Report and financial statements

For the year ended 30 September 2018

The Nuffield Trust for Research and Policy Studies in Health Services
Charity number: 209169
Company number: 382452

The Nuffield Trust
59 New Cavendish Street, London W1G 7LP

nuffieldtrust

The Nuffield Trust

The Nuffield Trust for Research and Policy Studies in Health Services (formerly The Nuffield Health and Social Services Fund) is a company limited by guarantee, registered in England and Wales as company number 382452. It is registered with the Charity Commission as charity number 209169.

Nuffield Trading Limited is a company registered in England and Wales as company number 6898100.

Patron

Her Royal Highness The Princess Royal

Registered office

59 New Cavendish Street, London, W1G 7LP.

Contents

Board of trustees

Andrew McKeon (Chair)	Ian Krieger FCA
Dr Rosie Benneyworth	Kathryn Matthews
Dr Jocelyn Cornwell	Julia Palca
Sir Michael Deegan CBE	Sir Hugh Taylor KCB (to 31 January 2018)
Tara Donnelly	Dr Christian van Stolk
Professor Tim Evans (to November 2018)	

Very sadly, Professor Tim Evans died on 9th November 2018. In a tribute to Tim, our chair Andy McKeon recorded our heartfelt appreciation of his care for patients; his major contribution to health care over many decades and our great sadness at the loss of a distinguished, kind and compassionate colleague.

Andrew McKeon is the Chair of the Governance and Remuneration Committee, the other members of which are Jocelyn Cornwell, Mike Deegan, Ian Krieger and Julia Palca.

Ian Krieger is the Chair of the Finance Committee. Other members are Kathryn Matthews and Christian van Stolk. Tim Evans was also a member of the Finance Committee.

Non-Trustee Member of the Finance Committee: Kevin Lowe FCA

Company secretary

Sara Longmuir

Senior staff

Nigel Edwards, Chief Executive

John Appleby, Director of Research and Chief Economist

Helen Buckingham, Director of Strategy & Operations (from 4th June 2018)

Candace Imison, Director of Policy

Fiona Johnson, Director of Communications

Sara Longmuir, Interim Director of Finance (from 21st May 2018)

David Miller, Director of Finance and Administration (to June 2018)

Senior associates and visiting fellows

Professor John Billings

Professor Sir Nick Black

Dr Richard Bohmer

Amy Caldwell-Nicholls

Dr Ronny Cheung

Richard Darch

Deirdre Heenan

Dr Bob Klaber

Sharon Lamb

Dr Richard Lewis

Professor Marcus Longley

Professor Nick Mays

Dr Ben Mearns

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Professor Judith Smith

Professor Peter C Smith

Dr David Steele OBE

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Charity number

209169

Trustees' annual report

The Trustees present their report and the financial statements of the charity for the year ended 30 September 2018. The Trustees have prepared the financial statements in accordance with *Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounting in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS102) (effective 1 January 2015) – Charities SORP (FRS102)* and the Financial Reporting Standard applicable in the United Kingdom and the Republic of Ireland.

The objects of The Nuffield Trust for Research and Policy Studies in Health Services (the Trust) are to promote, carry out or advance any charitable objects, and in particular the prevention or relief of sickness and the advancement of the health of the people of the United Kingdom, in particular through the promotion of improvements in the quality of health care and health policy. The Trustees have developed and adopted the following statement of purpose to underpin and guide the future work of the Trust.

Our vision

We want to help achieve a high-quality health and social care system that improves the health and care of people in the UK.

Our mission

We set out to do this by:

- improving the evidence base that leads to better care
- undertaking rigorous applied research and policy analysis to improve policy-making and practice
- providing expert independent commentary and analysis
- bringing policy-makers, practitioners and others together to develop solutions to the challenges facing the health and social care system.

Board of Trustees

The Trustees meet as a Board four times a year and consider all matters relating to the governance of the organisation and their responsibilities as Trustees.

The Board continued to follow the themes for the Trust's work programme set last year. Trustees agreed that in pursuing our mission, we should aim to work on issues that are important to patients; where the presenting situation may be amenable to change; where we can challenge orthodox thinking; help our audiences develop new insights; and where we can harness the expertise and enthusiasm of our staff.

In addition to the full Trustee Board, there are two Trustee committees. The Governance, Nominations and Remuneration Committee typically meets four times a year and has a remit to consider matters relating to the appointment of Trustees and Board development, governance issues for the organisation, and the remuneration of senior executives.

The Finance Committee meets at least four times a year and has responsibility for overseeing the financial functions of the Trust. This includes recommending the budget to the Board; appraisal of certain projects and contracts; and monitoring of the risk and investment management processes. It takes the lead in monitoring cybersecurity on behalf of the Board.

New Trustees follow an induction programme to gain familiarity with the Trust's work, governance procedures and ethos. The Trust maintains a Register of Interests for Trustees and staff.

Day-to-day management of the Trust's functions is the responsibility of the Chief Executive and the Senior Management Team, who operate within discretionary powers and protocols delegated by the Board.

The Chair of Trustees is Andrew McKeon (formerly a career public servant with the Department of Health and the Audit Commission) and the Chair of the Finance Committee is Ian Krieger (former Senior Partner and Vice-Chairman of Deloitte).

Other Trustees who served during the year are:

- Dr Rosie Benneyworth (Vice Chair of the National Institute for Health and Care Excellence and Director of Strategic Clinical Services Transformation for Somerset CCG)
- Dr Jocelyn Cornwell (Chief Executive and Founder of The Point of Care Foundation)
- Sir Michael Deegan CBE (Chief Executive, Central Manchester University Hospitals NHS Foundation Trust)
- Tara Donnelly (Chief Executive, Health Innovation Network)

- Professor Tim Evans (National Director for Clinical Productivity, Department of Health and formerly Medical Director and Deputy Chief Executive, Royal Brompton and Harefield NHS Foundation Trust) (to November 2018)
- Kathryn Matthews (Director of Barclays Bank UK plc, Pendal Group Ltd and J.P. Morgan Chinese Investment Trust)
- Julia Palca (Chair, Macmillan Cancer Support)
- Christian van Stolk (Vice President at RAND Europe)
- Sir Hugh Taylor KCB (to January 2018)
- Kevin Lowe, a non-Trustee member of the Finance Committee (Director of PwC with extensive experience in both the charity and health sectors).

None of the Trustees have received any payment, other than the reimbursement of expenses.

Senior associates

As well as our permanent staff, we are fortunate in being able to call on the expertise of our Senior Associates. Senior Associates are nationally known academics, clinicians, managers and policy-makers who contribute time and input to our work programme, serve on advisory panels overseeing aspects of the Trust's work, and offer expert peer review to our publishing programme. We gratefully acknowledge their support.

Public benefit

The Trustees have considered the Charity Commission's general guidance on public benefit and have taken it into account when reviewing the Trust's aims and objectives, and in planning its future activities. In particular, the Trustees consider how activities will contribute to the aims and objectives they have set. The main activities and beneficiaries are described in this report.

The Trust works to promote improvements in the quality of health care and health policy. In so doing, it seeks to improve patient care and health for all members of the public. All our charitable activities focus on health care policy and practice and are undertaken to further our charitable purpose for the public's benefit. The Trustees confirm, in light of the guidance, that the aims of the Trust fully meet the public benefit test and that the activities described in this report are undertaken in pursuit of its aims.

Overview

When we set our five year strategy in November 2015 we decided to widen our focus beyond Westminster and Whitehall and to work more closely with service leaders. As we reach the midpoint of our five-year strategy, we believe that decision was well judged. The external environment continues to be uncertain and politically volatile, making it more challenging to discern where national policy interventions can usefully be made. Working more closely with stakeholders and partners in the service has enabled us to bring new evidence and insights to colleagues at the frontline and has extended the reach and impact of our work. This year has seen the completion of some very significant analytical work with findings that have been well received and which, if taken up, have the potential to improve the organisation and delivery of care for patients.

Although the overwhelming focus of Government and Parliament has been on Brexit, the NHS has been the major domestic issue of concern to the public. After a period in which the evidence for a more sustainable funding solution for the NHS seemed to fall on deaf ears, the 70th anniversary of the NHS has proved to be a significant turning point. The Nuffield Trust has made a telling contribution to the discourse on NHS funding and finance and we now turn our attention to providing insights on how best to use the new settlement of an additional real terms increase of £20.5 billion over five years. Ahead of a Government Green Paper, we have also contributed to the debate on the much-needed reform of social care, drawing lessons from the long-term care system adopted in Japan.

We have completed a five-year programme monitoring the quality of care delivered by the NHS during a period of austerity. Our QualityWatch programme, undertaken in partnership with the Health Foundation, has become a trusted resource on quality indicators and now continues for a further two years.

The Trust has a very well-established reputation in the field of complex evaluations of new models of care. Our work with academic partners to develop a frailty risk score as part of a comprehensive approach to geriatric assessment has been shortlisted for a research excellence award. Working with partners from University College London and Imperial College London, we were successful in securing funding from the National Institute for Health Research (NIHR) to establish a rapid service evaluation team, which will conduct a series of evaluations for service leaders over the next five years. We have also been chosen as evaluation partners for 'Care City', a North East London partnership trialling new technologies that can improve patients' skills in managing their own care, and improve the organisation of care for people with complex long-term conditions.

We reached an important milestone this year in our work on acute medicine in smaller hospitals.

We have published our analysis of the steps service leaders should consider to ensure that acute medical care for patients is less fragmented and services safely staffed. Our broader study on medical generalism in smaller hospitals will be submitted to the NIHR for review this autumn.

The ability of the NHS to deliver value to the public from the additional investment announced in June will depend on resolving some long-standing and pressing workforce challenges. Currently the NHS is running with more than 100,000 vacancies, with significant problems across the nursing workforce and in a number of medical specialities.

Joint analysis on funding by the three major health think tanks has proved influential in securing a longer-term settlement for the NHS. Such is the scale of the workforce problem that we joined forces with colleagues from the Health Foundation and The King's Fund to support Health Education England (HEE) in the development of their workforce strategy and will continue to work together in the coming year.

The development and evaluation of new models of care has become a major and varied part of our work this year. We have completed five long-term projects to evaluate services designed to prevent avoidable hospital admissions or readmissions; assessed the potential of new technologies in primary care and for patients with chronic conditions; explored the barriers to adopting innovation in health care and the scope for transforming outpatient services.

We have set up a new programme of work investigating the health of children and young people and designated this as a sixth corporate priority. Our early publications from the programme, on emergency hospital use by children and young people and an international comparison of their health and wellbeing, received extensive media coverage and have helped establish the Trust as an active player in this field of research. Planned work on children and young people has provided a spur for the Trust to strengthen its growing relationship with the Nuffield Foundation, with plans for an integrated approach to researching children's health and wellbeing.

The Nuffield Trust endeavours to track the comparative performance of the UK's four health systems and to draw on international comparisons to illuminate trends and changes in patient services. This year, we have used international comparisons to track outcomes for children and young people and to evaluate how well the NHS performs overall. This and our other work is reported against the six strategic priority areas approved by Trustees – NHS and social care reform; quality; workforce; new models of care, older people and complex care; and children and young people's health. It documents the work we have undertaken and describes its impact and public benefit.

1: NHS and social care reform

Analysis and commentary on health and social care reform is central to our work and permeates all our work programmes, from the evaluation of new models of care, through services for children or for older people, to indicators of quality and workforce challenges. The particular focus of this work stream is responsive analysis that sheds light on NHS funding, the ramifications of Brexit, the challenges of service reorganization and the need for a sustainable approach to social care.

Objectives for this work programme

Our objectives for our work on NHS and social care reform are to provide high-quality evidence, authoritative policy analysis and timely commentary and policy recommendations on the challenges that face leading clinicians, service leaders and policy-makers.

Public benefit of this work

It is important that high-quality evidence and analysis are brought to bear on the major decisions affecting funding and provision of health and social care services. These are essential services funded by general and local taxation, as well as by individuals and families.

The public interest therefore requires that significant proposals and decisions on funding and services be subject to scrutiny and challenge. Our work offers independent and objective analysis to parliamentarians and others, allowing people to judge the merits of funding decisions, major reforms and policy initiatives.

1.1: Brexit

The Trust now has a well-established position as a provider of objective, evidence based analysis on the implications of Brexit for health and social care. Building on reports and events during 2016 and 2017, in October, we held the third in a series of breakfast briefings for key stakeholders. The three events were sponsored by MSD. In addition to our own commentary, we published three guest blogs, a legal commentary by senior associate Sharon Lamb, plus perspectives from the care sector and pharmaceutical industry.

Mark Dayan has been leading this work for the Trust. In November we published his briefing on how our future relationship with the EU will shape the NHS.

This examined the many aspects of regulation that need to be addressed to secure the future supply of medicines and medical devices. Mark wrote a submission to the House of Lords EU committee and gave a public lecture for the Royal College of Nursing. In January, he explored the particular implications of Brexit for Northern Ireland and gave evidence to the Scottish Parliament in March.

In May we held a parliamentary event jointly with UK in a Changing Europe (UKCEU). Chaired by Sarah Neville of the *Financial Times*, our panellists were Hilary Benn MP, Bernard Jenkin MP, Anand Menon of UKCEU and Nigel Edwards.

With each twist and turn of the negotiations, and with both major political parties deeply divided, the prospect of a 'no deal' Brexit looms over the NHS and the economy as a whole. In addition to the long-term implications for the NHS, attention has now shifted to some of the immediate problems the health service might face in just a few months' time. Our commentary has focused on the potential disruption to the supply of medicines and devices, staffing problems, additional cost pressures and the impact on reciprocal health care arrangements for UK and EU citizens. Our briefing, 'How will our future relationship with the EU shape the NHS?' was widely reported and our analysis remains that almost any deal would be better for the NHS than a 'no deal' exit from the EU.

Public benefit and impact of this work

Brexit will have profound implications for the NHS and social care, potentially leading to a worsening of existing workforce shortages; uncertainties over the supply of medicines and medical devices; threats to collaborative research programmes and the prospect that the NHS becomes a less attractive market for new medicines. We have become a trusted source for sober analysis of the challenges ahead. As part of the Chequers plan, the Government has committed to remaining within the framework of the European Medicines Agency and to retaining the EHIC cards which provide reciprocal health care for travellers across the EU - both measures that we identified as necessary and important.

1.2: NHS funding and finance

1.2.1: NHS finances

The story of NHS finances in 2017-18 is perhaps characterised by the narrow avoidance of crisis. In the lead up to the Chancellor's 2017 Budget we worked with colleagues in the Health Foundation and The King's Fund to model the spending increases required to keep pace with previous allocations to and developments in the NHS – roughly 4% per year historically.

We concluded that an additional £4 billion was required to keep the NHS on track during 2018-19. Our budget analysis was published on 8 November 2017 to widespread coverage.

In pre-budget commentary, John Appleby and Sally Gainsbury set out a series of reasons for increasing NHS funding, including the need to recognise the underlying deficit of £3.7 billion.

In the event, the Chancellor provided an additional £2.8 billion for the NHS – more than expected, but less than needed.

The three think tanks provided post-budget analysis as a Facebook Live event hosted by the *BMJ* and published a joint explanatory briefing. Throughout the year, we continued to monitor the deteriorating state of NHS finances quarter by quarter.

1.2.2: Longer-term funding settlement for the NHS

At the beginning of March our Chair, Andy McKeon, wrote a blog for the opening of our 2018 health policy summit. He predicted that new funding would become available for the NHS before too long and committed the Trust to examining how best the NHS could spend any additional funding and the pros and cons of any reforms or 'strings' that might accompany a further injection of cash. Later that month, the Prime Minister signalled her intention to reach a longer-term disposition for NHS funding that would avoid repeated hand-to-mouth emergency measures. This welcome news was the subject of much speculation about the size of any settlement, the strings to be attached to it and whether a settlement for social care would be announced at or around the same time. Many research organisations joined forces in different configurations to state their view on what the size of the settlement needs to be. The clear consensus was that real-terms annual increases of 4% are needed, with some higher sums needed early on to make up for a decade of austerity.

The Trust has long been active in making the case for a longer-term settlement and for a matching settlement for social care. Nigel Edwards had a 'Red Box' article in *The Times* talking about a two-part approach – immediate steps to relieve current pressures and longer-term change in how services are delivered. He also provided then Health Secretary Jeremy Hunt with a personal briefing.

The announcement of a 10-year funding settlement for the NHS was made on 18 June. The Prime Minister pledged to provide an additional £20.5 billion in real terms for the NHS over the next five years, with a matching plan to ensure the money was well spent. This was a highly significant change in Government policy. Over the summer period, NHS England held both formal and informal meetings with service leaders, partners and interested parties. Nine senior Nuffield staff were asked to contribute to the multiple work streams set up to feed into the formulation of the long-term plan. It reflects well on the Trust that our contributions have been actively sought by NHS England and NHS Improvement.

1.2.3: Learning from history

The NHS has been subject to six major plans and ten reorganisations in recent history. As part of our contribution to the development and delivery of the long-term plan for the NHS, we undertook an analysis of what history suggests are effective or, conversely, counterproductive approaches to spending new money and rolling out a major new approach to service delivery. A 'Learning from History' event was due to be held at the Institute of Government in October.

1.2.4: The NHS at 70

The year 2018 marks the seventieth anniversary of the NHS. After a decade of public sector austerity, a number of major organisations took the opportunity both to celebrate the achievements of the NHS and to warn that its sustainability was in doubt. It was no accident that the Prime Minister's announcement of a longer-term funding settlement for the NHS was made in the run-up to the July celebrations.

Our contribution was to work in partnership with the BBC, the Health Foundation, The King's Fund and the Institute of Fiscal Studies to produce a series of independent reports on the strengths and weaknesses of the NHS. Five reports were produced on NHS performance, funding, social care, public expectations and digital opportunities. We led on two of these reports and also co-ordinated all the communications activity on behalf of the four think tanks.

The BBC devoted a week of programming to the NHS at 70 and Nigel Edwards joined our other partners in a live broadcast from Birmingham University Hospital to mark the anniversary. John Appleby worked with the *BMJ* on their coverage of the NHS at 70, shaping the content and contributing a paper for it.

Our analysis of NHS performance 'How good is the NHS?', which compares the NHS with 14 other countries, was widely reported, with over 1000 mentions in national print and broadcast media. It continues to be cited at national level.

1.2.5: Understanding the Private Finance Initiative

The Private Finance Initiative (PFI) has been a major source of finance for NHS and other public service project in the last two decades. It remains controversial due to the high costs of servicing PFI contracts. Professor John Appleby has been in regular demand, particularly from broadcast media, to explain the costs of PFI and options for funding NHS services. He wrote a very well received explainer to demystify the issue which attracted a high number of page views and demonstrated again that there is a clear appetite for this type of resource from a trusted and independent source.

Public benefit and impact of this work

The Nuffield Trust has long argued that NHS funding needs to be put on a more secure footing. Our work on the underlying deficit has exposed the true state of NHS finances and led to

greater transparency in the way that NHS Improvement and NHS England report on financial performance.

Our own analysis over the last 10 years and more recent joint work with the Health Foundation and The King's Fund have provided an authoritative and independent account of the pressures on the service and has contributed to a significant change in Government policy.

As a direct result of her 'The Bottom Line' report, Sally Gainsbury presented her work to HM Treasury in May. She also had a major input to work undertaken by the National Audit Office and influenced the report's call for greater transparency on the underlying deficit. In September, NHS Improvement and NHS England acknowledged the size of the underlying deficit for the first time in their Quarter 1 report, confirming our assessment that it stands at over £4 billion.

1.3: Learning from Japan: older people and social care

With the English social care system on its knees and an imminent green paper expected to lay the foundations for change or even overhaul, the Nuffield Trust re-visited Japan to consider what lessons could be drawn from the introduction of the comprehensive long-term care system. Japan introduced a compulsory social insurance model for the over 40s in 2000 and its patterns of provision for older people focuses strongly on maintaining wellbeing and reducing social isolation.

The report takes a historical look at this system and how it was introduced, what stumbling blocks were encountered and different decisions made, and concludes that England is in a similar situation to that of Japan in the late 1990s. The report recommends that England would do well to focus on prevention, engage the public in a proper social care debate, and make benefits and costs transparent if it is to achieve a clear, appropriate, equitable and sustainable solution. The visit was part-funded by the Sasakawa Great Britain Foundation.

Public benefit and impact of this work

While NHS funding has been put on a more sustainable footing by the Prime Minister's funding announcement, social care remains in a state of freefall, with a collapsing provider sector, spiralling costs, inequities in funding arrangements and severe staffing shortages. Our report is a contribution to a much-needed and more strategic consideration of funding and reform options for the social care sector, set to be addressed in the Green Paper towards the end of 2018.

The report was launched at a well-attended All Party Health Group event on 9 May 2018 and attracted excellent media coverage in seven national newspapers, trade press and local and national radio. It has also been cited by policy-makers and parliamentarians. For instance, in June 2018, the Housing, Communities and Local Government and Health and Social Care

Committees' joint report called for a sustainable funding solution for adult social care which drew heavily on our Japan work.

Prior to the launch, report author Natasha Curry met with the green paper team at the Department for Health and Social Care. She has presented at a number of different conferences since the launch. Natasha has also been approached by a number of different organisations about potential joint work in this area. Following on from our focus on Japan, we are currently studying the German long-term care system.

1.4: Managing the hospital and social care interface: interventions targeting older adults

With hospitals struggling to meet targets and a crisis in social care, collaboration between the secondary health care and social care is a key area of focus in the drive to improving care in England. This report, published in March, uses case studies and quantitative research to explore innovative strategies that providers and commissioners have put in place to improve that interface, with a focus on what hospitals can do. It looks at collaboration to prevent avoidable hospital admissions; the interface between providers when patients are discharged from hospital; the relationship between commissioners and social care providers; and wholescale organisational integration.

Public benefit and impact of this work

A National Audit Office report on the interface between health and social care, published in July, references this report and also cites earlier joint work by the Trust and The King's Fund from 2012. The Healthy Towns Initiative has also picked up the report and the Trust is now a member of the Healthy Towns steering group.

1.5: British Social Attitudes Survey

On 28 February we launched the latest results of the British Social Attitudes survey on public satisfaction with the NHS and social care, analysis conducted jointly with The King's Fund. The results showed a significant drop in public satisfaction with the NHS and social care satisfaction and a sharp rise in dissatisfaction. Most striking was a seven percentage-point drop in satisfaction with GP services, taking it to its lowest since the survey began in 1983.

Public benefit and impact of this work

The British Social Attitudes survey presents an important 35-year data series on public attitudes to major social and economic issues. By part-funding and disseminating the results of the survey, we help to ensure that policy makers are informed of changing public views. Major changes in satisfaction, as revealed this year, may serve as a sentinel marker for declining performance and quality.

We secured in widespread coverage across the BBC network and on Sky News, as well as prominent articles in the *Financial Times*, *Telegraph*, *Times*, *Guardian* and *Daily Mail*. Our bespoke infographics, video clips and charts for digital and social media resulted in 50,000 impressions on social media.

The results elicited responses from a wide range of stakeholder groups, including NHS Providers, the NHS Confederation, the Royal College of Nursing, the Royal College of General Practitioners, the British Medical Association and NHS England.

1.6: Accountability and commissioning

In March, Nigel Edwards gave evidence to the House of Commons Health Select Committee inquiry into integrated care. The Committee Chair, Sarah Wollaston, is committed to surfacing the very wide range of concerns about emerging integrated care systems and whether these open the door towards privatisation of the NHS.

He wrote an extended article on strategic commissioning which received many positive responses and led us to develop a series of articles looking at practical considerations for commissioners and providers developing integrated care systems. The first of these, by our Senior Associate Richard Lewis, was published in March and explored the issues that integrated care systems (ICSs) will need to consider in allocating funding across the system.

The machinery that holds both providers and commissioners of NHS services to account has become even more complex with the advent of the 44 sustainability and transformation partnerships (STPs). Indeed, the advent of STPs means that NHS commissioning organisations have now been restructured eight times since the early 1990s. In November, we published a report exploring the challenges and opportunities they present.

The report, and a companion blog by Helen Buckingham, concludes that whatever the structure, ultimately it is leadership behaviour that will have a long-term impact on organisations and systems.

1.7: A strategic approach to NHS estates

As part of our support for STP leaders, we held a series of three linked workshops for STPs hoping to maximise the value of their NHS estate. Run in collaboration with the Realisation Collaborative and supported by the Health Care Financial Management Association (HFMA) and Community Health Partnerships (CHP), the workshops aimed to help local STP teams develop robust, fundable and implementable strategic estates plans. Our follow up report included practical suggestions for national bodies, local systems and third party advisors.

1.8: The NHS in Northern Ireland

Following a successful seminar and report on Scotland's NHS last year, we held a seminar in Belfast in January to explore how the Northern Ireland NHS is faring, and what lessons can be learned about the enablers and barriers to progress in service delivery and improvement.

A briefing report is planned, with a series of qualitative interviews to augment the evidence presented by seminar participants.

2: Quality of care

Objectives for this programme

We aim to provide authoritative analysis of quality initiatives and to monitor and comment on a wide range of quality indicators.

Public benefit of this programme

At a time of unprecedented financial pressure, it is vital that independent, non-statutory bodies continue to provide trusted, independent evidence on how quality of care is changing over time. We do this primarily through our QualityWatch programme.

2.1: QualityWatch

December 2017 marked the formal end of the first five year QualityWatch programme. A summary analysis of our work in partnership with the Health Foundation is set out below.

QualityWatch launched in 2013, in the wake of high-profile investigations into major failures of care, and as the NHS and public services were responding to the impact of funding constraints. The programme is primarily concerned with monitoring and commenting on what is happening to quality of care, with the aim of inciting action and improvement by presenting novel and independent analysis. Secondary objectives are to contribute to the development of new methods of measuring and assessing quality, and to provide a platform for a diverse range of perspectives on the quality of health and social care services.

QualityWatch provides an independent picture of the quality of care, to supplement and inform the work of other initiatives and the statutory national bodies. It has primarily focused on the NHS and social care in England, but also draws on evidence from the four countries of the UK and health systems in other comparable countries around the world. The programme places short-term changes within a wider historical context, where possible, rather than solely reporting the latest data.

During the course of the QualityWatch programme we have developed credible sets of indicators using existing sources of data to measure changes in the quality of health and social care. The 310 indicators are grouped into around 90 short stories on care quality.

We carried out a series of deeper analyses that focus on specific areas of health and social care quality, using innovative analysis, and providing new perspectives on how the quality of care is changing. By March 2018, when the extended first five-year programme ended, we had published 14 'Focus on' reports, two briefings, and two data blogs. We produced four annual statements that review the state of care quality in the NHS in England and how it has changed over time, and for the fifth year, an online briefing with visualisations of trends and a collection of blogs to mark the final year of the programme.

QualityWatch provided a platform for internal and external expert commentary, with 135 editorial items, including 79 blogs (34 by external authors); 17 'latest data' posts, 13 'indicator update' posts, and 26 news stories. The outputs are hosted on the QualityWatch website which has received acclaim for its clear presentation of data and analysis.

Public benefit and impact of this work

QualityWatch has told the story of quality during the first half of a decade of austerity. The programme has tracked a consistent deterioration in access to care, with major waiting time targets being missed and growing numbers of people being delayed in accessing hospital care. In addition, the programme has identified growing problems in mental health and social care. The programme has also consistently highlighted some of the good news stories in care quality – including high levels of patient satisfaction, and areas in which quality has been maintained despite growing demand or activity.

The 2017 annual statement reviewed trends over the last five years, concluding that "the opportunity cost of stabilising current overspending by trusts and prioritising emergency and primary care services may well be further deterioration in elective waiting lists and waiting times". Professor Sir Nick Black's blog for the end of the programme looks back across the four previous annual statements and provides a narrative on the 'meta' story we've been telling over the life of the programme.

There are inherent difficulties in measuring quality of care. Quality is complex to define; rigorous and consistent measurement and assessment is challenging; and there are significant limitations to the availability of data, with some areas well covered but others hardly at all. We have addressed these issues through the analysis, and also drawn attention to gaps and issues with data, most recently in relation to community care. During the life of the programme, we have developed new measures and methods for assessing quality and understanding trends. Examples include methods for comparing the hospital use of people with severe mental illness with people with other conditions and identifying admissions from care homes.

In addition to the reports, commentary and media work described above, we have also run regular events, most recently the Children and Young People roundtable at Nuffield Trust in June 2017.

We have a large and still-growing number of website users. The QualityWatch website's user numbers increased by 17% from 2016/17 to 2017/18. A large amount of our communications work has focused on the launch of major reports. Many of these have had enduring appeal, with reports from 2013 and 2014 still being amongst the most downloaded in 2017/18. By far the biggest driver of increased website traffic has been the success of the quality indicators: in 2017/18 (up to 19th March) 63% of unique page views was on indicator pages, 11% on blogs/editorial, 10% on 'Focus on' reports and 9% on long-form blogs.

The research outputs have featured in most national and specialist media outlets, with extensive coverage for the in-depth reports. Parliamentary impact has included citations in debates, questions and written answers, and in Health Select Committee reports.

The QualityWatch report on mental and physical health from October 2015 was cited in NHS England's new Mental Health Five Year Forward View, published in July 2016, and also featured at an international conference on integrated care.

Senior stakeholders across health and social care have contributed to QualityWatch and commented on its outputs, including royal colleges, national clinical directors, major health charities, and academic departments. QualityWatch outputs are also referenced in NHS guidance and policy.

We have agreed a further two years' funding for QualityWatch with the Health Foundation, during which we will refresh the current set of indicators, move to themed releases of information and transition the programme to be hosted on the Nuffield Trust website.

In the autumn of 2017, we published two final 'Focus on' reports, on dentistry and on community services, as part of our first five-year programme. Our June 2018 briefing looking at trends in emergency readmissions received widespread media coverage, including over 100 broadcast mentions and over 200 print and online mentions.

2.1.1 Inequalities in dental health

Our briefing on dentistry analysed routine and publicly available data on dental health outcomes and activity. It revealed that, across several different data sources, dental health is generally better in the south and east of England and poorer in the north of England. Disparities in dental health between richer and poorer communities are also striking.

2.1.2 Community services

On community services we found that it remains difficult to make a meaningful evaluation of the overall quality of community services because of a lack of routinely available quality data and national indicators of quality.

We returned to this concern with a blog in August by Jonathan Spencer and Sarah Scobie, which analysed the first tranche of data to come through from a new mandatory data set for community services.

2.1.3 Emergency readmissions

Prompted by a Healthwatch report published in December 2017, we examined trends in emergency readmissions and published a research report, an updated QualityWatch indicator and commentary by Jessica Morris in June 2018. This secured wide media coverage and led Healthwatch to convene a roundtable discussion in July with senior clinicians working in urgent care and senior Nuffield staff.

Public benefit and impact of this work

Throughout the first five years of the QualityWatch programme, we used our 'Focus on' report series to examine particular service areas in more depth to establish how patient care was faring in times of austerity. Our briefing on dentistry warned that although significant improvements have been made in the quality of people's dental health and care over time, this progress risks stalling if appropriate action isn't taken to tackle persistent inequalities. The analysis attracted strong national and regional media coverage on its publication in October, and prompted both oral and written parliamentary questions.

For community services, we noted that that there are roughly 90 million contacts per year with community services in the NHS – spanning the whole life course from pre-natal to elderly care, and with important specialist services such as prison health. National policy-makers have identified community services as increasingly important for the future provision of health care, as services move away from hospitals and closer to people's homes. We argued therefore that it is both pressing and important to have a coherent national picture of the quality of that care.

2.2: Prisoner health

The Health Foundation has agreed to part-fund an 18-month project exploring prisoner health. The project, conceived and led by Dr Miranda Davies, started in January and is a two-phase piece of work consisting of a literature review to identify what is known about prisoners' healthcare needs, followed by analysis of HES data to determine what can be learned about prisoners' health based on their use of secondary healthcare services.

An expert panel has been established to comment on the development and progression of the work. This met for the first time in July and includes representatives and academics from organisations working in the field of prisoner health. Three introductory blogs for the project have also been published; 'Numbers matter in prison'; 'Us and them: the impact of prejudice on prisoners' health care' and a third on pregnant women in prison.

Our work on prisoner health sits within our Quality workstream and benefits from Health Foundation funding, but is not part of the QualityWatch output. It will shed light on an under-reported area of health inequality. In June 2018, the BMA referenced the prisoner health project in their submission to the Health Select Committee inquiry into prison health care:

"We particularly welcome the Nuffield Trust's ongoing project to look at the health trends of the prison population and hope that government will consider carefully their findings once they are published, particularly how government can produce data which would allow better understanding of prisoner health."

2.3: The Francis Inquiry and board governance

In 2014, the Nuffield Trust published a 'one year on' report on the impact of the Francis Inquiry into the failings of care at Mid Staffordshire hospital. In January this year, the Universities of Manchester and Birmingham published their five year final report, to which the Nuffield Trust contributed.

3: The NHS workforce

Last year we stated that the two greatest problems facing the NHS were funding pressures and the state of workforce recruitment, retention and morale. We have continued our programme of analysis and commentary on workforce issues, with a major report on the staffing of acute medicine and detailed analysis of the gender and ethnicity pay gap in the NHS. Towards the end of the financial year we joined forces with the Health Foundation and The King's Fund to provide evidence and recommendations for the national workforce strategy on which the long-term plan for the NHS will depend.

Objectives for this programme

We believe that the workforce challenges facing health and social care are as serious as its funding problems.

By researching and advocating new approaches to workforce planning and deployment, we aim to provide policy-makers with high-quality evidence and analysis to inform workable solutions that will assure the supply of skilled and motivated staff into the future.

Public benefit of this programme

The sustainability of our health and social care services depend on a stable supply of sufficient permanent and skilled staff as well as the development of new and enhanced skills within the health and social care workforce. Our work identifies the specific challenges and solutions that must be addressed by government, parliamentarians and those with workforce responsibilities.

During the course of the year, the scale and complexity of the workforce challenges facing the NHS and social care have become an ever present backdrop for debates about current pressures and future opportunities/challenges. Figures published by NHS Improvement in September signalled 40,000 current nursing vacancies in the NHS and our own estimates of the effects of Brexit anticipate that the social care system could be 70,000 workers short after the UK leaves the European Union.

The Health Select Committee held a short enquiry, specifically on nursing shortages, to which we submitted evidence in October. We held a session on workforce planning as part of our 2018 summit and have published 25 comment pieces on workforce issues during the year.

3.1: Workforce strategy: Health Education England

Health Education England published a draft workforce strategy in December 2017 which began to acknowledge the seriousness of the situation but left key questions unanswered. Candace Imison joined forces with colleagues from the Health Foundation and The King's Fund to support HEE with a roundtable in May which looked at key workforce modelling assumptions. The publication of the definitive HEE strategy was put back first until November 2018 and then to January 2019 in order to reflect the proposals in the Long Term Plan for the NHS in England.

The three health think tanks have agreed to continue to work together to support HEE, to provide independent commentary on the scale of the workforce problems and to offer recommended solutions in the areas of workforce planning, recruitment and training, remuneration and retention.

Candace Imison has also presented at a Westminster Insight conference on developing a sustainable NHS workforce and attended a ministerial roundtable on the impact of Brexit on health professional education and training.

3.2: Staffing models for acute medicine

The NIHR-funded project on medical generalism in smaller hospitals, led by Louella Vaughan, prompted a separate commission from NHS England on staffing models for acute medicine.

The development of acute admissions units, ambulatory care services and other novel models for acute medicine all stem from attempts to meet the four-hour Accident and Emergency (A&E) target and are well intentioned efforts to improve flow through the hospital. However these, and other developments such as sub-specialisation, have had the unintended consequences of making it more difficult to staff acute and emergency medicine safely and fairly.

Across the country a stark variation in staffing numbers, roles and specialties prevails, and there is little correlation between the skill mix of specialists within these hospitals and the patient cases that are being dealt with. The configuration of acute medical services is becoming increasingly fragmented and complex, with patients being hived off into more and more specialist units of care.

Dr Louella Vaughan presented on this topic at the 2018 summit. The findings from the Acute Medical Models work, which includes a review of international approaches, were previewed at a very well attended successful conference with international speakers in early May.

In September, we published a slide pack resource by Candace Imison, drawing on a survey of smaller hospitals to assess the current state of acute medical care.

The survey interviewed medical directors and lead clinicians for acute/emergency medical care over a six-month period and found evidence of the huge challenges faced by smaller acute trusts in England, particularly in maintaining sufficient numbers of medical staff. The substantive report is due to be published in October.

Public benefit and impact of this work

Medical care for people who are acutely unwell is a major component of unscheduled work in hospitals large and small. Service models that work well in large hospitals, such as ambulatory care and frailty units, are not always viable for smaller hospitals and make existing staffing difficulties worse. Yet smaller hospitals account for half of all inpatient hospital provision so there is a clear public interest in identifying sustainable approaches to staffing them safely.

At pre-launch events and presentations our work in this area has been very well received by service leaders and by NHS England. NHS England intends to commission further work from us that will support local leadership teams and we are also exploring the scope to extend the analysis to cover maternity and paediatric services. Louella Vaughan and Nigel Edwards have been much in demand to support local areas that are rethinking their acute services as well as speaking at national and international conferences such as the Society of Acute Medicine's conference in Bournemouth and the forthcoming World Hospital Congress in Brisbane, Australia.

3.3: Gender and ethnicity pay gap analysis

Legislation came into force in April 2018 requiring organisations that employ more than 250 staff to publish details of salaries paid by gender.

We decided to establish the extent of the gender pay gap for NHS staff by examining the electronic staff record data on over 1.2 million NHS staff in England, held by NHS Digital. The first of a series of analyses by Laura Schlepper and John Appleby of the gender pay gap was published in May. This showed an 8.6% median pay gap in favour of men, comparable with other sectors of the economy. However, the headline figure does not tell the whole story, as the pay gap varies by occupation, pay band and age. Differences in average earnings pointed to some more significant inequalities within particular staff groups, some as high as 23%, prompting the Health Secretary to announce a review of the gender pay gap in medicine which is being led by Prof Jane Dacre, whom we met to discuss our findings in July.

The electronic staff record also shows the pay grades of NHS staff by ethnicity, allowing us to probe earnings differences within different staff groups. Research by the Fawcett Society has shown that the pay gap between men and women in Britain is also shaped by ethnic inequality.

We found that in the NHS a pay gap does exist and is again in favour of men for most ethnic groups.

A data blog commissioned from John Appleby by the *BMJ* attracted good online coverage for this issue, which we plan to pursue with further statistical analysis of the factors contributing to the gender and ethnic pay gaps.

Public benefit and impact of this work

The NHS is the UK's largest employer and could make a significant contribution to fostering greater equality in the workplace. It also has severe workforce shortages.

By analysing the factors which lead to income inequality for different groups of staff, we hope to contribute to better employment practice and improved staff retention. Our work in this area proved timely, given the Dacre review, and we continue to be asked to provide expert evidence and input to a number of groups, including NHS Employers, the Equality and Diversity Council and the Workforce Race Equality Strategy Implementation Team.

3.4: Tier 2 Visa caps for overseas nurses and doctors

In line with previous work on staffing shortages; as part of our joint Nuffield Trust/King's Fund/Health Foundation submission to the Prime Minister, we argued for an easing on the visa restrictions preventing the deployment of doctors and nurses from outside the EU. Many organisations, the Health Secretary and the Home Secretary made a plea for change.

An announcement was made on 15 June which will take doctors and nurses out of the migration cap altogether. This will hugely benefit the NHS but also other sectors of the economy that will be able to access more of the quota.

4: New models of health care delivery

We now have a substantial body of work on new models of care delivery. This is a very varied work stream which includes a series of evaluations analysing the changing structures and models within primary care; the impact and potential of new technologies to improve patient care and our NIHR-funded work on acute medical care in smaller hospitals.

Objectives for this programme

Through this programme, we aim to offer the service timely evidence on the opportunities and challenges presented by new models; to support practitioners embarking on service reform and to disseminate emerging insights to policy-makers, parliamentarians and service leaders. The overall aim is to support improvements in care that will benefit of patients and taxpayers.

Public benefit of the programme

There is a compelling imperative to devise new models of care delivery that will deliver enhanced care, reduce cost and contain demand for costly inpatient services. The considerable taxpayer investment in, and hopes for, these new models demands that their effectiveness be systematically evaluated. Our work aims to serve the public interest by illuminating which innovative models are most likely to secure access to more timely and effective approaches to health and social care delivery. Our work on the potential of digital technology to improve the quality and cost-effectiveness of patient care also picks up and responds to concern about the gap between the digital experience the public enjoys as consumers and the experience of patients in the NHS.

4.1: Evaluating the effectiveness of new models of care

4.1.1: Rapid Service Evaluation Team

We competed for and were successful in securing funding from the National Institute for Health Research (NIHR) for a five-year programme of rapid service evaluations. The programme, involving John Appleby, Chris Sherlaw-Johnson, Theo Georghiou and Jonathan Spencer together with researchers from University College London (UCL) and Imperial College London formally started its work on 1 April.

The team's first project – as directed by NIHR – is a rapid evaluation of the programme that imposes special measures on providers because of quality concerns.

It will focus on the relative effectiveness of the various elements of the regime.

Other evaluation topics are also being considered – including an evaluation of the Buurtzorg model of community nursing, a longer-term evaluation under the umbrella of service centralisation and one on stranded patients.

Planning is underway for a conference in January 2019 for researchers and commissioners of service evaluations. This will be a joint endeavour with our RSET partners from UCL and Imperial, the other NIHR-funded evaluation team BRACE (Birmingham, Rand and University of Cambridge) and the Health Foundation's analytics unit.

4.1.2: Care City Evaluation

Earlier in the year we were invited by Care City in East London to be the evaluation partner for their application as a test bed site for Wave 2 of the NHS England digital innovations programme. This is a major independent evaluation of the implementation of digital technology to improve the delivery of care in parts of North East London. In September we learned that the bid had been successful. This will be a major, multi-partner endeavour involving the Nuffield Trust, Care City and other local stakeholders.

Our success in winning the contract is a strong affirmation of our reputation in the field of complex evaluations. As a bid reviewer commented:

"Without question the applicants have assembled a very impressive consortium with vast experience, in all the right areas. They have full commitment from senior management and stakeholders in all the partners in the consortium and the adopting organisations in order to ensure smooth execution and adoption of the innovations and the support of world-class academics in the evaluation of the innovations. They are very well placed to make a huge success of the project".

4.1.3: Evaluating integrated care initiatives

Our Deputy Director of Research, Sarah Scobie, developed a very well-received resource to help service managers choose appropriate tools and measures for evaluating the effectiveness of integrated care initiatives. In addition to publication on our website in July, the resource pack has been marketed directly to stakeholders in Arm's Length Bodies (ALBs) and local NHS organisations.

4.1.4: Indicators of care quality

The Nuffield Trust is a respected source of analytical expertise with senior staff invited to serve as members of boards and committees that advise both on the development of national indicators and the ways data and indicators relating to the delivery of care are analysed and published by national programmes. Senior research analyst Chris Sherlaw Johnson is currently a member of the HQIP Methodology advisory Group which advises on methods used by the national clinical audit programmes for analysing and publishing data; the Technical

Working Group undertaking further development of the Standardised Hospital Mortality Indicator and the Clinical Services Quality Markers Progamme Board.

4.2: General practice and primary care

4.2.1: Access and continuity in general practice

In February we published an extended piece of thinking by Senior Fellow Dr Rebecca Rosen examining the trend in general practice to prioritise patient access.

New models are emerging that split out different services for different groups of patients: easy access schemes like walk-in centres for those who prioritise speed and convenience, and more intensive care for frail patients with many illnesses and complicated needs. This report examines how best to balance the proliferation of GP services which prioritise speed and convenience with the traditional strengths of general practice based on deep knowledge, community-based understanding and continuity of care. It concludes by looking at what GPs and national NHS bodies can do to get the best of both worlds. Rebecca spoke about her report at the 2018 summit.

This and other work led to a commission from NHS England to explore the relationship between initiatives to promote access and patients' experience of continuity in general practice. The project involved a rapid evidence review, interviews, site visits, roundtables and analysis of the GP patient survey at both individual and practice level. We presented the key findings to NHS England in May, which were very well received and our final report in mid-July. On the basis of the work so far NHS England have signalled enthusiasm for commissioning more follow-on work.

4.2.2: General practice at scale

Alongside the emergence of new types of GP service, we continue to witness a trend for practices to combine in collaborative federations, working 'at scale' to allow more efficient use of resources, to deploy staff more effectively and to focus on population health.

In an extension to our 'general practice at scale' programme with the Royal College of General Practitioners, we published the results of a second survey of GP practice and clinical commissioning groups (CCGs) to explore the changing landscape.

We found that the scaling up of general practice continues apace with 81% of general practice-based respondents reporting that they were part of a formal or informal collaboration, up from 73% in 2015.

The main priorities of all collaborations over the last year were: increasing access for patients, improving sustainability, and shifting services into the community. Both providers and

commissioners reported that time and work pressures were the biggest challenge to collaborations achieving their aims. The majority of respondents did not feel that they had been able to influence the development of local sustainability and transformation partnerships (STPs).

GPs were less optimistic than CCG members about the potential for STPs to deliver meaningful change in primary care and around half were resistant to moving to a new type of contract, fearing loss of control over decision-making and leadership in their practice.

4.2.3: Technology based primary care services

This year has seen the exponential growth of GP at Hand, a new and disruptive approach to delivering primary care through phone-based technology. We have tracked its development and the challenges it poses for traditional services through a series of blogs by Dr Rebecca Rosen, our Deputy Director of Research Sarah Scobie and Senior Fellow Sophie Castle-Clarke.

Public benefit and impact of this work

The Trust has consistently tracked developments in primary care and commented on emerging trends. Rising workload and enduring workforce shortages threaten the sustainability of primary care. This requires service leaders to think innovatively about making better use of allied health professionals in primary care and to make informed judgements about optimising the way practices are organised and grouped together. By marshalling the evidence, we aim to support decision makers and service leaders to make change successfully. In addition to publishing original research and commentary in this area, Senior Fellow Dr Rebecca Rosen is contributing to the GP partnership review commissioned by former health secretary Jeremy Hunt and led by Dr Nigel Watson; serves on NHS England's advisory group supporting the implementation of general practice at scale; and is working with the "Rethinking Medicine" initiative.

4.3: Digital technologies: benefits for patient care

This year has presented the Trust with opportunities to build on research work on digital technology commissioned and published in 2016. Our work for NHS England on digital requirements for new models of care led to a further commission to explore the impact for patients of the use of technology in primary care and in the same year, in partnership with KPMG, we published a major report on the potential benefits to patients of digital technologies. This body of work has led to commissions for further research.

One example is a report commissioned by the MS Society to look in depth at the benefits better use of data and innovative technology can bring to the lives of people living with multiple sclerosis. Published in July, it maps out what is already available, what more could be done, and how data and technology could be better exploited in future to improve MS health care.

The report examines four key areas in the lives and care of people with MS where the potential of data and technology could be harnessed to make a significant difference, helping people with MS take more control of their care; providing accessible and coordinated care; improving access to the right treatments at the right time and using data to better meet patient needs. In a companion blog, report author Sophie Castle-Clarke focused on the importance of developing patients' confidence in using technology. A blog in September by Sarah Scobie and Laura Schlepper exposed some of the common myths and preconceptions about which groups of patients are using new technologies confidently, finding for example that older patients are willing users of remote consultations.

As part of our partnership with the BBC for the NHS at 70, we published a briefing on what new technology will mean for the NHS and its patients.

Although notoriously difficult to predict, this report looks at four current trends and what they might mean for health care over the next decade if they continue to progress.

It covers genomics and precision medicine, remote care using digital tools, technology-supported self-management, and artificial intelligence and machine learning. In each area it asks some questions about how the NHS should prepare for these technological advances.

Public benefit and impact of this work

The Trust now has a significant body of work showing how central bodies, health care providers, commissioners, the third sector and technology companies can improve care for patients through better use of data and technology. Our 2016 report continues to be widely cited – including most recently by Lord Darzi's report on building a sustainable NHS.

4.4: Innovation and transformation

4.4.1: Adoption of innovation

We were asked by the Association of British Healthcare Industries to look at why the NHS has struggled to adopt new innovations (with a particular focus on medical technology or 'MedTech'). We started by asking why all well-evidenced innovations are not adopted at scale and whether the solutions proposed in the Accelerated Access Review (AAR) are sufficient to overcome the obstacles. We also wanted to understand what is needed to implement the AAR and how national bodies like the Academic Health Science Networks (AHSNs) and the Innovation National Networks (INNs) can fulfil the ambitions set out for them.

To address these questions we held a roundtable with representatives from industry, AHSNs, NHS procurement departments, clinicians and policy organisations. The conversation at the session was informed, in part, by a high-level literature scan; interviews with key stakeholders and two case studies of innovations that have failed to spread – namely the oesophageal Doppler monitor and the S-Cath suprapubic catheter. We published our findings in a briefing,

‘Falling short: Why the NHS is still struggling to make the most of new innovations’, in December 2017.

Public benefit and impact of this work

As a result of this work we were approached by Imperial College Health Partners to work with them on producing a white paper for innovation adoption in the NHS.

We jointly produced this paper with Imperial College Health Partners, the Innovation Unit and the Institute of Global Healthcare Innovation.

NHS England heavily drew on this white paper when producing proposals for an innovation strategy as well as for the forthcoming NHS Ten Year Plan. ‘Barriers to the spread of innovation’ was also the topic of a lunchtime round table at the 2018 summit, sponsored by MSD.

4.4.2: Transforming outpatient services

November saw a long-held wish to work on outpatient services come to fruition with an event jointly organised and run with NHS Improvement. There are over 100 million outpatient appointments every year. At a time when the NHS is under significant workforce and financial pressure, many leaders are turning their attention to outpatient services.

We brought together policy-makers, senior clinicians, outpatient managers and GPs with an interest in outpatient pathway redesign. We heard from eight leading clinicians about changes they have made to their outpatient services, ranging from virtual clinics to remote monitoring.

We gave attendees the chance to ask questions about the featured initiatives, and talk about the transformational change happening in their own organisation. Dr Bob Klaber, consultant paediatrician at Imperial College Healthcare NHS Trust, provided one of the case studies at the conference and also spoke at our 2018 summit on how working with GPs in their practices had improved their skills and confidence and reduced referrals.

We drew on this material for a briefing, published in August, which outlines a number of ways to improve efficiency within outpatient services through clinician-led innovation.

Public benefit and impact of this work

With outpatient services in England having experienced the sharpest rise in activity of all hospital services in recent years, there is a need for change, but little clear thinking about how to achieve top-down change. This work argues that bottom-up changes to the service are possible – sometimes with the help of technology – and that they do not have to be a major drain on finances. It provides a number of core principles for change at each stage of the outpatient process.

5: Older people and complex care

The needs of older people with multiple health problems are a major driver of cost and demand. How well those needs are met are a key indicator of care quality. The research projects in this strategic programme are also relevant to our work on NHS and social care reform; to our work on quality and to our analysis of new models of care. They are grouped together here as a discrete area of work because our experience in research and analysis is especially relevant to the area of complex care and multi-morbidity.

Objectives for this programme

Any explanation of the pressures facing health and social care starts by acknowledging the additional demands that result from having an ageing population with complex needs.

This programme provides authoritative analysis of the factors that underpin good care and the effectiveness of interventions designed to keep people well, avoid hospital admission or support their recovery. Each project within the programme has a common set of requirements which include the selection of a rigorous and appropriate methodology; the delivery of a timely report with clear findings or learning points that the client can use to adapt and develop its service or reflect in future work; wider learning points for the service; and a targeted dissemination strategy. Each also has a bespoke communications plan designed to ensure that its findings reach its primary and wider audiences. Several projects came to fruition towards the end of the financial year. We intend to capture their impacts over the coming year and expect the research findings to make a substantial contribution to increasing understanding of how to organize and deliver care more effectively for this key population group.

Public benefit of this programme

Older people and their families are the largest users of, and depend most on, our health and social care services. Understanding the drivers of good-quality care is essential for designing and delivering effective services. A key element of our work in the last two years has been to evaluate a series of initiatives which use volunteer services to augment the care and support offered to older people, often with the aim of reducing hospital admission or re-admission.

Much of the public discourse about older people, and people with multiple or complex conditions, revolves around increased demand and pressure on NHS services, delayed transfers of care and the need for a sustainable funding system for social care.

The development of better approaches to providing high quality care receives less attention, but this is the area on which some of the Trust's long term research projects have been focused. This year saw the completion of three of these.

5.1: Hospital-wide comprehensive geriatric assessment

The aim of this major NIHR-funded project has been to inform NHS managers, clinicians, patients and the public about how best to organise hospital services for frail older people, and has been undertaken in collaboration with clinical investigators at the Universities of Leicester, Southampton and Newcastle and with health economists at the London School of Economics and Political Science.

The study began in late 2014, with the bulk of the work conducted in 2016. Our work has involved innovative data linkage between clinic/research data sets and routine Hospital Episode Statistics (HES) data. This allowed us to look at longer-term hospital costs and outcomes of patients classified as 'frail' and to create a frailty risk score using HES.

Our work on the development of a frailty risk score was published in the Lancet in July and a web-based toolkit which allows commissioners to establish levels of frailty by hospital catchment area and by local authority area was published in August. We contributed four chapters to the NIHR study which is now going through their review process.

Public benefit and impact of this work

This work, if taken up by clinicians and commissioners, has the potential to directly improve the care delivered to frail older people in hospital. We have worked closely with the British Geriatric Society to promote the toolkit to clinicians. Our work on the frailty risk score has been shortlisted for an Office for National Statistics (ONS) research excellence award, which will help to extend its reach and impact.

5.2: Barking, Havering and Redbridge: evaluation of innovative delivery models

We have completed three linked evaluations for the London Borough of Barking, Havering and Redbridge to explore the effectiveness of an extended access initiative for local residents, a complex care hub for older patients and the provision of a bespoke GP support service for local care homes.

Residents in care homes in England generally receive their care from visiting GPs and other primary and community professionals. But this GP care is often reactive, with little proactive care and little continuity. As part of a comprehensive three-part evaluation project, Nuffield Trust was commissioned by Barking and Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Groups to evaluate a primary care service being piloted in four nursing homes. In our first report from the programme, published in April, we assess the impact of the new service on hospital attendance, and detail the experiences of staff and professionals delivering the new service. We find that there are benefits in providing proactive primary care for nursing homes, delivered by a designated GP within a service that specialises in older people.

We worked with Society Guardian to place an exclusive feature on the project for the launch of the report.

Care models for older people have tended to focus on a single condition, even though the growing prevalence of comorbidities means health care costs are increasing. Recognising this, BHR CCGs established the Health 1000 pilot – a 'one-stop practice' for patients with complex health needs, often delivering care within a person's own home. As part two of the comprehensive three-part evaluation project in outer east London, the Nuffield Trust evaluated this service, using a mixed-methods approach to understand who was using the service and its impact on health outcomes and resources, and on staff and patient experiences. The evaluation found no evidence that Health 1000 reduced the use of hospital services. However, the experiences and satisfaction of patients and staff were positive. Chris Sherlaw-Johnson's blog on the importance of paying attention to inconclusive results has been well received. The third and final report, evaluating an extended access initiative, has been completed and sent to the client.

5.3: Age UK and Royal Voluntary Service evaluations

Our evaluation of Age UK's Personalised Integrated Care Programme, which brings together voluntary, health and social care services to provide personalised support to older people, and which in part aims to reduce avoidable hospital care, has now been completed. This work was led by Theo Georghiou who also conducted a matched control analysis of a scheme run by Royal Voluntary Service in Leicester to help vulnerable older people who are being discharged home after a hospital admission.

Public benefit and impact of this work

There are many publicly funded initiatives that aim to reduce unnecessary hospital admissions, reduce length of stay and/or prevent readmissions to hospital. Service providers can be tempted to evaluate too early, or may have unrealistic aspirations for reducing costs or activity even though the new service delivers better care for patients.

Using well-designed evaluations to determine whether an initiative has had the desired effect could save public money either by terminating ineffective interventions or, more positively, by rolling out those which are shown to be beneficial. The Nuffield Trust has a strong reputation in the field of evaluation, as evidenced by a continuing flow of work in this area.

6: Children and young people

Dr Liz Fisher is leading the development of a new strategic programme for research into outcomes for children and young people, working with Dr Dougal Hargreaves and Nigel Edwards.

Objectives for this programme

Children's health services have been subject to less reform and reorganization than is the case for adult care, especially older adult care. Patterns of illness and disease have changed radically, without matching changes that could support children and their parents more effectively. The UK's already comparatively poor performance in improving health outcomes for children has stalled recently and child health inequality will worsen further without concerted action. Our programme aims to shed new light on the evidence and offer policy recommendations for national bodies and local service providers, leading to improvements in children's health.

6.1: Child health inequalities

On Christmas Eve 2017, we published our first major output from the programme - a report on child health inequalities. Written by Dr Lucia Kossarova, Dr Ronny Cheung, Dr Dougal Hargreaves and Eilís Keeble, the report, 'Admissions of inequality: emergency hospital use by children and young people', examined whether a child's socioeconomic background affects rates of admissions to hospital. The authors focused on three common conditions (asthma, diabetes and epilepsy) where more timely and effective care could prevent admissions. The report found that that while there has been some progress, a stubborn gap remains between rich and poor. Children from the most deprived areas are consistently more likely both to go to A&E and to need emergency hospital treatment than children from the least deprived areas.

We worked with *The Observer* to secure a front-page exclusive article on Christmas Eve, and the paper also carried a large feature interviewing paediatricians from Leicester Royal Infirmary.

6.2: International comparisons of health and wellbeing in early childhood

On 15 March, to coincide with the annual conference of the Royal College of Paediatrics and Child Health (RCPCH), we published a further paper on international health comparisons for children and young people, written by Visiting Fellow Ronny Cheung. The incoming President of the RCPCH, Dr Russell Viner, joined Nigel Edwards in providing a foreword to the report.

Developing work that was originally intended for publication by Public Health England, this report uses a similar methodology to Lucia Kossarova's 2015 QualityWatch report 'International comparisons of healthcare quality'.

In this case the approach is applied to services and outcomes for very young children. The report finds that the UK lags behind its peers in many important areas of child health, such as obesity or breastfeeding, and in no one area is it the best performing of comparable countries. This research has an unequivocal message: we must do much better for our children and young people. It received widespread media coverage and significant support from stakeholders.

6.3: Children and young people's mental health

On 11 September, Visiting Research Analyst Dougal Hargreaves and colleagues from UCL, Exeter University and Imperial College London published an article in the journal *Psychological Medicine*. It examines the six-fold rise in adolescents' reported mental health problems between 1995 and 2014.

Our communications team secured a major Channel 4 news feature for this work which also received broad coverage in national newspapers.

6.4: Health Select Committee inquiry into the first 1000 days of life

In September we made a submission to the Health Select Committee's inquiry into the first 1000 days of life (conception to two years old). It draws on our own research and outlines our own evidence-based perspective on a strategy for the first 1000 days. The submission has been shared with the Children and Maternal Health workstream within NHS England for the NHS 10-year plan.

6.5: Tri-Nuffield conference

Further work in the Children and Young People's programme will contribute to the Tri-Nuffield conference to be held in May 2019. This is a joint venture between the Nuffield Foundation, Nuffield College and ourselves and is intended to identify cross-cutting social policy issues which could become research priorities in the 2020s.

Public benefit and impact of this work

Patterns of disease in childhood and their treatments have changed radically in recent decades, but the way services are organised have not adapted significantly and, until recently, there has been far less policy focus on the health of children and young people than on older people. We aim to help redress the balance with our growing research programme, to the benefit of children's health. Our profile as a commentator has grown rapidly this year, with the very welcome consequence of attracting the interest of practising paediatricians who are keen to contribute to our work.

Assessing impact

Our mission is to provide evidence for better health care and the public benefit of our work is central to our role as an independent charity. We aim to produce and disseminate evidence that will provide the wider public with objective, authoritative information and analysis; influence the thinking of decision makers at national and local level; and help change policy and practice for the better.

During the course of the year, the Board of Trustees has reflected on the impact of our work and how best to define and capture it. We scrutinized our work against the tests of profile, influence and impact, defining impact as concrete policy or practice change.

A strong external profile for our work brings it to the attention of the public and helps to build influence with opinion formers and decision makers. Influence can be judged by the extent to which external organizations seek and respond positively to our reports and briefings. Securing policy or legislative reform or change in practice can be regarded as the 'gold standard' for impact but is less frequent, may take many years to achieve and often results from the cumulative efforts of multiple players.

Our external profile has grown this year as the detail in the next section shows. So too has our influence judging by the number of calls to give evidence or to provide oral briefings and presentations either privately or in conferences. New work has generated new interest. For example, our gender and ethnicity pay gap work has led to presentations to and involvement with work in this area being undertaken by NHS Employers, the Workforce Race and Equalities Strategy Group, the Equality and Diversity Council and Prof Jane Dacre's investigation of the gender pay gap in the medical workforce. There are a number of areas where our established reputation for thought leadership or analytical expertise has led to invitations to serve on national advisory groups and development programmes. Current examples include involvement in initiatives to reform the delivery of primary care and membership of boards advising on the use of data and the development of national indicators of care quality. Nine senior Nuffield staff have contributed to the work streams established by NHS England to prepare the Long Term Plan for the NHS.

We can also point to examples of where policy or practice has changed.

The Nuffield Trust, both independently and in collaboration with partners, has been presenting the evidence for additional and sustained funding for the NHS and social care for at least the last decade. The Prime Minister's announcement of substantial new funding and the creation of a long-term plan for the NHS is a clear demonstration of the cumulative influence and impact of our work. Less high profile, but a welcome advance in transparency, is the decision by NHS Improvement to acknowledge publicly the scale of the underlying deficit in NHS finances first identified by the Trust.

Underlying all three categories of impact is the quality of our work and our depth of knowledge and expertise. One test of this is the commissions given to the Trust by external organizations, where, for example, our very well-established reputation in the field of complex evaluations of new models of care has resulted in several exciting new commissions in areas such as digital technology.

Our impact on policy is also built on growing a unique position in our own knowledge and expertise in particular areas. Although early days, our work on prisoners' health and their use of health care has significant potential to impact on policy in this area over the next few years.

We will continue to refine our assessment of impact, including how it can be better recorded and reported and individual projects chosen and shaped to achieve the maximum benefit.

The Nuffield year in numbers

Communicating our work effectively is an essential precursor to achieving impact. This year we researched and published 25 full reports and a further dozen briefings and other resources. We produced 90 blogs to complement the reports as well as charts, infographics and social media collateral to extend their reach.

We use our weekly newsletter to give our most engaged stakeholders advance notice of forthcoming publications as well as creating targeted e-communications to engage new audiences with new reports and events.

We now have nearly 45,000 followers on Twitter, an increase of 15% during the year. Our Twitter threads, condensing key findings from our publications, have proved a very effective and popular means to highlight important research messages to time-poor followers.

All Nuffield Trust staff are encouraged to tweet and retweet from their own accounts and some senior staff, notably Nigel Edwards, John Appleby and Sally Gainsbury have many thousands of personal followers, greatly extending the reach of our work.

Nuffield trust staff contribute to a wide range of external, peer reviewed journals. This year, more than 20 current and recent staff have published in major journals including the BMJ, Lancet, British Journal of General Practice, Age and Ageing; BMJ Quality and Safety, the HSJ and the International Journal of Nursing Studies.

External conference presentations, workshops and seminars are an important mechanism for extending the reach and impact of our work. This year, Nuffield Trust staff have spoken at more than 70 events covering the whole range of our work. Topics this year include Brexit, integrated care, workforce challenges, NHS finances, nursing and digital transformation, the gender pay gap in the NHS, acute medicine, adoption of innovation, learning from Japan's social care system, and the changing shape of general practice. The National Institute of Health and Care Excellence (NICE); Association of British Healthcare Industries (ABHI), the Queen's Nursing Institute, Public Health England, Royal College of Anaesthetists, Royal College of Nursing, academic health networks (AHSNs) and universities are some of the organisations seeking our insights.

Nigel Edwards and Louella Vaughan have visited smaller hospitals all over England to talk about the challenges they face in staffing acute medical services. Nigel has undertaken more than 30 regional, national and international speaking engagements and development sessions on topics ranging from demand management, through acute medicine, strategic commissioning, integrated care and population health. Through the World Health Organisation he is contributing to the reform of the health system in Kyrgyzstan and to WHO thinking more widely.

We held ten externally facing events, including parliamentary seminars on Brexit and on social care in Japan and our tenth health policy summit.

A series of three linked workshops for STP leaders supported teams to rethink their estates strategies and we had three highly productive seminars for service leaders, on rethinking outpatient services; on reconfiguring acute medicine and on the social determinants of demand for health.

Our website had more than 426,147 visitors, averaging 1,672 per day across 610,413 sessions. Following the redevelopment of the website in 2016-17, we have continued to refine and add new functionality and have introduced colour photography and an improved search function.

A look at the publications that website visitors have chosen to download reveals a mix of new work published this year and some earlier reports that continue to have currency.

Four years on, our report on the 2014 Francis Inquiry came first out of ten; followed by two from this year, *The NHS at 70: How good is the NHS* and *Divided we fall: getting the best out of general practice*. Two reports from 2016, *Reshaping the workforce to deliver the care patients need,* and our four country comparison of the UK's health have also performed strongly.

We gave four sets of written evidence to the Health Select Committee committees and gave oral evidence on STPs and integrated care, NHS finances and Brexit. On Brexit, we also gave both written and oral evidence to the House of Lords committee and oral evidence to the Scottish Parliament. Our work was cited 30 times in parliamentary debates at Westminster.

The Nuffield Trust's media profile is strong. We had more than 5,500 print media or online and 3,500 broadcast mentions over the year. The months of November and June were particularly strong, in November following the Chancellor's autumn statement and in June/July as a result of our work with the BBC for the NHS 70th anniversary.

Financial review

Review of income and expenditure for the year ended 30 September 2018

The financial statements for the year to 30 September 2018 have been presented as consolidated accounts for the two entities: The Nuffield Trust for Research and Policy Studies in Health Services and Nuffield Trading Limited.

The Nuffield Trust benefits from an endowment which is primarily held in an investment portfolio. On a long-term basis, and in line with our financial strategy and reserves policy, we aim to maintain the value of these investments (adjusted for inflation). Given the above, in some years our annual report will show a significant surplus, while in others it will show a significant deficit. This year, as was the case last year, equity markets have performed well, so we are showing a surplus.

Total income for the year amounted to £3,852,000 (2017 - £4,034,000), of which £1,160,000 (2017 - £1,617,000) was generated from charitable activities and £2,692,000 (2017 - £2,417,000) was derived from other sources, namely investments, donations and other trading activities.

Income from charitable activities decreased by £457,000 between 2017 and 2018 due to a reduction in purely funded work, with more projects being either internally funded or delivered with a joint funding approach between us and other partnering organisations. Work on projects may span more than one year and income and expenditure are recognised taking into account the proportion of work completed at the year-end.

Income from other sources increased by £275,000 between 2017 and 2018 due to a £205,000 increase in investment income, an increase of £64,000 in donations and £6,000 of other earned income this year.

Total expenditure for the Trust for the year was £4,331,000 (2017 - £4,129,000), of which £3,810,000 (2017 - £3,847,000) related to charitable activities, which includes the costs of completing project work. Support costs in note 9 include costs of employing staff and providing the infrastructure to enable the work of the Trust to be completed. Direct spend on projects includes commissioning expertise; disseminating our work, including making it

available through open access; and ensuring that our work is subject to appropriate peer review.

Expenditure on charitable activities decreased by £37,000 between 2017 and 2018 due to the net effect of a decrease in expenditure on commissioned work and an increase in support costs, in particular staff costs.

Expenditure on raising funds increased by £151,000 between 2017 and 2018 due to investment management fees increasing by £40,000, reflecting the higher value of the endowment, and the staff costs allocated to generating funds increasing by £111,000.

Net gains on investments for the year were £4,220,000 (2017 - £5,711,000). Further details on investment performance are below. The net surplus for the year was £3,741,000 (2017 - £5,616,000).

Net assets at 30 September 2018

The Trust's consolidated net assets at 30 September 2018 were £89,450,000 (2017 - £85,709,000). This represents an increase of £3,741,000 (4.4%) compared with the net assets at 30 September 2017.

Investment performance

The overall return (before fees) on the total investment portfolio was £6,762,000 for 2018 (2017 - £8,048,000). The portfolio of investments had a total value at 30 September 2018 of £85,279,000 (2017 - £80,829,000).

Long-term analysis of available data (March 1994 to September 2018) shows that the total value of the investment portfolio, after taking into account withdrawals to support charitable purpose and investment management fees, has risen ahead of inflation, as measured by the consumer prices index. For the 12 months to 30 September 2018 the total value of the investment portfolio has risen 2.9% (2017 - 2.8%) ahead of inflation, as measured by the consumer prices index.

During the year under review the majority of investment assets of the Trust were managed by Sarasin and Partners LLP.

The funds managed by Sarasin and Partners LLP are invested in two funds which complement each other to achieve the approved investment strategy; the majority of funds are held in the pooled Endowments fund (formerly, Alpha CIF for Endowments), a diversified multi-asset exempt fund for charities, with the remaining funds held in a

segregated Global Equity Dividend fund, allowing greater exposure to global equity assets. Both funds have an ethical investment policy that includes avoiding tobacco stocks. The long-term investment objective for the combined portfolio is to achieve a total return, net of fees, of CPI +4.5% per annum. Over shorter time periods, performance is measured against a bespoke benchmark. The individual income yields on the Endowments fund and Global Equity Dividend portfolios were 3.2% and 2.7%, respectively, and the combined weighted yield across the aggregated portfolios was 3.1% at 30 September 2018 (2017 – 3.1%).

Following the 2017 investment review, Ruffer LLP continued to hold £678,000 (2017 - £633,000) in closed-end assets which will liquidate in accordance with their predetermined end dates. These funds held by Ruffer LLP continue to maintain a restriction on direct investment in tobacco.

The Trust's investment in JP Morgan Asset Management's European Property Fund is held separately from the assets managed by Sarasin and Ruffer. This fund is currently in liquidation. At 30 September 2018, the fair value placed on this investment, after taking account of redemptions of £695,000 (2017 - £655,000) received in the year, including cash held against currency hedge, was £106,000 (2017 - £597,000).

Financial strategy and reserves

The Trust's strategy is guided by its policy on expenditure, reserves and investments.

The Trust's policy on expenditure is to ensure there are adequate funds in order to generate a sufficient return to fund both the current and future charitable activities of the Trust. The Trust generates income from a variety of activities that support its core purpose and make the best use of its resources. Where the money generated is insufficient to cover its total expenditure, a proportion is drawn from the investment capital. In agreeing the level of resources, Trustees are mindful of their responsibility for the long-term stewardship of the Trust. Trustees take a risk-based approach, which aims to balance the Trust's ambition in meeting its charitable objectives; its ability to generate income; and its capacity to spend from investments, now and in the future.

The Trust's total reserves at 30 September 2018 were £89,450,000. As set out in note 20 to the accounts, £89,273,000 of this represents the expendable endowment with the balance of £177,000 in a designated fund to meet external costs related to self-funded projects that the Trust has committed to undertake.

The Trust's policy on reserves is based on ensuring that they are sufficient to support the long-term nature of its work and cope with fluctuations in annual income. The Trust's 'free reserves' exclude funds which can only be realised by disposing of tangible assets and are therefore £87,658,000. The Trustees consider reserves to be at an appropriate level as these funds are sufficient to meet the foreseeable future activities and income fluctuations.

The Trust's policy on investments is to take a long-term approach, investing globally in a range of assets with the intention of preserving the value of the endowment in real terms after any drawdown to fund expenditure. The Trust does not invest directly in tobacco or tobacco-related stocks.

The Trust's investment strategy is to manage the portfolio on a total return basis, income and capital combined. The Trust has an asset allocation that is geared towards equities because of their higher expected returns in the long term (based on historical performance). The Trustees recognise that the Trust will need to withdraw both investment income and some of the investment capital to fund the gap between its annual income and expenditure. This is set annually as part of the budget process based on the average value of the investment fund over the last 20 quarters.

Structure, governance and management

The Trust is a company limited by guarantee, registered in England and Wales as company number 382452. It is registered with the Charity Commission as charity number 209169.

The Trust's Articles of Association provide for a minimum of four Trustees, and a maximum of twelve. Trustees are appointed for an initial term of three years and may be reappointed for a second term and, in exceptional circumstances, a third term. Appointment as a Trustee is open to any suitably qualified member of the public. Newly appointed Trustees are provided with an induction programme, which sets out the activities of the Trust and their responsibilities as a Trustee.

Details of the Trust's current Trustees, and those who served during the year, are set out on page 4.

The Board of Trustees meets four times a year with the Chief Executive and the Senior Management Team to handle business that has not been formally delegated to the Chief Executive and to consider other matters related to the operations of the Trust. The Board of Trustees has established a number of standing committees to support it in its work.

The **Governance, Nominations and Remuneration Committee** assists the Trustees by overseeing: governance; nominations, succession planning, induction support and development of Board members (individually and collectively); human resource issues, including the remuneration packages for senior staff; and any other functions delegated by the Board.

The **Finance Committee** assists the Trustees by: overseeing all financial and investment aspects of the charity; overseeing systems of internal control; and monitoring risk management, so as to ensure the short- and long-term viability of the Trust.

The membership of these committees is shown on page 4.

Organisational structure and how decisions are made

The Trustees appoint a Chief Executive, to whom they delegate the responsibility for realising the Trust's strategies and objectives and for the day-to-day management of the Trust. The Chief Executive is supported by a Senior Management Team, to whom they delegate authority for financial and contractual decision, as detailed in the 'Scheme of Delegation of Financial and Contractual Authorities'. The corporate governance arrangements, including the scheme of delegation, are reviewed at least every two years. The last review and update was completed in March 2017 and the next review is scheduled to be completed by March 2019.

The Senior Management Team works within the framework set by the strategic plan and annual operating plan approved by the Board. Work programmes are produced for the different areas of activities. Progress on these work programmes is reported regularly to the Board, and approval secured for changes where necessary. It monitors, reviews and takes action on strategic goals and work programmes. Details of the current Senior Management Team and those who served during the year can be found on page 4.

Our funding

As a charitable trust, the Nuffield Trust has an expendable endowment worth £89,273,000 at 30 September 2018. This endowment provides the Trust with a valuable source of income (£2,542,000 in the current year). We also obtain funds by withdrawing a proportion of the investment capital each year, in line with our financial strategy.

These sources of funds are not adequate to fund all our activities but guarantee a consistent and completely unrestricted stream of funds. The sources of our other income, from charitable activities, donations and others, is set out in the Consolidated Statement of Financial Activities.

The sources of our funding are diverse, with no single organisation contributing a sufficient proportion of the income to create reliance or significant risk to the organisation were it to be withdrawn. This provides reassurance that our objectivity can be maintained.

Managing risk

The Trust's risk management approach, governed by the Board of Trustees, is documented as the Corporate Risk Assessment and Management Framework. This framework describes

the processes defining risk identification, assessment, recording, ownership, measurement and monitoring.

Within the framework, there are three categories of risks: 'static', i.e. unlikely to require significant change in the short to medium term; 'dynamic', i.e. ever changing and with management controls that are under constant review; and 'evolving', low-level risks which may, in the right environment, convert into high-level risks in the future, captured on a 'watch list'. The review frequency of each category has been defined to ensure appropriate levels of focus and resource are applied.

The Trust's Senior Management Team is responsible for ensuring that the risk management approach is adequately applied and for reporting to Trustees based on risk category and the defined review frequency.

A summary of the Trust's approach to mitigating the most significant risks is shown below.

	Management response	
Risk	**Management approach/plan**	**Monitoring process**
Levels of funding at the Trust are insufficient to support charitable activities	• Continual development and review of external funding opportunities • Defined objectives and restrictions set for investment managers	• Regular review of potential funding opportunities and bids in the pipeline • Regular review of investment manager performance
The Trust's independence is challenged	• Ensure suitable editorial control arrangements • Ensure suitable funding proportions (internal/ external funding) and that the sources of funding would not jeopardise independence, whether perceived or actual	• Review of editorial control and IPR commitments at contractual stage, ensuring fit for purpose • Regular review of funding sources
The skills and expertise within the Trust are not aligned to support the Trust's strategy	• Identify and record the required skills and experience. Measure existing skills and realign through recruitment or training and development. Promote training throughout	• Regular review of internal skills. Staff appraisal process and regular engagement between staff, line manager and senior management
There is a failing in Information Governance (IG) controls at the Trust.	• Maintain our ISO 27001 accreditation, continually improve our approach to IG, allow access to relevant training • Proactive approach to cyber security	• Internal and external audits of IG arrangements. Annual renewal of ISO/the NHS IG toolkit • Annual network security assessments

The risks surrounding data protection, cyber security and information governance are a key focus at the Trust. Given the prominence of these risks in the NHS and across the UK in general, particularly in reference to the enforcement of the General Data Protection Regulation (GDPR), the Trust has taken specific steps to ensure effective controls are in place to protect the sensitive data that we hold. These include:

- the recruitment of a dedicated Data Protection Officer
- cyber security training, both general awareness and technical
- maintaining our ISO27001 accreditation
- enhanced network security
- investment in the development of our knowledge of the General Data Protection Regulations.

The risk management approach identifies three core routes to success:

- engagement across all levels of the Trust, ensuring that risk management is considered throughout the business through team meetings, project planning and other forums
- recording and measurement using the approved formats, consistently applying the approved risk assessment framework
- review and improvement by the risk owner. Continual improvement is a core theme throughout the Trust's risk management approach.

Remuneration policy

The Trust aims to provide all staff with remuneration packages that are competitive, fair, equitable and sustainable within the available resources of the Trust. The pay and remuneration for members of the Senior Management Team is approved by the Governance, Nominations and Remuneration Committee. The pay and remuneration for all other staff is approved by the Chief Executive within the financial parameters approved by the Board upon recommendation from the Finance Committee. In reaching its recommendation, the Finance Committee considers key inflationary indicators (e.g. CPI) and the increases made by comparable organisations and the NHS.

During this year, we have undertaken a benchmarking exercise to ensure that we keep pace with the employment market. The result has been to define a clear job banding approach, approved by the Trustees, which gives clarity to our staff on matters concerning pay and

progression. This approach has been implemented and will be used to improve consistency in both recruitment and identifying and measuring development within our existing staff team.

Organisations which employ more than 250 people are required to publish figures comparing men and women's pay. During 2017/18 the Trust had less than 40 individuals on the payroll, and is not therefore under a legal obligation to publish gender pay gap information. As the Trust does have a relatively small number of employees, the position can change significantly over the course of the year as a result of small staffing changes. Trustees have agreed that this is information which they wish to keep under review and regular reports will be presented to the Governance, Nominations and Remuneration Committee.

Fundraising policy

Section 162a of the Charities Act 2011 requires us to make a statement regarding fundraising activities. Although we do not undertake fundraising from the general public, the legislation defines fundraising as "soliciting or otherwise procuring money or other property for charitable purposes." Such amounts receivable could include legacies and grants and are presented in our accounts within 'charitable activities'.

In relation to the above, we confirm that all solicitations are managed internally, without involvement of commercial participators, professional fundraisers, or third parties. The day-to-day management of all income generation is delegated to the executive team, who are accountable to the Trustees. We are not subject to any regulatory scheme (voluntary or otherwise) or relevant codes of practice, nor have we received any complaints in relation to fundraising activities or consider it necessary to design specific procedures to monitor such activities.

Organisational effectiveness

A staff survey was held during 2016/17 which identified some areas in which staff felt that improvements could be made. In response to this, a number of actions were taken during 2017/18, including:

- Strengthening communications from meetings of the Trustees and the SMT to all staff
- A number of senior staff being supported to develop their skills through taking a lead role in developing work programmes spanning a number of projects
- Actively strengthening joint working across the Policy and Research teams to maximise the contribution of skills to projects
- Re-purposing space within the existing office accommodation to facilitate cross-team working and to create a 'common room' area accessible to all staff
- Improving the appraisal process and the learning and development plan which arises from that
- Putting in place the pay and progression framework for all staff referenced in the 'Remuneration' section of this report

The Trust promotes employee wellness to aid good mental and physical health in the workplace and to help reduce absenteeism and workplace-related illnesses and improve organisational effectiveness. Several initiatives are in place:

- An Employee Assistance Programme is available to all staff and provides free, confidential and independent resource to help employees balance their work, family and personal life.
- Staff benefits include flexible working, eye care vouchers, flu vaccinations, regular staff lunches and secure onsite bicycle parking.
- During 2017/18 three members of staff volunteered to act as Mental Health First Aiders. As at 30th September 2018 one of those three had received formal training and the remaining two will be trained early in 2018/19.
- Staff participated in a 'Health & Well-being Week' in July 2018, during which healthy food options were available, and staff were offered the opportunity to try yoga and pilates classes, received free gym passes for that week and were able to receive a health check covering blood pressure, lung capacity, body fat, grip strength and resting heart rate. In addition, as part of the all staff away day held

that week, staff were able to discuss mental health at work and to consider activities they could undertake to support their own mental health.

    - Further health and wellbeing activities are arranged on an ad hoc basis under the auspices of the Employee Forum
- The Trust also supports staff undertaking activities in relation to charitable fund-raising.

Trustees receive a report at governance meetings of days lost due to staff sickness. During 2017-18, the proportion of working time lost to sickness was 3.2% (2016-17 – 2.1%), compared with the national average of 1.9% based on latest data available from 2017 (source: Office of National Statistics).

Subsidiary undertaking

The Trust operates a wholly owned trading subsidiary, Nuffield Trading Limited, to carry out non-charitable trading activity for the Trust. Details are included in Notes 2 and 23 to the accounts.

Responsibilities of the Trustees

The Trustees are responsible for preparing the Annual Report and the Financial Statements in accordance with the Companies Act 2006, and for being satisfied that the financial statements give a true and fair view. The Trustees are also responsible for preparing the financial statements in accordance with United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

Company law requires the Trustees to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period. In preparing these financial statements, the Trustees are required to:

- select suitable accounting policies and then apply them consistently
- make judgements and estimates that are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The Trustees are responsible for keeping adequate accounting records that show and explain the charity's transactions, disclose with reasonable accuracy at any time the

financial position of the charity, 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 charity and, hence, for taking reasonable steps for the prevention and detection of fraud and other irregularities.

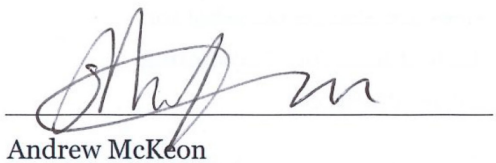
In preparing this Trustees' Annual Report, advantage has been taken of the small companies' exemption.

Auditors

The current Trustees have taken all steps they ought to have to make themselves aware of any information needed by the Trust's auditors for the purpose of their audit and to establish that the auditors are aware of that information. The Trustees are not aware of any relevant audit information of which the auditors are unaware.

BDO LLP have indicated their willingness to continue in office and a resolution to reappoint them will be proposed at a meeting of the Board of Trustees.

Approved by the Chair on behalf of The Nuffield Trust



17 January 2019

Andrew McKeon
Chair, Nuffield Trust

Independent auditor's report to members of the Nuffield Trust

Opinion

We have audited the financial statements of The Nuffield Trust for Research and Policy Studies in Health Services ("the Parent Charitable Company") and its subsidiary ("the Group") for the year ended 30 September 2018 which comprise the comprise the Consolidated Statement of Financial Activities, the Consolidated and Parent Charitable Company Balance Sheets, the Consolidated Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland* (United Kingdom Generally Accepted Accounting Practice).

In our opinion, the financial statements:

- give a true and fair view of the state of the Group's and of the Parent Charitable Company's affairs as at 30 September 2018 and of the Group's income and expenses and the Parent Charitable Company's income and expenses for the year then ended
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Companies Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Group and the Parent Charitable Company in accordance with the ethical requirements relevant to our audit of the financial statements

in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions related to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you, where:

- the Trustees' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Trustees have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Group or the Parent Charitable Company's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The other information comprises the information included in the Trustees' Annual Report, other than the financial statements and our auditor's report thereon. The Trustees are responsible for the other information.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinions on other matters prescribed by the Companies Act 2006

In our opinion, based on the work undertaken in the course of the audit:

- the information given in the Trustees' Report, which includes the Trustees' Report prepared for the purposes of Company Law, for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the Trustees' Annual Report, have been prepared in accordance with applicable legal requirements.

Matters on which we are required to report by exception

In the light of the knowledge and understanding of the Group and the Parent Charitable Company and its environment obtained in the course of the audit, we have not identified material misstatements in the Trustees' report.

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

- adequate accounting records have not been kept by the Parent Charitable Company, or returns adequate for our audit have not been received from branches not visited by us; or
- the Parent Charitable Company financial statements are not in agreement with the accounting records and returns; or
- certain disclosures of Directors' remuneration specified by law are not made; or we have not received all the information and explanations we require for our audit; or
- the trustees were not entitled to prepare the financial statements in accordance with the small companies regime and take advantage of the small companies' exemptions in preparing the Trustees' report and from the requirement to prepare a strategic report.

Responsibilities of Trustees

As explained more fully in the Trustees' responsibilities statement, the Trustees (who are also the directors of the charitable company for the purposes of company law) are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Trustees determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Trustees are responsible for assessing the Group's and the Parent Charitable Company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Trustees either intend to liquidate the Group or the Parent Charitable Company or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

We have been appointed as auditor under section 144 of the Charities Act 2011 and report in accordance with the Act and relevant regulations made or having effect thereunder.

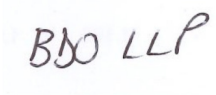
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located at the Financial Reporting Council's ("FRC's") website at:

https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Use of our report

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 Charitable Company's members as a body, for our audit work, for this report, or for the opinions we have formed.



Fiona Condron (Senior Statutory Auditor)

For and on behalf of BDO LLP, statutory auditor

Gatwick

Date: 22 January 2019.

BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127).

Consolidated statement of financial activities for the year ended 30 September 2018

	Note	Unrestricted funds 2018 £'000	Expendable endowment fund 2018 £'000	Total funds 2018 £'000	Total funds 2017 £'000
Income and endowments					
Donations	4	144	-	144	80
Investment income	5	-	2,542	2,542	2,337
Charitable activities	6	1,160	-	1,160	1,617
Other		6	-	6	-
Total income and endowments		**1,310**	**2,542**	**3,852**	**4,034**
Expenditure					
Raising funds	7	-	583	583	432
Charitable activities	8	3,810	-	3,810	3,847
Total expenditure before historic pension costs		**3,810**	**583**	**4,393**	**4,279**
Historic pension costs	24	(62)	-	(62)	(150)
Total expenditure		**3,748**	**583**	**4,331**	**4,129**
Realised and unrealised gains on investment assets	13	-	4,220	4,220	5,711
Net income/(expenditure) before transfers		**(2,438)**	**6,179**	**3,741**	**5,616**
Transfers	11	2,398	(2,398)	-	-
Net income/(expenditure) and net movement in funds		**(40)**	**3,781**	**3,741**	**5,616**
Reconciliation of funds – balances brought forward		217	85,492	85,709	80,093
Balances carried forward		177	89,273	89,450	**85,709**

The statement of financial activities includes all gains and losses recognised in the year. All income and expenditure derive from continuing activities. The notes on pages 66 to 87 form part of these financial statements.

Consolidated and charity balance sheet at 30 September 2018

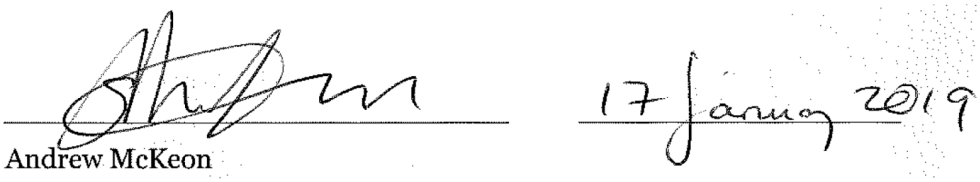
	Note	Consolidated 2018 £'000	Consolidated 2017 £'000	Charity 2018 £'000	Charity 2017 £'000
Fixed assets					
Tangible assets	12	1,792	1,837	1,792	1,837
Investments	13	85,279	80,829	85,279	80,829
		87,071	**82,666**	**87,071**	**82,666**
Current assets					
Debtors	14	451	537	529	584
Short term deposits	15	2,408	3,372	2,408	3,372
Cash at bank and in hand		119	133	41	84
		2,978	**4,042**	**2,978**	**4,040**
Creditors: amounts falling due within 1 year	16	(516)	(652)	(516)	(650)
Net current assets		**2,462**	**3,390**	**s2,462**	**3,390**
Creditors: amounts falling due after 1 year	17	(83)	(97)	(83)	(97)
Provisions for liabilities	18	-	(250)	-	(250)
Net assets		**89,450**	**85,709**	**89,450**	**85,709**
Funds					
Expendable endowment fund	20	89,273	85,492	**89,273**	85,492
Designated fund	20	177	217	177	217
Total funds		**89,450**	**85,709**	**89,450**	**85,709**

Consolidated and charity balance sheet at 30 September 2018

The surplus attributable to the Charity for the year ended 30 September 2018 was £3,741,000 (2017 - £5,616,000).

These financial statements have been prepared in accordance with the provisions applicable to companies subject to the small companies' regime.

Approved by the Chair on behalf of the Trustees of The Nuffield Trust and authorised for issue on 26 November 2018.



Andrew McKeon

Chair, Nuffield Trust

The notes on pages 66 to 87 form part of these financial statements.

Consolidated statement of cash flows for the year ended 30 September 2018

	Note	2018 £'000	2018 £'000	2017 £'000	2017 £'000
Cash used in operating activities	25		(3,293)		(2,700)
Cash flows from investing activities					
Dividends and interest from investments		2,542		2,337	
Proceeds from sale of investments		3,428		29,220	
Purchase of investments		(3,655)		(27,745)	
Cash generated by investing activities			2,315		3,812
Increase in cash and cash equivalents			(978)		**1,112**
Cash and cash equivalents at the beginning of the year			3,505		2,393
Cash and cash equivalents at the end of the year			**2,527**		**3,505**
Analysis of cash and cash equivalents					
Short term deposits	15		2,408		3,372
Cash at bank and in hand			119		133
Total funds			**2,527**		**3,505**

Notes on the financial statements

1. Accounting policies

The Nuffield Trust is an incorporated charity registered in England and Wales with the Charity Commission. The address of the registered office is given on the opening page of this document and the nature of its operations is set out in the report of the Trustees. The financial statements have been prepared in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounting in accordance with the Financial Reporting Standard applicable in the UK and Republic (FRS102) (effective 1 January 2015) – (Charities SORP (FRS102)), the Financial Reporting Standard applicable in the United Kingdom and the Republic of Ireland and the Companies Act 2006.

The preparation of financial statements in compliance with FRS 102 requires the use of certain critical accounting estimates. It also requires management to exercise judgement in applying the Charity's accounting policies.

Disclosure exemptions

In preparing the separate financial statements of the parent charity, advantage has been taken of the following disclosure exemptions available in FRS 102:

- No cash flow statement has been presented for the parent charity;
- Disclosures in respect of the parent company's financial instruments have not been presented as equivalent disclosures have been provided in respect of the group as a whole; and
- No disclosure has been given for the aggregate remuneration of the key management personnel of the parent company as their remuneration is included in the totals for the group as a whole.

Basis of consolidation

The consolidated accounts of the group incorporate the accounts of the charity and its subsidiary undertaking, all of which were prepared to 30 September 2018. The trading results of the subsidiary undertaking as shown in note 23 are consolidated on a line-by-line

basis within the consolidated statement of financial activities (SoFA). A separate SoFA for the charity is not presented as permitted by the Companies Act 2006.

Income

All incoming resources are recognised once the group and charity has entitlement to the resources, it is probable that the resources will be received, and the monetary value of incoming resources can be measured with sufficient reliability.

Investment income

Dividends and interest are included on an accruals basis.

Dividends and interest are stated inclusive of the relevant tax claim as the Trust has activities that are not liable to income tax.

Income from charitable activities

Revenue from performance-related grants and contracts is recognised only when funds have been utilised to carry out the activity stipulated in the agreement. This is generally equivalent to the sum of the relevant expenditure incurred during the year and any related contributions towards overhead costs.

Resources expended

These comprise costs of raising funds and charitable expenditure.

Costs of generating funds comprises expenses relating to management of the charity's investments and all costs associated with the charity's subsidiary company.

Direct charitable expenditure comprises commissioned work and expenditure on performance-related charitable contracts directly relating to the objects of the charity. Commissioned work is allocated and recognised as expenditure in full in the year of approval from the General Fund on the basis of the anticipated expenditure during the tenure of each piece of commissioned work. Liabilities are recognised as soon as there is a legal or constructive obligation committing the charity to pay out resources and including the associated costs of publication and dissemination. Expenditure on performance-related contracts is recognised only when the activity stipulated in the agreement has been completed. This is generally equivalent to the proportion of the relevant recognised income during the year.

Support costs include those relating to business support (including human resource and general administration expenses), executive management, governance, finance, and information systems. The details of support costs are shown under note 9.

Fixed assets

Furniture and equipment acquisitions have been capitalised and depreciation provided for at 25% on an annual straight line basis.

The leasehold premises (originally acquired by The Nuffield 1940 Trust in 1992) are depreciated over the remainder of the lease, currently 65 years. Straight line depreciation of 5% per annum is applied to capital additions. The Trustees consider whether there has been any impairment of the property on an annual basis.

Fixed assets investments

Investments are stated at market value as at the balance sheet date. The statement of financial activities includes the net gains and losses arising on revaluation and disposal throughout the year.

Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (purchase date if later). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening market value (or purchase date if later).

Staff pensions

During the year, the Trust was a member of one final salary pension scheme, the NHS Pensions Scheme, which is a public sector scheme. The NHS Pension Scheme is unfunded but as a statutory scheme, benefits are fully guaranteed by the Government. The Trust operates the Nuffield Group Personal Pension Plan (NGPPP), a defined contribution pension scheme administered by Legal & General and contributes to one other, private, defined contribution pension scheme. Accordingly, due to the nature of the schemes, the accounting charge for the period under FRS102 represents the employer contributions payable.

Funds

The expendable endowment fund was created by a donation from The Nuffield 1940 Trust. The income from this fund is on the terms equivalent to the objects of the Trust and is therefore not restricted. The terms of the fund allow the income to be accumulated and the capital to be spent as the Trustees determine.

Designated funds are funds that have been set aside by the Trustees for a specific purpose, with the balance constituting the charity's expendable endowment. An analysis of designated funds is provided in note 20.

Derivative financial instruments

Derivative financial instruments are recognised at fair value using a valuation technique with any gains or losses being reported in the consolidated statement of financial activities. Outstanding derivatives at reporting date are included under the appropriate format heading, depending on the nature of the derivative.

2. Subsidiary

The Trust owns the whole of the issued capital amounting to £1 (one ordinary share of £1 each) of Nuffield Trading Limited, a company registered in England and Wales with number 6898100. Its principal activity is non-charitable trading activity not covered by the Trust's main objectives. Nuffield Trading Limited gift aids its entire profit to the Trust.

3. Basis of consolidation

The consolidated financial statements incorporate the results of business combinations using the purchase method. In the balance sheet, the acquiree's identifiable assets, liabilities and contingent liabilities are initially recognised at their fair values at the acquisition date. The results of acquired operations are included in the consolidated statement of comprehensive income from the date on which control is obtained. They are deconsolidated from the date control ceases.

4. Donations income

	2018 £'000	2017 £'000
Donation income – for seconded staff (see note 9)	144	80

5. Investment income

Investment income received in the year was made up as follows:

	2018 £'000	2017 £'000
Investment portfolio	2,537	2,335
Bank interest	5	2
	2,542	**2,337**

All the investment income of £2,542,000 in 2018 was related to the expendable endowment fund (2017 - £2,337,000).

6. Charitable activities

	2018 £'000	2017 £'000
Income from projects	1,160	1,617

All the income from charitable activities of £1,160,000 in 2018 was related to the expendable endowment fund (2017 - £1,617,000).

7. Raising funds

	2018 £'000	2017 £'000
Investment management fees charged	396	356
Support costs (note 9)	187	76
	583	**432**

All the expenditure from raising funds of £583,000 in 2018 was related to the expendable endowment fund (2017 - £432,000).

8. Charitable expenditure

The objects of the Trust are to promote, carry out or advance any charitable objects, and in particular the prevention or relief of sickness and the advancement of the health of the people of the United Kingdom, in particular through the promotion of improvements in the quality of health care and health policy. All the activities of the charity are managed through a single structure with the impact of activities reported against the strategic objectives. Below is an analysis of this expenditure:

	2018 £'000	2017 £'000
Commissioned work	350	460
Direct spend	148	185
Support costs (as shown in note 9)	3,312	3,202
	3,810	**3,847**

All the charitable expenditure of £3,810,000 in 2018 was related to the expendable endowment fund (2017 - £3,847,000).

9. Allocation of support costs

Support costs allocated to different activities are set out here, showing the basis of the allocation.

	Generating funds 2018 £'000	Charitable activities 2018 £'000	Total allocate 2018 £'000	Total 2017 £'000
Staff time (nature of the charge)	143	2,472	2,615	2,523
Notional cost of seconded staff (nature of the charge)	-	144	144	80
Premises costs (use of area)	14	207	221	225
IT and telephone costs (staff time)	12	184	196	175
Travel and hospitality (staff time)	1	8	9	10
Professional fees (staff time)	2	20	22	23
Communications and PR (staff time)	6	98	104	97
General costs including irrecoverable VAT (staff time)	9	140	149	113
Governance fees (nature of the charge)	-	39	39	32
	187	**3,312**	**3,499**	**3,278**

Trustees' expenses included in general costs above amount to £nil (2017 - £nil). Governance fees include audit fees of £16,560 (2017 - £25,764) and for the charity only £16,560 (2017 – £25,764).

Secondments and placements

The Trust has benefitted throughout the year from three secondments. The Trust gratefully acknowledges the support and has estimated that the value is £144,000 (2017 - 1 person, £80,000).

10. Staff emoluments

	2018 £'000	2017 £'000
Salaries costs	1,924	2,141
Social security costs	218	231
Pension costs	248	269
Other staff costs	332	97
	2,722	**2,738**

The key management personnel of the charity, as defined by SORP, comprise the Trustees and Senior Staff as listed on page 4. The total employee benefits of the Trustees was nil for both 2018 and 2017, for Senior Staff during the year it totalled £697,000 (2017 - £631,000).

During the year, staff were recruited or assigned to specific project work. The costs of these colleagues are included in direct project expenditure.

	2018 £'000	2017 £'000
Project staff costs, allocated as direct project costs	107	215
Allocated as support costs	2,615	2,523
	2,722	**2,738**

The average number of employees employed by the group during the year was 35 (2017 - 42). All were employed by the charity.

Higher paid employees – Group and Charity

The numbers of employees for whom remuneration exceeded £60,000 were:

	2018 £'000	2017 £'000
£60,000 to £70,000	3	3
£80,000 to £90,000	1	3
£100,000 to £110,000	3	1
£110,000 to £120,000	-	1
£160,000 to £170,000	-	1
£180,000 to £190,000	1	-

Contributions were made to the Nuffield Trust Group Personal Pension Plan, which is a defined contribution scheme for 6 (2017 - 6) higher paid employees, to the NHS Pension Scheme, which is a defined benefit scheme for 1 (2017 - 2) higher paid employee and to a private personal pension defined contribution scheme for 1 (2017 - 1) higher paid employee.

11. Transfer between funds

Under the terms of the expendable endowment, any shortfall in unrestricted funds and the costs of meeting project commitments can be transferred from the expendable endowment.

	2018 £'000	2017 £'000
Net outgoing resources for the year from unrestricted charitable activities	(2,438)	(2,000)
Designated funds expended in the year	40	9
Transfer from expendable endowment to unrestricted funds	**(2,398)**	**(1,991)**

12. Tangible fixed assets

Consolidated and parent charity

	Leasehold properties £'000	Furniture and equipment £'000	Total £'000
Cost			
At 1 October 2017	2,202	230	2,432
At 30 September 2018	**2,202**	**230**	**2,432**
Depreciation			
At 1 October 2017	(371)	(225)	(596)
Provision during the year	(41)	(3)	(44)
At 30 September 2018	**(412)**	**(228)**	**(640)**
Net book value			
At 30 September 2018	**1,790**	**2**	**1,792**
At 30 September 2017	1,831	6	1,837

The leasehold properties were transferred from The Nuffield 1940 Trust on 30 November 2007 at deemed cost.

13. Fixed asset investments

Consolidated and parent charity

	2018 £'000	2017 £'000
Market value at 1 October 2017	80,180	75,325
Additions	3,655	27,745
Disposals	(3,113)	(26,064)
Unrealised gains	3,557	3,173
Market value at 30 September 2018	**84,279**	**80,179**
Short term deposits	1,000	650
Total investments at 30 September 2018	**85,279**	**80,829**
Historical cost of assets held at 30 September 2018	**65,602**	**64,777**
The geographical split of investments is as follows:		
UK	72,352	68,784
Overseas	12,927	12,045
	85,279	**80,829**

The following asset represents more than 5% by market value of the total portfolio as at 30 September 2018:

	2018 £'000	2017 £'000
Sarasin Alpha CIF for Endowments	67,967	66,395

Realised and unrealised gains on investments

	2018 £'000	2017 £'000
Unrealised gains	3,558	3,173
Realised gains	662	2,538
	4,220	**5,711**

14. Debtors

	Group 2018 £'000	Group 2017 £'000	Charity 2018 £'000	Charity 2017 £'000
Prepayments	70	69	70	69
Other debtors	381	468	381	456
Amounts owed by subsidiary company	-	-	78	59
	451	**537**	**529**	**584**

15. Short-term deposits

	Group 2018 £'000	Group 2017 £'000	Charity 2018 £'000	Charity 2017 £'000
Coutts Bank Deposit accounts	1,502	2,516	1,502	2,516
CCLA Term Deposit	100	50	100	50
Scottish Widows Bank Term Deposit	806	806	806	806
	2,408	**3,372**	**2,408**	**3,372**

16. Creditors: amounts falling due within one year

	Group 2018 £'000	Group 2017 £'000	Charity 2018 £'000	Charity 2017 £'000
Tax and social security	64	66	64	66
Commissioned work commitment	88	74	88	74
Accruals and other creditors	308	492	308	490
Leasehold obligation	56	20	56	20
	516	**652**	**516**	**650**

17. Creditors: amounts falling due after one year

	Group 2018 £'000	Group 2017 £'000	Charity 2018 £'000	Charity 2017 £'000
Leasehold obligations	83	97	83	97

18. Provisions for liabilities

	Group 2018 £'000	Group 2017 £'000	Charity 2018 £'000	Charity 2017 £'000
USS pension S75 provision	-	250	-	250

During the year, the Trust received confirmation from the Trustees of the USS pension scheme as to the amount of the Trust's S75 liability and that amount has been paid.

19. Financial instruments

The group's financial instruments may be analysed as follows:

	Group 2018 £'000	Group 2017 £'000
Financial assets		
Financial assets measured at fair value through the statement of financial activities	85,279	80,829
Financial assets that are debt instruments measured at amortised cost	2,978	4,042
Financial liabilities		
Financial liabilities measured at amortised cost	599	999

Financial assets measured at fair value comprise investments.

Financial assets measured at amortised cost comprise debtors, short-term deposits and cash at bank and in hand.

Financial liabilities measured at amortised cost comprise creditors.

Information regarding the group's exposure to and management of credit risk, liquidity risk, market risk, cash flow and interest rate risk is included in the Trustees' annual report.

Included within financial assets at fair value are a number of derivative instruments, including swaps and forward purchase arrangements, which form part of the organisation's overall investment strategy. As at 30 September 2018 the fair value of these derivatives was negative £49,000 (2017 – negative £91,000).

20. Funds

	Group 2018 £'000	Group 2017 £'000	Charity 2018 £'000	Charity 2017 £'000
Expendable endowment				
Balance at 1 October 2017	85,492	79,867	85,492	79,867
Excess of income over expenditure from financial activities	6,179	7,616	6,179	7,616
Transfer (to) designated funds	(2,398)	(1,991)	(2,398)	(1,991)
Balance as at 30 September 2018	**89,273**	**85,492**	**89,273**	**85,492**
Designated fund				
Balance at 1 October 2017	217	226	217	226
Excess of expenditure over income from financial activities	(2,438)	(2,000)	(2,438)	(2,000)
Transfer from expendable endowment	2,398	1,991	2,398	1,991
Balance as at 30 September 2018	**177**	**217**	**177**	**217**
Total funds				
Balance at 1 October 2017	85,709	80,093	85,709	80,093
Excess of expenditure over income from financial activities	3,741	5,616	3,741	5,616
Balance as at 30 September 2018	**89,450**	**85,709**	**89,450**	**85,709**

The expendable endowment fund was originally created by a gift from Viscount Nuffield in June 1940 to The Nuffield 1940 Trust. A designated fund is held to provide for the costs of completing research projects in progress at the year end.

21. Analysis of net assets between funds

	Tangible fixed assets £'000	Investments £'000	Other net assets/ (liabilities) £'000	Total £'000
Expendable endowment fund	1,792	85,279	2,202	89,273
Designated fund	-	-	177	177
Total funds	**1,792**	**85,279**	**2,379**	**89,450**

22. Summarised results for the Trust

Of the group surplus for the year of £3,741,000 (2017 – surplus of £5,616,000), the income and expenditure relating to the Trust is as follows:

	2018 £'000	2017 £'000
Total incoming resources	3,852	4,034
Total resources expended	4,331	4,129
Net (outgoing) resources before other gains/(losses)	**(479)**	**(95)**
Realised and unrealised gains on investment assets	4,220	5,711
Net movement in funds	**3,741**	**5,616**

23. Summarised results for subsidiary entity

Of the group surplus for the year of £3,742,000 (2017 – surplus of £5,616,000), the income and expenditure relating to the Charity's wholly-owned subsidiary entity, Nuffield Trading Limited, is as follows:

	2018 £'000	2017 £'000
Total incoming resources	84	81
Total resources expended	22	24
Net incoming resources before other gains/losses	**62**	**57**
Gift Aid distribution to ultimate parent company	62	57
Retained funds	**-**	**-**
Net movement in funds	-	-
Net assets	**-**	**-**

24. Staff pensions

The Trust is a current member of a defined benefit pension scheme; the NHS Pensions Scheme (NHSPS). Historically it was also a contributing member of the Universities Superannuation Scheme (USS) defined benefit pension scheme.

NHS Pensions Scheme

The Trust became a Direction Authority member of the NHS scheme from 1 February 2008. Contributions were made during the year on behalf of 2 (2017 - 2) employees. Employee contribution rates vary from 5% to 14.5%, depending on the member's pensionable earnings. Employer contributions are set by the Government Actuary at 14.3% for all members. Various changes were made to the scheme from 1 April 2008 which affected the definitions of pensionable earnings and contribution levels. The NHS Pension Scheme is unfunded but as a statutory scheme, benefits are fully guaranteed by the Government.

USS Pension Scheme

The USS is a funded multi-employer scheme. Following the departure of the Nuffield Trust's last remaining employee in the USS pension scheme in May 2015, an employer S.75 debt liability was triggered and became due in May 2016. During our work to quantify this liability it was identified that the Trust had two separate liabilities to the USS pension scheme. The first liability being the S75 liability related to former employees and the second arising as guarantor under an 'Approved Withdrawal Agreement' which the Trust entered into in October 2007.

The Trust has received the actuarial certificates from USS and has settled the S75 liability during this financial year. Our best estimate, based on the information available to us at the time, was that that this liability amounted to £250,000, whereas the certified liability paid was £188,500. This surplus of £62,500 was released at the same point as the payment was made.

The 'Approved Withdrawal Agreement' has clearly defined 'trigger events', which the Trust does not envisage occurring in the foreseeable future. Any liability will be calculated as at the date of the 'triggering event'. As such there is insufficient probability, as to both the timing and amount, of any liability due to USS to enable us to make a provision for this. In accordance with chapter 21 of Financial Reporting Standard 102, this potential liability is therefore disclosed as a contingent liability in note 27.

Nuffield Group Personal Pension Plan

The Trust established the Nuffield Group Personal Pension Plan (NGPPP) on 1 April 2009. This is a defined contribution pension scheme administered by Legal & General.

Employees are required to contribute a minimum of 4% of salary and the Trust contributes 14%. Thirty-six (2017 - 36) employees are members of the scheme.

The total pension charge for the period for all schemes was £248,000 (2017 - £269,000).

25. Reconciliation of net movement in funds to net cash flow from operating activities

Consolidated

	2018 £'000	2017 £'000
Net Income	3,741	5,616
(Gains) on investments	(4,220)	(5,711)
Depreciation of tangible fixed assets	44	48
Decrease/(increase) in debtors	86	(55)
(Decrease) in creditors	(402)	(261)
Investment income	(2,542)	(2,337)
Cash used in operating activities	**(3,293)**	**(2,700)**

26. Commitments under operating leases

The charity had minimum lease payments under non-cancellable operating leases as set out below:

	2018 £'000	2017 £'000
Not later than 1 year	36	28
Later than 1 year and not later than 5 years	144	110
Later than 5 years	2,166	1678
Total	**2,347**	**1,815**

27. Contingent liability

As detailed in note 24, the Trust has a liability as guarantor to the Universities Superannuation Scheme (USS) under the 'Approved Withdrawal Agreement' dated October 2007. The Trust does not envisage that any of the 'trigger events' will occur in the foreseeable future. As such there is insufficient probability as to both the amount and timing, which is calculated at the date of the 'triggering event', to enable the Trust to make a provision for any liability due to the USS pension scheme.

During the year, USS made a demand for payment of this liability. To ensure the Trust was meeting its obligations as a guarantor to the scheme, Counsel's opinion was sought on the matter. Counsel's opinion confirmed the legal advice which had already been received; that the liability was not yet due.

28. Related party transactions

The Trust owns the whole of the issued capital amounting to £1 (one ordinary share of £1 each) of Nuffield Trading Limited, a company registered in England and Wales with number 6898100. In accordance with SORP (FRS102), the Trust's transactions with Nuffield Trading Limited are set out below.

	2018 £'000	2017 £'000
Sales	22	23
Amounts due from Nuffield Trading Limited	78	59

There were no other related party transactions during the year.