



# **Review of the regulation and governance of NHS Charities**

## **Summary Report**

**October 2012**

**DH INFORMATION READER BOX**

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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>
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<b>For Recipient's Use</b>	

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## Introduction

1. NHS charities are charities that are linked directly to NHS bodies<sup>1</sup>. They are bound both by charity law and by NHS legislation. The latter enables NHS bodies to hold property on trust (usually charitable property), defines their purpose or objects, and gives the Secretary of State various powers including to appoint trustees to NHS bodies and to transfer funds between them in certain circumstances. As such, NHS Charities are distinct from independent charities established solely under charity law. References in this report to 'NHS Charities' are to NHS bodies acting as the corporate trustee and to bodies of trustees appointed for NHS bodies.
2. NHS Charities' funding supports innovation and research and enables the provision of additional facilities, services and equipment that enhance patient experience. As well as raising their own funds, they also have a special role as the automatic recipients of money the public may donate to an NHS body to express gratitude for the quality of care they have received, or out of a desire to improve local services.
3. A number of NHS Charities and their representative bodies and interest groups have called for reform. They raised concerns that the NHS legislative framework, and how it is applied, limits these charities' freedom to grow and best support their beneficiaries. The issue of Ministerial involvement in particular may be controversial with donors and the public, and could be seen to cut across the independence of charities that is required by law.
4. Ministerial and departmental considerations also prompted the review. The Government is committed to reducing regulation, to promoting localism and the Big Society, and also to freeing the NHS from central government controls. The Department of Health needs to take appropriate opportunities to manage with reduced resources.
5. Formal Terms of Reference are provided at Annex A. The review has considered all aspects of the current regulation and governance of NHS Charities, and what the future system should look like. We have gathered input and ideas from a range of NHS Charities and their representative groups, and met individually with NHS bodies. We worked closely with the Charity Commission to ensure that proposals are consistent with its perspective as sector regulator, and its future role and resources as well as their advice on compliance with charity law. We also engaged with the Cabinet Office and Law Commission, which are each undertaking or planning to undertake separate reviews of charity legislation.
6. This is a Summary Report that sets out: context and background (Part 1); the main issues identified with current policy (Part 2); analysis of the preferred policy option (Part 3); and conclusions and proposed next steps (Part 4). The Summary Report is backed by a full Review Report and further background material.

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<sup>1</sup> From April 2013, these will comprise NHS Trusts, NHS Foundation Trusts, Special Health Authorities, the NHS Commissioning Board and Clinical Commissioning Groups.

## Part 1 – Context and background to NHS Charities

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

7. Before the establishment of the NHS, many hospitals and other healthcare services were organised on a charitable basis, with their property and assets held in charitable trusts. The National Health Service Act 1946 transferred virtually all existing 'voluntary hospitals' to the Minister of Health, 'free of trusts', meaning property previously held on charitable trust ceased to be charitable property.
8. This Act also gave hospital boards the power to accept further trust property (cash, investments, endowments, equipment, land and buildings), and gave the Minister of Health power to appoint the hospital boards as trustee to hold this property for charitable purposes. These assets were to be held for purposes relating to hospital services, or for any other part of the health service associated with any hospital. NHS legislation from then on has provided various NHS bodies with the power to receive, hold and manage charitable property.

### **Current legislative basis of NHS Charities**

9. The National Health Service Act 2006 (which is a consolidating enactment) gives NHS bodies<sup>2</sup> 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 extends the powers to hold property on trust to the NHS Commissioning Board and Clinical Commissioning Groups (CCGs). It also provides for the abolition of Strategic Health Authorities (SHAs), Primary Care Trusts (PCTs) and NHS trusts and the repeal of the provisions within the 2006 Act that relate to them (including any powers they have relating to trust property), although the abolition of NHS Trusts will take place at some time later than 2013.
10. The default position for NHS Charities is that property is held on trust by the NHS body itself acting as a corporate trustee. However, the Secretary of State has the power to appoint special trustees or bodies of individual trustees to NHS bodies. These bodies of trustees have the power to accept gifts of trust property on the same terms as the NHS body.
11. The powers described above form the statutory basis for all 'NHS Charities'. Any written governing documents of the charities simply re-state the statutory provisions in respect of the purposes for which property may be held and dealt with, and cannot be amended in their own right.

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<sup>2</sup> NHS Trusts and FTs, SHAs, PCTs and Special Health Authorities, Clinical Commissioning Groups and the Commissioning Board

## Who are the beneficiaries of NHS Charities?

12. As NHS Charities' remit to hold property on trust is derived from statute, in effect this defines the charities' beneficiaries. The statutory remit for NHS trusts is:

to accept gifts of property (including property to be held on trust), **for the purposes of the NHS body** or for any purposes relating to the **health service**). There is some variation in the scope of the purpose for which property can be held for different NHS bodies. Further detail is provided in the following section and in the full review report.

13. The beneficiaries of NHS Charities are therefore NHS patients, not the charities' linked NHS bodies. Furthermore, the statutory remit means that donations paid to an NHS Charity, unless specified by the donor as being for that NHS body, are held to benefit patients of the whole of the NHS. In practice though it is recognised that donors are giving to support their local hospital or a particular service rather than giving to a named charity. Although their donations may be technically available to benefit patients across the wider NHS (depending on how the donation is framed), NHS Charity trustees normally choose to give priority to local needs and in particular through the vehicle of their linked NHS body.

## Main governance models of NHS Charities

14. NHS legislation determines an NHS Charity's governance model or how its trusteeship is arranged. There are four possible options:

- ***Corporate trustee***

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. Under this model, the directors act collectively as trustee for charitable property given to that organisation. It is permissible under charity legislation but much rarer in mainstream charities. NHS bodies acting as corporate trustee are required under charity law to act as an independent trustee would – solely in the interests of the charity and its beneficiaries (patients), and not in the potentially different interests of the organisation.

- ***Appointed bodies of individual trustees***

The 1990 National Health Service and Community Care Act made provision for the Secretary of State to appoint, by Order, a body of individual trustees to carry out the trustee function of NHS trusts. This provision is now replicated in the 2006 NHS Act and has been extended to other NHS bodies eg FTs, SpHAs. Once in post, the trustees are answerable to the Charity Commission and not to the linked NHS body. The Department's policy has been to appoint bodies of trustees at the request of NHS Trusts or Foundation Trusts, but only where significant charitable assets is held which justifies the engagement of independent people with expertise in charitable activities and financial management. Secretary of State previously delegated this power to the Appointments Commission – from October 2012, the NHS Trust Development Authority (NTDA) has taken on this role.

- **Special trustees**

The Secretary of State also retains powers to appoint Special Trustees for certain university hospitals or teaching hospitals. These trustees may only hold property on trust that is wholly or mainly for the hospitals for which they are appointed, and for purposes relating to hospital services or any other part of the health service associated with hospitals. They therefore have a narrower remit than other NHS Charities. Since 1990, most special trustees have been replaced by appointed bodies of individual trustees, and they remain in place for only three Trusts<sup>3</sup>.

- **Company limited by guarantee**

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 NHS Trust,(now Barts Health NHS Trust) and most recently for the Royal Brompton & Harefield Foundation Trust. This is subject to certain conditions such as the Secretary of State retaining the right to appoint the non-executive directors (as he would normally do for appointed trustee bodies). The arrangement enables the charities and their trustees to benefit from limited liability and other commercial freedoms.

15. A small number of NHS Charities are governed by Schemes of the Charity Commission. These reflect the underlying statutory remit of the charity. They are unincorporated and have no limited liability.

16. If an individual NHS body does not have sufficient charitable assets and/or income to manage them on an efficient and effective basis, it may ask the Secretary of State to use his powers to transfer its trust property to the trustees of another NHS body to act on its behalf (this may be referred to as an '**umbrella arrangement**'). The trustee to whom the property is 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**

17. 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, in particular:

- consequent to a change in the arrangements for the administration of a hospital or other establishment or facility
- where there have been a change in the functions of an NHS body other than a Foundation Trust
- where trustees have been appointed
- when specified NHS bodies dissolve.

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<sup>3</sup> Great Ormond Street Hospital, Moorfields Eye Hospital and the Royal Orthopaedic Hospital

18. The Department's position is that NHS legislative provisions 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 full extent of circumstances in which transfers should be made. It would therefore normally refuse such a request unless the circumstances are such that the transfer should go ahead. This is particularly the case where such transfers would have the effect of closing the charity that they have been appointed by the Secretary of State to act as trustee for.
19. 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 for research functions. They can do this by engaging in activities to stimulate charitable giving, such as through public appeals, competitions, sales etc, that provide part of their charitable income stream alongside bequests, donations, and other sources.

### **Charity Law and the mainstream charity sector**

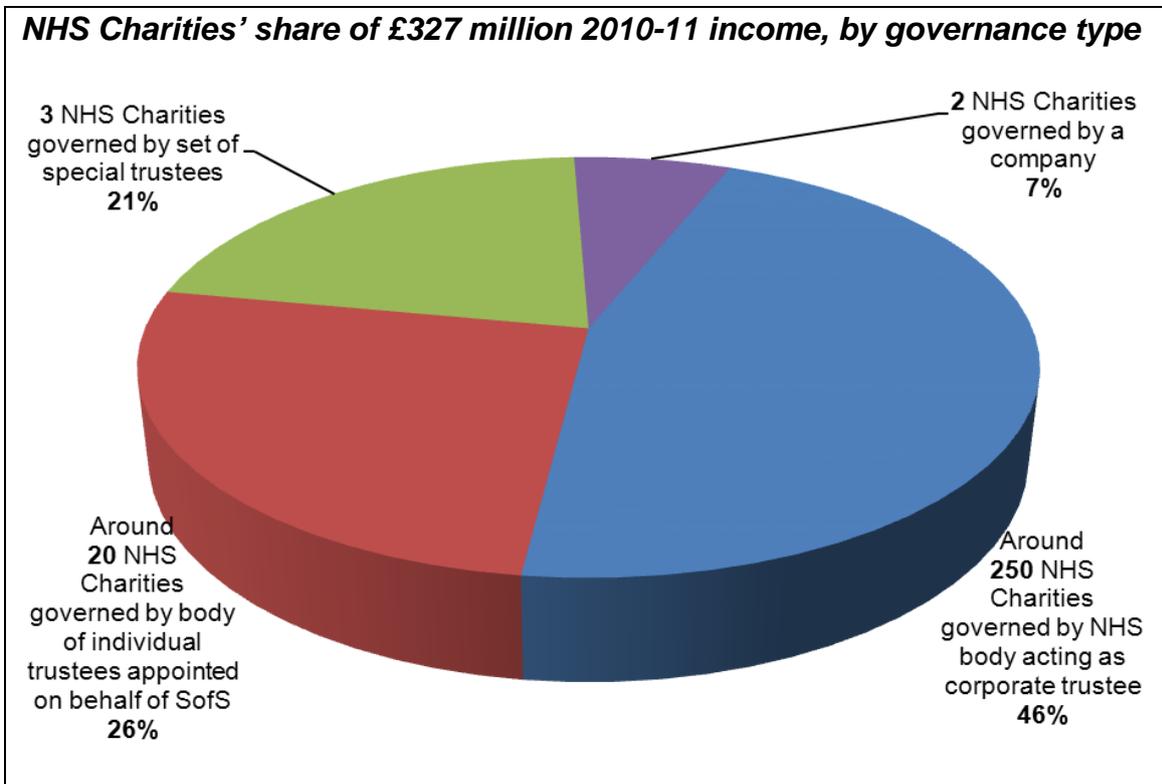
20. NHS Charities are a sub-section of the mainstream charity sector, and are bound by charity law<sup>4</sup> as well as by the NHS Act 2006. To be a charity, an organisation must be established for exclusively charitable purposes and must operate for public benefit. For a body to be a charity it must be independent; it must exist only in order to carry out its charitable purposes and not for carrying out the policies or instructions of another body. The full Review Report provides further detail on the legal, governance and financial framework of charities in England & Wales.
21. There are a number of charities working to support NHS patients that 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 independent charities outside the NHS Charities framework to raise funds, often as a specific appeal. The Air Ambulance movement is just one example of independent charities outside NHS legislation working effectively with NHS bodies to benefit NHS patients.
22. When any charity is formed, its governing document sets out the charity's purposes and how it is to be administered. Trustees are able to choose a charity structure appropriate to the size and character of the charity. Large and complex charities that may be exposed to higher levels of risk 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 a simple unincorporated trust with a couple of trustees is sufficient. Due to the overlaying constraints of NHS legislation, NHS Charities are less able to adapt their structure and governance to this extent.

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<sup>4</sup> As set out in the Charities Act 2011, which consolidated earlier Acts of 1993 and 2006 (though note that certain parts of the Charities Act 2006 remain in force).

## NHS Charities' income and assets

23. In 2010/11, there were around 280 NHS Charities. This number is currently reducing as PCTs 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. Annual accounts show 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>5</sup> accounted for over a third of the total, the top 15 for over half, and the top 30 for over two-thirds.
24. Great Ormond Street Hospital Children's Charity, has the largest income – £64 million in 2010-11, equivalent to around 20% of the Trust's income from the NHS budget – its income is greater than the next four largest NHS Charities combined.
25. The Christie Hospital Charitable Fund is by some margin the largest NHS Charity where the linked NHS body acts as corporate trustee. In 2010-11 it raised £12.6 million in charitable donations. The Charity works in close partnership with its linked NHS body, but given the scale of grant making decisions the Trust has had to establish robust controls to mitigate the risk of any conflict of interest.



<sup>5</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.

26. 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 – over £500m, much of the wealth dating back to the 1700s – and earns significant investment income.
27. At the other end of the scale, around 220 NHS Charities reported annual income of less than £1m. 169 of them have income less than £500,000. The 50 smallest registered NHS Charities have an average annual income of less than £10,000. Most of these are governed by PCTs acting as corporate trustee so will close by April 2013, with assets and funds transferred mainly to NHS providers' charities. In the mid-range, around 40 NHS Charities reported income in 2010-11 of between £1m and £3m.
28. A few NHS Charities are perceived to be national or regional rather than local organisations, and may have a highly professional fundraising operation. This is particularly the case for those focusing on areas such as children and cancer, where the potential donor base is large. However, even the largest NHS Charities are small in comparison with well-known mainstream health charities.
29. Overall, the NHS Charities sector is less developed in its marketing and fundraising strategies than mainstream comparators. Most NHS Charities are local in scope and outlook, and many do not engage in much if any active fundraising but rely on bequests in wills from former patients.
30. When set against NHS budgets, it is clear that many NHS Charities are viewed by NHS bodies as insignificant (only a handful raise funds equivalent to more than 1% of the income of their linked NHS body). However, the assets held income and by NHS Charities are by no means inconsequential.

### **NHS Charities' expenditure and exchequer funding**

31. NHS bodies themselves are emphatically not the beneficiaries of NHS Charities. However, most NHS Charities focus their provision of support to their beneficiaries via their own linked NHS body. There is clearly a convergence of aims. A recent review of NHS Linked Charities<sup>6</sup> in the context of the government accounting framework found that the charitable funding provided by NHS Charities can in effect replace exchequer funds, and is a source of "substitutionary funding".
32. 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 to emphasise that their funding enables the provision of facilities, services and equipment over and above those provided by NHS 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 right that should not need supplementing with charitable funds.

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<sup>6</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)

33. 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 for decision making by trustees if they wish to spend in areas normally or previously paid for from exchequer funds.
34. However, these sensitivities have been impacted by recent government financial accounting decisions. The Office of National Statistics 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. A separate decision, to apply International Accounting Standards to the NHS, means that 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. These new requirements and their implications are set out in Annex B.

### **Reviews of charity legislation**

35. Lord Hodgson of Astley Abbotts 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.
36. The review reported in July 2012 and is available through the Cabinet Office website<sup>7</sup>. The Government is expected to respond to the review's recommendations later this year. Whilst the review did not make any recommendations specifically about NHS charities, many of its recommendations will be relevant to them. 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.
37. The Public Administration Select Committee (PASC) is undertaking its own inquiry into charity regulation and the Charities Act 2006<sup>8</sup>, following on from Lord Hodgson's review, which is expected to report in early 2013.
38. 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).

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<sup>7</sup> <http://www.cabinetoffice.gov.uk/sites/default/files/resources/Review-of-the-Charities-Act-2006.pdf>

<sup>8</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/>

## Part 2 – Issues and problems with NHS Charities policy

### Differences between NHS Charities and mainstream charities

39. First, it is helpful to note that a number of factors mark out NHS Charities as distinct from mainstream charities:

Mainstream charities	NHS Charities
Established under standalone written governing document, specific to the charity. Governing document sets out the charity's objects (the goal, aims or ends for which the charity exists).	Established under NHS legislation. Any written governing document merely re-states NHS legislation. Objects are limited to those set out in NHS legislation.
Highly unusual to be subject to the power of a public body to transfer funds away from current trustees.	Secretary of State for Health has statutory power to transfer funds from current trustees to the trustees of other NHS bodies in specified (limited) circumstances.
Trustees are able to review their activities and purposes, and decide to update them if in interests of beneficiaries to do so.	Trustees cannot modify objects, as objects defined in statute.
Governing documents usually set out how trustees are to be appointed and the normal length of service. Norm is for existing trustees to have responsibility for appointing new trustees.	Cannot change trustee arrangements beyond those established by NHS legislation; SofS has statutory role in appointing and removing trustees and trustees cannot self-appoint.
Can opt for one of a range of legal models, including charitable Company Limited by Guarantee.	NHS Charities are unincorporated trusts and do not have own legal personality; unlimited liability for trustees (unless they are companies appointed as trustees).
Must prepare accounts within the Charity Commission's recommended accounting framework. Accounts exist on a standalone basis.	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.
Corporate trustee model permissible but rare, and presents governance challenges.	Corporate trustee model the 'default setting'.
Able to transfer funds (up to and including the full balances) to other charitable and non-charitable bodies by way of grant.	Transfer of funds is usually by Secretary of State Order. Where the effect of transfer would be to move trusteeship outside the NHS, it is outside the scheme set out in NHS legislation. DH must be consulted and may exceptionally agree.

## Dual regulation

40. NHS Charities must conform to Charity law, but NHS legislative provisions relating to transfers of funds and appointment of trustees are an additional layer of regulation. NHS Charities are effectively accountable to two regulators (the Charity Commission and Department of Health). Anecdotal evidence from NHS Charities suggests that the interplay of NHS legislation, charity law and the policy role of the Department of Health is the cause of significant confusion. Dual regulation creates a layer of bureaucracy for all parties. We estimate the policy, finance and legal costs to DH alone as being in excess of £100,000 per year.
41. NHS Charities' current special status and dual regulation is a result of history – in the 1940s, before the development of charity law and effective regulation of the sector there was felt to be a need to involve 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

42. NHS Charities have limited autonomy compared to mainstream charities:
- they are unable to adapt governance arrangements or take up different constitutional forms;
  - NHS Charity trustees are not free to review and seek to update their objects (to the extent permissible under charity law) in response to changes in beneficiary need or the external environment;
  - they cannot transfer funds without DH agreeing and then making the transfer through an Order on behalf of the Secretary of State (assuming the proposed transfer falls within SofS's powers in this regard) - this is not a constraint on their ability to grant (spend) funds but rather on transferring assets for others to spend in the future;
  - such a transfer can usually only take place between NHS bodies and trustees appointed for such NHS bodies – this means that NHS service providers that are not legally 'NHS bodies' cannot usually receive transfers from NHS Charities by Order;

(Where NHS bodies want to transfer funds to other non-NHS bodies and this would change the trusteeship, the Charity Commission practice is to ask for DH consent. This has been granted in exceptional circumstances, but given that the NHS legislation provides the Secretary of State with powers to transfer charitable property between NHS bodies and trustees appointed for them, the view has been taken that Parliament did not intend by the legislation for charitable property to be routinely transferred from NHS bodies to non-NHS bodies)

43. 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 say their freedom to manage the transactions as they would wish is hampered.
44. Because NHS Charities are normally unincorporated trusts with no legal personality, their trustees have unlimited liability. The risks associated with personal liability appear to be a barrier to those NHS Charities with bodies of individual trustees being able to engage trustees with the skill and expertise required. (Limited liability can be achieved through the appointment of a company as trustee as explained in paragraph 39).

### **Inflexibility and bureaucracy of the appointed individual trustee model**

45. If an NHS body acting as corporate trustee wishes for its NHS Charity to be governed by a body of individual trustees, this cannot happen without:
- a. a specific case being put to Ministers that they agree to;
  - b. processing two statutory instruments to appoint the trustees and transfer charitable property to them; and
  - c. engaging the NTDA to recruit and appoint between five and seven trustees.

This process is time consuming and bureaucratic, and there is little flexibility to tailor appointments to the operational needs of different charities.

46. Under current Appointments Commission guidance (now applied by the NTDA), current NHS employees are barred from serving as trustees check still valid. This 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. The corporate trustee is unable subsequently to change the arrangements back again without the same process in reverse (i.e. the order appointing the trustees being revoked after an order transferring the trust property back to the NHS body has been made), backed by a very clear case to do so – something that has never happened.
47. An appointed body of trustees is still unable to take on different legal forms that provide for limited liability. To overcome this, the Department has allowed a charitable Company Limited by Guarantee to be appointed as the sole individual trustee for two charities, but this was an extensive and resource intensive process. Although it would be more streamlined for future requests, each would still require individual case approval, parliamentary (SI) process and formal NTDA appointment process.
48. The new Charitable Incorporated Organisation model being introduced by the Charity Commission has been designed for smaller charities but will not be able to be adopted by NHS Charities without orders being made by the Secretary of State to appoint trustees to NHS bodies in each instance.

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

49. The inflexibility inherent in the current system is particularly problematic when it comes to dealing with changes in the NHS landscape. In the near future all remaining NHS Trusts will become, or merge with an existing, Foundation Trust, or may take on other forms. There will be further plurality of providers, and secondary care commissioning will transfer from PCTs to Clinical Commissioning Groups. The abolition of SHAs & PCTs, NHS Trust mergers and joint ventures all carry with them the associated need to move trusteeship of linked charitable funds (as is the case for their non-charitable property). Under the current system, this would not normally be possible without significant Ministerial involvement, departmental resource and parliamentary process (involving Statutory Instruments or Transfer Orders).
50. NHS Charities can also have difficulty in developing new partnerships. Those 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 that cannot be said to be for the purposes of the health service.

## **Unrealised potential of many NHS Charities**

51. The prevalence of the corporate trustee model can be said to have resulted in many NHS Charities being reactive rather than proactive – receiving money and spending it, with limited strategy for creating new income streams. Representatives of NHS Charities governed by a corporate trustee have told us that their Trusts typically perceive the charity to be a peripheral activity for the Trust Board. They are unable to benefit from both the time and expertise of external people with specialist knowledge of charitable activity such as fundraising and investment management. 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:

“So many NHS Charities are under-achieving [...] The corporate trustee framework has greatly hindered the development of NHS Charities. [...] 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.”

52. In some ways this lack of focus is not surprising; Board members of NHS bodies have other priorities 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.

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

53. NHS bodies are the main vehicle through which NHS Charities meet their charitable objects of supporting NHS patients (which forms part of their object of using funds for the purposes of their linked NHS body or for the

wider health service), so it is crucial that they maintain close links. Consequently, there are some advocates of the corporate trustee model. Some NHS Charities told us they feel that having a corporate trustee reduces the risk of waste or inefficiency in their charitable giving, by ensuring that funds are not spent on inappropriate projects. Some NHS bodies may want to remain as corporate trustee as this allows them to maintain influence on the charity's spending.

54. 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. The distinction between charity and Exchequer funds is not always clear enough, because the Board of the NHS body charged with administering Exchequer funds is the same Board acting as the corporate trustee administering charity funds.
55. There is anecdotal evidence from a number of NHS Charities that some NHS bodies may deal with their linked NHS Charity as if the NHS body itself were the beneficiary of charitable funds (with charitable funds ‘just another cost centre’) rather than the route for the charity to deliver benefit to NHS patients. The result can be spending decisions shaped by the policies and priorities of the NHS body, rather than solely 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 legal duty. As a result, NHS bodies acting as corporate trustees are required to put a lot of effort into demonstrating there is no conflict of interest. The Christie Hospital, which is the largest NHS charity governed by a corporate trustee, maintains comprehensive due diligence processes (see full Review Report for case study) but there is little evidence that such good practice is widely replicated.
56. In the mainstream charity sector, the corporate trustee model is allowed but rare. For the Charity Commission, as regulator, the question of independence is of utmost importance; an organisation that is charitable but is not independently constituted and operable cannot be a charity.

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

57. Any changes to NHS Charities’ 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. However, the Secretary of State’s powers to transfer funds are limited to the circumstances set out in legislation (i.e. broadly when there is a change in the administration of a hospital or other establishment, a change in the functions of an NHS body (other than an FT), or where trustees have been appointed for an NHS body and funds are to be transferred to them). These powers could not be exercised simply because he was minded to do so. In addition, such a transfer would not result in charitable funds becoming government funds; the funds would retain the same objects but would be the responsibility of another NHS Charity.

58. Regardless, these Secretary of State powers can be seen to cut across the independence of charities that is required under charity law, and consequently may influence the public perception of whether NHS Charities are truly independent.

59. Such perceptions may have been exacerbated by recent government accounting decisions that will require many NHS Charities with a corporate trustee to consolidate its accounts into its linked NHS body's accounts from 2013/14, and for all NHS Charities in England to be consolidated within the Department of Health's Resource Account from 2012/13. These changes and their implications are explained further in Annex B.

60. There is evidence that NHS Charities' close links with Government can inhibit NHS Charities' fundraising potential; this appears to be a particular issue for potential major individual donors, large corporate donors or grant-making organisations. One representative of an NHS Charity provided us with written feedback on their view:

"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."

61. The Ministerial role in NHS Charities appears to go against the grain of Government's intentions for a 'hands-off' relationship with the NHS, for localism and for the development of the Big Society. It is hard, from a policy perspective, to find strong counter arguments in support of such active involvement continuing.

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

62. Over the last few years, the Department has been approached by a small but growing number of NHS Charities and their legal advisors, requesting alternative arrangements for trustee appointments and funds transfers that challenge and sometimes go beyond those permissible under NHS legislation.

63. Barts and The London Charity has long argued that perceptions of a lack of independence are an obstacle to fundraising. In 2010, they approached the Department to seek the appointment of a company as a trustee. After extensive legal consideration we agreed to progress this. However, to pursue their independence further, they subsequently used provisions within the Charities Act to apply directly to the Charity Commission requesting it to settle a parliamentary scheme to remove the controls of the Secretary of State for Health. The Commission announced its decision in May 2012, agreeing in part only to the request. The Charity Commission and Cabinet Office will now have to take this forward.

64. In another recent case, an NHS Charity governed by an NHS body acting as corporate trustee has taken its own legal advice to be able to transfer all the NHS Charity's assets, liabilities and functions to an independent charity through a reversible Transfer Agreement and Deed of Covenant. Ordinarily such a transfer would not be permissible but it was lawfully agreed and actioned without reference to the Department.
65. In other instances the Department has been able to agree on an exceptional basis to requests to transfer NHS Charity 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.
66. Each time such requests are made they raise complex legal and policy questions for both the Department and the Charity Commission. Significant resources are required as well as ministerial and parliamentary time for the laying of statutory instruments, just to address the interests of a single NHS body or Charity. The NHS bodies and/or Charities themselves are also expending considerable sums to procure their own legal advice.

### **Conclusion – what do we want to achieve?**

67. We have identified a variety of problems and issues with the current regulatory environment for NHS Charities, which are pressing in the context of the strategic direction and pace of change in the NHS and the need to reduce regulation and public sector costs. There are a number of areas where change would be worthwhile, and there are strong arguments for allowing NHS Charities more scope for flexibility.
68. The fundamental aim of this review, as set out in the Department's business plan, 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].
69. There is no intention to amend NHS Charities' purposes or role, but it is clear that changes could have the potential to improve NHS Charities' ability to achieve their purposes and fulfil that role. Our overarching aim is to develop an enabling environment in which NHS Charities can provide greater benefit and better outcomes for NHS patients by:
- organising themselves in the most appropriate way, taking up more innovative governance models if needed;
  - having a constitutional framework (setting out purposes, powers, objects and governance) 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 include representation from NHS bodies
- having the ability to transfer funds without recourse to Ministerial involvement or statutory 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.

70. There are a number of prerequisites for any changes; they must:

- be scalable and straightforward to implement, without requiring overly costly or onerous transition, 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 their status in the future;
- maintain or enhance donor confidence; and
- eliminate risks of Ministers being perceived to have inappropriate influence or control over the operation of charities and management of their assets.

71. Required actions, in particular any new statutory provisions, to implement the changes will be subject to other legislative and operational priorities within DH and across government.

72. The following pages set out our preferred option for change, which addresses the problems and delivers what we want to achieve, while taking account of the parameters above. This option is not aiming to create new architecture, but can be delivered within existing charity law, which already caters to the needs of all types and sizes of charity.

## Part 3 – Development and consideration of options

### Initial consideration of options

73. The underlying problem is that of dual regulation through both NHS legislation and the Charities Act. The solution therefore has to be based on removing legislative overlaps and the operating constraints that they create. By definition, the Charities Act regulates all registered charities so the choice is whether to remove or amend all or just some NHS legislation.
74. We first considered the option of removing all NHS legislation relating to NHS Charities, at an agreed date in the future (with timing subject to NHS readiness and an available primary legislative vehicle). This would require all 'NHS Charities' to be replaced by independent charities wholly established under, and regulated by, charity law before that date.
75. We have ruled this option out at this time because it would jeopardise the NHS bodies' ability to automatically receive, and pass to their charity, any gifts, legacies and bequests that may be made to the 'NHS body' in the future. This increases the risk of contested wills, and NHS patients losing the chance to benefit from such gifts.
76. In addition, this option is not desirable as some NHS bodies may have good local reasons not to want to change their corporate trustee status. We think most if not all will be attracted over time by the advantages that a more independent relationship would provide so we should persuade such NHS Charities and their linked NHS bodies of the benefits of change, rather than force change on them.
77. It has been noted that the Law Commission intends (from 2013) to review the status of all charities established by statute (those NHS Charities that choose to remain established under NHS legislation would still be classed as such). A possible outcome would be wider government action around 2015 to modify or even abolish them. In that eventuality, the issue of protecting legacies would need to be addressed. The Department, as well as the NHS, would be able to contribute to the review, informed by initial outcomes of our own preferred approach as set out below.

### **Preferred option – remove most NHS legislation including SofS controls, and support early voluntary transition to linked but independent charities**

78. Under this proposal NHS bodies, acting as trustees, would be permitted (but would not be required) to transfer charitable property to any other charity. This would enable them to use a new charity as their charitable vehicle and transfer their current assets to it. The new charity, regulated solely by the Charity Commission, would be free to set its own constitution including objects, legal form and trustee appointments appropriate to its needs.
79. These governance and regulatory changes could take place without any immediate change to current legislative provisions. Subject to prior

agreement, as set out in the following section, we would permit current trustees to use their full powers under the Charities Act to transfer the trusteeship of charitable property to other charities. NHS Act 2006 provisions relating to the transfer of trust property between NHS bodies, and the appointment of trustees for NHS bodies would not be used (unless specific requests were made for the transfer of trust property or for trustees to be appointed by SofS, in which case the use of his powers would need to be considered. These provisions would be repealed at an agreed convenient date in the future (which should be the earliest opportunity available), apart from the provision for NHS bodies to accept and deal with trust property.

80. The transfer of assets to the new charity would not be reversible by the Secretary of State. However, other safeguards could protect the interests of NHS patients and the NHS body, in particular:

- The objects of the new charity would replicate current NHS objects (but could with agreement be broadened to related services)
- The NHS body would input to and approve the new charity's full governing document including trustee arrangements
- The NHS body would need to continue to provide support and patronage including rights to utilise its name, premises and potentially staff – we anticipate that many such agreements would be formalised in the form of a Memorandum of Understanding (MoU), although these would not be regulated by either DH or the Charity Commission.
- Under Charity law, any funds transferred to a new charity must continue to be used solely towards the purposes for which they have been originally received

81. NHS bodies would retain the power in NHS legislation to accept gifts of property to be held on trust, and to hold and deal with trust property, primarily for the purposes of accepting and passing on bequests to the new receiving charity. However, they could use this retained legislative power to continue to act as corporate trustee for all charitable funds, should they so wish. In these circumstances, the charity would remain established under NHS legislation rather than charity law (but other aspects of dual regulation would disappear).

82. NHS bodies and their charities would be briefed on the opportunities provided by the new approach, and guided and supported through the change process. We envisage that the Charity Commission, the Association of NHS Charities and DH could contribute to this support.

83. The differences between current NHS Charities and future independent 'NHS-focused' charities are summarised in the table at Annex C.

## Process for delivering the new model

### *Reviewing the Legal context*

84. Trustees, including NHS bodies as corporate trustees, have powers deriving from the Charities Act. These include powers to transfer assets under their control. However, as already described, 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 while the NHS legislation exists, NHS Charities cannot make such a transfer themselves but should request that the Secretary of State exercises his powers to make the transfer by order (where those powers are applicable). This means, in practice, that they have generally been unable to transfer funds under circumstances that do not fall within Secretary of State's power to transfer charitable property within the NHS or to non-NHS Charities. Ministers have in the past though, on advice, agreed to sanction transfers to charities outside the NHS in exceptional cases where there was a strong operational case (notably in allowing transfers to Air Ambulance charities).
85. The Department's position now is that wider transfers under the Charities Act could be sanctioned as routine rather than exceptional **if** there is a new policy case backed by a clear mandate from appropriate engagement and consultation. This would be secured by proposed consultation that would clarify which of the two statutory regimes that currently conflict (the NHS Act or the Charities Act) should take precedence when considering trustee powers. We could only proceed further if that consultation provided a clear consensus for change – a new policy protocol or 'mandate'.
86. Although we envisage trustees being able in future to make transfers to new trustees outside of the NHS legal framework, a particular problem arises where trustee bodies appointed by Secretary of State want to transfer all of the funds that they were appointed to manage, and consequently make their role obsolete in contravention of the purpose of their appointment. This would, effectively, amount to them disestablishing themselves, whereas given they have been established by an order of the Secretary of State, it is for him alone to disestablish them by revoking their appointment order.
87. To avoid this direct conflict with the NHS Act provisions (until they may be repealed), the Secretary of State must use his powers under the legislation to transfer all property from the trustees to the NHS body, and revoke the order providing for the trustees' appointment. At that point, the Board of the NHS body, acting as a (temporary) corporate trustee, would transfer the property to the new charity under the new policy protocol on transfers.
88. 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.

89. 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).
90. The primary legislation would then need to be amended as soon as possible to remove those provisions, which, as a matter of policy, were no longer being used – removing powers to appoint trustees would be subject to all current trustee bodies having transitioned to independent charity status.

### ***Gaining a mandate for revised legal context***

91. It is proposed that the Government consults on proposed changes to the regulation of NHS Charities, setting out its intention to create a permissive, enabling regime with no planned exercise of the Secretary of State's powers to transfer property between NHS bodies or appoint trustees for NHS bodies. The consultation would also set out the proposed safeguards to preserve the interests of patients and the NHS bodies through whom they benefit. This might include some broad principles around NHS centred objects. It would also establish a process whereby NHS bodies would establish new charities.
92. The consultation would also set out that Government had relaxed its interpretation of NHS legislation relating to NHS Charities, and intends 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 in accordance with the proposed enabling regime.
93. A clear positive response to the consultation, combined with the Government response and a statement to Parliament 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 relevant provisions of the legislation, as well as mitigating the identified legal risk.

### ***Establishing the new charities***

94. Following the mandate, NHS bodies would be able to discuss and agree themselves or with other interested parties, the appropriate form of a new charity and all details of its governance. Those NHS bodies whose charities already have appointed bodies of individual trustees would hold these discussions with the current trustees. Those operating as a corporate trustee may identify partners or advisors to assist them. All would be recommended to seek their own specialist legal advice.
95. Following agreement, the new charities would be registered with the Charity Commission and initial appointments made by locally determined process

96. An agreement (MoU) may also be established with the linked NHS body to formalise the relationship between the two bodies.
97. The NHS body acting as corporate trustee would then use its own powers under charity law to transfer all existing assets to the new charity. This transfer would be approved by the Charity Commission as long as it conformed to the new ministerial mandate.
98. However, in the case of appointed trustee bodies it would be for the Secretary of State to revoke the Order providing for their appointment and transfer the property from the trustees back to the NHS body. It would then be for the NHS body corporate trustee to make the transfer to the new charity. This would only be done with the prior and binding agreement of both parties to the full transfer process.
99. There are handling and presentational risks in this approach, in particular if the Secretary of State was perceived, albeit temporarily, to be 'reclaiming' charitable assets for his own purposes. However, such a process, would give the NHS body an additional safeguard by having the final say in a transfer of what could be substantial assets and funds that could only be revoked in the future with the consent of the new charity to which they had been transferred.
100. Remaining NHS Charities governed by an NHS body still acting as corporate trustee would be able to continue in existence should they choose not to transfer funds to an independent charity. They would not be able to request that the Secretary of State appoint trustees once the legislation was repealed – they could whilst it remains (although they may guided instead to use a new charity to achieve this). Nor would they be able to take on new limited liability legal forms or broaden their objects. They may also have to consolidate the accounts of the NHS Charity into Trust accounts.
101. The full process for delivering the change proposal is shown in diagram form in Annex D. We anticipate that the full process for an NHS body to transfer all of its charitable funds to an outside charity may take around six months but this will vary depending on the complexity of new arrangements. The process may be quicker where existing trustee bodies themselves become the trustees of the new charity.

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

102. 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. We would however encourage those seeking to establish trustee bodies to pursue this through the new route).

103. 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. In doing so, they would not be bound by current requirements to limit such transfers to between NHS bodies.

104. 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 for consultation and implementation***

105. 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
Assuming positive response to consultation, granting clear mandate for action, prepare and publish Department response including final mandate	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 the earliest opportunity in future, whenever suitable legislative vehicle becomes available #

# It may not be necessary to wait for a Health Bill as this could be achieved through charity legislation. Either the Cabinet Office review of the Charities Act, or the Law Commission review could result in a Charities Bill in the next few years.

## **How does the proposal meet key concerns and objectives?**

### ***Protecting the relationship between NHS bodies and linked charities***

106. Some NHS bodies have concerns that more ‘independent’ charities risk weakening their status as the ‘principal beneficiary’ of the charity (or more accurately the body whose patients are the principal beneficiary). But we see NHS bodies as having considerable influence, without that influence representing ‘control’ that would jeopardise the charity’s independence:

- They will be able to negotiate appropriate formal representation of their employees on the new trustee body, (although such trustees would have an overriding duty to act solely in the interests of the charity and its beneficiaries)
- They could also negotiate the overall objects and strategy of the new charity, and the charity’s use of their premises, branding and/or staff through a Memorandum of Understanding or similar agreement.
- Most significantly they would be responsible for effecting the initial transfer of funds, which they would withhold unless satisfied with the negotiated future working arrangements
- In the highly unlikely event of a future relationship breaking down they may establish a new agreement with a different charity (although they would not be able to recover any previously transferred funds)

### ***Realising the full potential of NHS Charities.***

107. 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. They would be encouraged to act to open up the opportunity for their charity to benefit from a Board composed of experienced, committed trustees, alongside employees of the NHS body who together could deliver a more effective charitable strategy.

108. The proposed option would also enable the new, independent NHS-focused charities the opportunity to develop partnerships and work more flexibly. Several separate NHS Charities could 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, including specialist healthcare, local community or regionally focused.

109. The ability to take a legal form that provides for limited liability could enable more and better trustees to be attracted, and these trustees could include representatives from NHS bodies. The removal of ministerial influence would engender perceptions of this increased independence from government that may encourage new donors and increase their fundraising potential, and as a result their ability to deliver the best outcomes for NHS patients.

### ***Addressing financial reporting issues***

110. NHS bodies acting as corporate trustee will more easily be able to establish an independent charity whose income and assets would not have to be consolidated. NHS bodies that decide to remain as a corporate trustee would be required to consolidate charitable funds, if those charitable funds meet the materiality threshold. In practice, we would expect that few if any NHS bodies would have to consolidate accounts after 2014 at the latest.
111. The implications of the ONS reclassifying NHS Charity funds to the central government sector affect all current NHS Charities, not just those governed by an NHS body acting as corporate trustee. However, charities established under the new framework would not fall within the ONS criteria. Consequently if, as we expect, all larger charities in time move to the new model, the requirement to consolidate charities into the Department of Health resource accounts may fall away.

### ***Meeting government objectives***

112. The new policy also would, when fully implemented, remove all Ministerial responsibilities in appointments and transfers, returning these powers to the front line and supporting key aims of deregulation, localism and NHS autonomy. Such responsibilities would be removed at the point of transfer for those NHS bodies that choose to manage their charitable interests through an independent charity. For those that retain the corporate trustee model, the statutory regime will, until repealed, still be relevant so some circumstances for ministerial involvement may arise.
113. If most NHS bodies use new charities, it would reduce if not fully remove the risks of NHS bodies having to consolidate charitable funds in their accounts, and for the Department to report them as part of NHS accounts. This would mitigate the significant risk of further negative media reporting and accusations of ministers 'taking control' of charitable funds.
114. 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.

### ***Reducing public sector resources and costs***

115. Both the Department of Health and the Charity Commission would be able to make efficiencies through not needing to maintain the current level of support for NHS Charities. Resource requirements may be expected to reduce once a substantial number of NHS bodies choose to manage their charitable interests through an independent charity, and fully once the legislation has been repealed. DH savings would include legal, policy and accounting functions as well as parliamentary costs. There would also be minor savings, as the NHS Trust Development Authority would no longer be required to appoint trustees on behalf of the Secretary of State.

## **Equality Duty**

116. A full consideration of equality is provided in the full report. In summary:
- d. 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.
  - e. 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.
  - f. 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.
  - g. 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.
117. 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.

## **Legal Risk**

118. The proposal is predicated on the ability to act in advance of repealing legislation by promoting a new interpretation of that legislation relating to NHS Charities, endorsed by a positive response to a consultation. We will only proceed if the response to the consultation is overwhelming positive.
119. The risk of legal challenge cannot be ruled out. This would be on the basis that 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:
120. 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.
121. 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.
- On balance, we consider that such a challenge would be unlikely.

## **Other Potential Issues**

122. There would be an initial higher workload for the Department to deliver the proposed consultation and to facilitate the requisite Orders for charities currently governed by bodies of individual trustees appointed by the Secretary of State. In addition, NHS bodies and Charities may need support and guidance to understand the options available to them.
123. NHS bodies whose future legacies and bequests exceed £5,000 a year will still need to register as a charity with the Charity Commission. This could be burdensome in terms of ongoing financial reporting, and the Charity Commission is not generally in favour of this. We will explore with the Commission whether it could waive the requirement to register a charity for those NHS bodies merely acting as post boxes.
124. Independent charities would usually employ their own staff. There may be implications for current staff on NHS conditions including pensions that would need to be addressed locally. These different situations already arise at some of the larger NHS Charities.
125. 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.

## Part 4 – Conclusion and next steps

126. This review has identified and documented a number of significant issues and problems related to the current system of governance of NHS Charities. While individually some of these could be addressed within the current regulatory regime, collectively they provide a compelling case for reform. The proposed solution 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. If sufficient NHS bodies and linked charities take advantage of the new framework, overall charitable support for NHS patients could be expected to grow.
127. Liberalising the framework in this way, 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, aspirations and charitable purposes.
128. This option envisages that NHS Charities would transition to the new model before the NHS legislation was repealed (it could take several years for a primary legislative vehicle to be available), because:
- responding to the charities’ calls for change would send a signal of the Government’s commitment to deregulation and localism;
  - acting swiftly would avoid the need for the Department to deal with burdensome requests to amend charities’ governance or transfer charitable funds as a result of changes in the NHS landscape.
  - it will enable those charities that wish to make changes that will improve the scope and scale of their fundraising to do so promptly
  - where independent charities are established there would no longer be a requirement for accounts to be reported on a consolidated basis
129. As part of the stakeholder engagement undertaken in this review we have tested the principles of our preferred option with a number of NHS Charities, and a range of NHS bodies, covering different sizes and types of charity. We have received a very positive response. The Association of NHS Charities and the Charity Commission are also strongly supportive.
130. Our proposals are consistent with the recommendations of Lord Hodgson’s recent review of the Charities Act for charities including the principle of the independence of charities. The forthcoming further review by the Law Commission may prompt the need for further consideration of any remaining NHS Charities operating as corporate trustees under statute, but no direct action is expected before 2015 if at all.
131. Assuming a positive consultation response, the NHS bodies and Charities that decided together to move to the new framework should then be able to do so from spring 2013.

## **Annex A – Review aim and terms of reference**

### **Review aim**

The fundamental aim of this review 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.

## Annex B – 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>9</sup>. The change was designed to improve transparency and understanding of financial statements.

IFRS International Accounting Standard (IAS) 27 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 ferral, so a review could take place of NHS Charities in the context of the government accounting framework.

The review group<sup>10</sup> produced its report<sup>11</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. A dissenting report<sup>12</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.

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.

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<sup>9</sup> Note that charities' Statement of Recommended Practice (SORP) is currently produced under UK GAAP.

<sup>10</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>11</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)

<sup>12</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)

## **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).

Following a review, the ONS – an independent body – concluded in September 2011 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 consider 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 –the British Museum's accounts are consolidated into DCMS accounts, and the National Army museum into MoD. However, many of the NHS Charities were concerned that the ONS reclassification could have a similar detrimental effect on public opinion as consolidation of accounts.

## Annex C – Comparison of current and new ‘NHS Charities’

<b>The current system – ‘NHS Charities’ are established under and bound by NHS legislation</b>	<b>Future system under new model – 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 limited 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.

## Annex D – Policy change and implementation process

