NHS
Whittington Health
NHS Trust

Trust Board meeting in Public Agenda

There will be a meeting of the Trust Board held in public on **Wednesday, 23 July 2025** from **9.15am to 10.50am** held at rooms A1 and A2 of the Whittington Education Centre, Highgate Hill, London N19 5NF

Item	Time	Title	Action
		Standing agenda items	
1.	*0915*	**Welcome, apologies, declarations of interest** *Julia Neuberger, Trust Chair*	Note
2.	*0916*	**Patient experience story** *Sarah Wilding, Chief Nurse & Director of Allied Health Professionals*	Note
3.	*0930*	**Draft minutes 21 May 2025 meeting** *Julia Neuberger, Trust Chair*	Approve
4.	*0932*	**Chair's report** *Julia Neuberger, Trust Chair*	Note
5.	*0940*	**Chief Executive's report** *Selina Douglas, Chief Executive*	Note
		Quality and safety	
6.	*0950*	**Quality Assurance Committee Chair's report** *Amanda Gibbon, Committee Chair*	Note
7.	*1000*	**Audit and Risk Committee Chair's report** *Rob Vincent, Committee Chair*	Note
		People	
8.	*1010*	**Workforce Assurance Committee Chair's report** *Rob Vincent, Committee Chair*	Note
		Governance	
9.	*1015*	**IPDC Chair's verbal report of 22 July meeting** *Junaid Bajwa, Committee Chair*	Note
10.	*1020*	**Q1 2024/25 delivery of corporate objectives** *Jonathan Gardner, Chief Strategy, Digital & Improvement Office*	Note
11.	*1025*	**Clinical Strategy** *Dr Clare Dollery Chief Medical Officer/Dr Charlotte Hopkins,*	Approve

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		Finance & Performance	
12.	*1030*	**Integrated performance scorecard** *Chinyama Okunuga, Chief Operating Officer*	Note
13.	*1040*	**Finance and capital expenditure report** *Terry Whittle, Chief Finance Officer*	Note
14.	*1050*	**Questions to the Board on agenda items** *Julia Neuberger, Trust Chair*	Note
15.	*1055*	**Any other urgent business** *Julia Neuberger, Trust Chair*	Note

Minutes of the meeting held in public by the Board of Whittington Health NHS Trust on 21 May 2025

Present:	
Baroness Julia Neuberger	Non-Executive Director & Trust Chair
Dr Clare Dollery	Acting Chief Executive
Dr Junaid Bajwa	Non-Executive Director (via MS Teams)
Amanda Gibbon	Non-Executive Director
Dr Charlotte Hopkins	Acting Medical Director
Professor Mark Emberton	Non-Executive Director
Chinyama Okunuga	Chief Operating Officer
Baroness Glenys Thornton	Non-Executive Director
Nailesh Rambhai	Non-Executive Director
Rob Vincent CBE	Non-Executive Director
Terry Whittle	Acting Deputy Chief Executive & Chief Finance Officer
Sarah Wilding	Chief Nurse & Director of Allied Health Professionals
In attendance:	
Liz O'Hara	Chief People Officer
Jonathan Gardner	Chief Strategy, Digital and Improvement Officer
Tina Jegede MBE	Joint Director of Inclusion & Nurse Lead, Islington Care Homes
Swarnjit Singh	Joint Director of Inclusion & Trust Company Secretary
Marcia Marrast-Lewis	Assistant Trust Secretary
Andrew Sharratt	Director of Communication & Engagement
Mirela Sidor	Patient Experience Manager (item 2)
Antoinette Webber	Head of Patient Experience (item 2)
Siobhan Mellett	Enhanced Recovery Specialist Nurse Practitioner (item 2)

The minutes of the meeting should be read in conjunction with the agenda and papers

No.	Item
1.	**Welcome, apologies and declarations of interest**
1.1	The Chair welcomed everyone to the meeting. There were no apologies.
1.2	The Chair restated the declared interests for herself, Junaid Bajwa, Mark Emberton, Rob Vincent and Nailesh Rambhai, who were all non-executive directors at University College London Hospitals (UCLH), and Amanda Gibbon, who was a non-executive director at the Royal Free Group. There were no new declarations of interest reported.
2.	**Patient story**
2.1	Sarah Wilding introduced the patient, Mr X, who attended the meeting to talk about his experience of receiving care from the Trust since 1997 and his role as a volunteer. He highlighted the following points to Board members:

	• His first experience of Whittington Health was in 1997 when he was brought to the emergency department (ED). His next interaction with the Trust was in 2008, when his GP advised him to attended the ED due to suspected appendicitis. He was immediately admitted as an inpatient and underwent an emergency appendectomy the same evening. Mr X reported that, on both occasions, he had received very good care and he was especially grateful for the speed with which he was treated for his appendicitis, which had become chronic. • Mr X attended Whittington hospital several times after that, with ear infections and other ailments. Most notably, he reported that his partner became an inpatient at Whittington Health, following his diagnosis of prostate cancer. Mr X explained that, as a former employee of the Bank of England, he had access to private health care but came to Whittington Health, when he realised that that a private hospital had limited resources to treat his cancer. Mr X was very complimentary about the care received at that time. • Since then, Mr X had made two further trips to the ED, following two accidents at home. The most recent accident took place in 2023, when he suffered a tear in the muscle in his right shoulder, for which he is still receiving treatment. Mr X thanked the staff involved in his care and reported that he had waited a significant period of time for a diagnostic test and a revised date for his procedure, which had been postponed.
2.2	During discussion, Board members raised the following points: • Clare Dollery apologised for the long waiting times for Mr X's appointments. She explained that the Trust was working hard to reduce the number of patients waiting for appointments, and, although there had been some considerable improvements, there was more to do. His story served as a reminder of the uncomfortable impact that long waiting times had on patients. On behalf of the Trust, Clare Dollery provided assurance to Mr X that the Trust would continue to work hard to reduce waiting lists. • Sarah Wilding asked Mr X to talk about his experience as a volunteer at the hospital. In response, he explained that he has a diploma in physical therapy and would therefore volunteer by giving hand massages to cancer patients in the chemotherapy unit and on care of the elderly wards. He found volunteering in this way both enjoyable and rewarding and said that time went by quickly on the days spent at the hospital. • Amanda Gibbon stated that long waiting lists were common across the NHS at this time. She asked whether there were any additional areas of support that the Trust could have offered while he was waiting. Mr X felt that the Trust did as much as possible for him as a patient. Currently, he was waiting for a physiotherapy appointment to treat a minor injury sustained at the gym. • Charlotte Hopkins asked whether, as a volunteer, he had observed any areas that could be improved or changed to help both patients and staff. Mr X said that he found that Cavell ward was sometimes congested and could be improved to facilitate better flow through the areas. He also fed back that the areas that he visited were clean and that food was prepared in hygienic surroundings.

	• Rob Vincent asked Mr X whether there were any other areas in which volunteers could be deployed. In reply, Mr X said that he had met two of his fellow volunteers while serving food to patients. The Chair agreed that it was beneficial for all of our volunteers to meet regularly. • Tina Jegede commended Mr X's contribution to the welfare of patients and suggested that he be linked with the Head of Wellbeing. • Clare Dollery added that massage therapists were on site offering hand massages as part of a staff wellbeing event. • Mr X stated that he would often provide a foot massage for his partner, who was receiving treatment for cancer, which he found to be soothing, and he felt that other cancer sufferers would also welcome feet and hand massages. • Antoinette Webber thanked Mr X for his story and for his time as a volunteer. She confirmed that Christmas parties and coffee mornings were arranged for volunteers to meet each other and that more would be done to ensure that volunteers met each other. **The Trust Board thanked Mr X for his patient story**
3.	**Minutes of the previous meeting**
3.1	The Board approved the draft minutes of the meeting held on 20 March 2025 as a correct record, subject to a correction in section 5.1 which should read as 10-year plan.
3.2	Action log updates were provided, as follows: • Sarah Wilding advised that the maternity patient story had been discussed with the Head of Midwifery and shared with the wider maternity team. She confirmed that the arrangements for combining women with complicated pregnancies on labour recovery wards were based on clinical need, and that patients who required close monitoring, were placed in high dependency wards, while women who were in labour were situated in side-rooms. Sarah Wilding added that members of the maternity team were also reminded of the importance of maintaining patient confidentiality and information governance. • Liz O'Hara confirmed that a listening event was planned to discuss violence and aggression from patients and visitors. The Chair suggested that non-executive colleagues be invited to the event to provide staff with the opportunity to discuss the issues with members of the Trust Board. Clare Dollery emphasised the need to support staff who had experienced incidents of violence and aggression. • Terry Whittle reported that a budget had been allocated for general improvements to the hospital site's environment.
4.	**Chair's report**
4.1	The Chair took the report as read. She highlighted the register of interests appended to her report. She also took the opportunity to thank Clare Dollery for her sterling work as the Acting Chief Executive since 1 April 2024. The Chair also thanked Charlotte Hopkins who had been seconded to the Trust as the Acting Medical Director from June 2024. Her time at the Trust would end on

	30 May and she would be missed by everyone who had had the opportunity to work with her. Clare Dollery would resume her substantive role as Chief Medical Officer, with effect from 1 June 2025.
4.2	The Chair also shared her observations from her walks around the hospital site and its service areas. She noted that many areas were noticeably cleaner, although improvements were still sometimes needed in the public toilets. The Chair reported that she had observed a clear, positive change in staff morale, with staff seeming friendlier and more approachable.
4.3	The Chair apprised Board members of two meetings that she attended. The first was a meeting with North Central London (NCL) End of Life Group which discussed improvements to end of life care across the sector. The second meeting was a University College London Hospital (UCLH) and Whittington Health experts' collaboration session held on 20 May. The event brought executives from both organisations together to discuss opportunities to collaborate. **The Trust Board received and noted the Chair's report.**
5.	**Chief Executive's report**
5.1	Clare Dollery summarised her report and drew Board members' attention to the following issues: • An NHS Chief Executives' leadership event took place on 29 April 2025, which focussed on feedback on the draft NHS 10-Year Plan, the importance of medium-term financial plans, and changes to the NHS Operating Model. • The Model Integrated Care Board (ICB) Blueprint was shared by NHS England (NHSE) with ICB leaders. This new guidance amended the role of the ICBs to that of a strategic commissioner with remits around population health, reducing health inequalities and access to high quality care. Under the new arrangements, NHSE's regional teams would focus on performance delivery and the accountability of providers' Boards. • There had been active planning for the implementation of neighbourhood working within Whittington Health. Both the Haringey Borough Partnership and Islington Borough Partnership had considered the role of neighbourhoods and how integrators would help to coordinate and facilitate their work. • The NCL ICB's Board had formally approved the decision-making business case for Start Well. This had confirmed the future position of the Trust's neonatal and maternity units, alongside maternity units in Barnet, North Middlesex University Hospital and at UCLH. She confirmed that all current maternity units in NCL would remain open, as planning for the implementation of the Start Well initiative continued. • The North Central and East London Provider Collaborative for Mental Health had launched an 18-month period of change in the provision of services previously provided at Simmons House. Under the new arrangements, there would be some beds for children and young people at the North London NHS Foundation Trust and home treatment teams and services for autism and learning difficulties would be enhanced.

	• Clare Dollery thanked Sarah Wilding and Chinyama Okunuga for their leadership at the nursing and midwifery awards and the administration awards event, which had taken place since the last report to the Board.
5.2	In discussion, Board members noted the following points: • Rob Vincent queried whether archived records were held on staff awards. In response, Clare Dollery confirmed that the awards were included in social media updates, and that the Communications Team would hold archive records for such events. • Rob Vincent also raised a query about concerns around the safeguarding functions at the NCL ICB. Sarah Wilding advised that providers had been requested to complete returns on their statutory safeguarding roles and that discussions on safeguarding roles at the NCL ICB were taking place and more would be known in due course. • Clare Dollery informed Board members that the NCL ICB had communicated with the NCL Health Alliance Executive Group on what the future for this function may look. • Clare Dollery thanked Charlotte Hopkins and Terry Whittle for their contributions and support. **The Trust Board noted the Acting Chief Executive Officer's report.**
6.	**Quality Assurance Committee Chairs Assurance Report**
6.1	Amanda Gibbon delivered a verbal report for the meeting held on 14 May 2025 and highlighted the following items: • The Committee reviewed the risk register, which showed an increase in new and highly scored risk entries. • The Committee discussed the increasing number of pressure ulcers and issues with equipment supplies for patients at home. • Good assurance was provided from the bi-annual safeguarding adults and children report. Concerns around pressures on staffing were also discussed. The use of multiple electronic patient record systems was highlighted as a source of particular challenges and risks, which made it difficult to gain a clear, real-time view of safeguarding activities. • The shortage of trained paediatric nurses was discussed. • The Committee reviewed progress with work to reduce ligature risks. • The Committee commended the Maternity Team for their successful year six maternity incentive scheme submission and noted that preparatory work had begun for the year seven submission. • The outcome of two clinical audits in respect of a postpartum haemorrhage and a third-degree tear were discussed. • The positive Friends and Family Test scores for the Barnet 0-19 Service were reviewed and the Committee welcomed the efforts made to engage service users through face-to-face interaction and a listening event. • A prevention of future deaths' notice (PFD) was discussed as an emerging issue. The Trust had not received notice of the inquest, so that the PFD was issued, without evidence from the Trust. A response was subsequently prepared which was sent to the Coroner and the Care Quality Commission. The Committee was informed that the Trust would work with the London

	Borough of Islington, which was also named in the PFD, to address the concerns highlighted. • An Ionising Radiation (Medical Exposure) Regulations inspection had resulted in the issue of an improvement notice for procedures and protocols. The Committee received assurance that all improvement actions would be implemented by the deadline. **The Board noted the Chair's verbal report for the Quality Assurance Committee meeting held on 14 May 2025.**
7.	**Eliminating Mixed Sex Hospital Inpatient Accommodation Statement of Assurance**
7.1	Sarah Wilding took the report as read. She explained that the Trust was required to provide assurance annually that patients who required inpatient/day case care were cared for in single gender accommodation. She drew Board members' attention to the recent UK Supreme Court decision, which had implications for transgender patients. Sarah Wilding explained that NHSE would review its guidance on same sex accommodation, in line with legislative changes and advice from the Equality and Human Rights Commission. The Trust's policy on same sex accommodation would be updated once the new guidance was issued. In the meantime, the Trust would continue to treat all patients with dignity and respect, based on clinical need. **The Trust Board approved the statement of assurance and noted the requirement to update both the policy and the statement of assurance when detailed guidance was available from NHS England.**
8.	**Annual Safeguarding Adults and Children Declaration**
8.1	Sarah Wilding presented the annual safeguarding adults and children declaration, which provided assurance that Whittington Health had met its statutory obligations. She confirmed that staffing in the children's safeguarding team had stabilised, with all statutory roles filled. Sarah Wilding highlighted the important partnership work between children and adult teams to support the most vulnerable children and adults locally.
8.2	Rob Vincent queried the recommendations made following the peer review of the children's safeguarding function at the Trust. Sarah Wilding advised 19 recommendations had been made, the majority of which had achieved compliance. Outstanding actions would be managed through planned team events and away days. The team would also look at the development of a strategic approach to safeguarding across the borough. **The Trust Board noted the Safeguarding Adults and Children Annual Declaration**
9.	**2024 NHS Staff Survey**
9.1	Liz O'Hara presented the report and highlighted the following key outcomes: • 2,351 members of staff responded to the survey, which represented an overall increase in the response rate by 1% from the previous year

	• The Trust achieved a staff engagement score of 6.98, showing a slight increase from the 2023 score of 6.94. • The Trust was slightly above average for six out of the nine people promises elements: 'we are compassionate and inclusive'; 'we are recognised and rewarded'; 'we each have a voice that counts'; 'we are always learning'; 'we are a team' as well as for the theme of 'Staff Engagement'. The Trust was average for: 'we are safe and healthy'; but scored slightly below average for: 'we work flexibly' as well as the theme of 'Morale'. • Staff engagement scores were positively reflected by positive impact made by health and wellbeing initiatives put in place at the trust. • There were four areas of focus for actions: health and wellbeing, improving management support when staff are unwell and improving the prevention of muscular skeletal problems; disability and making reasonable adjustments for disabled staff; improving staff appraisal rates and career progression; and promoting civility and respect.
9.2	Rob Vincent reported that the Workforce Assurance Committee would be looking at flexible working at a future meeting. Liz O'Hara explained that providing reasonable adjustments was also a key area of focus at UCLH and that both workforce teams would work together to make the necessary improvements. **The Board noted the results of the 2024 NHS Staff Survey and agreed the four actions areas.**
10.	**Annual workforce disability and race equality submissions**
10.1	Liz O'Hara introduced the report which provided an analysis of workforce, race equality and disability data. She confirmed that key actions arising from the analysis would be monitored by the Workforce Assurance Committee.
10.2	Tina Jegede highlighted the following workforce race equality standard (WRES) results: • Black and minority ethnic (BME) staff representation had increased from 45% to 49.2%. The level of unknown staff ethnicity disclosure had fallen to 13.8% from 18%. • Improvements had been seen in several indicators: bullying and harassment from staff and equal opportunities for progression. However, there had been a deterioration in indicators covering recruitment outcomes, disciplinary processes and bullying and harassment from patients. • The recruitment outcomes' indicator showed that the relative likelihood of white applicants being appointed from shortlisting compared to BME applicants had increased from 1.63% in 2024 to 1.79% in 2025. • The relative likelihood of BME staff entering the formal disciplinary process compared with white staff had increased to 2.51% in 2025 from 1.11% in 2024. The Trust was implementing the Restorative Just Culture initiative, which would help to reduce the number of disciplinary cases.

10.3	Tina Jegede reported the key findings from the workforce disability equality standard (WDES) indicators: • The number of staff who declared that they have a disability increased in 2025 by 1.6% from 2024 to 5.9% • Over the ten metrics, staff with a disability fared less well in terms of work experience when compared with staff with no disability. • Disabled staff felt under more pressure to return work when unwell compared with staff who were not disabled.
10.4	Tina Jegede drew attention to the action plans which focussed on recruitment, disciplinary processes, career progression, discrimination and bullying and harassment by patients, and reasonable adjustments. Swarnjit Singh welcomed the work on reasonable adjustments, which would continue as a priority. He reported that, during the previous year, the Trust was allocated a budget of £50,000 for reasonable adjustments which was used to provide support for 48 members of staff. In terms of the disproportionate presence of BME staff in formal disciplinary processes, Swarnjit Singh emphasised the importance of completing an equality impact analysis and drilling down in individual cases to see if the decision was justified, rather than only looking at the cumulative data provided.
10.5	During discussion, Board members raised the following points: • Glenys Thornton endorsed the approach used to carry out deep dives into disciplinary cases. • Liz O'Hara emphasised the need for a proportionate and equal response to disciplinary cases, plus the need to ensure that informal cases were treated equally and with the same rigour. • Rob Vincent commented on the increase in the BME workforce which had grown from 45% to 49%. It was acknowledged that better ethnicity reporting was a contributory factor. Tina Jegede added preceptor data showed that more BME staff were now in the organisation. • Chinyama Okunuga added that the transfer of the portering and domestic contract to inhouse provision had contributed to the increase in the BME workforce. She stated that this cohort of staff were the most junior across the organisation and that it was important to encourage the recruitment of BME staff across all levels. • Clare Dollery stated that unconscious bias did influence the level of support given to staff on a daily basis. This was often discussed in open forums with international medical graduates. • Charlotte Hopkins advised that that an expression of interest for a locally employed doctor tutor had been advertised. A candidate had been identified who would support international medical graduates, who were more susceptible to bully and harassment. • Chinyama Okunuga reported that anecdotal evidence suggested that Whittington Health had a reputation for bias and discrimination around the number of disciplinary cases directed at BME colleagues and that more needed to be done to change that perception.

	The Trust Board noted the outcomes from the WRES and WDES reports and approved their submission to NHS England by the deadline of 31 May.
11.	**Integrated Performance Report**
11.1	Jonathan Gardner presented the report. He drew attention to the outcome measures which were consistently above target. Chinyama Okunuga reported that meetings had been scheduled with community teams to develop recovery plans for areas that required additional support, specifically around waiting times in adult services for MSK and podiatry and children's services in relation to child development, mental health and Haringey communications. Sarah Wilding confirmed that there were two incidents of clostridium difficile in April, one of which was hospital acquired. The focus would remain on prevention in the hospital and on working with colleagues in the estates and facilities and infection prevention control teams.
11.2	Jonathan Gardener highlighted the following performance metrics: • All cancer metrics were on an upward trajectory. Performance against the 28-day faster diagnosis standard had been above the 75% target for two consecutive months. • The DMO1 diagnostic performance had decreased. • The number of 12-hour trolley waits increased from 71 in March to 223 at the end of April. • Performance against the ED four-hour waiting time standard was 70.3%. • Maternity births remained on a downward trajectory. • A new version of the performance report will be made available from May. • A total of three operations were cancelled and not rebooked during March • Theatre utilisation had marginally improved from 72.5% to 74.9%. The focus during the previous year had been on increasing the caseload and now, it would be on improving theatre utilisation. • The friends and family test scores had improved across all departments, registering 100% in maternity service. • Appraisal rates and compliance with statutory and mandatory training requirements had also improved.
11.3	In discussion, Board members raised the following issues: • Clare Dollery emphasised the need to become more productive and welcomed the focus on theatre productivity. • Tina Jegede commented that there was a declining birth rate in North Central London and an increasing birth rate in North East London. • Amanda Gibbon questioned whether the Start Well decision had had an impact in the number of maternity bookings. In reply, Jonathan Gardner confirmed that the number of bookings had remained static over the year. • Clare Dollery added that the reason for the re-emergence of Start Well was due to the falling birth rate which meant that a maternity unit would not have had the critical mass to be a safe, sustainable and high-quality facility. **The Trust Board noted the Integrated Performance Report**

12.	**Finance Report**
12.1	Terry Whittle presented the month one finance report and highlighted the following points: • At the end of April, the Trust reported a deficit of £3m, £1.4m adverse to plan. The deficit was driven by pay expenditure. Controls put in place on temporary staff bookings had started to take effect with a 26% reduction in temporary staffing costs between March and April. • The Trust delivered £0.47m in financial efficiency against a plan requirement of £1.8m • The Trust's cash balance was £46.4m, £3.8m favourable to plan. • Capital expenditure was £400k and it was expected that all of the 2025/26 capital allocation would be utilised.
12.2	Clare Dollery informed Board members that a communication had been sent out to all staff which explained the wider financial situation in the NHS, to help contextualise the changes needed to manage expenditure, especially staffing costs. **The Trust Board noted the finance report.**
13.	**Questions from the public**
13.1	There were no questions received.
14.	**Any other business**
14.1	There were no other items of business reported.

Meeting title	**Trust Board – public meeting**	**Date: 23 July 2025**
Report title	**Chair's report**	**Agenda item: 4**
Non-Executive Director lead	Julia Neuberger, Trust Chair	
Report authors	Swarnjit Singh, Trust Company Secretary, and Julia Neuberger	
Executive summary	This report provides an update and a summary of activity since the last Board meeting held in public on 21 May 2025.	
Purpose	Noting	
Recommendation	Board members are asked to note the report.	
Board Assurance Framework	All entries	
Report history	Report to each Board meeting held in public	
Appendices	None	

Chair's report

This report updates Board members on activities undertaken since the last Board meeting held in public on 21 May 2025.

I want to start by thanking all of our staff and volunteers for their continued hard work in delivering safe and quality services and a good experience for our patients during a time of very busy demand.

Staff awards

I thoroughly enjoyed attending the Trust's annual staff awards on 4 July. The theme of Living Our Values (innovation, compassion, accountability, excellence and equity) Everyday was ideal as we celebrated the amazing work that takes place by our teams. This year we received over 200 nominations, so the judging was very competitive. I want to thank Leah Davis, a radio presenter on Capital XTRA, and a stand-up comedian, who compered the awards excellently. Leah lives locally in north London and is due to come to the Whittington Health maternity department for the birth of her child. I also want to congratulate everyone who was nominated, who was selected to be a finalist, and who won their category. The full awards categories and winners are shown in the table overleaf.

Staff Award Category	Winner
Innovation or improvement of the year	Jen Gallagher, Clinical Psychologist and Joint Team Lead
Outstanding dedication to compassion	Kate Bayley, Barnet & Camden Children's Therapy Manager & Camden Designated Clinical Officer
Accountability: Paula Mattin emerging leader	Lisa Carrie, Critical Care Outreach Team Nurse
Respect: unsung hero	Sue Smallwood, Patient pathway coordinator
Commitment to Excellence in a clinical role	Hannah Williamson and Helen McGinley, Frailty CNS and Frailty Advanced Care Practitioner respectively
Commitment to Excellence in a non-clinical role	Mala Noor, Service Manager, Adult Community Services
Annabelle Lake Excellent Administrator of the year	Vanessa Dsane, Patient Coordinator, Access Centre
Outstanding Contribution to Ensuring Equity or reducing Health Inequalities	Louise Fisher, Communications and Engagement Officer
The Chair's award for living our Trust values	Haxhi Rrapi, Portering Manager
The patient award	All staff who cared for and supported the Vicary family

Private Board meeting, June 2025

The Board of Whittington Health held a private meeting on 23 June. The key items discussed at the meeting included the 2024/25 Annual Report and Accounts, the 2024/25 Quality Account, the quarter four delivery of our annual corporate objectives, the regular finance and capital expenditure report and our integrated performance report. The meeting also considered updates from the North Central London Health Alliance and on uro-oncology services. In addition, the meeting received reports from the chairs of the following board committees: Finance and Business Development, Quality Assurance, Improvement, Performance and Digital, and Charitable Funds. The Board approved revised terms of reference for the last three committees mentioned. Board members also had a seminar which included a helpful discussion on neighbourhood working.

Partnership Development Committee-in-Common

On 30 June, I chaired a meeting of the partnership development committee-in-common between University College London Hospitals NHS Foundation Trust (UCLH) and Whittington Health NHS Trust. The committee-in-common agreed revised terms of reference for the forum which will take effect from 1 September 2025. The Chief Nurses of both organisations, Vanessa Sweeney and Sarah Wilding, delivered a presentation which outlined the collaboration taking place in nursing and midwifery, and its focus on shared values, leadership, digital skills and knowledge, workforce, research, practise, and education. They identified four priority areas for the next 18 months: safety and quality, perinatal care, agile workforce, and access to education and research opportunities. The meeting reviewed a Programme Director's report which provided an update on priority areas for collaboration, the latest position for urology and uro-oncology and the opportunities

for collaboration in non-clinical areas such as legal services, training and development, inclusion and contract management.

Annual non-executive director appraisals
During June and July, I have completed all the appraisals required for non-executive directors on the board. Non-executive director colleagues have also been set specific objectives for their 2025/26 appraisal.

Consultant appointment panels
Since the despatch of papers for the last Board meeting held in public, the following recruitment panel took place, and I am grateful to Amanda Gibbon, Vice-Chair, who took part.

Post title	Non-Executive Director	Panel date
Anaesthetics	Amanda Gibbon	12 June 2025

North Central London Integrated Care Board
I am pleased to report that my term as a member of the Board as a partner member representing NHS trusts and foundation trusts has been extended from 1 July 2025 to 30 June 2026.

Other meetings
In addition to the meetings already outlined in this report, I have also participated in the following:

- The 23 May Charitable Funds Committee meeting
- Weekly North Central London Health Alliance calls
- The North Central London briefing on 29 May
- Regular one -to-one meetings with the Chief Executive and other members of the executive team
- On 9 June, I attended the corporate induction and a quarterly meeting between the London Borough of Islington and both Whittington Health and UCLH
- On 11 June, I received a briefing from the Information Technology team
- I attended the North Central London Integrated Care Board's (NCL ICB) Strategy Committee meeting on 18 June and had a separate meeting with Sarah Mansuralli, Chief Strategy and Population Health Officer
- On 19 June, I met with the programme team for the UCLH and Whittington Health collaboration, David Cheesman and Sana Burney
- On 25 June, I participated in the Medical Committee meeting
- On 7 July, I hosted a visit by Paul Najsarek, NCL ICB Chair to the Wood Green community diagnostic Centre with
- On 7 July, I also met with Dr Sarah Hyde, the new councillor for health and social are in Islington

I have also continued my informal walk abouts across Whittington Health, meeting individual staff, patients and visitors.

Meeting title	**Trust Board – public meeting**	**Date: 23 July 2025**
Report title	**Chief Executive report**	**Agenda item 5**
Executive lead	Selina Douglas, Chief Executive	
Report authors	Swarnjit Singh, Trust Company Secretary, and Selina Douglas	
Executive summary	This report aims to provide Board members with an update on strategic developments nationally, regionally and locally since the last the Board meeting held in public on 21 May 2025.	
Purpose	Noting	
Recommendation	Board members are invited to note the report.	
BAF	All Board Assurance Framework entries	
Appendices	1: 2024/25 Annual Report and Accounts Annual Reports 2: 2024/25 Quality Account Quality Account 2025 without cover.pdf	

Chief Executive's report

This is my first report to the Board as Chief Executive and I am delighted to have the opportunity to lead Whittington Health as its Accountable Officer. I would like to start by thanking all of my colleagues, who have been incredibly welcoming during my visits to different services on the acute and at community sites, for their hard work to maintain safe services in the face of high demand.

On 5 July, the NHS reached its 77th birthday and has done so at a very busy time with a significant amount of new national announcements being made recently.

Urgent and Emergency Care Plan

On 6 June, NHS England published the 2025/26 Urgent and Emergency Care Plan[1] which outlines how patients will receive better, faster and more appropriate emergency care. Supported with nearly £450m of investment, this Plan aims to deliver 40 new same day emergency care and urgent treatment centres, avoiding unnecessary hospital admissions; provide up to 15 mental health crisis assessment centres to help them avoid waiting in emergency departments; and almost 500 new ambulances will be rolled out across England by March 2026.

National maternity investigation launched to drive improvements

On 23 June, the Secretary of State for Health and Social Care announced that there will be a rapid investigation into NHS maternity and neonatal We will review the investigation's recommendations to ensure the actions outlined nationally are addressed appropriately and will be considered through our governance structures. services to help provide answers to families and to urgently improve care and safety. On 16 July, I attended the From Insight to Impact Conference supported by the Royal College of Midwives and Royal College of Obstetrics and Gynaecology which focused again on the importance of compassionate care in health and working with families and clinicians to design safe, high quality services.

2025/26 NHS Oversight Framework

The new NHS Oversight Framework was published on 26 June and sets out a consistent and transparent approach to assessing Integrated Care Boards, NHS trusts and foundation trusts, ensuring public accountability for performance and providing a basis for how the NHS England works with integrated care systems and providers to support improvement. The framework has been developed with the engagement and contributions from NHS leaders and staff, representative bodies and others through two public consultations and shows how organisations will be assessed, alongside a range of agree metrics, promoting improvement and providing support where it is needed most. At the time of writing this report, the national segmentation for individual providers was due to be published.

10-Year Health Plan

On 3 July, the Department of Health and Social Care published Fit for the Future: 10-year health Plan for England[2] which sets out in detail how the NHS will be transformed, with three national priority announcements: from hospital to community

[1] NHS England » Urgent and emergency care plan 2025/26
[2] Fit for the future: 10 Year Health Plan for England

settings, from analogue to digital, and, from sickness to prevention. The aims for these three priorities in the plan are shown in the table overleaf.

National shift	Aims and benefits
From hospital to community:	• Easier to see your GP and end the 8am scramble for appointments, through more GPs, longer opening hours and a guaranteed online appointment in 24 hours. • A Neighbourhood Health Centre in every community, open six days a week, 12 hours a day and staffed by GPs, nurses, care workers, physios, mental health workers and employment advisors. • NHS dental appointments thanks to new dental contracts tying newly qualified dentists to the NHS. • Faster referrals to specialists, prescriptions from your pharmacist and 24/7 neighbourhood mental health centres and dedicated mental health emergency departments.
From analogue to digital	• A digital single patient record will spare you repeating yourself and allow clinicians to design care around you. • AI-assisted doctors and self-referrals at your fingerprints through the NHS App, self-referral for talking therapies, and digitised therapies. • A digital red book will keep your children's health information in one place.
From sickness to prevention	• A partnership with supermarkets to set new standards for healthy options - making the healthy choice the easy choice for families. • A ban on energy drinks and a smoke free generation. • Expansion of weight loss services and treatments to tackle obesity. • New screening programmes, including home kits to test for cervical cancer. • More financial support for those on low incomes to help give kids the healthiest start in life. • More Mental Health Support Teams in school.

Review of patient safety across the health and care landscape

On 6 July, the Department of Health and Social Care also published Dr Penny Dash's independent review of patient safety across the health and care landscape in England[3]. This review looked at six national bodies (the Care Quality Commission, the National Guardian's Office, Healthwatch England and the Local Healthwatch network, the Health Services Safety Investigations Body, the Patient Safety Commissioner and NHS Resolution) and effective leadership and regulation of health and care systems in terms of patient safety. The main recommendations from the review are:

- To reinstate and significantly enhance the role of the National Quality Board
- Continue to build the Care Quality Commission with a clear remit and responsibility

[3] Review of patient safety across the health and care landscape

- Continue the Health Services Safety Investigation Body's role as a centre of excellence for investigations and clarify the remit of any future investigations
- Transfer the hosting arrangement of the Patient Safety Commissioner to the Medicines and Healthcare Products Agency, and broader patient safety work to a new directorate for patient experience within NHS England, transferring to the new proposed structure within Department of Health and Social Care
- Bring together the work of Local Healthwatch, and the engagement functions of integrated care boards and providers, to ensure patient and wider community input into the planning and design of services
- Strengthen and streamline functions relating to staff voice
- Reinforce the responsibility and accountability of commissioners and providers in the delivery and assurance of high-quality care
- Technology, data and analytics should be playing a far more significant role in supporting the quality of health and social care
- There should be a national strategy for quality in adult social care, underpinned by clear evidence

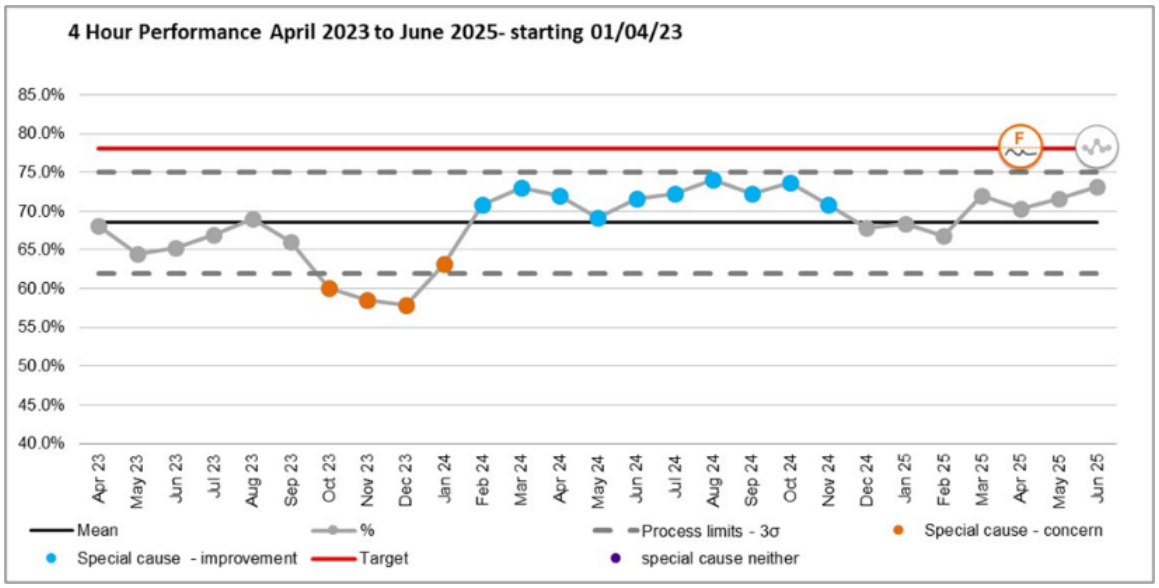
Industrial action
On 9 July, the British Medical Association (BMA) announced the outcome of its ballot. Resident doctors will take industrial action from 0700 on Friday, 25 July to 0700 on Wednesday, 30 July. The Secretary of State for Health and Social Care wrote to the co-chairs of the BMA Resident Doctor Committee and held constructive talks with them during the week ending 18 July. At this stage, Whittington Health is taking action to plan and prepare to minimise, where possible, the impact of this industrial action. Daily meetings have been taking place in preparation for the strikes. The Trust will be working with the ICB partners drawing on the experience from earlier industrial action. Patient safety remains our overriding priority.

London Chief Executives' event
On 17 July, I attended a meeting of chief executives with Caroline Clarke DBE, NHS England's Regional Director for London. The areas covered at the meeting included updates on diagnostic performance, the planned industrial action by resident doctors, the 10-year health plan and what it entails for London, an update on digital transformation work and on the future of commissioning.

2024/25 Annual Report and Accounts and Quality Account
In June, the Trust Board reviewed and approved our 2024/25 Annual Report and Accounts and our Quality Account which have been published on our webpages.

Emergency Department
The Emergency Department has continued to experience significant pressures. In June, performance against the four-hour access standard was below target, however, this was a marked positive step forward in emergency department performance, with performance going from 71.57% in May to 73.21%, demonstrating progress against the agreed improvement trajectory. Key contributors to this performance included a sustained performance exceeding 96% in the urgent treatment centre and 92% in the paediatric emergency department; an increased utilisation of the clinical decision unit and same day emergency care during out-of-hours periods; strengthened streaming pathways to align patients with appropriate care settings; and a focussed effort to minimise out-of-hours breaches.

Emergency Department attendances slightly decreased, from 9,198 in May to 9,127 in June, however, there has been an increase in average daily attendances from 297 patients in May to 304 in June. The number of 12-hour trolley breaches continued to decline, with 123 reported in June, down from 145 in May. Notably, mental health-related breaches saw a marginal reduction (20 in June, down from 22 in May) but remain above the year-to-date average. The Trust remains in active collaboration with system partners to improve timely access and discharge pathways for mental health patients. An executive led meeting has been scheduled with North London Foundation Trust in September to discuss how we can work together to improve the experience for mental health patients.



Reduction in Extended Accident & Emergency Waits

The proportion of patients experiencing stays exceeding 12 hours decreased to 5.5% in June, from 7.1% in May, supported by early system-wide escalation protocols involving community, mental health, social care and local authority partners; the continued delivery of the Flow Improvement Programme; a targeted reduction in criteria to reside and long length of stay; and an expansion of our virtual ward capacity and sustained success of the Airmid Bridging Service.

Visits

I have been struck by the kind welcome afforded me by all of the service teams I have been able to visit since starting at Whittington Health and am sorry that I cannot mention all of them here.

On 2 June, I visited the district nursing and virtual ward teams at the Hornsey Rise Health Centre, before seeing colleagues in our Emergency Department. On 19 June, I had the pleasure to visit the Wood Green Community Diagnostic Centre and see the positive impact it is having on the local population. At Wood Green, I was fortunate to also see the amazing North Central London Community Haemoglobinopathy Team who were celebrating World Sickle Cell Day. It was powerful to see engagement right in the heart of the community, raising awareness, breaking stigma, and promoting blood donation especially for sickle cell patients.

A breath of fresh air: garden opens at Tynemouth Road Health Hub

I was equally delighted to attend the Tynemouth Road Haringey Children & Young People Health Hub celebration of the official opening of its new therapeutic landscape garden on 27 June. The new urban green space has been designed to support health and wellbeing for local children, families, and staff. The project was brought to life through Whittington Health Charity's fundraising efforts and a successful bid for £150,000 from the Greener Communities Fund – a partnership between NHS Charities Together and the environmental charity Hubbub.

Pride in Health: Improving LGBTQIA+ cancer care at Whittington Health
Our Macmillan Support Team has been working on a project to better understand and improve LGBTQIA+ people's experience of health care. A training film and full training package is being developed. It will first be tested at Whittington Health

before being shared more widely across health and care services. We look forward to being able to share the training across the Trust soon to support greater awareness amongst our staff of the health inequalities affecting LGBTQIA+ people.

Health Equity Programme conference
I was also pleased to attend for part of our amazing health equity conference which highlighted information of health disparities and emphasised solutions through evidence-based practice and community collaboration, showcasing work that is already progressing at Whittington whilst inspiring participants to do more. The key message of the conference was that everyone has a role to play in building health equity and ensuring fair access to care and improved outcomes for all. I am particularly grateful; to Sana Burney who helped to organise the conference and to Professor Habib Naqvi MBE, Chief Executive of the NHS Race and Health Observatory who spoke passionately about the need to tackle health inequalities, and to the local Directors of Public health in Islington and Haringey.

All staff briefings
Three CEO All staff briefings took place on 12 and 23 June and on 10 July. The topics covered at the briefings include the new national plan for urgent and emergency care, the launch of a new supported mealtimes policy for patients, a spotlight on Pride month, the estates and facilities day held to celebrate our important staff who keep the trust and its community sites going each day, a spotlight on our first mini gastric bypass day case and the celebration of a Quality Improvement celebration event held on 8 July, the 10-year health plan, the review of patient safety across the health and care landscape and a spotlight on a simulated evacuation exercise in our intensive care unit.

OPAT project receives high commendation at UKHSA awards
I would like to congratulate colleagues from across our microbiology, pharmacy, digital informatics who were highly commended for their work in our outpatient parenteral antibiotic therapy (OPAT) service at the UKHSA Antibiotic Guardian Awards. Colleagues in the OPAT service manage patients with complex infections that are well enough to leave hospital and still need intravenous/complex anti-infectives or anti-infectives, that require regular monitoring. The project uses smart data to improve patient outcomes and support stewardship in patients' homes.

Extra Mile Awards
Each month we give out an award to one or two colleagues or teams that have gone the extra mile for patients or colleagues and really demonstrated our ICARE values. I would like to congratulate the following winners:

- Simon Anjoyeb, Workforce Inclusion lead, was nominated for always going the extra mile, supporting our staff networks with real care and consistency. He makes sure everyone feels included and heard. He has made sure that Whittington Health leads the way on inclusion not just with policies, but with action.
- Liliana Dobre, Catering Manager, who was nominated for delivering excellence every single day, being an amazing colleague, supervisor and peer who steps in when there have been unforeseen hiccups in hospitality, Liliana steps in and calmly resolves the situation. I have observed the way

she is with her staff members: supportive, helpful and a great hands-on team leader.

Annual staff awards

I thoroughly enioyed my first Whittington Health staff awards event to celebrate the wonderful achievements of our staff. Full details of the winners in each category are in the Chair's report to this Board meeting.

Meeting title	**Trust Board – private meeting**	**Date: 23 July 2025**
Report title	**Quality Assurance Committee Chair's report**	**Agenda item: 6**
Committee Chair	Amanda Gibbon, Non-Executive Director	
Executive leads	Sarah Wilding, Chief Nurse & Director of Allied Health Professionals, Clare Dollery Chief Medical Officer,	
Report author	Marcia Marrast-Lewis, Assistant Trust Secretary	
Executive summary	The Quality Assurance Committee met on 9 July 2025 and was able to take good assurance from the following agenda items considered: • Board Assurance Framework - Quality and Integration 2 entries • Surgery Quality Improvement Project – Martha's Rule • Patient Safety Incident Report • Patient Safety Incident Response Framework (PSIRF) report • 2024/25 Annual Complaints & PALs report • Patient Engagement and Patient Experience Audit • Q1 Maternity Board report • Perinatal Quality Surveillance Model • Fire Action Plan • Bi-annual Health & Safety Report • Safer Staffing The Committee took partial assurance from the following agenda items: • Risk Register report • Data Quality & Performance Pressure Ulcer Audit • Pressure Ulcer Update • Ligature risk assessment update In addition, the Committee noted: • Minutes of the meeting of the Quality Governance Committee held on 10 June 2025 when the following areas of escalation which covered: ○ Urology ○ Pressure Ulcers ○ Aggression and violence towards staff and how to support staff ○ HSL not meeting KPIs – lack of engagement and oversight of pathology services	

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	The Committee agreed that the following areas be brought to the Board's attention: 1. A prevention of future deaths notice and the coroner's findings linked with bi-annual safer staffing report 2. Urology and the strands of work to address the out of hours rota and uro-oncology MDT. 3. Pressure ulcers and the difficulties around inpatient non-concordance and NRS 4. Resident doctors' industrial action. 5. Increase in security incidents related to violence and aggression. 6. Patient Safety Incident Investigation into the death by suicide of a young person and talking therapies
Purpose	Noting
Recommendation	Board members are asked to: Note the Chair's assurance report for the Quality Assurance Committee meeting held on 9 July 2025
BAF	Quality 1 and 2 entries and Integration 2 entry
Appendices	1. 2024/25 Annual Complaints & PALs report 2. Bi-annual safer staffing report 3. PSII report

Committee Chair's Assurance report

Committee name	Quality Assurance Committee
Date of meeting	9 July 2025
Summary of assurance:	

1. Emerging Issues- QAC considered

a) Prevention of Future Deaths Notice - The Trust was in the process of preparing a formal response.

b) The Urology Service and measures to ensure it was sustained

c) Infection prevention and control in NICU and SCBU

d) Measures in place to ensure quality and performance were monitored during a focus on financial oversight

e) Staff concerns in estates and facilities

2. The Committee confirms to the Trust Board that it took good assurance from the following agenda items:

Surgery Quality Improvement Project– Martha's Rule

Committee members received a presentation on the implementation of Martha's Rule at WH. The initiative comprised of three components:

1. Patients are asked, at least daily, how they are feeling, if they feel better or worse which is responded to in a structured way.
2. All staff can escalate patients to the critical care outreach team.
3. An escalation route is available to patients and their relatives.

The Committee was informed that a telephone line had been launched on 2 December 2024 which is advertised in all adult and paediatric areas including ED. To date, the initiative had not revealed any deteriorating patients but had yielded a significant amount of learning and issues related to out of hours. A patient wellness questionnaire will include early warning scores that would facilitate good conversations with patients at their bedside.

The Committee noted that compared to other Trusts the direct telephone line was busier than most. Other trusts could receive between two to four calls per month compared to WH which received up to 12. Of the 85 calls received since December 26 were from people who were not inpatients and 59 inpatients. Nine patients were found to have concerns but were within their respective ceilings of care. There were no ITU admissions although one patient was referred to an ITU consultant. Most calls were received during out of hours

The Committee learned that funding for Martha's Rule was finite and would run out in November. Discussions were in progress to explore the governance of the telephone line after November and the expansion of the initiative into maternity.

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	The Committee thanked Lisa Carrie and Zoe Broadhead for their presentation and would look forward to receiving an update on progress in early 2026. **Q1 Board Assurance Framework (BAF) – Quality 1 and 2 and Integration 2 entries** The Committee discussed the risks to the delivery of the Trust's quality and integration strategic objectives. No changes were recommended to the BAF risk scores. **The Committee approved the Q1 BAF for the Quality and Integration 2 entries.** **Patient Safety Incident Investigation (PSII) report** The Committee considered a report on the outcome of an investigation into the death by suicide of a young person. The young person had received talking therapy through Haringey Adult Services which treated people from the age of 16. The investigation found that staff, who are trained to work with adults, did not have specialist training for working with children and young people. The service did not have a specific pathway for under 18s. Following the investigation, it was recommended that that the service age criteria for Haringey Adult Services are amended and brought in line with Camden and Islington to care for people aged 18+. It is recommended that the small numbers of 16- and 17-year-olds that are receiving a course of treatment are cared for by children's mental health services (CAMHS). **Annual Compliments, Complaints, and PALS Report** The Committee considered an annual overview of compliments, complaints, Patient Advice and Liaison Service (PALS) and quality alerts received during the period 1 April 2024 to 31 March 2025. Key highlights included: • 570 compliments, a decrease of around 10% on 2023-24 (631) • 362 complaints were received • The top 5 themes were communication, medical care, nursing care, attitude & delay • 98% of complaints were acknowledged within 3 working days, exceeding the internal target of 90% and in line with 2023-2024. • Around 7% of the complaints were de-escalated through the complaint lead investigator intervention eliminating the need for a written response. • Eight requests from the Parliamentary & Health Service Ombudsman (PHSO) for information were received, a decrease of 7 on 2023-2024 (15). • 402 PALS contacts were recorded (including 74 from GP practices regarding individual patients) a decrease of 332 in comparison to the previous year of 2,734 The Committee learned about joint working with UCLH and North Middlesex University Hospital to look at similarities, share learning and explore ways to engage individuals where English was not their first language. **The Committee noted the report** **Internal Audit Reports: Patient Engagement and Patient Experience**

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	The Committee considered Internal Auditors' review of their assessment of the systems and processes in place for measuring the success of outpatient engagement activities undertaken to improve the level of patient experience throughout the Trust. The review found that the Trust has good systems and processes in place for improving outpatient engagement and experience. Various initiatives included standardisation of appointment letters, multilingual patient surveys, and the establishment of focus groups and learning networks. The Outpatient Transformation Programme Board and the Quality Assurance Committee provided oversight of outpatient experience through regular reviews of complaints, Friends and Family Test results, and engagement activities. However, gaps remained in evidencing participation from gynaecology, including the reporting of national programme feedback, and the full implementation of outpatient transformation initiatives. The review received an Internal Audit opinion of reasonable assurance. **The Committee noted the report** **Maternity Services Quarterly Board Report – Q1 2025/26** The Committee received a summary of the work undertaken in the maternity department for quarter 1. The following points were highlighted: • A mock Care Quality Commission (CQC) visit was conducted on the 2nd May 2025. One of the main issues raised related to cleaning and specifically dust Ongoing discussions were in progress with estates and facilities. • The maternity unit in collaboration with the Maternity and Neonatal Voices Partnership developed an action plan to address the actions coming out of the CQC Patient Survey 2024. The action plan is monitored monthly through a multidisciplinary team meeting as well as through Patient Experience Group, Quality Governance Committee and at NCL LMNS board • The Trust will receive the return of its contribution into the incentive funds (£487,735), together with a share of unallocated funds (£319,860 in 2023, and around £400,000 in 2024). • The full Q1 2025/26 Perinatal Mortality Review (PMRT) report will be presented in the quarterly report to the board in September 2025. All PMRT reviews were on track. However, there were two terminations at >22 weeks due to fetal anomalies. • There were 116 incidents reported on Datix during the months of April and May. Themes identified related to o Massive Obstetric Haemorrhage (MOH) o Central CTG Monitoring o Term admission to NICU o 3rd degree tears o Medicines management • In accordance with MIS action 6 the midwifery coordinator in charge of labour ward has supernumerary status • There was 1 new midwife, 4.83WTE on short-term sickness, and 7.86 WTE on long-term sickness. Main reasons for absence related to stress related illness. **The Committee noted the Q1 maternity report.**

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	Population Health Update The Committee was informed that the Health Equity Steering Group had been mapping projects across the Trust that aimed to reduce inequalities. As part of the work a Health Equity event was held on 24 June which was attended by 60 people. Delegates included members of staff, colleagues from local councils, the voluntary sector, ICB partner providers and residents. Items covered at the event included a presentation from the NHS Race & Health Observatory, disparities in health outcomes related to ethnicity and deprivation. A panel session discussed adult community services and maternity care. Feedback from the event was positive and reported greater awareness of health inequalities and 10 people came forward to get involved with the programme. Key learning included the need to improve the communication strategy around health equity and broader representation across services and patient voices on panels at future events. Overall, the event proved to be a great step forward in building momentum around health equity. **The Committee noted the update on Population Health**
3.	**Committee members took moderate assurance from the following agenda items:** **Risk Register report** The Committee reviewed the risk register report which showed 48 risks ≥15 on the risk register, 43 of which were fully approved and five were awaiting approval. There were two new 15+ risks • 1641 - Limited baby electronic tracking tags available on maternity unit. Mitigating actions were in place. • 1635 - Safeguarding Data related to multiple record systems Six risks were increased • 1547 - Lack of storage space for IM&T equipment • 1502 - Complaints performance in Surgery & Cancer Division • 1169 - Fire deficiencies & non-compliance – PFI estate • 810 - Fire deficiencies & non-compliance –Retained Estate • 850 - Food safety training for ward staff serving patient food • 1621 - MASH Islington Three high risks were decreased: • 878 - Non-compliancy with National Cancer Access Standards • 1498 - Digital Imaging Software – Dental Service • 1589 - New Package of Care (POC) restrictions impacting virtual ward facilitating early discharge from hospital Two high risks were closed • 772 - S&C Division Not meeting CIP target and financial balance • 1597 - Due to Fire deficiencies NHSE Fire have recommended Block L Level 6 high risk patient groups be moved to lower level to reduce

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The Committee noted the Risk Register report.

Data Quality and Performance Management - Pressure Ulcer Audit
The Committee considered the report from the Internal Auditors review of the design of and compliance with the processes in place for managing, monitoring, and reporting on pressure ulcers. The audit identified some areas of good practice which included: a pressure ulcer improvement plan; pressure ulcer reporting; governance reporting of pressure ulcer management; and performance through the Pressure Ulcer Group; However, the review noted several data quality issues and weaknesses in the following areas:

- Periodic review of the Trust Data Quality policy.
- Clear procedural guidance within the Pressure Ulcer Prevention and Management Policy
- Inconsistencies in documenting, retaining and timely completing Waterlow assessments.
- Documentation of preventative measures for pressure ulcers including the Pressure Ulcer Prevention care plans and SSKIN Bundles.
- Clear procedural guidance of validation of pressure ulcer data and adherence.
- Timeliness of Incident Investigation.
- Poor compliance in relation to recording data accurately and completing the required validation.
- Clear KPI target reporting within performance reports.
- Mitigating NRS issues, which have since been followed up.

A number of follow up actions have been put in place and will be taken forward.

The Committee noted the report

Pressure Ulcer Update
The Committee discussed progress against the Pressure Ulcer Improvement Plan to reduce overall Trust attributable pressure damage by 10%, and full thickness pressure damage by 25% in 2024. There was an increase in the incidence of pressure ulcers in Q4. As a result, the pressure ulcer key performance targets were not achieved. This was due to ongoing delivery issues with NRS; operational and staffing pressures. Themes identified included, staff knowledge; delays in assessments, delays in care planning; patient concordance and non-engagement.

Activities and actions implemented included the implementation of pressure area care Quality Improvement projects, and improvements made in education This will be monitored through the Quality Governance Committee.

The Committee noted the report

Ligature risk verbal update
The Committee received a verbal update on the progress of anti-ligature work across the Trust. Work was ongoing in high-risk areas. A review of the

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	reporting on progress of the work was also in progress. An external site building had been identified for a risk assessment. Ligature risk assessment training was available via the Elev8 portal which would provide data on the number of trained assessors at the Trust. Ligature review meetings would continue to take place on a fortnightly basis. **The Committee noted the update** **Fire Action Plan update** The Committee considered the report which highlighted: • The capital remediation plan which received capital from NCL ICB and also the Estate Safety Fund which released the funding for the decant ward. • The design phase of the decant ward was expected to be completed by the end of the year. • Phase two of the fire alarm systems update programme was scheduled to be completed by the end of March 2026. • Holistic fire risks were under review which see the updating of the risk register and a risk matrix that would look at each fire element across the Trust. A similar process had been undertaken for community sites. • Additional works had been undertaken in relation to the evacuation lift and compartmentation. • Work on non-functioning dampers in Blocks A and L had commenced as part of the PFI issue • All surveys had been completed • Work to continue the installation of Fire stockings above doors had taken place. • All fire watch wardens were now substantive. • Fire and evacuation training had been increased and was meetings its KPI. • An Infrared fire sensor had been installed • A fire escape located at the Jenner Building had failed its structural assessment. Additional fire mitigations had been put in place. The Committee was assured that a full assessment of all fire strategies would be conducted across all sites to ensure that all fire risks were mitigated across the wider estate. **The Committee noted the report** **Health & Safety Bi-annual report** The Committee considered the report which was written to demonstrate the Trust's compliance with Health and Safety Legislation, Regulatory Reform (Fire Safety) Order 2005 NHS Health Technical Memoranda. The report highlighted the following: • There were 521 security incidents reported between 1 October 2024 and 31 March 2025, an increase of 242 from the previous quarter and primarily linked to violence and aggression. • The allergens food safety alert was still outstanding. 11 elements of the alert were raised in 2021. 10 actions out of the 11 had been completed. The final action related to staff training,

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	• Community Health and Safety inspections achieved a 98% compliance rate, exceeding the target. However, security inspections fell short, reaching 69% compliance. • Hospital Health and Safety Inspections achieved an 84% compliance rate. Security inspections are below target at 43%. • Fire safety inspections at the Hospital and Community sites achieved a compliance rate of 93% • Fire risk assessments have been carried out across all Trust areas. The Fire Team is in the process of reviewing and updating existing risk assessments • A total of 10 (RIDDOR) incidents were reported to HSE between 1st October 2024 to 31st March 2025. Appropriate actions and future risks have been mitigated. • Mandatory training for Health and Safety: 92%, Fire: 83% Moving and Handling: 90% and Conflict Avoidance: 84%. The Committee discussed the fire training compliance metric and agreed that it should be higher, considering the significant risks associated with fire safety within the Trust. Assurance was given that this would be a key priority for the newly appointed Fire Safety Manager, who will implement targeted interventions within non-compliant divisions. **The Committee noted the report** **Safer Staffing** The Committee considered the bi-annual Nursing and Midwifery report which outlined the Trust's response to the statutory requirements to have safe nursing and midwifery staffing across the organisation. Key highlights included the following: • The Trust was fully compliant with Recommendations of the Developing Workforce Safeguards • Areas of concern were identified in the paediatric ED which was substantively understaffed. The risk had been mitigated with the use of temporary staffing particularly around peak times. • Enhanced care was also an area of high use of temporary staff . A deep dive on the financial and safety aspects will be conducted. • A business case to increase the bed base on Ifor ward from 15 to 17 would be considered to mitigate the additional cost of two unfunded beds. • National piece work was in progress to look at a shortage of roles for graduate nurses and newly qualified midwives. **The Committee noted the report**
4.	**Present:** Amanda Gibbon, Non-Executive Director (Chair) Baroness Glenys Thornton, Non-Executive Director Dr Clare Dollery, Chief Medical Office Sarah Wilding, Chief Nurse & Director of Allied Health Professionals Chinyama Okunuga, Chief Operating Officer

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	Swarnjit Singh, Joint Director of Inclusion & Trust Company Secretary Tina Jegede, Joint Director of Inclusion & Islington Care Homes Lead **In attendance:** Selina Douglas, Chief Executive Nicky Sands, Deputy Chief Nurse Dr Phillip Lee, Associate Medical Director, Patient Safety Marcia Marrast-Lewis, Assistant Trust Secretary Matthew Minter, Associate Director of Clinical Governance Dr Ashling Lillis, Associate Medical Director, Quality Improvement & Clinical Excellence Zoe Broadhead, Lead Nurse, Critical Care and Outreach Lisa Carrie, CCOT nurse/Lead for Martha's Rule Project Manju Mandirathil, Business Manager to Chief Medical Officer Jonathan Gardner, Chief Strategy, Digital and Improvement Officer Sana Burney, Programme Lead Partnerships Liam Triggs, Director of Estates & Facilities Isabelle Cornet, Director of Midwifery **Apologies** Mark Emberton, Non-Executive Director

Meeting title	**Quality Assurance Committee**	**Date: 09/07/2025**
Report title	Annual Compliments, Complaints & PALS Report 2024-2025	**Agenda item: 4.3**
Executive Director Lead	Sarah Wilding, Chief Nurse and Director of Allied Health Professionals	
Report author	Paul Macpherson, PALS & Complaints Manager Antoinette Webber, Head of Patient Experience	
Executive summary	This report provides an annual overview of compliments, complaints, Patient Advice and Liaison Service (PALS) and quality alerts received during the period 1st April 2024 – 31st March 2025. **Compliments** • We formally recorded 570 compliments, a decrease of around 10% on 2023-24 (631). These exclude any compliments sent directly to services/staff which are not formally recorded via PALS. **Complaints** • During 2024-2025 we received 362 complaints, these are broken down by quarters (Q1) 101, (Q2) 78, (Q3) 73 and (Q4) 110. This is an overall increase of 5% (15) comparable to 2023-24 (347). • The top 5 themes were Communication, Medical Care, Nursing Care, Attitude & Delay • 98% of complaints were acknowledged within 3 working days, exceeding our internal target of 90% and in line with 2023-2024. • Our internal performance metric sets a response rate of 80% of complaints to be actioned within the expected timeframe (25/40 days). Our 2024-2025 performance against our internal KPI was 68% an improvement of 13% on our 2023-2024 performance of 55%.	

	• Around 7% of the complaints were deescalated through the complaint lead investigator intervention resulting in the complainant not requiring a written response • We received 8 requests from the Parliamentary & Health Service Ombudsman (PHSO) for information, a decrease of 7 on 2023-2024 (15). **PALS & GP concerns** • During 2024-25, a total of 2,402 PALS contacts were recorded (including 74 from GP practices regarding individual patients) a decrease of 332 in compassion to the previous year of 2,734. It is important to note that not all PALS enquiries are logged formally on Datix if the team can intervene and resolve the concern. • For the year 2025-26 PALS has adopted an alternative record keeping system which will reflect in the next annual report • 74% (1,777) of PALS enquiries related to concerns and 26% (625) were requests for information. • The Trust's Primary Care Liaison Manager oversees all GP Concerns, effective since 1st October 2024. **Quality Alerts** • We received 5 quality alerts from GP Practices, in line with 2023-24.
Purpose:	The Committee is asked to review and approve the attached Annual Report. This report provides a high-level overview of compliments, complaints, PALS and quality alerts for 2024-25. Please note this report is being presented for the Committee to approve the report's content; document design to be finalised for wider publication by September 2025.
Recommendation(s)	The Committee is asked to review and approve this report for circulation.
Risk Register or Board Assurance Framework	This links to BAF Quality 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.

Report history	The previous annual report for 2023-24 was presented to QGC in June 2024. This report for 2024-25 will be presented to QGC in June 2025 and will be available as a public document by September 2025.

Introduction

Whittington Health NHS Trust serves a diverse population of 500,000 living in the boroughs of Islington and Haringey, in addition to Barnet, Enfield, Camden and Hackney. The Trust has a strong focus on improving patient experience which continues to evolve.

The Trust values and recognises the importance of patient, service user and carers feedback, to help shape our services and drive ongoing improvements to reflect the needs of the population we service. The experience of patients is captured a number of ways, including the Friends & Family Test (FFT), complaints, PALS, focus groups and national surveys. We listen to our patients through patient engagement meetings, focus groups, our volunteering programme and in addition, bi-monthly Trust Board meeting starts with a patient story, presented by the patient and supported by staff.

In accordance with the NHS Complaints Regulations (2009) this report sets out a detailed analysis of the number and nature of complaints received by Whittington Health during the 2024/2025 financial year. This report includes details of PALS concerns, enquiries and compliments including concerns from GP Practices related to individual patients received during the same period.

This also report includes details of the number of complaints received during the year, performance in responding to complaints, Parliamentary and Health Service Ombudsman (PHSO) investigations, and action taken by the Trust in response to complaints.

The complaints team have a robust complaints process in place to monitor the progress of complaint investigations which is set out in the Trust Complaints Policy.

The complaints team chair weekly divisional lead investigator meetings to ensure complaint investigations are progressing and any barriers to timely completion identified.

All Divisions are facing challenges in completing their investigations including gathering information from the staff & patient systems involved, along with pulling the response together ensuring all issues have been addressed before presenting for quality assurance,

A dashboard of ‘live’ complaints is shared with our Divisions on a weekly basis, including a monthly patient experience dashboard which monitors FFT responses and complaint numbers by division.

All complaints are reported to Trust Board monthly, in the Integrated Board Performance report, which forms part of the Patient Experience Group report.

Themes and trends from complaints help us reflect on the care given, learn and shape now we deliver care. They also help us develop our Quality Account and Patient Experience Strategy priorities, ensuring we focus on what matters most to our patients.

In summary during 2024-2025 there were:

- Received 362 complaints requiring a response
    - (Q1 -101), (Q2- 78), (Q3 -73) and (Q4 – 110). This is an increase of 5% (15) in comparison to 2023-2024 (347).
- 98% of complaints were acknowledged within the stipulated 3 working days
    - exceeding our internal 90% target, an improvement of 1% on 2023-24.
- Our internal key performance indicator is to respond to 80% of complaints within the target response time. Our performance for 2024-25 was 68% compared to 55% in 2023-24, an improvement of 13% (Q1 73%, Q2 68%, Q3 69% & Q4 62%).

There were 5 requests for information from the Parliamentary & Health Service Ombudsman (PHSO) a decrease from 15 in 2023-24. Two cases with the PHSO under investigation, and we are awaiting the final decision on another having responded to the provisional decision.

- 570 compliments were received thanking 799 individuals or teams.
- A total of 2,500 PALS & GP concerns were received, compared to 2,734 in 2023-2024, showing a decline of 234.

To put these figures into context, during 2024-2025 as a very simple calculation 0.03% of patient encounters resulted in complaints and 0.2% resulted in a PALS concern. It is acknowledged that patients /services users may have multiple encounters across the Trust.

Table 1: Patient Encounters v Concerns comparison

Appointments/episodes of care	2023/24	2024/25
Emergency Department attendances	103,893	108,610
Outpatient appointments	424,128	436,115
Imaging Department attendances	187,352	216,896
Theatre procedures	8,398	8,861
Community episodes	543,376	576,976
Inpatient admissions	42,057	49,683
TOTAL	1,309,204	1,397,141
Complaints (number)	347	362
Complaints (%)	0.03%	0.03%
PALS concerns (number)	2,605	2,500

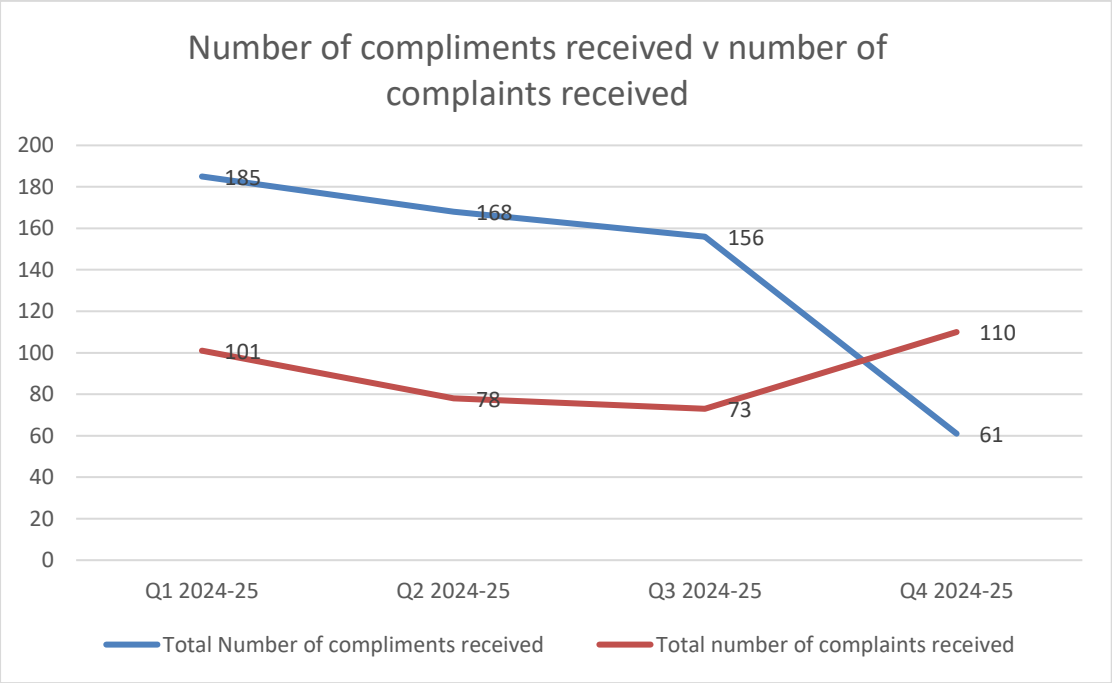
PALS concerns (%)	0.2%	0.2%

1.0 COMPLIMENTS

As a Trust we celebrate the great work undertaken by our staff and it is important to recognise that the number of compliments received by ICSU outweighs the volume of complaints we receive. During 2024-2025 we received 570 compliments through PALS (for 799 individuals or services) compared to 631 compliments during 2023-2024. These are compliments received via our PALS service or those sent directly to the Chief Executive's Office, however, many more compliments are received directly by services/staff and department across our Trust.

S&C received the largest number of compliments (177), followed by E&IM (165), ACW (80), ACS (63), CYPS (57), Corporate (23) and E&F (5). (As with complaints, it is important that as an organisation we share the successes from compliments, and share best practices, that can be emulated in other services across our Trust.

Graph 1: Compliments v Complaints volumes 2024-25 by quarter



Examples of compliments

My son has autism. The consultant, receptionist, everyone, they were amazing. They let my son stay elsewhere and volunteered to get a play therapist. It made a difference to his ability to access medical care. CYP

"thank you so much for all your help. She said she felt confident to come to the hospital knowing you are here to help.

Corporate

" You all do such a wonderful job. Thank you so much for today it was moving and much appreciated x "

EIM

…to thank a wonderful member of your team. Everything promised has been delivered and (name) kept her word regularly putting her words into action. I cannot praise this young woman highly enough. Please ensure that the appropriate people are made aware of her excellent work on my behalf.

ACS

…my thanks and compliments to the colposcopy team. The three women who carried out my colposcopy were so lovely and made what can be a very uncomfortable experience, so easy and relaxed. The team explained everything and engaged in conversation the whole time which not only put me at ease, but was incredibly empowering. ACW

The porter was incredibly kind and helpful to my elderly mother. He went above and beyond to ensure that are was safely seated in her taxi to her home. The step up to the taxi was higher than expected and he supported helping my mother into place. Thank-you so much for the kindness shown to my mother

E&F

"I had a gastric sleeve in 2021 and it's been life-changing. Whilst I went abroad to have further surgery, whereby I contracted C-diff which led to hospitalisation, the care treatment and expertise (at Whittington) was second to none, and I'm so grateful.

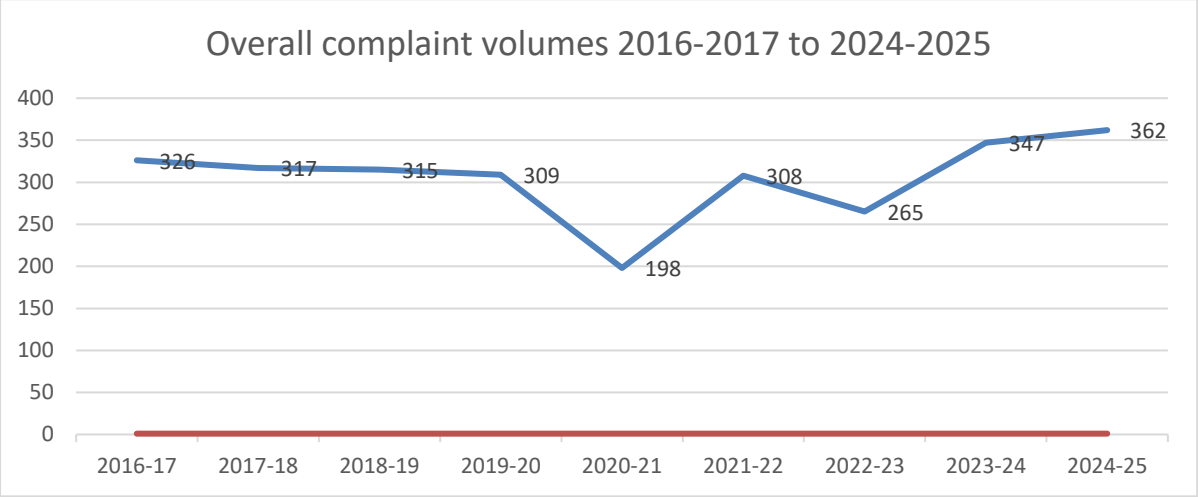
S&C

2.0 COMPLAINTS

2.1 Complaints across Directorates and Integrated Clinical Service Units (ICSUs) within our Trust

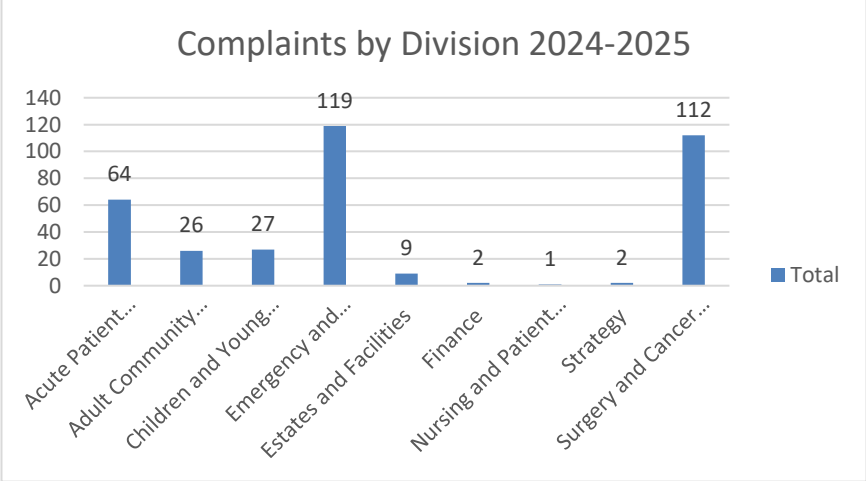
The number of complaints in 2024-25 is in line with the figures since 2016-2017 shown in graph 1 below. The decline noted in 2020-21 (198) occurred during Covid, the rationale for the drop can only be speculated as a reflection of the general public's support to the NHS during that time.

Graph 2: Overall complaint volumes



Emergency & Integrated Medicine (E&IM) Division received the largest number of complaints at 119, followed by Surgery & Cancer (S&C) Division 112, Acute Patient Access, Clinical Support and Women's (ACW), 64, Children and Young People (CYP) 27, Adult Community Services (ACS) 26, Estates & Facilities 9, Finance 2, Strategy 2 & Patient Experience 1. (See graph 3 below).

Graph 3: Complaints numbers by Division April 2024 to March 2025

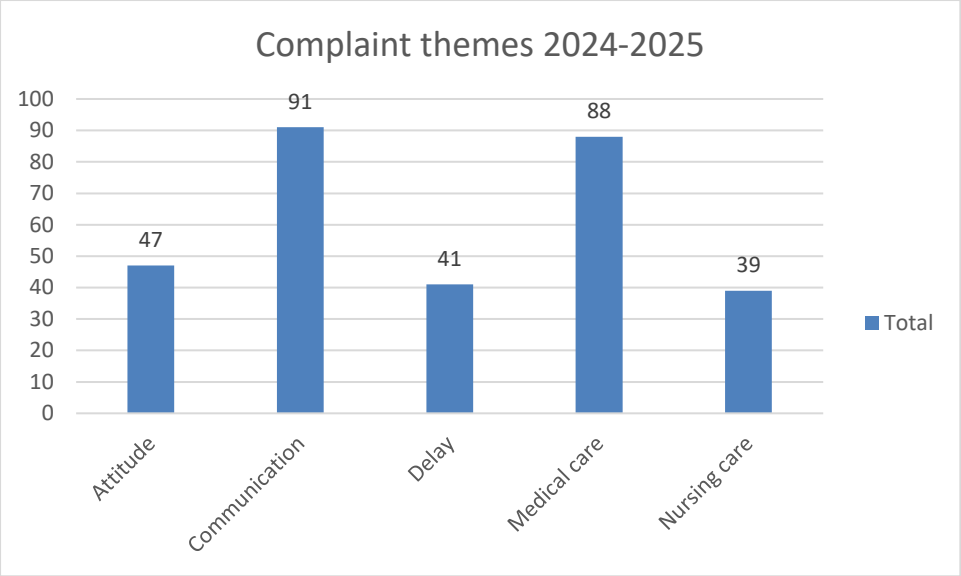


2.2 Complaints across the Trust by theme

Themes and trends from complaints are incorporated into the Quality Account and Patient Experience Strategy priority setting, to ensure we focus on what matters most to our patients, following their feedback.

The top 5 themes cited include communication between clinicians, patients, their families and carers is the most common theme received through complaints and remains an ongoing improvement priority for the Trust. These are the same top five themes as in 2023-24.

Graph 4: Top 5 complaint themes 2024-2025



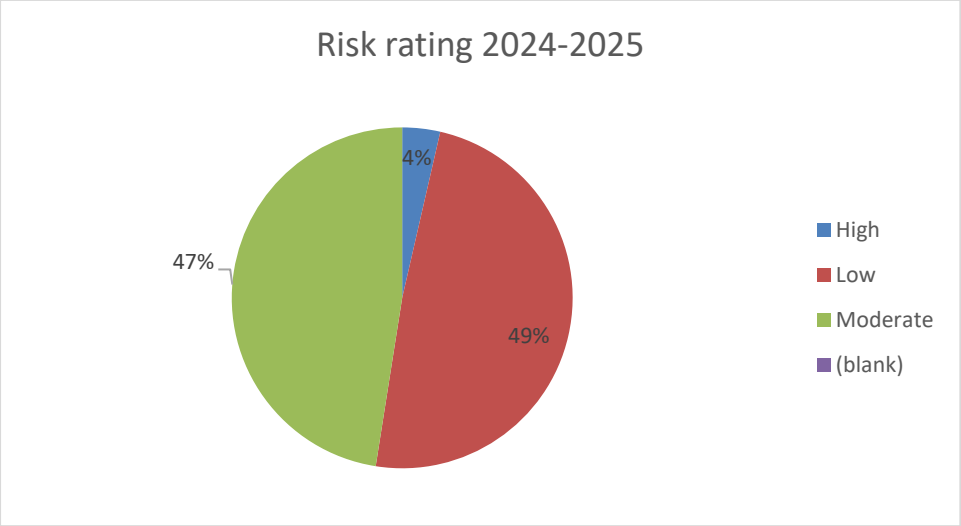
2.3 Complaints across the Trust by risk rating

All complaints are risk assessed by the PALS & Complaints team upon receipt and are risk-assessed by the lead investigator following completion of the investigation. High risk complaints are those where concerns are raised about patient care that may have had an adverse effect on a patients outcome or perhaps there is a risk of reputational damage. An example of a high-risk complaint would be an unexpected death, a missed or delayed diagnosis an allegation of assault, or where there is a WISH investigation underway. A moderate-risk complaint would be one where there may be a persistent or generic theme if the issue is not addressed promptly. A low-risk complaint would be one with one or two issues that should be addressed promptly, e.g. staff attitude or poor communication.

During 2024-25 - 13 (4%) of complaints were designated as ‘high’ risk compared to 9 (3%) complaints in 2023-24, an increase of 1%. Most complaints 177 (49%) were

designated ‘low’ risk and 172 complaints (47%) were designated ‘moderate’ risk. Please see Graph 5 below.

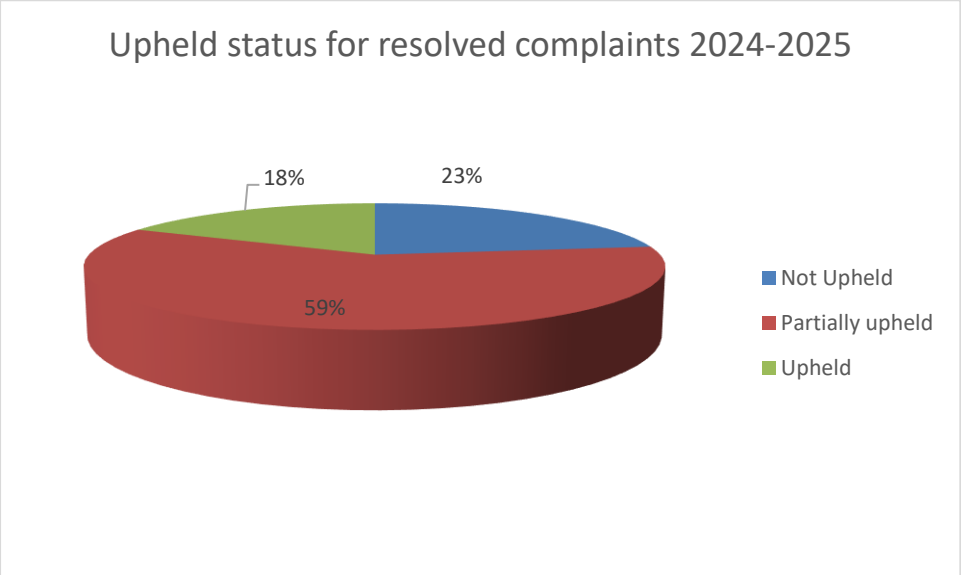
Graph 5: Complaints by risk rating 2024-2025



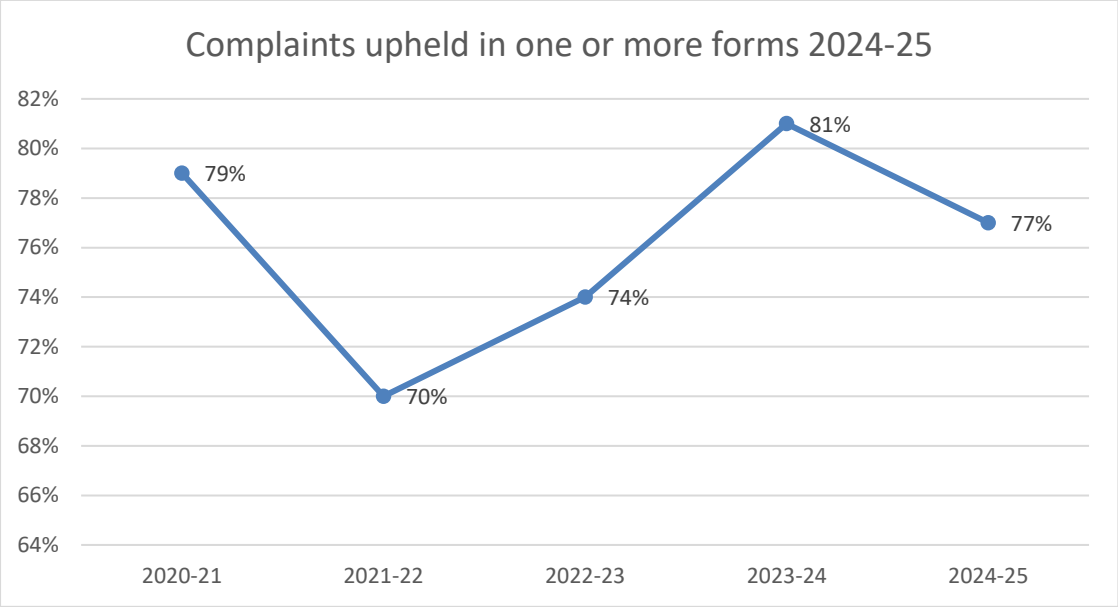
2.4 Complaints across the Trust by Upheld Status

Of the complaints that were closed during 2024-25, 62 (18%) were fully upheld, 208 (59%) were partially upheld and 80 (23%) were not upheld. 77% of closed complaints were upheld in one or more forms, compared to 2023-2024 where 81% of complaints were upheld, a decrease of 4% (Graphs 5 & 6).

Graph 6: Complaints by Upheld status 2024-2025



Graph 7: Complaints by Upheld Status annual comparison

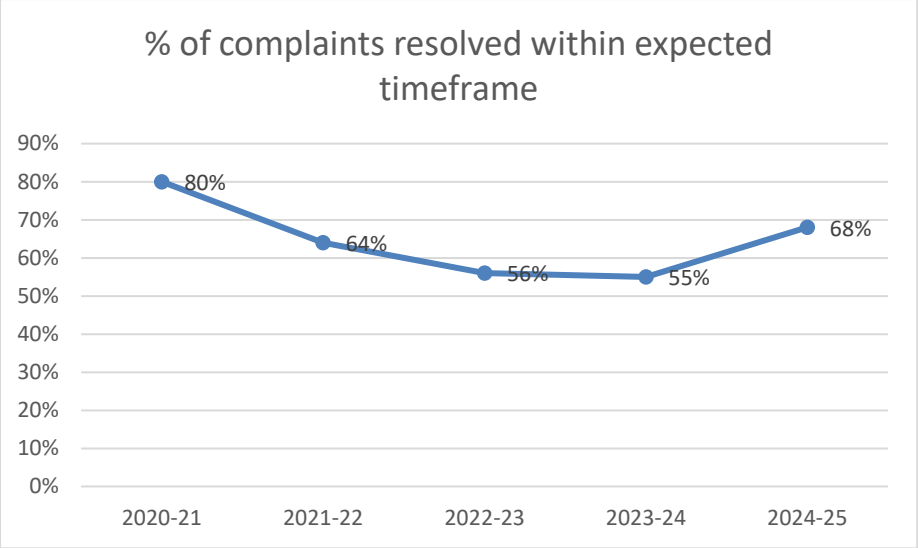


2.5 Response Timescales

The Trust internal performance KPI is for 80% of complaints to be responded to within the expected timeframe (either 25 or 40 working days) and some 'bespoke' timeframes, where the complaint is linked to an incident investigation or a particularly complex complaint or those involving other NHS Trusts.

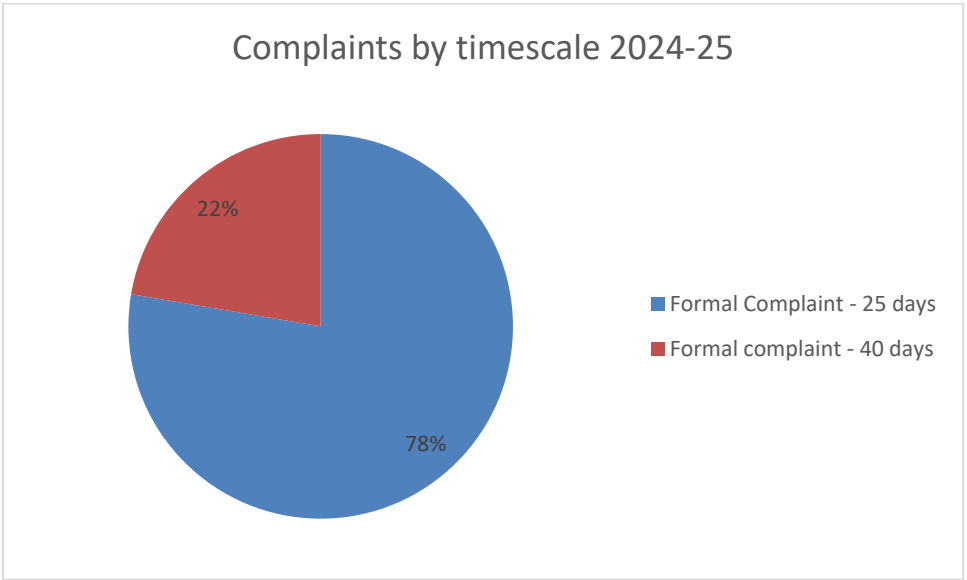
During 2024-25 we have seen an improvement in meeting our internal 80% performance target for the year, achieving 68%. During 2023-2024 55% of complaints were responded to within the targeted number of working days, in comparison to 83% in 2019-2020, 80% in 2020-21, 64% in 2021-22, 56% in 2022-23 & 55% in 2023-24 (graph 7).

Graph 8: Response timescales



Whilst it is recognised that much of the delay responding to complaints is due to capacity, winter pressure, as well as competing demands for clinical and administration time. We know that delays in responding to complaints leads to a poorer patient/ family and carer experience and work continues to improve performance and experience for our patients/carers to improve the response rates, within our S&C Division, an additional resource has been provided to support. In addition, weekly meetings are held with our 5 Divisions with a particular focus on the oldest complaints, complex complaints or those that are due, to avoid breaching. This has resulted in a steady reduction in the number of older complaints outstanding a response following an investigation, as well as a gradual improvement on the overall response rate across the Trust.

Graph 9: Complaints by Timescale 2024-2025



2.6 GP Quality Alerts

Quality Alerts relate to wider issues raised by GP practices, opposed to concerns about an individual patient, these are recorded as 'GP concerns' rather than a 'Quality Alert.' All quality alerts are immediately shared with the relevant division and promptly resolved.

Our Trust received 4 Quality Alerts, compared to 5 in 2023-24 – two related to delays in pathology & microbiology results to GP Practices, one related to the delays in offering two week wait appointments to Dermatology patient, and one related to an Echocardiogram (ECG) result being sent to the wrong GP Practice, with a similar name.

Table 2: Quality Alerts by Division 2024-2025

Division	2024-2025
EIM	1
ACW	2
S&C	1
Trust	4

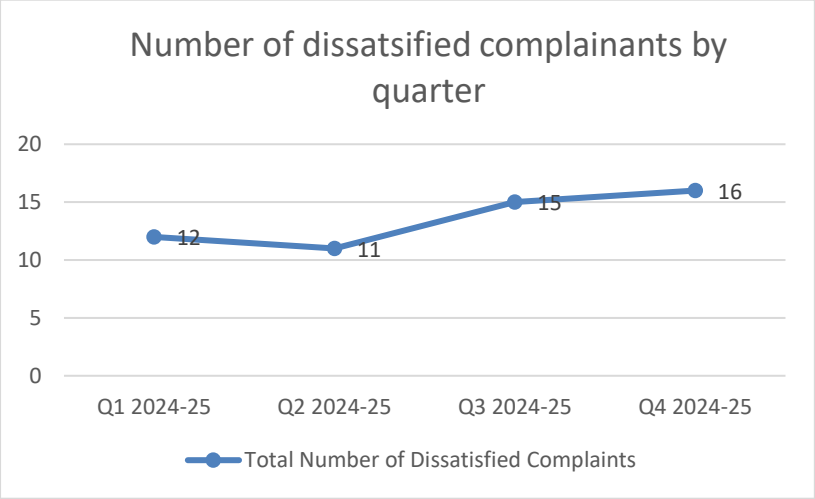
All quality alerts were responded to, and learning taken by the Divisions, including a review of resources to ensure generic mailboxes are monitored regularly and responses sent.

2.7 Dissatisfied complaints

Graphs 10 & table 3 below show the number of complainants returning responses as dissatisfied or requiring further clarification. During 2024-2025, we received 54 dissatisfieds, an increase of 17 on 2023-2024 (37). This includes a small number of complainants who have responded a few times.

Whilst all of our responses are subject to several reviews before they are finalised, there will always be some complainants who will remain dissatisfied despite every effort to address their concerns. All 'dissatisfied' complaints are shared with the Division involved and carefully reviewed to determine if anything further can usefully be added, and a further response or local resolution meeting is arranged as an opportunity to find a resolution to the dissatisfied complaint. In cases where dissatisfied complaints cannot be resolved, complainants are reminded of their right of referral to the PHSO. Some complainants benefit from a discussion with our clinical staff involved in their care, to clarify what had taken place during their attendance to our hospital. Delays in investigations impacts on our ability to meet our KIP's and delays in responses being sent to the complainant can dilute the sincerity of apologies that are offered in our complaint responses.

Graph 10: Dissatisfied complainants by quarter 2024-25



Division	Total
Surgery and Cancer Division	19
Community Health Services for Adults Division	5
Emergency and Integrated Medicine Division	15
Acute Patient Access, Clinical Support Services & Women's Health Division	8
Corporate	1
Children and Young People Services Division	6
Trust	**54**

2.8 Parliamentary Health Service Ombudsman (PHSO) Cases

The Parliamentary Health Service Ombudsman makes final decisions on complaints in the NHS in England, where the complainant remains dissatisfied following an investigation and complaint response. The PHSO investigates complaints where someone believes there has been an injustice or experiencing hardship because an organisation has not acted properly, given a poor service or failed to resolve their concerns to the complainant's satisfaction.

During 2024-25 our Trust received 8 requests from the PHSO, where they will require related complaint files and associated records, in order for the PHSO to review and consider whether they will undertake an independent review. This is a significant decrease of 50% compared to 15 in 2023-2024. In each case the information has been provided to the Ombudsman Service. Two cases with the PHSO under investigation, and we are awaiting the final decision on another having responded to the provisional decision.

2.9 Improvements and learning from complaints.

Divisions are required to develop and monitor actions resulting from complaints within their own risk and governance meetings.

One of the main purposes in investigating complaints is to identify opportunities for learning and to improve services for patients, their families and carers. With this in mind complaints learning is monitored and case examples of both complaints and compliments are reported within our Patient Experience Group (PEG) and subsequently to the Quality Governance Committee (QGC) and Quality Assurance Committee (QAC). Learning from complaints forms part of the new Patient Safety Incident Response Framework (PSIRF) which is being rolled out across our Trust.

Examples of learning to improve the patient experience.

Complaint	**Action and Learning**
A complaint that a patient with signs of a stroke was not transferred to the Hyper Acute Stroke unit at Queen Square in a timely manner resulting in a deterioration in their condition.	As a result of the complaint, although it was determined that the patient did not present to the hospital with classic signs of a stroke, an anonymised version of the complaint has been shared with the clinical teams in the Emergency Department for learning and staff reminded of the importance of stroke pathways & timelines. Staff training on appropriate escalation of delays to urgent processes including transfer to CT scan and interhospital transfers. In addition our CT radiology is implementing a process to allow better tracking of CT scans overnight to prevent future delays and to ensure that patients needing a fast-track transfer are prioritised. We are in discussion with the London Ambulance Service around how emergency hospital transfers are prioritised.
A complaint that an unexpected finding on a CT scan in October 2023 was not reviewed and the patient contacted for 5 months after the scan. The finding was highlighted on ICE as per protocol, but the clinical team did not review until the planned follow-up outpatient appointment in March 2024. (NB in the event the finding was not found to be sinister).	As a result of the complaint, Imaging introduced an enhanced system whereby the requesting clinician is sent an email where there is an unexpected finding and asked to review it. If no reply is received within 5 days, Imaging send a further email to the wider clinical group to ensure timely intervention.
A complaint about the care provided to a palliative patient approaching the end of his life at home. A specialised bed/mattress arrived late with no safety bars	As a result of the complaint, teaching for district nurses around stoma care reviewed, monthly round table discussions between Palliative Care & District Nursing to review what support is needed by families and ensure

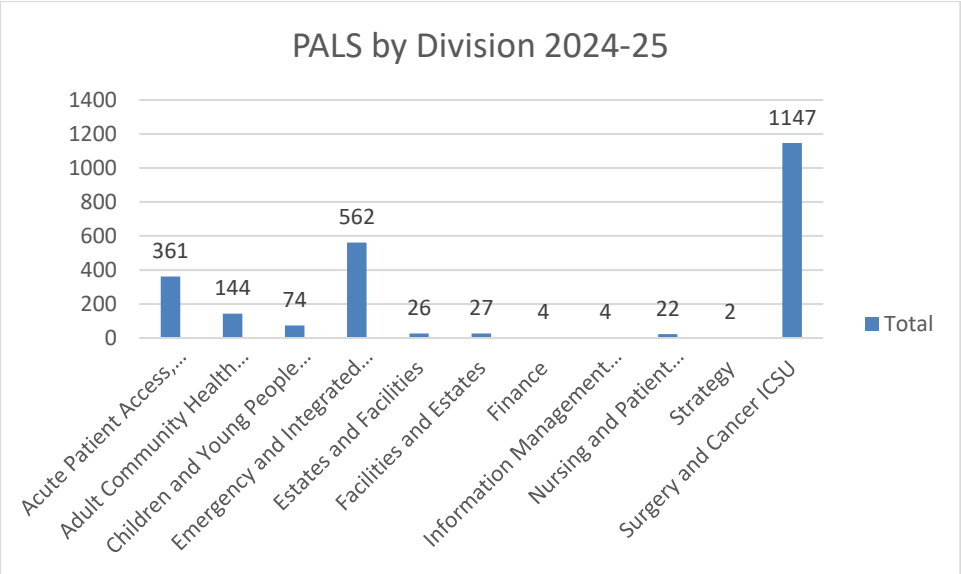
(which the patient had in hospital), poor interaction between palliative care and District nursing staff, poor stoma care, and staff arriving to administer care after the patient died.	both services working collaboratively. For end-of-life patients joint palliative and district nursing assessments to be arranged at the point of referral.
A complaint about problems experienced by a partially sighted patient who had difficulty navigating the main staircases.	As a result of the complaint, the patient was invited to attend and present his story to our Trust Board. The Trust also arranged a sight loss visit to the hospital to assess where other improvements needed to be made

3.0 PALS & GP concerns

3.1 PALS contacts by ICSU

A total of 2,402 PALS contacts (including those from GP Practices (29) were logged compared to 2,734 contacts during 2023-24. 74% (1,777) of PALS enquiries related to concerns and 26% (625) were requests for information. (With effect from 1st October 2024 GP concerns have migrated to the Trust's Primary Care Liaison team which commended on 1st October 2024, under the Chief Operating Officer (COO) portfolio.

Graph 11: PALS Contacts

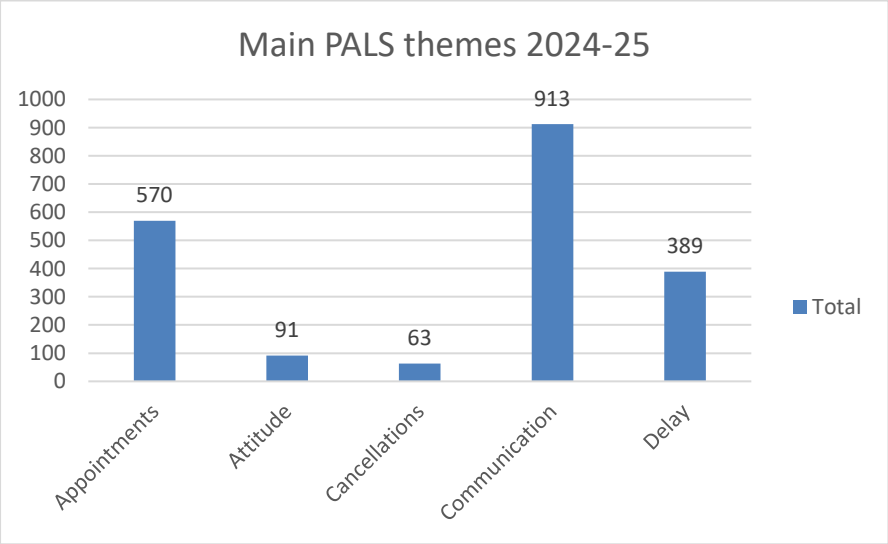


3.2 PALS Contacts by subject area

Graph 13 shows main themes as cited in the PALS contacts received. On receiving contact from patients, the PALS team will attempt to resolve the issue with the patient at the time e.g., access to appointments, however, if this has not been possible, the

PALS concern is then escalated to the relevant ICSU. These are the same PALS themes as for 2023-24.

Graph 13: Top themes for PALS concerns 2024-25

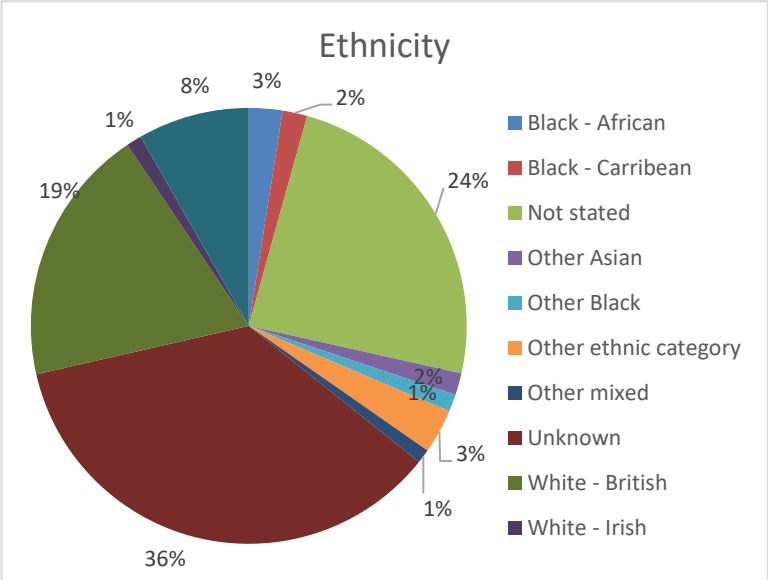


3.3 Diversity Data

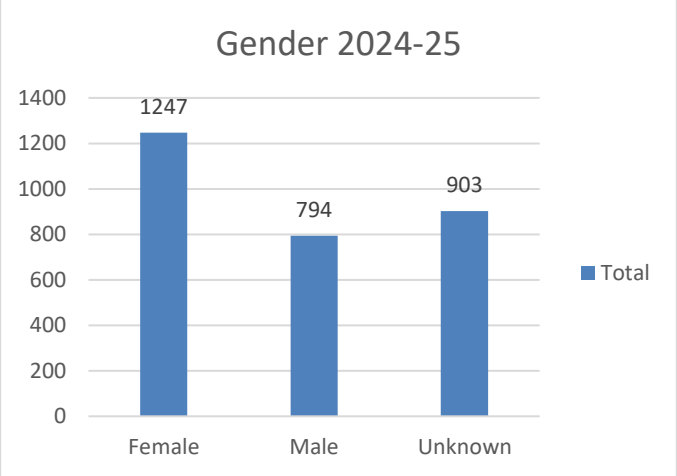
The PALS & Complaints team continue to cross-check diversity data through our electronic patient information systems (Careflow and RiO), although the information is also requested through the PALS & Complaints leaflet. All data collected from Datix is shared with the Department of Health through the KO41 annual report.

Graphs 14 and 15 below show the demographic data for Ethnicity & Gender for 2024-25. The data for age and disability figures had too many “unknowns” to provide a meaningful breakdown.

Graph 14: Ethnicity



Graph 15: Gender



3.4 NHS Choices

Our Trust continues to receive small number anonymous feedback via NHS Choices, which are included in the Compliments and PALS figures. All NHS Choices feedback is acknowledged, responded to and shared with the relevant Division. Where concerns were raised our acknowledgement included an invitation to contact the PALS team with details for further investigation. The number of concerns received via NHS Choices in 2024-25 was 15.

4.0 Support & Training

The PALS & Complaints team provides ongoing support to Divisions by ensuring the availability of training sessions on demand that can be delivered across several sites. The team also provides a complaints introductory session as part of Trust Induction and ad hoc complaints management training for relevant new employees.

The team continues to work closely with the Divisions to identify further ways in which it can be supportive and facilitate continuous learning and improvement.

During 2024-25 bespoke PALS & Complaint handling online and face-to-face training was delivered to 31 members of staff across all our organisation. Monthly sessions will continue during 2025-26 and are communicated through the Trust bulletins and in discussion with the senior Divisional teams.

5.0 PLANS FOR 2024-2025

5.1 To revisit the training provision for complaint handling to ensure a good understanding in the ICSUs. This should enable the ICSUs to increase the number of

staff skilled to undertake investigators and improve the quality and timeliness of complaint investigations.

5.2 To review the learning from those complaints that are upheld in any way to ensure that the learning is embedded in the working practices of the team/area involved. The aim is to reduce the likelihood of a recurrence.

5.3 To include complaints and compliments data into the new Patient Safety Incident Response Framework (PSIRF), to ensure learning and provision of a better patient experience.

Meeting title	**Quality and Assurance Committee**	**9/7/25**
Report title	**Nursing and Midwifery 6 monthly Safer Staffing Review Report**	**Agenda item: 5.5**
Executive director lead	Sarah Wilding Chief Nurse & Director of Allied Health Professionals	
Report authors	Marielle Perrault, Assistant Chief Nurse Maria Lygoura, Lead Nurse for Safer Staffing and Roster Utilisation	
Executive summary	• In line with National Quality Board (NQB) guidance (2016), The bi-annual Nursing and Midwifery Report outlines the Trust response to the statutory requirements to have safe Nursing and Midwifery staffing identified across the organisation. • This 6-month review report includes the following: • An overview of the organisation nursing and midwifery key performance indicators (KPIs) • Workforce initiative highlights will detail the nursing leadership engagement in national and regional efforts around Enhanced Therapeutic Observations and Care (ETOC), responding to increasing numbers of vulnerable patients needing support. The Trust provides enhanced care to 20–25 patients daily across services including ED. From June 2025, ETOC workforce data will feature in all Provider Workforce Returns. • All Nursing and Midwifery Establishment reviews were undertaken in April and May 2025 • The key findings from the 6 monthly Establishment Review of the Nursing and Midwifery workforce based on the Safer Nursing Care Tool (SNCT) and Mental Health Optimal Staffing Tool (MHOST) audits collected in February 2025 for all inpatient areas and Emergency Department (ED)	

- When funded and staffed to the recommended establishment levels, all areas meet safer staffing standards; with a few exceptions noted through specific recommendations. **(Appendix 4, Page 24)**

- A more in -depth analysis of enhanced care requirements will be undertaken outside of this process.

- Investment requirements have been identified and supported in principle by the Deputy and Chief Nurse. Further work will be done with the ICSUs to identify and support the funding steam required

- The committee is asked to endorse the establishment increase across the organisation, noted below:

Ward (ICSU)	**Funded bed capacity**	**Funded establishment R: Registered U: Unreg.**	**National guidance (RCN/NQB)**	**Recommendations**
IFOR (CYP)	15	36.25 wte **R**: 30.65 wte **U**: 5.60 wte	For 15 pts: 42.25 wte (90% **R**)	To support staffing up to 17 beds
Service	**Activity**	**Funded establishment R: Registered U: Unreg.**	**National guidance (RCN/NQB)**	**Recommendations**
Paeds ED	67 avg/day	**R:** 15.78 wte **U:** N/A	RCPCH 2022 RCN 2024 (Detail in report)	2.5 WTE Band 5 to cover the peak activity whilst further analysis is undertaken and reviewed

Purpose:

As per the National Quality Board (2016) (NQB) 'Expectation 1: Right Staff' and NHS Improvement (2018), 'The planning cycle'; this report seeks to assure Board and the public regarding the Trust's compliance to the statutory requirements to have safe Nursing and Midwifery staffing across the organisation

Recommendation

The Committee is asked to:

(i) Review that due process was followed in line with statutory requirements to review nursing and midwifery staffing levels bi-annually.

	(ii) Approve the recommendations made in this paper.
Risk Register or Board Assurance Framework	• BAF risk Quality 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective, or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation. • BAF risk People 4- Failure to recruit and keep high quality substantive staff could lead to reduced quality of care, and higher costs. • Risk register: Paediatric ED Safer staffing (reference 1564) Score 15
Report history	1. Establishment review meetings with Deputy Chief Nurse, Assistant Chief Nurse, Safer Staffing Lead Nurse, Associate Directors of Nursing and Midwifery (ADoN/M), Deputies, Matrons, and nursing recruitment team, Eroster team: Across April 2025 and May 2025 2. QGC: *TBC* 3. Nursing and Midwifery Leadership Group (NMLG): 30th June 2025 (circulated to group members week starting 23rd June 2025) 4. EMT: *TBC* 5. TMG: *TBC* 6. QAC: 9th July 2025 7. Public Board *TBC*

6 monthly Nursing and Midwifery Establishment Review Report

1. INTRODUCTION

1.1 This purpose of this report is to provide assurance to the Board of Directors (BoD) and other committees (see report history section) that the Trust Nursing and Midwifery staffing levels are compliant with the Developing Workforce Safeguards NHS Improvement (2018) incorporating the National Quality Board (2016) (NQB) Standards for safe Nursing and Midwifery staffing at Whittington Health NHS Trust. **(Appendix 1, Page 16)**

1.2 The guidance sets out the key principles and tools that providers should use to measure and improve their use of staffing resources to ensure safe, sustainable, and productive services, including introducing the care hours per patient day (CHPPD) metric. The three NQB's expectations that form the basis to making staffing decisions are as below:

1.3 The Bi -Annual Nursing and Midwifery Establishment reviews were undertaken in April and May 2025 to review the Nursing and Midwifery requirements. The reviews also provide a progress overview of the outcomes from the earlier Nursing and Midwifery establishment Reviews conducted in November 2024. It also reviews progress on recruitment for all additional safe staffing posts

agreed through this process in line with the Trust business planning procedures.

1.4 Each ICSU was represented by their ADoN or nominated deputy, with Matrons and departmental leads in attendance where possible. All members of the Triumvirates and finance team are offered the opportunity to attend. At present, the attendance from the wider MDTs is variable, with continued work in progress to ensure a multi-professional approach.

1.5

1.6 Safer staffing and skill mix reviews were undertaken the following clinical areas based on Safer Nursing Care Tool (SNCT) and Mental Health Optimal Staffing Tool (MHOST) audits undertaken across February 2025: The review process and data analysis systems provide a standardised approach to assure the Trust board that Nursing and Midwifery staffing is compliant with the required standards outlined in section 1.1:

- Inpatient adult and children wards (EIM, S&C and CYP)
- Emergency Department (ED) (EIM)
- Critical Care Unit (CCU) (S&C)
- NICU (CYP)
- Maternity services are assessed based on the Birthrate Plus report produced in November 2023 and national recommendations.

Exploratory reviews have been undertaken in clinical areas that have currently no recognised national audit tools. Those establishment reviews were undertaken based on activity, acuity and ERoster metrics.

- Theatres and Recovery (S&C)
- Day Treatment Centre- DTC (S&C)
- CCU Outreach Team (S&C)
- Chemotherapy suite and CNS teams (S&C)
- General Outpatients and Gynaecology outpatient (ACW)
- Endoscopy (EIM)
- TB services (EIM)
- Children Ambulatory Care/Day Care and Outpatient (CYP)
- Community services: the community safe staffing tool piloted last year has been restarted after a pause. At the time of this report, the audit has been undertaken in some community district nursing team in April 2025. A further collection is planned for June 2025. To be able to include the data in later establishment reviews a further 2 collections need to be undertaken and validated before it is included in the establishment review process.

2. ESTABLISHMENT REVIEW PROCESS AND METHODOLOGY

2.1 As part of the bi- annual establishment review process, all inpatient areas completed a Safer Nursing Care Tool (SNCT ©) audit (and Mental Health Optimal Staffing Tool- MHOST- for CYP) for 30 days during February 2025. This SNCT audit is mandated by the Developing Workforce Safeguards NHS Improvement (2018) and is used to inform the establishment review, alongside professional judgement, to establish safe staffing in the clinical areas.

The NQB recommend the use of other quality data sets to inform professional judgement including acuity and dependency tools, review of incident data, completion of key clinical processes such as health roster management, sickness/absence, quality indicators and user feedback.

Triangulation NQB methodology 2016 and 2018:

2.2 For this review, 6 months of key workforce data from 1st October 2024 to 31st March 2025 was collected and circulated in advance of the meetings with Locally held information to be completed by ICSUs included the following metrics:

- All Workforce data including vacancy, turnover, sickness, mandatory training, appraisal compliance, temporary staff expenditure (bank/agency)
- Establishment WTE for both funded and staff in post.
- Local budgetary data, year to date (YTD) spend.
- Roster template and budget alignment information
- Roster KPIs including Care Hours Per Patient Day (CHPPD), roster lead time compliance, annual leave percentage.
- Safer Nursing Care Tool (SNCT) inpatient validation audit data
- Red Shifts raised.
- Enhanced Care use information
- Healthcare Support Workers' completion of Care Certificate
- Workforce profiles where available (including age and diversity data)
- Falls and Pressure Ulcer data.
- Complaints and Serious Incident data

- Staff undertaking the Professional Nurse/Midwife Advocate programme.
- Advanced and specialist level practitioners and services covered.
- Local/National Guidance/recommendations
- Successes to celebrate in last 6 months period.
- Action plans to prepare further reviews.

2.3 At the review meetings, detailed discussions on the data provided enabled all ICSUs to highlight any areas of concern and to provide examples of innovation and good practice. Department roster template, finance and ESR alignment support review meetings are being undertaken. These outcomes were discussed to understand changes made to financial and rostering templates, and to ensure the changes continued to support patient safety alongside financial alignment.

Review of new ways of working, opportunities and change of skill mixes were discussed with consideration of roles such as:

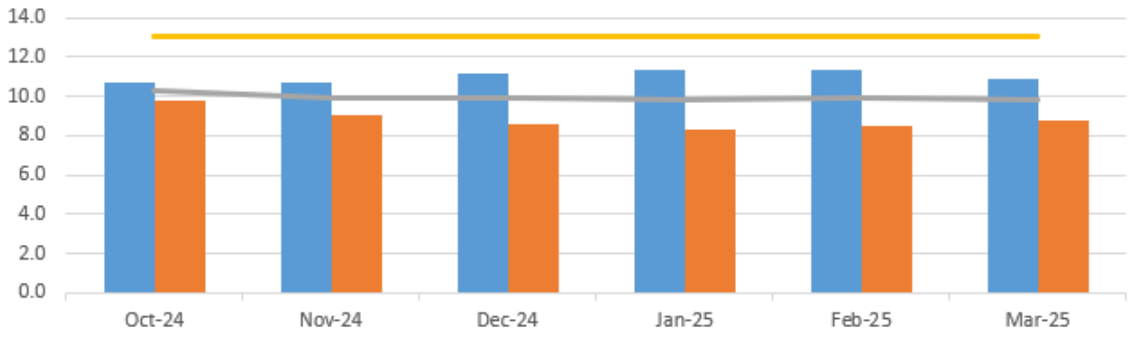
- Nursing Associates and Student Nurse Associate roles
- Advanced Practitioner roles and ability to support training and fund a position when they successfully pass the programme.
- Professional Nurse/Midwife Advocates
- Vacancies for graduates
- Future of Internationally Educated Nurses recruitment

Further detailed workforce planning discussions will be held within the next Establishment Reviews (October-November 2025) to inform the business planning and business case processes.

3. WORKFORCE KEY PERFORMANCE INDICATORS (KPI) FINDINGS

3.1 In March 2025, ESR reported that Whittington Health Nursing and Midwifery funded establishment represented 2092.28 WTE (1414.75 WTE Registered and 677.53 WTE Unregistered staff). This is a 2.6 % increase from October 2024 (+ 1.4% Registered and +3.9 % Unregistered).

3.2 In March 2025, the overall staff turnover shows a marginal improvement (10.38%) compared to September 2024 (10.94%) and has now been below the 13% target across all ICSUs for both Registered (10.00%) and Unregistered staff 10.76%) since November 2023 (13.68%).



	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Unregistered %	10.7	10.7	11.2	11.3	11.4	10.9
registered %	9.8	9.0	8.6	8.3	8.5	8.8
total %	10.3	9.9	9.9	9.8	9.9	9.9
Target	13.0	13.0	13.0	13.0	13.0	13.0

Table 1- Trust Registered/Unregistered Turnover October 2024-March 2025

Since April 2024, work is progressing across NCL to implement the band 2 to 3 uplift of the Health Care Assistant workforce. A working group has been set up, including HR ,staff side partners and Corporate Nursing to ensure complex financial, HR processes and governance are in place to complete the process in the best interest of the staff and organisation. The detailed business case is currently being reviewed through the relevant decision-making committees.

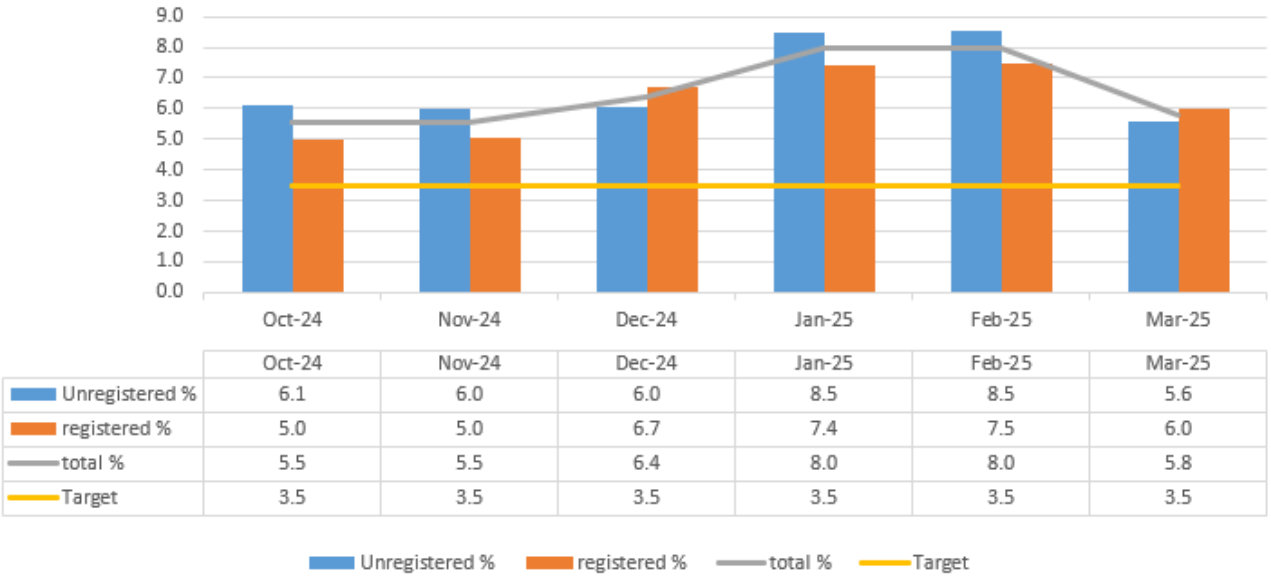
3.3 Staff sickness related absence remains above the Trust target of 3.5% at 6.5% in October 24 -March 25.

The themes for long term sickness remain as previous reports: mental health and musculoskeletal (MSK) disorders plus seasonal ailments for short term absences.

The average rate over the 6 months period shows a continued deterioration (6.8% Registered Vs 6.3% Unregistered) from last review period (5.1% Registered Vs 4.7% Unregistered)).

Work continues in partnership with HR and Occupational Health to support colleagues back to work.

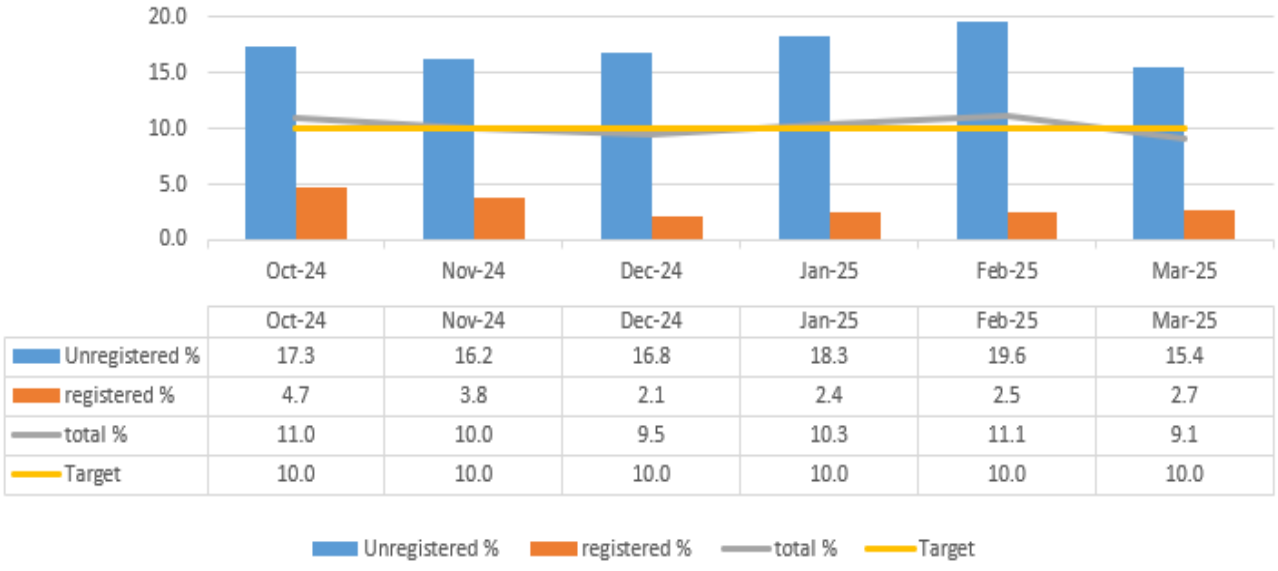
The most impacted ICSUs are ACS and ACW



	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Unregistered %	6.1	6.0	6.0	8.5	8.5	5.6
registered %	5.0	5.0	6.7	7.4	7.5	6.0
total %	5.5	5.5	6.4	8.0	8.0	5.8
Target	3.5	3.5	3.5	3.5	3.5	3.5

Table 2- Trust Registered/Unregistered Sickness October 2024-March 2025

3.4 The recruitment vacancy target (below 10 %) has overall improved from 11.3% in September 2024 at the last establishment review to 9.1%. The scores have deteriorated for unregistered staff (17.3% in last 6 months period compared to 15 % the previous review period). In contrast, the registered workforce vacancy rate has remained under 10% with an overall 3% average vacancy rate from October 24 to end of March 2025 (compared to 5% the previous period).



	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Unregistered %	17.3	16.2	16.8	18.3	19.6	15.4
registered %	4.7	3.8	2.1	2.4	2.5	2.7
total %	11.0	10.0	9.5	10.3	11.1	9.1
Target	10.0	10.0	10.0	10.0	10.0	10.0

Table 3- Trust Registered/Unregistered Vacancy Oct 2024- March 2025

3.5 Further detailed discussions on workforce data and KPIs will be held at the next Establishment Review meetings in October/November 2025 with ongoing monitoring and review of individual ICSU recruitment and retention plans, alongside ongoing monthly monitoring by ICSU leadership and corporate services.

3.6 Following staff feedback about roster fairness, wellbeing and the new flexible working policy the Safer Staffing and Roster Utilisation team is currently implementing Team Based Rostering (or self-rostering) for nurses across the organisation. The aim is to have all clinical areas included by the end of 2026. A post implementation evaluation will be shared in the next establishment review report. Currently 12 clinical areas are enrolled across ACW, EIM, CYP and S&C.

3.7 Over recent months, the nursing leadership teams have been actively engaged in national and regional forums on Enhanced Therapeutic Observations and Care (ETOC), previously known as 1:1 care. This work responds to rising demand for enhanced support, particularly for patients with mental health needs.
The trust provides ETOC to an average of 20–25 patients every 24 hours across services including EIM, CYP, and S&C. Additionally, EC requirements are now being recorded daily in ED, averaging three patients per day.
To improve workforce planning and care insight, ETOC data will be included in all Provider Workforce Returns (PWR) from June 2025. Following 12 months of detailed data collection and evaluation, a more comprehensive review will be undertaken.

3.8 The work to improve Net hours (under and over contracted hours worked by staff) is continuing and the overall position improving. Further work has been undertaken and the written proposal shared with Executive team to achieve a position where the following can be implemented.:

- That historical net over/under-utilised hours be cleared from the eRostering system as a one-time, exceptional measure. This recommendation follows comprehensive reviews which have confirmed that all reasonable avenues for resolution have been explored. Clearance will allow teams to reset their baseline and ensure more accurate forward planning. From this point onward, ICSUs will be expected to take full accountability for managing Net Hours in accordance with the eRostering Policy, with a renewed focus on compliance to policy standards.
- Supporting in principle, the recommendation to invest financially in the Eroster team recognising the need for additional capacity and expertise to strengthen service delivery, ensure ICSU compliance, and support improvements and projects

4. OUTCOME

4.1 The establishment reviews confirm that when nursing and midwifery levels are fully established with the recommended budgeted establishments, all areas meet the safer staffing standards except for the following:

- **Emergency and Integrated Medicine EIM):**

Paediatrics ED: 2.8WTE WTE band 5 Registered Nurse (below summary table. Also refer to **Appendix 4**)

Current position	- Establishment: 15.78 WTE - Coverage: 3 Registered Nurses (RNs) per shift (day and night) - Risk: Paediatric ED Safer Staffing on the Risk Register (Ref 1564, Score 15) - Mitigation: 4th Nurse through temporary staffing
Recommendation	To meet national safer staffing standards and manage clinical risk, the recommendation is: - Increasing to 4 RNs p on the 11:00–23:00 peak period, to cover the peak activity whilst further analysis is undertaken and reviewed -
Expected Benefits	- Enhanced patient safety and reduced clinical risk - Greater resilience in the face of acuity and demand - Improved training, development, and succession planning - Compliance with national and professional standards
Next Steps:	- Financial assessments complete; further audits planned to monitor demand trends - Alignment with long-term staffing models under review

The safer staffing team conducted an activity/acuity audit for paediatric ED (using SNCT and SafeCare) for the first time and independent of Adult ED.
Overall activity was also collected from 2022-2025.

The outcome showed (tables 4 and 5 below):

- Average daily activity of 67 patient per day /day (This aligns with SNCT data period)
- This represents 22% of the total ED activity.
- 64% of the patients received care in Major Paeds (43 average/day)
- 12% of patients triaged were category 1/2 (8 average/day)
- 2 HDU cubicles used.

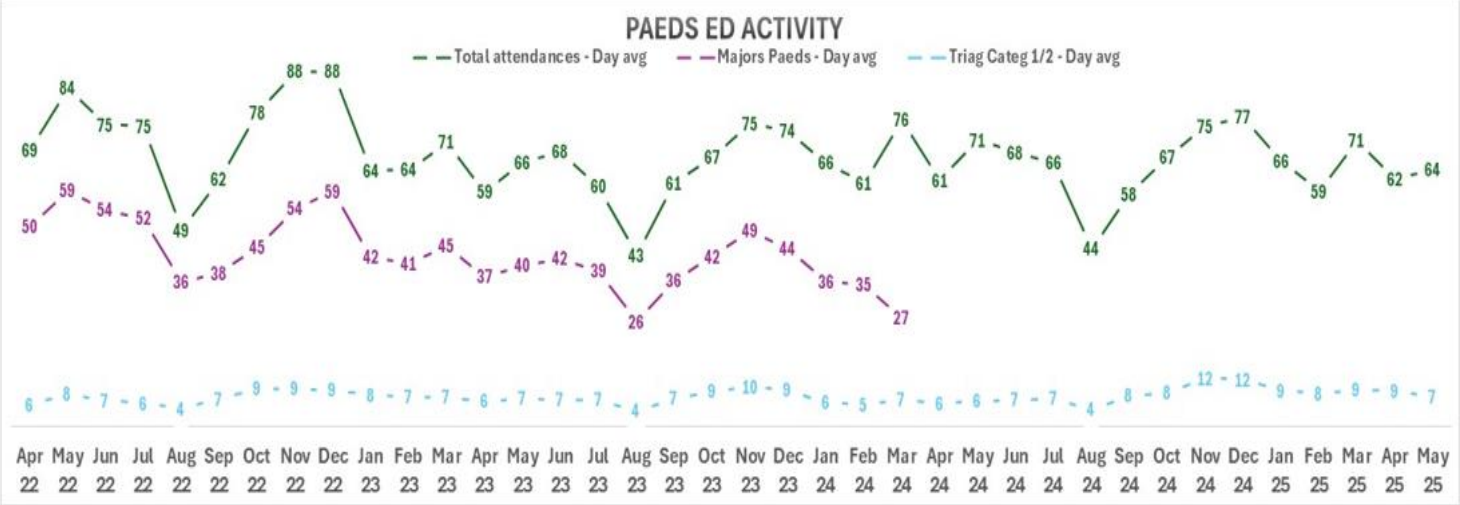


Table 4- Paeds ED activity 2022-2025

- There is increased attendance from 10.00 with a clear peak of higher presentation from 15.00 to 20.00. To meet this demand and complete the patient care pathway, there is a recommendation of an increase in Paediatric ED staffing from 11am to 11pm. (table 5)

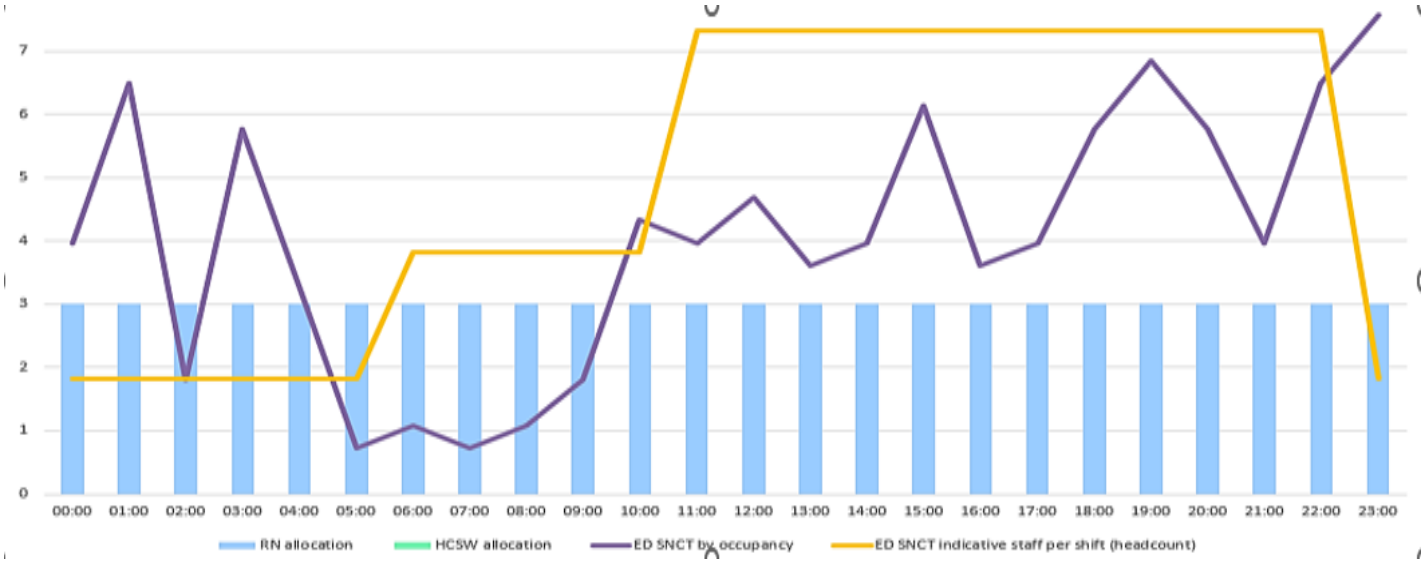


Table 5- Paeds ED – SNCT indicative deployment requirements- Feb 2025

Following the outcome of the review, the recommendations are:

- 5 RNs per shift (SNCT Feb 2025)
- Minimum of 2 paediatric nurses per shift (RCPCH, 2018)
- Minimum of 2 paediatric nurses per shift with trauma & emergency training (RCPCH, 2018)
- Triage RN (RCPCH, 2022)
- Practice development & support (RCPCH, 2018)
- 1:1 RN to patient ratio when resuscitation cubicles occupied (RCN)
- 1:2 RN to patient ratio when HDU/Level 2 cubicles occupied (RCN)

Further audits will be undertaken over the next 6 months to validate.

To meet safer staffing standards and reduce risk (Risk Register ref 1564, score 15), the leadership team recommends increasing staffing with the request to recruit 2.5 WTE band specifically for 11:00–23:00 peak hours.

Current position	- Establishment: 15.78 WTE - Coverage: 3 Registered Nurses (RNs) per shift (day and night) - Risk: Paediatric ED remains on the Risk Register (Ref 1564, Score 15)

This increase would:

- Address safety concerns and mitigate clinical risk.
- Enhance team resilience and skill mix.
- Support staff training, development, and succession planning.

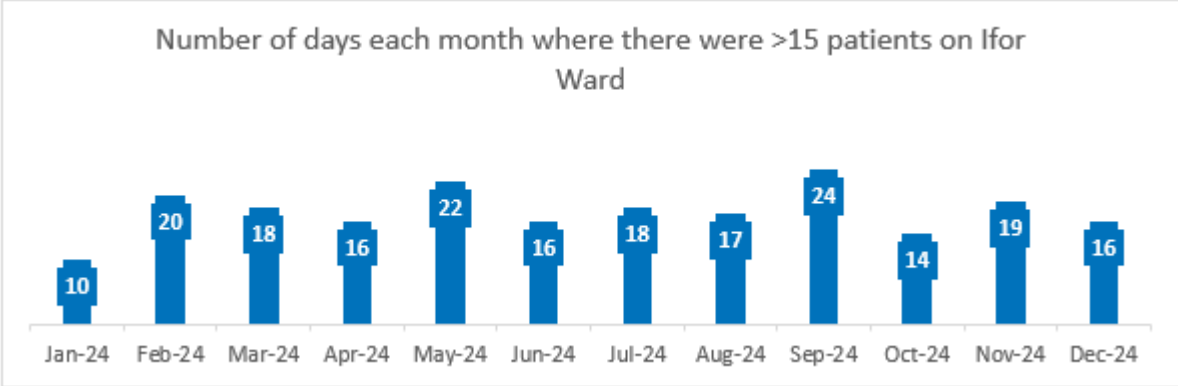
- Align with RCPCH and RCN standards on paediatric emergency care.

Further audits are planned to support a long-term staffing model based on trends and acuity.

➢ **Children and Young People (CYP):**

<u>Ifor Ward</u>
To agree in principle the increase in staffing associated with an increase in the bed base from 15-17. A business case been shared following joint work with the Safer Staffing team to produce an effective workforce model and skill mix.
Ifor ward is a 15 bedded ward. In October 2023, 2 additional were opened to support winter pressures and since then, it has operated on the basis that 17 patients can be accommodated at any one time. Additional staffing is currently sourced through temporary staffing.

Table 1 shows the number of days there are more than 15 patients in the ward.



➢ **Children and Young People (CYP):**

<u>Ifor Ward</u>: A request to put in 0.5 WTE band 7 Practice Development Nurse (PDN)

This is in addition to the current 0.5 WTE in post. The ward currently has a junior workforce which requires additional training and support to manage increased acuity and complexity of patients' profile (particularly the increase complex mental health needs). Following the review process this request has been declined. Mitigations put in place are the provision of increased training regarding supporting young people with mental health needs, and opportunities for support from the central education team.

4.2 Several departments and wards are experiencing intermittent staffing pressures due to sickness, staff turnover, vacancies, and higher patient care needs. To ensure patient safety, especially in high-pressure areas, temporary staff are deployed as needed to cover gaps and manage increased patient acuity and dependency. Red shifts/flags are monitored through the daily staffing meeting and Datix and mitigated through deployment or mitigations to

reduce risk to patient and staff. A summary can be found in **Appendix 2, Page 19**

4.3 As part of the establishment review and staffing requirement assessment, there was a focus on CHPPD analysis. Care hours per patient day (CHPPD) is a metric used in inpatient settings in healthcare to measure the amount of care provided per patient in a 24-hour period. CHPPD gives a picture of how staff are deployed and facilitates benchmarking with other wards in the hospital, or with similar wards in other hospitals. CHPPD covers both temporary and permanent care staff but excludes student nurses and student midwives and staff working across more than one ward. Information for all inpatient areas are detailed in **Appendix 3, Page 21**

4.4 Any additional posts requested to provide ongoing safe staffing service expansion/increased patient acuity are reviewed as part of the business planning, vacancy and financial review processes following agreement in principle by the Chief Nurse.

4.5 Outcome summary tables for each clinical area are available in **Appendix 4, Page 22**

5. RECOMMENDATIONS

- The proposed investment outlined in the executive summaries and report narrative, are supported to proceed through local planning and business cases.

- The Nursing and Midwifery establishments will formally be reviewed again at the bi-annual-review in Autumn 2025. The data collection and audits for this period will start in August 2025. Staffing metrics will be monitored monthly through various governance and performance forums.

- All the establishment reviews are used as part of the tools to assess changing demand and capacity to advise on ICSUs strategies. This ongoing work should inform some of the recommendations in the next establishment review.

- A deeper dive of enhanced care requirements will be undertaken outside of this process.

Appendix 1- Compliance with Recommendations of the Developing Workforce Safeguards (DWS)

Recommendation	Compliance	Evidence
1. Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance	Compliant	• Monthly Nursing & Midwifery Safe Staffing paper set out as per expectations of the NQB (2016) • Safer Nursing Care Tool recommendations with February and August data collection periods. • CHPPD reported monthly in comparison with peers
2. Trusts must ensure the three components are used in their safe staffing processes: – evidence-based tools (where they exist) – professional judgement – outcomes	Compliant	• Evident within the Bi-Annual Establishment Review packs
3. We will base our assessment on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable	Compliant	• Confirmation included in annual governance statement that our staffing governance processes are safe and sustainable
4. We will review the annual governance statement through our usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures	Compliant	• Confirmation included in annual governance statement that our staffing governance processes are safe and sustainable
5. As part of this yearly assessment we will also seek assurance through the SOF, in which a provider's performance is monitored against five themes	Compliant	• Quality dashboards developed for nursing and midwifery (e-rostering performance metrics) • Staffing governance meetings review/discuss KPIs and produce action plan with remedial actions for suboptimal performance.
6. As part of the safe staffing review, the Director of Nursing and Medical Director must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective, and sustainable	Compliant	• The Chief Nurse or Dep Chief Nurse attends and chairs the Annual Establishment Review meetings. • The Chief Nurse is positioned as responsible director for monthly Nursing & Midwifery safer staffing metrics. • The Chief Nurse plays an active leadership role for Safe Staffing evolvement and aspirations

7. Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting	Compliant	• Evident in the workforce strategy • Safer staffing discussed at a public Board
8. They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month	Compliant	• Quality dashboards developed for nursing and midwifery (e-rostering performance metrics) •
9. An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance5 and NHS Improvement resources. This must also be linked to professional judgement and outcomes	Compliant	• Evident in the format of this paper • Establishment Review Cycle demonstrates bi-annual reporting process following review of establishments
10. There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool	Compliant	• Evident and continuously reviewed by the Lead Nurse for Safe Staffing • Lead Nurse for Safe Staffing is responsible for the training of the Safer Nursing Care Tool (SNCT) and ensuring staff are aware that adaptions to the tool are not condoned
11. As stated in CQC's well-led framework guidance (2018)6 and NQB's guidance7 any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review	Compliant	• QIAs evident and located within the appendices
12. Any redesign or introduction of new roles (inc but not limited to physician associate, nursing associates & advanced clinical practitioners) would be considered a service change and must have a full QIA	Compliant	• QIAs evident and located within the appendices

13. Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance, and staff experience must be clearly described in these risk assessments	Compliant	• Escalation process and guidance included within the Staffing escalation procedure (under review) • Daily operational oversight and leadership for staffing led by allocated Senior Nurse
14. Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.	Compliant	• Escalation process and guidance included within the Safe Staffing for Nursing and Midwifery Trust Policy and Procedure (2023) • Daily operational oversight and leadership for staffing led by allocated Senior Nurse

Appendix 2 - Red Shifts/Flags

Table 1: All ICSUs/Divisions

Table 2: Maternity Services

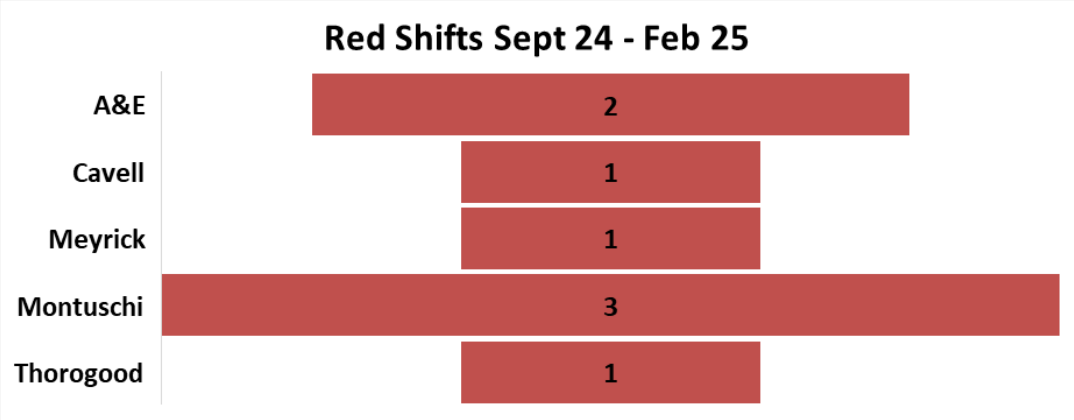
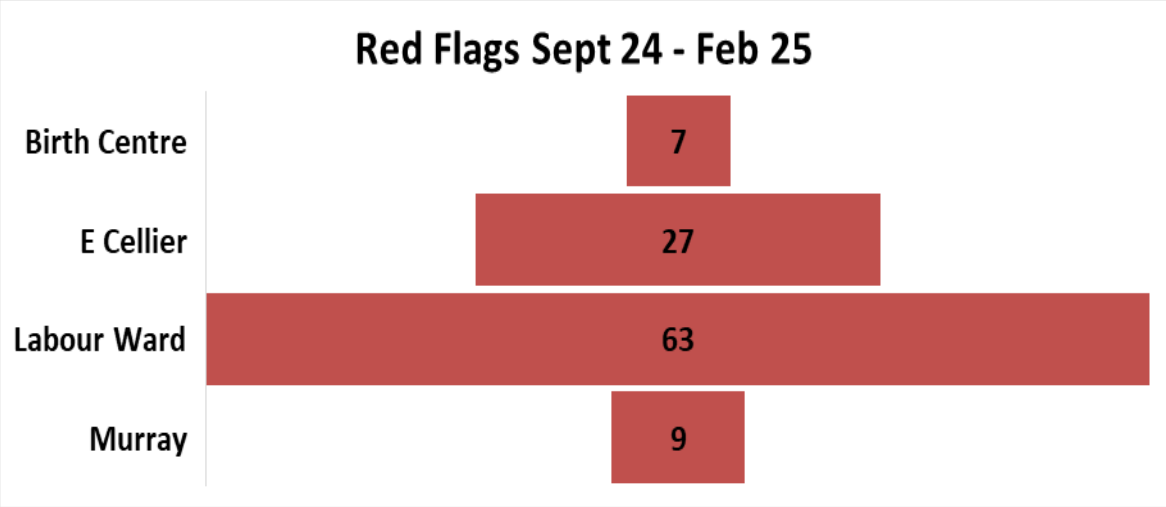
Table 1 (all ICSUS)	**Narrative**
	A total of 8 Red Shifts from September 2024 to February 2025. Several red shifts were downgraded following staff redeployment within the 1st hour of the shift and mitigation of the risk.

Table 2 – Maternity	**Narrative**
	Main reason for the Red Flags were inability for staff to take break and delays in delivery of care or transfer of care. The Birth Centre was suspended on several occasions to redeploy staff and mitigate the risk. Reported causes of the red flags were sickness and activity.

Appendix 3- Inpatients Care hours per patient day (**CHPPD**)

Table 1: Surgery and cancer

Table 2: Children and Young People

Table 3: Emergency and Integrated Medicine

Table 4: Maternity Services

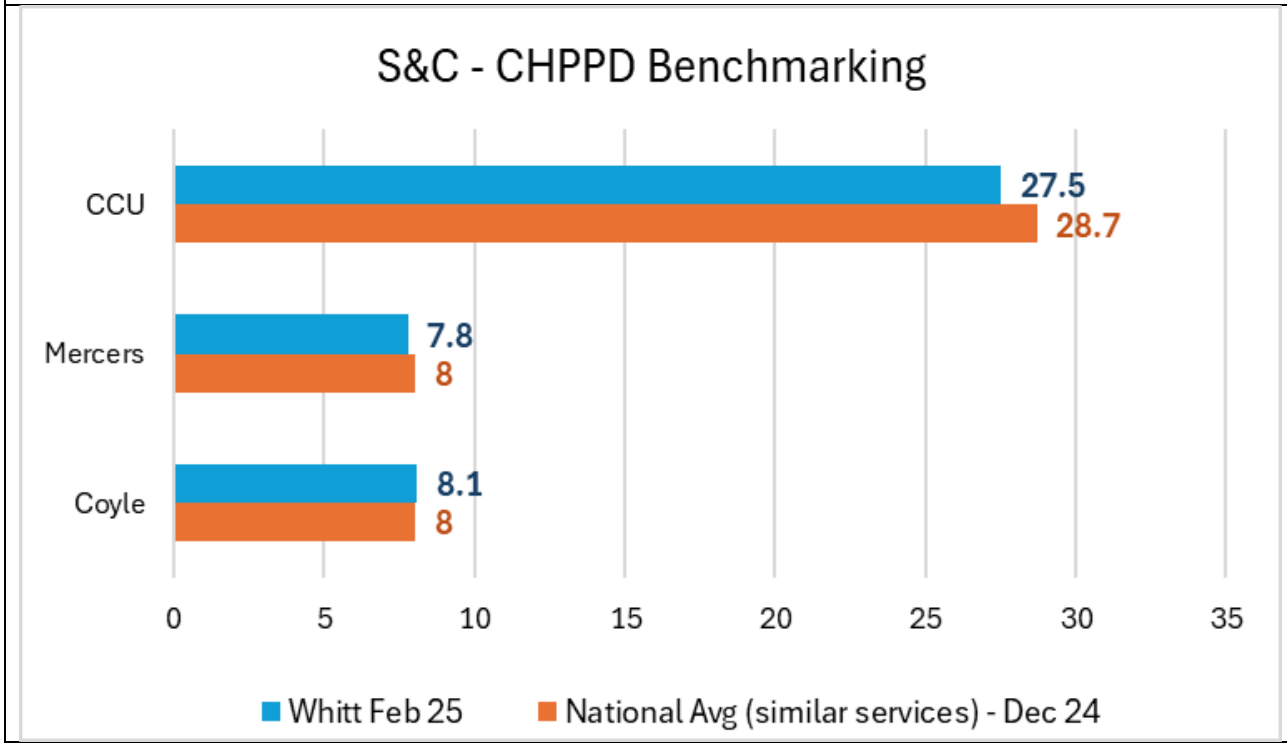
Table 1 – S&C CHPPD	**Narrative**
	CHPPD of the surgical wards was almost aligned with the national average in Feb 25. CHPPD in CCU below the national average (not occurring often) due to increased activity above the funded bed capacity on several occasions.

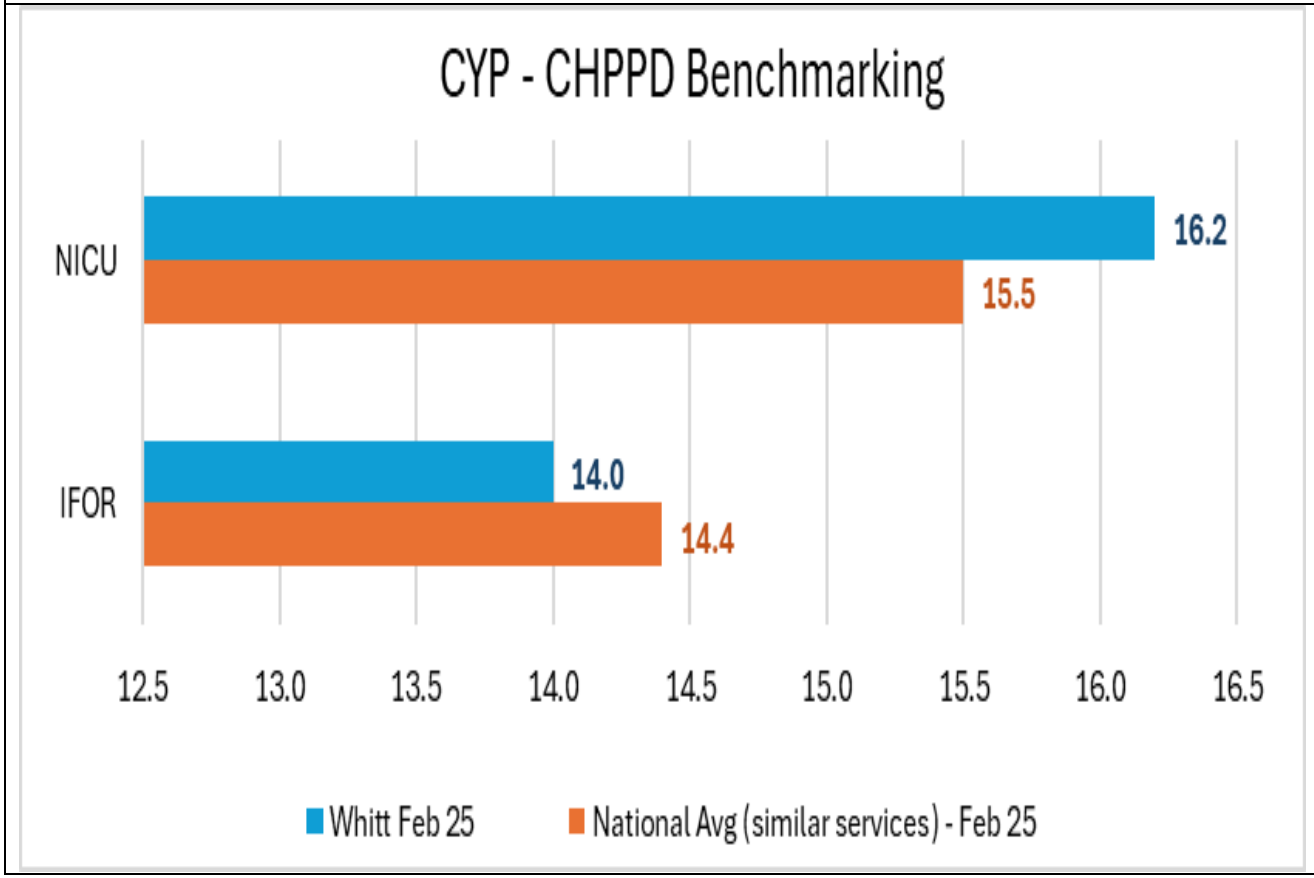
Table 2 – CYP CHPPD	Narrative
	CHPPD on NICU exceed national average by more than 0.5 (unit reported reduced activity during Feb 25, not aways possible to redeploy staff or give annual leave) CHPPD on Ifor ward is below the national average at acceptable level (less than 0.5 variance). Occupancy exceeded funded capacity on several days/shifts. NICU supported where possible.

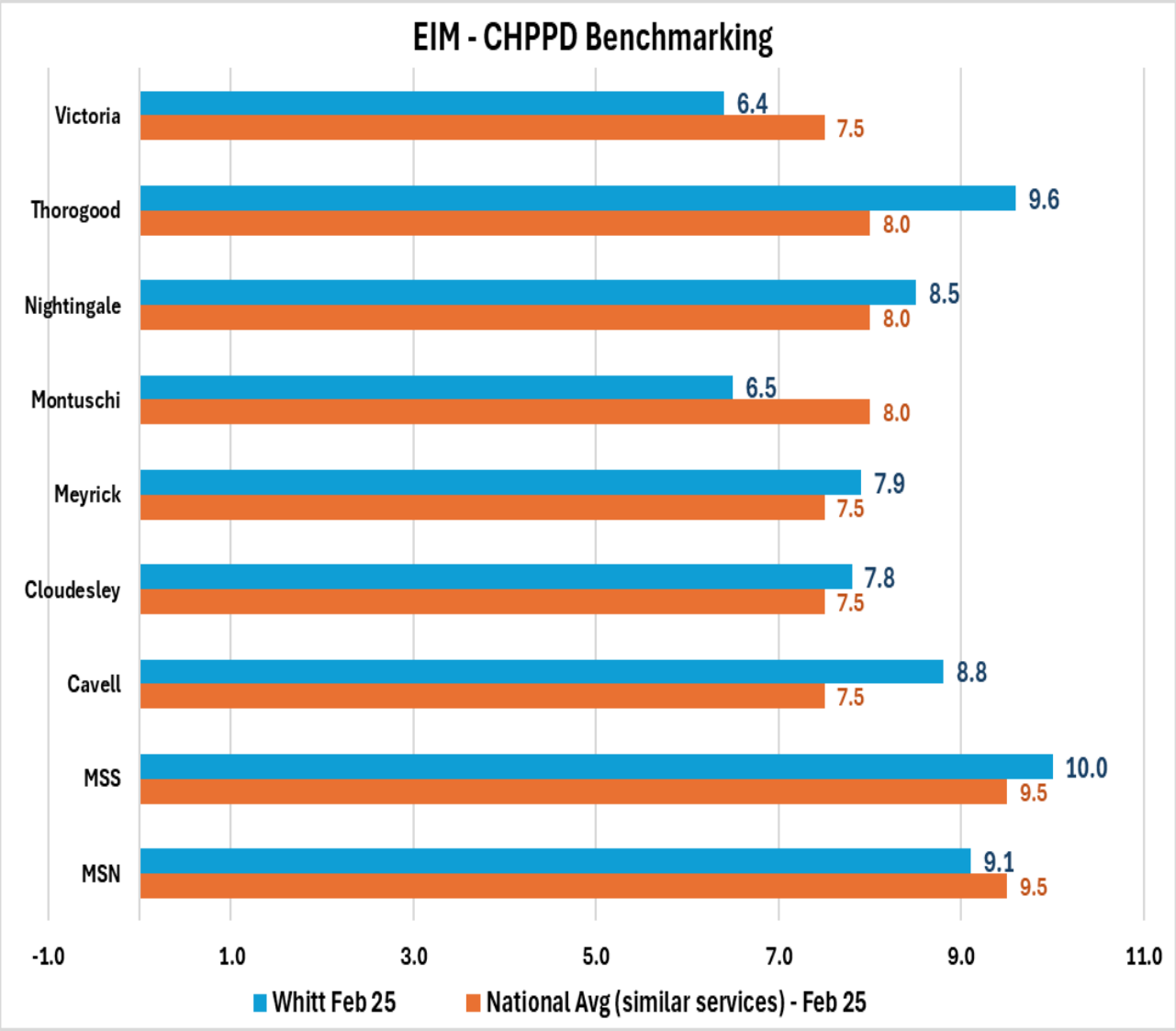
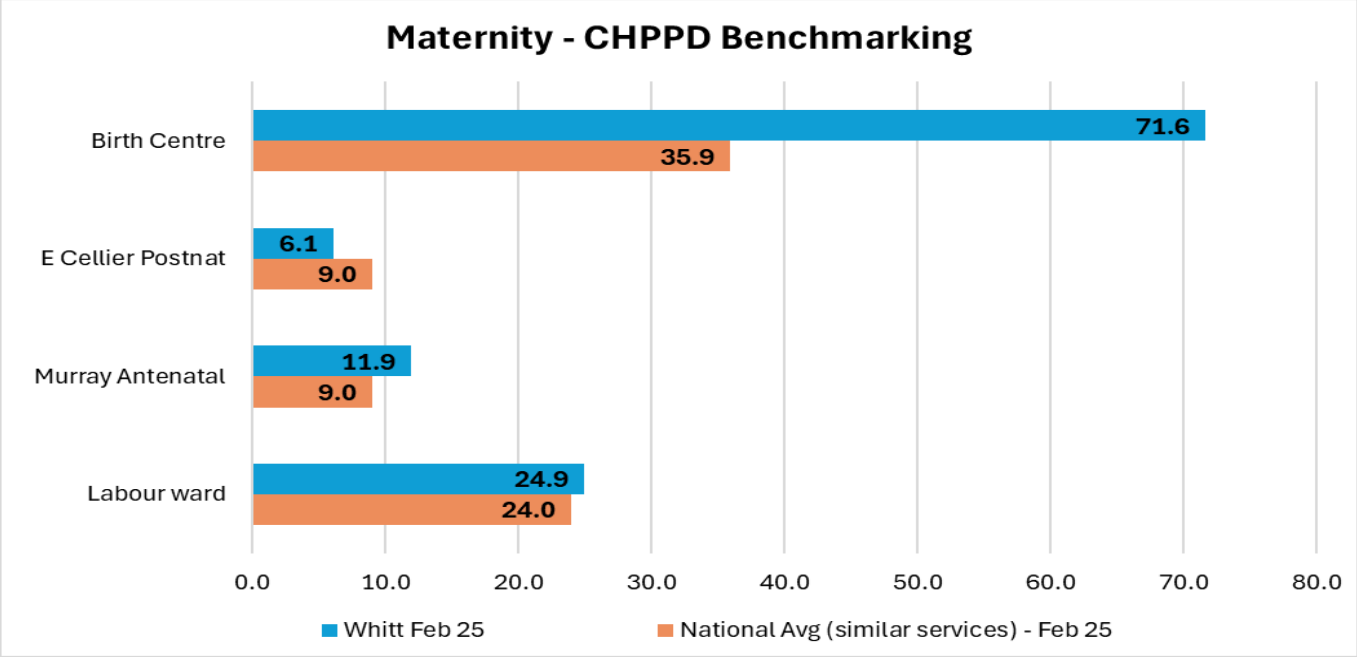
Table 3 – EIM CHPPD	Narrative
	There is a mixed picture of how local CHPPD compared to national average. CHPPD variance in 5 of the 9 wards is less than 0.5 unit. CHPPD on Thorogood and Cavell wards exceed national average by more than 1 unit (both wards know for high acuity and EC requirement) CHPPD on Montuschi, Victoria and MSN wards is below the national avg. CHPPD on Montuschi has been consistently below the national avg. Establishment review in 2024 approved the addition of 1 HCA on the night shifts. Acuity of patients is lower than in a standard cardiology ward.

Table 4 – Maternity CHPPD	Narrative
	CHPPD takes account of mothers and babies. CHPPD on Cellier ward has been consistently below the national avg. CHPPD include all staff on roster plus NIPPE RM. There is likely to be an improvement following the restructure of the maternity service. CHPPD on Murray ward has recently dropped below the national avg. Very high CHPPD in Birth Centre in comparison to the national average for several consecutive establishment review rounds. Service to consider sustainability of the existing service and staffing model. Staff redeployments from Birth Centre are not always reflected in the eRoster, therefore there is a degree of excessive calculation of the CHPPD for the setting and potentially undercalculation for Cellier and Murray wards

Appendix 4- Outcome summary tables

Table 1: Surgery and cancer

Table 2: Children and Young People

Table 3a and 3b: Emergency and Integrated Medicine

Table 4: Maternity Services

Table 1 - Surgery & Cancer (S&C)									
Ward/ clinical setting	**Description**	**Funded Bed capacity** **(Daily average occupancy Feb 25)**	**Funded Establishment Feb 2025 (wte)** **R**: Registered **U:** Unregistered	**SNCT funding recommendation as per Feb 25 Audit (wte).** Enhance Care Excluded	**SNCT funding recommendation as per Feb 25 Audit (wte).** Enhance Care Included	**Professional Bodies & guidelines recommendations**	**Reg : Patients ratio (as per roster planning)**		**Comments, recommendations, actions, proposed from Establishment R/V meeting**
							Day	Night	
Coyle ward	Non-elective orthopaedic, trauma, gen. surgery.	26 beds 23.5 pts/day	47.63 wte 23.73 wte **R** 18.90 wte **U**	39.39 wte 25.60 **R** 13.79 **U**	39.71 wte 25.81 **R** 13.90 **U**	RCN critical Ratio 1RN:8pt 20 RNs wte	1:5	1:7	No change
Mercers ward	Surgical ward for **spinal, bariatric**, emergency laparotomies,	18 beds 16.5 pts/day	31.00 wte 19.70 wte **R** 11.30 wte **U**	25.67 wte 16.69 wte **R** 8.98 wte **U**	25.67 wte 16.69 wte **R** 8.98 wte **U**	RCN critical Ratio 1RN:8pt 14.5 RNs wte	1:5	1:5	No change 8 single-rooms
Critical Care Unit (ICU)	Care of patients with single/multiple organ failure.	10 (+2) 10 pts/day	66.9 wte 66.9 Reg **R**	Not applicable	Not applicable	Intensive Care society: 67.5 – 10 beds 77.9 – 12 beds	1:1 for Level 3 1:2 for Level 2		Fluctuating occupancy above bed-base. 4 single rooms

Table 2 – Children and Young People (CYP)

Ward/ clinical setting	Description	Funded Bed capacity (Daily average occupancy Feb 25)	Funded Establishment Feb 2025 (wte) **R**: Registered **U:** Unregistered	SNCT funding recommendation as per Feb 25 Audit (wte). Enhance Care Excluded	SNCT funding recommendation as per Feb 25 Audit (wte). Enhance Care Included	Professional Bodies & guidelines recommendations	Reg : Patients ratio (as per roster planning)		Comments, recommendations, actions, proposed from Establishment R/V meeting
							Day	Night	
Ifor ward	For children with acute physical & mental health illness.	15 beds 14 pts/day range 10-18 pts/day	36.25 wte 30.65 wte **R** 5.60 wte **U**	33 wte 28.1 wte **R** 5.0 wte **U**	38.8 wte 29.1 wte **R** 9.7 wte **U**	RCN/NQB guidance for 15 patients 42.25 wte (90% RNs)	1:3	1:4	To make a decision to staff up to 17 beds to support activity
Neo Natal Unit (NICU)	Funded for 6 Level 3, 6 Level 2 and 11 special care cots	23 cots 11 pts/day	57.55 wte 54.56 wte **R** 2.99 wte **U**	Not applicable	Not applicable	RCN/NQB guide - 23 cots 67.40 wte (90% RNs)	1:1 - Level 3 1:2 - Level 2 1:4 - Sp Care		To support Ifor staffing as activity allows

Table 3a - Emergency & Integrated Medicine (EIM)- ED, Urgent care, and AAU									
Ward/ clinical setting	**Description**	**Funded Bed capacity** **(Daily average occupancy Feb 25)**	**Funded Establishment Feb 2025 (wte)** **R**: Registered **U:** Unregistered	**SNCT funding recommendation as per Feb 25 Audit (wte).** Enhance Care Excluded	**SNCT funding recommendation as per Feb 25 Audit (wte).** Enhance Care Included	**Professional Bodies & guidelines recommendations**	**Reg : Patients ratio (as per roster planning)**		**Comments, recommendations, actions, proposed from Establishment R/V meeting**
							Day	Night	
ED- Adult	Emergency department	298 avg attend/day	99.79 wte 70.50 wte **R** 29.29 wte **U**	100 wte 80 wte **R** 20 wte **U**	Not applicable	NICE 2015 & NQB 2018 See r/v pack	Not applicable		No change
ED- Paeds	Emergency department	67 avg attend/day	15.78 wte 15.78 wte **R**	27.50 wte 27.50 wte **R**	Not applicable	RCPCH 2022 & RCN 2024 See r/v pack	Not applicable		2.5 WTE band 5

SDEC/Amb care	Ambulatory and same day care		19.49 wte 14.25 wte **R** 5.24 wte **U**	Not applicable	Not applicable	Activity, performance & professional judgement	Not applicable		No change
Urgent Care Centre	Consisted of ACPs, ENPs & RD PDNs		13.44 wte 13.44 wte **R**	Not applicable	Not applicable	Activity, pathways, performance & professional judgement	Not applicable		No change
Acute Assessment Units (AAU)	For patients admitted from ED and require assessment and treatment prior to discharge or transfer to a ward	**34 beds** **32 pts/day**	**66.66 wte** **41.46** wte **R** **25.2** wte **U**	**65.93 wte** **47.47** wte **R** **18.46** wte **U**	**71.12 wte** **51.21** wte **R** **19.91** wte **U**	**RCN critical Ratio 1RN:8pt** **N/A for AAUs**	1:4.2	1:5.6	No change
Mary Seacole North (AAU)		16 beds 15 pts/day	33.33 wte 20.72 wte **R** 12.6 u wte **U**	30.88 wte 22.23 wte **R** 8.65 wte **U**	34.43 wte 24.79 wte **R** 9.64 wte **U**	RCN critical Ratio 1RN:8pt N/A for AAUs	1:4	1:5.3	
Mary Seacole South (AAU)		18 beds 17 pts/day	33.33 wte 20.72 wte **R** 12.6 wte **U**	35.05 wte 25.24 wte **R** 9.81 u wte **U**	36.69 wte 26.42 wte **R** 10.27 wte **U**	RCN critical Ratio 1RN:8pt N/A for AAUs	1:4.5	1:6	

Table 3b - Emergency & Integrated Medicine (EIM)- Inpatient wards								
Ward/ clinical setting	**Description**	**Funded Bed capacity**	**Funded Establishment**	**SNCT funding recommendati**	**SNCT funding recommendati**	**Professional Bodies &**	**Reg : Patients ratio (as per**	**Comments, recommendations**

		(Daily average occupancy Feb 25)	Feb 2025 (wte) **R**: Registered **U:** Unregistered	on as per Feb 25 Audit (wte). Enhance Care Excluded	on as per Feb 25 Audit (wte). Enhance Care Included	guidelines recommendations	roster planning)		, actions, proposed from Establishment R/V meeting
							Day	Night	
Cavell ward	Care of Older People (COOP), high % of pts dependent or require EC.	24 beds 23.8 pts/day	43.44 wte 21.19 wte **R** 22.25 wte **U**	42.63 wte 27.71 wte **R** 14.92 wte **U**	50.01 wte 32.51 wte **R** 17.50 wte **U**	RCN critical Ratio 1RN:8pt 16.5 RNs wte	1:6	1:8	No change
Cloudesley ward		25 beds 25 pts/day	43.45 wte 21.19 wte **R** 22.26 wte **U**	38.01 wte 23.70 wte **R** 13.33 u wte **U**	43.79 wte 28.46 wte **R** 15.33 wte **U**	RCN critical Ratio 1RN:8pt 17.1 RNs wte	1:6	1:8	No Change
Meyrick ward		25 beds 24.9 pts/day	43.44 wte 21.19 wte **R** 22.25 wte **U**	43.08 wte 28.00 wte **R** 15.08 wte **U**	47.90 wte 31.13 wte **R** 16.76 wte **U**	RCN critical Ratio 1RN:8pt 17.1 RNs wte	1:6	1:8	No change
Montuschi ward	Cardiology ward with 4 Level 2 Coronary Care beds	17 beds 16.9 pts/day	21.61 wte 16.42 wte **R** 5.19 wte **U**	27.35 wte 19.14 wte **R** 8.20 wte **U**	27.35 wte 19.14 wte **R** 8.20 un wte **U**	RCN critical Ratio 1RN:8pt 11.7 RNs wte	1:6	1:6	Add 1 HCA at night. Approved at est reviews 2024
Nightingale ward	Acute & chronic respiratory care, 4 Level 2 beds, 9 single-rooms.	23 beds 22.6 pts/day	38.25 wte 25.45 wte **R** 12.80 wte **U**	37.33 wte 19.14 wte **R** 8.20 wte **U**	38.29 wte 24.89 wte **R** 13.40 wte **U**	RCN critical Ratio 1RN:8pt 16 RNs wte	1:5	1:6	Add 1 HCA at night. Approved at est reviews 2024
Thorogood ward (Gastro & Haem)	Acute medical ward for gastro and haem conditions	25 beds 27 pts/day	45.42 wte 26.3 wte **R** 19.12 wte **U**	33.93 wte 22.06 wte **R** 11.88 wte **U**	49.35 wte 32.08 wte **R** 17.27 wte **U**	RCN critical Ratio 1RN:8pt 18 RNs wte	1:5	1:6	Th'good and Victoria wards swapped specialty and staff in May 25
Victoria ward (low acuity)	Medical ward for patients with low acuity	25 beds 24.6 pts/day	34.46 wte 22.92 wte **R**	42.21 wte 29.55 wte **R**	42.21 wte 29.55 wte **R**	RCN critical Ratio 1RN:8pt	1:6	1:8	Th'good and Victoria wards

			11.54 wte **U**	12.66 wte **U**	12.66 wte **U**	18 RNs wte			swapped specialty and staff in May 25

Table 4 – Maternity Summary							
Ward/ clinical setting/ service	**Description**	**Annual Births activity**	**Additional Annual Intrapartum Activity** (includes postnatal readmissions, antenatal cases requiring 1:1 etc)	**Funded Establishment** **Feb 2025 (wte)** **R**: Registered **U:** Unregistered	**BirthRate Plus workforce assessment. Nov 2023**	**Professional Bodies & guidelines (wte)**	**Comments, recommendations, actions, proposed changes from Establishment r/v meeting**
Maternity	Acute and community maternity services	2983	508	201.61 wte 155.87 wte **R** 45.74 wte **U**	171.02 wte	BR+ endorsed by NICE, RCM & RCOG	Service underwent a restructure in late 2024 resulting in adjustments to the establishments in several parts of the service.

Patient safety incident investigation (PSII) report

Incident ID number:	A118855
Date incident occurred:	03/10/24
Report approved date:	
Approved by:	

Distribution list

Name	Position
Nadine Jeal	ACS clinical director
Betty Njuguna	ACS Associate director of nursing
Lorraine Patel	ACS Associate Director of AHP and Haringey Borough Lead
Iliana Neshkova	ACS Risk and Quality Lead
Senior management team	Haringey Talking Therapies
Christina Keating	North Central London Child Death Overview Panel Designated Lead Nurse
Charlotte Davies	Haringey & Islington Child Death Overview Panel SPOC Safeguarding Children's Team – Whittington Health NHS
Nickola Rickard	Interim Head of Safeguarding Children Whittington Health NHS Trust
Tina Karema	Interim Named Nurse, Whittington Health Haringey Children's Community Services
Aliki Myrianidi	Hi intensity CBT trainee

About patient safety incident investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the Engaging and involving patients, families and staff after a patient safety guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

A note of acknowledgement

The investigation team acknowledge that this investigation and subsequent report is a result of a particularly traumatic incident where a client sadly died. The investigation team would like to pass on their condolences to the client's relatives, in particular his sister and mother and father who chose not to take part in the investigation process.

The team would like to thank all the staff members who have been part of the incident investigation process. In particular the trainee member of staff who was treating the client, the impact this incident has had on them is significant and we thank them for their openness and participation in this investigation.

Executive summary

Incident overview

On Thursday 3rd October 2024, a patient who was in treatment with Haringey Talking Therapies was found deceased in his home. At the time of the incident, he was 16 years and 11 months old. We were notified of this incident on Friday 04/10/24 by the Interim Named Nurse for Whittington Health, Haringey Children's Community Services. The patients' ethnic background was "White other", the family moved to the UK from Bulgaria when he was 6 years old. He spoke English, and he was in full time education.

The patient was found by his father deceased in the bathroom of the family home, with multiple superficial lacerations across left arm, leg, neck and chest, consistent with self-harm. It was also reported that the patient had consumed 1.5 litres of vodka. The patient was pronounced deceased at scene and taken to North Middlesex Hospital.

Following a triage assessment on 13/05/24, he had an assessment for guided self-help on 27/06/24, where he was stepped up to CBT for social anxiety. He had eight sessions of CBT between July and October 2024, the first 4 were face to face and the other four were online. His last session was on Tuesday 01/10/24.

The service routinely asks about suicidal ideation and assesses further if a patient reports risk. The patient's risk was frequently assessed and there was no suicidal risk reported in any of the contacts with the service. When asked about "thoughts of being better off dead or of hurting yourself in some way", he scored 0 (not at all). The self-reported questionnaires were not completed on the 01/10/24, but this was not the first time he missed them, and it is not considered unusual for patients not to complete them occasionally. The sessions notes do not indicate any risk was raised and the clinician confirmed this. There was no current or history of self-harm, no drugs or alcohol use, and he had not indicated any intention to take his own life. There were no child safeguarding issues identified. There was no indication that he met the threshold for escalation or active risk management.

Summary of key findings

The purpose of this PSII was to look at the service provision provided by Haringey Talking Therapies, for patients under 18 years of age, noting that even though the service inclusion criteria are 16+, talking therapy services are set up for adults and Haringey Talking Therapies has no specialist provision or pathway for children. This incident prompted the service to review whether it offers the right provision for this age group, and if it can adequately meet under 18s' needs, and consider improvements and changes in line with best practice.

The key findings of the report are:

- The team provides care for under 18s, even though staff are trained to work with adults and have no specialist training for working with children and young people
- The service does not have a specific pathway for under 18s.
- Young people with moderate to severe mental health difficulties should be diverted to Haringey CAMHS.
- There appears to be limited provision of mental health support services for young people with mild to moderate problems. Mild to moderate difficulties can be signposted to Open Door or primary care (GP and school support).
- Escalation routes for patients who display concern around mental health crisis exist, but for risk in younger patients may present differently to adults.
- At the time of the incident the patient was already in treatment and had been seen within 2 months of being assessed. Even though waiting times were not a factor in this case, there are generally long waits to access the service, and depending on the type of treatment this could be as much as 8 months. This leads to some unquantified risk for young people on the waiting list.

Summary of areas for improvement and safety actions

- Considering the risk implications, and the small numbers of 16- and 17-year-olds that are receiving a course of treatment the investigation team recommends that

the service age criteria to change to 18+, to be in line with adult services age criteria. This change should be done with agreement by the ICB and liaising with children's services.

- Following this sad incident in Haringey, the minimum age issue was raised at an NCL ICB level, as Enfield and Barnet Talking Therapies also offer a service for 16- and 17-year-olds. The ICB is looking at working out a way for a gradual change to 18+ for all three talking therapy services (to be in line with Camden and Islington talking therapies who are 18+), and for all under 18s to move to children's mental health services (CAMHS).
- Enfield and Barnet Talking therapy services are in agreement that the minimum age should change to 18+. The North London NHS Foundation Trust (who also runs the CAMHS services in the 3 boroughs) are in support of this and all three services are liaising to make the change at the same time.
- If the service changes the age criteria, 16- and 17-year-olds who have been referred prior to the official change and who are already under the Talking Therapies service should receive the offered treatment within that service. Those young people would be risk assessed and managed by established risk assessment and management procedures currently in operation within the service.
- If the minimum age criteria were to stay at 16 years, then formal training on young people's mental health should be carried out to assist staff with recognising the differences between presentation in children and adults. The service will also have to organise for all clinicians to complete level 3 child safeguarding training and access to regular child safeguarding supervision. As the service has over 70 clinicians this is expected to take months to complete.

Escalation routes for under 18s should be reviewed to ensure that adequate opportunities for escalation exist, and that staff know how to access and signpost these.

Contents

To update this contents table, click on the body of the table; select ‘update field’; and then ‘update page numbers only’; and then click ‘ok’.

Background and context

As outlined in the “NHS talking therapies for anxiety and depression manual” (version 7, March 2024), the NHS Talking Therapies, for anxiety and depression programme (formerly known as Improving Access to Psychological Therapies, IAPT) was developed to improve the delivery of, and access to, evidence-based, NICE recommended, psychological therapies for depression and anxiety disorders within the NHS.

NHS Talking Therapies services provide treatment for adults with depression and anxiety disorders that can be managed effectively in a uni-professional context. NICE-recommended therapies are delivered by a single competent clinician, with or without concurrent pharmacological treatment. NHS Talking Therapies services also provide treatment for people who have long-term conditions or other persistent physical symptoms in the context of depression and anxiety disorders.

The Haringey Talking Therapies services was set up in 2008, accessible to patients that are aged 16+. The service accepts referrals via the GP, other health care professionals and can self-refer which is the preferred route. Talking therapy services are set up for adults, but there are some that see 16+, such as Enfield and Barnet that were set up by the same lead as the Haringey service. Some services have a specific pathway for under 18s, but not the three NCL services.

This investigation will focus on the access criteria of the service for 16- and 17-year-olds and whether the service should continue seeing children. It also looks at the service’s procedures on identifying and managing risk and how they are interpreted by clinicians.

Description of the patient safety incident

On Thursday 3rd October 2024, a patient who was in treatment with Haringey Talking Therapies was found deceased in his home. At the time of the incident he was 16 years and 11 months old. We were notified of this incident on Friday 04/10/24 by the Interim Named Nurse for Whittington Health, Haringey Children's Community Services.

The patient was found by his father deceased in the bathroom of the family home, with multiple superficial lacerations across left arm, leg, neck and chest, consistent with self-harm. It was also reported that the patient had consumed 1.5 litres of vodka. The patient was pronounced deceased at scene and taken to North Middlesex Hospital.

Investigation approach

Investigation team

Role	Initials	Job title	Dept/directorate and organisation
Investigation commissioner/convenor:			
Investigation lead:	SH	Service manager	Community podiatry (independent investigator), Adult community services, Whittington health
Investigation lead:	EA	Clinical and Operational Lead	Haringey Talking Therapies, Adult community services, Whittington health

Summary of investigation process

The incident took place on Thursday 3rd October 2024 and we were notified on Friday 04/10/24 by the Interim Named Nurse for Whittington Health, Haringey Children's Community Services. A joint agency (JAR) response meeting was held on 8/10/24 attended by the service lead EA. EA reported the incident on the trust's patient safety system Datix on 8/10/24 and a rapid action review was completed. This incident was presented to the Whittington Improvement and Safety Huddle (WISH) on the 11/10/24 and on 22/11/24, when it was declared a PSII incident.

The family called the service on Monday 07/10/24 asking questions about the patient's treatment. The service lead EA spoke to the deceased's sister with the mother present on the 08/10/24, offered our sincere condolences and informed them of the patient's contact with our service. The family was provided with EA's contact details if they had any questions, and they were informed we would contact them

again. EA called the sister on 07/01/25 to inform the family about the investigation process and how they can contribute. The deceased's sister said she would inform her parents, and they would contact us if they wished to take part. As we did not have the parents' phone numbers a duty of candour letter was sent to the family's address on 21/01/25, also informing them of the investigation and inviting them to contact us if they wished to take part, something they did not pursue.

This final report has been approved by the ACS clinical director and the associate director of nursing, before being presented to the WISH panel for final approval. Actions will be followed up within the next month.

Terms of reference

1) Understand the scope of the service

What are the criteria and pathway for access to the Talking Therapies Service?
Is the service in line with national commissioning requirements and service specification?

2) Consider changes to provision of the service

If the service were to stop provision for under 18s what will the impact be and what will be the alternative provision?

If the service does continue with this provision to under 18s, what does the service need to do to meet the national guidelines?

Should the service provide care and support for children (people under the age of 18)?

3) Review of the service risk assessment procedures and interpretation of guidance

Is the patient risk assessment procedure easy to follow and understand?

How do staff interpret guidance and procedures, and do they feel confident doing so?

What is the escalation route and process should a member of staff be concerned about the risk posed by a patient?

The full terms of reference document is available in appendix 1.

Information gathering

The investigation considered the service specification and how it was designed to best support the patients that the service is commissioned to see. This involved reviewing the service specification and commissioning guidance, alongside national frameworks and service policies and procedures.

The member of staff involved in treatment of this patient was invited and took part in an exploratory conversation. This was to identify if they felt there were opportunities for improvements to the service based on this incident.

The investigation also reviewed documentation available to staff, in particular the risk assessment framework and the escalation email which is sent out. It considered if this was adequate and gave staff the right tools to be able support patients.

Findings

The investigation into this incident focussed on the service provision for 16- and 17-year-olds and the process for referral, escalation and risk assessment as set out in the terms of reference. The information gathered and findings are presented in sections, around the three terms of reference.

1. Understand the scope of the service

In this element of the investigation, the service's access criteria were reviewed, as well as the national standards for services working with under 18s.

Question 1: What are the criteria and pathway for access to the Talking Therapies Service?

The investigation team looked at the current access criteria for the Haringey Talking Therapy service, as specified in the service's operational policy document. According to the service inclusion criteria "*The service works with patients aged 16 and over who are registered with a Haringey GP or live in Haringey, experiencing mild to moderate common mental health problems including depression and anxiety disorders*."

There is no specific pathway or any special provision or arrangements for under 18s. The service offers the same referral and assessment process regardless of age, and the treatment options are the same to what adults usually receive.

Question 2: Is the service in line with national commissioning requirements and service specification?

The Haringey Talking Therapies specification from 2011-12 states age for accessing the service as 16+, and there is nothing further specific to under 18s.

According to the "NHS talking therapies for anxiety and depression manual" (version 7, March 2024), which provides national guidance for Talking Therapy services, anyone working with a child or young person should:

- Be trained to work with under 18s
- Understand their developmental needs and the differences in presentation between children, young people and adults
- Be aware of relevant legislation and safeguarding
- Use outcome measures validated for this age group.

The staff working in the Haringey Talking Therapies service meet the national competencies for working with adults, and they are not specifically trained in working with under 18s.

Furthermore, clinicians do not have "Level 3 child safeguarding training" (which should be the case for staff directly working with children), or regular children safeguarding supervision. The team can access advice from the trust's children's safeguarding leads when needed. This could be for under 18s under the service's care, or for adult patients with children (indirect access to children).

Lastly the outcome measures used in the service are the same used for adults.

The service is therefore in line with the service specifications on age, but not with national requirements.

2. Consider changes to provision of the service

As part of this incident review, we considered the implications of changing the age criteria, what is the likely impact if the service moved to 18+, and what alternatives exist in Haringey for this age group. The investigation also considered what changes are necessary if the service was to continue treating 16- and 17-year-olds, to meet national guidelines. The investigation team considered whether the service should continue working with this age group.

Question 1: If the service were to stop provision for under 18s what will the impact be and what will be the alternative provision?

As part of this review, an impact analysis has been conducted. The below table presents the number of 16- and 17-year-olds that were referred, assessed (minimum 1 appointment) as well as reasons for discharge in the period between April 2023 – December 2024 (a period of 21 months).

Referrals	16 years old	53
	17 years old	120
	Total	**173**
Discharged with no appointment	Recorded as not suitable and signposted or sent back to referrer	16
	Dropped out or declined	44
	Waiting to be booked at time of data extraction	10
	Total	**70**
Assessed (1 appointment)	16 years old	28
	17 years old	75
	Total	**103**
Discharged	Not suitable / signposted to other services	15
	Patient dropped out post treatment	28
	Completed	35
	On waiting list or in treatment	25

It should be noted that the service had 7819 referrals in the period, and the total number of referrals for 16- and 17-year-olds include patients who were part of community outreach workshops, and they were not referred or accessed the service beyond that. Of the 35 patients discharged as completed only 11 went on to have more than one session, the majority were as part of one-off community outreach workshops, and did not therefore have a course of treatment.

The above table shows that most (103) of the 16- and 17-year-olds were signposted or dropped out of treatment, and the numbers completing treatment are small. It is noted that only twenty-five 16- and 17-year-old were open on a waiting list or in treatment, out of about 1900 patients in waiting lists alone in the service in December 2024.

Alternative provision for 16- and 17-year-olds in Haringey

In Haringey, the main service for children and young people is the Haringey Child and Adolescence Mental Health Service (CAMHS), which treats children and young people under the age of 18 who have a GP in Haringey.

According to the CAMHS access policy (version 5.0, page 12): “The core business of specialist CAMHS is: “The assessment and treatment of moderate to severe mental health need and associated risks in young people under the age of 18 years”.”

Open Door is a registered charity offering a range of free psychological therapies for young people aged 12-24 who live in Haringey or have a Haringey GP.

Question 2: If the service does continue with this provision to under 18s, what does the service need to do to meet the national guidelines?

The following standards need to be met:

- Be trained to work with under 18s
- Understand their developmental needs and the differences in presentation between children, young people and adults
- Be aware of relevant legislation and safeguarding

- Use outcome measures validated for this age group
- The service would also need to understand the escalation risk for mental health and safeguarding risk for under 18s

Due to the small numbers of young people, the only viable option for the service will be to train a small number of clinicians to work with children. Additionally, this small "team" will need to complete "Level 3 child safeguarding training" and attend regular safeguarding training. Under 18s will need to be seen only by specific staff members. This could result in longer waiting times for this group, especially as there is often high staff turnover, and the service might have to regularly train new people to meet the requirements to work with this age group.

The alternative would be to train all staff and ensure that all clinicians complete "Level 3 child safeguarding training" (which would take at least 1 full day per clinician) and attend safeguarding supervision. This would compromise the service's core business and meeting national KPIs. The service currently (March 2025) has over 2100 patients on treatment waiting lists.

Regular safeguarding supervision, even if for a smaller group, would also add to the trust's child safeguarding team workload, and the implications of this need to be considered.

Question 3: Should the service provide care and support for children (people under the age of 18)?

Considering the above implications, and the small numbers of under 18 year olds that are receiving a course of treatment (minimum 2 sessions) and complete treatment, the investigation team believes that it is safer for under 18s, the service and the trust, for the service age criteria to change to 18+, to be in line with adult services' age criteria.

Following this sad incident in Haringey, the minimum age issue was raised at an NCL ICB level, as Enfield and Barnet Talking Therapies services also offer a service for 16- and 17-year-olds. The ICB supports working a gradual change to 18+ for all 3 talking therapy services (to be in line with Camden and Islington talking therapies who are 18+), and for under 18s to move to children's Mental health services (CAMHS).

Enfield and Barnet Talking therapy services are in agreement that the minimum age should change to 18+. The North London NHS Foundation Trust (who runs the CAMHS services in the 3 boroughs) is in support of this and all three services liaising to make the change at the same time.

3. Review of the service risk assessment procedures and interpretation of guidance

In this element of the investigation, the investigation team reviewed the service guidance and procedures on assessing patient risk, escalation, as well as staff induction, training and supervision. The investigation team also posed a number of questions to the member of staff who was involved with the patient's treatment.

Question 1: Is the patient risk assessment procedure easy to follow and understand?

Risk is regularly assessed in Talking Therapies. Patients are asked to complete self-reported measures for every appointment, including the PHQ-9 is a 9-item questionnaire assessing depression severity (Kroenke, Spitzer, & Williams, 2001). Risk is assessed via question 9 of the Patient Health Questionnaire (PHQ-9), which is:

Thoughts that you would be better off dead or of hurting yourself in some way (over the last 2 weeks)

0	1	2	3
Not At All	Several Days	More Than Half the Days	Nearly Every Day

If a patient scores 1 or above in this question then staff proceed to ask more questions and make a risk assessment as below:

1. Do things ever feel that bad that you think about harming yourself?

2. Do you ever feel so bad that life is not worth living?
3. Have you made plans to end your life?
4. Do you know how you would kill yourself?
5. Have you made any actual preparations to kill yourself?
6. Have you ever attempted suicide in the past?
7. How likely is it that you would act on these thoughts and plans?
   Rate on a scale of 0 to 10, where 0 is 'Not at all' and 10 is 'Certain'
8. What is stopping you from killing yourself now?

It should be noted that although the PH-Q-9 is diagnostic tool validated for use with over 18s, research evidence also suggests that it can be used to screen depression in an adolescent population (13-17 year olds) (Richardson, et al., 2010, Fonseca-Pedrero, et al., 2023).

Additionally, at triage patients are routinely asked about history of self-harm (have you ever self-harmed? method, frequency, and last time it occurred) and risk to or from others (e.g., anger, violence, abuse).

If risk is identified, staff need to proceed and create a risk management plan with the patient.

Staff felt that the risk assessment was not designed well enough for under 18s and suggested improvements. In particular, recognition of impulsivity and impulsive behaviour was felt to be lacking, and this could be better integrated into the risk assessment process, for example, a question such as:

"Would you say you're someone who tends to act on impulse? Can you think of examples when this has happened?"

This was felt to be able to allow the person being assessed to talk about impulsive behaviour and therefore help clinicians to seek to understand the likelihood of the client to change their mind or take action on impulse.

Staff also suggested that training touching upon impulsivity be provided as this would help staff in being able cover this topic. In particular staff felt it would be helpful to:

- Have workshops to practice framing impulsivity questions in a non-judgemental way and how to approach questions of the client's nature of impulsivity.
- Use case studies to teach escalation planning for impulsive clients.

Question 2: How do staff interpret guidance and procedures, and do they feel confident doing so?

The member of staff described ensuring that the client understood the questions posed in the risk assessment by using tools such as repeating the questions in different ways or reflecting questions back to the client to check understanding and interpretation.

It was recognised that assessing risk is very much a snapshot in time and that a client's risk may change often or based on particular events, and so it was recognised that signposting and providing clients with advice on urgent access options was needed to safety net the client.

Staff felt that more should be made of "professional judgement" if based on the risk assessment staff have a think that the client is perhaps at a higher risk and process of escalation, peer discussion and agreement on the next steps should be put in place.

Question 3: What is the escalation route and process should a member of staff be concerned about the risk posed by a patient?

The service is not designed for instant access or emergency response, and this is not its intention or what it is set up to provide. However, it was recognised that the service currently has long waits for treatment (approximately between 3 months to 8 months, depending on the treatment) this means that there is a level of unquantified risk within

the waiting list for clients who may need varying levels of support or intervention. Some clients' risk might escalate, even if their risk level was low when they entered the waiting list. Staff felt that a process of 'check ins' might be useful to systematically go through the list of people waiting to provide signposting and to provide at least a basic level of risk assessment, particularly for patients scoring 1 or more on question 9 of the Patient Health Questionnaire (PHQ-9).

Staff were familiar with adult crisis services but not as familiar with the CAMHS crisis services, as they didn't have to use it due to very low numbers of under 18s in caseloads.

The escalation route when staff identify risk is to consult their supervisor or the duty manager, and this is covered in staff inductions and the service's operational policy. There is a daily duty email sent out every day with instructions on how to escalate risk (template can be found in Appendix 2).

Staff induction, training and supervision processes

Risk assessment and management is covered in detail in all clinician's inductions. Risk is covered in the service new starters induction presentation, and all staff receive a 3-hour long risk management training as part of the induction, as well as training on how to conduct triages (which includes all the service risk procedures). The service guidance and procedures does not contain anything specific to under 18s.

All clinical staff, including trainees, have weekly clinical supervision for their cases as well as monthly line management. The service has a senior member of staff on duty every day (until 8pm Monday-Thursdays, until 5pm on Fridays) that staff can contact for any risk issues, if their supervisor is not available.

Summary of findings, areas for improvement and safety actions

The key findings of the report are that the team provides care for under 18s but does not meet the national standards for working with children, including specific training working with under 18s, and does not have a specific pathway for under 18s. The service

does have established escalation routes for patients who display risk, but consideration could be given to the fact that risk in children might present differently. Even though waiting times were not a factor in this case, there are generally long waits to access the service, and depending on the type of treatment this could be as much as 8 months. This leads to some unquantified risk in the waiting list.

Considering the risk and service implications, the investigation team believes that it is safer for under 18s, the service and the Trust for the service age criteria to change to 18+, to be in line with adult services' age criteria. This change should be done with agreement by the ICB and liaising with children's mental health services. Haringey CAMHS is commissioned for under 18s, therefore children should be referred to them.

Some areas for improvement include reviewing the service operational policy guidance on risk management, to make risk assessment and the escalation process clearer. These procedures already exist and are in staff guidance, but they need to also be clear in the service operational policy.

If the age criteria do not change then formal training on young people's mental health and risk assessment should be carried out to assist staff with recognising the differences between presentation in children and adults. The service will also have to organise for all clinicians to complete level 3 child safeguarding training and access to regular child safeguarding supervision. As the service has over 70 clinicians this is expected to take months to complete.

Safety action summary table

Areas for improvement								
	Safety action description ***(SMART)***	**Safety action owner**	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** ***(eg daily, monthly)***	**Responsibility for monitoring/ oversight** ***(eg specific group/ individual, etc)***	**Planned review date** ***(eg annually)***
1.	Update Service risk guidance and escalation in the Operational Policy	Evi Aresti, Haringey Talking Therapies Clinical and Operational Lead	31/06/25	In progress, updated and needs to be distributed	Operational policy	Yearly review	Service manager	Annually
2.	Work with ICB and the trust to change the age criteria to 18+	Evi Aresti, Haringey Talking Therapies Clinical and Operational Lead	31/06/25		GP communication Staff guidance Update website and inclusion criteria	Implemented once	Service manager	After completion
3	If action 2 does not go ahead then	Evi Aresti, Haringey Talking	March 2026					

	work on a plan for the service to meet national standards of training	Therapies Clinical and Operational Lead						

Appendices

Appendix 1 – Terms of Reference

ToR 1	***Understand the scope of the service***
Key questions	*What are the criteria and pathway for access to the Talking Therapies Service?* *Is the service in line with national commissioning requirements and service specification?*
Healthcare settings	*Haringey Talking Therapies*
Healthcare processes	Talking Therapies national guidance Local clinical access criteria and access policies

ToR 2	***Consider changes to provision of the service***
Key questions	*If the service were to stop provision for under 18s what will the impact be and what will be the alternative provision?* *If the service does continue with this provision to under 18s, what does the service need to do to meet the national guidelines?* *Should the service provide care and support for children (people under the age of 18)?*
Healthcare settings	*Haringey Talking Therapies* *Open Door (local young person's mental health charity)* *Child and Adolescent Mental Health Service (CAMHS)*
Healthcare processes	Local service provision comparison to determine what other services do compared to Whittington Health How do other services provide assessment and treatment for young people (underage of 18) National guidance around service provision for Children and young people (under the age of 18)

ToR 3	***Review of the service risk assessment procedures and interpretation of guidance***

Key questions	*Is the patient risk assessment procedure easy to follow and understand?* *How do staff interpret guidance and procedures, and do they feel confident doing so?* *What is the escalation route and process should a member of staff be concerned about the risk posed by a patient?*
Healthcare settings	*Haringey Talking Therapies*
Healthcare processes	Risk assessment process and policies Staff induction, training and supervision processes

Appendix 2 – daily duty email script

1) Your Screening Supervisor for today from 9 to 5pm is: NAME

Email:

Phone Number:

For qualified clinicians (PWPs, CBT therapists, counsellors) please continue to make your own clinical judgement for your screens and remember to move them along the pathway to the appropriate treatment or discharge option.

If you are unsure about a case and would like a second opinion, please move the client along the care pathway to 'Screening Supervisor'. Please contact DUTY if you are worried about risk or safeguarding concerns needing urgent attention.

For Trainees/Temporary Staff: once you have completed the screen, please move the client along the care pathway to 'Screening Supervisor'. You will know that screening supervision is completed when the stage code changes from SCSC to SCSCCSS. If you have any questions or want to discuss anything about a screen, please email the screening supervisor.

Please contact the DUTY Manager via Microsoft Teams, phone, or e-mail if there is **RISK** needing urgent attention.

When e-mailing, please **TITLE** your email as **URGENT** and **add 'High Importance Alert'.**

Duty will email or call you if they require further information or wish to clarify anything.'

2) Your Duty Manager for today from 9 to 5pm is: NAME

Email:

Phone Number:

Please contact duty for any urgent duty related issues like risk management, patient queries, or complaints, safeguarding or any crisis related concerns.

For urgent risk issues, please phone or call on Teams - don't only send an email.

Please also contact DUTY for reviewing any referrals to the LOCALITY TEAM. You must discuss with DUTY before emailing the form to the locality team.

3) Your 'Out Of Hours' Duty Manager for today from 5 to 8pm is: NAME

Email:

Phone Number:

In case of a crisis or emergency please contact me by phone (preferred), Teams or via email. Any outstanding screens needing supervision should be sent to tomorrow's screening supervisor please.

References

- Child and Adolescent Mental Health Service (CAMHS) access policy, (version 5.0, 2023), Barnet, Enfield and Haringey Mental Health NHS Trust.
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- Kroenke K., Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001;16(9):606–613
- "NHS talking therapies for anxiety and depression manual" (version 7, March 2024). Can be accessed here

nhs-talking-therapies-for-anxiety-and-depression-manual-v7.pdf

- Richardson L., McCauley E., Grossman D., McCarty C., Richards J., Russo J., Rockhill C., & Katon W., Evaluation of the Patient Health Questionnaire (PHQ-9) for Detecting Major Depression among Adolescents, Pediatrics. 2010 Nov 1;126(6):1117–1123

Meeting title	**Trust Board – public meeting**	**Date: 23 July 2025**
Report title	**Audit & Risk Committee Chair's Assurance report**	**Agenda item: 7**
Committee Chair	Rob Vincent, Non-Executive Director	
Executive lead	Terry Whittle, Chief Finance Officer	
Report authors	Marcia Marrast-Lewis Assistant Trust Secretary, and Swarnjit Singh, Trust Company Secretary	
Executive summary	This report details areas of assurance from the items considered at the Audit and Risk Committee meeting held on 19 June 2025. **Areas of significant assurance:** • 2024/25 Whittington Health Annual Report • 2024/25 Whittington Health Annual Accounts • ISA 260 • External Audit annual report • Draft Audit opinion • Internal Audit progress report and Head of Internal Audit Opinion • Internal audit review – patient engagement and patient experience • Board Assurance Framework • Counter-fraud annual report. **Areas of moderate assurance:** • Trust risk register • Internal audit review – data quality – pressure ulcers In addition, the Committee also noted the following reports: • Quality Assurance Committee Chair's assurance report for the meeting held on 14 May 2025 • Tender waiver and breaches report • Special payments, losses and write offs • Debtors' report **The key issues to report to the Board are:** • Internal audit annual report • Opinion on the year end statement • Value for money statement. • A new offence of failure to prevent fraud .	

Purpose	Noting
Recommendations	Board members are invited to: i. note the Chair's assurance report for the Audit and Risk Committee meeting held on 19 June 2025; and ii. note the successful conclusion to the 2024/25 annual accounts.
BAF reference	All entries
Report history	Board meetings following each Committee meeting
Appendices	1. LCFS 2024/25 Annual Report

Committee Chair's Assurance report

Committee name	Audit and Risk Committee
Date of meetings	19 June 2025
Summary of assurance:	

1. The Committee can report significant assurance to the Trust Board in the following areas:

2024/25 Annual Report

Committee members received the draft annual report and the Committee Chair thanked Swarnjit Singh for his work on the Annual Report and the assessment against NHS England's provider code of governance for NHS trusts. Committee members were informed that the report included updates on strategic developments and showcased the work of various teams. The Committee agreed that the report should provide details on pressures experienced during the year in the ED resulting in an increase with 12-hour trolley waits and the publicised corridor care. Committee members also agreed the report should reflect the changes made to the provision of inpatient mental health services with the closure of Simmons House.

Subject to the changes outlined, the Committee approved, in principle, the draft 2024/25 Annual Report which would be reviewed and agreed at the 23 June Board meeting.

2024/25 Whittington Health Annual Accounts

Committee members were able to take good assurance from the audit of the annual accounts which set out the key judgements made as part of preparation of the financial statements. The Assistant Director of Financial Services explained that the Trust was reporting a deficit position of £16.m which was adjusted to a financial deficit of £13.1m, once impairments were included. A prudent approach had been taken in relation to goods received not invoiced accruals, specifically in relation to aged balances. Following discussion between management and the audit team the liability was revised downwards by £2.1m been reduced by £2.1m with the addition of a corresponding credit note liability to NCL ICB. The impact on the Trust bottom line position was nil. The closed cash balance position was £46.2m. The Committee was informed that capital expenditure totalled £29.7m. Lessons learned from last year's audit had been implemented for the benefit of the current year. A further lessons' learned session would follow the completion of this year's audit was scheduled. The Committee was also informed that the private finance initiative (PFI) provision remained in place, at a reduced level. A desktop valuation of the estate had been carried out (full valuation undertaken 2023/24) which resulted in a £10.3m impairment. It was agreed that the Committee would be provided with the change log which would detail all changes made to the draft accounts between the current version and the final version to be submitted for onward consolidation in the whole of government accounts.

The Committee approved, in principle, the 2024/25 Annual Accounts, subject to minor amendments for review and final sign off at the 23 June Board meeting.

ISA 260 report

Committee members also welcomed and took good assurance from the ISA 260 report on the Trust's financial statements, in which KPMG stated their independence. The key issues highlighted in the ISA 260 by KPMG were, as follows:

- Four significant audit risks were identified. The first of which related to the management override of controls and expenditure recognition. here were no issues or errors that were identified during the audit to bring to Committee members' attention on this risk areas.
- The second risk related the valuation of the land and buildings which had seen an improvement of £17m, as a result of the reversal of recorded impairment to the fire affected blocks of the main hospital. KPMG had involved their valuation specialists to understand how the value added back was determined. KPMG were satisfied that a reasonable approach had been taken to determine the level of impairment to be recorded against each block, as at March 2025.
- The third risk related to the treatment of general accruals and provisions with a specific focus on goods received but not invoiced. A prudent approach had been taken in relation to accruals which reduced the amount for goods received but not invoiced by £2.1m and this had also been agreed by the North Central London Integrated Care Board (NCL ICB). The work related to goods received not invoiced remained ongoing as the external auditors found that there was excess prudence due to aged balances. As a result, the expenditure recognition risk was revised from being one of understatement to overstatement. In addition, KPMG raised a control deficiency relating to the calculation of the accruals for agency pay not yet invoiced as management's process for calculating the accrual was not sufficiently precise and was likely to lead to an overstatement of accruals.
- The final risk related to the legal claim provision valuation. KPMG were comfortable with the approach which was reasonable given the inherent uncertainty.
- For the value for money assessment, KPMG had not identified any significant weaknesses in the Trust's arrangements to achieve value for money. Strengthening of financial efficiency controls during 2024/25 had removed the significant value for money weakness reported in this area for 2023/24.

The Committee noted the outcome from the ISA 260 report

Representation letter

Committee members considered the draft letter of representation in connection with the financial statements covering comprehensive income, financial position, changes in taxpayers' equity and cash flows. KPMG drew the attention of the Committee to paragraphs 15a, 15b and 15c. Committee members were content to positively confirm compliance with the content of paragraphs 15a and 15b.

The Audit and Risk Committee approved the draft letter of representation.

Going Concern report
Committee members reviewed an assessment of the Trust's ability to continue as a going concern for at least 12 months, in line with accounting standards. No concerns were identified regarding cash flow over this period. The Trust has continued to demonstrate its ability to deliver financial performance whilst continuing to provide quality services.

The Committee agreed with the conclusion that there were no operating or other issues that would prevent the 2024/25 Annual Accounts being prepared on a going concern basis.

Draft 2024/25 External Audit Annual Report
KPMG presented a summary of their findings and key issues arising from their 2024/25 audit of Whittington Health which would be published alongside the Trust's annual report and accounts. KPMG highlighted two areas around the value for money statement. The first related to the weakness identified in the delivery of the efficiency programme in 2023/24. In accordance with the Code of Audit Practice, the issue was reviewed as part of the 2024/25 audit which gave an overall rating of reasonable assurance as the Trust had significantly strengthened the governance for the delivery of cost improvement programme (CIP) savings. The second area related to fire remediation and fire safety risks. KPMG were satisfied that the Trust had appropriately responded to the deficiencies identified and was taking forward works to improve fire safety.

The Committee approved the draft 2024/25 External Audit Annual Report

Internal Audit Annual Report and Head of Internal Audit Opinion
RSM issued the final Head of Internal Audit Opinion for 2024/25, based on the work performed during the year. Their assessment was that the Trust had an adequate and effective framework for risk management, governance and internal control and that their work had identified further enhancements to the framework to ensure that it remained adequate and effective. A level two opinion had been given. RSM highlighted the assurance ratings given to key reviews during the year which informed their opinion. This included a reasonable assurance rating for the review of critical care, patient engagement and patient experience; data security and protection toolkit; cost improvement programme; consultant job planning and risk management.

The Committee noted the progress with delivering the 2024/25 internal audit plan and welcomed the Head of internal Audit's Opinion.

Internal Audit Progress Report
RSM informed the Committee that the 2024/25 internal audit plan was complete. The final reports on patient engagement and experience and data quality had been issued and had an overall rating of reasonable and partial assurance respectively. The Committee welcomed the progress made against the 2025/26 plan which issued a draft report on virtual wards, and the audits of

	data security and protection, compliance to the Mental Health Act and data quality, and theatre utilisation were in progress. **Internal audit review – patient engagement and patient experience - outpatients** The Committee considered the audit review on patient engagement and patient experience which found the Trust had good systems and processes in place for improving outpatient engagement and experience. Overall, the review achieved a rating of reasonable assurance. The Committee was apprised of the four medium management actions which included the implementation of an action plan to support the delivery of management of actions. **The Committee noted the report.** **Board Assurance Framework** The Committee reviewed the quarter one 2025/26 Board Assurance Framework detailing risks to the delivery of the Trust's strategic objectives which had been reviewed by other Board Committees and the Trust Management Group. Committee members were informed that recent changes to risk scores were approved by the Trust Board and that the Finance and Business Development Committee and that the risk descriptor for the Integration 1 entry had been updated to reflect the uncertainty and current changes taking place in Integrated Care Boards (ICB) following the national announcement regarding changes and the publication of the Model ICB guidance. **The Committee noted the board assurance framework and approved the revised risk descriptor for the Integration 1 BAF entry.** **2024/25 Counter Fraud Annual Report and Functional Standard Return** Committee members received and noted the annual report and functional standard return for 2024/25 which confirmed that the Trust was fully compliant with requirements relating to fraud, bribery and corruption and service condition 24 of the NHS standard contract. RSM's Local Counter Fraud Specialist also outlined to Committee members that, with effect from 1 September 2025, section 199 of the Economic Crime and Corporate Transparency Act (2023) created a new criminal offence of failure to prevent fraud.
2.	**The Committee is able to report moderate assurance from the following items:** **Trust risk register** The Committee reviewed the risk register entries scored at 15 or higher and took moderate assurance that effective mitigations were in place. The report contained 42 risk entries and there were also five risk entries awaiting approval for inclusion on the risk register. The Committee was informed that the risks related to a lack of storage space for IM&T equipment and complaints performance in the surgery and cancer division had been increased. Non-compliance with national cancer access standards had been decreased. One

	risk had been closed related to surgery and cancer division not meeting their CIP target. **The Committee noted the risk register for entries scored at 15 and above.** **Internal audit review – data quality and performance management of pressure ulcers** The Committee noted the internal audit review report and its assessment of a partial overall risk assurance rating. The audit had looked at the data quality policy which was due for review and required an update to incorporate any revisions to the current iteration. The review also carried out sample testing of 19 pressure ulcers which found inconsistencies in relation to the completion of care assessments, a variation of electronic patient record systems across the Trust and community sites, and the duplication of data. The Committee was apprised of one high, six medium and one low priority action contained in the report which included strengthening of pressure ulcer training and Datix training. **The Committee noted the report and agreed to submit the audit report to the Quality Assurance Committee.** **Losses and special payments** The Committee was considered a report on an analysis of the debts owed to the Trust arising from salary overpayments and overseas visitors. Salary overpayments amounted to £142k and overseas visitors' debt totalled £788k split into three tranches for collection. There were no new losses to report. **Debtors' report** The Committee reviewed an analysis of aged debts by NHS and non-NHS organisations. NHS debts had decreased from £6.6m in February to £3.76m in May. Non-NHS debts totalled £3.8m in May, a decrease from £6.1m in February. **Tender waivers and breaches report** The Procurement Business Partner presented a paper which covered the period December 2024 to February 2025. He reported that tender waiver applications were agreed for a total expenditure of £2.3m. The Committee acknowledged the significant increase in the value of tender waivers which were driven by last minute funding received for fire remediation works. The Committee was informed that there were 28 unofficial breaches totalling £360k identified which represented an increase of 39% since the last report. The total value of the unofficial breaches was £360k which represented a 45% fall in value since the previous report.
3.	**Present:** Rob Vincent, Non-Executive Director (Committee Chair) Amanda Gibbon, Non-Executive Director Nailesh Rambhai, Non-Executive Director

	In attendance: Selina Douglas, Chief Executive Terry Whittle, Chief Finance Officer Clare Dollery, Chief Medical Officer Sharonjeet Kaur, RSM Jonathan Gardner, Chief Strategy, Digital and Improvement Officer Jerry Francine, Operational Director of Finance Martin Linton, Assistant Director of Financial Services Dean Gibbs, KPMG LLP Phil Montgomery, Procurement Business Partner Mohini Katoch, KPMG LLP Kirsty Clarke, Counter Fraud Specialist, RSM Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary Sarah Wilding, Chief Nurse and Director of Allied Health Professionals Vivien Bucke, Business Support Manager Ike Nkemena, Financial Controller Marcia Marrast-Lewis, Assistant Trust Secretary Bethany Sibley, Patient Safety Information Manager

Meeting title	**Audit and Risk Committee**	**Date: 19 June 2025**
Report title	**2025/21 Q1 Board Assurance Framework**	**Agenda item: 13**
Executive leads	• Quality entries: Sarah Wilding, Chief Nurse and Director of Allied Health Professionals, Clare Dollery, Chief Medical Officer and Chinyama Okunuga, Chief Operating Officer • People entries: Liz, O'Hara, Chief People Officer • Integration and Sustainable 3 entries: Jonathan Gardner, Chief Strategy, Digital & Improvement Officer • Sustainable 1 and 2 entries: Terry Whittle, Chief Finance Officer	
Report author	Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary and executive risk leads	
Executive summary	Committee members are presented with the Quarter one, 2025/26 Board Assurance Framework (BAF). Below are the headlines from board committees' respective reviews of BAF entries on which they lead, since the last Audit and Risk Committee meeting held on 23 March 2025. The key updates to report from this quarter are as follows: • At the end of quarter four, the Quality Assurance reviewed the BAF's entries Quality entries and proposed a change in wording for the Quality 2 BAF entry descriptor to reflect challenges in meeting cancer targets due to the level of demand. This was agreed at the Board meeting held on 20 March. • The Quality Assurance Committee also reviewed the BAF's Quality and Integration 2 entries at its 14 May meeting. It was agreed that it remained premature to reduce the scores for any of these entries. The Committee did, however, propose a further amendment to the risk descriptor for the Quality 2 entry to remove the reference to the theatre ventilation works which had been completed. Approval for this change will be sought at the 23 June Board meeting. • The Workforce Assurance Committee reviewed the People entries at its 14 April meeting and agreed with the rationale set out to support a reduction in the total	

	scores for both People entries to a score of 9. This was agreed at the 1 May Board meeting. • On 22 May, the Improvement, Performance and Digital Committee reviewed the Sustainable 3 entry and agreed that, in view of the recent coverage of damaging cyber-attacks on both Marks and Spencer and the Co-Operative Society, no changes be made to the total risk score for this entry. • The Finance and Business Development Committee reviewed the Sustainable 1 and 2 and Integration 1 entries on 29 May. It was agreed that the risk descriptor for the Integration 1 entry would be updated to reflect the uncertainty and current changes taking place in Integrated Care Boards following the national announcement regarding changes and the publication of the Model ICB guidance. • In addition, the Committee agreed that the Sustainable 1 entry would be updated to reflect the development of the Financial Recovery Plan as a key control and that the Sustainable 2 entry would be updated to include recent developments. These changes would be brought back to the Committee's next meeting for review and approval.
Purpose	Approval
Recommendations	Audit and Risk Committee members are invited to: i. note the reviews of BAF entries by respective board committees during quarter one; ii. approve the revised risk descriptor for the Integration 1 BAF entry; and iii. confirm the scores for respective entries.
Appendices	1: Revised risk descriptor for the Integration 1 entry 2: Q1 2025/26 Board Assurance Framework

Appendix 1: New risk descriptor for Integration 1 BAF entry

Current Integration 1 risk descriptor	Lack of system clarity, or specific changes brought about by national policy, a still maturing ICB, and an emerging provider alliance, (such as corporate services' rationalisations, Fuller report, community services review, "Start Well" review, and pathway reconfiguration), may result in unclear governance decisions and difficulty in strategic planning which impact adversely on patient services, particularly fragile ones, and the strategic viability of the Trust
Proposed new risk descriptor wording	Lack of system clarity, or specific changes brought about by national policy, or an ICB in flux, or the changing provider landscape, (such as neighbourhood working, corporate services' rationalisations, services reviews), may result in unclear governance decisions and difficulty in strategic planning which impact adversely on patient services, particularly fragile ones, and the strategic viability of the Trust. Specifically, there is a risk that due to lack of resources and attention and the pace of working the organisation is unable to sufficiently benefit from the opportunities or mitigate the risks presented by neighbourhood working.

Appendix 1: Q1 2025/26, Board Assurance Framework

Strategic objective and BAF risk entry	Principal risk(s)	Current score			Target score	Lead director(s)
		C	L	R		
Quality 1 – quality and safety of services	Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective, or well-led and which provides a positive experience for our patients and families, due to errors, or lack of care or lack of resources and a lack of a quality improvement focus, results in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation	4	5	20	4	Chief Nurse / Medical Director
Quality 2 – capacity and activity delivery	Due to a lack of capacity, there is an inability to meet elective recovery and clinical performance targets, resulting in a deterioration in service quality and patient care such as: • significant delays in the emergency and urgent care pathway department and an inability to place patients to appropriate ward beds • patients not receiving the timely elective care they need across acute and community health services • patients on a diagnostic and/or treatment pathway at risk of deterioration and the need for greater intervention at a later stage	4	5	20	4	Chief Operating Officer / Chief Nurse / Medical Director

Strategic objective and BAF risk entry	Principal risk(s)	Current score			Target score	Lead director(s)
		C	L	R		
	demand on cancer services and not meeting key cancer performance indicators.					
People 1 - staff recruitment and retention	Lack of sufficient substantive staff, due to increased staff departures and absence, and difficulties in recruiting and retaining sufficient staff, results in further pressure on existing people, a reduction in the quality of care, insufficient capacity to deal with demand, and increased temporary staffing costs	3	3	9	9	Chief People Officer
People 2 – staff wellbeing, engagement and equity, diversity and inclusion	Failure to improve staff health, wellbeing, equity, diversity and inclusion, empowerment, and morale, due to the continuing post-pandemic pressures, and the restart of services, poor management practices, and an inability to tackle bullying and harassment and behaviours unaligned with the Trust's values result in: • a deterioration in organisational culture, morale and the psychological wellbeing and resilience • adverse impacts on staff engagement, absence rates and the recruitment and retention of staff • poor performance in annual equality standard outcomes and submissions • a failure to secure staff support, buy-in and delivery of NCL system workforce changes and an increased potential for unrest	3	3	9	4	Chief People Officer

Strategic objective and BAF risk entry	Principal risk(s)	Current score			Target score	Lead director(s)
		C	L	R		
Integration 1 – ICB/S and Alliance changes	Lack of system clarity, or specific changes brought about by national policy, a still maturing ICB, and an emerging provider alliance, (such as corporate services' rationalisations, Fuller report, community services review, "Start Well" review, and pathway reconfiguration), may result in unclear governance decisions and difficulty in strategic planning which impact adversely on patient services, particularly fragile ones, and the strategic viability of the Trust	4	3	12	8	Chief Strategy, Digital & Improvement Officer & SIRO
Integration 2 – population health and activity demand	Local population health and wellbeing deteriorates because of a lack of available investment in, or focus on ongoing care and prevention work, and due to unsuccessful collaboration with local sector health and social care partners, resulting in continued high demand for services which is insufficiently met	4	3	12	8	Chief Strategy, Digital & Improvement Officer & SIRO
Sustainable 1 – control total delivery and underlying deficit	Increased exposure to financial risks arising from: • adverse changes to funding arrangements (e.g., block or ERF cap) • failure to manage budgets • unmitigated cost pressures • failure to deliver financial efficiency schemes or benefits associated with service transformation.	4	5	20	8	Chief Finance Officer

Strategic objective and BAF risk entry	Principal risk(s)	Current score			Target score	Lead director(s)
		C	L	R		
Sustainable 2 – estate modernisation	The failure of critical estate infrastructure, or continued lack of high-quality estate capacity, due to insufficient modernisation of the estate or insufficient mitigation, results in patient harm, poorer patient experience, or reduced capacity in the hospital	4	5	20	8	Chief Finance Officer
Sustainable 3 – digital transformation and interoperability	Risk that if we do not invest effectively in our digital strategy and in keeping technology hardware updated, cyber security solutions current and configured correctly, enable interoperability and testing of continual improvement of software (e.g. electronic patient record), ensure contracts are managed and supported and maintain the ability to report and enable clinicians to have access in a timely manner, with enough sufficient skilled workforce, then there is a possibility of catastrophic downtime. This could lead to serious impact on our ability to deliver any of our strategic objectives. Safety of clinical services will be at risk through inaccessibility of information. Empowering of staff will be at risk as work is made harder. Partnering with other will be hampered as GPs may not be able to refer or see results. And transformation will be impossible as operational processes operational	5	4	20	6	Chief Strategy, Digital & Improvement Officer & SIRO

Strategic objective and BAF risk entry	Principal risk(s)	Current score			Target score	Lead director(s)
		C	L	R		
	flow, efficiencies and cost improvement programme delivery will be severely hampered.					

Q1 2025/26 Board Assurance Framework

Quality entries

Strategic objective		**Deliver outstanding safe, compassionate care in partnership with patients**
Executive leads		Chief Nurse and Director of Allied Health Professionals; Medical Director; Chief Operating Officer
Oversight committees		Quality Governance Committee, Trust Management Group, Quality Assurance Committee
Principal risks	**Quality 1**	Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective, or well-led and which provides a positive experience for our patients and families, due to errors, or lack of care or lack of resources and a lack of a quality improvement focus, results in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation
	Quality 2	Due to a lack of capacity, there is an inability to meet elective recovery and clinical performance targets, resulting in a deterioration in service quality and patient care, such as: • significant delays in the emergency and urgent care pathway department and an inability to place patients to appropriate ward beds • patients not receiving the timely elective care they need across acute and community health services • patients on a diagnostic and/or treatment pathway at risk of deterioration and the need for greater intervention at a later stage • demand on cancer services and not meeting key cancer performance indicators.

Risk scores (I (Impact) L (Likelihood) S (Score))

Risk	**Quarter 1**			**Quarter 2**			**Quarter 3**			**Quarter 4**			**Target**
	C	**L**	**S**	**C**	**L**	**S**	**C**	**L**	**S**	**C**	**L**	**S**	
Quality 1	4	5	20										4
Quality 2	4	5	20										4

Controls and assurances

Key controls	Assurances	Tier
Maintain expanded rapid response services across adult community and children and young people's services and re-start other community services in a safe way, prioritising the vulnerable and maintain as much business as usual as possible to prevent escalation of other illnesses	• The weekly executive team meeting is alerted to any areas of concern	• 1st
	• Trust Management Group monitors the delivery of targets for elective, emergency department, outpatient, and community services each month.	• 1st
	• Quality Governance Committee reviews the risk register at each meeting	• 1st
	• The Quality Assurance Committee reviews the risk register at each meeting	• 2nd
Work with partners in the system to manage flow and demand to ensure patients are in the right place to receive care	• The monthly Trust Management Group (TMG) meeting reviews the elective recovery dashboard key performance indicators for Whittington Health and North Central London (NCL) partners	• 1st
	• Weekly NCL Operational Implementation Group • Monthly NCL: Cancer Alliance Board meetings	• 2nd • 2nd
Partner with service users to deliver our quality, safety, and patient experience priorities, with a focus on protecting people from infection and implement actions from the CQC inspection report	• The Quarterly Quality report is reviewed by the Quality Assurance Committee	• 2nd
	• Clinical and national audit findings, (compliance with Getting it Right First Time and National Institute of Clinical Excellence guidance) are reported to Quality Assurance Committee on a quarterly basis, along with any identified actions within the quarterly quality report	• 2nd
	• Quality Account priorities (monitoring of priorities is included within the quarterly quality report presented to Quality Assurance Committee	• 2nd
	• CQC Relationship Assurance meetings	• 3rd
	• Peer review visits	• 3rd
	• Delivery of Patient Experience Strategy annual implementation plan and patient experience is presented to Patient Experience Group (PEG), QGC and QAC	• 1st

Key controls	Assurances	Tier
	• Annual and bi-annual reports are produced for complaints, claims and legal cases, medicine optimisation, health and safety safeguarding and infection prevention and control presented to Quality Assurance Committee	• 2nd
	• Staff wellbeing is a priority for the Trust, offering resources to meet physical, social, and emotional wellbeing needs to keep staff and patients safe	• 1st
	• TMG confirmed changes to COVID-19 testing in line with national guidance	• 1st
	• Rollout of staff and patient COVID-19 and flu vaccination uptake reported monthly to TMG (in season)	• 1st
	• NCL Operational Implementation Group and Clinical Advisory Group	• 2nd
Incident reporting and action plans monitored to ensure learning and incidents, risks and complaints entered on Datix system	• Incident reporting policies monitoring of progress of the national patient safety strategy and response framework roll out.	• 1st
	• Weekly incident review meeting with Integrated Clinical Service Units (ICSU) risk managers	• 1st
	• Trust Risk Register reviewed by Quality Governance Committee, Quality Assurance Committee, Audit & Risk Committee and Trust Board	• 2nd
Mortality review group learning from deaths process and reporting	• Quarterly Learning from deaths report to Quality Assurance Committee;	• 2nd
Continued use of the full integrated performance report to monitor all areas of quality and activity	• Cancer performance is considered monthly at Executive Team Meeting, Trust Management Group, Cancer Board and by the Trust Board.	• 1st & 2nd
	• Reviewed monthly by respective ICSU Boards and committees e.g. Infection prevention and control and drugs and therapeutics	• 1st
Project Phoenix Quality Improvement drive now on	• Trust Learn, Innovate and Improve group meetings	• 1st

Key controls	Assurances	Tier
Tracker in place to monitor progress against the Quality Account priorities on a quarterly basis, with updates to the relevant sub-groups	• Updates on Quality Account priorities provided quarterly to patient safety, patient experience and clinical effectiveness groups and to the Quality Governance Committee	• 1st
Level 1 Quality Impact Assessments (QIAs) for service/pathway changes are monitored by operational managers and clinical managers. Level 2 QIAs (deemed moderate to high risk) are reported and approved by Medical Director and Chief Nurse at the QIA panel	• QIA panel	• 1st
	• QIAs are reported to the Quality Governance Committee and the Quality Assurance Committee	• 1st • 2nd
Well-led external review	• Review commissioned and draft report delivered by Deloitte LLP	• 1st

Gaps in controls and assurances

Gaps	Mitigating actions	Completion date
None identified		

People

Strategic objective		**Empower, support and develop an engaged staff community**
Executive lead		Chief People Officer
Oversight committees		People Committee; Trust Management Group; Workforce Assurance Committee (WAC)
Principal risks	**People 1**	Lack of sufficient substantive staff, due to increased staff departures and absence, and difficulties in recruiting and retaining sufficient staff, results in further pressure on existing people, a reduction in the quality of care, insufficient capacity to deal with demand, and increased temporary staffing costs
	People 2	Failure to improve staff health, wellbeing, equity, inclusion, empowerment and morale, due to the operational pressures, poor management practices, and an inability to tackle bullying and harassment and behaviours unaligned with the Trust's values result in: • a deterioration in organisational culture, morale and the psychological wellbeing and resilience • adverse impacts on staff engagement, absence rates and the recruitment and retention of staff • poor performance in annual equality standard outcomes and submissions • a failure to secure staff support, buy-in and delivery of NCL system workforce changes and an increased potential for industrial unrest

Risk scores (I (Impact) L (Likelihood) S (Score))

Risk	**Quarter 1**			**Quarter 2**			**Quarter 3**			**Quarter 4**			**Target**
	I	**L**	**S**	**I**	**L**	**S**	**I**	**L**	**S**	**I**	**L**	**S**	
People 1	3	3	9										9
People 2	3	3	9										4

Controls and assurances

Key controls	Assurances	
Psychological/wellbeing support to staff	• Trust Board, TMG, People Committee (PC), Partnership Group, and Workforce Assurance Committee (WAC) receive updates on activities • The importance of staff rest, and recuperation is emphasised and the ability to take annual leave was agreed by the executive team and Trust Management Group members and remains important • Implementing health and wellbeing discussions with all staff as part of annual appraisal reports • Ensuring Health and Wellbeing intranet hub is kept up-to-date and accessible • Delivery of the Health Wellbeing programme with regular reports to WAC	• 1st • 1st • 1st • 1st/2nd
Corporate and local staff survey action plans are being developed following the 2023 Staff Survey outcomes	• ICSU Boards and Directorates consider quarterly pulse surveys, annual staff survey results and create local action plans • Quarterly People Pulse report to TMG, Partnership Group (PG) and PC; 2nd tier assurance at WAC • Templates provided for ICSU/Directorate level and for team level to maximise empowerment through participation in making improvements • NHS staff survey outcomes and action plans report to the Trust Board, Workforce Assurance Committee, Trust Management Group, People Committee and Partnership Group • Listening events held on career progression and staff wellbeing reported to TMG and WAC	• 1st • 1st • 1st • 2nd • 2nd
Implemented activities under the #Caringforthosewhocare initiative	• The range of interventions provided for staff under the #Caring for those who care activities are reported to each meeting of the Workforce Assurance Committee, TMG, PG and PC	• 2nd
Implemented updated action plan for	• Workforce report to quarterly meeting of the Workforce Assurance Committee and People Committee and from well led indicators on the Trust Board's monthly integrated performance report	• 2nd

Key controls	Assurances	
recruitment and retention strategy		
Develop and implement a WRES improvement plan	• Annual workforce disability and race equality standard submissions paper to Workforce Assurance Committee, Trust Management Group and Trust Board • Workforce Assurance Committee reviews progress with the equality and inclusion action plan	• 2nd • 2nd
Inclusion strategy and action plan in place	• People Committee and Workforce Assurance Committee	• 2nd
Trust-wide Talent management and succession planning arrangements	• Further development and rollout of cohorts for the Bands 2 -7 development programme for black, Asian and minority ethnic staff	• 1st
People strategy	• Trust People strategy agreed at December 2023 Board meeting	• 2nd
Sexual safety in the workplace	• Taskforce established to take forward work to comply with the framework and updated policy guidance issued by NHS England and also the revised EHRC preventative directive	• 2nd

Gaps in controls and assurances

Gaps	Mitigating actions	Completion date
None currently identified		

Integration

Strategic objective		**Integrate care with partners and promote health and wellbeing**
Executive leads		Chief Executive; Chief Strategy, Digital & Improvement Officer
Oversight committees		Trust Management Group, Finance and Business Development Committee (Integration 1 entry); Quality Assurance Committee (Integration 2 entry); Trust Board
Principal risks	**Integration 1**	Lack of system clarity, or specific changes brought about by national policy, a still maturing ICB, and an emerging provider alliance, (such as corporate services' rationalisations, Fuller report, community services review, "Start Well" review, and pathway reconfiguration), may result in unclear governance decisions and difficulty in strategic planning which impact adversely on patient services, particularly fragile ones, and the strategic viability of the Trust.
	Integration 2	Local population health and wellbeing deteriorates, because of a lack of available investment in, or focus on ongoing care and prevention work, and due to unsuccessful collaboration with local sector health and social care partners, resulting in continued high demand for services which is insufficiently met

Risk scores (I (Impact) L (Likelihood) S (Score))

Risk	**Quarter 1**			**Quarter 2**			**Quarter 3**			**Quarter 4**			**Target**
	I	**L**	**S**	**I**	**L**	**S**	**I**	**L**	**S**	**I**	**L**	**S**	
Integration 1	4	3	12										8
Integration 2	4	3	12										8

Controls and assurances

Key controls	**Assurances**	**Tier**
Participation in NCL forums	• Regular communication with executive counterparts in other NCL bodies and good liaison through NEDs to other Trusts. Strong engagement by all Directors in NCL forums e.g. Senior Management Board	• 1st
	• CEO co-chairs the Haringey Borough Partnership	• 1st
	• COO is on various NCL operational groups	• 1st

Key controls	Assurances	Tier
	• Chief Strategy Officer (CSO) is on both borough partnerships and chairs the Haringey Neighbourhood board • Shared Chair with UCLH • Chair and CEO sit on the NCL provider alliance Board	• 1st
Implement locality leadership working plans through close liaison with Islington and Haringey councils	• Monthly Borough Partnership Boards attended by CEO and CSO • Monthly Haringey, Start Well, Live Well, Age Well boards attended by Whittington Staff • Islington and Haringey Overview & Scrutiny Committees meet ad hoc to consider any issues	• 1st • 3rd • 3rd
Participation in NCL pathway boards	• CSO chairs Community Diagnostic Hub Board • CSO attends NCL Diagnostic Board • CSO attends NCL Digital Board	• 2nd • 2nd • 2nd
Progress Anchor Institution work and population health work – Director of Strategy leading on an action plan around the key areas of employment, procurement, buildings, environment, partnerships. Participation in various groups in Haringey and Islington – to progress local employment, engage in regeneration schemes, support the green agenda and to promote the London Living Wage	• National anchor institution learning network • Haringey and Islington borough partnership *monthly* • Haringey neighbourhoods and inequalities board *monthly* • Islington Health and Social care academy *quarterly* • Islington London Living Wage working group *two weekly* • Annual report to the Trust Board on population health	• 1st • 1st • 2nd • 2nd • 2nd • 2nd • 2nd
Our population health report and anchor institution work reports to the Quality Assurance	• Trust Management Group • Quality Assurance Committee • Trust Board	• 1st • 2nd • 2nd

Key controls	Assurances	Tier
Committee every six months and Board every year.		
We have created an inequalities dashboard and now report on waiting times by ethnicity in our annual report.	• Yearly report to Board	• 2nd
Engagement with provider alliance	• The Trust is an engaged partner in the NCL Health Alliance and is fully engaged in the Complex Long Term Health Service conditions programme through membership of the steering group and clinical/professional leads for this programme.	• 1st

Gaps in controls and assurances

Gaps	Mitigating actions	Completion date
Neighbourhood working	Confirmation is needed on the final arrangements, including responsibility for the integrator function, to take forward this 2025/26 planning priority in the NCL system	Q1

Sustainable entries

Strategic objective		**Transform and deliver innovative, financially sustainable services**
Executive leads		Acting Deputy Chief Executive and Chief Finance Officer; Chief Operating Officer
Oversight committees		Financial Improvement Board; Trust Management Group; Finance and Business Development Committee; Improvement, Digital and Transformation Group; Improvement, Performance and Digital Committee
Principal risks	**Sustainable 1**	Adverse funding arrangements regionally or nationally; or failure to a) manage costs, b) reduce the run rate, c) properly fund cost pressures, due to poor internal control systems, or inability to transform services and deliver the cost improvement programme savings, or due to insufficient flexibility under a block contract along NCL system and provider alliance changes, result in an inability deliver the annual control total, a deterioration in the underlying deficit for the Trust, increased reputational risk and pressure on future investment programmes, or cancellation of key Whittington Health investment projects, and improvements in patient care and savings not being achieved.
	Sustainable 2	The failure of critical estate infrastructure, or continued lack of high-quality estate capacity, due to insufficient modernisation of the estate or insufficient mitigation, results in patient harm, poorer patient experience, or reduced capacity in the hospital.
	Sustainable 3	Risk that if we do not invest effectively in our digital strategy and in keeping technology hardware updated, cyber security solutions current and configured correctly, enable interoperability and testing of continual improvement of software (e.g. electronic patient record), ensure contracts are managed and supported and maintain the ability to report and enable clinicians to have access in a timely manner, with enough sufficient skilled workforce, then there is a possibility of catastrophic downtime. This could lead to serious impact on our ability to deliver any of our strategic objectives. Safety of clinical services will be at risk through inaccessibility of information. Empowering of staff will be at risk as work is made harder. Partnering with other will be hampered as GPs may not be able to refer or see results. And transformation will be impossible as operational processes operational flow, efficiencies and cost improvement programme delivery will be severely hampered.

Risk scores (I (Impact) L (Likelihood) S (Score))

Risk	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Target
	I	L	S	I	L	S	I	L	S	I	L	S	
Sustainable 1	4	5	20										8
Sustainable 2	4	5	20										8
Sustainable 3	5	4	20										5

Controls and assurances

Key controls	Assurances	
Create replicable better more efficient and effective pathways for the long-term including 'virtual by default' where possible and promoting self-management	• Clinical Divisions' monthly Board meetings • Community Estates Programme Group –fortnightly meetings • Monitoring of monthly updates at TMG • ICSU quarterly performance reviews • Monthly integrated performance report to Trust Board • Monthly elective recovery dashboard reviewed by TMG and elective recovery targets included in the revised integrated performance report	• 1st • 1st • 1st • 1st • 2nd • 1st
Maintain financial governance controls. Manage our expenditure to lower than last year's run-rate to enable investment in other services	• Monthly Investment Group • Monthly Transformation Programme Board • Monthly Finance report to Trust Management Group • ICSU deep dives at Finance & Business Development Committee • Monthly Finance report to Trust Board • Increased controls for temporary staff bookings and for the Vacancy Scrutiny Process to reduce expenditure • Vacancy freeze for corporate roles and for those areas which are either overspent or over-established already	• 1st • 1st • 1st • 2nd • 2nd • 1st
Monthly Financial Improvement Board	• Draft financial recovery plan developed and considered by TMG and F&BD in May • Financial efficiency work programme established to show progress against the 2024/25 Cost Improvement Programme (CIP) target • Finance & Business Development Committee reviews progress at its bi-monthly meetings	• 2nd • 1st • 2nd

Key controls	Assurances	
Accountability Framework	• Monthly performance reviews continued and targeted support provided to clinical divisions where this is identified	• 1st
Development of an estate plan Strong monitoring of fire safety procedures and compliance Capital programme addresses all red risks	• Estate Strategic Outline Case agreed by Trust Board • Monthly Private Finance Initiative monitoring group • Monthly Fire safety group • and fire warden training with a comprehensive fire safety dashboard reported monthly to TMG • Monthly Health and Safety Committee • Capital Monitoring Group	• 2nd • 1st • 1st • 1st • 1st • 1st
Estate Strategy is approved Strategic Outline Case for maternity and neonatal services phase 1 business case is approved	• The Trust has had confirmation of its 2025/26 £7.6m capital allocation for critical infrastructure risks. In addition, there is £5.6m in our capital expenditure plan for power infrastructure this financial year – both areas are key priorities. • Maternity Transformation Board monthly • Transformation Programme Board monthly • Finance & Business Development Committee next review in the Summer for phase 2 business case	• 1st • 1st • 2nd • 2nd
Pathology services	• Updates on contract performance to executive team every 6-8 weeks • Transformation Programme Board monthly • Finance & Business Development Committee and Trust Board	• 1st • 1st • 2nd
Community estate transformation programme Tynemouth Road is complete Consultation for Wood Green community hub is complete and approved	• Integrated Forum monthly review • Monthly summary report to Transformation Programme Board • Community Estates Programme Group every two weeks • Trust Board agreed empty sites as surplus to requirements • Overview & Scrutiny Committee and consultation (completed)	• 1st • 1st • 1st • 2nd • 3rd
Facilitate Trust's Agile working policy	• Monthly report to Transformation Programme Board	• 1st
Deliver maternity and neonatal transformation programme five workstreams meeting weekly –	• Monthly Maternity Transformation Programme Board • Monthly Transformation Programme Board	• 1st • 1st

Key controls	Assurances	
Ockenden, Culture, IT, Estates, Continuity of Carer		
2023/26 Sustainability (Green) Plan	• Agreed by Trust Board	• 2nd
Digital strategy has been written and tracking processes are in place. E.g. patient systems, information and technical services each have a tracker that is presented at IDTG and IDAC. Regular cyber security audits and an annual discussion and training at board on cyber security	• Digital strategy agreed by the Trust Board during 2021/22 with progress on implementation overseen by the Innovation and Digital Assurance Committee • Innovation and Digital Transformation Group meetings • Improvement, Performance and Digital Committee meetings • NCL Digital Board – updates provided quarterly • Annual national submissions • Cyber security audits • Updates and assurance on our resilience against cyber-attacks are reported to the Improvement, Performance and Digital Committee	• 2nd • 1st • 2nd • 3rd • 3rd • 3rd • 2nd
Create replicable better more efficient and effective pathways for the long-term including 'virtual by default' where possible and promoting self-management	• ICSU monthly Board meetings • Community Estates Programme Group –fortnightly meetings • Monitoring of monthly updates at TMG • ICSU quarterly performance reviews • Monthly integrated performance report to Trust Board • Monthly elective recovery dashboard reviewed by TMG and elective recovery targets included in the revised integrated performance report (IPR)	• 1st • 1st • 1st • 1st • 2nd • 1st •
Digital strategy has been written and tracking processes are in place. For example, patient systems, information and technical services each have a tracker that is presented at the Innovation and Digital	• Digital strategy agreed by the Trust Board during 2021/22 with progress on implementation overseen by the Improvement, Performance and Digital Committee • Innovation and Digital Transformation Group meetings • NCL Digital Board – updates provided quarterly • Annual national submissions	• 2nd • 1st • 2nd • 3rd • 3rd

Key controls	Assurances	
Transformation Group and to the Improvement, Performance and Digital Committee. Regular cyber security audits and an annual discussion and training at board on cyber security. Assurance is sought from key contractors on the resilience of their systems to cyber-attack.	• Cyber security audits • Training for Board members • Quarterly phishing attack exercises to test resilience and compliance reported to IDTG, TMG and IPDC	• 3rd • 2nd • 1st/2nd
IPR outcomes are reviewed by this Committee on behalf of the Board	• Different IPR metrics are presented at each Committee meeting by the Chief Operating Officer • Monthly ICSU performance reviews	• 2nd • 1st

Gaps in controls and assurances

Gaps	Mitigating actions	Completion date
Further controls such as mutually agreed redundancy schemes are being considered	Staffing expenditure controls have been implemented through a vacancy freeze in corporate areas and those that either overspent or already over their budgeted establishment	Q2

Assurance definitions:	
Level 1 (1st tier)	Operational (routine local management/monitoring, performance data, executive-only committees)
Level 2 (2nd tier)	Oversight functions (Board Committees, internal compliance/self-assessment)
Level 3 (3rd tier)	Independent (external audits / regulatory reviews / inspections etc.)

The following principles outline the Board's appetite for risk:

Risk category	Risk Appetite level based on GGI matrix	Indicative risk appetite range
Quality (patient safety, experience & clinical outcomes)	Cautious	3 - 8
Finance	Cautious / Open	3 - 10
Operational performance	Cautious	3 - 8
Strategic change & innovation	Open / Seeking	6 - 15
Regulation & Compliance	Cautious	3 - 8
Workforce	Cautious	3 - 8
Reputational	Cautious / Open	3 - 10

Risk scoring matrix (Risk = Consequence x Likelihood (C x L))

	Likelihood				
	1	2	3	4	5
Consequence	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Scores obtained from the risk matrix are assigned grades as follows:

1-3	Low risk	8-12	High risk
4-6	Moderate risk	15-25	Extreme risk

Trust-wide review and escalation of strategic risks

Trust Board Assurance Framework (BAF)

Decision to escalate to BAF as a strategic risk

Audit and Risk Committee	*Improvement Performance and Digital Committee*	*Finance and Business Development Committee*	*Quality Assurance Committee*	*Workforce Assurance Committee*

Trust Management Group – *reviews and recommends risks scored above 16 for escalation to the BAF*

Risks for escalation to the BAF

Quality Governance Committee	**People Committee**	**Clinical Divisions' Boards**	**Innovation & Digital Transformation Group**	**Estates Programme Board**	**Learn, Innovate and Improve meetings**	**Financial Improvement Board**

Patient Safety Group Patient Experience Group Clinical Effectiveness Group Safeguarding Committee Infection Prevention & Control Committee Health and Safety Committee Mortality Review Group Drugs and Therapeutics Committee Medicines Safety Group Quality Improvement / Research End of Life Care Group ICSU Quality Board Whittington Improvement Safety Huddle	Partnership Group Health and Wellbeing Group Staff equality networks Nursing & Midwifery Group Allied Health Professionals Group	Estates Steering Group PFI Management Group Digital Programme Board Procurement Steering Group Capital Monitoring Group Investment Group Income and Costing Steering Group Better Value Delivery Board

Meeting title	**Audit & Risk Committee**	**Date: 19/06/2025**
Report title	LCFS papers- June 2025	**Agenda item: 11**
Executive director lead	Terry Whittle, Chief Finance Officer	
Report author	Kirsty Clarke, Local Counter Fraud Specialist (RSM)	
Executive summary	**LCFS 2024/25 annual report** The LCFS annual report provides an overview of the counter fraud work undertaken during 2024/25, including both proactive and reactive work streams, in accordance with the approved LCFS work plan. The report sets out that the LCFS has pursued key workstreams including, but not limited to: • Undertaking a Trust-wide fraud and bribery risk assessment. • Concluding two Local Proactive Exercises (LPEs) in the areas of procurement and contract management, and consultant job planning. • Delivery of 22 bespoke fraud and bribery awareness sessions to 1,095 staff. • Received 12 referrals during the year, of which 11 have been closed and one remains ongoing. The annual report also includes the Counter Fraud Functional Standard Return (CFFSR) submission. The overall rating is recorded as green, which assesses the Trust as fully compliant with the requirements, with demonstrative evidence of the impact of counter fraud work undertaken available.	
Purpose:	The LCFS annual report provides an overview of the counter fraud work undertaken against the 2024/25 LCFS work plan, including both proactive and reactive work streams.	
Recommendation(s)	The Committee is asked to **note** the LCFS annual report.	
Risk Register or Board Assurance Framework	N/A	
Report history	N/A	
Appendices	N/A	

WHITTINGTON HEALTH NHS TRUST

Local Counter Fraud Specialist (LCFS) Annual Report 2024/25

Presented at the Audit and Risk Committee meeting on 19 June 2025

CONTENTS

EXECUTIVE SUMMARY

Our annual report provides a summary of the fraud prevention, detection and investigation work undertaken by your LCFS team. This report shows the work completed in 2024/25 against our agreed work plan, and in alignment with the NHS requirements to meet Government Functional Standard 013: Counter Fraud, and the NHS Counter Fraud Authority's (NHSCFA) counter fraud, bribery and corruption strategy.

Key messages and achievements

The Counter Fraud Functional Standard Return (CFFSR) resulted in an overall rating of green. The green rating assesses the Trust as fully compliant with the requirements, with demonstrative evidence of the impact of counter fraud work undertaken available. A copy of the full CFSSR submitted is included at Appendix A.

Two local proactive exercises (LPEs) were undertaken in respect of procurement and contract management, and consultant job planning. Management have agreed actions to address all the findings reported by the team during 2024/25. Further information can be found on page 14 of this report.

23 alerts and fraud prevention notices (FPNs) were shared with the appropriate Trust staff to highlight emerging risks and allow internal reviews of the current processes to safeguard against attack. Further information can be found on page 10 of this report.

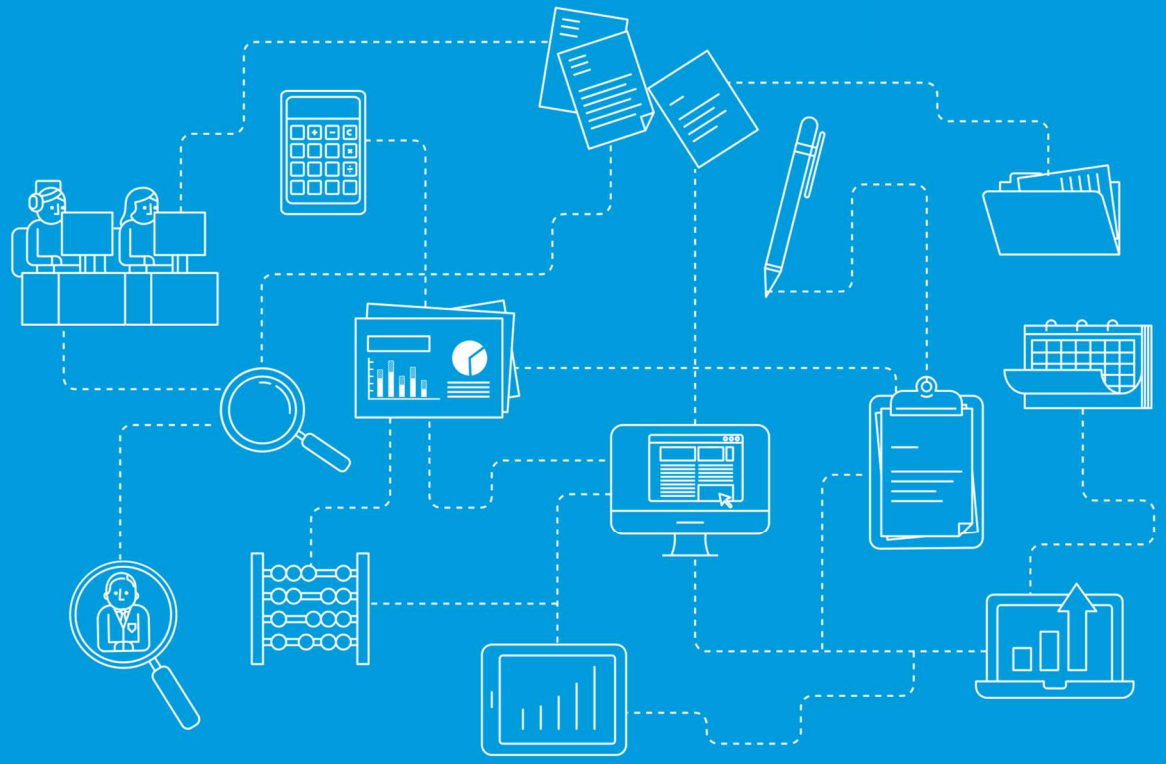
A fraud and bribery risk assessment (FBRA) refresh was undertaken to assess and identify your fraud risks. The outcome of the assessment was used to populate a fraud risk register, detailing 19 risks. Of these, 12 risk areas have been further reviewed, and are detailed along with the actions taken to mitigate against them on page five of this report.

12 referrals were received during the year, of which 10 were accepted for investigation, in accordance with the NHSCFA Anti-Fraud Manual. These resulted in identified losses of £972.64. Additionally, one disciplinary sanction was imposed; however, this will be recorded in 2025/26 upon closure of the case. Further information can be found on page 17 of our report.

22 fraud and bribery awareness sessions were delivered including an International Fraud Awareness Week campaign, and identity verification and cyber fraud awareness training sessions across health and multi-sector, attended by 1,095 members of Trust staff.

FRAUD RISKS

01



FRAUD RISK REGISTER

An FBRA was undertaken in 2024/25 to identify and assess the Trust's exposure to fraud and bribery risks. A fraud and bribery risk register (FBRR) was produced in order to inform the direction of LCFS and Trust activities to mitigate these risks. During the year we have also reviewed a number of fraud risks as part of your five-year strategy, and worked with the Trust to review these in line with your risk management policy. The risks reviewed in year are detailed in the table below, together with a summary of the activities undertaken to mitigate the risk. Your organisation's risk register is used to monitor fraud risks in line with your organisational risk processes. A single overarching fraud risk is recorded on your Corporate Risk Register.

Corporate Risk Register	Current risk rating
1618: There is a risk that individuals knowingly undertake a dishonest act with the intent of obtaining an advantage, avoiding an obligation (such as disclosure) or causing a loss to the Trust or individual(s) associated with the Trust.	**Moderate**

▲ **Risk level increased** ▼ **Risk level decreased** ▶ **Risk level remains broadly the same**

Risk Area	Current risk score	Change to risk	Work undertaken and rationale for any change
FBR1: pre-employment screening An employee provides counterfeit documents, or genuine documents that have been obtained using false information, as part of the recruitment process in order to gain or continue employment that may otherwise not be offered. **FBR2: recruitment** A candidate or employee unduly influences the recruitment process in order to gain employment for themselves or another that may otherwise not be offered.	**Low**	▶	Whilst concerns of recruitment fraud were the third most common referral type seen across RSM's healthcare client base in 2024/25, these risks have maintained a low residual risk score. The FBRA undertaken during 2024/25 identified that processes in place are aligned to NHS Employment Check Standards, with further centralised oversight processes in place for the engagement of temporary staff. The LCFS also delivered quarterly awareness sessions, available to staff across RSM's healthcare client base, aimed at improving knowledge surrounding verification of identity documents, qualifications and references, which were attended by Trust staff. The receipt of a number of referrals from Trust management relating to this fraud type is demonstrative of staff awareness of the risk and confidence in the reporting route. Additionally, three intelligence alerts have been issued relating to false identity fraud seen across the sector.

Risk Area	Current risk score	Change to risk	Work undertaken and rationale for any change
			These were shared with the relevant staff for confirmation that the Trust has not been targeted, and no concerns have been identified.
FBR3: dual working An employee works elsewhere or completes private work during their contracted hours with the Trust or whilst on sick leave and is paid by both employers for the same hours, receiving personal gain. **FBR6: declarations of interest, gifts and hospitality** An employee or supplier does not declare interests held, preventing appropriate monitoring and management of actual or perceived conflicts arising, or gift and hospitality offered or received, resulting perceived reputational risk and/ or breach of statutory requirements.	**Moderate**	▶	We concluded a joint LCFS and Internal Audit review in relation to consultant job planning. The objective of the exercise was to determine whether current systems surrounding consultant job planning and private practice were appropriate and the controls within the Trust sufficiently robust to mitigate the risk of fraud and bribery. Whilst our review identified the controls in this area were largely sufficient, a small number of gaps relating to the policies and procedural guidance in place and limitations in levels of compliance, were identified. Management actions have been agreed with the Trust to mitigate the highlighted risks and will continue to be monitored for implementation. Furthermore, the FBRA identified that although the template contract of employment at the Trust positively outlines staff responsibilities in relation to secondary employment, the supporting Sickness Absence Management Policy and Managing Conflict of Interest Policy require updates to ensure they are sufficiently robust from a counter fraud perspective. Throughout the year, we have delivered awareness sessions to senior management across the ICSUs, highlighting these risk areas and mitigations, including staff responsibilities It is noted that 33% of referrals received at the Trust in 2024/25 related to concerns of working elsewhere whilst sick or private work in NHS time, demonstrating staff awareness of these risks. During 2024/25 the Cabinet Office released data matches as part of the National Fraud Initiative (NFI) is biennial data matching exercise. Following release of matches in December 2024, a review of all high priority payroll to payroll matches, which indicate instances where Trust staff are also recorded within the payroll data at another participating organisation, was undertaken, with eight matches having been identified for further review.

Risk Area	Current risk score	Change to risk	Work undertaken and rationale for any change
FBR4: rostering An employee inputs falsified details onto a timesheet or falsifies a signature for personal gain.	Moderate	▶	The FBRA identified a range of controls in place to mitigate this risk, including the use of an electronic rostering system, with system restrictions built in. However, the risk retained a moderate residual risk score as a result of the rostering system not being utilised by all departments, as well as limitations within the Trust's eRostering Management Policy. Throughout the year, we have delivered awareness sessions to senior management across the ICSUs, highlighting these risk areas and mitigations, including staff responsibilities. During the year, one intelligence alert has been issued relating to timesheet fraud seen across the sector. This was shared with the relevant staff for information. Additionally, one referral received at the Trust in 2024/25 related to concerns of falsified bank shift claims, resulting in a loss of £472.64 to the Trust[1].
FBR7: invoicing An employee or third party submits false or duplicate invoices that do not accurately reflect the goods or services provided or contracted, resulting in a loss to the Trust. **FBR8: supplier set up and amendments** An employee or third party requests a change of bank account details in respect of a supplier with the intention to divert payments, resulting in a loss to the Trust.	Moderate High	▶	Whilst the FBRA identified that the controls in relation to this risk were largely sufficient, the risk associated with mandate fraud retains a high residual risk score. This is due to the continued prevalence of this type of fraud targeted at public facing bodies and it is acknowledged that the mitigation of these risks must be largely reactive given the continually developing sophistication of such attacks. During the year, 14 intelligence alerts have been issued related to mandate fraud and invoice fraud attempts seen across the sector during the reporting period. These were shared with the relevant staff for confirmation that the Trust has not been targeted. Additionally, we have delivered a bespoke fraud and bribery awareness session to the finance team, highlighting these risk areas, with associated prevention and reporting advice.

[1] During 2025/25, the LCFS will undertake a joint review with the Internal Audit team, to consider whether the Trust controls relating to rostering are sufficiently robust from a counter fraud perspective.

Risk Area	Current risk score	Change to risk	Work undertaken and rationale for any change
FBR9: credit cards An employee makes purchases using a Trust credit card in order to avoid due process and resulting in a loss to the Trust.	Moderate	▶	One referral received at the Trust in 2024/25 related to concerns of fraudulent payments on a Trust Charity credit card, resulting in a loss of £500. However, the Trust has not incurred any financial loss as the bank have accepted liability.
FBR14: contract management A third party dishonestly presents information certifying that work done meets agreed standards, or fails to declare unexpected changes to a contract, work done, or goods and services supplied resulting in the Trust paying for a service that does not meet the standard required or was agreed in advance. **FBR15: breach of procurement rules** An employee intentionally fails to adhere to procurement rules for personal gain, resulting in a loss to the Trust. **FBR16: supplier misrepresentation** A supplier misleads the Trust, resulting in the Trust being charged for products or services they have not agreed to, or for dishonest purposes, resulting in a loss to the Trust.	Moderate	▶	We participated in the NHSCFA national exercise into procurement, specifically relating to due diligence and contract management. The objective of the exercise was to determine whether current systems surrounding procurement and contract management were appropriate and the controls within the Trust sufficiently robust to mitigate the risk of fraud and bribery. The exercise identified a number of control gaps relating to the policies and procedural guidance in place and limitations in relation to the reporting and oversight arrangements. Management actions have been agreed with the Trust to mitigate highlighted risks and continue to be monitored for implementation. These gaps in control were reflected within the FBRA undertaken, and as a result this risk retains a moderate residual risk score. Furthermore, our national benchmarking report comparing single tender waiver (STW) usage for the period 1 April 2023 to 31 March 2024, across 60 NHS organisations, showed that the Trust benchmarked higher in STW usage than other similarly sized organisations in terms of budget and headcount.
FBR19: cyber An employee is unaware of associated cyber fraud risks and their actions can expose the organisation to security breaches and fraudsters obtaining funds/ services they are not entitled to.	High	▶	Whilst the FBRA identified the controls in relation to this risk were largely sufficient, the risk retains a high residual risk score. This is due to the continued prevalence of cyber fraud targeted at public facing bodies and it is acknowledged that the mitigation of these risks must be largely reactive given the continually developing sophistication of such attacks. The LCFS delivered quarterly awareness sessions, available to staff across RSM's healthcare client base, aimed at improving knowledge surrounding the current cyber threat landscape and cyber fraud prevention, which were attended by Trust staff.

EMERGING RISKS

The table below summarises the number of alerts issued across our client base, and how many of these were relevant and therefore issued to the Trust during the reporting period. This includes all NHSCFA FPNs issued. All relevant alerts have been shared with the appropriate Trust staff to allow internal review of the current process to safeguard against attack, and ensure that staff are aware of these risks, as well as being reported to the Chief Finance Officer and Audit and Risk Committee for information.

	NHSCFA FPNs and IBURNs issued	RSM alerts issued	Identified losses	Value of identified losses	Prevented losses	Value of prevented losses
Number at the Trust	8	15	0	£0.00	0	£0.00
Total across RSM client base	8	18[2]	0	£0.00	12	£685,129.56

NATIONAL FRAUD INITIATIVE

The National Fraud Initiative (NFI) is a biennial data matching exercise run by the Cabinet Office. The Cabinet Office receives data from around 1,200 participating organisations from across the public and private sectors, and cross references these to prevent and detect fraud.

The NFI data matching plays an important role in protecting the public purse against fraud. However, the NFI is only one element of an effective anti-fraud strategy. It must be supported by strong anti-fraud cultures and effective counter fraud policies and procedures that emphasise that fraud is unacceptable.

The following table provides an overview and update of all matches identified at the Trust as part of the 2024/25 exercise. The LCFS only reviews the high priority matches.

Payroll matches			
Category rating	**Total number of matches**	**Number of matches closed**	**Number of matches with enquires ongoing**
High	11	3	8
Medium	34	-	-
Low	47	-	-
Nil	29	-	-
Total:	**121**	**3**	**8**

[2] RSM 03,04&12 -24/25 related to a risk to GP practices and were issued to ICBs only.

COUNTER FRAUD FUNCTIONAL STANDARD RETURN

02

COMPLIANCE AGAINST GOVERNMENT FUNCTIONAL STANDARD 013

The NHSCFA requires NHS organisations to be compliant with the Government Functional Standard 013: Counter Fraud. It is the responsibility of the Trust to ensure it meets the required measurement of compliance, reported to the NHSCFA through completion and submission of a CFFSR.

Individual requirements are assessed using a RAG rating defined by the NHSCFA and an overall rating for each organisation is determined through a weighting system. The NHSCFA definitions for performance rating are:

- **Red:** Organisation does not meet the requirement.
- **Amber:** Organisation partially meets the requirement.
- **Green:** Organisation meets the requirement.

The submitted CFFSR is shown in appendix A.

2023/24 rating[3]	2024/25 rating	Requirement
Green	Green	1A - Accountable individual
Green	Green	1B - Accountable individual
Green	Green	2 - Counter fraud, bribery and corruption strategy
Green	Green	3 - Fraud, bribery and corruption risk assessment
Green	Green	4 - Policy and response plan
Green	Green	5 - Annual action plan
Green	Green	6 - Outcome-based metrics
Green	Green	7 - Reporting routes for staff, contractors and members of the public
Green	Green	8 - Report identified loss
Green	Green	9 - Access to trained investigators
Green	Green	10 - Undertake detection activity
Green	Green	11 - Access to and completion of training
Green	Green	12 - Policies and registers for interests, gifts and hospitality
Green	**Green**	**Overall rating**

Declaration

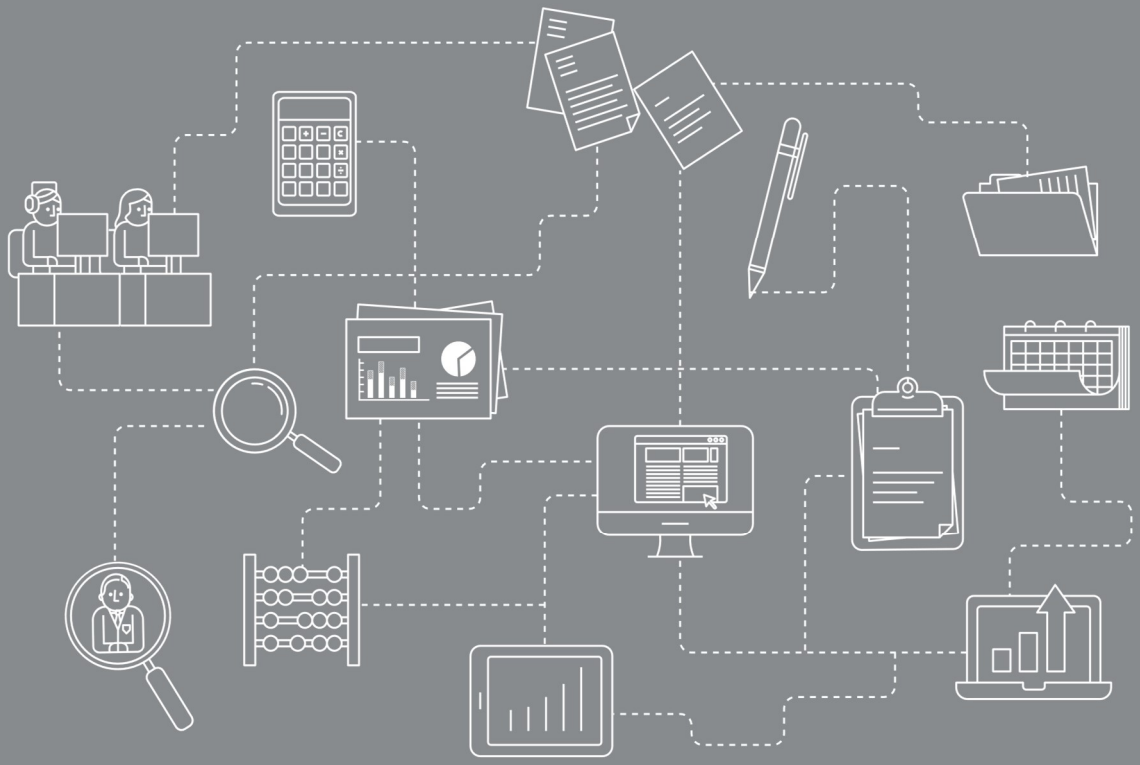
I declare that the counter fraud, bribery and corruption work carried out during 2024/25 has been self-reviewed against the Functional Standard requirements relating to fraud, bribery and corruption, and Service Condition 24 of the NHS Standard Contract, and that the above rating has been achieved.

Accountable Board Member signature	

[3] The 2023/24 was completed by the Trust's previous LCFS provider.

PROACTIVE ACTIVITIES

03



COMPLETED WORK PLAN ACTIVITIES

Planning and governance

- Attended four Audit and Risk Committee meetings.
- Liaised with key staff, including but not limited to:
  - Assistant Director of Financial Services and Counter Fraud Champion;
  - Audit and Risk Committee Chair;
  - Chief Finance Officer;
  - Chief Medical Officer;
  - Deputy Director of HR Operations;
  - Director of Communications and Engagement;
  - Head of HR Operations;
  - Partners Procurement Service Director; and
  - Trust Company Secretary.
- Attended the RSM Innovation Group to discuss and share knowledge, intelligence and emerging risk topics identified across our healthcare client base.
- Maintained representation and participation in the NHSCFA fraud risk knowledge hub working group and NHSCFA CLUE champion working group.
- Produced benchmarking reports relating to:
  - Reactive work: to identify key fraud referral areas and enable comparisons to similar organisations across our client base; and
  - Single tender waiver usage: to show waiver activity in comparison to other NHS organisations across our client base.

Risk mitigation

- Completed an FBRA to identify key fraud controls, and continued to monitor the resulting risk register.
- Delivered bespoke fraud and bribery awareness sessions to the following teams:
  - Acute Patient Access, Clinical Support Services and Women's Health Services ICSU SMT;
  - Adult Community Health Services ICSU SMT;
  - Children and Young People's Services ICSU SMT;
  - Emergency and Integrated Medicine Services ICSU SMT;
  - Finance;
  - Human Resources; and
  - Procurement.
- Produced and implemented counter fraud and bribery webpages and intranet pages.
- Delivered bespoke fraud and bribery awareness sessions at monthly inductions to new starters.
- Supplied the Trust with the quarterly RSM counter fraud newsletter, Notice Fraud.
- Circulated all relevant intelligence alerts and FPNs, and followed up any required actions.
- Delivered activities for International Fraud Awareness Week.
- Delivered quarterly fraud, bribery and identity document verification awareness sessions and quarterly cyber fraud awareness sessions.
- Reviewed 18 policies to ensure they are sufficiently robust from a counter fraud perspective.
- Commenced review of the high priority payroll NFI matches.

Proactive exercises

	Status	Number of actions raised
1. NHSCFA procurement exercise: due diligence and contract management	Presented to Audit and Risk Committee - January 2025	Three medium and 10 low priority
2. Consultant job planning (joint LCFS and internal audit)	Presented to Audit and Risk Committee - March 2025	Five medium priority

OUTCOME BASED METRICS

The tables below highlight the outcomes reported throughout 2024/25, in accordance with NHSCFA requirements.

Risk based exercises

Activity area	Total
Fraud and bribery risk assessment (FBRA)	
Number of fraud and bribery risks on current fraud risk register	19
Number of fraud and bribery risks recorded in line with the Trust risk management policy	1
Local proactive exercises (LPEs)	
Number of LPEs conducted during the reporting period	2
Number of LPEs recorded on the NHSCFA case management system	3[4]
Number of referrals generated from proactive work	1
Fraud prevented as a result of proactive work	-
System weakness reports (SWRs)	
Number of SWRs conducted during the reporting period	-
Number of SWRs recorded on the NHSCFA case management system (CLUE)	-
Number of new processes introduced, or processes adapted as a result of SWRs	-

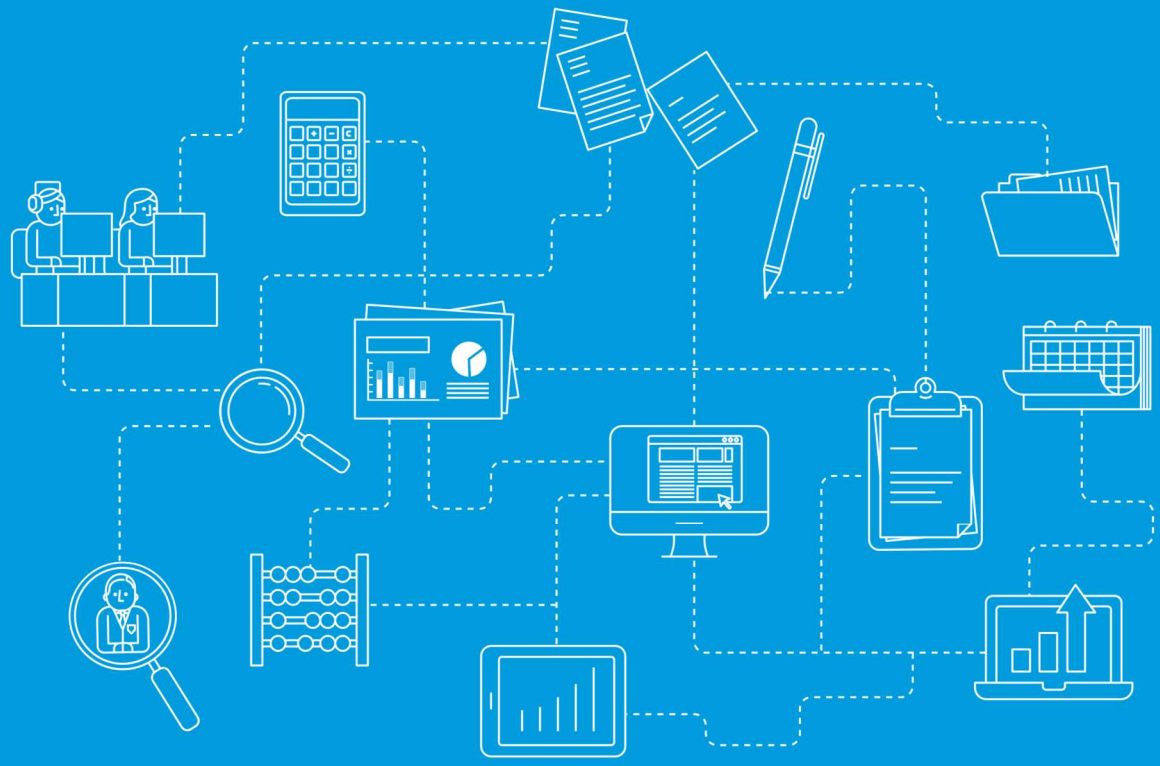
Other outcome areas

Activity area	Total
Management actions	
Number of management actions agreed	21
Number of management actions implemented	2
Policies	
Number of policies reviewed	18
Awareness sessions	
Number of awareness sessions delivered	22
Number of staff attended (As a percentage of all staff)	1,095 (25%)

[4] The NHSCFA procurement and contract management LPE was required to be recorded as two records on CLUE.

INVESTIGATION ACTIVITY

04



DETAILS OF REFERRALS

We are required to log referrals of potential fraud on CLUE. The NHSCFA do not permit the recording of referrals where it is clear from the outset that no fraud has occurred, or where there is no loss to the NHS. For transparency, these referrals are still reported to the Trust for your information. All investigations have been recorded on CLUE and, where appropriate, have been progressed in accordance with the investigation tool kit and in compliance with the NHSCFA requirements.

Referrals over time		
Year	**Number of referrals**	**Number of intelligence reports**
2023/24	0	0
2024/25	10	2

	Cases carried forward from 2023/24	Referrals received in year	Intel reports received	Investigations undertaken	Investigations closed	Investigations carried forward	Investigations recorded on CLUE	Reactive resource used
Total	0	10	2	12	11	1	10	44.69 days

Referral summary

Of the 12 referrals received during the year, these reflected the following:

Fraud type	Number of referrals received	Sources of referrals	Key outcomes
Banking fraud	One	Management	CF/6695/25: Fraud loss of £500 recorded, however, the bank has accepted liability. £944.70 fraud prevention recorded.
Email scams	One	General staff	-
Falsified bank shifts	One	Human Resources	CF/6095/24: Fraud loss of £472.64 recorded.
False documents	Three	NHSCFA and management	-
Misappropriation of cash	Two	NHSCFA and Human Resources	-
Private work in NHS time	Two	Human Resources	CF/5915/24: Disciplinary sanction imposed; however, this will be recorded in 2025/26 upon closure of the case.
Working whilst sick	Two	Human Resources and management	-

Sanctions and recoveries

All cases are subject to continual assessment to identify the most appropriate sanction, which may be a combination of criminal, disciplinary or civil, as although investigations are undertaken by the LCFS to identify criminal activity, it is not always appropriate or in the public interest for a criminal sanction to be applied. Where appropriate we will always seek to highlight any identifiable financial loss and assist in seeking recovery of this. The tables below show the number of sanctions applied within the year, and the value of fraud identified, and monies recovered.

Sanctions imposed	Number
Disciplinary	-
Civil	-
Criminal	-
Total sanctions	**-**

Redress imposed	Amount
Fraud identified	£972.64
Fraud prevented	£944.70
Fraud recovered	£0

USE OF RESOURCES

Proactive resources

The agreed work plan resource for 2024/25 was 60 proactive days. The table below shows the utilisation of the work plan and reactive resources for the year.

Area of activity	Days used
Proactive work	Redacted
Reactive work	Redacted
Total days	**Redacted**
Off plan activity	-

Cost of counter fraud, bribery and corruption work

The table below shows the cost of counter fraud work undertaken during the year.

Area of activity	Cost
Proactive activities (planning and governance, training, reporting and awareness, and proactive detection)	
Investigation activities	Redacted
Total costs	**Redacted**

Nominations overview

The table below details the nominated officers at the Trust during the reporting period.

Role	Name	Date of change
Accountable Board Member	Jerry Francine	Removed April 2024
Accountable Board Member	Terry Whittle	Added April 2024
Audit and Risk Committee Chair	Robert Vincent	Removed April 2024, Re-added March 2025
Audit and Risk Committee Chair	Amanda Gibbon	Added April 2024 Removed March 2025
Counter Fraud Champion	Martin Linton	-
Lead LCFS	James Shortall	Removed April 2024
Core team		
Lead LCFS	Kirsty Clarke	Added April 2024
Supporting LCFS (management)	Mark Kidd	
Supporting LCFS	Kitty Gibb	
Investigations		
Supporting LCFS (management)	Mark Fairhurst	Added April 2024
Supporting LCFS (management)	Matt Flegg	
Supporting LCFS (management)	Simon Gooding	
Supporting LCFS (management)	Sophie Coster	
Supporting LCFS (management)	Faith Read	
Supporting LCFS	Paul Gedge	
Supporting LCFS	Abbie Wilson	
Supporting LCFS	Neil Hankinson	

APPENDICES

05

APPENDIX A: CFFSR SUBMISSION

To comply with NHSCFA requirements we have included the completed full CFFSR is shown below.

Requirement	Rating	Evidence available to support rating
1A- A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation. The accountable board member is responsible for the provision of assurance to the executive board in relation to the quality and effectiveness of all counter fraud bribery and corruption work undertaken. The accountable board member is responsible for ensuring that nominations to the NHSCFA for the accountable board member, audit committee chair and counter fraud champion are accurate and that any changes are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process.	**Green**	• Board meeting minutes inclusive of LCFS work plan and progress report oversight • Organisational counter fraud, bribery and corruption work plan, reflective of the NHSCFA strategy and aligned to the fraud and bribery risk assessment • Annual report on counter fraud, bribery and corruption work, inclusive of a fully completed CFFSR • Progress reports to the Audit and Risk Committee: June 2024, September 2024, January 2025 and March 2025 • Meeting minutes, decisions, action points and records of their execution, evidencing monitoring and evaluation of counter fraud work conducted in compliance with the requirements • Audit and Risk Committee minutes evidencing monitoring and evaluation of counter fraud work conducted in compliance with the CFFSR: March 2024, June 2024, September 2024, January 2025 and March 2025 • Standing Financial Instructions • Documentation from the nominations process, inclusive of LCFS and Counter Fraud Champion nominations
1B- The organisation's non-executive directors, counter fraud champion or lay members and board/governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation. The counter fraud champion understands the threat posed and promotes awareness of fraud, bribery and corruption within the organisation. Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken is documented. Where recommendations have been made by NHSCFA	**Green**	• Board meeting minutes inclusive of LCFS work plan and progress report oversight • Organisational counter fraud, bribery and corruption work plan, reflective of the NHSCFA strategy and aligned to the fraud and bribery risk assessment • Meeting minutes, decisions, action points and records of their execution, evidencing monitoring and evaluation of counter fraud work conducted in compliance with the requirements • Audit and Risk Committee minutes evidencing monitoring and evaluation of counter fraud work conducted in compliance with the CFFSR: March 2024, June 2024, September 2024, January 2025 and March 2025 • Documentation from the nominations process, inclusive of LCFS and Counter Fraud Champion nominations • Communications to staff directly attributed to the Chief Finance Officer and Counter Fraud Champion • Annual report on counter fraud, bribery and corruption work, inclusive of a fully completed CFFSR

Requirement	Rating	Evidence available to support rating
following an engagement, it is the responsibility of the accountable board member to provide assurance to the board surrounding the progress of their implementation. The organisation reports annually on how it has met the requirements set by NHSCFA in relation to counter fraud, bribery and corruption work, and details corrective action where requirements have not been met.		
2- The organisation aligns counter fraud, bribery and corruption work to the NHSCFA counter fraud, bribery and corruption strategy. This is documented in the organisational over-arching strategy or counter fraud, bribery and corruption policy, and is submitted upon request. The counter fraud work plan and resource allocation are aligned to the objectives of the strategy and locally identified risks.	**Green**	• Counter Fraud and Bribery Policy and Response Plan including organisational strategy, referencing the NHSCFA strategy • Fraud and bribery risk assessment and register • Evidence of risk monitoring being conducted at a senior level (Risk Register- 1618) • Organisational counter fraud, bribery and corruption work plan, reflective of the NHSCFA strategy and aligned to the fraud and bribery risk assessment • Annual report on counter fraud, bribery and corruption work, inclusive of a fully completed CFFSR • Meeting minutes, decisions, action points and records of their execution, evidencing monitoring and evaluation of counter fraud work conducted in compliance with the requirements
3- The organisation has carried out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risk analysis is undertaken in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology and is recorded and managed in line with the organisation's risk management policy and included on the appropriate risk registers, and the risk assessment is submitted upon request. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the audit committee (or equivalent body).	**Green**	• Fraud and bribery risk assessment and register completed in accordance with GCFP core discipline FRA • Evidence of liaison with risk management staff within the organisation • Evidence of risk monitoring being conducted at a senior level (Risk Register- 1618) • Meeting minutes, decisions, action points and records of their execution, evidencing monitoring and evaluation of counter fraud work conducted in compliance with the requirements • Audit and Risk Committee minutes evidencing monitoring and evaluation of counter fraud work conducted in compliance with the CFFSR: March 2024, June 2024, September 2024, January 2025 and March 2025 • Organisational counter fraud, bribery and corruption work plan, reflective of the NHSCFA strategy and aligned to the fraud and bribery risk assessment • Progress reports to the Audit and Risk Committee: June 2024, September 2024, January 2025 and March 2025

Requirement	Rating	Evidence available to support rating
4- The organisation has a counter fraud, bribery and corruption policy and response plan (the policy and plan) that follows NHSCFA's strategic guidance and has been approved by the executive body or senior management team. The plan is reviewed, evaluated and updated as required, and levels of staff awareness are measured.	Green	• Counter Fraud and Bribery Policy and Response Plan including organisational strategy, referencing the NHSCFA strategy and aligned to the NHSCFA counter fraud manual resource document and template policy, and evidence of review • Organisational counter fraud, bribery and corruption work plan, reflective of the NHSCFA strategy and aligned to the fraud and bribery risk assessment • Evidence of risk monitoring being conducted at a senior level (Risk Register-1618) • Meeting minutes, decisions, action points and records of their execution, evidencing monitoring and evaluation of counter fraud work conducted in compliance with the requirements • Materials and supporting evidence to show that the policy and response plan has been communicated across the organisation • Evaluation measures including increase in referrals • Standing Financial Instructions
5- The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience. This includes (but is not limited to) defined objectives, milestones for the delivery of each activity and measurable areas for improvement in line with strategic aims and objectives. The plan is agreed, and progress monitored by the audit committee (or equivalent body).	Green	• Organisational counter fraud, bribery and corruption work plan, reflective of the NHSCFA strategy and aligned to the fraud and bribery risk assessment • Evidence of risk monitoring being conducted at a senior level (Risk Register- 1618) • Audit and Risk Committee minutes evidencing monitoring and evaluation of counter fraud work conducted in compliance with the CFFSR: March 2024, June 2024, September 2024, January 2025 and March 2025 • Evaluation materials, including reports on proactive exercises, where applicable evidencing reduction in risk or expenditure: procurement and contract management, and consultant job planning • Internal Audit reports: DSPT • Increased compliance with procedures: consultant job planning, single tender waiver usage • Evidence of findings suggested for, and influencing, policy development: 18 policies reviewed
6- The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance. This should be informed by national and local risk assessment, national benchmarking and other comparable data. Proactive and reactive outcomes and progress are recorded on the approved NHS case management system. Metrics should include all reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, criminal sanctions and disciplinary sanctions.	Green	• Organisational counter fraud, bribery and corruption work plan, reflective of the NHSCFA strategy and aligned to the fraud and bribery risk assessment • NHSCFA instructions and guidance on the use of the NHSCFA case management system • Approved NHS fraud case management investigation and local proactive exercise system records • Investigation files and evidence of review • Evaluation materials, including reports on proactive exercises, where applicable evidencing reduction in risk or expenditure: procurement and contract management, and consultant job planning

Requirement	Rating	Evidence available to support rating
	Green	• Audit and Risk Committee minutes evidencing monitoring and evaluation of counter fraud work conducted in compliance with the CFFSR: March 2024, June 2024, September 2024, January 2025 and March 2025 • Circulation and actioning of NHSCFA circulars, intelligence alerts, bulletins and local warnings guidance • Evidence derived from participation in the National Fraud Initiative
7- The organisation has well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption. Reporting routes should include NHSCFA's Fraud and Corruption Reporting Line and online reporting tool. All incidents of fraud, bribery and corruption are recorded on the approved NHS case management system. The incident reporting routes are publicised, reviewed, evaluated and updated as required, and levels of staff awareness are measured.	Green	• Organisational counter fraud, bribery and corruption work plan, reflective of the NHSCFA strategy and aligned to the fraud and bribery risk assessment • Counter Fraud and Bribery Policy and Response Plan including organisational strategy, referencing the NHSCFA strategy • Materials and supporting evidence to show that the incident reporting routes, including the NHSCFA online fraud reporting tool https://cfa.nhs.uk/reportfraud, have been communicated across the organisation • All reported incidents recorded on NHS fraud case management • Evaluation measures including increase in referrals • Evidence of the review of the incident reporting routes and subsequent amendments
8- The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery and corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA. The case management system is used to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise.	Green	• Counter Fraud and Bribery Policy and Response Plan including organisational strategy, referencing the NHSCFA strategy and aligned to the NHSCFA counter fraud manual resource document • NHSCFA Investigation Case File Toolkit incorporated in the NHS counter fraud manual • NHSCFA instructions and guidance on the use of the NHSCFA case management system • Approved NHS fraud case management investigation, and local proactive exercise system records • Investigation files and evidence of review • Evaluation materials, including reports on proactive exercises, where applicable evidencing reduction in risk or expenditure: procurement and contract management, and consultant job planning • All outcomes and sanctions achieved are recorded • Correspondence with third parties • Cases are closed on the approved NHS fraud case management system within one month of the conclusion of a case, with all relevant fields completed
9- The organisation employs or contracts in an accredited, person (or persons) nominated to the NHSCFA to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and	Green	• Counter Fraud and Bribery Policy and Response Plan including organisational strategy, referencing the NHSCFA strategy and aligned to the NHSCFA counter fraud manual resource document (investigation case file toolkit, witness statement review template and interview under caution review)

Requirement	Rating	Evidence available to support rating
deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery or corruption to account. The organisation will ensure that any changes to nominations are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process. The accredited nominated person (or persons) must demonstrate continuous professional competencies and capabilities on an annual basis by examples of practical application of skills and associated training to include (but is not limited to), obtaining witness statements, conducting interviews under caution and maintaining up to date knowledge of legal and procedural requirements.		• NHSCFA instructions and guidance on the use of the NHSCFA case management system • Approved NHS fraud case management investigation, and local proactive exercise system records • Investigation files and evidence of review • Relevant staff training and circulation of awareness materials • Meeting minutes, decisions, action points and records of their execution, evidencing that findings are fed back into improvements • Evidence that the witness statements and interviews under caution are regularly reviewed for compliance and quality, and interviews under caution are conducted in line with the National Occupational Standards and the PACE • Evidence of circulars and publications providing legal and procedural updates
10- The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption. Relevant information and intelligence may include (but is not limited to) internal and external audit reports, information on outliers, recommendations in investigation reports and NHSCFA led loss measurement exercises. The findings are acted upon promptly.	**Green**	• Fraud and bribery risk assessment and register completed in accordance with GCFP core discipline FRA • Evidence of liaison with risk management, internal audit, finance, payroll, and other staff • Evidence of risk monitoring being conducted at a senior level (Risk Register- 1618,) • Circulation and actioning of NHSCFA circulars, intelligence alerts, bulletins and local warnings guidance • Approved NHS fraud local proactive exercise system records • Evidence of planning of proactive prevention and detection exercises, and final reports: procurement and contract management, and consultant job planning • Relevant staff training and circulation of awareness materials, inclusive of learning aims and outcomes • Evaluation measures including increase in referrals • Evaluation of the results of proactive activities, demonstrating improvements
11- The organisation has an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media. This should cover the role of the NHSCFA, LCFS and the requirements and national implications of Government Counter Fraud Functional Standard providing a standardised approach to counter fraud work.	**Green**	• Counter Fraud and Bribery Policy and Response Plan including organisational strategy, referencing the NHSCFA strategy and aligned to the NHSCFA counter fraud manual resource document • Materials and supporting evidence to show that the incident reporting routes, including the NHSCFA online fraud reporting tool, have been communicated across the organisation • Evaluation measures including increase in referrals

Requirement	Rating	Evidence available to support rating
Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails and other media, making use of the NHSCFA's fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.		• Relevant staff training and circulation of awareness materials, including presentations (22 sessions to 1,095 staff), intranet materials and newsletters, inclusive of learning aims and outcomes • Fraud and bribery risk assessment and register completed in accordance with GCFP core discipline FRA • Meeting minutes, decisions, action points and records of their execution, evidencing monitoring and evaluation of counter fraud work conducted in compliance with the requirements. • Evidence of where awareness work has been evaluated and changed to maximise its impact
12- The organisation has a managing conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010. The effectiveness of the implementation of the process and staff awareness of the requirements of the policy are regularly tested.	**Green**	• Managing Conflicts of Interest Policy, in accordance with NHSE managing conflicts of interest guidance for staff and organisations, and referencing the Bribery Act 2010 and NHSCFA counter fraud manual • Publicity in relation to the Managing Conflicts of Interest Policy • Register of interest maintained • Evaluation measures including increase in referrals • Evidence of measures to evaluate awareness of the Managing Conflicts of Interest Policy among staff, including proactive prevention and detection exercises, and final reports: consultant job planning • 100% compliance with the requirement for decision making staff to make an annual return, and evidence of escalation

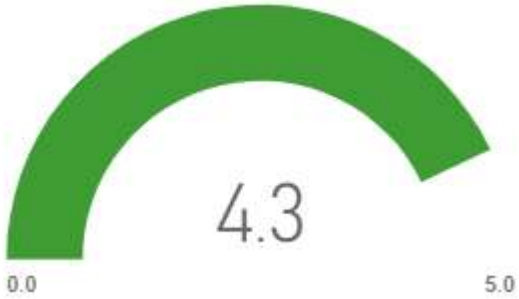
APPENDIX B: FRAUD CULTURE STAFF SURVEY

During 2024/25 RSM ran a survey to help us understand the level of knowledge and views of how fraud and bribery risks are dealt with, from almost 3000 staff across our health sector client base. The results of this survey help assess the effectiveness of the counter fraud work. The conflicts of interest and gifts and hospitality section focused on what may be accepted under your organisation's policy and assists in assessing staff understanding of the NHS England guidance.

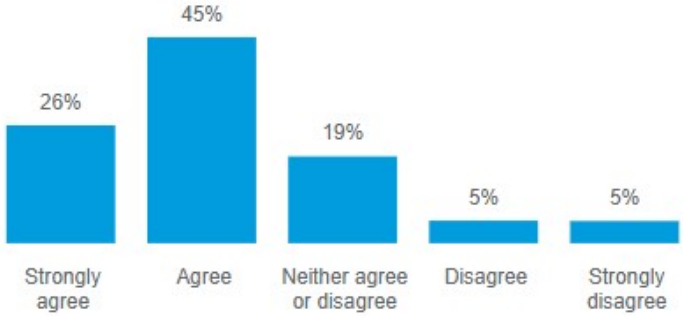
During the year the LCFS has continued to raise awareness and embed the anti-fraud culture within the Trust, acting as a deterrent against anybody intending to defraud the Trust and increasing staff awareness. We have seen an increase in referrals from the previous year, when none were received by the previous LCFS. It is of note that none of the referrals were received anonymously, indicating strong staff knowledge of and confidence in reporting routes, and the prevalence of referrals received from the Trust HR team is demonstrative of effective engagement with the counter fraud function During 2025/26 the LCFS will continue to build and maintain relationships with key staff groups to encourage more referrals and ensure that staff feel comfortable and empowered to report issues directly to the LCFS.

I am confident that I can identify suspicious activity in my organisation? (1 is not at all confident and 5 is very confident)

If I received an email purporting to be from the CEO asking me to arrange payments, I would feel confident in how to check the validity of the email?



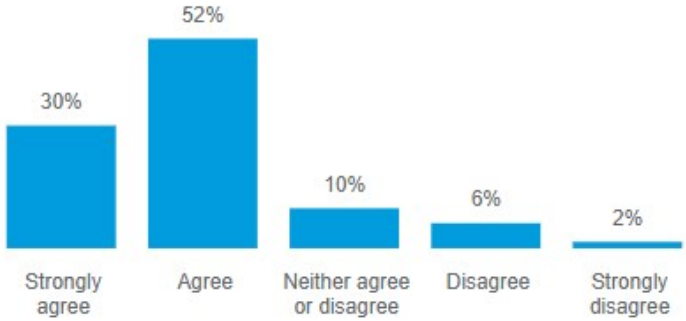
I consider fraud to be a key risk to my organisation?



If I suspected fraud, I would report it?

If I suspected bribery, I would report it?

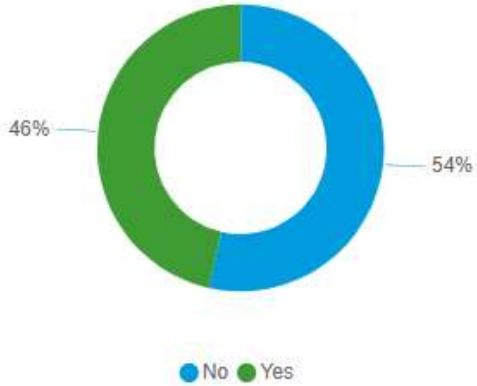
I know how to report fraud and bribery?



I am confident fraud and bribery will be investigated, regardless of the position of the persons involved?

I am confident in my understanding of my organisation's fraud and bribery policy?

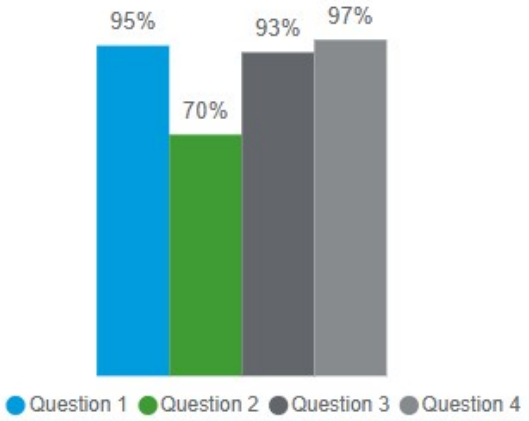
Have you undertaken any fraud or bribery training in the past year?



Conflicts of interest and gifts and hospitality

	Questions	Correct answer
1	I am a procurement manager at the Trust and my brother-in-law is the managing director of a medical equipment company. His company have submitted a bid to supply to my organisation. Should I declare this interest?	Yes
2	A supplier to the organisation is on site for a contract review meeting and has brought cakes for the contracting team. Can the cakes be accepted?	Yes
3	A long-term patient is finally being discharged home and gives £300 cash to the matron to divide between the team. It would work out to be £30 each. Can this be accepted?	No
4	A family member of a service user offers you a free stay at their holiday home. Can you accept this?	No

Percentage of correct responses



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Meeting title	**Trust Board – public meeting**	**Date: 23.07.2025**
Report title	**Workforce Assurance Committee Chair's report**	**Agenda item: 8**
Committee Chair	Rob Vincent, Non-Executive Director	
Executive lead	Liz O'Hara, Chief People Officer	
Report authors	Marcia Marrast-Lewis, Assistant Trust Secretary, Liz O'Hara and Rob Vincent	
Executive summary	Trust Board members are presented with the Workforce Assurance Committee Chair's report for the meeting held on 16 June 2025. **Areas of assurance:** • Chief People Officer verbal report • Board Assurance Framework – People 1 and 2 entries • Risk Register including a report on Children's safeguarding review • 2024/25 Quarter 4 corporate workforce performance report • 2024/25 Quarter 4 Guardian of Safe Working report • 2024/25 Quarter 4 Freedom to speak up report • People strategy update on Pillar 4 • Sexual Safety Charter • Estates and Facilities capital projects update • People Pulse Report • Workforce controls • Staff Story: refurbishment of the parents' room in neonatal intensive care unit The Committee agreed to bring the following areas to the attention of the Board: • Stella's story enabling staff development • Pillar 4 of the Workforce Strategy and people development. • Workforce controls. • Freedom to Speak Up. • Personal pledges in support of staff wellbeing. The initiative is aimed at reinforcing a culture of support and psychological safety across the Trust.	
Purpose	Noting	
Recommendation(s)	Board members are invited to note the Committee Chair's report	
BAF	People 1 and 2 entries	
Appendices	1: Guardian of Safe working report	

Committee Chair's assurance report

Committee name	Workforce Assurance Committee
Date of meeting	16 June 2025
Summary of assurance:	

1. The Committee is reporting significant assurance to the Board on the following matters:

Chief People Officer's report

The Committee received a verbal report from the Chief People Officer in which she highlighted key events and developments since the last meeting:

- A new national 10-year workforce plan was expected in late summer or early autumn. Which would include a target operating model for HR functions nationally, with opportunities for local input. The plan would replace the previous national workforce strategy and guide future HR direction.
- North Central London (NCL) is well-positioned due to existing shared services and collaborative infrastructure.
- Workforce controls remained a key focus, with Whittington facing similar financial constraints as other trusts. These pressures were being managed in coordination with finance and HR teams.
- The BMA is formally balloting members (resident doctors and excluding consultants) for potential industrial action related to the recent pay award, with the ballot closing on 7 July. Other unions, including the RCN, were surveying members but have not yet initiated formal ballots.
- Preparatory planning was underway to mitigate the impact of strike action.
- The NCL Integrated Care Board (ICB) was undergoing a restructure with a reduction of 50% of staffing, which may affect workforce initiatives across the system.
- The Trust has maintained regular engagement with HR colleagues at ICB and CPA levels to stay aligned and contribute to system-wide planning.

In discussion the Committee agreed the need for clear internal communication following the recent national funding announcement. It was important for to ensure that communications were aligned to staff expectations with organisational priorities.

The Committee noted the verbal update

Deep dive into People Strategy – pillar four Developing our People.

The Committee received a presentation on an update taking place on each of the five pillars of the People Strategy. The Committee learned that the fourth pillar covered development of staff and involved the following outcomes:

- Nine people had completed Level 6 and 7 leadership apprenticeships and 41 were participating on Level 5. The funding landscape for Level 7 apprenticeships was changing, necessitating a need to complete enrolment before January 2026.

- The organisation has offered various leadership and management courses, with one-fifth of staff completing them. Internal coaching has been provided to 30 people, and partnerships with NHS Select have trained 96 staff members.
- The Manager's Passport programme was in development, focusing on the employee journey, HR policies, and leadership development. The programme included e-learning and face-to-face sessions and would be added to managers' profiles on the learning management system.
- The organisation delivered its fourth cohort of the BME career development programme, trained 25 staff members, and offered interview, CV writing skills and one-to-one coaching. Future plans for the programme included delivering the programme across NHS organisations in London.
- During 2025 the Trust had launched a successful bid with NHSE for Race Strategy London.
- 88 staff members had completed restorative justice training during the past year. In autumn 2025 a train the trainer restorative conversations would be launched.

The Committee praised the workforce development initiatives for their energy, impact, and career-transforming potential. Concerns were raised about the sustainability of apprenticeship and trainee nurse associate programmes due to funding and staffing constraints. The importance of continuing neurodiversity training was noted. However, currently there were no further plans to run training during the current year. Future sessions would depend on available resources.

Committee members suggested additional training development opportunities which included leveraging existing training platforms, sharing senior staff career stories, and sustaining momentum for Band 2–7 staff through group coaching. The value of ad hoc support initiatives and the continuation of leadership programmes like NHS Select were also highlighted.

The Committee welcomed initiatives including the launch of Manager Forums, targeted roadshows promoting learning opportunities, and a Divisional Leadership Programme to support career progression from Band 8 upwards, especially in relation to Equality, Diversity, and Inclusion (EDI).

The Committee noted the report

Q4 Guardian of Safe Working Hours

The Committee received a report on the activities of the Guardian of Safe Working Hours which highlighted:

- 91 exception reports were lodged for the quarter with no immediate safety concerns.
- 113 hours of overtime was repaid either in time of in lieu (TOIL) or pay for additional hours worked.
- There were 20 whole time equivalent vacant posts recorded during the quarter limiting the need available for TOIL

- 67 reports were made by Foundation Year One Doctors, 13 by IMT/ST1 or ST2; eight by Foundation Year Two Doctors; and three by Speciality Registrars.
- The majority of reports came from people working in general surgery including urology and general medicine.
- There was one immediate safety concern raised which was reviewed in a timely manner.
- The reduction of the number of exception reports was thought to the related to the reduction in ambulance diverts from North Middlesex University Hospital and expanding the roll out of Minerva Airmid bridging service.

The Committee noted the report

Report from the Freedom to Speak Up Guardian

The Committee reviewed the report which highlighted:

- Nine new freedom to speak up champions had been recruited, bringing the total to 41. However, only five were currently active. Refresher training had been scheduled to improve visibility and engagement. Ongoing recruitment would continue, with the aim allocating one champion per clinical ward and representation areas like finance and IT.
- 61 initial concerns were received in Q3–Q4, up from 38 in the same period of the previous year. 105 concerns were raised or the year 2024/25 up from 73 for 2023/24.
- Increased reporting was seen as a positive indicator of trust in the system and psychological safety.
- There was a 10% increase in bullying and harassment concerns.
- 9% increase in concerns related to quality and safety.
- Worker safety and well-being concerns decreased from 25% to 10%, likely reflecting improved responsiveness and support, particularly from the OD team.
- Concerns from Black and Asian minority ethnic colleagues decreased from 48% to 30%, highlighting the need for continued focus on inclusion and accessibility.

Committee members discussed the importance of visibility of champions which was needed to encourage staff to come forward with concerns.

Sexual Safety Charter update

The Committee considered an update on the work undertaken to develop the NHS Sexual Safety Charter at Whittington Health. I

Key areas of focus included:

- The establishment of a policy subgroup to take forward a localised version of the national policy, tailored to Whittington's needs. This included clear processes for reporting sexual safety concerns and organisational responses.
- A comprehensive launch strategy with strong early feedback on the campaign's reach and impact across the organisation.

- Staff support and wellbeing which would focus on robust support mechanisms for staff, including Employee Assistance Programme resources and broader wellbeing initiatives.
- Collaboration with UCLH which has provided valuable insights, ensuring alignment with best practices across the system. Notably, all progress has been achieved without additional resources, relying on staff contributions during regular working hours highlighting the commitment and dedication of those involved.

The Committee was assured that the project remains on track, with strong momentum and cross-organisational engagement and would look forward to an update following the launch in September.

The Committee noted the report

Estates, Facilities and Capital Projects update
The Committee reviewed an update on the planning, scoping and development workstreams of the following key staff interest areas:

- Phase 1 of the N19 redevelopment has been completed successfully, receiving a 4.4/5 rating from 84 customer feedback interviews. Improvements included new menus, aesthetics, and offerings in response to a staff food and retail survey. Plans for the year included retendering the coffee shop, lunch deli, and general store, as well as introducing contemporary vending and improved seating/collaborative spaces.
- Capital planning enhancements created a third capital classification related to staff and patient experience in addition to strategic projects and BAU asset replacement. This category of capital funding was aimed at improving the environment for staff, visitors and patients with a focus on comfort and quality.
- An ongoing rolling programme of refurbishments to areas which included imaging, outpatients, and general upgrades to improve patient and staff environments
- A number of condition surveys across community sites were in progress to guide targeted investment in the second half of the year. Funding was also allocated for projects to include fire rectification works at Stuart Crescent and grant funded solar panel installations to reduce utility costs and support carbon reduction had been planned at specific community sites.
- Significant progress has been made on major projects and safety upgrades, including the full refurbishment of theatres one and two. Fire safety enhancements continued with alarm upgrades, LED emergency lighting, and fire stopping. Phase one of anti-ligature improvements were almost complete; phase two would begin later in the year.

The Committee discussed the condition and improvement of staff rest areas across the organisation which were essential for staff morale and wellbeing. Assurance was provided that rest and changing facilities remained a priority. A bid for charitable funding had been made to commence work on the refurbishment of the main changing facilities near the general exit.

The Committee noted the report

People Pulse Report (April 2025)
The Committee considered the key findings of the people pulse survey carried out in April:

- 318 responses were received, up from 256 in January.
- Engagement score rose to 6.79 from 6.69.
- Advocacy and involvement scores increased by 0.2 and 0.1 respectively.
- Motivation had also improved.
- Team support rose by 6%, and perceptions of health and wellbeing support improved by 4.2%.
- Awareness of organisational changes increased by 7.5%.
- 12.5% of respondents were fully aware that feedback could be made through change.nhs.uk.

The Committee noted that work would continue to implement staff survey action plans which were aligned with People Pulse findings.

Workforce Controls
Committee members reviewed a summary of the workforce controls that had been implemented at the Trust in May to manage expenditure on temporary pay which included the following:

- Divisional trajectories were agreed to maintain control over workforce pay.
- A recruitment pause was introduced in May; quality impact assessments for affected posts were undertaken to ensure patient care was not compromised.
- A vacancy freeze was applied in over-established and overspent corporate areas.
- Weekly vacancy and temporary staffing reviews were held to maintain oversight.
- Early data showed a reduction in spend in March and April with a slight increase in May. The Trust remained within its overall trajectory.
- Continued scrutiny of workforce controls is being maintained by the Executive Team and Trust Management Group.

Future focus would include closer scrutiny of substantive staffing costs and feedback on how pressures were managed.

The Committee noted the report

Quarter 1 Board Assurance Framework (BAF)
The Committee received the report which considered the risks to the delivery of the Trust's People strategic objective. The People one and two BAF entries had been reviewed, and it was agreed that there would be no changes to risk scores to either entry.

The Committee approved the quarter one 2025/26 BAF entries for the risks to the delivery of People strategic objectives and agreed that the scores for both entries remain unchanged.

Risk register

The Committee considered a report on the key changes to the risk register. Committee members noted the following high risks:

- 1537 – Barnet Healthy Children Programme: Full recruitment expected by September.
- 1525 – Domestic Cleaning: An ongoing concern.
- 1605 – Lack of uro-oncologist for the urology MDT; The Board had been briefed.
- 1612 –Long waiting times in Haringey Community Stroke Services.
- 1099 - Gynaecology Colposcopy - ongoing resource concerns for managing targeted pathways
- 1549 – Safeguarding Supervision (Barnet): Increased workload due to large teams; group supervision model being developed.
- 850 – Food safety training for ward staff: The risk waws expected to be reduced training programme underway.
- 1588 – Virtual Ward Pharmacy Capacity: Pharmacy staffing not yet aligned with increased virtual ward beds.
- 1605 – Anaesthetic Resource: Recruitment for two consultants recently completed.
- 1621 – Islington MASH (Multi-Agency Safeguarding Hub): Rising referrals compounded by a funding gap, maternity leave and expired local authority funding.
- 1564 – Paediatric ED safer staffing: Vacancies had been reduced, but current staffing included temporary and unfunded posts; a budget reallocation under review.
- 1430 – Haringey Rehabilitation Services: An underfunding concern, similar to stroke services.

1166 – Violence and aggression: Ongoing risk

The Committee noted the report

Q 4Workforce Performance KPIs

The Committee was informed that:

- Sickness absence rates had decreased slightly from 4.6% in Q3 to 4.5% in Q4.
- The vacancy rate increased from 6.3% in Q3 to 6.4% in Q4
- Turnover rates decreased from 9.9% in December 2024 to 9.3% in March 2025
- Compliance with statutory and mandatory training requirements was 87%.
- Appraisal compliance 78% in Q3 and fell to 76% in Q4.
- Time to hire performance rose to 63.5 days against a trajectory of 62 days.
- The number of employee relations cases had decreased, by 31 cases to 64 from Q2

- The time taken to resolve cases was an average of 77.5 working days in Q4. This was a decrease of 97.5 days from Q3. Of the 7 cases that were closed, 5 were grievances and 2 were disciplinaries.

The Committee noted the Q4 Workforce information report.

Staff Story – BME Band 2-7 Development Programme
Liz O'Hara introduced Stella Osaa a Domestic Team Leader who joined the meeting to talk about her journey through the Band 2-7 BME Development Programme and the impact it had on her role at the Trust.

Stella introduced herself as a domestic team supervisor at Whittington Hospital, she had responsibility for managing a team of domestic staff primarily involved in the cleaning of the hospital premises. She joined the BME development programme in mid- 2024 following an advertisement on the Trust's intranet. At that time, she was experiencing challenges managing her team and recognised that she needed to improve her leadership skills to manage her team more effectively.

She explained that when she joined Trust, she inherited a team made up of mainly men who had been in their roles for 15-20 years and were resistant to change. In addition, they were from a cultural background where men were seen as figures of authority, and women were more subservient. This created an environment where she struggled to assert her authority.

Stella informed the Committee that at the start of the programme her core objectives were to change her mindset, enhance her leadership skills, and understand diversity and equality at work. She told the group how the programme has helped her improve her communication skills, decision-making, and problem-solving abilities. She can now confidently make decisions for her team and resolves conflicts without the need to escalate issues to human resources. Stella's participation in the programme transformed her from someone who avoided speaking up to a confident leader who can express her views and make decisions. She now focuses on the future and looks for new ways to grow with her team. Stella plans to take on more responsibility within her department to empower others and share what she has learned. She aimed to put her views forward and suggest improvements.

Stella suggested making the BME development programme mandatory for all management levels, as it has significantly improved her leadership skills and confidence. She believes it would help other managers adjust and meet staff needs more effectively. In addition, she emphasised the importance of a flexible approach to the programme to ensure management support to help others benefit from it.

The Committee praised Stella's presentation, acknowledging her growth and the importance of the BME development programme.

2.	**Present:** Rob Vincent, Non-Executive Director (Committee Chair) Junaid Bajwa, Non-Executive Director Clare Dollery, Chief Medical Officer Liz O'Hara, Chief People Officer Chinyama Okunuga, Chief Operating Officer Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary Glenys Thornton, Non-Executive Director Terry Whittle, Chief Finance Officer & Acting Deputy Chief Executive Sarah Wilding, Chief Nurse and Director of Allied Health Professionals **In attendance:** Deborah Choudhury, Business Manager to Chief People Officer Eliana Chrysostomou, Acting Assistant Director of Learning and Organisational Development Selina Douglas, Chief Executive Marcia Marrast-Lewis, Assistant Trust Secretary Charlotte Pawsey, Deputy Director of Workforce Eva Tinka, Head of Staff Wellbeing and Staff Engagement Tina Jegede, Joint Director of Inclusion and Lead Nurse, Islington Care Homes Serena Wilshire, HR Business Partner Stella Osaa, Domestic Team Leader Mark Livingstone, Chief Allied Health Professional Ruben Ferriera, Freedom to Speak up Guardian Dr Zara Sayar, Guardian of Safe Working Hours **Apologies** Joanne Bronte, Acting Deputy Director of HR Operations

Meeting title	**Workforce Assurance Committee**	**Date: 16 June 2025**
Report title	**Guardian of Safe Working Hours Report Q4 2024/25**	**Agenda item: 7**
Executive director lead		
Report author	Dr Zara Sayar Guardian of Safe Working Hours (GoSWH)	
Executive summary	• High levels of acuity and high doctor patient ratios are the main reasons for ER submissions. • Nationally there are lower than previous numbers of resident doctors available to fill bank and agency shifts which leaves on-call teams very stretched. • The GoSWH has continued to work with the postgraduate department, HR, rota coordinators and the Resident Doctors Forum (RDF) during this period.	
Purpose:	• To provide assurance to the Board that Resident Doctors are working safe hours in accordance with the 2016 *Terms and Conditions of Service for NHS Doctors and Dentists in Training*.	
Recommendation(s)	The Board is asked to note this report.	
Risk Register or Board Assurance Framework	NA	
Report history	NA	
Appendices	NA	

Guardian of Safe Working Hours (GoSWH) Report Q4 2024-2025

1. Introduction

1.1. This report is presented to the Board with the aim of providing context and assurance around safe working hours for Whittington Health resident doctors.

1.2. In August 2016 the new Terms and Conditions (TCS) were introduced for doctors in training. There are clear guidelines of safe working hours and adequate supervision. Trainees submit an 'exception report' (ER) if these conditions are breached. The 2016 TCS has more recently been amended in 2019.

1.3. ERs are raised by resident doctors where day to day work varies significantly and/or routinely from their agreed working schedule. Reports are raised electronically through Allocate's E-Rota system. The educational/clinical Supervisor for the individual doctor and the GoSWH receives an alert which prompts a review of the ER and requires the supervisor to meet with the trainee to discuss the events leading to the ER and to take appropriate action to rectify. Such action may include time off in lieu or payment for additional hours worked. They are also asked to review the likelihood of a further exception recurring and address this with the trainee. Where issues are not resolved or a significant concern is raised, the GoSWH may request a review of the doctors' work schedule. The GoSWH, in conjunction with the Medical Workforce team, reviews all exception reports to identify whether a breach has occurred which incurs a financial penalty. The GoSWH will levy a fine to the department employing the doctor for those additional hours worked.

1.4. In line with the 2016 TCS a Resident Doctors Forum (RDF) has been jointly established with the GoSWH and the Director of Medical Education. It is co-chaired by the GoSWH and the Chief Registrars. The Forum meets on an alternate monthly basis and continues to have good attendance and engagement well above other local Trusts. Meetings are current a hybrid of a face to face and virtual meeting.

2. High level data

Number of doctors / dentists in training (total): 211
Number of doctors / dentists in training on 2016 TCS (total): 211
Job planned time for guardian: 1 programmed activity
Admin support provided to the guardian (if any): as required from MD office
Amount of job-planned time for educational supervision: N/A

3. Exception reports (with regard to working hours)

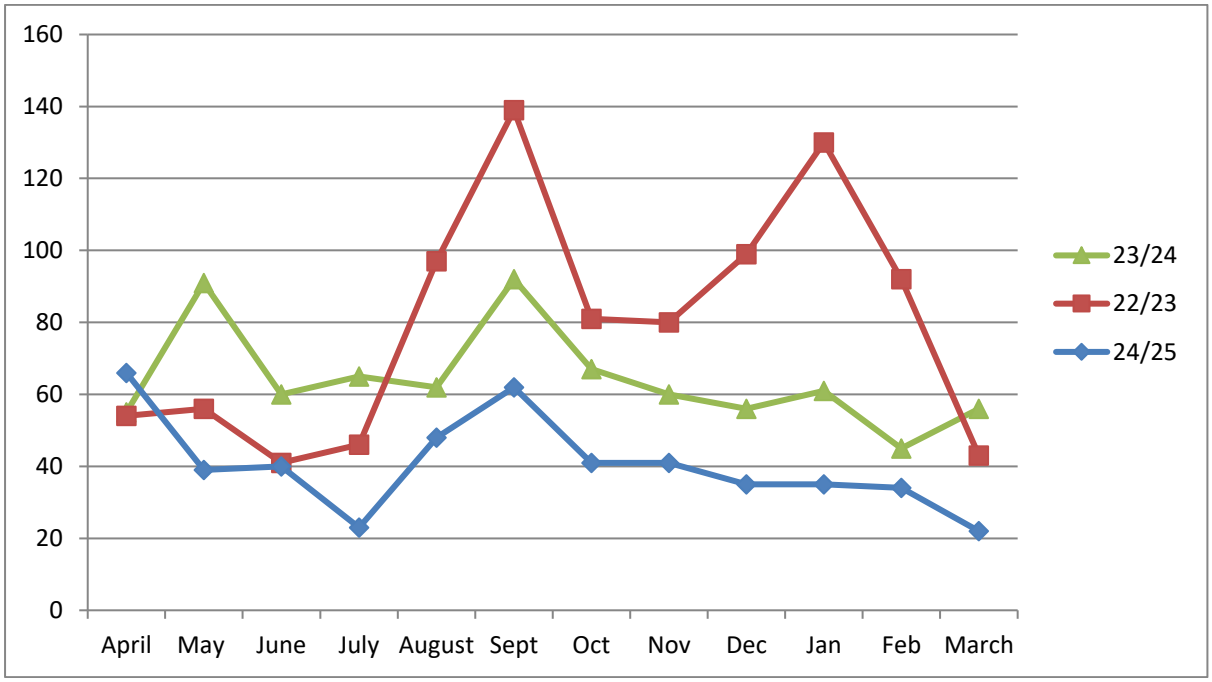
3.1. Between the 1st January and the 31st March 2025 there have been a total of 91 ERs raised. The table below gives details on where exceptions have been raised and the responses to deal with the issue raised.

Table 1: Exception reports raised and responses

2025		Jan	Feb	March	Total
Reports	Grand Total	35	34	22	91
	Closed	33	34	13	80
	Open	2	0	9	11
Individual doctors / specialties reporting	Doctors	18	12	11	41
	Specialties	5	4	3	12
Immediate concern		0	0	0	0
Nature of exception	Hours/Rest/pattern	33	34	21	88
	Education/Training/service support	2	0	1	3
Additional hours	Total hours	37	54	22	113
Agreed Action *('No action required' is the only response available for 'education' exception reports)*	Time off in lieu (hrs)	11	6	4	21
	Payment for additional hours (hrs)	21	27	8	56
	No action required (ERs)	1	1	1	3
	Other/Pending (ERs)	2	0	9	11
Grade	Foundation year 1	20	32	15	67
	Foundation year 2	6	0	2	8
	IMT/ST1 or ST2	8	1	4	13
	GP Specialty Registrar	0	0	0	0
	Specialty Registrar	1	1	1	3
Exception type *(more than one type of exception can be submitted per exception report)*	Work Load	21	18	15	54
	Pt/Dr ratio too high	9	14	4	27
	Rota gaps	1	2	3	6
	Late running WR	-	-	-	-
	Deteriorating patient	4	1	-	5
	Other	-	-	-	-
	Educational	-	-	-	-
Specialty	General Medicine	16	1	5	22
	General Surgery incl urology	10	30	12	52
	T&O	2	2	0	4
	Paediatrics	0	1	0	1
	Anaesthetics/ITU	0	0	0	0
	Radiology	0	0	0	0

	Psychiatry	0	0	0	0
	Obstetrics and gynaecology	1	0	0	1
	Accident and emergency	6	0	5	11
	Histopathology and micro	0	0	0	0
	Ophthalmology	0	0	0	0

Graph 1: Exception reports over three years by Month



3.2. The number of ERs submitted per month is very variable throughout the year and year on year. Overall, the numbers of ERs submitted this quarter were lower. This was discussed at the Resident Doctors Forum and thought to be due to the hospital being less busy. This may relate to a reduce number of patients diverted from North Middlesex Hospital following their merge with Royal Free Hospital. Another reason for this may be due to expanding inclusion criteria for Minerva discharge bridging pilot.

Immediate safety concerns

3.3. There was no immediate safety concern raised (ISC) raised over the three-month period.

Work Schedule reviews

3.4. There was no work schedule review requested over this three-month time period.

4. Establishment and Vacancy data

4.1 It has been confirmed that all bank staff are currently Whittington Health employees. All bank shifts documented above are therefore carried out by doctors already working within the Trust.

Table 2: Bank and agency usage Q3

ICSU	Bank		Agency		Locums Nest		Total	
	Hours	Cost (£)	Hours	Cost (£)	Hours	Cost (£)	Hours	Cost (£)
Emergency and integrated medicine	-	-	941	62215	7134	355870	8075	418085
Surgery and cancer	-	-	684	49246	3367.71	212184	4051.71	261430
ACW	139.5	8449	110.75	8700	1434.27	107728	1684.52	124877
Children and young people	-	-	-	-	690	39438	690	39438
ACW: Access centre clinical support and women's health *includes associate specialists								

Vacancies

4.2 There were a total of 20 vacant posts for this quarter which translates to a 19.6 WTE deficit.

Table 3: Vacancies per speciality Q3

Speciality	Current vacancies
General Medicine	2 Higher 1 Lower
General Surgery inc urology and T&O	1 Higher 1 Lower
Obstetrics and Gynaecology	3 Higher
Emergency medicine	1 Higher 1 Lower
Paediatrics (inc NICU)	4 Higher 1 Lower
Anaesthetics inc ITU	1 Higher 2 Lower
Radiology	1 Lower
Microbiology and Haematology	Nil
Psychiatry	1 Lower

5. Fines and payment Exception Reports (with regard to working hours)

5.1. For this quarter a total of 114 hours 16 mins to be re-paid either in time off in lieu (TOIL) or pay for additional hours worked. It would not be appropriate for TOIL accrued in one specialty to be rolled over to another specialty.

5.2. Currently, these hours equate to a total of approximately £2126.99 has been paid to the resident doctors directly.

5.3. The resident doctors have requested that GoSWH fines money is transferred to the post-graduate centre to pay towards lunch provisions for teaching. The finance department is facilitating the movement of this money.

Table 4: Breakdown of fines by ICSU

ICSU	Amount of Fine to Doctor (£)	Amount of Fine to Guardian (£)
Emergency and Integrated Medicine	177.00	294.99
Surgery and Cancer	813.90	1356.90
ACW	-	-
Children and Young People	-	-

6. Next steps

6.1. GoSWH to continue to ensure all remaining open ERs are signed off in a timely fashion. Changes made to the contract in 2019 enables the GoSWH to action outstanding ERs at 30 days.

6.2. The GoSWH to ensure that the ER fine money is transferred to the postgraduate centre as per the request of the request of the resident doctors. This continues to be reviewed at the RDF. It has also been discussed at the RFH why there are fewer numbers of doctors entering training positions and it was felt that this was largely due to competition for jobs and lack of opportunity. There was also a feeling of being undervalued by the process in that often many applications need to be completed, often without any feedback or even rejection when a job is not offered.

6.3. GoSWH now meeting HR and finance every two months to review data and any issues relating to the reports submitted.

6.4. GoSWH reports are being presented at the medical committee and feedback taken from medical staff is incorporated into the reports.

6.5. GoSWH has attended meetings highlighting the changes to the ER which will come into effect in August as a result of the new contract. GoSWH has already met with HR to try and support this process of change.

7. Conclusions

7.1. This quarter's report shows a steady but overall lower numbers of ER likely related to reduced number of patients diverted from North Middlesex Hospital following their merge with Royal Free Hospital and to expanding inclusion criteria for Minerva discharge bridging pilot.

7.2. The majority of ER continues to be seen in the EIM ICSU. This is likely to reflect the ongoing high levels of patient acuity in this area.

7.3. Primary events leading up to exceptions are issues due to workload and times when there is very minimal staffing on the wards due to rota gaps, on-call commitments and sickness.

7.4. There are still very low levels of reporting in certain specialities, e.g. anaesthetics, radiology etc. and at higher grades. Attempts are being made to increase engagement and there has been some improvement. This is a well-recognised issue nationally. The GoSWH continues to promote ER in these areas.

8. Recommendations

8.1. Workforce Assurance Committee is asked to note this report and inform the board in line with national guidance for GoSWH reports.

Meeting title	**Trust Board in Public**	**Date: 23 July 2025**
Report title	**2025/26 Quarter four delivery of Corporate Objectives**	**Agenda item: 10**
Director leads	Sarah Wilding, Chief Nurse & Director of Allied Health Professionals, Clare Dollery, CMO, Chinyama Okunuga, Chief Operating Officer (Quality entries); Liz O'Hara, Chief People Officer, (People entries); Jonathan Gardner, Chief Strategy, Digital and Improvement Officer, (integration entries); and Terry Whittle, Chief Finance Officer (sustainability entries),	
Report author	Jonathan Gardner	
Executive summary	Board members are presented with the quarter one outcome for performance indicators linked to the delivery of Whittington Health's annual corporate objectives (see appendix 1).	
Purpose	Noting	
Recommendation	Trust Board members are asked to receive and note the outcomes against performance indicators for delivery of Whittington Health's corporate objectives in quarter one 2025/26.	
BAF	All entries	
Report history	Trust Management Group, Executive team	
Appendices	1: Q2 delivery of corporate objectives	

2025/26 objectives
QUARTER ONE
UPDATE

Deliver outstanding safe and compassionate care in partnership with patients

↔

Exec: Chief Nurse / MD

Committee: Quality

worse
better
Same

Key metrics	Target	Score	RAG
SHMI score	1.14	0.92 Feb 2024 – Jan 2025	↔
Readmission rate	5.5%	3.94% in Q1	↑
Pressure ulcers grd. 4 and 3	64	Average per month 19 in q1	↓

Key metrics	Target	Score	RAG
RTT	72%	64.5%	↑
ED 4hr	95%	73.2%	↑
FFT % satisfaction	90%	93.9%	↑
PALS response	80%	68.4%	↓

Key metrics	Target	Score	Direction and RAG
48hrs DN referral	95%	90.7%	↓
2hr referral	N/A	86.9%	↓

Deliver Safe & Effective Care – continuous improvement in safety culture & delivery of best practice care • Embed the NHS Patient Safety Incident Response Framework (PSIRF) • Deliver Mental Health key priorities • Focus on improving infection prevention and control Improve cleaning and the wider PLACE scores	• The Trust is working with Tenderable (the Trust audit tool) to review audit programme, access to audit and extend the audit tool to introduce Accreditation. • A workshop to review PSIRF-1 year on is planned for August to get feedback from Divisions on how they feel PSIRF has been embedded and what they require further support with. The second cohort of PSIRF bitesize training has finished • Complaints: The performance figure for Q1 remained at 62%, the same as Q4 2024-25. Focused meetings continue to take place with the ICSU's, DCN and the complaints team to drive improvements on performance, alongside changes to the policy around the de-escalation of complaints and monthly complaints training sessions for staff. • FFT – Overall, the Trust maintained a score above the 85% NHS benchmark at 91% during Q1 with 8,785, responses received, an increase of 1,799 surveys. We were above the 5% NHS benchmark for negative responses at 4.82%. ED -"Very good and good" response rates sit at 81% below the NHS 85% benchmark, an increase of 3% on Q4, and a score of 13% for "very poor or poor" above the 5% NHS benchmark. Negative themes remain to be centred on waiting times, cleanliness, and staff attitudes. Actions - Outpatients- SMS FFT went live in February for Podiatry and Community Paediatric Audiology service. If successful, FFT SMS will be extended to Nutrition and Dietetics services. • The incidence of pressure ulcers in Q1 has remained the same at 216 compared to Q4 but the number of Category 3 & 4 pressure ulcers combined has reduced by 28%. New KPI target set to separate acute and community pressure ulcer incidence. Trust Pressure Ulcer Improvement Plan being formally reviewed by the Trust Pressure Ulcer Group in August 2025. • Infection Control and cleaning standards remains a priority particularly across the hospital site, with improved engagement with clinical teams and estates and facilities to drive improvements • MENTAL HEALTH – Five sub-groups have been developed to sit under the Trust Mental Health Steering Group; Reducing Restrictive Practice; Mental Health training; Mental Health Act Administration; physical health needs of mental health patients; suicide prevention. These groups meet regularly and are working across the Trust to improve the experience of patients
Improve performance for better patient experience and outcomes	• The SHMI remains as expected but has reduced for the last 3 periods which is positive. • A&E 4 hr standard performance has been maintained at over 72% on average inspite the unusual demand in UEC attendance, extreme weather that led to high patient acuity. Plans are in place through the Patient Flow programme to continually improve over the next months to reach the national target of 78%. • Cancer standards continues to maintain high standards at over 80% for both the FDS and 62 day cancer standards. The improvement has been achieved through focused support from the operational and clinical teams. • Improvements in theatre activity has led to significant reduction in over 65 week waits. Long waits still in fragile services such as LUTS and Vascular.
Improve population health & address health inequalities •Improve ethnicity data •Implement action plan as a response to the data on waiting times and DNAs by deprivation	• The CDC team has undertaken a QI project to improve ethnicity recording at the point of care in Ultrasound services, this resulted in a 11% reduction in the number of unknown ethnicity recorded within this service. The project will be rolled out across other CDC modalities and the findings will be disseminated across the acute site. • The Health Equity Steering Group remains committed to monitoring the implementation and impact of initiatives outlined in the Strategic Action Plan. A key area of focus is the analysis of current waiting times and Did Not Attend (DNA) rates, with particular attention to how these are influenced by ethnicity and levels of deprivation. A programme of work will be developed in alignment

Empower support and develop engaged staff

Exec: Workforce Director / COO

Committee: WAC

worse
better
Same

Key metrics	Target	Score	Direction and RAG
Turnover rate	13%	9.3%	
Vacancy rate	10%	5.2%	
Appraisal rate	85%	76.5%	
Mandatory training	85%	87.8%	

Key metrics	Target	Score	Direction and RAG
Staff Sickness	3.5%	4.02%	

Key metrics	Target	Score	Direction and RAG
Relative likelihood of disciplinary for BAME	*1*		
% staff recommending WH as place to work	65%		

Objective	Progress last quarter
Improve Staff Engagement & Wellbeing **•Embed the People Strategy and deliver improvement plan to improve staff working lives** **•Deliver equalities & inclusion programmes to actively tackle disparities in staff experience**	• **Ran a further cohort for Trauma Risk Management (TRiM)**: A peer-led early intervention model supporting staff after traumatic events, promoting recovery and reducing stigma. • **Continued to promote our new Employee Assistance Programme – Vivup**: Offers 24/7 counselling, online GP access, staff benefits, self-care resources, and discounts. Over 25% of staff have registered for the service to date, an **increase of 5% since last quarter.** • **The Local NHS Leaders' Wellbeing Programme is currently running**: An NHSE fully funded initiative training in house facilitators to deliver wellbeing-focused leadership development across the organisation.6 facilitators are being trained. • **Significantly increased the number of Mental Health First Aiders** • **Re-launch of Schwartz Rounds** with the first running in Q1 focusing on Civility and Respect • **Continued delivery of Staff Engagement Roadshows**: Taking wellbeing support directly to teams across sites, increasing accessibility and visibility. • **Ongoing facilitation of Reflective Sessions**: Helping teams navigate challenges together, build resilience, and improve team cohesion. • The OD team continued to support teams with their action planning on Staff Survey Results • The Inclusion and Wellbeing teams and the FTUSG are providing targeted support to help improve the culture within the Estates and facilities department, EIM and A&E • Four reflective and self-development inclusive anti-racist toolkits have been created to promote civility, respect and inclusion. These self-paced studies are optional, accessible on the intranet, and now loaded on Elev8 for tracking. • In Q1, the Board agreed to the Trust's annual WDES and WRES submissions to NHS England.
Recruit, develop and retain talent **•Deliver recruitment and retentions strategies for our hard to recruit clinical workforce;** **•Provide comprehensive leadership development programmes and support** **•Reduce bank and agency expenditure in line with the Trusts operating plan**	• The Ops School has been running courses to ensure that Ops teams are upskilled in managing in the current pressure and expectations of delivering performance and sustainability across the Operational standards. • The OD team are on schedule to deliver Managers Passport' which provides leadership and people management skills to new managers with new courses and e-learning. • Staff Survey Action plans are underway with several team support and interventions taking place across the organisation, including listening events and survey workshops. Surgery and Cancer Division held a listening event where the COO was invited to a panel to address some of the outcomes of the survey. • The 'Managers Passport' pilot has is underway and full launch to be expected in Q2 of 2025. • Staff Survey Action plans are underway with several team support and interventions taking place across the organisation, including listening events and survey workshops. • Continued use of apprenticeships to support leadership and career development and role specific development. • Using apprenticeships as a retention strategy to improve job satisfaction and reduce turnover. • Thee NHSE funded Bands 2-7 BME Career Development Programme application has launched with Information Sessions held in Q1. • Redesign of appraisal paperwork and training underway to ensure appraisals meet quality standards to support career development and staff wellbeing • HR led workshops to support the implementation of policies, such as Managing Sickness Absence, continued running in Q1 and two further modules on investigations and probation period have been designed as e-learning for Manager's Passport.

Actively collaborate to deliver integrated, joined up care for our communities

↔

Exec: Director of Strategy / COO

Committee: Board

worse
better
Same

Objective	Progress last quarter
Drive thinking and implementation of the "acute to community" and "treatment to prevention" shifts and lead "Neighbourhood Health Teams" **•Lead and expand NCL virtual ward and remote monitoring programme** **•Work with partners to drive, influence and implement neighbourhood health teams** **•Explore opportunities to expand our prevention work**	• Considerable work underway by ACS leaders and CSO with regard to neighbourhood working, design, implementation and collaboration. CSO chairs internal group working through the left shift design for acute to community. Two sprints held in Haringey and Islington • Having expanded the capacity in Virtual ward from 28 to 44 beds to reduce reliance on traditional inpatient settings and ease pressure on general wards, we now have underutilisation of the increased capacity. • Haringey UCR lead has now met with Frailty and Med Acute consultants and identified quick wins, including the introduction of fluid administration in the community. • A UCLH Direct Referral SOP has now been created to enable referrals from UCH Acute to Haringey and Islington Virtual Wards. • A medicines administration SOP for care agencies has been agreed and now VW can manage patients with medication administration and care needs via Airmid the bridging care agency • Remote Monitoring is now being done using a traditional RM method that is cost neutral to the trust. • An SOP has been drafted to allow transfers from UCLH into the General Virtual Ward and is currently being co-designed between Whittington and UCLH. • The Medicines Management SOP has been finalised and is now being implemented. A task and finish group will run over June to fully implement. • Doc Abode has been fully implemented, and new data is now available to support both day-to-day coordination and forward planning with resources. • VW and UCR Teams are now directly integrating with DN in Haringey to allow for direct referrals of patients and joint MDTs.
Collaborate with providers and system **•Use WH/UCLH joint board committee to drive new pathways to improve care and resilience** **•Actively participate in the Integrated Care System & UCL Health Alliance to support delivery of agreed system priorities, and work to create clear inequality objectives** **•Expand UCLH collaboration to deliver maximum possible funded elective care** **•Progress stated aims of the Start Well Decision Making Business Case**	• Start Well Decision making business case was approved, so we are now progressing design and implementation. • Joint governance arrangements now in place for both workforce and nursing with developing workplans • A range of joint pathways are in development including urology, osteoporosis and uro-gynaecology. • Joint community model in development for ENT and gynaecology with local GP federation • Following the ERF cap, a decision was made by the Southern Surgical hub committee to halt collaborative work across theatres. • However, we continue to work on a joint bid for the delivery of Urology services in the two Trusts.

Transform and develop sustainable and innovative services

Exec: Finance Director / COO

Committee: TMG

worse
better
Same

Key metrics	Target	Score	RAG
% CIP delivery against target	Annual Target £22m Q1 £6.8m target	£16.5m identified full year (75%) Q1 £3.5m delivered (51%)	
Average beds used	197	251	
Financial position	Annual Plan £1.4m deficit Q1 Plan £4.3m deficit	Deficit of £13.1m at year end Q1 Actual £7.1m deficit, £2.8m worse than plan	
Capital spend against plan	Annual Plan £25.9m Q1 Plan £1m	Annual forecast £25.9m Q1 Actual £1.7m	

Key metrics	Target	Score	RAG
Average LOS Non-elective	5.5	5.4	
% super stranded pts	18%	23.5%	
Elective activity against recovery plan (volume)	100% of Plan	Q1 100.8%	
Theatre utilisation	>85%	75.13%	

Objective	Progress since last quarter
Create focused improvement drive to deliver best value **•Continue three areas for transformation – flow, outpatients, and elective reform** **•Develop & deliver a robust multi-year productivity & cost improvement plan to reduce underlying deficit and move towards financial sustainability** **•Deliver in year financial targets**	• Flow: We are now benchmarking at the top for length of stay • Outpatients: DNA rates and cancellations have dramatically improved and PIFU programme starting • Elective: now focussing on theatre productivity. Late starts have already seen a fall. • The Trust is forecasting delivery of 75% of the annual efficiency target, with a pipeline of schemes to close the gap. The Trust has a draft financial recovery plan setting out the key underlying deficit drivers, linked to categories of improvement (e.g., premium pay and length of stay) to support financial recovery. The Trust is restructuring the improvement capacity across the financial improvement and transformation programmes to consolidate expertise and capacity to support a smaller number of prioritised high-impact programmes.
Deliver year two priorities of green plan	• New power transformer installed and commissioned into service. The unit is a key enabler for our Green Plan targeting a 4.5 tonne CO_2 reduction. • Whittington Health 'Green Group' established to promote environmental initiatives Capital funding confirmed from NHS Net Zero to decommission NO_2 manifold, x 17 anaesthetic machines (retrofit cylinder use); and x17 EV charger points and Solar Panel (community sites) schemes (>£0.4m).
Deliver estate transformation plans • **Power rectification** • **PFI rectification ~ finalise fire remediation business case & explore / secure funding** • **Maternity and Neonates (StartWell) redevelopment**	• Phase 1 of Power Infrastructure Project delivered. Energy Centre planning application submitted • £9.1m capital confirmed to support fire rectification (delivery of decant ward) for 25/26. • Maternity and Neonatal RIBA stage 2 design works (1:200) delivered. NCL ICS capital envelope agreed for Start Well project (programme subject to ICB Board decision end March).
Improve business intelligence and drive digital transformation **•Secure Frontline Digitisation financial support for our EPR procurement and gain OBC approval, complete procurement and FBC for new EPR.** **•Strengthen cyber resilience** **•Strengthen BI to drive improvement** **•Explore AI opportunities where funding allows**	• OBC submitted to the Regional team awaiting review pending endorsement letter from the ICB. Appointed consultancy support for the FBC completion. • Information - A new performance dashboard improving data visibility and operational efficiency across the Trust. Team is improving request handling through stakeholder engagement, a new form, triage system, and a full review of existing requests with divisional leads. • Infrastructure - DSPT audit was completed early with strong engagement and positive feedback despite toolkit changes. The technical team is negotiating better vendor deals and collaborating with national cyber leads to review and enhance key infrastructure solutions. • Patient Systems - The Trust finalised contract novation with EPR vendors, already yielding a 40% saving in a community project. Team is preparing for a planned CareFlow EPR upgrade on 2nd August, ensuring compliance and minimising clinical downtime to four hours.

Meeting title	**Trust Board – public meeting**	**Date: 23 July 2025**
Report title	**Our Clinical Strategy 2025-30**	**Agenda item: 11**
Director leads	Dr Clare Dollery Chief Medical Officer	
Report authors	Dr Charlotte Hopkins, Dr Helen Taylor, and Jonathan Gardner	
Executive summary	Whittington Health's Clinical Strategy sets out a five year vision to deliver high-quality, person-centred, and value-driven care across acute, community, and specialist services. It responds to growing demand, complex health needs, and widening inequalities in our community by focusing on integrated, sustainable, and digitally enabled care. 1. Strategic Vision As part of the North Central London Integrated Care System (ICS), Whittington Health's unique position as an integrated NHS Trust is able to break down traditional care barriers. This strategy aligns with national priorities such as the NHS Long Term Plan, Fuller Stocktake, and Core20PLUS5, with an emphasis on: Care closer to home: moving services into the community. Proactive and preventative care: promoting wellbeing and early intervention. Digital transformation: enhancing care through technology and data. 2. Key Enablers The strategy emphasises financial and environmental sustainability, and workforce resilience. Whittington Health commits to improving health outcomes, reducing variation, and supporting the NHS's net zero goals. 3. Our Value Proposition Developed with stakeholders, Whittington's value proposition highlights its neighbourhood model of care, expert generalist and specialist services, seamless patient pathways, and leadership in education and ambulatory care. Strong local partnerships underpin responsive healthcare. 4. Ways of Working The strategy outlines guiding principles for the way Whittington works: • Collaborative service design. • Data-driven, outcomes-focused care. • Tackling health inequalities.	

	• Prevention and supported self-care. • Integrated multi-disciplinary teams. • Streamlined ambulatory and day-case pathways. 5. Local Context Serving the diverse, growing populations of Islington and Haringey with their challenges due deprivation and health inequalities, Whittington Health is adopting a population health approach. As an anchor institution, it focuses on the wider determinants of health and commits to inclusive, equitable, and place-based care. 6. Clinical Chapters i. Older People: Coordinated, holistic support. ii. Long-Term Conditions: Proactive, integrated care. iii. Women and Neonates: Safe, personalised maternity and neonatal services. iv. Children and Young People: Accessible, family-centred care. v. Cancer: Early diagnosis and streamlined treatment. vi. Elective and Planned Care: Efficient, patient-friendly pathways. vii. Diagnostics: Faster, integrated access to investigations. viii. Urgent and Emergency Care: Safe, timely, and effective response. 7. Development Process This strategy was co-produced through a robust engagement process (Oct 2024 – May 2025) involving staff, patients, local partners, and board members. 27 engagement sessions and workshops took place of which 19 were internal and 8 involved external stakeholders. The result is a shared, actionable plan rooted in community need and organisational expertise. This strategy positions Whittington Health to lead integrated, equitable, and forward-looking care across North Central London, while improving outcomes and sustainability for the decade ahead.
Purpose:	Approval
Recommendation(s)	The Board is asked to approve this Clinical Strategy
Risk Register or Board Assurance Framework	
Report history	A draft was taken to TMG on the 1/07/2025
Appendices	1: Clinical Strategy

NHS

Whittington Health

NHS Trust

Our Clinical Strategy

2025 to 2030

Foreward

Welcome to Whittington Health's Clinical Strategy, which sets out our vision and direction for the next 5 years. This strategy articulates how we will deliver high-quality, person-centred, personalised and value-driven care across our acute and community services, while remaining financially and environmentally sustainable in an increasingly complex healthcare landscape.

Now more than ever, we face rising demand, more complex healthcare needs, widening health inequalities, and increased expectations from patients and communities. In response, this strategy defines clear clinical priorities that will guide our decisions, focus our efforts, and strengthen our role as a trusted provider of integrated healthcare in North Central London.

As part of the North Central London Integrated Care System (ICS), we are committed to working collaboratively across neighbourhoods, boroughs, and system partners. Our unique position as an integrated NHS Trust spanning acute, community, and specialist services enables us to lead the way in transforming care across traditional boundaries. This includes our role as a research-active teaching organisation, proudly affiliated with University College London Medical School.

Our strategy is grounded in national priorities, including the NHS Long Term Plan, the Fuller Stocktake on integrating primary care, and Core20PLUS5, which all call for a radical shift in how care is delivered. At the heart of this transformation are the **Three Left Shifts**, which form a core pillar of our approach:

1. **Shifting care from hospital to home and community** – delivering more care closer to where people live.
2. **Shifting from reactive to proactive and preventative care** – supporting people to stay healthy, independent, and well.
3. **Shifting from an analogue system to a digital one** – embedding digital innovation into the way we deliver care, communicate, and share information.

As part of this, we will strengthen our approach to medicines optimisation and management, ensuring the safe, effective, and sustainable use of medicines across care settings supporting better outcomes, reducing harm, and contributing to system-wide efficiency.

We also recognise that clinical excellence must go together with sustainability—financially, environmentally, and in terms of workforce resilience. This strategy outlines how we will harness digital innovation, improve population health outcomes, reduce unwarranted variation, and contribute to NHS net zero ambitions.

Crucially, we have developed a strong value proposition that reflects our commitment to partnership, prevention, and place-based care. It is this foundation that will enable us to deliver the transformation required—securely rooted in our local communities, yet aligned with a broader, integrated system vision for the future of health and care.


HELPING local people LIVE longer healthier lives!
NHS
Whittington Health
NHS Trust
I RECEIVE GREAT CARE!
I AM TREATED AS A PERSON!
IMPROVED PATIENT EXPERIENCE
COMPASSION
self management
I AM FULLY INVOLVED IN DECISION MAKING ABOUT MY CARE!
RESPECT
SAFETY
IT'S OUR PRIORITY IN EVERY ENCOUNTER!
WE WORK AS A TEAM TO HELP YOU NAVIGATE YOUR JOURNEY!
We are building LONG TERM RELATIONSHIPS
We have a VIBRANT & COMPLEX community
CO-ORDINATED CARE
GP
CM
AGE UK
INNOVATIVE EDUCATION & RESEARCH
SOCIAL CARE
LOCAL COUNCILS

Our vision, objectives and values

Our **Vision** motivates us:
"Helping local people live longer, healthier lives"

Our **Objectives** tell us how we will achieve our Vision, in partnership with our patients and service users:

- Deliver outstanding, safe, compassionate care
- Empower, support and develop engaged staff
- Integrate care with partners and promote health and wellbeing
- Transform and deliver innovative, financially sustainable services

Our **'I CARE' Values** guide how we act:
Innovation | Compassion | Accountability | Respect | Excellence
All our values are underpinned by Equity

INNOVATION
We will welcome ideas, be willing to change and to make new partnerships.

COMPASSION
We will value our relationships, treat people with kindness, look after each other and create an environment that fosters privacy and dignity.

ACCOUNTABILITY
We will take ownership for what we do, use the public's money well, learn from our mistakes, hold others to account and be open and honest.

RESPECT
We will treat people fairly, recognise individuality and deal with inappropriate behaviour.

EXCELLENCE
We will keep people safe, deliver high-quality services, keep on improving and learn from mistakes.

EQUITY
We will deliver services to patients and provide opportunities to staff that achieve outcomes which are fair and in line with our I.CARE values.

How we developed this strategy

We developed this strategy through an inclusive engagement programme from October 2024 to July 2025, involving staff at all levels, patients, and community partners.

We began with divisional workshops across October and November 2024, actively involving GPs, public health directors, and Healthwatch representatives through additional meetings. Alongside these, staff contributed via intranet and 'Back to Floor' questionnaires, helping shape the **Value Proposition**, **Key Principles**, and the **Whittington Ways of Working**.

This collaborative input identified the key chapters for further development. We then gathered additional insights through meetings with executives and Non-Executive Directors before presenting the proposed Value Proposition, Ways of Working, and chapter framework to the Trust Board for approval in November.

Between December 2024 and May 2025, we held two workshops for each chapter, engaging clinical and non-clinical staff as well as inviting Healthwatch, to co-create a clear vision and actionable steps to achieve our goals over the next five years.

Throughout the chapter development, dedicated sessions provided opportunities for feedback and constructive challenge, ensuring the strategy reflects diverse perspectives. This comprehensive process concluded in May 2025. You can find the timeline in Appendix 1.

Whittington Health's clinical value proposition

Created with stakeholders across our organisation, this value proposition seeks to describe what is specific and distinct about the clinical work of Whittington Health NHS Trust, compared to the other clinical service providers in our region.

"At Whittington Health, we are deeply embedded in the community, collaborating with local healthcare teams, primary care, Voluntary, Community and Social Enterprise organisations, and council services to deliver a neighbourhood health service. Our approach ensures that services are tailored to the diverse needs of our population, with a focus on reducing health inequalities. We provide expert generalist care for women, children, older people, and those with chronic conditions, alongside several advanced tertiary services. Our commitment to seamless patient navigation ensures timely access to the right care from early diagnosis to treatment. With an emphasis on ambulatory and day-case services, we also excel in clinical education and training, empowering healthcare professionals to deliver the highest standard of care. Through strong partnership working at the neighbourhood level, we ensure that our community receives coordinated, comprehensive support, no matter where they are on their healthcare journey."

Whittington Health's ways of working

Stakeholders across our organisation were also invited to consider a range of 'ways of working' that might help focus the content and delivery of the new clinical strategy.

- **Optimise innovative patient journeys** through partnering and co-design (UCLH, councils, patients, VCS, GPs etc)
- **Outcomes driven** through digital, data and a growing focus on research.
- **Reduce inequalities** by improving outcomes and making services accessible to the local population.
- **Keep patients well in the community** through supported self-management and prevention.
- **Multi-disciplinary working** and integrating with our local partners, community, acute and mental health teams.
- **Ambulatory and one-stop pathways** through innovation and being nimble.

Our population and communities

Islington and Haringey are home to diverse and relatively young populations, with recent trends showing slight aging and population growth[1]. Both boroughs experience significant deprivation, with a large proportion of residents living in the most deprived areas of England. This deprivation is closely linked to high rates of smoking and obesity, which are major contributors to long-term health conditions.

Health inequalities are stark, with noticeable differences in life expectancy between the most and least deprived communities. These disparities are driven by social determinants such as housing, poverty, employment, and access to healthcare. Mental health issues, cardiovascular disease, and respiratory conditions are more prevalent in these areas, and cancer diagnoses are on the rise[2].

To address these challenges, a population health approach is being adopted, focusing on the wider determinants of health, individual behaviours, community environments, and an integrated health and care system. Whittington Health, acting as an anchor institution, is committed to improving wellbeing through local employment, socially responsible procurement, creating healthy spaces, delivering inclusive services, and using data to drive equitable and sustainable change.

[1] Population data from ONS Mid-2022 Population Estimates
[2] Source: Primary care Mortality database and HealthEIntent 2023

Our clinical chapters

With over 150 services across our integrated care organisation, we worked with stakeholders to discover eight subject areas of focus for the clinical strategy, which correspond to our clinical value proposition that appears earlier in this document.

1. Older people
2. Long term conditions
3. Women and neonates
4. Children and young people
5. Cancer
6. Elective and planned care
7. Diagnostics
8. Urgent and emergency care

Chapter 1: Older people

Where we are

A provider of multiple well-developed Services for Older people that are integrated across community and hospital settings. We provide multi-disciplinary, proactive care in the community, outpatient services for older people, specialist inpatient care and front door frailty services.

We are committed to supporting liaison work for older people in other healthcare settings such as care homes, working with our mental health partners and wider voluntary sector colleagues across our local area.

Where we want to get to

To meet the growing demand, it is essential to understand the complex needs of the local population. We want to deliver services for older people aligning with the local health and social care system, ensuring full integration at the system level. The goal is to support older people in staying healthy and independent for longer. Providing care at the neighbourhood level is key to delivering tailored, accessible services close to home. We aim to provide care across they system that is attuned to the needs of the aging population.

What this means to me

"I understand where I am in my hospital journey, and so do the people caring for me. The staff who see me know how to assess and care for me, and I can be discharged quickly back to where I want to be with all kinds of support in the community that I can easily find."

Quotes are composites from feedback from many individuals and community groups

How we will get there

1

Lead a shared vision for healthy ageing

We will work with partners to lead the development and implementation of a shared vision for early identification of frailty, appropriate multidisciplinary management and specialist input. We will ensure alignment between stakeholders, including health and social care organisations focussing on neighbourhoods. Connecting with the local authorities on joint working to ensure we are working toward shared goals.

We will regularly collect and share data on the prevalence of frailty and dementia for example, projected growth in these areas, and relevant care outcomes and use the data to guide service development.

2

Develop integrated care for older people aligned with the NCL Age Well Strategy with a focus on prevention

We will review the services currently used by older people to identify any duplication or gaps across the care pathway, from community to inpatient care. This review will support the Age Well strategy, with a focus on preventing frailty. We will develop integrated services, such as multidisciplinary falls teams, to support self-management and reduce complications like fractures.

We will consistently focus on medication reviews to improve outcomes by safely tapering, reducing, stopping, or switching medicines. This aims to lower the risks of falls and cognitive impairment caused by polypharmacy.

We will also strengthen responsive community teams to reduce unnecessary hospital admissions and provide in-reach services that support early discharge.

During inpatient stays, we will deliver personalised, holistic care through a multidisciplinary team that includes the patient's wider support network, offering specialist geriatric, in-reach, and liaison services.

3

Workforce development for frailty expertise

We will train all staff working with older adults in frailty awareness and assessment, using frameworks such as the Skills for Health Frailty Core Capabilities. Additionally, we will create an integrated workforce plan to ensure an appropriate mix of specialist and generalist multidisciplinary teams to support older people with complex care needs across the pathway of community and acute services.

How we will get there continued

4

Engage communities and partners in care delivery

We will involve older people and their support networks in the co-design, delivery, and monitoring of older people's services. We will work together on developing integrated neighbourhoods with a focus on frailty prevention and create age and dementia friendly communities. Using social capital, the networks, relationships, and trust within communities we will improve proactive, integrated care by promoting further collaboration, engagement, and mutual support across health and social care systems. This can be achieved by strengthening local networks and relationships creating co-designed pathways for early intervention and support. We will build trusting relationships across sectors enabling shared responsibility and better communication between providers, patients, and communities.

5

Monitor and evaluate impact through outcomes

We will use agreed indicators to monitor the effectiveness of interventions for older people across all care settings. Such as:

- ensuring all new admissions to care homes in Islington and Haringey receive a review from a geriatrician within a month of admission to provide support and care planning in their own homes.
- ensuring older people are supported to create an advanced care plan centred around what is important to them that is documented in the universal care planning tool.
- monitoring adherence to national guidance for the assessment and management of older people who fall, including assessment of their bone health.

We will ensure that any service changes are evaluated for their impact on older people, using equality and diversity assessments and action plans to guide improvements in care access and delivery.

Chapter 2:
Long term conditions

Where we are

A provider of services at Whittington Health, we support a range of long-term conditions those related to cardiology, diabetes, respiratory, patients living with frailty, dermatology, menopause and gastroenterology and including long term specialist services such as Sickle Cell, Thalassaemia and the Lower Urinary Tract Symptoms (LUTS) service.

Where we want to get to

Being the centre of excellence in NCL for the diagnosis, management, and long-term care of patients with LTCs, providing a model of care that prioritises community-based interventions enabling self-management and patient activation and holistic patient care focused on the goals of the patient. and holistic patient care.

WH will be the central hub for the management of Long-Term Conditions (LTCs) across North Central London (NCL), becoming the first-choice provider for GPs and patients alike. We will establish a coordinated, community-first approach that connects primary care, secondary care, and tertiary care, ensuring seamless and efficient management of LTCs. Through our approach, most care will be delivered in the community, adhering to the best practices outlined, for example NICE guidance, ensuring patients receive the most effective treatments close to home.

Our multi-disciplinary teams (MDTs) will operate at the neighbourhood level, enhancing patient care with the support of Advice & Guidance (A&G) and Non-Face to Face appointments (where applicable), ensuring rapid access to expertise and advice for primary care professionals.

What this means to me

"I am seen as a person, can understand how to manage my own health, and my family and those who support me can be involved in a helpful way. My care is joined up and there are no gaps – if one spoke in the wheel is missing, things start to wobble and get worse from there."

How we will get there

1

Expand integrated, community-focused care

We will further strengthen links between primary, secondary, community services and the voluntary sector via regular multidisciplinary teams, specialist in-reach, and shared care pathways. We will collaborate with the system across conditions (for example diabetes, heart failure, respiratory) for joined-up management at a neighbourhood level.

2

Optimise early diagnosis and risk stratification

We will use population health data and GP collaboration for proactive case finding. We will prioritise diagnostics for high-risk patients while supporting primary care to manage lower-risk cases.

3

Empower multidisciplinary teams and upskill workforce

We will ensure we support upskilling of the wider clinical teams including AHPs and pharmacists to ensure we have the right members of our workforce seeing you at the right time.

We will also enhance culturally sensitive communication and patient support including through primary care . community pharmacy providing targeted training sessions.

4

Deliver patient-centred, efficient care pathways

We will reduce unnecessary referrals and duplication across care pathways, using virtual MDTs, Advice and Guidance, Consultant Connect and empower patients to take control of their care and when they need to be seen with Patient Initiated Follow-Up (PIFU).

We will work with our patient groups and GPs to ensure co-design is part of the new care models. We will ensure that medicines used for the treatment of LTCs is optimised and patient centred for individuals.

5

Use digital tools and telehealth

We will innovate and increase use of telehealth to support LTC management and reduce admissions. We will improve our data quality and data sharing between GPs, federations, and secondary care for seamless care delivery.

Chapter 3: Women and neonates

Where we are

A service provider of women's diagnostic, and gynaecology services both in the hospital and community.

We provide a midwifery led birth centre, a consultant led labour ward, and a level 2 neonatal intensive care unit. In addition, we provide a home birth service, community midwifery and neonatal community support across Islington and Haringey.

As part of the Start Well Programme Whittington Health has been identified as one of the sites that will grow its maternity and neonatal services to provide care for the population of North Central London. This will involve investment into our estates and workforce to meet the changing demands over time as well as a focus on reducing health inequalities.

Where we want to get to

Our vision is to deliver high-quality, equitable, and patient-centred care for women and neonates for the women and families of Islington and Haringey. Our vision for the community gynaecology services is to provide these services across all the boroughs of NCL. We are committed to ensuring that every woman and newborn receives comprehensive care that is accessible and well-informed. We will provide gynaecological diagnostic services through an integrated, one-stop model. We will strengthen partnerships, including more formal links with University College London Hospitals (UCLH), to enhance care delivery and improve outcomes through addressing health inequalities for all women and their babies.

What this means to me

"I can get the right care close to me. The people caring for me can find ways to communicate with me in my language and help me to understand what will happen across my pregnancy. There is continuity in my care, and as little stress as possible."

How we will get there

1

Implement the Start Well Programme

We will roll out the Start Well changes working with NCL ICB to ensure equitable access to high-quality care for women and neonates, regardless of their location. The programme will support addressing the health inequalities and poorer outcomes for Black and Asian women highlighted in recent national reports and will also include a programme to modernise the estate.

2

Develop one-stop models for gynaecology

We will create integrated one-stop models for gynaecology services that enhances convenience, streamlines the patient journey, and addresses health inequalities. This will include working with our community hubs in delivering menopause care supporting our community and workforce.

3

Strengthen partnerships and collaborations

We will build formal partnerships with UCLH and strengthen our relationships with perinatal mental health services, primary care, local networks, the Maternity and Neonatal Voices Partnership, social care and other key organisations to improve collaboration, share expertise, and ensure women and neonates have access to the best care and resources.

4

Enhance antenatal education and community engagement

We are committed to delivering comprehensive antenatal education alongside our partners within community settings to empower expectant mothers with the knowledge and support necessary to confidently navigate pregnancy and early parenthood.

Our approach focuses on providing personalised, patient-centred antenatal education tailored to everyone's language preferences and unique needs. This ensures that care is culturally sensitive and accessible, promoting informed and shared decision-making throughout pregnancy and childbirth.

We prioritise inclusivity by incorporating interpreting services, recognising neurodiversity and the need for cultural awareness so enabling equitable and meaningful engagement for all women.

5

Implement innovative technologies and improve workforce models

We will introduce innovative medical procedures and technologies (for example AI, surgical robotics), update staffing models, and ensure the IT systems are fit for purpose to support gynaecology, maternity, and neonatal services while addressing staffing and retention needs.

Chapter 4:
Children and young people

Where we are

We are a provider of acute and community services for children and young people. We provide acute paediatrics and neonatal services in the hospital and children's community health services in all boroughs in North Central London. Our community services include health visiting, school nursing, therapies, community paediatrics and children looked after services. We are the CAMHS provider for Islington and provide specialist speech and language therapy services at the Michael Palin Centre. We also provide audiology and newborn hearing screening services in all NCL boroughs.

Where we want to get to

Our vision is to create an integrated, accessible, and effective healthcare system for children across the whole NCL landscape, where care is seamless, collaborative, and centred around children, young people and families. We aim to break down barriers and ensure that every child's healthcare journey is connected, compassionate, and outcome driven. In acute and community services, we will:

1. Use a single digital record for children across the NCL landscape (reducing barriers)
2. Use data to inform and demonstrate impact and outcome.
3. Ensure better integration of our services with local partners including schools, children centres, council services and other healthcare providers.
4. Work with partners including commissioners to move towards a core service offer, reducing variation and addressing inequity of local provision.
5. We aspire to be the provider that families look to for integrated children's care of the highest standard.

What this means to me

"The services are responsive to us as a busy family, with a clear way to access help, and the support is given to us in a way that we can understand. We know how to navigate the system and don't fall through any cracks. My child is seen in the right place for them, so the right experts are nearby, and they feel safe."

How we will get there

1

Use digital tools and AI to enable improved care

We will enhance care delivery, productivity, and clinical reasoning to improve care, enabled by AI and automated systems. We will use these technologies to reduce the administrative burden on clinical staff, freeing time to focus on providing direct care and transforming services.

There will be digital access to reports from clinicians and appointment bookings.

2

Develop seamless care transitions and collaboration

We will promote and progress integrated care by supporting to teams to work collaboratively with partners, co-located where possible, ensuring smooth transitions across services and addressing health inequalities.

To support this, we will create borough based central points of contact for families, young people and service users to ask questions and access support.

3

Ensure accessible and fit-for-purpose estates and facilities

We will enhance the accessibility of estates by improving IT connectivity, language support, and physical environments tailored specifically to the needs of children, young people, and their families, including mental health services.

Where financially possible, services will be delivered in locations that best support children and young people (for example homes, schools, and community settings) through partnership working to provide care where it is most accessible and effective.

We will prioritise clinical spaces designed to deliver high-quality care that promotes the wellbeing of both staff and young patients, ensuring safety and comfort throughout the care journey.

How we will get there continued

4

Secure sustainable funding and workforce transformation

We will advocate and work with system partners for sustained funding streams to ensure equitable services for children, young people and families. We will maintain quality and safety of provision by ensuring there are appropriate service and staffing models to better meet demand.

5

Strengthen partnerships

We will enhance our relationships and collaboration with local authority services, schools, children centres, family hubs and other local provision to improve service delivery for children and young people.

We will work across systems to identify and prioritise joint responsibilities including working closely with primary care to ensure timely care for vulnerable patients and families.

6

Upskill workforce and expand clinical capacity

We will continue to develop the workforce in upskilling and extending clinical practices (for example independent prescribing, advanced clinical roles) to address capacity challenges and improve cultural competency.

We will prepare for the future by strengthening the workforce and building capacity for children and young people's services in the next five years.

Chapter 5: Cancer

Where we are

We provide cancer care to adult patients with breast, lung, gynaecological, skin, urological, upper and lower gastrointestinal cancers. We deliver systemic anti-cancer treatments (chemotherapy, immunotherapy, targeted treatments) to patients with breast, lung, upper and lower gastrointestinal cancers at the Whittington Hospital We work closely with UCLH to access specialist care for our patients i.e., complex cancer surgery, interventional oncology service or PET imaging.

We are a designated Paediatric Oncology Shared Care Unit providing shared care with Great Ormond Street.

The Whittington Hospital has a growing research portfolio, and patients will be offered participation in a clinical trial if appropriate. The Whittington Hospital also acts as a participant identification centre (PIC) for phase III and early phase studies hosted at UCLH, allowing patients the opportunity to participate in clinical trials as deemed appropriate by their treating team.

Where we want to get to

To offer personalised cancer care that is accessible, equitable, and integrated across our community from early diagnosis to survivorship.

We are committed to ensuring that every patient with cancer is seen as a whole person not just a diagnosis and receives timely, tailored, and compassionate care close to home. We aim to be a trusted, high-quality cancer service, integrated with London's Cancer centres and offer access to research trials and address health inequalities through earlier diagnosis, better outcomes, and improved patient experience.

What this means to me

"It is easy to get information at the right time to help me reduce my risk of getting cancer, and if I do get cancer, it will be diagnosed early. I don't have to tell my story repeatedly. I can get support from many sources, given to me in language and a level that I understand, at a pace that works for me, so that I can make my own decisions. I can feel confident that the ways to help me and my family are getting better every day."

How we will get there

1

Understand and engage our community

We will use data to identify high-need patients - complex health, social, or access needs including those with multiple conditions, including those at risk of late diagnosis or with barriers to care. Working with primary care, the voluntary services and community groups, we will co-design an engagement strategy focused on underserved populations.

Through our strong partnerships we will support the patients with wider social needs like housing, financial hardship, and mental health, using tools like social prescribing. Patients will be empowered through access to their own records and personalised care plans. Special attention will be given to younger adults with cancer and their unique challenges.

2

Create tailored, accessible pathways

We will develop cancer pathways that reflect local community needs and link seamlessly with other Trusts. Referral and diagnostic processes will be streamlined and easy to navigate, supported by public health messaging and patient education.

We will ensure all patients have equitable access to research, new treatments, and clear survivorship pathways that support recovery, monitoring, and quality of life after treatment.

3

Strengthen GP collaboration and education

We will support GPs and primary care teams with flexible training and digital decision-support tools to improve early detection and referral.

Working with NCL, we will embed practical, accessible education and promote use of online resources. We will also connect GPs with community cancer support services to enhance holistic, locally based care for patients.

How we will get there continued

4

Build trust and partnership with patients

We will deliver a cancer service that recognises, respects, and responds effectively to the diverse cultural, ethnic, linguistic, and social backgrounds of our patients throughout their cancer care journey. In this way we will deliver culturally competent, compassionate care with clear, consistent communication.

Patients and families will be actively involved in decisions, recognising the need for time and support to do this well.

5

Enhance screening engagement

We will work with our public health colleagues in the delivery of culturally relevant campaigns to address fears and misconceptions about screening.

Flexible, local screening options will be offered, with data used to target areas of low uptake and improve participation.

6

Utilise Data for continuous improvement

We will ensure services are clinically effective using relevant cancer data including cancer registry insights to ensure high-quality data informs care.

Clinicians will be empowered to use data to track progress, address disparities, and strive for better outcomes.

Chapter 6:
Elective and planned care

Where we are

We offer both day-case, and inpatient surgery across multiple specialties including general surgery, orthopaedics, bariatric, gynaecology, urology, gastroenterology, and pain management and a wide range of outpatient services.

In the community we provide adult and paediatric dental services.

Where we want to get to

Our vision is to establish a centre of excellence for spinal, bariatric, dental, and gynaecological services, where patients receive high-quality, integrated care throughout their journey.

We will have a focus on day case and ambulatory procedures pioneering the latest technological advances. This vision is built on a foundation of efficiency, transparency, continuous improvement and patient centred.

What this means to me

"I am seen as a whole person, it is clear to me what is going to happen from start to finish, and all the different people looking after me have the right information about me at the right time. I will know how long I might have to wait. I can have a say in how the whole treatment is put together if I want."

How we will get there

1

Define and streamline care pathways

We will collaborate with partners to implement clear care pathways, including same-day discharge and robust pre-assessment, with defined provider roles to reduce duplication, optimise perioperative medicines management and improve communication from referral to discharge. We will also optimise use of the Day Treatment Centre and ambulatory pathways to enhance same-day emergency surgery and discharge.

2

Optimise digital integration and data

We will integrate systems such as diagnostics into an EPR, remote monitoring, and compatible digital systems to enhance workflow, enable benchmarking, and support data-driven decision-making for continuous quality improvement. Use evidence-based management to drive service improvements.

3

Develop workforce skills and surgical excellence

We will ensure we develop a skilled and agile workforce through continuous training, recruitment for specialised roles, and investing in technology (for example robotic surgery) and advanced practitioners, including specialist nurses. We will ensure WH is an attractive place to work, for example access to work in tertiary centres for anaesthetists and surgeons to ensure recruitment.

4

Enhance partnerships and collaboration

We will strengthen partnerships with GPs, VCSEs, UCLH and other stakeholders, ensuring clear roles, responsibilities, and communication. Co-design pathways with patients, families and their supporters and ensure shared information across providers.

5

Focus on patient experience and outcomes

We will define clear outcome measures for each pathway such as clinical outcomes, readmission rates, and length of stay while enhancing recovery through community care and prehabilitation. Pathways will be co-developed throughout the process.

Chapter 7: Diagnostics

Where we are

Providing a comprehensive range of diagnostic services both within the hospital and at our Community Diagnostic Hub in Wood Green, Haringey. Our services include imaging, women's health diagnostics, histopathology, pathology, cardiology, audiology, neurophysiology, as well as diagnostic endoscopy and upper GI cancer diagnostics. However, we recognise a key challenge: diagnostic test data is currently not accessible across the wider health system or directly by patients, limiting integration and continuity of care.

Where we want to get to

Our vision is to deliver seamless, local, and patient-centred diagnostic services, reducing the need to travel for essential tests, especially for cancer detection, by improving data access, innovation, and collaboration across diagnostic pathways.

To improve health equity, we will ensure diagnostics accessibility through supporting those with additional needs such as those with cognitive impairment, mental health needs, those experiencing homelessness, people with learning disabilities and their wider families, carers and support networks.

What this means to me

"I can access care easily close to where I live, using my app. I understand the process, including where my results are going and when they might. The results of my tests are explained to me kindly in the way I understand best, and they go to the right place for the next step of my journey. I know what I need to bring with me, and the people I see me the right information to help me."

How we will get there

1

Streamline data access across sectors

We will collaborate with NCL to ensure real-time data sharing across healthcare sectors, enabling patients and clinicians to access the latest patient results and improve diagnostics and decision-making. This will result in reduced duplication and improve clinician decision making.

2

Align goals and strategies with operational teams

Through team working with operational teams to set SMART goals together that reduce waiting times and align diagnostic services with their clinical strategy to enable innovation and transformation.

3

Enhance local diagnostic capabilities

We will expand local diagnostic services in the hospital and community. In the hospital by installing advanced equipment like fluoroscopy for stenting and developing services such as endobronchial ultrasound (EBUS) and endoscopic submucosal dissection (ESD), reducing the need to refer patients to other hospitals.

In community further expanding the Community Diagnostic Centre space and tests available to the population (for example extended hours for phlebotomy services). This will also provide further access for harder to reach groups helping to address health inequalities.

4

Improve workflows between clinical and IT services

We will review and optimise diagnostic workflows, integrating diagnostic systems into the Electronic Patient Record (EPR) and linking to the NHS App. This will improve accessibility to results for all clinicians and patients. We will improve systems for alerting clinicians when test results are available, ensuring timely clinical decisions and efficient completion of necessary administrative tasks.

Chapter 8:
Urgent and emergency care

Where we are

A provider of urgent care for adults and children with an emergency department, same day emergency care, acute medical wards, a virtual ward for NCL and urgent response service for Islington and Haringey, for example the Integrated discharge team and rapid response team.

Where we want to get to

With the increasing demand year on year, we need to focus on shoring up our emergency offer, so it is fit for the future and offers the right service at the right time. We aim to reduce long waits and enhance diagnostic accuracy.

Our goal is to optimise the use of our same day emergency services, virtual wards and our links with community and social care. This will support us in reducing our admissions and length of stay for all our patients including those with additional challenges such as the homeless, those with learning disabilities, mental health conditions and those with cognitive impairment. By optimising processes, reducing unnecessary duplication and effective communication, we will ensure high-quality care for all patients, while minimising duplication and waste.

What this means to me

"My problem is diagnosed quickly and thoroughly, and the people caring for me explain what they mean simply. When I leave, I will have a plan and know who to go to for more help, and my GP will have the right information about the visit."

How we will get there

1

Enhance integrated care across teams

We will ensure seamless integration and sharing of information across hospital and community care, collaborating with stakeholders such as neighbourhood teams to provide holistic care and reduce unnecessary admissions.

2

Prioritise clinically reasoned diagnostics

We will implement timely, accurate diagnostics to inform clinical decisions improving patient outcomes and navigating them to the right pathway. This will include linked diagnostics systems and the EPR.

3

Focus on admission avoidance and early intervention

We will collaborate with NCL providers on alternative pathways to offer early interventions and integrated care reducing hospital admissions by ensuring patients receive the right care at the right time.

4

improve cross-team communication within the hospital, community and other providers

We will implement early escalation processes to specialists and enhance communication across teams, ensuring a coordinated approach to care and reducing delays. We will use case finding to sign post the most appropriate discharge pathway.

5

Standardise processes and equipment for efficiency

We will streamline clinical decision-making, reducing variation and unnecessary duplication, improving standard work and adopting best practices to enhance efficiency and ensure consistency in care delivery.

6

Multidisciplinary working

We will develop the skills and knowledge to further develop the multidisciplinary workforce in effectively delivering clinical pathways such as Day emergency Services and the virtual ward.

Taking this forward and key enablers

1

Electronic patient records (EPR) and IT systems

- **Interoperability:** To implement a single EPR across both acute and community care at Whittington Health. Maximising electronic prescribing, EPR/EPMA integration, medicines dashboards, and patient-facing tools for adherence to support safer transitions of care, shared records, and real-time decision support
- **Integration:** Work with our partners and NCL to ensure integration of IT systems or seamless data sharing between different sectors (primary, secondary, community, and social care) to allow real-time access to patient information, especially for long-term conditions, frailty, and emergency care. This will support shared care pathways, remote care models, and collaborative care across services (for example integrated care for diabetes, heart failure, respiratory conditions).
- **AI and automation:** Use AI to enhance diagnostics, automate administrative processes, for example patient letters to improve efficiency and improve patient engagement (appointment scheduling, results notification).
- **Data analytics:** Utilise data analytics for proactive care, identifying high-risk patients, and optimising patient flow, particularly in emergency care and diagnostics.

2

Estates and facilities

- **Integrated care environments:** When developing the estate, it will be vital that we ensure estates and facilities are designed to promote integration across primary, secondary, and community settings (for example co-located services, shared clinical spaces for MDTs).
- **Accessible facilities:** Design facilities that are accessible to vulnerable populations, including older and frail individuals, and families with young children. This includes physical spaces that are inclusive and adaptable to changing patient needs (for example wider corridors, multi-use rooms, language support for diverse communities).

3

Sustainability and net zero

- Enhance patient care and environmental responsibility by embedding sustainability into service design and estates planning. Reduce medicines waste and carbon emissions through precise prescribing and efficient supply models, supporting clinical outcomes alongside net zero goals.

4

Secure sustainable finances

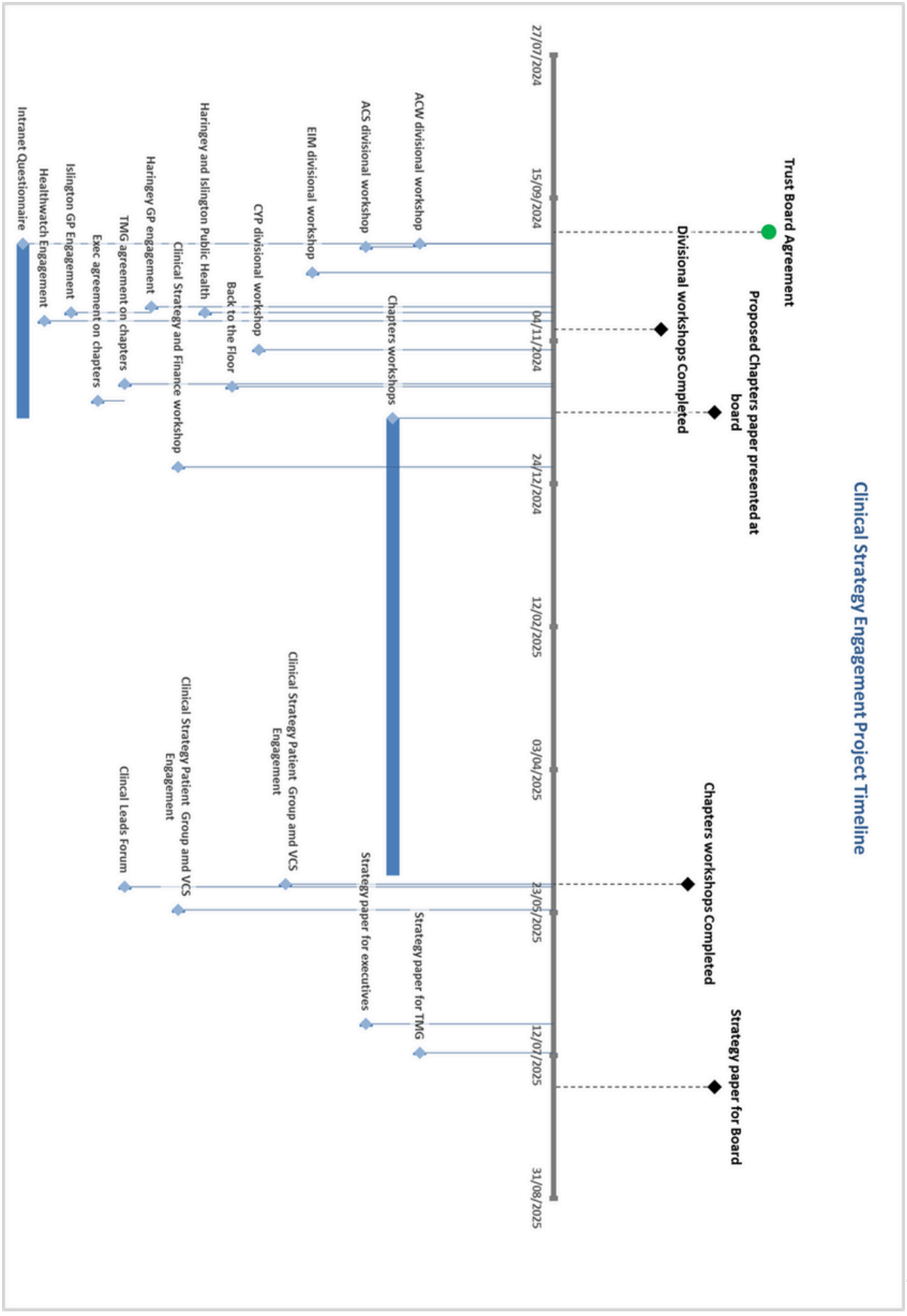
- **Financial deficit:** The Trust has an underlying financial deficit which is fundamentally due to excessive growth in the cost of services provided relative to funding received. To support this Clinical Strategy the Trust must deliver the financial plan over the next 4 years through the £24.1m recovery schemes. The integrated care approach which shifts care to earlier in a pathway and to the community from the hospital i.e. left shift is essential to our financial sustainability.
- **Financial sustainability models:** Ensure funding is aligned with clinical needs, especially for long-term conditions, CYP and frailty management. Work to explore innovative financial models that support the provision of services like remote care, AI diagnostics, and multidisciplinary care.
- **Efficiency gains:** Explore opportunities for efficiency gains to free up resources for other high-demand services and support the delivery of a financially balanced organisation.

5

Research and continuous quality improvement

- **Research:** Whittington Health will continue to integrate robust research across critical care, chronic disease, women's health, oncology, speech therapy, and community medicine underpinned by strong partnerships (UCLPartners, NIHR) and active trial support. This broad portfolio will demonstrate our commitment to reducing health inequalities, innovation and integrated patient care.
- **Data for outcome measurement:** Collect data on key outcome indicators (for example patient satisfaction, hospital admissions, referral rates) to evaluate the effectiveness of care pathways and interventions.

Appendix: Engagement timeline



Meeting Title	**Trust Board – public meeting**	**Date: 23 July 2025**
Report Title	**Integrated Performance Report**	**Agenda Item: 12**
Executive lead	Chinyama Okunuga, Chief Operating Officer	
Report Owner	Paul Attwal, Head of Performance, Jennifer Marlow, Performance Manager	
Executive Summary	Board members should note that all metrics are shown in summary, but only certain measures have been highlighted for further analysis and explanation based on their trajectory, importance, and assurance. **Infection Prevention and Control** During June 2025 there were 2 HCAI C Difficile infections and 0 MRSA Bacteraemia bringing the total number of MRSA Bacteraemia's to 0 for the year (April 2025 – March 2026). **Emergency Care Flow** During June 2025 performance against the 4-hour access standard was 73.21% which is lower than the NCL average of 78.1%, and the National average of 75.5%. In June 4.5% of patients spent more than 12 hours in ED **Cancer: 28-Day Faster Diagnosis Standard (FDS) May Performance – 80.8%** This is an improvement of 1.7% compared to April's performance of 79.1% **Cancer: 31 Days to First & Subsequent Treatment May Performance – 100%** This is the same as April's performance of 100%. **Cancer: 62-Day Combined Treatments May Performance – 80.8%** This is an improvement of 1.2% compared to April's performance of 79.6%. At the end of June 2025, the Trust's position against the 62-day backlog was 53 patients. **Referral to Treatment: 52+ Week Waits** Performance against 18-week standard for June 2025 was 74.2%, this is an improvement of 4.4% from May's performance of 69.8%. The Trust position against the 52-week performance worsened from 323 patients waiting more than 52-weeks for treatment in May 2025 to 347 in June 2025, this equates to 1.37% of the total RTT waiting list. The Trust had 39 patients waiting over 65 weeks at the end of June 2025 this is an increase of 4 from 35 in May 2025. **Complaints** Complaints Responded to Within 25 or 40 Working Days has improved from 60% in May 2025 to 68.4% in June 2025 and remains below the required standard of 80%. The Complaints Team continue to work closely with the Divisions to support with the completion of these and all complaint investigations.	

Purpose:	Review and assurance of Trust performance compliance
Recommendation	That the Board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan
Board Assurance Framework	Quality 1; Quality 2; People 1; and People 2.
Report history	Trust Management Group
Appendices	1: Integrated Performance Report 2: Key Performance Targets by March 2026

Whittington Health NHS Trust

Performance Report

July 2025

Key Exceptions for Noting (1 of 3)

Emergency Department and Patient Flow:

June 2025 performance against the 4-hour ED target remained below threshold; however, notable improvement was achieved, with performance rising to 73.21% in June 2025 from 71.57% in May 2025. This progress aligns with the Trust's agreed improvement trajectory and is attributed to targeted actions across four strategic areas, including UTC and Paediatric delivery, enhanced out-of-hours capacity, improved streaming pathways, and breach management.

Extended waits continue to decline, with 12-hour trolley breaches reduced to 123 (from 145), and the proportion of patients staying over 12 hours fell to 5.5%. Mental health-related breaches saw a modest decrease, though they remain above the year-to-date average. The Trust is actively collaborating with system partners to strengthen discharge pathways and access for mental health presentations.
Ambulance conveyances rose slightly to 1,518 but remained within expected performance ranges, supported by the ongoing success of the Royal Free Group diversion model.

Average Length of Stay remains stable but above benchmark levels. Reducing ALoS is a priority within future Flow Improvement Programme phases

Referral-to-treatment:

As of June 2025, the Trust's RTT compliance stands at 64.5%, below the 72% national standard, with several specialties—Neurology, Plastic Surgery, Vascular Surgery, and Lower Urinary Tract Services—performing under 50%. Urology shows improvement, with a backlog reduction of over 1,100 patients since December 2024. The overall RTT backlog is ahead of trajectory, supported by national validation efforts and strengthened admin training. The 52-week wait position remains non-compliant but stable. Diagnostic performance (DM01) has improved to 89.5%, with Endoscopy and CT achieving national standards, while Audiology, Echocardiography, Dexa Scans, and Sleep Studies continue to face ongoing capacity and funding constraints.

Key Exceptions for Noting (2 of 3)

Cancer:

In May 2025, the Trust achieved the national Faster Diagnosis Standard (FDS), with 80.8% of patients receiving a cancer diagnosis within 28 days of referral. This performance has remained stable for three consecutive months, underscoring strong pathway management and early diagnosis efforts. The 62-day cancer standard has also been met consistently for three months, with 75% of patients commencing treatment within the required timeframe, marking sustained progress well ahead of the March 2026 national compliance deadline.

Activity:

As of June 2025, the Trust continues to see improvement in the Did Not Attend rate for new outpatient appointments, though targets have not yet been met. Inpatient Elective care remains ahead of plan across all Divisions, reflecting strong operational delivery. However, Day Case activity and Outpatient performance are mixed, with several specialties under review as part of the ongoing Outpatient Transformation Programme. Efforts are focused on enhancing access, refining pathways, and improving scheduling to support sustained recovery across all services.

In June 2025, theatre utilisation averaged 80.1%, supported by operational improvements and targeted service reviews. Non-clinical cancellations remained low at 2.0%, with all affected patients rebooked. Mitigations are in place to reduce patient-initiated cancellations and strengthen attendance, while lower productivity reflects case mix in maternity and endoscopy theatres.

Key Exceptions for Noting (3 of 3)

Quality and Safety:

In June 2025, the Trust reported two cases of Clostridioides difficile infection (CDI), both classified as Community Onset-Hospital Associated, with no identified lapses in care or outbreak concerns following multidisciplinary reviews. Complaint activity remained consistent, with 38 formal responses required and 26 resolved, yielding a 68% response rate. Complaints were distributed across divisions, with the majority arising from EIM and S&C services.

Community – Children and Young People:

As of June 2025, long waits for children and young people (CYP) remain concentrated in neurodevelopmental pathways, particularly autism and ADHD assessments. Positive progress continues in Haringey's 0–11s and Islington's 0–5s services, supported by increased investment and expanded assessment capacity. Providers across North Central London are working to streamline these pathways, though historic backlogs remain a challenge. CAMHS services are showing improved access and reduced waiting times through enhanced triage and therapy prioritisation. Speech and Language Therapy services continue to face pressures, but targeted investment in Haringey and Barnet is supporting gradual improvement.

Community – Adults:

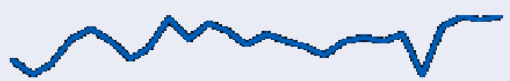
As of June 2025, operational challenges persist across specific ACS services, with the Islington Stroke Team remaining the only pathway breaching the 52-week wait threshold. A recovery plan is in place, supported by dedicated oversight, while Haringey has successfully recovered from similar issues. The division's overall access performance remains within target, with average waits at 38.6 days. Musculoskeletal services are showing improvement due to targeted funding, though referral-driven pressures persist. Podiatry continues to experience long waits linked to staffing constraints, with mitigation measures underway. Rapid Response is performing strongly against its target, but future referral volumes may rise due to the introduction of a centralised access system. Virtual Ward utilisation remains below target, with promotional efforts planned to drive uptake.

Performance Overview

4	• Significant performance variance from target or trajectory and/or SPC analysis shows special cause concerning variation • Performance is expected to continue to deteriorate in the short term
3	• Significant performance variance from target or trajectory and/or SPC analysis shows special cause concerning variation • Performance improvement is expected in the short term
2	• Marginal performance variance from target or trajectory • Performance improvement is being achieved/expected
1	• Performance achieving target or trajectory and/or SPC analysis shows special cause improvement variation

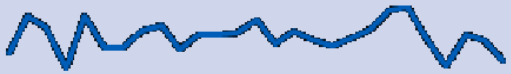
Status	Metric	Trend	Target	Latest Performance		Benchmark
Emergency Department and Patient Flow						
2	Percentage of Patients Attending A&E Should Be Admitted, Transferred or Discharged Within Four Hours		National standard – 78% March 2026	June 2025	73.21%	NCL – National –
1	Percentage of Patients Spending More Than 12 Hours in A&E		Less than 7.3%	June 2025	4.5%	Benchmark data currently unavailable
2	Percentage of Patients Arriving at the Emergency Department by Ambulance Handed Over Within 30 Minutes		National standard – 95%	June 2025	94.01%	
2	Number of Patients Not Meeting Criteria to Reside and Not Discharged		No more than 40 patients	June 2025	43	
2	Number of Mental Health Patients With a Decision to Admit Who Spent Over 12 Hours in A&E		Less than 174 for year (15 per month)	June 2025	20	
2	Average Length of Stay for Non-Elective Admissions (General and Acute)		7.7 days	June 2025	9.6	

Performance Overview

Status	Metric	Trend	Target	Latest Performance		Benchmark
Referral-to-Treatment and Diagnostics						
1	Total Number of Patients on the Referral to Treatment (RTT) Waiting List		Trajectory – 26,501 March 2026	June 2025	25,365	Benchmark data currently unavailable
2	Percentage of Incomplete RTT Pathways Waiting Less Than 18 Week		5% improvement – 72%	June 2025	64.5%	
3	Percentage of Patients Waiting Under Six Weeks for a Diagnostic Test		National standard - 99% March 2026	June 2025	89.49%	
2	Percentage of Patients Waiting Over 52 Weeks for Elective Treatment		No more than 1% by March 2026	June 2025	1.37%	
1	Percentage of Patients Receiving First Appointment Within 18 Weeks		National standard – 72% March 2026	June 2025	74.2%	
Cancer						
1	Percentage of Patients Receiving First Definitive Cancer Treatment Within 62 Days of an Urgent GP Referral		National standard - 75% March 2026	May 2025	80.8%	Benchmark data currently unavailable
1	Percentage of Patients Receiving First Definitive Treatment Within 31 Days of Cancer Diagnosis		National standard - 96%	May 2025	100%	
1	Faster Diagnosis Standard: Percentage of Patients with Cancer Diagnosed or Ruled Out Within 28 Days		National standard - 80% March 2026	May 2025	80.8%	

Performance Overview

Whittington Health NHS Trust

Status	Metric	Trend	Target	Latest Performance		Benchmark
Activity & Productivity						
2	Did Not Attend (DNA) Rates for New Appointments		Local Target – 9%	June 2025	10.6%	Benchmark data currently unavailable
1	First to Follow-Up Appointment Ratio		2.3	June 2025	1.73	
1	Ordinary Elective Care: Percentage of Activity Delivered Against Plan		Trajectory ≥ 100%	June 2025	104.73%	
2	Day Case Activity: Percentage of Activity Delivered Against Plan			June 2025	98.12%	
2	First Outpatient Attendances: Percentage of Activity Delivered Against Plan			June 2025	91.29%	
2	Outpatient Procedures: Percentage of Activity Delivered Against Plan			June 2025	94.54%	
2	Number of Births per Month		320 per month	June 2025	230	
3	Operating Theatre Utilisation Rate		>85%	June 2025	75.13%	
3	Number of Hospital Cancelled Operations		Zero	May 2025	12	

Performance Overview

Status	Metric	Trend	Target	Latest Performance		Benchmark
Quality and Safety						
1	Percentage of Patients Assessed for Venous Thromboembolism (VTE) Risk		National standard – 95%	June 2025	96%	Benchmark data currently unavailable
2	Inpatient Falls		400 (Less than 33 per month)	June 2025	34	
2	Number of Clostridioides Difficile Infections (C. Diff)		Local target- < 22 FYE	June 2025	2	
1	Number of Methicillin-Resistant Staphylococcus Aureus (MRSA) Infections		Zero tolerance	June 2025	0	
1	Percentage of Patients Readmitted as an Emergency Within 30 Days of Discharge		<5.5%	June 2025	3.67%	
1	Summary Hospital-Level Mortality Indicator (SHMI)		1	Feb 2024-Jan 2025	0.92	
1	Inpatient Survey Satisfaction Rate: Positive Responses		>90%	June 2025	95.1%	
3	Percentage of Complaints Responded to Within 25 or 40 Days		>80%	June 2025	68.4%	

Performance Overview

Status	Metric	Trend	Target	Latest Performance		Benchmark
Workforce						
1	Average Time to Hire (Days)		<=63 days	June 2025	56	Benchmark data currently unavailable
2	Percentage of Sickness Absence		<3.5%	May 2025	4.02%	
1	Vacancy Rate Percentage		<10%	June 2025	5.2%	
3	Percentage of Completed Appraisals		>85%	June 2025	77%	
1	Mandatory Training Completion Rate		>85%	June 2025	88%	
1	Staff Turnover Rate: Percentage Leaving in Last 12 Months		<13%	June 2025	9.3%	

Performance Overview

Status	Metric	Trend	Target	Latest Performance		Benchmark
Community – Children and Young People						
3	Percentage of CYP Patients Waiting Over 52 Weeks		No more than 1% of total service	June 2025	9.25%	Benchmark data currently unavailable
2	New Birth Visits by Health Visitors (Haringey and Islington)		95% Completed within 14 days	May 2025	92.08%	
2	Average Wait Time to First Appointment: CAMHS (Excluding Neurodevelopmental Disorders)		4 Weeks	June 2025	5	
1	Average Wait Time to First Appointment: Speech and Language Therapy (SLT)		13 Weeks	June 2025	11.4	
1	Average Wait Time to First Appointment: Occupational Therapy (OT)		18 Weeks	June 2025	8.7	

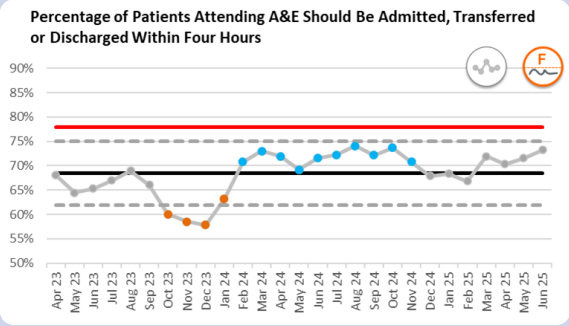
Performance Overview

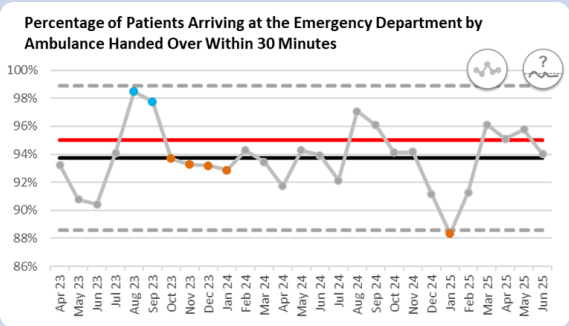
Status	Metric	Trend	Target	Latest Performance		Benchmark
Community – Adults						
1	Percentage of Patients Waiting Over 52 Weeks for an Appointment		No more than 1% of total service	June 2025	0.43%	Benchmark data currently unavailable
1	Percentage of Patients Seen Within 48 Hours of Referral to District Nursing		>80%	June 2025	90.7%	
1	Percentage of Patients with Urgent Rapid Response Referrals Seen Within 2 Hours		>80% (Local NCL Target)	June 2025	86.9%	
	Total appointments for District Nursing		No target – Monitoring only	June 2025	31,774	
1	Average Wait Time to First Appointment: All ACS Services		6 Weeks	June 2025	5.8	
1	Continuing Healthcare 28-Day Referral to Complete Assessment		Local Target 50-59.9%	June 2025	56%	

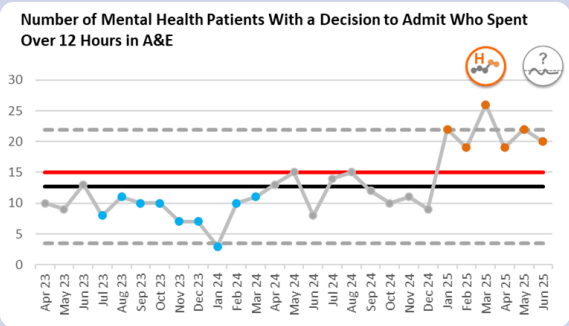
Emergency Department and Patient Flow

Whittington Health NHS Trust

Emergency Department







June saw an improvement in 4-hour Emergency Department (ED) performance, rising to 73.21% up from 71.57% in April. This positive movement reflects ongoing work to meet the agreed improvement trajectory, with a targeted focus on the following priority areas:

- Achieving >96% performance in UTC and >92% in Paediatrics
- Maximising use of the Clinical Decision Unit (CDU) and ED Same Day Emergency Care (SDEC) out of hours
- Enhancing streaming pathways to appropriate care settings
- Reducing out-of-hours breaches

ED attendance reduced from 9,198 in April to 9,127.in June.

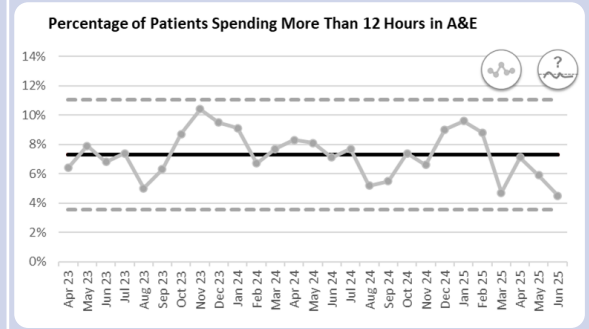
We saw the continued reduction in 12-hour trolley breaches from 145 in May to 123 in June. Although mental health-related 12-hour breaches decreased from 22 in May to 20 in June this is consistently higher and remains consistently above the year-to-date average. The Trust continues to work closely with system partners to address delays for mental health patients.

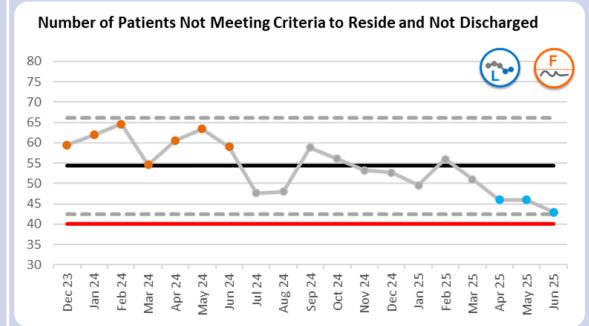
The proportion of patients spending over 12 hours in A&E decreased from 7.1% in April to 5.5% in May, supported by:

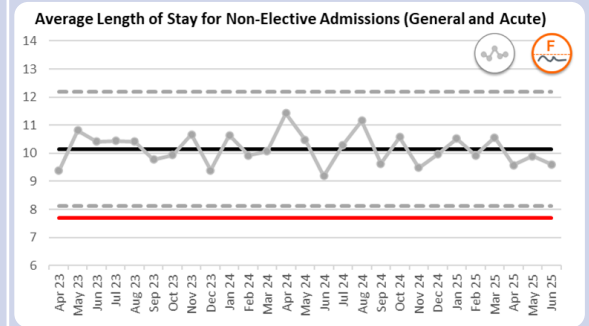
- Early system-wide escalation for discharge, involving community partners, social care, mental health providers, and local councils
- Implementation of actions from the Flow Improvement Programme
- A focus on reducing criteria to reside and long length of stay (LLoS)
- Expanded Virtual Ward capacity and continued success of the Airmid Bridging Service
- Utilisation of Airmid bridging service

Average Length of Stay (ALoS) has remained stable with reduced variability but continues to exceed target levels. Reducing ALoS remains a key area of focus for the Flow Programme going forward.

Ambulance conveyances increased slightly from 1,492 in May to 1,1518 in June reflecting the benefits of the Royal Free Group diversion model in managing emergency pressures more effectively.





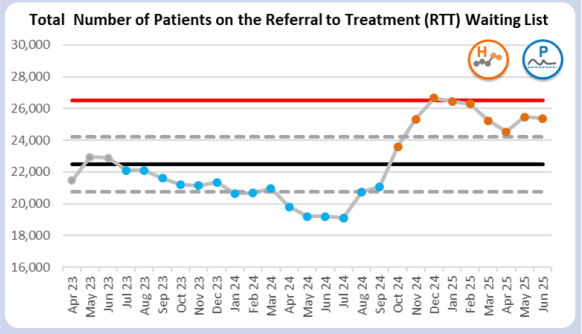


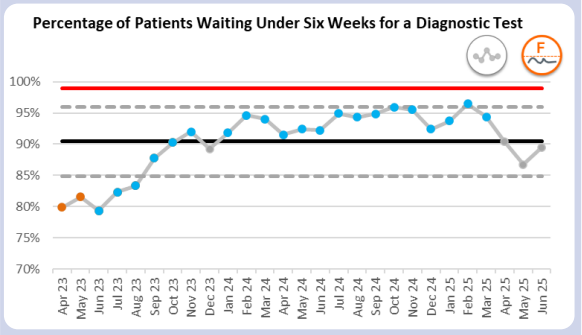
ICARE EQUITY

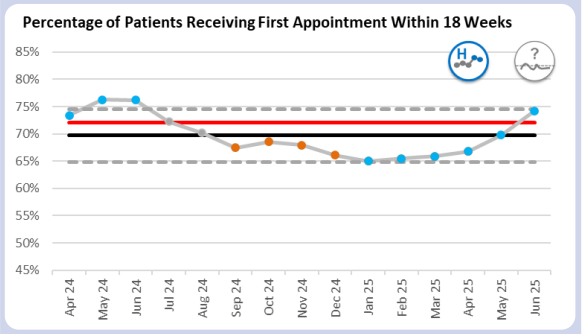
Referral-to-Treatment and Diagnostics

Whittington Health NHS Trust

Referral-to-Treatment and Diagnostics





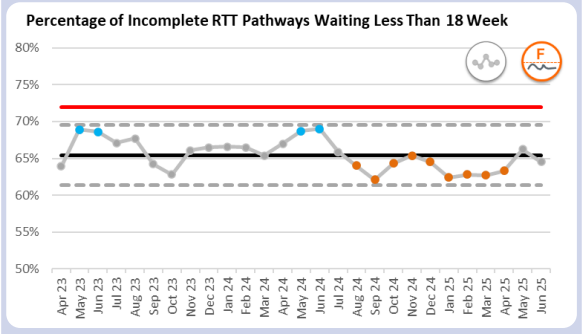


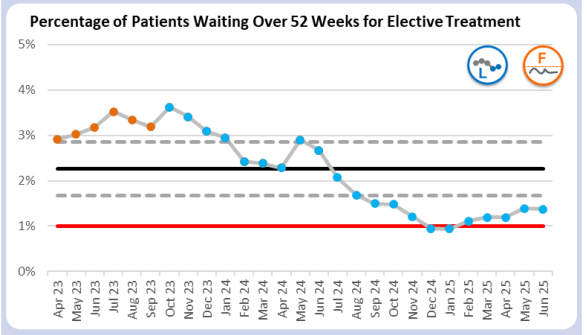
As of June 2025, the Trust is reporting an RTT compliance rate of 64.5%, which remains below the national standard of 72%. Several specialties including Neurology, Plastic Surgery, Vascular Surgery, and the Lower Urinary Tract Service continue to perform below 50% and are being closely monitored. Encouragingly, sustained improvement is evident within the Urology service, where the backlog has been reduced from 3,347 patients in December 2024 to 2,229 by the end of June. This reflects a concerted effort to address long-wait pathways and improve access.

The Trust remains actively engaged in NHS England's national Validation Sprint initiative, which is helping to improve the accuracy of patient waiting list data. A new training programme for administrative staff has also been launched to support stronger operational management of RTT pathways. Overall, RTT backlog performance remains ahead of projected trajectory, currently standing at 25,365 patients compared to the forecasted 26,501.

The 52-week position remains non-compliant however overall performance is stable

For DM01 diagnostics, performance has risen to 89.5%, marking a 2.8% improvement since May 2025, though remaining below the national target of 99% by March 2026. Endoscopy and CT modalities are currently achieving the required standard. However, Audiology, Echocardiography, Dexa Scans, and Sleep Studies continue to face persistent challenges, driven by ongoing capacity and funding constraints that are being addressed as part of the diagnostic improvement plan.

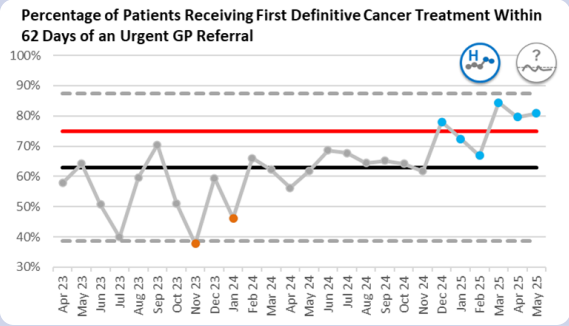


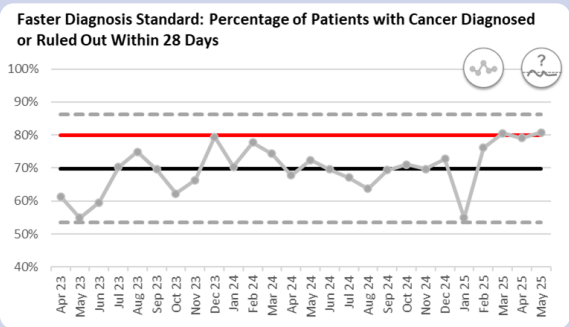


ICARE EQUITY

Cancer

Cancer





Faster Diagnosis Standard (FDS) The Trust achieved the national FDS target of ≥80% in May 2025, with 80.8% of patients receiving a cancer diagnosis within 28 days of referral. Performance has remained stable at or above the threshold for the past three months, reflecting effective pathway management and early diagnosis efforts.

62-Day Cancer Standard The target of 75% of patients commencing first definitive treatment within 62 days of referral has been met consistently for three consecutive months. This marks sustained progress ahead of the national compliance deadline of March 2026, supporting earlier treatment starts and improved patient outcomes.

In May 2025, 75% of Faster Diagnosis Standard (FDS) breaches occurred in three specialties: Lower GI (50), Gynaecology (37), and Urology (36). Despite these pressures, overall FDS compliance improved by 1.6%, exceeding the trajectory set for March 2026. Notable performance shifts were observed in Urology (down 6% to 58.6%) and Breast services (up 5.1% to 90.6%).

The Trust reported 10 breaches of the 62-day cancer standard, with Urology accounting for half of these (3 kidney and 2 prostate cases).

Service-specific updates highlight targeted improvement efforts:

Skin services launched a Teledermatology pathway on 3rd May with 10 slots per week, aiming to double this by September. To meet seasonal demand, an increase in weekend WLIs is planned, though funding and staffing remain risks.

Lower GI services filled four WTE vacancies, implemented a revised registrar rota to increase clinic capacity, and introduced an additional STT nurse role to drive performance improvements.

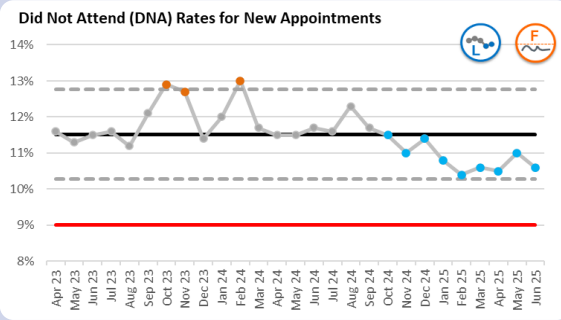
Gynaecology launched a Pipelle biopsy pathway on 21st May, reducing the need for general anaesthetic procedures and supporting FDS compliance.

Urology (Prostate) continues to face delays, with average MDT discussion occurring at day 26. Service redesign is underway, aiming to implement a one-stop model supported by Radiology. A CNS vacancy temporarily impacted mitigation efforts, but recruitment has now been completed. Funding from the NCL Cancer Alliance has enabled procurement of new biopsy equipment, supporting nurse-led LATP biopsies.

Activity and Productivity

Whittington Health NHS Trust

DNA

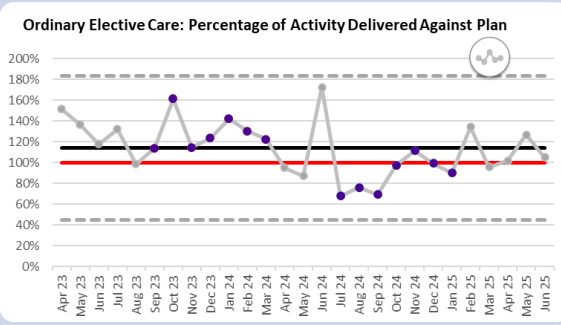


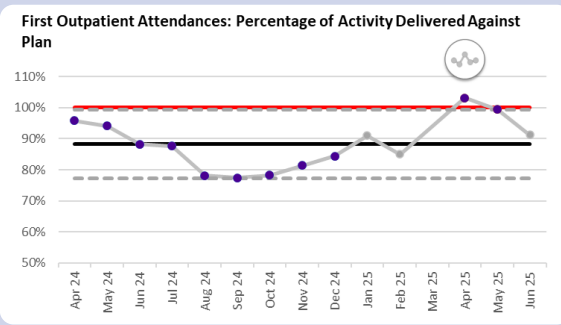
The Trust continues to observe a clear improving trend in the Did Not Attend (DNA) rate for new outpatient appointments, signaling positive momentum. While performance has not yet reached the expected target, these gains reflect ongoing efforts under the Outpatient Transformation Programme.

Targeted collaboration is underway with clinical divisions—initially concentrating on Urology and Gynaecology—to accelerate progress through tailored interventions and engagement. Early implementation outcomes across these specialties remain encouraging, with strong indications of enhanced scheduling stability and growing patient responsiveness.

If this positive trajectory continues, the Trust will explore broader implementation of the 6-4-2 model across additional services, with the aim of fostering greater consistency and efficiency in outpatient performance at a Trust-wide level.

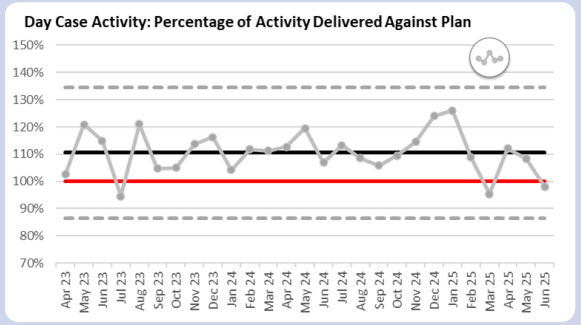
Activity

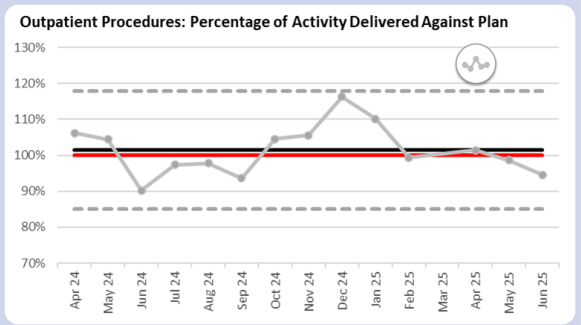




Elective care performance remains strong, with Inpatient Elective activity currently ahead of plan across all Divisions. This reflects effective operational delivery and robust scheduling, positioning the Trust favourably against its recovery trajectories.

However, Day Case, Outpatient Procedures, and First Outpatient Attendances activity has fallen below expected levels and continues to present a mixed picture. While overall First Attendances remain broadly positive, service-level variation persists, particularly in Dermatology, ENT GP Federation, and Trauma and Orthopaedics. These services are participating in the broader Outpatient Transformation Programme, which seeks to improve access, streamline referral pathways, and increase scheduling efficiency. Reviews are focused on resolving bottlenecks, optimising clinic templates, and considering alternative consultation models where appropriate. The aim is to support a sustained recovery and alignment with planned trajectories across all specialties.

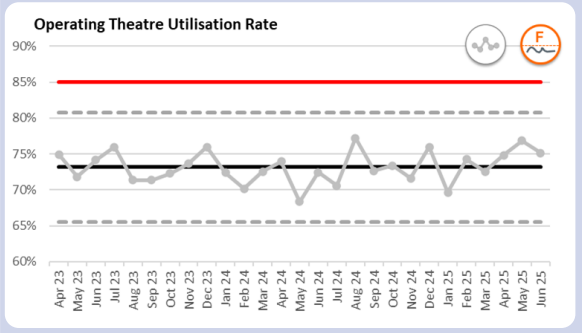


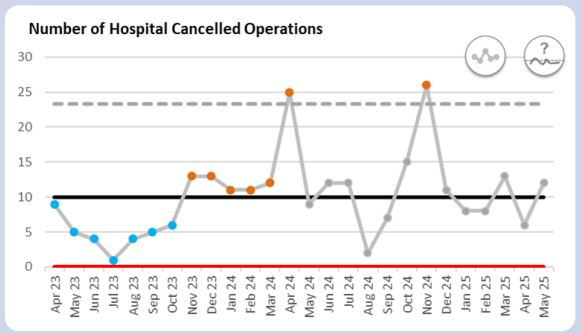


ICARE EQUITY

Activity and Productivity

Theatres





In June 2025 the overall utilisation average of 75.13% was influenced by the case mix within elective maternity and endoscopy theatres. However main theatre utilisation reached 80.1%, with weekly performance ranging from 75.4% to 86.9%.

The Trust has launched a theatre productivity improvement initiative focused on key operational metrics, including overall utilisation and cases completed per four-hour session. A new theatre start-up process has reduced late starts by over one-third, now averaging 16 minutes. In parallel, work is underway to address early finishes by increasing case bookings per session.

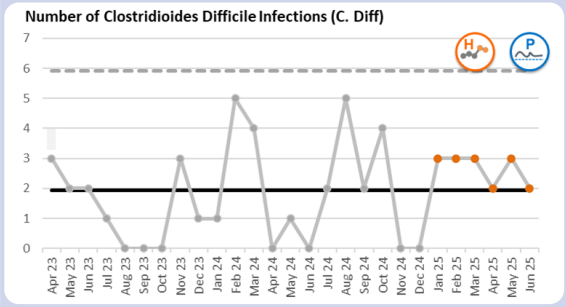
Dedicated working groups have been established to support Dental and Urology services in resolving barriers to optimal utilisation, while delays linked to radiology capacity are being addressed collaboratively.

In May 2025, two on-the-day cancellations in main theatres were attributed to Trust initiated, non-clinical reasons. One was due to a list overrun following a complex case, and the other linked to equipment delivery issues. Additional cancellations were caused by short-notice staff sickness, which has been mitigated by successful recruitment to vacant anaesthetic posts. All affected patients were rebooked within 28 days. Non-clinical cancellations remain consistently within the target of <5%, reporting at 2.0% in May.

To reduce patient-initiated cancellations, a number of mitigations are in place, including appointment reminders via mobile messaging and welfare calls providing tailored pre-operative guidance on medication and fasting. These measures support improved attendance and service continuity.

Quality and Safety

Infection Control

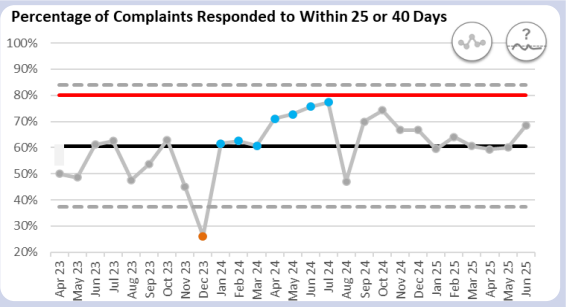


In June 2025, the Trust reported two cases of Clostridioides difficile infection (CDI), both Community Onset-Hospital Associated (COHA) cases. Post-infection reviews (PIRs) were conducted for both cases with input from the MDTs and no lapses in care were identified. Importantly, none of these cases were linked by time or location to suggest an outbreak.

Both cases were given antibiotics but were managed appropriately according to local antibiotic guidelines. One case was treated with antibiotics following a gram-negative bacteraemia, and due to drug allergies, had limited antibiotic options. The second case was a relapse of a C. diff infection in April 2025. The patient is receiving radiation treatment for Hodgkin's lymphomas including antibiotic prophylaxis.

Both patients received appropriate treatment. Multidisciplinary teams (MDTs) are actively engaged to ensure adherence to infection prevention and control protocols. PIR discussions following these infection incidents are held to identify any potential gaps in practice, promote shared learning, and support continuous improvement in patient care and outcomes. Samples have been sent to the UK Health Security Agency (UKHSA) reference laboratory for ribotyping to assist with epidemiological analysis.

Complaints



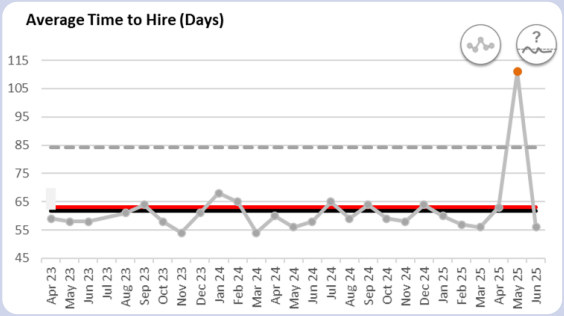
During June 2025, 38 complaints required a formal response, with 26 of these resolved within the month, resulting in a response rate of 68%. The complaints were evenly distributed between the EIM and S&C divisions (32% each), followed by ACW (20%), ACS (8%), and CYP (8%).

Risk assessments showed a stable trend in severity: 3% of complaints were high risk, 23% moderate, and 74% low risk. The dominant themes Attitude, Medical Care, and Communication remained consistent with previous months. Collaborative efforts between divisions and the Complaints Team are ongoing to address these issues and drive improvements in service quality.

Of the 26 complaints closed, 85% were upheld either in full 23% or partially 62%, with 15% not upheld. These outcomes underscore the Trust's commitment to listening to patient concerns and using feedback to inform better care practices.

Workforce

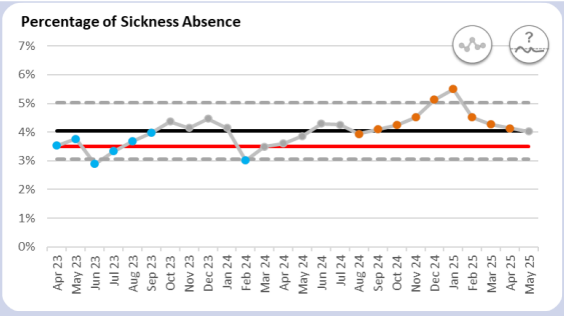
Time to Hire



Time to Hire (TTH) has consistently remained below the Trust's target of 63 days for the past six months, demonstrating continued recruitment efficiency. A brief spike in the previous month was linked to a temporary recruitment pause, but corrective action ensured performance returned to target by the following month.

The Trust maintains close oversight of TTH metrics, with any increases promptly escalated and reviewed in partnership with North London Partners Shared Services. This proactive and collaborative approach enables early identification of issues and supports continuous improvement in recruitment processes.

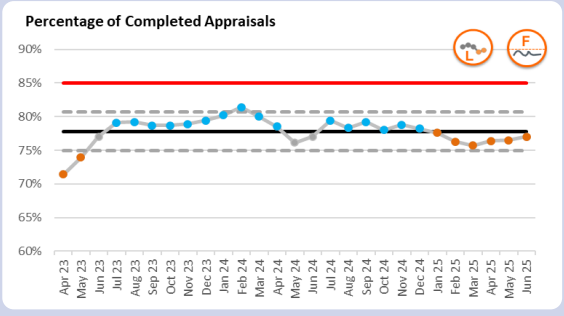
Sickness Absence



Sickness absence rates have remained above the Trust's target of 3.5% since September 2024, though a steady month-on-month decline is being observed.

Targeted support is in place to address both short-term and long-term absence, with hotspot areas under active review. Divisional teams continue to strengthen return-to-work processes, supported by improved engagement with the external Occupational Health Service to ensure timely assessments and promote staff wellbeing. To enhance management capability, the Workforce team is developing digital training for line managers, improving access to essential resources and supporting sustainable service delivery.

Appraisals



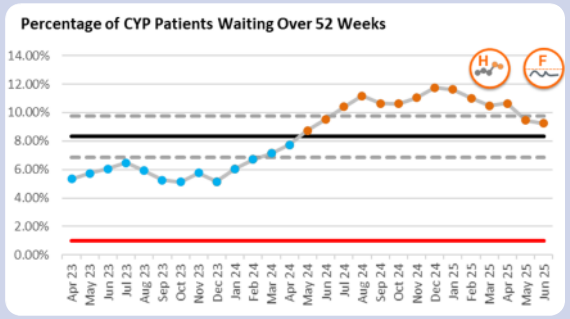
Appraisal completion has increased by 0.5% since the previous month, reflecting a positive trajectory in workforce engagement and performance development. The Trust continues to prioritise both the quality and consistency of appraisals, with improvement efforts aligned to areas identified in the staff survey. The Organisational Development (OD) team will be delivering targeted workshops designed to support both appraisers and appraisees in having structured, meaningful conversations.

To ensure sustained momentum, appraisal completion data is routinely monitored and reviewed at Performance Meetings, alongside detailed reports that are published and shared monthly with all divisions.

Community – Children and Young People

Whittington Health NHS Trust

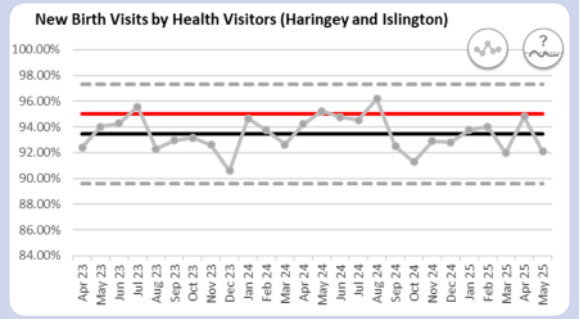
CYP

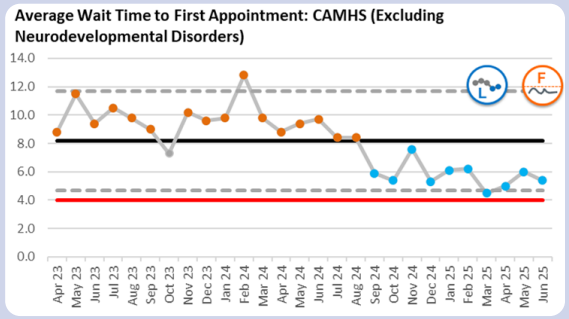


Children and Young People Waiting Over 52 Weeks

The number of children and young people (CYP) waiting over 52 weeks continues to be concentrated in neurodevelopmental pathways, particularly for autism and ADHD assessments. Encouraging progress is being made in Haringey's 0–11s service and Islington's 0–5s service, where reductions in long waits are evident. These improvements are attributed to increased investment in 2024 and successful mobilisation of additional assessment capacity by local teams.

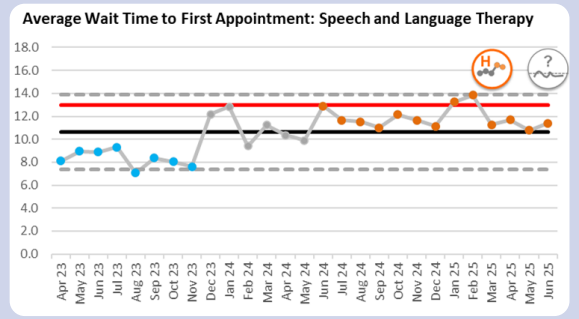
Alongside this, providers across North Central London (NCL) are collaborating to standardise and streamline neurodevelopmental pathways. Despite this coordinated effort, significant historic backlogs remain a challenge to achieving substantial reductions in waiting times.

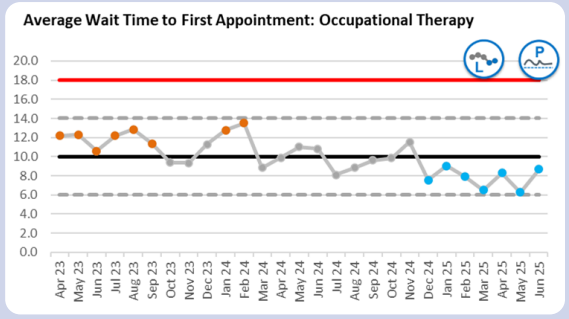




CAMHS Waiting Times

Child and Adolescent Mental Health Services (CAMHS) also continue to show positive reductions in average waiting times. A broad range of teams provide support across CAMHS, with ongoing work focused on improving access to first therapy appointments. Key initiatives include enhanced triage processes to ensure timely and appropriate care for CYP and families.





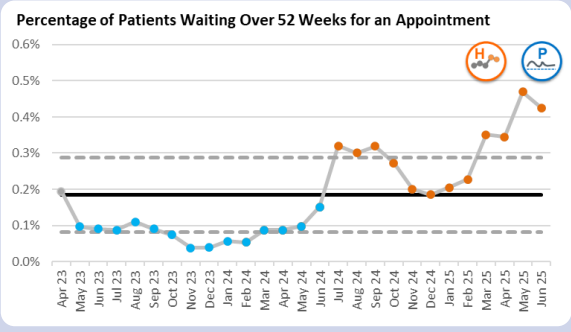
SLT Waiting Times

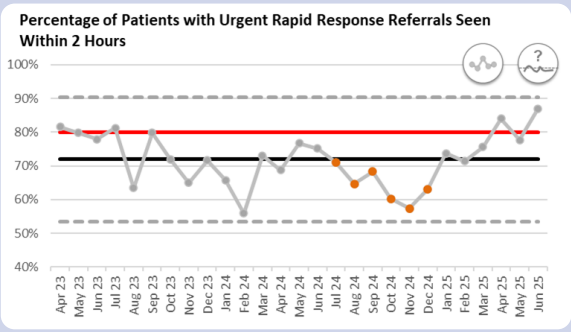
Speech and Language Therapy (SLT) services continue to face pressures in meeting target timeframes for all CYP. In Haringey and Barnet, teams are deploying additional one-off investment from NCL ICB to address the longest waits. While challenges persist, this targeted support is contributing to gradual improvement in service responsiveness.

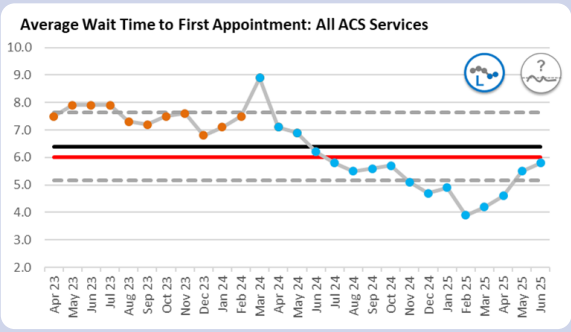
ICARE EQUITY

Community – Adults

Community







Operational challenges persist across select ACS services, prompting continued focus and targeted support. The only service with waits exceeding 52 weeks is **the Islington Stroke Team,** which remains a priority. A recovery plan is in place, and a dedicated operational manager has been seconded to provide improved oversight of processes and practice. Haringey previously faced similar issues but has since recovered.

ACS as a division over all on average the waiting time from referral to first attendance is **38.6 days** against a target of **under 42 days.**

Other services with ongoing waits of 18–30 weeks include:

MSK Routine:

- 80.2% of patients are now seen within six weeks (up from 56.3%)
- Average wait reduced to 3 weeks
- Improvement is linked to one-off £100k funding for February's 'Super Saturday' clinics
- Waiting list continues to grow due to rising referrals from Haringey and Islington
- Q2 pressures expected due to unfilled leaver posts as part of CIP plans; mitigations are being developed

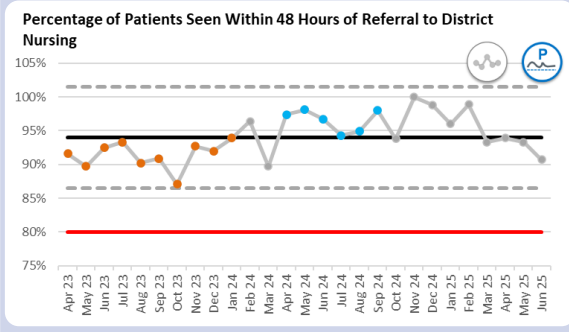
MSK CATS:

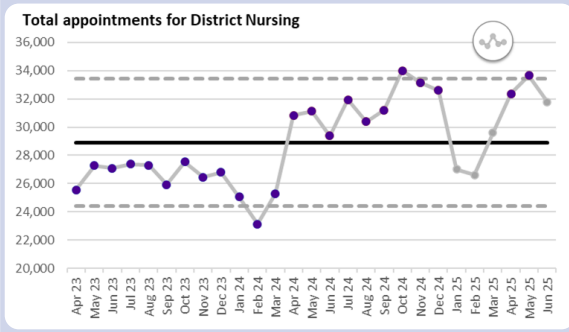
- 72.3% of patients are seen within six weeks (up from 31.9%)
- Average wait is 5.7 weeks
- Gains also linked to 'Super Saturday' clinics
- Referral growth continues to drive up the waiting list, which may impact future performance

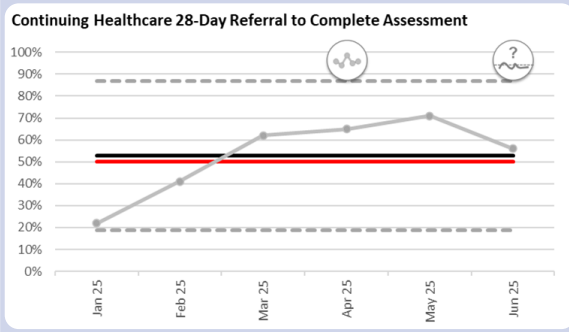
Podiatry: The service continues to face staffing pressures due to sickness and recruitment issues, though March showed some improvement. Long waits remain a key issue. To help address this, patients are being reallocated to Physiotherapy (via funded post), and tighter clinical access/home visit criteria are starting to improve flow.

Rapid Response: exceeds its target of patients seen within 2 hours, however there is an expectation the referrals will increase with a centralised referral system from **Integrated Care Coordination Hub (ICC)** now in operation, a single point of access in line with NHSE priorities for urgent care

Virtual Ward: Low utilisation this for the month of May at 50-60% against a target of 80% utilisation. A promotion programme is being planned to help increase awareness and increase utilisation.







Meeting title	**Trust Board in Public**	**Date: 23rJuly 2025**
Report title	**Finance Report - June (Month 3) 2025/26**	**Agenda item: 13**
Executive director lead	Terry Whittle, Chief Finance Officer	
Report author	Jerry Francine, Director of Operational Finance	
Executive summary	The Trust is reporting a deficit of £7.2m for June, which is £2.8m adverse to plan. The variance is attributed to pay overspends and slippage in delivery of financial efficiency savings. Capital expenditure at month 3 was £1.68m against a plan of £1.02m. The Trust is awaiting confirmation of funding for system and national programmes for delivery in 2025/26. The Trust's cash balance on 30th April was £40.83m, which is £4.28m favourable to plan.	
Purpose:	To note financial performance.	
Recommendation(s)	To note the financial performance to June 2025.	
Risk Register or Board Assurance Framework	BAF risks S1 and S2	
Report history	Finance and Business Development Committee (22/7)	
Appendices	None	

Trust is reporting a deficit of £7.2m at end of June This is £2.7m adverse to plan.

The Trust is reporting a YTD deficit of £7.2m for June, this is £2.8m adverse to plan.

ERF activity at end of June was £0.8m above the ERF cap.

The Trust delivered £3.5m of savings against a target of £6.8m YTD.

The Trust continues to incur pay cost pressures despite a continued reduction in temporary staffing expenditure. Pay expenditure was £5.5m overspent compared to the plan at end of June. Besides unidentified pay CIP other drivers for pay overspend include

- A&E including temporary escalation space - £0.8m
- Enhanced care - £0.4m
- Additional paediatric beds - £0.1m
- Ward general overspends - £0.6m due to additional beds and safer staffing levels.
- Childcare packages - £0.2m
- Unmitigated cost pressures (Appendix 2)

Overall, non-pay was £0.2m overspent YTD. Pressures on non-pay include

- Minerva (winter step-down) costs of £0.3m
- Increased clinical supplies relating to ERF performance of £0.8m
- Overspend on HSL pathology £0.3m
- Community equipment and dressings - £0.1m
- Overspend on histopathology and blood products - £0.3m
- Reactive maintenance - £0.1m

Cash of £40.83m as at 30th June

The Trust's cash balance on 30th June was £40.83m, which is £4.28m favourable to plan.

Confirmed Capital Allocation for 2025-26 is £25.95m

The Trust capital expenditure at end of June was £1.68m against a plan of £1.02m. The capital allocation includes £7.6m of national allocation towards fire remediation works.

Better Payment Practice Performance – 96.51% for non-NHS by value

Overall, the Trust's BPPC is 96.82% by volume and 95.71% by value for the three months year-to-date. The BPPC for non-NHS invoices is 97.01% by volume and 96.51% by value.

Summary of Income & Expenditure Position – Month 3

	In Month			Year to Date			
	Plan	Actual	Variance	Plan	Actual	Variance	Annual Budget
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income							
NHS Clinical Income	28,835	29,423	589	86,712	87,314	602	346,294
High Cost Drugs - Income	949	780	(169)	2,858	2,985	128	11,441
Non-NHS Clinical Income	1,657	1,749	92	4,970	5,377	407	19,881
Other Non-Patient Income	2,387	2,595	208	7,162	7,602	439	28,649
Elective Recovery Fund	5,219	6,068	849	15,364	16,213	849	62,321
	39,047	**40,615**	**1,569**	**117,066**	**119,491**	**2,425**	**468,586**
Pay							
Agency	(30)	(407)	(377)	(91)	(1,895)	(1,804)	(261)
Bank	(92)	(1,891)	(1,799)	(255)	(6,034)	(5,780)	(990)
Substantive	(28,547)	(28,051)	496	(86,500)	(84,447)	2,053	(345,698)
	(28,669)	**(30,349)**	**(1,680)**	**(86,845)**	**(92,376)**	**(5,531)**	**(346,949)**
Non Pay							
Non-Pay	(8,196)	(8,217)	(21)	(24,588)	(24,640)	(52)	(82,396)
High Cost Drugs - Exp	(1,003)	(951)	52	(3,009)	(3,195)	(186)	(12,034)
	(9,199)	**(9,168)**	**31**	**(27,597)**	**(27,835)**	**(239)**	**(94,430)**
EBITDA	**1,179**	**1,098**	**(81)**	**2,624**	**(720)**	**(3,344)**	**27,206**
Post EBITDA							
Depreciation	(1,906)	(1,781)	125	(5,717)	(5,327)	390	(22,869)
Interest Payable	(73)	(44)	29	(219)	(151)	68	(876)
Interest Receivable	139	168	29	442	556	114	1,185
Dividends Payable	(506)	(506)	0	(1,518)	(1,518)	0	(6,072)
P/L On Disposal Of Assets	0	0	0	0	0	0	0
	(2,346)	**(2,163)**	**183**	**(7,012)**	**(6,439)**	**573**	**(28,632)**
Reported Surplus/(Deficit)	**(1,167)**	**(1,065)**	**102**	**(4,388)**	**(7,160)**	**(2,772)**	**(1,426)**
Impairments	0	0	0	0	0	0	0
IFRS & Donated	(5)	(6)	(1)	(15)	(18)	(3)	(60)
Reported Surplus/(Deficit) after Impairments and IFRIC12	**(1,172)**	**(1,071)**	**101**	**(4,403)**	**(7,178)**	**(2,775)**	**(1,486)**

- Actual deficit for June is £1m (excluding donated asset depreciation and impairments), £0.1m better than planned.
- The YTD position includes non-recurrent benefits of £2.8m.
- Though the Trust is reporting an year to date over performance of £0.8m on its ERF activity, there is a significant risk of not being paid for activity above ERF plan.
- Work is progressing with all clinical and corporate divisions on management of cost pressures brought forward from 2024/25 and those arising in 2025/26. An extrapolation of the cost pressure position for the year would represent a significant risk to achievement of the financial plan. Included in Appendix 2 is the impact of unmitigated cost pressure on the pay overspend (£1.4m).

2.0 Income and Activity Performance

2.1 Income Performance – June

Income	In Month Income Plan £000's	In Month Income Actual £000's	In Month Variance £000's	YTD Income Plan £000's	YTD Income Actual £000's	YTD Variance £000's
A&E	2,395	2,359	(36)	4,712	4,641	(71)
Elective	2,461	2,747	286	4,922	5,344	422
Non-Elective	5,611	6,181	570	11,058	11,659	601
Critical care	638	330	(307)	1,255	782	(473)
Outpatients	5,699	6,214	516	11,398	12,365	967
Direct access	1,231	1,032	(199)	2,462	2,067	(395)
Community	6,899	6,899	0	13,797	13,797	0
Other clinical income NHS	4,851	4,442	(409)	39,965	39,643	(322)
NHS Clinical Income	**29,784**	**30,204**	**420**	**89,569**	**90,299**	**730**
Non NHS clinical income	1,657	1,749	92	4,970	5,377	407
Elective recovery fund (ERF)	5,219	6,068	849	15,364	16,213	849
Income From Patient Care Activities	**36,659**	**38,020**	**1,361**	**109,904**	**111,890**	**1,986**
Other Operating Income	**2,387**	**2,595**	**208**	**7,162**	**7,602**	**439**
Total	39,047	40,615	1,569	117,066	119,491	2,425

- Income was £2.4m above plan at end of June. £0.7m NHS clinical income, £0.8m ERF, £0.4m related to Non-NHS clinical income and £0.4m other operating. Overperformance on income is offset by related expenditure overspends.

- NHS Clinical income driven by £0.2m prior year, £0.2m imaging overperformance and £0.2m NHSE drug performance. Imaging and Drugs overperformance is offset by additional expenditure.

- Non-NHS clinical income overperformance of £0.4m mainly relates to start for life workforce pilot extension grant offset by additional expenditure.

2.2 Elective recovery fund (ERF) – June

- In May ERF overperformance was not reported due to constraints on ICB funding of ERF. Trusts within NCL ICB have now been advised to report actual performance. The £0.8m in month overperformance is overperformance for April to June.

- EIM and S&C are the main drivers of the overperformance and the overperformance is across inpatients and outpatients.

ERF Income by POD

POD	Annual Plan £000's	In Month Income Plan £000's	In Month Income Actual £000's	In Month Income Variance £000's	YTD Income Plan £000's	YTD Income Actual £000's	YTD Income Variance £000's
DC	22,493	1,912	1,933	21	5,555	5,743	188
EL	6,915	588	716	128	1,708	2,059	351
OP First	22,796	1,858	2,589	730	5,603	5,833	230
OP Procedure	10,117	860	830	(30)	2,498	2,578	80
Grand Total	62,321	5,219	6,068	849	15,364	16,213	849

ERF Performance by Division

Division	Annual Allocation	YTD Budget	YTD Actuals	YTD Variance
Acw	8,101	2,002	2,042	41
Children & Young People	7,318	1,808	1,693	-115
Emergency & Integrated Medicin	22,360	5,531	5,859	328
Surgery & Cancer	24,476	6,050	6,681	631
Corporate Central	65	-27	-62	-36
Grand Total	**62,321**	**15,364**	**16,213**	**849**

Top 5 specialties overperforming against ERF plan

- Gastroenterology £0.4m
- Urology £0.2m
- General Surgery £0.2m
- Spinal surgery £0.2m
- Imaging £0.1m

3. Expenditure – Pay & Non-pay

3.1 Pay Expenditure

Pay expenditure for June was £30.3m. This is an overall decrease of £0.3m from the June position.

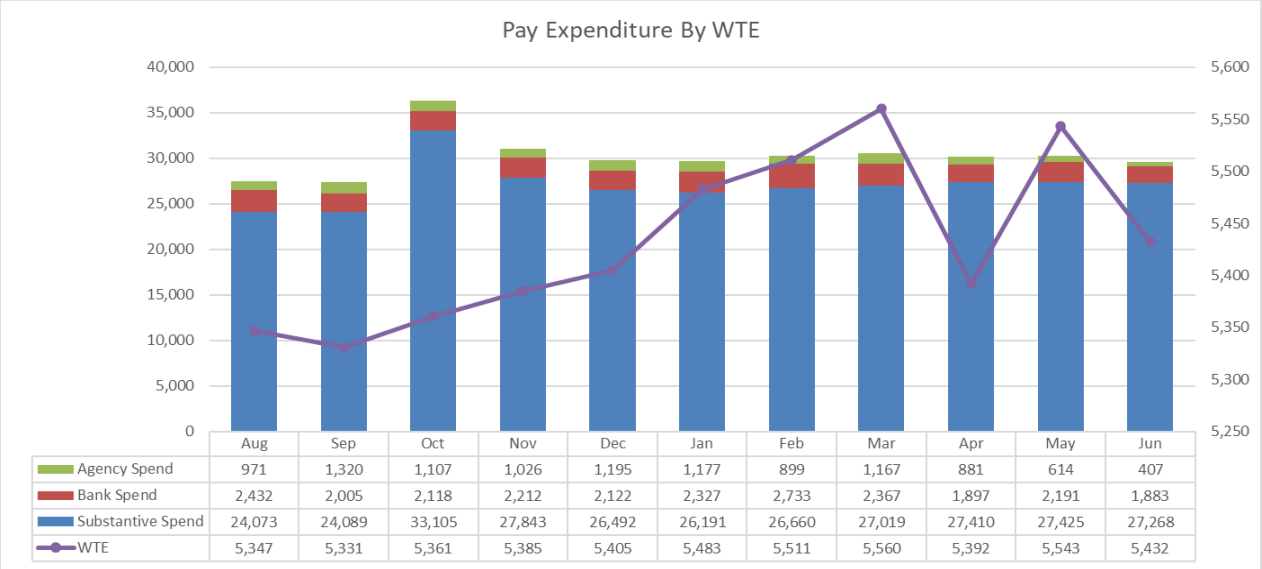
- Reduction in substantive pay of £157k due to bank holiday enhancements in prior month and non-recurrent benefit of £63k in June.
- The Trust is £0.6m below the bank and agency spend cap YTD. Temporary staffing spend in June was £0.5m lower compared to May due to enhanced pay controls and reduction in unfunded beds.

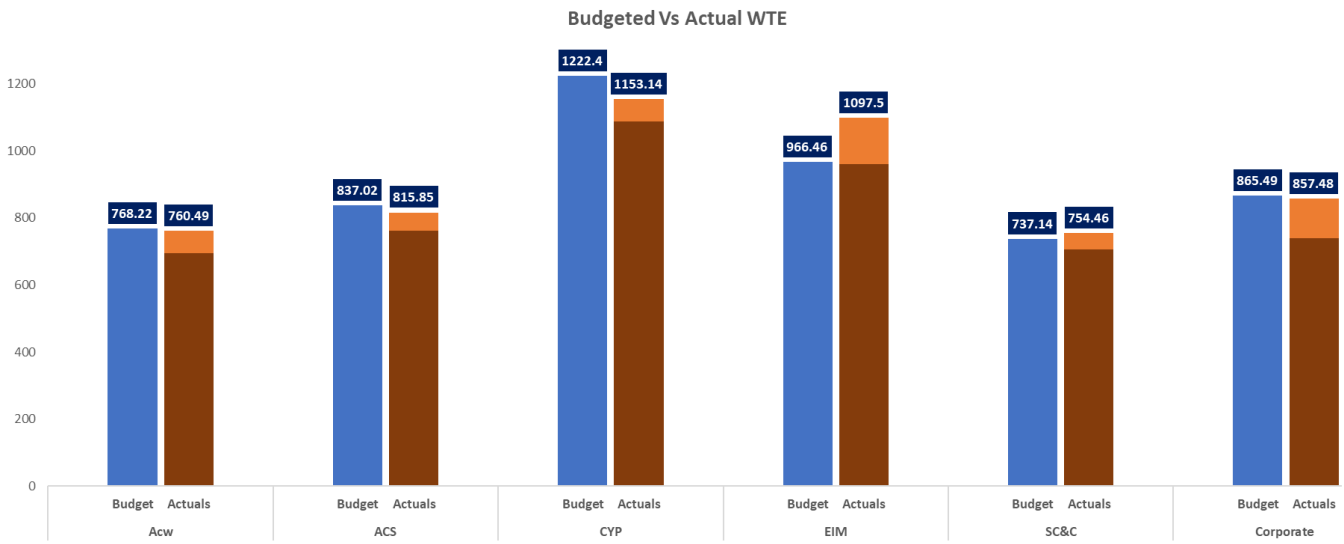
	2024-25				2025-26			
	Dec	Jan	Feb	Mar	Apr	May	Jun	Mov^t
Agency	1,195	1,177	899	1,167	881	614	407	(208)
Bank	2,122	2,327	2,733	2,367	1,897	2,191	1,883	(309)
Substantive	26,492	26,191	26,660	27,019	27,410	27,425	27,268	(157)
Total Operational Pay	**29,810**	**29,695**	**30,291**	**30,554**	**30,188**	**30,231**	**29,557**	**(673)**
Non Operational Pay Costs	(554)	304	(47)	19,848	1,141	467	792	325
Total Pay Costs	**29,256**	**29,999**	**30,244**	**50,402**	**31,329**	**30,698**	**30,349**	**(349)**

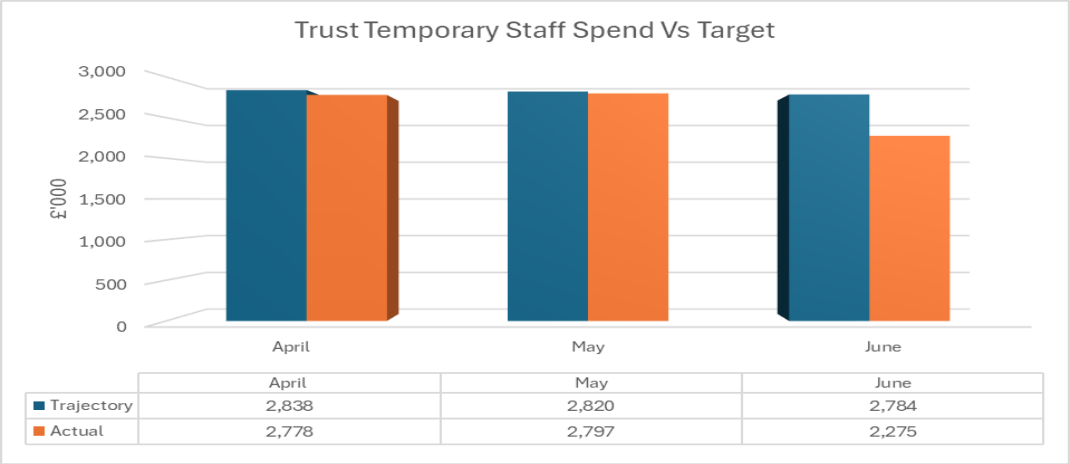
Enhanced Care

As part of additional reporting requirements from NHSE, Trusts are required to report on temporary staffing usage for enhanced care. The Trust booked 8,856 hours for enhanced care in June. Additional costs relating to enhanced care are one of the drivers for pay overspend.

		Hours Booked for Enhanced Care											
Category	**Division**	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
Agency	CYP	84	336	144									
	SC&C	176	24	24									
	EIM	204	0	48									
		464	**360**	**216**									
Bank	CYP	252	1,044	900									
	SC&C	636	1,236	816									
	EIM	5,508	7,500	6,924									
		6,396	**9,780**	**8,640**									
Total		**6,860**	**10,140**	**8,856**									







Agency spend excludes non-recurrent benefits included in corporate central

3.2 Non-pay Expenditure

Non-pay spend excluding high-cost drugs decrease of £0.4m mainly relates to the following:

- Non recurrent VAT benefit in month of £0.7m and release of central non pay accruals relating to historic invoices of £0.5m.
- There was an increase of bad debt provision of £0.5m compared to previous month.
- Continued increase in clinical supplies of £0.3m partly driven by insulin pumps and consumables and sterile disposables.

	2025-24				2025-26			
Non-Pay Costs	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Mov^t**
Supplies & Servs - Clin	4,582	4,066	3,716	4,582	3,576	4,160	4,447	287
Supplies & Servs - Gen	404	306	352	380	440	274	356	82
Establishment	197	375	337	413	317	368	309	(59)
Healthcare From Non Nhs	137	97	80	137	115	97	(151)	(248)
Premises & Fixed Plant	2,547	2,458	2,263	2,829	2,130	2,101	2,297	196
Ext Cont Staffing & Cons	141	164	306	525	194	127	221	94
Miscellaneous	824	1,568	979	3,386	1,034	1,468	726	(742)
Chairman & Non-Executives	11	11	11	11	11	11	11	0
Non-Pay Reserve	0	0	0	0	0	0	0	0
Total Non-Pay Costs	**8,844**	**9,044**	**8,043**	**12,264**	**7,816**	**8,607**	**8,217**	**(391)**

Excludes high-cost drug expenditure and depreciation.
Included in miscellaneous is CNST premium, Transport contract, professional fees, and bad debt provision.

Miscellaneous Expenditure Breakdown

	2025-24				2025-26			
Miscellaneous Breakdown	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Mov^t**
Ambulance Contract	199	224	184	216	159	188	173	(15)
Other Expenditure	(636)	(198)	34	(1,236)	107	233	(1,159)	(1,391)
Audit Fees	13	13	13	13	14	15	14	(1)
Provision For Bad Debts	333	174	(664)	1,754	(481)	(392)	156	548
Cnst Premium	765	765	754	766	847	773	810	37
Fire Security Equip & Maint	13	8	5	17	2	23	33	10
Interpretation/Translation	38	(6)	54	104	31	0	69	69
Membership Subscriptions	149	126	128	128	139	145	133	(12)
Professional Services	(51)	289	348	804	160	410	385	(25)
Research & Development Exp	1	1	2	58	0	1	1	(0)
Security Internal Recharge	0	41	0	0	12	11	13	1
Teaching/Training Expenditure	(3)	128	120	759	42	58	95	37
Travel & Subs-Patients	3	3	1	3	0	3	2	(1)
Work Permits	0	0	0	0	0	0	0	0
Write Down Of Inventories	0	0	0	0	0	0	0	0
Total Non-Pay Costs	**824**	**1,568**	**979**	**3,386**	**1,034**	**1,468**	**726**	**(742)**

3.3 Cost Improvement Programme (CIP)

The CIP (Cost Improvement Programme) target in the Trust plan for 2025–26 is £22m. The internal target set for clinical divisions, and corporate services, is £27m to account for a proportion of the brought forward liability associated with non-recurrent savings schemes in the prior year (2024/25). The increased internal efficiency target (of £5m) has been set to focus improvement in the Trust underlying financial position, which will otherwise deteriorate due to unfunded growth in the recurrent cost-base.

As of Month 3, £16.5 million has been identified. Of this, 80% of the schemes are currently under development - being worked upon by Divisions, awaiting full approval (e.g., completed Project Initiation Document and Quality Impact Assessment).

The unidentified efficiency gap is £5.5m to the plan requirement and £10.5m when measured against the internal target.

Trust is reporting actual CIP delivery of £3.5m against a plan requirement of £4.7m. When compared to the internal target, there is a YTD shortfall of £3.4m (50% of the YTD target).

£1.4m of non recurrent benefits in month were released centrally.

Divisions	25/26 CIP Target '£000	YTD CIP target '£000	YTD Actuals Recurrent '£000	YTD Actuals Non-Recurrent '£000	Total YTD Actuals Total '£000	YTD Variance to target '£000	Total Forecast '£000
ADULT COMMUNITY	3,560	890	67	0	**67**	(823)	3,560
CHILDREN & YOUNG PEOPLE	4,464	1,116	25	0	**25**	(1,091)	4,464
EMERGENCY & INTEGRATED MEDICINE	4,830	1,208	3	0	**3**	(1,205)	4,830
SURGERY & CANCER	4,651	1,163	3	134	**137**	(1,026)	4,651
ACW	4,968	1,242	51	0	**51**	(1,191)	4,968
DIVISIONS TOTAL	**22,473**	**5,618**	**149**	**134**	**283**	**(5,336)**	**22,473**
CORPORATE SERVICES	2,585	646	58	0	**58**	(588)	2,585
ESTATES AND FACILITIES	2,272	568	48	221	**268**	(300)	2,272
CENTRAL	0	0	1,385	1,464	**2,849**	2,849	0
TRUST TOTAL	**27,330**	**6,833**	**1,639**	**1,819**	**3,458**	**(3,374)**	**27,330**

4.0 Statement of Financial Position (SoFP)

The net balance on the Statement of Final Position as of 30th June 2025 is £206.41m, £1.07m lower than 31st May 2025, as shown in the table below.

Statement of Financial Position as at 30th June 2025	2024/25 M12 Balance	2025/26 M02 Balance	2025/26 M03 Balance	Movement in Month
	£000	£000	£000	£000
NON-CURRENT ASSETS:				
Property, Plant And Equipment	242,623	240,276	239,105	(1,171)
Intangible Assets	4,079	3,696	3,503	(194)
Right of Use Assets	36,104	35,259	34,836	(423)
Assets Under Construction	18,227	19,462	20,090	628
Trade & Other Rec -Non-Current	805	567	548	(19)
TOTAL NON-CURRENT ASSETS	**301,837**	**299,260**	**298,082**	**(1,178)**
CURRENT ASSETS:				
Inventories	1,308	1,394	1,500	105
Trade And Other Receivables	25,217	19,934	23,474	3,540
Cash And Cash Equivalents	46,276	41,248	40,828	(420)
TOTAL CURRENT ASSETS	**72,801**	**62,577**	**65,802**	**3,225**
CURRENT LIABILITIES				
Trade And Other Payables	(94,855)	(88,593)	(93,440)	(4,847)
Borrowings: Finance Leases	(1,025)	(1,025)	(1,025)	0
Borrowings: Right of Use Assets	(4,370)	(4,370)	(4,370)	0
Borrowings: Dh Revenue and Capital Loan - Current	(116)	(116)	(116)	0
Provisions for Liabilities and Charges	(227)	(375)	(224)	150
Other Liabilities	(2,216)	(2,652)	(1,609)	1,043
TOTAL CURRENT LIABILITIES	**(102,809)**	**(97,130)**	**(100,784)**	**(3,654)**
NET CURRENT ASSETS / (LIABILITIES)	**(30,007)**	**(34,553)**	**(34,982)**	**(429)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**271,830**	**264,706**	**263,099**	**(1,607)**
NON-CURRENT LIABILITIES				
Borrowings: Dh Revenue and Capital Loan - Non-Current	(1,392)	(1,392)	(1,392)	0
Borrowings: Finance Leases	(1,282)	(1,031)	(906)	125
Borrowings: Right of Use Assets	(32,055)	(31,234)	(30,823)	411
Provisions for Liabilities & Charges	(23,510)	(23,565)	(23,565)	0
TOTAL NON-CURRENT LIABILITIES	**(58,239)**	**(57,222)**	**(56,686)**	**536**
TOTAL ASSETS EMPLOYED	**213,591**	**207,484**	**206,413**	**(1,071)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	138,320	138,320	138,320	0
Retained Earnings	1,634	(4,473)	(5,544)	(1,071)
Revaluation Reserve	73,637	73,637	73,637	0
TOTAL TAXPAYERS EQUITY	**213,591**	**207,484**	**206,413**	**(1,071)**

The most significant movements in the month to 30th June 2025 were as follows:

NON-CURRENT ASSETS

Non-Current assets closed at £298.08m on 30th June 2025, a net decrease of £1.18m from previous month due the following:

- Capital expenditure for owned assets £0.61m
- Monthly depreciation: Owned assets (£1.37m)
- Monthly depreciation: Right of Use assets (£0.42m)

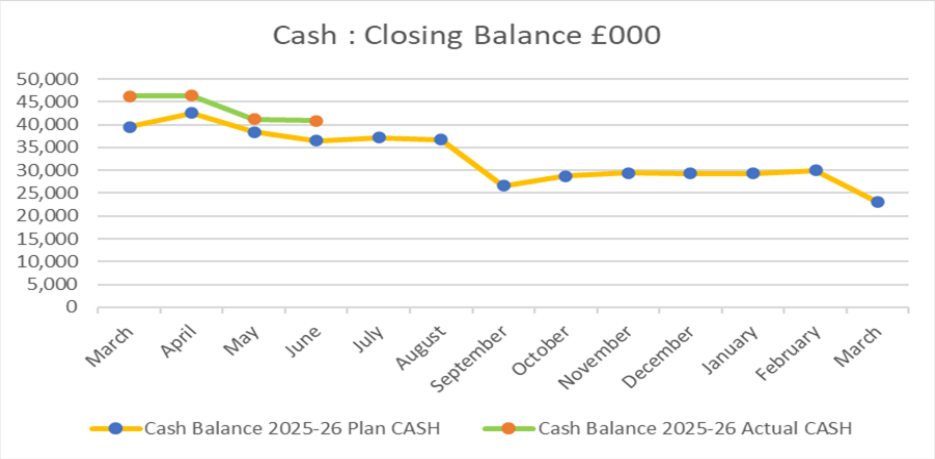
CURRENT ASSETS
Current assets closed at £65.80m in June 2025, a net increase of £3.23m from the previous month. Principal movements comprised Trade and Other Receivables increase of £3.54m and cash decrease of £0.42m as detailed below.

CURRENT LIABILITIES
Current liabilities increased by £3.65m in month. An increase of £4.85m in Trade and Other Payables is partially offset by a £1.19m decrease in Deferred Income (other Liabilities).

NON-CURRENT LIABILITIES
Non-Current liabilities closed at £56.67m in June 2025, a net decrease of £0.54m from previous month due predominantly to the repayment of Right of Use finance lease liabilities and other finance lease liabilities.

RETAINED EARNINGS
Retained Earnings closed at (deficit) (£5.54m) in June 2025, a net increase in deficit from the previous month's figure of (deficit) (£1.07m).

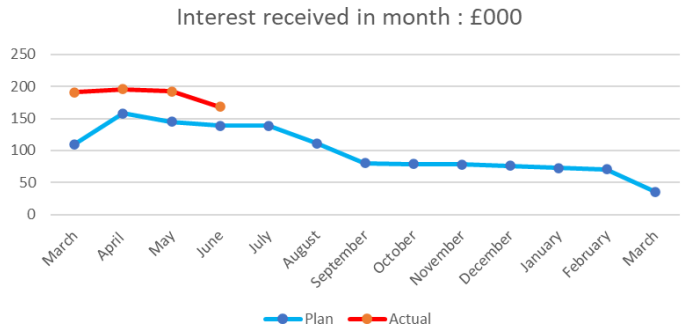
CASH
The Trust's cash balance at 30th June was £40.83m, which is £4.28m favourable to Plan, and a decrease of £0.42m from May's closing balance.



The in-month decrease is primarily due to the in-month reported deficit.

The 2025/26 Plan encompasses a reduction of £16.57m of cash over the 12 months to 31st March 2026. The Trust forecasts and closely monitors its cash position against Plan.

Interest Received
The interest received during June 2025 was £0.17m, which is 0.03m above Plan. June reflected the impact the favourable balance cash balance during month.



5.0 Capital Expenditure

The capital allocation for 2025-26 has increased to £25.95m following confirmation of £7.60m for Estates Safey Funding for the Fire Remediation programme and Solar PV Systems £0.42m; also including £5.48m Right of Use asset remeasurements and additions.

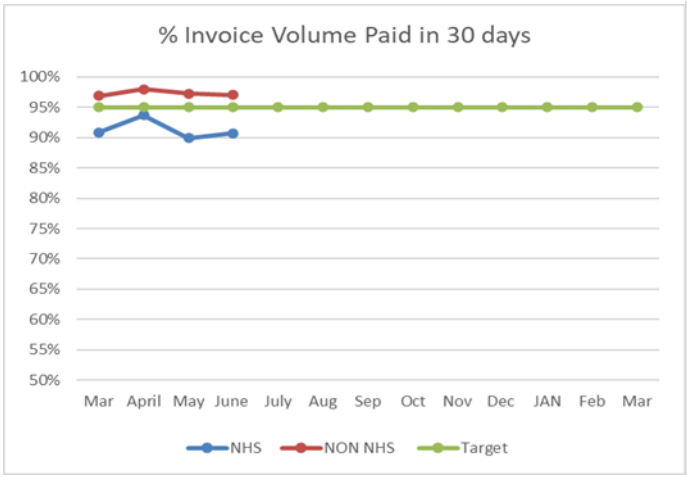
Capital Expenditure Summary Month 03: 30th June 2025

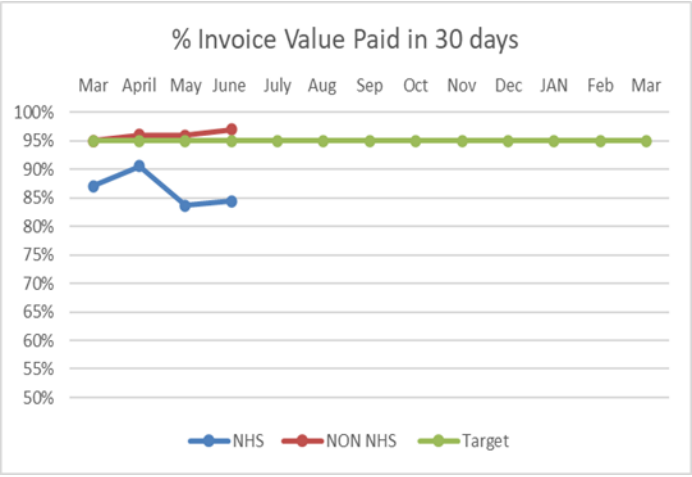
all figures: £000	Allocation				In Month			Year to Date		
	Allocation	Subsequent Allocation	Total Allocation	Total Programme	In-Month plan	Actual	Variance	YTD plan	Actual	Variance
ESTATES AND STRATEGIC PROJECTS CAPITAL PROGRAMME 2025/26	9,030	7,600	16,630	16,630	369	459	90	923	1,494	571
ICT	1,500		1,500	1,500	16	0	(16)	40	0	(40)
Solar PV systems		417	417	417	0	0	0	0	0	0
PACS	400		400	400	0	0	0	0	0	0
Equipment	500		500	500	16	0	(16)	40	0	(40)
Divisions	200		200	200	8	0	(8)	20	0	(20)
Contingency	425		425	425	0	0	0	0	0	0
Pharmacy Robot	402		402	402	0	0	0	0	0	0
Total Owned Assets	**12,457**	**8,017**	**20,474**	**20,474**	**409**	**459**	**50**	**1,023**	**1,494**	**471**
CDC Phase 3	0	0	0	0	0	1	1	0	184	184
RoU assets (new leases)	0		0	0	0	0	0	0	0	0
RoU assets (remeasures)	5,476		5,476	5,476	0	0	0	0	0	0
Total Right of Use	**5,476**	**0**	**5,476**	**5,476**	**0**	**0**	**0**	**0**	**0**	**0**
Total	**17,933**	**8,017**	**25,950**	**25,950**	**409**	**460**	**51**	**1,023**	**1,678**	**655**

The year-to-date expenditure at M03 is £1.68m against plan of £1.02m.

Better Payments Practice Code – Monitoring for 2024/25

The Trust is signed up to the NHS commitment to improve its Better Payment Practice Code (BPPC) whereby the target is to pay 95% of all invoices within the standard credit terms. Overall, the Trust's BPPC is 96.82% by volume and 95.71% by value for the 3 months year-to-date. The BPPC for non-NHS invoices is 97.01% by volume and 96.51% by value for the 3 months year-to-date. The charts below show performance for March to June 2025.


% Invoice Volume Paid in 30 days
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
Mar April May June July Aug Sep Oct Nov Dec JAN Feb Mar
NHS
NON NHS
Target


% Invoice Value Paid in 30 days
Mar April May June July Aug Sep Oct Nov Dec JAN Feb Mar
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
NHS
NON NHS
Target