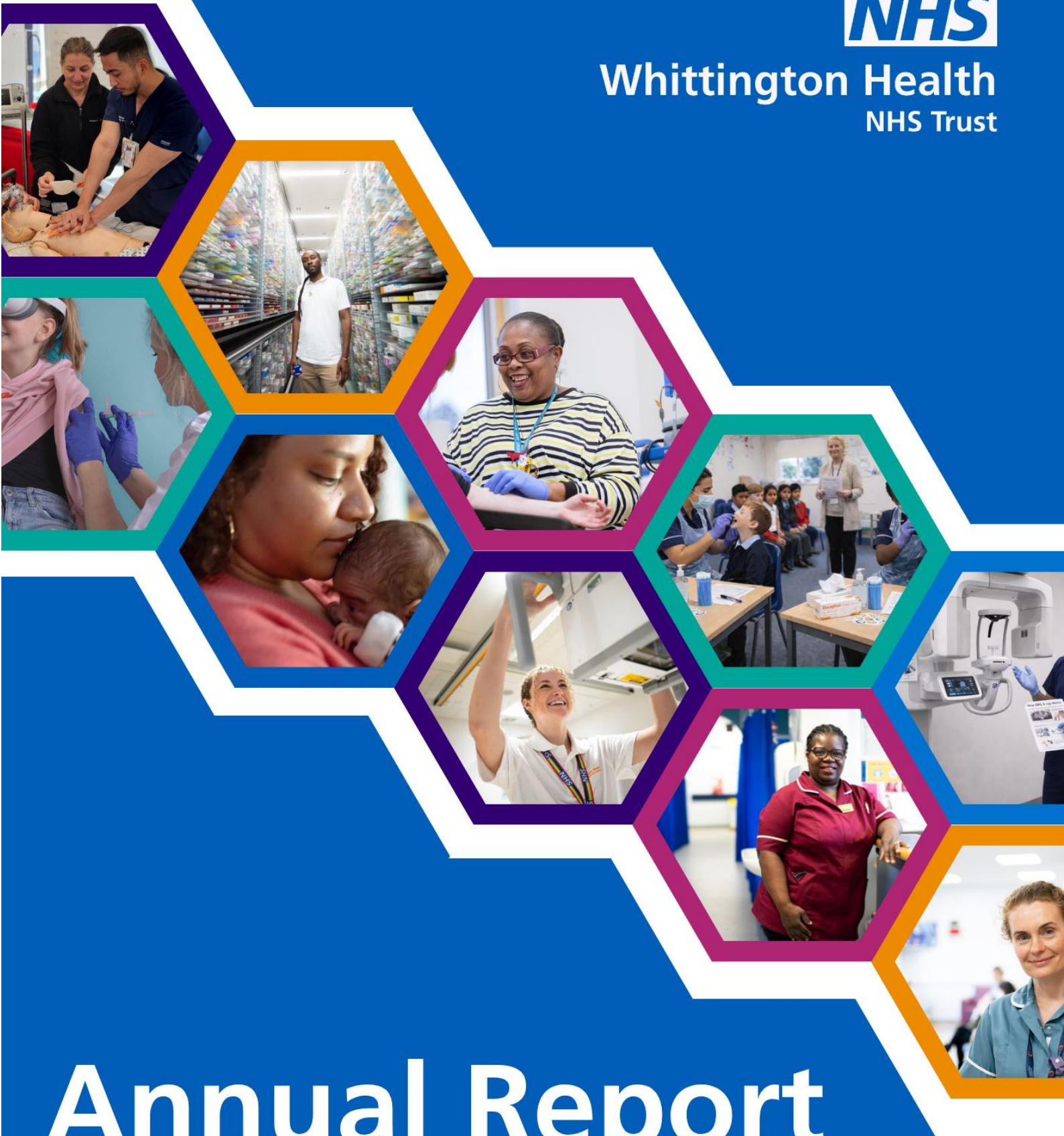




Whittington Health
NHS Trust



Annual Report 2025/26

Chair and Chief Executive's introduction

Welcome to our 2025/26 annual report which outlines how, over the past year, the tremendous work of the staff and volunteers of Whittington Health NHS Trust has supported over 500,000 people living across North Central London and beyond to live longer, healthier lives.

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

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

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

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

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

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

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

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

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

There were several changes to our Board and senior leadership team during the year. We would like to extend our sincere thanks to Charlotte Hopkins, Clare Dollery, Liz O'Hara and Jonathan Gardner for their valuable service and contribution to the Trust during their time on the Board and within the organisation.

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



Baroness Julia Neuberger
DBE
Trust Chair



Selina Douglas
Chief Executive Officer

Whittington Health in 2025/26



ED attendances

107,769



Community Nursing

254,977



Births

2,652



Dental Appointments

50,315



Physio and MSK
Appointments

79,187



Outpatient appointments

437,213



Day cases

28,042

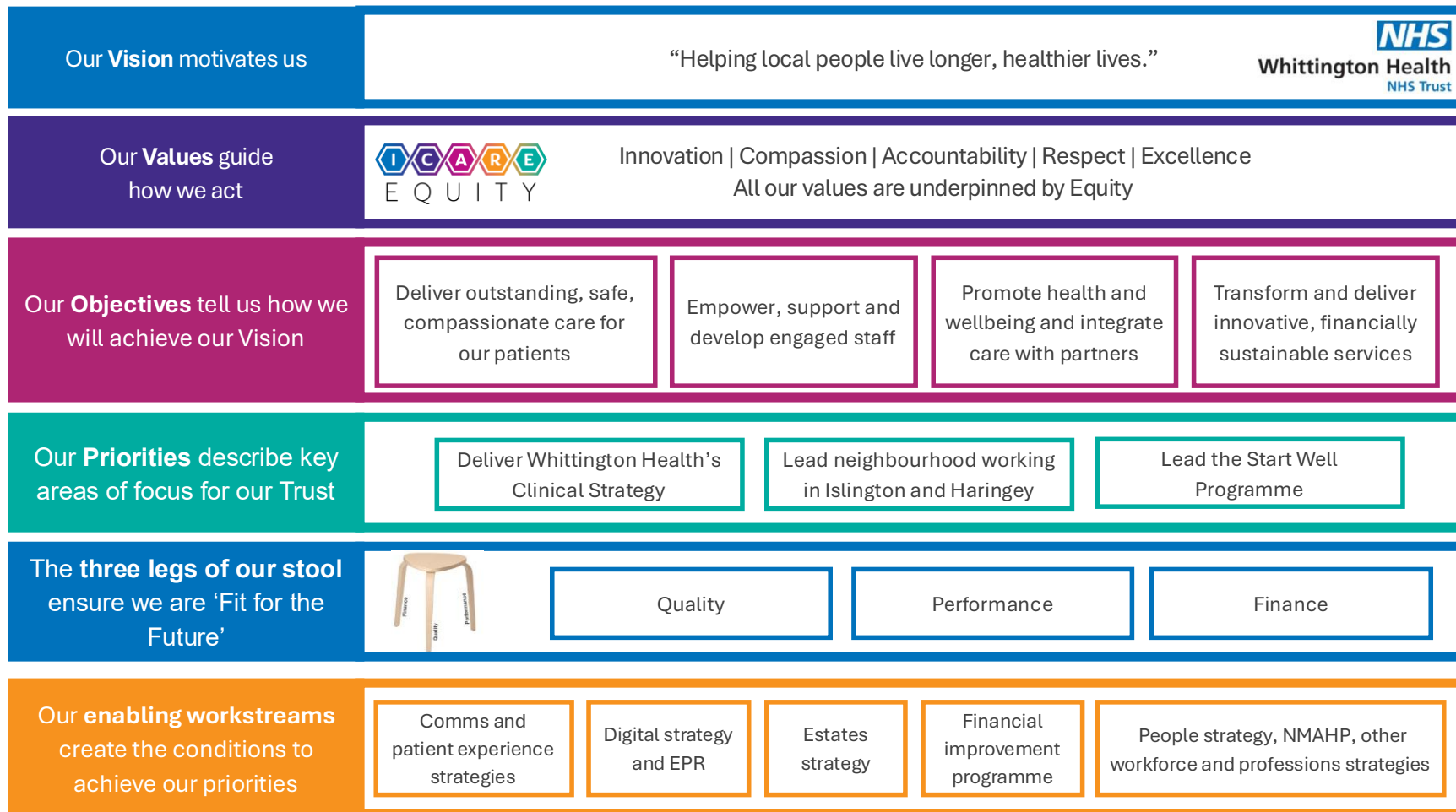


School appointments

144,314

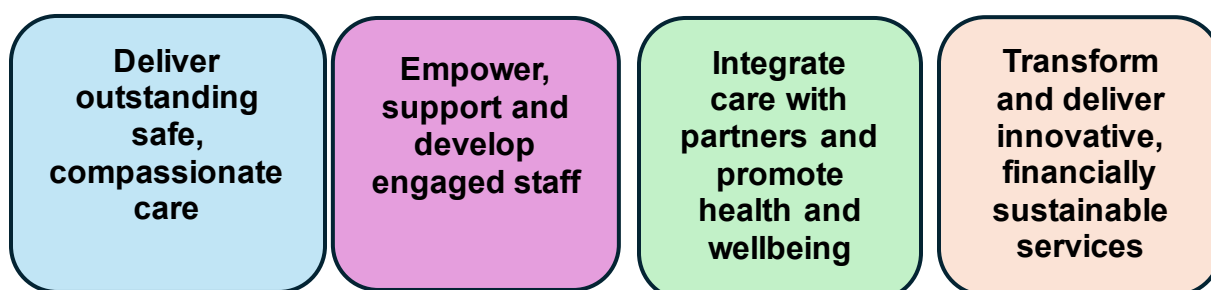
Trust strategy

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



Strategic objectives

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



Clinical strategy

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

The Clinical Strategy was developed through an intensive programme of workshops, surveys and engagement events between October 2024 and May 2025, which saw more than a thousand contributions which helped to shape our strategy. Responding to rising demand, increasing complexity and persistent inequalities, the strategy is grounded in national priorities to provide more care closer to home, place greater emphasis on prevention, and increase the use of digital technologies to improve care and patient experience. It defines the transformation required to ensure that patients receive the right care, in the right place, at the right time. The strategy is organised around eight clinical chapters:

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

Delivery depends on strong enablers, including digital and data capabilities, modern estates to support integrated working, sustainable financial plans and a commitment to research, quality improvement and environmental sustainability. The Clinical Strategy is owned by our staff and partners. It reflects their expertise, insight and ambition to provide outstanding care and to work collaboratively across North Central London. It provides a strong and coherent framework for the changes we will deliver

over the coming years, ensuring that Whittington Health continues to provide high-quality, equitable services for our communities — both now and into the future.

Our services

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

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

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

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

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

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

Strategic developments

UCLH and Whittington Health Collaboration

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

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

Start Well

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

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

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

Values

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



PERFORMANCE

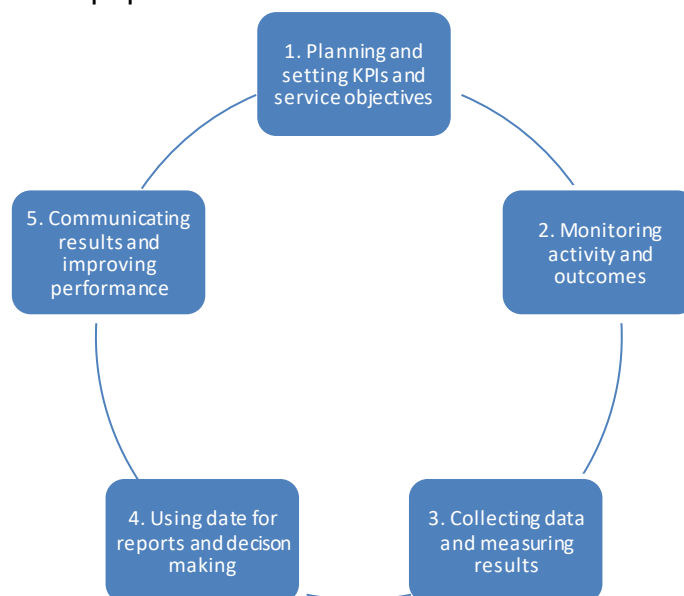
How we measure performance

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

This section of the annual report provides a comprehensive overview of Whittington Health NHS Trust's performance during the 2025/26 financial year, highlighting key achievements, challenges, and areas for improvement across healthcare delivery. Throughout the year, there was close monitoring of our performance against key metrics where performance was below target – particularly the four-hour emergency department access standard and, earlier in the year, for the nationally mandated cancer standards. In quarter four, Whittington Health was able to demonstrate significantly improved performance in both areas and further detail are provided in this section of the annual report.

Monitoring performance

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



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

National context

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

- 18-Week Referral to Treatment (RTT) target: All 124 acute hospital trusts in England failed to meet the target of treating 92% of patients within 18 weeks. As of early 2025, 3.1 million people had been waiting over 18 weeks, with 234,885 waiting over a year.
- Waiting List Size: The total elective care waiting list stood at approximately 7.54 million cases.
- Approximately 1.65 million people waited more than 4 hours in Accident & Emergency departments in England between April 2024 and March 2025.
- In 2024/25, England's cancer services faced ongoing challenges in meeting key performance targets, despite some areas of progress.
 - 62-Day Referral to Treatment Standard - In 2024, only 62.2% of patients began treatment within this timeframe, an improvement from 60.1% in 2023 but still significantly below the target of 85%. Noting the NHS has not met this target since December 2015.
 - The national standard for the 28-day Faster Diagnosis Standard was 75%. In November 2024, 77% of patients met the standard
 - Under the 31-Day Decision to Treat Standard a target of 96% of patients should start treatment within 31 days of the decision to treat. In December 2024, 92% of patients commenced treatment within 31 days, with radiotherapy patients experiencing longer waits.

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

Summary – Whittington Health

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

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

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

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

Our key performance highlights included the following:

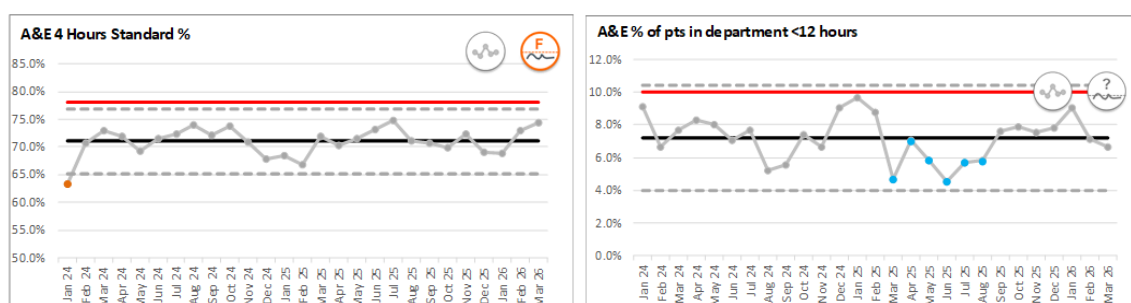
Emergency department

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

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

Statistical process control

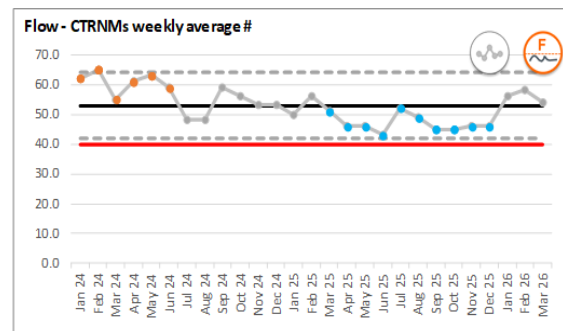
Whittington Health uses statistical process control charts to monitor, analyse, and review performance against key national targets over time. These charts enable the identification of trends, variation, and any emerging performance issues in a structured and evidence-based way. In the charts presented,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



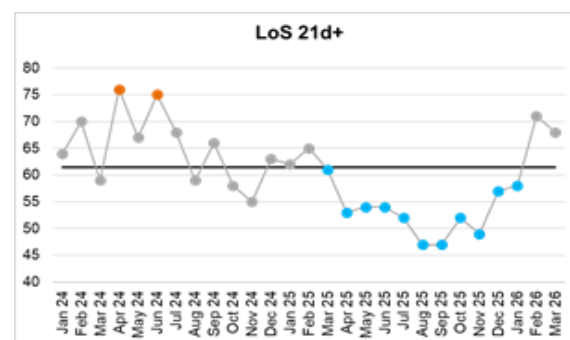
Performance against the four-hour ED standard averaged at 71.6% through 2025/26 an improvement of 0.7% from 2024/25. The Trust has delivered sustained improvement throughout the period.

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

Patient flow



The number of patients who do not meet the Criteria to Reside as a daily average based on a weekly snapshot

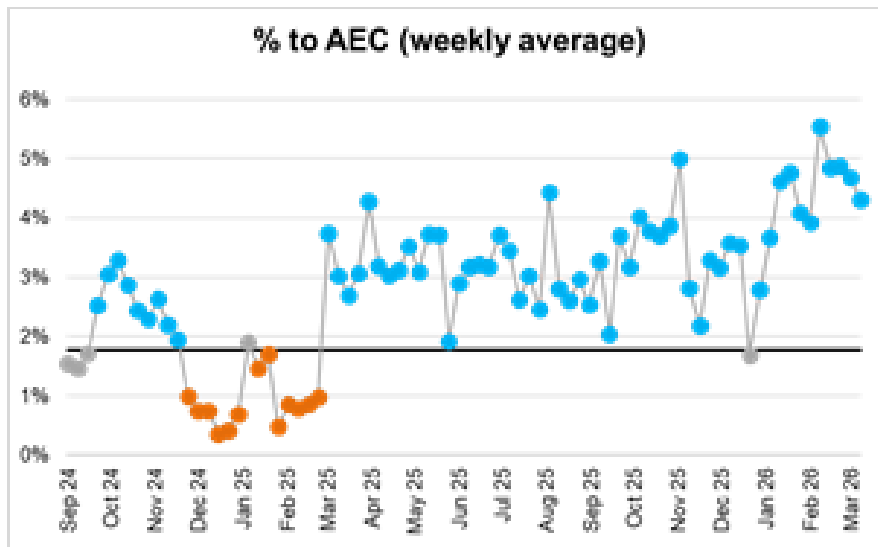


Length of Stay

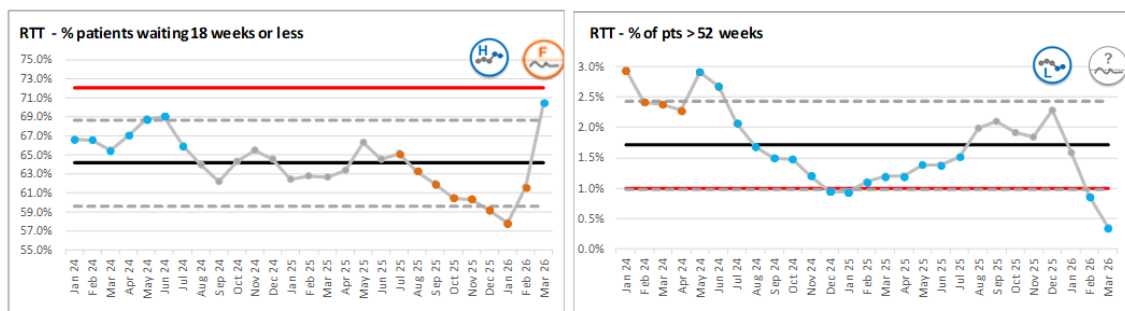
In 2025/26, Whittington Health continued to deliver its Flow Improvement Programme, resulting in a measurable reduction in the number of patients who do not meet the criteria to reside (CTR). The average number of non-CTR patients reduced to 49 in 2025/26, compared with an average of 55 in 2024/25, demonstrating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

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

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



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



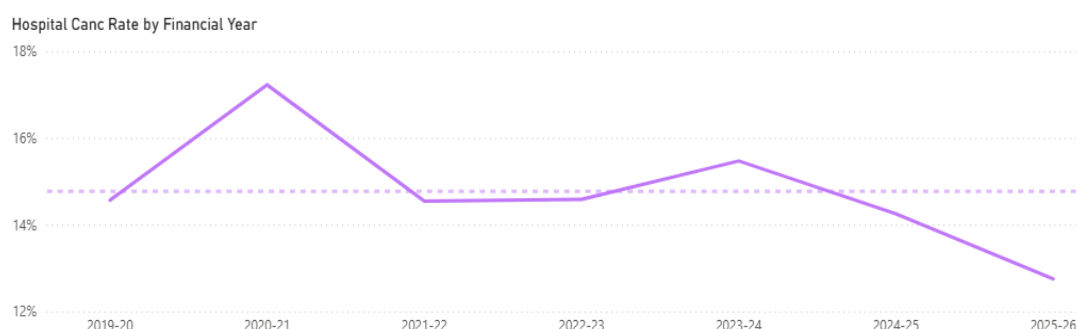
The Trust has not achieved the 92% RTT standard since before the pandemic. Performance during 2025/26 was variable and declined through the year, reaching a low point of 57.8% in January 2026. However, following implementation of the national Q4 Sprint initiative, performance improved significantly,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

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

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

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

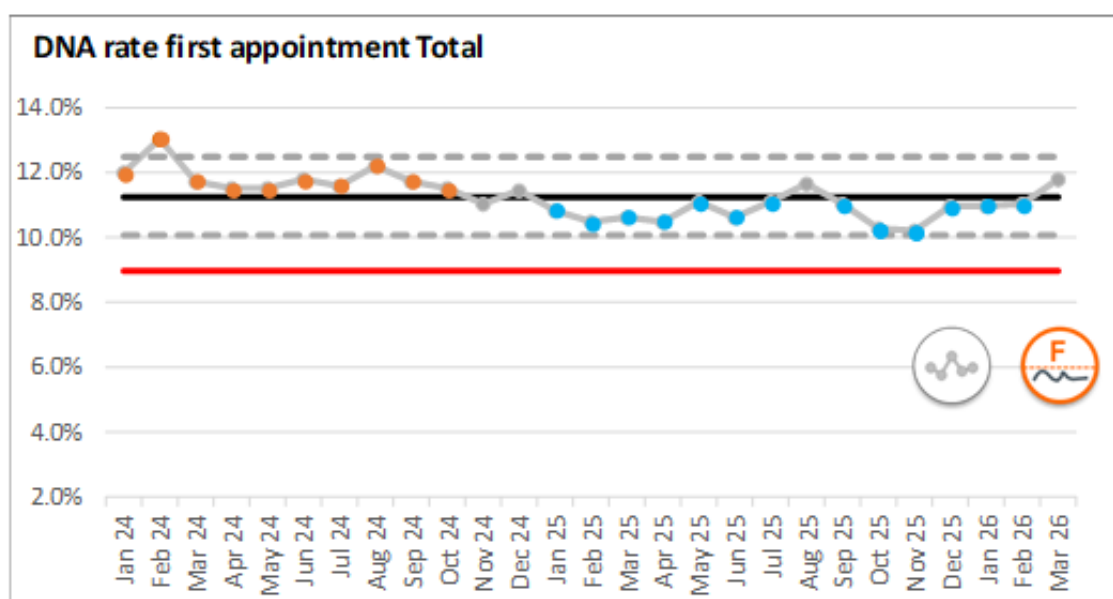
Improvement in outpatient hospital cancellations



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

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

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



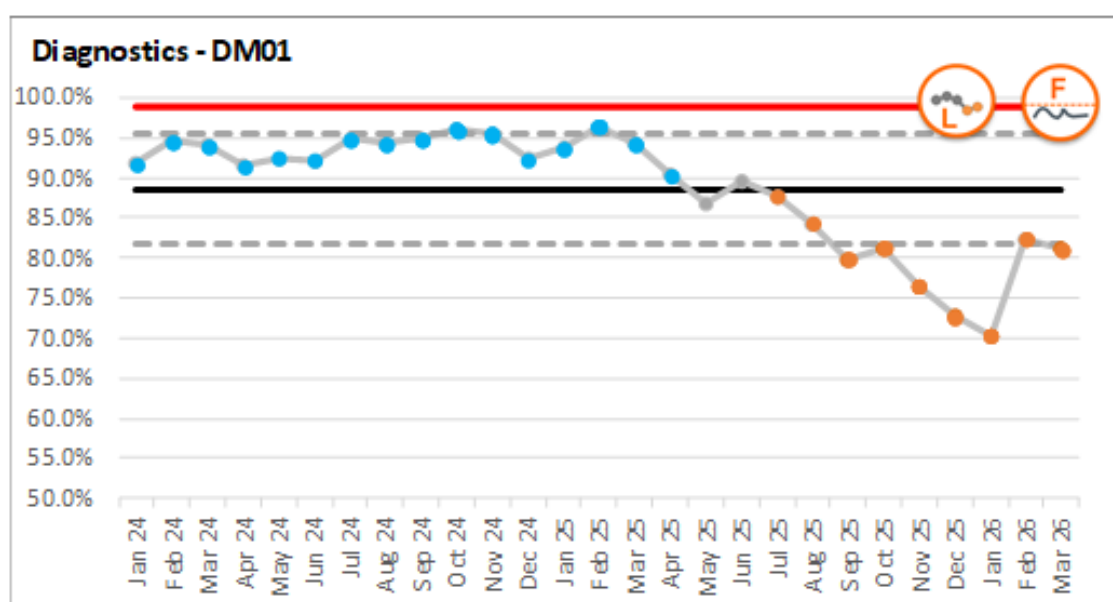
The rate of patients who did not attend (DNA) their first outpatient appointment reduced in 2025/26 to 10.9%, compared with 11.4% in 2024/25. This represents a

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

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

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

Diagnostics – DM01



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

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

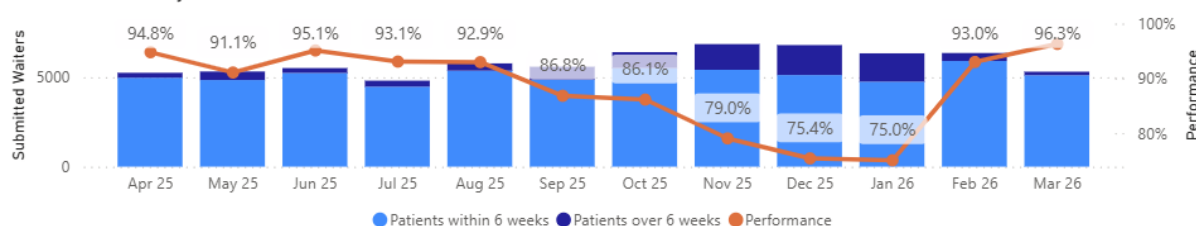
Imaging performance

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

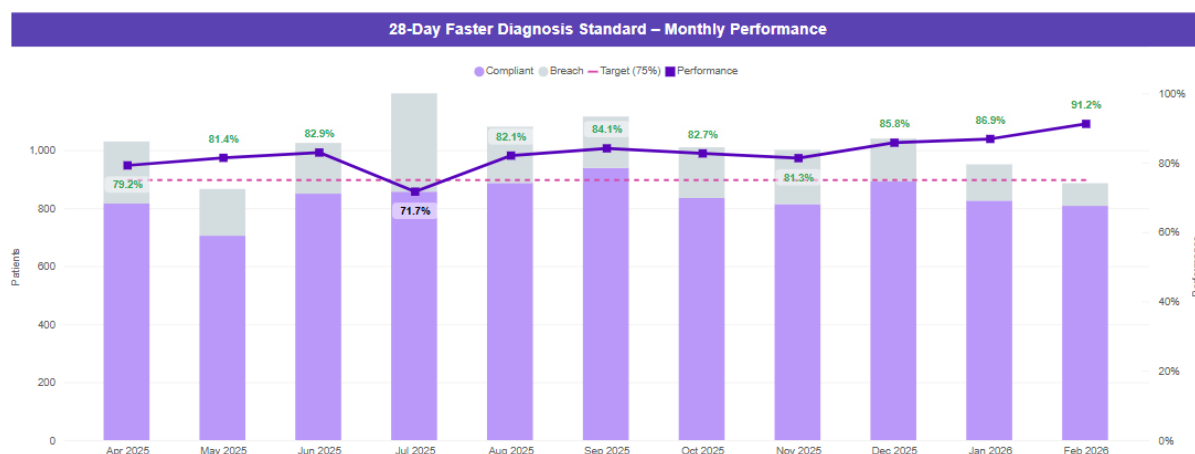
constraints and a reduction in waiting list initiative activity during the period. Performance recovered strongly in the final two months of the year, reflecting the successful impact of additional ultrasound capacity introduced through the Q4 Sprint initiative. As a result, delivery improved to 93%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

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

Submitted Monthly Performance



Cancer – faster diagnosis



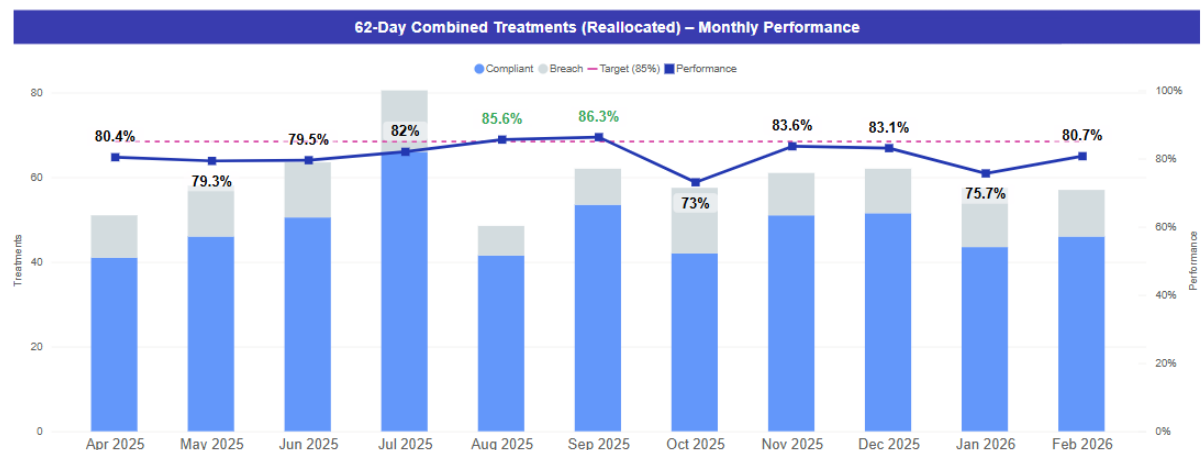
Performance against the cancer faster diagnosis standard (FDS) for 2025/26 averaged 82.4%, and exceeded the national standard of 75%. Performance peaked in February 2026, with delivery reaching 91.2%, placing the Trust as the number one performer for all NHS providers in England for that month.

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

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

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

Cancer – 62 days performance



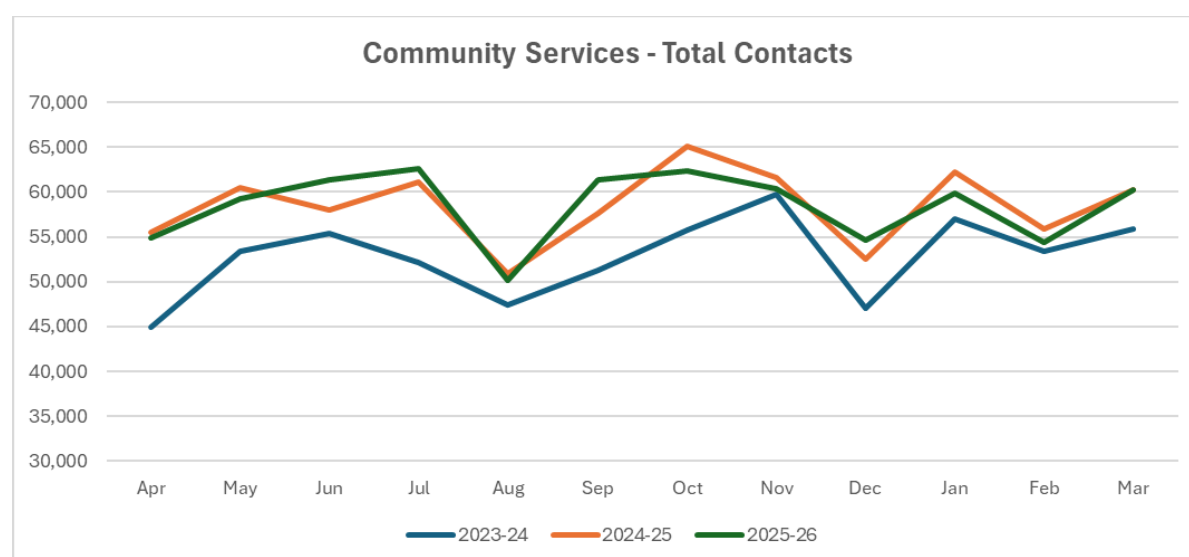
The constitutional national standard for 62-day cancer performance in 2025/26 was 85%, with a recovery standard of 80% set for the year. The Trust delivered an average combined 62-day performance of 80.9% during 2025/26, achieving the recovery standard. This represents a significant year-on-year improvement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

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

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

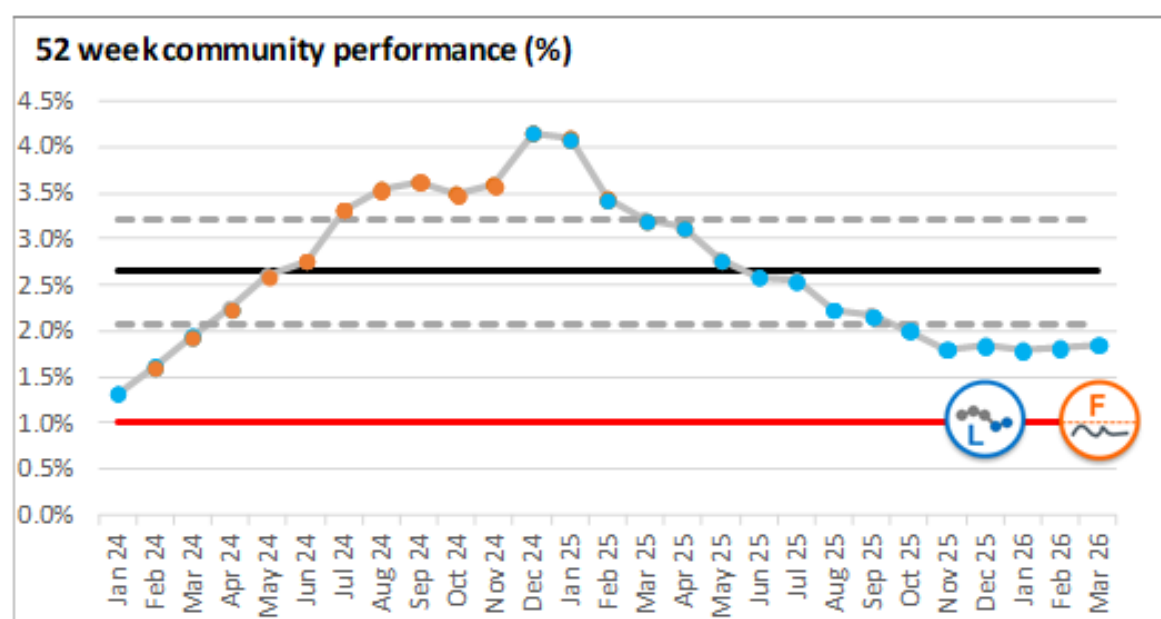
Community services

Total contacts



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

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



1Percentage of patients waiting more than 52 weeks on the community waiting list

Highlighted services to note are:

Podiatry

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

Community respiratory services

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

Musculoskeletal physiotherapy – digital transformation

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

MSK trailblazer pilot (Department of Work & Pensions-funded)

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

MSK community appointment days

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

East Haringey diabetes health inequalities programme

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

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

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

Islington community heart failure/ pharmacist pathway

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

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

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

Continuing healthcare

The Continuing Healthcare Team has delivered a rapid and sustained improvement in performance, with overall KPI achievement (assessment done within 28 days) increasing from 23% in January 2026 to 70% by March 2026. This step-change has been driven by streamlined assessment processes, strengthened multidisciplinary team working, and a clear focus on prioritisation to reduce assessment backlogs and delays. The improvement provides increased assurance around timeliness, compliance and patient experience within the continuing healthcare pathway.

Occupational therapy

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

The early language support for every child

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

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

Crucially, while referrals to specialist speech and language therapy services continue to rise overall, ELSEC-supported education settings in Barnet saw referrals increase by just 3%, compared with a 19% increase in education settings which do not benefit from the programme. This demonstrates how developing the Experts at Hand approach and

aligning with ELSEC can upskill staff in settings, ensure quick and flexible access to advice when it is needed, and enable timely support for children.

Neurodevelopmental sprint

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

- 170 children assessed during this process.
- 283 assessments completed for these children.
- Finalised outcomes on diagnosis rate being collated
- Priority list waiting times reduced to 0 months from 7-8 months, this means those with the highest level of need will be seen within the next available slot.
- Routine list waiting times remained substantially long, however, waiting times reduced from 39 months to thirty six months,.

Performance against national performance indicators

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

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

Safe

Safe – people are protected from abuse and avoidable harm	2021/22		2022/2023		2023/2024		2024/2025		2025/2026	
	Target	Outcome	Target	Outcome	Target	Outcome	Target	Outcome	Target	Outcome
Admission to adult facilities of patients aged under 16	0	0	0	0	0	0	0	81	0	360
Incidence of Clostridium Difficile *	0	10	<16	20	<13	22	<13	20	<13	23
Actual falls	400	344	400	381	400	334	400	349	400	321
Non-Elective C-section rate (%)	0	22.90%	0	25.40%	0	27.90%	0	29.70%	0	25.30%
Medication errors causing serious harm	0	0	0	0	0	1	0	0	0	0
Incidence of MRSA *	0	0	0	2	0	2	0	6	0	0
Safety Incidents	N/A	25	N/A	12	N/A	12	N/A	10	N/A	11
VTE risk assessment (%)	>95%	80.40%	>95%	95.50%	>95%	95.10%	>95%	95.60%	>95%	95.50%
Mixed sex accommodation breaches *	0	34	0	109	0	102	0	129	0	143

Effective

Effective – people's care, treatment and support achieve good outcomes, promote a good quality of life and are based on the best available evidence	2021/22		2022/2023		2023/2024		2024/2025		2025/2026	
	Target	Outcome	Target	Outcome	Target	Outcome	Target	Outcome	Target	Outcome
Breastfeeding initiated	>90%	91.60%	>90%	93.46%	>90%	92.50%	>90%	93.50%	>90%	92.10%
Smoking at delivery	<6%	4.06%	<6%	4.23%	<6%	3.80%	<6%	3.50%	<6%	

Effective – people's care, treatment and support achieve good outcomes, promote a good quality of life and are based on the best available evidence	2021/22		2022/2023		2023/2024		2024/2025		2025/2026	
										3.90%
Non-elective re-admissions within 30 days	<5.5%	4.92%	<5.5%	3.88%	<5.5%	3.85%	<5.5%	3.61%	<5.5%	3.63%
Mortality rate per 1000 admissions in-months	14.4	7.63	14.4	8.4	14.4	8.3	14.4	7.1	14.4	7.9
IAPT Moving to Recovery	>50%	51.89%	>50%	50.20%	>50%	47.80%	>50%	49.90%	>50%	49.70%
% seen within 2 hours of referral to district nursing night	>80%	97.37%	>80%	94.47%	>80%	92.70%	>80%	96.20%	>80%	95.50%
% seen within 48 hours of referral to district nursing night	>95%	95.48%	>95%	93.21%	>95%	91.40%	>95%	96.60%	>95%	94.10%
% of MSK patients with a significant improvement in function	>75%	89.79%	>75%	86.26%	>75%	79.20%	>75%	81.10%	>75%	94.90%
% of podiatry patients with significant improvement in pain	>75%	95.26%	>75%	86.68%	>75%	79.20%	>75%	92.70%	>75%	86.80%

Caring

Caring - Involving people in their care and treating them with compassion, kindness, dignity and respect	2021/22		2022/2023		2023/2024		2024/2025		2025/2026	
KPI description	Target	Outcome	Target	Outcome	Target	Outcome	Target	Outcome	Target	Outcome
Emergency department – FFT % positive	>90%	77.70%	>90%	76.00%	>90%	78.50%	>90%	80.90%	>90%	80.80%
Emergency department – FFT response rate	>15%	10.90%	>15%	11.50%	>15%	10.90%	>15%	8.20%	>15%	7.70%
Inpatients – FFT % positive	>90%	95.80%	>90%	93.50%	>90%	92.80%	>90%	93.60%	>90%	93.80%
Inpatients – FFT response rate	>25%	17.30%	>25%	19.30%	>25%	16.10%	>25%	19.00%	>25%	20.00%
Maternity - FFT % positive	>90%	98.50%	>90%	63.00%	>90%	97.80%	>90%	98.30%	>90%	98.50%
Maternity - FFT response rate	>15%	11.50%	>15%	14.80%	>15%	10.20%	>15%	21.60%	>15%	6.40%
Outpatients - FFT % positive	>90%	93.40%	>90%	90.30%	>90%	90.70%	>90%	90.70%	>90%	90.70%
Outpatients - FFT responses	40n0	591	400	1268	400	3934	400	3070	400	13461
Community - FFT % positive	>90%	97.70%	>90%	96.50%	>90%	95.70%	>90%	94.60%	>90%	93.00%
Community - FFT responses	1,500	5527	1,500	8,469	1,500	9,123	1,500	9734	1,500	19744
Trust Composite FFT - % recommend	>90%	88.78%	>90%	85.32%	>90%	89.58%	>90%	91.79%	>90%	93.15%
Staff FFT - % recommend	>70%	66.97	>70%	62.17%	>70%	63.68	>70%	67.52%	>70%	69%
Complaints responded to within 25 working days	>80%	59.90%	>80%	55.40%	>80%	53.90%	>80%	68.80%	>80%	65.70%

Responsive

Responsive - organising services so that they are tailored to people's needs	2021/22		2022/2023		2023/2024		2024/2025		2025/2026	
KPI description	Target	Outcome	Target	Outcome	Target	Outcome	Target	Outcome	Target	Outcome
Emergency department waits – 4 hours	>95%	78.30%	>95%	68.40%	>95%	65.30%	>95%	70.90%	>95%	71.60%
Median wait for treatment (minutes)	<60 mins	93	<60 mins	110	<60 mins	103	<60 mins	94	<60 mins	100
Ambulance handovers waiting more than 30 minutes	0	646	0	1175	0	905	0	1111	0	1533
Ambulance handovers waiting more than 60 minutes	0	283	0	566	0	196	0	88	0	88
12-hour trolley waits in A&E	0	83	0	2208	0	2940	0	3575	0	2889
Cancer – 31 days to first treatment	>96%	94.90%	>96%	89.90%	>96%	93.50%	>96%	94.50%	>96%	98.60%
Cancer – 62 days from referral to treatment	>85%	67.60%	>85%	47.70%	>85%	53.90%	>85%	57.60%	>85%	80.90%
Diagnostic waits (<6 weeks)	>99%	94.10%	>99%	85.89%	>99%	86.86%	>99%	94.12%	>99%	81.59%
Referral to treatment times waiting <18 weeks (%)	>92%	74.40%	>92%	67.80%	>92%	66.20%	>92%	64.90%	>92%	62.00%
Referral to treatment time over 52 weeks	0	384	0	607	0	500	0	301	0	76

Activity

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

Health equity

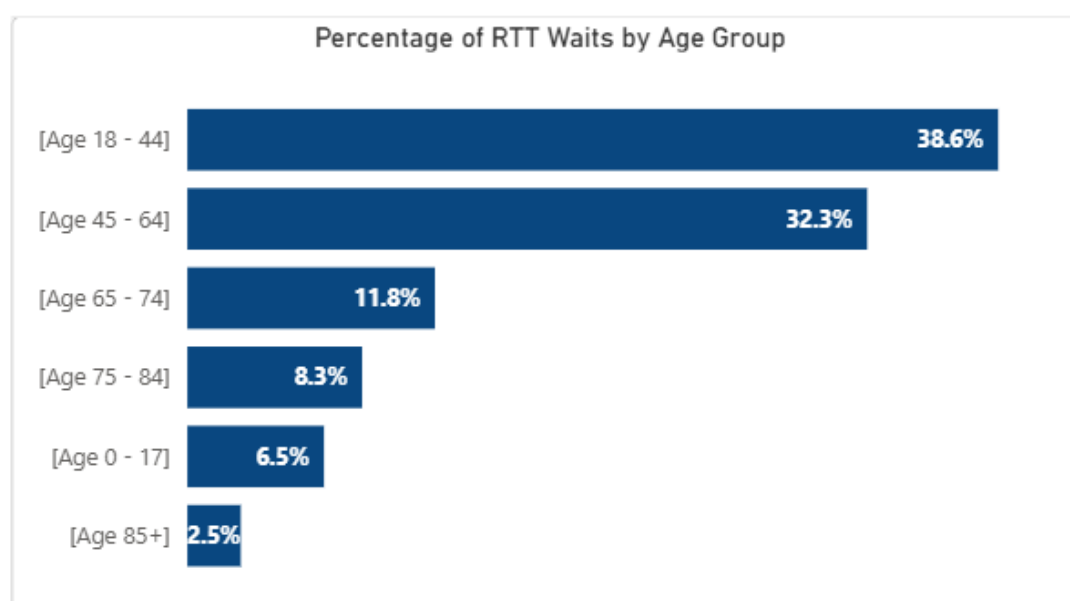
Waiting times

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

1. Referral to treatment (RTT)

a. Percentage of RTT waits by age group

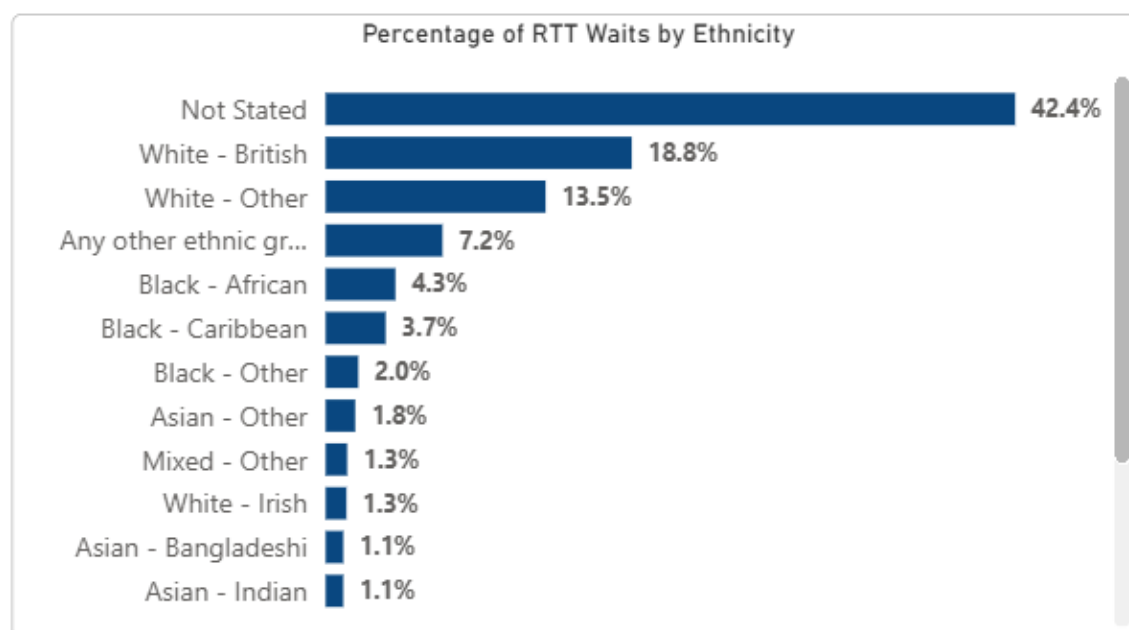
For 2025/26, the distribution of RTT waits remains broadly consistent with the previous year, with working-age adults continuing to account for the largest proportion of waits, though with some notable shifts. Patients aged 18 – 44 represent the largest share at 38.6%, increasing slightly from 37% in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



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

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

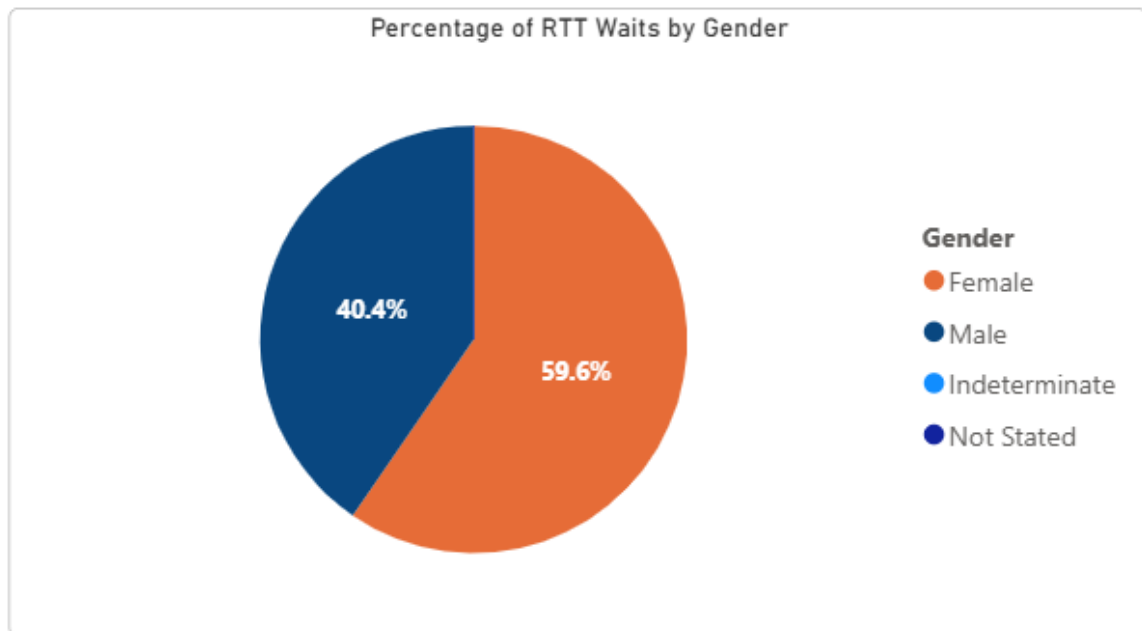
13% to 13.5%. All other ethnic group shows a small rise from 7% to 7.2%, indicating a stable representation of these populations. Black ethnic groups remain relatively consistent year on year, with Black African increasing slightly from 4% to 4.3% and Black Caribbean decreasing marginally from 4% to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



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

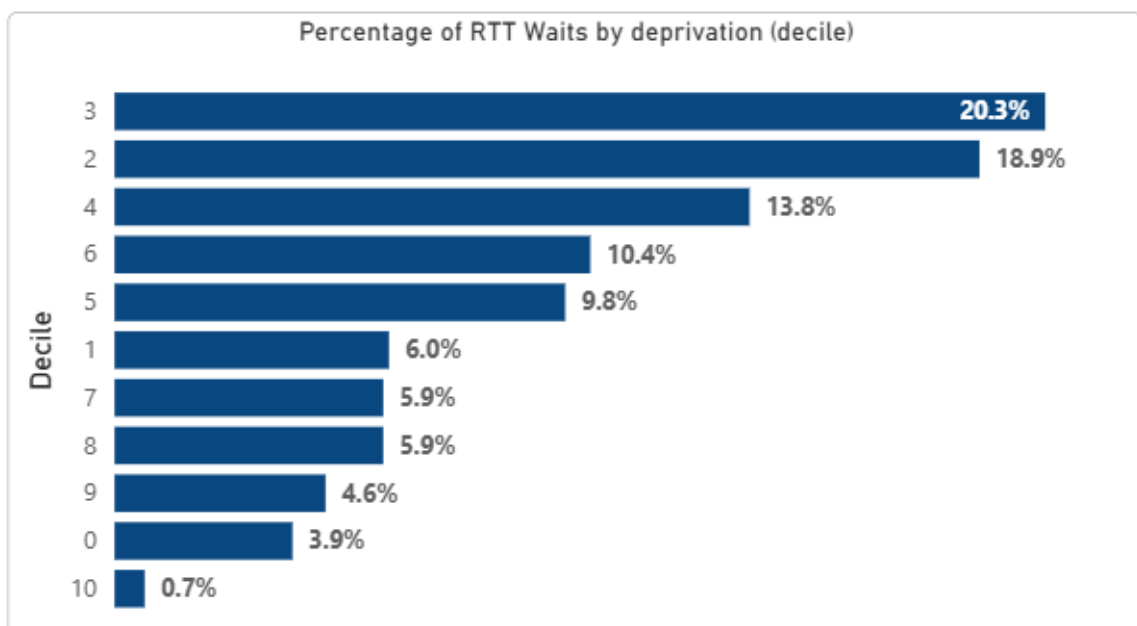
For 2025/26, the distribution of RTT waits (see the table overleaf) by gender remains very similar to the previous financial year, continuing to show a higher proportion of waits among females. Female patients accounted for 59.6% of RTT waits in 2025/26, compared with 56% in 2024–25, indicating a slight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

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



d. Percentage of RTT waits by deprivation (decile)

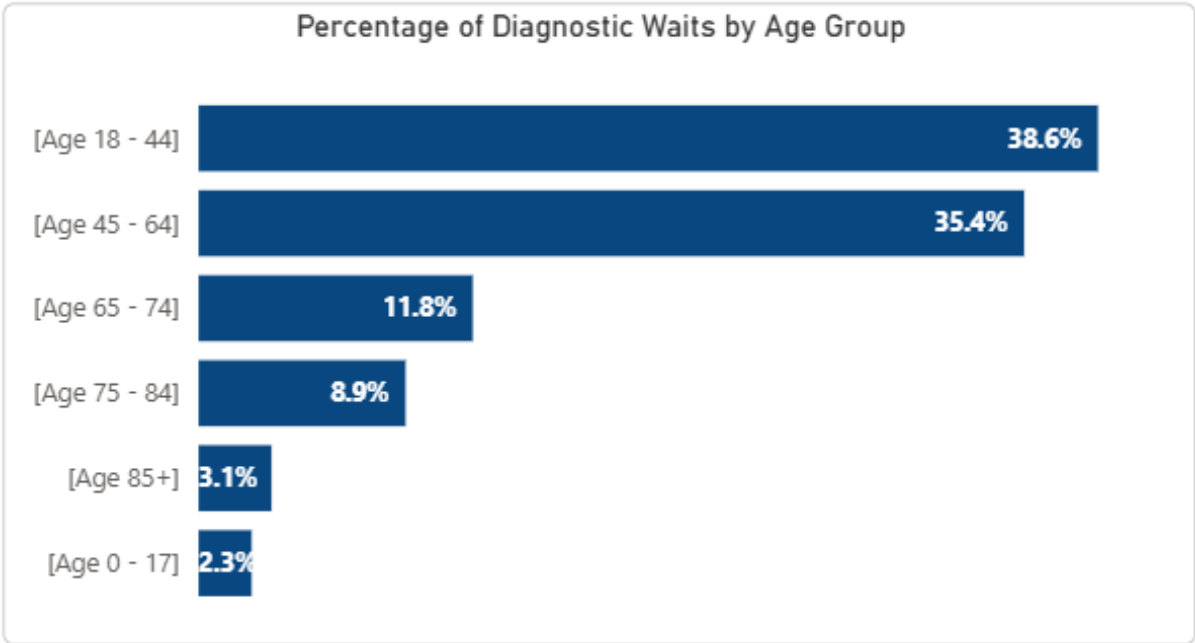
For 2025/26, the distribution of RTT waits by deprivation decile remains highly consistent with the previous financial year, continuing to show a concentration of waits among the more deprived populations. Deciles 2 and 3 account for the largest proportions of RTT waits at 18.9% and 20.3% respectively,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



2. Diagnostic waits

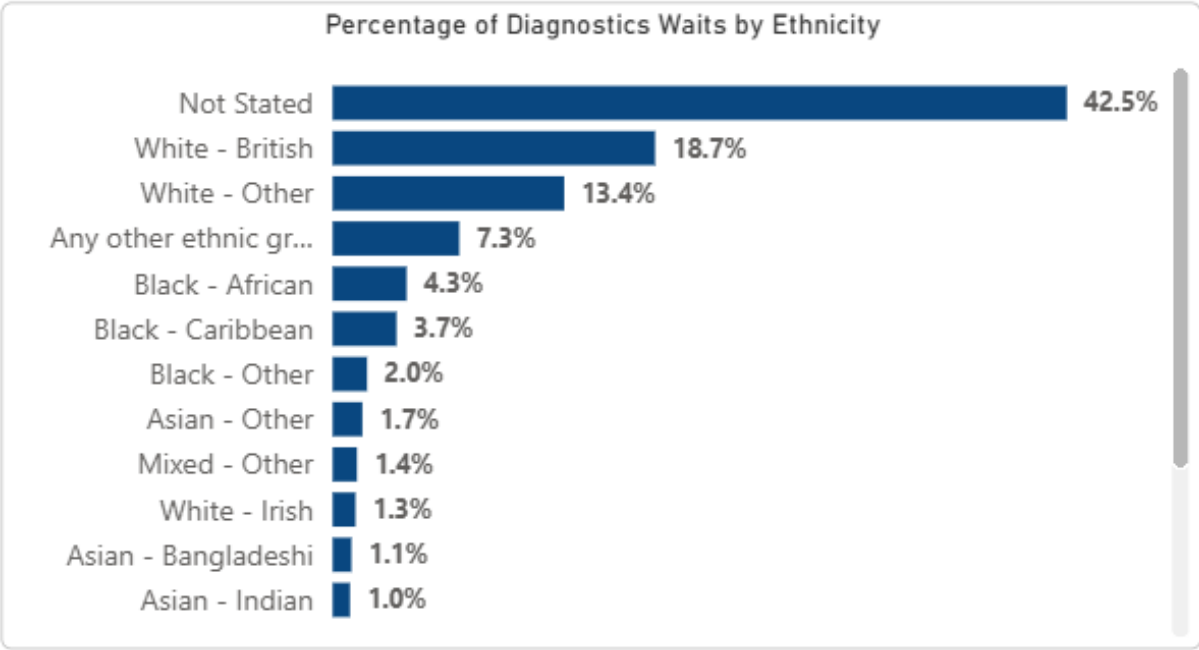
a. Percentage of diagnostic waits by age group

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



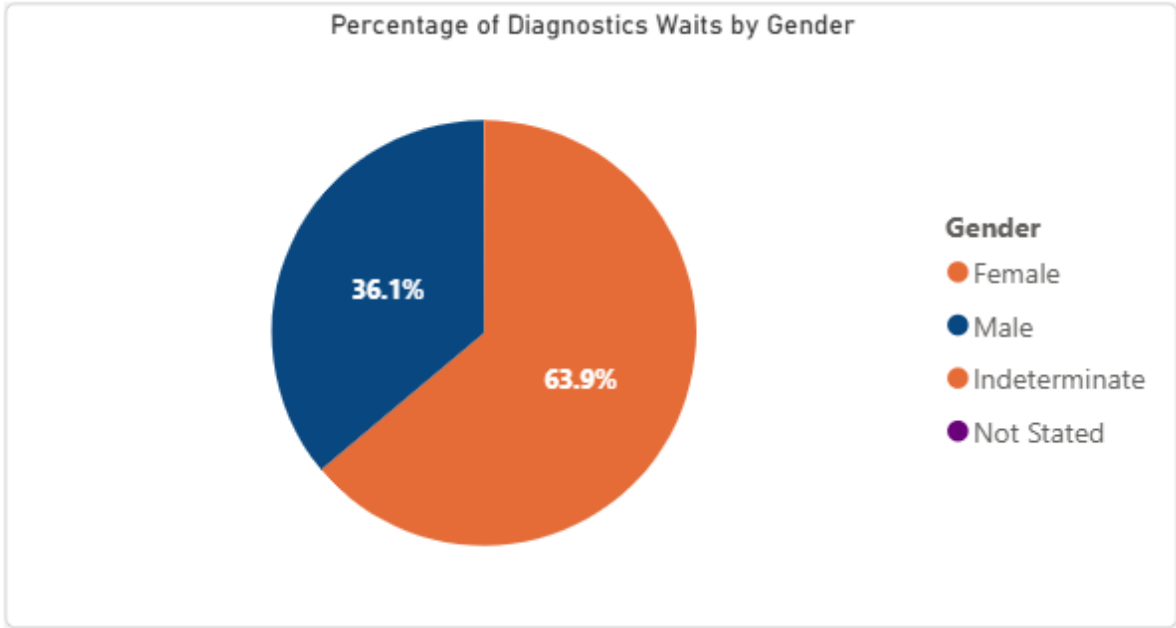
b. Percentage of diagnostic waits by ethnicity (or race)

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



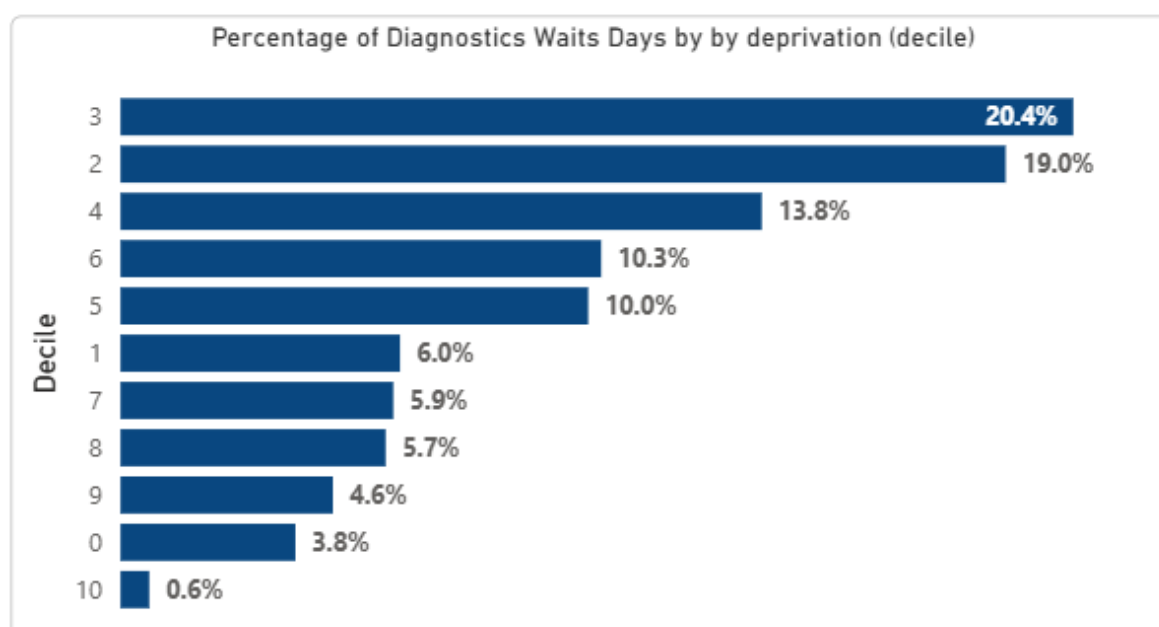
c. [Percentage of diagnostic waits by gender \(or sex\)](#)

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



d. Percentage of diagnostic waits by deprivation

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

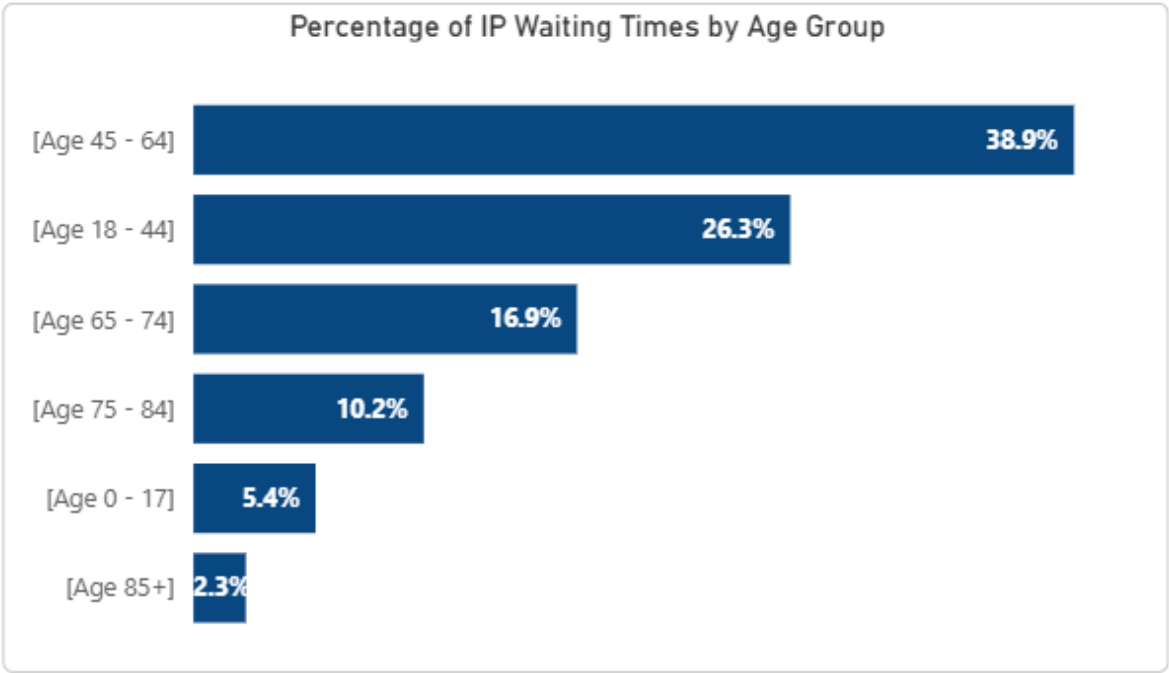


3. Inpatient waiting times

a. Percentage of inpatient waits by age group

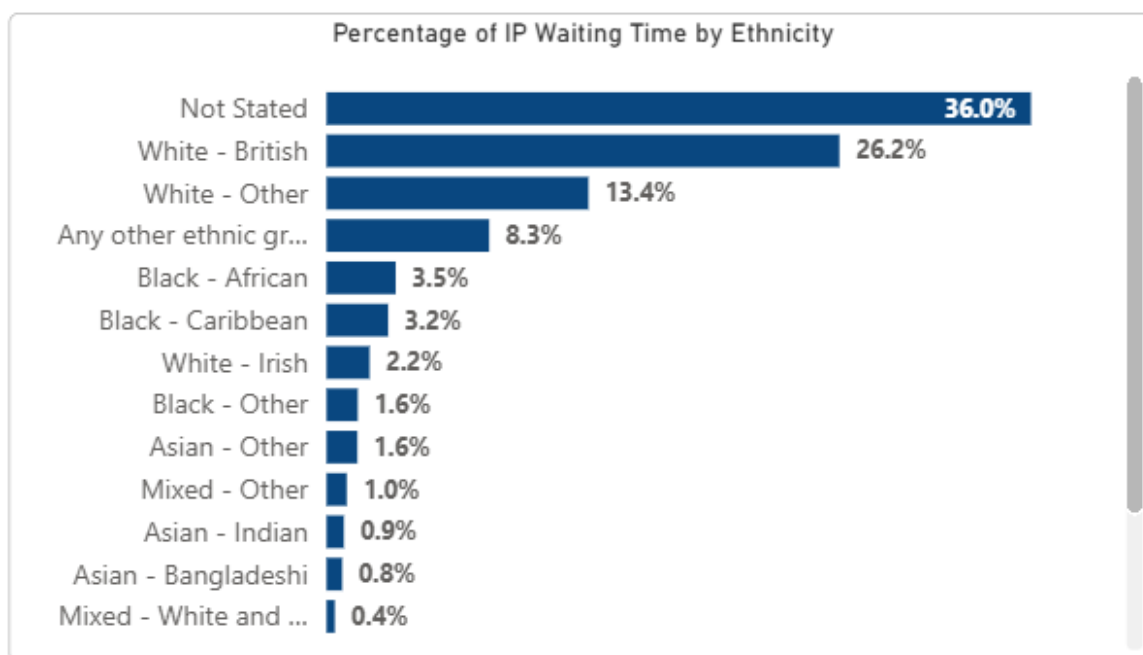
Inpatient (IP) waiting times by age group show a very similar profile to 2024/25, with waiting activity continuing to be most heavily concentrated among middle-aged adults. Patients aged 45 – 64 remain the largest group, accounting for 38.9% of IP waiting time, slightly down from 41% in 2024/25, suggesting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

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



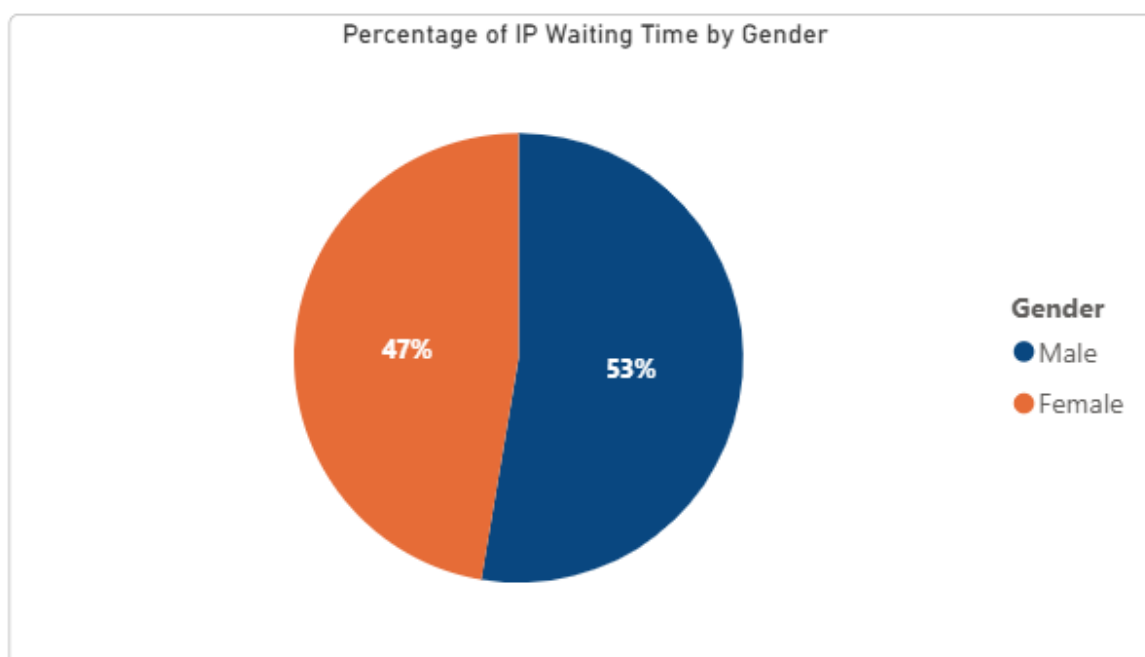
b. Percentage of inpatient waits by ethnicity (or race)

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



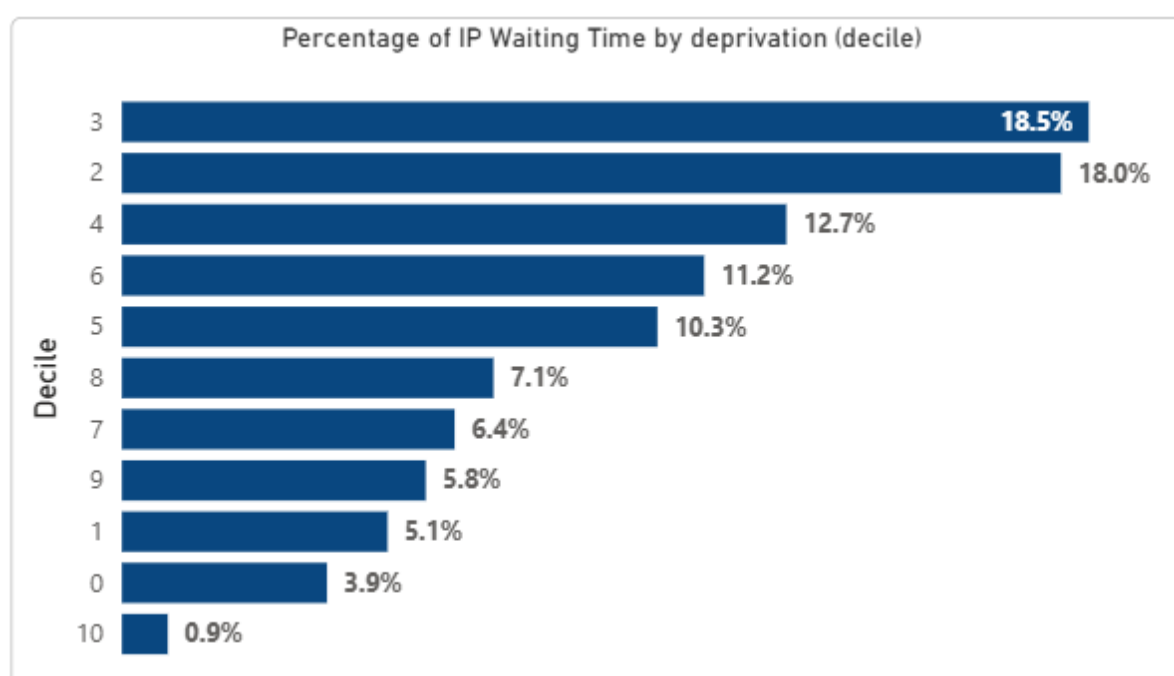
c. [Percentage of inpatient waits by gender \(or sex\)](#)

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



d. Percentage of inpatient waits by deprivation (decile)

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

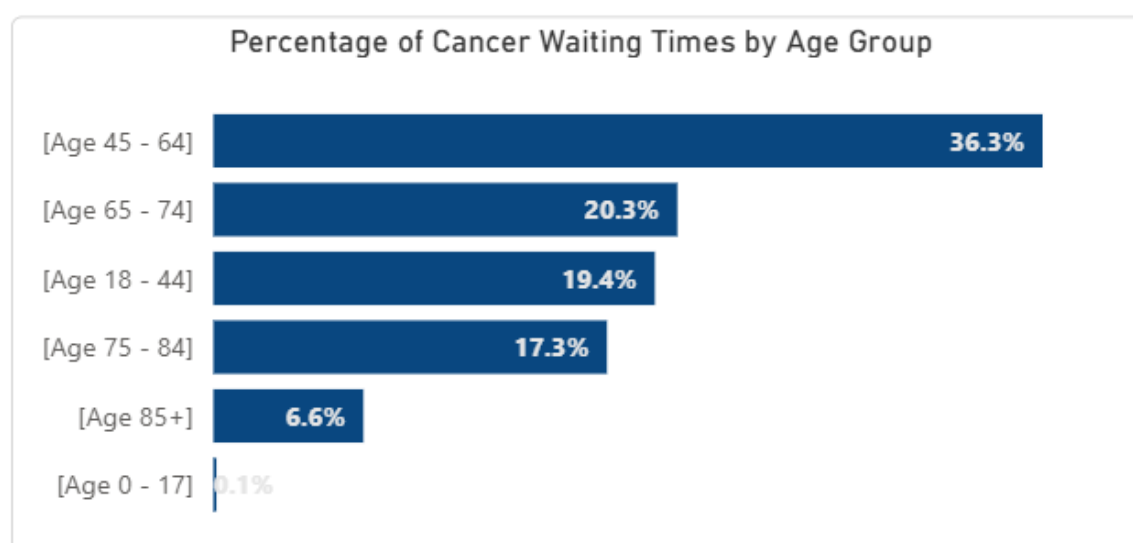


4. Cancer waiting times

a. Percentage of cancer waiting times by age group

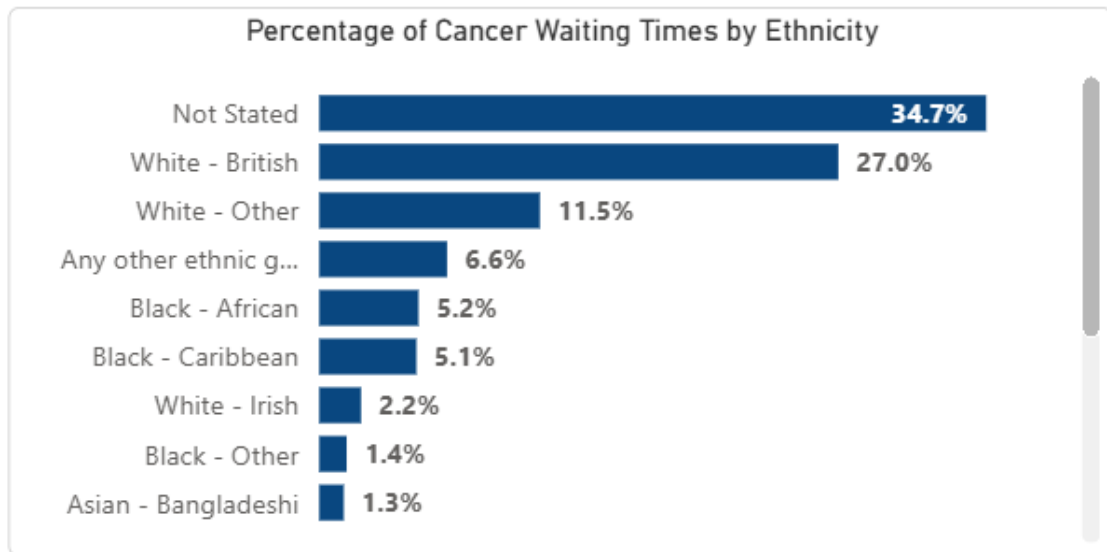
The age distribution of cancer waiting times shows strong continuity with the previous financial year 2024/25, with demand continuing to be centred on middle-aged and older adults rather than younger populations. The largest contribution still comes from those aged 45 – 64, whose share has edged up to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

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



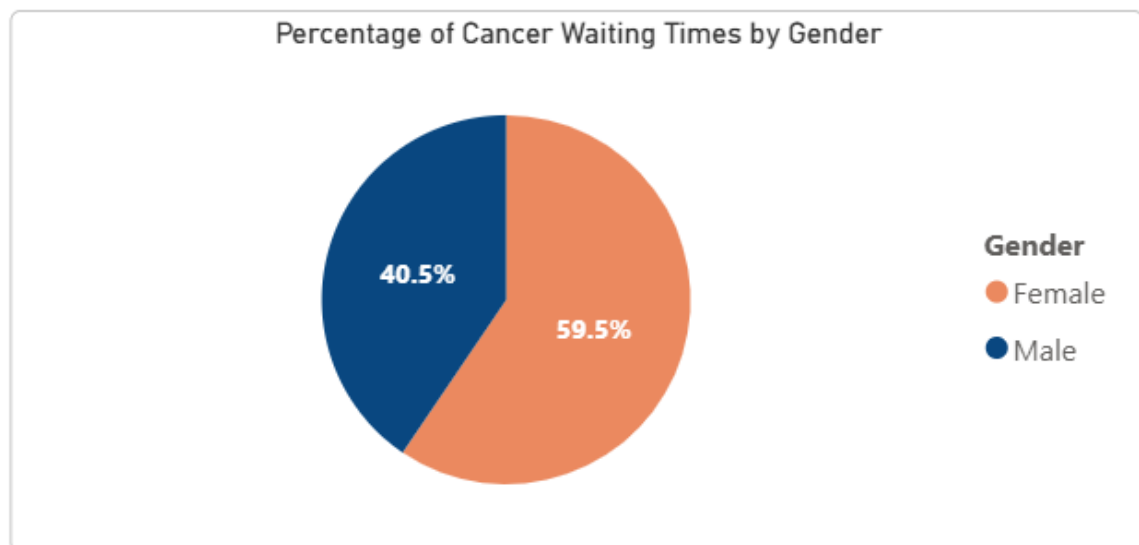
b. Percentage of cancer waiting times by ethnicity (or race)

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



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

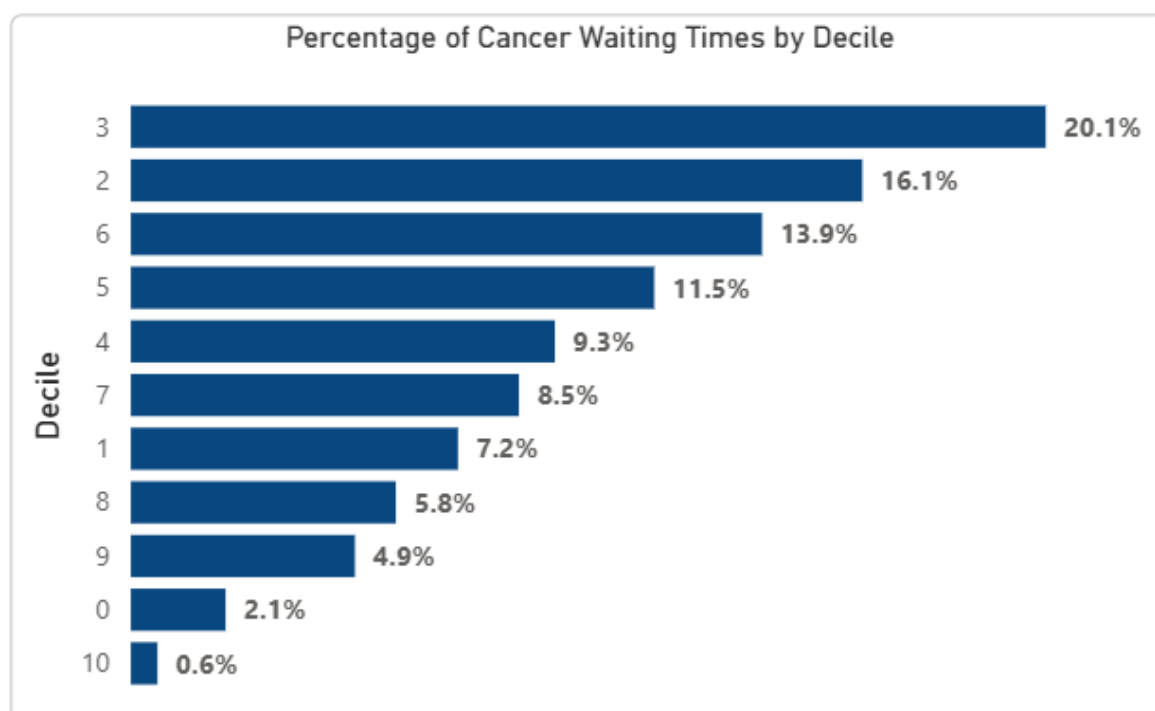
In 2025/26, cancer waiting time by gender shows a clear strengthening of the existing female predominance rather than a shift in balance. Females now account for 59.5% of total cancer waiting time, up from 56% in 2024/25, while the male share has fallen from 44% to 40.5%. This change represents a further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



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

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

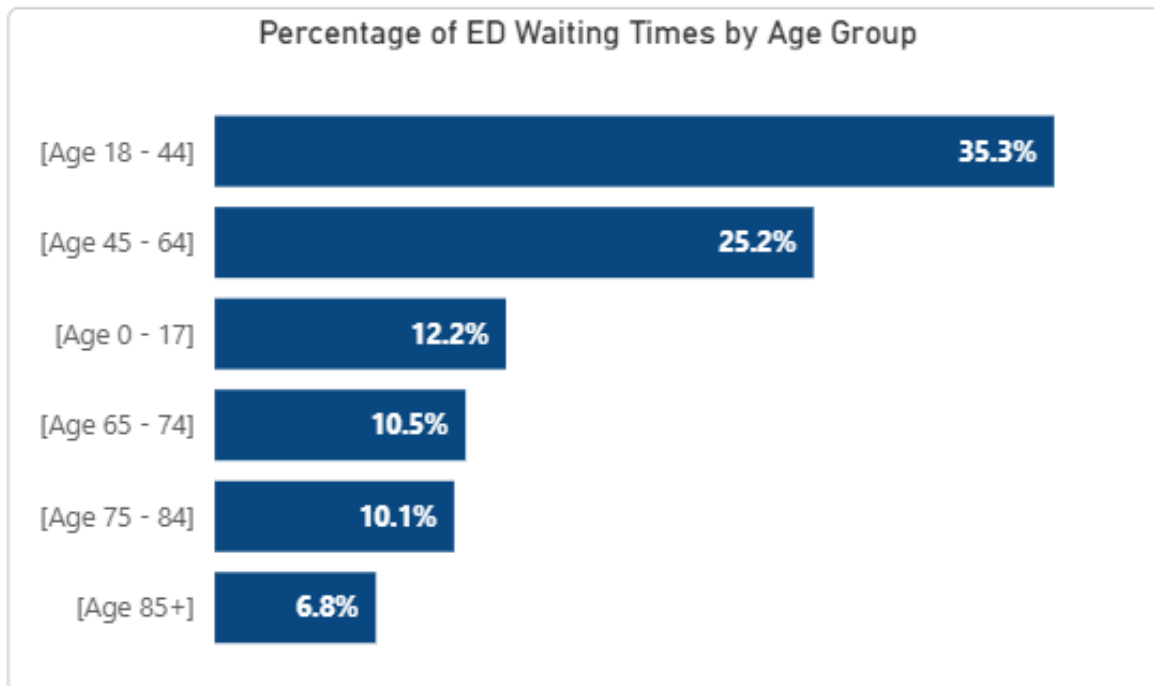
2 remains consistently high at just over 16%, underlining the sustained burden of cancer waits in these areas. There has been a re-ordering within the mid-range deciles, with decile 6 increasing to 13.9% and overtaking decile 4, which has dropped more sharply from 13% to 9.3%, suggesting shifts in where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



5. Emergency department waiting times

a. Percentage of emergency department waiting times by age group

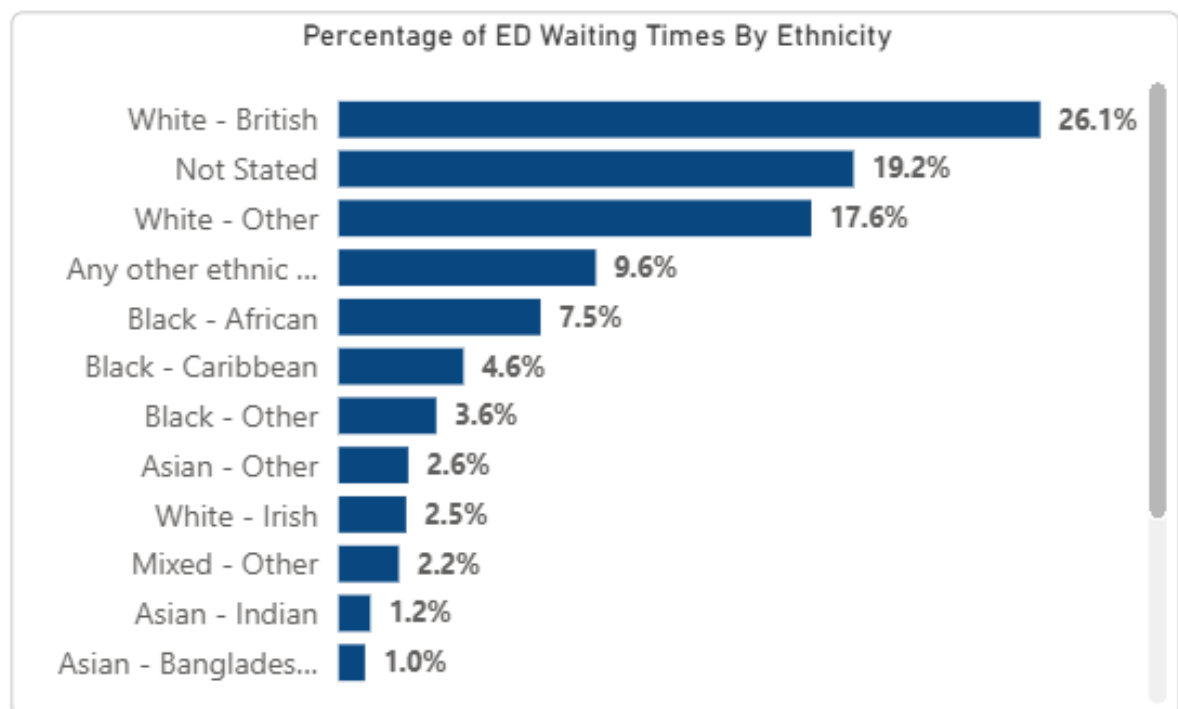
ED waiting times continued to be driven largely by younger and middle-aged adults, with little overall change from the previous year but some subtle rebalancing between age groups. Adults aged 18 – 44 remain the dominant group, accounting for around 35% of total ED waiting time, broadly consistent with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



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

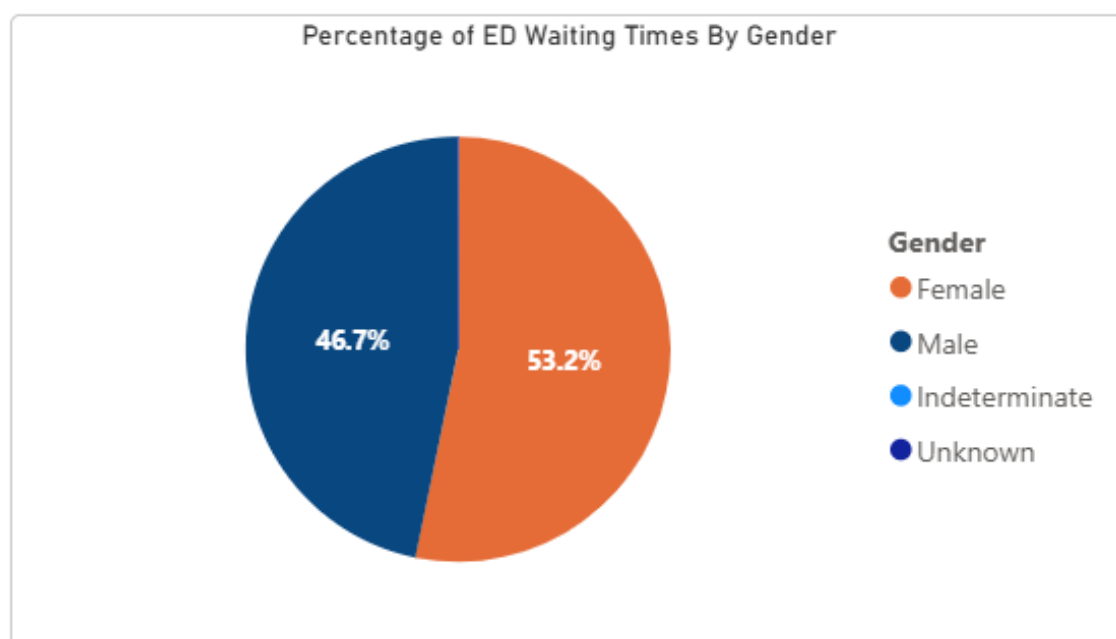
In 2025/26, the ethnicity breakdown of ED waiting time remains broadly familiar, but the ordering and emphasis have shifted slightly compared with 2024/25. White British patients continue to account for the largest single share, at 26.1%, only marginally lower than the previous year, indicating steady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

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



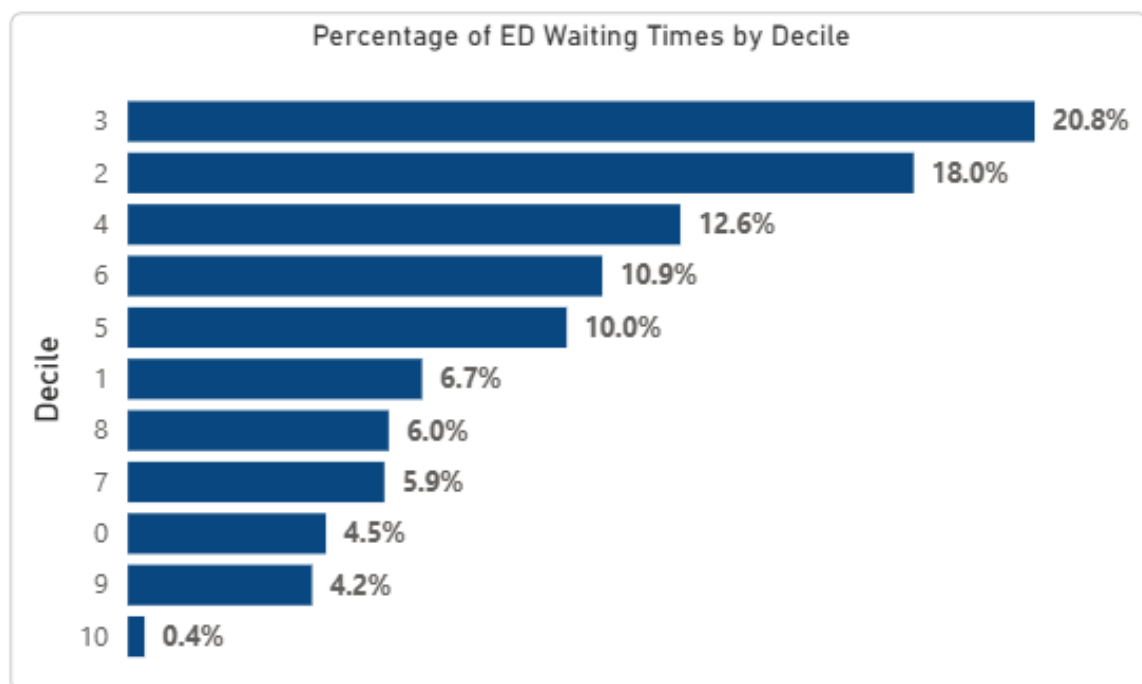
c. Percentage of emergency department waiting times by gender (or sex)

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



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

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



Case studies

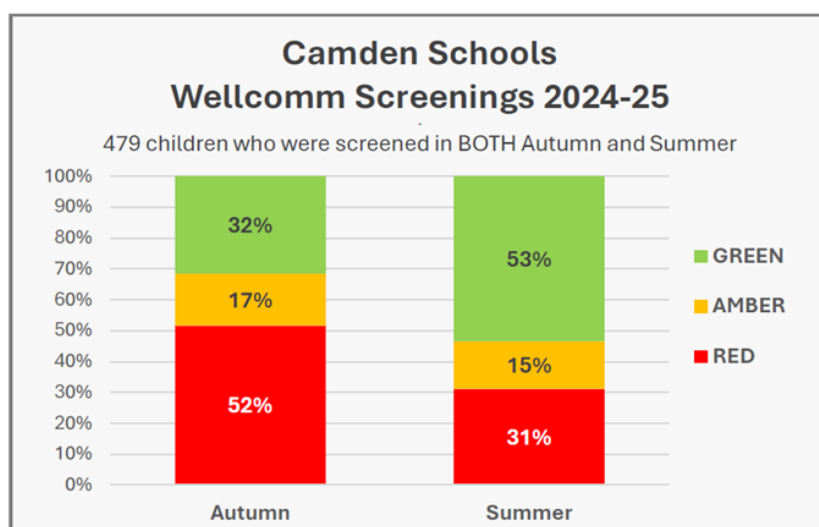
The following pages detail case studies from across the organisation which demonstrate the positive changes and improvements made in our services, as follows:

Camden Kids Talk Initiative – 2025/26

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

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

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



Enhanced Health in Care Homes (EHCH) West Haringey

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

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

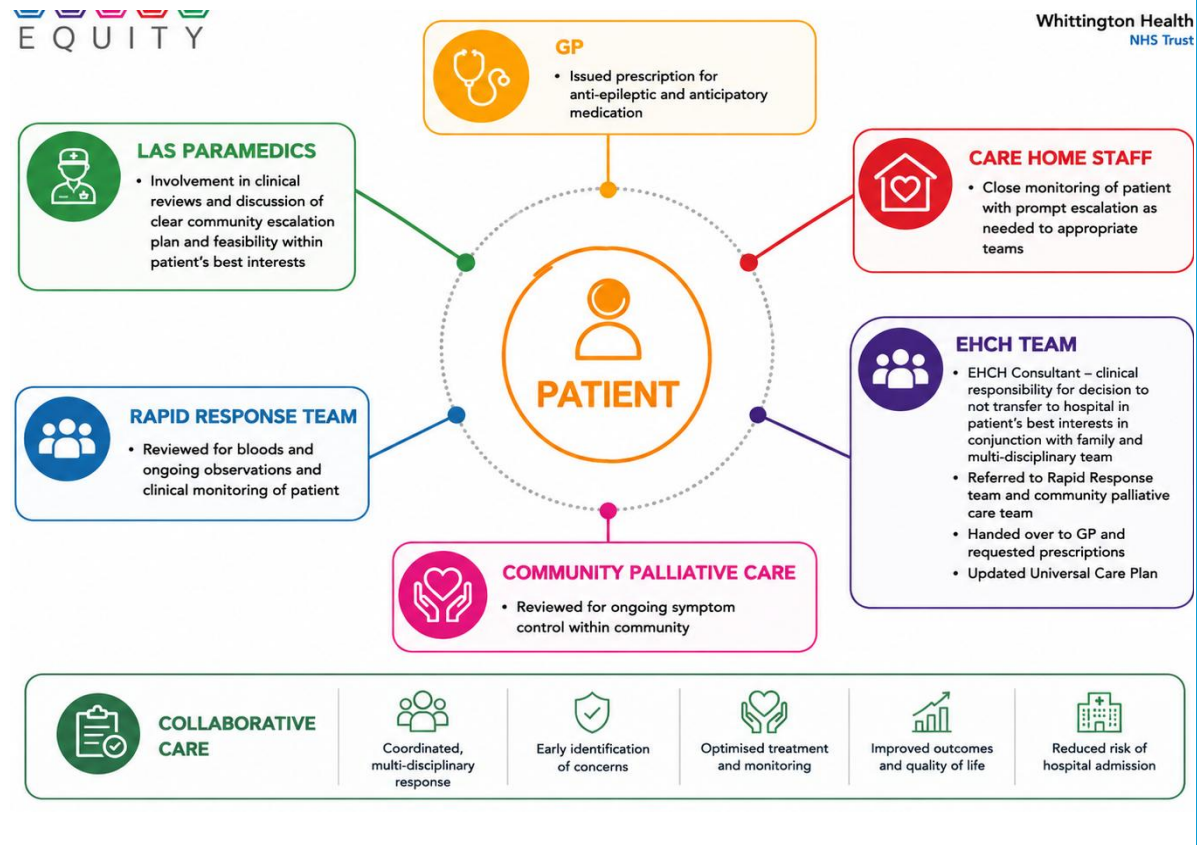
The patient had found her last hospital admission to be distressing and felt that her quality of life was extremely poor, and further interventions would increase distress. The patient and her husband were made aware that if further seizures occurred, this was likely a poor prognosis and possibly terminal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

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

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

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

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



Whittington Pharmacy Aseptic Unit Transformation Project

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

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

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

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

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

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

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

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



Implementing Robotic-Assisted Surgery at Whittington Health with Hugo

Our surgery & cancer clinical division identified a strategic opportunity to modernise surgical services through the introduction of robotic-assisted surgery. The Hugo system supports surgeons by providing a highly magnified 3D view of the surgical field together with precise, wristed instruments that can enhance dexterity and control during minimally invasive procedures. Robotic-assisted surgery does not replace the surgeon; instead, it enables them to perform complex operations with greater precision. Robotic-assisted surgery has the potential to offer a range of benefits, including smaller incisions, reduced blood loss, less post-operative pain, shorter hospital stays and faster recovery times, depending on the procedure and individual circumstances in addition to more efficient use of theatre capacity and a shift towards increased day case surgery.

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

What we did

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

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

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

Outcome

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

- The robotic surgery programme is established and ready for its first cases, with clear timelines and governance in place
- Workforce readiness significantly enhanced, with multidisciplinary teams training and continuing to build competency through simulation and structured learning

- A safe phased introduction model to be embedded, ensuring lower complexity cases will be prioritised during early adoption
- There is strong clinical and operational alignment, supporting sustainable rollout into routine theatre activity
- The robot will help to position Whittington Health as an innovative provider, ready to deliver enhanced surgical care and improved patient experience

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

Rapid Response case study: managing an acute exacerbation at home

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

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

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

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

Service highlights

- Timely collaboration with the LAS enabled a safe avoidance of unnecessary hospital conveyance.
- Comprehensive, assessment and treatment initiation in the home, addressing complex multimorbidity holistically.
- Effective multidisciplinary coordination between Rapid Response, senior clinicians, GP, and community teams.

- Safe initiation of acute treatment in the community, reducing risk of hospital-acquired complications.
- Strong patient and carer engagement, promoting confidence and self-management.
- Prevention of admission, demonstrating the department's ability to deliver high-acuity, patient-centred care safely at home.

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

Virtual Ward Remote Monitoring case study - heart failure remote monitoring

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

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

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

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

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

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

Service highlights

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

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

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

Background

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

Narrative

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

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

appropriate equipment provision and environmental adjustments to mitigate falls risk.

Co-ordination extended beyond acute issues: liaison with ophthalmology enabled his planned cataract surgery to proceed safely while under VW care, preventing delays to elective treatment. Chronic disease monitoring, including renal function and glycaemic control, was reviewed and optimised. Anticoagulation was safely reinstated with appropriate counselling and follow-up arrangements. Throughout the admission, care was individualised to balance patient autonomy with safety, supporting positive risk-taking while maintaining close clinical oversight.

Outcomes

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

Service highlights

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

Conclusion

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

Case study – Sickie Cell

Background

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

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

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

Care provided by the community red cell team:

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

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

Background

A referral was received from the Rapid Response team which highlighted that this was a 77-year-old-patient who lived alone, with no family. The patient had discharged themselves from hospital. A safeguarding alert, due to self-neglect, clutter at home and alcohol misuse was made. The patient was non-compliant with medication, had a moderate bilateral oedema, was at high risk of becoming severely unwell at home, and needed an integrated MDT input at home.

Initial home visit assessment:

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

Immediate actions taken following the home visit:

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

Follow-up actions taken:

- This patient's case was discussed at the MACC multidisciplinary team meeting and with MACCT GP. A care plan was devised and reviewed collectively.
- The case was presented in a teleconference to align the patient's GP, our adult community services clinical, and social services.
- **OT input/Fall intervention:** the patient was provided with a new walking frame for short distances, his mobility and transfers were assessed, and it was agreed to replace his current chair with a specialist chair in order to reduce the risk of falling and a subsequent risk of pressure damage; improved oedema management.
- **Pharmacist intervention:** a blister pack was provided and the pharmacist reviewed his medication and adapted to his lifestyle
- **Joint work with social services:** a deep clean of the patient's accommodation took place and a visit from pest control was arranged; carers were also put in place

- **A personalised care plan was designed:** the patient chose how many days he would accept the carer to visit and this made him feel in control as he had not been given this opportunity previously.
- **Digital connection:** the patient was provided with a mobile phone and a year's worth of mobile credit through our charity links. Occupational therapy services supported him to set up an Amazon account, which he has since used to complete his online grocery shopping

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

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

Haringey Children's Occupational Therapy Service

Background

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

What we did

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

Outcomes and impact

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

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

Areas for Improvement

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

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

In response to the Prime Minister's elective recovery plan, Wood Green Community Diagnostic Centre extended CT and MRI operating hours from 8:30am – 7:00pm to 8:00am – 8:00pm, Monday to Friday, starting in January 2025 — a strategic move to meet rising diagnostic demand across North Central London.

Without recruiting additional staff, the extended opening hours were delivered by redesigning rotas and staggering shifts within the existing radiography team — protecting staff wellbeing while also avoiding extra costs.

The operational setup was secured through direct engagement with The Mall's management, who confirmed early building access and adjusted parking logistics. Security arrangements were also reorganised with the supplier at no additional cost. Internal guidance and walkthrough videos were issued to staff to ensure readiness for 6 January 2025 rollout.

Rota modelling projected a 20% increase in scanning time, with CT and MRI appointment slots rising from 136 to 161 per week (+18.4%), largely due to added early morning and evening sessions — improving accessibility for working-age and commuter populations.

Increased patient footfall also boosted mall sales by 1.2%, as confirmed by The Mall management team, demonstrating mutual benefit for NHS and commercial partners.

This uplift in capacity enabled quicker patient throughput and greater flexibility for GP and hospital referrals, directly supporting NCL Trusts in maintaining the 96% monthly diagnostic test compliance target set by NHS England and the Care Quality Commission.

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

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

FINANCIAL PERFORMANCE REVIEW

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

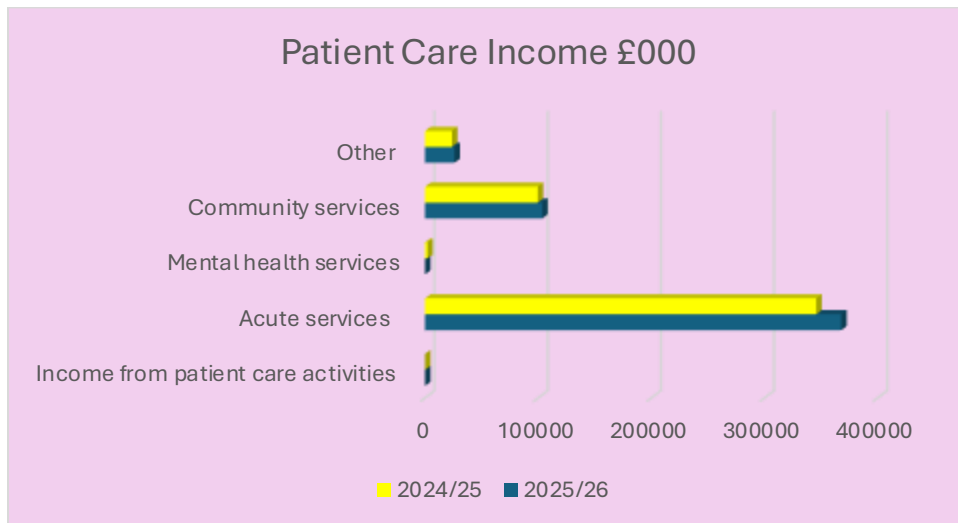
Statement of Comprehensive Income

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

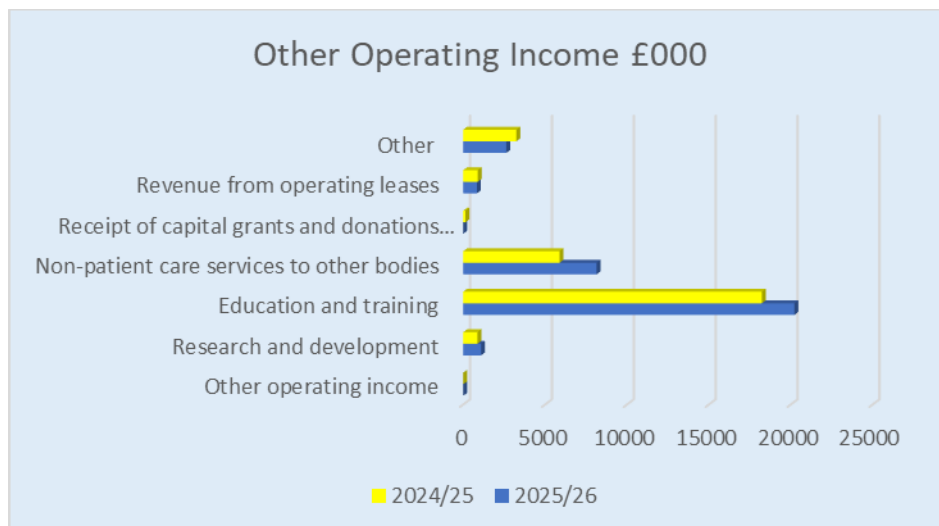
Income

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

Patient care income



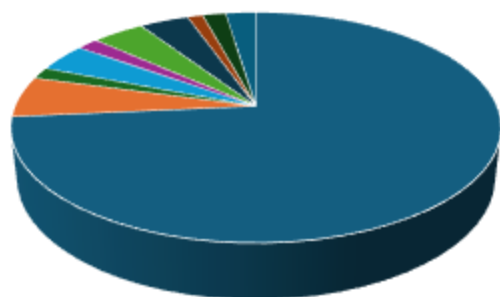
Other operating income



Operating expenses

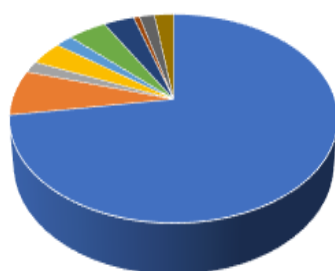
The charts overleaf provide a comparison of operating expenses by category for the 2025/26 and 2024/25 financial years

Operating Expenses 2025/26



- Pay and employment costs
- Supplies and services - clinical
- Supplies and services - general
- Drug costs
- Establishment
- Premises
- Depreciation
- Impairments
- Clinical negligence
- All Other categories

Operating Expenses 2024/25



- Pay and employment costs
- Supplies and services - clinical
- Supplies and services - general
- Drug costs
- Establishment
- Premises
- Depreciation
- Impairments
- Clinical negligence
- All Other categories

Going concern and value for money

As with previous years, the 2025/26 annual accounts were prepared on the going concern basis. This is in line with the Department of Health & Social Care's accounting guidance, which states that the Trust is a going concern if continuation of services exists. We have detailed in the paragraph above the positive trend in the Trust's finances. This improvement means that the Trust continues to comply with the Department of Health & Social Care's duty to break even over a three-year period.

Financial performance and statement of financial position

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

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

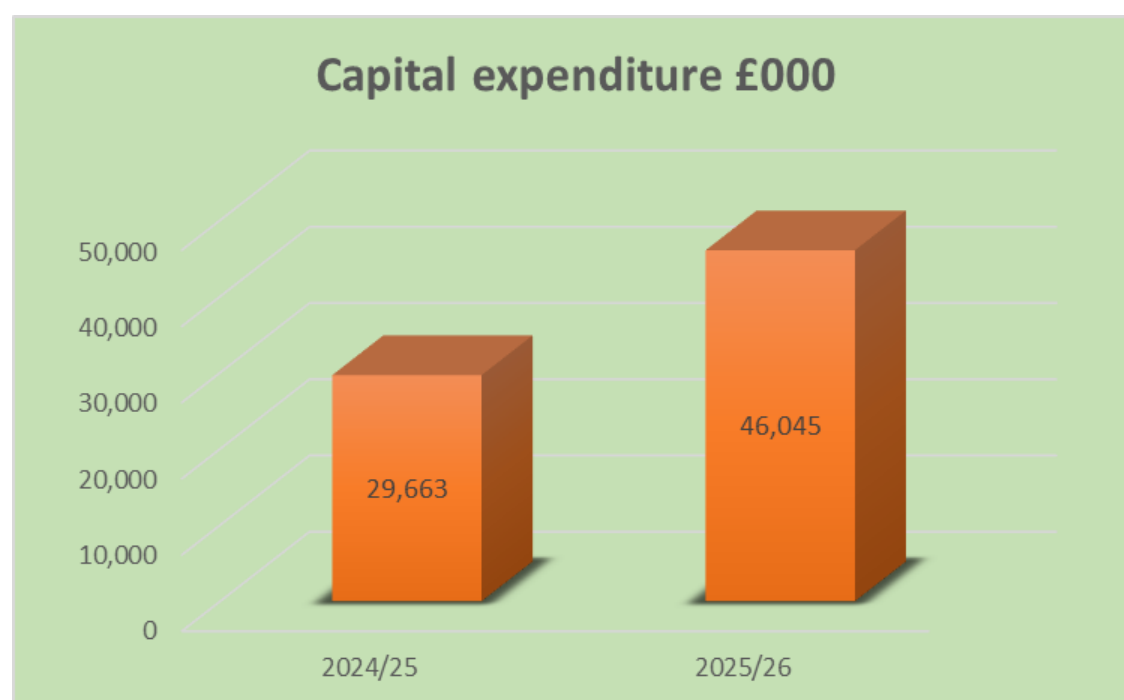
Cash

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

Property, plant and equipment

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

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



Borrowings

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

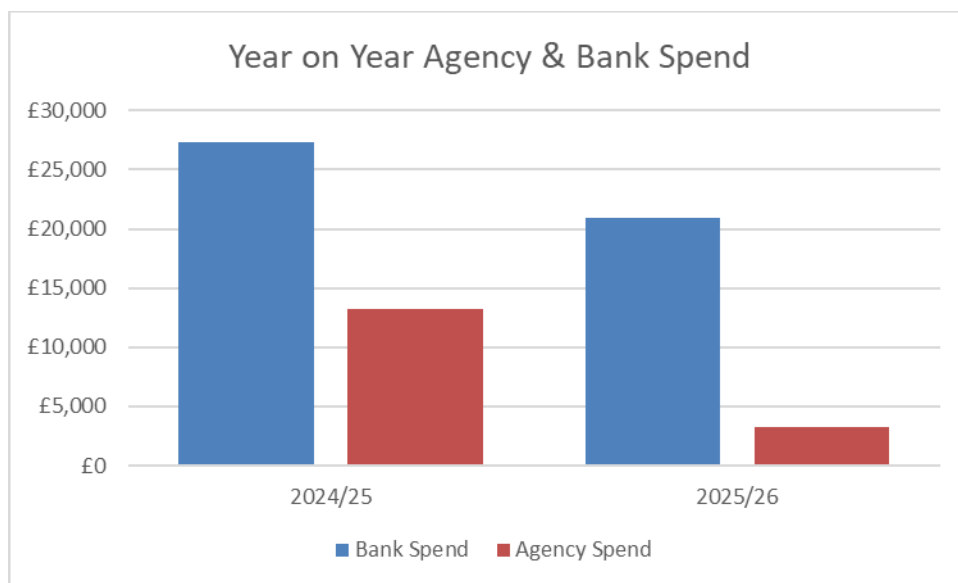
Spending on agency and temporary staff

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

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

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

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



STRATEGIC RISKS

The Trust has a robust risk management framework, and risk management policy and procedure as outlined in the annual governance statement. The key risks on our 2025/26 Board Assurance Framework (BAF) were as follows and covered our performance in four areas: quality and safety, people, integration and sustainability.

BAF entry	Principal risk(s)
Quality 1 – quality and safety of services	Failure to provide care which is ‘outstanding’ in being consistently safe, caring, responsive, effective, or well-led and which provides a positive experience for our patients and families, due to errors, or lack of care or lack of resources and a lack of a quality improvement focus, results in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation
Quality 2 – capacity and activity delivery	Due to a lack of capacity and the impact of industrial action by resident doctors, there is an inability to meet elective recovery and clinical performance targets, resulting in a deterioration in service quality and patient care such as: • significant delays in the emergency and urgent care pathway department and an inability to place patients to appropriate ward beds • patients not receiving the timely elective care they need across acute and community health services • patients on a diagnostic and/or treatment pathway at risk of deterioration and the need for greater intervention at a later stage
People 1 – staff recruitment and retention	Lack of sufficient substantive staff, due to increased staff departures and absence, and difficulties in recruiting and retaining sufficient staff, results in further pressure on existing people, a reduction in the quality of care, insufficient capacity to deal with demand, and increased temporary staffing costs
People 2 – staff wellbeing and equality, diversity, and inclusion	Failure to improve staff health, wellbeing, equity, diversity and inclusion, empowerment, and morale, due to the continuing post-pandemic pressures, and the restart of services, poor management practices, and an inability to tackle bullying and harassment and behaviours unaligned with the Trust’s values result in: • a deterioration in organisational culture, morale and the psychological wellbeing and resilience • adverse impacts on staff engagement, absence rates and the recruitment and retention of staff • poor performance in annual equality standard outcomes and submissions

BAF entry	Principal risk(s)
	a failure to secure staff support, buy-in and delivery of NCL system workforce changes and an increased potential for unrest
Integration 1 – ICS and Alliance changes	Lack of system clarity, or specific changes brought about by national policy, or an ICB in flux, or the changing provider landscape, (such as neighbourhood working, corporate services' rationalisations, services reviews), may result in unclear governance decisions and difficulty in strategic planning which impact adversely on patient services, particularly fragile ones, and the strategic viability of the Trust. Specifically, there is a risk that due to lack of resources and attention and the pace of working the organisation is unable to sufficiently benefit from the opportunities or mitigate the risks presented by neighbourhood working.
Integration 2 – population health and activity demand	Local population health and wellbeing deteriorates because of a lack of available investment in, or focus on ongoing care and prevention work, and due to unsuccessful collaboration with local sector health and social care partners, resulting in continued high demand for services which is insufficiently met
Sustainable 1 – control total delivery and underlying deficit	Increased exposure to financial risks arising from: - adverse changes to funding arrangements (e.g., block or ERF cap) - failure to manage budgets - unmitigated cost pressures - failure to deliver financial efficiency schemes or benefits associated with service transformation.
Sustainable 2 – estate modernisation	The failure of critical estate infrastructure, or continued lack of high-quality estate capacity, due to insufficient modernisation of the estate or insufficient mitigation, results in patient harm, poorer patient experience, or reduced capacity in the hospital
Sustainable 3 – digital strategy and interoperability	Risk that if we do not invest effectively in our digital strategy and in keeping technology hardware updated, cyber security solutions current and configured correctly, enable interoperability and testing of continual improvement of software (e.g. electronic patient record), ensure contracts are managed and supported and maintain the ability to report and enable clinicians to have access in a timely manner, with enough sufficient skilled workforce, then there is a possibility of catastrophic downtime. This could lead to serious impact on our ability to deliver any of our strategic

BAF entry	Principal risk(s)
	objectives. Safety of clinical services will be at risk through inaccessibility of information. Empowering of staff will be at risk as work is made harder. Partnering with other will be hampered as GPs may not be able to refer or see results. And transformation will be impossible as operational processes operational flow, efficiencies and cost improvement programme delivery will be severely hampered.

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

Anti-fraud, bribery, and corruption

Whittington Health is committed to reducing fraud and bribery against the NHS to a minimum, and all allegations of fraud related to our function are investigated by the Trust's local counter fraud specialist (LCFS). The Trust engaged RSM UK to provide its LCFS service during 2025/26. The LCFS worked to a risk-based annual plan which has been agreed by the Chief Finance Officer and the Audit and Risk committee. The plan is designed around the Government Functional Standard: 013 Counter Fraud, and the NHS Counter Fraud Authority's NHS requirements, designed to implement these for the NHS. Compliance with these requirements is reported to the audit and risk committee annually. The Trust's annual counter fraud functional standards return was completed at year-end and submitted to the NHS Counter Fraud Authority with an overall green rating. The chief finance officer is the executive lead for anti-fraud work.

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

DELIVER CONSISTENT, HIGH QUALITY, SAFE SERVICES

The accountable officers for quality and safety are the Chief Medical Officer and the Chief Nurse and Director of Allied Health Professionals. For quality assurance, the lead officer is the Chief Nurse and Director of Allied Health Professionals.

Registration with the Care Quality Commission

Whittington Heath NHS Trust is registered with the Care Quality Commission (CQC) without any conditions. During 2025/2026 the CQC undertook one inspection, which was an unannounced inspection of Urgent and Emergency services in October 2025.

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

The table below provides the rating summary for the CQC's most recent full inspection report published in March 2020. This was following an inspection in December 2019 of four core services (surgery, urgent and emergency care services, critical care, community health services for children and young people and families and specialist community mental health services for children and young people) and a well-led inspection in January 2020. The current CQC overall rating from this assessment is **'good'** overall for Whittington Health NHS Trust, with 'outstanding' ratings for our community health services and performance against the CQC's 'caring' domain.

The overall rating of the Trust has not changed following the CQC inspection of maternity services in 2023 or the inspection of urgent and emergency care in 2025.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires Improvement	Good	Good	Good	Good	Good
Community	Good	Good	Outstanding	Good	Outstanding	Outstanding
Children's Mental Health Services	Requires Improvement	Good	Outstanding	Good	Good	Good
Overall trust	Requires Improvement	Good	Outstanding	Good	Good	Good

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

Urgent and emergency services	
Overall	Requires improvement 
Safe	Requires improvement 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Requires improvement 

Urgent and emergency services are currently rated as ‘requires improvement’ overall, however the ‘requires improvement’ rating for ‘well-led’ is currently being appealed by the Trust. If the appeal is successful, the overall rating for Urgent and Emergency services would improve to ‘good’.

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

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

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

The CQC Single Assessment Framework¹, introduced in 2023, consists of five key questions for health and social care services which ask if services are safe, effective, caring, responsive to people’s needs and well-led. Each key question is underpinned by a set of quality statements. The CQC’s new approach includes listening more effectively to people’s experience of health and care services as well as the experiences of frontline staff.

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

¹ [Assessment framework - Care Quality Commission](#)

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

Quality priorities

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

Our 2025/26 Quality Account priorities were:

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

How the priorities were developed

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

Our key achievements are:

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

PATIENT SAFETY

Patient safety incidents

Since April 2024, the Trust has been operating under the Patient Safety Incident Response Framework (PSIRF) with positive feedback reported across the organisation. The Trust continues to actively encourage incident reporting to strengthen a culture of openness and transparency which is closely linked with high quality and safe healthcare.

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

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

Patient Safety Incident Response Plan:

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

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

Theme	Key theme
1	Patient falls
2	Medication/safety
3	Responding to a deteriorating patient
4	Pressure related skin damage
5	Delayed treatment & diagnosis
6	Unsafe discharge

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

Patient Safety Incident Investigations

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

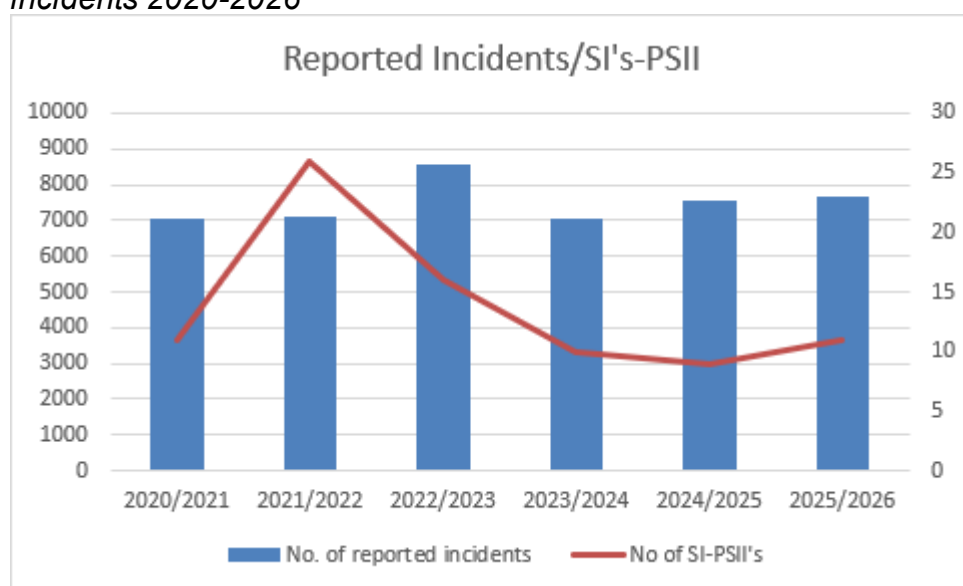
- The early identification of patient safety risks
- A consistent decision-making regarding learning responses and follow-up actions
- The timely escalation of significant events to services leads, divisional triumvirates, or quality governance structures
- Assurance that appropriate initial actions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

The Whittington Improvement and Safety Huddle (WISH) ensures there is a greater focus on learning, improvement, compassionate engagement, with supportive oversight.

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

During 2025/26, there were 11 PSII's requested. As illustrated in the graph below, the number of PSII's declared as a proportion of all patient safety incidents has remained similar since the implementation of PSIRF. This is a positive trend, indicative of an open, transparent safety culture where reporting of incidents is encouraged, with a higher volume of incidents which are near misses or low harm incidents.

Graph 1: Serious Incidents/PSII's declared, as a proportion of all patient safety incidents 2020-2026



To follow the PSIRF, Whittington Health focus on identifying the whole system issues and take a human factors approach. The WISH forum has supported the use of a variety of learning response tools, such as after-action reviews, SWARMS (learning response and improvement tool), and a multidisciplinary team (MDT) approach, Quality Improvement (QI) projects and audit projects, to drive change.

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

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

Never Events

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

During 2025/26, the Trust reported two Never Events which were investigated via PSIs, as per the national guidance. Summary details of both events are shown below:

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

Duty of candour

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

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

Infection Prevention and Control

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

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

Healthcare associated infections

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

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

Bloodstream infections

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

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

There has been a notable reduction in gram-negative bloodstream infections (GNBSIs) compared to the previous year. *Escherichia coli* bacteraemia reduced from

33 cases in 2024–25 to 16 cases in 2025/26, performing well below the trajectory of 32. Similarly, *Klebsiella spp* infections reduced from 12 to 5 cases, significantly below the trajectory of 13. These improvements reflect sustained focus on key interventions, including urinary catheter management, intravenous line care, and collaborative working across primary and community care pathways.

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

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

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

*Hospital Onset – Hospital Associated

Clostridioides difficile infections (CDI)

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

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

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

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

Acute respiratory infections

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

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

Surgical site infections

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

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

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

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

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

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

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

2025/2027 Antimicrobial Stewardship Strategy

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

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

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

Neonatal Unit Outbreak – *Enterobacter hormaechei* Colonisation

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

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

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

Water safety and ventilation assurance

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

opportunistic environmental pathogens such as *Pseudomonas aeruginosa* and *Legionella* spp.

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

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

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

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

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

IPC and the built environment – Start Well

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

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

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

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

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

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

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

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

PATIENT EXPERIENCE

Learning from National Patient Surveys 2025/2026

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

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

Adult Inpatient Survey 2024

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

Overall experience

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

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

Across the full survey:

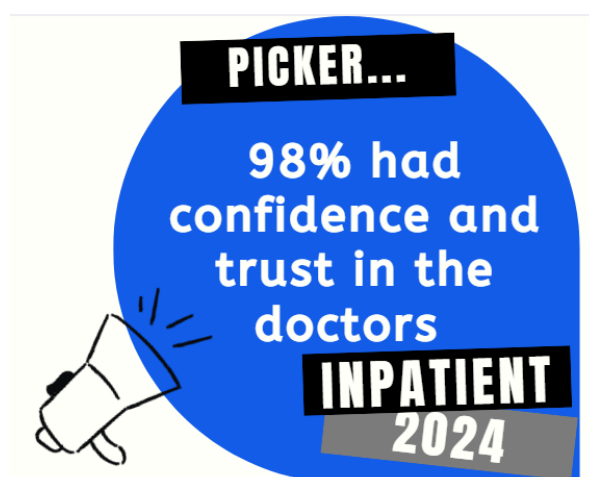
- The Trust achieved **significant improvement in 11 questions** between 2022 and 2024 results
- A further **2 questions showed significant improvement** between 2023 and 2024 results

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

Survey participation and demographics

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

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



Methodology and accessibility

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

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

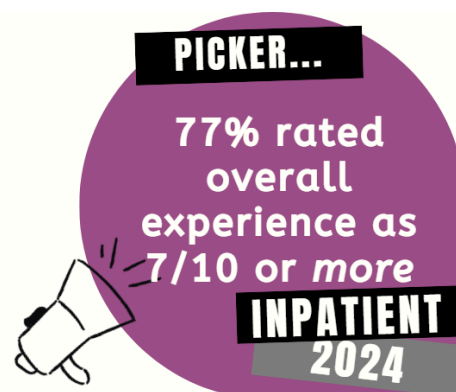
This comprehensive approach supports equitable participation across diverse patient groups.

New survey content (2024)

The 2024 survey introduced new sections covering:

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

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



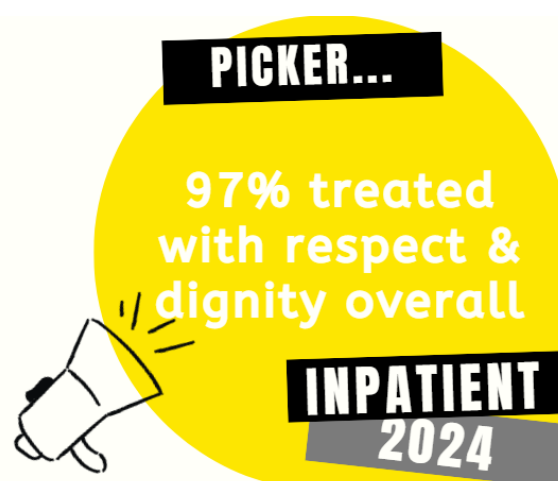
Our top five and bottom five scores from the survey compared with the national average are shown below.

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

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

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

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



Summary

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

Maternity survey 2025

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

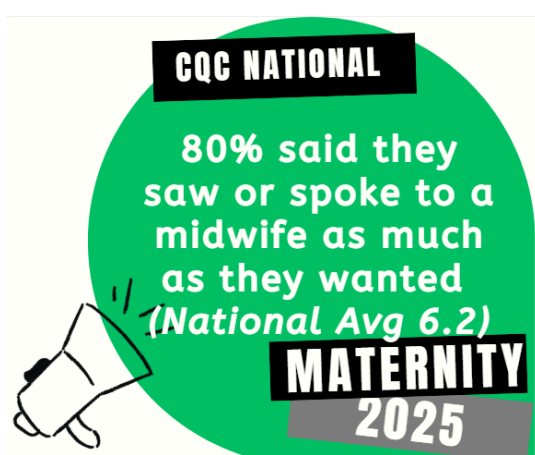
Participants were eligible if they were aged 16 or over at the time of delivery and had a live birth at an NHS trust between 1 and 28 February 2025. For trusts with fewer than 300 births in February, births from January 2025 were also included.

Overall experience

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

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

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



Survey participation and demographics

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

Best performance summary

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

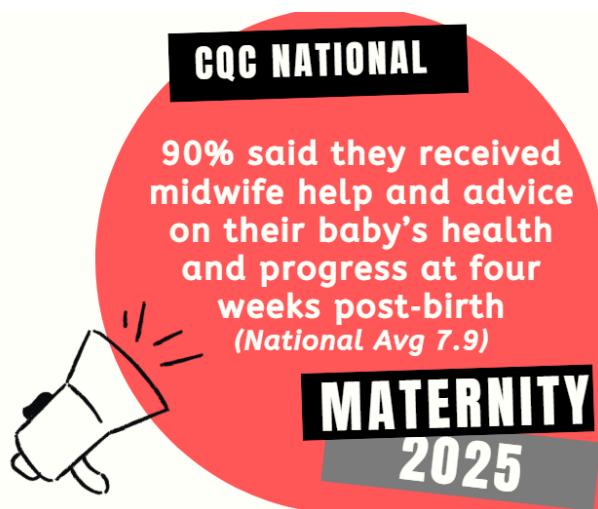
Top five Questions	Our score 2025	National average
Postnatal Care: Care at home after birth G4. Would you have liked to have seen or spoken to a midwife	8.0	6.2
Care in the Ward D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they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

Worst performance summary

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

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

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



Summary

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

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

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

2026/2027 National survey programme

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

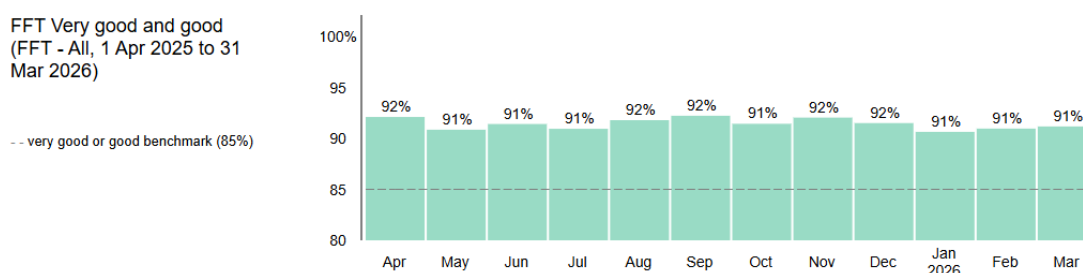
- **2026 Children and young people:** fieldwork July – October 2026, publication March 2027 (TBC)
- **2026 Urgent and emergency care:** fieldwork April – July 2026, November 2026 (TBC)
- **2026 Maternity:** fieldwork April – July 2026, publication November 2026 (TBC)
- **2025 Adult inpatients:** fieldwork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

Patient feedback: Friends and Family Tests

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

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

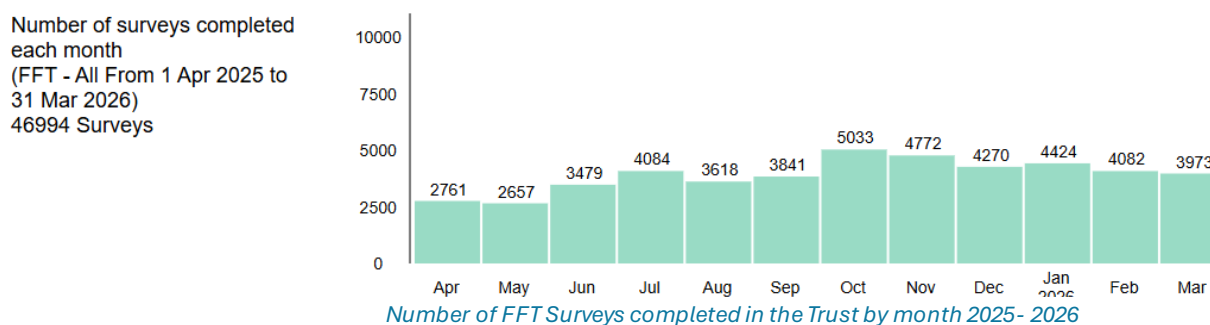
The graph below illustrates our monthly performance for “very good” and “good” ratings compared with the NHS 85% benchmark. It shows a consistently strong performance, with the Trust exceeding the national benchmark every month throughout the year.



Performance against the NHS benchmark by month 2025 - 2026

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

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



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



This work includes the ongoing collection of handwritten postcard feedback, which is uploaded into the electronic reporting system to ensure every patient voice is captured. Volunteers also provide valuable face-to-face FFT support across outpatient areas, maternity, and imaging, helping to improve accessibility and ensure patients are supported in sharing their feedback. This year we implemented FFT SMS in Maternity Postnatal services, community paediatric audiology, CDC centre, outpatient clinics and podiatry.

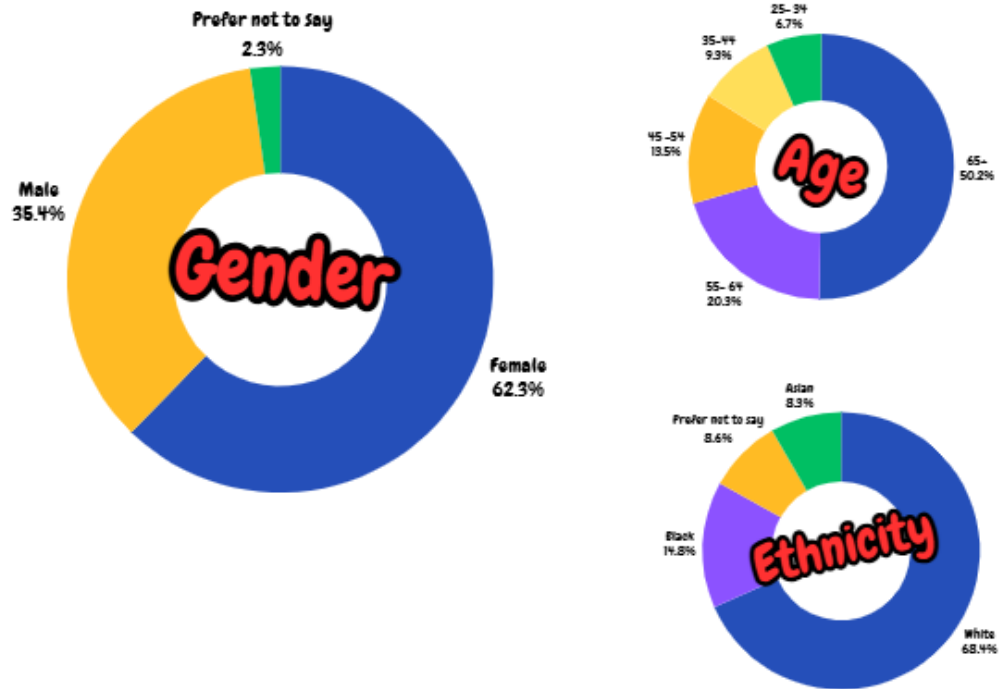
FFT responses are received from a range of sources, including:

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

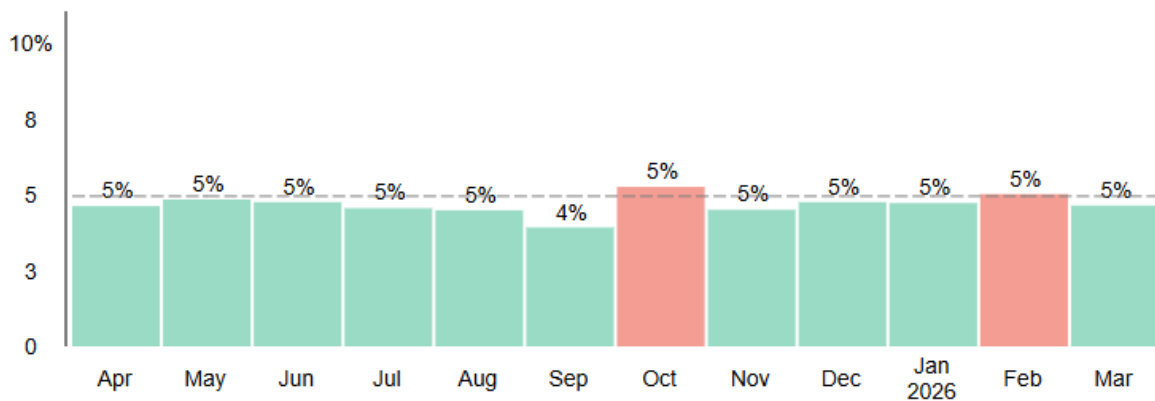
The FFT data shows that most respondents were women, with half aged 65 or older, a further 20% aged 55–64, and 68% were White. This demographic profile gives us important insight into who is currently engaging with the FFT and highlights areas where we may need to strengthen our approach to ensure inclusivity.

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

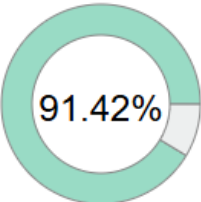
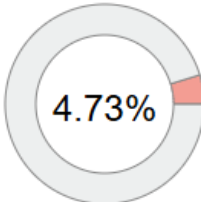
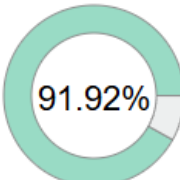
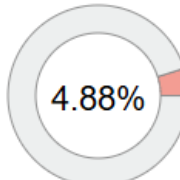
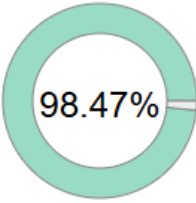
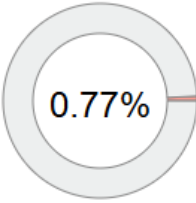
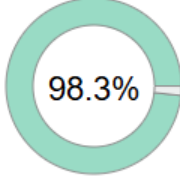
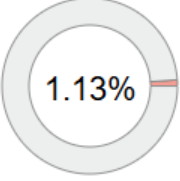
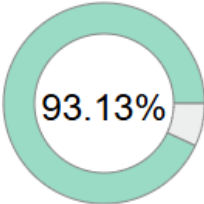
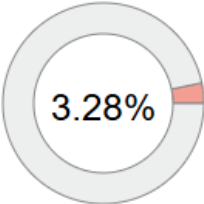
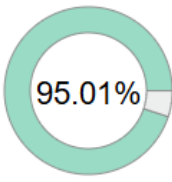
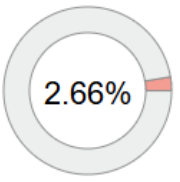
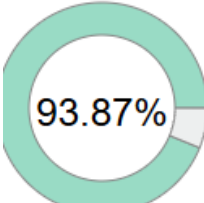
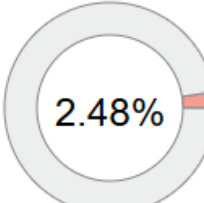
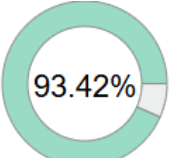
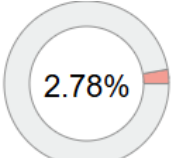
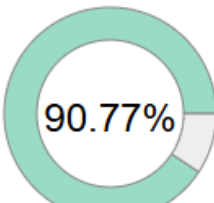
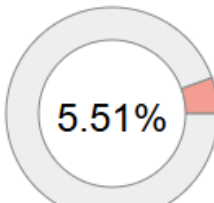
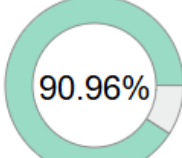
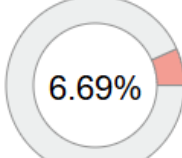
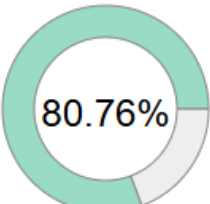
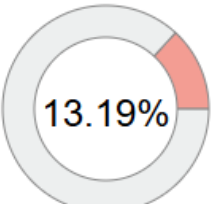
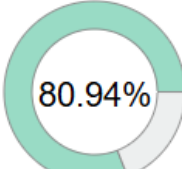
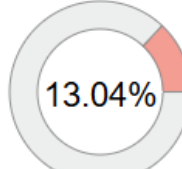
We also see clear under-representation from ethnic communities, which means we may not be fully hearing the experiences of groups who already face known inequalities in healthcare access and outcomes. Addressing this will require more inclusive feedback methods, wider use of interpreters and translated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



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



Poor and very poor responses for all FFTs

2025 - 2026			2024-2025	
 91.42% % very good or good	 4.73% % poor or very poor	FFT - All	 91.92% % very good or good	 4.88% % poor or very poor
 98.47% % very good or good	 0.77% % poor or very poor	FFT – Maternity Combined	 98.3% % very good or good	 1.13% % poor or very poor
 93.13% % very good or good	 3.28% % poor or very poor	FFT - Community	 95.01% % very good or good	 2.66% % poor or very poor
 93.87% % very good or good	 2.48% % poor or very poor	FFT - Inpatient	 93.42% % very good or good	 2.78% % poor or very poor
 90.77% % very good or good	 5.51% % poor or very poor	FFT - Outpatient	 90.96% % very good or good	 6.69% % poor or very poor
 80.76% % very good or good	 13.19% % poor or very poor	FFT – Emergency Department	 80.94% % very good or good	 13.04% % poor or very poor

INCREASED FFT SMS TEXT MESSAGES BY 18,461 TO 27,696 RESPONSES

IQVIA 2025-2026

Patient Experience & Engagement Strategy 2026–2030 – Summary



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



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

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

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

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



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

The strategy commits to three pillars, these are:

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

The strategy commits to three



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



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



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

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

The Q Factor

Summary

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

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

Learning

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

You said: Patients from minority backgrounds can experience barriers, including communication issues and concerns about discrimination.

We did: Whittington Health developed an educational initiative to improve awareness, inclusive communication, and staff understanding.

Impact: More person-centred interactions, improved trust, and better patient engagement.

Summary:

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

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

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

Learning:

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

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

You said: Waiting times were longer than expected and communication about delays was unclear.

We did: Emphasised clearer, more proactive communication and better expectation-setting during delays.

Impact: Improved transparency, reduced anxiety, and better patient understanding of waiting times.

Summary:

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

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

Learning:

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

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

You said: Difficulty accessing the right support and managing both physical and psychological impact of illness.

We did: Introduced coordinated multidisciplinary care, including psychological support and self-management strategies.

Impact: Improved symptoms, confidence, and quality of life through holistic care.

Summary:

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

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

Learning:

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

You said: Waiting times needed improvement and support events could be more detailed and interactive.

We did: Identified opportunities to improve clinic efficiency and enhance patient events with more information and discussion.

Impact: Better patient engagement, more meaningful support sessions, and improved experience.

Summary:

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

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

Learning:

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

You said: Care was highly positive, particularly communication, compassion, and coordination.

We did: Reinforced and sustained high standards of patient-centred care and teamwork.

Impact: Consistently positive patient experiences and increased confidence in services.

Summary:

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

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

Several months later, a second family member required urgent care after developing acute symptoms. Due to delays in ambulance response, alternative

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

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

Learning:

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

You said: Navigating complex, high-acuity care requires strong communication, coordination, and family involvement.

We did: Maintained a multidisciplinary, collaborative approach with clear communication and family inclusion.

Impact: Improved outcomes, better patient and family support, and smoother transitions across services.

CLINICAL EFFECTIVENESS

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

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

Our key achievements during 2025/26 included the following:

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



The projects presented were:

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

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

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

National audits

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

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

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

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

RESEARCH

Context

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

The Trust's research activity (R&D) has remained stable despite a reduction in core funding from the North London Regional Research Delivery Network. The in-house research & development office has continued to provide a robust and responsive service ensuring study set-up is proportionate and works with the Trust's developing priorities in an efficient and cost-effective way. The speed of approval process has been further reduced, and we continue to work to become 'national leaders' in this regard.

Staffing and staff engagement

Whittington Health currently has 20.5 whole time equivalent (WTE) research staff - an increase from 17.5 WTE in the previous year. The Trust has continued to support medical research fellow posts and consultant posts. The AHP (Allied Health Professions) Research Forum that began in January 2024 has been broadened to encompass Nursing, Midwifery and AHP (now NMAHP) and additional services have seen staff receive National Institute for Health and Care Research (NIHR), Health Education England, and other awards to facilitate protected time for research development (specialist physiotherapy and occupational therapy services).

Many of the Trust's clinicians remain research active. In the first six months of the year, there were more than 70 publications as demonstrated by a PubMed search for 'Whittington Health' or 'Whittington NHS' suggesting the final year output will have increased from the 113 such papers published in the 12 months to March 2025.

The Trust currently holds 1 research grant (Professor Ibrahim Abubakar's £2.5 million NIHR programme grant for applied research: research to improve the detection and treatment of latent tuberculosis infection) which has had a 'no-cost extension' in response to delays in meeting milestones, predominantly due to the COVID-19 pandemic and import changes in response to the UK leaving the European Union.

The table below sets out the recruitment of patients to NIHR portfolio studies during 2025/26. This figure shows a further increase in studies open to recruitment. These have been primarily facilitated by the R&D office function continuing to improve the efficiency of study set up. The R&D office have demonstrated a dynamic process with study set-up timelines taking on average 14 days to confirm capacity & capability (a reduction from 60-day average in 2023/24) and well within the government target of 60 days. The sponsorship process continued to receive positive feedback from colleagues, with the process reported to be simpler to navigate and more responsive. This is a significant step and a success of which we are proud.

	NIHR Portfolio		Non-Portfolio
	Patients recruited	Number of recruiting studies	Number of recruiting studies
Year			
2018/19	1077	49	7
2019/20	848	29	5
2020/21	1241	20	4
2021/22	921	27	5
2022/23	689	30	4
2023/24	1092	53	5
2024/25	1524	68	15
2025/26	1594	72	5

Completed trials and outcomes

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

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

GUARDIAN OF SAFE WORKING HOURS

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

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

The GoSWH presents a quarterly report to the Board with the aim of providing context and assurance around safe working hours for Whittington Health resident doctors. There continues to be a significant emphasis on the safety of resident doctors' working hours. This has been reflected in the ongoing engagement with the ER process by resident doctors and this continues to be monitored in terms of the ER submitted by grade and speciality. These clearly document the extra hours worked over and above their rostered hours and reasons for this, as well as breaks or any educational opportunities that are missed. The time accrued through exception reports continue to be reimbursed with either time off in lieu (TOIL) or payment (according to the choice of the resident doctor unless TOIL is mandated for safety. The reasons for extra hours worked are analysed, where possible, to try and effect change to prevent this from recurring where possible.

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

This year covered periods of industrial action by resident doctors. Ongoing high levels of acuity of patients meant that there continued to be a steady number of exception reports generated. Most of these are from foundation year one doctors and due to difficulties in finding appropriate time off in lieu on already stretched rotas, these are largely renumerated in financial payments.

The GoSWH continues to work closely with the resident doctors' forum to ensure there is a proactive approach to compliance with the 2016 terms and conditions. This is also where the spending of monies generated from exception reporting is discussed and

decided. It is currently being spent to provide lunch as teaching and educational sessions for the resident doctors. This process will continue.

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

INTEGRATED CARE ORGANISATION AND SYSTEM WORKING

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

Integrated Care Organisation

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

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

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

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

Borough Partnerships, Place based care and Neighbourhood Health

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

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

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

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

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

Key developments include:

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

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

Clinical Interface Group

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

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

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

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

North Central London Integrated Care System

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

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

Population health and anchor institution

Population health and inequalities

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

Strategic priorities

Our communities are becoming more diverse

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

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

Increase in disease burden – focus on Core20PLUS5 conditions

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

Higher A&E attendances and DNAs in deprived communities

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

Data Quality Improvements

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

Health equity conference

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

Examples of impact shared at the conference included:

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

Children and Young People

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

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

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

Anchor institution

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

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

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

WORKFORCE

Our people

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

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

Winter flu vaccinations

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

Connecting with our people

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

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

NHS staff survey

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

Participation

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

National benchmarking

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

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

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

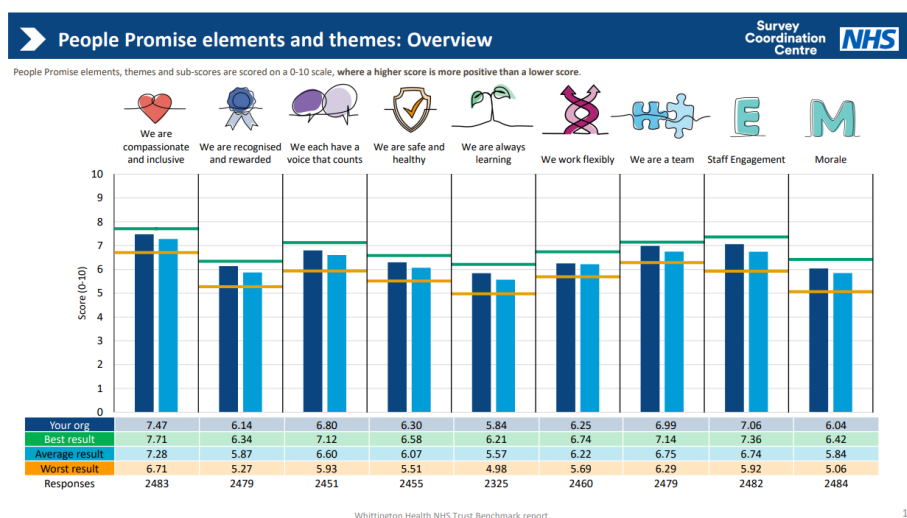
These results indicate that staff increasingly feel motivated, involved and positive about working at Whittington Health.

NHS people promise

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

The greatest improvements were seen in:

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



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

Staff feedback

Staff feedback highlights many strengths, including:

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

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

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

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

Equality and inclusion

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

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

2026/27 priorities

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

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

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

Workforce culture

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Statutory and mandatory training

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

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

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

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

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

Apprenticeships

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

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

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

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

Staff development

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

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

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

Additional Leadership development and training:

- Appraisal training for managers

- Neurodiversity in the workplace manager/senior leader's sessions (new) and there are also sessions for all staff
- Facilitated conversations
- Restorative conversations for managers
- British Sign Language
- Bespoke workshops and interventions for teams that need support in developing team-working and improving morale
- Coaching for individuals to support career development and working relationships
- Mediation training for staff to become accredited mediators and to join the internal mediation service
- Myers Briggs Type Indicator reports and feedback sessions to support team dynamics
- Functional skills in maths and English to support staff developing via an apprenticeship
- Various apprenticeships in both clinical and non-clinical areas to support staff development, ranging from level 2 (GCSEs level) to level 6 (degree level).
- The following modules were delivered by NHS Elect:
 - Interview skills
 - Compassionate leadership/compassionate conversations
 - Conflict and difficult conversations
 - Emotionally intelligent leadership
 - Leading change
 - Coaching skills (new)

Staff health and wellbeing

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

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

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

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

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

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

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

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

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

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

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

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

Embracing inclusion

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

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

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

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

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

Key activities supporting inclusion goals and ambitions included the following:

Chief Executive briefing

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

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

National inclusion events:

During the year we actively participated in national diversity and inclusion events, including Race Equality Week, International Women's Day, Pride Month, Black History Month, UK Disability History Month, and Lesbian, Gay, Bisexual, and Transgender History Month, Autism Acceptance Awareness Day, Dementia Action Week, Facilities and Estates Day, Mental Health Awareness Week, National Day for Staff Networks, See ME First Anniversary, Windrush Day.

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

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

Quarterly open forum & bi-monthly inclusion newsletter:

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

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

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

Staff development workshop & staff self-reflection toolkit

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

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

Support for disabled staff:

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

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

Global majority mentoring programme

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

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

The Trust worked on the importance of a reverse mentoring programme, where senior employees are mentored by those in more junior positions. This initiative encourages open and honest conversations, allowing senior staff to gain insights into the challenges faced by the global majority or BME employees.

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

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

[Ambitious about autism](#)

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

[Health equity - patients and service users](#)

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

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

[Recruitment panel guidance:](#)

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

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

[Bullying and harassment:](#)

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

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

Civility & respect policy

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

Allied Health Professional Apprenticeships

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

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

Bands 2-7 career development programme case study

Background

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

Objectives

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

Programme structure

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

Outcomes

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

Professional impact

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

Conclusion

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

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



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

Freedom to Speak up Guardian

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

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

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

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

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

Excellence in Medical Education

Undergraduate Medical Education

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

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

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

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

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

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

Postgraduate Medical Education

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMUNICATION AND ENGAGEMENT

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

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

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

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

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

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

We have also continued to demonstrate the momentum behind the implementation of the Start Well Programme at Whittington Health and the transformation of our

maternity estate, enabled by over £80 million of investment in the hospital's power infrastructure. At the start of the year, we received significant traditional and social media coverage as we unveiled what our future maternity services will look like following a 'once in a generation' investment.

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

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

In 2025/26 we worked hard to ensure that our amazing colleagues are recognised and congratulated for their hard work. This included another successful annual staff awards event which saw over 200 people from across the Trust nominated. The awards culminated in a special awards evening held at the Royal College of Physicians. This was in addition to continuing to recognise our colleagues who have been at Whittington Health for over 10 years, and those who go "above and beyond" via our monthly 'extra mile awards'.

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

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

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

INFORMATION GOVERNANCE AND CYBER SECURITY

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

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

During the year the Trust submitted the DSP Toolkit with a final submission result of Approaching Standards (with an Improvement Plan in place) for version 7. The version 8 DSP Toolkit has increased the threshold of compliance and burden on the Trust. As a result, the Trust expects to partially meet the standards with an improvement in place. The Trust's DSP Toolkit submission and former IG Toolkit submissions can be viewed online at www.dsptoolkit.nhs.uk.

All staff are required to complete information governance (IG) training on an annual basis. The Trust ended 2025/26 with 88% of staff being compliant. Training compliance rates are regularly monitored by the IG committee, including methods of increasing compliance. The IG department continues to promote requirements to train and targets staff with individual emails including news features in the weekly electronic staff noticeboard and it manages classroom-based sessions at induction.

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

INFORMATION MANAGEMENT AND TECHNOLOGY DEVELOPMENTS

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

Infrastructure:

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

Information:

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

Patient systems:

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

WHO safety checklists. It also provides better oversight of patients waiting for emergency surgery, and will facilitate better theatre time utilisation.

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

ESTATE, FACILITIES & CAPITAL DELIVERY

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

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

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

Maternity and neonatal buildings

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

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

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

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

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

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



Power infrastructure project

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

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

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

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



Fire remediation project

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

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

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

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

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

SUSTAINABILITY

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

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

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

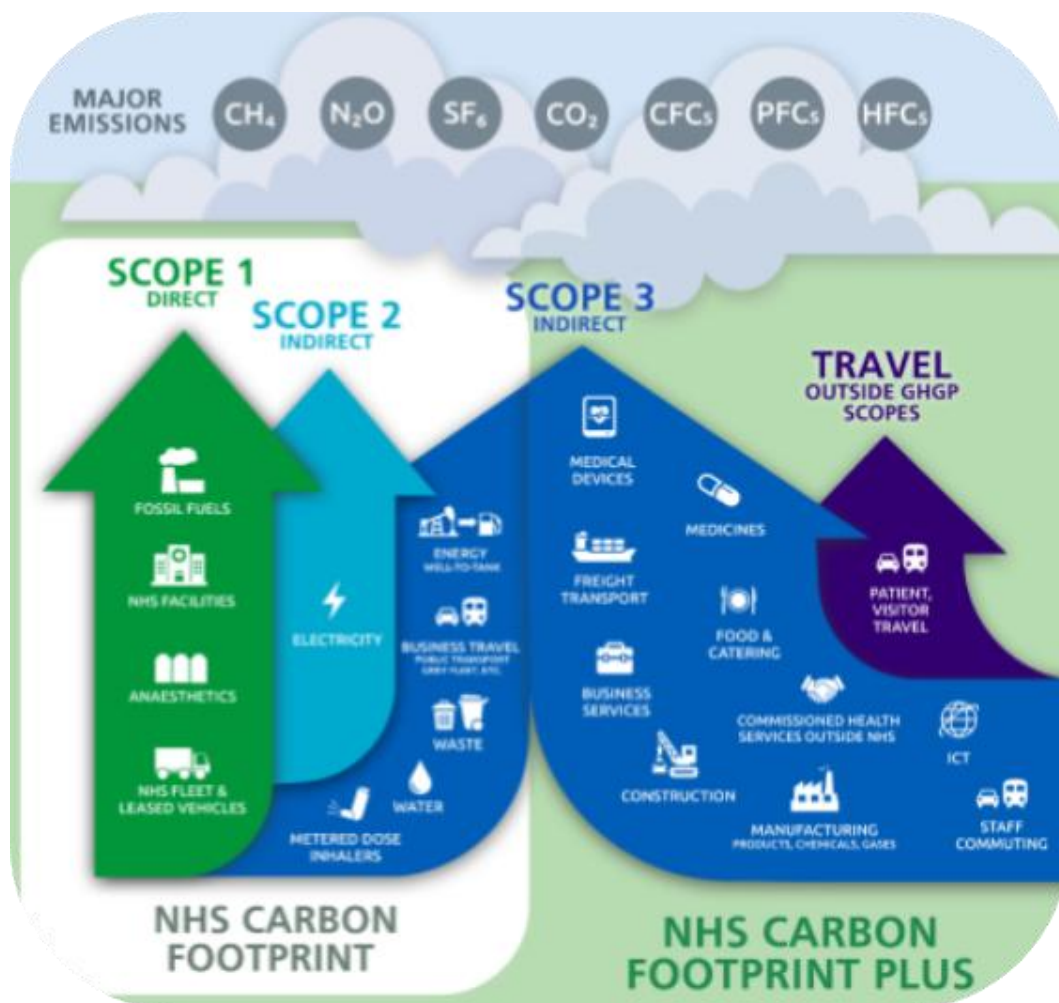


Figure 2: Scope of Emissions within the NHS (Delivering a 'Net Zero' National Health Service, 2020)

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

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

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

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

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

Our Green Plan

Our Green Plan, produced in 2025, outlines the national and local context of sustainability within the healthcare sector, discusses how sustainability aligns with our organisational vision and details how we intend to embed sustainability across our organisation. The key aims of the Green Plan are:

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

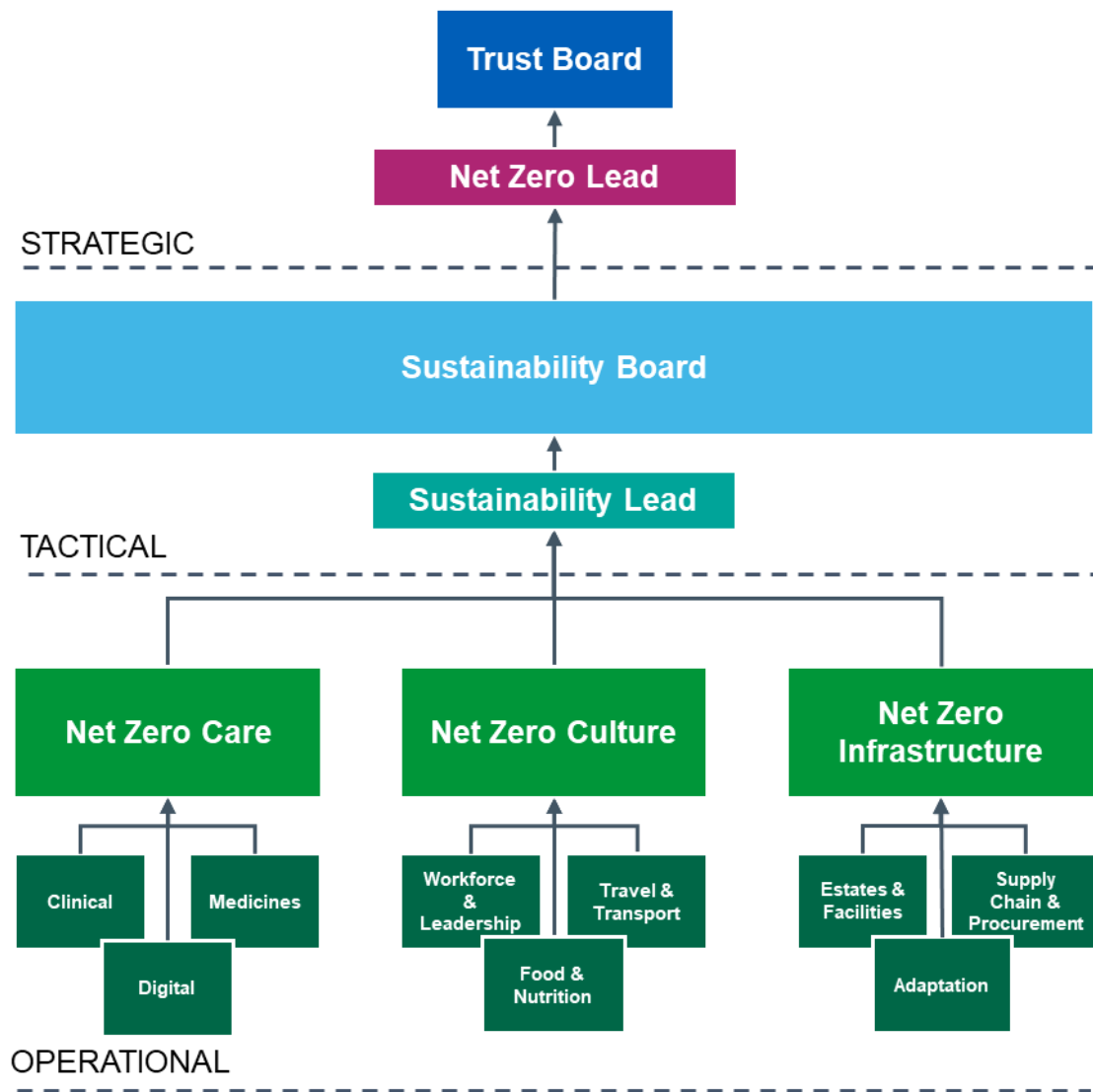
Historically at Whittington Health, we have taken an integrated approach to sustainability with a broad focus on energy reduction, tackling waste, improving local air quality, and promoting green space.

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

Green Plan initiatives

The focus in 2025/6 was to establish the Trust Governance for Sustainability (on the next page) with Carbon Architecture acting as the Sustainability Consultant to:

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



Trust board

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

Sustainability group

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

Working Groups

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

Whittington Green Group

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

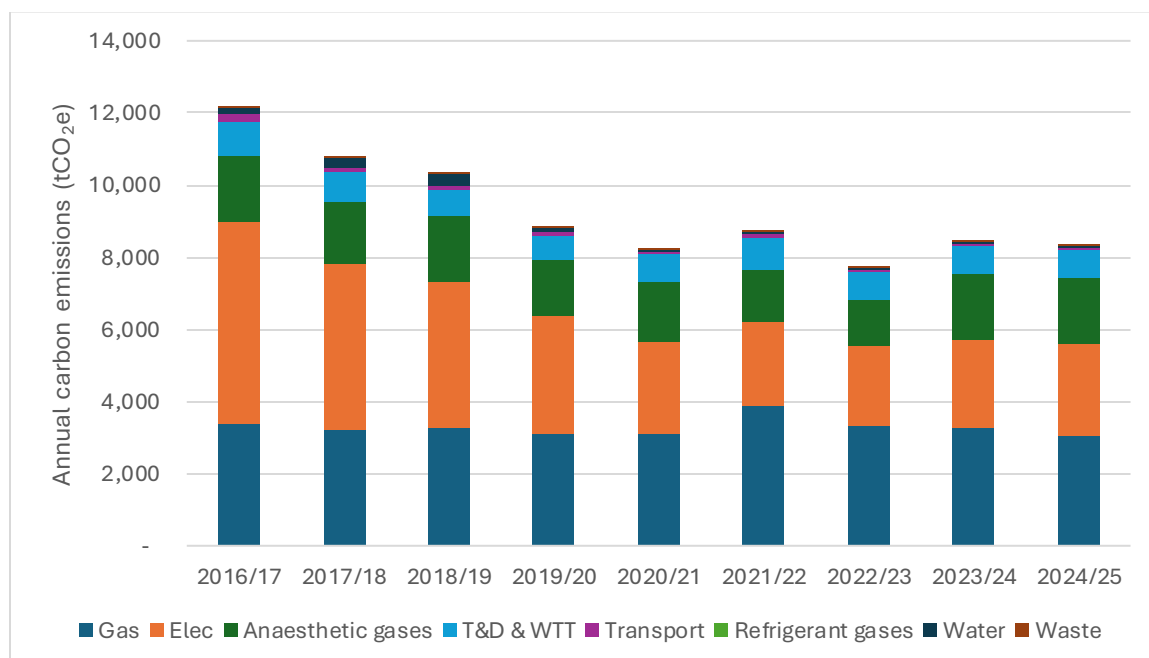
All staff

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

Carbon impact

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

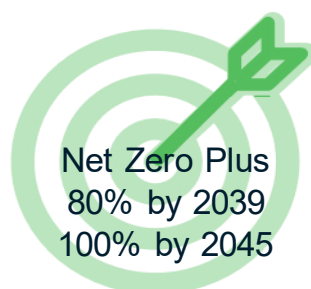
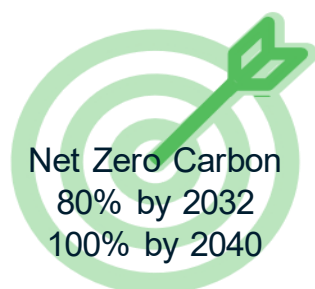
Building energy is responsible for 90% of the total footprint. Transitioning away from the use of fossil fuels is fundamental to achieving a net zero carbon footprint. Equally important is the use of purchased or self-generated renewable electricity as part of our estate redevelopment plans. Together,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



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

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

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



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

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

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

Net Zero Care Delivery Plan

Clinical Transformation

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

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

Where are we now?

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

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

Where do we want to be?

Key measures of success:

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

Digital

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

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

Where are we now?

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

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

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

Where do we want to be?

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

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

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

Medicines

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

Where are we now?

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

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

Where do we want to be?

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

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

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

Net Zero Culture Delivery Plan

Workforce

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

Where are we now?

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

Where do we want to be?

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

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

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

Nutrition and food

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

Where are we now?

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

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

Where do we want to be?

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

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

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

Travel and transport

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

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

Where are we now?

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

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

Where do we want to be?

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

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

Net zero infrastructure delivery plan

Estates and facilities

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

The key measures of success across estates and facilities are:

- Decreased energy (electricity and gas) consumption
- Decreased carbon use from energy

- Decreased waste production
- Increase of waste recycled
- Decreased water consumption
- Decreased carbon footprint

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

This is predominantly due to our more efficient consumption of electricity following the roll out of light emitting diode lighting across our estate as well as the ongoing decarbonisation of the UK grid. This is further supported by the reductions in gas and water consumption per m².

There has been a 13% increase in waste production since our baseline year, reaching a peak of 20.25 kg/m² in 2020/21 and 2021/22, owing to the operational challenges faced by the Trust in response to the COVID-19 pandemic. Changes in our management of waste has delivered a 47% reduction in waste between the years 2021/22 and 2024/25, however more work is needed to bring this back in line with our baseline year.

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

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

Energy

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

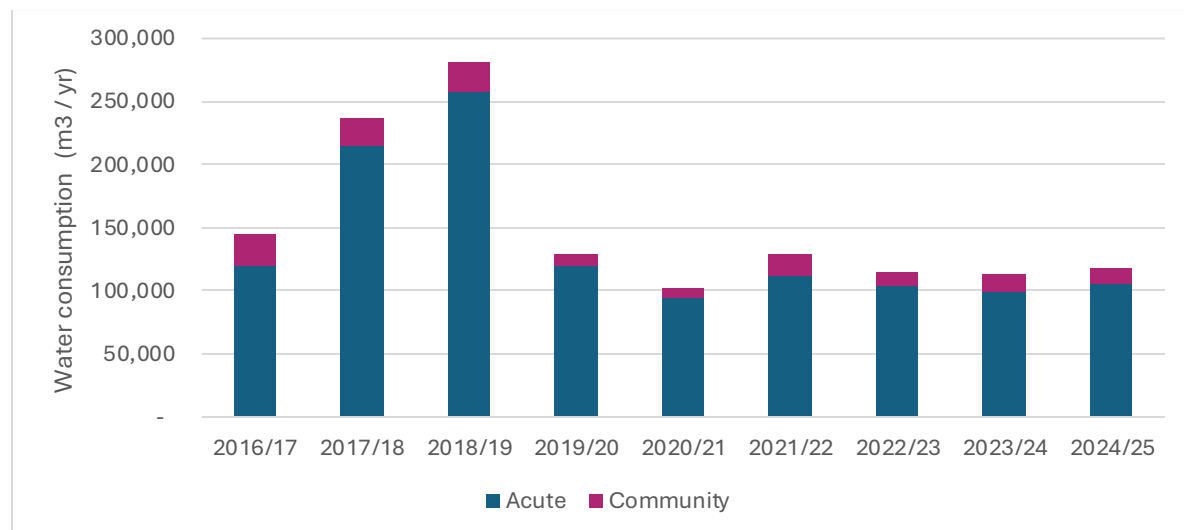
In 2024/25, 90% of our energy-related emissions were from our acute site – Whittington Hospital. Gas consumption drives the greatest portion of emissions at 47% across the estate, with electricity (100% renewable) at 41% and the remaining arising from well-to-tank and transmission and distribution.

A Heat Decarbonisation Plan has also been completed for both the acute site and the community sites, providing a strategic roadmap for future low-carbon heating. A key element of the plan was to build more resilient electrical power infrastructure at the hospital site to enable a transition away from gas. The Trust worked with a specialist contractor under the P22 Procurement Regime to design and install and connect a new 8.5 MVA power supply to the hospital site.

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

Water

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



Capital projects

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

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



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

Green space and biodiversity

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

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



EMERGENCY PREPAREDNESS

Whittington Health participated in the annual emergency preparedness, resilience and response (EPRR) assurance process led by NHS England. The core standards for EPRR are set out for NHS organisations to meet. The Trust's annual assessment was completed on 10 October 2025, by the North Central London, NHS England Assurance Team. The EPRR assurance requirements stipulated those providers self-assess compliance against the NHS core standards.

The Trust has achieved **SUBSTANTIALLY COMPLIANT**: EPRR and CBRN (chemical, biological, radiological, and nuclear) assurance outcome in accordance with standards achieved in 2025. The amber scores pertained to data protection and the Business Continuity policy.

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

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

CONCLUSION TO THE PERFORMANCE REPORT AND STATEMENT OF FINANCIAL POSITION

The above document represents the performance report and statement of financial position of Whittington Health for the financial year 2025/26. As the CEO, I believe this represents an accurate and full picture of the Trust for the year.

A handwritten signature in black ink, consisting of a series of loops and a long horizontal stroke at the end.

Signed

Chief Executive: Selina Douglas

Date: 26 June 2026

ACCOUNTABILITY REPORT

Members of Whittington Health's Trust Board

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

Non-Executive Directors

Julia Neuberger, Junaid Bajwa, Mark Emberton, Amanda Gibbon, Nailesh Rambhai, Glenys Thornton, Rob Vincent.

Directors

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

Membership of committees reporting to the Board

Audit and Risk Committee

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

Charitable Funds' Committee

Non-Executive Directors: Amanda Gibbon, Julia Neuberger, Nailesh Rambhai

Directors: Clare Dollery, Jonathan Gardner, Selina Douglas, Sarah Wilding, Terry Whittle

Finance & Business Development Committee

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

Directors: Clare Dollery, Selina Douglas, Terry Whittle, Chinyama Okunuga, Jonathan Gardner

Improvement, Performance and Digital Committee

Non-Executive Directors: Junaid Bajwa, Nailesh Rambhai, Mark Emberton

Directors: Jonathan Gardner, Terry Whittle, Chinyama Okunuga

Quality Assurance Committee

Non-Executive Directors: Mark Emberton, Amanda Gibbon, Glenys Thornton

Directors: Clare Dollery, Charlotte Hopkins, Clarissa Murdoch, Chinyama Okunuga, Swarnjit Singh, Sarah Wilding, Tina Jegede

Remuneration Committee

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

Workforce Assurance Committee

Non-Executive Directors: Junaid Bajwa, Glenys Thornton, Rob Vincent

Directors: Clare Dollery, Charlotte Hopkins, Liz O'Hara, Charlotte Pawsey, Chinyama Okunuga, Sarah Wilding, Terry Whittle, Swarnjit Singh, Tina Jegede

Whittington Health and UCLH Partnership Development Committee-in-Common

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

Non-executive director appraisal process

The chair and non-executive directors annually evaluate their performance through appraisal and identify any areas for development. The appraisal of the non-executive directors is carried out by the chair and the chair's appraisal is carried out by the senior independent director .

Trust Board of Directors' declarations of interest

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

In addition, at the commencement of each Board meeting, members of the Board are required to declare any interests in respect of specific items on the agenda. The declarations for 2025/26 are shown in the table below:

Voting member	Declared interests
Baroness Julia Neuberger DBE, Trust Chair and Non-Executive Director	- Independent, Cross Bench Peer, House of Lords - Chair, University College London Hospitals NHS Foundation Trust - Member of NCL ICB Strategy and Development Committee - Partnership Development Committee-in-Common - Occasional broadcasting for the BBC - Rabbi Emerita, West London Synagogue - Trustee, The Walter and Liesel Schwab Charitable Trust - Trustee, Rayne Foundation - Trustee, Leo Baeck Institute Academic Study of German Jewish relationships - Trustee, Yad Hanadiv Israel (Charitable Foundation) - Consultant, Clore Duffield Foundation (on Jewish matters) - Chair, Oversight Committee, City of London Centre - Public Voice Representative, Jewish Community's BRCA Testing Programme - Member of the Science and Technology Committee House of Lords - Vice Chair All-Party Parliamentary Group on Faith and Society

Voting member	Declared interests
	• APPG Dying Well – Member <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Clare Dollery, Acting Chief Executive	• Member of the Senior Management Board NCL Integrated Care Board • Ordinary shareholder of Smith and Nephew • Ordinary shareholder of Astra Zeneca • Ordinary shareholder of Unilever <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Sister-in-law Dr Caroline Dollery is a non-executive director on the board of NELFT.
Junaid Bajwa, Non-Executive Director	• Senior Partner, Head of UK & Science Partner, Pioneering Intelligence, Flagship Pioneering • GP (locum) • NHS England (GP appraiser) • Essential Guides UK Limited (Shareholder, GP locum services and educational work) • Non-Executive Director, University College London Hospitals NHS Foundation Trust • Non- Executive Director, Medicines and Healthcare products Regulatory Authority • Governor, Nuffield Health • Non- Executive Director, Nahdi Medical Corporation • Non-Executive Director Ondine • Visiting Scientist, Harvard School of Public Health • Trustee of the Board of Health Data Research UK (HDR UK) <u>Conflicts of interests that may arise out of any known immediate family involvement :</u> • Nil
Amanda Gibbon, Non-Executive Director	• Chair, RareCan Limited (start-up company looking to recruit patients with rare cancers into research in their disease areas. This post is currently unremunerated.) • Senior Independent Non-Executive Director, Royal Free London NHS Foundation Trust • External member of the Audit and Risk Assurance Committee of the National Institute for Health and Care Excellence • UCLH: Chair of the Biobank Ethical Review Committee for the UCL/UCLH Biobank for Studying Health and Disease and Chair of the UCLH Organ Donation Committee

Voting member	Declared interests
	• Director, The Girls Education Company Limited • Director, Garthgwynion Estate Limited • Director of Wycombe Abbey Services Limited <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • My four (adult) children each have personal shareholdings in Astrazeneca, Intuitive Surgical, Novo-Nordisk, Roche Holdings and Thermo Fisher Scientific GlaxoSmithKline and Smith & Nephew
Chinyama Okunuga, Chief Operating Officer	• Nil <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Son is an auditor at KPMG
Nailesh Rambhai, Non-Executive Director	• Non-Executive director, Pension Protection Fund • Non-Executive director, Birmingham Women's and Children's NHS FT • Non-Executive director, University College London Hospitals NHS Foundation Trust • Non-Executive director, Newbury Building Society • Director, Cholmeley Court Ltd • Member, Finance & Performance Committee, Birmingham & Solihull Integrated Care Board • Trustee, United Way UK • Assessor- Solicitors Qualifying Exam (SQE) • Solicitor – non-practicing <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Baroness Glenys Thornton, Non-Executive Director	• Chair and Trustee, Phone Co-op Foundation for Co-operative Innovation • Senior Associate, Social Business International • Senior Fellow, The Young Foundation • Council Member, University of Bradford • Emeritus Governor, London School of Economics • Trustee, Roots of Empathy UK • Patron, Social Enterprise UK • British Council All Party Parliamentary Group • Officer Sickle Cell & Thalassaemia APPG • Honorary Secretary Social Enterprise APPG • Vice Chair Dalits APPG

Voting member	Declared interests
	- Vice Chair APPG Media - Vice Chair APPG Parks and Green Spaces - Member of the Advisory Committee on Business Appointments (ACOPA), - Fellow of Social Innovation Cambridge centre for Social Innovation, Judge Business School, University of Cambridge. <u>Conflicts of interests that may arise out of any known immediate family involvement</u> - Daughter is employed at Whittington Health
Rob Vincent CBE, Non-Executive Director	- Non-Executive Director, University College London Hospitals NHS Foundation Trust - Trustee of Kilmarnock Community Trust <u>Conflicts of interests that may arise out of any known immediate family involvement</u> - Nil
Sarah Wilding, Chief Nurse and Director of Allied Health Professionals	- Nil <u>Conflicts of interests that may arise out of any known immediate family involvement</u> - Nil
Terry Whittle, Chief Finance Officer	- Chair of Whittington Pharmacy, Community Interest Company (CIC) - Vice-chair Healthcare Financial Management Association's Policy & Research Committee <u>Conflicts of interests that may arise out of any known immediate family involvement</u> - Wife is an operational manager at West Hertfordshire Teaching Hospitals NHS Trust
Clarissa Murdoch, Acting Medical Director	Nil <u>Conflicts of interests that may arise out of any known immediate family involvement.</u> Husband, Jerome Frost, is the CEO at ARUP Consultancy firm specialised in the sustainably built environment who have some healthcare related work.
Charlotte Hopkins, Acting Chief Medical Officer	- Nil <u>Conflicts of interests that may arise out of any known immediate family involvement</u> - Father is an outpatient in dermatology clinics at the Trust.

Voting member	Declared interests
Mark Emberton, Non-Executive Director	• Non-Executive Director University College London Hospitals NHS Foundation Trust Consultancy advice to: • Sonacare Medical • Angiodynamics • NINA Medical Profound Medical • Exact Imaging • Minomic Medical • Proteomix • Prostate cancer care undertaken at King Edward VII Hospital (London Urology Specialists) • All current research is Grant Council sponsored. Within the MRC / CRUK • Re-IMAGINE trial we receive £8million of in-kind industry contribution managed through the MRC MICA process <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Non-voting members	Declared interests
Jonathan Gardner Chief Strategy, Digital and Improvement Officer	• Director Whittington Pharmacy CIC • SRO for NCL Community Diagnostic Centres • Member NCL Diagnostic Board • Member NCL Digital Board • Member of Haringey Brough Partnership • Chair of the Haringey Neighbourhoods & Inequalities Board <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Tina Jegede MBE, Joint Director of Inclusion and Lead Nurse, Islington Care Homes	• Honorary lecturer at City St Georges University • Member of the NCL Workforce Development Delivery Board <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Sister-in-law is employed at the Trust's pathology services
Liz O'Hara, Chief People Officer	• Director, Pineapple Equity • Chief of People, University College London Hospital NHS Foundation Trust • Member of the NHS National Staff Council Executive <u>Conflicts of interests that may arise out of any known immediate family involvement</u>

Voting member	Declared interests
	Sister is the publishing director at the Lancet Group
Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary	- Secretary to the University College London Health Alliance Board and Chief Executive's Group - Management Side Co-Chair of the Equality, Diversity, and Inclusion subgroup of the NHS Staff Council Executive - Member of the North Central London Integrated Care Board's Population Health and Health Inequalities Steering Group. - Member of North Central London Integrated Care Board's People Committee <u>Conflicts of interests that may arise out of any known immediate family involvement</u> - Nil

REMUNERATION AND STAFF REPORT

The salaries and allowances of senior managers who held office during the year ended 31 March 2026 are shown in the table below. For the purposes of this report, senior managers are defined as the chief executive, non-executive directors and executive directors, and all Board members with voting rights.

Salaries and Allowances 2025/26						
Name and Title	Salary and fees (Bands of £5,000)	Taxable benefits (total to the nearest £100)	Annual performance related bonuses (in bands of £5,000)	Long-term performance related bonuses (in bands of £5,000)	AUDITED	
					Pension related benefits (in bands of £2500)	Total (in bands of £5,000)
	£000	£00	£000	£000	£000	£000
Non-Executive						
Baroness Julia Neuberger	40-45					40-45
Amanda Gibbon	10-15					10-15
Baroness Glenys (Dorothea) Thornton	10-15					10-15
Rob Vincent CBE	10-15					10-15
Junaid Bajwa	10-15					10-15
Nailesh Rambhai	10-15					10-15
Mark Emberton	10-15					10-15
Executive						
Selina Douglas - Chief Executive Officer from 2nd June 2025	160-165				7.5-10	170-175
Clare Dollery - Acting Chief Executive Officer to 1st June 2025 and Chief Medical Officer from 1st June 2025 to 31st January 2026	205-210					205-210
Terry Whittle - Chief Finance Officer and Deputy Chief Executive Officer	160-165	16			47.5-50	210-215
Charlotte Hopkins - Interim Chief Medical Officer to 31st May 2025	25-30				15-17.5	40-45
Liz O'Hara - Chief People Officer to 1st March 2026	15-20				10-12.5	30-35
Charlotte Pawsey- Interim Chief People Officer from 2nd March 2026	10-15				0-2.5	10-15
Jonathan Gardner - Chief Strategy Officer to 9th January 2026	110-115				57.5-60	170-175
Chinyama Okunuga Chief Operating Officer	135-140	26			45-47.5	180-185
Sarah Wilding Chief Nurse and Director of Allied Health Professionals	140-145				55-57.5	200-205
Swarnjit Singh-Joint Director of Inclusion and Trust Company Secretary	105-110				45-47.5	150-155
Tina Jegede-Joint Director of Inclusion and Lead Nurse, Islington Care Homes	95-100				45-47.5	140-145
Clarissa Murdoch- Interim Chief Medical Officer 1.2.26 to 31.3.26	25-30				0-2.5	25-30

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

Salaries and Allowances 2024/25				AUDITED		
Name and Title	Salary and fees (Bands of £5,000)	Taxable benefits (total to the nearest £100)	Annual performance related bonuses (in bands of £5,000)	Long-term performance related bonuses (in bands of £5,000)	Pension related benefits (in bands of £2500)	Total (in bands of £5,000)
	£000	£00	£000	£000	£000	£000
Non-Executive						
Julia Neuberger	40-45					40-45
Amanda Gibbon	10-15					10-15
Naomi Fulop Left 14.10.2024	5-10					5-10
Glenys (Dorothea) Thornton	10-15					10-15
Rob Vincent CBE	10-15					10-15
Junaid Bajwa	10-15					10-15
Nallesh Rambhai	10-15					10-15
Mark Emberton Commenced 15.10.2024	5-10					5-10
Executive						
Clare Dollery - Acting Chief Executive:	245-250				0	245-250
Terry Whittle - Chief Finance Officer and Deputy Chief Executive	165-170	5			105-107.5	270-275
Charlotte Hopkins - Interim Medical Director Started 3.6.24	150-155				52.5-55	200-205
Liz O'Hara - Chief People Officer	20-25				10-12.5	30-35
Jonathan Gardner - Director of Strategy and Corporate Affairs	140-145				27.5-30	170-175
Chinyama Okunuga Chief Operating Officer	125-130	17			17.5-20	140-145
Sarah Wilding Director of Nursing and Clinical Development	135-140				15-17.5	155-160
Swarnjit Singh-Joint Director of Inclusion and Trust Company Secretary	100-105				15-17.5	120-125
Tina Jegede-Joint Director of Inclusion and Lead Nurse, Islington Care Homes	90-95				47.5-50	140-145
Clarissa Murdoch- Acting Medical Director 1.4.24 to 2.6.24	25-30				10-12.5	40-45

Statement of the policy on senior managers' remuneration

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

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

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

Board members' pension entitlements for those in the pension scheme 2025/26 AUDITED

Name	Real increase in pension (bands of £2,500)	Real increase in lump sum (bands of £2,500)	Total accrued pension at 31 March 2026 (bands of £5,000)	Lump sum related to accrued pension at 31 March 2026 (bands of £5,000)	Cash equivalent transfer value at 31 March 2026 (to the nearest £1,000)	Cash equivalent transfer value at 31 March 2025 (to the nearest £1,000)	Real increase in cash equivalent transfer value (to the nearest £1,000)	Employer contribution to stakeholder pension
Executive Directors	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Selina Douglas	0-2.5	0	50-55	0	862	818	5	0
Terry Whittle	2.5-5	0-2.5	40-45	100-105	811	745	33	22
Jonathan Gardner	2.5-5	0	35-40	0	613	544	46	19
Chinyama Okunuga	2.5-5	0	30-35	5-10	541	477	39	17
Sarah Wilding	2.5-5	2.5-5	65-70	165-170	1,484	1,376	66	19
Tina Jegede	2.5-5	0-2.5	50-55	130-135	122	87	23	12
Swarnjit Singh	2.5-5	0-2.5	45-50	120-125	1,161	1,073	57	14
Liz O'Hara	5-7.5	7.5-10	65-70	150-155	1,354	1,186	111	3
Charlotte Hopkins	0-2.5	2.5-5	45-50	105-110	976	749	15	20
Clarissa Murdoch	0-2.5	0	65-70	165-170	1,522	1,436	0	4
Charlotte Pawsey	0-2.5	0	0	0	55	25	0	0

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

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

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

Audited fair pay and pay ratio disclosure

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

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

The percentage change in remuneration of the highest paid director

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

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

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

The range of staff remuneration

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

The 25th percentile, median and 75th percentile of staff remuneration

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

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

The 25th percentile, median and 75th percentile of staff remuneration, compared to the highest paid director

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

The banded remuneration of the highest paid director/ member of Whittington Health NHS Trust in the financial year 2025/26 was £195k to £200k (2024/25, £165k to £170k). The relationship to the remuneration of the organisation's workforce is disclosed in the below overleaf.

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

The highest paid director

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

Staff numbers and composition

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

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

Cost analysis of permanent and temporary staff members

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

Consultancy expenditure:

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

Off-payroll engagements

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

Exit packages

	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	No.	£000	No.	£000	No.	£000	No.	£000
<£10,000	2	7	9	33	11	40		
£10,000 - £25,000	1	15	4	61	5	76		
£25,001 - £50,000	1	25	2	62	3	87		
£50,001 - £100,000	4	316	3	238	7	554		
£100,001 - £150,000					0	0		
£150,001 - £200,000					0	0		
>£200,000					0	0		
Total	8	363	18	394	26	757	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where Whittington Health has agreed early retirements, the additional costs are met by the Trust.

A handwritten signature in black ink, consisting of a series of loops and a long horizontal stroke extending to the right.

Signed:

Chief Executive: Selina Douglas

Date: 26 June 2026

ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Whittington Health NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Whittington Health NHS Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

- Leadership of the risk management process through:
 - executive risk leads for each Board Assurance Framework entry
 - respective board committees reviewing their allocated Board Assurance Framework entries and reporting outcomes to the board and to the audit and risk committee through chair's assurance reports
 - the audit and risk committee having the full BAF as a standing item at each meeting
 - board members receiving regular updates at each meeting through board committee chairs' assurance reports on the review of respective BAF entries by its board committees
 - a thorough review of entries on the Trust Risk Register by respective executive leads to ensure that entries were up-to-date, appropriately scored and mitigated
- The audit & risk committee has delegated authority from the Board for oversight and assurance on the control framework in place to manage strategic risks to the delivery of the Trust's objectives and reviews the effectiveness of the Trust's systems of risk management and internal control

- It is supported in this by other Board Committees providing assurance to the board on the effective mitigation of strategic Board Assurance Framework entries and other key risks, as follows:
 - The quality assurance committee reviews and provides assurance to the board on the management of risks relating to quality and safety strategic objective, including all risk entries scored above 15 on individual Clinical Divisions' and corporate areas' risk registers
 - The finance & business development committee provides assurance to the Board on the delivery of the Trust's integration strategic objective and two of its sustainability strategic objectives and reviews risks scored higher than 15 which relate to finance, information governance, estates
 - The improvement, performance and digital committee considered risks to the delivery of the Trust's third sustainability strategic objective covering its digital strategy and interoperability with sector partners
 - The workforce assurance committee reviews all risks to the delivery of the organisation's people strategic objective, and their effective mitigation. It is supported in this by the quality assurance committee which also monitors those workforce risks related to patient quality and safety
 - The trust management group reviews the Board Assurance Framework in its entirety and leads on reviewing risks to the delivery of the organisation's Integration strategic objective
 - Each clinical divisions' board meeting has their respective risks as a standing item
 - A new Risk Compliance and Assurance Group was established to oversee significant risks, strengthen risk governance arrangements, and provide assurance to the Quality Assurance Committee and Trust Board on the effectiveness of risk management processes across the Organisation. .In addition, performance reviews for each clinical division consider their key respective risks
 - An annual review by our internal auditors of risk management arrangements and the control framework in place
 - A Risk Management Framework and risk management policy and procedure are place to provide guidance and advice to all staff
- An organisational governance structure, with clear lines of accountability and roles responsible for risk management is in place for all staff
- The chief executive has overall accountability for the development of risk management systems and delegates responsibility for the management of specific areas of risk to named directors
- All relevant staff are provided with risk management training as part of their induction to the Trust and face-to-face training from risk managers for those staff regularly involved in risk management
- An open culture to empower staff to report and resolve incidents and risks through the Datix recording system and to share learning with teams

The risk and control framework

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

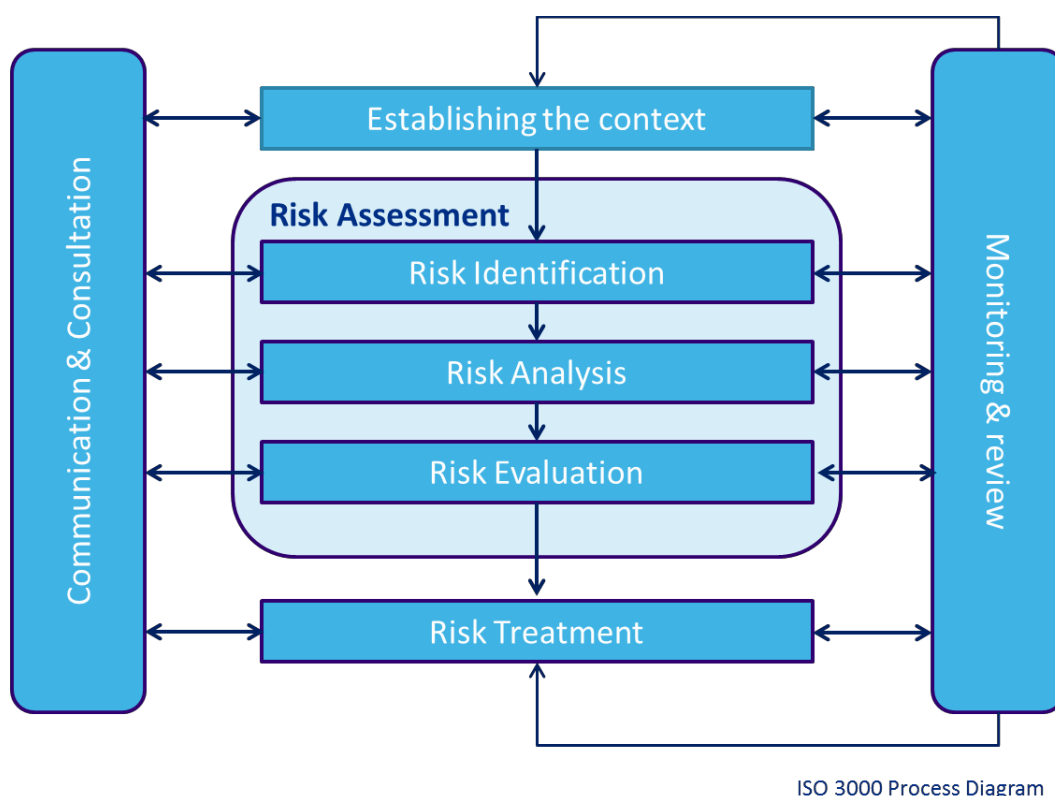
The Trust's approach to risk management aims to:

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

Risk management process

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

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



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

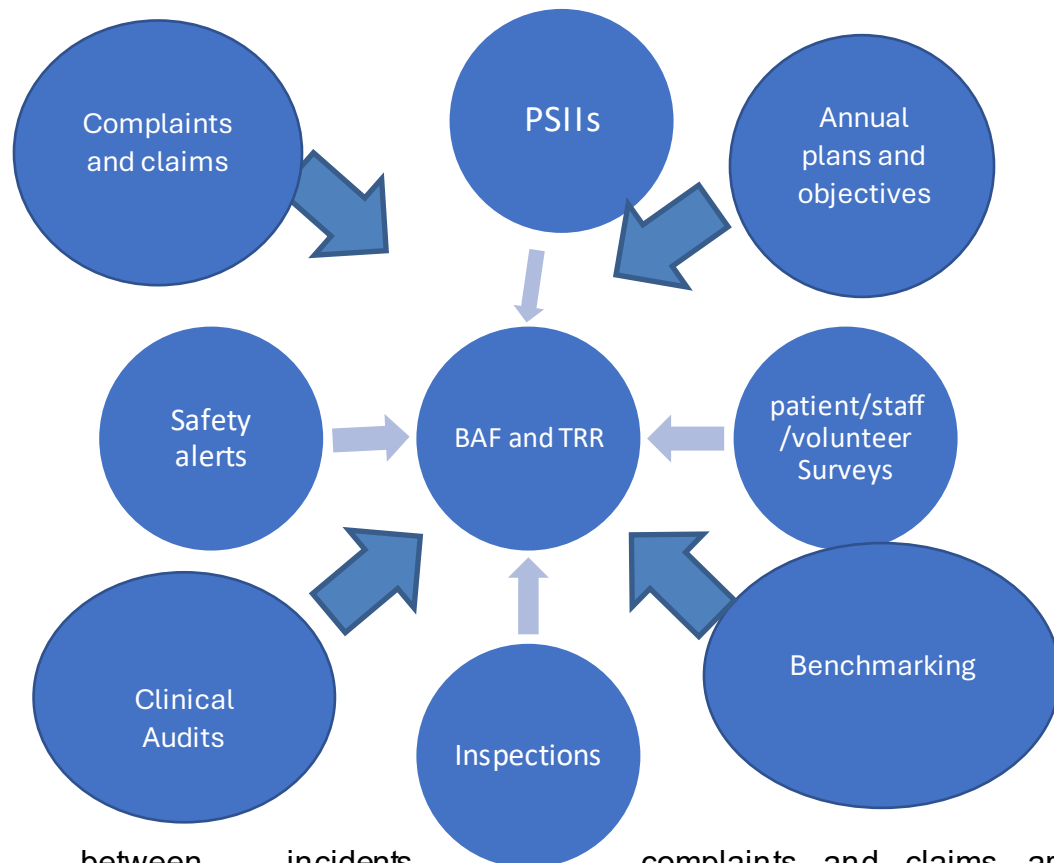
Trust-wide review and escalation of strategic risks

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



Risk identification

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



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

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

Risk assessment

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

Risk analysis and evaluation

An analysis of each risk is required to be undertaken to establish the initial grading of the risk by assessing the likelihood and consequences of the hazard if it did

occur. The Trust utilises a risk grading matrix which incorporates a risk tolerance measure. This process aims to ensure that risks are assessed consistently across the Trust. Once the grading is known and recorded in the Risk Register, the risk can be compared with other risks facing the Trust and prioritised according to significance. The list of all risks facing the Trust, in order of significance, makes up the Trust-wide Risk Register. Risk assessment is an integral part of the business planning process. Therefore, significant strategic risks will be identified by the Trust Board and managed through the Board Assurance Framework (BAF).

Risk control – monitoring, review and resolution

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

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

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

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

RSM also completed a review of risk management arrangements in May 2024 and

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

In particular, the review highlighted the following good evidence:

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

Board Assurance Framework

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

Structure and presentation

The 2025/26 BAF covered risks to the delivery of Whittington health's four strategic objectives: quality and safety, people, integration and sustainable. Its entries are detailed earlier in this annual report.

Assurances and gaps

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

BAF review and update

The review and updating of BAF entries is led by executive director risk leads, the Trust Company Secretary. In addition, key Board Committees review risks relevant to their terms of reference as set out previously.

Risk appetite

In line with good practice, the Trust completes an annual review of its risk appetite statement. This is first discussed and endorsed by members of the Audit and Risk Committee and then taken to the Board for approval. The risk appetite range is included within BAF reports presented to board and executive committees. Individual risks on the BAF are allocated a target score against which progress is reported in the BAF.

Embedding risk management

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

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

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

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

The board of directors

Membership of the board of directors in 2025/26 was made up of seven independent non-executive directors, including the Trust chair, and eight directors, of which five are voting members of the Board. In line with the code of governance for NHS provider trusts, the Board can confirm the independence of its non-executive directors as they have been appointed by NHS England and that:

- They are not and have not been an employee of the trust within the last two years
- They have not had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust
- They have not received or receive remuneration from the trust apart from a director's fee, do not participate in the trust's performance-related pay scheme or

- are a member of the trust's pension scheme
- had close family ties with any of the trust's advisers, directors or senior employees
- held cross-directorships or has significant links with other directors through involvement with other companies or bodies
- has served on the trust board for more than six years from the date of their first appointment unless an extension was agreed by NHS England
- They are an appointed representative of the trust's university medical or dental school.

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

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

The board of directors met six times during the year. A breakdown of attendance for the Board's meetings held in 2025/26 is shown below:

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

Job title and name (*denotes non-voting member of the Board)	Public Board meeting attended (out of 6 unless otherwise stated)
Acting Chief Medical Officer, Charlotte Hopkins,	1 out of 1
Acting Medical Director, Clarissa Murdoch	2 out of 2
Acting Chief People Officer, Charlotte Pawsey*	1 out of 1
Joint Director of Inclusion and Lead Nurse, Islington Care Homes, Tina Jegede*	6
Joint Director of Inclusion and Trust Company Secretary, Swarnjit Singh*	6

Board and Committee oversight and assurance

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

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

Audit and Risk Committee

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

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

Improvement, Performance and Digital Committee

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

Quality Assurance Committee

The quality assurance committee is a formal committee of the board and is accountable to the Board for reviewing the effectiveness of quality systems, including the management of risks to the Trust's quality and patient engagement strategic priorities as well as operational risks to the quality of services. The committee met six times in 2025/26. It also monitors performance against quarterly quality indicators, the quality account, and all aspects of the three domains of quality namely - patient safety, clinical effectiveness and patient experience.

Finance & Business Development Committee

The finance & business development committee reviews financial and non-financial performance across the Trust, reporting to the board. It also has lead oversight for risks to the delivery of Trust's strategic priorities relating to sustainability. The committee held five full meetings in 2025/26.

Workforce Assurance Committee

The workforce assurance committee met five times during 2025/26 and leads on oversight of BAF risks which relate to the Trust's staff engagement and recruitment and retention strategic priorities. It reviews performance against the delivery of key workforce recruitment and retention plans as part of its people strategy and the annual outcomes for equality standard submissions to NHS England. In addition, the committee will also review those staff engagement actions taken following the outcome of the annual NHS staff survey and delivery of the Trust's workforce culture improvement plan.

Partnership Development Committee with University College London Hospitals NHS Foundation Trust

The Partnership Development committee-in-common met quarterly during 2025/26 and reviewed progress with the key priority areas for increased collaboration between both organisations.

Workforce planning

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

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

- recruitment opportunities
- Middle grade doctor recruitment working group focussed on the emergency department

In 2025/26, Whittington Health complied with the “Developing Workforce Safeguards” through the following assurances:

- The chief medical officer and chief nurse and director of allied health professionals confirmed there are established processes to ensure that staffing is safe, effective and sustainable
- The nursing and midwifery staffing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) was reported to the board by ward or service area twice a year
- High level risks were reported to the workforce assurance committee
- Safe nurse staffing levels were monitored continuously, supported by ongoing assessments of patient acuity.
- Workforce intelligence and key performance indicators were reported alongside quality metrics at the board each month and were standing items on performance review group meetings. The workforce assurance committee received comprehensive corporate workforce information and analysis. Metrics included vacancy and sickness rates, turnover and appraisal compliance and temporary staffing
- Any changes and significant (over £50k) cost improvement plans had a quality impact assessment

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

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

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

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

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

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

The Trust was rated by the CQC as good in its use of resources as it had demonstrated a good understanding of areas of improvements with credible plans to achieve target performance. Furthermore, an external audit of our accounts by KPMG LLP also provided an independent view of the Trust's effective and efficient use of resources, particularly against value for money considerations

During 2025/26, Whittington Health had in place a range of processes which helped to ensure that it continued to use resources economically, efficiently and effectively. These included:

- monthly reporting of financial and non-financial performance to the Trust Board of directors and the finance and business development committee of the Board
- adherence to guidance issued by NHS England by establishing robust systems for the delivery of operational priorities
- the development and implementation of a medium-term financial recovery plan
- a monthly review of performance by the Trust Management Group and additional review meetings where clinical divisions and corporate directorates are held to account for financial and non-financial performance
- the production of annual reference costs, including comparisons with national reference costs
- the benchmarking of costs and key performance indicators against other combined acute and community Trust providers
- standing financial instructions, standing orders and a treasury management policy
- a budget holder's manual which sets out managers' responsibilities in relation to managing budgets
- guidance on the declaration of conflicts of interest and standards of business conduct
- reports by RSM as part of the annual internal audit work plan on control mechanisms which may need reviewing
- the Head of Internal Audit's opinion being presented to the audit and risk committee
- good performance under NHS England's Oversight Framework for NHS providers

Information governance

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

Nature of incident	Incident date	ICO reported date	ICO outcome
The subject access request service accidentally mis-merged and sent out two different patient records.	July 2025	July 2025	No further action
A staff member lost a printout of the community visits' day sheet which contained the personal data of 13 patients.	December 2025	December 2025	No further action

Data quality and governance

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

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

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

Annual Quality Account

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

Provider licence conditions

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

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

Code of governance for NHS provider trusts

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

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

Members of the audit and risk committee met on 23 June specifically to consider the key points from the draft financial statements and noted a summary of audit progress as presented by KPMG in relation to the financial statements. Committee members also considered a review which showed largescale compliance with the code of governance, with one exception – taking the remuneration of the first tier of management below executive directors to the remuneration committee – this will happen at its next meeting.

The audit and risk committee derive their assurance as to the completeness and accuracy of the financial statements from several ways:

- The completion of the final accounts audit by the external auditor and the issue of the ISA260 report which is the Auditor's report to the audit and risk committee.
- The Auditor's signature of the Audit Opinion stating, inter alia, that the Accounts represent a true and fair view.
- Prior to submission of the draft financial statements in April, these are reviewed by the chief finance officer and operational director of finance, and review points investigated and resolved.
- From the draft submission to the final audited submission, a change log is retained by the Trust for each of the accounts, annual report and provider financial return, detailing all changes which are proposed between the draft and final versions. This is approved by the chief finance officer in advance of the changes being made and included in the final submission.

The annual report and accounts have been prepared with significant review, discussion and contributions from executive and non-executive director members of the audit and risk committee. The executive team and trust management group members have reviewed and provided extensive input for the annual report iterations. The annual report and accounts were approved, in principle, by the Trust's Board at its meeting on 25 June 2026 with delegated authority given to the chief finance officer

and the chair of the audit and risk committee to make any further changes required. The assessments by the accountable officer and other directors that the annual report and accounts are fair, balanced and understandable and provide the necessary information for stakeholders to assess Whittington Health performance, business model and strategy are shown on the penultimate two pages of this annual report.

Review of effectiveness

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

Head of Internal Audit's Annual Opinion

RSM, the Trust's internal auditors confirmed that:

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

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

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

Conclusion

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



Signed:

Chief Executive: Selina Douglas

Date: 26 June 2026

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

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

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

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

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



Signed:

Chief Executive: Selina Douglas

Date: 26 June 2026

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

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

By order of the Board



Date... 26 June 2026 Chief Executive: Selina Douglas



Date.... 26 June 2026 Finance Director: Terry Whittle

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Annual Accounts for the year ended 31 March 2026

Statement of Comprehensive Income

		2025/26	2024/25
	Note	£000	£000
Operating income from patient care activities	3	497,478	471,111
Other operating income	4	32,937	29,273
Operating expenses	6,8	(529,341)	(512,746)
Operating surplus/(deficit) from continuing operations		1,074	(12,362)
Finance income	10	1,975	3,179
Finance expenses	11	(1,431)	(1,860)
PDC dividends payable		(6,056)	(5,588)
Net finance costs		(5,511)	(4,269)
Surplus / (deficit) for the year from continuing operations		(4,437)	(16,631)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(6,361)	(7,339)
Revaluations	15	3	672
Total other comprehensive income for the period		(6,358)	(6,667)
Total comprehensive income / (expense) for the period		(10,795)	(23,298)

Note 32 Adjusted Financial Performance provides a reconciliation of the deficit reported above to the Trust's surplus against its control total

Statement of Financial Position

		31 March 2026 £000	31 March 2025 £000
	Note		
Non-current assets			
Intangible assets	12	2,480	4,079
Property, plant and equipment	13	281,261	260,849
Right of use assets	16	27,669	36,104
Receivables	19	757	805
Total non-current assets		312,167	301,837
Current assets			
Inventories	18	0	1,309
Receivables	19	19,441	23,122
Cash and cash equivalents	20	55,363	46,276
Total current assets		74,804	70,706
Current liabilities			
Trade and other payables	21	(101,406)	(91,238)
Borrowings	23	(4,925)	(5,511)
Provisions	24	(7,200)	(227)
Other liabilities	22	(1,816)	(2,216)
Total current liabilities		(115,347)	(99,191)
Total assets less current liabilities		271,624	273,352
Non-current liabilities			
Borrowings	23	(25,736)	(34,729)
Provisions	24	(13,382)	(25,032)
Total non-current liabilities		(39,118)	(59,761)
Total assets employed		232,506	213,591
Financed by			
Public dividend capital		168,030	138,320
Revaluation reserve		67,279	73,637
Income and expenditure reserve		(2,803)	1,634
Total taxpayers' equity		232,506	213,591

The notes on pages 187 to 236 form part of these accounts.



Name
Position
Date

Selina Douglas
Chief Executive Officer
26 June 2026

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2025 - brought forward	138,320	73,637	1,634	213,591
Surplus/(deficit) for the year	-	-	(4,437)	(4,437)
Impairments	-	(6,361)	-	(6,361)
Revaluations	-	3	-	3
Public dividend capital received	29,710	-	-	29,710
Taxpayers' equity at 31 March 2026	168,030	67,279	(2,803)	232,506

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

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

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Income and expenditure reserve

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

Statement of Cash Flows

		2025/26	2024/25
	Note	£000	£000
Cash flows from operating activities			
Operating surplus / (deficit)		1,074	(12,362)
Non-cash income and expense:			
Depreciation and amortisation	6.1	22,901	20,711
Net impairments	7	6,408	3,587
Income recognised in respect of capital donations	4	-	(139)
Decrease in receivables and other assets		3,306	4,086
(Increase) / decrease in inventories		1,308	(219)
(Decrease) in payables and other liabilities		(5,258)	(27)
(Decrease) in provisions		(5,574)	(1,217)
Net cash flows from / (used in) operating activities		24,166	14,421
Cash flows from investing activities			
Interest received		1,935	3,340
Purchase of intangible assets		(825)	(714)
Purchase of PPE and investment property		(33,698)	(26,624)
Net cash flows from / (used in) investing activities		(32,588)	(23,998)
Cash flows from financing activities			
Public dividend capital received		29,710	372
Movement on loans from DHSC		(116)	(116)
Capital element of lease rental payments		(6,209)	(5,883)
Interest on loans		(41)	(43)
Other interest		(8)	(1)
Interest paid on lease liability repayments		(235)	(825)
PDC dividend (paid) / refunded		(5,593)	(6,199)
Net cash flows from / (used in) financing activities		17,509	(12,694)
Increase / (decrease) in cash and cash equivalents		9,087	(22,272)
Cash and cash equivalents at 1 April - brought forward		46,276	68,548
Cash and cash equivalents at 31 March	20	55,363	46,276

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

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

Note 1.3 Revenue from contracts with customers

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

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

Revenue from NHS contracts

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

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

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

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

Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.

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

Revenue from research contracts

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

NHS injury cost recovery scheme

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

Note 1.4 Other forms of income

Grants and donations

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

Apprenticeship service income

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

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement

Valuation

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

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

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

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

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

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

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

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

Impairments

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

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

De-recognition

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

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

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

Donated and grant funded assets

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

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

Private Finance Initiative (PFI) transactions

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

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings, excluding dwellings	18	89
Plant & machinery	5	15
Information technology	3	10
Furniture & fittings	5	10

Note 1.8 Intangible assets

Recognition

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

Internally generated intangible assets

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

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

Software

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

Measurement

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

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

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	Max life Years
Software licences	3	5

Note 1.9 Inventories

From 1st April 2025, the Trust no longer records Inventory balances in its financial statements as the values which would be recorded have consistently been immaterial. For 2024/25 and previous financial years, the pharmacy drugs inventory was recorded at the lower of cost and net realisable value, as measured using the first in, first out (FIFO) method. The value of the inventory expensed in respect of this one-off change was £1,014k.

Note 1.10 Cash and cash equivalents

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

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

Note 1.11 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

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

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

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

Financial assets and financial liabilities at amortised cost

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

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

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

Financial assets measured at fair value through other comprehensive income

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

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

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

Impairment of financial assets

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

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

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

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

Derecognition

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

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

Note 1.12 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 24.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 25.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £223m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for all of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £223m at 31 March 2026. In view of the fact that the change occurs in several years' time, the financial impact of the change cannot be quantified accurately at present.

Note 1.21 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Property, Plant and Equipment

The Trust's land and building assets are valued on the basis explained in Note 16 to the Accounts. Newmark Gerald Eve LLP, our independent valuer, provided the Trust with a valuation of land and building assets (estimated fair value and remaining useful life). The valuation, based on estimates provided by a suitably qualified professional in accordance with HM Treasury guidance, leads to revaluation adjustments. Future revaluations of the Trust's property may result in further changes to the carrying values of non-current assets.

Provisions

Provisions have been made for legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the accounts are prepared. These provisions are estimates of the actual costs of future cashflows and are dependent on future events. Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made. The carrying amounts and basis of the Trust's provisions are detailed in Note 34 to the Accounts.

Note 1.22 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates, and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if there is a change in the period, or in the period of the revision and future periods if the revision affects both current and future periods. We also refer to the following financial statement disclosure notes where further detail is provided on individual balances containing areas of judgement:

The following are estimation uncertainties which could potentially give rise to material misstatement:

- Note 14 Property, plant & equipment.

Department of Health and Social Care guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued."

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based upon modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The Trust commissioned independent RICS qualified valuers, Newmark, to carry out a desktop valuation of land and buildings using the modern equivalent asset methodology at 31 March 2026. Newmark (previously known as Gerald Eve) carried out a full valuation at 31st March 2024.

In developing the valuation of the estate the Trust makes use of the ability to assume a replacement site would be developed in an alternative location where it would be feasible and cost-effective to do so. In valuing the main Whittington Hospital site the Trust assumes a replacement hospital would be located within TFL Zones 3/4 within the Trust's main catchment population, whilst remaining feasible given the transport links available and ability to find space within the area.

The values in the valuer's report have been used to inform the measurement of property assets at valuation in these financial statements. The valuer exercises professional judgement in providing the valuation and it remains the best information available to the Trust. However, the valuer uses informed assumptions regarding obsolescence, rebuild rates and the area of the sites required to accommodate modern equivalent assets with the same service potential which could change and have a material impact upon the valuation.

A reduction in the estimated values would result in reductions to the Revaluation Reserve and / or a loss recorded as appropriate in the Statement of Comprehensive Income.

Changes in modern equivalent asset assumptions would be expected to lead to significant changes in the estimated values of land and buildings.

- Note 25 Provisions.

A material addition to the provision was made during the 2020/21 financial year, in respect of implications arising from the collapse of Whittington Facilities Ltd (WFL). The collapse of WFL meant that the main building transferred back into the ownership of the Trust, whereby the Trust is now responsible for the maintenance of the building, including the cost of major fire safety refurbishments for which WFL are being pursued under the terms of a 30 year contract. As a result of this dispute with WFL, legal proceedings have commenced. There will be a significant cost of rectifying building deficiencies not appropriately addressed by WFL.

In the judgement of the Trust, a provision remains appropriate as at 31 March 2026 to cover relevant potential liabilities. The Trust has reviewed the level at which the provision is held as at 31st March 2026, and adjusted it according to the most up to date legal, and other professional advice available.

The legal position is not concluded and the full costs of remediation are not yet known. The provision is based on the Trust's best estimate of the remediation costs.

Any accounting provision thus made is intended to reflect the material uncertainty around the situation which existed as at 31 March 2026, and should not be taken as admission of any liability on the part of the Trust.

Note 2 Operating Segments

The Trust's chief decision maker has been defined as the Trust Board, and is responsible for allocating resources across the Trust. The Trust's operational management structure is delivered through five clinical divisions (Divisions) covering acute and community services across London.

In line with IFRS 8, the Trust has determined that these Divisions are classed as a single segment with the agreed purpose of providing healthcare services.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

Note 3.1 Income from patient care activities (by nature)	2025/26	2024/25
	£000	£000
Acute services		
Income from commissioners under API contracts - variable element*	73,327	65,179
Income from commissioners under API contracts - fixed element*	274,744	262,834
High cost drugs income from commissioners	15,466	13,568
Other NHS clinical income	4,227	4,099
Mental health services		
Services delivered under a mental health collaborative	-	2,100
Community services		
Income from commissioners under API contracts*	83,336	81,042
Income from other sources (e.g. local authorities)	20,306	18,505
All services		
Private patient income	48	14
National pay award central funding***		890
Additional pension contribution central funding**	21,730	19,875
Other clinical income	4,294	3,004
Total income from activities	497,478	471,111

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)

	2025/26	2024/25
	£000	£000
Income from patient care activities received from:		
NHS England	47,373	43,848
Integrated care boards	421,230	399,540
Other NHS providers	4,227	6,199
Local authorities	20,306	18,505
Non-NHS: private patients	48	14
Non-NHS: overseas patients (chargeable to patient)	426	424
Injury cost recovery scheme	380	419
Non NHS: other	3,488	2,162
Total income from activities	497,478	471,111
Of which:		
Related to continuing operations	497,478	471,111
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2025/26	2024/25
	£000	£000
Income recognised this year	426	424
Cash payments received in-year	303	222
Amounts written off in-year	154	70

Note 4 Other operating income

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,091	-	1,091	873	-	873
Education and training	20,227	-	20,227	18,239	-	18,239
Non-patient care services to other bodies	8,149	-	8,149	5,882	-	5,882
Receipt of capital grants and donations and peppercorn leases	-	-	-	-	139	139
Revenue from operating leases	-	838	838	-	890	890
Other income	2,632	-	2,632	3,250	-	3,250
Total other operating income	32,099	838	32,937	28,244	1,029	29,273
Of which:						
Related to continuing operations			32,937			29,273
Related to discontinued operations			-			-

Note 5 Operating leases - Whittington Health NHS Trust as lessor

This note discloses income generated in operating lease agreements where Whittington Health NHS Trust is the lessor.

Note 5.1 Operating lease income

	2025/26 £000	2024/25 £000
Lease receipts recognised as income in year:		
Minimum lease receipts	838	890
Total in-year operating lease income	838	890

Note 5.2 Future lease receipts

	31 March 2026 £000	31 March 2025 £000
Future minimum lease receipts due in:		
- not later than one year	838	890
- later than one year and not later than two years	782	890
- later than two years and not later than three years	782	890
- later than three years and not later than four years	782	890
- later than four years and not later than five years	782	890
- later than five years	3,128	3,560
Total	7,094	8,010

Note 6.1 Operating expenses

	2025/26	2024/25
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	836	1,190
Staff and executive directors costs	389,196	371,992
Remuneration of non-executive directors	132	128
Supplies and services - clinical (excluding drugs costs)	30,417	36,173
Supplies and services - general	8,684	9,308
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	21,131	19,335
Establishment	8,970	10,330
Premises	21,796	22,850
Transport (including patient travel)	2,333	2,895
Depreciation on property, plant and equipment	20,477	18,376
Amortisation on intangible assets	2,424	2,335
Net impairments	6,408	3,587
Movement in credit loss allowance: contract receivables / contract assets	2,206	660
Movement in credit loss allowance: all other receivables and investments	748	-
Increase/(decrease) in other provisions	(5,172)	(940)
Change in provisions discount rate(s)	(81)	(56)
Fees payable to the external auditor		
audit services- statutory audit	168	163
other auditor remuneration (external auditor only)	-	-
Internal audit costs	77	91
Clinical negligence	9,650	9,082
Legal fees	1,722	1,280
Insurance (as a policy holder)	222	295
Research and development	13	157
Education and training	1,242	1,709
Expenditure on short term leases	159	74
Redundancy	1,268	465
Other	4,315	1,266
Total	529,341	512,746
Of which:		
Related to continuing operations	529,341	512,746
Related to discontinued operations	-	-

Note 6.2 Other auditor remuneration

	2025/26	2024/25
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	-	-

Note 6.3 Limitation on auditor's liability

The contract, signed during January 2022, states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £0.5m (2022/23: £0.5m), aside from where the liability cannot be limited by law. This is in aggregate in respect of all services.

Note 7 Impairment of assets

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	6,408	3,587
Total net impairments charged to operating surplus / deficit	6,408	3,587
Impairments charged to the revaluation reserve	6,361	7,339
Total net impairments	12,769	10,926

Note 8 Employee benefits

	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages	296,191	281,469
Social security costs	34,988	26,706
Apprenticeship levy	1,442	1,369
Employer's contributions to NHS pensions	54,920	50,300
Termination benefits	281	-
Temporary staff (including agency)	3,226	13,210
Total gross staff costs	391,048	373,054
Of which		
Costs capitalised as part of assets	584	597

Note 8.1 Retirements due to ill-health

During 2025/26 there were 2 early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £85k (£325k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2025/26	2024/25
	£000	£000
Interest on bank accounts	1,975	3,179
Total finance income	1,975	3,179

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	41	43
Interest on lease obligations	485	825
Interest on late payment of commercial debt	8	1
Total interest expense	534	870
Unwinding of discount on provisions	897	990
Total finance costs	1,431	1,860

Note 11.2 The late payment of commercial debts (interest) Act 1998

	2025/26	2024/25
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	8	1

Note 12.1 Intangible assets - 2025/26

	Software licences	Total
	£000	£000
Cost at 1 April 2025 - brought forward	19,199	19,199
Additions	825	825
Cost at 31 March 2026	20,024	20,024
Amortisation at 1 April 2025 - brought forward	15,120	15,120
Provided during the year	2,424	2,424
Amortisation at 31 March 2026	17,544	17,544
Net book value at 31 March 2026	2,480	2,480
Net book value at 1 April 2025	4,079	4,079

Note 12.2 Intangible assets - 2024/25

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2024 - as previously stated	18,485	18,485
Additions	714	714
Valuation / gross cost at 31 March 2025	19,199	19,199
Amortisation at 1 April 2024 - as previously stated	12,785	12,785
Provided during the year	2,335	2,335
Amortisation at 31 March 2025	15,120	15,120
Net book value at 31 March 2025	4,079	4,079
Net book value at 1 April 2024	5,700	5,700

Note 13.1 Property, plant and equipment - 2025/26

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2025 - brought forward	39,358	211,512	18,376	36,588	19,528	828	326,190
Additions	-	-	48,724	-	-	-	48,724
Impairments	-	(12,769)	-	-	-	-	(12,769)
Revaluations	-	3	-	-	-	-	3
Reclassifications	-	24,258	(28,573)	1,231	3,032	52	-
Valuation/gross cost at 31 March 2026	39,358	223,004	38,527	37,819	22,560	880	362,148
Accumulated depreciation at 1 April 2025 - brought forward	-	31,296	-	21,495	12,219	331	65,341
Provided during the year	-	6,435	-	5,705	3,303	103	15,546
Accumulated depreciation at 31 March 2026	-	37,731	-	27,200	15,522	434	80,887
Net book value at 31 March 2026	39,358	185,273	38,527	10,619	7,038	446	281,261
Net book value at 1 April 2025	39,358	180,216	18,376	15,093	7,309	497	260,849

Note 13.2 Property, plant and equipment - 2024/25

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2024 - as previously stated	39,186	184,067	41,360	30,226	17,416	281	312,536
Additions	-	14,469	9,291	31	-	117	23,908
Impairments	(18)	(10,908)	-	-	-	-	(10,926)
Revaluations	-	672	-	-	-	-	672
Reclassifications	190	23,212	(32,275)	6,331	2,112	430	-
Valuation/gross cost at 31 March 2025	39,358	211,512	18,376	36,588	19,528	828	326,190
Accumulated depreciation at 1 April 2024 - as previously stated	-	25,652	-	17,112	9,138	253	52,155
Provided during the year	-	5,644	-	4,383	3,081	78	13,186
Accumulated depreciation at 31 March 2025	-	31,296	-	21,495	12,219	331	65,341
Net book value at 31 March 2025	39,358	180,216	18,376	15,093	7,309	497	260,849
Net book value at 1 April 2024	39,186	158,415	41,360	13,114	8,278	28	260,381

Note 13.3 Property, plant and equipment financing - 31 March 2026

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	39,358	185,158	38,527	10,604	7,038	358	281,042
Owned - donated/granted	-	115	-	16	-	88	219
Total net book value at 31 March 2026	39,358	185,273	38,527	10,619	7,038	446	281,261

Note 13.4 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	39,358	180,094	18,376	15,041	7,309	386	260,564
Owned - donated/granted	-	122	-	52	-	111	285
Total net book value at 31 March 2025	39,358	180,216	18,376	15,093	7,309	497	260,849

Note 14 Donations of property, plant and equipment

During 2025/26 the Trust did not receive any contributions in kind. During 2024/25 the Trust received from its Charity, a contribution of income in kind towards capital expenditure, total £139k

Note 15 Revaluations of property, plant and equipment

Land, buildings and dwellings were valued in March 2026 by qualified independent valuers Newmark Gerald Eve LLP. The assets were valued on a depreciated replacement cost basis due to the specialised nature of the asset. The RICS Red Book defines specialised property as:

"a property that is rarely, if ever, sold in the market except by way of a sale of the business or entity of which it is part, due to the uniqueness arising from its specialised nature and design, its configuration, size, location or otherwise".

A summary of the Impairments and revaluations with comparatives is shown in the table below -

	31st March 2026	31st March 2025
Impairments		
Taken to Reserves	6,361	7,339
Taken to SoCI	6,408	3,587
Total Impairments	12,769	10,926
Revaluations	3	672
Net (Impairment) / Revaluation	(12,766)	(10,254)

Note 16 Leases - Whittington Health NHS Trust as a lessee

The Trust has several leased premises which provide local healthcare facilities.

Note 16.1 Right of use assets - 2025/26

	Property (land and buildings)	Total	Of which: leased from DHSC group bodies
	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	49,664	49,664	43,687
Additions	1,062	1,062	1,062
Remeasurements of the lease liability	(4,176)	(4,176)	(4,176)
Disposals / derecognition	(390)	(390)	(390)
Valuation/gross cost at 31 March 2026	46,160	46,160	40,183
Accumulated depreciation at 1 April 2025 - brought forward	13,560	13,560	11,504
Provided during the year	4,931	4,931	4,111
Accumulated depreciation at 31 March 2026	18,491	18,491	15,615
Net book value at 31 March 2026	27,669	27,669	24,568
Net book value at 1 April 2025	36,104	36,104	32,183
Net book value of right of use assets leased from other NHS providers			108
Net book value of right of use assets leased from other DHSC group bodies			24,460

The Trust remeasures lease liabilities annually to reflect rent changes and lease term changes in compliance with IFRS16. During 2025/26, the Trust reflected one total disposal and two partial disposals of properties held as Right of Use assets. Negative rent movements were reflected for several further Right of Use assets in 2025/26 compared with values previously provided and accounted at 2024/25 financial year. These factors contributed to the reduction in Right of Use values shown above

Note 16.2 Right of use assets - 2024/25

	Property (land and buildings)	Total	Of which: leased from DHSC group bodies
	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	44,484	44,484	39,109
Additions	1,622	1,622	1,622
Remeasurements of the lease liability	3,558	3,558	2,956
Valuation/gross cost at 31 March 2025	49,664	49,664	43,687
Accumulated depreciation at 1 April 2024 - brought forward	8,370	8,370	7,170
Provided during the year	5,190	5,190	4,334
Accumulated depreciation at 31 March 2025	13,560	13,560	11,504
Net book value at 31 March 2025	36,104	36,104	32,183
Net book value at 1 April 2024	36,114	36,114	31,939
Net book value of right of use assets leased from other NHS providers			530
Net book value of right of use assets leased from other DHSC group bodies			31,653

Note 16.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 23.1.

	2025/26	2024/25
	£000	£000
Carrying value at 1 April	38,732	39,435
Lease additions	1,062	1,622
Lease liability remeasurements	(4,176)	3,558
Interest charge arising in year	485	825
Early terminations	(390)	-
Lease payments (cash outflows)	(6,444)	(6,708)
Carrying value at 31 March	29,269	38,732

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Income generated from subleasing right of use assets is £0k and is included within revenue from operating leases in note 4.

Note 16.4 Maturity analysis of future lease payments

	Of which leased from DHSC group bodies:		Of which leased from DHSC group bodies:	
	Total		Total	
	31 March	31 March	31 March	31 March
	2026	2026	2025	2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	4,814	3,063	5,395	3,622
- later than one year and not later than five years;	24,188	19,775	32,955	28,019
- later than five years.	671	266	848	389
Total gross future lease payments	29,673	23,104	39,198	32,030
Finance charges allocated to future periods	(404)	(356)	(466)	(403)
Net lease liabilities at 31 March 2026	29,269	22,748	38,732	31,627
Of which:				
Leased from other NHS providers		215		632
Leased from other DHSC group bodies		22,533		30,995

Note 17 Investments in associates and joint ventures

The Trust is a member of the all provider collaborative within North Central London. The collaborative comprises 14 partners (4 acute trusts, 3 specialist trusts, 2 community trusts, 3 mental health trusts, a GP provider alliance and UCL). The collaborative is funded through annual contributions from all 14 partners. At a Board meeting in September 2023, it was agreed that the UCL Health Alliance, previously a company limited by guarantee, would move into UCLP, effective 31st October 2023. The alliance was renamed from "UCL Health Alliance" to the "NCL Health Alliance".

Note 18 Inventories

	31 March 2026 £000	31 March 2025 £000
Drugs	0	1,309
Total inventories	0	1,309
of which:		
Held at fair value less costs to sell	-	-

From 1st April 2025, the Trust no longer records Pharmacy Drugs inventory. The value of £1,014k was charged directly to expenditure at March 2026, to reflect this revised accounting policy.

Inventories recognised in expenses for the year were £21,425k (2024/25: £19,116k). Write-down of inventories recognised as expenses for the year were £0k (2024/25: £0k).

Note 19.1 Receivables

	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables	22,744	21,348
Allowance for impaired contract receivables / assets	(6,805)	(4,757)
Allowance for other impaired receivables	(1,395)	(647)
Prepayments (non-PFI)	3,123	4,722
Interest receivable	231	191
PDC dividend receivable	16	479
VAT receivable	188	372
Other receivables	1,338	1,413
Total current receivables	19,441	23,122
Non-current		
Contract receivables	505	512
Other receivables	252	293
Total non-current receivables	757	805
Of which receivable from NHS and DHSC group bodies:		
Current	19,097	15,407
Non-current	252	293

Note 19.2 Allowances for credit losses

	2025/26		2024/25	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	4,757	647	4,188	647
New allowances arising	4,569	748	1,095	(91)
Reversals of allowances	(2,363)	-	(435)	91
Utilisation of allowances (write offs)	(158)	-	(91)	-
Allowances as at 31 Mar 2026	6,805	1,395	4,757	647

Note 20 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2025/26	2024/25
	£000	£000
At 1 April	46,276	68,548
Net change in year	9,087	(22,272)
At 31 March	55,363	46,276
Broken down into:		
Cash at commercial banks and in hand	860	404
Cash with the Government Banking Service	54,503	45,872
Total cash and cash equivalents as in SoFP	55,363	46,276
Total cash and cash equivalents as in SoCF	55,363	46,276

Note 20.1 Third party assets held by the trust

Whittington Health NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March	31 March
	2026	2025
	£000	£000
Bank balances	7	7
Total third party assets	7	7

Note 21.1 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables	40,418	31,429
Capital payables	21,391	6,365
Accruals	25,485	41,062
Social security costs	4,283	3,580
Other taxes payable	4,386	4,205
Pension contributions payable	4,806	4,477
Other payables	637	119
Total current trade and other payables	101,406	91,238
Non-current		
Total non-current trade and other payables	-	-
Of which payables from NHS and DHSC group bodies:		
Current	22,017	15,194
Non-current	-	-

Note 22 Other liabilities

	31 March 2026 £000	31 March 2025 £000
Current		
Deferred income: contract liabilities	1,816	2,216
Total other current liabilities	1,816	2,216
Non-current		
Total other non-current liabilities	-	-

Note 23.1 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Loans from DHSC	116	116
Lease liabilities	4,809	5,395
Total current borrowings	4,925	5,511
Non-current		
Loans from DHSC	1,276	1,392
Lease liabilities	24,460	33,337
Total non-current borrowings	25,736	34,729

Note 23.2 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Lease Liabilities £000	Total £000
Carrying value at 1 April 2025	1,508	38,732	40,240
Cash movements:			
Financing cash flows - payments and receipts of principal	(116)	(6,209)	(6,325)
Financing cash flows - payments of interest	(41)	(235)	(276)
Non-cash movements:			
Additions	-	1,062	1,062
Lease liability remeasurements	-	(4,176)	(4,176)
Application of effective interest rate	41	485	526
Early terminations	-	(390)	(390)
Carrying value at 31 March 2026	1,392	29,269	30,661

	Loans from DHSC £000	Lease Liabilities £000	Total £000
Carrying value at 1 April 2024	1,624	39,435	41,058
Prior period adjustment	-	-	-
Carrying value at 1 April 2024 - restated	1,624	39,435	41,058
Cash movements:			
Financing cash flows - payments and receipts of principal	(116)	(5,883)	(5,999)
Financing cash flows - payments of interest	(43)	(825)	(868)
Non-cash movements:			
Additions	-	1,622	1,622
Lease liability remeasurements	-	3,558	3,558
Application of effective interest rate	43	825	868
Carrying value at 31 March 2025	1,508	38,732	40,240

Note 24.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Redundancy £000	Other £000	Total £000
At 1 April 2025	1,594	263	195	-	23,207	25,259
Transfers by absorption	-	-	-	-	-	-
Change in the discount rate	8	2	-	-	(110)	(100)
Arising during the year	(99)	103	(90)	657	3,620	4,191
Utilised during the year	(182)	(36)	(45)	-	(33)	(296)
Reversed unused	-	-	-	-	(9,385)	(9,385)
Unwinding of discount	44	11	4	-	854	913
At 31 March 2026	1,365	343	64	657	18,153	20,582
Expected timing of cash flows:						
- not later than one year;	184	35	-	-	6,981	7,200
- later than one year and not later than five years;	1,181	308	64	657	11,172	13,382
- later than five years.	-	-	(0)	-	0	0
Total	1,365	343	64	657	18,153	20,582

Principal changes and additions in the financial year are as follows:-The Trust entered into a Private Finance Initiative (PFI) arrangement in 2003 to build and maintain the main hospital through construction firm Whittington Facilities Ltd (WFL). On the 28th July 2020 WFL filed for administration. The collapse of WFL means that the main building has transferred back into the ownership of the Trust, whereby the Trust is now responsible for the maintenance of the building, including the cost of major fire safety refurbishments for which WFL are being pursued under the terms of a 30-year contract. As a result of this dispute with WFL, legal proceedings have commenced. There will be a significant cost of rectifying building deficiency not appropriately addressed by WFL. This provision has been reviewed and revised in line with the most up to date legal and other professional advice.

The legal position is not concluded on the PFI claim and the final outcome is not yet known. The current provision is based upon the Trust's best estimate, but the final settlement of the PFI claim could be higher or lower than estimated. Any accounting provision thus made is intended to reflect the material uncertainty around the situation which existed as at 31 March 2025, and should not be taken as admission of any liability on the part of the Trust.

Note 24.2 Clinical negligence liabilities

At 31 March 2026, £149,945k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Whittington Health NHS Trust (31 March 2025: £148,400k).

Note 25 Contractual capital commitments

	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	5,794	3,375
Total	5,794	3,375

Note 26 Financial instruments

Note 26.1 Financial risk management

Financial reporting standard IFRS7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. As a result of the continuing service provider relationship that the Trust has with Integrated Care Board (ICB) and the way the ICB is financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds, and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by Lancashire Teaching Hospitals NHS Foundation Trust (trading as East Lancashire Financial Services) in conjunction with the Finance Department, within the parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. The Trust's treasury activity is subject to review by the Trust's internal auditors as part of a scheduled programme, and also by executive / non-executive / external audit colleagues as the need arises.

Currency Risk

The Trust is principally a domestic UK-based organisation with the majority of transactions, assets and liabilities originating from the UK and denominated in Sterling. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

Borrowings are for 1 - 25 year in line with the associated assets, and interest is charged either at the rate set per the loan agreement, or at the National Loans Fund rate in the absence of such an agreement. The Trust therefore has low exposure to interest rate fluctuations. The Trust may also borrow from government for revenue financing, subject to approval by NHS England & related bodies. Interest rates are confirmed by DHSC (the lender) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

The majority of the Trust's revenue arises from contracts with other public sector bodies, therefore the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2026 are in receivables from customers, as disclosed in the Trade & Other Receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Integrated Care Boards (ICBs), which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its Prudential Borrowing Limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 26.2 Carrying values of financial assets

	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2026		
Trade and other receivables excluding non financial assets	16,618	16,618
Cash and cash equivalents	55,363	55,363
Total at 31 March 2026	71,981	71,981

	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2025		
Trade and other receivables excluding non financial assets	17,476	17,476
Cash and cash equivalents	46,276	46,276
Total at 31 March 2025	63,752	63,752

Note 26.3 Carrying values of financial liabilities

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2026		
Loans from the Department of Health and Social Care	1,392	1,392
Obligations under leases	29,269	29,269
Trade and other payables excluding non financial liabilities	85,418	85,418
Total at 31 March 2026	116,079	116,079

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2025		
Loans from the Department of Health and Social Care	1,508	1,508
Obligations under leases	38,732	38,732
Trade and other payables excluding non financial liabilities	76,473	76,473
Total at 31 March 2025	116,713	116,713

Note 26.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2026 £000	31 March 2025 £000
In one year or less	90,343	81,984
In more than one year but not more than five years	24,924	33,801
In more than five years	812	929
Total	116,079	116,714

Note 27 Losses and special payments

	2025/26		2024/25	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Bad debts and claims abandoned	41	158	121	83
Total losses	41	158	121	83
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	5
Ex-gratia payments	7	48	4	45
Total special payments	7	48	5	50
Total losses and special payments	48	206	126	133
Compensation payments received				

Note 28 Related parties

The Department of Health & Social Care (DHSC) is considered a related party. During the year the Trust has had a significant number of material transactions with the Department and with other entities for which the Department is the parent Department. The table below shows the net result of the material transactions within the DHSC group.

The Trust has two wholly-owned subsidiaries, Whittington Pharmacy CIC and Whittington Health Charity. Neither organisation is consolidated within these Accounts. A number of Whittington Health board members have a related party interest within these subsidiaries. The following figures represent the draft financial positions of each entity: The Pharmacy CIC's income for the financial year 2025-26 was £5,068k and expenditure £5,054k. Total receivables balance was £1,347k and payables balance was £472k at 31st March 2026. The Charity's total income was £1,329k and expenditure £1,479k, total receivables £1k and payables £343k.

	Income (£000s)	Expenditure (£000s)	Receivables (£000s)	Payables (£000s)
NHS North Central London ICB	405,341	-	8,685	-
NHS England (statutory entity)	31,212	7	327	33
NHS North West London ICB	13,689	-	133	-
NHS North East London ICB	10,965	-	498	-
Royal Free London NHS Foundation Trust	5,193	3,595	4,258	4,205
University College London Hospitals NHS Foundation Trust	2,220	4,571	2,802	12,200
NHS Hertfordshire and West Essex ICB	1,772	-	74	-
North London NHS Foundation Trust	1,183	1,885	635	3,017
Moorfields Eye Hospital NHS Foundation Trust	1,167	4	432	4
Barts Health NHS Trust	1,017	17	289	25
NHS South East London ICB	905	-	-	-
East London NHS Foundation Trust	825	-	441	-
NHS South West London ICB	516	-	4	-
Central and North West London NHS Foundation Trust	324	128	155	196
NHS Mid and South Essex ICB	280	-	48	-
NHS Bedfordshire, Luton and Milton Keynes ICB	237	-	-	-
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	201	-	-	-

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of the material transactions have been with:

	Income (£000s)	Expenditure (£000s)	Receivables (£000s)	Payables (£000s)
Islington London Borough Council	9,498	1,900	1,064	0
Haringey London Borough Council	305	22	390	0
Hackney London Borough Council	154	0	132	0
NHS Blood & Transplant	0	3,297	0	0

Note 30 Better Payment Practice code

	2025/26	2025/26	2024/25	2024/25
	Number	£000	Number	£000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	53,134	238,090	62,171	234,840
Total non-NHS trade invoices paid within target	50,890	225,342	60,205	222,990
Percentage of non-NHS trade invoices paid within target	95.8%	94.6%	96.8%	95.0%
NHS Payables				
Total NHS trade invoices paid in the year	2,310	23,661	2,838	24,909
Total NHS trade invoices paid within target	2,011	20,386	2,578	21,673
Percentage of NHS trade invoices paid within target	87.1%	86.2%	90.8%	87.0%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Note 31 Capital Resource Limit

	2025/26	2024/25
	£000	£000
Gross capital expenditure	46,435	29,802
Less: Disposals	(390)	-
Less: Donated and granted capital additions	-	(139)
Charge against Capital Resource Limit	46,045	29,663
Capital Resource Limit	46,045	29,663
Under / (over) spend against CRL	-	-

Note 32 Adjusted financial performance

	2025/26	2024/25
	£000	£000
Surplus / (deficit) for the period per SOCI	(4,437)	(16,631)
Remove net impairments not scoring to the departmental expenditure limit	6,408	3,587
Remove I&E impact of capital grants and donations	66	(78)
Adjusted financial performance surplus / (deficit)	2,038	(13,122)

Note 33 Breakeven duty financial performance

	2025/26
	£000
Adjusted financial performance surplus / (deficit)	2,038
Breakeven duty financial performance surplus / (deficit)	2,038

Note 34 Breakeven duty rolling assessment

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	139	508	1,120	3,614	1,165	(7,342)	(14,788)	(3,670)
Breakeven duty cumulative position	139	647	1,767	5,381	6,546	(796)	(15,584)	(19,254)
Operating income	176,853	186,300	278,212	281,343	297,397	295,007	294,211	309,255
Cumulative breakeven position as a percentage of operating income	0.1%	0.3%	0.6%	1.9%	2.2%	(0.3%)	(5.3%)	(6.2%)

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	6,158	29,362	1,568	2,370	511	6,638	606	(13,122)	2,038
Breakeven duty cumulative position	(13,097)	16,266	17,834	20,204	20,715	27,353	27,960	14,838	16,876
Operating income	323,394	348,646	350,183	395,340	408,948	431,557	465,818	500,384	530,415
Cumulative breakeven position as a percentage of operating income	(4.0%)	4.7%	5.1%	5.1%	5.1%	6.3%	6.0%	3.0%	3.2%

Staff costs				
	Permanent	Other	2025/26 Total	2024/25 Total
	£000	£000	£000	£000
Salaries and wages	275,129	21,062	296,191	281,469
Social security costs	34,988	-	34,988	26,706
Apprenticeship levy	1,442	-	1,442	1,369
Employer's contributions to NHS pension scheme	54,920	-	54,920	50,300
Pension cost - other	-	-	-	-
Other post employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	281	-	281	-
Temporary staff	-	3,226	3,226	13,210
Total gross staff costs	366,760	24,288	391,048	373,054
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	366,760	24,288	391,048	373,054
Of which				
Costs capitalised as part of assets	484	100	584	597

Average number of employees (WTE basis)				
	Permanent	Other	2025/26 Total	2024/25 Total
	Number	Number	Number	Number
Medical and dental	587	28	615	610
Ambulance staff	-	-	-	-
Administration and estates	1,257	147	1,404	1,401
Healthcare assistants and other support staff	737	110	847	876
Nursing, midwifery and health visiting staff	1,369	132	1,501	1,502
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	953	40	993	1,012
Healthcare science staff	-	-	-	-
Social care staff	-	-	-	-
Other	-	-	-	-
Total average numbers	4,903	457	5,360	5,401
Of which:				
Number of employees (WTE) engaged on capital projects	7	1	8	8

Reporting of compensation schemes - exit packages 2025/26

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	2	9	11
£10,000 - £25,000	1	4	5
£25,001 - 50,000	1	2	3
£50,001 - £100,000	4	3	7
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	8	18	26
Total cost (£)	363,000	394,000	£757,000

Reporting of compensation schemes - exit packages 2024/25

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	1	3	4
£10,000 - £25,000	1	-	1
£25,001 - 50,000	2	1	3
£50,001 - £100,000	3	-	3
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	7	4	11
Total resource cost (£)	£320,000	£35,000	£355,000

Exit packages: other (non-compulsory) departure payments

	2025/26		2024/25	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	6	281	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	12	113	4	35
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT / DHSC approval	-	-	-	-
Total	18	394	4	35
Of which:				
Non-contractual payments requiring HMT / DHSC approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF WHITTINGTON HEALTH NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Whittington Health NHS Trust ("the Trust") for the year ended 31 March 2026 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2026 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State for Health and Social Care with the consent of HM Treasury on 23 June 2022 as being relevant to NHS Trusts in England and included in the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Trust's services or dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the directors' conclusions, we considered the inherent risks associated with the continuity of services provided by the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the directors' assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an

opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls in particular the risk that Trust management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the funding provided to the Trust during the year. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

We also identified a fraud risk related to the completeness of accrued expenses. We considered that there may be an incentive for management to misstate accruals in order to report financial performance that was in line with the financial control totals delegated to the Trust. We assessed this to be most likely occur through omitting certain accruals.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included those posted to unusual accounts combinations and other unusual journal characteristics.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Assessed a sample of payments made after the year end in order to assess whether they had been recorded in the correct accounting period.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Trust is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the Trust is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws (GDPR), fraud, corruption and bribery legislation, and employment law, recognising the nature of the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the directors and other management

and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The directors are responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2025/26.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 177, the directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 176 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered

material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 176, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(2A) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we make written recommendations to the Trust under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Board of Directors of Whittington Health NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of Directors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Directors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2026 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of Whittington Health NHS Trust for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the NAO Code of Audit Practice.



Dean Gibbs
for and on behalf of KPMG LLP
Chartered Accountants
15 Canada Square
London
E14 5GL

DATE: 29 June 2026

ICARE EQUITY



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