

## **Review Report:**

*The regulation and governance of  
NHS Charities*

October 2012

**DH INFORMATION READER BOX**

Policy	Clinical	Estates
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<b>Cross Ref</b>	The engagement is supported by three documents: Exec Summary, Summary Report and Review Report
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<b>Action Required</b>	To consider your organisation's views on the proposal To feed back these views by closure date
<b>Timing</b>	<b>Responses by 31 January 2013</b>
<b>Contact Details</b>	David Pennington Strategy, Finance & NHS Directorate Department of Health Quarry, House, Quarry Hill, Leeds LS2 7UE 0113 254 5000
<b>For Recipient's Use</b>	

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# Part 1: Introduction and context

## Introduction

1. NHS charities are charities which have a duty to conform to charity law, but which are also linked directly to NHS bodies<sup>1</sup> and bound by NHS legislation. As such they are distinct from independent charities established solely under charity law.

2. Charitable giving and support as a whole makes a significant contribution to the quality of care provided by the NHS and NHS Charities in particular play an invaluable part in supporting patients. They have a special role as the charities that receive money donated by members of the public to NHS bodies (normally hospitals). Their funding supports innovation and research and enables the provision of additional facilities, services and equipment that enhance patient experience. Around 300 NHS Charities support the NHS to the tune of over £300m each year, and hold charitable assets in excess of £2bn. A very small number of NHS charities account for most of these assets and income.

3. NHS charities' statutory remit is derived from NHS legislation, which allows NHS bodies to hold property on trust both for the purposes of their linked NHS body, or for any purposes relating to the health service. The default position for NHS Charities is that the executive board of their linked NHS body acts collectively as a corporate trustee for the charitable funds. The only way to change this position is for the Secretary of State for Health to intervene to provide for the appointment of a body of individual trustees, independent of the NHS body. This task was previously delegated to the Appointments Commission and is now undertaken by the NHS Trust Development Authority (NTDA). NHS legislation also gives the Secretary of State the power to transfer charitable funds away from one NHS Charity to another in specified circumstances.

4. A number of NHS Charities and their representative bodies and interest groups have put the case for reform of this sub-section of the charity sector. They raised concerns that the current NHS legislative framework governing NHS Charities can limit these charities' freedom to grow and develop their charitable activity to best support their beneficiaries. NHS charities are regulated under NHS legislation and also by charity law, which can be burdensome. The issue of Ministerial intervention may be controversial with donors and the public, and could be seen to cut across the independence of charities that is required by law.

5. As sector regulator, the Charity Commission has a strong interest in ensuring that NHS Charities are independent. It put forward its view that NHS Charities have a fundamental problem with achieving and demonstrating independence. The Commission believes that releasing NHS Charities from NHS legislation would give trustees more flexibility to respond to beneficiary needs, and help them develop a more mature working relationship with service providers.

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<sup>1</sup> NHS Trusts, NHS Foundation Trusts, Special Health Authorities, Strategic Health Authorities and Primary Care Trusts (until April 2013 when they will be abolished,) and the NHS Commissioning Board and Clinical Commissioning Groups (once the relevant provisions of the Health and Social Care Act 2012 are in force).

It is also keen to reduce the burden and costs that the current system of dual regulation places on the Commission itself.

6. Other considerations also highlighted the need for this review. The Government is committed to reducing regulation, to promoting localism and the Big Society, and to freeing the NHS from central government controls. The Department of Health also needs to take every appropriate opportunity to manage with reduced resources.

7. This review of the role and governance of NHS Charities was announced in 2011 and was included as an action in the Department's structural reform plan. Through this review we have considered all aspects of the regulation and governance of NHS Charities, with a focus on any barriers these charities face in fulfilling their role (see Annex A for the full terms of reference).

8. While we were aware of growing calls from NHS Charities and others for some reform, options proposed to Ministers through this review needed to take account of a wide variety of perspectives about what the future system should look like. Therefore we have gathered input and ideas from across a range of interested parties, by holding stakeholder workshops and requesting written feedback from NHS Charities and their representative groups (see Annexes C and D for summaries), as well as meeting individually with NHS bodies. We have worked closely with the Charity Commission to develop proposals that are consistent with their interests and objectives. We have also engaged with the Cabinet Office and Law Commission, given that two other related reviews are underway or planned (see Annex B).

9. This report brings together the initial findings and conclusions resulting from the review, and proposes options for change for further consideration, development and agreement by all interested parties.

## Historical and legislative basis of NHS Charities

### **'NHS Charities' before the NHS**

10. Before the establishment of the National Health Service (NHS), healthcare was a mixture of charitable provision, limited national insurance and voluntary insurance schemes. Many hospitals and other healthcare services were organised on a charitable basis, with their property and assets held in charitable trusts. The NHS came into being partly because of the emergence of a view that healthcare was a right that should be universally available, not something to be gifted by charities.
11. On the appointed day – 5 July 1948 – the NHS took control of 480,000 hospital beds in England and Wales. Section 6 of the NHS Act 1946 transferred virtually all existing 'voluntary hospitals' to the Minister of Health from the appointed day, 'free of trusts'. The effect of this was that property previously held on clear charitable trusts for a hospital ceased to be charity property.
12. Section 7 of the NHS Act 1946 removed all trusts (restrictions) from charitable funds transferred to the NHS on the appointed day, and provided that trustees should use the funds 'so far as reasonably practicable' for the purposes for which they were held prior to the transfer.
13. The Act also gave hospital boards the power to accept further trust property, and gave the Minister of Health power to appoint the hospital Boards as trustee to hold charitable property (cash, investments, endowments, equipment, buildings and land) for charitable purposes. These assets were to be held for purposes relating to hospital services (including research), or to any other part of the health service associated with any hospital. As the health service developed, the ownership of hospital sites devolved to local NHS bodies.
14. NHS legislation from then onwards has provided various NHS bodies with the power to receive, hold and deal with property (including cash, investments, endowments, equipment, buildings or land) for charitable purposes. Numerous reorganisations of the NHS have resulted in whole categories of trustees being replaced by new categories, and cumulative changes since 1946 have created a patchwork of different statutory powers (see Annex H).

## Legislative basis of NHS charities

### *The right to hold property on trust*

15. The NHS Act 2006 provides that NHS bodies have the power to accept gifts of property (including property to be held on trust), for either the purposes of the NHS body or for any purposes relating to the health service. The Health and Social Care Act 2012<sup>2</sup> extends the powers to hold property on trust for the purposes of the NHS body to the NHS Commissioning Board and Clinical Commissioning Groups, and removes from the NHS Act 2006 the trust fund and trustees references with regard to SHAs and PCTs given that they are to be abolished.
16. It remains the case that NHS bodies are able to act as charity trustee by virtue of their above mentioned power in NHS legislation<sup>3</sup> – and the default position for NHS Charities is still that property is held on trust by the NHS body itself acting as a corporate trustee.
17. In 1973, powers were introduced for the Secretary of State to appoint Special Trustees to manage charitable property on behalf of Hospital Boards<sup>4</sup>. Since 1990, with the enactment of the National Health Service and Community Care Act, the Secretary of State has had the power to appoint trustees in relation to NHS Trusts (since extended to other NHS bodies). These bodies of trustees have the power to accept gifts of property on the same terms as the NHS bodies (for either purposes of the NHS body or any purposes relating to the health service).
18. The powers described above form the statutory basis for all 'NHS Charities'. Until the early to mid-1990s most NHS Charities were governed only by the statutory remit in legislation (i.e. there were no governing documents). The Charity Commission considered that there would be better management and governance of NHS Charity funds if they had formal written governing documents. It developed and promulgated 'model' trust deeds, and now the majority of NHS charities registered with the Charity Commission have declared 'Mathieson' trusts<sup>5</sup>, which simply re-state the statutory provisions in a model trust deed<sup>6</sup>.
19. The Charity Commission has taken the view that these written governing documents cannot be amended in their own right (beyond keeping up with

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<sup>2</sup> [http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga\\_20120007\\_en.pdf](http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf)

<sup>3</sup> However NHS Trusts and FTs have general powers in legislation to do things in connection with their functions, which arguably would include the power to receive, hold and deal with trust property even if that power were not explicitly mentioned.

<sup>4</sup> Section 29 of the National Health Service Reorganisation Act 1973

<sup>5</sup> See Attorney General v Mathieson [1907] 2 Ch 283

<sup>6</sup> As an example, the objects of the Guy's and St Thomas' Charity as expressed in its governing document re-state wording in NHS legislation: ANY CHARITABLE PURPOSE OR PURPOSES RELATING TO THE GENERAL OR ANY SPECIFIC PURPOSES OF THE GUY'S AND ST THOMAS' NHS FOUNDATION TRUST OR THE PURPOSES OF THE HEALTH SERVICE (AS DESCRIBED IN SECTION 1 OF THE NHS ACT 2006 OR ANY STATUTORY MODIFICATION OF THAT SECTION).

changes to the statutory remit in NHS legislation), because they simply express the underlying 'legislated' trusts. In addition NHS charities are unincorporated charitable trusts, and so unlike charitable companies, do not have their own separate legal personality.

### **Box 1: Definition of an NHS Charity**

An NHS charity is a registered charity whose trusts are regarded as exclusively charitable and for the public benefit:

- which has the power to hold property according to a statutory remit set out in the NHS Act 2006 ; and
- in respect of which the Secretary of State for Health has the power to appoint trustees; and to transfer property from one NHS trustee to another in specified circumstances set out in the 2006 Act, but does not have the power (without primary legislation) to alter the trusts the provisions establishing the charity and regulating its purposes and administration) applicable to the funds.

### **The beneficiaries of NHS Charities**

20. As NHS Charities' remit to hold property on trust is derived from statute, it is useful to consider this in more detail because it describes who will be the charities' beneficiaries. The statutory remit<sup>7</sup> for NHS trusts is:

“to accept gifts of property (including property to be held on trust, either for the **general or any specific purposes of the NHS trust** or for any purposes relating to the **health service**).

The reference to specific purposes of the NHS trust includes a reference to the purposes of a specific hospital or other establishment or facility at or from which services are provided by the NHS trust.”

There is some variation in the scope of the purpose for which trust property can be held for Foundation Trusts, Special Health Authorities and, from 2013, for Clinical Commissioning Groups and the NHS Commissioning Board, as well as for Special Trustees (who hold property solely for the purpose of the Hospital for whom they have been appointed). These are set out in Annex H.

21. There are two elements of this remit: for the health service, and for the general or any specific purposes of the NHS body. In relation to 'the general purposes of the [NHS body]', these 'purposes' can include services provided in partnership with a Local Authority on behalf of the NHS body.

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<sup>7</sup> Schedule 4, Part 2, para 14(2)(c) of the NHS Act 2006 defines the remit for NHS Trusts; the equivalent remits for other NHS bodies are expressed in similar terms. However this remit does not apply to the three NHS Charities with continuing bodies of special trustees, whose remit is limited through NHS legislation to the hospitals for which they have been appointed.  
[http://www.legislation.gov.uk/ukpga/2006/41/pdfs/ukpga\\_20060041\\_en.pdf](http://www.legislation.gov.uk/ukpga/2006/41/pdfs/ukpga_20060041_en.pdf)

22. 'Health service' is defined in NHS legislation, and it is generally agreed that 'purposes relating to the health service' means (and is limited to) services provided for the purposes of the health service continued under section 1(1) of the 2006 Act. Section 1(1) of the 2006 Act (as amended by the Health and Social Care Act 2012) This provides that the Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement (a) in the physical and mental health of the people of England, and (b) in the prevention, diagnosis and treatment of physical and mental illness'.
23. The beneficiaries of NHS Charities are therefore the 'people of England', not the charities' linked NHS bodies. The statutory remit means donations paid to an NHS charity are held to benefit patients of the whole of the NHS, not merely those supported by the local hospital or services. In practice, however, even though donors may not expressly restrict their donation to a particular hospital or service, the context of their donation often indicates a clear intent concerning use. It is generally recognised that they are not so much giving to a named charity, but to support their local hospital or a particular service.
24. As a result, although donations received by NHS Charities are technically available to benefit patients across the whole of the NHS, most NHS Charities set operational parameters which in effect limit their support to the patients of, and services provided by, the linked NHS body. The Charity Commission recognises and has no objection to the fact that most NHS Charities choose to give priority to local needs, despite having a much wider potential scope.

## **Governance models of NHS charities**

### ***Corporate trustee***

25. The corporate trustee model, where property held on trust is held by the NHS body itself acting as a corporate trustee, is the default setting for NHS Charities. This model, where the directors of an organisation act collectively as a trustee for charitable property, is permissible under charity legislation, though much rarer in mainstream charities. It is clear that under this model there is only a single trustee – the NHS body that has been appointed as corporate trustee. The members of the Board of the NHS body are not, individually, the trustees of the charity.
26. NHS bodies acting as corporate trustee are required under charity law to act exactly as an independent trustee would – solely in the interests of the charity and its beneficiaries, to further the charitable objects as set out in the statutory remit, and in accordance with any lawful trusts (restrictions) imposed by donors. Having a corporate trustee raises a number of issues for all those concerned with the administration of the NHS charitable funds – see the section of this review on issues and problems with the current policy.

### ***Appointed bodies of individual trustees***

27. NHS legislation makes provision for the Secretary of State to appoint, by Order, trustees to carry out the trustee function of the NHS body. Separate statutory provisions relate to the appointment of trustees for NHS Trusts, Foundation Trusts, and Special Health Authorities – and the Health and Social Care Act 2012 extended these provisions to the NHS Commissioning Board and Clinical Commissioning Groups and removed it from Primary Care Trusts and Strategic Health Authorities given that these bodies are to be abolished. Once in post, the trustees are answerable to the Charity Commission and not to the NHS Trust or NHS Foundation Trust (which are, in practice, the only NHS bodies for which trustees have been appointed) by reference to which they have been appointed.
28. NHS legislation does not stipulate the circumstances in which these trustees should be appointed. The Department's policy has been to establish bodies of trustees at the request of NHS Trusts or Foundation Trusts, but only where a significant level of charitable assets is held which justifies the engagement of independent people with expertise in charitable activities and financial management. Historically the Department has used assets of £10m as a threshold, although more recently we have developed and applied a broader set of business case criteria based on scale and operational needs set against the potential cost of operational and administrative support.
29. In practice, the Secretary of State does not make trustee appointments personally. Responsibility was delegated to the Appointments Commission for appointments of trustees to NHS Trusts and NHS Foundation Trusts, but in view of the abolition of the Appointments Commission, the NTDA has now been delegated this role. The NTDA will continue to make appointments in accordance with Guidance that was last updated by the Appointments Commission after consultation in 2009<sup>8</sup>.
30. To date, no trustee appointments have been made for other NHS bodies. Once in post, the independent trustees are answerable to the Charity Commission and not to the NHS Trust or NHS Foundation Trust by reference to which they have been appointed.

### ***Special trustees***

31. The Secretary of State also retains powers under NHS legislation to appoint special trustees for certain university hospitals or teaching hospitals. Special trustees may only hold property on trust where that trust is “wholly or mainly for hospitals for which they are appointed”, to be used for purposes relating to “hospital services (including research)” or “any other part of the health service associated with hospitals”. This contrasts with all other NHS trustees who may hold property for any purposes relating to the health service as well as for the purposes of the NHS body.

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<sup>8</sup> This guidance can be found at:

[https://www.appointments.org.uk/NewsDetails.aspx/32/Trustee\\_Guidance\\_for\\_NHS\\_Charities](https://www.appointments.org.uk/NewsDetails.aspx/32/Trustee_Guidance_for_NHS_Charities)

32. Although NHS legislation provides a framework for a continuing role for special trustees and handling of their trust property (see Annex E), in practice this is of lesser relevance as the appointment of special trustees has been replaced by the wider power to appoint bodies of individual trustees mentioned above, and only three sets of special trustees remain.

### ***Company limited by guarantee***

33. Although typically individuals are appointed as trustees, the definition of 'trustee' extends to any body corporate. This enabled Ministers to approve the appointment in recent years of a charitable Company Limited by Guarantee as a sole trustee for Barts and The London Charity, and most recently for the Royal Brompton and Harefield Hospital Charity Fund – subject to certain conditions such as the right to appoint the non-executive directors of that company being retained by Ministers.

### ***Schemes of the Charity Commission***

34. In addition, as a result of specific factors in each case, a number of NHS Charities are governed by Schemes of the Charity Commission. These have reflected (rather than amended) the underlying statutory remit of the charities. Charities governed by Scheme are by definition unincorporated and have no limited liability.

### ***Umbrella arrangement***

35. If an individual NHS body does not have sufficient charitable assets and/or income to manage the charitable funds on an efficient and effective basis it may ask the Secretary of State to use his powers to transfer, by order, its trust property to the trustees of another NHS body that acts on its behalf (this may be referred to as an 'umbrella arrangement'). The trustee to whom the funds have been transferred has sole rights to determine their use (subject to any specific restrictions imposed by original donors), although in practice they facilitate participation from the other body (or multiple bodies) through advisory committees.

### **Other legislative provisions**

#### ***Transfers of charitable property***

36. The Secretary of State has powers relating to the transfer of trust property between NHS bodies or to trustees appointed by him/her, in certain circumstances set out in NHS legislation:

- The Secretary of State can transfer, by Order, trust property between relevant health service bodies<sup>9</sup> where he has regard to a change or proposed change in the arrangements for the administration of a hospital or other establishment or facility or in the area or functions of any NHS body other than an FT.
- The Secretary of State also has powers relating to the transfer of trust property where trustees have been appointed. For example he may, by Order transfer the trust property from the particular NHS body (acting as corporate trustee) to the appointed trustees for that body. He can also transfer trust property from special trustees to a PCT (and in future, given PCTs will be abolished, to the NHS Commissioning Board or a clinical commissioning group), an NHS Trust, a Special Health Authority or a Foundation Trust, if he is of the opinion that the functions of the special trustees should be discharged by that body. Similarly he can transfer property from the trustees of NHS bodies to the special trustees.
- There are also provisions providing for the transfer of property to certain NHS bodies (including property held on trust) when specified NHS bodies dissolve.
- The Secretary of State also has other powers regarding the transfer of property between NHS bodies, including trust property.

37. The Department's position is that NHS legislative provisions, where they are more restrictive or prescriptive, take precedence over any general powers that trustees may have under the Charities Acts. As a result, where trustees wish to make a transfer of charitable property or make appointments themselves, the Department in effect views this as acting contrary to provisions in NHS legislation that set out the circumstances in which transfers should be made, so would normally refuse such a request.

### ***The power to raise money***

38. NHS legislation grants NHS bodies the power to raise money to assist the body in providing or improving any services or facilities or accommodation that is provided as part of the health service or to assist in connection with its functions with respect to research. They can do this by engaging in activities to stimulate charitable giving, such as through public appeals, competitions, sales etc. The Secretary of State has the power to vary or exclude any of these money-generating activities through directions, although there are no known circumstances where he has done so.

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<sup>9</sup> "relevant health service body" means an NHS body (which with the abolition of SHAs and PCTs will be an NHS trust, FT, SpHA, CCG, NHS Commissioning Board), special trustees and trustees for the Board, a CCG, an NHS trust or FT.

## Charities today

39. As NHS Charities are a sub-section of the charity sector, and are bound by charity law, it is useful to consider issues relating to charities more generally.

### Charity law

40. Charity law is a mixture of legislation and case law. It is designed to ensure charities' accountability and to protect charities and their property from abuse, whilst aiming for regulatory oversight of the use of charitable assets and trustees' compliance with their duties under charity law. It establishes standards that must be met, and a reporting regime around charities' compliance with those standards.
41. The Charities Act 2011 is the core of modern charity legislation. It consolidated the previous Charities Acts of 1993 and 2006. The 2006 Act made a number of changes to modernise the legal and regulatory framework. It strengthened the Charity Commission's role in promoting public trust and confidence in charities, with new powers where intervention is required, and increased charities' ability to take certain actions without the need for Charity Commission consent. It introduced a statutory definition of charity based on a list of broad charitable headings, and re-emphasised the need for all charities to exist for the public benefit. The Charities Act 2011, largely came into effect in March 2012,

### Definition and scope of charities

42. To be a charity, an organisation must be established only for charitable purposes (as defined in the Charities Act 2011<sup>10</sup>) and must operate for the public benefit. For a body to be a charity, it must be independent; it must exist only in order to carry out its charitable purposes. Charities should not exist for the purpose of carrying out the policies or instructions of another body, but they can properly enter into contractual arrangements to provide services where those fall within the scope of their objects.
43. There are approximately 162,000 registered charities in England and Wales, and perhaps another 180,000 which are regulated by the Commission, but not required to register either because their income is below the £5,000 registration threshold, or because they are excepted from registration by regulations. Another 13,000 charities in England and Wales are exempt from regulation or registration by the Commission; most of these now have another principal regulator (charity regulator)<sup>11</sup>. Registration with the Charity

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<sup>10</sup> The Charities Act contains 13 headings or descriptions of charitable purposes, including: the prevention or relief of poverty; the advancement of health or the saving of lives; the advancement of the arts, culture, heritage or science; the advancement of environmental protection or improvement; and the relief of those in need by reason of youth, age, ill-health, disability, financial hardship or other disadvantage.

<sup>11</sup> Information from the Charity Commission's website: <http://www.charity-commission.gov.uk>; see also [NAO briefing Regulating Charities: a landscape review](#)

Commission is evidence that the Commission has accepted that an organisation is charitable, and that the charity is subject to charity regulation.

44. Charities are responsible for a huge range and scope of work, supporting a wide variety of people and causes at home and abroad. Registered charities received around £57bn in income in 2011/12. The vast majority of these charities are small, with larger charities generating the bulk of the sector's income. 958 registered charities have an annual income of over £10m. The Charity Commission's figures show that around 6% of registered charities generate almost 90% of the total annual income recorded. The largest 500 charities (0.3% of those on the register) generate almost 50% of the total income<sup>12</sup> – a trend borne out in the NHS Charities sector too (see section on NHS Charities today).
45. Charities generally enjoy high levels of public trust and confidence. Research<sup>13</sup> carried out in 2011 into public confidence in institutions found charities to enjoy third highest levels of public trust (surpassed only by the armed forces and the NHS). However, public trust in charities was found to be volatile, ranging from a low of 42% trust in 2007 to a high of 70% in 2010.

#### **Box 2: Non-NHS health charities**

There are a number of charities that aim to support NHS patients which are not NHS Charities (i.e. they are not established under NHS legislation, or any form of statute, but are wholly independent charities solely regulated by the Charity Commission) – such as Hospital League of Friends. In addition NHS bodies are often involved in setting up wholly independent charities outside the NHS Charities framework to raise funds to benefit patients. And the Air Ambulance movement is just one example of independent charities outside NHS legislation working extremely effectively with NHS bodies to make a significant contribution to benefitting NHS patients.

Until 2007 a consultancy produced an annual league table of the 100 most valuable UK charity brands<sup>14</sup> (with 'brand value' calculated as a reflection of a brand's ability to generate future income). Cancer Research UK generated over £380m income in 2006 and was determined to be the most valuable charity brand in the UK, with an estimated brand value of £209 million. The consultancy considered cancer to be the most valuable sector within the top 100 charities. The British Heart Foundation was the tenth most valuable brand at £85 million.

### **How charities are governed**

46. When a charity is formed, its governing document sets out the charity's purposes and, usually, how it is to be administered. The governing document can take various forms – a trust deed, constitution, conveyance, will, articles of association, Royal Charter or Scheme of the Charity Commission.

<sup>12</sup>[http://www.charitycommission.gov.uk/about\\_us/contacting\\_us/press\\_office/media\\_information/about\\_charities\\_figures.aspx](http://www.charitycommission.gov.uk/about_us/contacting_us/press_office/media_information/about_charities_figures.aspx)

<sup>13</sup><http://nfpsynergy.net/trust-charities-down-over-10-percentage-points-last-general-election>

<sup>14</sup><http://www.intangiblebusiness.com/Reports/The-UKs-Most-Valuable-Charity-Brands-2006-379.html>

Everything a charity does must further its objects as set out in its governing document. Trustees have an overriding duty to act solely in the interests of the charity – they must always exercise independent judgement and manage any conflicts of interest.

47. The founders of a new charity are able to choose a structure appropriate to its anticipated size and character. Large and complex charities which may be exposed to higher levels of risk, such as by employing staff or entering into service provision, are likely to opt for a Charitable Company Limited by Guarantee, which limits the personal liability of trustees. For a smaller, purely grant-making charity with low turnover a simple unincorporated trust of a few trustees may be adequate.
48. Charity founders aim to ensure that a governing document serves the charity well for the foreseeable future, and allows for changing circumstances. However, over the passage of time new needs and unforeseen eventualities may cause the governing document to need updating. This is the duty of the charity trustees and how they do this depends on the nature of the change, the structure of their charity (company or unincorporated charity), the size, and the terms of their governing document. The Charity Commission sometimes needs to be involved, and the Register of Charities will always need to be updated.
49. Charity trustees are usually unpaid volunteers. They form the Board of a charity and have ultimate responsibility for directing its business. Trustees cannot delegate their duties and responsibilities relating to management and use of charitable funds, but can delegate implementation of trustee decisions.
50. There are various ways to appoint new trustees, and a charity's governing document will normally set out whether there is a minimum or maximum number of trustees, how they should be appointed and how long they can stay in office. The appointment of new trustees would normally be the responsibility of the existing trustees, but other arrangements can apply such as election or nomination by a membership or an external body.

### **Charity finance**

51. Charities do not normally pay income or corporation tax, capital gains tax or stamp duty. Charities often do not have to pay more than 20% of business rates on the buildings they occupy and may qualify for special VAT treatment. Donations to charities are exempt from inheritance tax and may be eligible for Gift Aid if made by tax payers.
52. Donations and other income are received in many different ways. In the case of appeals, donors may not themselves express the terms of their donations but it is implicit that they are restricted by the terms of the appeal. Trustees are responsible for establishing a process of receipt of funds that supports the correct classification of the funds they hold, and ensures accountability.

53. Some donations are received with trusts attached (restrictions imposed by the donor as to the use of the donation). A trust is a legal obligation, binding on trustees to deal with it in a particular way for the benefit of another person or class of persons or for certain purposes. These funds must be dealt with and accounted for as 'restricted' funds. Most funds are unrestricted or general funds, and received with no indication of an intended use from the donor, other than furthering the objects of the charity. Trustees may choose to 'designate' funds from unrestricted funds of the charity for a specific project. All trustees have an underlying duty to ensure that all direct charitable spending is demonstrably effective and efficient in furthering the objects of the charity and that it provides demonstrable public benefit.

### **Reviews of charity legislation**

54. Lord Hodgson of Astley Abbots was appointed in 2011 to lead a statutory review of the Charities Act 2006. The review's remit was to consider the operation and effectiveness of that Act, and identify changes to improve the legal and regulatory framework for charities.
55. The review reported in July 2012 and is available through the Cabinet Office website<sup>15</sup>. The Government is expected to respond to the review's recommendations later this year. Whilst it did not make any recommendations specifically about NHS charities, many of its recommendations will be relevant to NHS charities. The report emphasised the principle of charities' (and their regulator's) independence, which would support greater independence for NHS charities. It also made the case for further de-regulation, in return for which charities should be more transparent and accountable to their donors and beneficiaries.
56. The Public Administration Select Committee (PASC) is undertaking its own inquiry into charity regulation and the Charities Act 2006<sup>16</sup>, following on from Lord Hodgson's review, which is expected to report in early 2013.
57. In addition, the Law Commission has committed to undertake a charity law project beginning in spring 2013, potentially leading to a draft Bill by late 2015. The project will be a targeted review of areas of charity law that have been identified as carrying disproportionate regulatory or administrative burdens – including looking at streamlining the process of making constitutional amendments for charities established by Royal Charter or Statute (such as NHS Charities).
58. Further details of the Hodgson Review and the proposed Law Commission Review can be found at Annex B.

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<sup>15</sup> <http://www.cabinetoffice.gov.uk/sites/default/files/resources/Review-of-the-Charities-Act-2006.pdf>

<sup>16</sup> <http://www.parliament.uk/business/committees/committees-a-z/commons-select/public-administration-select-committee/inquiries/parliament-2010/regulation-of-the-charitable-sector-and-the-charities-act-2006/>

## NHS Charities today

59. NHS Charities are characterised by the fact that they are bound both by charity law and by their statutory remit set out in NHS legislation, and by the fact the Secretary of State for Health has the power to appoint and remove trustees, and to transfer funds between them. Close to 300 NHS Charities support NHS provision; their income was over £300m last year, and they hold charitable assets in excess of £2 billion.
60. NHS Charities are linked directly to NHS bodies – in addition to raising funds independently, they have a special role as the charities that automatically receive money donated by members of the public to NHS bodies (normally hospitals). Anecdotal evidence from NHS Charities suggests that in many, if not most, cases (particularly as most NHS Charities do not enjoy strong brand recognition) donors consider that they are donating directly to “their hospital”, or even their ward, not to a charity. They often do so to express gratitude for the quality of care they have received, or out of a desire to contribute to an improvement in the services available in their community.
61. NHS Charities play an invaluable part in supporting patients. Their funding supports innovation and research and enables the provision of additional facilities, services and equipment that enhance patient experience.

### ***NHS Charities’ income and assets***

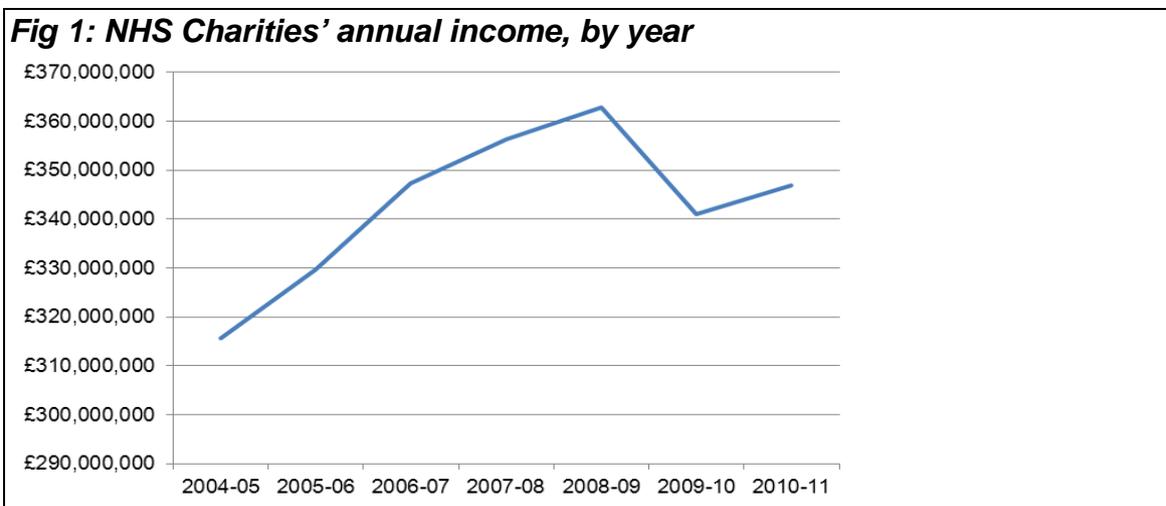
62. In 2010/11 there were around 280 NHS Charities. This number is currently reducing as PCTs (whose charities are typically smaller than those of provider bodies), divest their charitable property in advance of their planned abolition in 2013, and other NHS bodies continue to merge. From April 2013 there are likely to be around 150, although without any significant change in their combined assets and income.
63. Annual accounts information reported to the Charity Commission shows that NHS Charities had a combined annual income in 2010-11 of around £327 million, and that between them they hold assets of around £2.1 billion in over 2500 separately registered funds. Income is heavily skewed towards the charities linked to large, high profile Hospital Trusts; the top five NHS Charities<sup>17</sup> accounted for over a third of the total, the top 15 for over half, and the top 30 for over two-thirds.
64. At one end of the scale is Great Ormond Street Hospital Children’s Charity, which had the largest income by far in 2010-11 (by a margin of almost £50m compared to the next biggest earner; its income is greater than the next four largest NHS Charities combined). It generated income of almost £64 million in 2010-11 – equivalent to around 20% of the Trust’s income from the NHS budget – and was ranked number 25 in the Charity Market Monitor 2011 for

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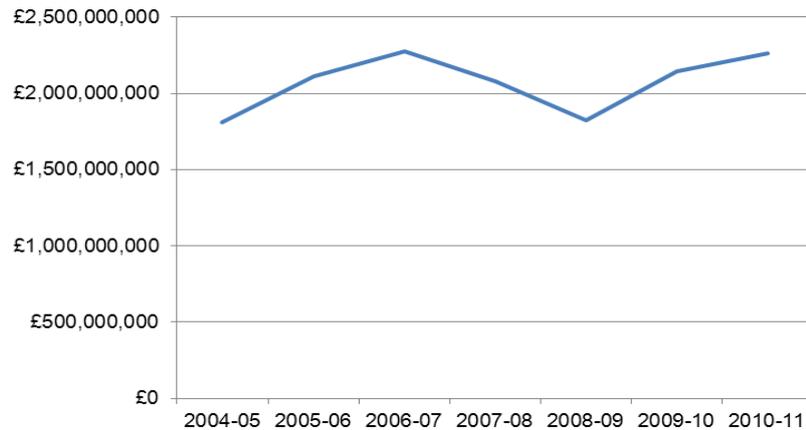
<sup>17</sup> Great Ormond Street Hospital Children's Charity; University College London Hospitals Charities; Barts and the London Charity; The Christie Hospital Charitable Fund; and Guy's and St Thomas' Charity.

fundraised income. To put that in the context of a mainstream charity operating in the health sector, its income is around the same as that of the Alzheimers Society.

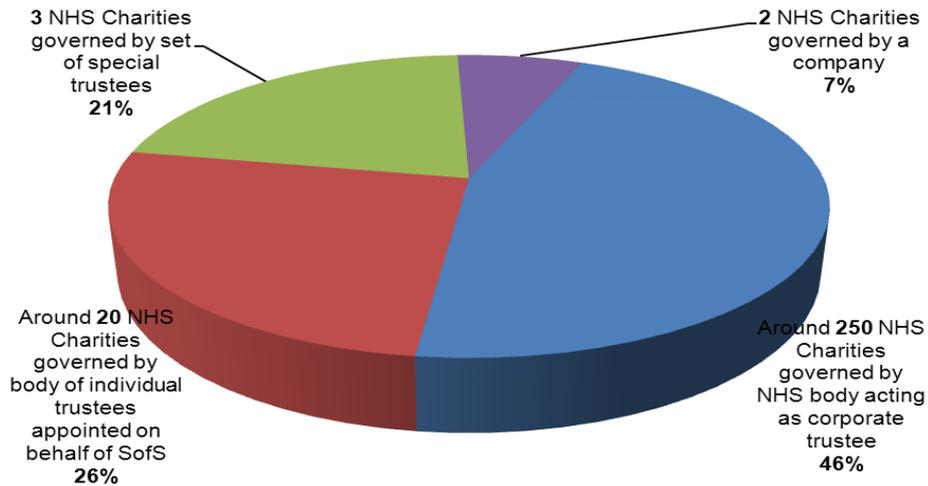
65. The Christie Hospital Charitable Fund is by far the largest NHS Charity where the linked NHS body acts as corporate trustee. The charity has a very active fundraising operation, and in 2010-11 raised £12.6 million in charitable donations. The Charity works in close partnership with its linked NHS body, The Christie NHS Foundation Trust, and the majority of its grants are a result of applications recommended by the Foundation Trust to the Charity. This particular charity tells us it has established robust governance processes to ensure that the corporate trustee decisions are isolated from those of the Executive board.
66. For almost all NHS charities, the majority of income comes from voluntary donations. One notable exception is Guy's and St Thomas' Charity, which holds the largest assets among NHS Charities. At around £520m (2010/11), these are more than double the amount controlled by the next largest asset holder, Barts and the London Charity. Much of this wealth dates back to the early 1700s when MP Sir Thomas Guy left one third of his estate to the hospital. Today, the charity's assets are held in financial investments (shares, equity investments, hedge funds, cash), property, and art and heritage. The Charity aims to realise investment gains of £20m per year, and was able to help with the construction of the Evelina Children's Hospital with a grant of £50m.
67. At the other end of the scale, almost 220 NHS Charities reported annual income of less than £1m, with 169 of them with income less than £500,000. The 50 smallest registered NHS Charities have an average annual income of less than £10,000.
68. A number of NHS bodies receive support from mainstream charities that are established wholly outside NHS legislation – many set up for specific fundraising appeals. However, the Department does not hold data on how many such charities there are supporting the NHS, not their income or assets.



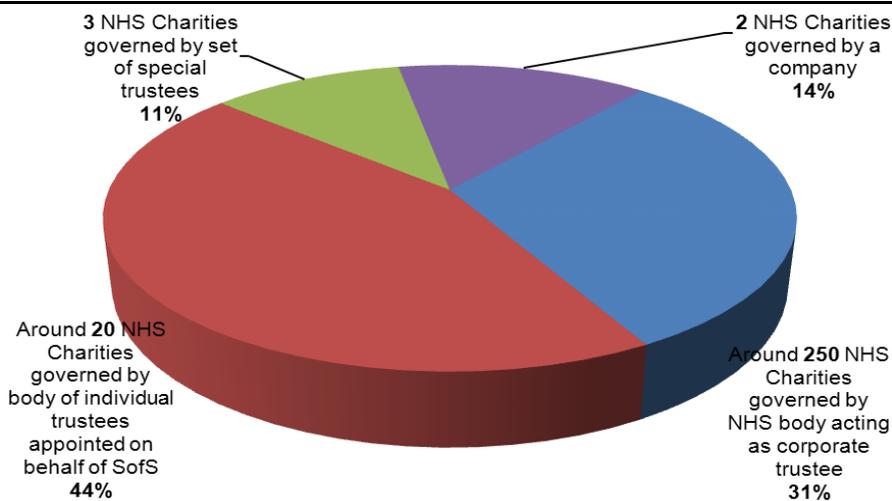
**Fig 2: NHS Charities' assets held, by year**



**Fig 3: NHS Charities' share of £327 million annual 2010-11 income, by governance type**



**Fig 4: NHS Charities' share of £2.1 billion assets, by governance type**



## ***Types and scale of NHS Charities***

69. Just as with mainstream charities, NHS Charities are diverse in terms of income, assets, activities and consequent legal responsibilities – they range from small grant making charities to those that are employers or landowners or engaged in elements of service provision.
70. Some NHS Charities – notably Great Ormond Street Children’s Hospital Charity – are perceived to be national rather than local charities, and have a highly professional fundraising operation. Most are very much local in scope and outlook, and do not engage in any active fundraising – although some count themselves among the most dominant local charities operating in their area, from any sector. They may rely on a stream of bequests in wills from patients wishing to express their gratitude for treatment received, or may earn income from investments built up from legacies and endowments.
71. As described above, some donations are received with trusts attached (restrictions imposed by the donor as to the use of the donation) and must be accounted for as such. Most funds are unrestricted, though trustees may choose to ‘designate’ funds for a specific project. The Charity Commission is concerned that a number of NHS Charities have in effect created restrictions beyond those legally required, with a raft of associated bureaucracy. As an example, when an NHS Charity wishes to fundraise for a specific purpose such as a ward, it should hold the received funds within the NHS Charity’s general funds and designate them for the specific project. Instead of doing this many NHS Charities have registered a large number of ‘special purpose’ charities, registered with the Charity Commission as subsidiaries of the NHS Charity<sup>18</sup>. The Charity Commission has been encouraging NHS Charities to ‘tidy up’ these charities, and this will need to be considered in any option proposed through this review.
72. It is generally recognised that the NHS Charities sector is less developed in terms of marketing and fundraising strategies than mainstream comparators (see section on issues and problems with the current policy). When set against NHS budgets, it is clear that many NHS charities are viewed by NHS bodies as insignificant (only a handful of NHS charities raise funds equivalent to more than 1% of the income of their linked NHS body). But in the context of the charity sector, the income and assets held by NHS Charities is by no means inconsequential.

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<sup>18</sup> Such special purpose linked charities use the same registered charity number, with a suffix, e.g. 245738-1.

## NHS Charities' expenditure and exchequer funding

73. Since 1946, NHS legislation has placed a general duty on the Health Minister to provide or secure the provision of services for the purpose of promoting a comprehensive health service. This duty was updated most recently through amendments made to section 1 of the 2006 Act made by section 1 of the Health and Social Care Act 2012.
74. As described above, many NHS Charities existed before the creation of the NHS. NHS Charities (and other healthcare charities) have continued to play an important role in providing support to NHS patients, in addition to the support they receive which derives from exchequer funding. This is partly enabled as a result of patients' desire to express gratitude and to support their local services, and perhaps in recognition that exchequer funding has been finite throughout the NHS' history.
75. The powers underlying NHS charities are found in NHS legislation, which empowers NHS bodies to hold property on trust "for the purposes of [the NHS body], or for any purposes relating to the health service." As a consequence the beneficiaries of NHS Charities are the 'people of England' referred to in NHS legislation, as they are beneficiaries of the health service. The NHS bodies themselves are emphatically not the beneficiaries. NHS Charities have a remit to act for the whole of the NHS, although most give priority to local needs, which in effect means they support their own linked NHS body. As NHS bodies exist to benefit NHS patients, and they are the vehicle through which NHS Charities support their beneficiaries, there is a clearly a convergence of objects.
76. Recently, the Review Group of NHS Linked Charities in the context of the government accounting framework<sup>19</sup> found that the charitable funding provided by NHS Charities can in effect replace exchequer funds. Its report stated: "If the [NHS Charity] did not fund specific expenditure, the NHS body could consider funding expenditure from its other resources. The substance of the arrangement is that the [NHS Charity] is a source of substitutionary funding". Consequently, from 2013-14 the accounts of an NHS Charity with a corporate trustee may need to be consolidated into its linked NHS body's accounts. The Office of National Statistics also recently classified all NHS bodies en bloc as central government bodies. This results in a requirement for all NHS Charities in England to be consolidated within the Department of Health's Resource Account from 2012/13. Further explanation of these changes is provided in Annex C.

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<sup>19</sup> The Review Group was set up to examine whether the International Accounting Standard on consolidation of accounts (see section X) should apply to the NHS in respect of NHS Charities. The Group contained representatives from across government, charity representatives, accountancy and other experts.  
[http://www.hm-treasury.gov.uk/d/frab\\_nhs\\_linked\\_charities\\_report\\_april\\_2011.pdf](http://www.hm-treasury.gov.uk/d/frab_nhs_linked_charities_report_april_2011.pdf)

77. A study reported in the Journal of Child Health Care<sup>20</sup> in 2008 found that up to half of funding in NHS specialist cancer centres in England and Wales had come from healthcare charities. The report authors felt that charities were making a significant contribution towards work which arguably should be paid for by the NHS, and that reliance on charitable funding could skew NHS priorities. In a BBC article about the report, the report author stated<sup>21</sup>: "For things which might be labelled as luxury that's fine, but essential things should come from central resources to ensure equal access."
78. For NHS Charities, the interplay between exchequer funding and charitable funding is a sensitive issue which can be controversial with donors and the public. Many NHS Charities go to great lengths in their promotional material to emphasise that their funding supports innovation and enables the provision of facilities, services and equipment over and above that provided by NHS funding. Some NHS Charities have told us that the Secretary of State's statutory powers relating to the appointment of trustees and transfers of funds have discouraged potential donors who are concerned that charitable funds could be used to substitute exchequer funding. The very concept of 'NHS charities' has been known to provoke a negative reaction from members of the public who feel that NHS provision is a citizen's right that should not need supplementing with charitable funds.
79. These risks were highlighted in the dissenting report<sup>22</sup> produced by members of the review group examining NHS Charities in the context of the government accounting framework. It said: "Donations to NHS Charities are dependent upon the goodwill of the community. Very often the degree of separation from direct NHS / governmental control which is demonstrated by the existence of an [independent] registered charity [...] is very important to those donors. Such charities receive frequent questions regarding their independence from the NHS [...] A particular concern of the public in the present economic climate is that donations may be counted in to fill gaps in NHS budgets. This suspicion will seem to be confirmed by consolidation of accounts [...]."
80. While this is a sensitive area, there is no hard and fast rule that charities must not subsidise or replace public services. The Charity Commission does however set clear criteria<sup>23</sup> for decision making by trustees if they wish to spend in areas normally or previously paid for from exchequer funds. The Commission's view is that grant-making charities should only agree to subsidise public services or other public provision when there is clear justification for doing so. In addition charities should act only within their objects and powers, and in the interests of the charity and beneficiaries, and they should ask questions and challenge assumptions about what public authorities are prepared to fund or have a duty to fund.

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<sup>20</sup> Linck et al: 'NHS and charitable funding for children and young people with cancer in England and Wales', J Child Health Care June 2008 12(12): 156-168

<sup>21</sup> <http://news.bbc.co.uk/1/hi/health/7424169.stm>

<sup>22</sup> [http://www.hm-treasury.gov.uk/d/frab\\_nhs\\_linked\\_charities\\_dissenting\\_report\\_april\\_2011.pdf](http://www.hm-treasury.gov.uk/d/frab_nhs_linked_charities_dissenting_report_april_2011.pdf)

<sup>23</sup> Section J of the Charity Commission guidance 'Charities and Public Service Delivery – An Introduction and Overview', <http://www.charity-commission.gov.uk/Publications/cc37.aspx#j>

## Differences between NHS Charities and mainstream charities

<b>Mainstream charities</b>	<b>NHS Charities</b>
Established under standalone written governing document, specific to the charity.	Established under statutory trusts derived from NHS legislation, which defines the charities' objects, their trustee arrangements and gives the Secretary of State a statutory role. Any written governing document merely re-states NHS legislation.
Highly unusual to be subject to the power of a public body to transfer trusteeship (funds) away from the current trustees.	Secretary of State for Health has statutory power to transfer funds away from current trustees in specified circumstances, to other NHS bodies or trustees.
Trustees are able to review their activities and purposes, and decide to update them if in the interests of beneficiaries to do so. They can change their objects (with Cy-pres limitation on extent of change) via Charities Act powers (if income below £10,000) or under authority provided by the Charity Commission.	Trustees cannot change objects, as objects have statutory basis. The Charity Commission has a reserved right to amend objects but only via a Parliamentary scheme, which is onerous and offers little flexibility.
Governing documents usually set out how trustees are to be appointed and the normal length of service. There is a variety of appointment methods but the norm is for existing trustees to appoint new trustees.	Cannot change trustee arrangements beyond those established by NHS legislation; Secretary of State has a statutory role in appointing and dismissing trustees and trustees cannot self-appoint.
Can opt for one of a range of legal models, including charitable Company Limited by Guarantee, with its benefits in terms of legal personality and limitation of contractual liability.	NHS Charities are unincorporated trusts and do not have own legal personality (unless a company has been appointed as trustee). Individually appointed trustees are not able to adopt CLG structure so remain personally liable for any misapplication of charitable funds etc. The corporate trustee model entails unlimited liability for the NHS body.
Must prepare accounts within the Charity Commission's recommended accounting framework. The decision on who will conduct the audit lies with the charity trustees. All charities must maintain accounting records and prepare public reports of their accounts. Accounts exist on a standalone basis.	Same accounting responsibilities as mainstream charities, but the decision on who will conduct the audit does not lie with trustees. From 2012/13, the accounts of <u>all</u> NHS Charities will need to be consolidated into DH's Resource Account. From 2013/14, the accounts of an NHS Charity with a corporate trustee liable to be consolidated into the NHS body's accounts. (See Annex C for more about these accounting changes).

<b>Mainstream charities</b>	<b>NHS Charities</b>
Governing document will usually contain the powers needed to allow a charity to merge with another. Can result in either a new charity being formed or one charity assuming control of another.	If two corporate trustee NHS Charities want to merge one has to cede to the other.
Corporate trustee model permissible but rare, and presents an ongoing governance challenge to ensure independence and to manage conflicts of interest.	Corporate trustee model the norm (over 90% of trustee arrangements, although a substantially lower percentage in terms of income and assets), and presents governance challenges.
Able to transfer funds (up to and including the full balances) to other charitable and non-charitable bodies by way of grant, <u>provided</u> trustees are satisfied this is in furtherance of the objects of the charity and there are reasonable safeguards that the new body applies the charity's objects to the funds.	Where trustees wish to transfer charitable property, and the effect of this would be to change the trusteeship, the immediate outcome is to act contrary to a previous decision of the Secretary of State. Consequently, the Charity Commission will not give agreement to such a transfer but directs the trustees to DH. DH would not normally agree unless there are good reasons for doing so, (eg if the services for which the funds have been donated are carried out by the non NHS body), because of interpretation that NHS legislation takes precedence over trustee abilities in charity law.
Donations paid to a charity often come with no clear donor expression of intent and therefore default to being held as unrestricted funds of the charity. Trustees then have full discretion to apply those funds for the charity's objects.	Donations paid to an NHS charity are held for the benefit of the whole of the NHS. In practice, the context of a donation often indicates a clear expectation concerning use so there is a strong onus on trustees to consider designating the funds, in order to reflect inferred donors' intentions. In practice, trustees' discretion is fettered.
Appeals are regulated by the Charities Act 2011. If the purposes of the appeal cannot be fulfilled the trustees must offer donations back to identifiable donors and apply to the Charity Commission for authority to apply the remainder for other purposes.	NHS legislation applies when an NHS Charity receives excess funds, and insufficient funds in response to an appeal. In both cases, trustees have power to apply funds held for any of the functions of the NHS body as considered appropriate. In this regard, NHS Charities are less accountable than their mainstream peers.

## Part 2: Issues and problems with the current policy

## Issues and problems with the current policy

- NHS Charities are accountable to two regulators, and the interplay of charity law, NHS legislation and the policy role of the Department of Health can be the cause of confusion and lack of clarity.
- Any changes to NHS Charities' objects or governance are only achievable through the action of the Secretary of State, who also holds the power to transfer charitable funds away from an NHS Charity's current trustees in specified circumstances.
- NHS Charities have far less autonomy than mainstream charities. Constraints relating to trustee appointments and transfers are restrictive, and a bureaucratic 'overlay' to universal charity standards.
- Inflexibility is particularly affecting the sector's ability to adapt to the changing NHS landscape; restructuring in the NHS requires Ministerial and Departmental intervention to enable the transfer of charity funds.
- NHS Charities – particularly those governed by corporate trustee, where their linked NHS body is the charity's trustee – are stifled by the current system. The charities are often an afterthought of NHS bodies, resulting in a passive non-strategic approach and charities failing to fulfil their fundraising potential.
- The corporate trustee model can lead to conflicts of interest, or the risk of appearance of conflicts of interest.
- NHS Charities can be inhibited by close association with Government and provisions for Ministerial involvement as this can affect donor confidence and their fundraising potential.

### **Dual regulation can be cause of confusion and bureaucracy**

81. The Charities Acts already provide for a common system of regulation of charities operating in England and Wales. The trustees of any charity, including NHS Charities, have a fiduciary and legal duty to conform to Charity law. NHS legislative provisions relating to transfers of funds and appointment of trustees are an additional layer of regulation.
82. Therefore, unlike mainstream charities, NHS Charities are effectively accountable to two regulators. Despite there being substantial published guidance from both the Charity Commission<sup>24</sup> and the Department of

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[http://www.charitycommission.gov.uk/Charity\\_requirements\\_guidance/Specialist\\_guidance/NHS\\_charities/nhsguidance.aspx](http://www.charitycommission.gov.uk/Charity_requirements_guidance/Specialist_guidance/NHS_charities/nhsguidance.aspx)

Health<sup>25</sup>, NHS Charities are often unsure which regulator to approach about different issues. There is also strong anecdotal evidence from NHS Charities that the interplay of NHS legislation, charity law and the policy role of the Department of Health is the cause of significant confusion. NHS trustees do not have the same powers as other charities in all areas, so must ensure they do not inadvertently breach requirements of NHS legislation in attempting to comply with Charity legislation (or vice versa). Charities are concerned that as a result their constitutional arrangements are opaque, which can impact on donor confidence.

83. The current system of dual regulation creates a layer bureaucracy for the NHS Charities themselves and for the Charity Commission – which goes beyond that applicable to mainstream charities – and for the Department of Health. NHS Charities commit resources to preparing and managing any requests to the Department, which may involve contracting legal advice. The Charity Commission operates a dedicated case working function for NHS Charities, to ensure operational compliance with NHS legislation over and above charity law regulation. Transfers and appointments relating to NHS Charities require evaluation, approval and processing within the Department of Health and through parliamentary procedures. This requires policy, finance and legal resource, plus the cost of publishing and laying Statutory Instruments. We estimate the cost to DH alone as being in excess of £100,000 per year.
84. NHS Charities' current special status and dual regulation is a result of history – in 1948, before the development of charity law and effective regulation of the sector there was felt to be a need to safeguard the involvement of NHS bodies and Ministers. Then, this supervision of charitable funds provided reassurance to donors. Now, it is hard to see any arguments for maintaining dual regulation and the duplication it entails. The Charity Commission is satisfied that removing the DH and Ministerial role in NHS Charities, bringing them onto a level playing field with mainstream charities and leaving them under the Commission's regulatory oversight, could deliver appropriate and proportionate levels of accountability.

### **Restricted autonomy**

85. NHS Charities currently have limited autonomy in comparison to mainstream charities; representatives of NHS Charities describe their charities to us as being unable to 'determine their own fate' in the way other charities can. Mainstream charities are able to review their activities and purposes, and decide to update them if the trustees decide it would be in the interests of beneficiaries to do so. They can change their objects via Charities Act powers (where income is below £10,000) or under authority provided by the Charity Commission.

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[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4134678](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4134678)

86. In contrast, NHS Charities' purposes and objects are defined by NHS legislation – the charities must take their objects directly from those set out in statute, and follow any changes if the legislation is amended from time to time. As a consequence, the charity trustees are not free to review and seek to update their objects in response to changes in beneficiary need or the external environment. The Charity Commission has a reserved right to amend objects by means of a Parliamentary scheme made under section 73 of the Charities Act 2011, but this is onerous and time consuming, and considered to be a disproportionate mechanism for change.

### ***Bureaucracy and inflexibility of moving away from corporate trustee model***

87. Furthermore, if an NHS body acting as corporate trustee wishes for its NHS Charity to be governed by individually appointed trustees, this cannot happen without the Department of Health producing two statutory instruments, followed by a process, run by the NTDA acting with delegated authority from the Secretary of State, to recruit and appoint five to seven trustees. The corporate trustee is unable subsequently to change the arrangements back again without the Secretary of State's consent.

88. This state of affairs is not only highly inflexible for NHS Charities, it creates a sub-optimal outcome no matter which path the charity takes. NHS Charities are either established under the corporate trustee model which, as will be shown below, is imperfect, or they must call on Secretary of State powers to move to appointment of a body of individual trustees. The process of appointing these individual trustees may be time consuming and bureaucratic, and NHS Charities tell us it results in a flawed model. Under Appointments Commission rules, NHS employees are barred from serving as trustees (although retired staff can). In the words of the representative of one NHS Charity governed by individually appointed trustees: "It seems more useful to have someone on the Board who understands the strategy and workings of the hospital, medicine, models of care of today rather than yesteryear. To have freedom to recruit the best trustees for the job is vital to our ability to function effectively". The lack of NHS body staff on the Board of Trustees can weaken the link between the NHS body and the NHS Charity, and there is anecdotal evidence of strained relationships and concerns from NHS bodies about the charity's spending decisions.

89. In addition, the three sets of NHS Charities governed by special trustees face constraints beyond those experienced by NHS Charities as a whole. Special trustees may only hold property on trust where that trust is wholly or mainly for hospitals for which they are appointed, to be used for hospital services or any other part of the health service associated with hospitals. We have heard from one NHS Charity with special trustee status that this can be limiting. As an example, if a project supporting the NHS that the charity wishes to fund is found not to provide the specific hospital with 100% of the benefit, the charity has been unable to make the full grant and the Trust itself has stepped in to subsidise the project from its general funds.

### ***Constraints in transferring charitable funds***

90. As described above, the Department's current policy interpretation of NHS legislation is that NHS legislative provisions, where they are more restrictive or prescriptive, take precedence over any general powers that trustees may have under charity law. As a result, where trustees request to transfer charitable funds (as distinct from simply making a grant to another body), the Department's view is that because NHS legislation provides for a Secretary of State role in effecting such transfers, NHS Charities should not be able to make such a transfer which falls within the Secretary of State's powers themselves. As a result, the trustees of NHS Charities cannot make transfers of trusteeship without the Department of Health agreeing, and then making the transfer through an Order of the Secretary of State.
91. NHS legislation only allows such a transfer to take place between relevant health service bodies (i.e. NHS bodies, the trustees appointed for them and special trustees). This means that NHS service providers that are not legally relevant health service bodies cannot receive transfers from NHS Charities unless the DH agrees there are exceptional circumstances. Such circumstances are typically related where the non-NHS body is providing the services for which the specific funds/property are restricted. In this event, DH may agree to a transfer (not effected by order) under general charity law powers to a body which is not a relevant health service body.
92. This is particularly problematic where the intended transfer of all of the Charity's property to another (non NHS) trustee body would have the effect of closing down the NHS Charity that they have been appointed by the Secretary of State to act as trustee for.
93. Although Ministerial powers in relation to NHS Charities do not impinge directly on the autonomy of trustees to make routine operational decisions, many NHS charities have put forward the case that their freedom is hampered to manage the level and range of transactions they would wish.
94. The Association of NHS Charities provided written feedback to us as part of this review. This included its view that: "Changes that would be open to other charities are either not available to NHS Charities or require a considerable investment in time and resources by both the charity involved and the Department of Health, including, often, parliamentary time."
95. Overall, the current regulatory environment and constraints resulting from NHS legislative provisions entail a lack of discretion for trustees of NHS Charities to take up constitutional forms and frameworks that best meet their needs. The lack of autonomy available to mainstream charities means there is no scope to adapt governance provisions; inevitably current arrangements may not always provide the best fit.

## **Inflexibility to adapt to changes in the NHS landscape**

96. The inflexibility inherent in the current system is particularly problematic when it comes to dealing with changes in the NHS landscape. The NHS has undergone considerable structural reform in recent years, including the introduction and expansion of Foundation Trusts and provision by independent treatment centres and social enterprises. Over the next few years, as a result of the Health and Social Care Act (2012), all remaining NHS Trusts will become or merge with a Foundation Trust (or possibly go forward in another form). There will be further plurality of providers, and secondary care commissioning will transfer from PCTs to Clinical Commissioning Groups. A significant amount of restructuring will take place which will impact on NHS Charities. For example, the abolition of SHAs and PCTs, and NHS Trust mergers and joint ventures all carry with them the associated need to move trusteeship of linked charitable funds. Under the current system, this is not normally possible without significant Ministerial and Departmental intervention to facilitate the transfer or consolidation of charity funds. Such intervention is time/resource consuming for DH, requires parliamentary measures in each instance and can result in delay for the charities/NHS bodies.
97. This inflexibility also means NHS Charities cannot operate fluidly within the new landscape or easily take advantage of developing new structures and partnerships. As an example, NHS Charities' objects are limited through NHS legislation to supporting 'purposes relating to the health service'. NHS Charities linked to NHS Trusts or Foundation Trusts that are partners in Academic and Health Science Centres (AHSCs) may find they are unable to support wider academic or research activity of the AHSC.
98. One of the respondents to our call for evidence commented on this issue. They wrote: "In light of the profound structural changes to the NHS, it will be important for NHS Charities to have the flexibility to advance health in the broadest sense, to have the capacity to organise themselves in a manner which is fit for purpose and achieves the best outcome for beneficiaries and which promotes greater engagement with the communities in which they operate."

## **Constraints on expansion**

### ***Unlimited liability***

99. NHS Charities are stifled by the current regulatory environment in other ways too. By default, because NHS Charities are unincorporated trusts which have no legal personality of their own, NHS Charity trustees have unlimited liability. This means that any misapplication of charitable trusts, breaches of trust or fiduciary duties would, in the case of individually appointed trustees, expose trustees to personal liability, and in the case of corporate trustees, entails unlimited liability for the NHS body acting as corporate trustee. The personal liability inherent in acting as trustee for an NHS Charity appears to be a barrier to engaging trustees with the expertise, skill and expertise required.

100. A lack of separate legal identity and unlimited trustee liability is the norm for small mainstream charities but larger charities exposed to greater risks such as employing staff or going beyond basic grant-making activities normally choose to create a corporate structure such as Charitable Company Limited by Guarantee (CLG). Even NHS Charities with appointed trustee bodies are not able to adopt the CLG structure directly - the Department has enabled two NHS Charities to move from corporate trustee model to having a CLG as trustee, with the appointment having conditions consistent with NHS legislation and the previous natural trustees appointed as company directors of the new body). This process would need to be replicated on an individual application basis for any other aspirant bodies.

### ***Unrealised potential of many NHS Charities governed by corporate trustee***

101. The prevalence of the corporate trustee model, where members of the Board of the NHS body collectively act as agent of the trustee of the charitable funds, appears to have resulted in the majority of NHS Charities being reactive rather than proactive. These charities are, as a general rule, widely recognised as having a passive approach – receiving money and spending it – with limited or no strategy for developing income and creating new income streams. Representatives of NHS Charities governed by a corporate trustee have told us that they perceive the charity to be an afterthought of the NHS Board, which they feel can have a negative effect on their development potential. It is common for the corporate trustee to meet for a limited period before or after the main NHS Board meeting, which can lead to trustees not effectively monitoring activities, and key decisions affecting the charity being deferred or not given sufficient time. This is in contrast with mainstream charities, where trustees dedicate time and commitment to regular Trustee meetings taking several hours, and can provide the charity’s operational management with a high level of support and advice.

102. The Charity Commission<sup>26</sup> advises that selection of trustees should be based on the charity's needs, and should take into account the range of skills and experience, and diversity of backgrounds needed to govern a charity effectively and bring different perspectives on beneficiaries' needs. There is an argument that the default position of an NHS body acting as corporate trustee may not provide NHS Charities with a diverse range of trustees with independent and impartial judgement, clarity about mission, and with a range of skills and experience including beneficiary perspectives.

103. One of the respondents to our call for evidence as part of this review, who has experience with more than one NHS Charity, described the problem from their perspective:

“So many NHS charities are under-achieving [...] The corporate trustee framework has greatly hindered the development of NHS charities. [...] my observations are that the level of support given by the corporate trustee is

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<sup>26</sup> As explained in the Commission’s guidance ‘Finding New Trustees — what charities need to know’, <http://www.charitycommission.gov.uk/Publications/cc30.aspx>

very poor and in some cases not fit for purpose. The problem lies in the scale of the charity relative to the parent body; the NHS Board are dealing with massive budgets, employing thousands and making complex decisions that impact on the health of the entire community.

Unsurprisingly, the charity is just a peripheral activity. Simply finding the time and intellectual space to provide viable support for the charity is difficult. [...] As a consequence the operational management of the charity is not adequately supported. [...] In terms of the trustee support, most charities have a distinct advantage over NHS charities, being more flexible and empowered.”

104. In some ways this lack of focus is not surprising; NHS Trust Directors have extremely busy jobs and have not chosen to be a charity trustee, therefore perhaps should not be expected to be as committed or involved in charitable business as trustees in the mainstream charity sector. And arguably the current situation is not good for the NHS either – the current framework requires the NHS to take on and expend time on charitable duties which are outside its core activity of managing Exchequer funding to deliver services in the most effective way. Undoubtedly, more NHS bodies would benefit from appointing trustee bodies but feedback suggests they are currently put off by the constraints put on such appointments.

105. There are of course exceptions to this rule (see the section on NHS Charities today). Those corporate trustees that have broken the mould appear to have achieved a major cultural shift, driven by dynamic and proactive charity executives committed to developing the charity. In some cases an effort has been made to set up a separate charity funds committee which brings in members from beyond the NHS Board, who can bring additional expertise. Yet even in these cases the NHS Board representing the corporate trustee retains control, and NHS Charities tell us that there is limited appetite from people willing to fulfil such an advisory only committee-type role, as they do not enjoy the status or recognition of charity trustee.

### **Potential conflict of interest inherent in corporate trustee model**

106. NHS bodies are the main vehicle through which NHS Charities meet their charitable objects of supporting NHS patients, so it is crucial that they maintain close links with one another. As described above the corporate trustee model – where the Board of the NHS body acts as the agent of the trustee in making and implementing decisions regarding the charitable funds – is the default setting for NHS Charities. There are some proponents of this model. Some NHS Charities told us they feel that having a corporate trustee reduces the risk of waste or inefficiency in their charitable giving. This viewpoint is echoed by some NHS bodies who would be unwilling to give up their corporate trustee role, as they feel this allows them to maintain influence on the charity’s spending and reduce the risk of the charity making inappropriate gifts, out of step with the NHS body’s aims and objectives (as a notional example, the gift of a scanner when it is not needed at that time). And many NHS Charities feel they benefit from their role as the default ‘official’ charity of their corporate trustee NHS body. As an example, some Trusts

acting as corporate trustee for their NHS Charity provide the charity with a prominent office on the hospital site. The charities benefiting from such arrangements told us they are uncertain whether they would enjoy the same relationship with the NHS body were it not acting as corporate trustee.

107. However, there are risks associated with the corporate trustee model. The corporate trustee needs to act independently in managing and operating the charity, and solely in the interests of the charity – yet the model creates the risk of conflicts of interest, or the risk of the appearance of conflicts of interest. This is partly because the distinction between charity and Exchequer funds is not always sufficiently clear. The Board of the NHS body charged with administering Exchequer funds is the same Board acting on behalf of the corporate trustee administering charity funds. There is anecdotal evidence from a number of NHS Charities that some NHS bodies appear to deal with their linked NHS Charity as if the NHS body itself were the beneficiary of charitable funds, rather than the route for the charity to deliver benefit to NHS patients. In the worst cases this amounts to treating charitable funds as if they were “just another cost centre” to call on.

108. This attitude has the potential to result in spending decisions shaped by the policies and priorities of the NHS body rather than purely with regard to the objects of the charity and beneficiaries’ needs. Where trustees administer and manage a charity directly in the interests of an NHS body, as opposed to the interests of its beneficiaries, this may be a breach of their duty – see Box 3 for a case study example of weak governance.

**Box 3: Poor governance practice by a corporate trustee**

The Charity Commission conducted an inquiry<sup>27</sup> into suspected poor governance practice of an NHS Trust acting as corporate trustee, following an allegation that the NHS Trust charged expenditure of around £300,000 to charitable funds, without authorisation. The inquiry found evidence of weak governance and control by the trustee and unauthorised expenditure – with no documentation supporting the transfer of funds in several cases and the charity trustee unable to confirm the reasons for the transfers.

Since the inquiry, the NHS Trust repaid the charitable funds to the charity and sought to address governance issues. A senior lead manager was identified to deal with all charitable fund issues and ensure appropriate governance and a Charities Committee, meeting separately from the main Trust Board, was established to act on behalf of the corporate trustee.

109. For the Charity Commission as regulator of the charities sector, the question of independence is of utmost importance; an organisation that is charitable but is not independently constituted and operable cannot be a charity. The Commission produces clear advice<sup>28</sup> on how corporate trustees

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[http://www.charitycommission.gov.uk/Charity\\_requirements\\_guidance/Specialist\\_guidance/NHS\\_charities/nhsinquiry.aspx](http://www.charitycommission.gov.uk/Charity_requirements_guidance/Specialist_guidance/NHS_charities/nhsinquiry.aspx)

<sup>28</sup>

[http://www.charitycommission.gov.uk/Charity\\_requirements\\_guidance/Specialist\\_guidance/NHS\\_charities/indicnhs.aspx](http://www.charitycommission.gov.uk/Charity_requirements_guidance/Specialist_guidance/NHS_charities/indicnhs.aspx)

can conduct the charity's affairs to ensure and demonstrate independence. This means that NHS bodies acting as corporate trustees are required to put a lot of effort into demonstrating there is no conflict of interest. It is difficult for corporate trustees to convey that there is no conflict of interest, because the nature of governance arrangements can implicitly cast doubt. The Christie Hospital, which is the largest NHS charity governed by a corporate trustee, maintains comprehensive due diligence processes (see Box 4) but there is little evidence that such good practice is widely replicated.

**Box 4 Good governance practice by a corporate trustee**

The Christie charity is governed by a Declaration of Trust. Most funds are unrestricted and are spent at the discretion of the corporate trustee in furtherance of the charity's objects (which are limited to the purposes of the Christie hospital). Within the unrestricted fund, there are two general funds (cancer appeal and general research) and 50 designated funds relating to individual departments and specialties through which the trustee respects the wishes of donors to benefit patient care, research and developments in particular areas of the hospital's activities.

The Charitable Funds Committee, acting for the corporate trustee, is responsible for the overall management of the charitable fund. The committee is required to:

- Manage the affairs of the Christie Hospital Charitable Fund within the terms of its declaration of trust, and appropriate legislation
- Manage the investment of funds in accordance with the Trustee Act 2000 and if necessary to appoint fund managers to act on its behalf
- Ensure funding decisions are appropriate, consistent with the charity and foundation trust objectives and provide added value and benefit to the patients and staff of the Trust, above those afforded by exchequer funds
- Implement, as appropriate, procedures and policies to ensure that accounting systems are robust, donations are received and accounted for as instructed and that expenditure is correctly recorded
- Approve the annual report and accounts and ensure that all relevant information is disclosed.

The committee receives recommendations from the Trust management board regarding the priorities of the Trust. The charity then considers these recommendations against the objectives of the charity and the funds available.

Newly appointed members of the board and charitable funds committee are briefed comprehensively on the charity's governance and activities. Last year, members received training on the Charity Commission booklet CC3, 'The Essential Trustee'.

In 2010, the Trust asked its legal advisors to advise on whether current procedures and practices comply with the test of independence for NHS Charities, as set out by the Charity Commission. The resulting report included a number of references to 'Good Practice' including praise for 'clearly drawn up' Terms of Reference and a good process of internal consideration of applications before they are put before the Committee. It noted that the Charitable Funds Committee appears to be aware of its responsibilities and seeks to comply with those responsibilities at all times and concluded that there is sufficient evidence to demonstrate that the Charity operates independently of the Trust.

110. In the mainstream charity sector, the corporate trustee model is permissible, but rare. For the Charity Commission the model represents an ongoing governance challenge to ensure independence and the proper

management of conflict of interest, particularly where a corporate trustee's non-charitable objectives may not align with the objects of the charity it manages.

## **NHS Charities' close association with Government**

111. As we have seen, any changes to NHS Charities' objects or governance are only achievable through the action of the Secretary of State, and the Secretary of State holds the power to transfer charitable funds away from an NHS Charity's current trustees but only to other NHS bodies and in limited circumstances. This potential for Ministerial intervention could be seen to cut across the independence of charities that is required under charity law. For a body to be a charity, it must be independent and exist in order to carry out its charitable purposes – not in order to implement the policies of a governmental authority or to carry out the directions of a governmental authority.

112. The issue of Ministerial involvement has been raised over the years by, among others, Barts and the London Charity (see below) which has called for the removal of Secretary of State powers in respect of charitable funds. The Department of Health, while sympathetic to the charity's arguments for greater independence, contends that the Secretary of State powers must be exercised within the usual constraints of public law. Although he has power to transfer charitable property between NHS bodies, the powers are limited to the circumstances set out in legislation (i.e. when there is structural change in NHS linked bodies), not simply because he is minded to do so. Furthermore such a transfer would not result in charitable funds becoming government funds. Regardless of this, it is clear that the scope for Ministerial involvement in NHS Charities can influence the public perception of whether charities are truly independent.

113. Similarly, recent accounting decisions (see Annex C) – which are a consequence of NHS bodies or Ministers being perceived to have ultimate control of NHS Charities – add to the difficulty of demonstrating independence because they signal the opposite.

114. There is evidence that NHS Charities' close links with Government do not go unnoticed by donors and the public, and can inhibit NHS Charities' fundraising potential. NHS Charities tell us that this is a particular issue when engaging in professional fundraising with major giving individuals, large corporate donors or grant-making organisations. The representative of one NHS Charity has told us the charity was rejected for the lucrative BBC appeal, for the reason that the charity's set-up was not felt to be wholly above-board. Respondents to our call for evidence felt strongly about this issue, with one explaining their view that:

“The Secretary of State's various control powers “create the perception that the Charity is a central government scheme, subject to government policy and established to pursue government defined goals. [The] statutory powers fundamentally damage the credentials of NHS Charities in the funding community.”

115. The Ministerial role in NHS Charities appears to go against the grain of Government's intention for a 'hands-off' Ministerial role in the NHS (although NHS Charities are not strictly speaking part of the NHS), for localism or for the development of the Big Society, and it is hard to find arguments in support of it continuing.

### **NHS Charities are devising own solutions**

116. Over the last two years, the Department has been approached by a small but growing number of NHS charities and their advisors, requesting the making of alternative arrangements for trustee appointments and the transfer of funds, beyond those allowable under NHS legislation. In one case we are aware of, an NHS Charity has taken matters into its own hands (see Box 5).

117. As mentioned, as NHS bodies come together with academic institutions to form AHSCs, they are finding that the level of co-operation and partnership between their members is not as easily applied to their associated NHS Charities. As an example, we have been approached by members of an AHSC about a wish for all the parties' associated NHS Charities to come together with an integrated grant making strategy and co-ordinated fundraising, to form a new charitable organisation with limited liability. This would not be possible without Secretary of State intervention preceded by considerable legal evaluation and a tailored process of approval and statutory implementation.

118. In 2009 Barts and The London Charity, one of the largest NHS Charities in terms of assets, entered into discussions with DH to seek approval for the restructuring of the charity as a single charitable company (with the charity's assets transferred to this new company) in order to remove the Secretary of State controls provided for in NHS legislation. The charity has long argued that by doing so it would be in a position to demonstrate to potential donors and supporters that it is independent of Government and therefore its assets and activities are not subject to state control or direction. The charity considers that current perceptions to the contrary are an obstacle to its optimum fundraising. At the time, to go some way to alleviating the charity's operational complexities, DH and the charity agreed to a different proposal – the appointment of a charitable company limited by guarantee as trustee – but the maintenance of Secretary of State powers.

119. The charity later brought an application to the Charity Commission requesting it to settle a parliamentary scheme for Barts and the London Charity which, if approved, would remove the controls of the Secretary of State. The Commission announced its decision in May 2012. It agreed to grant Barts and the London Charity a scheme to remove the Secretary of State's power to appoint and remove the charity's trustees, but not the Minister's power to transfer the charity's funds to another NHS charity. Processing this scheme, specific to Barts, will require considerable resource from the Charity Commission and parliamentary time. The Charity Commission and Cabinet Office will now take this forward. Barts and The

London Charity are unsurprisingly awaiting the results of this review of NHS Charities with interest.

**Box 5: NHS Charity has transferred funds to independent charity**

The Department was approached recently by an NHS Charity governed by an NHS body acting as corporate trustee. The NHS body's patients benefited from the support of two main charities – one the NHS Charity which the NHS body governed as corporate trustee, the other a wholly independent charity run as a Charitable CLG by independent trustees. The NHS body as corporate trustee felt that significant efficiencies would be obtained if both charities' activities and functions were brought into a single organisation – the independent charity. It also felt that this would confer greater independence, avoid the conflicts of interest inherent in the corporate trustee model, and create a simpler interface for patients, staff, donors and the wider public.

The corporate trustee has, by means of a Transfer Agreement, transferred all the NHS Charity's assets, liabilities and functions to the independent charity. A separate Deed of Covenant requires the NHS Charity to redirect any donations it receives in future to the independent charity. The independent charity's objects are to support patients of the associated NHS body, and it is required to deal with this income as restricted funds, meaning they are protected for NHS patients. The NHS Charity in effect will act as a post box, or shell charity in future.

Ordinarily such a transfer would not be permissible without agreement of the Department of Health. NHS legislation does not provide a route for the Secretary of State to transfer NHS Charitable funds to a non-NHS Charity, but the Department has exceptionally in the past allowed NHS Charities themselves to make such a transfer. The NHS body concerned in this case took their own legal advice and consider that the transfer could be reversed should the Transfer Agreement be shown to be unlawful, or should the receiving charity alter the composition of the Board of Trustees without permission of the NHS Charity.

120. In other instances the Department has, on legal advice, been able to respond on an exceptional basis to requests to transfer funds to a non-NHS body, notably from NHS Ambulance Trusts to local Air Ambulance charities. Officials are also currently working with representatives of Cambridge University Health Partners (CUHP) to develop a unique but legitimate trusteeship model to enable the NHS charities of CUHP's constituent Foundation Trusts to merge to be able to support the full needs of the Academic Health Science Centre.

121. Each time such requests are made they raise complex legal and policy questions for both the Department and the Charity Commission. Significant Departmental resources are required as well as ministerial and parliamentary time for the laying of Instruments, just to address the interests of a single NHS body or charity. NHS bodies and Charities are also expending considerable sums to procure their own legal advice.

## Part 3: Options for change

## What do we want to achieve?

122. The previous section of this review identified a variety of problems and issues with the current regulatory environment for NHS Charities. These problems are perhaps more pressing when considered in the context of drivers for change such as the strategic direction and pace of change in the NHS and the need to reduce regulation and public sector costs. It is clear there are a number of areas where change would be worthwhile, and there are strong arguments for allowing NHS Charities more scope for flexibility.
123. The fundamental aim of this review, as set out in the Department of Health business plan<sup>29</sup>, is to review current legislative powers relating to the governance and operation of NHS Charities to preserve and extend their independence from central government [emphasis added].
124. There is no intention to propose changes to amend NHS Charities' purposes or role; however it is clear that changes could have the potential to improve NHS Charities' *ability* to achieve their purposes and fulfil their role. In suggesting such changes our overarching aim is to enable NHS Charities to provide greater benefit for the NHS patients who are their charitable beneficiaries.
125. Therefore we aim to propose changes that could provide an enabling environment in which **NHS Charities** could deliver the best outcomes for their beneficiaries by:
- organising themselves in the most appropriate way, taking up more innovative governance models if needed;
  - having an accessible constitutional framework that meets a charity's individual needs and circumstances, and is contained in its own standalone written governing document rather than derived from and constrained by NHS legislation;
  - being regulated solely by the Charity Commission in a streamlined, effective and more efficient way, with no duplicate regulation by the Department of Health;
  - having self-appointing trustees as the norm, and the ability to transfer funds without recourse to Ministerial involvement or Parliamentary instruments;
  - having some flexibility to tailor their charitable objects as long as the interests of NHS patients are not compromised;
  - unleashing their fundraising potential, and potential to attract committed, experienced trustees; and
  - working flexibly and adapting to changes in the NHS landscape.

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[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_129297.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129297.pdf)

126. Any changes should allow **NHS patients**, as the beneficiaries of NHS Charities, to:
- benefit from NHS-focused charities collectively maximising their fundraising and grant making potential;
  - benefit from the NHS Charities' ability to organise to support integrated healthcare needs across a developing NHS provider landscape.
127. We would want changes to enable **NHS bodies** to:
- continue to be the primary vehicle through which these charitable assets provide benefit to NHS patients;
  - retain and improve appropriate influence on how charitable funds are deployed;
  - be in the lead in the extent and pace of change adopted by their current linked NHS Charity.
128. And for the **Government**, changes should:
- remove unnecessary regulatory intervention in the governance of NHS Charities, while ensuring patient interests are protected;
  - promote localism and allow NHS Charities to act, and be seen to act, independently.
129. There are a number of prerequisites for any changes; they must:
- be scalable and straightforward to implement, without creating an overly costly or onerous transition phase, and taking into account transitional issues relating to NHS staff currently working in NHS Charities;
  - protect charitable income streams, safeguard the relationship between an NHS Charity and its linked NHS body, and enable NHS Charities to continue to receive general donations and legacies left to a specific NHS body with which they are currently linked;
  - have the flexibility to allow smaller NHS Charities to continue to be governed by an NHS body acting as a Corporate Trustee, if appropriate for them, or to consider changing status in the future;
  - maintain or enhance donor confidence; and
  - eliminate any risk of Ministers being perceived to have inappropriate influence or control over the operation of charities and the management of their assets.
130. The following section of this review report proposes an option for change that should help to address the problems identified earlier in this review and deliver our overarching aim, while taking into account the above considerations.

## Preferred option for change

131. As discussed above, this review has not aimed to propose any option that would alter NHS Charities' purposes or role, only options that would provide an enabling environment in which NHS Charities could deliver the best outcomes for their beneficiaries. In addition, we are not aiming to create architecture that delivers 'the right way' to govern an NHS Charity – we are looking at what can be delivered within existing charity law, which already caters to the needs of all types and sizes of charity.

### **Option 1 – remove all NHS legislation relating to NHS Charities**

132. This option would entail the removal of all NHS legislation relating to NHS Charities, at an agreed date in the future. Under this option, 'NHS Charities' would in the future be replaced by independent charities wholly established under, and regulated by, charity law. There would be no provision for a Ministerial role in the appointment of trustees or the transfer of funds, and the charities would have no statutory remit but would be governed by a standalone written governing document.

133. As described earlier in this report, because NHS Charities' remit is in statute with any written governing document merely re-stating the underlying legislated basis of the Charity, the Charity Commission has taken the view that these written governing documents cannot be amended in their own right. It therefore follows that, despite NHS Charities being registered with the Charity Commission, the act of stripping away the relevant NHS legislation would in effect 'void' the charities. For this reason NHS Charities would need to create a new charity, or designate an existing independent charity, to receive their funds and 'take over' from them. It is possible that NHS Charities would seek economies of scale in income generation, administration costs, good governance and impact. Several NHS Charities might seek partnerships and create a new independent charity together.

134. This option would see the NHS Charity trustee(s) transfer across all funds from the original charity to the 'receiving' charity. The receiving charity's objects would need to mirror NHS Charities' existing NHS statutory objects, but could include additional health objects.

135. Once the NHS Charity had made its grant to the receiving charity, the NHS charity would be closed down and removed from the Register of Charities. The NHS body could retain influence in the 'new' charity in a variety of ways.

136. However, this option as it stands is not possible because removing every provision in NHS legislation relating to charitable property would jeopardise the ability of NHS Charities to receive donations. This is because as statutory bodies, NHS bodies need to have powers set out in statute enabling them to accept donations of charitable property in order to be able to so accept donations. If such powers were to be removed, then gifts and bequests made to NHS bodies for the benefit of NHS patients, the health service etc could not be accepted and passed on to NHS Charities by the NHS bodies. This carries

with it the risk of increased likelihood of contested wills, and NHS patients losing the chance to benefit from such gifts. In addition, this option may not be desirable in the short-term as it is preferable to persuade NHS Charities and their linked NHS bodies of the benefits of change, rather than force change upon them.

## **Option 2 – Remove NHS legislation relating to NHS Charities, apart from a provision to safeguard the receipt of gifts and bequests**

137. This option is very similar to option 1, as it involves liberalising the framework and allowing independent charities to ‘take over’ from NHS Charities. It would remove all aspects of NHS legislation that provide for any intervention by Ministers (and therefore would also remove the associated Departmental resource).
138. However, the option is different because NHS bodies would retain the power in NHS legislation to accept gifts of property including property to be held on trust. Ideally they would draw on this provision only for the purposes of accepting and passing on bequests, but in theory NHS bodies could use this legislative power to continue to rely on NHS legislation in order to act as corporate trustee for charitable funds, should they so wish. In these circumstances such a charity would remain established under NHS legislation rather than charity law, but would continue to be required to abide by charity law.
139. To reduce the likelihood of this occurring, the Charity Commission, Association of NHS Charities and the Department of Health would encourage NHS Charities to take up the benefits that could be unlocked through moving to an independent model with fit for purpose governance, and would work together to set out a step by step guide to making such a change.
140. In summary, under option 2:
- NHS legislation relating to NHS Charities would be removed at an agreed date in the future, apart from the provision enabling NHS bodies to accept and deal with gifts of property;
  - there would therefore be no legislative provision for a Ministerial role in the appointment of trustees or the transfer of funds;
  - the vast majority of ‘NHS Charities’ would transfer their present and future funds to independent charities with separate written governing documents and specific arrangements for trustee appointments, retaining the previous ‘NHS Charity’ registration solely for the purposes of receiving and passing on bequests to the NHS body. (The exception would be those NHS Charities currently governed by an NHS body acting as corporate trustee in reliance on NHS legislation, which wished to continue with this arrangement);
  - all former ‘NHS Charities’ would in the future be wholly regulated by charity law, but would remain strongly linked to the NHS by shared goals, aspirations and charitable purposes.

<b>The current system – ‘NHS Charities’ are established under and bound by NHS legislation</b>	<b>Future system under option 2 – Most former NHS Charities have transferred funds to independent ‘NHS-focused’ charities *</b>
NHS Charities established under NHS legislation. Any written governing document merely re-states NHS legislation.	Independent ‘NHS-focused’ charities are established under standalone written governing document, specific to the charity.
Secretary of State for Health has statutory power to transfer funds away from current trustees in specified circumstances.	Secretary of State for Health has <u>no</u> power to transfer funds away from trustees.
Trustees cannot modify objects, as objects defined in statute.	Trustees are able to review their activities and purposes and could decide to update objects if in the interests of beneficiaries to do so.
Cannot change trustee arrangements beyond those established by NHS legislation; SofS has statutory role in appointing and removing trustees and trustees cannot self-appoint. NHS employees cannot be trustee for Charities with appointed body of individual trustees.	Variety of trustee appointment models available, including self-appointing, membership, and ex-officio*. SofS has no role in appointing and removing trustees. NHS employees can take up appointments as trustees.
NHS Charities are unincorporated trusts and do not have own legal personality; unlimited liability for trustees.	Can opt for one of a range of legal models, including charitable Company Limited by Guarantee.
Same accounting responsibilities as mainstream charities, but from 2012/13 the accounts of <u>all</u> NHS Charities will need to be consolidated into DH’s Resource Account. From 2013/14 the accounts of an NHS Charity with a corporate trustee may need to be consolidated into the NHS body’s accounts.	Same accounting responsibilities as mainstream charities. Accounts highly unlikely to need to be consolidated into DH’s Resource Account or into the accounts of an NHS body .
Corporate trustee model the norm, and presents governance challenges.	Corporate trustee model permissible but rare, and presents governance challenges.
Transfer of funds only possible between NHS Charities and by Order. Where effect of transfer would be to change the trusteeship, this is considered contrary to NHS legislation. DH must be consulted and may only exceptionally agree.	Able to transfer funds to other charitable and non-charitable bodies by way of grant provided this is in furtherance of objects, and provided there are safeguards to protect the funds for the purposes intended.

\* These conditions apply only to new independent charities and not to those where NHS bodies continue to rely on the provisions of NHS legislation to govern as corporate trustee.

## **Process for delivering new model**

### ***Legal process and gaining a mandate***

141. As described earlier in this report, NHS legislation gives specific powers to NHS bodies to hold property on trust, and grants the Secretary of State a statutory role in appointing trustees and in transferring charitable property. The DH policy interpretation until now has been that these provisions take precedence over any general powers that trustees may have under charity law. The NHS legislation regarding transfers of charitable funds is limited to the Secretary of State's power to transfer funds between relevant health service bodies (i.e. NHS bodies, trustees appointed for such bodies and special trustees). Therefore, while the NHS legislation exists, NHS Charities are normally unable to make such a transfer themselves but should request that the Secretary of State exercises his powers (where the proposed transfer falls within the scope of those powers) to make the transfer. They are also unable to transfer funds to non-NHS Charities (although DH has agreed in exceptional cases in the past).
142. The Department intends to change this interpretation to no longer presume that NHS Act provisions taking precedence over charity law (the Charities Act), and instead recognise that NHS bodies (acting as corporate trustees) can in future make transfers to other trustees (subject to those transfers themselves being consistent with Charity law). To do this it needs a sufficient mandate from NHS bodies.
143. Such mandate will be provided by consulting on proposed changes to the regulation of NHS Charities, setting out its intention for a permissive regime in which there was no potential for Ministerial intervention in these charities' charitable funds. It would also set out that the Department is proposing in the future to allow NHS Charity trustees to use their wider trustee powers to transfer charitable funds to an independent charity established outside of NHS legislation (subject to limitations in respect of appointed trustee bodies as set out in the following paragraphs) . A positive response to the consultation, followed by a ministerial statement setting out how it is intended charitable property in the NHS should be dealt with in future would provide a mandate for action before the repeal of the legislation.
144. The consultation process will be directly with NHS bodies, charities and the other direct interests that participated in the earlier engagement, together with groups and organisation representing patients who are the beneficiary of the charities.
145. This would then free up NHS Charities to set up the new 'receiving' charitable vehicles and grant across their total funds. The successor charity's objects would need to match or be very similar to the original NHS Charity's in order for the grant to properly be made in furtherance of the objects of the NHS Charity, but this principle could be reinforced by the Secretary of State's post-consultation mandate. All transferring funds would have been donated on the basis of the NHS Charity's original objects, protecting them for NHS

patients. Any restricted funds would transfer with restrictions intact and unrestricted funds would transfer as designated funds. If the receiving charity had additional objects wider than the NHS Charity's statutory objects, then future donations would be used to further those wider objects (however future funds resulting from gifts to the NHS body would transfer in as designated, if not restricted funds).

146. It might be argued that creating a policy context that grants approval to NHS Charities to move charitable funds outside the current statutory scheme before that legislation is repealed is against Parliament's intention. However, in this instance wider (Charities) legislation also represent the intention of Parliament. The proposal seeks to interpret and apply their overlapping provisions. Consultation and the statement to Parliament provide appropriate opportunities for these proposals to be scrutinised, refined and endorsed.

147. There is no such legislative conflict over the creation of new charities with constitutions that differ from the statute based constitutions of current NHS charities (including in the appointment of trustees) as those charities are being established solely under provisions of the Charities Act. It is only the action of transferring current property to those charities that is problematic.

148. This Review Report, and particularly these explanatory sections, support the consultation and subsequent policy mandate process that has been outlined.

### ***Specific process for NHS Charities with trustees appointed by the SofS***

149. This option would see the continuance of NHS legislation allowing NHS bodies to hold property on trust for the time being, and therefore NHS Charities governed by an NHS body acting as corporate trustee would continue to have legal standing should they choose not to transfer funds to an independent charity.

150. But the 25 or so NHS Charities governed by a body of individual or special trustees appointed by Order by the Secretary of State would cease to exist if, in the future, the NHS legislation which led to their being established were removed. These charities would therefore need to take steps to establish or nominate receiving charities, and grant across their funds. (In practice this may well be an adaptation of their current charity and trustee body). As described above, we are proposing that such transfers take place in advance of NHS legislation being dismantled.

151. However, such a transfer would not be directly possible in the case of these bodies of trustees. They do have wider powers to transfer or dispose of charitable property under the Charities Act, but if a body of individual trustees were to make a grant of all their trust property in the expectation that they would no longer act as trustees in the future, it would effectively amount to the trustees deciding to make themselves (and any potential successors) obsolete. This would usurp the Secretary of State's role, provided for in legislation, to decide whether they should remain appointed or not. There is

therefore a direct conflict between the general provisions of the Charities Act and the specific and limiting provisions of the NHS Act.

152. The only appropriate course of action (in advance of any repeal of the primary legislation) would be for the Secretary of State to use his powers in NHS legislation to:

- transfer the property from the trustees to the NHS body for which the trustees are appointed; and
- revoke the Order providing for their appointment and

Once the transfer of the property back to the body's Board has occurred, it (the Board), acting as a (temporary) corporate trustee, would then transfer the property to the independent charity.

153. These Secretary of State powers would only be applied, if requested by both the NHS Charity and the NHS body, after they had come to a formal agreement (see following section on future relationship between NHS bodies and new charities). At no stage would any charitable property become Government property. It would therefore be important for the NHS Charity and linked NHS body to agree on the way forward before requesting necessary parliamentary measures to implement the change.

154. This proposed process for trustee bodies forms part of the consultation process that this Review Report supports and, subject to agreement, will be included in the proposed new policy mandate.

### ***NHS bodies wishing to continue to operate under NHS Act provisions***

155. In advance of any change to the primary legislation, for those NHS bodies that choose initially to continue to operate as a corporate trustee under the NHS legislation, it will be necessary to continue to apply those regulations as required on a case-by-case basis. A blanket policy of refusing to exercise the powers to transfer property or to appoint trustees could be challenged. We would however encourage those seeking to establish trustee bodies to pursue this through the new 'non-NHS' route).

156. In the event that current provisions for the transfer of charitable property by order are repealed, remaining NHS body corporate trustees and trustee bodies appointed under the NHS Act would need to use their own powers under Charities legislation to make any necessary transfers required as a result of changes in the administration of an NHS body (such as merger or dissolution), changes in the provision of patient services, or other circumstances. In doing so, they would not be bound by current requirements to limit such transfers to between NHS bodies.

157. In the event that current provisions for the appointment of trustees by Secretary of State are repealed, NHS supporting charities governed by trustee bodies could only be established through provisions of the Charities Act. More importantly, any remaining trustee bodies appointed by Secretary of State would fall, and such charities would revert by default to corporate trustee status.

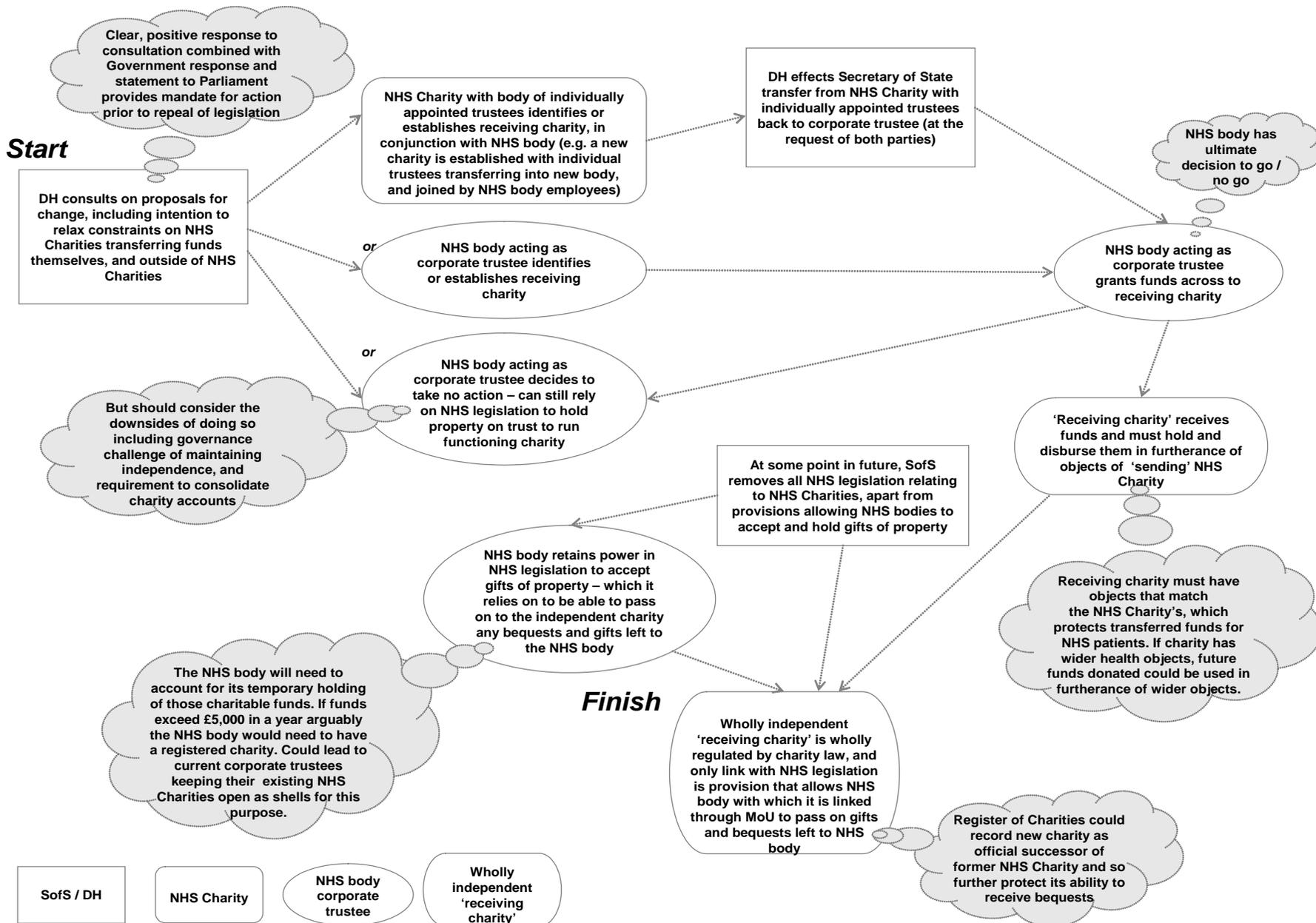
***Proposed timetable***

158. Subject to any unexpected issues or delays we expect the following timetable:

<b>Milestone / activity</b>	<b>Date</b>
Consultation takes place	October – December 2012
<i>Assuming positive response to consultation, granting clear mandate for action, prepare and publish Department response including final mandate</i>	Spring 2013
NHS Charities and NHS bodies that wish to move to independent model are able to proceed with change	Late Spring/Summer 2013
Government repeals primary legislation relating to NHS Charities apart from provision allowing NHS bodies to accept and hold gifts of property including property to be held on trust	At some point in future, whenever suitable legislative vehicle becomes available

159. It may not be necessary to wait for a Health Bill to repeal the NHS legislation relating to NHS Charities as this could be achieved through charity legislation. Either the Cabinet Office review of the Charities Acts or the Law Commission review of Charity Law (see Annex B) could result in a Charities Bill in the next few years.

**Fig 1 – Policy Change & Implementation Process**



## **Future relationship between NHS bodies and new independent charities**

160. We are aware that some NHS bodies (particularly those acting as corporate trustees) are concerned that moving to a model in which charitable funds are governed by independent trustees would lessen the NHS body's influence on decisions about which services or projects would be supported. Under this option we envisage that Trusts could hold considerable influence over the use of charitable funds, without that influence representing 'control' (which would jeopardise the charity's independence which is required by law). We envisage that an NHS body may wish to formalise its relationship with the charity receiving the NHS Charitable funds and could negotiate a Memorandum of Understanding or similar agreement.
161. This could confer some form of 'official partner' status on the charity receiving the NHS Charity's funds. The agreement could govern the relationship between the NHS body and the charity regarding:
- trustee appointments;
  - use of the Trust name and logo by the charity;
  - the ability of the charity to fundraise on the hospital site;
  - use of the NHS body's premises and resources, including staff, by the charity;
  - the process for agreeing future major operational or strategic change;
  - the transfer of gifts and bequests to the NHS body from the NHS to the charity.
162. The MoU could be subject to renewal, or cancellation should relations not prove to be sustainable. There would be no need to have a statutory or regulatory framework governing such an arrangement.
163. In addition, NHS bodies could maintain appropriate influence in the spending decisions of the charity and minimise the risk of the charity making inappropriate grants to the NHS body, through NHS body employees acting as trustees of the new charity. It is only NTDA guidelines that prevent this from happening now. It would be important for any employees of the NHS body acting as charity trustees to remember they have an overriding duty to act solely in the interests of the charity and its beneficiaries, not in the interests of any other organisation or their own personal interests. Also, if more than a minority of trustees were employees of the NHS body, or if there was a suggestion that the NHS body in effect had 'control', the NHS body would likely be required to consolidate the charity's accounts into those of the NHS body. The Charity Commission would also investigate breaches of trust.

## **Future models of trusteeship available**

164. Trustees of the receiving charities could be appointed using a combination of the following methods, all available under existing charity

regulation (assuming all individual trustee appointments would be for fixed but renewable terms):

- An NHS body could appoint a number of individual trustees (who could but need not be its members or employees);
- An/other interested organisation (e.g. patient group) could appoint a number of individual trustees;
- Individual trustees could have the power to appoint or co-opt a number of additional trustees;
- The Board of trustees could include ex officio trustees (trustees by virtue of their office), for example it could be part of the charity's constitution that the Chief Executive or Medical Director of the NHS body is an ex officio trustee;
- Individual trustees could appoint their own successors (self-appointing model); or
- The charity could be established to be membership based, with members responsible for electing the trustees (this may be of interest to Foundation Trusts).

### **Maintaining the ability for NHS bodies to act as corporate trustee**

165. This option would see the continuance of NHS legislation allowing NHS bodies to hold property on trust. While this power is envisaged to allow NHS bodies to continue to receive property on trust and divert it to an NHS Charity, this legislation would provide NHS Charities governed by an NHS body acting as corporate trustee with the legal standing to continue to run a functioning charity, should they choose not to transfer funds to an independent charity.

166. We recognise that for many of the smaller corporate trustee NHS Charities, the benefits of a change of status may not be compelling. The preferred option would not force these organisations to change, particularly because the corporate trustee model is available (albeit rare) among mainstream charities. However, NHS bodies would be encouraged to consider the benefits of change, as well as the downsides of remaining as a corporate trustee (such as the fact they may be required to consolidate the NHS Charity accounts into the accounts of the NHS body).

### **Implications for consolidation of accounts**

167. Under the preferred option, NHS bodies acting as corporate trustee should avoid the requirement to consolidate the accounts of the linked NHS Charity into those of the NHS body. NHS bodies that decided to remain as a corporate trustee could be required to consolidate charitable funds, but insignificant funds may not meet the materiality threshold and therefore be exempted.

168. The implications of the ONS reclassifying NHS Charity funds to the central government sector affect all NHS Charities, not just those governed by an NHS body acting as corporate trustee. This means that the accounts of any NHS Charity not replaced by an independent 'receiving' charity, would need to be consolidated into the Department of Health resource accounts and included in Whole of Government accounting. Again, insignificant funds may be exempted if they do not meet the materiality threshold.

### **Equality considerations and analysis**

169. The potential equality impact of the proposed changes in governance needs first to take account of the wider charities 'environment' for England & Wales, and then the position of NHS Charities in this environment. This is set out in paragraphs 170 to 176.

170. The general principle of fair and equal treatment for all applies to all charities. However Charity law recognises that some charities are set up to help particular groups in society for clear social objectives. Therefore charities have always been able to depart from these principles and restrict their beneficiary class to people of a particular characteristic (e.g. gender, ethnicity or age).

171. Previously legislation provided that, so long as a charity's constitution set out the class of people which it could benefit, and that class was not defined by reference to skin colour, then any consequent discrimination would not be unlawful. The Equality Act 2010 narrowed the scope of that exception. Now, charity founders that wish to do this have to explain to the Charity Commission why a restriction is justified, using the criteria in the Act. The Commission cannot register charities which want to restrict the benefits they provide in a way which isn't permitted by the Act.

172. Charity Law requires that charitable donations must be spent in furtherance of the charity's purposes and trustees are bound by this duty. In the event of new trustees being appointed to the charity, or the assets being passed to a different charity, they would remain bound by the same restrictions. It is possible to change these purposes; although the Charity's Commission's prior consent is usually needed.

173. Because NHS Charities' objects are defined in statute as 'the health service', the beneficiaries of NHS Charities are defined as the same 'people of England' who are supported by the NHS. As a consequence there should be no restriction on who can benefit from the activity of NHS Charities, except where funds have been received from donors for a more specific identified purpose (such as a particular ward or service), in which case they will be held and administered through a separate restricted fund (either administered as a charity in its own right, if it has income over the charity registration threshold, or within one of the registered NHS charities if below the threshold).

174. In addition, as public bodies NHS bodies are bound by the public sector equality duty set out in the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not. It is likely that those NHS Charities governed by an NHS body acting as corporate trustee are also currently bound by the public sector equality duty.
175. Unlike NHS bodies, mainstream (non’NHS) charities are not ‘named organisations’ listed in the Equality Act. However, the public sector equality duty also applies to other bodies who are in the process of ‘exercising public functions.’ That means that charities delivering public services must also comply with this duty when delivering such services. Almost without exception NHS Charities (as regulated under the NHS Act) do not themselves deliver public services, rather they undertake fund raising and grant making functions. It is possible that the independent charities which may receive NHS Charitable funds under this new governance proposal could also have separate service delivery functions in which case they would need to give due regard to comply with this duty.
176. The beneficiaries of current NHS Charities as set out in their statutory objects are the purposes of the **trust** and, for most, for any purposes relating to the **health service**. In practice most, in some cases all, of the funds raised are provided for the purposes of the linked hospital trust. However, some of the target hospital charities that have trustee bodies, such as Guys & St Thomas’s and Barts, have a deliberate strategy to also support, on a significant scale, health and well-being needs in the wider local communities with the most ethnically and socially diverse communities.
177. We have also considered the impact of charitable support by NHS Charities on groups with different protected equality characteristics and considered whether the new governance proposals may have an impact:
178. In general the extent and scope of fund raising is driven by the propensity of donors to support particular circumstances. In relation to health they will most readily support the needs of children and particular life threatening illnesses, particularly cancer, and to a lesser extent, heart disease, ageing conditions and particular disabilities. To that extent they already have some positive equality impact in respect of age and disability. The impact on other protected characteristics (such as race, religion, gender and sexual orientation) will be limited to the extent to which they may make disproportionate use of hospital services.
179. Information on income by NHS charity in Annex G confirms the high ranking of charities supporting hospitals that provide children’s services and cancer services. It is not possible to derive comprehensive data on how overall NHS charitable grant making might map with the specific services used by different protected groups across all hospitals but previously noted

factors do not at all lend themselves to any significant negative hypothesis.

180. These policy proposals seek only to change the governance of NHS charities, not the patients that their activities will benefit. We would not therefore anticipate any resulting negative impact on equality impact of any protected groups, indeed there should be some high level positive impacts:

- We would expect a significant number of charities currently governed by a hospital trust Board as corporate trustee, to move to having an appointed board of independent, dedicated trustees. Such trustee bodies (as are already in place in a small number of NHS Charities) may pay greater attention to the charity's equality duty and review practices including but not limited to grant making accordingly.
- Such trustee bodies are more likely to adopt a broader strategy to providing patient benefit including increasing support to local community healthcare, and in particular on health and well-being projects that may benefit race, lower socio-economic, elderly and carer related needs.
- Should any newly established independent charity which receives NHS Charitable funds wish to restrict its beneficiaries in future based on a specific, shared characteristic – such as age, disability, gender, or religion – it would need to review its governing documents to make sure they are in compliance with Equality Act 2010.
- The overall opportunities provided by this deregulation will facilitate further growth in the scale and scope of charities supporting healthcare in all local communities across all protected characteristics.

181. Where new charities are established it may require some staff to transfer from the current charity (where they will probably be NHS staff), to new charities. This may include a higher proportion of women. Current Trust directors and new charity trustees would have responsibilities under both employment and equalities legislation to ensure that they are not unfairly disadvantaged.

182. In summary:

- notwithstanding the right of individual charities to limit their beneficiary class (that is probably advantageous to some protected characteristics), NHS charities benefit all individuals to the extent that they require healthcare services that are provided in their locality.
- Although 'independent' charities would not be public bodies covered by the public sector equality duty (unless they were exercising public functions), they would be subject to regulation by the Charity Commission on adherence to the 2010 Equality Act.

- The deregulation proposals will create opportunities to expand charitable provision in localities where there is a greater proportion of protected groups, where this is not already established.
- We would expect the new governance arrangements, in particular the appointment of bodies of independent trustees, to result in some changes in the activities of the new charities that may benefit some protected characteristics further.

183. It would therefore be inappropriate and disproportionate to impose any specific condition relating to equality duties on the transfer of property/funds to the new charities. However, as part of the final consultation process, we should seek specific views on this analysis and consider any alternative representations and proposals.

### **How does the preferred proposal for change meet our objectives?**

184. It delivers the objectives identified above in terms of enabling **NHS Charities** to deliver the best outcomes for NHS patients. It delivers a permissive, enabling environment that allows those NHS bodies and Charities that wish to move to an independent model to do so relatively easily. Many NHS bodies acting as corporate trustee currently consider it too burdensome to request the appointment of a body of individual trustees under the current system. It is highly likely that they would be encouraged to act to open up the opportunity for their charity to benefit from a Board composed of experienced, committed trustees, with employees of the NHS body able to serve alongside them.

185. It also offers NHS Charities the opportunity to develop partnerships and work more flexibly. It is likely that many of the new independent charities would continue to support the patients of a single NHS body. However, we envisage that several separate NHS Charities would decide to transfer their funds to the same new independent charity, to create economies of scale. A range of models could be expected to develop.

186. This proposal would give NHS Charities the freedom to organise themselves in the most appropriate way, and take up more innovative governance models including those which limit the liability of trustees. They would be regulated solely by the Charity Commission in a streamlined, effective and more efficient way, with no duplicate regulation by the Department of Health. Crucially, the removal of Ministerial intervention would give them the ability to appoint their own trustees and transfer funds. They would benefit too from the perceptions of this increased independence and the resulting removal of the requirement to consolidate their accounts into those of either their linked NHS body (in the case of those governed by corporate trustee) or the Department of Health. Many NHS Charities tell us such a move would have a positive effect on their fundraising potential, and as a result their ability to deliver the best outcomes for NHS patients.

187. The proposal would meet our objectives for **NHS patients** as beneficiaries of these charitable funds. The changes should allow the new, independent NHS-focused charities to maximise their fundraising potential and support patients across a developing NHS provider landscape.
188. One of our objectives for **NHS bodies** was that they should continue to be the primary vehicle through which charitable assets provide benefit to NHS patients. As described above the funds transferred into the receiving charities would be protected for NHS patients on the grounds that they had been donated in furtherance of the NHS Charity's original objects. The proposal would also deliver our objectives for NHS bodies to be able to have appropriate influence on how charitable funds are deployed, and to be in the lead in the extent and pace of change adopted by their current linked NHS Charity.
189. The proposal also delivers objectives for **Government**. The proposed changes remove unnecessary Ministerial and regulatory intervention in the governance of these charities, supporting the deregulation agenda and minimising while protecting patient interests, promoting localism and independence. This option would be strongly supported by the wider charity sector, which would consider the Government to be taking positive steps to liberate a sub-section of the charity sector that had experienced what they view as unnecessary Ministerial intervention in the past. In particular it would assuage the concerns of those who have feared that the requirement to consolidate accounts was akin to Government 'taking control' of the charitable funds.
190. The proposal would also save time and money at the Department of Health and the Charity Commission – it would remove the DH requirement to process Orders to transfer funds (which would be particularly onerous in the upcoming phase of structural change and reconfiguration). It would remove the need for both organisations to consider the increasing levels of individual approaches for revised governance. Both organisations would be able to make efficiencies through not needing to maintain specialist resourcing and guidance for NHS Charities. There would also be minor savings as the NHS Trust Development Authority would not have to appoint individual trustees on behalf of the Secretary of State.
191. The proposals are consistent with, and indeed provide the opportunity for early adoption of, key recommendations from Lord Hodgson's review of the Charities Act, in particular making it easier to set up and run a charity, and promoting public trust and confidence.

### **Legal Risk**

192. The proposal is predicated on the ability to act in advance of repealing legislation by promoting a new policy interpretation of NHS legislation relating to NHS Charities, endorsed by a positive response to a consultation. It may be difficult to proceed if the response to the consultation is not overwhelming positive.

193. The risk of legal challenge cannot be ruled out. This would be on the basis that the NHS legislation sets out a scheme by which charitable property within the NHS will be transferred between NHS bodies and trustees established under the 2006 Act; and any independent trustees, that are considered to be needed, are established by order of the Secretary of State:
194. In enabling transfers of charitable property from NHS Charities to bodies outside the NHS, it could be argued that we are circumventing the NHS legislation that intended NHS charitable property to stay within the NHS, and thus going against the intention of Parliament.
195. The counter argument is that the NHS legislation is silent on the possibility of transfers being made from NHS bodies to non-NHS bodies, and was only meant to govern transfers within the NHS, and not to prevent transfers to non-NHS bodies taking place under charity law, and so allowing for this to happen does not go against the intention of Parliament.
196. In any event, we consider that there is unlikely to be any interest in bringing such a challenge.

#### **Other Potential issues**

197. There would be an initial slightly increased workload for the Department to deliver the proposed Government consultation and to facilitate the transfer Orders required for those charities currently governed by bodies of individual trustees appointed by the Secretary of State.
198. NHS bodies and charities would need to give further thought to employment issues. NHS bodies which act as corporate trustees may have NHS employees working wholly or mainly on charity business. If such a charity wished to move to the independent model those staff may be unwilling to move across if that meant losing NHS terms and conditions.
199. Under the proposal, NHS bodies would retain the power in NHS legislation to accept and hold gifts of property, and would be expected to rely on this power in order to act as a 'post box' to pass on future bequests etc. to the new wholly independent charities. NHS bodies would need to make appropriate arrangements for accounting for their temporary holding of such funds. If the funds exceeded £5,000 a year they may need to register as a charity with the Charity Commission, and this could result in NHS bodies keeping their original NHS Charities open to operate as 'shell' charities. This could be burdensome, and the Charity Commission is not in favour of such practices. We could explore with the Commission whether it would be able to waive the requirement to register a charity with the Commission for those NHS bodies merely acting as post boxes.
200. NHS bodies and Charities may need support and guidance to understand the options available to them. Ideally, they should be able to move to the new model without the need to resort to expensive

consultancy and legal support and the Association of NHS Charities could play a useful role.

### **Conclusion and next steps**

201. This review has identified and documented a number of issues and problems related to the current system of governance of NHS Charities. The option outlined above has the potential to create a permissive, enabling environment in which NHS bodies and Charities that wish to move to an independent model are able to do so, and those NHS bodies that wish to remain acting as corporate trustee are not forced to change.
202. Liberalising the framework to this degree, and allowing for 'NHS Charities' to be replaced by a raft of wholly independent 'NHS-focused charities' may seem like a radical step. However, it would be entirely consistent with Government priorities and ethos, and the new charities would remain linked to the NHS by shared goals and aspirations that may be backed by formal agreements. Moreover, there is no compulsion to change.
203. As part of the stakeholder engagement undertaken as part of this review we have tested the principles of our preferred option with a number of NHS Charities, a range of NHS bodies, The Association of NHS Charities, the Charity Commission, the Cabinet Office team undertaking the review of the Charities Act and others. We have received a very positive response. A final stage of engagement prior to finalising proposals and producing the new policy mandate, will build on the earlier engagement including broadening it to ensure direct feedback from the full scope and scale of NHS and charity interests.

# Annexes

## Annex A – Review aim and terms of reference

### Review aim

The fundamental aim of this review, as set out in the published 2011-2015 DH business plan<sup>30</sup>, is to review current legislative powers relating to the governance and operation of NHS Charities to preserve and extend their independence from central government.

The overarching aim of this work is to enable NHS Charities to provide greater benefit for the NHS patients who are their charitable beneficiaries.

### Review scope and terms of reference

This review of the governance of NHS Charities will examine whether and how the legislative framework could be amended to protect their independence and autonomy, minimise the regulatory burden, and empower them to serve their local communities in the way they believe is most appropriate. The review will be confined to the governance of 'NHS Charities', by which we mean bodies having the right to receive and hold property on trust under the National Health Service Act 2006. It does not extend either to independent local and national charities that may also support some NHS services, or to charitable organisations that may provide NHS services directly to patients (other than considering the potential role of NHS charities in supporting these services).

The review will be open and wide-ranging and will consider:

- The strategic role of NHS charities and current barriers to fulfilling this
- Alternative forms of trusteeship (how charitable funds are held)
- The process of appointing trustees
- Controls for the transfer of charitable funds between bodies (trustees)
- The effectiveness of charitable support for the NHS by NHS Charities
- Any other needs and opportunities that emerge from feedback

The review will take account of the views of individual charities and linked NHS organisations as well as representative interest groups.

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[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_129297.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129297.pdf)

## Annex B – Other relevant reviews

### Review of the Charities Act 2006

The Charities Act 2006 required the Minister for the Cabinet Office to appoint a person to undertake a review of the Act five years after the legislation was passed. In November 2011 Lord Hodgson of Astley Abbotts was appointed to lead the review<sup>31</sup>, the aim of which was twofold:

- 1) To report on the operation and effectiveness of the provisions of the 2006 Act
- 2) To consider whether further changes could be made to improve the legal and regulatory framework for charities

The review involved wide-ranging consultation with the charity sector and other stakeholders, supported by public perceptions research undertaken by IPSOS MORI.

The review reported in July 2012, making over 100 recommendations. The report is available here:

<http://www.cabinetoffice.gov.uk/sites/default/files/resources/Review-of-the-Charities-Act-2006.pdf>

At the Review launch, the Minister for Civil Society, Nick Hurd MP explained that the Government is likely to focus on recommendations that either (a) make it easier to set up and run a charity, and/or (b) promote public trust and confidence in charities. Recommendations that can be easily implemented are likely to be prioritised. The Office for Civil Society has asked its strategic partners to prioritise Lord Hodgson's recommendations using a green/amber/red traffic light system. The Government is expected to respond to the review later this year, once it has considered charity sector views.

### Law Commission review of Charities legislation

The Law Commission is due to undertake a charity law project as part of its Eleventh programme of law reform<sup>32</sup>.

This project will examine a range of issues concerning the constitution and regulation of charities and their activities. It will involve a targeted review of areas of charity law that have been identified as causing uncertainty and carrying disproportionate regulatory or administrative burdens

Part of the project will focus on charities that are structured as charitable corporations by Royal Charter or by statute (such as NHS charities). Changing the provisions of charities with statutory governing documents

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<sup>31</sup> <http://www.cabinetoffice.gov.uk/content/charities-act-review>

<sup>32</sup> [http://lawcommission.justice.gov.uk/docs/lc330\\_eleventh\\_programme.pdf](http://lawcommission.justice.gov.uk/docs/lc330_eleventh_programme.pdf)

requires a Parliamentary resolution, leading to cost and delay, even when the change is relatively minor. The Commission considers this to be a potentially disproportionately burdensome requirement for both the charity and Government departments involved in the change.

The Law Commission project will be informed by the Lord Hodgson review of the Charities Act 2006; some of the points arising from that review may be suitable for investigation by the Law Commission and may be referred to the Commission to become part of its project.

The project is due to begin in spring 2013, with a consultation paper published in late 2013. If both the Law Commission and Government agree subsequently that further work is appropriate, a final report and draft bill would be expected in 2015/16.

## Annex C – Accounting issues affecting NHS Charities

### Consolidation of NHS Charity accounts into NHS body accounts

Since 2009-10, Government Departments' resource accounts have been prepared under EU-adopted International Financial Reporting Standards (IFRS), which superseded the UK-based Generally Accepted Accounting Practice (UK GAAP)<sup>33</sup>. The change was designed to improve transparency and understanding of financial statements.

IFRS International Accounting Standard (IAS) 27 – Consolidated and Separate Financial Statements – requires consolidated financial accounts to be prepared for a group of entities under the control of a parent where there exists “the power to govern the financial and operating policies of an entity so as to obtain benefits from its activities”. Control is presumed to exist when the parent owns, directly or indirectly, more than half the voting power of an entity. Control also exists in certain circumstances even when the parent owns half or less the voting power.

This meant that the funds of NHS Charities (specifically those with a corporate trustee) would need to be consolidated into the NHS body's accounts. Failure to do so would risk an audit qualification.

HM Treasury originally granted NHS organisations a deferral from applying the accounting standard in 2009-10, to allow the NHS to review arrangements and prepare for implementation. In February 2010 HMT agreed to another year's deferral, so a review could take place of NHS Charities in the context of the government accounting framework.

The review group<sup>34</sup> produced its report<sup>35</sup> in April 2011, which recommended that IAS 27 should apply in full to the NHS in respect of NHS Charities. In practice this would apply only to corporate trustees, as the review group found that 'control' is present where an NHS body acts as corporate trustee, has wide direction over the allocation of funds, but routinely applies funds only to the NHS body which is the corporate trustee.

The Treasury, with other Relevant Authorities agreed to apply IAS 27 to NHS organisations from 1 April 2013. The further delayed implementation date was to allow issues around NHS reform in England to be resolved and allow time to achieve consistent and correct application across the NHS.

In practice, consolidation is only necessary subject to usual accounting materiality considerations (an amount judged to be of such importance that its

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<sup>33</sup> Note that charities' Statement of Recommended Practice (SORP) is currently produced under UK GAAP.

<sup>34</sup> The review group was chaired by an Accounting Standards Board member and included representation from HM Treasury, Audit Commission, Department of Health, Association of NHS Charities, NHS Healthcare Financial Management Association (HFMA), Charity Commission, Monitor, Chartered Institute of Public Finance Accountancy and the Devolved Administrations.

<sup>35</sup> [http://www.hm-treasury.gov.uk/d/frab\\_nhs\\_linked\\_charities\\_report\\_april\\_2011.pdf](http://www.hm-treasury.gov.uk/d/frab_nhs_linked_charities_report_april_2011.pdf)

omission or misstatement would affect understanding of the accounts – considered by many auditors as the equivalent of 1% of gross expenditure). In consolidated accounts, the expenditure of a charity that goes directly towards the income of a Trust cancel each other out so would not be expected to count towards the materiality threshold<sup>36</sup>.

In addition the Charities SORP is based on UK GAAP, which IFRS is replacing. Although NHS body accounts are being put onto an IFRS basis, it does not mean the charity's accounts must be too. The charity's accounts will still be prepared as a standalone document meeting Charity Commission SORP guidelines. However NHS Charities have 10 months to produce accounts, whereas the NHS is mandated to produce accounts within 11 weeks. Therefore NHS Charities would need to produce accounts in line with the shorter NHS timelines.

To apply IAS 27 Trusts will need to identify the charity's balances that are material and so need consolidating into the Trust's accounts, and consider whether any of them would need to be reflected differently as a result of the application of IFRS. If this is the case, they would need to make consolidation adjustments to these figures when including them in the Trust accounts.

Although charitable funds are protected in law to ensure they are applied for the purposes that the donor specifies, and although the legal and regulatory independence of charities is unaffected by their accounting framework, the decision to apply IAS 27 to NHS Charities was controversial.

A dissenting report<sup>37</sup> was prepared by four members of the review group. They felt that consolidated accounts would damage public perceptions of the independence of NHS Charities, and seem to confirm suspicions that donations are used to fill gaps in NHS budgets. They felt this could actually enhance the potential for bad practice within NHS bodies – a hard pressed finance team in an NHS Trust or Foundation Trust could come to regard the charitable funds as simply another budget. And in the media, critics warned that placing charitable assets worth £500m on the public balance sheet for the first time amounted to “the effective nationalisation of NHS Charities<sup>38</sup>” and could undermine people's willingness to give.

## **ONS reclassification of NHS Charities**

The Office of National Statistics (ONS) currently classifies NHS charities to the private sector as 'non-profit institutions serving households'. NHS Trusts and Foundation Trusts are classified in the public sector as central government (NHS Trusts were previously classified to the public sector as non-financial corporations).

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<sup>36</sup> From information provided in NAO workshop as part of HFMA annual conference 2011.

<sup>37</sup> [http://www.hm-treasury.gov.uk/d/frab\\_nhs\\_linked\\_charities\\_dissenting\\_report\\_april\\_2011.pdf](http://www.hm-treasury.gov.uk/d/frab_nhs_linked_charities_dissenting_report_april_2011.pdf)

<sup>38</sup> Sir Stephen Bubb, Chief Executive of the Association of Chief Executives of Voluntary Organisations quoted in the Health Service Journal in July 2011: <http://www.hsj.co.uk/acute-care/treasury-review-of-nhs-charities-sparks-nationalisation-fear/5032017.article>

Following a review, the ONS – an independent body – concluded that the governance arrangements for all NHS linked charities (whether corporate trustee or individually appointed trustees) are public sector in nature so they will be classified en bloc as central government bodies from 2012/13.

ONS considered that Ministerial control over the appointments process for both Independent and Corporate trustees was enough to warrant this reclassification to central government for all NHS linked charities.

This classification results in a requirement for all NHS linked charities in England to be consolidated within the Department of Health's overall Resource Account from 2012/13. This includes budgets and estimates, subject to usual accounting materiality considerations. Failure to comply would be likely to lead to the Department of Health's Resource Account being qualified by the National Audit Office.

The principle of basing budgetary controls, estimates and accounts on the ONS definition of central government was agreed with Parliament and is included within the Government's Financial Reporting Manual. The ONS classification reflects the internationally agreed definitions of the 'central government sector' and 'public spending'.

The ONS decision in itself does not require NHS organisations to consolidate their NHS linked charities into their Accounts at a local level. However, there will be some significant practical issues to resolve at both national and local level to achieve the consolidation of NHS linked charities into the Department of Health's Resource Account.

Reclassification is for accounting purposes only and does not mean that NHS Charities' fund become part of NHS budgets. Many other charities are already included within national accounts – for example the British Museum's accounts are consolidated into DCMS accounts, and the National Army museum into MoD. However, many of the NHS Charities that attended our workshops were concerned that the ONS reclassification could have a similar detrimental effect on public opinion as consolidation of accounts.

## Annex D – Useful terms

**Charities SORP** is the Statement of Recommended Practice: Accounting by Charities, published by the Charity Commission. It sets out the recommended practice for preparing the trustees' annual report and preparing accounts on an accruals basis. The accounting recommendations of the SORP do not apply to charities preparing receipts and payments, rather than accruals, accounts.

**Charitable company** is a charity which is registered as a company (potentially a Company Limited by Guarantee or CLG) with Companies House. Its governing document will usually take the form of articles of association, and it has its own legal identity.

**Charitable Incorporated Organisations (CIO)** is a new legal form for a charity, provided for by the Charities Act 2011 to enable smaller charities to obtain important benefits of incorporation without being burdened by the full extent of company law and regulation. A CIO is an incorporated form of charity which is not a company, which only has to register with the Charity Commission and not Companies House, is only created once it is registered by the Commission, and which can enter into contracts in its own right and its trustees will normally have limited or no liability for the debts of the CIO. The Charity Commission thinks that the CIO will be most suitable for small to medium sized organisations that employ staff and/or enter into contracts; it would be likely to be an attractive option for NHS Charities, were they free to opt for this model. The package of Secondary Legislation needed to complete the legal framework for CIOs are due to be considered by Parliament imminently, and the first CIOs could be set up early in 2013. The availability of the CIO structure to existing charities will be phased in over 2013-14 to help the Charity Commission manage anticipated volumes.

**Designated funds** are part of the unrestricted funds which trustees have earmarked for a particular project or use, without restricting or committing the funds legally. The designation may be cancelled by the trustees if they later decide that the charity should not proceed or continue with the use or project for which the funds were designated.

**Endowment funds** are funds which the trustees are legally required to invest or to keep and use for the charity's purposes. Endowment may be expendable or permanent. Expendable endowment is an endowment fund where the trustees have the power to convert the property into 'income'. There is no positive duty on the trustees to apply it for the purposes of the charity, unless and until this power to convert into 'income' is actually exercised. Permanent endowment is property of the charity that the trustees may not spend as if it were income. It must be held permanently, sometimes to be used furthering the charity's purposes, sometimes to produce an income for the charity.

**Governing document** means the formal document which sets out the charity's purposes and, usually, how it is to be administered. It contains, as a

minimum, information about the charity's objects (what the charity is set up to do), powers (how it will do those things), and trustees. It may take the form of a trust deed, constitution, conveyance, will, memorandum and articles of association, Royal Charter or Scheme of the Commission.

**Income and income funds** means all incoming resources that become available to a charity and that the trustees are legally required to spend in furtherance of its charitable purposes within a reasonable time of receipt. Income funds may be unrestricted or restricted to a particular purpose of the charity.

**Purposes** are usually expressed in the 'objects clause' of a charity's governing document. However, sometimes the statement of **objects** does not adequately or fully express the organisation's purposes. There is therefore a distinction between an organisation's purposes and the words that appear in its statement of objects. To be a charity, an organisation must have purposes which are exclusively charitable in law.

**Restricted funds:** Restricted funds are funds subject to specific trusts, which may be declared by the donor(s) or with their authority (e.g. in a public appeal) or created through legal process, but still within the wider objects of the charity.

**Trustees** are responsible for the general control and management of the administration of the charity. In the charity's governing document they may be collectively called trustees, the trustee board, managing trustees, the management committee, governors or directors, or they may be referred to by some other title.

**Unincorporated charities** are usually a trust or association. Unlike a charitable company, they do not have their own separate legal identity.

**Unrestricted funds** (including designated funds) are income or income funds which can be spent at the discretion of the trustees in furtherance of any of the charity's objects. If part of an unrestricted income fund is earmarked for a particular project it may be designated as a separate fund, but the designation has an administrative purpose only, and does not legally restrict the trustees' discretion to spend the fund.

## **Annex E – Summary of stakeholder written feedback**

As part of this review we produced and disseminated a briefing document to support the early seeking of views about how to revise the system governing NHS Charities. The document set out some of the key considerations to be taken into account and invited general ideas and comments. Eight NHS Charities responded, together with two organisations involved in supporting NHS Charities, as well as the Association of NHS Charities and the Charity Commission. The responses detailed below are from NHS Charities themselves unless otherwise stated.

### ***The role of NHS Charities***

One respondent felt that the starting point for the review should be to assist NHS Charities to deliver their vision – in their case their charity's role was to strive to support patients and enhance their experience. One respondent who works with several NHS Charities felt that these charities should be the primary conduit for financial support from a people in a local community to their local hospital. This should result in the charity's support: enhancing services provided by the hospital; providing additional benefits for patients and their visitors in order to improve their welfare; improving the quality of staff training (for the benefit of patients); and providing capital for premises and equipment that could not be funded from NHS budgets.

Many respondents could not understand why NHS Charities should be considered different from mainstream charities. However, one respondent felt that NHS Charities had a unique selling point, which was a preferred working relationship with their main beneficiary Trust. A further respondent felt that the role of NHS Charities was quite different from that of other health related charities.

### ***Dual regulation of NHS Charities***

Issues around NHS Charities' dual regulation under both NHS legislation and charity law were a key theme among respondents. Many charities felt that although they had received good support from DH alongside the Charity Commission, on balance dual regulation brought them no extra benefit but created extra administration and challenged the pace with which NHS Charities could approach new situations and a changing environment.

Similarly, although some charities were grateful for the added value the Appointments Commission could bring to the process of appointing individual trustees, all felt there was no reason why NHS Charities' trustees should not be self-appointing, as is the case with all other charities. Two charities even felt that the involvement of the Appointments Commission had been a hindrance, increasing administration costs and causing delay.

Most respondent NHS charities felt they were inhibited by the rigidity inherent in the current framework. They called for more flexibility to vary the number of trustees, for example to bring in trustees with new skills. There was also

concern that NHS employees were unable to act as trustees of NHS Charities with individually appointed trustees. One respondent felt this hampered their charity's ability to gain insight into the issues facing its partner hospital.

Overall respondents felt that the current system is unduly limiting for NHS Charities and is costly, bureaucratic and over-complex for the Department, the Charity Commission, and for the charities themselves.

Almost every respondent considered that it would be sufficient for NHS Charities to be regulated solely under Charity Law – the NHS legislation was no longer fit for purpose and DH or Ministerial involvement was unnecessary. One respondent called on the Department of Health to abandon its quasi charity regulatory role because “it causes confusion and gives rise to an absence of regulatory leadership”.

### ***Corporate trustee model***

Some respondents felt that the corporate trustee model inhibits NHS Charities as the Boards of NHS bodies are not able to dedicate sufficient time to charity business and may not have skills to help it to prosper. Around half of respondents felt the corporate trustee model created a risk of conflict of interest because the Board responsible for administering Exchequer funds is the same Board administering charity funds. And around half of respondents felt that the requirement for NHS bodies to implement International Accounting Standard 27, and consolidate the accounts of corporate trustee charities with their own, would exacerbate confusion and increase perceptions of a lack of independence of NHS Charities.

However while recognising the importance of independence, many respondents commented on the importance of the relationship between NHS Charities and their linked NHS body. One charity acknowledged that “we cannot fundraise or make grants effectively if there is confusion of lack of good communication between us.”

### ***Perceptions of independence from Government***

Many respondents commented on the fact that NHS Charities were at heart governed under NHS legislation, with Secretary of State controls, resulted in perceptions that NHS Charities lacked independence. One expressed this as a perception that “the charity is a central government vehicle, subject to government policy and established to pursue government defined goals, and that the State has a beneficial entitlement to the Charity's assets.” Around half of respondents felt that NHS Charities are inhibited or negatively affected by a perceived lack of independence from Government.

### ***Views on the requirements of any new system***

Most respondents were concerned to ensure that any new system maintains the current statutory provisions whereby donations, legacies and other gifts in

Wills made out to a hospital automatically divert to its linked NHS Charity. This was noted as an important source of income for NHS Charities.

Some NHS charities were keen for a future regime to enable them to expand their objects so they could support wider healthcare needs beyond the NHS. However others with strong connections to their linked NHS body (including a charity governed by a set of Special Trustees, which limits the focus on the needs of the specific hospital) considered that it would be to the detriment of their fundraising interests if they were forced to widen their charitable objects.

Several charities raised concerns about the unlimited contractual liability of Trustees and almost all respondents commented that NHS Charities should be liberated to be able to benefit from different charitable forms, such as Company Limited by Guarantee.

Finally, many respondents were concerned to ensure that the transition to any new model should avoid unnecessary or burdensome bureaucracy for individual charities.

## Annex F – Summary of stakeholder workshop views

As part of this review we held two workshops in October 2011 to hear from a range of stakeholders about their perspectives on the need for change, and ideas about change. Eighteen NHS Charities attended the workshops, together with the Charity Commission, the Association of NHS Charities and other organisations involved in supporting charities or NHS bodies.

Many participants who represented charities with a corporate trustee felt that this model was the cause of a lack of strategic approach, with the charity's development often viewed as unimportant when compared with Trust business. One participant said the corporate trustee model created a risk that members of the Trust Board treat charitable funds as just 'another cost centre' within the Trust budget.

Many NHS Charities wanted more flexibility – they were keen to find ways to work with partners as part of Academic Health Science Centres or to develop links with social enterprises, and felt the current regulatory environment restricted their ability to do so.

There was consensus that the provisions for NHS charities in NHS legislation had made sense when there was no charity legislative framework – but now everything that NHS Charities need to do and achieve can be provided for under charity law. One delegate commented that charity law was not 'broken', so did not require 'fixing' for NHS Charities.

### ***Drivers for change***

Workshop participants were asked to consider the drivers for why change should take place in the short-term – why now? Participants spoke about the importance of reputational issues; donors needed to have confidence they were donating to charity, not to another arm of Exchequer funding. Participants also felt that liberating NHS Charities from Secretary of State controls was consistent with the Government's ethos of liberating the NHS and promoting Big Society.

Overall, freeing NHS charities from NHS legislation and moving away from the corporate trustee model was seen as providing an excellent opportunity for charities to take on trustees with different expertise and perspectives, and to remove red tape (e.g. EU procurement rules). They also foresaw opportunities to boost fundraising through economies of scale and improved donor perceptions.

## ***Considering future scenarios***

At both workshops, participants discussed three future scenarios for governance framework options:

- 1) No change to current regulatory framework
- 2) Full de-regulation (charities enabled and regulated under Charity legislation only)
- 3) Streamlined current framework (NHS Charities still governed under NHS legislation but with some changes in legislative provisions or guidance)

### *1) No change*

There was agreement from all participants at both workshops that 'no change' was highly undesirable. Although this would suit a number of NHS charities, the status quo was oppressive and restrictive for a minority (which represent the majority of active charitable activity).

### *2) Full de-regulation*

Delegates felt that it should be possible to set a deadline (e.g. five years) in which NHS Charities would disengage from NHS legislation. All participants agreed there was a need to 'take people on a journey' and set out compelling arguments for change, rather than merely impose change.

Participants felt there should be a guarantee that NHS charity funds would continue to be used for the purposes intended, with steps taken to avoid a loss of assets outside the NHS. They also felt it should be possible for Trusts to nominate a special linked charity or official approved charity, to maintain a Trust's link with its current NHS Charity. Similarly it was important for NHS Charities to continue to be able to accept bequests and gifts in wills left to the NHS body – there were concerns that this relationship could be lost or compromised if there were full de-regulation.

There was a strong view that the Department of Health and the Charity Commission should advise against the corporate trustee model, but not ban it outright (given that the model exists elsewhere in charity law). However some felt that allowing the corporate trustee set-up to continue would mean the corporate trustee Board would never vote itself out of existence.

### *3) Streamlining current framework*

Participants felt that one option for streamlining might be to broaden the interpretation of the statutory basis for NHS Charities contained in the NHS Act, and enable charities to work more broadly to support healthcare, including health promotion.

However, participants all agreed that streamlining the current framework would be tinkering round the edges and would be a missed opportunity. And since any options to streamline the current framework might prove just as difficult to achieve as full deregulation, the consensus was that the Government should push ahead for full de-regulation and sole regulation under charity law.

Overall, most participants at both workshops were in favour of a permissive approach that does not stifle greater freedom for those who want it, while retaining the corporate trustee option for others.

### ***The views of NHS bodies***

In addition as part of this review we have engaged with various NHS bodies to seek their views. This includes NHS bodies whose linked NHS Charities are governed by individually appointed trustees, and those who act as corporate trustee for their linked NHS Charity. We found differing views across NHS bodies – some were supportive of NHS Charities becoming fully disengaged from NHS legislation. Some wished strongly to be able to retain a corporate trustee model.

## Annex G – The top 50 NHS Charities by income (as at 2010/11)

NHS Charity	Income 2010-11	Assets 2010-11	Who are the trustees?
Great Ormond Street Hospital Children's Charity	£63,923,000	£191,110,000	Special Trustees
University College London Hospitals Charities	£17,294,000	£87,811,000	Appointed body of individuals
Barts and the London Charity	£16,247,000	£228,839,000	Appointed CLG
The Christie Hospital Charitable Fund	£12,589,000	£36,755,000	NHS body as corporate trustee
Guy's and St Thomas' Charity	£11,867,000	£519,318,000	Appointed body of individuals
Addenbrooke's Charitable Trust	£9,058,000	£25,413,000	Appointed body of individuals
The Royal Marsden Hospital Charity	£6,945,000	£61,228,000	NHS body as corporate trustee
Oxford Radcliffe Hospitals Charitable Fund	£6,930,000	£15,452,000	Appointed body of individuals
Royal Brompton and Harefield Hospital Charitable Fund	£6,118,000	£64,780,000	Appointed Charitable CLG
Special Trustees of Moorfields Eye Hospital	£5,434,000	£30,991,000	Special Trustees
The Royal Free Charity	£5,321,000	£30,439,000	Appointed body of individuals
Leeds Teaching Hospitals Charitable Foundation	£5,254,000	£35,941,000	Appointed body of individuals
Imperial College Healthcare Charity	£5,200,000	£81,200,000	Appointed body of individuals
Central Manchester University Hospitals NHS Foundation Trust Charity	£5,025,000	£16,282,000	NHS body as corporate trustee
Clatterbridge Centre for Oncology Charitable Funds	£4,173,000	£1,368,000	NHS body as corporate trustee
Birmingham Children's Hospital Charities	£3,522,000	£7,888,000	Appointed body of individuals
Above and Beyond (raises funds for Bristol's nine central hospitals)	£3,456,928	£11,522,000	Appointed body of individuals
Cronfa Betsi Fund	£3,292,000	£10,213,000	NHS body as corporate trustee
North Bristol NHS Trust Charitable Funds	£3,077,000	£9,518,000	NHS body as corporate trustee
Queen Elizabeth Hospital Birmingham Charity	£2,902,000	£11,247,000	Appointed body of individuals
Maudsley Charity	£2,662,000	£97,073,000	NHS body as corporate trustee
Nottingham University Hospitals Charity	£2,654,000	£15,389,000	Appointed body of individuals
St George's Hospital Charity	£2,573,000	£14,828,000	Appointed body of individuals
Homerton University Hospital NHS Foundation Trust Charitable Fund	£2,540,000	£2,227,000	NHS body as corporate trustee
Buckinghamshire Hospitals NHS Trust Charitable Fund	£2,409,000	£7,403,000	NHS body as corporate trustee

<b>NHS Charity</b>	<b>Income 2010-11</b>	<b>Assets 2010-11</b>	<b>Who are the trustees?</b>
South Tees Hospitals Charitable Fund	£2,362,000	£7,971,000	NHS body as corporate trustee
Southampton Hospital Charity	£2,094,000	£4,127,000	NHS body as corporate trustee
The Alder Hey Charity	£2,081,303	£6,158,659	Appointed body of individuals
Kings College Hospital Charity	£2,031,000	£19,219,000	Appointed body of individuals
Newcastle Upon Tyne Hospitals NHS Charity	£2,026,000	£7,985,000	NHS body as corporate trustee
Sheffield Hospitals Charitable Trust	£2,005,000	£13,980,000	Appointed body of individuals
Velindre NHS Trust Charitable Fund	£1,966,000	£2,231,000	NHS body as corporate trustee
University Hospital of South Manchester NHS Foundation Trust Charitable Fund	£1,933,000	£9,425,000	NHS body as corporate trustee
Salisbury District Hospital Charitable Fund	£1,800,000	£9,300,000	NHS body as corporate trustee
Derby Hospitals Charitable Trust	£1,765,000	£6,368,000	NHS body as corporate trustee
University Hospital of North Staffordshire Charitable Fund	£1,753,000	£5,974,000	NHS body as corporate trustee
Abertawe Bro Morgannwg University NHS Trust Charitable Fund	£1,670,000	£5,169,000	NHS body as corporate trustee
Royal United Hospital Bath NHS Trust Charitable Fund	£1,655,000	£4,117,000	NHS body as corporate trustee
Leicester Hospitals Charity	£1,651,000	£5,865,000	NHS body as corporate trustee
Gloucestershire Hospitals NHS Foundation Trust General Charitable Fund	£1,643,000	£3,447,000	NHS body as corporate trustee
Kettering General Hospital NHS Foundation Trust General Charitable Fund	£1,640,000	£2,009,000	NHS body as corporate trustee
Heart of England NHS Foundation Trust Charitable Fund	£1,618,000	£7,967,000	NHS body as corporate trustee
South Devon Healthcare Charitable Fund	£1,561,000	£2,825,000	NHS body as corporate trustee
Cardiff and Vale University Health Board Charitable Fund	£1,553,000	£10,147,000	NHS body as corporate trustee
Newcastle Healthcare Charity	£1,518,000	£12,285,000	Appointed body of individuals
The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust Charitable Fund	£1,459,000	£5,159,000	NHS body as corporate trustee
Papworth Hospital Charity	£1,446,000	£7,212,000	NHS body as corporate trustee
Burton Hospitals NHS Trust Charitable Fund	£1,427,000	£1,948,000	NHS body as corporate trustee
East and North Hertfordshire NHS Trust Charitable Fund	£1,370,824	£3,795,000	NHS body as corporate trustee
Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Fund	£1,368,000	£6,981,000	NHS body as corporate trustee

## Annex H – NHS legislation relating to NHS Charities

(References to SHAs and PCTs will be revoked from April 2013. Schedules specific to those bodies are not included in this summary)

### National Health Service Act 2006

#### PART 11 PROPERTY & FINANCE

#### CHAPTER 2 TRUSTS

#### **212 Special trustees for a university hospital or teaching hospital**

(1) In this Act “special trustees” are trustees appointed by the Secretary of State in relation to England under—

- (a) section 29 of the National Health Service Reorganisation Act 1973 (c.32),
- (b) section 95 of the National Health Service Act 1977 (c. 49), and
- (c) this section,

for any hospital falling within subsection (2).

(2) A hospital falls within this subsection if, immediately before the day appointed for the purposes of section 29 of the National Health Service Reorganisation Act 1973 (c. 32), it was controlled and managed by a University Hospital Management Committee or a Board of Governors, other than—

- (a) a body on whose request an order was made under section 24(2) of that Act, or
- (b) a preserved Board within the meaning of section 15(6) of that Act.

(3) Special trustees must hold and administer the property transferred under the National Health Service Reorganisation Act 1973.

(4) The number of special trustees appointed under this section is such as the Secretary of State may from time to time determine after consultation with such persons as he considers appropriate.

(5) Special trustees have power to accept, hold and administer any property on trust, being a trust which is wholly or mainly for hospitals for which they are appointed, for all or any purposes relating to:

- (a) hospital services (including research), or
- (b) any other part of the health service associated with hospitals.

(6) The term of office of any special trustee appointed under this section must be fixed by the Secretary of State, but a special trustee may be removed by the Secretary of State at any time during the special trustee’s term of office.

(7) Subsection (3) is subject to sections 213 and 214.

#### **213 Transfers of trust property**

(1) The Secretary of State may, having regard to any change or proposed change—

- (a) in the arrangements for the administration of a hospital or other establishment or facility, or
- (b) in the area or functions of any NHS body other than an NHS foundation trust, by order provide for the transfer of any trust property from any relevant health service body to any other relevant health service body.

(2) In this section “relevant health service body” means—

- (a) an NHS body,
- (b) special trustees, or
- (c) trustees for a Primary Care Trust, an NHS trust or an NHS foundation trust.

(3) Where property is transferred by an order under this section to two or more bodies, it must be apportioned by them in such proportions as they may agree, or as may in default of agreement be determined by the Secretary of State, and the order may provide for the way in which the property must be apportioned.

(4) Where property is so apportioned, the Secretary of State may by order make any consequential amendments of the trust instrument relating to the property.

(5) In this section “special trustees” includes special trustees within the meaning of section 160 of the National Health Service (Wales) Act 2006 (c. 42).

#### **214 Transfer of functions and property to or from special trustees**

(1) If it appears to the Secretary of State at any time that all the functions of any special trustees should be discharged by a Primary Care Trust, an NHS trust, a Special Health Authority or an NHS foundation trust, he may by order provide for the transfer of all trust property from the special trustees to the body or, in such proportions as may be specified in the order, to those bodies.

(2) Before acting under subsection (1) the Secretary of State must consult the special trustees and other bodies concerned.

(3) If it appears to the Secretary of State at any time that—

(a) the functions of any special trustees should be discharged by the trustees for a Primary Care Trust, an NHS trust or an NHS foundation trust (“the trustees of the body”), or

(b) the functions of the trustees of the body should be discharged by special trustees, he may, after consulting the special trustees and the trustees of the body, by order provide for the transfer of all trust property from the special trustees to the trustees of the body, or from the trustees of the body to the special trustees.

(4) Where property is transferred by an order under this section to two or more bodies, it must be apportioned by them in such proportions as they may agree, or as may in default of agreement be determined by the Secretary of State, and the order may provide for the way in which the property must be apportioned.

(5) Where property is so apportioned, the Secretary of State may by order make any consequential amendments of the trust instrument relating to the property.

(6) “Special trustees” includes special trustees within the meaning of section 160 of the National Health Service (Wales) Act 2006.

#### **215 Trustees and property under section 222**

(1) Where property is given in pursuance of section 222 (power of NHS bodies to raise money) to or on trust for any purposes of a hospital for which special trustees have been appointed, the property may be held, administered and applied by the special trustees instead of by the body responsible for the hospital if that body and the special trustees agree.

(2) The body responsible for a hospital is—

(a) in the case of a hospital vested in an NHS trust or an NHS foundation trust, that trust, and

(b) in any other case, the Strategic Health Authority or Primary Care Trust exercising functions of the Secretary of State in respect of the hospital.

(3) Subsection (4) applies where property is given in pursuance of section 222—

(a) on trust for any purposes of a Primary Care Trust for which trustees have been appointed under paragraph 12 of Schedule 3,

(b) on trust for any purposes of an NHS trust for which trustees have been appointed under paragraph 10 of Schedule 4, or paragraph 10 of Schedule 3 to the National Health Service (Wales) Act 2006 (c. 42), or

(c) on trust for any purposes of an NHS foundation trust for which trustees have been appointed under section 51.

(4) Where this subsection applies and the trustees and the Primary Care Trust, NHS trust or NHS foundation trust agree, the property may be held, administered and applied by the trustees instead of by the Primary Care Trust, NHS trust or NHS foundation trust.

(5) Property given in pursuance of section 222 on trust may be transferred by order of the Secretary of State under section 213 or 214 in the same circumstances as other trust property may be transferred under either of those sections.

#### **216 Application of trust property: further provisions**

(1) Any discretion given by a trust instrument to the trustees of property transferred under—

(a) section 24 of the National Health Service Reorganisation Act 1973 (c. 32) (transfer of trust property from abolished authorities),

(b) section 25 of that Act (transfer of trust property held for health services by local health authorities),  
(c) section 92 of the National Health Service Act 1977 (c. 49) (further transfers of trust property),  
or  
(d) section 213 or 214 of this Act,  
is exercisable by the person to whom the property is so transferred and, subject to this section, the transfer does not affect the trusts on which the property is held.

(2) Where—

(a) property has been transferred under section 24 of the National Health Service Reorganisation Act 1973, or section 92 of the National Health Service Act 1977, and

(b) any discretion is given by a trust instrument to the trustees to apply the property, or income arising from the property, to such hospital services (including research) as the trustees consider appropriate

without any restriction on the kinds of hospital services and without any restriction to one or more specified hospitals, the discretion is enlarged so as to allow the application of the property or of the

income arising from the property, to such extent as the trustees consider appropriate, for any other part of the health service associated with any hospital.

(3) Subsection (2) applies on any subsequent transfer of the property under section 213 or 214.

### **217 Trusts: supplementary provisions**

(1) This section applies in relation to—

(a) section 51(1) to (3),

(b) sections 212 to 214,

(c) section 216,

(d) section 218,

(e) section 220,

(f) paragraphs 12 and 13 of Schedule 2,

(g) paragraph 12 of Schedule 3,

(h) paragraph 10 of Schedule 4, and

(i) paragraphs 8 and 9 of Schedule 6.

(2) A provision—

(a) contained in a provision to which this section applies,

(b) for the transfer of any property, includes provision for the transfer of any rights and liabilities arising from that property.

(3) Where a transfer of property by virtue of a provision to which this section applies is of, or includes—

(a) land held on lease from a third party, or

(b) any other asset leased or hired from a third party or in which a third party has an interest, the transfer is binding on the third party notwithstanding that, apart from this subsection, it would have required his consent or concurrence.

(4) “Third party” means a person other than the Secretary of State or an NHS body.

(5) Nothing in a provision to which this section applies affects any power of Her Majesty, the court (as defined in the Charities Act 1993 (c. 10)) or any other person, to alter the trusts of any charity.

(6) Nothing in section 12 of the Finance Act 1895 (c. 16) (which requires certain Acts and certain instruments relating to the vesting of property by virtue of an Act to be stamped as conveyances on sale) applies to—

(a) a provision to which this section applies, or

(b) an order made in pursuance of any such provision.

(7) Stamp duty is not payable on an order falling within subsection (6)(b).

### **218 Private trusts for hospitals**

(1) Subsection (2) applies where the terms of a trust instrument authorise or require the trustees, whether immediately or in the future, to apply any part of the capital or income of the trust property for the purposes of any health service hospital.

- (2) The trust instrument must be construed as authorising or requiring the trustees to apply the trust property to the like extent, and at the like times, for the purpose of making payments, whether of capital or income, to the appropriate hospital authority.
- (3) Any sum paid to the appropriate hospital authority must, so far as practicable, be applied by it for the purpose specified in the trust instrument.
- (4) “The appropriate hospital authority” means—
- (a) where special trustees are appointed for the hospital, those trustees,
  - (b) where the hospital is managed by, and trustees have been appointed for, an NHS trust, an NHS foundation trust or Primary Care Trust, the trustees,
  - (c) where the hospital is managed by an NHS trust, an NHS foundation trust or Primary Care Trust and neither paragraph (a) nor paragraph (b) applies, the NHS trust, NHS foundation trust or Primary Care Trust, and
  - (d) in any other case, the Strategic Health Authority or Special Health Authority exercising functions of the Secretary of State in respect of the hospital, or the Special Health Authority or Local Health Board exercising functions of the Welsh Ministers in respect of the hospital.
- (5) Nothing in this section applies to property transferred under section 24 of the National Health Service Reorganisation Act 1973.
- (6) In this section—
- “health service hospital” includes such a hospital within the meaning of section 206 of the National Health Service (Wales) Act 2006 (c. 42), and
  - “special trustees” includes special trustees within the meaning of section 160 of that Act.

### CHAPTER 3

#### PROPERTY TRANSFERRED UNDER THE NATIONAL HEALTH SERVICE ACT 1946

##### **219 Transferred property free of trusts**

- (1) All property vested in the Secretary of State in consequence of the transfer of that property under section 6 of the National Health Service Act 1946 (c. 81) (transfer of hospitals) is vested free of any trust existing immediately before that transfer.
- (2) The Secretary of State may use any such property for the purpose of any of his functions under this Act, but he must so far as practicable secure that the objects for which any such property was used immediately before that transfer are not prejudiced by the exercise of the power conferred by this subsection.

##### **220 Trust property previously held for general hospital purposes**

- (1) This section applies to property—
- (a) transferred under section 23 of the National Health Service Reorganisation Act 1973 (c. 32) (winding-up of hospital endowment funds), or
  - (b) transferred under section 24 of that Act (transfer of trust property from abolished authorities) and which immediately before the day appointed for the purposes of that section was, in accordance with any provision contained in or made under section 7 of the National Health Service Act 1946, applicable for purposes relating to hospital services or relating to some form of research, including any such property which has been further transferred under section 92 of the National Health Service Act 1977 (c. 49).
- (2) This section continues to apply to any such property after any further transfer under section 213 or 214.
- (3) The person holding the property after the transfer or last transfer must secure, so far as is reasonably practicable, that the objects of any original endowment, and the observance of any conditions attached to that endowment, including in particular conditions intended to preserve the memory of any person or class of persons, are not prejudiced by this Part of this Act.
- (4) “Original endowment” means a hospital endowment which was transferred under section 7 of the National Health Service Act 1946 (c. 81) and from which the property in question is derived.

(5) Subject to subsection (3), the property must be held on trust for such purposes relating to hospital services (including research), or to any other part of the health service associated with any hospital, as the person holding the property considers appropriate.

(6) Where the person holding the property is a body of special trustees, the power conferred by subsection (5) must be exercised as respects the hospitals for which they are appointed.

### **221 Voluntary hospitals**

(1) Subsection (2) applies where—

(a) any hospital provided by the Secretary of State in accordance with this Act was a voluntary hospital transferred by virtue of the National Health Service Act 1946, and  
(b) the character and associations of that hospital before its transfer were such as to link it with a particular religious denomination.

(2) Regard must be had in the general administration of the hospital to the preservation of that character and those associations.

## **CHAPTER 4 RAISING MONEY**

### **222 Power to raise money**

(1) This section applies to any NHS body other than a Local Health Board.

(2) A body to which this section applies has power to engage in activities intended to stimulate the giving (whether on trust or otherwise) of money or other property to—

(a) assist the body in providing or improving any services or any facilities or accommodation which is or are, or will be, provided as part of the health service, or  
(b) assist it in connection with its functions with respect to research.

(3) Subject to any directions of the Secretary of State excluding specified descriptions of activity, the activities authorised by this section include—

(a) public appeals or collections,  
(b) competitions,  
(c) entertainments,  
(d) bazaars,  
(e) sales of produce or other goods, and  
(f) other similar activities.

(4) The activities may involve the use of land, premises or other property held by or for the benefit of the body exercising the power.

(5) Subsection (4) is subject to any restrictions on the purposes for which trust property may be used.

(6) Subject to this section and section 215, the body at whose instance property is given in pursuance of this section must, after defraying out of it any expenses incurred in obtaining it, hold, administer and apply the property on trust for or for the purpose for which it was given.

(7) Where property held by a body under this section is more than sufficient to enable the purpose for which it was given to be fulfilled, the excess is applicable, in default of any provision for its application made by the trust or other instrument under or in accordance with which the property comprising the excess was given, for such purposes connected with any of the functions of the body as it considers appropriate.

(8) Where property held by a body under this section is insufficient to enable the purpose for which it was given to be fulfilled the body may apply so much of the capital or income at its disposal as is needed to enable the purpose to be fulfilled.

(9) Subsection (8) is subject in the case of trust property to any restrictions on the purpose for which the trust property may be applied and, in the case of money paid or payable by the Secretary of State under section 224 or 226, to any directions he may give.

(10) Where the capital or income applicable under subsection (8) is insufficient or is not applied to enable the purpose to be fulfilled, the property held by the body is applicable, in default of any provision for its application made by the trust or other instrument under or in accordance with

which the property was given, for such purposes connected with any of the functions of the body as it considers appropriate.

(11) Where under subsection (7) or (10) property becomes applicable for purposes other than that for which it was given the body applying the property must have regard to the desirability of applying it for a purpose similar to that for which it was given.

(12) References in this section to the purposes for which trust property may be used or applied include, in the case of trust property which has been transferred under section 213 or 214, references to those purposes as enlarged by section 216.

**The following provisions confer powers and duties to specified NHS bodies in the relevant sections of the 2006 NHS Act (excluding those to be abolished in 2013)**

## **NHS Trusts**

### **Paragraph 10 of Schedule 4 to the 2006 NHS Act** *Trust funds and trustees*

- (1) The Secretary of State may by order provide for the appointment of trustees for an NHS trust to hold property on trust—
- (a) for the general or any specific purposes of the NHS trust (including the purposes of any specific hospital or other establishment or facility at or from which services are provided by the NHS trust), or
  - (b) for any purposes relating to the health service.
- (2) An order under sub-paragraph (1) may—
- (a) make provision as to the persons by whom trustees must be appointed and generally as to the method of their appointment,
  - (b) make any appointment subject to such conditions as may be specified in the order (including conditions requiring the consent of the Secretary of State),
  - (c) make provision as to the number of trustees to be appointed, including provision under which that number may from time to time be determined by the Secretary of State after consultation with such persons as he considers appropriate, and
  - (d) make provision with respect to the term of office of any trustee and his removal from office.
- (3) Where under sub-paragraph (1) trustees have been appointed for an NHS trust, the Secretary of State may by order provide for the transfer of any trust property from the NHS trust to the trustees.

### **Paragraph 14 of Schedule 4 to the 2006 NHS Act**

- (1) An NHS trust may do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions.
- (2) In particular it may—
- (a) acquire and dispose of property,
  - (b) enter into contracts, and
  - (c) accept gifts of property (including property to be held on trust, either for the general or any specific purposes of the NHS trust or for any purposes relating to the health service).
- (3) The reference in sub-paragraph (2)(c) to specific purposes of the NHS trust includes a reference to the purposes of a specific hospital or other establishment or facility at or from which services are provided by the NHS trust.

## Foundation Trusts

### Section 47 of the 2006 NHS Act

#### *General powers*

- (1) An NHS foundation trust may do anything which appears to it to be necessary or expedient for the purpose of or in connection with its functions.
- (2) In particular it may—
  - (a) acquire and dispose of property,
  - (b) enter into contracts,
  - (c) accept gifts of property (including property to be held on trust for the purposes of the NHS foundation trust or for any purposes relating to the health service),
  - (d) employ staff.
- (3) Any power of the NHS foundation trust to pay remuneration and allowances to any person includes power to make arrangements for providing, or securing the provision of, pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay).
- (4) “The purposes of the NHS foundation trust” means the general or any specific purposes of the trust (including the purposes of any specific hospital at or from which services are provided by the trust).

### Section 51 of the 2006 NHS Act

#### *Trust funds and trustees*

- (1) The Secretary of State may by order provide for the appointment of trustees for an NHS foundation trust to hold property on trust—
  - (a) for the purposes of the NHS foundation trust, or
  - (b) for any purposes relating to the health service.
- (2) The order may—
  - (a) make provision as to the persons by whom trustees must be appointed and generally as to the method of their appointment,
  - (b) make any appointment subject to such conditions as may be specified in the order (including conditions requiring the consent of the Secretary of State),
  - (c) make provision as to the number of trustees to be appointed, including provision under which that number may from time to time be determined by the Secretary of State after consultation with such persons as he considers appropriate,
  - (d) make provision with respect to the term of office of any trustee and his removal from office.
- (3) Where trustees have been appointed for an NHS foundation trust under this section, the Secretary of State may by order provide for the transfer of any trust property from the NHS foundation trust to the trustees.
- (4) Where an NHS trust for which trustees have been appointed under paragraph 10 of Schedule 4 is given an authorisation, the order appointing the trustees has effect as an order under this section.
- (5) “The purposes of the NHS foundation trust” means the general or any specific purposes of the trust (including the purposes of any specific hospital at or from which services are provided by the trust).

## Special Health Authorities

### Paragraph 8 of Schedule 6 to the 2006 NHS Act

A Special Health Authority has power to accept gifts of property (including property to be held on trust, either for the general or any specific purposes of the Special Health Authority or for any purposes relating to the health service).

### Paragraph 9 of Schedule 6 to the 2006 NHS Act

(1) The Secretary of State may by order provide for the appointment of trustees for a Special Health Authority to hold property on trust—

(a) for the general or any specific purposes of the Special Health Authority (including the purposes of any specific hospital or other establishment or facility at or from which services are provided by the Special Health Authority), or

(b) for any purposes relating to the health service.

(2) An order under sub-paragraph (1) may—

(a) make provision as to the persons by whom trustees must be appointed and generally as to the method of their appointment,

(b) make any appointment subject to such conditions as may be specified in the order (including conditions requiring the consent of the Secretary of State),

(c) make provision as to the number of trustees to be appointed, including provision under which that number may from time to time be determined by the Secretary of State after consultation with such persons as he considers appropriate, and

(d) make provision with respect to the term of office of any trustee and his removal from office.

(3) Where under sub-paragraph (1) trustees have been appointed for a Special Health Authority, the Secretary of State may by order provide for the transfer of any trust property from the Special Health Authority to the trustees.

10 (1) The Secretary of State may by order provide for the appointment of trustees for an NHS trust to hold property on trust—

(a) for the general or any specific purposes of the NHS trust (including the purposes of any specific hospital or other establishment or facility at or from which services are provided by the NHS trust), or

(b) for any purposes relating to the health service.

(2) An order under sub-paragraph (1) may—

(a) make provision as to the persons by whom trustees must be appointed and generally as to the method of their appointment,

(b) make any appointment subject to such conditions as may be specified in the order (including conditions requiring the consent of the Secretary of State),

(c) make provision as to the number of trustees to be appointed, including provision under which that number may from time to time be determined by the Secretary of State after consultation with such persons as he considers appropriate, and

(d) make provision with respect to the term of office of any trustee and his removal from office.

(3) Where under sub-paragraph (1) trustees have been appointed for an NHS trust, the Secretary of State may by order provide for the transfer of any trust property from the NHS trust to the trustees.

# NHS Commissioning Board

## **13Y Board's incidental powers: further provision**

The power conferred on the Board by section 2 includes, in particular, power to—

- (a) enter into agreements,
- (b) acquire and dispose of property, and
- (c) accept gifts (including property to be held on trust for the purposes of the Board).

## **SCHEDULE A1 The National Health Service Commissioning Board**

### **Trust funds and trustees**

11

- (1) The Secretary of State may by order provide for the appointment of trustees for the Board to hold property on trust-
  - (a) for the general or any specific purposes of the Board, or
  - (b) for any purposes relating to the health service in England.
- (2) An order under sub-paragraph (1) may-
  - (a) make provision as to the persons by whom trustees must be appointed and generally as to the method of their appointment,
  - (b) make any appointment subject to such conditions as may be specified in the order (including conditions requiring the consent of the Secretary of State),
  - (c) make provision as to the number of trustees to be appointed, including provision under which that number may from time to time be determined by the Secretary of State after consultation with such persons as the Secretary of State considers appropriate, and
  - (d) make provision with respect to the term of office of any trustee and his or her removal from office.
- (3) Where trustees have been appointed by virtue of sub-paragraph (1), the Secretary of State may by order provide for the transfer of any trust property from the Board to the trustees.

# Clinical Commissioning Groups

## **SCHEDULE 1A Clinical Commissioning Groups**

### **Trust funds and trustees**

15

- (1) The Secretary of State may by order provide for the appointment of trustees for a clinical commissioning group to hold property on trust-
- (a) for the general or any specific purposes of the group, or
  - (b) for any purposes relating to the health service in England.
- (2) An order under sub-paragraph (1) may-
- (a) make provision as to the persons by whom trustees must be appointed and generally as to the method of their appointment,
  - (b) make any appointment subject to such conditions as may be specified in the order (including conditions requiring the consent of the Secretary of State),
  - (c) make provision as to the number of trustees to be appointed, including provision under which that number may from time to time be determined by the Secretary of State after consultation with such persons as the Secretary of State considers appropriate, and
  - (d) make provision with respect to the term of office of any trustee and his or her removal from office.
- (3) Where trustees have been appointed by virtue of sub-paragraph (1), the Secretary of State may by order provide for the transfer of any trust property from the clinical commissioning group to the trustees.

### **Incidental powers**

20

- The power conferred on a clinical commissioning group by section 2 includes, in particular, power to-
- (a) enter into agreements,
  - (b) acquire and dispose of property, and
  - (c) accept gifts (including property to be held on trust for the purposes of the clinical commissioning group).