Review of Governance of NHS Endowment Funds

November 2019

Julie Hutchison LLB TEP WS

Reflections on the importance of people and place

“We originally raised money with ‘TheWeePinkFergie’ for another cancer charity, but didn’t know where the money goes, so we now fundraise for the specific ward where she was treated, to keep it local.”

Donor to Ward 309 Breast Patients Fund (within NHS Grampian Endowment Fund)

“We’ve always worked closely with them [the children's oncology team at Ninewells] in the past and no doubt will in the future.”

Chair, local cancer charity which donates to the Paediatric Oncology Fund
(within Tayside NHS Endowments Fund)

“It’s good to have a local fund, compared to a national charity,
where you don’t feel it’s necessarily going to local services.”

NHS employee

Foreword

This report shines a light on a particular group of charities in Scotland which deserve to be better known.

Many may be surprised to learn there are sixteen NHS-linked charities in Scotland, holding a combined total of some £301m of charitable assets.[1] Over many decades, donations have been made by those wanting to thank and support particular aspects of NHS healthcare, be that community nurses, research into new forms of treatment, enhancing gardens for patients and their families to enjoy and many, many other areas. How those charitable funds are looked after, and the selection of decision-makers who oversee how they are used, are therefore questions of some importance, given the sums involved.

The core governance framework for these NHS-linked charities dates from legislation in the 1970s. Times have moved on, and it should come as no surprise that there is a need to consider afresh the nature of the governance arrangements which will place these valuable charities onto a sound footing for the future. Best practice and public expectations have evolved. Events in the last decade in particular have prompted the need to reconsider who should hold the role of trustee of an NHS-linked charity.

When this report was completed in November 2019, it would still be a few months before a seismic public health emergency took hold in Scotland and around the world. This foreword is not the place to reflect on the wide-ranging impacts of COVID-19 on society, the economy and the National Health Service. In a more limited sense, its impact on this report and its themes can be seen in four ways. First, publication of this report was understandably delayed. Second, the pandemic has prompted unprecedented fundraising activity, with NHS Charities Together emerging as a central recipient of donations and onward distributor of grants to NHS-linked charities across the UK.[2] The comments about fundraising in sections 5.18 to 5.22 of this report reflect a pre-pandemic view of fundraising and therefore understate this aspect. Third, the impacts of COVID-19 and the mental health consequences of the measures to contain its spread will create new/increased demands on NHS-linked charities. Fourth, our recommendation at 2.11 takes on new importance in terms of why continuity of use of the same charity number matters. Such an outcome facilitates how donations, and grants from bodies such as NHS Charities Together, can continue to be received by the NHS-linked charities in Scotland.

Although this report was written in 2019, all its recommendations remain unchanged. If anything, the pandemic has strengthened the need for the recommendations in this report to be implemented, to enhance the flexibility available to NHS-linked charities as they respond to the new and increased health and wellbeing challenges affecting their beneficiaries, namely NHS staff and volunteers, patients and the population of Scotland generally.

In arriving at the recommendations in this report, we have listened to input from many people (acknowledged in Appendix 5) who have generously given their time to share their expertise and experience as a donor, trustee, chair, NHS employee, lawyer, accountant, CEO, academic, civil servant, and the families of patients. The Scottish Charity Regulator, OSCR, has also provided valuable input throughout the process. This blend of insight has shaped what I believe is a balanced and proportionate set of recommendations.

[1] as at 31 March 2019

[2] https://nhscharitiestogether.co.uk/grantsawarded/

It has been my pleasure to chair this Review and to explore the governance and operation of these valuable charities. They are uniquely placed to play a creative and much-needed role in supporting how we cope with and recover from COVID-19. If the recommendations are implemented as we hope, I look forward to seeing these NHS-linked charities thrive into the future.

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Contents

Chapter 1 – Introduction and Background

Background and historic context

1.1 There are sixteen NHS-linked charities in Scotland, as listed in Appendix 1. Each charity is registered with OSCR, the Scottish Charity Regulator.

1.2 As at 31 March 2019, these sixteen charities held net assets totalling £301m.

1.3 The current legislative basis for NHS-linked charities in Scotland is contained in section 83(1) of the National Health Service (Scotland) Act 1978 (the 1978 Act). This gives power to a Health Board "to accept, hold and administer any property on trust for purposes relating to any service which it is their function to make arrangements for, administer or provide, or to their functions with respect to research."

1.4 The underlying legal entity of each NHS-linked charity is therefore a trust.

1.5 The charitable funds held in these sixteen charities in some cases pre-date 1978 and indeed the formation of the National Health Service in 1948. Pre-NHS philanthropy contributed to the founding of some of Scotland's oldest hospitals. In 1729 the very first Edinburgh Infirmary opened, paid for by public funds after an appeal was launched by the Royal College of Physicians of Edinburgh[3]. The donations and legacies which supported the Royal Hospital for Sick Children also paint a picture of nineteenth century philanthropy:

"Lady Jane Dundas made the exceptionally generous donation of £6500 to build and furnish one wing of the new Hospital, naming it the Lady Caroline Charteris Memorial Wing, after her sister. Colonel W. Lorimer Bathgate, one of the Directors…….endowed enough to fund the "Bathgate Ward" in memory of his sister Thomasine, and another Director left enough to fund a ward which was named the "Mackay Smith Ward" after him."[4]

1.6 With the arrival of the National Health Service in 1948, healthcare became a universal national provision, funded by taxes. It was not however the end of healthcare-focused donations and legacies, which continue to this day and are accounted for separately within these sixteen NHS-linked charities, as required by the 1978 Act.

1.7 Set against this backdrop from the eighteenth century onwards, it is therefore clear to see that the provision of healthcare in Scotland has always benefitted from the generosity of those who make donations or leave legacies.

More recent history

1.8 The 1978 Act underpins the governance and charitable purposes of the sixteen NHS-linked charities. The charitable purposes reflect the statutory purposes of the NHS itself set out in section 1(1) of the 1978 Act: "…to promote in Scotland a comprehensive and integrated health service designed to secure –
(a) improvement in the physical and mental health of the people of Scotland, and
(b) the prevention, diagnosis and treatment of illness,"

[3] https://org.nhslothian.scot/AboutUs/OurHistory/Pages/RIEHistory.aspx
[4] https://org.nhslothian.scot/AboutUs/OurHistory/Pages/RHSCHistory.aspx

It is a matter of long established practice that for those NHS-linked charities linked to a Health Board in a particular geographic area, the NHS-linked charity tends to reflect that geographic focus in its activities. Although the charitable purposes of all NHS-linked charities are in effect Scotland-wide, there is no difficulty with the practice which has emerged for the NHS-linked charities operating in this way. The narrower geographic focus of fourteen of the charities can be seen in their names listed in Appendix 1.

1.9 In line with the 1978 Act, the charity trustee of each NHS-linked charity is the related NHS Health Board, as a single corporate trustee. This means the same individuals who are board members of the NHS Health Board also act as officers of the corporate trustee of the related NHS charity. As a result of this overlap, there is an inherent conflict of interest where the interest of the NHS Health Board conflicts with the interest of the NHS-linked charity of which it is also the trustee.

1.10 This conflict of interest places the Health Board (acting as charity trustee) in a very sensitive position, with regards particular spending decisions it may choose to make with one hat on or the other. Since the charitable purposes of the NHS-linked charity match the statutory purposes of the NHS, the same item could represent valid expenditure by:

- the Health Board in relation to its NHS budget, or
- the Health Board as corporate trustee of the NHS-linked charity.

To seek to address this, practice has evolved to try to characterise an item of spend as being either:

- 'core' (and therefore to be publicly funded by the NHS) or
- 'non-core' i.e. an enhancement or addition to core provision (and therefore more suitable for the NHS-linked charity to fund).

This distinction is not one which charity law requires or recognises, since a wide range of expenditure with unrestricted funds would be considered to be in line with the NHS-linked charity's purposes. It is however an aspect of practice which has evolved as a means of trying to distinguish what the NHS-linked charity will provide funding for, and what the NHS provides, albeit with many grey areas in between. One might conclude that it reflects the existence of the conflict of interest of the decision-makers, where a route to managing that is to attempt to delineate core spend on the one hand, and non-core (and therefore charitable) expenditure on the other. More is said about this in section 5.39.

1.11 It is therefore easy to see that the 1978 Act places a Health Board in a difficult position by requiring it to hold these dual roles. It leaves a Health Board open to potential criticism for spending decisions it may make as charity trustee, if in some way the NHS-linked charity is seen to 'prop-up' the finances of the Health Board. This is exactly the backdrop to events which resulted in an inquiry in 2018 by OSCR[5], the Scottish Charity Regulator, into decision-making in 2014 by a charity, Tayside NHS Board Endowment Funds. The inquiry found that the Health Board (in its role as charity trustee) was effectively acting to meet a deficit incurred by the Tayside Health Board in its provision of NHS services. More is said on this in 1.16.

1.12 Although the establishment of this present Review in 2019 came just two months after OSCR published its Inquiry Report into Tayside NHS Board Endowment Funds, the case for change has been building for almost a decade.

[5] https://www.oscr.org.uk/media/3465/2019-01-31-section-33-report-final-pdf.pdf

1.13 In 2010, OSCR examined the charitable status of Lothian Health Board Endowment Fund as part of a review of the charitable status of selected charities on the Register. That review recommended "the charity take steps so that its charity trustees could demonstrate they were able, at all times, to fulfil their duties under the 2005 Act. The charity had to be able to show that, in a situation of conflict where the charity trustees' duty to the other body might influence how it used its funds, the charity trustees would decide only on the basis of the charity's interests and not the needs of the other body." (Who's in Charge, page 13) OSCR asked Lothian Health Board Endowment Fund to take a number of steps, which were put in place, relating to the induction process for trustees; a conflict of interest policy; and practical arrangements to show the public that the charity was acting autonomously, for example by taking its own independent legal advice and holding meetings separately from those of the Health Board.

1.14 In 2011, this case study was subsequently included in OSCR guidance entitled 'Who's in Charge: Control and Independence in Scottish Charities'[6]. In Chapter 2, OSCR identifies "certain structures and relationships that are more likely to lead to problems for charities as regards control and independence." It goes on to illustrate this with an example of a charity which is closely linked to another body and many of the same people are on the two boards. This is the case with the sixteen NHS-linked charities and the related Health Boards, in terms of the complete overlap of individuals involved.

1.15 Shortly after this, a different regulatory driver for change prompted further review. HM Treasury's Financial Reporting Advisory Board concluded in 2011 that the financial statements of linked charities such as NHS Endowments would require consolidation into the related NHS Health Board. A Steering Group was established in NHS Scotland to consider this. In the Group's 2013 Report, which had an accountancy focus with some related governance outputs, certain templates were shared including a Charter, Standing Orders and Endowment Fund Operating Instructions. These templates were shared as best practice examples, for use and adaptation locally, given that the NHS-linked charities had - and continue to have - no legally binding governing document.

1.16 In 2014, Tayside NHS Board Endowment Funds made a temporary variation to its policy and procedures to allow it to consider retrospective funding applications, which resulted in £3.6m being paid out to cover a range of projects where Tayside Health Board faced a deficit. This came under scrutiny in an OSCR Inquiry report published in February 2019. OSCR found there was mismanagement in the administration of the charity, with decision-making which "did not reflect a sufficient degree of detachment from Tayside Health Board or recognise that the charity's interests should be considered separately from those of Tayside Health Board." The money was later repaid in full by the Health Board to the charity.

1.17 In July 2018, an independent review was published by Grant Thornton UK LLP on agreed areas of NHS Tayside financial governance arrangements between the financial years 2012/13 – 2017/18. This report found:

"As the Trustees were all NHS Board Members we did note that the differing responsibilities become blurred over the period of time." (Page 23)

1.18 On 5th April 2019, in response to the OSCR report on the inquiry into Tayside NHS Board Endowment Funds published two months earlier, Jeane Freeman, Cabinet Secretary for

[6] https://www.oscr.org.uk/media/1396/whos-in-charge-guidance.pdf

Health and Sport, announced this present Review of Governance of NHS Endowment Funds.

1.19 On 29th May 2019, The Public Audit and Post-legislative Scrutiny Committee of the Scottish Parliament published a report on the 2016/17 and 2017/18 Audits of NHS Tayside[7]. It took evidence on the 2014 decision-making in Tayside NHS Board Endowment Funds. Its report states "The Committee agrees that there is a conflict of interest where the trustees of the endowment funds are the same individuals as the members of the NHS Board. The Committee therefore support the proposal from OSCR for the National Health Service (Scotland) Act 1978 to be reviewed by the Scottish Government with a view to ensuring that at least a majority of those in management and control of the endowment funds are independent of the relevant NHS board." (page 35)

1.20 It is important to conclude these introductory comments with some reassurance about practice in the broad group of NHS-linked charities in Scotland. In connection with its 2018 inquiry into Tayside NHS Board Endowment Funds, OSCR looked at the activities and governance of the 15 other NHS-linked charities. This included analysis of the charities' annual reports and accounts since 2014 and board meeting minutes. OSCR stated "The picture that has emerged from our analysis is generally positive and encouraging, and we hope this will help reassure existing and potential supporters of these charities. By and large, the NHS endowments charities in Scotland have appropriate charters, operating instructions, policies and terms of reference in place."[8]

Format of the Review

1.21 The format of this Review was shaped by the Chair and involved a core Project Group, whose members are identified in the Terms of Reference for the Review in Appendix 2.

1.22 The aim of the Review, as set out in the Terms of Reference, is to provide a report to the Scottish Government to identify the preferred option to strengthen the governance of the NHS Endowment Funds and to ensure that the management and control of these charitable funds is able to be independent of the relevant Health Board.

1.23 To ensure all sixteen NHS-linked charities were involved in the Review, a representative from each participated in a Reference Group, which met to provide insight and input and to receive updates on the work of the Review. The Reference Group members are identified in Appendix 5.

1.24 To support the work of the Review, two specialist sub-groups were formed to consider in detail the technical legal and accounting aspects involved.

1.25 The Chairs and Directors of Finance of NHS Health Boards have regular scheduled meetings. The Chair of the Review took the opportunity to attend a meeting of Chairs and a meeting of Directors of Finance, as well as a meeting of the Technical Accounting Group, to share updates on the work of the Review, to invite input and to answer questions.

1.26 Representatives from the sixteen NHS-linked charities also meet in a shared forum called the 'Endowment Network'. The Chair of the Review attended a meeting of this Network to share updates on the work of the Review, to invite input and to answer questions.

[7] https://digitalpublications.parliament.scot/Committees/Report/PAPLS/2019/5/29/Report-on-the-2016-17-and-2017-18-audits-of-NHS-Tayside-1

[8] https://www.oscr.org.uk/media/3273/2018-09-26-oscr-update-to-papls-cttee.pdf

1.27 In addition to these larger meetings, the Chair held a number of one-to-one and small group meetings on specific topics or with specific stakeholders. This enabled particular issues to be considered in more detail, such as VAT; the interests of the smaller NHS-linked charities; inviting views from non-executive Health Board members; and bringing the voice of donors and a clinician into the Review.

1.28 The draft recommendations were shared with the Reference Group in September 2019, to invite feedback.

Chapter 2 – Executive Summary

The following recommendations are made, to deliver the outcome that the governance of the sixteen NHS-linked charities is strengthened and that management and control of NHS-linked charities is independent of the relevant Health Board.

2.1 A Health Board should no longer be the corporate trustee of an NHS-linked charity.

2.2 Further work will be required after this Review to identify a precise legal mechanism for the appointment of the first independent Chair of an NHS-linked charity.

2.3 The open recruitment and appointment processes leading to the appointment of the second and subsequent Chair of an NHS-linked charity shall be determined by the trustees of that NHS-linked charity. The non-Health Board appointed trustees shall be in the majority in the process which selects the second and subsequent Chair.

2.4 The composition of the board of an NHS-linked charity should comprise the following elements:

(a) an independent Chair
(b) a majority of non-Health Board appointed trustees
(c) a minority of Health Board-appointed trustees

2.5 Health Boards should develop guidance on charity trustee nominations for Health Board-appointed trustees, which should be progressed via a suitable national shared forum involving all Health Boards.

2.6 Further work will be required after this Review to identify a precise legal mechanism for the appointment of the first non-Health Board appointed trustees of each NHS-linked charity.

2.7 After the tenure of a first non-Health Board appointed trustee comes to an end, the open recruitment and appointment processes leading to the appointment of a non-Health Board appointed trustee shall be determined by the NHS-linked charity. The non-Health Board appointed trustees shall be in the majority in the recruitment process which selects future non-Health Board appointed trustees.

2.8 A Trustee Recruitment Guide should be developed to reflect best practice in open recruitment, to support the NHS-linked charities in successfully recruiting non-Health Board appointed trustees. In this context, the Trustee Recruitment Guide should consider a range of matters including digital as well as non-digital means of advertising trustee vacancies, a trustee role description, and the use of a skills matrix.

2.9 NHS-linked charities should put in place induction training for all charity trustees as well as consider the need for ongoing training and support for all charity trustees.

2.10 The size of board of an NHS-linked charity should be no smaller than seven and no larger than eleven. The first Chair shall determine the size of the first board. Thereafter, an NHS-linked charity shall determine what size of board best suits its circumstances within these parameters from time to time, enabling local geographic considerations and other factors to be taken into account.

2.11 An NHS-linked charity should have a legally binding governing document of a type which involves limited liability for trustees. A statutory corporation model is recommended as the

preferred route for this, with suitable conversion wording to enable continuity of use of the same charity number. Appendix 3 illustrates the potential themes to be covered in this governing document, which would be contained within legislation.

2.12 It is anticipated that Standing Orders may supplement the new governing document. The preparation of a template for such Standing Orders, for local adaptation, should be considered further by a shared national forum.

2.13 Each NHS-linked charity should put in a place a Code of Conduct to provide guidance and set expectations on board behaviours.

2.14 Each NHS-linked charity shall establish a Charity Liaison Group to support ongoing communications between it and the relevant Health Board.

2.15 Each NHS-linked charity shall establish a new framework of contractual relationships between it and the relevant Health Board, to underpin a range of operational and governance arrangements.

2.16 An NHS-linked charity should review the content of its annual report and accounts, to reflect the latest best practice guidelines issued by OSCR, to ensure an appropriate balance between narrative and numbers. It is noted that each NHS-linked charity will make its own decisions about what form of other communications best meets local needs, when sharing news of projects being funded.

2.17 NHS-linked charities should implement the governance and operational recommendations in this report which will contribute to a finding that a Health Board is not able to control an NHS-linked charity. This would underline the independence of the NHS-linked charity and separately lead to an end to the requirement to fully consolidate the financial statements of the NHS-linked charity within the Health Board accounts.

2.18 Each NHS charity should consider updating its registered name, in line with OSCR processes for doing so.

2.19 Each NHS-linked charity should consider its brand and any consequences in terms of a licence agreement with the relevant Health Board.

2.20 It would be beneficial for each NHS-linked charity to review its classification of funds, in particular to re-validate restricted funds. A framework to support classification may be usefully explored in a national shared forum.

2.21 It is helpful for NHS-linked charities to continue to delegate certain decisions and to have a clear power to do so, to facilitate the smooth running of the charity and to bring in the valuable insight and expertise of others, within a defined framework. It is recommended that the new governing document for each NHS-linked charity makes specific reference to the power to delegate, to bring additional clarity and transparency to this area of decision-making. The power to delegate is therefore included in the illustrative governing document in Appendix 3.

2.22 In light of this Review, all existing Delegated Authorities should be reviewed and updated by the relevant NHS-linked charity, to reflect the outcome of this Review and the new operating practices which will emerge. In that context, the process for timely decision-making should be considered, as part of the updating of Delegated Authorities.

2.23 Each NHS-linked charity should deliver induction training to all those holding a Delegated Authority, to ensure they have a good understanding of the scope and limits of their authority, and the processes for escalating decisions involving financial amounts above the threshold set in the Delegated Authority.

2.24 Each NHS-linked charity should review its fundraising policies and procedures, and consider signing-up to the Fundraising Guarantee to commit to best practice fundraising.

2.25 Prior to the implementation of the recommendations in this Report, NHS-linked charities should identify and consider the range of future compliance actions arising, to support smooth handover to the incoming trustees. These compliance matters should be explored further in a national shared forum.

2.26 A suitable preparation and transition period for the implementation of these recommendations should be adopted, to enable practical arrangements to be made in advance of the implementation date on which many of the above changes would go live.

2.27 It is recommended that a date of 1st April is considered as a future implementation date, to match the start of the accounting period of the NHS-linked charities.

2.28 It is recognised that significant further work will be required by the Health Boards and NHS-linked charities to plan effectively for both the governance and operational changes recommended in this report. We recommend the use of a national shared forum as a means of co-ordinating various aspects of the preparations and post-implementation date work.

Chapter 3 – Options Considered and Discounted

3.1 In generating the options for consideration during the Review, four options were identified by the Legal Sub-group and submitted to the Project Group to form the basis of review and discussion. The options represent a spectrum from less to more change, and were discussed at a variety of meetings with different stakeholders, to describe the choices ahead and to invite views. A visual of these options is shown below.

Less Change — More Change

Option 1	Option 2	Option 3	Option 4
Minor changes to the status quo • Retain Health Board as corporate trustee • Add two or three non-Health Board Trustees	• End the role of the Health Board as corporate trustee • Chair to be independent of the Health Board • Board size between 7 and 11 trustees • Majority of trustees to be non-Health Board appointed trustees • Minority of trustees to be Health Board appointed trustees	• Implement the changes in Option 2 by way of a statutory corporation • Transparent new governing document is created • Introduction of limited liability for trustees is a positive outcome • Retains NHS context through link with NHS legislation. • Statutory conversion route intended to mean no new charity number is required	• Create entirely new charity which sits outside NHS legislation • New charity registration and number required • Assets to be transferred from old charity to new charity (where/ if possible)

3.2 The merits of two of the four options across this spectrum were considered and ultimately discounted. During the Review, these discounted options were known as ‘option 1’ and ‘option 4.’

3.3 In order to support consistent analysis of all four options, criteria were developed to judge their merits:

1. Does this option introduce some element of external input to trustee decision-making?
2. Does this option mean charity trustees have a clear line of accountability?
3. Does this option remove the inherent conflict of interest resulting from the Health Board also being the charity trustee of the NHS-linked charity?
4. Is this option proportionate in resolving the issues we are being asked to address?
5. Are any significant new problems created by this option?

Option 1 - Minor changes to the status quo

3.4 Option 1 was based on the status quo with one additional new feature: the addition of two or three non-Health Board trustees. This would mean the NHS-linked charity retained the Health Board as a corporate trustee, although the Health Board would no longer be the sole trustee, given the presence of two or three new non-Health Board trustees.

3.5 Option 1 would introduce some element of external input to NHS-linked charity trustee decision-making, addressing criteria 1. However, there are important weaknesses with option 1 in relation to criteria 2 and 3.

3.6 The continuing presence of the Health Board as a trustee is the fundamental weakness of option 1, failing the test in criteria 3. Further, as the Health Board acts as a body corporate in relation to its charity trustee role, this makes it difficult for others to look through and see and understand how the individual board members of that corporate trustee are accountable for their actions. An approach was favoured which resulted in a charity board composed of individual charity trustees, providing clear lines of accountability as set out in criteria 2.

3.7 A further weakness with option 1 was the reality of boardroom dynamics given the numbers of people involved. Although the Health Board is a single corporate trustee with 'one vote' on a matter, as compared to the two or three potential new non-Health Board charity trustees who in theory are in the majority, the reality could feel different. Keeping in mind that some of the largest Health Boards in Scotland have over 20 board members, each of those members would still be present alongside the two or three new non-Health Board trustees. It would require a particular degree of confidence and even bravery to disagree with a view being vocally supported by more than 20 others around a board table, even if together they hold just one vote. That is not a recipe for success.

3.8 In addition, a sizeable charity board with over 20 board members is neither necessary nor practical for NHS-linked charities. Option 1 would therefore have the opposite impact to that desired, by increasing the numbers of individuals involved.

3.9 A further difficulty with option 1 relates to the manner in which charity trustees are appointed. Health board members become part of the corporate trustee of the NHS-linked charity by default. This means that automatic trusteeship of the NHS-linked charity risks being an after-thought, of secondary importance to the primary focus of the role held by an individual in relation to the Health Board. This may be particularly true for those who hold a senior executive role within the NHS which comes with its own pressures and priorities. In this context, the following commentary in the Grant Thornton 2018 Review[9] is noted:

> "In most cases the meeting of the Endowment Fund Committee preceded a meeting of the NHS Board. Whilst we recognise this was a practical arrangement taking into account Non-Executives time it did contribute to the differing lines of responsibility and governance being blurred. In addition, a time constraint on the meeting of the Endowment Fund at times was noted as another session was planned in, so in one case the meeting of the Endowment Fund was restricted to 45 minutes for what looked a sizeable agenda and may be an example of the NHS Board reducing time to consider endowment decisions." (Page 20)

9 https://www.parliament.scot/S5_PublicPetitionsCommittee/General%20Documents/Letter_from_Paul_Gray_22_May_2018_inc_Grant_Thornton_Report_(Paper_1).pdf

3.10 A final difficulty with option 1 relates to the limitations which the NHS-linked charity would still face, in terms of not being able to recruit trustees for the full range of knowledge, skills and experience needed by the charity. The many Health Board members involved would primarily have been recruited for the knowledge, skills and experience which made them well suited to sitting on the NHS Health Board, as compared to sitting on the board of a charity. Option 1 would not fully address that issue as it enables the corporate trustee role of the Health Board to continue.

3.11 Summary of the problems associated with the Health Board as a corporate trustee

(a) **Overlap of personnel** - there is an overlap of personnel involved in making decisions for both the NHS Health Board, and also the NHS-linked charity. This leads to a conflict of interest which is a key issue this Review seeks to address.
(b) **Busy NHS senior executives** - many Health Board members are also executives with senior and busy roles within the NHS, potentially limiting the time which can be devoted to NHS-linked charity matters. There may be benefits to the NHS in freeing-up the time of these senior executives, such that they are no longer obliged to take on additional charity trustee responsibilities which come with charity law duties.
(c) **Lack of clear individual accountability** - as a corporate trustee operates as if it were a single person, this makes it difficult for others to see and understand how the individual members that make up that corporate trustee are accountable for their actions.
(d) **Large boards** - the number of individuals involved in a board meeting of an NHS-linked charity is driven by the size of the related Health Board. This means upwards of 20 people may be involved. Ending the role of the corporate trustee and enabling a smaller board size for an NHS-linked charity therefore offers an opportunity to streamline meetings and proceedings for an NHS-linked charity.
(e) **Trustees not recruited with a primary focus on what the charity needs** - the corporate trustee comprises members of an NHS Health Board who are not primarily recruited for the knowledge, skills and experience chosen by a charity. They are recruited primarily for their suitability to take on responsibilities for a public body (the NHS Health Board). As a consequence, the range of charity trustee knowledge, skills and experience available to the NHS-linked charity is necessarily limited by the corporate trustee.

3.12 In conclusion, option 1 does not go far enough to deliver effective change to strengthen the governance of NHS-linked charities.

Option 4 - Creating sixteen entirely new charities

3.13 The option known as ‘option 4’ was also considered and ultimately discounted. This option would involve the creation of sixteen new charities, with new charity numbers registered with OSCR. The assets of the old NHS-linked charity would be transferred to the new charity and the old charity wound-up (where possible). The changes to the composition of the board (as set out in recommendation 2.4) formed part of option 4, but crucially, this would be in the context of a newly formed charity with a free-standing governing document, such as a Scottish Charitable Incorporated Organisation (SCIO) or a company limited by a guarantee. This would take the NHS-linked charity outside the context of the National Health Service (Scotland) Act 1978. It could also give the trustees considerable discretion as to future changes to the charity’s structure and governance arrangements.

3.14 Option 4 would have met the first three tests in our assessment criteria. In relation to criteria 4 – proportionality – it was however felt to be disproportionate and went beyond the level of change required today to address the key issues, for reasons set out below.

3.15 In relation to criteria 5, additional new complexity could be involved in relation to the arrangements regarding the transfer of assets. In the current context, option 4 did not offer as readily actionable a solution as other options under consideration. The mechanics involved in the transfer of restricted funds would require to be looked at in detail. Option 4 would require significant additional work to clarify the detailed steps involved in a formal transfer of assets (including ensuring the security of future donations and legacies) from sixteen old charities to sixteen new ones, with no clear benefit at the current time in adopting this route.

3.16 A further aspect which counted against option 4 was that importance was placed in retaining some form of legal link and reassurance around the NHS context for the charities, albeit that in future they would be operating with a greater degree of independence. As such, there were attractions in achieving a governance outcome which meant the governing document was linked to NHS legislation. This would mean that any future changes to it would require a particular level of public scrutiny, which was felt to offer positive reassurance given the nature of public interest in donations to NHS-linked charities. Option 4 did not offer this ongoing link.

3.17 In relation to option 4, we also had regard to the position in England and Wales[10]. Changes have been made in that jurisdiction to create a choice for NHS-linked charities on whether or not to convert to independent status, involving a new and separate governing document and various transfer arrangements. In other words, NHS-linked charities in England and Wales now have the choice to move to independent status (option 4 in our terms). As at March 2017, seventeen NHS-linked charities of the 250 or so of that type in England and Wales had made the change to independent status. The corporate trustee model still remains the default position in England and Wales.

In our recommendations, all sixteen of the NHS-linked charities in Scotland are intended to benefit simultaneously from the implementation of steps to strengthen their governance through changes to the composition of their boards. This removes the element of choice for the charity on enacting trustee changes, which could otherwise be driven by whether the particular NHS-linked charity has the time and resources to take legal advice on the creation of a new governing document, for example. Instead, a new governing document is intended to be automatically implemented for all NHS-linked charities within legislation, to take effect on a future implementation date. Crucially, this means no NHS-linked charity in Scotland is left behind.

3.18 In conclusion, at the current time, option 4 goes beyond the level of change required to strengthen the governance of NHS-linked charities, as assessed according to the five criteria.

10 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/595968/NHS_Funds_held_on_Trust.pdf

Chapter 4 – Governance Recommendations

4.1 Chapter 3 set out information about the two options which were considered and discounted. This Chapter will consider the remaining two options – options 2 and 3 in the visual in section 3.1 - which together form the basis of our recommendations, tested against the criteria developed to judge their merits, repeated again here for ease of reference:

1. Does this option introduce some element of external input to trustee decision-making?
2. Does this option mean charity trustees have a clear line of accountability?
3. Does this option remove the inherent conflict of interest resulting from the Health Board also being the charity trustee of the NHS-linked charity?
4. Is this option proportionate in resolving the issues we are being asked to address?
5. Are any significant new problems created by this option?

4.2 Ending the role of the Health Board as corporate trustee

As set out in Chapter 1, the dual roles of a Health Board are problematic. Such arrangements date from legislation in the 1970s and no longer reflect good governance practice. The limitations on the role of the Health Board as corporate trustee are set out in section 3.11. In order to deliver an outcome which meets criteria 3 - removal of the inherent conflict of interest - we make the following recommendation:

Recommendation

A Health Board should no longer be the corporate trustee of an NHS-linked charity.

4.3 Chair of an NHS charity

An important element within the composition of the new NHS-linked charity board is the selection of the Chair. At the current time, the Chair of the NHS-linked charity may also hold the role of Chair of the Health Board. In the future model recommended in this review, it is anticipated that the NHS-linked charity Chair will be independent and will not hold a role in the relevant Health Board.

Further work will be required after this Review to identify a precise legal mechanism for the appointment of the first independent Chair of an NHS-linked charity. This includes consideration of who holds the power to appoint that first Chair. A number of guiding principles are important in relation to this process. Firstly, transparency, in terms of the open nature of the recruitment process. Secondly, the Health Board should not be involved as the body appointing the first Chair, in order to secure the appropriate degree of independence. It may be that a special panel is required for this one-off exercise, comprising independent individuals with a blend of relevant experience.

In anticipation of the support which may in due course be required by the NHS-linked charities in developing the selection process for future Chairs, the Review Chair had exploratory conversations with ACOSVO (Association of Chief Officers of Scottish Voluntary Organisations) which runs a Chairs' Network. The Chairs' Network comprises chairs of charities across Scotland, and may be able to offer support and assistance in the process which lies ahead, which can be further explored by a national shared forum of the NHS-linked charities.

Recommendation

Further work will be required after this Review to identify a precise legal mechanism for the appointment of the first independent Chair of an NHS-linked charity.

The open recruitment and appointment processes leading to the appointment of the second and subsequent Chair of an NHS-linked charity shall be determined by the trustees of that NHS-linked charity. The non-Health Board appointed trustees shall be in the majority in the process which selects the second and subsequent Chair.

4.4 Trustees of an NHS-linked charity

Looking at the future composition of an NHS-linked charity board, discussions within the Review looked at the benefits of blending a combination of NHS-experienced trustees with members of the public who brought with them a range of other skills and experience to the charity.

Although there was one view which said the entire trustee board should comprise members of the public without NHS Health Board connections, a consensus view emerged around a blended board.

Recommendation

The composition of the board of an NHS-linked charity should comprise the following three elements:

(a) an independent Chair
(b) a majority of non-Health Board appointed trustees
(c) a minority of Health-Board appointed trustees

4.5 Health Board-appointed trustees

In explaining why there is value in retaining some Health Board involvement on an NHS-linked charity board, it is important to appreciate the features of these sixteen charities which will continue to be unique, even with the implementation of the recommendations of this Review.

The high number of restricted funds held by NHS-linked charities means that, regardless of who holds the role of trustee, there will be a specific NHS focus on how those particular funds must be used. More detail on restricted funds is provided in section 5.23. Sitting alongside those restricted funds, there is then the more open and flexible question of how unrestricted funds are applied.

4.6 This is where the future strategy of the NHS-linked charity comes into play, and the range of external factors they take into account in shaping their plans. Clearly, there will be the opportunity to amplify the impact of certain NHS-funded work. It is anticipated that the Charity Liaison Group will be the discussion forum for exploring practical aspects to larger funding opportunities, as set out in section 4.24. At a more strategic level, it could also be useful to have a charity trustee who has an understanding of the strategy of the relevant Health Board, as insight to support strategic planning. The presence of at least one Health

Board-appointed trustee is intended to support the basis for positive future collaboration between the Health Board and the charity.

It is noted that, in England and Wales, their model for independent NHS charities still involves a recommendation of at least one trustee to be appointed by, or from, the NHS Health Board[11] (page 7).

4.7 In reviewing the scope for who might be appointed by the Health Board to the NHS-linked charity, it is anticipated that the non-executive directors of the Health Board would be among the suitable candidates for such a nomination. In not holding an executive role on the Health Board, they bring with them a particular perspective which minimises the risk of Health Board control re-emerging.

It is worth emphasising that the Health Board-appointed trustees are acting in a personal capacity, and are not collectively acting on behalf of the Health Board.

4.8 The number of Health Board-appointed trustees is variable, within certain parameters. The starting point is the interaction between recommendations 2.4 and 2.10. Health Board-appointed trustees must always be in the minority.

Size of board	Health Board appointed trustees (max.)
7	3
9	4
11	5

4.9 It will be a decision for a Health Board as to whether to choose to nominate the 'maximum minority' number of charity trustees. There may be both practical and accounting reasons for choosing not to do so. In terms of practical matters, there may be a limited number of interested persons happy to agree to take on the role of Health Board-appointed trustee.

4.10 A second factor a Health Board may wish to consider relates to the accounting matters set out in section 5.5. If fewer than 20% of the charity trustees are Health Board-appointed trustees, this may result in certain accounting requirements not coming into play, with the result that group accounting rules may not apply. For a combination of reasons, therefore, it is possible that practice may evolve such that only one or two trustee roles are nominated by a Health Board. The decision, however, is one for the Health Board to make.

4.11 Further to the size of board selected, certain quorum arrangements are then intended to apply. Provision has been made for this to be included in the governing document contained in legislation, intended to ensure that decisions are not controlled by the Health Board-appointed trustees (see Appendix 3).

Recommendation

Health Boards should develop guidance on charity trustee nominations for Health Board-appointed trustees, which should be progressed via a suitable national shared forum involving all Health Boards.

[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/756121/NHS_Charities-_Guidance-_November_2018.pdf

4.12 Trustee recruitment

The Scottish Governance Code for the Third Sector[12] includes certain effectiveness principles. These include: "having a transparent and timely trustee recruitment and induction process" (page 11).

4.13 Looking at this in the context of NHS-linked charities, it points to the value in open advertising of trustee vacancies for the majority non-Health Board appointed trustees. The Governance Code also mentions "regularly reviewing…… the composition and skills of the board" (page 11). This could be done by means of a skills matrix, noting the desired range of skills sought by the board, mapping the skills of current trustees to that matrix and identifying gaps or areas of weakness to be addressed through the recruitment process.

4.14 In order to preserve the outcome that a Health Board no longer controls an NHS-linked charity, it is considered sensible for non-Health Board appointed trustees to be in the majority in the selection process for appointing other non-Health Board appointed trustees. It is anticipated that detailed guidance on non-Health Board appointed trustee recruitment matters would be covered in a future Trustee Recruitment Guide, which could be developed via a national shared forum involving all NHS-linked charities.

4.15 Separately, a one-off process will be required to support the selection and appointment of the first non-Health Board appointed trustees for each NHS-linked charity. A number of guiding principles are important in relation to this process. Firstly, transparency, in terms of the open nature of the recruitment process. Secondly, the Health Board should not be involved as the body appointing the first non-Health Board appointed trustees, in order to secure the appropriate degree of independence. It may be that a special panel is required for this one-off exercise, comprising independent individuals with a blend of relevant experience. Further work will be required after this Review to identify the precise legal mechanism which will deliver these initial appointments.

Recommendation

Further work will be required after this Review to identify a precise legal mechanism for the appointment of the first non-Health Board appointed trustees of each NHS-linked charity.

After the tenure of a first non-Health Board appointed trustee comes to an end, the open recruitment and appointment processes leading to the appointment of a non-Health Board appointed trustee shall be determined by the NHS-linked charity. The non-Health Board appointed trustees shall be in the majority in the recruitment process which selects future non-Health Board appointed trustees.

A Trustee Recruitment Guide should be developed to reflect best practice in open recruitment, to support the NHS-linked charities in successfully recruiting non-Health Board appointed trustees. In this context, the Trustee Recruitment Guide should consider a range of matters including digital as well as non-digital means of advertising trustee vacancies, a trustee role description, and the use of a skills matrix.

[12] https://governancecode.scot/wp-content/uploads/2018/11/Governance-Code.pdf

4.16 New opportunities for volunteering

Given the combined effect of recommendations 2.4 and 2.10, at a minimum there could be at least 64 new trustee roles created which are open to members of the public (being at least four on each of the sixteen charity boards, including the Chair roles).

4.17 A transparent recruitment process includes the option to use digital means of advertising vacancies. There are a number of websites and social media options available for making the most of reaching a wider (and potentially younger) audience. In the course of one of the Reference Group meetings, the prospect of younger trustees was viewed as a positive prospect in discussions, noting that 2018 was Year of Young People in Scotland. It is also noted that one of the volunteering outcomes of the National Volunteering Framework is: "volunteering and participation is valued, supported and enabled from the earliest possible age and throughout life" (page 30). Age will not be the only aspect to diversity which NHS-linked charities will wish to consider, however.

4.18 We note another of the effectiveness principles of the Governance Code is "developing and improving our [the charity board's] capacity and capability with on-going support and training" (page 11). The need for a good induction process and trustee training came up on several occasions during the Review and forms part of our recommendations. It is noted that various sources of free trustee training exist in Scotland, including workshops delivered each February during The Gathering, and events held during Trustees' Week each November, to mention just two of many sources.

Recommendation

NHS-linked charities should put in place induction training for all charity trustees as well as consider the need for ongoing training and support for all charity trustees.

4.19 Size of board of an NHS-linked charity

At the current time, charity board meetings of NHS-linked charities can involve more than 20 people, given the size of some of the largest Health Boards (who also act as corporate trustee of the NHS-linked charity). Such a large number is not particularly conducive to effective and efficient decision-making, as discussed earlier in section 3.11.

No specific Scottish guidance on board size was identified. It was noted that, in England and Wales, section 5.6.2 of their Charity Governance Code[13] states "A board of at least five but no more than twelve trustees is typically considered good practice."

In considering what size of board is appropriate for an NHS-linked charity in future, the Review was mindful of the varying geography/population across different parts of Scotland. With this in mind, there are benefits in enabling local decisions to be made around the size of a board, within certain parameters. The lower end of this scale was tested with the five smallest NHS charities, and a general consensus emerged around seven being a preferred lower end for smaller boards. The upper end of eleven was chosen, noting that an uneven number was preferred to ensure a majority position for non-Health Board appointed trustees.

[13] https://www.charitygovernancecode.org/en/5-board-effectiveness

On a process point, it is anticipated that the first new Chair would determine the size of the first board. Thereafter, it is anticipated this is a decision for the trustees, from time to time. There is provision for this in Appendix 3, which will need dealt with in the legislative changes.

Recommendation

The size of board of an NHS-linked charity should be no smaller than seven and no larger than eleven. The first Chair shall determine the size of the first board. Thereafter, an NHS-linked charity shall determine what size of board best suits its circumstances within these parameters from time to time, enabling local geographic considerations and other factors to be taken into account.

4.20 A legally binding and transparent governing document

At the current time, NHS-linked charities are trusts without a trust deed. This is an unsatisfactory position for a number of reasons, including lack of transparency, and a legal form which brings with it personal liability for trustees. The current underlying legal form of an NHS-linked charity could therefore present a barrier to future trustee recruitment.

In looking at how to address these weaknesses in the current governance arrangements, a solution was found in the form of a statutory corporation – option 3 as shown in section 3.1. Put simply, a statutory corporation is a means of creating a charity's governing document in legislation. By adding a clause to 'convert' the trust to a statutory corporation, the same OSCR charity number will continue, if our recommendations are implemented as intended. It is vital this technical point is reflected in legislation to successfully implement the conversion, and there is provision for this in Appendix 3. As such, no steps are required to transfer assets to a new charity, since the statutory corporation in effect wraps-around the existing NHS-linked charity, safeguarding the NHS context for the NHS-linked charity.

The benefits delivered by option 3 are therefore viewed as important and valuable additions to option 2. Our recommendations therefore include the elements comprising options 2 and 3 together, rather than option 2 alone.

4.21 Recommending options 2 and 3 together is therefore viewed as a more proportionate outcome at the current time than option 4 set out in 3.13. Our recommended approach delivers a new governing document by automatic operation of law, requiring no additional work by an NHS-linked charity, which avoids them spending time and resources in establishing sixteen new core governing documents. This also offers a simpler overall result for the sixteen charities, in that their core governance arrangements remain similar and none is left behind. This offers continuing benefits in terms of how the NHS-linked charities co-ordinate the sharing of best practice into the future.

4.22 To accompany the core provisions in the new governing document, Standing Orders could be developed to cover more detailed aspects. It is noted that Standing Orders form part of the current governance landscape for NHS-linked charities, as mentioned in section 1.15. The process of revising and updating Standing Orders could be taken forward by a shared national forum, to facilitate re-use and sharing of templates.

Recommendation

An NHS-linked charity should have a legally binding governing document of a type which involves limited liability for trustees. A statutory corporation model is recommended as the preferred route for this, with suitable conversion wording to enable continuity of use of the same charity number. Appendix 3 illustrates the potential themes to be covered in this governing document, which would be contained within legislation.

It is anticipated that Standing Orders may supplement the new governing document. The preparation of a template for such Standing Orders, for local adaptation, could be considered further by a shared national forum.

4.23 Code of Conduct

The third principle of the Scottish Governance Code deals with board behaviour. There are various elements to this, and one stands out in particular: "creating a constructive board environment where diverse, and at times conflicting views are respected and welcomed, and decisions are reached collectively" (page 9).

How charity trustees interact with each other matters just as much as how in future they interact with important partners, such as the Health Board, donors and other stakeholders. We believe it will be beneficial to develop a Code of Conduct which covers expectations on board behaviours. Aspects of this work may be usefully taken forward in a national shared forum.

Recommendation

Each NHS-linked charity should put in place a Code of Conduct to provide guidance and set expectations on board behaviours.

4.24 Collaboration between NHS-linked charities and the related Health Board

It might be said that the nature of collaboration between an NHS-linked charity and its related Health Board is an operational matter, dealing with local communications and practicalities. It is however of such importance to how an NHS-linked charity operates in future that the theme of collaboration is dealt with in this chapter on governance.

There will always be a need for effective communication between a Health Board and the related NHS charity, given that the latter holds a significant number of restricted funds which donors have mandated to be spent in certain ways in healthcare settings operated by the former.

The NHS-linked charity can only effectively spend restricted funds by having a thorough understanding of the needs arising in the healthcare settings specified by the donor, generally involving places and people who are within the NHS. Beyond this, in relation to the unrestricted funds of an NHS charity, understanding the public health priorities of the local area and strategic priorities of the Health Board will be relevant factors informing the strategy of the NHS charity.

This kind of 'partnership working' is nothing new in a healthcare setting. One only has to look at Blood Bikes Scotland or Scotland's Charity Air Ambulance to see examples of

charitable organisations which are not part of the NHS, but work closely with the NHS. With this in mind, two aspects arise in relation to future collaboration, relating to a Charity Liaison Group (section 4.25) and contractual considerations (section 4.26).

4.25 Charity Liaison Group

It will be helpful to create a structured gathering point for interaction between each NHS-linked charity and the relevant Health Board, where clinical, financial and other Health Board insight can be shared with the NHS-linked charity. In turn, the NHS-linked charity can use this forum as a sounding board for plans involving major expenditure which could, for example, result in new equipment being available to the Health Board. An example which arose on several occasions during the Review was the desire to avoid a scenario where a charity purchased a piece of equipment which could not be accepted and placed into a hospital since the ongoing maintenance costs could not be funded by the Health Board.

Effective communication and collaboration could manage this risk.

4.26 The Charity Liaison Group must not, however, become a decision-making forum by the back door. The trustees of the charity must retain their responsibilities and the Charity Liaison Group would have a focus on communication and insight sharing. Should the Charity Liaison Group, with significant numbers of Health Board attendees, mistakenly become a decision-making forum on NHS-linked charity spending decisions, this would undermine the intent of this Review and could result in the Health Board members being viewed as 'shadow trustees' of the NHS-linked charity, which means they are charity trustees. This might also result in an auditor concluding that, once again, the Health Board is able to control the charity, resulting in the charity's financial statements being fully consolidated with the Health Board – undesired outcomes.

The terms of reference of the Charity Liaison Group would need to be carefully written to set out the intent and scope of the group, which might be chaired by the NHS-linked charity Chair. As set out in the Leadership principle of the Scottish Governance Code, it is important to recognise that; "responsibility and accountability is always retained by the [charity] board."

Recommendation

Each NHS-linked charity shall establish a Charity Liaison Group to support ongoing communications between it and the relevant Health Board.

4.27 Contractual considerations

A new framework of contractual relationships lies ahead to formally underpin all aspects of future co-operation between an NHS-linked charity and the relevant Health Board. The precise nature and range of these contracts will be a matter for each NHS-linked charity to decide, although it is anticipated that a national shared forum could assist in co-ordinating how templates may be created for shared use and local adaptation. The following is a guide but is not exhaustive:

- A Memorandum of Understanding to govern the relationship between the NHS-linked charity and the relevant Health Board, accompanied by separate contracts to deal with specific subjects e.g.
- A Service Level Agreement for provision of services (see section 5.6)

- A Brand licensing agreement (see section 5.17)
- A Data Sharing contract for sharing of personal data (see section 5.38)

Recommendation

Each NHS-linked charity shall establish a new framework of contractual relationships between it and the relevant Health Board, to underpin a range of operational and governance arrangements.

4.28 Minutes and communications

In the OSCR Inquiry Report into Tayside NHS Endowment Funds, one aspect to emerge was the lack of clarity in Minutes around the basis on which certain decisions were made. In the 2018 Grant Thornton Report, it is noted that "Within NHS Board meeting minutes there is no declaration of interests from Non-Executives in respect of outlining their role and responsibility as Trustees of the Endowment Fund, so it is unclear how potential conflicts of interest are managed" (page 27).

Although the above quote relates to Minutes of the Health Board, as compared to the NHS-linked charity, it does raise the point about the role of Minutes in relation to transparency. Some NHS-linked charities in Scotland currently publish their Minutes on a website.

4.29 The key mandatory mechanism for accountability and financial transparency for all charities in Scotland is the publication of the charity's annual report and accounts, filed each year with OSCR within 9 months of the end of the charity's accounting period. Across the sixteen NHS-linked charities, a variety of styles of annual report and accounts are adopted, reflecting different decisions on the balance of communication about numbers on the one hand, and the narrative around projects funded and beneficiary impact on the other. In this regard, we note OSCR's guidance on annual reports and accounts[14], and the emphasis on telling the story beyond just the numbers.

While we believe that it is going too far to mandate the publication of Minutes of trustee meetings, we believe there are benefits in NHS-linked charities carefully considering how they can communicate openly with their various stakeholders, including donors.

4.30 We note that practice varies across the sixteen charities, around communication methods and styles.

- Some of the NHS-linked charities have developed their own more detailed websites.
- Some make use of social media to highlight their activities and how funds have been spent.
- Some issue an online newsletter with updates.
- Just Giving webpages or other online donation mechanisms are in place for many of the NHS-linked charities.
- Some use their annual report and accounts in a more visual way, to clearly communicate the charity's strategy and achievements
- It is noted that the 2013 template for 'Generic Operating Instructions' (see section 1.15) makes reference to NHS-linked charities affixing a plaque in areas which have been improved/refurbished further to charity funds being used.

[14] https://www.oscr.org.uk/guidance-and-forms/trustees-annual-reports-good-practice-and-guidance/tar-dos-and-donts/

- Some NHS-linked charities have their own dedicated brand/logo which appears online and on printed materials, which is a visual indicator of its distinct charity status.

For an NHS-linked charity looking to enhance its communications, there are examples of good practice to be found among the points above.

Recommendation

An NHS–linked charity should review the content of its annual report and accounts, to reflect the latest best practice guidelines issued by OSCR, to ensure an appropriate balance between narrative and numbers. It is noted that each NHS-linked charity will make its own decisions about what form of other communications best meets local needs, when sharing news of projects being funded.

Chapter 5 – Operational Recommendations

5.1 Introduction

A wide range of accounting, operational and practical consequences flow from the governance changes set out in chapter 4.

5.2 Consolidated financial statements today

At the current time, although a separate set of annual accounts is produced for an NHS-linked charity, an additional step is required – namely, that they are consolidated within the related Health Board accounts. This step is required by International Finance Reporting Standards (IFRS) 10 as interpreted by HM Treasury's Financial Reporting Manual and applied by public bodies, including the NHS. In effect, the financial statements for the Health Board and the NHS-linked charity are presented as a single group, on the basis that the test is met which says that the Health Board is able to "control" the NHS-linked charity.

5.3 Ending consolidated financial statements in the future

It is intended that at a future point, full accounts consolidation should no longer be required. This is on the basis that, if the governance and operational changes are implemented as set out in this Report, the test of "control" would no longer be met when looking at the relationship between an NHS-linked charity and the related Health Board.

Looking at the detail of this in terms of the definition of "control" within IFRS10, the test below applies. In the language used, the "investor" is the Health Board and the "investee" is the NHS-linked charity:

An investor [Health Board] controls an investee [NHS-linked charity] if and only if the investor [Health Board] has all of the following elements:

- power over the NHS-linked charity i.e. the Health Board has existing rights that give it the ability to direct the relevant activities (the activities that significantly affect the NHS-linked charity's returns)
- exposure, or rights, to variable returns from its investment with the NHS-linked charity
- the ability to use its power over the NHS-linked charity to affect the amount of the Health Board's returns.

Note that all three criteria must be met, to arrive at the conclusion that a Health Board "controls" an NHS-linked charity, from an accounting perspective. With a particular focus on the first of the criteria, the "power over the investee" is likely to end when all of the following steps are taken:

- the Health Board is no longer the trustee of the NHS-linked charity;
- there is a minority of Health Board-appointed trustees on the new NHS-linked charity board;
- the statutory governing rules for the NHS-linked charity are updated to include quorum provisions, to deal with the scenario where a meeting is attended by a majority of Health Board-appointed trustees and a minority of non-Health Board appointed trustees – such a meeting would not be quorate. Appendix 3 includes provision for quorum arrangements.
- other changes set out in chapters 4 and 5 are implemented, to remove the risk of the Health Board holding operational control over the NHS-linked charity. The content of

new contractual arrangements between the bodies would be an important contributor to placing the relationship between the Health Board and NHS-linked charity on a new footing, to help evidence this.

Recommendation

We recommend that NHS-linked charities implement the governance and operational recommendations in this report which will contribute to a finding that a Health Board is not able to control an NHS-linked charity. This would underline the independence of the NHS-linked charity and separately lead to an end to the requirement to fully consolidate the financial statements of the NHS-linked charity within the Health Board accounts.

5.4 Transition period for financial statements

It is anticipated that there is likely to be a transition period where accounts consolidation still occurs, on the basis that accounting rules would still conclude that the Health Board is able to "control" the NHS-linked charity. This is likely to be the period immediately after the new NHS-linked charity board is in place, but before all operational matters have been updated and settled in new contractual arrangements. While this transition period may last for a year or two, it would not be a positive result for this to be an extended period, given that the need to consolidate accounts reflects a conclusion which says 'the Health Board is able to control the NHS-linked charity', which is the precise point this Review seeks to address.

5.5 Group accounting standards

Sections 4.8 – 4.10 look at the range of possible decisions by a Health Board, in terms of the number of appointments to make to the NHS-linked charity.

One of the potential factors in this decision could be the applicability, or not, of International Auditing Standards (IAS) 28. This has a focus on investments in associates and joint ventures and may be relevant when considering whether group accounting is required. In summary, this would look at whether the Health Board had "significant influence" over the NHS-linked charity. In interpreting this standard, whilst 20% of voting entitlement is one trigger for group accounting, it is not the only trigger and other factors need to be considered including whether the NHS Health Board is an investor in the relationship. Detailed analysis of IAS28 may be part of future work in a national shared forum to consider this technical point further, with the outcome built into the NHS Manual of Accounts to clarify consideration of this standard.

5.6 Access to resources

At the current time, NHS-linked charities have access to a wide range of resources provided by the NHS, as covered in existing Service Level Agreements between an NHS-linked charity and the Health Board. Each NHS-linked charity makes its own arrangements with the relevant Health Board around re-charge and costs borne by the NHS-linked charity in respect of these, which can include premises and office space, accounting services, human resources, payroll, procurement, insurance, equipment etc.

5.7 As set out in section 4.27, this Review anticipates that future arrangements around access to resources would be discussed and documented in new contractual arrangements between an NHS-linked charity and the relevant Health Board. This supports a flexible

outcome in relation to matters of practical operational detail, where preferences may vary from charity to charity.

5.8 To take one example of the range of potential future choices, consider human resources. At the current time, staff who focus some or all of their time on NHS-linked charity matters are employed by the NHS. In future:

- an NHS-linked charity may choose to have contractual arrangements in place with the relevant Health Board to enable such arrangements to continue, and re-charged as required.
- Secondment arrangements from the Health Board to the NHS-linked charity may be preferred.
- A TUPE route may be preferred to fully transfer existing NHS staff to the NHS-linked charity. Pension considerations would arise here.
- Future new hires may be made by the Health Board or the NHS-linked charity, as the case may be, reflecting the preferred approach.

It will be a matter for each NHS-linked charity to come to a view on its preferred approach, in the context of the broader operational decisions ahead. It may be helpful to further explore these issues in a national shared forum.

5.9 It is also noted that, at the current time, some of the NHS-linked charities collaborate on certain operational arrangements, such as investment management, to benefit from shared access to expertise or external services. Such arrangements can continue in future, should the trustees of those NHS-linked charities wish to continue the arrangements.

5.10 Procurement

NHS-linked charities could have more flexibility in how they choose services in future.

At the current time, NHS-linked charities follow public procurement rules when going through a process to identify a provider of goods or services. This Review has taken independent legal advice to consider whether public procurement rules might still apply to NHS-linked charities at a future point. This legal advice is based on the premise that all the recommendations in this report are implemented.

5.11 The Review has been advised that "following implementation in full of the proposals, as set out below, each NHS charity would no longer be regarded as a 'Contracting Authority' under procurement regulations and therefore would not be subject to public procurement regulations. This is on the basis that, as a change to the current position, no NHS body will have control over appointments exceeding 50% of board positions."

5.12 The Review has been advised that there is an important interaction between the end of accounts consolidation and the start of flexible procurement. "It is important to note that through the anticipated 'transition phase', those NHS charities that continue to consolidate their accounts with the relevant NHS boards should continue to follow the NHS procurement procedures." The rationale for this is found in section 5.2, since accounts consolidation reflects the conclusion that the Health Board is able to control the NHS charity, and a Health Board is subject to public procurement rules.

5.13 It should be noted that this procurement legal advice is addressed to the Chair of the Review only, for the purposes of this Report. This is an area an NHS-linked charity may want to explore at the appropriate future time, and may be an area for a national shared forum to further consider during the transition phase.

5.14 VAT

At the current time, NHS-linked charities do not have their own VAT registration. With the implementation of the recommendation that an NHS Health Board should no longer be a corporate trustee, it is anticipated that this position would change in future. This brings with it the possibility of a change in the VAT liabilities for an NHS-linked charity. NHS-linked charities will want to explore this further to understand local impacts through independent advice, which may be an area they wish to co-ordinate via a national shared forum.

5.15 Naming and brand

Throughout this report, the phrase "NHS-linked charities" has been used deliberately instead of "NHS Endowment Funds". There are several reasons for this. Firstly, an "endowment" is a technical accounting term which has a specific meaning. It is somewhat misleading to use it in connection with these NHS-linked charities since not all funds held are classified and restricted as an "endowment". Secondly, as a technical term, it may be viewed as rather off-putting and not user-friendly.

5.16 It is not unusual for charities to go through a re-branding exercise. The selection of a charity's name plays a vital communications role. In this regard, it is interesting to note that some of the sixteen NHS-linked charities already adopt different working names, as shown on the OSCR Register, although none has formally changed its registered name as yet:

- Borders Health Board Endowment Funds is known as "the difference"
- Lothian Health Board Endowment Fund is known as "Edinburgh and Lothians Health Foundation"

5.17 As mentioned in section 4.29, some of the NHS-linked charities have moved towards developing their own brand/logo, enabling the charity to present itself in a more distinct form online and in printed materials. Branding and logos should be areas for further work in due course, to ensure that, for example:

- any trade mark considerations are taken into account e.g. whether to apply to register a trade mark.
- A branding licence agreement between the NHS-linked charity and the Health Board is considered, to permit the Health Board to use the NHS-linked charity's branding in certain circumstances - something which may be mutually beneficial.
- If the NHS-linked charity is to continue to use the Health Board's name, straplines or branding, a licence agreement should be granted by the Health Board to the NHS-linked charity to permit such use.

Branding issues and the templates for the licence agreements are matters which could be explored further by a national shared forum in due course.

Recommendation

Each NHS-linked charity should consider updating its registered name, in line with OSCR processes for doing so.

Each NHS-linked charity should consider its brand and any consequences in terms of a licence agreement with the relevant Health Board.

5.18 Fundraising

A range of views have been expressed about the scope of fundraising activity of NHS-linked charities. On the one hand, there is a view that NHS-linked charities should not actively promote fundraising, that they should primarily operate on a reactive basis to receive funds and distribute funds. Such a view was expressed five years ago, as evidenced in the Minutes from Tayside NHS Endowments Fund in January 2014: "She [Communications Manager] further advised that in terms of publicity for endowments, communications tended to more reactive than proactive." That view was also heard during certain discussions in this Review.

5.19 On the other hand, through conversations with donors and evidence from the newsletters, websites, and annual reports and accounts of some of the NHS-linked charities, an active and energetic picture of fundraising emerges (as can be seen on the front cover of this Report). One example is the Shetland MRI scanner appeal.[15]

5.20 The voice of the donor

The Endowment Network was very helpful in enabling contact to be made with donors who were happy to talk about their experience, motivations and intentions.

The Chair spoke to Kerry Falconer, who has spent several years holding fundraising events for the Jamie King Fund, an individual fund within one of the NHS-linked charities:

"Our motivation for fundraising for this particular fund was due to my husband and two of his friends having been treated by [name of doctor] for prostate cancer. We were keen to 'give something back' to the 'Doc' and are delighted that he has been able to put the £80k+ to practical use and has demonstrated to us and our guests at the events exactly what he has used the funds for. Neither we, nor our donors, felt we were fundraising for the NHS Charity. It would appear that there is little or no marketing of the existence of these funds and I wonder if there is duplication and therefore economies and efficiencies that aren't being taken advantage of. Also – my observation is that many beneficiaries of the outputs of these funds (in our case, improvements in the delivery of prostate cancer treatment) are completely unaware that such improvements have been made possible due to charitable donations. Are we missing opportunities to 'ask' for donations at point of delivery, doctors' surgeries etc?"

This offers trustees interesting future food for thought, around how NHS-linked charities communicate with potential donors, and how the use of the funds is communicated to those who may be benefitting from them.

5.21 NHS charities as conduits for donations

A consistent theme which emerged in all conversations with donors was the targeted nature of donations. None of the conversations revealed donors who simply wanted to donate to the NHS-linked charity in general terms. Particular funds were the focus in each case, be that a fund relating to one specific ward or area of clinical research or, as seen in section 5.20, a restricted fund named after a loved one.

This has important implications for the scope of decision-making for the NHS-linked charity trustees. It is an important reason why it is felt valuable to retain a link between the Health

[15] https://shetlandmriscannerappeal.com/

Board and the NHS-linked charity, given that a significant number of the restricted funds can only be spent in particular ways involving specific wards/hospitals/groups etc. Unrestricted funds offer flexibility and discretion over how monies are used: here, the NHS-linked charity trustees will have wide scope to consider the strategy and priorities for the charity, to then use their resources to deliver on those strategic goals. For the many restricted funds in their care, the charity trustees are in effect carrying out the wishes of the donor.

5.22 Another conversation with a donor involved the example of a grant-making charity which itself donates to one of the NHS-linked charities. This donation was not general in nature in terms of its intended use: it was specifically to benefit community nurses in the area local to the grant-making charity. Annual donations from this grant-making charity to support community nursing (via the NHS-linked charity) were reported as having been made at least as far back as 1995.

The donor preference for supporting local healthcare services came through loud and clear.

5.23 Restricted funds

As was clear from the conversations with donors, it is a feature across the NHS-linked charities that they hold a high number of restricted funds. A restricted fund is one where the donor has set narrower conditions around how it must be spent; for example, in a particular ward or to further research into a particular medical condition. A 2019 review of the accounts of the NHS-linked charities in Scotland showed that 53.5% of the assets on their balance sheet are categorised as held in restricted funds or permanent funds, which shows the high degree to which donors wish to direct the end use of their donations.

5.24 It is noted that, in one example in Scotland, over 2,000 individual funds are held within one NHS-linked charity[16]. In another example shared with the Review's Chair, in 2013 an NHS-linked charity ran an audit on 800 individual funds which had historically been classified as restricted. The audit found that the majority had been misclassified and should have been recorded as unrestricted funds (with the result that greater flexibility would in future apply to how they could be spent, noting such spending would of course still need to be in line with the charity's purposes). It should be emphasised here that no funds were misspent, since the narrower spending criteria would logically have been valid within the broader unrestricted classification. From an administrative perspective, the end result was that fewer than 400 of the original 800 individual funds are now treated as "restricted funds" in that charity. The audit led to the creation of a new flowchart to support the classification of funds.

Given the long history of the NHS-linked charities, it is not surprising that so many individual funds have built-up over time.

Recommendation

It would be beneficial for each NHS-linked charity to review its classification of funds, in particular to re-validate restricted funds. A framework to support classification may be usefully explored in a national shared forum

[16] https://www.nhsggc.org.uk/about-us/media-centre/news/2018/04/endowments/

5.25 Delegated authority

A practical consequence of the high number of these restricted funds is the process which governs how they are spent. It would not be feasible for the trustees to be involved in every individual decision on how a particular restricted fund is spent, in particular where the sums involved are small. The practice has therefore evolved that authority to make certain spending decisions is delegated to certain NHS employees, e.g. a senior NHS staff member on the relevant ward named in the restricted fund. The term "steward" or "fund holder" is sometimes used to describe those NHS employees who hold that delegated decision-making power.

5.26 As one might expect, financial thresholds tend to apply, such that high value spending proposals must be escalated for further scrutiny and approval. The levels of these financial thresholds vary across the NHS-linked charities, in line with decisions made locally in each of the charities.

5.27 Delegation is a matter covered in the OSCR Guidance 'Who's in Charge'. Page 5 states: "If charity trustees are delegating authority to others to run part of a charity's affairs……..the charity trustees should set out in writing the limits and terms of this delegation of powers and communicate these clearly."

5.28 Page 21 states "Sometimes charity trustees choose to create a new committee or group for a specific purpose…….Charity trustees may delegate responsibilities to that group, but must ensure that there is a well-defined mechanism for retaining control over its affairs."

5.29 Page 23 states "If a charity is delegating authority to others to run part of its affairs, the charity trustees should set out in writing the limits and terms of this delegation of powers, communicate these clearly to all those involved, and observe these in practice." It goes on to state: "Charity trustees should review their constitution and delegated powers regularly to ensure that these remain up to date and in line with the accepted working practices. If this does not happen it can become unclear over time who is entitled to run a charity's affairs."

5.30 At the current time, there is no legally binding written constitution for the NHS-linked charities and recommendation 2.11 addresses this gap. This new governing document will bring clarity to trustee powers and places the power to delegate decision-making on a clearer and more transparent footing.

5.31 Some evidence points to certain process delays and difficulties which can arise with delegated decision-making. In one example considered by the Review Chair, in conversation with an NHS consultant who held a Delegated Authority, the consultant said no training had been given in how to exercise the Delegated Authority to spend up to certain limits. The consultant felt a clearer document would have helped to set the scope around that, as it was not immediately apparent to them how NHS-linked charity money was to be accessed. In one particular case of proposed spend of NHS-linked charity funds, this consultant had been waiting for over a year to hear if the proposal was accepted or rejected, during which time process delays emerged over the content of a terms of reference around the process for approving such proposals. The consultant commented "These are big sums and you need oversight, but the current process makes it impossible to make progress. It's cumbersome."

5.32 A second example which points to delay is found in the Minute of the NHS Tayside Endowment Fund Board from 24th January 2014. One of the trustees: "pointed out that the

use of aged funds has often been discussed at EAG [Endowment Advisory Group], and how funds have not been used as quickly as they should be."

5.33 For context, it is noted that these are just two examples. They do however point to the opportunity for process improvements to be made, to ensure timely use of restricted funds.

Recommendations

1. It is helpful for NHS-linked charities to continue to delegate certain decisions and to have a clear power to do so, to facilitate the smooth running of the charity and to bring in the valuable insight and expertise of others, within a defined framework. It is recommended that the new governing document for each NHS-linked charity makes specific reference to the power to delegate, to bring additional clarity and transparency to this area of decision-making. The power to delegate is therefore included in the illustrative governing document in Appendix 3.
2. In light of this Review, it is recommended that all existing Delegated Authorities are reviewed and updated, to reflect the outcome of this Review and the new operating practices which will emerge. In that context, the process for timely decision-making should be considered, as part of the updating of Delegated Authorities.
3. Each NHS-linked charity should deliver Induction Training to all those holding a Delegated Authority, to ensure they have a good understanding of the scope and limits of their authority, and the processes for escalating decisions involving financial amounts above the threshold set in the Delegated Authority.

5.34 Fundraising regulations and policies

The regulatory backdrop to fundraising has undergone change in recent times. Each of the NHS-linked charities should consider taking the steps which will result in the charity being in a position to sign-up to use the Fundraising Guarantee logo. This will ensure that the relevant policies and procedures are in place to self-certify, and is a positive signal to donors.

5.35 Each of the NHS-linked charities will require to prepare their own policies and procedures for fundraising practices, including a vulnerable persons policy, fundraising complaints policy and complaints procedure for communication to the public. A national shared forum could co-ordinate work on templates for these, for local adaptation.

5.36 The NHS-linked charities will require to review the supporter database collected by the Health Board and shared/transferred to the charity to understand whether individuals can lawfully be contacted by the NHS-linked charity under the law of data protection and PECR (Privacy and Electronic Communications Regulations) and the new ePrivacy Regulations.

Recommendation

Each NHS-linked charity should review its fundraising policies and procedures, and consider signing-up to the Fundraising Guarantee to commit to best practice fundraising.

5.37 Other compliance matters

The Review sought legal advice on the range of compliance steps an NHS-linked charity may need to consider. This pointed to a need to prepare website terms and conditions, a

website privacy policy and the need to consider compliance matters surrounding cookies and collection of consents to direct marketing/fundraising communications. It was also noted that anti-bribery policies and procedures would need to be updated and related training for staff would be required.

5.38 Data protection and information governance considerations

Once the governance changes in chapter 4 are implemented, such that the Health Board is no longer the corporate trustee of the NHS-linked charity, a new set of trustees are deemed an independent "controller" under data protection laws and will have a range of legal obligations.

A number of steps will be required in readiness for this change. Data processing agreements may be required with processors/service providers, where this is not organised via the Health Board, for example. Data sharing contracts may be needed between the Health Board and the NHS-linked charity. It will be helpful for this to be considered in a national shared forum.

Recommendation

Prior to the implementation of the recommendations in this Report, NHS-linked charities should identify and consider the range of future compliance actions arising, to support smooth handover to the incoming trustees. These compliance matters should be explored further in a national shared forum.

5.39 Characterising 'core' and 'non-core' expenditure in NHS charities

As mentioned in 1.10, whether a proposed item of expenditure represents something which mainstream NHS funds should pay for, or whether it is an add-on or enhancement such that it is something an NHS-linked charity might suitably fund, is something of a false distinction as a matter of charity law, since charity law requires no such boundary to exist.

In reality, it may reflect the self-awareness of the Health Board as corporate trustee in full realisation that, for many given items of expenditure, such items could be funded through one, or other, or both of its roles.

In a future scenario where the majority of decision-makers in the NHS-linked charity no longer wear dual hats, it may prove to be the case that the need to classify potential expenditure as core or non-core becomes less of an issue, in the absence of the conflict of interest. This is because the Health Board could no longer be said to be spending NHS-linked charity funds since it no longer controls the charity: it is the intent of this Review that this risk is removed.

If the recommendations of this Review are implemented, in the period ahead, the new board of each NHS-linked charity will have the opportunity to shape and create its new strategy. The public health priorities of the local area and strategic priorities of the Health Board form a relevant backdrop to the strategy of the NHS-linked charity, but the NHS-linked charity will ultimately shape and own its strategy. As is the case now, the many restricted funds will continue to be carefully applied in line with the conditions set by the donor, which offers particular reassurance to donors over how their donations are used.

Chapter 6 – Timeline and Transition

6.1 A sample timeline is set out in Appendix 4.

6.2 It is noted that the accounting period for all NHS-linked charities commences on 1st April each year. With that in mind, it may be helpful for a future Implementation Date to fall on 1st April, to match the preparation of accounts for the new accounting period.

6.3 To successfully deliver the recommendations in this Review, there will be a significant volume of work involved, which falls into three broad phases:

- a preparation phase, which has a focus on recruitment for the new Chairs and trustees
- a transition phase, which enables handover and knowledge-sharing to take place between the outgoing and incoming Chairs and trustees
- a post-implementation date phase, where the new Charity Liaison Groups are established and various contractual and operational matters are finalised by each NHS-linked charity.

6.4 The illustrative preparation phase in Appendix 4 stretches to a fifteen month period, with a focus on recruitment.

6.5 The transition phase in Appendix 4 is intended to be a minimum of three months after the preparation phase, to enable effective handover and knowledge-sharing between the outgoing and incoming Chairs and trustees. Depending on when this actually falls, it may be much longer than three months, ending with the implementation date on 1st April (which may be 1st April in the next again year).

6.6 Throughout this report, the use of a national shared forum has been signposted as a proposed means of co-ordinating work in preparation for the governance and operational changes ahead for the NHS-linked charities. This will enable, for example, any template documents to be prepared once and shared across all sixteen NHS-linked charities for local adaptation. The Chairs-elect might play a particular role within this national shared forum. Bringing together the potential areas for consideration by the national shared forum, the following is a non-exhaustive list:

- a Trustee Recruitment Guide
- Best practice relating to induction training for trustees
- Code of Conduct
- Various contractual template documents
- Charity Liaison Group terms of reference
- Data protection matters
- Standing Orders

Recommendations

A suitable preparation and transition period for the implementation of these recommendations should be adopted, to enable practical arrangements to be made in advance of the implementation date on which many of the above changes would go live.

It is recommended that a date of 1st April is considered as a future implementation date, to match the start of the accounting period of the NHS-linked charities.

It is recognised that significant further work will be required by the Health Boards and NHS-linked charities to plan effectively for both the governance and operational changes recommended in this report. We recommend the use of a shared forum as a means of co-ordinating various aspects of the preparations and post-implementation date work.

List of NHS-linked charities in Scotland

Details of the NHS-linked charities, as per OSCR registration, are set out below.

Name of NHS-linked charity	Charity registration number
Ayrshire & Arran Health Board Endowment Fund	SC007448
Borders Health Board Endowment Funds	SC008225
Dumfries & Galloway Health Board Endowment Fund	SC001116
Fife Health Board Endowment Funds	SC011988
Forth Valley Endowment Fund	SC035953
Grampian NHS Endowment Fund	SC017296
Greater Glasgow & Clyde Endowment Funds	SC005895
Highland Health Board Endowment Funds	SC016791
Lanarkshire Health Board Endowment Fund	SC005674
Lothian Health Board Endowment Fund	SC007342
National Waiting Times Centre Board Endowment Fund	SC045146
Orkney Health Board Endowment Funds	SC016919
Scottish Ambulance Service Endowment Funds	SC027131
Shetland Health Board Endowment Funds	SC011513
Tayside NHS Board Endowment Fund	SC011042
Western Isles Health Board Endowment Funds	SC001015

Terms of Reference

1. Name of the Team
NHS Endowment Funds Review – Project Group
2. Purpose of the Group
The purpose of the Project Group is to review the current governance arrangements of NHS Endowment Funds in Scotland and make recommendations to the Scottish Government regarding potential changes to the current position to ensure that those responsible for the management and control of these charitable funds are able to demonstrate at all times that they are acting in the interests of the charity.
3. Remit of the Group
To provide a report to Scottish Government on the preferred option to strengthen the governance of NHS Endowment Funds and to ensure that the management and control of these charitable funds is able to be independent of the relevant Health Board. This will include a review of: • Current models of structure and operation in Scotland; • The legislation underpinning the existing governance structures in Scotland; • The strengths and weaknesses of potential alternative models of governance including consideration of effectiveness and deliverability; • Possible approaches and timescales for the delivery of the preferred option.
4. Membership
The Project Group will be chaired by Julie Hutchison with support from: 1. Core team: • Laura Anderson, Head of Professional Advice and Intelligence, OSCR • Alan Eccles, Partner, Brodies • Jane Ferguson, Foundation Director, Edinburgh and Lothians Health Foundation • Alex Linkston, Chair, NHS Forth Valley • Tricia Marwick, Chair, NHS Fife • Gavin McEwan, Partner, Turcan Connell • Christine McLaughlin (or Deputy) • Project management and secretariat (SG)

2. Reference Group including representatives of all NHS Endowments Funds as well as key SG contacts

3. Other expertise as identified by the Project Group

5. Governance

The Project Group will report to Malcolm Wright, Director General Health & Social Care and Chief Executive NHSScotland.

Christine McLaughlin, Chief Finance Officer NHS Scotland and Director of Health Finance, Corporate Governance and Value will be the Sponsor Director for the Health and Social Care Management Board, co-ordinating the involvement of other Scottish Government officials as may be required.

6. Meetings

The Project Group will meet approximately every 4-6 weeks from April to September 2019.

Weekly progress calls will be put in place with the Chair and the SG secretariat.

7. Outputs

The Project Group will complete and submit a final report by the beginning of October 2019 on the findings of their review of the effectiveness and deliverability of options for strengthening the governance of NHS Endowment Funds. This report may also include recommendations on further actions or follow on work.

8. Review

The report will be reviewed by Scottish Government with appropriate reporting to Ministers.

Recommended changes to the National Health Service (Scotland) Act 1978

NHS-linked charities in Scotland

Status

X An NHS-linked charity in Scotland shall be a body corporate.

X [conversion wording to confirm continuity of Scottish charity number]

Purposes

X An NHS-linked charity has charitable purposes for the advancement of health for the public benefit to improve the physical and mental health of the people of Scotland and the prevention, diagnosis and treatment of illness.

Membership

X The board shall consist of no fewer than 7, and no more than 11, members.

X The first Chair shall determine the size of the first board. Thereafter, the trustees shall determine the size of the board from time to time.

X The majority of trustees shall be independent of the relevant NHS Board. In this context, "independent" means they must not be board members of the relevant Health Board, nor are such trustees appointed by the Health Board ("non-Health Board trustees")

X The first Chair and the first non-Health Board trustees shall be appointed by [mechanism to be identified so there is an appointer, which may involve a specially established independent selection panel.]

X After the tenure of a first non-Health Board appointed trustee comes to an end, the open recruitment and appointment processes leading to the appointment of a non-Health Board appointed trustee shall be determined by the NHS-linked charity. The non-Health Board appointed trustees shall be in the majority in the recruitment process which selects non-Health Board appointed trustees.

X The open recruitment and appointment processes leading to the appointment of the second and subsequent Chair of an NHS-linked charity shall be determined by the trustees of that NHS-linked charity. The non-Health Board appointed trustees shall be in the majority in the process which selects the second and subsequent Chair.

X The minority of trustees shall be nominated by the relevant NHS Board.

X The Chair and trustees shall be appointed for a three year term and shall be eligible for re-appointment for a second three year term. [Consider provisions for rotation to ensure tenure of all trustees does not come to an end at the same time].

X Trustees may resign office by notice in writing addressed to the Chair.

X [Procedures will exist for removal of trustees in appropriate circumstances, which may include:

- the disqualification of the trustee under charity law or other legal provisions
- the incapacity of the trustee
- the apparent insolvency of the trustee
- the absence of the trustee from meetings of the trustees over an extended period without permissions
- if the trustee's removal would otherwise be in the best interests of the charity].

Committees

X The Board of Trustees may establish committees for any purpose relating to its functions.

X A committee may include as members persons who are not trustees, but the chair of the committee must be a non-Health Board trustee.

Procedure and meetings

X The relevant quorum for meetings of the trustees shall be [TBC] and must comprise a majority of non-Health Board trustees.

X [Provisions for quorum if there is a vacancy]

X [Provisions for first-appointed board and transition]

X Other than the quorum provisions in X above, the Board of Trustees may determine its own procedures and those of its committees.

Expenses

X The Board may refund to each of the trustees and the members of any committee such reasonable expenses as the Board determines.

General powers

X The Board of Trustees may do anything which appears to it –

(a) to be necessary or expedient for the purposes of, or in connection with, the exercise of its functions;
(b) to be conducive to the exercise of those functions.

X The Board of Trustees may delegate the exercise of its functions to such extent and subject to such conditions as it considers appropriate, and may vary or revoke any delegations made.

Appendix 4

Timeline

This appendix sets out an illustrative timeline, to give a sense of the potential transition period involved in implementing the recommendations of this Review.

It takes a timeframe based on quarters, to indicate the potential focus of work in a future transition period ahead.

Q1 in Year 1 should not be taken to mean a January to March period, but rather whichever quarter falls when the legislative changes are passed by the Scottish Parliament.

15 months – Preparation phase			Minimum 3 months – Transition phase	Implementation phase	
Q1	**Q2**	**Q3/Q4/Q1**	**'Observer period'**	**1st April**	**Thereafter**
Legislative changes passed in an Act **Act contains future Implementation Date in Year 2.**	Recruitment process for 16 new Chairs is developed. Adverts go live.	Chair interview process gets underway and completes, with a forward appointment date to match the Implementation Date. Commence recruitment process for new non-Health Board trustees. Health Board considers nominations for the minority Health-Board appointed trustee roles	Chairs-elect have been identified. Health-Board appointed trustee candidates have been identified. Non Health board-appointed trustee candidates have been identified. Health Boards liaise with Chairs-elect and trustees-elect, to invite attendance at NHS-linked charity board meetings to facilitate effective handover and transition planning.	Implementation Date of Act falls in this period. It would be helpful if this were a 1st April date to reflect the accounting period of the NHS-linked charities. Appointment of new Chair and trustees of an NHS-linked charity takes effect on the Implementation Date. The role of the NHS Health Board as corporate trustee ends at the Implementation Date. NHS-linked charity sets-up Charity Liaison Group to support future collaboration and communications between the NHS-linked Charity and the Health Board.	Contractual matters between NHS-linked charity and Health Board are finalised. Charity Liaison Group is meeting on a scheduled basis.
A national shared forum, involving representatives from all 16 NHS-linked Charities, meets regularly to work on various future operational and transition arrangements.					

Appendix 5

Acknowledgements

The Chair would like to extend her thanks in particular to the Project Group

Name	Title (at time of the Review)	Organisation
Laura Anderson	Head of Professional Advice and Intelligence	OSCR
Alan Eccles	Partner	Brodies LLP
Jane Ferguson	Director	Lothian Health Board Endowment Fund (known as Edinburgh and Lothians Health Foundation)
Beth Grieve	Financial Accounting and Planning Manager	Scottish Government
Alex Linkston	Chair	NHS Forth Valley
Richard McCallum	Deputy Director, Health Finance and Infrastructure	Scottish Government
Gavin McEwan	Partner	Turcan Connell
Christine McLaughlin	Chief Finance Officer, NHS Scotland	Scottish Government
Tricia Marwick	Chair	NHS Fife

The Chair would like to thank all those who participated in meetings during the course of the Review, who shared their insight and whose contributions have helped to shape the recommendations. Reference Group members are identified with a *

Name	Title (at time of the Review)	Organisation
Laura Ace	Director of Finance	NHS Lanarkshire
Iain Addison *	Head of Area Accounting	NHS Highland
Pat Armstrong	Chief Executive	ACOSVO
Lesley Bowie	Vice-Chair	NHS Ayrshire and Arran
Debbie Bozkurt *	Head of Finance and Procurement	NHS Western Isles
Bob Brown *	Assistant Director of Finance	NHS Ayrshire and Arran
John Brown	Chair	NHS Greater Glasgow and Clyde
Joanne Brown	Partner	Grant Thornton
Ian Burgess	Chair	NHS Western Isles
Jacqueline Carrigan	Head of Finance	NHS Greater Glasgow and Clyde
Julie Carter *	Director of Finance and Logistics	Scottish Ambulance Service
Moira Cathcart	Senior Legal Advisor	OSCR
Linsey Craig	Public Appointments Manager	Scottish Government
David Crichton	Chair	NHS Health Scotland
Terry Currie	Chair	State Hospitals Board for Scotland
Patricia Donald	Non-Executive Member	NHS Lothian
Susan Douglas-	Chair	Golden Jubilee Foundation

Scott		
Mark Doyle *	Interim Director of Finance	NHS Orkney
Simon Dryburgh *	Assistant Director of Finance	NHS Forth Valley
Kerry Falconer	Fundraiser/donor	n/a
Julie Farr*	Charity Manager	NHS Fife
David Garbutt	Chair	NHS Education for Scotland
Dave Garden	Director of Finance	NHS Highland
Carol Gillies	Director of Finance	NHS Borders
Susan Goldsmith *	Director of Finance	NHS Lothian
Luan Grugeon	Non-Executive Member	NHS Grampian
Melissa Gunn	Non-Executive Member	NHS Dumfries and Galloway
Karen Hamilton	Chair	NHS Borders
Angela Harkness	Director of Global Development and Strategic Partnerships	Golden Jubilee Foundation
Stuart Holmes	Senior Solicitor	Central Legal Office
Brian Houston	Chair	NHS Lothian
Elizabeth Ireland	Chair	NHS National Services Scotland
Nicola Janczyk	Finance Manager	Scottish Ambulance Service
Duncan Keith	Head of Finance	Scottish Ambulance Service
Ruth Kelly	Deputy Director of HR	NHS Lothian
Garry Kidd *	Assistant Director of Finance	NHS Grampian
Ian Kinniburgh	Chair	NHS Orkney
Robert Kirkwood	Corporate Business Manager	Scottish Government
Rona Laing	Non-Executive Member	NHS Fife
Katy Lewis *	Director of Finance	NHS Dumfries and Galloway
Derek Lindsay	Director of Finance	NHS Ayrshire and Arran
Sheena Lonchay	Endowment Operational Manager	NHS Grampian
Derek Lonsdale	Head of Finance	NHS Orkney
Carolyn Low	Director of Finance	NHS National Services Scotland
Stuart Lyall *	Deputy Director of Finance	NHS Tayside
Lynda Lynch	Chair	NHS Grampian
Robert Mackinnon	Associate Director of Finance	NHS Tayside
Neena Mahal	Chair	NHS Lanarkshire
Alan Main	Senior VAT Manager	Saffery Champness
Craig Marriott	Deputy Director of Finance	NHS Lothian
Colin Marsland *	Director of Finance	NHS Shetland
Stephen Mather	Non-Executive Member	NHS Borders
Anita McCloy *	Senior Finance Manager	NHS Borders
Kenneth McDowell	Partner	Saffery Champness
Maria McFeat	Assistant Director of Finance	Scottish Ambulance Service
Claire McHarrie	Senior Policy Officer	Scottish Government
Marianne McJannett	Associate	TC Young
Trudy McLeay	Non-Executive Member	NHS Tayside
Nick Mitchell	Endowment Operational Manager	NHS Dumfries and Galloway
Brian Moore	Non-Executive Member	NHS Lanarkshire
Nicholas Morris	Chair	NHS Dumfries and Galloway
Euan Morrison	Director	Chiene + Tait
Colin Neil *	Director of Finance	Golden Jubilee Foundation
Alison Paines	Partner, Head of Charities	Withers LLP

Ann Pascoe	Non-Executive Member	NHS Highland
Andrew Patience	Director of Finance	NHS Health Scotland
Carol Potter *	Director of Finance	NHS Fife
Ian Ritchie	Non-Executive Member	NHS Greater Glasgow and Clyde
Boyd Robertson	Chair	NHS Highland
Gary Robinson	Chair	NHS Shetland
Alan Sharp	Assistant Director of Finance	NHS Grampian
Michael Sheils *	Head of Financial Services	NHS Greater Glasgow and Clyde
Norma Shippin	Director	Central Legal Office
Janice Sinclair	Head of Finance	NHS Education for Scotland
Gordon Smith *	Head of Corporate Finance	NHS Lanarkshire
Madeline Smith	Vice-Chair	NHS 24
Tom Steele	Chair	Scottish Ambulance Service
Ellen Stewart	Chancellor's Fellow	University of Edinburgh
Martin Togneri	Non-Executive Member	Scottish Ambulance Service
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