

Bundle Council of Governors (public) 16 December 2025

Agenda attachments

00 A – front cover public

00 B – membership

00 C – register Dec 2025

00 D – Agenda Public CoG 16 December 2025 FINAL

64.25 Welcome, apologies, declarations of interest and eligibility, confirmation of quoracy

65.25 Strategic partnership

65–25 Strategic partnership

65–25.1 Strategic partnership options appraisal V2

66.25 Any other business

67.25 To receive any questions or comments from members of the foundation trust or members of the public

Council of Governors Meeting in public

Tuesday 16 December 2025

15.00-15.45

Education Centre, QVH



Queen Victoria Hospital NHS Foundation Trust Council of Governors Membership December 2025

Members	
Jackie Smith	Trust Chair
Michele Augousti	Public governor
Chris Barham	Public governor
Colin Fry	Public governor
Antony Fulford-Smith	Public governor
Niamh Gavin	Staff governor
Richard Green	Public governor
Janet Hall	Public governor
John Harold	Public governor
Felicity Hatch	Public governor
Denise Holland	Public governor
Liz James	Public governor
Bob Lanzer	Stakeholder governor for WS County Council
Julie Mockford	Stakeholder governor for EG Town Council
David Porter	Public governor
Kokila Ramalingam	Staff governor
Charlie Robinson	Public governor
Rodabe Rudin	Public governor
Ken Sim	Public governor
Linda Skinner	Stakeholder governor for League of Friends
Roger Smith	Public governor
Jonathan Squire	Public governor
Jennifer Tite	Public governor
Graham True	Staff governor
Invited attendees	
Jagjit Dosanjh-Elton	Non-executive director
Peter O'Donnell	Non-executive director
Shaun O'Leary	Non-executive director
Jo Emmanuel	Non-executive director
Russell Hobby	Non-executive director
Aleema Shivji	Associate Non-executive director
Vivek Chaudhri	Associate Non-executive director
Abigail Jago	Acting Chief executive officer and Chief strategy officer
Leonora May	Company secretary (minutes)

Annual declarations by governors 2025/26

As established by section 22 of the Trust's Constitution, if a governor of the Trust has a relevant and material interest, or a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose the nature and extent of that interest to the members of the Council of Governors as soon as he/she becomes aware of it.

To facilitate this duty, governors are asked on appointment to the Trust and thereafter at the beginning of each financial year, to complete a form to declare any interests or to confirm that the governor has no interests to declare (a 'nil return'). Governors must request to update any declaration if circumstances change materially. By completing and signing the declaration form governors confirm their awareness of any facts or circumstances which conflict or may conflict with the interests of QVH NHS Foundation Trust. All declarations of interest and nil returns are kept on file by the Trust and recorded in the following register of interests which is maintained by the Company Secretary.

	Directorships, including non-executive directorships, held in private companies or public limited companies (with the exception of dormant companies).	Ownership, part ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or QVH.	Significant or controlling share in organisations likely or possibly seeking to do business with the NHS or QVH.	A position of authority in a charity or voluntary organisation in the field of health or social care.	Any connection with a voluntary or other organisation contracting for NHS or QVH services or commissioning NHS or QVH services.	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with QVH, including but not limited to lenders of banks.	Any "family interest": an interest of a close family member which, if it were the interest of that director, would be a personal or pecuniary interest.
Public governors							
Augousti, Michele	Director of Reach Business Consultants Ltd Non-executive director for Sussex Chamber of Commerce	NIL	NIL	NIL	NIL	NIL	NIL
Barham, Chris	Transcend Talent consultancy Limited- Non Executive Director	NIL	NIL	NIL	NIL	NIL	NIL
Fry, Colin	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Hall, Janet	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Holland, Denise	NIL	NIL	NIL	NIL	NIL	NIL	NIL
James, Liz	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Sim, Ken	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Smith, Roger	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Squire, Jonathan	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Fulford-Smith, Antony	Director of Right To Manage Company for block of flats in Maidenhead (NFP)	NIL	NIL	NIL	NIL	NIL	My wife is a bank nurse at QVH
Green, Richard	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Harold, John	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Hatch, Felicity	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Porter, David	Since 2010 I have been a director of DFP Market Services Limited, a management consultancy. The company has no connection with the NHS or QVH I am a Trustee/ director of Peredur Centre for the Arts. The Charity has no connection with the NHS or QVH	NIL	NIL	NIL	NIL	NIL	NIL
Robinson, Charlie	NIL	NIL	NIL	NIL	NIL	NIL	NIL

Rudin, Rodabe	NIL	NIL	NIL	NIL	NIL	NIL	NIL
Tite, Jennifer	NIL	NIL	NIL	NIL	NIL	NIL	NIL

Directorships, including non-executive directorships, held in private companies or public limited companies (with the exception of dormant companies).	Ownership, part ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or QVH.	Significant or controlling share in organisations likely or possibly seeking to do business with the NHS or QVH.	A position of authority in a charity or voluntary organisation in the field of health or social care.	Any connection with a voluntary or other organisation contracting for NHS or QVH services or commissioning NHS or QVH services.	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with QVH, including but not limited to lenders of banks.	Any "family interest": an interest of a close family member which, if it were the interest of that director, would be a personal or pecuniary interest.
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Staff governors

Gavin, Niamh	Member of EGAS, anaesthetists private practice	NIL	NIL	NIL	NIL	NIL	NIL
Ramalingam, Kokila	Director of ASK Residentials Ltd Director of ASKR Holdings Ltd	NIL	20% Shareholder in Raise Healthcare Pvt Ltd (QVH supplier)	NIL	NIL	NIL	NIL
True, Graham	NIL	NIL	NIL	NIL	NIL	NIL	NIL

Appointed governors

Lanzer, Bob	Director of Southeast Communities Rail Partnership CIC (Communities Interest Company)	NIL	NIL	NIL	Member of West Sussex County Council and Cabinet Member for Public Health and Wellbeing Member of the Sussex Health and Care Assembly	NIL	NIL
Skinner, Linda	LVS GR consultancy Limited- 100% ownership	NIL	NIL	NIL	NIL	NIL	NIL
Mockford, Julie	NIL	NIL	NIL	NIL	NIL	NIL	NIL

Fit and proper persons declaration

As established by regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the regulations"), QVH has a duty not to appoint a person or allow a person to continue to be a governor of the trust under given circumstances known as the "fit and proper person test". By completing and signing an annual declaration form, QVH governors confirm their awareness of any facts or circumstances which prevent them from holding office as a governors of QVH NHS Foundation Trust.

Categories of person prevented from holding office							
	The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.	The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.	The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).	The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.	The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.	The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.	The person has been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.
Public governors							
Augousti, Michele	NA	NA	NA	NA	NA	NA	NA
Barham, Chris	NA	NA	NA	NA	NA	NA	NA
Fry, Colin	NA	NA	NA	NA	NA	NA	NA
Hall, Janet	NA	NA	NA	NA	NA	NA	NA
Holland, Denise	NA	NA	NA	NA	NA	NA	NA
James, Liz	NA	NA	NA	NA	NA	NA	NA
Sim, Ken	NA	NA	NA	NA	NA	NA	NA
Smith, Roger	NA	NA	NA	NA	NA	NA	NA
Squire, Jonathan	NA	NA	NA	NA	NA	NA	NA
Fulford-Smith, Antony	NA	NA	NA	NA	NA	NA	NA
Green, Richard	NA	NA	NA	NA	NA	NA	NA
Harold, John	NA	NA	NA	NA	NA	NA	NA
Hatch, Felicity	NA	NA	NA	NA	NA	NA	NA
Porter, David	NA	NA	NA	NA	NA	NA	NA
Robinson, Charlie	NA	NA	NA	NA	NA	NA	NA
Rudin, Rodabe	NA	NA	NA	NA	NA	NA	NA
Tite, Jennifer	NA	NA	NA	NA	NA	NA	NA
Staff governors							
Gavin, Niamh	NA	NA	NA	NA	NA	NA	NA
Ramalingam, Kokila	NA	NA	NA	NA	NA	NA	NA

Categories of person prevented from holding office							
	The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.	The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.	The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).	The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.	The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.	The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.	The person has been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.
True, Graham	NA	NA	NA	NA	NA	NA	NA
Appointed governors							
Lanzer, Bob	NA	NA	NA	NA	NA	NA	NA
Skinner, Linda	NA	NA	NA	NA	NA	NA	NA
Mockford, Julie	NA	NA	NA	NA	NA	NA	NA

Meeting of the QVH Council of Governors
Tuesday 16 December 2025
15.00-15.45

Agenda: meeting session held in public		
Standing items		
Ref	Item	purpose
64-25	Welcome, apologies, declarations of interest and eligibility, confirmation of quoracy <i>Jackie Smith, Trust Chair</i>	-
Council business		
65-25	Strategic partnership <i>Abigail Jago, acting Chief executive officer</i>	<i>Support</i>
Meeting closure		
66-25	Any other business <i>By application to the Chair</i>	<i>Discussion</i>
Questions		
67-25	To receive any questions or comments from members of the foundation trust or members of the public <i>We welcome relevant, written questions on any agenda item from our staff, our members or the public. To ensure that we can give a considered and comprehensive response, written questions must be submitted in advance of the meeting (at least three clear working days). Please forward questions to Leonora.may1@nhs.net clearly marked "Questions for the Council of Governors". Members of the public may not take part in the Council of Governors discussion. Where appropriate, the response to written questions will be published with the minutes of the meeting.</i>	<i>Discussion</i>
Date of next meeting		
Next meeting of the council of governors to be held in public		
2 February 2026		

Quoracy

Any meeting of the Council of Governors requires a quorum of at least half of the total number of Governors to be present, with a majority of those present being Public Governors. No business shall be carried out at a meeting which is not quorate.

Report to: Council of governors
Agenda item: 65-25
Date of meeting: 16 December 2025
Report from: Abigail Jago, acting Chief executive officer
Jackie Smith, Trust Chair
Report author: Leonora May, Company secretary
Date of report: 8 December 2025
Appendices: Appendix one: QVH strategic partnership option appraisal
(report to Board at its meeting on 16 December 2025)

Strategic partnership

Introduction

At its public meeting on 16 December 2025, the Board will receive the strategic partnership option appraisal and make its decision about whether QVH will proceed with a partnership with Royal Surrey NHS Foundation Trust and Ashford & St Peters NHS Foundation Trust (RSASP) or Surrey and Sussex Healthcare Trust (SASH). The strategic partnership option appraisal to the Board is included with this report as appendix one.

The recommendation within the Board report is for the Board to approve QVH proceeding with a strategic partnership with RSASP and for the Board to endorse the next steps as outlined within the paper, including the appointment of a shared Chair and Chief executive officer. There is additional opportunity to build clinical and operational collaborations with SASH in tandem with or following on from agreement to progress a formal Trust partnership with RSASP. The recommended option is subject to Board approval.

Proposal

The appointment of a shared Chair and Chief executive officer between QVH and its chosen partner organisation(s) will be a key pillar of the partnership. The Council of Governors are responsible for appointing the Chair of QVH and approving the appointment of the Chief executive officer upon recommendation by the Trust's Nomination and remuneration committee.

In this context, the Council of Governors are asked to confirm support for the preferred partner and partnership as approved by the Board at its meeting on 16 December 2025 and to confirm support to appoint a shared Chair and Chief executive officer as a key pillar of the partnership, subject to the required process being conducted for these appointments.

Recommendation

Council is asked to **confirm support for the preferred partner and partnership** as approved by the Board at its meeting on 16 December 2025 and to **confirm support to appoint a shared Chair and Chief executive officer as a key pillar of the partnership**, subject to the required process being conducted for these appointments.

Report cover-page

References

Meeting title:	Board of Directors		
Meeting date:	16/12/2025	Agenda reference:	110-25
Report title:	QVH Strategic Partnership Option Appraisal		
Sponsor:	Abigail Jago – Acting Chief Executive Officer		
Authors:	Abigail Jago: Acting Chief Executive Officer, Kathy Brasier: Deputy Chief Strategy Officer		
Appendices:	None		

Executive summary

Purpose of report:	The purpose of the report is to consider the options for a future partnership for QVH and to recommend a preferred option. The Board of Directors is asked to support the preferred option for QVH to progress a future partnership with Royal Surrey NHS Foundation Trust and Ashford and St Peters NHS Foundation Trust Group model. This recommendation follows an appraisal against agreed criteria with NHSE and the Surrey and Sussex ICBs and recommendation from the Strategy and Culture Committee of the Trust Board.				
Summary of key issues	Two options have been considered within this appraisal: Option A, a partnership with Royal Surrey NHS Foundation Trust and Ashford & St Peter's NHS Foundation Trust (RSASP) and Option B, a partnership with Surrey and Sussex Healthcare Trust (SASH). Given the requirement to ensure QVH's operating model can efficiently and effectively deliver the <i>QVH Strategy 2025-2030</i>, enable a sustainable leadership model and ensure the most sustainable, value for money approach to providing corporate services a do nothing option has been discounted. The proposals have been evaluated against an agreed suite of criteria including the quality of patient care and ability to meet population needs, strategic alignment, financial sustainability and viability, and leadership, culture and deliverability				
Recommendation:	For the Board of Directors to approve QVH proceeding with a strategic partnership with RSASP and to endorse the next steps as outlined within the paper, including the timescales and process to appoint the shared Chair and Chief Executive Officer.				
Action required	Approval	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	<i>To deliver outstanding care</i>	<i>To innovate and improve</i>	<i>To be an excellent employer</i>	<i>To deliver sustainable services</i>	<i>To collaborate with others</i>

Implications

Board assurance framework:	BAF risks related to sustainability and leadership capacity
Organisational risk register:	132, 189, 190, 191
Regulation:	NHS England, ICB, CQC Well-Led
Legal:	None
Resources:	None

Assurance route

Previously considered by:	Strategy and Culture Committee
Next steps	- Joint transition planning including joint governance and financial review. - Progress planning for the appointment of the shared Chair and Chief Executive Officer.

QVH Strategic Partnership Option Appraisal

1 Executive Summary

This paper sets out the option appraisal to progress a strategic partnership for Queen Victoria Hospital NHS Foundation Trust (QVH). This partnership is a transformational strategic change for the organisation and will fundamentally reshape the organisational operating model.

The Board of Directors are asked to approve the preferred option to progress a future partnership with Royal Surrey NHS Foundation / Ashford & St Peters Foundation Trusts Group (RSASP).

This appraisal sets out the case for change and options evaluated in relation to the criteria and process agreed by the QVH Board of Directors, NHS England (NHSE) and NHS Sussex and NHS Surrey Integrated Care Board (ICB).

Two options have been considered within this appraisal: Option A, a partnership with Royal Surrey NHS Foundation Trust and Ashford & St Peter's NHS Foundation Trust Group (RSASP) and Option B, a partnership with Surrey and Sussex Healthcare Trust (SASH). Given the requirement to ensure QVH's operating model can efficiently and effectively deliver the *QVH Strategy 2025-2030*, enable a sustainable leadership model and ensure the most sustainable, value for money approach to providing corporate services, a do nothing option has been discounted.

Partnership proposals from RSASP and SASH have been evaluated against the agreed criteria which include domains for patient services, quality of patient care and ability to meet the needs of populations, strategic alignment, financial sustainability and viability, leadership, culture and deliverability.

RSASP are the preferred partner and recommended option. This recommendation has been informed by the evaluation process and consideration by the Strategy and Culture Committee.

To ensure rigour, a range of sensitivity assessments have been completed to test whether the preferred option is robust under different scenarios. In every scenario the preferred option continued to perform as the strongest.

Key factors that have influenced the evaluation and led to RSASP being the preferred provider include:

- **Leadership and delivery capabilities:** Established organisational leadership strength and a proven track record of strong financial and operational performance.
- **Specialist service alignment:** Aligned specialist and clinical services with existing clinical collaborations that provide future opportunities to further support resilience and sustainability of pan regional services.
- **Strategic alignment:** Strong alignment with *QVH Strategy 2025-30*, particularly regarding pan regional service provision and building on the Centre of Excellence development. RSASP also aligns closely with ICB priorities, including care closer to home, community diagnostics including Community Diagnostic Centre (CDC) scaling, and integrated pathways across the Sussex and Surrey system footprint.
- **Cultural alignment:** Shared emphasis on patient safety, learning, quality improvement, collaborative regional identity, specialist excellence, staff wellbeing and inclusive leadership.
- **Partnership / group model:** Established organisational experience in a partnership / group model.
- **Proven delivery of large-scale change collaboratively:** Evidenced by the successful partnership with ASPH, joint governance arrangements and experience of leading system-level transformation programmes.

- **Aligned governance model:** Alignment in governance approach including Foundation Trust status and operation with a Council of Governors

Whilst leadership bandwidth must be considered, risk will be mitigated through a dedicated Managing Director for QVH, phased implementation, clear governance structures and protected time for leaders.

SASH's proposal sets out a number of key strengths including clinical collaboration opportunities and proximity-based advantages, however this did not outweigh the material strengths of a partnership with RSASP that addresses the key challenges facing QVH in the future.

The financial assessment within the appraisal was based on information available within the partnership proposals and publicly sourced data. A comprehensive financial review and plan would therefore be a critical early requirement once a preferred partnership is agreed. SASH offers advantages associated with geographical proximity, however the financial resilience of RSASP provides strength to the group.

This option appraisal has focussed on identifying the preferred partner in terms of leadership collaboration - in the first instance a shared Chair and Chief Executive Officer (CEO). All evaluators identified that there is additional opportunity to build clinical and operational collaborations with SASH in tandem with or following on from agreement to progress a formal Trust partnership with RSASP.

In summary, partnering with RSASP offers a compelling opportunity to meet the long term case for change, deliver meaningful benefits to the populations served, enhance cross provider patient pathways and strengthen QVH's role as a strong collaborative system partner. The proposal has the strong support of the clinical leaders that took part in the evaluation and the Strategy and Culture Committee.

2 Context and Introduction

In November 2024 the *QVH Strategy 2025-2030* was approved by the Trust Board. The strategy set out key ambitions for QVH and its services. It was built upon vast stakeholder engagement (including patients, staff, GPs, commissioners, NHSE, NHS Providers, local population and the third sector) and in alignment with the requirements of commissioners, system partners and key stakeholders. The *QVH Strategy 2025-2030* was developed in the context of a range of national policies, strategies and programmes. The most current and notable of which was the then planned (now published) *NHS Fit for the Future: 10 Year Health Plan for England*. The strategy set out the proposed role of QVH as a Centre of Excellence for reconstruction and sleep (with a focus upon research, innovation and education), services for the local population (QVH Local), development of a new service model for children and integration of services to support optimising of service provision. At the point of strategy approval, the QVH Trust Board noted the importance of organisational agility given the volatile and uncertain NHS environment and the inherent change that may be required going forwards.

Since that time, the operating environment has materially changed with the inception of a new government and leadership of the NHS. This has resulted in a period of profound transformation, shaped by financial constraints, structural and operating model reform. Furthermore, there is a renewed policy emphasis in regard to the three key shifts set out in *Fit for the Future* (hospital to community, analogue to digital and treatment to prevention) and a focus upon integration, prevention, and productivity. These changes include a fundamental shift in funding regime and a focus upon reducing corporate overhead cost to improve value for money.

From a financial perspective, there is material change to financial delivery expectations including a requirement of breakeven plans and year on year cost reduction. The change in financial regime – in particular a cap on planned care activity (ERF cap), changes to patient activity tariff and anticipated changes to ‘top up’ payments and the shift from an income to cost based model presents significant challenge to QVH as does the requirement to materially reduce corporate cost and overheads. Locally the impact includes the collaboration and planned merger of Sussex and Surrey Heartlands ICBs and a system requirement to respond to the new national fair shares allocation, which will further reduce system funding for the future. Collaboration and partnership working are key to enable delivery of population requirements within a reduced financial envelope.

From a provider perspective, it is critical that QVH navigates the change in strategic context in order to progress delivery of its strategy and ensure sustainability of the services for the future. Fundamental change is required to the leadership and corporate model that supports delivery of clinical services. QVH must collaborate to ensure financial sustainability for the future and to progress delivery of the *QVH Strategy 2025-2030*.

Consideration of leadership models within this options appraisal has been informed by NHS England guidance on Provider Collaboratives and shared governance, and by the Federation of Specialist Hospitals (FSH) publication - *The Power of Specialism in the Future NHS* (April 2025). The FSH sets out four nationally recognised models of specialist hospital leadership, which are considered best practice and provide a framework for evaluating QVH’s future strategic positioning. These include:



QVH’s current operating model combines elements of both standalone and networked approaches. Within this options appraisal, exploration of options relate to a transition towards a linked model. This model is considered the most viable option for QVH, offering a balance between strategic alignment, operational efficiency and the preservation of QVH’s specialist identity and autonomy. A linked model would enable shared leadership and corporate functions, support system-level collaboration, and provide access to broader workforce and infrastructure resilience, while retaining QVH’s sovereignty.

Given the historical challenges of QVH in regard to potential partnerships, the strength of stakeholder opinion and the specialist and regional nature of many of its services, the process to explore partnership has been carefully considered in order to enable the successful implementation of the proposed transformational strategic change. This includes, at its core, a programme of work that is robust, transparent and engages key stakeholders. The approach to engagement has included patient groups, staff, the Council of Governors, Trust Board, Integrated Care Board and NHS England as both commissioner and regulator. The work programme commenced in April 2025. This has included the development of a case for change, strategic change approach and discussions with potential partners, the host Integrated Care Board and NHS England.

3 Stakeholder Engagement

At the start of the process a communication and engagement approach was developed. This included a suite of engagement commitments and distinct phases to promote transparency, inclusivity and clarity at every stage.

Internally, the partnership options process has been shaped by extensive engagement across the organisation, involving clinical directors and the triumvirate leadership teams. Staff engagement has been significant, with over 52 departments participating in structured workshops and approximately 900 individual pieces of feedback analysed. Externally, patients, peer group representatives, and primary care colleagues contributed through structured workshops. This feedback was triangulated with an independently commissioned report, which analysed survey data, informal engagement, and leadership discussions to ensure a comprehensive understanding of organisational sentiment.

Key themes of the engagement included support for collaboration particularly around clinical pathways, workforce development and financial sustainability, alongside concerns about losing QVH's specialist identity, autonomy, and culture. Staff consistently emphasised the importance of retaining QVH's reputation, maintaining visible and accessible on-site leadership and safeguarding patient care quality. They also expressed interest in expanded opportunities for training, career development, and research, with a clear preference for partnership models that preserve sovereignty and enable co-designed transformation. These insights directly informed the assessment criteria and the framing of strategic options, ensuring recommendations reflect workforce priorities and concerns.

In addition, to ensure a rigorous process, an internal Strategic Assurance Group (SAG) was established. Members of the group were nominated by clinical directors and the senior leadership team and included Consultants, nurses, Allied health Professionals (AHP), specialist nurses, a staff governor and corporate service representatives. The purpose of this group was to:

- Receive assurance of the on-going commitment to transparent engagement
- Provide input from different perspectives to the consideration of options
- Provide input to communications and engagement methods and materials
- Help cascade information and engagement opportunities to relevant teams and networks to support engagement activities
- Provide oversight on approaches for stakeholder engagement with particular emphasis on the engagement of people who find it harder to have their voice heard.

NHS England and the Sussex and Surrey Integrated Care Boards have been actively engaged throughout the partnership discussions.

Engagement with shortlisted partners included multiple discussions, document reviews, strategic alignment assessments, Chief Executive Officer (CEO) attendance at the QVH Executive Leadership Team and Board-to-Board sessions. This process has not only shaped the appraisal but also fostered trust and shared understanding regarding critical foundations for any future partnership and alignment in regard to the case for change.

4 Case for change

The purpose of the case for change is to clearly articulate why transformation of the operating model is essential for QVH. It builds on the case set out in the *QVH Strategy 2025-2030* and has been developed collaboratively and endorsed by the Executive Leadership Team (ELT), with input and support from the wider hospital leadership team, including clinical directors and triumvirate teams. The case for change is built upon five pillars: patients and services, landscape, people, leadership and culture, and financial outlook. These factors have directly informed the option appraisal criteria.

Dimension	
Patients and Services	• Current waiting list pressures risk patient outcomes without new capacity solutions, with delays growing for routine care and urgent treatment alike. • Some services are not fully aligned with national standards. Partnership opportunities will help to address these in an environment where investment is limited • QVH's has some service fragilities with in some cases dependence on single consultants or teams, creating sustainability risks. • Some pathways are fragmented which at times creates delay in accessing care at QVH. • Partnership offers pooled resources and capacity, enabling earlier access to care and reducing backlogs across pathways. • Shared clinical governance may strengthen resilience, quality standards, and learning in some areas. • Partnership enables QVH to strengthen safe, timely, high-quality care.
Landscape	• NHS England abolition and ICB consolidation marks transformational structural reform, requiring providers to adapt. • Surrey & Sussex population is projected to rise significantly over the next 15 years, driving demand. • An ageing population is increasing demand in frailty services and integrated models of care • Health inequalities remain stark, with life expectancy varying by more than 10 years in some areas. • National and local strategies emphasise prevention, early intervention and stronger integrated care. • Partnership gives QVH greater system voice, aligning our specialist services & integrated models. • Partnership and collaboration can support backlog recovery, integrated pathways and system resilience, ensuring specialist services contribute to collective goals.
People	• QVH's specialist workforce is a major strength but is also fragile due to the small scale of some teams • Small teams are highly vulnerable to sickness absence, turnover, and vacancies, creating immediate service risks in some cases. • Limited career progression opportunities in a small trust can impact recruitment and retention... • Partnership would provide access to broader career development opportunities. • Shared recruitment and rotation options may improve attraction, retention, and resilience of staff. • Broader workforce pools strengthen clinical cover and reduce fragility of small services
Leadership	• QVH corporate costs, although in line with other providers are disproportionate to income • Significant reductions in corporate costs required, requiring shared leadership models • Standalone leadership structures carry growing financial and operational risks. • Shared Chair/CEO and leadership arrangements are being implemented nationally for smaller providers to support resilience. • Partnership provides a managed route to share and strengthen leadership capacity. • Shared leadership model will strengthen resilience. • Partnership strengthens QVH's voice, role and influence • Aligns QVH with national direction / ensuring leadership is both sustainable and outward-facing
Financial Outlook	• The NHS is financially challenged, and the financial envelope for QVH is unsustainable alone. • Across Kent, Surrey, and Sussex, integrated care systems are operating at a deficit. • £7.5m (≈6%) recurrent savings required in 2025/26. • We anticipate that 2026/27 could require £8.5m (≈8%) recurrent savings for QVH. • Since COVID, our financial deficit has been mitigated through the receipt of additional top up funding, exceeding the value generated by the standard activity-based pricing model. • Top up funding is likely to be reviewed and potentially partially withdrawn, up to the value of £18m. • Corporate costs currently 9.5% of turnover, above NHS trusts (6%) • Clinical and corporate efficiencies of scale through a partnership is the only credible way to deliver mandated savings, reduce corporate costs, and protect frontline services.

5 Option Appraisal

5.1 Process and Governance Assurance

The options appraisal has been developed taking into consideration NHS England guidance *Assuring and Supporting Complex Change – Shared Leadership and / or Governance Arrangements of NHS Providers*. The approach has been designed to ensure that the appraisal process is structured, transparent and inclusive, and that any resulting recommendations are grounded in data and evidence, subject to appropriate challenge, aligned with both regulatory expectations and commissioner and system priorities. Oversight of the process has been maintained through QVH's established governance structures, with regular internal reporting to the Strategic Assurance Group, Executive Leadership Team, Strategy and Culture Committee and discussion at Board seminars. External assurance has been sought through ongoing engagement with NHS England and the Surrey and Sussex Integrated Care Board, who have provided advice on the approach and the balance of assessment criteria.

5.2 Partner long to short list

In alignment with best practice for major service change and NHS England guidance on partnership development, QVH compiled a comprehensive longlist of potential partnership opportunities. The aim was to ensure that all viable options were considered before narrowing the scope to a shortlist suitable for detailed appraisal. This longlist included providers across Kent, Surrey and Sussex as well as larger specialist centres. An evaluation was undertaken, considering strategic alignment, geographical proximity, service interdependencies and appetite to collaborate. This assessment was informed through engagement with key system stakeholders. Following Board review, two potential partners were shortlisted – SASH and RSASP. These two Trusts' offered opportunity for potential alignment with QVH's strategic priorities and a credible route to long-term sustainability for the organisation.

5.3 Assessment criteria

The criteria for assessment were developed based on the case for change. Oversight was provided through QVH's internal governance structures, including the Strategy and Culture Committee. Following engagement and feedback from NHS England and host ICB, the criteria were further refined to ensure alignment with the regulator and commissioner. The final criteria and weightings as agreed by NHSE / ICB are set out below:

Criteria	Test	Key test	Weight
1. Patient services, quality of patient care and meeting needs of populations	1.1	To what extent can the partnership strengthen clinical resilience?	25
	1.2	To what extent will the partnership afford improvements in patient pathways / subscale services?	
	1.3	To what extent will the partnership improve / not lessen quality (safety, experience and outcomes)?	
	1.4	To what extent does partnership support the needs of the population(s) served and address health inequalities?	
	1.5	To what extent is there demonstrable evidence of commitment to continuous improvement (CI) and learning?	
2. Strategic alignment	2.1	How well does the partnership support QVH strategy including the continuation and development as a centre of excellence for specialist services?	25
	2.2	How well does the partnership support delivery of ICB and national strategy?	
	2.3	Is there a shared understanding of and support for the strategic rationale for the partnership?	
	2.4	How far do partners demonstrate a track record of stakeholder engagement in strategy development?	
	2.5	Is the partnership supported by NHSE and strategic commissioners?	
3. Financial sustainability and viability	3.1	How well does the partnership enable financial viability of services (including subscale services)?	25
	3.2	To what extent does the partnership support reduction in corporate costs	
	3.3	To what extent does the partnership deliver cost reduction to enable financial resilience across the partnership?	
	3.4	To what extent does the partnership provide better value for money and use of resources for the taxpayer?	
4. Leadership, Culture & Deliverability	4.1	How well does the partnership enable sufficient executive and clinical leadership bandwidth to develop the partnership alongside day-to-day pressures and delivery?	25
	4.2	To what extent is there proven ability of senior leaders to deliver large-scale change and deliver collaboratively?	
	4.3	To what extent does the partnership strengthen leadership capacity and capabilities?	
	4.4	Does the proposed model present any risks due to size, complexity and existing organisational challenges and how well could these be mitigated?	
	4.5	What is the existing degree of collaboration between the trusts?	
	4.6	How far do partners align from a cultural and leadership perspective?	
	4.7	To what extent do leadership models support the QVH services voice and interests and provide QVH the appropriate seat at the leadership table	
	4.8	To what extent does the proposed model provide on-site senior leadership at QVH?	
	4.9	How effectively does the partnership engage and support the views / interest and support of key stakeholders?	

5.4 Potential Partner Proposals and supplementary information

The agreed criteria were shared with the two potential partners to inform their proposals. The proposals and a suite of supplementary information including Board and committee papers, patient and staff surveys, CQC reports, strategic plans, Annual Reports, Quality Accounts, and national benchmarking data were collated to inform the scoring process.

6 Scoring and Moderation Process

6.1 Scoring Principles and Approach

The scoring of partnership options was approached taking into account the following:

- Fairness: Ensuring equal access to information and consistent engagement with both providers.
- Objectivity: Evaluation informed by evidence and supported by clear rationale.
- Transparency: A clear methodology agreed with NHSE and ICB, tested by internal assurance.
- Consistency: Use of agreed criteria, key tests, and evidence packs for all respondents.

Each partnership option was assessed against the four equally weighted criteria:

- Quality of Patient Care / Meeting the Needs of the Population
- Strategic Alignment
- Financial Sustainability and Viability
- Leadership, Culture and Deliverability

Each criterion consisted of several key tests, which formed the framework for guiding decision-making. These key tests were tailored to each criterion and scores were weighted according to the proportion of tests within each criterion to generate an overall score.

Each key test was evaluated using a four-point scale: Not Met (0 points), Partially Meets (1 point), Meets (2 points), and Exceeds (4 points), providing a structured and consistent method for assessing option performance against the criteria

Once all key tests within a criterion had been evaluated, the total weighted score of those tests determined the overall score for that criterion. The scores for all four criteria were then combined to produce an overall score for each partner.

6.2 Scoring Cohort and Governance

The scoring process involved multi-disciplinary senior leaders. This included Executive Directors, Deputy Directors, Clinical Directors and triumvirate leaders. The team were guided through the process to ensure they applied a consistent approach to the scoring methodology. Evaluators were provided with equal notice to complete the scoring process.

The senior Finance team, supported by two rigorous check and challenge sessions with the Acting Chief Executive Officer and the Audit and Risk Committee Chair, scored financial assessments. This additional scrutiny tested assumptions and ensured the appropriate amount of challenge related to the available information.

All scoring decisions were supported by the two partnership proposals. Further objective evidence, such as performance data, CQC reports, strategic documents, engagement records and soft intelligence, were shared to support and inform decision-making. This information was included within an evidence pack for each partner, which was provided via a shared repository, and evaluators were required to record comments and rationale for transparency and audit purposes.

6.3 Moderation

Purpose and Process

Moderation was carried out by the Executive team to support fairness, objectivity, transparency and consistency. Its purpose was to confirm the final agreed evaluation scores for each key test and, based on these outcomes; recommend which organisation the Trust should pursue a partnership with. Importantly, moderation did not alter individual scores; original scoring remained intact for transparency and audit purposes.

Impartiality and Record Keeping

Proposals were assessed on their own merit against the evaluation framework. All discussions, rationale, and decisions during scoring and moderation were documented. All evaluations and conclusions were based on the information available at the time of the assessment, ensuring that decisions reflected the most accurate and relevant evidence accessible during the process. An independent individual attended the scoring and moderation process to ensure rigor and challenge and eliminate any areas of unconscious bias. The feedback concluded a robust process of evaluation and moderation had been followed.

7 Commissioner Feedback

As part of the review process, commissioners, led by the host ICB reviewed and fed back comments and considerations relating to proposals. The feedback noted the thoroughness and detail of proposals. The feedback did not stipulate a preferred provider from a commissioner perspective but did highlight a number of areas of consideration which have been taken into account within the assessment criteria including:

- Alignment with strategic and operational capabilities; requirement to evaluate how the proposed partnerships will impact service delivery and whether they will enhance the ability to meet the needs of patients and communities.
- Recognition of the bandwidth across Providers and recognising the role in specialised services.
- Consideration of partner synergies and strategic agility to respond to any future service changes.
- Consideration of the populations served by QVH.
- The importance of retaining QVH's specialist identity and resilience of pan regional services
- Strategic coherence and patient centred outcomes
- Maintaining strong communication and collaboration with all stakeholders. The process has been developed and implemented with engagement at its core.

In summary, the commissioner feedback has been taken into account within the option appraisal process. It is noted that as QVH transitions to a partnership operating model it will be critical to be agile, flexible and responsive to changes to both the commissioner and provider environment and associated priorities.

8 Option evaluation results

The proposals were evaluated against the agreed criteria and both partners presented credible partnership opportunities. RSASP emerged as the preferred option, achieving the highest total scores across the evaluated criteria. Whilst SASH offers proximity based advantages and a range of clinical collaboration opportunities, these did not outweigh the strengths of a partnership opportunity with RSASP.

Key factors impacting scores as follows:

Criteria 1: Patient services, quality of patient care and meeting needs of populations

Under this criterion, RSASP demonstrated strong specialist service alignment, consistent quality foundations, mature clinical networks, advanced diagnostics, academic partnerships and established continuous improvement culture. While SASH offers important proximity-based operational benefits, including more agile cross-site medical cover and improvement culture, these did not outweigh the strengths of a partnership opportunity with RSASP which include:

- **Specialist & Acute portfolio:** Strength of specialist / acute portfolio aligned to QVH services
- **Mature Clinical Networks:** Proven cross-cover arrangements and mature clinical networks across a range of services.
- **Regional Cancer Centre:** As a Regional Cancer Centre, RSASP provides significant pathway opportunities across specialist services for the benefit of patients
- **Advanced diagnostics:** Strengthens access to advanced diagnostics and provides opportunities for further tri-trust community diagnostic.
- **Workforce opportunities:** Clinical services could be supported by enhanced workforce resilience that may be strengthened through established joint rotas, on-call systems, a flexi-bank, and shared job planning.
- **Research and Education:** Strong educational and research environment, underpinned by the University of Surrey partnership; enhanced recruitment, retention, training, and academic alignment.
- **Continuous Improvement (CI) Culture:** Mature continuous improvement culture, recognised through an Outstanding Care Quality Commission Well-Led rating and supported by the 'True North' framework, dedicated transformation team and a strong learning environment.

Key risks identified relate primarily to geographical distance and so the successful delivery will depend on sustained clinical engagement and operational coordination across multiple sites.

The strengths of a partnership opportunity with **SASH** included:

- **Geographical proximity:** enabling more agile cross-site medical cover, shared rotas and joint escalation pathways
- **Collaboration opportunities:** in some key services
- **Neighbourhood and population-health:** models opportunities to align with QVH Local aligned with Sussex system priorities.
- **Continuous Improvement (CI) Culture:** SASH+ provides a structured and embedded CI approach, with Kaizen, Lean, staff training and cross-site development programmes.
- **Transformational appetite:** commitment to fundamental reconsideration of care models which might offer innovative opportunity for both organisations
- **Patient safety:** opportunities to further strengthen patient safety due to geographic proximity.

In summary RSASP scored higher in this domain, reflecting its specialist offering, consistent quality foundation, deep workforce and academic infrastructure. SASH provides proximity-based advantages however; this did not on a scoring perspective outweigh the strengths of RSASP. It does however indicate a number of potential collaboration opportunities for the future.

Criteria 2: Strategic Alignment

RSASP scored higher in this strategic fit domain. It demonstrates clear alignment with QVH's long-term specialist mission, stronger coherence with system priorities and close alignment with national NHS policy. Its governance model, academic infrastructure and specialist pathway opportunities further reinforce strategic fit.

SASH offers strong alignment with neighbourhood and QVH Local ambitions, particularly around community diagnostics and population health. However, as a DGH it provides more limited alignment for QVH's specialist and centre-of-excellence direction.

RSASP was evaluated as offering a strong strategic fit with QVH's long-term direction, system priorities, and national NHS policy intentions. Key areas of rationale include:

- **Alignment with QVH Strategy 2025–2030:** RSASP's specialist and acute portfolio strongly aligns with QVH's ambition to remain a regional centre of excellence for reconstruction and sleep. The group model supports QVH's strategic aspirations around research, elective optimisation, clinical networks and integrated pathways across Kent, Surrey and Sussex.
- **National policy alignment:** RSASP proposal directly reflects themes in the NHS Long Term Plan and wider 10-year policy direction, including early diagnosis, elective recovery, shared digital/Electronic patient record (EPR) systems, research-led innovation, and workforce resilience through collaborative models. The organisation's emphasis on continuous improvement and productivity also supports national efficiency and quality imperatives.
- **System and regional alignment (including Improving Lives Together strategy):** Strong alignment with ICB priorities around care closer to home, multi-site service models, community diagnostics (including CDC scaling), and integrated pathways across the Sussex system footprint. The Regional Cancer Centre role provides a coherent platform for pathway redesign across regional and specialist services, aligned with QVH's specialist operating model.
- **Academic and workforce strategy:** RSASP partnership with the University of Surrey supports QVH's long-term workforce, education and research ambitions, providing a credible platform for growing clinical academies, embedding research capability and supporting workforce pipelines.
- **Governance and delivery alignment:** The established RSASP group model offers a tested governance environment that mirrors QVH's ambitions for collaboration without loss of identity. Foundation Trust status across the group ensures compatibility with QVH's governance and regulatory expectations.

Identified risks relate to geographical distance. Delivering a shared strategic vision will depend on engagement across sites, but overall alignment with QVH, ICB and national strategy is strong.

SASH provides strategic advantages primarily in relation to QVH's emerging "QVH Local" ambitions, with the following strengths noted:

- **System and regional alignment (including Improving Lives Together strategy):** Strong coherence with neighbourhood models, Urgent and Emergency Care reform, population health management, community diagnostics and closer-to-home pathways. Proximity supports a coherent local footprint and strengthens QVH's role as a system partner within Sussex.
- **Alignment with QVH's local system priorities:** Opportunities for joint working in a number of clinical service areas that align with QVH's goals around integrated local pathways and improving access for Sussex residents.
- **Cultural alignment** with improvement and collaboration: SASH's engagement culture, SASH+ continuous improvement methodology and neighbourhood links support QVH's organisational ambition to strengthen local transformation capability.

Identified risks related to limited alignment with specialist services.

Overall, RSASP scored higher in this domain, offering a robust strategic fit with QVH's long-term specialist mission, system priorities and national policy direction. SASH provides meaningful

alignment with neighbourhood and local care models but did not support the depth of specialist focus, governance maturity and strategic alignment.

Criteria 3: Financial sustainability & viability

The financial evaluation and scoring has been undertaken based upon the partner proposals and information within the public domain. This does not include detailed financial assessment nor the rigour of a full business case. The assessment has therefore been approached with caution and the scoring is based upon the high-level rationale set out below.

RSASP was assessed as offering a credible and well-established platform for financial and corporate alignment, with the following strengths:

- **Clinical pathway efficiencies:** Alignment opportunities identified across a range of services with potential cost benefit.
- **Long-term efficiency gains:** Potential opportunities through digital convergence (Artificial Intelligence, Electronic Patient Record, analytics) and elective optimisation, building on existing RSCH/ASPH programmes.
- **Corporate services alignment:** Clear articulation of how corporate services alignment could work supported by RSASP developed Subsidiary Company (SubCo) model.
- **Experienced group model:** The existing RSASP group already operates shared leadership portfolios and corporate functions, providing tested governance, integration mechanisms, and senior management capacity.
- **Financial resilience:** RSASP is on plan year-to-date, with a strong cash position, low Deficit Support Funding (DSF) reliance, and intention to convert DSF into growth funding as block contracts shift.
- **Cost benchmark stability:** National Cost Collection data indicates stable performance (RSCH = 100; ASPH = 94), and a well-established CIP programme with a manageable target (~4%) and no high-risk schemes.
- **Deliverability confidence:** The proposal demonstrates a clear understanding of integration costs and outlines how savings, productivity improvements and reduced variation would offset these over time.

Identified risks were integration benefits would be expected over the medium /longer term, with less immediate financial upside due to the group's already strong cost base, geography moderates feasibility of some corporate and operational consolidation national changes that may impact the future design of SubCo arrangements. Overall, the RSASP proposal is viewed as setting out potential opportunities, stable governance, and lower delivery risk, though the scale of financial benefit is likely to materialise over time.

SASH was assessed as offering notable financial and operational alignment potential, particularly due to proximity, but with greater uncertainty about deliverability. Several strengths were identified:

- **Clinical and diagnostic efficiencies:** Alignment opportunities across some services may enable shared rotas and capacity to reduce costs and strengthen resilience.
- **Proximity advantage:** Geographic closeness increases feasibility, pace and practicality of shared rotas, workforce models, diagnostics, elective pathways and corporate services.
- **Corporate service alignment:** Opportunities for future alignment of corporate functions, executive portfolios and shared digital investment.
- **Existing relationships:** SASH's involvement in tri-site cancer collaboration and CDC development creates a platform for operational alignment.

Identified risks included current financial pressures and an untested group model.

Overall, given the absence of a detailed financial plan the financial assessment was not a differentiating factor. The scores for each provider for financial sustainability criteria were equal with some variation at a test level. The scores for RSASP were driven by financial resilience, proven integration capability, and a clear, structured approach to corporate and operational alignment.

SASH demonstrates meaningful theoretical opportunities, especially enabled by proximity, but some uncertainty was highlighted regarding realisation and the need for further clarity on governance, integration structures and investment capacity. In the absence of a detailed financial plan it is not possible to articulate the proposed financial gain and this will need to be a key priority once the partner is identified and transition planning can commence.

Criteria 4: Leadership, Culture and Deliverability

RSASP was evaluated by identifying areas of key strengths and risks and the rationale includes the following:

- **Stable executive team with proven track record:** Rated Outstanding for leadership by the CQC in 2025. This report cited inclusive, compassionate and values driven leadership, this enhances capability within an enhanced group model. There is also a clear direction of “True North” leadership framework with aligned strategic goals.
- **Structured succession planning:** the Elevate leadership programme and shared talent pipelines are proposed to expand capability across the Group. Leadership focusing upon talent development, inclusion, equity and diversity.
- **Cultural alignment** in regard to strong patient safety, learning and quality improvement culture, collaborative regional identity, specialist excellence orientation, focus on staff wellbeing and inclusive leadership
- **Established stakeholder engagement structures:** Extensive stakeholder engagement with staff, governors, patients and community events.
- **Established group leadership model:** Some shared executive portfolios in place within current group model, with executive leadership that is robust and experienced.
- **Proposed operating model:** The proposal includes a QVH Managing Director and site leadership team to ensure visible local leadership. Although there will be an expected phased approach to implementation and delivery.
- **Proven delivery of large-scale change collaboratively:** This is evidenced by the successful integration of ASPH, joint governance arrangements and experience of leading system-level transformation programmes.
- **Existing clinical collaborations:** There are clear connections with specialist and regional services.
- **Foundation trust:** Aligned governance with Council of Governors and Board.

While the model introduces some risk due to scale, geography and existing leadership bandwidth risks are mitigated through phased implementation, clear governance structures, protected time for leaders and formal mechanisms to ensure QVH’s specialist voice, autonomy and stakeholder interests are represented at the leadership table. The proposed leadership model with a site based Managing Director for QVH further strengthens leadership bandwidth.

SASH was evaluated by identifying areas of key strengths including the following:

- **Leadership visibility opportunity:** Proximity offers opportunities for Executive presence.
- **Collaborative intention:** proposal includes executive involvement and presence with a structured approach to engagement.
- **Programme structure:** Ring fenced partnership programme with a jointly appointed Managing/ Programme Director with proposed protected time for leaders to progress the partnership development.
- **Change Leadership:** Some leaders bring experience of change and improvement and SASH+ provides a structured methodology for collaboration. Focus upon patient centred care and cultural ethos.
- **Cultural alignment:** In regard to improvement, SASH state a provision for patient centred care and ‘family’ like ethos.

Risks identified included current leadership capacity, organisational experience of group model or operating with a Council of Governors, leadership experience of specialist or regional services and clarity regarding retaining the QVH voice.

Overall, RSASP scores higher, providing leadership resilience, clear governance, cultural alignment and a credible basis for sustained partnership development and stakeholder confidence.

9 Option Sensitivity Analysis

A range of sensitivity assessments were carried out to test whether the preferred option remains robust under different scenarios, altering any of the parameters would change the recommended decision. The changes tested were:

- Reduced the “Exceeds” judgement score from 4 to 3
- Increased the financial weighting from 25% to 40% and reducing the remaining three criteria from 25% to 20%
- A & B combined
- Removed the impact of outlier scores

In every scenario, the outcome was the same, i.e. the preferred partner remained RSASP and whilst the overall scores changed, there was still a material gap between the two options. This demonstrates robustness and reliability in the scoring model.

10 Preferred option and recommendation

On assessment of the evaluation scoring, benefits and risks Option A (a partnership with Royal Surrey / Ashford and St Peters NHS Trusts) is recommended as the preferred option. The option offers a compelling opportunity to enable QVH to partner and ensure that the Trust’s operating model can efficiently and effectively deliver the *QVH Strategy 2025-2030*, ensure a sustainable leadership model and ensure the most sustainable, value for money approach to providing clinical and corporate services. The option has been evaluated as the strongest to meet the case for change as set out through the agreed option assessment criteria evaluation. This option is supported by clinical leaders and the Strategy and Culture Committee.

11 Next steps

Following the approval of the preferred option to progress a strategic partnership with RSASP the next steps of the partnership development will include:

- QVH Board approval on 16th December 2025
- QVH Council of Governors support for partnership on 16th December 2025
- RSFT & ASPH Board approval
- Development of Memorandum of Understanding (MoU)
- Confirmation of timescales and process to appoint the shared Chair and Chief Executive Officer and transition arrangements for Chair and CEO.
- Development of transition plan in partnership with RSASP including ongoing stakeholder engagement and joint governance and financial reviews.
- Consideration with RSASP and SASH regarding collaboration opportunities.

12 Conclusion and recommendations

This options appraisal has been developed in response to significant strategic, financial, and operational challenges facing QVH and the wider NHS. It reflects the Trust's commitment to delivering its strategy, protecting its specialist services, and securing long-term sustainability through collaboration. Following a structured and inclusive process, two options were evaluated against agreed criteria. The preferred option, strategic partnership with RSASP, scored highest or equal across all domains and offers the strongest alignment with QVH's strategic objectives, financial requirements, and organisational values.

The partnership provides a credible route to sustainability, resilience, and strategic integration, while preserving QVH's identity and specialist role. It offers the greatest potential to mitigate risks identified in the Board Assurance Framework and to deliver the ambitions of the *QVH Strategy 2025–2030*.

The Board is asked to APPROVE QVH proceeding with a strategic partnership with RSASP and to ENDORSE the next steps as outlined within the paper, including the timescales and process to appoint the shared Chair and Chief Executive Officer.