Consultation response – January 2026:

Healthwatch Nottingham and Nottinghamshire
Developing NHS Online (Online NHS Trust)

Key concerns identified by Healthwatch Nottingham and Nottinghamshire

Based on our reading of the briefing and our insight from local engagement, we have identified the following key areas of concern that we believe require further clarification and mitigation in the design and implementation of the Online NHS Trust.

The issues below are summarised here for clarity and are explored in more detail in response to the consultation questions that follow.

Given the scale and nature of this proposal, including its potential impact on disabled people, older people and digitally excluded communities, we are concerned that no Equality Impact Assessment has been shared as part of this consultation.

Without a published equality analysis, it is unclear how equality considerations have informed the design of the Online NHS Trust, and this undermines confidence in the transparency and robustness of the consultation process.

Underestimation of workforce and relational support requirements

The briefing repeatedly states that the Online NHS Trust will require *"only a small proportion of the overall NHS clinical workforce to commit a small amount of additional time"*. This assumption appears unrealistic and insufficiently evidenced.

There is also no indication that NHS staff have been consulted on whether they are willing or able to provide this additional labour. This is a serious omission given the current state of the workforce. Recent Royal College of Nursing survey data shows that:

- only 31% of NHS staff feel there are enough staff to do their job properly,
- 45% report feeling unwell due to work-related stress,
- and 58% report coming to work despite not feeling well enough to perform their duties.

In this context, proposing a model that relies on clinicians providing additional hours risks embedding unsafe practice, worsening burnout and accelerating workforce attrition.

In addition, digital-first models do not remove the need for human support. Instead, they often increase demand for relational, explanatory and follow-up work, particularly for patients who:

- have lower digital confidence or access

- have complex needs or long-term conditions
- require reassurance, advocacy or ongoing clarification
- experience anxiety, trauma or mistrust of services

Relational care (especially for anxious, neurodivergent, traumatised or marginalised patients) is **time-intensive**, not time-light. Without recognising and resourcing this work, there is a risk that pressure is displaced onto clinicians, support staff, patients and carers.

The proposal that clinicians will deliver this work by offering "small additional amounts of time" also risks creating a de facto internal labour market within the NHS. For NHS Online to attract clinicians, it will need to compete financially with private and locum work, potentially driving up costs while drawing capacity from already stretched local services.

This raises questions about sustainability, affordability and whether NHS Online would in practice operate as a form of "side-hustle" for clinicians rather than a stable, integrated part of the NHS workforce.

Mitigation needed: transparent workforce modelling, evidence that staff have been consulted, realistic time assumptions, and explicit recognition of relational and support labour within virtual care pathways.

Tension between national, non-geographical care and place-based health systems

The proposal that the Online NHS Trust will operate "*unconstrained by geographical boundaries*" raises significant questions about alignment with existing commitments to place-based, neighbourhood and community-based care.

While national capacity may improve access for some patients, it is unclear how this model will:

- integrate with local services and pathways
- support continuity of care
- manage accountability when patients move between areas
- operate for mobile populations such as university students, who already experience fragmented care due to GP registration constraints

There is a risk that a nationally delivered virtual service could weaken local relationships, accountability and safeguarding if not carefully designed.

Mitigation needed: clear articulation of how local integration, responsibility and escalation will function within a national virtual model.

Missing integration with social care and local authority systems

The briefing makes no reference to how the Online NHS Trust will interface with adult social care, local authority safeguarding functions, reablement services or care packages.

In practice, many patients' needs span health and social care, particularly following hospital discharge, during deterioration in long-term conditions, or where safeguarding or capacity concerns arise.

A national, non-geographical trust will need to interface with hundreds of local authority systems, teams and processes, yet no plan or timetable is set out for how this will be achieved. Without this, there is a high risk that patients experience delays, duplication, unsafe handovers or loss of support at key transition points.

Mitigation needed: a clear and deliverable model for linking NHS Online pathways into local authority social care, safeguarding and community support systems before national roll-out.

Unsupported assumptions about public expectations of digital-first care

The briefing states that "*people increasingly expect a digital-first approach to care*", but provides no supporting evidence.

Our local insight *(for example Digital Exclusion v4.pdf report from Healthwatch England and 20231011_Nottingham_Nottinghamshire-Digital-Inclusion-Report-for-publication.pdf from Healthwatch Nottingham& Nottinghamshire)* suggests that expectations, preferences and suitability for digital care vary widely. Many people value digital access for administrative functions, but do not necessarily expect or prefer digital-first clinical care. People want choice**.** Expectation should not be conflated with preference, clinical appropriateness or equitable access.

Mitigation needed: clearer evidence, nuanced framing, and communications that emphasise choice rather than assumed demand.

Lack of published evidence behind 'proven virtual pathways'

The briefing repeatedly refers to "tried and trusted healthcare" and "proven models of virtual care delivery", yet no evidence base, outcome data or evaluation is provided to support these claims.

Establishing a new national NHS Trust on the basis of unspecified or unpublished evidence limits the ability of stakeholders and the public to assess safety, effectiveness, equity or value for money.

Mitigation needed: publication of the clinical, safety and outcome evidence that underpins the selection of pathways and the decision to scale them nationally.

Limited clarity on what is genuinely new for patients

Several elements described as benefits of the Online NHS Trust, such as access to appointments, test results and condition information via the NHS App, already exist in parts of the system.

The core challenges reported by patients locally are inconsistency in its implementation, variable GP participation, poor usability and unequal access, rather than the absence of digital tools

Mitigation needed: clarity on what will materially change or improve for patients compared to existing NHS App functionality, and how known implementation gaps will be addressed.

Lack of transparency around projected activity and capacity claims

The claim that the Online NHS Trust will deliver the *"equivalent of 8.5 million appointments and assessments"* lacks sufficient explanation.

Without clarity on:

- the timeframe
- underlying assumptions
- baseline comparisons
- what constitutes an "appointment" or "assessment"

it is difficult to assess the credibility or relevance of this figure from a patient or system perspective.

Mitigation needed: greater transparency and methodological explanation for headline activity projections.

Ambiguity and lack of clarity around health inequalities and technology design

The statement that *"health inequality considerations will be incorporated into technical requirements"* is unclear and lacks operational meaning.

It is not evident how health inequalities will be:

- translated into concrete system design requirements
- assessed during procurement
- tested for real-world impact
- monitored and enforced over time

There is a risk that inequalities are acknowledged in principle but not meaningfully addressed in practice.

Mitigation needed: explicit, testable requirements for inclusive design, accessibility, language support and differential impact monitoring.

Regulation and oversight of a fully virtual NHS trust

While the briefing states that the Online NHS Trust will be regulated in the same way as other NHS trusts, it does not explain how this will operate in practice for a national, fully virtual provider.

Questions remain about:

- how CQC inspections will be conducted
- how local intelligence and concerns will be surfaced
- how accountability will be exercised across multiple geographies
- how risks will be identified without a physical site or place-based footprint

CQC regulation relies heavily on: Site visits, Observations, Local leadership and governance.

Mitigation needed: clear explanation of regulatory and governance arrangements tailored to a virtual, national trust.

Governance capacity and Non-Executive Director remuneration

The published recruitment materials for NHS Online Non-Executive Directors indicate remuneration of £13,000 for a four-day-per-month role. For a national NHS Trust with significant clinical, digital, financial and reputational risk, this level of remuneration is unlikely to attract the calibre of governance expertise required, particularly for roles such as Audit, Risk or Quality Committee Chairs.

Weak governance in a high-risk digital provider would significantly increase the likelihood of safety, data protection and accountability failures.

Mitigation needed: assurance that governance capacity, expertise and remuneration are commensurate with the scale and complexity of this national trust.

Significant omission: safeguarding

We are particularly concerned that safeguarding is not explicitly addressed within the briefing.

For a digital-first, national trust, robust safeguarding arrangements for children and vulnerable adults are essential. Virtual-only interactions may increase the risk of safeguarding issues going undetected, including domestic abuse, coercive control and exploitation, as clinicians may have fewer environmental and relational cues than in face-to-face settings.

Clear protocols are needed for:

- identifying safeguarding concerns in virtual consultations
- escalating concerns across local authority boundaries
- working effectively with local safeguarding boards

- ensuring accountability when patients are not linked to a single place-based provider

Mitigation needed: explicit safeguarding frameworks embedded into design, workforce training, escalation pathways and governance arrangements in relation to online safety.

In addition, there is a risk of patients being targeted by scams or impersonation, with individuals purporting to be NHS Online providers and requesting personal or clinical information. A national digital service increases the risk of social engineering, particularly for older people, people with cognitive impairments and those with lower digital confidence.

Mitigation needed: strong identity verification processes, clear public guidance on how official NHS Online communications will operate, and rapid reporting and response mechanisms for suspected fraud.

Overall concern

Taken together, these issues suggest a risk that the Online NHS Trust could prioritise scale and efficiency without sufficient attention to relational care, equity, safeguarding and local accountability. Addressing these concerns early and transparently will be critical to ensuring the model improves access and outcomes without widening inequalities or undermining trust.

We are also concerned that the current proposal moves directly to national delivery across multiple conditions without a phased, place-based test-and-learn approach. Testing only a small number of clinical pathways is not the same as testing how a national virtual trust integrates with local health, social care, safeguarding and democratic accountability systems. A geographically bounded pilot, evaluated before scale-up, would significantly reduce system risk.

Response to Developing NHS Online Consultation questions & answers:

1. What insight(s) can you share on people's use of digital health services, such as signing up to and using the NHS App, using online referral tracking tools, booking appointments online or giving feedback virtually, in your local area?

Our engagement across Nottingham and Nottinghamshire shows that use of digital health services, including the NHS App, is highly uneven.

While some people value digital access for convenience, particularly for administrative tasks, many experience barriers including limited digital confidence, lack of access to devices or data, language barriers, disability-related access needs, and low trust in digital systems. Uptake and meaningful use are significantly lower among older people, people on low incomes, people with learning disabilities, people whose first language is not English, and some minoritised communities.

Importantly, digital access does not equate to digital confidence. Many people who are signed up to the NHS App report difficulties understanding information

presented, navigating referrals and test results, or knowing what action to take. This often results in increased anxiety and additional contact with services for clarification and reassurance.

2. What has worked well to upskill people on understanding, signing up to and accessing digital health services?

Our insight suggests that digital services work best when they are **supported by human, relational and community-based support**.

Effective approaches include:

- Trusted intermediaries such as community organisations, carers and social prescribers
- In-person support to set up and use digital tools, not just download them
- Simple explanations using plain language and real examples
- Ongoing support rather than one-off interventions

These approaches require sustained investment of time and staff capacity. Digital-first models that assume minimal additional workforce time risk underestimating the level of support required for safe, equitable access.

3. How can we help patients understand how the Online NHS Trust will work in practice, especially when:

a. choosing to be referred to NHS Online through a primary care appointment

b. arranging consultations and diagnostics through the NHS App

c. the stages of treatment along standardised pathways

For patients to make genuinely informed choices about referral to the Online NHS Trust, clear and consistent communication is essential.

A) Patients need to understand:

- That referral to the Online NHS Trust is optional and not the default
- How responsibility for their care will be managed across a national, virtual provider
- What happens if digital care does not work for them or their circumstances change
- How and when care will transfer back to local services if needed

Short primary care appointments may not provide sufficient time for this discussion without clear guidance and support for clinicians as patients need time to consider the option.

B) **Arranging consultations and diagnostics**

- Clear explanations of:
    - Who is responsible at each stage
    - How patients raise concerns or request changes
    - What happens if technology fails
- Offline alternatives must be visible, not hidden

C) **Stages of treatment**

- Visual pathway explanations (simple, accessible formats)
- Clear points of human contact
- Explicit reassurance about safety, continuity and escalation back to local services

4. What communication is needed to help patients and clinicians understand their new choice?

Communications should avoid assuming that patients expect or prefer digital-first care. While some patients welcome virtual options, expectations and preferences vary widely and are influenced by access, confidence and prior experiences.

Messaging should:

- Be consistent across GP practices and systems
- Emphasise choice rather than digital-first as a default
- Clearly explain suitability and limitations of virtual care
- Make non-digital routes highly visible and easy to access
- Support clinicians to have nuanced conversations about appropriateness

Without this, there is a risk that patients feel steered towards digital pathways due to system pressures rather than personal choice and that "choice" becomes unevenly applied, with digitally confident patients benefiting most.

All patient-facing information, training materials and public communications should be written at a reading age of 9–11, in line with NHS guidance. Current policy language is highly technical and ambiguous, which risks undermining informed consent and meaningful choice.

If patients cannot clearly understand how the Online NHS Trust works, they cannot make informed decisions about whether to use it or how it affects their care.

5. From your knowledge of local patient experiences, what do you see as the main benefits of the Online NHS Trust for patients in your local area? In your response, please identify where these benefits may differ for different cohorts (for example, considering characteristics, geography, digital literacy).

From our knowledge of local patient experiences in Nottingham and Nottinghamshire, the Online NHS Trust has the potential to improve access to elective care for some patients, particularly where long waiting times and limited specialist capacity currently affect local services.

For digitally confident patients, virtual consultations may offer greater flexibility, reduced travel and quicker access to specialist advice, particularly for follow-up appointments or routine reviews. This may be especially beneficial for people in work, education or with caring responsibilities, and for patients who currently travel significant distances for specialist care.

For some patients with long-term conditions, virtual care may reduce the burden of repeated in-person appointments, provided continuity of care and clear escalation routes are maintained.

However, these benefits are not experienced equally. Patients with lower digital confidence or access, including some older people, disabled people and those facing socio-economic disadvantage, may experience limited benefit unless substantial human support and non-digital alternatives are in place. While remote care may reduce physical travel barriers for some disabled people, others, including people with visual impairments, learning disabilities or neurodivergence, may encounter new accessibility challenges if digital systems are not carefully designed and supported.

Overall, the Online NHS Trust may offer meaningful benefits for some cohorts, but these are highly dependent on digital access, confidence and support. Benefits should therefore be assessed across different groups to ensure improvements in access do not inadvertently widen inequalities.

6. What are the key areas of concerns for local Healthwatch organisations about the offer of elective care through the Online NHS Trust and how should they be mitigated?

Healthwatch Nottingham and Nottinghamshire's key concerns regarding the offer of elective care through the Online NHS Trust, and the mitigations we believe are required, are set out in detail in the *Key concerns identified by Healthwatch Nottingham and Nottinghamshire* section at the start of this response.

In summary, these relate to the risks of widening health inequalities and digital exclusion, underestimation of workforce and relational care requirements, continuity of care and local accountability within a national virtual model, a robust governance structure, safeguarding of children and vulnerable adults, and the regulation and oversight of a fully virtual NHS trust.

7. How can we work with you and the public to design the Online NHS Trust?

Healthwatch can and should support co-design through engagement with diverse local communities, particularly those least likely to benefit from digital-first models.

This requires meaningful involvement, feedback loops and appropriate resourcing to ensure insights lead to tangible change.

8. How should DHSC evaluate whether the policy is a success for patients?

Evaluation should go beyond activity volumes and waiting times to include:

- Equity of access and outcomes
- Patient understanding and confidence
- Experience of continuity and coordination
- Ability to exercise choice and switch pathways
- Safety and safeguarding outcomes

9. What should the new Online NHS Trust learn about processes for capturing and responding to patient complaints?

Healthwatch Nottingham and Nottinghamshire's July 2024 report on NHS complaints — *Learning from complaints: experiences of people across Nottingham and Nottinghamshire* — highlights systemic barriers that patients commonly experience when seeking to raise concerns with health services. These include challenges navigating complex complaints pathways, lack of clarity about how concerns are handled, long delays in resolution, and limited feedback on actions taken once a complaint is made (see *Learning from complaints* report, Healthwatch Nottingham and Nottinghamshire, July 2024).

Applying these insights to the design of complaints processes for the Online NHS Trust, we believe the following principles are essential:

1. Accessible, multi-channel complaints routes
Complaints processes must be clearly visible and easily accessible through both digital and non-digital channels. Not all patients will use, or be comfortable with, digital pathways, and layers of automated processes can create barriers.

2. Clarity and support through the process
Patients should receive clear guidance on how to make a complaint, what will happen next, expected timeframes, and how to escalate if unresolved. Staff should be trained to navigate and communicate the complaints process effectively.

3. Timeliness and transparency
Delays in complaints handling can erode trust and confidence. Mechanisms should be in place to ensure timely acknowledgement and resolution, with transparent reporting on outcomes, learning and service changes resulting from complaints.

4. Integration with local systems and oversight
Complaints should not sit in isolation within a national digital trust. Mechanisms are needed to share complaints data and learning with local systems and organisations,

including Healthwatch, Integrated Care Boards and local providers, to ensure that issues with virtual care inform broader system improvements.

How patients of a non-geographical NHS Trust will access democratic and statutory routes of redress, including elected members, local authority health scrutiny committees and local advocacy, must be clearly defined. Without this, patients risk losing routes of accountability that exist for place-based NHS providers.

5. Independent feedback and escalation options

Patients must be able to escalate unresolved complaints through independent routes such as the Parliamentary and Health Service Ombudsman. The Online NHS Trust should clearly signpost these routes and actively support patients to use them.

The move to bring patient voice and feedback "in-house" within NHS organisations is particularly problematic for a national, non-geographical digital trust. The consultation document does not explain how independent patient voice, currently delivered by Healthwatch, elected members, Health Overview and Scrutiny Committees and advocacy organisations, will operate, be accessed or be resourced when care is delivered by a provider with no place-based footprint.

Without explicit provision for independent, external scrutiny, there is a real risk that complaints and patient experience are absorbed into internal systems that lack transparency, local intelligence and democratic accountability.

Learning from complaints must therefore be transparent and shared with local systems and independent bodies such as Healthwatch, so that issues arising from NHS Online care can still be challenged, scrutinised and acted on at a local level.

10. How should the Online NHS Trust ensure people's experiences are captured and used for service improvement?

Patient experience should be captured throughout care pathways using both qualitative and quantitative methods. Particular attention should be paid to identifying risks that may be less visible in virtual care, including safeguarding concerns. There must be clear evidence that feedback informs service improvement and is acted upon.

11. Do you have any wider comments that you would like to share?

The ambition to reduce waiting times and improve access is welcome. However, digital tools are not automatically fair or neutral. Without robust safeguards, clear accountability and sustained human support, the Online NHS Trust risks widening inequalities and undermining trust. Addressing these issues early will be essential to delivering benefits for all patients.

We note that while the consultation refers to the establishment of the Online NHS Trust as being under 'consideration', key elements of the model, including service scope and senior leadership recruitment, have already been publicly announced. This raises questions about the extent to which this consultation is intended to inform

strategic decisions, as opposed to implementation details. Clarity on this point would support meaningful engagement by Healthwatch and the public.

We are also concerned that the proposed operating model has not been tested in a defined geography that includes the full complexity of real-world care, including social care, safeguarding, discharge, complaints and democratic oversight. Rolling out a national digital trust without this system-level testing risks repeating past failures where technology worked in isolation but failed patients in practice.

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