NHS

Whittington Health

NHS Trust

Our Clinical Strategy

2025 to 2030

Foreward

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

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

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

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

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

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

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

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


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

Our vision, objectives and values

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

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

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

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

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

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

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

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

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

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

How we developed this strategy

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

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

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

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

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

Whittington Health's clinical value proposition

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

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

Whittington Health's ways of working

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

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

Our population and communities

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

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

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

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

Our clinical chapters

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

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

Chapter 1: Older people

Where we are

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

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

Where we want to get to

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

What this means to me

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

Quotes are composites from feedback from many individuals and community groups

How we will get there

1

Lead a shared vision for healthy ageing

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

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

2

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

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

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

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

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

3

Workforce development for frailty expertise

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

How we will get there continued

4

Engage communities and partners in care delivery

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

5

Monitor and evaluate impact through outcomes

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

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

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

Chapter 2:
Long term conditions

Where we are

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

Where we want to get to

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

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

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

What this means to me

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

How we will get there

1

Expand integrated, community-focused care

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

2

Optimise early diagnosis and risk stratification

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

3

Empower multidisciplinary teams and upskill workforce

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

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

4

Deliver patient-centred, efficient care pathways

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

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

5

Use digital tools and telehealth

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

Chapter 3: Women and neonates

Where we are

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

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

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

Where we want to get to

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

What this means to me

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

How we will get there

1

Implement the Start Well Programme

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

2

Develop one-stop models for gynaecology

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

3

Strengthen partnerships and collaborations

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

4

Enhance antenatal education and community engagement

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

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

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

5

Implement innovative technologies and improve workforce models

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

Chapter 4:
Children and young people

Where we are

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

Where we want to get to

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

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

What this means to me

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

How we will get there

1

Use digital tools and AI to enable improved care

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

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

2

Develop seamless care transitions and collaboration

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

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

3

Ensure accessible and fit-for-purpose estates and facilities

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

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

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

How we will get there continued

4

Secure sustainable funding and workforce transformation

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

5

Strengthen partnerships

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

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

6

Upskill workforce and expand clinical capacity

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

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

Chapter 5: Cancer

Where we are

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

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

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

Where we want to get to

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

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

What this means to me

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

How we will get there

1

Understand and engage our community

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

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

2

Create tailored, accessible pathways

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

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

3

Strengthen GP collaboration and education

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

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

How we will get there continued

4

Build trust and partnership with patients

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

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

5

Enhance screening engagement

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

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

6

Utilise Data for continuous improvement

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

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

Chapter 6:
Elective and planned care

Where we are

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

In the community we provide adult and paediatric dental services.

Where we want to get to

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

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

What this means to me

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

How we will get there

1

Define and streamline care pathways

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

2

Optimise digital integration and data

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

3

Develop workforce skills and surgical excellence

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

4

Enhance partnerships and collaboration

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

5

Focus on patient experience and outcomes

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

Chapter 7: Diagnostics

Where we are

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

Where we want to get to

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

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

What this means to me

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

How we will get there

1

Streamline data access across sectors

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

2

Align goals and strategies with operational teams

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

3

Enhance local diagnostic capabilities

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

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

4

Improve workflows between clinical and IT services

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

Chapter 8:
Urgent and emergency care

Where we are

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

Where we want to get to

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

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

What this means to me

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

How we will get there

1

Enhance integrated care across teams

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

2

Prioritise clinically reasoned diagnostics

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

3

Focus on admission avoidance and early intervention

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

4

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

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

5

Standardise processes and equipment for efficiency

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

6

Multidisciplinary working

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

Taking this forward and key enablers

1

Electronic patient records (EPR) and IT systems

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

2

Estates and facilities

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

3

Sustainability and net zero

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

4

Secure sustainable finances

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

5

Research and continuous quality improvement

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

Appendix: Engagement timeline