Bundle Trust Board meeting in PUBLIC 23 July 2026

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6 09:15 - Quality Assurance Committee Chair's report
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7 Improvement Performance & Digital Committee chairs report (verbal)

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NHS Whittington Health NHS Trust

Trust Board meeting in Public Agenda

There will be a meeting of the Trust Board held in public on **Thursday, 23 July 2026** from **9.30am to 10.50am** in Rooms A1 & A2 Whittington Education Centre

Item	Time	Title	Action
		Standing agenda items	
1.	*0930*	**Welcome, apologies, declarations of interest** *Julia Neuberger, Trust Chair*	Note
2.	*0935*	**Patient Story** *Sarah Wilding, Chief Nurse & Director of Allied Health Professionals*	Discuss
3.	*0950*	**Draft minutes 21 May 2026 meeting** *Julia Neuberger, Trust Chair*	Approve
4.	*0955*	**Chair's report** *Julia Neuberger, Trust Chair*	Note
5.	*1000*	**Chief Executive Officer's report** *Selina Douglas, Chief Executive Officer*	Note
		Quality and safety	
6.	*1010*	**Quality Assurance Committee Chair's report** *Mark Emberton, Committee Chair*	Note
7.	*1015*	**Improvement Performance & Digital Committee Chair's verbal report** *Junaid Bajwa, Committee Chair*	Note
8.	*1020*	**Audit & Risk Committee Chair's report** *Rob Vincent, Committee Chair*	Approve
9.	*1025*	**Charitable Funds Committee Chair's Assurance report for the meeting** *Amanda Gibbon, Committee Chair*	Note
		Finance & Performance	
10.	*1030*	**Finance report** *Terry Whittle, Chief Finance Officer*	Note
11.	*1035*	**Integrated performance report** *Chinyama Okunuga, Chief Operating Officer*	Note
12.	*1045*	**Questions to the Board on agenda items** *Julia Neuberger, Trust Chair*	Note
13.	*1050*	**Any other urgent business** *Julia Neuberger, Trust Chair*	Note

Minutes of the meeting held in public by the Board of Whittington Health NHS Trust on 21 May 2026

Present:	
Baroness Julia Neuberger	Non-Executive Director and Trust Chair
Rantimi Ayodele	Chief Medical Officer
Dr Junaid Bajwa	Non-Executive Director (via MS Teams)
Selina Douglas	Chief Executive Officer
Professor Mark Emberton	Non-Executive Director
Amanda Gibbon	Non-Executive Director and Vice-Chair (via MS Teams)
Chinyama Okunuga	Chief Operating Officer
Nailesh Rambhai	Non-Executive Director
Baroness Glenys Thornton	Non-Executive Director and Senior Independent Director
Rob Vincent CBE	Non-Executive Director (via MS Teams)
Terry Whittle	Deputy Chief Executive and Chief Finance Officer
Sarah Wilding	Chief Nurse & Director of Allied Health Professionals
In attendance:	
Tina Jegede MBE	Joint Director of Inclusion & Nurse Lead, Islington Care Homes
Marcia Marrast-Lewis	Assistant Trust Secretary
Sheik Pahary	Cancer Matron
Elvis Safari	Chemotherapy Unit Manager
Andrew Sharratt	Director of Communication and Engagement
Mirela Sidor	Patient Experience Manager (item 2)
Swarnjit Singh	Joint Director of Inclusion & Trust Company Secretary
Antoinette Webber	Head of Patient Experience

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

No.	Item
1.	**Welcome, apologies and declarations of interest**
1.1	The Chair welcomed everyone to the meeting and restated the interests of board members who also served as non-executive directors on other NHS boards. This covered herself, Junaid Bajwa, Rob Vincent, Mark Emberton and Nailesh Rambhai as non-executive directors of University College London Hospitals NHS Foundation Trust, and Amanda Gibbon as a non-executive director of the Royal Free London NHS Foundation Trust. Selina Douglas reported that a family member was currently employed on a casual basis in the staff canteen. **The Board noted the declaration from Selina Douglas which would be added to the 2026/27 register of declarations of interest for Board members**

2.	Patient Story
2.1	Sarah Wilding introduced a patient, who shared their experience of receiving treatment as a long-term breast oncology patient at Whittington Health. The patient described the clinical care received as consistently excellent, compassionate and person-centred, highlighted a sustained complete metabolic response following treatment and praised the expertise of the multidisciplinary team. She outlined the following issues: • The patient reflected on the unique culture of the Trust and thanked praised the clinical expertise and approach of her care team, particularly Dr. Emma Scurrell and Elvis Safari, which resulted in a sustained complete metabolic response and enabled her to maintain family and professional responsibilities. • Increased operational pressures were observed and included higher patient volumes, longer waiting times, and challenges with appointment scheduling and access to breast care nurses, • In addition, the communication infrastructure had not kept pace with service demand, especially outside scheduled consultations. • Drawing on her own experience following a change in treatment, the patient described severe side effects that resulted in emergency care attendance and additional healthcare interventions. The patient suggested that a structured follow-up discussion with a breast care nurse shortly after commencing treatment could have improved her understanding of the side effects, enabled earlier intervention and potentially reduced the need for urgent care. • The patient recommended several low-cost, high-value interventions, such as a structured follow-up with breast care nurses in group sessions, automated email acknowledgements, clearer response timeframes for patient enquiries, defined escalation pathways, and up-to-date written patient guidance, particularly after a significant treatment change, to help improve patient safety, early intervention, and operational efficiency.
2.2	In discussion, Board members raised the following points: • The Chair thanked the patient for sharing her experience and recognised the significant contribution of patient insight in shaping service improvements. The Chair also welcomed the positive feedback regarding the quality of clinical care and acknowledged the opportunities identified to strengthen communication, coordination and support arrangements. • Selina Douglas advised that communication remained one of the most common themes arising through patient feedback and complaints and agreed that further work was required to improve two-way communication with patients. She welcomed the patient's practical suggestions for improvement which would help the Trust to deliver services more efficiently and help to improve patient experience. Selina Douglas highlighted the event held last year for breast cancer patients and said that the Trust would look to hold more events to help support cancer patients. • Rantimi Ayodele welcomed the practical nature of the recommendations, particularly the potential use of group-based support models, and agreed that these approaches should be explored across a range of clinical pathways.

	• Nailesh Rambhai also acknowledged that more needed to be done to improve patient communication. • Sheik Pahary advised that work was already under way to strengthen clinical nurse specialist provision, including development of a business case to expand capacity and interim arrangements to provide additional support. Sheik Pahary added that the aim was for all newly diagnosed patients to have an allocated clinical nurse specialist. He also advised that work was taking place to improve operational processes within oncology services and reduce delays in treatment delivery. **The Board thanked the patient for her contribution and recognised both the outstanding care provided by the oncology team and the opportunities identified to further enhance patient communication and support. The Board agreed that a letter of thanks be sent to Elvis Safari and Dr Emma Spurrell**
3.	**Minutes of the previous meeting**
3.1	The draft minutes of the meeting held on 25 March 2026 were approved as a correct record and the updated action log was noted. There were no matters arising.
4.	**Chair's report**
4.1	The Chair highlighted the significant organisational changes currently taking place across the NHS, including the proposed reforms set out within the Health Bill, the abolition of NHS England and the substantial changes underway within the West and North London Integrated Care Board (ICB). She reflected that these changes were creating a period of uncertainty across the health and care system, particularly as organisations managed workforce reductions. The Chair acknowledged the challenges this uncertainty presented and thanked colleagues for continuing to maintain effective working relationships during a particularly complex period. **The Trust Board noted the Chair's report**
5.	**Chief Executive Officer's report**
5.1	Selina Douglas drew Board members' attention to the following issues: • There were significant national changes affecting the NHS, including the NHS Modernisation Bill, the abolition of NHS England and the transfer of its functions to the Department of Health and Social Care, the introduction of a single patient record for maternity services and frailty care by 2028. She added that the Trust would continue to work closely with West and North London partners to influence emerging priorities and future strategy. • Implementation of the Trust's Electronic Patient Record remained a major strategic programme and the importance of learning from the experience of other organisations to ensure Whittington Health had a successful and safe implementation. • Staff were thanked for their professionalism and commitment during the recent period of industrial action by resident doctors. Moreover, the British Medical Association's ballot of consultants and associate specialist doctors

	for industrial action, as part of their dispute with the government over pay and improvements to working lives was highlighted. • The Trust's continued focus was on urgent and emergency care pathway performance, reducing the elective backlog, neighbourhood health and sustaining the operational improvements achieved during the last quarter of the previous financial year. • On 13 May the Trust was visited by a National Audit Office team as part of their work to improve the flow of patients through accident and emergency departments. On 2 June, Baroness Casey of Blackstock was due to visit as part of her review to reform the adult social care system. • Whittington Hospital's surgical hub had successfully been fully accredited for both adults and children. In addition, the community diagnostic centre in Wood Green had received confirmation from the UK Accreditation Service that they have been accredited for BS 7000:2017 for diagnostic imaging services. • Huda Mohamed, Female Genital Mutilation Specialist Lead Midwife, had been appointed as an expert advisor for the national Maternity and Neonatal taskforce. • Whittington Health ended 2025/26 with no Methicillin-Resistant Staphylococcus Aureus infections at all and it was important to thank all the staff in our estates and facilities teams, and on our wards, who helped to make this happen. • There had been two fantastic internal events which recognised and celebrated the contributions of staff. The first was the admin awards held on 30 April. At the event held on 7 May, the annual celebration of nurses and midwives took place and Tisenia Alombro, Dementia Clinical Nurse Specialist, was the worthy winner of the Chief Nurse's Award. • Congratulations were due for Olawale Oshiru, Healthcare Assistant, and Seema Singh, Deputy Director of Operations, surgery & cancer clinical division, on winning extra mile awards. Olawale had gone significantly beyond his role to design and implement two automation systems which had been transformative for the service team. Seema had led and successfully delivered the Getting It Right First Time accreditation for the hospital's surgical hub.
5.2	During discussion, Board members raised the following points: • The Chair drew attention to concerns raised during the parliamentary debate on the King's Speech and emphasised the importance of maintaining public and staff confidence in the security and governance of patient information. • Nailesh Rambhai welcomed the sustained improvement in urgent and emergency care performance but observed that the achievement had been supported by additional investment and staffing above budgeted establishment levels. He felt therefore that the baseline budget for the emergency and integrated medicine clinical division may need further consideration. • Chinyama Okunuga highlighted the importance of recognising talent and potential across the workforce, as skills may otherwise remain hidden without opportunities for development and progression. Using the example

	of Olawale Oshiru, she emphasised the value of creating opportunities for staff to contribute beyond their substantive roles. • The Chair agreed and emphasised the importance of identifying, supporting and developing talented individuals across the organisation to enable career progression and maximise their contribution to the Trust. **The Board noted the Chief Executive Officer's report**
6.	**Quality Assurance Committee Chair's Assurance Report**
6.1	Mark Emberton presented the report of the meeting held on 13 May 2026 and highlighted the following: • Rantimi Ayodele was welcomed to her first meeting of the Quality Assurance Committee. • The Committee carried out a deep dive into paediatric emergency services and discussed workforce challenges, leadership capacity, staff turnover and risks associated with the planned service move. Committee members also highlighted recurrent concerns regarding patient access and communication, particularly difficulties contacting services by telephone or email and rearranging appointments. This echoed the themes highlighted in the patient story earlier on the Board meeting's agenda. • The Committee reviewed and approved the Trust's Antimicrobial Strategy. • Committee members also discussed maternity services, and acknowledged that the Trust would not be compliant with year 7 of the maternity incentive scheme and the ongoing digital risks previously reported to the Board. • The Committee reviewed and approved its annual report and reviewed its effectiveness in line with guidance from DAC Beachcroft. Committee members had fed back on the need to create capacity for focussed discussion of key strategic issues. • Sarah Wilding drew attention to the six-monthly safer staffing review, which had been considered by the Committee. **The Trust Board noted the Quality Assurance Committee Chair's Assurance Report of the meeting held on 13 May 2026 and approved:** • **the revised scores for Quality 1 and Quality 2 entries on the Board Assurance Framework;** • **the updated Antimicrobial Strategy;** • **the revised Committee terms of reference; and** • **the three Patient Safety Incident Investigation reports**
7.	**Annual Eliminating mixed sex hospital inpatient accommodation statement of assurance**
7.1	Sarah Wilding presented the annual compliance statement on eliminating mixed sex accommodation. Board members agreed that there had been no material change since the previous year and that the Trust continued to minimise breaches wherever possible and monitored compliance through routine performance reporting.
7.2	Glenys Thornton advised that the Equality and Human Rights Commission was

	due to publish guidance relating to the recent Supreme Court ruling on biological sex. She noted that the implications for NHS organisations were still emerging and anticipated that the issue would attract increased scrutiny across the health sector.
7.3	The Chair observed that the potential implications included whether future national guidance from NHS England might require changes to existing arrangements and the challenges associated with demonstrating compliance where estate capacity was limited. Sarah Wilding confirmed that the Trust would review any new guidance once it was published and consider the implications for local policy and practice. **The Trust Board approved the Eliminating Mixed Sex Accommodation Compliance Statement**
8.	**Finance Report**
8.1	Terry Whittle presented the financial position for April 2026 and highlighted the following points: • At the end of April, the Trust reported a deficit of £2.1 million, in line with the break-even financial plan. The deficit was primarily driven by costs associated with industrial action by resident doctors. • Progress continued to be made in reducing temporary staffing expenditure, with agency expenditure falling below £350k in April. At the same time, it was encouraging that bookings of temporary bank staff had reduced. However, there was more to do to further reduce bank staffing expenditure as further reductions were required to achieve the Trust's financial objectives for the year. • The Trust's cash position remained good with a balance of £44.30m, which was £11.11m favourable to plan This year's capital expenditure plan was currently £64m and could increase if strategic projects such as the Start Well programme and the electronic patient record project were approved. **The Board noted the Finance report for April**
9.	**Integrated Performance Report**
9.1	Chinyama Okunuga presented the report and highlighted the following areas: • Operational teams had delivered significant performance improvements in urgent and emergency care and on , referral to treatment (RTT) during quarter four to put Whittington Health in a good position at the start of the new financial year. There had also been progress in reducing patients waiting more than 12 hours in the emergency department. Board members also received updates on diagnostic performance, • Performance against cancer targets had remained consistently strong for the last 8-9 months • There was a need for performance in audiology and neurophysiology to improve. • The work on the same day emergency care facility was expected to further improve patient flow and performance.
9.2	

9.3	Sarah Wilding Sarah Wilding reported that the Trust and system partners were working hard with Provide, the new community equipment supplier. She explained that confirmation of the C difficile target for 2026/27 was awaited and would be communicated to Board members once received. Sarah Wilding added that the safer staffing metrics were included in the integrated performance report for the first time. Charlotte Pawsey reported that the focus over the last two months had been to improve appraisal rates. She also confirmed that compliance with statutory and mandatory training was above target and that sickness absence had reduced from 5.5% in February to 3.5% in March. In discussion, Board members raised the following points: • Selina Douglas emphasised that the Trust's RTT improvement had been achieved through sustained operational effort and additional clinical activity which saw 1,000 extra appointments being made available every weekend. She highlighted the significant impact that reduced waiting times had on patient outcomes and experience. • Rantimi Ayodele welcomed the sustained improvement in cancer performance and advised that the Trust's Cancer Board was now able to focus on learning and pathway improvement, particularly for patients with a confirmed cancer diagnosis, rather than solely concentrating on operational recovery. • Amanda Gibbon welcomed improvements in podiatry performance and enquired whether a similar approach could be adopted within musculoskeletal (MSK) services to address long waiting times. In response, Chinyama Okunuga acknowledged the challenges within MSK services and advised that work was under way to develop recovery plans, including targeted improvement initiatives and community-based interventions to reduce waiting times. • Selina Douglas added that a shift to online triage with photographic submissions in podiatry had resulted in improved service efficiency, and outlined plans for MSK clinics to address waiting times, for which further details would be developed over the summer. She thanked Sam Holder, Podiatry Manager, who had been instrumental in transforming the service and had also worked to improve the health literacy of patients and their families. • The Chair commented that a recurrent theme throughout the meeting had been of individual staff members making exceptional contributions to service improvement. She suggested that the Board formally recognise those achievements. **The Board noted the integrated performance report and agreed that a note of thanks from the Board be sent to Sam Holder for his work in podiatry services**
10.	**Questions from the public**
10.1 10.2	A question from Philip Richards, a local resident, was received. as follows: Pressure ulcers - bearing in mind the history with NRS, the previous supplier, what action is being taken to improve the current situation?

10.3	In response, Sarah Wilding explained that: • Historically, issues with the previous community equipment supplier led to delays in accessing appropriate pressure-relieving equipment, increasing clinical risk. • With the transition to the new community equipment provider, Provide, the Trust has worked closely with local authority and integrated care board colleagues to support mobilisation and address past challenges. • We have strengthened Trust-level governance, enabling better monitoring of risks and earlier escalation of concerns. Since Provide has taken over the contract, we remain having issues with supply of equipment, and we will continue to work with system partners to embed these improvements and maintain a strong focus on prevention and timely access to equipment.
10.4	The Chair thanked Mr Richards for all his helpful questions, as they provided a valuable opportunity to draw attention to issues of importance to patients and the wider community.
11.	**Any other business**
11.1	There were no items reported.

21 May 2026 meeting action log:

Agenda item	Action	Lead(s)	Progress
Declarations of interest	Include Selina Douglas's declaration on the register for Board members for 2026/27	Marcia Marrast-Lewis	Completed
Patient story	Send a letter of thanks to Dr Emma Spurrell and to Elvis Safari	Chinyama Okunuga	Completed
Integrated Performance Report	Send a letter of thanks to Sam Holder for his work to transform podiatry services	Selina Douglas	Completed

Actions carried forward

Agenda item	Action	Lead(s)	Progress
Integrated Performance report	Carry out a deep dive into complaints performance and processes	Sarah Wilding	Completed at June Board
Integrated Performance report	Arrange for the virtual ward teams to come to the Board for further discussion and consideration of their work and challenges.	Chinyama Okunuga	Due at the June Board
Action log	Review the draft metrics to measure the successful delivery of the Clinical Strategy to the Quality Assurance Committee (QAC)	Clarissa Murdoch and Rantimi Ayodele	Due at the next QAC meeting

Meeting title	**Trust Board – public meeting**	**Date: 23 July 2026**
Report title	**Chair's report**	**Agenda item: 4**
Non-Executive Director lead	Baroness Julia Neuberger, Trust Chair	
Report authors	Swarnjit Singh, Trust Company Secretary, and Julia Neuberger	
Executive summary	This report provides an update and a summary of activity since the last Board meeting held in public in May 2026.	
Purpose	Noting	
Recommendation	Board members are asked to note the report.	
Board Assurance Framework	All entries	
Report history	Report to each Board meeting held in public	
Appendices	None	

Chair's report

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

First, on behalf of all Board members, I want, as ever, to thank our staff and volunteers for their continued hard work and help in providing quality services and a good experience for our patients during a very busy time, with high demand for services and against a backdrop of heat warnings.

Private Board meeting and seminar, June 2026
The Board of Whittington Health held private a meeting on 25 June. The main agenda items covered included approval for our 2025/26 Annual Report and Annual Accounts, along with approval for our 2025/26 Quality Account publication; noting chair's assurance reports from three board committees: finance and business development, charitable funds and workforce assurance; feedback from service visits; approving an outline business case for the procurement of a new electronic patient record; and finance and integrated performance reports. The Board also had a facilitated development seminar after the meeting, where they discussed the key factors behind successful and effective unitary boards.

Appointment of our new chair
Amanda Gibbon, Non-Executive Director and our current Vice-Chair, will become chair of Whittington Health from 1 October 2026. I have loved every moment of my time serving as chair of Whittington Health and I have no doubt that it will continue to go from strength to strength after the end of my term. I am thrilled to be handing over to Amanda and wish her every success. Dame Caroline Clarke, Regional Director for NHS England in London, said: "Amanda brings a wealth of experience and a deep understanding of Whittington Health to this role. As London works to transform how care is delivered, including shifting services closer to home and into communities, trusts like Whittington will be at the heart of that change."

Annual staff awards
I am delighted to report that I attended our annual staff awards on 9 July. The theme for the evening was Living Our Values Everyday (innovation, compassion, accountability, excellence and equity). Those values were very much in evidence as we celebrated the amazing work carried out by our staff and teams. This year we received over 300 nominations, and I would like to congratulate everyone who was nominated. The full awards categories and winners are shown in the table below.

Staff Award Category	Winner
Innovation or improvement of the year	Ambulatory Care Improvement Group
Outstanding dedication to compassion	Liz Relf, Team Lead for Mainstream Therapies
Accountability: Paula Mattin emerging leader	Rosemary Duodu-Appiah, Locality Manager, Haringey Health Visiting Service
Respect: unsung hero	Aminur Rahman, Rota Coordinator

Staff Award Category	Winner
Commitment to Excellence in a clinical role	The Emergency Department Team
Commitment to Excellence in a non-clinical role	Kate Ferry, Director of Operations Community Dental Service
Annabelle Lake Excellent Administrator of the year	Miranda Reynolds, Adult Community Services Business Manager
Outstanding Contribution to Ensuring Equity or reducing Health Inequalities	MacMillan Cancer Support
Charitable fundraiser of the year	Islington Community CAMHS at the Northern Health Centre
The Chair's award for living our Trust values	Lesley Platts, Associate Director of AHP and CYP Services Islington Nathan Mpelenda, Ambitious College Intern and Admin support for Barnet & Enfield Paediatric Audiology Sana Burney, Programme Lead, University College London Hospitals NHS Foundation Trust and Whittington Health NHS Trust partnership
The patient award	Everyone who supported Esther Rozner and her baby on her maternity journey

Other meetings

In addition to the meetings already outlined in this report, I have also carried out several walkabouts on the acute site meeting individual staff, patients and visitors. I also participated in the following activities:

- 28 May, several 1:1s with the Chief Executive Officer and other executive directors
- 3 June, meeting with the Chief Operating Officer
- 15 June, visit to the Stuart Crescent Health Centre with the Chief Executive Officer
- 17 June, appraisal of the Chief Executive Officer and meeting with the Start Well Programme lead
- 22 June, appraisal pre-Board meeting call with Non-Executive Director colleagues
- 23 June, Extraordinary Board meeting
- 24 June, meetings of the Charitable Funds and medical Committees
- 25 June, private Board meeting and development seminar and a meeting of the Remuneration Committee
- 26 June, monthly meeting with Mark Lam and Dominic Cook
- 6 July, informal walkabouts on the acute site and a meeting with the Chief Executive Officer
- 9 July, Annual staff awards
- 16 July, meeting with the Chief Operating Officer

Meeting title	**Trust Board – public meeting**	**Date: 23 July 2026**
Report title	**Chief Executive Officer's report**	**Agenda item 5**
Executive lead	Selina Douglas, Chief Executive Officer	
Report authors	Swarnjit Singh, Trust Company Secretary, and Selina Douglas	
Executive summary	This report provides an update on national, regional and local developments since the last meeting held on 21 May.	
Purpose	Noting	
Recommendation	Board members are invited to note the report.	
BAF	All Board Assurance Framework entries	
Appendices	1: 2025/26 Annual Report and Accounts	

Chief Executive Officer's report

Since the Board met in public in May, there have been two periods of sustained hot weather, with temperatures consistently exceeding heatwave thresholds and reaching above 30 degrees Celsius. This additional pressure has resulted in increased ambulance conveyances, higher emergency department (ED) attendances, and a greater proportion of frail older people and patients with respiratory, cardiovascular and dehydration-related presentations. The impact of the heat has also been felt across inpatient flow, with reduced discharge rates from wards, with all possible beds open, particularly among older and more vulnerable patients where discharge arrangements have required additional support and risk assessment during periods of extreme heat. We have an occupancy rate of 110% as we have had in excess of 30 patients to assess in ED most mornings. These factors have contributed to increased bed occupancy, longer waits for admission from the emergency department and ongoing pressure on patient flow across the Trust.

There have been several key reports and national guidance which have come from the Department of Health and Social Care and NHS England, as follows:

Learning from the Ockenden and Amos reviews
In early July, two important reports were published on maternity and neonatal care. Donna Ockenden published her review into Nottingham University Hospital NHS Trust which set out years of serious and repeated failures in care. It also contained lessons for all of our services to learn. Our Chief Nurse, Sarah Wilding wrote out to all staff on Monday on behalf of the whole Trust Board to encourage everyone to read the report. Baroness Amos also published her report into maternity services nationally. Sir Jim Mackey, NHS England CEO described its publication as a "moment in our history that requires our collective leadership to act with real urgency in addressing the failings and harm experienced by women, babies and families and improve maternity and neonatal care". We know that, overall, the Whittington babies and their families receive high quality, compassionate and effective maternity and neonatal care. We also have an excellent relationship with our Maternity and Neonatal Voices Partnership who act as critical friends and help bring service user voices into maternity and neonatal services. However, there is no place for complacency in any of our services.

Actions that we have already taken include leaders in our Acute Patient Access, Clinical Support services and Women's Health Division writing out to colleagues in their division setting out how we must learn from the report, listen to colleagues and service users and implement any changes required. In addition, we are already actively reviewing our Home Birth Model and on-call arrangements, inequalities work and we have successfully implemented the Birmingham Symptom-specific Obstetric Triage System (a standardised maternity triage system endorsed by major health bodies like the Royal College of Obstetricians and Gynaecologists). With reference to Donna Ockenden's findings about mortuary care in Nottingham, our work continues to review our position against the Fuller recommendations (following an investigation into how David Fuller was able to carry out inappropriate and unlawful actions in the mortuary of Maidstone and Tunbridge Wells NHS Trust). We are also already working on plans to extend Martha's Rule which allows any in-patient or their

relative to seek a second opinion if they have concerns about their condition, to our maternity service, one of Donna Ockenden's key recommendations.

Our response will be supported by the work already underway across our maternity and neonatal services. The Start Well programme provides a framework to bring these improvements together across the system – strengthening pathways, improving consistency, and supporting safer and more resilient services. It will also support more joined up care for families and, over time, help enable further improvements in our facilities and service models, building on the changes we are making now to improve outcomes and experience for babies and their families. We realise that the past few weeks have been difficult for all of our colleagues working in our maternity and neonatal services and want to thank them for their ongoing commitment to providing the very best, safest and most compassionate care possible and to working together to learn everything we can from these important reports.

In terms of next steps, in order to take the actions needed in response to the national Amos review of maternity and neonatal services, the Ockenden review into maternity care in Nottingham and NHS England's resulting 10-point plan, the mortuary assurance requirements set out in the Fuller review and our preparations for a NHS London region perinatal insight visit on 14 September, we are bringing our response together within a single executive framework for maternity & neonatal services, organised around six domains: executive & board leadership; safety, quality & clinical outcomes; governance & regulatory assurance; operational delivery & performance; people, culture & engagement; and Start Well transformation.

Lord Mann review

Following the horrendous attacks on the Jewish community in North Central London in April, we wrote to all staff to offer support and to emphasise the message that antisemitism, racism, or any other form of discrimination, have no place in our organisation as it is contrary to our values, and that should anyone experience or witness it, please report it so that we can tackle it and protect our staff. Equally, in advance of the 16 May march and counter-protest expected in central London, we wrote to all staff to support them and to re-iterate Whittington Health's zero tolerance approach to incidents of abuse, violence, and aggression against our staff.

I am clear that racism, discrimination and antisemitism have no place in the NHS or in wider society. I am closely following the Lord Mann Review into antisemitism and other forms of racism in the NHS and healthcare regulatory system, published on 4 June. The review calls for a more cohesive, transparent and proactive approach across the NHS, with stronger leadership grip and clearer systems to identify, report and act on antisemitism and racism. The Trust has accepted all of the key recommendations. We have already taken action by holding a listening event with staff as part of work on promoting civility and respect at Whittington Health, in line with our ICARE values.

NHS London has been clear that the Mann review reinforces the importance of consistent, visible leadership across all organisations. The key expectations for NHS trusts include:

- Stronger accountability and leadership– with clearer expectations for boards and executives to lead action on racism and embed an anti-racist culture.
- New national staff standards – setting minimum expectations for preventing, responding to and learning from incidents of racism.
- Improved reporting and investigation – with clearer national guidance and more consistent processes across employers and regulators.
- Mandatory training and capability building – including enhanced anti-racism training for leaders and updated equality and inclusion training for all staff
- A renewed focus on culture and inclusion – ensuring that every member of staff and every patient feels safe, respected and able to access care without fear.

Preventing unlawful access to patient records
Following incidents in Nottingham and Cambridge, NHS England wrote to all providers to reinforce the message that staff need to be clear that there is no place in the NHS for people who misuse patients' medical information. The guidance for staff makes clear that everyone working in health and care has a professional and legal responsibility to protect people's confidential information and that accessing patient records out of curiosity or for personal reasons is illegal. The Chief Medical Officer and Chief Nmurse have written to all staff to remind them of the need to uphold the standards of professionalism that our patients, colleagues and community rightly expect and have made clear that any unauthorised access will be investigated and may result in disciplinary action, as well as a referral to the police.

Minimum standards of patient experience – electives
NHS England also wrote to NHS trusts to highlight the need to improve their experience of patients waiting for treatment and highlighted the minimum standards for planned care once a referral has been accepted in secondary care. NHS England developed the minimum standards (see table below) with patient groups involved.

Stage	Minimum standards
When a patient is referred	Standard 1: You will know within 28 days whether your referral has been accepted or what the next steps are.
While a patient is on the waiting list and throughout their care	Standard 2: Communication will be clear and easy to understand. If you have specific communications' needs, you will have the opportunity to tell your provider these. Standard 3: When your referral is accepted, you will get information to help you while you wait. Standard 4: You will get regular updates on your wait, at least every 12 weeks. Standard 5: Before your appointments, you will be able to tell your provider of any additional needs and reasonable adjustments you require.

Planning and understanding appointments	Standard 6: You will receive clear information about your appointments at least 21 days in advance. Standard 7: If your appointment is cancelled, by either you or your provider, a new date will be communicated within 28 days. Standard 8: You will be told when your care is complete and what happens next.

Quality strategy for NHS-funded care in England

On 14 July, Professor Frankie Swords, National Medical Director, NHS England, and Duncan Burton, Chief Nursing Officer for England, NHS England published a new national Quality strategy to provide a 10-year framework for delivering high-quality care for all patients and communities. Developed under the oversight of the National Quality Board, with engagement and contributions from a wide range of stakeholders, the strategy supports delivery of the government's 10 Year Health Plan and its ambitions for greater transparency, a stronger patient and staff voice, and a renewed commitment to tackling inequalities. The strategy does not introduce new policies or priorities. Instead, it brings together existing commitments and focuses on the areas where clear standards and proven approaches can deliver the greatest improvements. In doing so, it sets out a shared approach to quality across three interdependent domains: safety, effectiveness, and experience. Progress across all three domains is essential to improving outcomes, reducing inequalities, and delivering better value for the public. All three areas need to be prioritised at every level and in every organisation. The Trust's Management Group and the Board's Quality Assurance Committee will review the new strategy and take forward the actions needed, including how the strategy will update our local plans, priorities and improvement programmes, the interdependence of safety, effectiveness and experience and considering all three in decision-making and performance oversight, and considering how the strategy's recommendations on leadership, accountability, improvement, use of data and community engagement can strengthen local quality approaches. The ambition set out in the strategy is simple: to create an NHS where high-quality care is the norm everywhere, for everyone. Achieving this will require commitment, consistency, and collaboration across the whole system.

Staff standards

On 6 July, the department of health and social care published NHS Staff Standards, which provide a clear framework for employers to improve staff experience. The standards set out a nationally required minimum standard, providing a clear framework for employers to improve staff experience. The intention to create the NHS Staff Standards was announced in the NHS 10 Year Health Plan in July 2024. The standards were developed by the Department of Health and Social Care (DHSC) and NHS England through discussion with NHS unions staff side and with NHS Employers. The standards cover six priority areas: line management; health and wellbeing; tackling racism; promoting flexible working; violence prevention and reduction; and championing sexual safety.

The standards will underpin the NHS People Promise and use existing frameworks for good employment practice. The purpose of setting national standards is to

address pockets of poor practice, reduce variation and support overall improvement in staff experience. This should have a positive impact on indicators such as absence and retention, and in turn enhance patient experience. Implementation of the standards will be mandatory and will be reflected in the NHS Oversight Framework, which will draw on relevant staff survey questions as indicators. Employers will make their own regular assessment of progress and work with staff side and unions on implementation.

Leadership and Management Framework
On 6 July, the new NHS leadership and management Framework was also launched. It sets clear expectations for all NHS leaders and managers, including line managers. This includes a code of practice and leadership and management standards for all NHS leaders and managers. For the first time, the NHS has a single national framework describing what excellent leadership and management looks like across every setting, profession and level of responsibility. The framework provides a shared language for development, career progression and professional expectations. It will support stronger management capability, competent, compassionate and inclusive leaders, better staff experiences and, ultimately, improved care for patients. The Trust's Management Group and Workforce Assurance Committees will review reports on both the staff standards and the leadership and management framework and our plans to implement them locally.

London Life Sciences Strategy
While London is home to nearly 10 million patients, three of the world's top 15 research universities, and more than 2,700 life sciences companies for too long, promising innovations have struggled to move beyond localised pilots into system-wide change. The London Life Sciences Strategy, published on 10 June, is a co-ordinated response to that challenge, setting out how to make London the most attractive city in the world for life sciences innovation, and — crucially — how we ensure that innovation translates into better, fairer care for Londoners.

Industrial action
The British Medical Association's (BMA) decision to suspend planned industrial action by resident doctors which was due to start on 15 June has been welcomed across the NHS in England. Sir James Mackey, NHS Chief Executive, held a call on 15 June to update NHS providers, including the significantly enhanced career progression opportunities and improvements to the training experience for resident doctors. He also outlined the commitment to improve the contracts and circumstances for locally employed doctors, for which NHS England will set out the terms in due course. I would like to thank all colleagues who helped plan to mitigate the impact of the cancelled industrial action. Separately, on 6 July, the BMA announced the results of its statutory ballots for industrial action. The outcome showed that 76% of consultant doctors in England have voted in favour of industrial action; however, while speciality, associate specialist and specialist doctors also voted in favour of industrial action, with turnout of 42%, the threshold to take industrial action was not met.

London Region Perinatal Insight Visit
Whittington Health received confirmation from NHS England (London region) that it will be visited on 14 September as part of the London region's refreshed approach to

supportive perinatal quality oversight. It is aligned with the Perinatal Quality Oversight Model (PQOM) and provides an opportunity for shared reflection, learning, and mutual understanding of priorities, enablers and barriers to transformation, as well as opportunities for collective solutions.

National Oversight Framework
In the latest NHS England update for Quarter 4, Whittington Health remained in Segment 3. As before, the Trust initially came out in Segment 1, before being restricted to Segment 3, due to its financial position. I have followed this up with NHS England's London regional team to explain that we delivered a small surplus in 2025/26 and have a plan to deliver a balanced budget for 2026/27. I will keep Board members informed on the outcome of that discussion. In addition, on 11 June, NHS England published its updated 2026/27 NHS Oversight Framework. The update retains the core architecture and oversight approach from the 2025/26 Oversight Framework. It has been updated to reflect the maturing operating model, introduces delivery segmentation for Integrated Care Boards (ICBs) and clarifies the role of NHS England's regional teams in overseeing performance.

2025/26 Annual Report and Accounts
I am pleased to report that our audited annual accounts and annual report were submitted to NHS England and would like to thank all colleagues involved in their production.

Neighbourhood Health
The national neighbourhood health agenda has continued to accelerate following publication of the 10-Year Health Plan and associated guidance. As an Integrated Care Organisation (ICO), Whittington Health is well positioned to support the transition towards neighbourhood health services and population health delivery models. Since the Board seminar in April, the Trust has moved from strategic planning into delivery. In Haringey, the Neighbourhood Integrated Neighbourhood Team (INT) Test Bed is now underway, supported by a formal memorandum of understanding between partners, multidisciplinary workstreams and a developing analytics function. Work is focussed on testing new models of integrated neighbourhood care, improving proactive care for people with long-term conditions and frailty, and reducing avoidable demand on acute services.

In Islington, partners are reviewing the mobilisation of the INT model and working collaboratively to develop the future neighbourhood model, drawing on learning from Haringey and wider neighbourhood development work. Whittington Health is supporting this work alongside primary care, local authority, voluntary, community and social enterprise organisations and system partners to refine the operating model, governance arrangements and priority pathways, with a focus on strengthening integrated care, improving outcomes and reducing inequalities.

Alongside this, the Trust has commenced a series of clinical pathway reviews focused initially on frailty, diabetes, heart failure, and respiratory disease. These workshops are bringing together acute, community, primary care and voluntary sector colleagues to identify opportunities to improve population health outcomes, enhance patient and staff experience, reduce inequalities, and shift appropriate care closer to home. Early opportunities include strengthening prevention, improving self-

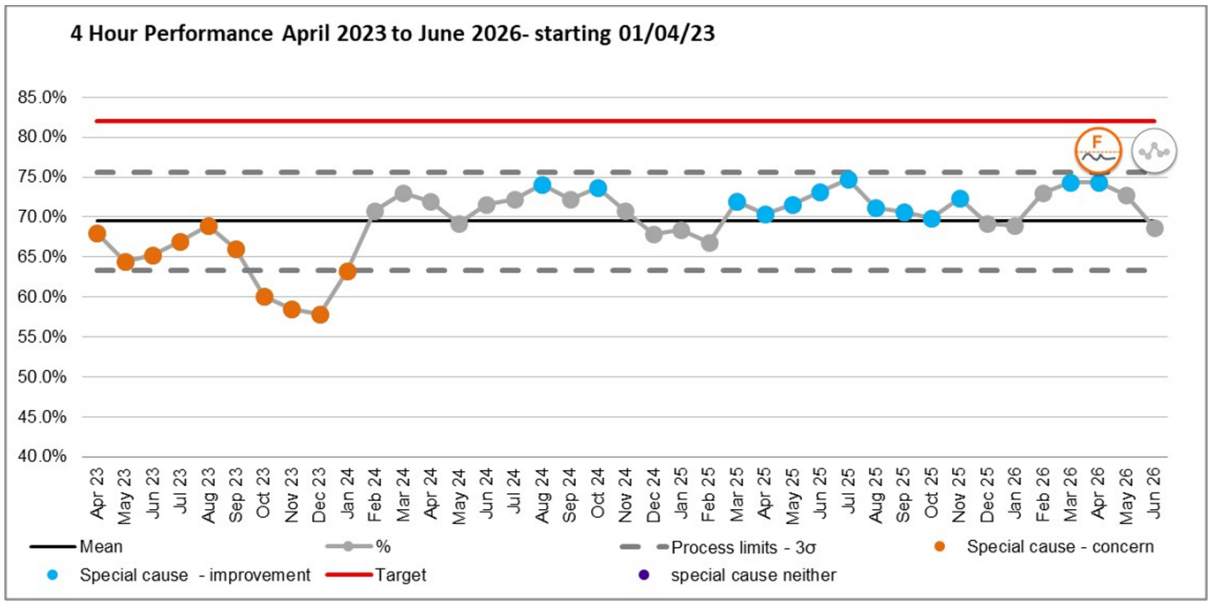
management support, enhancing step-up and step-down pathways, and expanding community-based specialist support.

The Neighbourhood Programme Board has received an update on Children and Young People's (CYP) services, and recognised that many neighbourhood principles – locality-based delivery, prevention, multidisciplinary working and partnership with councils, schools and voluntary organisations – are well established within CYP services. There is an opportunity to further align CYP delivery with neighbourhood development, particularly through stronger place-based working and greater integration plans for which will mature over the coming year.

Looking ahead, the Trust will continue to develop its neighbourhood strategy in response to national policy, including the emerging role of Integrated Care Boards as strategic commissioners and the wider shift towards neighbourhood-level planning. A particular focus will be given to articulating what neighbourhood health means for Whittington as an ICO, ensuring all clinical services understand their contribution to prevention and population health, and positioning the Trust to play a leading role in future neighbourhood delivery models across West North London.

Urgent and Emergency Care

In June 2026, urgent and emergency care (UEC) performance against the four-hour access standard dropped to 68.81% compared to 72.31% in May. This drop in performance was driven by the relocation of the paediatric emergency department, ambulatory care and Children's ambulatory care and the loss of the current emergency department same day elective care, as part of the estates decant work



Alongside this, patient attendances continue to as the trust daily average increased to 320 per day in June versus 312 in May. The remains well above daily average for the last 12 months superseding the daily average over the winter period. The combination of the decant work, increase in attendances and the delay in completion of the

Extended Emergency Medicine Ambulatory Care, which was due to come online in March, has resulted in being below the agreed trajectory for UEC 4-hour performance. Following subsequent engagement with NHS England, a revised target of 74% has been agreed for the period April to June 2026, recognising that the new service will not be fully operational until July 2026.

There was an increase in 12-hour emergency department trolley breaches, from 197 in May 2026 to 276 in June 2026, reflecting increase in attendances and pressures in flow where the Trust saw a daily average of 56 patients not meeting the criteria to reside. Mental health-related breaches decreased from 26 in May to 15 in June.

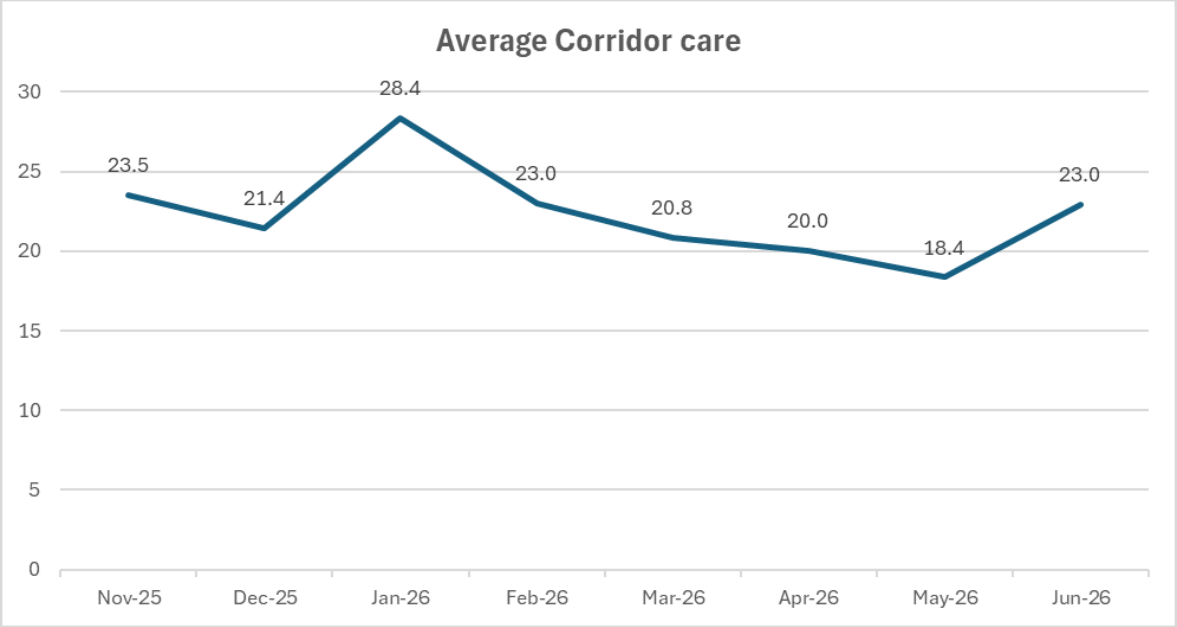
Referral to Treatment
Our referral to treatment (RTT) 18-week performance for June 2026 is due for submission on the 22 July 2026 therefore figures reported here are unvalidated. Performance against the 18-week standard is currently at 67.91%, representing a 4.4% shortfall against the national planning trajectory of 72.31%. This variance is largely driven by deterioration in a small number of specialties, most notably in dermatology and ear, nose and throat services, both of which experienced an approximate over 15 percentage point decline during the month. Notwithstanding the overall RTT position, long-wait performance remains strong and well controlled. The proportion of patients waiting over 52 weeks stands at 0.35%, significantly below the national threshold of 1%, and there are no patients waiting over 65 weeks, indicating sustained grip on the longest waits.

Diagnostic performance in June 2026 has improved to 80.4%, a slight improvement of 0.5 percentage points from May. However, capacity constraints persist in key areas, particularly audiology and neurophysiology, which continue to impact overall diagnostic waiting times. Targeted specialty-level recovery plans are being implemented, focusing on stabilising capacity through recruitment, pathway optimisation, and restoring activity, to support delivery of national diagnostic standards over the coming months.

Cancer performance
Performance against key cancer waiting time standards remains strong. For the Faster Diagnosis Standard (28-day), performance in May 2026 was 88.8%, comfortably exceeding the national target of 80%, and demonstrating sustained effectiveness in delivering timely diagnoses for patients referred with suspected cancer. However, variation persists at specialty level, with ongoing challenges in gynaecology and urology linked to workforce constraints and pathway delays

Delivery against the 31-day decision to treat to first definitive treatment standard has dipped, with performance at 94.2%, marginally below the national threshold of 96%. Performance against the 62-day referral to treatment standard was 80.3% in May, remaining compliant with national requirements. Overall, cancer pathway performance demonstrates consistent compliance with national standards, underpinned by strong pathway management and operational oversight, though maintaining this position will depend on sustaining capacity and managing demand across the diagnostic and treatment pathway.

Corridor care



There was an increase in average corridor care in June to 23 patients per day in reflecting the increase in attendances and flow issues. This continues to be review as part of the Flow Improvement Programme.

Surgical hub accreditation

I am very pleased to share that we have received formal confirmation from Professor Tim Briggs, GIRFT Programme Lead and NHS England National Director for Clinical Improvement and Elective Recovery that the Whittington Hospital elective surgical hub has been fully accredited for both adults and paediatrics. This is an excellent achievement for the organisation and a significant recognition of the clinical and operational excellence within our teams. The visiting panel highlighted the professionalism, enthusiasm, and commitment of our staff, all of which clearly shone through during the accreditation visit. My huge thanks go to everyone involved in preparing for the assessment and to all those who continue to drive improvements in surgical flow, utilisation, and patient experience. The accreditation provides us with further momentum as we strengthen our elective recovery work.

Wood Green Community Diagnostic Centre accreditation

I am equally delighted that our fantastic community diagnostic centre in Wood Green has received confirmation from the UK Accreditation Service that we have been accredited for BS 7000:2017 for diagnostic imaging services. This is an important milestone for the centre and reflects the significant work undertaken across the service to strengthen governance, quality assurance and operational processes. It also reinforces the high standards of diagnostic care being delivered to patients across the system. I would like to take this opportunity to thank the Wood Green team and colleagues across the Trust and system partners who supported the preparation for the assessment process. This was a collective effort, and the outcome reflects the commitment and professionalism of everyone involved.

Service visits

In partnership with the Chair, on 15 June I had the pleasure of visiting our Stuart Crescent Health Centre and meeting staff. In addition, on 6 July, I visited the day treatment centre and theatres on our acute site, and on 15 July, I went to see the Hillingdon community dental service at the Uxbridge dental centre.

All staff briefings

The last staff briefing event was held on 16 July and covered topics including the Trust's annual staff awards event; the Summer People Pulse survey for staff; the completion of the initial phase pf the Block K upgrade as part of wider work to improve our power capacity; the grand opening of Hugo, our ne robot that will help our surgeons to provide even more precise surgery with less pain, a shorter stay in hospital and a faster recovery time; and our financial performance in quarter one and the additional measures such as tighter controls on temporary staffing and centralised information technology procurement.

NHS
Whittington Health
NHS Trust










Annual Report 2025/26

Chair and Chief Executive's introduction

Welcome to our 2025/26 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.

Across all our services, our staff have shown exceptional commitment, compassion and resilience. Together, they have cared for hundreds of thousands of patients across our hospital and community settings, maintaining high standards of safety and quality in what remains a challenging operating environment. We are particularly proud of the continued strength of our staff culture, rooted in our ICARE values, and the progress we have made in creating a more inclusive, supportive and empowering workplace.

A central focus this year has been our improvement work, especially in relation to activity and access targets. Like the rest of the NHS, we have faced sustained pressure from rising demand, capacity constraints and workforce challenges. Despite this, we have delivered meaningful improvements across key performance areas. We have strengthened our approach to managing patient flow, reduced waits in a number of pathways and improved delivery against important standards such as cancer diagnosis and treatment. Our work to reduce long waits and bring down our overall waiting list has been a key priority, alongside improving the reliability of outpatient services and diagnostic capacity. These improvements reflect a more disciplined and data-driven approach to performance management, combined with the dedication of our clinical and operational teams.

There are a number of case studies contained in our annual report at the end of the performance, patient experience and workforce sections which help to demonstrate the achievements of which we are proud.

Alongside operational performance, we have continued to invest in our organisational culture. We have placed a strong emphasis on listening to our staff, supporting their wellbeing and creating opportunities for development and progression. Our focus on equity, diversity and inclusion has led to tangible improvements, and we are seeing the positive impact of initiatives to support leadership development, reduce inequalities in experience and strengthen staff engagement. We know that a positive and inclusive culture is fundamental to delivering high-quality care, and this remains a core priority for the Trust.

We are pleased to highlight that one of the significant strengths of Whittington Health remains the level of care and compassion demonstrated by our hardworking staff. Our key challenges remain to deliver high quality services safely for our patients while maintaining strong activity performance and delivering a financially sustainable organisation. In addition to those priorities, we look forward to 2026/27 to delivering successfully on our important priorities – the Start Well programme, neighbourhood working in Haringey and Islington and our clinical strategy.

This year has also seen significant progress in our role as an effective and sustainable system partner within North Central London. We have worked closely with colleagues

across the Integrated Care System, local authorities, primary care and the voluntary sector to deliver more coordinated, patient-centred care. Our contributions to neighbourhood working, virtual ward models, discharge pathways and population health initiatives demonstrate the value of working collaboratively across organisational boundaries. We have also continued to strengthen our longstanding partnership with University College London Hospitals NHS Foundation Trust, delivering shared services and pathway improvements that benefit patients across the system.

Our 2025/30 Clinical Strategy provides a clear framework for the future, setting out how we will continue to transform services, address health inequalities and ensure long-term sustainability. Programmes such as Start Well, along with wider estate and digital investments, will play an important role in improving the quality and accessibility of care for our communities.

We want to thank our staff, volunteers, partners and the communities we serve. Their support, dedication and trust are what make our achievements possible. We also want to warmly thank our volunteers and charitable supporters, whose contributions make a meaningful difference to patients and staff alike.

There were several changes to our board and senior leadership team last year. On the board, Charlotte Hopkins was our acting chief medical officer, and along with her, we would also like to thank Clare Dollery, Liz O'Hara and Jonathan Gardner for their service at the Trust.

As we look ahead to 2026/27, we remain focused on delivering further improvement in access and outcomes, strengthening our culture, and playing our full part as a trusted and effective partner across West and North London. Together, we will continue to build a strong, sustainable organisation that provides high-quality care for all.

Baroness Julia Neuberger DBE
Trust Chair

Selina Douglas
Chief Executive Officer

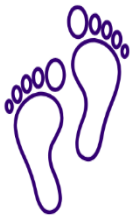
Whittington Health in 2025/26

ED attendances

107,769

Community Nursing

254,977



Births

2,652

Dental Appointments

50,315

Physio and MSK Appointments

79,187

Outpatient appointments

437,213

Day cases

28,042

School appointments

144,314

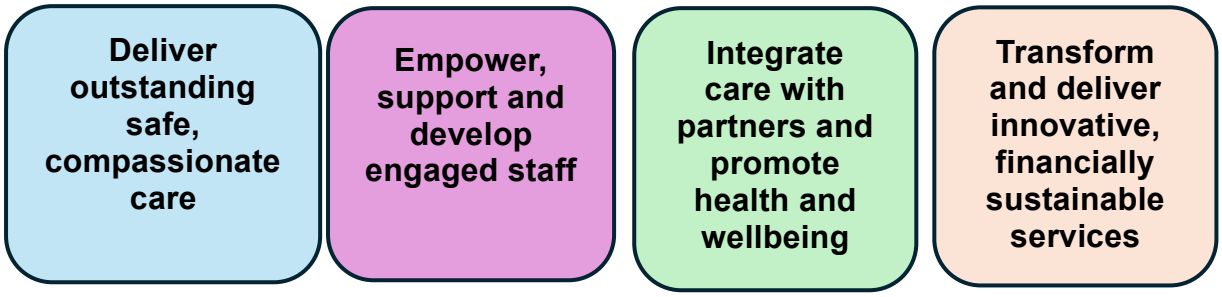
Trust strategy

Whittington Health's strategy for 2025/26 is shaped by our vision of *helping local people live longer, healthier lives* and our ICARE values, underpinned by equity. Our four long-term strategic objectives guide the organisation's direction and are included on our board assurance framework.

Our **Vision** motivates us	"Helping local people live longer, healthier lives." NHS Whittington Health NHS Trust
Our **Values** guide how we act	ICARE EQUITY Innovation | Compassion | Accountability | Respect | Excellence All our values are underpinned by Equity
Our **Objectives** tell us how we will achieve our Vision	Deliver outstanding, safe, compassionate care for our patients Empower, support and develop engaged staff Promote health and wellbeing and integrate care with partners Transform and deliver innovative, financially sustainable services
Our **Priorities** describe key areas of focus for our Trust	Deliver Whittington Health's Clinical Strategy Lead neighbourhood working in Islington and Haringey Lead the Start Well Programme
The **three legs of our stool** ensure we are 'Fit for the Future'	 Quality Performance Finance
Our **enabling workstreams** create the conditions to achieve our priorities	Comms and patient experience strategies Digital strategy and EPR Estates strategy Financial improvement programme People strategy, NMAHP, other workforce and professions strategies

Strategic objectives

As shown overleaf, Whittington Health continues to have four long-term strategic objectives, as follows, which are reflected in our Board Assurance Framework:



Clinical strategy

Our Clinical Strategy 2025–30 sets out how Whittington Health will deliver high-quality, person-centred and financially sustainable care over the next five years, ensuring we remain fit for the future and continue to help local people live longer, healthier lives. Developed through extensive engagement with staff, patients, voluntary sector partners, GPs, Healthwatch and local authorities, the strategy reflects what matters most to our communities and the professionals who care for them.

The Clinical Strategy was developed through an intensive programme of workshops, surveys and engagement events between October 2024 and May 2025, which saw more than a thousand contributions which helped to shape our strategy. Responding to rising demand, increasing complexity and persistent inequalities, the strategy is grounded in national priorities including the three ‘left shifts’. It defines the transformation required to ensure that patients receive the right care, in the right place, at the right time. The strategy is organised around eight clinical chapters:

- Older People
- Long-term Conditions
- Women and Neonates
- Children and Young People
- Cancer
- Elective and Planned Care
- Diagnostics
- Urgent and Emergency Care

Delivery depends on strong enablers, including digital and data capabilities, modern estates to support integrated working, sustainable financial plans and a commitment to research, quality improvement and environmental sustainability. The Clinical Strategy is owned by our staff and partners. It reflects their expertise, insight and ambition to provide outstanding care and to work collaboratively across North Central London. It provides a strong and coherent framework for the changes we will deliver over the coming years, ensuring that Whittington Health continues to provide high-quality, equitable services for our communities — both now and into the future.

Our services

Whittington Health provides a broad and integrated range of acute and community services to populations across Islington and Haringey, as well as specialist services for North Central London. We operate from a major acute site and more than thirty community locations to deliver care close to home.

Our care model is rooted in expert generalist practice across women's health, paediatrics, long-term conditions and older people, supported by advanced tertiary services. Increasingly, care is delivered through ambulatory, prevention-focused and one-stop pathways that ensure smooth transitions from diagnosis to treatment.

Through Neighbourhood Health work, we collaborate with primary care, local authorities, mental health providers and the voluntary sector to design coordinated, preventative services that reduce inequalities. We also maintain a strong educational footprint, training medical students, nurses, allied health professionals and postgraduate doctors.

Our research portfolio continues to grow in partnership with the National Institute for Health and Care Research (NIHR) and the NIHR Regional Research Delivery Network (RRDN), ensuring patients benefit from innovation, evidence-based care and access to emerging treatments.

At the frontline, our staff remain central to shaping our future direction. Their expertise and insight have informed the Clinical Strategy, grounding our plans in real-world need. As delivery progresses, pathways and action plans will continue to be clinically and operationally led.

Together, our services form a coherent, integrated system of care rooted in partnership, prevention and clinically led transformation.

Strategic developments

UCLH and Whittington Health Collaboration

Whittington Health works closely with University College London Hospitals (UCLH), building on a long-standing partnership that includes the joint delivery of services such as UCLH@Home, a nurse-led virtual ward, and the joint tuberculosis MDT meeting, bringing together expertise across both organisations.

With oversight from the joint Chair, the collaboration continued in 2025/26 to focus on improving clinical outcomes, strengthening service resilience and ensuring the long-term sustainability of local services. Pathway changes introduced across urology, uro-oncology, ENT, rheumatology and maternity are now well embedded and continue to progress under shared clinical oversight. Regular joint governance forums support consistent alignment, robust quality oversight and the flexibility to respond to emerging needs, enabling the collaboration to evolve in line with the priorities of both organisations while maintaining high-quality, patient-centred care.

Start Well

In March 2025, the North Central London Integrated Care Board approved a major reconfiguration of maternity and neonatal services across the sector, consolidating care on four sites: Whittington Health, Barnet Hospital, North Middlesex University Hospital and UCLH. This decision, alongside over £67 million of capital investment, confirms Whittington Health's role as a key provider of maternity and neonatal care.

For Whittington Health, the programme brings significant improvements including two additional delivery suites, refurbished labour ward and postnatal spaces, ensuite bathrooms for all rooms, upgraded neonatal cots, and an improved entrance and waiting area, ensuring modern, family-centred facilities.

Following confirmation of our system leadership role, a senior programme director joined the Trust in December 2025. Early implementation planning has focused on maintaining service continuity and workforce stability through refining detailed demand and capacity modelling, developing activity dashboards, and aligning Trust-level planning with system-wide workstreams. This will ensure the programme moves forward safely and delivers better access, experience and outcomes for families.

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.

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 2025/26 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, earlier in the year, for 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.

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.

National context

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 Referral to Treatment (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 Accident & Emergency departments in England between April 2024 and March 2025.
- In 2024/25, 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.

Summary – Whittington Health

Whittington Health NHS Trust has delivered notable improvements across key operational areas, including emergency department (ED) performance, Cancer Services, RTT pathways, waiting list management, and community services. These improvements reflect sustained effort to stabilise performance, improve patient flow, and strengthen service oversight.

Despite this progress, significant challenges remain across these service areas, driven largely by ongoing capacity constraints, rising demand, workforce pressures, and

system-wide factors. Performance in some areas remains fragile, with waiting times and backlogs continuing to impact patient experience and operational resilience.

The Trust is actively progressing a range of actions to address these challenges, with a focus on increasing capacity, reducing waiting times, improving pathway productivity, and enhancing the quality and consistency of service delivery. This includes continued focus on recovery and transformation programmes, closer performance management, and collaboration with system partners to support sustainable improvement and improved outcomes for patients.

Our key performance highlights included the following:

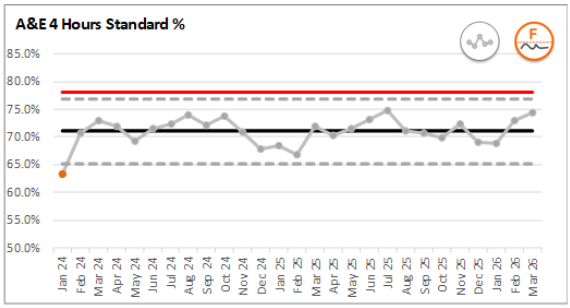
Emergency department

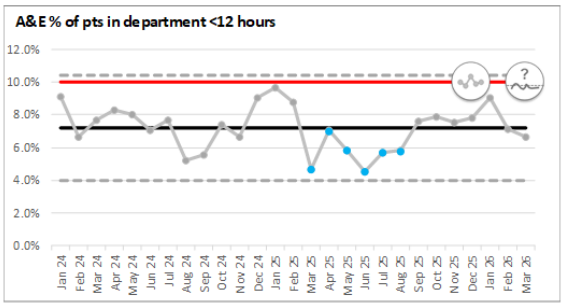
2025/26 was another busy year for ED services at Whittington Health as with a total of 107,769 patients attended the hospital's ED, reflecting sustained high demand.

Despite this pressure, performance remained resilient. Supported by the commitment of local staff and delivery of improvements aligned to the NHS urgent and emergency care recovery plan, 71.6% of patients spent less than four hours in the ED during 2025/26. Attendance volumes were marginally lower than the previous year, with 841 fewer patients compared to 108,610 attendances in 2024/25, although overall demand remained significant throughout the year.

Statistical process control

Whittington Health uses statistical process control charts to monitor, analyse, and review performance against key national targets over time. These charts enable the identification of trends, variation, and any emerging performance issues in a structured and evidence-based way. In the charts presented, the red line denotes the national target or expected performance standard. The black line represents the overall mean (average) performance across the reporting period, providing a baseline against which variation is assessed. The dotted lines indicate the upper control limit and lower control limits, which define the expected range of normal variation based on historical data. Performance falling within the control limits reflects typical ("common cause") variation, whereas data points outside these limits, or consistent patterns within them, may indicate "special cause" variation. This helps to highlight areas requiring further investigation or targeted intervention.

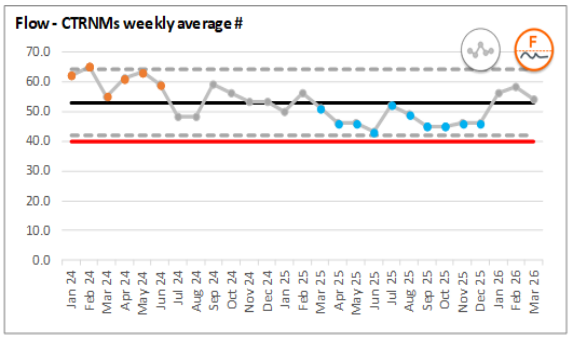


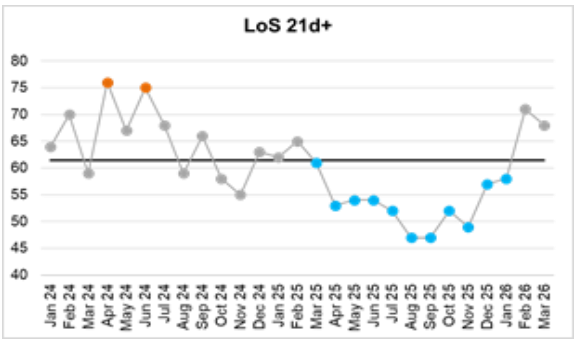


Performance against the four-hour ED standard averaged at 71.6% through 2025/26 an improvement of 0.7% from 2024/25. The Trust has delivered sustained improvement throughout the period.

Patients in the A&E greater than 12-hour saw an improvement during the first half of the financial year of 2025/26 following improvements made by the Trust's Flow Improvement Programme. The main contributory factors for this have been continued high numbers of medically optimised patients in hospital, discharge delays due to a lack of capacity in community and social care settings particularly during the winter months.

Patient flow

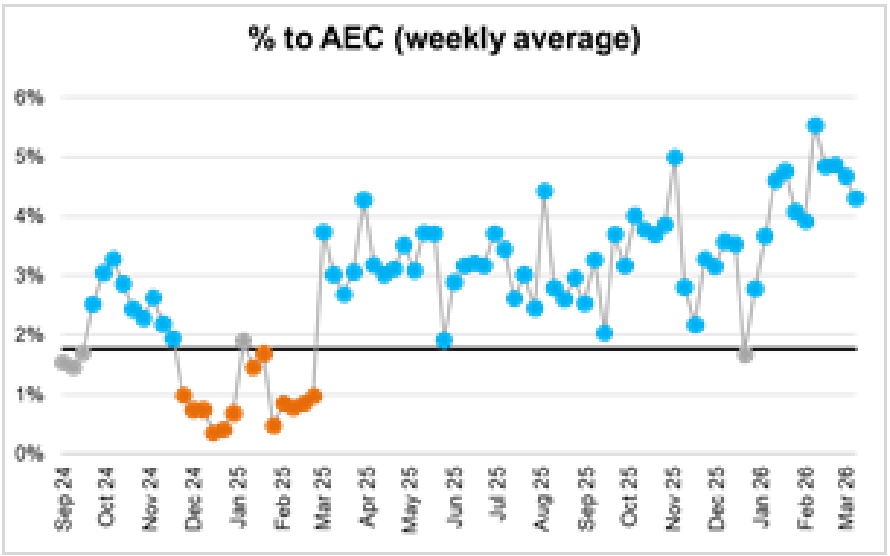




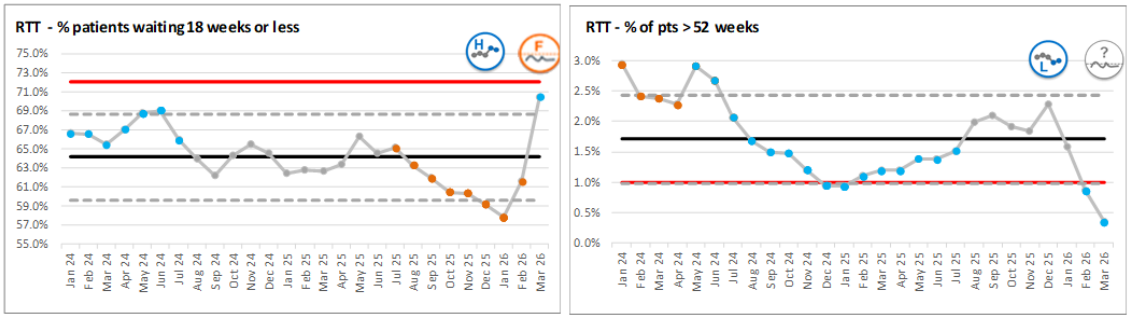
In 2025/26, Whittington Health continued to deliver its Flow Improvement Programme, resulting in a measurable reduction in the number of patients who do not meet the criteria to reside (CTR). The average number of non-CTR patients reduced to 49 in 2025/26, compared with an average of 55 in 2024/25, demonstrating progress in improving discharge pathways, inpatient flow and reducing long length in stay particularly in patients in hospital greater than 21 days.

While this improvement represents a positive trend, the number of patients not meeting CTR remains above the expected target and continues to place pressure on bed capacity and patient flow across the organisation. This indicates that, although interventions have been effective, further work is required to strengthen discharge processes, system coordination and community capacity to support timely onward care.

Reducing the cohort of non-CTR patients remains a key priority for 2026/27, with the Flow Improvement Programme continuing to focus on earlier discharge planning, enhanced multidisciplinary working, and closer collaboration with system partners to deliver sustained reductions and improved patient flow.



The proportion of patients streamed to ambulatory care has increased significantly during 2025/26, rising from an average of below 1.8% in 2024/25 to 3.9% in 2025/26. This represents a sustained improvement in front-door streaming and more effective utilisation of ambulatory pathways. Increased Ambulatory Care streaming has been a key contributor to improved ED performance, supporting patient flow and reducing pressure on core ED capacity. The impact of this improvement is now embedded and provides a clear operational benefit. Ambulatory care streaming will remain a core component of the urgent and emergency care model in 2026/27, with further scope to consolidate and optimise performance.



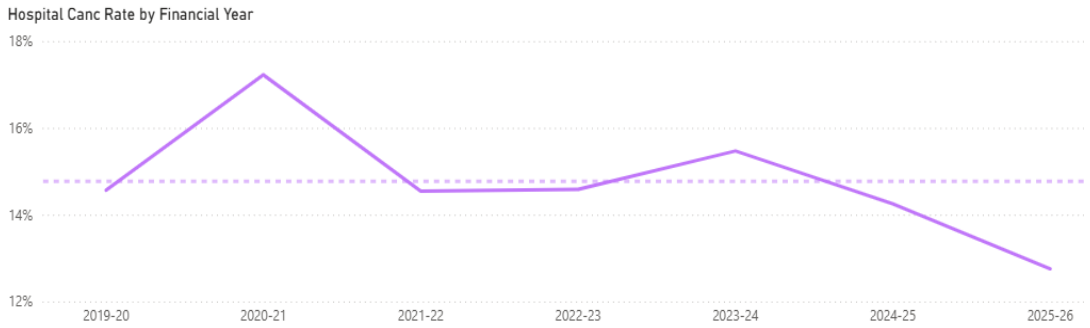
The Trust has not achieved the 92% RTT standard since before the pandemic. Performance during 2025/26 was variable and declined through the year, reaching a low point of 57.8% in January 2026. However, following implementation of the national Q4 Sprint initiative, performance improved significantly, with the Trust closing the year at 71.17%.

Overall, the Trust delivered an average RTT performance of 62.9% against the national standard. The improvement achieved by year-end reflects the combined impact of the Q4 Sprint and sustained operational focus throughout the year. Eighteen-week RTT performance improved by 11.99% compared with the December 2025 baseline, demonstrating strengthened pathway management and more effective utilisation of available capacity.

Progress was also made in controlling long waits. The proportion of 52-week waits reduced to 0.35% of the total RTT waiting list, remaining comfortably below the national threshold of 1% and meeting the required standard. No 65-week breaches were reported at year-end, providing additional assurance on waiting list oversight.

In parallel, the RTT waiting list reduced by 6,605 patients from a December 2025 baseline of 28,580 to 21,975 by the end of March 2026, supporting improved performance sustainability moving into 2026/27.

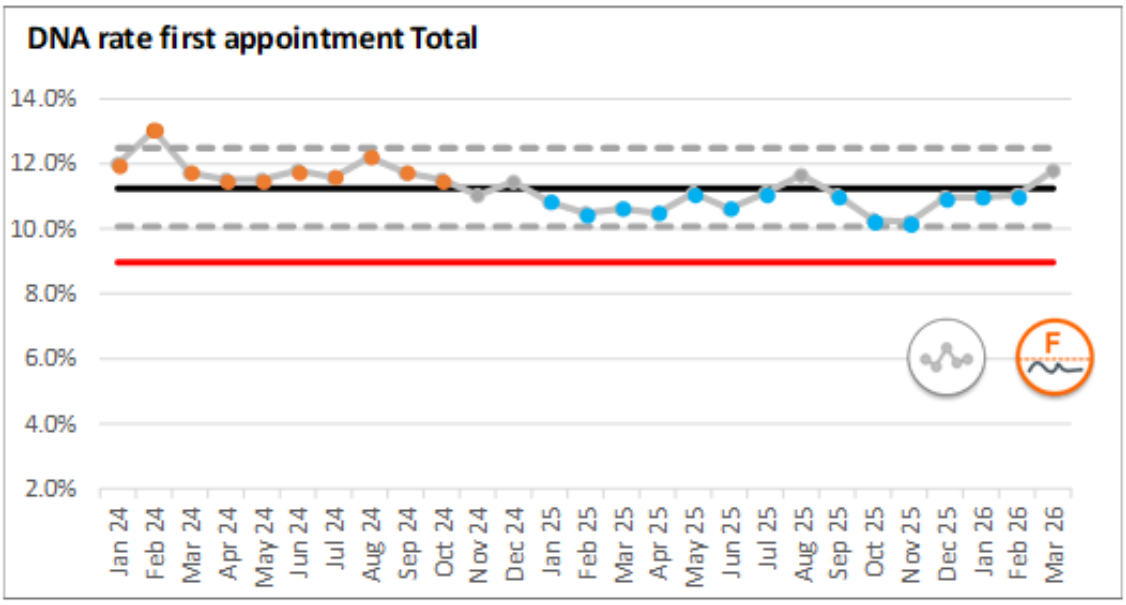
Improvement in outpatient hospital cancellations



The Trust's hospital cancellation rate measures the proportion of scheduled outpatient appointments that are cancelled rather than delivered within a defined period. During 2025/26, performance improved significantly, with the cancellation rate reducing to 12.75%, the lowest level achieved since before the Covid-19 pandemic. This has contributed to an improvement in operational reliability and patient experience.

This improvement reflects work to strengthen operational processes, improve clinic planning and architecture, and enhance patient communication to reduce avoidable cancellations. A strong focus has also been placed on improved data monitoring and tracking, alongside clearer accountability and enhanced training and competency development for staff.

These initiatives have contributed to more efficient use of clinical capacity and increased confidence in clinic delivery. Further refinement and embedding of these approaches will continue into the new financial year, supporting continued reduction in cancellations, improved patient experience, and more sustainable outpatient performance.



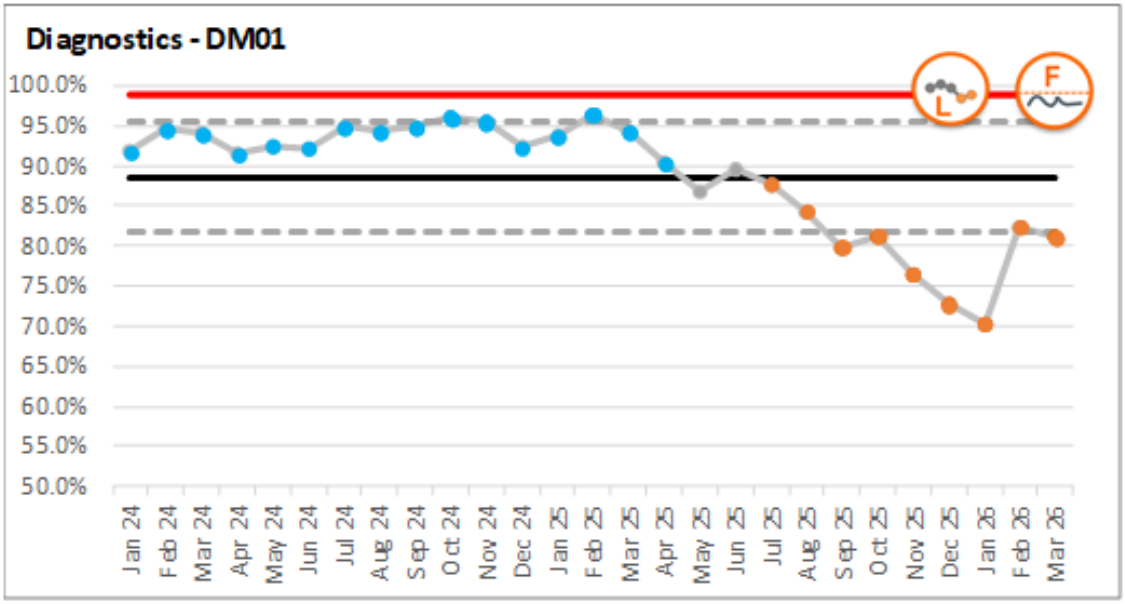
The rate of patients who did not attend (DNA) their first outpatient appointment reduced in 2025/26 to 10.9%, compared with 11.4% in 2024/25. This represents a

modest but positive year-on-year improvement, reflecting continued focus on patient communication and appointment management.

Despite this improvement, the Trust's DNA rate remains significantly higher than national outpatient DNA levels, which typically sit below 7% across England. This gap indicates persistent challenges in maximising clinic utilisation and ensuring patients can attend their first appointment as planned.

Reducing DNAs therefore remains a key operational priority. Work will continue in 2026/27 to strengthen reminder and cancellation processes, improve use of digital communications, support proactive patient engagement, and ensure opportunities to reallocate unused capacity at short notice. Sustained focus in this area will be critical to improving clinic efficiency, patient experience, and delivery against elective recovery objectives.

Diagnostics – DM01



Performance against the DM01 diagnostic standard, patients waiting less than six weeks for a diagnostic test, deteriorated during 2025/26, with average delivery of 81.9%, compared to 94.1% in 2024/25. Encouragingly, performance improved during the final two months of the year, reflecting the positive impact of additional ultrasound capacity. This increased diagnostic throughput and provided targeted support to the wider elective recovery programme.

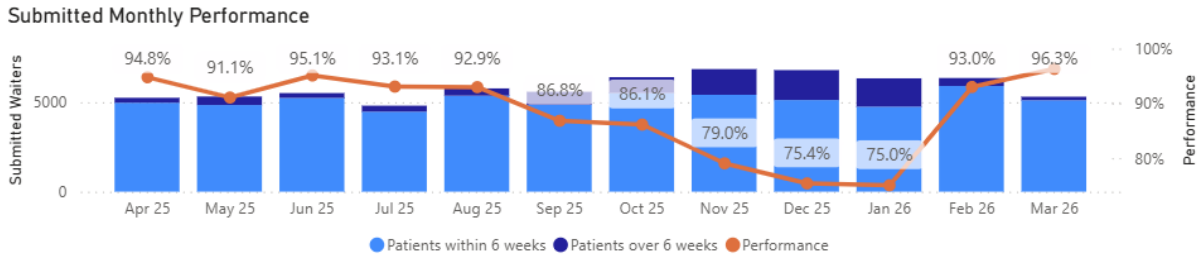
However, ongoing capacity constraints within audiology and neurophysiology continue to adversely affect overall delivery against the DM01 standard. These services remain a key operational risk, and further targeted mitigations will be required to stabilise performance and support sustained improvement in 2026/27.

Imaging performance

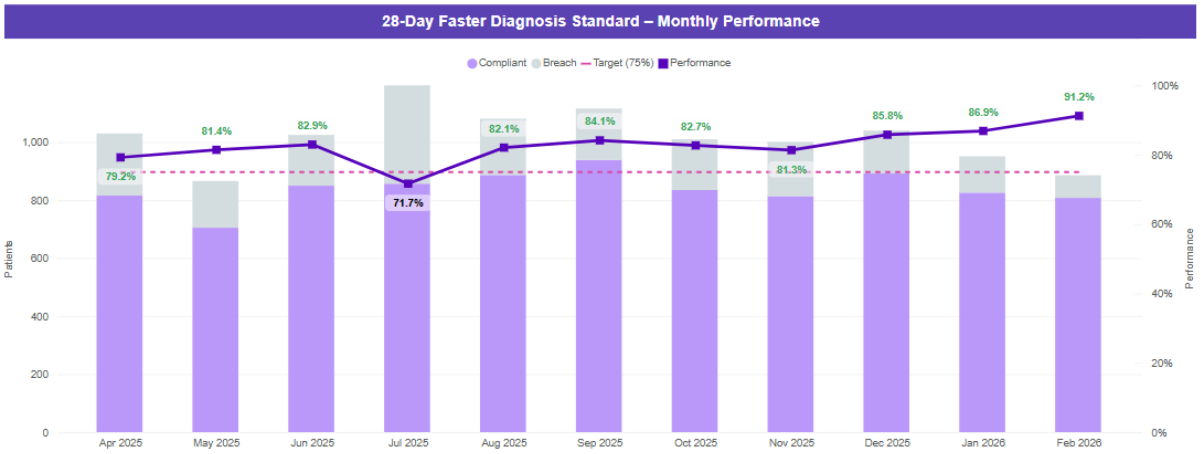
Imaging performance deteriorated significantly between September 2025 and January 2026, reaching a low point of 75%. This decline was primarily driven by capacity

constraints and a reduction in waiting list initiative activity during the period. Performance recovered strongly in the final two months of the year, reflecting the successful impact of additional ultrasound capacity introduced through the Q4 Sprint initiative. As a result, delivery improved to 93% in February and 96.3% in March 2026.

This recovery restored imaging performance to levels consistent with those achieved in 2024/25, when average delivery was 94.8%, providing assurance that targeted capacity interventions can effectively stabilise and sustain performance.



Cancer – faster diagnosis



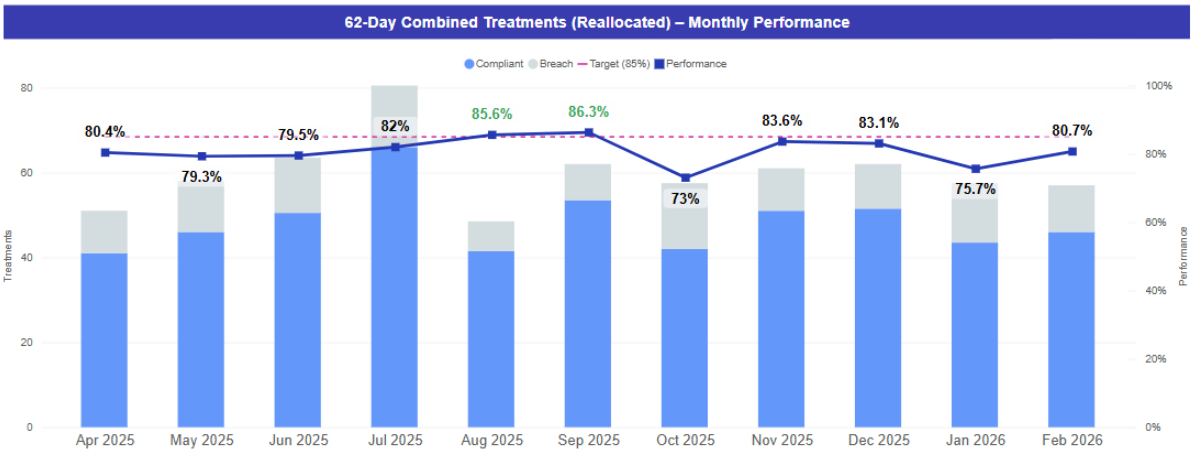
Performance against the cancer faster diagnosis standard (FDS) for 2025/26 averaged 82.4%, and exceeded the national standard of 75%. Performance peaked in February 2026, with delivery reaching 91.2%, placing the Trust as the number one performer for all NHS providers in England for that month.

All tumour groups demonstrated improvement over the course of the year. Targeted work continues, particularly within gynaecology and urology pathways, to support consistent achievement of the standard and further strengthen performance during the coming year. The national requirement for 2026/27 is to improve delivery of the 28-day FDS to 80% by March 2027.

Notably, FDS performance has improved significantly without a commensurate increase in capacity. While transformational pathway redesign has supported improvement in specific areas, the overall uplift has largely been driven by a strengthened focus on breach validation and data quality. This includes the accurate exclusion of non-FDS pathways, correct application of clock adjustments where patients did not attend first appointments (DNA), and improved capture of valid FDS clock stops.

Enhanced breach validation has also enabled clearer identification of high-impact constraint areas requiring focused intervention, such as turnaround times for specific diagnostic modalities or extended waits for particular outpatient clinics. This improved visibility supports targeted action with clinical services to mitigate sustained performance risks and maintain momentum.

Cancer – 62 days performance



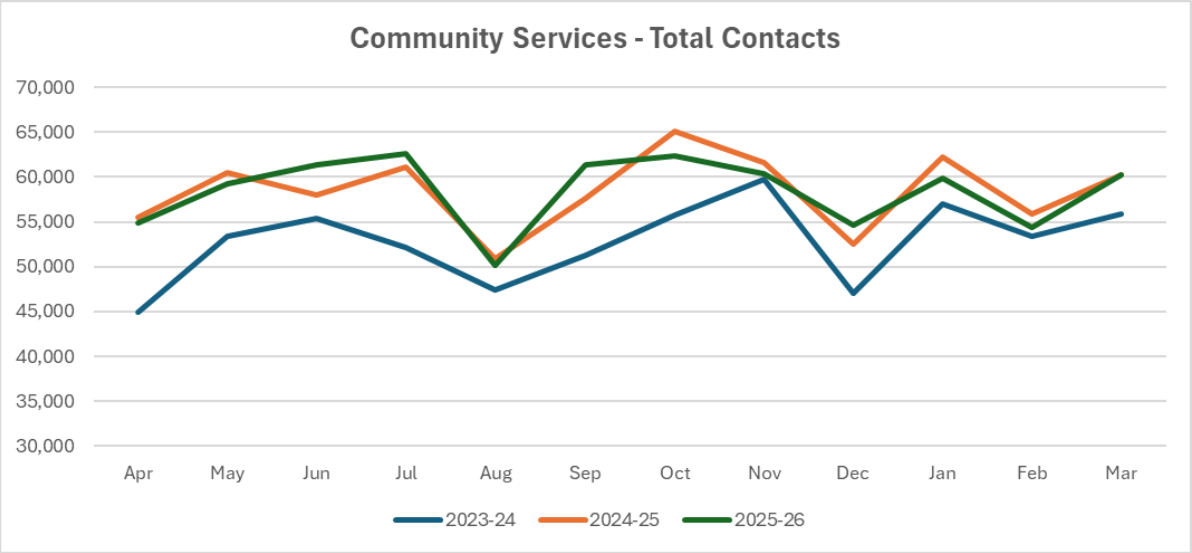
The constitutional national standard for 62-day cancer performance in 2025/26 was 85%, with a recovery standard of 80% set for the year. The Trust delivered an average combined 62-day performance of 80.9% during 2025/26, achieving the recovery standard. This represents a significant year-on-year improvement of 13 percentage points from 67.9% in 2024/25 and places the Trust in a strong position moving forward.

In line with national guidance, since October 2023 all providers have been required to report against a combined 62-day measure, including GP referrals, upgrades, screening and breast symptomatic pathways. Adoption of this combined approach has supported continued improvement in the Trust's compliance against the 62-day standard.

Ongoing pathway improvements will continue to be embedded across shared-care provider pathways, supporting further performance stability and sustained delivery against recovery and constitutional standards.

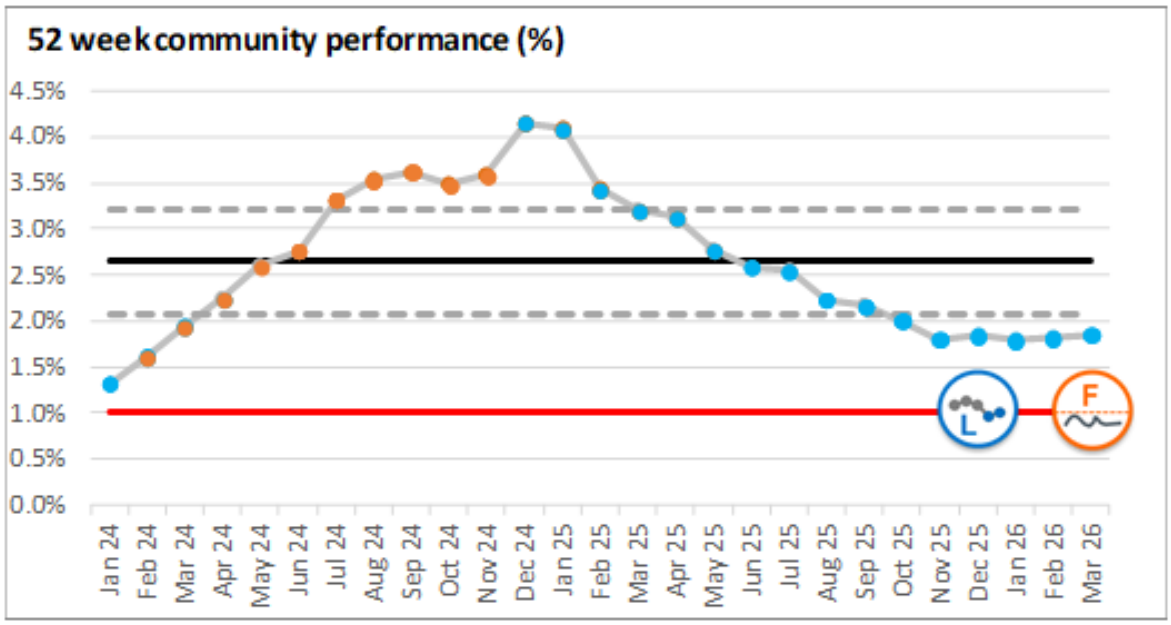
Community services

Total contacts



Finanical Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2023-24	44,901	53,401	55,356	52,195	47,411	51,303	55,792	59,695	47,065	57,019	53,432	55,827	633,397
2024-25	55,546	60,427	57,958	61,048	50,882	57,589	65,063	61,657	52,489	62,189	55,902	60,229	700,979
2025-26	54,905	59,211	61,376	62,603	50,191	61,343	62,374	60,355	54,647	59,905	54,417	60,283	701,610

Total community contacts rose to 701,610 in 2025/26, an increase of 631 from the previous year. Improvements were noted in a number of services, driven by enhanced clinics and changes in delivery models, however, staffing and capacity constraints continue to challenge services such as MSK, podiatry, community rehabilitation, and therapy services. The size of the waiting list over 52 weeks in the community continues to be dominated by long waiters in the Autism service.



Highlighted services to note are:

Podiatry
Direct access to imaging and antibiotic prescribing has been introduced, reducing reliance on GP appointments and enabling more timely clinical decision-making. In addition, biannual Homeless Outreach Podiatry clinics have been delivered across both boroughs, significantly improving access to foot care for underserved populations and addressing unmet need among people experiencing homelessness.

Community respiratory services
In-reach respiratory clinics have been established within community settings including Mulberry Junction, Better Lives Service and The Grove (Haringey). These clinics have improved engagement with lung health services for people experiencing homelessness and substance misuse by providing accessible diagnostics (including spirometry), supporting earlier diagnosis, and delivering continuity of care in trusted, non-traditional healthcare environments.

Musculoskeletal physiotherapy – digital transformation
A digital transformation programme has been implemented within musculoskeletal (MSK) physiotherapy, including the rollout of robotic process automation across administrative teams, targeting a 75% reduction in administrative workload. In parallel, the GetUBetter digital platform has been rolled out across primary care to support early self-management, reduce avoidable referrals, and moderate demand on MSK services.

MSK trailblazer pilot (Department of Work & Pensions-funded)
A successful three-month MSK trailblazer pilot was delivered in partnership with the Shaw Trust, and integrated physiotherapy with employment support for unemployed patients. The pilot achieved faster access to MSK care, reduced waiting list pressures, and improved patient-reported outcomes, while supporting individuals to remain in or return to work. Continuation funding has been secured for a further year, enabling expansion and consolidation of the model.

MSK community appointment days
Innovative, neighbourhood-based MSK community appointment days (CADs) have been delivered, bringing together MSK services, employment support and wider partner organisations through a single access point. Previously delivered in Haringey, the first Islington event was fully booked with 240 attendees. The model has demonstrated strong engagement and will continue to be rolled out across both boroughs.

East Haringey diabetes health inequalities programme
A co-production programme was delivered with African and Caribbean residents to better understand barriers to accessing diabetes care. Key insights identified included:

- Cultural barriers, with dietary advice not aligned to cultural practices
- Communication challenges, including complex language, inflexible systems and inconsistent messaging
- Knowledge gaps, with low awareness and limited culturally relevant information.

The findings are informing targeted, equity-focused service improvements aimed at reducing health inequalities and improving diabetes outcomes within the local community.

Islington community heart failure/ pharmacist pathway

A proactive, pharmacist-led pathway has been implemented to systematically review GP heart failure registers, improving early identification and ensuring patients are not lost to follow-up. The pathway introduces a clear triage model, enabling:

- Escalation of higher-risk patients to the Community Heart Failure Team
- Optimised management within primary care, supported by specialist advice

This approach strengthened the collaboration between GPs, pharmacists, community nursing teams and specialist services, reduces unwarranted variation, minimises unnecessary referrals, and improves timely escalation, continuity of care and overall system efficiency

Continuing healthcare

The Continuing Healthcare Team has delivered a rapid and sustained improvement in performance, with overall KPI achievement increasing from 23% in January 2026 to 70% by March 2026. This step-change has been driven by streamlined assessment processes, strengthened multidisciplinary team working, and a clear focus on prioritisation to reduce assessment backlogs and delays. The improvement provides increased assurance around timeliness, compliance and patient experience within the continuing healthcare pathway.

Occupational therapy

Children and young people's services in Islington were given additional funding to review and update the education, health and care plans for a cohort of 85 children in mainstream schools over a year. At the end of the project, all 85 reviews were completed and 68 children discharged. It is expected that the reduction in caseload numbers will facilitate the team to transform the service offer in the coming year.

The early language support for every child

This programme in Barnet was established in 2024 to improve early identification and support for children with speech, language and communication needs, the Trust through 2025/26 has seen first-hand the difference that empowering and working in partnership with education staff can make. By equipping staff with the skills to identify speech, language and communication needs early, and to deliver evidence-based interventions within their own settings, children can receive support immediately rather than waiting to be seen by specialists.

The impact from the first year of the early language support for every child (ELSEC) pilot in Barnet has been clear. Staff confidence in identifying speech, language and communication needs increased from 51% to 88%, and confidence in providing support rose from 45% to 88%. More than 3,400 children were screened through the pilot, with almost half initially identified as having additional needs. Following targeted support, that figure reduced to 27%.

Crucially, while referrals to specialist speech and language therapy services continue to rise overall, ELSEC-supported settings in Barnet saw referrals increase by just 3%, compared with a 19% increase in settings without the programme. This demonstrates how developing the Experts at Hand approach and aligning with ELSEC can upskill staff in settings, ensure quick and flexible access to advice when it is needed, and enable timely support for children.

Neurodevelopmental sprint

Islington child and adolescent mental health services (CAMHS) ran a focussed and intensive 2 weeks of neurodevelopmental assessments in February 2026. During the 2 weeks of the sprint the service focused on completing neurodevelopment assessments. Staff across CAMHS freed up time from their normal areas of work to support delivery of 280 assessments for children and young people. The service has very long waiting times for assessment and this was an innovative way to try and reduce waiting times. The outcomes from this sprint were, as follows:

- 170 children assessed during this process.
- 283 assessments completed for these children.
- Finalised outcomes on diagnosis rate being collated
- Priority list waiting times reduced to 0 months from 7-8 months, this means those with the highest level of need will be seen within the next available slot.
- Routine list waiting times reduced to three years, a reduction of three months from prior to the sprint.

Performance against national performance indicators

The tables below and overleaf detail Whittington Health's track record of performance over the last five years for key national performance indicators.

Table one: At-a-glance performance against national targets during the period 2021/2026

Safe

Safe – people are protected from abuse and avoidable harm	**2021/22**		**2022/2023**		**2023/2024**		**2024/2025**		**2025/2026**	
KPI description	**Target**	**Outcome**	**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	0	360
Incidence of Clostridium Difficile *	0	10	<16	20	<13	22	<13	20	<13	23
Actual falls	400	344	400	381	400	334	400	349	400	321
Non-Elective C-section rate (%)	0	22.90%	0	25.40%	0	27.90%	0	29.70%	0	25.30%
Medication errors causing serious harm	0	0	0	0	0	1	0	0	0	0
Incidence of MRSA *	0	0	0	2	0	2	0	6	0	0
Safety Incidents	N/A	25	N/A	12	N/A	12	N/A	10	N/A	11
VTE risk assessment (%)	>95%	80.40%	>95%	95.50%	>95%	95.10%	>95%	95.60%	>95%	95.50%
Mixed sex accommodation breaches *	0	34	0	109	0	102	0	129	0	143

Effective

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**		**2025/2026**	
KPI description	**Target**	**Outcome**	**Target**	**Outcome**	**Target**	**Outcome**	**Target**	**Outcome**	**Target**	**Outcome**
Breastfeeding initiated	>90%	91.60%	>90%	93.46%	>90%	92.50%	>90%	93.50%	>90%	92.10%
Smoking at delivery	<6%	4.06%	<6%	4.23%	<6%	3.80%	<6%	3.50%	<6%	

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		2025/2026	
										3.90%
Non-elective re-admissions within 30 days	<5.5%	4.92%	<5.5%	3.88%	<5.5%	3.85%	<5.5%	3.61%	<5.5%	3.63%
Mortality rate per 1000 admissions in-months	14.4	7.63	14.4	8.4	14.4	8.3	14.4	7.1	14.4	7.9
IAPT Moving to Recovery	>50%	51.89%	>50%	50.20%	>50%	47.80%	>50%	49.90%	>50%	49.70%
% seen within 2 hours of referral to district nursing night	>80%	97.37%	>80%	94.47%	>80%	92.70%	>80%	96.20%	>80%	95.50%
% seen within 48 hours of referral to district nursing night	>95%	95.48%	>95%	93.21%	>95%	91.40%	>95%	96.60%	>95%	94.10%
% of MSK patients with a significant improvement in function	>75%	89.79%	>75%	86.26%	>75%	79.20%	>75%	81.10%	>75%	94.90%
% of podiatry patients with significant improvement in pain	>75%	95.26%	>75%	86.68%	>75%	79.20%	>75%	92.70%	>75%	86.80%

Caring

Caring - Involving people in their care and treating them with compassion, kindness, dignity and respect	2021/22		2022/2023		2023/2024		2024/2025		2025/2026	
KPI description	Target	Outcome	Target	Outcome	Target	Outcome	Target	Outcome	Target	Outcome
Emergency department – FFT % positive	>90%	77.70%	>90%	76.00%	>90%	78.50%	>90%	80.90%	>90%	80.80%
Emergency department – FFT response rate	>15%	10.90%	>15%	11.50%	>15%	10.90%	>15%	8.20%	>15%	7.70%
Inpatients – FFT % positive	>90%	95.80%	>90%	93.50%	>90%	92.80%	>90%	93.60%	>90%	93.80%
Inpatients – FFT response rate	>25%	17.30%	>25%	19.30%	>25%	16.10%	>25%	19.00%	>25%	20.00%
Maternity - FFT % positive	>90%	98.50%	>90%	63.00%	>90%	97.80%	>90%	98.30%	>90%	98.50%
Maternity - FFT response rate	>15%	11.50%	>15%	14.80%	>15%	10.20%	>15%	21.60%	>15%	6.40%
Outpatients - FFT % positive	>90%	93.40%	>90%	90.30%	>90%	90.70%	>90%	90.70%	>90%	90.70%
Outpatients - FFT responses	40n0	591	400	1268	400	3934	400	3070	400	13461
Community - FFT % positive	>90%	97.70%	>90%	96.50%	>90%	95.70%	>90%	94.60%	>90%	93.00%
Community - FFT responses	1,500	5527	1,500	8,469	1,500	9,123	1,500	9734	1,500	19744
Trust Composite FFT - % recommend	>90%	88.78%	>90%	85.32%	>90%	89.58%	>90%	91.79%	>90%	
Staff FFT - % recommend	>70%	66.97	>70%	62.17%	>70%	63.68	>70%	67.52%	>70%	
Complaints responded to within 25 working days	>80%	59.90%	>80%	55.40%	>80%	53.90%	>80%	68.80%	>80%	65.70%

Responsive

Responsive - organising services so that they are tailored to people's needs	2021/22		2022/2023		2023/2024		2024/2025		2025/2026	
KPI description	**Target**	**Outcome**	**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%	>95%	71.60%
Median wait for treatment (minutes)	<60 mins	93	<60 mins	110	<60 mins	103	<60 mins	94	<60 mins	100
Ambulance handovers waiting more than 30 minutes	0	646	0	1175	0	905	0	1111	0	1533
Ambulance handovers waiting more than 60 minutes	0	283	0	566	0	196	0	88	0	88
12-hour trolley waits in A&E	0	83	0	2208	0	2940	0	3575	0	2889
Cancer – 31 days to first treatment	>96%	94.90%	>96%	89.90%	>96%	93.50%	>96%	94.50%	>96%	98.60%
Cancer – 62 days from referral to treatment	>85%	67.60%	>85%	47.70%	>85%	53.90%	>85%	57.60%	>85%	80.90%
Diagnostic waits (<6 weeks)	>99%	94.10%	>99%	85.89%	>99%	86.86%	>99%	94.12%	>99%	81.59%
Referral to treatment times waiting <18 weeks (%)	>92%	74.40%	>92%	67.80%	>92%	66.20%	>92%	64.90%	>92%	62.00%
Referral to treatment time over 52 weeks	0	384	0	607	0	500	0	301	0	

Activity

	Actual	Actual	Actual	% difference (2022/23 vs 2023/24)	Actual	% difference (2023/24 vs 2024/25)	Actual	% difference (2024/25 vs 2025/26)
Admissions	**2021/22**	**2022/23**	**2023/24**	**% Difference**	**2024/25**	**% Difference**	**2025/26**	**% Difference**
Non-Elective Admissions	15,333	12,624	12,525	-0.78%	14,423	15.2%	16,603	15.1%
Elective Admissions	1,379	2,178	2,554	17.26%	2,741	7.3%	2,687	-2.0%
Day Case	21,406	23,158	23,458	1.30%	26,145	11.5%	28,055	7.3%
ED attendances	107,703	106,462	103,891	-2.41%	108,610	4.5%	107,769	-0.8%
Face to Face Patient Contacts	**2021/22**	**2022/23**	**2023/24**	**% Difference**	**2024/25**	**% Difference**	**2025/26**	**% Difference**
At our hospital	444,423	475,465	500,799	5.33%	510,399	1.92%	511,785	0.3%
In the community	532,341	572,191	605,768	5.87%	653,734	7.92%	626,293	-4.2%
Total	**976,764**	**1,047,656**	**1,106,567**	5.62%	**1,164,133**	5.20%	1,138,078	5.20%
Community	**2021/22**	**2022/23**	**2023/24**	**% Difference**	**2024/25**	**% Difference**	**2025/26**	**% Difference**
Community Nursing Visits	236,495	221,726	226,714	2.25%	257,200	13.45%	254,990	-0.9%
Physio Appointment	31,755	63,535	69,276	9.04%	76,666	10.67%	79,198	3.3%
Health and School Nurse Visit	53,872	56,977	57,099	0.21%	59,702	4.56%	57,566	-3.6%
Dental Appointment	44,143	45,456	47,783	5.12%	50,315	5.30%	47,675	5.2%

Health equity

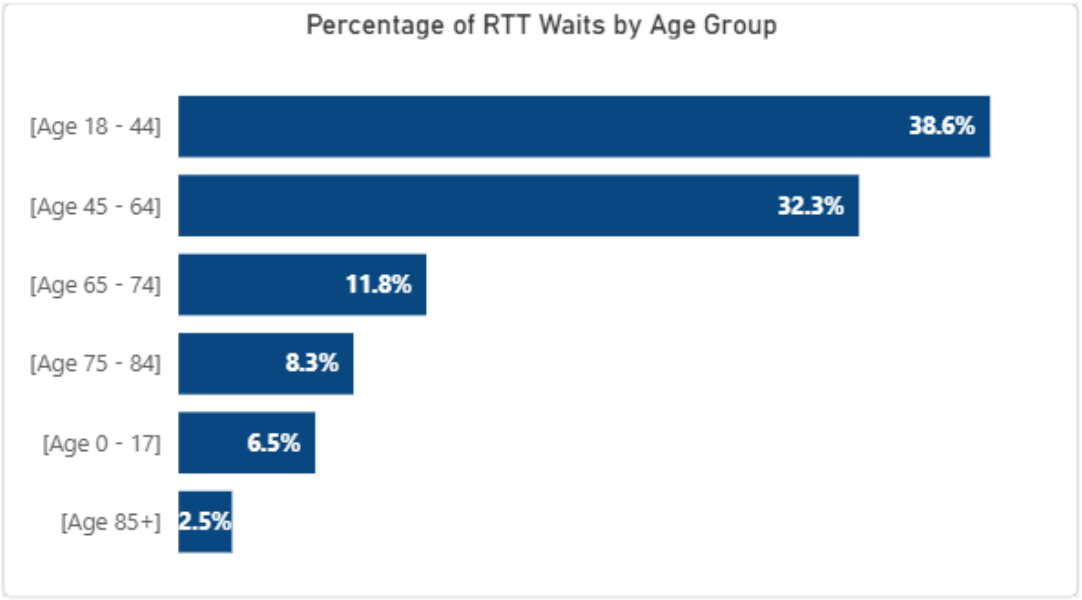
Waiting times

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.

1. Referral to treatment (RTT)

a. Percentage of RTT waits by age group

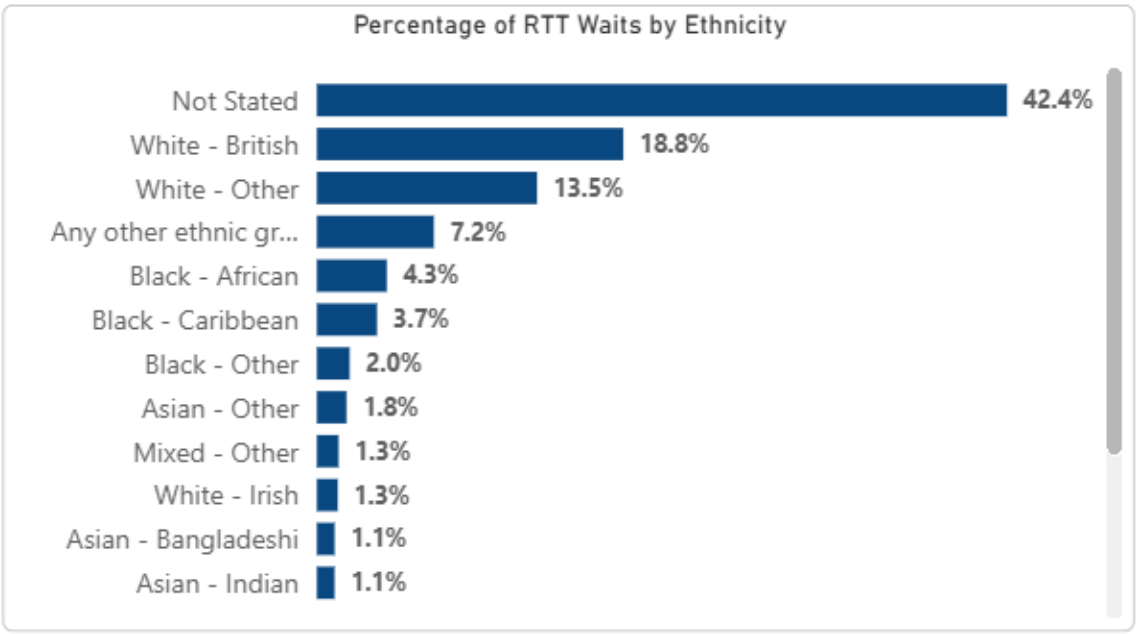
For 2025/26, the distribution of RTT waits remains broadly consistent with the previous year, with working-age adults continuing to account for the largest proportion of waits, though with some notable shifts. Patients aged 18 – 44 represent the largest share at 38.6%, increasing slightly from 37% in 2024/25, while the 45/64 age group remains the second largest but has fallen marginally from 33% to 32.3%. In contrast, older age groups show a modest reduction in their share of RTT waits, with those aged 65–74 decreasing from 13% to 11.8% and those aged 75–84 from 9% to 8.3%, suggesting some relative improvement for older patients. The proportion of waits for children and young people aged 0–17 has increased from 5% to 6.5%, while those aged 85 and over remain the smallest group and have reduced slightly from 3% to 2.5%. Overall, the 2025–26 data indicates a continued concentration of RTT waits among the adult working-age population, alongside a small shift away from older age groups compared with 2024–25.



b. Percentage of RTT waits by race (or ethnicity)

The 2025/26 race profile of RTT waits remains largely stable compared with 2024/25, though there are some modest improvements in data completeness and small shifts across groups. The largest category continues to be "Not Stated," accounting for 42.4% of RTT waits, which represents a reduction from 45% in the previous year and suggests a slight improvement in ethnicity recording. Among stated ethnicities, White British patients remain the single largest group at 18.8%, broadly unchanged from 19% in 2024/25, while the proportion of White Other patients has increased marginally from

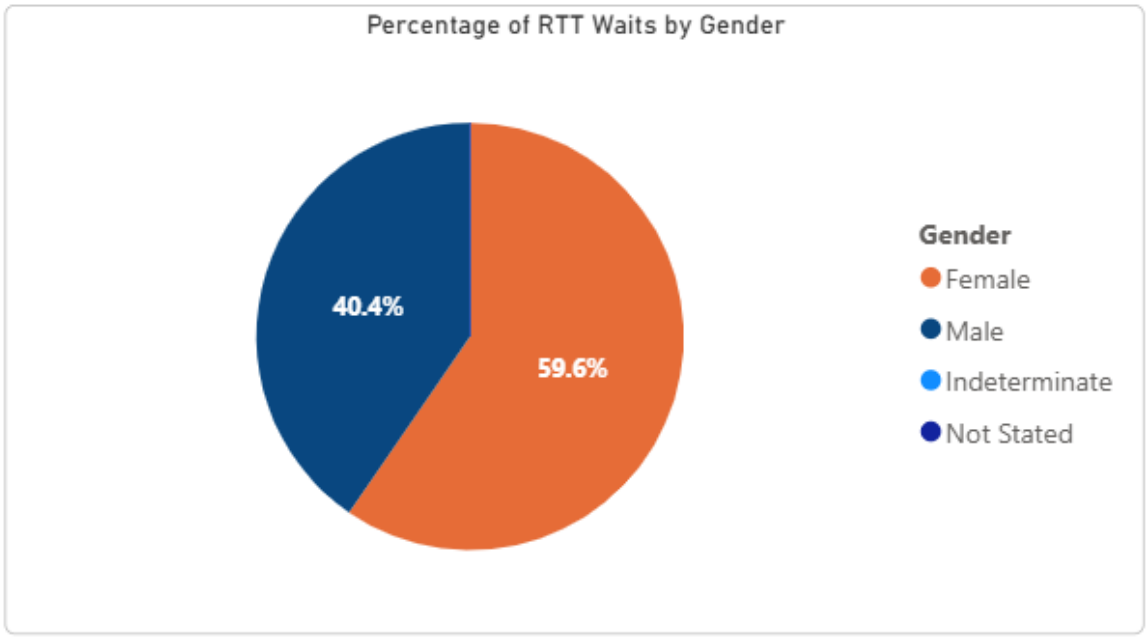
13% to 13.5%. All other ethnic group shows a small rise from 7% to 7.2%, indicating a stable representation of these populations. Black ethnic groups remain relatively consistent year on year, with Black African increasing slightly from 4% to 4.3% and Black Caribbean decreasing marginally from 4% to 3.7%. Smaller ethnic groups, including Asian Other, Mixed Other, White Irish, and specific Asian categories such as Indian and Bangladeshi, each continue to account for a low but steady proportion of RTT waits. Overall, the 2025/26 data highlights continuity in the ethnic distribution of RTT waits, alongside a welcome, though limited, reduction in unknown ethnicity compared with 2024/25.



c. Percentage of RTT waits by gender (or sex)

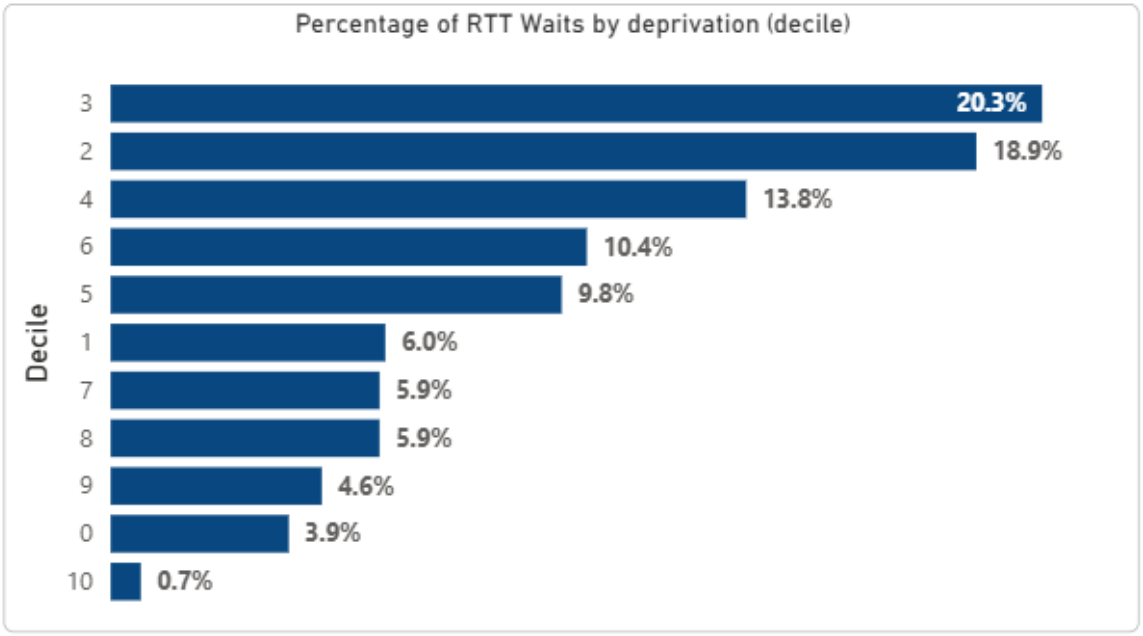
For 2025/26, the distribution of RTT waits (see the table overleaf) by gender remains very similar to the previous financial year, continuing to show a higher proportion of waits among females. Female patients accounted for 59.6% of RTT waits in 2025/26, compared with 56% in 2024–25, indicating a slight but continued increase year on year, while the proportion for males has reduced marginally from 44% to 40.4%. This suggests a gradual widening of the gender gap in RTT waits, with females consistently experiencing a larger share of waiting activity.

As in 2024/25, there are no recorded RTT waits within the “not stated” or “indeterminate” categories, demonstrating sustained completeness and quality of gender data reporting. Overall, the 2025/26 data reinforces the established pattern of higher RTT waits among females, with only minimal change in the overall gender balance compared with the previous year.



d. Percentage of RTT waits by deprivation (decile)

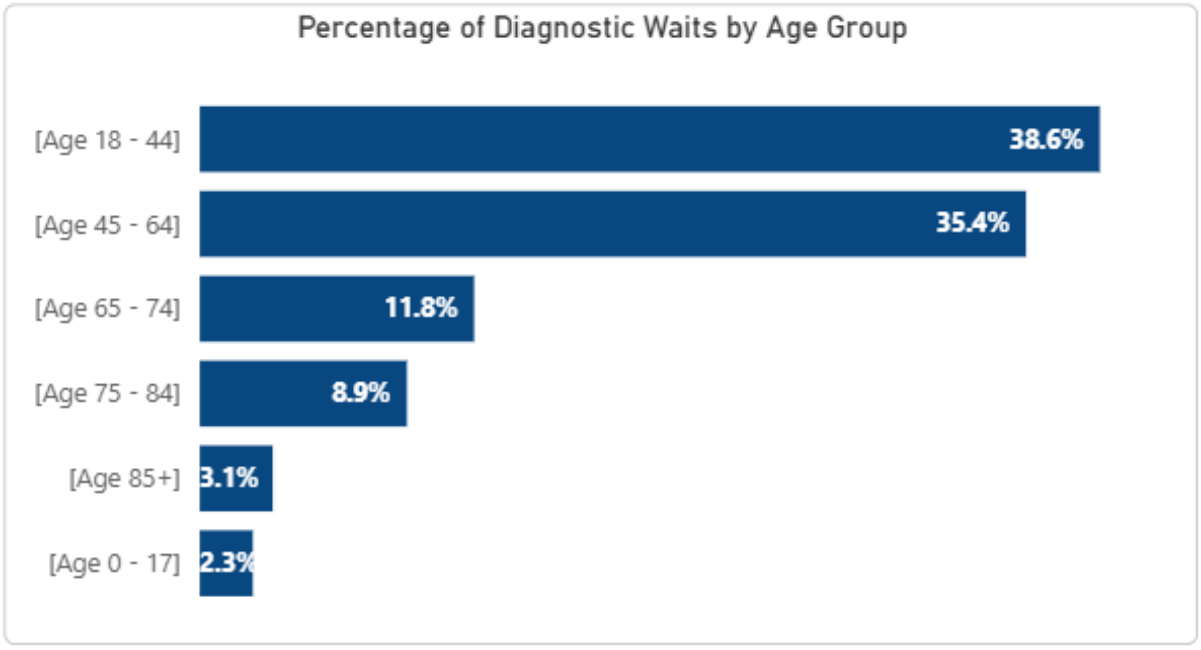
For 2025/26, the distribution of RTT waits by deprivation decile remains highly consistent with the previous financial year, continuing to show a concentration of waits among the more deprived populations. Deciles 2 and 3 account for the largest proportions of RTT waits at 18.9% and 20.3% respectively, both broadly in line with 2024/25 (18% and 20%), reinforcing the persistent relationship between higher deprivation and service demand or waiting activity. Mid-range deciles (4 to 6) remain relatively stable year on year, with only marginal changes, indicating a steady spread of RTT waits across these groups. In contrast, the least deprived deciles (9 and 10) continue to represent the smallest shares, with decile 10 decreasing slightly from 1% to 0.7%, and decile 9 falling from 5% to 4.6%, suggesting that RTT waits remain disproportionately lower among the most affluent populations. Overall, the 2025/26 data mirrors the pattern observed in 2024/25, highlighting enduring inequality in RTT waits by deprivation, with minimal year-on-year movement across deciles.



2. Diagnostic waits

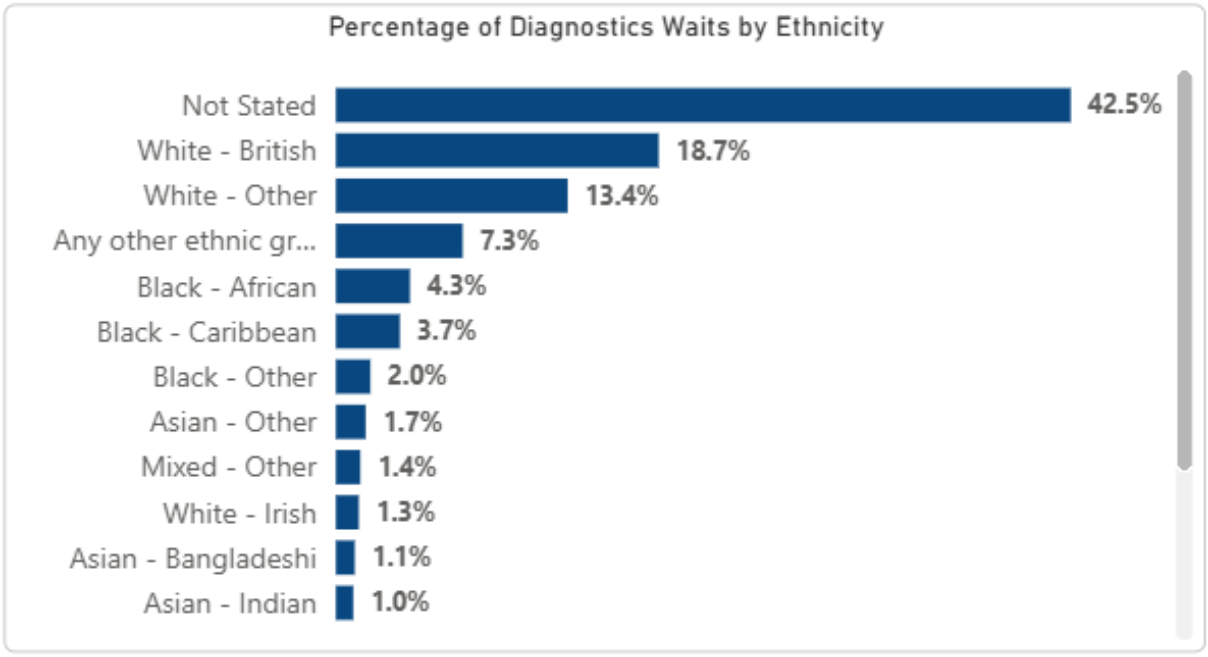
a. Percentage of diagnostic waits by age group

For 2025/26, diagnostic waits continue to be concentrated among working-age adults, with a more pronounced shift toward those aged 18–44 and 45–64 compared with 2024–25. The 18–44 age group now accounts for 38.6% of diagnostic waits, up from 35% in the previous year, while the 45–64 group has increased notably from 31% to 35.4%, together comprising nearly three-quarters of all diagnostic activity. In contrast, older age groups show a modest reduction in their share of waits, with those aged 65–74 decreasing from 13% to 11.8% and those aged 75–84 falling from 10% to 8.9%, suggesting some relative improvement or rebalancing for older patients. The youngest and oldest cohorts also represent a smaller proportion in 2025–26, with ages 0–17 falling from 6% to 2.3% and those aged 85+ declining slightly from 4% to 3.1%. Overall, compared with 2024/25, the 2025/26 data highlights increased diagnostic demand or waiting pressure among the core working-age population, alongside a reduced proportional impact on children and older adults.



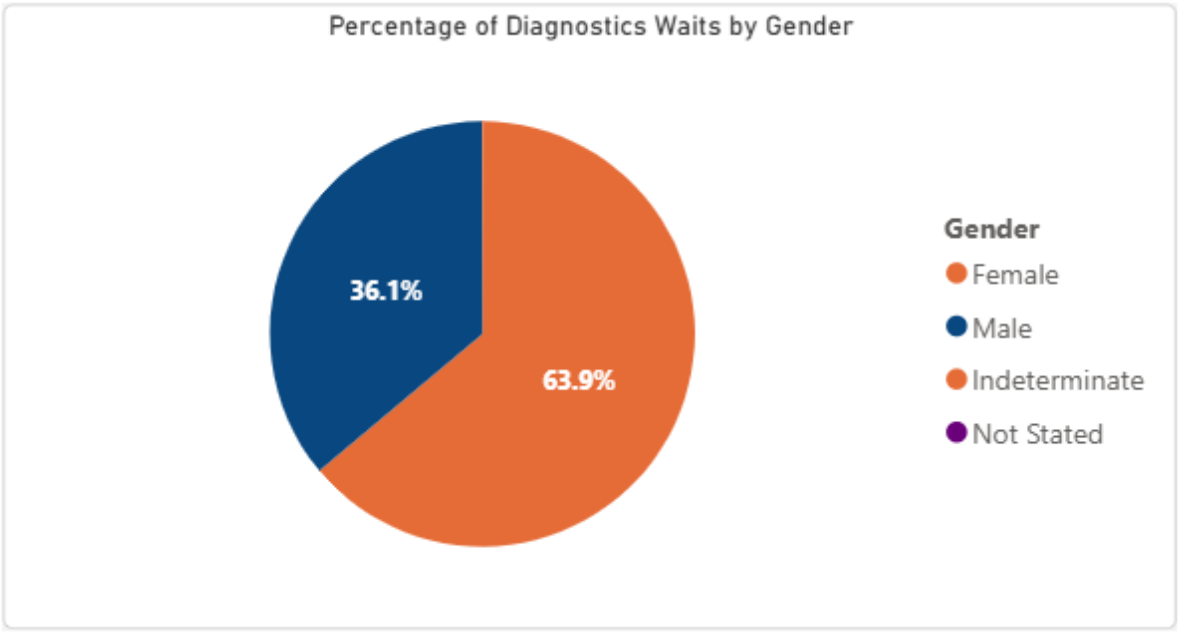
b. Percentage of diagnostic waits by ethnicity (or race)

In 2025/26, the overall ethnicity profile of diagnostic waiting lists remains largely consistent with 2024/25, with only small shifts across most groups. “Not stated” continues to account for the largest share at 42.5%, though this is an improvement from 45% the previous year, suggesting a gradual uplift in data completeness. Among recorded ethnicities, White British remains the largest group at 18.7% (slightly down from 19%), while White Other has increased marginally from 13% to 13.4%. The proportion for “Any other ethnic group” has also edged up from 7% to 7.3%. Black ethnic groups show minimal change overall, with Black African rising slightly from 4% to 4.3% and Black Caribbean decreasing from 4% to 3.7%. Other groups — including sian Other, Mixed Other, White Irish, and specific Asian categories such as Bangladeshi and Indian—continue to represent smaller but stable proportions. Overall, the 2025/6 data closely mirrors the previous year, with the most notable improvement being the modest reduction in unknown ethnicity, although it still represents a significant share of the dataset. The table is shown overleaf.



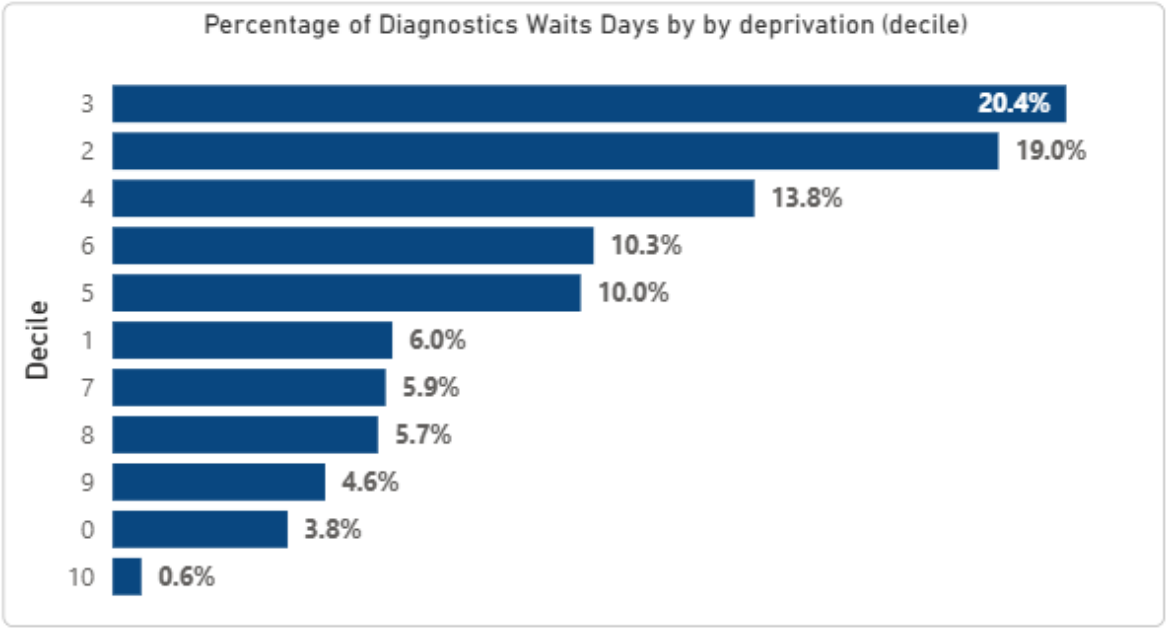
c. Percentage of diagnostic waits by gender (or sex)

The 2025/26 information shows a very clear and consistent pattern in the gender split of diagnostic waiting lists, with little change from the previous year. Females continue to account for the majority of waits at 63.9%, while males make up 36.1%, almost identical to the 64% and 36% split seen in 2024/25. This stability suggests that the underlying drivers of demand by gender have remained largely unchanged year on year. Unlike ethnicity data, there are no notable gaps in recording, with “not stated” and “indeterminate” categories effectively absent, indicating strong data completeness. Overall, the picture is one of continuity rather than change, with a persistent skew towards female patients in diagnostic waiting activity.



d. Percentage of diagnostic waits by deprivation

The distribution of diagnostic waits by deprivation decile remains closely aligned with the pattern observed in 2024/25, continuing to demonstrate a clear socioeconomic gradient. The highest proportion of diagnostic waits remains concentrated in the more deprived areas, with deciles 2 and 3 accounting for 19.0% and 20.4% respectively, both marginally higher than the previous year (18% and 20%), reinforcing the persistent association between deprivation and diagnostic demand or waiting impact. Mid-range deciles (4 to 6) show minimal year-on-year movement, indicating a stable distribution of waits across these populations. In contrast, the least deprived deciles continue to account for the smallest share of diagnostic waits, with decile 10 decreasing further from 1% in 2024/25 to 0.6% in 2025–26, and decile 9 falling from 5% to 4.6%. Overall, the 2025/26 data mirrors the previous year's profile, highlighting enduring inequalities in diagnostic waiting patterns, with waits remaining disproportionately higher among more deprived communities and little evidence of significant redistribution across deprivation deciles.

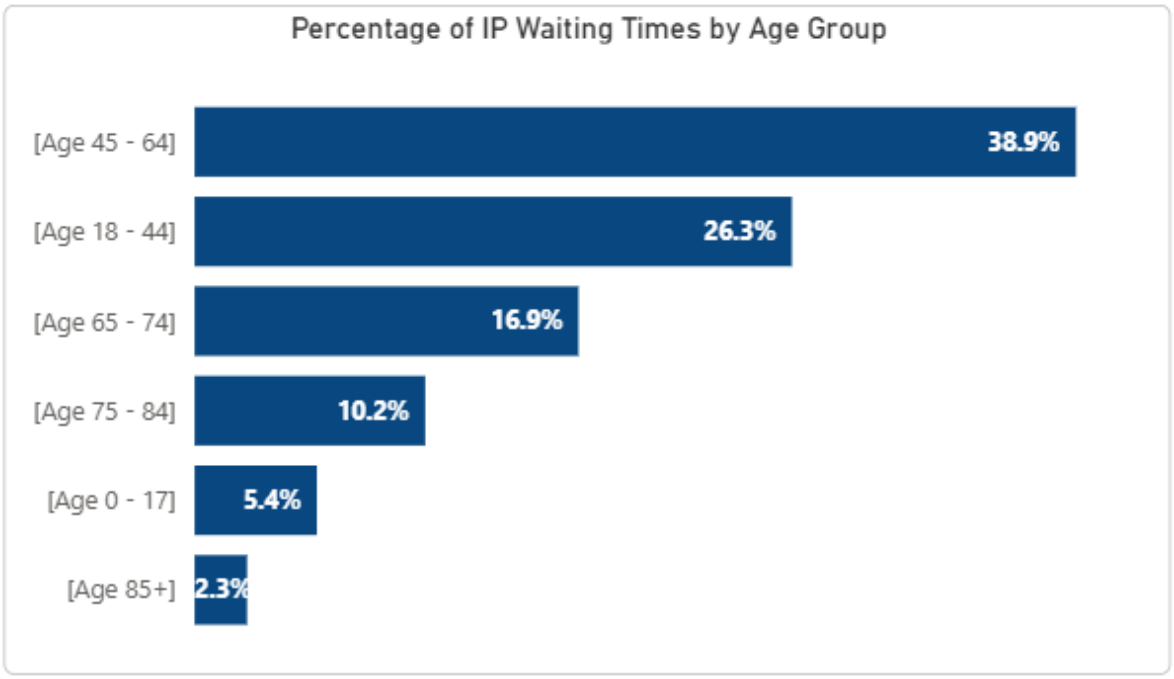


3. Inpatient waiting times

a. Percentage of inpatient waits by age group

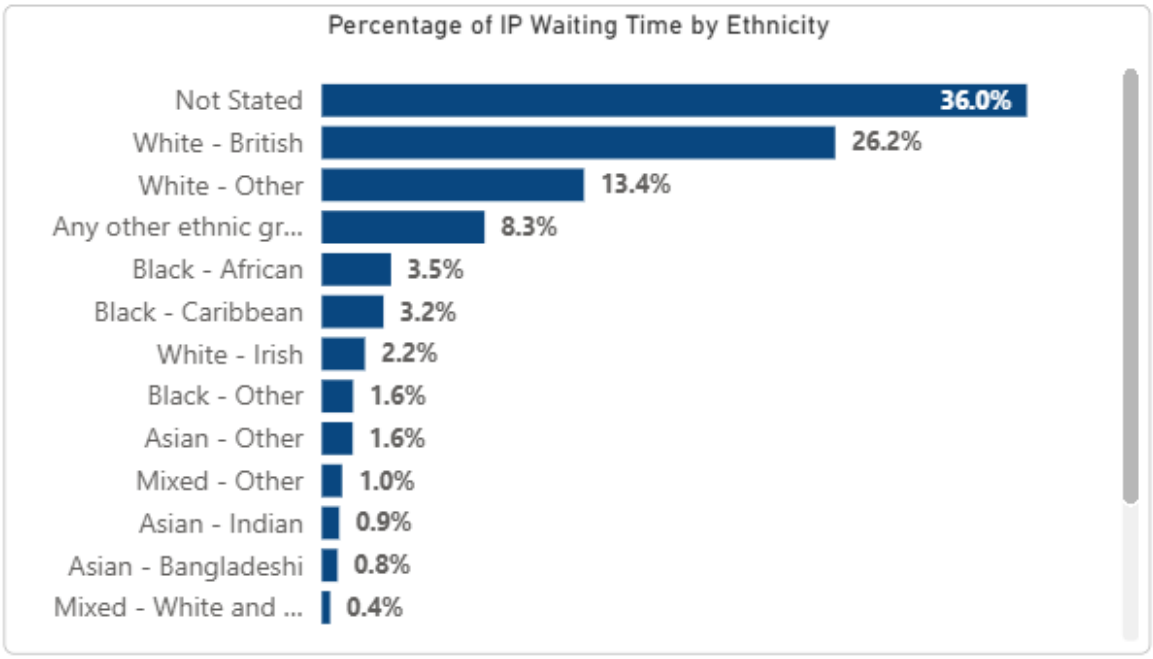
Inpatient (IP) waiting times by age group show a very similar profile to 2024/25, with waiting activity continuing to be most heavily concentrated among middle-aged adults. Patients aged 45 – 64 remain the largest group, accounting for 38.9% of IP waiting time, slightly down from 41% in 2024/25, suggesting a modest rebalancing rather than a fundamental shift. The 18 – 44 age group remains stable at 26.3%, broadly unchanged from 26% in the previous year, reinforcing the sustained impact of working-age adults on inpatient demand. Older age groups show small increases, with those aged 65 – 74 rising from 16% to 16.9% and those aged 75 – 84 increased from 9% to 10.2%, indicating a gradual upward pressure from an ageing population. In contrast, children aged 0 – 17 account for a slightly smaller share (5.4% vs 6%), while the 85+ group remains the smallest, increasing marginally from 2% to 2.3%. Overall, the 2025/26 data closely mirrors the picture in 2024/25, highlighting continued

pressure on inpatient services driven primarily by adults aged 18 – 64, alongside subtle increases among older cohorts.



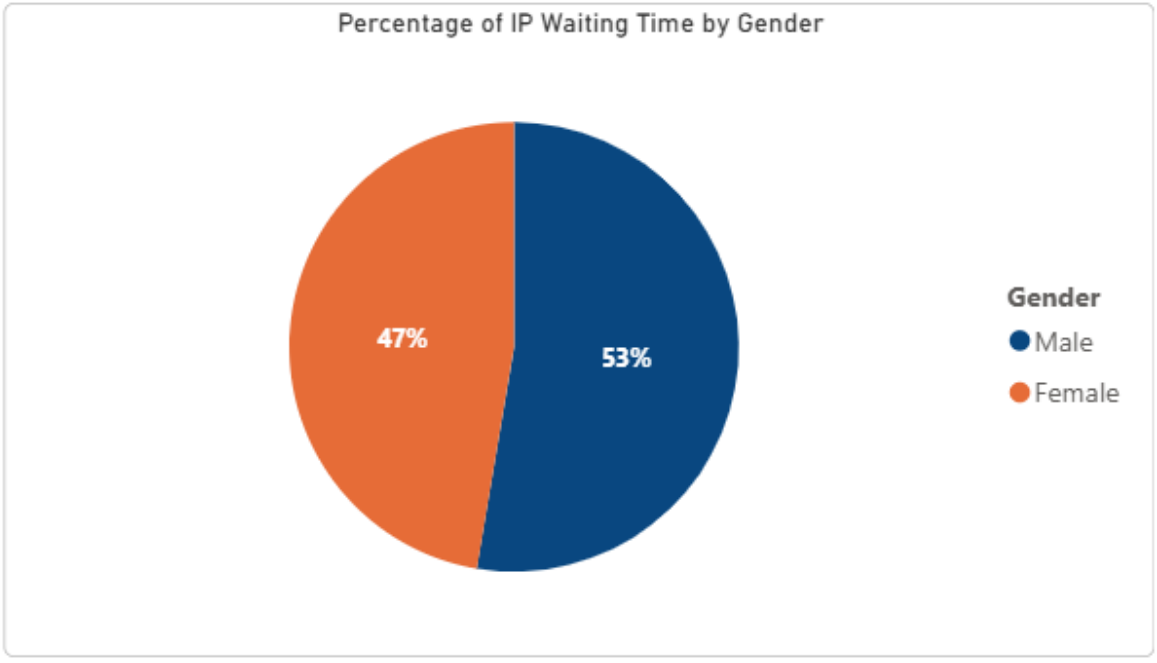
b. Percentage of inpatient waits by ethnicity (or race)

The ethnicity profile of inpatient waiting time remains broadly consistent with 2024–25, with only small shifts across most groups and a continued reliance on incomplete ethnicity data. The largest category remains “not stated,” accounting for 36.0% of total IP waiting time, down from 38% in the previous year, indicating a modest improvement in ethnicity recording but still representing over a third of activity. White British patients continue to comprise the largest recorded ethnic group at 26.2%, broadly stable compared with 26% in 2024 – 25, while White Other has increased slightly from 12% to 13.4%. “Any other ethnic group” has also risen marginally from 8% to 8.3%, suggesting steady representation. Black ethnic groups show small increases overall, with Black African rising from 3% to 3.5% and Black Caribbean from 3% to 3.2%, while smaller groups — including White Irish, Asian Other, and mixed ethnicity categories — remained low and relatively stable. Overall, the 2025/26 data closely mirrors the previous year, showing continuity in the ethnic distribution of inpatient waiting time alongside a gradual, though limited, improvement in data completeness.



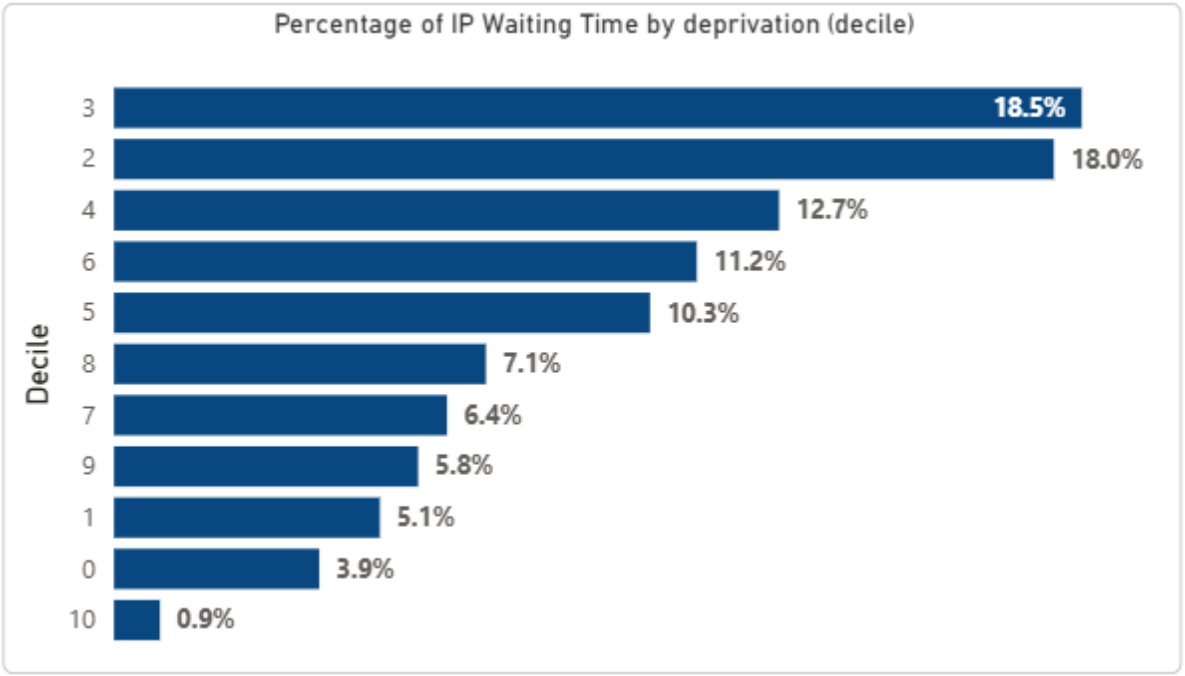
c. Percentage of inpatient waits by gender (or sex)

The distribution of IP waiting time by gender remains unchanged compared with 2024/25, indicating a stable and consistent pattern year on year. Males account for 53% of total IP waiting time, while females account for 47%, mirroring the exact split observed in the previous financial year. This stability suggests that there has been no material shift in relative inpatient demand, access, or waiting experience between genders over the two reporting periods. The absence of variation also indicates consistent data quality and recording practices, with inpatient pressures remaining evenly distributed in broadly the same proportions across both genders. Overall, the 2025/26 data reinforces a steady gender profile for inpatient waiting times, with no evidence of widening or narrowing disparity compared with 2024/25.



d. Percentage of inpatient waits by deprivation (decile)

As seen before, the distribution of IP waiting time by deprivation decile remains closely aligned with the pattern seen in 2024/25, continuing to demonstrate a clear concentration of waiting time among more deprived populations. Deciles 2 and 3 together accounts for the largest share at 18.0% and 18.5% respectively, broadly reflecting the previous year when these deciles represented 19% and 18%, and reinforcing the persistent relationship between deprivation and inpatient pressure. Mid-range deciles (4 to 6) show only marginal change, with decile 4 remaining stable at around 12.7% – 13% and deciles 5 and 6 together accounting for just over one fifth of waiting time, indicating a consistent spread across these groups. In contrast, the least deprived deciles continue to represent the smallest proportions, with decile 10 decreasing notably from 2% in 2024/25 to 0.9% in 2025/26, and decile 9 falling slightly from 6% to 5.8%. The 2025/26 data mirrors the previous year's profile, highlighting enduring inequalities in inpatient waiting time, with demand and prolonged waits remaining disproportionately concentrated among residents of more deprived areas and little evidence of meaningful redistribution across deprivation deciles.

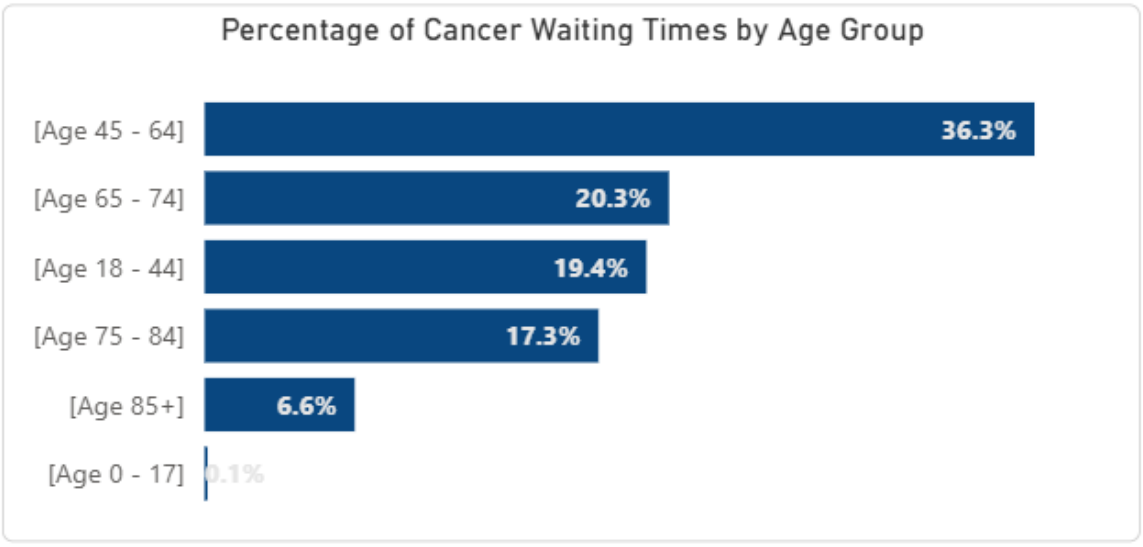


4. Cancer waiting times

a. Percentage of cancer waiting times by age group

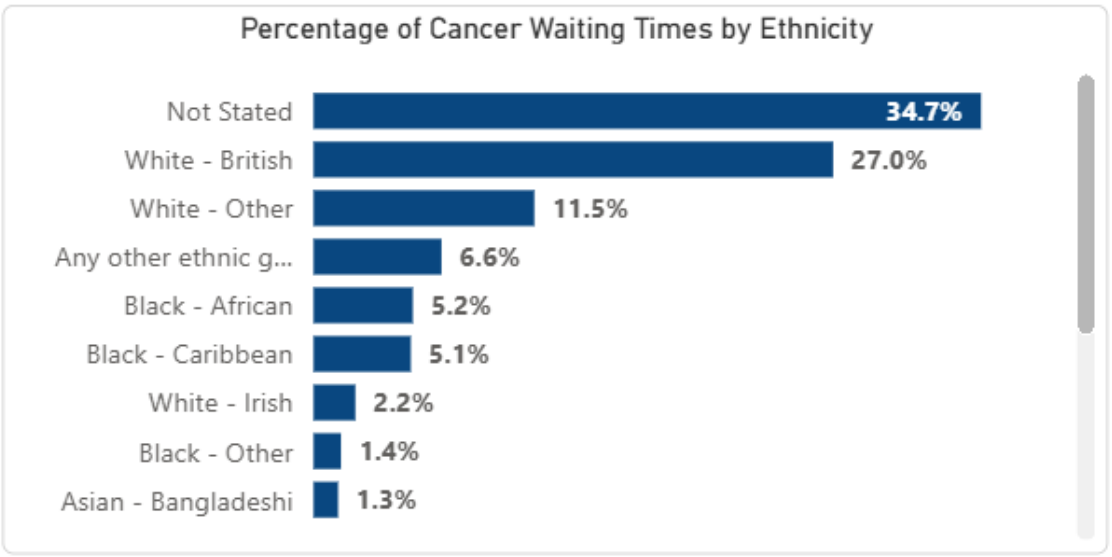
The age distribution of cancer waiting times shows strong continuity with the previous financial year 2024/25, with demand continuing to be centred on middle-aged and older adults rather than younger populations. The largest contribution still comes from those aged 45 – 64, whose share has edged up to 36.3% from 35%, underlining their ongoing prominence within cancer pathways. The balance between adjacent adult age groups remains broadly steady, although the proportion of waits attributable to 18 – 44-year-olds reduced slightly to 19.4%, while the 65 – 74 group dipped marginally to 20.3%. In contrast, the oldest patients account for a growing share of waiting time, with both the 75 – 84 and 85+ groups increasing year on year, reflecting gradually rising pressure linked to an ageing population. As in the previous year, children and

young people make up a negligible proportion of cancer waiting time. Overall, the 2025–26 profile reinforces a stable, age-related pattern in cancer waits, with only subtle shifts occurring within an otherwise consistent distribution.



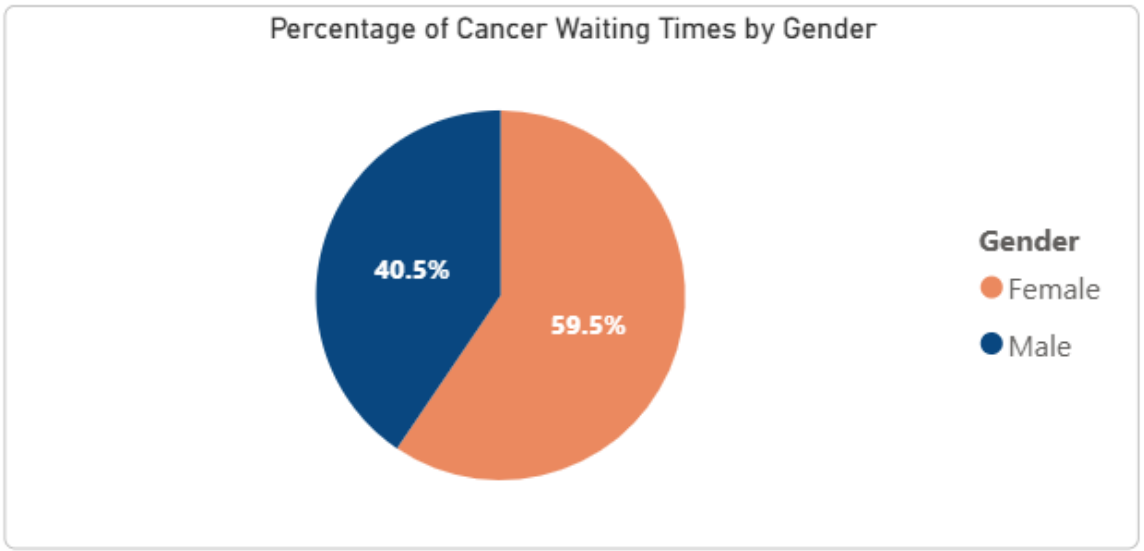
b. Percentage of cancer waiting times by ethnicity (or race)

In 2025–26, the ethnic profile of cancer waiting times shows a familiar structure to the previous year, though with a few subtle shifts worth noting. Cases where ethnicity is not recorded continue to represent the largest segment, rising slightly to 34.7% from 33% in 2024–25, highlighting an ongoing limitation in data completeness. Among patients with stated ethnicity, White British patients remain the most prominent group, accounting for 27.0% of total waiting time, marginally lower than the 28% seen last year, while the proportion attributed to White Other has fallen more noticeably from 14% to 11.5%. Representation within Black ethnic groups has increased overall, with both Black African and Black Caribbean categories rising to just over 5% each, suggesting a modest rebalancing compared with 2024–25. Other ethnic groups, including “Any other ethnic group” and smaller Asian categories, remain a comparatively small but stable component of the overall picture. Taken together, the 2025–26 data reflects broad continuity in ethnic distribution alongside incremental changes within specific groups, set against a persistent challenge of incomplete ethnicity recording in cancer pathways.



c. Percentage of cancer waiting times by gender (or sex)

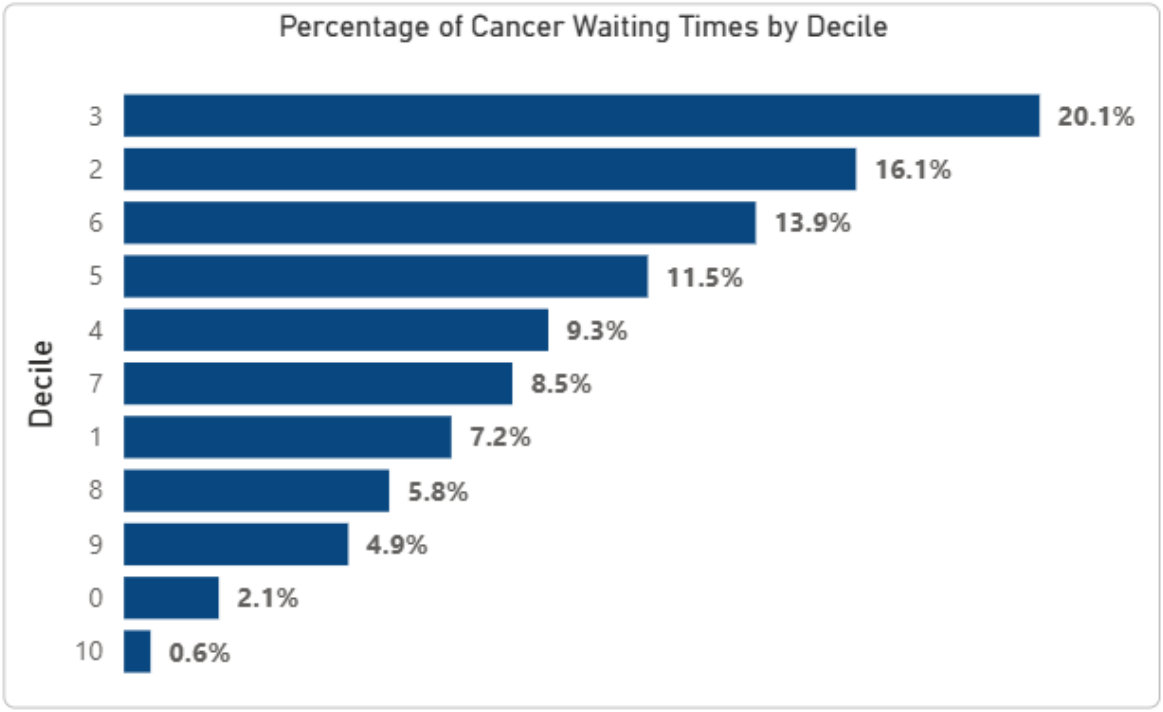
In 2025/26, cancer waiting time by gender shows a clear strengthening of the existing female predominance rather than a shift in balance. Females now account for 59.5% of total cancer waiting time, up from 56% in 2024/25, while the male share has fallen from 44% to 40.5%. This change represents a further widening of the gender gap rather than year-to-year stability, suggesting that cancer pathway pressures are becoming increasingly concentrated among female patients. The scale of the increase indicates more than minor fluctuation and may reflect changes in referral volumes, treatment duration, or pathway complexity. Overall, the 2025/26 data reinforces and intensifies the pattern observed in the previous year, with cancer waiting time continuing—and increasingly—tilted toward females.



d. Percentage of cancer waiting times by deprivation (decile)

In 2025/26, cancer waiting time continues to be unevenly distributed across deprivation deciles, with the largest share remaining concentrated in more deprived communities, but with some noticeable reshaping compared with 2024/25. Decile 3 has emerged as the single largest contributor, rising from 19% to 20.1%, while decile

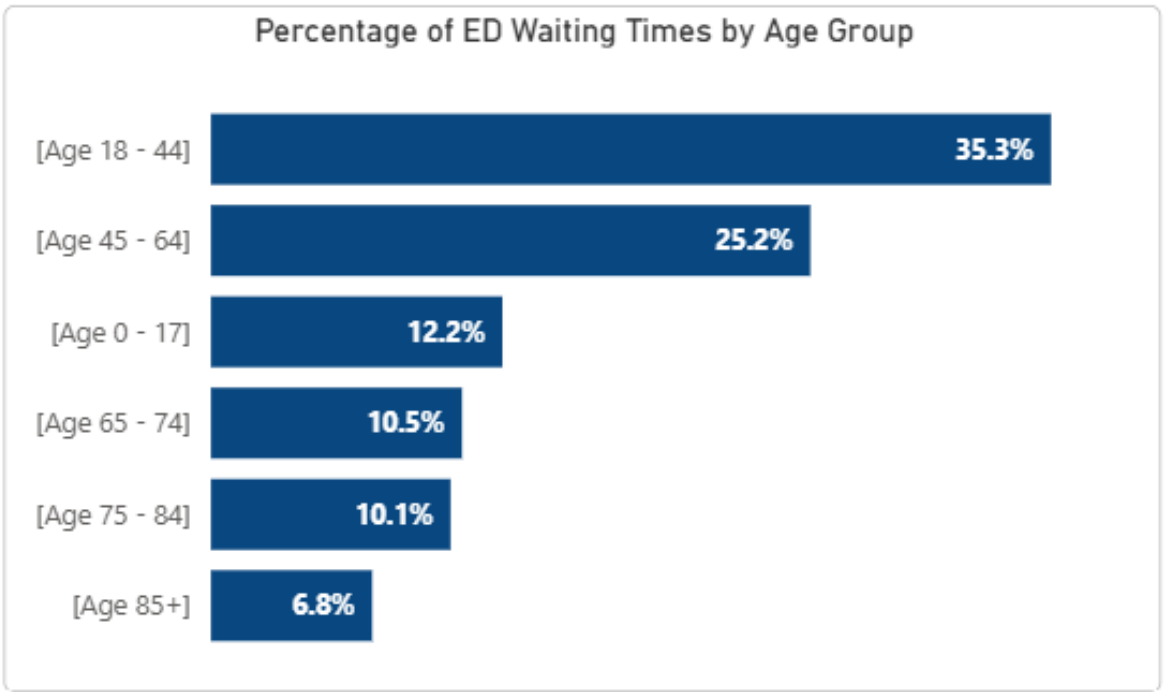
2 remains consistently high at just over 16%, underlining the sustained burden of cancer waits in these areas. There has been a re-ordering within the mid-range deciles, with decile 6 increasing to 13.9% and overtaking decile 4, which has dropped more sharply from 13% to 9.3%, suggesting shifts in where waiting pressures are being experienced. The least deprived deciles continue to account for a very small proportion of waiting time, with decile 10 falling further to just 0.6%, reinforcing the stark gradient between the most and least deprived populations. While the general pattern seen in 2024/25 persists, the 2025/26 data points to a subtle redistribution within deprivation groups rather than complete stability, with cancer waiting pressures remaining disproportionately focused in areas of higher deprivation.



5. Emergency department waiting times

a. Percentage of emergency department waiting times by age group

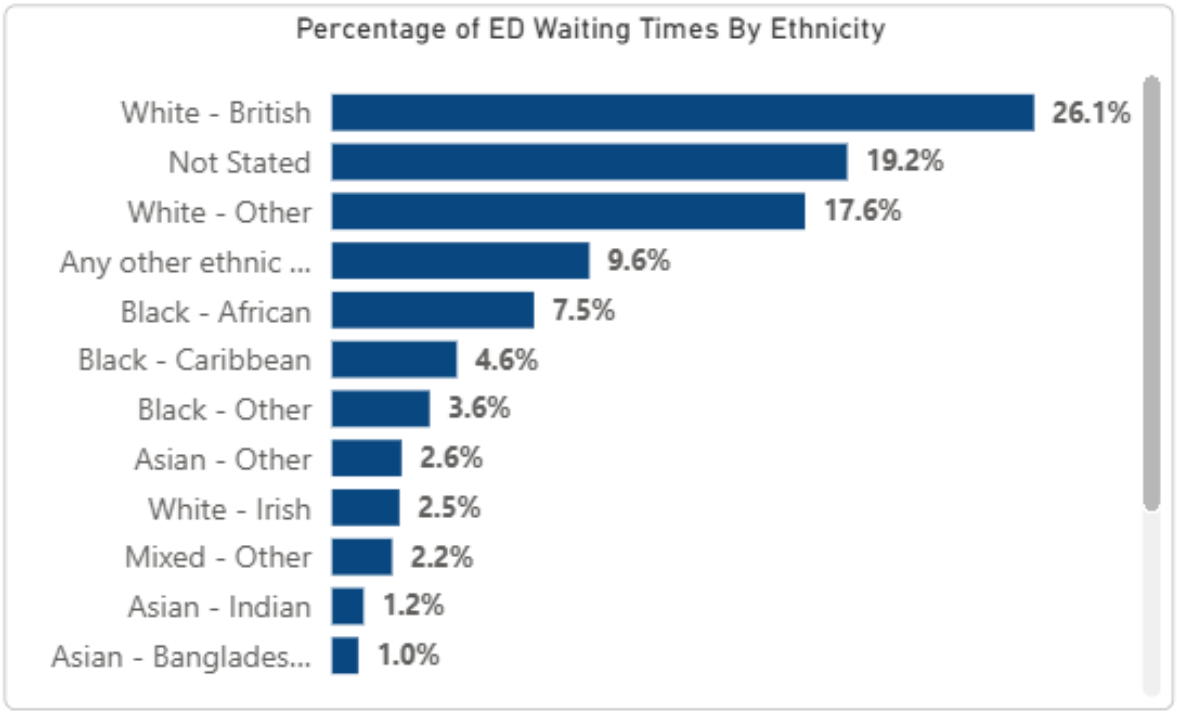
ED waiting times continued to be driven largely by younger and middle-aged adults, with little overall change from the previous year but some subtle rebalancing between age groups. Adults aged 18 – 44 remain the dominant group, accounting for around 35% of total ED waiting time, broadly consistent with the 36% seen in 2024/25 and highlighting their ongoing reliance on urgent care services. The 45 – 64 age group has increased its share more noticeably, rising from 23% to 25.2%, suggesting growing pressure from this cohort as presentations become more complex. At the other end of the age range, children aged 0 – 17 now make up a smaller proportion of waiting time, falling from 16% to just over 12%, while older adults aged 65 and over collectively account for a slightly higher share than last year, reflecting gradual increases across the 65 – 74, 75 – 84 and 85+ groups. Taken together, the 2025/26 picture feels relatively stable, but with signs of increasing ED demand among older working-age and elderly patients rather than younger cohorts.



b. Percentage of emergency department waiting times by ethnicity (or race)

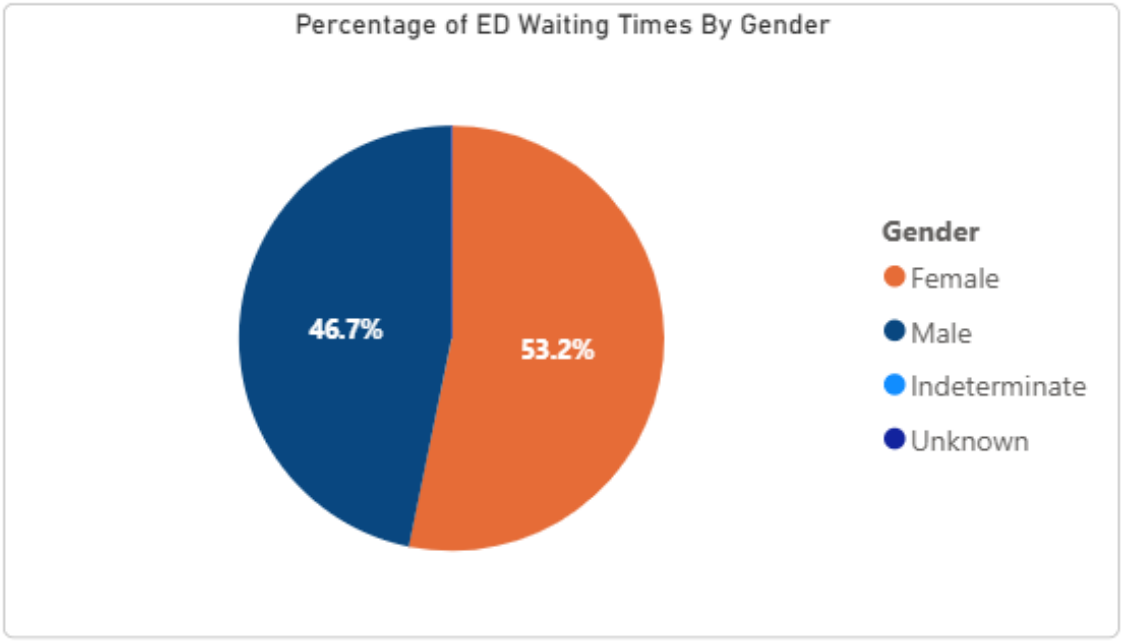
In 2025/26, the ethnicity breakdown of ED waiting time remains broadly familiar, but the ordering and emphasis have shifted slightly compared with 2024/25. White British patients continue to account for the largest single share, at 26.1%, only marginally lower than the previous year, indicating steady demand from this group. One of the more noticeable changes is the increase in cases where ethnicity is not stated, rising from 16% to 19.2%, which suggests some deterioration in data completeness rather than changes in service use.

The contribution from White Other patients has declined from 20% to 17.6%, while most other ethnic groups show only small movements, remaining relatively stable year on year. Black African patients continue to have a higher share of ED waiting time than other Black ethnic categories, increasing slightly to 7.5%, while proportions for Asian and mixed ethnic groups remain low and largely unchanged. Overall, the 2025/26 picture reinforces a consistent ethnic profile for ED waiting times, with minor shifts driven more by changes in reporting and relative positioning than by any fundamental redistribution of demand across ethnic groups.



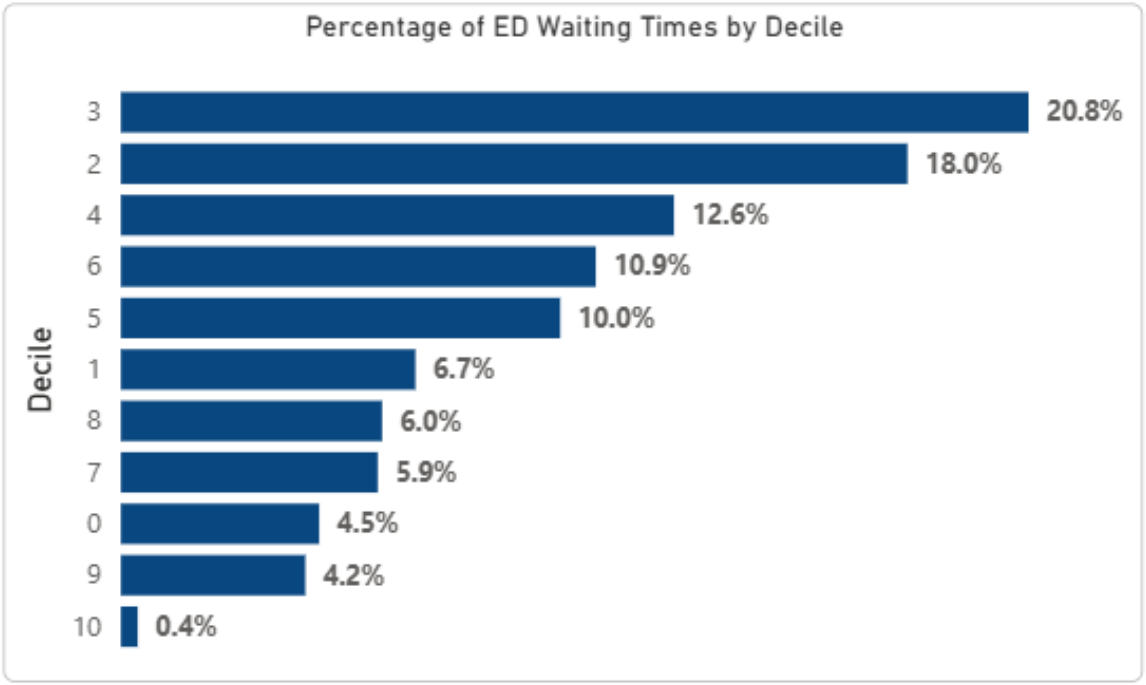
c. Percentage of emergency department waiting times by gender (or sex)

The gender split of ED waiting time remains remarkably stable, with only a very slight softening in the male share compared with the previous year. Female patients account for 53.2% of total ED waiting time, marginally higher than the 53% recorded in 2024 – 25, while the proportion attributable to males has eased from 47% to 46.7%. These movements are minimal and point to continuity rather than change, suggesting that patterns of ED use by gender have remained largely unchanged year on year. The near-even balance between the two groups indicates that pressures continue to be shared relatively evenly across genders, with no indication of emerging divergence or structural shift in demand during 2025/26.



d. Percentage of emergency department waiting times by deprivation (decile)

The distribution of ED waiting time across deprivation deciles looks strikingly similar to last year, continuing to underline how strongly urgent care demand is linked to deprivation. The highest levels of waiting time are still concentrated in the more deprived groups, with decile 3 accounting for 20.8% and decile 2 close behind at 18.0%, both effectively unchanged from 2024/25 and together representing almost two-fifths of all ED waiting time. The middle deciles show only modest variation, with deciles 4, 5 and 6 each contributing around one-tenth, indicating a fairly even spread once outside the most deprived areas. In contrast, the least deprived deciles make up a very small share of ED waiting time, with decile 10 remaining negligible at just 0.4% and decile 9 at 4.2%. Overall, rather than any meaningful shift year on year, the 2025/26 data reinforces a well-established gradient, where ED pressures remain most acute in communities experiencing higher levels of deprivation, with little sign of this pattern easing.



Case studies

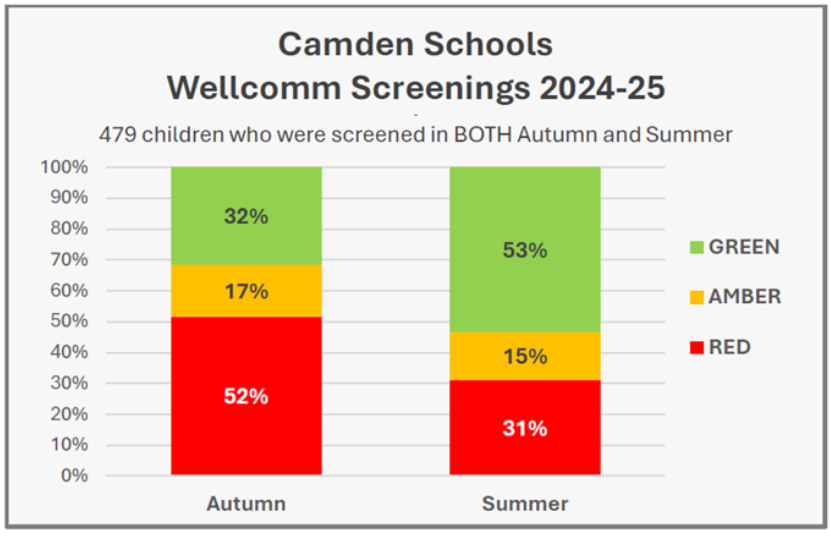
The following pages detail case studies from across the organisation which demonstrate the positive changes and improvements made in our services, as follows:

Camden Kids Talk Initiative – 2025/26

Camden Kids Talk (CKT) is a multi-agency strategic approach to improving communication skills and outcomes universally for children aged 0-5 years across the borough. The initiative was born out of necessity with high and rising levels of communication need in Camden, and an inequality shown for those experiencing social disadvantage, which had only been exacerbated by the covid-19 pandemic

A major strand of the initiative has been close joint work between the CKT team and local schools in areas of high deprivation and with high levels of speech, language and communication needs. Work has involved audits of existing provision, training, induction policy support, coaching and video-reflection, joint classroom planning, parent sessions and communication screening for every single child attending each setting, ensuring each child has an appropriate support plan in place from the term they start nursery. WellComm screening is utilised at a minimum of 2 points in the year to track individual and cohort progress, with the screen allowing for a simple RAG rating, with green indicating communication skills as would be expected for age, amber suggesting communication skills around 6-12 months below what is expected and red suggesting skills a year or more below that expected for chronological age. Outcomes for both full years the project has been running have been similar and very positive, with subsequent savings for individual schools, local health services and the Local Authority, not to mention the social, education and mental health benefits of improved.

The initiative continues to grow and expand with all schools involved now being self-sufficient in collecting and utilising WellComm data and most having a member of the senior leadership team who carries out quality assurance of the communication environment and policies as well as coaching for school staff around communication practice and interventions.



Enhanced Health in Care Homes (EHCH) West Haringey

Whilst attending a residential home for routine reviews, staff noted that an ambulance was outside. There was discussion with paramedics as they had been called twice that morning to review an 85-year-old patient with advanced dementia due to concern regarding seizures. This patient had previously been seen by the EHCH team for a comprehensive geriatric assessment and the creation of an universal care plan which stated consideration of hospital transfer for reversible causes.

Following a review of the patient's previous notes, including hospital care records, a previous Accident and Emergency department admission was noted, along with a rapid response review over the last six months, with similar episodes. The EHCH consultant clinically reviewed the patient alongside a London Ambulance Service (LAS) paramedic. The patient's observations remained within the normal range bar ongoing low Glasgow Coma Scale and there was no further clinical seizure activity. A subsequent discussion with patient's husband at bedside (the patient lacked capacity) alongside the LAS paramedic regarding clinical concern for likely seizures and ongoing management within best interests. The patient's husband was very clear that priority should be comfort/symptom control and to remain at care home.

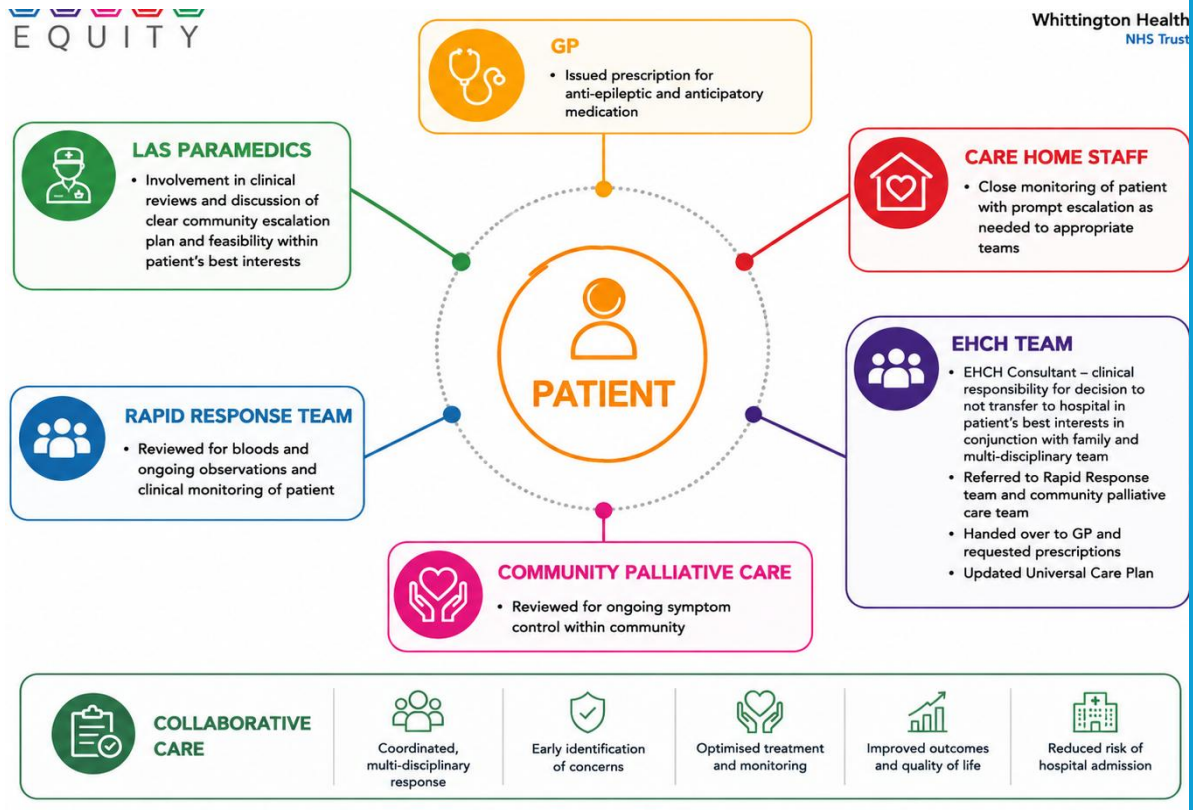
The patient had found her last hospital admission to be distressing and felt that her quality of life was extremely poor, and further interventions would increase distress The patient and her husband were made aware that if further seizures occurred, this was likely a poor prognosis and possibly terminal event The feasibility of ongoing management within a residential home was discussed and paramedic and care home staff developed a clear escalation plan

The EHCH consultant phoned the duty GP following discussion to handover and requested prescription for anti-epileptic medication and anticipatory end-of-life medication. The patient was referred to the rapid response team for blood tests to exclude any obviously reversible cause such as electrolyte imbalance/infection and ongoing clinical review. The patient was also referred to the palliative care team due to a high risk of ongoing deterioration and the plan to support with preferred place of care and death in residential home.

The patient's medication was rationalised by the EHCH consultant and handed over to care home staff and her GP. The universal care plan was updated with clear instructions regarding further seizures to assist care home staff, paramedics, out-of-hours GP and hospital teams and provided guidance for ongoing symptom control within the care home and not for further hospital transfers, unless the seizures cannot be controlled.

A copy of the patient's plan was placed on the hospital electronic notes system in case she was admitted to hospital with uncontrolled seizures and staff would be aware of the community services' plan to establish a syringe driver and short admission for symptom control and to discharge back to the residential home for ongoing end-of-life care

The EHCH matron reviewed the situation. The patient is now stable with no further seizures. Hospital admission was avoided and has a clear community escalation plan as per the universal care plan, with relevant community teams involved.



Whittington Pharmacy Aseptic Unit Transformation Project

The Whittington Aseptic Unit plays a critical role in preparing patient-specific chemotherapy and immunotherapy treatments for cancer patients. To maintain compliance with evolving good manufacturing practice (GMP) requirements, improve contamination control, and support the long-term sustainability of the service, significant investment was required to modernise the unit's facilities, equipment, and working practices.

Funding for a replacement isolator was approved in 2023/24, with additional funding awarded by NHS England in December 2024 to support a wider transformation of the Aseptic Unit. The project aimed to address regulatory requirements, improve workflow and operator safety, and enhance the quality and resilience of aseptic production services.

The transformation project was completed during 2025/26, with the Aseptic Unit successfully reopening in December 2025. Key improvements included:

- Integration of vapourised hydrogen peroxide (VHP) gassing technology into the new isolator, enabling automated bio-decontamination of internal surfaces.

- Conversion of the isolator to positive pressure operation to ensure compliance with current regulatory requirements.
- Installation of a new transfer hatch between production and final checking areas to improve workflow, reduce contamination risks, and enhance operator safety.
- Relocation of the production dispensary and clinical trials dispensing areas to support revised workflows.
- The introduction of new gowning procedures and improvements to changing facilities to strengthen contamination control and staff safety.

The project was delivered alongside a comprehensive programme of validation and quality assurance activities, including user requirement specifications, design qualification, installation qualification, operational qualification, performance qualification, process validation, and operator validation. The project has significantly modernised the Aseptic Unit, improving regulatory compliance, operational efficiency, contamination control, and product quality. Automated VHP decontamination has reduced reliance on manual cleaning processes, increasing consistency and supporting compliance with GMP requirements.

The quality of the refurbishment and validation programme was recognised during a visit from the Regional Quality Assurance Team in July 2025, who commended the team's diligence and confirmed that the refurbishment had been completed to a high standard, supporting the future operational life of the unit.

Further success was demonstrated during the Regional Quality Assurance Audit in April 2026, where the Aseptic Unit achieved an overall low risk rating for patient safety. This was a significant achievement following the introduction of a new isolator, VHP technology, and extensive redesign of the aseptic suite. The audit team praised the professionalism, openness, and positive culture demonstrated by the aseptic team throughout the transformation programme. The project has strengthened the Trust's ability to provide safe, high-quality aseptic services and supports the ongoing delivery of vital cancer treatments to patients across the organisation.

Implementing Robotic-Assisted Surgery at Whittington Health with Hugo

Our surgery & cancer clinical division identified a strategic opportunity to modernise surgical services through the introduction of robotic-assisted surgery. This aims to enhance precision in complex procedures, improve patient outcomes, and support more efficient use of theatre capacity, including a shift towards increased day case surgery.

Introducing a new surgical modality requires significant preparation to ensure safe implementation, including workforce training, governance arrangements, patient pathways, and appropriate case selection.

What we did

During 2025/26, we progressed a comprehensive implementation programme to safely introduce robotic-assisted surgery:

- Investment in robotic technology, including installation and preparation of the system for clinical use
- Established a multidisciplinary programme and governance structure, including a dedicated steering group and implementation plan
- Structured workforce training programme:
  - Three multidisciplinary teams (surgeon, assistant, and nurse) identified for external training
  - Ongoing simulation and hands-on training using the robotic system on site
- Phased clinical rollout model agreed, starting with lower complexity procedures (e.g. gall bladder, hernia and gynaecological cases) before progressing to more complex surgery
- Defined implementation timelines, including the first planned robotic theatre list on 29 June 2026, followed by regular operating lists
- Clear progression plan, with intent to expand into major procedures (bariatric, gynaecology and colorectal) once teams have achieved competency

The programme has been delivered through close collaboration between surgical, anaesthetic, nursing, operational and governance teams, with a strong focus on safety and readiness.

Outcome

While clinical activity has not yet commenced, we have achieved significant progress in preparing for a safe go-live, as follows:

- The robotic surgery programme is established and ready for its first cases, with clear timelines and governance in place
- Workforce readiness significantly enhanced, with multidisciplinary teams training and continuing to build competency through simulation and structured learning
- A safe phased introduction model to be embedded, ensuring lower complexity cases will be prioritised during early adoption
- There is strong clinical and operational alignment, supporting sustainable rollout into routine theatre activity
- The robot will help to position Whittington Health as an innovative provider, ready to deliver enhanced surgical care and improved patient experience

The first robotic-assisted surgical procedures are scheduled for late June 2026, marking a significant milestone, with plans to scale the service over subsequent months.

Rapid Response case study: managing an acute exacerbation at home

An 82-year-old patient with significant multimorbidity which included chronic obstructive pulmonary disease (COPD), hypertension, type 2 diabetes, stage 3 chronic kidney disease, heart failure with preserved ejection fraction, and mild cognitive impairment was referred to the Rapid Response service by the LAS, following 24 hours of worsening shortness of breath, fatigue, and weakness. Given the patient's complexity and frailty, hospital conveyance was considered; however, the LAS appropriately sought an urgent community assessment via the Rapid Response team.

On arrival, the clinician completed a comprehensive assessment in the patient's home. Observations showed elevated blood pressure (160/95 mmHg), heart rate 92 bpm, oxygen saturation 93% on room air, bibasal crackles with scattered wheeze, green-brown sputum, mild peripheral oedema, and raised blood glucose. The clinical picture suggested an acute infective exacerbation of COPD with concurrent cardiovascular and metabolic strain.

Through close collaboration with the patient's GP and a senior on-call clinician, immediate treatment was safely initiated at home. Short-acting bronchodilators and oral antibiotics were prescribed, alongside structured monitoring of blood pressure and blood glucose. The patient and her daughter were supported with education on breathing techniques, positioning, medication adherence, and early recognition of red flag symptoms.

Over the following 72 hours, the patient stabilised without requiring hospital admission. Clear safety-netting advice was provided and a coordinated follow-up with primary care and community teams ensured continuity. The patient and her family expressed reassurance and confidence in the care delivered at home.

Service highlights

- Timely collaboration with the LAS enabled a safe avoidance of unnecessary hospital conveyance.
- Comprehensive, assessment and treatment initiation in the home, addressing complex multimorbidity holistically.
- Effective multidisciplinary coordination between Rapid Response, senior clinicians, GP, and community teams.
- Safe initiation of acute treatment in the community, reducing risk of hospital-acquired complications.
- Strong patient and carer engagement, promoting confidence and self-management.
- Prevention of admission, demonstrating the department's ability to deliver high-acuity, patient-centred care safely at home.

This case exemplified the department's capacity to manage medically complex patients in the community, combining complex clinical decision-making, multidisciplinary collaboration, and person-centred care to achieve safe and positive outcomes.

Virtual Ward Remote Monitoring case study - heart failure remote monitoring

A patient was referred to the virtual ward (VW) for remote monitoring following an exacerbation of heart failure. In line with pathway protocol, he received an initial face-to-face home visit to establish clinical stability and introduce the remote monitoring model.

During the visit, the patient was provided with a blood pressure monitor, pulse oximeter, weighing scales, and tympanic thermometer. A trained care assistant delivered practical education to ensure he was confident using the equipment accurately. This was complemented by a same-day assessment from an experienced community matron, who applied advanced clinical skills to undertake a comprehensive review, optimise his management plan, and reinforce concordance with his treatment during the acute phase.

As is often the case with heart failure, the patient was uncertain about his current medication dosages, particularly where titration had occurred during recent care episodes. The VW multidisciplinary team (MDT) reviewed his regimen, clarified dosing, and incorporated any necessary adjustments into his management plan. Clear communication was maintained with community heart failure services and his GP via email and telephone to ensure a seamless transition of care and reduce risk associated with multiple handovers.

A key focus of the intervention was patient education, where the patient was supported to understand the importance of daily weights, fluid balance monitoring, and early recognition of red flag symptoms. He developed greater awareness of how intercurrent illness and co-morbidities could precipitate decompensation and when to escalate concerns appropriately.

The patient remained under VW remote monitoring for 14 days, receiving a structured telephone follow-up, blood test monitoring, and ad hoc clinical reviews following diuretic dose adjustments. The MDT provided reassurance, addressed emerging concerns promptly, and differentiated between clinically significant changes and non-concerning variations, ensuring safe and proportionate escalation when required.

By the end of the episode, the patient demonstrated increased confidence in self-management and engagement with his care plan. He expressed appreciation for the additional education, accessibility of the team, and reassurance provided throughout his recovery.

Service highlights

- A blended model of care, combining face-to-face assessment with structured remote monitoring.
- Rapid MDT input, including advanced clinical review and medication optimisation.
- Robust cross-sector communication, reducing transition-of-care risks.
- Empowerment through education, improving concordance and self-management.
- Proactive monitoring and early intervention, preventing avoidable deterioration and readmission.
- Responsive escalation framework, supporting patient safety and continuous service improvement.

This case demonstrated how the Virtual W remote monitoring pathway safely supports patients with heart failure exacerbations at home, combining clinical oversight, patient education, and coordinated multidisciplinary care to enhance outcomes and reduce hospital dependency.

Hospital at Home / Virtual Ward case study - repatriation from Barnet Hospital to the Islington Virtual Ward

Background

An 87-year-old patient was repatriated under the virtual ward (VW) pathway following admission with recurrent falls resulting in left-sided facial fractures, managed conservatively. His medical history was significant for Parkinson's disease with severe postural hypotension, paroxysmal atrial fibrillation, CKD stage 3, mild cognitive disorder, type 2 diabetes, cataracts, and metastatic squamous cell carcinoma. He lived alone with daily care support but continued to mobilise independently despite high falls risk.

Narrative

On transfer to the VW, he remained symptomatic with significant postural blood pressure drops and ongoing falls risk. A comprehensive MDT assessment was undertaken at home. Medication reconciliation identified that apixaban for atrial fibrillation had been omitted from his blister pack and discharge documentation, and he had missed anticoagulation follow-up.

The team delivered a holistic review encompassing medical optimisation, therapy input, pharmacy oversight, and capacity assessment regarding risk awareness and independent mobilisation. Midodrine was carefully titrated with pharmacy support to improve symptomatic hypotension. Occupational therapy ensured appropriate equipment provision and environmental adjustments to mitigate falls risk.

Co-ordination extended beyond acute issues: liaison with ophthalmology enabled his planned cataract surgery to proceed safely while under VW care, preventing delays to elective treatment. Chronic disease monitoring, including renal function

and glycaemic control, was reviewed and optimised. Anticoagulation was safely reinstated with appropriate counselling and follow-up arrangements. Throughout the admission, care was individualised to balance patient autonomy with safety, supporting positive risk-taking while maintaining close clinical oversight.

Outcomes

- Improved control of postural hypotension following medication titration.
- Safe reinstatement of anticoagulation with structured follow-up.
- Reduced falls risk through therapy-led interventions and multidisciplinary team (MDT) planning.
- Successful completion of planned cataract surgery.
- Avoided hospital readmission during the VW episode.

Service highlights

- Safe and efficient repatriation, reducing acute bed occupancy while maintaining high clinical oversight.
- Robust cross-sector medication reconciliation, identifying and rectifying high-risk prescribing omissions.
- Integrated multidisciplinary working, including medical, pharmacy, therapy, and frailty expertise delivered in the patient's home.
- Holistic chronic disease optimisation, not solely focused on the presenting problem.
- Coordination of elective and specialist care, demonstrating continuity across primary, community, and secondary services.
- Person-centred, risk-balanced care, enabling independence while maintaining safety.

Conclusion

This case highlights the strength of the Hospital at Home model in managing complex frailty and multimorbidity following acute admission. Through coordinated, proactive MDT intervention, the Virtual Ward delivered safe repatriation, prevented readmission, optimised long-term conditions, and maintained continuity of care by demonstrating the department's capacity to manage high-acuity patients effectively in the community.

Case study – Sickle Cell

Background

This service saw a 60-year-old gentleman with sickle cell disorder. He had grown up in Ghana, then lived with his mother until her death seven years ago and his own health and social situation declined thereafter when he moved to a flat in North Central London.

- No engagement with haematology services in the past five 5 years, and no recent surveillance of sickle cell disorder or preventative care (does not attend appointments).
- Reported weight loss, urinary tract symptoms, dental pain
- Deteriorating mental health and frailty and self-neglect
- Difficult social housing living conditions, with no hot water or electricity for several months
- A vulnerable person who has previously been coercively controlled by drug dealers. He had previously been assaulted, and sustained facial fractures
- Loney and mistrusting of healthcare professionals

This patient gradually engaged with the North Central London Community Red Cell Service over several months through gentle outreach from the nursing team.

Care provided by the community red cell team:

- In regular contact with three community nurses who invested countless hours in building a trusting relationship with him. The patient was open to engagement with other services when supported by these nurses who accompany and advocate for him, which enables an opportunity for him to build trust with others.
- The patient engaged with the community matron who was able to take a through clinical history and physical examination in the community clinic and started investigations for weight loss, urinary tract symptoms and the recommended routine surveillance of sickle cell disease. We were able to share this assessment with his GP to seek their support and to join up his care with other providers
- The patient was offered health promotion guidance and preventative care. He was also referred to a specialist community dental service in North Central London, which the nursing team will assist him to access.
- The community nursing team visit him regularly at his home and have been able to assess his living situation and make a detailed safeguarding referral. The team is now working with social services, his GP and the Haematology team to address both his health and social care needs.
- The patient often accepts elements of care sporadically. He regularly attends the community red cell clinic where he can access care on his terms and at his convenience.
- Without this degree of flexibility, outreach and trust, the patient would find accessing care impossible

Multi-Agency Care & Coordination (MACC) Team – a patient's journey

Background

A referral was received from the Rapid Response team which highlighted that this was a 77-year-old-patient who lived alone, with no family. The patient had discharged themselves from hospital. A safeguarding alert due to self-neglect, clutter at home and alcohol misuse. The patient was non-compliant with

medication, had a moderate bilateral oedema, was at high risk of becoming severely unwell at home, and needed an integrated MDT input at home.

Initial home visit assessment:
A comprehensive geriatric assessment was completed by our community matron nursing associate who clarified that what mattered to this patient was to have a supply of food, as he has not eaten for the previous five days. Several risks were identified and a care plan jointly developed with the patient, who felt listened to.

Immediate actions taken following the home visit:

- **Safeguarding concerns**: referred to social services and allocated a social worker to work jointly on this case
- **Falls risk**: the patient was referred for a fall alarm and was also referred internally to the occupational therapy department.
- **Fire risk and pest infestation**: referred to the London Fire Brigade, a home visit was arranged, and the patient was added to vulnerable adult register list
- **Risk of nail infection associated with a long toenail curving inward**: referred to podiatry services
- **Poor medication compliance**: referred to our pharmacists
- **Risk of becoming malnourished**: referred to a care navigator who set up an urgent delivery through The Bridge Renewal Trust charity and a local food bank.

Follow-up actions taken:

- This patient's case was discussed at the MACC multidisciplinary team meeting and the with MACCT GP. A care plan was devised and reviewed collectively.
- The case was presented in a teleconference to align the patient's GP, our adult community services clinical, and social services.
- **OT input/Fall intervention**: the patient was provided with a new walking frame for short distances, his mobility and transfers were assessed, and it was agreed to replace his current chair with a specialist chair in order to reduce the risk of falling and a subsequent risk of pressure damage; improved oedema management.
- **Pharmacist intervention:** a blister pack was provided and the pharmacist reviewed his medication and adapted to his lifestyle
- **Joint work with social services:** a deep clean of the patient's accommodation took place and a visit from pest control was arranged; carers were also put in place
- **A personalised care plan was designed:** the patient chose how many days he would accept the carer to visit and this made him feel in control as he had not been given this opportunity previously.
- **Digital connection**: the patient was provided with a mobile phone and a year's worth of mobile credit through our charity links. Occupational therapy services supported him to set up an Amazon account, which he has since used to complete his online grocery shopping

Impact of MACCT/Care Coordination input: the patient has been well-managed under district nursing care team with the following outcomes:

- Community matrons attended district nursing team handovers, monitoring progress and offering advice/education
- Foot oedema healed following district nursing care and the provision of community equipment
- A care package is in place
- The patient's flat was decluttered and is now pest-free. He also has improved access to food and is able to manage bills with the new digital device
- Overall, there has been a significant improvement in the patient's health
- He is nearing discharge from the district nursing team and there have been no further episodes of hospital admission.

Haringey Children's Occupational Therapy Service

Background

Haringey Children's Occupational Therapy service provides short-term, goal-focused intervention based on the ICF model. While effective for many children, this model does not support long-term monitoring or preventative care for children with lifelong neurological conditions such as cerebral palsy (CP). Without structured surveillance, children are at risk of deterioration in upper limb function, reduced participation, and increased need for complex interventions.

What we did

To address this gap, a monthly Upper Limb cerebral palsy integrated pathway service (CPIPS) clinic was introduced. The clinic provides structured surveillance, standardised assessment, and early intervention using existing staff and resources. A pilot model was used to test feasibility, refine processes, and collect outcome data.

Outcomes and impact

Clinic activity: 8 clinics completed with 16 families providing feedback, as follows:

- 100% (16/16) found the appointment useful
- 100% (16/16) would attend again
- 100% (16/16) would recommend the clinic
- 81% (13/16) initially understood the reason for attendance (improved following explanation)

Areas for Improvement

- Clearer communication before the appointment
- Opportunity for private discussion with clinicians
- Potential integration with lower limb CPIPS clinics

Wood Green Community Diagnostic Centre: extending imaging hours to support elective recovery

In response to the Prime Minister's elective recovery plan, Wood Green Community Diagnostic Centre 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, the extended opening hours were delivered by redesigning rotas and staggering shifts within the existing radiography team — protecting staff wellbeing while also 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 6 January 2025 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 enabled quicker patient throughput and greater flexibility for GP and hospital referrals, directly supporting NCL Trusts in maintaining the 96% monthly diagnostic test compliance target set by NHS England and the Care Quality Commission.

Staff and patient feedback was positive, with early/late appointments helping reduce Did Not Attends and improving access for patients with daytime responsibilities.

This low-cost, data-driven model is currently being evaluated for potential rollout across other Community Diagnostic Centres sites in the region.

FINANCIAL PERFORMANCE REVIEW

The Trust agreed a (deficit) plan of (£1.49m) for 2025/26. The Trust delivered an adjusted financial performance surplus of £2.04m for 2025/26 after adjustments for fixed asset impairments, donations and donated asset depreciation. This was £3.46m better than plan.

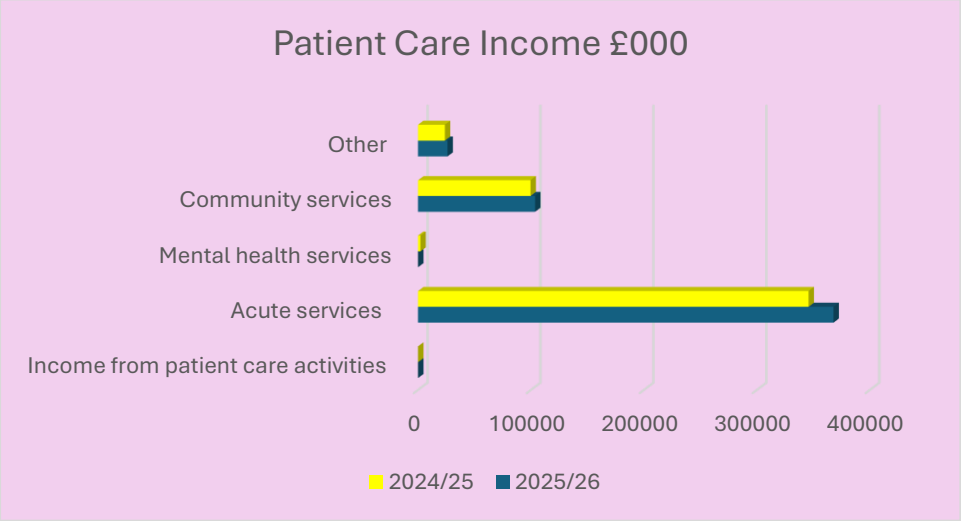
Statement of Comprehensive Income

	2025/26	2024/25
	£000	£000
Operating income from patient care activities	497,478	471,111
Other operating income	32,937	29,273
Operating expenses	(529,341)	(512,746)
Operating surplus/(deficit) from continuing operations	**1,074**	**(12,362)**
Finance income	1,975	3,179
Finance expenses	(1,431)	(1,860)
PDC dividends payable	(6,056)	(5,588)
Net finance costs	**(5,511)**	**(4,269)**
Surplus / (deficit) for the year	**(4,437)**	**(16,631)**
Other comprehensive income		
Will not be reclassified to income and expenditure:		
Impairments	(6,361)	(7,339)
Revaluations	3	672
Total comprehensive income / (expense) for the period	**(10,795)**	**(23,298)**
Adjusted financial performance (control total basis):		
Surplus / (deficit) for the period	(4,437)	(16,631)
Remove net impairments not scoring to the Departmental expenditure limit	6,408	3,587
Remove I&E impact of capital grants and donations	66	(78)
Adjusted financial performance surplus / (deficit)	**2,038**	**(13,122)**

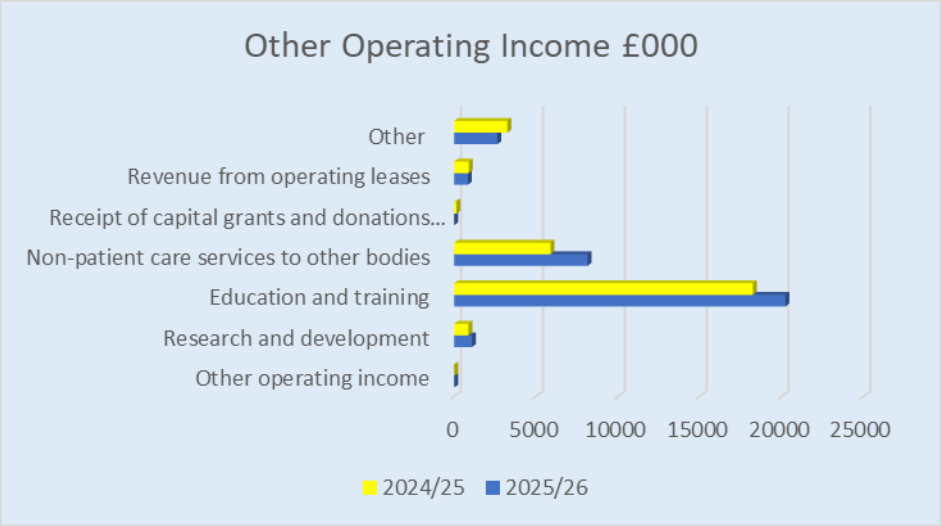
Income

The Trust's income as shown above is comprised of Patient Care and Other Operating categories. The breakdown of income within these categories and compared to the previous financial year is shown in the charts below.

Patient care income

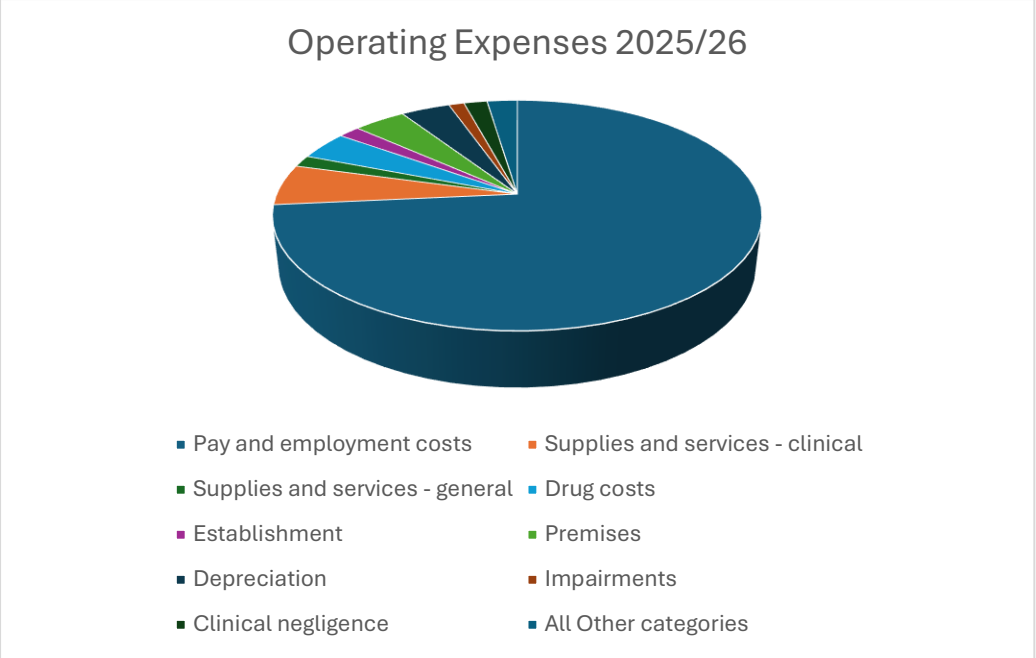


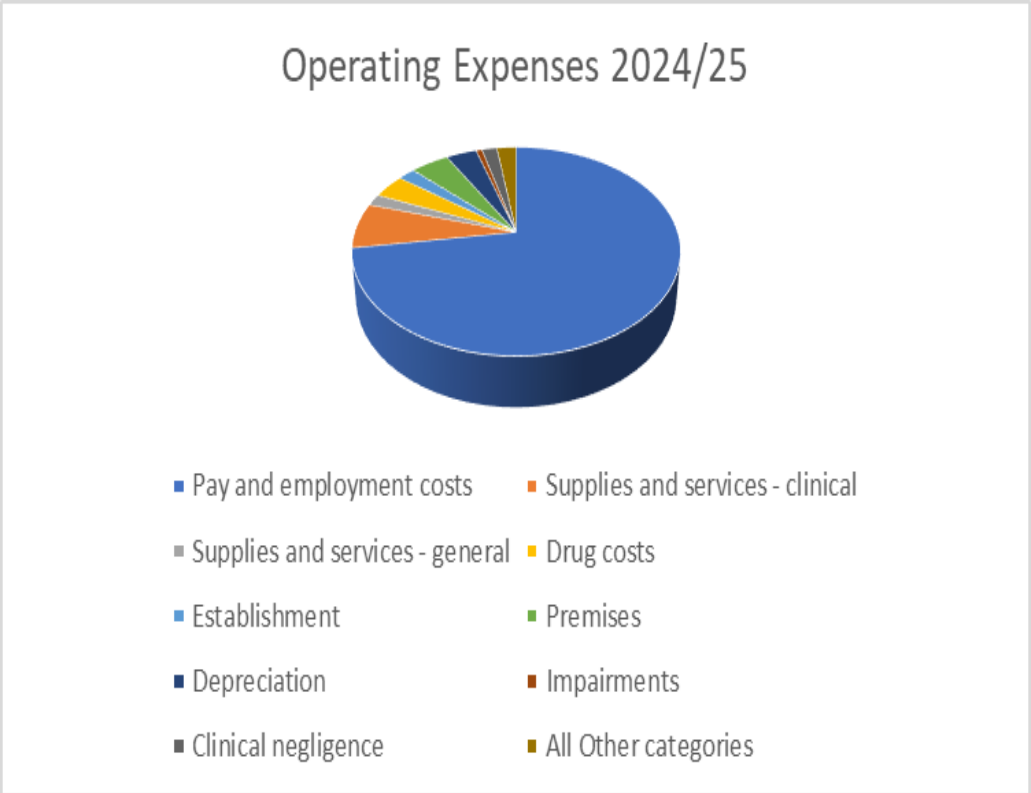
Other operating income



Operating expenses

The charts overleaf provide a comparison of operating expenses by category for the 2025/26 and 2024/25 financial years





Going concern and value for money

As with previous years, the 2025/26 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.

Statement of Financial Position		
	31 March 2026	31 March 2025
	£000	£000
Non-current assets		
Intangible assets	2,480	4,079
Property, plant and equipment	281,261	260,849
Right of use assets	27,669	36,104
Receivables	757	805
Total non-current assets	**312,167**	**301,837**
Current assets		
Inventories	0	1,309
Receivables	19,441	23,122
Cash and cash equivalents	55,363	46,276
Total current assets	**74,804**	**70,706**
Current liabilities		
Trade and other payables	(101,406)	(91,238)
Borrowings	(4,925)	(5,511)
Provisions	(7,200)	(227)
Other liabilities	(1,816)	(2,216)
Total current liabilities	**(115,347)**	**(99,191)**
Total assets less current liabilities	**271,624**	**273,352**
Non-current liabilities		
Borrowings	(25,736)	(34,729)
Provisions	(13,382)	(25,032)
Total non-current liabilities	**(39,118)**	**(59,761)**
Total assets employed	**232,506**	**213,591**
Financed by		
Public dividend capital	168,030	138,320
Revaluation reserve	67,279	73,637
Income and expenditure reserve	(2,803)	1,634
Total taxpayers' equity	**232,506**	**213,591**

The Trust's financial position for the year ending 31 March 2026 is detailed above, indicating effective arrangements in the use of resources and a positive trend in financial results. However, as a Trust with an underlying financial deficit, we continue to face a challenging financial future.

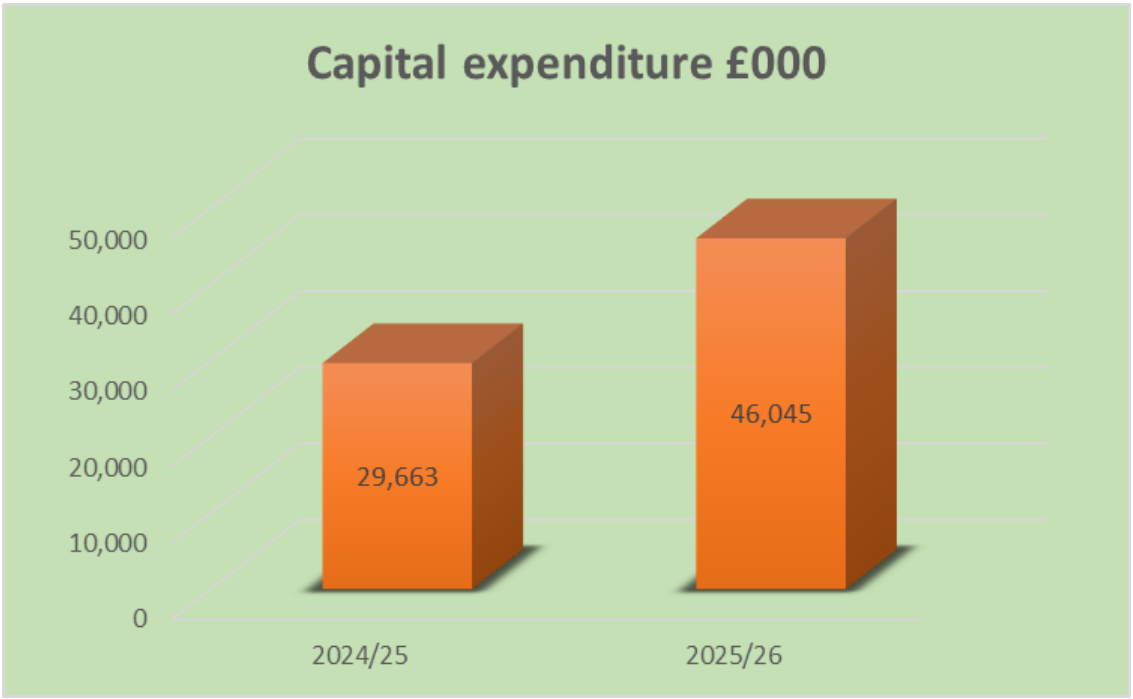
Cash

The Trust ended the financial year with a cash balance of £55.3m, which is in excess of 30 days' requirement, and an increase of £9.1m from the cash balance at 31 March 2025. The increase is driven primarily by public dividend capital which had been drawn down and expended on capital projects during the 2025/26 financial year, however, the cash had yet to leave the Trust's bank account at 31 March 2026. The Trust received £25.2m of public dividend capital to its strategic capital priorities.

Property, plant and equipment

The Trust's outturn capital expenditure for the year was £46.0m, which matched our capital resource limit. This was an increase of 55% over the 2024/25 capital programme, reflecting the Trust's core strategic priorities of power, Start Well maternity and neonatal, fire remediation, information and communication technology, and other projects.

This significant programme of capital investment is the principal driver for the £20.4m increase in property, plant and equipment values shown above.



Borrowings

The Trust's recorded borrowings reduced by £9.6m between March 2025 and March 2026, due primarily to re-measurements of lease liabilities and several disposals/ partial disposals of leased premises. A similar reduction can be seen in the Right of Use (leased) assets shown above.

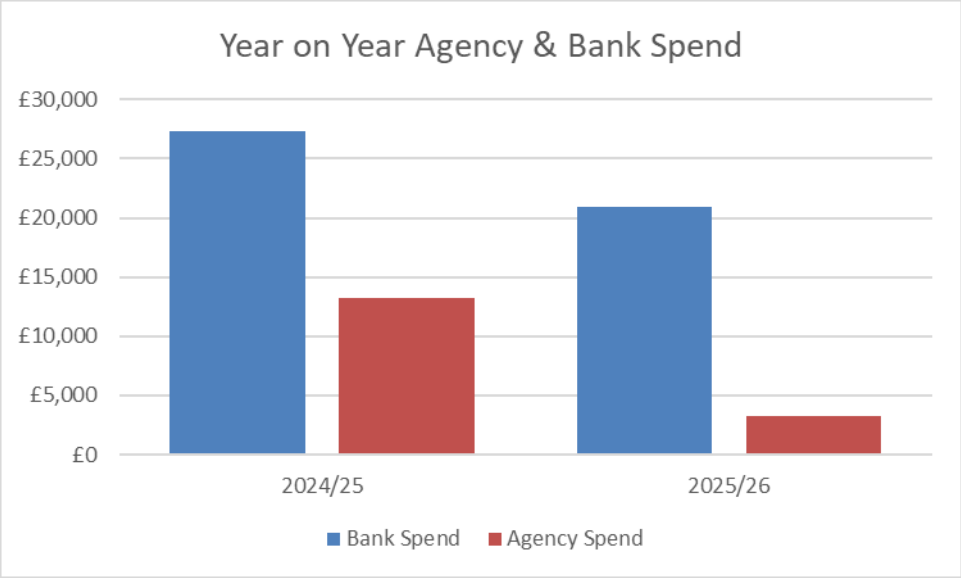
Spending on agency and temporary staff

The Trust spent £3.2m on agency staff for 2025/26, which was £10.0m lower than agency expenditure in 2024/25. This represented 0.8% of total pay costs.

Expenditure on bank staff was £21.1m, which was £6.3m lower than for the previous financial year.

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 developed a range of measures to monitor and control temporary staffing expenditure.

The graphs below show the level of expenditure on bank and agency staff for the 12 months to 31st March 2026, and comparison for the year to March 2025.



STRATEGIC RISKS

The Trust has a robust risk management framework, and risk management policy and procedure as outlined in the annual governance statement. The key risks on our 2025/26 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 the impact of industrial action by resident doctors, 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, or an ICB in flux, or the changing provider landscape, (such as neighbourhood working, corporate services' rationalisations, services reviews), may result in unclear governance decisions and difficulty in strategic planning which impact adversely on patient services, particularly fragile ones, and the strategic viability of the Trust. Specifically, there is a risk that due to lack of resources and attention and the pace of working the organisation is unable to sufficiently benefit from the opportunities or mitigate the risks presented by neighbourhood working.
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	Increased exposure to financial risks arising from: • adverse changes to funding arrangements (e.g., block or ERF cap) • failure to manage budgets • unmitigated cost pressures • failure to deliver financial efficiency schemes or benefits associated with service transformation.
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 workforce, then there is a possibility of catastrophic downtime. This could lead to serious impact on our ability to deliver any of our strategic

BAF entry	Principal risk(s)
	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 2025/26. 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.

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

DELIVER CONSISTENT, HIGH QUALITY, SAFE SERVICES

The accountable officers for quality and safety are the Chief Medical Officer 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 NHS Trust is registered with the Care Quality Commission (CQC) without any conditions. During 2025/2026 the CQC undertook one inspection, which was an unannounced inspection of Urgent and Emergency services in October 2025.

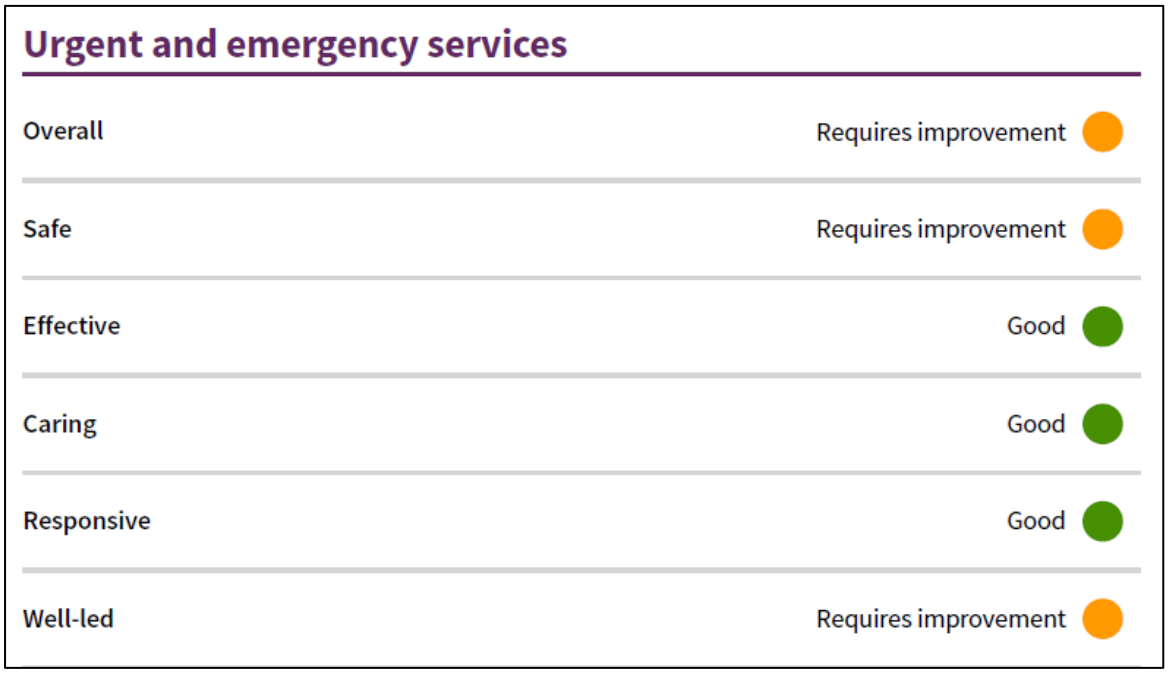
There were four CQC relationship meetings held in 2025/2026, which focussed on key performance and risk, an update on Barnet 0-19 children's services, urgent and emergency care and medicines management.

The table below provides the rating summary for the CQC's most recent full inspection report published in March 2020. This was 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) and a well-led inspection in January 2020. The current CQC overall rating from this assessment is **'good'** overall for Whittington Health NHS Trust, 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 or the inspection of urgent and emergency care in 2025.

	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

In October 2025, the CQC carried out an unannounced inspection of urgent and emergency services.



Urgent and emergency services are currently rated as 'requires improvement' overall, however the 'requires improvement' rating for 'well-led' is currently being appealed by the Trust. If this is rating review is successful, it would change the overall rating for Urgent and Emergency services to 'good'.

A refresh of the Trust's CQC action plan has been undertaken to confirm that the closed actions have been reviewed with the responsible clinical division(s) in 2025, whilst ensuring that they are reflective of the current Trust position, and they are monitored at the divisional quality meetings.

A series of peer reviews and quality visits were carried out to support clinical areas improve the quality of care and to share good practice.

In preparation for a potential CQC well-led inspection, the Trust has undertaken a self-assessment of the CQC well-led question in the Single Assessment Framework. Work is also on-going with the Trust Board, Trust Management Group and wider teams to raise awareness of the expectations of a CQC well-led review.

The CQC Single Assessment Framework[1] , introduced in 2023, consists of five key questions for health and social care services which ask if services are safe, effective, caring, responsive to people's needs and well-led. Each key question is underpinned by a set of quality statements. The CQC's new approach includes listening more effectively to people's experience of health and care services as well as the experiences of frontline staff.

During an inspection CQC will assign scores based on the evidence categories for each quality statement assessed. These scores are then translated into a rating which remain as outstanding, good, requires improvement, and inadequate.

[1] Assessment framework - Care Quality Commission

The CQC is currently undertaking a consultation on the Single Assessment Framework which closes in June 2026 and will then be followed by pilots of any new Single Assessment Framework.

Quality priorities

Our quality priorities support our commitment to helping local people live longer, healthier lives. They are informed by feedback from patients, staff, and community partners, and aligned to our objective to deliver outstanding safe and compassionate care in partnership with patients.

Our 2025/26 Quality Account priorities were:

- Ensuring patients receive safe and effective care that is delivered with kindness, compassion and in collaboration with patients and carers.
- Improving the Trust environment to enhance patient experience.
- Reducing health inequalities in our local population by ensuring that when patients need to access our services, they have clear guidance, accessible routes and supported and listened to throughout.
- We will continue to develop services to meet the needs of our population.

How the priorities were developed

Our priorities were shaped through engagement events with local communities and staff, and informed by data from incident learning, mortality reviews, complaints, claims, audits, surveys, and national guidance such as National Institute for Health and Clinical Excellence (NICE) and national audit data.

Our key achievements are:

- “What matters to me” work: Quotes and images developed; posters complete; screensaver rolled out.
- Incident-reporting promoted through Whittington improvement and safety paper (WISP) newsletter and regular training; learning consistently reinforced.
- Trust-wide Friends and Family Test (FFT) scores remained consistently above the 85% National Health Service (NHS) benchmark and are routinely reported to patient experience group (PEG), quality governance committee (QGC) and quality assurance committee (QAC).
- Patient–Led Assessment of the Care Environment (PLACE) now a standing PEG item; and this feedback is used to demonstrate environmental improvements.
- All high-risk areas were audited. Estates works, staff training, and enhanced care levels were implemented, with progress monitored fortnightly. Acute training compliance was largely achieved, and improvements were seen in community training compliance.
- Implementing standardised and reduced numbers of outpatient letters, lowering cancellations/DNAs, and a 6–4–2 booking model. Our centralised booking pilot was expanded into rheumatology & neurology services with positive key performance indicators (KPIs) and further rollout is planned for 2026/2027.

PATIENT SAFETY

Patient safety incidents

Since April 2024, the Trust has been operating under the Patient Safety Incident Response Framework (PSIRF) with positive feedback reported across the organisation. 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.

Following the implementation of Learning from Patient Safety Events (LFPSE) in November 2023, the recording of harm to a person was 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 death incidents are recorded as fatal.

Total number of patient safety incidents attributable to Whittington Health NHS Trust reported by level of harm caused / financial year	**2023/24**	**2024/25**	**2025/26**	**Total**
No harm	4726	4459	4539	13712
Low harm	1757	2439	2263	6454
Moderate harm	514	471	409	1394
Severe harm	24	18	10	52
Fatal	12	20	9	41
(Pre-LFPSE 2023) Death - caused by the incident	2	0	0	2
(Pre-LFPSE 2023) Death - (NOT caused by the incident)	12	0	0	12
Total	7047	7407	7230	19563

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.

Top six themes outlined in the Patient Safety Incident Response Plan for 2025/26

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 2025/26 PSIRP as it was felt they were not patient safety incidents rather reported for noting.

Patient Safety Incident Investigations

A daily triage meeting is held to provide a rapid, structured, multidisciplinary review of all incidents reported within the previous 24 hours; bank holidays and weekends are reviewed at the next available meeting. The meeting ensures:

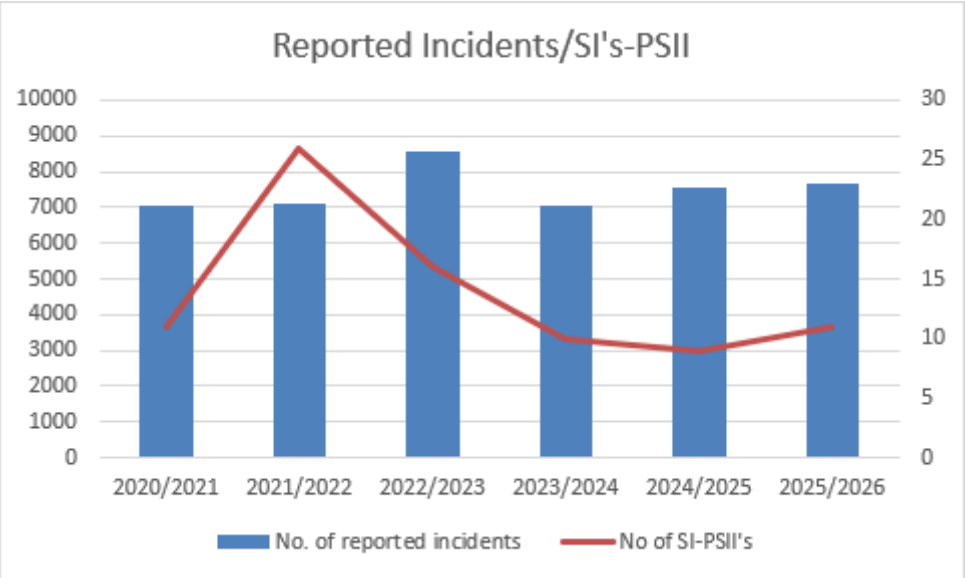
- The early identification of patient safety risks
- A consistent decision-making regarding learning responses and follow-up actions
- The timely escalation of significant events to services leads, divisional triumvirates, or quality governance structures
- Assurance that appropriate initial actions have been taken to safeguard patients, staff and services.

The Whittington Improvement and Safety Huddle (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 a number of 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.

During 2025/26, there were 11 PSIIs requested. As illustrated in the graph below, the number of PSIIs declared as a proportion of all patient safety incidents has remained similar since the implementation of PSIRF. 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 2020-2026



To follow the PSIRF, Whittington Health focus on identifying the whole system issues and take a human factors approach. The WISH forum has 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 2025/26, the Trust reported two Never Events which were investigated via PSIIs, as per the national guidance. Summary details of both events are shown below:

- A136357 – emergency & integrated medicine clinical division – misplaced naso-gastric tubes found to be in the left lung
- A124977 – acute patient access, clinical support services & women's health clinical division – a swab was retained post-procedure.

Duty of candour

Since 2014 there has been a statutory duty of candour to be open and transparent with patients and families about patient safety incidents which have caused moderate harm or above. The Trust complies with its statutory obligations but also strives to apply being open principles for low harm patient safety incidents which do not meet the statutory criteria.

For incidents reported between April 2024 and March 2025, 109 required duty of candour. 102 of the incidents had duty of candour requirements fulfilled and seven were outstanding at the end of the financial year and were reviewed by the relevant risk managers.

Infection Prevention and Control

The infection prevention and control (IPC) programme at Whittington Health NHS Trust continues to operate under robust clinical leadership, with the head of IPC and deputy director of infection prevention and control (deputy DIPC) providing strategic and operational oversight under the accountability of the chief nurse as director of infection prevention and control (DIPC). The infection prevention and control team (IPCT), comprising of specialist IPC nurses and support staff, work collaboratively with microbiology and infectious diseases consultants to deliver a comprehensive, integrated infection prevention service across both acute and community settings.

The IPCT maintains a strong focus on the prevention, surveillance, and management of infections and associated risks to patients, service users, staff, and the wider community. This is achieved through systematic risk assessment, implementation of evidence-based policies aligned to the National Infection Prevention and Control Manual, continuous surveillance, audit, education, and responsive outbreak management. The Trust continues to provide assurance through structured reporting to internal governance forums, including the trust board and quality governance committee, as well as to external stakeholders such as the North Central London Integrated Care Board), UK Health Security Agency (UKHSA), and NHS England.

Healthcare associated infections

The management of healthcare-associated infections (HCAIs) remains a key quality and patient safety priority for the Trust. Surveillance systems are well established, with all notifiable infections subject to rigorous review through multidisciplinary post infection reviews (PIRs), ensuring identification of contributory factors, shared learning, and continuous improvement.

During 2025/26, the Trust has demonstrated improvement in several key bloodstream infection indicators, particularly in relation to methicillin-resistant *staphylococcus aureus* (MRSA) and gram-negative bacteraemia, reflecting strengthened infection prevention practices, improved antimicrobial stewardship, and enhanced system-wide collaboration. However, challenges remain in reducing *clostridioides difficile* infections and sustaining reductions in bloodstream infections from specific organisms such as *E coli*.

Bloodstream infections

In 2025/26, the Trust reported zero MRSA bacteraemia cases, achieving the national trajectory target of zero and demonstrating a significant improvement from the six cases reported in 2024/25. This reflects strengthened control measures around management of colonisation, improved skin integrity management, and targeted education across clinical teams.

Methicillin-sensitive *staphylococcus aureus* (MSSA) bacteraemia accounted for five cases during the year. While not subject to the same national zero-tolerance trajectory as MRSA, these cases continue to be reviewed through PIR processes to identify preventable factors and reinforce best practice.

There has been a notable reduction in gram-negative bloodstream infections (GNBSIs) compared to the previous year. *Escherichia coli* bacteraemia reduced from 33 cases in 2024–25 to 16 cases in 2025/26, performing well below the trajectory of 32. Similarly, *Klebsiella spp* infections reduced from 12 to 5 cases, significantly below the trajectory of 13. These improvements reflect sustained focus on key interventions, including urinary catheter management, intravenous line care, and collaborative working across primary and community care pathways.

Conversely, *pseudomonas aeruginosa* bacteraemia increased slightly to four cases, exceeding the trajectory of three. Although numbers remain small, this highlights the need for continued vigilance, particularly in relation to environmental sources and water safety systems.

Table 1: 2025/26 Blood-Stream Infections (BSIs)

BSI	NHS England trajectory	Count for the year (HOHA*)	Outcomes
Methicillin-resistant *S. aureus* (MRSA) bacteraemia	0	0	Achieved target; sustained improvement from previous year
Methicillin-sensitive *S. aureus* (MSSA) bacteraemia	-	5	Ongoing PIR review; focus on skin integrity and device care
Gram-negative BSIs			
• *E Coli*	32	16	Significant reduction; below trajectory
• *Klebsiella spp.*	13	5	Sustained reduction; improved line and catheter care
• *Pseudomonas aeruginosa*	3	4	Slight increase; ongoing environmental and water safety focus

*Hospital Onset – Hospital Associated

Clostridioides difficile infections (CDI)

The Trust reported 25 cases of *C. difficile* infection in 2025/26, exceeding the annual trajectory of 22 and representing a slight increase from the previous year. PIRs have identified themes consistent with national trends, including delays in sample collection, ability to provide prompt isolation due to capacity, and optimisation of antimicrobial prescribing.

Table 2: *Clostridioides difficile* Infections for the year 2025/26

HCAI	NHSE trajectory	Count for the year	Outcomes
C. difficile infection	22	25	Above trajectory; targeted improvement work in progress

Targeted improvement work continues, focusing on early recognition and isolation, antimicrobial stewardship interventions, improved gastrointestinal assessment and documentation, and regular review of medications such as proton pump inhibitors and laxatives. These measures are being reinforced through education, audit, and clinical engagement across divisions.

Acute respiratory infections

The Trust continues to manage seasonal pressures associated with acute respiratory infections, with influenza remaining a significant contributor to winter activity. IPC measures, including prompt identification, patient isolation or cohorting, use of appropriate personal protective equipment, and reinforcement of respiratory hygiene, have remained central to outbreak prevention and control.

The IPCT has maintained a high level of operational visibility during peak periods, working closely with clinical teams, bed management, and microbiology services to support timely risk assessment and patient placement decisions. Education for staff, patients, and visitors on hand hygiene and respiratory etiquette continues to underpin prevention strategies.

Surgical site infections

The Trust has maintained compliance with national mandatory surveillance requirements for surgical site infections (SSI), undertaking surveillance for neck of femur fracture procedures across three quarters in 2025/26.

SSI rates remained low overall, with no infections reported in quarter 1 (0/44 procedures) and quarter 2 (0/39 procedures), and one infection reported in quarter 3 (1/55 procedures), equating to a rate of 2%. While this represents a slight increase compared to zero infections in the previous year, the overall rate remains low and within expected variation given procedural volumes.

Table 3: **2025/26 SSI Surveillance – neck of femur**

Quarter	Number of procedures	SSI cases reported	Rate
Q1 (Apr – Jun 2025)	44	0	0%
Q2 (Jul – Sep 2025)	39	0	0%
Q3 (Oct – Dec 2025)	55	1	2%

Note: *Q4 (Jan to Mar 2026) still ongoing for reporting on 30 June 2026*

Ongoing surveillance and participation across multiple quarters continue to strengthen the reliability of data and support benchmarking against national datasets. Learning

from identified cases is shared through clinical governance processes to ensure continuous improvement in surgical practice and perioperative care.

2025/2027 Antimicrobial Stewardship Strategy

The Trust has implemented its Antimicrobial Stewardship (AMS) Strategy 2025/2027, aligned to the UK National Action Plan for Antimicrobial Resistance (AMR) and NHS England priorities. The strategy sets out a comprehensive, system-wide approach to optimise antimicrobial use, reduce the risk of healthcare-associated infections such as Clostridioides difficile, and mitigate the emergence and spread of antimicrobial resistance. Key priorities within the strategy include:

- Strengthening governance and oversight through regular reporting to IPC and medicines optimisation committees
- Embedding antimicrobial review and 'Start Smart – Then Focus' principles within clinical practice
- Reducing unnecessary broad-spectrum antibiotic use and promoting timely IV-to-oral switch
- Enhancing diagnostic stewardship to support appropriate prescribing decisions
- Delivering targeted education and training for prescribers and multidisciplinary teams
- Improving data quality, surveillance, and feedback on antimicrobial usage and resistance trends

During 2025/26, progress has been made in embedding these principles across clinical services, with continued collaboration between infection prevention and control, microbiology, pharmacy, and clinical teams. The AMS programme remains a critical enabler in reducing HCAIs, particularly *C. difficile* infections and Gram-negative bloodstream infections, and provides ongoing assurance that antimicrobial use within the Trust is safe, effective, and aligned to national standards.

Neonatal Unit Outbreak – *Enterobacter hormaechei* Colonisation

During 2025/26, the Trust continued to manage a complex and protracted outbreak of enterobacter hormaechei colonisation within the neonatal intensive care unit and special care baby unit. The outbreak, initially identified in August 2024, showed a recurrence during 2025/26, consistent with environmental persistence.

A comprehensive, multidisciplinary response was maintained, with strong collaboration between IPC, clinical teams, microbiology, estates and facilities, and the UKHSA. Enhanced environmental decontamination, including hydrogen peroxide vapour, rigorous surveillance, and reinforcement of core IPC practices were sustained throughout.

Importantly, no invasive infections were identified, and patient safety was maintained. The outbreak has highlighted the critical interface between IPC and the environment, particularly in high-risk clinical areas such as neonatal care, where infrastructure, ventilation, and environmental design significantly influence infection risk.

Water safety and ventilation assurance

The Trust continues to recognise water and ventilation systems as critical components of infection prevention and control, particularly in mitigating risks associated with

opportunistic environmental pathogens such as pseudomonas aeruginosa and legionella spp.

IPC plays a central role within the Trust's water safety group and ventilation safety governance structures, providing expert clinical input, oversight, and encourage to ensure compliance with national standards, including HTM 04-01 (Safe Water in Healthcare Premises) and HTM 03-01 (Specialised Ventilation for Healthcare Premises).

During 2025/26, IPC strengthened its oversight of water safety through:

- Active participation in Water Safety Group meetings and escalation of risks where assurance is limited
- The review and interpretation of microbiological sampling results, including identification of trends and potential risks
- Advising on control measures for positive findings, including flushing regimes, outlet management, and remedial actions
- Supporting incident management where waterborne organisms are identified in clinical areas

Similarly, IPC continues to provide assurance in relation to ventilation systems, ensuring that clinical environments meet required standards for airflow, pressure differentials, and filtration, particularly in high-risk areas such as theatres, isolation rooms, and critical care.

These systems remain a key area of focus, with ongoing work required to strengthen compliance, improve oversight, and ensure timely communication of risks to enable proactive mitigation.

IPC and the built environment – Start Well

IPC continues to act as a key expert stakeholder in the design, development, and assurance of the built healthcare environment, ensuring that infection prevention principles are embedded at the earliest stages of planning and design.

During 2025/26, IPC has played a significant role in the Trust's Start Well redevelopment programme, providing specialist input into clinical design, layout, and infrastructure to ensure compliance with Health Building Notes (HBNs) and Health Technical Memoranda (HTMs).

The IPC approach is underpinned by a clear principle that infection prevention requirements should be designed into environments rather than retrospectively mitigated, with IPC setting standards and working collaboratively with estates, architects, and project teams to achieve compliant and safe solutions.

This proactive engagement supports the delivery of safer clinical environments, reduces reliance on operational workarounds, and strengthens long-term infection prevention resilience across the Trust estate.

Overall, the Trust has demonstrated strong performance and improvement in key HCAI indicators during 2025/26, particularly in achieving zero MRSA bacteraemia and significant reductions in gram-negative bloodstream infections.

The management of the neonatal enterobacter hormaechei outbreak, alongside ongoing work in water and ventilation safety, highlights the increasing importance of environmental and infrastructure factors in infection prevention. The Trust has demonstrated resilience and a proactive approach in addressing these complex risks.

IPC's role as an expert partner in the built environment, particularly through the Start Well programme, provides assurance that future clinical environments will be designed to support safe, high-quality care.

The Trust remains committed to continuous improvement, embedding IPC as a core component of patient safety, and maintaining robust assurance to the Board and external stakeholders.

PATIENT EXPERIENCE

Learning from National Patient Surveys 2025/2026

The Trust received the results for three national patient experience surveys during 2025-2026. These were:

- Maternity: fieldwork April - June 2025, publication 10 December 2025
- National Adult inpatient 2024: fieldwork January - April 2025, publication September 2025

Adult Inpatient Survey 2024

The national adult inpatient survey is held annually, with patient cohorts being those who had spent one or more nights in hospital during November 2024, fieldwork was January – April 2025 and results were published nationally on 10 September 2025.

Overall experience

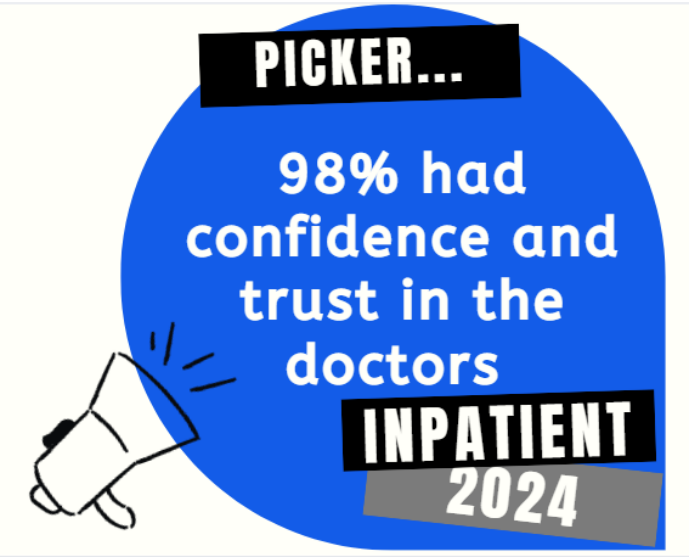
The Trust achieved an overall experience score of **7.9**. This represents:

- **No statistically significant change** from the 2023 score of 8.0
- **A notable improvement** from the 2022 score of 7.5

Across the full survey:

- The Trust achieved **significant improvement in 11 questions** between 2022 and 2024 results
- A further **2 questions showed significant improvement** between 2023 and 2024 results

These results indicate a sustained upward trajectory in several key areas of patient experience.



Survey participation and demographics

1,250 patients were invited to take part, **our response rate was 29%** in line with the previous two years, although there had been a slight increase on those who responded, increasing from 337 in 2023 to 348 in 2024, against a national average response rate of 41%.

- ethnicity – no significant change with 56% White
- gender – again no notable change with the majority of responses being from women, 56% and 43% men.

Methodology and accessibility

The survey was delivered using a **mixed-mode** approach, combining online and paper questionnaires. Invitations and reminders were issued via both letter and text message. To ensure accessibility and inclusivity, the survey was offered in a wide range of formats, including:

- Braille
- Easy Read
- British Sign Language
- Non-English languages
- Telephone-assisted completion
- Screen-reader compatible online version
- Freephone language line for translation support

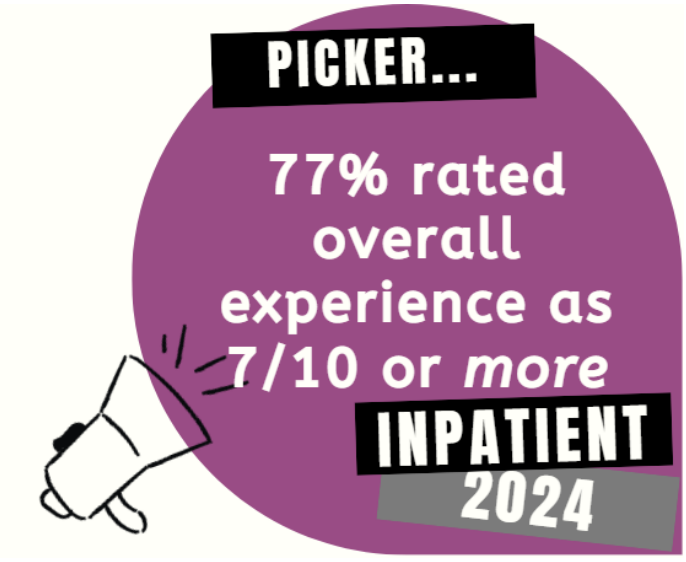
This comprehensive approach supports equitable participation across diverse patient groups.

New survey content (2024)

The 2024 survey introduced new sections covering:

- **Basic needs** (personal hygiene, food, medication)
- **Individual needs** (religious, cultural, dietary, language, accessibility)

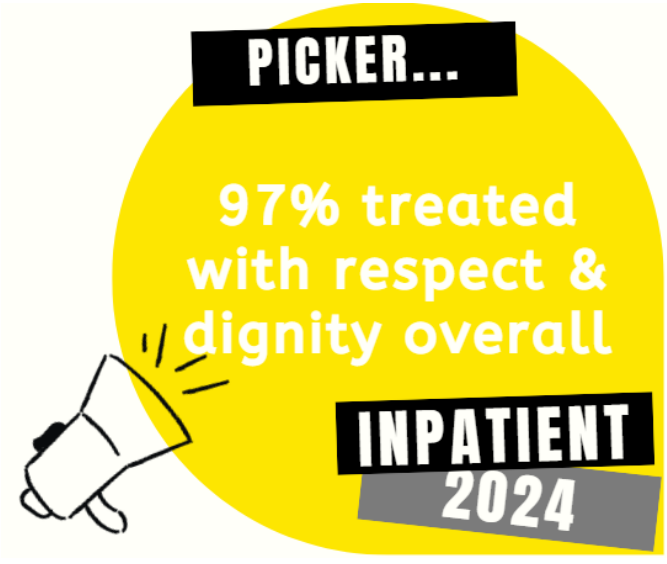
As these sections are newly introduced, results are **not comparable** with previous years. They will, however, provide a valuable baseline for future monitoring.



Our top five and bottom five scores from the survey compared with the national average are shown below.

Top five scores compared to national average	
5.2	Thinking about any medicine you were to take home, were you given any of the following? [nb: the survey listed specific medicines]
7.1	Did the hospital staff explain the reason for changing wards during the night in a way you could understand?
4.2	Were you ever prevented from sleeping at night by any of the following? I was not prevented from sleeping at night?
6.0	To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?
8.2	Before you left the hospital, were you given any information about what you should or shouldn't do after leaving hospital? This includes any verbal, written or online information?

Bottom five scores compared to national average	
6.3	Thinking about your care and treatment, did hospital staff take into account the following individual needs? Religious needs (e.g. space to pray / meditate)
5.5	How did you feel about the length of time you were on the waiting list before your admission to hospital?
6.9	Thinking about your care and treatment, did hospital staff take into account the following individual needs? Language needs (e.g. translation, braille)
5.1	Were you able to get hospital food outside of set mealtimes? This could include additional food if you missed set mealtimes due to operations/procedures or another reason.
7.5	Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?



Key successes included people being offered food that met their dietary requirements, increasing from 85% in 2021 to 94% (above the picker average of 90%). Other successes were **doctors included patients in conversation at 97%,** 1% above the Picker average and an increase of 3% on our 2021 results of 94% and told who to contact if worried after discharge, at 72%, 8% increase on our 2021 results.

98% of respondents **have confidence and trust in the doctors** and **97% of our patients were treated with dignity and respect**. These positive results are testament to the hard work and care of our clinical staff, and we aim to improve on these scores and on the experience of our patients.

Summary

The 2024 Adult Inpatient Survey results show a **stable overall experience score**, continued **improvement across multiple question areas**, and **consistent participation patterns**. The Trust's performance demonstrates progress since 2022 and maintains parity with 2023, despite increasing operational pressures. The introduction of new survey domains in 2024 will enhance future insight into fundamental and individual patient needs.

Maternity survey 2025

The 2025 Maternity Survey was the twelfth carried out to date. Invitations were sent to 43,955 maternity service users across 119 NHS trusts, and 16,755 completed responses were received, an adjusted response rate of 38.53% (excluding undelivered questionnaires). The Maternity Survey is split into six sections that ask questions about antenatal care, labour and birth, care in the ward after birth, postnatal care, triage: assessment and evaluation and complaints

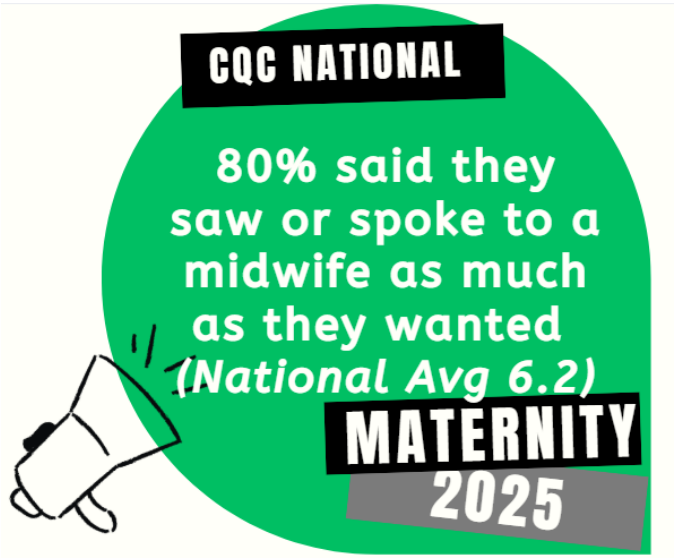
Participants were eligible if they were aged 16 or over at the time of delivery and had a live birth at an NHS trust between 1 and 28 February 2025. For trusts with fewer than 300 births in February, births from January 2025 were also included.

Overall experience

A pattern of **strong performance in relational care** (staff interactions, triage, and feeding support), contrasting with weaker outcomes in antenatal check-ups, ward-based postnatal care, and labour and birth, exacerbated in some areas by low response rates. Compared with all trusts, we **scored about the same on 48 questions**, b**etter on 4 and much better than expected on 1 question**.

Overall, our results show continued improvement over the past two years, with sustained performance and stable national benchmarking outcomes.

Comparisons with other NHS trusts	2025	2024	2023
About the same	48	49	44
Much better than expected	1	0	0
Better than expected	4	2	1
Somewhat better than expected	2	0	3
Somewhat worse than expected	1	3	4
Worse than expected	0	0	1
Much worse than expected	0	0	1



Survey participation and demographics

Our response rate **increased by 2%, rising to 39%** in 2025 (up from 37% in 2024), matching the national average of 39%. A total of 115 out of 300 people completed the survey, five more than in 2024. Among respondents, **76%** reported **English as their main language**, and **96% required no additional communication support**.

Best performance summary

The 2025 results show a robust performance in several aspects of postnatal care, with scores consistently above the national average and improvements, compared with 2024 where comparable data is available. Overall, the 2025 results reflect strong, patient-centred postnatal care, with improvements in key communication and support measures, and performance consistently exceeding national benchmarks.

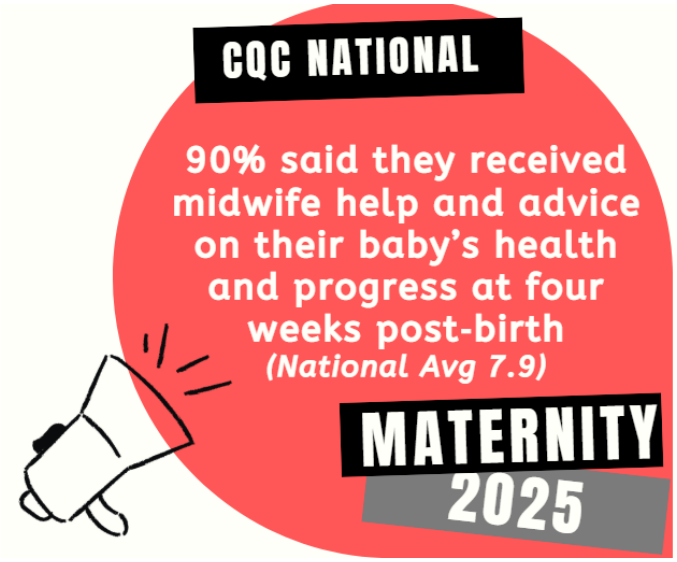
Top five Questions	Our score 2025	National average
Postnatal Care: Care at home after birth G4. Would you have liked to have seen or spoken to a midwife	8.0	6.2
Care in the Ward D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?	8.9	7.4
Postnatal Care: Care at home after birth G16. In the four weeks after the birth of your baby, did you receive help and advice from midwives about your baby's health and progress?	9.0	7.9
Postnatal Care: Care at home after birth G13. Were you given information about your own physical recovery after the birth?	7.7	6.9
Postnatal Care: Care at home after birth G5. Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?	8.6	7.8

Worst performance summary

The 2025 maternity survey results highlight areas where performance fell below the national average or declined compared with our 2024 results. These findings indicate opportunities for strengthening consistency, communication, and continuity of care across the maternity pathway.

Bottom five Questions	Our score 2025	National average	Our score 2024
Antenatal Care: During your pregnancy B12. During your pregnancy, did midwives provide relevant information about feeding your baby?	6.2	7.3	Not available
Care in the Ward D2. On the day you left hospital, was your discharge delayed for any reason?	5.6	6.2	6.0
Labour and Birth: Your labour and birth C7. During your labour, were you ever sent home when you were worried about yourself or your baby?	8.6	9.1	9.0
Antenatal Care: During your pregnancy B13. Did you have confidence and trust in the staff caring for you during your antenatal care?	8.0	8.4	8.0
Antenatal Care: Antenatal check-ups B4. During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?	6.9	9.0	7.4

Overall, the 2025 results point to recurring themes around communication, continuity, and personalisation of care, particularly during antenatal appointments and discharge processes. Targeted actions in these areas will be essential to improve patient experience and align more closely with national performance levels.



Summary

The 2025 Maternity Survey results show that our Trust continues to make steady progress, with overall performance remaining stable and, in several areas, improving compared with previous years. We performed at a similar level to other trusts on most questions and achieved better or much better-than-expected results in a small but meaningful number of areas. More importantly, no areas were rated worse or much worse than expected, demonstrating consistency in the quality of care delivered.

Evidence of interpersonal care, particularly the support provided by staff, quality of triage assessment, and improvements in postnatal communication stand out as a key strength for the Trust. Several of our highest-scoring questions relate to personalised advice, continuity of postnatal support, and responsiveness of midwifery care, with results consistently above the national average.

However, the results also highlight areas where improvements are needed. Lower-performing results relate mainly to antenatal care, awareness of medical history, provision of feeding information during pregnancy, and discharge delays from the postnatal ward. These findings reflect recurring themes around communication, continuity of information, and operational processes, all of which affect the overall patient experience. Addressing these issues will be essential to ensuring a more consistent, personalised, and well-coordinated care across the maternity pathway.

2026/2027 National survey programme

During 2026/27, we will be participating in the following patient experience surveys:

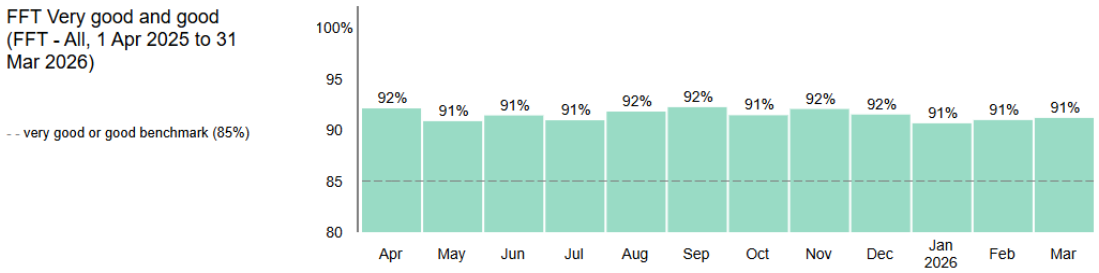
- **2026 Children and young people:** fieldwork July – October 2026, publication March 2027 (TBC)
- **2026 Urgent and emergency care:** fieldwork April – July 2026, November 2026 (TBC)
- **2026 Maternity:** fieldwork April – July 2026, publication November 2026 (TBC)
- **2025 Adult inpatients:** fieldwork January – April 2026, publication August 2026 (TBC)

Patient feedback: Friends and Family Tests

Our Friends and Family Test (FFT) response rates continue to demonstrate high levels of patient satisfaction. 91% of patients rated our services as “very good” or “good”, placing us well above the NHS benchmark of 85%.

In contrast, only 4.73% of patients rated their experience as “very poor” or “poor”, which remains below the NHS benchmark of 5% and represents a slight improvement on last year’s negative response rate.

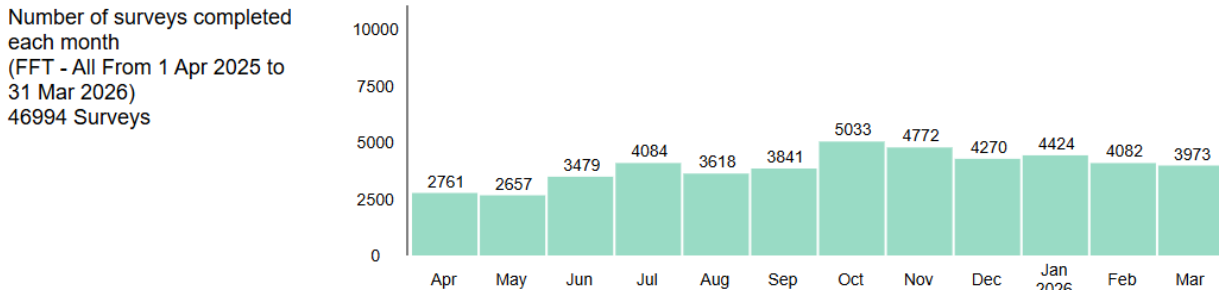
The graph below illustrates our monthly performance for “very good” and “good” ratings compared with the NHS 85% benchmark. It shows a consistently strong performance, with the Trust exceeding the national benchmark every month throughout the year.



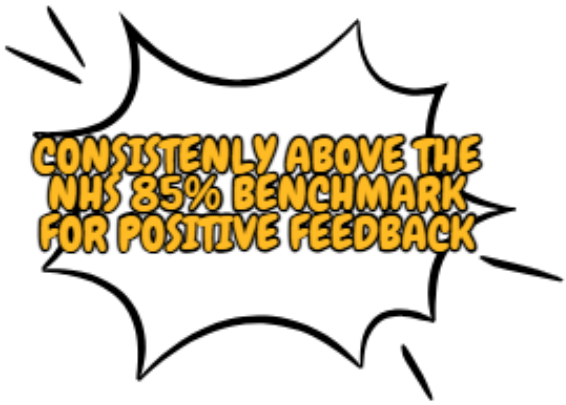
Performance against the NHS benchmark by month 2025 - 2026

A total of 46,994 surveys were completed in 2025/2026, marking a significant increase of 17,457 responses compared with 29,537 in 2024/2025. October 2025 achieved the highest monthly submission volume, with 5,033 responses, compared with 3,085 in July of the previous year, an impressive rise of 1,947. This growth is three times higher than the increase seen the year before (603).

This exceptional uplift aligns with a targeted intervention led by the Patient Experience Team, who expanded the use of SMS-based feedback collection across several community areas. This focused approach has clearly strengthened engagement and supported a more representative understanding of patient experience across the Trust.



Number of FFT Surveys completed in the Trust by month 2025- 2026



Work continues across the Patient Experience and Voluntary Services team to promote and increase FFT responses. Looking ahead to 2026/27, a key priority is the recruitment of ward befrienders and FFT volunteers, who will play a vital role in supporting patients to complete FFTs and enhancing the overall patient experience by supporting our commitment to drive improvements.

This work includes the ongoing collection of handwritten postcard feedback, which is uploaded into the electronic reporting system to ensure every patient voice is captured.

Volunteers also provide valuable face-to-face FFT support across outpatient areas, maternity, and imaging, helping to improve accessibility and ensure patients are supported in sharing their feedback. This year we implemented FFT SMS in Maternity Postnatal services, community paediatric audiology, CDC centre, outpatient clinics and podiatry.

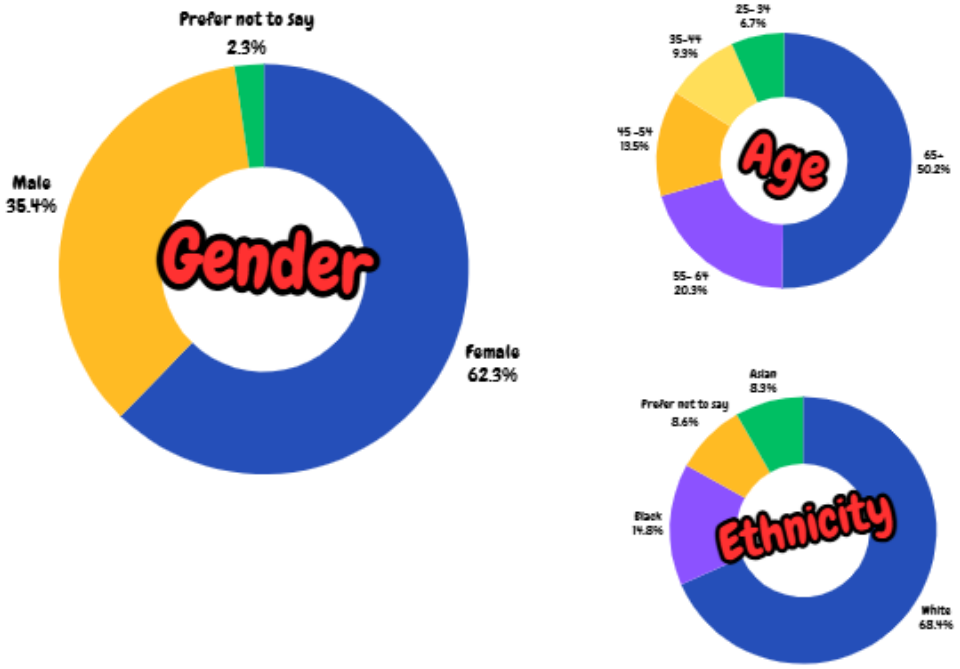
FFT responses are received from a range of sources, including:

- SMS/text 28,297 and increase of 18,461 responses on 2024/2025
- Smartphone app/tablet/kiosk before or at point of discharge or at appointment 3,788 responses, a reduction of 229 responses on 2024/2025
- Paper/postcards at the point of discharge 7, 584 responses
- Online survey after discharge/appointment 7, 312 responses
- Telephone survey after discharge of appointment 0 responses

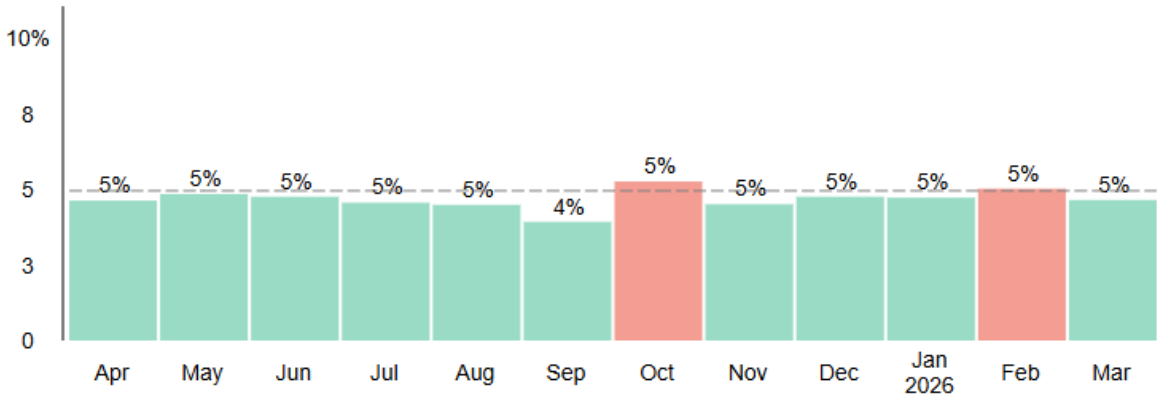
The FFT data shows that most respondents were women, with half aged 65 or older, a further 20% aged 55–64, and 68% were White. This demographic profile gives us important insight into who is currently engaging with the FFT and highlights areas where we may need to strengthen our approach to ensure inclusivity.

The demographic profile of our FFT respondents highlights several areas for improvement in how we gather and act on patient feedback. Men remain significantly under-represented in our survey returns, which risks creating a gender imbalance in our understanding of patient experience and indicates the need for more targeted approaches to increase male participation. In addition, because older adults make up the majority of respondents, their feedback disproportionately shapes our overall results, reinforcing the importance of prioritising improvements in the services they use most frequently, particularly outpatient care, inpatient wards, and frailty-related pathways, however, this also indicates that a more targeted approach to obtaining feedback from younger patients important, as not to exclude their opinions.

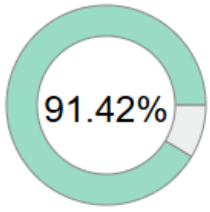
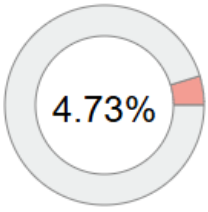
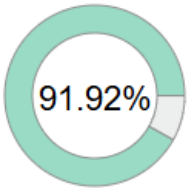
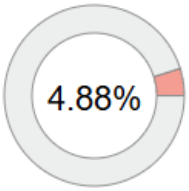
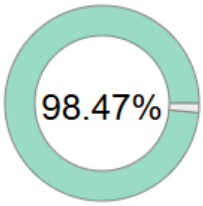
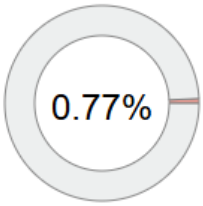
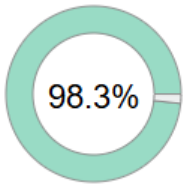
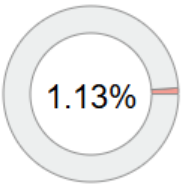
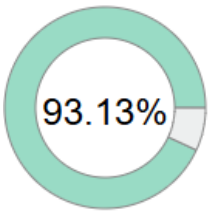
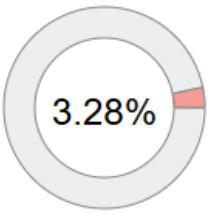
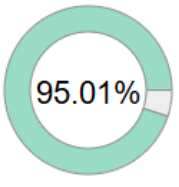
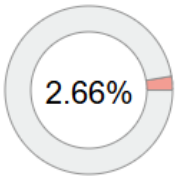
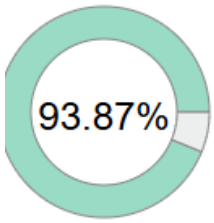
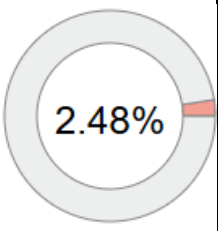
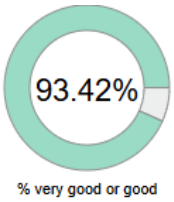
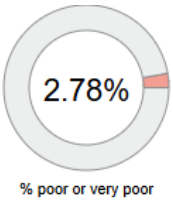
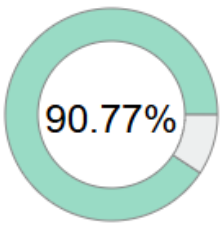
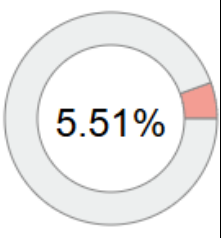
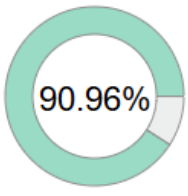
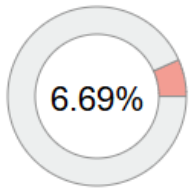
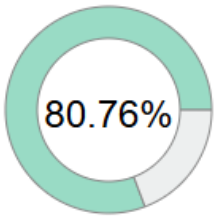
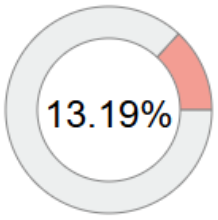
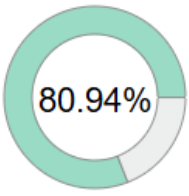
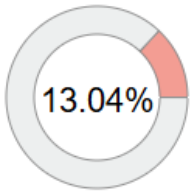
We also see clear under-representation from ethnic communities, which means we may not be fully hearing the experiences of groups who already face known inequalities in healthcare access and outcomes. Addressing this will require more inclusive feedback methods, wider use of interpreters and translated materials, greater volunteer support, and targeted outreach through trusted community networks to ensure we are capturing the voices of all patient groups across our diverse local population.



The graph below illustrates the month-by-month percentage of responses rated “very poor” or “poor,” compared against the NHS benchmark of <5%. Over the reporting period, there are ten months where our results fell below the 5% threshold. This demonstrates a positive and sustained improvement in patient experience, reflecting the effectiveness of our ongoing quality and service-improvement efforts and an improvement on last year’s results where we fell below the expected target for six months.



Poor and very poor responses for all FFTs

2025 - 2026			2024-2025		
 % very good or good	 % poor or very poor	**FFT - All**	 % very good or good	 % poor or very poor
 % very good or good	 % poor or very poor	**FFT – Maternity Combined**	 % very good or good	 % poor or very poor
 % very good or good	 % poor or very poor	**FFT - Community**	 % very good or good	 % poor or very poor
 % very good or good	 % poor or very poor	**FFT - Inpatient**	 % very good or good	 % poor or very poor
 % very good or good	 % poor or very poor	**FFT - Outpatient**	 % very good or good	 % poor or very poor
 % very good or good	 % poor or very poor	**FFT – Emergency Department**	 % very good or good	 % poor or very poor

Patient Experience & Engagement Strategy 2026–2030 – Summary

Ensure clear, compassionate, and consistent communication across all patient interactions. Complaints, FFT and national survey feedback has consistently highlighted that communication is a critical component of experience. Our patients/carers have told us that clear, timely, compassionate and consistent communication, with both patients and between ourselves is essential to feeling informed, respected, and confident in the care we provide.

The Patient Experience team ran an online survey—translated into the Trust's five most-used languages—to understand the experiences of patients who speak English as a second language. Despite wide promotion and an extended deadline, responses were low, which indicates that while efforts were made to reach diverse communities, more targeted and culturally appropriate approaches are needed.

Our Patient Experience and Engagement Strategy for 2026/2030 sets out a clear vision for how we will elevate the experience of every patient, carer, and family member who uses our services. Built around listening, engaging, and empowering, the strategy outlines a focused action plan that strengthens how we hear and respond to what matters most to our communities.

At its heart, this strategy commits us to enhancing how we communicate, connect, and care. We aim to create environments where every individual feels genuinely heard, respected, and supported throughout their entire healthcare journey. We believe that true quality care goes beyond clinical excellence and requires compassion, empathy, and partnership. By empowering our workforce, improving access to feedback, and embedding the patient voice in decision-making, we will ensure that every interaction reflects our commitment to dignity, respect, and person-centred care.

This strategy charts a path towards a culture where feedback drives improvement, staff feel confident and supported to deliver outstanding experiences, and patients feel valued as true partners in their care.

"A good patient experience in the NHS is defined by several key principles and practices that ensure care is safe, compassionate, personalised, and coordinated."

The strategy commits to three pillars, these are:

- **Communication** – making sure every patient feels listened to, kept informed, and actively involved, while doing what we say we will do
- **Engagement** – fostering collaborative relationships between our community, patients, carers, and staff
- **Environment** – creating spaces that support comfort, dignity, and wellbeing

A clean, safe, and comfortable environment is key to positive patient experiences. You told us cleanliness, hygiene, and food quality matters.

Volunteers from the North London Sight Loss Council supported the Trust with a detailed review of site signage and accessibility. This work followed a powerful patient story shared at Trust Board, where a visually impaired patient highlighted the challenges they faced when navigating the hospital.

Engaging patients & carers is vital to shaping services that meet real needs. By listening, involving, and collaborating, we build trust, improve outcomes, & amplify seldom-heard voices.

Patient experience: patient stories presented to the Board during 2025/26:

The Q Factor

Summary

This patient story highlighted the experiences of individuals from a minority background accessing healthcare, emphasising the need for equitable care and inclusive communication. It reflected that some people may delay seeking care due to concerns about discrimination or past experiences, and that inequalities in communication can still occur.

Insights gathered from patient interviews informed an educational initiative to improve understanding, encourage open dialogue, and address barriers to access. Key learning points include using person-centred communication, avoiding assumptions, listening actively, and acknowledging mistakes when they happen. Overall, the story reinforces the importance of compassionate, respectful care to ensure all patients feel safe and supported.

Learning

This highlights the importance of person-centred communication, including avoiding assumptions and using open questions to understand individual needs. Encouraging patients to lead conversations builds trust and engagement, while active listening demonstrates respect. Acknowledging and apologising for mistakes also supports transparency and helps maintain confidence in care.

You said: Patients from minority backgrounds can experience barriers, including communication issues and concerns about discrimination.
We did: Whittington Health developed an educational initiative to improve awareness, inclusive communication, and staff understanding.
Impact: More person-centred interactions, improved trust, and better patient engagement.

Summary:

A long-term patient in their early 60s has been receiving care from the Trust for several decades. Their experience reflects generally positive care, including support previously provided to a close family member who received cancer treatment.

In mid-2024, the patient presented to the Emergency Department following an injury at home and was referred for diagnostic imaging. While initially advised that the imaging would take place within two weeks, the actual waiting time extended to approximately six weeks. After the scan, there was a further delay before a follow-up outpatient appointment with a specialist was arranged. At the specialist consultation, surgery was recommended with an expected timeframe of 3–6 months. However, the scheduled surgery date exceeded this timeframe and was subsequently postponed due to prioritisation of urgent cancer cases. A new surgery date was later agreed between the patient and clinician.

Overall, the patient expressed appreciation for the quality of clinical care received over the years. However, they highlighted inconsistencies between communicated and actual waiting times, as well as a need for clearer, more proactive communication regarding delays and changes to treatment plans. In recognition of the care received, the patient has since chosen to volunteer within the Trust, contributing to patient experience initiatives by offering companionship and supportive interactions to others undergoing treatment.

Learning:
The patient's experience demonstrates that, while overall care was positive, delays and inconsistent communication can significantly affect the patient journey. Waiting times for diagnostics and treatment exceeded initial expectations, highlighting the importance of providing clear, timely updates and managing expectations, particularly during periods of service pressure.

Despite this, the compassionate care received left a strong positive impression, reflected in the patient's decision to volunteer within the Trust. Their role in supporting other patients illustrates how positive experiences can encourage individuals to contribute meaningfully through empathy, support, and human connection.

You said: Waiting times were longer than expected and communication about delays was unclear.
We did: Emphasised clearer, more proactive communication and better expectation-setting during delays.
Impact**:** Improved transparency, reduced anxiety, and better patient understanding of waiting times.

Summary:
A patient in their late 40s with a long-term respiratory condition experienced a sudden deterioration in symptoms following a distressing breathing episode, leading to increased anxiety and impact on daily life. After initial challenges accessing support, they were referred to a specialist respiratory service. Assessment identified a condition affecting the upper airway, and the patient was referred for psychological support alongside clinical care.

Through coordinated, multidisciplinary input, the patient developed a better understanding of their condition and learned effective self-management strategies, resulting in improved symptoms, confidence, and quality of life. The patient highlighted the value of being actively involved in their care and praised the coordinated, person-centred approach. What began as a distressing experience became a positive and transformative journey. They have since expressed interest in supporting others by sharing their experience and contributing to peer support initiatives.

Learning:
This learning highlights the powerful impact of a holistic, integrated approach to care, where strong communication, collaboration, and patient engagement can

transform even the most difficult journeys into positive and hope-filled experiences. The patient's story demonstrates the value of involving patients as partners in their care and recognising the importance of psychological and peer support in improving outcomes. It also emphasises the potential of lived experience to inspire others, whether through advocacy, peer support groups, or promoting self-management and independence at home. Sharing this model more widely offers an opportunity to enhance patient experience and outcomes across other services and organisations.

You said: Difficulty accessing the right support and managing both physical and psychological impact of illness.
We did: Introduced coordinated multidisciplinary care, including psychological support and self-management strategies.
Impact**:** Improved symptoms, confidence, and quality of life through holistic care.

Summary:
A patient in their late 30s was diagnosed with a serious condition in 2024, beginning treatment overseas before continuing care within a UK specialist service. They received ongoing multidisciplinary treatment, including chemotherapy and radiotherapy, and reported a highly positive experience, highlighting the professionalism, compassion, and coordination of care.

The patient also attended an education and support event, which was valued for providing practical advice, clinical insight, and peer connection. They expressed interest in contributing to future service development and awareness work.
While overall feedback was very positive, areas for improvement included waiting times and opportunities to enhance support events through more detailed information and greater patient-led discussion.

Learning:
The patient's experience highlights the positive impact of compassionate, high-quality care and effective patient engagement. Their feedback reflects the value of coordinated, patient-centred treatment, while the success of the support event shows how engagement can strengthen experience and connection with services. Their willingness to contribute to awareness efforts reinforces the importance of involving patients as partners in improving care. At the same time, feedback on delays in routine treatment points to an opportunity to improve efficiency and ensure consistently positive experiences.

You said: Waiting times needed improvement and support events could be more detailed and interactive.
We did: Identified opportunities to improve clinic efficiency and enhance patient events with more information and discussion.
Impact: Better patient engagement, more meaningful support sessions, and improved experience.

Summary:

A patient in their early 40s attended the Emergency Department during a public holiday with multiple injuries following an accident. They were promptly assessed and received timely investigations and treatment, including imaging and immediate clinical intervention. The patient described care from the emergency and orthopaedic teams as highly professional, compassionate, and well-coordinated. Staff demonstrated strong clinical expertise, clear communication, and a patient-centred approach, ensuring the patient felt informed and reassured throughout.

Following assessment, a specialist clearly explained the diagnosis and treatment options, including risks and benefits, enabling the patient to feel confident and actively involved in decision-making. The patient proceeded to surgery shortly afterwards. In the lead-up, proactive communication provided reassurance, and on the day, staff were supportive, attentive, and kind, contributing to a positive experience. The patient continues to receive outpatient follow-up care and expressed strong appreciation for the professionalism, teamwork, and consistently compassionate approach across services.

Learning:
This highlights key opportunities to improve patient experience through stronger communication, coordination, and continuity of care. Gaps in communication can increase anxiety and lead to avoidable use of emergency services, reinforcing the need for clear, timely information. Proactive follow-up, particularly by clinical nurse specialists, can improve understanding and outcomes. Strengthening communication systems and coordination roles will promote consistency, reduce distress, and build patient confidence.

You said: Care was highly positive, particularly communication, compassion, and coordination.
We did: Reinforced and sustained high standards of patient-centred care and teamwork.
Impact: Consistently positive patient experiences and increased confidence in services.

Summary:
This story describes the experiences of two family members who, within a short period, each faced serious and life-threatening health conditions, transitioning between the roles of patient and carer.

The first individual presented to the Emergency Department with severe illness and was rapidly assessed and treated. During their admission, they experienced a cardiac arrest requiring resuscitation and intensive care support. Following stabilisation, multiple complex conditions were diagnosed, requiring ongoing multidisciplinary input and specialist follow-up after discharge. Throughout this period, close family members were actively involved, kept informed, and supported to be part of decision-making.

Several months later, a second family member required urgent care after developing acute symptoms. Due to delays in ambulance response, alternative transport to hospital was arranged. On arrival, they were promptly assessed and

diagnosed with a serious bowel condition, including a tumour requiring emergency surgery. Following successful surgical intervention, they received coordinated post-operative care and support, including specialist nursing input to aid recovery and adjustment to long-term changes.

Across both experiences, the family highlighted the high standard of care, strong collaboration across multiple teams, and clear, compassionate communication from staff. Despite the emotional and physical challenges faced, these factors helped them navigate complex care pathways and achieve more stable outcomes. The story also reflects the lasting impact of care experiences, with one individual expressing a desire to use their lived experience to support others in a similar situation in the future.

Learning:
This highlights the vital role of seamless multidisciplinary teamwork, clear communication, and compassionate care in supporting patients through highly traumatic experiences. The coordinated approach across the Emergency Department, ICU, Mercers Ward, and Oncology ensured continuity, efficiency, and a consistently high standard of patient-centred care. Both patients' experience demonstrates how working collaboratively can significantly improve outcomes and help patients adjust to life-changing circumstances. One of the patient's desire to give back by supporting others further reinforces the lasting impact of positive care experiences and the value of empowering patients to contribute to and enhance future services.

You said: Navigating complex, high-acuity care requires strong communication, coordination, and family involvement.
We did: Maintained a multidisciplinary, collaborative approach with clear communication and family inclusion.
Impact**:** Improved outcomes, better patient and family support, and smoother transitions across services.

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 for quality improvement (QI) and clinical effectiveness, continued to strengthen the clinical effectiveness agenda. Regular reports on clinical effectiveness, including national and local audit, National Institute for Health and Care Excellence (NICE) recommendations, local clinical management guidelines, clinical policies and quality improvement initiatives, are received and discussed at the CEG alongside updates from the Multidisciplinary Trauma team and Organ Donation Group. Reports are collated and summarised for review at the Quality Governance Committee (QGC) and included in the quarterly quality report for the Quality Assurance Committee and Trust Board.

Our key achievements during 2025/26 included the following:

- Work to re-structure all online clinical guidelines completed during Q1, enabling instantaneous Trust reporting on review date compliance. The presentation of each existing "legacy" Intranet sub-page which lists clinical guidelines by their primary specialty was finalised during Q2, and we have made additional refinement to the paediatric Intranet guideline page in order to reflect the sub-clinical areas and further improve the user experience. Ten clinical specialities have 100% of their respective clinical guidelines "in date".
- The Trust Antimicrobial Guidelines (EOLAS) have continued to expand over the reporting period. To support consolidation and improve accessibility of infection-related guidance, infection pharmacists have led the migration of content from the Trust intranet to EOLAS. In parallel, the antimicrobial stewardship team is undertaking a comprehensive review of all infection guidelines to ensure alignment with the hospital-wide antibiogram.
- There has been a significant resurgence of GIRFT activity over the past six months to include highly positive virtual reviews for CAMHS, Sickle cell & Thalassaemia and Chronic Pain alongside a successful Surgical Hub accreditation.
- We remain committed to celebrating of areas of excellence and success and sharing relevant learning. In July 2025, we held our annual QI celebration afternoon, and once again saw a variety of Improvement projects presented to a multidisciplinary audience. Over half of these projects were able to demonstrate how they have led to cost savings as well as improving the care we give to patients. After each presentation there was a chance for questions, with notable positive engagement from the audience.

The projects presented were:

- Imbedding vaccination into the Hospital pharmacy service: opportunities and impact
- Treating tobacco and nicotine dependency
- Sustainability in ophthalmology
- Implementing the hot cholecystectomy pathway
- Improving elective coding
- The patient flow programme
- Improving frail patients flow through the ED
- Wood Green community diagnostic centre ethnicity recording project
- Improving iron overload monitoring and outcomes in transfusion-dependent thalassaemia
- Improving adherence to rapid tranquilisation guidelines in the ED

This year has also seen two departments hold their own QI celebrations: the adult community services clinical division and the pharmacy team. Both of these areas had set the expectation that each team would have worked on a QI project throughout the year and as a result there were some great projects completed.

The QI Lead has continued to lead QI training regularly, as well as leading sessions on existing staff courses. This training helps to further develop improvement capacity across the Trust, and coaching or advice sessions on individual projects are also offered.

National audits

During 2025/2026, a total of 66 national clinical audits including 6 national confidential enquiries covered relevant health services that Whittington Health provides. The Trust participated in 98% of these national clinical audits and 100% of national confidential enquiries.

The Trust also participated in 22 non-mandatory national clinical audits, a notable increase from the previous year.

Clinical audit reporting continues to provide a vital mechanism to capture care quality across the organisation. In particular, we recognised the importance of national clinical audit as one of the strongest tools at our disposal to drive quality improvement across a wide range of specialities.

Clinical audits provide a rich and valuable data source for measuring the quality of care; they enable us to see what is working well and what is not and to identify where change would have the greatest impact. Learning from outcomes has therefore remained a key priority, facilitated by regular Trust Improvement afternoons, clinical audit workshops, Quality Improvement training and coaching sessions and bespoke training of staff cohorts.

RESEARCH

Context

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

The Trust's research activity (R&D) has remained stable despite a reduction in core funding from the North London Regional Research Delivery Network. The in-house research & development 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 further reduced, and we continue to work to become 'national leaders' in this regard.

Staffing and staff engagement

Whittington Health currently has 20.5 whole time equivalent (WTE) research staff - an increase from 17.5 WTE in the previous year. 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 been broadened to encompass Nursing, Midwifery and AHP (now NMAHP) and additional services have seen staff receive National Institute for Health and Care Research (NIHR), Health Education England, and other awards to facilitate protected time for research development (specialist physiotherapy and occupational therapy services).

Many of the Trust's clinicians remain research active. In the first six months of the year, there were more than 70 publications as demonstrated by a PubMed search for 'Whittington Health' or 'Whittington NHS' suggesting the final year output will have increased from the 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) 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 the UK leaving the European Union.

The table below sets out the recruitment of patients to NIHR portfolio studies during 2025/26. This figure shows a further 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 14 days to confirm capacity & capability (a reduction from 60-day average in 2023/24) and well within the government target of 60 days. 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	1524	68	15
2025/26	1594	72	5

Completed trials and outcomes

Publication of a selection of trials (performed at or recruiting at Whittington Health) in the last year are described below, study titles in bold are sponsored by Whittington Health NHS Trust:

- Bivalent prefusion F vaccination in pregnancy and respiratory syncytial virus hospitalisation in infants in the UK: results of a multicentre, test-negative, case-control study *The Lancet Child & Adolescent Health* 2025;9(9): 655-662.
- **Cross-sectional study of healthcare professionals' estimates of the health numeracy of inpatients and outpatients in a UK secondary care setting** *BMJ public health* 2025;3(2): e002659-002659. eCollection 2025.
- Exploring the Acceptability of Post-bariatric Nutritional-Behavioral and Supervised
- Exercise Intervention (BARI-LIFESTYLE): A Mixed Methods Evaluation *Obesity Surgery* 2025;35(7): 2471-2479.
- HER-SAFE study design: an open-label, randomised controlled trial to investigate the safety of withdrawal of pharmacological treatment for recovered HER2-targeted therapy-related cardiac dysfunction *MJ Open* 2025;15(2): no pagination.
- Low-dose CT for lung cancer screening in a high-risk population (SUMMIT): a prospective, longitudinal cohort study *The Lancet.Oncology* 2025;26(5): 609-619.
- **Palin Stuttering Therapy for School aged Children and usual treatment: A randomised controlled trial feasibility study** *Journal of fluency disorders* 2025;84 106114.
- The COVIDTrach prospective cohort study on outcomes in 1982 tracheostomised COVID-19 patients during the first and second UK pandemic waves *Scientific Reports* 2025;15(1): no pagination.

GUARDIAN OF SAFE WORKING HOURS

Significant changes were brought into effect in February 2026 regarding the exception reporting process. The main changes include:

1. All reports bypass the supervisor and are now signed out by Human Resources (HR) and are overseen by the Guardian of Safe Working Hours (GoSWH);
2. Confidentiality clauses are now in place meaning that the exception reports (ER) that are submitted and their outcomes are not allowed to be discussed with their teams and fines are levied accordingly;
3. Any ER that are more than two hours need to be submitted with a probity statement;
4. Time frames for submission have been adjusted – there is now a 28-day limit (rather than 7 or 14 that were previously in place) on when ER can be submitted and these need to be signed out by HR within 7 days; and
5. Additional fines can be levied if there are delays in providing access to the ER system

The GoSWH 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 ER process by resident doctors and this continues to be monitored in terms of the ER submitted by grade and speciality. These clearly document the extra hours worked over and above their rostered hours and reasons for this, as well as breaks or any educational opportunities that are missed. The time accrued through exception reports continue to be reimbursed with either time off in lieu (TOIL) or payment (according to the choice of the resident doctor unless TOIL is mandated for safety. The reasons for extra hours worked are analysed, where possible, to try and effect change to prevent this from recurring where possible.

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 is 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.

This year covered periods of industrial action by resident doctors. Ongoing high levels of acuity of patients meant that there continued 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 on already stretched rotas, these are largely renumerated in financial payments.

The GoSWH 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.

The tenure of the current GoSWH ended on 23 April 2026 and a successor has been appointed.

INTEGRATED CARE ORGANISATION AND SYSTEM WORKING

Delivering Whittington Health's strategic priorities requires strong collaboration across the North Central London Integrated Care System and beyond. In 2025/26, system working continued to strengthen clinical pathways, improve population health outcomes and address health inequalities.

Integrated Care Organisation

As an integrated care organisation, Whittington Health continues to demonstrate the value of multi-disciplinary and multi-agency collaboration in delivering joined-up, patient-centred care.

We continue to run discharge hubs for both Whittington Health and UCLH, maintaining safe and efficient transfers of care. We have also sustained our leadership role in the North Central London virtual wards (now called Hospital at Home) programme across UCLH, North Middlesex and the wider system.

The Islington Complex Virtual Ward has matured into a resilient high-acuity community service, jointly delivered with UCLH consultants, providing hospital-level care at home and strengthening cross-Trust integration.

Our multidisciplinary teams remain central to delivering neighbourhood-based, preventative and rapid-response support across Islington PROFACCT (INCs and ICAT) and Haringey (MACCT). These teams bring together a wide range of specialists to prevent hospital admissions and enable timely discharge.

Borough Partnerships, Place based care and Neighbourhood Health

In 2025/26, Whittington Health strengthened its commitment to local partnership working by forming a collaborative alliance that positions the organisation as an integrator across both Islington and Haringey. This role supports delivery of shared borough priorities and underpins the development of neighbourhood-based models of care.

Whittington Health continues to hold key leadership roles within both borough partnerships. As part of our integrator function:

- Our Clinical Director for Adult Community Services now chairs the Haringey Neighbourhoods and Inequalities Board, ensuring that Whittington Health Community Services are aligned to neighbourhood priorities and actively shaping neighbourhood health delivery.
- The Chief Executive continues as co-chair of the Haringey Borough Partnership, contributing to collaborative decision-making and strategic alignment across partners.
- We have supported the implementation of neighbourhood programmes in both boroughs, helping to create clearer integrated pathways, consistent operational approaches and stronger interfaces between organisations.

These integrator arrangements will continue into 2026/27, supported by regular meetings and enhanced alignment between local authorities, voluntary sector

partners, primary care and mental health services. This approach brings partners together around shared local priorities, helping ensure residents receive coordinated, place-based support.

Key developments include:

- embedding multi-disciplinary team on the neighbourhood footprint in 2026/27 to support more proactive and responsive care
- strengthening borough-wide coordination to support the shift from acute care to community care
- aligning Whittington Health community services more closely with local authority and neighbourhood footprints to ensure consistency in delivery and improved resident experience

Neighbourhood working will continue to evolve in 2026/27, shaping future models of care by enhancing local prevention, strengthening integration and improving access to joined-up community health and care services.

Clinical Interface Group

The Clinical Interface Group remains a key forum for strengthening working relationships between primary and secondary care. In 2025/26, we worked closely with the ICB, local GPs and neighbouring Trusts to support system wide improvements at the interface between primary and secondary care.

Key developments included the implementation of the primary/secondary care interface workstream, introducing updated standards to reduce common issues for patients moving between care settings. A new system has been established to notify secondary care of practice not aligned with these standards — such as inappropriate requests for GPs to follow up hospital-ordered tests — and to share patient safety alerts where such actions have led to potential or actual harm, supporting learning and improvement.

The group also supported the introduction of new cardiology pathways, including updated guidance for managing non-urgent chest pain and interpreting 24-hour tape results. These changes enable faster access to results for patients and reduce unnecessary referrals to secondary care.

Through ongoing engagement with local GPs, the group has raised and resolved issues affecting primary care, including experience of the new pathology service, and supported the introduction of new Whittington Health services such as changes to bariatric pathways. The forum continues to provide a shared space for primary and secondary care to understand pressures across the system, helping foster stronger relationships and more effective joint working.

North Central London Integrated Care System

We continued to play a key role in the North Central London Integrated Care System, contributing to shared priorities through active participation in the Clinical Advisory Group, Chief Executive Group and other core system committees. We also work closely with partners through the NCL Health Alliance, the provider collaborative bringing all Trusts together to address system-wide challenges and reduce health inequalities. Our senior leaders have been instrumental in shaping and strengthening

the University College London Health Alliance, ensuring Whittington Health remains central to collaborative, integrated care across North Central London.

Population health and anchor institution

Population health and inequalities

In 2025/26 Whittington Health continued to strengthen its population health and health equity approach, building on the strategic priorities launched in 2024. Through coordinated work across services, enhanced data insight, and deeper engagement with our communities and partners, we continue working towards reducing avoidable, unfair variations in experience, access and outcomes.

Strategic priorities

Our communities are becoming more diverse

Work continued to improve the accessibility of patient letters and information, to ensure compliance with the Accessible Information Standard and enabling on-page translation into multiple languages.

We strengthened partnership working with local councils, voluntary and community organisations, the Integrated Care Board, and residents, as work progressed to deliver the neighbourhood health model. Activity focused on ensuring that services, communications, and data better reflect the diversity of our population and accurately capture community need.

Increase in disease burden – focus on Core20PLUS5 conditions

Work continued to address rising levels of cardiovascular, respiratory, cancer, and mental health conditions, particularly in the most deprived areas. A range of targeted programmes demonstrated improvements in access and outcomes, which were showcased at the health equity conference and aligned to Core20PLUS5 priorities.

Higher A&E attendances and DNAs in deprived communities

We continued to work with partners to understand patterns of A&E attendance and DNA rates, particularly among inclusion groups. Flow-improvement initiatives, partnership-led multidisciplinary teams, and targeted community-based interventions contributed to reductions in 12-hour breaches, corridor care, and avoidable A&E attendances. Proactive, neighbourhood-based support continues to focus on patients with the greatest levels of need, building on the work of the MACCT and the Proactive Frailty and Complex Care Team.

Data Quality Improvements

Through the Health Equity Steering Group, improving ethnicity and inclusion-group recording has been a continued focus. Waiting list data is now presented disaggregated by ethnicity and deprivation. Work also began to develop a Trust-wide approach to the digital reasonable adjustment flag ahead of the Accessible Information Standard deadline in September 2026.

Health equity conference

To celebrate and showcase the extensive work delivered against our health equity priorities, and to strengthen engagement with staff and wider stakeholders, a health equity conference was held in 2025. The event provided a platform to share learning, highlight achievements, and raise awareness of the programmes driving meaningful change across our communities.

Examples of impact shared at the conference included:

- Heart failure: A 30% reduction in emergency department attendances and a 51% reduction in hospital admissions among patients living in the most deprived areas, following proactive outreach and personalised support.
- Pulmonary rehabilitation: 90% of people referred through the direct-access pathway for individuals experiencing addiction or homelessness had never previously been offered pulmonary rehabilitation, demonstrating improved reach into underserved groups.
- Care-experienced young people: Since January 2024, 172 contacts were made to support 53 young people transitioning into adult services, helping to ensure safer, more equitable pathways into adulthood.
- Tobacco dependency: Recording of smoking status improved from 72% to 88%, and 42% of inpatients supported through the programme remained smoke-free at three months.

Children and Young People

Across Haringey, Islington, Barnet and Camden, our acute and community children and young people's (CYP) services continued to focus on reducing access barriers and improving outcomes for the most vulnerable, directly aligned with the national Core20PLUS5 CYP priorities.

CYP services span acute paediatrics, CAMHS, therapies, audiology, newborn hearing screening, health visiting and school nursing. Its key areas of progress included:

- Improved access to CAMHS through community in-reach into schools and early-years settings, alongside culturally adapted and neurodivergent-friendly interventions, resulting in increased engagement and reduced waiting times for targeted pathways.
- Therapies outreach using drop-ins, interpreter-supported appointments and accessible reports, enabling earlier identification of needs and better engagement from families experiencing deprivation or language barriers.
- Strengthened audiology and newborn hearing screening, with active non-attender tracking and flexible interpreting models improving KPIs and reducing missed appointments among vulnerable groups.
- Targeted acute paediatric asthma support, including home and school visits and housing advocacy, which contributed to improved asthma control and fewer emergency attendances.
- Enhanced health visiting, with a proportionate universal model, centralised booking with interpreter support, and targeted programmes such as the Metropolitan Early Childhood Service Hub increasing uptake of mandated reviews and improving early identification.

Anchor institution

During 2025/26, Whittington Health continued to play an active role as an anchor institution across Haringey and Islington, working in partnership with local authorities, the Integrated Care System, and other public-sector anchors. This work focused on maximising the Trust's contribution to local social value through employment, procurement, and partnership working, supporting inclusive economic growth and addressing wider determinants of health. Activity aligned with place-based priorities, including local recruitment, support for residents furthest from the labour market, and collaboration with community and voluntary sector partners.

We supported 120 work shadowing placements, primarily for school students across London. In July 2025, we delivered a targeted doctors' shadowing week for 18 sixth form students from Camden, Islington and Haringey, focusing on those without existing connections to medicine and those eligible for free school meals. We also continued to host T Level students, with seven learners from Westminster Kingsway College completing placements across 2024/2025. We continued our partnership with Project Search and The Autism Project, both supported internship programmes that provide young people with learning disabilities and autism with meaningful work placements and skills development to support their transition into employment.

Throughout 2025/26, we have continued to develop and expand programmes of work to improve our services and ensure they better meet the needs of the populations we serve.

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.

Staff Group	Headcount	FTE
Additional professional scientific and technical	414	347.00
Additional clinical services	827	743.91
Administrative and clerical	1123	1053.39
Allied health professionals	666	586.63
Estates and ancillary	309	259.85
Healthcare scientists	59	54.87
Medical and dental	670	596.10
Nursing and midwifery registered	1548	1441.41
Students	27	25.10
Grand Total	**5643**	**5108.27**

Winter flu vaccinations

The Trust ran the winter flu vaccination programme for staff using a variety of approaches at the hospital and community sites. The vaccination campaign was coupled with supporting all staff to make informed choices about getting vaccinated. The Trust continued to utilise the vaccination centre located in the Jenner Building on the acute site, meaning that the staff vaccination programme could be delivered from a dedicated space. 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 39.7% versus 39% across London and 38.2% across North Central London. The Trusts 2025 uptake was a 5.4% increase from 2024.

Connecting with our people

We have regular communications channels with staff at our chief executive officer all staff briefings, and electronic newsletters with key initiatives being publicised via screensavers. We continue to monitor our performance through several committees and involve staff through the following:

- workforce assurance committee
- partnership group
- medical negotiating subcommittee
- A range of staff network groups

NHS staff survey

The NHS Staff Survey provides a vital insight into staff experience, engagement, wellbeing and organisational culture. In 2025, Whittington Health participated for the fifteenth year as an integrated care organisation, with all eligible staff invited to take part.

Participation

Of 5,432 eligible staff, 2,493 responded, giving a 46% response rate. This represents a further improvement on the previous year and is only 1% below the median response rate for acute and acute & community NHS trusts. The continued increase in participation reflects growing staff confidence that feedback is listened to and acted upon.

National benchmarking

In 2025, Whittington Health achieved its strongest staff survey performance to date.

The Trust ranked first overall for positive staff experience among acute and acute & community trusts using Picker, improving significantly from twelfth position in 2024. This reflects more positive movement, and fewer areas of decline, than peer organisations. Both staff engagement and morale improved again in 2025 and remain on an upward trajectory.

- Staff engagement score: 7.06, above the benchmark average of 6.74
- Staff morale score: 6.04, above the benchmark average of 5.84

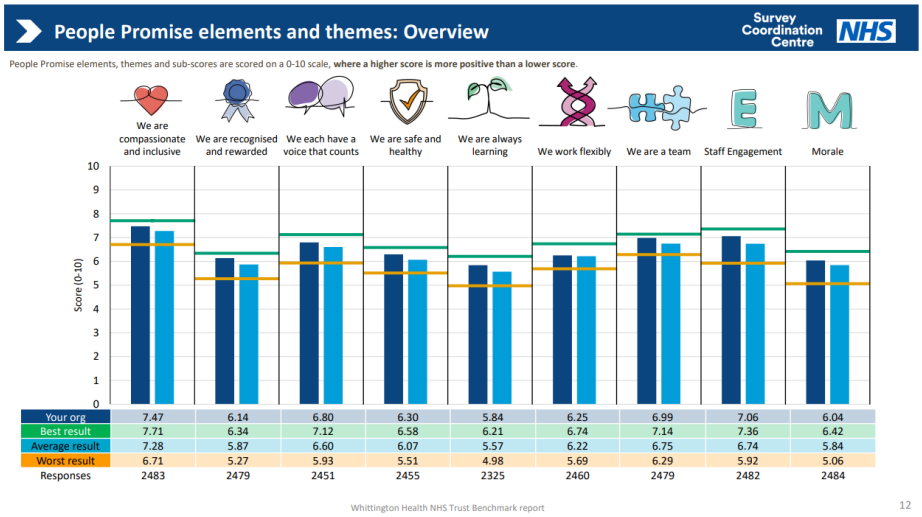
These results indicate that staff increasingly feel motivated, involved and positive about working at Whittington Health.

NHS people promise

In 2025, Whittington Health scored above average across all seven NHS People Promise elements, as well as for staff engagement and morale. All seven People Promise themes showed year-on-year improvement when compared with 2024. The table below shows Whittington Health results against the People Promise elements and against the themes of staff engagement and morale for 2025.

The greatest improvements were seen in:

- We work flexibly
- We are safe and healthy
- Staff morale



This reflects sustained organisational focus, targeted divisional actions and ongoing Trust-wide listening and engagement activity.

Staff feedback

Staff feedback highlights many strengths, including:

- Supportive local teams and line managers
- Pride in delivering high-quality patient care
- A strong sense of team working and belonging
- Confidence in raising concerns and learning from incidents

The survey also identifies areas where further improvement is required. Key themes include:

- Career development and progression
- Bullying, harassment and incivility
- Workload pressure and stress
- Reasonable adjustments for staff with long-term health conditions or disabilities

These themes are consistent with findings from trust wide listening events, People Pulse surveys, and workforce equality data.

Equality and inclusion

Performance against both the workforce disability equality standard (WDES) and workforce race equality standard (WRES) improved in 2025.

- Seven of eight WDES indicators improved, including increased confidence that reasonable adjustments are being made
- All of the WRES indicators improved, with a narrowing of experience gaps between black and minority ethnic staff and white staff

2026/27 priorities

The 2025 Staff Survey demonstrates sustained improvement in staff experience alongside clear evidence of where further work is required. The Trust has agreed three continued priorities for 2026/27:

- **Career development**, including clearer pathways and meaningful development conversations
- **Reasonable adjustments and disability inclusion**, ensuring staff with long-term conditions are supported
- **Civility and respect**, addressing bullying, harassment and abuse and strengthening compassionate leadership

Progress against these priorities will be supported through Trust-wide listening events, divisional action planning and a continued commitment to demonstrating how staff feedback leads to change.

Workforce culture

Building a compassionate, inclusive and respectful workplace culture remains a core priority for Whittington Health. Central to this commitment is our ambition to be a **listening organisation**, where staff voices directly shape organisational decisions and improvement activity.

This approach is underpinned by insight from the annual **NHS Staff Survey** and quarterly **People Pulse** surveys, which continue to inform our cultural priorities and interventions. To complement this data, and to deepen staff engagement, the

Organisational Development (OD) team delivered a programme of Trust-wide **listening events** during autumn 2025, aligned with the Staff Survey launch.

The events focused on four priority themes identified through staff feedback:

1. Disabilities and reasonable adjustments
2. Career development
3. Health and wellbeing
4. Civility and respect

A total of 143 staff attended these sessions, which were co-hosted by executive directors acting as senior sponsors. Feedback from participants was overwhelmingly positive, reinforcing that meaningful engagement builds trust, strengthens staff confidence that feedback leads to action, and enhances the overall staff experience. Further listening events are planned for 2026 to support deeper exploration of Staff Survey findings and ongoing improvement.

Coaching continues to play an important role in supporting a positive organisational culture. In 2025, 41 staff accessed coaching through the Trust's internal coaching network. To build capacity and sustainability, nine staff completed coaching foundation level training, enabling them to join the internal coaching pool.

To maintain high-quality coaching practice, the Trust delivered:

- Three continuing professional development sessions with external providers
- Four coaching supervision sessions
- Two coaches' huddles, facilitated by the OD team

The Trust's mediation service is designed and delivered to support the informal resolution of workplace conflict in a solution-focused and empowering way, enabling individuals to be heard and to shape how matters are resolved.

Team interventions continue to take place across Whittington Health to support culture. The interventions offer leaders and teams, the time and space to address challenges such as team performance, changes, and disharmony in teams. The team interventions are supported by data collected from the Staff Survey and local surveys. In response to feedback from the 2024 Staff Survey, the OD team undertook a comprehensive review of appraisal documentation and processes. This included staff focus groups and benchmarking appraisal frameworks from other organisations.

As a result, refreshed appraisal paperwork was introduced to promote more focused, meaningful and developmental conversations. Key enhancements include stronger emphasis on:

- Equality, diversity and inclusion
- Health and wellbeing
- Career development and progression

Recognising time pressures highlighted through listening events, a new appraisee guide was also developed, replacing formal appraisee training. This practical resource supports staff to prepare effectively for appraisals and to maximise the value of these conversations.

Statutory and mandatory training

During 2025/26, the Trust continued to play an active role in NHS England's statutory and mandatory training reform programme. In line with national developments, we have adopted the emerging national mandatory learning policy and established a local Mandatory Learning Oversight Group to provide robust governance and strategic oversight. The group includes senior representation from Trust Divisions and staff groups and meets monthly to review compliance, address risks and agree priorities.
To improve staff experience and reduce duplication, the Trust also implemented system interfaces that enable the transfer of mandatory training data between Whittington Health and other NHS organisations. This has significantly reduced the need for new starters to repeat training already completed elsewhere and directly supports our wider *Improving Doctors' Lives* work.

Core mandatory training continues to be delivered primarily through online learning, accessed via the Trust's in-house learning management system, Elev8. For training delivered wholly or partly via e-learning, we use nationally accredited eLearning for Healthcare content, ensuring consistency, quality and alignment with NHS standards.

Compliance with statutory and mandatory training remained stable throughout the year at approximately 87%, exceeding the Trust target of 85%.

The Trust has also worked closely with North Central London partners to roll out part two of the Oliver McGowan mandatory training in learning disability and autism. Whittington Health has made strong progress in this area, reporting compliance rates of 61% for Tier 1 and 54% for Tier 2 in February 2026, reflecting sustained organisational focus and engagement.

Corporate induction continued to be delivered monthly as an online event, welcoming new starters and supporting rapid integration into the Trust. Induction sessions benefit from visible senior leadership involvement, including contributions from the chair, chief executive officer, chief medical officer, chief nurse, director of allied health professionals and joint directors of inclusion, alongside a wide range of additional speakers. This approach reinforces organisational values and provides new colleagues with early access to essential information and support.

Apprenticeships

Apprenticeships remain a key element of the Trust's workforce development and talent pipeline strategy. During 2025/26, we continued to expand and embed apprenticeship pathways, supporting both the development of future Allied Health Professionals and a wide range of clinical, corporate and leadership career routes.

The Trust currently offers apprenticeships from Level 2 to Level 6, covering roles such as pharmacy assistant, dental nursing, business administration, HR, physiotherapy, pharmacy technician and senior leadership. This breadth provides accessible development opportunities for staff across the organisation.

In 2025/26, 199 staff were enrolled on an apprenticeship programme, with one fifth recruited directly into the Trust at the start of their apprenticeship. During the year, 40 staff successfully completed their apprenticeship, half of whom achieved an operational or departmental manager level 5 qualification.

Apprenticeships continue to be promoted through Trust forums and recruitment and development events, supporting career progression, workforce sustainability and our commitment to growing talent from within Whittington Health.

Staff development

Whittington Health places high value on the continuous development of its people, recognising that a skilled, confident and supported workforce is essential to delivering high-quality, compassionate care. Throughout the year, the Trust has provided a wide range of learning and development opportunities designed to support personal growth, career progression and organisational capability. In 2025/26, staff development activity was delivered through a blended approach, combining face-to-face and virtual learning.

Over the last year, the following programmes and development offers were delivered by Trust staff and partner organisations:

- A London-wide Band 2-7 black and minority ethnic (BME) career development programme, which supports BME staff in Agenda for Change bands 2-7, provided career development and personal development. Whittington Health has been awarded funding by NHS England to run two cohorts for all NHS organisations across London.
- A Manager's Passport. The Manager's Passport consists of HR modules that are fundamental to management, as well as OD modules to enhance leadership skills. These modules include:
  - Employee relations (ER) Investigations
  - Managing probationary review
  - Understanding sexual misconduct in the workplace
  - Flexible working
  - Managing sickness absence
  - Appraisals for managers
  - Giving and receiving feedback
  - Situational leadership
  - Conflict and difficult conversations
- The OD team reviewed the leadership development offering and has aligned the modules using the new NHS Management and Leadership Framework. In 2025/26, they 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:
- OD leadership skills sessions
  - Coaching conversations
  - Conflict and difficult conversations
  - Giving and receiving feedback
  - Situational leadership
  - Assertive communication and setting boundaries
- Inclusion team sessions:
  - Anti-racism and inclusive cultures
  - Compassion in practice: understanding disability and reasonable adjustments for managers and all staff

Additional Leadership development and training:

  - Appraisal training for managers

    - Neurodiversity in the workplace manager/senior leader's sessions (new) and there are also sessions for all staff
    - Facilitated conversations
    - Restorative conversations for managers
    - British Sign Language
    - Bespoke workshops and interventions for teams that need support in developing team-working and improving morale
    - 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
    - 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 (GCSEs level) to level 6 (degree level).
- The following modules were delivered by NHS Elect:
    - Interview skills
    - Compassionate leadership/compassionate conversations
    - Conflict and difficult conversations
    - Emotionally intelligent leadership
    - Leading change
    - Coaching skills (new)

Staff health and wellbeing

During 2025/26, Whittington Health continued to strengthen its commitment to staff wellbeing and engagement, maintaining a proactive, preventative approach while ensuring timely and responsive support for those who need it most. Our overarching ambition remains unchanged: to place staff wellbeing at the heart of everything we do. A significant new addition to the Trust's wellbeing offer in 2025/26 was access to the Vivup employee assistance programme, which now forms a core component of our wellbeing and staff benefits provision. Vivup offers confidential, 24/7 support for personal, emotional and practical concerns, helping colleagues to manage challenges both inside and outside of work and supporting overall wellbeing, resilience and work–life balance.

As part of the Vivup offer, staff have access to:

- Confidential counselling and wellbeing support, available through self-referral
- Digital GP appointments, improving access to timely medical advice and reducing pressure on staff to attend appointments during working hours
- Practical support and advice on issues such as financial concerns, legal matters and family responsibilities
- Staff benefits and savings supporting employees with everyday living costs.

These benefits complement the Trust's broader wellbeing offer and form part of our holistic approach to supporting staff health, resilience and work–life balance.

Alongside our year-round wellbeing offer, the Trust also introduced a Christmas Hardship Food Stall initiative, enabling staff to access food essentials over the festive

period. This initiative responded directly to cost-of-living pressures and demonstrated practical compassion and solidarity with colleagues during a challenging time of year.

During 2025/26, significant progress has been made in embedding wellbeing and engagement across the organisation, including:

- The continued rollout and visibility of the Whittington staff wellbeing brand, supported by the staff wellbeing booklet, which provides clear access to a comprehensive five-level wellbeing framework.
- Specialist delivery of wellbeing support by the head of wellbeing and staff engagement and the senior staff wellbeing practitioner, enhancing capacity for targeted support and strengthening Trust-wide wellbeing leadership.
- A noticeable improvement in staff engagement, with feedback indicating a shift from disengagement towards renewed confidence that the Trust listens and acts.

Throughout 2025/26, the Trust maintained and expanded a wide range of internal wellbeing and engagement initiatives, including:

- Trauma Risk Management Support: An evidence-based framework offering early intervention for staff exposed to traumatic events.
- Team Reflective Sessions: Facilitated sessions providing teams with a safe space to reflect, recover and build cohesion.
- Specialist Psychological Support: Delivered in partnership with Health City, supporting complex psychological presentations, including global conflict-related trauma.
- Mental Health First Aid Training: Ongoing in-house training to reduce stigma, encourage early support and strengthen mental health awareness across the Trust.
- Wellbeing Champions: A growing network of peer volunteers leading local wellbeing activity and signposting staff to timely support.
- Staff Engagement Roadshows: Bringing wellbeing services directly to teams, strengthening inclusion and connection, particularly for remote or hard-to-reach staff groups.
- Touch Tuina Medical Massage: Therapeutic support for staff working in high-pressure areas such as the Emergency Department.
- Health Promotion Webinars: Sessions addressing areas such as men’s mental health, immunity and physical wellbeing.
- Leadership Development Training: Supporting leaders to run reflective sessions and create psychologically safe environments.
- Wellbeing Wednesday: Mid-week initiatives encouraging staff to pause, reflect and practise self-care.
- Wellbeing Calendar: A structured programme of campaigns covering mental health, stress, nutrition, hydration, grief and other key themes.
- On-site Physical Activity: Subsidised classes such as Pilates to support physical health.
- Financial Wellbeing Resources: Accessible via the Trust intranet.
- In-house Smoking Cessation Support: Delivered by a specialist adviser.
- Proactive Wellbeing Visits: Regular outreach to teams by the Wellbeing Team to raise awareness and encourage early support.

In addition to internal provision, the Trust continued to actively promote a range of national and regional wellbeing services, ensuring staff can access support confidentially when needed. These included:

- Bereavement Support Line (Hospice UK) – free, confidential support for NHS staff.
- Frontline19 UK – specialist psychological support for frontline workers.
- Practitioner Health – confidential NHS mental health and addiction service for health and care professionals.
- The BMA Counselling Service – 24/7 support for doctors and their families.
- Haringey Talking Therapies – NHS psychological therapies for common mental health conditions.
- Switchboard LGBT+ Helpline – inclusive support and a safe space for discussion.
- NHS England and NHS Elect Wellbeing Programmes, including the *Happier Working Lives* initiative.

Embracing inclusion

The Inclusion team at Whittington Health continued to support the Trust in meeting its compliance obligations under the Equality Act 2010, by promoting fair treatment and equal opportunities for all staff, regardless of protected characteristics such as race, gender, age, disability, sexual orientation, religion, and other relevant factors. The team helped the Trust in fulfilling its statutory public sector equality duty, submitting required reports to NHS England as previously outlined. This includes responsibilities related to:

- Disability Confident accreditation requirements
- Pay gap reporting for gender, race, and disability
- Workforce race and disability equality standard annual submissions
- Medical workforce race equality standard
- Bank workforce race equality standard

The team focussed on creating and applying comprehensive inclusion policies that guide decision-making within the organisation. These policies foster an inclusive environment and actively promote a positive, supportive culture. This approach helps every employee feel valued, respected, and empowered to contribute to the organisation's success.

The LGBTQ, Staff Race Equity Nationality Network (SRENN), Women+, and WhitAbility networks work with members to further the goals outlined in both The Trust and staff network mission statements. Additionally, the See ME First initiative acted as a unifying platform that links all staff network efforts, supports staff engagement organisation wide, and reaches those who are not active members of the networks.

Both the staff network and See ME First demonstrate the Trust’s strong dedication to building a workplace culture that is anti-racist and values diversity in all forms, aligning with the Trust's ICARE principles. These forms of staff engagement help promote inclusion, boost morale and retention, and provide structured support, development, and channels for raising concerns. They enable employee-led insights to drive innovation, improve staff performance, enhance organisational efficiency, and positively impact patient experience and outcomes.

Key activities supporting inclusion goals and ambitions included the following:

Chief Executive briefing

The Trust chief executive officer's fortnightly briefings have ensured that inclusion remains a visible strategic priority throughout the year. By personally endorsing equity goals and setting clear expectations, the chief executive officer has driven cross-organisational accountability and translated the Trust's commitments into measurable actions for the equality and inclusion agenda.

These briefings have also amplified staff-network insights and diversity data, bringing lived experience into executive decision-making and enabling conversation and Trust-wide engagement on the inclusion agenda and work on systemic barriers. The sustained, visible sponsorship has strengthened trust, boosted participation in engagement initiatives, and helped embed inclusive practices across the organisation.

National inclusion events:

During the year we actively participated in national diversity and inclusion 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, Autism Acceptance Awareness Day, Dementia Action Week, Facilities and Estates Day, Mental Health Awareness Week, National Day for Staff Networks, See ME First Anniversary, Windrush Day.

The events and communications are led by staff networks and supported by senior leaders. These activities celebrated staff diversity, promoted cultural awareness and learning, and created safe spaces for dialogue and storytelling that strengthened colleague wellbeing and belonging.

The Trust programme combined internal workshops, panel discussions and community partnerships, amplifying lived experience and informing policy and training priorities. As events are often held in public areas, public engagement during these events also demonstrated the Trust's visible commitment to inclusion and encouraged ongoing public participation in the year's inclusion initiatives.

Quarterly open forum & bi-monthly inclusion newsletter:

Quarterly open meetings are held to deal with unfairness within the Trust. These meetings give staff a place to share their personal experiences, understand patterns of exclusion, and point out organisational obstacles. By combining personal stories with data and expert advice, these meetings help staff see how racism and discrimination hurt marginalised colleagues. They turn individual stories into concrete evidence and encourage everyone to take responsibility for finding solutions.

The forums have four main goals: to gather insights with regular updates that help improve workforce data; to show leadership's support and track progress through public discussions on issues; to empower staff and build trust by offering safe spaces that acknowledge experiences and encourage reporting; and to involve staff in the Trust's broader inclusion goals and plans to drive systemic change.

As part of these, the Trust has introduced a bi-monthly inclusion newsletter to reiterate information on the inclusion agenda and showcase individual and team inclusion efforts.

Staff development workshop & staff self-reflection toolkit

The Inclusion team offers training sessions, including an anti-racism workshop for various career levels, and continuously updates their preceptorship programs. These combine evidence-based content, real-life stories, and practical tools to help managers and staff identify and challenge discrimination. The aim is to improve cultural awareness, reduce exclusion, prevent marginalisation, and incorporate equity into daily supervision and service.

The self-reflection and development toolkits support individuals and teams in assessing allyship, cultural awareness, inclusive team and psychological safety through checklists and action plans. This toolkit is integrated into meetings and appraisals to foster awareness of bias, promote inclusion, and set growth goals, ultimately enhancing staff engagement and reducing discrimination.

Support for disabled staff:

Promoting reasonable adjustments will remain a priority in 2026/27. During the reassessment of the Trust's Disability Confident accreditation, a number of actions to improve experiences for disabled staff (including job seekers) were identified that need to be actioned to apply for a level 3 accreditation (leader status).

These actions include improving the accessibility of our website and recruitment processes, increasing information on support for job seekers, providing training for managers and staff on neurodivergence, and promoting career development pathways for disabled staff. We will also work to improve information on the Disability Support Hub and continue training on supporting disabled staff in the workplace

Global majority mentoring programme

The external mentorship and support for the global majority staff programme, initially launched as a pilot between Whittington Health and UCLH is continuing. The offer is intended to support existing mentoring programs and is suited for staff who have experienced racism and mistrust. The scheme continues to offer participants increased confidence and motivation, a safe space for reflection and discussing challenging situations, and career planning.

Reverse mentoring programme: 'Ask Aunty' - support for our internationally trained professionals:

The Trust worked on the importance of a reverse mentoring programme, 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 the global majority or BME employees.

We will be taking part in the Ask Auntie Programme for 2026/27. This will enable us, as an inclusive organisation, to support our colleagues who are internationally trained and ensure they have access to guidance from other staff who can provide that important support. The reverse mentoring approach is supported by a comprehensive

induction and adaptation guide for internationally recruited staff, which aims to help them in their new roles and environment.

Ambitious about autism

The team supports the aim of increasing employment rates for autistic people, enhancing the Trust's ability to retain neurodiverse staff, and contributing to organisational inclusion and local economic participation. These programs blend education and work experience to help reduce inequalities among individuals with autism by integrating autism-aware practices throughout the Trust. Additionally, the team promotes the Trust's engagement and sustainability by highlighting the benefits for the organisation and staff who are better informed on how to support individuals with autism.

Health equity - patients and service users

The team supports the Trust's work on health inequalities and inclusion for patients and service users. They organised a briefing on sickle cell disease with external experts, patient representatives, clinicians, nurses, allied health professionals, administrative staff, voluntary partners, and carers. The event showed the Trust's commitment to prompt, fair, team-based care, innovative practices, culturally sensitive services, staff training, involving patients and carers, and working with voluntary groups.

The Inclusion team is helping put the capital midwife anti-racism framework into action, turning goals into practical steps for the Start Well programme. This includes integrating anti-racism into policies, management, KPIs, and information to better serve women and birthing people from diverse backgrounds. They also provide monthly inclusion training on cultural safety and anti-racism, review maternity services, fill data gaps, and promote staff feedback.

Recruitment panel guidance:

The promotion and implementation of the Diverse Panel Guidance continues to enhance current recruitment policies to promote equitable recruitment, ensuring that the most appropriate candidates are selected while eliminating active discrimination, fostering trust, and establishing a positive workplace environment. The diverse recruitment panels are required to reflect a mix of gender and other protected characteristics.

There is training for panel members, and it serves to reduce unconscious bias, apply consistent fair assessment methods, manage reasonable adjustments and improve candidate experience, leading to better recruitment decisions, increased workforce representation in senior positions where there is likely to be much less representation. Progress is monitored through offer rates by protected characteristic.

Bullying and harassment:

Using the workforce race equality standards, we have seen that colleagues from global majority ethnic minority backgrounds are more likely than white colleagues to report experiencing bullying, harassment, or abuse from co-workers. We have been recognised for our efforts in tackling bullying and harassment and have been invited to participate in a study by Birmingham University, commissioned by the Race Health Observatory, to learn more about how we work as an organisation. The insights from

this study will help support the ongoing work of the Violence Prevention and Reduction Group, which aims to address bullying and the violence and aggression reported by staff from patients and service users.

Civility & respect policy

In response to staff survey, the Trust has finalised its Civility and Respect policy, establishing clear standards of behaviour, defined reporting routes, and transparent resolution processes to protect staff dignity, reduce conflict, and promote psychological safety across all staff group. The policy strengthens accountability for managers, supports consistent handling of concerns and investigations, and underpins inclusion by reducing bullying, harassment and micro-aggressions contributing to improved staff wellbeing, retention, and service quality. A targeted roll-out will be carried out beginning with leadership and team briefings, organisation wide communications, followed by implementations, confidential reporting launch and ongoing monitoring.

Allied Health Professional Apprenticeships

During 2025/26, the Trust continued to invest in Allied Health Professional's (AHP) degree apprenticeships as a key workforce development route. The year marked a milestone with the successful qualification of the Trust's first physiotherapy apprentices, alongside the recruitment of three new apprentices across speech and language therapy and occupational therapy. In total, the Trust is currently supporting nineteen AHP degree apprentices across multiple professions.

Looking ahead, the Trust has identified AHP degree apprenticeships as a key opportunity to further strengthen workforce sustainability and widen access into AHP careers. A thorough report was presented to the Workforce Assurance Committee, setting out a proposed future direction to embed apprenticeships more fully as a core workforce pipeline. This ambition includes the implementation of dedicated AHP apprentice roles, progressive job plans, and a standardised pre and post-qualification recruitment process, supporting the Trust's commitment to a resilient and inclusive workforce that reflects the communities it serves.

Bands 2-7 career development programme case study

Background

The Bands 2-7 black and minority ethnic (BME) career development programme, developed and pioneered by the Organisational Development team at Whittington Health, was later delivered in partnership with Once4London. Workforce Race Equality Standard data showed that BME employees were disproportionately concentrated in lower pay bands, with significantly fewer in higher bands. The programme's primary objective was to address the underrepresentation of Black Minority Ethnic (BME) staff in senior roles within the National Health Service (NHS).

Objectives

- Increase the presence of BME staff in senior NHS positions.
- Support career development to attract and retain BME talent.
- Empower participants with skills, confidence, and leadership abilities.

Programme structure

The programme offered taught modules such as CV writing, presentation skills, MBTI profiling, leadership, finance, and HR; practical on-the-job training supported by placement managers; opportunities for self-directed professional development; group coaching for reflection and self-awareness; and one-on-one coaching with psychometric profiling to help participants explore careers and address feelings of stagnation.

Outcomes

- In the pilot, **9 out of 20 participants** were promoted following completion.
- Subsequent cohorts expanded to **50 participants** across London, enabling networking and sharing of lived experiences.
- Among the expanded cohort, **6 out of 50** participants have already been promoted.
- **Over 80%** reported increased confidence and self-awareness.
- Approximately **two-thirds** gained clearer career direction and readiness for progression.
- **6 in 10** strengthened their professional voice and influence.
- **Nearly half** developed stronger leadership identity, networks, and a growth mindset.
- The programme fosters not only knowledge but also skills, confidence, identity, and a sense of belonging.

Professional impact

- Participants report increased confidence in leading discussions and presentations.
- Enhanced communication and networking skills.
- Improved ability to navigate systemic challenges as BME staff.
- Greater capacity to set goals and plan career steps.
- Developed self-awareness, understanding strengths, weaknesses, and personality traits.
- Built resilience and perseverance in facing professional challenges.

Conclusion

This case study demonstrates how Whittington Health has utilised targeted career development initiatives to significantly enhance career prospects, confidence, and leadership capacity among BME staff within the Trust and across London. The programme's success is evidenced by participant promotions, improved self-awareness, and the cultivation of resilient, capable leaders ready to progress within the health system.

The Trust is immensely proud to have launched this initiative, which not only supports the professional growth of BME colleagues but also fosters a stronger, more inclusive workplace culture. The positive impact seen in both individual achievements and collective progress underscores the value of investing in such programmes. Whittington Health remains committed to empowering its staff and championing diversity at every level.

Participants from across London on the Band 2-7 BME Leader Programme

Freedom to Speak up Guardian

During 2025/26, the Trust saw a significant level of engagement, with a total of 98 initial concerns raised by staff. The 2025 NHS Staff Survey results for Whittington Health showed a positive upward trend, with the organisation consistently performing above the national benchmark for psychological safety. 72.11% of staff felt secure raising concerns about unsafe clinical practice, and 70.21% felt safe speaking up about general concerns. However, a key issue remains the "action gap," a disparity in which the feeling of safety in speaking up is not yet fully matched by confidence that the organisation will take tangible action.

Throughout the year, the service focused on building worker confidence and ensuring that speaking up becomes business as usual. The Guardian received 98 initial concerns requiring action across the full year. Confidence remained high, with only three concerns submitted anonymously over the entire year: two in the first half and one in the second half. This highlights staff confidence to speak up openly. The Speak Up Champions' Network currently comprises 44 Champions, with over half from an ethnic minority background. From the concerns received, bullying and harassment remains a significant theme. At the same time, quality and safety emerged as a primary concern during the first half of the year. There is also an upward trend in the number of ethnic minority staff raising concerns, reflecting the Trust's commitment to removing barriers for all staff groups.

From April 2025 to September 2025, which covers the first and second quarters, 58 initial concerns were received. For the first time, Quality and Safety was the highest-rated theme at 26%, while bullying and harassment accounted for 25% of cases. During this period, there was a significant increase in concerns raised by allied health professionals, estates, and ancillary staff, and cases from medical and dental staff doubled compared to the same period the previous year.

From October 2025 to March 2026, covering the third and fourth quarters, 40 initial concerns were received. During these months, there was a significant increase in concerns regarding bullying and harassment, which rose to 45% of cases. Concerns regarding worker safety and wellbeing decreased from 23% to 7%. Most concerns in this period were raised by nurses, midwives, and allied health professionals, while administrative and clerical roles also saw a significant increase in reporting. Demographically, 57% of individuals raising concerns during this second half of the year identified as from an ethnic minority background.

The Guardian has identified several key priorities to continue improving the speaking-up culture over the next year. These include mandatory "Speak Up" training for all staff, "Listen Up" training for managers, and "Follow Up" training for senior leaders. To close the "action gap," a standard requirement will be implemented to follow up with every reporter within 15 days of their concern being escalated. The Trust also aims to expand the network to include at least one Speak Up Champion per clinical ward, and in the finance, and information technology departments. Also, start work to identify and remove specific barriers faced by overseas trained and temporary workers. Finally, the Guardian will maintain regular weekly visits to community and hospital sites to ensure they remain accessible and approachable to all staff.

Excellence in Medical Education

Undergraduate Medical Education

Whittington Health Trust is a central University College London (UCL) site for clinical placements, visiting electives and the iBSc.

Facilities and information technology access have improved, including expanded WiFi-access and the use of the Whittington Education Centre for MBBS Finals, reflecting the Trust's growing role in high-stakes undergraduate assessment, alongside strengthened safety and induction processes.

Educational governance is robust, with systematic approaches to enhancing the student voice through learning surveys, regular feedback loops like "You Said, We Did" actions, and peer-tutor programmes that supports learning while empowering resident doctors. There are strong student satisfaction outcomes across years 4 and 5 and clear pathways for raising and resolving concerns.

Curriculum delivery across years 4 and 5 has been actively enhanced through increased and targeted teaching, simulation, and skills-based learning supported by a growing number of clinical teaching fellows whose impact on teaching quality has been highly rated by students. This includes the successful delivery of the year 5 remediation programme, for which teaching fellows have received an excellence in medical education award.

Learner support is strengthened through proactive pastoral care and improved attendance monitoring, complemented by the appointment of a dedicated midwifery tutor to enhance teaching and support within women's health placements.

Supervisors are well supported through accredited training, job-planned teaching time, and access to UCL educational resources, with multiple successful applications for honorary clinical lecturer and honorary associate professor titles, reflecting strong engagement with academic development and educational leadership

Postgraduate Medical Education

The postgraduate medical education (PGME) Faculty has delivered another successful year of education and training to our resident doctors. Our Faculty of Educators, both consultants and resident doctors, continued to set a high standard, combining expertise with commitment. The PGME team remains focused on keeping training relevant, meeting evolving professional development needs, and actively driving innovation rather than simply responding to it.

Whittington Health's feedback in the General Medical Council National Training Survey (GMC NTS) was exceptional in 2025, building decisively on gains made in previous years. The GMC NTS assesses the experience of resident doctors and consultant trainers and is the UK's most important annual benchmark of NHS trusts' performance in postgraduate medical training. Compared to 2024, Whittington Health showed improvement in all 18 indicators with a 45% increase in the number of 'green scores' achieved (performance in the top national quartile). Outstanding feedback was achieved in some star performing specialist teams. Multiple green scores were awarded to geriatric medicine, the emergency medicine GP programme, acute

internal medicine and gastroenterology. Letters of commendation were received for geriatric medicine and internal medicine training for sustained improvement over 3 years. We hope to rise to the challenge of maintaining this momentum and extend progress across the Trust despite ongoing pressures.

Burnout remains a significant concern. In the 2025 GMC NTS, nationally one in five resident doctors were at high risk of burnout, rising to six in ten at moderate or high risk of burnout. At Whittington Health, the PGME Team and Faculty are committed to addressing these concerns, supporting resident doctors across the Trust, on both a personal and group level. Our consultant educational supervisors are generally of exceptional quality, providing a supportive, personalised approach. This is recognised to the extent that the Trust is often approached to help with the training of resident doctors in difficult circumstances. The PGME Team continue to support and develop our consultant educators, including providing training courses for new educators and refresher courses for those who are established and experienced.

Creating a positive training experience is a central aim of the PGME Team and the Faculty of Educators. This includes providing initiatives which reinforce a culture where resident doctors feel recognised, supported and valued. Over the past year, for example, we have again organised and/or provided support for events such as an Internal Medicine Trainee Away Day, a 'Graduation' Celebratory Event for Foundation doctors completing their first years, and training focused on mentoring and coaching.

Innovation in training has remained a clear focus. In partnership with Lucinda Worlock (specialist in voice and communication training), the PGME Team delivered the second iteration of our novel 'Preparing for Interview Course', a practical, in-person training programme designed to support senior trainees as they prepare for upcoming consultant interviews. Building on a highly successful pilot, the programme was refined using participant feedback and again received outstanding responses. Resident doctors told us the communication skills they learnt extended well beyond interviews, including being valuable in high-pressure clinical environments. Notably, there has been great success in that many participants subsequently secured substantive consultant posts at their first attempt.

The PGME Team has further developed and embedded training programmes not typically 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 in 2025, we adapted the format to reach a wider audience. We facilitated a 'Good Clinical Practice' course for those wanting to get involved in research and in 2025, broadened access to include resident doctors, locally employed doctors, consultants and research-active nurses. The PGME Team also brought in the Active Bystander Company, to deliver training to an initial cohort of resident doctors. This equipped them with practical tools to call out poor behaviours, particularly when inappropriate or threatening. Following strong feedback, the PGME Team will be offering this training again in the upcoming year. The long-term aim is to extend this training, to make it available to all resident doctors and their consultant trainers and supervisors at Whittington Health.

Recognition of excellence has remained a priority. The PGME Team has continued to run the Whittington Health PGME Star Awards for resident doctors working above and beyond usual practice across all specialties. In addition to this local recognition, 18 of our foundation doctors received a Foundation Merit Award from NHSE for high

performance in categories of clinical excellence, leadership, teaching excellence, quality improvement, foundation e-portfolio and outstanding contribution. This represents a particularly strong year of achievement.

A major development in 2025, was the creation of the first Whittington Health PGME Simulation Education Lead role. A consultant trainer with extensive experience in simulation education has been appointed and is already driving progress. Their initial focus is building a dedicated faculty in postgraduate medical simulation education, connecting existing areas of excellence across the Trust and developing simulation education that involves the whole multidisciplinary team, to mirrors the clinical environment. This marks a significant step forward and signals a clear commitment to innovation in this space.

The PGME Team has also worked closely with the Trust to implement NHSE's '10 Point Plan to improve resident doctors' working lives', launched in 2025. Study leave has been a key area of progress. With a dedicated study leave coordinator post initiated in 2023 and early adoption of complex new processes under the national plan, Whittington Health has seen a substantial increase in funding for study leave coming into the Trust, both for external and locally delivered courses, with an increase of just under 40% over the past three years.

The PGME Team and Faculty of Educators has continued partnership working with teams across the Trust. The Whittington Education Centre team continues to host the national PACES examination twice a year on behalf of the Royal College of Physicians (RCP), supported by many Whittington Health consultant examiners. Feedback from the RCP consistently highlights the high standard of delivery, alongside the invaluable contribution of many Whittington Health patients. The PGME Team continues to support the Whittington Health Library in providing access for all staff to evidence-based clinical knowledge resources and major scientific journals. For resident doctors, access to preparation for professional exams is also provided.

The PGME Team were again awarded funding from NHS England to support the continuing professional development (CPD) of specialty and specialist doctors and locally employed doctors in the Trust. With this, the team ran the annual competitive CPD Funding Award scheme. Applications were of the usual high quality and were assessed in partnership with the Trust's newly appointed Tutor & Advocate. This inhouse scheme has enabled specialty and specialist doctors and locally employed doctors to access training in clinical skills and medical education, take professional exams and attend conferences, with clear benefits for both professional development and patient safety.

Over the last year, the PGME Team has therefore continued to strengthen postgraduate medical education and training at Whittington Health, supporting both resident doctors and educators while maintaining a clear focus on quality, innovation and experience. Ensuring that doctors feel valued remains central to sustaining morale and driving further improvement.

Looking forward, the Trust will continue to build on these successes, to further sustain and strengthen Whittington Health's reputation for excellence in education and training and as a place where doctors actively chose to work and develop their careers.

COMUNICATION AND ENGAGEMENT

Maintaining the momentum generated last year by our new four-year Communications and Engagement Strategy, the team have delivered a number of commitments set out in the document for early delivery. These included:

- Roll out of the “Whit-Team Briefing” to all of our clinical divisions. This new cascade briefing system makes sure key information and updates are consistently shared with colleagues up and down the organisation.
- Continued evolution of our new brand-toolkit, which provides colleagues with the resources, templates, advice and resources they need to create high-quality, professional documents and resources such as posters. This year, this included adding a new AI chatbot to the toolkit to help colleagues to access the resources they need even more quickly.
- Continued to recruit members of “Whittington Voices”. This is an opportunity for local people, whether they use our services or not, to get involved in helping to shape our future. We have sought their input to help us shape a number of projects over the year, including recently the development of communications to support a new hospital car parking policy.
- Refreshing and relaunching our staff wellbeing offer, Caring for those who care, alongside our dedicated colleague wellbeing team.

This is a four-year strategy, so changes will take time to implement. Not everything will happen right away. In 2025/26 we started a review of the information on our public website and staff intranet, and the platform on which both are built. The platforms are now 20 years old, and have a large volume of content that has been added over the years.

We commissioned an external report on how to improve the intranet, established a Website and Intranet Working Group to review the content across both sites and make decisions on what content needs to be on there, and contributed to a project to move the patient leaflets that are on our website from pdf format to html, to improve their accessibility. We will build on all these projects in 2026/27, resulting in platforms that contain better information that is easier to find and access.

During 2025/26 Whittington Health has been able to promote positive developments and improvements to patient care across both local and national media. This has included hosting the BBC at our community diagnostic centre (CDC) for a day in February, to help explain how CDCs are helping to ensure that patients nationally get the diagnostic procedures they need and into treatment where needed more quickly.

In November, BBC radio visited to tell Eddy’s story. Eddy is an Ambitious About Autism College intern who took part in an ongoing programme Whittington Health supports aimed at equipping local autistic people with the skills they need to get into the job market. Eddy completed his placements at our hospital and since graduating from the Ambitious College programme, he is now working as a healthcare assistant in our hospital’s endoscopy department.

We have also continued to demonstrate the momentum behind the implementation of the Start Well Programme at Whittington Health and the transformation of our maternity estate, enabled by over £80 million of investment in the hospital's power infrastructure. At the start of the year, we received significant traditional and social media coverage as we unveiled what our future maternity services will look like following a 'once in a generation' investment.

Internally, we ran a number of successful campaigns to mitigate the risks facing the organisation. This included significant work to support the organisation to get "fit for the future" and operate more efficiently whilst still delivering high quality, timely care. We established a dedicated hub containing information, resources, tips and dozens of case studies to show where teams across the organisation have delivered improvements to inspire others.

We continued to demonstrate how our partnership with UCLH is resulting in higher quality care for our combined populations throughout the year. This included examples such as joint work that showed that positron emission tomography imaging is safe and clinically valuable in pregnant women with breast cancer. We also profiled a small, but growing, number of staff who work at both UCLH and Whittington Health – dividing their time between both organisations, breaking through silos and sharing best practice.

In 2025/26 we worked hard to ensure that our amazing colleagues are recognised and congratulated for their hard work. This included another successful annual staff awards event which saw over 200 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 who have been at Whittington Health for over 10 years, and those who go "above and beyond" via our monthly 'extra mile awards'.

This year we also have new data to help us evaluate our performance as a communications team. For the first time we asked all Whittington Health colleagues questions about communications as part of the NHS annual staff survey. The results are both hugely positive but also provide us with more granular information about how best to provide colleagues with the information they need to do their roles safely and effectively. At an organisational level, the data shows:

- 75% of colleagues rate Whittington Health's communications as "excellent" or "good" overall.
- 98% of colleagues are positive about our communications, overall.
- Colleagues told us their most important source of news and information were:
    - Whit-Team briefing, delivered by their team manager
        - Over 80% of colleagues said that they had been part of a team meeting in the past month.
    - CEO fortnightly briefing (watching live or the recording)
    - Friday all-staff NoticeBoard email
    - Whittington Health staff intranet.

We will use this data to help shape our communications for the coming year, and to help us benchmark performance year-on-year.

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 and Social Care and is hosted and maintained by NHS England. It combines the legal framework including the UK General Data Protection Regulations 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 submitted the DSP Toolkit with a final submission result of Approaching Standards (with an Improvement Plan in place) for version 7. The version 8 DSP Toolkit 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.

All staff are required to complete information governance (IG) training on an annual basis. The Trust ended 2025/26 with 88% of staff being compliant. Training 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.

In February 2026, our Board members also received training on cyber security from an external provider as part of an NHS England programme for boards.

INFORMATION MANAGEMENT AND TECHNOLOGY DEVELOPMENTS

During 2025/26 the following changes and developments took place across the Trust:

Infrastructure:

- **Xtreme to Cisco Network replacement**: The network infrastructure is undergoing significant changes, transitioning from Xtreme Networks to Cisco, which is expected to offer better reliability, performance, security and support for future growth.
- **Rubrik backup solution**: Implementation of new solution for backup of Trust information technology systems and data, optimising data protection resilience including cloud storage and cyber protection.
- **MS Sentinel SIEM solution**: central log management solution for improved infrastructure event management and cyber threat protection
- **Network Access Control**: successful enablement of network access control measures across all community sites.

Information:

- **Ambulatory Emergency Care Dashboard:** A new Power Business Intelligence dashboard was developed to support monitoring of Ambulatory Emergency Care activity, providing improved visibility of same-day emergency care pathways, admission avoidance and service performance.
- **Bluespier Theatres System Implementation and Dashboard Redevelopment:** Following implementation of the Bluespier theatre management system, the Theatres Power Business Intelligence dashboard was redeveloped to align with the new data source. The updated dashboard continues to provide reliable insight into theatre productivity, utilisation, delays and trends, ensuring continuity of performance reporting and strengthening analytical support for operational oversight and service planning within surgical services.
- **Continued Improvement of Trustwide Power Business Intelligence Dashboards:** The Information Department continued to enhance and embed the Trust's established Power Business Intelligence dashboards, improving data quality, performance and usability. These dashboards provide routinely used, near-real-time insights that support operational oversight, productivity monitoring and patient access across acute and community services.
- **RiO Cloud Migration Strengthening Business Intelligence and Community Reporting:** The migration of Rio to a cloud-hosted environment delivered a more resilient and higher-performing Business Intelligence data platform, enabling more reliable and higher-frequency community data feeds. This has improved the timeliness and performance of community reporting and dashboards, while providing a more scalable foundation for community analytics.

Patient systems:

- **Bluespier Go-Live:** A new Theatres management system that more closely integrates with our CareFlow electronic patient record (EPR) was implemented in March, replacing the legacy ORMIS system which had been discontinued by the

vendor. The new system has streamlined the booking workflow and digitised the WHO safety checklists. It also provides better oversight of patients waiting for emergency surgery, and will facilitate better theatre time utilisation.

- **Move of Barnet 0-19 service to Rio EPR:** After joining Whittington, the Barnet 0-19 service was successfully transitioned to using Rio which involved extensive data migration work in collaboration with the Information Team, process mapping and training. This was a huge accomplishment in the short timescales and means that all Barnet community paediatric services are now on one system.
- **Rio migration to cloud hosted environment**: The Rio EPR system was transitioned from System C's on-prem hosting to a cloud-based environment hosted by Access Group. This will facilitate better support due the reduced complexity and improved resilience.
- **Keystone upgrade:** An update to the software used for sending letters and radiology results to GPs will ensures we are on a supported platform with the associated cyber resilience this brings, and facilitates future improvements in how documents are processed.
- **Vitals continued roll-out:** The system is now used in the Chemotherapy suite for eObs and also the use of glucose monitoring functionality has been implemented across the Trust replacing paper and improving visibility.

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

Whittington Health NHS Trust is committed to improving the maternity and neonatal services at Whittington Hospital so that families in our community continue to receive safe, modern and high-quality care. Updating these facilities has been an important ambition for the Trust for many years.

At the same time, we must prioritise essential fire safety and power infrastructure works across the hospital. These upgrades are critical to keeping patients, staff and visitors safe, and they form the foundation of our long-term plans for the site.

Our overall strategy is simple: to make sure people receive the right care, in the right place, and in the right environment—supporting our vision of helping local people live longer, healthier lives.

The current maternity and neonatal unit, located across Blocks D, E, N and P, now requires significant refurbishment to meet modern standards and to create the best possible experience for families.

In 2023, the North Central London (NCL) Start Well programme restarted its review of maternity services across the area. As part of this work, the designs for the Whittington M&N redevelopment were refreshed. A high-level 1:500 design has been approved by the Trust, and a more detailed 1:200 design has been developed and agreed in principle.

Once the Start Well decision-making business case is formally approved, Whittington Hospital’s maternity services will be confirmed as a key part of the future NCL maternity and neonatal network. At that point, the Trust will review and approve the 1:200 design so that the next stage of detailed planning (the 1:50 design) can begin.

Power infrastructure project

A strategic review of the hospital's high-voltage (HV) and low-voltage (LV) electrical systems in 2023/24 confirms that much of the existing infrastructure is approaching the end of its operational life. As a result, the Trust is addressing resilience risks and reducing single points of failure to safeguard continuity of care for patients and staff. Strengthening the power infrastructure is essential both to support future clinical developments — such as maternity and neonatal improvements — and to meet the energy requirements of the Trust's wider estate plans, including decarbonisation and progress toward the 2040 net-zero target.

In 2023, the Trust appointed a specialist contractor through the P22 framework to design and install a new 8.5 MVA power supply for the hospital. The new cabling and switchgear are now in place, with final connection to the hospital's existing network scheduled for May 2025. To manage short-term risks, the Trust has also installed a temporary transformer to reduce overheating concerns while longer-term solutions are delivered.

The centrepiece of this programme is a new energy centre on the site of the former Boiler House. This facility will provide a modern HV switch room serving the entire hospital, new transformers and generators, and upgraded LV switch rooms for key clinical buildings. These improvements remove known risks in the current system and provide full N+1 resilience across the site. Planning approval for demolition of the old Boiler House is already secured, and the planning application for the new energy centre is being prepared for submission.

This is a multi-year, fully funded investment programme designed to protect patient services, support future clinical expansion, and modernise the hospital's energy infrastructure. Construction of the new energy centre enabling works began in 2025/26, marking a major step forward in delivering a safer, more resilient, and more sustainable acute hospital campus.

Fire remediation project

Following the fire incident in January 2018, the Trust took decisive action to terminate the private finance initiative contract for Blocks A and L, bringing these buildings back into the retained NHS estate. Since then, the Trust has undertaken a comprehensive programme of surveys and technical assessments to identify fire safety deficiencies and define the scope of required remediation works.

Working in close partnership with NHS England and the London Fire Brigade, the Trust has established a clear and jointly governed pathway for risk mitigation, regulatory compliance, and long-term rectification. Immediate risk-reduction measures were implemented, including a waking fire watch operating outside core hours to provide early detection capability. The Trust's Fire Safety Team has also strengthened staff preparedness through updated fire procedures, training, and enhanced operational protocols.

Significant progress has already been made. Fire doors across Blocks A and L have been repaired or replaced, and a new fire curtain has been installed in the main atrium to improve compartmentation. Enabling works for a new fire alarm system are underway, with containment and cabling now in place; the existing alarm system remains operational while the new system is installed in phases. Emergency lighting upgrades have been completed across key circulation areas and plant rooms.

To support the full remediation programme, designs for a new decant ward are being finalised, enabling construction to begin this year. Once operational, this facility will allow the Trust to safely relocate patients from affected wards so that intrusive fire safety works can be carried out efficiently and without disruption to clinical services.

An updated fire strategy for Blocks A and L has been developed, and the Trust continues to work closely with the London Fire Brigade to secure the necessary approvals for the remediation programme. In parallel, the Trust is collaborating with NHS England to agree a sustainable and deliverable funding solution to address the fire safety deficiencies identified.

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.

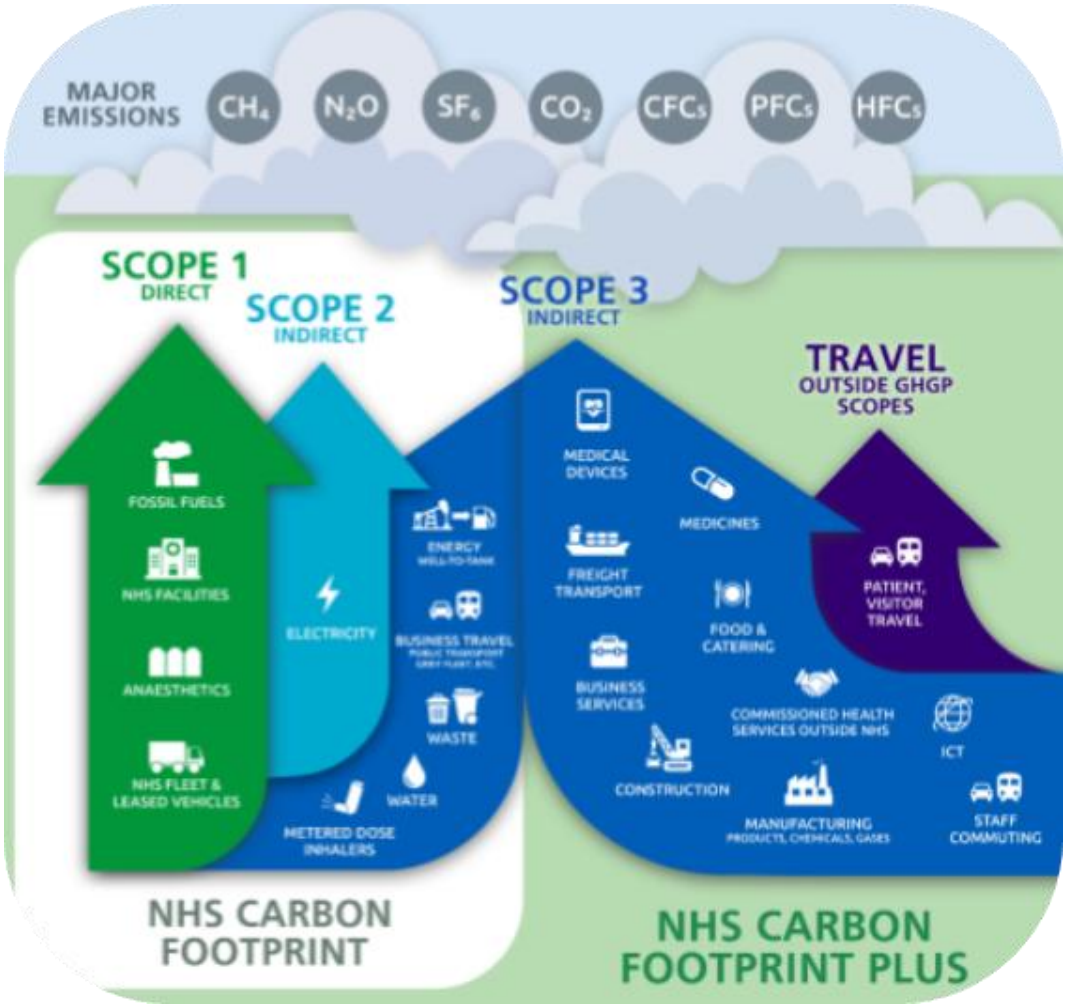


Figure 1: Scope of Emissions within the NHS (Delivering a 'Net Zero' National Health Service, 2020)

In October 2020, the NHS became the first health system in the world to commit to achieving net zero emissions. In July 2022, the NHS in England became the first

health system to embed net zero into legislation, through the Health and Care Act 2022.

The 'Delivering a 'Net Zero' National Health Service' report set out two clear and feasible targets for the NHS net zero commitment:

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 2025, 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.

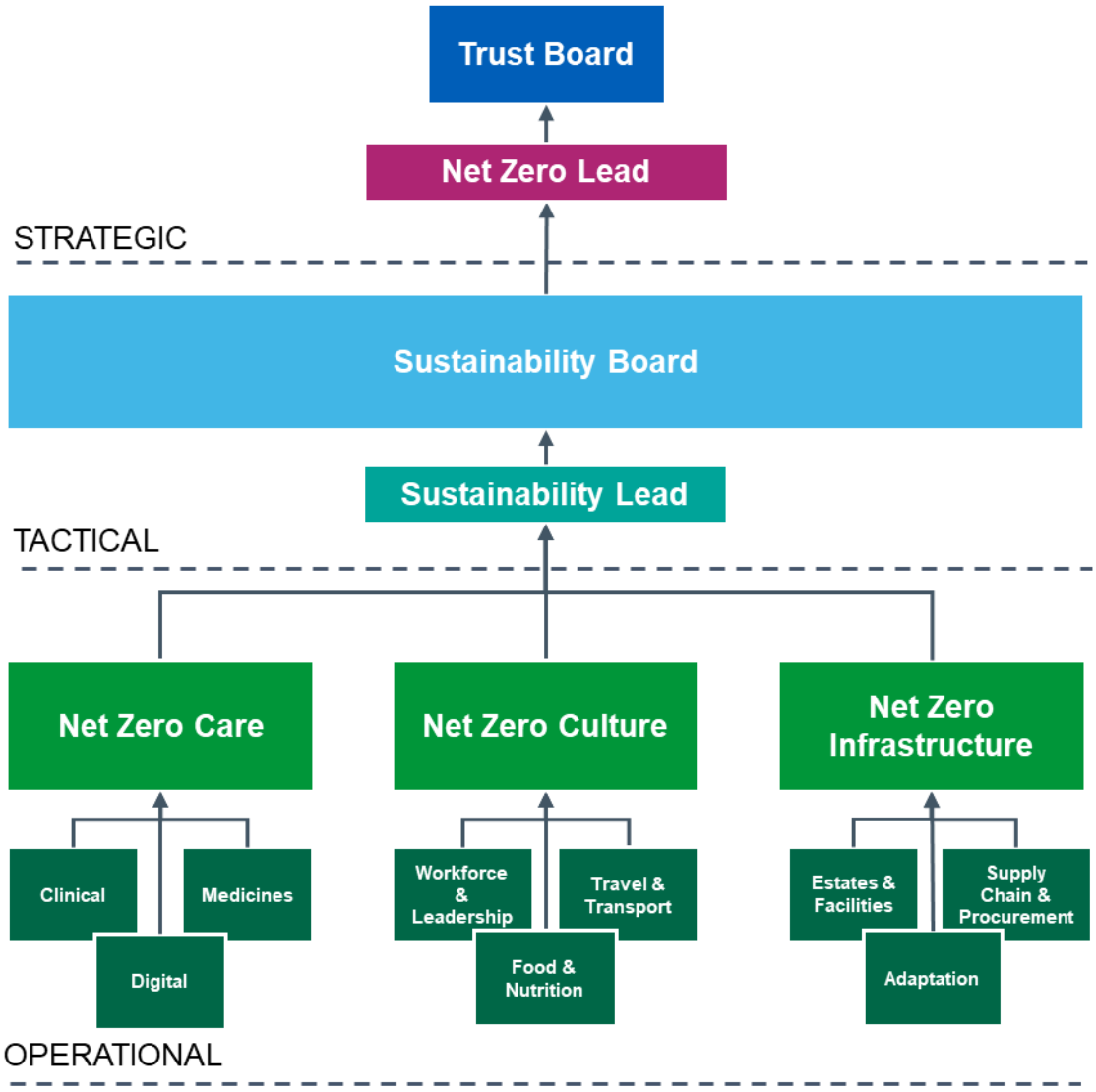
Historically at Whittington Health, we have taken an integrated approach to sustainability with a broad focus on energy reduction, tackling waste, improving local air quality, and promoting green space.

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).

Green Plan initiatives

The focus in 2025/6 was to establish the Trust Governance for Sustainability (see overleaf) 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.



Trust board

The Green Plan will be approved by the Trust board and reviewed annually. The transformation committee will provide oversight and assurance on delivery. Sustainable development will be championed at board level by our designated net zero lead.

Sustainability group

A sustainability group will be developed to deliver the implementation of the green plan. The sustainability group will meet quarterly to progress actions and is responsible for formalising an annual report to be submitted to the board by the lead executive director. The sustainability group will be further supported by dedicated sub-committees to assist implementation of the Green Plan across its various sectors.

Working Groups

We will establish working groups to meet every month to develop delivery plans against each of the focus areas. These delivery plans will provide a pipeline of projects for each year alongside setting responsibilities, timeframes for delivery, and metrics for monitoring.

Whittington Green Group

This staff network provides a forum for all environmentally minded staff across all Trust departments. Champions are ambassadors for sustainability and green initiatives within in their work area and the wider trust. They act as a conduit between the Trust's sustainability group and wider staff to disseminate information, provide feedback and generate ideas. They support in gaining excitement and further engagement with sustainability across our workforce.

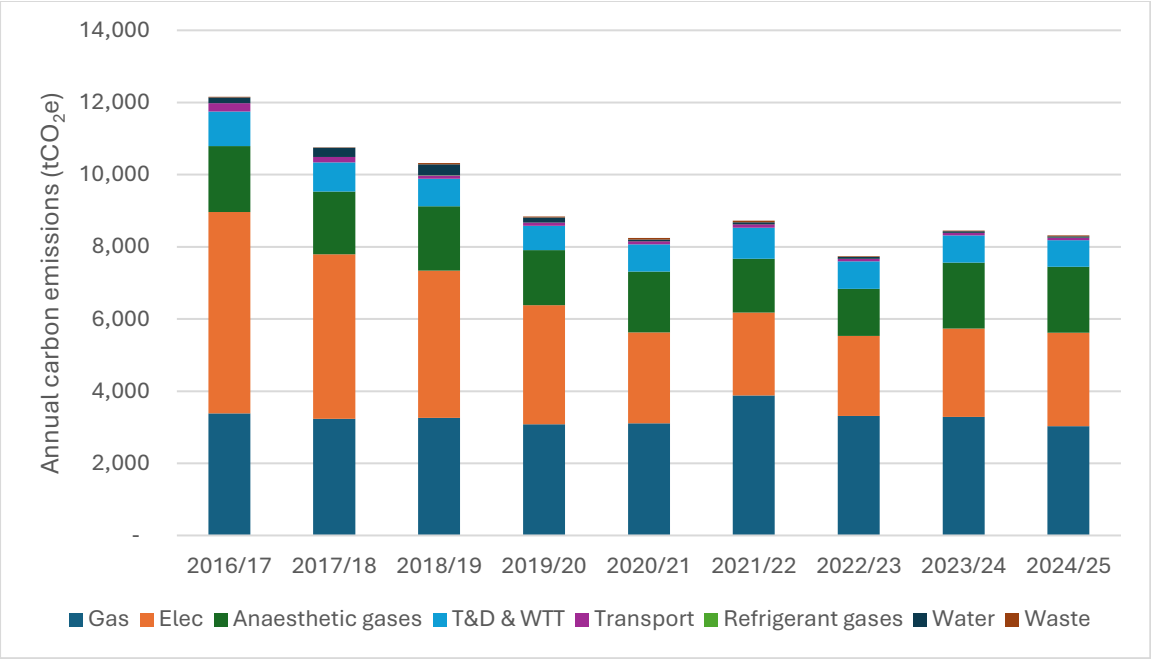
All staff

All staff have a role to play in delivering this Green Plan. We will continue engagement and dialogue, further building understanding and support for both practical action and deepening ambition.

Carbon impact

Teams across our Trust have been focused on reducing our direct emissions for many years. Figure 3 shows that to-date, we have reduced 32% since our baseline year 2016/17. This has been driven by efforts to reduce energy consumption and significantly by decarbonisation of the energy grid.

Building energy is responsible for 90% of the total footprint. Transitioning away from the use of fossil fuels is fundamental to achieving a net zero carbon footprint. Equally important is the use of purchased or self-generated renewable electricity as part of our estate redevelopment plans. Together, these actions represent a significant medium-term opportunity.



We recognise that although our historic performance has been good, a large contribution has been made by the reduction in carbon intensity of grid electricity. We cannot rely on the rate of grid decarbonisation to continue

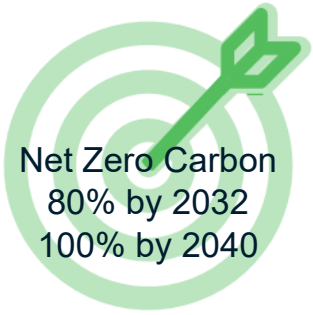
indefinitely and thus must develop our own roadmap to ensure we achieve our ambition for emissions reductions.

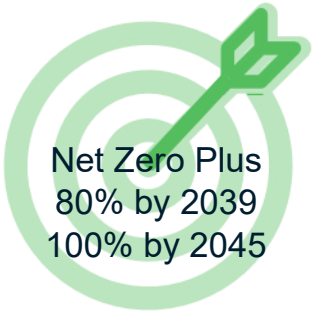
We have selected a baseline year of 2016/17 for our reduction targets as this is the earliest year for which we have high quality data. Our targets for NHS Carbon Footprint reductions are:

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

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

Up until now, our efforts have largely focused on reducing our direct (Scope 1 & 2) emissions. However, a greater proportion of our total emissions are likely to originate from our supply chain. As such, we intend to begin exploring the quantification of our NHS Carbon Footprint Plus, starting with initial data collation where possible.





Net Zero Care Delivery Plan

Clinical Transformation

The NHS Long Term Plan sets out a vision for how the NHS plans to improve care for patients over the next ten years, reducing inequalities, improving outcomes and improving patient's experience of care. Health and care partners in North Central London (NCL) are working together to deliver this vision locally as part of the NCL Integrated Care System (ICS).

With a strong focus on preventative, integrated, streamlined and digitally enabled care, provided 'as close to home as possible', delivery of these plans will support our ambition to provide clinically excellent, great value care in the most environmentally sustainable way possible.

Where are we now?

Optimising outpatient care and transforming care delivery can offer environmental sustainability benefits, alongside improvements in clinical

outcomes, patient experience, and financial efficiency. Patient Initiated Follow-Up (PIFU) enables individuals with long-term conditions or those requiring multiple follow-up appointments to schedule their own appointments as needed. By reducing routinely scheduled visits that may not be clinically necessary, PIFU supports patient self-management, provides greater flexibility and control, and helps avoid unnecessary travel and resource use. Furthermore, this also helps the Trust to free up appointment spaces for other patients who might need them more urgently.

We launched a “Gloves Off” campaign in Critical Care to reduce healthcare-associated bloodstream infections (BSIs) linked to excessive and inappropriate glove use. The initiative focuses on improving hand hygiene by promoting a risk-based approach to glove use, particularly during IV medication. The core message is that non-sterile gloves are only necessary when there is a risk of exposure to blood, bodily fluids or harmful chemicals. After one year of roll-out, the unit saw a marked reduction in improper glove use, better hand hygiene and a reduction in BSIs. By April 2024, the Infection Prevention and Control (IPC) team expanded the campaign Trust-wide including targeted training by staff group to address ingrained habits and misconceptions among both staff and patients.

Where do we want to be?

Key measures of success:

- Percentage of outpatient consultations delivered remotely
- Reductions in follow up outpatient consultations linked to new models of care (including advice and guidance, one stop clinics, patient-initiated follow-ups)
- Virtual hospital activity (avoided admissions and reduced length of stay)
- Reduction in use of non-sterile disposable gloves & single use personal protective equipment.

Digital

At a Trust level we plan to transform our services to ensure our vision is achieved and we are offering a rich patient and staff digital experience. Our strategic objectives are:

- Digitally Connected Patients - empowering patients to actively manage their health and care
- Digitally Enabled Workforce - enabling staff to access shared health and care records
- Business Intelligence and Analytics - insight driven culture to improve quality, outcome and research
- Digital Infrastructure – to provide secure access and interoperability

Where are we now?

Our Patient Portal allows patients to see all their out-patient appointments, view and download appointment letters, add forthcoming appointments to their own digital calendar and find directions to our hospital and community sites.

We have achieved over 99% digitalisation of outpatient clinic letters sent using Docman Connect via the national Message Exchange for Social Care and Health (MESH) network. The immediate benefit of this digitalisation is efficiency; GPs receive letters faster to support patients promptly and practices no longer need to scan letters into their systems and administrative efforts are minimised as they no longer need to deal with letters going missing in the post. Furthermore, this has reduced paper waste aligning with the Greener NHS agenda and will save Trust £80,000 per year.

We have configured personal computers in non-clinical areas to turn off during the night to save energy. We also work with Lenovo who collect old equipment to be reused, and recycled.

Where do we want to be?

Although our Patient Portal allows patients to view all their appointments, patients still need to contact us by telephone to cancel or reschedule appointments. We want to develop the Patient Portal to provide these features going forward.

To maximise hardware lifespan, support digital inclusion and minimise waste, new equipment should be repairable. Therefore, all equipment will be managed to encourage repair and upgrades instead of disposal.

Our virtual ward service to remotely monitor patients should be developed to reduce both staff and patient travel and hospital beds. We also plan to move our electronic patient records to the Cloud to improve security and faster access to data.

Medicines

Medicines have a significant environmental impact, which we aim to reduce through more efficient use, minimising waste and selecting lower-carbon alternatives where appropriate.

Where are we now?

The use of desflurane, a volatile anaesthetic agent, has ceased on site. Nitrous oxide, used predominantly for anaesthesia, is a potent greenhouse gas, making up more than 80% of total emissions from medical gases in the NHS with a global warming potential (GWP) around 300 times that of carbon dioxide. It has historically been supplied via a medical gas pipeline, however, there is high leakage associated with piped nitrous oxide. To enable decommissioning, a pilot was run for four weeks where piped nitrous oxide was switched to portable nitrous oxide cylinders on anaesthetic machines within all theatres. This pilot worked as expected and proved the equipment operated correctly and was reliable.

We have also explored the use of alternative anaesthetic gases to replace the use of Entonox, a high GWP gas. In the emergency department, penthrox (methoxyflurane) has been introduced as an alternative to Entonox for acute trauma pain such as shoulder breaks.

Where do we want to be?

Although remaining stock of desflurane was not used, its presence highlighted the importance of effective medical stock management. Following the success of the nitrous oxide cylinders pilot, the Trust plans to decommission its manifold and implement cylinders across the site. Entonox is largely used in the maternity department which has plans for refurbishment. It is unlikely that reduction of Entonox will be addressed until this work begins. However, when it does, the Trust will ensure to either explore alternatives or introduce gas capture.

Pressurised metered dose inhalers (pMDI) contain hydrofluoroalkane, a potent greenhouse gas. We will continue to take steps to increase the use of low carbon inhalers, such as dry powder inhalers (DPIs) in place of the more carbon intensive pMDI. Following national guidance and providing education for clinical staff on cleaner prescribing will be crucial to ensure low carbon inhalers are prescribed.

Using the Greener Pharmacy Toolkit, we also aim to switch from intravenous to oral antibiotics and to review the arrangements for both the disposal and recycling of inhalers and insulin cartridges.

Net Zero Culture Delivery Plan

Workforce

Our people are our greatest asset in delivering our Green Plan. We need to harness the enthusiasm and commitment of our staff, raise awareness of the environmental impact of our activities, encourage staff to think differently and help them by 'making it easy to do the right thing'.

Where are we now?

- We have appointed a Net Zero Lead
- The Whittington Green Group provides a forum to share, promote and encourage green sustainability projects across the Trust through providing a regular meeting for volunteered Green Champions. This helps staff to become informed and support current projects, and to raise ideas and processes driving these ambitions within the Trust, supporting the Trust's Green Plan.
- Our cycle-to-work scheme encourages staff to commute via active travel.

Where do we want to be?

We want to expand sustainability-focused staff benefits such as access to electric vehicle salary sacrifice schemes to support staff wellbeing and extend the Trust's sustainability impact into the community.

Collaboration and knowledge sharing internally and across partner organisations is an integral element for achieving our net zero goals. This requires support from our comms team as we aim to showcase a regular sustainability case study from within the Trust. This will celebrate staff-led initiatives, inspire others and promote a culture of continuous improvement.

To strengthen Trustwide understanding of sustainability, we will broaden access to environmental training across all staff levels. This includes incorporating sustainability into staff inductions and training. To support day-to-day staff engagement, sustainability training will be promoted through channels such as screensavers.

Nutrition and food

A healthier, more sustainable diet not only has lower associated emissions but also helps to improve the physical wellbeing of staff and patients through the prevention of diet related illness, as well as potentially providing wider social benefits for local communities through the procurement of locally sourced food.

Where are we now?

At the Hospital site, our newly refurbished N19 restaurant and two commercial retail outlets provide a range of meal choices for staff and visitors. Currently, we change our menus at least twice a year to use more seasonal ingredients as well as having a plant-based menu, although we believe there are opportunities to enhance the current food offer. We also have several vending machines on site which allows 24/7 food access. These smart fridges and smart hot drink machines allow access to nutritious food for staff and visitors who cannot visit the hospital's cafés and restaurants during opening hours.

For patient meals, we have reduced food wastage by switching from bulk cooking to individual plating. The Trust will be procuring a new supplier in the lifetime of this plan and will ensure that sustainability is a fundamental component in the process to select a new patient food provider.

Where do we want to be?

We want to provide nutritious, affordable and environmentally sustainable food for our patients, staff and visitors that both supports health and wellbeing and minimises waste.

The Trust will identify opportunities to make menu options healthier and offer low-carbon meals that use seasonal produce and require minimal processing, in line with the NHS England Low Carbon Menu Bank.

We aim to substantially reduce the amount of food waste generated by both retail and patient catering. We also need to improve waste segregation to support our ambition to increase recycling (preventing food waste from contaminating other waste streams).

Travel and transport

Changes to clinical care models, including those enabled by digital transformation, will reduce the number of individual patient and visitor journeys to our hospitals and make an important contribution to reducing overall travel related emissions.

However, we also need to work to reduce the number of car journeys made by patients, visitors and staff when they do need to travel to one of our sites, particularly using an internal combustion engine, and to promote less carbon intensive modes of travel such as active travel, public transport and electric vehicles. These alternative forms of travel offer a multitude of co-benefits. For example, active travel not only reduces emissions, but also improves physical and mental wellbeing, reduces congestion and improves air quality.

Where are we now?

We recognise that the future of UK transport is zero-emissions and have already begun to prepare for this by upgrading our electric vehicle infrastructure with 16 charging points installed across the estate and over 95% of our fleet electrified.

We are working with local authorities to identify opportunities to promote public transport and active travel. We have already implemented a Cycle to Work Scheme that enables staff to save up to 39% on a bike and accessories through tax-efficient salary deductions. This scheme offers multiple benefits: staff can choose any make and model, spread the cost over time, improve their health through active travel, and significantly reduce their carbon emissions.

Where do we want to be?

We have developed a detailed Green Travel Plan, actively engaging our communities and staff in a dialogue about actions we can take to encourage more sustainable forms of travel.

We also want to improve local air quality and reduce our emissions footprint tied to travel and transport and to ensure we are prepared for the decarbonisation of travel.

Net zero infrastructure delivery plan

Estates and facilities

Emissions relating to estates and facilities account for 78% of the NHS direct carbon footprint, predominantly through emissions tied to energy use. A significant proportion of the NHS carbon footprint plus also relates to estates and facilities including food and catering, travel, logistics and construction, which has been the largest single contributor to our carbon footprint plus over recent years.

The key measures of success across estates and facilities are:

- Decreased energy (electricity and gas) consumption
- Decreased carbon use from energy
- Decreased waste production
- Increase of waste recycled
- Decreased water consumption
- Decreased carbon footprint

Table 2 provides an overview of our performance against these key performance indicators over the last 9 years. As shown in the table, our NHS Carbon Footprint has decreased by 32% from our 2016/17 baseline.

This is predominantly due to our more efficient consumption of electricity following the roll out of light emitting diode lighting across our estate as well as the ongoing decarbonisation of the UK grid. This is further supported by the reductions in gas and water consumption per m^2.

There has been a 13% increase in waste production since our baseline year, reaching a peak of 20.25 kg/m^2 in 2020/21 and 2021/22, owing to the operational challenges faced by the Trust in response to the COVID-19 pandemic. Changes in our management of waste has delivered a 47% reduction in waste between the years 2021/22 and 2024/25, however more work is needed to bring this back in line with our baseline year.

For the purpose of this strategy, estates and facilities comprises the key themes energy, water, capital projects, greenspace and biodiversity, and waste.

KPI	Unit	Baseline 2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Trend
Electricity consumption	kWh/m^2	164	167	165	153	128	126	124	128	135	
Gas consumption	kWh/m^2	190	182	184	181	183	229	196	194	179	
Carbon from energy	$kgCO_2e/m^2$	126	111	107	95	89	94	84	91	90	
Waste production	kg/m^2	9	5	16	15	20	20	12	10	11	
Waste recycled	%	0	0	0	0	0	0	0	0	1	
Water impact	m^3/m^2	1	2	3	1	1	1	1	1	1	
NHS Carbon Footprint	tCO_2e	12,156	10,753	10,319	8,841	8,245	8,724	7,743	8,450	8,314	
NHS Carbon Footprint Plus	tCO_2e	Pending									N/A

Energy

Emissions from energy use in buildings currently represents 90% of our total NHS Carbon Footprint. On this basis, reducing energy consumption and transitioning to lower carbon generation technologies will be a key element of our pathway to achieving our reduction targets.

In 2024/25, 90% of our energy-related emissions were from our acute site – Whittington Hospital. Gas consumption drives the greatest portion of emissions at 47% across the estate, with electricity (100% renewable) at 41% and the remaining arising from well-to-tank and transmission and distribution.

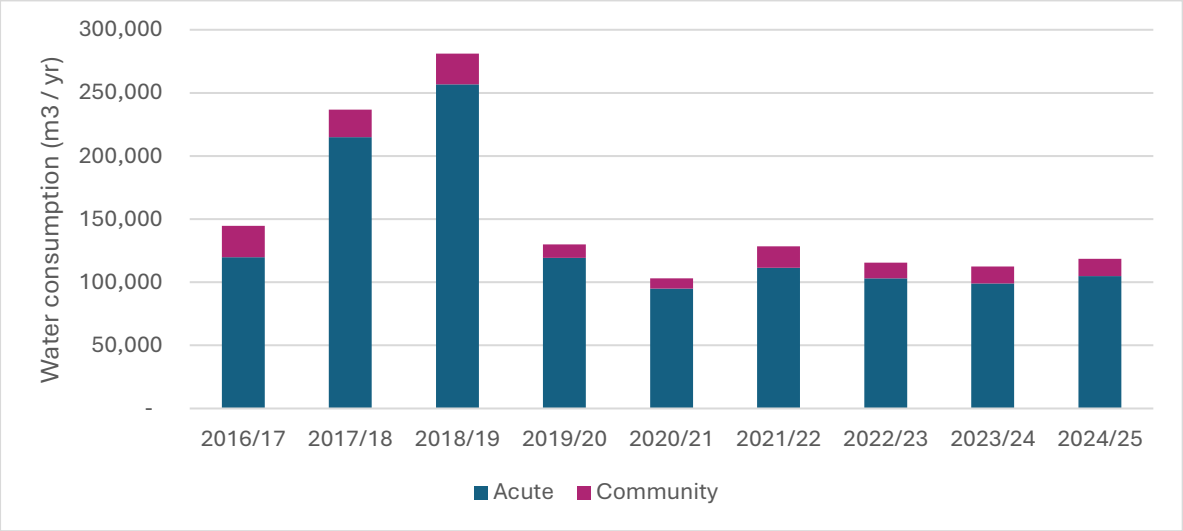
A Heat Decarbonisation Plan has also been completed for both the acute site and the community sites, providing a strategic roadmap for future low-carbon heating. A key element of the plan was to build more resilient electrical power infrastructure at the hospital site to enable a transition away from gas. The Trust worked with a specialist contractor under the P22 Procurement Regime

to design and install and connect a new 8.5 MVA power supply to the hospital site.

At the end of 2023/24, the Trust was awarded £417,000 in funding to install solar panels at five of our health centres. This is part of a £100 million package from Great British Energy for the NHS to install solar power to help drive down energy bills, offering better value for the taxpayer.

Water

Overall, the site has reduced its water usage from 2016/17 to 2024/25 by 18%. There was a rise in consumption from 2017/18 reaching nearly 300,000 m3 in 2018/19. This resulted from a leak which went unidentified for several months.



Capital projects

The Trust has a major programme of estate improvement with annual investment in critical infrastructure, statutory compliance, IT and equipment. In addition, the Trust has several major projects in the pipeline to increase capacity and improve the functional suitability of our estate.

One case study involves the project to upgrade our hospital's theatre ventilation system. Having clean air circulating through our hospital is really important, especially in areas where surgery is taking place. This project involved replacement of 35-year-old ducting and installing three new air handling units to provide extra resilience where previously we had only one air handling unit.


Delivery of three new air handling units: Recovery, Theatre 1, Theatre 2 (left) Capital Projects Team (right)

Green space and biodiversity

We recognise that air pollution is a major hazard to human health and that this is particularly acute for an inner-city Trust such as ours. We are also aware that our heating, emergency power and transportation systems contribute to this issue.

We have a board approved green space strategy embedded in our wider estates plan. Example schemes include converting an underused space outside labour ward at Whittington into a garden with a variety of flora planted to provide a peaceful area for our maternity patients.



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 10 October 2025, 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 2025. The amber scores pertained to data protection and the Business Continuity policy.

The trust received amber ratings for standard 44 and 49, which have since been updated. An EPRR 2025/2026 action plan, is in place to respond to the amber-rated standards.

NHS England Core Standards	Core Standards total	Assessment outcome Red	Assessment outcome Amber	Assessment outcome Green
EPRR	54 (1-54)	0	2	52
CBRN	14 (55-73)	0	0	19

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 2025/26. As the CEO, I believe this represents an accurate and full picture of the Trust for the year.

Signed 

Chief Executive: Selina Douglas

Date: 26 June 2026

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, Amanda Gibbon, Nailesh Rambhai, Glenys Thornton, Rob Vincent.

Directors

Clare Dollery (to 31 January 2026), Jonathan Gardner (to 9 January 2026), Charlotte Hopkins (to 31 May 2025), Tina Jegede, Liz O'Hara (to 1 March 2026), Clarissa Murdoch (1 February 2026 to 31 March 2026), Chinyama Okunuga, Swarnjit Singh, Sarah Wilding, Terry Whittle, Charlotte Pawsey (2 March 2026 to 31 March 2026).

Membership of committees reporting to the Board

Audit and Risk Committee

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

Charitable Funds' Committee

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

Finance & Business Development Committee

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

Improvement, Performance and Digital Committee

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

Quality Assurance Committee

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

Remuneration Committee

Non-Executive Directors: Julia Neuberger, Junaid Bajwa, 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, Charlotte Pawsey, 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, Rob Vincent
Directors: Clare Dollery, Terry Whittle, Jonathan Gardner, Charlotte Hopkins, Clarissa Murdoch, Selina Douglas

Non-executive director appraisal process

The chair 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 chair and the chair's appraisal is carried out by the senior independent director .

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 2025/26 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 • Member of NCL ICB Strategy and Development Committee • Partnership Development Committee-in-Common • 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) • Consultant, Clore Duffield Foundation (on Jewish matters) • Chair, Oversight Committee, City of London Centre • Public Voice Representative, Jewish Community's BRCA Testing Programme • Member of the Science and Technology Committee House of Lords • Vice Chair All-Party Parliamentary Group on Faith and Society

Voting member	Declared interests
	• APPG Dying Well – Member <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Clare Dollery, Acting Chief Executive	• Member of the Senior Management Board NCL Integrated Care Board • Ordinary shareholder of Smith and Nephew • Ordinary shareholder of Astra Zeneca • Ordinary shareholder of Unilever <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Sister-in-law Dr Caroline Dollery is a non-executive director on the board of NELFT.
Junaid Bajwa, Non-Executive Director	• Senior Partner, Head of UK & Science Partner, Pioneering Intelligence,Flagship Pioneering • GP (locum) • NHS England (GP appraiser) • Essential Guides UK Limited (Shareholder, GP locum services and educational work) • Non-Executive Director, University College London Hospitals NHS Foundation Trust • Non- Executive Director, Medicines and Healthcare products Regulatory Authority • Governor, Nuffield Health • Non- Executive Director, Nahdi Medical Corporation • Non-Executive Director Ondine • Visiting Scientist, Harvard School of Public Health • 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
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 and Chair of the UCLH Organ Donation Committee

Voting member	Declared interests
	• Director, The Girls Education Company Limited • Director, Garthgwynion Estate Limited • Director of Wycombe Abbey Services Limited <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
Chinyama Okunuga, Chief Operating Officer	• Nil <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Son is an auditor at KPMG
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 • Director, Cholmeley Court Ltd • Member, Finance & Performance Committee, Birmingham & Solihull Integrated Care Board • Trustee, United Way UK • Assessor- Solicitors Qualifying Exam (SQE) • Solicitor – non-practicing <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Baroness Glenys Thornton, Non-Executive Director	• Chair and Trustee, Phone Co-op Foundation for Co-operative Innovation • 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 • Officer Sickle Cell & Thalassaemia APPG • Honorary Secretary Social Enterprise APPG • Vice Chair Dalits APPG • Vice Chair APPG Media • Vice Chair APPG Parks and Green Spaces

Voting member	Declared interests
	• Member of the Advisory Committee on Business Appointments (ACOBA), • Fellow of Social Innovation Cambridge centre for Social Innovation, Judge Business School, University of Cambridge. <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 • Trustee of Kilmarnock Community Trust <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Sarah Wilding, Chief Nurse and Director of Allied Health Professionals	• Nil <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 (CIC) • Vice-chair Healthcare Financial Management Association's Policy & Research Committee <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Wife is an operational manager at West Hertfordshire Teaching Hospitals NHS Trust
Clarissa Murdoch, Acting Medical Director	
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-	• Non-Executive Director University College London Hospitals NHS Foundation Trust Consultancy advice to: • Sonacare Medical

Voting member	Declared interests
Executive Director	• 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> • Nil
Non-voting members	**Declared interests**
Jonathan Gardner Chief Strategy, Digital and Improvement Officer	• Director Whittington Pharmacy CIC • SRO for NCL Community Diagnostic Centres • Member NCL Diagnostic Board • Member NCL Digital Board • Member of Haringey Brough Partnership • Chair of the Haringey Neighbourhoods & Inequalities Board <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	• Honorary lecturer at City St Georges University • Member of the NCL Workforce Development Delivery Board <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Sister-in-law is employed at the Trust's pathology services
Liz O'Hara, Chief People Officer	• Director, Pineapple Equity • Chief of People, University College London Hospital NHS Foundation Trust • Member of the NHS National Staff Council Executive <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Sister is the publishing director at the Lancet Group
Swarnjit Singh, Joint Director of	• Secretary to the University College London Health Alliance Board and Chief Executive's Group • Management Side Co-Chair of the Equality, Diversity, and

Voting member	Declared interests
Inclusion and Trust Company Secretary	Inclusion subgroup of the NHS Staff Council Executive • Member of the North Central London Integrated Care Board's Population Health and Health Inequalities Steering Group. • Member of North Central London Integrated Care Board's People Committee <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 2026 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.

Salaries and Allowances 2025/26						
					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						
Baroness Julia Neuberger	40-45					40-45
Amanda Gibbon	10-15					10-15
Baroness 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	10-15					10-15
Executive						
Selina Douglas - Chief Executive Officer from 2nd June 2025	160-165				7.5-10	170-175
Clare Dollery - Acting Chief Executive Officer to 1st June 2025 and Chief Medical Officer from 1st June 2025 to 31st January 2026	205-210					205-210
Terry Whittle - Chief Finance Officer and Deputy Chief Executive Officer	160-165	16			47.5-50	210-215
Charlotte Hopkins - Interim Chief Medical Officer to 31st May 2025	25-30				15-17.5	40-45
Liz O'Hara - Chief People Officer to 1st March 2026	15-20				10-12.5	30-35
Charlotte Pawsey- Interim Chief People Officer from 2nd March 2026	10-15				0-2.5	10-15
Jonathan Gardner - Chief Strategy Officer to 9th January 2026	110-115				57.5-60	170-175
Chinyama Okunuga Chief Operating Officer	135-140	26			45-47.5	180-185
Sarah Wilding Chief Nurse and Director of Allied Health Professionals	140-145				55-57.5	200-205
Swarnjit Singh-Joint Director of Inclusion and Trust Company Secretary	105-110				45-47.5	150-155
Tina Jegede-Joint Director of Inclusion and Lead Nurse, Islington Care Homes	95-100				45-47.5	140-145
Clarissa Murdoch- Interim Chief Medical Officer 1.2.26 to 31.3.26	25-30				0-2.5	25-30

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

Salaries and Allowances 2024/25					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 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				0	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

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 2025/26 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 2026 (bands of £5,000)	Lump sum related to accrued pension at 31 March 2026 (bands of £5,000)	Cash equivalent transfer value at 31 March 2026 (to the nearest £1,000)	Cash equivalent transfer value at 31 March 2025 (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**
Selina Douglas	0-2.5	0	50-55	0	862	818	5	0
Terry Whittle	2.5-5	0-2.5	40-45	100-105	811	745	33	22
Jonathan Gardner	2.5-5	0	35-40	0	613	544	46	19
Chinyama Okunuga	2.5-5	0	30-35	5-10	541	477	39	17
Sarah Wilding	2.5-5	2.5-5	65-70	165-170	1,484	1,376	66	19
Tina Jegede	2.5-5	0-2.5	50-55	130-135	122	87	23	12
Swarnjit Singh	2.5-5	0-2.5	45-50	120-125	1,161	1,073	57	14
Liz O'Hara	5-7.5	7.5-10	65-70	150-155	1,354	1,186	111	3
Charlotte Hopkins	0-2.5	2.5-5	45-50	105-110	976	749	15	20
Clarissa Murdoch	0-2.5	0	65-70	165-170	1,522	1,436	0	4
Charlotte Pawsey	0-2.5	0	0	0	55	25	0	0

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.

Audited 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 2025/26, there was an increase of 17.9% from the last financial year in the remuneration of the highest paid director (2024/25: 13.0% decrease). The highest paid director was not paid performance pay or bonuses in 2025/26, (nil in 2024/25).

The average percentage change in the remuneration of employees of the entity, taken as a whole

In 2025/26, permanent staff received a national pay award of 3.6% (2024/25: 6.95%).

The range of staff remuneration

Remuneration ranged from the bands £25k-£30k to £215k-£220k.

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.

	2025/26	2024/25
	£	£
25th percentile	30,162	29,114
Median	38,682	37,567
75th percentile	54,710	52,809

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 2025/26 was £195k to £200k (2024/25, £165k to £170k). The relationship to the remuneration of the organisation's workforce is disclosed in the below overleaf.

	2025/26		2024/25	
	£	Highest paid director: ratio	£	Highest paid director: ratio
25th percentile	30,162	6.5	29,114	5.8
Median	38,682	5.1	37,567	4.5
75th percentile	54,710	3.6	52,809	3.2

The highest paid director

In 2025/26, no individual received remuneration in excess of the highest paid Director (two in 2024/25). Remuneration ranged from the bands £15k-£20k to £215k-£220k (2024/25 £15k-£20k to £250k-£255k).

Staff numbers and composition

Breakdown of temporary and permanent staff members (staff numbers):

Average Whole Time Equivalent (WTE)	Permanent staff 2025/26	Other / temporary staff 2025/26	Permanent Staff 2024/25	Other / temporary staff 2024/5
Medical and dental	587	28	546	64
Administration and estates	1,257	147	1,203	198
Healthcare assistants and other support staff	737	110	737	139
Nursing, midwifery and health visiting staff	1,369	132	1,303	199
Scientific, therapeutic and technical staff	953	40	926	86
Total	**4,903**	**457**	4,715	686

Cost analysis of permanent and temporary staff members

Staff group	2025/26 £000	2024/25 £000
Permanent staff		
Admin and estates	93,407	73,461
Medical and dental	76,433	63,151
Nursing and midwives	74,763	82,635
Scientific, Therapeutic and Technical	65,921	58,128
Healthcare assistants and other support staff	33,164	30,580
Apprentice Levy	1,442	1,369
Permanent total	**345,130**	**309,324**
Temporary staff		
Admin and estates	5,485	9,326
Medical and dental	4,566	11,653
Nursing and midwives	8,561	13,103
Scientific, Therapeutic and Technical	1,390	4,549
Healthcare assistants and other support staff	4,186	5,224
Temporary total	**24,188**	**43,855**
Total of Trust Funded Permanent and Temporary	**369,318**	**353,179**

Consultancy expenditure:

The Trust spent £ nil on consultancy in 2025/26 (in 2024/25, it was nil).

Off-payroll engagements

The Trust is required to disclose all off-payroll engagements as of 31 March 2026 for more than £245 per day and that last longer than six months. The Trust does not have any of these engagements.

Exit packages

	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	2	7	9	33	**11**	**40**		
£10,000 - £25,000	1	15	4	61	**5**	**76**		
£25,001 - £50,000	1	25	2	62	**3**	**87**		
£50,001 - £100,000	4	316	3	238	**7**	**554**		
£100,001 - £150,000					**0**	**0**		
£150,001 - £200,000					**0**	**0**		
>£200,000					**0**	**0**		
Total	**8**	**363**	**18**	**394**	**26**	**757**	**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: 26 June 2026

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 personally 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 2026 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 reviewing its risk management strategy and confirming its risk appetite statement and the key risks, both emerging and principal, to the delivery of its strategic objectives, through the following actions:

- 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
  - the audit and risk committee having the full BAF as a standing item at ach meeting
  - board members receiving regular updates at each meeting through board committee chairs' assurance reports on the review of respective BAF entries by its board committees
  - a thorough review of entries on the Trust Risk Register by respective executive leads to ensure that entries were up-to-date, appropriately scored and mitigated
- 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 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
    - Each clinical divisions' board meeting has their respective risks as a standing item
    - A new executive forum for risk management and the review of risk register entries has also been established
    - In addition, performance reviews for each clinical division consider their key respective risks
    - An annual review by our internal auditors of risk management arrangements and the control framework in place
    - A Risk Management Framework and risk management policy and procedure are place to provide guidance and advice to all staff
- 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:

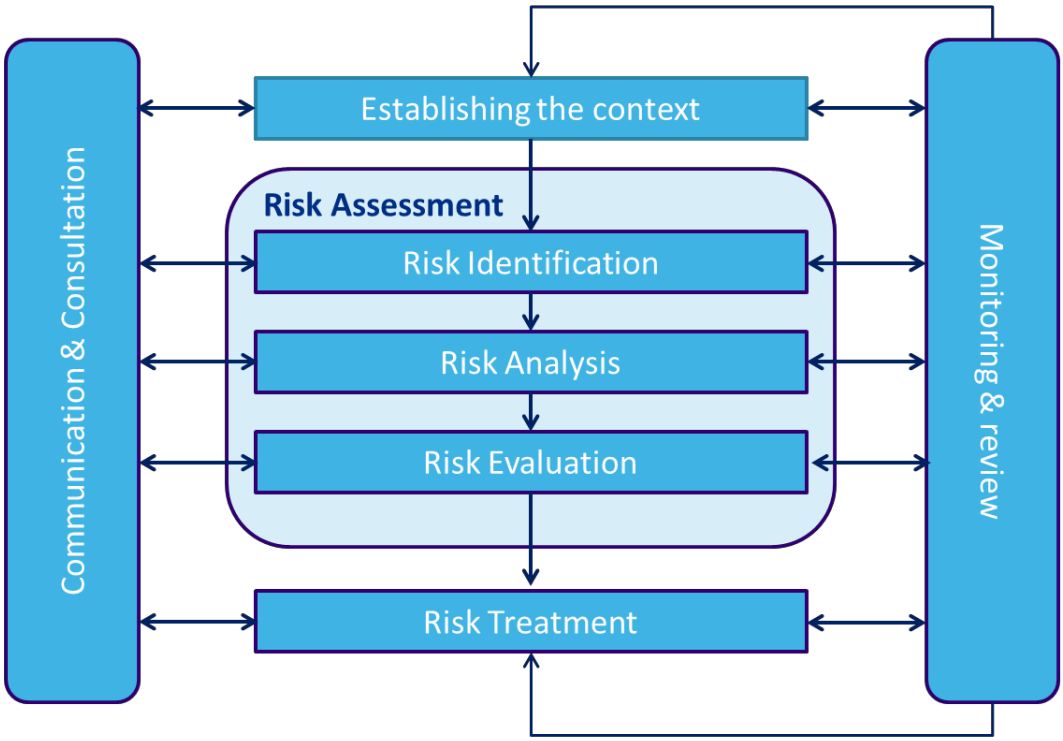
- embed the effective management of risk as part of everyday practice

- 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 in the diagram overleaf.

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



ISO 3000 Process Diagram

The Trust-wide approach to the escalation of risks in the organisation is shown overleaf.

Trust-wide review and escalation of strategic risks

Trust Board Assurance Framework (BAF)

Decision to escalate to BAF as a strategic risk

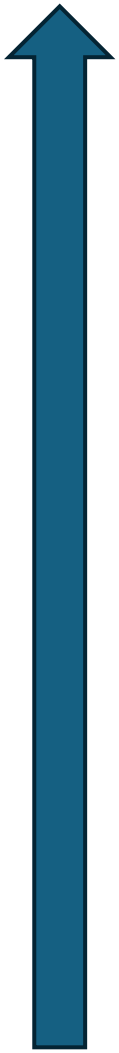
Audit and Risk Committee	***Improvement Performance and Digital Committee***	***Finance and Business Development Committee***	***Quality Assurance Committee***	***Workforce Assurance Committee***

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

Risks for escalation to the BAF

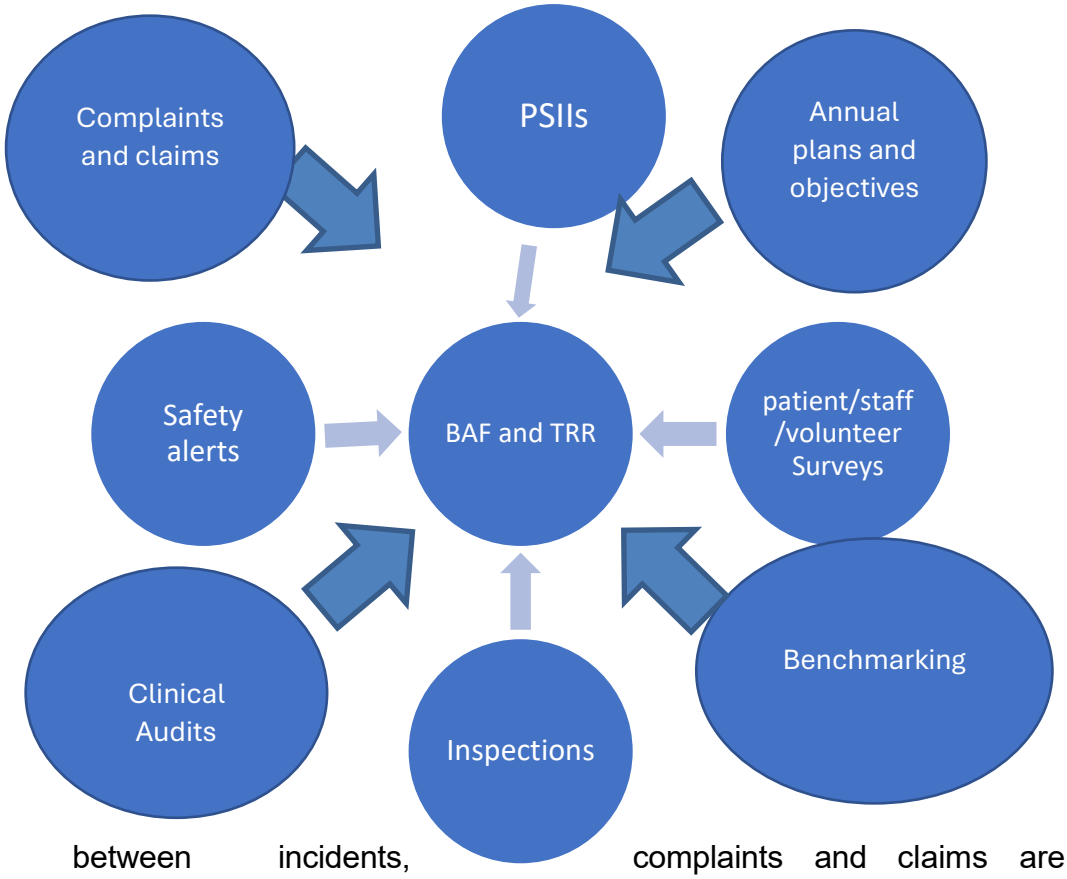
Quality Governance Committee	**People Committee**	**Clinical Divisions' Boards**	**Innovation & Digital Transformation Group**	**Estates Programme Board**	**Learn, Innovate and Improve meetings**	**Financial Improvement Board**

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



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 2025/26 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, the Trust Company Secretary. In addition, key Board Committees review risks relevant to their terms of reference as set out previously.

Risk appetite

In line with good practice, the Trust completes an annual review of its risk appetite statement. This is first discussed and endorsed by members of the Audit and Risk Committee and then taken to the Board for approval. 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 board of directors

Membership of the board of directors in 2025/26 was 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
- had close family ties with any of the trust's advisers, directors or senior employees
- held 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 care 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 2025/26 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	5 out of 6
Non-Executive Director, Mark Emberton	6
Non-Executive Director, Amanda Gibbon	5 out of 6
Non-Executive Director, Nailesh Rambhai	6
Non-Executive Director, Glenys Thornton	6
Non-Executive Director, Rob Vincent	6
Chief Executive Officer, Selina Douglas	5 out of 5
Acting Deputy Chief Executive, Clare Dollery	5 out of 5
Chief Finance Officer, Terry Whittle	6
Chief Operating Officer, Chinyama Okunuga	6
Chief Nurse & Director of Allied Health Professionals, Sarah Wilding	6
Chief People Officer, Liz O'Hara*	5 out of 5
Chief Strategy, Digital and Improvement Officer, Jonathan Gardner*	3 out of 3
Acting Chief Medical Officer, Charlotte Hopkins,	1 out of 1

Job title and name (*denotes non-voting member of the Board)	**Public Board meeting attended (out of 6 unless otherwise stated)**
Acting Medical Director, Clarissa Murdoch	2 out of 2
Acting Chief People Officer, Charlotte Pawsey*	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 UCLH. 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 held five meetings last year 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 met six times in 2025/26. It also monitors performance against quarterly quality indicators, the quality account, 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 held five full meetings in 2025/26.

Workforce Assurance Committee

The workforce assurance committee met five times during 2025/26 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 2025/26 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 Trustwide 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 2025/26, Whittington Health complied with the "Developing Workforce Safeguards" through the following assurances:

- The chief medical officer 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 the workforce assurance committee
- 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 board each month and were standing items on performance review group meetings. 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 declared interests for 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 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. Furthermore, an external audit of our accounts by KPMG LLP also provided an independent view of the Trust's effective and efficient use of resources, particularly against value for money considerations

During 2025/26, 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
- the development and implementation of a medium-term financial recovery plan
- 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
- the 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 as 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 audit and risk committee
- 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
The subject access request service accidentally mis-merged and sent out two different patient records.	July 2025	July 2025	No further action
A staff member lost a printout of the community visits' day sheet which contained the personal data of 13 patients.	December 2025	December 2025	No further action

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 23 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. Committee members also considered a review which showed largescale compliance with the code of governance, with one exception – taking the remuneration of the first tier of management below executive directors to the remuneration committee – this will happen at its next meeting.

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 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 the draft and final versions. This is approved by the chief finance officer 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 were approved, in principle, by the Trust's Board at its meeting on 25 June 2026 with delegated authority given to the chief finance officer

and the chair of the audit and risk committee to make any further changes required. 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 audit and risk committee, 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 the majority of the internal reviews completed during the financial year. This included a good 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: 26 June 2026

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: 26 June 2026

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... 26 June 2026 Chief Executive: Selina Douglas

Date.... 26 June 2026 Finance Director: Terry Whittle

Certificate on summarisation schedules

Trust Accounts Consolidation (TAC) Summarisation Schedules for Whittington Health NHS Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2025/26 have been completed and this certificate accompanies them.

Finance Director Certificate

1. I certify that the TAC schedules have been compiled and are in accordance with:

- the financial records maintained by the NHS Trust and
- accounting standards and policies which comply with the Department of Health and Social Care's Group Accounting Manual or any deviation from these policies has been explained in the confirmation questions in the TAC schedules except for the immaterial misstatements reported in the auditor's report to those charged with governance.

2. I certify that the TAC schedules are internally consistent and that there is one residual validation error as notified to, and agreed for submission with, NHS England.
3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Trust

Terry Whittle, Chief Finance Officer
26 June 2026

Chief Executive Certificate

1. I acknowledge the accompanying TAC schedules, which have been prepared and certified by the Director of Finance, as the TAC schedules which the Trust is required to submit to NHS England.
2. I have reviewed the schedules and agree the statements made by the Director of Finance above.

Selina Douglas, Chief Executive

[Date]

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Annual Accounts for the year ended 31 March 2026

Statement of Comprehensive Income

	Note	2025/26 £000	2024/25 £000
Operating income from patient care activities	3	497,478	471,111
Other operating income	4	32,937	29,273
Operating expenses	6,8	(529,341)	(512,746)
Operating surplus/(deficit) from continuing operations		**1,074**	**(12,362)**
Finance income	10	1,975	3,179
Finance expenses	11	(1,431)	(1,860)
PDC dividends payable		(6,056)	(5,588)
Net finance costs		**(5,511)**	**(4,269)**
Surplus / (deficit) for the year from continuing operations		**(4,437)**	**(16,631)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(6,361)	(7,339)
Revaluations	15	3	672
Total other comprehensive income for the period		**(6,358)**	**(6,667)**
Total comprehensive income / (expense) for the period		**(10,795)**	**(23,298)**

Note 32 Adjusted Financial Performance provides a reconciliation of the deficit reported above to the Trust's surplus against its control total

Statement of Financial Position

	Note	31 March 2026 £000	31 March 2025 £000
Non-current assets			
Intangible assets	12	2,480	4,079
Property, plant and equipment	13	281,261	260,849
Right of use assets	16	27,669	36,104
Receivables	19	757	805
Total non-current assets		**312,167**	**301,837**
Current assets			
Inventories	18	0	1,309
Receivables	19	19,441	23,122
Cash and cash equivalents	20	55,363	46,276
Total current assets		**74,804**	**70,706**
Current liabilities			
Trade and other payables	21	(101,406)	(91,238)
Borrowings	23	(4,925)	(5,511)
Provisions	24	(7,200)	(227)
Other liabilities	22	(1,816)	(2,216)
Total current liabilities		**(115,347)**	**(99,191)**
Total assets less current liabilities		**271,624**	**273,352**
Non-current liabilities			
Borrowings	23	(25,736)	(34,729)
Provisions	24	(13,382)	(25,032)
Total non-current liabilities		**(39,118)**	**(59,761)**
Total assets employed		**232,506**	**213,591**
Financed by			
Public dividend capital		168,030	138,320
Revaluation reserve		67,279	73,637
Income and expenditure reserve		(2,803)	1,634
Total taxpayers' equity		**232,506**	**213,591**

The notes on pages X to X form part of these accounts.

Name
Position
Date

Selina Douglas, CEO

26-Jun-26

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2025 - brought forward	**138,320**	**73,637**	**1,634**	**213,591**
Surplus/(deficit) for the year	-	-	(4,437)	**(4,437)**
Impairments	-	(6,361)	-	**(6,361)**
Revaluations	-	3	-	**3**
Public dividend capital received	29,710	-	-	**29,710**
Taxpayers' equity at 31 March 2026	**168,030**	**67,279**	**(2,803)**	**232,506**

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' 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' equity at 31 March 2025	**138,320**	**73,637**	**1,634**	**213,591**

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	2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating surplus / (deficit)		1,074	(12,362)
Non-cash income and expense:			
Depreciation and amortisation	6.1	22,901	20,711
Net impairments	7	6,408	3,587
Income recognised in respect of capital donations	4	-	(139)
Decrease in receivables and other assets		3,306	4,086
(Increase) / decrease in inventories		1,308	(219)
(Decrease) in payables and other liabilities		(5,258)	(27)
(Decrease) in provisions		(5,574)	(1,217)
Net cash flows from / (used in) operating activities		**24,166**	**14,421**
Cash flows from investing activities			
Interest received		1,935	3,340
Purchase of intangible assets		(825)	(714)
Purchase of PPE and investment property		(33,698)	(26,624)
Net cash flows from / (used in) investing activities		**(32,588)**	**(23,998)**
Cash flows from financing activities			
Public dividend capital received		29,710	372
Movement on loans from DHSC		(116)	(116)
Capital element of lease rental payments		(6,209)	(5,883)
Interest on loans		(41)	(43)
Other interest		(8)	(1)
Interest paid on lease liability repayments		(235)	(825)
PDC dividend (paid) / refunded		(5,593)	(6,199)
Net cash flows from / (used in) financing activities		**17,509**	**(12,694)**
Increase / (decrease) in cash and cash equivalents		**9,087**	**(22,272)**
Cash and cash equivalents at 1 April - brought forward		**46,276**	**68,548**
Cash and cash equivalents at 31 March	20	**55,363**	**46,276**

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 2025/26 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 the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such 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 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.

Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.

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.

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 value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use 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. 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. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

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 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) 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 of 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
Buildings, excluding dwellings	18	89
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. Subsequent measurement of intangible assets is at cost less amortisation.

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

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

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

From 1st April 2025, the Trust no longer records Inventory balances in its financial statements as the values which would be recorded have consistently been immaterial. For 2024/25 and previous financial years, the pharmacy drugs inventory was recorded at the lower of cost and net realisable value, as measured using the first in, first out (FIFO) method. The value of the inventory expensed in respect of this one-off change was £1,014k.

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 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

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 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

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 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

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 24.2 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 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 25.

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

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of 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 2025/26.

Note 1.20 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 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and 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.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £223m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for all of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £223m at 31 March 2026. In view of the fact that the change occurs in several years' time, the financial impact of the change cannot be quantified accurately at present.

Note 1.21 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 1.22 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 2026. 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 2026 to cover relevant potential liabilities. The Trust has reviewed the level at which the provision is held as at 31st March 2026, 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 2026, and should not be taken as admission of any liability on the part of the Trust.

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)	2025/26 £000	2024/25 £000
Acute services		
Income from commissioners under API contracts - variable element*	73,327	65,179
Income from commissioners under API contracts - fixed element*	274,744	262,834
High cost drugs income from commissioners	15,466	13,568
Other NHS clinical income	4,227	4,099
Mental health services		
Services delivered under a mental health collaborative	-	2,100
Community services		
Income from commissioners under API contracts*	83,336	81,042
Income from other sources (e.g. local authorities)	20,306	18,505
All services		
Private patient income	48	14
National pay award central funding***		890
Additional pension contribution central funding**	21,730	19,875
Other clinical income	4,294	3,004
Total income from activities	**497,478**	**471,111**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 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 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 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:	2025/26 £000	2024/25 £000
NHS England	47,373	43,848
Integrated care boards	421,230	399,540
Other NHS providers	4,227	6,199
Local authorities	20,306	18,505
Non-NHS: private patients	48	14
Non-NHS: overseas patients (chargeable to patient)	426	424
Injury cost recovery scheme	380	419
Non NHS: other	3,488	2,162
Total income from activities	**497,478**	**471,111**
Of which:		
Related to continuing operations	497,478	471,111
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2025/26	2024/25
	£000	£000
Income recognised this year	426	424
Cash payments received in-year	303	222
Amounts written off in-year	154	70

Note 4 Other operating income

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,091	-	**1,091**	873	-	**873**
Education and training	20,227	-	**20,227**	18,239	-	**18,239**
Non-patient care services to other bodies	8,149		**8,149**	5,882		**5,882**
Receipt of capital grants and donations and peppercorn leases		-	**-**		139	**139**
Revenue from operating leases		838	**838**		890	**890**
Other income	2,632	-	**2,632**	3,250	-	**3,250**
Total other operating income	**32,099**	**838**	**32,937**	**28,244**	**1,029**	**29,273**
Of which:						
Related to continuing operations			32,937			29,273
Related to discontinued operations			-			-

Note 5 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 5.1 Operating lease income

	2025/26	2024/25
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	838	890
Total in-year operating lease income	**838**	**890**

Note 5.2 Future lease receipts

	31 March 2026	31 March 2025
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	838	890
- later than one year and not later than two years	782	890
- later than two years and not later than three years	782	890
- later than three years and not later than four years	782	890
- later than four years and not later than five years	782	890
- later than five years	3,128	3,560
Total	**7,094**	**8,010**

Note 6.1 Operating expenses

	2025/26	2024/25
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	836	1,190
Staff and executive directors costs	389,196	371,992
Remuneration of non-executive directors	132	128
Supplies and services - clinical (excluding drugs costs)	30,417	36,173
Supplies and services - general	8,684	9,308
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	21,131	19,335
Establishment	8,970	10,330
Premises	21,796	22,850
Transport (including patient travel)	2,333	2,895
Depreciation on property, plant and equipment	20,477	18,376
Amortisation on intangible assets	2,424	2,335
Net impairments	6,408	3,587
Movement in credit loss allowance: contract receivables / contract assets	2,206	660
Movement in credit loss allowance: all other receivables and investments	748	-
Increase/(decrease) in other provisions	(5,172)	(940)
Change in provisions discount rate(s)	(81)	(56)
Fees payable to the external auditor		
audit services- statutory audit	168	163
other auditor remuneration (external auditor only)	-	-
Internal audit costs	77	91
Clinical negligence	9,650	9,082
Legal fees	1,722	1,280
Insurance (as a policy holder)	222	295
Research and development	13	157
Education and training	1,242	1,709
Expenditure on short term leases	159	74
Redundancy	1,268	465
Other	4,315	1,266
Total	**529,341**	**512,746**
Of which:		
Related to continuing operations	529,341	512,746
Related to discontinued operations	-	-

Note 6.2 Other auditor remuneration

	2025/26	2024/25
	£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 6.3 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 7 Impairment of assets

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	6,408	3,587
Total net impairments charged to operating surplus / deficit	**6,408**	**3,587**
Impairments charged to the revaluation reserve	6,361	7,339
Total net impairments	**12,769**	**10,926**

Note 8 Employee benefits

	2025/26 Total £000	2024/25 Total £000
Salaries and wages	296,191	281,469
Social security costs	34,988	26,706
Apprenticeship levy	1,442	1,369
Employer's contributions to NHS pensions	54,920	50,300
Termination benefits	281	-
Temporary staff (including agency)	3,226	13,210
Total gross staff costs	**391,048**	**373,054**
Of which		
Costs capitalised as part of assets	584	597

Note 8.1 Retirements due to ill-health

During 2025/26 there were 2 early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £85k (£325k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. 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 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 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 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 at 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 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2025/26	2024/25
	£000	£000
Interest on bank accounts	1,975	3,179
Total finance income	**1,975**	**3,179**

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	41	43
Interest on lease obligations	485	825
Interest on late payment of commercial debt	8	1
Total interest expense	**534**	**870**
Unwinding of discount on provisions	897	990
Total finance costs	**1,431**	**1,860**

Note 11.2 The late payment of commercial debts (interest) Act 1998

	2025/26	2024/25
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	8	1

Note 12.1 Intangible assets - 2025/26

	Software licences	Total
	£000	£000
Cost at 1 April 2025 - brought forward	**19,199**	**19,199**
Additions	825	**825**
Cost at 31 March 2026	**20,024**	**20,024**
Amortisation at 1 April 2025 - brought forward	**15,120**	**15,120**
Provided during the year	2,424	**2,424**
Amortisation at 31 March 2026	**17,544**	**17,544**
Net book value at 31 March 2026	**2,480**	**2,480**
Net book value at 1 April 2025	**4,079**	**4,079**

Note 12.2 Intangible assets - 2024/25

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**18,485**	**18,485**
Additions	714	**714**
Valuation / gross cost at 31 March 2025	**19,199**	**19,199**
Amortisation at 1 April 2024 - as previously stated	**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 13.1 Property, plant and equipment - 2025/26

	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 2025 - brought forward	**39,358**	**211,512**	**18,376**	**36,588**	**19,528**	**828**	**326,190**
Additions	-	-	48,724	-	-	-	**48,724**
Impairments	-	(12,769)	-	-	-	-	**(12,769)**
Revaluations	-	3	-	-	-	-	**3**
Reclassifications	-	24,258	(28,573)	1,231	3,032	52	**-**
Valuation/gross cost at 31 March 2026	**39,358**	**223,004**	**38,527**	**37,819**	**22,560**	**880**	**362,148**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**31,296**	**-**	**21,495**	**12,219**	**331**	**65,341**
Provided during the year	-	6,435	-	5,705	3,303	103	**15,546**
Accumulated depreciation at 31 March 2026	**-**	**37,731**	**-**	**27,200**	**15,522**	**434**	**80,887**
Net book value at 31 March 2026	**39,358**	**185,273**	**38,527**	**10,619**	**7,038**	**446**	**281,261**
Net book value at 1 April 2025	**39,358**	**180,216**	**18,376**	**15,093**	**7,309**	**497**	**260,849**

Note 13.2 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 - as previously stated	**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 - as previously stated	**-**	**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 13.3 Property, plant and equipment financing - 31 March 2026

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	39,358	185,158	38,527	10,604	7,038	358	**281,042**
Owned - donated/granted	-	115	-	16	-	88	**219**
Total net book value at 31 March 2026	**39,358**	**185,273**	**38,527**	**10,619**	**7,038**	**446**	**281,261**

Note 13.4 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£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 14 Donations of property, plant and equipment

During 2025/26 the Trust did not receive any contributions in kind. During 2024/25 the Trust received from its Charity, a contribution of income in kind towards capital expenditure, total £139k

Note 15 Revaluations of property, plant and equipment

Land, buildings and dwellings were valued in March 2026 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 is shown in the table below -

	31st March 2026	31st March 2025
Impairments		
Taken to Reserves	6,361	7,339
Taken to SoCI	6,408	3,587
Total Impairments	**12,769**	**10,926**
Revaluations	**3**	**672**
Net (Impairment) / Revaluation	**(12,766)**	**(10,254)**

Note 16 Leases - Whittington Health NHS Trust as a lessee

The Trust has several leased premises which provide local healthcare facilities.

Note 16.1 Right of use assets - 2025/26

	Property (land and buildings)	Total	Of which: leased from DHSC group bodies
	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**49,664**	**49,664**	**43,687**
Additions	1,062	**1,062**	1,062
Remeasurements of the lease liability	(4,176)	**(4,176)**	(4,176)
Disposals / derecognition	(390)	**(390)**	(390)
Valuation/gross cost at 31 March 2026	**46,160**	**46,160**	**40,183**
Accumulated depreciation at 1 April 2025 - brought forward	**13,560**	**13,560**	**11,504**
Provided during the year	4,931	**4,931**	4,111
Accumulated depreciation at 31 March 2026	**18,491**	**18,491**	**15,615**
Net book value at 31 March 2026	**27,669**	**27,669**	**24,568**
Net book value at 1 April 2025	**36,104**	**36,104**	**32,183**

Net book value of right of use assets leased from other NHS providers	108
Net book value of right of use assets leased from other DHSC group bodies	24,460

The Trust remeasures lease liabilities annually to reflect rent changes and lease term changes in compliance with IFRS16. During 2025/26, the Trust reflected one total disposal and two partial disposals of properties held as Right of Use assets. Negative rent movements were reflected for several further Right of Use assets in 2025/26 compared with values previously provided and accounted at 2024/25 financial year. These factors contributed to the reduction in Right of Use values shown above

Note 16.2 Right of use assets - 2024/25

	Property (land and buildings)	Total	Of which: leased from DHSC group bodies
	£000	£000	£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 16.3 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 23.1.

	2025/26	2024/25
	£000	£000
Carrying value at 1 April	**38,732**	**39,435**
Lease additions	1,062	1,622
Lease liability remeasurements	(4,176)	3,558
Interest charge arising in year	485	825
Early terminations	(390)	-
Lease payments (cash outflows)	(6,444)	(6,708)
Carrying value at 31 March	**29,269**	**38,732**

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 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.
Income generated from subleasing right of use assets is £0k and is included within revenue from operating leases in note 4.

Note 16.4 Maturity analysis of future lease payments

	Total 31 March 2026 £000	Of which leased from DHSC group bodies: 31 March 2026 £000	Total 31 March 2025 £000	Of which leased from DHSC group bodies: 31 March 2025 £000
Undiscounted future lease payments payable in:				
- not later than one year;	4,809	3,063	5,395	3,622
- later than one year and not later than five years;	24,460	19,685	33,337	28,005
- later than five years.	-	-	-	-
Total gross future lease payments	**29,269**	**22,748**	**38,732**	**31,627**
Finance charges allocated to future periods	-	-	-	-
Net lease liabilities at 31 March 2026	**29,269**	**22,748**	**38,732**	**31,627**
Of which:				
Leased from other NHS providers		215		632
Leased from other DHSC group bodies		22,533		30,995

Note 17 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 18 Inventories

	31 March 2026	31 March 2025
	£000	£000
Drugs	0	1,309
Total inventories	**0**	**1,309**
of which:		
Held at fair value less costs to sell	-	-

From 1st April 2025, the Trust no longer records Pharmacy Drugs inventory. The value of £1,014k was charged directly to expenditure at March 2026, to reflect this revised accounting policy.

Inventories recognised in expenses for the year were £21,425k (2024/25: £19,116k). Write-down of inventories recognised as expenses for the year were £0k (2024/25: £0k).

Note 19.1 Receivables

	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables	22,744	21,348
Allowance for impaired contract receivables / assets	(6,805)	(4,757)
Allowance for other impaired receivables	(1,395)	(647)
Prepayments (non-PFI)	3,123	4,722
Interest receivable	231	191
PDC dividend receivable	16	479
VAT receivable	188	372
Other receivables	1,338	1,413
Total current receivables	**19,441**	**23,122**
Non-current		
Contract receivables	505	512
Other receivables	252	293
Total non-current receivables	**757**	**805**
Of which receivable from NHS and DHSC group bodies:		
Current	19,097	15,407
Non-current	252	293

Note 19.2 Allowances for credit losses

	2025/26		2024/25	
	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	**4,757**	**647**	**4,188**	**647**
New allowances arising	4,569	748	1,095	(91)
Reversals of allowances	(2,363)	-	(435)	91
Utilisation of allowances (write offs)	(158)	-	(91)	-
Allowances as at 31 Mar 2026	**6,805**	**1,395**	**4,757**	**647**

Note 20 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.

	2025/26	2024/25
	£000	£000
At 1 April	**46,276**	**68,548**
Net change in year	9,087	(22,272)
At 31 March	**55,363**	**46,276**
Broken down into:		
Cash at commercial banks and in hand	860	404
Cash with the Government Banking Service	54,503	45,872
Total cash and cash equivalents as in SoFP	**55,363**	**46,276**
Total cash and cash equivalents as in SoCF	**55,363**	**46,276**

Note 20.1 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 2026	31 March 2025
	£000	£000
Bank balances	7	7
Total third party assets	**7**	**7**

Note 21.1 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables	40,418	31,429
Capital payables	21,391	6,365
Accruals	25,485	41,062
Social security costs	4,283	3,580
Other taxes payable	4,386	4,205
Pension contributions payable	4,806	4,477
Other payables	637	119
Total current trade and other payables	**101,406**	**91,238**
Non-current		
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	22,017	15,194
Non-current	-	-

Note 22 Other liabilities

	31 March 2026 £000	31 March 2025 £000
Current		
Deferred income: contract liabilities	1,816	2,216
Total other current liabilities	**1,816**	**2,216**
Non-current		
Total other non-current liabilities	**-**	**-**

Note 23.1 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Loans from DHSC	116	116
Lease liabilities	4,809	5,395
Total current borrowings	**4,925**	**5,511**
Non-current		
Loans from DHSC	1,276	1,392
Lease liabilities	24,460	33,337
Total non-current borrowings	**25,736**	**34,729**

Note 23.2 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Lease Liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2025	**1,508**	**38,732**	**40,240**
Cash movements:			
Financing cash flows - payments and receipts of principal	(116)	(6,209)	**(6,325)**
Financing cash flows - payments of interest	(41)	(235)	**(276)**
Non-cash movements:			
Additions	-	1,062	**1,062**
Lease liability remeasurements	-	(4,176)	**(4,176)**
Application of effective interest rate	41	485	**526**
Early terminations	-	(390)	**(390)**
Carrying value at 31 March 2026	**1,392**	**29,269**	**30,661**

	Loans from DHSC	Lease Liabilities	Total
	£000	£000	£000
Carrying value at 1 April 2024	**1,624**	**39,435**	**41,058**
Prior period adjustment	-	-	**-**
Carrying value at 1 April 2024 - restated	**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**

Note 24.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2025	**1,594**	**263**	**195**	**-**	**23,207**	**25,259**
Transfers by absorption	-	-	-	-	-	**-**
Change in the discount rate	8	2	-	-	(110)	**(100)**
Arising during the year	(99)	103	(90)	657	3,620	**4,191**
Utilised during the year	(182)	(36)	(45)	-	(33)	**(296)**
Reversed unused	-	-	-	-	(9,385)	**(9,385)**
Unwinding of discount	44	11	4	-	854	**913**
At 31 March 2026	**1,365**	**343**	**64**	**657**	**18,153**	**20,582**
Expected timing of cash flows:						
- not later than one year;	184	35	-	-	6,981	**7,200**
- later than one year and not later than five years;	1,181	308	64	657	11,172	**13,382**
- later than five years.	-	-	(0)	-	0	**0**
Total	**1,365**	**343**	**64**	**657**	**18,153**	**20,582**

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.

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 24.2 Clinical negligence liabilities

At 31 March 2026, £149,945k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Whittington Health NHS Trust (31 March 2025: £148,400k).

Note 25 Contractual capital commitments

	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	5,794	3,375
Total	**5,794**	**3,375**

Note 26 Financial instruments

Note 26.1 Financial risk management

Financial reporting standard IFRS7 requires disclosure of the role that financial instruments have had during the period in creating or changing 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 liabilities originating 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 2026 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 26.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	16,618	**16,618**
Cash and cash equivalents	55,363	**55,363**
Total at 31 March 2026	**71,981**	**71,981**

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**
Cash and cash equivalents	46,276	**46,276**
Total at 31 March 2025	**63,752**	**63,752**

Note 26.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	1,392	**1,392**
Obligations under leases	29,269	**29,269**
Trade and other payables excluding non financial liabilities	85,418	**85,418**
Total at 31 March 2026	**116,079**	**116,079**

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**

Note 26.4 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 2026 £000	31 March 2025 £000
In one year or less	90,343	81,984
In more than one year but not more than five years	24,924	33,801
In more than five years	812	929
Total	**116,079**	**116,714**

Note 27 Losses and special payments

	2025/26		2024/25	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Bad debts and claims abandoned	41	158	121	83
Total losses	**41**	**158**	**121**	**83**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	5
Ex-gratia payments	7	48	4	45
Total special payments	**7**	**48**	**5**	**50**
Total losses and special payments	**48**	**206**	**126**	**133**

Compensation payments received

Note 28 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 2025-26 was £5,068k and expenditure £5,054k. Total receivables balance was £1,347k and payables balance was £472k at 31st March 2026. The Charity's total income was £1,329k and expenditure £1,479k, total receivables £1k and payables £343k.

	Income (£000s)	Expenditure (£000s)	Receivables (£000s)	Payables (£000s)
NHS North Central London ICB	405,341	-	8,685	-
NHS England (statutory entity)	31,212	7	327	33
NHS North West London ICB	13,689	-	133	-
NHS North East London ICB	10,965	-	498	-
Royal Free London NHS Foundation Trust	5,193	3,595	4,258	4,205
University College London Hospitals NHS Foundation Trust	2,220	4,571	2,802	12,200
NHS Hertfordshire and West Essex ICB	1,772	-	74	-
North London NHS Foundation Trust	1,183	1,885	635	3,017
Moorfields Eye Hospital NHS Foundation Trust	1,167	4	432	4
Barts Health NHS Trust	1,017	17	289	25
NHS South East London ICB	905	-	-	-
East London NHS Foundation Trust	825	-	441	-
NHS South West London ICB	516	-	4	-
Central and North West London NHS Foundation Trust	324	128	155	196
NHS Mid and South Essex ICB	280	-	48	-
NHS Bedfordshire, Luton and Milton Keynes ICB	237	-	-	-
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	201	-	-	-

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	9,498	1,900	1,064	0
Haringey London Borough Council	305	22	390	0
Hackney London Borough Council	154	0	132	0
NHS Blood & Transplant	0	3,297	0	0

Note 30 Better Payment Practice code

	2025/26	2025/26	2024/25	2024/25
Non-NHS Payables	**Number**	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	53,134	238,090	62,171	234,840
Total non-NHS trade invoices paid within target	50,890	225,342	60,205	222,990
Percentage of non-NHS trade invoices paid within target	95.8%	94.6%	96.8%	95.0%
NHS Payables				
Total NHS trade invoices paid in the year	2,310	23,661	2,838	24,909
Total NHS trade invoices paid within target	2,011	20,386	2,578	21,673
Percentage of NHS trade invoices paid within target	87.1%	86.2%	90.8%	87.0%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Note 31 Capital Resource Limit

	2025/26	2024/25
	£000	**£000**
Gross capital expenditure	46,435	29,802
Less: Disposals	(390)	-
Less: Donated and granted capital additions	-	(139)
Charge against Capital Resource Limit	**46,045**	**29,663**
Capital Resource Limit	46,045	29,663
Under / (over) spend against CRL	**-**	**-**

Note 32 Adjusted financial performance

	2025/26	2024/25
	£000	**£000**
Surplus / (deficit) for the period per SOCI	(4,437)	(16,631)
Remove net impairments not scoring to the departmental expenditure limit	6,408	3,587
Remove I&E impact of capital grants and donations	66	(78)
Adjusted financial performance surplus / (deficit)	**2,038**	**(13,122)**

Note 33 Breakeven duty financial performance

	2025/26
	£000
Adjusted financial performance surplus / (deficit)	2,038
Breakeven duty financial performance surplus / (deficit)	**2,038**

Note 34 Breakeven duty rolling assessment

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	£000	£000	£000	£000	£000	£000	£000	£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	139	647	1,767	5,381	6,546	(796)	(15,584)	(19,254)
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	0.1%	0.3%	0.6%	1.9%	2.2%	(0.3%)	(5.3%)	(6.2%)

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	6,158	29,362	1,568	2,370	511	6,638	606	(13,122)	2,038
Breakeven duty cumulative position	(13,097)	16,266	17,834	20,204	20,715	27,353	27,960	14,838	16,876
Operating income	323,394	348,646	350,183	395,340	408,948	431,557	465,818	500,384	530,415
Cumulative breakeven position as a percentage of operating income	(4.0%)	4.7%	5.1%	5.1%	5.1%	6.3%	6.0%	3.0%	3.2%

Staff costs

	Permanent £000	Other £000	2025/26 Total £000	2024/25 Total £000
Salaries and wages	275,129	21,062	**296,191**	281,469
Social security costs	34,988	-	**34,988**	26,706
Apprenticeship levy	1,442	-	**1,442**	1,369
Employer's contributions to NHS pension scheme	54,920	-	**54,920**	50,300
Pension cost - other	-	-	**-**	-
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	281	-	**281**	-
Temporary staff	-	3,226	**3,226**	13,210
Total gross staff costs	**366,760**	**24,288**	**391,048**	**373,054**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**366,760**	**24,288**	**391,048**	**373,054**
Of which				
Costs capitalised as part of assets	484	100	**584**	597

Average number of employees (WTE basis)

	Permanent Number	Other Number	2025/26 Total Number	2024/25 Total Number
Medical and dental	587	28	**615**	610
Ambulance staff	-	-	**-**	-
Administration and estates	1,257	147	**1,404**	1,401
Healthcare assistants and other support staff	737	110	**847**	876
Nursing, midwifery and health visiting staff	1,369	132	**1,501**	1,502
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	953	40	**993**	1,012
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**4,903**	**457**	**5,360**	**5,401**
Of which:				
Number of employees (WTE) engaged on capital projects	7	1	**8**	8

Reporting of compensation schemes - exit packages 2025/26

	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	2	9	**11**
£10,000 - £25,000	1	4	**5**
£25,001 - 50,000	1	2	**3**
£50,001 - £100,000	4	3	**7**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**8**	**18**	**26**
Total cost (£)	363,000	394,000	**£757,000**

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 resource cost (£)	£320,000	£35,000	**£355,000**

Exit packages: other (non-compulsory) departure payments

	2025/26		2024/25	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	6	281	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	12	113	4	35
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT / DHSC approval	-	-	-	-
Total	**18**	**394**	**4**	**35**
Of which:				
Non-contractual payments requiring HMT / DHSC approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Meeting title	**Trust Board – public meeting**	**Date: 23 July 2026**
Report title	**Quality Assurance Committee Chair's report**	**Agenda item: 6**
Committee Chair	Professor Mark Emberton, Non-Executive Director	
Executive leads	Sarah Wilding, Chief Nurse & Director of Allied Health Professionals, Chinyama Okunuga, Chief Operating Officer, and Dr Rantimi Ayodele, Chief Medical Officer	
Report authors	Marcia Marrast-Lewis, Assistant Trust Secretary, Swarnjit Singh, Trust Company Secretary	
Executive summary	The Quality Assurance Committee met on 8 July and was able to take good assurance from the following agenda items considered: • Board Assurance Framework - Quality 1 and 2 entries • 2025 Adult Safeguarding Activity Annual Report • 2025/26 Children Safeguarding Annual Report • Patient Safety Incident Response Framework Report • Five Patient Safety Incident Investigation Reports • Maternity Report • Internal audit (RSM) review of Duty of candour • Ligature risk reduction In addition, the Committee received a presentation on the Islington Child and Adolescent Mental Health Services Neurodevelopmental 'Sprint' pilot and noted the risk register report The Committee agreed that the following areas be brought to the Board's attention: 1. The continued mismatch between demand and capacity across several services, including neurodevelopmental assessments, safeguarding, maternity and community services, and the need for a broader discussion regarding organisational priorities and service sustainability. 2. The national maternity requirements following publication of recent national reviews and reports, the need for a coherent improvement programme across maternity and neonatal services, and the potential resource implications associated with delivering this programme. 3. Ongoing patient safety risks arising from the use of multiple non-integrated electronic patient record systems and the importance of	

	maintaining Board oversight of digital interoperability risks and the mitigations implemented. 4. Recurring themes from patient safety investigations, including paediatric observations, information sharing between systems and services, and the need to strengthen evidence that learning from investigations is translated into sustainable improvement.
Purpose	Approval
Recommendation	Board members are asked to: i. note the Chair's assurance report for the Quality Assurance Committee meeting held on 8 July 2026; ii. note the review of the Board Assurance Framework Quality entries and the decision to leave the current scores unchanged; iii. note the 2025/26 annual reports for adults and children; and iv. approve the four patient safety incident investigation reports shown as appendices.
BAF	Quality 1 and 2 entries
Appendices	1. 2025/26 Adult Safeguarding Activity Annual Report 2. 2025/26 Children Safeguarding Annual Report 3. PSII report A136357 4. PSII report A132358 5. PSII report A132115 6. PSII report A136047

Committee Chair's Assurance report

Committee name	Quality Assurance Committee
Date of meeting	8 July 2026
Summary of assurance:	

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

Q2 Board Assurance Framework – Quality 1 and 2 entries
The Committee reviewed risks relating to the delivery of the Trust's Quality strategic objectives and agreed that no changes should be made to the total risk scores for the relevant entries at this time.

Children and Young People Presentation – Neurodevelopmental Assessment Sprint
Joanne Flanagan provided a presentation on the Islington Child and Adolescent Mental Health Services neurodevelopmental assessment sprint, undertaken to address lengthy waiting times for autism and attention deficit hyperactivity disorder assessments. Committee members heard that during a two-week intensive programme, 170 children were seen and 283 assessments completed. The priority waiting list was reduced from 7–8 months to immediate access, and routine waiting times were reduced by approximately three months. The Committee welcomed the significant achievement and noted the positive impact of partnership working across health, education and local authority services. Committee members recognised, however, that while the sprint had generated valuable learning and improvements, demand continued to significantly exceed capacity and sustainable long-term solutions would need to be developed. The Committee also noted the work to secure additional investment to support future delivery of neurodevelopmental services and that the Trust would promote its comprehensive service model to commissioners.

2025/26 Adult Safeguarding Annual Report
Theresa Renwick presented the annual safeguarding adults report. The Committee learnt of the continued increase in safeguarding referrals, reflecting a national trend, and received assurance regarding the quality of safeguarding arrangements, training compliance and partnership working. Particular attention was drawn to a new process for identifying patients who had repeated safeguarding referrals, aimed at improving multi-agency intervention and reducing avoidable harm. The Committee also welcomed progress through the Mental Health Steering Group on initiatives to strengthen domestic abuse identification and support, and plans to introduce level 3 safeguarding adults training. The Committee commended the safeguarding team for its significant contribution.

2025/26 Children's Safeguarding Annual Report
Nickola Rickard presented the annual safeguarding children report. The Committee received assurance that strong safeguarding arrangements and effective partnership working were in place. The report highlighted increasing complexity of safeguarding cases, pressures associated with special educational needs and disabilities reforms, workforce capacity challenges and increasing demand within Multi-Agency Safeguarding Hub activity. Committee members discussed the growing number of children and young people remaining in acute

hospital beds for prolonged periods while awaiting appropriate placements and recognised the associated quality, safety and safeguarding risks. The Committee was also advised of continued work to improve safeguarding training compliance and supervision, particularly within maternity services.

Q1 Patient Safety Incident Review Framework Report
Phillip Lee presented the first quarter Patient Safety Incident Review Framework (PSIRF) report and highlighted trends in incident reporting across the organisation. The Committee noted that falls, pressure ulcers and issues relating to discharge and transfers of care continued to feature prominently within incident reporting data. Committee members also received assurance regarding the management of ongoing patient safety investigations and the progress being made in reducing historic investigation backlogs. The Committee discussed the importance of demonstrating how learning from investigations translated into measurable and sustained quality improvement and agreed that further work should continue to strengthen this aspect of PSIRF implementation.

Patient Safety Incident Investigation Reports
The Committee reviewed five completed patient safety incident investigation reports. The cases involved:

- the care of a newborn infant who experienced severe deterioration after admission with jaundice;
- the death of a patient presenting with complications associated with sickle cell disease;
- a safeguarding incident involving the unauthorised removal of a baby from Trust care;
- a Never Event relating to a misplaced nasogastric tube; and
- the death of a patient who absconded from hospital before later taking their own life.

Committee members welcomed the detailed investigations and associated learning shared. Attention was drawn to recurring themes concerning paediatric observations, mental health pathways, information sharing, safeguarding processes and documentation standards. Committee members also highlighted the importance of ensuring reports were accessible and compassionate for families and requested further consideration of how completed investigations and improvement actions were presented publicly. The Committee agreed that improving evidence of sustained organisational learning and measurable improvement remained a key focus.

Maternity Quality and Safety Report
Isabelle Cornet presented the maternity quality and safety report. The Committee discussed the implications of recent national maternity reviews and reports, including the impact on staff wellbeing and service users. Members received assurance regarding progress with Maternity Incentive Scheme requirements, maternity governance arrangements, training compliance and actions being developed in response to the latest national recommendations.

The report highlighted several areas requiring ongoing attention, including:

- safeguarding training compliance;
- Saving Babies' Lives Care Bundle training;
- staff survey findings;

	• governance requirements under the revised Maternity Incentive Scheme; • workforce capacity and resource pressures; and • the organisational response to the national maternity agenda. Committee members recognised the significant pressures facing maternity and neonatal services. The noted their support for the development of a structured improvement programme that incorporated governance, culture, workforce, patient experience and quality improvement priorities. Committee members also highlighted the importance of supporting staff through a period of significant national scrutiny and change. **Internal Audit Report – Duty of Candour** Nicola Sands presented the Internal Audit report on Duty of Candour. The audit received a rating of reasonable assurance and identified strong compliance in relation to verbal duty of candour, governance arrangements, reporting processes and staff training. The Committee reviewed four recommendations designed to strengthen processes further, particularly in relation to timeliness of written communications. Committee members were assured that improvement actions were already underway and that the backlog of overdue written duty of candour responses had reduced significantly. **Ligature Risk Reduction Programme** Chinyama Okunuga provided an update on the Ligature Risk Reduction Programme. Committee members noted that a specialist external provider had now been commissioned to support independent review of assessments, documentation, training arrangements and future risk assessments. The work was expected to start in August and would provide additional assurance regarding the Trust's management of ligature risks and the controls in place. **Care Quality Commission Update** Sarah Wilding provided a verbal update regarding Care Quality Commission (CQC) activity. The Committee was informed that the CQC had advised that it would undertake further consideration of the Trust's ratings review. Committee members also noted ongoing dialogue with the regulator regarding historic incidents and forthcoming engagement meetings. The Committee would continue to monitor regulatory activity closely and provide updates to the Board, as appropriate
2.	**Risk register** Sarah Wilding summarised the quality risk register. The Committee discussed the development of a Trust-wide violence and aggression risk and associated reduction strategy. The Committee was informed that the previous violence and aggression risk had transitioned to an organisational risk, supported by a Trust-wide strategic response. Committee members were assured that no significant incidents had occurred in the paediatric emergency department since relocation despite some extended waiting times. The Committee discussed the impact of the recent heatwave and received assurance regarding daily incident management arrangements, deployment of cooling equipment, escalation processes and business continuity responses across clinical areas. Committee members commended staff for their response to the operational and patient safety challenges created by the extreme weather conditions.

3.	**Present:** Mark Emberton, Non-Executive Director (Chair) Baroness Glenys Thornton, Non-Executive Director Amanda Gibbon, Non-Executive Director Rantimi Ayodele, Chief Medical Officer Tina Jegede, Joint Director of Inclusion and Islington Care Homes Lead Chinyama Okunuga, Chief Operating Officer Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary Sarah Wilding, Chief Nurse & Director of Allied Health Professionals **In attendance:** Joanne Flanagan, Divisional Director, Children and Young People Nickola Rickard, Named Nurse Safeguarding Children Theresa Renwick, Head of Safeguarding Adults Isabelle Cornet, Director of Midwifery, ACW Clinical Division Selina Douglas, Chief Executive Officer Phillip Lee, Assistant Medical Director, Patient Safety Matthew Minter, Associate Director of Clinical Governance Clarissa Murdoch, Deputy Chief Medical Officer Nicola Sands, Deputy Chief Nurse Carolyn Stewart, Executive Assistant to the Chief Nurse Ruth Law, Assistant Medical Director, Quality Improvement & Clinical Excellence

Meeting title	**Quality Assurance Committee**	**Date: 08.07.2026**
Report title	**2025 Annual Safeguarding Adults Activity Report**	**Agenda item: 3.1**
Executive lead	Sarah Wilding, Chief Nurse & Director of Allied Health Professionals	
Report author	Theresa Renwick, Head of Vulnerable Adults	
Executive summary	**Background** Committee members are presented with the annual report of activity which took place during the 2025 calendar year, the issues identified. **Issues** Adult safeguarding activity continued to rise significantly in 2025, with referrals increasing in line with national trends and nearly doubling since 2020. Neglect and acts of omission remained the most common concern, with patterns around alleged harm, victim gender, and location consistent with previous years. A new joint Mental Health Steering Group was established with the North London Foundation Trust to improve the care and experience of mental health patients. A wide range of staff have received additional specialist training. Safeguarding training compliance remains strong, with most mandatory training above 85%. The safeguarding team has also expanded its education offer across multiple Trust programmes. Deprivation of Liberty Safeguards (DoLS) applications declined in 2025; the reasons are unclear and will be explored through audit, while preparation for the future Liberty Protection Safeguards will commence, once national timelines are confirmed. The Domestic Abuse Lead role was introduced as a pilot in partnership with Islington Violence against Women and Girls services. The pilot has increased staff awareness, training, and case discussions. The Trust also remains active in regional work on non-fatal strangulation.	

	Learning from Safeguarding Adult Reviews have strengthened responses to repeat concerns, including proactive reviews of patients with multiple referrals and the introduction of safeguarding supervision for Community Matrons. The Safeguarding team also continues to contribute to improving safe and timely discharge processes. **Next steps** Our future priorities include closer joint working with children's safeguarding colleagues, further DoLS auditing, the development of level 3 adult safeguarding training, a strengthening of the community safeguarding presence, and continued leadership on improving holistic care for patients with mental health needs.
Purpose	Review and assurance
Recommendation(s)	The Quality Assurance Committee is asked to: i. note and discuss the annual report of adult safeguarding activity in 2025; ii. take assurance that there are systems in place to protect vulnerable adults whilst in our care; and iii. be assured that partners have confidence that Whittington Health is fulfilling its role as a statutory partner in safeguarding vulnerable adults at risk in the wider community and west and north London health and care sector.
Risk Register or Board Assurance Framework	Board Assurance Framework risk entry 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation
Report history	This annual activity report supplements and builds on the bi-annual safeguarding adult reports, the last being presented to the Quality Assurance Committee in November 2025.
Appendices	1: Annual Safeguarding Adults Activity report, 1 January 2025 - 31 December 2025.

Appendix 1:

Annual Safeguarding Adults Activity report 1 January 2025-31 December 2025.

1. Introduction

1.1 This annual report for safeguarding adults informs the Trust Board of activity and progress in improving and strengthening the safeguarding arrangements for vulnerable adults across Whittington Health NHS Trust. It covers the period from 1 January - 31 December 2025. The report provides assurance around the following areas:

- Activity within the safeguarding adult team
- Compliance levels for mandatory training
- Identification of areas for improvement, and actions taken
- Responding to and learning from safeguarding concerns raised from internal incidents and serious incidents; Safeguarding Adult and Domestic Homicide Reviews and regulatory inspections
- Work plan and objectives for the coming period of review

1.2 Below is an example of a case managed by the Safeguarding Adult Team.

CASE STUDY

Clare is a 58 year old woman who lives in her own home and requires support for both her mental and physical health. Safeguarding adult concerns had been raised by Whittington Health community teams predominantly due to self-neglect and not taking medication prescribed.

Having been closed to community mental health services, Clare was re-referred and picked up by mental health services, which included an inpatient episode for approximately one month.

Upon discharge, Clare was initially compliant with her medication, and continued to receive relevant community support for both her physical and mental health.

Towards the end of 2025, Clare again began refusing to take any medication. Safeguarding adult concerns were raised by Whittington Health community teams concerned about the risk of self-neglect. An assessment of capacity undertaken earlier in the year had indicated Clare lacked capacity to make decisions around her physical health.

The new initiative starting in Q2 of 2025-2026 of the Trust safeguarding adult team reviewing and escalating any patients with three or more safeguarding adult concerns in one year was used to ensure a continued multi-agency approach towards Clare, ensuring all were aware of the actions of other teams and professionals.

2. Data for safeguarding adults

2.1 The period covered in this report has seen the volume of safeguarding adult referrals remain high. Since 2020, there has been an 88% increase, as shown in table 1 below. Table 2 below shows the monthly totals of safeguarding adult referrals for 2025.

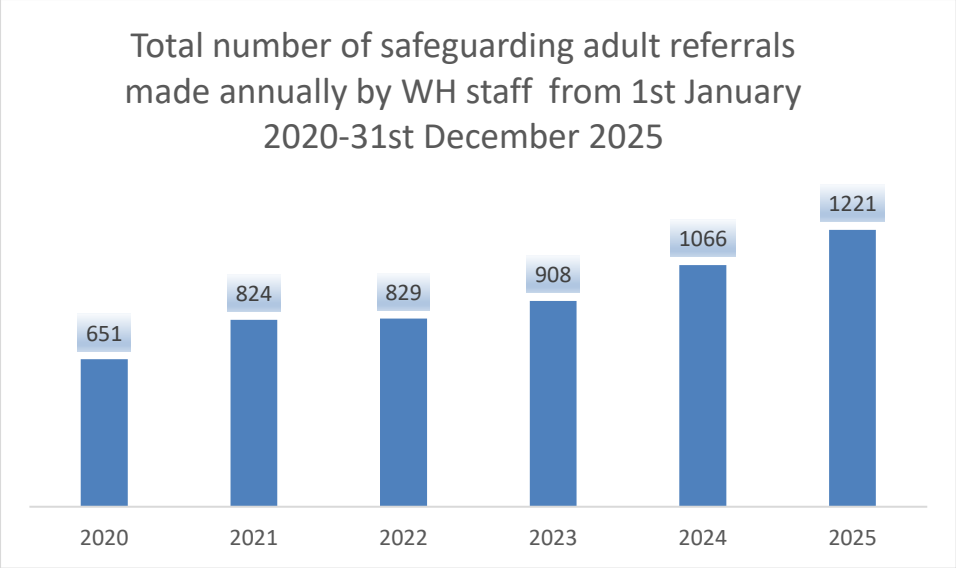


Table 1

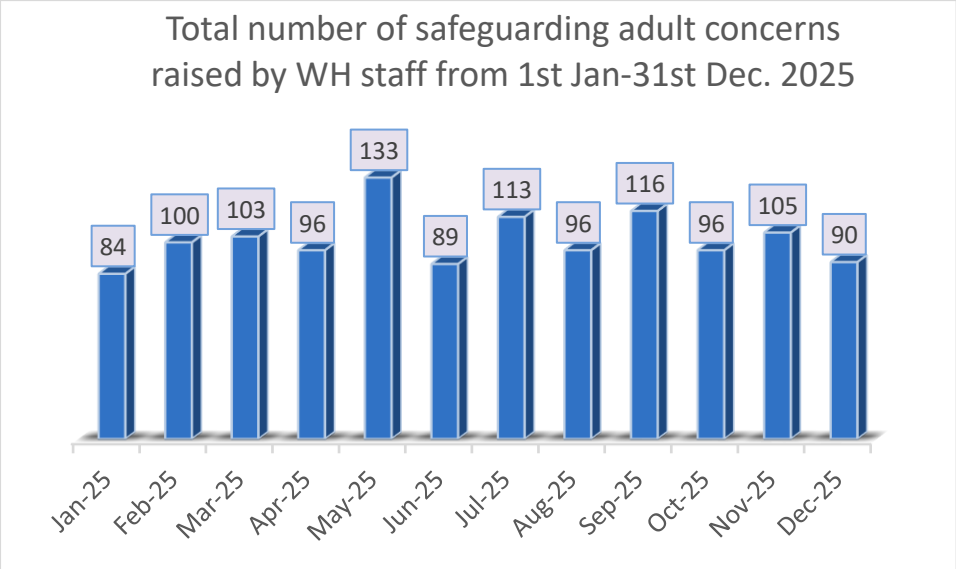


Table 2

2.2 Demographics, category of alleged abuse and persons alleged to have caused harm are given in tables 3-8, starting with gender in table 3 below. The tables show the continued high levels of safeguarding adult referrals, with categories and location of alleged abuse mirroring national data from the most recent NHS Digital report published in August 2025 (though covering the preceding year April 2024-March 2025)[1].

[1] Safeguarding adults, England, 2024 to 2025 - GOV.UK

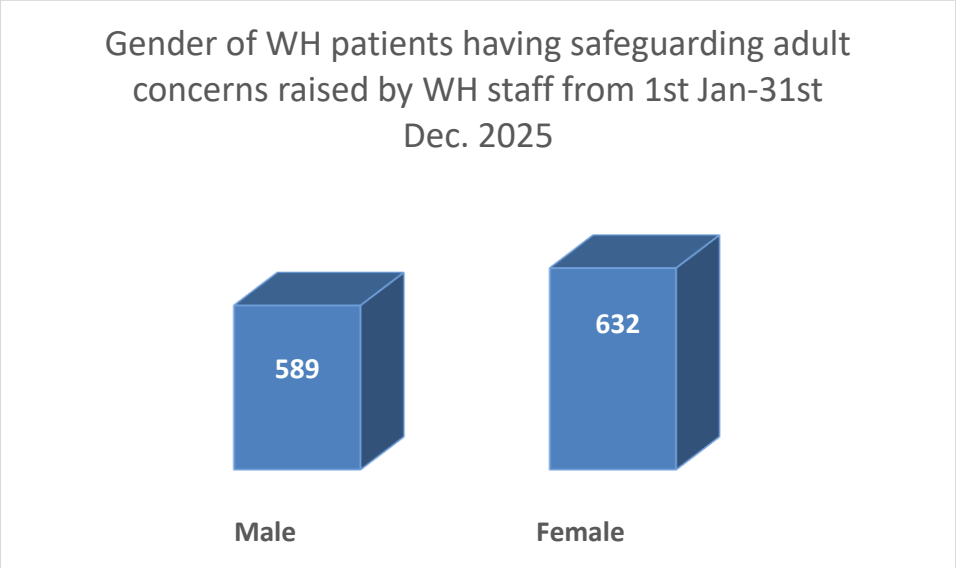


Table 3

2.3 Table 4 below shows the age range of 50-74 had the highest number of safeguarding adult referrals during this reporting period.

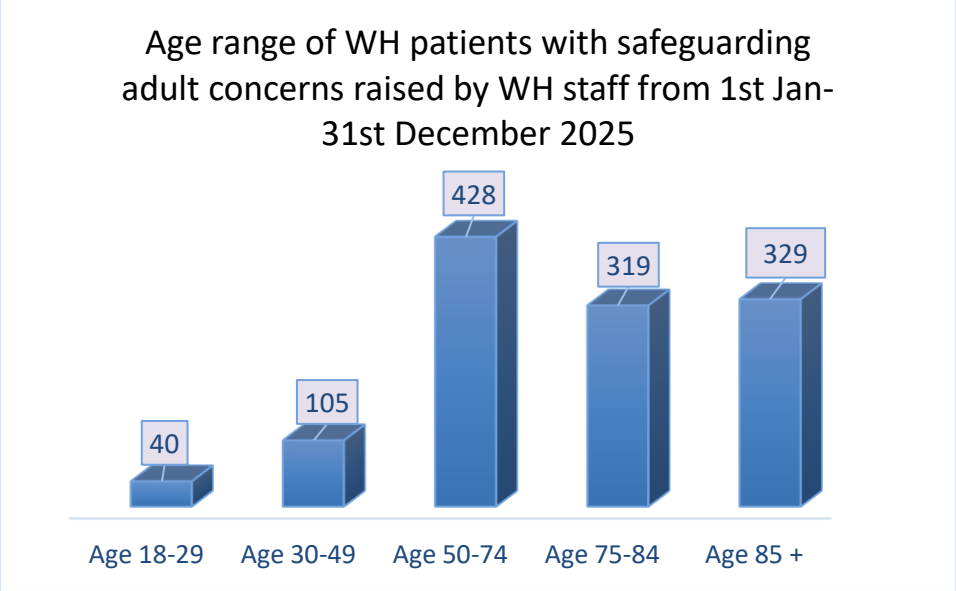


Table 4

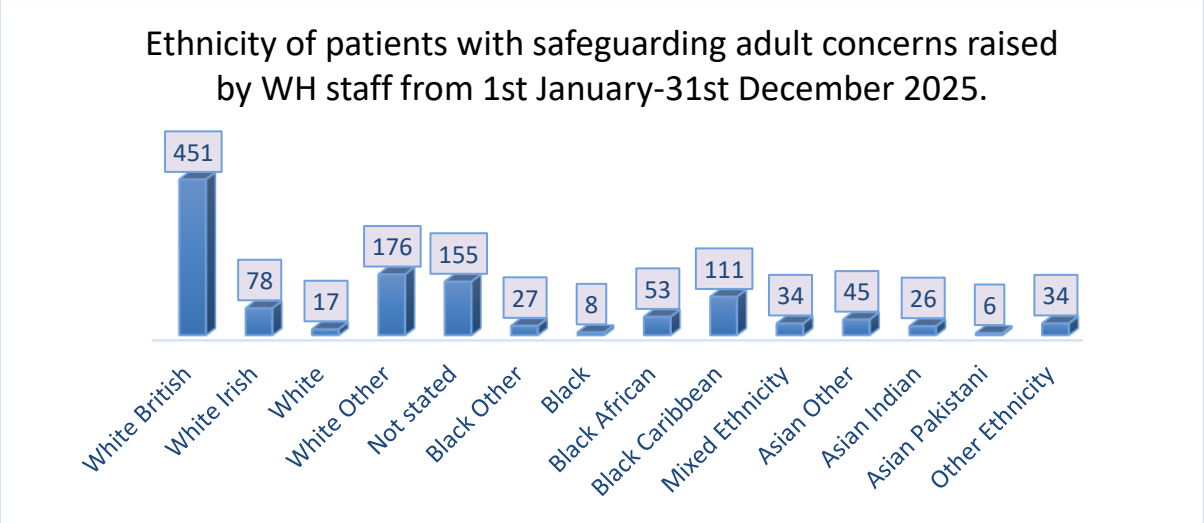


Table 5

2.4 Neglect and acts of omission is the highest identified category of alleged abuse during this time period, in line with national findings, as shown in table 6 below.

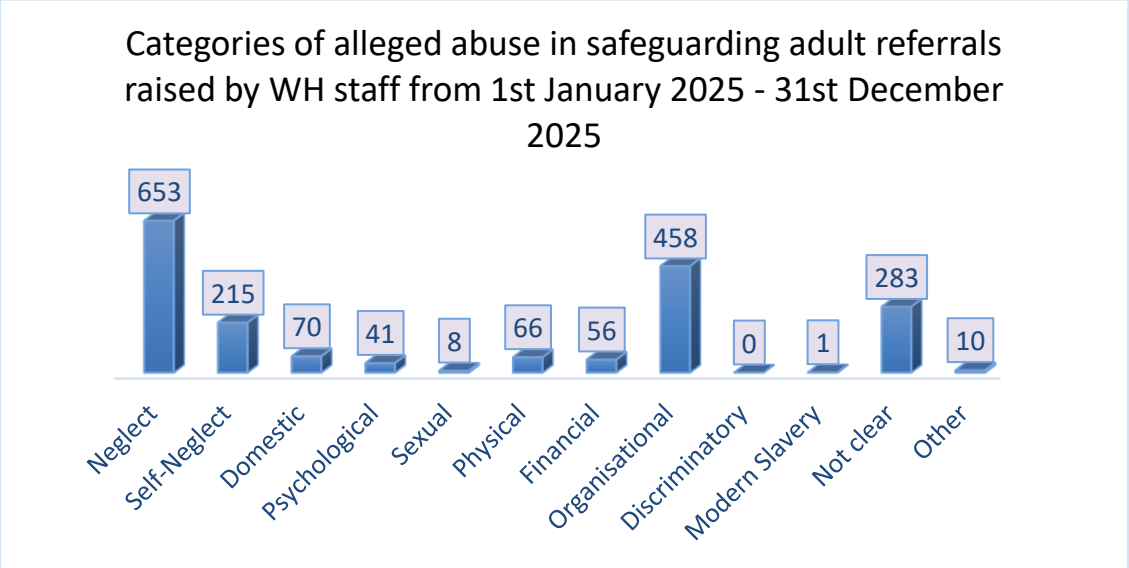


Table 6

2.5 Unusually, the highest category of person alleged to have caused harm during this time frame is unclear from the information contained in the referrals, Face to face training will continue to highlight the importance of putting as much information as possible on referral forms to ensure the concern can be addressed in a timely and comprehensive manner.

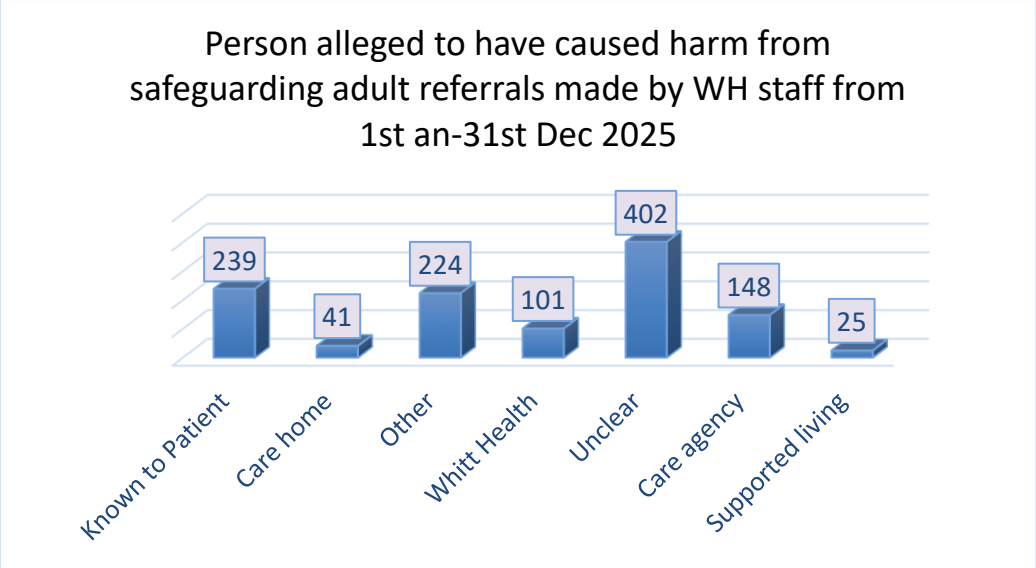


Table 7

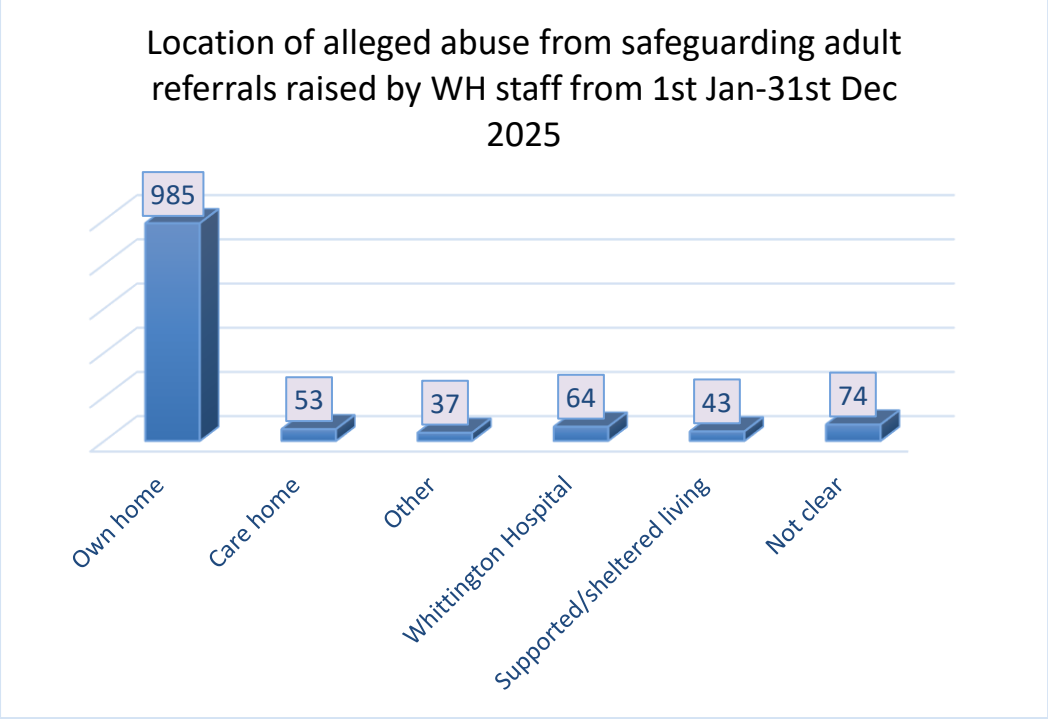


Table 8

2.6 Table 9 below shows the local authorities receiving the safeguarding adult referrals.

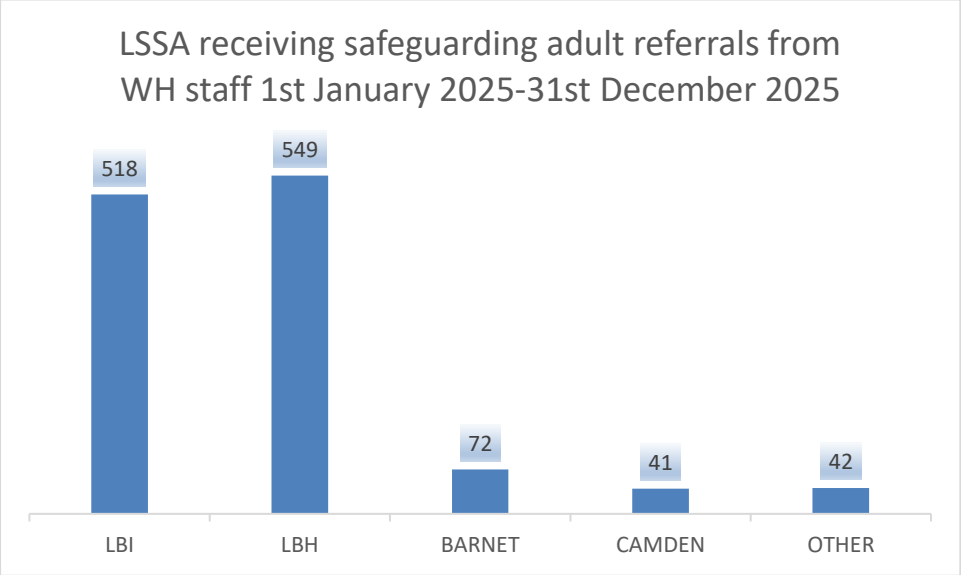


Table 9

2.7 Table 10 shows the monthly number of safeguarding adult referrals raised by Whittington Health staff in 2025.

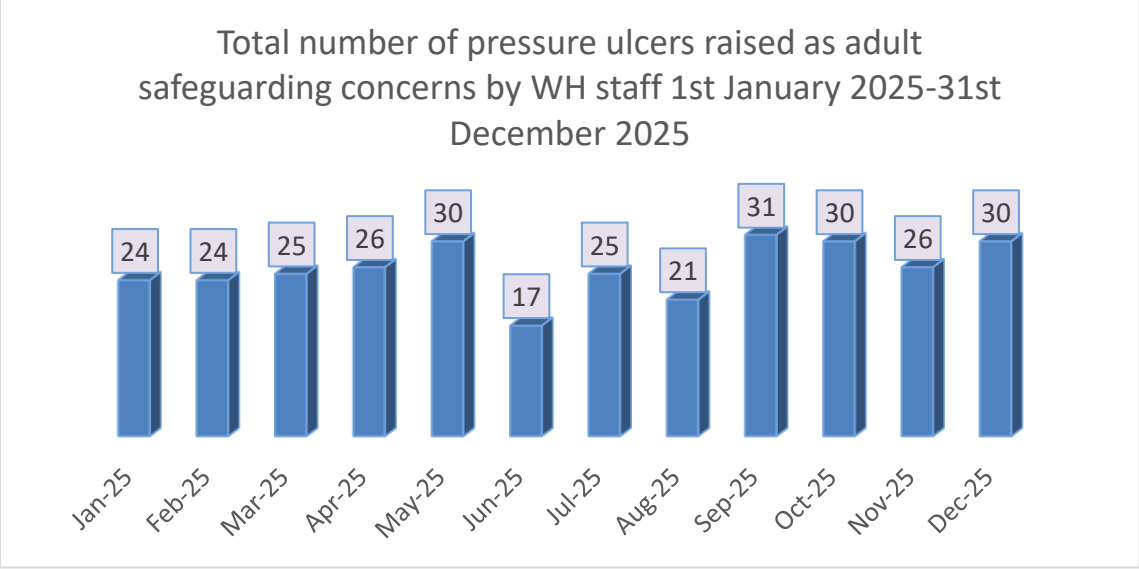


Table 10

2.8 Table 11 overleaf shows the service lines raising safeguarding adult concerns, using CQC criteria. It is noticeable that only three referrals came from maternity, and this will need to be addressed.

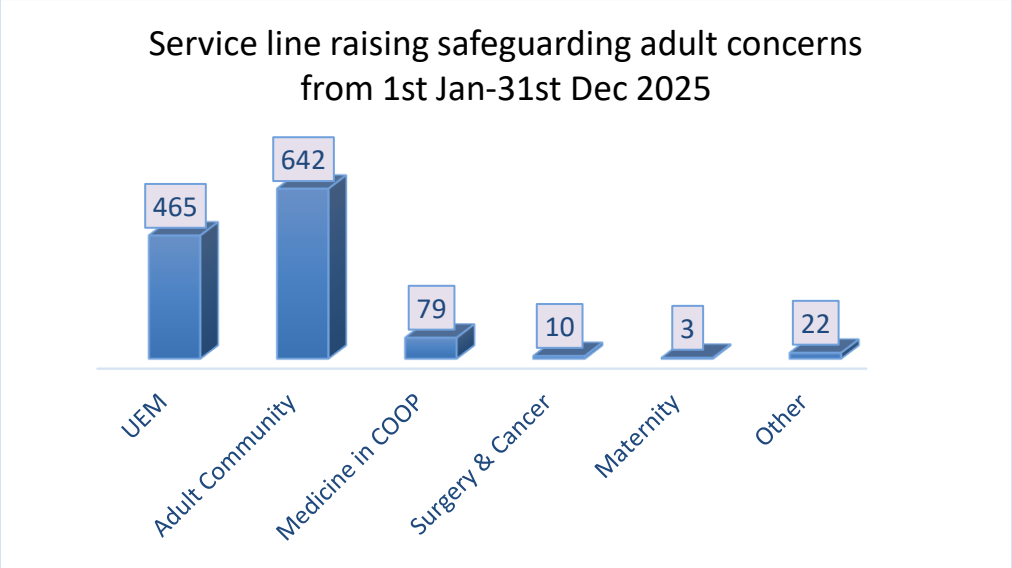


Table 11

2.9 Table 12 below shows the number of Urgent DoLS applications raised from 2020-2025, with 2025 having the lowest total. Such as reduction will be monitored.

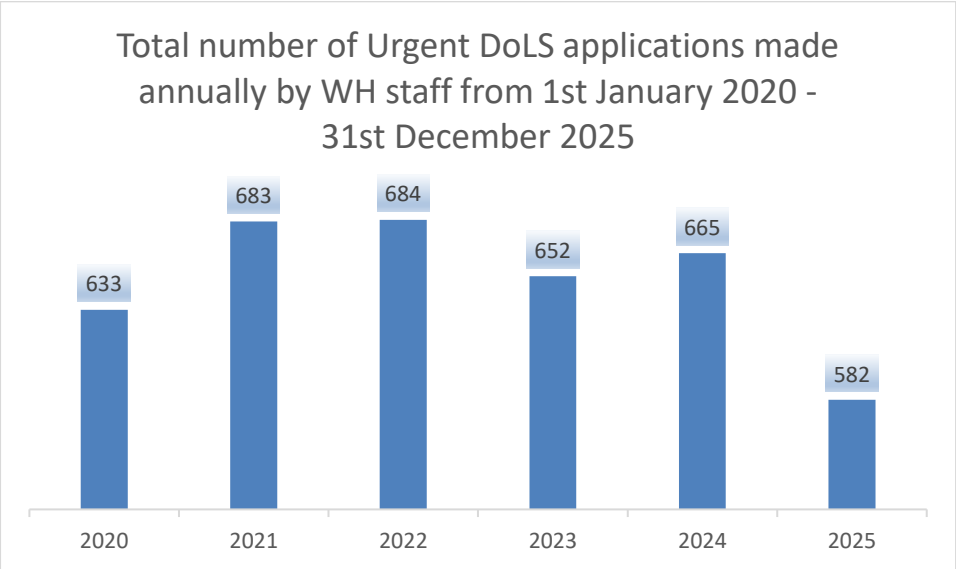


Table 12

2.8 Table 13 overleaf shows the monthly total of urgent DoLS applications made during 2025.

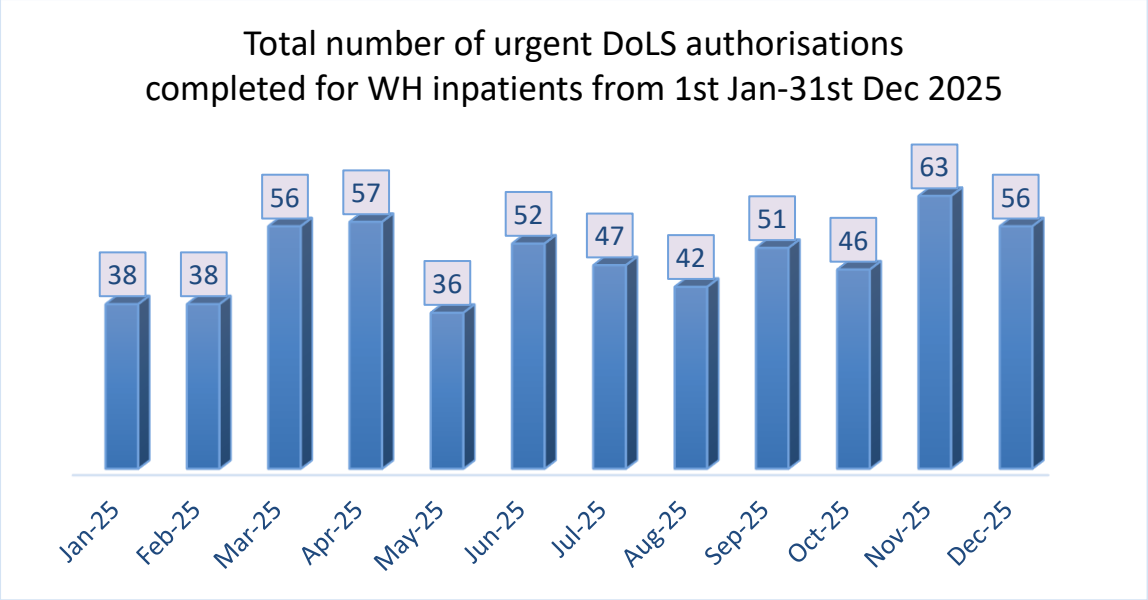


Table 13

3. Allegations made against staff

3.1. The Allegations against Staff Policy, rewritten and relaunched in October 2023 has implemented a robust system for investigating allegations made against staff.

3.2 The Trust is engaged in work being undertaken by both Safeguarding Adult Boards around formalising a process for allegations against Persons in Positions of Trust (PiPOT).

3.3. 13 allegations have been received during this reporting period, all following the Staff Allegations and Safeguarding Policy and involving the local authority in the process.

3.4 Three staff have needed to be placed through the Trust Disciplinary processes, with one staff member was dismissed.

3.5 The majority of staff with allegations made against them are Health Care Support Workers (HCSW) so maintaining our additional training to this cohort of staff is essential. In addition, additional training around, for example, moving and handling, has been provided.

4.0 Training

4.1 Table 14 below shows monthly mandatory training compliance for safeguarding adults' levels 1&2, and Basic Awareness of Prevent and PREVENT level 3.

4.2 Table 15 gives number of sessions and number of staff trained in additional training sessions as part of established Trust training programmes.

4.3 Bespoke training sessions take place as requested, though we do not capture these figures.

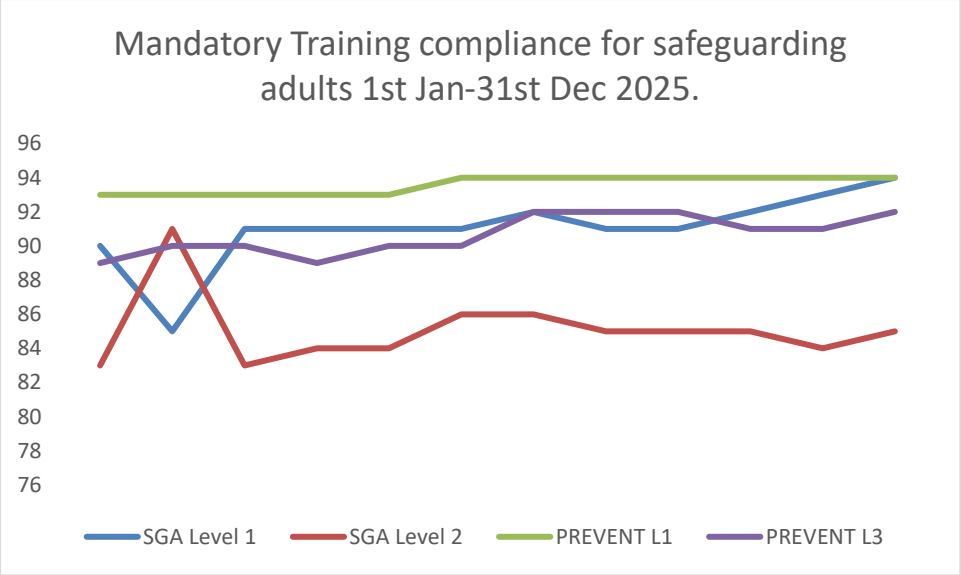


Table 14

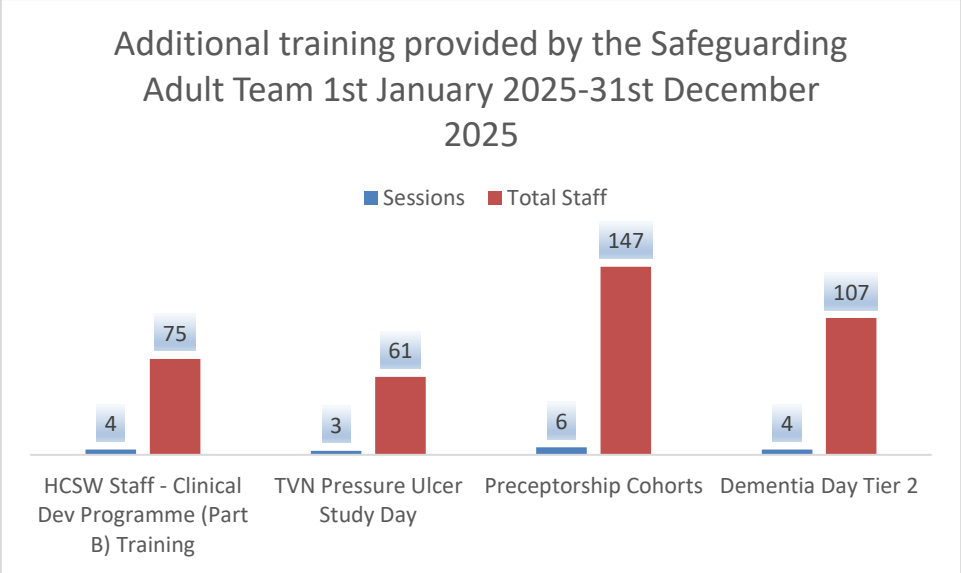


Table 15

5.0 Learning from safeguarding adult reviews (SAR) and domestic homicide reviews (DHR) / domestic abuse related death reviews (DARDR)

5.1 Learning and action plans from Safeguarding Adult Reviews (SARs) and DHRs/ DARDR are presented to the Integrated Safeguarding Committee and through sub groups of the relevant Safeguarding Partnerships and Safeguarding Adult Board (SAB).

5.2 Whilst the recognition that suicide amongst victims of domestic abuse and violence resulted in DARDRs, requests from partners for information will still use the phrase Domestic Homicide Review dependent on date of death, hence both phrases being used.

5.3 The Trust has been involved in eight Safeguarding Adult Reviews (SARs) in this reporting period.

5.4 Learning identified has centred on communication between agencies and escalation processes.

5.5 Escalating concerns, and use of multi-disciplinary forums for discussion and planning have also been themes which require acknowledgement.

5.6 The safeguarding adults team have responded to these SARs by introducing a review of all patients who have had three or more safeguarding adult concerns raised in the previous year, and escalating as required to external agencies, and arranging multi-agency meetings.

5.7 Safeguarding adult supervision has also been introduced for community matrons, in addition to the weekly safeguarding and MCA drop in for community staff, and attendance at MADE (hospital discharge planning meetings), as required.

5.8 One DHR is currently open, and DHR used due to date of death. No findings have been identified as the request for chronologies came in towards the end of 2025.

6. 2026 work plan

- Maintain current levels of training.
- Support the new Domestic Abuse Lead in developing the domestic abuse agenda for the Trust.
- Continue identifying areas for improvement for mental health patients
- Identify processes and appropriate frameworks to ensure escalation of complex cases happens in a timely manner
- Joint work with the Safeguarding Children Team around MCA, PREVENT and online harm.
- Undertaking a repeat audit of the use of DoLS to understand reduction in numbers
- Development of level 3 safeguarding adult training for relevant staff
- Continue to develop a presence in the community teams.
- With the Associate Medical Director, continue to lead on the provision of developing systems to ensure patients with mental health diagnosis receive holistic care appropriate to their need

7. Recommendations

The Quality Assurance Committee is asked:

i. note and discuss the annual report of adult safeguarding activity in 2025;
ii. take assurance that there are systems in place to protect vulnerable adults whilst in our care; and
iii. be assured that partners have confidence that Whittington Health is fulfilling its role as a statutory partner in safeguarding vulnerable adults at risk in the wider community and west and north London health and care sector.

Meeting title	**Quality Assurance Committee**	**Date: 08.07.2026**
Report title	**2025/26 Annual Safeguarding Children Report**	**Agenda item: 3.2**
Executive lead	Sarah Wilding, Chief Nurse & Director of Allied Health Professionals	
Report author	Nickola Rickard, Head of Safeguarding Children	
Executive summary	**Background** This report provides a summary of the work undertaken by children's safeguarding April 2025 to March 2026 The Childrens safeguarding teams continue to provide support and advice, training and supervision to operational teams. This covers 0-19/Allied Health Professionalss/Child and Adolescent Mental Heelth Services/ Paediatric Infant Psychology/and audiology amongst others in the community. In the acute setting the Named Dr, Paediatric Liaison Health visitor, Safeguarding Midwives and the Named Nurse provide training supervision and advice to emergency department, neonatal intensivfe care unit, maternity and paediatric staff. **Issues** There is much to celebrate with the progress made this past year despite ongoing challenges and a robust and collaborative safeguarding childrens team who are visible and proactive. The demand for safeguarding supervision has grown beyond the capacity of the core safeguarding teams. We considered introducing Safeguarding Champions to provide arm's-length support to community teams; however, we concluded that the risks associated with this model outweigh the benefits, particularly given the importance of maintaining a consistent and robust approach across all teams. Named professionals maintain a strategic presence in their respective safeguarding children's partnerships and the acute trust, they work collabaratively with operational teams across the organisation. Despite highlighting the under resourcing of the Mullti-Agency Safeguarding Hub (MASH) health team in Islington, we have not been able to resolve this issue with our partners.	

	Changes nationally and locally with integared care boards (ICBs) and children's social care have inhibited progress on securing additional funding. Mitigations are in place however there is a risk that this could lead to burn out of the substantive team as they absorb the additional responsibiities of MASH. The Islington team have benefitted from the consistent input of one individual who is covering maternity leave. The Childrens social care reforms will add additional pressure across our services, the ask is not clear at present, we continue to engage at a strategic and operational level to proactively gauge how we can meet our statutory duties with a limited resource. Maternity has faced a number of challenges with frontline staff not consisitently following safeguarding procedures. Deviation from best practice is being addresed via a programme of training and a robust plan to address the key themes of professional curiosity, information sharing, documentation and understaning safeguarding responsibilities. This is being supported by the appointment of a Domestic abuse lead post. The peer review recommendations from last year have mostly all been implemented with one outstanding recommendation, that is job plans for the named nurses, this will be addressed in the coming months. Safeguarding processes have, and continue to be, reviewed to ensure we are meeting our statutory and regulatory obligations. The triumverate of Haringey, Islington and Barnet have undertaken S11 audits in the past year, this has evidenced that we are meeting our statutory obligations under the Chldren Act. There is a yearly audit schedule mapped to the themes emerging from the above safeguarding childrens partnerships. The childrens ward has experienced a number of 'social admissions' with delayed discharge, when this is young people who have Mental health needs and/or dysregualted behaviour this creates a contextual safeguarding risk for acutely unwell children. Staff have also experienced significant assault. This is a national issue, and as a multidisciplinary team we met to discuss solutions and have taken this to the West and North London ICB with a view to having a local pathway/ set of key principles that helps us to mitigate the risk. We have made some progress with being able to produce safeguarding data digitally. This is in its infancy and is only

	applicable to 0-19 teams.. The challenge remains in that we have multiple Electronic Patient Records (EPR) across the trust. Data quality lacks the robustness we want to achieve. It is positive that a Single EPR system is being explored with the input of safeguarding. **Next steps** The key children's safeguarding priorities for 2026/27 are shown on pages 18-19 of the appended report.
Purpose:	Review and assurance
Recommendation(s)	The Quality Assurance Committee is asked to: - i. note and discuss the 2025/26 annual report for children's safeguarding; ii. take assurance that there are systems in place to protect children and young people from abuse and neglect whilst in our care; iii. be assured that partners have confidence that Whittington Health is fulfilling its role as a statutory partner in safeguarding children and young people at risk in the wider community and health and care economy; and iv. have assurance that where there are gaps, we are taking corrective action to ensure we safeguard children and young people from harm.
Risk Register or Board Assurance Framework	Board Assurance Framework risk entry 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation
Report history	Safeguarding Committee
Appendix 1:	1: 2025/26 Annual Children's Safeguarding Report

Appendix 1: Annual Safeguarding Children report, April 2025 – March 2026

1. Introduction Safeguarding Children and young people.

Whittington Health NHS Trust's Safeguarding Children's Service maintains strong links within the North Central London Integrated Care System (NCL ICS), operating under Integrated Care Board (ICB) arrangements following NHS reforms, which expanded the ICB footprint to cover 13 boroughs. The Trust is an active statutory partner within the safeguarding partnerships of its coterminous boroughs: Barnet, Haringey and Islington.

The Trust's safeguarding arrangements are guided by the *Intercollegiate Document: Safeguarding Children and Young People and Children and Young People in Care: Competencies for Healthcare Staff* **(5th edition, 2025)**, which replaces the 2019 framework and consolidates previous guidance. This updated national framework sets out the competencies, roles and responsibilities required across all levels of the healthcare workforce, including Board members, senior leaders, and Named and Designated Professionals.

In line with this guidance, the Trust has established Named safeguarding professionals and a nominated Board-level lead to provide leadership, expert advice, supervision, and organisational assurance. Named professionals represent the organisation within multi-agency safeguarding partnerships and contribute to a range of local and system-wide safeguarding groups and sub-groups.

The Head of Safeguarding Children provides strategic oversight of the Trust's compliance with statutory safeguarding duties, supports quality assurance and improvement activity, and contributes to partnership working across the ICS. These arrangements are aligned with the NHS England Safeguarding Accountability and Assurance Framework (5th edition, 2026), which reinforces safeguarding as a core responsibility across all NHS organisations and systems.

This annual safeguarding report provides partial assurance to the Trust Board regarding safeguarding activity, performance, and progress in strengthening arrangements to protect children and young people within Whittington Health NHS Trust. Assurance includes the following:

- Governance and accountability
- Safeguarding children policy review
- Training and development
- Safeguarding children activity and performance
- Partnership working
- Risk management and escalation
- Learning from child safeguarding practice reviews.
- Quality Improvement initiatives
- Challenges and risks
- Conclusion and recommendations.

2. The Safeguarding Children Team

The statutory role of the Named Nurses, Named Midwife, Named Doctors and Whittington Health safeguarding advisors is to provide expert leadership, advice and

support to the Trust to ensure that children at risk of harm are appropriately identified, protected and supported. This is achieved through oversight of safeguarding practice and assurance that processes are applied consistently in line with the Children Acts 1989 and 2004, Working Together to Safeguard Children (2026), and the Intercollegiate Document: Safeguarding Children and Young People and Children and Young People in Care – Competencies for Healthcare Staff (5th edition, 2025).

The safeguarding advisor teams are aligned to the boroughs of Barnet, Haringey and Islington, enabling place-based working and effective multi-agency collaboration. They act as a key interface between the Trust and partner agencies, including Children's Social Care, Multi-Agency Safeguarding Hubs (MASH), the police and wider safeguarding partners, in line with strengthened expectations for multi-agency safeguarding arrangements set out in Working Together 2026.

Safeguarding supervision remains a core priority for locality-based safeguarding advisors, supporting staff to manage complex cases, reflect on practice and fulfil their safeguarding responsibilities. This includes both formal and informal supervision, as well as support with safeguarding enquiries and processes. The safeguarding teams have continued to strengthen their visibility across operational services; this can be challenging due to the availability of private spaces to have confidential discussions. The Named Nurses set up and advertised a monthly drop in for staff to access with any queries they may have, unfortunately there was no uptake on that offer, it has now been stood down. All Safeguarding children's policies have been revised in the last year to ensure alignment with current statutory guidance and national expectations.

Targeted safeguarding training is delivered across services, informed by audit activity, learning from Child Safeguarding Practice Reviews, and emerging national and local themes. Bespoke sessions are provided to locality teams on a range of safeguarding topics. In addition, structured safeguarding training for junior doctors is delivered by the Named Doctor and Paediatric Liaison Health Visitor, alongside regular teaching sessions within the Emergency Department. Work is also underway to develop a safeguarding induction resource to support new staff.

Demand for safeguarding support and supervision continues to increase, consistent with national trends and the enhanced expectations within Working Together 2026, including greater emphasis on early help, multi-agency working and responding to complex and overlapping harms. This has created additional pressure on existing capacity. In response, the safeguarding service is working with operational leads to develop a revised supervision model to ensure equitable access to high-quality, structured safeguarding supervision across all services.

The Trust currently does not have a dedicated Named Nurse for Acute Services, which has been identified as a risk through peer review. This function is being supported through interim arrangements by the Named Nurse for Islington Community Services; however, these arrangements were intended to be temporary and do not provide the dedicated acute leadership capacity required to fully meet intercollegiate and statutory expectations. While the Trust benefits from the expertise of an experienced Paediatric Liaison Health Visitor and a Named Nurse providing

ongoing cover, this longstanding arrangement represents an organisational risk and is being reviewed to ensure sustainable compliance with national safeguarding standards.

3. Safeguarding supervision:

All staff are able to access both ad hoc and planned safeguarding supervision. On IFOR ward, multidisciplinary team (MDT) meetings take place twice weekly, including one with a specific paediatric ED focus, supporting shared learning and reflective discussion. The Neonatal team holds a weekly safeguarding meeting, led by the Named Doctor and supported by midwifery colleagues, which provides a structured forum for case discussion and supervision.

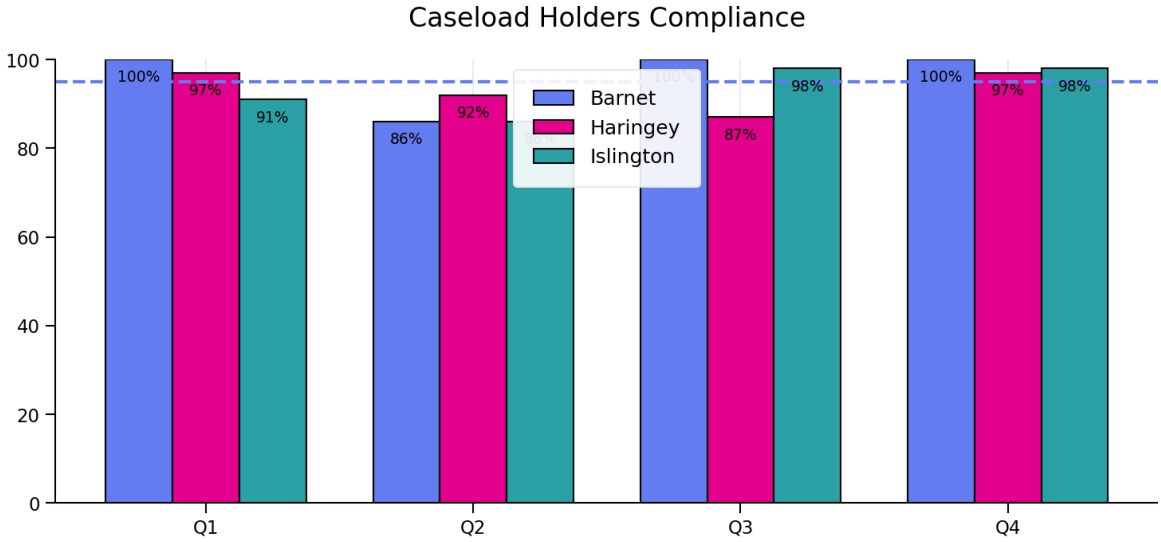
Safeguarding midwives operate an open-door policy and offer responsive, ad hoc supervision. In addition, progress has been made in strengthening a more formalised and structured approach to safeguarding supervision within midwifery services. While full compliance with individual safeguarding supervision has not yet been achieved, there has been significant improvement, and compliance levels have increased across all teams.

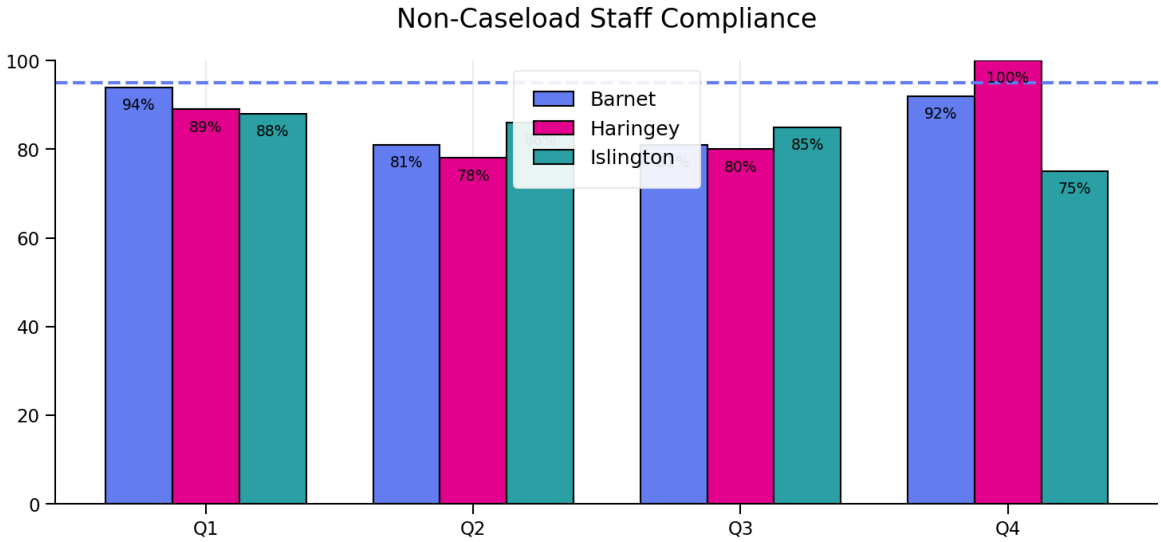
Some of the challenges for the safeguarding Midwives in achieving full compliance relate to the safeguarding resource not always being utilised in its intended advisory capacity. Work is ongoing with operational teams to reinforce the expectation that safeguarding is everyone's business and concerns are appropriately supported through the safeguarding advisors and Named Midwife, ensuring consistent oversight and expertise.

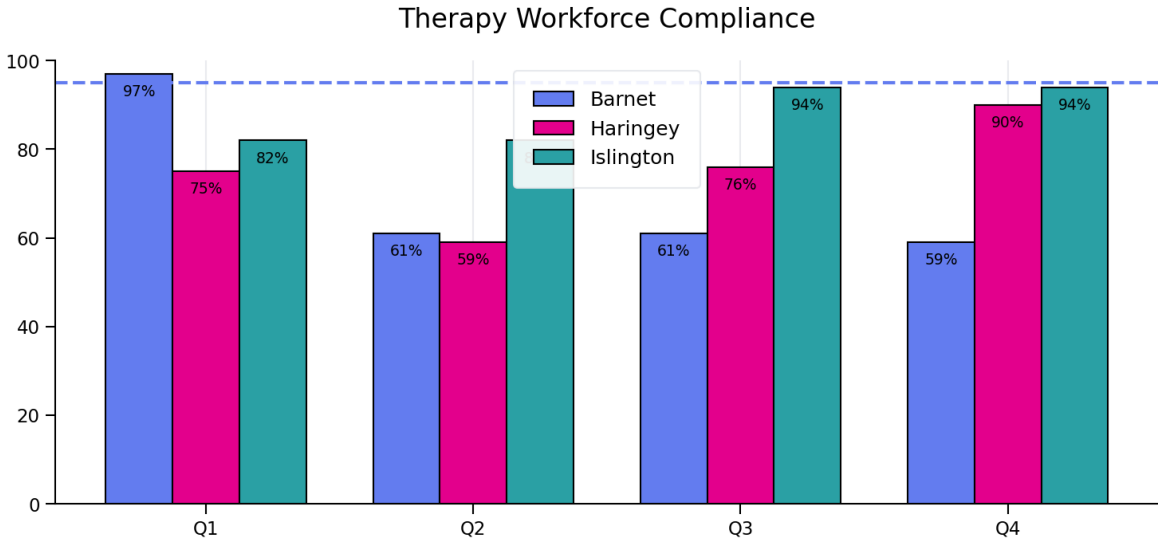
Within the community, the Named Nurse for Islington provides safeguarding supervision to Clinical Nurse Specialists and supports wider community teams. The Head of Safeguarding Children is currently providing interim support to Children's Continuing Care while the organisation reviews future Named Nurse provision within the hospital.

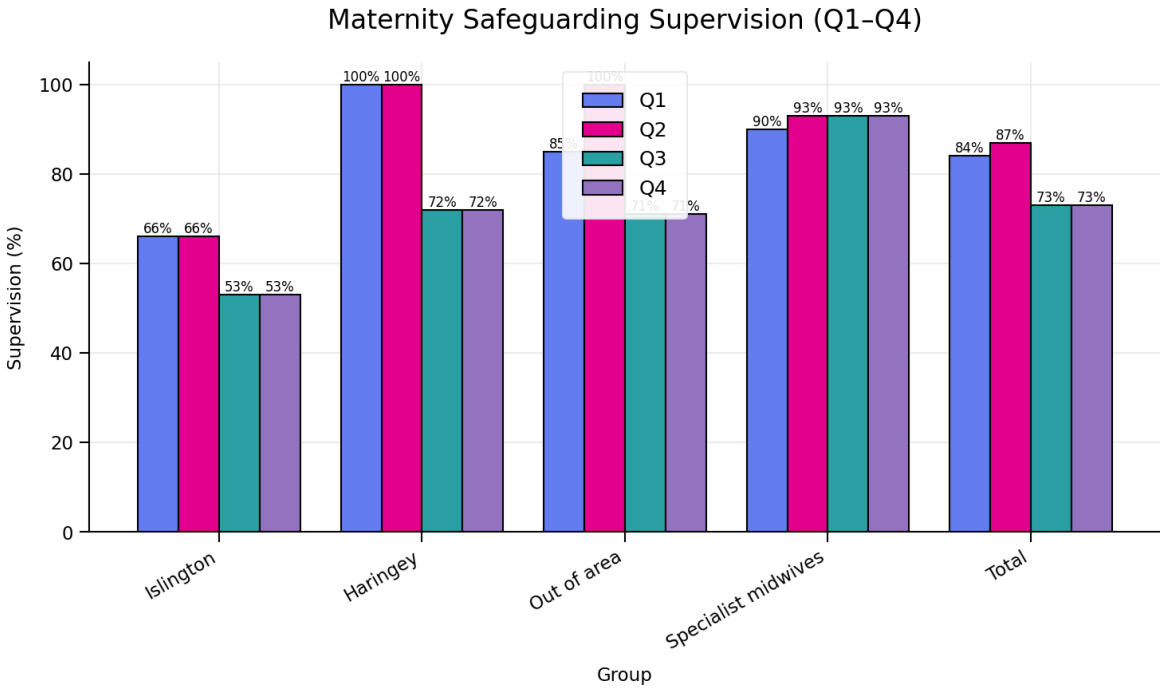
Overall, the Safeguarding Children's Team is actively reviewing and strengthening its supervision model to ensure it remains comprehensive, accessible, and effective for operational colleagues. This is reflected in a significant increase in staff accessing safeguarding support, alongside improved supervision compliance across services.

The charts below show the safeguarding supervision activity across community in the last 12 months.









Maternity Safeguarding supervision compliance demonstrated variation across the year, with an initial improvement from 84% in Q1 to 87% in Q2, followed by a sustained decline to 73% in both Q3 and Q4. While specialist midwives consistently maintained high levels of engagement (90–93%), compliance across borough-based teams showed greater variation, with persistent challenges in Islington and a reduction in performance across Haringey and out-of-area midwives in the latter half of the year.

- A number of recurring and compounding factors have impacted the ability to achieve 100% compliance:
- Safeguarding team capacity: The maternity safeguarding service operates with 2.0 WTE, which continues to present a challenge in balancing delivery of safeguarding supervision alongside wider operational and strategic responsibilities.
- Sustained service pressures within community midwifery: Across all quarters, the community midwifery service has experienced the effects of restructure, staffing vacancies, sickness, and annual leave. These pressures intensified in Q3 and Q4, placing the service under considerable strain. As a result, clinical priorities were prioritised, limiting midwives' ability to allocate protected time for safeguarding supervision.
- Leadership instability: In Q3 and Q4, long-term sickness at Band 7 level resulted in inconsistent team leadership. This impacted workload management, reduced opportunities to prioritise and coordinate supervision, and led to fewer team meetings where supervision is routinely delivered.
- Engagement challenges: Ongoing difficulties engaging specific teams in safeguarding supervision were evident in Q1 and Q2, with escalation to senior leadership. While this has been monitored, variation in engagement has persisted.
- Despite these challenges, safeguarding supervision has continued to be delivered through a flexible and accessible model. Alongside planned supervision sessions, needs-led (ad hoc) supervision is frequently provided by safeguarding midwives. The team's co-location within the community

midwifery office has supported accessibility and responsiveness, ensuring staff are able to seek safeguarding advice and support as required.

Key Annual Message

- Safeguarding supervision compliance improved in the first half of the year but declined and remained below target in the second half, reflecting the cumulative impact of workforce capacity constraints, sustained service pressures, and leadership instability. While a flexible supervision model has maintained access to safeguarding support, further work is required to strengthen capacity, stabilise leadership, and ensure protected time for supervision.

External supervision

The Trust has one external supervisor for the Safeguarding Named Professionals. Our Safeguarding advisors are currently being supported by the Named Professionals, this is not ideal. Safeguarding advisors often provide advice challenge and oversight on complex cases; this may involve colleagues/senior leaders and cross-agency dynamics. External supervision provides an impartial space where advisors can discuss concerns without fear of bias or influence.

Cross-cutting exception themes

Common themes include workforce capacity pressures, safeguarding team availability, increased demand and case complexity, operational pressures such as MASH coverage, and engagement challenges including booking and attendance. Actions taken include increasing supervision availability, improving targeting, and adapting delivery models.

Conclusion

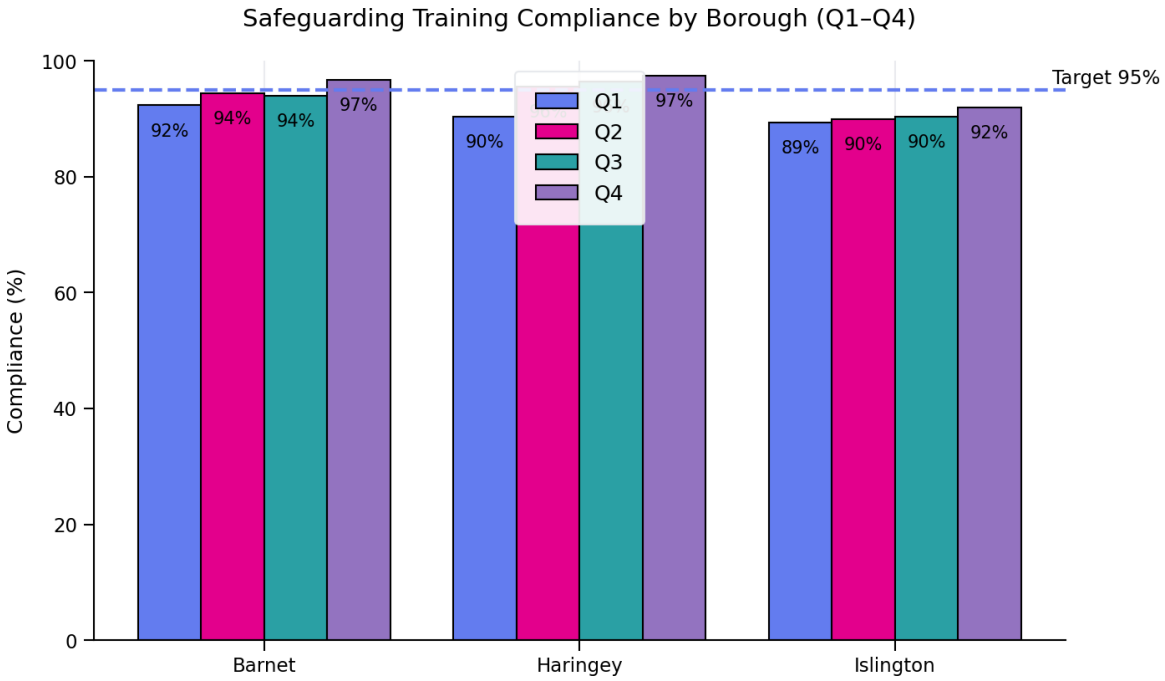
Safeguarding supervision is well embedded for caseload-holding practitioners, providing strong assurance. However, system pressures continue to affect non-caseload staff and therapy services. While some boroughs demonstrate recovery and resilience, sustained challenges in therapy and maternity services require continued strategic focus.

4. Children & Young People Safeguarding Training.

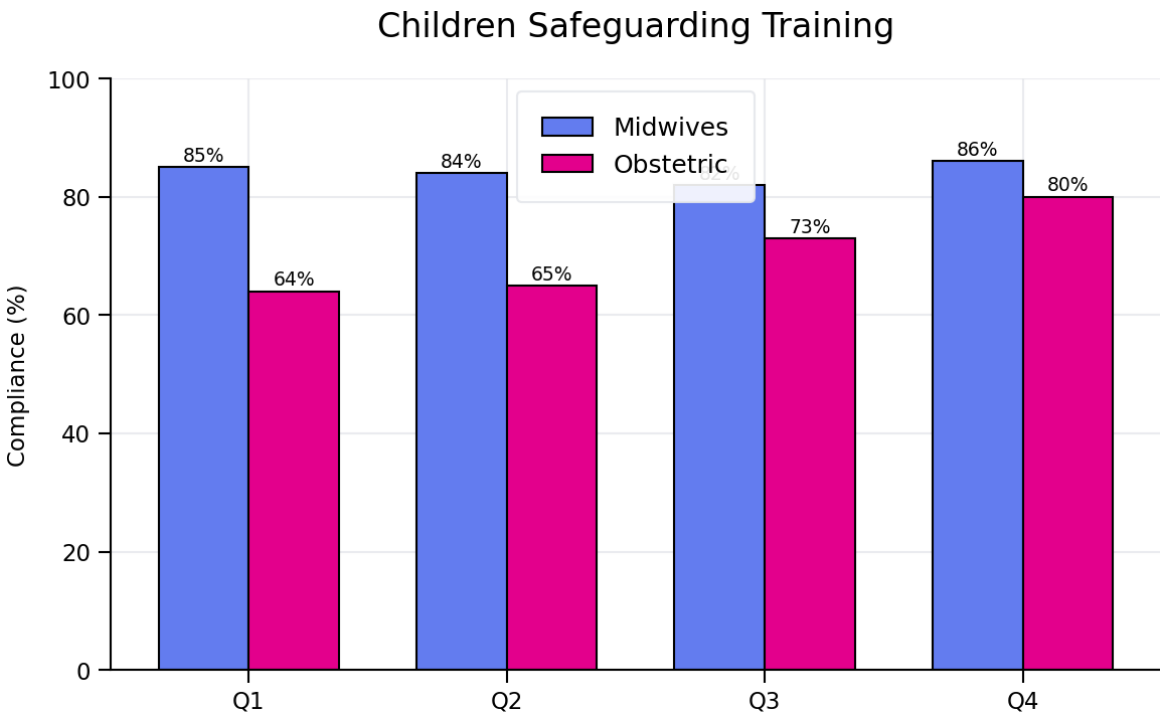
Safeguarding Training Compliance — Annual Summary

This section summarises safeguarding training compliance across Whittington Health NHS Trust for **April 2025 – March 2026**, drawing on all available quarterly data

Training compliance is benchmarked against the requirements of the Intercollegiate Guidance 2025, which sets out the minimum training standards for healthcare staff. The below Chart demonstrates high compliance and improvement across the year for every boroughs 0-19 teams. Where there were dips in compliance this was proactively addressed by The Named nurses in partnership with operational leads.



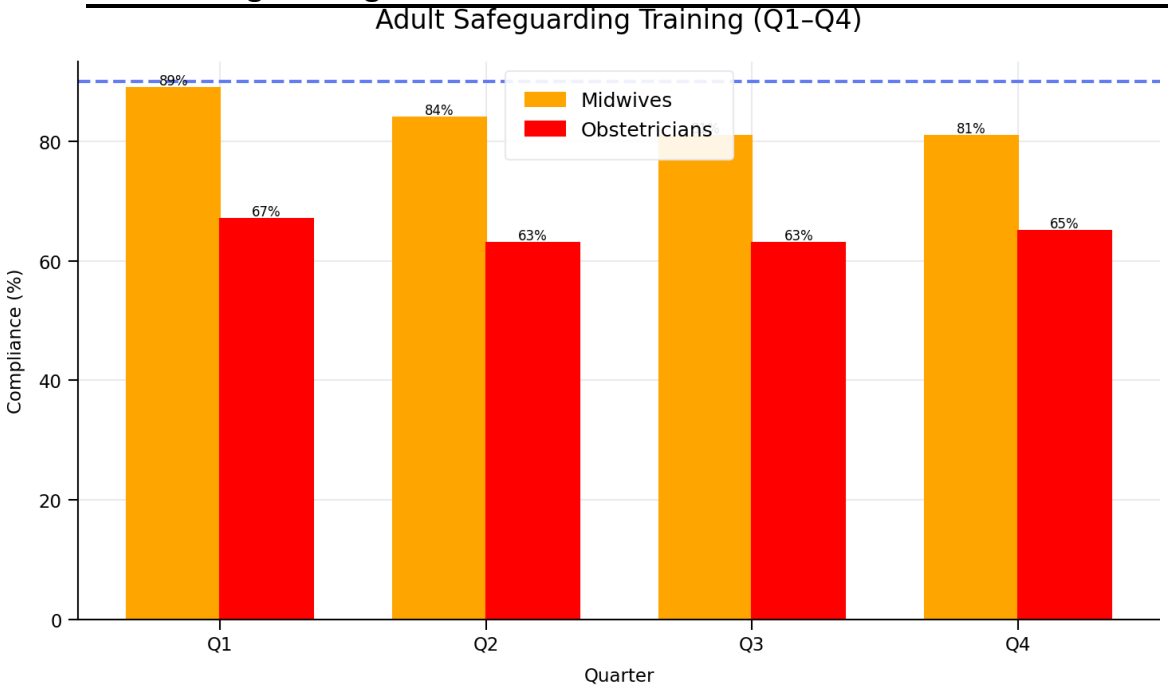
Maternity Safeguarding Training (Q1–Q4)
Children Safeguarding Training – Annual Overview



Children Safeguarding

Children's safeguarding training shows steady performance among midwifery staff with a recovery in Q4. Obstetricians demonstrate a clear improving trend across the year, although compliance remains below the 90% target. Overall, multidisciplinary alignment has improved, with a narrowing gap between staff groups by Q4. Work continues to improve compliance across all staff groups. The Named midwife for safeguarding has been instrumental in leading the change in partnership with the Head of Midwifery.

Adult safeguarding



Adult safeguarding training demonstrates a gradual decline among midwifery staff, plateauing in Q4. Obstetrician compliance remains consistently low throughout the year with minimal improvement. This represents a sustained risk area, with compliance remaining below the 90% target across both staff groups and requiring targeted improvement actions.

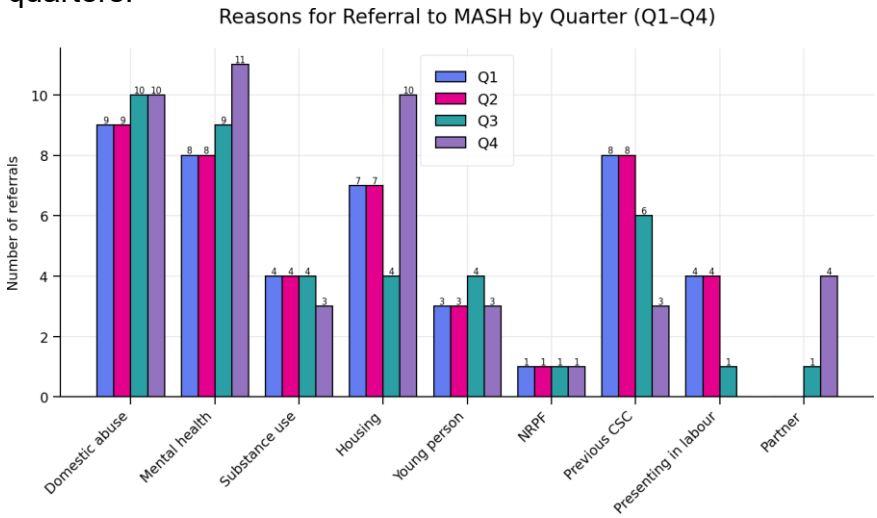
5. Safeguarding referrals across the organisation

The complexity of safeguarding remains a prevalent feature of our safeguarding work across children's services in the acute and community settings.

The high incidence of mental health presentations has persisted, most notably in the acute setting as was the case in the last reporting period. A total of 374 referrals were made to Children's social care by the acute paediatric teams, a more detailed narrative is provided later in the report. Referrals by the Midwifery team are highlighted in the below graph.

Maternity Referrals to MASH – Reasons by Quarter (Q1–Q4)

This chart shows the breakdown of reasons for referral to MASH across all four quarters.



The chart demonstrates consistent drivers of referrals across all quarters, with domestic abuse and mental health remaining the predominant factors. Housing instability shows a notable increase in Q4, while previous CSC involvement decreases over time, suggesting a shift towards new referrals and broader social complexity.

Safeguarding Community Referrals

Community Safeguarding Referrals – Full Year (Q1 to Q4)

The chart overleaf presents safeguarding referrals by type across Barnet and Haringey over Q1 to Q4.

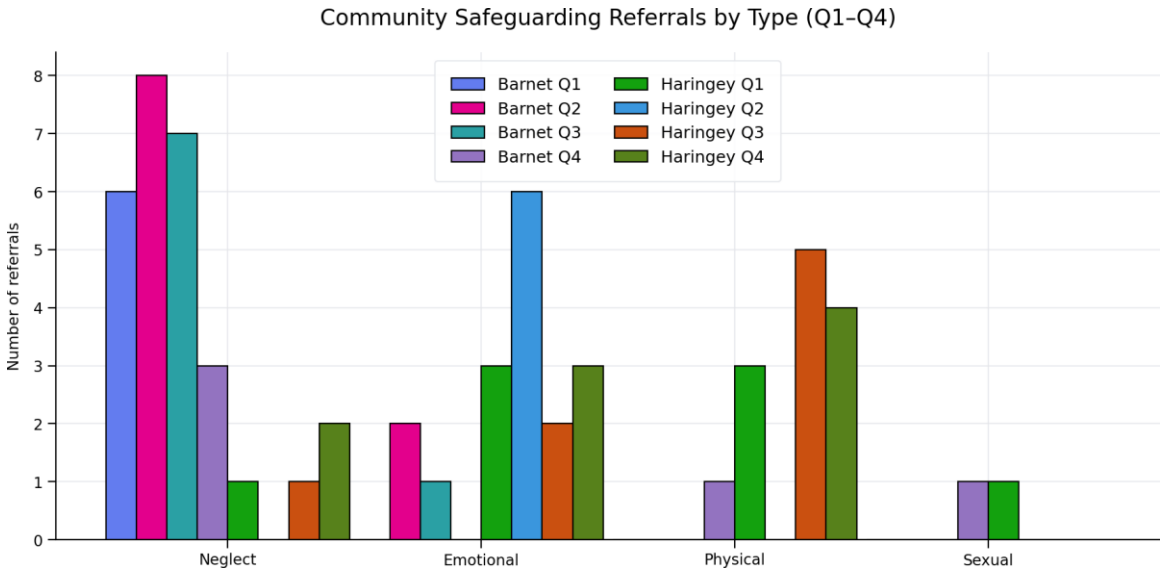
Mapping the referral types across the boroughs is not consistent, Islington relies on LA data which is not comparable and is therefore excluded from this report. This is an action to be addressed in the coming months. It should also be noted that direct comparison of the referrals across Haringey and Barnet should be avoided as each borough has differing demographics and population needs. However, across the full year, distinct safeguarding patterns are evident between Barnet and Haringey.

Barnet demonstrates a consistent profile characterised predominantly by neglect-related referrals across all quarters. This suggests sustained chronic and cumulative safeguarding need, likely linked to ongoing socioeconomic pressures, parenting capacity concerns, and longer-term vulnerability rather than acute safeguarding incidents.

While small increases in emotional abuse referrals emerge in Q2 and Q3, and isolated physical and sexual abuse cases appear in Q4, neglect remains the dominant driver of safeguarding activity in Barnet throughout the year. This consistency indicates a stable but persistent demand profile requiring targeted early intervention and long-term support strategies.

In contrast, Haringey demonstrates a dynamic and variable safeguarding profile across quarters. Q1 shows a mixed distribution of abuse types, followed by a concentration of emotional abuse in Q2, a marked increase in physical abuse in Q3, and a return to a mixed profile in Q4. This fluctuation reflects changing patterns of risk and may indicate a combination of acute safeguarding incidents, relational harm, and broader contextual factors influencing demand. The variability in Haringey suggests a more complex safeguarding landscape, requiring flexible and responsive services capable of addressing multiple forms of harm. The contrast between the two boroughs highlights differing underlying needs, with Barnet characterised by chronic, cumulative risk, and Haringey by shifting and potentially more acute safeguarding concerns.

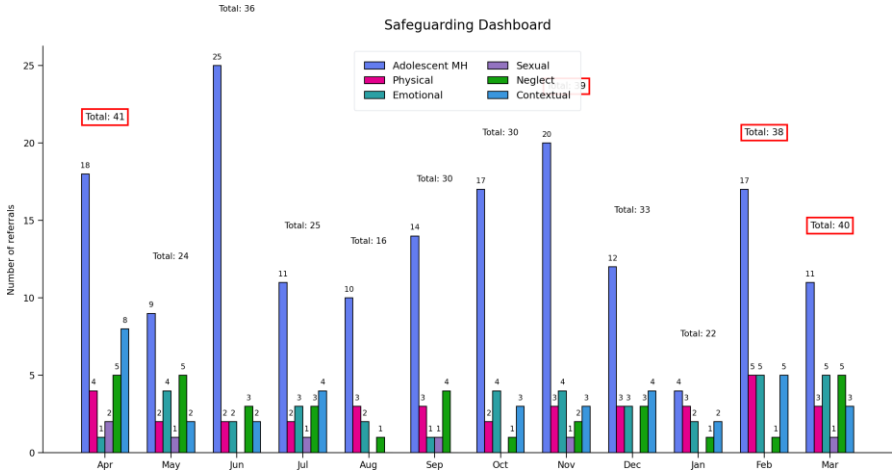
These findings reinforce the importance of borough-specific approaches to safeguarding, including targeted interventions for neglect in Barnet and adaptable, multi-faceted responses to varied safeguarding presentations in Haringey.



Acute Paediatric safeguarding referral activity for the year

The below chart shows Paediatric Safeguarding demand remains consistently high across the year, with a total of **374** referrals with no sustained period of low activity. Peaks occur repeatedly, particularly between November and March, indicating cyclical escalation rather than isolated surges. Adolescent mental health presentations are the primary driver of demand, accounting for approximately **45%** of referrals and reflecting increasing complexity and clinical need within safeguarding cases. Neglect continues as a constant baseline pressure, while contextual safeguarding shows fluctuating and less predictable trends. Overall, the data demonstrates a system under sustained pressure, with increasing integration required between safeguarding and mental health pathways to manage both acute and chronic risk effectively. The safeguarding children team work closely with the

Paediatric mental health team to proactively manage the complexity of mental health presentations; this includes escalation to statutory partners. Proactive work is underway with one of our LAs to agree a set of key principles to ensure children and young peoples basic needs are met when they are on an acute paediatric ward and are under the care of the LA. More strategic work is underway across NCL to consider how we can reduce prolonged hospital admissions for young people who unable to leave the ward due to lack of placement and are social admissions. The Patient story included is just one example of how systems fail to safeguard young people despite collaboration.



Patient Story

A young person presented to the Emergency Department in significant distress, expressing suicidal ideation. The presentation was rooted in deep emotional conflict: while assigned female at birth, the young person identified as male and felt unable to live authentically due to restrictive religious expectations within the family home. This internal conflict had escalated to a crisis point.

The young person described a highly controlled home environment. They had been removed from formal education and were being home-schooled by a sibling. Opportunities for social interaction, identity development and external support were therefore severely limited. During assessment, the young person disclosed both physical and emotional abuse within the home.

At the point of presentation, the young person made the decision to sign a Section 20 agreement independently and clearly stated that they did not feel safe to return home. This reflected both the level of risk within the home environment and the young person's determination to seek safety.

Children's Social Care recognised that the young person's needs could be met safely within a foster placement and began the process of identifying a suitable home. However, there was a significant delay in securing an appropriate placement. During this time, the young person remained on a paediatric ward.

What followed was a prolonged hospital admission lasting several months. Over that period:

- The young person's mental health deteriorated significantly
- Episodes of distress escalated, resulting in challenging behaviours
- There were instances where staff were physically assaulted
- Other acutely unwell patients on the ward were impacted by the disruption

Despite repeated escalation across services and to senior levels, a timely resolution was not achieved. The absence of a suitable placement meant the young person remained in an environment that was not designed to meet their complex emotional and psychological needs.

Crucially, the young person experienced a profound sense of abandonment. They described feeling rejected by their family and, increasingly, unsupported by the very systems intended to protect them.

As delays continued, the young person's mental health reached a critical point. The prolonged instability and lack of appropriate placement ultimately resulted in a severe deterioration, requiring admission to a Tier 4 mental health unit.

This case illustrates the profound consequences when a vulnerable young person, already experiencing rejection within their home, encounters delay and limitation within the safeguarding system. While individual services responded with commitment, the absence of timely placement and coordinated resolution resulted in deterioration that may have been preventable.

Child safeguarding practice reviews (CSPR's)

Learning from CSPR's is shared across the organisation via 7-minute learning sessions/ learning sets/Grand round/MDT meetings and staff forums. Learning will

also be discussed in safeguarding supervision. Training that emerges from the learning is put on by the safeguarding children's partnerships and the locality teams.

Communication remains a central theme from local and national reviews. Learning and action plans from the CSPRs and serious incidents are presented to the Integrated Safeguarding Committee and through subgroups of the relevant Safeguarding children Partnerships. A CSPR tracker is presented to committee quarterly to give assurance that the trust embeds learning from reviews.

6. Safeguarding policy review

Safeguarding children's policies have all been reviewed in the last year. One is currently out for consultation and should be ratified in the next quarter. All policies are shared with partners for their input (ICB/Operational teams) All policies have been mapped to ensure compliance with the revised **Working together to Safeguard Children** (December 2026) and where necessary to remain compliant with Safeguarding children, young people and adults at risk in the NHS Safeguarding accountability and assurance framework 4th edition (June 2024).

The trust safeguarding team will work with the Policy assurance group (PAG) within the trust to monitor and update polices in line with the trusts governance framework.

Safeguarding Children – Updated and on the Intranet
Domestic abuse – updated and on the intranet
Safeguarding Supervision – Updated and on the intranet
Safeguarding Training – updated and on the intranet
FGM – updated and on the intranet
Chaperone Policy – out for consultation

7. Conclusion and Priorities for 2026/2027

This report provides an overview of safeguarding children activity across Whittington Health NHS Trust between April 2025 and March 2026. The safeguarding service continues to provide expert advice, training and supervision across community and acute services, supporting staff to identify and respond to risk effectively. Demand has increased significantly and now exceeds core team capacity, presenting a sustainability risk.

Key challenges include ongoing under-resourcing within the Islington MASH health team, increasing numbers of prolonged 'social admissions', and variability in compliance with safeguarding procedures within maternity services. Despite these challenges, the Trust continues to meet its statutory safeguarding responsibilities and demonstrates strong partnership working.

Key Risks

• Insufficient safeguarding capacity to meet increasing demand
• Lack of substantive Named Nurse for Acute Services
• Ongoing MASH capacity pressures in Islington
• Prolonged paediatric admissions due to lack of placements
• Variation in supervision and training compliance
• Data quality limitations across multiple systems

Key Recommendations 2026–2027
1. Workforce: Establish a substantive Named Nurse for Acute Services and review safeguarding team capacity.
2. System Working: Develop an NCL-wide pathway for managing social admissions and reduce delays in discharge.
3. Supervision: Review safeguarding supervision model to ensure equitable access and protected time.
4. Training: Achieve a minimum of 90% compliance across all staff groups, with targeted focus on obstetrics and adult safeguarding.
5. Digital: Improve safeguarding data quality and support development of a single EPR system.
5.Partnerships: Escalate and influence system partners to address MASH capacity and placement sufficiency.

Conclusion
The Trust continues to demonstrate strong safeguarding arrangements and effective partnership working. However, increasing demand, system pressures, and workforce constraints present ongoing risks. Delivery of the above priorities will be essential to ensure safe, effective and sustainable safeguarding practice.

8. Recommendations

The Quality Assurance Committee is asked to: -

i. note and discuss the 2025/26 annual report for children's safeguarding;
ii. take assurance that there are systems in place to protect children and young people from abuse and neglect whilst in our care;
iii. be assured that partners have confidence that Whittington Health is fulfilling its role as a statutory partner in safeguarding children and young people at risk in the wider community and health and care economy; and
iv. have assurance that where there are gaps, we are taking corrective action to ensure we safeguard children and young people from harm.

Whittington Health NHS Trust

Patient Safety Incident Investigation (PSII) Report

Date of incident	[Redacted]
Incident ID number	[Redacted]
PSII Approved by	[Redacted]
Job Title	Associated Director of Nursing EIM Division
Signature	[Redacted]
Date Approved by Whittington Improvement & Safety Huddle (WISH)	24/04/2026
Date Presented at Quality Assurance Committee	08/07/2026
Date Noted in Chairs Report at Trust Board	tbc

Participants of the PSII	
Name	**Role**
[Redacted]	Lead Nutrition Nurse Specialist
[Redacted]	Clinical Lead Speech Therapy and Nutrition and Dietetics
[Redacted]	Senior Gastroenterology Dietitian
[Redacted]	Nutrition Nurse Specialist

Distribution list List who will receive the final draft and the final report (e.g. patients/relatives/staff involved, board)	
Name	**Position**
[Redacted]	Chief Nurse
[Redacted]	
[Redacted]	Committee
[Redacted]	Matron Emergency and Integrated Medicine (EIM)
[Redacted]	Ward Manager, Victoria Ward
[Redacted]	Associate Director of Nursing (ADoN EIM)
[Redacted]	Manager Speech and Language Therapy and Nutrition and Dietetics
[Redacted]	Gastroenterology Dietitian
[Redacted]	Clinical Lead Dietetics
[Redacted]	Senior House Officer
[Redacted]	Consultant Endocrinologist
[Redacted]	Specialist Registrar
[Redacted]	Senior House Officer
[Redacted]	Foundation Year 1 Resident
[Redacted]	Senior House Officer
[Redacted]	Staff Nurse (S/N)
[Redacted]	Staff Nurse (S.N)
[Redacted]	Staff Nurse (SN
[Redacted]	Locum Clinical Fellow (AAU)
[Redacted]	Consultant Care of Older People
[Redacted]	Physiotherapist
[Redacted]	Physiotherapist

Version Control				
Version number draft/final	Date	Responsible person	Amendments made	Sent to
V1.0	[Redacted]	[Redacted] Lead Nutrition Nurse Specialist	First draft	[Redacted] Risk and Quality Manager EIM
V1.1	[Redacted]	[Redacted] Risk and Quality Manager EIM	Approved TOR added General review and updated formatting	[Redacted] Lead Nutrition Nurse Specialist [Redacted] Manager Speech Therapy and Nutrition and Dietetics [Redacted] Senior Gastroenterology Dietitian
V1.2	[Redacted]	[Redacted], Lead Nutrition Nurse Specialist [Redacted] Manager Speech Therapy and Nutrition and Dietetics	Further updates	[Redacted] Risk and Quality Manager EIM
V1.3	[Redacted]	[Redacted], Risk and Quality Manager EIM	Further updates	[Redacted] Lead Nutrition Nurse Specialist [Redacted] Manager Speech Therapy and Nutrition and Dietetics [Redacted], Senior Gastroenterology Dietitian [Redacted] ADoN EIM
V1.4	[Redacted]	[Redacted], ADoN EIM	Review and comments	[Redacted] Lead Nutrition Nurse Specialist
V1.5	[Redacted]	[Redacted], Lead Nutrition Nurse Specialist	Further updates	[Redacted] Risk and Quality Manager EIM

				[Redacted] Manager Speech Therapy and Nutrition and Dietetics [Redacted] Senior Gastroenterology Dietitian
V1.6	[Redacted]	[Redacted] Risk and Quality Manager EIM	Formatting corrected	[Redacted] Manager Speech Therapy and Nutrition and Dietetics
V1.7	[Redacted]	[Redacted] Manager Speech Therapy and Nutrition and Dietetics	Action plan updated	[Redacted] Risk and Quality Manager EIM
V1.8	[Redacted]	[Redacted] Risk and Quality Manager EIM	Review and update with comments received, ready for final review	[Redacted] Lead Nutrition Nurse Specialist [Redacted] Manager Speech Therapy and Nutrition and Dietetics [Redacted], Senior Gastroenterology Dietitian [Redacted] ADoN EIM
V1.9	[Redacted]	[Redacted], ADoN EIM [Redacted] CD EIM	Divisional sign off	EIM triumvirate
V2.0	[Redacted]	02.04.26	Trust sign-off	Whittington Improvement and Safety Huddle (WISH)
V2.1	[Redacted]	[Redacted], Manager Speech Therapy and Nutrition and Dietetics [Redacted] Senior Gastroenterology Dietitian	Updated report after WISH	[Redacted], Risk and Quality Manager EIM

V2.2	[Redacted]	[Redacted] Manager Speech Therapy and Nutrition and Dietetics [Redacted] Senior Gastroenterology Dietitian	Further updates	[Redacted] Risk and Quality Manager EIM
V2.3	[Redacted]	[Redacted] Risk and Quality Manager EIM	Updates from WISH completed	[Redacted] Head of Patient Safety & Legal Services
V2.4	[Redacted]	[Redacted] Risk and Quality Manager EIM	Updates to be reviewed at WISH for sign off	[Redacted] Head of Patient Safety & Legal Services
V2.5	[Redacted]	[Redacted] Risk and Quality Manager EIM	Final formatting	EIM triumvirate [Redacted] Manager Speech Therapy and Nutrition and Dietetics [Redacted] Senior Gastroenterology Dietitian WISH
V2.6	[Redacted]	[Redacted] Chief nurse [Redacted] ADoN EIM	Updated further comments	[Redacted] Lead Nutrition Nurse Specialist [Redacted] Manager Speech Therapy and Nutrition and Dietetics [Redacted] Senior Gastroenterology Dietitian
V2.7	[Redacted]	[Redacted] Lead Nutrition Nurse Specialist [Redacted], Manager Speech Therapy and Nutrition and Dietetics	Updated further comments	WISH

		[Redacted] Senior Gastroenterology Dietitian		
V2.8	[Redacted]	[Redacted], Risk and Quality Manager EIM	Updated with comments from WISH	[Redacted] Manager Speech Therapy and Nutrition and Dietetics [Redacted] Senior Gastroenterology Dietitian WISH
			Anonymised report sent to QAC	Quality Approval Committee (QAC)
			Report approved	Whittington Trust Board (WTB)

About patient safety incident investigations

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

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

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

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

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

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

A note of acknowledgement

The Learning Response Leads ([Redacted], [Redacted] and [Redacted]) would like to thank the staff who contributed to reviewing the patient safety incident summarised in this report. Thank-you for your support, your openness, and your transparency. Your insights into how care is delivered on Victoria Ward has helped us to understand what happened. Each of you has helped us better understand how the technology and tools, organisation, task, person, internal environment, and external influences impact on the performance of staff working on Victoria Ward.

We know we have committed, professional and caring staff working in Whittington Hospital Victoria Ward. We know you go to work every day aiming to deliver safe patient care.

Our role as Learning Response Leads is to gather insight into the healthcare settings and systems in which you work: Our focus has been on learning how teams working on Victoria Ward deliver patient care, the challenges, constraints and demands you work with, and how systems factors impact on safe patient care. We are not here to judge or criticise: We are here to facilitate learning in a supportive, caring, and collegiate way. Without the insights and contributions made by the staff who participated in the review, the report would not have been possible. So, thank-you.

Contents

Executive summary

4.1 Incident overview

4.1.1. On [Redacted] [Redacted] attended the Emergency Department (ED) at Whittington Hospital (WH), after a follow up phone call by AAU Doctor relating to CT chest result.

4.1.2. [Redacted] was transferred to Victoria Ward that evening.

4.1.3 A nasogastric tube (NGT) was inserted on [Redacted] at [Redacted] and a feed was started, due to run for 9 hours.

4.1.4. On [Redacted] around [Redacted] [Redacted] health deteriorated.

4.1.5. A chest x-ray (CXR) was performed and the NGT found in the left lung

NGT removed on [Redacted]

4.1.6. [Redacted] passed away in evening of [Redacted].

4.2 Summary of key findings

4.2.1 The NG Tube guidance was not adhered to at times during the care of [Redacted]

4.2.2 Documentation was not complete and inaccurate when inserting and maintaining the NG tube for administering medication and feeds.

4.2.3 No documentation evident detailing capacity assessment specific to NGT insertion or conversation explaining what a nasogastric tube was, the benefits and risks or goal/duration of enteral feeding.

4.2.4 Incorrect documentation of tube length at nostril as day nurse documented what the NEX length (nose-ear-xiphisternum) used for assessing how far to insert the tube had been during the day nurse's unsuccessful attempt.

4.2.5 There were two occasions whereby Nursing staff documented under another Nurse's login (however name of nurse documenting was clear). While this was an incidental finding, it did not impact on sequence of events or the outcome. This has been added to the Action Plan to ensure there is Trust wide awareness to address why this might be occurring.

4.2.6 Tube length discrepancy between the day staff and night staff recordings were not identified and joint checking of the tube length by day nurse and night nurse did not occur at handover. Day Nurse unable to recall what tube length was handed over.

4.2.7 Fluid balance chart was not correctly maintained.

4.2.8 While tube length was corrected on fluid balance chart and nursing evaluation records retrospectively, it was not changed on the NG insertion document.

4.2.9 Medication and flush signed for at [Redacted] by night nurse, but pH only checked with day nurse at [Redacted] (unclear whether medications were signed for, prior to pH checks and administration).

4.2.10 Medications and water flushes prescribed too frequently requiring frequent pH checks to confirm tube position

4.3 Summary of areas for improvement and associated safety actions

4.3.1 Reduction of accepted pH range post NGT insertion from 1.0 – 5.5 to 1.0-5.

4.3.2 Introduction of NGT Risk Assessment Checklist and improve compliance of documentation of position checks

4.3.3 Increased use of NGT MDT decision tool and documentation of capacity assessments and rationale/risk/benefits of insertion of NGT

4.3.4 Improved use of NGT insertion records

4.3.5 Improved recording of fluid balance charts for patients receiving NGT feeding

4.3.6 Improved handover of patients at bedside by nursing staff

4.3.7 Increased attendance at training opportunities provided by Nutrition Nursing Team

4.3.8 Increased attendance at training opportunities

4.3.9 For staff to only use their personal log in to electronic noting system

4.3.10 To explore new solutions to confirming NG tube position

Duty of Candour

Different elements	Yes	No	Date	By whom?
Was the patient / NoK contacted and apologised to?	☒	☐	01/01/2026	[Redacted] Matron
Was this followed up in writing?	☒	☐	20/01/2026	[Redacted] Matron
Has the family agreed to receive the final report?	☐	☐	Click or tap to enter a date.	
Has the duty of candour been complied with?	☐	☐	Click or tap to enter a date.	

Background and context of the patient safety incident

1.1 In literature it is well documented that NG tubes can migrate from the stomach to the lungs usually as a consequence of coughing, vomiting, pulling at the tube or insecure fastening of the tube. (NPSA Alert 2005). This is also reflected in the Trust "Nasogastric Tube feeding for adults" guideline and the Nasogastric Tube Core Care Plan.

1.2 Victoria Ward is a 25 bedded ward on level 5 of the Whittington Hospital caring for patients under the Gastroenterology and Endocrinology Teams.

1.3 Levels of dependency range from moderate to high. The ward has a high ratio of patients with alcohol related cognitive impairment and/or aggressive behaviour as well as high dependency patients with other causes for delirium and cognitive impairment. The acuity is measured by safer care measuring tool. The acuity on the [Redacted] and [Redacted] was reported as meeting the required staffing levels.

1.4 The ward has 4 bays with 4 side rooms (commonly used for patients requiring isolation or palliative care)

1.5 Standard daily staffing usually includes 4 registered nurses (RN) and 4 Healthcare support workers (HCSW) and 1 Senior nurse (Band 6 or 7) acting as nurse in Charge (NIC). If a Band 6 or 7 nurse is not on duty, a Band 5 nurse will be the NIC but will also carry a caseload of allocated patients. When the Band 6 or 7 NIC leaves at 5pm, one of the Staff nurses will take over NIC duties in addition to their patient allocation.

1.6 Staffing levels are reviewed by the Ward Manager or NIC together with the Matron, with risk assessments to establish if additional staff are required to provide safer care e.g. 1-1 supervision.

1.7 On the day the NGT was inserted [Redacted], during the night shift and the shift the next morning [Redacted], the allocated registered nurses were permanent members of staff.

1.8 Nutrition nurse Specialists provide a teaching programme for NG/enteral training, which includes but not limited to: Clinical Induction, Newly Qualified nurses, Band 6&7 Refresher, Student nurse forum, Service Away days, Enteral Rolling Programme, Enteral Study Days, ITU Enteral study sessions, NG Roadshow. An e-learning module in NGT management is in development via Learning and Development Department. This is not part of the mandatory training programme.

7. Investigation approach

7.1 Investigation Team			
Role	Initials	Job title	Department
Lead investigator	[Redacted]	Lead Nutrition Nurse Specialist	EIM Nutrition Nursing Service (Nutrition and Dietetics)
Investigator	[Redacted]	Senior Gastroenterology Dietitian	EIM Nutrition and Dietetics
Investigator	[Redacted]	Clinical Lead Speech Therapy and Nutrition and Dietetics	EIM Speech and Language Therapy
Facilitator	[Redacted]	Risk and Quality Manager	Emergency and Integrated Medicine
Divisional sign off	[Redacted]	ADoN	Emergency and Integrated Medicine
Divisional sign off	[Redacted]	Clinical Director	Emergency and Integrated Medicine

7.2 Summary of investigation process

7.2.1 The incident was reported via the Trust Datix system by Consultant in Care of the Older Person (COOP) which due to the serious nature was escalated immediately to Senior Leaders within the Trust.

7.2.2 Lead Nutrition nurse was informed by Associate Director of Nursing (ADON EIM) and a timeline and overview were completed.

7.2.3 Rapid Action Review (RAR) was completed by Victoria Ward Manager to gather information and an initial investigation into the incident was commenced.

7.2.4 The RAR was presented to the Senior Leadership team and Trust Patient Safety Leads via the Whittington Improvement Safety Huddle (WISH) forum on [Redacted]. The Associate Medical Director for Patient Safety and members of the Executive Team including the Chief Nurse and Chief Medical officer led this. Due to the seriousness of the incident and its outcome, it was agreed that a more thorough and detailed report was required in the form of a PSII report. There was also discussion of the RAR at the EIM Quality meeting.

7.2.5 Staff involved in the incident were interviewed to establish recall of version of events with transcripts sent to them for approval.

7.2.6 A multi-disciplinary team (MDT) meeting was arranged with attendance by Governance Teams, Consultants, Doctors, Nursing staff, Matron, Ward Manager, Nutrition nurses, Dietitian, Speech and Language therapist and Physiotherapist.

7.2.7 On completion of this report, a copy will be sent to members of staff involved for accuracy checking.

7.2.8 The final report will be reviewed by the WISH committee and approved. The report will then be presented at the Quality Assurance Committee and after the coroner's inquest is held, it will be noted at the Trust Board.

7.2.9 Once approved, report will be shared with the family and submitted to the coroner.

7.2.10 Actions will be monitored by Emergency and Integrated Medicine Quality Committee and the Nutrition Steering Group.

7.3 Terms or reference summary

7.3.1 Clinical pathway and decision-making process

7.3.2 Management of the patient (including nursing & doctor's events)

7.3.3 Wider system learning and resilience

7.4 Information gathering

7.4.1 Timeline and overview of events completed by Lead Nutrition nurse on day ADON informed of incident. This was via review of electronic patient record on CareFlow and examination of paper fluid balance charts.

7.4.2 Guidelines and policies have been reviewed in terms of procedures and guidance surrounding NGT insertion, position checks and management of NGT feeding.

7.4.3 Conversations were undertaken with 5 Registered nurses and 3 Health Care Assistants to establish details surrounding [Redacted] care.

7.4.4 MDT meeting was held and led by Risk and Quality Manager for EIM which focused on events and Systems Engineering Initiative for Patient Safety (SEIPS) criteria to establish areas for learning and review of processes. The review included the Acute

Medicine Matron, ward manager and nurses involved and consultant for Victoria Ward involved and Imaging staff

8. Findings

8.1 All Findings

8.1.1 [Redacted], at [Redacted] [Redacted] was reported by the night nurse to have had a cough and expectorating thick yellow phlegm. Physio reviewed at [Redacted] and reported [Redacted] was able to bring secretions to mouth and cleared with Yankeur suction

8.1.2 On [Redacted]: Endocrinology review documented for x-ray post NG insertion, this is not 1st line protocol for confirming tube position on Trust Guidelines nor NPSA guidance but is Consultant preference. An x-ray was not taken due to confirmation of position using pH as per Trust/NPSA protocol.

8.1.3 Medical entry records that [Redacted] was informed he would have an NGT inserted. There is no documented MDT decision tool or documentation of the discussion relating to rationale, benefits or risks or a capacity assessment on the.

8.1.4 Both nurses who attempted/completed insertion are experienced and expressed confidence in their competency and confidence in the procedure.

8.1.5 Medical Team and Nursing staff were aware that as per Trust guidelines, the NGT must be inserted before 1700h. Tube was inserted at [Redacted].

8.1.6 The first and unsuccessful NGT insertion attempt was documented in nursing review as not tolerating the procedure, however time of attempt was not documented, as per local NG guidance.

8.1.7 First procedure was abandoned due to coughing (notes reflect procedure was not tolerated, with reports of severe coughing during interview of the nurse).

8.1.8 2nd insertion of NGT, there was no coughing reported and tube insertion reportedly not difficult.

8.1.9 pH of 5.5 was obtained and documented on NG Insertion Record which is within the range stipulated by the NPSA (2005 updated 2016) and Trust guidance.

a. Initial tube length was incorrectly documented as 65cm (this was reported NEX (nose, ear xiphisternum) measurement.) from first unsuccessful

attempt. Regardless of success/failure of insertion, a NEX measurement provides guidance on the approximate length of the NGT needed to be inserted.

b. This was corrected to 58cm on fluid balance chart retrospectively (time unknown)
c. tube length of 58cm documented by the day registered nurse on [Redacted] and [Redacted]
d. Night registered nurse on [Redacted] documented 65cm (the original length on the NG insertion document).

8.1.10 The Night Nurse reported during interview that there was not any tube movement or manipulation. The Night nurse has reported [Redacted] did visualise the tube length however there remains discrepancy between [Redacted] measurements (65cm) and the ones recorded on the fluid balance by the day nurses on [Redacted] and [Redacted] (58cm)

8.1.11 If there were any loose tapes, manipulation of the tube or change in tube length at the nostril, safe position of the NGT should have been confirmed prior to using the tube.

8.1.12 Handover between day staff and night staff on [Redacted] did not occur at the bedside as is normal practice. The night nurse reflected that the handover did not happen at the bedside due to day nurse requiring access to the handover which was on the computer at the Nurses' station.

8.1.13 It was documented that the feed was running and completed overnight. All medications were given and charted.

8.1.14 There was discrepancy regarding between when the feed was due to end [Redacted] and what was documented on the fluid chart [Redacted] however the night nurse confirmed that the feed had stopped at the correct time when the dose was completed.

8.1.15 [Redacted] had been recommended to be nil by mouth on admission and had received minimal nutrition for 6 weeks at home (under 500kcal per day). At time of NGT insertion he had been Nil by mouth (NBM) for 3 days. Even if information from North Middlesex University Hospital had been received confirming [Redacted] was risk feeding, decision to administer NG feeding would still have been planned due to malnutrition. However, the NGT MDT decision tool was not completed.

8.1.16 At [Redacted] on [Redacted], medications scheduled for [Redacted] were signed as administered on Medicines management system (CMM), and flush was documented on the fluid balance chart. However, the pH and tube length prior to flush and medication administration were not documented. The Night Nurse did report at interview that [Redacted] checked pH with the day nurse before [Redacted]. The day nurse confirmed that a pH check took place but was not aware of which patient it was for.

8.1.17 Medical Team was notified immediately when [Redacted] deteriorated. Night nurse and day nurses were involved in interventions to provide treatments instructed by Medical Team.

8.1.18 Medications and flushes scheduled for 08:00 were withheld as pH could not be confirmed due to inability to obtain an aspirate on the morning of [Redacted].

8.1.19 Radiology found that the NG tube was in the left lung.

8.1.20 NGT removed after Xray on [Redacted]. Time not known as not documented.

8.1.21 Previous Never Event (NE) around NG feeding in 2015 and 2016 were reviewed, both relating to tube migration after initial correct placement. This was secondary to reported coughing, vomiting, delirium and manipulation of tube by the patient. The cause of this NE may be similar as tube likely did migrate, however there is no definitive answer as to what happened.

Action from the previous NE's which have been completed include:

- avoidance of NGT insertion for feeding after 5pm which remains policy

- a robust training education program is in place (refer to table in Section 6)

- MDT decision making tool was developed to guide decision making surrounding appropriateness of NGT feeding

- Regular updates of NGT feeding guideline and core care plan.

NGT feeding was on the EIM Risk Register since 2014, however was removed in November 2024 due to no incidents after 2016/17.

8.1.22 There have been three National Patient Safety Agency (NPSA) alerts regarding NGT. These have been reviewed:

8.1.23 2011 NPSA alert focused on enforcing the 2005 recommendations; clarification that no liquids (feed, flushes, medication) must be administered via the NGT before

position checks and guidance provided on documentation criteria when reporting X-rays to confirm NGT position. These were implemented at Whittington Hospital.

8.1.24 The 2016 NPSA Alert was directed at Trust boards and the processes that support clinical governance, not frontline staff. These were implemented at Whittington Hospital.

8.2 Areas for improvement and associated safety actions

8.2.1. Reduction of accepted pH range post NGT insertion from 1.0 – 5.5 to 1.0-5.

- Attend governance forums for sign off:
  - WISH
  - Nursing Midwifery Leadership Group
  - EIM Quality Meeting
  - NG Roadshow
- Meet senior nursing staff to discuss new changes to pH and NG Risk Assessment checklist
- Communication to wider MDT/Trust of new changes:
  - Email, screensaver information on Intranet
  - Weekly Noticeboard
  - Back to the floor presentation

8.2.2. Introduction of NGT Risk Assessment Checklist and improve compliance of documentation of position checks

- Dissemination of NGT Risk Assessment checklist
- Nursing staff to complete risk assessment checklist whenever accessing NGT and as per protocol
- Use of NGT core care plans

8.2.3. Increased use of NGT MDT decision tool and documentation of capacity assessments and rationale/risk/benefits of insertion of NGT

- NG Roadshow promoted the use of the tool
- Presentation at Gastroenterology Academic Meeting
- Present to EIM and surgical teams

8.2.4. Improved use of NGT insertion records

- All staff inserting NGT to complete NG Insertion Record (including unsuccessful attempts, amendments) at time of procedure including a verbal handover

8.2.5. Improved recording of fluid balance charts for patients receiving NGT feeding

- Fluid balance charts to reflect all start and finish times of feeds/flushes and medications accurately and legibly.

8.2.6. Improved handover of patients at bedside by nursing staff

- Nursing handover of patients to occur at bedside with visualisation of tube length, confirmation of feed administration status and correct position checks having been completed.

8.2.7. Increased attendance at training opportunities provided by Nutrition Nursing Team

- To review alternative opportunities, consideration to be given to identifying practical ways to support attendance at the Nutrition Nursing Service's nasogastric tube feeding training programme amid competing service demands.

8.2.8. Increased attendance at training opportunities

- Develop e-learning module on NGT management
- Provide opportunities for resident doctor training on NGT, including considering timings and frequency of medications
- Ensure e-learning module for interpretation of tube position on x-ray FY2 and above is available on Elev8 and monitoring of compliance is performed.

8.2.9. To explore new innovative solution to confirming NG tube position

8.3. Learning Response Tool Analysis [SEIPS]	
	Further Details
Tools and Technology	• pH strips showing 5.5 accepted as safe – reliance on a single test

	• Confusing or hard to locate x-ray request options. NG x-ray request called "NG feeding" which is not clear, however not relevant to this incident • Impact: Staff followed guidance as they understood it, however gaps in knowledge evident on occasion.
Tasks	• NG insertion requires multiple steps, high precision tasks (measurement, aspiration, pH, documentation) • Additional care (oral suctioning, airway management, IV medications) competed for attention • Handover disrupted by ward events • pH5.5 threshold allowed feeding without radiological verification • Impact: Critical NG safety tasks were vulnerable to omission under workload in a disturbed environment
Internal Environment	• Victoria ward highly acute, frequently chaotic with behavioural disturbances • Frequent interruptions during procedures and handovers • Limited quiet/safe space for clinical decision making or checking • Impact: Environmental pressures increased risk of error and reduced capacity for safety-critical focus
Person	• Competing demands and task-switching – reduced ability to complete complex safety critical procedures • Nurses demonstrated strong professionalism but acknowledged the human factor pressures • Fear and distress after discovering the mal positioned tube • Impact: Reduced ability to complete/document all steps
Organisation	• No routine system ensuring families are updated when patients with fluctuating cognition make significant decisions
External Environment	• National NG safety alerts advocate pH checks as 1st line management for confirmation of tube position stressing risk of x-ray misinterpretation – creating reluctance to rely solely on x-rays which clinicians and nurses erroneously consider safer methods of NGT position confirmation

9. Next of Kin questions

9.1 Was consent given for NGT insertion?

There is no documentation of explicit consent being sought or obtained, however the dietitian felt that consent was implied when she discussed the plan to commence NG feeding with [Redacted].

9.2. Why was CXR not done?

It is not Trust policy or NPSA recommendations to routinely do a CXR of all NGTs. Checking pH is first-line assessment of NGT position. It was requested for [Redacted] due to the Consultant's own personal practice around NG insertion, though an x-ray was not taken due to confirmation of position using pH as per Trust/NPSA protocol. [Redacted] showed no evidence of deterioration or compromise after the NG insertion on [Redacted], during his NG feed or up until handover time the following morning of [Redacted]

9.3. Why did things go so wrong?

It is not immediately evident why things went wrong. It is likely due to a number of factors which include reports of coughing/thick secretions which may have dislodged the tube and Trust policy not being followed surrounding documentation of NGT position checks using pH and tube length (Refer to 8.1.18). There is also discrepancy in the documented tube length between day and night nursing staff, although both report documenting what measurement they did see (Refer to 8.1.9). This adds to the difficulty in coming to a definitive conclusion.

10. Appendices

10.1 Appendix 1 – Terms of Reference

ToR 1	*Clinical pathway and decision-making process*
Key questions	1. Was the decision to NG feed clinically appropriate? 2. What is the consent process for a NG feed and was this communicated to the patient pre-procedure? 3. Was the procedure carried out according to local or national guidance? 4. What are the known risks with a NG feed and were these considered before insertion?
Healthcare settings	• *Clinical SOP/guideline for management of NG tube feeding*
Healthcare processes	• *Internal: policies/guidelines within Whittington Health* • *National NICE guidelines on NG feeding* • *National Patient Safety Alerts (NPSA) 2005, 2011, 2016*

ToR 2	*Management of the patient (including nursing & dr's events)*
Key questions	1. Was the patient under the correct specialist care for older people? 2. Was the placement of the NG tube checked before administering feeds and were regular checks carried out to identify signs of blockage or displacement? 3. Was risk mitigation immediately put in place? 4. Did documentation reflect NGT and feed as per policy standards? 5. What were the contributing factors to the deterioration of the patient and were these identified timely and managed appropriately?
Healthcare settings	• *Management of patients with NG tubes on the wards*
Healthcare processes	• *National Nutrition Nurses Group good practice guidelines for safe insertion and ongoing care of Nasogastric Tubes 2023* • *National NICE guidelines on NG feeding 2006 (updated 2017)*

ToR 3	*Wider system learning and resilience*
Key questions	1. Is the internal policy for NG insertion in line with national guidance? 2. Was the most up to date policy in line with National Guidance, had the policy changed during COVID? 3. What can we learn to improve the monitoring of patients with a NG feed? 4. Is training for the management of NG feeding for nurses appropriate and are nurses up to date with the training? 5. Was adequate supervision for the nursing staff relevant to NG feeding? 6. Are there similarities in previous NG tube investigations? 7. Were staffing levels appropriate?

Healthcare settings	• Safer staffing • Training records
Healthcare processes	• *National NICE guidelines on NG feeding* • *Safety alert from July 2016*

ToR 4	*Patient/family Questions*
Key questions	1. Was consent given for NGT insertion? 2. Why was CXR not done? 3. Why did things go so wrong?

10.2 Appendix 2 - Timeline / patient journey map

[Redacted]:

- [Redacted] attended Emergency Department (ED) at Whittington Hospital (WH) on advice of Ambulatory Care Doctor due to concerns flagged during a follow up call relating to computed tomography scan (CT) chest result. Call made by Senior House Officer. [Redacted] was verbalising being unwell, struggling to breathe and unable to eat for days.
- Presented in ED with loss of appetite, vomiting for four days, ongoing shortness of breath, 20kg weight loss, coughing and difficulty swallowing for two weeks.
- Differential diagnoses include aspiration pneumonia, hypernatremia, hypercalcaemia and constipation.
- Plan for Speech and Language Therapist (SLT) review. Placed Nil by Mouth (NBM) pending review.
- [Redacted] was transferred to Victoria ward late at night under care of Consultant Endocrinologist.
- An x-ray of [Redacted] chest on [Redacted] showed a stable right lower zone atelectasis (atelectasis occurs when the alveoli in the lungs lose air) and collapse and opacity likely corresponding to the known 8mm right lower lobe pulmonary nodule. Left lower zone opacity may represent collapse/consolidation

[Redacted]:

- Food chart reflects that patient was offered porridge despite NBM status (however [Redacted] did not eat any porridge, as [Redacted] was unable to swallow)
- First review by Victoria ward Endocrinology Team by Specialist Registrar, Senior House Officer and Foundation Year 1 Resident: Remains NBM.

- Plan for Dietitian discussion re nutrition and possible PEG in future.
- First SLT review: Noted overt aspiration signs therefore advised continued NBM. History of chronic oropharyngeal dysphagia and previous Video fluoroscopic Swallowing Study (VFSS) with discussion around possible PEG. Presents with mild dysphonia (weak voice). Await NMUH SLT handover.
- Weaned off oxygen saturating at 90-94% (target range)
- Referred to Dietitian by Medical Team FY1 Resident Doctor
- Physiotherapist: Blood Pressure (BP) high and patient short of breath – not safe to continue mobilising.

[Redacted]:

- Endocrinology review SHO and FY1 Resident Doctor. [Redacted] was informed a nasogastric tube (NGT) would be inserted. [Redacted] was not orientated to year or day but orientated to place. Team have documented for x-ray post NGT insertion.
- Dietitian review: Identified as seriously underweight with Body Mass Index (BMI) of 14.9m2., (Healthy range 18.5-25). Discussed NGT feeding and clarified that an NGT is a temporary measure until longer term feeding plan discussed, i.e. Percutaneous Endoscopic Gastrostomy (PEG) [Redacted] appeared to be in agreement.
- Physiotherapy: Secretions can be managed with Yankeur (a tool that safely removes secretions from the mouth without damaging the tissues), but large volumes present.
- Unsuccessful NGT insertion attempt (time not recorded) by nurse; documented in nursing review that [Redacted] did not tolerate the procedure.
- [Redacted]: NGT inserted by nurse [Redacted] on request of nurse [Redacted], following earlier unsuccessful attempt.
- Tube length documented as 65cm. pH of 5.5 obtained and confirmed by nurse [Redacted] and nurse [Redacted]. Feed commenced [Redacted].
- NGT insertion record completed by nurse [Redacted].
- SLT advised to continue with NBM and NGT feeding until collateral information regarding swallow and Video Fluoroscopy Study of Swallow (VFSS) report can be obtained from North Middlesex University Hospital (NMUH).
- [Redacted] wife expressed that [Redacted] had declined PEG previously but may have changed [Redacted] mind. [Redacted] brought in letters from NMUH.

[Redacted]:

- At [Redacted] the night nurse C documented secretions “sucked” via Yankeur suction.

- Night nurse [Redacted] documented "thick phlegm covering tongue, sucking given to clear off completely.
- At [Redacted] the length of the NG tube was documented as 65cm.
- At [Redacted] Medical team, was informed by Sister in Charge that [Redacted] was hypoxic and saturating at just 90% on a 15 Litre rebreathing mask. This was detected at handover. The doctor's impression was querying new hospital acquired pneumonia, hypovolaemia (a low volume of fluid in the body), hypernatremia (sodium levels in the blood being too high), lithium toxicity (too much lithium in the body). Plan: commence IVABs (intravenous antibiotics). IVF (intravenous fluids), continue NG feed, not currently running
- Frequent medications and water flushes prescribed requiring repeated pH checks to confirm tube position. While there is no guidance surrounding this, education will suggest consideration of frequency medications are prescribed.
- Day nurse [Redacted] attempted pH at [Redacted] but was unable to get aspirate therefore medications not given. Tube length documented as 58cm at nostril. This appears to be after [Redacted] showing signs of deterioration.
- Next of Kin (NOK) was informed of deterioration and discussed likelihood of poor outcome.
- CXR requested [Redacted], reported at [Redacted]; white out of left lung. NGT in left lung. NGT removed after x-ray.
- Retrospective entry [Redacted] by nurse [Redacted] regarding tube insertion on [Redacted]. This documented coughing during initial attempt to insert NGT and that nurse [Redacted] incorrectly documented the tube length of the second NGT. Nurse [Redacted] did not insert the tube, but [Redacted] documented the tube insertion on behalf of [Redacted] colleague Nurse [Redacted]. Nurse [Redacted] reports double-checking pH 5.5 on insertion with nurse [Redacted]. Nurse [Redacted] discussed with doctors who agreed to cancel CXR as pH within range had been obtained (as per Trust policy).
- Physiotherapist advised the patient can be deep suctioned if needed.
- Documentation stated: Feed running and completed overnight. All medications given and charted. This is unclear documentation relating to when feed stopped. Feed was prescribed for 9 hours on [Redacted] commencing at [Redacted] therefore due to stop at [Redacted]. The fluid balance chart reflects feed documented until [Redacted]. The day nurse on [Redacted] contacted the night nurse who reported feed had stopped at the correct time when the dose was completed. This shows a discrepancy between documentation and verbal feedback.
- Fluid balance chart misleading regarding duration of feeding.

- [Redacted]: Seen by physiotherapist and deep suctioned. Copious secretions but do not look like feed. Advice: Patient can be deep suctioned if needed.
- Reviewed by Care of Older People (COOP) Consultant (documented [Redacted]). Brief examination: generalised sarcopenia, eyes open spontaneously, mumbling a few words, holding [Redacted] hand. Some air entry upper zone of left lung; good air entry right lung however remains tachypnoeic (abnormally rapid and shallow breathing) and high work of breathing. It was felt over all [Redacted] had slightly improved from earlier entries. Consultant called NOK [Redacted] of [Redacted] to update. After discussion with NOK Consultant returned to patient's bedside and noted sudden change. [Redacted] had deteriorated and felt [Redacted] was in his final moments. Decision made to make [Redacted] comfortable. NOK was reinformed.
- [Redacted] passed away at [Redacted]
- Retrospective entry on [Redacted] updated on [Redacted] having received collateral from NMUH on [Redacted]. In [Redacted] presented with severe motor and sensory oropharyngeal dysphagia, all consistencies carry high risk. VFSS – due to severity of swallow presentation and weight loss, PEG was recommended, [Redacted] cancelled his PEG procedure. NMUH team deemed him to have capacity for this decision.
- Case referred to the coroner.

11. References

11.1. NPSA 2005 alert

NRLS-0180B-Nasog
astric-tu_sition-2005

11.2. NPSA 2011Alert

11.3. NPSA 2016

11.4. NPSA 2016 Resource Set

11.5. Local WHT NG Guideline (reviewed March 2025)

11.6.
NICE: Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition; Clinical guideline

12. Safety Action Summary Table:

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
1	Reduction of accepted pH range post NGT insertion from 1.0 – 5.5 to 1.0-5.0	Attend governance forums for sign off: WISH Nursing Midwifery Leadership Group (NMLG) EIM Quality meeting NG Road show	Lead Nutrition Nurse	05/03/2026	WISH 09/01/26 NMLG 28/01/26 EIM Quality 06/02/26	N/A	N/A	Lead Nutrition Nurse	N/A	
		Meet senior nursing staff to discuss new changes to pH and NG Risk Assessment checklist	Nutrition Nursing team	06/02/2026	06/02/26	Manual compliance audits and spot checks	N/A	Lead Nutrition Nurse	N/A	
		Communication to wider MDT/Trust of new changes: Email, screensaver, information on Intranet, Weekly Noticeboard,	Nutrition Nursing team		06/02/26 10/02/26	N/A	N/A	Lead Nutrition Nurse	N/A	

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
		Back to the Floor Presentation			04/03/26					
2	Introduction of NGT Risk Assessment Checklist and improve compliance of documentation of position checks	Dissemination on 06/02/26	Ward Managers/ Nutrition Nursing team and Dietitians	06/02/26	06/02/26	Monitor use by NG audits and spot checks	6 monthly	Lead Nutrition Nurse	May 2026	
		Nursing staff to complete risk assessment checklist whenever accessing NGT and as per protocol Use of NGT core care plans	Ward Managers PDNs Dietitians Nutrition Nursing team	6/2/2026	6/2/2026	Monitor use by NG audits and spot checks	6 monthly	Lead Nutrition Nurse	May 2026	
3	Increased use of NGT MDT	NG Roadshow promoted the use of the tool	Consultants/clinical teams			NG audits and spot checks	Prior to any NGT placed	Lead Nutrition Nurse and	6 monthly	

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
	Decision Tool and documentation of capacity assessments and rationale/risk /benefits of insertion of NGT.	Presentation at Gastroenterology Academic Meeting	Dietitians Nutrition Nursing Team Nutrition Nursing team & Dietitian	February 2026 11/03/26	February 2026 11/03/26			Lead Dietitian	review	
		Present to EIM and Surgical Teams	Dietitians & Nutrition Nurses	01/05/2026		N/A	N/A	Lead Nutrition Nurse/ Lead Dietitian	N/A	
4	Improved use of NGT insertion records	All staff inserting NGT to complete NG Insertion Record (including unsuccessful attempts, amendments) at time of procedure	Ward Managers Practice Development Nurses (PDN)	Implemented January 2025	Implemented January 2025	NG Audit and spot checks	NG audit Spot checks on wards	Lead Nutrition Nurse	NG Audit May 2026	

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
		including a verbal handover.	Clinical Teams							
5	Improved recording of fluid balance charts for patients receiving NGT feeding	Fluid balance charts to reflect all start and finish times of feeds/flushes and medications accurately and legibly	Ward Managers PDNs Dietitians	01/06/2026		Audit Spot checks on the ward	Once yearly NG audit	Trust wide	tbc	
6	Improved handover of patients at bedside by nursing staff	Nursing handover of patients to occur at bedside with visualisation of tube length, confirmation of feed administration status and correct position checks having been completed.	Ward Managers	15/04/2026		Feedback from Ward Managers to Matrons and ADoNs of divisions	Monthly	Trust wide	01/08/2026	
7	Increased attendance at training opportunities provided by Nutrition	To review alternative opportunities, consideration to be given to identifying practical ways to support attendance at the Nutrition	Senior Nurses Ward Managers/PDNs	Completed Established program in place	Completed Established program in place	Attendance lists and regular feedback to senior nursing staff	Attendance records	Lead Nutrition Nurse	Bi monthly report to NSG	

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
	Nursing Team	Nursing Service's nasogastric tube feeding training programme amid competing service demands.	Matrons Nutrition Nursing Team							
8	Increased attendance at training opportunities	Develop E-learning module on NGT management	Nutrition Nursing Team and Learning and Development (to set up) Matrons/ Senior nursing staff/PDNs to encourage compliance	December 2026	January 2027	Learning and Development report	Learning and Development report	Lead Nutrition Nurse	Progress to be reviewed in October 2026	

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
		Provide opportunities for Resident doctor training on NGT, including considering timings and frequency of medications: Liaise with PGME Lead to schedule slots on training programme	Nutrition Nursing Team	August 2026 (Induction of new doctors)	When training programmes occur	Training logs	When training programmes occur	Lead Nutrition Nurses/PGME Lead	September 2026	
		Ensure E-learning module for interpretation of tube position on Xray fY2 and above is available on Elev8 and monitoring of compliance is performed	Learning and Development Team	June 2026	TBC	Learning and Development report	Learning and Development report	Learning and Development report EIM Clinical Director S&C Clinical Director	June 2026	

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
9	Use of electronic systems	For staff to only use their personal log in to electronic noting system with designated name and position as per NMC documentation standards	Ward Managers	01/05/2026		Audit	Monthly	Matrons	01/09/2026	
10	To explore new solution to confirming NG tube position	For example NGPOD	Nutrition Nursing Team	October 2026		Review of new technology	N/A	Lead Nutrition Nurse/ Trust	March 2027	

Patient Safety Incident Investigation (PSII) Report

Date of incident	[redacted]
Incident ID number	[redacted]
PSII Approved by	[redacted]
Job Title	EIM ADoN
Signature, date	[redacted] 15.04.26
Date Approved at Whittington Improvement & Safety Huddle (WISH)	24.04.26
Date Presented to Quality Assurance Committee (QAC)	08/07/2026
Date Noted at Trust Board	

Version Control				
Version number draft/final	Date	Responsible person	Amendments made	Sent to
V1.0	20.02.26	[redacted] Risk and Quality Manager EIM	Approved TOR added	[redacted] Consultant [redacted] Matron
V1.1	26.03.26	[redacted] Risk and Quality Manager EIM	Datix number corrected Reported completed	[redacted] Consultant [redacted] Matron [redacted] ADON
V1.2	09.04.26	[redacted] Deputy ADoN [redacted] ADoN [redacted] CD	Review report and comments	[redacted] Matron [redacted] Risk and Quality Manager EIM
V1.3	12.04.26	[redacted] Matron [redacted] Risk and Quality Manager EIM	Amended accorded to comments	[redacted] Consultant [redacted] Matron [redacted] ADON [redacted] CD [redacted] Head of Patient Safety and Legal Services
V1.4	15.04.26	[redacted] Risk and Quality Manager EIM	Updated with changes received from [redacted] ADON [redacted] Head of Patient Safety and Legal Services Divisional sign off, [redacted] ADoN EIM	[redacted] Consultant [redacted] Matron [redacted] ADON WISH
V1.5	21.04.26	[redacted] Risk and Quality Manager EIM	Updates from WISH	[redacted] Consultant [redacted] Matron [redacted] ADON [redacted] Service Manager- Mental Health Liaison Teams

V1.6	23.04.26	[redacted] Risk and Quality Manager EIM	Updates job title CD Team Manager for the Whitington MHLT	WISH [redacted] Consultant [redacted] Matron [redacted] ADON [redacted] Service Manager- Mental Health Liaison Teams
V1.7	29.04.26	WISH	Trust sign off	Whittington Improvement and Safety Huddle (WISH)
V1.8	30.04.26	[redacted] Risk and Quality Manager EIM	Table 7 amended	[redacted] Head of Patient Safety & Legal Services

Distribution list List who will receive the final draft and the final report (e.g. patients/relatives/staff involved, board)	
Name	Position
[redacted]	Consultant Post take in ED Gastroenterology
[redacted]	JCF medical team
[redacted]	F1 medical team
[redacted]	NHSP Clinical Nurse Specialist (MH)
[redacted]	F2 medical team
[redacted]	ST1
[redacted]	Medical Examiner
[redacted]	NHSP Clinical Nurse Specialist (MH)
[redacted]	ED doctor
[redacted]	NHSP Clinical Nurse Specialist (MH)
[redacted]	Clinical Nurse Specialist MHLT
[redacted]	Social Worker
[redacted]	NHSP Clinical Nurse Specialist (MH)
[redacted]	Psychiatric Liaison Nurse North London NHs Foundation trust
[redacted]	Service Manager- Mental Health Liaison Teams (UCLH, Royal Free & Whittington Hospitals)

[redacted]	Team Manager for the Whitington MHLT

Participants of the PSII	
Name	Role
[redacted]	Acute Medical Consultant
[redacted]	Matron EIM
[redacted]	Dept ADoN EIM
[redacted]	Ward Manager AAU
[redacted]	Head of Vulnerable Adults
[redacted]	Team Manager for the Whitington MHLT
[redacted]	Service Manager- Mental Health Liaison Teams (UCLH, Royal Free & Whittington Hospitals)
[redacted]	Consultant Psychiatrics MHLT

1. About patient safety incident investigations

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

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

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

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

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

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

2. A note of acknowledgement

The Learning Response Leads ([redacted], [redacted] and [redacted]) would like to thank the staff who contributed to reviewing the patient safety incident summarised in this report. Thank-you for your support, your openness, and your transparency. Your insights into how care is delivered in the Whittington Hospital Emergency Department and inpatients wards in collaboration with the Mental Health Liaison Team has helped us to understand what happened. Each of you has helped us better understand how the technology and tools, organisation, task, person, internal environment, and external influences impact on the performance of staff working in the Emergency Department and inpatients wards in collaboration with the Mental Health Liaison Team.

We know we have committed, professional and caring staff working in the Whittington Hospital and along with the Mental Health Liaison Team. We know you go to work every day aiming to deliver safe patient care.

Our role as Learning Response Leads is to gather insight into the healthcare settings and systems in which you work: Our focus has been on learning how teams working in deliver patient care, the challenges, constraints and demands you work with, and how systems factors impact on safe patient care. We are not here to judge or criticise: We are here to facilitate learning in a supportive, caring, and collegiate way. Without the insights and contributions made by the staff who participated in the review, the report would not have been possible. So, thank you.

3. Contents

4. Executive summary

4.1. Incident overview

4.1.1. [redacted]had attended the Whittington Health NHS Trust Emergency Department (ED) the previous Friday [redacted]

4.1.2. [redacted] presented after a mixed overdose and drinking a small amount of bleach. Toxicity was low, but there was concern about possible need for an OGD (oesophago-gastro-duodenoscopy)

4.1.3. During the weekend [redacted] left the ED department, against medical advice and self-presented again.

4.1.4. [redacted] was admitted to Mary Seacole South ward on [redacted], however self-discharging against medical advice despite staff encouraging [redacted]to stay.

4.1.5. [redacted] self-presented back to the hospital in the early hours of [redacted], was seen in ED and again. [redacted] was then admitted to Mary Seacole South later that day.

4.1.6. [redacted] self-discharged, against medical and nursing advice from the ward that evening [redacted].

4.1.7. On [redacted] at [redacted], [redacted] was brought in by ambulance, [redacted] was discovered suspended from a ligature in the park. Despite resuscitation attempt by London Ambulance Services and Whittington Health NHS Trust [redacted] died at [redacted] in the Whittington Health Emergency Department.

4.1.8. There was no legal framework in place at this time and ED notes from Mental Health Liaison Team (MHLT) show that the [redacted] was discharged from MHLT.

4.2. Summary of key findings

4.2.1. Repeated referrals without timely assessment
4.2.2. Mental health pathway confusion between ED and Ward
4.2.3. Inconsistent conclusions about capacity
4.2.4. No use of legal frameworks when absconding
4.2.5. Correct use of seclusion in ED
4.2.6. Relevant previous actions from earlier investigations were timely completed

4.3. Summary of areas for improvement and associated safety actions

4.3.1. Improvement to documentation

4.3.2. Clear Mental Health Service structures, including review of the Service Level Agreement between Whittington Health Trust and North London Foundation Trust.

4.3.3. Staff training on use of legal frameworks

4.3.4. Roll out of comparable escalation process of CODE 10 in Acute Assessment Unit (AAU) wards

5. Duty of candour

Different elements	Yes	No	Date	By whom?
Was the patient / NoK contacted and apologised to?	☒	☐	[redacted]	[redacted] Matron
Was this followed up in writing?	☒	☐	[redacted]	[redacted] Matron
Has the family agreed to receive the final report?	☒	☐	[redacted]	[redacted] Matron

6. Background and context of the patient safety incident

6.1. [redacted]past medical history includes Emotionally Unstable Personality Disorder (EUPD) and Bipolar Personality Disorder (BPD), previous self-harm and suicide attempts.

6.2. [redacted] attended Whitting Health Emergency Department only 2 before his attendances covered in this report. In [redacted] [redacted] left before [redacted] was seen and in [redacted], [redacted] was seen for a feeling of food stuck after eating, this cleared after drinking water.

6.3. [redacted] attended the ED and AAU multiple times over the weekend of [redacted] as described in the Incident Overview Section 4.1.

6.4. Emergency Department and Urgent Care Centre at the Whittington is a medium sized London Emergency Department that sees approximately 110,000 patients per annum who are undifferentiated ill adults and children.

6.5. Safer staffing was reviewed for ED and between [redacted] and [redacted] staffing was safe.

6.6. The Acute Assessment Unit (AAU) is based on two wards Mary Seacole North and Mary Seacole South. It receives predominantly adult medical patients requiring emergency admission and medical assessment and treatment, including mental health patients. Patients are cared for by the acute medicine team led by a consultant physician with aim of either discharge home or transfer to a specialist ward within 48 hours. This is a busy unit, and due to its nature has consistently high turnover of patients arriving any time during a 24-hour period.

6.7. Mary Seacole South is an 18 bedded unit with 4 side rooms inclusive.

7. Investigation approach

7.1. Investigation Team

Role	Initials	Job title	Department	Other
Lead Investigator	[redacted]	Consultant	EIM	
Investigator	[redacted]	Matron	EIM	

Facilitator, PSIRF trained	[redacted]	Risk and Quality Manager	EIM	
Investigator	[redacted]	Team Manager for the Whitington MHLT	North London Mental Health Partnership	

7.2. Summary of investigation process

7.2.1 This incident was reported on the Trust's incident reporting system, Datix [redacted]on [redacted] and a Rapid Action Review outlining the key facts, was presented at the Whittington Improvement and Safety Huddle (WISH) on [redacted] by the Deputy Associated Director of Nursing EIM.

7.2.2 Attendees at WISH were:

- Clinical Director for Emergency & Integrated Medicine (EIM) Division (Chair)
- Chief Medical Officer
- Deputy Chief Nurse for Quality Governance
- Associate Director of Quality Governance
- Head of Patient Safety & Legal Services
- Deputy Associate Director of Nursing for EIM
- Quality & Risk Manager for EIM
- Patient Safety Information Manager

7.2.3. It was formally noted that the incident would be investigated by way of a Patient Safety Incident Investigation (PSII).

7.2.4. A System Engineering Initiative for Patient Safety (SEIPS) was completed on 05.03.2026 with in attendance staff from Whittington Health and North London Foundation Trust.

7.2.5. Once the PSII is completed, it will be shared with Whittington Health and North London Foundation Trust staff involved in the investigation for factual accuracy.

7.2.6. The London Foundation Trust have reviewed and confirmed agreement with the actions 23.04.26

7.2.7. The final report will be approved by the WISH panel, presented at the Quality Assurance Committee and noted at Trust Board and shared with [redacted] family.

7.2.8. Actions identified from the investigation will be monitored through the Emergency & Integrated Medicine Division.

7.3. Terms or reference summary

7.3.1. What clinical pathways are used in ED and AAU for patients presenting with mental health issues and are there any barriers and facilitators that impact on the care the patient receives on this pathway?

7.3.2. How are decisions communicated between teams and how are they documented?

7.3.3. How did the internal environment, technology & tools, organisation of work (i.e. staffing, resource allocation culture etc person (i.e. leadership teamwork roles and responsibilities) tasks and external influences impact on clinical decision making

7.3.4. Exploring the acuity on the shift and other incidents that might have influenced decision making during the shift.

7.3.5. Learning from previous events, appendix 3.

7.4. Information gathering

7.4.1. Review of Patient electronic notes and templates on CareFlow

7.4.2. Review of Rapid Response Huddle (RRH) North London Mental Health Partnership

7.4.3. Multidisciplinary meeting using System Engineering Initiative for Patient Safety (SEIPS) to show the network of contributory factors involved in this incident.

7.4.4. Look back review of previous incident report.

8. Findings

8.1. All Findings

Repeated Mental Health referrals without timely assessment.

8.1.1. Across [redacted], [redacted] was repeatedly referred to mental health services, yet there were delays or incomplete follow through.

8.1.2. [redacted] – Request for MHLT review due to escalating behaviour and seclusion. No documented assessment at that time.

8.1.3. [redacted] – MHLT assessment took place but was only uploaded at [redacted], creating a documentation delay that likely impacted communication.

8.1.4. [redacted] – MHLT notes that they are “unable to confirm suicidal ideation” and acknowledged [redacted] could not recall yesterday’s assessment. This indicates deterioration but does not trigger immediate reassessment.

8.1.5. [redacted] – Medical team makes a Mental Health (MH) referral due to fresh delusions and memory impairment. It was noted that some MH staff who assessed [redacted] did not have access to CareFlow

8.1.6. [redacted] - During the review that [redacted] received from the MHLT, the appropriate mental state examination, risk assessment and mental capacity assessment for

decisions around [redacted] mental health care were not established to determine the required care plan for admission to the ward.

Mental health pathway confusion

8.1.7. [redacted] MHLT states that 'no further action is required' discharging [redacted] from the MHLT Service. The ED MHLT did not refer [redacted] to the inpatient MHLT to take over [redacted] care during admission as would be the normal process.

8.1.8. [redacted] Mental Health Crisis Assessment Service (MHCAS) was contacted, and it was established that a referral to Ward Psychiatry Liaison team was needed and this was actioned by MHCAS.

8.1.9. MH Ward referrals require a 24-hour response time, as per the Service Level Agreement (SLA), however there is scope for an urgent referral, and this was not followed.

Inconsistent capacity conclusions despite fluctuating mental state

[redacted] was placed on MCA and secluded with 1:1 observations, awaiting full MHLT assessment

[redacted]: MHLT concluded [redacted] had capacity, denies suicidal ideation, and is safe for discharge.

[redacted]: medical records again raise concerns about capacity.

[redacted]: MHLT notes state [redacted] could not recall prior assessments; however, they advised [redacted] was not suitable for an inpatient MH bed.

[redacted]: Medical team identified active delusions and memory loss, yet no urgent capacity reassessment occurred.

No use of legal frameworks

8.1.10. There was no use of the legal frameworks by Whittington Health staff despite repeated attempts to self-discharge against medical advice. Given the MHLT had reviewed [redacted], staff were following the entry from MHLT noting that [redacted] was discharged from the MHLT service as considered low risk.

8.1.11. [redacted] Notes in CareFlow state, nurse not able to legally able to restrain forcefully. Nurse in Charge informed security [redacted] was not on any legal framework. The Nurse in Charge did escalate it to the medical team, however, did not use the mental capacity act to prevent [redacted] leaving

8.1.12. [redacted] Notes in CareFlow state, security unable to restrain [redacted] as there is no legal framework in place. Subsequently [redacted] left the ward.

8.1.13. [redacted] was appropriately secluded and un-secluded several times during [redacted] time in ED.

8.2. Areas for improvement and associated safety actions

8.2.1. Improvement to documentation:

- Create a template 'MHLT Mental Health Patient Care Plan' on CareFlow for ward environment.
- MHLT handovers to clearly state updated action plans in place for management of the patient when transferred to a WH ward.
- All North London NHS Foundation Trust working at Whittington Health NHS Trust staff to have access to generic CareFlow login

8.2.2. Clear Mental Health Service structures

- Service structure changes to be communicated clearly with other services.
- Agency MH staff: induction on ED-to-ward pathway for Mental Health patients
- Parallel assessments and ongoing assessments to continue in ward environments

8.2.3. Staff training on use of legal frameworks

- Increased understanding of use of frameworks at ward level
- Use of frameworks for Security staff, SOP to be developed

8.2.4. Roll out of comparable escalation process to CODE 10, to AAU wards

8.3. Learning Response Tool Analysis SEIPS

Select as applicable	Further Details
Tools and Technology	• Immediate uploading of MHLT notes to CareFlow • Development of Ward MHLT template on CareFlow
Tasks	• Handover between ED and AAU and MH teams was inconsistent • Parallel assessments and ongoing assessments to continue in ward environments
Person	• Communication failures .1. Patient's partner raised concerns repeatedly but felt dismissed. .2. MHCAS received calls from Whittington Health but unclear guidance was given about 5(2) and next steps. • Staff were over focused on capacity structure being in place to be able to hold the patient. • Security staff hesitant to hold • Incorrect information provided about ability to hold a patient on the ward
Organisation	• Mental health pathway confusion (ED vs ward teams)
Internal Environment	• AAU sometimes functions like an overflow for ED mental health patients, but in MH Services is treated as a ward.

External Environment	• Service redesign of mental health services with the positive use of MHCAS • Timely MH assessments away from EDs • Weekends and nights create additional gaps (liaison team not present; reliance on MHCAS).

9. Next of Kin questions

The coroner forwarded concerns raised by [redacted] ex-partner. Some of which can be addressed below:

9.1. The photograph of the Fit Note from the GP Surgery and the GP medical record requested by family on [redacted]. This should be addressed by the GP.

9.2. The Emergency call from [redacted] to London Ambulance Service (LAS).

This needs to be addressed by LAS.

9.3. The photograph of the medical paperwork dated [redacted]. Whittington Health NHS Trust identified this as a test paper for electrocardiogram equipment (ECG).

9.4. The photograph of a notification from Lambeth Children's Home Court Case.

Whittington Health is unable to comment on this.

9.5. [redacted] tried to access services at Highgate Hospital but was denied access.

This is not addressed in this report and is for the North Londen Foundation Trust to respond.

9.6. The number mentioned in the concerns raised that contacted [redacted] ex partner has been identified as the Gastro service at Whittington Health.

9.7. The family was not consulted on how [redacted] body should be kept.

The mortuary preserves the body by keeping the body frozen, the mortuary at Whittington Health is being redeveloped and can therefore not offer any visits to families.

10. Appendices

10.1. Appendix 1 – Terms of Reference

1. What clinical pathways are used in ED and AAU for patients presenting with mental health issues and are there any barriers and facilitators that impact on the care the patient receives on this pathway?
    a. Was the patient's capacity assessed on presentation and was this documented?
    b. Was a 1:1 considered?
    c. Was a referral to MHLT made timely?

d. How was the discharge from the MHLT communicated?

e. What legal framework is available in ED and on the Ward?

f. Was this an absconsion if [redacted] was not being held on any legal framework?

2. How are decisions communicated between teams and how are they documented?

    a. ED staff and MHLT staff

        i. Was the patient medically fit for discharge?

        ii. Was the patient completely discharged from MHLT care or was MHLT going to follow up once admitted to a ward?

        iii. What action should be taken if MHLT notes the patient has capacity and does not require 1:1, however if the patient tries to leave, they should have another capacity assessment?

    b. ED staff and Security staff

3. How did the internal environment, technology & tools, organisation of work (i.e. staffing, resource allocation culture etc person (i.e. leadership teamwork roles and responsibilities) tasks and external influences impact on clinical decision making

4. Exploring the acuity on the shift and other incidents that might have influenced decision making during the shift.

5. Learning from previous events,
    a. [redacted] Patient escorted from ED and committed suicide [redacted]
    b. [redacted] Patient absconded from ED and was found on Archway tracks [redacted]
    c. [redacted] Patient committed suicide after discharge from ED [redacted]
    d. [redacted] Patient committed suicide after discharge ED [redacted]
    e. Veritas report [redacted]

10.2. Appendix 2 - Timeline / patient journey map

10.2.1. On [redacted] at [redacted]: [redacted] was brought in by Ambulance (BIBA) following suicide attempt. [redacted] was assessed by a medical doctor to have no capacity to leave the department: impairment of mind due to active psychosis, unable to weigh up information given. Accepted by the medical team for admission at [redacted].

10.2.2. Initial assessment by Mental Health Liaison Team (MHLT) at [redacted] showed active hallucinations, suicidal risk, lacked capacity; placed on 1:1 supervision. To be assessed by Liaison psychiatry once medially cleared.

10.2.3. At [redacted] [redacted] asked to go outside for a breath of fresh air and made an unsuccessful attempt to abscond. This information was handed over to the medical team during clerking.

10.2.4. At [redacted] a formal capacity assessment was documented in Emergency Department (ED). [redacted] was deemed not to have capacity to weigh up information by the medical team.

10.2.5. In ED [redacted] is off and on secluded due to repeated absconding attempts and fluctuating behaviour. Remained on 1:1 during the night shift.

10.2.6. On [redacted] at [redacted] a note from Whittington Health Mental Health Liaison Team (WHMHLT) is added to CareFlow: Medical team request for MHLT to see [redacted] due to escalating behaviour, attempt to de-escalate unsuccessful and [redacted] was secluded and placed on Mental Capacity Act (MCA). Plan to remain on 1:1 and the fully assess by MHLT when medically optimised.

10.2.7. At [redacted] – Medical Team Consultant noted on CareFlow; Reviewed by Psychiatric Liaison Nurse (PLN); [redacted] was discharged from MHLT with crisis contact provided. [redacted] left ED for a cigarette and did not return; police welfare check was initiated at 11.12hrs. Medical staff was concerned as the medical treatment was not completed. [redacted] returned to ED at [redacted] on [redacted] own and further treatment commenced. Plan to complete Esophagogastroduodenoscopy (OGD) to assess degree of oesophageal damage.

10.2.8. At [redacted] MHLT note added to CareFlow by the MHLT. Date and time of the assessment [redacted]. [redacted] declines to have a full discussion and states that [redacted] feels fine after having sobered up. States [redacted] has a good support system and denied currently having any thoughts of ending his life. [redacted] is aware of Community Single Point on Access (CSPA) and the number of the Crisis Line was given.

10.2.9. Part 2 of the MHLT assessment is uploaded to CareFlow at [redacted]: Further history was taken including the Mental Status Examination (MSE), which mentions that [redacted] has insight in to [redacted] difficulties and feels [redacted] can seek for help. There is no reason to doubt [redacted] capacity to make decision around [redacted] treatment and care, demonstrating that he can retain, weight and repeat information.

10.2.10. Part 3 of the MHLT assessment is uploaded to CareFlow at [redacted]: [redacted] reported that last night's incident was spur of the moment and [redacted] denied any current suicidal thoughts, plan or intent. Plan: discharge from Psychiatric Liaison

10.2.11. At [redacted] a referral for the OGD is booked.

10.2.12. At [redacted] the anaesthetist assesses [redacted] for the OGD, [redacted] now declines the OGD. Noted that risk of not having the investigation explained and that [redacted] has capacity to make this decision.

10.2.13. [redacted] - Admitted to Mary Seacole South Ward (MSS); self-discharged at [redacted] against advice (with a friend). Doctor raised concerns regarding capacity and suicide risk; LAS and Police informed but unable to assist as there is no known location for [redacted]. The friend was contacted who confirmed [redacted] was with her.

10.2.14. Returned to ED at [redacted]; [redacted] was allocated to the Medical Over Flow (MOF) chairs

10.2.15. On [redacted] at [redacted] [redacted] was referred to MHLT

10.2.16. At [redacted] MHLT review states that [redacted] was fully assessed yesterday. Unable to confirm whether [redacted] has suicidal ideation. [redacted] is unable to recall being seen by the Mental health liaison nurse. Plan for further review when medically ready for discharge.

10.2.17. At [redacted] a further MHLT review on CareFlow states, for ongoing review. [redacted] is not suitable for an acute mental health bed given [redacted] low level of risk. No 1:1 required.

10.2.18. [redacted] is transferred to MSS at [redacted]

10.2.19. At [redacted] a discussion with [redacted] family friend expressing being extremely concerned about [redacted] behaviour. Plan to re-contact MHLT.

10.2.20. At [redacted] an MSE completed by medical team, showing [redacted] is not able to remember meeting the same doctor yesterday and now having active delusions.

10.2.21. Referral to MHLT completed at [redacted]

10.2.22. At [redacted] the MHLT in ED are intending to review [redacted], however [redacted] has moved to MSS ward and the MHLT notes on CareFlow: No further action from MHLT medically admitted to MSS

10.2.23. At [redacted] the MSS Nurse queries MH review due to ongoing behavioural concerns. The doctor contacts the MHLT and raised concerns that there was no MH input or further assessment after the referral at [redacted]. MH team advised that documentation isn't clear but refers to the fact that MH teams change when patients are medically admitted to a ward. MH review is agreed to review, and a referral is made to the MH for wards. Advised capacity assessment in the moment if attempts to leave, as [redacted] mental state is fluctuant. Whittington Health staff were not aware of this as the last entry from the MHLT noted [redacted] had capacity, the crisis number was also provided, and [redacted] was discharged from the MHLT.

10.2.24. [redacted] [redacted] leaves the ward during handover time. Nurses encouraged [redacted] to stay and called security. Notes in CareFlow state, Nurse not able to legally able to restrain forcefully. Nurse in Charge informed security the patient was not on any legal framework. Security unable to restrain [redacted] as there is no legal framework in place. The fact that [redacted] has already been discharged by the MHLT nurse, a medical adult nurse would have not felt it to be appropriate and comfortable to go against this advice.

10.2.25. [redacted] [redacted] Next of Kin (ex-partner) informed.

10.2.26. On [redacted] at [redacted], [redacted] was brough in by ambulance, [redacted] was found hanging in a park. CPR commenced by emergency services, downtime was unknown.

10.2.27. At [redacted] ED doctor spoke with Mr [redacted] son and friend

10.2.28. At [redacted] CPR stopped in ED patient deceased. Family asked to come and see [redacted]. Time of death [redacted]

10.2.29. Medical Examiner review and referral was made to the coroner on [redacted].

10.3. ToR reference 5

Previous investigations actions relevant to this case focussed on:

10.3.1. Veritas report [redacted];

- Whittington Health (WH) and Camden & Islington Mental Health Trust (C&IMHT) work together to establish a memorandum of understanding to facilitate joint investigations. This was completed and the trust have worked together on several investigations since.
- The existing mental health 4-hour review pro-forma has been added to electronic system, Medway (previous system to CareFlow). Camden & Islington Integrated Liaison Assessment Team (C&I ILAT) staff complete this form, and conduct reviews every four hours for service users that stay for longer periods of time in ED, creating a robust, retrievable and auditable record of these reviews. This is available on CareFlow.
- Co-location of psychiatric liaison service within ED. This is in place.

10.3.2. MH pack for ED, this was developed in 2022 and is still in place.

10.3.3. Fortnightly meeting with Whittington Health NHS Trust and MHLT were set up in 2022. Currently this is replaced by a daily meeting discussing ED and ward-based MH patients at 11 am. There is a further monthly meeting on Thursdays.

10.3.4. Adult Missing Patient Policy was developed in 2023; this includes information on contacting relatives and police. This is in date and available to staff on the Whittington Health NHS Trust intranet.

10.3.5. ED staff have received MH awareness training including communication and escalation processes to follow when working with patients with under MH services. This training is ongoing and delivered on a continuous basis.

10.3.6. Introduction of CODE 10 protocol within the ED department. This was in place in May 2025 and There is an opportunity to implement a comparable CODE 10 approach within AAU wards.

10.3.7. LAS handover documentation to be added to a shared drive so it is available for all to see. This is in place.

10.3.8. Training around capacity assessments for ED nursing staff was identified in the last PSII Dec 2025. Band 7 nurses have had Mental Health focused sessions in last 6 months. There has been further training organised by the MHLT for all WH staff ED and ward staff.

11. Safety Action Summary Table:

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
1	Improvement to documentation	Create a template 'MHLT Mental Health Patient Care Plan' on CareFlow for ward environment.	[redacted] Matron	01/06/2026		Audit of compliance in using template once available on CareFlow	N/A	EIM Quality Committee	01/11/2026	
		MHLT Handovers to clearly state updated action plans in place for management of the patient when transferred to the ward.	[redacted] Team Manager for the Whitington MHLT	01/05/2026		Audit	Monthly	EIM Quality Committee	01/08/2026	
		All North London NHS Foundation Trust (NHSP) staff to have access to generic CareFlow login	[redacted] Team Manager for the Whitington MHLT	01/05/2026		N/A	N/A	EIM Quality Committee	01/05/2026	
2	Clear Mental Health Service structures	Service structure changes to be communicated clearly with other services.	[redacted] Team Manager for the Whitington MHLT	01/05/2026		Email confirmation	N/A	EIM Quality Committee	01/06/2026	

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
		Review of the Service Level Agreement between Whittington Health Trust and North London Foundation Trust.	[redacted] Chief Nurse Whittington Health NHS Trust	01.06.2026		Contract reviewed and renewed	As per SLA agreement	Trust Mental Health Steering Group	As per SLA agreement	
		Agency MH staff: induction on ED-to-ward pathway for Mental Health patients	[redacted] Team Manager for the Whitington MHLT	01/05/2026		Email confirmation	N/A	EIM Quality Committee	01/06/2026	
		Parallel assessments and ongoing assessments to continue in ward environments	[redacted] Team Manager for the Whitington MHLT	01/05/2026		Email confirmation	N/A	EIM Quality Committee	01/06/2026	
3	Staff training on use of legal frameworks	Increased understanding of use of frameworks at ward level	[redacted] Matron	01/05/2026		Audit	Monthly	EIM Quality Committee		
		Use of frameworks for Security staff, SOP to be developed	[redacted] Security Manager	01/05/2026		SOP available to Security staff	N/A	Security Service	01/06/2026	

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
4	Roll out of comparable escalation process to CODE 10, to AAU wards	To develop a comparable escalation process as CODE 10 for the wards, SOP to be rolled out	[redacted] Matron Rahat Ahmed, Security Manager	01/05/2026		SOP available	Monthly	EIM Quality Committee	01/06/2026	

Patient Safety Incident Investigation (PSII) Report - Summary

Date of Incident	12/09/2025
Incident ID Number	A132115
PSII Approved By	[Redacted]
Job Title	Co-Clinical Director (Women's Health), Acute Patient Access, Clinical Support Services and Women's Health Division
Signature	[Redacted] 30th March 2026
Date Approved at Whittington Improvement & Safety Huddle (WISH)	24th April 2026
Date Presented at Quality Assurance Committee	
Date Noted at Trust Board	

1. Executive Summary

1.1. Incident Overview

1.1.1. A [Redacted] with known safeguarding concerns gave birth at Whittington Health and was staying on the postnatal ward with her newborn baby. Staff had identified a new safeguarding concern that needed to be explored to ensure both mother and baby were safe.

1.1.2. Staff were advised that the family should remain in hospital until a Discharge Planning meeting could be arranged. However, there was confusion among staff about who should organise this meeting, and the Safeguarding Midwives were not available at the time to guide the process.

1.1.3. Before the Discharge Planning meeting could take place, the baby was removed from the postnatal ward by a family member. Because the staff were not aware the baby had left, and the baby was not wearing an electronic security tag, staff were unable to confirm the baby's location. As a precaution, the staff activated Code Yellow, an emergency procedure used when a baby is removed from the postnatal ward unexpectedly.

1.1.4. The emergency response was activated quickly, and the baby was soon confirmed to be safe with family members.

1.1.5. The Investigation Team has since reviewed the incident and identified several improvements to ensure clearer communication, better safeguarding processes, and safer discharge planning in the future.

1.2. Summary of Key Findings

1.2.1. The investigation identified multiple system-level weaknesses across the antenatal, postnatal, and emergency response stages that contributed to the safeguarding risks in this case.

1.2.2. **Safeguarding information was not reliably shared.** Safeguarding concerns identified in the Paediatric Emergency Department were not passed on to Maternity or Health Visiting teams. Fragmented electronic systems, outdated referral forms, and inconsistent monitoring of safeguarding inboxes resulted in missed or unacted referrals.

1.2.3. **Incorrect or incomplete safeguarding processes were used.** Use of outdated Muti-Agency Safeguarding Hub (MASH) referral form, resulting in the referral not reaching Muti-Agency Safeguarding Hub. Safeguarding plans were not documented on the correct proforma, making them difficult to locate on the EPR (Electronic Patient Record).

1.2.4. **Staff knowledge, confidence, and role clarity varied significantly for safeguarding processes.** Staff were unsure about how to arrange Discharge Planning meetings, legal limitations regarding enforcing a parent to remain on the postnatal ward, and escalation pathways when Safeguarding Midwives were absent.

1.2.5. **New safeguarding concerns were identified postnatally but not acted upon effectively.** Concerns relating to the [Redacted] presence, advice from the Health Visitor to make a Muti-Agency Safeguarding Hub referral, and the need for Children's Social Care involvement were not consistently documented or actioned.

1.2.6. **Discharge planning processes were unclear and inconsistently applied.** No Discharge Planning meeting was organised with Children's Social Care involvement. The Muti-Agency Safeguarding Hub referral recommended by the Health Visitor was not completed.

1.2.7. **The baby was removed from the postnatal ward before formal discharge.** No security baby tag was applied and no documented refusal, the postnatal ward entrance/exit was not being actively monitored, and staff were unaware the baby had left until the mother informed them.

1.2.8. **Code Yellow was activated appropriately, but policy use was inconsistent.** The emergency response was largely effective, but the correct

proformas were not used, not all staff understood their Code Yellow roles, the policy was difficult to find on the Trust Intranet, LAS (London Ambulance Service) was contacted unnecessarily, and Police involvement was not well documented.

1.2.9. **There were missed opportunities throughout the pathway.** Earlier, clearer risk assessments (including regarding the father), correct documentation, and timely multi-agency communication could likely have prevented the need for a Code Yellow response.

1.3. Summary of Areas for Improvement and Associated Safety Actions

1.3.1. The investigation identified three key areas requiring improvement to strengthen safeguarding practice and prevent recurrence.

1.3.2. **Strengthening Safeguarding Information Sharing and Record Keeping**

- Implement a reliable process so Paediatric Emergency Department safeguarding information is routinely shared with the Maternity Safeguarding Team.
- Ensure all staff understand and follow the correct Muti-Agency Safeguarding Hub referral pathway through targeted education and study days.
- Reinforce consistent record-keeping across EPR systems, including uploading Muti-Agency Safeguarding Hub referrals and ensuring liaison between community and maternity teams.
- Promote a Think Family approach to ensure risks related to all household members, including fathers, are assessed and documented.

1.3.3. **Improving Staff Capability, Training and Confidence in Safeguarding Processes**

- Strengthen staff training on transparent, collaborative communication with families in safeguarding contexts.
- Educate staff on the legal framework relating to parents leaving hospital, clarifying what can and cannot be enforced.
- Build staff confidence in managing safeguarding concerns independently when specialist midwives are not available.

- Continue to complete annual live Code Yellow emergency drills to improve familiarity and operational readiness, including Code Yellow responsibilities for Gold, Silver, and Bronze Teams on call.

1.3.4. **Strengthening Policies, Standard Operating Procedures and Organisational Structure**

- Improve intranet search functionality so the Code Yellow policy is easily found.
- Update the Baby Tagging Policy to clarify actions when parents decline an XTAG (security tag which is applied around the baby's ankle) without a Child Protection Plan (CPP) in place.
- Review and clarify Standard Operating Procedures for maternity safeguarding cover arrangements, ensuring appropriate skill mix and EPR access.
- Update the Code Yellow proforma to include mandatory escalation to Maternity Senior Leadership.
- Drive organisational culture change to reduce over-reliance on Safeguarding Midwives and embed safeguarding responsibility across maternity teams.

1.3.5. The safety actions address areas for improvement in information sharing, staff competency, and system preparedness, aiming to prevent recurrence and strengthen maternity safeguarding across Whittington Health. Once implemented, these actions will provide clearer processes, improve staff confidence, and ensure safer, more coordinated care for vulnerable mothers and babies.

NHS
Whittington Health
NHS Trust

Patient Safety Incident Investigation (PSII) Report

Date of incident	[Redacted]
Incident ID number	[Redacted]
PSII Approved by (Division)	[Redacted]
Job Title	Associate Director of Nursing for EIM
Signature	[Redacted] 01.06.26
Date Approved at the Whittington Improvement Safety Huddle (WISH)	05/06/2026
Date Presented at Quality Assurance Committee	08/07/2026
Date noted in Chairs Report at Trust Board	

Participants of the PSII	
Name	Role
[Redacted]	Clinical Investigator and co-author - Consultant Haematologist
[Redacted]	Co-author - Patient Safety Information Manager
[Redacted]	Patient Advocate - Patient Safety Partner
[Redacted]	Consultant Haematologist
[Redacted]	Locum Consultant Haematologist
[Redacted]	Specialty Registrar
[Redacted]	ST1, ACCS-EM
[Redacted]	Ward Nurse
[Redacted]	Matron for AAU, SDEC and Infusion Unit

Distribution list	
Name	Position
[Redacted]	Consultant Haematologist
[Redacted]	Locum Consultant Haematologist
[Redacted]	Specialty Registrar
[Redacted]	ST1, ACCS-EM
[Redacted]	Ward Nurse
[Redacted]	Matron for AAU, SDEC and Infusion Unit
[Redacted]	Quality and Risk Manager for EIM
[Redacted]	Associate Director of Nursing for EIM
[Redacted]	Clinical Director for EIM
Whittington Improvement & Safety Huddle (WISH)	Panel members for approval
Quality Assurance Committee	Panel members for presentation
Trust Board	Panel members for noting.

1. About patient safety incident investigations

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

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

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

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

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

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

2. A note of acknowledgement

The learning response team would like to thank the healthcare staff who engaged with the investigation, for their openness and willingness to support improvements in this area of care. Your insights into how care is delivered for our patients at Whittington Healthcare NHS Trust has helped us to understand what happened. We know that we have committed, professional and caring staff working at the Whittington. We know you go to work every day aiming to deliver safe patient care.

Our role as learning response leads is to gather insight into the healthcare settings and systems in which you work: Our focus has been on how teams working in our Emergency Department, Haematology, Pain Management and Thorogood Ward work together to deliver patient care. The challenges, constraints and demands that you work with, and how systems factors impact on safe patient care. We are not here to judge or criticise; we are here to facilitate learning in a caring, supportive and collegiate way. The insights and contributions of participating staff informed the findings of this report and ensured that quality improvement measures and safety actions were appropriately identified.

Thank you.

3. Contents

4. Executive summary

4.1. Incident overview

4.1.1. On [Redacted], [Redacted], a patient with known sickle cell disease whose care is managed by the Whittington Hospital, presented to the Emergency Department (ED) with back, abdominal and hip pain. Initial observations were recorded as normal, and [Redacted] individualised sickle cell pain protocol commenced.

4.1.2. On [Redacted], [Redacted]was admitted to Thorogood Ward. The management plan, for [Redacted] pain control was for oral-only pain medication, confirmed by the Haematology team. During the transfer between ED and Thorogood Ward, [Redacted] analgesia prescription was no prescribed without explanation, likely inadvertently.

4.1.3. During admission, [Redacted] intermittently did not engage with observations and blood tests, despite multiple requests from the Haematology team. This non-engagement appeared to be influenced by [Redacted] pain levels at the time. Venous access was also challenging, though blood test results were obtained on [Redacted] and [Redacted]. Within the 12 hours before [Redacted] death, [Redacted] pain control had been changed to parenteral morphine using a patient-controlled analgesia (PCA) device. This PCA was bolus-only, meaning it did not provide a continuous background infusion; instead, the patient needed to be awake and alert to self-administer analgesia. The dose used was not considered high, particularly given [Redacted] known high opioid tolerance.

4.1.4. On [Redacted], at approximately [Redacted], [Redacted] became unresponsive and had a pulseless electrical activity (PEA) cardiac arrest. [Redacted] was resuscitated and had a return of spontaneous circulation (ROSC) was achieved. However, following intubation, [Redacted] experienced a second PEA arrest later that morning. Despite resuscitation efforts, [Redacted] passed away at [Redacted].

4.2. Summary of key findings

4.2.1. **Pain Management Challenges** – There was unintended interruption to [Redacted] analgesia prescription during transfer of care from ED to Thorogood Ward; disagreement between [Redacted] and the clinical team regarding the appropriate pain protocol; incomplete observations following initiation of PCA (according to the PCA policy).

4.2.2. **Patient Engagement and Monitoring** – [Redacted] frequently did not engage in observations, blood tests, and clinical reviews which resulted in limited ongoing

assessment and monitoring, with escalation not always occurring in a timely or consistent manner.

4.2.3. **Deterioration Recognition** – Earlier indicators of escalating pain and risk were present; however, [Redacted] experienced rapid clinical deterioration overnight.

4.2.4. **Communication and Documentation** – There was inconsistent handover communication between ED and Thorogood Wood staff, and the absence of active verification and documentation of Next of Kin details limited timely involvement and escalation.

4.2.5. **Escalation and Emergency Response** – Timely response was made to both cardiac arrests.

4.3. Summary of areas for improvement and associated safety actions

4.3.1. **Pain Management and Protocol Implementation**

Improve consistency and continuity in the implementation of pain management protocols for patients with Sickle Cell Disease, ensuring adherence to agreed analgesia plans and uninterrupted pain management during transfers of care.

4.3.2. **Monitoring, Patient Engagement, and Escalation**

Strengthen processes for managing repeated non-engagement of observations, blood tests, and reviews, ensuring timely escalation, shared decision-making, and senior clinical oversight.

4.3.3. **Venous Access Planning**

Enhance early identification and management of patients with difficult venous access for taking bloods, to reduce delays in essential blood investigations and improve biochemical monitoring.

4.3.4. **Recognition and Response to Deterioration**

Improve early recognition of clinical deterioration in high-risk sickle cell patients, particularly overnight, with proactive escalation when early warning signs are present.

4.3.5. **Opioid and PCA Risk Management**

Strengthen monitoring and multidisciplinary oversight of patients requiring high-dose opioids and PCA use, with early involvement of pain specialists to mitigate risks such as respiratory depression and timely observations in accordance with the PCA policy.

4.3.6. **Communication, Documentation, and Next of Kin Processes**

Improve clarity and consistency of communication between clinical teams, documentation of agreed care plans and verification of Next of Kin details.

4.3.7. **Learning from Emergency Response**

While emergency response to cardiac arrests was timely and appropriate, further learning should focus on upstream prevention and mitigation of deterioration rather than resuscitative care alone.

5. Duty of candour

Different elements	Yes	No	Date	By whom?
Was the patient / NoK contacted and apologised to?	☒	☐	01/05/2026	[Redacted]
Was this followed up in writing?	☒	☐	07/05/2026	[Redacted]
Has the family agreed to receive the final report?	☒	☐	Click or tap to enter a date.	[Redacted]
Has the duty of candour been complied with?	☒	☐	07/05/2026	[Redacted]

6. Background and context of the patient safety incident

Patient Background

6.1.1. [Redacted] was well known to the Trust for the management of sickle cell disease (SCD), with Whittington Clinical Haematology team providing [Redacted] specialist care since 2024. [Redacted] condition was complex and challenging to manage, characterised by high frequency, multi-site hospital attendances for pain management and inconsistent attendance at his outpatient clinic appointments.

6.1.2. Between June 2025 and December 2025, [Redacted] attended the Emergency Department on 30 separate occasions, resulting in 10 hospital admissions at the Whittington, and additional attendances and admissions at other organisations. A period of regular red cell exchange transfusions was given during 2025, intended as a disease modifying therapy to suppress abnormal sickle haemoglobin levels and reduce the risk of complications. This treatment did not reduce his hospital presentations or admissions.

6.1.3. The Haematology team's ongoing clinical impression was that [Redacted] was experiencing opiate dependence and chronic complex pain, both related to and exacerbated by long term over-prescription of parenteral opioids. [Redacted] case was discussed at the Haematology red cell multi-disciplinary team meeting (MDT) in [Redacted], and a decision was made to revise [Redacted] local sickle cell pain

management protocol. The revised protocol restricted the prescribing of parenteral opioids to a maximum of three doses on initial presentation, with transition to an oral only opioid regimen if analgesia was still required.

6.1.4. The protocol was intended as a clinical guide, allowing flexibility based on acute assessment, ideally with the Haematology team's input or approval. The rationale for this change was discussed with the [Redacted] on multiple occasions from [Redacted] onwards, including during [Redacted] final admission. The revised pain management approach remained a point of ongoing disagreement between [Redacted] and the Haematology team.

Organisational Background

6.1.5. Throughout [Redacted], Whittington Hospital experienced sustained and exceptional operational pressure driven by very high levels of unscheduled care demand. Trust wide bed occupancy remained consistently above 90%, creating a highly constrained environment for admissions and significantly limiting inpatient monitoring capacity, diagnostic flow, and timely discharge.

6.1.6. These pressures were most acutely felt within the Emergency Department (ED), which manages approximately 110,000 attendances annually, more than double its original design capacity. This longstanding mismatch between demand and infrastructure resulted in chronic crowding, delayed clinical assessment, and severely restricted patient flow.

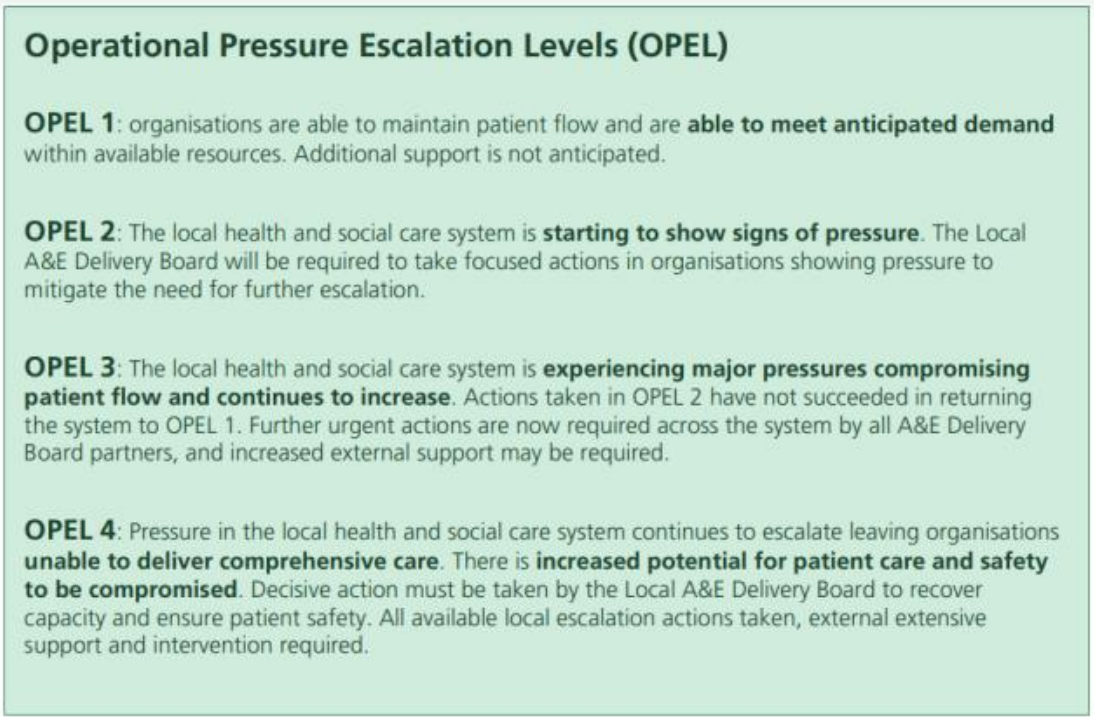
6.1.7. Compounding these challenges, there was a national junior doctor industrial action from [Redacted] to [Redacted], resulting in reduced resident medical staffing across many organisations. At Whittington Hospital, this led to fewer junior doctors on duty, slower clerking and review processes, and increased reliance on senior clinicians and advanced practitioners. Although some specialty teams retained adequate overnight cover, the overall system operated with reduced resilience. Nursing staff levels remained in line with the safer staffing levels planned establishments across the hospital; however, nurses were caring for a high number of acutely unwell patients, with significantly increased workload intensity and operational strain.

6.1.8. On [Redacted], ED demand was particularly high with 322 attendances, exceeding the [Redacted] daily average. Performance against the four-hour standard fell to 58.39%, compared with a monthly average of 68%, and 37 patients waited over 12 hours for admission. These indicators reflected severe difficulty progressing patients

through the system, primarily due to restricted numbers of patients being discharged from the wards and limited bed availability.

6.1.9. At this point, the Trust was operating at OPEL 4, necessitating corridor care, widespread overcrowding, and extended waits for medical review and inpatient admission. Within this context, [Redacted] waited approximately 3.5 hours to be assessed by a doctor and spent a total of 28 hours in the ED before being transferred to an inpatient ward.

- **Opel 4 -** Operational Pressure Escalation Levels (OPEL) are a way for NHS trusts to report levels of pressure consistently. There are 4 OPEL levels, defined as follows:



Operational Pressure Escalation Levels (OPEL)

OPEL 1: organisations are able to maintain patient flow and are **able to meet anticipated demand** within available resources. Additional support is not anticipated.

OPEL 2: The local health and social care system is **starting to show signs of pressure**. The Local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation.

OPEL 3: The local health and social care system is **experiencing major pressures compromising patient flow and continues to increase**. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required.

OPEL 4: Pressure in the local health and social care system continues to escalate leaving organisations **unable to deliver comprehensive care**. There is **increased potential for patient care and safety to be compromised**. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required.

6.1.10. [Redacted] was admitted to Thorogood Ward, a 24-bedded interim wait ward for patients who do not meet the criteria to reside, i.e., those who are medically optimised. Of these, eight beds are ringfenced for haematology patients. As part of winter bed escalation, capacity was increased to 28 beds, with a corresponding increase in staffing levels to ensure safe patient care. Nursing staff have received additional training to support the care of patients with sickle cell disease (SCD), including local training delivered by the Sickle Cell Clinical Nurse Specialist (CNS) team and access to an online SCD learning module. Patient-Controlled Analgesia (PCA) competency is recognised as an additional key skill, and Thurgood nursing staff are encouraged to complete PCA training to enhance the care provided within the unit.

6.1.11. Against a backdrop of hospital-wide occupancy exceeding 90%, Thorogood Ward was operating at near full capacity throughout this period. This resulted in increased pressure on staff workload, coordination of diagnostics, and timeliness of routine medical review.

6.1.12. On the night of [Redacted] deterioration, the ward was also short of one nurse scheduled for duty, due to sickness absence. Staff described this as safe but slightly stretched, with competing and concurrent clinical priorities.

7. Investigation approach

7.1. Investigation Team

Role	Initials	Job title	Department	Other
Lead Clinical Investigator	[Redacted]	Consultant Haematologist	Haematology	
Co-author & investigator	[Redacted]	Patient Safety Information Manager	Quality Governance Team	

7.2. Summary of investigation process

7.2.1. This incident was reported on the Trust's incident reporting system, Datix [Redacted] on [Redacted] and a Rapid Action Review outlining the key facts, was presented at the Whittington Improvement and Safety Huddle (WISH) on [Redacted] by [Redacted], Lead for Resuscitation, and [Redacted], Matron for Acute Assessment Unit (AAU), Same Day Emergency Care (SDEC) and Infusion Unit.

7.2.2. Attendees at WISH were:

- Associate Medical Director for Patient Safety (Chair)
- Acting Chief Medical Officer
- Chief Nurse
- Deputy Chief Nurse
- Associate Director of Quality Governance
- Head of Patient Safety and Legal Services
- Chief Allied Health Professional
- Patient Safety Information Manager
- Deputy Associate Director of Nursing for EIM

- Quality and Risk Manager for EIM

7.2.3. It was formally noted that the incident would be investigated by way of a Patient Safety Incident Investigation (PSII).

7.2.4. Once the PSII is completed, it will be shared with the staff involved for factual accuracy. The final report will be approved by the WISH panel, presented at the Quality Assurance Committee and noted at Trust Board.

7.2.5. Actions identified from the investigation will be monitored through the Emergency & Integrated Medicine Division.

7.3. Terms or reference summary

7.3.1. Staffing and Training

7.3.2. Clinical pathway and Decision-Making Process

7.3.3. Clinical Monitoring/Documentation and Escalation

7.4. Information gathering

7.4.1. [Redacted] notes were reviewed.

7.4.2. Staff involved in Chiamaka's care met with the clinical investigator, co-author and Patient Safety Partner (acting as an advocate for the patient as there was no Next of Kin).

7.4.3. Learning response tools were used to identify key findings, quality improvements and safety actions required

8. Findings

8.1. All Findings

8.1.1. On the night of [Redacted], [Redacted] presented to the Emergency Department (ED) with back, abdominal and hip pain consistent with previous sickle cell pain crises. Initial observations were within normal limits, and clinical assessment found no overt evidence of additional complications such as infection, acute chest syndrome, or haemodynamic or respiratory compromise.

8.1.2. Initial management in ED was clinically appropriate and complied with [Redacted] individualised sickle cell pain management protocol. This included three initial doses of parenteral morphine, followed by transition to an oral morphine regimen, alongside

usual supportive measures, and referral to the acute medical team for further assessment and management. [Redacted] received timely senior review by a consultant physician during the post take ward round at [Redacted] on [Redacted], with a decision made to admit and continue the oral analgesia regimen.

8.1.3. Following transfer from ED to Thorogood Ward late on the night of [Redacted], it was noted that the oral opioid prescription (Sevredol) was no longer active on the electronic prescribing system. A PRN prescription for oral morphine (10–15mg, minimum interval 90 minutes) had been in place from [Redacted] on [Redacted], with a documented administration at [Redacted]. This prescription was discontinued at [Redacted] on [Redacted]; however, there is no documented rationale for this, and it is therefore unclear why this occurred.

- **Sevredol** - Immediate-release oral tablet containing morphine sulphate, used for treating severe pain, often for acute pain.

8.1.4. As a result, there was an approximate 5-hour period ([Redacted] on [Redacted]) during which no active oral morphine prescription was available, potentially contributing to suboptimal pain control.

8.1.5. Once [Redacted] requested analgesia and the issue was identified by ward staff, the on-call medical team responded promptly, prescribing and administering two stat doses of oral morphine 10mg at [Redacted] on [Redacted] and [Redacted] on [Redacted]. While this demonstrates an appropriate and timely response to [Redacted] immediate pain requirements, an ongoing PRN prescription could have been reinstated overnight rather than relying on individual stat doses.

8.1.6. A regular PRN prescription of oral morphine (10mg, minimum interval 2 hours) was subsequently reinstated by the haematology team at [Redacted] on [Redacted].

8.1.7. During the admission, [Redacted] was reviewed regularly by the Haematology team, including early senior review during the consultant ward round on the morning of [Redacted]. Further discussion took place regarding the rationale for the oral only opioid regimen and attempts were made to engage [Redacted] in shared decision making. Despite this, [Redacted] continued to express dissatisfaction with [Redacted] pain management.

8.1.8. Given the persistence of hip pain, possible orthopaedic pathology was appropriately considered, with imaging and specialist opinion arranged. [Redacted] continued to report significant pain, and during a clinical review on the morning of [Redacted], visible distress was documented in [Redacted] medical notes. At this point, analgesia was escalated to parenteral opioids. Appropriate investigations, including a chest x-ray and abdominal ultrasound (in response to the mildly abnormal liver function

tests (LFT)), were arranged promptly and did not identify any significant acute pathology.

- **Parenteral Opioids** - Used for rapid, effective management of severe pain, particularly when the oral route is compromised by vomiting, dysphagia, or in emergency/postoperative settings.
- **Liver Function Tests (LFT)** - Blood tests that measure enzymes, proteins, and bilirubin to evaluate liver health, check for damage, inflammation, or infection.

8.1.9. Later that evening, on [Redacted], because of persistent uncontrolled pain, a clinical decision was made to commence parenteral morphine using a bolus only patient controlled analgesia (PCA) device. This was started at approximately [Redacted] under the supervision of the anaesthetic team. Nursing staff appropriately escalated concerns regarding ongoing severe pain while on the PCA, and anaesthetic staff reviewed [Redacted] on multiple occasions overnight, including spending prolonged periods attempting to secure intravenous access. From the anaesthetic perspective, staffing levels were consistent with a standard night shift and the decision to initiate PCA was considered clinically appropriate given [Redacted] escalating needs for analgesia.

- **Patient Controlled Analgesia (PCA)** - A pump system allowing patients to self-administer preset doses of IV opioids for pain control.

8.1.10. Nursing observations recorded overnight up to [Redacted] on [Redacted] did not trigger escalation using the National Early Warning Score (NEWS), with documented parameters within expected limits. Review of practice indicates that the NEWS policy was the primary framework for monitoring and escalation. This contributed to reduced adherence to the PCA policy, which requires enhanced and more frequent observations for patients receiving PCA. As a result, the frequency of observations undertaken was lower than would be anticipated for a patient on PCA.

- **National Early Warning Score (NEWS)** – A tool used to determine the degree of illness of a patient using six physiological findings and one observation.

8.1.11. A CT scan of the hip, as recommended by the orthopaedic team, was performed at approximately [Redacted] on [Redacted], requiring transfer to and from the Radiology department; PCA analgesia remained available throughout.

8.1.12. At [Redacted] on [Redacted], nursing observations identified a marked deterioration in oxygen saturations to below 70%, followed by loss of responsiveness. [Redacted] experienced a pulseless electrical activity (PEA) cardiac arrest. Return of spontaneous circulation was achieved following cardiopulmonary resuscitation,

administration of Naloxone, and treatment of hypoglycaemia. Severe metabolic derangements, including significant acidosis and hypoglycaemia, were identified.

- **Pulseless electrical activity (PEA)** - A form of cardiac arrest where the heart shows organised electrical activity on an electrocardiogram (ECG) but no mechanical contraction, resulting in no detectable pulse.
- **Cardiopulmonary resuscitation** - An emergency procedure combining chest compressions (100–120/min) and rescue breaths to maintain blood flow and oxygenation during cardiac arrest.
- **Hypoglycaemia** - Blood glucose below 4.0 mmol/L
- **Acidosis** - A condition characterised by an excess of acid in the blood and body tissues.

8.1.13. Shortly after intubation and insertion of invasive monitoring lines, [Redacted] suffered a second cardiac arrest. Despite prolonged and advanced resuscitation efforts, return of spontaneous circulation could not be achieved, and [Redacted] was pronounced deceased at [Redacted].

8.1.14. A post-mortem examination confirmed that [Redacted] died from a fat embolism. Following further review with the Haematology team, it is recognised that while patients with sickle cell disorder are at risk of fat embolism syndrome (FES), this is a rare complication. There were no signs or symptoms suggestive of FES on admission, and [Redacted] did not fall into a high-risk category as described in published national cohorts (which more commonly include clinically non-severe patients, such as those with HbSC).

- **Haemoglobin SC (HbSC) Disease**: A type of sickle cell disease characterised by episodes of pain and anaemia, caused by red blood cells breaking down more quickly than normal.

8.1.15. There are no definitive diagnostic tests for fat embolism; it remains a clinical diagnosis and is often only confirmed at post-mortem. Review of the case has been limited by a lack of detailed documentation in regard to observations, making it difficult to establish a clear trajectory of deterioration. If a gradual “drift” had been evident, escalation to urgent red cell exchange and consideration of plasma exchange might have been possible. However, given that [Redacted] was clinically stable enough to undergo CT imaging in the early hours and that the deterioration appears to have been acute, such interventions would likely not have been feasible.

- **Fat embolism syndrome (FES):** A clinical condition characterised by the widespread release of fat emboli into the systemic circulation. These emboli

obstruct the capillary network, impair microcirculation, and trigger a systemic inflammatory response.

Observation Overview

8.1.16. Throughout the admission, [Redacted] intermittently declined routine observations and blood tests, despite repeated explanation by the Haematology team regarding their clinical importance. Difficult venous access also contributed to delays in obtaining blood samples. Nevertheless, blood results were available on [Redacted] and [Redacted], and abnormal findings (including deranged liver function tests) were acted upon appropriately. There were no clear biochemical indicators of any additional acute pathology, nor predictors of the subsequent rapid clinical deterioration.

8.1.17. Non-engagement of treatment or investigations should be clearly documented in the patients notes with risks and consequences explained by staff. Capacity should be considered where appropriate, with escalation to senior clinicians if concerns arise. While non-engagement was acknowledged clinically and efforts were made to re-engage [Redacted], documentation does not consistently demonstrate full adherence to this procedure. In particular, there is limited evidence of recorded capacity considerations, senior escalation decisions, or clearly documented mitigation plans following non-agreement (such as agreed minimum observation sets, adjusted monitoring strategies, or review timeframes).

8.1.18. There is no documented evidence that [Redacted] inability to engage triggered a formal assessment of potential confusion related to his medical status or a structured mental capacity assessment. [Redacted] was generally described as alert, communicative, and able to articulate [Redacted] wishes, and [Redacted] inability to engage was therefore interpreted as deliberate and informed. However, there is limited documentation demonstrating explicit consideration of whether pain, opioids, metabolic disturbance, or evolving clinical illness might have affected his capacity at specific times.

8.1.19. With respect to physiological observations, the principal gap identified was during the final six hours prior to the first cardiac arrest. This period immediately followed PCA initiation, during which Trust PCA policy indicates a requirement for increased frequency of routine observations. The PCA guideline indicates the following frequency of observations:

- every 30 min. for 2 hours,

- 1 hourly for 4 hours
- 4 hourly if stable until PCA discontinued
- 4 hourly for 24 hours after discontinuation of PCA
- every 5 minutes for 15 minutes after administration of clinician bolus.

8.1.20. The absence of documented observations during this timeframe may have contributed to delayed recognition of deterioration and missed opportunities for earlier intervention. There was limited documentation regarding reasons for missed observations or actions taken to mitigate this risk.

Additional Considerations

8.1.21. It was identified that Next of Kin details had not been checked and confirmed during the admission, which may have limited timely family involvement and opportunities for escalation as [Redacted] condition deteriorated.

8.2. Areas for improvement and associated safety actions

8.2.1. Improve consistency and continuity in the application of sickle cell pain protocols, including clear adherence to agreed analgesia plans and uninterrupted pain management during transfers of care.

- Implement a standardised sickle cell pain management checklist to be used at admission and during all transfers of care, including explicit confirmation of the agreed analgesia plan.
- Introduce a mandatory pain protocol handover section within transfer documentation between ED, wards, and speciality teams to prevent interruptions in analgesia.
- Provide targeted education for medical and nursing staff on implementation of sickle cell pain management protocols, including escalation pathways when concerns arise.

8.2.2. Strengthen processes for managing repeated non-engagement of observations, blood tests, and reviews, ensuring timely escalation, shared decision-making, and senior clinical oversight.

- Develop a clear escalation guideline for repeated non-engagement of observations, blood tests, or reviews, including time and situation-based

triggers for senior medical involvement, to support patient engagement and safety decision making.

- Embed shared decision-making documentation prompts within clinical notes to ensure non-engagement, discussions of risk, and agreed mitigations are clearly recorded.

8.2.3. Enhance early identification and management of patients with difficult venous access to reduce delays in essential blood investigations and improve biochemical monitoring.

- Introduce early venous access risk identification for patients with known or anticipated difficult access, to be documented at admission.
- Promote the use of alternative access strategies (e.g. ultrasound guided cannulation) to minimise delays in investigations.

8.2.4. Improve early recognition of clinical deterioration in high-risk sickle cell patients, particularly overnight, with proactive escalation when early warning signs are present.

- Reinforce early warning score escalation standards for high-risk sickle cell patients, with specific guidance for overnight periods.
- Introduce a high-risk sickle cell marker on ward whiteboards or electronic systems to prompt increased vigilance and proactive review.
- Conduct multidisciplinary safety huddles for patients with escalating pain or repeated monitoring issues incorporating Martha's Rule to empower staff, patients, and families to escalate concerns about deterioration at any time alongside existing clinical escalation pathways.

8.2.5. Strengthen monitoring and multidisciplinary oversight for patients requiring high-dose opioids and PCA use, with early involvement of pain specialists to mitigate risks such as respiratory depression.

- Require early referral to the acute pain team for patients with high opioid requirements or concerns regarding sedation or respiratory risk.
- Provide refresher training for ward staff on PCA management (including the PCA policy).

8.2.6. Improve clarity and consistency of communication between clinical teams, documentation of agreed care plans and verification of Next of Kin details to support timely escalation and involvement.

- Implement an admission checklist requiring active verification and documentation of Next of Kin details, confirmed directly with the patient.

- Improve consistency of multidisciplinary documentation of agreed care plans, including pain management and escalation of care.

8.2.7. While the emergency response to the cardiac arrests was timely and appropriate, further learning should focus on prevention and mitigation of deterioration.

- Disseminate learning from this incident with a focus on upstream prevention, including monitoring, escalation, and analgesia management rather than resuscitation alone.
- Embed identified learning points into ward-based education sessions and safety briefings.
- Review similar high-risk cases to identify themes and system wide improvements.

8.3. Learning Response Tool Analysis – Systems Engineering Initiative for Patient Safety (SEIPS)	
Select as applicable	Further Details
Person	**Patient** • Sickle Cell with recurrent pain crises. • Strong preference for previous IM analgesia protocol; resistant to new protocol (orals only). • At times declined observations and blood tests. • Episodes of shouting in pain and distress behaviours. **Staff** • ED staff (practitioners, nurses). • Medical and haematology teams. • Orthopaedics and trauma teams. • Ward nurses. • Anaesthetists for IV access and PCA initiation. • Porters. **Staff-related factors** • Varied adherence to updated sickle cell pain protocol. • Multiple handovers at shift changes. • Complexity of managing pain in a patient with high analgesic tolerance. • Difficulty obtaining IV access. • Non-response from on-call medical team at one point (phone off-site).
Tasks	**Key clinical tasks required** • Pain assessment and management. • Delivery of the updated sickle cell protocol. • Monitoring observations.

	• Obtaining blood tests. • Imaging: X-ray and CT. • Communication regarding care escalation. • Responding to deteriorating physiology. **Task-related issues** • Pain protocol intermittently discontinued or not followed consistently. • Insufficient dosing of Sevredol within first 24 hours. • Delays and failed attempts at blood sampling. • Difficulty completing abdominal ultrasound. • Delay until PCA initiated despite severe and escalating pain. • Multiple escalations for pain requiring STAT morphine. • Complex decision-making around fracture vs. VOE-related pain. • At time of deterioration, staff attempted escalation but could not reach on-call team.
Tools and Technology	• EPMA for prescribing and protocol implementation. • Ultrasound-guided IV access. • PCA pump for morphine. • Monitoring equipment (observation machines). • London Care Record for recent analgesia history. **Tool-related issues** • EPMA showed incomplete/insufficient dosing but not actioned promptly. • PCA only started very late after prolonged severe pain episodes. • Observations declined by the patient → reduced capacity for early recognition of deterioration. • Phone/bleep communication failure (“doctor on call phone switched off-site”).
Organisation	• Updated sickle cell protocol (September 2025) mandated orals only after first 3 s/c doses, with no IMs. • Multi-specialty involvement (ED, medicine, haematology, ortho, anaesthetics). • Handover processes between teams. • Weekend/OOH staffing model. **Organisational issues** • Complexity of implementing a newly changed protocol in a patient resistant to it. • Unclear governance over analgesia changes during admission (protocol stopped then restarted). • Out-of-hours escalation difficulties. • Coordination problems between teams (orthopaedics reviewing for possible fracture, haematology requesting scans, radiology availability).
Internal Environment	• Busy ED and acute medical ward environment. • Night-time reviews, reduced staffing. • Noise, distress, and emotionally heightened ward interactions.

	• Physical environment constraints: patient could not travel to Thalassaemia Unit in a bed. **Environmental issues** • Movement limitations affecting blood collection. • Night-time overcrowding or delays affecting ability to escalate pain management promptly.

9. Patient advocate questions

9.1.1. Were [Redacted] previous experiences of sickle cell crises or complications considered in decision making?

[Redacted] extensive history of recurrent sickle cell pain crises, frequent ED attendances, admissions, and prior complications was well known to the Trust and clearly informed clinical decision-making throughout the admission. [Redacted] individualised sickle cell pain management protocol had been formally revised in [Redacted] following MDT discussion, specifically in response to [Redacted] pattern of high-frequency presentations, limited benefit from disease-modifying therapy, and concerns regarding opiate dependence and chronic complex pain. Decisions regarding analgesic strategy, escalation, and monitoring during this admission were made within this established context, with regular specialist haematology input.

9.1.2. Did staff clearly explain why the monitoring and tests were needed and the risks, if not carried out?

There is evidence that staff, particularly the Haematology team, repeatedly explained to [Redacted] the importance of routine observations, blood tests, and monitoring, including their role in identifying complications of sickle cell disease and detecting early deterioration. Despite this, [Redacted] intermittently declined observations and investigations. While explanations were given, documentation does not consistently detail the specific risks of non-engagement discussed at each episode or confirm [Redacted] understanding at those points.

9.1.3. When patients do not engage in tests and interventions, was the possibility of patient confusion due to their medical status or a mental capacity issue considered?

The question has been addressed in 8.1.15 of the report.

9.1.4. Is there a procedure for handling patients that do not engage in treatment/tests and was it followed?

This question has been addressed in 8.1.14 of the report.

9.1.5. Were the patient's requests for pain medication considered?

Yes, [Redacted] repeated expressions of distress and requests for improved pain control were acknowledged and acted upon. Analgesia was escalated appropriately over the course of admission, progressing from oral opioids to parenteral opioids and ultimately to PCA morphine under anaesthetic supervision. These decisions reflected ongoing reassessment of pain severity and responsiveness to treatment, balanced against known clinical risks and prior concerns regarding opioid dependence.

9.1.6. If the deterioration was recognised and actioned earlier, would it have made a difference to the outcome?

It is not possible to state this with certainty. [Redacted] experienced a sudden and severe deterioration characterised by profound hypoxia, metabolic derangement and rapid cardiac arrest. Earlier recognition, particularly during the period of reduced observations following PCA initiation, may have allowed earlier intervention, such as escalation of monitoring, reversal of opioid effects, or earlier critical care involvement.

The presence of a designated sickle cell and haematology unit, such as Thorogood, provides an important opportunity to build continuity, rapport, and therapeutic relationships between patients and nursing staff. This familiarity can support earlier recognition of subtle changes in behaviour, cognition, or pain presentation that may precede measurable physiological deterioration and are not always immediately reflected in vital signs alone. Such early cues may prompt timely escalation and review.

While this may have improved the opportunity for intervention, there is insufficient evidence to conclude that earlier action would definitively have altered the final outcome.

10. Appendices

10.1. Appendix 1 – Terms of Reference

10.1.1. Staffing and Training

- Did the Resident Doctor strike affect medical, orthopaedic, anaesthetic or haematology cover? If yes, what mitigations were in place?
- Were there delays in reviewing, prescribing, escalation or transfer of the patient due to staffing shortages or reduced senior decision-maker presence, and if so, what were the mitigating actions in place to manage this?
- Were on-call or night-time medical teams able to respond to 2222 calls?

- What can we learn from the delay or difficulty in obtaining medical review early on 19/12/25?
- Were the nursing staffing levels appropriate for the acuity and dependency of patients on the ward?
- Are all nursing staff appropriately trained and competent in providing sickle cell care, including completion of the available e-learning module, and in the safe use and management of PCA?

10.1.2. Clinical pathway and Decision-Making Process

- Was the sickle cell protocol followed? Is it readily accessible to all staff?
- Was there any evidence that bias or misconceptions about sickle cell–related pain affected clinical decision making, analgesia escalation, or the timeliness of treatment provided?
- What can we learn from the patient's pain management? Was local policy followed and are they in line with national guidelines?
- Were clinical guidelines followed for patient-controlled analgesia (PCA)?
- Was PCA the most appropriate pain relief for the patient?

10.1.3. Observations, Clinical Monitoring and Escalation

- Were the observation intervals suitable and appropriate for a patient on escalating controlled drugs and a PCA?
- What can we learn for a deteriorating patient who does not engage in observations?
- What can we learn from a patient who demonstrates fluctuating levels of engagement with their care?
- Was the patient's pain management plan informed by input from a multidisciplinary team?
- What can we learn from the documentation of care plans and communication between multidisciplinary teams for this patient?
- Were there systemic or process gaps in identifying alternative causes of the patient's pain and deterioration?
- Was a patient specific analgesia care plan completed, up to date, and aligned with the patient's assessed pain management needs?

10.2. Appendix 2 - Timeline / patient journey map

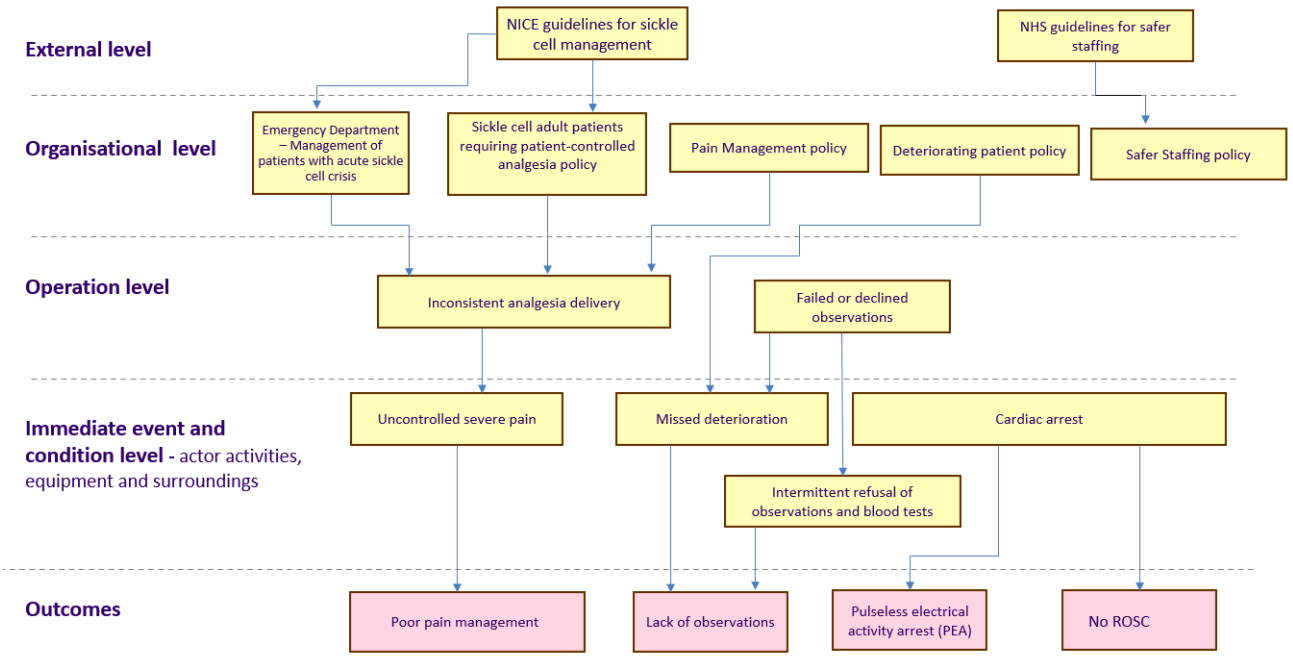
Date / Time	Chronology	Comments
[Redacted]	ED assessment for back, abdominal and hip pain with normal obs.	Initial stable presentation.
[Redacted]	Emergency clerking: VOC suspected; protocol initiated.	Revised oral-focused protocol. Risk of mismatch between patient expectation and protocol.
[Redacted]	ED nursing stable observations.	No deterioration.
[Redacted]	Post-take ward round: admit, continue oral analgesia.	Plan appropriate. Need for bloods uncertain.
[Redacted]	Sickle cell review; disagreement with Chiamaka over protocol.	Communication difficulty. Patient distressed; risk of non-engagement.
[Redacted]	Ortho review: x-ray ordered.	Appropriate escalation. Awaiting imaging.
[Redacted]	Transfer; observations declined; pain protocol stopped unexpectedly.	Analgesia disruption. Unclear discontinuation of protocol.
[Redacted]	Pain under-treated; sevredol inadequate.	Analgesia gap identified. Under-dosing contributed to worsening pain.
[Redacted]	Haem review; [Redacted] verbally abusive;	Escalating conflict. Significant barriers to engagement.

	continues to not engage in protocol.	
[Redacted]	non-engagement of blood tests despite need.	Reduces ability to clinically monitor. Delay in essential investigations.
[Redacted]	Sleeping; declined observations.	Limited monitoring. Repeated obs declined.
[Redacted]	Nursing review stable.	No concerns.
[Redacted]	Agrees to bloods; multiple failed attempts.	Difficult access. Delays blood investigations.
[Redacted]	Escalation to Thal Unit for bloods.	Appropriate step. Delay until specialist team available.
[Redacted]	Severe pain; doctor unreachable; analgesia given later.	Pain escalation overnight. Medical response delay overnight.
[Redacted]	Severe pain; IM morphine given.	Breakthrough pain. Protocol deviation due to severity.
[Redacted]	Improved; behavioural incident; US rebooked.	Inappropriate behaviour. Scan delayed.
[Redacted]	Concern for hip fracture; ortho review.	Significant finding. Possible earlier imaging delay.
[Redacted]	PCA installed due to severe pain.	Appropriate escalation. Late escalation due to recurrent uncontrolled pain.

	[Redacted]	Severe pain; PCA ongoing; CT at [Redacted]; deterioration.	Condition unstable overnight. Possible delay in recognising deterioration. CT confirmed no hip fracture.
	[Redacted]	1st Cardiac Arrest: ROSC achieved.	Severe metabolic disturbance. Potential opioid contribution; hypoglycaemia.
	[Redacted]	2nd Arrest; refractory PEA; death at [Redacted].	Clinical decline unresponsive to treatment.

10.3. Appendix 3 - AcciMap

10.3.1. An AcciMap shows the network of contributory factors involved in this incident. It is a multi-layered diagram which illustrates how various factors at different levels of the system contributed to the incident.



11. References

- Standards for the Clinical Care of Adults with Sickle Cell Disease in the UK (2018)

Sickle Cell Disease in Childhood: Standards and Recommendations

- NICE Quality Standard (QS58): Sickle Cell Disease

NHS Sickle Cell and Thalassaemia Screening Programme Standards

- No-Ones Listening Inquiry

No-Ones-Listening-PDF-Final.pdf

- The use of Patient Controlled Analgesia

The use of Patient Controlled Analgesia (PCA)

12. Safety Action Summary Table:

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
1	Improve consistency and continuity in the application of sickle cell pain protocols, including clear adherence to agreed analgesia plans and uninterrupted pain management during transfers of care.	Implement a standardised sickle cell pain management checklist to be used at admission and during all transfers of care, including explicit confirmation of the agreed analgesia plan	Olivia Kudum Sickle Cell CNS	1/9/2026		Checklist adoption rate Careflow audit	Monthly initially until checklist embedded	EIM Quality Committee		
		Ensure anaesthetic teams add all PCA initiations (including out-of-hours) to the CareFlow Pain Management list and complete the PCA audit form immediately after starting PCA,	Pain Management Team	1/9/2026		PCA referral protocol	Monthly monitoring of PCA referrals	EIM Quality Committee		

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
		particularly for sickle cell patients, to enable Pain Service visibility and timely review.								
		Provide targeted education for medical and nursing staff on implementation of sickle cell pain management protocols, including escalation pathways when concerns arise.	Olivia Kudum Sickle Cell CNS	1/9/2026		Staff training records Elevate module completion records		EIM Quality Committee		

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
2	Strengthen processes for managing repeated non-engagement of observations, blood tests, and reviews, ensuring timely escalation, shared decision making, and senior clinical oversight.	Develop a clear escalation guideline for repeated non-engagement of observations, blood tests, or reviews, including time- and situation-based triggers for senior medical involvement, to support patient engagement and safety decision making.	Dr Emma Draser	1/9/2026		Escalation guideline to be created, to then add to Sickle Cell in Adult Clinical policy Clinical guidelines approval Audit of care records	Monthly	EIM Quality Committee		
		Embed shared decision-making documentation prompts within clinical notes to ensure non-engagement, discussions of risk, and	Dr Emma Draser	1/9/2026		Notes audit (non-engagement & escalation)	Monthly	EIM Quality Committee		

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
		agreed mitigations are clearly recorded.								
3	Enhance early identification and management of patients with difficult venous access to reduce delays in essential blood investigations and improve biochemical monitoring.	Introduce early venous access risk identification for patients with known or anticipated difficult access, documented at admission.	Haematology Team	1/9/2026		Documentation audit Patient feedback	Monthly	EIM Quality Committee		
		Promote the use of alternative access strategies (e.g. ultrasound guided cannulation) to minimise delays in investigations.	Haematology Team	1/9/2026		Datix trends		EIM Quality Committee		

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
4	Improve early recognition of clinical deterioration in high-risk sickle cell patients, particularly overnight, with proactive escalation when early warning signs are present.	Reinforce early warning score escalation standards for high-risk sickle cell patients, with specific guidance for overnight periods.	Kelly Collins ADON EIM	1/9/2026		EWS compliance audit Datix trends		EIM Quality Committee		
		Introduce a high-risk sickle cell marker on ward whiteboards or electronic systems to prompt increased vigilance and proactive review.	Spiwe Jolomole Ward manager Thorogood	1/8/2026		PRR / outreach referrals		EIM Quality Committee		
		Conduct multidisciplinary safety huddles for patients with escalating pain or repeated monitoring issues	Haematology team	1/8/2026		Safety huddle records Marta rule audit		EIM Quality Committee		

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
		incorporating Martha's Rule to empower staff, patients, and families to escalate concerns about deterioration at any time alongside existing clinical escalation pathways.								
5	Strengthen monitoring and multidisciplinary oversight for patients requiring high dose opioids and PCA use, with early involvement of pain specialists to mitigate risks such as respiratory depression.	Require early referral to the acute pain team for patients with high opioid requirements or concerns regarding sedation or respiratory risk.	Dr Emma Draser	1/9/2026		Pain team audit of referral		EIM Quality Committee		
		Provide refresher training for ward staff on recognition of opioid related	Pain Management Team and Olivia Kudum CNS	1/9/2026		Training attendance audit Staff feedback		EIM Quality Committee		

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
		deterioration and PCA management (including the PCA policy).								
6	Improve clarity and consistency of communication between clinical teams, documentation of agreed care plans and verification of next of kin details to support timely escalation and involvement.	Implement an admission checklist requiring active verification and documentation of next of kin details, confirmed directly with the patient.	Spiwe Jolomole Ward manager Thorogood	1/9/2026		NOK verification compliance		EIM Quality Committee		
		Improve consistency of multidisciplinary documentation of agreed care plans, including pain management and escalation of care.	Haematology team	1/9/2026		Documentation audits		EIM Quality Committee		
7	While the emergency response to the	Disseminate learning from this incident.	Patient Safety Team	1/9/2026		Email / WISP / Intranet		EIM Quality Committee		

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
	cardiac arrests was timely and appropriate, further learning should focus on upstream prevention and mitigation of deterioration rather than resuscitative care alone.	Embed identified learning points into ward-based education sessions and safety briefings.	EIM Quality and Governance Leads	1/9/2026		Teaching attendance		EIM Quality Committee		
		Review similar high-risk cases to identify themes and system wide improvements.	Hester De Graag Quality ad Risk Manager for EIM	1/9/2026		Thematic case reviews		EIM Quality Committee		

Meeting title	**Trust Board – public meeting**	**Date: 23.07.2026**
Report title	**Audit & Risk Committee Chair's Assurance report**	**Agenda item: 8**
Committee Chair	Rob Vincent, Non-Executive Director	
Executive lead	Terry Whittle, Chief Finance Officer	
Report authors	Marcia Marrast-Lewis Assistant Trust Secretary, and Swarnjit Singh, Trust Company Secretary, Rob Vincent and Terry Whittle	

Executive summary	This report details areas of assurance from the items considered at the Audit and Risk Committee meeting held on 23 June 2026.
	
	Areas of significant assurance:
	• Internal Audit Annual Report
	• Head of Internal Audit Opinion
	• Internal audit reviews:
	  ○ Duty of Candour
	  ○ Risk management
	• 2026/27Counter fraud progress report and annual work plan
	• Q2 2026/27 Board Assurance Framework
	
	Areas of moderate assurance:
	• Trust risk register
	• Tender waivers and breaches
	• Losses and special payments
	• Debtors' report
	
	The Committee also considered the Quality Assurance Committee Chair's assurance report
	
	The Committee agreed that the following items be escalated to the Trust Board:
	1. Outstanding issues affecting the submission of the annual accounts. The Committee noted that some issues remained the subject of further work and discussion with auditors before submission of the accounts. The further work needed was completed in the following days and the accounts and annual report were then submitted to NHS England, who were kept aware.	

Purpose	Approval	

Recommendations	Board members are invited to: i. note the Chair's assurance report for the Audit and Risk Committee meeting held on 23 June 2026; and ii. approve the Committee's updated terms of reference
BAF reference	All entries
Appendices	1. Audit and Risk Committee terms of reference

Committee Chair's Assurance report

Committee name	Audit and Risk Committee
Date of meetings	23 June 2026
Summary of assurance:	

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

Internal audit annual report & Head of internal Audit Opinion
The Committee received the Internal Audit Annual Report and Head of Internal Audit Opinion from RSM. The Head of Internal Audit confirmed a Level 2 positive assurance Opinion, consistent with the previous year, and concluded that the Trust maintained an adequate and effective framework of governance, risk management and internal control. The Committee noted that all internal audit recommendations remained on track for implementation and welcomed the continued positive assurance position. The Committee thanked RSM for their work throughout the year and the constructive assurance relationship maintained with the Trust.

The Committee noted and welcomed the internal audit progress report.

Internal Audit Progress report
The Committee received an update on delivery of both the 2025/26 and 2026/27 Internal Audit Plans. Two further audits had been completed since the previous meeting, and both received reasonable assurance opinions, thereby concluding the 2025/26 audit programme. Good progress was already being made against the 2026/27 programme, with three reviews underway and no overdue audit recommendations. Five recommendations had been implemented and closed since the previous meeting.

The Committee took significant assurance from the effective management of audit actions and continued delivery of the audit programme.

Duty of Candour Internal Audit Review
The Committee considered the Duty of Candour audit report which provided a reasonable assurance rating. Committee members were informed that the review identified generally robust arrangements, including clear governance structures, defined roles and responsibilities, training arrangements and monitoring processes.

The review identified opportunities to strengthen compliance through improved timeliness of written responses, enhanced thematic reporting and ensuring consistent application of processes across all care settings. Management confirmed that actions had been agreed, responsibility assigned and some had already been completed.

Committee members welcomed the positive findings and considered the report valuable in providing additional insight into the Trust's Duty of Candour processes. Committee members particularly welcomed confirmation that

	lessons had been identified and disseminated from the cases reviewed. It was agreed that the report would also be shared with the Quality Assurance Committee. **The Committee noted the report and took significant assurance from the effectiveness of the Trust's Duty of Candour arrangements**. **Risk Management Internal Audit Review** The Committee reviewed the Risk Management audit report which received a reasonable assurance rating. The review found a well-established risk management framework supported by clear governance arrangements, Board Assurance Framework processes and divisional risk registers. Areas identified for improvement included strengthening consistency in the recording of controls and gaps, clearer ownership and timescales for actions, enhanced monitoring of risk management training and continued review of risk movement and scoring. Committee members discussed the observation regarding the relative stability of certain Board Assurance Framework risks. The Committee noted that several risks had been actively reviewed by Board committees during the year and that decisions not to reduce scores reflected the continuing external and operational pressures facing the Trust, rather than inactivity in risk management. The Chief Nurse and Company Secretary confirmed that all of the review's recommendations had been accepted. **The Committee welcomed the report and took significant assurance from the effectiveness of the Trust's risk management arrangements**. **2025/26 Counter Fraud Annual Report** Committee members received the annual Counter Fraud report and noted completion of the 2025/26 work programme. The Committee welcomed confirmation that referral levels had increased considerably compared to previous years, rising to 22 referrals during the year. Committee members agreed that this reflected improved awareness of fraud reporting routes and a strengthening counter fraud culture across the organisation. The Committee also noted the introduction of new "failure to prevent fraud" legislation and the impact this would have on future fraud risk assessment arrangements. While the annual NHS Counter Fraud Authority return remained substantially compliant, one amber rating had been recorded to reflect the additional work required to address this new legislative requirement. **The Committee welcomed the report and took significant assurance from the effectiveness of the Trust's counter fraud arrangements.** **Board Assurance Framework** The Committee reviewed the Quarter 1 Board Assurance Framework and endorsed the proposed changes to risk scores following consideration by the relevant Board committees. The Committee acknowledged the deliberate

	decision by the Workforce Assurance Committee to maintain the current workforce risk scores. pending further evidence. Committee members also reviewed the Trust's highest-rated strategic risk relating to cyber security (Sustainability 3) and acknowledged the evolving cyber threat environment and the emerging risks associated with artificial intelligence (AI). The Committee was assured that appropriate controls remained in place, including Board-level cyber security training, and agreed that AI-related risks should continue to be monitored through the existing cyber security assurance framework. **The Committee noted that the Q1 2026/27 Board Assurance Framework** **Quality Assurance Committee** The Committee reviewed the Chair's report and took good assurance from the following areas: • The good progress had been made in preparation for a well-led inspection, with further work required to update specific action plans, including in maternity services. • Patient experience remained below the expected standards in the paediatric emergency department, and a deep dive review would be undertaken to provide further assurance and identify improvement actions. • There was a concerning increase in the number of violence and aggression incidents affecting frontline staff across both community and acute settings. The Committee emphasised the need for continued focus and alignment with the Workforce Assurance Committee on this issue, recognising the impact on staff wellbeing. • The improvements highlighted in the annual people-led assessment of the care environment **The Committee noted the Quality Assurance Committee's assurance report**
2.	**The Committee can report moderate assurance from the following items:** **External Audit Progress Report and Annual Accounts** Committee members received a detailed update from KPMG on progress with the audit of the 2025/26 annual accounts. Committee members were advised that audit work remained ongoing in a number of areas, including provisions, accruals, NHS debtor impairments, receivables and inventory accounting treatment. KPMG highlighted that the cumulative value of audit differences identified to date was approaching materiality thresholds and that additional testing was being undertaken in several areas. The Committee discussed in detail the treatment of aged NHS receivables, provisions relating to restructuring costs and the accounting treatment of goods received not invoiced. Management outlined the rationale for the accounting judgements made and confirmed that significant resources had been mobilised to support audit completion. KPMG acknowledged that substantial progress had been made and the Committee was advised that there remained a risk to the planned accounts

timetable and that completion would depend upon satisfactory resolution of outstanding audit matters.

The Committee took moderate assurance from the progress being made and noted the ongoing audit risks and the potential implications for the accounts timetable.

Private Finance Initiative Litigation
The Committee received a verbal update concerning a significant development in the Trust's private finance initiative (PFI) litigation. Committee members were advised that new information had emerged in relation to historical document disclosure requirements which could potentially impact the Trust's litigation strategy. The Committee was informed that, if confirmed, the issue may have implications for the valuation of provisions within the annual accounts and consequently affect the submission of the final accounts to NHS England.

Management confirmed that discussions with legal advisers, NHS England and other stakeholders were underway and that an extraordinary Board discussion might need to be convened.

The Committee noted the update

Tender Waivers and Breaches
The Committee discussed the report on tender waivers and breaches. Committee members were advised of an increase in waiver activity during March associated with year-end expenditure, particularly within the estates and facilities department. The Committee learnt that waiver activity had reduced significantly during April and May and that procurement teams had reinforced expectations regarding competitive procurement processes and value for money assessments.

Committee members were concerned about the increase in procurement breaches and were informed that many breaches related to retrospective purchase orders and failures to follow established purchasing processes. Management outlined actions being taken to address this issue, including the implementation of a new electronic "smart waiver" system, additional controls and enhanced staff communications.

The Committee took moderate assurance from the mitigating actions in place and requested continued oversight of procurement compliance and breach levels.

Trust risk register
The Committee reviewed the risk register update as at end April 2026, it was confirmed that the Trust had 53 risks scored at 15 and above, of which 49 were approved. There were no new or increased risks.

The Committee reviewed high-scoring and long-standing risks, including:
- Paediatric Emergency Department accommodation risks;

- Maternity records and digital risks;
- Estates infrastructure risks, including ventilation systems; and
- Workforce-related risks.

Committee members requested that long-standing risks continued to receive periodic deep dives through the relevant Board committees to ensure appropriate scrutiny and progress against mitigation plans.

The Committee was assured that work to strengthen risk descriptions, scoring and assurance would continue. Terry Whittle advised that, based on recent progress, there was a need to review the scores for cleaning and storage risks. He added that, while, high-scoring estates risks remained, there was a clear multi-year capital programme in place, which would reduce the risk over time.

The Committee took assurance that key risks remain actively managed and subject to ongoing review.

The Committee noted the risk register for entries scored at 15 and above

Losses and special payments
The Committee received a report on losses and special payments and considered proposed write-offs relating to three overseas visitor invoices totalling £2,184 and one dental charge invoice totalling £268.

Committee members welcomed the continued work being undertaken to recover debts arising from salary overpayments and overseas visitors. The Committee was advised that, of the outstanding salary overpayment debt, £45k was being recovered through agreed payment plans, £34k was subject to ongoing recovery action and £68k had been referred to the Trust's external debt collection agency. In relation to overseas visitor debt, the Committee noted that outstanding balances totalled £925k, with £375k managed by the Trust's debt collection provider, £277k subject to active recovery action and £271k being repaid through instalment arrangements.

The Committee approved the proposed write-offs.

Debtors' report
The Committee reviewed the aged debtors report and discussed the continued growth in historic NHS debtor balances, particularly those relating to other NHS organisations. Committee were informed of the challenges associated with resolving longstanding disputes and obtaining timely responses from partner organisations. The Committee also noted the issues raised by the external auditors regarding the evidence supporting impairment provisions against certain NHS receivables and the work underway to strengthen documentation and recovery processes. Management provided assurance that active engagement continued with relevant organisations to resolve outstanding balances and reduce exposure to future financial risk.

	The Committee noted the report and took moderate assurance that appropriate mitigating actions were in place, whilst recognising the continued risk posed by aged debtor balances.
3.	**Present:** Rob Vincent, Non-Executive Director (Committee Chair) Amanda Gibbon, Non-Executive Director Nailesh Rambhai, Non-Executive Director **In attendance:** Terry Whittle, Chief Finance Officer Kirsty Clarke, Counter Fraud Specialist, RSM Sharonjeet Kaur, Associate Director RSM Dean Gibbs, Engagement Director KPMG LLP Martin Linton, Assistant Director of Financial Services Clive Makombera, Director RSM Marcia Marrast-Lewis, Assistant Trust Secretary Phill Montgomery, Procurement Business Partner Chinyama Okunuga, Chief Operating Officer Swarnjit Singh, Trust Company Secretary Bethany Sibley, Patient Safety Information Manager Nicola Sands, Deputy Chief Nurse Jerry Francine, Operational Director of Finance

	Audit & Risk Committee terms of reference
1. 1.1	**Constitution** The Board of Directors hereby resolves to establish a Committee to be known as the Audit & Risk Committee (the Committee). This Committee is a non-executive committee of the Board and has no executive powers other than those expressly delegated.
1.2	The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires for any employee, and all employees are directed to co-operate with any request made by the Committee to attend, as and when required.
1.3	The Committee is also authorised by the Board to obtain external legal or other professional advice, if it considers this necessary, via the Trust Secretary.
2. 2.1	**Role** The role of the Audit & Risk Committee is to provide assurance to the Board of Directors and the Accountable Officer through a means of independent and objective review of: • the arrangements in place for governance, risk management, management and internal control • the comprehensiveness, reliability and integrity of assurances to meet the Board and the Accountable Officer's (Chief Executive) requirements.
2.2	To support this, the Audit & Risk Committee will have particular engagement with the work of Internal and External Auditors and with financial reporting issues.
3. 3.1	**Membership** The Audit & Risk Committee will be appointed by the Board of Directors. The Committee shall be made up of three, independent Non-executive Directors, one of whom will chair the Committee. The Chair of the Committee will normally attend the Annual General Meeting prepared to respond to any questions on the Committee's activities. Members shall be appointed for a defined term, subject to
3.2	Board approval.
3.3	The Chair of the Trust must not be a member of the Committee.
3.4	Only members of the Committee have the right to attend and vote at Committee meetings. The Committee may require other officers of the Trust and other individuals to attend all or any part of its meetings.
	At least one member of the Audit & Risk Committee must have recent and relevant financial experience. The Committee should collectively have skills and experience in finance, audit, risk management and governance.

4.	**Quorum and attendance**
4.1	The quorum necessary for the transaction of business shall be at least two members, including at least one member with recent and relevant financial experience. . A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by it.
4.2	The Secretary of the Committee shall maintain a register of attendance which will be published in the Trust's Annual Report.
4.3	The Chief Finance Officer will be the lead executive director for the Committee.
4.4	The Chief Executive and other Executive Directors shall attend Committee meetings by invitation only. This shall be required particularly when the Committee is discussing areas of risk or operational matters that are the responsibility of that Director. When an internal audit report or other report shows significant shortcomings in an area of the Trust's operations, the Director responsible will normally be required to attend in order to respond to the report. The Chief Executive should be invited to attend annually to discuss with the Audit & Risk Committee the process for assurance that supports the Annual Governance Statement.
4.5	Other attendees include appropriate external and internal audit functions and local counter fraud specialist (LCFS) representatives shall normally attend meetings. In addition, The LCFS shall attend to agree a work programme and report on their work as required.
4.6	At least once a year the external and internal auditors shall be offered an opportunity to report to the Committee any concerns they may have in the absence of all Executive Directors and officers. This need not be at the same meeting.
4.7	The Trust Secretary will act as the Committee's Secretary and will also be in attendance. Attendance may be in person or via virtual/remote means in accordance with Trust policy.
5.	**Frequency of meetings**
5.1	The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. The Committee shall meet at least four times per year (normally five), with additional meetings arranged as required , with one meeting devoted to the draft annual accounts.
5.2	The external or internal auditor may request a meeting when they consider it necessary.

6. 6.1	**Agenda & papers** Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.
6.2	Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five working days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance, then they will be forwarded to Committee members at the same time as the agenda.
7. 7.1	**Duties** The Committee should carry out the following duties for the Trust. In carrying out these duties, the Committee will focus on high-level assurance and avoid duplication of detailed operational management.
7.2	**Governance, risk management and internal control** The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.
7.3	In particular, the Committee will review the adequacy of: i. all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission's requirements), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors; ii. the Board Assurance Framework and the underlying integrated assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements; iii. the policies for ensuring compliance with relevant regulatory, legal, and code of conduct requirements in conjunction with the Board's Quality Assurance Committee; iv. the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority; v. the system of management for the development, approval and regular review of all trust policies, including those for ensuring compliance with relevant regulatory, legal and code of conduct requirements vi. the financial systems; vii. the system of management of performance and finance across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives viii. the internal and external audit services, and counter fraud services; and ix. compliance with Board of Directors' Standing Orders (BDSOs) and Standing Financial Instructions (SFIs)

7.4	The Committee should review the Assurance Framework process on a periodic basis, at least twice in each year, in respect of the following: i. the process for the completion and up-dating of the assurance framework; ii. the relevance and quality of the assurances received; iii. whether assurances received have been appropriately mapped to individual committee's or officers to ensure that they receive the due consideration that is required; and iv. whether the Board Assurance Framework remains relevant and effective for the organisation.
7.5	The Committee shall review the arrangements by which Trust staff can raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety, or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.
7.6	In relation to the management of risk, the Committee will: i. maintain an oversight of the Trust's risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements; ii. review processes to ensure appropriate information flows to the Committee from executive management and other board committees in relation to the Trust's overall control and risk management position; iii. receive reports from other Committees highlighting control risks identified during the course of their work which require further review action and outlining the action to be taken; iv. review the effectiveness and timeliness of actions to mitigate critical risks including receiving exception reports on overdue actions; and v. review the statements to be included in the Annual Report concerning risk management.
7.7	The Committee will, at least once a year, review on behalf of the Board of Directors the operation of, and proposed changes to, the standing orders, standing financial instructions and scheme of delegation.
7.8	The Committee will monitor the effectiveness of the processes and procedures used in undertaking due diligence
7.9	In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit, the LCFS, and other assurance functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.
7.10	The Committee will receive periodic assurance on the management of debtor balances and tender waivers, focusing on material risks, trends, and control effectiveness..

7.11	The Committee shall review at each meeting a report of tender waivers since the previous meeting.
	Internal Audit
7.12	The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and this can be evidenced by appropriate independent assurance to the Committee and Board of Directors. This will be achieved by: i. consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal; ii. review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework; iii. consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources; iv. ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; v. monitoring and assessing the role of and effectiveness of the internal audit function on an annual basis in the overall context of the Trust's risk management framework; and vi. ensuring that previous internal audit recommendations are followed up on a regular basis to ensure their timely implementation.
	External Audit
7.13	The Committee shall review the work and findings of the External Auditor appointed by the Trust Board and consider the implications and management's responses to their work. This will be achieved by: i. approval of the remuneration to be paid to the external auditor in respect of the audit services provided; ii. consideration of recommendations to the Trust Board relating to the appointment and performance of the external auditor; iii. confirming the independence of the external auditor, including approval of any non-audit work and fees; iv. discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy; v. discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee; and vi. review all external audit reports, including agreement of the annual audit letter before submission to the Board of Directors and any work carried out outside the annual audit plan, together with the appropriateness of management responses.
7.14	**Counter Fraud** The Committee will review the adequacy of the Trust's arrangements by which staff may, in confidence raise concerns about possible improprieties in matters of financial reporting and control and related matters.

7.15	In particular, the Committee will: i. review the adequacy of the policies and procedures for all work related to fraud and corruption in line with NHS Counter Fraud Authority standards and requirements; ii. approve and monitor progress against the operational counter fraud plan; iii. receive regular reports and ensure appropriate action in significant matters of fraudulent conduct and financial irregularity; iv. monitor progress on the implementation of recommendations in support of counter fraud; v. receive the annual report of the local counter fraud specialist.
7.16	**Raising concerns (whistleblowing) policy** The Committee will oversee and review the effectiveness of arrangements that enable staff to raise concerns freely and without fear of detriment. .
7.17	The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow-up action.
7.18	**Other assurance functions** The Committee will also provide assurance to the Board of Directors in the following areas: i. It shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the Trust; ii. These will include, but will not be limited to, any reviews by NHS England (NHSE), Department of Health Arm's Length Bodies or Regulators / Inspectors (e.g. Care Quality Commission, NHS Resolution, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.); iii. In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. Particularly with the Quality, Committee, it will meet at least annually with the Chair and/or members of that Committee to assure itself of the processes being followed; iv. In reviewing the work of the Quality Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function at least annually; v. The Audit & Risk Committee should incorporate within its schedule a review of the underlying processes for the Information Governance Toolkit and the Quality Accounts production to be able to provide assurance to the Board that these processes are operating effectively prior to disclosure statements being produced; vi. The Audit & Risk Committee will oversee the work of the Health and Safety Committee and receive regular performance and assurance reports; and vii. The Audit & Risk Committee will oversee the work of the Information Governance Committee and receive regular performance and assurance reports.
7.19	**Management** The Committee shall request and review reports and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

7.20	They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements.
	Financial reporting
7.21	The Committee will monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. In particular, it will: i. review the Annual Report and Financial Statements, together with the external auditor's report to those charged with governance (ISA260), and recommend the accounts to the Trust Board of Directors, for formal approval and adoption, focusing particularly on the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee; ii. changes in, and compliance with, accounting policies and practices; iii. unadjusted mis-statements in the financial statements; iv. major judgmental areas; and v. significant adjustments resulting from the audit.
7.22	The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors.
	Appointment, reappointment, and removal of external auditors
7.23	The Committee shall appoint the Auditor Panel to make recommendations to the Board of Directors on its behalf, in relation to the setting of criteria for appointing, re-appointing, and removing external auditors.
7.24	The Committee shall approve the terms of reference of the Auditor Panel and review the function and membership of the Auditor Panel annually.
8.	**Reporting**
8.1	The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.
8.2	Approved minutes will be forwarded to the Board of Directors for noting and the minutes of all meetings shall be formally recorded and approved at the subsequent meeting. A formal summary report or draft minutes will be submitted to the Trust Board following each meeting, thus enabling the Trust Board to oversee and monitor the work programme, functioning and effectiveness of the Committee. Matters of significant concern will be escalated to the Board promptly outside the routine reporting cycle where necessary.
8.3	Members and those present should state any conflicts of interest and the Committee Secretary will minute them accordingly.

8.4	In advance of the next meeting, the minutes and the log of action points will be circulated to all involved, so that the action log can be updated and included in the papers for the meeting.
8.5	The minutes of the Committee, once approved by the Committee, will be submitted to the Board of Directors for noting. The Committee Chair shall draw the attention of the Board of Directors to any issues in the minutes that require disclosure or executive action.
8.6	The Committee will report annually to the Board of Directors on its work in support of the Annual Governance Statement, specifically commenting on the completeness and integration of risk management in the Trust, the integration of governance arrangements. A summary of the Committee's work will be included in the Trust's Annual Report.
8.7	The Committee will make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.
8.8	The Committee will produce an annual report to the Board of Directors reviewing its effectiveness and performance and to make any recommendations for change that it is considered necessary for approval.
8.9	The Committee will receive and consider minutes from other Board Committees when requested. The Committee will also receive and consider other sources of information from the Chief Finance Officer.
9.	**Monitoring and review**
9.1	The Committee will produce an annual work plan and, in line with good corporate governance practice, carry out an annual review of effectiveness against its terms of reference and delivery of its annual work plan. The Committee should considering any areas for improvement identified during the meeting. The Committee Secretary will support this process by ensuring agendas align with the Committee's responsibilities.
9.2	The Board of Directors will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.
9.3	The Committee should consider holding a discussion at the end of some meetings with regards to the effectiveness of the committee, considering those areas highlighted within The Committee Secretary will assess agenda items to ensure they comply with its responsibilities.
9.4	These terms of reference were approved by the Board of Directors in July 2026 and will be reviewed at least annually

Meeting title	**Trust Board – public meeting**	**Date: 23.07.2026**
Report title	**Charitable Funds Committee Chair's Assurance report**	**Agenda item: 9**
Committee Chair	Amanda Gibbon, Non-Executive Director	
Executive lead	Terry Whittle, Deputy Chief Executive and Chief Finance Officer	
Report authors	Marcia Marrast-Lewis, Assistant Trust Secretary, and Amanda Gibbon, Committee Chair	
Executive summary	A meeting of the Charitable Funds Committee was held on 24 June 2026 to consider the following items: • Month 2 Financial position • A Charity report for the period 1 March to 31 May 2026. • Charity Annual report 2025/26 • Applications for funding There were no items covered at this meeting for which the Committee is reporting limited assurance to the Board Areas that Committee members agreed to bring to the attention of the Board are: 1. The Sanctuary Garden Programme – Board approval is required for the proposed contractor appointment and expenditure, following completion of the procurement process. 2. Unrestricted Income and Financial Sustainability and the ongoing challenge of generating unrestricted income to support the Charity's operating costs and future growth. 3. Revised Terms of Reference which incorporate a number of updates to ensure continued alignment with governance requirements and good practice.	
Purpose	Note	
Recommendation(s)	Board members are invited to note the Chair's assurance report for the Charitable Funds Committee meeting held on 24 June 2026.	
Appendices	None	

Committee Chair's Assurance report:	Charitable Funds Committee
Date of meeting	24 June 2026

Summary of assurance:

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

Charity report
The Head of the Charity provided an update on fundraising performance, sector context, donor engagement and delivery of charitable projects. He confirmed that charitable income for 2025/26 had reached a record £1.3m, representing a threefold increase over the last three years despite being delivered without the benefit of a major legacy gift and during a challenging fundraising environment for NHS charities.

The Committee discussed the sustainability of future income and received assurance regarding actions being taken to diversify funding sources, including:

- development of a new regular giving programme;
- continued investment in challenge event fundraising, including the London Marathon;
- growth in legacy fundraising and donor stewardship activity; and
- development of new corporate and community fundraising opportunities.

Committee members also welcomed the continued success of the sleeper chair appeal and noted recent significant donor contributions, including funding for a further ten chairs.

Menopause Hub Programme
The Committee received an update on delivery of the Menopause Hub programme following the award of a £41,000 NHS Charities Together grant. Committee members learnt that work was progressing to establish the service, including the recruitment and training of menopause champions across the Trust, with implementation expected during autumn 2026. The Committee took assurance that the grant funding was being used appropriately and that delivery plans were progressing as intended**.**

Michael Palin Centre
The Committee received an update regarding the Michael Palin Centre. Members welcomed confirmation of a £60,000 donor contribution. The Committee discussed the importance of strengthening and formalising the partnership between the Trust, the Charity and the Michael Palin Centre through a clearer operating framework and service-level arrangements. The Committee also agreed in principle that the Centre should make an annual contribution towards Charity operating costs, reflecting the significant fundraising and administrative support provided by the Charity team. Committee members reflected on the national reputation of the Michael Palin Centre and the importance of recognising its contribution to specialist speech and language services, research and training.

The Committee took significant assurance from progress in strengthening governance and partnership arrangements with the Michael Palin Centre.

Sanctuary Garden Development
The Committee received a detailed update on the Sanctuary Garden project and the outcome of the procurement process. Committee members were informed that the preferred contractor, Carmel Crest, had achieved the highest quality assessment score and submitted the most economically advantageous tender. The estimated construction cost of £478,825 including VAT was below initial budget assumptions and left only a small remaining funding gap.

The Committee was also informed that confirmation of the contractor would enable release of the major donor pledge of £350,000, allowing the project to proceed. Subject to final Board approval required under the Charity's delegated authority arrangements, the Committee endorsed the recommended contractor.

The Committee discussed ongoing maintenance arrangements, volunteer involvement and opportunities for further fundraising linked to specific elements of the garden design. The Committee took significant assurance regarding project governance, fundraising performance and delivery arrangements for the Sanctuary Garden.

Unrestricted Income and Sustainability
The Committee discussed continuing challenges associated with securing unrestricted income which is important to meet the costs of running the charity. Committee members noted that most recent fundraising growth had been linked to restricted projects and that many donors remained reluctant to contribute towards overheads or operating costs. The Committee discussed approaches taken to embed a contribution to project management and delivery costs within future funding applications and major donor agreements. The Committee recognised this as a sector-wide issue and agreed that growing and maintaining a sustainable unrestricted income base would remain a strategic priority.

Whittington Babies
The Committee received an update on discussions which are in train with the trustees of Whittington Babies, an independent charity operating separately from Whittington Health Charity. The discussions are focused on how best to approach future fundraising for the neonatal service and involve both charities as part of an ambitious Whittington Health Charity project tied to the Start Well redesign of the maternity and neonates service. The Committee recognised the significant historic contribution made by Whittington Babies but noted that a consolidated approach would strengthen governance arrangements, reduce donor confusion and support future fundraising ambitions, particularly in relation to maternity and neonatal redevelopment programme

Month 2 Financial report

	The Committee was updated on the financial position to 31 May. Total income was reported as £112k, with expenditure of £156k, resulting in a deficit of £44k. The investment portfolio's performance showed a gain of £86k from 1st April 2026 to 31st May 2026. The total fund balance on 31st May 2026 was £1.357m. Cash balances remained strong at £609k. Committee members noted that two restricted funds relating to the Sanctuary Garden projects were currently reporting deficit balances. Assurance was provided that this reflected the timing of expenditure and pledged income rather than any underlying funding concern and that receipt of the Pears pledge would restore the funds to a positive position. The Committee also discussed the recent volatility in investment markets and recognised the importance of maintaining oversight of investment performance and risk. Committee members agreed that a dedicated review of investment management arrangements should be scheduled and that a small group of trustees would meet with investment advisers and report back to the Committee. The Committee took assurance from the overall financial position of the Charity and the continued monitoring of investment performance and cash reserves. **Annual Report and Accounts** The Committee reviewed the draft Annual Report and unaudited Accounts for 2025/26 ahead of the external audit process. Committee members were informed that the draft accounts reported a trading deficit of £150k and an investment loss of £97k, resulting in an overall accounting deficit of £247k for the year. The Committee recognised, however, that these figures needed to be considered alongside the Charity's strong fundraising performance, with income increasing by 65% year-on-year and expenditure increasing by 27% as a consequence of increased charitable activity and project delivery. The Committee discussed the distinction between accounting deficits and cash performance, as cash balances had reduced by only £41k over the year despite significant investment in charitable projects and activities. The Committee also reviewed the narrative sections of the Annual Report which emphasised the importance of clearly demonstrating the impact of charitable funding on patients, staff and services. The draft report would return to Committee for final approval following completion of the external audit. **The Committee took moderate assurance from the Charity's financial position pending completion of the external audit.** **Applications for funding** The Committee reviewed several funding applications and was satisfied that appropriate charitable funding was available to support the proposals. **Menopause Hub** The Committee noted that a formal funding application for the Menopause Hub would be submitted retrospectively to provide a clear audit trail against the NHS Charities Together grant funding received. Members were advised

	that the proposal represented a straightforward "funds received, funds spent" arrangement and was necessary to ensure appropriate governance and reporting against grant conditions. It was agreed that the application could be approved by correspondence outside of the meeting **Cardiology Service Improvements** The Committee considered applications to support a patient queue management system and staff environment improvements within Cardiology. Members noted that the proposals would be funded from charitable donations specifically designated to support Cardiology services and therefore aligned with donor intentions. The Committee discussed the proposed queue management system and sought assurance that relevant digital, information management and patient experience teams had been consulted. Members highlighted the importance of ensuring that any technology procured was compatible with existing Trust systems and supported improvements in patient experience. Further discussion focused on managing patient expectations regarding waiting times and ensuring clear communication regarding how the system would operate. Management confirmed that the relevant teams had been consulted and were supportive of the proposal. **The Committee approved the Cardiology applications** **Michael Palin Centre Annual Activities** The Committee considered a funding request to support the Michael Palin Centre's annual programme of training, workshops and specialist activities. Members noted that the proposal represented a more streamlined approach to funding, whereby an agreed programme of activity would be approved in advance rather than requiring separate applications throughout the year. The Committee heard that the funding had been raised specifically for the Michael Palin Centre and did not create any call on the Charity's unrestricted resources. The Committee discussed how this arrangement could support greater flexibility and autonomy whilst maintaining appropriate financial controls, with all expenditure remaining subject to normal Charity governance and invoicing processes. Members also noted the benefits of the programme in supporting the Centre's national training, research and tertiary service offer. **The Committee approved the funding request and welcomed the improved approach to managing annual activity funding.** **Sleeper Chairs** The Committee reviewed a proposal to purchase additional sleeper chairs following the success of the Sleeper Chair Appeal. Members heard positive feedback regarding the impact of existing chairs on patient and family experience, particularly for relatives wishing to remain with loved ones during periods of care. The Committee noted the additional benefit of providing patients with a more comfortable alternative to remaining in bed for extended periods**.**

	Discussion focused on practical considerations, including storage capacity on wards and ensuring that any additional chairs were allocated only to areas that had confirmed both a clinical need and sufficient space. Management confirmed that Associate Directors of Nursing had been consulted and that requests had originated from clinical teams following assessment of local capacity requirements. **The Committee approved the proposal and welcomed the demonstrable patient and family benefits arising from charitable investment in the sleeper chair programme.** **Future Funding Rounds** The Committee noted that a previous invitation for applications linked to improvements in the healthcare environment had not generated any specific bids from staff. Members reflected that the Charity continues to support improvements to patient environments through major projects, including the Sanctuary Garden and service-specific funding requests, and agreed to review the effectiveness and focus of future funding rounds at a later date. **The Committee approved all funding applications presented** **Governance and Committee Effectiveness** The Committee reviewed its annual effectiveness assessment and Terms of Reference. Committee members concluded that the Committee continued to operate effectively and remained compliant with Charity Commission and NHS charitable funds requirements. The Committee discussed opportunities to strengthen governance arrangements further through benchmarking against other NHS charities, review of committee membership and regular review of key charitable risks. An updated charity risk register will be presented to the next meeting, and a separate review of investment management arrangements will be undertaken.
2.	**Attendance:** **Present:** Amanda Gibbon, Non-Executive Director (Committee Chair) Nailesh Rambhai, Non-Executive Director Julia Neuberger, Non-Executive Director Terry Whittle, Deputy Chief Executive and Chief Finance Officer Nikki Sands Deputy Chief Nurse Clarissa Murdoch, Acting Chief Medical Officer **In attendance:** Marcia Marrast-Lewis, Assistant Trust Secretary Vivien Bucke, Business Support Manager Ellen Kyriacou, Charity Accountant Martin Linton, Assistant Director Financial Services Sam Lister, Head of Charity Katherine Mobey, Fundraising Manager Sydney Ramunno, Grants Officer

	Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary **Apologies:** Selina Douglas, Chief Executive Officer Tony Rice, Independent Member

Meeting title	**Trust Board Public**	**Date: 23 July 2026**
Report title	Finance Report - June (Month 3) 2026/27	**Agenda item: 10**
Executive lead	Terry Whittle – CFO & Deputy Chief Executive	
Report author	Senior Finance Team	
Executive summary	**Background (What?)** This report provides the Trust's financial position for Month 3 (June 2026) against the approved 2026/27 financial plan. The Trust is reporting a year-to-date deficit of £4.8m, which is £1.6m adverse to plan. **Issue (So What?)** The key drivers are: • Under recovery on ERF activity • Pay overspends relating to industrial action costs, unfunded service pressures, continued temporary staffing usage, Emergency Department pressures and additional bed capacity. • CIP delivery of £3.0m against a year-to-date target of £5.75m **Next Steps (What Next?)** The Trust is implementing a financial recovery programme focused on: • Strengthening expenditure controls and reducing pay expenditure. • Accelerating development and approval of CIP schemes and increasing recurrent savings delivery. • Improving elective and outpatient performance to recover ERF income. • Addressing divisional overspends and unfunded cost pressures through targeted recovery plans.	
Purpose:	Review M3 financial performance	
Recommendation(s)	• Review the Month 3 financial position and note the reported year-to-date deficit of £4.8m, £1.6m adverse to plan. • Review the risks associated with the current CIP delivery shortfall and underlying expenditure pressures.	
Risk Register or Board Assurance Framework	Sustainability 1	
Report history		
Appendices		

Year to date financial performance - £4.8m actual deficit - £1.5m adverse to plan	The Trust is reporting a YTD deficit of £4.8m at the end of June, this is £1.6m adverse to plan. The in-month deficit was £0.9m which was £0.4m worse that plan. The year-to-date performance includes impact of industrial action of £0.6m.
Income - £0.4m behind plan	Income is behind plan by £0.4m at the end of June predominantly due to underperformance in day cases and electives. At end of June, ERF is behind plan by £0.7m. mainly due to industrial action in April and underperformance in day cases in June.
Headcount	The actual WTE for June was 5,247 that was 137wte below plan but 45wte more than previous month. Increase is predominantly due to higher temporary staffing usage.
Pay Expenditure	Pay expenditure is adverse to plan with year-to-date variance of £4.1m. This is predominantly driven by industrial action cost (£0.5m), overspends relating to unfunded, ED, Medical wards and slippage on efficiency plans.
Non-Pay Expenditure	Non-pay expenditure for the month was £8.8m. Ongoing pressure within non-pay includes legal fees, clinical supplies, and unidentified CIP.
Efficiency	The Trust delivered £3m savings which is a shortfall of £3.9m against the internal YTD target of £6.9m.
Cash	The Trust's cash balance on 30th June was £44.18m, which is £21.24m favourable to plan, a decrease of £2.98m from May's closing balance.
Capital	The total 2026-27 allocation at the time of writing is £79.28m, comprising £23.43m of internally funded capital and £55.85m of Public Dividend Capital (PDC) funded capital. Year to date expenditure on capital is £1.4m
Better Payment Practice Performance	Overall, the Trust's BPPC is 91.23% by volume and 87.84% by value. The BPPC for non-NHS invoices is 91.46% by volume and 88.16% by value.
Forecast	The Trust continues to forecast delivery of its planned breakeven position for 2026/27. A programme of recovery actions is currently being developed and implemented to reduce pay expenditure further and support delivery of the Trust's planned financial position.

Summary of Income & Expenditure Position – Month 3

	In Month			Year to Date			
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Annual Budget £'000
Income							
NHS Clinical Income	32,678	31,429	(1,250)	94,928	93,732	(1,196)	388,501
High Cost Drugs - Income	652	1,371	719	1,992	3,346	1,354	8,002
Non-NHS Clinical Income	1,767	1,783	16	5,216	5,407	192	20,768
Other Non-Patient Income	2,590	2,524	(66)	7,654	7,694	39	30,609
Elective Recovery Fund	6,136	5,730	(406)	17,154	16,413	(741)	70,372
	43,824	**42,837**	**(987)**	**126,944**	**126,592**	**(352)**	**518,252**
Pay							
Agency	10	(332)	(342)	(23)	(904)	(881)	(141)
Bank	(271)	(1,509)	(1,238)	(412)	(4,332)	(3,921)	(1,582)
Substantive	(30,829)	(29,808)	1,021	(90,295)	(89,558)	737	(366,837)
	(31,090)	**(31,650)**	**(560)**	**(90,729)**	**(94,795)**	**(4,065)**	**(368,560)**
Non Pay							
Non-Pay	(9,387)	(8,833)	554	(28,158)	(26,764)	1,395	(104,758)
High Cost Drugs - Exp	(967)	(1,055)	(89)	(2,901)	(2,858)	43	(11,603)
	(10,354)	**(9,888)**	**466**	**(31,059)**	**(29,622)**	**1,438**	**(116,361)**
EBITDA	**2,380**	**1,299**	**(1,081)**	**5,155**	**2,175**	**(2,980)**	**33,331**
Post EBITDA							
Depreciation	(2,170)	(1,777)	393	(6,509)	(5,770)	739	(26,035)
Interest Payable	(74)	(40)	34	(222)	(122)	100	(883)
Interest Receivable	37	219	182	111	646	535	439
Dividends Payable	(571)	(571)	0	(1,713)	(1,713)	0	(6,852)
P/L On Disposal Of Assets	0	0	0	0	0	0	0
	(2,778)	**(2,169)**	**609**	**(8,333)**	**(6,959)**	**1,374**	**(33,331)**
Reported Surplus/(Deficit)	**(398)**	**(870)**	**(472)**	**(3,178)**	**(4,783)**	**(1,606)**	**0**
Impairments	0	0	0	0	0	0	0
IFRS & Donated	(6)	(3)	3	(17)	(9)	9	(71)
Reported Surplus/(Deficit) after Impairments and IFRIC12	**(404)**	**(873)**	**(469)**	**(3,195)**	**(4,792)**	**(1,597)**	**(71)**

- The YTD deficit is £4.8m (excluding donated asset depreciation and impairments), £1.6m worse than planned.
- At end of Q1, £1.5m of non-recurrent mitigations were released into the position. The position also includes £0.6m of strike costs.
- The Trust submitted a breakeven plan (excluding donated asset depreciation and impairments). This includes £23m efficiency target for 2026-27. The internal financial efficiency target is £27m to support improving the underlying position as per the financial strategy.

Income and Activity Performance

2.1 Income Performance – June

Income	In Month Income Plan £000's	In Month Income Actual £000's	In Month Variance £000's	YTD Income Plan £000's	YTD Income Actual £000's	Income Diff £'000 £000's
Elective	2,972	2,405	(567)	7,977	7,426	(551)
Outpatients	3,203	3,314	111	9,104	8,954	(151)
Other clinical Income	0	11	11	0	34	34
ERF Balance	(39)	0	39	72	0	(72)
ERF	**6,136**	**5,730**	**(406)**	**17,154**	**16,413**	**(741)**
Variable Imaging	**621**	**483**	**(138)**	**1,722**	**1,736**	**14**
HCD (Variable)	**857**	**1,212**	**355**	**2,599**	**2,789**	**190**
Devices	**127**	**169**	**42**	**360**	**426**	**(65)**
Chemo Deliveries	**204**	**185**	**(19)**	**565**	**185**	**(380)**
Total Variable	**7,945**	**7,780**	**(166)**	**22,401**	**21,549**	**(983)**
UEC	**8,043**	**7,993**	**(50)**	**24,129**	**24,171**	**42**
A&E	76	69	(7)	230	224	(6)
Non-Elective	1,627	1,104	(523)	4,935	4,356	(579)
Critical Care	727	760	33	2,207	1,671	(536)
Direct Access	1,124	1,141	17	3,116	3,099	(17)
Elective	138	67	(71)	378	239	(139)
Imaging	195	350	155	541	611	69
Outpatients	2,198	2,050	(148)	6,146	6,139	(7)
Community	7,232	7,232	0	21,697	21,697	0
Ambulatory	16	18	1	45	65	20
HCD Block	196	196	0	593	593	0
Block Adjustment	0	544	544	0	1,194	1,194
Other clinical Income NHS	9,949	9,228	(721)	27,655	27,882	227
NHS Clinical Income	**39,467**	**38,530**	**(937)**	**114,074**	**113,491**	**(583)**
Non NHS clinical income	**1,831**	**1,783**	**(48)**	**5,442**	**5,407**	**(34)**
Income From Patient Care Activities	**41,298**	**40,313**	**(985)**	**119,516**	**118,898**	**(618)**
Other Operating Income	**2,526**	**2,524**	**(2)**	**7,428**	**7,694**	**265**
Total	**43,824**	**42,837**	**(987)**	**126,944**	**126,592**	**(352)**

- Income is £0.35m behind plan year-to date predominanltly due to underperformance against ERF activity.
- ERF activity is below plan (£0.7m) at end of Q1
- Other operating income is over plan £0.27 which is research income which is offset with expenditure
- Included in the income position is the adverse impact of ongoing dispute with NHSE relating to high cost drugs (£0.4m ytd and £1.7m for 2026-27)

2.2 Elective recovery fund (ERF) ICSU Income – Q1

ERF Income by ICSU

ICSU	Annual Plan £000's	In Month Income Plan £000's	In Month Income Actual £000's	In Month Income Variance £000's	YTD Income Plan £000's	YTD Income Actual £000's	YTD Income Variance £000's
ACW	8,752	814	720	(93)	2,127	2,100	(26)
CYP	6,791	600	568	(32)	1,651	1,588	(62)
EIM	25,874	2,206	2,343	137	6,172	6,423	251
S&C	29,345	2,555	2,099	(456)	7,132	6,302	(830)
Corp	(389)	(38)	0	39	73	(0)	(73)
Grand Total	70,372	6,136	5,730	(406)	17,154	16,413	(741)

Trust is below its ERF activity by £0.8m at end of quarter 1. Under performance is predominantly within Surgery Division partly offset by over perforamnce in EIM.

ERF Income by POD

POD	Annual Plan £000's	In Month Income Plan £000's	In Month Income Actual £000's	In Month Income Variance £000's	YTD Income Plan £000's	YTD Income Actual £000's	YTD Income Variance £000's
DC	25,299	2,266	1,930	(336)	6,200	5,738	(462)
EL	7,610	667	475	(192)	1,849	1,688	(162)
OP First	26,533	2,245	2,363	118	6,448	6,281	(167)
OP Procedure	10,930	958	962	4	2,656	2,706	50
Grand Total	70,372	6,136	5,730	(406)	17,154	16,413	(741)

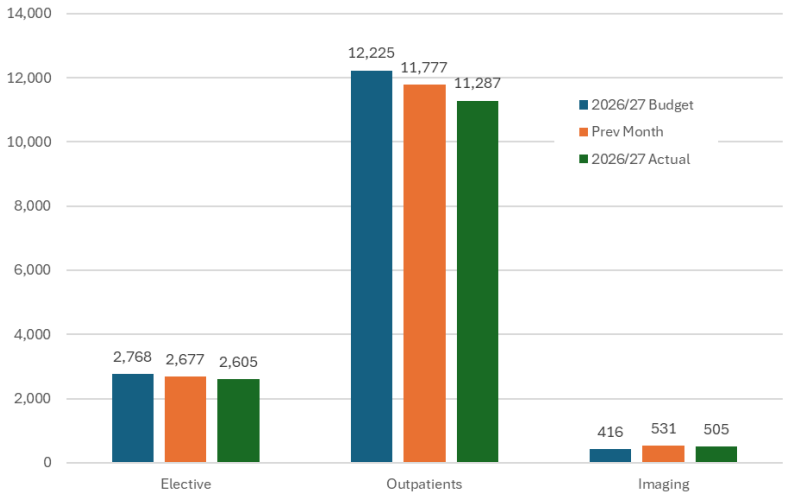
Specialties driving the underperformance year to date are

- Electives:
  - Trauma & Orthopedics – £0.16m
  - Urology – £0.14m
  - Spinal Surgery - £0.10m

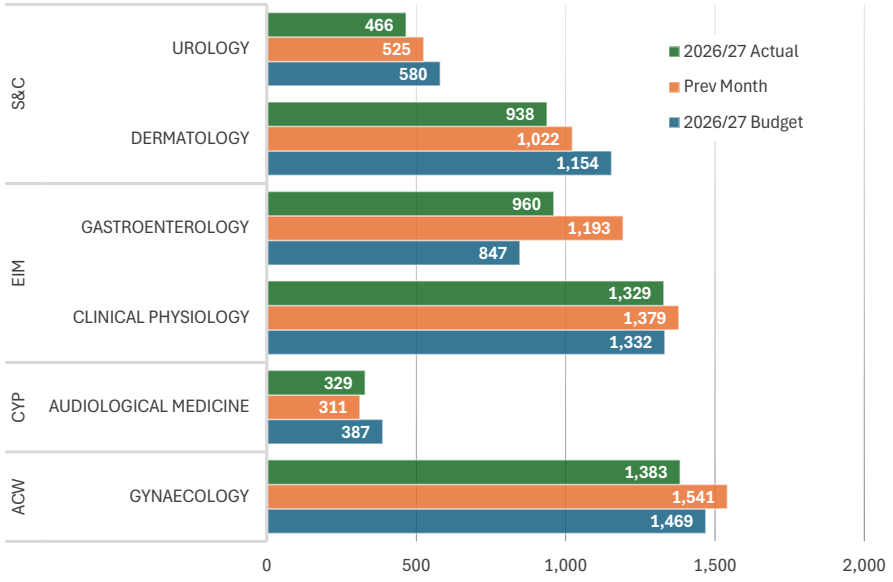
- Outpatients:
  - Dermatology - £0.11m (DNA of 10.6%)

- Overperformance in EIM is predominantly due to outpatient activity within Gastroenterology.

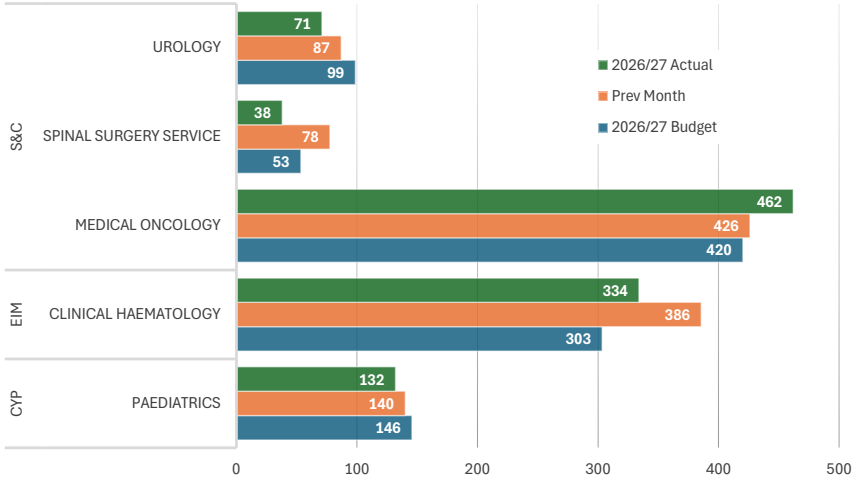
ERF Activity Performance – June



ERF Performance
Elective and outpatients have underperformed against previous month and the plan for June.



Outpatients
Overperformance in Gastroenterology offset by underperformance in Urology and Dermatology



Elective
Underperformance within surgical specialities

3. Expenditure – Pay & Non-pay

3.1 Pay Expenditure

Operational Pay expenditure for June was £31.6m. There was an increase of £0.4m on bank and substantive pay expenditure compared to May. Pay award funding of £5m was received in month. Medical pay awards of £0.5m was paid in June.

Key YTD Pay pressures in the financial position:

- Industrial Action costs - £0.5m.
- Unfunded Thorogood beds - £0.6m
- Childcare packages - £0.3m
- Emergency Medicine including temporary escalation spaces - £0.3m
- Wards general overspends - £0.4m
- Phlebotomy and pathology unfunded roles- £0.1m
- Virtual Ward nursing costs offset with income - £0.1m

	2025-26				2026-27			
	Dec	Jan	Feb	Mar	Apr	May	Jun	Mov^t
Agency	343	282	320	578	253	285	332	47
Bank	1,846	1,662	1,621	2,116	1,570	1,243	1,509	266
Substantive	29,163	28,820	28,706	29,483	29,686	29,328	29,991	663
Total Operational Pay	**31,352**	**30,764**	**30,647**	**32,178**	**31,508**	**30,856**	**31,833**	**976**
Non Operational Pay Costs	(1,682)	160	(101)	19,599	423	357	(183)	(540)
Total Pay Costs	**29,670**	**30,924**	**30,546**	**51,777**	**31,931**	**31,214**	**31,650**	**437**

Enhanced Care

Enhanced care usage has reduced by 408 hours compared to May but is still significantly higher than April usage. The usage continues to exceed funded budgeted establishment.

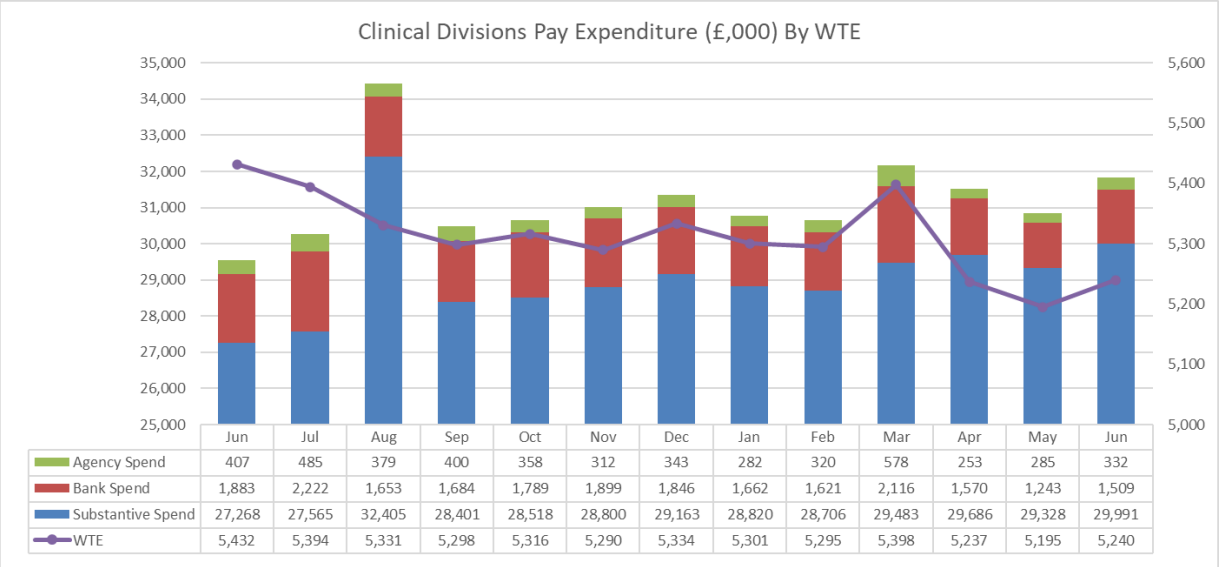
Pay Type	Apr-26	May-26	Jun-26
Substantive hours	5,196	5,616	5,460
Agency Hours	60	120	24
Bank Hours	6,996	8,568	8,412
Total	**12,252**	**14,304**	**13,896**
WTE equivalent	**75.45**	**88.09**	**85.58**

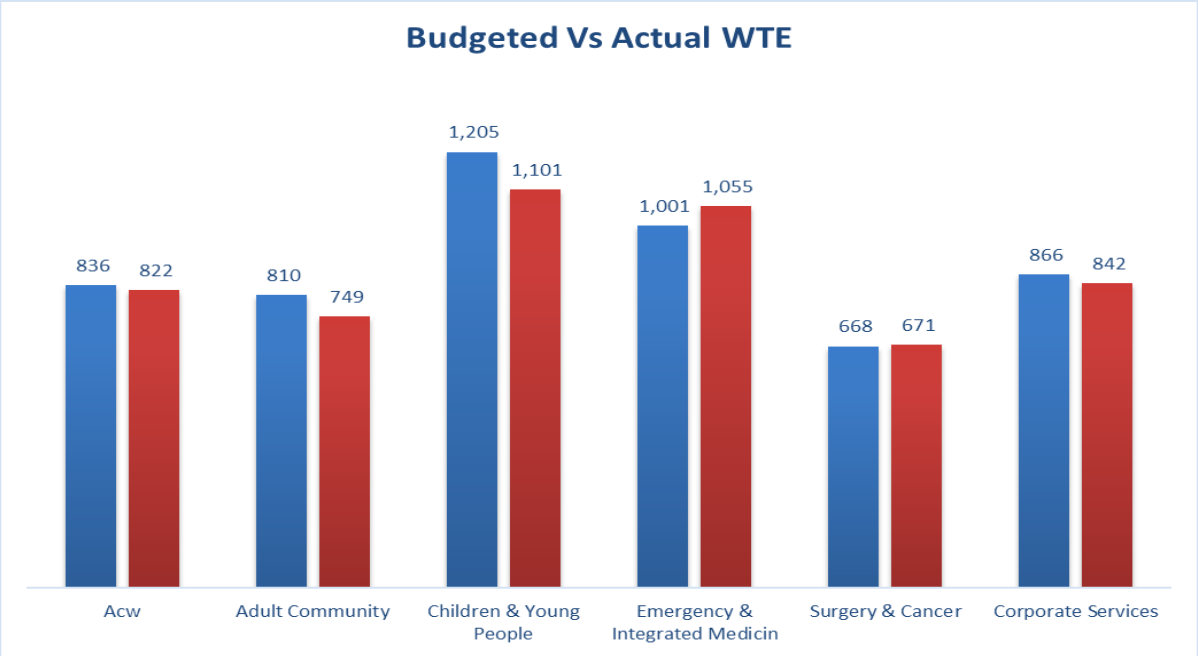
Division	Substantive	Bank	Agency	Total
CYP	1.77	2.66	0.15	4.58
S&C	2.36	4.36	0.00	6.73
EIM	29.49	44.79	0.00	74.27
	33.63	**51.81**	**0.15**	**85.58**

Impact of Sickness on temporary staffing expenditure

The trust booked around 10,500 hours to cover sickness in June. This is 582 hours higher than compared to May. The sickness cover for June equates to 64.81 wte.

Used Hours	Apr-26	May-26	Jun-26	Total
Bank	8,331	8,644	9,305	26,280
Agency	1,129	1,298	1,218	3,645
Subtotal	**9,460**	**9,941**	**10,523**	**29,925**
WTE Equivalent	**58.26**	**61.22**	**64.81**	**184.29**





3.2 Non-pay Expenditure

Non-pay expenditure excluding high-cost drugs decreased by £0.2m compared to May 2026. Key movements include:

- Non recurrent benefit relating to reduction in the provision for bad debts of £1m
- Increase in pathology costs of £0.1m relating to pathology and blood
- £60k insourcing costs in Oncology and Pain in month to cover gap in long term sickness. Cancer non pay is £66k overspend YTD.
- Increase in Orthopaedics clinical supplies of £65k compared to prior month.
- £50k increase in dental rental costs offset by income.
- Decrease in legal fees of £0.1m compared to previous month. YTD spend on legal fees relating to ongoing litigation is £0.7m.

Excludes high-cost drug expenditure and depreciation.
Included in miscellaneous is CNST premium, Transport contract, professional fees, and bad debt provision.

	2025-26				2026-27			
Non-Pay Costs	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Mov^t**
Supplies & Servs - Clin	3,611	5,260	4,379	6,459	3,841	4,045	4,646	601
Supplies & Servs - Gen	236	334	316	489	392	264	290	26
Establishment	261	313	(207)	345	215	173	211	38
Healthcare From Non Nhs	96	126	66	44	84	82	75	(7)
Premises & Fixed Plant	2,004	2,219	1,419	3,150	1,982	2,088	2,202	114
Ext Cont Staffing & Cons	181	382	351	523	251	399	399	0
Miscellaneous	120	1,106	781	(472)	2,088	2,005	998	(1,007)
Chairman & Non-Executives	11	11	11	11	11	11	12	1
Non-Pay Reserve	0	0	0	0	0	0	(0)	(0)
Total Non-Pay Costs	**6,521**	**9,751**	**7,116**	**10,549**	**8,864**	**9,067**	**8,833**	**(234)**

Miscellaneous Expenditure Breakdown

	2025-26				2026-27			
Miscellaneous Breakdown	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Mov^t**
Ambulance Contract	173	193	(45)	203	192	186	164	(22)
Other Expenditure	(1,412)	(771)	95	(6,876)	115	112	151	39
Audit Fees	15	15	7	186	15	14	29	15
Provision For Bad Debts	(14)	327	(113)	4,288	319	41	(988)	(1,029)
Cnst Premium	804	807	785	780	1,024	1,024	1,028	4
Fire Security Equip & Maint	10	22	10	33	11	17	28	10
Interpretation/Translation	44	32	(5)	26	13	49	34	(15)
Membership Subscriptions	135	151	(34)	143	158	159	146	(14)
Professional Services	215	235	134	394	154	322	243	(79)
Research & Development Exp	0	0	0	8	(0)	3	3	0
Security Internal Recharge	16	15	(56)	15	15	15	17	1
Teaching/Training Expenditure	131	79	0	325	71	58	142	84
Travel & Subs-Patients	3	1	3	4	2	4	2	(2)
Work Permits	0	0	0	0	0	0	0	0
Write Down Of Inventories	0	0	0	0	0	0	0	0
Total Non-Pay Costs	**120**	**1,106**	**781**	**(472)**	**2,088**	**2,005**	**998**	**(1,007)**

3.3 Cost Improvement Programme (CIP)

The CIP target in the Trust plan for 2026–27 is £23m. The internal target set for clinical divisions and corporate services, is £27.7m to account for a proportion of the brought forward liability associated with rollover unidentified gap in the prior year (2025/26). The increased internal efficiency target (of £4.7m) has been set to focus improvement on the Trust underlying financial position, which will otherwise deteriorate due to unfunded growth in the recurrent cost-base.

YTD Performance

Trust is reporting actual CIP delivery of £3m against a YTD target of £6.9m, resulting in a delivery of 44% and YTD shortfall of £3.9m (56% of the YTD target). There is £1.3m of finance central non recurrent benefits.

Division	26/27 CIP Target (£,000)	YTD CIP Target (£,000)	Recurrent YTD Actuals (£,000)	Non Recurrent YTD Actuals (£,000)	Total YTD Actuals (£,000)	YTD Variance to Target (£,000)
ADULT COMMUNITY	3,312	828	263	0	263	(566)
CHILDREN & YOUNG PEOPLE	4,899	1,225	0	600	600	(625)
EMERGENCY & INTEGRATED MEDICINE	4,905	1,226	3	211	214	(1,012)
SURGERY & CANCER	4,619	1,155	2	18	20	(1,135)
ACW	4,947	1,237	261	3	265	(972)
DIVISIONS TOTAL	22,682	**5,671**	**529**	**832**	**1,361**	**(4,309)**
CORPORATE SERVICES	2,570	643	28	1,342	**1,370**	727
ESTATES AND FACILITIES	2,406	602	56	0	**56**	(545)
CENTRAL		0	228	0	**228**	228
TRUST TOTAL	27,659	**6,915**	**842**	**2,174**	**3,016**	**(3,899)**
CORPORATE						
CHIEF OPERATING OFFICER	142	12	0	0	0	(12)
FINANCE	354	30	11	1,335	1,345	1,316
IM&T	746	62	0	0	0	(62)
MEDICAL DIRECTOR	195	16	3	0	3	(13)
NURSING & PATIENT EXPERIENCE	463	39	0	0	0	(39)
TRUST SECRETARIAT	202	17	0	0	0	(17)
WORKFORCE	468	39	15	7	22	(17)
CORPORATE TOTAL	**2,570**	**214**	**28**	**1,342**	**1,370**	**1,156**

Forecast

The current forecast delivery is c£9.6m against internal target of £27.7m, resulting in a substantial forecast shortfall.

75% of schemes are under development, with £8.4m of potential savings identified within the opportunities pipeline. These schemes are being actively progressed by divisional teams and PMO workstreams but have not yet completed the required governance processes, including submission and approval of Project Initiation Documents (PIDs) and Quality Impact Assessments (QIAs).

There is ongoing work to increase the recurrency and level of CIP for 2026-27.

4.0 Statement of Financial Position (SoFP)

The net balance on the Statement of Final Position as of 30th June is £227.71m, £0.87m lower than 31st May 2026, as shown in the table below.

Statement of Financial Position as at June 30th 2026	2026/27 M02 Balance	2026/27 M03 Balance	Movement in Month
	£000	£000	£000
NON-CURRENT ASSETS:			
Property, Plant And Equipment	244,644	243,411	(1,233)
Intangible Assets	2,308	2,221	(86)
Right of Use Assets	26,922	26,550	(372)
Assets Under Construction	34,603	34,832	229
Trade & Other Rec -Non-Current	428	423	(5)
TOTAL NON-CURRENT ASSETS	**308,903**	**307,437**	**(1,466)**
CURRENT ASSETS:			
Inventories	(0)	41	41
Trade And Other Receivables	14,959	19,583	4,624
Cash And Cash Equivalents	47,164	44,183	(2,981)
TOTAL CURRENT ASSETS	**62,122**	**63,807**	**1,684**
CURRENT LIABILITIES			
Trade And Other Payables	(88,401)	(91,181)	(2,780)
Borrowings: Finance Leases	(597)	(597)	0
Borrowings: Right of Use Assets	(4,211)	(4,211)	0
Borrowings: Dh Revenue and Capital Loan - Current	(116)	(116)	0
Provisions for Liabilities and Charges	(551)	(542)	9
Other Liabilities	(8,242)	(7,014)	1,228
TOTAL CURRENT LIABILITIES	**(102,117)**	**(103,661)**	**(1,543)**
NET CURRENT ASSETS / (LIABILITIES)	**(39,995)**	**(39,854)**	**141**
TOTAL ASSETS LESS CURRENT LIABILITIES	**268,908**	**267,584**	**(1,325)**
NON-CURRENT LIABILITIES			
Borrowings: Dh Revenue and Capital Loan - Non-Current	(1,276)	(1,276)	0
Borrowings: Finance Leases	(58)	17	75
Borrowings: Right of Use Assets	(23,498)	(23,121)	377
Provisions for Liabilities & Charges	(15,490)	(15,490)	0
TOTAL NON-CURRENT LIABILITIES	**(40,322)**	**(39,870)**	**452**
TOTAL ASSETS EMPLOYED	**228,587**	**227,714**	**(873)**
FINANCED BY TAXPAYERS EQUITY			
Public Dividend Capital	168,030	168,030	0
Retained Earnings	(5,200)	(6,073)	(873)
Revaluation Reserve	65,757	65,757	0
TOTAL TAXPAYERS EQUITY	**228,587**	**227,714**	**(873)**

The most significant movements in the month to 30th June 2026 were as follows:

NON-CURRENT ASSETS

Non-Current assets closed at £307.44m on 30th June 2026, a net decrease of £1.4m from previous month due the following:

- Capital expenditure for owned assets £0.32m
- Monthly depreciation: Owned assets (£1.41m)
- Monthly depreciation: Right of Use assets (£0.37m)

CURRENT ASSETS

Current assets closed at £63.81m in June 2026, a net increase of £1.68m from the previous month. Principal movements comprised Trade and Other Receivables increase £4.62m, and Cash decease of £2.98m as analysed below.

CURRENT LIABILITIES

Current liabilities increased by £1.54m during the month. This movement was primarily driven by a £2.78m increase in trade creditors, which was partially offset by a £1.23m decrease in Other Liabilities (deferred income).

NON-CURRENT LIABILITIES

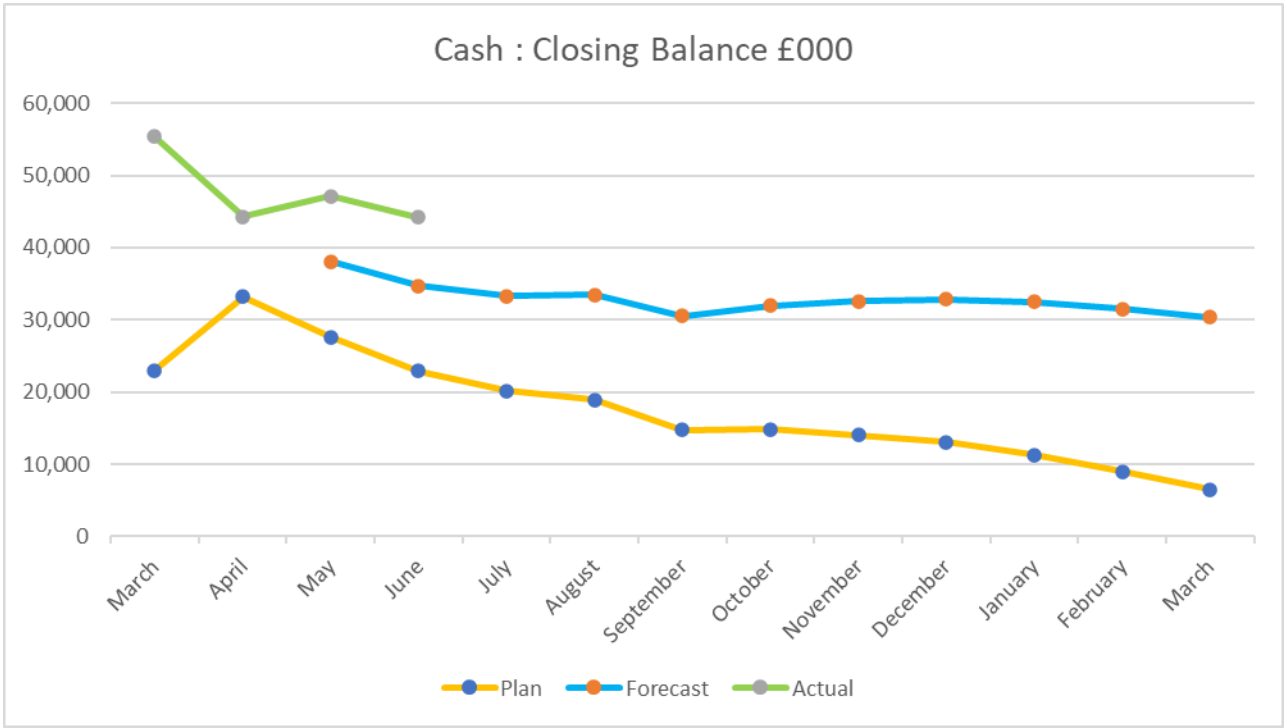
Non-Current liabilities closed at £39.87m in June 2026, a net decrease of £0.42m from previous month due predominantly to the repayment of Right of Use finance lease liabilities and other finance lease liabilities.

RETAINED EARNINGS

Retain Earnings closed at (negative) (£6.07m) in June 2026, a net (decrease) from the previous month's figure of (£0.87m), reflecting the Trust's in-month deficit.

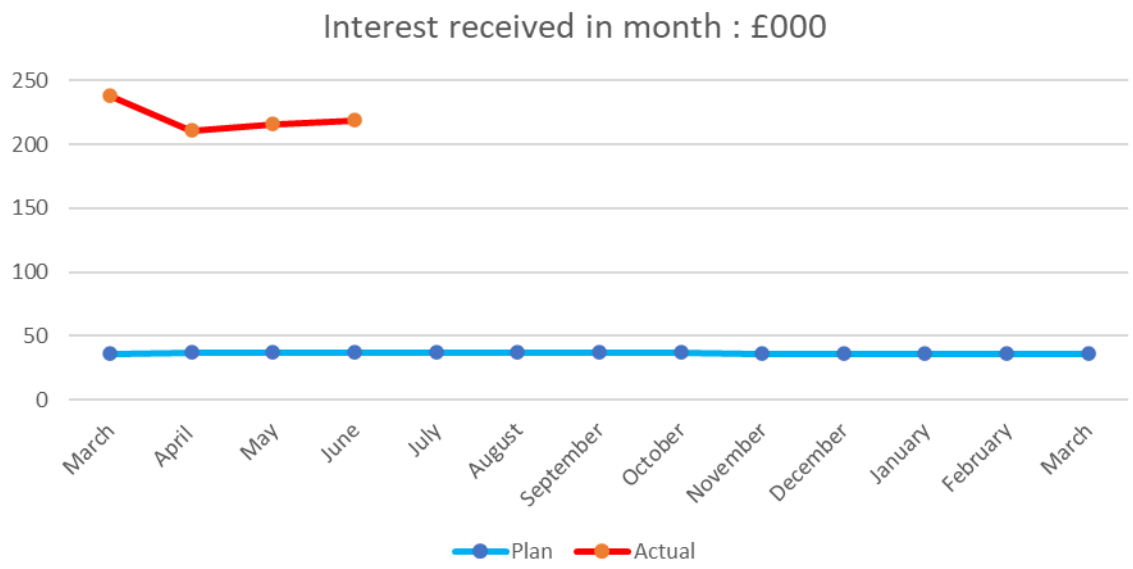
CASH

The Trust's cash balance on 30th June was £44.18m, which is £21.24m favourable to Plan, a decrease of £2.98m from May's closing balance. This positive variance from Plan arose from receipt of Elective Sprint income of £1,56m; Targeted support income of £2.50m and Haringey Neighbourhood Test Bed income of £1.30m in March 2026. These generated an improved cash position which has been perpetuated at June 2026. The in-month decrease was predominantly comprised of reduction in capital creditor as previously forecast.



Interest Received

The interest received in June 2026 of £0.22m is 0.18m above Plan. This favourable variance is the result of higher-than-planned cash balances and interest rates remaining higher for longer than originally planned.



5.0 Capital Expenditure

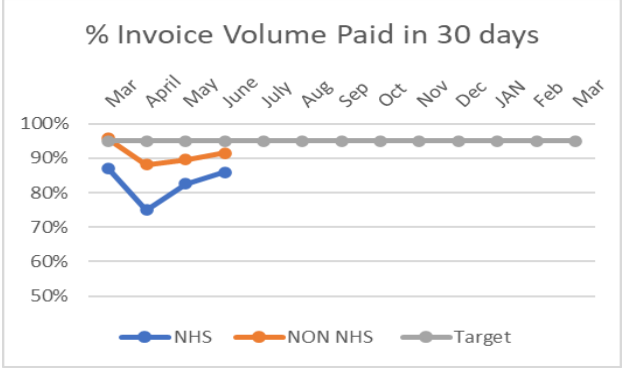
The total capital allocation for 2026/27 consists of £23.43m of internally funded capital together with an indicative £55.85m of Public Dividend Capital (PDC) funding for major projects including Startwell £11m; bringing the total capital allocation to £79.28m

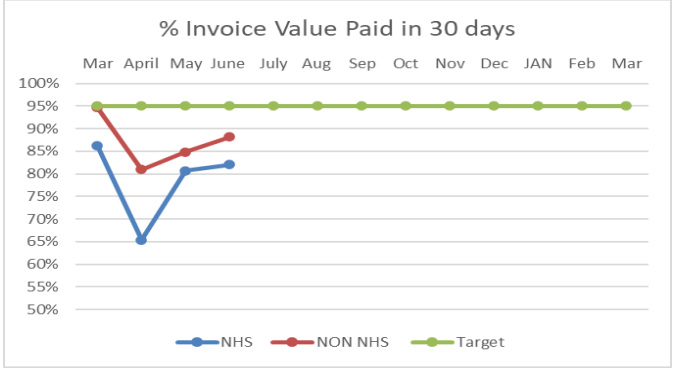
Capital Summary Month 03: 30th June 2026							
all figures: £000	Allocation	In Month			Year to Date		
Internally funded	**Total Allocation**	**In-Month Forecast**	**In-Month Actual**	**In-Month Variance**	**YTD Forecast**	**YTD Actual**	**YTD Variance**
Estate & Strategies Project Capital Programme 2627	13,400	622	151	(471)	1,556	818	(738)
ICT 2627	1,500	60	78	18	150	81	(69)
Other Urgent Priorities 2627	562	20	0	(20)	50	0	(50)
EPR	3,121	45	0	(45)	113	0	(113)
Pharmacy Robot	643				0	0	0
Equipment 2627	750	30	0	(30)	76	0	(76)
Division 2526	250	10	0	(10)	26	0	(26)
MES	450			0			0
Total Owned Assets	***20,676***	***787***	***229***	***(558)***	***1,971***	***899***	***(1,072)***
ROU assets (new leases)							
ROU assets (remeasure increases)	2,750	110	0	(110)	274	0	(274)
ROU assets (remeasures decrease)							0
ROU assets (disposals)							0
Total Right of Use	***2,750***	***110***	***0***	***(110)***	***274***	***0***	***(274)***
Total Internaly Funded	***23,426***	***897***	***229***	***(668)***	***2,245***	***899***	***(1,346)***
Externally Funded							
ESF and PCS Power	19,387	0	90	90	0	123	123
ESF and RCS Fire	5,500	0	0	0	0	317	317
P1- Startwell - £11m	11,000		0	0		73	73
Community HCs	613	0	0	0	0	0	0
RCS CDC	16,400	0	0	0	0	0	0
ED Redev, MH rooms and Dis lounge	2,750	0	0	0	0	8	8
Imaging equipment	200	0	0	0	0	0	0
Total Externaly PDC Funded	***55,850***	***0***	***90***	***90***	***0***	***520***	***520***
Total	***79,276***	***897***	***318***	***(579)***	***2,245***	***1,419***	***(826)***

As of 30th June 2026, the YTD capital expenditure was £1.42m against plan of £2.25m which is £0.83m lower than plan.

Better Payments Practice Code – Monitoring for 2026/27

The Trust is signed up to the NHS commitment to improve its Better Payment Practice Code (BPPC) whereby the target is to pay 95% of all invoices within the standard credit terms. Overall, the Trust's BPPC is 91.23% by volume and 87.84% by value. The BPPC for non-NHS invoices is 91.46% by volume and 88.16% by value. The charts below show performance for March to June 2026.





Meeting Title	**Trust Board – Public Meeting**	**23 July 2026**
Report Title	**Integrated Performance Report**	**Agenda Item: 11**
Executive lead	Chinyama Okunuga, Chief Operating Officer	
Report Owner	Paul Attwal, Operational Director of Performance, Jennifer Marlow, Performance Manager	
Executive Summary	**Background** Board members are presented with the July 2026 integrated performance report. All metrics are shown in summary, but only certain measures have been highlighted for further analysis and explanation based on their trajectory, importance, and assurance. **Issues** Performance in these following areas are drawn to Board members' attention: **Infection Prevention and Control** During June 2026 there was 1 HCAI C Difficile infection and 0 MRSA Bacteraemias, bringing the total number of MRSA Bacteraemia's to 0 for the year (April 2026 – March 2027). **Emergency Care Flow** During June 2026, performance against the 4-hour access standard declined to 68.81%, down from 72.13% in May 2026. The Trust's performance remained below both the West and North London healthcare system average of 80% and the national average of 75%. In June, 7.6% of patients spent more than 12 hours in the Emergency Department, with 277 12-hour trolley breaches recorded. Targeted recovery actions continue, including the expansion of admission avoidance pathways, discharge improvement work and implementation of flow improvement initiatives. **Cancer: 28-Day Faster Diagnosis Standard (FDS) May Performance – 88.8%** This is an improvement of 4.7% compared to April's performance of 84.1%. **Cancer: 31 Days to First and Subsequent Treatment May Performance – 94.2%** This is a decline of 4.1% compared to April's performance of 98.3% **Cancer: 62-Day Combined Treatments May Performance – 80.3%** This is a decline of 3.5% compared to April's performance of 83.8% **Referral to Treatment (RTT): 52+ Week Waits** Performance against 18-week standard for June 2026 was 68.04%, this is a decline of 2.3% from May's performance of 70.34%. The Trust's position against the 52-week performance remains strong, with only 0.36% of patients waiting more than 52 weeks for treatment and no patients waiting over 65 weeks. **Did Not Attends (DNA)** The Trust's overall DNA rate for June 2026 was 9.91% against a target of less than 9%. This is an improvement of 0.08% from 99.9% in May 2026.	

	Complaints Complaints responded to within 25 or 40 working days improved by 7.7%, from 65% in May 2026 to 72.7% in June 2026. The Complaints Team continues to work closely with Divisions to support the timely completion of all complaint investigations and ensure sustained improvement. **Note:** Following the implementation of new theatre software, there have been some issues affecting data reporting. These are currently under review and are expected to be resolved within the next one to two months. **Next steps** There will be deep dives into areas off plan during performance review meetings for respective clinical divisions.
Purpose:	Review and assurance of Trust performance compliance
Recommendation	The Board is asked to take assurance that the Trust is managing performance compliance and is putting into place remedial actions for areas off plan
Board Assurance Framework	Quality 1; Quality 2; People 1; and People 2.
Report history	Trust Management Group
Appendices	1: Integrated Performance Report

NHS
Whittington Health
NHS Trust

Whittington Health NHS Trust

Integrated Performance Report

July 2026

ICARE EQUITY

Integrated Performance Report Overview

NHS Whittington Health NHS Trust

The Whittington Health Integrated Performance Report provides an overview of the Trust's operational, clinical, and workforce performance, highlighting key achievements and areas requiring attention as we continue to deliver safe, effective, and timely care.

ICARE EQUITY

Key Exceptions for Noting

NHS Whittington Health NHS Trust

Emergency Department and Patient Flow

UEC performance declined to 68.8% in June 2026 (from 72.1% in May), driven by sustained growth in attendances, workforce pressures, increased mental health presentations, and ongoing discharge delays contributing to overcrowding. Twelve-hour ED trolley breaches increased significantly to 277, although mental health-related breaches improved, reducing from 26 in May to 15 in June. Flow metrics, including No Criteria to Reside (NCTR) and Long Length of Stay (LLoS), remained largely unchanged, with discharge delays continuing to be impacted by social care and brokerage challenges. Improvement efforts remain focused on strengthening system-wide discharge processes, reducing variation in out-of-hours performance, expanding admission avoidance pathways, and delivering key flow improvement and corridor care actions to support recovery.

Referral to Treatment and Diagnostics

RTT performance in June 2026 remains below trajectory at an unvalidated 68.0% against a national planning target of 72.3%, primarily driven by deterioration in Dermatology and ENT; however, the overall waiting list reduced by 480 patients to 23,012, remaining below the Trust target. Long-wait performance continues to be well controlled, with 52-week waits at 0.36%, significantly below the national threshold, and no patients waiting over 65 weeks. Diagnostic performance improved slightly to 80.5% in June, although capacity constraints in audiology and neurophysiology continue to impact delivery. Recovery actions are focused on recruitment, pathway optimisation, and activity restoration to improve performance against national standards.

Cancer

Cancer performance remains strong overall, with the Trust achieving 88.8% against the Faster Diagnosis Standard (FDS) in May 2026 and maintaining an unvalidated position of 86.0% in June. Performance against the 31-Day Treatment Standard remains robust at 94.2% in May, improving to an unvalidated 100% in June, while the 62-Day Combined Treatment Standard improved from 80.3% in May to an unvalidated 85.2% in June. Although overall performance is improving, challenges remain within specific tumour pathways, particularly Urology, Lung and Upper GI services, where diagnostic and treatment delays continue to impact constitutional standard delivery. Targeted pathway improvements, including prostate pathway redesign and regional work to strengthen lung cancer diagnostics, are being implemented to support sustained recovery.

Activity and Productivity

Performance against key elective access metrics showed improvement in June 2026, with first appointment DNA rates reducing to 9.9%, the first time performance has fallen below 10%, reflecting strengthened patient engagement and pathway improvements. Advice and Guidance responsiveness deteriorated, with 61.8% of requests answered within two days, driven by performance challenges in high-volume specialties including Haematology and Endocrinology. Theatre productivity improved significantly, with a 70% reduction in late starts between April and June following focused operational interventions to improve session efficiency. Non-clinical cancellations remained above expected levels, largely due to staffing and bed capacity issues, while targeted pathway changes have been implemented to reduce clinical cancellations within Urology.

ICARE EQUITY

Key Exceptions for Noting

NHS Whittington Health NHS Trust

Quality and Safety

Quality and patient safety indicators were broadly stable in June 2026, with one hospital-associated Clostridioides difficile infection reported; following multidisciplinary review, the case was deemed unavoidable and learning shared. Complaints performance was 73%, below the 80% target, with communication, medical care and delays remaining the predominant themes, although improvement actions continue across divisions. Full thickness pressure ulcers decreased significantly compared with the previous month across both acute and community settings; however, patient engagement, timely assessment and escalation remain key areas for improvement. Targeted pressure ulcer prevention initiatives, including staff engagement events, policy review and a Trust-wide plan, are being progressed to support sustained improvements in patient safety.

Safer Staffing

Workforce indicators remained largely stable in June 2026, with red shifts increasing slightly from one to two and unfilled rostered shifts remaining unchanged at 13%, reflecting ongoing staffing pressures associated with sickness absence and vacancies. The unregistered staff fill rate increased to 130%, driven by higher enhanced care activity and additional support requirements, while workforce unavailability rose to 26%. Roster approval performance continued to improve, increasing to 54.6 days, demonstrating progress in workforce planning and governance. Staffing levels continue to be closely managed through daily reviews, temporary staffing deployment and focused workforce planning actions to maintain safe staffing levels.

Workforce

Workforce performance remained mixed in June 2026, with appraisal compliance maintained at 78%, supported by a reduction in the number of teams below target and the introduction of refreshed appraisal documentation, guidance and training. Sickness absence remained above the Trust target at 4.4%, with mental health, musculoskeletal conditions and colds continuing to be the main drivers of absence. Targeted divisional actions and ongoing wellbeing, attendance management and appraisal improvement initiatives remain in place to support workforce performance.

Children and Young People

Children and Young People's services continue to make progress in reducing waiting times through targeted investment and recovery programmes, with significant reductions in long waits achieved in Barnet and Haringey. The majority of children waiting over 52 weeks remain within autism and ADHD pathways, with a multi-borough backlog reduction proposal being developed with the ICB to improve access over the next three years. Health Visiting performance has also improved, with service reviews and process improvements contributing to increased delivery of timely new birth visits, particularly in Barnet.

Community - Adults

Community services performance remains mixed, with increasing waiting times in MSK Physiotherapy and Pain services due to rising demand, capacity constraints and pathway changes, although recovery actions are underway. Continuing Healthcare continues to perform strongly, consistently achieving national and NCL assessment targets, while Community Podiatry and Stroke Services have delivered improvements in waiting times and access following investment and service redesign. Falls Services remain challenged by workforce capacity pressures, resulting in increased waiting times in Islington. Recruitment, service transformation and recovery initiatives remain focused on improving access, reducing waits and supporting sustainable recovery.

ICARE EQUITY

Performance Overview

NHS Whittington Health NHS Trust

Status	Metric	Trend	Target	Period	Trust
Emergency Department and Patient Flow					
3	Percentage of Emergency Patients Admitted, Transferred, or Discharged Within Four Hours		82% or higher by March 2027	June 2026	68.81%
2	Percentage of Patients Spending More Than 12 Hours in ED		6.5% or less	June 2026	7.6%
4	Number of Non-Mental Health Patients With a Decision to Admit Who Spent Over 12 Hours in ED		0	June 2026	262
3	Number of Mental Health Patients With a Decision to Admit Who Spent Over 12 Hours in ED		0	June 2026	15
3	Corridor Care – Average Number of Patients Per Day		0	June 2026	22.3
	% of Emergency Activity Diverted to Ambulatory Care		TBC	June 2026	5.1%
3	Average Length of Stay for Non-Elective Admissions (General and Acute)		7.7 days or less	June 2026	10 days
2	Average Length of Stay for Elective Admissions (General and Acute)		2.5 days or less	June 2026	2.66 days
3	Number of Patients Not Meeting Criteria to Reside and Not Discharged		40 or less	June 2026	54
1	Percentage of Patients Readmitted as an Emergency Within 30 Days of Discharge		5.5% or less	June 2026	3.68%

ICARE EQUITY

Performance Overview

NHS Whittington Health NHS Trust

Status	Metric	Trend	Target	Period	Trust
Referral to Treatment and Diagnostics					
1	Total Number of Patients on the Referral to Treatment (RTT) Waiting List		Less than 24,961 by March 2027	June 2026	23,012 Unvalidated
2	Percentage of Incomplete RTT Pathways Waiting Less Than 18 Week		78% or higher	June 2026	68.04% Unvalidated
2	Percentage of Patients Waiting Over 52 Weeks for Elective Treatment		0% or less by March 2027	June 2026	0.36% Unvalidated
3	Percentage of Patients Waiting Under Six Weeks for a Diagnostic Test		91% or higher by March 2027	June 2026	80.49%
Cancer					
1	Faster Diagnosis Standard: Percentage of Patients with Cancer Diagnosed or Ruled Out Within 28 Days		80% or higher by March 2027	May 2026	88.8%
1	Percentage of Patients Receiving First Definitive Treatment Within 31 Days of Cancer Diagnosis		94% or higher by March 2027	May 2026	94.2%
1	Percentage of Patients Receiving First Definitive Cancer Treatment Within 62 Days of an Urgent GP Referral		80% or higher by March 2027	May 2026	80.3%

ICARE EQUITY

Performance Overview

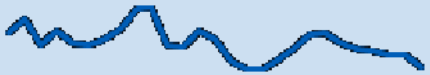
NHS Whittington Health NHS Trust

Status	Metric	Trend	Target	Period	Trust
Activity and Productivity					
1	First to Follow-Up Appointment Ratio (Acute)		1.8 or less	June 2026	0.96
3	Did Not Attend (DNA) Rates for New Appointment		5.6% or less by March 2027	June 2026	9.91%
	GP Referrals to an Acute Service		TBC	June 2026	11,083
	Total Referrals to Acute Service		TBC	June 2026	26,450
3	Advice and Guidance % of Responses Within 2 Days		80% or higher	June 2026	61.83%
2	First Outpatient Attendances: Percentage of Activity Delivered Against Plan		100% or higher	June 2026	94.84%*
2	Outpatient Procedures: Percentage of Activity Delivered Against Plan		100% or higher	June 2026	92.80%*

ICARE EQUITY

*Figures are based on flex positions and are subject to change.

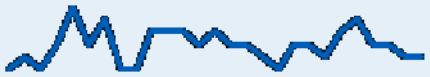
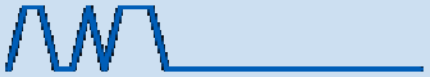
Performance Overview

Status	Metric	Trend	Target	Period	Trust
Activity and Productivity					
3	Ordinary Elective Care: Percentage of Activity Delivered Against Plan		100% or higher	June 2026	82.73%*
2	Day Case Activity: Percentage of Activity Delivered Against Plan		100% or higher	June 2026	95.09%*
2	Operating Theatre Utilisation Rate		85% or higher	June 2026	78.36%
4	Number of Hospital Operations Cancelled on the Day		0	May 2026	24
	Cancelled Operations not Rebooked Within 28 Days		0	May 2026	Not available
	Number of Births per Month		TBC	June 2026	244

*Figures are based on flex positions and are subject to change.

Performance Overview

NHS Whittington Health NHS Trust

Status	Metric	Trend	Target	Period	Trust
Quality and Safety					
1	Percentage of Patients Assessed for Venous Thromboembolism (VTE) Risk		95% or higher	June 2026	96.14%
1	Inpatient Falls		Less than 400 for 2025/26	June 2026	29
1	Number of Clostridioides Difficile Infections (C. Diff)		Less than 22	June 2026	1
1	Number of Methicillin-Resistant Staphylococcus Aureus (MRSA) Infections		0	June 2026	0
1	Number of Acute Pressure Ulcers (Grades 3 to 4)		Less than 51 for 2026/27	June 2026	4
1	Summary Hospital-Level Mortality Indicator (SHMI)		1	March 2025 – February 2026	0.87
1	Inpatient Survey Satisfaction Rate: Positive Responses		90% or higher	June 2026	94.95%
2	Percentage of Complaints Responded to Within 25 or 40 Days		80% or higher	June 2026	72.7%

ICARE EQUITY

Performance Overview

NHS Whittington Health NHS Trust

Status	Metric	Trend	Target	Period	Trust
Safer Staffing					
2	Red Shifts - Number of Shifts Assessed As High Staffing Risk Based on Safe Staffing Indicators		0	June 2026	2
	Red Flags – Inpatient Maternity		TBC	June 2026	12
	Care Hours Per Patient Day - Average Direct Care Hours Delivered Per Patient Over a 24-Hour Period		N/A	June 2026	10.5
1	Percentage Fill Rate for Registered Staff - Proportion of Planned Registered Staffing Covered on Wards		Between the range of 95% - 105%	June 2026	96%
3	Percentage Fill Rate for Unregistered Staff - Proportion of Planned Unregistered Staffing Covered on Wards		Between the range of 95% - 105%	June 2026	130%
2	Percentage of Unfilled Rostered Shifts - Proportion of Planned Staffing Not Filled Across All Rostered Services		Less than 10%	June 2026	12.96%
2	Roster Approval Lead Time - Number of Days in Advance Rosters Are Finalised and Approved Before Going Live		56 days or more	June 2026	54.6
2	Percentage of Workforce Unavailable for Rostering Including Maternity Leave		Between the range of 20% - 24%	June 2026	26.04%

ICARE EQUITY

Performance Overview

NHS Whittington Health NHS Trust

Status	Metric	Trend	Target	Period	Trust
Workforce					
1	Mandatory Training Completion Rate		85% or higher	June 2026	89.2%
3	Percentage of Completed Appraisals		85% or higher	June 2026	78.1%
3	Percentage of Sickness Absence		3.5% or less	June 2026	4.4%
1	Staff Turnover Rate: Percentage Leaving in Last 12 Months		13% or less	June 2026	9.1%
1	Vacancy Rate Percentage		10% or less	June 2026	5.24%
1	Average Time to Hire (Days)		63 days or less	June 2026	55

ICARE EQUITY

Performance Overview

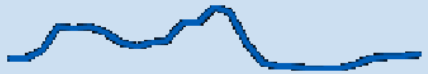
NHS Whittington Health NHS Trust

Status	Metric	Trend	Target	Period	Trust
Community – Children and Young People					
2	New Birth Visits by Health Visitors (Haringey)		95% or more completed within 14 days	May 2026	91.3%
2	New Birth Visits by Health Visitors (Islington)		95% or more completed within 14 days	May 2026	92.75%
2	New Birth Visits by Health Visitors (Barnet)		95% or more completed within 30 days	May 2026	94.66%
4	Percentage of CYP Patients Waiting Over 52 Weeks		Less than 1% of total service	June 2026	8.69%
1	Average Wait Time to First Appointment: Occupational Therapy (OT)		18 weeks or less	June 2026	8.5 weeks
1	Average Wait Time to First Appointment: Speech and Language Therapy (SLT)		13 weeks or less	June 2026	10.1 weeks
2	CAMHS Wait Times to First Appointment (Excluding Neurodevelopmental Disorders)		4 weeks or less	June 2026	5.3 weeks
3	First Community CYP Health Service Activity Within 18 Weeks		78% by March 2027	June 2026	64.68%

ICARE EQUITY

Performance Overview

NHS Whittington Health NHS Trust

Status	Metric	Trend	Target	Period	Trust
Community – Adults					
2	Average Wait Time to First Appointment (All ACS Services)		6 weeks or less	June 2026	6.3 weeks
1	Percentage of Patients Waiting Over 52 Weeks for an Appointment		Less than 1% of total service	June 2026	0.12%
1	Percentage of Patients with Urgent Rapid Response Referrals Seen Within 2 Hours		80% or higher	June 2026	80.8%
1	Continuing Healthcare 28-Day Referral to Complete Assessment		50% or higher	June 2026	61.11%
	Total Appointments for District Nursing		No target – Monitoring only	June 2026	30,478
1	Percentage of Patients Seen Within 48 Hours of Referral to District Nursing		80% or higher	June 2026	96.3%
2	Number of Category 3 and 4 Pressure Ulcers in Adult Community Care		Less than 209 for 2026/27	June 2026	21
	Percentage of Virtual Ward Occupancy		80%	June 2026	Not Available
4	First Community Health Service Activity Within 18 Weeks		78% by March 2027	June 2026	67.74%

ICARE EQUITY

Emergency Department

Whittington Health NHS Trust

Urgent and Emergency Care (UEC) Performance Summary

UEC performance decreased to 68.81% in June 2026 from 72.13% in May. Performance was impacted by a continued increase in attendances, which stood at 9,611 an increase of 500 compared to the same month in 2025.

Key Drivers of 4-Hour Performance Challenges

- Out-of-hours variability: Continued fluctuations in performance, particularly during evenings and weekends, which has been further impacted by increases in out of hours attendances
- Workforce pressures: Elevated sickness levels among medical and nursing staff
- Increased Mental Health presentations
- Delayed discharges, resulting in overcrowding

12 hr ED trolley breaches saw a significant increase to 277 in June from 197 May, there was however a significant decrease in mental health related 12-hour breaches to 15 in June from 26 May.

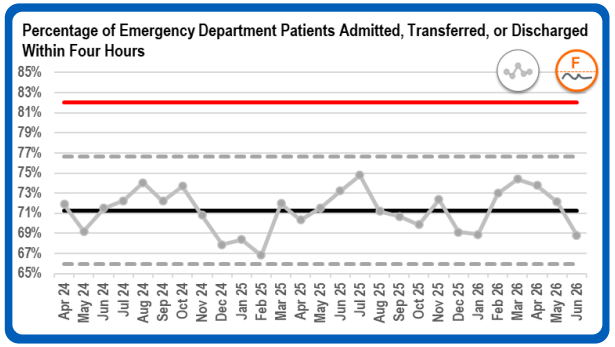
NCTR and LLOS remained stable in June compared to May, with no real improvements in either, this was predominantly driven by delays in social care and brokerage. Closer collaboration with Local Authorities continues to support earlier discharges, along with developing more effective prevention of unnecessary admissions.

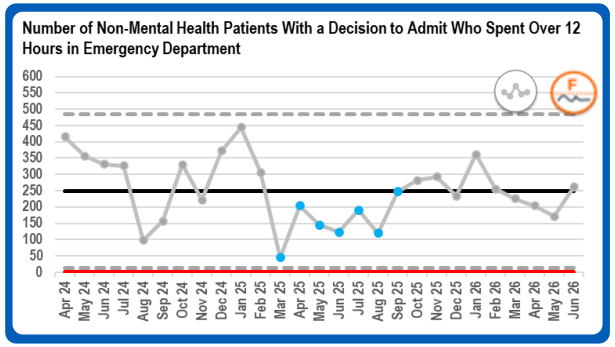
Strategic Priorities Moving Forward

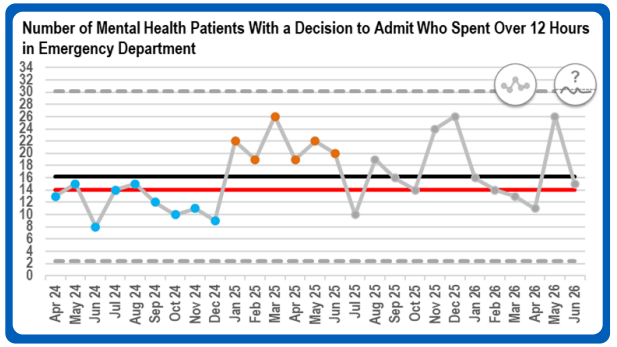
- Early system-wide discharge escalation: Engaging community services, social care, mental health providers, and local councils, following DAG discussion.
- Improvements with admission avoidance using Hospital at Home and other local authority pathways.
- Full implementation of Flow Improvement Programme actions.
- Reducing criteria to reside and long length of stay (LLoS).
- Implement GIRFT Corridor care actions.

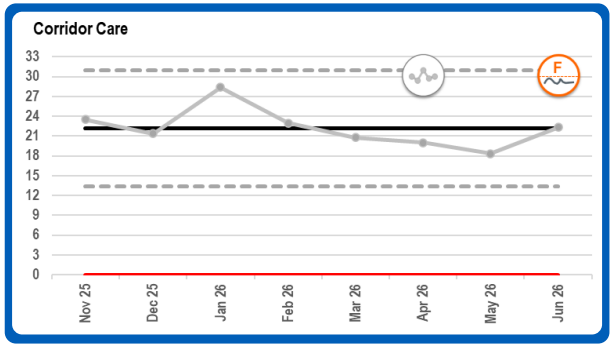
Targeted Performance Goals

- Optimising out-of-hours care to reduce variation in waiting time.
- Increased use of streaming pathways.
- Enhanced admission avoidance pathways to support flow and patient care.
- Expanded Extended Emergency Medicine Ambulatory Care (EEMAC) footprint to support treatment times.









ICARE EQUITY

Referral-to-Treatment and Diagnostics

Whittington Health NHS Trust

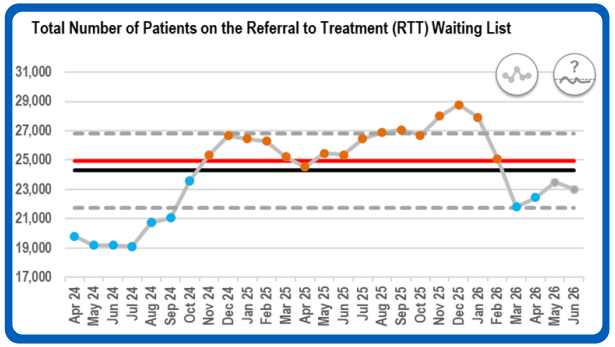
Referral-to-Treatment and Diagnostics

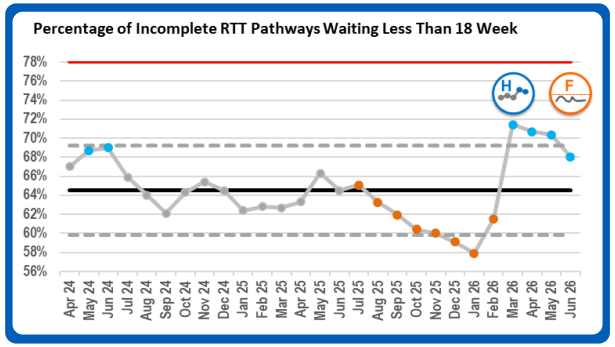
RTT: The unvalidated total RTT back log for June 2026 is currently at 23,012 which remains below the target of 24,961 and is an improvement of 480 from 23,492 in May 2026.

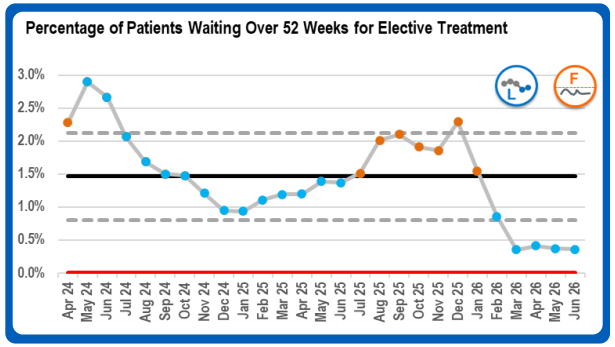
RTT 18-week performance for June 2026 is due for submission on the 22nd July 2026 therefore figures reported here are unvalidated, performance against the 18-week standard currently at 68.04%, representing a 4.29% shortfall against the national planning trajectory of 72.31%. This variance is largely driven by deterioration in a small number of specialties, most notably Dermatology and ENT, both of which experienced an approximate over 15 percentage point decline during the month.

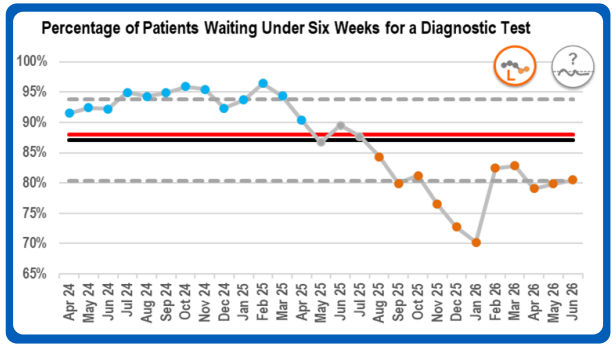
Notwithstanding the overall RTT position, long-wait performance remains strong and well controlled. The proportion of patients waiting over 52 weeks stands at 0.36%, significantly below the national threshold of 1%, and there are no patients waiting over 65 weeks, indicating sustained grip on the longest waits.

DM01: Diagnostic performance in June 2026 has improved to 80.49%, a slight improvement of 0.59 percentage points from May. However, capacity constraints persist in key areas, particularly audiology and neurophysiology, which continue to impact overall diagnostic waiting times. Targeted specialty-level recovery plans are being implemented, focusing on stabilising capacity through recruitment, pathway optimisation, and restoring activity, to support delivery of national diagnostic standards over the coming months.









ICARE EQUITY

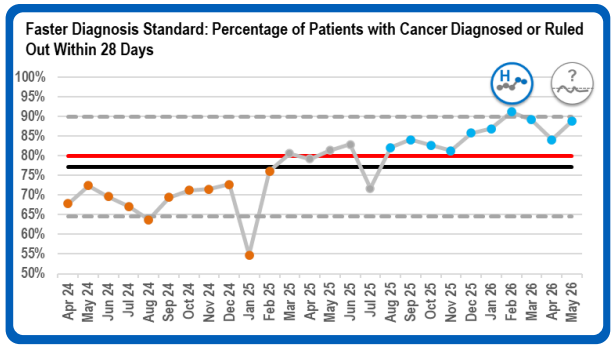
Cancer

Faster Diagnosis Standard: Percentage of Patients with Cancer Diagnosed or Ruled Out Within 28 Days

Performance against the 28-Day Faster Diagnosis Standard (FDS) achieved 88.8% for May 2026. Unvalidated June 2026 position is at 86%.

Performance in Gynaecology improved in May with the service achieving 75.2%.

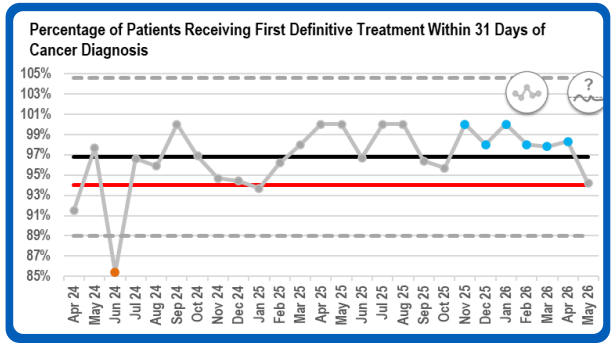
The Urology performance in May 2026 achieved 69.2%. The performance has improved and the service is working on streamlining the prostate pathway implementing an MRI pathway via the CDC Wood Green centre.



Percentage of Patients Receiving First Definitive Treatment Within 31 Days of Cancer Diagnosis

Performance against the 31-Day Treatment Standard May 2026 achieved 94.2%. Unvalidated June 2026 position is at 100%. The Trust has continued to sustain and deliver effective pathway management.

The Urology service achieved 75% for May 2026 having challenges within the surgical pathway.



Percentage of Patients Receiving First Definitive Cancer Treatment Within 62 Days of an Urgent GP Referral

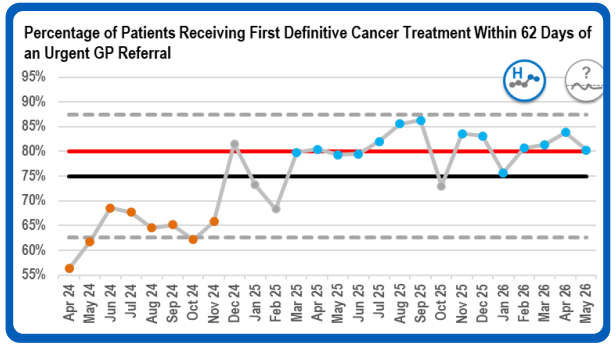
Performance against the 62-Day Combined Treatments Standard was 80.3% in May 2026. The unvalidated June position is 85.2%

Lung performance achieved 75% for May 2026. The pathway continues to experience regional scrutiny, with the NCL Cancer Alliance prioritising lung cancer improvement work. UCLH have capacity challenges for the EBUS diagnostic pathway, with the aim of improving turnaround times and strengthening resilience across the pathway.

The Upper GI service achieved 66.7% for May 2026 with an improved unvalidated performance for June 2026 at 75%

The Urology performance achieved 70% in May 2026. Delays continue to be linked to the slow implementation of the one-stop pathway, which has not yet been fully adopted across the service.

Gynaecology performance achieved 71.4% and the remaining tumour groups all achieved above the constitutional standard of 85% for May 2026



Activity and Productivity

Whittington Health NHS Trust

Did Not Attend (DNA) and Advice and Guidance (A&G)

DNA: The Trust achieved a key milestone in June 2026, with DNA rates for first appointments reducing to 9.91%, and hopefully marks an ongoing trend of improvement as June remains below 10%. This is due to improved patient engagement and targeted pathway changes, supported by strengthened processes, enhanced communication, and a focus on maximising clinic utilisation.

A&G: In June 2026, the Trust received 689 Advice and Guidance requests, of which 61.83% (426) were responded to within two days, a decline of 10.31% from 72.14% in April.

Highest volumes were in Haematology, Endocrinology, and Cardiology. Haematology received 112 requests, with 56.3% responded to within two days (down 20.3% from 76.6% in May). Endocrinology received 80 requests, achieving 75% (down 22.3% from 97.3%). Cardiology received 99 requests, with 82.8% responded to within two days (up 10.1% from 72.7%).

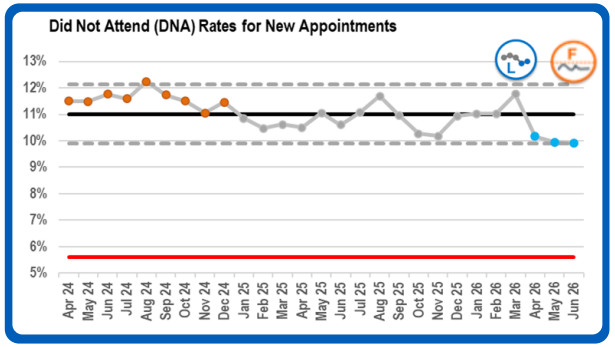
Theatres

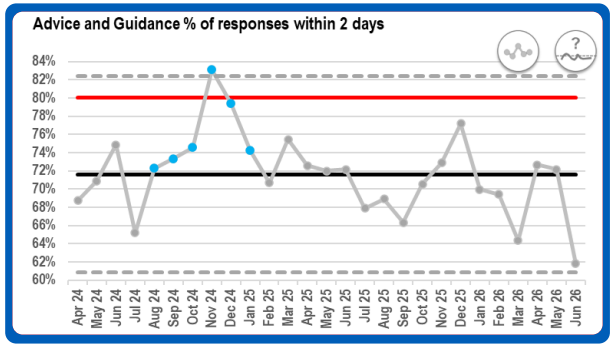
Theatre utilisation

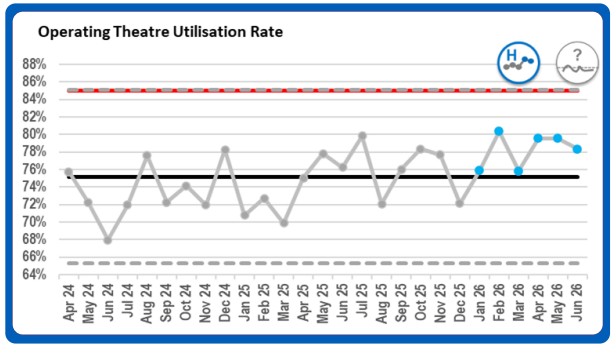
- Late starts decreased significantly 70%, from April to June 2026 as result of daily huddle focussing on timely team brief and “send” for first patient and ensuring agreed golden patient
- Focussed support for Dental, Gynaecology and Urology, benchmarking against peer providers productivity data, cases / session
- Use of actual procedure time from theatre management system to inform booking and ensure improved utilisation of allocated theatre time.

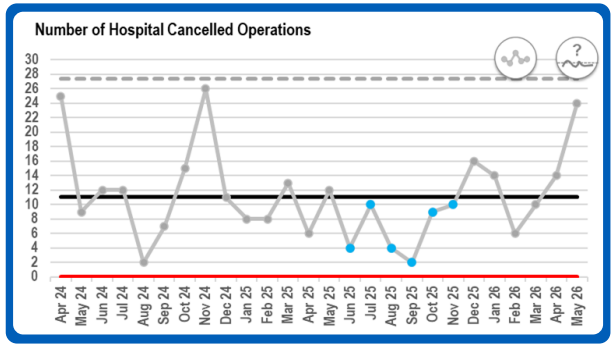
Cancellations

- High number of non-clinical cancellations 21, median 11, of which 12 were due to changes in bank booking for theatre staff and 6 due to bed availability
- High Urology clinical cancellations mitigated with adoption of GIRFT recommended new pathway to screen for urinary infections and provide timely antibiotic treatment to support completion of procedure









ICARE EQUITY

Quality and Safety

NHS Whittington Health NHS Trust

Infection Prevention and Control

In June 2026, the Trust reported one case of Clostridioides difficile infection (CDI) which was classified as a Hospital-onset, Hospital-associated (HOHA) case.

The patient had known co-morbidities and established risk factors for CDI who required broad-spectrum antibiotics in response to clinical condition.

A post-infection review (PIR) was undertaken with multidisciplinary team (MDT) involvement. Following review, the case was deemed unavoidable.

PIR discussions are conducted for each CDI case to identify any gaps in practice, facilitate shared learning, and support continuous improvement in the quality and safety of patient care.

The findings and learning points from this PIR have been shared with relevant stakeholders, who have been asked to disseminate them to their teams to promote awareness and reinforce good practice.

Complaints

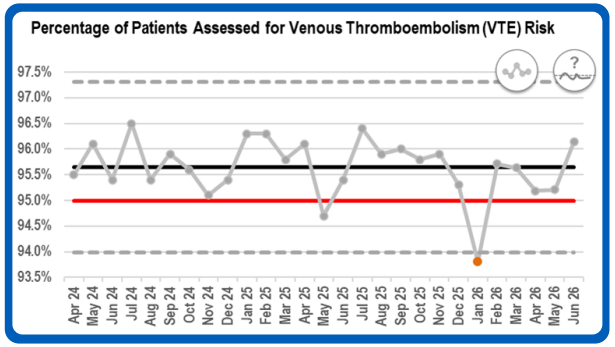
In June 2026, complaints performance was 73% (56/77), which is below the 80% target. A total of 77 complaints were due a response during the month.

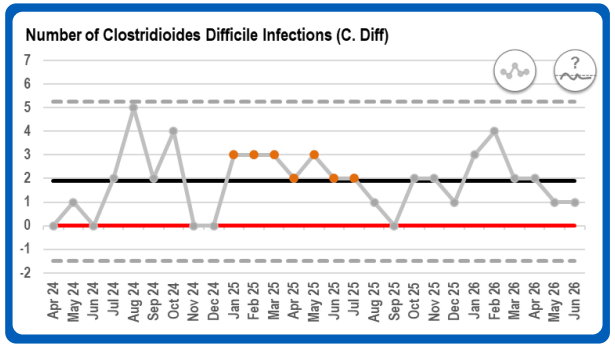
The complaints due a response in June 2026 were allocated across the Divisions as follows: Emergency Integrated Medicine 30% (23), Surgery and Cancer 25% (19), Acute Clinical and Women's Services 19% (15), Adult Community Services 10% (8), Estates and Facilities 10% (7), and Children and Young People 6% (5).

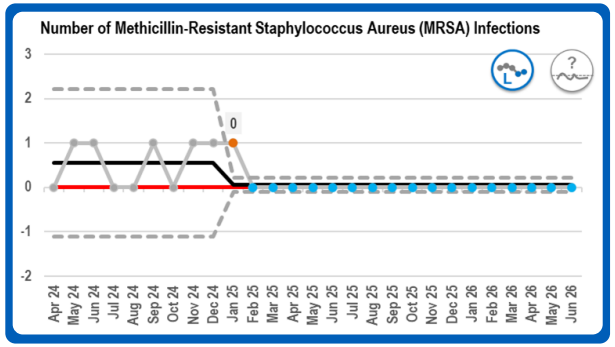
Severity of complaints: 5% (4) were designated as 'high' risk, 23% (18) as 'moderate' risk, and 72% (55) as 'low' risk.

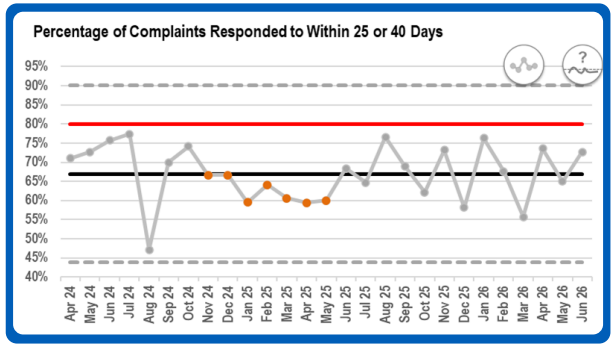
Themes: The main themes from the complaints due a response in June 2026 remained broadly consistent with previous months, namely Communication, Medical Care and Delays. Divisions and the Complaints Team continue to work collaboratively to address these areas through targeted learning and improvement actions.

Of the 56 complaints closed during June 2026, 23% (13) were 'upheld', 63% (35) were 'partially upheld', and 14% (8) were 'not upheld', meaning that 86% of complaints closed during the month were upheld in full or in part.









ICARE EQUITY

Quality and Safety

NHS Whittington Health NHS Trust

Pressure Ulcers

There were 25 full thickness pressure ulcer incidents affecting 20 patients in May 2026; a decrease of 17 from the previous month.

Acute Pressure Ulcers:

Four category 3 pressure ulcers developed on four patients in the hospital setting, a decrease of three from May 2026. Three of the category 3 pressure ulcers were deterioration of pre-existing pressure damage. The damage occurred across four different clinical areas, indicating variability rather than concentration within a single service. Key learning themes identified include the impact of patient non-engagement or inability to tolerate repositioning and seating guidance, and the effect of prolonged sitting periods. These themes highlight the importance of proactive assessment, consistent monitoring, and important of patient education and use of different communication strategies to support engagement.

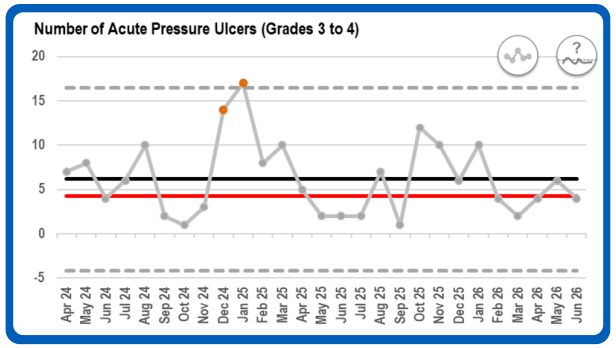
Community Pressure Ulcers:

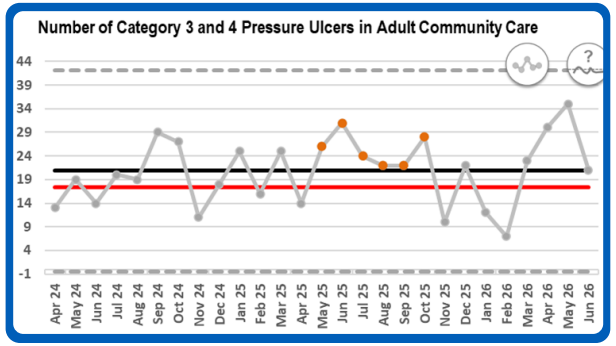
Twenty-one category 3 pressure ulcers developed on sixteen patients in the community setting, a decrease of fourteen from May 2026. Two patient with multiple co-morbidities and complex needs developed 3 of more pressure ulcers.

Key learning themes include completion of planned assessments during visits, delayed escalation of worsening wounds, and patient non-engagement with agreed prevention plans. These factors continue to impact the effectiveness of preventative interventions and timely treatment.

The Trust is undertaking a number of pressure ulcer focused listening events for nurses and MDT staff to better understand the practicalities of the challenges in implementing effective pressure ulcer prevention care; the feedback will be used to support the new Trust Pressure Ulcer Improvement Plan which is currently in development, addressing the key themes identified across both settings.

Trust divisions, alongside the Pressure Ulcer Group, are actively reviewing these findings to inform targeted and coordinated improvement strategies. In parallel, the Trust Pressure Ulcer Prevention Policy is under review to ensure alignment with best practice, strengthen clinical guidance, and support sustained improvements in patient safety and outcomes.





ICARE EQUITY

Safer Staffing

Whittington Health NHS Trust

Safer Staffing

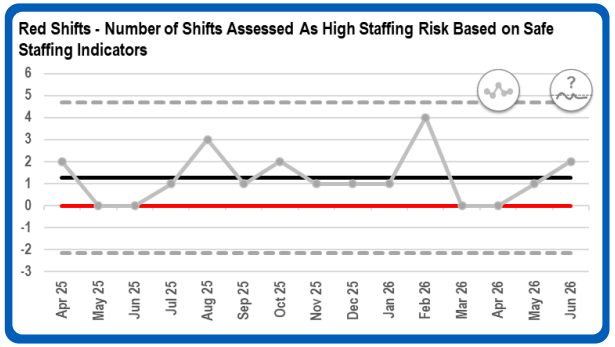
Red Shifts: June 2026 recorded 2 red shifts, compared with 1 red shift in May 2026. The increase reflects a small number of shifts affected by staffing pressures and short-notice gaps. Overall, red shifts remain low and continue to be managed through daily staffing reviews, staff redeployment and temporary staffing support. Over the last 12 months, the Trust has maintained a relatively low level of red shifts.

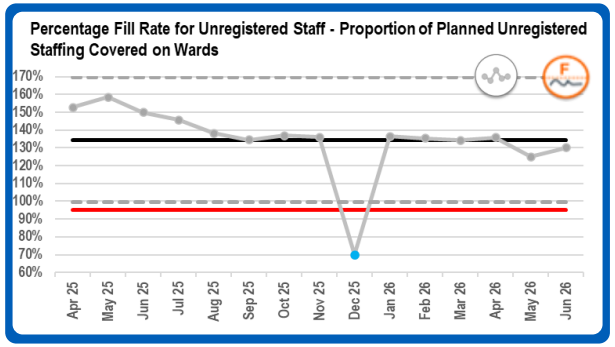
Percentage Fill Rate for Unregistered Staff: The unregistered workforce fill rate was 130% in June 2026, compared with 125% in May 2026. This continues to reflect higher levels of enhanced care activity and additional support requirements above planned establishment levels. Temporary staffing usage remains closely monitored, with deployment processes supporting safe staffing across clinical areas.

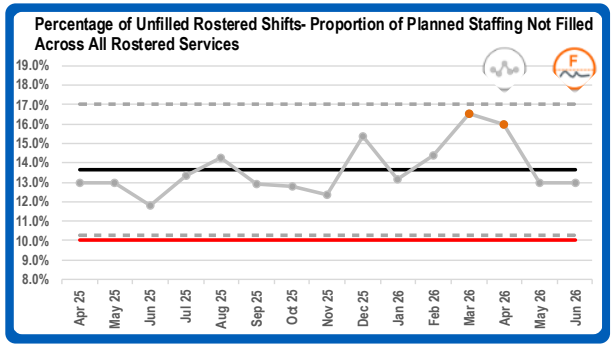
Percentage of Unfilled Rostered Shifts: Unfilled rostered shifts remained broadly stable at 13.0% in June 2026, compared with 13.0% in May 2026. Remaining gaps continue to be largely attributable to short-notice sickness, vacancies and unforeseen staff absence. Roster management and proactive workforce planning remain key areas of focus.

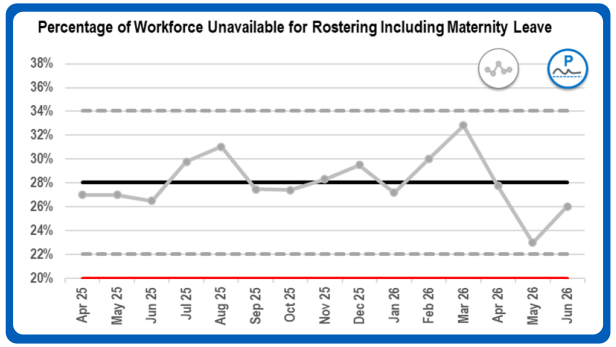
Roster Approval Lead Time: Roster approval performance improved to 54.6 days in June 2026, compared with 50 days in May 2026. Although still slightly below the organisational target, this demonstrates continued improvement in roster planning and governance. Performance is reviewed through Staffing Governance meetings, with targeted actions in place for areas requiring further improvement.

Percentage of Workforce Unavailable: Workforce unavailability increased to 26.0% in June 2026, compared with 23.0% in May 2026. The main contributing factors remain annual leave, sickness absence and parenting leave. While performance is above the target range, ongoing management through Staffing Governance meetings and continued focus on absence management and roster planning aim to support improvement.









ICARE EQUITY

Workforce

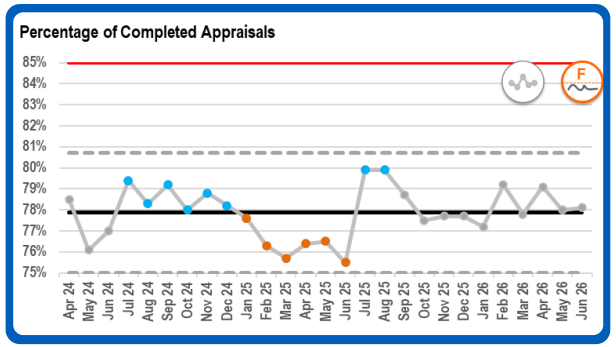
Appraisals

Appraisal compliance across the Trust has been maintained at 78%. Acute Clinical and Women's Services (ACW) and Estates and Facilities are the only divisions currently achieving the Trust target, with compliance of 86%.

Corporate Divisions and Surgery and Cancer continue to have the lowest compliance levels (below 71%) and represent the greatest opportunity to improve the Trust's overall performance. Senior divisional leaders are asked to review compliance at team level and ensure robust improvement plans are in place, including protected time for managers and staff to complete appraisals.

The number of teams below the Trust target has reduced from 195 in May 2026 to 172, demonstrating continued progress, although further improvement is required.

Following staff consultation, the Trust's appraisal documentation has been refreshed to improve usability and the overall experience for both appraisers and appraisees. This has been supported by updated guidance and training delivered by the Organisational Development Team to increase engagement, improve the quality of appraisal conversations, and promote a more consistent approach across the organisation.

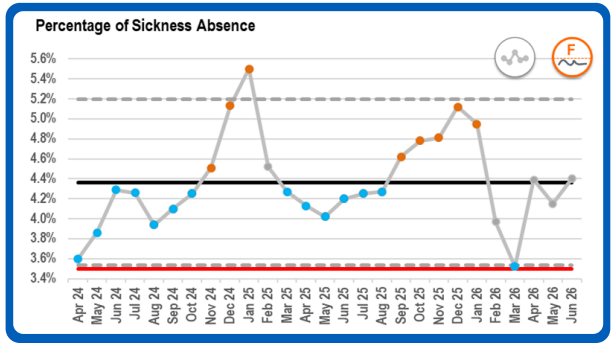


Sickness Absence

The Trust's sickness absence rate for June was 4.4%, which remains above the Trust target of 3.5%.

Whilst this continues to exceed the target, the position is relatively consistent with sickness absence levels seen over the past two years, reflecting established seasonal variance. Mental health related absence accounted for the highest number of days lost during June, followed by MSK problems and colds. These continue to represent the most significance causes of sickness absence and reinforce the importance of maintaining a proactive approach to well-being, early intervention and timely management support. Performance across divisions remains variable. All clinical divisions reported sickness absence above the Trust target as well as some of the corporate services namely Estates and Facilities, Medical Directorate, Nursing and Patient Experience.

The remaining Corporate Services continue to perform under the Trust 3.5% target –Chief Operating Officer, Finance, IM&T, Procurement, Strategy and Improvement and Workforce.



Community – Children and Young People

Whittington Health NHS Trust

Community CYP

Number of Children and Young People Waiting Over 52 Weeks

The significant majority of Children and Young People (CYP) waiting over 52 weeks to be seen are waiting for an autism or ADHD assessment in Haringey or Islington. WH service leads are currently working with WNL ICB and other local providers on a proposal to reduce the backlog over the next 3 years. The proposal is focused on delivering a substantial number of assessments across 5 boroughs. If funding is agreed this will support a significant improvement in provision for children, young people and families.

For the last 18 months CYP therapy services in Haringey and Islington have been working hard to use additional one off investment to support a reduction in waiting times. The additional funding has been used to increase staff capacity to complete initial assessments and deliver therapy interventions. The investment has been targeted at reducing the longest waiting times.

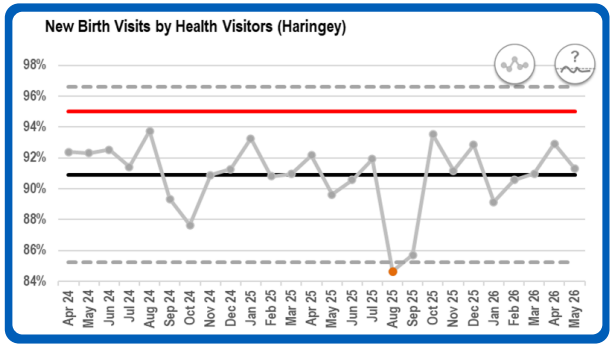
In Barnet the number of CYP waiting 30+ weeks has reduced from 120 in January 2025 to 0 and the number of CYP waiting 18+ weeks has reduced from 236 in January 2025 to 56. As of May 2026, **1,904** assessments have been completed during this project, 91% of the September 2026 target.

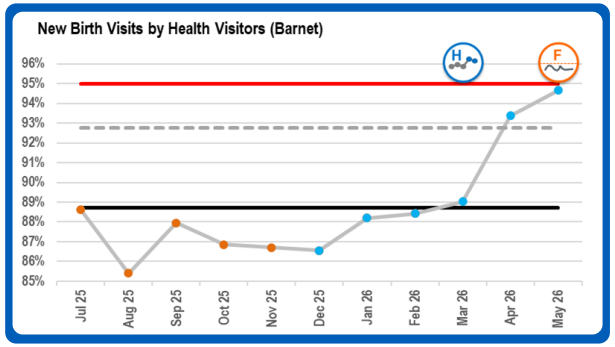
In Haringey the number of CYP waiting over 18 weeks has reduced, in particular there has been improvement in the early years team. 1,047 assessments have been completed during this project, 59% of the 1,787 target to be completed by March 2027.

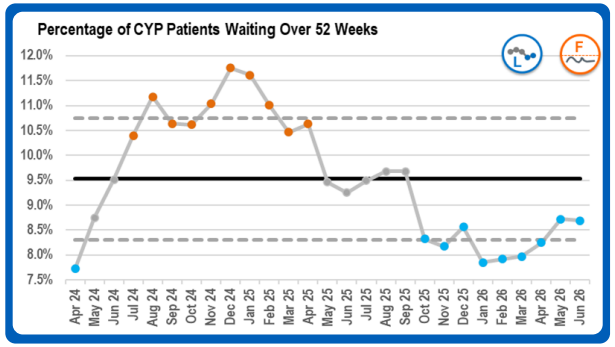
Health Visiting – New Birth Visits

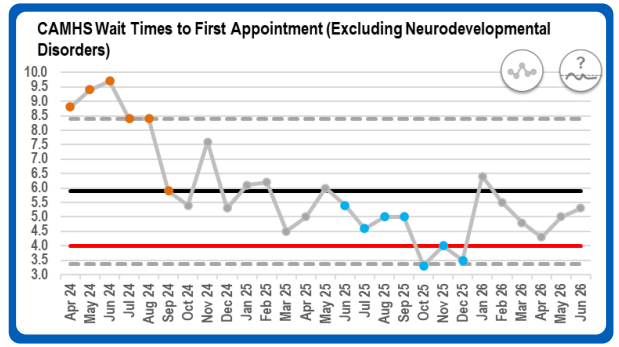
Work continues across the 3 health visiting services to increase the number of visits completed within timeframe is progressing. As detailed in previous reports this includes reviews of visits completed outside target timeframes to identify issues that can be addressed as well as working to improve systems and processes.

Some of the impact of this work is shown in this month's performance – a significant improvement has been achieved in Barnet.









ICARE EQUITY

Community - Adults

NHS Whittington Health NHS Trust

Community Adults

MSK Physiotherapy and Pain: waiting times continue to increase due to rising demand and reduced capacity, with Pain services most affected following system-wide pathway changes that have shifted activity from acute to community services without additional resource.

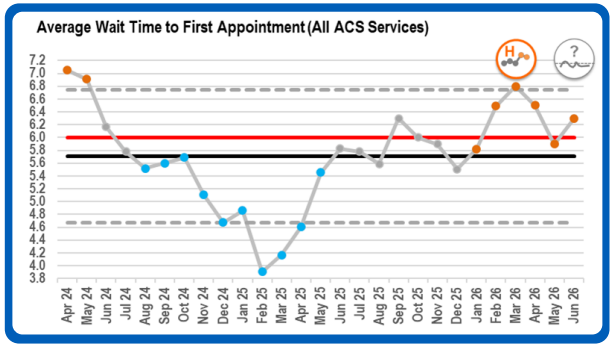
MSK CATS performance remains relatively stable but above target. Recovery actions include targeted recruitment, high-volume community appointment days, a new Pain Introduction Group, development of OA Knee group consultations, continuation of the MSK Trailblazer pilot, and exploration of non-recurrent funding to pilot AI solutions to support service recovery.

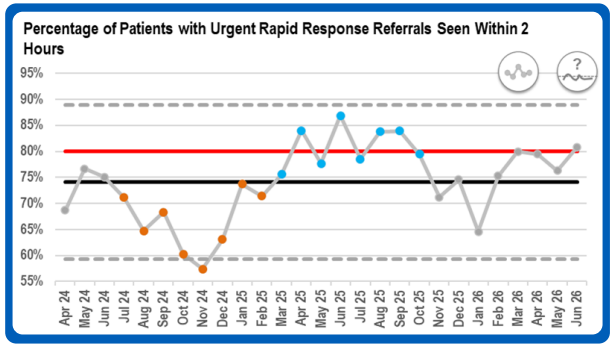
Community Podiatry: Continued improvement trajectory in Podiatry all disciplines. Significant improvement in biomechanics waiting times, longest wait is now under 18 weeks for Biomechanics, and under 6 weeks for all other podiatry. Largely now moved into a BAU state across Podiatry. Some instability may occur over the coming months due some potential staff leavers but monitoring and backfill recruitment underway

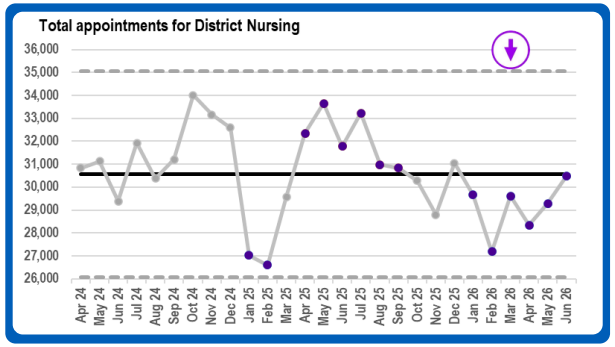
Continuing Healthcare (CHC): Performance continues to recover, with the service consistently achieving both the North Central London (NCL) and national 28-day assessment target of 80%. The transfer of the ICB CHC operational service to CLCH completed on 1 July, with some commissioning functions remaining within the ICB. The transition has been managed safely with no significant impact on performance to date. We will continue to monitor the new arrangements closely to identify and mitigate any emerging delays or operational risks.

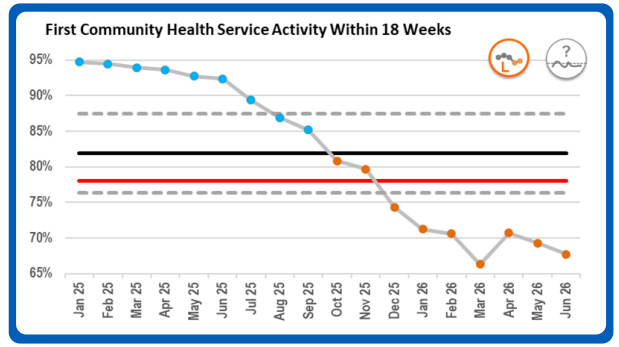
Falls Service: Waiting times in Islington have increased due to limited specialist Falls Physiotherapy capacity and ongoing staffing pressures. Escalation actions are underway, with additional clinical support being identified and strengthened triage and risk monitoring in place.

Community Stroke Services: Continued improvement in access and waiting times across Haringey and Islington following workforce investment and service redesign. Haringey has eliminated waits over 30 weeks, while Islington has significantly reduced long waiters and overall waiting lists. Workforce capacity remains the key risk, with further recruitment and service transformation planned to support sustainable recovery.









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