# Board in common

## Questions from the public

**Tuesday 15 July 2025, 9:30-12:00**

**The Oak Suite, W12 Conference Centre, Hammersmith Hospital**

This document summarises the questions submitted in writing to the board in common for the meeting on 15 July 2025 and the responses provided.

### Questions relating to capital funding

Why is no clear way forward spelled out on the rebuilding and renewal of St Mary's Hospital, which not only serves a hugely diverse and needy local population but has a national and international profile for research and innovation?

In January 2025, the Secretary of State for Health announced that St Mary's Hospital (SMH) was assigned to "Wave 3" of the New Hospitals Programme funding streams – with construction not due to begin on SMH until 2036.

As a result of this announcement, several groups (including MPs, Westminster City Council, Imperial College, and the Trust) all came together to form a Taskforce to determine a way forward for SMH to be built before this proposed date. This has involved a good deal of exploratory work into funding mechanisms and possible avenues of work.

Due to the complex nature of the hospital redevelopment, and the scale of funding required, it is important that due diligence is done by the Taskforce, and that appropriate stakeholders are consulted. This is to ensure that when a proposed way forward is announced, the details and direction are clear, unambiguous, and fully costed with potential funding models assigned.

At the time of the January 2025 announcement, it was agreed that the design and town planning activities for the new hospital would continue. The Trust has received the first tranche of funding to support this work which will commence in September. This is in parallel to the Trust and Taskforce partners continuing to explore funding mechanisms to accelerate the delivery of the new SMH.

Why is there no capital funding at all for its' sister hospitals in the Imperial Group, Hammersmith and Charing Cross?

In January 2025, the Secretary of State for Health announced that the Hammersmith and Charing Cross hospitals were assigned to "Wave 3" of the New Hospitals Programme funding streams – with construction not due to begin until 2036.

As these are important hospital sites in need of rejuvenation, the Trust petitioned NHP for some interim funding to support some key strands of activity which could be

accomplished as “No Regrets” work packages, to prepare the way for the main construction work to begin in 2036.

However, the Trust was not granted the additional funding sources by NHP, and so work cannot continue for the time being. Additionally, given the scale of activity to be conducted across the Trust with all the required redevelopment work, the urgent nature of the work at Hammersmith and Charing Cross hospitals is not as time critical as it is for St Mary’s Hospital. As such, the Trust has made the decision to focus the majority of effort in driving that forward.

However, conversations remain live with Hammersmith and Fulham council to identify potential opportunities, and these will be evaluated and acted upon, as and when they arise.

By contrast what funding is allocated for the new Neighbourhood Centres envisaged across NW London as part of the NHS 10 Year Plan to allow primary care to be “closer to home"?

The design and development of Integrated Neighbourhood Teams is one of the priorities within North West London Integrated Care Systems Joint Forward Plan. The goal is to simplify access to care for people who need it infrequently, provide more proactive and personalised care organised around a multidisciplinary team (linked to specialist input where needed) for people with long term health needs, and offer greater support to prevention. The focus for 2025/26 is on two care models: proactive care for older adults with frailty; and children and young people’s health.

Neighbourhood Centres were announced as part of the NHS 10 Year Plan and need to be incorporated into local capital investment plans. The Acute Provider Collaborative will be supporting local partners as they bid to be part of Phase 1 of the nationally announced programme to be involved in the National Neighbourhood Health Implementation Programme (https://www.gov.uk/government/news/government-takes-action-to-deliver-neighbourhood-health-services). Since the 10 Year Plan publication earlier this month, no capital has yet been allocated to these plans across NW London. Decisions on capital investment will follow in time as these plans progress.

## Question relating to productivity

Turning to paper 4.3.3 (*Productivity Report*) which analyses in great detail over some 30 pages productivity issues across the Collaborative and can be summed up as saying APC-wide productivity has improved +5.7% in 2024/25 vs the prior year, compared to a +2% national average and that productivity remains 2.5% below pre-pandemic (2019/20) levels, but that’s significantly better than the national position (which is 10.9% lower), the question remains as to what is the overall definition of productivity and what part is played in it by the morale of the workforce?

Productivity is measured in various ways for healthcare, one of which is the measure undertaken nationally by NHS England. The definition for this measure is as per below:

“Productivity is a measure of outputs relative to inputs, which is well-established in the wider economy. In healthcare, it can be summarised as the amount of activity the NHS delivers (appointments, scans, etc) for the inputs used in delivering that activity (on staff, consumables, buildings, etc). Broadly speaking, increasing the volume of outputs by more than the volume of inputs leads to productivity growth, or maintaining output but with fewer inputs. It is important to measure these improvements, as it describes how public resources are utilised and may demonstrate the extent to which public services are delivering value-for-money.” (Source: NHS trust productivity (2025/26), [draft] methodology document)

More details can be found here NHS England » NHS productivity

Another useful published briefing on NHS productivity is available on the House of Commons library here CBP-10313.pdf. This paper sets out how and why healthcare productivity is measured, reflecting different views on what should be measured and what different measures mean. It also lays out recent trends in NHS productivity, the explanations given for these trends and outlines the potential changes that have been proposed to increase productivity.

There is a section within this paper specifically addressing research linking ‘staff morale’ to the productivity challenge (section 4.4).

## Questions relating to the North West London Elective Orthopaedic Centre (EOC)

Please clarify exactly how the issues with the Federated Data Platform were resolved, and what is happening with the unresolved issue with clinicians accessing patient records across different platforms. Both appear to relate to digital issues which are interfering with the fullest use of the EOC. All patients in NWL with applicable conditions are interested, the arrival of which was greeted with such enthusiasm by patients, and we note a paper is critical on "productivity", which has presumably been affected. We should appreciate more detail, and to understand whether the EOC is operating at closer to full capacity - and, if not, how this is affected by these issues, and what is being done to solve them. I raised the 2nd bullet-pointed issue at Information Governance and there was concern from a clinical safety point of view, and this was being taken up, we understand.

Clinicians on site at the EOC now have access to their local records, including the ability to request tests. However, a key outstanding issue remains: the imaging systems (PACS) across the four Trusts are not yet integrated for viewing images directly from the EOC.

To mitigate this, images are manually uploaded to Cerner (Electronic Patient Records). While this process introduces a short but unavoidable delay that poses a clinical risk, it is actively managed by the EOC team through immediate uploads and subsequent review by the operating surgeon.

Have there been any issues of clinical safety arising from the above issues?

While it is recognised that surgeons currently do not have access to live images, this is mitigated by making electronic images available via Cerner.

To date, there have been no known clinical safety incidents arising from this issue.

EOC: The first main reference to the EOC in the papers on page 19 refers to "high activity, strong outcomes and reduced orthopaedic waiting list inequalities across NW London". It then mentions In addition challenges on "managing activity and financial flows, with funding discussions ongoing". Whilst Ms Nightingale highlights the benefits to patients, Ms Downs "raised the need to balance referrals" and Mr O'Donnell "called for more radical referral reforms to avoid cancellations". The next steps include progressing funding discussions with the ICB, and standardising pre-op assessments and pooling patients. There is also a favourable comment on strong & positive feedback on the EOC at 2.6.3 on page 246 is accompanied by, again, concerns about its financial sustainability remain.

i. What has changed in the agreed ICB funding model?

The NHS England 2025/26 priorities and operating guidance revised the rules under which the EOC was operating. When it was launched we had a payment for activity model which meant that we were paid for all the work we do, to one where there is now a cap on the amount of activity the ICB will pay for. In addition, a productivity gain is expected which means the same volume of activity is now expected to be delivered using fewer theatre sessions or lists.

ii. What is meant by balancing referrals, and by radical referral reforms?

The EOC operates as an inpatient service, where surgeons suggest/propose high-volume, low-complexity patients for procedures at the centre. This model helps free up capacity at the home Trust for more complex cases and reduces the risk of on-the-day cancellations due to seasonal pressures.

At present, not all Trusts are taking the same advantage of the EOC. To address the current imbalance in referral volumes from partner organisations, the EOC is working to standardise key processes, including:

- Centralising and pooling patients across surgeons and sites
- Standardising referral criteria and pre-operative assessment (POA) pathways
- Developing a shared/single patient tracking list (PTL) via the Federated Data Platform (FDP) to improve visibility and streamline referral acceptance

These efforts aim to reduce administrative burden, increase throughput, and align with GIRFT (Getting It Right First Time) recommendations for delivering high-volume, efficient elective care.

iii. Were/Are the FDP/Cerner issues affecting the financial sustainability in this first year (and now going forward), and are these taken into account when dealing with the financial stability issues?

In its first year, the EOC experienced a planned reduction in productivity due to its start-up phase, which was anticipated and factored into financial planning. While the Federated Data Platform (FDP) is accessible to all partner organisations, the EOC currently only has visibility of patients who have been proposed. Work is ongoing to implement a shared or single Patient Tracking List (PTL), which will

allow the EOC team to triage patients more effectively based on clinical need and waiting times. Improved access to a shared PTL will support financial sustainability by enabling the EOC to proactively prepare patients for surgery, broaden the pool of eligible cases, and increase surgical throughput. These developments are being considered as part of the wider strategy to address financial stability going forward.

iv. What are the mitigations referred to, what level of usage is there from each Trust, and are there any blockages to use found by analysis?

Each Trust has been allocated theatre lists with productivity plans aimed at increasing activity and optimising case numbers per list.

**Mitigations in Place**

Cost Control through List Consolidation

To maintain financial efficiency, the EOC applies a two-week rule: underfilled theatre lists are stood down with two weeks' notice, allowing for effective staff redeployment. Additionally, a shift towards more day-case procedures – driven by new surgical contributors – has helped improve throughput.

Due Diligence via Intra-Trust Patient Pooling

To ensure equitable access and shared benefit across the collaborative, the EOC supports intra-Trust pooling of patients. This enables a more balanced referral flow and better utilisation of available capacity.

Trust Usage and Blockages

Usage levels vary by Trust, aligned with their allocated lists and productivity targets. While all Trusts are engaged, the absence of a shared Patient Tracking List (PTL) currently limits the EOC's ability to proactively identify and triage patients across the system. This is a key operational blockage under active review, with work ongoing to implement a shared PTL that will enhance visibility and coordination.

v. What are the "strategic priorities" referred to?

The strategic priorities of the NWL EOC are centred around transforming elective orthopaedic care for the North West London population. These include:

- Centralising routine orthopaedic surgeries within a dedicated, purpose-built facility at Central Middlesex Hospital.
- Maintaining a protected elective surgical environment, separate from emergency services, to:
- Provide faster and fairer access to treatment.
- Minimise cancellations and delays caused by emergency pressures.

- Ensure consistently high-quality care delivered by experienced orthopaedic surgeons.
- Improve clinical outcomes and enhance the overall patient experience.
- Reduce waiting times for routine orthopaedic procedures across the sector.

These priorities underpin the operational and clinical model of the NWLEOC and guide its ongoing development.

## Question relating to virtual wards

Virtual Wards use is referred to. What wearable devices, apps, etc are used in remote monitoring, and how is consent of the patient dealt with? (Many of the patients may be vulnerable). In light of the proposals for the Single Patient Record (referencing such devices, apps) in the 10 year Plan, there is some patient concern about the use of such devices in future from an information governance point of view, and it would be useful to know what is used for Virtual Wards, even though the SPR is not in being as yet.

At London North West University Healthcare NHS Trust (LNWH), we participate in the North West London (NWL) Virtual Ward programme, which uses the *Doccla* remote monitoring platform. This enables safe monitoring of patients at home using a preconfigured kit containing medical-grade devices, including:

- Pulse oximeter (for oxygen saturation),
- Blood pressure monitor,
- Thermometer, and
- Weighing scale.

Patients are issued a tablet with the Doccla application, which securely transmits data to clinical teams. All devices are sanitised, reset, and quality-checked between patients to ensure safety and privacy.

**Consent and Support for Vulnerable Patients**
Before enrolment, patients undergo a clinical suitability assessment to ensure that remote care is safe and appropriate, taking into account their clinical condition, home environment, and digital confidence.

Informed consent is obtained through a direct discussion covering the purpose of the virtual ward, the technology used, how data is handled, and the right to opt out at any time without impact on their ongoing care. Where a patient lacks capacity, decisions are made in line with the *Mental Capacity Act 2005*, involving carers and relevant professionals where appropriate.

**Data Protection and Information Governance**
The Doccla platform was procured through standard NHS processes and is fully compliant with the UK GDPR and the Data Protection Act 2018. A Data Protection Impact Assessment (DPIA) has been completed, and implementation is governed by our Chief Information Officer in partnership with the NWL ICB Virtual Ward programme. All patient data is encrypted and stored securely, with controlled access. Devices have patient-set passwords and are wiped and reconfigured following each care episode.

**Integration with the Single Patient Record (SPR)**
As the regional SPR develops, we remain committed to ensuring that any integration of wearable or remote monitoring data is governed by strong data protection standards, transparency, and clear patient consent. All significant changes are overseen by a multi-agency governance process led by our Deputy Medical Director and NWL ICB programme board.

We recognise that patients — especially those who are vulnerable — may have concerns about digital healthcare and data sharing. We are committed to upholding their rights, dignity, and confidence as we continue to evolve our care models. As a reflection of this, 86% of our adult virtual ward patients said they would recommend our service through the Friends and Family Test — and this figure was 100% for our paediatric virtual ward — demonstrating our commitment to working collaboratively with patients while ensuring a safe and positive care experience.

We welcome ongoing dialogue with patients and community representatives on this important topic.

## Questions relating to the Collaborative Data and Digital Committee Report

### What are the "latency issues" at LNWH and THHFT?

Latency is the term we use to refer to the lag between data being updated in the Cerner system (which is the legal clinical record) by a clinician and it appearing in the FDP, which we use for improving patient management through a suite of applications, including one called timely care hub which gives staff on the ward a view of what patients are waiting for and whether they have received it.

Currently at LNWH and THHFT data flows from Cerner to the Trusts' data warehouses before being sent to the FDP. The data warehouses were designed for general reporting, most of which does not need to be real time. This means that they create a lag of several minutes between Cerner being updated and you being able to

see this in the Time Care Hub or the Discharge Management System or other solutions. This is not a clinical risk, but it is an irritation and makes the FDP less useful to our clinicians

ICHT and CWFT have developed direct connections between the Cerner and the FDP so do not see the same problem. We are working on resolving this for LNWH and THHFT and are confident it will be resolved in a few weeks.

How are the "data centres" and their use of energy and water factored into the Collaboration's green plan and Sustainability?

The IT teams and sustainability leads work together to ensure that the environmental impact of the Trusts' data centres is considered in the Green Plan. This will include completion of NHSE's Data Centre Sustainability Self-Assessment.

The Care Information Exchange as it is at the moment is valued by many patients; it appears that there is an intention potentially to change provider. Will the substance of CIE remain as currently, and what does it add to the NHS App? Is this what is referred to in para 3 bullet point 4?

The NHS App is being developed to provide an increased range of functionality. If at any time in the future there was a change of system, it is intended that the information that is provided by the Care Information Exchange will continue to be available to patients.

Ambient Scribe pilot, recording clinical visits as they occur. What patient consent will be obtained for recording, and what are the protocols for clinician's checking the resultant "product" of the recording (especially as AI is involved) from a clinical safety point of view? It appears from the 2nd bullet point in para 3 that various tools are being piloted, and that caution is noted as to only using HMRA approved tools. Have all tools currently piloted been through information governance approval, and if so where (nationally/locally)?

Guidance has been given to all the clinicians that are participating in the pilots that patients must be informed that that this technology will be used. Agreeing to do this and to check the resulting text prior to it being committed to the record is a prerequisite to their participation.

We are evaluating the range of ambient scribe tools that are available through a series of pilots. The aim of the pilots is to inform us of the benefits and challenges of these tools in advance of seeking approval from the APC Digital and the AI Committee to proceed with wider use. This would require a business case being developed that will look across the whole market of ambient scribe products that are available for use in an acute healthcare setting.

I am extremely concerned with the way everything is going digital whether we like it or not. Soon enough there will be costly mistakes paid by patients. And when digital does not work, who or what takes over? Having had to change my car because of ULEZ I had my first encounter with TFL. As a result, I received an email last year to be told they had been hacked and personal information had been stolen.

The shift toward digital systems in healthcare is accelerating. While that brings significant benefits, such as improved access to information, streamlined workflows and enhanced patient engagement, it also introduces new cyber security challenges. That is why we're working hard to ensure that digital transformation is not just about technology, but also about safety and resilience. We are actively addressing these risks through several measures:

- Incident tracking and learning - We monitor and review digital-related clinical incidents so that issues are identified early and can be addressed before they impact patient care.
- Risk governance - All systems are reviewed for data protection, clinical safety, and residual risks.
- Education and communication - We're investing in digital literacy for staff to help everyone understand the cyber security risks that we face.
- Contingency planning - We maintain business continuity plans to manage situations where digital systems are unavailable. For example, we keep an up-to-date local copy of the medical records for inpatients to ensure we can still see clinical information about them even if we lose access to our main electronic patient record system.

## Questions relating to Mount Vernon Hospital (MVH) and Hillingdon Minor Injuries Unit (MIU)

The report says the service at Hillingdon will be improved by the transfer of the permanent staff to Hillingdon hospital and improve the service at Hillingdon which is largely agency staffed. This assumption assumes staff will transfer and not leave or retire. Because of the additional travelling staff will have it's likely to mean staff leaving. This will then mean more agency staff at Hillingdon and therefore defeats the arguments put forward for an improved service.

If ANP/ENPs leave because they have chosen to work at MVH and do not wish to transfer to Hillingdon this will surely put more strain on junior drs at Hillingdon? Are Hillingdon running a recruitment drive to increase their number of nurse practitioners?

We are confident that we can achieve the desired staffing levels for the minor injuries unit at Hillingdon Hospital and plans are in place for this.

As set out in the rationale, merging services allows redeployment of experienced staff to under-resourced areas, following the appropriate staff consultation. We do not plan to hold a recruitment process for nurse practitioners.

Has any short-term workforce risk modelling been done alongside the Hillingdon transfer plan, particularly around attrition, retirements, or increased agency reliance if permanent staff opt not to relocate?

An EQIA (Equity Quality Impact Assessment) has been performed for the transfer plan that includes these issues.