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Trust Board meeting in Public Agenda

There will be a meeting of the Trust Board held in public on **Friday, 25 September 2026** from **10.45am to 11.35am** in Rooms A1 & A2 Whittington Education Centre

Item	Time	Title	Action
Standing agenda items			
1.	1045	Welcome, apologies, declarations of interest <i>Julia Neuberger, Trust Chair</i>	Note
2.	1046	Draft minutes, 23 July 2026 meeting <i>Julia Neuberger, Trust Chair</i>	Approve
3.	1050	Chair's report <i>Julia Neuberger, Trust Chair</i>	Note
4.	1055	Chief Executive Officer's report <i>Selina Douglas, Chief Executive Officer</i>	Approve
Quality and safety			
5.	1105	Quality Assurance Committee Chair's report <i>Mark Emberton, Committee Chair</i>	Note
6.	1110	Workforce Assurance Committee Chair's report <i>Rob Vincent, Committee Chair</i>	Note
Finance & Performance			
7.	1115	Integrated performance report and Q4 Health Equity Update <i>Ellis Pullinger, Acting Chief Operating Officer</i>	Note
8.	1125	Finance report <i>Terry Whittle, Chief Finance Officer</i>	Note
9.	1130	Questions from the public <i>Julia Neuberger, Trust Chair</i>	Note
10.	1135	Any other urgent business <i>Julia Neuberger, Trust Chair</i>	Note



Whittington Health
NHS Trust

Minutes of the meeting held in public by the Board of Whittington Health NHS Trust on 23 July 2026

Present:	
Baroness Julia Neuberger	Non-Executive Director and Trust Chair
Dr 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
Chinyama Okunuga	Chief Operating Officer
Nailesh Rambhai	Non-Executive Director (via MS Teams)
Baroness Glenys Thornton	Non-Executive Director and Senior Independent Director
Rob Vincent CBE	Non-Executive Director
Terry Whittle	Deputy Chief Executive and Chief Finance Officer
Sarah Wilding	Chief Nurse & Director of Allied Health Professionals
In attendance:	
Tara Egan	Lead Nurse, Women's Health, Outpatients & Imaging, Clinical Nurse Specialist Gynae-Oncology. (Item 2)
Vanessa Johnson	Patient Advice and Liaison Service and Complaints Officer (Item 2)
Marcia Marrast-Lewis	Assistant Trust Secretary
Mike Smith	Head of Communications and Engagement
Mirela Sidor	Patient Experience Manager (item 2)
Swarnjit Singh	Joint Director of Inclusion & Trust Company Secretary
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. Apologies were received from Tina Jegede, Joint Director of Inclusion & Nurse Lead, Islington Care Homes.
1.2	The Chair 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. The Board noted the declarations of interests.

2.	Patient Story
2.1	Sarah Wilding introduced a patient, who was a long-standing service user and a Trust volunteer, and who was attending the meeting to share her experience of women's health services and a recent inpatient admission.
2.2	The patient described her positive experiences over 10-15 years with the women's health clinic, including recent successful surgery, and spoke positively about the attentive care she had received from clinicians, nurses and ward staff. She particularly praised the support received following surgery earlier this year and thanked staff working across the women's health service and on Coyle ward. The patient also reflected on her unique perspective as both a patient and volunteer, having observed the commitment and professionalism of staff across the organisation.
2.3	The patient raised issues with the quality and suitability of inpatient food and explained that the food delivered was sometimes inedible or not as ordered, which resulted in her having to rely on family members for suitable meals. The patient emphasised the importance of food for patient recovery and suggested that gathering feedback from patient who did not eat their meals would be a really important task in informing the teams tasked with improving the food offering.
2.4	In discussion, Board members raised the following points: • Glenys Thornton reflected on her own experience as an inpatient on Nightingale ward and acknowledged the important of nutrition for patient recovery. • Amanda Gibbon thanked the patient for sharing her story and acknowledged that the Trust had spent considerable time focussed on improvements in cleanliness across wards. She suggested that it was important for senior staff to taste the food on offer for inpatients, because the availability of nutritious food was critical to helping patients get well again. She also welcomed the suggestion of surveying inpatients who did not eat any food. • Sarah Wilding thanked the patient for sharing her experience and agreed that nutrition was fundamental to patient outcomes and recovery. She reported that work was taking place in partnership with the estates and facilities team. • Selina Douglas thanked the patient for the positive feedback regarding women's health services, which were an integral part of the Trust's clinical strategy and welcomed any additional observations for improvement. She reported that, together with Chinyama Okunuga, she had acted as a volunteer and taken food to inpatients where similar feedback regarding the food provision had been received. In addition, Selina Douglas highlighted the high quality of the kosher food offer for Jewish patients. • Rob Vincent shared an observation from a family member's recent experience at another NHS hospital where it was clear that nursing staff were very busy managing competing priorities. He suggested that it would be helpful to consider using staff or volunteers whose sole focus was to support feeding for inpatients.

	Terry Whittle acknowledged the feedback and explained that several areas for improvement in the food provided were being worked on and that it remained a priority improvement area for the action plan in response to the findings from annual Patient-Led Assessments of the Care Environment. The Chair commented that some patients benefitted from high calorie and energy drinks and that some NHS providers had taken to making their own. She thanked the patient for her feedback on the service and on the food provided and suggested that she came back to a future Board meeting in 6-9 months' time to provide further feedback on food quality informed by her time as a volunteer. The Board thanked the patient for her feedback and her continued support as a Trust volunteer and agreed that work would continue to investigate in-house options for drinks for inpatients and that the patient should come back in 6-9 months' time to update the Board on food quality.
3.	Minutes of the previous meeting
3.1	The draft minutes of the meeting held on 21 May 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 drew attention to the following points: - This would be Chinyama Okunuga's last Board meeting before she moved to Epsom and St Helier University Hospital and, on behalf of the Board, thanked her for her significant contribution to the organisation and wished her well for the future. - In line with her appointment as Chair of the Care Quality Commission (CQC), appropriate arrangements would be put in place to manage any actual or perceived conflicts of interest while still Chair of the Trust. In particular, she would recuse herself from any Board discussions relating directly to matters that may impact the CQC in its role as regulator. The annual staff awards, held on 9 July, had been a success and celebrated the dedication and achievements of staff across the organisation.
4.2	Glenys Thornton reported that she had enjoyed the annual staff awards event and thanked everyone involved in organising it. The Trust Board noted the Chair's report
5.	Chief Executive Officer's report
5.1	Selina Douglas outlined the following issues: During the five heatwaves this summer, Whittington Health had sustained operational pressures with increased emergency department (ED) attendances, higher patient acuity and continued pressure on patient flow. Activity levels had remained significantly above expected for this time of the year and if they continued at this rate, it would mean that an additional 10,000 patients would be seen during the year in the emergency

	department, far in excess of the unit's original capacity with continued challenges related to bed occupancy, discharge pathways and corridor care. She recognised the considerable efforts of staff in managing these pressures. Future planning would need to take account of the increased impact of extreme heat. • The Trust's planning needed to plan for the increased likelihood of higher temperatures each summer, as there were challenges posed by older buildings which lacked adequate air conditioning and required significant capital investment to help modernise facilities on both the hospital and community sites. Currently, emergency preparedness, resilience and response team protocols were being employed to manage the impact of heatwaves. • Work was taking place in Haringey and Islington to expand multi-agency care coordination teams (MACC), develop integrated neighbourhood teams, and negotiate with local authorities and GP federations to select priority neighbourhoods for new models of care. • The Trust was also investing in data capability and analytics, partnering with University College London Hospitals NHS Foundation Trust (UCLH) to improve population health management, and considering board-to-board meetings with primary care partners to further integration.
5.2	Sarah Wilding updated Board members on the national and local initiatives in maternity and neonatal care and the Start Well programme. She explained that Whittington Health was responding to national recommendations, particularly from the Ockenden and Amos reports, by developing a framework with six domains to monitor and implement required changes, focusing on both clinical outcomes and patient experience. Selina Douglas added that partnership work was taking place with other local NHS partners organisations (e.g., UCLH and the West and North London Integrated Care Board) to share learning, align recommendations, and prepare for a central booking system, with a focus on increasing elective caesarean sections and managing rising complexity across the system.
5.3	During discussion, Board members raised the following points: • Swarnjit Singh commented that the last three years had been the hottest on record, which indicated the increasing impact of climate change on health services, and suggested that the Board consider whether climate change should be included within the Trust's strategic risk framework. The Chair agreed and requested that a discussion paper on climate change as a strategic risk be brought to a future Board meeting. • Junaid Bajwa referred to the changing national policy environment and asked whether there was scope for further collaboration with primary care partners to improve outcomes for the population served by the Trust. • In response, Selina Douglas confirmed that the Trust was already working closely with the GP Federations in Haringey and Islington through Integrated Neighbourhood Teams, the MACC model, cardiovascular disease programmes and population health initiatives. She advised that discussions were also taking place regarding future multi-neighbourhood provider arrangements and opportunities to develop shared data and analytics capability with partners. In addition, she highlighted plans for

	multi-neighbourhood provider contracts, and efforts to ensure primary care and hospital services were aligned rather than shifting workload between sectors. The Chair highlighted the opportunity to strengthen links between neighbourhood health work and research activity and suggested that research partnerships should be considered as part of future developments. The Board noted the report and agreed that a further discussion on having the impact of climate change as a strategic risk be presented to the Audit and Risk Committee.
6.	Quality Assurance Committee Chair's Assurance Report
6.1	Mark Emberton presented the report of the meeting held on 8 July 2026 and highlighted the following areas of good assurance taken by the Committee: - A deep dive was held into the child and adolescent mental health services neurodevelopmental assessment sprint carried out by the children's and young people's services clinical division and the Committee heard that approximately 170 children and young people had been assessed. The initiative had successfully reduced waiting lists. However, demand continued to exceed the available capacity, and it was recognised that short-term initiatives alone would not be sufficient to address the underlying demand pressures. - In maternity services, interactions with women and families were often taking longer as staff provided additional reassurance and support which reflected the heightened public awareness of maternity safety issues following publication of recent national reviews. - The Committee reviewed recurrent patient safety risks, such as non-integrated electronic patient record systems and the themes from safety investigations, which included issues related to paediatric observations and information sharing.
6.2	In discussion, Board members raised the following points: - The Chair found that several of the themes raised by the Committee were of strategic significance, particularly the patient safety themes, and should be tracked through future Committee work on a regular basis. - In reply, Mark Emberton confirmed that the Committee intended to monitor these themes and highlighted that many of the issues being identified related to wider organisational capacity constraints. He advised that difficult strategic decisions might ultimately be required regarding organisational priorities and resource allocation, as capacity challenges were reported across multiple service areas especially dermatology, neurophysiology, and musculoskeletal services. The Board noted the Quality Assurance Committee Chair's report; noted the review of the Board Assurance Framework's Quality entries and the decision to leave the current scores unchanged; noted the 2025/26 annual reports for adults and children; and approved the four Patient Safety Investigation reports

7.	Improvement Performance & Digital Committee
7.1	Junaid Bajwa delivered a verbal report for the meeting held on 16 July 2026 and highlighted the following issues: • The Committee reviewed the outcomes from the Quarter 4 elective recovery sprint and noted the significant improvements achieved, including a 12.2% improvement in Referral to Treatment (RTT) performance, reductions in the overall waiting list and 52-week waits, and the Trust becoming one of the most improved organisations nationally. The Committee discussed how these improvements could be sustained through pathway redesign, targeted capacity, stronger operational management and embedding improvements into business-as-usual arrangements. The Committee had also noted a subsequent deterioration in RTT performance since March and received assurance that recovery actions were in place, including capacity increases, pathway redesign and operational management. • Consultation was taking place on a draft 2026/30 Digital Strategy. The strategy would focus on supporting neighbourhood health, interoperability, productivity, cyber resilience and the use of data to help drive improvements. • The external cyber environment remained a significant risk for all NHS organisations. In addition, the Committee discussed the growing use of Artificial Intelligence (AI) and suggested that the Trust should consider AI implementation and governance risks as part of its broader digital risk framework. • There continued to be good progress with the electronic patient record's Atlas programme.
7.2	In discussion, Trust Board members raised the following points: • The Chair welcomed the Committee's consideration of AI-related risks and agreed that this was an area of increasing importance for the NHS. She suggested that the issue should come back to the Board at an appropriate point in the future to ensure adequate oversight of governance, risk and assurance arrangements associated with AI deployment. • Junaid Bajwa agreed and confirmed that the Committee would continue to monitor developments and consider how AI risks should be reflected within the Trust's risk management arrangements. The Board noted the report and agreed that the Improvement Performance and Digital Committee would consider the inclusion of AI-related risks within the Trust's risk framework and bring a future update to the Board.
8.	Audit & Risk Committee Chair's report
8.1	Rob Vincent presented the report of the meeting held on 23 June 2026 and outlined the following issues: • The Committee received internal audit review reports from the independent auditor, RSM, on compliance with duty of candour guidance and risk management arrangements. Both reviews gave a rating of reasonable assurance, the second highest possible. The Committee welcomed the findings.

8.2 8.3	• The Committee also reviewed the 2025/26 Counter Fraud Annual Report which detailed that the number of referrals to the local counter fraud service had increased, reflecting improved awareness and confidence in the Trust's counter fraud arrangements. The Committee also received assurance that the Trust continued to strengthen its fraud prevention and detection processes. • A significant proportion of the meeting had rightly focussed on the Trust's 2025/26 Annual Accounts and the external audit process. At the time of the Committee meeting, some complex accounting and disclosure issues remained under discussion, including matters related to NHS pensions, estate valuations and legal disclosures. These matters were subsequently resolved, following further discussions between management and the external audit team. During discussion, Board members raised the following points: • Terry Whittle confirmed that the annual accounts had been submitted and had subsequently received an unqualified true and fair opinion from the external auditors. He further advised that the Trust had received a satisfactory value for money assessment. • Rob Vincent highlighted that this was the final contractual year with KPMG LLP as the Trust's external auditors and that Deloitte LLP had now been appointed to lead on external audit services. • Rob Vincent thanked Terry Whittle, Martin Linton, Jerry Francine and the wider finance team for their work in completing the annual accounts process within a challenging timeframe. He acknowledged that the audit process had at times been demanding and external auditors had provided appropriate challenge throughout. • As part of the annual review of committee effectiveness, revised terms of reference were presented to the Board for approval. The Chair stated the Board's thanks and appreciation to the finance team for the successful completion of the annual accounts process. The Board noted the Chair's assurance report and approved the revised Audit and Risk Committee Terms of Reference.
9. 9.1	Charitable Funds Committee Chair's Assurance report Amanda Gibbon presented the report for the meeting held on 24 June 2026 and referred to the following items from which good assurance were taken: • The Charity had achieved a successful year, raising approximately £1.3 million in the last financial year. This represented a significant increase in income and reflected the Charity team's success in securing grants and donations. • Charitable funding had supported a range of projects and initiatives across the Trust, including plans for a new sanctuary garden within one of the hospital courtyards, complementing the existing children's garden and contributing to the wellbeing of patients, visitors and staff. • The Charity continued to focus on increasing levels of unrestricted income, which was needed to ensure core charitable activities could be sustained

9.2	alongside project-specific fundraising. • Current fundraising priorities included early discussions with Whittington Babies in relation to opportunities to work collaboratively in support of the Start Well programme. The aim would be to maximise fundraising opportunities and enhance the patient and family environment. • The Charity's reserves had reduced in line with planned expenditure and investment in charitable projects. Draft 2025/26 annual accounts would be presented to a future Committee meeting. In discussion, Board members raised the following points: • The Chair welcomed the Charity's fundraising performance and praised the team for the work being undertaken. She reflected on the positive impact of recent charitable initiatives, including the provision of sleeper chairs for families supporting loved ones in hospital, and noted the importance of demonstrating tangible benefits from charitable donations. • Selina Douglas highlighted the contribution of charity champions across the organisation and advised on the strong engagement from staff in supporting charitable activities. She commented that the increasing visibility of charity-funded projects across hospital sites was helping staff, patients and visitors better understand the impact of charitable giving. • Rob Vincent referred to the Trust's memorial mosaic project and the role the Charity had played in supporting and enabling the initiative. He welcomed ongoing plans to expand similar projects across the Trust estate and recognised their value for staff, patients and the wider community. The Board noted the report and welcomed the continued growth and visibility of the Charity.
10.	Quarter One Finance Report
10.1	Terry Whittle presented the financial position at the end of quarter one and drew attention to the following areas: • At the end of the first quarter of 2026, the Trust reported a year-to-date deficit of £4.8m, which was approximately £1.6m adverse to plan. The Trust had planned for a deficit position during the first half of the financial year, with recovery expected later in the year. The adverse variance was largely attributable to exceptional costs, including legal and professional fees associated with the private finance initiative dispute, and costs arising from industrial action. • Sustained operational pressures had also affected the financial position. Increased emergency department attendances, higher patient acuity and sustained demand throughout the heatwave period had generated additional staffing and operational costs that had not been anticipated within the original financial plan. • The most significant underlying concern remained expenditure on the Trust's bank workforce. Agency expenditure remained broadly in line with plan, but expenditure on bank staffing was approximately £1.5m per month above planned levels. Corrective management actions were being implemented to address pay bill pressures and bank staffing costs.

10.2	• There was no change to the forecast year-end financial position which envisaged a break-even position. The Trust's cash position remained good with £44m and there were no immediate concerns regarding liquidity. • The value of the Trust's confirmed 2026/27 capital expenditure programme had increased substantially and now stood at approximately £80m, reflecting the successful attraction of external funding for estate and infrastructure improvements. Work was progressing on major schemes, including the energy centre and fire safety programmes, with procurement activity expected to progress during the autumn. During discussion, Board members raised the following issues: • Rob Vincent reflected on a recent visit with the estates and facilities team and commented on the scale and complexity of the capital programme being delivered across a constrained hospital site. He praised the estates and facilities team for their programme management in view of the significant challenges involved in coordinating multiple major projects while maintaining service delivery. • Selina Douglas highlighted an additional capital funding opportunity relating to the Community Diagnostic Centre and stated that the proposed funding came with challenging delivery timescales which would require careful programme management to determine whether the scheme could be completed within the required timeframe. • In response, Terry Whittle acknowledged the challenge and confirmed that further work was underway to assess delivery options and the implications for the wider capital programme. The Board noted the Quarter one Finance report
11.	Integrated Performance Report
11.1	Chinyama Okunuga presented the report and emphasised the following areas: • Urgent and Emergency Care performance had been significantly affected by the sustained heatwave and the associated increase in demand. Daily emergency department (ED) attendances had increased substantially above normal levels, with one day recording approximately 340 attendances, compared to an expected average of around 180. • London Ambulance Services arrivals had also reached unprecedented levels and exceeded those experienced during previous winter periods. • Bed utilisation during periods of peak demand had resulted in increased corridor care. Significant efforts were recognised in managing these pressures and performance had begun to improve as temperatures had reduced. A positive impact had been made by the Emergency Medicine Ambulatory Care Unit which had supported patient flow and reduced pressure in the ED. • Performance against national cancer targets remained strong, with the Trust continuing to perform well, maintaining positive engagement with the North Central London Cancer Alliance. • RTT performance had deteriorated following the improvements achieved through elective recovery sprints in quarter four. As a result, the Trust had submitted a recovery plan to NHS England and had identified a number of

	specialties requiring targeted intervention, including dermatology and neurophysiology. Work was under way to improve productivity, secure additional capacity and explore further waiting list initiatives. • A new funding opportunity had arisen to support reductions in musculoskeletal waiting times and the Trust intended to submit a bid in response.
11.2	Sarah Wilding provided an update on performance against quality metrics. She reported that, although the infection prevention and control threshold had still not been published nationally, performance remained stable and that there were no significant concerns regarding healthcare-associated infections. She advised that there had been a 40% increase in the numbers of complaints received and outlined work to improve the management of patient feedback and complaints. Sarah Wilding also updated the Board on safer staffing metrics. She reported that only two nursing shifts had been rated red during the reporting period, reflecting the flexibility of nursing teams in redeploying staff to areas of greatest need. Fill rates for some unregistered staffing groups remained above target. This was largely attributable to enhanced care requirements, increased patient acuity and pressures at the front door. Short-term sickness absence and parental leave continued to present workforce challenges.
11.3	In discussion, Board members raised the following points: • Nailesh Rambhai asked about the effectiveness of advice and guidance arrangements and whether these were successful in reducing outpatient referrals and improving access to specialist advice. • In response, Chinyama Okunuga explained that advice and guidance was effective in principle but acknowledged that implementation remained variable across specialties. She acknowledged that successful adoption required changes to clinical job planning and outpatient models. Work was under way as part of a wider outpatient transformation programme, which also included a focus on reducing Did Not Attend rates, increasing virtual appointments and reviewing referral pathways. • Mark Emberton observed that consultants frequently provided large volumes of informal advice to patients and colleagues outside formal advice and guidance systems. He commented that this activity was often unseen and difficult to quantify but nevertheless represented a valuable contribution to patient care. • The Chair advised that patients frequently reported difficulties in contacting hospital services by telephone and suggested that improved responsiveness remained an important aspect of patient experience. The Board noted the significant operational challenges experienced during the reporting period and thanked staff across the organisation for their continued commitment in maintaining performance and patient safety during sustained periods of pressure.

12.	Questions from the public
12.1	The Board received four questions from a member of the public and agreed that Question 1 would be addressed during the meeting, with responses to the remaining questions provided separately.
12.2	Question 1 asked what policy applied to patients who did not wish their records to be shared with other NHS and care organisations through systems such as the London Care Record, whether an opt-out process existed and what the consequences of opting out might be.
12.3	In response, Terry Whittle advised that the Trust followed the One London information-sharing arrangements and that patients wishing to opt out of the London Care Record could do so through a process managed by the West and North London Integrated Care Board. He explained that the purpose of the shared care record was to improve the efficiency and safety of care by allowing authorised healthcare professionals to access relevant patient information, including clinical history, medication records and diagnostic results, when care was being provided across organisational boundaries.
12.4	Terry Whittle further advised that opting out would not affect access to information within Whittington Health systems but could result in delays or duplication when patients received care from multiple organisations, as clinicians may need to repeat assessments, obtain additional histories or undertake repeat tests where information was unavailable.
12.5	Rantimi Ayodele added that the London Care Record could also play an important role during periods of planned or unplanned system downtime. She reflected that, where local systems were temporarily unavailable, clinicians could use the shared record to access key patient information and maintain safe continuity of care. The Board noted the response.
13.	Any other business
13.1	There were no items reported.

23 July 2026 meeting action log:

Agenda item	Action	Lead(s)	Progress
Patient Story	Investigate inhouse options for drinks for inpatients.	Sarah Wilding	Progress with this action will be monitored by the Quality Assurance Committee
	Consider opportunities to engage the patient in their capacity as a volunteer representative and bring them back to the Board in 6-9 months' time for an update on food quality.	Sara Wilding	This has been included on the forward plan for the March 2026 Board meeting
Chief Executive's report	Take a paper to the Audit and Risk Committee Board on whether climate change should be considered a strategic risk.	Chief Operating Officer, Trust Company Secretary	In hand for the Committee's October meeting
IPDC Chair's assurance report	Consider and develop the Trust's approach to Artificial Intelligence governance and risk management and report back through the Improvement, Performance and Digital Committee.	Iolanda Pedrosa	This work will be presented in Q3



Meeting title	Trust Board – public meeting	Date: 25 September 2026
Report title	Chair’s report	Agenda item: 3
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 on 23 July 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 is my last report to the Board on activities undertaken since the last Board meeting held in public on 23 July before I stand down as Chair of Whittington Health NHS Trust on 30 September, having served since April 2020.

I must say that it has been an honour and a pleasure to have been part of senior leadership team here and I have thoroughly enjoyed my time working with colleagues and volunteers at the Trust and within the wider North Central London health and social care system and above all to hear vital feedback from patients about our services and how we can make a difference to their lives. I would also like to congratulate Amanda Gibbon who will be taking over as Chair from 1 October and who I know understands well the opportunities and challenges for Whittington Health.

I would like to start by warmly thanking our staff and volunteers for their incredibly hard work, particularly during what has been an unprecedented summer of activity.

NHS Online

I would like to congratulate Dame Caroline Clarke who left NHS England's London regional team to join the new Online NHS Trust to be its chief executive. I know that digital transformation is an area that Caroline cares deeply about as it has the power to transform patients' experience of care. She has been a great supporter of Whittington Health and our local health and care system.

Anna Bokobza, Giovanna Leeks, Ellis Pullinger and Chinyama Okunuga

I am delighted to welcome three new colleagues who join the Board. First, Anna Bokobza joined Whittington Health in July as our new Chief Strategy Officer. Anna joins us from Essex Partnership University NHS Foundation Trust, where she was Director of Strategy. She has extensive experience spanning acute, community and mental health services, informed by senior leadership roles at Imperial College Healthcare NHS Trust, alongside an earlier career in strategy consulting. Living in North Central London with her family and serving as a trustee of North London Hospice since 2022, she brings a strong local connection and a deep understanding of the communities the organisation serves.

Secondly, Giovanna Leeks joined us in September as our new Chief People Officer. Giovanna was previously Chief People Officer at The Princess Alexandra Hospital NHS Trust and brings with her over 20 years of experience and knowledge of people-led initiatives including recruitment; workforce and performance management; staff wellbeing and employee relations, from both private and NHS organisations such as NHS England, Kingston Hospital NHS Foundation Trust and the Royal Free London Group, Hertfordshire Community NHS Trust and Lewisham and Greenwich NHS Trust. I would also like to thank Charlotte Pawsey, who has been our Acting Chief People Officer, while we recruited to this substantive position.

Finally, we welcome Ellis Pullinger who also joined us in September as our Interim Chief Operating Officer. Ellis has over 20 years of operational management experience in the acute hospital sector. He is an experienced Chief Operating Officer

who has held this position at several other providers including Buckinghamshire Healthcare NHS Trust, Frimley Health NHS Foundation Trust, King's College Hospital NHS Foundation Trust, University Hospitals Sussex NHS Foundation Trust, London North West University Healthcare NHS Trust and St George's University Hospitals NHS Foundation Trust. In addition, Ellis was the joint Senior Responsible Officer for the implementation of the Epic electronic patient record system at both King's and Guy's and St Thomas' NHS Foundation Trust in October 2023 where this deployment continues to be the largest of its size globally for this solution. Ellis replaces Chinyama Okunuga who has been an incredible colleague to work alongside. On behalf of the Board, I would like to thank Chinyama for her leadership of our operational teams and her commitment to delivering great care for our patients. I wish her well in her future role as Site Chief Executive for Epsom and St Helier.

Private Board meetings, July and September 2026

The Board of Whittington Health held private a meeting on 23 July. Key items on the agenda included a comprehensive update on maternity and neonatal services against a backdrop of the national Amos and Ockenden reports and new guidance issued by NHS England; a review of progress with the implementation of the recommendations arising from the Fuller Inquiry and the approval of a linked Board Assurance Statement; and a review of developments with the strategic work to procure a new electronic patient record system. On 2 September, the Board held an additional private meeting where an outline business case for the Start Well programme was approved.

Consultant recruitment

I am grateful to Glenys Thornton, Non-Executive Director, for participating in the selection panel held on 22 July for the recruitment of a Consultant in Acute and General Medicine

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:

- 24 July, monthly meeting Mark Lam, Chair of the Royal Free London NHS Foundation Trust
- 4 August, meetings with Terry, Sarah Wilding, and an introductory meeting with Anna Bokobza
- 5 August, I completed the annual appraisals for Amanda Gibbon and Glenys Thornton, Non-Executive Directors, and had my own appraisal carried out by Glenys in her role as Senior Independent Director
- 10 August, I attended an online discussion about the findings and recommendations from the Ockenden review of maternity services at Nottingham University Hospitals NHS Trust and the national Amos review
- 18 August, I had a pre-meeting to discuss the agenda for September's meeting of the University College London and Whittington Health Partnership Development Committee-in-Common
- 2 September, I attended a private Board meeting
- 11 September, catch-ups with Selina Douglas and Terry Whittle



Meeting title	Trust Board – public meeting	Date: 23 September 2026
Report title	Chief Executive Officer's report	Agenda item 4
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 23 July. It also presents three issues for approval before their submission to NHS England – our Winter Plan, the maternity and neo-natal 10-point plan and our annual Provider Capability Assessment.	
Purpose	Approval	
Recommendation	Board members are invited to note the report and to approve the 2026/27 Winter Plan Board Assurance Statements, the maternity and neonatal 10-point plan, and the Provider Capability self-assessment for submission to NHS England.	
BAF	All Board Assurance Framework entries	
Appendices	1: Maternity and neo-natal 10-point plan assurance template 2: Winter Plan summary 3: Winter Plan Board Assurance Statements 4: Provider Capability Assessment	

Chief Executive Officer's report

Heatwaves

I would like to start my report by highlighting the extraordinary pressure on patients and hospital services from the impact of the prolonged period of hot weather and health alerts experienced this summer. Clinical, operational and corporate teams worked closely to maintain safe services and support patients, visitors and colleagues. There is important learning from this period that we will take into plans for next summer. I would like to thank colleagues across the organisation for their professionalism and commitment during this challenging period.

Thirwell inquiry report

On 15 September, following publication of the Thirwell inquiry report¹ into maternal deaths at the Countess of Chester Hospital NHS Foundation Trust, the Secretary of State for health and Social Care made a statement² in the House of Commons apologising to the families involved and set out the immediate actions³ that will be taken to strengthen arrangements for patient safety and safeguarding. The actions include urgent work on cot-cams to improve safety and give reassurance to parents with babies in hospital, along with tougher accountability for NHS managers, stronger inspections and safeguarding reforms.

NHS England Maternity Insight Visit

On 14 September 2026, the Whittington Health maternity service welcomed an insight visit from the NHS England's London Regional Team. The multidisciplinary review team included regional clinical, quality and service user representatives. The visit provided positive feedback on our maternity service. Reviewers described the service as open and transparent, with a strong understanding of its operational challenges and clear plans in place to address them. I am pleased to report that the NHS England team recognised a well-established culture of learning and continuous improvement across the service. The review team also acknowledged the complexity of the current operating environment and the ambitious programme of transformation under way. They noted that the Start Well programme is likely to influence the timing and delivery of future developments. Overall, the visit provided positive external assurance regarding the maternity service's leadership, culture, and commitment to ongoing improvement. The Trust looks forward to receiving the formal feedback letter from NHS England and will consider any recommendations as part of its ongoing programme of service improvement.

I would also like to take this opportunity to thank Isabelle Cornet, our Director of Midwifery, who is leaving Whittington Health. On 15 September, interviews were held and new Director of Midwifery has been appointed. I visited our maternity unit and have agreed to shadow staff in our maternity services and on our wards to help gain direct insight

¹ [Report of the Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018 – Summary report](#)

² [Government response to the Thirlwall Inquiry - GOV.UK](#)

³ [Government to act on Thirlwall patient safety recommendations - GOV.UK](#)

Maternity and Neonatal programme Outline Business Case

I am delighted to report that, following the Board's approval on 2 September of the first outline business case for the enabling works for the Start Well estate programme. The Board's decision has allowed £34.5 million to be released for the first major phase of work to transform maternity and neonatal facilities at Whittington Hospital, with construction activity set to step up while maternity and neonatal services remain open throughout the redevelopment. The planned works will deliver major enabling works needed before the hospital's maternity and neonatal facilities can be transformed. The wider programme will create more modern facilities, increase neonatal capacity and improve the environment for women, pregnant people, babies and families. Importantly, our maternity and neonatal services will remain open throughout the work and our priority is to ensure everyone who gives birth with us has a positive experience - that will remain our focus, at every stage.

Maternity and Neonatal 10-point plan

In August, NHS England has issued a national Maternity and Neonatal 10-Point Plan assurance process to support implementation of the actions arising from the Independent National Maternity and Neonatal Investigation and other recent maternity reviews. The programme seeks to strengthen governance, leadership, workforce, safety and quality arrangements across maternity and neonatal services and forms part of the wider national maternity improvement agenda. Whittington Health's Plan. As part of this guidance, NHS providers have been asked to submit a standardised national reporting template to their NHS region with a baseline assessment on 25 September and a progress update on 31 December 2026, which is shown in appendix 1.

National Oversight Framework

The National Oversight Framework results for Quarter 1, 2026/27 have been finalised and published and Whittington Health was informed that we are in segment 3. This remains unchanged since the last assessment for Quarter 4 2025/26. Our average metric score is 2.00. As with previous outcomes, Whittington Health initially came out in segment 2 but has been restricted to segment 3, due to our financial position. We have taken corrective action to help improve our financial position through the appointment of independent external support from Kingsgate who helped us to review performance in several areas and identify actions to take to deliver savings, and more recently, MLC Partners have been appointed to help reduce our expenditure, particularly on temporary staff.

NHS England Mid-Year Review

On 15 September, NHS England's London regional team held a mid-year performance review with the Trust. The key outcomes expected and actions we are taking from the review are to submit next week recovery plans for services where we are behind our expected performance trajectory against referral to treatment targets. This covers dermatology, gynaecology, general surgery and ear, nose and throat services. NHS England also highlighted that, although there was an improvement in the last week, our performance is also behind trajectory for the four-hour urgent and emergency care pathway, and a clear recovery plan is being produced for submission to NHS England. In addition, the review looked at diagnostic performance in audiology services and Whittington Health is going to progress an insourcing solution to help ensure that the performance trajectory for this area will

deliver the improvement required. As part of enhanced support, NHS England will hold fortnightly meetings with us to review performance on referral to treatment and against the four-hour urgent and emergency care access standard.

Integrated Care Board Strategy consultation

The West and North London Integrated Board (ICB) is developing a draft 10-year strategy which will set out plans to improve health, reduce inequalities and create a more sustainable NHS for the future while helping people live longer and healthier lives in this health and care system. The ICB is using insights from community engagement, wider research and feedback from more than 75 organisations and experts across its 13 London boroughs to inform the strategy's development. This week represented another important milestone in its development as partners came together to test and strengthen the priority populations and emerging interventions that had been identified. Our new Chief Strategy Officer, Anna Bokobza, attended and during group discussions system partners explored what must change for individuals, teams, organisations and the wider system, to turn strategy into action. Leaders also recognised that as a system, we must be willing to take risks and learn together, particularly given the significant and unsustainable cost of maintaining the status quo. Over the coming weeks the ICB will continue to refine the strategy before approval is sought at its October Board meeting.

NHS England Regional Medical Director Visit

Chris Streather, NHS England's Regional Medical Director for London, visited Whittington Health on 11 September. He was hosted by the Chief Medical Officer and Chief Strategy Officer. The visit was well received and provided an opportunity to discuss the Trust's strategic priorities, including the Clinical Strategy, quality performance, the Atlas electronic patient record procurement and how we can strengthen the measurement and visibility of community outcomes across the region.

Chris Streather subsequently visited our Hornsey Rise Health Centre, meeting colleagues from the following services - Hospital at Home and Rapid Response, District Nursing, Community Paediatrics/Early Years and Physiotherapy. The visit showcased the excellent work being delivered across our community services, including integrated health and social care approaches to early years across Islington and Haringey, and the flexibility provided by clinicians working across Hospital at Home and Rapid Response to respond to changing needs across the boroughs. Our discussions also highlighted some of the challenges facing community teams, including the impact of the recent heatwave on staff working across the community estate and violence and aggression experienced by lone workers, with particular concern about increasing racist abuse directed towards healthcare staff. The visit provided a valuable opportunity to demonstrate the strength of Whittington Health's integrated acute and community model and discuss how its impact can be better captured through regional metrics.

Winter Plan

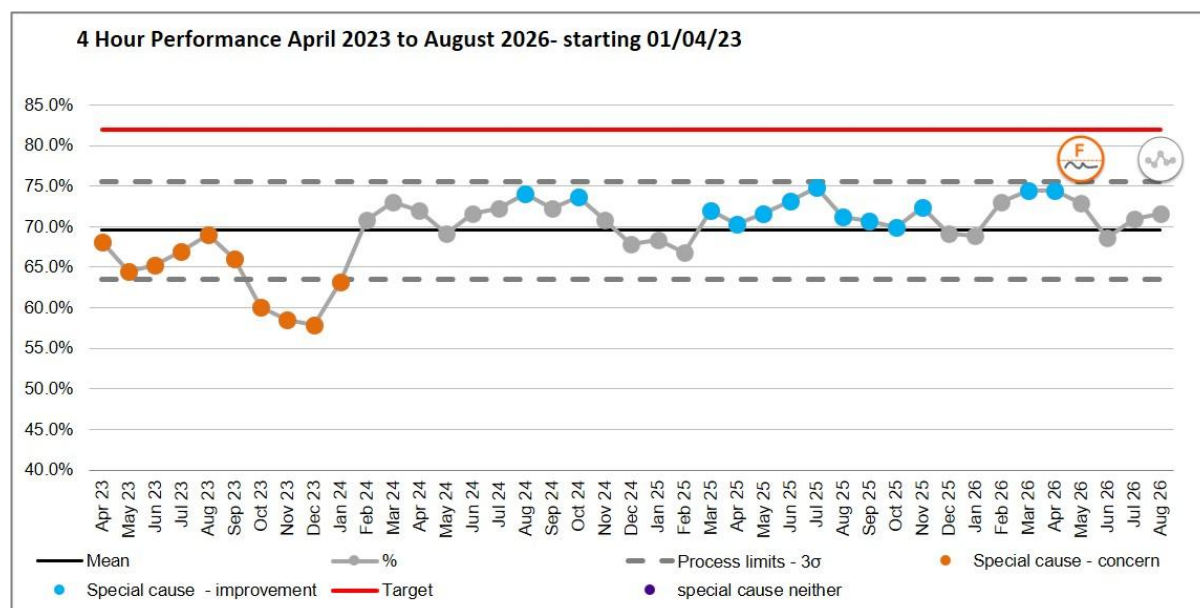
Whittington Health has developed its 2026/27 Winter Plan through engagement with our system partners, including the London Ambulance Service. It is brought to the Board for approval of the accompanying Board Assurance Statements which will be submitted to NHS England. The Winter Plan's arrangements are shown in appendix 2 and the Statements can be found in appendix 3.

Provider Capability Assessment

In line with the NHS oversight framework, NHS England will be using provider capability assessments to understand how capable a trust is of improving without additional support. The focus on provider boards' awareness of the challenges facing their organisation, along with the actions needed to address them, is intended to promote board self-awareness and transparency with regional oversight teams. A self-assessment template has been completed by chief officers and discussed with the chairs of key Board Committee. The template is shown in appendix 4 and covers six areas - strategy, leadership and planning, quality of care, people and culture, access and delivery of services, productivity and value for money, and financial performance and oversight. Board members' approval is sought for the template to be submitted to NHS England.

Urgent and Emergency Care performance

In August 2026, UEC performance increased to 71.6% from 70.94% in July, however this was behind the agreed trajectory of 74%. This was driven by out of hours variability, workforce pressures, increase in mental health presentations and discharge delays and the rotation of resident doctors. Key areas of focus are for the urgent treatment centre and paediatric performance to return to their trajectories. The Extend Emergency Medical Ambulatory Care service (EEMAC) is fully embedded, supporting decompression and delivering against expected streaming numbers through the service. 15-minute ambulance offloads remain above 80% and is above the expected trajectory.



There was a decrease in 12-hour emergency department trolley breaches from 283 in July to 170 in August. Patients who do not meet the criteria to reside remained static in August with significant delays in their placement and brokerage with local authority partners and further work is underway with system partners to help resolve these delays. An average of 18 beds were closed during the month of August through reductions in the average long length of inpatients.

Referral to Treatment

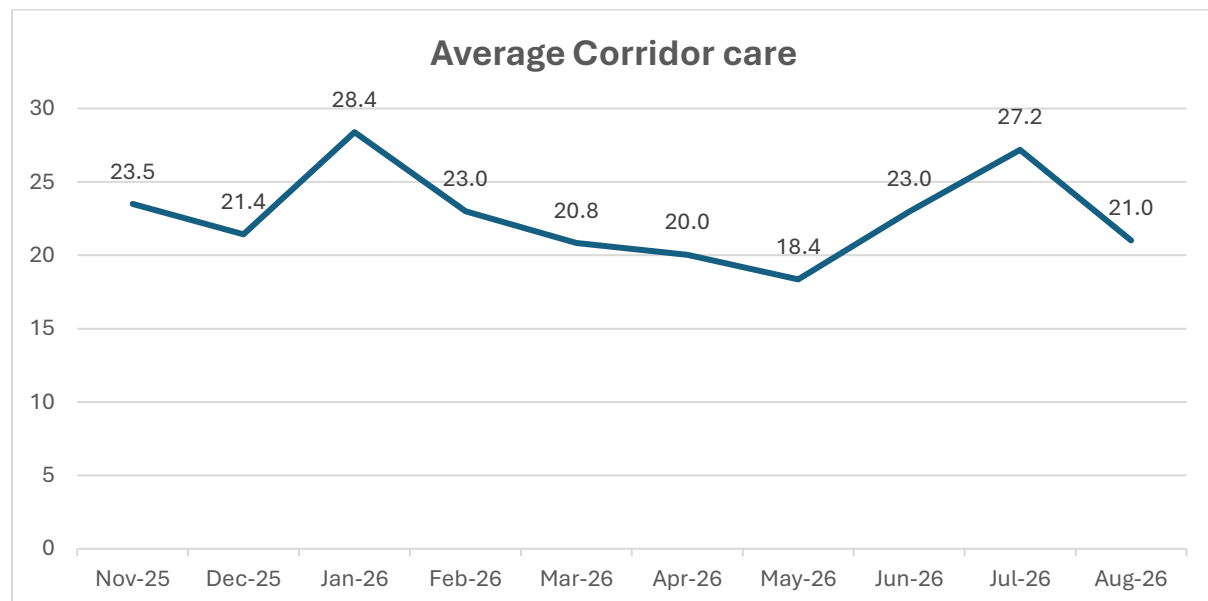
Our performance against the referral to treatment 18-week target for August 2026 is due for submission on 23 September 2026 and therefore figures reported here are

unvalidated. They show that performance against the 18-week standard was at 67.19%, representing a 0.81% shortfall against the updated expected performance of 68% and a 6.19% shortfall against the national planning trajectory of 73.38%. This variance is largely driven by deterioration in specialties, most notably general surgery (admitted pathways), gynaecology, dermatology and ear, nose and throat services. Notwithstanding the overall referral to treatment position, long-wait performance remains strong and well controlled. The proportion of patients waiting over 52 weeks stands at 0.45%, 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 August 2026 stabilised and achieved 81.6%, a slight improvement of 0.1% points from July. 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, focussing on stabilising capacity through recruitment, pathway optimisation, and restoring activity, to support delivery of national diagnostic standards over the coming months.

Corridor care

There was a decrease in average corridor care in August to 21 patients per day in reflecting seasonal variation in attendances. This continues to be review as part of the Flow Improvement Programme.



Cancer performance

Performance against key cancer waiting time standards continues to remain strong. For the Faster Diagnosis Standard (28-day), performance in July 2026 was 89.1%, 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 a specialty level, with ongoing challenges in gynaecology and urology linked to workforce constraints and pathway delays. The gynaecology performance declined in July 2026 to 68.4% from 70.9% in June 2026. Performance in the urology service improved in July 2026 achieving 72.9%.

Delivery against the 31-day decision to treat to first definitive treatment standard was exceeded with performance at 100% against the national threshold of 96%. Our performance against the 62-day Combined Treatments Standard was 75% in July 2026 which is a decline in performance from June 2026 at 87.2%. The July 2026 performance was impacted by six patient pathways being excluded from the cancer waiting times submission that were reportable. This has been raised to NHS Digital. Including these patients would show the Trust achieving the 80% standard required for the 62-day target.

Musculoskeletal trailblazer

On 15 September, I had the pleasure of visiting Whittington Health's Community Musculoskeletal (MSK) team and learnt that they are working with the Department of Work and Pensions to deliver a trailblazer programme of offering more intensive MSK Physiotherapy alongside work coaching. This has included a number of MSK Community Appointment Days where patients on our waiting list are invited to a 'What matters to you?' style day where they can explore their MSK condition alongside other offers including health checks, dieticians, talking therapy, local fitness offers as well as return to work coaching and or financial or benefits support. So far, we have more than 186 patients (54% over age 50) who are part of the supported return to work offer with 24 patients already returned to being economically active, 54% of them for more than 30 hours a week.

Adult inpatient survey

The National Adult Inpatient Survey 2025 results were published nationally by the Care Quality Commission on 28 August 2026. Whittington Health had a 29% response rate, in line with 2024's outcome, and compared with a national average response rate of 38%. The majority of respondents were aged over 65 years (60%) and 72% identified as having a white ethnicity. The Trust's overall patient experience score was 8.2, in line with the national average of 8.2 and representing an improvement from 7.9 in 2024. Respect and dignity scored 9.0, while kindness and compassion scored 8.9, demonstrating consistently positive experiences of interpersonal care. Overall, Whittington Health performed similarly to most NHS trusts nationally. Of the benchmarked questions, one question was rated better than expected, 45 questions were rated about the same, two questions were rated somewhat worse than expected, two questions were rated worse than expected and there were no questions where we were rated much better or much worse than expected.

This report highlights the top and bottom five benchmarked scores for Whittington Health, compared both to the national average across all trusts and to our performance last year. Our strongest performing areas compared with the national average were patients not being prevented from sleeping because of room temperature; staff taking account of patients' cultural, mental health and accessibility needs. Our identified areas for improvement include information on who patients should contact after discharge if they are worried about their condition; the length of time patients wait for admission; the waiting time for a ward bed following arrival in hospital; access to food outside of set mealtimes; and support from health and social care services following discharge.

Violence and aggression against NHS staff

As a result of concerns about the increasing levels of violence and aggression experienced by Whittington Health's staff, I wrote to the Chief Executive of the London Borough of Islington and to the Chief Superintendent of the Metropolitan Police in Islington to seek their help for a co-ordinated response. Between 1 January and 29 July 2026, Whittington Health recorded 410 incidents involving harm to staff, with the Emergency Department reporting the highest number across the organisation. Violence and aggression remain one of the most significant risks facing our workforce, affecting staff wellbeing and our ability to provide safe and compassionate care.

Our staff care for some of the most vulnerable members of our community, often in a highly pressurised environment. We recognise that distress, mental health, substance misuse, homelessness, and other complex social factors may contribute to some incidents and require a compassionate and trauma-informed response. However, I am equally clear that no member of staff should be expected to accept abuse, threats, intimidation, or physical assault as part of their role. Alongside the co-ordinated work with partners in Islington, Whittington Health had continued to strengthen our own arrangements for such violent incidents through improved reporting, staff training, preventative measures and importantly, support for staff following incidents of violence and aggression.

All staff briefing

The most recent briefing for all staff took place on 10 September and highlighted the following areas: our Annual General Meeting which is being held on 25 September to review our performance in 2025/26 and to outline our future plans; work taking place to improve the discharge from hospital of patients living in Haringey and Islington who are medically fit and have therapy needs which will be delivered in the community; the Streetsfest event held in Finsbury Park to support local people sleeping rough or experiencing homelessness and I am proud of the Whittington Health staff who attended and offered support for people living with conditions including heart failure, respiratory disease and diabetes; and an update from Rantimi Ayodele on the work taking place to refresh of our Clinical strategy.

Operation Eddington

On Tuesday 18 August, we carried out a joint fire training exercise with London Fire Brigade on the vacant Eddington Ward. The exercise tested our response to a fire in an acute clinical setting and helped London Fire Brigade practice search and rescue procedures in a realistic healthcare environment. Three fire engines attended the hospital site, and the team used training dummies and staff volunteers who acted as patients. The exercise was a success and there were valuable lessons learned from this experience of what to do in a real fire. I would like to thank everyone who was involved.

Inaugural art show

Our first Whittington staff art show was a huge success. The exhibition ran in the hospital atrium from Thursday 27 August to Friday 4 September and featured 27 colleague artists and 61 works. This creative idea was drawn up by paediatricians, Jane Simpson and Florence Holbrook who, after discovering an abundance of artistic talents across the Trust, were inspired by the Royal Academy's Summer

Exhibition, to launch this inaugural exhibition to share these talents of their colleagues with the local community.



Extra Mile Award winners

I am pleased to report that this month's winners of the Trust's extra mile awards are Heather Jenkins and Gabriella Palliser-Ames. Heather is our named Midwife for Safeguarding and was nominated in recognition of the exceptional compassion, kindness and dedication she consistently demonstrates in her role, embodying the very best of our values. She goes above and beyond in supporting her colleagues, always taking the time to listen, offer reassurance and provide practical and emotional support when it is most needed. Her empathy is genuine and felt by everyone she works with.

Gabriella works as in the Patient Advice and Liaison team and is a Complaints Officer. She was recognised for her excellent service to patients and visitors, and was cited for an example where she noticed a patient in the main atrium in clear visible distress, shaking and sweating profusely. Gabriella went out of her way to sit with the patient, provide reassurance and ask what the problem or problems were. The patient managed to confirm that he was in the hospital for an outpatient (although they had arrived early). The patient said they were desperate not to miss the appointment which they said was to discuss possible spinal surgery. The patient said they were too upset and were in too much pain to attend the appointment. With the assistance of colleagues in the PALS team, Gabriella ensured that the outpatient team were aware that the patient could not attend due to illness so that it could be re-arranged. Gabriella then took the patient to the emergency department (ED), spoke to the Matron & Mental Health nurse. Gabriella then waited with the patient

until he was triaged in the ED. While waiting Gabriella continued to provide comfort and support to the patient who remained visibly upset, distressed and in pain.

Peter Khaimah

I am deeply sorry to announce the passing of Peter Kaimah who worked at Whittington Health for many years, beginning his career in the Portering team before later joining the Transport team. Throughout his time here, he built strong friendships and earned the respect and admiration of everyone who had the privilege of working with him. Peter was loved by many colleagues across the Trust, and he represented the very best of the Whittington. On Friday, 11 September, Trust colleagues held a vigil in the Whittington Gardens to honour and remember Peter. His dedication, warmth, gentle nature, and friendly smile will not be forgotten.



Meeting title	Trust Board	Date: 25.09.2026
Report title	Maternity and Neonatal 10 Point Plan: baseline assurance return and Maternity Triage benchmarking audit	Agenda item:
Executive lead	Sarah Wilding, Chief Nursing Officer Ms Rantimi Ayodele, Chief Medical Officer & SRO for Start Well at Whittington Health	
Report author	Isabelle Cornet, Director of Midwifery Rhonda Fleming Co-Clinical Director, ACW	
Executive summary	Background (what) The trust has worked on the completion of the two national returns required by NHS England as per their letter in appendix 1 regarding the Maternity and Neonatal 10 points plan baseline assurance (appendix 2) and the maternity triage benchmarking audit (appendix 3). Both require Board approval before submission to the NHS England region by Friday 25 September 2026, with a progress return due 31 December 2026. So what (issue): Regarding the 10 points plan, 18 of the 26 baseline deliverables (69%) fall short of full compliance, 4 are non-compliant. The non-compliant ones are: - Commencement of the rollout of Martha's Rule across maternity and neonatal services - The reporting of identified variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data including the board demonstrating how the trust is responding to the variation identified? - Demonstration that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months? - The Trust board having undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service. In the triage audit, 48 of 82 standards (59%) are not fully in place, 12 of them not in place at all. The later ones are: - Share information and discharge summaries in a timely way with relevant care partners, including primary care and	

community midwifery, with clear accountability for communicating outcomes, actions and next steps to the woman's usual care provider.

- Provide a well-publicised 24/7 single contact number, answered promptly by clinically active midwives trained and experienced in maternity triage; telephone maternity triage should not be diverted to labour wards where prompt response may not be possible.
- Gather feedback regularly through multiple channels (e.g., surveys, focus groups, real-time tools) and review this regularly to inform continuous service improvement.
- Present monthly data and quality improvement work in accessible patient-facing and staff-facing formats and use it to improve service quality.
- Adopt the national maternity and neonatal Patient Reported Experience Measure (PREM) when available.
- Value qualitative lived experience alongside quantitative data, recognising that small numbers of serious concerns can reveal system issues not visible in aggregated metrics.
- Collect and review all data outlined in the measurement strategy wherever feasible, ensuring a robust and representative sample; at minimum include attendance patterns, peak times and waiting times and examine inequalities for initial triage.
- Where a metric cannot be captured, identify improvements needed to enable future capture, including timescales and whether the process is manual or automated.
- Review data at appropriate intervals daily, weekly, monthly and quarterly to identify trends, patterns and improvement areas.
- Establish processes for teams to frequently review data, reflect on insights or changes, and respond to support continuous improvement.
- Include demographic variables such as ethnicity, language, deprivation and disability, as outlined in the measurement strategy, to understand local population needs and address inequalities in access and outcomes.
- Be transparent with women about why data is collected and how it will be used to improve care, especially in communities with lower trust in the healthcare system.

Regarding the data metrics requiring capturing, 5 are partially captured and 8 are currently not captured. The later ones are:

- Proportion of women who attend without prior telephone triage
- Proportion of women who leave without further reviews or care following initial triage, despite an identified need for further review or care.
- Rate of calls to telephone triage per 1,000 births.
- Proportion of women who call telephone triage but do not attend in person.
- Proportion of dropped or unanswered calls to telephone triage.

	- Qualitative and quantitative data on the experience of women using maternity triage services, collected through existing local feedback methods and transitioning to the national maternity and neonatal Patient Reported Experience Measure when available. - Frequency and diversity of feedback collected, including review by ethnicity to confirm feedback reflects the service population. - Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback, and the associated impact of these improvements. The main causes are: there is no 24/7 telephone triage service, no maternity triage patient-experience (FFT) data flow, and a hybrid paper/digital record with no interface between systems. What next The submission for the initial assessment to NHSE is to be done by 25th September through the NHS Future Platform. The blockers have been identified and an action plan is being established. The cost of some blockers have been calculated as requested. Progress against the action plan is to be submitted to NHSE by 31st December 2026.
Purpose:	Approval The board is asked to approve both national returns for submission to the NHS England region by 25 September 2026 and to record its sign-off, which is a mandatory field on each return. Discussion is also invited on the risks and investment set out below.
Recommendation(s)	The board is asked to: • Approve the baseline assessment and the completed triage benchmarking audit for submission to the NHS England region by 25 September 2026 and confirm the named executive and sign-off date on both returns. • Note all the non-compliant deliverables, standards and matrixes.
Risk Register or Board Assurance Framework	
Report history	
Appendices	• Appendix 1 – NHS England letter, Maternity and Neonatal 10 Point Plan assurance process. • Appendix 2 - Maternity and neonatal services 10-points plan reporting • Appendix 3 – Maternity triage specification benchmarking audit tool.

Winter Plan Summary

2026/27





National Winter Plan Guidance

NHS trusts and foundation trusts

- Providers are accountable for operational delivery through winter. Trusts must:
- Complete an organisational winter plan by the end of August, with staff flu vaccination programmes ready to launch and preparatory actions under way now
- Implement the Model Emergency Department, Model Acute Pathway and Model discharge pathway requirements ahead of winter, with the elimination of corridor care treated as a patient safety priority, while maintaining elective capacity throughout the winter period
- Assure tested arrangements for escalation, infection prevention and control, on-call leadership and staff welfare, and protect delivery of agreed 2026/27 trajectories

Winter Pressures Escalation Capacity and Triggers

As part of the bed reconfiguration plan during the summer period, we aimed to close 12 beds through closing portions of wards in a phased way

- Currently we have closed 18 medical beds closed

The opening of additional ward beds will be based on the metrics outlined below with an associated weighting that triggers when the score exceeds 18 or more.

- If a metric is not relevant or applicable this would score a 0
- Triggers that are grouped will only have 1 score

No.	Triggers	Weighting
1	≥15 predicted DTA's in ED unplaced at 15:00 and remaining in the ED and reviewed at 16:45 (pick one)	5
	≥11 predicted DTA's in ED unplaced at 15:00 and remaining in the ED (pick one)	3
	≥7 predicted DTA's in ED unplaced at 15:00 and remaining in the ED (pick one)	2
2	≥6 additional patients in trolleys in Majors (corridor care) once cubicles are full	5
3	More than 5 medical outliers in Surgical beds for >2days	3
4	>7 12-hour trolley breaches per day	3
5	Surgical elective cancellations due to bed pressures	3
6	>24 hrs to facilitate ITU step downs	2
7	>2 closed beds due to infection control reasons	2
8	OPEL 4 for two consecutive days in a row	3
9	Increased delays for repat > X days	1
10	Bed predictor showing -25 end of day	2
11	Sector diverts for more than 2hrs resulting in >5 LAS out of area per hour during this period	1
12	More than 4 MH patients in ED awaiting placement > 24hrs	2

Escalation Capacity

NCTR has reminded high throughout summer at circa 25% of the beds base and is likely to increase over Winter resulting in increased corridor care, high numbers of DTA's and increased overcrowding in ED

There are two options in relation to additional escalation bed capacity in Winter which are outlined below:

Option 2: Open Eddington Beds

- Capacity for 16 beds
- Approximate costs for Jan to March (3 months opening on 11th of Jan)
 - £450k or £171k per month
 - Risk of Eddington already in use for decant work

Option 3: Utilise the bridging service

- Capacity for 20 P1 'beds' provided at home
- Approximate costs for Dec to March (4 months)
 - £257k or £65k per month

UCLH and the RFH are potentially interested in collaborating and leveraging economies of scale to reduce the cost of bridging as a sector. The costs comparison against opening Eddington beds is outlined below:

Options	Jan-May	Monthly cost
Option 2: Eddington 16 beds (open 11th Jan)	£450k	£171k
Option 3: Bridging 20 patients	£257k	£65k
Difference between bridging and Inpatient beds	£193k	£106k

Winter Pressures Escalation Capacity Phasing Plan

- During winter pressures, we would plan to phase the opening of core beds in increments of 5 based on demand. This will ensure we are able to maintain safety in ED and on the wards. Once the core capacity during the summer period is re-opened, we will:
- Flex 4 additional medically optimised bed on Thorogood
- Utilise the Eddington winter surge bed capacity if demand continues
- Eddington which has 16 beds will be opened on a phased basis in the same increments with a staffing rota in place for January
- An example of a phasing plan is outlined below when triggering a score >18

Summer Bed Closures (Max 20)	Cascade 1	Open 5 beds
	Review Triggers if scoring >18	
	Cascade 2	Open 5 beds
	Review Triggers if scoring >18	
	Cascade 3	Open 5 beds
	Review Triggers if scoring >18	
	Cascade 4	Open 5 beds
	Review Triggers if scoring >18	
Thorogood Flex Beds (4)	Cascade 5	Open 4 beds on Thorogood
	Review Triggers if scoring >18	
	Cascade 6	Open 10 beds on Eddington
Winter Surge Capacity 16 beds	Review Triggers if scoring >18	
	Cascade	Open 6 beds on Eddington

- The beds opened may vary depending on the location of where beds are closed
- There is an expectation that all remedial works will have either been completed or ceased by early November. Fire remediation work should not be planned to occur during winter if there is an impact on inpatient bed capacity.



Emergency Department Plans

Urgent Treatment Centre

- See and treat model supporting all area
- Additional HCA to support ENPs with patient tasks (e.g. applying casts)?
- Additional GP until 6-10 7-days a week (funded via underspend in LCW contract)
- Extend the overnight ENP specialist rate for winter

Majors/Mex

- EEMAC 24/7 to support overnight capacity (if not funded by constitutional funding) in November
- Additional dedicated porter to support with patient's movements
- Increased cleaning provision to ensure rooms are turned around as quickly as possible

Paediatrics

- Additional daily consultant 12-22

Nursing

- Additional corridor care nursing provision

Mental Health

- Additional MH provision on-site to support with quicker assessment and turnover of this patient cohort



Acute Medicine- Post Take & Outliers

Post Take and Outliers

- Providing 1 x second discharge registrar at the weekend to focus on discharges and flow from 08:00 -14:00
- Post Take/Outliers in ED 1 x WTE SHOS - trigger for this will be >30 DTAS in ED
- Outliers 1 x WTE Consultant for 5 mornings – trigger for this will be >30 DTAS in ED

Operational actions

- Continue working with the IDT team to focus on removing blockages and escalating to support discharge of patients with criteria not met to reside.
- Ensure IDT are maximising Minerva to ensure flow is maintained.
- Admission avoidance where possible, utilising virtual ward, frailty, ambulatory care.
- Regular review of rota's as part of BAU in response to sickness absence

Proposed Timelines

- Phasing of the ED staff will commence in October to support the increase pressures seen in ED
- The re-opening of closed bed will open based on the pressures seen with all beds if required opening between October to November
- Beds will likely reduce capacity around the Xmas period and re-open in January
- Additional flex of 4 additional medically optimised beds on Thorogood from November if all core beds have been re-opened
- Option 1: Eddington beds required will plan to come online in January if bridging is not utilised
 - Total of 32 medically optimised beds and will require medical buy into maximise capacity
- Option 2 – bridging will mean Eddington will not need to open

Winter Schemes	Oct	Nov	Dec	Jan	Feb	March
ED Staffing						
Re-opening of closed Beds						
	10 opened	10 opened	10 closed	10 opened		
Thorogood flex (4 beds)						
		4 opened	4 closed	4 opened		
Option 2: Eddington (16) or						
				10 opened	6 opened	
Optoin 3: Bridging (20)						

- Recovery will be used where required to support post operative elective activity when non elective surgical demand increases.
- SDEC or EEMAC cannot be used to bed patients due to the impact on flow and decompression of ED

Winter Funding

As part of the planning round and Delivery Plans presented at TMG, £1.2m was set aside for winter pressures with confirmation from NWL of an additional £800k of funding. The plan below outlines the winter plan with Options 2 and 3 and associated costs. The only that delivers close to the £1.2m envelope is Option 3, which is the recommended option

- Winter Plan costs would reduce by circa £240k through release of constitutional standards funding for 24/7 EEMAC
- The costs of Option 3 could be further reduced through partnering with UCLH and RFH

Option 1: Do nothing £0

Option 2: £1.397m

- ED staffing
- Acute Medicine
- Eddington 16 beds
- Thorogood flex beds (4)
- TTA pharmacists

Option 3: £1.204m

- ED staffing
- Acute Medicine
- Bridging service (20)
- Thorogood flex beds
- TTA pharmacists

Total Costs of Winter Plans

Option 1: Eddington, Thorogood and Workforce Plans £1.397m

Service / Area	WTE	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total Cost
Total Escalation Beds Costs -Eddington	29.52	0	0	0	102,257	159,797	159,797	421,851
Total of Mattresses -Eddington		0	0	0	6,543	10,469	10,469	27,482
Total of ED Costs	12.43	74,685	74,685	74,685	74,685	74,685	74,685	448,107
Total EEMAC	7.00	0	47,977	47,977	47,977	47,977	47,977	239,885
Total of Acute Medicine	2.28	0	0	0	31,308	31,308	31,308	93,923
Total of Thorogood Flex Beds	4.48	0	24,298	24,298	24,298	24,298	24,298	121,488
TTA Pharmacists x 2 8x	2.00	0	0		14,789	14,789	14,789	44,367
Grand Total	57.71	£74,685	£146,959	£146,959	£301,856	£363,322	£363,322	£1,397,103

Option 2: Bridging Thorogood and Workforce Plans £1.204m

Service / Area	WTE	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total Cost
Total of ED Costs	12.43	74,685	74,685	74,685	74,685	74,685	74,685	448,107
Total EEMAC	7.00	0	47,977	47,977	47,977	47,977	47,977	239,885
Total of Acute Medicine	2.28	0	0	0	31,308	31,308	31,308	93,923
Total of Thorogood Flex Beds	4.48	0	24,298	24,298	24,298	24,298	24,298	121,488
Total Minerva		0	0	64,113	64,113	64,113	64,113	256,452
TTA Pharmacists x 2 8a	2.00	0	0		14,789	14,789	14,789	44,367
Grand Total	28.19	£74,685	£146,959	£211,072	£242,380	£242,380	£242,380	£1,204,222



On Call Plans & Site Management

Weekday meetings

- Silvers will join the 16:45 weekday bed meetings
- Gold will join the 16:45 weekday bed meetings where able
- Gold/Silver may be required to join sector calls where needed out of hours
- Gold/Silver will join the 20:15 calls each day

Weekend meetings

- Weekend site meetings have been established and are embedded 3 x per day
- Silvers will be onsite during the weekends in winter commencing from 1st of January 2025 to 31st March 2025 unless the site is on OPEL 4
- In OPEL 4 at the weekends/ BH, Silvers are expected to be on site to support with flow and provide operational support
 - Silvers will attend all the site meetings and join any sector calls as necessary
- Gold will join the 08:30 and 16:45 and 20:15 site meetings at the weekends
- As required Gold will join any sector discussions in relation to diverts or redirections

Site Management

- Site Management team remains unchanged however there will be expanded site presence on the wards and ED during winter throughout enhanced walkarounds out of hours and at weekends



Infection Prevention & Control

The Infection Prevention and Control Team (IPCT) will continue to provide specialist clinical advice, support and guidance to staff and service users throughout the winter period. The IPCT plays a vital role in supporting services across the Integrated Care Organisation (ICO) by preventing and reducing the incidence and transmission of healthcare-associated infections (HCAIs). This helps to protect patients and staff, reduce avoidable pressures on clinical services, and support safe and effective patient flow and capacity management.

The IPCT operates a five-day service, Monday to Friday, from 09:00 to 17:00, with out-of-hours infection advice and support provided by the on-call Microbiology team.

Throughout the winter period, the team will maintain:

- High visibility and a proactive presence within clinical areas across the hospital, including regular attendance at Site Safety meetings.
- Close working relationships with Site Practitioners, Infectious Diseases and Microbiology teams to support the timely risk assessment and management of patients with suspected or confirmed infections.
- Ongoing surveillance and monitoring of infection trends and microbiological data to support early identification of emerging risks, internal oversight and mandatory external HCAI reporting requirements.
- Timely investigation and management of outbreaks and infection-related incidents, supported by targeted education, training and IPC interventions to minimise transmission and reduce HCAIs.
- Effective respiratory infection testing pathways to support timely diagnosis, appropriate patient placement and cohorting, and minimise the risk of onward transmission.
- Effective multidisciplinary HCAI and outbreak review meetings involving key stakeholders, applying Patient Safety Incident Response Framework (PSIRF) principles to identify learning, drive improvement and support appropriate reporting.



Rapid Response and Virtual Ward

Rapid Response

- Referral activity remains high, with increasing referrals via the UCR SPOA, driven by growing community healthcare needs, an ageing population, and a continued focus on avoiding unnecessary hospital admissions.
- Demand continues to be carefully balanced against the staffing requirements needed to support Virtual Ward services.
- During periods of sustained pressure, the service may temporarily close to new Rapid Response referrals in line with the agreed escalation and service closure SOP

Hospital@ Home

- Remote Monitoring: 8 beds.
- Islington Complex Virtual Ward: 8 beds.
- General Virtual Ward: 24 beds (12 Haringey, 12 Islington), with capacity flexed according to patient acuity and service demand
- Discuss HH suitability at huddles and wards rounds, prompting awareness to increase referrals
 - One pager developed to raise awareness of criteria and referral process
- Increase utilisation from a baseline of 68% to 80% from September to November

Discharge to Assess (D2A) 6-month pilot

- Provides hospital in-reach and dedicated discharge slots throughout the week to support timely patient discharge.
- Seven-day service facilitating safe discharge and ongoing care at home.
- Supports hospital flow and helps avoid unnecessary delays in discharge.



Outpatient IV Antimicrobial Therapy (OPAT)

- The OPAT team provides specialist service to enable patients with complex or chronic infections requiring high-risk antibiotics to be managed safely in the community settings:
- Identify patients suitable to have their IV antibiotic treatment managed in the community for early discharges / admission avoidance.
- Advice on convenient IV or oral antibiotic regimes to facilitate discharges / admission avoidance.
- Facilitate self-administration of IV antibiotics at home to provide convenience for patients and reduce workforce pressure
- Coordinate MDT review with clinical and community services.
- Ensure timely, safe and effective switch to oral antibiotic options.
- Optimise treatment duration, reduce drug cost and wastage.
- Safety oversight and governance to reduce risk of re-admission, patient harm and errors.
- Current maximum caseload of 10-15 patient (saving 2 beds/day).
- The service is awaiting financial agreement, which would see the service increasing to 25 - 50 patient caseload (saving 4 to 8 beds/day).



No Criteria to Reside & Discharge

Reduce the number of patients not meeting the "Criteria to Reside" by improving discharge processes and addressing bottlenecks in the system.

Target for NCTR is <45 throughout the winter period

Reassess Workflow:

- Review the IDT processes and focus on early escalations of delays to expediate discharges of patients
- Early discussions with external partners to focus on solutions for barriers in discharge- during daily meetings, create additional calls
- Utilise early use of alternative resources- such as bridging if the patient meets criteria, SHP, Bridge Trust renewal

Collaborate with Local Authorities to Expedite Acceptance of Care Packages

- OPEL 4 agreed actions cards related to NCtR numbers to discharge 3 additional patients
- Deep dive into reasons for high NCtR numbers in partnership with local authority e.g. delays or complexities



Vaccination Programme

- Planning is underway to maximise uptake of flu vaccinations among staff and eligible patients ahead of the winter period, helping to increase immunity and reduce the impact of seasonal illness.
- Housebound and care home patients to receive vaccinations.
- A targeted vaccination promotion campaign, including in-reach activity and the use of vaccination champions across services, will support uptake.
- Vaccination champions will be identified across the organisation to encourage and promote vaccine uptake among staff.
- Aim to achieve a 5-percentage point increase in frontline staff flu vaccination uptake compared with the previous year.
- Supporting local authority discharge support staff to be offered Flu vaccination in shared health and LA sites to enable a robust workforce to support patient flow
- The vaccination programme will run from October to March with the below staffing



Pathology & Phlebotomy

- Circulating winter viruses have a major impact on pathology testing volumes and therefore pressures on the service during the winter season. Winter pressures are unpredictable year to year and dependent on several independent factors e.g., viral strains, vaccine uptake, weather etc but previous year data shows the winter seasons drives the COVID/flu testing up by around 2.5 times from summer to peaks in winter. A busy winter virus season especially Influenza, also drives up the demand for related routine investigations e.g., FBC, CRPs, blood cultures
- As part of a demand optimisation workstream the Trust has made great strides in reducing unwarranted viral PCR tests, but these tests are directly driven by the rates of circulating viruses and therefore be completely controlled. The Pathology service is outsourced, and additional workload should be accommodated by HSL but might be reflected in a cost pressure as the contract is based on cost per test.
- Phlebotomists rotate between bleeding the wards in the morning and attending clinics on Level 5, so the mornings clinics are limited in staffing capacity. Waiting times for Outpatient Phlebotomy clinics may worsen over the winter months. High levels of sickness can also drive staff sickness rates and result in a cost pressure due to increased bank staff usage
- Clinic hours can be extended to provide additional capacity if required to create additional appointment capacity (funding not available within establishment –would result in a cost pressure)

Acute Paediatrics

Actions that will be taken – no additional funding required:

- Daily review of bed capacity and predicted demand with Paediatric ED, with agreed escalation triggers for opening surge beds, redeploying available staffing and accessing additional support.
- Maximise CAU pathways to avoid unnecessary inpatient admissions where clinically appropriate.
- Senior clinical decision-making early in the day to support timely admission, treatment and discharge decisions.
- Proactive discharge planning from admission, including early identification of investigations, treatment and discharge requirements.
- Identify patients suitable for Hospital at Home at the point of admission, supporting earlier discharge where clinically appropriate.
- Utilise senior nursing and clinical staff flexibly across Ifor, CAU and Paediatric ED, according to patient acuity and demand.
- Cohort patients where clinically appropriate to minimise the use of isolation cubicles and maximise available bed capacity.
- Daily review of long-stay patients, with a clear escalation plan for identified barriers to discharge.
- Enhanced weekend discharge planning to avoid unnecessary bed occupancy over weekends.
- NICU OOH team (Registrar) to support Paediatric ED / Ifor subject to NICU acuity
- NICU outreach team and transitional care fully recruited and will support early discharge

Actions that require additional funding

- Fund additional surge capacity to flex Ifor to 23 beds in response to increased winter demand across NCL.
- Fund additional temporary/bank staffing to safely support surge bed capacity and maintain safe staffing during periods of sustained or exceptional demand 1 WTE per day, 1 WT per night



Theatres & Critical Care

Elective & Day Case Procedures

- To meet the Trust Activity & Income Plan, it will be a priority to maintain admitted activity throughout Q3 and Q4
- Coyle and Mercers Surgical wards to continue to be ringfenced for Elective and Non elective surgical patients.
- COO/ DCOO sign off for any potential cancellations due to bed pressure
- Winter closure for 2 weeks w.c. 21st Dec and 28th Dec 2026. Hybrid lists to support cancer; Obstetric; urgent cases only with NEL CEPOD and Trauma only

Management of Activity & demand

- Robust S&C team planning (6,4,2 meeting & Elective Surgery Recovery meeting) to forecast and plan elective admissions
 - Continued theatre activity with prioritised;
 - P2 caseloads (including cancer)
 - RTT Breaches
- Ongoing theatre improvement initiatives to optimise productivity

Critical Care Bed base

- Critical care has secured recurrent funding to increase the core bed base from 10 beds to 11 beds for 9 months of the year
- Additional funding will allow the bed base to increase to 12 for 3 months (January, February & March)

Management of Acuity & demand

- Robust S&C team planning (6,4,2 meeting & daily surgical meeting) to forecast and plan elective admissions in consideration of critical care capacity

Collaboration

- Continuation of our close working with NCL Critical Care Network and use of the access transfer service in times of extremis



Pharmacy & Mortuary

On board additional staff in support of additional beds.

- 1 x B6 pharmacist for Eddington Ward @18 beds
- 1 x B5 pharmacy technician for Eddington Ward @18 beds

BCP in place to determine and support articulation of service levels (Green/Amber/Red).

- Medicine stock list reviews for winter escalation wards ensuring accurate medicines needed and quantities present in the areas dependent on bed numbers.
- Staffing structure re-organised to support TTA workload over the Christmas period i.e., trainee pharmacists.
- Annual leave (21st Dec - 3rd Jan) organised and approved with a focus on core patient facing activities only.
- Financial Dashboard in place to monitor increased medicines expenditure associated with additional beds
- Dynamic review of weekend staffing numbers and flex as required in keeping within increased medical staffing and discharges.

If funded

- On board additional staff in support of Pharmacy TTA Prescribing Service – 2x B8a Pharmacist

Mortuary

- There is established relationship with an off-site provider of body storage (fridge and freezer) which will be used where additional storage is required.
- Use of offsite storage would incur transport and storage costs outside of what is budgeted for



Haringey – Winter Plan



Whittington Health
NHS Trust



Aims of Our Winter Plan

- Strengthen system capacity and coordination
- Ensure continuity of care
- Support workforce resilience
- Prepare for varying levels of demand
- Mitigate risks and challenges

Winter Specific Pressures and Challenges

- Seasonal illnesses and increased need for services over Winter.
- Weather alerts/ severe weather warnings
- Capacity in A&E departments
- Pressures on primary health systems including GPs and district nurses.
- Workforce and capacity challenges.
- Housing, homelessness and environmental concerns.
- Increased risk of burnout to unpaid carers.
- Tackling health inequalities.

haringey.gov.uk



Islington Council- Support Winter Pressure

Key focus areas

- Workforce and Operational Resilience
- Provider Capacity and Market Management
- Integrated Front Door and Admission Avoidance
- Housing, Homelessness and Complex Discharge
- Supporting Hospital Flow and Timely Discharge
- Prevention, Public Health and System Working

A collage of ten hexagonal images featuring diverse healthcare professionals and patients. The images show a woman holding a baby, two nurses in green scrubs, a woman in a yellow jacket sitting in a chair, two men in green shirts, a woman in a blue shirt and gloves, a man in a blue shirt and glasses, three people in blue vests labeled 'WINSTON GUIDE', and a woman in a blue shirt talking on a phone next to a colorful wall with heart patterns.

Winter Planning 26/27

Board Assurance Statement (BAS)



1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please include the Trust / Provider name at the top of the tab.

This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist

This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026**.



Winter Planning 26/27

Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down): Whittington Health Trust
If Other, write Provider/Trust Name:
Contact details (email, phone number):
Date: 01/07/2026

Please complete these sections					
Assurance statement			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes	Going to September Board	
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	To be supported by Chief Nurse	
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes	Input from LAS, Haringey and Islington	
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	UEC session being held 18/09/2026	
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	Chin Okungua/ Ellis Pullinger (commencing 21/ 09/2026)	
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes	Operational escalation to COO Trust escalation- COM/ TMG/ Board	

Winter Planning 26/27

Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.

Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Section B: 26/27 Winter Plan checklist		Please complete these sections		
		Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention				
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes	
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes	
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes	
Occupancy and discharge				
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes	
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: • coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. • executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. • targeted operational actions to reduce long discharge delays. • Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	No	Discharge lounge to support GIRFT recommendations will require additional capital investment and is being discussed at CIG 12/08/2026 D2A pathway being developed Escalation processes in place however NCTR remain persistent
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	
Capacity				
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes	Paeds medical staffing BC being submitted to support resilience and senior d
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes	
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes	Will require funding for 24/7 EEMAC through constitutional standards
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes	
Flow				
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	Discharge lounge to support GIRFT recommendations will require additional capital investment and is being discussed at CIG 12/08/2026
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes	
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	No	Escalation arrangements are in place however there is a risk to NCTR rates which have remained persistent through summer
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes	
Infection Prevention and Control (IPC)				
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes	
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	
Leadership and operational grip				
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes	
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes	
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes	
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes	
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes	
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes	
Specific actions for Mental Health Trusts				
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Yes	
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	Yes	
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.	Yes	

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

Trust / Provider Name: Whittigton Health

Provider CEO name: Selina Douglas

Date reviewed: 25/09/2026

Provider Chair name: Julia Neuberger

Date reviewed: 25/09/2026

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Ellis Pullinger

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

Yes

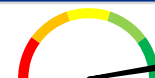
Please confirm date reviewed

14/09/2026

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 5 - Full assurance



		Rating
Section B	Prevention	5 - Full assurance
	Flow, occupancy and discharge	4 - Substantial assurance
	Capacity and community	5 - Full assurance
	UEC Flow	3 - Moderate assurance
	Infection Prevention and Control (IPC)	5 - Full assurance
	Leadership and operational grip	5 - Full assurance
	Specific actions for Mental Health Trusts	5 - Full assurance

Provider capability self-assessment template 2026

Providers should use the form and the supporting annex to rate themselves across each domain and, following Chair and CEO sign-off, submit to their regional oversight lead by **5pm Friday October 2**.

I. Strategy, leadership and planning

Capability statements	Proposed domain rating
	Amber-Green
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	Yes – Whittington Health's 2026/31 plan, submitted as part of the last business planning round, sets out our organisational priorities and the overall direction for the Trust, focusing on delivering our clinical strategy, and is leading on both Neighbourhood working and Start Well programmes in the West and North London Integrated Care System. Whittington Health demonstrates strong and mature system leadership, with a well-established track record of delivering organisational objectives through partnership working and collaborative models of care. The Trust is recognised as a key partner in shaping and delivering integrated care through collaborative leadership, service transformation and place-based working. The Trust's strategic priorities are closely aligned with system objectives and are delivered through a range of integrated programmes, including neighbourhood health, Hospital at Home, population health management and partnership working with UCLH. The long-standing strategic partnership with UCLH has enabled shared leadership, clinical collaboration, pathway redesign, workforce development and more effective use of resources, supported by joint governance arrangements, collaborative service developments and shared appointments. The Trust plays a significant leadership role within place-based partnerships across North Central London and is a key partner in the development and delivery of integrated models of care. In Haringey and Islington, Whittington is working with place-based partners to lead the development and implementation of neighbourhood health models that support earlier intervention, proactive care for rising-risk populations, reduced avoidable admissions and more care delivered closer to home. Through its role as an integrator within these arrangements, the Trust helps bring together health, care, local authority, voluntary sector and community partners to support neighbourhood-level planning, delivery and improvement. This includes supporting the

	development and delivery of Integrated Neighbourhood Teams, enabling organisations to work collectively around the needs of local populations and contributing to improved outcomes and reduced health inequalities. The Trust has also been confirmed as the host organisation for the Start Well programme, demonstrating confidence in its ability to lead complex place-based transformation programmes on behalf of system partners. Through this role, the Trust is supporting the delivery of a shared vision for children, young people and families by bringing together partners across health, local government and the voluntary sector to improve outcomes and reduce inequalities. As an integrated acute and community provider, the Trust is well placed to bridge organisational boundaries and support joined-up care across pathways and settings. This is evidenced through its leadership of neighbourhood development, delivery of Hospital at Home, multidisciplinary approaches for people with frailty and complex needs, integrated cancer pathways, maternity and neonatal transformation, and wider service redesign programmes that support timely intervention, coordinated care and avoidance of unnecessary hospital attendance or admission. The Trust's integrated provider model provides a strong foundation for system working, enabling services to be designed and delivered around the needs of local populations rather than organisational boundaries. Through its acute, community and neighbourhood services, the Trust works with partners to improve care coordination, support earlier intervention, address unwarranted variation and reduce health inequalities across the communities it serves. The Board receives regular assurance on system partnership activity through established governance arrangements and maintains active engagement with the Integrated Care Board, provider collaboratives and place-based partnerships. There is clear evidence that the Trust consistently balances organisational priorities with system benefit and contributes positively to collective decision-making, service transformation and delivery. Underpinning these priorities, Whittington Health's Clinical strategy sets out our five-year vision for providing high-quality, person-centred and value-driven care across our acute and community services, while ensuring we remain financially and environmentally sustainable in an increasingly complex healthcare landscape. Our Digital strategy is being refreshed. It is aligned with the national left shift (from analogue to digital) priority in the NHS 10 Year Health Plan and our health and social care system's ambitions to
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	modernise through embracing technology, expanding digital patient tools, utilising artificial intelligence and moving away from paper-based or outdated systems. Our medium-term financial recovery plan priorities for this element of the left shift and the medium-term financial plan are also aligned. The focus of the transformation plan on financial priorities, the Start Well, Neighbourhoods, collaboration with University College London Hospitals NHS Foundation Trust (UCLH), and a new electronic patient record are clearly aligned. Our governance arrangements are as follows for these priority areas: • Our Neighbourhood Health Board reports into the Trust's Management Group • The Board has agreed the governance arrangements for the two elements of the Start Well programme covering transformation of the estate and maternity neonatal services. In addition, there are governance arrangements with the W&N London Integrated Care Board's Start Well Programme Board which includes system partners. • Our digital plans have governance arrangements which include scrutiny and oversight by the Board's Improvement Performance and Digital Committee. • Progress with our Clinical strategy is overseen by the Board's Quality Assurance Committee. • The delivery of our medium time financial recovery plan is overseen by the Board's Finance and Business Development Committee. • All Board Committees present a Chair's assurance report to the Board following meetings highlighting successes as well as areas of concern that need to be escalated to the Board itself. Our areas for development in this domain are shown below: • A refreshed Clinical strategy with performance indicators for improved health outcomes • An updated Whittington Health strategy so that it aligns with the West and North London Integrated Care Board's new 10-year strategy that is being consulted on currently • A successful involvement in the Haringey neighbourhood test bed pilot • An updated medium term financial recovery plan • A response to the opportunities identified to support sustainable financial development at the Trust • A refreshed Digital strategy and a new strategy for Artificial Intelligence • A refreshed Estate strategy
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	An updated succession plan for the recruitment of two non-executive directors in 2027 when their terms of office end and for chief officer roles. Whittington Health has assessed itself as amber-green rather than green for this domain as the above areas for development highlight areas for further assurance, particularly on finances and also in meeting national targets for referral to treatment waiting times, the four-hour access standard in the urgent and emergency care pathway and in diagnostic waiting times.
2. If in breach of licence: The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	Whittington Health has no ongoing enforcement action from NHS England and is compliant with its licence conditions.
3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan.	As of 7 September, Whittington Health currently has a full complement of board positions which all are filled. During 2025/26, the following changes took place: - NHS England led the recruitment campaign for a new Trust Chair. Our current Vice-Chair was successful and will become our Chair on 1 October 2026 providing important continuity and a sound understanding of the Trust's strategy, opportunities and challenges. - NHS England agreed extensions to the respective terms of office for all remaining non-executive directors. - Substantive appointments have been made to the following executive director roles: Chief Medical Officer, Chief Strategy Officer and Chief People Officer. - The Deputy Chief Executive (held by the Chief Finance Officer) role was made substantive. The current Chief Operating Officer leaves the Trust at the end of September. A recruitment exercise has been carried out, and a substantive appointment has been made for a replacement who will join us in quarter four. In the meantime, an experienced interim Chief Operating Officer will join us for a fixed term appointment in September too. Two of our non-executive directors will end their final terms of service on the Board in 2027 - at the end of April and October respectively - and planning is underway to recruit replacement board members for these roles, with the appropriate knowledge,

	skills and experience needed for an Audit and Risk Committee chair and also for a member of our Quality Assurance Committee, in partnership with NHS England's appointments team. All executive directors have clear accountabilities for operational areas and have specific, linked performance objectives. Governance arrangements for these areas include the following: • A Neighbourhood Health Board which reports into the Trust's Management Group. • The Board's Improvement, Performance and Digital Committee provides oversight on our left shift digital work.
4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	Whittington Health is seen as an effective and collaborative partner in the W&NL health and care system and can highlight the following examples: • The Trust has a partnership agreement with UCLH in our West and North London Integrated Care System and this has shown how we share resources with the chair, a proportion of non-executive directors which is helpful strategically, and there is good work on how we work together for service provision, clinical joint appointments which is discussed by a joint executive committee and a Partnership Development Committee-in-Common • In March 2025, the then North Central London Integrated Care Board (ICB) 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, confirmed Whittington Health's role as a key provider of maternity and neonatal care. • 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. • As part of the left shift set out in the 10-Year Plan, the Trust is playing a leading role as an integrator in neighbourhood health in both Haringey and Islington, alongside primary care, local authority, voluntary, community and social enterprise and provider partners. • 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 North Central London Health Alliance, the provider collaborative which brings together all Trusts in the former North Central London ICB together, to address system-wide challenges and reduce health inequalities • Board members meet ICB colleagues regularly, for example, Mike Bell the West & North London ICB's Chair spoke at our Senior Leaders' Forum in quarter two. • The Trust is actively working with local authority partners in Haringey and Islington borough partnership meetings. • We also have a number of mutual aid collaborations with other providers in our system - for example surgery with the Royal Free London NHS Foundation Trust. • 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 through the Proactive Frailty and Complex Care Team and in Haringey through the Multi-Agency Care and Coordination Team. These teams bring together a wide range of specialists to prevent hospital admissions and enable timely discharge. • We have established a Clinical Interface Group as a key forum for strengthening working relationships between primary and secondary care and to support system wide improvements. 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. ○ introduction of new cardiology pathways, including updated guidance for managing non-urgent chest pain and interpreting 24-hour tape results. These changes enable
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	faster access to results for patients and reduce unnecessary referrals to secondary care. ○ resolution of issues affecting primary care services, 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. ● 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. ● We also continue 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. ● Other evidential examples include our hosting of the shared Partners Procurement Service. This is a collaboration between Whittington Health, Moorfields Eye Hospital NHS Foundation Trust, and the Royal Free London NHS Foundation Trust to deliver high quality and cost-effective procurement and logistics services for the participating partners, who equally own the service. ● In addition, Whittington Health is one of seven NHS providers in North Central London who are members of the North London Partners Shared Services for recruitment and occupational health services. ● Whittington Health also works collaboratively with the North London NHS Foundation Trust on support for mental health patients who present at our emergency department and is also a member of the North Central London Community Children and Young People's Mental Health Services Provider Collaborative. ● Finally, a further example of collaborative working is that Whittington Health was asked to take over the Barnet 0-19 service by the Integrated Care Board, following the departure of another provider. Our governance arrangements for this area include the following: ● Borough Partnership Boards in Islington and Haringey ● The W&N London ICB's Management Board ● An executive-to-executive forum to take forward partnership working with UCLH
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	The Executive Group and Board of the North Central London Health Alliance (the provider alliance)
5. The trust has an effective cyber security strategy and uses digital technology to support organisational improvement	Whittington Health has a digital strategy in place and is currently consulting on a refreshed version which will take us to 2030 and align fully with the digital to analogue aims of the 10-Year Health Plan. The refreshed strategy will be considered by our Board in quarter three. Our digital vision is to be: - the best provider in the UK at using integrated community and hospital data to improve care for frail older people, women and children. - a leading NHS provider in the use of digital, data and technology to improve outcomes and experiences for our patients, service users and staff. The strategic pillars underpinning our new digital strategy are, as follows: <u>Digital Services</u>: Improving the experience of patients, service users and staff through accessible, user-centred digital services. <u>Data and Insight</u>: Using trusted data and intelligence to support decision-making, population health management and continuous improvement. <u>Technology Foundations</u>: Providing secure, resilient and innovative infrastructure, systems and platforms that enable modern healthcare delivery. The new strategy will highlight our 2026-30 strategic digital ambitions as: Ambition 1: A Single, Longitudinal Care Record By 2030, clinicians across Whittington Health will access a single, longitudinal patient record spanning hospital, community and neighbourhood care. This will encompass a converged electronic patient record; interoperable data flows and support multi-disciplinary team-based neighbourhood care. Ambition 2: Neighbourhood-Enabled, Digitally Supported Care Digital will underpin care closer to home and personalised, proactive services. It will provide the following: - mobile digital access for neighbourhood teams - digitally supported care planning - digital access for patients where appropriate - information easily shared with system partners - a maximisation of the use of the current technology in place at a local, regional and national level Ambition 3: Data-Driven Decision Making The Trust will move from retrospective reporting to near-real-time operational and population insight with population health

	management at the centre of what we do; strong data governance and quality; and a single version of the truth. Ambition 4: Productivity, Automation and Workforce Support Digital will be used deliberately to release clinical and operational capacity through a reduction in the administrative burden; a single sign-on functionality; improved usability and reliability; increased professionalisation of the digital and data workforce, with all Trust digital and data staff professionally registered, or working towards registration, by 2030 in line with emerging national expectations for the profession; and a cautious, safe adoption of automation and Artificial Intelligence. Ambition 5: Secure, Resilient and Sustainable Foundations Cyber security, infrastructure and resilience are Board-level safety priorities with a strategic risk on our Board Assurance Framework covering cyber security and digital interoperability which is reviewed every two months by the Board's Improvement, Performance and Digital Committee. This ambition of the new strategy will strengthen further our cyber resilience and improve service reliability and recovery. Ambition 6: Digital Inclusion and Accessible Digital Care By 2030, Whittington Health will ensure that digital services reduce (not widen) health inequalities, with inclusive design, targeted support for people at risk of digital exclusion, and clear alternatives where digital is not appropriate. Examples of where digital innovation has already supported organisational improvements are shown below: - Our digital strategy is clinically led and grounded for the successful delivery of the Trust's Clinical Strategy. - Digital communication has been used for a key operational priority – the reduction of Did Not Attends by strengthening reminder and cancellation processes, supporting proactive patient engagement, and ensuring opportunities to reallocate unused capacity at short notice. A sustained focus in this area will improve clinic efficiency, patient experience, and delivery against elective recovery objectives. - 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. - Our Patient Portal allows patients to see all their out-patient appointments, view and download appointment letters, add
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	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 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. 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 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 Cyber security is a core component of the Trust's Digital Strategy and is embedded across all digital programmes and investments, rather than being treated as a standalone workstream. The Trust maintains a strong focus on cyber resilience through robust governance arrangements, use of national NHS cyber security services and tools, regular phishing simulation exercises, and ongoing oversight of cyber risks. Senior leaders, including the Senior Information Risk Owner, receive appropriate training and support to fulfil their information governance and cyber accountability responsibilities. Digital technology is also being used to support organisational improvement through enhanced infrastructure monitoring, strengthened identity and access management, and improvements in data quality and system reliability. In addition, Board members have received training on cyber security from an external provider, the Templar International Group Limited, commissioned by NHS England. Our governance arrangements for this area are, as follows: • The Board approves all key organisational strategies and is due to see the new Digital Strategy in quarter three. • The Board's Improvement Performance and Digital Committee will review the refreshed Digital strategy and make a recommendation to the Board on its adoption. This forum also reviews regular updates (along with the Board) on progress with the procurement of a new electronic patient record and
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	escalates any areas of concern to the Board through its Chair's assurance report. • The Trust's Management Group will first see key proposals on digital matters before they are considered by the relevant Board Committee. • An executive-led Innovation, Digital and Transformation Group has responsibility for overseeing digital transformation work. • In addition, the Board's Audit and Risk Committee annually reviews an assessment by our independent internal auditors, RSM, on compliance with Data Security & Protection Toolkit requirements by NHS England.
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II. Quality of care

Capability statements	Proposed domain rating
	Amber-Green
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt).	Whittington Health NHS Trust has established arrangements for monitoring and improving quality of care. These include implementation of the Patient Safety Incident Response Framework recent review of PSRIP in response to data intelligence. Daily review of patient safety events, local and Trust-wide mortality review, clinical audit and Getting It Right First Time oversight, patient experience and complaints reporting, and escalation through the Quality Governance Committee and Quality Assurance Committee to the Board. The Board also receives patient stories and quality and safety information to support its oversight. The management of risk continues to be strengthened through the establishment of a Risk Committee. A recent external review of risk management by our independent internal auditors noted positive improvements and have us the second highest assurance rating possible.
7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	Whittington Health NHS Trust has established systems for capturing, reviewing and escalating patient experience intelligence. Ward-level patient experience information is shared monthly with nursing teams, and the patient experience strategy is being implemented through local action plans. The Board receives regular reporting on complaints, Patient Advice & Liaison Service (PALS), Friends and Family Test feedback, patient stories and other qualitative and quantitative measures, with established routes for escalating serious or recurring issues. Patient and service-user involvement is supported through patient panels, focus groups and Patient Safety Partners.
8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	Information from Care Quality Commission inspections, regulatory correspondence and other external reviews is monitored and used to inform service improvement plans. Progress against resulting actions is reviewed through relevant governance groups. The outcomes of annual People-Led Assessments of the Care Environment are regularly brought to a Board Committee and to the Board itself. In the last two years, there has been a significant focus on improving cleanliness and results for this element of the assessment

	have improved considerably. Our focus now is to improve on our assessment for the food provided for patients. Following a patient story brought which is head as a standing item at our Board meetings in public, work took place to improve wayfinding arrangements for visually impaired patients and visitors. This work was delivered in partnership with an external specialist organisation for visual impairment and with relevant patients. The Whittington Maternity and Neonatal Voices Partnership represents all women, birthing people and their families from all communities, cultures and backgrounds in Islington, Haringey and other local boroughs. Led by maternity and neonatal leads, this independent forum for parents, parents to be, peer supporters and health care professionals work together to be a critical friend to review, improve and contribute to the development of Whittington Health's maternity and neonatal services. and ensure codesign is at the heart of the maternity and neonatal care. An area of development is to strengthen the triangulation of quality intelligence: incidents, mortality, complaints, PALS, patient experience, Care Quality Commission (CQC), safeguarding, clinical audit and workforce data, to drive improved outcomes through quality improvement methodology and integrated data quality dashboards. Further work to demonstrate the efficacy of governance infrastructure is currently underway and will be completed in October. Evidence of our impact can be seen in: • strengthened Duty of Candour monitoring arrangements. • improved incident categorisation and data quality. • community engagement activity continuing to develop, including collaboration with the North London Sight Loss Council to improve accessibility and staff awareness of the needs of people with visual impairment • Positive CQC Engagement feedback and active management of CQC action plans. Our areas for development in this domain are: • A refreshed approach to Quality which aligns with requirements set out in the Quality Strategy for NHS-funded care in England, published by the National Quality Board on 14 July 2026
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	• An improved food offer for inpatients to respond to the findings of the last People-Led Assessment of the Care Environment • An updated Patient Experience strategy • As referenced in domain 1, a refreshed Clinical strategy We have assessed ourselves and amber-green for this domain, rather than green, as the development areas shown above highlight where assurance is required.
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III. People and culture

Capability statements	Proposed domain rating
	Amber-Green
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience	Whittington Health has a rolling programme of work aligned with the yearly publication of the NHS Staff Survey, where the results are analysed to understand key areas of focus. This analysis along with action plans are shared through the organisations governance structure up to board to ensure oversight and commitment. Whittington Health also participates in the People Pulse surveys which run during quarters 1, 2 and 4 to ensure the organisation is continuously monitoring staff experience and ensuring the organisation's focus is in the correct areas.
10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels	Whittington Health has full schedule of mandatory and developmental training which covers specific skills requirements as well as broader topics. Mandatory training compliance is reported monthly into Trust Board as part of our integrated performance report and is monitored by senior leadership. Whittington Health provides specific career development programmes such as Band 2-7 career development for ethnic minority staff and iCARE Leadership, Managers Passport, Anti-racist and Inclusive Cultures and coaching and mentoring programmes. Analysis of development programmes are carried out annually and reported through the organisation's governance structures.
11. Staff can express concerns in an open and constructive environment	Whittington Health has a well-established Freedom to Speak Up function that supports openness and transparency. The Guardian and Speak Up Champions provide accessible routes for raising concerns. Reporting has increased and reflects a healthy culture, particularly the fact that so few concerns are raised anonymously. Staff are encouraged to report all incidents and near misses in a no blame culture. Staff are actively encouraged to raise concerns with their line manager in first instance. Where this is not possible, Speak Up Champions and the Freedom to Speak Up Guardian offer alternative options for staff to raise concerns. There are circa 30 Speak Up Champions from a range of roles and backgrounds across both acute and community sites to support staff raising concerns across the organisation. All

	Speak Up Champions have completed on-line training on raising concerns. Our areas for development in this domain are: • A refreshed People strategy which is currently at the engagement and consultation stage with stakeholders • Deliver further reductions in temporary staffing expenditure, particularly bank workers. • Publication of our new Violence Prevention and Reduction strategy which includes collaborative work with Islington Council and the local Metropolitan Police to tackle the significant increase in incidents of violence and aggression against staff. • Implement our plan for the national Leadership and Management Framework to support stronger management capability, competent, compassionate and inclusive leaders, better staff experiences and improved care for patients. • Embed the published NHS Staff Standards to improve staff experience in the areas of line management; health and wellbeing; tackling racism; promoting flexible working; violence prevention and reduction; and championing sexual safety. We have assessed ourselves and amber-green for this domain, rather than green, as the development areas show where further assurance is required.
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IV. Access and delivery of services

Capability statements	Proposed domain rating
	Amber-Green
12. Plans are in place to improve performance against the relevant access and waiting times standards	At the end of quarter four 2025/26, following a series of sprints by our clinical divisions, Whittington Health was the most improved provider in England for waiting times. Planning was completed in January 2026 to ensure the Trust achieves RTT performance of 78.1% by March 2027 and achieve 92% compliance by March 2029. This remains an area of focus following our mid-year review with NHS England's regional London team. The Trust has comprehensive improvement plans for areas where standards have yet to be achieved. Progress is monitored monthly through monthly performance review meetings for each of our clinical divisions, with corrective actions tracked and escalated as required. Drivers of underperformance are routinely reviewed through Trust Management Group and Board meetings to ensure appropriate oversight and support the delivery of sustained improvement.
13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients	Patient waiting times are actively monitored through the patient waiting list, with performance reviewed regularly to support timely access to care. Service lines are also reviewed weekly at the Trust's Planned Care Delivery Group. The Trust's Access Policy underpins the consistent and equitable management of patient pathways. Appointments are allocated according to waiting time and clinical priority, ensuring resources are directed to those with the greatest need. The Trust is also developing approaches to stratify waiting lists based on population health needs, enabling a more targeted and equitable delivery of care.
14. Appropriate population health targets have been agreed with the ICB	Population health targets are agreed jointly with the ICB and are monitored through regular joint board meetings. Through divisional board governance arrangements, Trust teams understand how their roles and services contribute to improving population health outcomes and reducing health inequalities. Work is taking place in our community services teams to meet the CORE20PLUS5 priorities for adults and children. The Board

	receives a quarterly report on waiting times by age, disability, race and sex. 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. Our areas for development and focus in this domain are to: • successfully deliver the performance expectations for national constitutional standards by the end of March 2027 and to deliver our Outpatients' Transformation Programme, with improved communication opportunities for patients. • relaunch our approach to health inequalities, including our health equity steering group and to consider partnering with the Faculty of Health at the Royal Free London NHS Foundation Trust. We have assessed ourselves and amber-green for this domain, rather than green, as there is a need to demonstrate a sustained track record of successful delivery against key indicators for performance in the urgent and emergency care pathway, on referral to treatment and in diagnostic tests.
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V. Productivity and value for money

Capability statements	Proposed domain rating
	Amber-Green
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	Productivity metrics, including length of stay, theatre utilisation, outpatient Did Not Attend rates, workforce productivity measures and other key operational indicators, are routinely reported through Board and divisional performance reports, providing regular oversight of performance and enabling timely identification of opportunities for improvement. Productivity performance is reviewed through established governance structures, including Board committees, executive management groups and divisional performance meetings. These forums provide challenge, scrutiny and accountability for delivery, with clear escalation processes where performance falls below expected standards. Divisional performance reporting includes detailed analysis of trends, variation and underlying drivers of performance, supporting informed decision-making and targeted improvement activity. The Trust makes systematic use of benchmarking information from national and regional sources, including the NHS Model Health System, alongside internal trend analysis, operational intelligence and clinical insight, to identify opportunities to improve productivity and reduce unwarranted variation. Outputs from this analysis are used to inform business planning, service transformation, efficiency programmes and financial recovery initiatives. The organisation continues to strengthen its analytical capability through the wider adoption of Statistical Process Control (SPC) methodologies and data-driven performance management approaches. SPC is already embedded within selected clinical services and is being progressively expanded across the organisation to support and enhance evidence-based decision-making. Our areas for development and focus in this domain are to: • deliver the four workstreams of our Improvement Programme which focuses on non-pay, people and pay, clinical value and patient flow. • improve our delivery of cost improvement programme savings in the last two quarters of the financial year. • implement the plans to deliver opportunities to support sustainable financial improvement in maternity services, district nursing, theatre utilisation, outpatients, medical

	staffing and for patients who do not meet the criteria to reside. Whittington Health has assessed itself as amber-green for this domain, rather than green, as there is a need to demonstrate a successful delivery of key change programmes highlighted for sustainable financial improvement.
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VI. Financial performance and oversight

Capability statements	Proposed domain rating
	Amber-Green
16. The trust has a robust financial governance framework and appropriate contract management arrangements	The Trust operates a well-established financial governance framework with clear accountability through the Trust Board, Finance and Business Development Committee and Audit and Risk Committee. Our internal audit plan's coverage is aligned to the Trust's strategic objectives, Board Assurance Framework and principal risks, providing independent assurance over key financial controls and governance arrangements. As well as being risk-based, the internal audit plan is agreed through wide consultation with chief officers and then is independently stress-tested by our non-executive directors who sit on the both the Audit and Risk and Finance and Business Development Committees. Annual external audit of the statutory accounts, together with assurance over outsourced services where applicable, provides additional validation of financial stewardship. Financial performance, contracting, efficiency delivery, capital expenditure and financial sustainability are reviewed routinely through established governance forums ((e.g., Trust Management Group or Finance and Business Development Committee) with clear escalation routes for significant risks. High-risk and material financial issues ((e.g., PFI litigation, Fire Rectification) are subject to enhanced Board oversight, with detailed reporting, risk assessment and mitigation plans. Variances from plan and emerging risks are identified early through monthly reporting, enabling timely management intervention and corrective action.
17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do	The Trust maintains a comprehensive Quality Impact Assessment (QIA) process covering all Cost Improvement Programmes and service changes, ensuring that financial decisions are assessed for their impact on quality, safety and patient outcomes.

not adversely affect patient care and outcomes	All schemes require clinical review and approval prior to implementation, with ongoing monitoring where risks are identified. Executive clinical leadership of the Cost Improvement Programme is provided through the Chief Nursing Officer and Director of Allied Health Professionals, ensuring quality and financial objectives remain aligned. Financial performance, efficiency delivery, capital expenditure, cash management and balance sheet risks are reported regularly to the Board and Finance and Business Development Committee. The Trust has developed a financial recovery plan focused on addressing underlying structural drivers of the deficit, with delivery monitored through established governance arrangements. Financial risks are routinely reviewed through the corporate risk management framework, enabling mitigating actions to be implemented where required. No material quality or patient safety concerns have arisen directly as a consequence of approved efficiency programmes.
18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	The Trust actively participates in system financial planning processes and works collaboratively with partners to support the achievement of system financial objectives. Financial plans are developed in alignment with system assumptions and priorities, with key planning risks and dependencies considered through both Trust and system governance arrangements. The Trust demonstrates flexibility in its governance processes, including the use of extraordinary meetings where required, to support timely plan development and decision-making. The Trust maintains constructive relationships with system partners, balancing organisational responsibilities with wider system objectives and supporting collective solutions where appropriate. The Trust is working closely with commissioners and provider partners to deliver financial recovery initiatives and address underlying financial challenges across the system.

	The Trust continues to contribute to neighbourhood, left-shift and service transformation initiatives designed to optimise the use of NHS resources and improve population outcomes. Our areas for development and focus in this domain are to: • implement an updated medium term financial recovery plan. • deliver a breakeven position at year-end. Whittington Health has assessed itself as amber-green for this domain, rather than green, as the NHS National Oversight Framework outcome shows that, while Whittington Health comes out in segment two, its financial position restricts it to segment three.
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Signed on behalf of the Board of Directors

Chair: _____

Signature: _____ Date: _____

Signed on behalf of the Board of Directors

Chief Executive: _____

Signature: _____ Date: _____



Meeting title	Trust Board – public meeting	Date: 25 September 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, and Swarnjit Singh, Trust Company Secretary and Joint Director of Inclusion	
Executive summary	The Quality Assurance Committee met on 9 July and was able to take good assurance from the following agenda items considered: • Board Assurance Framework - Quality 1 and 2 entries • Quality Governance Committee update • Fuller Inquiry Action Plan • 2025/26 Medicines Optimisation Annual Report • 2026/27 Quarter one Quality report • 2026/27 Quarter one Maternity Quality and Safety report • 2026/27 Quarter one Patient Experience and Complaints reports • 2025/26 Quarter four Learning from Deaths report • Paediatric Emergency Department update • Ligature Risk Reduction Programme update • Bi-annual Health and Safety report • Pressure Ulcer Improvement Programme update • National Quality Strategy update In addition, the Committee received a presentation on reducing preventable harm from thrombosis and anticoagulation improvement work and noted the risk register report The Committee agreed that the following areas be brought to the Board's attention: 1. The implications of the NHS National Quality Strategy and the work needed to align future governance, assurance and quality management arrangements to the requirements set out in the published guidance. 2. The significant national maternity programme requirements, associated workforce pressures and resourcing implications. 3. The progress achieved on the Fuller Inquiry action plan and Board responsibilities regarding mortuary governance and assurance.	

	4. Assurance on a stable Summary Hospital-level Mortality Indicator of 0.87.
Purpose	Noting
Recommendation	Board members are asked to note the: i. Chair's assurance report for the Quality Assurance Committee meeting held on 9 September 2026; ii. 2025/26 Medicines Optimisation report and the 2025/26 Complaints and Compliments Annual Report; iii. Q3 review of the Board Assurance Framework Quality entries and the decision to leave the current scores unchanged; and iv. Q4 2025/26 Learning from Deaths report.
BAF	Quality 1 and 2 entries
Appendices	1. 2025/26 Medicines Optimisation Annual Report 2. 2025/26 Complaints and Compliments Annual Report 3. 2026/27 Q3 Board Assurance Framework 4. 2025/26 Q4 Learning from Deaths report

Committee Chair's Assurance report

Committee name	Quality Assurance Committee
Date of meeting	9 September 2026
Summary of assurance:	
1.	The Committee confirms to the Trust Board that it took good assurance from the following agenda items: Q3 Board Assurance Framework – Quality 1 and 2 entries The Committee reviewed the entries 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. Committee members welcomed the review of performance against the metrics agreed by the Trust's Board for respective entries. Reducing preventable harm from thrombosis and anticoagulation The Committee received a presentation from Ian Man, Lead Pharmacist, Anticoagulation Services, on the quality improvement work undertaken to address risks associated with anticoagulation and thromboprophylaxis. The work had been developed in response to previous incidents and focussed on improving venous thromboembolism risk assessment compliance, preventing duplicate anticoagulant prescribing and strengthening referral pathways. Committee members were informed that new digital reporting had been introduced which identified patients without prophylaxis and those receiving more than one anticoagulant. Junior doctors and clinical pharmacists were expected to review each exception, assess indication, dose, bleeding risk, and any planned therapeutic overlap, then clarify, amend, document or escalate treatment. The Committee welcomed the multidisciplinary and digitally enabled approach taken. The Committee discussed variation in compliance between specialties and requested that poor compliance be escalated to the Chief Medical Officer to improve engagement with services that demonstrated lower levels of risk assessment compliance. Fuller Inquiry Action Plan Stuart Richardson updated the Committee on the implementation of the Fuller Inquiry recommendations and advised that 22 actions were required and six had been completed with sixteen in progress. The Committee received assurance that there was no evidence of significant operational failure or unsafe environment within mortuary services and that a recent inspection by the Human Tissue Authority had been positive. However, further work was needed on safeguarding arrangements relating to deceased persons; executive oversight and accountability; annual Board assurance reporting; workforce capacity within mortuary leadership roles; the alignment of external mortuary service arrangements with Fuller requirements; and a formal review of security and CCTV arrangements. The Committee also noted that future Board assurance reports would be required in relation to mortuary services.

2025/26 Medicines Optimisation Annual Report

The Committee received substantial assurance from the Medicines Optimisation Annual Report and were informed:

- of a continued increase in medication incident reporting, which reflected a positive reporting culture;
- there was also a reduction in the proportion of incidents resulting in moderate or severe harm fell from 1.25% in the previous year to 0.8% in this annual report;
- six quality improvement projects had been presented nationally at the Clinical Pharmacy Congress
- policies, guidelines and standard operating procedures were under review;
- there was significant progress in the pharmacy redesign through digital transformation, including pharmacy automation and the introduction of robots over the following months;
- Cost-effective prescribing and waste reduction generated approximately £875k in savings, although total medicines expenditure exceeded £20m and was expected to rise further because of new medicines and increased utilisation.

The Committee also discussed Care Quality Commission (CQC) readiness, patient understanding of medicines at discharge and ongoing work to improve patient engagement and education regarding medication. Committee members received assurance from Stuart Richardson that funding had supported cooled treatment areas and appropriate cabinets, policies and that standard operating procedures were in place, and education and support are being used where practice does not consistently match the required framework; insulin management was cited as a current focus area.

In addition, in response to a query on the highlighted low patient-reported understanding of medicine side effects and discharge medicines, Stuart Richardson said the relevant survey score was about 4.8 out of 10, consistent with other organisations but acknowledged it as too low, and described the use of pharmacy lanyards, cards and QR codes to help, alongside further planned work on follow-up or alternative ways to engage patients after discharge.

Maternity Board Report

The Committee discussed significant activity arising from the national maternity agenda, including implementation of recommendations from recent national maternity reviews, the national 10-point plan, Maternity Incentive Scheme (MIS) requirements and preparations for a regional insight visit.

The Committee was informed that:

- NHS England required benchmarking against the maternity 10-point plans and triage standards by 25 September, followed by reassessment on 31 December.
- the MIS submission is due at the end of November, and an implementation plan would come to the next Quality Governance Committee meeting.
- a maternal death occurred in August after a cardiac collapse in triage. The team performed a perimortem c-section, and the baby was born alive and well. A postmortem, coroner's process and a maternity and newborn

safety investigation (MSNI) were pending, with family approval for the MNSI review; psychological support had been offered to staff and service users present in triage.

During discussion, the Committee raised survey findings that some women felt discharged before they were comfortable and lacked confidence and trust during antenatal care. Sarah Wilding agreed that antenatal care needed focussed work and linked this to midwifery staffing and frequent staff movement. Isabelle Cornet later explained that the patient-experience action plan had been paused because of engagement with the Maternity and Neonatal Voices Partnership and a query over payment issues, which had now been resolved, and the plan had subsequently been relaunched.

In response to a query about managing the 10-point plan and MIS workload after the current Director of Midwifery left, Sarah Wilding provided assurance that additional operational support was being provided for MIS, and the trust was considering a distributed model for clinical oversight. Interviews for an interim director of midwifery were also scheduled to take place on 15 September.

The Committee recognised the significant contribution of Isabelle Cornet and her leadership of maternity services over the previous five years and wished her well in her future career.

2026/27 Q1 Quality Report

The Committee reviewed the Quarter 1 Quality Report and noted the following issues:

- There was a continued focus on the Patient Safety Incident Response Framework priorities, particularly falls and pressure ulcer damage.
- Compliance with the duty of candour had improved, particularly the timeliness of responses. The aim now was to achieve a greater consistency in the quality of conversations with patients and letters issues. The central patient-safety team was expected to provide clearer messaging that met both statutory requirements and organisational values.
- Four claims had been received and ten had been closed.
- A quality improvement lead had been recruited as a maternity cover.

Committee members discussed a reported increase in severe physical harm incidents. While no immediate concerns regarding specific causes had been identified, the Committee requested further statistical analysis and triangulation to determine whether the observed increase represented normal variation or a developing trend.

2026/27 Q1 Patient Experience Report and 2025/26 Complaints and Compliments Annual Report

The Committee reviewed the Quarter 1 Patient Experience report and the Annual Report for Complaint and Compliments. Positive developments included a celebration of Patient Experience Week, the valuable contributions from volunteers and the growing role of the chaplaincy team.

The Committee was informed of the following issues:

- while outcomes in the national Friends and Family Test results remained above the national benchmark of 85%, response rates varied considerably. The team was working to improve response rates the adult and paediatric emergency departments;
- The Patient Experience and Information Management and Technology teams together with Acuvia were investigating and addressing the issues arising from an electronic feedback system generating excessive patient contact requests;
- Complaints and Patient Advice and Liaison Service (PALS) contacts had increased, with PALS contacts exceeding 6,000 partly because reporting systems had improved.
- Key complaint themes remained communication, medical care, nursing care, attitude and delays, and there had been limited progress in reducing those recurring themes.
- A report on Artificial Intelligence (AI)-generated complaints was being taken to the Trust's Management Group because AI-assisted submissions were increasing the length of time it took to fully reply to the concerns raised.

Committee members noted that complaint themes remained consistent and centred on communication, delays, medical care and patient experience. The Committee supported further work to develop alternative approaches to complaint handling and resolution.

In response to a query on how Jewish patients were supported without a dedicated Jewish chaplain, Nicola Sands reported that a Jewish organisation had met with the Trust and was planning further support, including festival-related activity and a suitable patient meeting area, particularly in maternity. It was noted that the Trust also worked with a local rabbi, who was scheduled to support New Year celebrations and was also helping to develop broader arrangements.

Pressure Ulcer Improvement Programme

The Committee received assurance regarding the work undertaken to reduce pressure ulcers across both hospital and community services. The Committee observed that performance in quarter one was below the trajectory required to achieve the Trust's reduction targets, however, overall trends showed improvement compared with the previous year.

The Committee welcomed the multidisciplinary review undertaken during the quarter and supported the development of a revised improvement plan focussed on recurring themes including care planning, the early identification of skin damage, particularly in patients with darker skin tones, patient and carer engagement in repositioning and offloading, data quality and quality improvement methodologies. Committee members were assured that targeted actions were being implemented and noted the early indications that performance had begun to improve during quarter two.

A multidisciplinary event involving more than 40 people from quality and risk, hospital and community services, therapies, practice development and safeguarding gathered frontline feedback. That input is being used to co-produce the 2026–27 pressure-ulcer action plan, which will go to the pressure-

ulcer group for review and will prioritise communication, engagement, carers and documentation.

Paediatric Emergency Department Update

The Committee received assurance regarding the continued improvement of the paediatric emergency department following the temporary relocation in June and July to facilitate essential estate works. Committee members were assured that the relocation and subsequent return to the refurbished area had been completed safely and without any reported quality or patient safety incidents. In addition, the Committee noted that anti-ligature works in room 5 were complete.

The Committee welcomed evidence of improved patient experience, including a reduction in complaints relating to staff attitude and increasingly positive feedback from patients and families. Committee members also noted progress in recruitment to the nursing establishment, the development of the workforce, and the appointment of additional leadership support. Assurance was also provided that several previously identified environmental and safety risks had now been addressed, including anti-ligature works and improvements for the management of mental health presentations, which had resulted in the closure of high-rated risks on the divisional risk register.

Committee members also welcomed the fact that observation compliance remained consistently above 90%. Amanda Gibbon separately reported receiving assurance during a site visit that observation audits were achieving a high level of compliance.

Health and Safety Report

The Committee reviewed the biannual Health and Safety Report and was broadly assured regarding overall compliance. Committee members were informed of the following issues:

- For the reporting period from 1 October 2025 to 31 March 2026, the Trust met or exceeded the 85% reporting target across the main incident categories. Fifty-two of 1,636 incidents were not reported within seven days, representing 3%, and the current risk from delayed reporting was assessed as low.
- Health, fire and security policies were 83% up to date against a 100% target and a policy register and update programme are being maintained through the Health and Safety Committee. Compliance with mandatory training was 94% for health and safety, 85% for fire, 92% for moving and handling and 88% for conflict avoidance, with monthly monitoring continuing.
- Community health-and-safety inspections reached 98%, while community security inspections were 73%. Hospital health-and-safety inspections were 80%, hospital security inspections 56%, and fire inspections 84% at both community and hospital sites. The security team was targeting poor responders through face-to-face visits and monthly reminders.
- Fire-risk-assessment completion was 59% for the acute site, 20% for community sites and 45% for shared community sites as of March 2026, against a 100% target.

Amanda Gibbon commented that these levels of fire risk assessments were not sufficient given the trust's fire-risk profile and it was agreed that more recent

	data be provided after the meeting. The Committee noted the mitigations in place which included additional security, a 24/7 fire watch, extra drills, fire wardens and an enhanced fire-response team. The Committee was also informed by Chinyama Okunuga of the lessons learnt from a major fire exercise undertaken with the London Fire Brigade which would be included in the wider assurance position alongside the updated fire-risk-assessment data. 2025/26 Q4 Learning from Deaths Report The Committee received good assurance from the Learning from Deaths Report. Committee members noted a stable Summary Hospital-level Mortality Indicator (SHMI) of 0.87; structural judgement review rates were significantly above the 25% national requirement goal; and a positive organisational engagement in mortality review processes. The Committee also noted learning arising from Prevention of Future Death (PFD) reports, including improvements to hyperbaric oxygen treatment pathways and communication support arrangements for patients whose first language is not English. In addition, the Committee was informed that a death involving a misplaced nasogastric tube was reviewed as a Never Event. The Trust had since updated its guidance and policy and reinforced how nursing staff check tubes. Ligature Risk Reduction Programme The Committee welcomed continued progress with the Ligature Risk Reduction Programme and was assured that physical works had now been completed in high-risk areas, including the paediatric emergency department. Committee members also welcomed the appointment of an external specialist adviser who was supporting policy procedure and ward-assessment reviews. The principal remaining concern related to variable training compliance in high-risk clinical areas, particularly paediatric emergency services, maternity and child and adolescent mental health services. The Committee supported plans to increase training compliance above the required threshold. National Quality Strategy Rantimi Ayodele delivered a presentation and briefed the Committee on the new NHS National Quality Strategy's ten-year framework. Committee members learnt that the strategy's emphasis was on planning, control, improvement and assurance, alongside the development of modern service frameworks and an increased focus on outcomes, variation and patient voice. The Committee recognised that implementation of the new strategy's requirements would require significant organisational consideration and agreed that further work would be required to understand implications for existing governance, quality systems and Board oversight arrangements.
2.	Risk register Sarah Wilding summarised the risk register. She advised that the majority of higher-rated risks continued to relate to estates, infrastructure and digital systems. Committee members were informed that improvements had been made in several risks through mitigations relating to water safety, infection prevention and control, and safeguarding arrangements. New and escalated

	risks included delays associated with patients no longer meeting the criteria to reside and ongoing waiting list pressures within audiology, musculoskeletal services and community pathways. The Committee discussed the complexity of the criteria to reside risk and noted that delays increasingly involved a broader range of patient groups than traditionally associated with delayed discharge. The Committee requested that future reports provide more detail regarding the categories of patients contributing to this risk. Quality Governance Committee Chair's report Rantimi Ayodele reported on the August meeting of the Quality Governance Committee (QGC) which was informed of an increase in harm incidents and high-risk complaints and requested further triangulation of patient safety and complaints data to better understand whether underlying trends had been identified. The QGC received assurance that work was underway to develop enhanced dashboards and reporting arrangements. The QGC also noted concerns related to controlled drugs governance following a current patient safety incident investigation and a diversion-related concern. Committee members received assurance that an independent external review of governance processes, professional practice and monitoring arrangements would be commissioned. The Care Quality Commission had also been informed of the original incident.
3.	Present: Professor Mark Emberton, Non-Executive Director (Chair) Baroness Glenys Thornton, Non-Executive Director Amanda Gibbon, Non-Executive Director Dr 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: Kelly Collins, Associate Director of Nursing, Emergency and Integrated Medicine Clinical Division Isabelle Cornet, Director of Midwifery, ACW Clinical Division Selina Douglas, Chief Executive Officer Sharon D'Souza, Clinical Director, Children & Young People Clinical Division Sarah Gillis, Associate Medical Director Learning from Deaths Annie Hurst, Deputy Director, Estates & Facilities Ruth Law, Assistant Medical Director, Quality Improvement & Clinical Excellence Phillip Lee, Assistant Medical Director, Patient Safety Ian Man, Lead Pharmacist, Anticoagulation Services Marcia Marrast-Lewis, Assistant Trust Secretary Matthew Minter, Associate Director of Clinical Governance Stuart Richardson, Chief Pharmacist and Joint Clinical Director Acute Patient Access, Clinical Support Services & Women's Health Nicola Sands, Deputy Chief Nurse Carolyn Stewart, Executive Assistant to the Chief Nurse



Meeting title	Quality Assurance Committee	Date:	09.09.2026																				
Report title	2026/27 21 Q3 Board Assurance Framework – Quality entries	Agenda item:	1.3																				
Executive leads	Sarah Wilding, Chief Nurse and Director of Allied Health Professionals, Rantimi Ayodele, Chief Medical Officer, and Chinyama Okunuga, Chief Operating Officer																						
Report authors	Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary, Marcia Marrast-Lewis Assistant Trust Secretary and Sarah Wilding																						
Executive summary	Background Committee members are presented with the quarter three 2026/27 Board Assurance Framework (BAF), for risks to the delivery of our quality objectives Issues At its July meeting, the Committee reviewed both BAF entries as well as performance against quality metrics. It agreed with the recommendation to not amend the risk scores for either entry. Following the review of the scores for both entries at its May meeting, the Committee agreed that a further review took place at its November meeting. In readiness for the that meeting, performance against the metrics agreed for both entries is currently positive as shown in the July integrated performance report and is highlighted in the table below, for ease of reference: <table><tr><th>Metrics</th><th></th><th>Quality 1</th><th>Quality 2</th></tr><tr><td>• VTE assessment: (95% target)</td><td></td><td>95.2%</td><td rowspan="5"></td></tr><tr><td>• MRSA (0 cases)</td><td></td><td>0</td></tr><tr><td>• Readmissions: (better than 5.5% target)</td><td></td><td>3.46%</td></tr><tr><td>• Mortality (SHMI) – (below 1)</td><td></td><td>0.89</td></tr><tr><td>• Patient satisfaction: (90% or higher)</td><td></td><td>92.09%</td></tr></table>			Metrics		Quality 1	Quality 2	• VTE assessment: (95% target)		95.2%		• MRSA (0 cases)		0	• Readmissions: (better than 5.5% target)		3.46%	• Mortality (SHMI) – (below 1)		0.89	• Patient satisfaction: (90% or higher)		92.09%
Metrics		Quality 1	Quality 2																				
• VTE assessment: (95% target)		95.2%																					
• MRSA (0 cases)		0																					
• Readmissions: (better than 5.5% target)		3.46%																					
• Mortality (SHMI) – (below 1)		0.89																					
• Patient satisfaction: (90% or higher)		92.09%																					

	RTT (1% waiting more than 52 weeks)			0.4%
	RTT (78% waiting 18 weeks or less)			68.3%
	80% for cancer (62 days pathway)			87.2%
	80% for cancer (28 days wait)			86.7%
	94% for cancer (31 days)			100%
	86% for diagnostics			81.5%
	82% for ED four-hour target			70.9%
	0% for 12-hour ED waits			8%
Having reviewed the current position, there is no recommendation at this time to amend the scores for either Quality 1 or Quality 2. Committee members are invited to consider the current ratings, the effectiveness of the controls and assurances in place, and whether any changes to the risk assessments are required. Next steps At this stage, there is no recommendation to and the score for either BAF entry. Following consideration by the Committee, the agreed position on the Quality BAF entries will be reported to the Board through the Committee Chair's assurance report.				
Purpose	Discussion and approval			
Recommendations	The Committee is asked to: - review the Quarter 3 Board Assurance Framework Quality entries; - consider the adequacy of the controls and assurances in place; - agree that the scores remain the same (Quality 1: 12; Quality 2: 16); and - recommend any proposed amendments for inclusion in the Board Assurance Framework.			
BAF references	- Quality 1: quality and safety of services - Quality 2: capacity and activity delivery			
Appendices	1: Q3 2026/27 Board Assurance Framework Quality entries			

Appendix 1: 2026/27 Quarter 3, Board Assurance Framework – Quality entries

Strategic objective and BAF risk entry	Principal risk(s)	Current score			Target score	Lead director(s)
		C	L	R		
Quality 1 – quality and safety of services	There is a risk that the Trust may fail to deliver consistently outstanding care that is safe, effective, caring, responsive, and well-led. This risk arises from potential errors, omissions in care, insufficient staffing or resources, and an inadequate or inconsistent focus on continuous quality improvement. Should this risk materialise, it could lead to avoidable patient harm, deterioration in patient experience, regulatory and financial impacts, challenges in attracting and retaining staff, and reputational damage that undermines confidence in the organisation.	4	3	12	8	Chief Nurse, Chief Medical Officer, Chief Operating Officer
Quality 2 – capacity and activity delivery	Due to limited capacity, there is an inability to meet elective recovery and clinical performance targets, resulting in a deterioration in activity and the services delivered so that: • there are significant delays in the emergency and urgent care pathway department and an inability to place patients to appropriate ward beds • patients do not receive the timely elective care they need across acute and community health services • patients on a diagnostic and/or treatment pathway are at risk of deterioration and greater intervention at a later stage	4	4	16	8	Chief Operating Officer, Chief Nurse, Chief Medical Officer

Quality entries

Strategic objective		Deliver outstanding safe, compassionate care in partnership with patients
Executive leads		Chief Nurse and Director of Allied Health Professionals; Medical Director; Chief Operating Officer
Oversight committees		Quality Governance Committee, Trust Management Group, Quality Assurance Committee
Principal risks	Quality 1	There is a risk that the Trust may fail to deliver consistently outstanding care that is safe, effective, caring, responsive, and well-led. This risk arises from potential errors, omissions in care, insufficient staffing or resources, and an inadequate or inconsistent focus on continuous quality improvement. Should this risk materialise, it could lead to avoidable patient harm, deterioration in patient experience, regulatory and financial impacts, challenges in attracting and retaining staff, and reputational damage that undermines confidence in the organisation.
	Quality 2	Due to limited capacity, there is an inability to meet elective recovery and clinical performance targets, resulting in a deterioration in activity and the services delivered so that: • there are significant delays in the emergency and urgent care pathway department and an inability to place patients to appropriate ward beds • patients do not receive the timely elective care they need across acute and community health services • patients on a diagnostic and/or treatment pathway are at risk of deterioration and greater intervention at a later stage

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

Risk	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Target
	C	L	S	C	L	S	C	L	S	C	L	S	
Quality 1	4	3	12	4	3	12	4	3	12				8
Quality 2	4	3	16	4	3	16	4	3	16				8

Controls and assurances

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

Key controls	Assurances	Tier
	and legal cases, medicine optimisation, health and safety safeguarding and infection prevention and control presented to QAC	
	• Staff wellbeing is a priority for the Trust, offering resources to meet physical, social, and emotional wellbeing needs to keep staff and patients safe	• 1 st
	• Rollout of staff and patient flu vaccination uptake reported monthly to TMG (in season)	• 1 st
Incident reporting and action plans monitored to ensure learning and incidents, risks and complaints entered on Datix system	• Incident reporting policies monitoring of progress of the national patient safety strategy and response framework roll out.	• 1 st
	• Weekly incident review meeting with Clinical Divisions' risk managers and week day triage meeting	• 1 st
	• The Trust Risk Register is reviewed at meetings of the following corporate governance forums: Chief Officers' Meeting, QGC, Trust Management Group, QAC, and the Audit & Risk Committee.	• 2 nd
Mortality review group learning from deaths process and reporting	• Quarterly Learning from deaths report to QAC;	• 2 nd
Continued use of the full integrated performance report to monitor all areas of quality and activity	• Cancer performance is considered monthly by Trust Management Group, Cancer Board and the Trust Board.	• 1 st & 2 nd
	• Reviewed monthly by respective Clinical Divisions' Boards and committees e.g. Infection prevention and control and drugs and therapeutics	• 1 st
Tracker in place to monitor progress against the Quality Account priorities on a quarterly basis, with updates to the relevant sub-groups	• Updates on Quality Account priorities provided quarterly to patient safety, patient experience and clinical effectiveness groups and to the QGC	• 1 st
Level 1 Quality Impact Assessments (QIAs) for service/pathway changes are monitored by operational managers and clinical	• Quality Impact Assessment (QIA) panel	• 1 st
	• QIAs are reported to the QGC and the QAC	• 1 st • 2 nd

Key controls	Assurances	Tier
managers. Level 2 QIAs (deemed moderate to high risk) are reported and approved by Medical Director and Chief Nurse at the QIA panel		
Well-led review	An internal self-assessment against well-led requirements was agreed by the Board in Q4 2025/26, along with briefings in Q1 2026/27	2nd

Gaps in controls and assurances

Gaps	Mitigating actions	Completion date
None currently identified		

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

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

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

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

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

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

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

Trust-wide review and escalation of strategic risks

Trust Board Assurance Framework (BAF)						
Decision to escalate to BAF as a strategic risk						
Audit and Risk Committee	Improvement Performance and Digital Committee	Finance and Business Development Committee	Quality Assurance Committee	Workforce Assurance Committee		
Trust Management Group – reviews and recommends risks scored above 16 for escalation to the BAF						
Risks for escalation to the BAF						
Quality Governance Committee	People Committee	Clinical Divisions' Boards	Innovation & Digital Transformation Group	Estates Programme Board	Learn, Innovate and Improve meetings	Financial Improvement Board
Daily Triage meeting Patient Safety Group Patient Experience Group Clinical Effectiveness Group Safeguarding Committee Infection Prevention & Control Committee Health and Safety Committee Mortality Review Group Drugs and Therapeutics Committee Medicines Safety Group Quality Improvement / Research End of Life Care Group ICSU Quality Board Whittington Improvement Safety Huddle			Partnership Group Health and Wellbeing Group Staff equality networks Nursing & Midwifery and Allied Health Professionals Group		Estates Steering Group PFI Management Group Digital Programme Board Procurement Steering Group Capital Monitoring Group Investment Group Income and Costing Steering Group Better Value Delivery Board	





Meeting title	Quality Assurance Committee	Date: 09.09.2026
Report title	Quarterly Learning from Deaths (LfD) Report Q4, 01st January to 31st March 2026	Agenda item: 3.11
Executive lead	Dr Rantimi Ayodele, Chief Medical Officer	
Report authors	Dr Sarah Gillis, Associate Medical Director Learning from Deaths and Ruby Carr, Project Lead for Learning from Deaths	
Executive summary	Background Committee members are presented with the quarterly learning from deaths report. Key issues During Q4, 01st January to 31st March 2026, there were 93 adult inpatient deaths, excluding deaths in the Emergency Department (ED), reported at Whittington Health (WH). 4 adult structured judgement reviews (SJRs) were requested for Quarter 4, and of these, all 4 have been completed. 56 (64 including ED deaths) non-SJR mortality reviews were completed. There were no maternal deaths There was 1 neonatal death There were no paediatric deaths The latest published Summary Hospital-level Mortality Indicator (SHMI) is 0.87 for Whittington Health and is for the data period January to December 2025. There were no diagnostic groups highlighted as an area of concern. Next steps This report will be an appendix to the QAC chair's report top the September Board meeting.	
Purpose:	The paper summarises the key learning points and actions identified in the mortality reviews completed for Q4, 1 st January to 31 st March 2026.	
Recommendation(s)	Committee members are invited to: • Recognise the assurances highlighted for the robust process implemented to strengthen governance and improved care around inpatient deaths and performance in reviewing inpatient	

	deaths which make a significant positive contribution to patient safety culture at the Trust. • Be aware of the areas where further action is being taken to improve compliance data and the sharing of learning.
Risk Register or Board Assurance Framework	Captured on the Trust Quality and Safety Risk Register
Report history	None
Appendices	Appendix 1: NHS England Trust Mortality Dashboard Appendix 2: PMRT neonatal death (appended to document)

1. Introduction

- 1.1 This report summarises the key learning identified in the mortality reviews completed for Quarter 4 of 2025/26. This report describes:
- Performance against local and national expectations in reviewing the care of patients who have died whilst in this hospital. This report focuses on deaths of inpatients.
 - The learning taken from the themes that emerge from these reviews.
 - Actions being taken to both improve the Trust's care of patients and to improve the learning from deaths process.

2. Background

- 2.1 In line with the NHS Quality Board "National guidance on learning from deaths" (March 2017) the Trust introduced a systematised approach to reviewing the care of patients who have died in hospital.
<https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf>
- 2.2 The Trust requires that all inpatient deaths be reviewed. The mortality review should be by a consultant not directly involved with the patient's care.

A Structured Judgement Review (SJR) should be undertaken by a trained reviewer who was not directly involved in the patient's care, if the case complies with one of the mandated criteria listed below:

- Deaths where families, carers or staff have raised concerns about the quality-of-care provision.
- All inpatient deaths of patients with learning disabilities (LD) and autism.
- All inpatient deaths of patients with a severe mental illness (SMI) diagnosis. SMI is defined as schizophrenia, schizoaffective disorders, bipolar affective disorder, severe depression with psychosis. In addition to where these diagnoses are recorded in a patient's records, the use of Clozapine, Lithium and depot antipsychotic medication are indicative of these diagnoses.
- Deaths recommended by the Medical Examiner service as needing further review.
- All deaths in a service where concerns have been raised either through audit, incident reporting processes or other mortality indicators.
- All deaths in areas where deaths would not be expected, for example deaths during elective surgical procedures.
- Deaths where learning will inform the provider's existing or planned improvement work, for example deaths where the patient had treatment relating to blood transfusion.
- All inpatient paediatric, neonatal, and maternal deaths are reviewed as per national guidance and included in this report.

3. Mortality Review Quarter 3, 2025/26

- 3.1 There was 1 neonatal death which is currently been reviewed
- 3.2 There were no paediatric deaths.
- 3.3 There were no maternal deaths.

- 3.4 There were 93 adult inpatient deaths (excluding deaths in ED) reported at WH in Q4. Table 1 shows the distribution of deaths by departments/teams.

Table 1: Death by Department/Team

Department/Team	Number of deaths
Acute Admissions Unit (Mary Seacole North and South)	20
Cavell	8
Cloudesley	7
Meyrick	11
ITU (Intensive Treatment Unit)	13
Nightingale (respiratory)	16
Montuschi (Coronary Care Unit)	3
Thorogood	1
Victoria	6
Coyle	4
Mercers	3
Eddington	0
Cearns	0
Highgate Mental Health Centre	1
Theatres Recovery	0
Child/neonatal	1
Maternal	0
Total:	93 (94 incl. neonatal death)

- 3.5 Table 2a shows the total number of mortality reviews and SJRs required and how many of these reviews are outstanding. There has been some feedback that mortality reviews and departmental Morbidity and Mortality meetings have been delayed due to the pressure of resident doctor industrial action.

Table 2a: Total number of Mortality reviews and SJRs required.

	Number of reviews required	Completed Reviews	Outstanding reviews
Adult Mortality Reviews	89	56	33
Neonatal and Paediatric Mortality Reviews	1	1	0
SJR	4	4	0

3.6 Table 2b provides a breakdown of SJRs required by department.

Table 2b: SJRs required for each department/ team

Department	Number of SJRs	Number outstanding
Acute Admissions Unit (Mary Seacole North and South)	2	0
Cavell	0	0
Cloudesley	0	0
Meyrick	0	0
ITU	1	0
Nightingale	1	0
Montuschi (Coronary Care Unit)	0	0
Victoria	0	0
Coyle	0	0
Mercers	0	0
ED	0	0
Thorogood	0	0
Theatres Recovery	0	0
Other	0	0
Total:	4	0

Table 3: Reasons for deaths being assigned as requiring an SJR during Quarter 4, 2024/25

Criteria for SJR	Number of SJRs identified	Completed SJRs	Comments
Staff/clinician raised concerns about care	2	2	
Family raised concerns about quality of care	0	0	
Death of a patient with Serious mental illness (SMI)	0	0	
Death in surgical patients	0	0	This is also a Coroner's Referral
Paediatric/maternal/neonatal/intra-uterine deaths	1	-	Paediatric & Neonatal deaths follow a different reviewing process
Deaths referred to Coroner's office without proposed cause of death	0	0	
Deaths related to specific patient safety or QI work	0	0	

Criteria for SJR	Number of SJRs identified	Completed SJRs	Comments
Death of a patient with a Learning disability	2	2	
Medical Examiner Concern	0	0	
Patient Safety Incident Investigations	0	0	
Unexpected Death	0	0	
Concerns raised through audit, incident reporting or other mortality indicators	0	0	
Definite COVID-19 Health Care Acquired Infection (HCAI)	0	0	
Total including Neonatal Deaths	5	5	

3.7 Deaths requiring an SJR form (or equivalent tool) are reviewed by a second independent clinician, not directly involved with the case. The case is then discussed in the department mortality meeting. Each SJR is fully reviewed to ensure all possible learning has been captured and shared.

3.8 The aim of this review process is to:

- Engage with patients' families and carers and recognise their insights as a source of learning, improve their opportunities for raising concerns.
- Embed a culture of learning from mortality reviews in the Trust.
- Identify and learn from episodes relating to problems in care.
- Identify and learn from notable practice.
- Understand and improve the quality of End-of-Life Care (EoLC), with a particular focus on whether patient's and carer's wishes were identified and met.
- Enable informed and transparent reporting to the Public Trust Board with a clear methodology.
- Identify potentially avoidable deaths and ensure these are fully investigated through the Serious Incident process and are clearly and transparently recorded and reported.

4. Mortality Dashboard

4.1 There were 93 adult inpatient deaths (excluding ED deaths) recorded in Quarter 4, 2025/26 at Whittington Health.

4.2 The National Guidance on Learning from Deaths gives a suggested dashboard which provides a format for data publication by Trusts. Whittington Health has chosen to adopt this dashboard locally. The dashboard is provided in Appendix 1 – NHS England Trust Mortality dashboard. This dashboard shows data from 1 April 2017 onwards.

4.3 The number of inpatient and ED deaths in Q4 2025/26 was 100. All deaths within in ED were reviewed.

4.4 There were 2 adult learning disability deaths and no deaths of a patient diagnosed with Autism. There were no patients who had a severe mental illness (SMI).

4.5 The radial graph below compares all crude adult mortality rates (including ED deaths) for Whittington health in 2018-19, 2019-20, 2020-21, 2021-22, 2022-23, 2024-25 and Q1 – Q4 2025/26.

Graph 1: Crude Adult Mortality at Whittington Health comparing previous years (April 2018 – March 2026)

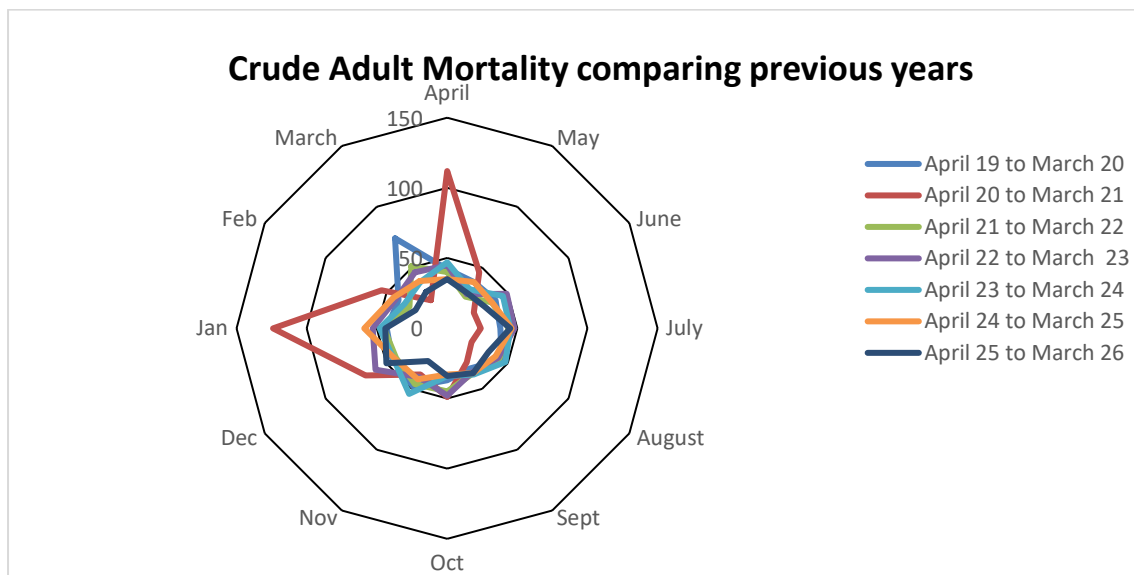


Table 4: Number of inpatient and ED deaths each month over the past 6 years

Month	April 18 to March 19	April 19 to March 20	April 20 to March 21	April 21 to March 22	April 22 to March 23	April 23 to March 24	April 24 to March 25	April 25 to March 26
April	34	42	112	40	45	47	35	35
May	37	38	46	26	28	32	38	29
June	33	40	22	37	49	46	37	31
July	25	38	24	44	48	45	46	45
August	26	45	20	43	42	48	40	34
Sept	29	33	28	37	36	38	37	37
Oct	30	37	49	45	48	34	33	34
Nov	37	48	38	46	40	54	42	27
Dec	44	45	67	42	59	44	43	50
Jan	42	43	124	45	53	48	59	44
Feb	32	40	54	31	42	35	44	26
March	48	74	23	51	46	38	39	30
Total	417	523	607	487	536	509	493	422

Summary Hospital-level Mortality Indicator (SHMI)

The latest published Summary Hospital-level Mortality Indicator (SHMI) is 0.87 for Whittington Health and is for the period January to December 2025

5. Prevention of Future Deaths (PFDs)

One PFD was issued to the Trust since the last Learning from Death Report. This was issued on 11th June 2026 and relates to the death of a patient after a routine gastroscopy oesophageal dilatation procedure. The patient suffered from a gas embolism and subsequently died after transfer for treatment on 22/11/25. Gas embolism is a very rare event, but there was no clear pathway for referral to HyperBaric Oxygen Therapy (HBOT). A pathway is due to be published on the intranet, and this includes information on recognition, management and transfer for the time sensitive treatment required for air embolism. The HBOT centre in London had been closed without notification and sadly the patient had to be transferred to Norfolk for treatment; the HBOT centre in London has now reopened. Contact details for all UK HBOT centres are included in the pathway. A response to the PFD has now been sent to H.M. Coroner. PFD notices in this case were also issued to AAGBI and RCoA (Association of Anaesthetists Great Britain and Ireland, and Royal College of Anaesthetists) and also NHS England.

A PFD was issued to the Royal College of Midwives, the Institute of Health Visiting and the Royal College of General Practitioners regarding the death of a baby who was admitted and died at the Whittington on 03/10/25. In essence the baby's parents spoke no or limited English and required interpreters. When they called for 999 for help the person speaking to the London Ambulance Service was not with the child and there was a delay because of the categorisation of the call. In primary care, professionals often give safety netting advice and for those requiring interpretation services, they need to be made aware that a 999 call should be made by someone with the patient and that interpreters are available to help the ambulance service triage the call. The PFD information has been shared with our Midwifery Bereavement Lead and will be cascaded. As this PFD was not directed to us, no response to the PFD is required from the Trust.

6. Themes and learning from mortality reviews Quarter 3, 2025/2026

- 6.1 In patients with clostridium difficile, a rising neutrophil count and a worsening c diff severity score should prompt discussion about switching antibiotics. They should be discussed with microbiology.
- 6.2 Non-Whittington staff involvement in acute care on the Whittington site is unusual. If felt indicated should be in exceptional circumstances with all members of the senior team (silver and gold) involved in the decision as was the case in this patient.
- 6.3 Continue involving the SNOD (Specialist Nurse for Organ Donation) in all patients where organ retrieval may be possible.
- 6.4 Post cardiac arrest debrief is good practice and occurring

Other adult deaths

We sadly had a death after a patient was fed into a misplaced nasogastric tube (NGT). This is a never event. There has been a PSII, and the case has recently been reviewed by H.M. Coroner, who was satisfied that the Whittington had responded with improved guidance and regular audits. There is an updated NGT guidance on the intranet which should be referred to when patients have

an NGT placed and feeding commenced. The pH cut off for commencing feed is now 5, rather than 5.5.

Summary of learning:

- New pathway for recognition and management of air embolism and referral for HBOT
- Ensure when safety netting patients that for those patients or relatives where they need translation services, they are aware that translation services are available during 999 calls
- Treatment dose tinzaparin – reminder of importance of reviewing tinzaparin dosage after both a positive and a negative CTPA
- In patients with clostridium difficile (c.diff) a rising neutrophil count and a worsening c diff severity score should prompt discussion about switching antibiotics. They should be discussed with microbiology
- Non-Whittington staff involvement in acute care on the Whittington site is unusual. If felt indicated should be in exceptional circumstances with all members of the senior team (silver and gold) involved in the decision as was the case in this patient.
- Continue involving the SNOD (Specialist Nurse for Organ Donation) in all patients where organ retrieval may be possible.
- Post cardiac arrest debrief is good practice and occurring
- Updated guidance on the intranet available for the decision, placement and checking of NGT

Evidence of good End of life care (EOLC)

No concerns raised in SJRs reviewed

7. Dissemination of Learning

There will be a summary of the learning from this report provided to the departmental mortality leads and additionally shared with divisional governance leads.

8. Summary of MRG minutes

Ongoing SHMI below 1 with no disease outliers

Plan to do joint audit with coding lead to look at depth and accuracy of coding

New folder for all mortality reports in resident doctor shared drive. Access required for quality managers

Plan from QGC- TOR for mortality meetings and minutes

Appendix 1



Whittington Health: Learning from Deaths Dashboard - March 2025-26



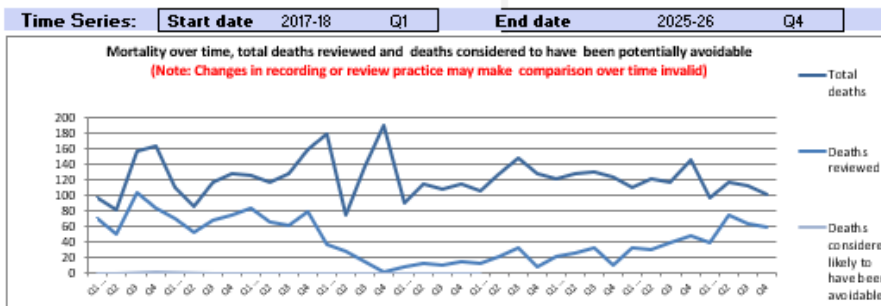
Description:

The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
30	26	18	11	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
101	112	58	64	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
424	491	235	149	0	0



Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Probably avoidable but not very likely	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
This Month 0 -	This Month 0 -	This Month 0 -	This Month 0 -	This Month 0 -	This Month 0 -
This Quarter (QTD) 0 -	This Quarter (QTD) 0 -	This Quarter (QTD) 0 -	This Quarter (QT) 0 -	This Quarter (QT) 0 -	This Quarter 0 -
This Year (YTD) 0 -	This Year (YTD) 0 -	This Year (YTD) 0 -	This Year (YTD) 0 -	This Year (YTD) 0 -	This Year (Y) 0 -

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	1	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
3	7	1	5	0	0

Medicines Optimisation Annual Report 2025/26

STUART RICHARDSON

Chief Pharmacist

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Glossary

AAR – After Action Review
ACS - Adult Community Services
ACP – Advanced Clinical Practitioner
ACW – Acute Patient Access, Clinical Support Services and Women's Health
ADIOS – Abusable Drugs Investigational Software
AHP – Allied Healthcare Professional
AMS – Antimicrobial Stewardship
ATO – Assistant Technical Officer
BCG vaccine - Bacillus Calmette–Guérin vaccine
BSAC – British Society for Antimicrobial Chemotherapy
C&V – Cost & Volume
CAS – Casualty card
CD – Controlled Drug
CDAO - Controlled Drug Accountable Officer
CDC – Community Diagnostic Centre
CIP – Cost Improvement Plan
CMM – CareFlow Medicines Management
COpAT - Complex Outpatient Antimicrobial Therapy
CQC – Care Quality Commission
CQUIN – Commissioning for Quality and Innovation
CT – Clinical Trials
CYP - Children and Young People Services
D&TC – Drug and Therapeutics Committee
DM&D - Dictionary of Medicines and Devices
DOAC – Direct Oral Anticoagulant
DPI – Drug Powder Inhaler
DQ – Design Qualification
ED – Emergency Department
EHCH – Enhanced Health in Care Homes
EIM – Emergency and Integrated Medicine
EPMA – Electronic Prescribing and Medicines Administration
ES – Educational Supervisor
FAC – Final Accuracy Checker
GMP – Good Manufacturing Practice
GOLD - Global Initiative for Chronic Obstructive Lung Disease
GP – General Practitioner
GPICS – Guidelines for the Provision of Intensive Care Services
HCP – Healthcare Professional
HEE – Health Education England
HSL – Health Services Laboratories
ICAT - Integrated Community Ageing Team
ICB – Integrated Care Board
ICS – Integrated Care System
IETS - Initial Education and Training Standards
IM&T – Information Management and Technology
IMP – Investigational Medicinal Product
IP – Independent Prescriber

IPMO – Integrating Pharmacy and Medicines Optimisation
 IPS - Integrated Paediatric Service
 IQ – Installation Qualification
 iQAAPS - Quality Assurance Audit and Performance System
 ITU – Intensive Treatment Unit
 IV – intravenous
 IVIg – Intravenous Immunoglobulin
 JCVI - Joint Committee on Vaccination and Immunisation
 JFC - Joint Formulary Committee
 LFG - Local Faculty Group
 LIN – Local Intelligence Network
 LUTS – Low Urinary Tract Service
 MACTT – Multi Agency Care and Coordination Team
 MDT – Multi-Disciplinary Team
 MEDL – Medical Emergency Document Library (Summarised Guidelines)
 MHRA – Medicines and Healthcare products Regulatory Agency
 MON – Medicines Optimisation Network
 MP – Medicines Policy
 MSG – Medicines Safety Group
 MSK – Musculoskeletal
 MSO – Medicines Safety Officer
 NCL - North Central London
 NHS – National Health Service
 NICE – National Institute for Health and Care Excellence
 NQPP - Newly Qualified Pharmacist Prescriber
 NRT – Nicotine Replacement Therapy
 NTeD – National Tariff Excluded Drug
 OPAT – Outpatient Parenteral Antimicrobial Therapy
 OQ – Operational Qualification
 PAS – Patient Administration System
 PGD – Patient Group Direction
 PIL – Patient Information Leaflet
 pMDI – Pressurised Metered Dose Inhaler
 POD – Patient Own Drug
 PPS – Point Prevalence Survey
 PQ – Performance Qualification
 PRR - Pharmacy Risk Register
 PSA – Patient Safety Alert
 PSF – Patient Safety Forum
 PSIRF - Patient Safety Incident Reporting Framework
 PTPT – Pre-registration Trainee Pharmacy Technician
 PTS - Prescription Tracking System
 QI – Quality Improvement
 RAR – Rapid Action Review
 RCEM - Royal College of Emergency Medicine
 RDS - Robotic Dispensing System
 RNOH - Royal National Orthopaedic Hospital
 SACT - Systemic Anti-Cancer Therapy

SAM - Self-Administration of Medicines
SDEC – Same Day Emergency Care
SEIPS – System Engineering Initiative for Patient Safety
SI - Serious Incidents
SIEAG - Serious Incident Executive Advisory Group
SLA – Service Level Agreement
SLWG - Short Life Working Group
SMT - Science Manufacturing Technician
STOMP/STAMP - Stopping The Over-Medication of children and young People with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP)
ToR – Terms of Reference
TP – Trainee Pharmacist
TPN - Total Parental Nutrition
TTA – To-Take-Away medication
UAT - User Acceptance Testing
UCLH – University College London Hospitals
UKCPA – UK Clinical Pharmacy Association
URS - User Requirement Specification
UTI - Urinary Tract Infection
VHP – Vaporised Hydrogen Peroxide
VTE – Venous Thromboembolism
VW – Virtual Ward
WH – Whittington Health
Whittington CIC – Community Interest Company
WHO – World Health Organisation
WTE – Whole time equivalent

EXECUTIVE SUMMARY

This report provides assurance to the Trust Board on the governance, safety, effectiveness, financial stewardship and strategic development of medicines optimisation across Whittington Health NHS Trust during the 2025/26 financial year. It demonstrates the continued contribution of pharmacy and medicines optimisation services to improving patient outcomes, supporting integrated care, enhancing patient safety, delivering value and driving innovation across acute, community and specialist services.

Medicines governance remained robust through the Drug and Therapeutics Committee and Medicines Safety Group. During the year, 36 medicines-related policies and guidelines were reviewed, 76 NICE and NCL formulary treatments were adopted, and 166 non-formulary requests were considered. The Pharmacy Risk Register provided oversight of key organisational and operational risks relating to medicines use.

Patient safety remained a key priority. A total of 850 medication incidents were reported during 2025/26, representing continued improvement in reporting culture, whilst incidents resulting in moderate or greater harm reduced to 0.8%. The Medicines Safety Group led multidisciplinary learning from incidents, implementation of Patient Safety Incident Response Framework (PSIRF) principles, oversight of NHS Patient Safety Alerts and strengthening of controlled drug governance. Enhanced audit programmes, training initiatives and learning events have contributed to safer medicines use across the organisation.

Clinical pharmacy services continued to evolve across all specialties. Pharmacy teams supported improvements in Emergency and Integrated Medicine, Surgery, Cancer Services, Children and Young People's Services, Women's Health and Adult Community Services. Significant achievements included the successful reopening and transformation of the aseptic unit, implementation of new clinical pathways, expansion of pharmacist prescribing, optimisation of medicines management processes and development of specialist services across acute and community settings.

The Antimicrobial Stewardship and OPAT/COpAT services achieved significant recognition during the year. Antimicrobial consumption reduced substantially, new stewardship strategies and guidelines were introduced, and the OPAT service received national recognition through award nominations and conference presentations. The Trust continued to demonstrate leadership in antimicrobial stewardship, innovation and research.

The Trust vaccination service continued to reduce health inequalities and improve access to vaccination. During 2025/26, over 9,500 COVID-19 and influenza vaccinations were delivered across inpatient, community, outreach and care home settings. Staff influenza vaccination uptake increased compared with the previous year through a targeted campaign and peer-to-peer vaccination model.

Digital transformation continued at pace. Major achievements included implementation of the PIC upgrade for pharmacy robotics, development of the Medicines Finance Dashboard, deployment of the 'Where's My TTA' dashboard, expansion of electronic prescribing solutions within community services and continued development of Power BI reporting

capabilities. Progress also continued on the Pharmacy Modernisation Programme, including procurement of new robotic dispensing systems and redesign of pharmacy infrastructure.

Medicines expenditure totalled £20.4 million in 2025/26, an increase of 8.3% driven largely by growth in high-cost medicines activity. Despite this, effective procurement, biosimilar adoption, contract management and medicines optimisation initiatives delivered approximately £875,000 of savings across the Trust and wider health system. The introduction of a comprehensive Medicines Finance Dashboard has further strengthened financial governance and performance monitoring.

Sustainability and transformation remained central to service development. Pharmacy teams delivered a comprehensive Medicines Transformation Programme focused on reducing medicines waste, improving productivity, embedding greener pharmacy principles and identifying cost-saving opportunities. Significant progress was made in reducing avoidable waste, improving workflow efficiency and supporting the Trust's wider Green Plan objectives.

Workforce development continued to be a major focus throughout the year. The department expanded education and training opportunities across all staff groups, supported trainee pharmacists and pharmacy technicians, strengthened independent prescribing capability and developed clear professional development pathways. Five pharmacists achieved independent prescribing qualifications during the year, with all trainee pharmacists expected to qualify as prescribers from August 2026. Staff engagement and wellbeing initiatives also contributed to improved survey results across all People Promise domains.

Whittington Pharmacy Community Interest Company (CIC) continued to deliver a high-quality outpatient pharmacy service, dispensing over 96,000 prescription items to more than 57,000 patients. Patient satisfaction remained high, waiting times remained below service standards, and new digital innovations including self-service kiosks and prescription tracking further enhanced patient experience. All surpluses generated by the CIC continue to be reinvested into patient care and service development.

Looking ahead to 2026/27, priorities include refreshing the Medicines Optimisation Strategy, implementing the new Pharmacy Workforce Strategy, progressing pharmacy modernisation and robotics programmes, expanding digital medicines systems, strengthening governance and safety processes, supporting neighbourhood and integrated care models, reducing medicines waste, delivering sustainable financial efficiencies and continuing to develop the pharmacy workforce to meet future NHS challenges.

2025/26 in numbers

160,779

Inpatient items dispensed

10,517

Discharge prescriptions dispensed

55,884

Stock items issued to wards

19 minutes

Outpatient Pharmacy average waiting time

56,353

Outpatient prescriptions dispensed

5,779

Injectable chemotherapy items dispensed

270,000

Medicines clinically verified by Pharmacists

807

Medication related incidents reported

2,582

Referrals to community pharmacies via Discharge Medicines Service

512

Queries received from patients or healthcare professionals through Medicines Information helpline

8,669

Anticoagulation INR patient contacts

1,053

Patients delivered regular medicines via Homecare service

36

Medicines related guidelines, policies and PGDs reviewed by D&TC

22

Pharmacist independent prescribers on trusts live register

5

New clinical trials opened with support from Pharmacy team

£20.4m

Medicines expenditure in 25/26

£875,000

Trust and system-wide savings delivered in medicines

9,500

COVID-19 and Influenza vaccine doses administered to individuals as part of the vaccination campaign 2025/26

1.0 INTRODUCTION

Medicines management encompasses a range of activities intended to improve the way that medicines are selected, procured, prescribed, dispensed and administered.

This report summarises the activities of groups and committees responsible for the management of medicines at Whittington Health and describes developments throughout the 2025/26 year and plans for 2026/27.

2.0 STRATEGY, LEADERSHIP AND GOVERNANCE

2.1 STRATEGY AND LEADERSHIP

The Executive Lead for Medicines Optimisation (MO) at Whittington Health NHS Trust is the Medical Director. The Chief Pharmacist in conjunction with the Chief Nurse & Director of AHPs and their corresponding teams work closely to support the MO agenda across the organisation and implementation of the Pharmacy and Medicines Optimisation Strategy (Appendix 1). This strategy outlines key areas of focus for the current and future 3-5 years aligned to the trust objectives and will continue to be refined over the next year to align with the National, Regional and developing NCL System Wide Medicines Optimisation agenda.

The Integrated Medicines Optimisation Committee (IMOC), a subcommittee of the ICB Quality and Safety Committee, is a system wide forum, chaired by an Executive member of the ICB bringing together all partners across the system to oversee Medicines Optimisation within each of the sectors. Whittington Health and Community Services are represented on this Committee by the Chief Pharmacist for Whittington Health. The recently agreed system governance structure is detailed below in Figure 1. The ICB has a substantively appointed Chief Pharmacist who facilitates system wide working and provides communication channels between the system and National and Regional Pharmacy Leadership groups.

The NCL Medicines Optimisation Network (MON) has a 'Vision to improve the health and wellbeing of people living in NCL, through the best use of medicines and pharmacy'. Two principal committees sit within the network: the Joint Formulary Committee (JFC) and the Pharmacy Leaders Forum. To support integrated working across the region, these Committees include healthcare professional representation from primary care, provider Trusts (secondary care, tertiary care and mental health) and commissioning organisations.

NCL ICS Medicines Optimisation Governance Structure

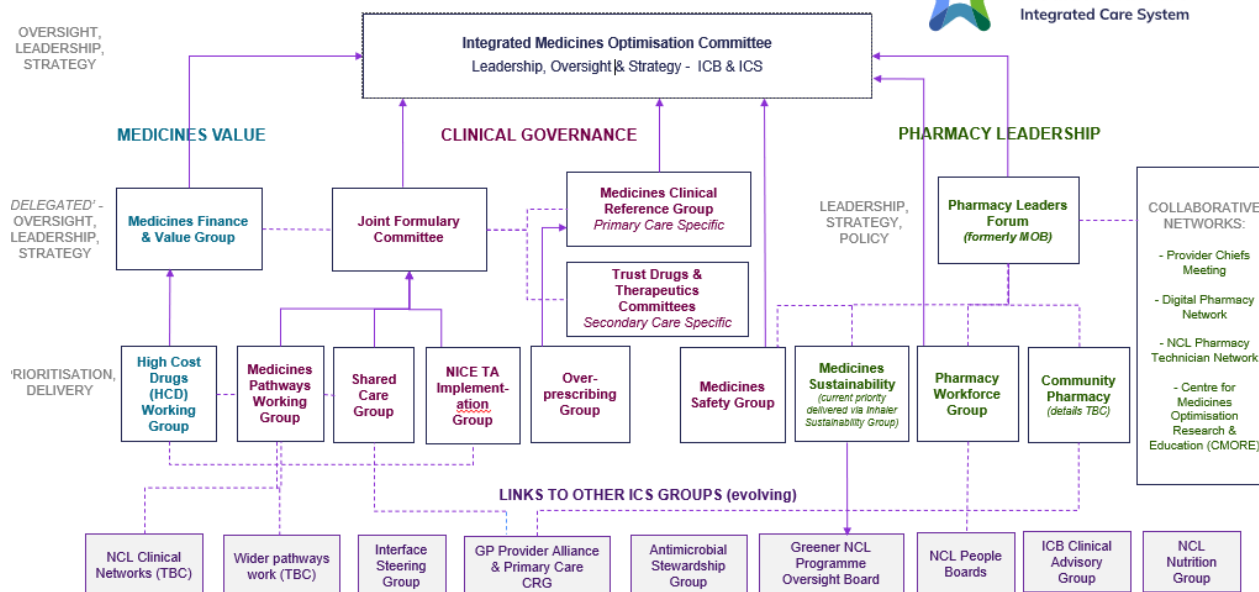


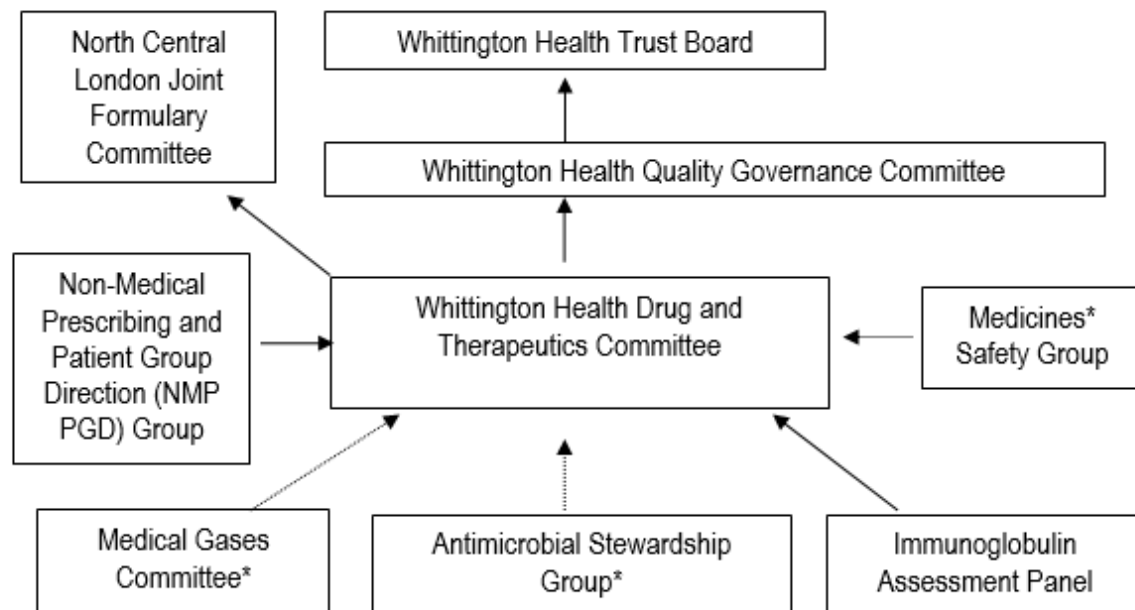
Figure 1 – System governance structure

2.2 GOVERNANCE

Locally, the Whittington Health Drug and Therapeutics Committee (D&TC) provide multi-disciplinary leadership to ensure appropriate management of medicines and the continuous improvement in the safe use of therapies within the organisation. This includes both acute and community settings.

The D&TC meet every two months to consider new drugs applications, Patient Group Directions (PGD), medicines-related guidelines, ratification of treatments approved by NCL Joint Formulary Committee (JFC) and NICE, and any other issues concerning medicines management in the Trust. Several Trust groups report to D&TC (see organogram below).

The D&TC also work collaboratively with the North Central London Medicines Optimisation Network (NCL MON), particularly with the NCL JFC. This collaborative work with NCL MON includes for example: local implementation of JFC and other NCL groups decisions; sharing information about local use of drugs or previous D&TC decisions which may support JFC evaluations; review of draft JFC documents and gathering of local experts' opinion; maintenance of NetFormulary (NCL formulary platform).



*Note additional reporting arrangements:

- The Medical Gases Committee formally reports to the Health & Safety Committee, with patient safety related aspects escalated via the D&TC. The MGG will provide a report once a year to the D&TC.
- The Medicines Safety Group formally reports to the Drugs & Therapeutics Committee but also reports twice a year to the Patient Safety Committee.
- The Antimicrobial Stewardship Group formally reports to the Infection Prevention and Control Committee but shares quarterly reports with the D&TC.

Figure 2. D&TC reporting organogram

D&TC in 2025/26:

- 6 regular meetings held
- 36 documents reviewed for approval, among medicines-related guidelines, SOPs and policies - for example, the guideline for Epilepsy Treatment in Adults and the SOP for Alcohol Detoxification Service via Ambulatory Care Unit .
- 42 NCL JFC and 34 NICE treatments ratified and added to WH formulary (pending further actions if relevant). This included Methoxyflurane (Penthrox®) for emergency relief of moderate to severe pain in paediatric patients with trauma and associated pain and melatonin for sleep deprivation in adult critical care.
- 166 requests for 'one-off' use of non-formulary drugs were reviewed, of which 140 were approved. This has greatly reduced from 253 requests submitted for 24/25 financial year and reflects hard work by the formulary team and a QI project within the area.
- Dr Halima Amer became D&TC Chair in Spring of 2026 and is becoming established in her new role, working closely with the formulary team to oversee D&TC activities.

Plans for 26/27 include ensuring drug applications are submitted for medications with multiple one-off non-formulary requests and establishing a high-cost drugs policy, to help streamline processes. In addition, as part of the NHS 10 Year Health Plan, a move to a Single National Formulary (SNF) is anticipated within the next 2 years. We will work closely with our NCL and national formulary colleagues to assist with this transition.

3.0 SAFETY

3.1 MEDICINES SAFETY GROUP

The Medicines Safety Group (MSG) meets every two months and reports to both the Drug and Therapeutics Committee (D&TC) and the Patient Safety Group (PSG). The multidisciplinary group is chaired by the Deputy Chief Nurse and includes representatives from pharmacy, nursing, divisional management and risk management, ensuring medicines safety issues are reviewed from an organisation-wide perspective.

The MSG plays a key role in overseeing medicines safety across the Trust and supporting delivery of the Patient Safety Incident Response Framework (PSIRF), recognising medication incidents as one of the Trust's patient safety priorities. Its focus includes medicines administration, omitted doses and high-risk medicines, particularly anticoagulants and insulin.

The group provides oversight of medication incident trends, incidents escalated through the Trust's safety processes (i.e. Whittington Incidents Safety Huddle (WISH)), controlled drugs governance, medicines-related risks, NHS Patient Safety Alerts, MHRA safety communications and divisional medicines safety concerns. Through regular review of these areas, the MSG supports learning, promotes safer use of medicines and ensures appropriate actions are implemented across services.

3.2 MEDICATION INCIDENTS REPORTED ON DATIX

The Medicines Safety Team share monthly reports with the Pharmacy Team Leads and Divisional Risk Managers. Incident reports are kept in a centralised share drive.

Year	Number of medication incidents reported	Number of incidents causing moderate or greater harm (%)
2020/21	604	7 (1.2%)
2021/22	525	8 (1.5%)
2022/23	683	7 (1%)
2023/24	689	10 (1.5%)
2024/25	732	9 (1.25%)
2025/26	850	7 (0.8%)

Table 1 – Medication incidents reported since 2020/21

All incidents causing moderate or greater harm are reviewed at the daily triage meeting and by the Pharmacy Risk and Incident Group.

Patient Safety Incident Response Framework (PSIRF)

Following the introduction of PSIRF in November 2023, reporting of patient safety and medication incidents initially declined, likely reflecting the increased complexity of the reporting process and additional information required within incident forms. Reporting levels have subsequently recovered and now exceed those seen prior to PSIRF implementation.

Under PSIRF, harm is no longer used as the primary criterion for escalation to the Whittington Incident Safety Huddle (WISH). Investigation processes have also changed, with Rapid Action Reviews (RARs) replacing traditional 72-hour reports. RARs are initially reviewed within Divisions and, where appropriate, escalated to WISH. A range of new investigation methods can then be utilised, including After Action Reviews (AARs), multidisciplinary swarms, safety huddles and focused reviews.

Controlled drug incidents remained the most frequently reported medication incident type during 2025/26, followed by administration errors, omitted doses, and prescribing and dispensing incidents. Trends and learning from these incidents are regularly reviewed through the Medicines Safety Group.

Hospital nursing staff submitted the highest number of medication incident reports, followed by pharmacy staff and district nursing teams. By Division, Emergency and Integrated Medicine (EIM) reported the greatest number of incidents, followed by Acute Patient Access, Clinical Support Services and Women's Health (ACW).

Work carried out by the MSG in 2025/26

During 2025/26, the Medicines Safety Group (MSG) led a number of initiatives to strengthen medicines safety, governance and organisational learning across the Trust. Key achievements included:

- Collaboration with Nurse Educators and Pharmacy teams to deliver Medicines Safety Week, promoting the Trust's medicines-related PSIRF priorities and raising awareness of the MHRA Yellow Card Scheme.
- Adoption of the SEIPS (Systems Engineering Initiative for Patient Safety) methodology to facilitate a workshop with the Dispensary and Distribution teams following a cluster of dispensing incidents, identifying learning and improvement opportunities.
- Revision of the Trust's incident reflection tool to incorporate SEIPS and PSIRF principles, supporting a more structured approach to learning from incidents.
- Introduction of unfractionated heparin within the Emergency Department to support the management of vascular patients requiring transfer to specialist centres.
- Review and enhancement of controlled drug audit questions and scoring criteria to improve audit accuracy and minimise false-negative findings.

- Optimisation of the use of ADIOS® reporting to strengthen monitoring arrangements and support earlier identification of unusual controlled drug supply patterns.
- Development and implementation of a Movement of Ward Procedure, providing stronger governance and oversight of medicines transfers and stock management during ward openings, closures and relocations.
- Continued collaboration with the Thrombosis Group to improve documentation and governance surrounding VTE assessment, prescribing and transfer of care.
- Ongoing promotion of best practice in the management of time-critical medicines across clinical services.
- Continued support for implementation of actions arising from the National Patient Safety Alert relating to the incorrect recording of penicillin and penicillamine allergies.

These initiatives have contributed to strengthening medicines safety systems, improving governance arrangements and promoting a culture of continuous learning across the organisation.

Learning from incidents

All medication safety incidents are reviewed by the Medicines Safety Officer (MSO) and trend identification and subsequent learning is shared throughout the organisation in the following ways:

1. Articles in '**Medicines Matter**'. This is a quarterly Pharmacy publication that is sent to all staff and available on the intranet. Topics covered in 2025/26 included:
 - Medicines safety week feedback
 - Incidents involving Medicines Reconciliation
 - Updates on National Patient Safety Alerts
 - Drug shortages
 - Five rights of medicines administration
 - Penicillamine/penicillin allergy documentation
 - Update on prescribing fluoroquinolones safely
2. Articles in **Whittington Improvement and Safety Paper (WISP)**. This is a bi-monthly publication produced by the Risk Department and available on the intranet. Topics covered in 2025/26 included:
 - Ward medicine cabinets refurbishment update
 - Vaccination QI project update
 - Focus on incidents involving PSIRF medication priorities
 - Clinical alert regarding G6PD deficiency
3. Contributions to the monthly **Patient Safety Forum (PSF)** ensuring medicines safety and incident feedback are included as a regular agenda:
 - Prescribing related incidents of all levels of harm
 - Semaglutide formulation updates

- Safe prescribing and timely specialist referrals for complex cases e.g. clozapine treatment, complex thrombosis case, and insulin safety.
 - Useful resources for safe prescribing e.g. Eolas®, Renal Drug Database®, Toxbase®, artesunate calculator.
 - Prescription protocols for ensuring safe prescribing e.g. OPAT and smoking cessation.
4. Incident themes discussed during the **‘Back to the Floor’ initiative** led by the Medicines Management Nurse. Topics in 2025/26 included:
- Controlled drug management
 - Insulin safety and anticoagulation
 - Management of patient’s own drugs (POD)
5. **Learning within and supported by pharmacy:**
- Regular clinical pharmacy teaching sessions and weekly pharmacy team meetings
 - The Pharmacy Department ‘medicines safety message of the week’
 - o Pharmacy team leads report medication incidents to their Divisional Quality & Safety Meetings.
 - o Feedback to ward staff via the ward pharmacy network and medicines management champions.
 - o Feedback to the local MSO & CDAO (Controlled Drugs Accountable Officer) network – this includes community colleagues as well as other local hospitals.
6. **Individual feedback** is also carried out in person and via Datix by the MSO during investigation of incidents. Reflection tool has been updated and implemented for use by all staff group.
7. **Group feedback** has been conducted as part of cluster review especially recurring incidents observed within Dispensary. This was an important piece of work to engage Dispensary and Distribution team members to contribute suggestions for process improvement as well as gaining confidence in reporting any concerns.

Peer Reviews across the Trust

- Collaboration with Trust’s Clinical Governance team to prepare and to conduct peer review, focusing on medicines management and medical gas safety.
- Development and launch of a well-led information board for the Pharmacy Team to improve communication, engagement, and visibility of governance activities.
- Work in partnership with Pharmacy colleagues from RNOH to prepare for and undertake a medicines management peer review, facilitating the sharing of best practice and quality improvement initiatives.

Medicines optimisation – self administration

- Installation of new medicines cupboards and bedside locker to optimise medication storage capacity and organisation
- Improvement of compliance with storage standards
- Support to the implementation of the Self-Administration of Medicines (SAM) programme.

3.3 NHS ENGLAND NATIONAL PATIENT SAFETY ALERTS

The MSG work with Pharmacy and the Trust Compliance Officer to develop action plans for patient safety, drug recall and drug shortage alerts to ensure completion dates are adhered to. All safety alerts are recorded on Datix.

Alerts (relevant to Whittington) actioned and closed during 2025/26 included:

- International shortages of Tuberculosis treatment. National allocation had been secured to ensure outpatient pharmacy are able to source.
- Bumetanide shortage and collaborate with Trust's Lead Cardiologist for prompt action.
- Rasburicase treatment is made available and formalised in the Trust's guideline for treatment of tumour lysis syndrome.
- All MHRA recalls and actions as per MSG reports.
- On-going work is in progress for ensuring completion of tasks relating to NatPSA/2025/006/NHSPS.

3.4 CONTROLLED DRUGS

The Pharmacy Department has responsibility for the governance surrounding the safe and secure handling of Controlled Drugs (CDs) within the Trust to fulfil current UK legislation such as the Misuse of Drugs Act 1971 and Controlled Drugs (Supervision of Management and Use) Regulations 2013 DOH.

The governance arrangements in place currently include:

- All CD incidents are reported on Datix and automatically forwarded to the Chief Pharmacist / Deputy Chief Pharmacist, CD Accountable Officer, Medicines Governance & Clinical Support Pharmacist and Medication Safety Officer.
- Quarterly audits on all wards and departments using the Tendable® app as a way of ensuring accessibility to all staff and standardised practice.
- Quarterly audit tools have been developed for Pharmacy Omnicell®, providing assurance on the management of CDs in Pharmacy department.
- CD Datix incidents are escalated to the Chief Pharmacist/Deputy Chief Pharmacist and CDAO where required and reviewed in detail by the Medicines Governance & Clinical Support Pharmacist and Medication Safety Officer.

- Rapid Action Reviews (RAR) for unaccounted for CD losses are routinely escalated to the WISH and subsequent submission to NHS England.
- Where appropriate, incidents of concern and unaccounted for losses are escalated to the Police CD Liaison Officer and NHS England Controlled Drug Division, Chief Pharmacist and Trust Controlled Drug Accountable Officer (CDAO).
- Local Intelligence Network (LIN) reports are submitted quarterly to the NHS England CD Officer detailing numbers and types of CD related incidents for regional review.
- Regular reviews are undertaken of our ordering and prescribing of CDs using ADIOS® (Abusable Drugs Investigational Software) to identify any areas of abnormal activity relating to CDs.
- Medication Safety Officer also attends to the Pan-London CDAO meeting, sharing challenges and good practice with the Network.

As an example, a medication administration error occurred involving diazepam oral liquid. The prescribed dose was intended to be administered using the standard-strength preparation; however, the supply was a concentrated formulation. As a result, the administered volume corresponding to the prescribed dose for the standard-strength product, leading to an overdose of diazepam. This patient safety incident report and learning was shared with nursing and pharmacy teams, strengthening our understanding and practice when checking and authorising the use of patient's own medicines and documentation of schedule 4 CDs.

In the past year, several common themes were identified within CD incidents, with actions put in place to provide targeted improvements such as:

- Implementation of a focussed workstation within Medicines Education Workshops (MEWS) addressing good practice for the documentation of errors occurring during CD record keeping processes.
- Creation of Task & Finish group for recurring breakages of fentanyl ampoules across Theatres areas.
- Clarify the processes and promote safe practice across the clinical area and with Security about safe and lawful handling of illicit substance.

Patient Harm	2025/26
No harm	179
Low harm	21
Moderate harm	2
Death	0
Total number of CD incidents	202

Table 2: Breakdown of the CD incidents for 2025/26 by patient harm

In 2025/26 there were 15 reported incidents of unaccounted CD losses, slightly less than the previous year (n=18).

In Q4, there was an incident relating to a professional of concern. Initial investigation indicated that a substantial volume of CDs had been diverted from legitimate clinical use. An immediate review of CD records, stock balances, and administration documentation was undertaken. Relevant managers, the CDAO, and external authorities were notified in accordance with the Trust CD Policy.

Whilst the incident report is in progress, measures were implemented to strengthen oversight of controlled drug management, including enhanced auditing, review of access controls, and reinforcement of staff responsibilities relating to controlled drug handling and documentation.

A summary of actions to improve general controlled drugs governance throughout the Trust include:

- The backlog of expired CDs was reviewed and destroyed in accordance with relevant procedures by January 2026. A monthly destruction schedule has since been implemented to ensure the timely disposal of expired CD stock and prevent future backlogs.
- Ward signature list template was updated.
- Optimise CD audit questions and scoring systems to provide assurance and improved accuracy.
- Timely escalation and resolution of compatibility issues between oral syringes and oral adaptors to prevent spillage during the measurement of CD liquids.
- Collaborate with the Dispensary and EPMA teams to ensure that electronic CD register entries are appropriately signed upon final checking and release of controlled drugs, and that usernames and passwords are not saved or shared on dispensing workstations.
- Facilitate PSIRF learning responses addressing significant or recurrent CD incidents.
- Reinforcing education on CD governance through a repeat of MEWS sessions focussing on ward CD management
- Collaboration with PDNs to disseminate good practice training, including the use of educational videos
- Review of the ward level CD disposal process for wasted / partially prepared doses.

Plans for 2026/27

- Implement the updated CD policy, strengthening processes for ordering non-stock CDs, return processes, audit, management of illicit substance, and reporting to NHSE.
- Finalise of the process for denaturing and safe disposal of CDs across the Trust.
- Implement the optimised CD audit plan for ensuring audit are conducted in a robust and non-bias approach i.e. conduct with a nursing staff and by a Pharmacy team member from a different Division.
- Complete PSII for incident relating to division of CDs.
- Continue to run an annual CD audit refresher training.

3.5 PHARMACY RISK REGISTER

The Pharmacy Risk Register (PRR) is a subsection of the ACW Division risk register. Whilst the risk register predominantly incorporates risks associated with the delivery of pharmacy services, it also contains several risks associated with medicines management that apply across the Trust.

The content of the pharmacy risk register is the responsibility of the Chief Pharmacist. The Deputy Chief Pharmacist & Clinical Services Lead has delegated responsibility for the daily ongoing review of the PRR.

The PRR is formally reviewed each quarter. All new risks are approved at the ACW Divisional Quality and Risk Meeting and ACW Divisional Board. Risks scoring above 15 are noted at the ACW Division Board meeting, Divisional Quarterly Performance Reviews and approved by a member of the Executive Team.

At the end of 2025/26, there were 16 risks on the PRR graded as per the table below.

Risk	Consequence	Progress and mitigations as of 31 st March 2026	Current risk rating
OPEN (PRR)			
Medicine Storage and Handling - 827	CQC and ongoing internal audits demonstrate need for continual monitoring at ward level of medicines storage and handling.	Organisational risk. Phase 2 cabinetry works completed in June 2025. However, noted that 3 areas still required swipe access, 13 areas require replacement of floor standing cupboards, 5 areas require wall cabinets, 13 areas require IV fluid storage and 7 areas require new fridges. To be added to list of works for Q1 26/27.	6
Medicines stock shortage - 306	Omission of medicines due to unavailability may result in patient harm.	Nationally recognised risk. Regular drug shortage meetings held to manage and mitigate ongoing and new supply issues.	12
Non-Windows 11 Compliant Pharmacy Digital Systems - 1634	Systems will not work as expected post upgrade to windows 11, support from suppliers will be minimal as utilising an unsupported operating system	Powergate (compliant as of July 2025). Chemocare – awaiting when a compliant version will be released to market. CMM EPMA PSC – awaiting business case outcome for funding to enable upgrade of CMM.	8
WiFi Dependency & Disparity across Inpatient Wards - 1624	Impact on staff delivering care i.e. administering medication, access to drug charts in clinical areas on some wards during Wi-Fi outages	Risk being reviewed to move to IM&T as actions should sit with them. Pharmacy have been involved in designs/redesigns for new areas (e.g. ED SDEC and Decant Ward) to ensure network ports are available in clinical areas in the event of Wi-Fi downtime.	12

Pharmacy Aseptic unit exceeding overall capacity (including Quality Assurance capacity) - 1396	Inability to provide timely chemotherapy for patients attending Chemotherapy Day unit. Regular QA meetings and internal audit schedule was not met due to staffing/capacity issues in the team.	Unit will be fully opening in April 2026, production of elastomeric pumps will be outsourced. This should hopefully ensure unit does not exceed capacity of chemotherapy. Risk remains open until unit is in full production to monitor overall unit capacity.	9
Provision of Chemotherapy During Aseptic Isolator Works - 1284	Third party commercial supplier potentially unable to continue provision of chemotherapy, impacting service delivery and patient care	NHSE capital monies have been spent to carry out additional works including integrating VHP gassing technology into Isolator, installation of a transfer hatch within the aseptic unit and other reconfiguration/remedial works. Aseptic unit will be fully opening in April 2026. Risk remains open until unit is in full production.	8
Limited contingency plan for pharmacy staff manufacturing chemotherapy - 1524	Lack of trained staff can lead to delay in patient's receiving their doses, poorer patient outcomes and future capacity issues on chemotherapy day unit and pharmacy production to recover from inactive period.	Through restructure and approved business case team has increased by a band 5 and band 6 who are now in post. Additional rotational band 5 created to increase resilience across the department. Significant training burden in technical services as Aseptic Unit in shutdown due to Isolator works which will delay training of new staff.	9
High ambient temperatures of ward/unit treatment rooms - 1471	Temperatures fluctuate at ward level; high temperatures pose risk to medication integrity	Organisational Risk. 2 areas ED and NICU require air conditioning units. Limited funding and capacity available within Estates and Facilities to upgrade this financial year, added to list of works for Q1 26/27.	8
Risk of Transferring of patient between EPMA / Non-EPMA areas (and vice versa) - 434	Risk of double dosing/missed doses, or incomplete medication records (e.g. split between paper and electronic) being presented to clinicians due to transfer of patients between Paper based prescribing areas and CMM EPMA Live area (and vice versa)	Currently, working through upgrade to v8.2 which will facilitate ED deployment. Business Case written for interface between CMM and Omnicell, awaiting submission to capital monitoring group.	12
Pharmacy Robotics System - End of Life - 1591	Risk to the efficiency of critical medicine supply to patients, ultimately strengthening ability to provide better patient care and improve	Robotic Designs have been finalised and finalising plans for dispensary redesign). Pharmacy robot purchased and currently being stored in Germany.	12

	operational performance.		
Rheumatology Homecare Services - 1485	Delays in Rheumatology homecare prescriptions being sent to pharmacy resulting in delays in initiation and continuation of biologic medications for patients.	Invest to Save approved to support an additional 0.5WTE Homecare/Procurement pharmacy technician who will bring stability to the team for a fixed term period of 1 year.	9
The use of Patient Group Directions (PGDs) - 1503	Failure to comply with processes resulting in medicines being supplied/administered out with guidance/legislation.	Organisational risk. Improvement highlighted in training, renewals and competency completion. Audits process needs improving as low engagement has been received with this.	9
Pharmacy Staffing on Neonatal Unit - 1566	Suboptimal pharmacy staffing levels based on the national neonatal and paediatric pharmacist group standards. Impacting delivery of service.	Identified 0.9WTE shortfall in staffing, mitigated through cross-cover from other roles. Startwell AHP business case submitted and awaiting outcome on this which outlined ask for extra staffing to support shortfall.	9
Lack of interoperability (ICE/DAWN) - 1417	Manual entry of information increases risk of error, which could lead to wrong dosing instructions to patients and increased risk to patient safety	Access to the test domain on DAWN has been granted and information received from HSL. Testing to proceed on implementation of the interface. Awaiting further updates on timelines.	6
Flow of patients from Hospital @ Home back into ED on CMM EPMA - 1497	Due to Hospital @ Home patients not having a inpatient spell on the PAS System CareFlow patients may be administered medications which are no longer relevant or required as part of their treatment	Working Group in progress looking to transition Hospital @ Home patient admissions as inpatients. EPMA/Pharmacy ED team monitor during working hours.	6
Pharmacy Homecare services - 1483	Delays in patient treatment initiation, delays in deliveries and missed doses for patients.	KPIs monitored monthly. Incidents reported via DATIX and followed up with homecare providers.	6
CLOSED			
Diversion of Schedule 5 Controlled Drugs (Codeine	Closed August 2025. Agreed in conjunction with CDLAO, Clare Dollery, Medical Director and Stuart Richardson, Chief Pharmacist. To reduce and close risk providing mitigations and ongoing monitoring is in place across the trust. Assurances that should		12

and Dihydrocodeine)	diversion be suspected or identified in the future that reporting mechanisms in place to swiftly identify and respond.	
IRIS Licenses limits being exceeded on CMM - 1509	Closed December 2025. Received confirmation that upgrade v8.2 version will fix licensing issue and automated reports received daily which highlight when licenses are ready to expire.	10

Table 3 – Risks on Pharmacy Risk Register

All risks are under constant review and are being actively managed. Updates on mitigations in place are noted within the risk register.

3.6 SAFETY FOCUS AND PLANS FOR 2026/27

- Continue to work effectively across disciplines with the Lead Nurse for Medicines Management.
- Contribute to Whittington Improvement and Safety Paper (WISP - previously Spotlight on Safety) and Medicines Matter publications.
- Continue to support the Associate Medical Director for Patient Safety in organising topics for the Patient Safety Forum (PSF).
- Continue to use incidents to improve the e-prescribing system and training regarding its use.
- Continue to contribute to the London Medicines Safety Network groups.
- Continue to work with Divisional Risk Managers to support medication incident investigations, implementation of actions and timely closure of incidents.
- Review and standardise practice for medication provision over community services.
- Work with the organisation to ensure governance processes are defined for the completion and resulting actions of medicines management audits on Tendable.
- Ensure robust governance and processes in place for the supply and management of ward stock both within Pharmacy and on wards/ clinical areas.
- Facilitate the implementation of actions recommended by WISH to improve the safe use of medicines.

4.0 QUALITY CARE AND EFFECTIVENESS

Pharmacists are becoming increasingly responsible for the clinical management of patients and all new Pharmacist graduates will be independent prescribers by the time they graduate from 2026. The department has planned for this and created a Newly Qualified Pharmacist Prescriber Generic Scope of Practice.

The workforce strategy 2023-26 outlined the vision for our workforce in line with the NHS Long Term Plan and the NHS People Plan. Significant milestones were achieved in nearly all the workstreams noted within the strategy at the end of March 2025, but further achievements were then progressed by March 2026:

- Successful establishment of a substantive band 7 post within the Digital team.
- Production team re-banded their Assistant Technical Officers (ATOs) JDs to band 3 from band 2 in line with other production units.
- A small team of staff have been invited and attending increasing numbers of careers events at local schools to promote Whittington Health as an employer for the local population.
- A training provider has been identified to support the development of Final Accuracy Checkers (FACs) for senior ATOs.
- Most clinical screening activities previously conducted in the dispensary have now been devolved to the appropriate clinical teams.
- Many Medicines Management Pharmacy Technicians (MMPTs) are now undertaking line management and educational supervision responsibilities with continued support.
- NCL Education Programme Directors worked collaboratively to create a Newly Qualified Pharmacist Prescriber (NQPP) generalist scope which outlines prescribing activities that these novice prescribers will be able to undertake together with support they will be provided.
- Creation of development pathways for technicians and pharmacy support staff which depicts the training journey through their careers. This complements the pharmacist development pathway that was developed the previous year.

4.1 CLINICAL PHARMACY SPECIALTIES

4.1.1 Emergency and Integrated Medicine (EIM)

Key achievements in 2025/26:

EIM Overall

- Integrated safety story for sharing incidents and lessons learnt at monthly EIM Pharmacy Team meeting continue to build transparent and open culture in clinical governance and promoting the Trust's PSIRF priorities.

- Actioned NPSA alerts and actions plans, including antituberculosis medications and bumetanide shortage.
- Effective management of drug shortages and discontinuation and implementation of contingency plans across the Trust. Affected medicines include: Gastrografin®, procyclidine and prochlorperazine injections as well as rivastigmine patches.
- Senior EIM pharmacists have taken an active role in supporting the new cohort of trainee pharmacists who are training to become pharmacist prescribers upon qualification.
- Delivery training to Junior Doctors during their onboarding.
- Successful implementation of TTA packs logbook aligned with the Trust's TTA pre-pack policy. Continue to review the range and volume of TTA packs for ensuring efficient use of resources.
- Achieved goal of senior pharmacists in EIM team utilising their non-medical prescribing qualifications on a regular basis to support clinical operations.

Emergency and Acute Medicine:

- New intravenous fluid storage unit in the Emergency Department, for ensuring stock optimisation for acute patient cohorts.
- Royal College of Emergency Medicine (RCEM) quality improvement project in progress relating to time critical medications in ED and reduction in the delay of administration and omission of these medicines, especially medicines for treating Status Epilepticus and Parkinson's Disease. Establish professional networking with London North West University Healthcare NHS Trust.
- Increasing trend of patient referral and admissions for medical iron infusion demonstrated a full implementation of ferric derisomaltose treatment guideline at Ambulatory Care Unit and continue to report adverse drug reactions.
- Supported in the implementation of MEDL guidelines across the trust e.g. First Fit and Status Epilepticus.
- Updated Antidotes Availability for Emergency Services Guideline and ensured the compliance of stock availability in ED.
- Updated Acute Alcohol Withdrawal Guideline to account for the temporary Chlordiazepoxide shortage.
- Reviewed ED Omnicell stock list and eliminated all discrepancies.
- Completed a product switch from Procyclidine Injections (discontinued) to Benztropine Injection and ensured stock is available in all relevant areas.

Integrated Medicine

- New medicines cabinets deployment at Victoria and Thorogood wards, demonstrating compliance in safe and effective medicines storage.
- Ongoing participation in the NCL Inhaler Sustainability Group, with updated Trust Adult Asthma Diagnostic Pathway including recommendations for use of DPIs (lower carbon emissions) vs pMDIs.
- Greater awareness across the Pharmacy team about treatment of tobacco dependency through teaching and optimising product range across inpatient areas.

- Presentation of 'Treating Tobacco and Nicotine Dependency' project at Trust QI celebration event.
- Approval and publishing of 'Quit and the Whitt' Box SOP.

Outpatient Clinics and Endoscopy

- Effectively managed recall of Gastrografin implementing alternative and communicating across the Trust.
- Streamlined communications between Clinical Nurse Specialists and Pharmacy for prioritising and effectively managing orders for Endocrinology clinic, Hepatology clinic and Thalassemia unit. This helps to avoid duplications in workload and miscommunication for ensuring timely supply of medicines for the named patient.

Priorities for 2026/27:

- Continue to optimise skillset and clinical interests for EIM Pharmacy team members, through training and education, team engagement activities and supporting senior pharmacists to be the role model for the team.
- Support Senior Pharmacists in EIM team to become non-medical prescribers, optimising their knowledge and skillset for clinical practice and facilitating Trainee Pharmacists for completing their Foundation Training Year and Qualification.
- Support Senior Pharmacists in EIM team to undertake Leadership and Management courses.
- Continue to support safe and secure handling and management of CDs as per Trust's CD Policy as well as review of ADIOS[®] report for ensuring medicines with misuse and abuse potential are managed appropriately across EIM.
- Continue to support in the implementation of MEDL guidelines across the trust.
- Incorporate EIM priorities and objectives within the Pharmacy Workforce Transformation strategy and development of an action plan.
- Continue to develop cost-saving and sustainability initiatives across EIM by reducing medicines wastage and utilising newly available financial dashboards to analyse potential cost improvement projects.
- Transfer of patients own medication initiative in ED to reduce medication wastage and improve availability of patient's critical medications.
- Collaborate with Red Cell and Gastroenterology MDT to further scope out future roles within pharmacy.
- Reaudit for previous Inhaler Sustainability Project with potential for QI according to results.
- Explore and scope for future quality improvement projects including timely availability and administration of critical drugs in ED (linking to the national Royal College of Emergency Medicine programme) and optimising usage of TTA packs.

4.1.2 Surgery and Cancer

Surgery

Key achievements in 2025/26:

- Workforce Development:
 - New Total Parenteral Nutrition (TPN) training pack for pharmacy staff.
 - Independent Pharmacist Prescribers actively prescribing in Critical Care and surgical wards.
 - Successful completion of UCL Critical Care course and PG Certificate Advanced Pharmacy Practice Critical Care.
 - Accuracy Checking Technician (ACT) course for technicians.
- Medicines Management
 - New medicines cabinets in Theatres/Mercers and larger bedside lockers in Critical Care Unit to optimise medicines storage in clinical areas.
 - Supporting regular pharmacy-led governance programme of Medicines Management and Controlled Drugs audits across S&C.
 - Collaboration with MDT to disseminate learning from medication incidents.
 - Updated Medicines Management SOP for Theatres, Community Dental Clinics, Emergency Drug Box SOPs for Critical Care and Theatres.
 - Clinical support to Pharmacy Procurement team in managing medicines shortages and discontinuations across surgical and critical care services (e.g. Gastrografin, thiamine, IV clonidine, phosphate polyfusor, IV sodium bicarbonate, epidurals, diamorphine, dantrolene).
- Cost improvements
 - Mitigation of significant cost pressures for contrast media.
 - Reduce plastic waste and costs by implementing Propofol 2% in place of 1% preparations in Critical Care.
 - Switch to more cost-effective preparations, e.g. levosimendan and liquid vitamin D preparation
 - Implementation of audit tool for TPN prescribing and waste to support future CIPs/QI projects.
- Clinical
 - Led on new guideline for Continuous Beta-Lactam antibiotic infusion in Critical Care.
 - Collaboration across NCL Critical Care ODN to harmonise use of melatonin and remifentanyl.
 - Collaboration with Whittington MDT for new/updated clinical speciality guidelines (Dental sedation guideline, Refeeding guideline, TPN guideline Peripheral vasopressors) and Patient Group Directions (MRSA prepack, dental local anaesthetics, local anaesthetics and steroids for Ultrasound and MSK).

- Introduction of new drug preparations for improved patient care (propofol 2% for reduced lipid burden in sedated patients in Critical Care, new easier to reconstitute dantrolene for malignant hyperthermia).
- Utilisation of smart pump functionality in Critical Care for propofol for patient safety.
- Supported Bariatric MDT with implementation of Tirzepatide Weight Loss Clinic and Bariatric Day Case Pathway.
- Specialist Pharmacist teaching sessions for Critical Care clinicians, for nurses on TPN.

Priorities for 2026/27:

- Further improve governance within S&C through auditing, training and process reviews.
- Implement electronic CD ordering and better utilisation of Tendable in Dental Clinics.
- Collaborative CIP with nutrition team reviewing parenteral nutrition product range.
- Minimise risks associated with paper-based prescribing in Day Surgery (Bluespiers).
- Implement pharmacist support for Pre-Assessment Clinic.
- Implement continuous beta-lactam antibiotic infusions in Critical Care.
- Review weekend pharmacy service provision to Critical Care as result of GPICS 3.
- Increase collaboration across NCL Critical Care Pharmacy Network.
- CIP for simple analgesia in Day Surgery.

Cancer Services

Key achievements in 2025/26:

- Funding for a new isolator was approved in the 23/24, with additional funding granted by NHSE in December 2024 to support a transformation project of the Aseptic unit.
- This Aseptic Unit transformation project was completed during 25/26, with the Aseptic unit re-opening in December 2025. Some of the key changes included;
 - Integrating VHP gassing technology to the new isolator to automate the bio decontamination of the interior surfaces improving the quality and safety of products prepared within the Isolator.
 - Switching the isolator to positive pressure to ensure regulatory compliance.
 - Installing a new transfer hatch within the Aseptic unit to improve workflow and health and safety of the operators.
 - Relocating the Production dispensary and Clinical Trials dispensing areas to facilitate workflow changes.
 - New gowning procedures within the Aseptic unit to improve contamination control and improve operator safety.
- All works were carried out according to regulatory standards and requirements with appropriate documentation and validations undertaken including writing of User Requirements Specifications (URS), Design Qualifications (DQ), Installation

Qualifications (IQ), Operational Qualifications (OQ), Performance Qualifications (PQ), Process validations and Operator validations.

- Successful visit from the Regional Quality Assurance Team to the Whittington Aseptic Unit in July 2025 to review the refurbishment and associated validation activities. They were impressed by the team's diligent efforts and commended their hard work in bringing the unit to its current standard. The inspection confirmed that the build quality of the refurbishment is of a high standard, which should support the extended operational life of the unit.
- Regional Quality Assurance Audit was undertaken in April 2026. An overall risk rating linked to patient safety is assigned to the aseptic unit (categories of overall risk are high, medium and low). The Whittington Aseptic Unit was regarded as **low risk** which is a fantastic achievement following such significant works and process change after the introduction of a new isolator, new VHP technology and redesign of the aseptic suite. The team were commended on the work they had done to date, their openness, professionalism and culture within the unit.
- Various recruitment activities:
 - Technician positions – B7 Chief Technician, B6 Senior Technician and B5 Specialist Technician all recruited into successfully.
 - ATO position – recruited into successfully.
- ATO on track to successfully complete Science Manufacturing Technician (SMT) level 3 course.
- Regular submission of audit-related data and quality indicators via the new online system, iQAAPS, as required by Regional Quality Assurance teams.
- Rolled out ChemoScheduler module (added to the ChemoCare v6 system) after completing training, building locally/updating all protocols and undertaking UAT (User Access Testing), which will enable improved scheduling by enhanced coordination, improved accuracy of patient appointments and real-time updates for the wider team.
- Rolled out Pathology Interface within Chemocare to enable results reporting on Chemocare and auto-populate feature when authorising treatments reducing the risk of human error and improving efficiency and patient safety.
- Facilitated timely access to new treatments ensuring all new protocols for systemic anti-cancer therapies (SACT) were built and validated for safety and clinical use.

Priorities for 2026/27:

- Upgrade Chemocare Worksheets/Labels module to enable upgrade to Windows 11 compliant version of Chemocare.
- Work with System C and the SACT Dataset team to move to reporting of SACT Dataset version 4
- Create action plan to address deficiencies from 2026 Regional Quality Assurance audit and work through completion of actions.
- Maintain the Quality Management System to ensure ongoing compliance to GMP standards.

- Explore ways in which pharmacists can regularly support clinics and provide face-to-face counselling for our new patients on the Chemotherapy Suite through the development of a business case to fund additional pharmacist support.
- Continue to support development of collaborative models with UCLH.

4.1.3 Children and Young People Services (CYP)

Key achievements in 2025/26:

- Palivizumab to Nirsevimab clinic switch reflecting NHSE and Joint Committee on Vaccination and Immunisation (JCVI) guidance.
- Approval of charity funding for Kidzmed project to support reduction in liquid medication spend
- Completion of new neonatal parenteral training package and update of training workbook for rotational pharmacist
- Selected for poster presentation at the Clinical Pharmacy Congress for work on Caffeine Citrate Quality Improvement Project
- Completion of independent prescribing course in paediatric diabetes
- Extra Mile awards given to two members of the team for support of complex palliative care patients and the Paediatric Lifeforce Team.

Priorities for 2026/27:

- Further improve governance within CYP through auditing, training and process reviews.
- Proton pump inhibitor (PPI) use in paediatrics Quality Improvement Project.
- Pilot group for Kidzmed project to be completed.
- Review of continuous infusions in NICU to align with London Neonatal guidance.
- CLEO SOLO (electronic FP10) to be implemented in Islington Child and Adolescent Mental Health Services, Health Visiting and Community Paediatrics (Islington + Haringey).
- Implementation of self-administration policy in Acute Paediatrics.

4.1.4 Acute Patient Access, Clinical Support Services and Women's Health (ACW)

Women's Health

Key achievements in 2025/26:

- Delivering alternative medicines effectively in the face of national shortages and product switches (e.g. fentanyl/bupivacaine epidural bags).
- Deep dive paper on maternity incidents in relation to intravenous iron product switch presented at Medicine Safety Group

- CMM EPMA updates to maternity TTA bundles and new drug administration times to avoid clash with midwifery handover.
- Implementation of pre-filled syringe medication for drugs used in anaesthesia.

Priorities for 2026/27:

- Further improve governance within ACW through auditing, training and process reviews.
- Continue to explore further pre-filled syringe medication for drugs used in anaesthesia.
- Support midwifery team in the use of PGD's approved by the Trust.
- Implement 'bring your own medicines' and 'self-administration' policy in Maternity.

4.1.5 Adult Community Services (ACS)

Key achievements in 2025/26:

- CLEO SOLO for electronic FP10 implemented (Phase 2).
- Improved medication governance:
 - Use of Tendable across community services.
 - Development and review of policies and guidelines.
- Increased numbers of pre-registration pharmacy technicians (PTPT) placements in ACS.
- Increased time for Pharmacy Technicians in community roles.
- Whittington Pharmacy ACS representation across NCL and regional groups in the areas of polypharmacy, Hospital at Home and integrated medicines.

Priorities for 2026/27:

- Support Neighbourhood Health Services development with pharmacy part of the essential requirements.
- Build out further pharmacy integration with both systems and staff in:
 - Community Heart Failure
 - Community Respiratory
 - District nursing – (EPMA and centralised medication management)
- Further improve governance within ACS through auditing, training and process reviews.

4.2 ANTIMICROBIAL STEWARDSHIP & OPAT/COPAT

Antimicrobial Stewardship and Outpatient Parenteral Antimicrobial Therapy / Complex Outpatient Antimicrobial Therapy (OPAT/COpAT)

Key achievements in 2025/26:

- Successful appointment of new Lead AMS Consultant (Dr. Conor Bowman).
- Development of Trust AMS Strategy in-line with NHSE Call to Action Letter on AMR, 5-year AMS National Action Plan 2024 to 2029 and NHS 10-year Health Plan.
- Ongoing AMS Audit/QI initiatives
 - WH Lady Bugs Project
 - WH ED co-amoxiclav review
 - PADL (penicillin allergy de-labelling project)
 - IVOST (IV to PO switch therapy) audit and QI on Mercers ward
- 14% drop in DDDs (defined daily doses) /1000 admissions (excluding LUTS) between 24/25 and 25/26.
- 21% drop in DDSs/1000 admissions (including LUTS) between 24/25 and 25/26.
- 15k drop in expenditure excluding LUTS, vs 42k including LUTS.
- Migration of Trust antimicrobial guidelines to Eolas.
- Development of 5 new antimicrobial/infectious diseases guidelines.
- OPAT service nominated for HSJ Digital Award and UKHSA Antibiotic Guardian Award (Highly Commended)
- Publication R. CANTON, A-N. LIM, C. VANESSA and J. DIAZ-REGANON (2025) Uncomplicated urinary tract infections – from an invisible impact to a visible change in complex care. *Clinical Infectious Diseases*. <https://doi.org/10.1093/cid/ciaf705>
- Presented at National and International Conferences:
 - BSAC AMR Spring Conference – Inpatient antipseudomonal review
 - BSAC OPAT Regional Workshop – Initial Results of OPAT PPS pilot
 - BSAC OPAT National Conference – PPS
 - ESCMID Global (Vienna) - Invisible impact, visible changes: understanding the uTI experience symposium (presentation panellist)
 - ESCMID Global (Munich) - Retrospective review of antipseudomonals (poster) and OPAT PPS results (oral)
- Principal Investigator Study Site - MicroGuide 2 Study randomised controlled trial of the impact of MicroGuide 2 computerised decision support modules on antimicrobial prescribing behaviours and clinical outcomes
- NIHR Programme Development Grants (PDG) submission - GADSA: Gamified Antimicrobial stewardship Decision Support App for training healthcare professionals.
- Panellist at the BSAC UTI Masterclass Module 2 Webinar (Diagnostics, Pharmacology, and Guidelines) webinar.
- Updated and expanded the Trust OPAT Guideline (including implementation of new pathways for discharge to enable golden discharges + utilisation of CMM protocols, introduction of benzylpenicillin via elastomerics and switch to saline for piperacillin tazobactam and flucloxacillin)

- Ensured Whittington had a cost-saving from generic switch for Dalbavancin and buffer to saline switch for elastomerics.
- Infection Pharmacist completed Associate Principal Investigator Scheme and leading on international multicentre SNAP Trial.
- Infection Pharmacist completed mentoring of a pharmacist undertaking clinical fellowship in Ghana (via Commonwealth Pharmacists Association).
- Infection Pharmacist credentialled as an Advanced Clinical Practitioner following completion of MSc ACP
- Infection Pharmacist performed in the cast of *Lifeline: The Musical* to spread AMR awareness
- Contribute to the UCL MSc in Clinical Pharmacy, International Practice and Policy (MSc CPIPP) Programme course.
- Implement continuous infusion of beta-lactams on ITU to optimise treatment efficacy and improve patient outcome.
- Successfully migrated serology to HSL including antimicrobial drug levels.

Priorities for 2026/27:

- Update backlog of expired clinical guidelines.
- Embed new methodology for the trust quarterly AMS Point Prevalence Survey. This utilises the Careflow clinical noting system where the outcome result of the AMS prescribing review can be viewed by the ward teams and the audit report compiled and generated from Careflow. This will set the foundation for the AMS Power BI dashboard reporting that has proposed for 2027.
- Collaborate with Lower Urinary Tract Symptoms (LUTS) team and IM&T to develop LUTS clinic Power BI dashboard for real-time reporting of prescribing trends, treatment outcomes and adverse drug reactions in this area of high antibiotic prescribing.
- Penicillin Allergy Delabelling (PADeL) project to offer direct oral penicillin challenge to adult patients with a label of allergy to one or more penicillin but with an allergy history suggesting low risk for true penicillin allergy and in keeping with non-immunological side effects.

4.3 COVID-19 AND INFLUENZA VACCINATION

Vaccination saves lives and helps reduce hospital attendances and antibiotic consumption. Whittington Health vaccination service has been running for > 5 years to help address vaccine access and inequality and improve vaccination uptake within the NCL sector.

Key achievements in 2025/26:

COVID-19 vaccination programme

The COVID-19 vaccination programme continued to be complex – with the dynamic nature of the national COVID-19 vaccination programme (e.g. changes to the type of vaccines use

within the programme, eligibility criteria and commissioning), need for close coordination with ICB commissioner to manage central stock holdings and need to optimise use of multidose vials and reduce wastage.

The total doses of COVID-19 vaccine administered in 2025/26 was less than in 2024/25 (4335 versus 7241 doses, respectively) due to the changes in the eligibility criteria as the population immunity to SARS-CoV-2 increases.

Setting	Spring (Doses)	Autumn/Winter (Doses)
Community - Care home	706	665
Community – House bound	1057	888
Inpatient / Vaccine centre	400	612
TOTAL	2163	2172

Influenza vaccination programme

The total doses of flu vaccine administered in 2025/26 was comparable to 2024/25 (5165 versus 5329 doses, respectively). This was against a falling trend in vaccine uptake nationally.

Setting	Doses
Community - Care home	597
Community – House bound	1229
Maternity	412
Staff	1847
Inpatient / Vaccine centre	1080
TOTAL	5165

Staff influenza vaccination programme

In previous years, Whittington staff flu vaccine uptake was approximately 80%. However, post-pandemic and since the Occupational Health service was taken over by the external provider services, North London Partners Shared Service (NLPSS), which do not provide roving vaccination service on wards, staff flu vaccine uptake had fallen significantly to < 40%.

Whittington Health managed to achieve the 2025/26 NHS England target of 5% increase in staff vaccination uptake compared to the 2024/25 baseline. Vaccination uptake increased from 33.6% in 2024/25 to 39.5% in 2025/26 following a campaign led by the Clinical Lead and Operations Lead for the Vaccination Service, and with the Vaccination Pharmacist providing training and support for the peer-to-peer flu vaccinators. Peer-to-peer flu

vaccinators included nurses, midwives, pharmacists and physiotherapists across the community and hospital sites.

QI Project / Audit

- Clinical Pharmacy Congress (CPC) Poster – Embedding vaccination into the hospital pharmacy service: opportunities and impact.
- Whittington Quality Improvement Celebration – Embedding vaccination into the hospital pharmacy service: opportunities and impact.
- Contributed to the UKHSA conference poster – Covid-19 and Influenza vaccination delivery in hospital settings for underserved groups at the Whittington Hospital and University College London Hospitals.

Priorities for 2026/27:

- Deliver NCL Vaccination Outreach Service through flexible, community-led delivery models to improve uptake and engagement – including targeted outreach activity e.g. pop-up clinics and community-based delivery, and supporting community and outreach events, particularly in underserved communities and among populations least likely to access routine services
- Using data-driven approach to determining vaccination locations, delivery models, and priority cohorts, with a clear focus on populations and communities experiencing lower uptake and higher levels of unmet need.
- Work in partnership / collaboration with Local Authorities, the ICB, voluntary and community sector organisations, and other relevant partners to optimise communications, engagement, and coordination of vaccination activity.
- Embed vaccination awareness and education, a focus on wider health and wellbeing, and a Making Every Contact Count (MECC) approach as core components of the outreach offer, supporting trust, confidence, and sustained community engagement.
- Support surge delivery and outbreak response requirements, including the rapid mobilisation of vaccination activity where required, as agreed on a case-by-case basis with the Commissioner
- Negotiate contract funding with ICB commissioners and Islington and Haringey GP Federation.
- Identify location for static Vaccination Centre to accommodate walk-in sessions for staff vaccination, outpatients and members of the public.

4.4 ANTICOAGULATION AND VTE

Key achievements in 2025/26:

- Oral anticoagulation e-referral forms completed on Careflow, including the referrals document and GP communication letter – simpler process for all concerned.
- Reduced paper waste with e-referrals forms and reduced time with administrative duties, thereby introducing time efficiencies.
- CIP Implementation of apixaban generics as first choice direct oral anticoagulant (DOAC) in Atrial Fibrillation patients from October 2025.
- Expansion of the anticoagulation MDT to include a cardiologist with the view of supporting patient oral anticoagulation reviews.
- Under block contract and reduced the number of referrals each month by ensuring that appropriate referrals were sent to local anticoagulation services which were closer to the patient.
- Reviewed all housebound patients with the view to moving suitable patients to DOACs, thereby minimising INR follow ups (which generate a nominal fee for the Trust).
- Trust anticoagulation guidelines reviewed and updated.

Priorities for 2026/27:

- Reduce follow ups by continuing to review AF / VTE patients with consideration for DOAC switch where suitable.
- Support primary care with review of complex queries to enable the initiation of the most suitable oral anticoagulant.
- Minimise paper burden and waste. Records held electronically will not need rescanning following completion of clinical reviews and free up more administration time
- Interface work between System C and DAWN 4s to ensure auto-update of INR results and requests across the interface between the systems
- Quality improvement project – audit concurrent use of antiplatelets when DOACs prescribed
- Quality improvement project – assessment of the use of CHADVASC and HASBLED/ORBIT score documentation in referrals
- Consider the switch from tinzaparin to enoxaparin – potential CIP target
- Following several DATIX incidents involving both oral and injectable anticoagulants, work with EMPA to develop a report highlighting patients on wards either not on any anticoagulants or on more than one anticoagulation. Report to support pharmacists on wards with screening.

Venous Thromboembolism (VTE) risk assessment

Key achievements in 2025/26:

- VTE prevention award – National Thrombosis UK – one of three winners in one category.
- VTE risk assessment compliance has consistently exceeded 95% over the last four quarters, with Gynaecology inpatients improving the most in the past year from <70% to 91%.
- Supporting virtual ward / Rapid Response with ensuring VTE risk assessments through education, training and creating a bespoke electronic risk assessment tool
- Development of an electronic record to be shared with ward pharmacists and junior doctors which will show whether patients are on VTE prevention medications and whether there are patients on two therapies inappropriately.

Priorities for 2026/27:

- Working towards VTE exemplar status – areas of improvement include patient information supply and recording. Working to improve this area by working with EPMA team to add a section on VTE prevention and link to the National Thrombosis UK PIL.
- Areas requiring improvement include Spinal Surgery, Trauma & Orthopaedics, and Urology, with updates planned to specialist review proformas.
- Virtual wards (VW) Haringey require implementation of mandatory VTE risk assessments for patients admitted to VW. Training to be conducted with non-medical prescribers to improve risk assessment uptake.
- Rolling audits to assess the quality of VTE prevention prescribing in ward areas
- Peri-operative bridging services – record the number of patients where a plan has been created and shared with surgical teams.
- Root-cause-analysis – investigate use of an AI system (Solventum) used in Newcastle to speed up the process of diagnosis/location of hospital acquired VTEs.

4.5 MEDICINES MANAGEMENT

Medicines Management Audits

Regular medicines management audits provide assurance on the safe and secure handling of medicines across wards, departments and clinics. Monthly nursing and midwifery audits are undertaken using Tendable, supported by quarterly pharmacy spot checks. Areas reviewed include medicines storage, expiry date monitoring, security arrangements and oxygen management.

During 2025/26, audit processes were strengthened through the introduction of joint pharmacy and nursing reviews in higher-risk clinical areas, enabling earlier identification and resolution of medicines safety concerns.

Tendable has improved reporting capability by providing automated reports and action plans, supporting local quality improvement and demonstrating compliance with regulatory standards, including CQC requirements. Further work is underway to strengthen governance arrangements for the reporting, monitoring and completion of audit actions across Divisions.

Medicines management audit results are reviewed through the Medicines Safety Group and reported to the Drug and Therapeutics Committee, providing organisational assurance and oversight of medicines governance. This process supports continuous improvement in medicines safety, storage and handling across the Trust.

Results

The below table shows compliance of wards, departments and clinics.

Division	Q4 25/26	Q3 25/26	Q2 25/26	Q1 25/26
S+C	86%	85%	90%	89%
EIM	85%	84%	92%	90%
CYP	88%	92%	89%	89%
ACW	85%	94%	92%	98%
Total	86%	89%	91%	92%

Table 4 - Medicines Management audit compliance by each Trust Division

All dentist clinics and community sites were audited.

Summary

Safe and secure handling of medicines has seen some improvements across the trust. To enhance the safe storage of medicines further we have implemented the following:

- Phase 2 and 3 of replacing the medicine cabinets is complete, all ward and clinic areas have metal wall cabinets on one lock suite and new CD cabinetry which is compliant to British Standard regulations. This enables better security and tidier storage of medicines.
- Phase 4 will be carried out in 2026 to ensure the floor standing cabinets for TTAS and external products are installed. Bulk item and fluid storage has been improved in some areas with completion planned by the end of 2026.
- Additional areas have cooling systems installed ensuring medicines are kept at an optimum temperature.
- The calibrated thermometers have been replaced.
- Daily tidying of medicine trolleys has seen improvements of managing medicines in some areas.
- Green transfer bags for nurses to use for Patient's own Medicines and discharge medicines (TTAs).

4.6 HOMECARE

Homecare services deliver ongoing medicine supplies and, where necessary, associated care, initiated by the hospital prescriber, direct to the patient’s home with their consent. At the Whittington, our Homecare service provides high-cost medicines used in the management of long-term conditions within Gastroenterology, Rheumatology, Dermatology and Haematology. The graph below illustrates the growing number of patients supported by the Homecare service between 2021 and April 2026.

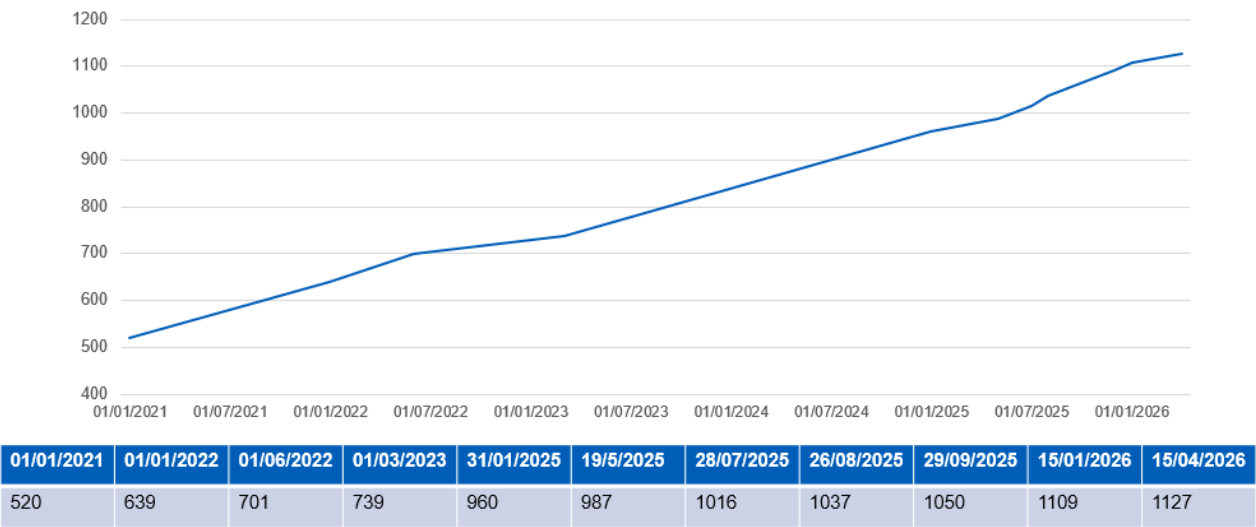


Figure 3. Number of patients under Homecare services at Whittington Health.

This data highlights the continuous growth in patient volume, which significantly contributes to the workload managed by the Pharmacy team.

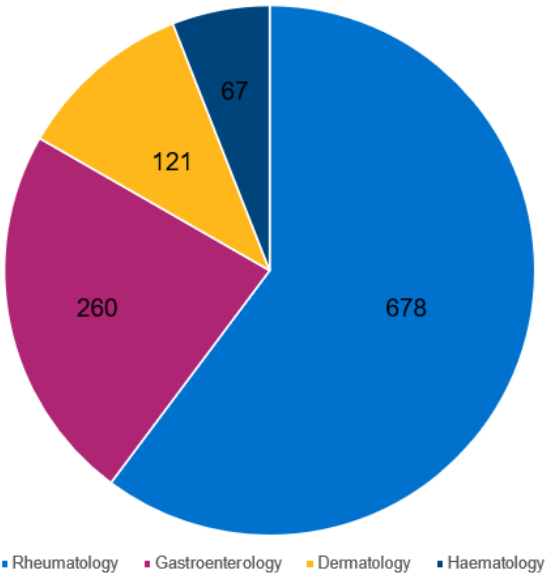


Figure 4. Number of Homecare patients under each Clinical Speciality at Whittington Health.

As of 15/04/2026, Rheumatology (60%) was the top specialty for Whittington Hospital homecare patients, followed by Gastroenterology, Dermatology, and Haematology.

Key Achievements in 2025/26:

- Implementation of the Ustekinumab and Tocilizumab biosimilar pens and syringes for all new patients and eligible patients established on treatment.
- Invest to Save project approved to fund Homecare/Procurement Pharmacy Technician post and enable efficiencies and savings through further Ustekinumab biosimilar switches and other opportunities.
- Previous changes to Rheumatology processes achieved through QI project were embedded into day-to-day practice in 25/26 and improved general efficiency of the service. This has been reflected in key performance indicators and significant reduction in number of patient complaints.

Challenges in 2025/26:

- The inability to establish new Homecare services (such as Infliximab SC and Risankizumab SC for Gastroenterology), driven by limited staffing capacity within the Pharmacy Homecare and Procurement team.

Priorities for 2026/27:

- Strengthen governance:
 - Finalise and seek approval for the Homecare Medicines Policy.
 - Establish a Homecare Oversight Group to provide strategic direction.
 - Update and implement relevant Standard Operating Procedures (SOPs) for managing homecare prescriptions.
 - Implement new Service Level Agreement (SLA for desferrioxamine homecare service).
- Enhance patient experience:
 - Assess current service levels through patient satisfaction surveys and incident reviews to ensure issues are addressed and all RPS standards for Homecare are met.
- Review service capacity and workforce:
 - Evaluate current service needs.
 - Explore funding opportunities from other medical specialties (e.g., Gastroenterology) to support ongoing increases in patient activity.
 - Review staffing structure and identify training and competency requirements to ensure resilience and business continuity.
 - Streamline processes and implement digital solutions (e.g., utilisation of homecare provider portals and exploration of digital prescribing).

4.7 CLINICAL TRIALS

The Clinical Trials (CT) Pharmacy team supports the Trust to carry out robust research, contributing to new clinical knowledge and evaluating new treatments. The Pharmacy team is responsible for the overall management of Investigational Medicinal Products (IMPs).

In line with previous years, during 25/26, 5 new clinical trials involving IMPs were opened in the Trust and supported by the CT Pharmacy team. These included 1 commercial and 4 non-commercial studies across a range of specialties. Additionally, one commercial haematology trial that had previously been inactive became active during the 25/26 year. By the end of 25/26, there were 20 IMP CTs open and supported by pharmacy.

For 26/27, further clinical trials are expected to open at WH with pharmacy input. These include studies evaluating the efficacy of intravenous iron and subcutaneous recombinant erythropoietin in ICU survivors with moderate to severe anaemia, as well as new mental health and paediatric trials.

In addition, the Medicines and Healthcare products Regulatory Agency (MHRA) will introduce updated clinical trials regulations during Spring of 2026. The CT Pharmacy and Research Team will work together to review and implement these changes.

4.8 RESEARCH, AUDIT AND QUALITY IMPROVEMENT

The Pharmacy Department continues to develop and support a culture of research and publication.

Any audit, service evaluation, quality improvement or research project undertaken by pharmacy is registered with Whittington Health Clinical Governance Department.

The table below summarises projects that were completed in 2025/26.

Project Title	Type
Antibiotic Point Prevalent audit (Weekly)	Audit
Antibiotic consumption - Expenditure and Defined Daily Doses (FY 2025/26)	Audit
Controlled drugs audits (annually)	Audit
Medicines management walk about – Adherence to RPS safe and secure guidance	Audit
Non-Medical Prescribers audit	Audit
Inpatient survey to assess the patient experience of pharmacy services	Service Evaluation
Audit to assess the quality of fracture risk and bone health reviews for patients under the Islington REACH falls service	Audit
Audit to assess Adherence to Antibiotic Prescribing on Paediatric Ward in Accordance with Trust Antimicrobial Guideline	Audit
Audit to assess steroid prescribing in accordance with trust's Paediatric Acute Wheeze Guideline	Audit

Audit to assess compliance to the TTA pre-pack policy following Omnicell optimisation in Emergency Dept	Audit
Audit to assess Antimicrobial Stewardship compliance to National IV to Oral switching standards	Audit
Audit to assess the use of Insulin in adult inpatients with Type 2 diabetes	Audit
A Service evaluation/audit of the Timeliness of Medicines Reconciliation following Hospital Admission at Whittington Health	Service Evaluation
Improving and sustaining VTE risk assessment compliance in gynaecology	QI
Improving CD compliance through pharmacist -led education for ward nurses	QI
Improving the efficiency of the non-formulary medicine request process	QI
Reducing the number of stock items dispensed to patients by dispensary	QI
Optimising the delivery of nutrition in critically ill patients sedated with Propofol	QI
Improving the cost and therapeutic effectiveness of Caffeine Citrate in infants with Apnoea of Prematurity	QI

Table 5 – Pharmacy projects in 25/26

Following the introduction of Pharmacy Guidance for Quality Improvement the previous year and a successful QI celebration event in 2025, more teams were able to conduct QI projects leading to an even more successful QI celebration event in March 2026. Many of these projects have been selected to be presented at the Clinical Pharmacy Congress 2026 and the Trust QI Day.

This year more of the projects demonstrated core QI principles, however they were predominantly led by pharmacists. Going forward we are hoping to engage more with our technical workforce. A departmental 'Introduction to QI' session led by the trust QI lead in June 2026 will aim to upskill technicians to get more involved.

4.9 EXTERNAL ASSESSMENTS

External Regional Quality Assurance Audit Report of Aseptic Preparation

The Regional Quality Assurance Team visited the Whittington Aseptic Unit in July 2025 following refurbishment and validation work. The Unit was praised for its high-quality build, diligence and achievements, with all inspection observations addressed. A further audit in accordance with EL (97)52 was undertaken in April 2026 and rated the unit as **low risk** to patient safety, recognising the team's professionalism, openness and successful implementation of major upgrades. An action plan will address any remaining deficiencies.

For more details, see section 4.1.2 (Cancer Services – Key achievements).

Medicines Management Initiatives – CQC & Internal Audit

A CQC inspection within the Emergency Department took place in October 2025. Medicines optimisation was scored as a good standard of care. There were appropriate arrangements for the safe management and oversight of medicines, although the CQC identified some areas for improvement relating to pharmacy returns of patient own medications. Actions have now been implemented to ensure timely storage and return of patient own medicines. It was noted that the approach to medicines management reflected current professional guidance and best practice. Medicines were prescribed, supplied, and administered in line with relevant legislation, national guidance, and the Mental Capacity Act 2005.

Regular quality audits (mock-CQC visits) have taken place across the trust. These visits have representation by Lead Pharmacists and/or the Medicine Management Lead Nurse to ensure standards related to safe and secure handling of medicines are adhered to. An action tracker has been created to ensure actions are followed up on and change implemented when appropriate. Improvements are also recommended to clinical teams, which have senior and divisional oversight.

A peer review with Royal National Orthopaedic Hospital is scheduled for April 2026 focussing on key areas in the acute hospital as well as within the community reviewing medicines management.

The 2025 CQC engagement call focused on key areas where pharmacy provided updates on the following:

1. Outlining how we use any AI tools to support medication safety.
2. Outlining how as a pharmacy team we support safe transfer of care, how patients are supported on admission, medicines reconciliation process and discharge processes.
3. Overall strategy relating to medicines optimisation, the pharmacy workforce, departmental objectives, antimicrobial stewardship and pharmacy related quality improvement projects.

4.10 PATIENT EXPERIENCE

As part of the Trust wide approach to delivering the best patient experience for WH service users, the WH pharmacy team undertake inpatient experience surveys on a bimonthly basis. Service users will be spoken to by a member of the Pharmacy team and asked about their experience of using the pharmacy services on wards at WH. The survey questions are based loosely on the medication related questions of the CQC inpatient survey.

Throughout May 25 – Nov 25 (Figure 5) the number of responses remained consistent at approx. 50, except for September when the response rate dipped to 23. Although patients reported they were generally satisfied with the inpatient pharmacy service there was variability with the responses to the other questions. Explaining the side effects of medications to patients continues to be a challenging area.

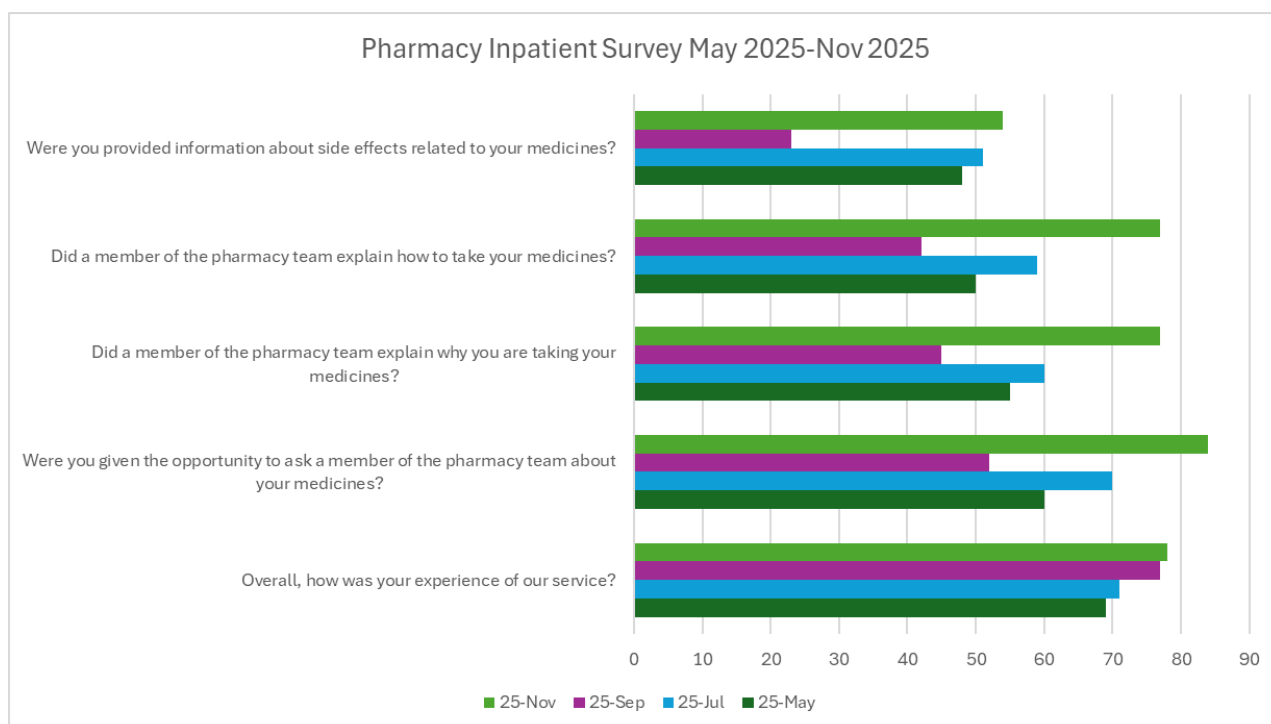


Figure 5. Pharmacy inpatient survey May 2025 – Nov 25

At the end of 2025 the questions were reviewed and simplified (Figure 6). Although the overall satisfaction with the service remained similar to before, the review patients reported that there was greater interaction with the pharmacy team. Going forward we are hoping to conduct ‘Person-centred care’ training to equip more pharmacy staff to have meaningful conversations with patients

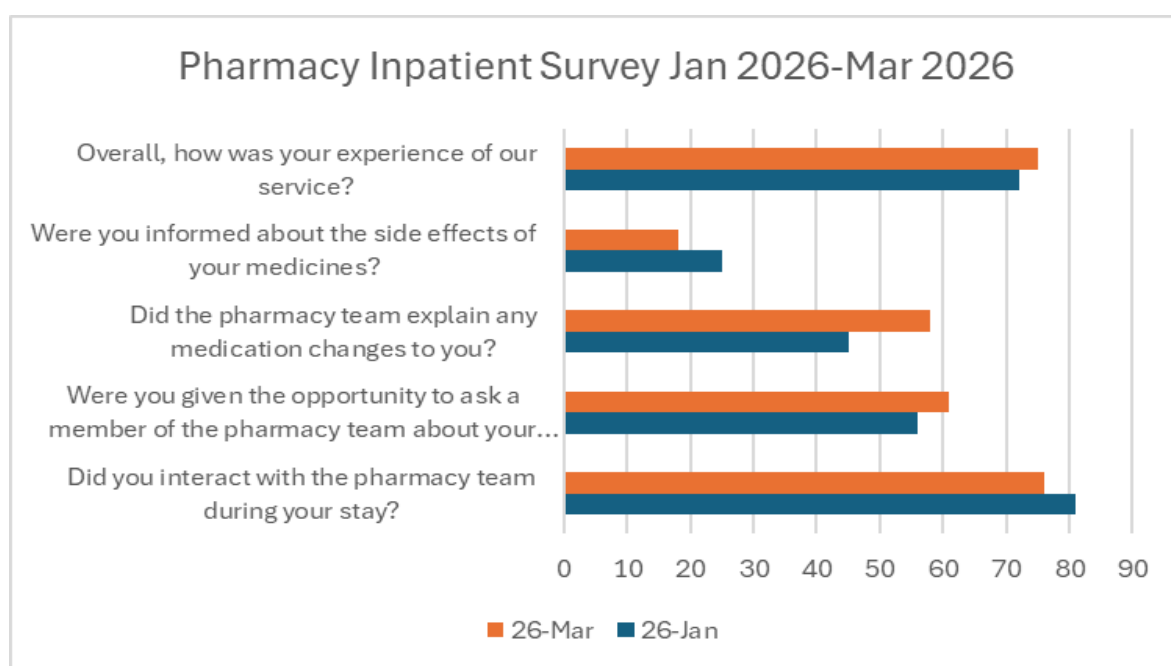


Figure 6. Pharmacy inpatient survey Jan 2026 – Mar 26

5.0 DIGITAL TRANSFORMATION

The Pharmacy Digital and Informatics (PDI) Team continued to drive the digital transformation of medicines optimisation services across Whittington Health during 2025/26. Through the development of innovative digital solutions, enhanced reporting capabilities and modernisation of core pharmacy infrastructure, the team has improved operational efficiency, strengthened governance, enhanced patient experience and supported safer, more effective use of medicines across acute and community services.

Pharmacy Robotics Replacement & Pharmacy Modernisation Programme

The Trust's robotic dispensing systems (RDS) are fundamental to the medicines supply infrastructure, supporting both inpatient and outpatient pharmacy services. As the existing robotic infrastructure are over 10 years old and has reached end of life, a major Pharmacy Modernisation Programme was approved to upgrade the RDS and redesign the pharmacy dispensary and distribution areas, which have remained largely unchanged for over 25 years.

Significant progress has been made during 2025/26, including:

- Completion of detailed capacity modelling to ensure future robotic systems can accommodate projected activity across inpatient and outpatient services.
- Procurement of two state-of-the-art robotic dispensing systems.
- Completion of the design phase for the modernised dispensary and distribution areas.
- Development of redesigned workflows to maximise automation, productivity, efficiency and patient safety.

Implementation is planned during Summer 2026, with the modernised pharmacy infrastructure and new RDS expected to be fully operational by the end of 2026

ARiM to PIC upgrade

As a prerequisite for the introduction of the new RDS, the department successfully migrated from the legacy ARiM platform to Omnicell PIC software in January 2026.

The upgrade was implemented across both inpatient and outpatient robotic systems, improving system functionality, enhancing resilience and ensuring compatibility with the next generation of robotic technology. Staff training has been fully embedded into routine operational practice.

Community Services Digital Expansion

Digital transformation has continued across community services with the successful implementation of Phase 2 of CLEO SOLO electronic FP10 prescribing. The system enables prescribers to issue prescriptions electronically across a wider range of community settings, reducing administrative burden, improving efficiency and supporting safer prescribing processes.

Outpatient Pharmacy Digital Innovation - Launch of CIC PTS kiosk

The Pharmacy Digital and Informatics Team worked collaboratively with TMS Insight to develop and launch a self-service Prescription Tracking System (PTS) kiosk within Whittington Pharmacy Community Interest Company (CIC) i.e. Outpatients Pharmacy.

The kiosk enables patients to electronically register prescriptions on arrival, reducing queues and waiting times while allowing pharmacy staff to focus their attention on patients requiring additional support. The initiative has improved patient flow, enhanced the outpatient experience and supports the wider digital ambitions of the CIC.

Optimisation of Medicines Supply Processes - RXSELECT modifications

A significant redesign of the CMM RXSELECT ordering and dispensing template was completed during the year. Enhancements included automated identification of ward stock items, improved visibility of supply routes and clearer identification of re-dispensed medicines on the RXSELECT sheet used for dispensing purposes.

The project has improved workflow efficiency within dispensary and distribution services, reduced manual processing and strengthened governance surrounding medicines supply. Outcomes from the project were subsequently presented as a departmental Quality Improvement initiative.

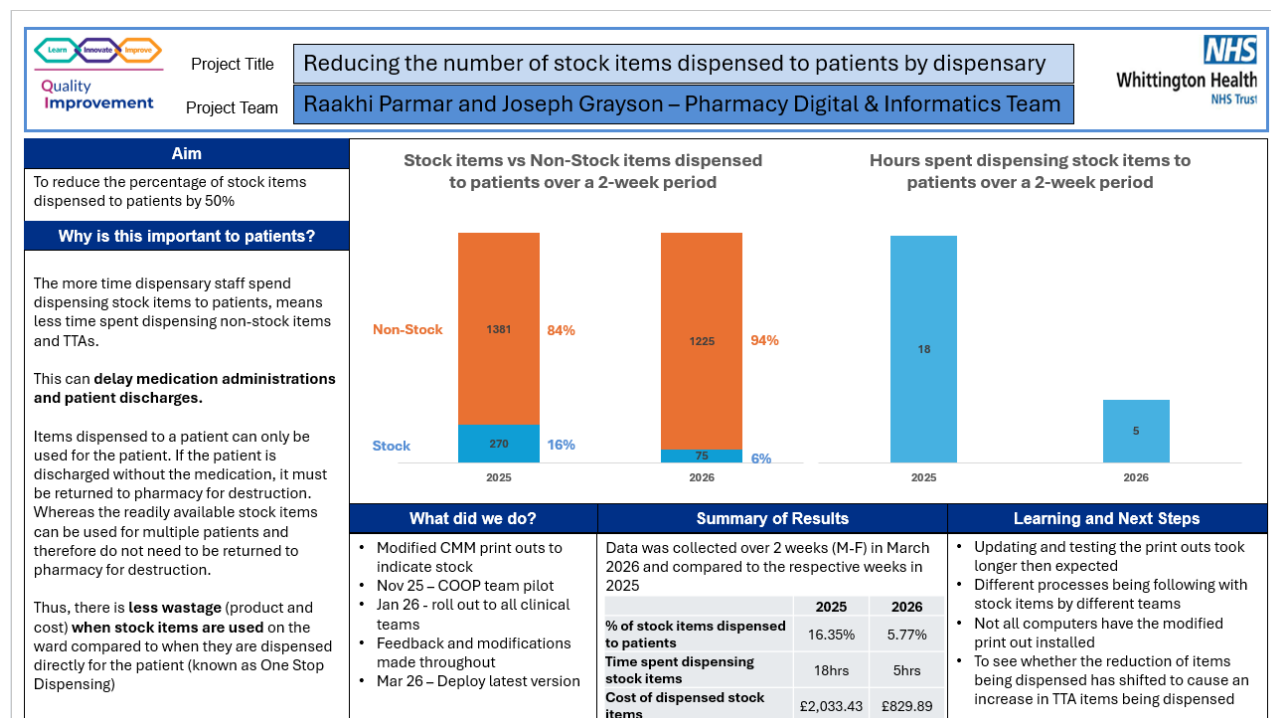


Figure 7. QI Project: Reducing the number of stock items dispensed to patients by Dispensary

Digital Transfer of Care - PharmOutcomes and Discharge Medicines Service

Electronic referral of patients to community pharmacies through PharmOutcomes remains fully embedded within discharge processes. The system supports the NHS Discharge Medicines Service by enabling seamless transfer of medicines-related information between hospital and community pharmacy teams.

During 2025/26, Whittington Health continued to achieve some of the highest referral rates across North Central London (consistently above 8% target), demonstrating strong adoption of the service and supporting safer transitions of care following hospital discharge.

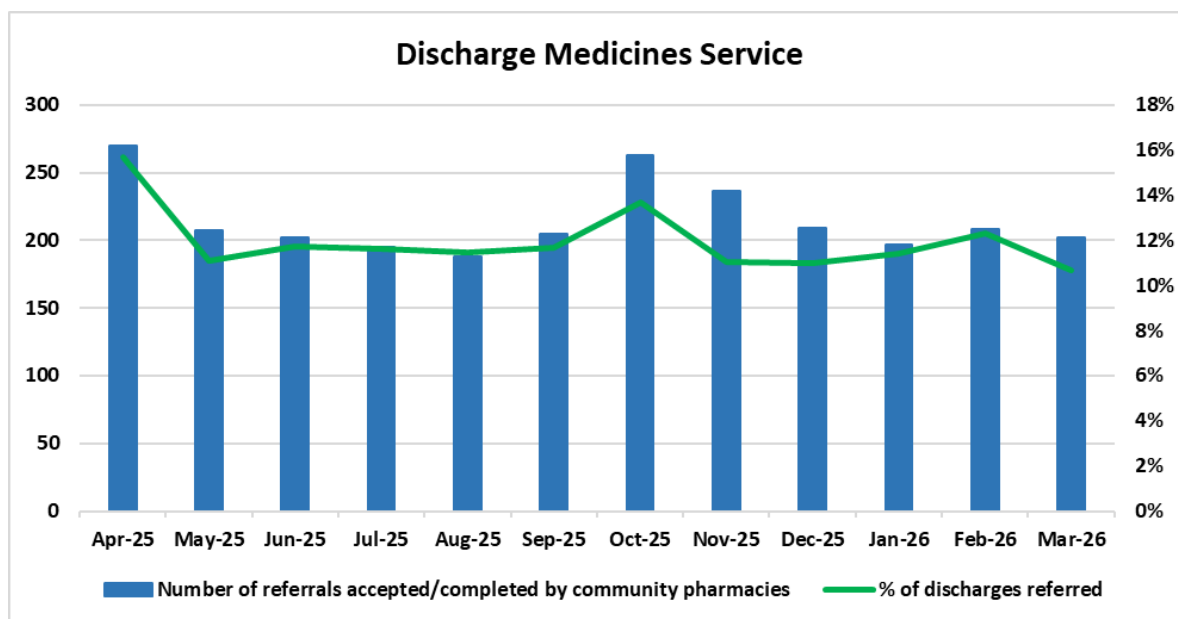


Figure 8. Patient referrals to community pharmacy via Discharge Medicines Service (DMS)

Reporting and Informatics

The Pharmacy Digital and Informatic team continues to develop and manage pharmacy reporting solutions in-house, with increasing use of Power BI to support operational management, financial governance and clinical service improvement.

Medicines Finance Dashboard

A comprehensive [Medicines Finance Dashboard](#) was launched during 2025/26, providing near real-time visibility of medicines expenditure across the Trust.

Key benefits achieved include:

- Improved transparency of medicines expenditure.
- Standardised reporting across clinical divisions.
- Enhanced ability to identify expenditure trends and cost pressures.
- Greater engagement with clinical teams regarding medicines optimisation.
- Identification of approximately £100,000 per annum in duplicated reporting through improved financial reporting accuracy.

The dashboard now forms a key component of medicines financial governance and supports delivery of the Trust's Cost Improvement Programme objectives.

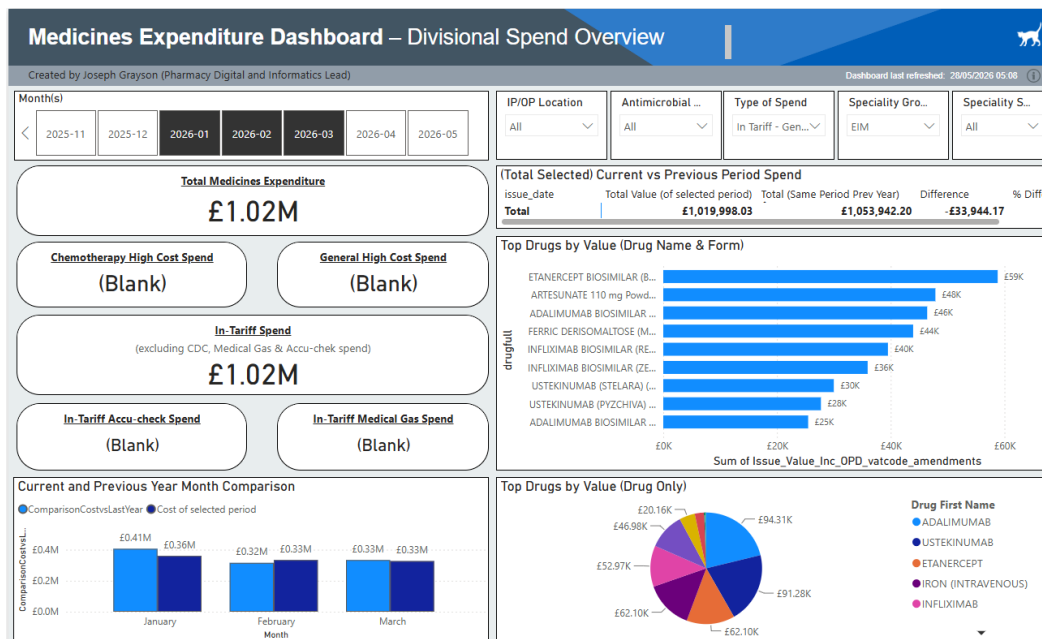


Figure 9. Medicines Expenditure Dashboard

OPAT/COpAT Point Prevalence Dashboard

Working collaboratively with the Antimicrobial Stewardship Team, the Pharmacy Digital and Informatics Team developed an OPAT/COpAT Point Prevalence Dashboard to support benchmarking of antimicrobial prescribing and clinical outcomes across NHS organisations. Anonymised data was submitted by different Trusts via a Microsoft Form.

The project was presented nationally at the British Society of Antimicrobial Chemotherapy Conference and has subsequently secured support to progress as a national pilot programme. This work demonstrates the growing role of digital analytics in supporting research, service improvement and antimicrobial stewardship.

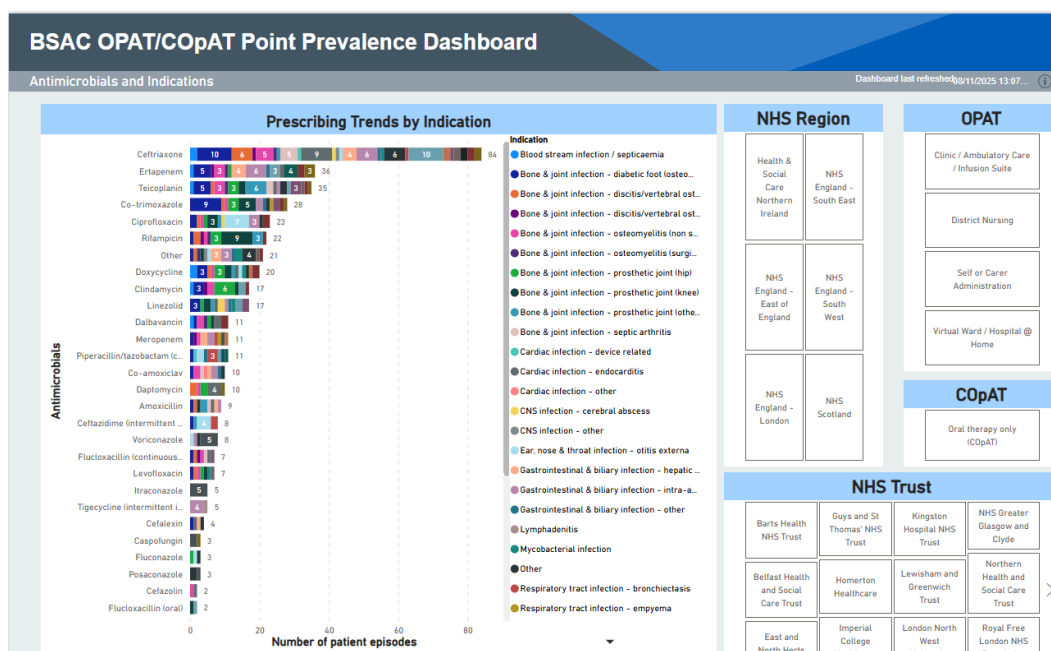


Figure 10. BSAC OPAT/COpAT Point Prevalence Dashboard

'Where's My TTA' Dashboard

To support patient flow and improve discharge processes, the Pharmacy Digital and Informatics Lead developed the 'Where's My TTA?' dashboard. The dashboard provides real-time visibility of discharge prescriptions throughout the entire dispensing journey, from prescribing through to delivery to the ward.

Initial pilot implementation on Thorogood ward has received positive feedback from ward teams and discharge coordinators. Benefits include:

- Improved transparency of discharge processes.
- Reduced delays and duplicate enquiries.
- Enhanced communication between clinical teams and pharmacy.
- Better support for timely patient discharge.

Trust-wide implementation is planned during 2026/27.

Where's My TTA – Search by ward

Created by Joseph Grayson - Pharmacy Digital and Informatics Lead

Dashboard last refreshed: 29/05/2026 08:25:00

Select Ward

All

ward	hospital_no	CMM_Full name	No of CD's	Prescription_Type	TTA_Status_Message
CAVELL			1		[Status]: TTA started, but not marked as complete by the Prescriber [Contact/Who to chase]: Prescriber - ask to review TTA
CAVELL			0	TTO	[Status]: A Prescriber has made a change or addition has been made to the TTA since the Pharmacist last reviewed it [Contact/Who to chase]: V inform them of amendment
CAVELL			0		[Status]: TTA started by Dieticians but no prescriber has reviewed the TTA [Contact/Who to chase]: Prescriber - ask to review TTA
CAVELL			0		[Status]: TTA written and checked by the Pharmacist but not booked into the Inpatient Dispensary [Contact/Who to chase]: Ward Pharmacist o
CAVELL			0		[Status]: TTA started, but not marked as complete by the Prescriber [Contact/Who to chase]: Prescriber - ask to review TTA
CAVELL			3	TTO	[Status]: TTA Delivered to ward before today on 28/05/2026 @ 17:24:54 [Contact/Who to chase]: Check TTA Cupboards/Patient POD locker. TTA today's date by the Inpatient Dispensary so it should already be on the ward. If not found contact ward Pharmacist/Technician
CAVELL			0		[Status]: TTA written and checked by the Pharmacist but not booked into the Inpatient Dispensary [Contact/Who to chase]: Ward Pharmacist o
CAVELL			2		[Status]: TTA written and completed by the Prescriber but not checked by the pharmacist [Contact/Who to chase]: Ward Pharmacist - ask to ch
CAVELL			0		[Status]: TTA written and checked by the Pharmacist but not booked into the Inpatient Dispensary [Contact/Who to chase]: Ward Pharmacist o
CAVELL			0		[Status]: TTA started by SALT but no prescriber has reviewed the TTA [Contact/Who to chase]: Prescriber - ask to review TTA
CAVELL			0	TTO	[Status]: TTA Delivered to ward before today on 28/05/2026 @ 18:36:38 [Contact/Who to chase]: Check TTA Cupboards/Patient POD locker. TTA today's date by the Inpatient Dispensary so it should already be on the ward. If not found contact ward Pharmacist/Technician
CELLIER MOTHERS			0	TTA Dispensing on the Ward	[Status]: TTA Delivered to ward before today on 27/05/2026 @ 12:05:48 [Contact/Who to chase]: Check TTA Cupboards/Patient POD locker. TTA today's date by the Inpatient Dispensary so it should already be on the ward. If not found contact ward Pharmacist/Technician
CELLIER MOTHERS			0	TTA Dispensing on the Ward	[Status]: TTA Delivered to ward before today on 27/05/2026 @ 12:05:48 [Contact/Who to chase]: Check TTA Cupboards/Patient POD locker. TTA today's date by the Inpatient Dispensary so it should already be on the ward. If not found contact ward Pharmacist/Technician
CELLIER MOTHERS			0	TTA Dispensing on the Ward	[Status]: TTA Delivered to ward before today on 28/05/2026 @ 12:34:09 [Contact/Who to chase]: Check TTA Cupboards/Patient POD locker. TTA today's date by the Inpatient Dispensary so it should already be on the ward. If not found contact ward Pharmacist/Technician
CELLIER MOTHERS			0	TTA Dispensing on the Ward	[Status]: TTA Delivered to ward before today on 27/05/2026 @ 12:05:48 [Contact/Who to chase]: Check TTA Cupboards/Patient POD locker. TTA today's date by the Inpatient Dispensary so it should already be on the ward. If not found contact ward Pharmacist/Technician
CELLIER MOTHERS			0	TTA Dispensing on the Ward	[Status]: TTA Delivered to ward before today on 28/05/2026 @ 12:34:09 [Contact/Who to chase]: Check TTA Cupboards/Patient POD locker. TTA today's date by the Inpatient Dispensary so it should already be on the ward. If not found contact ward Pharmacist/Technician
CELLIER MOTHERS			0		[Status]: TTA written and completed by the Prescriber but not checked by the pharmacist [Contact/Who to chase]: Ward Pharmacist - ask to ch
CLOUDESLEY			0		[Status]: TTA started, but not marked as complete by the Prescriber [Contact/Who to chase]: Prescriber - ask to review TTA

Figure 11. 'Where's My TTA' Dashboard

6.0 FINANCIAL PERFORMANCE

Financial stewardship was a key priority during 2025/26, ensuring the safe, sustainable and cost-effective use of medicines across the Trust. Despite continued growth in medicines expenditure, driven by increasing clinical activity and high-cost therapies, robust financial management, procurement initiatives and medicines optimisation programmes delivered significant efficiencies while supporting high-quality patient care and contributing to the Trust's wider Cost Improvement Plan and sustainability objectives.

Medicines expenditure in 2025/26 is summarised in table 6 and figure 12 below:

	2025/26	2024/25	Variance (£)	Variance (%)
National Tariff excluded Drugs ('High-Cost')	£14,356,358	£12,709,090	£1,647,268	13.0%
General 'in-tariff' medicines	£5,659,322	£5,707,858	£-48,536	-0.9%
Medical Gases (In-tariff)	£414,303	£439,503	£-25,200	-5.7%
Total	£20,429,983	£18,856,451	£1,573,532	8.3%

Table 6 - Medicines expenditure in 25/26

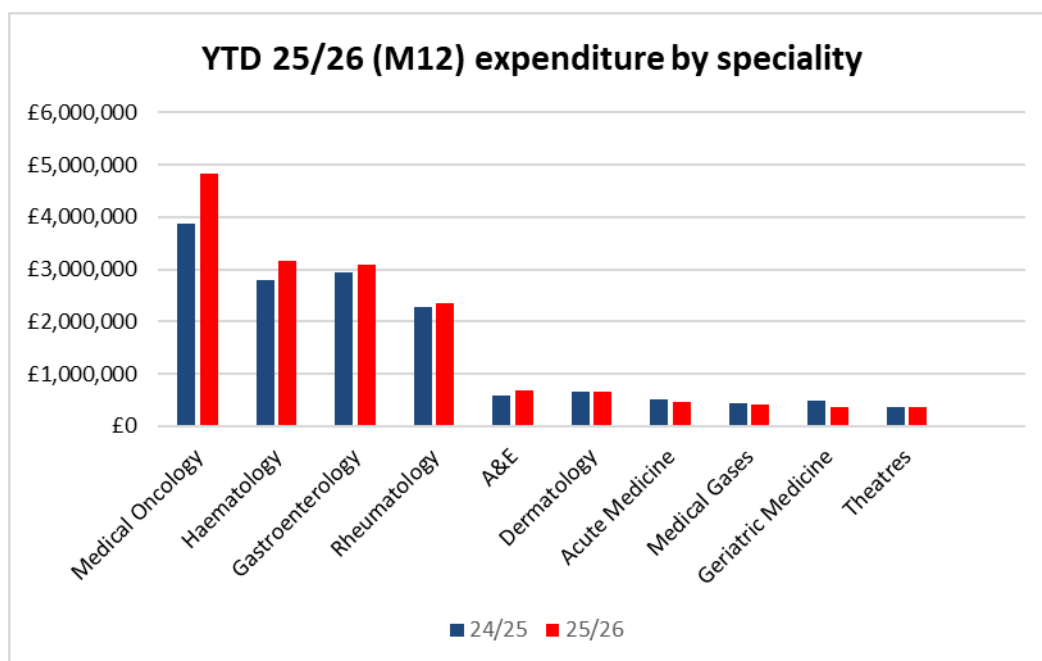


Figure 12: 24/25 vs 25/26 expenditure by speciality

Total medicines expenditure increased by **8.3%** in 2025/26 compared with 2024/25 (Table 6), primarily due to increased expenditure on **National Tariff Excluded Drugs (NTEds)**.

Medical Oncology, Haematology, Gastroenterology and Rheumatology remained the highest spending specialties, reflecting increasing use of high-cost biologic medicines and

systemic anti-cancer therapies. Expenditure within Medical Oncology and Haematology increased significantly owing to higher clinical activity and the temporary purchase of commercially prepared chemotherapy products while the Trust's aseptic unit was closed. Following the partial reopening of the aseptic unit in December 2025, oncology medicines expenditure has reduced progressively.

Gastroenterology expenditure also increased modestly despite the successful introduction of lower-cost ustekinumab biosimilars. This reflected increasing clinical activity and greater use of other high-cost biologic therapies, including vedolizumab.

In contrast, expenditure on **in-tariff medicines decreased by 0.9%**—the first reduction for several years—despite inflationary pressures affecting medicines such as contrast media. Reduced expenditure in areas including Acute Medicine and Geriatric Medicine reflected a range of medicines optimisation initiatives delivered during the year. These included procurement improvements, supplier contract optimisation and increased use of lower-cost generic medicines, generating more than **£270,000** of in-tariff savings.

Cost Improvement Programme (CIP)

During 2025/26, the Pharmacy team identified and delivered a wide range of medicines optimisation initiatives that generated savings for both the Trust and the wider North Central London system. These included Trust Cost Improvement Programme schemes alongside system-wide initiatives, delivered across inpatient, outpatient and homecare services.

Overall, medicines optimisation initiatives delivered approximately **£875,000** in savings during 2025/26.

Planning for 2026/27 has focused on identifying additional opportunities to support delivery of the Trust's Cost Improvement Programme while maintaining high-quality, evidence-based patient care.

Medicines Finance Dashboard and Divisional Reporting

In January 2026, Pharmacy launched a new Medicines Finance Dashboard to support routine monitoring and reporting of medicines expenditure across the Trust.

The dashboard provides more timely, consistent and accurate financial information, enabling quarterly review of medicines expenditure within each Division. It has already supported targeted reviews of medicines, including intravenous iron and gastroenterology biologics, identifying opportunities for further optimisation.

During 2026/27, the dashboard will be fully embedded within routine financial governance, supporting regular engagement with Divisions to identify medicines optimisation opportunities, improve financial oversight and inform future service planning.

Further information on the digital development of the Medicines Finance Dashboard is provided in Section 5.

7.0 IMPROVEMENT AND INNOVATION

7.1 SERVICE IMPROVEMENT AND INNOVATION

The Pharmacy team have worked on several projects which have enhanced our efficiency and improved patient care and safety. Some examples below:

- **Medicines Finance Dashboard** – newly implemented tool to support review of medicines spend across the Trust. See section 5 for more details.
- **On-call Consultation** – reviewed Pharmacy on-call service provision, supporting supply of out of hours medication and clinical advice.
- **Phase 2 Implementation of new medicines cabinets and controlled drug cabinetry across the Trust** – to support compliance of safe and effective medicines and controlled drugs storage.
- **Medicines Transformation Project** - supporting productivity and efficiency through reducing avoidable medicines waste. See section 7.3 for more details.
- **Aseptic Unit Transformation Project** – new isolator implemented and key changes such as integrating VHP gassing technology and switching the isolator to positive pressure. For more details, see section 4.1.2 (Cancer Services – Key achievements).

7.2 INNOVATIVE PHARMACY ROLES

Whittington Health Pharmacy department has a number of innovative roles and has made significant progress in developing roles to support the integrated care agenda.

In 25/26, the following roles have been developed through establishment review, restructures and successful business cases which have recruited to.

- **B5 Clinical Trials Pharmacy Technician (Sept 2025)** – new full-time role (previously 0.5WTE) approved to support growing clinical trials activity in line with the trust's research strategy. This has led to significant improvement in governance and patient care, as well as increased collaboration with the MDT.
- **B5 Homecare & Procurement Pharmacy Technician (Apr 2026)** – new full time post funded through an 'invest to save' project (previously 0.5WTE), aiming to generate operational efficiencies and medicines savings.
- **Band 6 Technical Services Senior Technician** – new full time post funded through business case, aiming to support increased workload within technical services and provide senior leadership to the team.

7.3 MEDICINES AND SUSTAINABILITY

Sustainability is an area that has received increased attention in Pharmacy as well as Trust wide over the past couple of years in line with supporting a greener NHS. As part of the Pharmacy 2025/26 departmental priorities, we developed a Medicines Transformation Programme which focussed on supporting productivity and efficiency through reducing avoidable medicines waste.

The Medicines Transformation Programme consisted of 3 workstreams:

1. **Reducing Medicines & Overall Waste:** To achieve zero avoidable medicines waste across the Trust by optimising stock management & procurement, enhancing medicines use, supporting safe prescribing, & empowering staff & patients—driven by data, digital tools, & research. Minimise non-recyclable materials, promote recycling, cut carbon emissions, & stimulate cost-efficient, sustainable pharmacy practices.
2. **Improving Workflow & Workforce Productivity & Efficiency through** process innovation & better resource utilisation creating a highly efficient, digitally enabled workforce.
3. **Determining Medicine Saving opportunities:** Review all potential opportunities at a Divisional level to reduce medicines expenditure driven by data, digital tools & QI/audit.

Reducing Medicines Related Waste	Improving Workflow & Workforce Productivity & Efficiency	Determining Medicine Saving opportunities
• Priority 1: Optimise Stock Management • Priority 2: Optimise Medicines Management at Ward Level • Priority 3: Optimise Prescribing • Priority 4: Promote a 'Greener' Sustainable Pharmacy Working Environment	• Priority 1: Refresh Pharmacy Scorecard • Priority 2: Digitise manual forms & paper-based processes • Priority 3: Eliminate/Streamline redundant processes or duplicated tasks • Priority 4: Optimise Procurement Processes	• Priority 1: Divisional Financial Dashboard • Priority 2: Review of CIPs • Priority 3: Review CIPs – CMU contract changes • Priority 4: Review of Define/Refine & Extend +

Figure 13: Medicines Transformation Programme workstreams and priorities.

Reducing Medicines Related Waste

The work delivered across stock optimisation, ward-level medicines management, prescribing improvement and greener pharmacy initiatives shows a clear pattern: tighter controls, smarter use of data, and targeted behaviour change have reduced waste, improved efficiency and generated meaningful financial savings. Stock reviews, expiry monitoring, RxSelect enhancements and focused communications have reset ward stock

levels, reduced duplication and strengthened POD (patient own drug) use. These actions alone have already produced measurable gains — including avoided duplicate TTAs, reduced unnecessary weekend resupply, and rationalised EDC stock. At ward level, strengthened POD processes, improved returns management and shifting operational tasks (e.g., chlorhexidine ordering, feed ordering trials) have reduced pharmacy workload and prevented unnecessary dispensing.

Prescribing-focused projects have laid the groundwork for further cost and carbon reductions through non-formulary switches, intravenous-to-oral (IV-to-PO) conversion, liquid-to-solid optimisation, OTC (over the counter) discharge controls and deprescribing. Meanwhile, greener-pharmacy initiatives — including RPS Bronze progress, plastic reduction, inhaler recycling and targeted product switches — have reduced environmental impact and prepared the Trust for higher-level sustainability accreditation.

Improving Workflow & Workforce Productivity and Efficiency

The refreshed pharmacy scorecard, updated procurement forms and streamlined borrowing process have strengthened governance, reduced paperwork and improved workflow efficiency across the service. Regular scorecard reporting now provides clearer visibility of performance trends and operational pressures, while redesigned forms have improved auditability and reduced administrative burden. The move toward digital processes — including electronic DOAC forms and a review of wider system constraints — has clarified future EPMA priorities and supports long-term planning for further digitisation.

Workforce planning has been embedded into the Pharmacy Workforce Strategy, improving alignment between staffing and service demand and laying the foundation for future productivity measures. Collectively, these achievements have enhanced governance, reduced delays, improved cooperation between sites, and strengthened staff morale — contributing to a more efficient, responsive and future-ready pharmacy service.

Determining Medicine Saving Opportunities

The development of the medicines spend dashboard, supported by validated CMM data, structured training and quarterly divisional reviews, has significantly strengthened financial governance. Divisions now have clearer visibility of spend trends, improved reporting methodology and defined action plans, contributing to more efficient analysis and an estimated £100k benefit from removing duplicating transactions. Alongside this, systematic CIP reviews — including cross-trust benchmarking and an approved Invest to Save proposal — have generated a combined £893k benefit across Trust and system partners, with over 70 opportunities explored during 25/26.

Contract management has also improved through proactive implementation of CMU contract changes, monthly monitoring and tighter oversight of off-contract purchasing, achieving over 85% variance auditing. Digital benchmarking tools such as DEFINE/REFINE and Exend+ have been embedded into spend reviews, enabling clearer identification of variation and targeted improvement actions. Together, these achievements have enhanced financial stewardship, accelerated savings delivery and strengthened the Trust's ability to plan, benchmark and optimise medicines expenditure.

8.0 EDUCATION, TRAINING AND WORKFORCE

Education, training and workforce development remained a strategic priority during 2025/26, supporting the continued transformation of pharmacy practice and delivery of high-quality patient care. Investment in training, independent prescribing, leadership development and career progression strengthened the capability of pharmacists, pharmacy technicians and support staff, ensuring the workforce is well prepared to meet future service demands across acute, community and integrated care settings.

Undergraduate Students

Whittington Health continues to support undergraduate pharmacy education by hosting students from all four years of the UCL MPharm programme. Placements are tailored to each year of study, progressing from introductory patient care experiences to clinically focused placements that develop professional and clinical skills.

To enhance learning, the department has developed bespoke workbooks for third- and fourth-year students, complementing the UCL curriculum with structured learning activities and feedback. Clear feedback pathways have also been established for students and supervisors, enabling continuous improvement of future placements.

Trainee Pharmacists

During 2025/26, the department supported four trainee pharmacists, including three on NHSE-funded cross-sector programmes incorporating placements within General Practice. Cross-sector training continues to provide valuable experience across primary and secondary care.

This year also marked the introduction of independent prescribing training for trainee pharmacists, in line with the General Pharmaceutical Council's Initial Education and Training Standards. All trainees successfully completed the required supervised prescribing practice across both sectors and are expected to register as independent prescribers from August 2026. Feedback through the NHSE National Education and Training Survey confirmed Whittington Health as a highly regarded training organisation.

Clinical Pharmacy Diplomas

Supporting postgraduate education remains a priority. Junior pharmacists are encouraged to complete a postgraduate diploma in clinical pharmacy practice before progressing to independent prescribing qualifications.

During 2025/26, sixteen pharmacists were supported through the UCL Diploma in General Pharmacy Practice, with an additional pharmacist completing a programme at Keele University. Financial support, educational supervision and protected learning continue to underpin successful completion.

Apprenticeships and Pre-registration Trainee Pharmacy Technicians

Education and training for pharmacy technicians continues to expand. Educational and Practice Supervisors work collaboratively to support Level 2 and Level 3 learners, with approximately half of the pharmacy technician workforce now holding Educational Supervisor qualifications.

The department achieved full General Pharmaceutical Council compliance for pharmacy support staff training requirements. Three new pre-registration trainee pharmacy technicians commenced their two-year apprenticeship programme during 2025/26, while the previous cohort successfully completed training, with one joining the Trust as a Homecare and Procurement Pharmacy Technician.

Although the department has successfully contributed to cross-sector technician training, changes to the national training model mean these placements will not continue beyond the current programme.

Local Faculty Group

Local Faculty Groups form part of the governance structure for the education and training of trainee pharmacists and pre-registration trainee pharmacy technicians.

The Pharmacy Local Faculty Group met three times during the year to oversee education and training for trainee pharmacists and pharmacy technicians.

The group continues to provide effective governance and has supported the development of new training opportunities such as:

- Additional technician rotations within district nursing services and Clinical Trials
- Improvements to Surgery and Women's & Children's clinical rotation programmes based on trainee feedback.

Training Programmes

The department continued to invest in professional development by supporting staff to undertake a range of internal and external educational programmes. In 25/26 we supported the following courses:

- Mary Seacole Leadership programme
- Rosalind Franklin leadership programme
- MSc in Advanced Clinical Pharmacy - Bath University
- Understanding Microbiology for Aseptic services – Leeds University
- Supervisory skills for technical services - Leeds University

These programmes continue to strengthen leadership capability, specialist expertise and succession planning across the department.

Non-Medical Prescribing (NMP) Qualification for Pharmacists

Expanding pharmacist independent prescribing remains a strategic priority.

During 2025/26, five pharmacists successfully completed independent prescribing qualifications, increasing the Trust's live register to 18 active pharmacist prescribers. Many are now practising within the Advanced Generalist Scope of Practice.

With newly qualified pharmacists registering as prescribers from August 2026, the department has worked collaboratively across North Central London to develop a general prescribing scope for Newly Qualified Pharmacist Prescribers. This framework will support safe, supervised prescribing while ensuring consistency across the region.

Workforce Development

The Education and Training team has continued to support career development across all staff groups through clearly defined development pathways for pharmacists, pharmacy technicians and pharmacy support staff.

These pathways have been incorporated into induction programmes, displayed within departmental learning resources and embedded within line management processes to facilitate career conversations and professional development planning.

This work supports recruitment, retention and succession planning while helping staff understand opportunities for progression throughout their careers.

Staff Survey

The 2025 Picker National Pharmacy Staff Survey achieved a response rate of 66%.

Performance improved across all nine People Promise domains, with particularly positive improvements in morale, teamwork, learning, recognition and reward.

Results were shared through departmental wellbeing forums, enabling staff to identify priorities for improvement. An action plan has subsequently been developed focusing on key areas:

- Equity of work allocation
- MMPT management of medicine reconciliation and TTAs
- Being heard and recognised
- Team involvement in QI projects
- Refurbishment of men's toilet
- Signposting to mental health well-being resources

Monthly wellbeing forums introduced following previous staff feedback have continued and remain well supported, demonstrating the department's ongoing commitment to staff wellbeing, engagement and continuous improvement.

9.0 WHITTINGTON PHARMACY COMMUNITY INTEREST COMPANY

Whittington Pharmacy CIC (WPCIC) is a modern outpatient pharmacy located within Whittington Health NHS Trust, providing a safe, efficient and patient-centred dispensing service. As a wholly owned Community Interest Company operating on a not-for-profit basis, all surpluses are reinvested into local healthcare services, supporting improvements that directly benefit patients and the wider community.

The pharmacy dispenses outpatient prescriptions issued by the Trust and offers a comprehensive range of over-the-counter medicines and retail products, promoting self-care while supporting the diverse needs of patients, visitors and staff.

During 2025/26, WPCIC dispensed over **96,000 prescription items** for more than **57,000 outpatients and Emergency Department attendees**. Average prescription waiting time was **18.8 minutes**, exceeding the agreed service standard. Pharmacists also resolved more than **2,000 clinical prescribing queries**, working closely with clinical teams to ensure prescribing complied with local and national guidance and supporting safe, timely patient care.

The annual Community Interest Company Report (CIC34) demonstrated continued financial stability, with a small operating surplus generated during the year. As in previous years, all profits will be reinvested to support service development and enhance patient care. Retail offerings were also refreshed to better meet the needs of patients, staff and the local community.

Workforce development remained a priority, with colleagues supported to undertake accredited dispensing and independent prescribing qualifications. The pharmacy also continued to provide placements for trainee pharmacists and undergraduate pharmacy students, contributing to the education and development of the future pharmacy workforce.

A pharmacist-led prescribing clinic, established in partnership with the Rheumatology Department, continued to develop successfully. Independent Prescribing Pharmacists now deliver two clinics each week, reducing prescribing workload within Rheumatology while improving patient access to treatment and supporting more efficient clinical pathways. Plans are in place to expand this model to additional patient groups.

Patient experience remained consistently positive, with more than **80% of respondents reporting they were satisfied or very satisfied** with the service. Continued use of the Prescription Tracking System (PTS5) has transformed the outpatient dispensing process, with over **80% of patients** using self-service kiosks to register prescriptions. This has reduced queueing, improved workflow and enabled staff to prioritise patients requiring additional support. A text messaging service was also introduced to notify patients when prescriptions are ready for collection and to gather feedback, further enhancing convenience and service quality.



Figure 14 – Whittington Pharmacy CIC

10.0 FINAL WORD

This report outlines the significant contributions to patient care throughout 25/26 through medicines optimisation, innovation and pharmacy service developments. In addition, there have been enhancements in governance arrangements relating to medicines use, improvements in the sustainable use of medicines and development of the workforce in terms of training and role creation and adaptation.

As the team enter 2026/27, the key areas of focus are as follows:

Strategic Priorities

- Refresh the Medicines Optimisation Strategy in line with national, ICS, and Trust clinical and workforce strategies.
- Redesign and update Pharmacy Inpatient service, including redesign of physical environment and upgrade of Robotics.
- Phase 4 of medicines cabinetry will be rolled out to ensure the floor standing cabinets for TTAS and external products are installed.
- Engagement and development of key documents relating to EPR procurement process and support roll out

Safety and Risk Management

- Improve governance and oversight of community medication incidents.
- Enhance CD governance through electronic registers and training.
- Implement actions from WISH and PSIRF to improve medication safety.
- Standardise medication provision practices across community services.

Digital Transformation

- Develop and deploy new dashboards (e.g., Pharmacy Friend and Nursing Friend).
- Trust wide roll out of Where's my TTA dashboard
- Expand the use of CLEO SOLO EPS (electronic FP10 prescribing)

Workforce Development

- Operationalise the NCL Newly Qualified Pharmacist Prescriber (NQPP) generalist scope of practice for newly appointed Band 6 pharmacists who have qualified as PIPs
- Launch a new workforce strategy for 2026–29.
- Continue expansion of PTPT and TP training programmes.
- Continue to strengthen inclusivity and equity in workforce development.
- Development of support staff/technician workforce with respects to training capability and leadership.

Clinical Service Enhancements

- Explore ways in which pharmacists can regularly support clinics e.g. Osteoporosis clinic, pre-op assessment
- Develop MMPTs to be operational leads for ward services ensuring workload management and discharge co-ordination

- Improve patient experience by employing Person Centred Care consultations when talking to patients.
- Completion of Kidzmed project - looking at converting patients from liquid medication to oral tablets
- Implement CIP projects i.e. standardisation of TPN bags
- Collaboration with digital team and IM&T to develop Power BI dashboards for real-time reporting of prescribing trends, treatment outcomes e.g. LUTS clinic
- Complete Penicillin Allergy Delabelling (PADeL) project to offer direct oral penicillin challenge to adult patients with a label of allergy to one or more penicillin

Cancer Services

- Upgrade Chemocare Worksheets/Labels module to enable upgrade to Windows 11 compliant version of Chemocare.
- Work with System C and the SACT Dataset team to move to reporting of SACT Dataset version 4.

Sustainability and Waste Reduction

- Minimise medicines waste and improve disposal/recycling practices.
- Promote low-carbon inhalers.

Quality Improvement and Innovation

- Increase application of QI projects completed by pharmacy technicians and support staff.
- Improve efficiency of ward pharmacy provision to allow focus on project work for junior pharmacists and technicians 1-2x week.

Education and Training

- Support prescribing qualifications for pharmacist's post-diploma.
- Expand Educational Supervisor qualifications across the technician workforce.
- Engagement with workforce development pathways for all staff.

11.0 APPENDICES

Appendix 1: Pharmacy Department Medicines Optimisation Strategy 2026/2027

Vision and priorities:			
Deliver outstanding safe, compassionate care in partnership with patients	Empower, support and develop an engaged staff community	Integrate care with partners and promote health and wellbeing	Transform and deliver innovative, financially sustainable services
Implement updated versions of EPMA as an enabler to future developments Implement electronic prescribing and medicines administration (EPMA) software across the Emergency Department and Paediatric Virtual Ward and community services where possible. Focus on Antimicrobial Stewardship and support delivery of the National Five-Year action plan on Antimicrobial Resistance 2024-2029 Expand the utilisation of CLEO EPS to support flow, timely provision of medicines and enhance patient experience To implement electronic controlled drugs stock ordering to improve efficiency of processes and governance. Implement Sense Plus Abloy Locks to all trust patient own drug (POD) lockers to improve security control	Create and implement relevant aspects of the Pharmacy Workforce Strategy 2026-2029. Implement the Newly Qualified Pharmacist Generalist Scope Develop a competent, empowered and inclusive pharmacy workforce aligned to professional frameworks. Undertake a review of staff wellbeing and engagement in collaboration with the Trust Wellbeing Encourage staff to undertake leadership and advanced practice programmes in line with Professional requirements. Review and develop actions in support of the outcomes of the 25/26 Staff Survey.	Implement additional cross sector pharmacy roles to deliver consistent medicines optimisation support across inpatient services and community services such as Neighbourhoods. Work with UCLH, other external partners and local provider organisations on areas of collaboration to focus on preventative medicine and enable more efficient, safer and effective patient care. Work in partnership with Integrated Neighbourhood teams to co-ordinate medicines related care, reduce health inequalities and promote prevention and wellbeing at Neighbourhood level.	Embed robotic automation processes and utilise informatics i.e. Power BI reporting to support clinical prioritisation, optimise medicines use, demonstrate safe care and enhance operational and financial efficiency Continue to identify and implement procurement medicines cost saving opportunities. Undertake horizon scanning and implement savings plans in conjunction with NCL Pharmacy partners to deliver best value care for the Trust and across the ICS. To deliver Medicines Transformation Programme with aim to reduce medicines waste, eliminate inefficient processes, & embed sustainable, cost-effective workflows across key pharmacy functions Implement in collaboration with colleagues the Medicines related priorities of the Trust Green Plan. Redesign and update Pharmacy Inpatient service, including redesign of physical environment and upgrade of Robotics.

Introduction

Whittington Health NHS Trust serves a diverse patient population of 500,000 living in the boroughs of Islington and Haringey, in addition to Barnet, Enfield, Camden and Hackney. The Trust maintains a strong commitment to enhancing patient experience, with continuous improvements and developments over time.

We value the feedback of patients, service users and carers, recognising its vital role in shaping our services and driving continuous improvement. Feedback is gathered through multiple channels, including the Friends and Family Test (FFT), complaints, PALS, patient stories, focus groups, service-specific surveys and national surveys. We also engage directly with patients through engagement meetings, focus groups and our volunteering programme. In addition, every bi-monthly Trust Board meeting begins with a patient story, shared by the patient and supported by staff, ensuring that patient voices remain central to organisational discussions and decision-making.

In line with the NHS Complaints Regulations (2009), this report provides an overview of complaints, Patient Advice and Liaison Service (PALS) concerns and compliments received between April 2025 and March 2026. It summarises the volume of complaints, performance against response-time standards, Parliamentary and Health Service Ombudsman (PHSO) activity, and the actions taken by the Trust in response to the issues raised.

The complaints team operates a robust process, as set out in the Trust Complaints Policy, to monitor and oversee the progress of all complaint investigations. To support timely and effective case management, the team chairs weekly meetings with lead investigators to review, progress, address barriers and ensure investigations remain on track for completion.

All divisions continue to face challenges in completing complaint investigations within expected timeframes. These delays are driven by difficulties in gathering information from staff, multidisciplinary investigations and patient systems, alongside the time required to compile a comprehensive response that addresses all issues before it can be submitted for quality assurance.

A dashboard of 'live' complaints is shared with our divisions on a weekly basis, including a monthly patient experience dashboard which monitors FFT responses and complaint numbers by division, with three areas of focus. All complaints are reported to quarterly to the Patient Experience Group, Quality Governance Committee and Quality Assurance Committee.

Themes and trends from complaints help us reflect on the care given, learn and shape now we deliver care. They also help us develop our You Said, We Did (YSWD), Quality Account and Patient Experience Strategy priorities, ensuring we focus on what patients told us matters most.

In summary during 2025-2026 we:

- Received 506 complaints requiring a response
 - (Q1 -111)
 - (Q2- 115)
 - (Q3 -146)
 - (Q4 – 134).

This is an increase of 40% (144) in comparison to 2024-2025 (362).

- 98% of complaints were acknowledged within 3 working days, exceeding our internal 90% target, in line with 2024-2025 despite the significant rise in complaints.
- Our internal key performance indicator is to respond to 80% of complaints within the target response time. Our performance for 2025-2026 was 66% compared to 68% in 2024-2025, a slight downturn (Q1 62%, Q2 70%, Q3 64% & Q4 67%).
- There were 3 requests for information from the Parliamentary & Health Service Ombudsman (PHSO) a decrease from 6 in 2024-2025. Two cases remain with the PHSO pending its decision of whether to undertake a full investigation.
- 444 compliments were received thanking 661 individuals or teams.
- A total of 5,375 PALS concerns/enquiries were received, compared to 2,500 in 2024-2025, an increase of 2,875

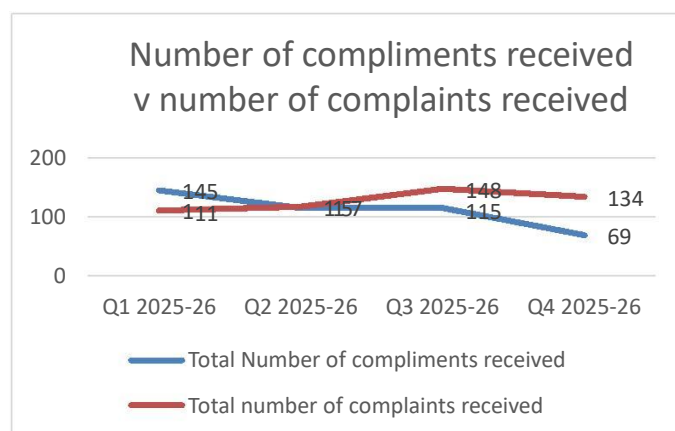
To provide context, a very small proportion of patient activity resulted in formal feedback during 2025–2026: approximately 0.0004% of patient encounters led to a complaint, and 0.0038% resulted in a PALS concern. It is recognised that patients and service users may have multiple encounters across the Trust, which should be considered when interpreting these figures.

Table 1: Patient Encounters v Concerns comparison

Appointments/episodes of care	2024/25	2025/26
Emergency Department attendances	108,610	107,769
Outpatient appointments	436,115	438,941
Imaging Department attendances	216,896	225,342
Theatre procedures	8,861	9,978
Community episodes	576,976	588,505
Inpatient admissions	49,683	54,152
TOTAL	1,397,141	1,424,687
Complaints (number)	362	510
Complaints (%)	0.0003%	0.0004%
PALS concerns (number)	2,500	5,375
PALS concerns (%)	0.0017%	0.0038%

1.0 COMPLIMENTS

As a Trust, we recognise and celebrate the excellent work delivered by our staff, and it is important to note that compliments continue to outweigh the number of complaints received. During 2025–2026, PALS recorded 443 compliments (covering 661 individuals or services), compared with 570 in 2024–2025. These figures reflect only the compliments formally captured through PALS or those sent directly to the Chief Executive's Office; many more positive messages are received informally by teams and departments across the Trust.



S&C received the largest number of compliments (129), followed by E&IM (97), CYP (75), ACW (62), ACS (60), Corporate (14) and E&F (6). As with complaints, it is important that as an organisation we share the successes from compliments, and share best practices, that can be emulated in other services across our Trust.

Compliment Examples

Dear SCBU, a simple 'thank you' doesn't feel adequate enough to convey our deep gratitude for the love and care shown to our son during his stay with you. You met us at the most vulnerable part of our lives and handled us with such remarkable love, compassion and humour. CYP

With my special thanks for being so concerned and helpful in order to ease my pain considerably, with your useful suggestions professionally during all these months. ACS

I'm writing to express my sincere appreciation for the exceptional care I received at the Fertility Centre. From the moment I arrived, Erica demonstrated expert knowledge in their field that immediately put me at ease. What truly distinguished Erica, however, was the deep personal care and empathy she showed throughout the entire process. ACW

I just wanted to pass on my THANKS to whoever put the new surface on the stairs. I feel much safer! E&F

Mary Seacole North, everyone was fantastic, I recovered well, they all took great care of me. All fantastic throughout; fantastic care overall EIM

"To all the amazing staff at Mercers Ward including nurses, doctors, admin, cleaners, porters and the rest. THANK YOU! I'm so grateful for your care, expertise and compassion. The work you do is amazing and I wish you all the happiness you well deserve."

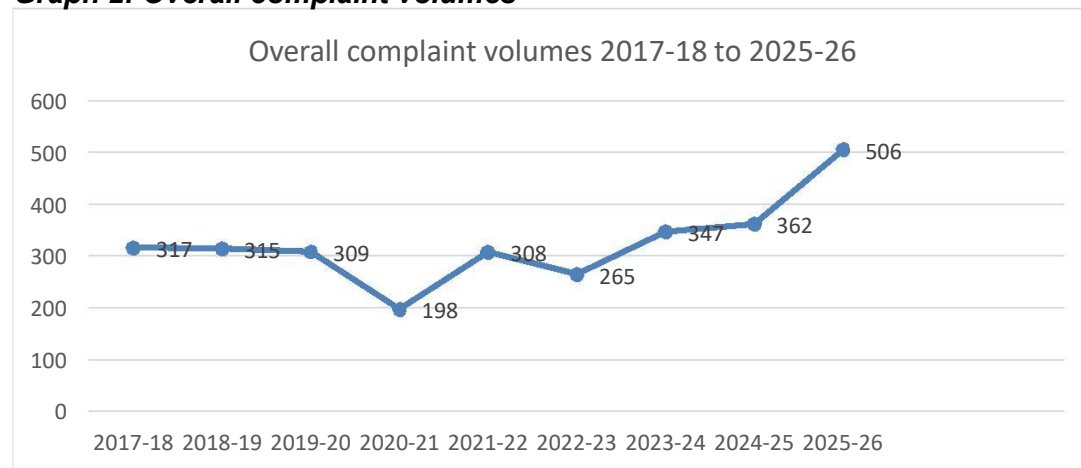
S&C

2.0 COMPLAINTS

2.1 Complaints across Divisions

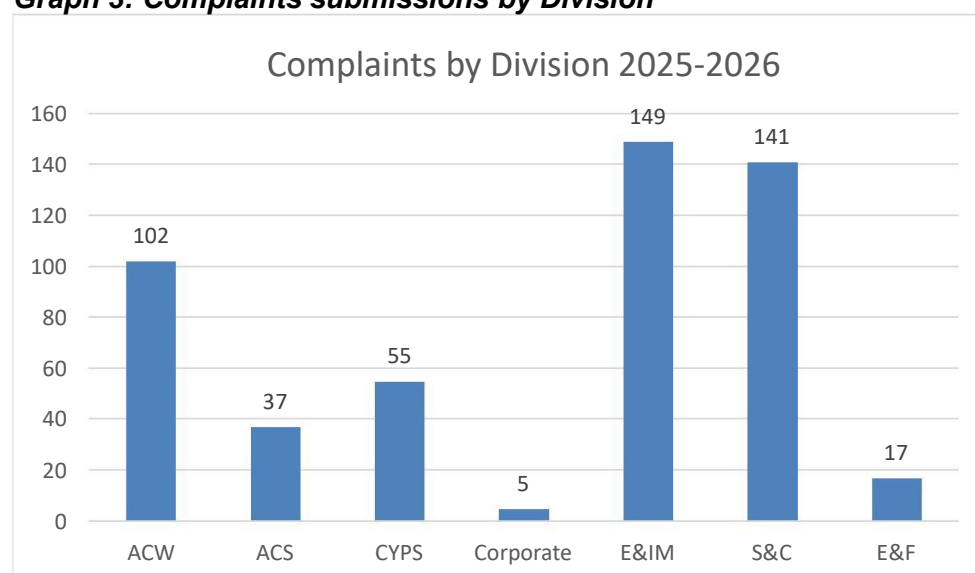
The number of complaints received in 2025–26 shows a marked increase, as illustrated in Graph 2. The reduction seen in 2020–21 (198 complaints) occurred during the Covid period; while the reasons cannot be confirmed, it is likely to reflect the exceptional circumstances and the strong public support for the NHS at that time.

Graph 2: Overall complaint volumes



Emergency & Integrated Medicine (E&IM) Division received the largest number of complaints at 149, followed by Surgery & Cancer (S&C) Division 141, Acute Patient Access, Clinical Support and Women's (ACW), 102, Children and Young People (CYP) 55, Adult Community Services (ACS) 37, Estates & Facilities 17, Corporate (Finance, Strategy & Patient Experience) 5. (See graph 3 below).

Graph 3: Complaints submissions by Division

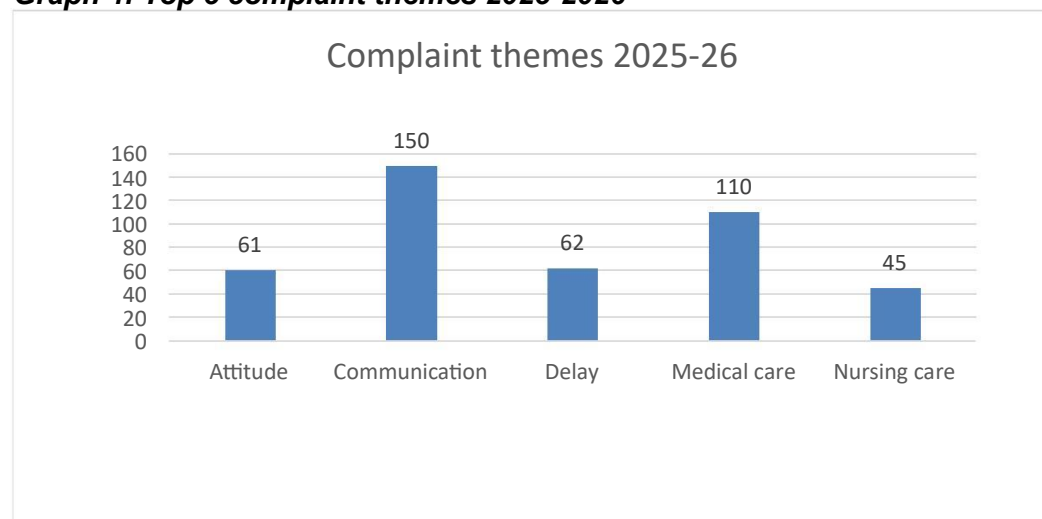


2.2 Complaints across the Trust by theme

Themes and trends from complaints directly inform the Quality Account and the priority-setting within the Patient Experience Strategy, ensuring that feedback from patients shapes targeted actions and drives meaningful improvements in the areas that matter most to them.

The top 5 themes cited include communication between clinicians, patients, their families and carers. This is the most common theme received through complaints and remains an ongoing improvement priority for the Trust. These are the same top five themes as in 2024-25.

Graph 4: Top 5 complaint themes 2025-2026

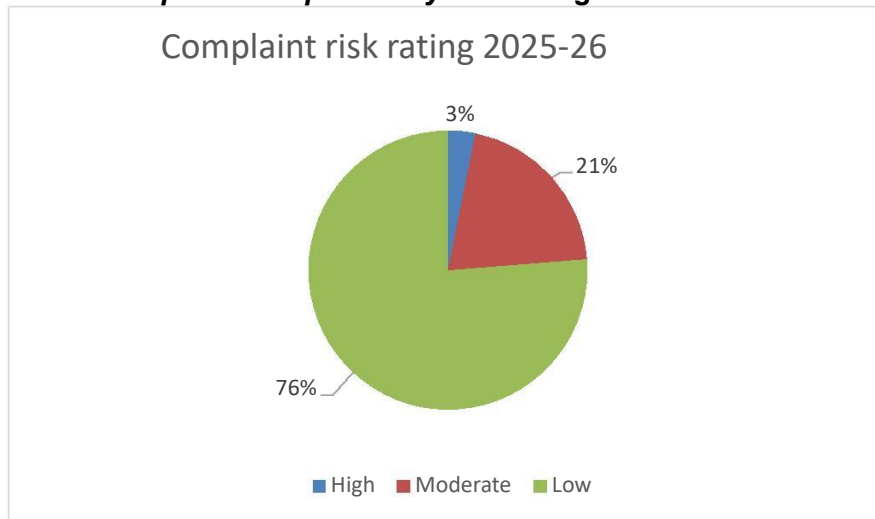


2.3 Complaints across the Trust by risk rating

All complaints undergo a two-stage risk assessment: first by the PALS and Complaints team upon receipt, and again by the lead investigator on completion of the investigation to ensure risks are fully understood and appropriately managed. High risk complaints are those where concerns are raised about patient care that may have had an adverse effect on a patient's outcome or perhaps there is a risk of reputational damage. An example of a high-risk complaint would be an unexpected death, a missed or delayed diagnosis an allegation of assault, or where there is a WISH (Whittington Improvement Safety Huddle) investigation underway. A moderate-risk complaint would be one where there may be a persistent or generic theme if the issue is not addressed promptly. A low-risk complaint would be one with one or two issues that should be addressed promptly, e.g. staff attitude or poor communication.

During 2025-26 - 16 (3%) of complaints were designated as 'high' risk, most complaints 386 (76%) were designated 'low' risk and 104 complaints (21%) were designated 'moderate' risk. Please see Graph 5 below.

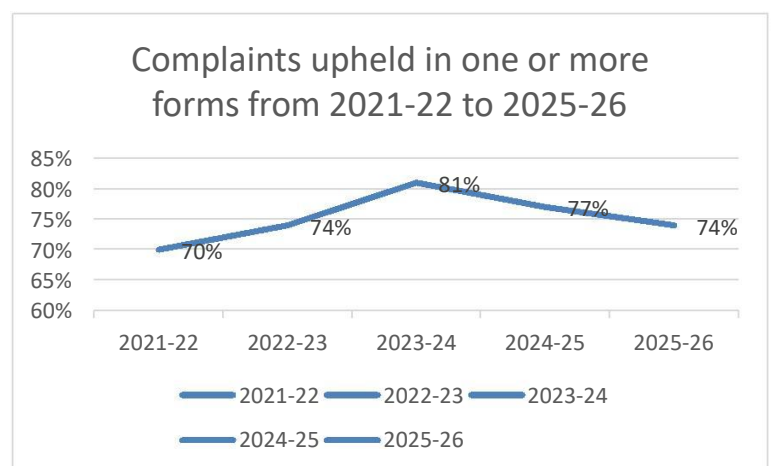
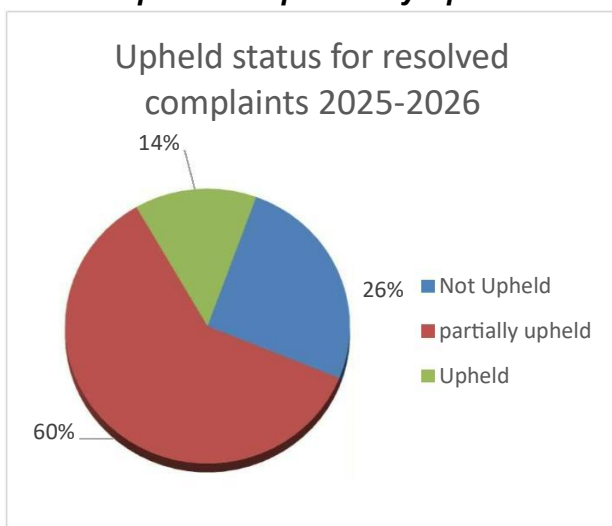
Graph 5: Complaints by risk rating 2025-2026



2.4 Complaints across the Trust by Upheld Status

Of the complaints that were closed during 2025-26, 64 (14%) were fully upheld, 280 (60%) were partially upheld and 118 (26%) were not upheld. 74% of closed complaints were upheld in one or more forms, compared to 2024-2025 where 77% of complaints were upheld, a decrease of 3% (Graphs 6 & 7). Upheld complaints are those where all (or some elements) of the complaint are found to be proven.

Graph 6: Complaints by Upheld status 2025-2026



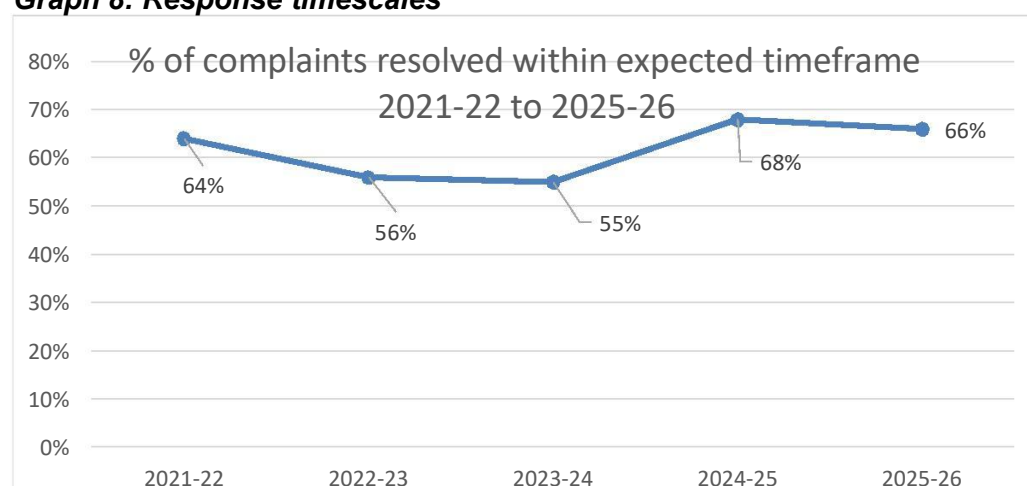
Graph 7: Complaints by Upheld Status annual comparison

2.5 Response Timescales

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

During 2025–26, performance against the Trust's internal 80% response-time target declined slightly, with compliance at 66% compared with 68% in 2024–25. This reduction occurred despite a 40% increase in complaint volume, which has placed additional pressure on investigation and response capacity. (See graph 8).

Graph 8: Response timescales



It is recognised that delays in completing complaint responses are largely driven by capacity constraints, winter pressures and competing clinical and administrative demands. These pressures are further compounded by the significant increase in complaint volumes and the growing use of artificial intelligence by complainants, which often results in more complex and detailed submissions requiring additional time to review and address fully. We also acknowledge that delays negatively affect the experience of patients, families and carers, and work continues across all divisions to improve both performance and the overall experience of those raising concerns.

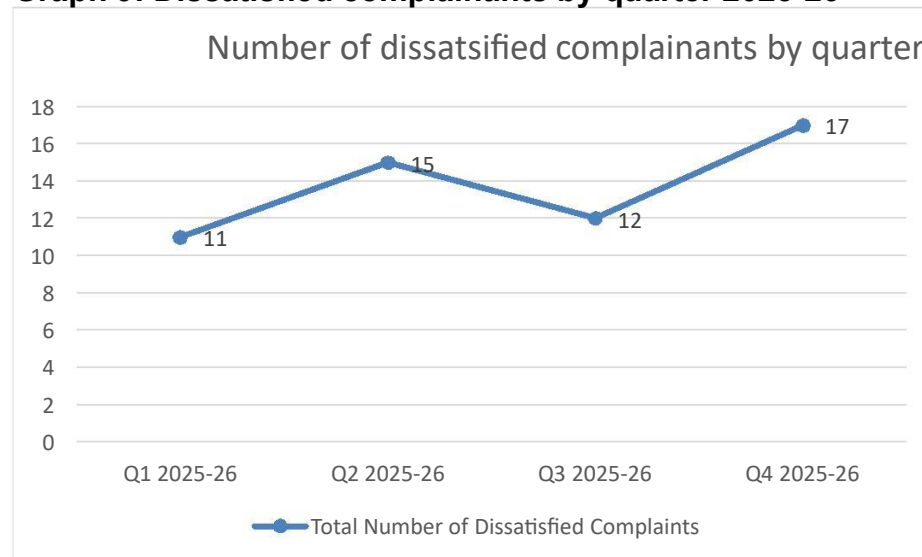
In addition, S&C have increased clerical capacity (1 part time), and weekly meetings are held with all five Divisions with a specific focus on the oldest cases, complex investigations and complaints approaching their due date, to reduce the risk of breaching response times. This has resulted in a steady reduction in the number of older complaints outstanding a response following an investigation, as well as a gradual improvement on the overall response rate across the Trust.

2.7 Dissatisfied complaints

Graphs 9 & table 3 below show the number of complainants returning responses as dissatisfied or requiring further clarification. During 2025-2026, we received 55 'dissatisfied's', an increase of 1 on 2024-2025 (54). This includes a small number of complainants who have responded more than once.

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

Graph 9: Dissatisfied complainants by quarter 2025-26



Division	Total
Surgery and Cancer Division	21
Community Health Services for Adults Division	6
Emergency and Integrated Medicine Division	15
Acute Patient Access, Clinical Support Services & Women's Health Division	7
Corporate	0
Children and Young People Services Division	6
Trust	55

2.8 Parliamentary Health Service Ombudsman (PHSO) Cases

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

During 2025–26, the Trust received three requests from the Parliamentary and Health Service Ombudsman (PHSO) for complaint files and associated records to support consideration of an independent review. This represents a 40% reduction compared with eight requests in 2024–25. All required information was provided to the Ombudsman Service in each case.

The Trust received one final decision from the PHSO following our response to the provisional findings. This case, relating to EIM, resulted in a financial settlement of £2,000 being made to the complainant alongside a further apology. An associated Action Plan is also required. The original complaint was raised in August 2022.

The Trust was also notified that the actions & response to another complaint relating to S&C were found to be sufficient & the case was closed by the Ombudsman Service without further actions being required. This complaint was originally raised with the Trust in March 2024.

2.9 Improvements and learning from complaints.

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

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

Examples of learning to improve the patient experience.

Complaint	Action and Learning
By way of example, we received a complaint about the communication with a patient who arrived late for an appointment at the Wood Green Community Diagnostic Centre (CDC). The patient was turned	Following receipt of the complaint, the CDC manager contacted the patient, provided an explanation as to why the appointment could not proceed, (which was due to a previous patient becoming unwell), then re-arranged the patient's appointment, and ensured the

away but not provided with a concise and thorough reason why.	results were reported as quickly as possible and shared with the patient. Staff at the CDC have been reminded of the importance of providing clear information to patients if appointments cannot proceed, encouraged staff to be more flexible where possible if patients arrive late for appointments, and arranged some refresher training for staff to improve patient interaction and communication.
A complainant raised concerns about the recent changes in the process for Rheumatology patients needing to renew their existing prescription, e.g. the need for regular blood tests before prescriptions can be issued & the need for timely communication between the departments. The complaint showed that not all staff understood the change in process and had not explained it correctly to the patient.	Following receipt of the complaint the patient was contacted by the service to explain the change in process.
Two complainants awaiting shoulder surgery raised concerns that the potential administration of a nerve block to their neck prior to the procedure was not explained to them either during outpatient consultations or at the pre-operative assessment stage. As a result, both complainants raised concerns as to the potential outcome of the nerve block but had no opportunity to raise those concerns in advance.	Following receipt of the complaint It was identified that the question of a possible nerve block was not consistently advised to patients in advance, some were advised, some not. As a result of the complaint Information leaflets and surgical invitation letters are being reviewed and amended to include information about nerve blocks so patients can make informed decisions about their use. All patients attending a pre-operative assessment prior to shoulder surgery to be advised of the potential of having a nerve block.
A complainant who was 34 weeks pregnant raised concerns that they contacted the Maternity Triage area as they were experiencing involuntarily shaking, excessive sweating & seeing glitter/sparkles. Ther complainant was advised to wait at home as they had a pre-	It was identified that the advice given was inappropriate & had not been recorded correctly in the patient records. The complainant should have been advised to attend hospital as soon as they were able to, irrespective of having an appointment the following day.

arranged midwifery appointment the next day.	The member of staff & the wider team reminded of the importance of following the established protocol in such cases and that all calls to the triage area need to be properly recorded so there is a record for other staff reference. The anonymised complaint was also shared with the wider Maternity team as a learning opportunity.
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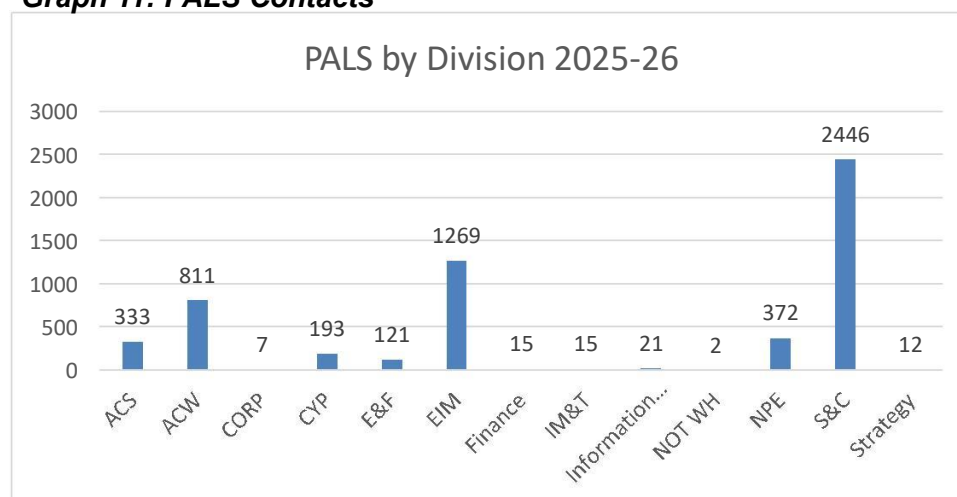
3.0 PALS

3.1 PALS contacts by Division

From April 2025 PALS has adopted an alternative record keeping system (on spreadsheet rather than Datix), which reflects a large increase of recorded PALS contacts (5,617) during 2025-26; an increase from 2,402 in 2024-2025. 82%% (4,647) of PALS enquiries related to concerns and 18% (987) were requests for information.

(With effect from 1st October 2024 GP concerns have migrated to the Trust's Primary Care Liaison team which commenced 1st October 2024, under the Chief Operating Officer (COO) portfolio.

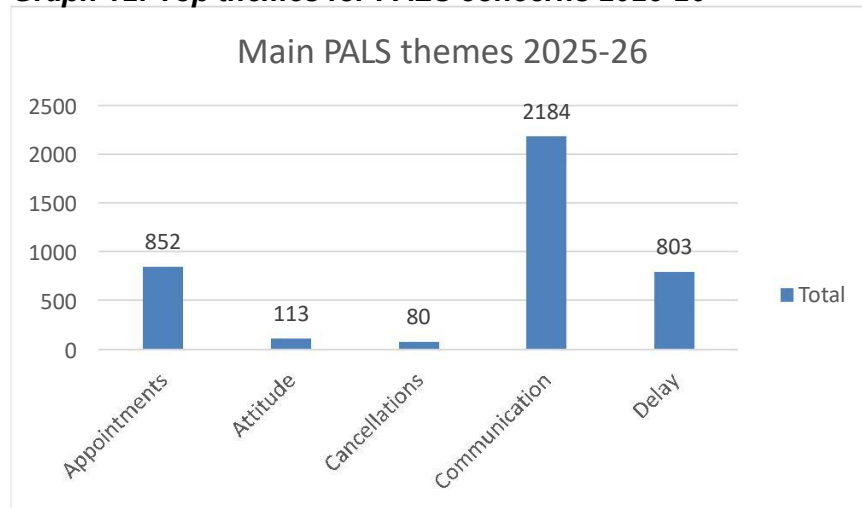
Graph 11: PALS Contacts



3.2 PALS Contacts by subject area

Graph 12 shows main themes as cited in the PALS contacts received. On receiving contact from patients, the PALS team will attempt to resolve the issue with the patient at the time e.g., access to appointments, however, if this has not been possible, the PALS concern is then escalated to the relevant ICSU. These are the same PALS themes as for 2023-24.

Graph 12: Top themes for PALS concerns 2025-26

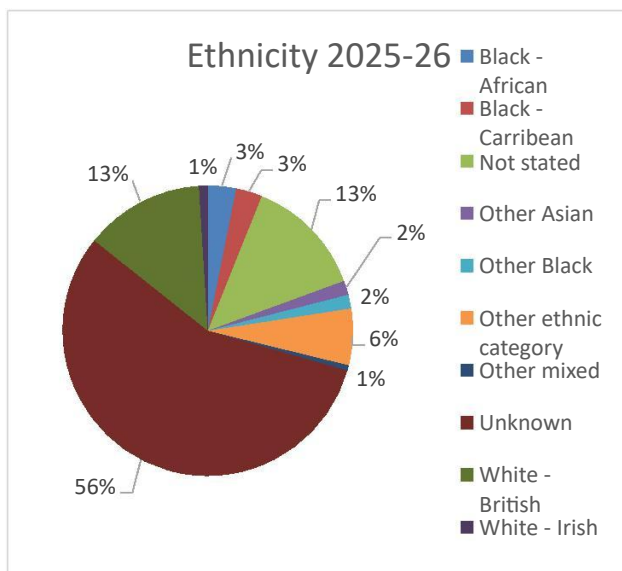


3.3 Diversity Data

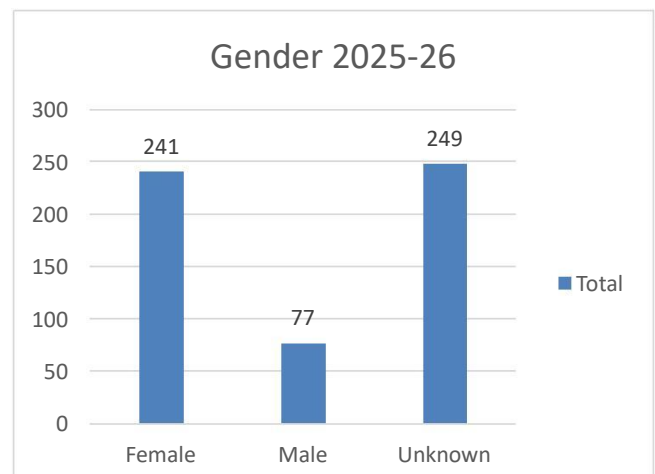
The PALS & Complaints team continue to cross-check diversity data through our electronic patient information systems (Careflow and RiO). All data collected from Datix is shared with the Department of Health through the KO41 annual report.

Graphs 13 and 14 below show the demographic data for Ethnicity & Gender for 2025-26. The data for age and disability figures had too many “unknowns” to provide a meaningful breakdown.

Graph 13: Ethnicity



Graph 14: Gender



4.0 Support & Training

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

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

During 2025-26 bespoke PALS & Complaint handling online and face-to-face training was delivered to 26 members of staff across all our organisation. Monthly sessions will be offered during 2026-27 and are communicated through the Trust bulletins and in discussion with the senior Divisional teams.

5.0 Plans for 2026-2027

5.1 To revisit the training provision for complaint handling and ensure a good understanding in the divisions. This should enable the divisions to increase the number of staff skilled to undertake investigations and improve the quality and timeliness of complaint investigations.

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

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

5.4 To continue working with the divisions on the importance of early contact with complaints to discuss and potentially de-escalate complaints.

5.5 Promote the new Complaints, Concerns & Unreasonably Persistent and Vexatious policy once finalised and approved.



Meeting title	Trust Board – Public meeting	Date: 25 September 2026
Report title	Workforce Assurance Committee Chair's report	Agenda item: 6
Committee Chair	Rob Vincent, Non-Executive Director	
Executive lead	Charlotte Pawsey, Acting Chief People Officer	
Report authors	Marcia Marrast-Lewis, Assistant Trust Secretary, Swarnjit Singh, Trust Company Secretary and Joint Director of Inclusion, and Rob Vincent and Charlotte Pawsey	
Executive summary	Trust Board members are presented with the Workforce Assurance Committee Chair's report for the meeting held on 10 August 2026. Areas of assurance: • Chief People Officer's update • People Strategy Development • Leadership and Management Framework • National Staff Standards • Guardian of Safe Working Hours Report • Board Assurance Framework - People entries • Estates and Facilities Workforce Transformation The Committee is reporting moderate assurance to the Board on the following matters: • Q1 2026/27 Workforce key performance indicators • Career development • Balance of contracted hours The Committee agreed to highlight the following areas to the attention of the Board: • The work taking place to implement the Resident Doctors' deal and the associated organisational workforce implications. • Progress in finalising the Trust People Strategy and its alignment with new national workforce standards. • The introduction of the NHS Leadership and Management Framework and NHS Staff Standards. • Continued challenges relating to reductions in bank staffing expenditure and workforce productivity. • The growing complexity of workforce case management and resulting pressures on the Workforce team. • The work taking place to provide career development opportunities for non-clinical staff groups. • Workforce wellbeing concerns reflected through increasing sickness absence levels.	

Purpose	Noting
Recommendation(s)	Board members are invited to note the Committee Chair's report for the meeting held on 10 August 2026
BAF	People 1 and 2 entries
Appendices	1: 2026/27 Q2 Board Assurance Framework 2: 2025/26 Q4 Guardian of Safe Working report

Committee Chair's assurance report

Committee name	Workforce Assurance Committee
Date of meeting	8 June 2026
Summary of assurance:	
1.	The Committee is reporting significant assurance to the Board on the following matters: Chief People Officer's update The Committee received a verbal update on several significant national workforce developments and local workforce pressures, as follows: • Progress had been made in implementing the national resident doctors' deal, including changes to pay, training opportunities, career development, contractual arrangements for locally employed doctors and fee reimbursement. A task and finish group, which included resident doctor representatives, had been established and work was underway to identify affected staff and implement the required changes. The Committee received assurance that all actions required to date had been progressed. • NHS Transforming People Services programme and the Future Workforce Solution, aimed to replace the electronic staff record. Preparatory self-assessments and data submissions were underway, and further details were awaited on the timescale for implementation. It was agreed that a further update on the Future Workforce Solution would be brought to the Committee's October meeting, with a broader update on Transforming People Services scheduled for January 2027. • Although agency staffing expenditure had reduced significantly, bank staffing expenditure remained high at approximately £1.5m per month. The Committee was assured that the People and Pay workstream of the Improvement programme would remain a key area of focus, with additional controls and interventions implemented. The Committee also recognised the wellbeing implications for staff undertaking significant additional hours to maintain service delivery. • The Committee further acknowledged the increasing pressures on Workforce services which arose from increased employee relations casework and concurrent organisational change programmes. Committee members heard that the complexity of cases continued to increase and that several large-scale change programmes were currently underway. The Committee received assurance that the position was being actively managed and agreed that workforce capacity and resourcing should be reviewed, as the national workforce reforms became clearer. People Strategy The Committee reviewed progress on the refresh of the Trust's People Strategy. Committee members were assured that extensive engagement had taken place across the organisation, including consultation with executive colleagues, the Partnership Forum with staff side colleagues, staff networks, and a Trust-wide survey. The Committee noted that there remained strong support for the proposed strategic pillars, with feedback largely focused on operational issues rather than strategic direction. Committee members welcomed plans to align the

strategy with the newly published NHS Staff Standards and Leadership and Management Framework prior to final approval.

Leadership and Management Framework

The Committee received an update on implementation of the newly published NHS Leadership and Management Framework. Committee members learned that much of the Trust's existing leadership development work already aligned well with the national framework and that current programmes, talent processes and appraisal arrangements were being reviewed to ensure compliance.

The Committee welcomed plans to incorporate the framework into leadership development programmes, recruitment processes and appraisal documentation, while ensuring strong executive sponsorship and organisational ownership. The Committee received assurance that the Trust was well placed to implement the framework and that a phased approach was in place.

National Staff Standards

The Committee reviewed the recently published NHS Staff Standards covering line management, health and wellbeing, violence prevention and reduction, sexual safety, tackling racism and flexible working.

Committee members received assurance that the Trust already had substantial programmes of work in place across all six priority areas and that the focus would be on aligning existing initiatives within the national framework. The Committee noted that these standards would form part of future national oversight arrangements.

Guardian of Safe Working Hours Report

The Committee received the quarterly report from the Guardian of Safe Working Hours. Committee members noted recent national reforms to exception reporting arrangements, including increased confidentiality protections for resident doctors and changes to how outcomes are determined.

The Committee was advised that despite these changes, exception reporting levels remained broadly consistent with previous reporting periods and that only one genuine safety concern had been identified during the quarter. The predominant causes of exception reports remained workload and working hours pressures. The Committee received assurance that exception reporting arrangements remain effective and well managed.

Estates and Facilities Workforce Transformation

The Committee received a detailed update regarding a series of workforce consultation exercises undertaken within the estates and facilities department. Committee members heard that eight formal consultation processes had been undertaken, covering services including portering, facilities management, estates on-call arrangements, waste management, security, reception and retail services.

	The Committee received assurance that all consultation processes had been undertaken in partnership with Staff Side representatives, and in accordance with Trust policy. In addition, Committee members were informed that significant progress had been made with modernising services, aligning workforce models with national benchmarking and improving operational efficiency whilst maintaining service quality. The Committee commended the leadership shown throughout these programmes and received assurance that staff had been appropriately supported throughout the process. Quarter 1 Board Assurance Framework The Committee reviewed and approved the Quarter 2 Board Assurance Framework entries relating to the Trust's People risks and received assurance that the existing controls and mitigating actions remain appropriate. The Committee agreed that there was insufficient evidence at this stage to justify changes to the current risk scores and therefore recommended that all People risk scores remain unchanged.
2.	The Committee is reporting moderate assurance to the Board on the following matters Career Development and Staff Survey Feedback The Committee considered a detailed review of staff survey feedback relating to career development opportunities, particularly among non-clinical staff, healthcare support workers and administrative and clerical colleagues. Committee members noted concerns regarding inconsistent access to development opportunities, a perceived lack of transparency around funding for continuing professional development opportunities (CPD) and variable managerial support for career development activities. The Committee welcomed the immediate actions being taken which included enhanced communication to staff, work-shadowing opportunities and manager development, whilst supporting further work to assess options for a dedicated CPD funding process for non-clinical staff groups. The Committee received assurance that a structured improvement plan was being developed but requested ongoing oversight of progress and outcomes. Workforce Key Performance Indicators The Committee reviewed workforce performance indicators and noted: • Sickness absence had increased from 3.5% in Quarter 4 to 4.4% in Quarter 1. • Mandatory training compliance remained strong at 89%. • Appraisal compliance remained below target at 78%. • Formal workforce case numbers remained high, with 273 active cases. • Average case resolution times had improved to 82.5 days, below the Trust's target of 90 days. Committee members discussed the potential correlation between increasing workforce stress and increased sickness absence levels. The Committee agreed that close monitoring should continue.

	Balance of Contracted Hours Programme The Committee received an update regarding the programme to reset and reconcile historic balance of contracted hours arrangements for nursing, midwifery and allied health professional staff groups. Committee members were informed that following initial implementation, concerns had been raised regarding the accuracy of information and confidence in the process. A revised approach had subsequently been agreed involving manager-led validation and correction of balances using local knowledge and supporting evidence. The Committee received assurance that the revised programme was progressing appropriately and that no significant financial implications had been identified. Members requested confirmation that any accounting implications are fully understood and agreed between workforce and finance teams.
3.	Present: Rob Vincent, Non-Executive Director (Committee Chair) Junaid Bajwa, Non-Executive Director Selina Douglas, Chief Executive Officer Tina Jegede, Joint Director of Inclusion and Lead Nurse, Islington Care Homes Sarah Wilding, Chief Nurse and Director of Allied Health Professionals Charlotte Pawsey, Acting Chief People Officer Chinyama Okunuga, Chief Operating Officer Rantimi Ayodele, Chief Medical Officer In attendance: Marcia Marrast-Lewis, Assistant Trust Secretary Serena Wilshire, HR Business Partner Mark Livingstone, Chief Allied Health Professional Joanne Bronte, Acting Deputy Director of HR Operations Marielle Perraut, Assistant Chief Nurse Leanne Chaney, Assistant Director of Learning and Organisational Development. Liam Trigges, Director of Estates and Facilities Martin Linton, Assistant Director Financial Services Apologies: Glenys Thornton, Non-Executive Director Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary Terry Whittle, Chief Finance Officer & Deputy Chief Executive



Meeting title	Workforce Assurance Committee	Date: 10.08.2026
Report title	2026/27 Q2 Board Assurance Framework – People entries	Agenda item: 4.1
Executive leads	People entries: Charlotte Pawsey, Acting Chief People Officer	
Report authors	Marcia Marrast-Lewis, Swarnjit Singh, Charlotte Pawsey	
Executive summary	Background Workforce and Assurance Committee members are presented with the quarter two 2026/27 Board Assurance Framework (BAF) entries related to the Trust's People strategic objective, for review and approval Issue At its June meeting The Committee reviewed the Quarter 1 2026/27 BAF People entries and agreed that no changes to the risk scores were required, as follows: • People 1: Staff recruitment and retention remained at 9 (target 9). • People 2: Staff wellbeing, engagement and equity, diversity and inclusion remained at 9 (target 4). The Committee discussed the control gap related to leadership and talent development for ethnic minority staff at Band 8a and above staff and were given assurance that this remains an area of focus but is hamstrung by a lack of funding. Committee members also welcomed the findings of the internal audit review of risk management, which awarded the Trust the second-highest assurance rating and provided positive assurance regarding the effectiveness of the BAF and risk management framework, with no significant weaknesses identified. Next steps	

	No changes are recommended to either People risk score at this stage. Work continues to address the outstanding control gap relating to the Band 8a+ leadership development programme The next formal review of the People BAF entries will take place at the 10 October Committee meeting. It is proposed that this review be accompanied by an update, including data on the difficulties in recruiting to and retaining sufficient staff in specialist roles.
Purpose	Approval
Recommendations	Workforce Assurance Committee members are asked to: i. review and approve the Q2 BAF People 1 and People 2 entries for risks to the Trust's people strategic objective and their respective scores (appendix 1); and ii. note that the next Committee meeting will receive an update on difficulties in recruiting to and retaining sufficient staff in specialist roles
Appendices	1: Q2 2026/27 Board Assurance Framework – People 1 and 2 entries

Appendix 1: Q2 2026/27, Board Assurance Framework – People entries

Strategic objective and BAF risk entry	Principal risk(s)	Current score			Target score	Lead director(s)
		C	L	R		
People 1 - staff recruitment and retention	A lack of sufficient substantive staff, due to increased staff sickness absence rates, and difficulties in recruiting to and retaining sufficient staff in specialist roles, results in further pressure is placed on the existing workforce, and creates insufficient capacity to deal with demand, and increased temporary staffing costs and adversely impacts patient experience. This is further exacerbated by difficulties in recruiting to skilled and/or specialist roles.	3	3	9	9	Acting Chief People Officer
People 2 – staff wellbeing, engagement and equity, diversity and inclusion	A failure to continue to improve the staff experience relating to staff health and wellbeing, equity, diversity and inclusion, development, culture, empowerment, and morale, and tackle to bullying and harassment and sexual misconduct behaviours, unaligned with the Trust's values results in: • a deterioration in organisational culture, morale and the psychological safety, wellbeing and resilience of staff • an adverse impact on staff engagement • deteriorating outcomes in annual equality standard outcomes and submissions • a poor reputation as an organisation to work for in poor patient experience	3	3	9	4	Acting Chief People Officer, Joint Directors of Inclusion

Q1 2026/27, Board Assurance Framework – People entries

Strategic objective		Empower, support and develop an engaged staff community
Executive lead		Chief People Officer
Oversight		Trust Management Group; Workforce Assurance Committee (WAC)
Principal risks	People 1	A lack of sufficient substantive staff, due to increased staff sickness absence rates, and difficulties in recruiting to and retaining sufficient staff in specialist roles, results in further pressure is placed on the existing workforce, and creates insufficient capacity to deal with demand, and increased temporary staffing costs and adversely impacts patient experience. This is further exacerbated by difficulties in recruiting to skilled and/or specialist roles.
	People 2	A failure to continue to improve the staff experience relating to staff health and wellbeing, equity, diversity and inclusion, development, culture, empowerment, and morale, and tackle to bullying and harassment and sexual misconduct behaviours, unaligned with the Trust's values results in: - a deterioration in organisational culture, morale and the psychological safety, wellbeing and resilience of staff - an adverse impact on staff engagement - deteriorating outcomes in annual equality standard outcomes and submissions - a poor reputation as an organisation to work for in poor patient experience

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

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

Risk score metrics:

People 1 entry	People 2 entry
- Sickness absence rates - Recruitment metrics for specialist roles - Temporary staffing costs - Formal sickness absence processes - Specific role recruitment data	- Annual staff survey outcomes and action plans - Quarterly People Pulse outcomes - Annual workforce disability and race equality indicators - Increased formal employee relations cases linked to allegations of bullying and harassment

People 1 entry	People 2 entry
	Implementation of recommendations from the independent, external race equity report commissioned by Whittington Health

Controls and assurances

Key controls	Assurances	
Psychological/wellbeing support to staff	- Trust Board, Trust Management Group (TMG), Partnership Group (PG), and Workforce Assurance Committee (WAC) receive updates on activities - The importance of staff rest, and recuperation is emphasised and the ability to take annual leave was agreed by the executive team and Trust Management Group members and remains important - Implementing health and wellbeing discussions with all staff as part of annual appraisal reports - Ensuring Health and Wellbeing intranet hub is kept up-to-date and accessible - Delivery of the Health Wellbeing programme with regular reports to WAC	1st 1st 1st 1st/2nd
Corporate and local staff survey action plans are being developed following the 2025 Staff Survey outcomes	- Clinical Divisions' Boards and Directorates consider quarterly pulse surveys, annual staff survey results and create local action plans - Quarterly People Pulse report to TMG, PG; 2nd tier assurance at WAC - Templates provided for Clinical Divisions/Directorate level and for team level to maximise empowerment through participation in making improvements - NHS staff survey outcomes and action plans report to the Trust Board, WAC, TMG and PG - Listening events were held on the three agreed priorities for action: career progression; civility and respect; and reasonable adjustments and were reported to TMG and WAC	1st 1st 1st 2nd 2nd
Implemented activities under the #Caringforthosewhocare initiative	The range of interventions provided for staff under the #Caring for those who care activities are reported to each meeting of the Workforce Assurance Committee, TMG, and PG.	2nd

Key controls	Assurances	
Implemented updated action plan for recruitment and retention strategy	Quarterly Workforce reports to meeting of the Workforce Assurance Committee and from well led indicators on the Trust Board's monthly integrated performance report	2nd
Develop and implement a WDES and WRES improvement plans	- Annual workforce disability and race equality standard submissions paper to WAC, TMG and PG - Workforce Assurance Committee reviews progress with the equality and inclusion action plan	2nd 2nd
Inclusion strategy and action plan in place	Trust Management Group, Workforce Assurance Committee, Trust Board	2nd
Trust-wide Talent management and succession planning arrangements	Further development and rollout of cohorts for the Bands 2 -7 development programme for black, Asian and minority ethnic staff	1st
People strategy	and A consultation is underway currently on a refresh of the Trust's People strategy which was agreed in December 2023 by the Board	2nd
Sexual safety in the workplace	Taskforce established to take forward work to comply with the framework and updated policy guidance issued by NHS England and also the revised EHRC preventative directive	2nd
Independent review of Inclusion function to take place in Q3 and Q4	The review's recommendations are being implemented and were reported to the TMG and WAC in Q1.	3rd and 2nd

Gaps in controls and assurances

Gaps	Mitigating actions	Completion date
Band 8A+ development programme has been delayed for some time	Discussions are due to take place with colleagues at Imperial NHS Trust before this is developed further.	To be confirmed by the Organisational Development team

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

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

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

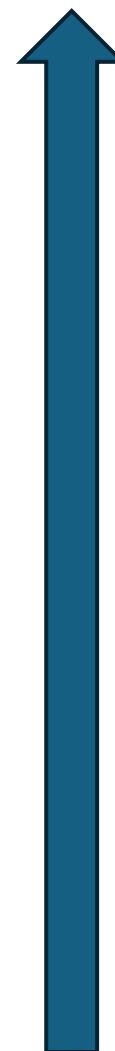
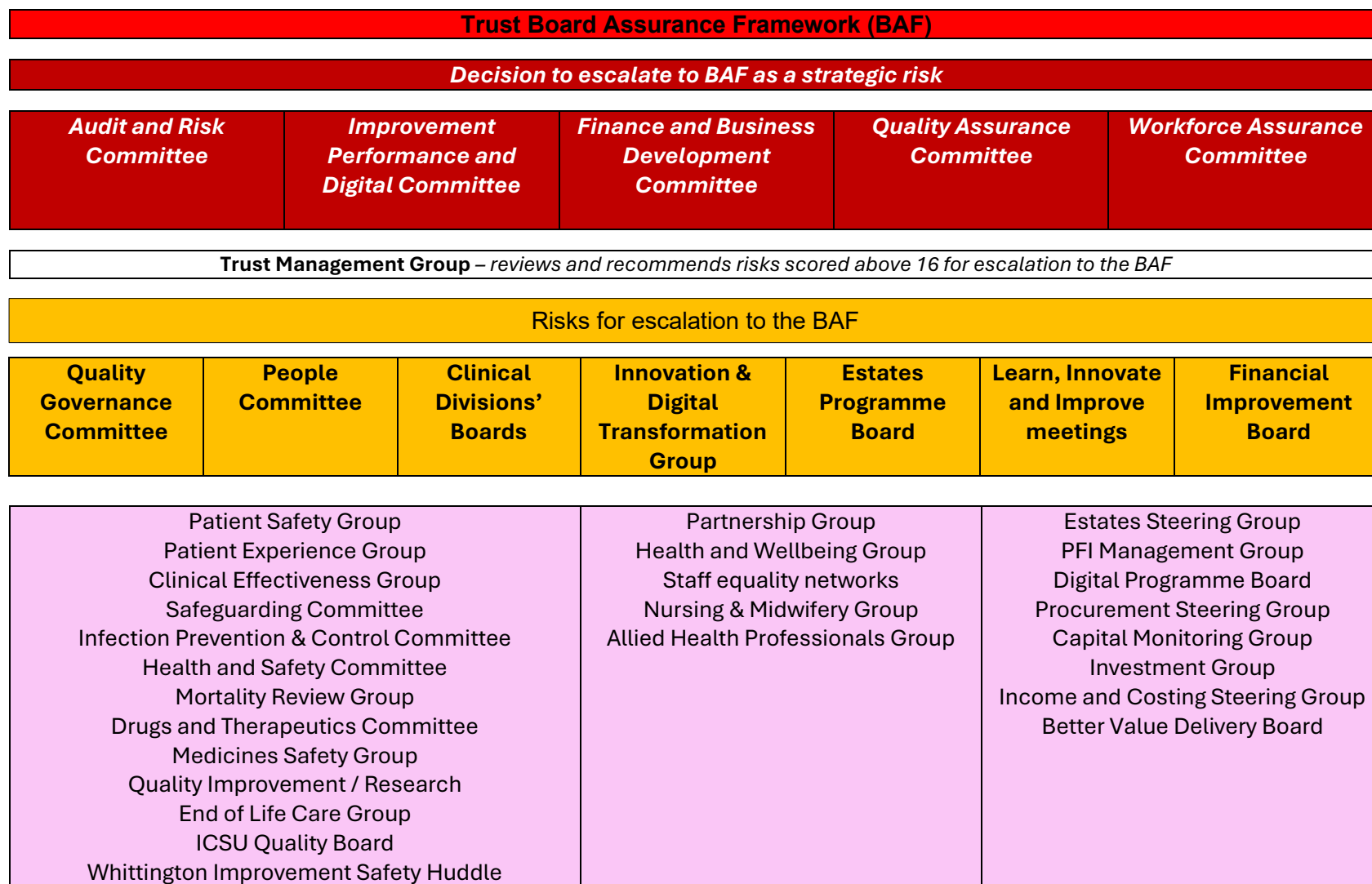
Risk scoring matrix (Risk = Consequence x Likelihood (C x L))

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

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

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

Trust-wide review and escalation of strategic risks





Meeting title	Workforce Assurance Committee	Date: 28/07/2026
Report title	Guardian of Safe Working Hours Report Q4 2025/26	Agenda item:
Executive director lead	Dr Rantimi Ayodele, Chief Medical Officer	
Report author	Dr Anna Gorringer, Guardian of Safe Working Hours (GoSWH)	
Executive summary	• Exception Reporting Reforms came into place on 4th Feb 2026. • Exception reports now bypass the educational supervisor and are signed out by HR/GoSWH along with other changes to access, time frames and confidentiality surrounding the reports. • The GoSWH continues to work with the postgraduate department, HR, rota coordinators and the Resident Doctors Forum (RDF) during this period. • A new GoSWH, Dr Anna Gorringer, started on on 23rd April 2026. Thank you to Dr Zara Sayer for her hard work in the role over the previous 3 years.	
Purpose:	• To provide assurance to the Board that Resident Doctors are working safe hours in accordance with the 2016 <i>Terms and Conditions of Service for NHS Doctors and Dentists in Training</i>.	
Recommendation(s)	The Board is asked to note this report.	
Risk Register or Board Assurance Framework	Board Assurance Framework: People 1 - staff recruitment and retention	
Report history	NA	
Appendices	NA	

Guardian of Safe Working Hours (GoSWH) Report Q4 2025-2026

1. Introduction

- 1.1. This report is presented to the Board with the aim of providing context and assurance around safe working hours for Whittington Health resident doctors.
- 1.2. In August 2016 the new Terms and Conditions (TCS) were introduced for doctors in training. There are clear guidelines of safe working hours and adequate supervision. Resident doctors submit an 'exception report' (ER) if these conditions are breached. The 2016 TCS has most recently been amended in June 2026.
- 1.3. ERs are raised by resident doctors where day to day work varies significantly and/or routinely from their agreed working schedule. Reports are raised electronically through Allocate's E-Rota system. Since the reforms introduced in February 2026, the majority of exception reports go directly to the HR team, rather than the resident's clinical supervisor, who action the resident's preferred compensation. Such action may include time off in lieu or payment for additional hours worked. Where issues are not resolved or a significant concern is raised, the GoSWH may request a review of the doctors' work schedule. The GoSWH, in conjunction with the Medical Workforce team, reviews all exception reports to identify whether a breach has occurred which incurs a financial penalty. The GoSWH will levy a fine to the department employing the doctor for those additional hours worked.
- 1.4. In line with the 2016 TCS a Resident Doctors Forum (RDF) has been jointly established with the GoSWH and the Director of Medical Education. It is co-chaired by the GoSWH and the Chief Registrars. The Forum meets on an alternate monthly basis and continues to have good attendance and engagement, particularly from Foundation doctors. Meetings are current a hybrid of a face to face and virtual meeting.

2. High level data

Number of doctors / dentists in training (total): 224

Job planned time for guardian: 1 programmed activity

Admin support provided to the guardian (if any): as required from MD office

Amount of job-planned time for educational supervision: 0.25PA per educational supervisor

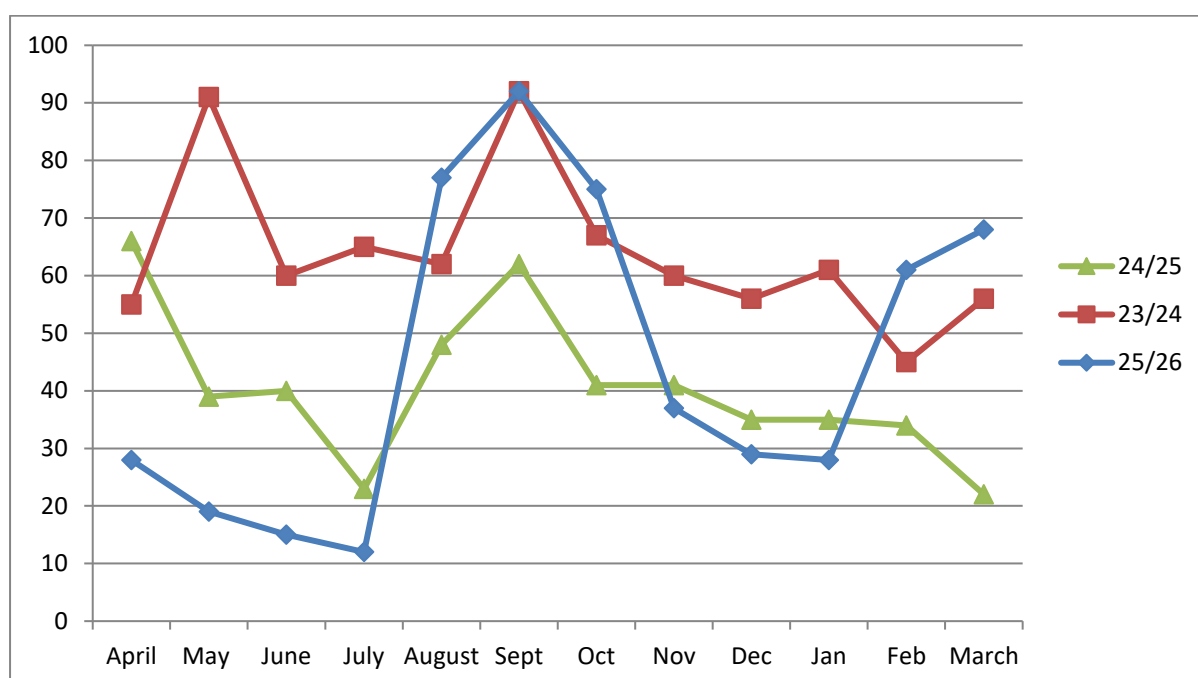
3. Exception reports (with regard to working hours)

3.1. Between the 1st January and 31st March 2026 there have been a total of 157 ERs raised. The table below gives details on where exceptions have been raised and the responses to deal with the issue raised. The data included differs from previous reports and is in line with the new Exception Reporting system introduced from 4th February 2026.

Table 1: Exception reports raised and responses

2025-26		Jan	Feb	Mar	Total
Reports	Total	28	61	68	157
Immediate safety concern		3	0	1	4
Nature of Exception	Additional hours: an unscheduled early start	0	1	1	2
	Additional hours: an unscheduled late finish	28	55	51	134
	Breaches of non-resident on-call patterns	0	0	0	0
	The inability to take contractual breaks	0	0	0	0
	Inadequacy of clinical support	0	0	0	0
	Inadequacy of rostered skills mix	0	0	0	0
	Raising concerns of a suspected non-compliant rota pattern	0	0	0	0
	Missed Educational Opportunities	0	1	1	2
Agreed Action ('No action required' is the only response available for 'education' exception reports)	Time off in lieu (TOIL)	5	9	2	16
	Payment for additional hours	23	47	50	120
	No action required	0	1	1	2
	Withdrawn	0	4	15	19
Additional concerns / breaches resulting in penalty fines	Detriment or threat of detriment related to exception reporting	0	0	0	0
	Information breach	0	0	0	0
	Access and completion resolved in time	0	0	0	0
	Access and completion breaches	0	0	0	0
	Breach of maximum 13hr shift	0	2	8	10
	Breach of contractual working hours (other; as per 2016 TCS)	0	0	0	0

Graph 1: Exception reports over three years by Month



3.2. The number of ERs submitted per month is very variable throughout the year and year on year. This quarter follows the same trend of previous years. There does not seem to be a significant increase in exception reporting following the introduction of reforms in February 2026. This will continue to be monitored.

Immediate safety concerns

3.3. There were four immediate safety concerns (ISC) was raised over the three-month period. Two were incorrectly submitted / withdrawn. Two related to the same clinical concern and the GoSWH recommended a Datix be submitted to explore the issue further.

Work Schedule reviews

3.4. No work schedule reviews were required in this period.

Detriment related to Exception Reporting

3.5. There were no concerns raised about detriment or threat of detriment due to exception reporting in this period. The GoSWH has introduced a survey for Q1 2025-26 to explore further any experiences of detriment related to exception reporting.

4. Establishment and Vacancy data

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

Table 2: Bank and agency usage Q4

ICSU	Bank		Agency		Locums Nest		Total	
	Hours	Cost (£)	Hours	Cost (£)	Hours	Cost (£)	Hours	Cost (£)
Emergency and integrated medicine	-	-	105	5,924.54	5882.10	439,129	753.25	387708
Surgery and cancer	-	-	-	-	3,398.23	257,666	243	185452
ACW	76.5	4,859	-	-	763.53	62,811	154.5	79720
Children and young people	-	-	-	-	783.25	60,649	82	62084
ACW: Access centre clinical support and women's health *includes associate specialists								

Vacancies

4.2 There were a total of 21 vacant posts for this quarter (19 WTE vacant). However when less than full time data and additional posts which were not part of the establishment (academic or supernumerary posts) there was a 2.0 WTE gained.

Table 3: Vacancies per speciality Q4

Speciality	Current vacancies
Acute internal medicine	1 Higher 1 IMT3 1 IMT1/2 1 FY2
General surgery	2 Higher
Urology	1 Higher
Geriatric Medicine	1 Higher 1 GP
Emergency medicine	1 Higher 1 Lower 2 FY2
Anaesthetics inc ITU	1 Higher 1 Lower
Endocrine and diabetes	1 FY1
Gastroenterology	1 Higher

Paediatrics	2 Higher
Audiovestibular medicine	1 Higher
Dental Core Training	1 Lower
Higher and lower are the terms used by the post-graduate centre to describe seniority of trainee	

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

5.1. For this quarter a total of 159 hours 45 minutes has been repaid either in time off in lieu (TOIL) or pay for additional hours worked.

5.2. Currently, these hours equate to a total of approximately £3,483.54

5.3. In terms of penalty payments, there have been £262.29 levied for doctor penalty payments and £310.85 Guardian fines levied.

5.4. The funds raised from penalty payments are spent on behalf of the resident doctors in accordance with NHS employers guidance on permitted uses of fines monies. Fine monies must be used only to benefit the education, training and working environment of doctors, and should prioritise wellbeing-focused initiatives. The resident doctors have requested that GoSWH fines money is transferred to the post-graduate centre to pay towards lunch provisions for teaching. This continues to be under review at the Resident Doctors Forum. The finance department is facilitating the movement of this money.

6. Next steps

6.1. Significant changes came into effect with regard to exception reporting on 4th Feb 2026. There main areas for change include:

- i. Time frame for ER is now increased to 28 days; the choice of TOIL or payments is determined by the doctor submitting the report (unless when TOIL is mandatory for safety) and these need to be signed out within seven days.
- ii. ERs are signed out by HR/GoSWH and not by the clinical supervisor (CS).
- iii. If a resident doctor needs to stay late then the reasons for this are not to be questioned – it is their clinical judgement and that needs to be protected. There is a distinction between ER <2 hours and those >2 hours. If > 2 hours, a probity form needs to be completed (no geolocation data is currently requested).
- iv. Additional fines can be levied for breaches in confidentiality (eg. if discussed with CS).
- v. If access is not granted to the exception reporting system within seven days of the resident doctor starting, a further fine is levied.

Work on this continues and the GoSWH and HR are working closely with other hospitals within NCL and England to ensure that we are in line with other trusts.

- 6.2. The GoSWH to ensure that the ER fine money is transferred to the postgraduate centre as per the request of the request of the resident doctors. This continues to be reviewed at the RDF.
- 6.3. GoSWH continues to meet HR and finance every two months to review data and any issues relating to the reports submitted.
- 6.4. GoSWH reports are being presented at the medical committee and feedback taken from medical staff is incorporated into the reports.
- 6.5. GoSWH reports will also be presented at the RDF so the resident doctors are able to see the contents and aid transparency in the process. GoSWH has also been actively engaged with the '10 point plan to improve resident doctors' working lives'.
- 6.6. GoSWH continues to be part of the London and National GoSWH groups and the first national GoSWH meeting (organised by GoSWH) has been held which was highly informative.
- 6.7. The new GoSWH started on 23rd April 2026.

7. Conclusions

- 7.1. This quarter's report shows that ER are in line with those generated from previous years, with no significant increase yet noted following the introduction of reforms in February 2026.
- 7.2. Primary events leading up to exceptions are issues due to workload and times when there is very minimal staffing on the wards due to rota gaps, on-call commitments and sickness.
- 7.3. Low levels of reporting in particular areas is now no longer an area of focus given the confidentiality around ER, but this will continue to be monitored and resident doctors will continue to be encouraged to ER from all area and at all levels.

8. Recommendations

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



Meeting title	Trust Board – public meeting	Date: 25 September 2026
Report title	Integrated Performance Report	Agenda Item: 7
Executive lead	Chinyama Okunuga, Chief Operating Officer	
Report authors	Paul Attwal, Operational Director of Performance, Jennifer Marlow, Performance Manager	
Executive summary	Background Board members are presented with the September 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 August 2026 there was 3 healthcare-associated Clostridioides difficile infection and 0 MRSA Bacteraemias, bringing the total number of MRSA Bacteraemias to 1 for the year (April 2026 – March 2027). Emergency Care Flow During August 2026, performance against the 4-hour access standard was 71.6%, this is an improvement of 0.78% compared to July's performance of 70.82%. The Trust's performance remained below both the West and North London healthcare system average of 80.4% and the national average of 75%. In August 6.7% of patients spent more than 12 hours in the Emergency Department, with 157 12-hour trolley breaches recorded. Cancer: 28-Day Faster Diagnosis Standard (FDS) July Performance – 89.1% This is an improvement of 2.4% compared to June's performance of 86.7% and remains above the target of 80% Cancer: 31 Days to First and Subsequent Treatment July Performance – 100% This is the same as June's performance of 100% Cancer: 62-Day Combined Treatments July Performance – 75% This is a worsening of 12.2% compared to June's performance of 87.2% Referral to Treatment (RTT): 52+ Week Waits The unvalidated performance against 18-week standard for August 2026 was 67.23%, this is a worsening of 1.05% compared to July's performance of 68.28%. The Trust's position against the 52-week performance remains	

	strong, with only 0.45% of patients waiting more than 52 weeks for treatment. Did Not Attends (DNA) The Trust's overall DNA rate for first appointments in August 2026 was 11.1% against a target of less than 9%. This is a worsening of 0.81% compared to July's performance of 10.29%. Complaints Complaints responded to within 25 or 40 working days performance for August was 63.6%, this is a worsening of 12.5%, compared to July's performance of 76.1%. 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-two months.
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 2: 2025/26, Q4 Health equity report

Whittington Health NHS Trust

Integrated Performance Report

September 2026



Integrated Performance Report Overview

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.

Slide	Section
3-4	Key Exceptions for Noting
5-13	Performance Overview
14	Emergency Department and Patient Flow
15	Referral-to-Treatment and Diagnostics
16	Cancer
17	Activity and Productivity
18-19	Quality and Safety
20	Safer Staffing
21	Workforce
22	Community – Children and Young People
23	Community – Adults

Key Exceptions for Noting

Emergency Department and Patient Flow

August 2026 UEC performance improved to 71.6%, up from 70.8% in July, despite increased attendances and ongoing workforce pressures, including staff sickness, resident doctor rotations and higher mental health demand.

Performance was supported by a significant reduction in 12-hour ED trolley breaches, which fell from 283 to 170, alongside a reduction in mental health 12-hour breaches from 19 to 15.

NCTR and long length of stay remained stable, with discharge delays continuing to be driven primarily by social care and brokerage capacity constraints. Improvement efforts remain focused on discharge flow, admission avoidance, corridor care actions, out-of-hours performance, and expansion of ambulatory care pathways.

Referral to Treatment and Diagnostics

RTT performance for August 2026 is currently 67.2% (unvalidated), remaining below both the Trust's expected performance level and national trajectory, with challenges concentrated in General Surgery, Gynaecology, Dermatology and ENT. Recovery actions are focused on waiting list validation, reducing DNAs, managing provider capacity and increasing clinic availability.

Long-wait performance remains strong, with 52-week waits at 0.45% and no patients waiting over 65 weeks.

Diagnostic performance remained stable at 82.19%, with ongoing capacity pressures in Audiology and Neurophysiology being addressed through targeted recovery plans.

Cancer

Performance against the 28-Day Faster Diagnosis Standard was 89.1% in July 2026, remaining above the national standard, with the unvalidated August position at 88.5%.

Performance against the 31-Day Treatment Standard remained strong at 100% in July 2026 and is forecast to continue at 100% in August.

Performance against the 62-Day Combined Treatment Standard declined to 75.0% in July 2026, partly due to six reportable pathways being excluded from the national submission; Colorectal, Gynaecology, Lung, Upper GI and Urology services all performed below the national standard.

Activity and Productivity

First outpatient DNA performance deteriorated to 11.1% in August, above the 10% target, with non-attendance particularly affecting ENT (25%) and Pain Management (24%), while Advice and Guidance performance improved to 67.9% of requests responded to within two days.

Theatre utilisation improved across several specialties, most notably Gynaecology, through stronger list management and productivity initiatives. Patient-initiated cancellations remained the main cause of lost theatre capacity, with mitigation measures including standby patient processes and pathway improvements in Urology to reduce clinical cancellations.

Key Exceptions for Noting

Quality and Safety

Three hospital-onset Clostridioides difficile infections were reported in August 2026, with post-infection reviews completed and learning shared across services to strengthen infection prevention and control practices. Complaints performance was 63.6%, below the 80% target, with communication, delays and admission arrangements remaining the most common themes.

Pressure ulcer performance improved, with 25 incidents reported compared to 42 in July, although performance remains below trajectory, particularly in community services. Improvement work continues across both hospital and community settings, focusing on staff communication, patient and carer engagement, risk assessment and preventative care.

Safer Staffing

Safe staffing performance improved in August 2026, with reductions in red shifts, maternity red flags and net under-hours indicating more effective workforce deployment and operational oversight.

Registered nurse fill rates decreased and unfilled roster gaps increased, reflecting ongoing pressures from vacancies, sickness absence, annual leave and maternity leave. Workforce unavailability also increased during the month, impacting overall staffing resilience. Recruitment, retention, sickness management and roster optimisation remain key priorities to support safe and sustainable staffing across the Trust.

Workforce

Appraisal compliance decreased to 75% from 78% in July, with ACW remaining the only division meeting the Trust target, while Corporate Divisions and Surgery & Cancer continue to have the lowest compliance levels.

Trust-wide sickness absence remained above target at 4.31%, with mental health and musculoskeletal conditions continuing to be the main contributors to lost working time. Targeted action is underway to improve appraisal compliance, staff engagement and workforce wellbeing across the organisation.

Children and Young People

Health Visiting new birth visit performance has continued to improve, with Barnet achieving 92% in July 2026 compared to 82% in July 2025, and sustained improvements also being seen in Haringey. However, the number of children and young people waiting over 52 weeks for a first appointment continues to increase, largely driven by demand within the Haringey Social Communication Team. Additional ICB investment and ongoing pathway redesign work are expected to support reductions in waiting times for autism and ADHD assessment services.

Community - Adults

Demand continues to exceed capacity across MSK services, resulting in sustained waiting time pressures despite ongoing recovery actions and early signs of improvement, including a significant reduction in Pain Service waits.

Virtual Ward utilisation remained below target in both Haringey and Islington due to referral and operational pressures, while Urgent Community Response achieved its 2-hour performance target.

Community Podiatry performance remains strong, with no patients waiting over 18 weeks and further service improvements being implemented to enhance access and efficiency.

Performance Overview

Status	Metric	Trend	Target	Period	Trust
Emergency Department and Patient Flow					
3	Percentage of Emergency Patients Admitted, Transferred, or Discharged Within 4 Hours		82% or higher by March 2027	August 2026	71.6%
2	Percentage of Patients Spending More Than 12 Hours in the Emergency Department		6.5% or less	August 2026	6.7%
3	Number of Non-Mental Health Patients With a Decision to Admit Who Spent Over 12 Hours in the Emergency Department		0	August 2026	157
3	Number of Mental Health Patients With a Decision to Admit Who Spent Over 12 Hours in the Emergency Department		0	August 2026	15
3	Corridor Care – Average Number of Patients Per Day		0	August 2026	21
	Percentage of Emergency Department Activity Diverted to Ambulatory Care		TBC	August 2026	5.1%
2	Average Length of Stay for Non-Elective Admissions (General and Acute)		7.7 days or less	August 2026	8.71 days
2	Average Length of Stay for Elective Admissions (General and Acute)		2.5 days or less	August 2026	2.99 days
3	Number of Patients Not Meeting Criteria to Reside and Not Discharged		40 or less	August 2026	55
1	Percentage of Patients Readmitted as an Emergency Within 30 Days of Discharge		5.5% or less	August 2026	4.01%

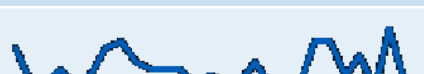
Performance Overview

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	August 2026	22,918 Unvalidated
3	Percentage of Incomplete RTT Pathways Waiting Less Than 18 Weeks		78% or higher	August 2026	67.23% Unvalidated
2	Percentage of Patients Waiting Over 52 Weeks for Elective Treatment		0% or less by March 2027	August 2026	0.45% Unvalidated
3	Percentage of Patients Waiting Under Six Weeks for a Diagnostic Test		91% or higher by March 2027	August 2026	82.19%
Cancer					
1	Faster Diagnosis Standard: Percentage of Patients with Cancer Diagnosed or Ruled Out Within 28 Days		80% or higher by March 2027	July 2026	89.1%
1	Percentage of Patients Receiving First Definitive Treatment Within 31 Days of Cancer Diagnosis		94% or higher by March 2027	July 2026	100%
2	Percentage of Patients Receiving First Definitive Cancer Treatment Within 62 Days of an Urgent GP Referral		80% or higher by March 2027	July 2026	75%

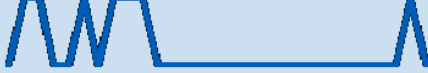
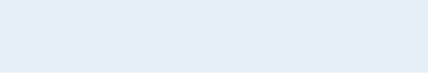
Performance Overview

Status	Metric	Trend	Target	Period	Trust
Activity and Productivity					
1	First to Follow-Up Appointment Ratio (Acute)		1.8 or less	August 2026	0.95
4	Did Not Attend (DNA) Rates for New Appointment		5.6% or less by March 2027	August 2026	11.1%
	GP Referrals to an Acute Service		TBC	August 2026	9,585
	Total Referrals to Acute Service		TBC	August 2026	22,320
3	Advice and Guidance % of Responses Within 2 Days		80% or higher	August 2026	67.91%
1	First Outpatient Attendances: Percentage of Activity Delivered Against Plan		100% or higher	August 2026	101.19%*
2	Outpatient Procedures: Percentage of Activity Delivered Against Plan		100% or higher	August 2026	92.11%*

Performance Overview

Status	Metric	Trend	Target	Period	Trust
Activity and Productivity					
1	Ordinary Elective Care: Percentage of Activity Delivered Against Plan		100% or higher	August 2026	103.48%*
3	Day Case Activity: Percentage of Activity Delivered Against Plan		100% or higher	August 2026	89.08%*
3	Operating Theatre Utilisation Rate		85% or higher	August 2026	76.36%
3	Number of Hospital Operations Cancelled on the Day		0	July 2026	8
2	Cancelled Operations not Rebooked Within 28 Days		0	July 2026	1
	Number of Births per Month		TBC	August 2026	212

Performance Overview

Status	Metric	Trend	Target	Period	Trust
Quality and Safety					
1	Percentage of Patients Assessed for Venous Thromboembolism (VTE) Risk		95% or higher	August 2026	95.06%
2	Inpatient Falls		Less than 400 for 2025/26	August 2026	41
2	Number of Clostridioides Difficile Infections (C. Diff)		Less than 22	August 2026	3
1	Number of Methicillin-Resistant Staphylococcus Aureus (MRSA) Infections		0	August 2026	0
2	Number of Acute Pressure Ulcers (Grades 3 to 4)		Less than 51 for 2026/27	August 2026	5
1	Summary Hospital-Level Mortality Indicator (SHMI)		1	May 2025 – April 2026	0.88
	Inpatient Survey Satisfaction Rate: Positive Responses		90% or higher	August 2026	Not available
3	Percentage of Complaints Responded to Within 25 or 40 Days		80% or higher	August 2026	63.6%

Performance Overview

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	August 2026	1
	Red Flags – Inpatient Maternity		TBC	August 2026	19
	Care Hours Per Patient Day - Average Direct Care Hours Delivered Per Patient Over a 24-Hour Period		N/A	August 2026	10.2
2	Percentage Fill Rate for Registered Staff - Proportion of Planned Registered Staffing Covered on Wards		Between the range of 95% - 105%	August 2026	90%
3	Percentage Fill Rate for Unregistered Staff - Proportion of Planned Unregistered Staffing Covered on Wards		Between the range of 95% - 105%	August 2026	118%
2	Percentage of Unfilled Rostered Shifts - Proportion of Planned Staffing Not Filled Across All Rostered Services		Less than 10%	August 2026	14%
	Net Over Hours - Amount of Additional Staffing Hours Worked Above Planned Roster Levels		N/A	August 2026	12,941
	Net Under Hours - Shortfall of Staffing Hours Against Planned Roster Levels		N/A	August 2026	36,837
1	Roster Approval Lead Time - Number of Days in Advance Rosters Are Finalised and Approved Before Going Live		56 days or more	August 2026	52
3	Percentage of Workforce Unavailable for Rostering Including Maternity Leave		Between the range of 20% - 24%	August 2026	28%

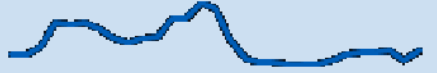
Performance Overview

Status	Metric	Trend	Target	Period	Trust
Workforce					
1	Mandatory Training Completion Rate		85% or higher	July 2026	90%
2	Percentage of Completed Appraisals		85% or higher	July 2026	75%
3	Percentage of Sickness Absence		3.5% or less	July 2026	4.31%
1	Staff Turnover Rate: Percentage Leaving in Last 12 Months		13% or less	August 2026	8.9%
1	Vacancy Rate Percentage		10% or less	August 2026	5.2%
	Average Time to Hire (Days)		63 days or less	August 2026	Not available

Performance Overview

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	July 2026	93.56%
2	New Birth Visits by Health Visitors (Islington)		95% or more completed within 14 days	July 2026	92.53%
2	New Birth Visits by Health Visitors (Barnet)		95% or more completed within 30 days	July 2026	92.44%
4	Percentage of CYP Patients Waiting Over 52 Weeks		Less than 1% of total service	August 2026	10.25%
1	Average Wait Time to First Appointment: Occupational Therapy (OT)		18 weeks or less	August 2026	8.5 weeks
1	Average Wait Time to First Appointment: Speech and Language Therapy (SLT)		13 weeks or less	August 2026	14.1 weeks
2	CAMHS Wait Times to First Appointment (Excluding Neurodevelopmental Disorders)		4 weeks or less	August 2026	4.5 weeks
3	First Community CYP Health Service Activity Within 18 Weeks		78% by March 2027	August 2026	63.93%

Performance Overview

Status	Metric	Trend	Target	Period	Trust
Community – Adults					
2	Average Wait Time to First Appointment (All ACS Services)		6 weeks or less	August 2026	5.9 weeks
1	Percentage of Patients Waiting Over 52 Weeks for an Appointment		Less than 1% of total service	August 2026	0.12%
1	Percentage of Patients with Urgent Rapid Response Referrals Seen Within 2 Hours		80% or higher	August 2026	80.2%
1	Continuing Healthcare 28-Day Referral to Complete Assessment		50% or higher	August 2026	77.42%
	Total Appointments for District Nursing		No target – Monitoring only	August 2026	29,273
1	Percentage of Patients Seen Within 48 Hours of Referral to District Nursing		80% or higher	August 2026	95.7%
2	Number of Category 3 and 4 Pressure Ulcers in Adult Community Care		Less than 209 for 2026/27	August 2026	20
3	Percentage of Virtual Ward Occupancy		80%	August 2026	69.49%
4	First Community Health Service Activity Within 18 Weeks		78% by March 2027	August 2026	61.78%

Urgent and Emergency Care (UEC) Performance Summary

UEC performance increased to 71.60% in August 2026 from 70.82% in July. Performance was impacted by higher-than-expected attendances in August

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
- Rotation of resident doctors
- Increased Mental Health presentations and 72-hour breaches

12 hr ED trolley breaches saw a significant decrease to 170 in August from 283 in July, there was also a decrease in MH 12-hour breaches to 15 in August from 19 in July.

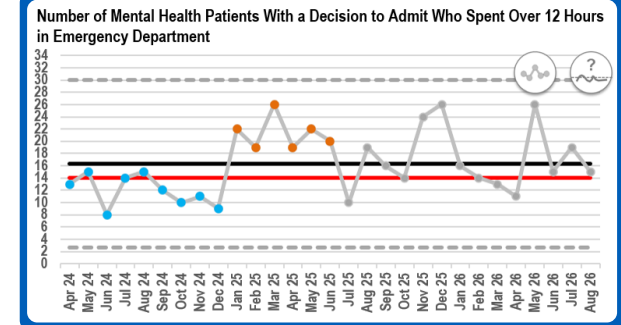
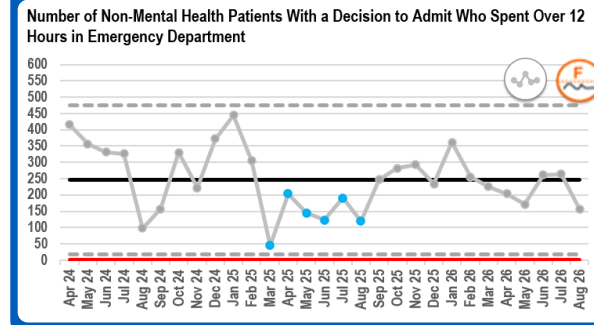
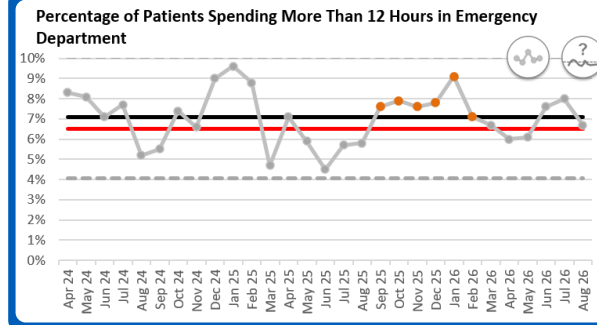
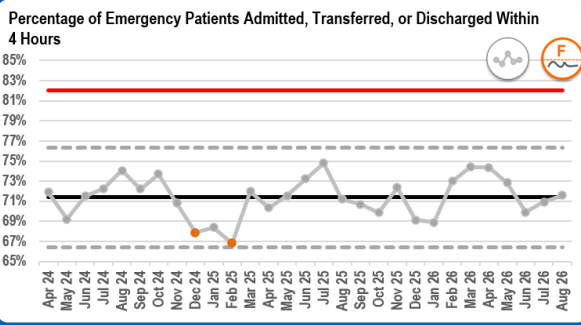
NCTR and LLOS remained stable in August compared to July, with no real improvements in either, this was predominantly driven by delays in social care and brokerage. Closer collaboration with Local Authorities continues to support earlier discharges, along with developing more effective prevention of 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 focus on UTC performance
- Enhanced admission avoidance pathways to support flow and patient care.
- Expanded Extended Emergency Medicine Ambulatory Care (EEMAC) footprint to support treatment times.



Referral-to-Treatment and Diagnostics

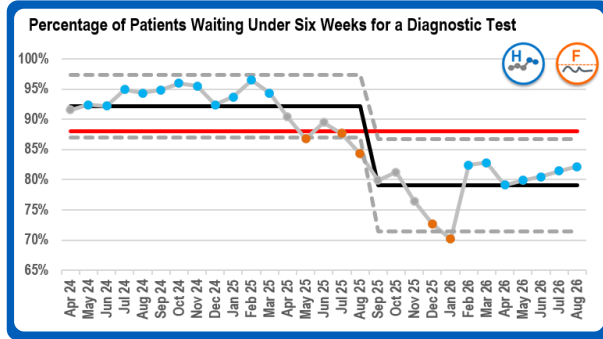
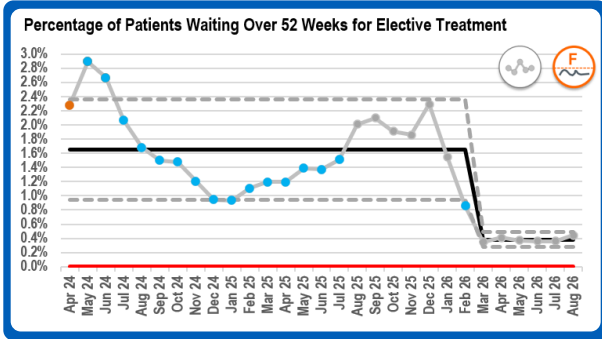
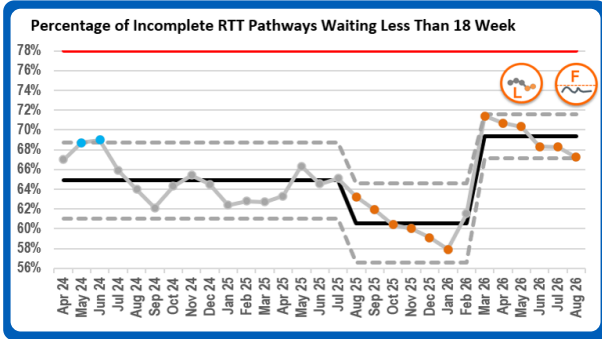
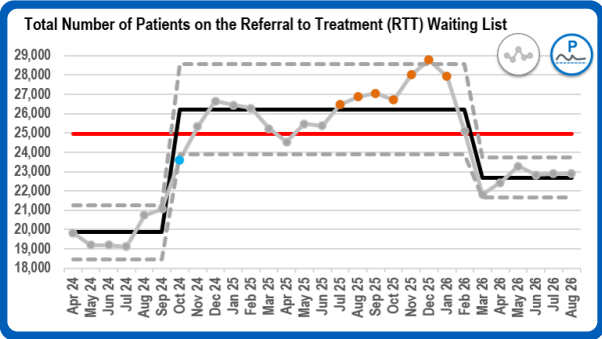
Referral-to-Treatment and Diagnostics

RTT: 18-week performance for August 2026 is due for submission on the 23rd September 2026 therefore figures reported here are unvalidated, performance against the 18-week standard currently at 67.23%, representing a 0.77% shortfall against the updated expected performance of 68% and 6.15% shortfall against the national planning trajectory of 73.38%. This variance is largely driven by deterioration in a number of specialties, most notably General Surgery (Admitted pathways), Gynaecology, Dermatology and ENT.

Focussed actions are underway within the four specialties mentioned above to improve overall RTT position and to achieve the expected end of year performance target. Following actions are taking place to improve overall RTT delivery including validation of waiting lists, focus on reducing DNA rates, management of SLAs with other service providers and ensuring ringfenced capacity for specific services including administrative time and additional clinics.

Notwithstanding the overall RTT position, long-wait performance remains strong and well controlled. The proportion of patients waiting over 52 weeks stands at 0.45%, 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 August 2026 has stabilised achieving 82.19%, a slight improvement of 0.7% points from July. 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.



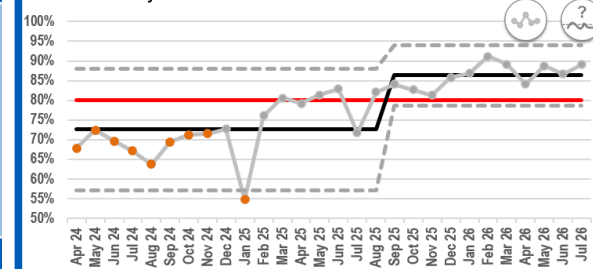
Faster Diagnosis Standard: Percentage of Patients with Cancer Diagnosed or Ruled Out Within 28 Days

Performance against the 28-Day Faster Diagnosis Standard (FDS) achieved 89.1% in July 2026. The unvalidated position for August is 88.5%.

The Gynaecology performance declined in July 2026 to 68.4% from 70.9% in June 2026.

Performance in the Urology service improved in July 2026 achieving 72.9%.

Faster Diagnosis Standard: Percentage of Patients with Cancer Diagnosed or Ruled Out Within 28 Days

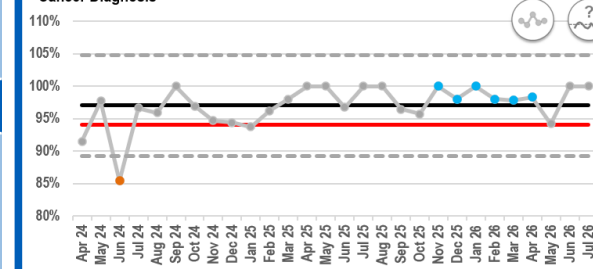


Percentage of Patients Receiving First Definitive Treatment Within 31 Days of Cancer Diagnosis

Performance against the 31-Day Treatment Standard in July achieved 100%. The unvalidated August 2026 position is at 100%.

The Trust has continued to sustain and deliver effective pathway management.

Percentage of Patients Receiving First Definitive Treatment Within 31 Days of Cancer Diagnosis



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 75% in July 2026 which is a decline in performance from June 2026 at 87.2%. The July 2026 performance was impacted by 6 patient pathways being excluded from the CWT submission that were reportable. This has been raised to NHS digital.

The below services all achieved below the national standard for July 2026.

The Colorectal service achieved 57.1%.

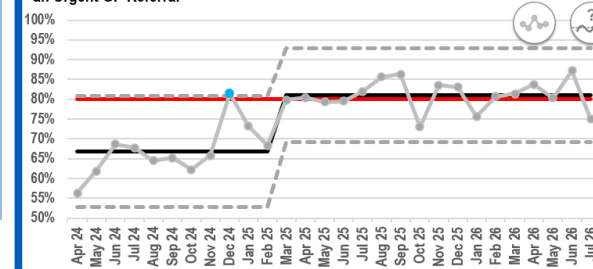
The Gynaecology service achieved 33.3%.

The Lung service achieved 58.3%.

The Upper GI service achieved 71.4%.

The Urology service achieved 66.7%.

Percentage of Patients Receiving First Definitive Cancer Treatment Within 62 Days of an Urgent GP Referral



Activity and Productivity

Did Not Attend (DNA) and Advice and Guidance (A&G)

DNA: The Trust's First Outpatient Appointments DNA rate was 11.1% in August 2026, an increase of 0.81% from 10.29% in July 2026, and above the 10% target.

This mirrors the pattern seen during the summer months in 2025, suggesting some seasonal impact associated with the holiday period and reduced patient availability.

Higher levels of non-attendance were driven in part by a small number of specialties, notably ENT (25%) and Pain Management (24%). The Trust continues to focus on improving patient engagement, strengthening appointment communications and maximising clinic utilisation to reduce avoidable non-attendance and improve performance.

A&G: In August 2026, the Trust received 642 Advice and Guidance requests, with 67.9% (436) responded to within two days.

This represents a 2.2% improvement from 65.7% in July. The highest volumes were received in Haematology (104 requests, 80.8% responded to within two days), Cardiology (96 requests, 61.5%), and Endocrinology (57 requests, 84.2%).

Theatres

Theatre Utilisation: Theatre Utilisation improved through timely list starts and effective preparation of the first ("golden") patient. Gynaecology utilisation increased from 73% to 82%, with more cases completed per session through improved booking based on actual procedure times.

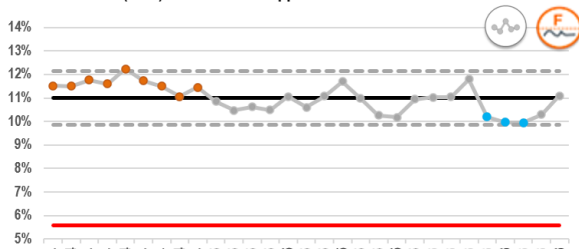
Support for Dental and Urology services has continued using benchmarking against peer organisations to improve productivity and cases completed per session.

Booking challenges were experienced due to seasonal changes in patient availability and choice, particularly within Spinal services, where a greater proportion of shorter, lower-complexity procedures were undertaken.

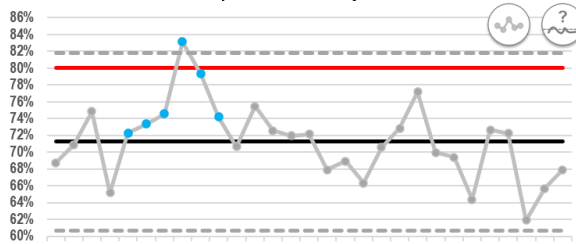
Cancellations: Patient-initiated cancellations accounted for 35 cases (83% of all cancellations). To reduce the impact of late-notice cancellations, a standby patient process has been introduced in Orthopaedics and will be expanded to other specialties.

Higher clinical cancellations in Urology were addressed through a new pathway based on GIRFT recommendations, supporting earlier identification and treatment of urinary infections and helping more patients proceed with their planned procedure.

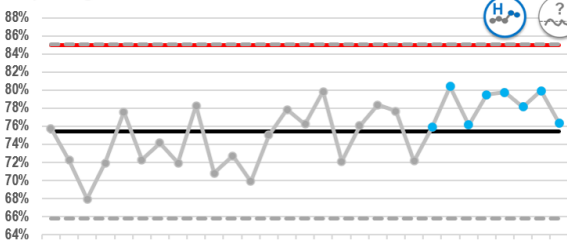
Did Not Attend (DNA) Rates for New Appointments



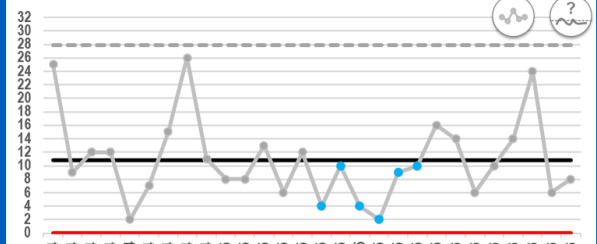
Advice and Guidance % of responses within 2 days



Operating Theatre Utilisation Rate



Number of Hospital Cancelled Operations



Infection Prevention and Control

In August 2026, the Trust reported three cases of Hospital-onset, Hospital-associated (HOHA) *Clostridioides difficile* infections (CDI).

The first patient received broad spectrum antibiotics and laxatives as part of their clinical management, both increase the risk of CDI. The second case was in an immunosuppressed patient with known risk factors for CDI who received clinically indicated antimicrobials. The third case had established risk factors for CDI and required prolonged course of appropriate antimicrobial treatment which increased the risk of CDI.

Post-infection reviews (PIR) were undertaken for the three cases with multidisciplinary team (MDT) involvement. The reviews were 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.

Key findings and learning points from the PIRs were shared with relevant stakeholders, who were asked to disseminate the information to their teams to promote awareness, reinforce good practice, and support ongoing IPC efforts.

Complaints

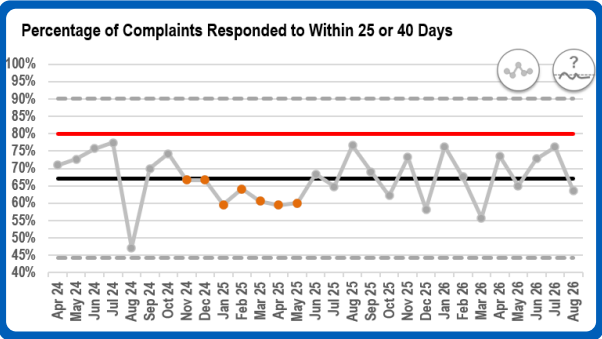
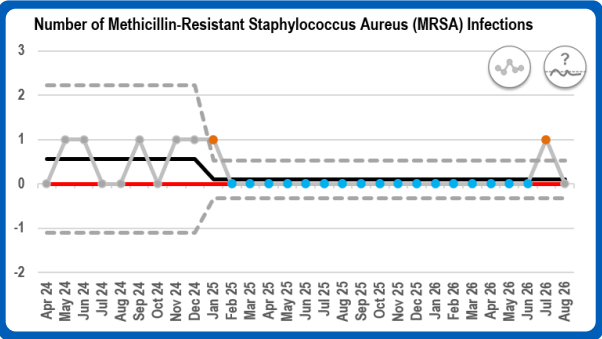
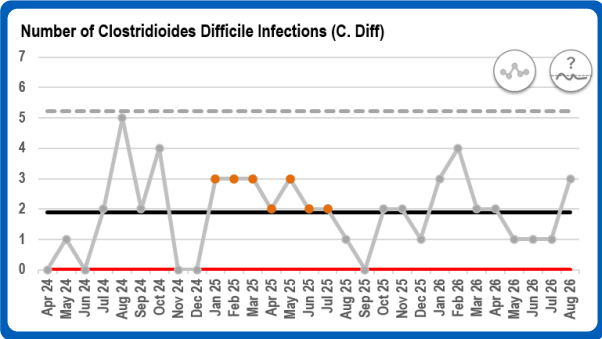
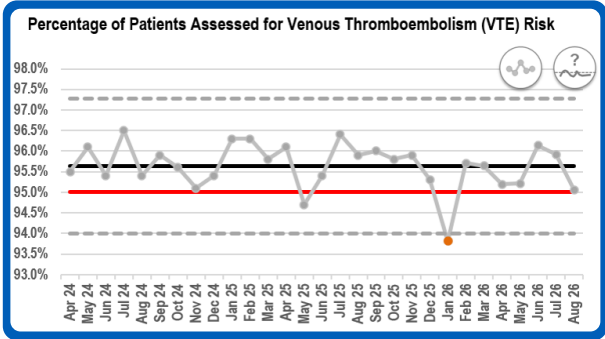
In August 2026, complaints performance was 63.6% (28/44), which is below the 80% target. A total of 44 complaints were due a response during the month.

The complaints due a response in August 2026 were allocated across the Divisions as follows: Surgery and Cancer 34% (15), Emergency Integrated Medicine 25% (11), Acute Clinical and Women’s Services 18% (8), Children and Young People 11% (5), Adult Community Services 7% (3), and Estates and Facilities 5% (2).

Severity of complaints: 2% (1) was designated as ‘high’ risk, 20% (9) were designated as ‘moderate’ risk, and 78% (34) were designated as ‘low’ risk.

Themes: The main themes from the complaints due a response in August 2026 remained broadly consistent with previous months, namely Communication, Delays and Admission Arrangements. Divisions and the Complaints Team continue to work collaboratively to address these areas through targeted learning and improvement actions.

Of the 28 complaints closed during August 2026, 7% (2) were ‘upheld’, 79% (22) were ‘partially upheld’, and 14% (4) were ‘not upheld’, meaning that 86% of complaints closed during the month were upheld in full or in part.



Pressure Ulcers

There were 25 full thickness pressure ulcer incidents affecting 21 patients in August 2026; a decrease of 17 from the previous month.

Acute Pressure Ulcers:

Five category 3 pressure ulcers developed on five patients in the hospital setting, a decrease of four from July 2026. The damage occurred across three different clinical areas; four of which within Surgery & Cancer division.

Key learning themes identified include the vulnerability of skin under or next to medical consumables, and challenges with patient non-engagement or inability to tolerate repositioning and seating guidance.

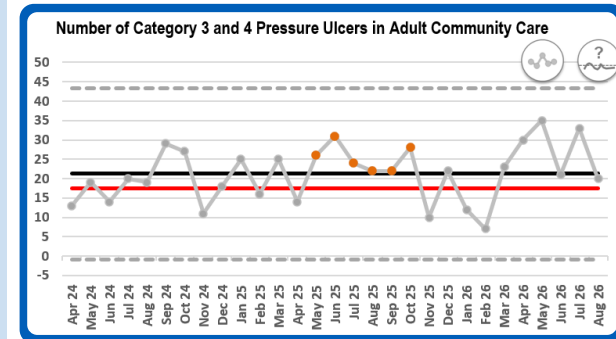
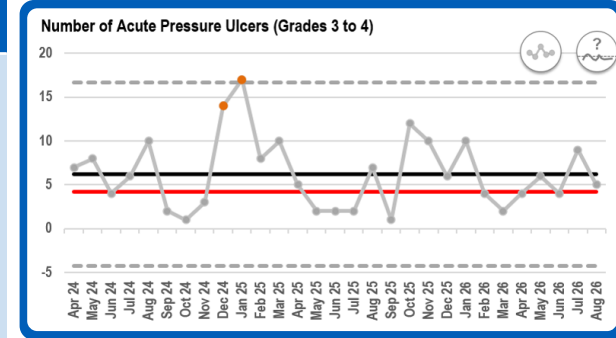
Community Pressure Ulcers:

Nineteen category 3 and one category 4 pressure ulcers developed on sixteen patients in the community setting, a decrease of thirteen from July 2026. Three patients developed two or more pressure ulcers, with 1 patient sustaining three category 3 pressure ulcers in the same anatomical location. The category 4 was a deterioration of a previously reported category 3 pressure ulcer. Data was similar in both the Islington & Haringey boroughs.

Themes identified include challenges with completing planned assessments during home visits, communicating at risk patients at team handovers, and patient non-engagement with agreed prevention plans.

The Trust pressure ulcer Key Performance Indicator targets for both hospital and community are below trajectory, particularly in the community setting.

Focused work on staff handovers, communicating at risk patient and carer engagement has taken place recently in the community setting, as well as utilising feedback from the ACS PU listening event into the weekly pressure ulcer Learning meetings. Within the hospital, focused areas of improvement include working with MDT teams to improve communication, managing at risk patients with darker pigmented skin, and skin assessment.



Safer Staffing

Red Shifts & Red Flags: August 2026 recorded 1 red shift, an improvement from 3 in July 2026, indicating reduced severe staffing pressures. There were 19 red flags in maternity, a reduction from 28 in July 2026. While staffing pressures continued to result in delays to time-critical care and pain relief administration, overall reporting suggests improved resilience within maternity services.

Care Hours Per Patient Day (CHPPD): CHPPD was 10.2 in August 2026, down from 10.3 in July and 10.5 in June, continuing a gradual reduction. This is likely linked to increased use of cohorting arrangements for suitable patients, supporting more efficient deployment of nursing resources while maintaining safe care.

Percentage Fill Rates: Registered staff fill rates decreased to 90% in August 2026 from 94% in July, reflecting ongoing vacancy, sickness, annual leave and maternity leave pressures. Despite this, escalation, redeployment and temporary staffing arrangements continued to support safe care delivery. Unregistered staff fill rates remained above establishment at 118% in August 2026, compared with 128% in July. This reduction is likely linked to increased cohorting arrangements, although fill rates remained sufficiently high to support ongoing need for Enhanced Care.

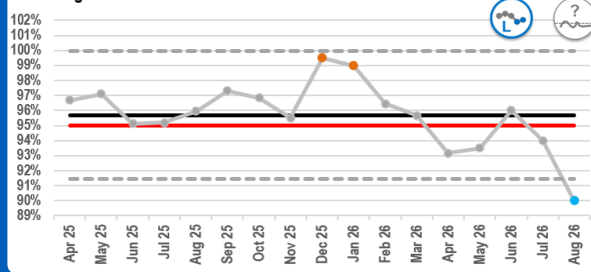
Percentage of Total Unfilled Roster: Total unfilled roster increased to 14% in August 2026 from 12% in July 2026. Vacancy levels, sickness absence and leave commitments continue to contribute to gaps.

Net Hours: August 2026 reported 12,941 net over-hours and 36,837 net under-hours. Over-hours remained stable compared with July, while under-hours reduced from 54,238, demonstrating improved roster management and workforce utilisation. Services continue to review staffing balances and roster accuracy through governance processes

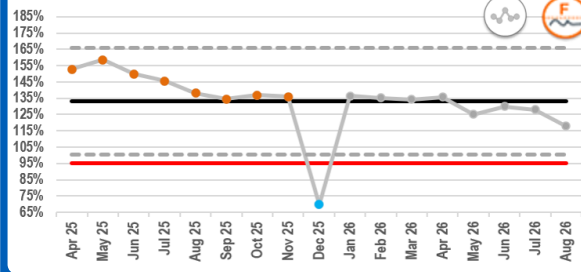
Roster Approval Lead Time: Roster approval lead time was 52 days in August 2026 compared with 51 days in July 2026. Performance remains broadly stable and within the Trust's established range.

Percentage of Workforce Unavailable: Workforce unavailability increased to 28% in August 2026 from 25% in July 2026. Annual leave utilisation during the summer period, sickness absence and maternity leave continued to impact workforce availability.

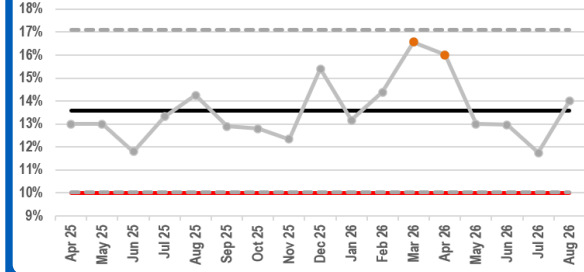
Percentage Fill Rate for Registered Staff - Proportion of Planned Registered Staffing Covered on Wards



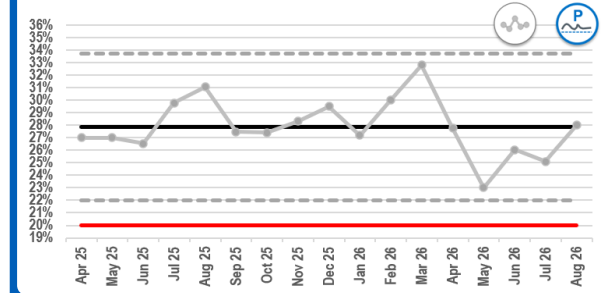
Percentage Fill Rate for Unregistered Staff - Proportion of Planned Unregistered Staffing Covered on Wards



Percentage of Unfilled Rostered Shifts - Proportion of Planned Staffing Not Filled Across All Rostered Services



Percentage of Workforce Unavailable for Rostering Including Maternity Leave



Appraisals

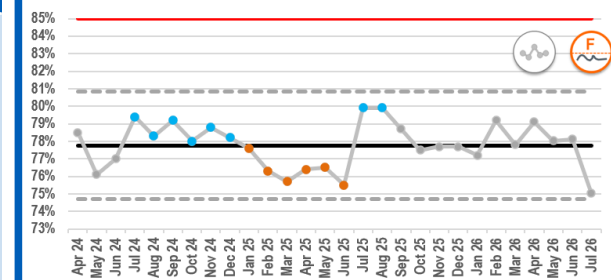
Appraisal compliance across the Trust has fallen to 75% from 78% in July. Acute Clinical and Women's Services (ACW) are the only division currently achieving the Trust target, with compliance of 88%.

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 increased to 191 from 172 in July.

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. Training is available via the Organisational Development Team.

Percentage of Completed Appraisals



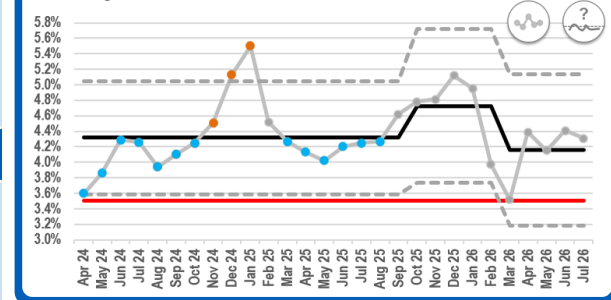
Sickness Absence

The overall Trust sickness absence rate came in at 4.31% for July which remains above the organisational 3.5% target.

The highest sickness rates were reported in Estates and Facilities (5.65%), EIM (5.23%) and Nursing and Patient Experience (4.86%), while ACW (3.47%) was the only clinical division operating below the Trust target. Corporate services generally reported lower levels of absence with several areas recording rates below 2%. Gastrointestinal problems were the most common reason for absence, followed by colds, coughs and flu.

However, the greatest impact on lost time was from anxiety, stress and depression conditions highlighting the continuing effect of mental health-related absence on workforce availability. MSK conditions were also significant contributors. Therefore, while short-term infectious illnesses continue to drive absence frequency, longer duration mental health and MSK conditions remain the principal reasons for overall sickness absence levels.

Percentage of Sickness Absence



Community – Children and Young People

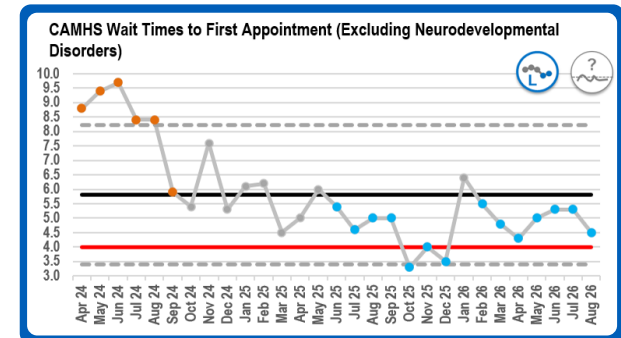
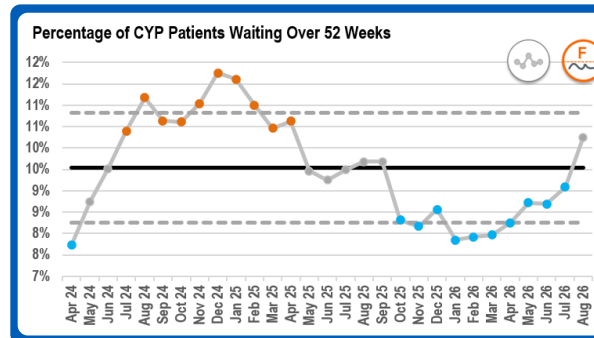
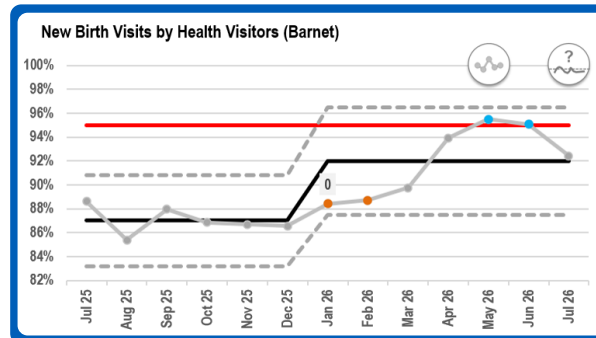
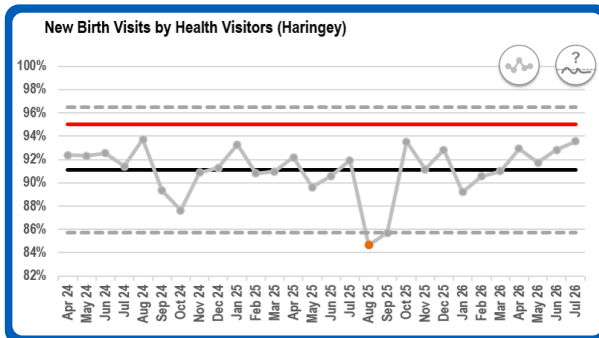
Community CYP

Health Visiting New Birth Visits

There has been improvement in the New birth visit performance in the Barnet health visiting service over the last 12 months (92% July 2026 compared to 82% July 2025). In June 2026, the service reached the performance target of 95% of visits completed within 30 days of a baby being born. The service continues to focus on improving systems and processes, ensuring that all capacity is used. The teams are also working with temporary staff to mitigate the impact of staffing gaps and to ensure essential service provision is maintained while recruitment into roles progresses. New birth visit performance has also improved over the last 7 months in the Haringey health visiting service.

Long Waits Reduction – 52 Plus Weeks

The percentage of children and young people (CYP) waiting over 52 weeks for a first appointment has been increasing each month since January 2026. The majority of the CYP waiting over 52 weeks are in the Haringey Social Communication Team, the autism assessment service for 0-11 year olds. New additional investment was agreed by West and North London ICB at the end of July to support work to reduce the long waiting times across North Central London for all autism and ADHD assessment services. Whittington Health services will receive part of this investment, and this will support a reduction in waiting times once the additional capacity is in place. Further work is happening alongside the additional investment to progress changes in assessment pathways to improve provision for children and families.



Community Adults

MSK Physiotherapy and Pain: Waiting times remain above target as demand continues to exceed commissioned capacity. MSK Physiotherapy referrals have increased by 72% since 2021, without corresponding workforce or funding growth.

Current average waits remain high across key services:

Physiotherapy (Routine Opt-In): 35 weeks, with 6,616 patients waiting over 18 weeks.

Pain Service: 31 weeks, with 184 patients waiting over 18 weeks and 9 patients waiting over 52 weeks.

CATS: 8 weeks, with 14 patients waiting over 18 weeks.

Recovery measures include recruitment, temporary capacity, Community Appointment Days and a Pain Introduction Group, which reduced Pain waits from 58 to 28 weeks in four months. ICB modelling identifies a recurrent requirement for an additional 7.5 WTE physiotherapists. Recurrent investment, automation and AI-enabled productivity solutions are being pursued; however, demand continues to outpace capacity. The MSK Trailblazer pilot continues to support healthcare inequalities and return-to-work outcomes.

Early signs of improvement are evident, but demand growth continues to outpace commissioned capacity.

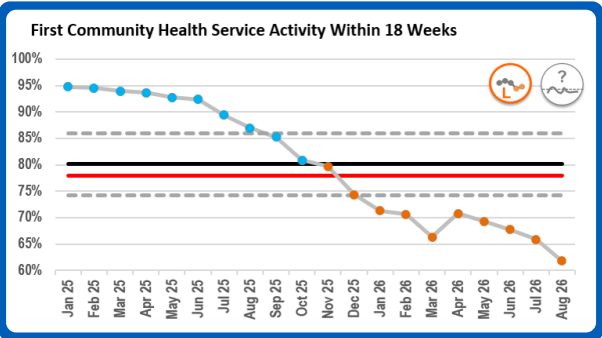
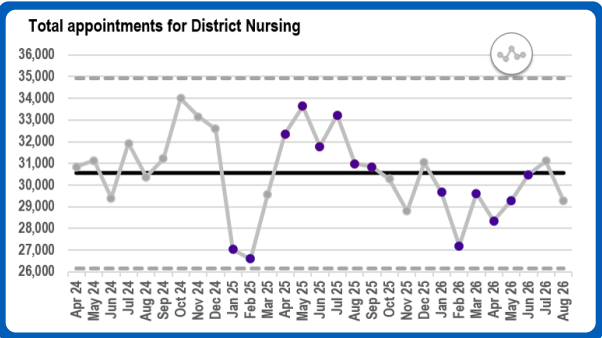
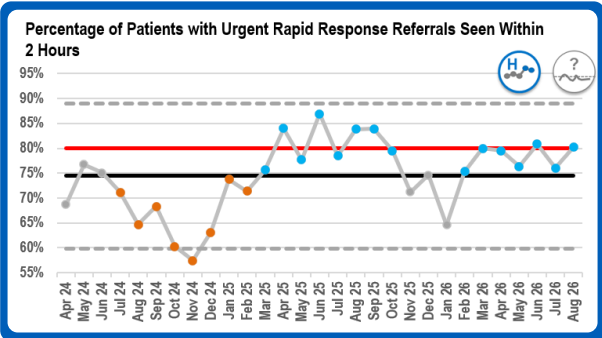
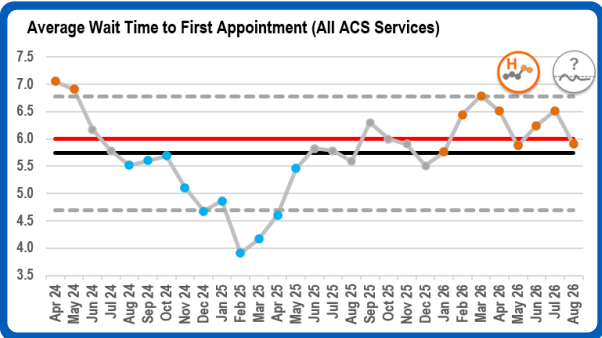
Hospital at Home (Virtual Ward) : Haringey achieved 75.5% utilisation, below the 80% target and July's 79.6%.

Islington achieved 63.4%. Performance was impacted by a drop in referrals while the case finder was on annual leave for the final two weeks of August. We are reviewing how to provide adequate cover. In Haringey, there was increased demand and reduced staffing at NMUH that required additional support from Whittington staff. Wider pressures included bus strikes, Tube closures and the heatwave, which contributed to staff sickness and made community visits more challenging.

A utilisation recovery plan is under way to reach 80% consistency.

Haringey and Islington UCR: received 217 referrals, with 83.4% seen within their respective target timeframes overall. Performance for high-risk 2-hour referrals was 81.6% (71 of 87), achieving the 80% target.

Podiatry: Continued improvement in Community Podiatry. No patients waiting more than 18 weeks across all disciplines within Podiatry, including Biomechanics, only 38 patients waiting 16 weeks. About to launch Get U Better for Bio patients to try before given an appointment. Also trialling virtual nail surgery assessment appointments for completion of consent and assessment (as no treatment given) currently patients have to come in using up an appointment.





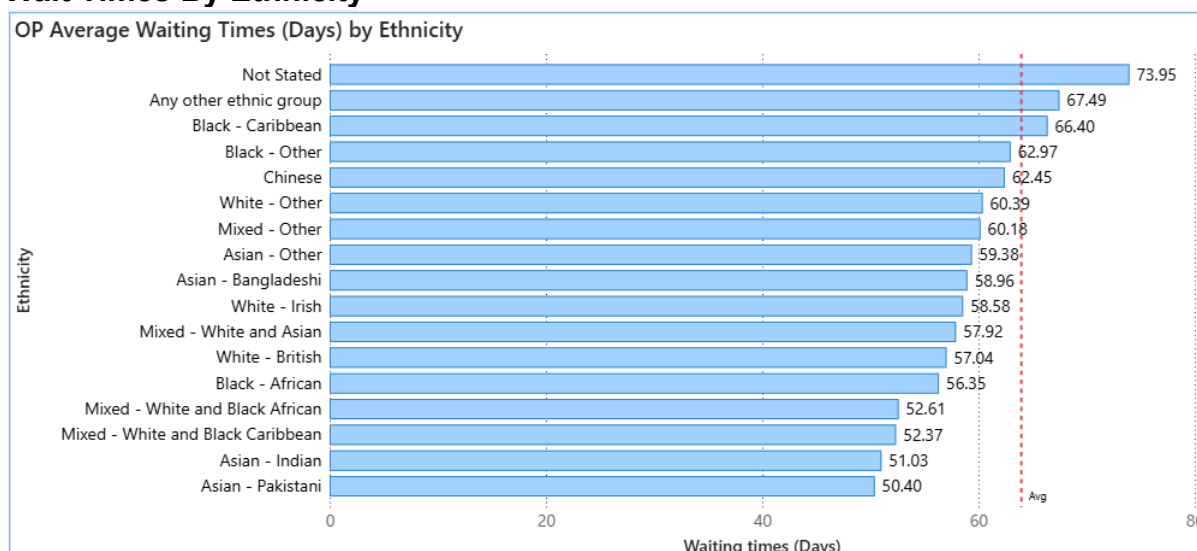
Meeting title	Trust Board – public meeting	Date: 25.09.2026
Report title	Q4 Health Equity Report	Agenda: appendix for item 7
Executive lead	TBC	
Report authors	Iolanda Pedrosa, Chief Information Officer, and Tawanda Maposa, Assistant Director of IM&T - Information	
Executive summary	Background It is a corporate aim of Whittington Health to be able to routinely publish information on patient waiting times by diversity demographics to help improve health equity. This is the first time that the Trust Board has had a report which attempts to present this information. The IM&T team are still developing the dataset for monitoring health equalities for waiting times across all trust services which involves linking several datasets so this will get better with time. The information contained overleaf shows that: • Patient ethnicity recording needs to achieve a greater coverage in all of our services, including outpatients, so that it is above the 96% target. • By race, the longest waits were recorded for patients for whom we hold no ethnicity data. The group experiencing the second longest waits were black patients. • By sex, the information shows that male patients waited on average longer than female patients, following a referral. • By deprivation, the longest waits for treatment were experienced by patients from the most deprived areas in NCL.	
Purpose	Noting	
Recommendation	Board members are asked to note the Q4, 2025/26 health equity report on waiting times	
BAF	Quality 1	
Report history	Quarterly report to the Board	
Appendices	None	

Health Equality Report – Waiting Times, reporting period: Q4 2025/26

Between Q3 and Q4 2025/26, outpatient average waiting times increased across all recorded ethnic groups, continuing the upward trend seen in the previous quarter. In Q4, the longest average waits among recorded ethnicities were for Any other ethnic group (67.49 days), Black – Caribbean (66.40 days) and Black – Other (62.97 days). This compares with Q3, when Black – Other had the longest average wait at 55.90 days.

Overall, the increase in waits was widespread rather than confined to a single ethnic group, although differences between groups remain and should continue to be monitored. Separately, patients whose ethnicity was Not Stated recorded an average wait of 73.95 days, substantially higher than 53.45 days in Q3. This should be considered primarily as a data-quality concern, reinforcing the importance of improving ethnicity recording to support more reliable health inequalities analysis.

Wait Times By Ethnicity



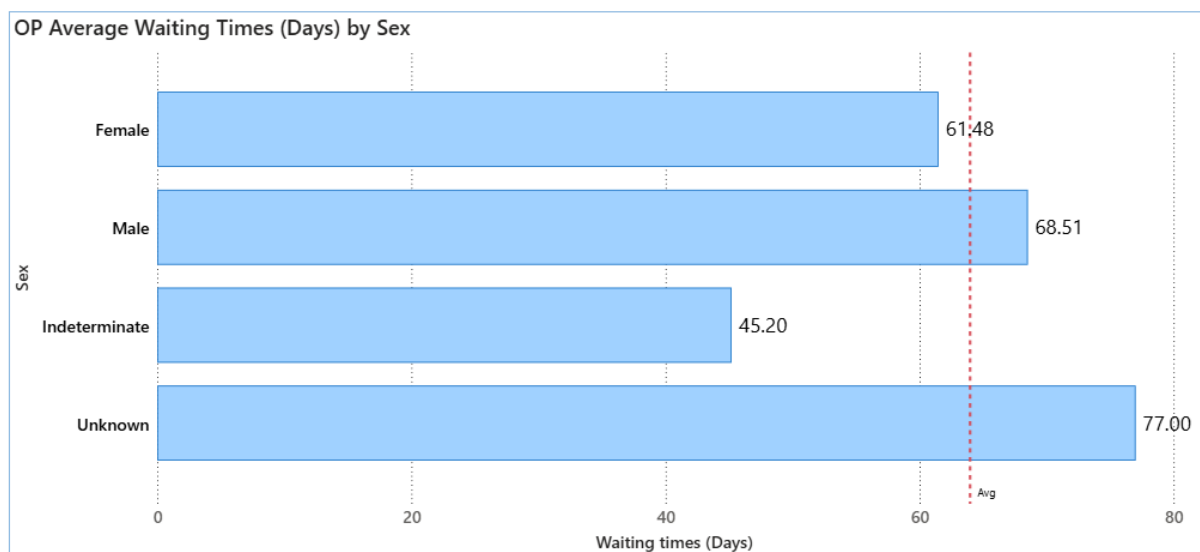
Summary Data - Ethnicity Outpatients

Ethnicity	Number of OP	WaitingTimes (Days)	Avg. Waiting Times (Days)	% of OP (by Ethnicity)	% of OP Wait Days (by Ethnicity)
Mixed - White and Black African	159	8365	52.61	0.27%	0.22%
Asian - Pakistani	256	12902	50.40	0.44%	0.34%
Mixed - White and Asian	230	13321	57.92	0.39%	0.35%
Chinese	303	18922	62.45	0.52%	0.50%
Mixed - White and Black Caribbean	400	20947	52.37	0.68%	0.56%
Asian - Bangladeshi	728	42925	58.96	1.24%	1.14%
Asian - Indian	861	43934	51.03	1.47%	1.17%
Mixed - Other	1007	60601	60.18	1.72%	1.61%
White - Irish	1152	67484	58.58	1.96%	1.80%
Black - Other	1132	71281	62.97	1.93%	1.90%
Asian - Other	1214	72093	59.38	2.07%	1.92%
Black - Caribbean	2097	139231	66.40	3.57%	3.71%
Black - African	3147	177318	56.35	5.36%	4.72%
Any other ethnic group	4207	283921	67.49	7.17%	7.56%
White - Other	9344	564317	60.39	15.92%	15.03%
White - British	14395	821146	57.04	24.52%	21.87%
Not Stated	18074	1336654	73.95	30.79%	35.59%
Total	58706	3755362	63.97	100.00%	100.00%

Wait Times By Sex

Between Q3 and Q4 2025/26, outpatient average waiting times increased for both male and female patients, continuing the upward trend seen in the previous quarter. Male patients continued to experience longer waits, increasing from 49.48 days in Q3 to 68.51 days in Q4, while female waits rose from 46.51 to 61.48 days. The gap between males and females has therefore widened from around 3 days to 7 days, which should continue to be monitored for any persistent difference in patient experience.

The Indeterminate and Unknown categories should be interpreted cautiously as data-quality categories rather than evidence of differences between male and female patients. In Q4, they recorded average waits of 45.20 and 77.00 days respectively, but the Q3 report showed that these categories involved very small patient numbers, making their averages particularly sensitive to individual long waits.

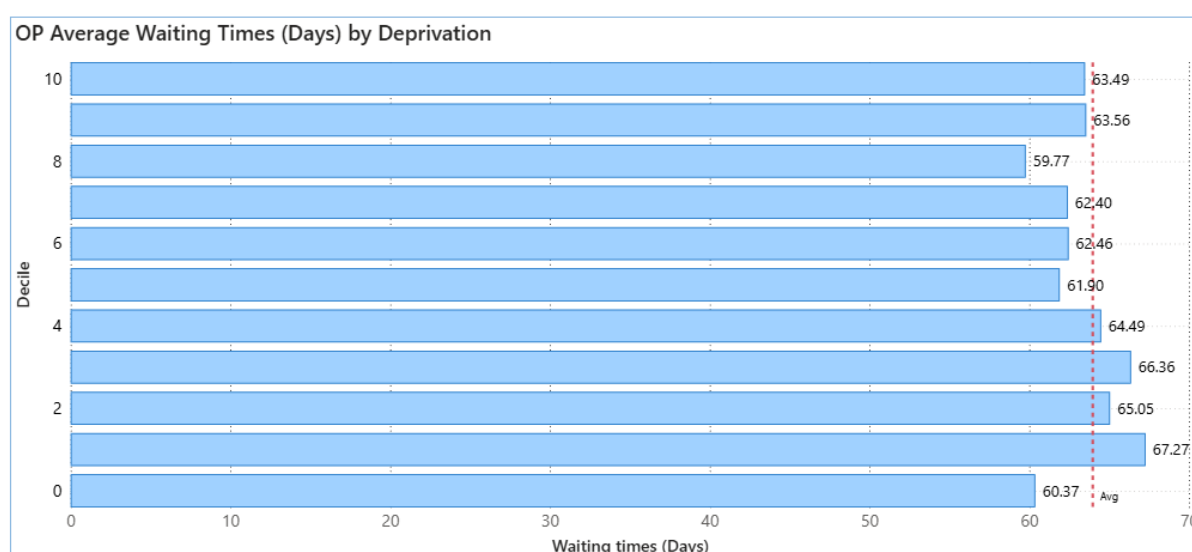


Sex	Number of OP	WaitingTimes (Days)	Avg. Waiting Times (Days)	% of OP (by Sex)	% of OP Wait Days (by Sex)
Female	37883	2328860	61.48	64.53%	62.01%
Indeterminate	5	226	45.20	0.01%	0.01%
Male	20817	1426199	68.51	35.46%	37.98%
Unknown	1	77	77.00	0.00%	0.00%
Total	58706	3755362	63.97	100.00%	100.00%

Wait Times By Deprivation

The Q4 data shows a fairly narrow spread in outpatient waiting times across deprivation deciles, ranging from 59.77 days in decile 8 to 67.27 days in decile 1. This represents a clear increase from Q3, when waits ranged from approximately 45.79 to 49.56 days across the deprivation spectrum.

Despite the overall rise, there is no clear or consistent deprivation gradient in Q4. Decile 1 records the longest average wait at 67.27 days, but neighbouring and other more deprived deciles do not follow the same pattern, while some less deprived groups also have waits above 60 days. The findings therefore suggest that the increase in waiting times is broadly distributed across deprivation levels, rather than showing a consistent relationship between deprivation and longer waits. Continued monitoring will be important to identify whether a clearer inequality pattern emerges over time.



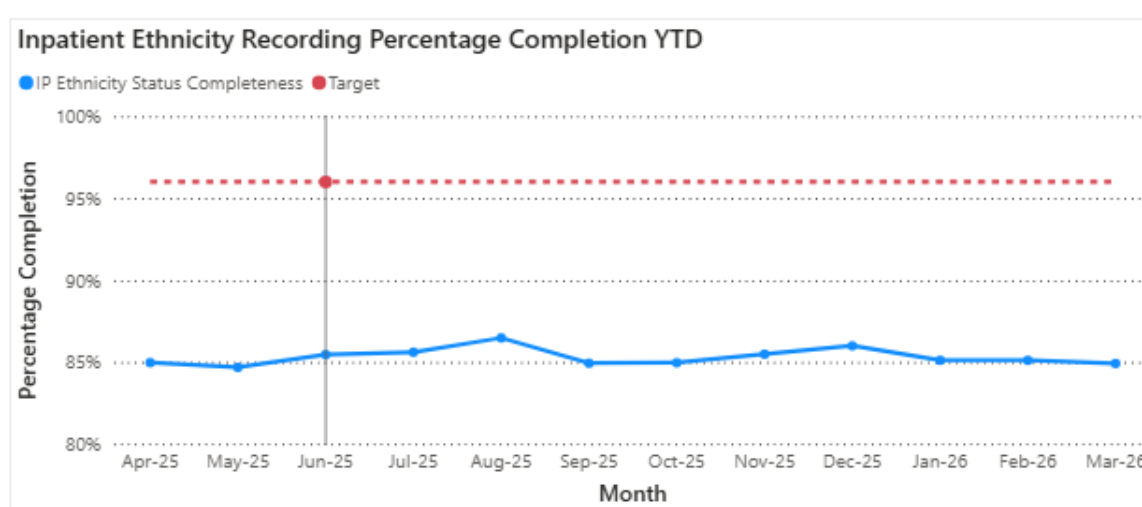
Summary Data - Deprivation Outpatients

Decile	Number of OP	WaitingTimes (Days)	Avg. Waiting Times (Days)	% of OP (by Deprivation)	% of OP Wait Days (by Deprivation)
10	379	24061	63.49	0.65%	0.64%
9	2923	185780	63.56	4.98%	4.95%
8	3658	218625	59.77	6.23%	5.82%
7	3586	223779	62.40	6.11%	5.96%
6	6703	418643	62.46	11.42%	11.15%
5	6037	373713	61.90	10.28%	9.95%
4	7973	514163	64.49	13.58%	13.69%
3	11599	769697	66.36	19.76%	20.50%
2	10407	676987	65.05	17.73%	18.03%
1	3110	209200	67.27	5.30%	5.57%
0	2331	140714	60.37	3.97%	3.75%
Total	58706	3755362	63.97	100.00%	100.00%

Equity – Ethnicity Recording by Activity Type

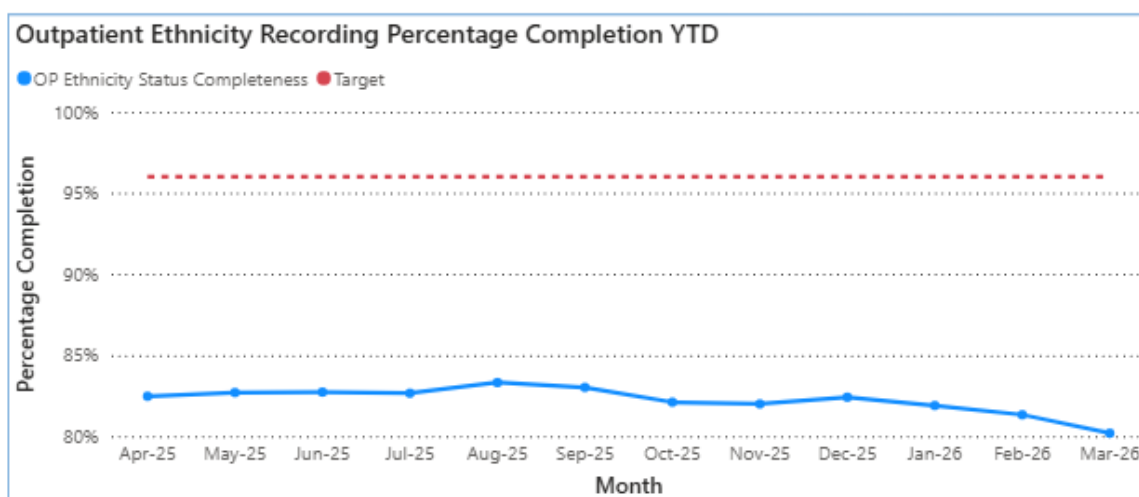
Inpatient ethnicity recording has remained broadly stable throughout 2025/26, but continues to fall short of the 96% target. Completion remained around 85% for most of the year, reaching its highest point of approximately 86.5% in August before fluctuating within a relatively narrow range. The improvement seen towards December was not sustained, with recording falling back to around 85% between January and March 2026. This extends the pattern reported in Q3, where performance was described as stable but with limited progress towards the required standard.

Overall, the year-end position suggests consistent but persistently below-target performance, with no sustained improvement towards the 96% target. The continuing gap highlights the need to maintain focus on improving ethnicity data capture within inpatient pathways.



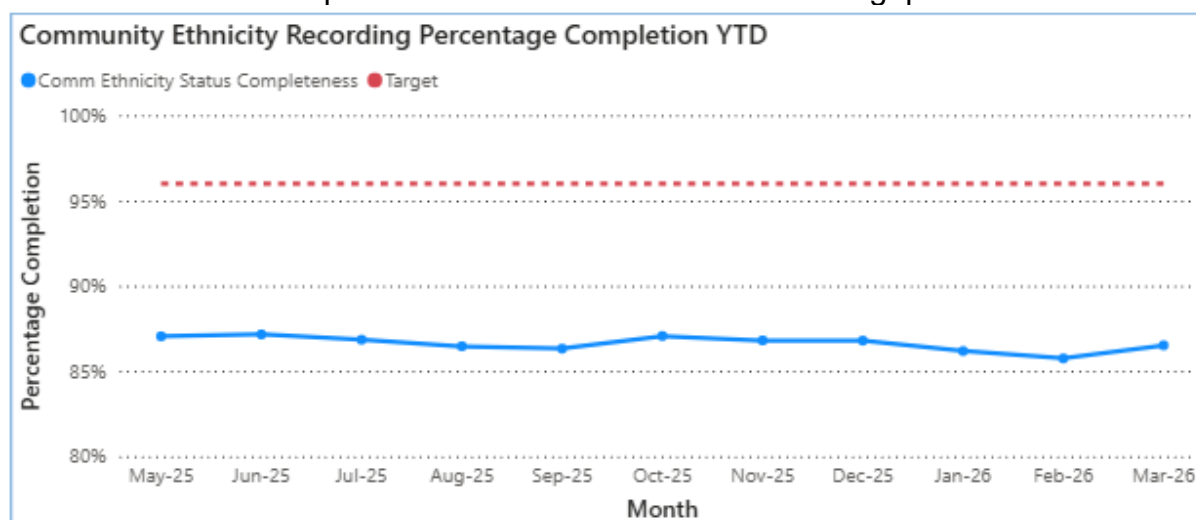
Outpatient ethnicity recording remained **relatively stable but below the 96% target** for much of 2025/26, generally fluctuating between 82% and 83%. Performance peaked at around **83% in August**, before gradually declining during the second half of the year. This continues the pattern identified in Q3, when outpatient recording was already highlighted as persistently below target.

Of particular note is the further decline towards year end, with completeness falling through January and February to around **80% in March 2026, the lowest level recorded during the year**. This widening gap from the 96% target suggests that improving ethnicity data capture within outpatient pathways should remain a key area of focus.



Community services show little overall change in ethnicity recording during 2025/26, with completion consistently sitting at around 86–87%. After reaching around 87% in October, performance eased during the winter months, reaching its lowest point in February before recovering slightly to approximately 86.5% in March 2026. This broadly continues the pattern already evident in Q3, where only modest month-to-month variation was observed.

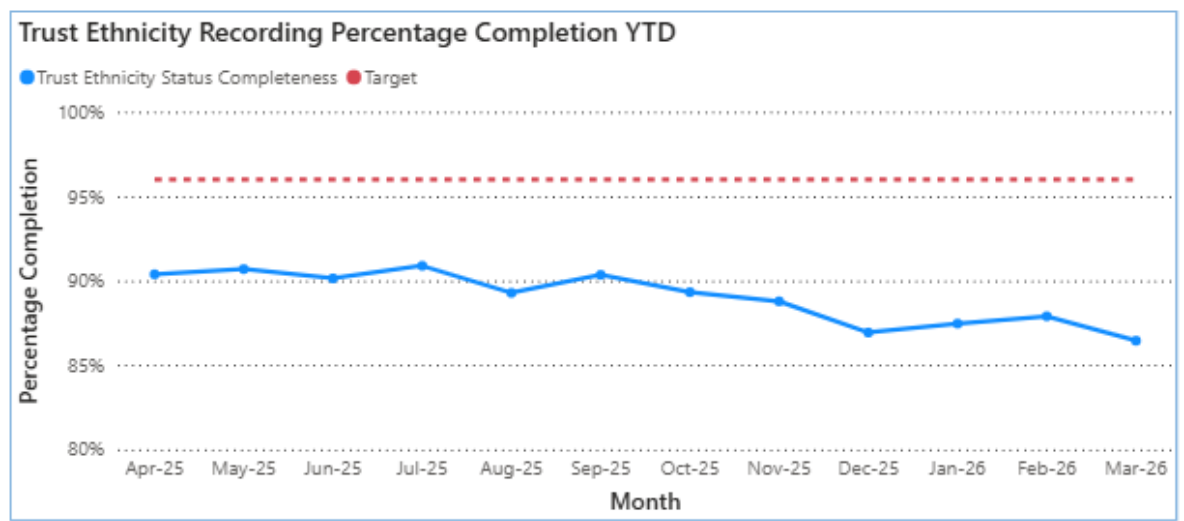
Although recording has been relatively consistent, the year closed almost where it started and remains around 9–10 percentage points below the 96% target, indicating that more sustained improvement will be needed to close the gap.



At Trust level, ethnicity recording shows a more noticeable downward trend over the course of 2025/26. Completion was around 90–91% during the first part of the year, but performance weakened from October onwards, falling to approximately 87% in December. This builds on the decline already highlighted in the Q3 report.

There was a modest recovery during January and February, but this was not sustained, with completeness falling again to around 86.5% in March 2026 – the lowest point of the year. The year-end position is therefore around 4 percentage

points lower than at the start of the financial year and nearly 10 percentage points below the 96% target, highlighting a deterioration in overall ethnicity data completeness that will require renewed focus across services.



Summary Data - Ethnicity Recording by Activity Type YTD				
A&E	Inpatient	Outpatient	Community	Overall Trust Performance
89.04%	85.29%	82.21%	86.62%	86.21%



Meeting title	Trust Board – public meeting	Date: 25 September 2026
Report title	Finance Report - August (Month 5) 2026/27	Agenda item: 8
Executive lead	Terry Whittle, Chief Finance Officer & Deputy Chief Executive	
Report author	Senior Finance Team	
Executive summary	Background This report provides the Trust's financial position for Month 5 (August 2026) against the approved 2026/27 financial plan. The Trust is reporting a year-to-date deficit of £5.7m, which is £1.9m adverse to plan. Issue 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. Next steps The Trust is implementing a financial recovery programme focused on: • Strengthening expenditure controls and reducing pay expenditure through targeted support. • 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 M5 financial performance	
Recommendation(s)	• Review the Month 5 financial position and note the reported year-to-date deficit of £5.7m, £1.9m adverse to plan. • Review the risks associated with the current CIP delivery shortfall and underlying expenditure pressures.	
Risk Register or Board Assurance Framework	Sustainable 1	
Report history	Monthly report to the Board	
Appendices	None	

CFO Message

Finance Report M05 (August)

Year to date £5.7m actual deficit

The Trust is reporting a YTD deficit of £5.7m at the end of August, this is £1.9m adverse to plan. Included in the year-to-date performance is the impact of industrial action of £0.6m, PFI litigation legal fees (£0.9m) and impact of heat waves.

Income - £0.5m ahead plan

Income is ahead of plan by £0.6m at the end of August due to pass through costs (high-cost drugs) and other non-NHS clinical income offset by expenditure.

At end of August, the Trust is below its Elective Recovery Fund by £1.1m. The unvalidated RTT 18-week performance for August 2026 was at 67.19%, representing a 0.81% shortfall against the updated expected performance of 68% and 6.19% shortfall against the national planning trajectory of 73.38%.

Headcount & Pay expenditure

Actual whole time equivalent for August was 5,218.26. This was lower than July by 19.78. Reduction bank WTE of 41.78 was partly offset by increase in substantive WTE. The Trust will need to reduce its temporary staffing usage without increase in substantive expenditure to deliver the 2026-27 financial plan.

Pay expenditure for the month was £31.8m and £1.6m adverse to plan. In month there was resident doctors' arrears of £0.1m, relating to prior years pay deal, and ongoing pay pressures relating to unfunded beds and emergency activity.

Non-Pay Expenditure

Non-pay expenditure for the month was £8.9m. Ongoing pressures continue to be on pathology and legal fees and slippage on efficiency schemes.

Efficiency

The Trust delivered £8.9m savings which is a shortfall of £2.6m against the internal YTD target of £11.5m.

Cash

The Trust's cash balance on 31st August was £38.43m, which is £19.47m favourable to Plan. There was minimal movement from July's closing balance of £38.40m

Capital

The total capital allocation for 2026/27 comprises £23.43m of internally funded capital and £55.85m of indicative Public Dividend Capital (PDC). As of 31st August 2026, the YTD capital expenditure was £4.15m against plan of £6.63m which is £2.48m lower than plan.

Better Payment Practice Performance Forecast

Overall, the Trust's BPPC is 92.74% by volume and 90.75% by value. The BPPC for non-NHS invoices is 92.28% by volume and 90.75% by value.

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. Recovery is reliant on reduced pay expenditure (bank), additional control measures, and delivery of improved productivity to achieve operational performance targets.

Summary of Income & Expenditure Position – Month 5

	In Month			Year to Date			Annual Budget
	Plan	Actual	Variance	Plan	Actual	Variance	
	£'000	£'000	£'000	£'000	£'000	£'000	
Income							
NHS Clinical Income	31,337	31,536	199	157,097	157,471	374	383,699
High Cost Drugs - Income	1,087	889	(199)	5,367	5,673	306	12,804
Non-NHS Clinical Income	1,733	1,814	81	8,688	9,074	387	20,762
Other Non-Patient Income	2,551	2,783	231	12,757	13,407	650	30,609
Elective Recovery Fund	5,634	5,397	(237)	29,175	28,020	(1,155)	70,372
	42,343	42,419	75	213,084	213,646	562	518,246
Pay							
Agency	(8)	(389)	(381)	(38)	(1,766)	(1,728)	(141)
Bank	(129)	(1,378)	(1,249)	(678)	(7,162)	(6,484)	(1,562)
Substantive	(30,159)	(30,081)	78	(150,552)	(149,317)	1,235	(366,989)
	(30,296)	(31,848)	(1,552)	(151,268)	(158,245)	(6,977)	(368,692)
Non Pay							
Non-Pay	(9,329)	(8,024)	1,305	(46,875)	(44,322)	2,553	(104,620)
High Cost Drugs - Exp	(967)	(872)	95	(4,834)	(4,881)	(47)	(11,603)
	(10,296)	(8,896)	1,401	(51,709)	(49,204)	2,506	(116,223)
EBITDA	1,751	1,675	(76)	10,106	6,198	(3,909)	33,331
Post EBITDA							
Depreciation	(2,170)	(2,158)	11	(10,848)	(9,851)	998	(26,035)
Interest Payable	(74)	(50)	24	(370)	(212)	158	(883)
Interest Receivable	37	169	132	185	1,002	817	439
Dividends Payable	(571)	(571)	0	(2,855)	(2,855)	0	(6,852)
P/L On Disposal Of Assets	0	0	0	0	0	0	0
	(2,778)	(2,610)	167	(13,888)	(11,916)	1,973	(33,331)
Reported Surplus/(Deficit)	(1,026)	(935)	91	(3,782)	(5,718)	(1,936)	0
Impairments	0	0	0	0	0	0	0
IFRS & Donated	(6)	(3)	3	(29)	(14)	15	(71)
Reported Surplus/(Deficit) after Impairments and IFRIC12	(1,032)	(938)	94	(3,811)	(5,732)	(1,921)	(71)

- The YTD actual deficit is £5.7m (excluding donated asset depreciation and impairments), £1.9m worse than planned.

At end of M5, £3.1m of non-recurrent mitigations were released into the position. The year-to-date deficit also includes £0.6m of industrial action expenditure.

- 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 – August

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	2,666	2,443	(222)	13,708	12,777	(931)
Outpatients	2,985	2,954	(31)	15,522	15,243	(279)
ERF Balance	(16)	0	16	(55)	0	55
ERF	5,634	5,397	(237)	29,175	28,020	(1,155)
Variable Imaging	565	608	44	2,936	3,014	78
HCD (Variable)	885	682	(203)	4,370	4,676	306
Devices	0	9	9	0	9	9
Chemo Deliveries	112	49	(63)	582	550	(32)
Total Variable	7,196	6,746	(451)	37,063	36,269	(795)
A&E (UEC)	2,283	1,848	(435)	11,269	10,658	(612)
Non-Elective (UEC)	4,977	4,495	(482)	24,566	24,353	(213)
SDEC (UEC)	939	1,353	414	4,883	5,632	749
UEC Adjustment	0	503	503	0	75	75
UEC	8,200	8,200	0	40,718	40,718	0
A&E	69	77	8	342	332	(10)
Non-Elective	1,675	1,143	(532)	8,264	6,862	(1,403)
Critical Care	752	252	(500)	3,710	2,184	(1,526)
Direct Access	1,022	947	(74)	5,313	5,082	(232)
Elective	108	75	(34)	559	526	(33)
Imaging	177	227	49	922	1,048	125
Outpatients	2,014	1,801	(213)	10,429	10,311	(118)
Community	7,232	7,232	0	36,161	36,161	0
Ambulatory	13	26	13	67	112	44
HCD Block	202	202	0	997	997	0
Block Adjustment	0	1,282	1,282	0	3,152	3,152
Other clinical Income NHS	9,398	9,612	214	47,092	47,412	320
NHS Clinical Income	38,059	37,822	(237)	191,639	191,164	(475)
Non NHS clinical income	1,809	1,814	6	9,064	9,074	10
Income From Patient Care Activities	39,867	39,636	(231)	200,703	200,239	(465)
Other Operating Income	2,476	2,783	307	12,381	13,407	1,027
Total	42,343	42,419	75	213,084	213,646	562

- Income is £0.6m ahead of plan year-to date. Whilst ERF is significantly underperforming (-£1.1m), High cost drugs (£0.3m) & other operating income (£1.0m) are overperforming.
- ERF activity is below plan (£0.2m) for August bringing the YTD value to an underperformance of £1.1m.
- Other operating income is over plan by £1.0m and is made up of research income (£0.4m) which is offset with expenditure and education funding (£0.4m) year to date.
- Included in the income position is the adverse impact of ongoing dispute with NHSE relating to high cost drugs (£0.7m YTD and £1.7m for 2026-27).

2.2 Elective recovery fund (ERF) ICSU Income – M5

ERF Income by ICSU							
ICSU	Annual Plan	In Month Income Plan	In Month Income Actual	In Month Income Variance	YTD Income Plan	YTD Income Actual	YTD Income Variance
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
ACW	8,752	697	698	1	3,626	3,666	40
CYP	6,791	541	568	27	2,814	2,727	(87)
EIM	25,874	2,074	2,258	184	10,631	10,906	275
S&C	29,345	2,338	1,873	(465)	12,159	10,722	(1,437)
Corp	(389)	(16)	0	17	(55)	(0)	54
Grand Total	70,372	5,634	5,397	(237)	29,175	28,020	(1,155)

Trust is below its ERF activity by £1.1m year to date with August contributing 0.2m underperformance to this. Under performance is predominantly within Surgery Division.

ERF Income by POD							
POD	Annual Plan	In Month Income Plan	In Month Income Actual	In Month Income Variance	YTD Income Plan	YTD Income Actual	YTD Income Variance
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
DC	(42,291)	(3,590)	(3,716)	(126)	(17,663)	(18,353)	(690)
EL	7,610	606	526	(80)	3,153	2,967	(187)
OP First	94,123	7,747	7,764	17	39,156	38,907	(250)
OP Procedure	10,930	871	823	(48)	4,529	4,500	(29)
Grand Total	70,372	5,634	5,397	(237)	29,175	28,020	(1,155)

Specialties driving the underperformance year to date are

- Day case/Electives:
 - Endoscopy – £0.6m
 - Trauma & Orthopaedics – £0.3m
 - Urology - £0.2m
- Outpatients:
 - Dermatology - £0.2m
 - Medical Oncology - £0.2m
 - Breast Surgery – £0.1m

ERF & Referral to Treatment (RTT)

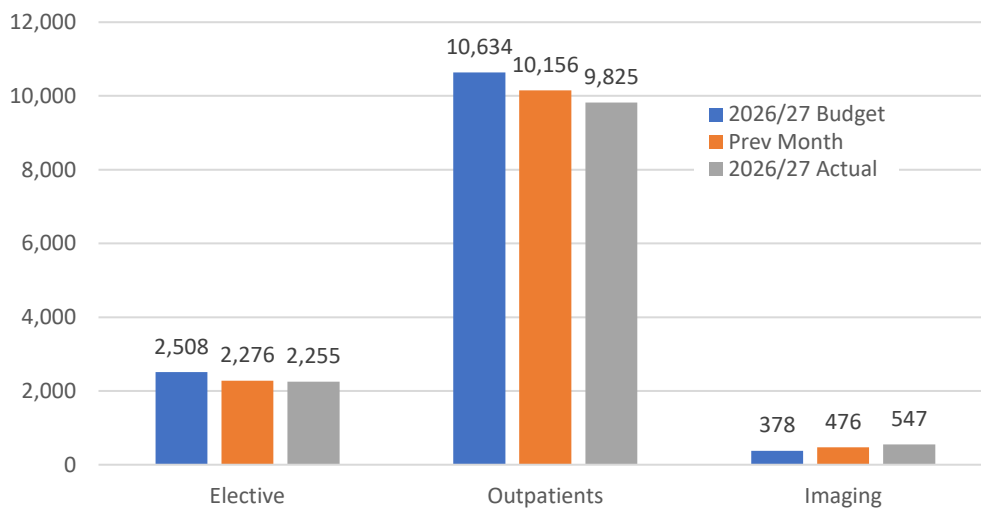
Unvalidated RTT 18-week performance for August 2026 against the 18-week standard is currently at 67.19%, representing a 0.81% shortfall against the updated expected performance of 68% and 6.19% shortfall against the national planning trajectory of 73.38%. This variance is largely driven by deterioration in a number of specialties, most notably General Surgery (Admitted pathways), Gynaecology, Dermatology and ENT.

Notwithstanding the overall RTT position, long-wait performance remains strong and well controlled. The proportion of patients waiting over 52 weeks stands at 0.45%, significantly below the

national threshold of 1%, and there are no patients waiting over 65 weeks, indicating sustained grip on the longest waits.

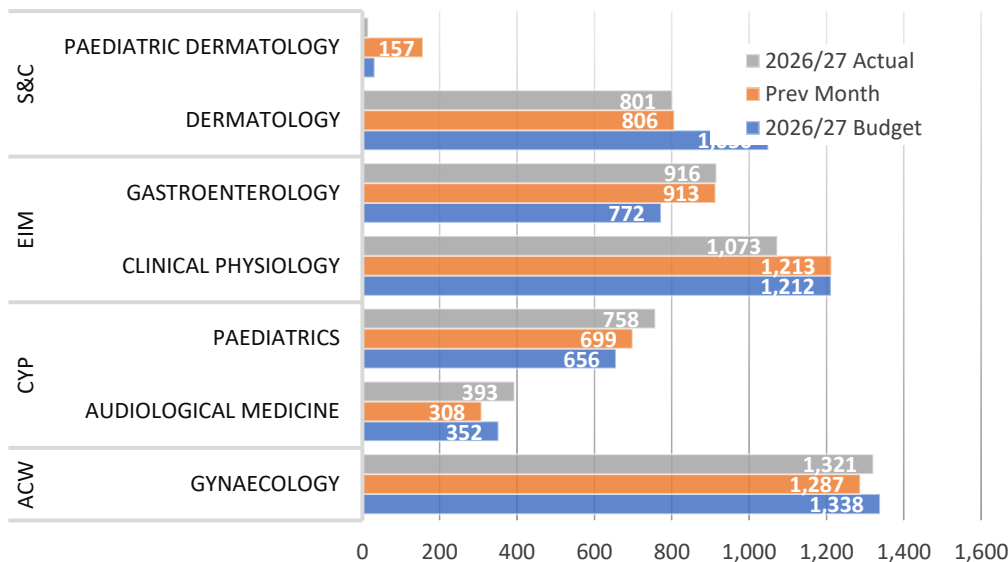
Diagnostic performance in August 2026 has stabilised achieving 81.6%, a slight improvement of 0.1% points from July. However, capacity constraints persist in key areas, particularly audiology and neurophysiology, which continue to impact overall diagnostic waiting times. Targeted specialty-level recovery 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.

ERF Activity Performance – August



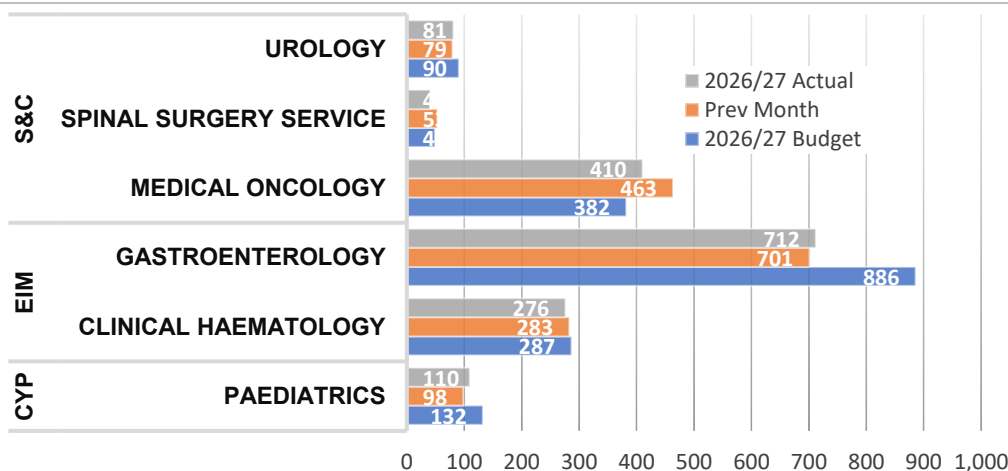
ERF Performance

Elective and outpatients have underperformed against the plan and have seen a decline in comparison to previous month.



Outpatients

Dermatology specialities have underperformed against plan. Gastroenterology continues to outperform plan like paediatrics. Audiology had an increase in activity for august and has outperformed its plan.



Elective

Gastroenterology has had similar month compared to July. medical oncology has had decrease compared to previous month but continues to be ahead of plan.

3. Expenditure – Pay & Non-pay

3.1 Pay Expenditure

Operational Pay expenditure for August was £31.8m which was £0.2m higher than previous month. Increase in substantive staffing was mainly due to new starters in Procurement shared Service (0.08m) and medical wards (£0.08m). There was also £0.07m of resident doctor pay arrears for FY22-24 relating to prior years pay deal. Agency decrease of £0.1m due to an insourcing adjustment in July. There were decreases in bank usage within medical wards of £0.1m

Key YTD Pay pressures in the financial position:

- Industrial Action costs - £0.6m.
- Unfunded Thorogood beds - £1.1m
- Childcare packages - £0.4m
- Emergency Medicine including temporary escalation spaces - £0.5m
- Wards general overspends (sickness and vacancy cover) - £0.7m

	2025-26			2026-27					Mov't
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	
Agency	282	320	578	253	285	332	473	391	(82)
Bank	1,662	1,621	2,116	1,570	1,243	1,509	1,451	1,378	(73)
Substantive	28,820	28,706	29,483	29,686	29,328	29,991	29,475	29,774	299
Total Operational Pay	30,764	30,647	32,178	31,508	30,856	31,833	31,399	31,543	144
Non Operational Pay Costs	160	(101)	19,599	423	357	(183)	203	305	102
Total Pay Costs	30,924	30,546	51,777	31,931	31,214	31,650	31,602	31,848	245

Bank & Agency Trends

Division	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Agency Expenditure					
Acw	14	30	41	21	21
Adult Community	3	0	(3)	0	0
Children & Young People	171	194	204	212	234
Corporate Services	11	14	38	16	13
Emergency & Integrated Medicin	40	27	36	89	77
Surgery & Cancer	14	20	17	135	45
Agency Total	253	285	332	473	391
Bank Expenditure					
Acw	281	222	251	222	277
Adult Community	89	100	118	94	131
Children & Young People	105	96	136	126	132
Corporate Services	318	179	254	221	223
Emergency & Integrated Medicin	467	428	480	528	389
Surgery & Cancer	310	219	270	261	226
Bank Total	1,570	1,243	1,509	1,451	1,378

- Average year to date agency expenditure is £0.3m a month. This expenditure is forecast to reduce with the expected change is the provision of childcare packages from February 2027.
- The Trust will need to reduce its bank expenditure by at least half to deliver plan for 2026-27.

Enhanced Care

Enhanced care has reduced by 3,840 hours compared to July and the average for Q1. Although there was no usage of agency for enhanced care in the month, the overall usage continues to exceed the funded establishment.

Pay Type	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Substantive hours	5,196	5,616	5,460	4,776	4,632
Agency hours	60	120	24	36	-
Bank hours	6,996	8,568	8,412	7,992	4,332
Total	12,252	14,304	13,896	12,804	8,964

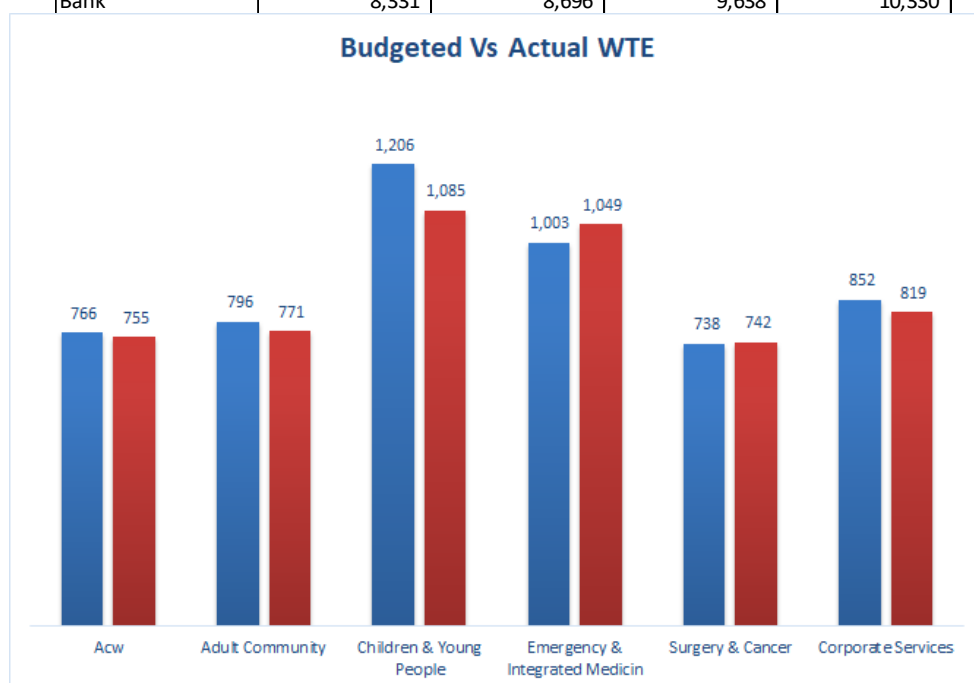
WTE equivalent	75.45	88.09	85.58	78.85	55.21
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Division	Substantive	Bank	Agency	Total
CYP	1.85	1.48	-	3.33
S&C	2.29	-	-	2.29
EIM	24.39	25.20	-	49.59
WTE equivalent	28.53	26.68	-	55.21

Impact of Sickness on temporary staffing expenditure

The trust booked around 10,500 hours to cover sickness in August. This is 1,200 hours lower than compared to July. The sickness cover for August equates to 64.97 wte.

Used Hours	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Total
Bank	8,331	8,696	9,638	10,330	9,481	46,476
					1,069	6,510
					10,550	52,985
					64.97	326.31



3.2 Non-pay Expenditure

Non-pay expenditure excluding high-cost drugs decreased by £1.6m compared to July 2026. Key movements include:

- Non-recurrent benefit of £1.0m.
- Decrease in planned and reactive maintenance of £0.3m.
- Increase in Professional Services of £0.2m mainly relating to additional support to the efficiency programme.
- Reduction in clinical supplies in Orthopaedics of £0.1m.

	2025-26			2026-27					
Non-Pay Costs	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Mov^t
Supplies & Servs - Clin	5,260	4,379	6,459	3,841	4,045	4,646	4,478	4,330	(148)
Supplies & Servs - Gen	334	316	489	392	264	290	342	284	(58)
Establishment	313	(207)	345	215	173	211	258	217	(41)
Healthcare From Non Nhs	126	66	44	84	82	75	150	106	(45)
Premises & Fixed Plant	2,219	1,419	3,150	1,982	2,088	2,202	2,452	2,053	(399)
Ext Cont Staffing & Cons	382	351	523	251	399	399	368	342	(26)
Miscellaneous	1,106	781	(472)	2,088	2,005	998	1,551	681	(871)
Chairman & Non-Executives	11	11	11	11	11	12	12	12	0
Non-Pay Reserve	0	0	0	0	0	(0)	0	0	0
Total Non-Pay Costs	9,751	7,116	10,549	8,864	9,067	8,833	9,612	8,024	(1,588)

Excludes high-cost drug expenditure and depreciation.

Included in miscellaneous is CNST premium, Transport contract, professional fees, and bad debt provision.

Miscellaneous Expenditure Breakdown

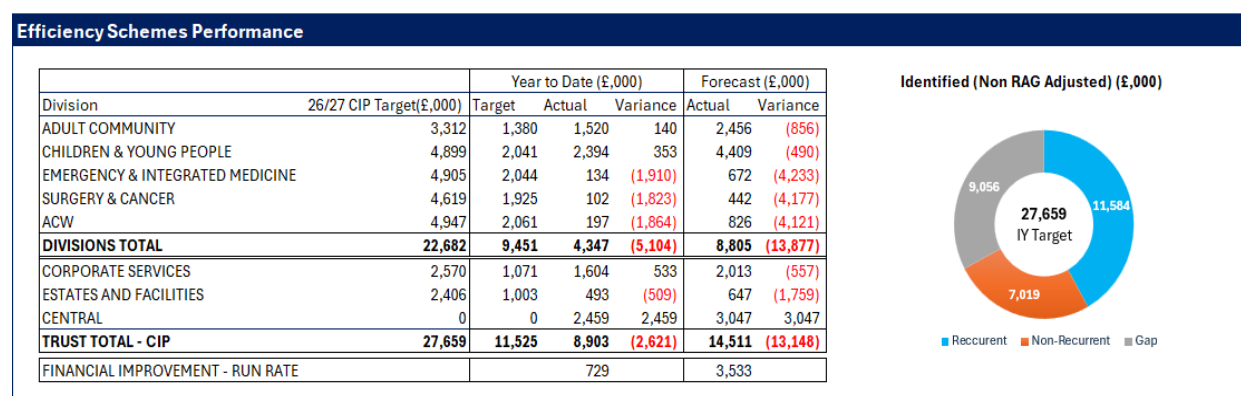
	2025-26			2026-27					
Miscellaneous Breakdown	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Mov^t
Ambulance Contract	193	(45)	203	192	186	164	206	183	(23)
Other Expenditure	(771)	95	(6,876)	115	112	151	243	(917)	(1,160)
Audit Fees	15	7	186	15	14	29	19	19	(0)
Provision For Bad Debts	327	(113)	4,288	319	41	(988)	(537)	(473)	64
Cnst Premium	807	785	780	1,024	1,024	1,028	1,024	1,019	(4)
Fire Security Equip & Maint	22	10	33	11	17	28	27	27	0
Interpretation/Translation	32	(5)	26	13	49	34	39	14	(26)
Membership Subscriptions	151	(34)	143	158	159	146	143	153	10
Professional Services	235	134	394	154	322	243	278	459	180
Research & Development Exp	0	0	8	(0)	3	3	3	66	63
Security Internal Recharge	15	(56)	15	15	15	17	15	20	5
Teaching/Training Expenditure	79	0	325	71	58	142	90	108	18
Travel & Subs-Patients	1	3	4	2	4	2	2	4	3
Work Permits	0	0	0	0	0	0	0	0	0
Write Down Of Inventories	0	0	0	0	0	0	0	0	0
Total Non-Pay Costs	1,106	781	(472)	2,088	2,005	998	1,551	681	(871)

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 £8.9m against a YTD target of £11.5m, resulting in a delivery of 77% and YTD shortfall of £2.6m (23% of the YTD target). The Trust also recognised £0.7m of run rate improvements resulting in total improvement of £9.6m YTD.

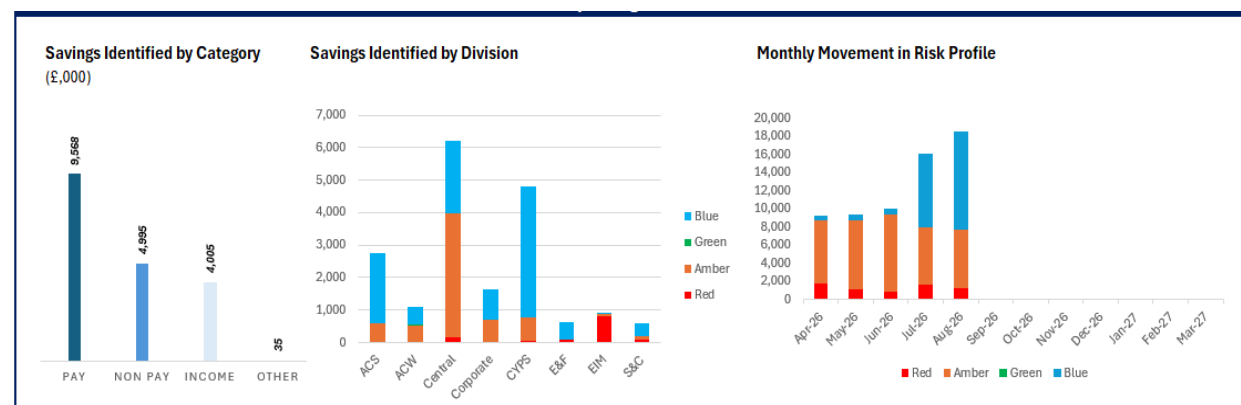


Forecast

The current forecast delivery is c£14.5m (£7.1m recurrent & £7.4m non recurrent) against internal target of £27.7m, resulting in an adverse to plan of £13m.

61% of schemes are under development, with £7.7m in 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 Financial Position as of 31 August 2026 was £226.77m, representing a decrease of £0.90m compared with 31st July 2026, as shown in the table below.

Statement of Financial Position as at August 31st 2026	2026/27 M04 Balance	2026/27 M05 Balance	Movement in Month
	£000	£000	£000
NON-CURRENT ASSETS:			
Property, Plant And Equipment	241,972	240,232	(1,740)
Intangible Assets	2,135	3,741	1,606
Right of Use Assets	26,178	26,194	15
Assets Under Construction	35,877	35,488	(388)
Trade & Other Rec -Non-Current	401	406	6
TOTAL NON-CURRENT ASSETS	306,563	306,061	(502)
CURRENT ASSETS:			
Inventories	41	17	(25)
Trade And Other Receivables	25,763	27,064	1,301
Cash And Cash Equivalents	38,347	38,430	83
TOTAL CURRENT ASSETS	64,151	65,511	1,360
CURRENT LIABILITIES			
Trade And Other Payables	(87,651)	(91,219)	(3,568)
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	(533)	(533)	0
Other Liabilities	(10,561)	(8,817)	1,744
TOTAL CURRENT LIABILITIES	(103,668)	(105,492)	(1,824)
NET CURRENT ASSETS / (LIABILITIES)	(39,517)	(39,982)	(464)
TOTAL ASSETS LESS CURRENT LIABILITIES	267,046	266,080	(966)
NON-CURRENT LIABILITIES			
Borrowings: Dh Revenue and Capital Loan - Non-Current	(1,276)	(1,276)	0
Borrowings: Finance Leases	92	166	75
Borrowings: Right of Use Assets	(22,744)	(22,753)	(10)
Provisions for Liabilities & Charges	(15,443)	(15,443)	0
TOTAL NON-CURRENT LIABILITIES	(39,371)	(39,306)	65
TOTAL ASSETS EMPLOYED	227,674	226,773	(901)
FINANCED BY TAXPAYERS EQUITY			
Public Dividend Capital	168,030	168,030	0
Retained Earnings	(6,113)	(7,014)	(901)
Revaluation Reserve	65,757	65,757	0
TOTAL TAXPAYERS EQUITY	227,674	226,773	(901)

The most significant movements in the month to 31st August 2026 were as follows:

NON-CURRENT ASSETS

Non-Current assets closed at £306.06m on 31st August 2026, a net decrease of £0.50m from previous month due the following:

- Capital expenditure for owned assets £1.65m
- Monthly depreciation: Owned assets (£1.79m)
- Monthly depreciation: Right of Use assets (£0.37m)

CURRENT ASSETS

Current assets closed at £65.51m in August 2026, a net increase of £1.36m from the previous month. Principal movements comprised Trade and Other Receivables increase £1.30m, and Cash increase by £0.10m as analysed below.

CURRENT LIABILITIES

Ther Current liabilities increased by £1.82m during the month. This movement was primarily driven by a £3.57m increase in trade creditors, which was largely offset by a £1.74m decrease in other liabilities (deferred income for NHS £1.36m & non-NHS £0.40m).

NON-CURRENT LIABILITIES

Non-current liabilities closed at £39.31m in August 2026.

RETAINED EARNINGS

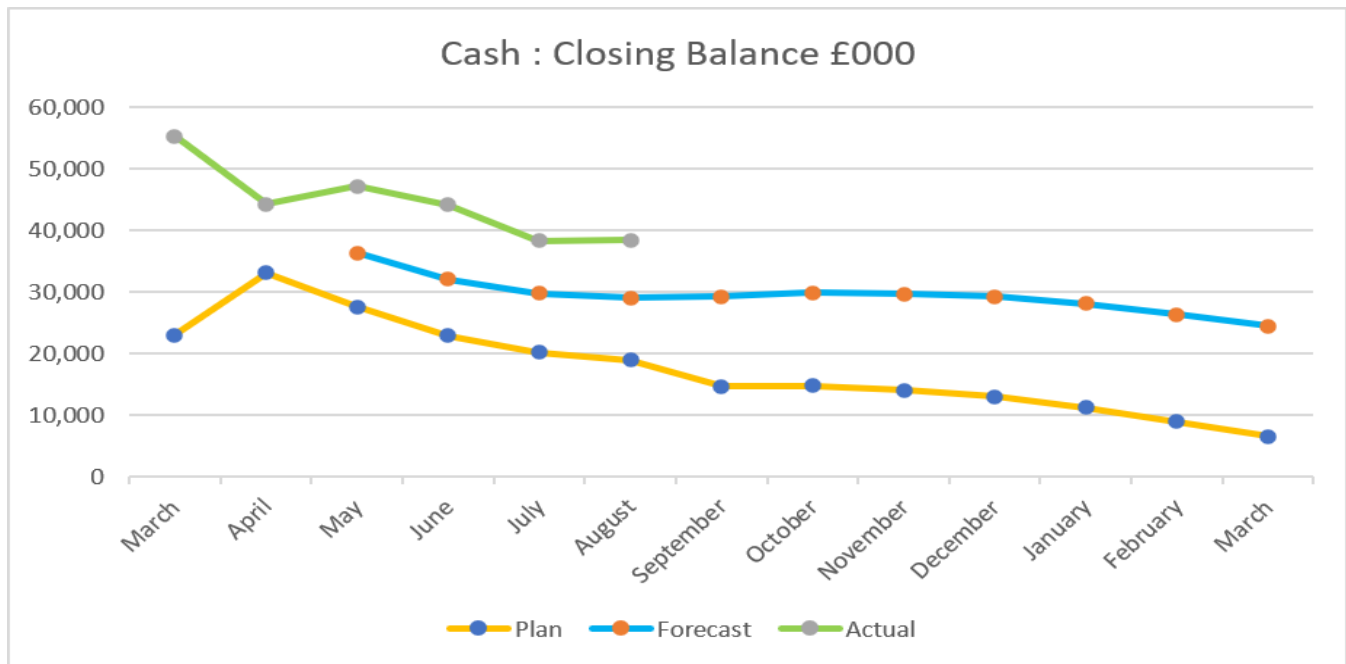
Retain Earnings closed at (negative) (£6.70m) in August 2026, a net (decrease) from the previous month's figure of (£0.94m), reflecting the Trust's in-month deficit.

CASH

The Trust's cash balance on 31st August was £38.43m, which is £19.47m favourable to Plan. This was almost unchanged from July's closing balance of £38.40m, with principal factors being:

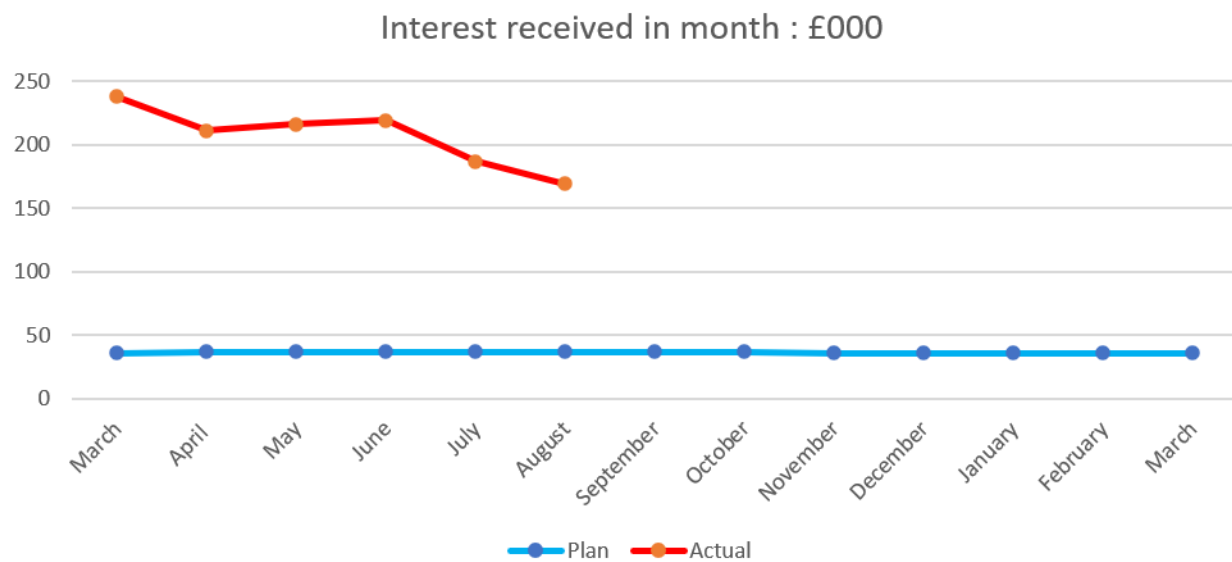
- Continuing underlying deficit is more than cash-releasing CIPS offset by:
- Receipt of VAT reclaim for the returns submitted in July and August within the month of August totalling £5.03m

The August cash balance shown above is equivalent to 29 days' trading. For 31st March 2027, a closing balance of £24.45m is forecast; equivalent to 18 days' trading.



Interest Received

The interest received in August 2026 of £0.17m is 0.13m 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 comprises £23.43m of internally funded capital and £55.85m of indicative Public Dividend Capital (PDC) funding for major projects, including £11.0m for Start well, bringing the total capital allocation to £79.28m.

Capital Summary Month 05: 31st August 2026							
<i>all figures: £000</i>	Allocation	In Month			Year to Date		
	Total Allocation	In-Month Forecast	In-Month Actual	In-Month Variance	YTD Forecast	YTD Actual	YTD Variance
Internally funded							
Estate & Strategies Project Capital Programme 2627	13,400	2,263	460	(1,803)	4,752	1,929	(2,823)
ICT 2627	1,500	90	75	(15)	330	185	(145)
Other Urgent Priorities 2627	562	30	0	(30)	110	0	(110)
EPR	3,121	67	35	(32)	247	112	(135)
Pharmacy Robot	643	0	250	250	0	260	260
Equipment 2627	750	45	(0)	(45)	166	185	19
Division 2526	250	15	0	(15)	56	0	(56)
MES	450	0		0	0	0	0
Total Owned Assets	20,676	2,510	819	(1,691)	5,661	2,672	(2,989)
ROU assets (new leases)							
ROU assets (remeasure increases)	2,750	163	387	224	600	387	(213)
ROU assets (remeasures decrease)							0
ROU assets (disposals)							0
Total Right of Use	2,750	163	387	224	600	387	(213)
Total Internally Funded	23,426	2,673	1,206	(1,467)	6,261	3,059	(3,202)
Externally Funded							
ESF and PCS Power	19,387	0	108	108	0	272	272
ESF and RCS Fire	5,500	0	16	16	0	268	268
P1- Startwell - £11m	11,000	367	308	(59)	367	502	135
CDC phase III	16,400		14	14		29	29
Community HCs	613	0	0	0	0	0	0
ED Redev, MH rooms and Dis lounge	2,750	0	1	1	0	16	16
Imaging equipment	200	0	0	0	0	0	0
Total Externally PDC Funded	55,850	367	447	80	367	1,086	719
Total	79,276	3,040	1,653	(1,387)	6,628	4,146	(2,482)

As of 31st August 2026, the YTD capital expenditure was £4.15m against plan of £6.63m which is £2.48m 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 92.74% by volume and 90.75% by value. The BPPC for non-NHS invoices is 92.28% by volume and 90.75% by value. The charts below show performance for March to August 2026.

