Restricted Fund	Unrestricted Fund	Total funds 2015	Total funds 2014
	£000	£000	£000	**£000**	£000
Tangible assets	-	-	1,243	1,243	1,456
Programme related investment	-	-	526	526	526
Financial Investments	828,426	-	21,265	849,691	853,656
Net assets	-	391	2,565	2,956	3,860
Net liabilities	(962)	-	(25,599)	(26,561)	(27,950)
Total funds	**827,464**	**391**	**-**	**827,855**	**831,548**

The Restricted Fund relates to funds from the Q initiative in 2015 of £975k, of which £584k was used. The balance of £391k is expected to be used in 2016.

18. Operating lease and other financial commitments

At 31 December 2015, the Foundation has a property lease, which expires in July 2019, for its office premises of £1,019k payable in one year, leaving a remaining balance of £2,547k (2014: £4,585k).

19. Financial instruments

Financial assets held at amortised cost comprise cash at bank and in hand, short term cash deposits and the Group's debtors excluding prepayments (Note 14).

Financial liabilities held at amortised cost comprise the group's short and long term creditors and provisions (Note 15).

20. 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 or contracted with in 2015 are noted in the table overleaf:

Board member	Role in organisation receiving funding	Organisation
Deirdre Kelly	• Consultant Paediatrician	Birmingham Children's Hospital NHS Foundation Trust
Margaret Goose	• Honorary Fellow	Royal College of Physicians (of London)
Andrew Morris	• Fellow	Royal College of Physicians of Edinburgh
	• Fellow	Academy of Medical Sciences
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
	• Director	Worldwide Universities Network
	• Director	Yorkshire Universities
	• Senior Associate Fellow	Royal Society of Medicine
	• Fellow	Royal Society of Edinburgh
	• Fellow	Academy of Medical Sciences
	• Fellow	Birkbeck College
	• Fellow	Royal College of Physicians
	• Fellow	Royal College of Surgeons
	• Fellow	Royal College of Physicians and Surgeons (Glasgow)
David Dalton	• CEO	Salford Royal NHS Foundation Trust
	• Vice Chair	Greater Manchester Academic Health Science Network
	• Chair	NHS Quest

Member of staff	Role in organisation receiving funding	Organisation
Anita Charlesworth	• Vice Chair	Whittington Health
Jo Bibby	• Non-executive	Salford Royal NHS Trust
Jennifer Dixon	• Board member	NatCen
	• Fellow	Royal College of Physicians
	• Honorary Professor	Imperial College London School of Hygiene and Tropical Medicine LSE
Will Warburton	• Fellow	Imperial College London

During the year, Victoria Fund, a subsidiary of the Foundation received an investment contribution of £52.5m from the charity. Medtrust, a subsidiary of the Foundation donated its profit of £124k to the Foundation as a gift aid.

21. Subsidiary Companies

The Foundation has two subsidiary undertakings:

a) Medtrust Innovations Limited (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 and in the Group balance sheet as an intangible fixed asset. Medtrust undertakes an impairment review each year.

At 31 December 2015, Medtrust had fixed assets of £526k (2014: £526k). This was also the value of its net assets matching the value of the shareholders' funds.

During the year Medtrust generated income of £125k (2014: £105k) and expended £0.7k (2014: £2k) resulting in an operating profit of £124k (2014: £103k). The sum equivalent to its taxable profits was donated to the Foundation using gift aid as provided for in Medtrust's Articles of Association.

b) The Victoria Fund LP Incorporated (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 exempted 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 2015, the Victoria Fund had fixed assets of £188,003k (2014: £132,144k) and the value of its net assets was £194,567k (2014: £139,757k). Net profit in the year was £2,562k (2014: £8,724k).

22. Grant Funding

The Foundation made £15,797k of grants in 2015. 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 to name a few. 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	Number of Grants	Total £000
Improving Service Delivery		
Sheffield Teaching Hospitals NHS Foundation Trust	5	1,000
Ashridge Business School	4	630
University College London	5	573
University of Southampton	4	497
London Ambulance Service	1	486
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group (SES & SP CCG)	1	419
The Royal College of Anaesthetists	1	400
UCLPartners	3	320
Lightbox Entertainment	4	297
University of Birmingham	2	280
East Midlands Improvement Science Development Network	1	280
The Office for Public Management	5	272
Salford Royal NHS Foundation Trust	4	261
University of Oxford	2	253
The King's Fund	2	235
Oxford Health NHS Foundation Trust	3	214
Royal Surrey County Hospital NHS Trust	1	181
South West London and St Georges Mental Health NHS Trust	4	155
South West London and St Georges NHS Trust	4	71
Universities UK	2	153
NHS Borders	2	150
University Hospitals Southampton	2	148
University of Aberdeen	3	128
University of Leicester	4	115
Academy of Medical Sciences	3	115
Kidney Research UK	2	110
The Evidence Centre	8	107
Cardiff University	2	103
Andrew Constable Ltd	6	99
University of Hull	1	96
University College London Hospitals NHS Foundation Trust	2	92
Royal Free London NHS Foundation Trust	3	91
Uscreates	9	158
Social Science Research Solutions	2	86
Bill Lucas Partnership Ltd	4	79
Frontline Consultants Ltd	4	77
Christie Hospital NHS Trust	1	75
Berkshire Healthcare NHS Foundation Trust	1	75
Cystic Fibrosis Trust	2	75
Barts Health NHS Trust	3	75
York Teaching Hospitals NHS Foundation Trust	1	75
Hull and East Yorkshire Hospitals NHS Trust	1	75

Organisations	Number of Grants	Total £000
Peninsula Community Health	1	75
Buxted Medical Centre	1	75
HfT	1	75
Heart of England NHS Foundation Trust	1	74
St George's University Hospitals NHS Foundation Trust	1	74
St Gemma's Hospice	1	73
St Luke's Hospice	1	73
NHS Lanarkshire	1	73
South Eastern Health & Social Care Trust (SEHSCT)	1	72
Great Ormond Street Hospital for Children NHS Trust	1	70
NHS Lothian	1	68
North Bristol NHS Trust	1	64
Cynergy	7	89
University of Sheffield	2	53
RAND Europe	4	100
University of Manchester	1	48
SHW Health Limited	2	42
Solutions for Public Health	2	40
Ipsos MORI	3	38
University of Nottingham	1	37
South London and Maudsley NHS Foundation Trust	3	67
Aligned Consultancy Ltd	1	37
Peninsula College of Medicine and Dentistry	1	35
University of York	2	35
NHS Education for Scotland	1	30
Airedale NHS Foundation Trust	2	30
Worcestershire Health and Care NHS Trust	1	30
Office of Health Economics	1	30
University of Newcastle upon Tyne	1	30
East London NHS Foundation Trust	1	30
Devon Partnership NHS Trust	1	30
Bridges Self-Management Limited	1	30
NHS Greater Glasgow and Clyde	1	30
NHS Grampian	1	30
The British Association for Parenteral and Enteral Nutrition	1	28
Betsi Cadwaladar University Health Board	2	28
City and Hackney Clinical Commissioning Group	1	27
Firefly Research and Evaluation Ltd	2	27
Paul Batalden	4	26
Therese Turner Ltd	3	24
Live Group	3	24
Newcastle University	3	15
Point of Care	1	14
BMJ Group	2	11
Eastern Academic Health Science Network	4	20
North West Coast Academic Health Science Network	2	20
East Midlands Academic Health Science Network	2	20
Health Innovation Network South London	2	20

Organisations	Number of Grants	Total £000
West of England Academic Health Science Network	2	20
Kent Surrey and Sussex Academic Health Sciences Network	2	20
Imperial College Health Partners	2	20
John Radcliffe Hospital	1	10
Wessex Academic Health Science Network	2	20
South West Academic Health Science Network	2	20
North East and North Cumbria Academic Health Science Network	2	20
University of Warwick	1	10
Greater Manchester Academic Health Science Network	2	20
University of Bradford	1	10
Northern Ireland HSC Safety Forum	2	20
Yorkshire and Humber Improvement Academy	2	20
Tavistock Consultancy	1	10
NHS Scotland QI Hub	2	20
British Society for Anitmicrobial Chemotherapy	1	9
Carl Macrae	1	8
Oxford Academic Health Science Network	2	12
Joy McAvoy	2	5
Royal Infirmary of Edinburgh NHS Trust	1	5
Royal College of Physicians of Edinburgh	1	5
International Futures Forum	1	5
Carol Culshaw	2	4
Veterans Education and Research Association of Northern New England, Inc. Q	1	2
Other	43	790
Write Backs		(697)
Total Improving Service Delivery	**300**	**11,660**

Improving Public Policy		
Behavioural Insights Team (BIT)	2	682
Centre For Evidence Based Medicine - University of Oxford	1	344
London School of Economics	3	307
University of Nottingham	1	257
Warwick Business School	1	212
University of South Wales	2	89
World Health Organisation	1	73
C M Monitor Ltd	4	68
Imperial College London	2	57
The Social Care Institute for Excellence	1	52
The King’s Fund	2	43
University of Leicester	1	24
Research Matters Ltd.	1	20
University of York	1	19
ICS Integrare	2	18
Institute for Fiscal Studies	1	18
Johns Hopkins Bloomberg School of Public Health	1	12
Office of Health Economics	1	10
Peter Thomas Ltd	1	6

Organisations	Number of Grants	Total £000
Andrew Hudson	1	6
Durham University	2	5
Other	1	20
Total Improving Public Policy	**33**	**2,344**

Improving Population Health		
University of Oxford	1	323
Social Finance Ltd	1	125
Salzburg Global Seminar	1	97
C3 Collaborating for Health	1	48
Family Nurse Partnership National Unit	1	40
Centre for Innovation in Voluntary Action	1	20
London School of Hygiene & Tropical Medicine	1	9
Total Improving Population Health	**7**	**662**
Other		
Charitable Giving (Governor Grants)	15	215
Total Other	**15**	**215**
Total Grant Funding	**355**	**15,797**

THE HEALTH FOUNDATION
KEY ADVISERS AND REGISTERED OFFICE
FOR THE YEAR ENDED 31 DECEMBER 2015

Key advisers

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CHARITY'S REGISTERED OFFICE
The Health Foundation
90 Long Acre
London WC2E 9RA

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.

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Registered charity number: 286967
Registered company number: 1714937