NHS
Whittington Health
NHS Trust

Annual Report 2024/25

Helping local people live longer, healthier lives

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NHS Trust

2024/25 Annual Report

v1.13


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
SOCIAL CARE
LOCAL COUNCILS
INNOVATIVE EDUCATION & RESEARCH

Chair and Chief Executive's introduction

Welcome to our 2024/25 annual report which outlines how, over the past year, the tremendous work of the staff and volunteers of Whittington Health NHS Trust has supported over 500,000 people living across North Central London and beyond to live longer, healthier lives.

Over the year we have continued to:

- provide safe care to our patients as we progressed plans to tackle the post-COVID-19 backlog in some services
- work collaboratively with our partners in the North Central London Integrated Care System, the North Central London Health (provider) Alliance and University College London Hospitals NHS Foundation Trust
- support the health and wellbeing and resilience of our brilliant and dedicated staff who have maintained their excellent resilience in the face of considerable pressures
- progress improvements in our workplace culture
- improve our partnership work with local authority partners to tackle local health inequalities

We are pleased to highlight the following significant achievements, set against our four strategic objectives. They are the result of teams from across the organisation pulling together to make great things happen. There are a number of case studies contained in our annual report which help to demonstrate the achievements of which we are proud.

Delivering outstanding, safe and compassionate care

- The national Care Quality Commission (CQC) cancer patient experience survey this year showed that, with an overall score of 9 out of 10, Whittington Health is now the highest ranked in North Central London, and second in London equal to the prestigious specialist cancer hospital – the Royal Marsden, having jumped 39 rankings from last year.
- We delivered significant improvements in our performance against the three national cancer standards for diagnosis.
- In maternity services, we implemented a new obstetric triage system. In triage, our maternity service users ranked us in the top five highest scoring trusts in the CQC's maternity survey.
- Performance against the four-hour emergency department standard averaged just under 71% last year, up over 5% despite the emergency department seeing nearly 5,000 more patients than last year however we did see too many 12 hour waits.
- At the start of the year, on average, 667 people had been waiting more than a year for planned care. By the end of the financial year, we had cut that to 353.
- There was a successful implementation of the national Patient Safety Incident Response Framework which replaced the Serious Incident Framework.

Empower, support and develop engaged staff

This objective is important because it is about how we support and enable all our people to develop and thrive at work, helping to support the excellence of our services.

- We are pleased that approximately 20% of our staff completed staff development courses last year.
- The annual staff survey showed that Whittington Health's engagement score which points to how committed people are to their organisation, role, and work, as well as how involved, enthusiastic, and dedicated they are, is above the NHS national average. Similarly, the survey outcomes showed that the morale of our staff was up this year, building on improvements over the past two years.
- We have also bolstered our organisational development team including the health and wellbeing support and development available to colleagues from across the organisation.
- We responded to feedback from the 2023 NHS staff survey by providing £50k of funding for reasonable adjustments for staff to continue to work if they have disability or long-term condition.

Integrate care with partners and promote health and wellbeing

Whittington Health has been a collaborative and engaged partner, as follows:

- We worked alongside other North Central London partners to develop, consult and agree proposals for maternity and neonatal services, otherwise known as Start Well. The decision making business case meaning our maternity and neonatal units will stay open was approved setting us on course for a bright future for our services
- Building on our long history of working together, Whittington Health NHS Trust and University College London Hospitals NHS Foundation Trust (UCLH) agreed that there is a case for closer collaboration to improve clinical outcomes and to ensure greater sustainability for local services. This collaboration is clinically and operationally driven and, importantly, this is not about merging, as both organisations remain separate.
- This year we strengthened oncology services, built on our provision of the UCLH@Home (nurse-led virtual ward); and developed a joint theatre plan to ensure theatre capacity was utilised across both sites for patients requiring elective treatment.

Outside the UCLH partnership, we continued to innovate to keep local people healthy. The following examples are highlighted:

- Our virtual ward service expanded its virtual bed base, which helped us to keep people out of hospital, especially over winter. The service has also expanded remote monitoring to keep its patients even safer.
- We launched the Islington Complex Virtual Ward, which delivers high-acuity, hospital-level care in the community, a collaboration between Whittington Health and UCLH consultants to provide cross-Trust integrated delivery of care.
- We also saw much deserved recognition for our Multi Agency Care and Coordination (MACC) team in Haringey, whose successful approach was used as a case study in NHS England's Chief Medical Officer's annual report.
- Our neonatal intensive care unit team were the first in London to receive a gold accreditation from the charity Bliss.
- Our commitment to advancing health equity for our patients is shown in the annual report's performance section where we publish information on waiting times by ethnicity and deprivation.

- Following the temporary closure of Simmons House, extensive work with North Central East London Provider Collaborative (NCEL) has resulted in an interim 18 month plan to augment community home treatment and increase beds at the Beacon Unit.

Transform and deliver innovative, financially sustainable services

- We ended the year with a deficit of 13.1m (measured on a control total basis) at the end of March, £2.2m adverse to plan. Thanks are due to every single person across the organisation who spent every Whittington Health pound wisely. It also worth remembering that doing so was no mean feat, as we managed to find nearly £15 million in cost saving efficiencies last year.
- One of the ways we have done this was by reducing the amount we spend on agency staff by 20%.
- We invested £5.8m last year upgrading the power infrastructure on our hospital site as part of our green programme. Future projects, including our maternity transformation, will require this extra power boost.
- We secured over £400,000 from the Government to fund the installation of solar panels on five of our health centres in the community. Once installed, they will also save us over £40,000 a year in electricity costs, as well as helping to save the planet from the climate crisis.
- We also invested significant sums of capital funding to totally refurbish theatres 1 and 2, which will help to keep patients and colleagues even safer.

We also recognise the overwhelming help and response of our volunteers, as well as the charitable donations received from both local people and organisations to help support our patients and staff. We are very grateful to our volunteers, local people and organisations.

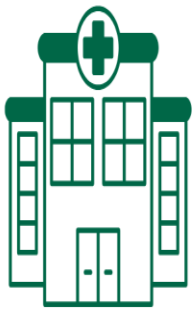
There were several changes to our board and senior leadership team in 2024/5. On the Trust Board, we welcomed Charlotte Hopkins who replaced Clarissa Murdoch as our acting chief medical officer, and Mark Emberton who replaced Naomi Fulop as the University College London-nominated non-executive director. We would also like to thank Clare Dollery who led the executive team as acting chief executive this financial year. The achievements shown within our annual report are testament to her excellent leadership, drive and steadfast stewardship of the team, and the Trust. We are very grateful to her.

Baroness Julia Neuberger DBE
Trust Chair

Selina Douglas
Chief Executive

Dr Clare Dollery
Chief Medical Officer

A day in the life at Whittington Health in 2024/25

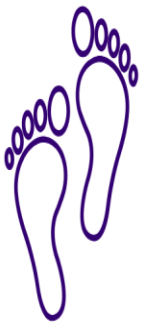


ED attendances

298

Community Nursing

724



Births

7

Dental Appointments

138

Physio and MSK Appointments

239

Virtual Appointments

191

Day cases

72

School Appointments

156

PERFORMANCE REPORT

Overview

Whittington Health is one of London's leading integrated care organisations – helping local people to live longer, healthier lives.

Whittington Health provides hospital and community care services to over half a million people living in Islington and Haringey as well as those living in Barnet, Enfield, Camden and Hackney. During 2024/25, we provided a comprehensive range of acute and community health services, and we also provided dental services in ten London boroughs. Every day, we aim to provide high quality and safe healthcare to people either in our hospital, in their homes or in nearby clinics. We are here to support our patients throughout their healthcare journey – this is what makes us an integrated care organisation.

Our services and our approach are driven by our vision

We have an excellent reputation for being innovative, flexible and responsive to the changing clinical needs of the local population, and for leading the way in the provision of integrated community and hospital services. We are treating more patients than ever before, and we are dedicated to improving services to deliver the best care for our patients, with a clear focus on integrating care for women, children, and the adult and frail.

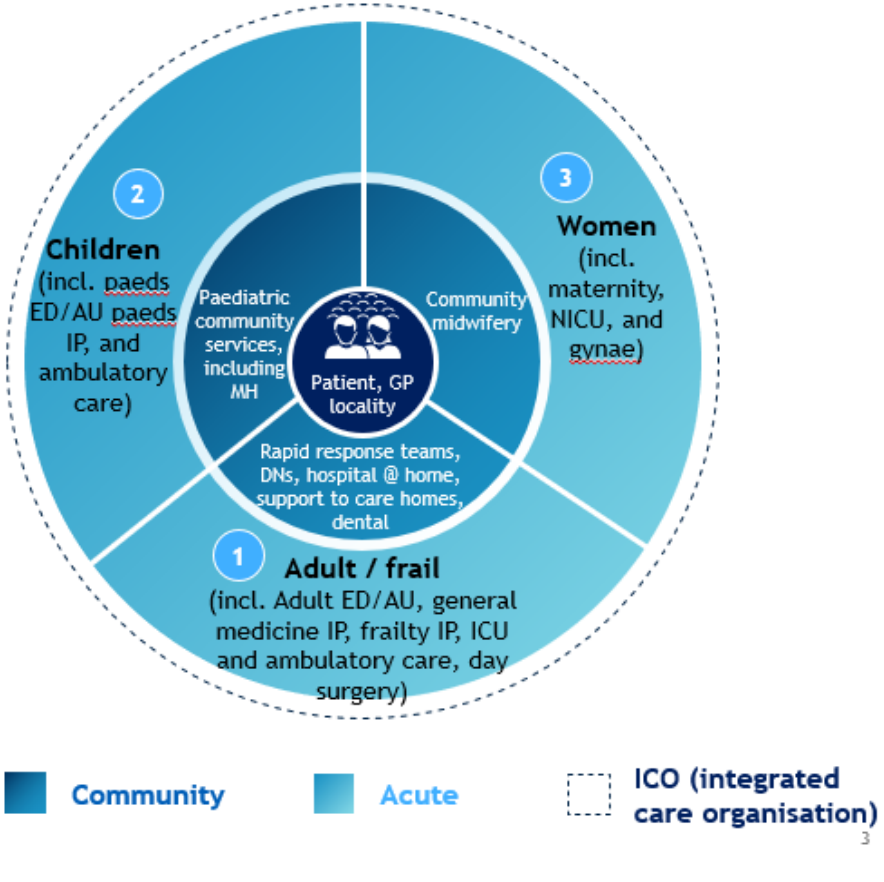
Trust strategy

The Trust's four strategic objectives and underpinned by linked annual corporate aims, whose delivery is monitored each quarter by the Board.

Service strategy

SERVICE STRATEGY

integrating care in all settings supporting population needs across three core pillars to deliver outstanding community and hospital services



Long term strategic objectives and annual corporate objectives

Within each of our four strategic objectives we have set out more specifically what we mean and what our ambition is through our annual corporate objectives:

Strategic objective	**Deliver outstanding safe, compassionate care in partnership with patients**
Annual corporate objective 1	**Deliver safe & effective care – continuous improvement in safety culture & delivery of best practice care:**
➢ Implement the new NHS Patient Safety Incident Response Framework (PSIRF). ➢ Develop Mental Health key priorities ➢ Implement national maternity services recommendations and local priorities	
Annual corporate objective 2	**Improve performance for better patient experience and outcomes**
➢ Deliver a 78% performance against the four-hour access standard in ED ➢ Deliver cancer standards	
Annual corporate objective 3	**Improve population health & addressing health inequalities:**
➢ Improve ethnicity data collection ➢ Publish waiting times by deprivation and ethnicity	
Strategic objective	**Empower, support and develop engaged staff**
Annual corporate objective 4	**Improve Staff Engagement & Wellbeing:**
➢ Develop the People Strategy further and deliver our improvement plan to improve staff working lives ➢ Deliver equalities & inclusion programmes to actively tackle disparities in staff experience	
Annual corporate objective 5	**Recruit, develop and retain talent:**
➢ Deliver recruitment and retentions strategies for our hard to recruit clinical workforce ➢ Provide comprehensive leadership development programmes and support	
Strategic objective	**Actively collaborate to deliver integrated, joined up care for our communities:**
Annual corporate objective 6	**Drive new models of place-based care in the community and edge of hospital**
➢ Lead and expand NCL virtual ward and remote monitoring programme ➢ Expand and improve new adult and CYP models of care in localities with our local partners	
Annual corporate objective 7	**Collaborate with providers and the system:**
➢ Use UCLH joint board committee to drive new pathways to improve care and resilience ➢ Actively participate in the NCL Integrated Care System & NCL Health Alliance to support delivery of agreed system priorities, and work to create clear inequality objectives	

Strategic objective	Transform and develop sustainable and innovative services
Annual corporate objective 8	**Create focused improvement drive to deliver best value**
➢ Develop & deliver a robust multi-year productivity & cost improvement plan ➢ Prioritise three areas for improvement: flow / outpatients / electives ➢ Develop & deliver a robust multi-year productivity & cost improvement plan to reduce underlying deficit and move towards financial sustainability ➢ Deliver in year financial targets	
Annual corporate objective 9	**Deliver year one priorities of green plan**
➢ Deliver year one priorities of green plan	
Annual corporate objective 10	**Deliver estate transformation plans**
➢ Power rectification ➢ PFI rectification ~ finalise fire remediation business case & explore / secure funding ➢ Maternity and Neonates redevelopment: secure system support & agree funding strategy ~ phase 1 delivery & phase 2 planning	
Annual corporate objective 11	**Improve business intelligence and drive digital transformation:**
➢ Strengthen Business Intelligence to drive improvement ➢ Implement of digital strategy year three priorities	

Values

The Trust's ICARE values were developed through staff engagement and consultation and continue to be fundamental to everything we do at Whittington Health. They are underpinned by an overarching value of equity and form the basis of expected staff behaviours.

Our services

Our service priorities are focussed on our population needs: integrating care in all settings with an emphasis on women, children and frail adult patients and residents.

Our priority is to deliver the right care, at the right time, and in the right place for our patients. We provide an extensive range of services from our main hospital site and run services from over 30 community locations in Islington and Haringey, and our dental services are run from sites across ten London boroughs.

As an integrated care organisation, we bring safe and high-quality services closer to home and speed up communication between community and hospital services, improving our patients' experience reducing admissions and speeding up discharge. Key to our approach is partnering with patients, carers, GPs, social care, mental health and other healthcare providers.

Our organisation has a highly regarded educational role. We teach undergraduate medical students (as part of University College London Medical School) and nurses and therapists throughout the year, alongside providing a range of educational packages for postgraduate doctors and other healthcare professionals. We also have a growing research arm which is exceeding Clinical Research Network targets.

We are proud of our staff and their commitment to delivering safe and high-quality care every day of the year. During the last financial year, our community and hospital teams have once again been impressive in their professionalism. Patients were supported to be at home where they could and only came to hospital when it was necessary.

Strategic developments

UCLH and Whittington Health Collaboration

Building on our long history of working together, Whittington Health and UCLH have agreed that there is a case for closer collaboration to improve clinical outcomes and ensure greater sustainability for local services. This collaboration is clinically and operationally driven while the organisations remain separate.

In 2024/25 we prioritised work on our clinical pathways. This included strengthening oncology services, building on our provision of UCLH@Home (nurse-led virtual ward); and developing a joint theatre plan to ensure theatre capacity is utilised across both sites for patients requiring elective treatment. We have also looked to improve resilience in services such as neurophysiology and rheumatology through joint working and have continued to work on establishing resilient women's health pathways. We will extend our joint focus to include both workforce and research in 2025/26.

Start Well

In late March 2025, the North Central London Integrated Care Board approved the recommendations for the future of maternity and neonatal services in this integrated care system. The decision came after a rigorous process, including a public consultation and extensive work with clinicians to develop recommendations to improve the quality of services to give babies and children the best start in life, support the best outcomes for pregnant women and people, and reduce health inequalities. The agreed were for:

- Maternity and neonatal services to be consolidated onto four hospital sites: Whittington Health, Barnet Hospital, North Middlesex University Hospital and University College London Hospitals.
- All four hospitals to provide at least level two neonatal care, and both obstetric and midwifery led maternity care. Home births would also continue to be available across North Central London.

Case study: Maternity services collaboration with UCLH

Pregnant women can access maternity care at a unit of their choice. This means people who live within Barnet, Camden, Haringey, Enfield or Islington may choose a hospital outside of these areas and those who live outside the NCL boroughs can access maternity care at a hospital within NCL.

During the maternal pathway, women may develop complications and need specialist obstetric and neonatal input during pregnancy and would be referred to the tertiary unit at UCLH for pregnancy and/ or birth. At the same time there has been a significant national increase in women planning a caesarean birth (due to clinical recommendation and patient choice) – which has had implications on theatre capacity and women's experience of the planned C-section pathway.

Women's Health teams at Whittington Health and UCLH have been working collaboratively since 2023 to utilise maternity theatre and recovery capacity efficiently across UCLH and Whittington maternity services. Women with a healthy pregnancy and at low risk of complications are given an additional choice of Whittington maternity services for birth. This reduces pressure on UCLH and increases capacity for specialist care (e.g. maternal medicine, fetal medicine, and abnormally invasive placenta cases). Clinically suitable women are identified at UCLH and the possibility of birth at WH is discussed. The women are then transferred to WH for their planned C-section. The teams continue to work together maximise the current pathway and further consolidate and build on this pathway, in view of the NCL Start Well Programme.

Simmons House and North Central, East London Provider Collaborative

Following the temporary closure of Simmons House in 2023 there has been extensive engagement and the North Central East London Provider Collaborative (NCEL), of which Whittington Health is a member, has agreed and is implementing interim plans that will ensure service continuity whilst final decisions are made about a long term service model. The interim arrangements include increased bed capacity at the Beacon inpatient unit, increased capacity to support young people with a learning disability and autistic young people and an expanded provision by the North Central London Home Treatment Team. NCEL will carefully evaluate the interim plans over the 18 months they will be in place. Over the course of the engagement process, stakeholders; families, carers, young people and professionals in both inpatient and community-based services provided helpful feedback to NCEL about a range of aspects of service provision which NCEL have summarised in a "you said, we did" document available from their website.

PERFORMANCE

How we measure performance

Our Board and its key committees use an integrated performance report which has been developed to include a suite of quality and other indicators at Trust and service level. This enables the centralised reporting of performance and quality data as well as the improved triangulation of information. The integrated performance report is based on the Care Quality Commission's five domains of quality: safe, effective, caring, responsive and well led. The selection of indicators is based on NHS England's guidance for national outcome areas and the Trust's local priorities. On a quarterly basis, progress is also reviewed against our strategic objectives. In addition, there are monthly reviews of performance by each of our five clinical divisions.

This section of the annual report provides a comprehensive overview of Whittington Health NHS Trust's performance during the 2024/25 financial year, highlighting key achievements, challenges, and areas for improvement across healthcare delivery. Throughout the year, there was close monitoring of our performance against key metrics where performance was below target – particularly the four-hour emergency department access standard and the nationally mandated cancer standards. In quarter four, Whittington health was able to demonstrate significantly improved performance in both areas and further detail are provided in this section of the annual report.

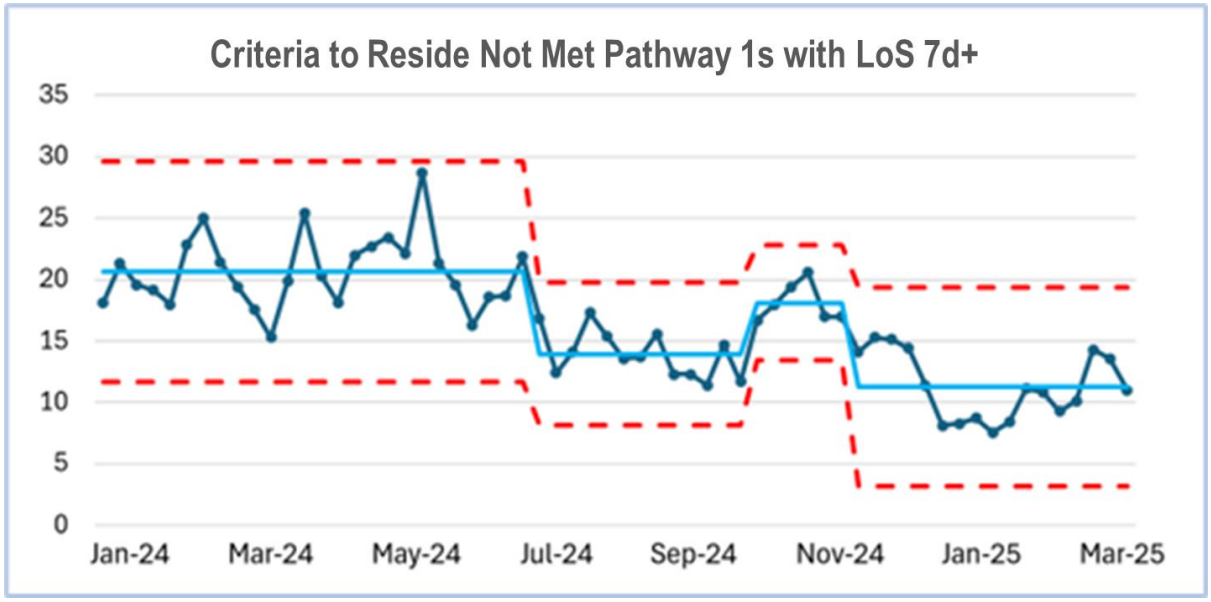
Our key performance highlights included the following:

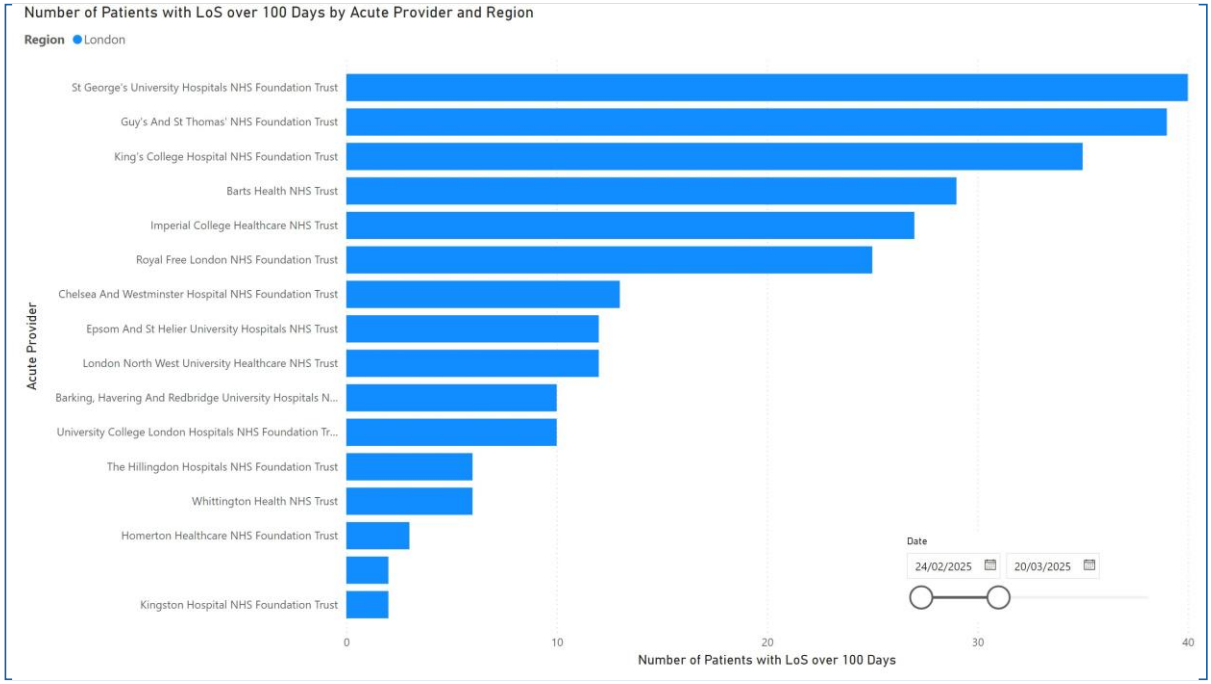
Significantly improved four-hour Emergency department (ED) performance and London Ambulance service handover times in 2024/25 compared to 2023/24, resulting in improved patient experience, safety and reducing waiting times, despite providing mutual aid through being the receiving hospital for sector diverts. Although there is more work to do, we were recognised as being one of the most improved EDs in London.

While we are pleased with these improvements, we recognise that 12-hour trolley breaches continued to remain high in most months of 2024/25. The main contributory factors for this have been high numbers of medically optimised patients in hospital, discharge delays due to a lack of capacity in community and social care settings. These are a particular concern in the winter months and we are working to reduce their occurrence to change the experience of our patients and remove the safety issues that can result from long waits. Further data is provided later in this report.

Significant improvement in non-elective inpatient length of stay.
This year Whittington Health developed its Flow Programme and established an Interim Wait Unit to prevent patients from deconditioning, whilst awaiting social care placement. This enabled patients to regain and maintain their independence following a hospital admission and was supported by allied health professionals (AHPs) and nursing teams, enabling medical teams to focus on patients with medical needs. This was acknowledged in the improvement at a sector level and our movement in the North Central London sector level rankings from 4th to 3rd. The graphs below show the improvement in length of stay for those awaiting support packages at home (pathway 1) and the chart below illustrates the smaller number of patients with very long lengths

of stay compared with other Trusts. As part of our strengthened partnership with Haringey council this year, Haringey social workers are now based on the hospital site joining those for Islington. Our Accident and Emergency Delivery Board has worked with system partners using an improvement approach to discharge with an emphasis on partnership and data – using our improved use of contemporaneous data via Power Business Intelligence dashboards. (The hospital uses a set of criteria to decide if a patient needs to be cared for in hospital or could get equivalent care outside hospital – this is the criteria to reside CtR – CtR not met indicates that the patient could be cared for outside a hospital if other services were in place)

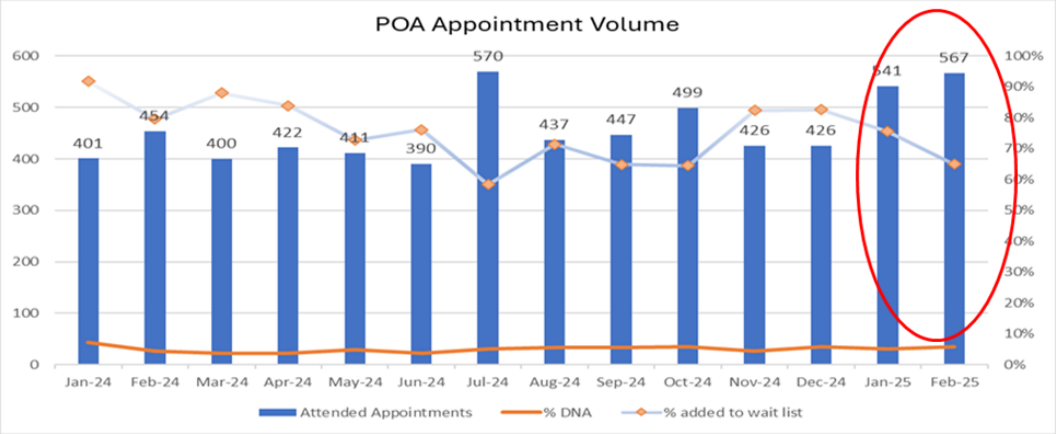




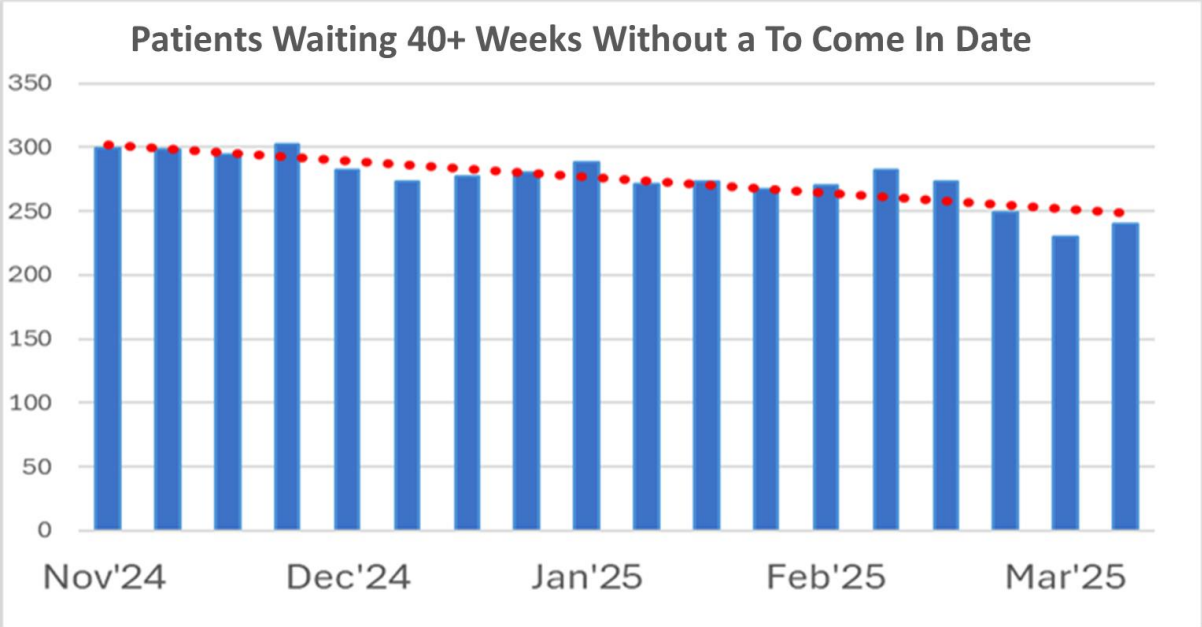
Improving planned care waiting times

Our teams have established three workstreams to reduce waits for patients needing elective care. These focused on preoperative assessment (POA), booking and

scheduling, and productivity and efficiency. These included introduction of a new digital offering – Lifebox for preassessment and expansion of the POA nursing team and revision of the clinical triage process. These have all helped to improve the number of patents seen in preassessment by 35% in quarter 4 2024/25 (see overleaf).

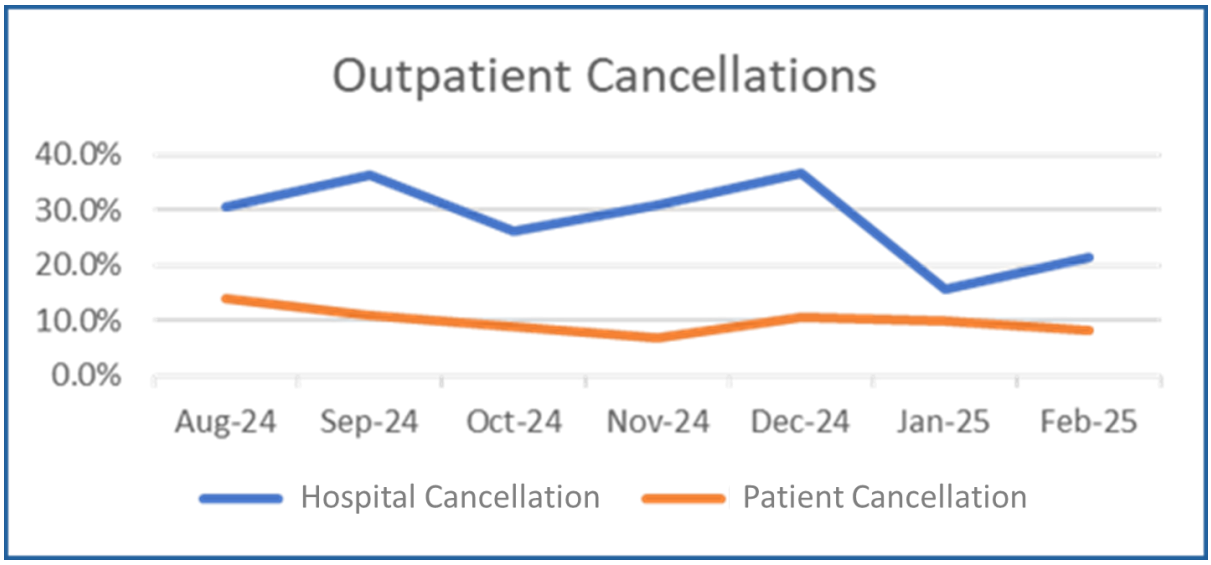


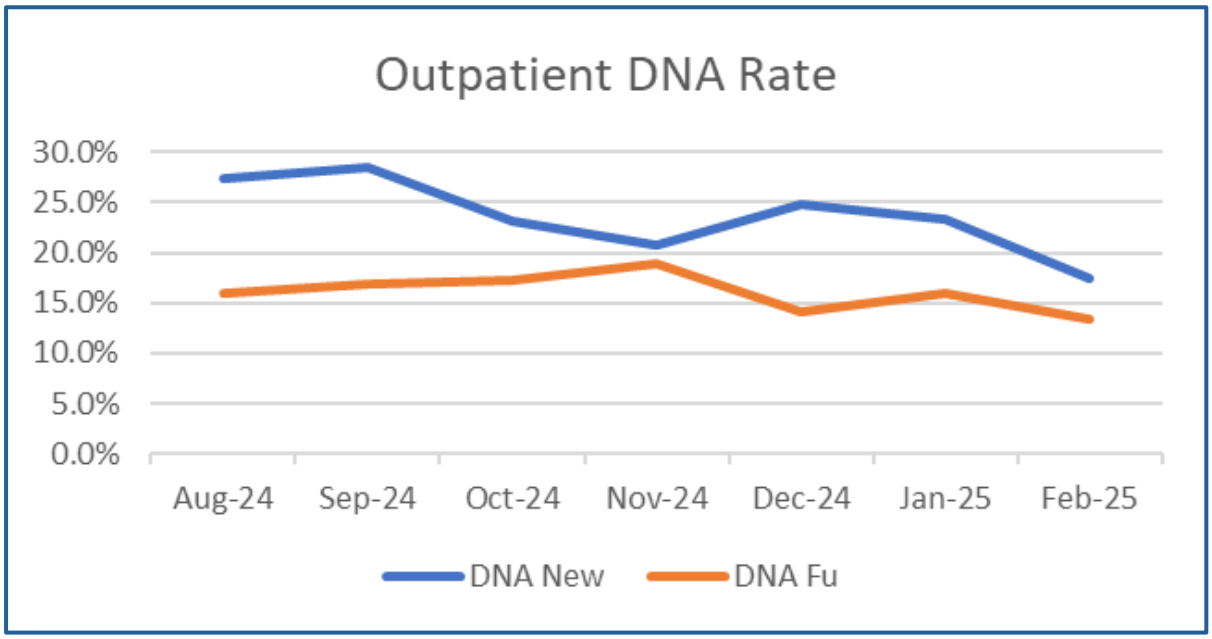
These and other measures have also contributed to a reduction in the numbers of patients waiting over 40 weeks without knowing their date of admission. (Note TCI means to come in – this indicates a patient has an admission for their procedure booked)



Improvement in outpatient care

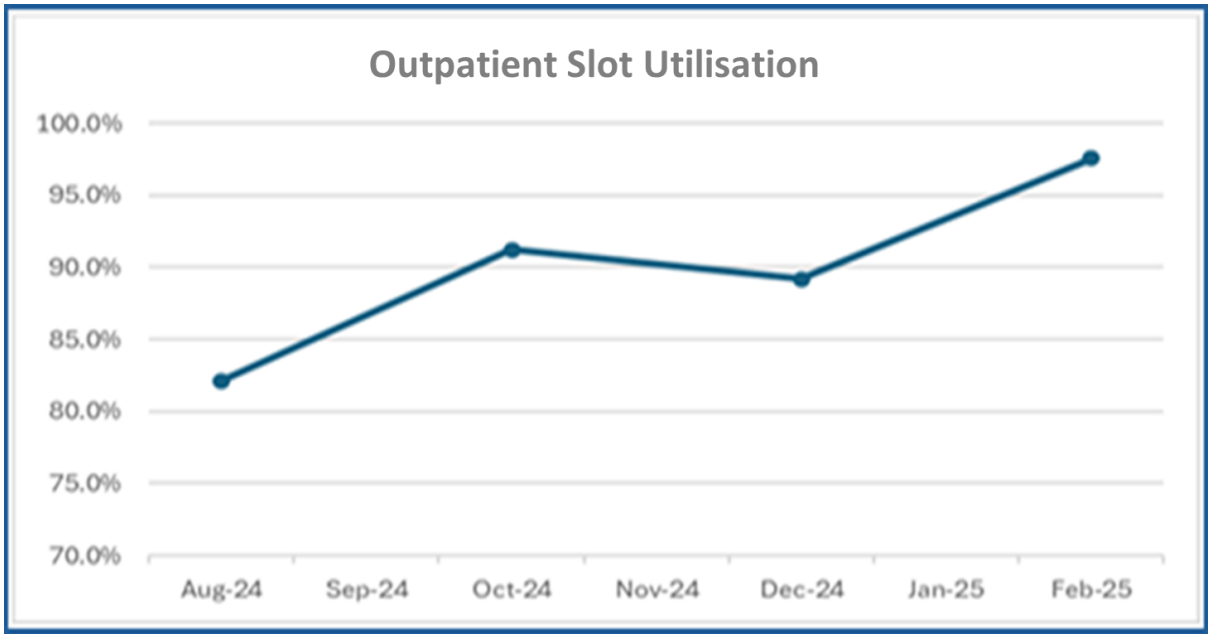
The outpatient improvement program has focused on better processes, patient experience including communication and better clinic architecture which includes the monitoring of data and tracking and training and competencies for staff. The success is reflected a reduction in cancellations of appointments by either the hospital or by patients and in reduced rates of patients not attending new or follow up appointments which frequently reflect prior communication problems. We have started with Urology as a service and the following three graphs show the huge progress made in that area.





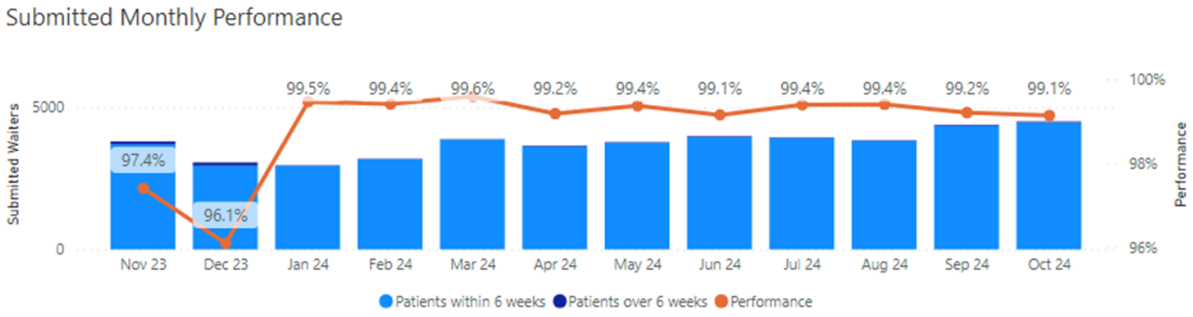
Note DNA = did not attend in relation to a clinic appointment

This work allows our doctors nurses and allied health professionals and other staff to be more effective and help more patients needing outpatient care. This includes improved patient access and treatment times for patients through improvements in referral to treatment and diagnostic waiting times in endoscopy, rheumatology, diabetes, respiratory and haematology services. This supports the national drive to ensure patients are not waiting more than 18 weeks for treatment.



Imaging performance

Our team have designed several innovations in imaging this year including longer opening hours in our Community Diagnostic Centre in Wood Green helping those with daytime responsibilities access care and a new CT scanner in our emergency department at the Whittington Hospital site in Archway. Our delivery of timely diagnostic imaging showed excellent performance, and our team were asked to share their projects with a group of London Chief Executives – the graph below is an extract from that presentation. Overall, the proportion of patients waiting less than six weeks improved from 84% in 2023/24 to 94.8% in 2024/25.



Improvements to gynaecological cancer waiting times

A successful business case resulted in improvements in waiting times. This was achieved by factors such as the recruitment of medical and nursing staff to meet the needs of the local community with shorter waiting times for first appointments (2-7 days) and diagnostics for women referred with suspected gynaecological cancer. Robotic process automation has made triaging for target referrals timely and efficient. The purchase of additional diagnostic equipment and the daily monitoring of results has shown improvements in meeting the national FDS (Faster Diagnosis Standard) to rule out/ confirm cancer diagnosis within 28 days.

Our team established a general oncology assessment unit (OAU): This has been fully functioning since Autumn 2024. It is an innovative service which streamlines patients from gateway areas and ensures they are seen at the right time and place. The OAU has provided 250 patient reviews. Many of these patients would have attended the emergency department or ambulatory care for review prior to Autumn 2024. The unit has also provided assessment for patients on the malignancy of unknown origin pathway, these patients were historically reviewed in oncology outpatient clinics. This makes their investigations and care more streamlined improving their experience.

Patient experience

The Trust achieved a marked improvement in the national cancer patient experience survey with a 39-place improvement in the rankings. In the national inpatient survey, of the 215 trusts participating, Whittington Health is in the top eight for significantly improved scores going from 7.5 to 8.0 out of 10.

2024 Staff survey

The percentage of staff who would recommend our Trust as a place to work improved by 4% since 2023 and is joint 7th in London. Staff experience in our Trust improved in five of the seven People Promise elements, as well as for the themes of staff engagement and morale. Notably, improvements in 'We are safe and healthy' and 'Morale' have been significant. This follows a year focusing on staff wellbeing and a program of community engagement roadshows. We know there are other areas where we should strive to improve, and we are working on our chosen priority areas for 2025/26.

Critical radiology results alerts process

In early July 2024, the Imaging department went live with an automated radiology findings alerting system. The system emails the referring clinician or GP Practice immediately when a radiologist finds a significant finding on a radiology image, reducing the possibility of urgent findings being missed and not acted upon. So far over 13,000 alert emails have been distributed to referrers. One clinician commented "I just received an email informing me of an abnormal CXR on one of my patients. I can't express how pleased I am that we have a system that does this for abnormal results. Absolutely brilliant for patient care."

Microbiology and digital Informatics

Whittington Health's established outpatient parenteral antimicrobial therapy (OPAT) service provides care closer to home, releases hospital beds and supports antimicrobial stewardship in line with national transformational objectives. A dynamic information dashboard was developed by our team, linked directly to patient medical records. The live OPAT dashboard allows for easy display and analysis of patient outcomes, patient safety and quality of service against national benchmarks and good practice recommendations from the British Society of Antimicrobial Chemotherapy. The project has been nominated for the following national awards: Improving Out of Hospital Care through Digital Award (HSJ Digital Awards) and the Innovation and Technology category of the (United Kingdom Health Security Agency Antibiotic Guardian Shared Learning & Awards).

Research & development

The surgery and cancer team actively participate in research and our patients (breast, colorectal, orthopaedic, anaesthetics, bariatrics, colorectal) are recruited in research studies. We have impressive recruitment numbers for several studies – and our surgery and cancer team have more than 10 publications each year.

Oral health promotion

The Community Dental Service is dedicated to improving oral health outcomes of the community through evidence-based education, prevention and intervention programmes, with children and adult services in health & social care, education, charity and voluntary organisations. The 2024/2025 period was marked by significant growth, innovation, and strategic alignment across the Whittington oral health promotion (OHP) team. As the commissioned provider of community-based OHP across ten boroughs in North Central and Northwest London, the service continued to strengthen delivery, embed quality, and support system-wide priorities in prevention, early intervention, and workforce development.

Emergency department

ED attendances rose from 103,891 in 2023/24 to 108,610 in 2024/25. Performance against the four-hour ED target improved to 70.9%, a 5.9% increase on the previous year. However, 12-hour trolley breaches remained high due to discharge delays and extended inpatient stays.

Referral to treatment

The Trust achieved an average of 64.9% against the 92% RTT target. While two 78-week breaches were reported, they were eliminated by the year's end. Plans are in place to ensure that fewer than 1% of patients wait over 52 weeks.

Diagnostics

Performance improved to 94%, with imaging services reaching 98.4%.

Cancer care

The Faster Diagnosis Standard averaged 68.6%, with February 2025 surpassing the target at 76.1%. Referral-to-treatment performance for the 62-day cancer pathway showed month-on-month improvement but remained below the 85% target, averaging 60.2%.

Community services

Total community contacts rose to 678,901, an increase of 60,177 from the previous year. Improvements were noted in MSK Physiotherapy and CATS services, driven by enhanced clinics such as "Super Saturday." Staffing and capacity constraints continue to challenge podiatry, community rehabilitation, and therapy services.

Health visiting

In Q4, 92.7% of new birth visits were completed within the 14-day target, while 88.5% of 6–8-week reviews were conducted on time.

National context

NHS England struggled to meet key performance targets, including RTT, cancer care, and ED wait times. However, Whittington Health outperformed national averages in several areas, reinforcing confidence in local service delivery.

Monitoring and reporting

Performance is regularly reviewed through scorecards and organisational meetings to identify underperformance and implement corrective actions.

Summary

Whittington Health NHS Trust achieved notable improvements in ED performance, diagnostics, and community services, while challenges remain in RTT, cancer care, and discharge delays. Efforts are ongoing to address capacity constraints, reduce waiting times, and enhance overall service provision.

2024/25 Performance outcomes

Table one: At-a-glance performance against national targets during the period 2021/2025

Safe – people are protected from abuse and avoidable harm	**2021/22**		**2022/2023**		**2023/2024**		**2024/2025**	
KPI description	**Target**	**Outcome**	**Target**	**Outcome**	**Target**	**Outcome**	**Target**	**Outcome**
Admission to adult facilities of patients aged under 16	0	0	0	0	0	0	0	81
Incidence of Clostridium Difficile *	0	10	<16	20	<13	22	<13	20
Actual falls	400	344	400	381	400	334	400	349
Non-Elective C-section rate (%)	0	22.90%	0	25.40%	0	27.90%	0	29.70%
Medication errors causing serious harm	0	0	0	0	0	1	0	0
Incidence of MRSA *	0	0	0	2	0	2	0	6
Safety Incidents	N/A	25	N/A	12	N/A	12	N/A	10
VTE risk assessment (%)	>95%	80.40%	>95%	95.50%	>95%	95.10%	>95%	95.60%
Mixed sex accommodation breaches *	0	34	0	109	0	102	0	129
Effective – people's care, treatment and support achieve good outcomes, promote a good quality of life and are based on the best available evidence	**2021/22**		**2022/2023**		**2023/2024**		**2024/2025**	
KPI description	**Target**	**Outcome**	**Target**	**Outcome**	**Target**	**Outcome**	**Target**	**Outcome**
Breastfeeding initiated	>90%	91.60%	>90%	93.46%	>90%	92.50%	>90%	93.50%
Smoking at delivery	<6%	4.06%	<6%	4.23%	<6%	3.80%	<6%	3.50%
Non-elective re-admissions within 30 days	<5.5%	4.92%	<5.5%	3.88%	<5.5%	3.85%	<5.5%	3.61%
Mortality rate per 1000 admissions in-months	14.4	7.63	14.4	8.4	14.4	8.3	14.4	7.1
IAPT Moving to Recovery	>50%	51.89%	>50%	50.20%	>50%	47.80%	>50%	49.90%
% seen within 2 hours of referral to district nursing night	>80%	97.37%	>80%	94.47%	>80%	92.70%	>80%	96.20%
% seen within 48 hours of referral to district nursing night	>95%	95.48%	>95%	93.21%	>95%	91.40%	>95%	96.60%
% of MSK patients with a significant improvement in function	>75%	89.79%	>75%	86.26%	>75%	79.20%	>75%	81.10%
% of podiatry patients with significant improvement in pain	>75%	95.26%	>75%	86.68%	>75%	79.20%	>75%	92.70%
Caring - Involving people in their care and treating them with compassion, kindness, dignity and respect	**2021/22**		**2022/2023**		**2023/2024**		**2024/2025**	
KPI description	**Target**	**Outcome**	**Target**	**Outcome**	**Target**	**Outcome**	**Target**	**Outcome**
Emergency department – FFT % positive	>90%	77.70%	>90%	76.00%	>90%	78.50%	>90%	80.90%

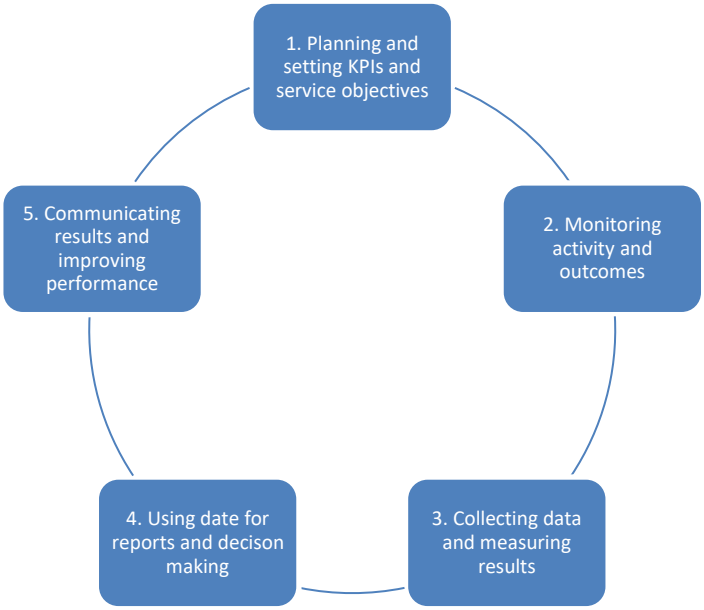
Emergency department – FFT response rate	>15%	10.90%	>15%	11.50%	>15%	10.90%	>15%	8.20%
Inpatients – FFT % positive	>90%	95.80%	>90%	93.50%	>90%	92.80%	>90%	93.60%
Inpatients – FFT response rate	>25%	17.30%	>25%	19.30%	>25%	16.10%	>25%	19.00%
Maternity - FFT % positive	>90%	98.50%	>90%	63.00%	>90%	97.80%	>90%	98.30%
Maternity - FFT response rate	>15%	11.50%	>15%	14.80%	>15%	10.20%	>15%	21.60%
Outpatients - FFT % positive	>90%	93.40%	>90%	90.30%	>90%	90.70%	>90%	90.70%
Outpatients - FFT responses	40n0	591	400	1268	400	3934	400	3070
Community - FFT % positive	>90%	97.70%	>90%	96.50%	>90%	95.70%	>90%	94.60%
Community - FFT responses	1,500	5527	1,500	8,469	1,500	9,123	1,500	9734
Trust Composite FFT - % recommend	>90%	88.78%	>90%	85.32%	>90%	89.58%	>90%	91.79%
Staff FFT - % recommend	>70%	66.97	>70%	62.17%	>70%	63.68	>70%	67.52%
Complaints responded to within 25 working days	>80%	59.90%	>80%	55.40%	>80%	53.90%	>80%	68.80%
Responsive - organising services so that they are tailored to people's needs	**2021/22**		**2022/2023**		**2023/2024**		**2024/2025**	
KPI description	**Target**	**Outcome**	**Target**	**Outcome**	**Target**	**Outcome**	**Target**	**Outcome**
Emergency department waits – 4 hours	>95%	78.30%	>95%	68.40%	>95%	65.30%	>95%	70.90%
Median wait for treatment (minutes)	<60 mins	93	<60 mins	110	<60 mins	103	<60 mins	94
Ambulance handovers waiting more than 30 minutes	0	646	0	1175	0	905	0	1111
Ambulance handovers waiting more than 60 minutes	0	283	0	566	0	196	0	88
12-hour trolley waits in A&E	0	83	0	2208	0	2940	0	3575
Cancer – 31 days to first treatment	>96%	94.90%	>96%	89.90%	>96%	93.50%	>96%	94.50%
Cancer – 62 days from referral to treatment	>85%	67.60%	>85%	47.70%	>85%	53.90%	>85%	57.60%
Diagnostic waits (<6 weeks)	>99%	94.10%	>99%	85.89%	>99%	86.86%	>99%	94.12%
Referral to treatment times waiting <18 weeks (%)	>92%	74.40%	>92%	67.80%	>92%	66.20%	>92%	64.90%
Referral to treatment time over 52 weeks	0	384	0	607	0	500	0	301

Activity

	Actual	Actual	% difference	Actual	% difference (2022/23 vs 2023/24)	Actual	% difference (2023/24 vs 2024/25)
Admissions	**2021/22**	**2022/23**	**% Difference**	**2023/24**	**% Difference**	**2024/25**	**% Difference**
Non-Elective Admissions	15,333	12,624	-17.67%	12,525	-0.78%	14,423	15.2%
Elective Admissions	1,379	2,178	57.94%	2,554	17.26%	2,741	7.3%
Day Case	21,406	23,158	8.18%	23,458	1.30%	26,145	11.5%
ED attendances	107,703	106,462	-1.15%	103,891	-2.41%	108,610	4.5%
Face to Face Patient Contacts	**2021/22**	**2022/23**	**% Difference**	**2023/24**	**% Difference**	**2024/25**	**% Difference**
At our hospital	444,423	475,465	6.98%	500,799	5.33%	510,399	1.92%
In the community	532,341	572,191	7.49%	605,768	5.87%	653,734	7.92%
Total	**976,764**	**1,047,656**	7.26%	**1,106,567**	5.62%	**1,164,133**	5.20%
Community	**2021/22**	**2022/23**	**% Difference**	**2023/24**	**% Difference**	**2024/25**	**% Difference**
Community Nursing Visits	236,495	221,726	-6.24%	226,714	2.25%	257,200	13.45%
Physio Appointment	31,755	63,535	100.08%	69,276	9.04%	76,666	10.67%
Health and School Nurse Visit	53,872	56,977	5.76%	57,099	0.21%	59,702	4.56%
Dental Appointment	44,143	45,456	2.97%	47,783	5.12%	50,315	5.30%

Monitoring performance

The Trust's performance management framework acknowledges the national context and addresses local quality and service priorities. Whittington Health has a culture of continuous improvement, using the cycle of performance management, and a system of performance reporting against agreed measures and quality priorities. The monthly performance scorecard allows continuous monitoring of specific datasets, such as quality and finance, service specific information and deviation from commissioned targets. This information is used to monitor compliance with service standards and contract review and to populate national external data sets.



Outcomes against key scorecard indicators are reported to the weekly Executive Team meeting, twice a month to the Trust's Management Group, monthly to respective Division Boards, regularly to board committees, monthly to the Trust Board itself and are monitored and reviewed through monthly performance reviews with the Divisions. All reports are discussed at these meetings to identify reasons for any underperformance, as well as reviewing progress of any remedial action plans put in place. The Trust continues to review performance to ensure we continue to monitor the things that matter to the delivery of high-quality care.

Review of performance

In April 2025, NHS England released performance data for the 2024/25 financial year (covering the period April 2024 to February 2025), which highlighted both progress and ongoing challenges across key performance indicators (KPIs). Below is a summary of the NHS's performance against its main targets:

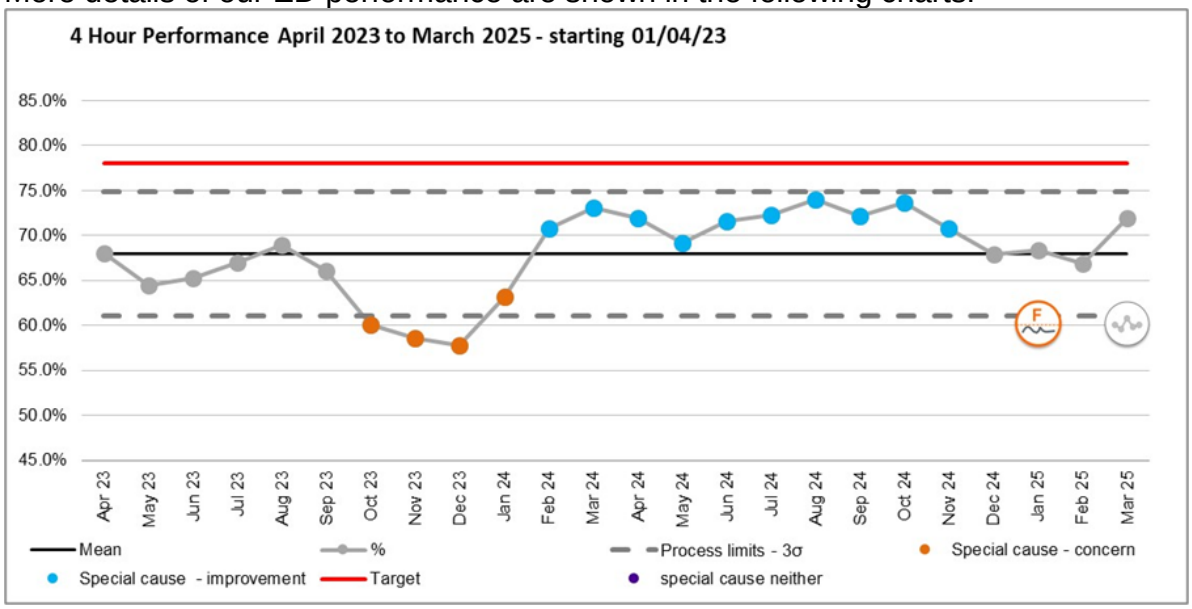
- 18-Week RTT target: All 124 acute hospital trusts in England failed to meet the target of treating 92% of patients within 18 weeks. As of early 2025, 3.1 million people had been waiting over 18 weeks, with 234,885 waiting over a year.
- Waiting List Size: The total elective care waiting list stood at approximately 7.54 million cases.
- Approximately 1.65 million people waited more than 4 hours in A&E between April 2024 and March 2025.

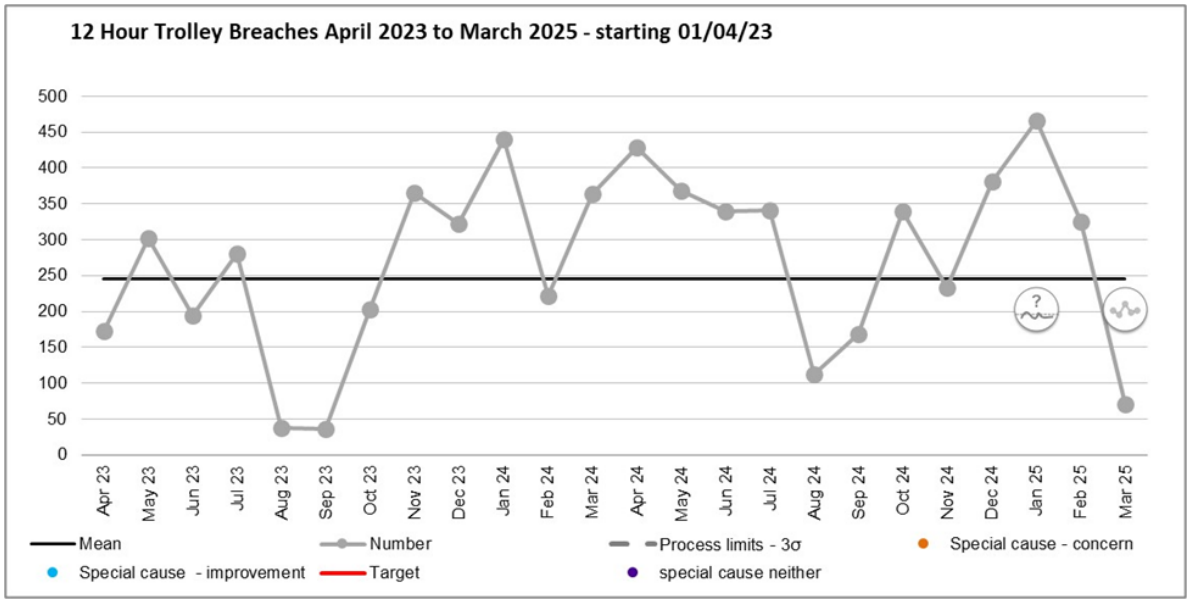
- Between April 2024 and March 2025, NHS England's cancer services faced ongoing challenges in meeting key performance targets, despite some areas of progress.
    - 62-Day Referral to Treatment Standard - In 2024, only 62.2% of patients began treatment within this timeframe, an improvement from 60.1% in 2023 but still significantly below the target of 85%. Noting the NHS has not met this target since December 2015.
    - National improvement in the delivery of the 28-day Faster Diagnosis Standard (75%). In November 2024, 77% of patients met this standard.
    - Against the 31-Day Decision to Treat Standard target of 96% of patients should start treatment within 31 days of the decision to treat, in December 2024, 92% of patients commenced treatment within 31 days, with radiotherapy patients experiencing longer waits.

When comparing this national data directly against the figures for Whittington Health NHS Trust, it showed that, in several key areas, local people can be confident that their NHS is doing what is needed to ensure that everyone who needs care receives it as quickly and safely as possible.

2024/25 was a very busy year for ED services at the Whittington, with figures showing 108,610 patients coming through the hospital front door during the period 1 April 2024 to 31 March 2025. Despite this significant pressure, and thanks to local staff delivering the improvements set out in the NHS urgent and emergency care recovery plan, performance for the year 2024/25 saw 70.9% of people coming to the emergency department spending less than four hours in Whittington Hospital's ED department, despite seeing an increase in attendances from 103,891 in 2023/24 to 108,610 in 2024/25.

More details of our ED performance are shown in the following charts.

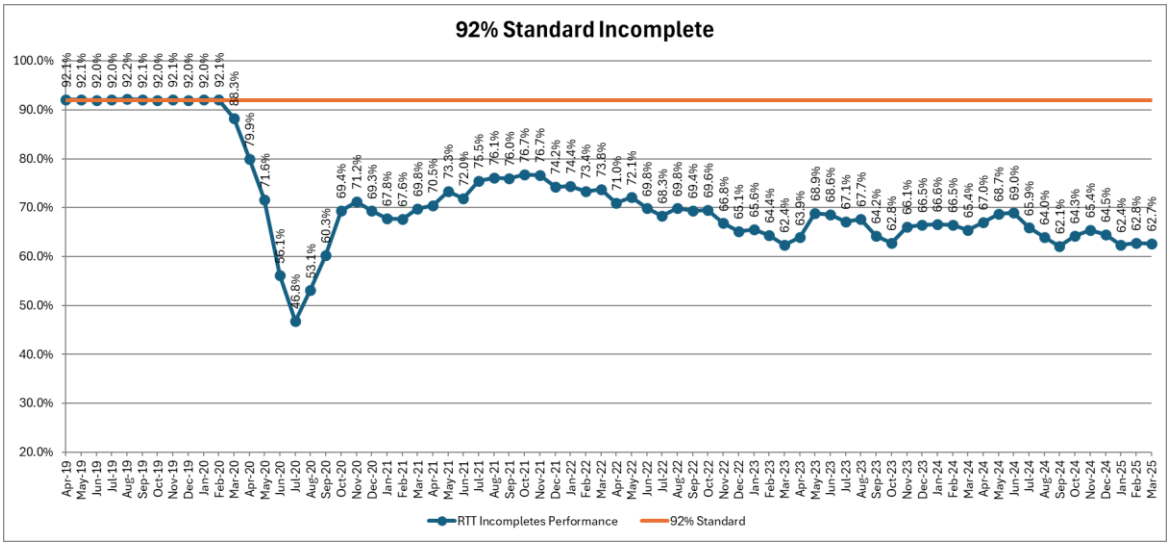




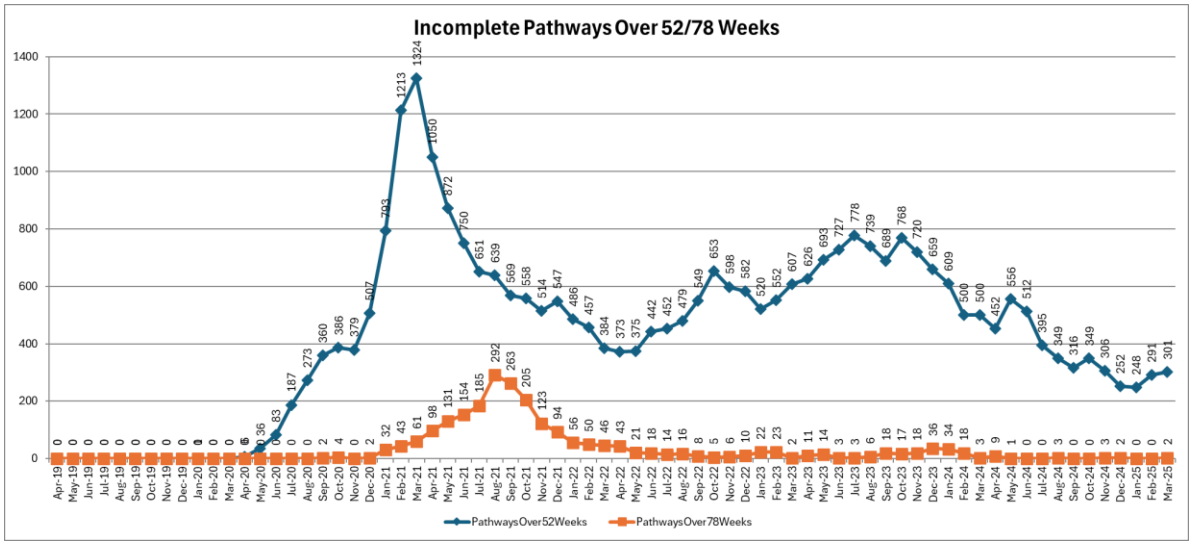
Performance against the four-hour ED standard averaged at 70.9% through 2024/25 an improvement of 5.9% from 2023/24. The Trust has delivered sustained improvement throughout the period

12-hour trolley breaches continued to remain high throughout 2024/25. The main contributory factors for this have been high numbers of medically optimised patients in hospital, discharge delays due to a lack of capacity in community and social care settings.

Referral To Treatment – 78 weeks

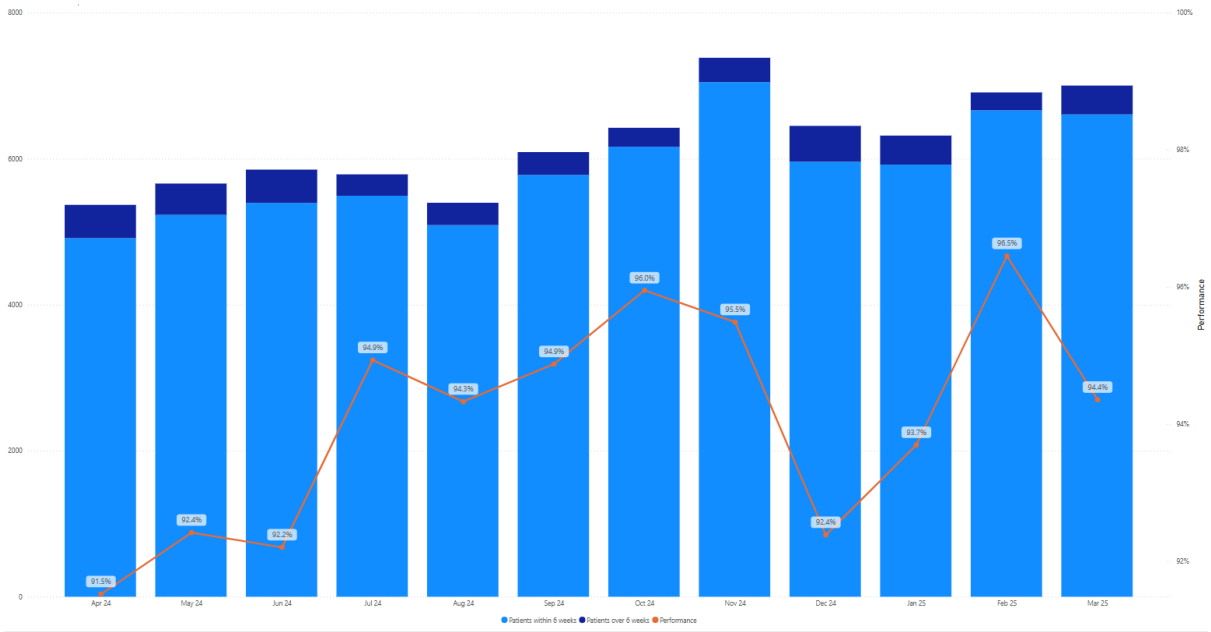


The Trust has not achieved the 92% referral to treatment standard since before the pandemic. Performance through 2024/25 remained consistent with an average performance of 64.9%.



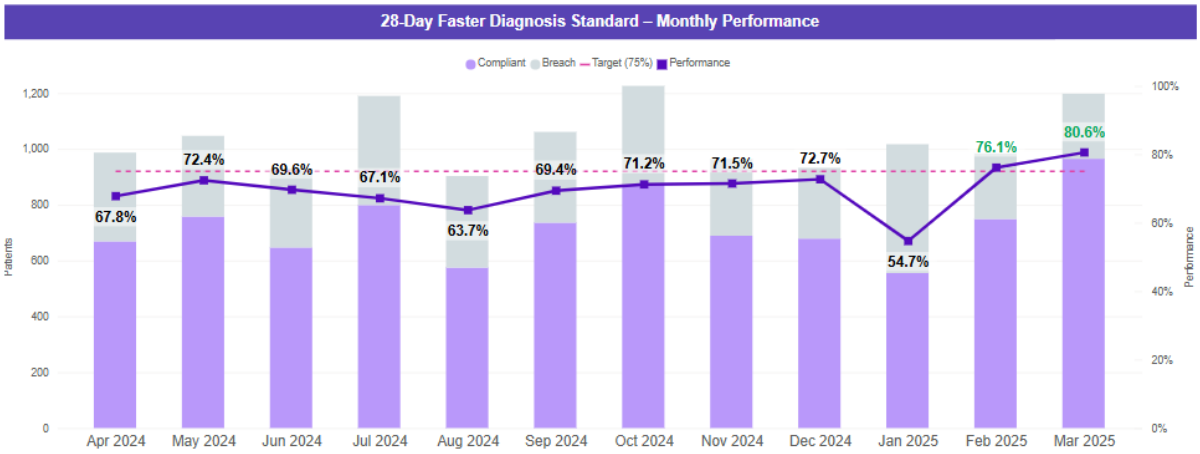
The Trust ended 2024/25 with two 78-week breaches against the national ask of zero 78-week breaches. Ongoing plans are in place to mitigate the next required standard of not having more than 1% of patients on a referral to treatment pathway over 52 weeks. The numbers of patients waiting over 52 weeks since referral has markedly reduced.

Diagnostics – DM01



Performance against the DM01 standard, that patients should wait less than six weeks for a diagnostic test continued to improve during 2024/25 for the Trust with an average performance at 94%. Our imaging services was a consistent high performer against the standard achieving an average of 98.4% through the year.

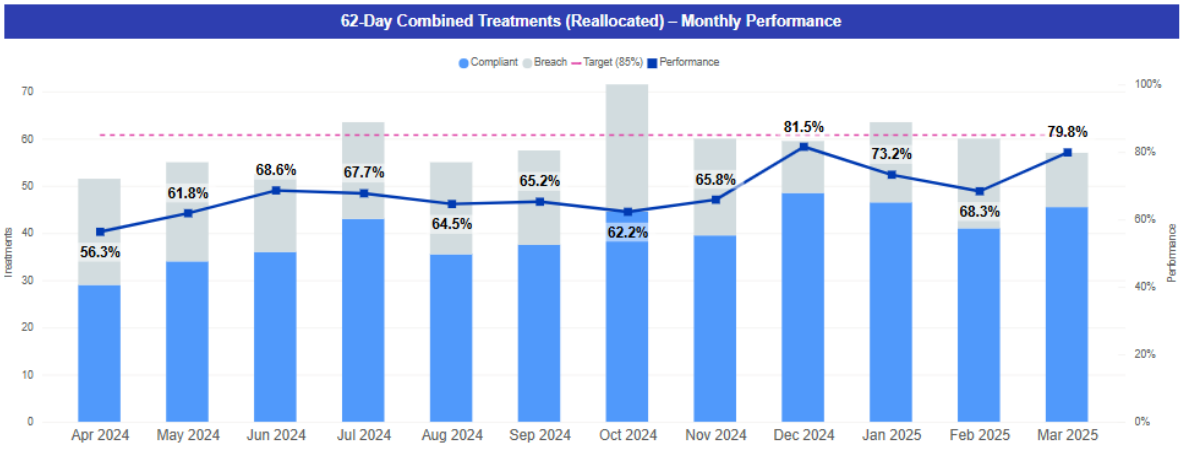
Cancer – Faster Diagnosis



Cancer Faster Diagnosis Standard (FDS) performance for 2024/25 averaged out at 68.6% against a standard of 75%, with February 2025 over-achieving against the standard at 76.1% The two tumour groups that consistently did not meet the standard were gynaecology and urology, predominately because of capacity constraints. Improvement plans are in place to support overall delivery.

The standard required for 2025/26 is to increase performance against the 28-day FDS to 80% by March 2026. All services will have demand and capacity models developed to ensure services can deliver the required standard and forecasted targets.

Cancer – 62 days performance



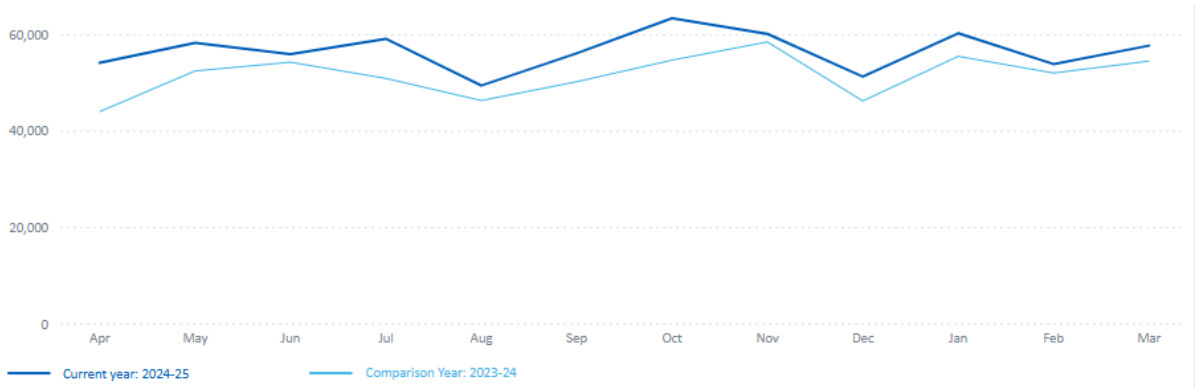
The national standard for 2024/25 for 62 days performance was 85%. The average Trust performance for 2024/25 was 67.9% against a combined allocation. Industrial action has also impacted the delivery of this standard.

As per national guidance, since October 2023 all providers are expected to report against a combined 62-day performance i.e. include GP referrals, upgrades, screening and breast symptomatic. The introduction of a combined performance has improved the Trust's compliance against the 62-day standard. There has been a month-on-month

improvement since November 2023, apart from January 2024 which saw a greater impact from strike action.

Community services' performance

Total contacts



	Apr	May	Jun	Qtr 1	Jul	Aug	Sep	Qtr 2	Oct	Nov	Dec	Qtr 3	Jan	Feb	Mar	Qtr 4	Total
2023-24	43,952	52,382	54,199	150,533	50,838	46,245	50,145	147,228	54,622	58,397	46,157	159,176	55,416	51,954	54,417	161,787	618,724
2024-25	54,099	58,238	55,883	168,220	59,060	49,363	56,035	164,458	63,309	60,067	51,204	174,580	60,190	53,826	57,627	171,643	678,901

The total number of contacts for community services for 2024/25 were 678,901, an increase of 60,177 compared to the previous year. Highlighted services to note are:

- **Podiatry -** Biomechanics patients continue to face the longest waits, as this is not a core service. Focus remains on core pathways, with work underway to transfer suitable Biomechanics patients to MSK Physio. Home visits remain a challenge; the domiciliary caseload is being reviewed to ensure eligibility, with ineligible patients redirected to clinic appointments. The service has been impacted by staff sickness.
- **Community Rehabilitation -** Waiting times for community therapies continue to rise in some teams. Targeted work in the Haringey Stroke pathway has reduced patient numbers. All services are under review to identify efficiency improvements.
- **Musculoskeletal (MSK) routine physiotherapy -** There was a significant improvement in performance, reaching 80.2% in March 2025 compared to earlier figures in January 2025. The progress is largely attributed to the introduction of enhanced 'Super Saturday' clinics, which were made possible through last-minute funding from NHS England and the GIRFT (Getting It Right First Time) programme. These additional clinics have played a key role in increasing capacity and reducing waiting times.
- **MSK Clinical Assessment and Triage Service -** There was a significant improvement in performance, with a 72.3% rate in March 2025. This progress was largely driven by enhanced clinics, including "Super Saturday" sessions, made possible through funding from NHS England and the Getting it Right First Time (GIRFT) project.
- **MSK (CATS and Physiotherapy) -** The number of patients waiting over 12 weeks has decreased by 121 in March 2025 compared to the previous months, reflecting sustained efforts to reduce delays for those waiting the longest. However, the overall waiting list has increased by 8.4%, rising from 5,859 to 6,352. This growth

underlines the need to further investigate demand drivers and ensure future capacity planning is robust and responsive.

- **Therapy services.** Work is ongoing to reduce waiting times for first appointments and provision of interventions in therapy services. The impact of this work in the Barnet Speech and Language Therapy (SLT) service is shown by the increase in the percentage of children and young people being seen for first appointments within target periods. Teams continue to focus on the balance between seeing those newly referred and the provision of therapy for those on the caseload. Islington Council has increased investment in the mainstream Occupational Therapy (OT) Service, and this will support a reduction in waiting times. Short term investment in Haringey and Barnet is being used to support further reduction in waiting times for SLT. Current challenges in utilising the available funding include difficulty recruiting staff to fixed term roles and delivering the target reductions in temporary staffing. Service leads are working on alternative approaches to ensure the investment is used and that improvements in provision are achieved for children, young people and families.
- **Haringey Health Visiting.** In Quarter 4 2024/25 (January to March) the service completed 92.7% of new birth visits within the 14-day target. The target is 95% and the service closely tracks this vital activity. Health visiting teams also measure completion of 6–8-week reviews for all babies. In Q4 in Haringey 88.5% of 6–8-week reviews were completed before the baby turned 8 weeks. This is the highest number the service has ever recorded within 8 weeks. It also means that teams were able to record infant feeding status at 6 weeks for 95.3% of babies so service data can be included in national reporting for the first time.

Case study: Whittington Health Community Heart Failure Inequalities Service:

The Community Heart Failure Inequalities service is an initiative for adults living with heart failure in Haringey's most deprived communities. The service aligns with the Population Health Strategy and North Central London's core offer requirements. It supports proactive triaging of heart failure registers from each GP surgery, enabling diagnosis review, echocardiogram confirmation, and the maintenance of efficient heart failure registers through data cleansing.

The team provides multidisciplinary meetings with cardiologists and other clinicians, as needed, to optimise personalised care and reconnect patients lost to follow-up. The project also reviews GP lists to confirm heart failure diagnosis through up-to-date echocardiograms and blood tests, depending on presenting symptoms. Medication optimisation is a primary goal, with aims to titrate to maximum tolerated doses for optimal evidence-based outcomes for patients.

The project aimed to improve the productivity and outcomes of the service by reducing did not attend (DNA) rates and emergency department visits for its patients with the project achieving a 30% reduction in emergency department attendance in 2024-2025 and a 51% reduction in inpatient admissions compared to 2023-2024 data. The target population was initially focused on the 85% most deprived areas of Haringey (mainly East), but has since expanded to the West, which has 60% deprivation, to further address inequalities.

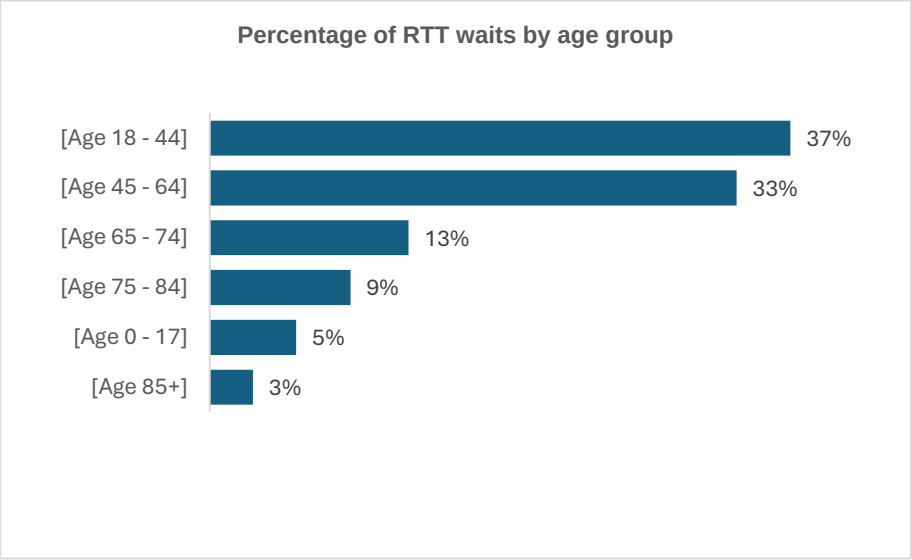
The project has established good relationships with general practices and voluntary/community organisations, such as those supporting alcohol dependence,

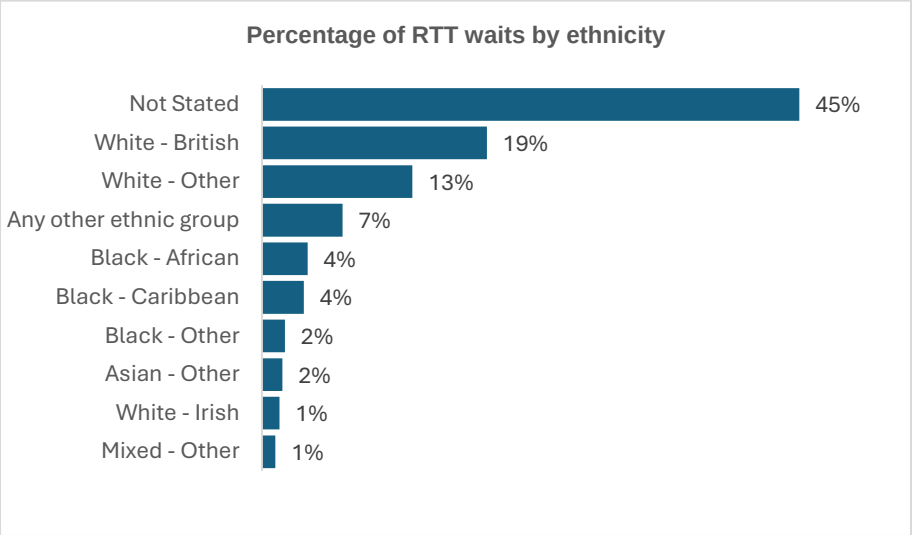
homelessness, the Somali community, and supported living accommodations. Referral sources range from secondary care, primary care, and self-referrals through active case finding with regular health events. 69% of reviewed patients are from an ethnic minority background.

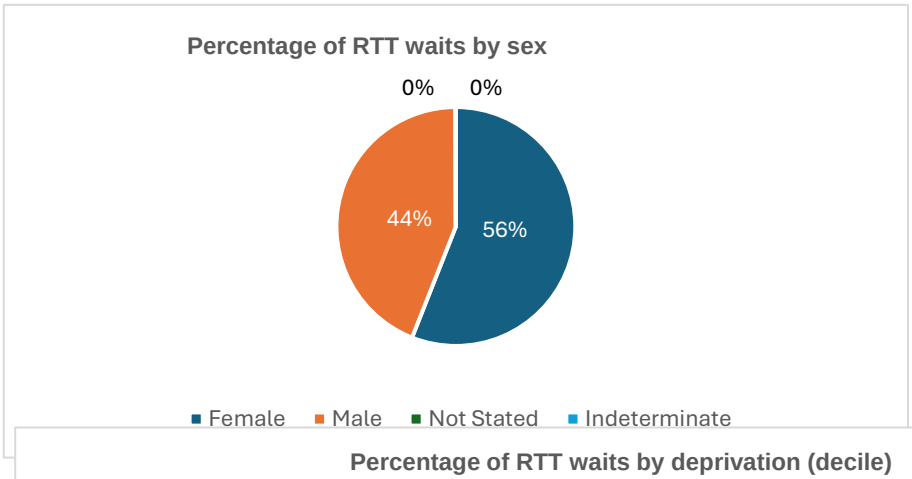
Waiting times

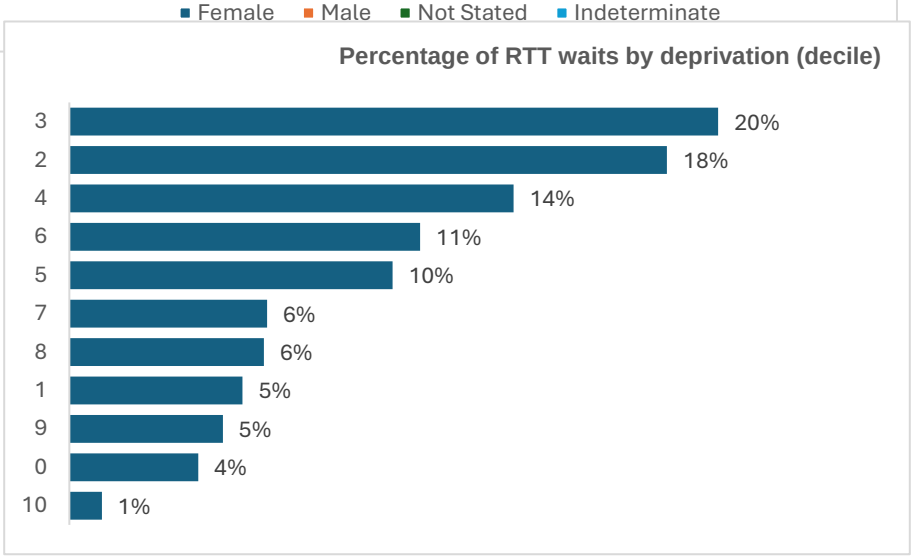
In line with NHS England's statement on health inequalities, the next few pages show our waiting times disaggregated by age, deprivation, ethnicity and sex, particularly for referral to treatment, diagnostic test, inpatients, cancer and for the emergency department.

Referral to treatment (RTT)

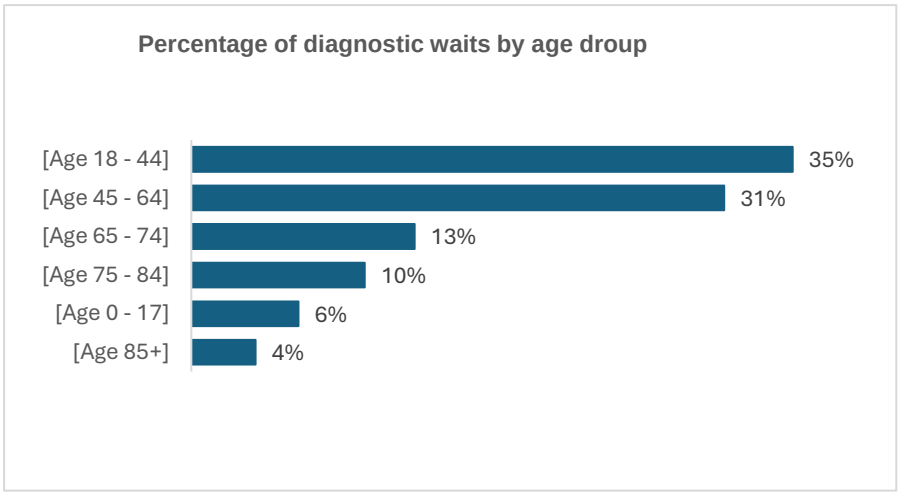


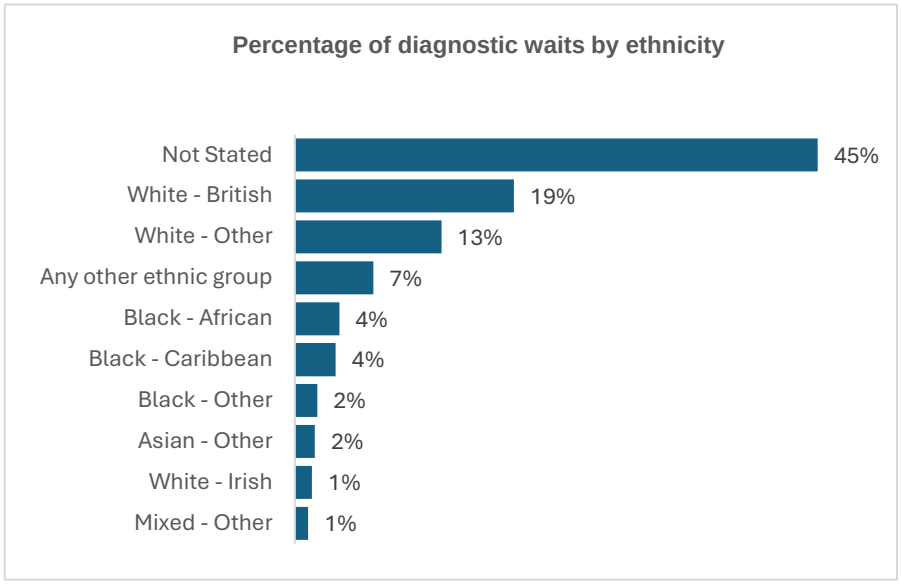


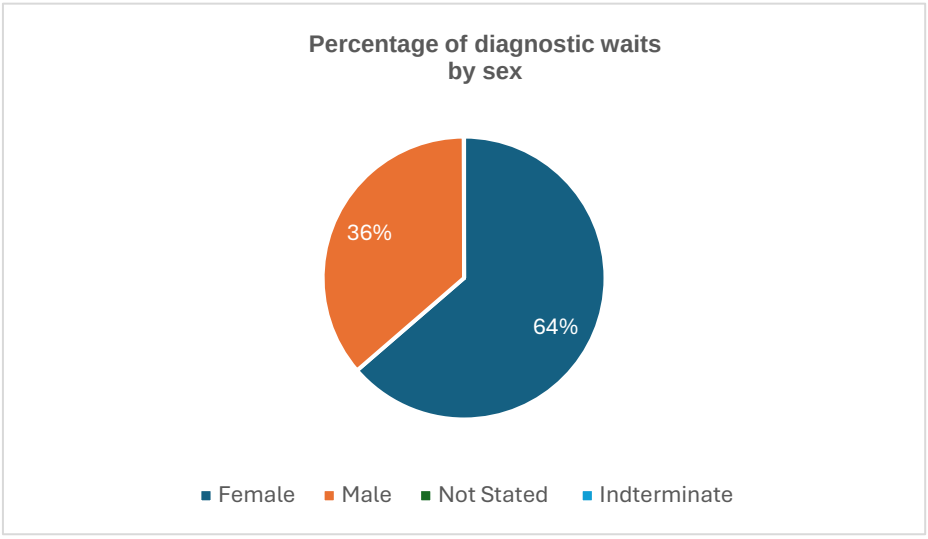


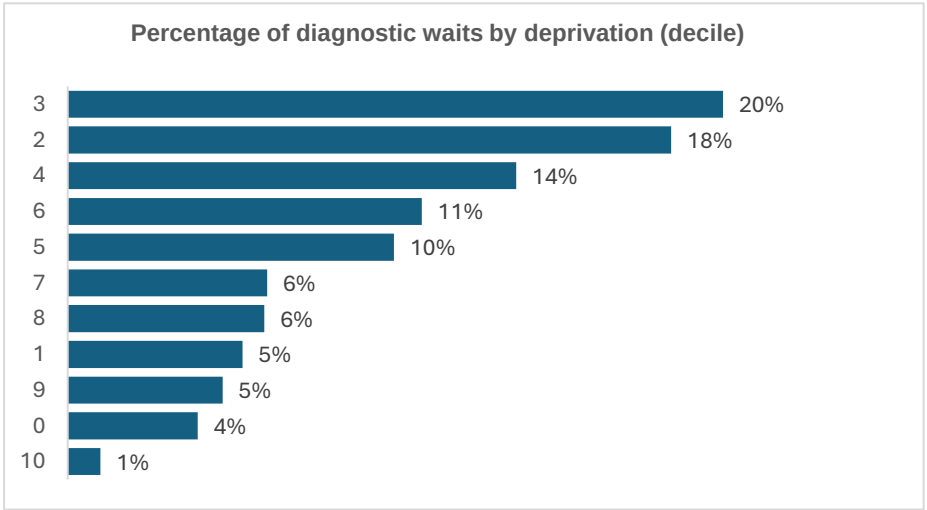


Diagnostic waits

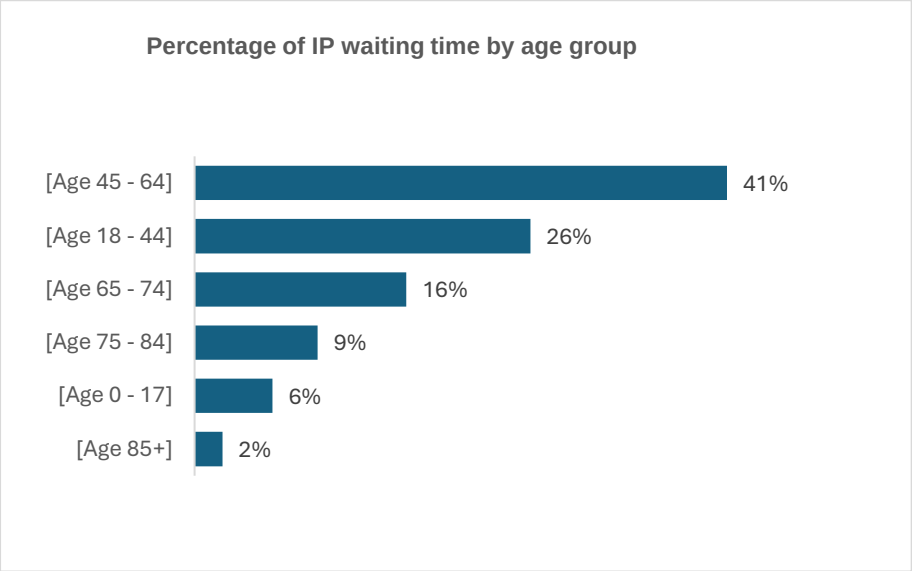


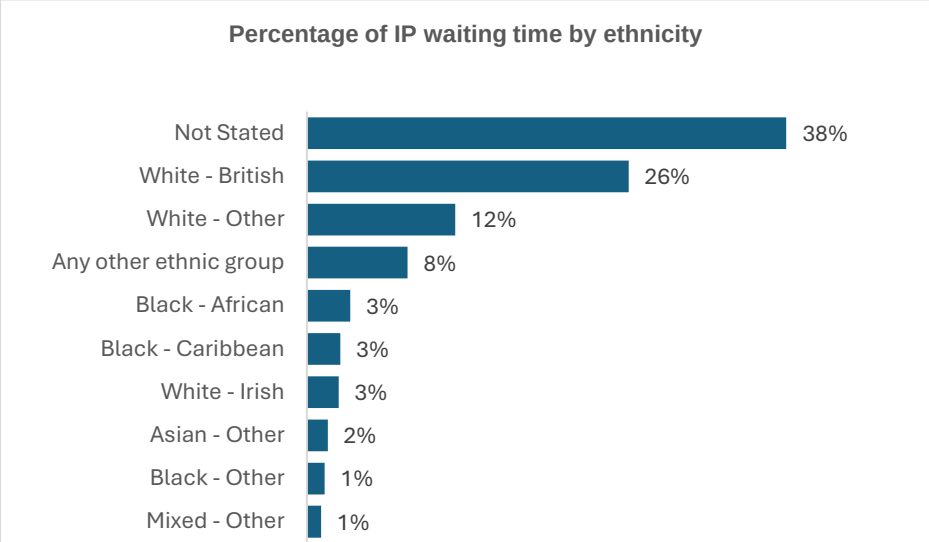

Percentage of diagnostic waits by ethnicity
Not Stated
White - British
White - Other
Any other ethnic group
Black - African
Black - Caribbean
Black - Other
Asian - Other
White - Irish
Mixed - Other
45%
19%
13%
7%
4%
4%
2%
2%
1%
1%

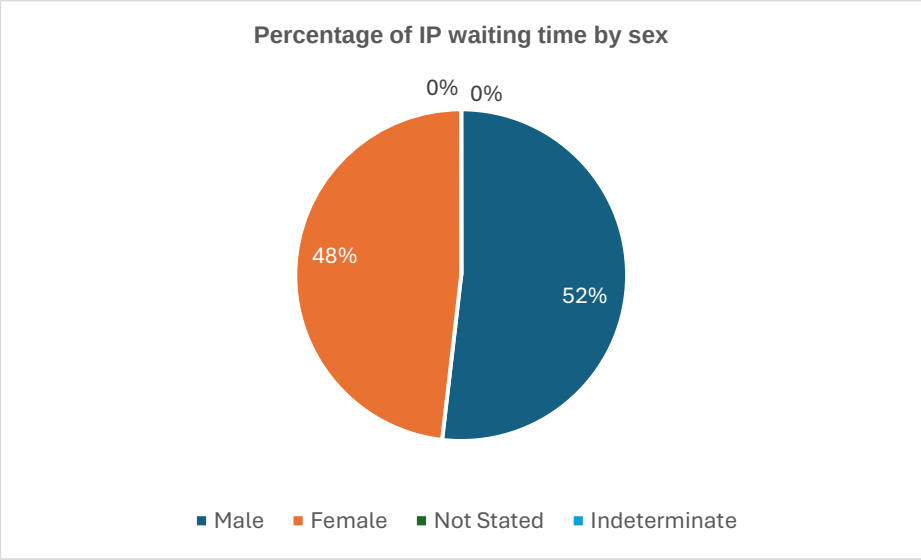

Percentage of diagnostic waits by sex
36%
64%
Female
Male
Not Stated
Indterminate

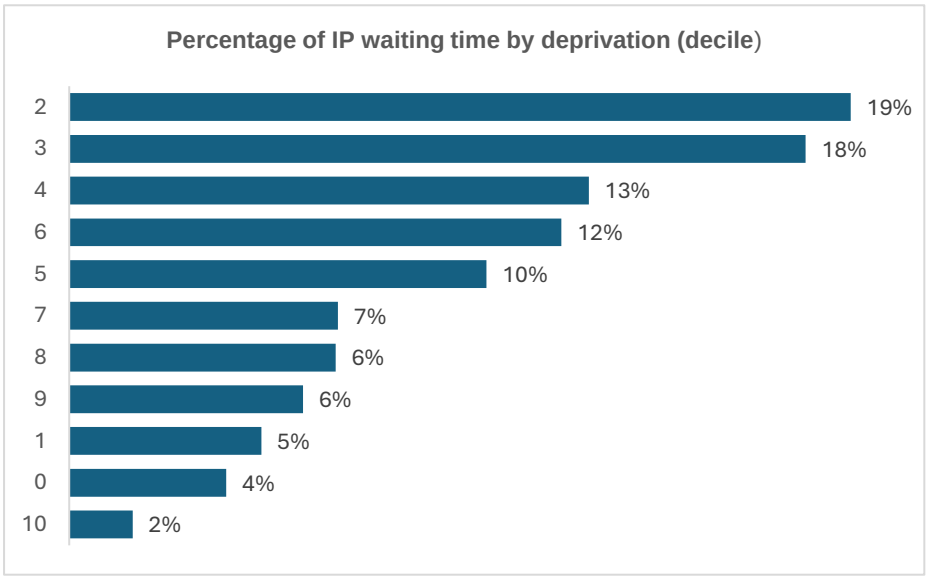

Percentage of diagnostic waits by deprivation (decile)
3
2
4
6
5
7
8
1
9
0
10
20%
18%
14%
11%
10%
6%
6%
5%
5%
4%
1%

Inpatient (IP) waiting times

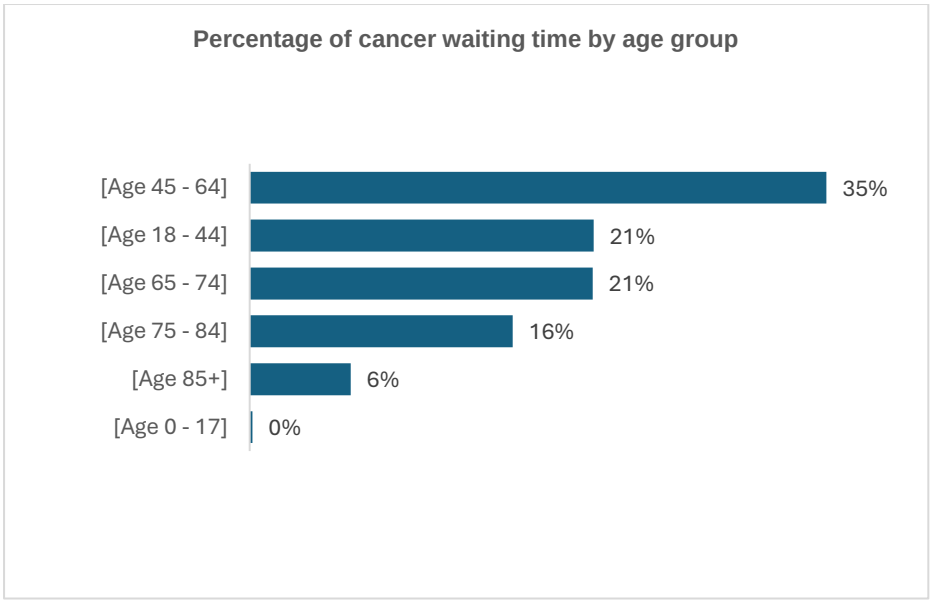


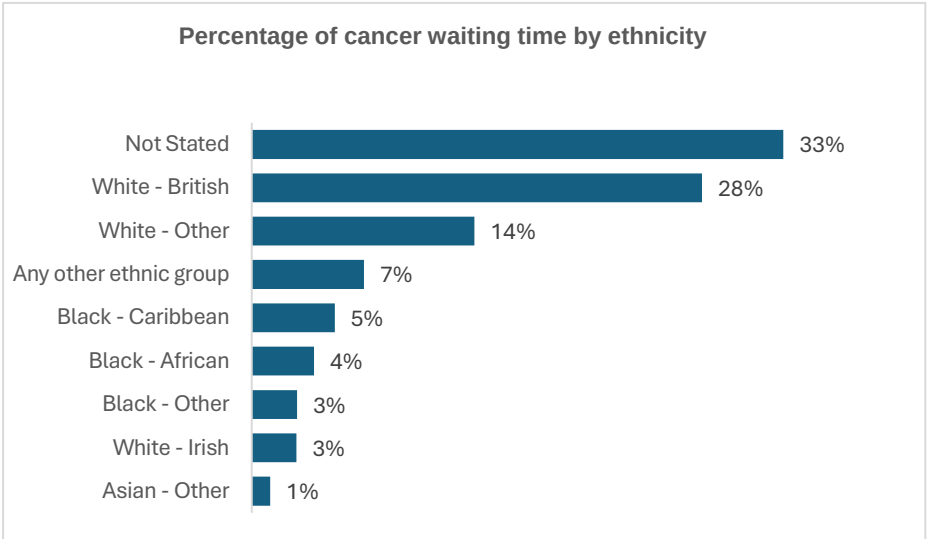


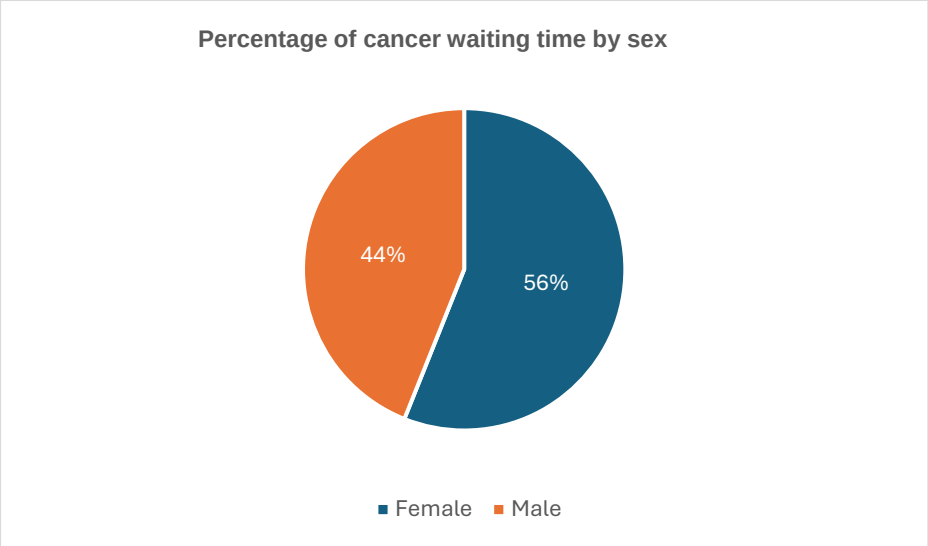


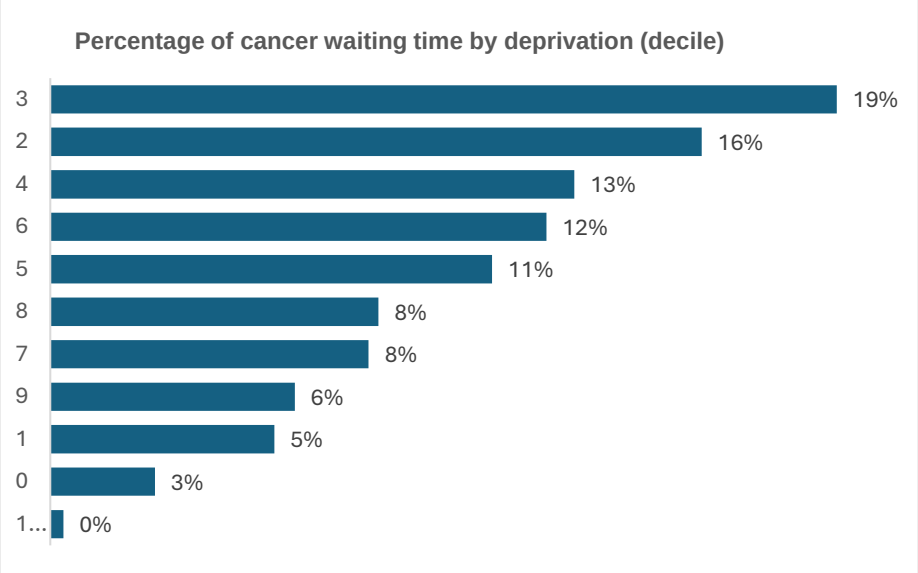


Cancer waiting times

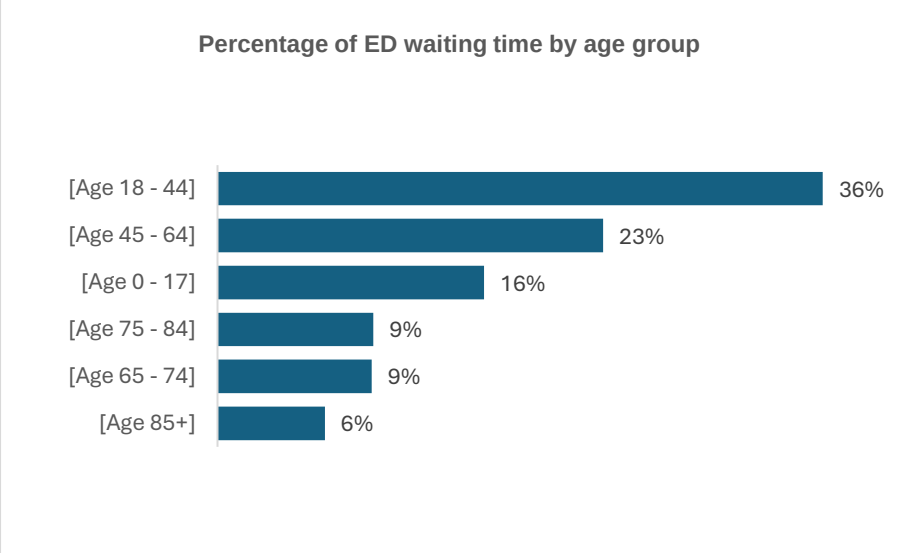


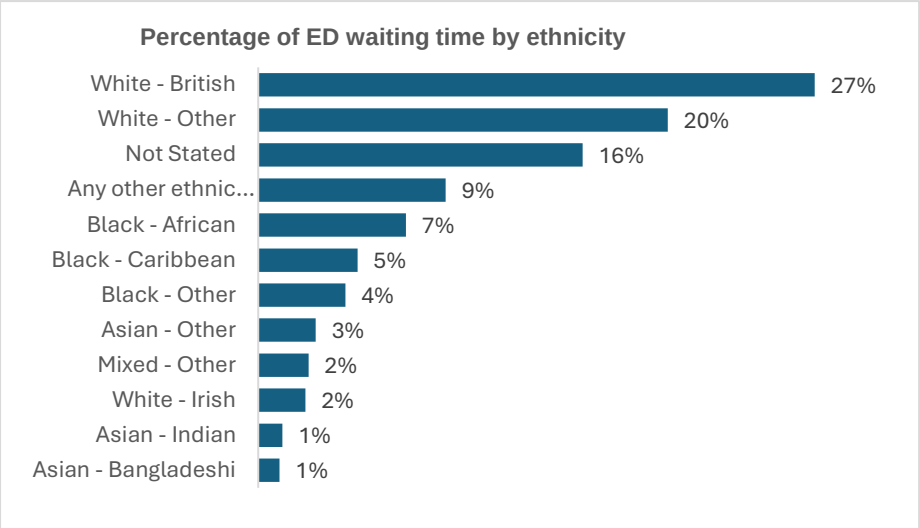


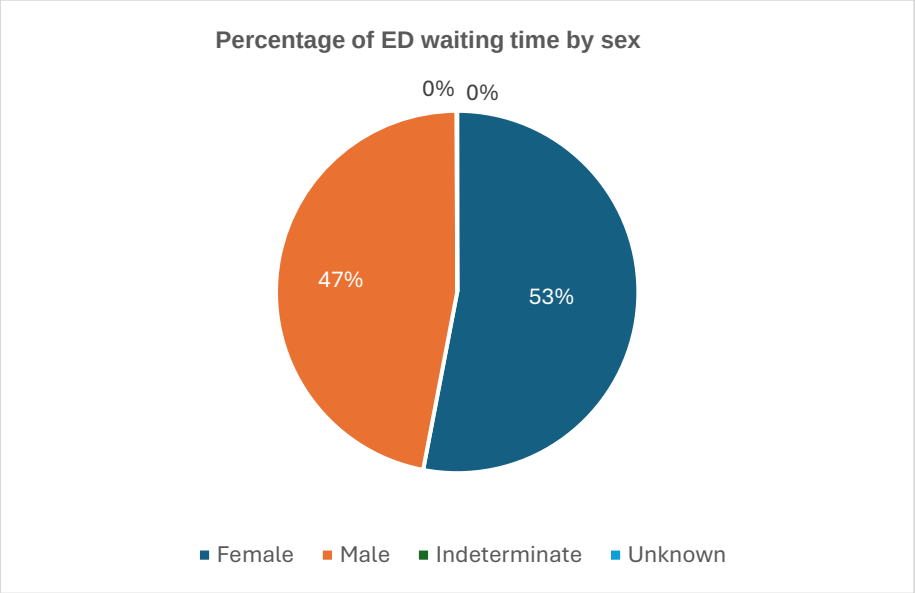


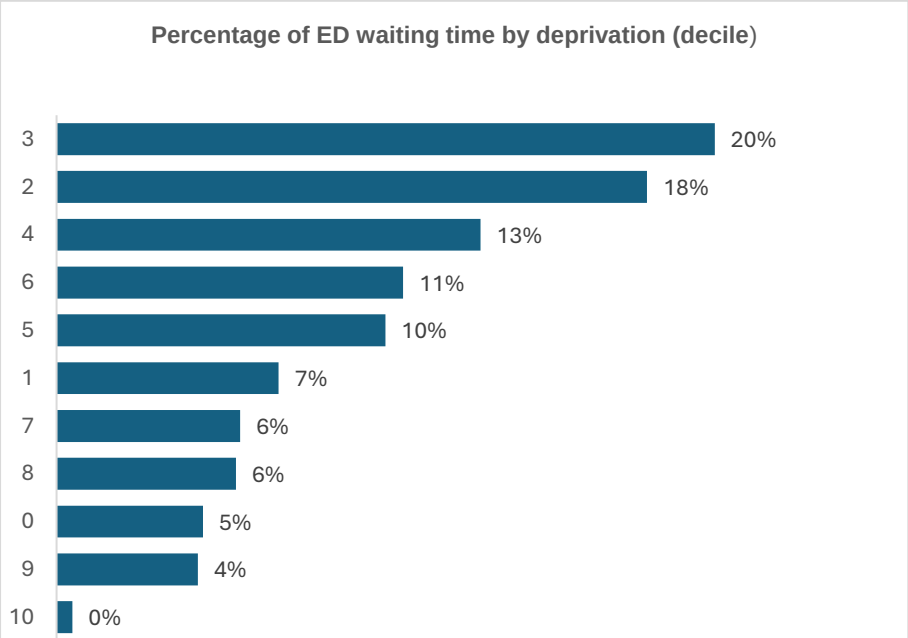


Emergency department waiting times




Percentage of ED waiting time by ethnicity
White - British
White - Other
Not Stated
Any other ethnic...
Black - African
Black - Caribbean
Black - Other
Asian - Other
Mixed - Other
White - Irish
Asian - Indian
Asian - Bangladeshi
27%
20%
16%
9%
7%
5%
4%
3%
2%
2%
1%
1%


Percentage of ED waiting time by sex
0%
0%
47%
53%
Female
Male
Indeterminate
Unknown


Percentage of ED waiting time by deprivation (decile)
3
2
4
6
5
1
7
8
0
9
10
20%
18%
13%
11%
10%
7%
6%
6%
5%
4%
0%

Case study: Whittington Health Musculoskeletal Out-Patient Physiotherapy Community Appointment Days

The Musculoskeletal (MSK) Physiotherapy Community Appointment Days (CADs) held in 2024/2025 were designed to provide same-day access to specialist MSK services alongside broader health and wellbeing support. This included assessments, advice, health promotion, rehabilitation, and connections to voluntary sector services. By holding the clinics in non-medical settings like leisure centres, the initiative aimed to improve patient self-management, reduce waiting lists, and foster collaboration with community teams.

Key outcomes:

- Patient reach: 383 patients were seen over two days, with a 35% DNA rate.
- Waiting list Impact: 173 patients were removed from the waiting list, representing 45% of attendees.
- Patient feedback: services were rated highly on a 0–10 helpfulness scale. The most valued non-physio supports included dietitians, walking groups, and self-management services.
- Follow-up: 20 patients opted back into physiotherapy within 2–3 months.

Challenges & Successes:

- Areas for Improvement: Enhance the booking system, adjust event duration, and refine patient communication.
- Community Engagement: Strong partnerships with local organizations (e.g., Tottenham Hotspur, Thrive into Work) were highlighted as key to success.

Future Plans: The model will be extended to Islington patients in April 2025, leveraging Access Islington Hubs for early intervention and wraparound support (e.g., wellbeing, housing, employment)

Conclusion: The CADs successfully integrated MSK care with community resources, reducing waiting lists and empowering patients. This model demonstrates the value of collaborative, preventative care and will be expanded to serve more residents in the coming year. This initiative exemplifies the service's commitment to innovative, patient-centred care and community collaboration.

FINANCIAL PERFORMANCE REVIEW

The Trust agreed a deficit plan of £10.9m for 2024/25. The Trust delivered an adjusted financial performance deficit of £13.1m for 2024/25 after adjustments for fixed asset impairments, donations and donated asset depreciation. This was £2.2m behind plan. In previous years, the Trust had either delivered or performed better than plan for eight consecutive years.

Like other NHS providers, the Trust is operating in a constrained financial environment, with financial pressures attributed to emergency bed pressures, price inflation, capital funding availability, and the cost-of-service provision given changes in demand for services (e.g., acuity of urgent and emergency care presentations and difficulties with discharging patients for onward care). These challenges, amongst other factors, have placed pressure on the underlying financial position of the Trust. The Trust is continuing to work towards improving its underlying financial performance, with partners, so that the longer-term financial sustainability of the organisation is secured.

Statement of Comprehensive Income

Statement of Comprehensive Income

	2024/25 £000	2023/24 £000
Operating income from patient care activities	471,111	436,160
Other operating income	29,273	29,658
Operating expenses	(512,746)	(470,061)
Operating surplus/(deficit) from continuing operations	**(12,362)**	**(4,243)**
Finance income	3,179	3,592
Finance expenses	(1,860)	(2,179)
PDC dividends payable	(5,588)	(5,881)
Net finance costs	**(4,269)**	**(4,468)**
Surplus / (deficit) for the year from continuing operations	**(16,631)**	**(8,711)**
Surplus / (deficit) for the year	**(16,631)**	**(8,711)**
Other comprehensive income		
Will not be reclassified to income and expenditure:		
Impairments	(7,339)	(19,055)
Revaluations	672	581
Total comprehensive income / (expense) for the period	**(23,298)**	**(27,185)**
Adjusted financial performance (control total basis):		
Surplus / (deficit) for the period	(16,631)	(8,711)
Remove net impairments not scoring to the Departmental expenditure limit	3,587	9,257
Remove I&E impact of capital grants and donations	(78)	60
Adjusted financial performance surplus / (deficit)	**(13,122)**	**606**

Going concern and value for money

As with previous years, the 2024/25 annual accounts were prepared on the going concern basis. This is in line with the Department of Health & Social Care's accounting guidance, which states that the Trust is a going concern if continuation of services exists. We have detailed in the paragraph above the positive trend in the Trust's finances. This improvement means that the Trust continues to comply with the Department of Health & Social Care's duty to break even over a three-year period.

Financial performance and statement of financial position

Above, we detailed the Trust's financial position for the year ending 31 March 2025, which indicated effective arrangements in the use of resources. However, as a Trust with an underlying financial deficit, we continue to face a challenging financial future.

Cash

The Trust ended the financial year with a cash balance of £46.3m, which is more than 30 days' requirement. This is a reduction of £22.2m from the end of 2023/24, the reduction driven primarily by capital expenditure during the year, and the Trust's income and expenditure deficit. The Trust received £0.4m of public dividend capital to support capital schemes and programmes.

Property, plant and equipment

The Trust's outturn capital expenditure for the year was £29.7m, which matched our Capital Resource Limit. Within this total, £3.6m related to Right of Use assets comprising remeasured and new leases, and £26.1m to owned assets. Significant capital schemes within the owned asset expenditure included the Power Upgrade, Fire Remediation and Mortuary projects, in addition to updates to information technology and hardware.

Receivables (debtors)

The Trust's current receivables at the end of the financial year were £23.1m. This was £3.9m lower than in 2023/24, with the contract receivables decrease of £4.9m driving this reduction.

Payables (creditors)

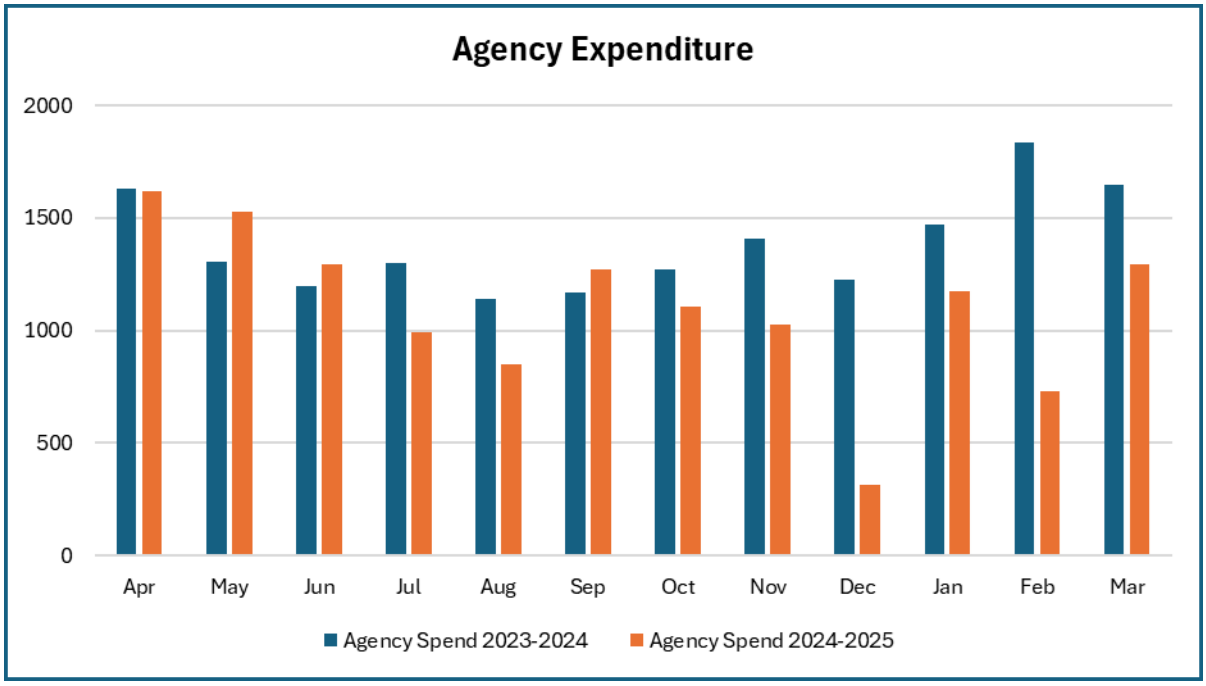
The Trust's payables at the end of the financial year totalled £91.2m,which was £1.8m lower than in 2023/24. Trade payables increased by £8.4m, capital payables decreased by £2.8m and accruals decreased by £7.3m. The combined creditor performance remained strong during the financial year, with the Trust now reporting payment of 94.2% of the value of invoices within 30 days, compared with 95.6% in 2023/24.

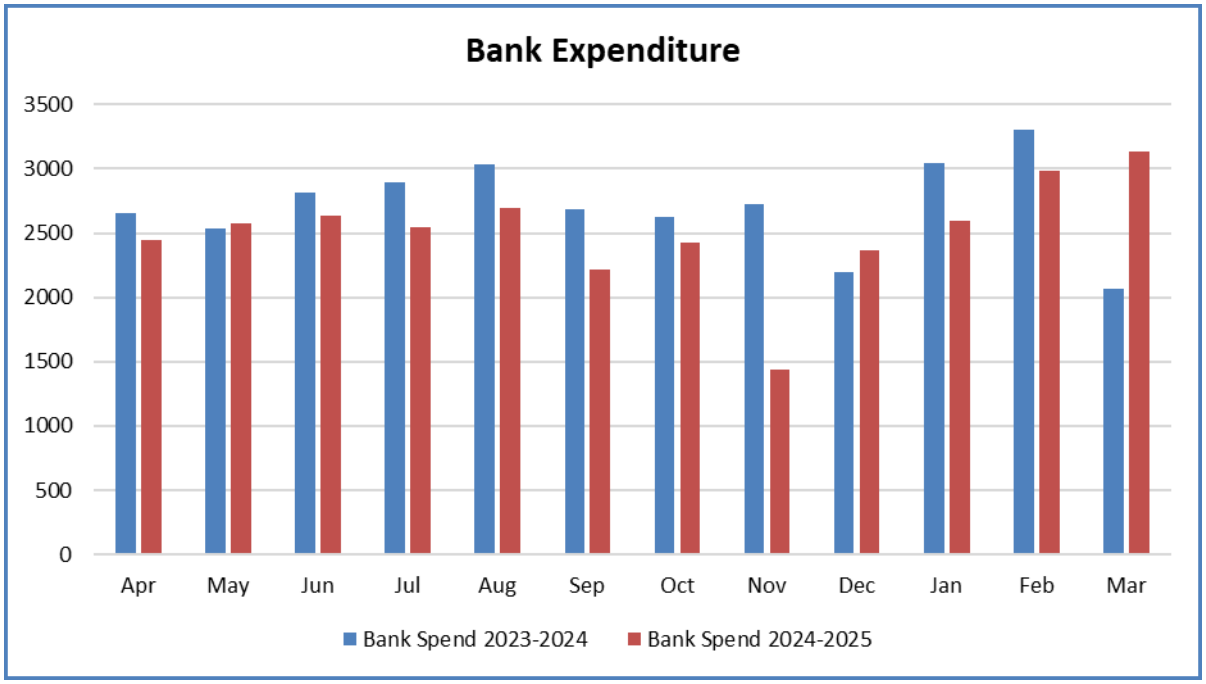
Spending on agency and temporary staff

The Trust spent £13.2m on agency staff for 2024/25, which was £3.7m lower than agency expenditure in 2023/24. This represented 3.5% of total pay costs. In addition to agency spend the Trust spent £30.6m on bank staff, which was £2.0m lower than for the previous financial year. Additional staffing requirements to support system bed pressures, new non-recurrent investments, enhanced care and the support of elective recovery schemes were the main drivers for this increase. Some of these increased costs were partially offset by additional income.

The Trust is aware that maintaining and improving our performance in relation to the use of agency and temporary staff is fundamental to delivering high quality care and financial sustainability. The Trust has continued to develop other measures to monitor and control temporary staffing expenditure.

The graphs below show the level of expenditure on bank and agency staff during 2024/25 and include a comparison for 2023/24.





STRATEGIC RISKS

The Trust has a robust risk management framework and policy and procedure s as outlined in the annual governance statement. The key risks on our 2024/25 Board Assurance Framework (BAF) were as follows and covered our performance in four areas: quality and safety, people, integration and sustainability.

BAF entry	Principal risk(s)
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
Quality 2 – capacity and activity delivery	Due to a lack of capacity and theatre ventilation works, 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
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
People 2 – staff wellbeing and equality, 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

BAF entry	Principal risk(s)
	• a failure to secure staff support, buy-in and delivery of NCL system workforce changes and an increased potential for unrest
Integration 1 – ICS 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
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
Sustainable 1 – control total delivery and underlying deficit	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 – 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
Sustainable 3 – digital strategy 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

BAF entry	Principal risk(s)
	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.

Each of these risks has a clear mitigation plan and assurance process in place.

Anti-fraud, bribery, and corruption

Whittington Health is committed to reducing fraud and bribery against the NHS to a minimum, and all allegations of fraud related to our function are investigated by the Trust's Local Counter Fraud Specialist (LCFS). The Trust engaged RSM UK to provide its LCFS service during 2024/25. The LCFS worked to a risk-based annual plan which has been agreed by the Chief Finance Officer and the Audit and Risk Committee. The plan is designed around the Government Functional Standard: 013 Counter Fraud, and the NHS Counter Fraud Authority's NHS Requirements, designed to implement these for the NHS. Compliance with these Requirements is reported to the Audit and Risk Committee annually. The Trust's annual counter fraud functional standards return was completed at year-end and submitted to the NHS Counter Fraud Authority with an overall green rating. The Chief Finance Officer is the executive lead for anti-fraud work. In February 2024, Trust Board members held a seminar where they received expert external advice on corruption and the provisions of the Bribery Act 2020, including coverage of gifts and hospitality, facilitation payments, and declarations of conflicts of interest.

DELIVER CONSISTENT, HIGH QUALITY, SAFE SERVICES

The accountable officers for quality and safety are the medical director and the chief nurse and director of allied health professionals. For quality assurance, the lead officer is the chief nurse and director of allied health professionals.

Registration with the Care Quality Commission

Whittington Heath are registered with the Care Quality Commission (CQC) without any conditions. The CQC did not inspect the trust from April 2024 – March 2025.

There were four CQC relationship meetings held in 2024/2025, which focussed on fire remediation works, medicines management and Barnet 0-19 Children's services which Whittington Health NHS Trust welcomed in to the Trust in April of 2024. The medicines management engagement meeting is an annual meeting between the CQC pharmacy team and Trust pharmacy team.

The table below provides the rating summary for the CQC's final report published in March 2020 following an inspection in December 2019 of four core services (surgery, urgent and emergency care services, critical care, community health services for children and young people and families and specialist community mental health services for children and young people). The Trust's current CQC overall rating from this assessment is 'Good' for Whittington Health, with 'Outstanding' ratings for our community health services and performance against the CQC's '*Caring'* domain. The overall rating of the Trust has not changed following the CQC inspection of maternity services in 2023 and remains 'Good' overall.

	Safe	Effective	Caring		Responsive	Well-led	Overall
Acute	Requires Improvement	Good	Good		Good	Good	Good
Community	Good	Good	Outstanding		Good	Outstanding	Outstanding
Children's mental health services	Requires Improvement	Good	Outstanding		Good	Good	Good
Overall trust	Requires Improvement	Good	Outstanding		Good	Good	Good

The CQC action plan remains a focus for improvement; the closed actions have been reviewed with the responsible Clinical Divisions in 2024 to ensure that they are reflective of the current Trust position, and they are monitored at the divisional Quality meetings.

In 2023, the CQC said a new 'Single Assessment Framework' would replace the 'Key Lines of Enquiry' (KLOEs). However, the five domain names (Safe, Effective, Caring, Responsive, and Well-Led) remain, along with the existing ratings (outstanding, good, requires improvement, and inadequate).

The Trust's focus is on promoting a more vigorous learning and safety culture, improving the quality of care where it's needed most, and addressing inequalities in healthcare.

The new assessment framework retains the five domain names and the four-point rating scale. It will assess services against quality statements, which have replaced the key lines of enquiry (KLOEs), prompts, and rating characteristics.

The CQC will gather evidence both on-site and off-site to make an assessment. The types of evidence we will consider are grouped into six evidence categories:

- People's experience of health and care services
- Feedback from staff and leaders
- Feedback from staff and partners
- Observation
- Processes
- Outcomes

Assessments may be responsive (in response to information of concern) or planned. In both cases, the CQC will be flexible and may expand the scope of an assessment as needed. Currently we are working with the Clinical Division leads to develop the quality statements for their services and ensure that they have a centrally accessible evidence base under the six categories above to support the quality statements, ahead of any inspection.

Quality priorities

Our quality priorities, as set out in the Quality Account, are aligned to the Trust's commitment to helping local people live longer, healthier lives and build on factors such as quality performance, clinical or public health proposals and our ambition, to continually improve and provide even better care.

Quality priorities for 2024 onwards have been developed following a range of engagement events with the public and our stakeholders. They are aligned to the Trust's Corporate Objectives "Deliver outstanding safe and compassionate care in partnership with patients".

- Ensuring patients are seen by the right person in the right place at the right time.
- Access and attendance.
- Reducing health inequalities in our local population.
- Improving the Trust Environment to Improve Patient Experience.

The Trust held several engagement events across the Trust and community sites to gather feedback from people who use our services and staff. This feedback was combined with intelligence from a range of data and information, such as learning from Patient safety incident investigations (PSIIs) reviews of mortality and harm, complaints, claims, clinical audits, patient and staff experience surveys, and best practice guidance from sources such as the National Institute for Health and Care Excellence (NICE) and national audit data to help establish ongoing priorities and any new priorities to be added in 2025/26.

Key achievements from 2024/25 included:

- The Birmingham Symptom Specific Obstetric Triage System (BSOTS) has been implemented in Maternity Triage.
- 75% of Trust staff have had Oliver McGowan training delivered.
- The Transformation team have been reviewing outpatient letters to ensure that clinic and ward locations match hospital signage. Outpatient letters fully updated in Urology, Gynaecology and elderly care. The remaining areas will be completed once central administration team implemented.
- The Virtual ward and rapid response urgent response 2hr/4hr/24hour targets to ensure timely patient care and admission avoidance are being met.
- The new codesigned NCL Community Red Cell (sickle cell) Service with partners and patients in North Middlesex University Hospital and UCLH is up and running, with Emma Drasar as lead.
- Providing accessible information to those patients with learning disabilities has been achieved and the Trust webpage is live and is being used by patients.
- Virtual ward beds are being fully utilised. There are currently 44 beds at Whittington Health (20 acute split between Haringey and Islington), 16 remote monitoring beds, 8 Islington Complex VW beds.
- In collaboration with our mental health partners at the North London NHS Foundation Trust, violence reduction training is being provided to all staff to support mental health patients waiting for a mental health bed.
- Training on the use of restrictive practice and de-escalation techniques for adults have been provided.

Case study: Martha's Rule

This is a national patient safety initiative to ensure the vitally important concerns of the patient and those who know the patient best are listened to and acted upon. It is in response to (among others) the death from sepsis of Martha Mills, aged 13, whose family's concerns were not listened to. Whittington is one of the 143 phase one hospital sites across England working on the implementation of Martha's Rule.

One part of Martha's Rule was launched at Whittington in December 2024 across adult and children's areas with a Martha's Rule phoneline. This enables patients or their relatives to escalate concerns directly to the Critical Care Outreach Team (CCOT).

Between December 2024 and February 2025, this phoneline was used by 33 patients/relatives, an average of 11 a month. 80% of the calls have been made outside normal working hours and 60% have been about non-clinical concerns. Reassuringly, referrals to this phoneline have not unearthed unexpected patient safety issues. However, we are gaining valuable learning about difficult patient experience issues. All the referrals require time and are often complex.

The intention of Martha's rule is to listen to close family members in order to ensure the safety of deteriorating patients. We are also seeing benefits for the patient/relative experience as they appreciate having a clinical person to call with concerns. This benefit reaches beyond the patients or relatives who use the service. Iin initial feedback from a visiting relative (survey), the existence of the phoneline provided reassurance.

Freedom to Speak up Guardian

In 2024/25, a new Chief People Officer was appointed to the Trust as well as retaining her substantive role at UCLH. This appointment also enabled a realignment of portfolios within the executive team and the Freedom to Speak Up (FTSU) Guardian now sits within the Workforce directorate, with the Chief People Officer taking executive responsibility for this in both organisations. This change has enabled networking of both Freedom to Speak Up Guardian services across Whittington Health and UCLH enabling shared learning and support.

The FTSU Guardian continues to work closely with the Communications, Human Resources, Inclusion and Organisational Development teams and Head of Well-being. This enables a multi-professional approach to concerns raised and themes to be identified and acted upon. In addition, work has been undertaken in relation to cultural behaviours, bullying, harassment, and detriment in a serious, committed, and constructive manner, contributing to ongoing improvement in services and staff experience. Additionally, the Freedom to Speak Up Guardian continues to play a key role in de-escalating conflicts, enhancing communication at both individual and team levels, supporting the Organisational Development team in mediations, conflict resolutions, facilitated conversations and listening events.

In collaboration with the Head of Wellbeing and Staff Engagement, the Guardian and the Speak Up Champions are actively participating in the Roadshow Engagement initiative across various community sites. Their presence aims to raise awareness about the importance of speaking up, providing staff the confidence to voice concerns in a safe and supportive environment. As a direct result of these efforts, the number of concerns being raised by staff has increased, indicating that the initiative positively encourages people to speak up. Furthermore, the roadshow initiative has led to a noticeable rise in applicants expressing interest in becoming Speak Up Champions within the Community. This shows that more staff members are becoming aware of the importance of speaking up and are motivated to promote a culture of raising concerns safely across the Trust.

During this year, the Freedom to Speak Up Guardian received 105 initial concerns that required action. One concern was raised anonymously and was reported internally and investigated. Concerns received per quarter were as follows: Quarter 1 – 20, Quarter 2 – 24, Quarter 3 - 36, and Quarter 4 – 25. Notably, there was a spike in concerns raised in Quarter 3. Overall, there was a significant increase on the number of concerns raised if compared to preceding years - April 2023 to March 2024 - when 73 initial cases were reported, and April 2022 to March 2023 with 84 initial concerns and April 2021 to March 2022 when 84 concerns were reported. This was the year where more concerns were recorded. The ongoing upward trend in concerns being raised suggests a growing confidence in speaking up as an alternative route to escalate and address concerns. Each concern created new opportunities for change and improvement. We continue working ensuring everyone raising concerns feels safe, listen, welcomed and appreciated for this valuable contribution.

In this year, the lead theme from concerns received is bullying and harassment, with 45 cases, with an element of other inappropriate attitudes or behaviours with 17 cases, and 15 cases with an element of worker safety or wellbeing, and 15 cases with an element of patient safety/quality.

The Guardian has identified several priorities for the next twelve months to continue staff engagement regarding raising concerns, and they include:

- Promotion and implementation of Freedom to Speak Up training for all staff. This training initiative aims to address barriers, enhance confidence, and empower individuals at all levels to voice concerns and contribute to a positive and responsive organisational culture. By promoting freedom to speak up training, we seek to foster a workplace environment where every member feels supported and encouraged to speak up, ultimately contributing to improved patient safety, worker well-being, and organisational excellence.
- Continue to prioritise regular visits to both community and hospital sites to maintain ongoing visibility of Freedom to Speak Up. Ensure that the Guardian is accessible and approachable during these visits to foster a culture of Trust and openness.
- Continue the recruitment and training of Speak Up Champions, focusing on areas not yet covered by the Network. And implement new refresh training for all Champions.
- Develop and deepen collaborative relationships, training, learning and support between support networks

Case study: Oncology Assessment Unit (OAU)

Audits showed that on average approximately 200 oncology patients were treated in ED annually. These patients would have been more appropriately treated within the Systemic Anti-Cancer Treatment (SACT) unit.

This innovative service streamlines general oncology and patients on the malignancy of unknown origin pathway from gateway areas such as the emergency department, ambulatory care or clinics. This ensures that patients are seen in the right place at the right time by the right person.

The OAU consists of one bed and one chair and is based in our chemotherapy unit. It is staffed by 1 junior clinical fellow and 2 acute oncology clinical nurse specialists. This service is available Monday to Friday, 9-5pm.

The service provides support and assessment to patients who are undergoing SACT treatment and suffering from toxicities of their cancer treatment.

Since the service began in October 2024, 280 patients have been seen to date.
It has been well received and evaluated by our oncology patients.

PATIENT SAFETY

Patient safety incidents

The Trust transitioned to the Patient Safety Incident Response Framework on 1st April 2024 which has been well received across the Trust. The Trust continues to actively encourage incident reporting to strengthen a culture of openness and transparency which is closely linked with high quality and safe healthcare.
Incident reporting has continued to increase every year

Since the implementation of LFPSE (Learning from Patient Safety Events) in November 2023, person harm changed and is now recorded as physical and psychological harm. The data below is based on all levels of physical harm caused to the patient and there is no differential between death caused or not caused by the incident; all incidents where the patient died regardless of the nature of the safety incident are recorded as fatal.

Table 1: Total number of incidents reported by level of harm caused / financial year

	2022/2023	2023/2024	2024/2025	Total
No Harm	4697	5175	4500	14372
Low Harm	2466	3357	4456	10279
Moderate Harm	825	1071	888	2784
Severe Harm	16	40	21	77
Fatal	0	20	28	48
(Pre-LFPSE 2023) Death - caused by the incident	5	2	0	7
(Pre-LFPSE 2023) Death - (NOT caused by the incident)	37	13	0	50
Total	8046	9678	9893	27617

Patient safety Incident Response Plan:

The top six themes within the Patient Safety Incident Response Plan (PSIRP) are outlined in the table below. The latest incident reported data will be triangulated and analysed alongside other patient safety sources and reviewed with a view to make any recommendations to change any of the top themes and priorities.

Table 2: Top six themes outlined in the Patient Safety Incident Response Plan for 2024/25

Theme	Key Theme
1	Patient Falls
2	Medication/Safety
3	Responding to a deteriorating patient
4	Pressure related skin damage
5	Delayed Treatment & Diagnosis
6	Unsafe discharge

Security incidents were not included in the 2024/25 Patient Safety Incident Response Plan (PSIRP) as it was felt they were not patient safety incidents, and were reported for noting.

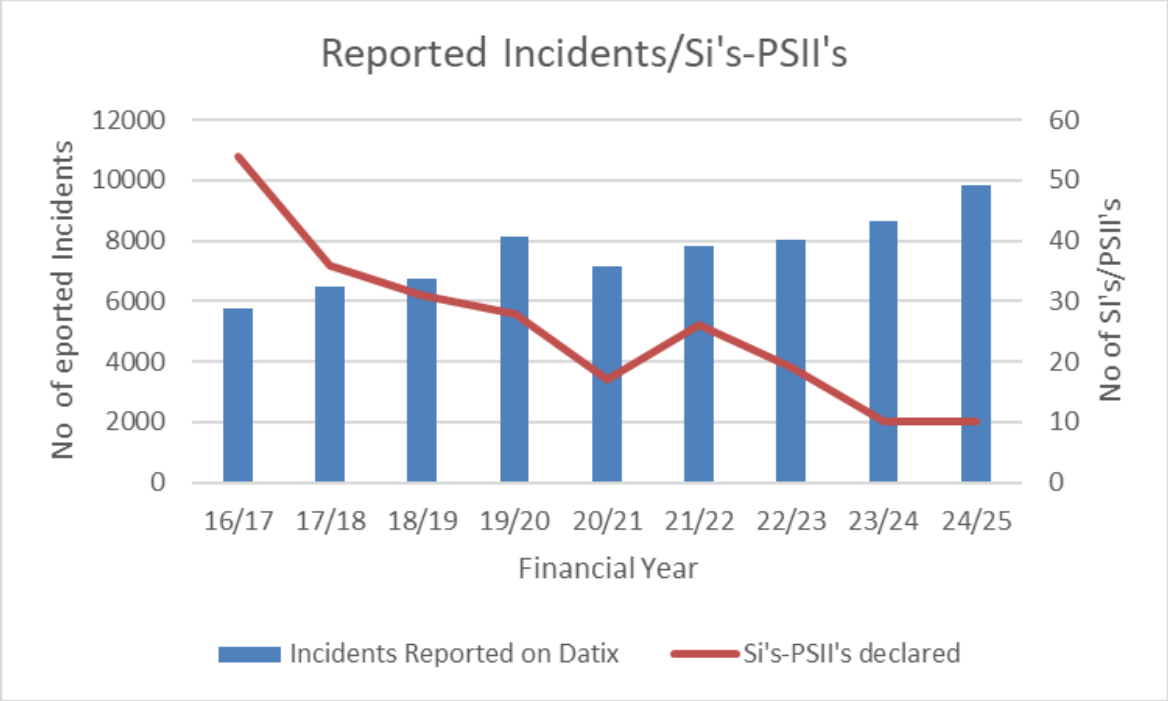
Patient Safety Incident Investigations

An executive-led implementation group has overseen the implementation of PSIRF. The Whittington Improvement and Safety Huddle (WISH) replaced the Serious Incident Executive Action Group (SIEAG); WISH ensures there is a greater focus on learning, improvement, compassionate engagement, with supportive oversight.

Under the PSIRF the Trust is no longer required to declare serious incidents based on predefined thresholds, However, there are several mandated incidents where a Patient Safety Incident Investigation (PSII) must be completed. Where it is felt there is new learning and improvement the Trust utilises the most appropriate learning response tool. The Trust has improvement plans and workstreams in place in relation to pressure related skin damage, falls and medication safety. This ensures the Trust can focus more time and resource on learning and improving.

Five Serious Incidents (reported before the implementation of PSIRF) were closed during 2024/25. During 2024/25 there were 10 PSIIs reported on the Strategic Executive Information System (StEIS); this is the system used to report and monitor the progress of Serious Incident investigations across the NHS. As illustrated in the graph below, the number of Serious Incidents (pre-April 2024) and PSIIs declared as a proportion of all patient safety incidents has been reducing since 2016. This is a positive trend, indicative of an open, transparent safety culture where reporting of incidents is encouraged, with a higher volume of incidents which are near misses or low harm incidents.

Graph 1: Serious Incidents/PSIIs declared, as a proportion of all patient safety incidents 2016-2025



To comply with the Patient Safety Incident Response Framework (PSIRF), Whittington Health focusses on identifying whole system issues and take a human factors approach. WISH have supported the use of a variety of learning response tools, such as After-Action Reviews, SWARMS (learning response and improvement tool), and a Multidisciplinary team (MDT) approach, Quality Improvement (QI) projects and audit projects, to drive change.

Completed investigation reports with a summary letter, highlighting key findings and changes made as a result, are shared with the patient and/or family member with an offer of a meeting with the Trust to discuss the findings.

Lessons learned following each investigation were shared with all staff by a variety of methods including the 'Big 4' in theatres, and 'message of the week' in Maternity, Obstetrics, Trust-wide multimedia such as a regular patient safety newsletter.

Never Events

A Never Event is defined as a serious, largely preventable, patient safety incident that should not occur if the available preventative measures have been implemented; this is a list of specific events defined nationally.

During 2024/25, the Trust reported two Never Events which were both wrong sided blocks.

A124287 – Surgery & Cancer ICSU – Wrong sided block
Description: A right sided supraclavicular local anaesthetic block was performed for left sided surgery. A patient safety incident investigation has been launched and is under way.

A121287 (2024.10486) – Surgery & cancer ICSU – Wrong sided block
Description: Following a fall the patient required a paravertebral local anaesthetic block for rib fractures. The block was done on the left side (incorrect side). A patient safety incident investigation was launched, and we expect completion of this by Summer 2025, with the lessons learnt implemented at the same time.

Maternity and Newborn Safety Investigations (MNSI)

The Maternity and Newborn Safety Investigations (MNSI) programme is part of a national strategy to improve maternity safety across the NHS in England. All NHS trusts with maternity services in England refer incidents to MNSI.

The MNSI programme was established in 2018 as part of the Healthcare Safety Investigation Branch and is now hosted by the Care Quality Commission.

MNSI investigates incidents that meet the criteria as previously defined within the Each Baby Counts programme or MNSI defined criteria for maternal deaths. During the investigations MNSI investigates all clinical aspects of the incident, as well as aspects of the workplace environment and culture surrounding the incident.

Between the 1st April 2024 to 31st March 2025, there were two cases referred to MNSI.

The first case related to neonatal death at term. The MNSI team reported problems with recording observations, communications within the multidisciplinary team, and some delay in the birth of the baby from the time the decision was taken to deliver to actual delivery.

The second case related to an intrauterine death at birth, this was referred to MNSI but due to difficulties engaging the family, this case was not taken up by MNSI. An internal review did not identify service delivery problems and highlighted some areas of good practice.

In line with PSIRF principles, both cases will be reviewed by our executive team, and disseminated within the Trust.

Perinatal Mortality Review Tool

The use of the PMRT is a requirement for the Safety Action 1 of the Maternity Incentive Scheme. The Perinatal Mortality Review Tool (PMRT) supports systematic, multidisciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and babies who die in the post-neonatal period having received neonatal care. PMRT provides a structured process of review, learning, reporting and actions to improve future care.

Between 1 April and 30 June 2024:

There was one case that met eligibility criteria for PMRT review. This was an intra uterine death of a single twin. The case was review by the PMRT group and no care and or service delivery problems contributing to the outcome were identified.

Between 1 July and 30 September 2024:

There were three stillbirths, all above 22 weeks gestation, that met eligibility criteria for PMRT review. Relevant learning and improvement opportunities identified include improving identification of placental abruption, improving pathways of admission for pregnant patients with concurrent medical problems, improving care for patients with a history of domestic violence, improving facilities for bereaved families, and improving access and coordination across various electronic patient record platforms used in maternity.

These improvement actions have been embedded in the maternity/medicine standard operating procedures and debriefs and learning summaries have been completed and shared with families of the bereaved.

Infection prevention and control

A senior specialist nurse heads the Trust's infection prevention and control (IPC) programme and procedures, under the guidance and supervision of the Chief Nurse and Director of Allied Health Professionals, who is the accountable officer and Director of Infection Prevention and Control (DIPC). The Infection Prevention and Control Team (IPCT) comprises clinical IPC nurse specialists and non-clinical staff. The team work collaboratively with the infectious disease and microbiology consultants to provide a full infection service to the hospital and community sites, across Whittington Health NHS Trust.

The primary focus of the IPCT function is the prevention and management of infections and its associated risks among patients, service users, members of staff, and the public within the locality. This is achieved through on-going risk assessment and mitigations, board assurance, policy development, surveillance, audit, management of infections and associated risks, education, and training.

The team reports on healthcare associated infections (HCAI) to both internal stakeholders, such as the Trust Board, the Quality Assurance Committee and the Executive team; and external stakeholders, both regionally and nationally, such as North Central London-Integrated Care Board (NCL-ICB), UK Health Security Agency (UKHSA), and National Health Service England & National Health Service Improvement (NHSE/NHSI).

Healthcare Associated Infections (HCAI)

A HCAI, or nosocomial infection, is described by the National Institute for Health and Care Excellence (NICE) in the Quality Standard [QS113] published in February 2016, as any infection occurring that:

- is a direct outcome of a contact with or following treatment in a health or social care setting including healthcare delivered in the community, or
- an existing infection brought in by patients, visitors, service users or members of staff from the outside community into the healthcare setting that subsequently is transmitted to others.

The UKHSA monitors the numbers of certain HCAIs in various settings through a routine surveillance programme.

The Integrated Care Board (ICB) conducts surveillance of incidents and provides advice on the prevention and control of HCAIs in different types of organisations within the sector, including nurseries, schools, GP surgeries, hospitals, care homes and hospices.

Surveillance and Management of HCAIs

The prevention and reduction of HCAIs at Whittington Health is of vital importance. The Trust's IPC policies and procedures centre on preventive measures to reduce the numbers of avoidable infections in patients, service users and members of staff. The IPCT conducts audits to identify and review any non-compliance to IPC policies and procedures. Any reported gaps, incidents or non-compliance are presented at the quarterly Infection Prevention and Control Committee (IPCC) for discussion and agreement of appropriate actions.

The IPCC conducts multi-disciplinary post-infection reviews (PIR) for all notifiable HCAIs reported to UKHSA to identify probable causes and factors that lead to the infection incident, including any areas of care that can be improved or any lapses. Good practice and shared learning from the PIRs are shared to ensure continuous improvement in patient care, outcomes and experience.

HCAIs reported under the national surveillance are categorised to identify healthcare exposure and establish a greater granulation of the healthcare association of the cases.

2024/25 saw an increase in HCAIs amongst patients. With the emerging resistance of pathogens to antimicrobials and an aging population, it is becoming more and more difficult to supress and combat infectious diseases.

Table 1: Healthcare Associated Infections reported for the year 2024-25

HCAI	NHSE set trajectory	Count for the year	Outcomes
Methicillin-resistant S. aureua (MRSA) Bacteraemia	0	6	The year 2024/25 saw a notable increase of MRSA bacteraemia reported by the Trust compared to last year's 2 cases. Several cases were known to be colonised with MRSA and with skin break down associated with uncontrolled eczema and wounds resulting in bacteraemia. PIR conducted for the cases that did not pinpoint specific risk and source of infection and were deemed as contaminants. Identified learning outcomes were shared with MDTs, and dedicated work streams are underway through continuous audit and education.
Gram-negative Bloodstream Infections			
E Coli	32	33	The NHS Standard Contract for 2024/25 includes quality requirements for NHS organisations to minimise Gram-negative bloodstream infections (GNBSIs) to threshold levels set by NHSE. These requirements support the delivery of the Antimicrobial Resistance National Action Plan 2024/2029 which includes a target to prevent any increase in all GNBSIs from 2019/20 baseline by year 2029, and this is not limited only to healthcare-associated infections as a large number are community-associated. With an aging population, the targeted 17% reduction nationally is not being met. Whittington Health continues to work with other organisations and community centres within the north-central London locality to ensure shared learning and management by instigating measures such as urinary catheter passports and IV-line care to support the national plan.
Klebsiella spp	16	12	
Pseudomonas aeruginosa	3	7	

HCAI	NHSE set trajectory	Count for the year	Outcomes
Clostridioides difficile **(C. diff) Infections**	22	24	While the Trust is 2 counts over its ceiling for the year 2024-25, the number of cases reported remains the same as that of the previous year. Common themes and shared learning identified from PIRs conducted were targeted on: • Appropriate and timely sending of samples for testing • Prompt isolation for suspected infectious diarrhoea cases where isolation facilities are available • Regular review of antibiotic prescription especially for high-risk patients • Switch IV antibiotics to oral where possible. • Reviewing laxative and proton-pump inhibitor use for patients developing loose stools • Poor GI assessments and poor documentation/charting of bowel movements on stool charts These outcomes are shared with the MDTs to share and discuss with their respective colleagues to improve care.
Acute Respiratory Infections (ARI)	Many of the ARIs this season were due to Influenza A between the months of October 2024 and mid-February 2025 with 373 cases reported in the year followed by Influenza B with 255 cases. 27 of these cases were hospital-acquired and 2 flu outbreaks were managed in the Trust in the year. The Trust also reported 69 cases of Respiratory Syncytial Virus (RSV) of which 5 were acquired by patients while admitted. Whittington Health reported 1 RSV-related outbreak for the year. There were 98 COVID-19 cases recorded in the year with 26 definite hospital-onset (more than 15 days of admission) while 16 had probable hospital-onset (between 8 to 14 days of admission). Although this is relatively a small number compared to previous years after 5 years into the SARS-COV 2 pandemic, the Trust still had to manage 7 COVID-19 outbreaks in the hospital in the year. The IPC team continue to educate patients, members of staff and service users the importance of hand hygiene, appropriate use of personal protective equipment (PPE) and good respiratory etiquette to protect one another.		

<table>
<tr><th>HCAI</th><th>NHSE set trajectory</th><th>Count for the year</th><th>Outcomes</th></tr>
<tr><td>Surgical Site Infections (SSI)</td><td colspan="3">The national mandatory surgical site infections (SSI) surveillance reporting requires participation in at least one quarter for each orthopaedic surgical procedure in a year. Whittington Health committed to and complied with reporting for three quarters in 2024/25 on neck of femur fracture surgery.

Table A: Neck of Femur SSI Surveillance
<table>
<tr><th>Period</th><th>No of operations</th><th>SSI reported</th></tr>
<tr><td>Quarter 1: Apr to Jun 2024</td><td>39</td><td>0</td></tr>
<tr><td>Quarter 2: Jul to Sep 2024</td><td>32</td><td>0</td></tr>
<tr><td>Quarter 3: Oct to Dec 2024</td><td>25</td><td>0</td></tr>
</table>

The SSI risk is above the national 90th percentile in both above operations, although the number of operations occurring are small and could distort percentages. It is recommended by the UK Health Security Agency (UKHSA) that surveillance should be undertaken in more than one consecutive period or continuously so that ‘more precise rates can be estimated from a larger set of cumulative data (UKHSA 2013 – Protocol for the Surveillance of Surgical Site Infection).</td></tr>
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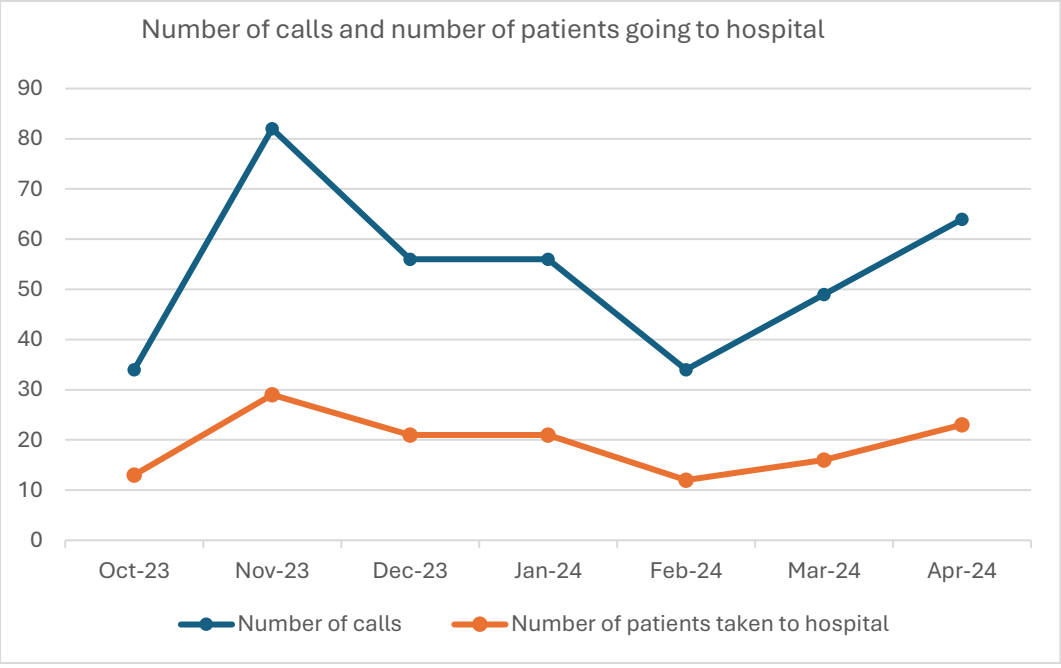
Case study: Haringey Urgent Response London Ambulance Service /Urgent Care Response (LAS/UCR) Car project

Led by Anthony Antoniou, this initiative aimed to have a senior clinician, a nurse or allied health professional, join a paramedic in a response car each day. The goal was to review category 3 and 4 calls with the aim of keeping patients at home and reducing conveyance to the hospital. Category three calls are for 'Urgent' calls such as abdominal pains, and which will include patients to be treated in their own home while category four are 'Less Urgent' calls such as diarrhoea and vomiting and back pain).

This was an innovative collaborative project between the London Ambulance Service, Central London Community Healthcare NHS Trust (CLCH), North Middlesex University Hospital (NMUH), and the Whittington Health Urgent Response team in Haringey.

The majority of calls were for falls, so having the nurse or therapist join the paramedic provided a multidisciplinary approach to keep patients safe and at home. The community staff were also able to quickly access services (which paramedics cannot) to get equipment or arrange next-day reviews. Keeping appropriate patients at home without attending the emergency department (ED) improved patient experience and reduced ED pressures. Having the urgent care staff work alongside the paramedics also improved the community staff's acute skills, knowledge, and confidence, while also increasing access to community services and equipment.

The national average conveyance rate to hospital when the London Ambulance Service sees patients alone is 65-70%. Since joining the project in November 2023, the conveyance rate has been 32-38%, with an average of 33% over the first 6 months. This equates to keeping an additional 60 patients from going to the hospital if the London Ambulance Service had seen them alone.



PATIENT EXPERIENCE

Learning from national patient surveys

The Trust received the results to four national patient experience surveys during 2024/25. These were:

- 2023 National Adult Inpatient Survey (published September 2024
- 2024 Urgent & Emergency Care (UEC) (published July 2024)
- 2024 Maternity Survey (published February 2024)
- 2023 National Cancer Patient Experience Survey (published July 2024)

Adult Inpatient Survey 2023

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services. The NPSP is commissioned by the Care Quality Commission (CQC), the independent regulator of health and adult social care in England.

The national adult inpatient survey is held every year, with a patient cohort for the 2023 survey being those who spent one or more nights in hospital during November 2023, with fieldwork taking place between January to April 2024. The findings were published nationally in September 2024.

1,250 patients were invited to take part, with a response rate of 29% (337 responses), a slight decrease on 2022 (350). There were no significant changes in respondents' demographics, albeit with a slight increase in those aged 36-50 and a slight decrease in those of a Christian religion.

We were in the top 8 trusts to have the most improved score for overall experience, going from 7.5 to 8.

Top five scores (compared with national average)

With reference to sleeping, there are a total of five questions related to "were you prevented from sleeping at night" after which there are sub-questions such as room temperature, noise from other patients, noise from staff, hospital lighting and I was not disturbed, some of which were new questions.

Question	2023 score	National Average	2022 results
Q6_8 I was not prevented from sleeping	4.1	2.9	New question
Q6_6 Room temperature	9.3	8.3	New question
Q14 Did you get enough help from staff to eat your meals	8.1	7.4	7.1 ↑
Q8 Did the hospital staff explain the reasons for changing wards during the night in a way you could understand	7.1	6.7	6.1 ↑
Q34 Before being admitted onto a virtual ward, did hospital staff give you enough information about the risks and benefits of continuing your treatment on a virtual ward	7.1	6.4	New question

Bottom five scores (compared to national average)

Of our bottom five these related to the following sections admission into hospital, the hospital or ward; and your care and treatment and related to information and communication, food, and cleanliness.

Question	2023 score	National Average	2022 results
Q4 How would you rate the quality of information you were given while you were on the wating list to be admitted to hospital? This includes verbal, written or online information	6.7	7.5	New question
Q5 How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital	5.9	6.7	6.0 (Q4) ↓
Q9 How clean was the hospital room or ward that you were staying in	8.2	9.0	8.1 (Q8) ↓
Q15 Where you able to get food outside of mealtimes	4.5	6.0	4.6 ↓
Q27 Did you feel able to talk to members of hospital staff about your worries and fears	6.9	7.7	6.8 (Q26) ↑

98% of our patients said they were treated with dignity and respect

Our overall scores for each section can be seen in the table below, in comparison to last year's score, representing improved scores, no significant change or a decline in results.

Section No	Title	Score	2022 comparison
1	Admission into hospital	6.3	No significant change
2	The hospital and ward	7.4	7.1
3	Doctors	8.7	No significant change
4	Nurses	8.1	7.8
5	Your care and treatment	8.0	7.7
6	Virtual ward	7.6	No significant change
7	Leaving hospital	6.8	6.7
8	Feedback on the quality of care	3.0	No significant change
9	Kindness and compassion	8.8	No significant change
10	Respect and dignity	8.9	8.4
11	Overall experience	8.0	7.5

Alongside successes and areas for improvements we were above the national average for the following questions:

Number	Question
Q6 _6	Were you ever prevented from sleeping at night by any of the following, room temperature?

Number	Question
Q6_8	Were you ever prevented from sleeping at night by the following, I was not prevented from sleeping.
Q8	Did the hospital stall explain the reasons for changing the wards during the night in a way you could understand?
Q14	Did you get enough help from staff to eat your meals?
Q17	When you asked doctors a question, did you get answers you could understand?
Q26	How much information about your condition or treatment was given to you?
Q29	Do you think the hospital staff did everything they could to help control your pain?
Q33	Were you given enough information about the care and treatment you would receive while on a virtual ward?
Q34	Before being admitted onto a virtual ward, did hospital staff give you information about the risks and benefits of continuing your treatment on a virtual ward?
Q41	Thinking about any medicine you were to take at home, were you given any of the following information?

97% of our patients said they had confidence and trust in the doctors

As a result of the National Adult Inpatient 2023 survey results, the patient experience team supported by our facilities and nutrition colleagues undertook ward walks throughout November in line with the patient cohort for the 2024 survey.

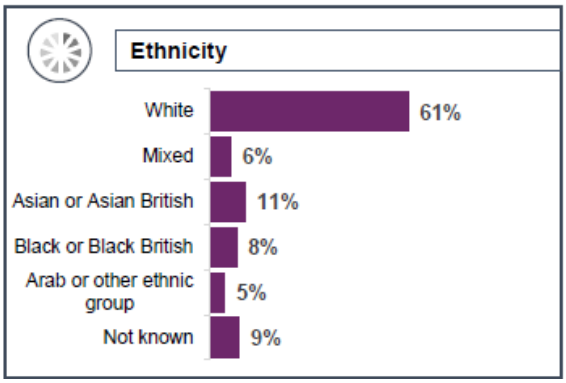
The wards walk support by the Deputy Chief Nurse were an opportunity for us to speak with staff and patients around the results, areas for improvement and to raise awareness of what we have done or our plans for the areas of improvement.

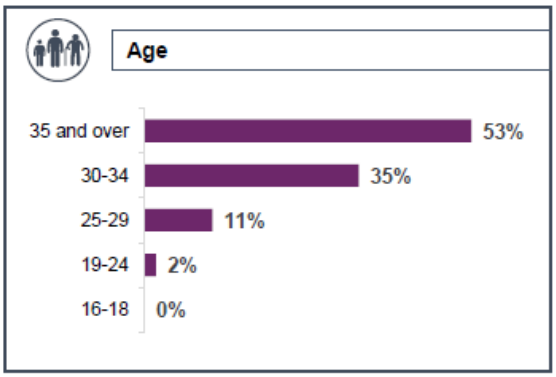
Our facilities teams spoke to staff and undertook audits on cleaning and our nutrition team spoke to staff about how to obtain food outside mealtimes alongside reviewing how food is stored in the kitchens and fridges. As part of these walks, the patient experience team surveyed patients on our bottom five areas for improvement.

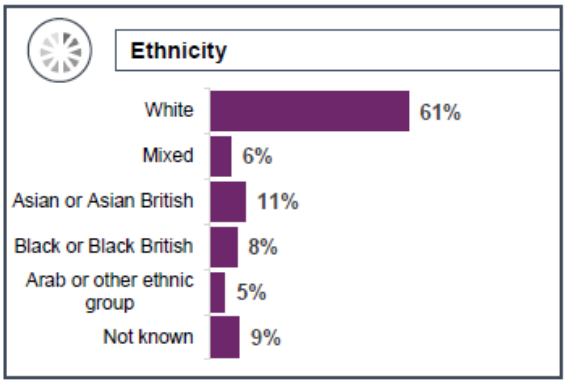
Our triage (assessment and evaluation) was in the top five of NHS trusts with the highest score

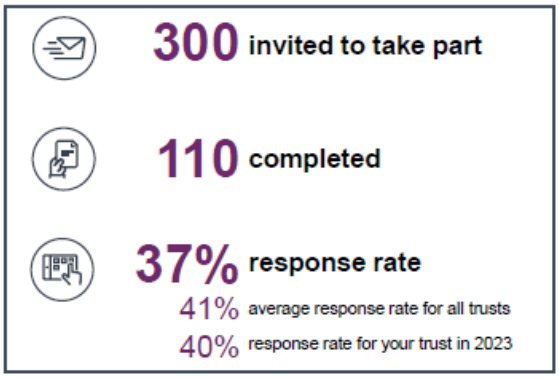
2024 Maternity Survey

The CQC benchmark report detailed 300 invited to take part, with 110 completed, this equates to a 37% response rate a slight reduction on our 2023 results of 40%.









Where service user experience is best

- ✓ **Postnatal Care: Care in the ward after birth:** Partner or someone else close to service user was able to stay as much as the service user wanted
- ✓ **Postnatal Care: Care in the ward after birth:** Healthcare professionals doing everything they could to manage service user's pain
- ✓ **Labour and Birth: The staff caring for you:** Being offered the opportunity to ask questions about the labour and birth
- ✓ **Postnatal Care: Care in the ward after birth:** Being able to get help from staff when needed
- ✓ **Care after birth:** Midwife/midwifery team being aware of service user and baby's medical history

Where service user experience could improve

- ○ **Antenatal care: During your pregnancy:** Relevant information provided from midwives to service users about feeding their baby
- ○ **Complaints:** Service users considering making a complaint about the care they received during their maternity journey
- ○ **Labour and Birth: The staff caring for you:** Being treated with respect and dignity
- ○ **Labour and Birth: The staff caring for you:** Feeling that concerns raised were taken seriously
- ○ **Care after birth:** Being told who to contact if advice needed about potential changes to mental health after birth

Whittington Health antenatal check-ups were in the top five of NHS trusts with the highest score

Benchmarking

Our benchmarking table below shows how we scored for each evaluative question in the survey compared to other Trusts that took part. Where data is missing, this signifies a low number of responses.

Section	Highest	Lowest	Whittington Health
Antenatal Care	8.5	6.7	7.7
• Antenatal check-ups?	8.6	7.5	8.6
• During your pregnancy	8.9	7.9	8.5
• Triage (assessment & evaluation	8.8	7.3	8.6
You labour & birth	8.5	7.7	No data
• Staff caring for you	8.7	7.6	8.3
Postnatal care	8.4	6.3	8.0
• Care in the ward after birth	8.4	6.3	8.0
• Feeding your baby	8.8	7.2	7.9
Complaints	6.9	5.3	5.4

Our care in the ward after birth was in the top five of NHS trusts with the highest score

2023 National Cancer Patient Experience

The National Cancer Patient Experience survey is undertaken annually and conducted by NHS England, the survey involved 131 NHS Trusts and is in its 13th iteration. The survey focuses on various aspects of cancer care, including diagnosis process, treatment options, communication with healthcare professionals, and overall support. The survey aims to gather feedback and evaluate the experiences of individuals with a cancer diagnosis.

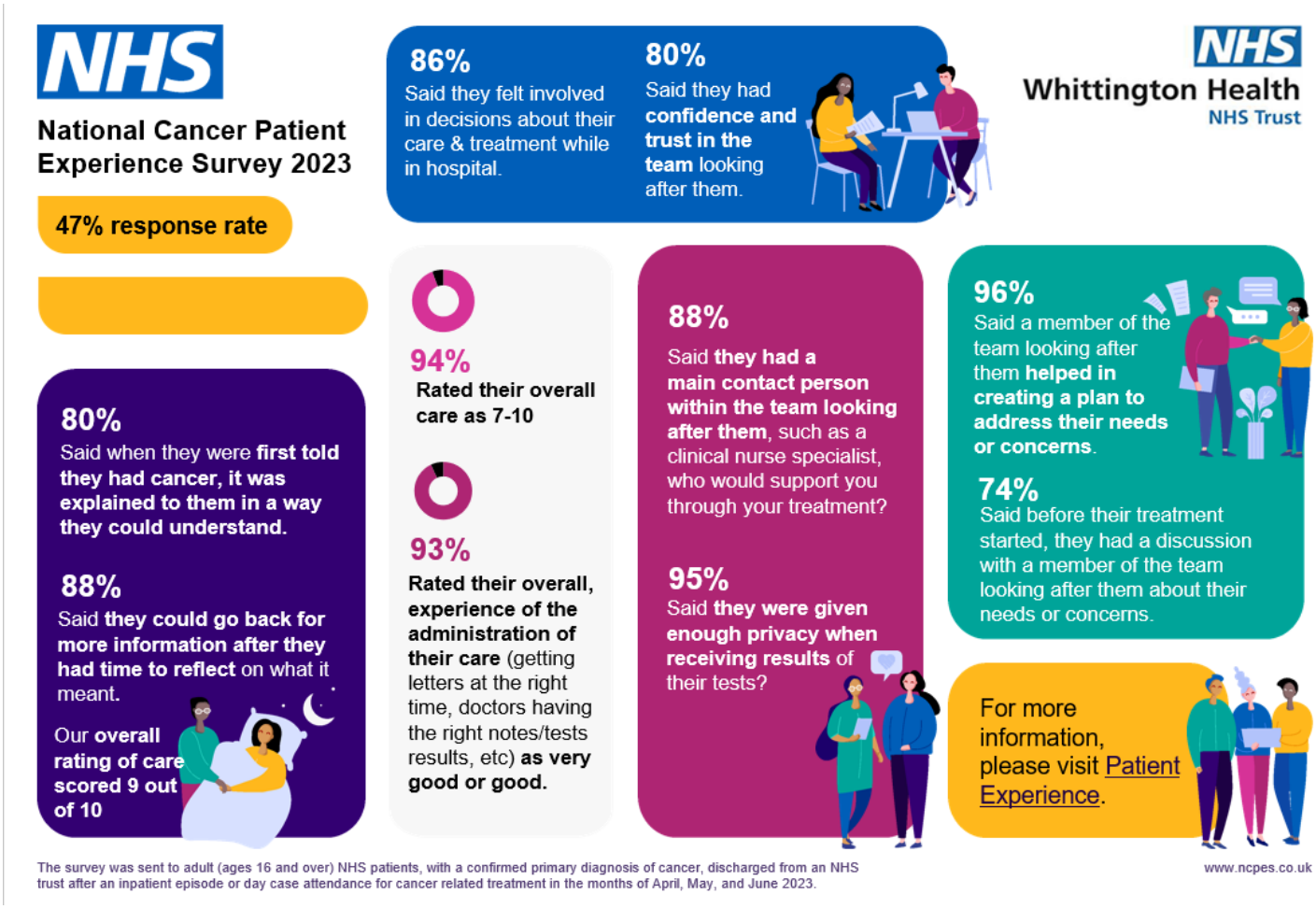
Case study: Cancer: patient experience 2023 results

The National Cancer Patient Experience survey was published in 2024/25 and allows patients to give feedback on their care. It helps us understand where care is working well and how to improve.

We have seen big improvements: We are now the highest ranked service in NCL, and equal 47th in England. We jumped 39 rankings from last year. We are ranked second in London. Our overall rating of care scored nine out of ten. We only had one question scoring below the ‘expected range’ this year, against five last year.

Sadly, none of our respondents identified themselves as being from minoritised ethnic groups: all respondents identified as white or ‘unspecified’. We are working with community leaders to close this gap. Congratulations to everyone across our cancer pathways for your hard work and dedication to your patients. We will look at the detailed results to identify opportunities and concerns as we continue to improve

our services. The full results will be published online soon. Read more on the NCPES website: https://www.ncpes.co.uk



86% of our patients said they had confidence and trust in all the team looking after them during their stay in hospital

Friends & Family Test

Response Rates

Our Friends and Family Test (FFT) response rates shows that 92% of patients rated our service as “very good or good” above the NHS 85% benchmark and 4.88% for “very poor or poor” below the NHS 5% benchmark. The graph below shows the percentage for “very good and good” results against the NHS 85% benchmark month on month and shows a consistent achievement above the score.

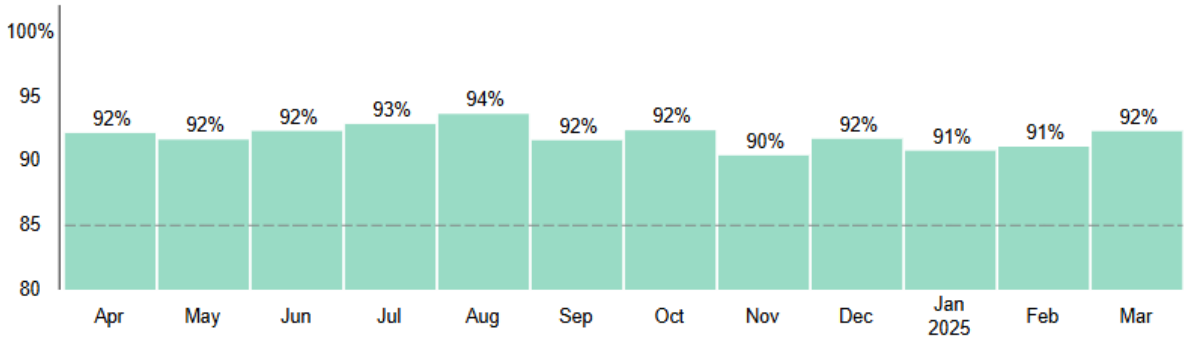


Figure 1: Performance against the NHS benchmark by month

A total of 29,537 FFTs were completed for the year, this is a slight reduction on the previous year of 40 (29,577). July 2024 received the highest volume of submissions of 3,085 an increase of 603 on the previous year (2,482). The increase coincides with a focused intervention from the Patient Experience team in supporting the completion of FFT's using volunteers, staff awareness and promotion.

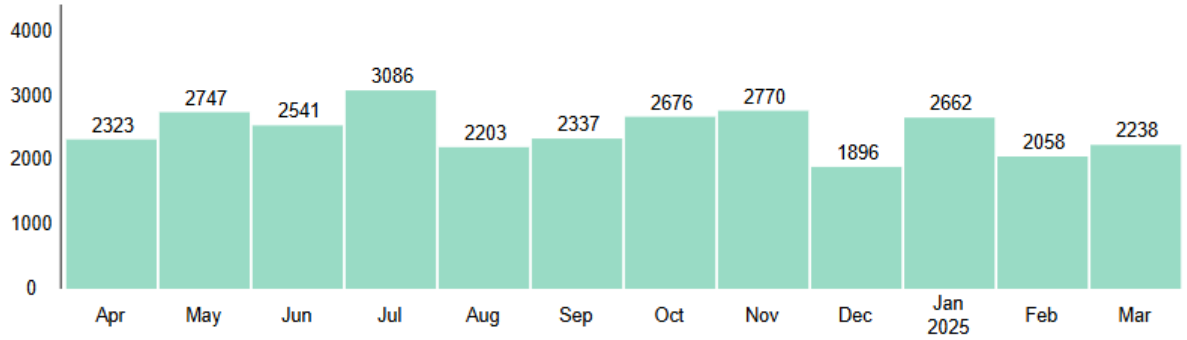


Figure 2: Number of FFT Surveys completed in the Trust by month

Graphs 2 and 3 detail performance month on month in comparison to the previous year. The patient experience team with the support of volunteers have worked tirelessly to support the organisation improve upon our recommendation figures in line with our strategy, this has seen an improvement on our 2023-2024 figures.

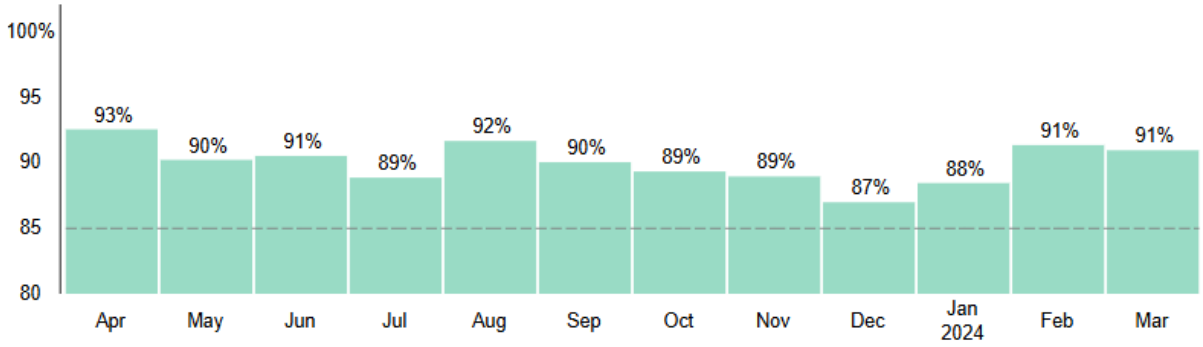


Figure 3: Very good and good responses for all FFTs 2023-24

Work continues within the Patient Experience team and Voluntary Services to promote and collect FFT responses, with a focus for 2025-26 on recruiting ward befriender and FFT volunteers to support the completion of FFTs and improve on our patients 'experience. This includes the ongoing work of collecting handwritten postcards to

upload to the electronic reporting system. Volunteers provide additional support with FFTs in outpatients, maternity, and imaging with face-to-face collections.

We consistently achieved above the NHS 85% benchmark for very good and good results in our Friends and Family Test survey

FFT responses are received from a range of sources, including:

- SMS/text 9,836 responses
- Smartphone app/tablet/kiosk before or at point of discharge or at appointment 4,017 responses
- Paper/postcards at the point of discharge 8,147 responses
- Online survey after discharge/appointment 7, 414 responses
- Telephone survey after discharge of appointment 0 responses

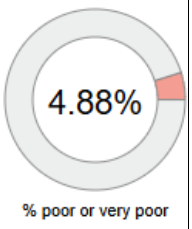
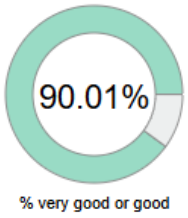
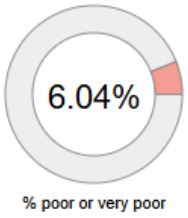
The automated SMS/text message is in place, with the largest number of SMS/text responses being received for the Emergency department 7,767. This year we implemented FFT SMS in Maternity postnatal services, community paediatric audiology, Community Diagnostic Centre, outpatient clinic and podiatry.

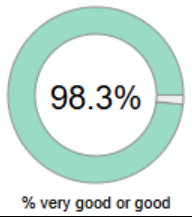
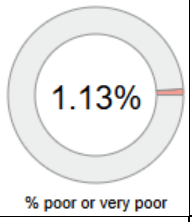
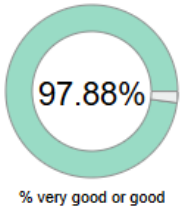
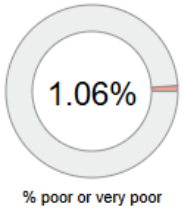
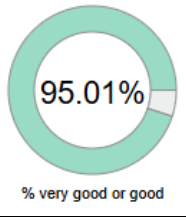
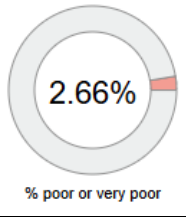
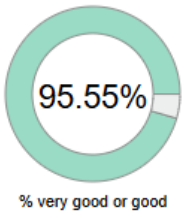
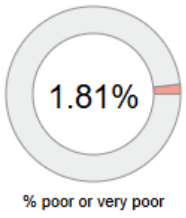
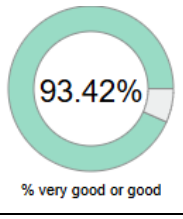
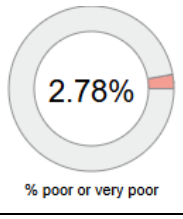
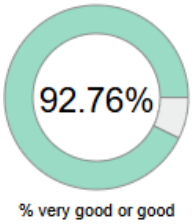
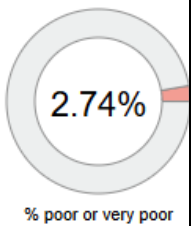
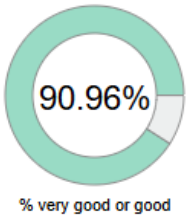
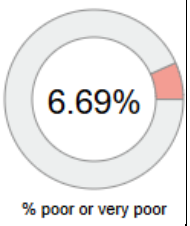
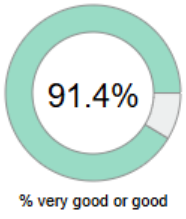
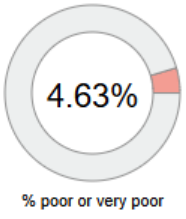
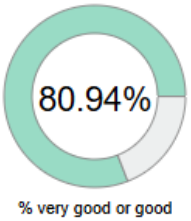
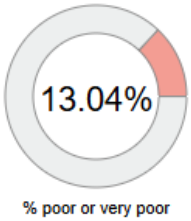
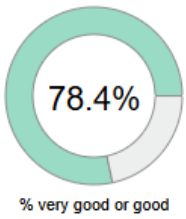
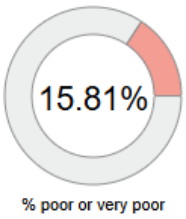
95% of our patients rated their care in the community as good or very good

Scoring

Overall positive scoring has increased by 8% from 84% to 92%, above the 85% NHS benchmark, and we have seen a decrease in negative responses from 6% to 5% below the 5% benchmark.

It is noted that the lowest scoring was within the emergency and outpatient departments' FFTs, which has been significantly impacted by operational pressures, OPEL 4 and industrial action throughout the year. On further analysis, a success is that the Trust has maintained a level above the 85% NHS benchmark month on month for the complete year. The chart below demonstrates the percentages of "very good/good" versus "poor/very poor" responses.

	2024-25		2023-24	
FFT - All				

FFT – Maternity Combined				
FFT - Community				
FFT - Inpatient				
FFT - Outpatient				
FFT – Emergency department				

92% of our patients rated their care as good or very good

The graph below shows the percentage for “very poor and poor” results against the NHS 5% benchmark month on month and shows seven months where we achieved below the 5% benchmark, except for the winter months.

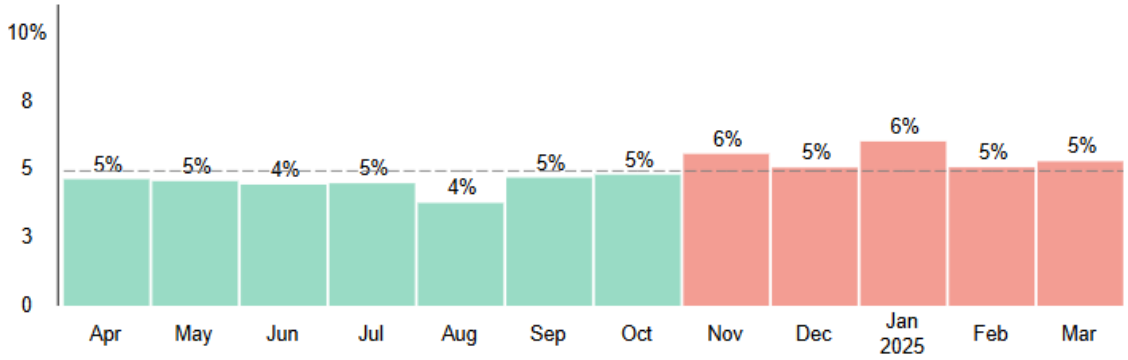
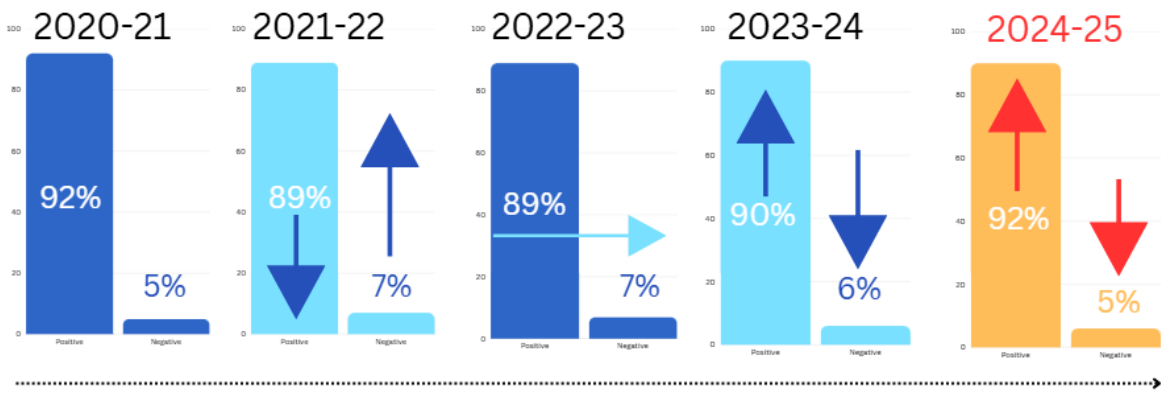


Figure 4: Poor and very poor responses for all FFTs

98% of our maternity patients rated their care as good or very good

Our 2023/25 Patient Experience and Engagement Strategy has an action plan which includes several objectives around engagement, listening and responding to feedback and empowering staff. The strategy in its final year, below are where we have met our objectives and plans for the new 2026/2029 Patient Experience Strategy.

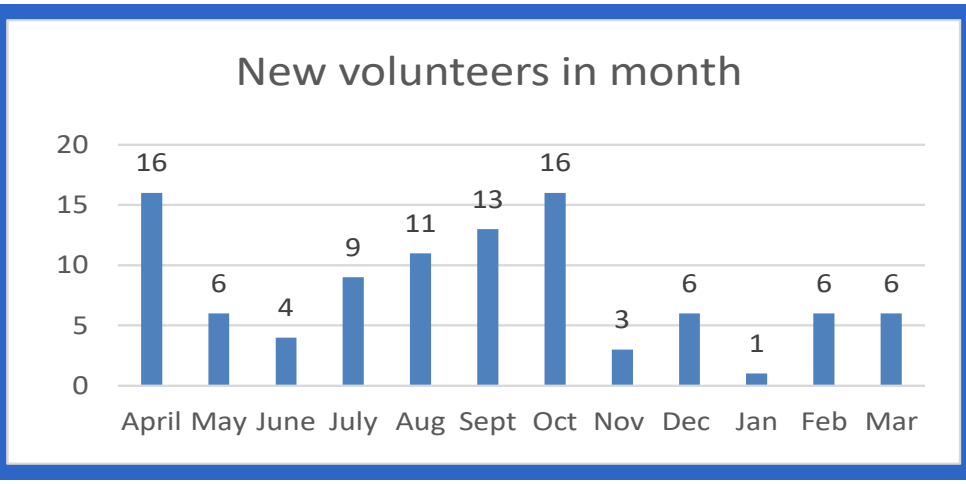
Ambition 1: Return to baseline response rate from pre-COVID, ensuring that each area has the questions available in a range of languages and formats to maximise accessibility.



Where we have improved on response rates pre-covid can be seen in the table below.

Dept	Jan 2020	Percentage	Jan 2025	Percentage
ED	819 (7,956)	10%	410 (9,061)	5%
Community	619 (34,304)	1.8%	1,213	Not available
Inpatient	502 (3,039)	16.5%	607 (1,880)	* 32% *
Maternity	Nil	Nil	109 (4,637)	* 2% *
Outpatient	409 (18,751)	2.2%	308 (34,132)	* 4% *

Ambition 2: To increase active patient involvement and participation throughout the Trust at all levels**.**



Ambition 3: To increase active patient involvement and participation throughout the Trust at all levels. Where people are working in partnership with us, we will recognise their contribution.

As an organisation we are committed to building positive, trusted and enduring relationships to ensure that our patients, their relatives, communities and carers are at the heart of all that we do. Informing, involving, and engaging with communities helps us to understand what is important to the people we provide services for, and respond to their needs where possible. We have developed a recompense protocol for patients and members of the public who engage with us and this has also supported inclusion from all sections of our communities.

Throughout the year the team ran community focus group sessions, specific to the Outpatients' transformation work. These in-person sessions provided insights and opportunities for learning. These engagements included a review of outpatient letters, young Black men and "Did not attend "(DNA) rates and an online survey for patients for whom English is a second language or speakers of other languages.

Ambition 4: Create a page on the patient facing internet for 'You Said We Did'.

We implemented a "you said, we did" intranet and internet page and included in welcome to ward board

Ambition 5: Ensure that FFT questions are accessible to as many patients and carers as possible to ensure the responses reflect the diverse patient population. Return to baseline response rate from pre-COVID, ensuring that each area has the questions available in a range of languages and formats to maximise accessibility**.**

The FFT language survey is available in 14 other languages and in an easy read format

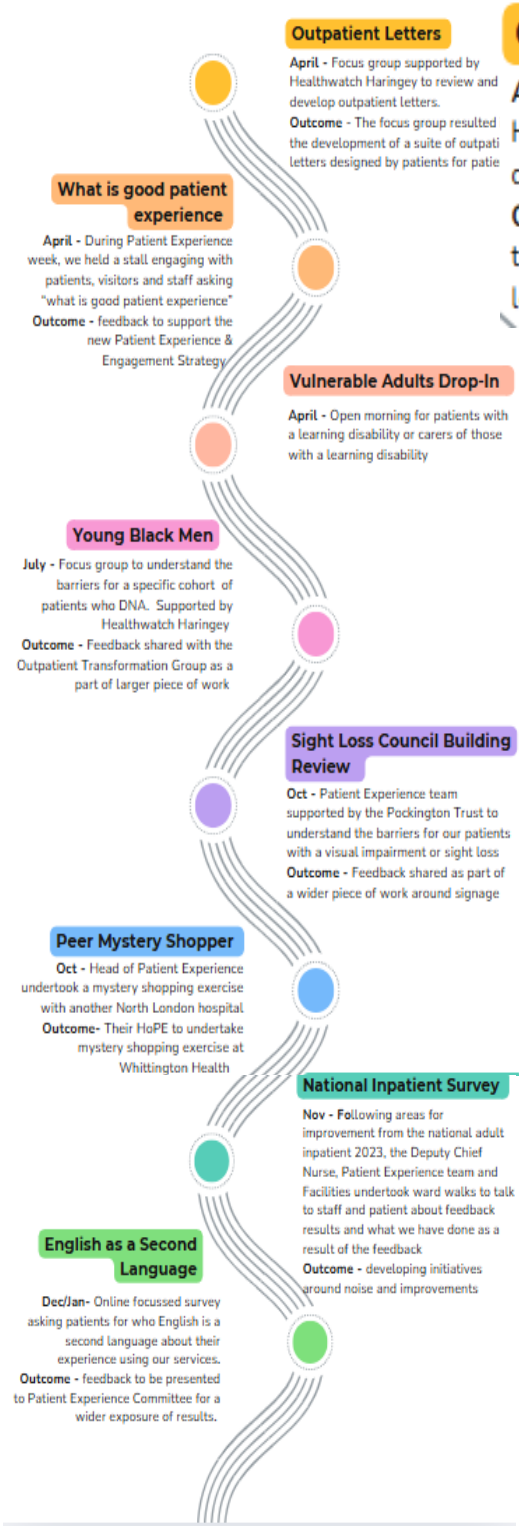
Ambition 6: Create a toolkit for staff around how to engage with patients and with advice about different forms of patient engagement.

We created an engagement toolkit for staff

Stream 6: Support and empower our staff to improve patient experience.
Ambition 7: Creating a standardised dashboard or report each quarter for each Clinical Division.

We created a dashboard to monitor the performance of our clinical divisions on complaints and the FFT

Engagement



Outpatient Letters

April - Focus group supported by Healthwatch Haringey to review and develop outpatient letters.
Outcome - The focus group resulted in the development of a suite of outpatient letters designed by patients for patients

Young Black Men

July - Focus group to understand the barriers for a specific cohort of patients who DNA. Supported by Healthwatch Haringey
Outcome - Feedback shared with the Outpatient Transformation Group as a part of larger piece of work

Sight Loss Council Building Review

Oct - Patient Experience team supported by the Pockington Trust to understand the barriers for our patients with a visual impairment or sight loss
Outcome - Feedback shared as part of a wider piece of work around signage

National Inpatient Survey

Nov - **Fo**llowing areas for improvement from the national adult inpatient 2023, the Deputy Chief Nurse, Patient Experience team and Facilities undertook ward walks to talk to staff and patient about feedback results and what we have done as a result of the feedback
Outcome - developing initiatives around noise and improvements

English as a Second Language

Dec/Jan- Online focussed survey asking patients for who English is a second language about their experience using our services.
Outcome - feedback to be presented to Patient Experience Committee for a wider exposure of results.

Case study: Community Parkinson's Service

The Whittington Health Community Parkinson Service comprises one consultant nurse, one geriatrician, both with a special interest in Parkinson's disease, along with four consultant neurologists.

The Parkinson's consultant nurse currently has a caseload of over 450 patients who are under the care of the named consultants at the Whittington Hospital Parkinson Service.

The Parkinson's UK Excellence Network has found 2,183 patients with Parkinson's Disease in the Integrated Care Board area of North Central London. Due to population growth, and an aging population, the prevalence and incidence of Parkinson's disease is anticipated to grow. It has been predicted that there will be an 18% increase in prevalence, and a 39% increase in incidence by 2030, with a further predicted doubling of prevalence and incidence by 2065. In Haringey and Islington, the caseload of patients is anticipated to grow by 20% by the year 2030.

The Whittington Health Community Parkinson's service currently provides an in-reach service into the acute hospital, weekly outpatient clinics, and inpatient assessment for patients affected by Parkinson's disease, regardless of their main acute hospital centre of care.

The Whittington Health Community Parkinson's service has enabled strong joint working relationships with the following NHS services:

- Community mental health, Haringey and Islington
- Community memory services, Haringey and Islington
- Community therapists, Islington and Haringey
- Community matrons, Islington and Haringey
- District nurses, Islington and Haringey
- Community palliative care team Haringey
- Islington nursing homes
- GPs and GP practices.
- Acute Parkinson's teams in North Middlesex Hospital, Royal Free and University College London Hospital, Parkinson's specialist teams.

An important aspect of the role of the Parkinson Consultant Nurse role is to enable care to be focused on the community and to support admission avoidance. To ensure that everyone affected by Parkinson's disease residing in the catchment area of Whittington Health NHS Trust, has equity of access to a Community Parkinson's Nurse/Practitioner, in Spring 2025, the service was given funding for two additional community nurses. A legacy of excellence has been established, and the goal is to safeguard and expand the Whittington Health Community Parkingson's Service to serve the growing needs of patient s with Parkinson disease.

Case study: (from patient family)

My father has been living with Parkinson's for around 10 years and was originally under the care of a central London hospital. We received good yearly care but had no community support. After being admitted for pneumonia twice this year, we asked

to be transferred to our local north London hospital, the Whittington, for my father's Parkinson's care because of the excellent community nurse. Being cared for by a community nurse who could advocate for my father and communicate our concerns as a family with the medical teams was invaluable.

The importance of the correct amount and timing of medication makes a huge difference to my father's movement function and communication, especially when he is unwell. The nurse specialist, Sandra, was able to liaise with the care team on the ward and get the best care for my father from a Parkinson's perspective. Because Sandra was community-based and in the local hospital where my father was being treated, she was able to observe him, speak to us as a family, and ensure he received the best care for his Parkinson's. She was also able to fit him with a PKG watch, which showed he was being under-medicated.

Since the medication has been adjusted, my father is swallowing much better, producing less saliva, and holding himself more upright. He has made a very good recovery from the pneumonia, which had been aggravated by the Parkinson's not being managed as best it could be. Having community-based Parkinson's nurses working with local hospitals to provide the best care for patients with a complex neurological condition is invaluable. This seamless integration of community and hospital care has made a significant difference in my father's wellbeing and recovery.

CLINICAL EFFECTIVENESS

Driven by its vision of 'Helping local people live longer, healthier lives', Whittington Health is committed to continually improve the care it provides to its patients. Whittington Health believes that '*Better Never Stops'* and this attitude is embedded within the Trust's two-way approach to quality improvement.

The Clinical Effectiveness Group (CEG), chaired by the Associate Medical Director (AMD) for Quality Improvement (QI) and Clinical Effectiveness, continues to strengthen the clinical effectiveness agenda. Regular reports on clinical effectiveness, including national and local audits, National Institute for Health and Care Excellence (NICE) recommendations, local clinical management guidelines, clinical policies and quality improvement initiatives are discussed at the CEG, alongside updates from the Multidisciplinary team (MDT) and Trauma and Organ Donation Groups. Reports are summarised for review at the Quality Governance Committee (QGC) and included in the quarterly quality report for the Quality Assurance Committee and Trust Board.

Clinical effectiveness continues to build upon the significant assurance commendation from our last external review, and across the six key effectiveness domains.

Our key achievements during 2024/25 included the following:

- The initiation and completion of the clinical guideline disaggregation work programme. Historically, clinical guidelines were assigned to a single document category "Clinical Guideline" so they could not be sub-grouped or filtered by specialty for reporting purposes. To rectify this, every online clinical guideline has been re-categorised and re-assigned to new clinical guideline sub-specialties.
- The Medical Emergencies Document Library Guidelines (MEDL Guidelines) programme continued to develop and garnered organisational wide interest and collaboration. These key pathways support decision making for doctors through appropriate interpretation in the clinical context. A total of 23 MEDLs are approved for use, and cover areas such as Acute Atrial Fibrillation, Delirium, Upper Gastrointestinal Bleed and Last Days of Life.
- This year, the Trust had three identified transformation improvement priorities (flow, elective improvement, and outpatient transformation) alongside the agreed six PSIRF safety priorities (patient falls, medication safety, responding to a deteriorating patient, pressure related skin damage, delayed treatment and diagnosis and unsafe discharges). We have been working to embed and align Quality Improvement within these priorities, working closely with the Improvement delivery team. The Trust has approximately 120 centrally registered QI projects ongoing.
- The Quality Improvement team consists of two part time QI Leads and two AMDs for QI. We have been working to identify the long-term direction for opportunities and challenges for a more cohesive improvement programme and have visited other Trusts as well as surveying clinical leads on improvement. We have worked to form a wider improvement team and aim to build capacity in this area. To help this, we have launched the improvement hub, which takes place quarterly, and draws together staff with an interest in improvement and facilitates presentations and a discussion around a topic.

- To develop Quality Improvement capacity, the team have developed a QI coaching and training programme. The first cohort of training began at the end of the financial year and has 15 staff members from different professional backgrounds. These staff will be trained to coach improvement projects and will be able to support the improvement work within their Clinical Division. Offering this training programme is aligned to our strategic goal to develop more improvement capacity across Whittington Health. In addition to this training and the QI Enabled training, the Quality Improvement team have been delivering teaching on improvement on a wide variety of staff courses, including to international nurses across NCL, nursing preceptorship, resident doctor induction and the AHP fellowship development course

National audits

This year, we have achieved gold standard participation in all mandatory national clinical audits and national confidential enquiries. We continue to ensure the timely review of published reports to make recommendations for quality improvement as appropriate.

During 2024/2025, 67 national clinical audits including seven national confidential enquiries (NCEPOD) covered relevant health services that Whittington Health provides. Whittington Health participated in 100% national clinical audits and 100% of national confidential enquiries. We submitted 27/27 cases across the seven NCEPOD studies.

The Trust also registered an additional 14 non-mandatory national audits for completion.

Clinical audit reporting continues to provide a vital mechanism to capture care quality across the organisation. Learning from outcomes has remained a priority, facilitated by regular organisational multidisciplinary audit and effectiveness afternoons, clinical audit workshops, QI training and coaching sessions and bespoke training of staff cohorts.

Getting it right first time (GIRFT)

In 2024/25 the Trust took part in eight GIRFT reviews, seven NCL gateway reviews and one site visit (Orthopaedics). These reviews cover areas across all Directorates and action plans for both site and system wide improvement have been completed and/or are in process.

Improvement celebrations

We also remain committed to the celebration of areas of excellence and shared learning. In July 2024, we held a QI “Quickfire” celebration event where the following Improvement projects were presented to a multidisciplinary audience:

- Enhancing a deteriorating patient pathway
- Improving pertussis vaccine uptake in maternity
- Improving confidence in managing medical problems in pregnancy and post-partum
- Time to analgesia in a sickle cell crisis
- Improving MDT working for adults with a learning disability

- Leading change and improvement in Antenatal Education
- Reducing the number of calls and time spent locating prescriptions in pharmacy
- Hearing better: Reducing waiting times in audiology
- Haringey urgent response through the London Ambulance Service/Urgent care response project
- Implementing clinical photography into the dermatology service.

End of life care

The Whittington Health End of Life Group (EoLC) was co-chaired by Dr Charlotte Hopkins (Acting Chief Medical Officer) and Sarah Wilding (Chief Nurse and Director of Allied Health Professionals) and was clinically led by Dr Anna Gorringe (palliative medicine consultant). It meets quarterly and leads the delivery of continuous improvement in end-of-life care within the Trust. The Specialist Palliative Care team (SPCT) provides both clinical liaison support and education for teams caring for inpatients with end-of-life care needs – those patients likely to be in their last year of life and those who sadly die in hospital.

The SPCT has approximately 750 referrals per year and sees just over half of the approximately 500 patients who die in our hospital each year. The number of referrals to the SPCT continues to rise each year, as does the complexity of the caseload, with most patients referred in an unstable or deteriorating phase of their illness. The SPCT proactively supports advance care planning discussions, including recording a patient's preferred place of care and death, and whether this is achieved. Where appropriate, this is uploaded into the London Universal Care Plan, so it is visible to all urgent and emergency care staff.

The Trust participates in the National Audit for Care at the End of Life (NACEL). To date, the Trust's results for clinical care compare favourably with national average scores, despite being a low outlier for workforce. Over the past years, in response to the NACEL staff survey results, the SPCT has renewed its focus on staff education and development. Several well-received teaching sessions have been provided to medical and nursing staff as well as to allied health professionals. We are working with our patient engagement and communications teams looking at ways to increase feedback for the 2025 NACEL audit, which is underway.

Case study: Cervical Screening Health Equity Audit Actions

There is a growing body of evidence that highlights the significant inequalities which exist in uptake of the cervical screening pathway within the UK, with many barriers to uptake persisting. Lower attendance and poorer uptake of cervical screening varies across demographics and socio-economic status (age, marital status, income and education), and wider social determinants of health (social identity, religious and cultural beliefs).

Other perceived barriers include physical and learning disabilities, negative previous screening experiences, traumatic experiences (sexual violence survivors, stigma), personal attitudes (fear and embarrassment and not getting round to it), and service delivery (difficulty making an appointment, inconvenient timings and accessibility).

The actions from the prior audit which have now been completed included:

- An updated patient leaflet
- A self-swab policy has been completed and self-swab leaflets are being advertised
- Digital version of the patient survey has been launched, using IPads and QR codes
- Anti-racism/inclusion training in outpatients – LGBTQIA training sessions on the Trust's electronic training platform - Elev8
- Cervical Cancer awareness stand in January 2025 to promote screening and reduce DNA rates and patient cancellations

RESEARCH

Context

The last year saw continued growth and celebrated success of the Trust's research activity.

The Trust's research activity has remained stable. The in-house Research & Development (R&D) office has continued to provide a robust and responsive service ensuring study set-up is proportionate and works with the Trust's developing priorities in an efficient and cost-effective way. The speed of approval process has been dramatically shortened (below), and we continue to work to become 'national leaders' in this regard.

Regional recognition of the Trust's research achievements was celebrated at the North Thames Local Clinical Research Network (LCRN) awards in August 2024 – held to mark the end of the LCRN contribution. Whittington Health saw nominations in six categories and were winners in the following ones:

- R&D Office of the Year (jointly awarded with Royal Free NHS Trust)
- Principal Investigator of the Year (jointly awarded to The Whittington's Dr Karen DeSouza and Dr Louise Ma)
- Exceptional Performance in Commercial Research Delivery - in recognition of the Haematology (Red Cell) and Research Teams.

Staffing and staff engagement

Whittington Health currently has 17.5 whole time equivalent (WTE) research staff - an increase from 16.9 WTE in the previous year, with further growth plans in place. The establishment of a Red Cell Research Fellow post is a significant achievement of which we are proud.

The Trust has continued to support medical research fellow posts and consultant posts. The AHP (Allied Health Professions) Research Forum that began in January 2024 has gained momentum and additional services saw staff receive National Institute for Health and Care Research (NIHR), Health Education England and other awards to facilitate protected time for research development (dietetics, midwifery, community diabetes services, specialist physiotherapy services).

Further progress has been made with collaborations between the Trust and University College London (UCL) and London Metropolitan University, with collaborative grant bids submitted with both Universities.

Many of the Trust clinicians remain research active. This is demonstrated by research publication records. A PubMed search for 'Whittington Health' or 'Whittington NHS' reveals a steady rise in publications year on year, with more than 113 such papers published in the 12 months to March 2025.

The Trust currently holds 1 research grant (Professor Ibrahim Abubakar's £2.5 million NIHR Programme Grant for Applied Research: Research to Improve the Detection and Treatment of Latent Tuberculosis Infection (RID-TB)) which has had a 'no-cost

extension' in response to delays in meeting milestones, predominantly due to the COVID-19 pandemic and import changes in response to Brexit.

The table below sets out the recruitment of patients to NIHR portfolio studies during 2024/25. This figure shows a substantial increase in studies open to recruitment. These have been primarily facilitated by the R&D office function continuing to improve the efficiency of study set up. The R&D office have demonstrated a dynamic process with study set-up timelines taking on average 30 days to confirm capacity & capability- a 50% reduction on the previous year's 60-day average. The sponsorship process continued to receive positive feedback from colleagues, with the process reported to be simpler to navigate and more responsive. This is a significant step and a success of which we are proud.

	NIHR Portfolio		**Non-Portfolio**
	Patients recruited	**Number of recruiting studies**	**Number of recruiting studies**
Year			
2018-19	1077	49	7
2019-20	848	29	5
2020-21	1241	20	4
2021-22	921	27	5
2022-23	689	30	4
2023-24	1092	53	5
2024-25	1086	68	15

Completed trials and outcomes

Publication of a selection of trials (performed at or recruiting at Whittington Health) in the last year are described below:

- Efficacy and safety of ciclosporin versus methotrexate in the treatment of severe atopic dermatitis in children and young people (TREAT): a multicentre parallel group assessor-blinded clinical trial. The British journal of dermatology 2023;189(6): 674-684.
- Health-related quality of life in patients with β-thalassemia: Data from the phase 3 BELIEVE trial of luspatercept. European journal of haematology 2023;111(1): 113-124.
- Impact of nutritional-behavioural and supervised exercise intervention following bariatric surgery: The BARI-LIFESTYLE randomized controlled trial. Obesity (Silver Spring, Md.) 2023;31(8): 2031-2042.
- Reduction in transfer of micro-organisms between patients and staff using short-sleeved gowns and hand/arm hygiene in intensive care during the COVID-19 pandemic: A simulation-based randomised trial. Journal of the Intensive Care Society 2023;24(3): 265-276.
- Development and description of a theory-driven, evidence-based, complex intervention to improve adherence to treatment for tuberculosis in the UK: the IMPACT study. Health Psychology and Behavioral Medicine 2024;12(1): 2277289.
- Accelerometer and Survey Assessed Physical Activity in Children with Epilepsy: A Case-Controlled Study. Paediatric exercise science 2024; 1-9.

GUARDIAN OF SAFE WORKING HOURS

The Guardian of Safe Working Hours presents a quarterly report to the Board with the aim of providing context and assurance around safe working hours for Whittington Health resident doctors. There continues to be a significant emphasis on the safety of resident doctors' working hours. This has been reflected in the ongoing engagement with the exception reporting process by both resident doctors and their supervisors. These clearly document the extra hours worked over and above their rostered hours and reasons for this, as well as the breaks that are missed. The time accrued through exception reports continue to be reimbursed with either time off in lieu or payment. The reasons for extra hours worked are analysed to try and effect change to prevent this from recurring where possible.

This year covered a short period of industrial action by resident doctors. Ongoing high levels of acuity of patients means there continue to be a steady number of exception reports generated. Most of these are from Foundation Year One doctors and due to difficulties in finding appropriate time off in lieu of already stretched rotas, these are largely renumerated in financial payments.

There continues to be good engagement with the process of exception reporting as laid out in the 2016 terms and conditions. There has been an ongoing effort to encourage all specialities to promote and encourage the use of exception reporting and a particular emphasis on those at higher levels of training where low levels of exception reporting are typically seen. The reasons for this are multifactorial but over the last year there have been more exception reports from historically lower reporting specialities such as paediatrics and psychiatry.

The Guardian of Safe Working Hours continues to work closely with the resident doctors' forum to ensure there is a proactive approach to compliance with the 2016 terms and conditions. This is also where the spending of monies generated from exception reporting is discussed and decided. It is currently being spent to provide lunch as teaching and educational sessions for the resident doctors. This process will continue.

Case study: NCL ICB Care Homes Oral Health Training Programme

A key success this year was delivering the Oral Health Promotion Training Programme for care homes in North Central London. Due to existing OHP coverage in most boroughs, targeted delivery was focused on Barnet and Haringey, where the need was greatest. From July 2024 to January 2025, the team successfully:

- engaged 50 care homes (out of a target of nearly 60)
- trained 350 staff members, including care workers, nurses, and managers
- embedded person-centred oral care guidance, with a focus on dementia-friendly approaches

This programme delivered measurable impact and strong engagement across the sector, with positive feedback on improved staff confidence and awareness of oral health's role in general wellbeing

NCL Supervised Toothbrushing Programme

Another major achievement has been the expansion of the North Central London Supervised Toothbrushing Programme, aimed at reducing oral health inequalities among children aged 3–4 years in the most deprived wards of the five North Central London boroughs. The goal was to recruit 80–120 early years settings by June 2025. As of 31 March 2025:

- 72 settings have already joined the programme
- 58 are actively delivering supervised toothbrushing
- The remaining settings are due to launch with support visits and staff training scheduled
- This initiative forms a central part of local preventative oral health delivery, equipping children with daily habits that support long-term health outcomes.

Barnet Oral Health Promotion Integration

Barnet's Oral Health Promotion (OHP) services were formally transitioned to Whittington Health team from the 0-19 service. This marked a significant organisational milestone, completing full OHP coverage across all ten boroughs in North Central and North West London: Barnet, Camden, Enfield, Haringey, Islington, Brent, Ealing, Harrow, Hounslow, and Hillingdon. This transition has enabled consistent service delivery, shared resources, and stronger cross-borough collaboration, creating a joined-up approach to oral health improvement across London.

OHP contract with Hillingdon (Supervised Toothbrushing Programme)

For the first time, Whittington Community Dental Service was commissioned by the London Borough of Hillingdon to deliver a supervised toothbrushing programme from September 2024 to August 2025. The contract focuses on reaching 120 children across 20 early years settings in the most deprived wards. As of 31 March 2025:

- 23 settings have been recruited
- 15 are already delivering the programme
- The remaining settings are scheduled to begin in the coming months

Oral Health Promotion Masterclass

A significant innovation this year has been the design and launch of the Whittington OHP Masterclass - a structured, in-house training course for Community Dental Service's dental nurses, created to expand professional capacity within the OHP team.

Spanning five days, the course includes two days of face-to-face classroom learning, a self-directed learning period, where participants prepare and present on a chosen oral health topic, a period of practical delivery experience in community settings and a final assessment and examination. Importantly, the Masterclass forms part of a broader succession planning and quality improvement strategy, designed to future-proof the service by developing a highly skilled, prevention-focused workforce. This work directly supports the delivery of upcoming Supervised Toothbrushing Programme initiatives and aligns with government manifesto commitments to prioritise prevention and early years health.

Conclusion

The 2024/2025 year has seen Whittington's OHP team extend its reach, build strategic capacity, and deliver high-quality, targeted oral health promotion across all ten boroughs. With new partnerships in place, expanded programmes underway, and a skilled workforce leading delivery, the service is well-positioned to meet future priorities and continue reducing oral health inequalities in the communities we serve, and living up to the Whittington ICARE values, and vision of helping local people live longer, healthier lives.

INTEGRATED CARE ORGANISATION AND SYSTEM WORKING

Integrated Care Organisation

As an integrated care organisation, we demonstrate the value of collaborative working in multi-disciplinary and in multi-agency approaches to health and care. Our figures continue to show some of the lowest admission rates in North Central London.

The Trust continues to run the single discharge hub for us and UCLH. We have also been instrumental in the setup of the virtual wards for both UCLH and North Middlesex and we are the North Central London transformation lead for virtual wards and virtual monitoring.

We launched the Islington Complex Virtual Ward, which delivers high-acuity, hospital-level care in the community, a collaboration between Whittington Health and UCLH consultants to provide a cross-Trust integrated delivery of care

We continue to run multidisciplinary teams in the community, both in Islington through the Integrated Care Teams “INCs” and Integrated Care Aging Team, and in Haringey, through the multi-agency anticipatory care (MAAC) team. These bring many different specialties together to help solve problems for patients and residents to prevent admissions or ensure a speedier discharge.

We have worked with partners in North Central London to bid for, co-design and set up a community service for patients living locally with Red Cell disease (sickle cell, thalassaemia and rare inherited anaemias). The new service will launch shortly.

Primary Care Networks and GP Federations

During 2024/25 we continued to work closely with GPs and commissioners in Haringey and Islington. Examples of this included:

- continuing to develop the integrated diabetes team that supports and trains GPs to keep patients’ diabetes managed in the community
- our team working with Age UK and the GPs to use an e-frailty index to find and support patients before they deteriorated
- providing nurse associates and first contact musculoskeletal practitioners to the primary care networks

Clinical Interface Group

We have a well-established monthly clinical interface group. This is attended by GP representatives from the local medical committee, North Central London Clinical Commissioning Group and GP Federations and representatives from the Trust’s clinical and operational teams, to work on solving any issues and exploring how we can work in more innovative and efficient ways together for the benefit of our patients. The group has been used as an exemplar and replicated in the other acute Trusts in North Central London. These Trust clinical interface groups are now meeting monthly as the North Central London Interface Steering Group to further enhance and improve sector working and consistency for the five boroughs at the interface between primary, community and secondary care.

Localities and Integrated Care Borough Partnerships

This year, Whittington Health continued to work even more closely with our colleagues in the councils, mental health trusts, GPs, and the voluntary sector to implement the vision for our joined-up services based around localities. We have been key leaders in the Borough Partnership Boards for Islington and Haringey, supporting new models of care. Our chief strategy officer chairs the Haringey Neighbourhoods and Inequalities Board and our chief executive co-chairs the Haringey Borough Partnership.

North Central London Integrated Care System

We continue to play an instrumental role in the North Central London Integrated Care System. We have worked well coordinating elective activity and recovery by providing capacity for other Trusts where they need it. Whittington Health has taken on many urology and general surgery cases from the Royal Free and UCLH to help spread the load and reduce the backlog of patients waiting as quickly as possible. The Clinical Advisory Group and the Chief Executive Group have continued to be crucial parts in the system along with other operational and corporate groups. We have been represented on all the critical committees. Our Chair, Chief Executive and other executives have also been instrumental in the set up and running of the University College London Health Alliance (provider collaborative).

Community Diagnostic Centre

This year we were delighted to open the phase two of the Community Diagnostic Centre (CDC) in the heart of Haringey in the Wood Green Shopping City. Good collaborative working with the landlord led to opening of the basement of the centre on time and on budget. We are now open with ophthalmology, ultrasound, x-ray and blood tests and MRI and CT. We are excited about the opportunity to site more diagnostics in Haringey and, hopefully, to make them easier to access for our diverse population. This is one of two linked community diagnostic centres in North Central London, the other being run by the Royal Free London in Finchley Memorial Hospital.

Community Diagnostic Centre achievements

- Since opening over 77,000 patients have been seen at Wood Green CDC and 89,414 diagnostic tests have been completed.
- 77% of the people we have seen here live in the three areas of greatest deprivation in Haringey.
- We have proven that we are easier to access than the Hospital because for the most deprived patients, the rate of non-attended appointments is lower (6%) at the CDC compared to the Hospital (10%).
- We provide GP direct access for all our tests so patients can receive diagnostic imaging without having to attend a main hospital site or wait for a hospital referral.
- As of February 5, 2024, Wood Green CDC has commenced piloting its ‘Straight to CT’ pathway. This pathway is designed to detect primary lung cancer when a patient undergoes a chest X-ray. If any abnormalities are seen, the patient will receive a CT scan during the same appointment. This approach aims to minimise the need for multiple diagnostic appointments and mitigate potential delays in diagnosing primary lung cancer.
- We are converting a room to do lung function tests in a one stop shop.

The All-Party Parliamentary Group for Diagnostics report recognised Wood Green CDC for its exemplary engagement approach. “The success of Wood Green CDC

highlights how personalised engagement is instrumental in shifting referral patterns to enhance integration between CDCs and primary care providers, thereby improving patient care".

Case study: Wood Green Community Diagnostic Centre (CDC): Extending Imaging Hours to Support Elective Recovery

In response to the Prime Minister's Elective Recovery Plan, Wood Green CDC extended CT and MRI operating hours from 8:30am–7:00pm to 8:00am–8:00pm, Monday to Friday, starting in January 2025 - a strategic move to meet rising diagnostic demand across North Central London.

Without recruiting additional staff, extended hours were delivered by redesigning rotas and staggering shifts within the existing radiography team - protecting staff wellbeing while avoiding extra costs. The operational setup was secured through direct engagement with The Mall's management, who confirmed early building access and adjusted parking logistics. Security arrangements were also reorganised with the supplier at no additional cost. Internal guidance and walkthrough videos were issued to staff to ensure readiness for the 6th January rollout.

Rota modelling projected a 20% increase in scanning time, with CT and MRI appointment slots rising from 136 to 161 per week (+18.4%), largely due to added early morning and evening sessions - improving accessibility for working-age and commuter populations. Increased patient footfall also boosted mall sales by 1.2%, as confirmed by The Mall management team, demonstrating mutual benefit for NHS and commercial partners.

This uplift in capacity of the service enabled more tests for more patients using the service and greater flexibility for GP and hospital referrals, directly supporting NCL Trusts in maintaining the 96% monthly diagnostic test compliance target set by NHSE.

Staff and patient feedback was positive, and early/late appointments helped to reduce Did Not Attend rates and improve access for patients with daytime responsibilities. This low-cost, data-driven model is currently being evaluated for potential rollout across other community diagnostic centre sites in the region.

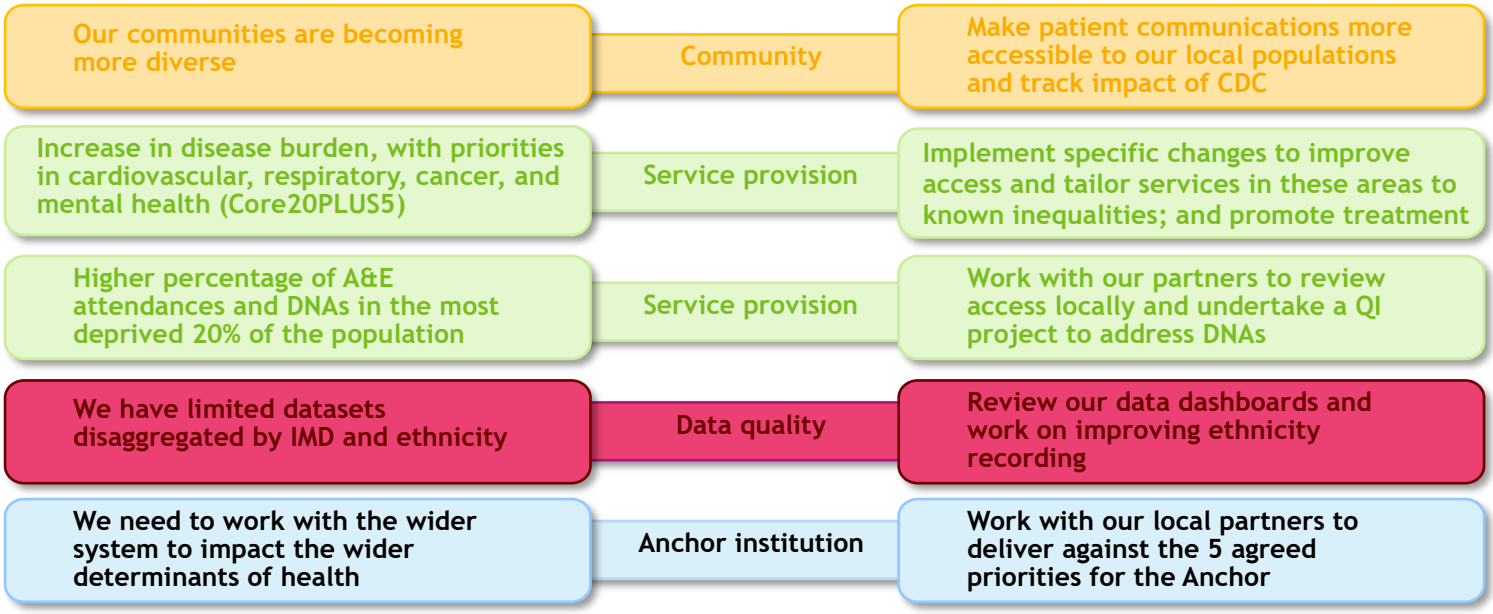
University College London Hospitals NHS Foundation Trust

Throughout the year, we continued to work well with UCLH in various areas of collaboration, including breast services, maternity, nuclear medicine, and general surgery. Orthopaedic and oncology services also continue to work well together. This year also saw the beginnings of a more formal relationship with UCLH in the creation of a committee-in-common subcommittee of both boards and a formal report from our advisors on best next steps.

Population Health and Anchor institution

Population Health and Inequalities

In 2024/25 Whittington Health teams continued to progress our population health strategy objectives and actions stemming from our regular population health report.



Our notable projects that contributed to these aims included the following:

- **Health Literacy**: Improved letters and designed leaflets in Women's Health to meet the needs of patients that have health literacy challenges.
- **Easy Access to the CDC**: 75% of referrals to the CDC are from 40% of the most deprived groups demonstrating its impact. DNA rates lower for most deprived.
- **Tailored Access to therapies**: Talking therapies outreach to community centres and mosques to increase access and reduce stigma
- **Community Heart Failure**: Proactive triaging of patients on heart failure registers in 4 GP surgeries. 85% of those identified were in the 20% most deprived cohort. 50% reduction in acute readmissions rates by those engaged with the service.
- **Cardiac rehab**: Social prescribing for cardiac rehab: Through participation in the Voluntary and Community Service (VCSE) Forum we identified the need for a social prescribing service specific to the needs of cardiac rehab patients
- **ED attendance work**: Multidisciplinary teams with VCSE partners for frequent emergency department attenders, with a majority living in the 20% most deprived areas in NCL 15% reduction in A&E attendances.
- **Pulmonary Rehabilitation**: Direct access for those with addiction and homelessness. 90% of patients referred through this pathway had never been offered PR before
- **Tobacco Dependency Service**: 42% of smokers receiving ongoing tobacco dependency treatment by the in-house service are smoke free by 3 months post discharge.
- **Diabetes Management**: Turkish, African and Caribbean diabetes patients with 57% of people cold-called now engaging with diabetes team with interpreters and culturally tailored dietary education. 81% of those attending subsequent sessions began managing their diabetes better.

Case study: North Central London Community Red Cell Service:

The report "No one listening" was published on November 15, 2021, following an inquiry into the avoidable deaths and failures of care for sickle cell patients. It was jointly published by the All-Party Parliamentary Group on Sickle Cell and Thalassaemia and the Sickle Cell Society, a national charity that supports and represents people affected by sickle cell disorders. As a result of this report, the Trust and its partner services set up a specialised community red cell service.

The North Central London Community Red Cell Service is hosted by the Whittington NHS Trust, in partnership with UCLH and the Royal Free Hospital (RFH). The service covers the five boroughs of North Central London: Camden, Islington, Enfield, Haringey, and Barnet. This red cell service has been funded by NHS England for two years, and mobilisation commenced in April 2024.

The service provides specialist nursing, psychological input, and a multidisciplinary approach to patients with sickle cell and thalassemia in the community setting. Clinics are delivered from local community sites, along with home visits where appropriate. The service has a close working relationship with social care and collaborates with the hyper-acute units and emergency departments to create a smooth transition of care.

The North Central London Red Cell Service is for adult patients (over 16) living with sickle cell, thalassemia, and other rare inherited anaemias who are local residents, under the system's Specialist Haemoglobinopathies teams. Since the service launched in April 2024, 965 red cell patients have been identified and are being targeted for intervention across the five boroughs served. The red cell service has built strong relationships with support networks, professionals, and community groups across these boroughs, including the Red Cell Network, Sickle Cell Society, Sickle Cause, the UK Thalassaemia Society, and Healthwatch Haringey.

Case study: Sickle Cell Service Developments

The following improvements were achieved by our Sickle Cell services:

Ambulatory emergency care pathway implementation

- A new same-day care pathway for clinically eligible patients
- Operational Monday–Friday, 08:30–16:30, with access to AEC until 21:00
- It enables timely pain management and reduces hospital admissions

Thorogood Ward – preferred sickle cell disease inpatient area

- Thorogood ward was designated as preferred ward for Sickle Cell admissions
- Consultant Nurse Specialist-led nursing training is underway to support transition from Victoria ward
- A focus on continuity and the quality of specialist care

Apheresis capacity increased by 50%

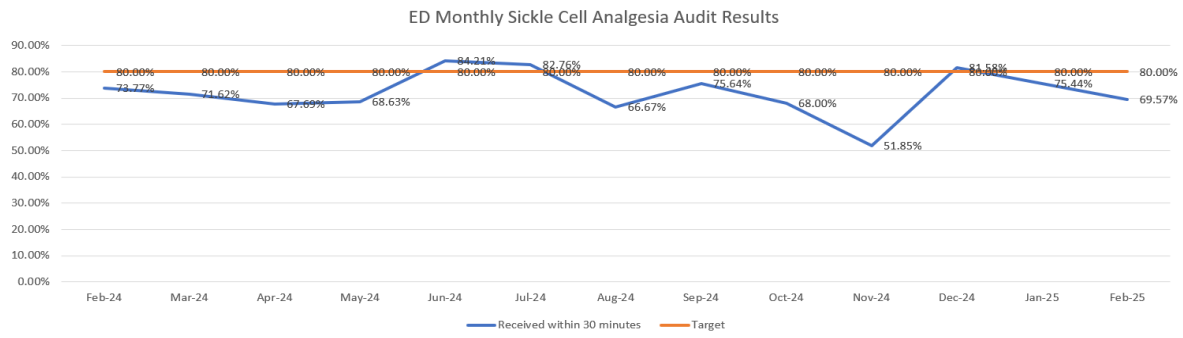
- A successful business case in collaboration with NHS Blood and Transplant
- Expanded capacity for automated red cell exchange
- Aims to reduce acute complications and improve long-term outcomes

Peer review success

- An external review highlighted multiple areas of good practice
- Staffing challenges were identified amid growing demand and treatment complexity

ED collaboration

- Stronger partnership with the emergency department has improved the time to analgesia for patients
- Enhanced patient experience during acute presentations



WORKFORCE

Our people

Whittington Health employs just over 5,500 staff, providing high quality care to our patients and across our local community sites. The table below provides a breakdown across our clinical and non-clinical groups.

Professional Groups	Staff numbers
Prof Scientific and Technical	409
Additional Clinical Services	800
Administrative and Clerical	1120
Allied Health Professionals	699
Estates and Ancillary	251
Healthcare Scientists	59
Medical and Dental	654
Nursing and Midwifery Registered	1525
Students	23
Grand Total	**5540**

In 2024/2025, we recruited 29 internationally educated nurses, 3 midwives and 4 allied healthcare professionals. These staff were recruited from India, the Philippines, South Africa, the Caribbean and other parts of the world. These internationally educated staff have been additional to our UK recruited staff, they helped to improve our overall vacancy position in the hospital and community and added a richness of diverse cultures to our organisation. They have also come to us with a wealth of clinical experience. We recruited these internationally educated staff to care for adults, children, mothers, and families in both our hospital and in the community.

Our recruitment was part of the pan-London Capital Nurse International Recruitment Consortium. These staff are now working in many different areas and are very much part of Whittington Health. This recruitment was in part facilitated by our successful bid nationally for financial assistance for these individuals and support for them to undertake their objective structured clinical examination assessments. We continue to attract UK nurse graduates and offer apprenticeship programmes.

Winter flu and COVID-19 vaccinations 2024

The Trust ran vaccination programmes for staff for both COVID-19 and flu using a variety of approaches at the hospital and community sites. The vaccination campaigns were coupled with supporting all staff to make informed choices about vaccination. This year there was a change in the delivery model as a new vaccination centre has been established in the Jenner Building on the acute site, meaning that the staff vaccination programme could be delivered from a dedicated space also available to members of the public. The team continued to carry out roving clinics across the acute site and visited community sites to deliver vaccines. The Trust flu vaccination uptake was at 35.8% versus 34.8% across London, and the Trust COVID-19 vaccination uptake was 26.5%. versus 17.1% across London. We hope to do improve on this still further in the coming years.

Connecting with our People

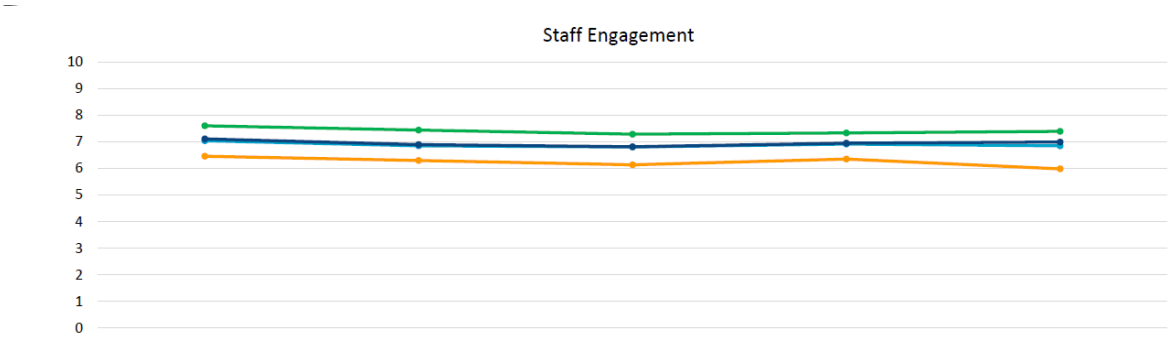
We have regular communications channels with staff at our Chief Executive briefings, and electronic newsletters with daily messages on desktops. We work closely with staff side and other staff representatives and were supportive of all staff during the periods of industrial action during 2023. We continue to monitor our performance through several committees and involve staff through the following:

- Workforce assurance Committee
- Partnership Group
- Medical Negotiating sub committee
- A range of staff network groups

NHS staff survey

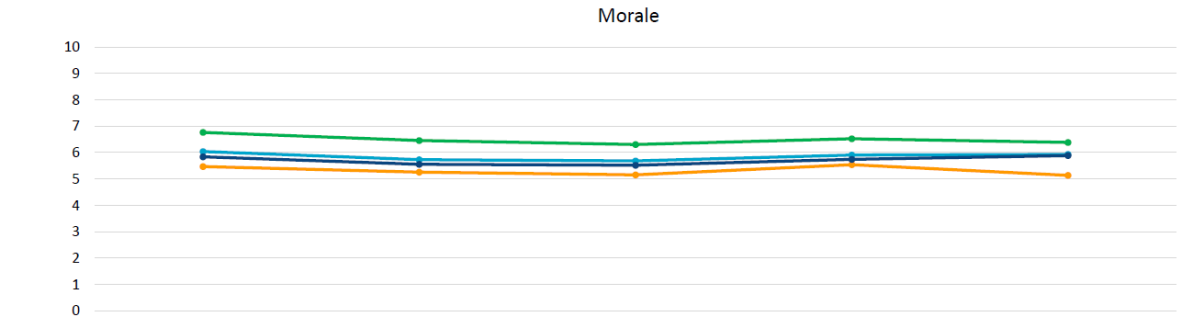
Of Whittington Health's 5,234 eligible staff in 2024, 2,351 took part in this survey, a response rate of 45%, which is 4% below the median response rate for the 122 acute and acute & community trusts in the benchmark group. Compared to the previous year, the Trust's own response rate increased by 1% from 44% in the 2023 Staff Survey.
The survey is one of the largest workforce surveys in the world and is carried out every year to improve staff experiences across the NHS. It gives staff a voice and provides organisations with an insight into morale, staff engagement, wellbeing, culture and perception of service delivery. Whittington Health is part of the Acute and Acute & Community Trusts.

Whittington Health's staff engagement score is 6.98, which is slightly above the national average of 6.84 and an improvement on the previous two years' scores, which were 6.81 in 2022 and 6.94 in 2023.



	2020	2021	2022	2023	2024
Your org	7.10	6.89	6.81	6.94	6.98
Best result	7.60	7.44	7.28	7.32	7.39
Average result	7.03	6.84	6.80	6.91	6.84
Worst result	6.45	6.29	6.13	6.34	5.98
Responses	2164	2265	2018	2118	2347

Whittington Health's score for staff morale is 5.88, below the national average of 5.93. However, this result is an improvement from the morale score of the last two years, which was 5.52 in 2022 and 5.74 in 2023.



	2020	2021	2022	2023	2024
Your org	5.84	5.55	5.52	5.74	5.88
Best result	6.76	6.45	6.30	6.52	6.38
Average result	6.04	5.73	5.68	5.90	5.93
Worst result	5.47	5.26	5.16	5.54	5.13
Responses	2151	2255	2017	2120	2343

The table below shows Whittington Health results against the People Promise elements and against the themes of staff engagement and morale for 2024.

Results are presented in the context of the 'best', 'average' and 'worst' results for the total 122 Acute and Acute & Community Trusts.

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.26	5.99	6.71	6.09	5.71	6.05	6.85	6.98	5.88
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	2343	2338	2314	2321	2182	2323	2333	2347	2343

In 2024, Whittington Health is not ranked as 'worst' or 'best' in any of the themes. The Trust is slightly above average for the themes of:

- 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
- Staff engagement

The Trust was average for one theme: We are safe and healthy. The Trust has scored slightly below average for the themes of:

- We work flexibly
- Morale

This year, the recommended Trust wide priorities for 2025/26 which will increase morale, engagement, and support staff retention. These priorities will be the themes for Trust-wide listening events. The People Promise themes and areas of focus include:

- **Disability:** In particular around making reasonable adjustments for people with LTC or illness.
- **Health & Wellbeing:** In particular, improving management support when staff are unwell and improving the prevention of Musculo Skeletal (MSK) problems.
- **Career development:** particularly by improving appraisal completion rates and quality as well as by promoting apprenticeship opportunities and career pathways

Workforce Culture and "Caring for Those Who Care"

Through its Workforce Assurance Committee, the Board monitors culture and behaviours in workforce information reports (for example, employee relations cases), the annual equality workforce submissions on disability and race and also ensures they are aligned with Whittington Health's values). The Trust's work to support good working relationships, and to promote compassion and inclusion throughout the Whittington Health culture, has continued, alongside a focus on providing staff with rest and respite in short lunchtime sessions.

Below are some of the main changes, programmes and campaigns to enhance culture and workplace relationships and environments.

- The range of services offered under the branded 'Caring for Those Who Care' or "#CFTWC" logo has been continuously augmented, with a range of new programmes and services offered in-house, within the integrated care system (ICS), and nationally, to provide staff with the widest choice of supportive opportunities.
- Trauma Informed Management has been launched to support staff support and response to incidents.
- Targeted listening events and community engagement roadshows, a simple and impactful back-to-basics initiative that aims to bring staff support teams to colleagues, meeting staff where they are.
- Relaunched our Living our Values training for all staff
- The Restorative Just Culture programme continued to take place across the organisation and further training dates have been secured for 2025-26.
- Cherron Inko-Tariah, MBE and Inclusion Leader, was invited to be a keynote speaker at the Trust's Leadership Conference to highlight the importance of staff voice in making meaningful changes to the organisation and supporting culture change.

Statutory and mandatory training

The Trust continued to deliver most core mandatory training skills via online learning which staff access through the inhouse learning management system "Elev8". The platform provides users with a clear overview of their current compliance status and

an easy, accessible way to either complete eLearning or book onto courses that require attendance. New starters are given access to the platform and are able to complete learning prior to starting.

The organisation has also signed up to the "StatMand Staff Movement Memorandum of Understanding" to accept some prior training from a list of 261 other NHS organisations in England, including all provider NHS trusts, integrated care boards, community interest companies and commissioning support units and most national bodies. This will help to improve our compliance rates. During 2024/25, compliance with our statutory and mandatory training remained stable at around 86%, against a target of 85%.

The Trust is continuing to work with our North Central London partners, for the introduction and implementation of the Oliver McGowan Mandatory Training on Learning Disability and Autism. The training, which is two tiered, includes an eLearning module (part 1) and a live training session (part 2). By the end of March 2025, 78% of staff had completed the eLearning module.

Trust corporate induction continued to be run once a month as an online event, designed to welcome staff and provide key information to enable new starters integrate quickly into the organisation. The event is supported by the chair, chief executive, chief medical officer, chief nurse and director of allied health professionals, joint directors of inclusion as well as a great variety of other speakers, such as freedom to speak up guardian, head of wellbeing, library services and a great many more.

Staff development

Whittington Health places great value on developing staff through courses. This year we have been able to do this using a hybrid approach of face-to-face and virtual delivery with internal and external trainers. In the last year, the following was delivered by in-house staff and with partners:

- A fourth cohort of the Band 2-7 BME career development programme ran, which supports BME staff in AFC bands 2-7 in Whittington Health, providing career development, personal development and insights into understanding Whittington Health's recruitment and selection process. Whittington Health has been awarded funding by NHS England to run two cohorts for all NHS organisations across London.
- A new Band 8A and above BME leadership programme has run, called 'Working Uphill', which was delivered by BRAP, a leading charity focusing on equality through learning, change, research, and engagement.
- The Organisational Development team is continuing to review the Leadership development offering and is working on a tiered programme approach for aspiring, new and existing managers. In 2024/25 we ran a series of standalone leadership, management and personal development courses which were delivered in-house and by internal and external providers, and consisted of the following modules:
    - Bringing values to life (new)
    - PowerPoint tips and tricks (new)
    - Telling powerful stories (new)
    - Meeting facilitation (new)
    - Communicating with confidence (new)

- Coaching conversations (new)
- Open Interview Coaching and Practice (new)
- Time management (new)
- Minute Taking
- Report Writing
- Understanding your drivers
- Communicating with authority
- Discovering your motivation
- Seven influencing tactics
- Resolving Telephone Conflict
- Courageous conversations
- Restorative conversations for managers
- Workplace Conflict
- Giving and Receiving Feedback
- Situational Leadership
- Assertiveness and Boundary Setting
- Introduction to Finance
- Managing Sickness Absence
- Employee Relations
- Recruitment and Selection training
- Capability policy implementation training
- Anti-racist and inclusive cultures
- Workforce Disability Equality Standards and Reasonable Adjustments
- Understanding off autism in the workplace training (Ambitious About Autism)

Additional Leadership development and OD and Wellbeing interventions:

- Appraisal Training for Managers and Appraisal Training for Appraisees has been re-designed and re-launched
- British Sign Language
- Mental Health First Aid Training and Refresher (MHFA England)
- Trauma Informed Management Training
- Bespoke workshops and interventions for teams that need support in developing team-working and improving morale
- Affina Team Journey, this focused on the research and findings from Professor Michael West on effective team working
- Coaching for individuals to support career development and working relationships
- Mediation training for staff to become accredited mediators and to join the internal mediation service
- Myers Briggs Type Indicator reports and feedback sessions to support team dynamics
- 360-degree feedback for individuals to understand how they impact on others and to support career development
- Functional Skills in maths and English to support staff developing via an apprenticeship
- Various apprenticeships in both clinical and non-clinical areas to support staff development, ranging from level 2 (GCSE's level) to level 7 (master's level).

- The following modules were delivered by NHS Elect:
  - Interview Skills

- Career Planning
- Teaming and psychological safety
- Online facilitation
- Applications Skills (for career development)
- Compassionate Leadership
- Conflict and Difficult Conversations
- Communication Skills
- Emotionally Intelligent Leadership
- Leading Change

Staff Health and Wellbeing

In 2024/2025, we continued our commitment to staff wellbeing and engagement, building on a proactive and preventative approach while enhancing expedited support when needed. Our vision remains clear: to prioritise staff wellbeing in everything we do. As a result, this year saw significant positive improvements in this area, including a 4% increase in staff survey responses, indicating that employees feel the organisation supports their wellbeing, the largest Increase since 2020 in this element of the staff survey.

Key achievements and initiatives

- The successful launch of the Whittington Staff Wellbeing brand and publication of the Staff Wellbeing Booklet - raising awareness and making the staff wellbeing service more accessible through a comprehensive five-levels of wellbeing framework.
- A positive shift in staff engagement, with employees moving from disengagement to a hopeful belief in meaningful action.
- A noticeable cultural shift in staff wellbeing and engagement is evident, with executive and senior leaders integrating wellbeing into their daily work and interactions, embedding staff wellbeing into the fabric of the organisation.
- The recruitment of a Senior Staff Wellbeing Practitioner has enhanced our ability to deliver tailored wellbeing support and foster a wellbeing-focused culture across the Trust.
- Over 65% of the 2024/2026 strategic staff wellbeing objectives have already been achieved, allowing us to set even more ambitious goals for the future of staff wellbeing and Engagement.

New and ongoing internal staff wellbeing and engagement offers include:

- TRiM (Trauma Risk Management) Support: a gold-standard, evidence-based approach to support staff who have experienced traumatic events. This structured framework provides early intervention, helping identify individuals at risk and offering timely support to minimise the impact of Trauma. 16 TRiM Practitioners and 10 TRiM managers were trained in Q4.
- Team Reflective Sessions: Providing staff with a space to decompress and navigate challenges together, promoting quicker and positive recovery and team cohesion.
- Specialist Psychological Support: Partnership with Health City for expert support on complex psychological issues such as global conflict trauma.
- Ongoing inhouse Mental Health First Aid Training: Regular in-house training for Mental Health First Aiders - reducing stigma around mental health support,

promoting early intervention, and providing a structured approach to mental health support across the workplace.

- Wellbeing Champions – Numbers continue to grow through active recruitment by the Wellbeing Team, these peer volunteers lead small but impactful wellbeing initiatives to embed wellbeing in teams and signpost to relevant wellbeing resources in a timely manner.
- Staff Engagement Roadshow: taking staff support services directly to teams across all areas, enhancing inclusion and fostering a sense of belonging, particularly for remote or hard-to-reach services/teams.
- Touch Tuina Medical Massage: Providing therapeutic massage for staff within high-pressure environments like ED- to alleviate physical and mental stress, improve focus, and support overall wellbeing.
- Strong collaboration with Haringey Talking Therapies to offer regular tailored wellbeing webinars for Whittington staff, proactively addressing issues such as stress, burnout etc.
- Health Promotion Webinars: Regular webinars on topics such as Men's Mental Health Awareness and Boosting Immunity, providing staff with strategies to enhance their mental and physical health.
- Leadership Development Training: In-house training for leaders to facilitate reflective sessions, fostering a supportive environment for staff wellbeing.
- Menopause Support: Monthly Menopause Café, funded by the Whittington Charity, offering a safe space for discussion and peer support for staff experiencing menopause.
- Chair Yoga – A gentle, accessible lunch time wellbeing offer supporting relaxation for all staff, specifically desk-based staff. An ideal activity for wheelchair users.
- Wellbeing Wednesday: A focus on midweek wellbeing initiatives/activities encouraging staff to focus on self-care, reflection.
- Wellbeing Calendar: A structured schedule of targeted wellbeing campaigns and health promotions covering topics like mental health, stress, nutrition, hydration, grief etc.
- Healthy Eating Initiatives: Introduction of the "Five a Day" healthy eating fruit and veg stall at Whittington Hospital to encourage nutritious eating habits.
- Subsidised onsite physical activity classes such as Pilates are available at the hospital site to improve physical wellbeing.
- Financial wellbeing resources are available on the intranet.
- The Trust has an inhouse smoking cessation specialist.
- Regular wellbeing visits to teams across the Trust are conducted by the Wellbeing Team raising awareness and encouraging early wellbeing interventions.
- The 'check-in and check-out' toolkit for managers to look after their staff continues to be promoted for use at the start and end of team meetings.

External routes of support

- National and regional wellbeing support services are regularly promoted and made accessible. These include, but are not limited to:
- Bereavement Support Line: A confidential bereavement support line, operated by Hospice UK, free to access for NHS staff from 8:00am - 8:00pm, seven days a week.
- Frontline19 UK: Service offering one off or weekly sessions as needed. Psychological support for frontline workers via phone or remote platform.

- Practitioner Health is a free, confidential NHS primary care mental health and addiction service with expertise in treating health & care professionals.
- The BMA: Offers a free 24/7 counselling service to all doctors, their partners and dependents.
- Haringey Talking Therapies (formerly IAPT Haringey): A free NHS psychological therapy service offering support for a range of common mental health difficulties such as depression and anxiety, obsessive compulsive disorder, post-traumatic stress disorder and more.
- Switchboard LGBT+ Helpline: A safe space for anyone to discuss anything.
- A host of staff wellbeing courses from NHS England and NHS Elect such as – Happier working lives initiative (aimed at creating happier, healthier, and more productive teams across the NHS.) are offered and promoted.

Apprenticeships

The Trust has been engaging in developing and embedding the apprenticeship pathway to develop future allied health professionals, as well as other career pathways, offering development opportunities for staff across the organisation. The apprenticeships on offer are ranging from level 2, pharmacy assistant to level 7 senior leaders, and specialist subject areas, such as dental nursing, business administration, HR, physiotherapy or pharmacy technician. In 2024/25 Whittington Health had 148 apprentices currently enrolled on a course, out of which one third are existing staff. We are continuing to promote apprenticeships through various forums and events to develop careers at Whittington.

Modern Slavery Act

Whittington Health's aim is to provide care and services that are appropriate and sensitive to all. We always ensure that our services advance equality of opportunity, equality of access, and are non-discriminatory. We are proud of our place in the local community and are keen to embrace the many cultures and traditions that make it so diverse. The diversity of this community is reflected in the ethnic and cultural mix of our staff. By mirroring the diversity that surrounds us, our staff are better placed to understand and provide for the cultural and spiritual needs of patients. In accordance with the Modern Slavery Act 2015, the Trust has made a statement on its website regarding the steps taken to ensure that slavery and human trafficking are not taking place in any part of its own business or any of its supply chains.

We have robust recruitment practices to safeguard against slavery and adhere to the NHS employment checks standard to verify an individual's right to work. We have a range of policies for staff to be able to raise their concerns and the Trust has been formally accredited by the Living Wage Foundation.

Embracing inclusion

The principal aim of the Inclusion team at Whittington Health is to ensure compliance with the Equality Act 2010, thereby promoting fair treatment and equal opportunities for success among all staff members within the organisation, irrespective of their protected characteristics. These characteristics include race, gender, age, disability, sexual orientation, religion, and other relevant factors. The Inclusion team is responsible for leading the Trust in its adherence to the statutory public sector equality duty, as well as fulfilling statutory obligations and submitting requisite reports to NHS England, as detailed below:

- Disability Confident accreditation requirements
- Gender, race and disability pay gap reporting
- Workforce disability and race equality standard submissions
- Medical workforce race equality standard
- Bank workforce race equality standard

The team continue to ensure that the organisation's inclusion practices and policies guide decision-making processes to create an inclusive environment and shape the overall organisational culture towards a great place to work where everyone feels valued and respected.

The See ME First initiative, along with ongoing efforts from staff networks, continues to support staff engagement. The networks, LGBTQ, Staff Race Equity Nationality Network (SRENN), Women+ and WhitAbility, collaborate with members to advance the goals outlined in both The Trust and staff network mission statements. Both reflect the Trust's strong commitment to fostering a workplace culture that is anti-racist and values diversity in all its forms and is aligned with the Trust's ICARE values. This dedication seeks to enhance staff performance and improve organisational efficiency and contribute to patient experience and outcome.

Key activities supporting inclusion goals and ambitions included the following:

- Quarterly open forum: These are held to address systemic inequalities within the Trust. These events offer a platform for individuals to share their experiences. Additionally, it enhances awareness and understanding of how racism and discrimination impact marginalised staff, while encouraging employee involvement in tackling inclusion challenges.
- National inclusion events: Participation in national network events including Race Equality Week, International Women's Day, Pride Month, Black History Month, UK Disability History Month, and Lesbian, Gay, Bisexual, and Transgender History Month**.**
- Support for disabled staff: We had a strong focus on disability and reasonable adjustments in the workplace. We launched a new policy and training for managers and staff on how to access reasonable adjustments effectively to help staff remain in work. As evidenced by the 2024 NHS staff survey outcomes, promoting reasonable adjustments for staff will continue to be a priority in 2025/26.
- Preceptorship training: The development and contribution to preceptorship training continues, alongside the creation of a comprehensive induction and adaptation guide for internationally recruited staff, aim to support them in their new roles and environment.
- Recruitment panel guidance: The promotion and implementation of the Diverse Panel Guidance to enhance current recruitment policies to promote equitable hiring, ensuring that the most appropriate candidates are selected while eliminating active discrimination, fostering trust, and establishing a positive workplace environment.
- Reverse mentoring programme: The implementation of the reverse mentoring program, where senior employees are mentored by those in more junior positions. This initiative encourages open and honest conversations, allowing senior staff to gain insights into the challenges faced by Black and Minority Ethnic (BME) employees.

- Staff self-reflection and development: The development of an Inclusion self-reflection and development toolkit/checklists focused on anti-racist and inclusive practices and team culture to foster active engagement and allyship.
- Ambitious about autism: Promotion and support for internship programs designed to assist young people with autism in gaining employment. These programs combine education and work experience, helping to reduce inequalities for individuals with autism.

Allied Health Professional Apprenticeships

The Trust continues its commitment to the ongoing education and development of future allied health professionals (AHP) through degree apprenticeship programmes. In 2024/25 the Trust welcomed a further seven apprentices across physiotherapy, occupational therapy, diagnostic radiography and speech and language therapy - bringing the total number of apprentices in the Trust to 16. In addition to the new apprentices, we also saw four apprentices graduate and join the workforce, three in occupational therapy and one diagnostic radiography. In 2025, the Trust will see its first Apprentice Dietitian start in May, whilst continuing with its existing offer across the other AHP professions.

Over the past year, the Trust has developed a strategy for AHP apprenticeships with a focus on long term sustainability across all Clinical Division. The ambition is to support local people into roles whilst also providing opportunities for existing staff to upskill through degree level apprenticeships.

Healthcare Support Workforce Development Team

The Trust continues to provide training and development for our clinical healthcare support workforce (HCSW) across all Clinical Divisions. In 2024/25, the team trained over 400 HCSWs from a range of settings across all areas of the Trust compared to 288 the previous year. Key to the success of the support workforce training programmes is strong engagement with stakeholders across the Trust. The team continues to contribute to NCL support workforce networks and NHS England support workforce networks. During 2024/25 we saw several additional programmes go live through these networks for the healthcare support workforce, including the Higher Development Award and an e-learning package to upskill AHP support workers regarding pre-registration student placements. The next phase of the HCSW strategy is to embed an NCL HCSW passport, which will be piloted in 2025 across several teams within the Trust and across other NCL Trusts. This will help our vital healthcare support workforce capture their current and future learning and development needs, mapped against a career development framework.

Trade unions

The following four tables* are published in accordance with The Trade Union (Facility Time Publication Requirements) Regulations 2017. **** 2024/25 data is to be validated***

Table 1: Number of relevant trade union officials

	2024/25	**2023/24**
Total number of employees who were relevant trade union officials	19	17
Total WTE employees who were relevant trade union officials	17	16

Table 2: Percentage of time spent on facility time

Percentage of working hours spent on facility time	**Number of employees 2024/25**	**Number of employees 2023/24**
0%	2	1
1%-50%	17	16
51%-99%	0	0
100%	0	0

Table 3: Percentage of total pay bill spent on facility time

	2024/25	**2023/24**
Total cost of facility time	£107,953	£66,900
Total pay bill*	£359,844,000	£337,177,000
Percentage of total pay bill spent on facility time	0.03%	0.02%

*****Excluding bank and agency costs

Table 4: Percentage of time spent on trade union activities

	2024/25	**2023/24**
Total hours spent on paid trade union activities by relevant trade union officials	0	0
Total paid facility time hours	2100	2020
Percentage of total paid facility time spent on trade union activities	0%	0%

Excellence in Medical Education

Undergraduate Medical Education

Whittington Health is one of the three central sites delivering clinical placements for University College London medical students in year 4 and 5 of the MBBS programme. The Trust provides placements in medicine, surgery, paediatrics, obstetrics and gynaecology and emergency medicine. In addition, the Trust also hosts popular 1st, 2nd and 6th year student selected components, Clinical and Professional Practice and the iBSc in paediatric and child health.

Whittington Health has a well-deserved reputation for excellence in medical education harnessed though close collaborative working. Innovative teaching practices – delivered by an enthusiastic and committed faculty of clinical teachers - enhances engagement in learning through, for example, student-led multidisciplinary gastroenterology meetings. The addition of clinical teaching fellows in recent years has significantly improved local teaching, which now also includes simulation and formative exam preparation. Students also receive excellent formative preparation from the clinical skills team throughout the year.

Whittington Health excels at pastoral support of students through its Personal- and Student Education Tutor schemes. A safe and supportive learning environment is created by a dedicated faculty and Undergraduate Education and Management team.

Examinations are hosted in all years. Examiners are recruited both locally and centrally; and examiners enjoy the friendly and supportive nature of clinical examinations hosted at The Whittington Hospital.

Whittington Health has been cited by the UCL Medical School visiting team as an exemplar site for the roll-out of the electronic timetabling system and commended the Whittington site for continuing to nourish undergraduate education despite national workforce challenges.

Postgraduate Medical Education

The Postgraduate Medical Education (PGME) Faculty continues to innovate and provide excellence in educating our resident doctors. The PGME Team is constantly looking for ways to ensure training remains relevant and practical, ensuring we meet the curriculum and professional development requirements of our resident doctors.

At Whittington Health, the morale of our resident doctors and general satisfaction with their training experience is of the utmost importance. Our PGME team and Faculty of Educators are committed to addressing these concerns, supporting and valuing resident doctors across the Trust, on both a personal and group level. Over the last year, for example, we have organised and/or provided support for events such as an Internal Medicine Trainee Away Day, a ‘Graduation’ Celebratory Event for Foundation doctors completing their time in training, a Whittington Health PGME Stars programme to recognise resident doctors going above and beyond expectations and provided training involving mentoring and coaching. Such events bring a focus on our resident doctors feeling valued by Whittington Health, which has a significant impact on wellbeing.

In the General Medical Council's National Training Survey, Whittington Health again had some star performing specialist teams. Multiple green scores (with feedback in the highest range) were awarded to Neonatal Medicine (our top performing specialty), Respiratory Medicine, Trauma & Orthopaedics, Internal Medicine Training Stage 1 and Geriatric Medicine. Our Foundation Surgery Programme received a Letter of Recognition from the NHS Quality Team for improvement and good performance across a four-year period. Furthermore, across the whole Trust there were improvements in scores relating to 7 out of 18 domains. We hope that this performance will provide a springboard for further improvements in feedback for the Trust in the 2025 survey.

Over the last year, the PGME team designed novel training programmes. We worked in partnership with Lucinda Worlock (specialist in voice and communication training) to design, develop, run and evaluate the 'Preparing for Interview Course', a practical, in-person training programme designed to support senior resident doctors as they prepare for upcoming consultant interviews. Our initial pilot programme was incredibly successful, with remarkably good feedback from attendees and success in the course graduates being appointed to substantive consultant posts. We aim to build on this success whilst adapting the course to optimise all elements and will be running it again in 2025.

The PGME team has further developed and embedded training programmes not usually available to resident doctors. For example, we have continued to provide the 'Clinical Research and Statistical Methods' programme by Professor Henry Potts (University College London) and are adapting the format to increase access to more resident doctors in 2025. We previously supported and facilitated a 'Good Clinical Practice' (GCP) course for those wanting to get involved in research. This year we are opening this course to resident doctors, locally employed doctors and consultant trainers across the Trust.

Furthermore, the PGME team has secured the services of the Active Bystander Company to deliver training at Whittington Health. This training has been shown to give people the confidence and language techniques to call out poor behaviours, particularly when inappropriate or threatening. We wanted to provide this training at Whittington Health in response to a national research paper raising concerns relating to sexual harassment affecting resident doctors and other junior doctors in some specialties. The PGME Team plans to ensure this training is offered to all doctors who come to Whittington Health to train.

The PGME Team has continued to run the Whittington Health PGME Star Awards for resident doctors and awarded a PGME Star to a consultant Educational Supervisor for the first time, after a Clinical Fellow doctor shared how inspirational this consultant had been to their professional development. We are fortunate to have a superb Faculty of Educators at Whittington Health and we plan to acknowledge this by expanding this award scheme for resident doctors to nominate consultant trainers.

The Trust has also been awarded funding for the first time to develop trainers in Simulation Education for resident doctors. As a result, the PGME team developed a new post of PGME Simulation Lead. We also supported departments with state-of-the-art Simulation kits, such as a AirSim Difficult Airway training kit for the Intensive

Care Medicine (ICM) team. This will be an exciting time in Simulation Education at Whittington Health, and we hope that the new PGME Simulation Lead will bring innovation and focus to this very important aspect of medical training.

The PGME Team and Faculty of Educators has continued partnership working with teams across the Trust. For example, the Whittington Education Centre team once again provided the national PACES examination on behalf of the Royal College of Physicians, with a significant number of Whittington Health consultant trainers taking part as examiners. The PGME Team supported the library, with the provision of access to major scientific journals for all staff across the Trust, and with access to examination preparation for resident doctors. The PGME Team also supported the Department of Paediatrics in providing an Infant Hip Examination Trainer and an Infant Breast-Feeding Package accessible to all staff within the team.

The PGME Team were again awarded funding from NHSE to support the continuing professional development (CPD) of specialty and specialist doctors and locally employed doctors in the Trust. The team used this funding to run a competitive CPD Funding Award scheme. Applications were of exceptional quality and the Trust has been able to contribute towards doctors undertaking courses in practical clinical skills training, professional examinations, conferences, and postgraduate academic medical education training. This was recognised via a celebratory afternoon to congratulate the winners of these awards

The last year has been a time of achievement and change in our Whittington Health Library (WHL). The physical space was rejuvenated, with grants from the Trust's charity furnishing the ‘Michael Clift Wellbeing Room’ to make it a better place than ever for our learners. Our Library Team was re-energised by the appointment of a new head librarian, Adam Tocock, who led on national projects including the creation and publication of ‘The National Searching Guidance’ for all NHS librarians tasked with searching for evidence, and who then implemented this guidance at Whittington Health. This has encouraged an ever-greater liaison between staff and the Library Team who, through their popular mediated evidence searching service, provide the knowledge and information essential to ensure that decisions are based on the best current evidence, whether clinical or relating to wider Trust processes.

The WHL also provides guidance on safe patient care through provision of tools such as ‘BMJ Best Practice’ and ‘UpToDate’. Furthermore, the Library Team have developed a collaboration with the North Central London Research Network (NoCLoR) which has effectively doubled their training provision this year, bringing benefits to all WHL partners across North Central London (NCL).

The Whittington Education Centre (WEC) Team have continued to fully support education and training over the last year within the Trust, across NCL and nationally, Following a successful bid to the Trust’s charity, the WEC Team were able to host monthly Menopause Cafés to raise awareness and support colleagues going through the Menopause. They continued to support the Grand Rounds and have helped in developing and delivering online educational content for midwives and ICU nurses. They reached out to the ‘Ambitious about Autism Programme’ and provided ‘Supported Internship’ placements for young people with autism adapting to the workplace environment.

The WEC Team was successful in securing ongoing funding to provide the London and KSS Obstetrics and Gynaecology 'Return to Acute Clinical Practice Course' and ran this for the first time last year. Working with NCL colleagues, the WEC Team delivered pan-NCL training conferences in Menopause, Primary Care Paediatrics and Diabetes. Working with Maternity colleagues, they hosted an 'FGM Awareness and Deinfibulation Workshop' with high profile international speakers and survivors from across the country. The WEC Team successfully continued to run the MRCP PACES Exams on behalf of the Royal College of Physicians for the 10th year. This commitment was recognised by receiving UK PACES Champion Awards.

In the future, the Trust will continue to build on all these successes in postgraduate medical education. We will continue to drive forward initiatives and educational projects to support both our resident doctors and our excellent Faculty of Educators. This will further sustain and develop Whittington Health's reputation for excellence in education and training and as a place where people want to come to work and train.

Case study: North Central London's Dialectical Behaviour Therapy for Adolescent (DBT-A) Service.

This service was commissioned by the North Central and East London Child and Adolescent Mental Health Services Provider Collaborative and provided by Whittington Health NHS Trust.

- The number and complexity of young people, experiencing social, emotional and mental health concerns, that present to A&E continues to increase. A portion of these young people have additional admissions to inpatient Child and Adolescent Mental Health (CAMHS) Units. A recent study demonstrated a 64% increase in presentations of CYP experiencing a mental health crisis to A&Es.
- DBT-A aims to support young people, through helping them regulate their emotional state, reduce their use of crisis, ED and inpatient services.
- Our service has demonstrated a positive reduction in ED presentations and crisis service use.
- In addition, the service, based on previous inpatient bed days for individual young people, has demonstrated a reduced need for and reduced use of bed days.
- The DBT-A service provides an intensive offer to a small caseload of young people aged 13-18. We have supported circa 40 young people since becoming operational. Of the 35 young people, based on their previous admission history/bed day usage, we have prevented circa 950 inpatient bed days – across Mental Health and Acute Hospitals. The reduction of inpatient bed days represents a significant financial saving.
- Alongside the above service focused elements, we have demonstrated a positive impact on young people's lived experience, with an improvement in overall function, improvement in educational status, reduction in trauma symptoms and increase socialisation/engagement in a range of activities

COMUNICATION AND ENGAGEMENT

2024/25 was an exciting year for the Trust's Communications and Engagement team with the publication in October of a new four-year communications and engagement strategy. The document sets out ambitious plans to improve how staff, patients, partners, and our wider community stay informed and engaged with the work we do.

One of the key priorities is improving internal communication, to ensure that colleagues have the information they need, when they need it, to do their job as effectively and efficiently as possible. But the strategy also focuses on engaging more effectively with patients, service users, carers, stakeholders, and partners across the local health and care system and our local communities.

This is a four-year strategy, so changes will take time to implement. Not everything will happen right away, but we have already delivered several of the improvements we set out in the document including the roll out of a new cascade briefing system to make sure key information and updates are consistently shared with colleagues across the organisation.

We have also launched a new brand-toolkit which provides colleagues with the resources, templates, and advice they need to create high-quality, professional documents and resources such as posters. The toolkit incorporates our inclusive language guide which was developed earlier in the year to help empower and include Whittington Health staff to create an environment where everyone feels valued, respected, and heard.

We are also working closely with colleagues from our patient experience team to embed the voice of our patients and service users at the heart of everything we do. We are building on and adding to exemplars such as the long-standing and well embedded partnership between our maternity and neonatal services and the Whittington Health Maternity and Neonatal Partnership.

During the year we launched "Whittington Voices". We know that people across the communities we serve are experts in what matters to them and what works for them. We want to engage with everyone who is affected by the care we provide to ensure our services continue to improve in ways that help deliver our vision. That is why Whittington Voices provides an opportunity for local people, whether they use our services or not, to get involved in helping to shape our future. Recruitment to join Whittington Voices is now open and more details can be found by visiting www.Whittington.nhs.uk/WhittingtonVoices.

During the year, Whittington Health promoted positive developments and improvements to patient care across both local and national media. In May 2024, we were proud to welcome both ITV and Sky news to meet with some of our Sickle Cell patients who were expected to be amongst the first to benefit from a transformative new treatment when it was approved for use in the NHS by the National Institute for Health and Clinical Excellence. We welcomed ITV back in February 2025 to speak to patients about another development in the care and treatment of patients with red cell conditions when a new gene editing treatment was approved.

We saw Sky News report from our Community Diagnostic Centre in Wood Green in January 2025, as they used the centre as a case study for the future of NHS care on the day that the Government announced its elective care reform plans, which included plans to expand the use of such centres nationally.

Internally, we ran several successful campaigns to mitigate the risks facing the organisation. These have included a cyber security week, which aimed to promote good information governance and to equip people with the skills and knowledge they need to avoid being a victim of cyber risks such as phishing or spoofing both at work and in their personal lives. Because preventing fires is everyone's responsibility, we also held a fire safety week. Across the week we reminded colleagues about our key fire safety policies, reminded them of the training available to stay fire safe and highlighted key fire risks we face, such as the increased risk to our patients who are receiving oxygen and those who use emollient creams. In 2023, we launched a Violence and Aggression communications campaign to support the introduction of our Trust's new staff safety policy, and in 2024, our campaign was included as part of NHS England's best practice guide.

Across the year, we continued to enjoy excellent and supportive relationships with our colleagues at the North Central London (NCL) Integrated Care Board and with our counterparts across other health and care organisations who make up the NCL Integrated Care System. The value of system working has been demonstrated through our combined efforts to encourage the take up of seasonal vaccinations and on the major Start Well programme to improve maternity care and care for children and young people. This included very close working to support the development and delivery of a public consultation period on the proposed changes, which saw over 3,000 local people making their voice heard.

We have continued to demonstrate how our partnership with UCLH is resulting in higher quality care for our combined populations throughout the year. This has included examples such as our longstanding joint TB service, a new hospital@home service for UCLH patients living with Sickle Cell, provided by Whittington Health, and how our combined multidisciplinary team working across both Whittington Health and ULCH are delivering improved care for patients with other red cell conditions.

We worked hard to ensure that our amazing colleagues are recognised and congratulated for their hard work. This has included another successful annual staff awards event which saw over 300 people from across the Trust nominated. The awards culminated in a special awards evening held at the Royal Colleague of Physicians. This was in addition to continuing to recognise our colleagues with long service over 10 years and those who go "above and beyond" via our monthly 'Extra Mile Awards'.

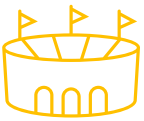
We also continued to keep people informed via our social media channels, which this year we added to as we launched onto Instagram for the first time:

More people viewed our posts than the population of Islington, Camden and Haringey combined

We have more followers than Holloway Road Station gets passengers in a day.

Time spent watching our YouTube videos was more than the time to cycle from Whittington hospital to Tangier in Morrocco.

The amount of people who viewed our content could fill Emirates Stadium nearly 12 times.



INFORMATION GOVERNANCE AND CYBER SECURITY

Whittington Health takes its requirements to protect confidential data seriously and over the last five years has made significant improvements in many areas of information governance, including data quality, subject access requests, freedom of information and records management.

The Data Security and Protection (DSP) Toolkit is a policy delivery vehicle produced by the Department of Health; hosted and maintained by NHS England. It combines the legal framework including the UK General Data Protection Regulations (UK GDPR) and the Data Protection Act 2018, and central government guidance including the NHS Code of Practice on Confidentiality and the NHS Records Management Code of Practice. The framework ensures the Trust manages the confidential data it holds safely and within statutory requirements.

During the year the Trust achieved DSP Toolkit compliance with a final submission result of Standards Met for version 6. The version 7 DSPT has increased the threshold of compliance and burden on the Trust. As a result, the Trust expects to partially meet the standards with an improvement in place. The Trust's DSP Toolkit submission and former IG Toolkit submissions can be viewed online at www.dsptoolkit.nhs.uk and www.igt.hscic.gov.uk.

Regarding IG training, all staff are required to complete this annually. The Trust ended 2024/25 with 88% of staff being IG training compliant. Compliance rates are regularly monitored by the IG committee, including methods of increasing compliance. The IG department continues to promote requirements to train and targets staff with individual emails including news features in the weekly electronic staff Noticeboard and it manages classroom-based sessions at induction.

INFORMATION MANAGEMENT AND TECHNOLOGY DEVELOPMENTS

During 2024/25, the information management and technology team was proud of the following achievements:

Technical service:

- **Windows 11 Upgrade**: The organisation is currently in the process of upgrading all systems to Windows 11, ensuring enhanced security features, improved performance, and a more modern user interface.
- **ISDX Decommissioning and Transition to SIP**: The legacy ISDX telephony system has been phased out and replaced with a Session Initiation Protocol (SIP) based system, which will provide more flexible and scalable communication solutions.
- **Xtreme to Cisco Core Changes**: The network infrastructure is undergoing significant changes, transitioning from Xtreme Networks to a Cisco core, which is expected to offer better reliability, performance, and support for future growth.
- **Thorogood uninterruptible power supply (UPS) Replacement**: The UPS systems provided by Thorogood are being replaced to ensure continuous power availability and protect critical systems from power outages and fluctuations.
- **Roll Out of Multi-Factor Authentication (MFA) to All Staff for NHSMail**: MFA is being implemented for all staff using NHSMail to enhance security by requiring multiple forms of verification before granting access to email accounts.
- **Transition from VMware to Nutanix**: The organization is moving from VMware to Nutanix for its virtualization needs, aiming to simplify management, reduce costs, and improve the scalability and performance of its IT infrastructure.

Information:

- **Health Inequalities Dashboard**: The development of a comprehensive dashboard to monitor health inequalities, providing valuable insights and data to inform policy decisions and improve health outcomes across different demographics.
- **Depth of Coding Investment**: Significant investment in coding development to enhance the review process, working closely with clinicians and operational leads to optimise coding performance.
- **0-19 Barnet Health Visiting and School Nursing Services Data Migration**: The migration of data for health visiting and school nursing services in Barnet, ensuring seamless transition and integration of information to support the health and well-being of children and adolescents.
- **Faster Data Feed for Community**: Upgrading the data feed frequency enabling more timely and accurate data collection and analysis to better serve community health needs.
- **POA Dashboard**: The creation of a detailed dashboard to show referrals numbers, clinic appointments, cancellations, and DNAs, offering critical insights to support service planning, enhance patient access, and reduce missed appointments.
- **Theatres Dashboard**: The implementation of a comprehensive dashboard to monitor theatre productivity, delays, trends, session details, and income forecasts, providing key insights to optimise resource use, improve efficiency, and support strategic planning within surgical services.

Patient systems:

- **RiO Upgrade**: The RiO electronic patient records were upgraded to enhance functionality, improve user experience, and ensure compliance with the latest standards.
- **Ambulatory Care Using ED Style Whiteboard for ECDS Compliance**: The ambulatory care team adopted an emergency department style whiteboard to comply with Emergency Care Data Set requirements, facilitating better tracking and management of patient care.
- **Digital Care Plans on CareFlow EPR for Wards**: Digital care plans have been introduced on the CareFlow Electronic Patient Record (EPR) system for hospital wards, streamlining the documentation process and improving the coordination of patient care.
- **Vitals Application Upgrade and Cannula Module Implementation**: The Vitals application was upgraded, and a new cannula module has been implemented and rolled out to hospital wards and ambulatory care services, enhancing patient monitoring and care delivery.
- **CIS2 Spine Authentication for iPads:** CIS2 spine authentication has been enabled for iPads, allowing use of the RiO system on these devices, improving accessibility and efficiency for healthcare providers and enabled MIA app to be retired, with associated cost savings.
- **Robotic Process Automation (RPA) Processes for Patient Registration and Referral Management**: RPA processes are now live for registering patients and moving outpatient referrals from the electronic referral system to CareFlow, enabling electronic triaging of referrals and streamlining administrative tasks.

Case study: Imaging Department DM01 Performance

The Imaging Department consistently delivered high diagnostic performance throughout the 2024/25 financial year, maintaining exceptional compliance with DM01 targets, contributing to improved patient experience and overall healthcare outcomes.

The imaging team has worked collaboratively to ensure capacity is utilised effectively, with modality leads, booking teams, and clinical staff coordinating efforts to maximise efficiency. Regular capacity and demand reviews have enabled proactive scheduling adjustments, ensuring appointment slots are filled and reducing the risk of underutilisation. Active patient tracking and monitoring have been integral to minimising breaches, with dedicated staff reviewing referral pathways and prioritising urgent cases where necessary. By fostering a culture of teamwork and shared responsibility, the department has maintained a seamless patient flow, meeting DM01 targets while delivering high-quality diagnostic services.

In response to growing demand, both ultrasound and CT services have expanded their operating hours, allowing for greater patient throughput and reduced turnaround times. To accommodate the sustained rise in MRI referrals, additional weekend lists were implemented on an ad-hoc basis. This proactive approach ensures that demand is met efficiently, preventing backlog accumulation and improving patient flow.

A key driver of improved performance has been the redesign of booking templates. By maximising available slots within operational hours, the department has increased daily scan capacity while maintaining high-quality service delivery.

ESTATE, FACILITIES & CAPITAL DELIVERY

Our Trust is committed to investing in the estate to ensure we provide high quality care for our population and a modern working environment for our teams. The vision for our estate is “To provide high quality patient and staff focused environments that support our vision to help local people live longer, healthier lives”.

A key enabler to delivering this ambition is the availability of capital funding, providing the means to replace existing facilities and invest in new developments to realise our strategic objectives. Capital funding availability is a constraint for the NHS in England, and this is equally felt at Whittington Health. The Trust is focused on maximising the capital funds available for investment, as well as carefully prioritising where investment is made to across the estate.

Key highlights of our Estates and Facilities delivery plan are shown below.

Maternity and neonatal buildings

The Trust is fully committed to updating and improving the clinical services within the existing maternity and neonatal (M&N) unit at Whittington Hospital for the benefit of the local community. This has been a priority of the Trust for many years but due to limited availability of funding, investment in our fire remediation and power infrastructure projects are now the Trust’s top priorities in its estate strategy.

Our strategy makes sure that we can deliver the right care in the right place and in the right environment both now and in the future, to deliver our vision of “Helping local people live longer healthier lives.”

The current maternity and neonatal unit located within blocks D, E, N and P require substantial updating and refurbishment.

With the reengagement of the NCL ‘Start Well’ review in 2023 on the reconfiguration of maternity services within the ICB area of operation, the M&N design has been back through a 1:500 design review which was accepted by the Trust and a 1:200 design has been produced and agreed in principle. Following the formal approval of the Start Well decision-making business case, maternity services at the Whittington Hospital site are assured as a key part of the North Central London maternity and neonatal services of the future, the 1:200 design will now require Trust approval before the detailed 1:50 design of the Start Well phase of the project can commence. This will allow the Start Well phase to be accurately costed and an agreed programme of works set out.

Power infrastructure project

Following a high-level strategic review of the high voltage (HV) and low voltage (LV) systems at the hospital in 2023/24, it was identified that many of the systems are reaching the end of their working life. There are some risks associated with resilience and single points of failure. Investment in the power infrastructure on the acute hospital site is crucial as both an enabler for future strategic developments (e.g. maternity and neonatal services), as well as ensuring the Trust meets the power demands of their current estate development plan, including decarbonisation and the net zero carbon target of 2040.

In 2023, the Trust appointed a specialist contractor under the P22 Procurement regime to design and install a new 8.5 MVA power supply to the hospital site. The cables and associated switchgear for this new power supply have now been installed and a final connection to the existing hospital HV cable will be complete by May 2025. At the same time, the Trust has installed a new transformer on site as a temporary measure to reduce an overheating risk with the existing transformers. This temporary transformer will eventually be replaced with the construction of a new energy centre on the site of the Old Boiler House. The new energy centre will house a new HV switch room serving the entire hospital site, HV transformers and generators and new replacement LV switch rooms to Blocks C and K, all required to reduce known critical risks with the existing power infrastructure system and to provide N+1 resilience to the entire site. A planning application for the new energy centre development is shortly to be submitted and approval has already been granted to demolish the old Boiler House. The power infrastructure project is a long-term project to be carried out over several years with allocated funding. It is anticipated that construction of the new energy centre will commence in 2025.

Fire remediation project

Following a fire at the hospital in January 2018, the Trust subsequently terminated the private finance initiative contract for Blocks A and L, which is now part of the retained NHS estate. The Trust has been working to survey and identify fire safety deficiencies within Blocks A & L to inform a schedule of rectification works. As part of this programme, the Trust works closely with both NHS England and the London Fire Brigade (as the fire regulatory authority) to agree plans for risk mitigation and rectification of the deficiencies. To immediately mitigate the risk of a fire situation, a waking fire watch was established within Blocks A & L patrolling the building out of working hours to provide an early warning and the Trust's Fire Team have reviewed, updated and trained staff on the fire policies and procedures in the event of a fire. Fire doors to Blocks A & L have been repaired or replaced and a new fire curtain has been installed within the entrance atrium to the hospital. Some containment and cabling works for a new fire alarm system have been installed and, for the time being, the existing fire alarm system remains in operation, whilst the sectional installation of a new fire alarm system is undertaken. . Designs for a new decant ward are being developed so that construction works can commence this year. Once completed, the decant ward will then allow the Trust to empty those currently occupied wards so that fire remediation works can be carried out in the ward areas. New emergency lighting has been installed in many of the common areas and plant rooms (non-patient wards/areas) in Blocks A & L.

An updated fire strategy has been produced for Blocks A & L and the Trust is working with London Fire Brigade to obtain the necessary approvals to the fire remediation works required. The Trust is working closely with NHS England and the ICB to find a workable solution to the fire deficiencies identified and the funding required to complete the works.

Mortuary refurbishment project

The Trust's mortuary facility serves both the hospital and the local community through a long-standing agreement with the London Borough of Islington. Following a Human Tissue Authority (HTA) inspection and report in June 2022, the HTA identified a number of issues with the Trust's mortuary facility. The Trust has completed a refurbishment project of the mortuary to bring the facility up to current HTA compliance standards through a comprehensive refurbishment project.

The refurbishment project involved the construction of a fully compliant temporary facility on the hospital site by SME Ltd before the existing mortuary was temporarily closed for the duration of the refurbishment works. The main project involved several key improvements to the facility including, replacing old storage fridges and freezers and increasing the storage capacity from 52 to 73 spaces to reduce the previous heavy reliance on external storage facilities, upgrading the post-mortem room and installing a new Air Handling Unit to comply with current HTM standards.

Quinn Construction Ltd commenced the main refurbishment works in August 2024 and the project was completed by December 2024 ensuring that the mortuary meets the highest HTA standards of compliance. The upgraded facility offers state of the art equipment, increased capacity and enhanced quality, ensuring better service and ensuring compliance with the HTA standards required for our licence. The Mortuary team provided a seamless service during the transition period while the mortuary building was refurbished, working with colleagues at St Pancras Mortuary and utilising a temporary body store that was created on the trust site. This refurbishment provides a greater experience for all professionals visiting and working in the mortuary including hospital staff, police, pathologists and funeral directors. In addition, the Trust have been able to renew their service level agreement with the London Borough of Islington Council and secure a higher level of annual funding due to the increase in the mortuary's capacity which is supporting the ongoing provision to the local community.

SUSTAINABILITY

In recent times, many organisations around the UK have declared a climate emergency alongside the UK's legally binding target under the Climate Change Act to reduce its emissions to Net Zero by 2050. With approximately 20% of carbon emissions arising from energy use in buildings and the public sector accounting for approximately 2% of total UK emissions, the public sector must contribute to the delivery of Net Zero and show leadership by decarbonising its heat.

In 2020, the National Health Service launched the campaign 'For a Greener NHS' which outlines a practicable, evidence-based route to a Net Zero NHS. This roadmap set out the following targets:

- Net Zero by 2040 for the NHS Carbon Footprint, with an ambition for an 80% reduction by 2028 to 2032.
- Net zero by 2045 for the NHS Carbon Footprint Plus, with an ambition for an 80% reduction by 2036 to 2039.

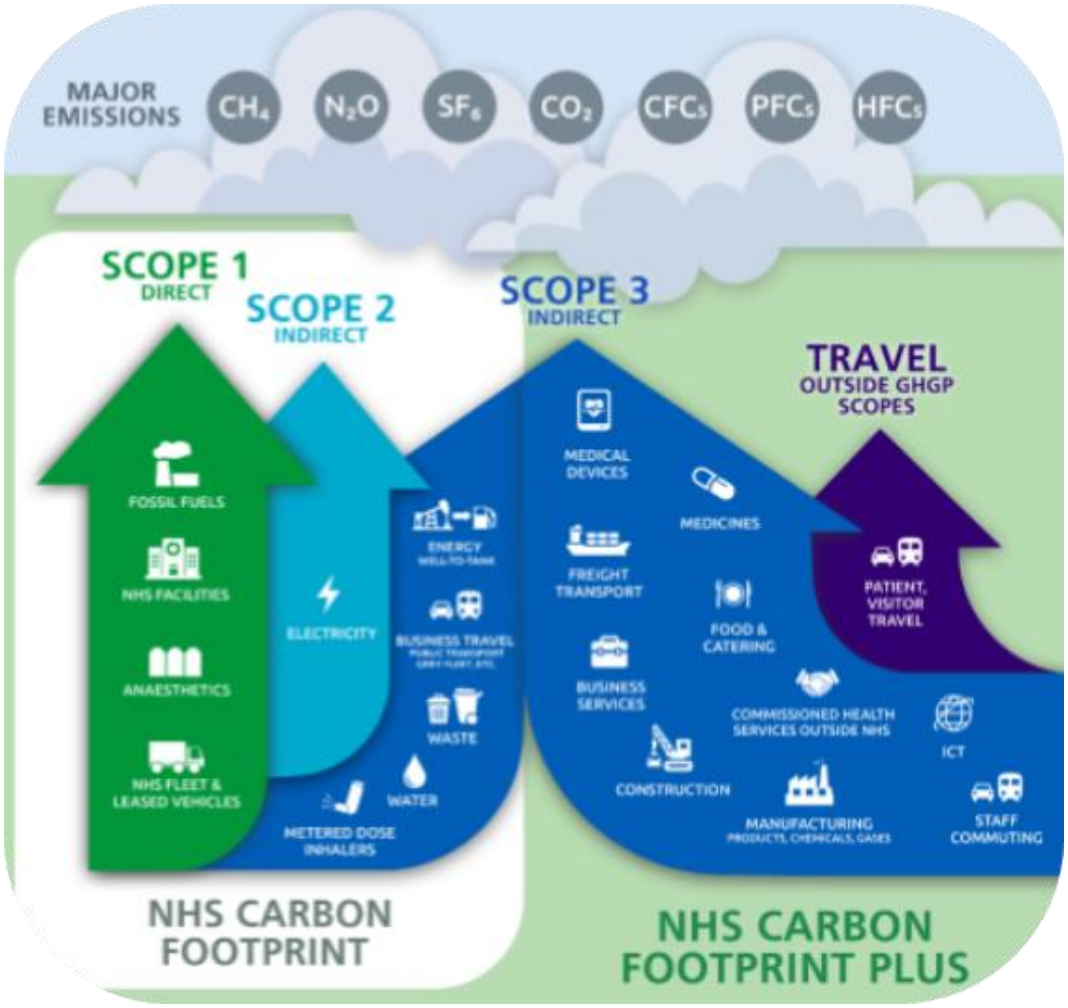


Figure 1: Scope of Emissions within the NHS (Delivering a 'Net Zero' National Health Service, 2020)

In 2021, the UK government committed to fully decarbonising the electricity system by 2035. This means that the major challenge for public sector bodies to reach net zero for direct emissions will be the decarbonisation of heat, which is still predominantly provided by combustion of fossil fuels such as natural gas and heating oil.

As a provider of healthcare and a publicly funded organisation, Whittington Health is committed to ensuring the long-term sustainability of the natural environment to deliver sustainable healthcare and to safeguard human health. Whittington Health will continue to help local people live longer and healthier lives, even in the context of rising utility costs, by ensuring we use environmental, financial, and social assets in a sustainable manner.

While there is an enormous challenge for us to reach the targets set out by *Greener NHS*, Whittington Health recognises that the most significant immediate challenge to reach net zero for our NHS carbon footprint is the decarbonisation of heat use in our buildings. It is crucial to take steps now to ensure that the Trust not only meets these net zero targets but is at the forefront of sustainability within the healthcare sector.

The Trust has already demonstrated this by completing its own Green Plan and has utilised the low carbon skills fund to develop its Heat Decarbonisation Plan.

Our Green Plan

Our Green Plan produced in 2022 outlines the national and local context of sustainability within the healthcare sector, discusses how sustainability aligns with our organisational vision and details how we intend to embed sustainability across our organisation. The key aims of the Green Plan are:

- An improved approach to monitoring and reporting sustainability key performance indicators.
- A qualitative assessment of our performance in several key *Areas of Focus* (as defined by the Sustainable Development Unit (SDU)).
- A defined set of actions to progress the Trust's sustainable development.
- An appraisal of the potential risk and opportunities associated with our wider sustainability strategy.

Historically at Whittington Health, we have taken an integrated approach to sustainability with a broad focus on energy reduction, tackling waste, improving local air quality, and promoting green space.

Whilst we continue to ensure these areas are driven forward, we recognise that the scale of the challenge set out within the targets outlined above will mean that our primary focus for the future must be the drive to reach net zero for both the emissions we can control (NHS carbon footprint) and those which we can influence (NHS carbon footprint plus).

All Trust Green Plans must now be refreshed for the next 3-year cycle in line with statutory guidance by 31st July 2025.

2025 Green Plan Initiatives

The focus for 2025 will be establishing the Trust Governance for Sustainability (shown in Figure 2 below) with Carbon Architecture acting as the Sustainability Consultant to:

- Be accountable for the Trust's Green Plan and to update this annually to ensure the Trust is meeting its objectives.
- Work across the Trust to design initiatives that ensure Whittington Health is on course to meet the ambitious net zero targets.

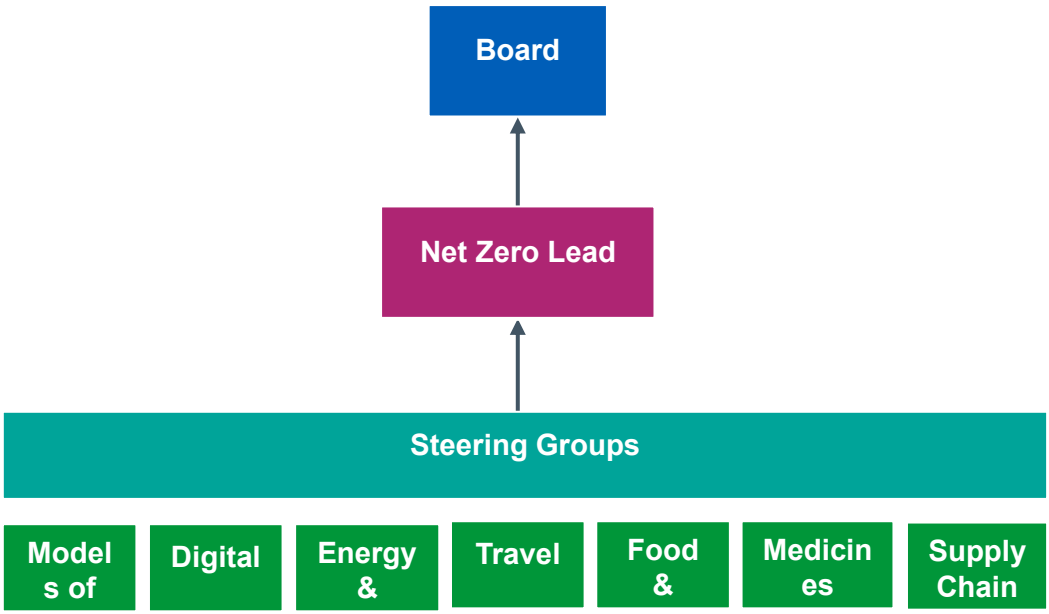


Figure 2: Proposed sustainability governance structure.

Among other schemes, another focus for 2025 will be to finalise the strategy of decarbonising heat over the Trust's estate. In January 2025, the Trust updated their Heat Decarbonisation Plan which was originally produced in April 2022. This plan presents the solution for moving away from gas-fuelled heating on site and steer towards low carbon alternatives such as Air Source Heat Pumps.

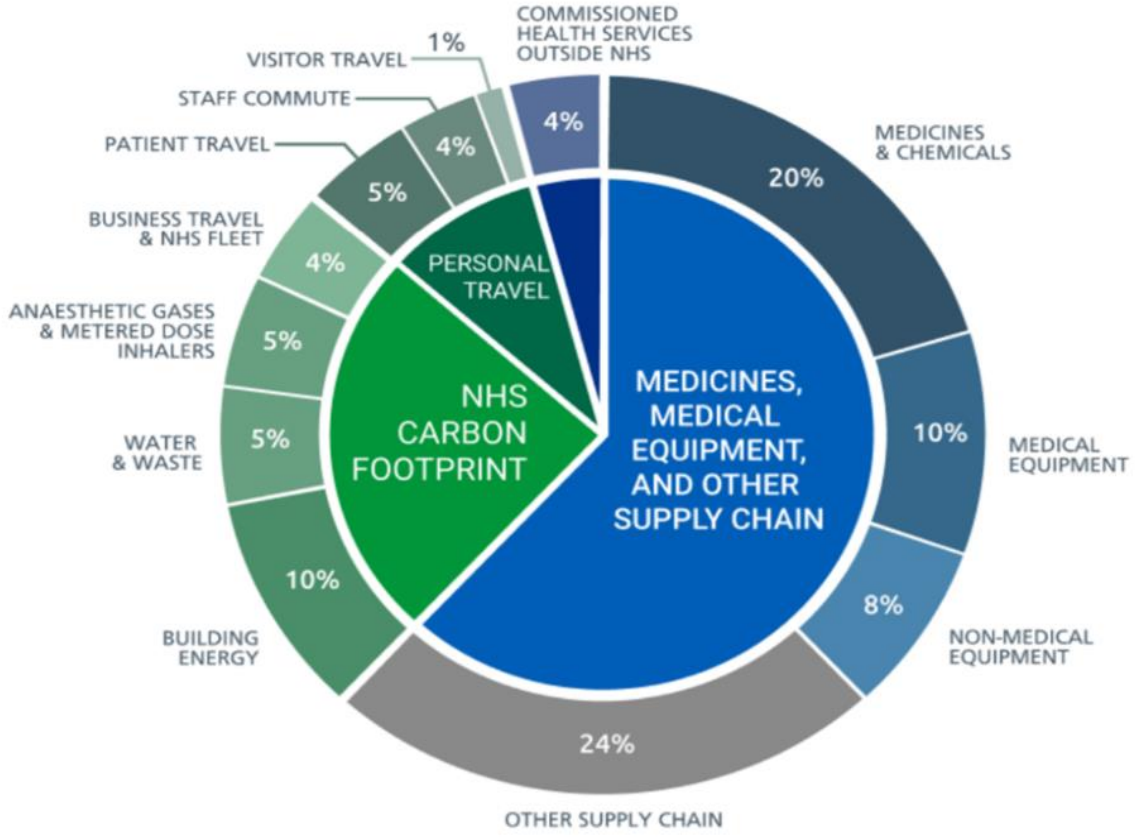


Figure 3: NHS Average Emissions Breakdown by Source

Carbon impact

Teams across our Trust have been focused on reducing our direct emissions for many years. Figure 4 shows that, to date, we have reduced our emissions by 45% since our baseline year of 2016/17. This has been driven by efforts to reduce energy consumption and significantly by the ongoing decarbonisation of the electricity grid.

Following on from an initial phase of LED lighting installation in 2022, the Trust is focussed on rolling out further LED lighting in A & L Blocks and Highgate Wing. Considerable investment in the region of £1 million will be needed to achieve this, however, we estimate the project to payback over three years and a 1 GWh reduction in electricity consumption (£300k annual utility saving) will be achieved.
Regarding Anaesthetic gases, the Trust is also working on another scheme in collaboration with our Pharmacy Team to address nitrous oxide. This involves making an assessment and collaborating with the supplier of our anaesthetic machines to enable retrofit of nitrous oxide cylinders, thereby reducing the requirement of piped nitrous oxide and facilitating the ultimate decommissioning of our manifold.

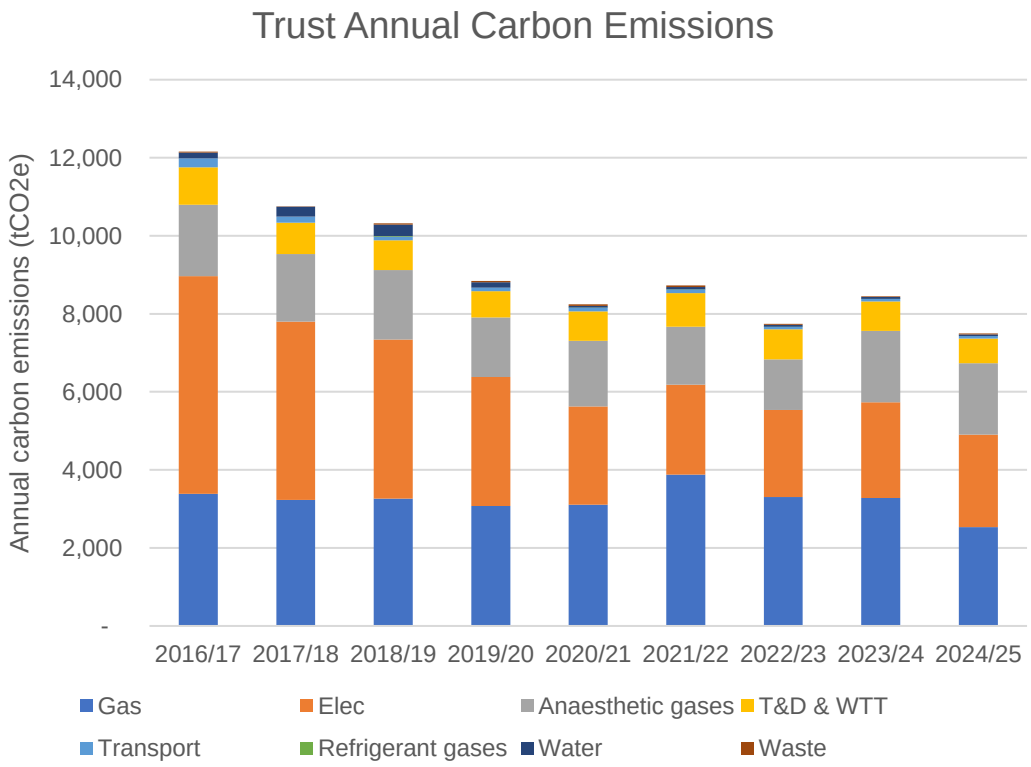


Figure 4: Annual NHS Carbon Footprint Emissions (MDIs & Business Travel Data Missing)

Energy usage

Emissions from energy use currently represents 73% of our total NHS carbon footprint. On this basis, reducing energy consumption and transitioning to lower carbon technologies will be a key element of our pathway to achieving our reduction targets.

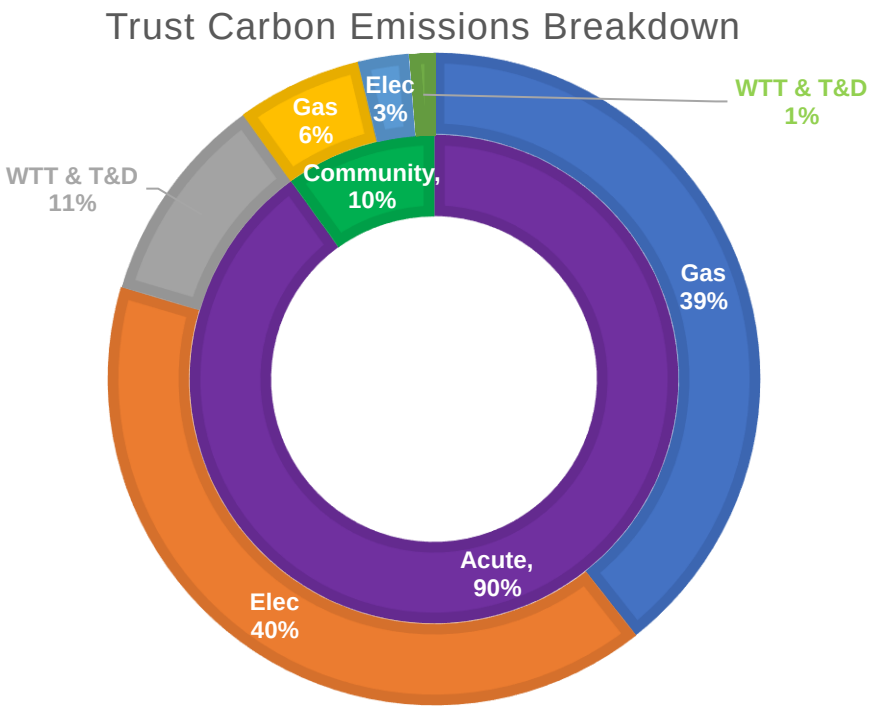


Figure 5: Breakdown of Emissions for Building Energy Use 2024/25

There is a similar split between gas and electricity consumption at the acute site (39% and 40% respectively) with the remaining energy use emissions arising from well-to-tank (WTT) and transmission & distribution. On the community side, most emissions are from gas consumption, accounting for 63% of total community site energy usage.

With more renewable energy being fed into the electricity grid and a reduced reliance on fossil fuels for power generation, we can expect gas to make up an ever-increasing proportion of our NHS carbon footprint. Eliminating the use of natural gas for heating our estate is a key long-term step to reaching net zero. The Trust is working with our sustainability consultant, to monitor energy usage and find opportunities for energy reduction opportunities. This will become more apparent now that the BMS has been upgraded, allowing more optimisation opportunities to be identified.

To move towards more sustainable energy sources, in April 2024, the Trust moved to a new electricity supplier, 'BrytEnergy', to supply zero carbon, 100% renewable electricity sourced solely from solar, wind, and hydro generation. Furthermore, as part of the new funding from Great British Energy, the Trust was awarded £417,000 to install solar panels at five health centres, saving over £40,000 a year and supporting investment into frontline care.

The Trust plans to improve its energy management over the next two years through continuation of our smart meter and AMR rollout programme and by implementing a system to automatically monitor consumption and identify opportunities to make savings. This will eliminate problems we are facing with receiving our data from utility companies and instead collecting our data in real-time. We also need to work harder to educate and engage our workforce to make behavioural changes which will reduce demand for energy across our estate.

Waste management

The Facilities' waste team continue to drive improvement through Whittington hospital's in-house recycling centre. Having built upon the success of previous years, in which the main hospital became a zero waste to landfill site, the proportion of total waste recycled is over 14%, a 2% increase from 2023/24.

The significant contribution of clinical waste is due to the use of necessary personal protective equipment which needs disposal through incineration.

The Facilities' team also maintained the practice of baling and storing cardboard waste on-site until there is enough to fill a whole waste consignment. This minimises transport and external labour costs, as well as reducing the associated road miles.

Figure 7 below shows the breakdown of the main hospital's waste streams last year.

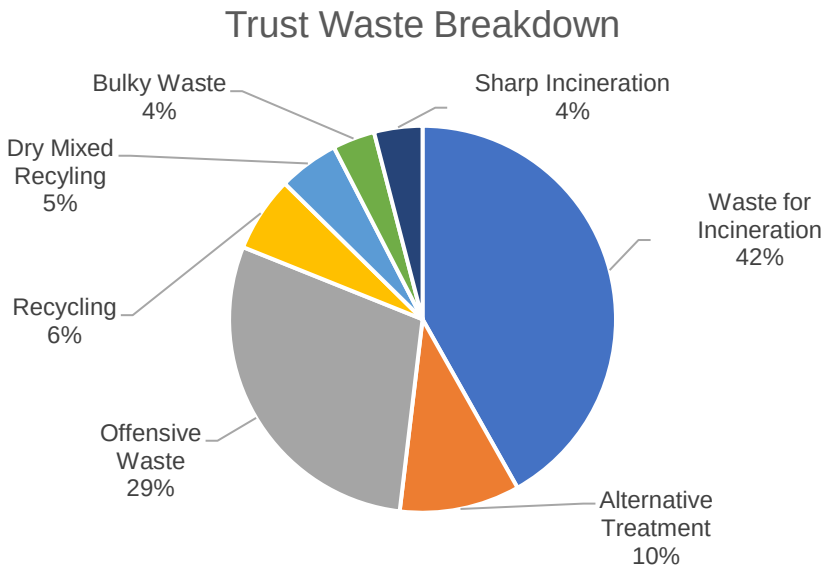


Figure 6: Whittington Hospital Waste Breakdown by Type 2024/25

Looking forward, we will continue to focus on driving down total waste production whilst increasing the proportion sent for recycling. The Trust will also focus on improving the tracking of waste generation and recycling rates across our community sites.

Water usage

Whittington Health Trust is aware that, although it may not appear to be critical at present, water scarcity is a growing concern in the UK. In 2019, the chief executive of the Environment Agency predicted that, with the impact of climate change and a rising population, the UK may not have sufficient water to meet its needs in as little as 20-25 years. We are also aware that the supply and distribution of water has an intrinsic carbon cost which adds to the Trust's supply chain emissions. As a significant consumer of water, we recognise that we need to act now to mitigate these risks.

In the last financial year, the Trust moved away from Castle Water and signed up to an agreement with ADSM to manage our water usage. Figure 8 shows that overall, the site has reduced its water usage from 2016/17 to 2024/25 by 25%, where the lowest consumption in 2020/21 arose due to the pandemic as fewer staff and visitors came to site. There was a rise in consumption from 2017/18 reaching 300,000m³ in 2018/19. This resulted from a leak which went unidentified for several months. The reason it took so long to identify the issue was due to a lack of regular data monitoring on site, which further emphasises the importance of identifying abnormal consumption quickly.

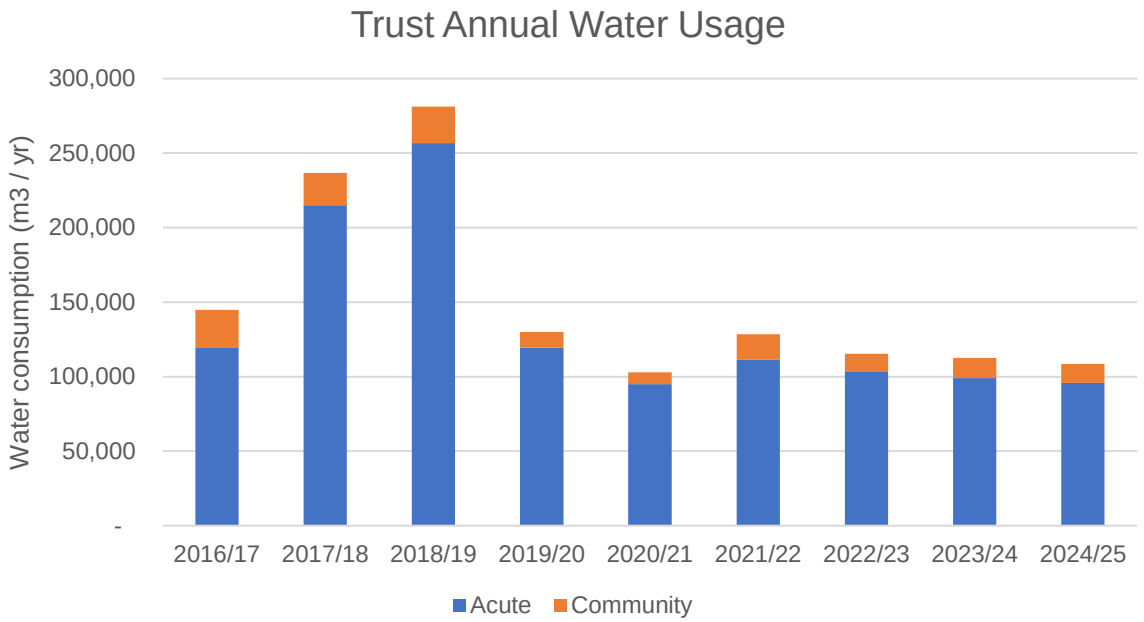


Figure 7: Site Water Consumption from 2016/17 to 2024/25

It is necessary to educate staff and patients about their role in water usage. Campaigning and raising awareness of the issue is a positive way of reducing waste at the point of use.

Up until this point, our focus has primarily been on reducing our scope 1 & 2 emissions. However, a greater proportion of our total emissions are likely to originate from our supply chain. As such, our primary focus will need to shift to the quantification of our NHS carbon footprint plus, for which we are currently collating data.

Procurement

We continue our commitment to reduce the wider environmental and social impact associated with the procurement of goods and services, in addition to our focus on carbon. Following completion of the SDU's Sustainable Development Assessment Tool, we have identified several areas where we can look to improve the sustainability of our procurement practices.

Examples include the inclusion of sustainability specific criteria within tenders for goods & services and improved data capture to enable tracking of the carbon impact of our supply chain. Furthermore, we have recently conducted an in-depth review of our current utilities procurement contracts and are now considering options for the future to ensure that, going forward, we receive a

cost-effective, high-quality service that will not be at odds with our sustainability goals.

For the Trust's supply chain to be compliant with PPN06/21, in 2025, select suppliers must publish carbon reduction plans, while others must make a public pledge to achieve Net Zero by 2050.

Travel & Logistics

The Trust is engaged in a collaborative relationship with Islington Council to improve sustainable transport within the borough. The development of the Trust's Travel Plan will strengthen the Trust's clear focus on greener travel with the intended aim both of reducing the carbon footprint of our business operations and supply chain and to improve the air quality of the local area.

Whittington operated a total of 13 electric fleet vehicles primarily for the purpose of business travel between community sites. This represents more than 50% of the Trust's vehicle fleet. Some larger petrol/diesel powered vehicles are retained for functions such as security and pharmaceutical deliveries. Business travel by car is conducted with the electric pool cars wherever possible. This has been facilitated through the Trust's investment of 16 electric vehicle (EV) charging points at the acute site, as well as several others across the community sites. In addition to our EVs, the Trust issued approximately 370 oyster cards to community staff to encourage the use of public transport instead of journeying by petrol/diesel cars.

In line with our clinical strategy, the estate strategy will reduce the number of locations we deliver clinical services from, ensuring they are demographically positioned to serve our community more efficiently. This will reduce the travel times of our patients and staff, therefore reducing the carbon impact of all associated journeys made.

EMERGENCY PREPAREDNESS

Whittington Health participated in the annual emergency preparedness, resilience and response (EPRR) assurance process led by NHS England. The core standards for EPRR are set out for NHS organisations to meet. The Trust's annual assessment was completed on 23 October 2024, by the North Central London, NHS England Assurance Team. The EPRR assurance requirements stipulated those providers self-assess compliance against the NHS core standards.

The Trust has achieved **SUBSTANTIALLY COMPLIANT**: EPRR and CBRN (chemical, biological, radiological, and nuclear) assurance outcome in accordance with standards achieved in 2024. The four amber score pertained to data protection and information governance. The trust received amber ratings for standard 2 and 28, which have since been updated. The EPRR 2024/2025 action plan, is in place in response to the amber standards.

NHS England Core Standards	Core Standards total	Assessment outcome Red	Assessment outcome Amber	Assessment outcome Green
EPRR	54 (1-54)	0	2	54
CBRN	14 (55-73)	0	0	19

In 2024, NHS England, decided to conduct a deep dive into *Cyber Security.* The outcome assessment of cyber security was fully compliant.

CONCLUSION TO THE PERFORMANCE REPORT AND STATEMENT OF FINANCIAL POSITION

The above document represents the performance report and statement of financial position of Whittington Health for the financial year 2024/25. As the CEO, I believe this represents an accurate and full picture of the Trust for the year.

Signed 

Chief Executive: Selina Douglas

Date: 24 June 2025

ACCOUNTABILITY REPORT

Members of Whittington Health's Trust Board

Further details about our Board members, including their knowledge, skills and experience can be found on the Trust's website: Trust Board Members

Non-Executive Directors

Julia Neuberger, Junaid Bajwa, Mark Emberton (from 15 October 2024), Naomi Fulop (to 14 October 2024), Amanda Gibbon, Nailesh Rambhai, Glenys Thornton, Rob Vincent.

Directors

Clare Dollery, Jonathan Gardner, Charlotte Hopkins (from 3 June 2024), Tina Jegede, Liz O'Hara, Clarissa Murdoch (to 2 June 2024), Chinyama Okunuga, Swarnjit Singh, Sarah Wilding, Terry Whittle.

Membership of committees reporting to the Board

Audit and Risk Committee

Non-Executive Directors: Rob Vincent, Amanda Gibbon, Glenys Thornton, Nailesh Rambhai

Charitable Funds' Committee

Non-Executive Directors: Amanda Gibbon, Julia Neuberger, Nailesh Rambhai
Directors: Clare Dollery, Jonathan Gardner, Charlotte Hopkins, Sarah Wilding, Terry Whittle

Finance & Business Development Committee

Non-Executive Directors: Naomi Fulop, Amanda Gibbon, Rob Vincent, Nailesh Rambhai
Directors: Clare Dollery, Terry Whittle, Chinyama Okunuga, Jonathan Gardner

Improvement, Performance and Digital Committee

Non-Executive Directors: Junaid Bajwa, Naomi Fulop, Nailesh Rambhai, Mark Emberton
Directors: Jonathan Gardner, Terry Whittle, Chinyama Okunuga

Quality Assurance Committee

Non-Executive Directors: Naomi Fulop, Amanda Gibbon, Mark Emberton, Glenys Thornton
Directors: Clare Dollery, Charlotte Hopkins, Clarissa Murdoch, Chinyama Okunuga, Swarnjit Singh, Sarah Wilding

Remuneration Committee

Non-Executive Directors: Julia Neuberger, Junaid Bajwa, Naomi Fulop, Amanda Gibbon, Nailesh Rambhai, Glenys Thornton, Rob Vincent, Mark Emberton

Workforce Assurance Committee

Non-Executive Directors: Junaid Bajwa, Glenys Thornton, Rob Vincent
Directors: Clare Dollery, Charlotte Hopkins, Liz O'Hara, Chinyama Okunuga, Sarah Wilding, Terry Whittle, Swarnjit Singh, Tina Jegede

Whittington Health and UCLH Partnership Development Committee-in-Common

Non-Executive Directors: Julia Neuberger, Junaid Bajwa, Glenys Thornton, Rob Vincent
Directors: Clare Dollery, Terry Whittle, Jonathan Gardner, Charlotte Hopkins

Non-executive director appraisal process

The Chairman and non-executive directors annually evaluate their performance through appraisal and identify any areas for development. The appraisal of the non-executive directors is carried out by the chairman.

Trust Board of Directors' declarations of interest

In line with the Nolan principles of public life, Whittington Health NHS Trust is committed to openness and transparency in its work and decision making. As part of that commitment, we maintain and publish a register of interests which draws together declarations of interests made by members of the Board of Directors.

In addition, at the commencement of each Board meeting, members of the Board are required to declare any interests in respect of specific items on the agenda. The declarations for 2024/25 are shown in the table below:

Voting member	Declared interests
Baroness Julia Neuberger DBE, Trust Chair and Non-Executive Director	• Independent, Cross Bench Peer, House of Lords • Chair, University College London Hospitals NHS Foundation Trust • Chair, Board of Trustees, Independent Age • Occasional broadcasting for the BBC • Rabbi Emerita, West London Synagogue • Trustee, The Walter and Liesel Schwab Charitable Trust • Trustee, Rayne Foundation • Trustee, Leo Baeck Institute Academic Study of German Jewish relationships • Trustee, Yad Hanadiv Israel (Charitable Foundation) • Trustee, Lyons Learning Project (independent education charity dedicated to all aspects of Jewish Learning) • Consultant, Clore Duffield Foundation (on Jewish matters) • Commissioner, Commission on the Integration of Refugees • Bereavement Commissioner, UK Commission on Bereavement • Chair, Oversight Committee, City of London Centre • Public Voice Representative, Jewish Community's BRCA Testing Programme

Voting member	Declared interests
	• Member of the Science and Technology Committee House of Lords • Vice Chair All-Party Parliamentary Group on Faith and Society • Member, North Central London Integrated Care Board Strategy Committee • Member, North Central London Integrated Care Board Partnership Committee <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Clare Dollery, Acting Chief Executive	• None <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Junaid Bajwa, Associate Non-Executive Director	• Chief Medical Scientist, Microsoft • Essential Guides UK Limited (Shareholder, GP locum services and educational work) • Merck Sharp and Dohme (shareholder and ex- employee) • NHS England (GP appraiser) • GP, Operose Health • Non-Executive Director, University College London Hospitals NHS Foundation Trust • Non-Executive Director, Medicines and Healthcare products Regulatory Authority • Non-Executive Director, Medica Group Plc • Governor, Nuffield Health • Non- Executive Director, Nahdi Medical Corporation • Non- Executive Director, eConsult • Non-Executive Director Ondine • Visiting Scientist, Harvard School of Public Health • Associate Professor, University College London • Trustee of the Board of Health Data Research UK (HDR UK) <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Professor Naomi Fulop, Non-	• Honorary contract, University College London Hospitals NHS Foundation Trust • Professor of Health Care Organisation & Management,

Voting member	Declared interests
Executive Director	Department of Applied Research, University College London • Non-Executive Director, COVID Bereaved Families for Justice (CBF4J), (CBF4J is a core participant in modules 1 & 2 of the Covid Inquiry represented by Broudie, Jackson & Canter solicitors and individually represented by them).
Amanda Gibbon, Non-Executive Director	• Chair, RareCan Limited (start-up company looking to recruit patients with rare cancers into research in their disease areas. This post is currently unremunerated.) • Senior Independent Non-Executive Director, Royal Free London NHS Foundation Trust • External member of the Audit and Risk Assurance Committee of the National Institute for Health and Care Excellence • UCLH: Chair of the Biobank Ethical Review Committee for the UCL/UCLH Biobank for Studying Health and Disease • Director, The Girls Education Company Limited • Director, Garthgwynion Estate Limited • Director of Wycombe Abbey Services Ltd <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • My four (adult) children each have personal shareholdings in GlaxoSmithKline and Smith & Nephew
Liz O'Hara, Chief People Officer	• Director of Workforce, University College London Hospitals NHS Foundation Trust • Director, Pineapple Equity <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Chinyama Okunuga, Chief Operating Officer	• Non-Executive Director, Whittington Pharmacy Community Interest Company <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Nailesh Rambhai, Non-Executive Director	• Non-Executive director, Pension Protection Fund • Non-Executive director, Birmingham Women's and Children's NHS FT • Non-Executive director, University College London Hospitals NHS Foundation Trust • Non-Executive director, Newbury Building Society

Voting member	Declared interests
	• Director, Cholmeley Court Ltd • Member, finance & performance committee, Birmingham & Solihull Integrated Care Board • Trustee, United Way UK <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Baroness Glenys Thornton, Non-Executive Director	• Member of the House of Lords, Opposition Spokesperson for Women and Equalities • Member, Advisory Group, Good Governance Institute • Chair and Trustee, Phone Co-op Foundation for Co-operative Innovation • Chair, Advisory Board of Assistive Healthcare Technology Association • Senior Associate, Social Business International • Senior Fellow, The Young Foundation • Council Member, University of Bradford • Emeritus Governor, London School of Economics • Trustee, Roots of Empathy UK • Patron, Social Enterprise UK • British Council All Party Parliamentary Group • Vice Chair Social Enterprise • Vice Chair Dentistry & Oral Health • Vice Chair Domestic Violence & Abuse • Vice Chair Get Refusal • Vice Chair Homelessness • Co-Chair Respiratory Health • Officer Sickle Cell & Thalassaemia • Honorary Secretary Social Enterprise • Vice Chair Dalits • Officer of the All-Party Parliamentary Group on the British Curry Catering Industry • Shadow Minister for Culture Media & Sport <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Daughter is employed at Whittington Health
Rob Vincent CBE, Non-Executive Director	• Non-Executive Director, University College London Hospitals NHS Foundation Trust • Commissioner: UK Electoral Commission <u>Conflicts of interests that may arise out of any known immediate family involvement.</u> • Nil

Voting member	Declared interests
Sarah Wilding, Chief Nurse and Director of Allied Health Professionals	• Non-Executive Director, Whittington Pharmacy Community Interest Company <u>Conflicts of interests that may arise out of any known immediate family involvement.</u> • Nil
Terry Whittle, Chief Finance Officer	• Chair of Whittington Pharmacy, Community Interest Company <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Clarissa Murdoch, Acting Medical Director	• Nil <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Husband is Chair at ARUP (Consultancy firm specialising in the sustainable built environment who have some healthcare related work)
Charlotte Hopkins, Acting Chief Medical Officer	• Nil <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Father is an outpatient in dermatology clinics at the Trust.
Mark Emberton, Non-Executive Director	Consultancy advice to: • Non-Executive Director University College London Hospitals NHS Foundation Trust • Sonacare Medical • Angiodynamics • NINA Medical Profound Medical • Exact Imaging • Minomic Medical • Proteomix • Prostate cancer care undertaken at King Edward VII Hospital (London Urology Specialists) • All current research is Grant Council sponsored. Within the MRC / CRUK • Re-IMAGINE trial we receive £8million of in-kind industry contribution managed through the MRC MICA process <u>Conflicts of interests that may arise out of any known immediate family involvement</u>

Voting member	Declared interests
	• Nil
Non-voting members	**Declared interests**
Jonathan Gardner Chief Strategy, Digital and Improvement Officer	• Nil <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Tina Jegede MBE, Joint Director of Inclusion and Lead Nurse, Islington Care Homes	• Nil <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary	• Secretary to the University College London Health Alliance Chief Executives' Group • Member of the North Central London People Board • Member of the North Central London Population Health and Health Inequalities Steering Group • Management Side Co-Chair of the Equality, Diversity, and Inclusion subgroup of the NHS Staff Council <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil

REMUNERATION AND STAFF REPORT

The salaries and allowances of senior managers who held office during the year ended 31 March 2025 are shown in the table below. For the purposes of this report, senior managers are defined as the chief executive, non-executive directors and executive directors, and all Board members with voting rights.

Name and Title	Salary and fees (Bands of £5,000)	Taxable benefits (total to the nearest £100)	Annual performance related bonuses (in bands of £5,000)	Long-term performance related bonuses (in bands of £5,000)	Pension related benefits (in bands of £2500)	Total (in bands of £5,000)
	£000	£00	£000	£000	£000	£000
Non-Executive						
Julia Neuberger	40-45					40-45
Amanda Gibbon	10-15					10-15
Naomi Fulop Left 14.10.2024	5-10					5-10
Glenys (Dorothea) Thornton	10-15					10-15
Rob Vincent CBE	10-15					10-15
Junaid Bajwa	10-15					10-15
Nailesh Rambhai	10-15					10-15
Mark Emberton Commenced 15.10.2024	5-10					5-10
Executive						
Clare Dollery - Acting Chief Executive:	245-250					245-250
Terry Whittle - Chief Finance Officer and Deputy Chief Executive	165-170	5			105-107.5	270-275
Charlotte Hopkins - Interim Medical Director Started 3.6.24	150-155				52.5-55	200-205
Liz O'Hara - Chief People Officer	20-25				10-12.5	30-35
Jonathan Gardner - Director of Strategy and Corporate Affairs	140-145				27.5-30	170-175
Chinyama Okunuga Chief Operating Officer	125-130	17			17.5-20	140-145
Sarah Wilding Director of Nursing and Clinical Development	135-140				15-17.5	155-160
Swarnjit Singh-Joint Director of Inclusion and Trust Company Secretary	100-105				15-17.5	120-125
Tina Jegede-Joint Director of Inclusion and Lead Nurse, Islington Care Homes	90-95				47.5-50	140-145
Clarissa Murdoch- Acting Medical Director 1.4.24 to 2.6.24	25-30				10-12.5	40-45

Liz O'Hara is substantively employed at UCLH NHS Foundation Trust. Liz O'Hara's total remuneration across the two NHS trusts was in the range £185k to £190k.

Clare Dollery chose not to be covered by the pension arrangements during the reporting year.

Salaries and Allowances 2023/24					AUDITED	
Name and Title	Salary and fees (Bands of £5,000)	Taxable benefits (total to the nearest £100)	Annual performance related bonuses (in bands of £5,000)	Long-term performance related bonuses (in bands of £5,000)	Pension related benefits (in bands of £2500)	Total (in bands of £5,000)
	£000	£00	£000	£000	£000	£000
Non-Executive						
Julia Neuberger	40-45					40-45
Amanda Gibbon	10-15					10-15
Naomi Fulup	10-15					10-15
Glenys (Dorothea) Thornton	10-15					10-15
Rob Vincent CBE	10-15					10-15
Junaid Bajwa	10-15					10-15
Nailesh Rambhai Started 10th October 2023	5-10					5-10
Executive						
Helen Brown - Chief Executive, From 1.4.2023 to 3.12.2023	125-130				0	125-130
Matthew Shaw - Chief Executive, From 4.12.2023 to 31.3.2024	30-35				0	30-35
Kevin Curnow - Chief Finance Officer, and Deputy CEO, left 20th August 2023	55-60				0	55-60
Terry Whittle - Chief Finance officer started 15th November 2023	55-60				0	55-60
Jerry Francine, Acting Chief Finance Officer From 1.7.2023 to 14.11.2023	45-50				17.5-20	65-70
Clare Dollery - Medical Director and Acting CEO from 4.12.2023	215-220				0	215-220
Norma French - Director of Workforce, Left 31.3.2024	110-115				32.5-35	145-150
Liz O'Hara - Chief People Officer, from 27.3.2024	0				0	0
Jonathan Gardner - Director of Strategy and Corporate Affairs	135-140				5-7.5	140-145
Chinyama Okunuga Chief Operating Officer	120-125	15			47.5-50	170-175
Sarah Wilding Director of Nursing and Clinical Development	130-135				0	130-135
Swarnjit Singh-Director of Race,Equality,Diversity and Inclusion and Trust Corporate Secretary	100-105				0	100-105
Tina Jegede-Director of Race,Equality,Diversity and Inclusion and Lead Nurse Islington care homes	85-90				0	85-90

Statement of the policy on senior managers' remuneration

The Remuneration Committee follows national guidance on the salary of senior managers. All elements of remuneration, including 'annual cost of living increases', when applicable, continued to be subject to performance conditions. Other decisions made by the Committee are reflected in the tables above. This is subject to the achievement of goals being objectively assessed. The governance arrangements for the committee form part of the Whittington Health's standing orders, reservations and delegation of powers and standing financial instructions.

In line with the requirements of the NHS Codes of Conduct and Accountability, the purpose of the Committee is to advise the Trust Board about appropriate remuneration and terms of service for the chief executive and other executive directors including:

- all aspects of salary (including any performance-related elements/bonuses)
- provisions for other benefits, including pensions and cars
- arrangements for termination of employment and other contractual terms

Board members' pension entitlements for those in the pension scheme 2024/25 AUDITED

Name	Real increase in pension (bands of £2,500)	Real increase in lump sum (bands of £2,500)	Total accrued pension at 31 March 2025 (bands of £5,000)	Lump sum related to accrued pension at 31 March 2025 (bands of £5,000)	Cash equivalent transfer value at 31 March 2025 (to the nearest £1,000)	Cash equivalent transfer value at 31 March 2024 (to the nearest £1,000)	Real increase in cash equivalent transfer value (to the nearest £1,000)	Employer contribution to stakeholder pension
Executive Directors	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Terry Whittle	5-7.5	7.5-10	40-45	100-105	745	603	81	22
Jonathan Gardner	0-2.5	0	35-40	0	544	473	22	19
Chinyama Okunuga	0-2.5	0	30-35	5-10	477	419	14	17
Sarah Wilding	0-2.5	0	60-65	160-165	1,376	1,253	21	19
Tina Jegede	2.5-5	2.5-5	45-50	125-130	87	1,055	0	12
Swarnjit Singh	0-2.5	0	45-50	115-120	1,073	972	24	14
Liz O'Hara	5-7.5	10-12.5	55-60	140-145	1,186	973	124	3
Charlotte Hopkins	2.5-5	2.5-5	35-40	85-90	749	629	46	20
Clarissa Murdoch	2.5-5	0-2.5	60-65	165-170	1,436	1,255	0	4

The Trust's accounting policy in respect of pensions is described in Note 9 of the complete Annual Accounts document that will be uploaded to www.whittington.nhs.uk in September 2025. As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pensions.

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued because of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement, which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member because of their purchasing of additional years of service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The real increase in CETV reflects the increase in the CETV effectively funded by the employer. It takes account of the increase in the accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Pay multiples

Non-Executive Directors

The Trust follows NHS England's guidance for appointing non-executive directors.

The terms of the contract apply equally to all non-executive directors except for the chair, who has additional responsibilities and accountabilities. The remuneration of a non-executive director is £13,000. The chair received remuneration of £41,100 for 2024/25.

Salary range
The Trust is required to disclose the ratio between the remuneration of the highest-paid director in their organisation and the median remuneration of the workforce.

The mid-point remuneration of the highest paid director at Whittington Health in 2023/24 was £165,933 (2024/24: £190,344). This was 4.5 times the median remuneration of the workforce, which was £37,567 (2023/24: 4.9 times, £37,350).

In 2024/25, there were two employees (one in 2023/24) who received remuneration exceeding that of the highest-paid director.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind and severance payments. It does not include employer contributions and the cash equivalent transfer value of pensions.

Fair Pay and Pay Ratio Disclosure
For several years, the Government Financial Reporting Manual (FReM) has required NHS trusts to disclose the median remuneration and the ratio between median remuneration, and the banded remuneration of the highest paid director.

From 2021/22 onwards, the FReM now also requires the disclosure of top to median, lower quartile and upper quartile staff pay multiples (ratios) as part of the Remuneration Report.

These additional requirements are reported below.

The percentage change in remuneration of the highest paid director

In 2024-25, there was a decrease of 13.0% from the last financial year in the remuneration of the highest paid director. The highest paid director was not paid performance pay or bonuses in 2024/25, (nil in 2023-24).

The average percentage change in the remuneration of employees of the entity, taken as a whole
In 2024-25, permanent staff received a national pay award of 6.9% (2023/24 5%).

The range of staff remuneration
The remuneration of all staff ranged from the bands £15k-£20k to £195k-£200k.

The 25th percentile, median and 75th percentile of staff remuneration
The 25th percentile, median and 75th percentile of total remuneration of the reporting entity's staff (based on annualised, full-time equivalent remuneration of all staff at the reporting date, are shown below. The figures are the same for the salary component of remuneration of the reporting entity's staff (based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) as at the reporting date.

	2024-25	2023-24
	£	£
25th percentile	29,114	28,407
Median	37,567	37,350
75th percentile	52,809	50,952

The 25th percentile, median and 75th percentile of staff remuneration, compared to the highest paid director
Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of total remuneration of the organisation's workforce. This is shown as a ratio of the highest paid director's remuneration as compared to the 25th percentile, median and 75th percentile salary.

The banded remuneration of the highest paid director / member of Whittington Health NHS Trust in the financial year 2023-24 was £165k to £170k (2023-24, £190k to £195k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

	2024-25		2023-24	
	£	Highest Paid Director: Ratio	£	Highest Paid Director: Ratio
25th percentile	29,114	5.8	28,407	6.8
Median	37,567	4.5	37,350	5.2
75th percentile	52,809	3.2	50,952	3.8

The highest paid director
In 2024/25, two individuals received remuneration more than the highest paid Director (one in 2023/24). Remuneration ranged from the bands £15k-£20k to £250k-£255k (2023/24 £15k-£20k to £240k-£245k).

Staff numbers and composition

To comply with the requirements of the Department of Health and Social Care's Group Accounting Manual, the Trust is also required to provide information on the following:

- staff numbers and costs
- expenditure on consultancy
- off-payroll arrangements; and
- exit packages.

Breakdown of temporary and permanent staff members (staff numbers)

Average Whole Time Equivalent (WTE)	**Permanent Staff 2024/25**	**Temporary Staff 2024/25**	**Permanent Staff 2023/24**	**Temporary Staff 2023/24**
Medical and dental	546	64	435	59
Administration and estates	1,203	198	1,135	298
Healthcare assistants and other support staff	737	139	720	145
Nursing, midwifery and health visiting staff	1,303	199	1,160	207
Scientific, therapeutic and technical staff	926	86	871	120
Total	**4,715**	**686**	**4,321**	**829**

Cost analysis of permanent and temporary staff members

Staff group	24/25 £000	23-24 £000
Permanent Staff		
Admin and estates	73,461	68,848
Medical and dental	63,151	62,367
Nursing and midwives	82,636	71,633
Scientific,Therapeutic and Technical	58,128	55,984
Healthcare assistants and other support staff	30,580	27,892
Aprentice Levy	1,369	1,282
Permanent Total	**309,324**	**288,006**
Temporary Staff		
Admin and estates	9,326	9,607
Medical and dental	11,653	13,030
Nursing and midwives	13,103	13,772
Scientific,Therapeutic and Technical	4,549	7,323
Healthcare assistants and other support staff	5,224	5,439
Temporary Total	**43,855**	**49,171**
Total of Trust Funded Permanent and Temporary	**353,179**	**337,177**

Consultancy expenditure:
The Trust spent £ nil on consultancy in 2024/25 (£0.4m in 2023/24).

Off-payroll engagements

The Trust is required to disclose all off-payroll engagements as of 31 March 2025 for more than £245 per day and that last longer than six months. The Trust does not have any of these engagements.

Exit packages 2024/25

	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	No.	£000	No.	£000	No.	£000	No.	£000
<£10,000	1	2	3	7	**4**	**9**		
£10,000 - £25,000	1	15			**1**	**15**		
£25,001 - £50,000	2	72	1	28	**3**	**100**		
£50,001 - £100,000	3	231			**3**	**231**		
£100,001 - £150,000					**0**	**0**		
£150,001 - £200,000					**0**	**0**		
>£200,000					**0**	**0**		
Total	**7**	**320**	**4**	**35**	**11**	**355**	**0**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for

in full in the year of departure. Where Whittington Health has agreed early retirements, the additional costs are met by the Trust.

Signed: …

Chief Executive: Selina Douglas

Date: 24th June 2025

ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Whittington Health NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Whittington Health NHS Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has a robust approach to risk management, demonstrated through leadership of the risk management process through the Board annually reviewing its risk management strategy and risk appetite and its risks, both emerging and principal, to the delivery of its strategic objectives, and by the following:

- Leadership of the risk management process through:
  - executive risk leads for each Board Assurance Framework entry
  - respective board committees reviewing their allocated Board Assurance Framework entries and reporting outcomes to the board and to the audit and risk committee through chair's assurance reports
  - board members reviewing the Board Assurance Framework and key entries on the Trust Risk Register on a quarterly basis
  - a thorough review of entries on the Trust Risk Register by respective executive leads to ensure that entries were up-to-date and appropriately scored
- The audit & risk committee has delegated authority from the Board for oversight and assurance on the control framework in place to manage strategic risks to the delivery of the Trust's objectives and reviews the effectiveness of the Trust's systems of risk management and internal control
- It is supported in this by other Board Committees providing assurance to the board on the effective mitigation of strategic Board Assurance Framework entries and other key risks, as follows:
  - The quality assurance committee reviews and provides assurance to the board on the management of risks relating to quality and safety strategic objective, including all risk entries scored above 15 on individual Integrated

Clinical Service Units' (Clinical Divisions) and corporate areas' risk registers
    - The finance & business development committee provides assurance to the Board on the delivery of the Trust's integration strategic objective and two of its sustainability strategic objectives and reviews risks scored higher than 15 which relate to finance, information governance, estates
    - The improvement, performance and digital committee considered risks to the delivery of the Trust's third sustainability strategic objective covering its digital strategy and interoperability with sector partners
    - The workforce assurance committee reviews all risks to the delivery of the organisation's people strategic objective, and their effective mitigation. It is supported in this by the quality assurance committee which also monitors those workforce risks related to patient quality and safety
    - The trust management group reviews the Board Assurance Framework in its entirety and leads on reviewing risks to the delivery of the organisation's Integration strategic objective
    - In addition, performance reviews for each Integrated Clinical Service Unit considered their key respective risks
- An organisational governance structure, with clear lines of accountability and roles responsible for risk management is in place for all staff
- The chief executive has overall accountability for the development of risk management systems and delegates responsibility for the management of specific areas of risk to named directors
- All relevant staff are provided with risk management training as part of their induction to the Trust and face-to-face training from risk managers for those staff regularly involved in risk management
- An open culture to empower staff to report and resolve incidents and risks through the Datix recording system and to share learning with teams

The risk and control framework

The aim of the Trust's risk management strategy is to support the delivery of organisational aims and objectives through the effective management of risks across all the Trust's functions and activities through effective risk management processes, analysis and organisational learning.

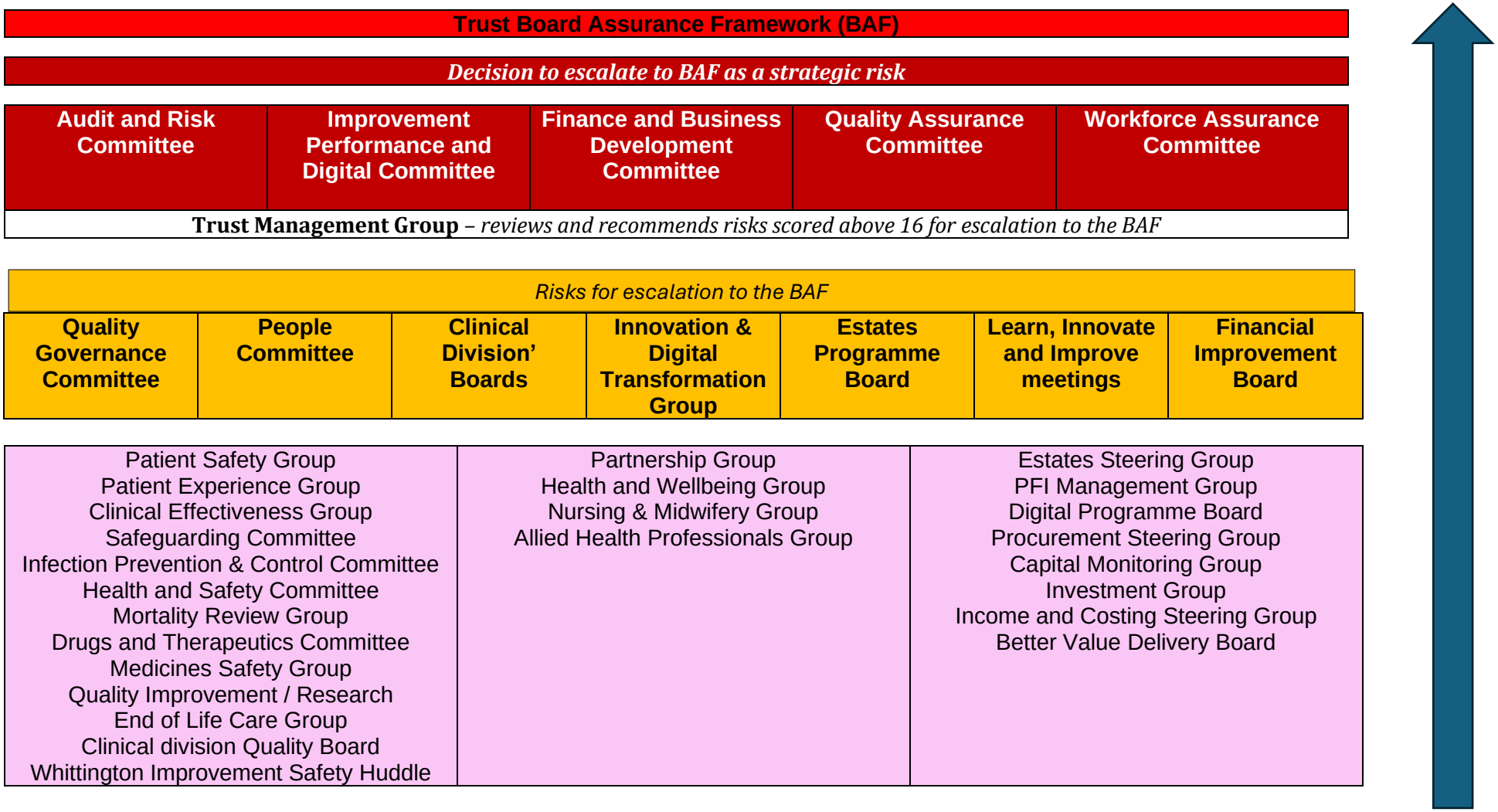
The Trust's approach to risk management aims to:

- embed the effective management of risk as part of everyday practice
- support a culture which encourages continuous improvement and development
- focus on proactive, forward looking, innovative and comprehensive rather than reactive risk management
- support well thought out decision-making

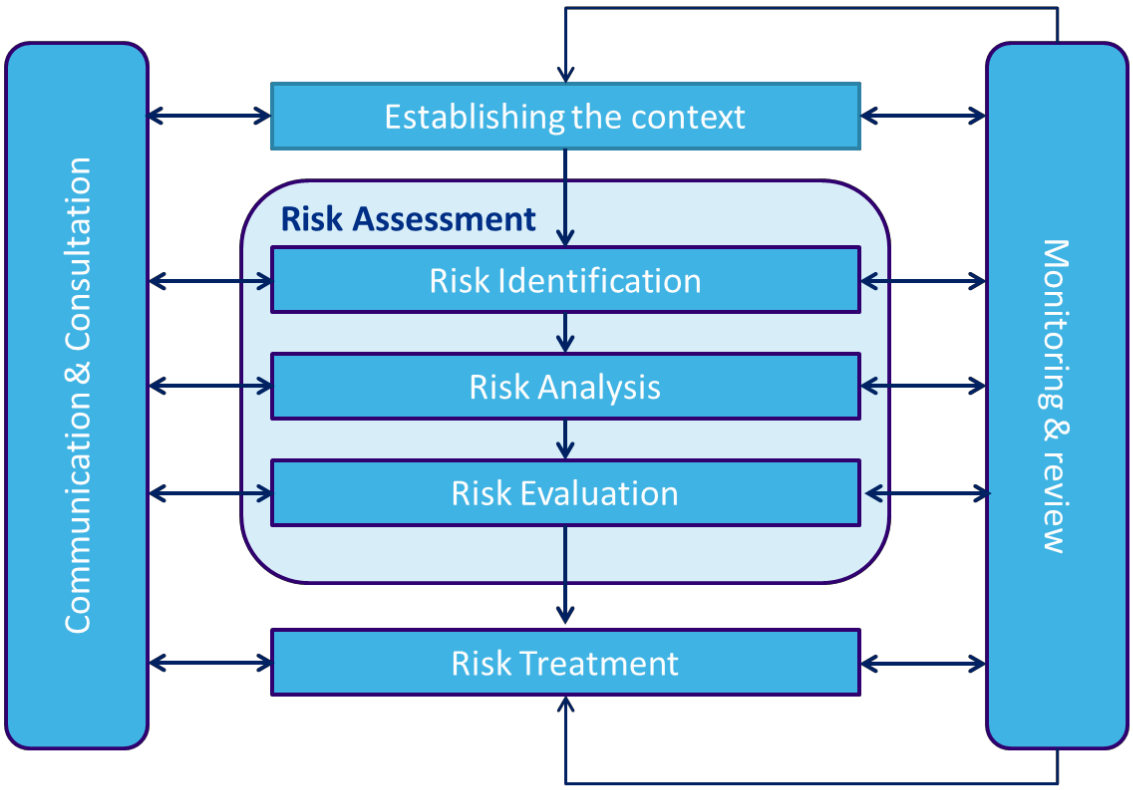
Risk management process

Whittington Health adopts a structured approach to risk management by identifying, analysing, evaluating and managing risks. Where appropriate, staff will escalate or de-escalate risks through the governance structures in place at the Trust as shown overleaf.

Trust-wide review and escalation of strategic risks



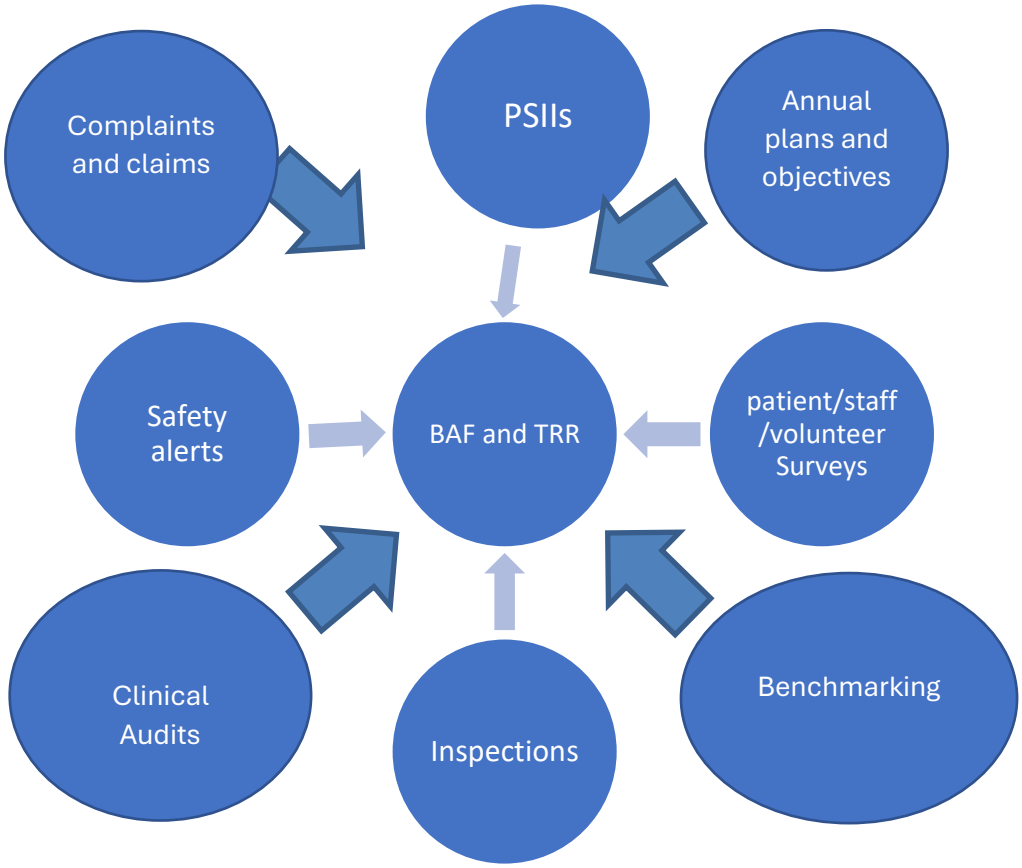
A snapshot of the Trust's risk management process is highlighted below



ISO 3000 Process Diagram

Risk identification

A hazard or threat is a source or issue of potential harm to the Trust achieving its objectives. Risk identification is the process of determining what, where, when and why something could occur. Risks to the Trust can be identified from several sources, both reactive and proactively, examples of a few of these are displayed in the diagram overleaf:



Trends between incidents, complaints and claims are regularly scrutinised via the Trust's quarterly aggregated learning report which is reviewed by the Patient Safety and Quality Assurance Committees to identify any risks to the Trust.

Managers must ensure that their risk registers are reviewed monthly, and where new sources of risk are identified that these are documented and responded to appropriately and are escalated when required.

Risk assessment

When a new risk is identified a Risk Assessment Consideration form is completed and presented to the relevant committee/Board for approval. The assessment should clearly state the likelihood for the risk to cause harm and what preventative or control measures are required to respond effectively to the risk. Once approved by the appropriate group this should then be added to Datix with an identified review date established.

Risk analysis and evaluation

An analysis of each risk is required to be undertaken to establish the initial grading of the risk by assessing the likelihood and consequences of the hazard if it did occur. The Trust utilises a risk grading matrix which incorporates a risk tolerance measure. This process aims to ensure that risks are assessed consistently across the Trust. Once the grading is known and recorded in the Risk Register, the risk can be compared with other risks facing the Trust and prioritised according to significance. The list of all risks facing the Trust, in order of significance, makes up the Trust-wide Risk Register. Risk assessment is an integral part of the business

planning process. Therefore, significant strategic risks will be identified by the Trust Board and managed through the Board Assurance Framework (BAF).

Risk control – monitoring, review and resolution

Controls are the actions utilised to lessen or reduce the likelihood or consequence of a risk being actualised, the severity of that risk if it does occur. The controls in place for each risk should be detailed on Datix and describe the steps that need to be taken to manage and/or control the risk. These should be updated as progress is made.

There are four main ways to manage risks utilised by the Trust which are outlined in the table below:

Acceptance	The risk is identified and logged, and no action is taken. It is accepted that it may happen and will be responded to if it occurs.
Avoid	Where the level of risk is unacceptably high and the Trust cannot, for whatever reason, put adequate control measures in place the Trust Board will consider whether the service/activity should continue in the Trust.
Transfer	A shift in the responsibility or impact for loss to another party e.g. insurance for the risk occurrence or subcontracting. For a clinical risk transfer – a decision for a patient requiring a high-risk surgical procedure (where the expertise or equipment is unavailable in the Trust) to be transferred to a specialist centre for treatment. The risk of transferring the patient must be less than the risk of operating in the Trust environment.
Mitigation	The impact of the risk is limited, so if it does occur (and cannot be avoided) the outcome is reduced and easier to handle. Making and carrying out risk reduction action plans is the responsibility of a line manager and /or risk lead.

Local risk registers in our Clinical Divisions and in corporate departments along with the in-year operational risk register and board assurance framework (BAF), seek to present an overview of the main risks facing the organisation. The local risk registers are reviewed, updated and monitored regularly by the relevant Clinical Division Board and corporate services' leads and, if necessary, a risk can be escalated onto the corporate risk register, which is monitored by the Trust Management Group and Quality Assurance Committee. Respective BAF entries are monitored by executive director risk leads who assess the status of their risk entry and its effective mitigation. The BAF is also monitored by the Audit and Risk Committee and Trust Board.

RSM also completed a review of risk management arrangements in May 2024 and concluded that there was a good level of maturity and assurance within the risk management arrangements evidenced through the Board Assurance Framework and Trust Risk Register. A further review was carried out by RSM in quarter four and concluded with a positive assessment of reasonable assurance, the second highest rating possible.

In particular, the review highlighted the following good evidence:

- The Trust had a Risk Management Framework underpinned by a Risk Management Policy and Procedure. Both documents had recently been updated in line with the recommendations from previous internal audit reviews and actions raised which evidences the commitment by management for continuous improvement and development.
- The current Framework and Policies and Procedures in place provided sufficient foundation and guidance around the risk management processes of the Trust including risk appetite, risk methodology, risk assessment and identification of risks, the Board Assurance Framework, Trust Risk Registers, and training.
- The BAF provided the Trust Board and its Committees with assurances that the Trust is managing risks to delivery of its four strategic objectives - Quality, People, Integration and Sustainable.
- At the time of the audit, nine principal risks (BAF entries) had been identified across the four strategic objectives. Each had controls and assurances in place to demonstrate how risks are being mitigated and managed across a tiered assurance level.

Board Assurance Framework

The Board Assurance Framework (BAF) provides a structure for reporting of the principal strategic risks to the delivery of the Trust's business and was reviewed regularly last year. It identified the risk appetite and the controls and assurances in place to mitigate these risks, the gaps or weaknesses in controls and assurances, and actions required to further strengthen these mechanisms. The Audit and Risk Committee leads on oversight of the mitigation of risks to delivery of the Trust's strategic objectives and was supported by other relevant board committees and the Trust's Management Group.

Structure and presentation

The 2024/25 Board Assurance Framework (BAF) covered risks to the delivery of Whittington health's four strategic objectives: quality and safety, people, integration and sustainable. Its entries are detailed earlier in this annual report.

Assurances and gaps

The BAF includes assurances, and these were rated as relevant to the control/risk reported on. The assurances are timely and are also updated over time. Furthermore, there is allocated responsibility for submission and assessment. The BAF also highlights gaps within assurances which trigger the development of actions to improve them.

BAF review and update

The review and updating of BAF entries is led by executive director risk leads and key Board Committees review risks relevant to their terms of reference as set out previously).

Risk appetite

In line with good practice, the Trust completed an annual review of its risk appetite statement. This was discussed and endorsed by members of the Audit and Risk Committee. The risk appetite range is included within BAF reports presented to board and executive committees. Individual risks on the BAF are allocated a target score

against which progress is reported in the BAF.

Embedding risk management

Risk management is embedded throughout the organisation in a variety of ways including:

- Face-to-face training for key risk managers
- Review of the risk register entries by the Quality Assurance Committee and the Trust Management Group
- Oversight of BAF entries by Board Committees and the Trust Management Group
- A review of the BAF, each quarter by the Trust Board

In addition, the Trust can highlight the following in its risk and control framework:

- The clinical governance agenda is led by the Trust's Chief Nurse and Director of Nursing Allied Health Professionals and the Chief Medical Officer. Monitoring arrangements are delivered through a structure of committees, supporting clear responsibilities and accountabilities from board to front line delivery
- The Quality Assurance Committee is a key committee of the Board, which affords scrutiny and monitoring of our risk management process and has oversight of the quality agenda. Serious incidents and the monitoring of the Trust Risk Register is a standing item
- The Trust's clinical governance structure ensures there are robust systems in place for key governance and performance issues to be escalated from frontline services to the Board and gives assurance of clinical quality. It gives a strong focus on service improvement and ensures high standards of delivery are maintained.
- The Board and the relevant committees use a performance scorecard which has been developed to include a suite of quality indicators at Trust and service level aligned to each of the CQC's *five domains of Quality*
- The Trust's quality improvement strategy is encapsulated in our work on the journey to outstanding programme. The programme is a structured quality improvement plan, and we have quality improvement plans in all services to monitor and demonstrate compliance with the CQC's fundamental standards and against each of the CQC's domains and Key Lines of Enquiry (KLOE)

The Board of Directors

Membership of the Board of Directors is currently made up of seven independent non-executive directors, including the Trust chair, and eight directors, of which five are voting members of the Board. In line with the code of governance for NHS provider trusts, the Board can confirm the independence of its non-executive directors as they have been appointed by NHS England and are not/have not been:

- an employee of the trust within the last two years
- had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust
- has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme

- has close family ties with any of the trust's advisers, directors or senior employees
- holds cross-directorships or has significant links with other directors through involvement with other companies or bodies
- has served on the trust board for more than six years from the date of their first appointment is an appointed representative of the trust's university medical or dental school.

The key roles and responsibilities of the Board are as follows to:

- set and oversee the strategic direction of the Trust
- review and appraisal of financial and operational performance
- review areas of assurance and concerns as detailed in the chair's assurance reports from its board committees
- discharge their duties of regulation and control and meet our statutory obligations
- ensure the Trust continues to deliver high quality patient quality and safety as its primary focus, receiving and reviewing quality and patient safety reports and the minutes and areas of concern highlighted in board committees' minutes, particularly the Quality Assurance Committee, which deals with patient quality and safety
- receive reports from the Audit and Risk committee, the annual internal auditor's report and external auditor's report and to take decisions, as appropriate
- agree the Trust's annual budget and plan and submissions to NHS England
- approve the annual report and annual accounts

The Board of Directors met six times during the year. A breakdown of attendance for the Board's meetings held in 2024/25 is shown below:

Job title and name (*denotes non-voting member of the Board)	**Public Board meeting attended (out of 6 unless otherwise stated)**
Chair and Non-Executive Director, Julia Neuberger	6
Non-Executive Director, Junaid Bajwa	6
Non-Executive Director, Mark Emberton	1 out of 3
Non-Executive Director, Naomi Fulop	3 out of 3
Non-Executive Director, Amanda Gibbon	6
Non-Executive Director, Nailesh Rambhai	5
Non-Executive Director, Glenys Thornton	6
Non-Executive Director, Rob Vincent	6
Acting Deputy Chief Executive, Clare Dollery	6
Chief Finance Officer, Terry Whittle	6
Chief People Officer, Liz O'Hara	5
Chief Operating Officer, Chinyama Okunuga	5
Chief Nurse & Director of Allied Health Professionals Sarah Wilding	6
Chief Strategy, Digital and Improvement Officer, Jonathan Gardner*	6

Job title and name (*denotes non-voting member of the Board)	**Public Board meeting attended (out of 6 unless otherwise stated)**
Charlotte Hopkins, Acting Chief Medical Officer	5 out of 5
Clarissa Murdoch, Acting Medical Director	1 out of 1
Joint Director of Inclusion and Lead Nurse, Islington Care Homes, Tina Jegede*	6
Joint Director of Inclusion and Trust Company Secretary, Swarnjit Singh*	6

Board and Committee oversight and assurance

The Board of Directors leads on integrated governance and delegates key duties and functions to its sub-committees. In addition, the Board reserves certain decision-making powers including decisions on strategy and budgets.

In the last year, the key committees within the structure that provided assurance to the Board of Directors were audit and risk, charitable funds, improvement, performance and digital, quality assurance, finance and business development; remuneration, workforce assurance; and a partnership development committee with University College London Hospitals NHS Foundation Trust. There are a range of mechanisms available to these committees to gain assurance that our systems are robust and effective. These include utilising internal and external audit, peer review, management reporting and clinical audit. Following each board committee meeting, the chair submits an assurance report to the board escalating any areas of concern and highlighting items from which good or reasonable assurance was taken at the meeting.

Audit and Risk Committee

The audit and risk committee is a formal committee of the Board and is accountable to the Board for reviewing the establishment and maintenance of an effective system of internal control. The Committee holds five meetings per annum at appropriate times in the reporting and audit cycle. This committee is supported on its assurance role by the finance & business development, quality and workforce assurance committees in reviewing and updating key risks pertinent to their terms of reference.

This committee also approves the annual audit plans for internal and external audit activities and ensures that recommendations to improve weaknesses in control arising from audits are actioned by executive management. The committee ensures the robustness of the underlying process used in developing the BAF. The board monitors the BAF and progress against the delivery of annual objectives each quarter, ensuring actions to address gaps in control and gaps in assurance are progressed.

Improvement, Performance and Digital Committee

This forum is a formal committee of the Board with a remit to provide assurance to the Board on the delivery of the Trust's digital strategy and on performance against key national and local indicators.

Quality Assurance Committee

The quality assurance committee is a formal committee of the Board and is accountable to the Board for reviewing the effectiveness of quality systems, including the management of risks to the Trust's quality and patient engagement strategic priorities as well as operational risks to the quality of services. The committee meets six times per year. It also monitors performance against quarterly quality indicators, the quality accounts and all aspects of the three domains of quality namely - patient safety, clinical effectiveness and patient experience.

Finance & Business Development Committee

The finance & business development committee reviews financial and non-financial performance across the Trust, reporting to the Board. It also has lead oversight for risks to the delivery of Trust's strategic priorities relating to sustainability. The committee holds six full meetings each year.

Workforce Assurance Committee

The workforce and education committee met four times during 2024/25 and leads on oversight of BAF risks which relate to the Trust's staff engagement and recruitment and retention strategic priorities. It reviews performance against the delivery of key workforce recruitment and retention plans as part of its People Strategy and the annual outcomes for Equality Standard submissions to NHS England. In addition, the committee will also review those staff engagement actions taken following the outcome of the annual NHS staff survey and delivery of the Trust's workforce culture improvement plan.

Partnership Development Committee with University College London Hospitals NHS Foundation Trust

The Partnership Development committee-in-common met quarterly during 2024/25 and reviewed progress with the key priority areas for increased collaboration between both organisations.

Workforce planning

As in previous years, workforce assumptions were contained in our annual plan submission to the North Central London Integrated Care System. Our workforce planning process was aligned and integrated with the Trust's business planning process and led by individual Clinical Divisions. Throughout the process, Clinical Divisions' Clinical and Operational Directors were supported by HR Business Partners who advised and challenged Clinical Divisions on the workforce impact of their plans and ensured alignment with workforce and clinical strategies. This involved:

- Working with Clinical Divisions to discuss workforce issues such as recruitment and retention, activity planning, education requirements and the delivery of key performance indicators
- Analysing and monitoring workforce changes at a local level (and at an aggregated Trust-wide position)
- Ensuring current and future workforce needs were represented in business plans, considering growth, as well as options to develop new roles, new ways of working, and associated training implications.
- Monthly 'run rate' meetings, to analyse temporary staffing to ensure long term recruitment strategies are in place

- A dedicated nurse recruitment team focusing on international and local recruitment opportunities
- Middle grade doctor recruitment working group focussed on the emergency department

In 2024/25, Whittington Health complied with the "Developing Workforce Safeguards" through the following assurances:

- The Acting Medical Director and Chief Nurse and Director of Allied Health Professionals confirmed there are established processes to ensure that staffing is safe, effective and sustainable
- The nursing and midwifery staffing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) was reported to the Board by ward or service area twice a year
- High level risks were reported to Workforce Assurance Committee quarterly
- Safe nurse staffing levels were monitored continuously, supported by ongoing assessments of patient acuity.
- Workforce intelligence and key performance indicators were reported alongside quality metrics at the Trust Board each month and were standing items on Performance Review Group meetings (PRGs). The Workforce Assurance Committee received comprehensive corporate workforce information and analysis. Metrics included vacancy and sickness rates, turnover and appraisal compliance and temporary staffing
- Any changes and significant (over £50k) cost improvement plans had a quality impact assessment

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust published on its website a register of interests Board members and for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance). The register was updated in line with further declarations made during the year and declarations of interest is a standing agenda item at all board, board committees and executive committees for members to provide updates.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that the Trust's obligations under equality, diversity and human rights legislation are complied with. This includes oversight and assurance provided by the Trust Management Group and Workforce Assurance Committee and Trust Board. These corporate governance forums reviewed and approved the Trust's annual workforce disability and race equality standard submissions to NHS England. In addition, they also agreed the Trust's statutory annual public sector duty report for publication to demonstrate compliance with duties contained in the 2010 Equality Act.

The Trust undertook risk assessments on the effects of climate change and severe weather and have developed a Green Plan following the guidance of the Greener NHS programme. The Trust also ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with as part of our emergency planning and business continuity plans.

Review of economy, efficiency and effectiveness of the use of resources

The Trust was rated by the Care Quality Commission (CQC) as good in its use of resources as it had demonstrated a good understanding of areas of improvements with credible plans to achieve target performance. In particular, the CQC identified that the Trust has an excellent track record of managing its expenditure within available resources.

During 2024/25, Whittington Health had in place a range of processes which helped to ensure that it continued to use resources economically, efficiently and effectively. These included:

- monthly reporting of financial and non-financial performance to the Trust Board of directors and the finance and business development committee of the Board
- adherence to guidance issued by NHS England by establishing robust systems for the delivery of operational priorities during set out
- a monthly review of performance by the Trust Management Group and additional review meetings where Clinical Divisions and corporate directorates are held to account for financial and non-financial performance
- the production of annual reference costs, including comparisons with national reference costs
- benchmarking of costs and key performance indicators against other combined acute and community Trust providers
- standing financial instructions, standing orders and a treasury management policy
- a budget holder's manual which sets out managers' responsibilities in relation to managing budgets
- guidance on the declaration of conflicts of interest and standards of business conduct
- reports by RSM part of the annual internal audit work plan on control mechanisms which may need reviewing
- the Head of Internal Audit's opinion being presented to the committee
- an external audit of our accounts by KPMG LLP who also provided an independent view of the Trust's effective and efficient use of resources, particularly against value for money considerations
- good performance under NHS England's Oversight Framework for NHS providers

Information governance

The following table shows the incidents and outcomes of investigations in relation to information governance breaches this year which were reported to the Information Commissioner's Officer (ICO):

Nature of incident	Incident date	ICO reported date	ICO outcome
A visit sheet containing confidential data was lost	May 2024	May 2024	No further action
Data sent to staff member containing personal confidential data of many other staff.	December 2024	January 2025	No further action
Seven families were accidentally sent confidential information about a large group of patients.	March 2025	March 2025	This is to be confirmed

Data quality and governance

Data governance is essential for the effective delivery of patient care and for improvements to patient care we must have robust and accurate data available. Whittington Health completed the following actions in the last year towards improved data quality:

- Monthly monitoring of national data quality measures
- Reviews of specific data sets (e.g. Referral to Treatment Patient Treatment List) with specific regard to data quality. Regular spot checks were carried out by the Trust's Validation Team
- Weekly Referral to Treatment review meetings for cancer, community and acute services
- Our Data Quality Review Group ensured all aspects of data quality standards were maintained and reviewed
- Continuing to review the awareness of key staff of their responsibilities around data quality and proposing approaches to achieve improvement if necessary
- Reviewing the scope of material internal data sets with specific regard to data quality and summarise those known with their main characteristics, any known data quality issues and owners in overview
- The integrated performance report uses statistical process control charts to help performance monitoring and accountability

Whittington Health NHS Trust will continue to monitor and work to improve data quality by using the above-mentioned Data Quality Review Group, with the aim to work with Clinical Divisions to improve awareness of responsibilities and to share learning to help improve data quality.

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. The Board's Quality Assurance Committee provides assurance on the Quality Account and the quality priorities and along with other Board committees helps to ensure the maintenance of effective risk management and quality governance systems.

Provider licence conditions

In terms of the NHS provider license condition four, the Board confirmed that the

Trust applies principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services. In particular, the Board is satisfied that the Trust has established and implements:

- an effective Board and Committee structure
- clear responsibilities for the Board and Committees reporting to the Board and for staff, reporting to either the Board or its Committees
- clear reporting lines and accountabilities throughout the organisation

Code of governance for NHS provider trusts

With reference to code provisions, the Trust's current, independent external auditors, KPMG LLP, were appointed following a full competitive tender exercised for approved providers on the NHS framework. Their core contract tenure is from 1 April 2023 to 31 March 2026, with extension options available.

Whittington Health NHS Trust submitted its draft annual accounts in advance of the national deadline. The Trust's policy is that its external auditor provider is not normally requested to provide any non-audit services.

Members of the Audit and Risk Committee met on 19 June specifically to consider the key points from the draft financial statements and noted a summary of audit progress as presented by KPMG in relation to the financial statements. The key points included:

The Audit and Risk Committee derive their assurance as to the completeness and accuracy of the Financial Statements from several ways:

- The completion of the Final Accounts Audit by the external auditor and the issue of the ISA260 Report which is the Auditor's report to the Audit and Risk Committee.
- The Auditor's signature of the Audit Opinion stating, inter alia, that the Accounts represent a true and fair view.
- Prior to submission of the Draft Financial Statements in April, these are reviewed by the Chief Finance Officer (CFO) and Operational Director of Finance, and review points investigated and resolved.
- From the Draft submission to the Final Audited Submission, a change log is retained by the Trust for each of the Accounts, Annual Report and Provider Financial Return, detailing all changes which are proposed between Draft and Final versions. This is approved by the CFO in advance of the changes being made and included in the Final submission.

The annual report and accounts have been prepared with significant review, discussion and contributions from executive and non-executive director members of the Audit and Risk Committee. The executive team and trust management group members have reviewed and provided extensive input for the annual report iterations. The annual report and accounts are due to be approved by the Trust's Board at its meeting on 23 June 2025. The assessments by the accountable officer and other directors that the annual report and accounts are fair, balanced and understandable and provide the necessary information for stakeholders to assess Whittington Health performance, business model and strategy are shown on the penultimate two pages of this Annual Report.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the committee and quality assurance committee, if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place. The board ensures the effectiveness of the system of internal control through clear accountability arrangements.

Head of Internal Audit's Annual Opinion

RSM, the Trust's internal auditors confirmed that:

The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

This opinion was based on the positive assessments of reasonable assurance for internal reviews completed during the financial year. This included a substantial assurance rating for the review of key financial controls.

The overall opinion is consistent with the those for preceding years which demonstrate a good level of effectiveness in the Trust's system of internal control.

Conclusion

I confirm that no significant internal control issues have been identified.

Signed: 

Chief Executive: Selina Douglas

Date: 24 June 2025

Statement of the chief executive's responsibilities as the accountable officer of the Trust

The Chief Executive of NHS England, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the Trust
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year

As far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed:

Chief Executive: Selina Douglas

Date: 24 June 2025

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the Board

Date... 24th June 2025... Chief Executive: Selina Douglas

Date.... 24th June 2025 Chief Finance Officer: Terry Whittle

NHS
Whittington Health
NHS Trust

Annual Report

2024/25

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Whittington Health NHS Trust

Annual accounts for the year ended 31 March 2025

Statement of Comprehensive Income

	Note	2024/25 £000	2023/24 £000
Operating income from patient care activities	3	471,111	436,160
Other operating income	4	29,273	29,658
Operating expenses	7,9	(512,746)	(470,061)
Operating surplus/(deficit) from continuing operations		**(12,362)**	**(4,243)**
Finance income	11	3,179	3,592
Finance expenses	12	(1,860)	(2,179)
PDC dividends payable		(5,588)	(5,881)
Net finance costs		**(4,269)**	**(4,468)**
Surplus / (deficit) for the year		**(16,631)**	**(8,711)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(7,339)	(19,055)
Revaluations	17	672	581
Total comprehensive income / (expense) for the period		**(23,298)**	**(27,185)**

Statement of Financial Position

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Intangible assets	14	4,079	5,700
Property, plant and equipment	15	260,849	260,381
Right of use assets	18	36,104	36,114
Receivables	21	805	679
Total non-current assets		**301,837**	**302,874**
Current assets			
Inventories	20	1,309	1,090
Receivables	21	23,122	27,016
Cash and cash equivalents	22	46,276	68,548
Total current assets		**70,706**	**96,654**
Current liabilities			
Trade and other payables	23	(91,238)	(92,997)
Borrowings	25	(5,511)	(3,954)
Provisions	26	(227)	(220)
Other liabilities	24	(2,216)	(3,470)
Total current liabilities		**(99,191)**	**(100,641)**
Total assets less current liabilities		**273,352**	**298,887**
Non-current liabilities			
Borrowings	25	(34,729)	(37,105)
Provisions	26	(25,032)	(25,266)
Total non-current liabilities		**(59,761)**	**(62,371)**
Total assets employed		**213,591**	**236,516**
Financed by			
Public dividend capital		138,320	137,948
Revaluation reserve		73,637	80,304
Income and expenditure reserve		1,634	18,264
Total taxpayers' equity		**213,591**	**236,516**

The notes on pages 168 to 213 form part of these accounts.

Name Selina Douglas

Position Chief Executive Officer

Date 24/06/2025

Statement of Changes in Taxpayers Equity for the year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**137,948**	**80,304**	**18,264**	**236,516**
Surplus/(deficit) for the year	-	-	(16,631)	**(16,631)**
Impairments	-	(7,339)	-	**(7,339)**
Revaluations	-	672	-	**672**
Public dividend capital received	372	-	-	**372**
Taxpayers' and others' equity at 31 March 2025	**138,320**	**73,637**	**1,634**	**213,591**

Statement of Changes in Taxpayers Equity for the year ended 31 March 2024

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**120,707**	**98,778**	**26,975**	**246,460**
Surplus/(deficit) for the year	-	-	(8,711)	**(8,711)**
Impairments	-	(19,055)	-	**(19,055)**
Revaluations	-	581	-	**581**
Public dividend capital received	17,241	-	-	**17,241**
Taxpayers' and others' equity at 31 March 2024	**137,948**	**80,304**	**18,264**	**236,516**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2024/25 £000	2023/24 £000
Cash flows from operating activities			
Operating (deficit)		(12,362)	(4,243)
Non-cash income and expense:			
Depreciation and amortisation	7.1	20,711	18,675
Net impairments	8	3,587	9,257
Income recognised in respect of capital donations	4	(139)	-
(Increase) / decrease in receivables and other assets		4,086	(1,282)
(Increase) in inventories		(219)	(148)
Increase / (decrease) in payables and other liabilities		(27)	9,267
(Decrease) in provisions		(1,217)	(9,639)
Net cash flows from / (used in) operating activities		**14,421**	**21,888**
Cash flows from investing activities			
Interest received		3,340	3,529
Purchase of intangible assets		(714)	-
Purchase of PPE and investment property		(26,624)	(35,652)
Net cash flows from / (used in) investing activities		**(23,998)**	**(32,123)**
Cash flows from financing activities			
Public dividend capital received		372	17,241
Movement on loans from DHSC		(116)	(116)
Capital element of lease rental payments		(5,883)	(4,909)
Interest on loans		(43)	(47)
Other interest		(1)	(11)
Interest paid on lease liability repayments		(825)	(730)
PDC dividend (paid)		(6,199)	(5,635)
Net cash flows from / (used in) financing activities		**(12,694)**	**5,793**
Increase / (decrease) in cash and cash equivalents		**(22,272)**	**(4,442)**
Cash and cash equivalents at 1 April - brought forward		**68,548**	**72,990**
Cash and cash equivalents at 31 March	22	**46,276**	**68,548**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity’s services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use. IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

The Trust entered into a Private Finance Initiative (PFI) arrangement in 2003 to build and maintain the main hospital through construction firm Whittington Facilities Ltd (WFL). On the 28th July 2020 WFL filed for administration. The Trust is now responsible for the maintenance of the building. Further details if the financial arrangements and implications are discussed in further detail under the Provisions note.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	12	48
Plant & machinery	5	15
Information technology	3	10
Furniture & fittings	5	10

Note 1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Software licences	3	5

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of pharmacy drugs inventories is measured using the first in, first out (FIFO) method.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost or fair value through income and expenditure as appropriate

Financial liabilities classified as subsequently measured at amortised cost or fair value through income and expenditure as appropriate.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.12 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 26.1 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 27, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Third party assets

patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

Note 1.20 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Property, Plant and Equipment

The Trust's land and building assets are valued on the basis explained in Note 16 to the Accounts. Newmark Gerald Eve LLP, our independent valuer, provided the Trust with a valuation of land and building assets (estimated fair value and remaining useful life). The valuation, based on estimates provided by a suitably qualified professional inaccordance with HM Treasury guidance, leads to revaluation adjustments. Future revaluations of the Trust's property may result in further changes to the carrying values of non-current assets.

Provisions

Provisions have been made for legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the accounts areprepared. These provisions are estimates of the actual costs of future cashflows and are dependent on future events.Any difference between expectations and the actual future liability will be accounted for in the period when suchdetermination is made. The carrying amounts and basis of the Trust's provisions are detailed in Note 34 to the Accounts.

Note 1.21 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to berelevant. Actual results may differ from those estimates, and the estimates and underlying assumptions are continuallyreviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if therevision affects only that period, or in the period of the revision and future periods if the revision affects both currentand future periods. We also refer to the following financial statement disclosure notes where further detail is provided on individual balances containing areas of judgement:

The following are estimation uncertainties which could potentially give rise to material misstatement:

- Note 14 Property, plant & equipment.

Department of Health and Social Care guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued."

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based upon modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The Trust commissioned independent RICS qualified valuers, Newmark, to carry out a desktop valuation of land and buildings using the modern equivalent asset methodology at 31 March 2025. Newmark (previously known as Gerald Eve) carried out a full valuation at 31st March 2024.

In developing the valuation of the estate the Trust makes use of the ability to assume a replacement site would be developed in an alternative location where it would be feasible and cost-effective to do so. In valuing the main Whittington Hospital site the Trust assumes a replacement hospital would be located within TFL Zones 3/4 within the Trust's main catchment population, whilst remaining feasible given the transport links available and ability to find space within the area.

The values in the valuer's report have been used to inform the measurement of property assets at valuation in these financial statements. The valuer exercises professional judgement in providing the valuation and it remains the best information available to the Trust. However, the valuer uses informed assumptions regarding obsolescence, rebuild rates and the area of the sites required to accommodate modern equivalent assets with the same service potential which could change and have a material impact upon the valuation.

A reduction in the estimated values would result in reductions to the Revaluation Reserve and / or a loss recorded as appropriate in the Statement of Comprehensive Income.

Changes in modern equivalent asset assumptions would be expected to lead to significant changes in the estimated values of land and buildings.

- Note 25 Provisions.

A material addition to the provision was made during the 2020/21 financial year, in respect of implications arising from the collapse of Whittington Facilities Ltd (WFL). The collapse of WFL meant that the main building transferred back into the ownership of the Trust, whereby the Trust is now responsible for the maintenance of the building, including the cost of major fire safety refurbishments for which WFL are being pursued under the terms of a 30 year contract. As a result of this dispute with WFL, legal proceedings have commenced. There will be a significant cost of rectifying building deficiencies not appropriately addressed by WFL.

In the judgement of the Trust, a provision remains appropriate as at 31 March 2025 to cover relevant potential liabilities. The Trust has reviewed the level at which the provision is held as at 31st March 2025, and adjusted it according to the most up to date legal, and other professional advice available.

The legal position is not concluded and the full costs of remediation are not yet known. The provision is based on the Trust's best estimate of the remediation costs.

Any accounting provision thus made is intended to reflect the material uncertainty around the situation which existed as at 31 March 2025, and should not be taken as admission of any liability on the part of the Trust.

Note 1.22 Note 1.28 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2024/25:

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.

- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.

- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed. PPE and right of use assets currently subject to revaluation have a total book value of £218.4m as at 31 March 2025. Assets valued on an alternative site basis have a total book value of £171.8m at 31 March 2025.

Note 2 Operating Segments

The Trust's chief decision maker has been defined as the Trust Board, and is responsible for allocating resources across the Trust. The Trust's operational management structure is delivered though five clinical divisions (Divisions) covering acute and community services across London.

In line with IFRS 8, the Trust has determined that these Divisions are classed as a single segment with the agreed purpose of providing healthcare services.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

Note 3.1 Income from patient care activities (by nature)	2024/25 £000	2023/24 £000
Acute services		
Income from commissioners under API contracts - variable element*	65,179	52,984
Income from commissioners under API contracts - fixed element*	262,834	259,230
High cost drugs income from commissioners	13,568	12,057
Other NHS clinical income	4,099	3,733
Mental health services		
Services delivered under a mental health collaborative	2,100	3,100
Community services		
Income from commissioners under API contracts*	81,042	77,985
Income from other sources (e.g. local authorities)	18,505	13,336
All services		
Private patient income	14	29
National pay award central funding***	890	168
Additional pension contribution central funding**	19,875	11,880
Other clinical income	3,004	1,658
Total income from activities	**471,111**	**436,160**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2024/25 £000	2023/24 £000
NHS England	43,848	34,859
Integrated care boards	399,540	379,445
Other NHS providers	6,199	6,833
Local authorities	18,505	13,336
Non-NHS: private patients	14	29
Non-NHS: overseas patients (chargeable to patient)	424	436
Injury cost recovery scheme	419	419
Non NHS: other	2,162	803
Total income from activities	**471,111**	**436,160**
Of which:		
Related to continuing operations	471,111	436,160
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2024/25	2023/24
	£000	£000
Income recognised this year	424	436
Cash payments received in-year	222	286
Amounts written off in-year	70	88

Note 4 Other operating income

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	873	-	**873**	705	-	**705**
Education and training	18,239	-	**18,239**	17,645	-	**17,645**
Non-patient care services to other bodies	5,882		**5,882**	7,657		**7,657**
Receipt of capital grants and donations and peppercorn leases		139	**139**		-	**-**
Charitable and other contributions to expenditure		-	**-**		181	**181**
Revenue from operating leases		890	**890**		893	**893**
Other income	3,250	-	**3,250**	2,577	-	**2,577**
Total other operating income	**28,244**	**1,029**	**29,273**	**28,584**	**1,074**	**29,658**

Note 6 Operating leases - Whittington Health NHS Trust as lessor

This note discloses income generated in operating lease agreements where Whittington Health NHS Trust is the lessor.

Note 6.1 Operating lease income

	2024/25	2023/24
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	890	893
Total in-year operating lease income	**890**	**893**

Note 6.2 Future lease receipts

	31 March 2025	31 March 2024
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	890	893
- later than one year and not later than two years	890	893
- later than two years and not later than three years	890	893
- later than three years and not later than four years	890	893
- later than four years and not later than five years	890	893
- later than five years	3,560	4,465
Total	**8,010**	**8,930**

Note 7.1 Operating expenses

	2024/25	2023/24
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	1,190	736
Staff and executive directors costs	371,992	337,177
Remuneration of non-executive directors	128	120
Supplies and services - clinical (excluding drugs costs)	36,173	35,163
Supplies and services - general	9,308	8,154
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	19,335	16,474
Consultancy costs	-	415
Establishment	10,330	11,406
Premises	22,850	25,178
Transport (including patient travel)	2,895	2,734
Depreciation on property, plant and equipment	18,376	16,004
Amortisation on intangible assets	2,335	2,671
Net impairments	3,587	9,257
Movement in credit loss allowance: contract receivables / contract assets	660	421
Increase/(decrease) in other provisions	(940)	(9,302)
Change in provisions discount rate(s)	(56)	-
Fees payable to the external auditor		
audit services- statutory audit	163	158
Internal audit costs	91	84
Clinical negligence	9,082	8,913
Legal fees	1,280	485
Insurance	295	252
Research and development	157	471
Education and training	1,709	2,086
Expenditure on short term leases	74	91
Redundancy	465	-
Other	1,266	913
Total	**512,746**	**470,061**

Note 7.2 Other auditor remuneration

	2024/25	2023/24
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**-**	**-**

Note 7.3 Limitation on auditor's liability

The contract, signed during January 2022, states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £0.5m (2022/23: £0.5m), aside from where the liability cannot be limited by law. This is in aggregate in respect of all services.

Note 8 Impairment of assets

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	3,587	9,257
Total net impairments charged to operating surplus / deficit	**3,587**	**9,257**
Impairments charged to the revaluation reserve	7,339	19,055
Total net impairments	**10,926**	**28,312**

Note 9 Employee benefits

	2024/25 Total £000	2023/24 Total £000
Salaries and wages	281,469	256,336
Social security costs	26,706	24,672
Apprenticeship levy	1,369	1,282
Employer's contributions to NHS pensions	50,300	38,894
Temporary staff (including agency)	13,210	16,867
Total gross staff costs	**373,054**	**338,051**
Of which		
Costs capitalised as part of assets	597	874

Note 9.1 Retirements due to ill-health

During 2024/25 there were 4 early retirements from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £325k (£459k in 2023/24).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2024/25	2023/24
	£000	£000
Interest on bank accounts	3,179	3,592
Total finance income	**3,179**	**3,592**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2024/25	2023/24
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	43	47
Interest on lease obligations	825	731
Interest on late payment of commercial debt	1	11
Total interest expense	**870**	**789**
Unwinding of discount on provisions	990	1,390
Total finance costs	**1,860**	**2,179**

Note 12.2 The late payment of commercial debts (interest) Act 1998

	2024/25	2023/24
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	1	11

Note 14.1 Intangible assets - 2024/25

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**18,485**	**18,485**
Additions	714	**714**
Valuation / gross cost at 31 March 2025	**19,199**	**19,199**
Amortisation at 1 April 2024 - brought forward	**12,785**	**12,785**
Provided during the year	2,335	**2,335**
Amortisation at 31 March 2025	**15,120**	**15,120**
Net book value at 31 March 2025	**4,079**	**4,079**
Net book value at 1 April 2024	**5,700**	**5,700**

Note 14.2 Intangible assets - 2023/24

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2023 - as previously stated	**18,511**	**18,511**
Reclassifications	(26)	**(26)**
Valuation / gross cost at 31 March 2024	**18,485**	**18,485**
Amortisation at 1 April 2023 - as previously stated	**10,114**	**10,114**
Provided during the year	2,671	**2,671**
Amortisation at 31 March 2024	**12,785**	**12,785**
Net book value at 31 March 2024	**5,700**	**5,700**
Net book value at 1 April 2023	**8,397**	**8,397**

Note 15.1 Property, plant and equipment - 2024/25

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024 - brought forward	**39,186**	**184,067**	**41,360**	**30,226**	**17,416**	**281**	**312,536**
Additions	-	14,469	9,291	31	-	117	**23,908**
Impairments	(18)	(10,908)	-	-	-	-	**(10,926)**
Revaluations	-	672	-	-	-	-	**672**
Reclassifications	190	23,212	(32,275)	6,331	2,112	430	**-**
Valuation/gross cost at 31 March 2025	**39,358**	**211,512**	**18,376**	**36,588**	**19,528**	**828**	**326,190**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**25,652**	**-**	**17,112**	**9,138**	**253**	**52,155**
Provided during the year	-	5,644	-	4,383	3,081	78	**13,186**
Accumulated depreciation at 31 March 2025	**-**	**31,296**	**-**	**21,495**	**12,219**	**331**	**65,341**
Net book value at 31 March 2025	**39,358**	**180,216**	**18,376**	**15,093**	**7,309**	**497**	**260,849**
Net book value at 1 April 2024	**39,186**	**158,415**	**41,360**	**13,114**	**8,278**	**28**	**260,381**

Note 15.2 Property, plant and equipment - 2023/24

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - as previously stated	**47,888**	**183,601**	**30,571**	**25,500**	**13,159**	**281**	**301,000**
Additions	-	19,182	11,675	4,726	4,231	-	**39,814**
Impairments	(9,752)	(18,560)	-	-	-	-	**(28,312)**
Revaluations	-	581	-	-	-	-	**581**
Reclassifications	1,050	(737)	(313)	-	26	-	**26**
Disposals / derecognition	-	-	(573)	-	-	-	**(573)**
Valuation/gross cost at 31 March 2024	**39,186**	**184,067**	**41,360**	**30,226**	**17,416**	**281**	**312,536**
Accumulated depreciation at 1 April 2023 - as previously stated	**-**	**20,256**	**-**	**13,385**	**6,520**	**225**	**40,386**
Provided during the year	-	5,396	-	3,727	2,618	28	**11,769**
Accumulated depreciation at 31 March 2024	**-**	**25,652**	**-**	**17,112**	**9,138**	**253**	**52,155**
Net book value at 31 March 2024	**39,186**	**158,415**	**41,360**	**13,114**	**8,278**	**28**	**260,381**
Net book value at 1 April 2023	**47,888**	**163,345**	**30,571**	**12,115**	**6,639**	**56**	**260,614**

Note 15.3 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	39,358	180,094	-	18,376	15,041	-	7,309	386	**260,564**
Owned - donated/granted	-	122	-	-	52	-	-	111	**285**
Total net book value at 31 March 2025	**39,358**	**180,216**	**-**	**18,376**	**15,093**	**-**	**7,309**	**497**	**260,849**

Note 15.4 Property, plant and equipment financing - 31 March 2024

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	39,186	158,182	-	41,360	13,035	-	8,278	28	**260,069**
Owned - donated/granted	-	233	-	-	79	-	-	-	**312**
Total net book value at 31 March 2024	**39,186**	**158,415**	**-**	**41,360**	**13,114**	**-**	**8,278**	**28**	**260,381**

Note 16 Donations of property, plant and equipment

The Trust received from its Charity, a contribution of income in kind towards capital expenditure, total £139k

Note 17 Revaluations of property, plant and equipment

Land, buildings and dwellings were valued in March 2025 by qualified independent valuers Newmark Gerald Eve LLP. The assets were valued on a depreciated replacement cost basis due to the specialised nature of the asset. The RICS Red Book defines specialised property as:

“a property that is rarely, if ever, sold in the market except by way of a sale of the business or entity of which it is part, due to the uniqueness arising from its specialised nature and design, its configuration, size, location or otherwise”.

A summary of the Impairments and revaluations with comparatives as shown in the table below -

	31st March 2025	31st March 2024
Impairments		
Taken to Reserves	7,339	19,055
Taken to SoCI	3,587	9,257
Total Impairments	**10,926**	**28,312**
Revaluations	**672**	**581**
Net (Impairment) / Revaluation	**(10,254)**	**(27,731)**

Note 18 Leases - Whittington Health NHS Trust as a lessee

The Trust has several leased premises which provide local healthcare facilities.

Note 18.1 Right of use assets - 2024/25

	Property (land and buildings) £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2024 - brought forward	**44,484**	**44,484**	**39,109**
Additions	1,622	**1,622**	1,622
Remeasurements of the lease liability	3,558	**3,558**	2,956
Valuation/gross cost at 31 March 2025	**49,664**	**49,664**	**43,687**
Accumulated depreciation at 1 April 2024 - brought forward	**8,370**	**8,370**	**7,170**
Provided during the year	5,190	**5,190**	4,334
Accumulated depreciation at 31 March 2025	**13,560**	**13,560**	**11,504**
Net book value at 31 March 2025	**36,104**	**36,104**	**32,183**
Net book value at 1 April 2024	**36,114**	**36,114**	**31,939**

Net book value of right of use assets leased from other NHS providers	530
Net book value of right of use assets leased from other DHSC group bodies	31,653

Note 18.2 Right of use assets - 2023/24

	Property (land and buildings) £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2023 - brought forward	**40,580**	**40,580**	**35,684**
Prior period adjustments	-	**-**	-
Valuation / gross cost at 1 April 2023 - restated	**40,580**	**40,580**	**35,684**
Additions	479	**479**	-
Remeasurements of the lease liability	3,425	**3,425**	3,425
Valuation/gross cost at 31 March 2024	**44,484**	**44,484**	**39,109**
Accumulated depreciation at 1 April 2023 - brought forward	4,135	**4,135**	3,571
Provided during the year	4,235	**4,235**	3,599
Accumulated depreciation at 31 March 2024	**8,370**	**8,370**	**7,170**
Net book value at 31 March 2024	**36,114**	**36,114**	**31,939**
Net book value at 1 April 2023	**36,445**	**36,445**	**32,113**

Net book value of right of use assets leased from other NHS providers	562
Net book value of right of use assets leased from other DHSC group bodies	31,377

Note 18.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 25.1.

	2024/25	2023/24
	£000	£000
Carrying value at 1 April	**39,435**	**40,439**
Lease additions	1,622	479
Lease liability remeasurements	3,558	3,425
Interest charge arising in year	825	731
Lease payments (cash outflows)	(6,708)	(5,639)
Carrying value at 31 March	**38,732**	**39,435**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.
These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 18.3 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2024	31 March 2024
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	5,395	3,622	3,838	-
- later than one year and not later than five years;	33,337	27,615	20,349	18,172
- later than five years.	-	-	15,248	13,790
Total gross future lease payments	**38,732**	**31,237**	**39,435**	**31,962**
Finance charges allocated to future periods	-	-	-	-
Net lease liabilities at 31 March 2025	**38,732**	**31,237**	**39,435**	**31,962**
Of which:				
Leased from other NHS providers		242		564
Leased from other DHSC group bodies		30,995		31,398

Note 19 Investments in associates and joint ventures

The Trust is a member of the all provider collaborative within North Central London. The collaborative comprises 14 partners (4 acute trusts, 3 specialist trusts, 2 community trusts, 3 mental health trusts, a GP provider alliance and UCL). The collaborative is funded through annual contributions from all 14 partners. At a Board meeting in September 2023, it was agreed that the UCL Health Alliance, previously a company limited by guarantee, would move into UCLP, effective 31st October 2023. The alliance was renamed from "UCL Health Alliance" to the "NCL Health Alliance".

Note 20 Inventories

	31 March 2025 £000	31 March 2024 £000
Drugs	1,309	1,090
Total inventories	**1,309**	**1,090**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £19,116k (2023/24: £16,507k). Write-down of inventories recognised as expenses for the year were £0k (2023/24: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £181k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 21.1 Receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Contract receivables	21,348	26,163
Allowance for impaired contract receivables / assets	(4,757)	(4,188)
Allowance for other impaired receivables	(647)	(647)
Prepayments (non-PFI)	4,722	3,221
Interest receivable	191	352
PDC dividend receivable	479	-
VAT receivable	372	353
Other receivables	1,413	1,762
Total current receivables	**23,122**	**27,016**
Non-current		
Contract receivables	512	432
Other receivables	293	247
Total non-current receivables	**805**	**679**
Of which receivable from NHS and DHSC group bodies:		
Current	15,407	18,246
Non-current	293	247

Note 21.2 Allowances for credit losses

	2024/25		2023/24	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**4,188**	**647**	**3,948**	**647**
New allowances arising	1,095	(91)	1,213	-
Reversals of allowances	(435)	91	(792)	-
Utilisation of allowances (write offs)	(91)	-	(181)	-
Allowances as at 31 Mar 2025	**4,757**	**647**	**4,188**	**647**

Note 22 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2024/25	2023/24
	£000	£000
At 1 April	**68,548**	**72,990**
Net change in year	(22,272)	(4,442)
At 31 March	**46,276**	**68,548**
Broken down into:		
Cash at commercial banks and in hand	404	432
Cash with the Government Banking Service	45,872	68,116
Total cash and cash equivalents as in SoFP	**46,276**	**68,548**
Total cash and cash equivalents as in SoCF	**46,276**	**68,548**

Note 22.1 Third party assets held by the trust

Whittington Health NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2025	31 March 2024
	£000	£000
Bank balances	7	7
Total third party assets	**7**	**7**

Note 23 Trade and other payables

	31 March 2025 £000	31 March 2024 £000
Current		
Trade payables	31,429	22,938
Capital payables	6,365	9,220
Accruals	41,062	48,442
Social security costs	3,580	3,574
Other taxes payable	4,205	3,557
PDC dividend payable	-	131
Pension contributions payable	4,477	4,100
Other payables	119	1,035
Total current trade and other payables	**91,238**	**92,997**
Non-current		
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	15,194	12,590
Non-current	-	-

Note 24 Other liabilities

	31 March 2025 £000	31 March 2024 £000
Current		
Deferred income: contract liabilities	2,216	3,470
Total other current liabilities	**2,216**	**3,470**
Non-current		
Total other non-current liabilities	**-**	**-**

Note 25.1 Borrowings

	31 March 2025 £000	31 March 2024 £000
Current		
Loans from DHSC	116	116
Lease liabilities	5,395	3,838
Total current borrowings	**5,511**	**3,954**
Non-current		
Loans from DHSC	1,392	1,508
Lease liabilities	33,337	35,597
Total non-current borrowings	**34,729**	**37,105**

Note 25 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Lease Liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2024	**1,624**	**39,435**	**41,058**
Cash movements:			
Financing cash flows - payments and receipts of principal	(116)	(5,883)	**(5,999)**
Financing cash flows - payments of interest	(43)	(825)	**(868)**
Non-cash movements:			
Additions	-	1,622	**1,622**
Lease liability remeasurements	-	3,558	**3,558**
Application of effective interest rate	43	825	**868**
Carrying value at 31 March 2025	**1,508**	**38,732**	**40,240**

	Loans from DHSC	Lease Liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2023	**1,740**	**40,439**	**42,178**
Cash movements:			
Financing cash flows - payments and receipts of principal	(116)	(4,909)	**(5,025)**
Financing cash flows - payments of interest	(47)	(730)	**(777)**
Non-cash movements:			
Additions	-	479	**479**
Lease liability remeasurements	-	3,425	**3,425**
Application of effective interest rate	47	731	**778**
Carrying value at 31 March 2024	**1,624**	**39,435**	**41,058**

Note 26 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2024	**1,448**	**193**	**217**	**23,629**	**25,486**
Change in the discount rate	(1)	(1)	(1)	(57)	**(59)**
Arising during the year	307	108	-	1,719	**2,133**
Utilised during the year	(192)	(43)	(32)	(7)	**(274)**
Reversed unused	-	-	-	(3,031)	**(3,031)**
Unwinding of discount	32	6	11	954	**1,004**
At 31 March 2025	**1,594**	**263**	**195**	**23,207**	**25,259**
Expected timing of cash flows:					
- not later than one year;	192	35	-	-	**227**
- later than one year and not later than five years;	1,402	228	195	21,685	**23,509**
- later than five years.	(0)	1	0	1,523	**1,523**
Total	**1,594**	**263**	**195**	**23,207**	**25,259**

Principal changes and additions in the financial year are as follows:-The Trust entered into a Private Finance Initiative (PFI) arrangement in 2003 to build and maintain the main hospital through construction firm Whittington Facilities Ltd (WFL). On the 28th July 2020 WFL filed for administration. The collapse of WFL means that the main building has transferred back into the ownership of the Trust, whereby the Trust is now responsible for the maintenance of the building, including the cost of major fire safety refurbishments for which WFL are being pursued under the terms of a 30-year contract. As a result of this dispute with WFL, legal proceedings have commenced. There will be a significant cost of rectifying building deficiency not appropriately addressed by WFL. This provision has been reviewed and revised in line with the most up to date legal and other professional advice.

Note 26.1 Clinical negligence liabilities

At 31 March 2025, £148,400k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Whittington Health NHS Trust (31 March 2024: £122,767k).

Note 27 Contingent assets and liabilities

	31 March 2025	31 March 2024
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	-	(18)
Gross value of contingent liabilities	**-**	**(18)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**-**	**(18)**
Net value of contingent assets	**-**	**-**

The legal position is not concluded on the PFI claim and the final outcome is not yet known. The current provision is based upon the Trust's best estimate, but the final settlement of the PFI claim could be higher or lower than estimated. Any accounting provision thus made is intended to reflect the material uncertainty around the situation which existed as at 31 March 2025, and should not be taken as admission of any liability on the part of the Trust.

Note 28 Contractual capital commitments

	31 March 2025	31 March 2024
	£000	£000
Property, plant and equipment	3,375	5,808
Total	**3,375**	**5,808**

Note 29 Financial instruments

Note 29.1 Financial risk management

Financial reporting standard IFRS7 requires disclosure of the role that financial instruments have had during the period in creating or charging the risks a body faces in undertaking its activities. As a result of the continuing service provider relationship that the Trust has with Integrated Care Board (ICB) and the way the ICB is financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds, and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by Lancashire Teaching Hospitals NHS Foundation Trust (trading as East Lancashire Financial Services) in conjuntion with the Finance Department, within the parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. The Trust's treasury activity is subject to review by the Trust's internal auditors as part of a scheduled programme, and also by executive / non-executive / external audit colleagues as the need arises.

Currency Risk

The Trust is principally a domestic UK-based organisation with the majority of transactions, assets and liabilitiesoriginating from the UK and denominated in Sterling. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

Borrowings are for 1 - 25 year in line with the associated assets, and interest is charged either at the rate set per the loan agreement, or at the National Loans Fund rate in the absence of such an agreement. The Trust therefore has low exposure to interest rate fluctuations.The Trust may also borrow from government for revenue financing, subject to approval by NHS England & related bodies. Interest rates are confirmed by DHSC (the lender) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

The majority of the Trust's revenue arises from contracts with other public sector bodies, therefore the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2025 are in receivables from customers, as disclosed in the Trade & Other Receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Integrated Care Boards (ICBs), which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its Prudential Borrowing Limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 29.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	17,476	**17,476**
Other investments / financial assets	-	**-**
Cash and cash equivalents	46,276	**46,276**
Total at 31 March 2025	**63,752**	**63,752**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	23,777	**23,777**
Other investments / financial assets	-	**-**
Cash and cash equivalents	68,548	**68,548**
Total at 31 March 2024	**92,325**	**92,325**

Note 29.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	1,508	**1,508**
Obligations under leases	38,732	**38,732**
Trade and other payables excluding non financial liabilities	76,473	**76,473**
Total at 31 March 2025	**116,713**	**116,713**

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	1,624	**1,624**
Obligations under leases	39,435	**39,435**
Trade and other payables excluding non financial liabilities	80,600	**80,600**
Total at 31 March 2024	**121,659**	**121,659**

Note 29.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2025 £000	31 March 2024 £000
In one year or less	81,984	84,554
In more than one year but not more than five years	33,801	20,813
In more than five years	929	16,292
Total	**116,714**	**121,659**

Note 30 Losses and special payments

		2024/25		2023/24	
		Total number of cases	Total value of cases	Total number of cases	Total value of cases
		Number	£000	Number	£000
	Losses				
	Cash losses	-	-	-	-
1	Fruitless payments and constructive losses	-	-	1	1,166
	Bad debts and claims abandoned	121	83	156	181
2	Stores losses and damage to property	-	-	1	296
	Total losses	**121**	**83**	**158**	**1,643**
	Special payments				
	Compensation under court order or legally binding arbitration award	1	5	-	-
	Extra-contractual payments	-	-	-	-
	Ex-gratia payments	4	45	2	13
	Special severance payments	-	-	-	-
	Extra-statutory and extra-regulatory payments	-	-	-	-
	Total special payments	**5**	**50**	**2**	**13**
	Total losses and special payments	**126**	**133**	**160**	**1,656**
	Compensation payments received				

1 During the 2022/23 financial year, the Trust had commenced a capital project to develop an integrated health hub. Due to increasing capital and revenue costs, it was necessary to cancel the project in 2023/24, at which point £1,166k of costs had been incurred. The loss was reimbursed to the Trust by North Central London ICB.

2 A fire at one of the Trust's health centres during August 2023 resulted in a loss of £296k as shown above. The loss was the subject of a claim with NHS Resolution, and reimbursement of the loss was received in 2024/25 less an excess of £20k.

Note 31 Related parties

The Department of Health & Social Care (DHSC) is considered a related party. During the year the Trust has had a significant number of material transactions with the Department and with other entities for which the Department is the parent Department. The table below shows the net result of the material transactions within the DHSC group.

The Trust has two wholly-owned subsidiaries, Whittington Pharmacy CIC and Whittington Health Charity. Neither organisation is consolidated within these Accounts. A number of Whittington Health board members have a related party interest within these subsidiaries. The following figures represent the draft financial positions of each entity: The Pharmacy CIC's income for the financial year 2024-25 was £4,315k and expenditure £4,306k. Total receivables balance was £884k and payables balance was £361k at 31st March 2025. The Charity's total income was £800k and expenditure £1,195k, total receivables £1k and payables £227k.

	Income (£000s)	Expenditure (£000s)	Receivables (£000s)	Payables (£000s)
NHS North Central London ICB	373,078	-	5,348	-
NHS England - Core (now including expenditure and payables for all regions and central specialised commissioning)	42,673	-	330	16
NHS North West London ICB	12,490	-	30	-
NHS North East London ICB	9,471	-	28	-
Royal Free London NHS Foundation Trust	3,696	-	2,857	2,195
East London NHS Foundation Trust	2,767	-	2,256	-
University College London Hospitals NHS Foundation Trust	2,241	1,032	1,947	8,552
NHS Hertfordshire and West Essex ICB	1,373	-	8	-
North Middlesex University Hospital NHS Trust	1,144	-	-	-
Moorfields Eye Hospital NHS Foundation Trust	951	28	529	4
North London NHS Foundation Trust	890	1,698	572	3,377
NHS South East London ICB	702	-	4	-
NHS South West London ICB	356	-	-	-
Central and North West London NHS Foundation Trust	246	82	63	-

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of the material transactions have been with:

	Income (£000s)	Expenditure (£000s)	Receivables (£000s)	Payables (£000s)
Islington London Borough Council	9,479	1,848	2,479	0
Hackney London Borough Council	386	67	63	0
Haringey London Borough Council	336	156	1,211	0
NHS Blood & Transplant	0	3,479	0	43

Note 32 Events after the reporting date

No events after the reporting date of 31 March 2025 have been recorded.

Note 33 Better Payment Practice code

Non-NHS Payables	2024/25 Number	2024/25 £000	2023/24 Number	2023/24 £000
Total non-NHS trade invoices paid in the year	62,171	234,840	64,771	224,378
Total non-NHS trade invoices paid within target	60,205	222,990	63,474	215,865
Percentage of non-NHS trade invoices paid within target	96.8%	95.0%	98.0%	96.2%
NHS Payables				
Total NHS trade invoices paid in the year	2,838	24,909	3,747	19,902
Total NHS trade invoices paid within target	2,578	21,673	3,520	17,674
Percentage of NHS trade invoices paid within target	90.8%	87.0%	93.9%	88.8%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 34 Capital Resource Limit

	2024/25 £000	2023/24 £000
Gross capital expenditure	29,802	43,718
Less: Disposals	-	(573)
Less: Donated and granted capital additions	(139)	-
Plus: Loss on disposal from capital grants in kind and peppercorn lease disposals	-	-
Charge against Capital Resource Limit	**29,663**	**43,145**
Capital Resource Limit	29,663	43,145
Under / (over) spend against CRL	**-**	**-**

Note 35 Breakeven duty financial performance

	2024/25 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(13,122)
Remove impairments scoring to Departmental Expenditure Limit	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	**(13,122)**

Note 36 Breakeven duty rolling assessment

Adjusted financial performance (control total basis):	2024/25 £000	2023/24 £000
Surplus / (deficit) for the period	(16,631)	(8,711)
Remove net impairments not scoring to the Departmental expenditure limit	3,587	9,257
Remove I&E impact of capital grants and donations	(78)	60
Adjusted financial performance surplus / (deficit)	**(13,122)**	**606**

	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000
Breakeven duty in-year financial performance	139	508	1,120	3,614	1,165	(7,342)	(14,788)	(3,670)
Breakeven duty cumulative position	4,110	4,618	5,738	9,352	10,517	3,175	(11,613)	(15,283)
Operating income	176,853	186,300	278,212	281,343	297,397	295,007	294,211	309,255
Cumulative breakeven position as a percentage of operating income	2.3%	2.5%	2.1%	3.3%	3.5%	1.1%	(3.9%)	(4.9%)

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000	2023/24 £000	2024/25 £000
Breakeven duty in-year financial performance	6,158	29,362	1,568	2,370	511	6,638	606	(13,122)
Breakeven duty cumulative position	(9,126)	20,237	21,805	24,175	24,686	31,324	31,931	18,809
Operating income	323,394	348,646	350,183	395,340	408,948	431,557	465,818	500,384
Cumulative breakeven position as a percentage of operating income	(2.8%)	5.8%	6.2%	6.1%	6.0%	7.3%	6.9%	3.8%

Staff costs

	Permanent	Other	2024/25 Total	2023/24 Total
	£000	£000	£000	£000
Salaries and wages	254,047	27,422	**281,469**	256,336
Social security costs	26,706	-	**26,706**	24,672
Apprenticeship levy	1,369	-	**1,369**	1,282
Employer's contributions to NHS pension scheme	50,300	-	**50,300**	38,894
Pension cost - other	-	-	**-**	-
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	13,210	**13,210**	16,867
Total gross staff costs	**332,422**	**40,632**	**373,054**	**338,051**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**332,422**	**40,632**	**373,054**	**338,051**
Of which				
Costs capitalised as part of assets	446	151	**597**	874

Average number of employees (WTE basis)

	Permanent	Other	2024/25 Total	2023/24 Total
	Number	Number	Number	Number
Medical and dental	546	64	**610**	494
Ambulance staff	-	-	**-**	-
Administration and estates	1,203	198	**1,401**	1,433
Healthcare assistants and other support staff	737	139	**876**	865
Nursing, midwifery and health visiting staff	1,303	199	**1,502**	1,367
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	926	86	**1,012**	991
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**4,715**	**686**	**5,401**	**5,150**
Of which:				
Number of employees (WTE) engaged on capital projects	7	1	**8**	16

Reporting of compensation schemes - exit packages 2024/25

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	1	3	**4**
£10,000 - £25,000	1	-	**1**
£25,001 - 50,000	2	1	**3**
£50,001 - £100,000	3	-	**3**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**7**	**4**	**11**
Total cost (£)	£320,000	£35,000	**£355,000**

Reporting of compensation schemes - exit packages 2023/24

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	4	**4**
£10,000 - £25,000	-	3	**3**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	-	1	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**8**	**8**
Total resource cost (£)	£0	£162,000	**£162,000**

Exit packages: other (non-compulsory) departure payments

	2024/25		2023/24	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	4	35	7	145
Exit payments following Employment Tribunals or court orders	-	-	1	17
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**4**	**35**	**8**	**162**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF WHITTINGTON HEALTH NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Whittington Health NHS Trust ("the Trust") for the year ended 31 March 2025 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State for Health and Social Care with the consent of HM Treasury on 23 June 2022 as being relevant to NHS Trusts in England and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Trust's services or dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the directors' conclusions, we considered the inherent risks associated with the continuity of services provided by the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the directors' assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit and Risk Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Reading Board and Audit and Risk Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls in particular the risk that Trust management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk as a large proportion of the Trust's revenue was contracted on a block basis and there was not significant estimation uncertainty in the remaining elements at year end. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

We also identified a fraud risk related to the existence and accuracy of accrued expenses due to an overstatement risk. We assessed this to most likely occur through overstating accruals and/or understating prepayments.

We did not identify any additional fraud risks.

In determining the audit procedures we took into account the results of our evaluation of some of the Trust-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included those posted to unusual accounts combinations and other unusual journal characteristics.
- Evaluating the business purpose of significant unusual transactions.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Agreeing a sample of year end accruals to relevant supporting documents, including actual invoices after year end, where applicable.
- Performing cut-off testing of expenditure in the period around 31 March 2025 to determine whether amounts have been recorded in the correct period.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and from inspection of the Trust's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Trust is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the Trust is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws and employment law recognising the regulated nature of the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Accounting Officer and other management and inspection of regulatory and legal correspondence, if any. Therefore, if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The directors are responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2024/25.

Directors', Accountable Officer's and Audit and Risk Committee's responsibilities

As explained more fully in the statement set out on page 159, the directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust on Page 158 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

The Audit and Risk Committee is responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 159, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(2A) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we make written recommendations to the Trust under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Board of Directors of Whittington Health NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of Directors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Directors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2025 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of Whittington Health NHS Trust for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the NAO Code of Audit Practice.

Dean Gibbs

for and on behalf of KPMG LLP

Chartered Accountants

15 Canada Square

24th June 2025