The Health Foundation
Inspiring Improvement

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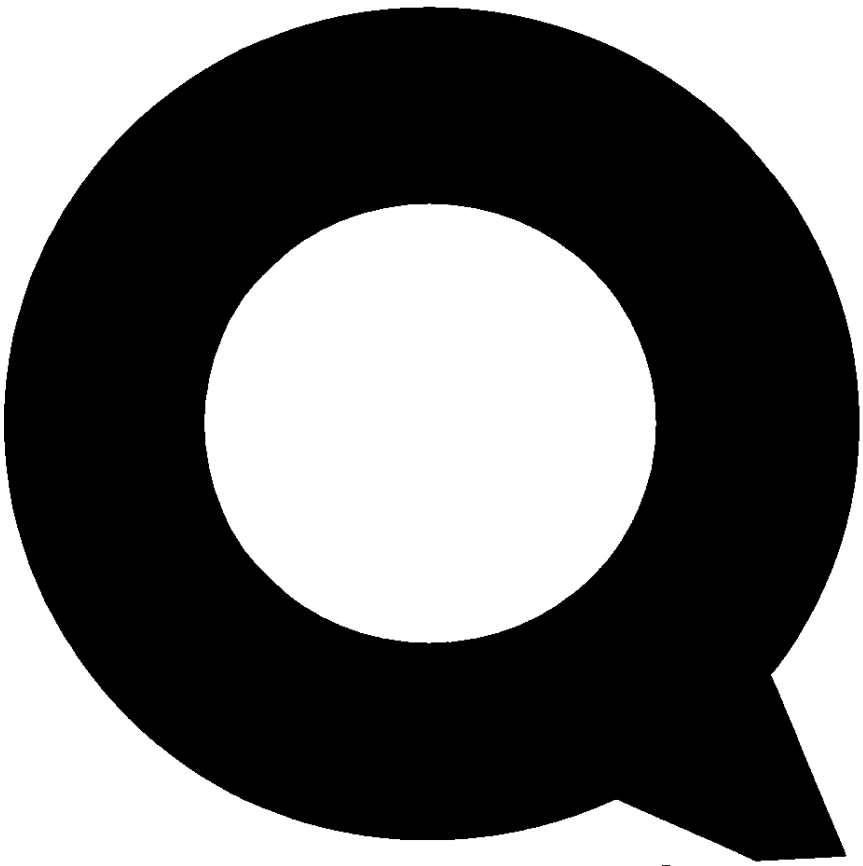
Annual Report and Financial Statements

for the year ended December 2009



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Message from the Chair

Above all, I want to pay tribute to Vin McLoughlin, our Director of Quality and Performance Analysis, who sadly died in November 2009. Vin made an immense contribution to the work of the Foundation and is sadly missed by everyone here and by her friends and colleagues in the health and academic communities.

Challenges and impact

The world was dominated by the financial downturn in 2009 and this will have a knock-on effect on public spending over the next few years We made an early intervention to cast light on the debate about how much improving quality could reduce costs by commissioning a systematic review of the evidence This has been highly influential, and, alongside other work, reinforces our commitment to improving quality

We also decided to focus our new Shine award scheme on promoting ideas for improving quality and productivity This award scheme provides opportunities for people to develop, test and gather evidence to support their ideas about how to improve healthcare quality Healthcare practitioners are supported to try out ideas in a way that can be measured The first round was launched in September and generated a high level of interest which led to the selection of 18 award holders, with around £75,000 invested in each project Given the level of interest and critical importance of the issue, we will continue with the same theme in 2010

The increasing number of past and present Health Foundation award holders working in influential roles across the UK all played a key role in spreading good practice, showing real leadership at the leading edge of healthcare practice We also continued to influence policy makers and politicians, national organisations, professional bodies, academics and patient organisations about the central importance of quality improvement in healthcare

- Chief Executive Stephen Thornton's membership of the Department of Health's National Quality Board has positioned the Foundation at the heart of debate and provides us with a unique opportunity to promote our views For example, we led a discussion about the need to align thinking on the interpretation of hospital standardised mortality ratios and the publication of performance data, and played a key role in establishing a government working group to sort this out
- We provided evidence and advice to the Department of Health via the 'Quality, Innovation, Productivity and Prevention' initiative, led by a former governor of the Foundation, Jim Easton
- We responded to policy consultations on topics that are core to our purpose, including quality accounts, the Scottish Government's development of a quality strategy, and the Conservative Party's consultation on personal health records We also contributed rigorous evidence to the growing debate on quality and productivity, disseminating our systematic review and sharing good practice

- In recognition of the central role attributed to strategic health authorities (SHAs) in the Next Stage Review, Stephen Thornton toured England's SHAs to build our relations with their senior staff and promote the Foundation as a source of valuable expertise and advice His visit to NHS North East was significant in our subsequent decision to support them with their delivery of the Safer Care North East patient safety strategy
- We engaged actively with the Health Select Committee's inquiries into patient safety and commissioning The approach of our Safer Patients Initiative (SPI) was recognised by the government's response to the former stating that it 'fully supports' the recommendation that the SPI measures for boards are adopted throughout the NHS.

The Health Foundation's 'Engaging with Quality Initiative' came to an end in 2009 The independent evaluation of the scheme concluded that it had been successful in mobilising large numbers of clinicians across a wide range of organisational settings These clinician-led initiatives to improve quality have led to greater standardisation of professional practice, more equitable care, greater quality control and improved patient satisfaction The scheme has contributed to the engagement of royal colleges and professional bodies in quality improvement and strengthened their capacity to support it The projects have also influenced change at national and local level

We developed a new flagship leadership for improvement scheme, GenerationQ, which integrates the best thinking on leadership development with improvement science The scheme was launched in late 2009 and the first cohort will start work in April 2010

Critically, we have started to address the issue of how best to ensure the sustainability and spread of our work Now that our early programme investments are producing results, we need to maximise our impact on healthcare policy, practice and research This will involve new ways of working with practitioners and other improvement networks Finally, we have discovered that the evaluation of complex improvement interventions presents continuing challenges, not least because the best approaches to evaluation are hotly debated in the literature We continue to work hard to ensure that new evaluations are based on best practice and we will work hard to ensure that our evaluations generate real-time learning and a summative judgement of effectiveness

The Health foundation will continue to rise to the challenge of promoting excellent healthcare which is safe, effective, efficient and equitable and I would like to thank all our staff, friends and supporters who have committed to achieving this ideal

Sir Alan Langlands
Chair – Board of Governors

Governors' report

The board of trustees ('the governors') of the Health Foundation ('the Foundation') present their annual report for the year ended 31 December 2009 under the Companies Act 2006 and the Charities Act 1993, together with the audited financial statements for that year.

This report reviews the Health Foundation's activities, successes and challenges in 2009.

In setting our objectives and planning our activities, the governors, in accordance with section 4 of the Charities Act 2006, have considered the impact of the public benefit requirement, including the guidance issued by the Charity Commission.

About the Health Foundation

The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK

The Health Foundation wants the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable We believe that in order to achieve this, health services need to continually improve the way they work

We are here to inspire and create the space for people, teams, organisations and systems to make lasting improvements to health services.

Working at every level of the healthcare system, we aim to develop the technical skills, leadership, capacity, knowledge, and the will for change that are essential for real and lasting improvement

Our analysis of the problems in healthcare quality

The UK healthcare system is large, increasingly complex, dynamic and increasingly costly. These conditions create significant challenges to achieving high-quality care consistently, everywhere. Deficiencies have been identified across all the domains of quality.

Underlying all of these problems are numerous factors, including the following

- The belief that the most important investment to improve quality is the development of new cures
- There is often failure to quickly translate research findings into practice and many tried and tested interventions have not been implemented
- Clinical autonomy can result in a lack of accountability to managers and peers and tolerance of behaviours that add to waste and inefficiencies
- There are many operational deficits, which mean that staff constantly have to recover from latent errors within the system
- Clinicians only see a snapshot of the patient's care, yet the quality of care is determined by many different process steps provided by many different people
- The external environment, including methods of financing, performance assessment, regulation and organisational structures, can have unintended consequences on the quality of care
- The design and planning of workforce is weak, including the development of team working

Potential solutions

There are many potential solutions for a healthcare system. The Health Foundation places particular emphasis on those we believe have the greatest potential to make lasting and widespread change. They are:

A sustained focus on continuous improvement in the quality of health services

As well as identifying new cures, demonstrating the clinical effectiveness of new interventions and addressing the underlying determinants of health, better health outcomes can also be achieved by improving the quality of health services This has been a neglected area Health systems need to focus on closing the gap between best and current practice To achieve this, leaders need to know about and be competent in leading for improvement

An emphasis on the importance of internal (intrinsic) motivators, alongside external (extrinsic) ones

There has been a dominant focus on external drivers of change (for example, regulation, economic incentives and performance management) when internal drivers of behavioural change (such as professionalism, skills development, organisational development and leadership) can be a stronger motivator Both are necessary, but there needs to be a strong emphasis on finding ways to support and channel the motivations of professionals for greater health gain Good leadership is critical to achieving the right blend of drivers and, in particular, appealing to the internal motivators of staff and peers

Act at all levels of the healthcare system and ensure they are aligned for quality

To achieve high-quality care for every patient, every time, there is a need to work across the whole healthcare system and to ensure that the different parts of the system relate to each other in support of quality This includes

- one-to-one interactions between a patient and a clinician
- the clinical micro system
- the delivery systems
- interventions designed to achieve change at the national level

Redefine the nature of the relationship between the people who use services and those who provide them

One critical determinant of quality of care is the interaction between people who use services and their clinical team To achieve the best outcomes, people need to be enabled to play an active role in their healthcare and for their care to be personalised This demands a different approach to the way clinicians and the wider healthcare system engage with individuals and local communities

Build knowledge, technique/ skills and new practices

Performance data such as clinical measures and patient reported outcomes can identify the gap between best and current practice New skills need to be developed – for example, testing and analysing what is known about effective care, how to make changes across the system and how to support self-management Bringing about new practices requires recognition of the organisational factors and human factors involved – for example, varying resources, the need for teamwork in a sector with unstable and unformed teams, and the need for processes to ensure that patients' wishes are taken into account

Our strategic aims and approach

Given our understanding of the problems and solutions for improving quality of healthcare, the Health Foundation works to make progress on five strategic aims. These are underpinned by the four 'pillars' of our approach that describe the four key aspects of what we do.

Our five strategic aims:

- Improving the quality of care by transforming the dynamic between people who use services and those who provide them
- Engaging with clinical communities to improve healthcare quality and value
- Transforming organisational approaches to deliver safer patient care
- Developing leaders to improve health and healthcare services
- Building and promoting knowledge on how to improve care

Our approach:

- Identify We provide the evidence and highlight the success stories to show that improvement is possible
- Innovate We help people to take a step back, innovate, and plan the practicalities of change
- Demonstrate We put ideas to work, share our learning and turn demonstration into accepted practice
- Encourage We work across every level of the healthcare system to create advocates for our approach

Identify

Before we can do anything, we need to prove that change is necessary We use our wide-ranging expertise to help people understand the consequences of poor-quality healthcare at local and national levels

- We commission new research to pinpoint any gaps between best and current practice and to highlight the barriers to improvement
- We bring clarity to existing evidence by synthesising, reviewing and sharing learning from other sectors
- We support the exchange of knowledge about effective methods and practice
- We highlight the challenges and potential solutions
- We commission independent evaluation of our programmes to generate rigorous evidence of improvement

Innovate

There is always a different way to work, yet often it is hard to ignore what you are used to doing and find the better way So we help people to take a step back, innovate, and plan the practicalities of change We encourage innovation from across the healthcare system, a good idea is a good idea, no matter how small it is or where it comes from

- We provide opportunities for leaders, teams and organisations to think creatively and come up with new ways of working
- We support people and teams in the health service to try out their ideas in a way that can be measured and proven
- We bring in learning and initiatives that have been shown to be successful elsewhere, and support organisations to implement them in the health service
- We design innovative leadership and organisational development programmes to help make change happen

Demonstrate

Showing people real improvements in health services is the best way to convince them that change is achievable So we put ideas to work and share our learning. And by showing our ideas being implemented on an ever-larger scale, we create excitement about quality improvement, and turn demonstration into accepted practice

- We invest in, and work with, healthcare teams and organisations to close the gaps between actual and best practice
- We show how barriers to quality can be overcome in everyday practice, and create working models that can be refined and developed at a local level
- We share our ideas and the emerging lessons and dilemmas as the programmes develop
- We invest significantly in demonstration programmes and improvement collaboratives to show how new ideas can be implemented at a larger scale

Encourage

From politicians to patients, we work at every level of the healthcare system to create advocates for our approach By inspiring people, giving them the evidence for change and the opportunity to put it into action, we aim to put quality at the top of the health agenda

- We build knowledge and stimulate leading-edge thinking on the science of healthcare improvement
- We collaborate with others to spread our learning
- We support leaders across the health system to build skills and create supportive organisational cultures
- We support networks of individuals, teams and organisations to create the space and skills to reflect on and devise new solutions
- We engage with professional bodies and the health professions to develop knowledge, skills and approaches
- We inform the development of health policy

Assessment of progress in strategic aim: Supporting patients' active contribution to improving health and healthcare

During 2009, our demonstration project Co-creating Health continued to stretch our thinking. The challenge of embedding self-management support within current care demonstrates that for individuals to be active in their care, we need clinicians, managers, services and systems that invite and enable an active role. Creating these conditions demands changes to the way in which services are organised and delivered, as well as changes to the behaviours and attitudes of those providing care.

We explored these themes through a series of scoping papers, roundtables and some primary research to explore mechanisms for shifting the dynamic between the people who use services and the people who provide them This included reports on engaging communities to improve access to care, approaches to improve patient feedback to make services more responsive, people's emotional experience of care and the factors that influence this, access to health records as a mechanism for engendering greater power and responsibility, and approaches to improve the clinician–patient consultation

What we said we would do in 2009 and how we measured up:

We continued to deliver Co-creating Health, which explores approaches to, and the impact of, self-management support Sites identified a number of critical challenges, which they continue to work to overcome These include recruiting clinicians and service users to training programmes that are demanding in terms of time commitment, supporting clinicians following the formal training to implement the techniques learned, creating systems that enable timely follow-up with patients on progress against their goals, applying quality improvement techniques and aligning the case for these changes with the wider commissioning agenda Strong and consistent clinical and managerial leadership remains a key factor for success

During the year, we increased the capacity of the programme office, enabling it to provide more support to the sites The sites began to make strides towards the end of the year in their approaches to recruitment to the training programmes It became apparent that the constraints in the initial design, the lack of capacity in the programme office, and the greater lead-in time needed for planning and preparation meant that we were not going to achieve the original targets for activating patients through the self-management programme or re-orientating the approach of clinicians through the advanced development programme The board agreed to extend the life of the programme, so that we can continue to gather the evidence both on how to transform the way that self-management support, which is at the heart of care planning, is delivered, and on its impact

In December, the board agreed a reframing of our strategic aim in recognition that quality of care will be improved by transforming the dynamic between people who use services and those who provide them – specifically by working on the structures, processes and behaviours that shape interactions within the healthcare system

Our work in Malawi entered its second phase The Institute for Healthcare Improvement took on the role of lead partner and the programme was renamed MaiKhanda (meaning 'mother and child' in Chichewa) The partnership has started to deliver visible improvements in the involvement of women in their care and applying quality improvement techniques within the health facilities We formed a partnership with the Scottish Executive to provide placements of clinical staff in Malawi in order to support the quality improvement activities The programme team recognise the challenge of determining the impact of a large-scale intervention in a complex system, and continue to work closely with the evaluation team to interpret the emerging findings

We selected a design team to lead our 18-month demonstration programme on shared decision making The purpose of the programme is to demonstrate how shared decision making can be effectively implemented in practice The team will focus on several clinical areas and domains, including primary and secondary care, in two major centres in the UK

Our aim was to launch the second round of Closing the Gap in 2009 In light of the decision to reframe the strategic aim, we deferred the launch of the programme until 2010

Grant funding:

The total funding in 2009 for this strategic aim was £3 1m Additional funding of £643k was provided for the Co-creating Health programme to support clinical leadership knowledge capture and more support for quality improvement training We provided further funding of £396k to the Centre for International Child Health for the continuing evaluation of the MaiKhanda (Malawi) programme Additional funding of £763k was provided to the Institute for Healthcare Improvement for the Malawi programme due to the fall in the value of the pound (the programme is funded in US dollars) The University of Edinburgh (Scottish Executive) received £200k to provide placements for this programme (see above) The Newcastle upon Tyne Hospitals NHS Foundation Trust received £750k, including in-kind support, for the new shared decision making programme

Our plans for 2010:

Identify

- Commission further research into the dynamic between people who use services and the people who provide them Scoping of appropriate research will define the nature of work to be commissioned

Innovate

- Continue the design phase of our new programme to explore approaches to successful implementation of shared decision making

Demonstrate

- Conclude phase 1 of Co-creating Health in August The focus of the final period will be to consolidate the impact of the three interventions and continue to build numbers going through the training programmes
- Develop an extension phase to the current programme of Co-creating Health in order to build upon and strengthen the work within the demonstrator sites and strengthen and sustain impact within the sites
- Continue our work in Malawi to reduce maternal and neonatal mortality through our MaiKhanda programme
- Focus the second round of Closing the Gap on evidence-based interventions that can transform the relationship between people using services and people providing them

Encourage

- Focus our influencing work on shaping policy by sharing emerging findings from Co-creating Health with policy makers through a programme of site visits
- Continue to share our learning from Co-creating Health through development of tools to support wider uptake and by encouraging wider engagement with self-management support by connecting others with an interest in this area
- Share our learning on factors that influenced the patient–clinician relationships and their implications for the quality of care through a Health Service Journal (HSJ) supplement

Assessment of progress in strategic aim: Engaging with clinical communities to improve healthcare quality and value

Our significant investment in clinical team development and in professional leaders over the last five years is now producing returns. We have built our understanding of how to engage clinicians in improving the quality of the care that they provide for patients, and the challenges of turning good will and enthusiasm into measurably better outcomes for patients. This work places us in a good position to make minor mid-term adaptations to our approach to influencing clinical communities.

The Foundation is starting to have a significant impact on the professional bodies that we have chosen to work closely with Most importantly, we are shifting ideas beyond traditional professional approaches such as guidelines and clinical audit, to more systems-based approaches We undertook a royal college study tour that was particularly effective in encouraging professional leaders to work more successfully in partnership We expect the appointment of a Royal College Quality Improvement Fellow to achieve even greater traction during 2010

While we are pleased with the considerable energy and enthusiasm for improvement that has been generated among participants in the Engaging with Quality Initiative projects, we remain challenged by the complexity of delivering measurable improvements in clinical and patient reported outcomes The scheme-level evaluation confirms evidence from other studies that the relationship between quality improvement interventions and improved health outcomes is not straightforward, but depends on the context within which change is being implemented, and may take a considerable period of time to deliver results This is a challenge that we continue to address through both our programme activities and our growing research and development (R&D) work

What we said we would do in 2009 and how we measured up:

Launch a new award, Closing the Gap through Clinical Communities We appointed 11 high-quality clinical teams to our new clinical improvement award scheme, the design of which builds on our learning from the Engaging with Quality awards Through these awards, we are supporting improvement in primary, secondary and tertiary care, mental health and ambulance services, and across a wide range of health issues and geographical regions The awards encourage the clinical teams to use a number of effective improvement approaches and to place patients at the heart of their work We appointed a new technical provider to the Foundation, Berkshire Consultancy, to deliver a tailored learning and development programme for each of the teams

Manage the final stages of the Engaging with Quality Initiative Seven of the eight teams involved completed their projects in 2009 and the scheme-level evaluation by RAND Europe/Health Economics Research Group, Brunel University, was completed This demonstrated that the professional bodies involved in the projects generated a high level of clinician engagement, and most projects have implemented strategies that will enable improvement activity to continue into 2010 and beyond In November, we held a successful end-of-award event in which over 100 people participated As part of the spread strategy for this award scheme, we made two further awards to participating teams, both from the Royal College of Physicians, to promote further improvement work in the fields of chronic obstructive pulmonary disease (COPD) and inflammatory bowel disease (IBD)

Continue to manage Engaging with Quality in Primary Care awards The development programme for the nine teams involved came to a successful conclusion in June and there is clear evidence that the programme enhanced the effectiveness of the teams In addition, the awards scheme has made a useful contribution to building the evidence for the best processes for, and value of, engaging patients and patient representatives in quality improvement

Encourage professional bodies and organisations to take a lead in promoting improvement
We continued our strategy to build long-term relationships with selected royal colleges and professional bodies to encourage them to make improvement activities a strategic priority
This included

- appointing an expert in quality improvement to work with the Royal College of General Practitioners, the Royal College of Physicians and the Royal College of Psychiatrists
- commissioning a study tour to exemplar sites in Boston, USA, for leaders of selected Colleges, healthcare and education organisations
- supporting the Royal College of Physicians and the Royal College of Psychiatrists to communicate their quality improvement work more effectively
- supporting learning and development for improvement for national and local clinical audit teams nominated by the Healthcare Quality Improvement Partnership

Implement our agreed strategy to promote learning about improvement As part of our strategy to promote improvement as a significant part of professional education and development, we commissioned the first stage of the Learning Communities Initiative This study will enable us to gain a better understanding of how healthcare organisations can create and develop environments that support improvement The study will report in mid-2011

Grant funding:

The total funding in 2009 for this strategic aim was £6 1m We provided funding of £243k to the Royal College of Physicians to fund an expert in quality improvement Each of the new Closing the Gap through Clinical Communities programme sites were awarded £475k, which includes in-kind support The sites include

- Cambridge University Hospitals NHS Foundation Trust and the East of England Perinatal Network
- Central and North West London NHS Foundation Trust
- East Midlands Ambulance Service NHS Trust
- NHS Forth Valley Health Board
- Kidney Research UK and the East Midlands Renal Network
- Royal College of Physicians (two separate projects)
- Royal College of Psychiatrists
- University of Nottingham
- Vascular Society of Great Britain and Ireland
- Warwickshire Primary Care Trust

Our plans for 2010:

Identify

- Reformulate the strategic aim to ensure that we reflect the challenges of the change process that we want to address
- Agree and implement a dissemination strategy for the Engaging with Quality Initiative and related Strengthening Impact awards

Innovate

- Approve the detailed project and learning and development plans for the 11 Closing the Gap through Clinical Communities award holders and finalise the evaluation commissions
- Participate in the Learning Communities Initiative study learning events

Demonstrate

- Consider whether to extend our investment in learning and development for improvement for clinical audit teams nominated by the Healthcare Quality Improvement Partnership in the light of experience in the first year

Encourage

- Review the final reports of the Engaging with Quality in Primary Care award holders and support dissemination of findings
- Support the Health Foundation quality improvement expert in her work with the selected medical Royal Colleges
- Continue to explore with other interested parties how service accreditation might be a driver for improvement
- Run a study tour for clinical educators to a leading health system

Assessment of progress in strategic aim: Transforming organisational approaches to deliver safer patient care

Our focus in 2009 was largely on embedding and spreading the approaches developed in the Safer Patients Initiative (SPI). We did this through launching the Safer Patients Network, a member-driven network of former SPI hospitals working together to embed and sustain improvement in safety, build new knowledge in patient safety and support capability in the wider system. In addition to this, we developed strategic partnerships with four SHAs and supported work to test safer patient approaches outside the acute sector – specifically mental health, community-based services and maternity care.

Our evidence to the Health Select Committee inquiry into patient safety was instrumental in informing their recommendations

In addition, we have been developing broader approaches to patient safety, drawing on approaches from high-reliability organisations and lean approaches to improving flow to reduce harm

What we said we would do in 2009 and how we measured up:

Safer Patients Initiative We have taken a proactive approach to influencing national policy through providing evidence to the Health Select Committee, with many of their recommendations drawing from the experience of the SPI We have continued to support safety activity at national level in England, Wales, Scotland and Northern Ireland

Safer Patients Network Eighteen of the 21 original SPI organisations signed up to participate in the Safer Patients Network through which they are strengthening the impact of original interventions and have begun to test new approaches for the benefit of the wider service Two sites have been selected for our innovation and testing programme and are working on building reliable processes of care in junior doctor rotation systems and antimicrobial prescribing All sites have identified key challenges in sustaining their work on safety, these include securing timely and reliable data, engaging busy frontline staff in improvement work, and maintaining senior commitment and attention during periods of wider service change

Approaches to safety beyond acute care In primary care, we developed a partnership with Quality Improvement Scotland to test and develop new approaches to safety, covering medication reconciliation at discharge from hospital and at outpatients, improving clinical communication between specialist outpatient clinics and primary care to optimise shared management, and developing safe and reliable systems for managing results

Safety in community-based services We have supported the development of a set of change packages for community-based services

Mental health trusts We have supported a collaborative of four mental health trusts working on leadership for patient safety, a common care process that is known to be a factor in causing harm to patients (medication safety), and a care process identified by the participating organisation (communication at transition points, patients' perceptions of safety)

Working with strategic health authorities (SHAs) We established partnerships with two further SHAs to support the development of their patient safety infrastructure, bringing the total number of partnerships to four NHS South West have launched a region-wide safer improvement collaborative with our support, NHS North West have developed a safety improvement structure to support adoption of improved safety practice, NHS South Central have launched a community-based services improvement collaborative, and NHS North East are developing an enhanced safety improvement structure with our support

Building capability

- We supported the Clinical Human Factors Group to build capability in human factors training
- Plans to support a wider network of organisations working on safety did not materialise as these were dependent on others bringing forward effective plans
- We continued to support the Patient Safety First campaign in England as a co-funder By the end of 2009, the campaign had over 60% of acute trusts in England actively working on at least two change areas
- We facilitated learning between the four UK countries by supporting a learning set for the national safety leads from each country

Safer Clinical Systems Following the launch of Safer Clinical Systems at the end of 2008, award holders have worked to identify and test a range of tools and interventions to improve safety from a systems perspective and are building an evidence base to support this approach Teams have continued to work in the agreed areas, and we have extended the first phase in order to allow greater time for methods to be tested The programme has demonstrated the challenge of introducing methods from high-reliability organisations into healthcare The learning from this experience is helping us design an way to introduce these approaches in a structured way and will form the basis of phase 2 of the programme

Flow, Cost, Quality We are supporting two hospitals to explore the relationship between patient flow through a health system and the implications this has for safety and cost

Grant funding:

The total funding in 2009 for this strategic aim was £2 6m We provided funding, including in-kind support, of £1 2m to the 18 sites taking part in the Safer Patients Network (£65k per site) We provided £350k each to NHS North West and NHS North East to help develop their patient safety infrastructure We provided £100k to the Clinical Human Factors Group to build capability in human factors training

Our plans for 2010:

Identify

- Contribute to the UK evidence base on systems approaches to improving patient safety through publication of the findings from the Warwick and Imperial Study to Examine Reliability in Healthcare
- Disseminate learning from our work to examine the relationship between patient flow and patient safety and their impact on costs

Innovate

- The Safer Patients Network will develop and test new approaches for improving patient safety
- Report on a new approach to identify waste that arises from poor clinical care processes
- Continue to test approaches to safety in new clinical settings, specifically community-based services, maternity, mental health and primary care

Demonstrate

- Draw together the learning from phase 1 of our Safer Clinical Systems programme in order to describe an approach and a range of tools and interventions to improve systems reliability and patient safety outcomes
- Extend some aspects of the site work to place greater emphasis on the business case for safety

Encourage

- Continue to share our learning from the Safer Patients Initiative, including the perspectives from the sites, the Journey to Safety research study, the Institute for Healthcare Improvement, and the evaluation
- Support capability building in the wider healthcare system through continued involvement in Patient Safety First to its conclusion in March, and the Safer Patients Network's mentoring programme
- Build on our investment in the safety infrastructure of the wider system by
  - continuing our partnership with NHS South West, NHS South Central, NHS North West and NHS North East
  - supporting the Clinical Human Factors Group in promoting knowledge of human factors in healthcare, seeking to achieve real change at the front line
  - providing a forum for national safety initiatives' leads to share and learn from activities in the four home countries

Assessment of progress in strategic aim: Developing leaders to improve health and healthcare services

We continued to build our understanding about the interventions that work in developing leaders and leadership for quality improvement, and contributed to the formal evidence base on this. We have recognised that we need to revisit our strategic aim, update it in light of our growing understanding of the issues, and align this to our ambitions to shape the organisational context that enables leadership for quality improvement to flourish.

What we said we would do in 2009 and how we measured up:

Convene a leadership for quality improvement international roundtable This was well attended and we used ideas and knowledge arising from the event to distil our existing knowledge and learning of leadership for quality improvement to feed into the design of the new leadership programme, GenerationQ

Existing schemes We continued to encourage others to improve quality by

- recruiting a further cohort of four Quality Improvement Fellows and continuing to support 16 Leadership Fellows, 15 Leaders for Change and two Harkness Fellows
- developing communities of practice among past and current award holders
- supporting a weekend conference for all past and present Quality Improvement Fellows

Maximise our learning from leadership programme evaluations We commissioned a set of robust and systematically derived statements of principles on what leadership development interventions effect specific behaviours and competencies from the Centre for Innovation in Health Management (CIHM) at Leeds University We used this statement to inform our leadership for improvement work

Synthesise and communicate our learning to influence policy and practice We have used a range of opportunities to raise the profile of our work on leadership for quality improvement

- Speaking at conferences for example, the Community Practitioners' and Health Visitors' Association (CPHVA)/ Unite conference, Royal College of Nursing/ Healthcare Events conference on Nursing Leadership, and the Queen's Nursing Institute annual conference for Queen's Nurses
- Running workshops for example, the British Association of Medical Managers (BAMM)/ Health Foundation event for Medical Leadership Fellows

- Advising about leadership development on an ad hoc basis, including discussions with the National Leadership Council in England
- Writing articles for professional publications, including a regular column for the Nursing Times on leadership for quality improvement, and an article for the Scottish Government on leadership and policy development
- We have continued to work with a wide range of professional bodies to ensure dissemination of the Health Foundation's learning, and improved access to the Foundation's awards and learning across the full range of patient representative organisations and health professionals, including pharmacists, health scientists, and allied health professionals

New leadership for improvement scheme
We developed a new flagship leadership for improvement scheme, GenerationQ, which integrates the best of leadership development thinking and improvement science We selected Ashridge Consulting and Unipart Expert Practices to co-design and deliver this scheme The scheme was prepared for launch in 2009 Through a process of co-design, we have developed a framework of leadership descriptors that will contribute to the development of our other leadership work As the first round of the scheme will be subject to further refinement, we will delay the commissioning of an external evaluation until 2010

We are in the process of developing a communications plan to disseminate our learning from the programme-wide evaluation conducted by the Organisational Research & Consultancy Network (ORCNI) team and the Shared Leadership for Change (Health Inequalities) scheme, which concluded in December 2009 (and was not part of the ORCNI evaluation) Each Shared Leadership team commissioned its own impact assessment The results of the assessments were not easy to generalise They were mixed and context specific Teams felt that the timescale was too short to convey any accurate picture of changes made, and would have preferred a longitudinal approach to evaluation that could have picked up ongoing impact over the next two years or more

Scoping new improvement scientist scheme
We have undertaken initial scoping work on the feasibility of establishing a new award scheme designed to develop the evidence base and build capacity in improvement science

In addition, we developed a partnership with Monitor to understand and promote the role of foundation trust boards in assuring and improving safety through carrying out a diagnostic exercise with a number of NHS trusts

Grant funding:

The total funding in 2009 for this strategic aim was £1 8m We provided funding, including in-kind support, to Quality Improvement Fellows in the following organisations Bolton Primary Care Trust (£242k), Salford Royal NHS Foundation Trust (£272k), Sheffield Teaching Hospitals NHS Foundation Trust (£313k), and Winchester and Eastleigh Healthcare NHS Trust (£322k) We continued to fund the ORCNI team (£102k) in their evaluation of our leadership schemes

Our plans for 2010:

Identify

- Review the strategic aim to ensure that it better reflects our ambition to create organisational contexts, as well as individual capabilities, that are more conducive to improving quality
- Build understanding about the nature and delivery of effective leadership and other developmental interventions for improving quality

Innovate

- Design a new fellowship to increase the evidence base for improvement science
- Continue to work in partnership with Monitor and others to create exemplar boards with a deeper understanding about their role in quality and safety

Demonstrate

- Launch the first round of GenerationQ
- The evaluation of the leadership programme by ORCNI and the award-centred evaluations of the Shared Leadership (Health Inequalities) scheme will report their findings

Encourage

- Disseminate findings from the evaluation of our leadership schemes and promote our learning to a wide range of stakeholders and audiences
- Continue to build capacity for improving quality This will occur through managing round seven of Quality Improvement Fellows, beginning the selection of round eight, managing the final round of Leadership Fellows, managing three cohorts of Clinician Scientist Fellowships, and delivering learning events for the final cohort of Harkness Fellows
- Continue to strengthen the impact of our work

Assessment of progress in strategic aim: Building and promoting knowledge on how to improve care

During 2009, we took forward a significant portfolio of work, running several well-received events and producing a number of timely publications. Each achieved a significant profile in the policy and service worlds. The Intra-UK chartbook, comparing the four UK countries across the dimensions of quality, demonstrated that the Foundation's focus is UK-wide, not just England. It gained positive feedback from the four UK home countries. In addition, the research that has been funded through Quest for Quality and Improved Performance (QQUIP) into value for money in healthcare at York University and the London School of Economics (LSE) has provided valuable insights at a time when the NHS is moving into a new era of financial constraints. Building on this, we commissioned an evidence review, Does improving quality save money?, which has generated high-profile debate.

The board agreed a new R&D strategy in September 2009 This plans to build on the strengths of the research activities undertaken since the launch of QQUIP in 2005 The new strategy aims to ensure that research is more centrally positioned in the Foundation's work overall It will build our reputation as an organisation that not only promotes improvement on the ground but also makes a leading contribution to building theory and empirical evidence in the field of improvement, and makes this new knowledge accessible to decision makers at all levels of the health system The strategy is built around four operational work streams

- best research evidence – which summarises what is currently known in the literature and makes it available to decision makers and leaders
- best practice – which will develop and use innovative case study methodologies to address the considerable gaps in the evidence, explain the processes underlying observable changes on the ground and provoke discussions between key stakeholders about the nature of improvement
- primary empirical research – which will fund innovative original research in tightly defined areas that are not being addressed by other funders
- building capacity and capability for improvement science – which will focus on developing future applied academic leadership for improvement science

A high-profile product of these work streams will be a series of improvement reports These will focus on defined areas of practice, bringing together performance data, best evidence, case studies, value for money analysis and a Health Foundation stance on the implications for policy and practice

In 2009, we brought to the board initial assessments of the impact of each of our strategic aims for the period 2003–09 Organisational impact assessment is an emerging science and presents many challenges These have included

- how to measure impact in long-term programmes whose focus continues to evolve
- how to balance the use of a generic measurement framework with a narrative-based approach
- how to develop an analysis that is underpinned by and explains our organisational theory of change
- how to ensure that interpretations are clearly presented and supported by evidence

What we said we would do in 2009 and how we measured up:

Introduce new arrangements for a new-look QQUIP programme, while continuing to produce reports and commission new work During the year, we published a series of reports under the QQUIP programme These included

- a comparative review of quality across the four UK countries Quality in healthcare in England, Wales, Scotland and Northern Ireland an intra-UK chartbook, by Kim Sutherland and Nick Coyle
- The link between health spending and health outcomes for the new English primary care trusts and Measuring value for money in healthcare concepts and tools, research led by Peter Smith at the University of York
- a briefing on the work of Gwyn Bevan and Mara Airoldi from the LSE working with NHS Isle of Wight on making value for money choices in service development

Hold the 4th International Quality Improvement Exchange This was held in February 2009

Manage the production of final evaluation reports for Safer Patients Initiative 1 and 2, Engaging with Quality Initiative and the leadership programme Final evaluation reports were provided for Safer Patients Initiative 1, the Engaging with Quality Initiative and Shared Leadership for Change We also commissioned an evaluation of the Safer Patients Network

Publish the findings from our learning from the Safer Patients Initiative We developed plans for peer-reviewed articles and journal supplements based on Safer Patients Initiative 1, and a book about the learning from the Safer Patients Initiative, which will be taken forward in early 2010

Undertake further development work on quality improvement methods, and continue to manage our commissioned evaluations and commission evaluations of new schemes We contributed to and led events to explore the methods for generating evidence of effectiveness in interventions to improve quality These included a session at the 2009 International Forum on Quality & Safety in Healthcare, a roundtable with our evaluation contractors, and a roundtable to explore the different sources of learning generated through Safer Patients Initiative 1

Carry out primary research

- A study to compare the characteristics of the boards of high-performing hospitals was commissioned from researchers at the Harvard School of Public Health towards the end of the year and is expected to report in 2011
- The University of Leicester is conducting an ethnographic study of efforts to reduce central venous catheter bloodstream infections in intensive care units in England
- We funded the Commonwealth Fund to extend their survey of the UK sample from their initial International Health Policy Survey of Primary Care Physicians
- Develop impact assessment reports for each strategic aim The board considered impact assessments for all five strategic aims and we made preparations to bring all of the material together in a report for early 2010

In addition:

- We produced a summary of the theory of change in the summer
- The board reviewed a paper outlining the aims, process and timescale for undertaking a mid-term review of our strategic plan
- We published a report on Improvement Leadership by Professor John Øvretveit, timed to influence the work of the National Leadership Council
- We produced a number of products which have made an important and high-profile contribution to the ongoing debate about value for money, including Professor John Øvretveit's Does improving quality save money?
- We presented our research work at several high-profile national and international conferences
- We provided advice and peer review on evaluation to the British Heart Foundation, Macmillan Cancer Support, the National Institute for Health Research Service Delivery and Organisation programme, and the Chief Scientist Office in Scotland

Grant funding:

The total funding in 2009 for this strategic aim was £488k We provided £180k to the Harvard School of Public Health, £100k to the Commonwealth Fund survey and £132k to the University of Leicester

Our plans for 2010 in evaluation and strategy:

- Generate new perspectives about how to define the science and scholarship of improving quality and safety We will hold an invitational Colloquium which will bring together 30 of the world's leading researchers and practitioners in the field They will present original thinking and reflect on the scope and limits of the bodies of knowledge that need to be considered in fashioning new knowledge, and methods to test this knowledge to improve the quality of care
- Promote the spread of learning from the Colloquium through a Symposium at the 2010 International Forum on Quality & Safety in Healthcare, a formal report, and plans for academic publications
- Present an account of the development of the Foundation's work and impact since 2003 in a consolidated impact assessment report
- Promote and spread our learning from the impact assessment report
- Stimulate thinking about how best to integrate value for money concerns into scheme design and evaluation

Our plans for 2010 in research and development:

- Work with colleagues to ensure that research is integrated in all the Foundation's programming activities, including undertaking research scans and context-setting research to inform the review of strategic aims and improvement programme development
- Continue to build the evidence base for improvement, exploring new ways of creating, summarising, analysing and presenting research evidence, and integrating this with practical experience and expertise The research strategy sets out our four work streams
  - best evidence will commission reviews of research literature, both large-scale systematic reviews and smaller-scale scoping reviews This work stream has commenced by commissioning a review of the evidence on whether coordination of care improves quality and saves money An evidence review will consider how best to achieve spread of improvement initiatives and scale-up from pilots and demonstration projects to whole organisation or whole system approaches to delivery Further systematic evidence reviews will be commissioned throughout the year
  - learning from practice will commission five case studies on topics linked to strategic aims, to develop an in-depth understanding of the enablers and barriers to improving practice
  - primary research will commission original research in areas of direct interest to the Foundation's strategic focus, including exploring the vital role played by the internal context of organisations in the successful implementation of initiatives to improve quality of healthcare The 'Lining up' project will report on how an intervention to reduce central venous catheter bloodstream infections is implemented in intensive care units in England Findings will be available from March 2011 Primary research will also continue to be commissioned around the issue of value for money in health services, understanding how value for money concepts can inform commissioning decisions in financially constrained times Another strand of research will investigate how investment in prevention activities for specific conditions may affect hospital utilisation rates for these conditions over time
  - building capacity for improvement science will develop new training opportunities for applied improvement science researchers
- Meet the information needs of decision makers and leaders in the service, as well as policy makers and academics, by providing tailored research products in print and online, responding to the findings of qualitative research with our audience and potential audiences

Developing the organisation

For the Foundation, 2009 was a year of significant organisational development.

- We implemented our new business model, launching two new types of offering Closing the Gap and Shine award schemes Both of these were well received and attracted a high number of good-quality applications
- The board approved a new research and development strategy that will raise the profile of R&D as one of the Foundation's programming activities, help to ensure that our work is underpinned by the best evidence and contribute to the external knowledge base about how to improve care
- The board also approved a communications strategy to ensure that we improve our engagement, extend our reach and increase our influence on policy and practice

Programming:

We reviewed our internal processes to identify opportunities to standardise and streamline our work We reviewed our current approaches to programme reporting to improve and standardise accountability mechanisms and learning capture from programming activity And we reviewed opportunities to maximise our learning from programmes across strategic aims and consolidate learning across themes relevant to practitioners and policy makers

Human resources and organisational development:

We undertook our first staff survey to assess the needs and perceptions of working life at the Foundation and incorporated the results into the development of our organisational ways of working The results were very encouraging, with the Foundation achieving a 71 7% satisfaction index There was a very high level of staff satisfaction, but areas to work on included managing individuals' workloads and communicating our strategy more effectively

We revised our performance and development review process and introduced 360-degree feedback

We conducted extensive work on the design and implementation of a new pay structure and we launched three new benefits a sabbatical policy, childcare vouchers, and annual leave 'flex'

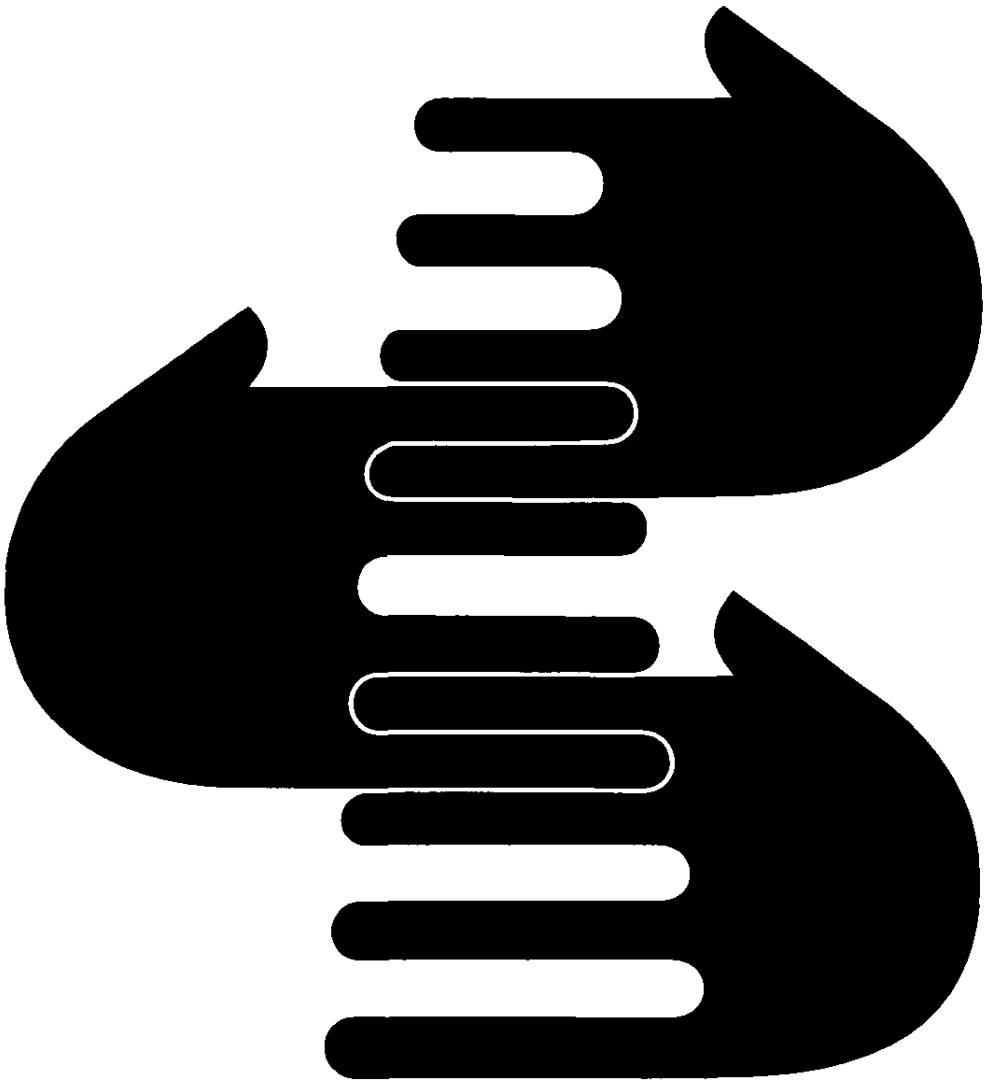
Knowledge management:

We made progress in building a knowledge culture, with greater recognition of the need to capture and interpret knowledge

Good progress was made in developing key supporting tools such as the intranet and website However, due to limited staff time and expertise, we made limited progress on customer relationship management We did complete a full scoping exercise but implementation was delayed until 2010

Governance:

- We began to strengthen our approach to financial management, risk and control, and renewed our efforts to achieve value for money for our goods and services, which will need to be embedded further in 2010
- We agreed and began a formal internal audit programme delivered by Deloitte
- We conducted an audit of required key skills provided by governors to identify gaps
- We appointed a consultant to carry out a review of board performance



Financial review and results for the year

In 2009, we saw a dramatic recovery in equity values, resulting in a return, after costs, of £96.1m (£18.6m income, £79.5m of net capital gains, £2.1m of investment management costs) compared with a negative return of £109m in 2008. This equates to a return of 16.2% (negative 15.1% in 2008), reflecting the vastly improved positions of global stock markets.

Investment income fell by £3 9m to £18 6m in 2009 This reflects the fall in global equity values in 2008 and the subsequent reduction in dividends

The total resources expended in 2009 were £25m compared with £20 9m in 2008, an increase of £4 1m

The 2009 4% 'spendable amount' (as described on page 36) was £27 4m This has resulted in an unrestricted fund balance of £4 5m, which has been allocated for future spending

Charitable spending during 2009, as recognised in the statement of financial activities (SOFA), relates to the Foundation's strategic aims in the following proportions

As described on page 48, unconditional grant obligations (the majority) are recognised in the SOFA at the point when a legal or constructive obligation is created The majority of programme costs and almost all payments will occur later, and may have a significantly different timing pattern As a result, it may be more helpful to look at spending proportions over a three-year period These are

Charitable activities
Spending for 2009

Supporting patients	20%
Engaging with clinical communities	33%
Transforming organisational approaches	18%
Developing leaders	14%
Building and promoting knowledge	5%
General quality improvements & residual schemes (including closed)	10%

Charitable activities
Spending for 2007 - 2009

Supporting patients	20%
Engaging with clinical communities	21%
Transforming organisational approaches	21%
Developing leaders	24%
Building and promoting knowledge	7%
General quality improvements & residual schemes (including closed)	6%

Investment and spending 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 and constraints
- investment strategy is delegated to the Investment Committee, this includes asset allocation issues and manager arrangements, some aspects of the latter are further delegated to sub-groups of the committee

The governors have decided, as a matter of policy, that the Foundation should

- operate as a perpetual endowment
- seek to maintain the real value of the endowment, this is expressed in terms of a capital preservation target of £690m at 31 December 2008, indexed at RPI+1% thereafter
- target an average spending rate of 4%, taking one year with another The 4% 'spendable amount' is calculated using a three-year trailing average, with any over/under spend carried forward to following periods

The governors have agreed that the Foundation's investment objectives should be

- return – an average long-term (five to seven years) real return of RPI+5% after deduction of all fees and costs relating to investment management and supervision
- risk – a predicted annual standard deviation in returns of no more than 12%

Having taken proper advice, the governors believe these objectives to be achievable Investment policy will be reviewed regularly in the ordinary course of business, however, should the actual endowment value depart from target by more than 20%, an immediate review will be triggered A 'trigger event' did occur during the early part of 2009, after due consideration, it was decided to make no changes At the end of the year, the endowment value was 9% below target

The governors have previously decided that it would be inappropriate for a health-related charity to invest in tobacco companies The Foundation has reduced investment in tobacco companies as close as practically possible to zero, 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

During the year, Mercer Ltd has continued to assist the Investment Committee in several areas, including manager selection There were several manager changes during 2008

- six new quoted equity mandates were agreed (and funded)

- one new fixed-income manager was appointed (and funded)
- two property managers were appointed (and funded)

Year-end and target allocations for the endowment are

Asset class	Year-end allocation	Target allocation
Quoted equities	80%	50%
Fixed income strategies	14%	10%
Property and other real assets	6%	15%
Other alternative assets	-	25%

The Foundation will also hold cash or near-cash to fund grant and other costs

It will take some time to fully implement the alternative asset allocation across the wide range of investment possibilities Cambridge Associates Ltd have been selected to assist the Investment Committee with manager selection and other aspects of this work

Expenditure policy

The investment spending policy sets out the spending formula for the Foundation The Foundation may choose to flex expenditure up or down to reflect wider considerations, not least the timing and funding needs of programmes

Grant making policy

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

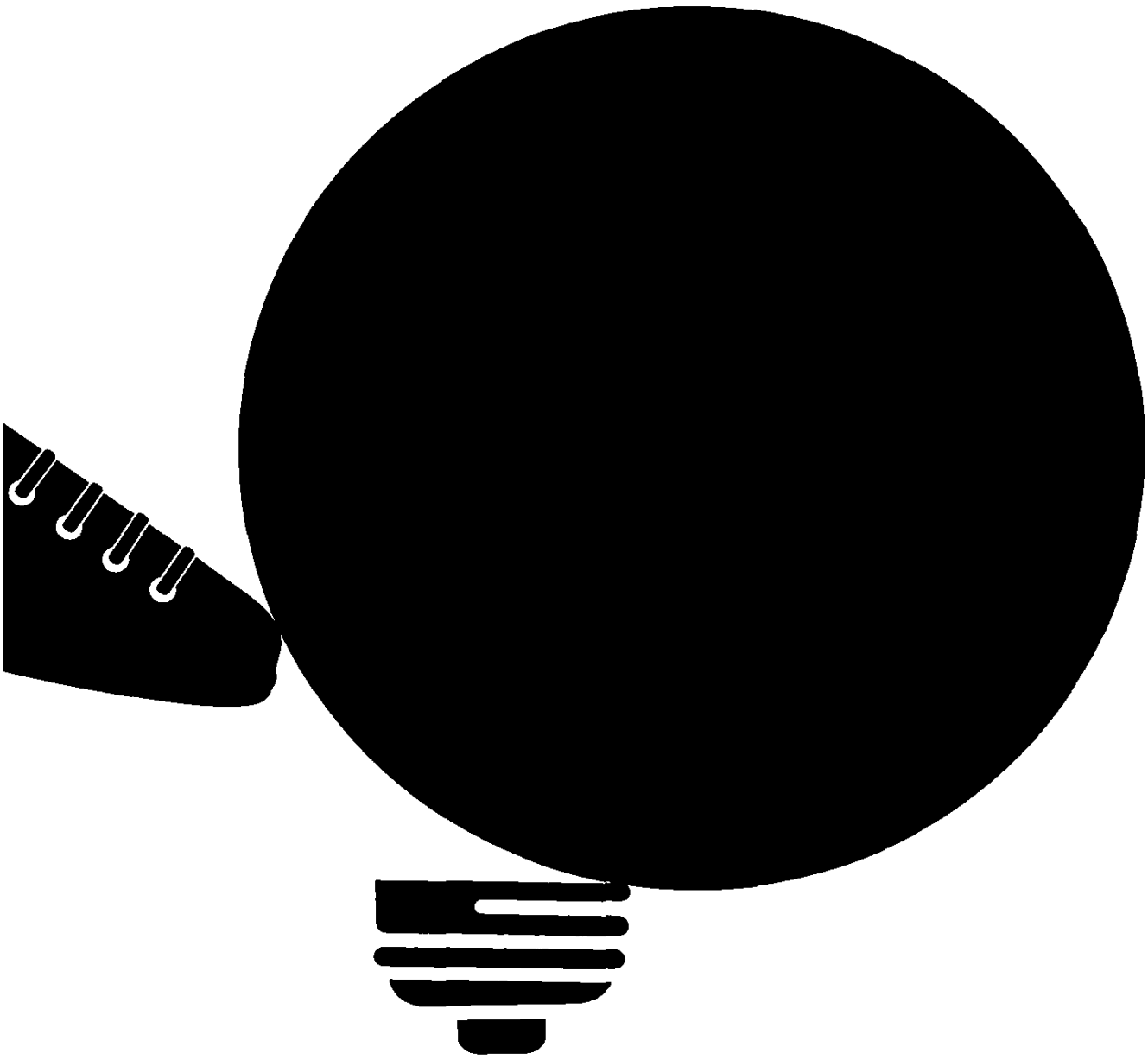
Reserves policy

The Foundation's resources are all expendable at the discretion of the governors However, there is presently no intention to exercise this discretion and the Foundation is operated as a perpetual body

The expendable endowment fund was created following the sale of PPP Healthcare Group (PPP) to GRE Group in 1988 The fund balance represents the proceeds of the sale, which were donated to the Foundation by the owners of PPP, plus cumulative net investment gains, less transfers to the unrestricted fund as described below 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 the expendable endowment fund (see 'Investment and spending policy and strategy')

The unrestricted fund is used to finance the charitable activities of the Foundation The investment policy allows for the spendable amount to be taken one year with another The governors treat the expendable endowment and income funds as a combined resource for grant making They do not, therefore, consider a particular level of income reserves as being necessary

Following the application of the spending rule, it is the policy of the governors to spend unrestricted funds within a reasonable timeframe If a balance on unrestricted funds remains at the year end, it is carried forward in anticipation of future projects



Statement of governors' responsibilities and corporate governance

The governors are responsible for their annual report, and for the preparation of financial statements for each financial year in accordance with applicable law and United Kingdom Generally Accepted Accounting Practice, which give a true and fair view of the incoming resources and the application of resources of the Foundation during the year, and of the state of affairs as at the end of the financial year 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 which 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, which 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 of disposition and are properly applied
- proper records are maintained and that 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 charity's auditors are unaware The governors have each taken all the steps that we ought to have taken as governors in order to make ourselves aware of any relevant audit information and to establish that the charity's auditors are aware of that information

Corporate governance

Processes are in place to ensure that performance is monitored and that appropriate management information is prepared and reviewed regularly by both the executive team and the board of governors Internal controls over all forms of commitment and expenditure continue to be refined to improve efficiency

A new out-sourced provider for internal audit was appointed in October 2008 and a programme of internal audit has taken place during 2009 This included audits covering governance, use of consultants and third party suppliers, the investment process, IT effectiveness, insurance arrangements, payroll, and grant and purchase payment process

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

Risk management

The board of governors is responsible for the management of risks faced by the Foundation, it has ensured that a formal risk management strategy is in place and that a supporting risk management process has been implemented

The risk management process identifies the risks that the Health Foundation faces and then identifies the potential impact, the likelihood of occurrence and the measures in place to mitigate the risk

The key areas of strategic risk during 2009 were internal controls, investment of the endowment, disaster recovery, governance and contracting The main elements of our mitigating activity were as follows

- Internal controls 2009 was the first year of our three-year programme of internal audits provided by Deloitte The reports on a wide range of our essential activities are listed above. The reports generated valuable pointers for the Foundation to further improve its controls The resulting programme of work to implement the recommendations has commenced and will be completed in 2010
- Investment of the endowment During a year of significant global stock market volatility, the Foundation continued its programme of asset diversification to maximise our capacity to spread risk sensibly, including increasing the holdings in alternative assets
- Disaster recovery The Foundation established a team to re-think and re-write the disaster recovery plan, giving it a suitably strong focus on recovering IT systems The installation of remote working technology during the year has been a critical step in enabling the Foundation to continue functioning in the event of a disaster

- Governance The final quarter of the year saw a thorough external and independent review of the performance of the board of governors, resulting in a comprehensive programme of work to further improve the Foundation's approach to governance for completion in 2010
- Contracting The Foundation's increasing reliance on contracting with other parties to achieve important objectives led to a requirement to re-work our approach to contracting During the early part of the year, we updated and replaced all of our standard models, accompanied by staff training that focused on improving understanding of the intellectual property issues that are critical for the Foundation's success

During 2009, the essential elements of the Foundation's risk management process were

- regular review by the executive team of the risk register, the addition of newly identified risks and appropriate action where necessary to mitigate the risks
- twice-yearly detailed reports to the Audit Committee
- twice-yearly reports to the board of governors on the most significant risks

Through the risk management process established, the governors are satisfied that the major risks are being identified and that suitable mitigation is being undertaken and/or planned It is recognised that systems can only provide reasonable but not absolute assurance that major risks have been adequately managed

Conflicts and disclosure policy

The Foundation has drawn up and implemented a conflict of interest policy, which explains the nature of potential conflicts of interest It requires governors, independent members of committees and staff to declare all such conflicts Governors and independent members of committees are also required to notify the secretary of any association with a body or organisation that is or might become an applicant for funds from the Foundation A register of all notifications received is kept and produced for inspection at all board meetings

In addition, the policy provides that the Foundation may not consider applications in respect of work in which a governor is personally and directly involved, and may only consider applications in respect of work of a department or institute with which a governor, independent member of a committee or staff member is connected provided that the person concerned makes a prior disclosure of the interest, does not have sight of the papers relating to the application, and is absent from any meeting while the application is being discussed

Related party transactions

Details of transactions with related parties are set out in Note 15

On behalf of the board

Sir Alan Langlands
Chair
17 June 2010

Independent auditors' report

We have audited the financial statements of the Health Foundation for the year ended 31 December 2009 which comprise the statement of financial activities, the balance sheet, the cash flow statement and the related notes numbered 1 to 16 These financial statements have been prepared in accordance with the accounting policies set out therein

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

The governors' (who are also the directors of the Health Foundation for the purpose of company law) responsibilities for preparing the annual report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice) and for being satisfied that the financial statements give a true and fair view are set out in the statement of governors' responsibilities

Our responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements and International Standards on Auditing (United Kingdom and Ireland)

We report to you our opinion as to whether the financial statements give a true and fair view, have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice and have been prepared in accordance with the Companies Act 2006 We also report to you if, in our opinion, the information given in the governors' annual report is consistent with the financial statements

In addition, we report to you if, in our opinion, the charitable company has not kept adequate accounting records, if the charity's financial statements are not in agreement with those records, if we have not received all the information and explanations we require for our audit, or if certain disclosures of governors' remuneration specified by law are not made

We read the governors' annual report and consider the implications for our report if we become aware of any apparent misstatements within it Our responsibilities do not extend to other information

Basis of opinion

We conducted our audit in accordance with International Standards on Auditing (United Kingdom and Ireland) issued by the Auditing Practices Board An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements It also includes an assessment of the significant estimates and judgements made by the governors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the charitable company's circumstances, consistently applied and adequately disclosed

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error In forming our opinion, we also evaluated the overall adequacy of the presentation of information in the financial statements

Opinion

In our opinion

- the financial statements give a true and fair view of the state of the charity's affairs as at 31 December 2009 and of its incoming resources and application of resources, including its income and expenditure, for the year then ended
- the financial statements have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice
- the financial statements have been prepared in accordance with the Companies Act 2006
- the information given in the governors' annual report is consistent with the financial statements

Michael Hicks
Senior Statutory Auditor

For and on behalf of
Horwath Clark Whitehill LLP
Statutory Auditor
St Bride's House
10 Salisbury Square
London EC4Y 8EH

17 June 2010

Statement of financial activities
For the year ended 31 December 2009

Registered Company No 1714937 Registered Charity No 286967

	Notes	Unrestricted Fund £000	Expendable Endowment Fund £000	**Total Funds 2009 £000**	Total Funds 2008 £000
INCOMING RESOURCES					
Donations		1	-	**1**	-
Investment income	2	18,580	-	**18,580**	22,435
Total incoming resources		**18,581**	-	**18,581**	22,435
RESOURCES EXPENDED					
Cost of generating funds					
Investment management	3	-	2,145	**2,145**	2,259
Net incoming resources available for charitable application		**18,581**	**(2,145)**	**16,436**	**20,176**
Charitable activities	**4 to 6**				
Supporting patients		4,586	-	**4,586**	5,418
Engaging with clinical communities		7,542	-	**7,542**	2,425
Transforming organisational approaches		3,965	-	**3,965**	6,985
Developing leaders		3,182	-	**3,182**	1,435
Building and promoting knowledge		1,205	-	**1,205**	1,447
General quality improvements & residual schemes (including closed)		2,212	-	**2,212**	771
Total charitable expenditure		**22,692**	-	**22,692**	**18,481**
Govenance costs	7	200	-	**200**	182
Total resources expended		**22,892**	**2,145**	**25,037**	**20,922**
Net incoming/(outgoing) resources for the year before transfer		**(4,311)**	**(2,145)**	**(6,456)**	**1,513**
Net transfers	12	**2,340**	**(2,340)**	-	-
Net incoming/(outgoing) resources for the year after transfer		**(1,971)**	**(4,485)**	**(6,456)**	**1,513**
Net gain/(loss) on investments	9	-	79,450	79,450	(129,017)
Net movement in funds		**(1,971)**	**74,965**	**72,994**	**(127,504)**
		6,464	568,187	**574,651**	702,155
Balances at 31 December		**4,493**	**643,152**	**647,645**	**574,651**

All transactions relate to continuing operations

The notes on pages 47 to 54 form part of these financial statements

Balance sheet
For the year ended 31 December 2009

	Notes	Unrestricted Fund £000	Expendable Endowment Fund £000	**Total Funds 2009 £000**	Total Funds 2008 £000
FIXED ASSETS					
Tangible fixed assets	8	237	-	**237**	332
Investments	9	17,733	643,780	**661,513**	594,856
Total fixed assets		**17,970**	**643,780**	**661,750**	595,188
CURRENT ASSETS					
Cash and short term deposits		13,163	-	**13,163**	7,295
Debtors	10	281	-	**281**	184
Total current assets		13,444	-	**13,444**	7,479
CREDITORS					
Amounts falling due within one year	11	(16,070)	(628)	**(16,698)**	(14,889)
Net current liabilities		**(2,626)**	**(628)**	**(3,254)**	(7,410)
Total assets less current liabilities		**15,344**	**643,152**	**658,496**	587,778
CREDITORS					
Amounts falling due after more than one year	11	(10,851)	-	**(10,851)**	(13,127)
Net assets		**4,493**	**643,152**	**647,645**	574,651
FUNDS					
Unrestricted fund		4,493	-	**4,493**	6,464
Expendable endowment		-	643,152	**643,152**	568,187
Total funds		**4,493**	**643,152**	**647,645**	574,651

Approved by the board on 17 June 2010 and signed on its behalf by

Sir Alan Langlands
Chair

Jan Sobieraj
Chair of the Audit Committee

All transactions relate to continuing operations
The notes on pages 47 to 54 form part of these financial statements

Cash flow statement
For the year ended 31 December 2009

	Notes	Total Funds 2009 £000	Total Funds 2008 £000
Net cash inflow from operating activities	a	**(23,325)**	(22,831)
Return on investment and servicing of finance	b	**18,575**	22,430
Capital expenditure and financial investments	c	**10,618**	(3,022)
(Decease)/Increase in cash in the year		**5,868**	(3,423)
Cash at 1 January		**7,295**	10,718
Cash at 31 December		**13,163**	7,295

CASH FLOW STATEMENT NOTES

a) Reconciliation of charges in resources to net cash inflow from operating activities

Net incoming resources	**(6,456)**	1,513
Depreciation	**125**	148
Interest received	**(5,042)**	(3,590)
Interest paid and bank charges	**5**	5
Dividends received	**(13,408)**	(18,845)
Property income received	**(130)**	-
Investment fees	**2,145**	2,259
(Increase)/decrease in debtors	**(97)**	292
Decrease in creditors	**(467)**	(4,613)
	(23,325)	(22,831)

b) Return on investment and servicing of finance

Interest received	**5,042**	3,590
Interest paid and bank charges	**(5)**	(5)
Dividends received	**13,408**	18,845
Property income received	**130**	-
	18,575	22,430

c) Capital expenditure and financial investment

Property of investments	**(86,601)**	(130,293)
Sale of Investments	**99,394**	129,554
Investment fees	**(2,145)**	(2,259)
Purchase of fixed assets	**(30)**	(24)
	10,618	(3,022)

Notes to the financial statements
For the year ended 31 December 2009

1. ACCOUNTING POLICIES

a) Basis of accounting

The financial statements have been prepared under the historical cost convention, as modified by the revaluation of investments and in accordance with applicable Accounting Standards and the Companies Act 2006 The governors have adopted the recommendations contained in the Statement of Recommended Practice Accounting and Reporting by Charities (SORP) issued by the Charity Commission in March 2005

b) Investment income

Investment income include is accounted for on an accruals basis Dividends, including tax recovery, are credited to income when the stock is first priced on an ex-dividend basis

c) Resources expended

All expenditure is accounted for on an accruals basis

- **Cost of generating funds represents** investment consultancy, management and custodian fees together with an apportionment of 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
- **Grants awarded** 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 provided as the related work is undertaken Grants awarded, but not paid, are recorded as a liability within the balance sheet
- **Salary and other costs** (support costs) are allocated to charitable strategic aims on a fixed basis (20% to aims 1 to 4, 10% to aims 5 and to General quality improvement) This was changed on 1 January 2009 following a review of the methodology In 2008, the allocation was on the estimated time spent on strategic aims, prior year comparatives have not been adjusted as a result of this change in estimate as the change is not material As shown in note 4
- **Retirement pensions** and related benefits to defined contribution schemes are charged to the unrestricted fund in the accounting period in which the contributions are payable
- **Governance costs** comprise all costs attributable to ensuring the public accountability of the charity and its compliance with regulation and good practice These costs include costs related to statutory audit together with an apportionment of support costs based on time spent
- **VAT** All VAT is irrecoverable and is included as part of the expenditure to which it relates

d) Foreign currencies

Foreign currency balances have been translated at the rate of exchange ruling at the balance sheet date except where balances have been designated to hedge certain grant obligations In these cases the rate at date of implementation is used 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

e) 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 Consequently, the statement of financial activities treats all movements as changes in the value of the investment portfolio Realised gains also include any fees accounted for at source

f) Investment assets

Investments listed on a recognised stock exchange are stated at the mid-market value at the date of the balance sheet

g) Tangible fixed assets

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 & equipment	over 5 years
Computers	over 3 years
Leasehold improvements	over 10 years

2. INVESTMENT INCOME

	2009 £000	2008 £000
Dividend income	**13,408**	18,845
Interest income	**5,042**	3,590
Property income	**130**	-
	18,580	22,435

3. COST OF GENERATING FUNDS

Investment management

	2009 £000	2008 £000
Investment managers' fees	**1,697**	1,902
Custodian fees	**223**	141
Investment consultancy	**127**	-
Investment consultancy	**90**	216
Other investment cost	**8**	-
	2,145	2,259

The cost of generating funds includes an allocation of support costs, prior year comparatives have not been reclassified

4. ANALYSIS OF TOTAL RESOURCES EXPENDED

	Grants £000	Programme costs £000	Salary costs £000	Other costs £000	**2009 £000**	2008 £000
Charitable activities						
Supporting patients	3,112	247	787	440	4,586	5,418
Engaging with clinical communities	6,144	171	787	440	7,542	2,425
Transforming organisational approaches	2,568	170	787	440	3,965	6,985
Developing leaders	1,764	191	787	440	3,182	1,435
Building and promoting knowledge	488	103	394	220	1,205	1,447
General quality improvements & residual schemes (including closed)	1,521	78	393	220	2,212	771
Total charitable expenditure	**15,597**	**960**	**3,935**	**2,200**	**22,692**	**18,481**
Allocation of (salary) support costs to						
Cost of Generating Funds			**127**			
Governance Costs			**110**			
			4,172			

The above expenditure relates to the provision of financial and other assistance in satisfaction of the objectives for which the Foundation was established Grants of £15,502,000 were given to projects based in institutions and £95,000 to individuals More detail about grant funding for each strategic aim can be found in the governors' report starting on page 6

5. OTHER COSTS

	2009 £000	2008 £000
Other costs		
Rent, service charge, rates & office costs	**558**	600
Consultancy	**384**	223
Communications & publications	**374**	359
Other staff costs	**353**	344
Recruitment fees	**118**	156
IT services	**163**	212
Depreciation	**125**	148
Other costs	**125**	283
Total	**2,200**	**2,325**

6. PARTICULARS OF EMPLOYEES

	2009 £000	2008 £000
Particulars of employees		
Salaries	**3,187**	2,819
National insurance	**342**	311
Other pension costs	**375**	347
	3,904	3,477
The full time equivalent, average number of persons employed by the Foundation during the year	**57**	53

In addition to the staff listed above, the Foundation used contract and agency staff to cover for some vacant posts and also to cover short-term increases in the workload in some departments The total cost of these staff was £268,715 (2008 £307,770)

Employees whose emoluments were greater than £60,000

Band			No	No
£60,001	–	£70,000	**2**	3
£70,001	–	£80,000	**1**	3
£80,001	–	£90,000	**3**	3
£90,001	–	£100,000	**1**	-
£120,001	–	£130,000	**-**	1
£130,001	–	£140,000	**3**	1
£160,001	–	£170,000	**1**	1
£200,001	–	£210,000	**1**	1
			12	13

Eleven of the above employees are members of the defined contribution pension scheme Contributions in the year in respect of these employees were £212,771 (2008 £207,000) Outstanding contributions at 31 December 2009 were £91,907 (2008 £9,318)

7. GOVERNANCE EXPENDITURE

	2009 £000	2008 £000
Governance expenditure		
Audit fees	**24**	23
Governance support costs	**110**	132
Governors' expenses	**10**	16
Governor recruitment and training	**44**	-
Board review and analysis	**10**	-
Other board expenses	**2**	3
Legal expenses - constitutional matters	**-**	8
	200	182

During the year, 12 governors received £9,623 in respect of travel, subsistence & external entertainment (2008 11 governors received £16,839) In addition, the following governors were paid for advice relating to their expertise in our schemes See the table below.

Governors	Programme	2009 £	2008 £
Chris Ham	International Quality Exchange	**8,740**	6,183
Jim Easton	Quality Improvement Fellows	**500**	-

The governors and staff were covered by joint liability and other insurance policies in the year to 31 December 2009

8. FIXED ASSETS

	Leasehold improvements £000	Computer equipment £000	Furniture & equipment £000	**Total £000**
Cost				
At 1 January 2009	362	94	467	923
Additions	-	30	-	30
At 31 December 2009	**362**	**124**	**467**	**953**
Depreciation				
At 1 January 2009	194	49	348	591
Provided	36	33	56	125
At 31 December 2009	**230**	**82**	**404**	**716**
Net book value				
At 31 December 2009	**132**	**42**	**63**	**237**
At 1 January 2009	**168**	**45**	**119**	**332**

9. INVESTMENTS

	Quoted investments £000	Cash deposits £000	Total £000
a) Analysis of investment holdings			
Market value	**511,610**	83,246	**594,856**
Additions	**81,601**	5,000	**86,601**
Withdrawals	**(16,148)**	(83,246)	**(99,394)**
Net increase in market value	**79,450**	-	**79,450**
Market value at 31 December 2009	**656,513**	**5,000**	**661,513**
Cost at 31 December 2009	**540,722**	**5,000**	**545,722**

	2009 £000	2008 £000
b) Market value at 31 December is made up of investments		
Property Investments		
UK- propery funds	**35,402**	-
Listed on recognised stock exchanges		
UK- equities	**228,026**	165,458
UK- fixed interest securities	**87,404**	69,006
Overseas- equities	**304,036**	272,119
Overseas- fixed interest securities	**1,645**	-
Cash	**5,000**	5,027
	661,513	511,610

The governors consider that any incidental cash balance held by an investment manager is an integral part of its asset allocation and have included it in the appropriate asset class

Included within UK equities is an amount of £9,640 relating to an unrealised gain on a future contract The contract value of £526,510 is to expire on 19 March 2010

Included within overseas fixed interest securities is an amount of £54,581 relating to an unrealised loss on four future contracts Two contracts with a total value of £959,262 will expire on 8 March 2010, one contract with a value of £643,452 is to expire on 22 March 2010 and one contract with a value of £915,600 is to expire on 29 March 2010

10. DEBTORS

	2009 £000	2008 £000
Debtors		
Accrued income	**77**	109
Prepayments	**193**	47
Other debtors	**11**	28
	281	184

11. CREDITORS

	Unrestricted Fund £000	Expendable Endowment Fund £000	2009 £000	2008 £000
Amounts falling due within one year				
Grants	15,235	-	**15,235**	13,194
Investments fees	-	628	**628**	875
Trade creditors and other accruals	738	-	**738**	757
National Insurance and PAYE taxes	97	-	**97**	63
	16,070	**628**	**16,698**	**14,889**
Amounts falling due after more than one year				
Grants – within two to five years	10,033	-	**10,033**	13,127
Grants – after five years	818	-	**818**	-
Total liabilities	**26,921**	**628**	**27,549**	**28,016**

12. TRANSFERS

	Unrestricted Fund £000	Expendable Endowment Fund £000	Total Funds 2009 £000
Transfers			
Transfer of opening balance	(6,464)	6,464	-
Transfer of investment income	(18,580)	18,580	-
Transfer of 4% spendable amount	27,384	(27,384)	-
Net transfers	**2,340**	**(2,340)**	-

All capital gains/ losses and costs relating to the investment portfolio are shown within the endowment fund in the SOFA The investment policy allows for the 4% spendable amount to be transferred to the unrestricted fund each year The £27 4m spendable amount for 2009 is represented by an opening balance of £6 5m, investment income of £18 6m and a transfer of £2 3m from the endowment fund

13. OPERATING LEASE COMMITMENTS

The Foundation had annual commitments not recorded on its balance sheet as follows

	Lease and building 2009 £000	**Equipment leases 2009 £000**	Lease and buildings 2009 £000	Equipment leases 2008 £000
Leases which expire				
Within one year	-	-	-	4
Within two to five years	**483**	**7**	483	7

14. MEMBERS' LIABILITY

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

15. RELATED PARTY TRANSACTIONS

Due to the specialist nature of the projects funded it is inevitable that circumstances may occasionally arise where governors, committee members or staff are associated with organisations that 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 approval arrangements

16. SUBSIDIARY UNDERTAKINGS

The Health Foundation owns 100% of the share value of the subsidiary, Medtrust Innovations Limited

The subsidiary traded again in 2009 The turnover for the year ended 31 December 2009 was £175 (2008 £216) and after charging administrative expenses of £175 (2008 £216) from the parent organisation, the profit for the year was £NIL

At 31 December 2009, the subsidiary had a current account receivable from the parent of £2 (2008 payable of £209), and its aggregate capital and reserves were £2

The company has not been consolidated in the financial statements as its inclusion would not be material in providing a true and fair view

Governance and administration
For the year ended 31 December 2009

REFERENCE AND ADMINISTRATIVE DETAILS

The Health Foundation is a registered charity (No 286967) and a company limited by guarantee (No 1714937) The Registered Office is as shown on the back cover

Present members/governors and any past governors who served during the year are listed on page 57 together with the names of independent members of committees and the executive The names of the Foundation's professional advisers are set out on page 58

OBJECTS OF THE FOUNDATION

The Health Foundation is an independent charity that aims to improve health and the quality of healthcare for the people of the UK and beyond The Foundation's charitable objects enable it to support

- education and training of people involved in the provision, management and administration of healthcare
- medical research and the application of the results
- the relief of sickness and disability and the relief of the elderly
- public health initiatives

STRUCTURE, GOVERNANCE AND MANAGEMENT

The charity is governed by its Memorandum and Articles of Association adopted on 24 July 1996 and last amended on 14 January 2008 The charity'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

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 Governors meet at least four times a year At these meetings, governors review strategy and operational/investment performance and approve operating plans and budgets In addition to receiving a comprehensive governors' manual as part of their induction process, training opportunities for governors are brought to the attention of the board and individual governors

The board of governors delegates the exercise of certain powers in connection with the management and administration of the Foundation as set out below Regular performance reports are provided to the board, as well as the minutes of committee meetings, to assist it to fulfil its role of monitoring and evaluating the organisation's performance

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 and a clear set of responsibilities and authority

The Nominations Committee is responsible for proactively monitoring and advising on reviewing 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, governance reviews relating to the committee's responsibilities as set out above, as requested by the board

The Audit Committee's role is to assist the board in meeting its responsibilities in respect of financial reporting, to provide a channel of communication between the Foundation's external auditors and the board and to oversee the implementation of the Foundation's risk management strategy and internal audit process

The Investment Committee has two roles The first is to assist the governors with developing and setting an investment policy that is appropriate to the Foundation's needs The second is to devise and implement 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 Director of Finance and Administration are members of this committee

The Remuneration Committee's role is to approve 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 executive team In June 2009 this committee replaced the Chairman's Committee, which had acted in this capacity and had also assisted the board in the formulation and review of strategy and policy The Chief Executive and the Director of HR and Organisational Development are members of this committee

CHIEF EXECUTIVE

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 executive directors

GROUP STRUCTURE

The Foundation has a wholly owned subsidiary, Medtrust Innovations Limited The subsidiary is set up to carry out non-charitable trading activities (for example, exploitation of intellectual property rights) to raise funds to donate to the Foundation under Gift Aid

MEMBERS OF THE BOARD AND COMMITTEES

The following served as members / governors during 2009

Name	Member / Governor	Nominations Committee	Audit Committee	Investment Committee	Remuneration Committee
Alan Langlands	Chair	✔			✔
Jim Easton	Resigned 8 July 2009	Until 8 July 2009			
Adrienne Fresko	Vice chair	Chair		✔	Chair From 18 June 2009
Mark Goldman	✔		✔		
Margaret Goose	✔	✔	Appointed 10 Dec 2009		
Chris Ham	Resigned 10 March 2010				Until 10 March 2010
Deirdre Kelly	✔		Until 10 Dec 2009		
Bridget McIntyre	Appointed 23 Dec 2009				
Andrew Morris	✔	Appointed 10 Dec 2009			
Maxine Power	Appointed 18 June 2009		Appointed 10 Dec 2009		
John Savill	✔				
Jan Sobieraj	✔		Chair		✔
John Wilford	✔			Chair	✔

INDEPENDENT MEMBERS OF COMMITTEES

The following served as independent members of committees during 2009

Name	Audit Committee
Andrew Baigent	✔

EXECUTIVE

Stephen Thornton	Chief Executive
Jo Bibby	Director of Improvement Programmes
Helen Bradburn	Director of Public Affairs and Communications (appointed 7 January 2009)
Kate Husselbee	Director of HR & Organisational Development
Martin Marshall	Clinical Director and Director of Research and Development
Vin McLoughlin	Director of Quality and Performance Analysis (deceased 29 November 2009)
Dale Webb	Director of Evaluation & Strategy (appointed 1 April 2009)
Jonathan Sheldon	Director of Finance and Administration (Company Secretary)

PROFESSIONAL ADVISERS

SOLICITORS

Bates, Wells & Braithwaite London LLP, 2–6 Cannon Street, London EC4M 6YH
Trowers & Hamlins LLP, Sceptre Court, 40 Tower Hill, London EC3N 4DX
Withers LLP, 16 Old Bailey, London EC4M 7EG

EXTERNAL AUDITORS

Horwath Clark Whitehill LLP, St Bride's House,10 Salisbury Square, London EC4Y 8EH

INTERNAL AUDITORS

Deloitte LLP, 2 New Street Square, London EC4A 3BZ

BANKS

Royal Bank of Scotland, Corporate Banking, 9th Floor, 280 Bishopsgate, London EC2M 4RB
Bank of Scotland, Commercial Banking, 7th Floor, 155 Bishopsgate, London EC2M 3YB
Kleinwort Benson Private Bank Limited, 30 Gresham Street, London EC2V 7PG

INVESTMENT FUND MANAGERS

Aberdeen Asset Management PLC, 10 Queen's Terrace, Aberdeen, AB10 1YG
BlackRock Advisor (UK), Murray House, 1 Royal Mint Court, London EC3N 4HH
Cordea Savills, Lansdowne House, Berkeley Square, London W1J 6ER
Fidelity Pension Management, 25 Cannon Street, London EC4M 5TA
Henderson Global Investors, 201 Bishopsgate, London EC2M 3AE
JP Morgan Fleming, Finsbury Dials, 20 Finsbury Street, London EC2Y 9AQ
McKinley Capital, 30 Old King's Highway South, Suite 200, Darien, CT 06820, USA
MFS Investment Management, Paternoster House, 65 St Paul's Churchyard, London EC4M 8AB
Mondrian Investment Partners Limited, Fifth Floor, 10 Gresham Street, London EC2V 7JD
River & Mercantile Asset Management LLP, 30 Coleman Street, London EC2R 5AL

CUSTODIAN

State Street Bank and Trust Company, 525 Ferry Road, Edinburgh EH5 2AW

INVESTMENT ADVISERS

Mercer Limited, 80 Hanover Street, Edinburgh EH2 1EL
Cambridge Associates Limited, 80 Victoria Street, 4th Floor, London SW1E 5JL

PERFORMANCE MEASUREMENT

WM Company, 525 Ferry Road, Edinburgh, EH5 2AW

The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK.

We want the UK to have a healthcare system of the highest possible quality - safe, effective, person-centred, timely, efficient and equitable We believe that in order to achieve this, health services need to continually improve the way they work

We are here to inspire and create the space for people, teams, organisations and systems to make lasting improvements to health services

Working at every level of the healthcare system, we aim to develop the technical skills, leadership, capacity, knowledge, and the will for change, that are essential for real and lasting improvement

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Registered company number 1714937

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