Online NHS Trust Board Agenda

Date of meeting: 1st June 2026

Venue: Room 4.4, Wellington House, 133-155 Waterloo Road, SE1 8UG

The Board meeting will be preceded by a meet and greet from 9.00am, an informal discussion on ways of working for the Board (9.30 – 10.00am) and an update on progress to date and Q&A with members of the programme team (10.00 – 11.30am), followed by a short break (11.30 – 11.45am).

Time	Agenda item	Paper	Purpose	Lead
11.45 – 11.50	1. Welcome, introductions, apologies and declarations of interest	Verbal	For noting	Chair
11.50 – 12.15	2. Establishing Trust governance	A	For approval	Katy Cox
12.15 – 12.20	3. Business continuity plan	B	For approval	Pete Sinden
12.20 – 12.25	4. Organisational charter for sexual safety in healthcare	C	For decision	Katy Cox
12.25 – 12.35	5. The Equality Act 2010 and Equalities and Health Inequalities Impact Assessment	D	For approval	Anita Davidson
12.40 – 12.50	[redacted]	[redacted]	[redacted]	[redacted]
12.50 – 13.00	7. Provider licence conditions	F	For approval	Katy Cox
13.00 – 13.30	LUNCH			
13.30 – 13.45	8. Transition to new Trust	G	For noting	Katy Cox
13.45 – 14.00	9. Risk register	H	For noting	Anita Davidson
14.00 – 14.20	10. Developing the Trust vision, values and strategy	I	For approval	Katy Cox
14.20 – 14.40	[redacted]	[redacted]	[redacted]	[redacted]
14.40 - 14.45	12. Any other business	Verbal		Chair

Online NHS Trust Board

Establishing Trust governance

Date of meeting	1 June 2026
Paper reference	A
Author	Katy Cox, Organisational Build Workstream Lead
To be presented by	Katy Cox, Organisational Build Workstream Lead
Summary	This paper sets out the Trust governance from 1 June, the proposed schedule of Board and Committee meetings and the policies required from 1 June.
Recommendations	The Board is asked to: • establish the Audit and Risk Committee and Nominations and Remuneration Committee and approve their terms of reference (appendices A and B); • approve the appointment of Ruth May as Senior Independent Director/Deputy Chair and Chair of the Nominations and Remuneration Committee and the appointment of Mary Basterfield as the Chair of the Audit and Risk Committee (with Ian Abbs and Omar Din as members of the Committee); • approve the paper setting out responsibilities (appendix C) for publication on the Trust's website; and • approve the 34 policies required on establishment of the new Trust (appendix E).

1. Executive Summary

1.1. The Trust Board is responsible for the strategies and actions of the organisation and is accountable to the public and, ultimately, to Parliament (via NHS England and DHSC).

1.2. The Code of Governance for NHS provider trusts requires the Board to establish an Audit Committee and a Remuneration Committee that report to the Board. Terms of reference for an Audit and Risk Committee and a Nominations and Remuneration Committee have been drafted. In addition to these committees, the existing programme governance structures have transferred into the new Trust and the Senior Leadership Team will report to the Trust Board.

1.3. The 34 policies required on establishment of the Trust have been identified and drafted.

2. Trust governance

2.1. The Trust Board is responsible for the strategies and actions of the organisation and is accountable to the public and, ultimately, to Parliament (via NHS England and DHSC). The Board also monitors the achievement of the organisation's objectives (and risks that might prevent them from being achieved) and receives assurances that the organisation is operating as it should.

2.2. From establishment of the Trust on 1 June 2026, the Board will comprise the Chair and six Non-Executive Directors (NEDs), as stipulated in its establishment order. At its inaugural meeting on 1 June 2026, the Nominations and Remuneration Committee will consider appointment of an Associate NED (who will be a non-voting member of the Board) and the approach to appointing the executive directors.

2.3. The Code of Governance for NHS provider trusts requires the Board to establish an Audit Committee (comprising only non-executive members but not including the chairperson) and a Remuneration Committee (with membership including at least two NEDs and the Chair) that report to the Board.

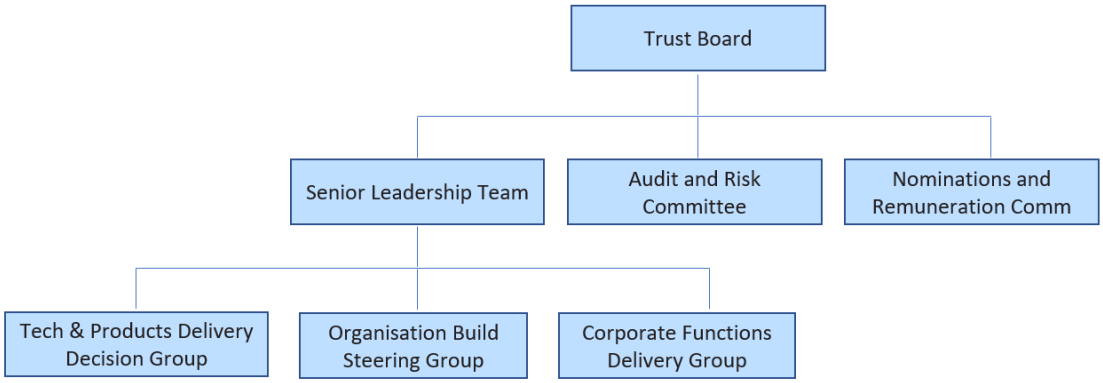
2.4. Board committees are focused on providing assurance to the Board and the scope of each committee is set out in their Terms of Reference. Draft terms of reference for the Audit and Risk Committee and Nominations and Remuneration Committee can be found in appendix A and appendix B respectively. **The Board is asked to establish the Audit and Risk Committee and Nominations and Remuneration Committee and approve their terms of reference.** It is proposed that the Terms of Reference (in particular, the membership) of the Nominations and Remuneration Committee be reviewed once the recruitment of Executive Directors has concluded.

2.5. It is proposed that Mary Basterfield chairs the Audit and Risk Committee with membership comprising Omar Din and Ian Abbs and meetings taking place on a quarterly basis. It is proposed that Ruth May is appointed as Senior Independent Director/Deputy Chair and chairs the Nominations and Remuneration Committee with membership comprising all other Non-Executive Directors (including the Associate NED) and meetings taking place at least once a year (and more frequently when required). **The Board is asked to approve the appointment of Ruth May as Senior Independent Director/Deputy Chair and Chair of the Nominations and Remuneration Committee and the appointment of Mary Basterfield as the Chair of the Audit and Risk Committee (with Ian Abbs and Omar Din as members of the Committee).**

2.6. The Code of Governance for NHS provider trusts requires the responsibilities of the chair, chief executive, senior independent director if applicable, board and committees to be clear, set out in writing, agreed by the board of directors and publicly available. A draft paper can be found in appendix C. **The Board is asked to approve the paper setting out responsibilities (appendix C) for publication on the Trust's website.**

2.7. Further committees will be established in advance of the launch of clinical services and a paper will be brought to a future Board meeting setting out the proposed committee structure.

2.8. In addition to these committees, on establishment of the new Trust, the existing programme governance structures have transferred into the new Trust as set out in the diagram below. The terms of reference for the Senior Leadership Team are included in appendix D.



3. Schedule of Board and Committee meetings

3.1. It is proposed to hold Board meetings monthly for at least the first 12 months.

3.2. NHS Trusts are expected to hold Board meetings in public on a regular basis (and publish meeting agendas and papers). In practice, most Trusts hold public Board meetings every month or every other month.

3.3. It is proposed to hold Board meetings in public from July 2026, with a private session to follow if required for confidential or commercially sensitive items. The agenda and papers will be published on the Trust's website in advance of the meeting and members of the public wishing to attend will be able to register to attend and submit any questions in advance.

3.4. As the Trust will only be established on 1 June, it was not possible to hold the first Board meeting in public. However, the papers will be reviewed and, where papers are not confidential or commercially sensitive, will be published on the Trust's website.

3.5. Proposed Board meeting dates for the rest of the calendar year are as follows:

- w/c 29 June
- w/c 27 July
- w/c 24 August
- w/c 28 September
- w/c 26 October
- w/c 23 November
- w/c 14 December

3.6. The Nominations and Remuneration Committee and Audit and Risk Committee will agree meeting schedules in line with their Terms of Reference at their first meetings.

4. Policies

3.1. NHS Trusts are required to have policies in place in order to ensure patient safety, maintain regulatory compliance and guarantee corporate accountability.

3.2. Working with the Director of Corporate Governance of University College London Hospitals NHS FT, a streamlined list of 66 policies was determined as ultimately required by the Trust. Most Trusts have over 200 policies, creating a significant burden to update and monitor them. It is the Trust's intention to reduce this burden, whilst ensuring there is an appropriate policy framework in place.

3.3. Development of policies has been prioritised based on when they will be required by the Trust:

- Establishment of the Trust – 1 June 2026
- Application to CQC – autumn 2026
- Registration with the CQC – current planning assumption 1 February 2027
- Launch of clinical services – Quarter 3 2027/28
- As new workforce groups are included in NHS Online – Post launch (date TBC)

Policies required at each stage:

	1 June 2026 - establishment of new Trust	Autumn 2026 - application to CQC	1 Feb 2027 - registration with the CQC	Q3 2027/28 – launch of clinical services	Post launch - introduction of further workforce groups
Workforce	1	1	1	0	2
Org build	25	3	5	5	0
Technology	6	1	1	1	0
Clinical Pathways	0	6	5	0	0
Comms and Engagement	1	0	1	0	0
PMO	1	0	0	0	0
Total	34	11	13	6	2

3.4. The 34 policies required on establishment of the new Trust on 1 June have been reviewed through existing programme governance routes (e.g. relevant steering group/s) and undergone legal review ahead of final approval being sought from the Board.

3.5. The programme has also tracked the actions, processes and standard operating procedures arising from each policy to support effective implementation and ensure that no critical requirements are overlooked.

3.6. Review dates reflect the need to review some policies as the Trust evolves and appoints its Executive team, onboards its clinical workforce, undertakes testing and commences delivery of clinical services. Post launch of clinical services, it is anticipated that policies will be reviewed on a more consistent (and less frequent) review cycle.

3.7. Policies are included in Appendix E. **The Board is asked to approve the 34 policies required on establishment of the new Trust.**

5. Recommendation(s) and next steps

4.1. The Board is asked to:

- establish the Audit and Risk Committee and Nominations and Remuneration Committee and approve their terms of reference (appendices A and B);
- approve the appointment of Ruth May as Senior Independent Director/Deputy Chair and Chair of the Nominations and Remuneration Committee and the appointment of Mary Basterfield as the Chair of the Audit and Risk Committee (with Ian Abbs and Omar Din as members of the Committee);
- approve the paper setting out responsibilities (appendix C) for publication on the Trust's website; and
- approve the 34 policies required on establishment of the new Trust (appendix E).

4.2. The programme team will continue to develop the proposed committee structure for the Trust and bring a paper to a future Board meeting.

4.3. The programme team will continue to draft policies required for CQC registration and launch of clinical services and seek approval from the Board at the appropriate time.

Appendix A: Draft Audit and Risk Committee Terms of Reference

1. Role and purpose

1.1. The Audit and Risk Committee (the Committee) is responsible for overseeing, monitoring and reviewing corporate reporting, the adequacy and effectiveness of the governance, risk management and internal control framework and systems and areas of legal and regulatory compliance at the Online NHS Trust (the Trust) and the external and internal audit functions.

1.2. The Committee provides the Board of Directors of the Trust (the Board) with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities both generally and in support of the annual governance statement.

1.3. The duties and responsibilities of the Committee are more fully described in section 7 below.

2. Constitution

2.1. The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference.

2.2. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

2.3. In carrying out its role the Committee will primarily utilise the work of internal audit, external audit and other assurance functions. It is also authorised to seek reports and assurance from Executive Directors and managers and will maintain effective relationships with the chairs of other Board committees to understand their processes of assurance and links with the work of the Committee.

2.4. The Committee is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's Standing Financial Instructions (SFIs), as set out in the Governance Manual.

3. Membership

3.1. The members of the Committee will be appointed by the Board, will be independent Non-Executive Directors of the Trust and will not include the Chair of the Board.

3.2. The Committee will consist of not less than three members, at least one of whom will have recent and relevant financial experience, ideally with a qualification from one of the professional accountancy bodies.

3.3. The Board will appoint the Chair of the Committee from among its members (the Committee Chair). The Committee Chair may be the Deputy Chair of the Board. However, in the event that the Deputy Chair must act as Chair of the Board for an extended period of time, the Deputy Chair will resign as Committee Chair. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of themselves to chair the meeting.

3.4. Only members of the Committee have the right to attend and vote at Committee meetings. The following will be invited to attend meetings of the Committee on a regular basis:

- representative(s) from the external auditor;
- representative(s) from the internal auditor;
- representative(s) from the counter fraud service;
- Chief Financial Officer (once appointed and Finance Lead until that date);
- Chief Medical Officer (once appointed); and
- Trust Secretary.

3.5. The Chief Executive Officer will be invited to attend meetings of the Committee, at least annually, to discuss with the Committee the process for assurance that supports the annual governance statement.

3.6. Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of risk or operation that are the responsibility of a particular Executive Director or manager.

4. Attendance and Quorum

4.1. Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or Trust Secretary in advance.

4.2. The quorum for a meeting will be two members. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any

of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3. When an Executive Director or manager is unable to attend a meeting they should appoint a deputy to attend on their behalf.

5. Frequency of meetings

5.1. The Committee will meet at least four times each year and otherwise as required.

5.2. At least once each financial year the Committee will meet with representatives of the external and internal auditors without management being present to discuss their remit and any issues arising from their audits.

5.3. Outside of the formal meeting programme, the Committee Chair will maintain a dialogue with key individuals involved in the Trust's governance, including the Chair of the Board, the Chief Executive Officer, the Chief Financial Officer, the Chief Medical Officer, the external audit lead partner and the head of internal audit.

6. Authority

6.1. The Committee is authorised:

- to act within its terms of reference;
- to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions; and
- to obtain such internal information as is necessary and expedient to the fulfilment of its functions. All members of staff are directed to co-operate with any request made by the Committee.

7. Duties and responsibilities

7.1. The Committee will carry out the following duties for the Trust:

<u>Integrated Governance, Risk Management and Internal Control</u>

7.2. The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities, that supports the achievement of the Trust's objectives. In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the annual governance statement), together with the head of internal audit opinion,

external audit opinion or other appropriate independent assurances, prior to submission to the Board;
- the underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of annual disclosure statements; and
- the policies and arrangements for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reviews, reporting and self-certifications, including the NHS Constitution, the Trust's NHS provider licence, registration with the Care Quality Commission and the Trust's constitution, standing orders and standing financial instructions and management of conflicts of interest.

Internal Audit

7.3. The Committee will ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Accounting Officer and Board. This will be achieved by:

- considering the provision of the internal audit service and the costs involved;
- reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in any risk assessment;
- considering the major findings of internal audit work (and the appropriateness and implementation of management responses) and ensuring coordination between the internal and external auditors to optimise audit resources;
- ensuring the internal audit function is adequately resourced and has appropriate standing within the Trust; and
- monitoring the effectiveness of internal audit and carrying out an annual review.

External Audit

7.4. The Committee will review and monitor the external auditors' integrity, independence and objectivity and the effectiveness of the external audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved by:

- considering the appointment and performance of the external auditors, including making recommendations to the Board regarding the appointment,

reappointment and removal of the external auditors in line with criteria agreed by the Board and the Committee;
discussing and agreeing with the external auditors, before the external audit commences, the nature and scope of the audit as set out in the annual external audit plan;

- discussing with the external auditors their evaluation of audit risks and assessment of the Trust and the impact on the audit fee;
- reviewing all external audit reports, including reports addressed to the Board, and any work undertaken outside the annual external audit plan, together with any significant findings and the appropriateness and implementation of management responses; and
- ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services taking into account relevant ethical guidance.

Financial Reporting

7.5. The Committee will monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

7.6. The Committee will ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board. The Committee will review the annual report and financial statements before these are presented to the Board in order to determine their completeness, objectivity, integrity and accuracy and the letter of representation addressed to the external auditors from the Board. This review will cover but is not limited to:

- the annual governance statement and other disclosures relevant to the work of the Committee;
- areas where judgment has been exercised;
- appropriateness and adherence to accounting policies and practices;
- explanation of estimates or provisions having material effect and significant
- variances;
- the schedule of losses and special payments, which will also be reported on
- separately during the financial year;
- any significant adjustments resulting from the audit and unadjusted audit differences; and
- any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

7.7. The Committee will provide advice, where requested by the Board, on whether the annual report and accounts, taken as a whole, are fair, balanced and

understandable, and provide the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy.

Counter Fraud

7.8. The Committee will review the effectiveness of arrangements in place for counter fraud, anti-bribery and corruption to ensure that these meet the NHS Counter Fraud Authority's standards and the outcomes of work in these areas, including reports and updates on the investigation of cases from the local counter fraud service.

Raising Concerns/Freedom to Speak Up

7.9. The Committee will review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns and possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently with appropriate follow-up action and safeguards in place for those who raise concerns.

7.10. The Committee will ensure that the Trust's policy reflects the minimum standards for raising concerns set out by NHS England and that the arrangements in place are regularly audited.

8. Meeting administration

8.1. Meetings of the Committee will be convened by the Trust Secretary at the request of the Committee Chair or any of its members, or at the request of external or internal auditors if they consider it necessary.

8.2. The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Chief Financial Officer and the Trust Secretary. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than five working days before the date of the meeting.

8.3. Distribution of any papers after this deadline will require the agreement of the Committee Chair. The corporate governance team will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

8.4. Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee. Once approved by the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

9. Accountability and Reporting

9.1. The Committee Chair will report to the Board following each meeting, drawing the Board's attention to any matters of significance or where actions or improvements are needed.

9.2. The Committee will report to the Board at least annually on its work in support of the annual governance statement, specifically commenting on:

- the fitness for purpose of the board assurance framework;
- the completeness and maturity of risk management in the Trust;
- the integration of governance arrangements; and
- the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

9.3. The Trust's annual report will include a section describing the work of the Committee in discharging its responsibilities including:

- the significant issues that the Committee considered in relation to financial statements, operations and compliance, and how these issues were addressed;
- an explanation of how the Committee has assessed the effectiveness of the external audit process and the approach taken to the appointment or reappointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and
- if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.

9.4. The Committee will conduct an annual review of its effectiveness.

10. Supporting documents

- National Health Service Act 2006
- Code of Governance for NHS Provider Trusts (NHS England)
- National Audit Office Code of Audit Practice
- Public Sector Internal Audit Standards (HM Treasury)
- NHS Counter Fraud Authority's counter fraud standards
- NHS England's guidance on Freedom to Speak Up guidance

Appendix B: Draft Nominations and Remuneration Committee Terms of Reference

1. Role and purpose

1.1. The Nominations and Remuneration Committee (the Committee) is responsible for identifying and appointing Executive Director positions on the Board of Directors of the Trust (the Board) and for determining their remuneration and other conditions of service.

1.2. The scope of the Committee covers:

- Nomination: composition of the Board, succession planning, appointment process, continuation in office of Executive Directors, significant commitments and conflicts of interest.
- Renumeration: remuneration policy, individual remuneration packages, levels of remuneration, terms and conditions of office of the Trust's Executive Directors, performance targets, expenses claims, severance payments.

1.3. The duties and responsibilities of the Committee are more fully described in section 7 below.

2. Constitution

2.1. The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference.

2.2. The Committee is responsible for identifying and appointing candidates to fill all the Executive Director positions on the Board and for determining their remuneration and other conditions of service.

2.3. Its constitution and terms of reference are set out below and can only be amended with the approval of the Board.

3. Membership

3.1. The members of the Committee will be appointed by the Board and shall comprise of the Chair of the Trust and all Non-Executive Directors (including Associate Non-Executive Directors).

3.2. The Senior Independent Director shall be appointed as the Chair of the Remuneration and Nomination Committee by the Board.

3.3. In the absence of the appointed Committee Chair, another Non-Executive Director will chair the meeting.

3.4. Only members of the Committee have the right to attend and vote at Committee meetings.

3.5. Once appointed, the Chief Executive shall be a voting member of the Committee for the appointments or removal of other Executive Directors only.

4. Attendance and Quorum

4.1. The quorum necessary for the transaction of business shall be at least 4 Non-Executive Directors.

4.2. In addition to members of the Committee, the following shall normally attend all meetings, at the invitation of the Committee:

- Chief Executive Officer (once appointed)
- Director of Workforce (once appointed)
- Trust Secretary (once appointed)

4.3. The Chief Executive and the Director of Workforce shall attend all meetings except for any items relating to their own positions, performance or remuneration. Other Trust staff will be invited to attend for specific agenda items with the agreement of the Committee Chair. No director will be present when his or her position, performance or remuneration is being discussed.

4.4. The corporate governance team will provide appropriate administrative support to the Committee Chair and Committee members. This will include agreement of the agenda with the Committee Chair, collation and circulation of papers, producing the minutes of the meetings, keeping a record of agreed actions and follow up, and advising the Committee Chair and members of the Committee as appropriate.

5. Frequency of meetings

5.1. The Committee shall meet a minimum of once per annum.

5.2. The Chair may convene additional meetings of the Committee if necessary to consider business that requires urgent attention.

6. Authority

6.1. The Committee is authorised:

- to act within its terms of reference

- to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions; and
- to obtain such internal information as is necessary and expedient to the fulfilment of its functions. All members of staff are directed to co-operate with any request made by the Committee.

7. Duties and Responsibilities

Nominations

7.1.1. Review as required the structure, size, composition, and diversity of the Board, and provide input to the formal board evaluation process.

7.1.2. Provide assurance to the Board that there is appropriate succession planning in place for Executive Directors and the organisational level below.

7.1.3. Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy.

7.1.4. Be responsible for identifying and appointing candidates to fill posts within its remit as and when they arise.

7.1.5. Before any appointment is made to the executive team, evaluate the balance of skills, knowledge, experience and diversity and in the light of the evaluation, review a description of the role and capabilities required for a particular appointment.

7.1.6. Ensure that the appointment process is designed to attract the best candidates, through the use of a range of open advertising or the services of external advisers to facilitate the search. The Committee will seek to provide assurance that candidates fully reflect a wide range of backgrounds and the Trust's commitment to equality, diversity and inclusion and that the recruitment process will consider candidates on merit and against objective criteria.

7.1.7. The Committee will be consulted with regarding any temporary or interim arrangements for appointing Executive Directors.

7.1.8. Approve any matters relating to the continuation in office of any executive director at any time including the suspension or termination of service of an Executive Director as an employee of the Trust subject to the provisions of the law and their service contract.

7.1.9. Ensure that a proposed Executive Director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

7.1.10. Ensure there is a process in place that proposed Board appointees disclose any business interests that may result in a conflict of interest prior to the appointment and that any future business interests that could result in a conflict are reported.

7.1.11. Ensure that the Trust has an appropriate policy in place to check that proposed Board appointees and existing Board members comply with the requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test.

Renumeration

7.1.12. Establish and keep under review a remuneration policy in respect of all Very Senior Managers.

7.1.13. When setting the remuneration policy for Very Senior Managers, ensure it is in line with pay and employment conditions across the Trusts and the wider NHS, and that it is benchmarked against other Trusts of comparable scale and complexity.

7.1.14. Within the terms of the agreed policy and in consultation with the Chief Executive, approve the total individual remuneration package of each Very Senior Manager and ensure any external required approvals are received.

7.1.15. In accordance with all relevant laws, regulations and Trust policies, approve and keep under review the terms and conditions of office and levels of remuneration for Very Senior Managers, ensuring that remuneration is sufficient to attract, retain and motivate individuals of the quality, skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose and at a level which is affordable for the Trust, including:

- Contractual and/or non-contractual remuneration, including any performance-related pay or bonus;
- Provisions for other benefits, including pensions and allowances;
- Payable expenses; and
- Any termination and/or severance payments.

7.1.16. Approve the performance targets for any performance related pay schemes and authorise payments against those targets.

7.1.17. The Committee will receive a report from the Chair of the Trust Board on the outcome of the annual assessment of the performance of the Chief Executive prior to its submission to NHS England. The Committee will consider this outcome when reviewing changes to the Chief Executive's remuneration.

7.1.18. The Committee will receive a report from the Chief Executive on the outcome of the annual assessment of the performance of the individual Executive Directors and will consider this outcome when reviewing changes to individual director's remuneration levels.

7.1.19. Where appropriate, authorise any severance payments including redundancy payments, settlements and compromise agreements for all staff as determined within current NHS rules, ensuring that they are fair to both the individual and the organisation.

8. Meeting administration

8.1. Meetings of the Committee will be convened by the Trust Secretary at the request of the Committee Chair or any of its members.

8.2. The agenda of items to be discussed at the meeting will be agreed by the Committee Chair and the Trust Secretary. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than five working days before the date of the meeting.

8.3. Distribution of any papers after this deadline will require the agreement of the Committee Chair. The corporate governance team will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

8.4. Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee. Once approved by the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

9. Accountability and Reporting

9.1. The Committee shall make whatever recommendations to the Trust Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

9.2. The Committee Chair, on behalf of the Committee, shall make a statement in the annual report about its activities and the process used to decide remuneration.

9.3. The Committee will conduct an annual review of its effectiveness.

10. Supporting documents

- National Health Service Act 2006
- Code of Governance for NHS Provider Trusts
- NHS England guidance on Very Senior Managers' Pay
- Care Quality Commission Fit and Proper Persons Requirement Guidance
- HM Treasury Managing Public Money
- Equality Act 2010
- NHS England Equality, Diversity, and Inclusion Improvement Plan

Appendix C: Responsibilities of the Chair, Senior Independent Director, Board and Committees

Role	Responsibilities
Chair	• Leads the board and is responsible for its overall effectiveness and governance. • Sets the board agenda and ensures sufficient time for strategic discussion. • Promotes a culture of openness, constructive challenge, honesty and debate. • Ensures effective relationships between executive (and senior management) and non-executive directors. • Ensures directors receive accurate, timely and clear information. • Supports board development, induction and effectiveness reviews. • Ensures responsibilities are clearly defined and governance arrangements are effective. • Maintains the distinction between board leadership and executive management.
Trust Board	• Collectively responsible for the performance, strategy and long-term sustainability of the trust. • Sets the organisation's vision, values and strategic direction. • Oversees quality, safety, clinical governance, financial stewardship and risk management. • Ensures compliance with statutory and regulatory obligations. • Promotes culture, integrity and accountability across the organisation. • Oversees internal controls, audit and assurance arrangements. • Holds executive directors to account for delivery and performance. • Ensures appropriate systems, resources and governance processes are in place. • Shares collective responsibility for all board decisions.
Senior Independent Director (SID)	• Acts as a sounding board and support for the Chair. • Serves as an intermediary for directors where required. • Leads appraisal of the Chair by the non-executive directors (overseen by NHS England). • Provides an additional route for concerns that cannot be addressed through the Chair or Chief Executive. • Supports board effectiveness and independent challenge.

Role	Responsibilities
Chief Executive (see note 1 below)	• Leads the executive management of the trust and is responsible for operational delivery. • Implements the strategy and policies agreed by the board. • Acts as the trust's accounting officer with responsibility for stewardship of public resources. • Ensures effective management of performance, workforce, finance and service delivery. • Provides leadership to staff and promotes organisational culture and values. • Advises the board on operational matters, risks and performance. • Works in partnership with the Chair while maintaining a clear separation between governance and management responsibilities. • Ensures the board receives accurate and timely information to support decision-making.
Audit and Risk Committee	• The Audit and Risk Committee is responsible for overseeing, monitoring and reviewing corporate reporting, the adequacy and effectiveness of the governance, risk management and internal control framework and systems and areas of legal and regulatory compliance at the Online NHS Trust and the external and internal audit functions. • The Committee provides the Trust Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities both generally and in support of the annual governance statement. • The duties and responsibilities of the Committee are more fully described in Appendix A, section 7.
Nominations and Remuneration Committee	• The Nominations and Remuneration Committee is responsible for identifying and appointing Executive Director positions on the Trust Board and for determining their remuneration and other conditions of service. • Responsibilities of the Committee include: ○ Nomination: composition of the Board, succession planning, appointment process, continuation in office of Executive Directors, significant commitments and conflicts of interest.

Role	Responsibilities
	○ Renumeration: remuneration policy, individual remuneration packages, levels of remuneration, terms and conditions of office of the Trust's Executive Directors, performance targets, expenses claims, severance payments. • The duties and responsibilities of the Committee are more fully described in Appendix B, section 7.
Senior Leadership Team	• Delivery oversight: overseeing day-to-day delivery of the programme against agreed milestones, deliverables and timelines and agreeing corrective actions where delivery is off track; • Strategic alignment: ensuring the programme remains aligned to agreed strategic objectives; • Resource allocation: reviewing resource requirements, prioritising deployment and resolving resource constraints that impact delivery; and • Issues and risk management: resolving issues and managing risks, escalating to the Board as appropriate.

Notes

1. The Chief Executive is expected to be appointed during September 2026 and in post as soon as possible thereafter (dependent on the notice period of the successful candidate). In the period between the Trust being established and the Chief Executive taking up his/her post, the Programme Director(s) will fulfil these responsibilities.

Appendix D: Senior Leadership Team Terms of Reference

1. Purpose

The purpose of the NHS Online Programme Senior Leadership Team (SLT) is to provide clear leadership, oversight and decision-making to ensure delivery of the NHS Online Programme.

2. Constitution

These Terms of Reference define the remit, membership and governance arrangements of the SLT.

3. Membership

The SLT consists of the following core members (or their designated deputies):

- Programme Directors (Chair)
- Trust Chair (attending on a monthly basis)
- Technology Lead
- Clinical and Non Clinical Leads
- Organisational Build Lead
- Comms and Engagement Lead

Other individuals can be invited to attend as required by the agenda.

4. Attendance and quorum

- SLT members are expected to attend all meetings unless absence is unavoidable.
- Identified nominated deputies can be appointed to attend on SLT member behalf.
- Quorum will be four members of the SLT.

5. Frequency of meetings

- Meetings are held weekly.
- Conduct: Members must adhere to the Seven Principles of Public Life (Nolan Principles) and declare any conflicts of interest at the start of each meeting.

6. Authority

- SLT is authorised to act within its terms of reference.
- To request the attendance of other individuals to help support and enable discussions.
- To use all relevant information that is necessary and expedient to the fulfilment of its function.

7. Responsibilities

The SLT is responsible for:

- Delivery oversight: overseeing day-to-day delivery of the programme against agreed milestones, deliverables and timelines and agreeing corrective actions where delivery is off track;
- Strategic alignment: ensuring the programme remains aligned to agreed strategic objectives;
- Resource allocation: reviewing resource requirements, prioritising deployment and resolving resource constraints that impact delivery; and
- Issues and risk management: resolving issues and managing risks, escalating to the Board as appropriate.

8. Meeting administration

- A standing agenda will be in place

- Any supporting papers will be circulated in advance of each meeting, where possible.
- A record of key decisions, actions and escalations will be maintained for each meeting.
- An action log will be maintained detailing named leads and clear timescales for each action with outstanding actions reviewed at each meeting.

9. Accountability and reporting
    - The SLT is accountable to the Trust Board and will provide assurance in relation to programme delivery and risk within the scope of these Terms of Reference.

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Online NHS Trust Senior Leadership Team: Standard Agenda

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1. Governance, actions and decisions (10 mins)
    - Apologies and confirmation of quorum.
    - Declarations of interest relevant to today's agenda.
    - Review action log, focusing on overdue actions.

2. Programme delivery (25 mins)
    - Programme Director update
    - Clinical product update
    - Non clinical product update
    - Technology update
    - Organisational build update
    - Delivery plan review: progress against milestones, dependencies, slippage and immediate actions required.

3. Risks, issues and mitigations (10 mins)
    - Changes to risks
    - Any issues requiring escalation

4. Communications and engagement (10 mins)
    - Upcoming messages
    - Stakeholder engagement
    - Actions needed to support delivery

5. Summary of decisions and next steps (5 mins)
    - Confirm decisions taken, actions assigned, owners and deadlines, and capture any other urgent business.

Appendix E: Policies

34 policies are included in this appendix for approval. The following 24 policies have been through full programme approvals including a legal review:

Ei	Data protection and confidentiality
Eii	Declaration of interests, gifts and hospitality
Eiii	Disciplinary
Eiv	Grievance
Ev	Freedom of Information and Environmental Information Regulations
Evi	Development, approval and review of policies
Evii	Anti-fraud, bribery and corruption
Eviii	Raising concerns, freedom to speak up and employee led complaints
Eix	Emergency preparedness, resilience and response
Ex	Health and safety
Exi	Information governance
Exii	Cyber security
Exiii	Expenses
Exiv	Management of annual leave and special leave
Exv	Maternity, adoption, paternity/maternity support and shared parental leave and pay
Exvi	Modern slavery
Exvii	Pay progression
Exviii	Pay protection
Exix	Sexual misconduct in the workplace
Exx	Managing disability, sickness absence and supporting health and wellbeing at work
Exxi	Remote working
Exxii	Working time directive
Exxiii	Fit and proper persons (directors) policy
Exxiv	Purchase of non-audit services from external auditor

Legal review and updates are ongoing for the following 10 policies:

Exxv	Equality, diversity and inclusion
Exxvi	Risk management
Exxvii	Governance manual (SFIs, SOs & SoD)
Exxviii	Media, websites, intranet and social media
Exxix	Workplace alcohol and substance misuse
Exxx	IT acceptable use
Exxxi	Procurement
Exxxii	Secondment and temporary promotions
Exxxiii	Managing performance, appraisal and maintaining high professional standards
Exxxiv	Flexible working

At the meeting on 1 June the Board will be advised of any significant amendments as a result of legal review.

Online NHS Trust Board

Business Continuity Plan

Date of meeting	1 June 2026
Paper reference	B
Author	Peter Sinden
To be presented by	Peter Sinden
Summary	This paper presents the Trust's initial Business Continuity Plan (BCP), developed in support of the approved Business Continuity and Disaster Recovery (BCDR) Policy.
Recommendation(s)	The Board is asked to approve the attached Business Continuity Plan (BCP) as the Trust's initial operational continuity framework for the establishment phase, recognising that the plan will expand and mature as services, systems, workforce, and operational responsibilities develop.

1. Executive Summary

1.1. The attached Business Continuity Plan translates the Business Continuity Policy into practical operational arrangements for responding to disruptive incidents during the Trust's establishment phase.

1.2. At establishment, the Trust is not yet delivering services to patients. The immediate continuity focus is therefore on maintaining programme delivery, supplier coordination, digital development activity, information access, and recovery of key operational artefacts and systems. The Plan has been intentionally designed to be proportionate to this stage and will evolve as the Trust's activities develop.

2. Strategic and Regulatory Context

2.1. Business continuity arrangements are a statutory and regulatory requirement for NHS organisations under the Civil Contingencies Act 2004, NHS Act 2006, Health and Care Act 2022, and NHS England Emergency Preparedness, Resilience and Response (EPRR) guidance.

2.2. The attached Plan supports compliance with those obligations by establishing practical incident response, escalation, recovery, and coordination arrangements appropriate to the Trust's establishment phase and dependencies.

3. Key Features of the Plan

3.1 The Plan establishes practical arrangements for:

- incident identification, escalation, activation, and stand-down procedures;
- continuity of critical organisational and programme functions;
- recovery coordination for digital platforms, information assets, and supplier-supported services;
- maintenance of out-of-band access to critical BCDR documentation and contacts;
- governance and accountability arrangements during disruptive incidents; and
- coordination with NHS England, NECS, suppliers, and partner organisations where incidents affect shared services or hosted environments.

3.2 The Plan reflects the fact that many foundational controls currently remain inherited through NHS England-hosted arrangements and supplier-delivered services.

3.3 While the proposed Accountable Emergency Officer (AEO) is required to be filled by and executive, as the Trust has no appointed executives at establishment, this is delegated to the Programme Director until such time as an executive can take up the post.

4. Recommendation and next steps

4.1 The Board is asked to approve the attached Business Continuity Plan as the Trust's initial operational continuity framework for the establishment phase.

4.2 It should be noted that additional maturity will be required as the Trust appoints permanent executives and moves toward the launch of clinical service provision.

Online NHS Trust

Business Continuity Plan

Version number	1
Issue date	1st June 2026
Approved by	Trust Board
Responsible Director	Programme Director (AEO Delegate)
Policy Author	Hannah Patterson
Documents to read in conjunction with this policy	Business Continuity Policy

Review and amendment log:

Version no.	Type of change (full review, minor)	Date change was made	Description of change

Contents

5. Introduction

5.1.1 This Business Continuity Plan (BCP) sets out how Online NHS Trust will maintain or rapidly restore its priority activities in the event of a disruptive incident. It provides clear procedures for activation, incident response, recovery, and stand-down, aligned to the Trust's Business Continuity and Disaster Recovery (BCDR) Policy.

5.1.2 The Objectives of this plan are:

- Ensure continuity of the Trust's critical functions during disruption.
- Define clear command, control, and escalation structures.
- Identify minimum service levels and recovery time objectives (RTOs) for priority activities.
- Ensure BCDR documentation is accessible when primary systems are unavailable.
- Protect staff, information assets, and the Trust's reputation.
- Meet statutory obligations under the Civil Contingencies Act 2004, NHS Act 2006, and Health and Care Act 2022.

6. Scope

6.1.1 This plan applies to all Trust activities, all Board members, employed and contracted staff, and all systems and information assets including:

- NHS England-provided platforms (Microsoft 365, SharePoint, Teams)
- Trust-procured business systems (payroll, HR)
- Trust-built digital services and products (hosted on AWS and other cloud providers)
- Code repositories, version control systems, and software development pipelines
- All suppliers and third parties whose services are critical to Trust operations

7. Roles and Responsibilities

7.1.1 The following roles hold authority under this BCP. At establishment, the Trust is supported by secondees, interim resources, and supplier-delivered teams. In particular, the formal role of Accountable Emergency Officer (AEO) is delegated to the Programme Director, in the absence of appointed executives at establishment. Roles and responsibilities will be reviewed as the permanent executive team is recruited.

Role	Responsibility	Authority
Trust Board (Collective)	Corporate accountability for BCDR compliance. Receives annual assurance report. Approves this plan and significant updates.	Strategic oversight
Programme Director (AEO Delegate)	Overall accountability for BCM compliance. Authority to invoke this BCP. Leads incident assessment. Notifies NHS England and ICB where required.	Plan invocation authority
Trust Secretary	Operational lead for BCP administration. Coordinates communication cascade. Maintains out-of-band documentation. Logs all decisions and notifications.	Operational coordination
Non-Executive Directors	Independent scrutiny. Ensure BCDR on committee forward plans. Hold AEO to account.	Governance scrutiny
Programme CDIO	Oversees DR for Trust-built systems and digital infrastructure. Coordinates technical recovery.	Technical DR authority
Architecture & Engineering Lead	Implements and tests DR controls for Trust-built systems including backup, failover, and cloud DR.	Technical implementation
Cyber Security Lead	Leads response where disruption has a cyber or security dimension. Advises on information security aspects of the response.	Security response lead
Information Governance Lead	Advises on IG implications during incident response and data recovery.	IG advisory
All Staff and Contractors	Understand and comply with this plan. Store documents in approved locations. Report incidents promptly. Support response when required.	Individual compliance

8. Definitions and abbreviations

4.1 Definitions:

Term	Definition
Business Continuity Management (BCM)	A management process that identifies potential threats to the Trust and the impacts those threats could have on operations. BCM provides a framework for building organisational resilience with the capability for an effective response that safeguards the interests of key stakeholders, reputation, and value-creating activities. The Trust's BCM arrangements shall align with ISO 22301:2019 and the NHS England Business Continuity Management Toolkit.
Business Continuity Plan (BCP)	A documented set of procedures and information developed, compiled, and maintained in readiness for use in the event of an incident to enable the Trust to continue delivery of its critical activities at an acceptable predefined level.
Disaster Recovery (DR)	The technical subset of BCM concerned specifically with restoring IT systems, data, and infrastructure following failure or disruption. DR plans address how technology services are recovered to support business continuity.
Recovery Time Objective (RTO)	The maximum acceptable period of time within which a system, application, or business process must be restored following a disruptive incident.
Recovery Point Objective (RPO)	The maximum acceptable amount of data loss measured in time; i.e. the point in time to which data must be recoverable following a disruptive incident.
Business Impact Analysis (BIA)	The process of analysing the Trust's functions and the effect that a disruption to those functions would have, to determine the criticality of each function and inform recovery priorities.
Critical Function	A business activity or service that, if disrupted, would have a significant impact on the Trust's ability to discharge its statutory obligations or meet its contractual commitments.
Organisational Artefacts	All documents, records, data files, code, configurations, and other outputs produced by or on behalf of the Trust in the course of its operations, regardless of the system or platform on which they reside.
Maximum Tolerable Period of Disruption (MTPD)	The duration after which the Trust's viability would be irreparably compromised if a given function were not restored.

Accountable Emergency Officer (AEO)	The individual designated under section 252A(9) of the NHS Act 2006 as responsible for ensuring the organisation is properly prepared for dealing with a relevant emergency. For BCDR purposes, the AEO holds overall accountability for BCM compliance.
North East Commissioning Support (NECS)	The primary supplier engaged by NHS England to deliver Service Desk and End User Support services to Online NHS Trust under the terms of the MOU. NECS provides first-line service desk, remote 1.5 and second-line support, logistics, warehousing, and asset management services.
Silver Service Tier	The service tier applicable to Online NHS Trust under the MOU. Silver tier defines the following IT DR commitments: Recovery Time Objective (RTO) of 4 hours; Recovery Point Objective (RPO) of 24 hours; service availability of 99.5%; and planned maintenance downtime window of Wednesday 18:00–20:00. Service Desk hours are Monday to Friday 07:00–19:00 (excluding Bank Holidays).
IT Service Management (ITSM) Tool	The ServiceNow platform used by NHS England and NECS to log, track, and manage IT incidents, service requests, and assets. Online NHS Trust's assets and service records are maintained within ServiceNow for the duration of the MOU.
Memorandum of Understanding (MOU)	The agreement between NHS England and Online NHS Trust (FSP MOU NHSE/Online NHS Trust v0.3, April 2026, effective 1 June 2026) that governs the provision of Service Desk and End User Support services to Online NHS Trust for an initial term to 31 March 2027.

4.2 Abbreviations:

Business Continuity Management (BCM)
Business Continuity Plan (BCP)
Disaster Recovery (DR)
Recovery Time Objective (RTO)
Recovery Point Objective (RPO)
Business Impact Analysis (BIA)
Accountable Emergency Officer (AEO)
Amazon Web Services (AWS)
North East Commissioning Support (NECS)
IT Service Management (ITSM)
Memorandum of Understanding (MOU)
Future Services Programme (FSP)
Joiners, Movers and Leavers (JML)
NHS England (NHSE)
Integrated Care Board (ICB)

9. Priority Systems and Recovery Objectives

Priority Systems	Category	RTO	RPO / MTPoD	Min. Service Level
End-user computing & [redacted]	NHS England-provided (MOU)	4 hours	24 hours	Silver tier – 99.5% availability
Trust-procured business systems (payroll, HR)	Trust-procured	24 hours	24 hours	Business-hours service restoration
Trust-built digital products [redacted]	Trust-built	24 hours	24 hours	Development and tests environments available within one business day
Code repositories and version control [redacted]	Trust-built	4 hours	4 hours	Core engineering access restored same working day
Board governance and decision-making	Corporate	Immediate to 4 hours	N/A	Alternative communication and decisions routes always available
BCDR documentation (out-of-band access)	Foundational	Immediate	N/A	Always accessible

10. Resource Requirements

Resource Category	Details
People	AEO, Trust Secretary, CDIO, CSO, Architecture & Engineering Lead, IG Lead, Corporate functions support
Premises	Primary: NHS England-provided office space. Wellington House, London and Wellington place, Leeds.
Technology	[redacted]
Information	Out-of-band document store containing: this BCP, BCDR policy, escalation contact list, DR runbooks, key operational procedures.
Supplies / Equipment	End-user computing devices, secure remote access equipment, collaboration tooling, and associated corporate technology assets required to support Trust mobilisation and governance activities.

11. BCDR Risk Register

Risk	Likelihood	Impact	Treatment / Mitigation
Loss of NHS England-provided IT services [redacted]	Low	High	MOU SLA: RTO 4hr / RPO 24hr. [redacted]
Loss of access to physical office (premises unavailable)	Low	Low	Remote working capability [redacted]
Third-party [redacted] BCP invocation affecting Trust services	Low	High	Trust will conduct independent impact assessment and activate own BCPs where required. AEO is designated contact for third-party notifications.
Cyber security incident / ransomware	Low/Medium	High	Security Lead takes responsibility. Incident reported to NHS England and NCSC. DR runbooks for Trust-built systems. Version control and backup regime.
Loss of key personnel (AEO or Trust Secretary)	Low	High	Succession contacts documented.
MOU expiry / exit from NHS England IT support	Planned	High	IT exit readiness plan to be developed no later than 31 December 2026. 90 days' notice required under MOU.
Data loss from Trust-built systems	Low	High	Backup and restoration regime. Version control [redacted]. Annual restoration tests. RPO defined per system.

12. Plan Activation

12.1 Triggers for Activation

12.1.1 This BCP should be considered for activation when any of the following conditions are met:

- One or more critical Trust functions have fallen, or are imminently likely to fall, below their minimum acceptable service level.
- A disruptive event has caused significant loss of access to people, premises, technology, or information.
- A key supplier (including NHS England / NECS) has invoked its own BCP or declared a major incident affecting Trust services.
- A cyber security incident is confirmed or strongly suspected that affects Trust systems or data.
- Any event assessed by the AEO as posing a material risk to the Trust's ability to discharge its statutory obligations.

12.2 Incident Levels

Incident Level	Description	Action
Standby / Watch	Potential disruption identified. Monitoring heightened. No activation required yet.	AEO and Trust Secretary alerted. Situation monitored. Out-of-band docs confirmed accessible.
Partial Activation	One or more functions disrupted but Trust can maintain minimum service levels with adjustments.	AEO declares partial activation. Relevant BCPs invoked. Communication cascade initiated. Logging commenced.
Full Activation	Multiple critical functions disrupted or minimum service levels cannot be maintained.	AEO declares full activation. All relevant BCPs invoked. NHS England / ICB notified. Incident log maintained. Recovery commenced.

12.3 Activation Procedure

1. Disruptive event identified or reported to AEO / Trust Secretary.
2. AEO Delegate assesses the incident against activation triggers.
3. AEO Delegate determines activation level (Standby / Partial / Full) and formally declares.
4. Trust Secretary initiates communication cascade using out-of-band contact list.

5. Incident log opened. All decisions, actions, and notifications recorded.
6. Relevant continuity solutions and recovery actions invoked per this plan.
7. Where required (Full Activation), NHS England and relevant ICB notified.

12.4 Escalation Procedures

12.4.1 If the AEO Delegate cannot be reached, the Trust Secretary assumes interim coordination authority and continues to attempt to contact the AEO Delegate. If an incident escalates to a major or critical incident, the Trust's incident management procedures apply in parallel – there will be a single command and control structure.

12.5 Stand-Down Procedure

1. AEO Delegate (or delegated authority) formally declares stand-down when all critical functions are restored to normal operating levels.
2. Trust Secretary notifies all activated staff, contractors, and relevant external parties.
3. Incident log closed and filed in out-of-band store.
4. Hot debrief convened within 48 hours of stand-down.

13. Communications

13.1 Internal Communications

13.1.1 Upon activation, the Programme Director initiates a communications cascade to notify all relevant individuals. The cascade must use contact details held in the out-of-band contact list.

Audience	Method	Lead
Chair	Direct telephone (personal mobile)	Programme Director
All Board members (incl. Chair, NEDs)	Telephone / personal email	Programme Director
All staff with BCP roles	Telephone / personal email / out-of-band communication	Programme Director
All staff (general awareness)	Teams / personal email	Programme Director

13.2 External Communications

Audience	When	Lead	Method
NHS England	Full activation or if supplier-originated incident	AEO Delegate	Direct contact per EPRR Policy
[redacted] Service Desk	IT incident requiring MOU-level support	Programme CDIO	[redacted] portal / telephone
Key suppliers / partners	Where their cooperation is required for response or recovery	AEO Delegate	Direct contact per out-of-band contact list
Media	Only if required	Communications Lead	Agreed media statement

13.3 Information Sharing

13.3.1 All information sharing during an incident must comply with the Trust's Information Governance Policy and GDPR obligations. Personal data must not be disclosed to

unauthorised parties. The IG Lead advises on data protection matters during response and recovery.

14. Recovery

14.1 Recovery Strategies

System / Function	Recovery Strategy	Lead	RTO
NHS England-provided IT [redacted]	NECS service restoration per MOU Silver tier. Trust monitors via [redacted] monthly Service Review meetings.	Programme Director	4 hours (MOU SLA)
Trust-built digital systems [redacted]	Cloud-native DR: multi-AZ deployment, automated failover, infrastructure-as-code. Restore from tested backups.	Programme CDIO	24 hours
Code repositories [redacted]	Version control provides inherent recovery. Access restored via alternative credentials or repository mirrors.	Architecture & Engineering	4 hours
Trust-procured systems (payroll, HR)	Supplier-provided DR per contract. Trust to verify supplier DR test evidence annually.	Programme Director	24 hours
Physical access to premises	Remote working [redacted]	Programme Director	Immediate (remote)
BCDR documentation	Out-of-band document store – accessible immediately and independently of primary systems.	Programme Director	Immediate

14.2 Return to Normal Operations

14.2.1 Recovery is not complete until all of the following are confirmed:

- All affected systems and functions restored to normal operating levels.
- Any data loss or integrity issues identified, resolved, and documented.
- All staff and contractors stood down and notified.
- Post-incident debrief completed.
- Incident log closed and filed.

15. Incident Response and Contacts

15.1 Command and Control Structure

Role	Incident Function	Contact	Details
Chair	Incident Oversight. Decision authority. External notifications.	[redacted]	[redacted]
Trust Secretary	Incident Coordinator. Communications cascade. Logging.	[redacted]	[redacted]
AEO Delegate (Programme Director)	Incident Commander. Decision authority. External notifications.	[redacted]	
Programme Director	Incident Commander. Decision authority. External notifications.	[redacted]	[redacted]
CDIO	Technical Response Lead. DR actions for digital systems.	[redacted]	
Architecture & Engineering	Technical implementation. Backup restoration. Failover.	[redacted]	[redacted]
IG Lead	IG and data protection advice.	[redacted]	[redacted]
[redacted]	[redacted]		[redacted]
Head of Communications	Draft and issue press communication as required	[redacted]	[redacted]

15.1.1 The Incident Coordination Centre (primary) is the NHS England-provided office. Where this is unavailable, the Trust will operate in a remote working configuration [redacted]

15.2 Decision Support and Logging

15.2.1 All decisions must be logged in the incident log from point of activation to stand-down.

15.2.2 The incident log must be maintained in a format accessible via the out-of-band store.

15.2.3 Trust Secretary is responsible for logging, including time, decision, decision-maker, and rationale.

Online NHS Trust Board

Signing of the sexual safety in healthcare – organisational charter

Date of meeting	1 June 2026
Paper reference	C
Author	Demelza Turner
To be presented by	Katy Cox, Organisational Build Workstream Lead
Summary	This paper sets out the rationale for the Trust to nominate a member of the Board to sign the Trust up to the sexual safety in healthcare charter.
Recommendation	This paper recommends that the Board signs up to the sexual safety in healthcare charter and commits to its principles.

1. Executive Summary

1.1. Those who work, train and learn within the healthcare system have the right to be safe and feel supported at work. In 2023, NHS England published the sexual safety in healthcare charter ("the charter"), for healthcare providers to sign to commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours toward our workforce.

1.2. NHS England, all NHS provider trusts, all integrated care boards and many non-NHS organisations who deliver patient care have signed the charter.

1.3. This paper recommends that the Board signs up to the charter and commits to its principles.

2. The sexual safety in healthcare organisational charter

2.1. Those who work, train and learn within the healthcare system have the right to be safe and feel supported at work. In 2023, NHS England published the charter for healthcare providers to sign to commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours toward our workforce.

2.2. By signing the charter, the Trust would be committing to implementing ten core principles and actions to enforce a zero-tolerance approach to unwanted,

inappropriate and/or harmful sexual behaviours within the workplace. The ten commitments are:

1. we will actively work to eradicate sexual harassment and abuse in the workplace
2. we will promote a culture that fosters openness and transparency and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours
3. we will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate. For example, women, black, ethnic minority, disabled and LGBTQ+ groups
4. we will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours
5. we will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour
6. we will ensure appropriate, specific, clear policies are in place. They will include appropriate and timely action against alleged perpetrators
7. we will ensure appropriate, specific, clear training is in place
8. we will ensure appropriate reporting mechanisms are in place
9. we will take all reports of sexual misconduct seriously, and appropriate and timely action will be taken in all cases
10. we will transparently capture and share data on the prevalence of sexual misconduct and staff experience of sexual misconduct

2.3. These commitments are reflected in the Trust's drafted sexual misconduct in the workplace policy that has been submitted for Board approval.

2.4. Although it is not a legal requirement to sign the charter, it does signal that the Trust is taking proactive steps in relation to:

- Equality Act requirements
- CQC assessment expectations as set out in the Safeguarding section of the CQC assessment framework

2.5. NHS England, all provider Trusts, all ICBs and 255 non-NHS organisations have signed the charter.

2.6. NHS England has developed an assurance framework for each commitment to assure delivery.

3. Recommendation and next steps

3.1. It is recommended that the Board sign up to the charter and commit to the principles.

3.2. If the decision is made to sign up to the charter, a Board member will need to be nominated to email england.domesticabusesexualviolence@nhs.net to sign on behalf of the Trust.

3.3. If the decision is made to sign up to the charter, an assessment against the assurance framework will be brought to a future Board meeting.

Online NHS Trust Board

The Equality Act 2010 and Equalities and Health Inequalities I Assessment (EHIA)

Date of meeting	1 June 2026
Paper reference	D
Author	Adrian Matthews
To be presented by	Anita Davidson
Summary	This paper summarises Online NHS Trust legal responsibility under the Equality Act 2010 and the refreshed NHS Online Equalities and Health Inequalities Impact Assessment (EHIA).
Recommendations	The Trust Board is asked to: i. Note that Online NHS Trust is subject to Public Sector Equality Duty (PSED) which is a legal responsibility under Section 149 of the Equality Act 2010 ii. Approve the Equality objectives that set out how the Trust will meet its statutory duty and contribute to reducing inequalities iii. Note the refreshed NHS Online Programme EHIA iv. Endorse the continued use of the EHIA as a live document, with a planned full review and sign-off through Online NHS Trust Board within six months

1. Executive Summary

1.1. This paper provides an update on the Trust's statutory equalities responsibilities under the Equality Act 2010 and the NHS Online Programme's approach to reducing health inequalities.

1.2. As an NHS Trust, it is subject to the Public Sector Equality Duty (PSED) under section 149 of the Equality Act 2010, which places a legal responsibility upon the Trust when exercising their functions.

1.3. Four Equality objectives set out how we will meet our statutory duties and contribute to reducing inequalities in access, experience and outcomes for both patients and staff.

1.4. The Equality and Health Inequalities Impact Assessment (EHIA), approved in January 2026, has been proportionately refreshed in May 2026 to reflect programme progress.

1.5. The updated EHIA strengthens impact analysis and mitigation and will be subject to full revalidation by November 2026.

1.6. The Board is asked to note:

- Its statutory responsibilities
- The use of Equality Objectives to ensure these duties are met
- The refreshed EHIA; and
- To endorse the continued use of the EHIA as a live document.

2. Background

2.1. The Online NHS Trust has been established to be a national provider of elective outpatient care delivered digitally and is expecting to launch clinical services in Q3 2027/28.

2.2. In its status as an NHS Trust, the Online NHS Trust is subject to the Public Sector Equality Duty (PSED) under section 149 of the Equality Act 2010. This places a legal responsibility on the Trust, when exercising its functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

2.3. The NHS Online Programme has set four Equality Objectives to show how statutory duties will be met and these objectives will be reviewed regularly, and progress will be reported publicly on an annual basis.

2.4. The NHS Online Equalities and Health Inequalities Impact Assessment (EHIA) was originally developed to assess the potential impacts of the programme on diverse population groups and to identify mitigating actions to reduce inequalities.

2.5. Given the evolving nature of the NHS Online Programme, it was agreed that the EHIA would be treated as a live document, requiring periodic review and refresh to reflect new insights, data, and programme changes.

3. Online NHS Trust Equality Objectives

3.1. The Online NHS Trust is required to set Equality Objectives and for progress against the objectives to be publicly shared annually.

3.2. The objectives have been developed with input and support from NHSE Equalities Team and are provided in full detail at Annex A.

3.3. The headline four Equality Objectives are:

- **1: Equitable access to digital services**
  To consider inequalities in scope and build of digital products
- **2: Fair and inclusive digital design and decision-making**
  Ensure that digital systems, technologies and decision-making processes do not disadvantage people with protected characteristics
- **3: An inclusive and supportive workforce**
  Create a fair, inclusive and supportive working environment
- **4: Strong governance, accountability and engagement**
  Embed equality, diversity and inclusion into our governance, leadership and decision making

4. EHIA refresh - May 2026

4.1. The EHIA was refreshed reflecting programme developments, scope changes, and updated impacts on equality groups, with input from internal stakeholders, subject matter experts, and the NHSE Equalities Team. The refreshed EHIA has been provided at Annex B.

4.2. Insight was strengthened following engagement with external partners, incorporating learning from programme activity such as recent joint webinars with organisations including the Patients Association.

4.3. Mitigation actions and governance alignment was reviewed to ensure proportional, measurable responses to inequalities and readiness for Online NHS Trust Board consideration.

5. Notable updates from the EHIA refresh

5.1. Strengthening the EHIA's focus on digital inclusion, accessibility, standards and safeguarding—reinforcing a "digital-first but not digital-only" approach, with improved access (mobile and web), enhanced training, and stronger user feedback mechanisms.

5.2. Deeper analysis of protected characteristics, with clearer commitments to accessibility standards, reasonable adjustments, and safeguarding, alongside greater recognition of the benefits and risks of virtual care.

5.3. Enhancing the consideration of health inequalities through more detailed risks and mitigations for vulnerable groups, supported by expanded engagement (including with Patients Association) and clearer links between insight, actions, and ongoing governance.

5.4. Included alignment and reference to NHSO Equality Objectives.

6. Key findings from the EHIA refresh

6.1. The core conclusions of the original EHIA remain valid.

6.2. Strengthened the EHIA by identifying additional risks and opportunities, with refined mitigation actions to better target health inequalities and ensure compliance with the Public Sector Equality Duty.

6.3. Reduced risk by keeping the EHIA current and aligned with programme changes, improving the programme's ability to anticipate and address adverse impacts.

6.4. Confirmation of no direct financial impact, with ongoing governance in place to maintain the EHIA as a live document and ensure formal review and assurance by 30 November 2026.

7. Recommendations

7.1. The Trust Board is asked to:

- Note that Online NHS Trust is subject to Public Sector Equality Duty (PSED) - a legal responsibility under Section 149 of the Equality Act 2010.
- Approve the Equality objectives that set out how the Trust will meet its statutory duty and contribute to reducing inequalities.
- Note the refreshed NHS Online EHIA.
- Endorse the continued use of the EHIA as a live document, with a planned full review and sign-off through Trust Board within six months.

Annex A – Online NHS Trust Equality Objectives

Equality objectives

Online NHS Trust has been established to be a national provider of elective outpatient care delivered digitally and is expecting to launch clinical services in Q3 2027/28. It will operate to the same regulatory, governance and safety standards as any other NHS Trust, but without a physical hospital site.

Using NHS Online is optional. Anyone who prefers face-to-face appointments will continue to use existing services as usual.

Our Public Sector Equality Duty

As an NHS Trust, we are subject to the Public Sector Equality Duty (PSED) under section 149 of the Equality Act 2010. This places a legal responsibility on us, when exercising our functions, to have due regard to the need to:

1. Eliminate unlawful discrimination, harassment and victimisation
2. Advance equality of opportunity between people who share a protected characteristic and those who do not
3. Foster good relations between people who share a protected characteristic and those who do not

These duties apply to all aspects of our work, including the design and delivery of services, digital platforms, commissioning and procurement activity, employment practices, policy development and strategic decision-making.

As an NHS Trust focused on digital delivery, we recognise that the way services are designed and delivered can have a significant impact on access, experience and outcomes. Digital services have the potential to improve efficiency and convenience, but also risk excluding some people if equality considerations are not embedded from the outset. Meeting the Public Sector Equality Duty therefore requires us to give explicit consideration to digital inclusion, accessibility and health inequalities, alongside workforce equality and organisational culture.

We pay due regard to the needs of people who share one or more of the nine protected characteristics defined in the Equality Act 2010:

1. Age
2. Disability
3. Gender reassignment
4. Pregnancy and maternity
5. Race
6. Religion or belief
7. Sex
8. Sexual orientation
9. Marriage and civil partnership

We are also mindful of the interaction between protected characteristics and wider factors associated with health inequalities, including deprivation, digital access and confidence, language, literacy and geography.

Our Equality Objectives

Our equality objectives set out how we will meet our statutory duties and contribute to reducing inequalities in access, experience and outcomes for both patients and staff. These objectives are reviewed regularly, and progress is reported publicly on an annual basis. Our approach is informed by Equalities and Human Rights Commission and the PSED

Equality Objective 1: Equitable access to digital services

To consider inequalities in scope and build of digital products that will ensure that people can access and use our digital services on an equitable basis, regardless of protected characteristic, disability, or confidence when services launch.

NHS Online will be following the Government's Digital accessibility requirements as far as possible and only deviating where there is an identified need to adhere to clinical safety.

Target 1a: Design and maintain digital services that meet recognised accessibility standards
Target 1b: Provide reasonable adjustments and accessible information formats in public facing information about the service.

Equality Objective 2: Fair and inclusive digital design and decision-making

Ensure that digital systems, technologies and decision-making processes do not disadvantage people with protected characteristics and are developed in a fair, transparent and inclusive way - supporting a level playing field in experience and outcomes.

Target 2a: Embed equality considerations throughout service design and change
Target 2b: Regularly engage with service users to feedback, inform service design and ensure that patient's experience is captured.

Equality Objective 3: An inclusive and supportive workforce

Create a fair, inclusive and supportive working environment where all staff have equal opportunity to thrive, progress and contribute, including within remote and digital-enabled roles.

Target 3a: Take steps to address any inequalities in recruitment, retention, development and progression
Target 3b: Support flexible and inclusive ways of working where possible and ensure that reasonable adjustments are available and effective
Target 3c: Ensure policies created support improved recruitment, retention, development and experience of our workforce.

Equality Objective 4: Strong governance, accountability and engagement

Embed equality, diversity and inclusion into our governance, leadership and decision-making, ensuring accountability and meaningful engagement with patients, staff and communities.

Target 4a: Provide assurance of the Public Sector Equality Duty objectives through board-level oversight

We will publish equality information and report progress against these objectives annually.

PSED is an ongoing duty, and these objectives will be kept under review to ensure they remain meaningful, proportionate and responsive to the needs of the populations we serve and the people who work for us.

Annex B – NHS Online Equalities and Health Inequalities Impact Assessment (EHIA)

NHS England: Equality and Health Inequalities Impact Assessment (EHIA) template

Please read NHS England's internal guidance on the development of EHIAs before completing this document. **Please note a copy of the draft policy must be provided together with the EHIA to whoever is being asked to review your policy and the EHIA**. Key resources are available if you join the Equality and Health Inequalities Network (EHIN) on the NHS Futures site.

A completed copy of this form, together with the policy, **must** be provided to the decision makers. The decision makers must consider this assessment when they make their decision about the policy.

1. Name of the policy

The term 'policy' refers to **any** activity carried out by NHS England. This covers decisions, policies, programmes, provisions, proposals, initiatives, criteria, practices and activities across NHS England's commissioning, regulatory, oversight, employment or other functions.

NHS Online

2. Brief summary and purpose of the policy in a few sentences:

In your summary, please also confirm who the policy will affect (e.g. patients and/or staff)

NHS Online Programme is working to establish a new, NHS owned, national digital elective care provider that focusses solely on delivering elective care virtually. It will offer an expanding range of end-to-end specialist elective care services, as a choice for all patients across England. The elective care backlog currently stands at over 7 million patients. The recent Darzi Review along with the 10-year plan outlines the crisis position the NHS stands in today and highlights where the NHS system is 'broken' and outlines the commitment to restore the NHS constitutional standard of 92% of patients beginning elective treatment within 18 weeks. The 10 Year Health Plan specifically referenced increasing the availability of virtual services for NHS patients and stated that "by 2035, most outpatient care will happen outside of hospitals" through digital tools with support from clinicians when needed. The government has called for bold new ideas to solve the current crisis, the creation of NHS Online trust seeks to answer this demand.

NHS Online would provide end-to-end elective care services in some clinically appropriate specialties and pathways, matching appropriate digital services to appropriate patient cohorts, from referral and clinical triage to initial consultation and treatment. The digital first entity will deliver patient care unconstrained by geographical boundaries, offering the ability to better align clinical capacity with patient demand. Patient pathways will be delivered remotely, utilising the existing workforce more effectively through more flexible working arrangements whilst taking full advantage of the latest technologies and innovations to deliver more standardised, and timely patient care. NHS Online has set an Equality Objective of 'An inclusive and supportive workforce' to drive design and delivery that will ensure the service supports flexible and inclusive ways of working.

While the NHS App is the primary digital entry point for NHS Online, services can be accessed via both mobile devices and web browsers on computers, reducing reliance on smartphones while maintaining alternative routes where needed to support inclusion. Web-based access supports compatibility with a wider range of assistive technologies and desktop accessibility tools. Accessibility and reasonable adjustments are central to the service model. NHS Online has set an Equality Objective of 'Equitable access to digital services' that is cognisant of both, using this objective to drive service design and delivery and ensure statutory duties are met.

The creation of NHS Online has the potential to unlock capacity, increase patient choice and create numerous benefits for the NHS, including:

- Improved access and choice for patients to receive care virtually
- Potential to deliver over 8 million patient interactions in the first 3 years of roll-out, with 6 million delivered as appointments and the remainder as virtual triage to advice and guidance, avoiding the need for an appointment.
- Reduction in the waiting list for the specialties and pathways covered by NHS Online
- A reduction in costs and travel time for patients choosing to access care at NHS Online
- A new opportunity for NHS workforce to work flexibly and remotely with additional learning and development benefits provided through accessing clinical expertise and training across traditional geographical and organisational barriers
- An organisation offering virtual-first care with the opportunity to dedicate investment in broadening patient choice and NHS care to hard to reach / reluctant socio-economic groups, supporting health equality priorities.
- Opportunity to improve access for some groups e.g. those for whom English is not their first language and those isolated by geography or mobility

The planning and design of NHS Online will ensure health inequalities are considered and mitigated at every stage. Impacts on health inequalities will be considered and addressed in all project workstreams, and the diverse needs of patients and clinicians will be responded to through inclusive policy and practice.

NB: This document has been in use since the start of the NHS Online programme. Whilst we recognise the organisation will be the Online NHS Trust from the 1 June 2026, we have not yet updated the language to reflect that change.

NHS Online has set an Equality Objective of 'Strong governance, accountability and engagement' to ensure that DEI is embedded within governance considerations and decision-making and that engagement is meaningful in order to support effective service design. This objective is cross-cutting for all recommendation areas below and in being monitored by Trust Board, will ensure that NHS Online is meeting its Public Sector Equality Duty objectives.

Summary of key recommendations

National	
Support referring routes to feel confident referring into NHS Online	Develop accessible educational resources for GP's and other referring healthcare professionals. These should include accessible formats such as captioned 'how to' videos and easy-read leaflets. The informational resources should cover: • What NHS Online is • The specialties and pathways NHS Online offers care for • Eligibility criteria for patients to be referred into NHS Online, promoting inclusivity and support available for patients • Information on patient choice and consent Clear referral guidance should be provided, outlining the minimum equipment, digital skills and literacy a patient will need to be able to receive virtual care.
Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using the NHS Online platform.	Provide multi-modal support services for NHS Online clinical workforce, patients, and NHS Online administrative staff should be made available, including: • Synchronous support – via a dedicated helpdesk for real-time assistance using the platform • Asynchronous resources – such as accessible user guides, FAQs and captioned video tutorials This support should be accessible through a direct link from NHS Online platform, in both the clinical and patient facing sites, as well as being integrated into the existing NHS App support pages. These actions will support delivery of NHSO Equality Objectives relating to 'Equitable access to digital services' and 'An inclusive and supportive workforce'. A feedback mechanism must be built into the platform to identify and resolve any usability or technical issues, allowing NHS Online platform design and capabilities to be continuously improved and ensuring an inclusive and accessible standard is maintained.

Consider health inequalities in technical procurement and inclusive user centred platform design	Incorporate EHIA actions into technical requirements to procure all technology integrated within NHS Online platform, accessed primarily through the NHS App, that considers accessibility, ease of use and patient experience. Technical requirements should include: compatibility with a wide range of browsers and devices; absence of download/plug-in requirements for patients; and features to capture patient feedback. Explore the use of technologies to improve the accessibility of NHS Online particularly for patients who have difficulty reading, writing, accessing the internet, or whose first language is not English. Accessibility features will also be to support employees who have additional needs working for NHSO. Produce guidance for NHS Online on how the digital platform design can be inclusive and accessible, to ensure a standard is maintained throughout any updates and additions. In particular, guidance should include: design considerations to support; people with disabilities (hearing, sight etc) and carers (proxy access).
Training for healthcare professionals providing care through NHS Online	Provide training for healthcare professionals who will be delivering care through NHS Online. Examples include: Understanding how to adhere to standardised pathways, understanding non-verbal cues, behavioral guidance for delivering care via virtual pathways to help patients feel more engaged, importance of patient choice, understanding the limitations of NHS Online, understanding how to use translation services effectively and Safeguarding in virtual environments. The user interface design will be strongly focused on intuitive systems, which should mean minimal extra training is required for platform use, helping to reduce overall burden.
Raise patient awareness particularly of choice and benefits	Produce patient information materials (using national template materials) and run patient facing campaigns to increase patient awareness and trust in NHS Online. Materials should promote the benefits, detail what receiving care through NHS Online entails, provide reassurance around personal data, promote patient choice, and provide reassurance of maintaining non-digital channels that patients can easily revert to. Ensure materials are in an accessible format, consider translation where appropriate. Patient campaigns will be based on insights and evidence to ensure channels used will also reach marginalised groups; this may be through digital and non-digital channels to ensure maximum impact. Campaigns should be evaluated to ensure channels used to reach these groups are effective.

	We will build in learning from other sectors and industries in relation to strengthening the mitigation around customer/patient understanding and support. For example, where a digital-first model has been introduced to support customer service delivery, convenience and productivity.
Co-design services with affected communities and test with disabled users and non-English speakers.	The NHS Online programme is actively testing and co-designing with affected communities through the work of the User Research Team. This activity is described in the engagement and consultation section below (section 6). Additionally, NHS Online is being built to allow multiple people to attend virtual consultations – for example translators or carers in addition to a patient. Attendance will be secure so that only approved participants can join that session. At launch, NHS Online has committed to providing a service so that patient-provided chaperones, carers or translators can attend at the discretion of the patient. NHS Online is looking at options to provide chaperones/translators in due course, but this capability may not be available at initial launch.
Maintain analogue routes (phone, in person booking) and proactively offer assisted digital support hubs.	The NHS Online service will be reliant on patients being able to access the NHS App and therefore access to a device will be needed. Patients who do not have access to digital devices will continue to receive high quality NHS care as they currently do. We are working with partners and patients to identify and address issues of potential digital exclusion. Where in-person interaction is required as part of the end-to-end NHS Online care journey (e.g. diagnostics), it is critical to ensure common, high-quality patient experience as far as possible. NHS Online will utilise a National Diagnostics Service to provide equitable, consistent experience for all service users as far as possible, irrespective of geographic location for their local diagnostic test. NHS Online aims to provide access to local diagnostic testing within a 25 mile radius of a patient's home.
Monitor equity metrics (who uses online services, outcomes by protected characteristic) and publish results. These steps are central to NHS inclusive digital frameworks and third sector guidance	As an NHS Trust, NHS Online will meet all statutory reporting requirements relating to equity monitoring and the publication of results. Data and service quality metrics are integral to service design and delivery, and the Programme team will work with suppliers and stakeholders to determine how equity metrics can be monitored in line with legal and regulatory requirements.

Referrers	
Equipment and skills check	When referring into NHS Online, healthcare professionals should first check whether the patient has access to the appropriate technology, internet connection and the digital, reading and writing skills required to effectively receive care virtually. It is recommended that referrers consider asking patients about their ability to use digital tools for healthcare as a part of patient records. For digitally nervous patients, referrers should signpost patients to free resources and local digital inclusion schemes to help improve their digital and health literacy and where appropriate, and if wanted by the patient, support arrangements for the patient to access the technology in a local setting. Signpost to patient guidance and NHS Online helpdesk for technical support when required.
Improve understanding of non-adopters	Maintaining non-digital means of accessing quality health services and information is important to avoid discriminating against those who cannot or choose not to use digital health and care services. NHS Online recognises that it will not be suitable for all patients, and is not being built with the intention of converting all patients onto virtual pathways where physical care may be more suitable or preferrable for the patient. However, NHS Online should actively collect feedback from patients who have declined referral, captured by the referrer, and from those who failed to complete a virtual pathway, through a mechanism in the platform. Feedback should capture demographics where possible. This will help build understanding around key barriers and enable further exploration into potential exacerbated health inequalities and allow for continuous platform improvements.

3. Main potential positive or adverse impact(s) of the policy for protected characteristic groups summarised

Please briefly summarise the main potential impact(s) (positive or adverse) on people with the nine protected characteristics (as listed below). Central resources to help make these assessments can be found on the Equality and Health Inequalities Network hosted on FutureNHS (please request access to this network, as it is for members only).

If after careful consideration, you conclude that your policy will not impact adversely or positively on the protected characteristic groups listed below, please state '**neutral**.' Information on mitigation of adverse impacts is included in the Developing EHIAs Guidance.

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact(s) of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
Age: e.g. older people; middle years; early years; children and young people; or people of a particular age (e.g. 32 years old)	**<u>Older people</u>** **Adverse**: • Age and technology confidence: A higher proportion of older people are not confident users of the internet and may lack digital skills (1). Older people may therefore shy away from accessing healthcare virtually. Some older people may not be referred to NHS Online appointments by their GP due to assumptions about these cohorts. • Digital exclusion: Older people are less likely to own a mobile device (2), and compared with younger cohorts, they may be less likely to see the latest technology as essential. Therefore, they may not regularly update their hardware or use the latest models which could lead to compatibility issues with NHS App. In addition, a lack of access to appropriate devices, reliable internet connectivity, or the necessary digital skills can prevent engagement with online services altogether. These factors may lead to poorer experiences when accessing care through NHS Online and may discourage older people from seeking care via digital routes in the future. • Receiving healthcare virtually may increase feelings of loneliness and isolation, by removing the need to travel to the appointment and engage with staff and/or other patients. • Older people may increasingly rely on support from others to use technology, but this support may not always be available and could cause anxiety and/or compromise patient confidentiality if relying on others to assist with technology throughout the care pathway. • A lack of or less established digital skill set may result in older people struggling to distinguish between real and	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits • Regularly engage with service users to feedback, inform service design and ensure that patient's experience is captured in line with NHSO Equality Objectives targets – 'Fair and inclusive digital design and decision-making'. **Referrers** • Equipment and skills check • Improve understanding of non-adopters

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact(s) of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	fraudulent web links relating to their care and therefore they may be more likely to fall victim to scammers. This may cause anxiety for them and their family when receiving links from the healthcare setting to access their appointment. • Accessibility barriers such as cognitive impairment and physical deterioration (i.e., vision, hearing, motor skills for typing) may impact older people's ability to access care through digital devices (3), which may lead to a poorer user experience. • Patients will see different healthcare professionals throughout their care pathway as part of NHS Online model. This may provide less opportunity for healthcare professionals to identify issues (such as frailty deterioration, impact of comorbidities or potential safeguarding issues) compared to traditional models of care. **Positive** • Receiving care through NHS Online may remove the need for older adults with poorer immune systems to come into hospitals, and can reduce the risk of infectious diseases • Older adults are more likely to have mobility issues or existing health conditions, which may make it difficult to travel to a face-to-face appointment. Placing older adults on a virtual pathway could provide a more accessible, convenient way to access healthcare. **<u>Middle years</u>** **Adverse** • People in this age group may be living with other family members, including children. This could mean a lack of	

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact(s) of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	privacy, leading to the patient being less open to their health professional during a remote consultation (4). **Positive** • People who are employed may lead busy lifestyles and may find taking time off work for healthcare appointments disruptive to their schedule and may lose pay. Receiving care virtually could provide more flexibility and make attending appointments more convenient; allowing patients to have a consultation from any location that suits them, including their home and workplace. It can also reduce travel time for patients and reduce the amount of time needed away from work (4). • People in this age group may be carers for their children, relatives, friends, or neighbors. Being placed on a virtual care pathway can be more convenient, helping to reduce anxiety and reduce the amount of time normally required to accompany the patient to healthcare settings (4). • Receiving care virtually may align closely with how this age group interacts with other aspects of society, offering the same level of convenience they expect from services like online banking and online food delivery. **<u>Children and Young people</u>** **Adverse** • Young people may not have a private space at home to have a confidential remote appointment. This may lead to the healthcare professional missing safeguarding needs or sensitive information as the patient does not feel safe or able to disclose information due to fear of being overheard by other members of the household.	

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact(s) of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	• Children may associate devices with play and may find it difficult concentrating when accessing care virtually. • There is often an assumption that young people are digital natives, and are comfortable engaging with technology. However, not all young people have basic digital skills (5) and this can lead to feelings of exclusion and embarrassment if this expectation is placed upon them. **Positive** • Receiving care through digital pathways can encourage and enable young people to be more directly engaged in their healthcare. This can empower patients to take control over their healthcare, forming good habits for future digital health use. • Receiving care virtually can prevent children and young people from needing to travel to and from physical healthcare settings, potentially reducing the number of missed appointments and time away from school.	
Disability: any long-term physical or mental impairment; substantially effecting day-to-day activities.[1]	**Adverse** • Some people with a disability may be less likely to be internet users and less likely to have a high ability in using the internet, compared to people without a disability. The variety of activities they use the internet for can also be more limited (1,6). Therefore, some patients may experience difficulties accessing care this way. • People with visual (i.e. reading) or physical (i.e. typing) impairments will have limited access to digital healthcare. To mitigate this, patients are likely to require add-on functions	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform.

[1] For further information about the definition of 'disability' for the purposes of the Equality Act 2010, please see: Disability: Equality Act 2010 - Guidance on matters to be taken into account in determining questions relating to the definition of disability (HTML) - GOV.UK (www.gov.uk)

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact(s) of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	such as voice-assistance and detection unless they have access to carers. • People with neurodiverse conditions that affect reading, comprehension, or writing may find it difficult to access digital healthcare effectively and may require assistance from a digitally competent carer. • Confidentiality can be compromised for patients who do not usually require the assistance of carers but need support to access care virtually. • In many mental health conditions, non-verbal cues such as speech pressure, facial expression and fidgeting may represent an accurate depiction of a patient's attitude and emotional states (7,8). Digital healthcare pathways may provide less opportunity for healthcare professionals to identify additional issues through nonverbal cues and behaviours compared to traditional appointments. • Receiving care virtually may increase feelings of loneliness and isolation, by removing the need to travel to the appointment and engage with other staff and/or other patients throughout the face-to-face appointment experience. This can make it more difficult for healthcare professionals to become aware of any issues between the carer and patient. • Receiving care virtually may make it more difficult for the patient to build a relationship with their healthcare professional if interactions are felt less personable. • People with mobility difficulties may find it difficult to manoeuvre their body to show certain areas to the healthcare professional on camera. • Visually impaired patients rely on non-visual signals such as sound. There is a risk that remote consultations may not always omit a clear audio, which may have an adverse impact on the patient's experience (4).	• Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits • Design and maintain digital services that meet recognised accessibility standards in line with NHSO Equality Objectives and statutory duties (42). • Regularly engage with service users to feedback, inform service design and ensure that patient's experience is captured in line with NHSO Equality Objectives targets – 'Fair and inclusive digital design and decision-making'. • Utilise a National Diagnostics Service to provide equitable consistent experience for all service users as far as possible, irrespective of geographic location for their local diagnostic test. NHS Online aims to provide access to local diagnostics within 25 mile radius of a patient's home. **Referrers** • Equipment and skills check

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact(s) of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	• People with mental health conditions may not be comfortable speaking openly about problems at home, due to fear of being overheard by other household members. • People with learning disabilities may find it difficult to follow the instructions for navigating the NHS App (4). **Positive** • People with long-term conditions spend a significant amount of time in healthcare settings for routine appointments. Being placed on a virtual care pathway could enable greater flexibility by allowing patients to access care remotely and only traveling for essential diagnostics or face-to-face appointments. Research undertaken in primary care has identified online forms to be particularly beneficial for such routine appointments (9). Therefore, remote care in secondary care could be an effective and safe option to remotely monitor patients with long-term conditions. • Receiving care virtually can provide an opportunity for healthcare professionals to see the patient's home environment which can provide more context for the patient's care plan. • For patients on the autistic spectrum, receiving care virtually may be preferable to face-to-face contact, as it reduces unpredictability and disruption to routines which could otherwise cause patients to feel anxious (10). • Adults with anxiety disorders may prefer receiving care virtually (10), as it removes the need to visit public places, including transport, which could induce anxiety. • For some people, including those who are neurodivergent, receiving care virtually may reduce anxiety and sensory overload compared with face-to-face appointments.	• Improve understanding of non-adopters **In addition** • Consider providing a comprehensive list of all compatible accessibility software's • Provide reasonable adjustments digital flags within platform and accessible information formats • Ensure delivery of NHSO Equality Objective 'Equitable access to digital services'. • Embed equality considerations throughout service design and change

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact(s) of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	• People with mobility disabilities may find receiving care virtually more accessible as they do not need to travel to their appointment. This can also help to build feelings of independence. • Many people with long-term conditions spend a significant amount of time in healthcare settings for routine appointments. By receiving care virtually, the amount of patient time and money spent to attend healthcare appointments can be reduced. • People with certain conditions or disabilities may benefit from the asynchronous nature of some virtual care methods such as online forms, compared with traditional appointments where there may be an unspoken pressure to answer quickly as the clinician is present in real time. In an online form, patients can take their time to thoroughly consider their responses and requests before communicating. • Patients who regularly require diagnostic tests followed by a consultation to review test results can spend many hours in the healthcare setting waiting for their appointments. By delivering care through NHS Online, patients could have their diagnostic tests completed quickly in a local facility, followed by a remote interaction scheduled for when the results are ready. • For patients with complex issues, virtual pathways can enable multidisciplinary team appointments to take place more easily, as healthcare professionals can join the consultation from any location.	

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact(s) of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
Gender reassignment and/or people who identify as Trans.[2]	**Adverse** • Some transgender people may be more likely to experience prejudicial attitudes when using healthcare services (11). This may potentially lead some people to feel they are placed on a virtual pathway because of their gender reassignment. • Receiving care virtually may increase feelings of loneliness and isolation by removing the need to travel to the appointment and engage with staff and/or other patients throughout the face-to-face appointment experience. **Positive** • Some transgender people may feel more anxious about accessing healthcare because of the discrimination they face (11). Access to virtual care pathways provides an alternative option for people from this group to access healthcare, whilst allowing them to avoid visiting public spaces including public transport, if this would cause them to feel anxious. • Virtual care can allow patients to attend their appointment anonymously if they would prefer to, by removing the need to physically walk into a healthcare setting. • Care around patients going through gender reassignment may be complex, involving both mental health and physical health (12). Virtual care can enable multidisciplinary team consultations to take place more easily, as healthcare professionals from different departments and/or locations can attend a consultation, allowing more joined-up care. • Patients may feel more comfortable speaking honestly and openly to healthcare professionals in their own home.	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits **Referrers** • Equipment and skills check • Improve understanding of non-adopters

[2] A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex.

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact(s) of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
Marriage & civil partnership[3]: people married or in a civil partnership.	**Adverse** • People may not always want their partner to know about their health conditions, and they may not have access to a private space to speak openly to the healthcare professional in their home. • People in an abusive relationship may not have access to a private space to have a confidential virtual appointment, which may lead to the healthcare professional missing safeguarding needs as the patient does not feel safe to disclose important information. **Positive** • Receiving care virtually may provide people in this group with more opportunities to receive healthcare in a private space, for example having a health interaction in a private space at work.	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits **Referrers** • Equipment and skills check • Improve understanding of non-adopters
Pregnancy and maternity: women while pregnant and during maternity leave.	**Adverse** • Some pregnant women may not have a private space at home to have confidential virtual appointments. Some women may not feel safe or able to respond openly to routine questions of a sensitive nature or speak about issues with their partner. This can lead to the healthcare professional	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online

[3] Please note that the provisions on marriage and civil partnership are limited in relation to service-delivery (See: Developing Equalities and Health Inequalities Impact Assessments (EHIAs): Page 8)

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact(s) of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	missing important information as the patient doesn't feel safe to speak honestly (13). • New motherhood can be a lonely period for some women, and virtual care pathways may inadvertently isolate women as they have less opportunity to meet other mothers and parents in healthcare settings or face-to-face group sessions (14). • Non-verbal cues may be more difficult to observe through virtual appointments, and healthcare professionals may not be able to spot signs of patient anxiety or depression. **Positive** • For pregnant women with transport and/or childcare needs or complications or who live in remote and rural areas that require lengthy travel, access to virtual care may be a helpful tool in reducing unnecessary travel for routine follow ups. • Public transport can be a stressful environment for pregnant women and women with newborn babies, as it can be an unstable and crowded environment. Access to virtual care can reduce feelings of anxiety by removing the need to travel to healthcare settings (13). • Virtual appointments can provide an opportunity for healthcare professionals to see the patient's home environment, which can offer the healthcare professional a more holistic view of home life for new and expecting mothers.	administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits **Referrers** • Equipment and skills check • Improve understanding of non-adopters
Race and ethnicity[4]: includes colour and	**Adverse**	**National:**

[4] Addressing racial inequalities is about identifying any ethnic group that experiences inequalities. The Equality Act 2010 prohibits discrimination on the basis of colour, nationality and ethnic or national origins. Race and ethnicity includes people from any ethnic group incl. BME communities, non-English speakers, Gypsies, Roma and

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact(s) of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
ethnic and national origins.	• Language and literacy: Both the NHS App, website and respective status services currently do not specifically support users whose first language is not English. Approximately 1.6% of the population (863,000 people) in England and Wales reported in the 2011 Census that they either could not speak English or Welsh at all or not well. This was particularly high for Bangladeshi (16.2%), Chinese (15.3%), White Other (12.2%) and Pakistani (11.2%) groups, and especially pronounced for women (15,16). • Language and literacy barriers: Non-English speakers and users with low literacy may experience difficulties navigating text-heavy interfaces on NHS Online. Limited availability of translated content, complex medical terminology, and dense written instructions can reduce understanding and confidence when using digital services. Where remote consultations lack access to interpreters or appropriate accessible formats, patient experience may be significantly poorer, increasing the risk of misunderstanding and unmet need. Evidence and sector analyses highlight these real-world harms and underline the need for system-level responses to prevent widening health inequalities. • There are differences in attitudes towards certain health conditions amongst different cultures. Mental health for instance has been stigmatised in Asia and seen as a source of shame (17). Some people may therefore not feel comfortable receiving virtual care if they lack a private space at home and fear being overheard by family members. • Minority ethnic groups are more likely to live in multigenerational households, some of which may be	• Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits • NHS Online could enable pairing doctors who speak languages other than English with patients who speak those languages (not required for Day 1 service MVP). **Referrers** • Equipment and skills check • Improve understanding of non-adopters

Travelers, migrants etc. who experience inequalities. So, for example, this includes addressing the needs of BME communities but is not limited to addressing their needs, it is equally important to recognise the needs of White groups that experience inequalities.

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact(s) of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	overcrowded (18), which could lead to a lack of private space for confidential virtual appointments. • Some cultures may view virtual care as inferior care compared with face-to-face appointments. • Different cultures may interpret logos, colours and symbols in different ways. The NHS App used in England would be tailored for western society and may be less user friendly for people from other cultures. • According to a US study, non-white populations are more likely to report low levels of trust in healthcare providers than white populations (20). Fewer quality interactions had a significant effect on this low trust (20). Patients will see different healthcare professionals throughout their care pathway as part of the NHS Online model. Receiving care from different healthcare professionals virtually may decrease certain populations' trust in the service. • People from minority ethnic groups have lower levels of trust in how data is protected and have more concerns about their data being used to discriminate against them (39). This may mean that this group would be less likely to choose to receive care through NHS Online. **Positive** • Current research suggests, across the UK population, 90.8% of people are internet users. Although some ethnic groups fall below the population average, this difference is small (90.4% for Indian and 90.5% for White ethnic groups). It is therefore unlikely that specific ethnicities would be adversely impacted from accessing care virtually. In contrast, the percentage of internet users in the Chinese ethnic group is significantly higher than the UK overall at 98.6% (19). Access	

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact(s) of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	to virtual care platforms may therefore help improve access to health services for people from the Chinese ethnic group. • Compared with other ethnic groups, people from Black ethnic groups tend to travel the least. Accessing virtual care may therefore be preferable for Black ethnic groups as it removes the need to travel for their appointment, thus improving access to healthcare (21).	
Religion and belief: people with different religions/faiths or beliefs, or none.	**Adverse** • Some religious groups discourage internet use and/or have no access to devices (4), including Orthodox Jewish, Brethren, Amish, and some Muslim communities. Certain groups of people may therefore feel excluded from accessing virtual healthcare services. • Some religious groups may distrust the current healthcare system and may find that receiving virtual care negatively impacts their ability to trust their healthcare provider, due to a lack of personal interaction and transactional nature of the service (22). **Positive** • Some religious groups have fixed prayer times, requiring people to pray at dedicated times during the day. Although some NHS sites have prayer rooms, it may be stressful for some people trying to locate the prayer rooms in an unfamiliar environment. Access to virtual care can help improve convenience and reassurance for these patients by removing the time spent travelling to healthcare settings and allowing more flexibility to be at home and places of worship during times of prayer. • Some religious groups may restrict medical interventions and subsequently restrict engagement with health professionals. Access to virtual care can provide a discreet way for patients	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits **Referrers** • Equipment and skills check • Improve understanding of non-adopters

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact(s) of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	to engage with healthcare that would otherwise be restricted or monitored. This can provide a confidential, open space for patients to disclose sensitive information or discuss topics that may be taboo in the religion (i.e. sexual health).	
Sex: men; women.	**Adverse** • Current data shows a minor difference in the number of internet users between men (93%) and women (91%) in the UK. The gap becomes slightly larger when looking at the over seventy-five population (23). Women aged over seventy-five could therefore be unable to, or less confident in engaging with NHS Online. • Some research has shown that men feel more positive towards health care technologies being used for their care (24). Women could feel less confident or willing to receive care through a virtual pathway. • Identification is needed to register to the NHS App, which will be the front door for the service. This could adversely affect divorced and married women who have changed their name as it could make the identification process take longer, which could delay care. • Research has identified that women may be more expressive through non-verbal cues compared with men, particularly through facial expressions (25). Accessing healthcare virtually could remove opportunities to identify important information through non-verbal cues which could lead to missing safeguarding needs. • Both men and women can be victims of domestic abuse, although women are significantly more likely to experience abuse (26). Accessing care through a virtual pathway may reduce face-to-face appointments which may make it harder for patients to report abuse and for healthcare professionals to spot indicators of abuse.	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits • Safeguarding policy is in development to include safeguarding considerations for domestic abuse **Referrers** • Equipment and skills check • Improve understanding of non-adopters

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact(s) of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	Positive • Women may be more likely to be caring for children. Receiving care through a virtual pathway could allow for more flexibility and reduce the need to travel and pay for childcare • Research has shown that some men feel more positive towards health care technologies being used for their care (24). Offering men the choice of receiving care through NHS Online might encourage more men to access healthcare and receive treatment.	
Sexual orientation: Lesbian; Gay; Bisexual; Heterosexual.	**Adverse** • LGBTQIA+ patients have disproportionately worse health outcomes and experiences of healthcare (27). This group may feel less comfortable being treated through NHS Online due to not knowing who will be completing their treatment/s, with a fear they may hold bias towards them. • Lesbian, Gay and Bisexual people may be less willing to have online appointments and may be less satisfied with online services in healthcare (28). This could make this group less likely to engage with care through NHS Online. **Positive** • Some people in this group may feel more comfortable speaking to healthcare professionals in their own environment about sensitive issues. Accessing healthcare through a virtual pathway could increase patient choice around the type of appointment they can choose to receive care.	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits **Referrers** • Equipment and skills check • Improve understanding of non-adopters

4. Information and communication support needs

Have you considered whether steps are necessary to meet the information and communication support needs of patients, service users, carers and patients? Please place an 'x' in the appropriate box below.

Yes x	No

The Accessible Information Standard (AIS): Where those needs relate to a disability, impairment or sensory loss or wider disability related translation or interpretation needs please see the Accessible Information Standard.

Community languages and translation: Where English is not the first language please see the 'Improvement framework: community language translation and interpreting services'

Please complete the box below.

Is this standard or guidance relevant?	**Yes**	**No**
The Accessible Information Standard	x	
The Improvement Framework: community language translation and interpreting services	x	

5. Main potential positive or adverse impact for people who experience health inequalities

Please briefly summarise the main potential impact (positive or adverse) on people at particular risk of health inequalities (as listed below). In particular, you must consider outcomes in terms of the **effectiveness** of health services, the **safety** of the services, and the **quality of the experience** undergone by patients.

If after careful consideration, you conclude that your policy will not impact on patients who experience health inequalities adversely or positively, please state '**neutral**.' Information on mitigation of adverse impacts is included in the Developing EHIAs Guidance.

Groups who commonly face health inequalities[5]	Summary explanation of the main potential positive or adverse impact of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
Looked after children and young people and people with experience of the care system.	**Adverse** • People in this group may be less likely to have a private space to access care on a virtual pathway and therefore may not feel comfortable using NHS Online. • Accessing care through NHS Online could negatively affect continuity of care as multiple consultants could be picking up different parts of the pathway. Appointments in a traditional care setting may be with one consultant who is aware of all the patients history and how this may affect their treatment. • Inequalities exist between children and young people in and out of care settings. Those in looked after settings are more likely to experience digital exclusion; in both the ability to use the internet and to access devices (29). This may be a barrier for these patients to access and use NHS Online. • Phone or internet use could be restricted for people in this group due to safeguarding needs (30), which could mean they would not be suitable to be placed on a virtual care pathway. • Reduced face-to-face contact in virtual pathways may limit opportunities for clinicians to identify safeguarding concerns or accessibility needs through observation alone, increasing reliance on timely and consistent use of national flags such as reasonable adjustments, CP-IS and FGM-IS. **Positive** • Looked after children and young people may need to be accompanied to face-to-face appointments, with carers sometimes not having the time to travel to and from	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits • Safeguarding policy is in development to include Child Safeguarding **Referrers** • Equipment and skills check • Improve understanding of non-adopters **In addition** • Where proxy access is required, ensure this is provided on a case-by-case basis

[5] Please note many groups who share protected characteristics have also been identified as facing health inequalities.

Groups who commonly face health inequalities[5]	Summary explanation of the main potential positive or adverse impact of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	healthcare settings. Receiving care virtually may create more flexibility and be more convenient for this group.	
Carers of patients: unpaid, family members.	**Adverse** • Having a patient go through NHS Online could increase care responsibilities and burden for unpaid carers (39), e.g. the patient will be at home rather than hospital or having to take readings from monitoring devices *(though not planned for Day 1 MVP)* at home where this previously would have been done in a healthcare setting. • The adoption of digital appointment details compared to paper appointment letters may present a barrier to carers who take on responsibility of coordinating appointments. **Positive** • Carers could benefit from care accessed through NHS Online as it may increase convenience, reducing or removing travel time and reducing time spent waiting in healthcare settings. • Accessing care through NHS Online may reduce the need for unpaid carers to take time off work to accompany the patient to face-to-face appointments.	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits • Enabling proxy access on a case by case basis where carers are responsible for coordinating patient appointments could support carers to access digital appointment details and reminders **Referrers** • Equipment and skills check • Improve understanding of non-adopters

Groups who commonly face health inequalities[5]	Summary explanation of the main potential positive or adverse impact of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
People who experience homelessness. People on the street; staying temporarily with friends /family; in hostels or B&Bs and other temporary accommodation.	**Adverse** • People in this group are less likely to have access to technology e.g. smartphones and laptops, or consistent access to Wi-Fi to access healthcare virtually. • This group are less likely to possess identification documents, which could prevent them from registering with NHS Online. • Homeless people find it more difficult to access care through a GP (31). This could decrease the likelihood of this group being referred into NHS Online and onto a virtual care pathway. • Some people in this group may have lower levels of digital literacy, this may make them less comfortable and confident accessing care through a virtual pathway. • Accessing care virtually could decrease interaction between people in this group and healthcare professionals, which could lead to further feelings of isolation **Positive** • NHS Online could provide a means to access care throughout a pathway without needing to be available in the same location. This could increase continuity of care for this group as they are less likely to have a fixed address and may not be able to access care in the same setting consistently.	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits **Referrers** • Equipment and skills check • Improve understanding of non-adopters **In addition** • If formal identification is needed to first access the service, provide a means for this to be done face-to-face to remove barriers if formal ID is not held by a patient.
People in contact with the criminal justice system: offenders in	**Adverse** • Currently, offenders in prison are typically not permitted to use the NHS App, for security and practicality reasons. As the NHS App will be the patient front door	**National:** • Support referring routes to feel confident referring into NHS Online

Groups who commonly face health inequalities[5]	Summary explanation of the main potential positive or adverse impact of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
prison, probation populations, ex-offenders.	for NHS Online, these patients may be excluded from being referred in. • People in this group who are currently in prison may not be allowed access to digital devices that may be needed on some virtual care pathways such as mobile phones, computers, and wearable monitoring devices. This could slow down their care or lead to delayed updates on their health being submitted. • People in this group may be less likely to be digitally literate, which may exclude them from receiving care through NHS Online. • Reducing the number of face-to-face appointments needed when receiving care through a virtual pathway could isolate patients with previous lived experience of imprisonment and decrease their opportunities to engage with their community. **Positive** • NHS Online could decrease health inequalities for offenders in prison who may face restrictions about when they can travel to hospital, with around 40% of outpatient appointments being missed by those living in prison due to lack of chaperone availability (32). NHS Online could positively benefit this group as having less off-site appointments may make it easier for them to attend appointments. There may also be a reduction in appointments needed where patient and/or clinician can input updates on the platform. • The prevalence of unmet health need and non-concordance with health care provision is greater in this group compared to the general population. NHS Online	• Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits **Referrers** • Equipment and skills check • Improve understanding of non-adopters

Groups who commonly face health inequalities[5]	Summary explanation of the main potential positive or adverse impact of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	could improve access and thereby reduce this inequality.	
People with drug and alcohol dependence.	**Adverse** • This group may feel less comfortable being treated through NHS Online as the healthcare professionals through their care pathway are likely to change, so they may not know who will be completing their treatment/s. This may create a worry they could receive care from someone who may hold a stigma towards them. • People in this group are more likely to have co-occurring conditions (33) and may have more complicated care needs. NHS Online may not be suitable for all care pathways, or for those with multiple complicated co-morbidities and mean people in this group may not be suitable to receive care through NHS Online. **Positive** • Treatment through NHS Online could allow people in this group to access healthcare in an environment in which they feel more comfortable, as they are more likely to feel marginalised, stigmatised and judged when accessing healthcare (33). • People in this group often delay seeking care due to the time it takes to access (34). NHS Online could provide a way for this group to seek medical care and advice earlier and more flexibly, reducing the time taken in face-to-face appointments.	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits **Referrers** • Equipment and skills check • Improve understanding of non-adopters
People or families on a low income.	**Adverse** • Socioeconomic disadvantage: Individuals in this group experience socioeconomic disadvantage and may face barriers to accessing NHS Online due to the cost of	**National:** • Support referring routes to feel confident referring into NHS Online

Groups who commonly face health inequalities[5]	Summary explanation of the main potential positive or adverse impact of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	mobile data, broadband, and suitable digital devices. Those living in unstable or temporary housing may also lack consistent internet access or private spaces to engage with digital health services, reducing continuity of care. These challenges can limit sustained engagement with NHS Online, increase missed appointments or incomplete interactions, and contribute to existing health inequalities. • People in this group may be less likely to have access to regular / consistent Wi-Fi / mobile data, which may exclude them from being able to access care through NHS Online and/or mean they have negative experiences accessing care virtually. • People in this group are less likely to have strong digital literacy (35), which could be a barrier to using NHS Online and/or feeling comfortable receiving care virtually. **Positive** • People in this group may not be able to afford travel to and from hospital settings. NHS Online would remove the need to travel for the majority or all of a pathway for the patient. • People in this group may struggle to miss work or pay for childcare to attend hospital appointments (4). NHS Online could (almost) completely remove the need for this when receiving treatment in certain specialties and pathways.	• Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits **Referrers** • Equipment and skills check • Improve understanding of non-adopters
People with poor literacy or health literacy: (e.g. poor understanding of health services, low levels of reading or writing ability,	**Adverse** • Patients may find it difficult to understand the written instructions on how to access and/or use NHS Online technology. Having too much information written in leaflets can also feel overwhelming (4).	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical

Groups who commonly face health inequalities[5]	Summary explanation of the main potential positive or adverse impact of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
or people who do not speak fluent English).	• 43% of adults in England struggle with low health literacy, and 61% when the information includes numbers as well as words. This means many people find it hard to navigate the healthcare system, especially online (36). People in this group may be much less likely to engage with NHS Online if there is not the appropriate support available to help them. • People in this group may be more likely to misinterpret questions or provide inaccurate information in response to forms of virtual care such as online forms. This could lead to added burden of repeated questioning or could increase clinical risks associated with inaccurate information. • Users with low literacy may struggle with text-heavy interfaces. Limited translations and inaccessible formats can reduce understanding and confidence, while remote consultations without interpreters may worsen patient experience, delay care and lead to missed appointments. **Positive** • People in this group may benefit from receiving care through NHS Online as the digital tools will provide easier access/signposting to further information when / if needed. • Accessing healthcare virtually may be more comfortable for people in this group, as visiting an NHS hospital could be stressful to navigate. NHS Online would allow them to access care in the comfort of their own home. • Using NHS Online with appropriate support could provide an educational opportunity for people in this group.	workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits **Referrers** • Equipment and skills check • Improve understanding of non-adopters

Groups who commonly face health inequalities[5]	Summary explanation of the main potential positive or adverse impact of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	• Literacy covers not only reading and writing but also speaking and listening. Given that the NHS has a diverse workforce with a range of accents, some patients with poorer language skills may find it challenging to understand health professionals verbally [68]. For those who struggle with listening and speaking, NHS Online could offer care options such as online forms to make engaging easier for them.	
People living in deprived areas.	**Adverse** • People living in deprived areas are less likely to have the ability and means to access the internet, making NHS Online potentially less accessible for these groups of people (37). • Those living in smaller spaces may not have access to a private space to have confidential virtual care at home. **Positive** • People living in these areas can often have poor public transport links / services. Patients receiving their care via NHS Online could reduce their need to travel to hospital settings.	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits **Referrers** • Equipment and skills check • Improve understanding of non-adopters

Groups who commonly face health inequalities[5]	Summary explanation of the main potential positive or adverse impact of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
People living in remote, rural, coastal and island locations.	**Adverse** • People living in these areas are more likely to have bad mobile device reception / Wi-Fi connection and may struggle to access digital tools / virtual appointments (37). • Populations in rural communities are increasingly older and are less likely to have access to high-speed broadband and mobile phone network coverage. This poses a risk of digital exclusion and consequently a barrier for people from rural communities to access NHS Online (38). • People in this group may welcome the opportunity to travel to appointments and engage with their community. There is a potential that receiving care virtually at home may cause feelings of isolation or exclusion if the opportunity to attend an appointment face-to-face is removed. **Positive** • People living in these areas are more likely to need to travel further for their appointments. By receiving care through NHS Online, the need to travel to appointments could be significantly reduced or completely removed on some pathways. • Because of distance and lack of resources, people living in rural areas have worse access to health and related services, which may prevent people from using the services (38). NHS Online can help people access a wide range of healthcare more easily as it reduces the need to travel long distances. • NHS Online can enable access to a wider pool of clinicians and specialists, which may be particularly	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits **Referrers** • Equipment and skills check • Improve understanding of non-adopters

Groups who commonly face health inequalities[5]	Summary explanation of the main potential positive or adverse impact of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	beneficial for those living on or near bases in rural or remote areas who would otherwise need to either travel longer distances for specialised care, or be limited to accessing specialists at their local hospital.	
Refugees, asylum seekers or those experiencing modern slavery.	**Adverse** • Refugees, asylum seekers or those experiencing modern slavery may be less likely to have the ability and means to access the internet, making NHS Online less accessible for these groups of people (4). • Patients may feel nervous about engaging through technology; for fear of being charged, detained or deported through engaging with healthcare services. • It may be difficult for people in this group to engage with virtual care through NHS Online if the platform is only available to view in English. • People in this group may not have the required identification documents needed to sign up to the NHS App which could exclude them from or delay their ability to receive care through NHS Online. • People in this group may rely on libraries and other public spaces for digital access, and some may borrow phones to book health appointments. This can compromise privacy and make it difficult for individuals to comfortably manage sensitive or confidential healthcare matters. • Online and telephone healthcare can be perceived as confusing and impersonal, which may exacerbate language barriers and make communication more challenging compared with face-to-face consultations. **Positive**	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits **Referrers** • Equipment and skills check • Improve understanding of non-adopters

Groups who commonly face health inequalities[5]	Summary explanation of the main potential positive or adverse impact of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	• People in this group may move frequently or have less settled accommodation and could therefore benefit from receiving care virtually via NHS Online. • NHS Online can help improve access for refugees who may not be familiar with the transport system and removes the need to pay for travel. • For those experiencing modern slavery, receiving care virtually through NHS Online could provide a more discreet way of accessing healthcare. • Earlier access to care: People in this group who are on NHS waiting lists may feel in limbo or overlooked while awaiting treatment, with their lives effectively on hold - sometimes for extended periods. NHS Online can help reduce waiting times for healthcare, this could significantly improve both outcomes and the overall experience of people seeking asylum who require treatment.	
People who are digitally excluded: People who have little or no access to digital devices or internet connection, or who lack the skills and knowledge to use digital devices, processes and systems.[6]	**Adverse** • Having to understand the NHS App and technology could increase burden on the patient and feelings of exclusion (4). • Patients who don't understand the technology may worry about privacy and feel hesitant to use the service (4). • People in this group may have to rely on public devices or assistance from others to access care virtually, which could mean they withhold sensitive information due to lack of privacy.	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design

[6] This also includes those at risk of exclusion due to evolving technology, financial challenges, life transitions, or inadequate support for adapting to digital advancements.

Groups who commonly face health inequalities[5]	Summary explanation of the main potential positive or adverse impact of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	• People who are digitally excluded may be unable to access NHS Online due to a lack of suitable devices, reliable connectivity, or digital skills, preventing engagement with online services. Where booking, triage, or communication is primarily digital, this can result in missed appointments, delayed care, and reduced access to timely support. Digitally excluded groups may also have lower uptake of preventive services delivered online. In addition, patient experience may be poorer where remote consultations lack interpreters or accessible formats. **Positive** • Accessing care through NHS Online could create opportunities for people in this group to improve their digital skills and knowledge. This can build confidence in accessing and using technologies that would benefit other areas of the patients' lives (i.e. cost savings).	• Training for healthcare professionals providing care through NHS Online • Raise patient awareness particularly of choice and benefits **Referrers** • Equipment and skills check • Improve understanding of non-adopters
Members or former members of the armed forces, and service families.	**Adverse:** • Digital exclusion and connectivity issues - Some service families live on bases or in remote or overseas locations where internet connectivity may be unreliable, making consistent use of online platforms difficult. • Mobility and registration challenges - Frequent relocations can lead to delays or complications with GP registration and transfer of records, which may limit access to online services that depend on an active GP registration. **Positive:** • Service families often relocate due to assignments, which can result in frequent moves and disrupted	**National:** • Support referring routes to feel confident referring into NHS Online • Design and implement user support services for the clinical workforce, patients and NHS Online administrative staff using NHS Online platform. • Consider health inequalities in technical procurement and inclusive platform design • Training for healthcare professionals providing care through NHS Online

Groups who commonly face health inequalities[5]	Summary explanation of the main potential positive or adverse impact of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
	access to care. NHS Online could benefit this group by enabling continuity of care regardless of where they are based. • NHS Online can enable access to a wider pool of clinicians and specialists, which may be particularly beneficial for those living on or near bases in rural or remote areas. • Online consultations reduce the need for travel and time off work or caring duties, which can be especially valuable for service families managing deployments or irregular schedules. • Veterans with long-term physical or mental health conditions may benefit from easier access to follow-up appointments, monitoring, and support through virtual services.	• Raise patient awareness particularly of choice and benefits **Referrers** • Equipment and skills check • Improve understanding of non-adopters

Other groups experiencing health inequalities. Please name:	Summary explanation of the main potential positive or adverse impact of your policy	Actions taken to mitigate adverse impact and/or maximise the positive impact
Gypsy Roma Traveler People	**Adverse** • Limited access to the internet and poor digital skills: Gypsy Roma Traveller (GRT) people are twice as likely to have never used the internet compared to the general population, and are more likely to lack digital skills, with the majority having no access to the internet (40). This can be a significant barrier for these patients to access NHS Online. • Limited literacy: In the UK, GRT communities have the highest rates of illiteracy of any ethnic group (41). This may significantly impact on their ability to engage with NHS Online, leading to disengagement, poorer patient experience	**National:** • Support local patient information/ communications • Support healthcare staff with best practice guidance • Consider health inequalities in technical procurement • Raise patient awareness of choice and benefits • Training for healthcare professionals

	and poorer quality of information communicated to healthcare professionals. • Gypsy Roma Traveller people living in rural areas may be less likely to have access to reliable mobile phone network coverage, which could decrease the quality of the Video Conferencing (VC). This poses a risk of digital exclusion and consequently a barrier for people from these communities accessing VC. **Positive:** • Less discrimination: GRTs communities often experience open prejudice and discrimination with the assumption that they will 'cause trouble' and 'be difficult' (42). NHS Online may encourage people in this group to access care who otherwise would feel uncomfortable visiting NHS sites in person due to fear of discrimination or prejudice. • Continuity of care: GRT communities who regularly move may find it challenging to have continuity of care when using face-to-face appointments. NHS Online can provide improved continuity of care as it can be accessed remotely.	**Referrers** • Equipment and skills check • Improve understanding of non-adopters

6. Engagement and consultation

a. Has **your team** undertaken any engagement or consultative activities in relation to the policy that considered how to address equalities issues or reduce health inequalities? Please place an 'x' in the appropriate box below.

Yes x	No

b. If yes, please list up to 5 of the most important engagement or consultation activities by completing the table below.

Name of engagement and consultative	Summary of engagement or consultative activity undertaken and what was learned from it in relation to addressing equalities issues and/or reducing health inequalities. How that has informed the final policy?	Date of activity (Month/Year)

activities undertaken			
1	Internal workshop	Workshop with internal NHS Online team to review impacts of NHS Online on each of the characteristic groups and develop recommendations based on the impacts identified.	August 2025
2	Reviewed by NHS Online Programme Board	EHIA document taken to NHS Online Programme Board on 2 October 2025 for review and comment. Board members include, but are not limited to, clinical representatives, digital experts and a representative from DHSC. Document updated in line with all comments received. Programme Board discussion identified the importance of NHS Online design as an opportunity to improve equity, with abilities such as advanced language interpretation either through technology or utilising the national workforce that NHS Online will have.	October 2025
3	NHS App meeting with the Health and Wellbeing Alliance	The NHS App team met with the Health and Wellbeing Alliance in December 2025 to look at barriers to the uptake and use of the NHS App and website by specific population groups. The session was attended by NHS Online colleagues and the insights gained informed the development of the EHIA. In particular, the section on Gypsy Roma Traveler People was added following this meeting.	December 2025
4	User Research within the NHS Online Technology workstream	Ongoing user research is being conducted by a dedicated team within the NHS Online Technology workstream. To date, the team has engaged 38 patient participants through a mixture of one-to-one, in-depth interviews and co-design workshops, conducted both remotely and in person (50/50 split). The team has covered a range of geographies, age groups and gender. Representation has been achieved across the four priority pathways and participants from a range of ethnicities and socioeconomic backgrounds have been engaged, as defined by the Index of Multiple Deprivation. For example, the team delivered a co-design workshop with Muslim women who have lived experience of menopause and endometriosis, and has also conducted pop-up research with an older adult community group in a deprived area of Leeds. The team has undertaken user research with professional users, including GPs, GP practice staff, and secondary care clinicians. So far, 17 sessions have been conducted with these groups, spanning a range of specialties, experience levels, and geographic locations. All sessions to date have been conducted remotely. **Planned research and ongoing engagement** User research will remain a continuous and embedded activity within the Technology workstream throughout the development of the NHS Online Platform. The team will continue to monitor the demographics of their sample to identify gaps and ensure participants reflect the diversity of people who may use the service.	2025 2026

		Engagement plans include maintaining regular contact with community groups and building long-term relationships to support iterative testing and feedback. This will involve continued collaboration with groups such as an LGBT prostate cancer support group and the Sandwell African Caribbean Mental Health Foundation, alongside outreach to additional communities as needs emerge. The team will also continue regular engagement with professional users throughout development and will track a range of factors to ensure that research remains aligned with the expected workforce and those likely to be impacted by the service. This includes exploring access needs and reasonable adjustment requirements for professional users. To date, research has highlighted that individuals within the priority pathways face a combination of physical, emotional, and cultural factors that influence their ability to access and use the service. These insights are being mapped into the service design and captured as user needs, helping to identify and reduce potential barriers to access. This process will continue throughout development as further research is conducted. A similar approach is being taken with professional users, with their needs actively fed into service design and ongoing iteration to ensure the platform is as inclusive and usable as possible.	
5	Healthwatch Consultation	The preferred delivery mechanism for NHS Online is a new NHS Trust, which is subject to approval by the Secretary of State. A statutory part of this process is for Healthwatch to conduct a consultation with all 153 local Healthwatch organisations; this 12-week consultation is currently underway, having launched 15 December 2025. This consultation will gain patient perspectives on the NHS Online service to form part of the design and development considerations. Outcomes from the consultation will inform the EHIA.	December 2025 – March 2026
	Workshop with the VCSE Health and Wellbeing Alliance 27/1/26	Workshop with the VCSE Health and Wellbeing Alliance to discuss the draft recommendations in the EHIA and the views from VCSE organisations representing communities that face the worst heath inequalities. The engagement facilitated discussion around the experience of carers, digital exclusion and languages primarily, with themes around equity of access and data also emerging. There were no objections to our recommendations, and information shared informed them further. As part of the workshop outcomes, we are reviewing and learning from the resources below: Katie heard (Good Things Foundation): https://www.goodthingsfoundation.org/policy-and-research/indicators-of-digital-inclusion Lorna Darknell (British Red Cross): How digital exclusion impacts people seeking asylum) Chloe Rollings (Carers Partnership): Identifying and supporting unpaid carers in England to improve integrated system working - Resource… Katie Heard (Good Things Foundation) https://www.goodthingsfoundation.org/policy-and-research/research-and-evidence/research-2025/belief…	January 2026

		Jess Leigh (Samaritans): https://media.samaritans.org/documents/Samaritans_SPS_ForPeopleWithNoFixedAddress_2024_WEB.pdf Lea Maquin (Maternity): https://jointpolicyunit.org.uk/interpreting-essential-component-of-safe-maternity-neonatal-care/ - information collected around asylum seeking and refugee mothers, as well as deaf mothers may be useful. British Sign Language is a legal language now and many deaf/deafblind people cannot speak/write/read English	
6	Lived Experience Partners workshop 11/3/26	Workshop with lived experience partners facilitated by NHS England colleagues. The group was asked their thoughts, feelings and expectations when they heard NHS Online. What information they would want upfront to feel safe and confidence and how they will receive updates to their care. Discussion was focused on some of the positives from NHS Online, with a number of patients asking how records will be updated across the health system, how safeguarding support will work and digital access. It was noted that this would work well for some populations who find navigating face to face services difficult – e.g. Gypsy, Roma, Travellers, Liveaboard boaters, unpaid carers and ex-offenders.	March 2026
7	Patients Association webinar 11/5/26	Webinar hosted by the Patients Association with 175 patients on the call. Discussion focused on what NHS Online was, and patients expectations of the service. Questions ranged from digital access / choice to technical aspects of how the programme will work	May 2026
8	National Voices Policy Leads session 18/5/26	**TBC**	May 2026

7. What other key sources of evidence have informed your impact assessment?

Evidence Type	Key sources of available evidence	Date of evidence (Year)
Published evidence	1. Department for Digital, Culture, Media & Sport (2020) *Internet - Taking Part Survey 2019/20*. https://www.gov.uk/government/publications/taking-part-201920-internet/internet-taking-part-survey-201920. 2. Ipsos MORI (2020) *The Health Foundation COVID-19 Survey*. https://www.health.org.uk/sites/default/files/2020-06/Health-Foundation-polling-contact-tracing-app-May-2020.pdf 3. Sakaguchi-Tang, D.K., Bosold, A.L., Choi, Y.K. and Turner, A.M. (2017) 'Patient portal use and experience among older adults: systematic review', *JMIR Medical Informatics*, 5(4), p.e38. doi: 10.2196/MEDINFORM.8092. 4. National Voices (2021) *Unlocking the digital front door: keys to inclusive healthcare*. https://www.nationalvoices.org.uk/publications/unlocking-digital-front-door-keys-inclusive-healthcare 5. Carnegie UK Trust (2017) *#NotWithoutMe: A digital world for all?* NotWithoutMe-2.pdf 6. Ofcom (2017) *Internet use and attitudes*. https://www.ofcom.org.uk/__data/assets/pdf_file/0018/105507/internet-use-attitudes-bulletin-2017.pdf 7. Philippot, P., Feldman, R.S. and Coats, E.J. (eds.) (2003) *Nonverbal behavior in clinical settings*. Oxford: Oxford University Press. 8. Argyle, M. (1978) 'Non-verbal communication and mental disorder', *Psychological Medicine*, 8(4), pp. 551–554. doi: 10.1017/s0033291700018766. 9. Banks, J. et al. (2018) 'Use of an electronic consultation system in primary care: a qualitative interview study', *British Journal of General Practice*, 68(666), pp. e1–e8. doi: 10.3399/BJGP17X693509. 10. Oxford Precision Psychiatry Lab (2020) *Digital technologies and telepsychiatry*. Digital technologies and telepsychiatry – NIHR Oxford Health Biomedical Research Centre 11. Bradford, J., Reisner, S.L., Honnold, J.A. and Xavier, J. (2013) 'Experiences of transgender-related discrimination and implications for health: results from the Virginia Transgender Health Initiative Study', *American Journal of Public Health*, 103(10), pp. 1820–1829. 12. Ellis, S., Bailey, L. and McNeil, J. (2015) 'Trans people's experiences of mental health and gender identity services: A UK study', *Journal of Gay & Lesbian Mental Health*, 19(1), pp. 1–17. 13. The Royal College of Midwives (2020) *Guidance on appropriate application for virtual consultations and practical tips for effective use*.	

Evidence Type	Key sources of available evidence	Date of evidence (Year)
	https://www.rcm.org.uk/media/4192/virtual-consultations-v20-24-july-2020-review-24-august-2020-1.pdf . 14. Kent-Marvick, J., Simonsen, S., Pentecost, R. et al. (2020) 'Loneliness in pregnant and postpartum people and parents of children aged 5 years or younger: a scoping review protocol', *Systematic Reviews*, 9, p.213. 15. Office for National Statistics (2021) *Language, England and Wales: Census 2021*. https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/language/bulletins/languageenglandandwales/census2021#english-language-proficiency . 16. Office for National Statistics (2018) *English language skills*. English language skills - GOV.UK Ethnicity facts and figures. 17. Unite For Sight (2012) *Module 7: Cultural Perspectives on Mental Health*. https://www.uniteforsight.org/mental-health/module7 . 18. SAGE (2020) *Housing, household transmission and ethnicity*. S0923_housing_household_transmission_and_ethnicity.pdf 19. Office for National Statistics (2019) *Internet use*. Internet use - GOV.UK Ethnicity facts and figures. 20. Halbert, C.H., Armstrong, K., Gandy, O.H. and Shaker, L. (2006) 'Racial differences in trust in health care providers', *Archives of Internal Medicine*, 166(8), pp. 896–901. doi: 10.1001/ARCHINTE.166.8.896. 21. Department for Transport (2020) *Travel by distance, trips, type of transport and purpose*. Travel by distance, trips, type of transport and purpose - GOV.UK Ethnicity facts and figures 22. Turner, A. et al. (2022) 'Unintended consequences of online consultations: a qualitative study in UK primary care', *British Journal of General Practice*, 72(715), pp. e128–e137. doi: 10.3399/BJGP.2021.0426. 23. Office for National Statistics (2020) *Internet users, UK: 2020*. https://www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/bulletins/internetusers/2020 24. The Health Foundation (n.d.) *Exploring public attitudes towards the use of digital health technologies and data*. https://www.health.org.uk/publications/long-reads/exploring-public-attitudes-towards-the-use-of-digital-health-technologies 25. LaFrance, M. and Vial, A.C. (2015) 'Gender and nonverbal behavior', in *APA Handbook of Nonverbal Communication*, pp. 139–161. doi: 10.1037/14669-006.	

Evidence Type	Key sources of available evidence	Date of evidence (Year)
	26. Office for National Statistics (2020) *Domestic abuse in England and Wales overview: November 2020*. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2020 . 27. NHS England (n.d.) *LGBT+ health*. NHS England » LGBT+ health 28. Healthwatch in Sussex & Sussex NHS Commissioners (2020) *Preferences towards the future of health and social care services in Sussex – findings during the Coronavirus pandemic*. https://www.healthwatchwestsussex.co.uk/report/2020-10-02/preferences-towards-future-health-and-social-care-services-sussex-findings-during 29. Anderson, K. and Swanton, P. (2019) *Digital Resilience, Inclusion & Wellbeing For Looked After Children & Young People*. https://d1ssu070pg2v9i.cloudfront.net/pex/carnegie_uk_trust/2019/10/16155840/Glasgow-Digital-Resilience-Report-Final-Download.pdf . 30. NICE (2021) *Looked-after children and young people*. https://www.nice.org.uk/guidance/ng205 . 31. Heaslip, V., Green, S., Simkhada, B., Dogan, H. and Richer, S. (2021) 'How do people who are homeless find out about local health and social care services: a mixed method study', *International Journal of Environmental Research and Public Health*, 19(1), p.46. doi: 10.3390/ijerph19010046. 32. Nuffield Trust. (2020) *Locked out? Prisoners' use of hospital care*. Locked out? Prisoners' use of hospital care 33. Making Every Adult Matter Coalition (2022) *Multiple disadvantage and co-occurring substance use and mental health conditions*. London: Making Every Adult Matter. https://meam.org.uk/publications/page/2/ . 34. Harris, M. (2020) 'Normalised pain and severe health care delay among people who inject drugs in London: Adapting cultural safety principles to promote care', *Social Science & Medicine*, 260, p. 113183. 35. Department for Digital, Culture, Media & Sport (2020) *Internet - Taking Part Survey 2019/20*. https://www.gov.uk/government/publications/taking-part-201920-internet/internet-taking-part-survey-201920	

Evidence Type	Key sources of available evidence	Date of evidence (Year)
	36. NHS England (2025) *Tackling digital exclusion and health literacy: How libraries can help bridge the gap*. NHS England » Tackling digital exclusion and health literacy: How libraries can help bridge the gap 37. NHS England (2019) *Digital inclusion for health and social care*. Digital inclusion for health and social care - NHS England Digital 38. Local Government Association (2017) *Health and wellbeing in rural areas*. Health and wellbeing in rural areas | Local Government Association 39. Good Things Foundation (2025) *Beliefs and trust barriers to engaging with digital health services: a literature review.* Beliefs and trust barriers to engaging with digital health services: a literature review | Good Things Foundation 40. J. Scadding and S. Sweeney, "Friends Families and Travellers: Report on Digital Inclusion in Gypsy and Traveller Communities Digital Exclusion in Gypsy and Traveller communities in the United Kingdom," 2018, Accessed: Jul. 12, 2022. [Online]. Available: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/datasets/2011censusanal 41. Renecassin, "Factsheet: Gypsies, Travellers and Roma in the UK and Europe." https://www.renecassin.org/wpcontent/uploads/2015/04/Gypsy-Roma-and-Traveller-Factsheet.pdf (accessed Jul. 13, 2022). J. Atterbury, "Fair Access for all?," 2010 42. Understanding accessibility requirements for public sector bodies - GOV.UK	
Other published written consultation, engagement or other involvem		

Evidence Type	Key sources of available evidence	Date of evidence (Year)
ent findings [7]		
Research	User research professional within the NHS Online Technology workstram are conducting ongoing user research with both patients and professional users. So far, 38 patients have participated in interviews and co-design workshops, delivered remotely and in person, representing diverse geographies, ages, genders, ethnicities, and socioeconomic backgrounds, and covering all four priority pathways. Activities include workshops with Muslim women on menopause and endometriosis and pop-up research with older adults in deprived areas. Additionally, 17 remote sessions have been conducted with GPs, practice staff, and secondary care clinicians across multiple specialties, experience levels, and locations.	2025
Expert knowledge: For example, expertise within the team or expertise drawn on external to your team	In addition to the engagements listed above; • **Reviewed by colleagues in NHSE National Health and Justice Integrated Adults team -** Document was shared with these colleagues to review the section covering People involved in the criminal justice system: offenders in prison/on probation, ex-offenders. Comments were reflected in the document. • **Reviewed by Associate Medical Director for System Improvement and Professional Standards, Medical Directorate, NHS England South East Region -** Document was shared with this clinical colleague for comment, specifically around the secure and detained estate section, however the document was reviewed in full, with suggestions amended in the document. • **Shared for comment with the Communications and Engagement and Clinical Pathways Steering Group members, including NHS Healthcare Inequalities Improvement Programme comms lead –** Helpful resources and reading, such as the most recent Good Things Foundation report where shared, and learning from these have been subsequentially fed into this document and design of NHS Online.	
Other (if any)		

[7] Other published information means relevant authoritative published reports or information on which you have been able to draw,

8. Were there any important gaps in the identified evidence, in relation to equalities and /or health inequalities, and are there any steps that may reasonably be taken to address these gaps?

As the first service of its kind in England, NHS Online will require ongoing evidence collection as it is implemented. This will be achieved through the design of robust evaluations assessing its impact, including effects on health inequalities, alongside a continuous feedback loop embedded within NHS Online to support ongoing improvement.

9. Is your assessment that your policy will support compliance with the Public Sector Equality Duty? Please add an 'x' to the relevant box below and include an explanation of your assessment. You might find the guidance helpful when answering this question.

	The policy will support	**The policy may support**	**Uncertain if the policy will support**	**The policy will not support**
Tackling discrimination, harassment and victimisation		x		
Advancing equality of opportunity	x			
Fostering good relations	x			

Assessment

- **Tackling Discrimination**: *May support*
  The proposal includes mitigations and training to reduce bias, but risks remain for digitally excluded and vulnerable groups.
- **Advancing Equality of Opportunity**: *Will support*
  NHS Online will support equal access to care. The service will deliver reduced waiting times for patients (first appointments) through the creation of additional capacity. Waiting times vary regionally and reductions will improve clinical outcomes for patients. Some activity delivered by NHS Online will be non-RTT, this will release capacity in other trusts to deliver additional RTT activity and further reduce waiting times. NHS Online will also improve access for many underserved populations such as groups facing mobility issues, geographic isolation and language needs through virtual care, inclusive design, and flexible pathways.
- **Fostering Good Relations**: *Will support*
  The proposal promotes patient choice, transparency, inclusive communication, and engagement with diverse communities to build trust.

10. How confident are you that the actions outlined above will support reducing health inequalities? Please add an 'x' to the relevant box below and include any explanation of your assessment. You might find the guidance helpful when answering this question.

	Very confident	Somewhat confident	Not very confident	Not at all confident
Reducing inequalities people face in access to health care	x			
Reducing inequalities in health outcomes for patients	x			
Reducing inequalities in the effectiveness of services and the health outcomes achieved for patients	x			
Reducing inequalities in the safety of the services and health outcomes achieved for patients	x			
Reducing inequalities in the quality of the experience undergone by patients and the health outcomes achieved for patients.	x			

Assessment

- **Reducing inequalities people face in access to health care** – *Confident*

NHS Online will improve access for patients with physical access issues created by geographical restraints, mobility issues, cost related barriers and more. NHS Online will free up clinical capacity in physical providers for the pathways covered, meaning those not able to, or choosing not to, access care through NHS Online will still benefit from increased access to services.

- **Reducing inequalities in health outcomes for patients** – *Confident*

NHS Online has the potential to reduce inequalities in health outcomes by widening access to a national pool of consultants. This enables patients who may lack local access to specialist services to receive timely expert care regardless of geographic location. Furthermore, the use of standardised clinical pathways can reduce unwarranted variation in care delivery, thereby improving consistency in treatment and lowering the risk of unequal outcomes.

- **Reducing inequalities in the effectiveness of services and the health outcomes achieved for patients** – *Confident*

The proposal enables more timely care, better alignment of clinical capacity with demand, and will create standardised pathways to increase consistency in the care received by patients in the same pathways.

- **Reducing inequalities in the safety of the services and health outcomes achieved for patients** – *Confident*

Safety is enhanced through standardised pathways, training for clinicians, and mechanisms to monitor and improve service delivery for diverse patient groups.

- **Reducing inequalities in the quality of the experience undergone by patients and the health outcomes achieved for patients** – *Confident*

NHS Online incorporates feedback loops, accessible formats, and patient choice, aiming to improve experience and outcomes across all demographics. As NHS Online will increase clinical capacity in physical providers in the pathways covered, it will also increase the quality of experience for patients in physical providers as they should be able to be seen faster.

11. Summary assessment of this EHIA's findings

Please summarise whether the findings are that this policy will or will not contribute to eliminating prohibited conduct (including discrimination, harassment, and victimisation), advancing equality of opportunity, fostering good relations, and/or reducing health inequalities. If no impact is identified, please summarise why below.

The findings from the Equality and Health Inequalities Impact Assessment (EHIA) indicate that the NHS Online proposal will make a positive contribution to both:

- Advancing equality of opportunity, and
- Reducing health inequalities

The proposal is designed to improve access to elective care through virtual services, which can particularly benefit groups facing barriers such as geographic location or isolation, mobility challenges, low income, and language limitations. It incorporates inclusive design standards, patient choice, and support mechanisms to mitigate risks of digital exclusion and ensure equitable service delivery.
While some risks remain, especially for digitally excluded or vulnerable populations, the proposal includes clear mitigations and continuous feedback mechanisms to address these. Therefore, the overall impact is expected to be positive and supportive of NHS England's equality and health inequality objectives.

THESE DETAILS ARE FOR INTERNAL USE ONLY

A. Contact details re this EHIA

Lead Officer name and email:	Jonathan Brown, [redacted]
Team/Unit name:	Programme Director for NHS Online Programme
Division name:	Deputy Chief Executive Office (DCEO)
Directorate name:	Delivery and Private Office

B. Contact with the Equalities and Involvement Team

If the policy is complex, high profile and/or sensitive, you are advised to liaise with the Equalities and Involvement Team (E&I).

Policy	Complex policy	High profile policy	Sensitive policy
No			

If yes above	Date	Any comments
Contact with E&I Team first requested	16 January 2026	There is not a new policy for NHS Online at this stage, however the establishment of a new NHS Trust to deliver NHS Online is a strategic policy direction. Slides regarding the programme were shared with the Equalities team at the time of sharing the EHIA.
Date advice provided by E&I Team	20 January 2026	Useful comments regarding considerations for mitigations that have been incorporated into Version 0.7.
Date confirmed by E&I that proper and proportionate consideration appears to have been given to equalities and health inequalities.	23 January 2026	Kevin Holton, Joint Deputy Director E&I Team confirmed that the EHIA could progress through Programme governance processes and to SRO as part of the decision-making process.
Engagement with the NHS Online team to input into the EHIA refresh	13 May 2026	As NHS Online approaches its establishment as a Trust on 1 June, a review and refresh of the programme EHIA is now commencing to ensure it remains current, robust, and reflective of the latest position. Content updated with the latest work of the Programme team.
Engagement with the E&I Team on the EHIA refresh	19 May 2026	As NHS Online approaches its establishment as a Trust on 1 June, a refreshed version of the programme EHIA shared for comments and input from E&I Team. Comments acknowledged, addressed and/or incorporated where relevant.

C. Responsibility for EHIA and decision-making

Responsible officer name and post title:	David Probert, Deputy Chief Executive, NHS England	
Responsible officer e-mail address:	[redacted]	
Director/Deputy Director Name:	Full post title: Jonathan Brown, Programme Director for NHS Online Programme	E-mail address: [redacted]

D. Considered by NHS England, Board or Committee[8]

Name of the Panel, Board or Committee:	NHS Online Programme Board	Date of meeting: 2 October 2025 and 28 January 2026 (over email)
Brief overview of decision made in response to the EHIA process outcomes: What has the Panel, Board or Committee done to take account of the PSED and to have regard to reducing health inequalities in its decision-making?		
Programme Board approved original draft at meeting of 2 October 2025. Further work and development taken place over the ensuing 3.5 months, leading to circulation of updated Version 0.7, approved by Programme Board over email 28 January 2026 (following input and sign off from NHSE Equalities team). Programme Board provided comments that have been incorporated into Version 0.7 and content that considerations and mitigations are within Programme delivery plans to address through design and delivery of service and delivery model.		

E. Key dates

Date signed off by Senior Responsible Officer (SRO):[9]	2 October 2025 and 29 January 2026
Date signed off by Panel, Board or Committee:	2 October 2025 and 28 January 2026

[8] Only complete if the **policy** is to be considered by a Panel, Board or Committee. If it will not be considered by a Panel, Board or Committee please respond N/A.
[9] The Senior Manager or Director responsible for signing off the policy is also responsible for signing off the EHIA.

Date EHIA published (if appropriate):	Expectation is that EHIA will be published by DHSC on or after establishment of new NHS Online Trust (expected 1 June 2026).
EHIA review date[10]:	1 June 2026 – proportionate rapid review to ensure latest work reflected ahead of Trust establishment 30 November 2026 – schedule full review to be completed within 6 months

[10] This will normally be the review date for the policy unless a decision has been made to have an earlier review date.

Online NHS Trust Board

Provider licence conditions

Date of meeting	1 June 2026
Paper reference	F
Author	Katy Cox, Organisational Build Workstream Lead
To be presented by	Katy Cox, Organisational Build Workstream Lead
Summary	This paper sets out the provider licence conditions that the Trust will not be compliant with on establishment and the timescales by which it expects to be compliant.
Recommendations	The Board is asked to note the provider licence conditions the Trust is not currently compliant with and the timescales for achieving compliance and approve the letter to NHSE setting this out.

1. Executive Summary

1.1. NHS trusts are required to hold an NHS provider licence (issued by NHS England). The Online NHS Trust will not comply with three of the provider licence conditions on establishment (1 June 2026) due to the early stage of its development and the fact that it will not be providing any clinical services.

1.2. NHS England has requested that the Trust write and confirm the conditions which it will not be compliant with on establishment and set out the timescales by which it expects to be compliant.

2. Background

2.1. Section 81 of the Health and Social Care Act 2012 requires that any organisation providing health care services for the NHS, including NHS trusts, must hold an NHS provider licence. Ordinarily, applicants must apply to NHS England (NHSE) for a licence and, if they meet the published licensing criteria (which includes the requirement to be CQC registered if carrying out regulated activities) NHSE must grant the application and issue a licence.

2.2. However, if the applicant is an NHS trust, the process is different. The legislation operates so that NHS trusts, on establishment, are deemed to have applied for and to

have met the criteria to be issued with a licence. In practice, this means that when a new NHS trust is established, it does not need to apply for a licence, or to be registered with CQC. NHSE must grant the application and issue the licence following establishment, regardless of whether the NHS trust is providing health care services or not.

2.3. NHSE has requested that the Trust write and confirm the conditions which it will not be compliant with on establishment and set out the timescales by which it expects to be compliant.

3. Provider licence conditions

3.1. The provider licence conditions are set out at https://www.england.nhs.uk/publication/nhs-provider-licence-standard-conditions/.

3.2. A number of conditions are not applicable to the Trust at this time. For example, "**G6: registration with the Care Quality Commission** 1. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able to lawfully provide health care services for the purposes of the NHS" does not currently apply as the Trust is not providing health care services for the purposes of the NHS (and the Trust intends to seek registration with the CQC from February 2027 so will comply with this condition from the point it is providing health care services for the purposes of the NHS). Similarly "**IC2: Personalised Care and Patient Choice** 4. Information and advice about patient choice of provider made available by the Licensee shall not be misleading" does not currently apply as the Trust is not making available any information or advice about patient choice of provider. However, the Trust will ensure it complies with this condition when it is treating patients and making such information and advice available.

3.3. Three conditions have been identified which the Trust will not comply with on 1 June:

- **WS3: Digital Transformation** 2 requires the Licensee to comply with information standards published under section 250 of the 2012 Act and required levels of digital maturity as set out in guidance published by NHS England from time to time where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2). The Trust's digital infrastructure is in development but services are being designed with these information standards in mind and the digital maturity assessment is being tracked to ensure full compliance at the launch of clinical services (Q3 2027/28 based on the current programme plan).
- **G7: Patient eligibility and selection criteria** 1 requires the Licensee to set transparent eligibility and selection criteria, apply those criteria in a transparent

way and publish those criteria. The Trust is developing an access policy which will include patient eligibility and selection criteria and will be published on the Trust's website. The policy will be approved by the point of CQC registration (1 February 2027 based on the current programme plan).

- **NHS2: Governance arrangements**
    - 3c requires the Licensee to have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity. As detailed above, the Trust's digital infrastructure is in development but digital maturity requirements are a key part of the design and the Trust will be fully compliant with this condition at the launch of clinical services (Q3 2027/28 based on the current programme plan).
    - 6e requires that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources. The Trust has commenced and intends to continue engaging with patients, staff and other relevant stakeholders as part of the design and services and this will include engagement on quality of care as development progresses. The Trust anticipates fully complying with this condition following the launch of clinical services (Q3 2027/28 based on the current programme plan).
    - 6f requires that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. Following establishment the Trust will evolve its governance to ensure clear accountability for quality of care by the point of CQC registration (1 February 2027 based on the current programme plan).

3.4. The draft letter to NHSE is included in the appendix. **The Board is asked to note the provider licence conditions the Trust is not currently compliant with and the timescales for achieving compliance and approve the letter to NHSE setting this out.**

4. Next steps

4.1. NHS England proposes to take the Online NHS Trust provider licence to its Executive Committee for approval.

4.2. The London Region will provide regulatory oversight ensuring that the Trust is fully compliant with licence conditions prior to providing clinical services.

Appendix: Letter to NHS England

Sir James Mackey
Chief Executive
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

Wellington House
133-155 Waterloo Road
London
SE1 8UG

cc Caroline Clarke, London Regional Director
Miranda Carter, Director of System Architecture

Dear Sir Jim

Online NHS Trust – provider licence

As an NHS trust, we understand that the Online NHS Trust must hold a provider licence. However, as the Trust is not operational and is not yet providing healthcare services there are three licence conditions which the Trust is not currently compliant with:

- **WS3: Digital Transformation** 2 requires the Licensee to comply with information standards published under section 250 of the 2012 Act and required levels of digital maturity as set out in guidance published by NHS England from time to time where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2). The Trust's digital infrastructure is in development but services are being designed with these information standards in mind and the digital maturity assessment is being tracked to ensure full compliance at the launch of clinical services (Q3 2027/28 based on the current programme plan).
- **G7: Patient eligibility and selection criteria** 1 requires the Licensee to set transparent eligibility and selection criteria, apply those criteria in a transparent way and publish those criteria. The Trust is developing an access policy which will include patient eligibility and selection criteria and will be published on the Trust's website. The policy will be approved by the point of CQC registration (1 February 2027 based on the current programme plan).
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- 3c requires the Licensee to have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity. As detailed above, the Trust's digital infrastructure is in development but digital maturity requirements are a key part of the design and the Trust will be fully compliant with this condition at the launch of clinical services (Q3 2027/28 based on the current programme plan).
- 6e requires that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources. The Trust has commenced and intends to continue engaging with patients, staff and other relevant stakeholders as part of the design and services and this will include engagement on quality of care as development progresses. The Trust anticipates fully complying with this condition following the launch of clinical services (Q3 2027/28 based on the current programme plan).
- 6f requires that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. Following establishment the Trust will evolve its governance to ensure clear accountability for quality of care by the point of CQC registration (1 February 2027 based on the current programme plan).

In support of our application for a provider licence, please find attached the Trust's Establishment Order. I can also confirm that fit and proper person checks have been completed for all Board members.

We look forward to working with Caroline and her team to demonstrate compliance with these conditions at the appropriate time. If there is any further information you need in the meantime please do not hesitate to contact me.

Yours sincerely

John Browett

Chair, Online NHS Trust

Attached: Online NHS Trust establishment order

Online NHS Trust Board

Transition to new Trust

Date of meeting	1 June 2026
Paper reference	G
Author	Katy Cox, Organisational Build Workstream Lead
To be presented by	Katy Cox, Organisational Build Workstream Lead
Summary	In preparation for the establishment of the Online NHS Trust on 1 June 2026, work has been undertaken to transition the programme from NHS England to the new Trust. This work has included: establishing Trust governance, seconding staff from NHS England to the Trust, novating contracts, establishing enabling functions, securing indemnity cover and developing a website, intranet and communications plans.
Recommendation	The Board is asked to note the work that has been undertaken to transition the programme from NHS England to the new Trust.

1. Executive Summary

1.1. In preparation for the establishment of the Online NHS Trust on 1 June 2026, work has been undertaken to transition the programme from NHS England to the new Trust. This work has included: establishing Trust governance, seconding staff from NHS England to the Trust, novating contracts, establishing enabling functions, securing indemnity cover and developing a website, intranet and communications plans.

1.2. The Board is asked to note the work that has been undertaken to transition the programme from NHS England to the new Trust.

2. Background

2.1. The Online NHS Trust will be established on 1 June 2026. The Trust will initially be established with limited functions[1] and will become operational on 1 February 2027.

2.2. This paper sets out the steps that are being taken to transition from a programme within NHS England to the new Trust to ensure continuity of programme delivery and maintain progress against the committed timeline of launching clinical services in Q3 2027/28.

2.3. The programme team has identified the essential requirements to support safe and legal establishment and has been tracking progress through weekly meetings which will continue until early June.

3. Trust governance

3.1. Governance has been established for the 1 June as follows:

- **Recruitment and induction of Chair and Non-Executive Directors (NEDs)** - NHS England has appointed (with effect from 1 June 2026) the Chair and six NEDs. Induction programmes have been developed. A paper regarding appointment of an Associate NED and recruitment of executive directors will be considered at the Nominations and Remuneration Committee meeting on 1 June;
- **Governance structures** – at its meeting on 1 June, the Trust Board will be asked to approve responsibilities of the Chair, SID, Board and Committees and these will be publicly available (on the Trust's website). The Board will also be asked to approve Terms of Reference for the Audit and Risk Committee and Nominations and Remuneration Committee (see agenda item 2 which sets out governance structures from 1 June 2026);
- **Policies** – policies required for establishment of the new Trust have been drafted for approval by the Board (see agenda item 2 which includes further detail on the approach to policy development). A business continuity plan for the new Trust has been developed for approval by the Board (see agenda item 3); and
- **Risk register** – the latest risk register will be reported to the Board at its first meeting on 1 June (see agenda item 9). Once the strategic objectives for the Trust

[1] The functions of the Trust between the establishment date and the operational date (as set out in the establishment order) are:
(a) entering into NHS contracts;
(b) entering into other contracts including contracts of employment;
(c) preparing to register with the Care Quality Commission; and
(d) doing such things as are reasonably necessary to enable it to begin to operate satisfactorily with effect from the operational date.

have been agreed, a Board Assurance Framework (detailing risks to achieving the strategic objectives) will be developed.

4. Transferring programme resources – NHS England staff

4.1. In March 2026 the programme received internal (NHSE) legal advice that Transfer of Undertakings (Protection of Employment)[2] was unlikely to apply to the NHS England staff supporting the programme at the point of Trust establishment (1 June 2026), but it might apply at a later date, depending on any proposals the new NHS Trust might have for the programme work.

4.2. Secondment agreements have therefore been developed for the small number (8) of NHS England staff in the Deputy Chief Executive Office (DCEO) directorate that are supporting the programme and these agreements are expected to be signed on 1 June 2026.

4.3. Following the conclusion of an internal recruitment process at the end of May, a further 7 NHS England staff are expected to be seconded to the Trust over the next three months (exact dates will be subject to notice periods agreed with individuals' line managers).

4.4. The programme is also supported by 2 staff through informal 'loan' arrangements.

5. Novation of contracts

5.1. Contracts entered into by NHS England with third parties to develop NHS Online that are ongoing on 1 June 2026 will be novated (transferred) to the Trust. The novation will not happen automatically or under a statutory scheme; a contractual process is required, the details of which depend on the terms of each contract. NHS England's solicitors are reviewing the relevant contracts to put the necessary arrangements in place.

5.2. Four contracts will novate from NHS England to the Trust on 1 June 2026. In addition, an access agreement will allow the Trust to continue to access the current Statement of Works (running to end of July 2026) with the technology delivery partner (the contract held by NHSE cannot be novated as it is a broader contract including other, non-NHS Online SoWs.

[2] Deriving from UK Regulations, TUPE operates in certain circumstances where there is a transfer of a business entity or a set of services from one organisation to another. Where TUPE applies the employment of those employees engaged in the transferring entity or services is maintained, such that they transfer to the new organisation.

5.3. Contracts that will conclude by 31 May 2026 do not need to be novated to the Online NHS Trust. Contracts that will commence on or after 1 June 2026 will be entered into directly by the Trust.

[redacted]

7. Enabling functions

[redacted]

- [redacted]

[redacted]

8. Indemnity cover

8.1. NHS Resolution will provide Liabilities to Third Parties Scheme (LTPS)[3] cover to the Trust from 1 June 2026. The Trust will seek Clinical Negligence Scheme for Trusts (CNST) cover[4] from the point it commences testing with real patient data and is registered with the CQC (1 February 2027 based on current programme plan). Although membership of the scheme is voluntary, all NHS Trusts (including Foundation Trusts) in England currently belong to the scheme.

9. Communications

9.1. A website (onlinetrust.nhs.uk – please note this link won't work until 1 June) has been developed to meet statutory duties regarding transparency, regulatory requirements and national NHS digital guidelines. The website has been

[3] LTPS typically covers employers' and public liability claims from NHS staff, patients and members of the public. LTPS covers claims arising from breaches of the Human Rights Act, the Data Protection Act and the Defective Premises Act, as well as defamation, unlawful detention and professional negligence claims. LTPS also extends to cover the personal liabilities of the members of NHS boards, including non-executive directors. Personal injury cover is unlimited in value and there is no limit on the number of claims members may make in any membership year.

[4] CNST handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later).

developed in accordance with NHS identity guidelines and government digital standards and provides essential information and policies for public and stakeholders. There are plans to expand website functionality based on user research in the lead up to launch of clinical services in Q3 2027/28.

9.2. A staff intranet has been developed to ensure everyone working on the programme can access key corporate documents including final versions of trust policies, as well as being an internal communications channel. The intranet has initially been set up as a new Microsoft Teams channel and SharePoint hub. A specification for a wider staff intranet for use by all Trust staff (including the clinical workforce) will be developed ahead of launch of clinical services.

9.3. An internal comms plan for 1 June has been developed and is being implemented, including distribution of a staff induction pack and a team workshop on 2 June. An external comms plan for Trust launch and announcement of the Chair and NEDs has been developed, working closely with DHSC and No 10. Announcement of the new Trust and Chair and NED appointments is expected on 1 June.

9.4. The new Trust logo has been developed (in line with NHS Identity Guidelines) and branding guidance has been developed (and will be available on the intranet) for the new Trust to use from 1 June. Further work will be undertaken on branding once the executive team has been recruited.

10. Recommendation

10.1. The Board is asked to note the work that has been undertaken to transition the programme from NHS England to the new Trust.

Online NHS Trust Board

Risk register

Date of meeting	1 June 2026
Paper reference	H
Author	Adrian Matthews
To be presented by	Anita Davidson
Summary	This paper summarises the current NHS Online Programme risk position, highlighting the highest scoring risks for Board oversight and the overall risk profile, alongside actions to manage and mitigate risk.
Recommendations	The Board is asked to: • Note the current highest scoring risks and the overall programme risk position • Review progress on mitigations and risk management actions • Provide strategic direction and support where required to reduce overall risk exposure

1. Executive summary

1.1. This paper provides an update on the current risk position across the NHS Online Programme. Five risks are currently rated at 16 and above and have been escalated for Board visibility, including two risks scoring 20 (very high) and three risks scoring 16 (high). These risks represent the most significant potential impacts to delivery at this stage of the programme and are outlined at Section 2.

1.2. Alongside these, the programme continues to manage a broader risk register covering all delivery areas. The overall distribution of risks demonstrates a balanced and actively managed position, with the majority of risks sitting below the escalation threshold and being managed through programme governance, delivery teams, and Senior Leadership Team oversight. These risks are summarised at Section 3.

2. Key risks overview

2.1 The below table outlines the current top scoring risks for NHS Online held in the central risk register. These risks represent the highest areas of exposure and require Board-level visibility and oversight. The risk scoring matrix is shown at Annex A.

Risk ID	Title	Description	Likelihood	Impact	Trend	Latest update / mitigations	Risk score
NHSO-R-111	Procurement delays due to funding and business case approval uncertainty	Ongoing procurements of delivery partner arrangements are dependent on timely availability of funds and external (NHSE/DHSC/HMT) approvals of business cases where each stage has uncertain lead times	4	5	→	[redacted]	20
NHSO-R-112	Uncertainty in technical complexity impacting delivery	Costs, timelines, and scope may be impacted due to evolving technical complexity and unclear requirements, resulting in delivery uncertainty	5	4	→	[redacted]	20
NHSO-R-110	Low uptake and adoption of NHS Online service	Service uptake may be low due to limited referrer / patient / clinician awareness of NHSO resulting in delayed benefits realisation and potential financial pressures	4	4	→	[redacted]	16
NHSO-R-109	Failure to secure commissioner contracts to deliver NHS Online services	Commissioners may not contract NHSO services due to uncertainty around the service offer, capacity, quality, and start date for accepting referrals, delaying benefits realisation and creating financial pressures	4	4	↓	[redacted]	16
NHSO-R-001	External technical dependencies (NHSE platforms) not onboarded when needed	Programme delivery may slow due to reliance on NHSE platforms that require significant onboarding time, are dependent on NHSE prioritisation and may be impacted by organisational change.	4	4	↓	[redacted]	16

3. Programme risk profile overview

3.1 The below table sets out the overall Programme risk profile. The colour coding shows the RAG for that range according to the Programme risk scoring matrix.

3.2 This profile shows that while a small number of risks require escalation, a significant volume of lower-scoring risk is actively managed to prevent escalation and protect delivery.

3.3 Progress has been made in mitigation planning across the programme, including strengthened delivery planning, procurement acceleration, improved alignment with national partners, and greater clarity on technical delivery and dependencies.

Risk score range	Number of risks
≤5	13
6–10	37
11–15	37
≥16 (Board level)	5

4. Approach to risk management, scoring and external alignment

4.1 Risk is managed actively and tracked in a central Smartsheet system, supported by PMO and delivery-led reviews and clear mitigation ownership. Risks are aligned to programme plans and managed collaboratively across delivery teams.

4.2 Risk scores in this report reflect the programme's assessment of delivery risk. Engagement with DHSC and national partners continues, recognising that external scoring may differ due to a broader portfolio perspective. Any differences reflect scope rather than disagreement and are communicated transparently.

5. Recommendations and next steps

5.1 The Board is asked to:

- Note the current high-scoring risks and overall risk profile
- Provide strategic direction and support where required to reduce overall risk exposure

Annex A – NHS Online Risk scoring matrix

Risk scoring matrix - to determine the overall score of the risk:

Likelihood	Impact				
	1 - Very Low	2 - Low	3 - Moderate	4 - High	5 - Very High
5 - Very Likely	5	10	15	20	25
4 - Likely	4	8	12	16	20
3 - Possible	3	6	9	12	15
2 - Unlikely	2	4	6	8	10
1 - Rare	1	2	3	4	5

	Low Risk (1-6)
	Moderate Risk (8-10)
	High Risk (12-16)
	Extreme Risk (20-25)

Likelihood descriptors - to determine how likely or probable it is that the risk will occur:

Probability score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
% Probability	< 20%	20% - 39%	40% - 59%	60% - 79%	> 80%
Frequency/how likely to happen	This probably will never happen/recur	Do not expect it to happen/recur, but it is possible	Will probably happen/recur, but is not a persisting issue or circumstance	Very likely to happen/recur; possibly frequently	Extremely likely to happen/recur on a very regular basis

Impact descriptors - to determine the Risk Category (A-I) and score the potential impact/consequence of the risk occurring:

1- very low - 5. very high

Impact	1. Very Low	2. Low	3. Moderate	4. High	5. Very high
A. Injury	Minor injury not requiring first aid.	Minor injury or illness, first aid treatment needed.	RIDDOR / Agency reportable.	Major injuries or long-term incapacity / disability.	Death or major permanent incapacity
B. Patient experience	Unsatisfactory patient experience not directly related to patient care.	Unsatisfactory patient experience — readily resolvable.	Mismanagement of patient care.	Serious mismanagement of patient care.	Totally unsatisfactory patient outcome or experience
C. Customer experience	Negligible impact on the quality of services delivered to the customer.	Minor impact on the quality of services delivered to the customer.	Considerable impact on the quality of the services delivered to the customer, leading to request for work to be redone.	Major impact on the quality of the services delivered to the customer resulting in a complaint from the customer	Severe impact on the quality of the services delivered to the customer resulting in customer seeking compensation and/or cancelling contract
D. Service / organisational design and future operations	Negligible impact on viable service delivery organisation and/or Loss / interruption>1 hour.	Minor impact on viable service delivery organisation and/or Loss / interruption>8 hours.	Major impact on viable service delivery organisation and/or Loss / interruption>1 day.	Significant impact on viable service delivery organisation and/or Loss / interruption>1 week	Halting impact on viable service delivery organisation and/or Prolonged loss of service or facility
E. Staffing and skill mix	Short term low staffing level temporarily reducing service quality / deliverability	Ongoing low staffing level reducing service quality / deliverability.	Late delivery of key objective / service due to lack of staff. Ongoing unsafe staffing.	Uncertain delivery of key objective / service due to lack of staff.	Non-delivery of key objective / service due to lack of staff.
F. Financial / asset	Impact up to £0.1m p/a	Impact up to £0.5m p/a	Impact up to £1m p/a	Impact up to £2m p/a	Impact over £2m p/a
G. Inspection / audit	Minor recommendations. Minor non-compliance with standards and/or policies.	Recommendations given. Non-compliance with standards and/or policies.	Reduced rating. Challenging recommendations. Non-compliance with core standards and/or policies.	Enforcement action. Critical report and Low rating. Major non-compliance with core standards and/or policies.	Prosecution. Zero rating. Severely critical report
H. Adverse publicity / reputation	Rumours.	Short term damage with stakeholders. Minor effect on staff morale.	Longer term damage with individual stakeholders. Significant effect on staff morale.	Widespread stakeholder damage. Local media > 3 days	Sustained and widespread stakeholder damage. National media > 3 days
I. Data Security and Protection	There is absolute certainty that no adverse effect can arise from the breach	A minor adverse effect must be selected where there is no absolute certainty. A minor adverse effect may be: The cancellation of a procedure but does not involve any additional suffering. Disruption to those who need the data to do their job.	An adverse effect may be: Release of confidential information into the public domain leading to embarrassment. Unavailability of information leading to the cancellation of a procedure that has the potential of prolonging suffering but does not lead to a decline in health. Prevention of someone doing their job such as cancelling a procedure that has the potential of prolonging suffering but does not lead to a decline in health.	Potential pain and suffering / financial loss: Reported suffering and decline in health arising from the breach. Some financial detriment occurred. Loss of bank details leading to loss of funds. Loss of employment	Death / catastrophic event. A person dies or suffers a catastrophic occurrence
J. Technology design and implementation	Negligible workarounds expected to be absorbed within development budgets without impacting delivery timelines or budget	Minor impact likely resolved at a cost of less than £50,000 or causing a delay of less than one month for one component.	Major impact to anticipated budget (more than £500,000) or overall programme timing (delay of more than 2 months)	Significant change to programme budget (more than £2m) or timeline (more than 6-month delay to the entire programme)	No foreseeable technology solution option, fundamentally changing deliverables and scope of the outcome

Online NHS Trust Board

Developing the vision, values and strategy

Date of meeting	1 June 2026
Paper reference	I
Author	Katy Cox, Organisational Build Workstream Lead
To be presented by	Katy Cox, Organisational Build Workstream Lead
Summary	This paper sets out the key strategic planning requirements of NHS Trusts and a proposed approach for the Online NHS Trust.
Recommendation	The Board is asked to agree the approach for Trust strategy development.

1. Executive Summary

1.1. Key strategic planning requirements for NHS Trusts are driven by the Code of Governance for NHS Provider Trusts, the Medium Term Planning Framework and the CQC Well-led framework and application process.

1.2. Strategic planning undertaken to date includes initial discovery work, an NHS England and AWS/Amazon Executive Visioning day and development of an initial budget and medium term financial plan for the Trust.

1.3. It is proposed to commence strategy development in September 2026 to allow Executive Directors to be involved once appointed (by end October 2026). It is intended that the Board approves the strategy in February 2027. The Board is asked to agree the approach for strategy development.

2. Key strategic planning requirements of NHS Trusts

2.1. The NHS England Code of Governance for NHS Provider Trusts ("the Code") states that "the board of directors should establish the trust's vision, values and strategy, ensuring alignment with the ICP[1]'s integrated care strategy and ensuring decision-making complies with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS

[1] Whilst Integrated Care Partnerships (ICPs) remain part of the statutory structure, policy direction has shifted strongly towards strengthening ICBs and reducing duplicated governance. Some ICPs have stopped having regular meetings and many ICB footprints have changed as a result of restructures, mergers and clustering.

resources. The board of directors must satisfy itself that the trust's vision, values and culture are aligned."

2.2. The Codes also states that "the board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality". In practice most Trusts satisfy this requirement through publication of a Quality Strategy. All Trusts must publish annual Quality Accounts describing quality improvement priorities and performance and these are generally aligned to a multi-year Quality Strategy.

2.3. The Medium Term Planning Framework was published by NHS England in October 2025 and required Trusts to develop five year strategic plans supported by three year numerical returns (2026/27-2028/29).

2.4. Under the CQC Well-led framework, trusts are assessed on whether they have "an aspirational vision and a statement of values, with a realistic strategy and robust plan for delivery with clear objectives and timescales…produced together with people who use the trust's services, staff and system partners." The CQC application form requires the Trust to set out a 'statement of purpose' including the Trust's aims and objectives. Discussions with the CQC have confirmed that the statement of purpose should reflect the services the Trust will provide at the point of registration and that this can evolve over time as the Trust's strategy develops. The Trust intends to apply to the CQC at the end of November 2026 for registration in February 2027.

2.5. Any values developed by Trusts are expected to align with the six core values defined in the NHS Constitution:

- Working together for patients
- Respect and dignity
- Compassion
- Commitment to quality of care
- Improving lives
- Everyone counts

2.6. NHS England's Green plan guidance requires Trusts to have a published, board-approved Green Plan that is aligned with the organisational strategy and updated annually. The relevant team in NHS England has confirmed that the Trust should have a proportionate green plan in place by 1 April 2027.

3. Strategic planning undertaken to date

3.1. **Discovery work** conducted between January and April 2025 set out a vision for NHS Online as "a new national NHS provider of elective virtual care adding capacity and driving efficiency in the NHS".

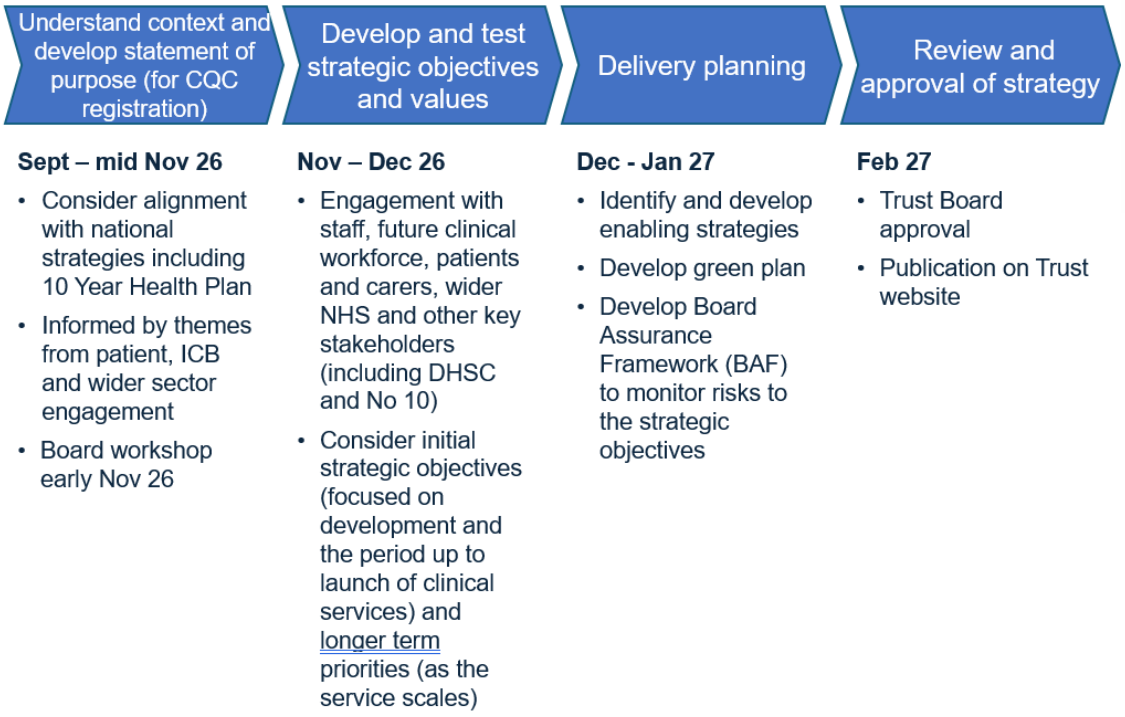
[redacted]

3.3. An **initial budget and medium term financial plan** has been developed for submission to NHS England (see agenda item [X]).

4. Proposed approach for strategy development for the Online NHS Trust

4.1. The full Board (including Executive Directors) is expected to be appointed by the end of October 2026 and it is proposed to commence strategy development shortly thereafter.

4.2. The diagram overleaf sets out the proposed approach for strategy development:



5. Recommendation(s) and next steps

5.1. The Board is asked to note and provide any comments on the proposed approach for strategy development.

5.2. The proposed approach with be shared with NHSE London Region to confirm any specific requirements or deadlines.