30 words which spell change for Scotland's NHS charities

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Introduction

For readers who need a short introduction to the 16 NHS charities in Scotland, in order to more fully understand the background for this paper, see sections 1.1 to 1.20 of the 2019 Review.

What follows is a response to the following 30 words contained in the Scottish Government's Programme for Government, published in September 2026:

"...Simplifying the NHS by replacing the current 14 territorial Health Boards with two Strategic Health Boards and build on planned reforms to further reduce the number of special Health Boards."

What do those 30 words mean for the 16 NHS charities in Scotland? The answer matters, not least because these charities hold more than £300m representing funds donated by members of the public, businesses and grant makers going back many decades. Indeed, some of these funds are connected to the pre-NHS era, with origins in the eighteenth or nineteenth century: health philanthropy has a long history in Scotland. Not only are we looking here at some charities with long heritage and significant assets for use to benefit the people of Scotland; viewed in a wider UK context, these charities arguably also represent an aspect of the public's emotional and cultural attachment to a unique national institution: the NHS.

In this article, I don't set out to offer definitive answers. My intent is to take a step back and identify what I see as some of the key questions which need to be considered first. My reason for focusing first on the questions rather than the answers is simple: ask the wrong questions and you'll get the wrong answers. I also set out some of the factors to weigh-up in the decision-making which lies ahead.

1 Start by finding the right questions to ask

As I see it, the most vital question to ask is this: what is the optimal number of NHS charities in Scotland?

If a consensus can be found in answering that question, in my view the legal mechanisms can then be made to fit the desired end outcome. Identify where you want to get to, then work backwards.

In considering that vital question, what might be some of the key considerations? I would expand the question as follows: what is the optimal number of NHS charities in Scotland, taking account of the optimal approach to:

(a) maintaining and developing public confidence and trust in NHS charities;
(b) building relationships with future donors who feel especially connected to their local health care teams and services, including retaining donors who are already supporting an NHS charity;
(c) efficient and effective operational systems and processes for NHS charities;

(d) building and maintaining the kind of effective relationships on the ground which underpin delivery of public benefit by the NHS charities;
(e) an equitable outcome, which recognises that rural and island communities may have specific needs reflecting their different circumstances; and
(f) enabling a board of charity trustees to be truly effective in exercising their trustee duties over a realistic scale of activity and operations, which means going beyond compliance.

These six factors are highly relational: all are about *people*. In some ways, they are enabled by geographic proximity, which aids the kind of interactions which build trust between people. This is not, however, the same as saying that the answer to the question is necessarily "we still need 16 NHS charities in Scotland."

2 Does one size still fit all?

A guiding principle in the 2019 Review recommendations was that a 'once for Scotland' approach was favoured. By this, I mean that the changes envisaged in that Review were intended to apply across all 16 NHS charities, such that all 16 organisations moved forward into a more modern governance structure, all 16 had a clearer governing document and all 16 could finally recruit their own charity trustees. At the end of that process, it was still anticipated that there would be 16 NHS charities.

In my view, thinking with a 'blank piece of paper' 7 years on, it is not clear to me that current thinking should be constrained by assuming that the same outcome is still best suited to all 16 charities. In today's changed context, namely the backdrop of the re-organisation of Scotland's NHS health boards, I am making no assumptions that there is a universal solution which might best suit all 16 NHS charities. It is possible that a differentiated approach may offer a more sensible outcome, and I am keeping an open mind on the answer to the vital question which I have posed.

3 Why does 'Place' matter?

If taking a uniform approach to all 16 charities is not necessarily an optimal outcome, what are the alternatives?

For the 14 charities linked to territorial health boards (see list in Appendix 1), is the optimal outcome that the charities continue to mirror the new structure of the NHS, such that there are 2 new charities: one for east and one for west Scotland? Let's explore why that might and might not be a good idea.

I am reminded of two of the quotes which opened the 2019 Review's Report: *"We originally raised money…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."* And similarly: *"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."*

In section 1 above, I mentioned that there were highly relational factors to consider, when looking at how to approach the future shape of the NHS charities in Scotland. People give to people. We know donors are motivated by strong emotional connections when wanting to act to show gratitude to those who have helped them, often during the worst of times. When people feel they can see how their money has been spent in their own community, that 'proof point' arguably validates their decision to give more than data in an Annual Impact Report. Place, physical proximity and personal connection all matter; but again, that is not the same thing as saying "we still need 16 NHS charities in Scotland."

4 What about the other 2 NHS charities?

Before turning to look at the 14 NHS charities linked to territorial health boards, it's worth recognising the 2 other NHS charities. One is already Scotland-wide in its activities: Scottish Ambulance Service Endowment Funds. Its focus is self-explanatory. The other is NHS Golden Jubilee Charity. In what lies ahead, their particular needs and objectives also need to be taken into account.

5 Would you like east and west and lots of restricted (yet flexible) funds?

In exploring some hypothetical scenarios, I do so not to advocate for any particular option, but to play devil's advocate and use this space for exploration.

If Scotland is going to end up with 2 Strategic Health Boards (one for east, one for west), let's look at whether or not 2 new charities might also be an optimal answer. Let's also assume that these 2 hypothetical charities benefit from (majority) independent boards of trustees, as envisaged in the 2019 Review. That's because, in terms of time alone (although there are other important reasons too), board members of those 2 new Strategic Health Boards will be quite busy enough with the huge scale of what they will be dealing with, without also having responsibility for two new large charities as well.

Let's give our 2 new charities imaginary names, eg. "East of Scotland NHS Charity" and "West of Scotland NHS Charity."

Let's now imagine a patient and their family in Aberdeen who wish to give to their "local" NHS charity. I am going to assume that the patient and their family living in Aberdeen are going to want to know that their donation is still being spent in the north-east of Scotland, and not in Dundee, Kirkcaldy or Melrose.

Today in 2026, such a donation would be made to NHS Grampian Charity, Scottish Charity No. SC017296.

Now imagine in our hypothetical East of Scotland NHS Charity, there is a restricted fund called "Grampian's NHS Health Fund." It is a restricted fund which means it can only be spent in the geographic area formerly served by Grampian NHS health board (or some other geographic definition of "Grampian"). That however still enables considerable flexibility in *how* it can be spent – the only limitation is *where*.

From a brand/naming perspective, this could be presented externally as follows: "Grampian's NHS Health Fund is a ringfenced fund held within the East of Scotland NHS Charity, Scottish Charity No. SCxxxxxx."

In other words, Grampian's NHS Health Fund is not a standalone charity, but is a sub-fund held within another charity – the East of Scotland NHS Charity. A donation intended for general use in Grampian could be held within such a sub-fund. If the donation was more specific (as is often the case), for example to "Ward X in Hospital Y", such a sub-fund would then be created within the East of Scotland NHS Charity, to mirror the condition attached to the gift.

At a sub-East of Scotland level, let's imagine there were local charity management teams in place in Grampian, Tayside, Fife, Lothian, Borders etc, with certain day-to-day management responsibilities for the operation of the sub-funds within their local area. This local charity management team might have responsibilities around strategy development (in tandem with the trustees, who have overall responsibility), delivery of the strategy, annual planning, co-ordination of fundraising activity, communications, building and maintaining relationships with local NHS health teams where grants

are being spent. These activities are examples and are not exhaustive. The partnership working and collaboration between the local charity management team and the NHS services in their area would be a critical factor for success, just as it is today.

A key part of this imagined scenario involves considering at what level grant making decisions would be made. Just as happens today, there could be formal delegated authorities, with larger grants requiring more elevated scrutiny, oversight and decision making – perhaps involving the East of Scotland NHS Charity trustees themselves in the largest cases - and smaller grants being subject to decisions at regional/local levels, all within a grant making policy seen, approved and kept under review by the East of Scotland NHS charity board. Remember that today, 'Fund Stewards' and delegated authorities are business-as-usual within how the NHS charities operate. Sometimes decision-making power on grants sits with senior NHS staff on a ward named in a restricted fund. It is nothing new to have grant-making decisions at different levels, reflecting a proportionate approach.

Let's go one stage further, as I test this idea. There is no (theoretical) difference in this scenario between having 2 charities (east and west Scotland) and having just 1 charity: Scotland's NHS Charity, with regional charity management teams sitting underneath. Whether a single charity is a desirable outcome, however, is another question entirely. My point is this: it's a possible scenario to consider.

6 Do you really want a mega-merger creating one charity with thousands of sub-funds?

There are many limitations, risks and opportunities with the concept of a single 'Scotland's NHS Charity' which has thousands of sub-funds, absorbing a mega-merger of all 16 existing charities and their many sub-funds.

Let's consider one aspect and risk of such a mega-merger: the financial accounting required for such a significant number of sub-funds (the exact number of which is not currently known to me, but I would imagine into the thousands). In recent years, many of the individual NHS charities have been reviewing their own sub-funds, to better understand their classification as restricted or otherwise. This has often led to the positive outcome that there is a significant reduction in the number of restricted funds, which supports more streamlined grant making. Bringing all of those sub-funds from 16 charities across onto one new financial accounting IT platform would be quite the transition task: not without risk. Future mis-posting of entries would also be a risk. The question is whether adequate risk mitigation would be possible, if this scenario were to be pursued.

There is also a question of how to approach today's sub-funds which are currently classified as unrestricted. As noted in section 1.8 of the Review Report, the charitable purposes of the NHS charities are in effect all Scotland-wide today, although the practice has emerged that each charity operates in its own "patch" as defined by the relationship it has to its related Health Board. It is an interesting question to consider, whether the unrestricted funds of the 16 charities could (as a matter of law) be intermixed since their charitable purposes are the same, but one would question whether that result promoted the goal of public confidence and trust in the NHS charities. If it is correct that such unrestricted funds could be merged (a big if), in the event of any merger, it could be prudent to designate those funds to respect their heritage, but this question is in the realms of law and accounting rules for others to answer, and only arises in the event that any charity merger is even considered.

Future cost allocation would also be a consideration. How would the operating costs of the hypothetical Scotland's NHS Charity be allocated across the thousands of sub-funds? Which costs

would be central costs, for sharing across several funds, and which costs would only be allocated to one region's sub-fund? One might imagine regional charity management teams and fundraising colleagues more clearly under their own regional line. What management roles would an imagined Scotland's NHS Charity require? There would need to be one person with overall management accountability – would there be a new overall CEO role, Charity Finance Director role (with many finance team members) etc? How are they paid for? The finance questions might be possible to resolve, but they are definitely complicated, involving a high degree of detail. Very careful work would be required to get that right.

In the hypothetical scenario of a single Scotland's NHS Charity, one might also ponder if a new CEO role offers a potential opportunity in terms of the external-facing aspects of such a post, acting as an ambassador for the role of health philanthropy which has a long history in Scotland. As the topic of philanthropy gains momentum in the UK generally, and in Scotland in particular, having a figurehead to champion health philanthropy in Scotland might be seen as useful and desirable.

In any new model, there are also other practical resource access decisions to consider relating to charity premises, HR, payroll, procurement, staff pensions, insurance etc. I won't repeat here the details of sections 5.6 to 5.14 from the 2019 Review. I simply identify them as continuing practical considerations which would need to be explored in whatever new model is favoured.

7 A future landscape of regional NHS charities, and some smaller mergers?

Let's explore another alternative scenario. Since 2019, several of the larger NHS charities in Scotland have evolved to develop their own regional brand identity. At least two have changed their formal registered name with OSCR, the Scottish Charity Regulator, reflecting the wise decision to drop the "Endowments" word, a word which is misleading and mis-characterises the nature of what an NHS charity is and can do. Several of the NHS charities also now have simpler operating names, albeit their formal name for accounting/legal purposes remains unchanged. These are all positive developments.

Against this backdrop, what if a number of the larger NHS charities in Scotland would rather become new ringfenced charities, while still retaining their close working relationships with their local/regional NHS health services and collaborating closely with the NHS through appropriate new partnership/contractual agreements?

In England, albeit under different legislation and with a different background context, over 25 NHS charities have now become independent since 2010, while still remaining close partners to their local NHS health services. This is another option among many in the 'art of the possible' in what lies ahead.

What would the consequences be, should this route be favoured by some but not all of Scotland's 16 NHS charities? What would happen to those charities which did not wish to individually spin out? Would the optimal outcome for some of the smaller NHS charities be to merge with one of the larger ones nearby, taking the sub-funds approach set out above in section 5 above and maintaining a local charity management team? There is already Scottish practice in evidence where the investment portfolio management arrangements of one of the NHS charities is administered alongside the portfolio of one of the larger NHS charities. Equally, two other NHS charities have recently separated out their previously combined investment management arrangements: a reminder that preferences can change over time. A question for stakeholders to explore would be: given the background context of mergers among the 14 territorial Health Boards, which is intended to create two Strategic Health Boards in Scotland, would any of the smaller NHS charities find this a good moment to benefit from

the convenience or economies of scale which might come from a merger, with all the protections for ongoing recognition of sub-funds and the ongoing role for local charity management teams? If one went down this path, one could imagine ending up with fewer than 16 legal entities, but with continuing scope to name and promote geographic sub-funds as required.

What would be the view in rural and island areas? In the context of the future shape for regional/local councils, I note that the Programme for Government specifically mentions exploring a bespoke solution for island communities, including exploring a Single Authority Model. This leads to the question: what outcome is preferred by the more rural and islands-based NHS charities? What outcome best serves their communities?

8 What about the existing restricted funds?

To be quite clear, nothing in what lies ahead should pose any threat to existing restricted funds. Donors can be reassured that money given specifically for X remains focused on supporting X. From an accounting and legal perspective, the conditions attached to existing restricted funds in all NHS charities would need to remain in place, even in the event of charity mergers. That is 'BAU' in the world of charity law and regulation. Money held for Ward X in Hospital Y would, just as today, need to remain ringfenced for Ward X in Hospital Y. If Ward X closed in the years ahead, or a new hospital replaced Hospital Y, there is already a process available with OSCR to reorganise restricted funds which are otherwise at risk of being obsolete: that is also BAU, and ensures donated funds can remain effective.

OSCR, the Scottish Charity Regulator, will of course be engaged in the conversations which lie ahead, not least because of the monetary amounts involved across the 16 charities and the need to ensure they are properly safeguarded through any transition. Legislation sets out the circumstances in which changes require OSCR's consent. Any charity amalgamation requires OSCR's consent.

9 Take care not to lose a future legacy

Looking elsewhere in the UK, figures from Smee and Ford show that legacies to NHS/hospital charities in England and Wales have shown a 5 year average growth rate of over 7% (sadly the report does not cover Scotland). At least 3 of Scotland's NHS charities have received notable legacy income in recent years, however, and the possibility of more gifts in Wills is a realistic prospect, given changing population demographics. What if someone names an NHS charity in their Will, and in the years ahead that charity has merged or transferred its assets to a new NHS charity, and the Will has not been updated?

Scottish charity legislation from 2023 sets out new provisions around the recording of charity mergers and the treatment of legacies. This covers the situation where the assets of one charity are transferred to another; or where two or more charities are amalgamated. A notification procedure exists, whereby the transfer or amalgamation can be formally notified to and recorded by OSCR. This means if someone has bequeathed a legacy in their Will to one of the "old" NHS charities which no longer exists, the legacy could generally be treated as belonging to the "new" NHS charity. This should be kept in mind as an enabling provision, in what lies ahead.

10 Where, and at what level, should trustee decision-making sit?

In this paper, I began by setting out what I believe to be the vital question to be addressed: what is the optimal number of NHS charities in Scotland? In exploring the answer to that question, there is also a governance lens which can be overlaid. Another way to ask the same question is: at what geographic

level should trustee decision-making sit? How proximate should trustees be to where donations are being given, and where public benefit is being delivered? This is what sits behind the factor (f) I identified in my opening question.

To my mind, there might or might not be a 'Goldilocks test' here.

In general terms, it is possible for a charity to be too small to be effective, with the result that it can be sensible to wind-up and transfer its assets to be 'housed' within another charity, to benefit from economies of scale in terms of costs, and to benefit from access to other expertise it might not have on its own. Its mission could be said to continue, just delivered via other means.

In the non-NHS grant making sector more generally, there are also examples of charitable organisations at a different end of another kind of scale: complexity. Some grant makers operate on a simpler and more transactional basis; receiving applications for funding, reviewing them, making decisions, arranging for funds to be paid out, and receiving reports on how funds have been spent. Monitoring the performance of an investment portfolio can be part of that picture too. Such grant makers typically do not form in-depth ongoing relationships with grantees, they do not receive ongoing donations and are not involved in fundraising. In a reductionist sense, it's financial administration with a few add-ons.

If this were all that an NHS charity did, perhaps a single NHS charity for Scotland could work. But to view NHS charities in this way is to vastly diminish their potential, and indeed to ignore the reality on the ground, and ignore how many of the NHS charities have already evolved their activities, their delivery of programmes, and their approach to strategic partnership working with other bodies. For example, on that last point see the recent cancer research and genetics project with a focus on the opportunity for early intervention, co-funded by 7 of the NHS charities in Scotland (see References section for news item).

In view of both the geographic spread of activities, and the detailed dialogues which sit behind building effective delivery on the ground, I would therefore question if a hypothetical single NHS charity board could ever truly be effective across the Scotland-wide scale involved.

11 Don't take NHS health philanthropy for granted

There are also risks ahead, if the future pathway for the NHS charities in any way undermines their reputation, and therefore donor confidence and trust. NHS charities are not the only choice available to donors, when considering how to support health-focused organisations in their area. One positive evolution since the 2019 Review has been in the realm of fundraising and communications. Many of the NHS charities make clear on their website that they are the "official" NHS charity in their area – an information point which both informs and reassures donors. Trusted donor relationships are a key asset for a charity. Particular care is therefore required to ensure such relationships are not affected by whatever lies ahead.

As well as risks, there is also the particular opportunity ahead for the NHS charities in 2028 with the 80th anniversary of the NHS. Depending on the timeline for the implementation of changes to come, if the process which lies ahead can be handled well for the charities, this represents a positive opportunity to engage with donors around the time of a notable anniversary.

12 Don't forget the voice of the beneficiary

Have a quick look back at the quotes in section 3 above. Place matters to people who want to give.

NHS staff and patients are beneficiaries of the NHS charities; indeed, we are all potential beneficiaries of NHS charities, because we are all likely to need help from NHS healthcare at some point in our lives. What answer to the question in this paper would give YOU confidence and build trust in the charity board which is making spending decisions to deliver benefits in the area you live in? Beneficiary (and donor) input should be included in the decision-making processes which lie ahead.

13 The benefits of futureproofing Scotland's NHS charities

In the coming months, care is required to hold two things in balance at the same time. First, not to 'throw the baby out with the bathwater' in quickly jumping to one preferred solution over another. Second, to accept that this is a much-needed moment - perhaps a once in 50 years opportunity - to strengthen the foundational structure for how Scotland's NHS charities can be supported to thrive into the future, finally enabling the charities to recruit their own trustees.

On that latter point, many recommendations from the 2019 Review remain as valid today (in my view) as they were in 2019. My only observation is that if a strengthened charitable structure is under consideration, a SCIO (Scottish Charitable Incorporated Organisation) might be more clearly on the table today as a more proportionate model, compared to how it appeared in 2019, due to the changed context. Let's imagine 16 (or fewer, if so desired) SCIOs were set up in the coming months, and the assets of the 16 NHS charities were granted over to them with all the existing restrictions and donor conditions attached (thereby safeguarding their use as intended by donors): might that offer a useful non-legislative way forward? These are all questions for another day, questions for the "how" stage, and this paper has rather explored the initial "what if" which comes first. It is, however, well worth remembering that fully safeguarding the NHS charity assets in this (or a similar) way in the coming months offers significant additional futureproofing benefits. First, it means that any future NHS re-organisation in years to come would not risk impacting the NHS charities. Second, the valuable time of NHS Directors of Finance and Scottish Government civil servants would not in future need to be diverted to technical charity-related matters. The possibility of enabling those two positive outcomes should be noted in what lies ahead.

14 Where do we go from here?

During times of change, people can react differently. Emotions can be heightened. Some might see a new opportunity on the horizon and feel positive about that. Some people will inwardly ask themselves how their role may be affected and might feel worried. Will power and decision-making move and how will that affect me? Do I need to defend my 'patch'? I encountered those emotions first-hand when I chaired the 2019 Review, and I expect they will arise again in what lies ahead: it's human nature.

In closing, let's remind ourselves of the consequences of the Programme for Government. Today, Scotland's NHS charities have a unique integrated legal relationship with their related NHS health board. Given that 14 health boards are to be replaced by just 2 health boards, a considerable amount of time and thought will be needed to work through the options and create a roadmap ahead for the 16 NHS charities in Scotland. More important than the substantive legal questions, however, is the dialogue process which comes before it. That dialogue process will enable a full exploration of the desired end outcome. Law can then be put to work as the tool to deliver that change. Identify where you want to get to, then work backwards.

Appendix 1

The 14 territorial Health Boards are indicated with a *

Operational charity name on OSCR Register	Formal registered charity name on OSCR Register	Value of assets held as at 2025 or 2026
Ayrshire and Arran Health Board Charity Fund *	Ayrshire & Arran Health Board Endowment Funds	£8,231,160
NHS Borders Health Charity*	Borders Health Board Endowment Funds	£5,346,853
NHS Dumfries and Galloway Charity *	Dumfries & Galloway Health Board Endowment Funds	£8,914,726
Fife Health Charity *	Fife Health Board Endowment Funds	£14,978,000
Forth Valley Giving *	NHS Forth Valley Endowment Funds	£3,185,050
Golden Jubilee National Hospital (Scotland)	NHS Golden Jubilee Charity	£11,007,627
NHS Grampian Charity *	Grampian Health Board Endowment Funds (NHS Grampian)	£47,576,000
NHS Greater Glasgow And Clyde*	Greater Glasgow Health Board Endowment Funds	£107,960,000
NHS Highland Charity *	Highland Health Board Endowment Funds	£10,535,391
Lanarkshire Health Charity *	Lanarkshire Health Charity	£5,243,196
NHS Lothian Charity *	NHS Lothian Charity	£85,806,000
Orkney Health Board Endowment Funds *	Orkney Health Board Endowment Funds	£979,887
Scottish Ambulance Service Endowment Funds	Scottish Ambulance Service Endowment Funds	£1,465,173
Shetland Health Board Endowment Funds *	Shetland Health Board Endowment Funds	£2,255,357
NHS Tayside Charitable Foundation, Tayside Children's Health Charity*	Tayside NHS Board Endowment Funds	£28,952,000
Western Isles *	Western Isles Health Board Endowment Funds	£600,565
	TOTAL	£343,036,985

Asset values taken from 2026 or 2025 accounts.

References

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