NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 17 July 2026, 10:00 a.m.
Alex House, Level 1, Collaboration Room
10 Station Road, Wood Green, London, N22 7TR

Contact: Fola Irikefe, Principal Scrutiny Officer

E-mail: fola.irikefe@haringey.gov.uk

Councillors: Zahra Beg and Caroline Stock (Barnet Council), Larraine Revah and Arun Kumar (Camden Council), Alev Cazimoglu and Chris Joannides (Enfield Council), Lucia das Neves (Haringey Council), Joseph Croft and Kiran Prasad (Islington Council).

Quorum: 4 (with 1 member from at least 4 of the 5 boroughs)

AGENDA

1. ELECTION OF CHAIR

To elect the Chair of the Committee for the 2027/27 municipal year.

2. ELECTION OF VICE-CHAIR(S)

To elect the Vice-Chair(s) of the Committee for the 2026/27 municipal year.

3. FILMING AT MEETINGS

Please note this meeting may be filmed or recorded by the Council for live or subsequent broadcast via the Council's internet site or by anyone attending the meeting using any communication method. Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on. By entering the 'meeting room', you are consenting to being filmed and to the possible use of those images and sound recordings.

The Chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual, or may lead to the breach of a legal obligation by the Council.

4. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

5. URGENT BUSINESS

The Chair will consider the admission of any late items of Urgent Business. (Late items will be considered under the agenda item where they appear. New items will be dealt with under item 10 below).

6. DECLARATIONS OF INTEREST

A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and
(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Register of Members' Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interests are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct

7. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

To consider any requests received in accordance with Part 4, Section B, paragraph 29 of the Council's constitution.

8. MINUTES (PAGES 1 - 10)

To confirm and sign the minutes of the North Central London Joint Health Overview and Scrutiny Committee meeting on 9th March 2026 as a correct record.

9. NCL JHOSC MEMBERSHIP & TERMS OF REFERENCE (PAGES 11 - 18)

To note the membership and Terms of Reference for the North Central London, Joint Health Overview and Scrutiny Committee 2026/27.

10. WEST & NORTH LONDON ICB UPDATE (PAGES 19 - 48)

The Committee should consider the update of the merger of the North Central London (NCL) and North West London (NWL) Integrated Care Board (ICB) and now to be known as West and North London ICB.

11. WORK PROGRAMME

This paper provides an outline of items for consideration as part of the 2026/27 work programme for the North Central London Joint Health Overview and Scrutiny Committee.

12. WHITTINGTON HEALTH NHS TRUST QUALITY ACCOUNT (PAGES 49 - 154)

The Committee is required to consider and comment on Whittington Health NHS Trust Quality Account.

13. NEW ITEMS OF URGENT BUSINESS

14. DATES OF FUTURE MEETINGS

To note the dates of future meetings:

18 September 2026
27 November 2026
29 January 2027
19 March 2027

Fola Irikefe, Principal Scrutiny Officer
Email: fola.irikefe@haringey.gov.uk

Fiona Alderman
Head of Legal & Governance (Monitoring Officer)
George Meehan House, 294 High Road, Wood Green, N22 8JZ

Thursday, 9 July 2026

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Agenda Item 8

MINUTES OF MEETING NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON FRIDAY 9TH MARCH 2026, 10.00am - 13.00pm

IN ATTENDANCE:

Councillors Pippa Connor (Chair), Paul Edawrds, Larraine Revah (Vice-Chair) and Matt White.

Substitute for Councillor Jill Seargent was in attendance as a substitute for Councillor Philip Cohen.

ALSO IN ATTENDANCE:

- Jo Baty, Director of Adult Social Care, Haringey Council
- Natasha Benn, Chair, Joint Partnership Board
- Richard Dale, Chief Strategy Officer, NWL & NCL ICB
- Fola Irikefe, Principal Scrutiny Officer
- Chloe Morales Oyarce, Head of Communications and Engagement
- Sarah Morgan, Chief People Officer
- Sara Suttun, Corporate Director for Adults, Housing and Health, Haringey Council

Attendance Online

- Councillors Kemi Atolagbe and Tricia Clark

FILMING AT MEETINGS

Members present were referred to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'. The Chair informed those present that the meeting was being recorded for the purpose of accuracy.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Philip Cohen, Chris James and Andy Milne.

URGENT BUSINESS

None.

DECLARATIONS OF INTEREST

The Chair declared an interest in that she was a member of the Royal College of Nursing and also that her sister was a GP in Tottenham.

DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

The Committee received a deputation from Alan Morten of Haringey Keep Our NHS Public (KONP) that focussed on the Governments 10 Year Plan, NLC ICB staffing and funding costs and the future of NCL JHOSC. The deputation emphasised that the ideas within the 10-Year Plan were great but there was very little detail to go with the aspirations put forward. Alen Morten expressed that there was common knowledge that there is no new funding available and that the ICB would be becoming more of a growing a strategic commissioner and therefor removed from the problems for each locality.
The deputation also covered the issue of digitisation, acknowledging that there are benefits but questions the aspirations of the Federated Data Platform (FDP) and Secure Data Environment (SDE) and what will be done with the publics data. A Financial Times article highlighting the links between NWL ICS and links to Global Council was also a concern given that NCL was in the process of merging with them.

Alan Morten highlighted that big data companies buying up small data start up and creating a monopoly and this is against the interests of the general public. The ask from Haringey KONP is for the JHOSC to seek assurance that data is used the benefit of residents and not for large data companies. Haringey KONP is further exasperated by the fact that the Integrated Care System will be dealing with a larger population once merged.

Richard Dale, Chief Strategy Officer, NWL & NCL ICB explained that will come back regarding digital and data as part of the overall strategy piece (**Follow Up**). The Chief Strategy Officer briefed that the London Care Record has been in place for up to 5 years, lots of use with clinicians who can read peoples care records, held securely in NHS environment. Amazon web services and Google clous is also use by a number of Trusts and there are clauses in place to ensure that the data can’t be used outside of NHS environment.

It was explained further that FDP is a nationally procured platform and available for Trusts to use and it’s up to each Trust to take a judgment about choosing to use it. The Chair acknowledged the difference between where this sits with the providers as opposed to the ICB. **Recommendation:** The committee to ask hospitals within the JHOSC area if they are using Palantir to run their data sourcing for them and if not, what was the reason behind their choice not to use them.

Councillor Connor asserted that the JHOSC can ask for information around data protection and information governance policies with the ICB as part of their role in managing their data responsibilities and carrying our risk assessments related to the data platforms, so they are not completely removed from the process. In essence, Councillors on the JHOSC can scrutinise how the ICB is managing its data responsibilities and not whether Trusts are/are not utilising the system to which the Chief Strategy Officer, ICB confirmed.

Councillor White expressed relief over the information provided regarding who would have to access the system and the data, however, on reflection of the post office scandal the provider was able to access information that they weren’t supposed to. Councillor White enquired over how we get assurance in view of the fact the data platform is provided by a large company not based in the UK. The Chief Strategy Officer responded and expressed that there is extensive due diligence, and the

platform is bound by the laws in the UK and each Trust utilising the services should also be carrying out their own due diligence. Councillor White said ultimately, he was not re-assured that our data would be protected. **Follow Up**: The Chair concluded that once the information is retrieved by various Trusts on if they are using the platform, the next stage would be to contact NHS England and express concerns and seek re-assurances that our resident's data was being protected.

Concillor Connor put a question to Haringey KONP about when Palantir Technology is mentioned whether the concern is that the data will be taken form from a secure data service and that the company. The Chair enquired about what evidence is being drawn on to highlight the concerns. Alan Norton expressed that there is concern but it isn't based on any individual information but is based on the owners of these companies. Europe is trying to set up their own alternative – Eurostack. Mr Norton also reported that Palantir also acquired a contract from the Ministry of Defence without any competition and herein lies the problem.

Councillor Revah agreed with Councillor White's comments and sought clarity around digital inclusion as not everyone has a smart phone, and this could lead to a significant number of people falling through the gap. The Chief Strategy Officer confirmed that face-to-face and letter communication was still in place and also needs to be improved alongside the development of neighbourhood working.

Councillor Edwards enquired about what kind of information companies may wish to access and what could be the penalties they could possibly face. The Chief Strategy Officer explained using that through the cloud service data is stored and stays within the UK for the Trusts, there are specific controls and UK law and the ICB has a data access committee which provides oversight.

The Chair thanked the deputation.

MINUTES

Health Inequalities

The Chair explained that in relation to the Health Inequalities item she had enquired about the Rise Project as it was based in Haringey and the website didn't have up to date information which was key for those wishing to access the service and on reviewing the site again this week, the last event for 'sister circle' was still showing as 2019.

Royal Free & North Mid merger

In relation to the item on the Royal Free merger with North Mid, clarity about savings plans in its entirety and what makes up the deficit and is causing it and should form an action when considering finances in 2026/27.

Work programme 2026/27

In terms of the new mental health unit at Chase Farm and maternity service at the North Mid, the action should be considered on the future work programme as not enough information was provided at the time.

Terms of reference

In relation to the committee's terms of reference, these were accepted and agreed the current approach to administering the meetings with officers rotating so it could go through due to the challenges of agreeing to funding support arrangements, However, the Committee also agreed that the approach was not sustainable as the officer may at times be from a different borough to the Chair. It was decided that a letter from all the NCL JHOSC members should go out in future with all members signing it.

ACTION TRACKER

To follow up on the following:

- Palantir – amber
- North Middx and Royal Free Merger – amber
- St Pancreas engagement – to be kept updated about the outcomes
- Financial Update – Royal Free and North Mid, to ensure the actions as highlighted above that can come as part of usual annual finance update in year.

NHS 10 YEAR HEALTH PLAN AND NEIGBORUHOOD HEALTH DELIVERY

Richard Dale, Chief Strategy Officer, NWL & NCL ICB briefed the committee that the presentation provided a summary of current progress and that they would be finalising broader plans over the summer. There have been ongoing conversations about moving care from hospitals to communities, whilst ensuring that diverse needs are met. The neighbourhood health approach focusses on the involvement of carers and families as part of the process all whilst considering the concerns about recruitment and retaining community-based staff.

The objective is for technology to enhance and support care whilst also retaining the offline option. Key for digital services is to use data to better understand those with greater needs and inequalities and in view of this, tailor services This will be delivered through Neighbourhood Health focussing on adults with complexities and long-term conditions. Data will be used for early diagnosis and proactive treatment. The shared patient record is important and key to seamless care. In terms of preventing ill heath, this is the priority and working better with the voluntary and community sector will support this. The conversations with the public will continue throughout.

Richard Dale also highlighted the changing role of the ICB, as part of the merger of NCL and NWL ICB which is driven by the need to deliver a 50% reduction in running costs. At the centre of the Neighbourhood Health model is multi-disciplinary teams that work alongside existing health services and to move into this space they are now working with Integrators in each borough building on the work on the Inequalities Fund and how it can be scaled up.

The Chair expressed the importance of a joined-up conversation with regards to this and hence the importance of having Jo Baty, Director of Adult Social Care, Haringey Council and Sara Suttun, Corporate Director for Adults, Housing and Health, Haringey Council involved in the discussions relating to the10 Year Plan. The Chair enquired about the neighbourhood offer which residents reported as being confused

by what was on offer and who was doing what. She further sought to know what will change in the light of the merger and how will local focus be retained. The Chief Strategy Officer, NWL & NCL ICB expressed the need to have a clear road map and working with Integrators to understand all the community assets, primary care has specialist social prescribers will help with some of the navigation. Corporate Director for Adults, Housing and Health, Haringey Council explained that we are in the process of developing the Neighbourhood Plan which would be signed off by the Health and Wellbeing Board and as part of this work the voluntary and community sector is already integrated into the planning work.

The Chief Strategy Officer explained that a communication subgroup had been set up where all the organisations are represented in order to be able to pick up how we ensure consistent communication, knowing who is taking the lead and how the information gets out to the community. In Haringey, the capacity building a strong offer through the voluntary and community sector organisations. There is a need to strengthen the direct communication with residents and using other organisations to facilitate it.

The plan is to develop alongside ICB infographics exploring ‘what are neighbourhoods and what changes will be seen on the ground. In Haringey there is already a Multi-Agency Care Coordination Team (MAC) who are working on identifying target cohorts and how to work and co-produce with residents. There is also a community prevention strand to the work to co-produce priorities and the communications sub-group is ultimately working closely with the workforce who will deliver.

Councillor Connor enquired that if the right messaging is going to the workforce, from strategic position what will be done to ensure the information is seamless across all the boroughs to ensure everyone is getting the correct information. The Chief Strategy Officer explained that each borough has a communications programme and they are now reviewing their commissioning processes and developing a shared understanding of who is the most vulnerable in the community through partners and neighbourhood working.

Councillor Revah enquired over how they will we ensure that some people don’t get left behind as they were during covid and it was explained that the gaps in the data have been closed and so there is a better understanding of the more isolated members of the community. Work was also carried out with the London Care Record regarding the definition of a care team. Councillor Revah expressed scepticism about whether people would really be reached.

The Chief Strategy Officer emphasised that as things come together well Neighbourhood Health Plans will actually be better at reaching people who are harder to reach. On enquiry about how information will be shared with social care within the new model, the Director of Adult Social Care, Haringey Council explained we come together in different forums already and this will be more efficient way of doing this e.g. MARAC, opportunity to work better with community activists who work with the most vulnerable community members. The new way of working has come together due to depleted resources, but it means that all agencies will now be working more efficiently.

The Chair commented that Baroness Casey is currently looking into the independent commissioning of adult social care where she is concerned about the separate health and social care services and funding and impact on equalities. The Chair enquired if work was underway exploring adult social care and NHS funding and how they could be funded together. The Chair enquired over what would be done once Barness Casey's report proposes and aligns with joint commissioning. The Chief Strategy Officer expressed that interface between social care and health is critical including the Better Care Funding and there is already joint support and that more joined up work was something that they were looking into. The committee heard that as part of the joint review process, conversations will take place with all the local authorities about how to increase joint work in advance of the publication of the outcomes.

The Chair explained the governance structure needed clarity in terms of where the Adult Social Care Directors amongst the boroughs would sit on the board and whether it would be one borough representing all the 13 boroughs amongst NCL and NWL. Richard Dale explained that one of the Leaders and a Chief Executive is on the board presently and discussions are ongoing about how things will work.

The Corporate Director for Adults, Housing and Health explained that the Haringey Team is Better Care Funded (BCF) already so this will now be expanded into Neighbourhood teams. The committee heard that in2027/28 there will be a piece on borough partnerships and there may need to change the local decision routes and Health and Wellbeing boards will be strengthened as where Neighbourhood Plans and decisions on funding will take place with then. **Action:** The Chair expressed that a follow up piece on the strengthened role of the Health and Wellbeing Board and pooled budgets would be helpful.

Councillor Seargent informed the committee about a neighbourhood approach in Graham Park in Barnet where residents were unaware of social prescribing and the benefits and lacked clarity regarding if they should go to GPs or hospitals at any given time Councillor Sergeant also asked about Integrators. The Chief Strategy Officer explained that Integrators are existing organisations in each borough taking on additional responsibilities to draw people together. There will be funding invested in the neighbourhood delivery process but not directly to the organisations. **Recommendation:** Given that there is no further funding, further information on how they are progressing and how they are delivering more for less though Integrators will be something that the Committee needs to consider in more detail as they progress.

The Corporate Director for Adults, Housing and Health explained that there aren't additional contracts but there are memorandums of understanding to formalise and strengthen the way of working. It was also highlighted that not all authorities are taking the lead. **Action**: What is the impact on the developing relationship where there are authorities not taking the lead? The chair expressed that this could be explored with two authorities with opposing approaches, one which is heavily involved and one with a more hands off approach.

Councillor Atolagbe enquired which other ICBs they were working with due to data concerns and GDPR and what was being done for hard-to-reach groups. The Chief Strategy Officer responded that extensive work across all the London ICB's takes place in terms of data sharing and hence why the London Care Record was put in place and there is a data sharing agreement as Londoners are mobile and may need to access services away from home etc. In terms of working with communities that don't always access services and the approach, the are no longer saying the individuals are 'hard to reach' but that some services are not designed appropriately. Neighbourhood health will be looking at how we provide better tailored services and do things differently in future. For example, the longest waiters in terms of elective care are those from deprived communities on zero hours contracts so this is something that needs to be addressed.

The Chair of the Joint Partnership Board responded that in terms of bringing local communities and the voluntary sector is brilliant at supporting the interests of people, however she raised concerns in respect of training and particularly when looking at things from an intersectional perspective. It was enquired over what was being done in respect of unconscious bias so that the voluntary and community sector and the Integrators have a sense of how to see things from another person's perspective and this is particularly key for the Integrators. The Chief Strategy Officer explained that some work had been carried out with the voluntary and community sector about viewing people as individuals and health equity is at the core of the strategy and it needs to be further refined into polices and in turn training and development. **Action:** ICB colleagues to seek advice about how to include the expertise of the Joint Partnership Board.

The Chair expressed her concerns about the idea of virtual wards and ultimately the impact on the carer and explained that an audit was requested to look at how they are coping in this role as they are unpaid careers, picking up the burden. The Chief Strategy Officer explained that work is currently underway monitoring the impact on carers and explained that the terminology 'virtual wards' is also unhelpful as it enraptures acute care being delivered by professionals in people's homes. **Action:** work carried out to come back on virtual wards.

The Chair asked colleagues in social care if they were aware of an additional ask to carers in a rehabilitation route. The Director of Adult Social Care, Haringey Council explained the Carers Strategy was being implemented aware of concerns with discharge and big ask to do more. The Chair of the Joint Partnership Board explained that they were trying to make sure carers were actively involved and in the room in terms of developing governance around strategy. Involving various sectors of the local authority and linking in with unpaid carers, GPs, social care, housing and other key services to ensure a holistic approach was also important.

Councillor Revah expressed that disabilities haven't been mentioned in the paper and it is important. Councillor Revah further emphasised that given carers don't have formal training and enquired how it was being monitored. Sarah Morgan, Chief People Officer, NCL & NWL ICB as part of the People Strategy for NCL, they had identified one hundred thousand unpaid carers and work was done through the five councils looking at supporting unpaid carers and in NWL they are currently looking at unpaid workers packages. **Action:** Look at where this work has now got to from the

Peoples Strategy and pick up on the work undertaken in NWL and whether it can be implemented in NCL.

Councillor Sergeant raised the point that although there are unpaid carers, there are also people who don't have unpaid carers as well, socially isolated people and enquired whether there was any work being carried out for identifying people who may fall through the net before they are left with caring role. Richard Dale agreed and that neighbourhood teams will address these first in terms of the neighbourhood work. The Chair expressed that there seemed to have been some excellent work from the MAC and it would be useful to know if it was sustainable financially and could be rolled out across the five boroughs.

The Chair of the Joint Partnership Board briefed that there were also isolated people without carers and whether any work has been done in terms of people with unfit and abusive careers? The Chief Strategy Officer expressed that if the work with partners comes together well then this will give greater insight into the more complex type of relationships. The closest model is the MAC team although its presently more clinical than what they envisage, it is the closest thing to the neighbourhood model that they plan for. The plan over the summer is looking at how to scale the model across all the boroughs. **Action.**

NCL & NWL ICB MERGER & CHANGE UPDATE

Sarah Morgan, Chief People Officer opened the item explaining that it was this time a year ago the process began for reducing costs of the ICB by fifty percent and process to merge NWL and NCL as a strategic commissioner. The merger will take place by 1 April 2026 subject to approval by NHS England to create West and North London Integrated Care Board and a £12 billion commissioning budget and 48% of London's population.
The model ICB blueprint will include continued commissioning for outcomes around strategic commissioning from the workforce perspective and the development of the Neighbourhood Workforce Strategy and work in health. Operating model relationship, need greater caution around this and no gaps within the transition process. The ICB's role is to commission services for the population and ensure there is strategic direction and this has been an important role. Relationship with providers will be changing especially in terms of holding to account. The Close down board meeting will be on 24 March with the merged inaugural meeting on 1 April. The public board meetings in July will cover their Engagement Strategy to shape where they are as an organisation to move forward.

Councillor Revah enquired if change would mean a named relationships with key people for the borough will change? The Councillor expressed concerns about how things will work locally and in response it was explained that it was dependant on the issue for example some issues will be relevant for the ICB whilst others will be the Integrator etc. Councillor Revah requested a list of who would be the key people are once things are established and it was confirmed it could be done. **Action**.

Councillor White made the comment that if the Integrators will work differently in different boroughs in terms of contacts and the reality will be that some things work better in different boroughs depending on the area. The Chief People Officer

concurred that NCL and likewise NWL will have strengths and weaknesses in the way things are done, and the next steps will be to learn from the merged organisation.

Rod Wells, Haringey KONP expressed that from both a patients and governance point of view there needs to be a list of the different responsibilities from April 2026 with the significant changes. Some clarity on responsibility of ICB, Integrators would also be helpful. Rod Wells also enquired if the two JHOSC's would remain separate to which the Chair confirmed they would be.

Councillor Atolagbe enquired about what work and areas will be compromised as described in the paper. The councillor asked if they had a rough figure of how many would go for voluntary redundancy and would the saving make an impact and then this will be followed by recruitment and what impact would that then have? The Chief People Officer explained that focus will be on statutory requirements but there have been cuts in other areas and recruitment will be from for internal staff from a ringed pool of people. It was explained work was still underway and so they didn't know where the gaps were. Councillor Connor expressed that Trusts will now essentially be marking their own homework and the Chief People Officer explained that this was already happening. **Action**: A future paper marking out who has responsibility for various elements between the Trusts, ICB and NHS England will be useful.

Councillor Clarke expressed that's she was surprised given the meeting of the merged board is to be held on 1 April, knowledge of who will sit on the board is still unavailable. The Chief People Officer explained that there are conversations with the local authorities taking place regarding who will sit on the Board amongst the thirteen boroughs.

Councillor Connor enquired about continuing healthcare funding and different boroughs allocated different amounts and whether the ICB will be allocating all the boroughs the same amount with a one size fits all approach? Sarah Morngan explained that this was an ongoing piece of work looking across the 13 boroughs and how to split it as lead by the Chief Nurse. The Committee heard that they had not worked out the impact of Fair Funding Deal.

The Chair summarised that the JHOSC had an overview but the detail with regards to how the Integrators will work with the Health and Wellbeing Board, how information is fed to the top level to influence the strategic commissioning are amongst the areas the JHOSC will seek further assurance on going forward. Understanding the operational model in more detail will also be key. From the perspective of the JHOSC another key consideration is how we ensure we get the right people into meetings in order to ensure accountability and where the JHOSC sits with the governance structure.

The Chair of the Joint Partnership Board enquired over when budget is being considered for service, if guidelines are used for levelling up or is it a different approach. The Chief Strategy Officer explained that this is the area to come back to, nationally the funding formula is based on deprivation and the core offer for services such a mental health and community services is across the board for all authorities. Following the core offer they will then look at what else can be done for specific

communities and hence working with the VCS. Additional funds have also been allocated for hitting waiting lists and A&E targets.

WORK PROGRAMME

The Chair of the Joint Partnership Board explain the work of the Joint Strategic Board as a co-production group that helps to review issues in the borough, represent various groups including the older people's reference group, dementia, physical disabilities, autism to name a few and address intersectionality. The Chair expressed the desire for formal recommendation to attend all future meetings as chair of the Joint Partnership Board.

The Chair expressed that Healthwatch used to attend and she agreed that something that is important for the boroughs to think about will be how experts in the room can add the extra level of expertise to discussions. Councillor Connor enquired if Councillors were happy for this from the perspective of key VCS organisations in their boroughs as well. Councillor Edwards expressed that he was not opposed to the idea and e.g. Age UK Barnet may be helpful to the Committee and felt it was important to have the relevant people from the relevant organisations.

Councillor White clarified that whether someone should actually be co-opted to the meetings. The Chair clarified that it wasn't to co-opt the various organisations but to just be kept informed about the meetings and then to take a decision on whether they choose to attend or not. Councillor Clarke expressed that people are always able to come and be invited as non-voting guests. Councillor Revah suggested that the other members of the committee should also invite members of their Joint Partnership Board (should they also be active within their given authority). **Action**: Councillors to consider and provide feedback on people and organisations they feel would be helpful to be invited to the meetings to contribute.

Councillor Clark informed the Committee it would be her last meeting and that she had enjoyed working with colleagues over the past eight years. Councillor Connor thanked Councillor Clark for her contribution and hard work. Councillor Seargent also added it would be Councillor Edwards last meeting and his work on Adult Health. Councillor White also extended his thanks to Councillor Pippa Connor for chairing the JHOSC so well for such a long time. Councillor Clark concurred the excellent role Councillor Connor has played as Chair. Councillor Revah also commended Councillor Connor and wished all the Councillors stepping down the best.

The meeting ended at 12.25

Report for: North Central London, Joint Health Overview and Scrutiny Committee – 17th July 2026

Title: North Central London Joint Health Overview and Scrutiny Committee Membership and Terms of Reference

Report authorised by: Ayshe Simsek, Democratic Services and Scrutiny Manager

Lead Officer: Fola Irikefe, Principal Scrutiny Officer
Tel: +44 20 8489 4673, E-mail: fola.irikefe@haringey.gov.uk

Ward(s) affected: N/A

Report for Key/ Non Key Decision: N/A

1. Describe the issue under consideration

1.1 The North Central London (NCL) Joint Health Overview and Scrutiny Committee (JHOSC) is asked to agree their memberships and note the terms of reference.

2. Recommendations

2.1.1 The Committee is asked to note the terms of reference **(Appendix A)** of the NCL JHOSC as agreed at the meeting on 30 January 2026.

3. Reasons for decision

3.1 The terms of reference and membership of the scrutiny panels above need to be confirmed at the first meeting of each municipal year.

4. NCL JHOSC Committee

4.1 As agreed at the respective Council/ OSC meeting in the five boroughs that make up the NCL JHOSC, the proposed two Councillors for the 2026/27 of the NCL JHOSC are listed below:

Local Authority	Councillors
Barnet	Councillor Zahra Beg Councillor Caroline Stock
Camden	Councillor Larraine Revah Councillor Arun Kumar

Enfield	Councillor Alev Cazimoglu Councillor Chris Joannides
Haringey	Councillor Lucia das Neves TBC
Islington	Councillor Joe Croft Councillor Kiran Prasad

5. North Central London Joint Health Overview and Scrutiny Committee

5.1 The revised terms of reference, agreed by the JHOSC at its meeting on 30 January 2026, are as follows:

- To engage with relevant NHS bodies on strategic area wide issues in respect of the co-ordination, commissioning and provision of NHS health services across the whole of the area of Barnet, Camden, Enfield, Haringey and Islington;
- To respond, where appropriate, to any proposals for change to specialised NHS services that are commissioned on a cross-borough basis and where there are comparatively small numbers of patients in each of the participating boroughs;
- To respond to any formal consultations on proposals for substantial developments or variations in health services across affecting the area of Barnet, Camden, Enfield, Haringey and Islington;
- The joint committee will work independently of both the Cabinet and health overview and scrutiny committees (HOSCs) of its parent authorities, although evidence collected by individual HOSCs may be submitted as evidence to the joint committee and considered at its discretion;
- The joint committee will seek to promote joint working where it may provide more effective use of health scrutiny and NHS resources and will endeavour to avoid duplicating the work of individual HOSCs. As part of this, the joint committee may establish sub and working groups as appropriate to consider issues of mutual concern provided that this does not duplicate work by individual HOSCs; and
- The joint committee will aim work together in a spirit of co-operation, striving to work to a consensual view to the benefit of local people.

5.2 A revised terms of reference for the JHOSC is attached **(Appendix A)**

6. Contribution to strategic outcomes

6.1 The contribution scrutiny can make to strategic outcomes will be considered as part of its routine work.

7. Statutory Officers Comments

Finance and Procurement

7.1 The Chief Finance Officer has confirmed the Haringey representatives on the JHOSC are not entitled to any remuneration. As a result, there are no direct financial implications arising from the recommendations set out in this report.

Legal

7.2 The Assistant Director for Corporate Governance has been consulted on the contents of this report.

Equality

7.3 Each authority has a public sector equality duty under the Equalities Act (2010) to have due regard to:

- Tackle discrimination and victimisation of persons that share the characteristics protected under S4 of the Act. These include the characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (formerly gender) and sexual orientation;

- Advance equality of opportunity between people who share those protected characteristics and people who do not;

- Foster good relations between people who share those characteristics and people who do not.

7.4 The proposals outlined in the report relate to the membership and terms of reference for the NCL JHOSC and carry no direct implications for the five boroughs general equality duty. However, the Committee should ensure that it addresses these duties by considering them within its work programme and those of its panels, as well as individual pieces of work. This should include considering and clearly stating;

- How policy issues impact on different groups within the community, particularly those that share the nine protected characteristics;

- Whether the impact on particular groups is fair and proportionate;

- Whether there is equality of access to services and fair representation of all groups within Haringey;

- Whether any positive opportunities to advance equality of opportunity and/or good relations between people, are being realised.

7.5 The Committee should ensure that equalities comments are based on evidence. Wherever possible this should include demographic and service level data and evidence of residents/service-users views gathered through consultation.

9. Use of Appendices

Appendix A – NCL JHOSC Terms of Reference

10. Local Government (Access to Information) Act 1985

DRAFT TERMS OF REFERENCE – North Central London Joint Health Overview & Scrutiny Committee (NCL JHOSC) (Barnet, Camden, Enfield, Haringey, Islington)

1 - Purpose of Committee

1.1 The North Central London (NCL) Joint Health Overview & Scrutiny Committee (JHOSC) (Barnet, Camden, Enfield, Haringey, Islington) will operate formally as a statutory committee.

1.2 The purpose of the JHOSC is to:

- engage with relevant NHS bodies on strategic area wide issues in respect of the co-ordination, commissioning and provision of NHS health services across the whole of the area of Barnet, Camden, Enfield, Haringey and Islington.
- respond, where appropriate, to any proposals for change to specialised NHS services that are commissioned on a cross-borough basis and where there are comparatively small numbers of patients in each of the participating Boroughs.
- respond to any formal consultations on proposals for substantial developments or variations in health services affecting the North Central London (NCL) area of Barnet, Camden, Enfield, Haringey and Islington on behalf of Councils who have formally agreed to delegate this power to the JHOSC.

1.3 The Committee will have regard to the Department of Health & Social Care's guidance on health overview and scrutiny which states that *"the primary aims of health scrutiny are to strengthen the voice of local people and provide local accountability"* and should *"ensure that local people's needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe".*[1]

Powers

1.4 The JHOSC is established by the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. These regulations have been amended by the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment and Saving Provision) Regulations 2024. This enables two or more local authorities to appoint a joint overview and scrutiny committee of those authorities to exercise relevant functions subject to terms and conditions as the authorities may consider appropriate.

1.5 The JHOSC will comprise of Councillors across the same five Boroughs in order to enable effective scrutiny of the West and North London ICB (covering the areas of Barnet, Camden, Enfield, Haringey and Islington)

1.6 The West and North London ICB should provide relevant information about any significant forthcoming reorganisation of NHS services in the NCL(Barnet, Camden, Enfield, Haringey and Islington) area to the JHOSC in a timely manner.

[1] https://www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles/health-overview-and-scrutiny-committee-principles

Relationship to HOSCs

1.7 The JHOSC will work independently of both the Cabinet and health overview and scrutiny committees (HOSCs)[2] of its parent authorities, although evidence collected by individual HOSCs may be submitted as evidence to the joint committee and considered at its discretion.

1.8 The JHOSC will seek to promote joint working where it may provide more effective use of health scrutiny and NHS resources and will endeavour to avoid duplicating the work of individual HOSCs. As part of this, the committee may establish sub and working groups as appropriate to consider issues of mutual concern provided that this does not duplicate work by individual HOSCs; and

1.9 The agenda papers of JHOSC meetings will be provided to each of the local authorities in the NCL JHOSC(Barnet, Camden, Enfield, Haringey, Islington) area for publication on their websites.

1.10 The minutes of JHOSC meetings will be provided to the HOSCs for possible inclusion in their agenda papers. If the HOSCs are minded including this as an item on their agenda, any HOSC members who are also members of the JHOSC may wish to use this item as an opportunity to provide a verbal update on issues raised at the previous JHOSC meeting.

2 - Membership of Committee

2.1 The Committee shall be comprised of up to ten members in total, with a maximum of two members nominated from each of the five NCL Boroughs (Barnet, Camden, Enfield, Haringey, Islington)

2.2 Appointments to the JHOSC will usually be approved at each authority's Council AGM at the beginning of the municipal year and expire at the end of the same municipal year.

2.3 Appointments by each authority to the JHOSC will reflect the political balance of that authority.

2.4 Members who hold an executive post shall not be appointed to the JHOSC.

2.5 It is strongly advisable that one of the members nominated by each Borough is the Chair of their local HOSC as this helps to strengthen the links between the JHOSC and the HOSCs. It may also be beneficial for the second nominated member from each Borough to be the Chair or a member of their main Overview & Scrutiny Committee (OSC).

Chair/Vice-chairs

2.6 The Committee shall appoint a Chair and up to two vice-Chairs at the beginning of the first meeting of each municipal year.

[2] The name and structure of HOSCs varies between Boroughs so, in this context, HOSC refers to the Scrutiny Committee or Panel that usually deals with health policy issues.

The administrative support will be rotated on an annual basis, at the start of the municipal year, between the five boroughs and in the following order:

Appointed Chair's borough 2026/2027 (Haringey to provide support for first 6 months of the municipal year to allow effective handover and continuity)

- Islington 2027/28
- Enfield 2028/2029
- Barnet 2029/2030
- Camden 2030/2031

This is to ensure close working and continuity for effective progression of actions and responsibilities.

Quorum

2.7 The quorum for the Committee shall be:

a) At least four members of the Committee; and
b) At least one member from at least four of the five Boroughs.

Substitutes & Co-opted members

2.8 Member substitutes from each authority will be accepted. It will be the responsibility of individual committee members and their local authorities to arrange substitutions and to ensure that the lead authority is informed of any changes prior to the meeting.

2.9 Where a substitute is attending the meeting, it will be the responsibility of the nominated member to brief them in advance of the meeting.

2.10 The Committee shall reserve the right to consider the appointment of additional temporary co-opted members in order to bring specialist knowledge to inform specific work streams or agenda items. Any co-opted member appointed will not be permitted to vote at meetings.

3 – Protocol for meetings

3.1 Meetings of the Committee will be conducted under the Standing Orders of the Local Authority hosting and providing democratic services support and will be subject to these terms of reference.

Work programme

3.2 A schedule of meetings will be agreed by the Committee at the beginning of each municipal year. The Committee shall hold five ordinary meetings of the Committee in each municipal year.

3.3 The Committee may also hold up to two further meetings in each municipal year for the specific purpose of scrutinising the draft Quality Accounts produced annually by NHS Trusts that provide services in Barnet, Camden, Enfield, Haringey, Islington area.

3.4 In addition to ordinary meetings of the Committee, extraordinary meetings may be called from time to time as and when appropriate. An extraordinary meeting of the Committee may be called by the Chair after consultation with the vice-Chairs.

3.5 The Committee shall be regularly consulted on the setting of items for the agendas of future meetings through a standing item on the work programme at every ordinary meeting of the Committee. Members of the Committee can also submit suggestions for future agenda items to the Chair and vice-Chair(s) at any time.

3.6 The Chair and vice-Chair(s) will usually meet with senior representatives from the west and North London ICB covering(Barnet, Camden, Enfield, Haringey, Islington) and any other relevant NHS organisations approximately 6-8 weeks in advance of an ordinary meeting of the Committee in order to determine the agenda for the meeting and the content of the reports. This should include consideration of any input from the other Committee members.

Meetings

3.7 Ordinary meetings of the Committee will normally be held at 10am and are typically scheduled to last for two and a half hours. The Committee may vary the scheduling and timings of the meetings as and when required.

3.8 The Committee will normally hold an informal private 30-minute meeting just before the main meeting, in order to allow Committee members to discuss any procedural issues and possible lines of enquiry relating to the reports in the agenda pack. The Committee may vary the arrangements for this as and when required.

3.9 The venues for meetings of the Committee will normally be rotated regularly across all five Boroughs in the NCL(Barnet, Camden, Enfield, Haringey, Islington)area.

Voting

3.10 The Committee will usually endeavour to reach its decisions by consensus. However, in the event that a vote is required, each Member present will have one vote. In the event of there being an equality of votes, the Chair of the meeting will have the casting vote.

Deputations/Questions

3.11 A deputation may be received by the Committee if a request stating the object of the deputation is received by the Chair and/or committee clerk at least three clear days prior to the meeting.

3.12 Up to 15 minutes shall usually be allocated to deputations on the Committee agenda.

3.13 The deputation spokesperson will be given five minutes to introduce the deputation referring to the matters in their deputation requisition. After this they may answer any questions from Committee members. The Chair will allocate a maximum amount of time for each deputation and will have regard to other items of business on the agenda when doing so.

West and North London update

NHS
West and North London

Joint Health Overview and Scrutiny Committee

July 2026

Context

A single West and North London ICB	NHS West and North London ICB serves 4.5 million residents across 13 boroughs
Responding to the national requirement to transform ICBs	We are working to reduce operational budgets by 50% and shift to the strategic commissioning model set out in the national ICB Blueprint, by redesigning structures and ways of working
Sharper focus on population health, outcomes and equity	We base strategic commissioning decisions on population need, reduce inequalities, use data and engagement more effectively and direct resources to improve outcomes and value
Clearer, simpler, more consistent organisation	We are ensuring WNL ICB is easier to navigate, financially sustainable, aligned to statutory functions, and built on clear delineation of responsibilities
Our purpose as WNL ICB	Our focus is to strategically commission healthcare services that improve health and lives of West and North London residents, both now and in the future

WNL patch and communities

Across West and North London, **we spend around £12 billion a year** on health and care serving 13 boroughs with a population of approximately 4.5m people.

Challenges and opportunity

- Across West and North London, we spend around £12 billion a year on health and care for a population of approximately 4.5m people.
- **Most of the £12 billion spent a year on health and care is currently used in hospitals and crisis services.** This has been important to manage hospital demand, and short-term pressures, but it is not delivering fair outcomes and is unsustainable.
- **Life chances across West and North London are not equal.** There is a 17-yearvariation in healthy life expectancy across neighbourhoods, with people in our most deprived communities experiencing significantly poorer outcomes.
- **We have to maintain a grip over the commissioning reality of today** while driving the emergence of new commissioning models and provider relationships e.g. partnerships, integrators, collaboratives.
- Fundamentally, **we aren't yet where we want to be**.

NHS
West and North London

West and North London Integrated Care Board

A new organisation

1 April 2026 marked the formation of West and North London Integrated Care Board.

There is huge complexity in bringing together two organisations and we have worked to ensure a smooth transition.

As the new organisation continues to take shape, we expect the new structure to be fully in place after the summer.

The ICB exists **to strategically commission healthcare services that improve the health and lives of West and North London residents**. We add value to the system by:

- **Understanding the needs of local people** through data, connection with our communities and a clinically-led approach
- **Making informed decisions on how to best meet those needs** within our budget
- **Use commissioning levers** to drive consistency, equity and improve outcomes for patients

NHS
West and North London

A summary of our changing role

From		To
Borough level partnerships	→	**Integrator models to lead locally**
Regulation and performance management of NHS Trusts	→	**Strategic commissioner, improving population health through proactive and preventative care**
Detailed service design and day to day oversight of service delivery	→	**Providers and partners to take more local ownership in oversight of key services**

NHS
West and North London

Priorities for West and North London ICB's first year

Deliver operational commitments and financial plan

Agree and monitor commissioner financial plan for 26/27, support providers with efficiency, deliver NHSE performance requirements, and statutory commitments.

Set the new organisation up for success

Delivery of 'day 1' executive commitments, **complete staff recruitment**, ensure clear comms to partners, **establish governance** structures, align legacy systems and develop values.

Invest the 1% for impact

Prioritise **high-impact population health interventions**, learning lessons about how we take forward the longer-term strategy. In 2026/27, this investment amounts to £60m (£120m full year effect), with plans to increase this by this by 1% annually up to 5%.

Develop a clinically-led strategy

Understand population needs **through segmentation and variation in outcomes,** set a clear plan for change in spend for **greatest impact in outcomes, demand and cost.**

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The West and North London Integrated Care Board 10-year strategy is being developed

We want to work to improve health and services for 4.5 million people living across our 13 boroughs.

There are three connected goals guiding our strategy.

1. Healthier lives for everyone

- Help people stay well for longer
- Prevent illness, not just treat it
- Reduce health gaps between communities

2. Less pressure on services

- Support people earlier and closer to home
- Focus help on those who need it most
- Make it easier to manage health day-to-day

3. Make the best use of our money

- Spend where it makes the biggest difference
- Reduce waste and variation
- Keep services affordable for the future

The strategy will be developed working with our communities and shaped by resident and patient insight

Retaining our statutory duties

- The new ICB still retains our **statutory responsibilities and we have put risk assessments in place for each function during transition**

- The ICB is committed to ensuring that **safeguarding arrangements** remain robust and will maintain existing partnerships with local safeguarding boards and agencies to ensure we can deliver high quality services for residents

- The ICB will continue to provide Designated Clinical Officers for CYP SEND. Although there are different hosting arrangements for NCL DCOs, the ICB will provide oversight of all DCOs and continue to support joined up working and sharing of best practice.

- **All Age Continuing Healthcare and Complex Care individualised commissioning responsibilities were delegated to Central London Community Healthcare NHS Trust (CLCH) from 1 July 2026.** WNL ICB holds statutory responsibilities for the service, including oversight and final decision-making, while the assessment and contracting for the services has transferred to CLCH.

Continued partnership working

- We have worked with council partners to develop **Better Care Fund plans** and has submitted to NHS England. This will be a transitional year with opportunity to set baseline metrics, develop understanding and learning so that we can make informed decisions for future years through strengthened Health and Wellbeing Boards.

- We have worked with councils, health providers, schools and parents to submit initial **SEND reform plans** in June that contain proposals to support children earlier and based on need. We also have a number of other transformation plans to improve services and will develop system wide enablers, such as better use of data and digital support to develop and deliver our core offer.

- We no longer convene **borough partnerships**. We are working to develop and define the role of the integrators and set out clear expectations for their responsibilities and accountabilities to the ICB and to Borough Partnerships. The Neighbourhood Commissioning and Transformation Unit will be the contact point within WNL ICB.

NHS
West and North London

All Age Continuing Healthcare and Complex Care

On 1 July, the ICB successfully transferred our complex care and All Age Continuing Care operational function to Central London Community Healthcare NHS Trust CLCH).

This transfer introduces additional expertise in service delivery, unlocks new opportunities for innovation, and enhances professional support for staff.

The ICB retains statutory responsibilities and oversight of the service and recruitment to the structure is underway to deliver these duties.

All service users have received letters regarding the changes in the operational function. This has included the fact that there is no change to contact details for the service. Therefore, services should see no change to their existing care packages/case manager.

SEND arrangements

NHS
West and North London

The ICB recognises its continued role as part of local area partnerships to support children and young people with SEND.

- The ICB **will nominate individuals to attend each local area's SEND Partnership Board**, with further discussion to understand the supporting governance structures. Attendance at sub-level groups will need further consideration. We will work closely with area partnerships likely to be inspected within the next 12 months on the partnership approach to self-evaluation and overall readiness. The ICB will support the close involvement of health partners in SEND governance arrangements.

- Each **borough will have a named individual from the ICB CYP Commissioning team** to provide a single point of contact in regard to commissioned services.

- As per SEND Reform Plans**, the ICB will continue to collaborate with local authority partners on the establishment of the SLT Advanced Practitioner roles,** understand and facilitate the commissioning arrangements require for some of the Experts at Hand provision and liaise with providers and local authorities on the most effective and efficient ways to support data sharing.

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West and North London

WNL ICB representation at meetings

We will continue to work collaboratively with partners and ensure appropriate representation and accountability at statutory meetings:

- **Health and Wellbeing Boards** – we have allocated a named Director level contact for each Board. Where a decision is required, we will ensure representatives with the right authority and knowledge are in attendance.

- **Joint Health Overview and Scrutiny Committees (JHOSCs)** – We will continue to attend formal JHOSC meetings where there are relevant items on the agenda relating to our strategic commissioning role and responsibilities.

- **Health and Social Care Scrutiny Committees (HASCs)** – ICB will attend HASCs based on relevant agenda items relating to our strategic commissioning responsibilities. In some cases it may be more appropriate for providers or integrators to take a lead, depending on the topic.

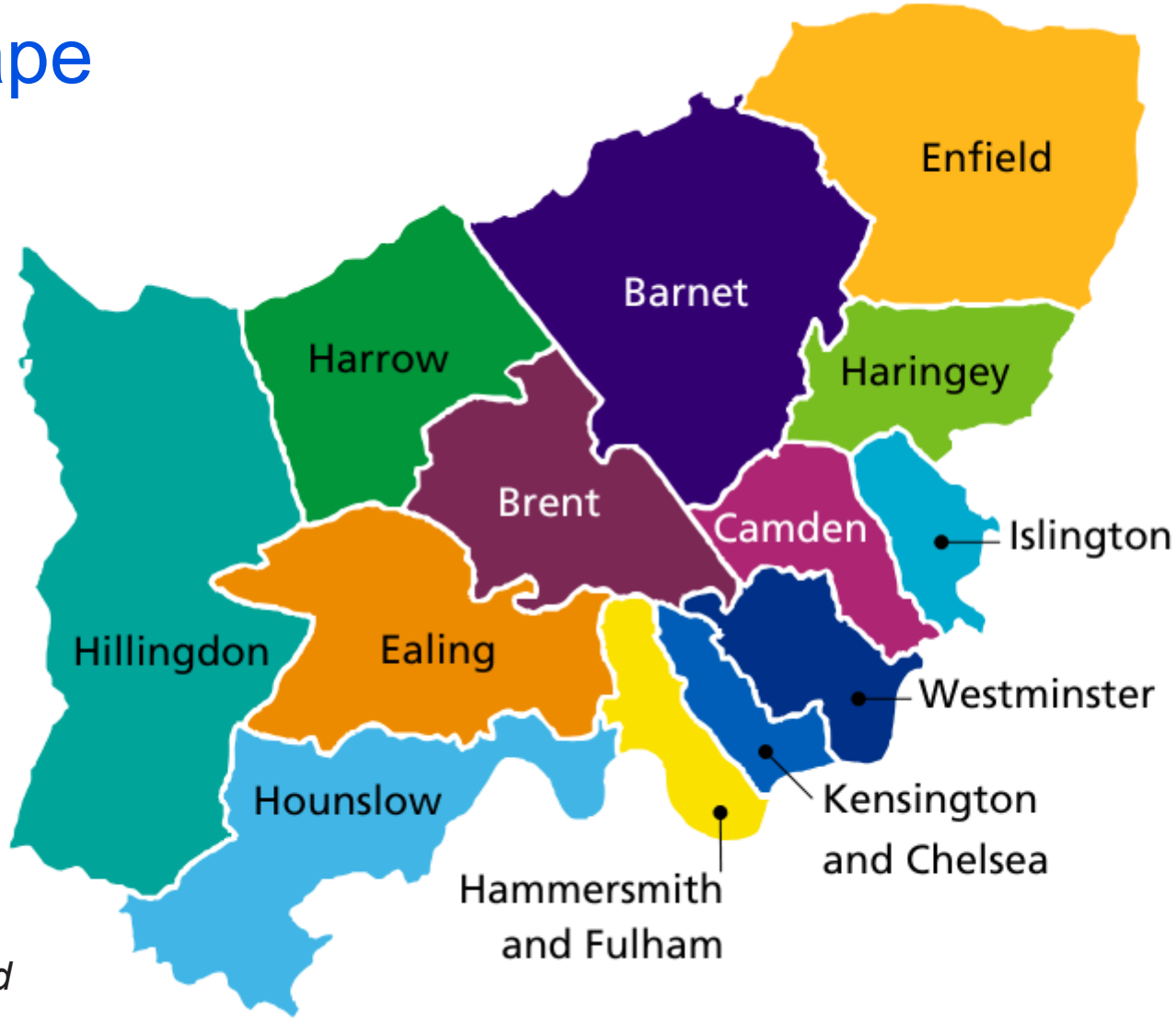
Primary Care Commissioning Overview

NHS
West and North London

- The Primary Care Commissioning Team leads the design, contracting, performance management and transformation of primary care services across WNL covering over 500 providers across general practice, dental, optometry and community pharmacy.
- The team integrates contracting, commissioning, programmes and business functions to deliver delegated and locally commissioned services, ensuring a streamlined and consistent approach.
- Its core responsibilities include procurement and contract management, performance and regulatory assurance, service development and improvement, and delivery against national and local priorities, working collaboratively with clinical, finance, workforce, neighbourhood and strategy colleagues.
- The Primary Care Commissioning Pillar is made up of 4 units:
  - **Primary Care Contracting**
  - **Commissioning and Programmes**
  - **Business Processes**
  - **Business Transfers**

Primary care landscape

- **Practices: 508**
  NWL: 329 NCL: 179
- **PCNs: 79**
  NWL: 47 NCL: 32
- **Neighbourhoods: 53**
  NWL: 33 NCL: 20
- **Federations – 16**
  NWL: 10 NCL: 6
- **Primary Care Provider Collaboratives: 2**
  Primary Care Provider Collaborative and General Practice Provider Alliance



Primary Care Commissioning Priorities

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Improving quality and reducing unwarranted variation: Continued focus on data-driven approach to drive improved quality and reduce unwarranted variation

Enhanced commissioning: roll out of Cardio Renal Metabolic services and review enhanced commissioning offer for increased alignment to support left shift

Neighbourhood models and delivering the left shift: defining core GP role, and role in neighbourhood model, including development of Integrated Neighbourhood Teams

Access: ensuring delivery of new national GP contract requirements, with continued focus on access, clinically urgent appointments and continuity

Improvement and change support: understanding and optimising demand / capacity and providing tools / targeted interventions to support practices

Strengthening contract management and performance oversight and developing a strategic approach to procurements, including APMS procurements

Primary Care Business Transfer Delivery Unit

NHS
West and North London

- In line with the Model ICB Blueprint, some Primary Care and Medicines Optimisation functions are proposed to transfer to provider organisations across NCL and NWL.
- This supports the ICB's future role as a strategic commissioner rather than a delivery organisation.
- The proposed changes aim to:
  - *Embed operational functions closer to frontline care delivery*
  - *Improve integration between commissioning and providers*
  - *Enhance responsiveness and support for practices and patients*
  - *Reduce duplication and streamline governance across the system*
  - *Support improved outcomes and more joined-up care for residents*
- There are proposed to be two separate provider teams: one supporting North Central London and one supporting North West London. Teams will work within their respective geographies rather than across the full West and North London footprint.
- Work is underway to identify the receiving providers, with staff transfer anticipated end of 2026/27

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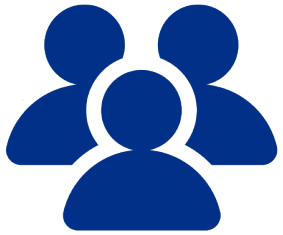
West and North London

Community and mental health NHS providers



Community

- Central London Community Healthcare NHS Trust
- Central and North West London NHS Foundation Trust
- Whittington Health NHS Trust
- West London NHS Trust
- Royal Free London NHS Foundation Trust

Mental health

- Central and North West London NHS Foundation Trust
- North London NHS Foundation Trust (including Tavistock and Portman)
- West London NHS Trust

NHS
West and North London

Our providers – Acute and general

Chelsea and Westminster Hospitals NHS Foundation Trust

- Chelsea and Westminster Hospital
- West Middlesex University Hospital

Guy's and St Thomas' NHS Foundation Trust

- Royal Brompton Hospital

The Royal Marsden Hospital

Imperial College Healthcare NHS Trust

- Charing Cross Hospital
- Hammersmith Hospital
- St Mary's Hospital

London North West University Healthcare NHS Trust

- Central Middlesex Hospital
- Ealing Hospital
- Northwick Park Hospital
- St Mark's Hospital

NHS
West and North London

Our providers – Acute and general

Royal Free London NHS Foundation Trust

- Barnet Hospital
- Edgware Community Hospital
- Finchley Memorial Hospital
- Chase Farm Hospital
- North Middlesex University Hospital

The Hillingdon Hospitals NHS Foundation Trust

- Hillingdon Hospital
- Mount Vernon Hospital

The Royal Marsden NHS Foundation Trust

- The Royal Marsden in Chelsea

University College London Hospitals NHS Foundation Trust

- University College Hospital

Whittington Health NHS Trust

Provider collaboratives

- North Central London Health Alliance
- North Central London Community CYP Mental Health Services Provider Collaborative
- North West London Acute NHS Provider Group

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West and North London

Our providers – Specialist

- Royal National Orthopaedic Hospital
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Moorfields Eye Hospital NHS Foundation Trust
- London Ambulance Service NHS Trust
- West London Children's Healthcare

What has changed for NHS Trusts?

There are some changes to how the ICB now works with NHS Trusts. The ICB's new role as a strategic commission means we more focused on population health strategy, patient outcomes, commissioning frameworks and resource allocation.

This means fewer operational requests from the ICB and less direct ICB involvement in operational delivery activities that are better led elsewhere

This includes:

- Borough level operational management, where the ICB no longer leads operational system flow or discharge coordination.
- System programmes such as digital and diagnostics pathway transformation are now being led by providers
- Assurance and escalation of individual quality and patient safety incidents has moved to NHS England
- Routine provider performance management has also moved to NHS England.

NHS
West and North London

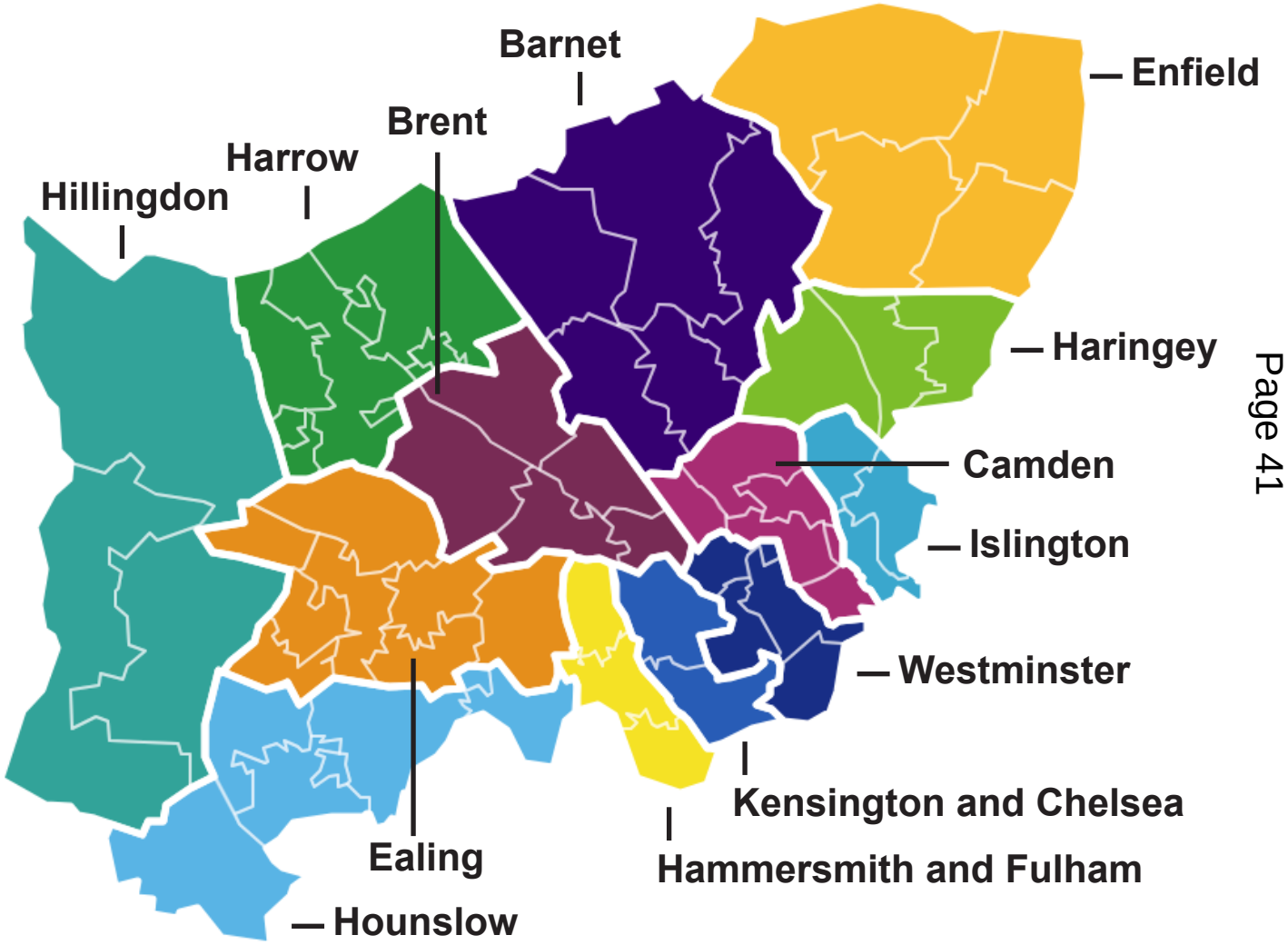
Our neighbourhoods

We are changing how care is delivered so it is more proactive and preventative for residents.

We have ambitious plans to transform services so that they are organised around “neighbourhoods”.

There are 53 in WNL, agreed by local partnerships.

Locally-led delivery will help care to be closer to communities and the people we serve.



Key

Neighbourhood boundaries

Neighbourhood health

Working in closer partnership with local authorities and the voluntary sector, we are moving towards a **preventative and proactive care approach** that will better respond to people's individual needs, because health and wellbeing are shaped by more than just medical care.

To support this transition, we have ringfenced 1% of our 2026/27 budget for investment in making **three big changes as part of a "left shift"** to how the NHS works, moving:

- from hospital to community
- from analogue to digital
- and from sickness to prevention.

In 2026/27, this investment amounts to £60m (£120m full year effect), with plans to increase this by this by 1% annually up to 5%.

Delivering Neighbourhood Health

Ongoing investment

In the coming year, we will continue to move investment from secondary care to neighbourhood, community and mental health services to improve sustainability, reduce acute demand and address inequalities, without destabilising providers.

In west and north London, we have identified three areas of focus for 2026/27:

- Integrated Neighbourhood Teams for complex adults
- Mobilisation support for integrators
- Core offers and pathway upgrades

Integrator arrangements

To facilitate this, an “integrator” in each borough will act as the “glue” that allows a diverse range of partners to work together. Bridging the gap between NHS, local authority and voluntary sectors, integrators range from single organisations to alliances of several partners.

NHS
West and North London

What are integrators and how will they work?

Role of Integrators

Integrator facilitate the delivery of Neighbourhood health and bridge the gap between NHS, local authority and voluntary sectors

Integrators will collaboratively work to:

- Coordinate delivery, support neighbourhood and place-based models and act as the leader and facilitator of neighbourhood integration on the ground
- Support borough partnerships, to improve collaboration and helping create the conditions needed for neighbourhood health services to succeed
- Provide additional leadership, coordination and support to help neighbourhood health services develop at pace and scale, improving outcomes and reducing inequalities for local communities

Borough	NWL Hosts* and NCL arrangements
Enfield	NMUH, Enfield GP Fed
Haringey	WH, Haringey GP Fed, Haringey Council
Islington	UCLH, WH, Islington GP Fed, Islington Council
Camden	UCLH, Camden GP Feds (x2)
Barnet	CLCH, Barnet GP Fed
Bi-borough	CLCH
H&F	CLCH
Harrow	CLCH
Brent	CNWL
Hillingdon	CNWL
Ealing	WLT
Hounslow	WLT

Looking ahead

- Following the formation of NHS West and North London on 1 April, we **continue to inform and engage stakeholders** throughout the implementation, involving partners in our decisions when we can.
- **Recruitment is ongoing**, and we expect the new organisation's final structure to be in place by summer this year. Please bear with us while we ensure our posts are filled.

Our involvement framework

- Work is also underway develop our involvement framework and in the coming months our Involvement, Engagement and Insight team will be talking to colleagues, local communities and residents to inform its approach.

Our priorities and organisational strategy

- Work is underway to **focus our priorities** and **shape our future** strategy. We aim to have our **strategy in place by autumn** and will involve local stakeholders at key points.

Governance

- **West and North London ICB Board of Members** comprises 20 voting members: the Chair, Non-Executive Members, Partner Members (local authority, Trusts/Foundation Trusts and Primary Care) and ICB Executives.

- We have now confirmed **non-executive and partner members**: find out who they are here

- There will be **three local authority representatives** on WNL ICB Board and we are waiting for confirmation of who these representatives will be following recent local elections.

- A **top-level committee structure** has been developed – with the objective of ensuring a robust governance framework that reflects the new purpose and operating landscape for the ICB. You can find out more about how we are run on our website.

NHS
West and North London

Our Executive Team

Interim Chief Executive Officer
Katie Fisher

Chief Finance Officer and Deputy CEO
Stephen Bloomer

Chief Medical Officer
Dr Jo Sauvage

Chief Nursing Officer
Jennifer Roye

Chief People Officer
Sarah Morgan

Chief Strategy Officer
Richard Dale

Chief Transformation Officer
Sarah McDonnell-Davies

Executive Director of Transition
Ian Porter

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Quality Account Priorities 2025 – 2026

JOSC meeting 17 July 2026

Nicola Sands Deputy Chief Nurse

Quality Account 2025/26

The quality priorities for 2025 /26 aligned to the Trust's Corporate Objective to "Deliver outstanding safe and compassionate care in partnership with patients". The 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

Key achievements from 2025/26

- 91% FFT positive experience (above the NHS benchmark of 85%)
- High rank for Acute and Community Trusts for staff survey performance
- Zero MRSA blood stream infections
- Significant reduction in E.Coli and Klebsiella bloodstream infections
- Strong maternity survey performance in postnatal care
- Continued growth in research participation and clinical audit performance
- Focus on safety, access, health inequalities and service transformation

Quality Priorities 2026/27

We will deliver consistently safe and effective care, delivered with kindness, compassion and in partnership with patients, carers and families.

We will improve the physical, sensory and digital environments across our services so that they support dignity, accessibility, safety and a positive patient experience.

We will reduce health inequalities by making our services easier to access, understand and navigate, particularly for groups who experience poorer outcomes or barriers to care

We will continue to develop and redesign services to meet the changing needs of our local population, supporting timely, joined-up care and avoiding unnecessary hospital attendance.

Priority 1 enablers

We will deliver consistently safe and effective care, delivered with kindness, compassion and in partnership with patients, carers and families.

- Align divisional Quality Improvement (QI) programmes to Quality Account priorities, ensuring projects demonstrate contribution.
- Embed structured patient engagement in key pathways.
- Implement PSIRF learning themes within continuous improvement cycles.
- Strengthen triangulation of learning from incidents, complaints and patient feedback.

Priority 2 Enablers

- **We will improve the physical, sensory and digital environments across our services so that they support dignity, accessibility, safety and a positive patient experience.**

- Deliver targeted QI programmes focused on high-risk environments (e.g. ED, maternity and outpatient areas).
  • Co-design environment improvements with patients and carers using PLACE and experience feedback.
  • Implement actions arising from PLACE assessments, patient feedback, environmental audits, food audits, safety inspections and executive walkarounds.
  • Improve the reliability and usability of digital systems supporting care delivery.
  • Deliver estates and infection prevention actions to enhance privacy, dignity and safety.

Priority 3 Enablers

We will reduce health inequalities by making our services easier to access, understand and navigate, particularly for groups who experience poorer outcomes or barriers to care

- Embed an equity focus within all QI programmes, ensuring projects demonstrate impact on reducing inequalities.
  - Expand targeted engagement with underserved and underrepresented groups.
  - Improve accessibility through better use of interpreting services and inclusive information.
  - Redesign access pathways using population health data and partnership working.

Priority 4 Enablers

We will continue to develop and redesign services to meet the changing needs of our local population, supporting timely, joined-up care and avoiding unnecessary hospital attendance

- Ensure the flow improvement programme, with a focus on EUC and ED, consistently applies QI methodologies.
  - Expand Same Day Emergency Care (SDEC) and community-based models.
  - Improve patient flow through real-time data, pathway optimisation and multidisciplinary working.
  - Embed continuous improvement within operational flow programmes.

Comments and Questions

Thank you

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Quality Account

2025 / 2026

Includes Quality Priorities for 2026/27

Part 1: Statement on Quality from the Chief Executive

Welcome to the 2025/26 Quality Account for Whittington Health NHS Trust. It is a pleasure to sign off this year's Quality Account for the second time as Chief Executive.

Quality remains the foundation of everything we do. It shapes our decisions, drives improvement and inspires us to find innovative ways to deliver care more effectively. Even in a challenging environment, our commitment to providing safe, compassionate and high-quality care has remained true.

The past year has been one of the most challenging that the NHS has faced in recent memory. Throughout the year, I have been open with colleagues about the difficult financial and performance challenges we face.

While the scale of that challenge is significant, our focus has never been solely on finance. The future of our Trust depends on maintaining a careful balance between three equally important priorities: quality, performance and financial sustainability. None can succeed without the others.

This Quality Account highlights the dedication, expertise and compassion of our staff, and the progress we have made together over the past year. Despite the challenges we have faced, there is much to be proud of. Across our services, colleagues have remained focused on delivering safe, effective and compassionate care, achieving significant improvements in patient safety, patient experience and staff engagement.

Our commitment to patient safety has delivered tangible results. We recorded zero cases of MRSA and achieved significant reductions in bloodstream infections, reflecting the strength of our infection prevention and control practices.

Feedback from patients continues to be overwhelmingly positive, with 91% of respondents to the Friends and Family Test reporting a positive experience of our services. This has been supported by sustained improvements across national patient surveys, providing reassurance that, even during periods of significant pressure, we have continued to deliver care that is responsive, compassionate and centred around the needs of those we serve.

I am particularly proud of the experience of our staff this year. The Trust achieved its strongest-ever staff survey results, ranking first in engagement and morale scores amongst comparable organisations. This reflects the dedication of our colleagues and the culture we continue to build together, one where people feel engaged, valued and empowered to contribute to improvement.

These achievements have been delivered against a backdrop of increasing demand, growing patient complexity and ongoing pressures across urgent and emergency care, elective services and discharge pathways. They are a testament to the resilience, professionalism and innovation of our teams.

As we look ahead to 2026/27, our focus remains firmly on delivering the highest standards of safe, quality care for every patient. We are committed to making targeted improvements in areas where we know we can make the greatest difference, including reducing patient falls, strengthening medication safety, preventing pressure damage and ensuring patients are discharged safely and with the right support in place.

Alongside these priorities, we will continue to foster a culture of openness and continuous learning, where the experiences of our patients and the voices of our staff help shape our services, drive clinical excellence and support our efforts to address health inequalities.

We also recognise that great care does not begin and end within our Trust. By continuing to strengthen our partnerships across health and care services, we will continue to integrate care more effectively, ensuring patients receive joined-up support closer to home and experience seamless care throughout their journey.

I confirm that this Quality Account will be discussed at the Trust Board, and I declare that, to the best of my knowledge, the information contained in this Quality Account is accurate.

Selina Douglas

Chief Executive Officer

1.1: Trust information and What is a Quality Account?

About the Trust

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

Whittington Health provides hospital and community care services to over half a million people living in Islington and Haringey as well as those living in Barnet, Enfield, Camden and Hackney. During 2025/26, we provided acute and community health services, and we also provided dental services in 10 London boroughs. Every day, we aim to provide high quality and safe healthcare to people either in our hospital, in their homes or in nearby clinics. We are here to support our patients throughout their healthcare journey – this is what makes us an integrated care organisation.

Our services and our approach are driven by our vision

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

The Trust's strategic objectives for 2026/27 are:

What we do: Deliver outstanding safe and compassionate care in partnership with patients

Our vision is: Helping local people live longer, healthier lives.

Our clinical service strategy is:

The Whittington Health's Clinical Strategy, which sets out our vision and direction for the next 5 years. 2025 -2030 will be launched in April 2026.

The strategy articulates how we will deliver high-quality, person-centred, personalised and value-driven care across our acute and community services, while remaining financially and environmentally sustainable in an increasingly complex healthcare landscape. Now more than ever, we face rising demand, more complex healthcare needs, widening health inequalities, and increased expectations from patients and communities.

In response, this strategy defines clear clinical priorities that will guide our decisions, focus our efforts, and strengthen our role as a trusted provider of integrated healthcare in North Central London. As part of the NHS West and North London Integrated Care System (ICS), we are committed to working collaboratively across neighbourhoods, boroughs, and system partners. Our unique position as an integrated NHS Trust spanning acute, community, and specialist services enables us to lead the way in transforming care across traditional boundaries.

The golden threads are tackling health inequalities, keeping patients well in a community setting, having efficient patient pathways and strengthening local partnerships.

It includes eight clinical chapters which cover older people, long term conditions, women and neonates; children and young people; cancer; elective and planned care; diagnostics; and urgent and emergency care.

What is a Quality Account?

Quality Accounts are annual public reports produced by providers of NHS healthcare. They set out clear and robust information about the quality of the services delivered during the year. The reports are designed to give assurance to patients, service users, carers, the public and commissioners that healthcare providers are routinely reviewing all aspects of the services they provide to their local communities, and that they are focusing attention on areas where improvement is most needed.

Quality Accounts are both retrospective and forward-looking. They review performance from the previous year, highlighting areas of good practice as well as where further improvement is required. They also set out the organisation's priorities for quality improvement in the forthcoming financial year, explaining how these priorities have been identified and how progress will be monitored.

Part 2: Priorities for Improvement and Statements of Assurance from the Board

This section of the Quality Account describes the priorities identified for quality improvement in 2026/2027. It also sets out a series of statements of assurance from the Board on key quality activities and provides details of the Trust's performance against core indicators.

The progress made against priority areas for improvement in the quality of health services identified in the 2025/26 Quality Account can be found in '**Part 3: Review of Quality Performance**' which starts on page 72.

2.1 Priorities for improvement 2026

We have aligned our priorities for 2026 to the Patient Safety Incident Response Framework (PSIRF) priorities:

PSIRF Priorities 2026

- Reducing patient falls
- Ensuring medication safety
- Early recognition and escalation of deteriorating patients
- Pressure damage prevention
- Minimising delayed treatment
- Safe discharge

Trust Strategic Priorities

The Trust has four strategic, long-term objectives to:

- deliver outstanding safe, compassionate care
- empower, support and develop engaged staff
- integrate care with partners and promote health and wellbeing
- transform and deliver innovative, financially sustainable services

Our strategic objectives are underpinned by linked annual corporate aims, which are agreed by the Board.

For the four strategic organisational objectives, there are eleven linked annual corporate objectives:

1. Deliver safe and effective care – continuous improvement in safety culture and delivery of best practice care
2. Improve performance for better patient experience and outcomes
3. Improve population health and address health inequalities
4. Improve staff engagement and wellbeing
5. Recruit, develop and retain talent
6. Drive new models of place-based care in the community and edge of hospital
7. Collaborate with providers and the system
8. Create focused improvement drive to deliver best value
9. Deliver year one priorities of green plan
10. Deliver estate transformation plans
11. Improve business intelligence and drive digital transformation

Our Quality Account consultation process:

Whittington Health recognises that achieving sustainable quality improvement requires long-term programmes of work that are robustly designed, delivered and monitored.

To support this approach, the Trust undertook a programme of engagement activity across Trust and community sites to gather feedback from people who use our services and from our staff. This feedback was triangulated with intelligence from a wide range of data sources, including learning from incidents, mortality and harm reviews, complaints and claims, clinical audit activity, patient and staff experience surveys, and relevant best-practice guidance such as that issued by the National Institute for Health and Care Excellence (NICE) and national audit programmes. This collective insight informed the identification of both continuing priorities and any new priorities for inclusion in 2026/2027.

The specific objectives developed to deliver the agreed 2026/27 priorities have been refined and agreed by the clinicians and managers who hold direct accountability for their delivery. These objectives have been considered and approved through the Trust's formal governance structures and relevant committees. The Quality Account, including the 2026/27 priorities and objectives, has also been shared with our commissioners, whose comments are included in the appendices.

Monitoring of progress against priorities

The monitoring and reporting on progress against the quality priorities is via the Clinical Effectiveness Group. The Quality Governance Committee reviews progress on a quarterly basis and any concerns are escalated to the Quality Assurance Committee, a committee of the Trust Board.

Quality Account Priorities

Within each priority, key milestones and targets are identified to monitor progress which are reviewed in the context of the wider Quality Account priority ambition.

The key milestones and targets are highlighted below, and in the table that follows we have provided a rationale for selecting this area for focus, details of the improvement plans, and detail on the monitoring data and progress indicators.

- We will deliver consistently safe and effective care, delivered with kindness, compassion and in partnership with patients, carers and families.
- We will improve the physical, sensory and digital environments across our services so that they support dignity, accessibility, safety and a positive patient experience.
- We will reduce health inequalities by making our services easier to access, understand and navigate, particularly for groups who experience poorer outcomes or barriers to care.

- We will continue to develop and redesign services to meet the changing needs of our local population, supporting timely, joined-up care and avoiding unnecessary hospital attendance.

Quality Account Priority	Why are we focusing on this as an area for improvement?	What are we doing to improve?	Goals for 2026/27	Performance Indicators
We will deliver consistently safe and effective care, delivered with kindness, compassion and in partnership with patients, carers and families.	Patient safety, communication and partnership are key drivers of outcomes and experience, particularly for frail, complex and vulnerable patients. Feedback from patients, incidents and complaints highlights the need for consistent communication, shared decision-making and reduction of avoidable harm.	• Align divisional Quality Improvement (QI) programmes to Quality Account priorities, ensuring projects demonstrate contribution. • Embed structured patient engagement in key pathways. • Implement PSIRF learning themes within continuous improvement cycles. • Strengthen triangulation of learning from incidents, complaints and patient feedback.	• Achieve a 25% reduction in category 3 and 4 pressure ulcers and a 10% reduction in overall hospital-attributable pressure ulcers. • Achieve a 10% reduction in community-acquired category 3 and 4 pressure ulcers and a 20% reduction in total community-attributable pressure ulcers (categories 2–4). • Meet the national benchmark for patients reporting involvement in decisions about their care. • Achieve a 10% reduction in complaints relating to communication.	• Patient safety incident rates per 1,000 bed days, analysed by harm level (interpreted alongside reporting practice and severity). • Themes from Patient Safety Incident Investigations (PSIIs). • Complaints and Friends and Family Test (FFT) themes relating to communication. • Percentage of patients reporting feeling listened to and involved (survey/FFT). • Reduction in avoidable harm indicators.
We will improve the physical, sensory and	The care environment, including digital systems, directly impacts	• Deliver targeted QI programmes focused on	• Maintain PLACE cleanliness scores above	• PLACE assessment results and national

Quality Account Priority	Why are we focusing on this as an area for improvement?	What are we doing to improve?	Goals for 2026/27	Performance Indicators
digital environments across our services so that they support dignity, accessibility, safety and a positive patient experience.	patient safety, dignity and experience. Feedback and PLACE assessments highlight variability in environment quality, accessibility and system reliability.	high-risk environments (e.g. ED, maternity and outpatient areas). • Co-design environment improvements with patients and carers using PLACE and experience feedback. • Implement actions arising from PLACE assessments, patient feedback, environmental audits, food audits, safety inspections and executive walkarounds. • Improve the reliability and usability of digital systems supporting care delivery. • Deliver estates and infection prevention actions to enhance privacy, dignity and safety.	98%. • Maintain all PLACE domains above 90% and implement targeted improvement plans where required. • Achieve a 10% reduction in environment-related and patient catering complaints against the 2025/26 baseline. • Complete at least 95% of environmental and catering actions within agreed timescales.	benchmarking. • Patient feedback relating to cleanliness, privacy, dignity, accessibility and food quality. • Compliance with safety actions from inspections and reviews. • Digital system performance (uptime and incident reports). • Number and themes of environment-related complaints.

Quality Account Priority	Why are we focusing on this as an area for improvement?	What are we doing to improve?	Goals for 2026/27	Performance Indicators
We will reduce health inequalities by making our services easier to access, understand and navigate, particularly for groups who experience poorer outcomes or barriers to care.	Health inequalities persist across access, experience and outcomes. Data shows variation in waiting times, access and engagement across different population groups, including those with language, disability or socioeconomic barriers.	• Embed an equity focus within all QI programmes, ensuring projects demonstrate impact on reducing inequalities. • Expand targeted engagement with underserved and underrepresented groups. • Improve accessibility through better use of interpreting services and inclusive information. • Redesign access pathways using population health data and partnership working.	• We will aim to meet the national target of a 5.6% DNA rate for first appointments. • Reduce variation in waiting times between population groups. • Increase feedback from underrepresented groups.	• Waiting times segmented by ethnicity, deprivation, gender, IMD and vulnerability. • DNA and cancellation rates by population group. • Uptake of interpreting services and accessible information. • Patient feedback from underserved groups. • Percentage of services with up-to-date accessible patient information.
We will continue to develop and redesign	Increasing demand and patient complexity require services to be	• Ensure the flow improvement programme,	• Achieve an average non-elective length of stay of 7.7	• ED 4-hour and 12-hour performance.

Quality Account Priority	Why are we focusing on this as an area for improvement?	What are we doing to improve?	Goals for 2026/27	Performance Indicators
services to meet the changing needs of our local population, supporting timely, joined-up care and avoiding unnecessary hospital attendance.	redesigned to improve flow, reduce delays and deliver more care closer to home. Delays in care and discharge impact safety, experience and outcomes.	with a focus on EUC and ED, consistently applies QI methodologies. • Expand Same Day Emergency Care (SDEC) and community-based models. • Improve patient flow through real-time data, pathway optimisation and multidisciplinary working. • Embed continuous improvement within operational flow programmes.	days or less. • Reduce delayed transfers of care to no more than 40 patients (NCTR). • Reduce ED 12-hour waits to no more than 6.5% of patients.	• Length of stay and delayed transfer of care metrics. • RTT 18-week and 52-week performance. • Cancer pathway standards (28-, 31-, and 62-day). • Alignment with 26/27 planning guidance emphasising the development of neighbourhood services and closer to home care.

2.2 Statements of Assurance from the Board

The Trust provides statements of assurance to the Trust Board in relation to:

- Mixed sex hospital accommodation
- Modern slavery
- Safeguarding adults and children.

Mixed sex accommodation declaration

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. The Trust are committed to providing every patient with same sex accommodation to help safeguard their privacy and dignity when they are often at their most vulnerable. Patients who are admitted to hospital or come in for a planned day case will only share the room or ward bay where they sleep, with members of the same gender, and same gender toilets and bathrooms will be close to their bed area.

There are some exceptions to this. Sharing with people of the opposite sex may sometimes be necessary. In addition to clinical need other reasons for exceptions would be in a major incident or to maintain infection prevention and control isolation. This will only happen by exception and will be based on clinical need in areas such as intensive/critical care units, emergency care areas and some high observation bays. In these instances, every effort will be made to rectify the situation as soon as is reasonably practicable and staff will take extra care to ensure that the privacy and dignity of patients and service users is maintained.

Modern Slavery Act

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

Safeguarding Adults and Children Declaration 2025/26

Equality, Diversity and Inclusion

Whittington Health NHS Trust is committed to providing equitable, inclusive and non-discriminatory care in accordance with the Equality Act 2010 and the NHS Constitution. The Trust recognises and values the diversity of the population it serves and ensures services are culturally informed, accessible and responsive to individual needs. Workforce diversity supports understanding of cultural, spiritual and social needs, promoting safe and personalised care.

In line with the Modern Slavery Act 2015, the Trust publishes an annual Modern Slavery Statement outlining actions taken to prevent slavery and human trafficking within its services and supply chains.

Safeguarding Adults and Children Declaration 2025/26

Whittington Health NHS Trust is committed to safeguarding and promoting the welfare of children, young people and adults at risk. The Trust meets its statutory responsibilities under the Children Act 1989, Children Act 2004, Working Together to Safeguard Children 2026, and the Care Act 2014. Safeguarding is embedded across the organisation and remains a core responsibility for all staff to ensure care is delivered in a safe, secure and compassionate environment.

Governance and Leadership

Robust governance arrangements ensure effective oversight and accountability for safeguarding. The Chief Nurse and Director of Allied Health Professionals is the Executive Director with responsibility for safeguarding children and adults. Heads of safeguarding and named and designated safeguarding professionals provide expert leadership, advice and assurance.

The Joint Safeguarding Committee meets quarterly and reports through the Quality Assurance Committee to the Trust Board. Safeguarding arrangements are supported and challenged by the West and North London ICB

Think Family Approach

In line with Working Together to Safeguard Children 2026 and the Children Act 2004 duty to cooperate, the Trust adopts a child-centred, whole-family (“Think Family”) approach, recognising that safeguarding risks often affect multiple family members and may involve cumulative or intersecting harms.

The Safeguarding Children and Safeguarding Adults teams work collaboratively to address risks including domestic abuse, both child and adult sexual abuse and exploitation, contextual and online harm, Prevent-related vulnerabilities, and risks associated with transition from childhood to adulthood.

Systems and Processes

The Trust has effective systems to safeguard patients and the workforce. Disclosure and Barring Service (DBS) checks are completed for all staff, with enhanced checks where roles involve children and/or adults at risk. A Designated Officer manages workforce safeguarding concerns and works closely with Local Authority Designated Officers (LADO) in accordance with statutory guidance.

For adults, the Trust follows the Persons in Position of Trust (PiPoT) framework.

Systems support identification, information-sharing, escalation and follow-up of safeguarding concerns, including for children and adults who miss appointments and where risks may indicate impairment of health or development under the Children Act 1989, and care and support needs in line with the Care Act 2014.

Policies

Safeguarding adults and safeguarding children's policies and procedures are in place and reviewed regularly to ensure alignment with current legislation and statutory guidance, including the Children Acts 1989 and 2004 and Working Together to Safeguard Children 2026, and Safeguarding Adults Policy 2025. Policies are overseen by the Joint Safeguarding Committee and Quality Assurance Committee, with accountability to the Trust Board.

Training

Safeguarding training is mandatory and role-specific for all staff. Training is delivered in accordance with Working Together to Safeguard Children 2026, the Safeguarding Children Intercollegiate Document (2025) and Adult Safeguarding: Roles and Competencies for Health Care Staff (2024), ensuring staff are competent to recognise risk, take timely action and fulfil statutory safeguarding duties.

Assurance

The Trust is an active partner in Local Safeguarding Children Partnerships (Haringey, Islington and Barnet) and Safeguarding Adults Boards (Haringey and Islington). Section 11 audits under the Children Act 2004 and partnership challenge processes provide assurance, and learning from safeguarding reviews is monitored and embedded.

Declaration

This summary provides assurance to the Trust Board that Whittington Health NHS Trust is meeting its statutory safeguarding responsibilities under the Children Act 1989, Children Act 2004, Working Together to Safeguard Children 2026 and the Care Act 2014, with effective governance, systems, workforce competence and partnership arrangements in place.

Subcontracted Services

Whittington Health provided services across the acute and community services in 2025/26. Of these services a number were subcontracted.

The Trust reviews all data available to them on the quality of care provided by sub-contracted services. The finance team review with the division responsible for the service and via contract management review process.

The income generated by the relevant health services reviewed in 2025-26 represents 100% of the total income generated from the provision of relevant health services that Whittington Health provides.

A breakdown of the individual subcontracted services can be found below:

Sub-Contractor **[Name]** **[Registered Office]** **[Company number]**	**Service Description**
Camden and Islington NHS Foundation Trust, 4th Floor, East Wing, St Pancras Hospital, 4 St. Pancras Way, LONDON NW1 0PE	Provider of Psychology services
London Central and West Unscheduled Care Collaborative Ltd [LCW UCC Ltd] St Charles for Health and Wellbeing Exmoor Street W10 6DZ	Urgent Care Centre Provider
The Royal Free NHS Foundation, Trust, Royal Free Hospital, Pond Street, London, NW3 2QG	Ophthalmology outpatients and PET/CT scans, Vascular
University College London Hospitals NHS Foundation Trust, University College, Hospital, 235 Euston Road, London NW1 2BU	ENT Outpatient Service Endoscopy (Bowel Scope Screening SLA) – Haematology (Lymphoma Tests)
WHITTINGTON PHARMACY CIC, Whittington Pharmacy, High Gate Hill, London, N19 5NF, 10593765	Pharmacy
Pathology Joint Venture - Health Services laboratories (“HSL”)	Support the provision of pathology services

Participation in Clinical Audits 2025/2026

During 2025/2026**, 66** national clinical audits including **6** national confidential enquiries covered relevant health services that Whittington Health provides.

During that period, Whittington Health participated in **98%** of national clinical audits and **100%** of national confidential enquiries of those it was eligible to participate in.

The national clinical audits and national confidential enquiries that Whittington Health was eligible to participate in during 2025/2026 are detailed in **Appendix 1.** This includes the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Additionally listed are the **22** non-mandatory national audits in which the Trust also participated during 2025/2026, **See Appendix 2.**

Whittington Health intends to continue to improve the processes for monitoring the recommendations of National Audits and Confidential Enquires in 2026/2027 by ensuring:

- National audit and national confidential enquiries will remain the predominant feature of our Divisional clinical audit and effectiveness programmes.
- Learning from excellence will continue to form an intrinsic part of our work, and innovative ways of promoting and celebrating successes will be considered and shared.
- Multidisciplinary Improvement Afternoons will include reflective learning on national clinical audit findings and associated quality improvement.
- The Clinical Effectiveness Group will continue to ensure actions from national audit reports are scrutinised and monitored at the highest level.
- Internal pathways and processes will be subject to rigorous and ongoing monitoring to ensure optimal performance.

The reports of **30** national clinical audits/national confidential enquiries were reviewed by the provider in 2025/2026.

Examples of results and actions being taken for a national clinical audit:

National Cardiac Arrest Audit Public Report 2023-24:

The National Cardiac Arrest Audit (NCAA) collects data on in-hospital cardiac arrests attended by resuscitation teams in the UK.

The annual report published in April 2025 demonstrated that Whittington Health has achieved **excellent** results in the following areas:

- Whittington rate of cardiac arrest on the wards per 1000 hospital admissions remains well below the national average at 0.31 compared to 0.47.
- Whittington overall Return of Spontaneous Circulation (ROSC) > 20 mins is 60% compared to 52.4% nationally.
- Whittington in-hospital ROSC > 20mins 63.8% compared to 45% nationally
- Whittington ‘survival to hospital discharge’ is 42.1% compared to 25.2% nationally

- Whittington 'survival to hospital discharge for Ward arrests' is well over double the national average 45.5% compared to 16.8%

Whittington Health achieved **good** results in the following area:

- The overall cardiac arrest rate including Emergency Department (ED) and level 3 areas has reduced compared to the previous year and is close to the national average: 1.11 compared to 0.98.

Action to be taken:

To facilitate continuous improvement, staff have been asked to improve the use of National Early Warning System (NEWS 2) and 'Call for Concern' in the Emergency Department.

British Association of Urological Surgeons (BAUS): Environmental Lessons Learned and Applied to the Bladder Cancer Pathway (ELLA) Audit

Healthcare causes 5% of global greenhouse gas emissions and there are many opportunities to decarbonise clinical delivery whilst maintaining quality patient care. Healthcare's environmental footprint causes collateral human harm, both now and for future generations. Clinically led transformation will play an essential part in the NHS reaching its net zero targets. This audit was a baseline audit against 'Getting it Right First Time' (GIRFT) recommendations for decarbonising the bladder cancer care pathway. It assessed national practice variation and estimated "excess" addressable greenhouse gas emissions associated with practice.

The overall assurance for this audit was **green**.

Example actions to be taken from national recommendations:

Result	Action to be Taken
Using advice and guidance to optimise secondary care referrals	NIL
Delivering one-stop haematuria assessment	Most haematuria referrals are seen in a one stop clinic. Need to review the option of same day CT Urography (CTU)
Decarbonising the flexible cystoscopy procedure	Irrigation bag sizes used: 250mL Patient attire for cystoscopy: Own clothes Number of absorbent pads used: 0-1
Performing flexible cystoscopy in a clinic setting	Nil
Avoiding overuse of CT urogram for haematuria assessment	Ultrasound for Non-visible Haematuria (NVH) CTU for Visible Haematuria or according to clinical Judgement for high-risk patients
Maximising day-case bladder tumour resection rates	Need to review service and assess number of cases done as day cases and how to improve on service

Result	Action to be Taken
Optimising anaesthesia for bladder tumour resection	Advice: Not use nitrous oxide. Increase rate of spinal anaesthesia to a 36% benchmark. Reduce Intravesical Therapy (IVI) use to 50% of cases
Decarbonising the bladder tumour resection surgical field	Items only opened when needed (based on probable use estimates) Reusable gowns and drapes used instead of single use. Suction liners avoided
Offering biopsy and ablation at check flexible cystoscopy	Review current practice and consider setting up a Transurethral Laser Ablation (TULA) service

Local Clinical Audits:

Whittington Health intends to continue to improve the processes for monitoring the recommendations of local clinical audits in 2026/2027 by ensuring:

- Reactive local audits, vital to patient safety, will remain of intrinsic value to local clinical audit and effectiveness programmes.
- Project proposals will continue to be subject to a centralised and multidisciplinary quality review to prevent duplication and to ensure alignment to speciality priorities.
- Bespoke clinical audit training packages will continue alongside pre-existing workshops open to staff of all designations and grades.
- Speciality performance in relation to local clinical audit will continue to be monitored on an ongoing basis, with regular reporting via the Divisional Board meetings.

The reports of **61** local audits were reviewed by the provider in 2025/2026.

Example of results and actions being taken for a local clinical audit:

Evaluation of the Transfusion-Associated Circulatory Overload (TACO) checklist in Clinical Use

TACO is defined as acute or worsening respiratory compromise and/or acute or worsening pulmonary oedema during or up to 12 hours after transfusion.

The Medicines and Healthcare Products Regulatory Agency (MHRA) issued a National Patient Safety Alert in April 2024 ‘Reducing the risk of Transfusion associated circulatory overload’. In response, the TACO risk assessment tool was modified and incorporated into the Trust Transfusion Record. The audit objective was to measure the TACO risk assessment tool usage rate and mitigating measures initiated.

The TACO risk assessment appears to be well adopted into practice as excellent engagement was seen in 97% (30/31) of cases audited.

Where a TACO checklist was performed, 73% (22/30) demonstrated the need for mitigating action.

Actions taken:

The following actions were included in the teaching slides:

- Highlight to users the significance of inputting transfusion observations on vitals in real time, to improve the accuracy of transfusion data.
- Highlight to users the importance of completing assigned actions.

Transient loss of Consciousness (TLOC) audit

Transient loss of consciousness (TLoC) is a common presentation to medical admission units (MAU) with multiple aetiologies. TLOC was originally audited in 2010/11 when the National Institute of Health and Clinical Excellence (NICE) TLOC guidance was first published, the guidance was updated in 2023 and to which this audit relates. A base-line audit was completed; intervention work was subsequently undertaken and a re-audit completed. The re-audit demonstrated a considerable increase in compliance with the following actions noted as required for further improvement:

- To improve assessment, a flow chart is to be added to the Medical Emergency Department Library protocol.
- Discussion with ED to see if a TLOC proforma on *CareFlow would be useful.

**CareFlow refers to the Electronic Patient Record and clinical communication platform widely used across the NHS.*

Re-evaluation of Treatment Escalation Plan documentation for Orthopaedic patient admissions post intervention

Treatment Escalation Plans (TEPs) are crucial for ensuring patient-centred care by clearly outlining ceilings of care and guiding healthcare teams during episodes of acute deterioration. In the orthopaedic patient population, which includes both paediatric and frail elderly patients with multiple co-morbidities, establishing a TEP at the point of admission is recommended by NICE and local trust policies. However, evidence suggests that TEP documentation in this setting is often inconsistent, potentially leading to inappropriate resuscitation, unwanted escalation of care, and distress for patients and their families.

This re-audit has shown improved compliance from the baseline audit, and the following actions are being taken:

- Dissemination of information regarding importance of TEP documentation in departmental meetings.
- Training and awareness of the appropriate clinical note form to be completed on Careflow for TEP documentation.
- Creation of educational material (posters) with the above information to be displayed in the handover room/doctors' offices

To assess the quality of Whittington Community Dental Service Dento-Alveolar Trauma Assessments

The Community Dental Service accepts referrals for dental trauma from primary care settings across 10 London Boroughs. The service needs to ensure that these are being managed appropriately which includes seeing patients in a timely manner, conducting the correct investigations and referring for specialist advice/management as necessary. The International Association of Dental Trauma (IADT) outlines how to manage traumatic dental injuries and the unfavourable outcomes to be aware of. The rationale for this audit is to ensure that these guidelines are being followed.

The audit found that there are some areas where the service is doing well and other areas requiring improvement with the following actions required:

Result	**Action to be Taken**
Time between receipt of trauma referral and initial trauma assessment	Discussion with triaging team/administration staff to identify how trauma referrals can be easily identified and booked into clinician diaries in appropriate time frame
Collecting the correct clinical and radiographic observations at initial and follow up dental trauma consultations Seeking specialist advice – currently performing well	• Discussion with specialists regarding results of the audit and implementation of any further action plan. • Teaching session to be delivered to the wider service regarding trauma management, use of dental trauma stamp, and highlighting complex trauma to specialists. • Survey: to identify the reason why the dental trauma stamp is not being utilised in order to help identify how it may be improved or be more accessible to staff. • Written protocol: to develop a written protocol on managing trauma assessments that are in line with trauma guidelines as well as Trust standards.

Participating in Clinical Research

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

The Trust's research activity has remained stable. The in-house Research & Development (R&D) office has continued to provide a robust and responsive service ensuring study set-up is proportionate and works with the Trust's developing priorities in an efficient and cost-effective way. The speed of approval process has been 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), HEE (Health Education England) and other awards to facilitate protected time for research development (specialist physiotherapy and occupational therapy services).

Many of the Trust 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 (RID-TB)) which has had a 'no-cost extension' in response to delays in meeting milestones, predominantly due to the COVID-19 pandemic and import changes in response to Brexit.

The table below sets out the recruitment of patients to NIHR portfolio studies during 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	1674	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-Behavioural 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.

Registration with the Care Quality Commission (CQC)

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.

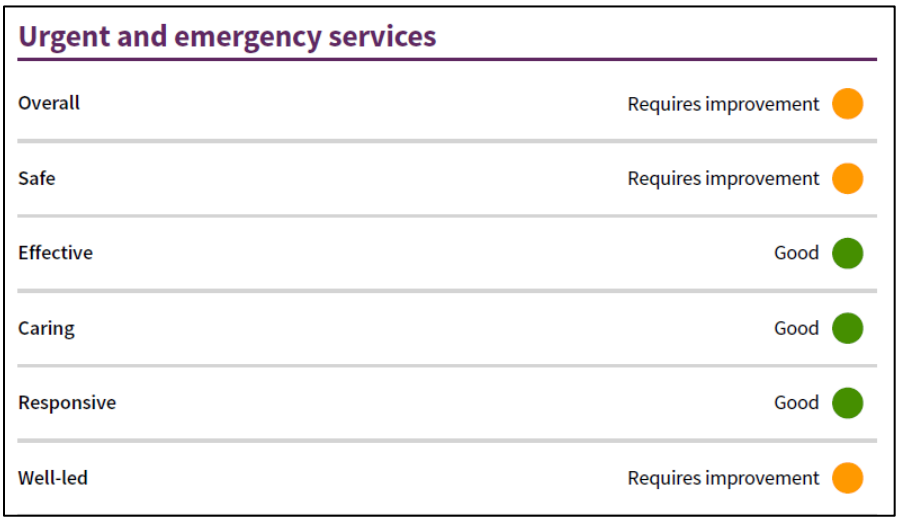
There were four CQC relationship meetings held in 2025/2026, which focussed on key performance and risk, an update on Barnet 0-19 Children's Services, Urgent and Emergency Care and medicines management.

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, CQC carried out an unannounced inspection of Urgent and Emergency services.



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 have been undertaken to support clinical areas improve the quality of care and to share good practice.

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

The CQC Single Assessment Framework, 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 need
- 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.

The CQC is currently undertaking a consultation[1] on the Single Assessment Framework which closes in June 2026 but would then be followed by pilots of any new Single Assessment Framework.

Information Governance (IG) Assessment Report

Information governance (IG) is to do with the way organisations process or handle information. The Trust takes its requirements to protect confidential data seriously and continually seeks to strengthen the many areas of information governance, including data quality, subject access requests, freedom of information and incident management.

The Data Security and Protection Toolkit (DSPT) is a policy delivery vehicle produced by the Department of Health and Social Care; hosted and maintained by NHS England. It combines the legal framework including the UK General Data Protection Regulations (UK GDPR) and the Data Protection Act 2018, and central government guidance including the NHS Code of Practice on Confidentiality. It also combines aspects of various professional standards, such as Cyber Essentials and ISO27001. The framework ensures the Trust manages the confidential data it holds safely and within statutory requirements.

During the year the Trust implemented an improvement plan to achieve DSPT compliance and to improve compliance against other standards. As a result, the Trust hopes to meet the majority of the mandatory objectives. The Trust's DSPT submission and former IG Toolkit submissions can be viewed online at www.dsptoolkit.nhs.uk.

Regarding IG training, all staff are required to this annually. The Trust ended IG training compliant compliance at the time of reporting is 89% against a target of 90%. 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 includes news features in the weekly electronic staff Noticeboard and manage classroom-based sessions at inductions.

Information Governance Reportable Incidents

IG reportable incidents are reported to the Department of Health and Information Commissioner's Office (ICO). Reportable incidents are investigated and reported to the Trust's incident panel, relevant executive directorate or ICSU and the Caldicott Guardian and the Senior Information Risk Owner (SIRO). The IG committee is chaired by the SIRO who maintains a review of all IG reportable incidents and pro-actively monitors the action plans. The Trust declared three reportable incidents in 2025/26 at the time of reporting.

Data Quality and Clinical Coding

The Trust maintains robust oversight of data quality across all national data submissions. Quality checks are undertaken at the point of submission, and any issues identified by NHS Digital are promptly investigated and addressed. Where challenges relate to system constraints, the Trust continues to work collaboratively with system suppliers to ensure that necessary fixes are incorporated into planned system upgrades in line with contractual arrangements.

Key Community Services data indicators are routinely reviewed through the RiO User Group. This forum enables the Trust to identify priority data quality issues, monitor progress against improvement initiatives, and share updates with stakeholders. The outcomes of external clinical coding audits are detailed in the table 1 below.

The Trust continues to develop and enhance its Power BI Data Quality Dashboard, which provides a central, self-service platform for Divisions to review core data quality metrics. The dashboard supports drill-down analysis to service and clinic level, enabling teams to take targeted corrective action where required. Additional metrics are being introduced on an ongoing basis to strengthen local monitoring and assurance.

To further embed a culture of high-quality data, the Trust will continue to implement the following actions:

- Support services to actively use data quality dashboards to monitor and improve their own data, with ongoing expansion of available metrics.
- Issue targeted data quality alerts to services where improvements in data entry are required, supported by visibility within the Power BI dashboard.
- Routinely review data quality at Divisional Performance Reviews through dedicated agenda sections.
- Continue to perform routine waiting lists data audits
- Produce and present a quarterly Data Quality report to the Innovation & Digital Transformation Group (IDTG).
- Introduce high-level data quality oversight through the Information Governance Committee (IGC).
- Deliver all data quality actions set out within the Data Quality Improvement Plan (DQIP) under Schedule 6 of the NHS Standard Contract, working closely with West and North London ICB (WNL).
- Continue a programme of regular internal clinical coding audits.
- Apply systematic benchmarking where comparable data sources are available.
- Maintain a structured programme of clinical coding audits with associated action plans.
- Actively participate in national and WNL ICB data quality improvement initiatives, including work relating to daily data flows, theatre activity submissions, Virtual Wards, and the Community Services Data Set (CSDS).

Table: External clinical coding audit results 2025/26

	Standard Met	**Standard Exceeded**	**Whittington External Audit Results**	**Audit Achievement**
Primary Diagnosis	*>=90%*	*>=95%*	97%	Standard Exceeded
Secondary Diagnosis	*>=80%*	*>=90%*	98.9%	Standard Exceeded

Primary Procedure	*>=90%*	*>=95%*	97.2%	Standard Exceeded
Secondary Procedure	*>=80%*	*>=90%*	94.6%	Standard Exceeded

Source: Whittington Annual Clinical Audit 2025-26

End of life care

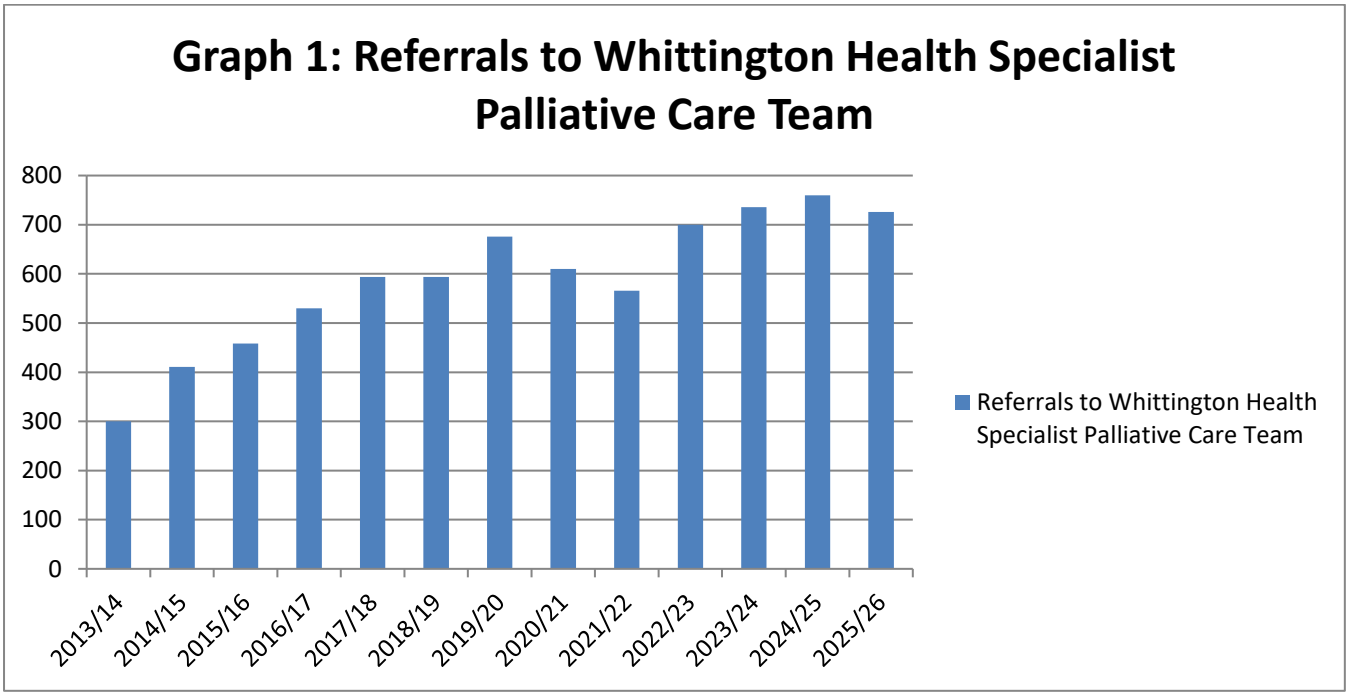
Adult Specialist Palliative Care Service

The Whittington Hospital Specialist Palliative Care team (SPCT) is a liaison service providing advice and guidance to the acute hospital teams caring for patients with palliative care needs. We manage physical symptoms, provide psychological support to patients and families, and engage in advance care planning to ensure that patients are discharged to their preferred place of care and die in their preferred place of death. We also provide education for non-specialist clinicians delivering palliative and end of life care.

The team has a visible presence across all hospital adult wards, including ambulatory care and ED. We have robust relationships and maintain regular contact with the Haringey (North London Hospice) and Islington (CNWL) community palliative care teams to facilitate joined up care across settings for patients and families.

Activity

At Whittington Health we cared for 447 adult patients who died during an acute admission (including in the Emergency Department) in 2025. The SPCT saw well over half of these patients. Our referrals for March 2025 to March 2026 were 726 which is similar to last year (760). Our staffing levels are unchanged since 2022 when our referrals were around 570 per year.



As well as increasing numbers of referrals, the complexity of our caseload has increased over time, particularly the amount of complex family support required. 80% of patients referred to SPCT in Q1 of 2025/26 were in an unstable or deteriorating phase of their illness at the time of referral, 8% were dying and only 12% of referrals were in a stable phase of illness:

Month	Deteriorating	Dying	Stable	Unstable	Total
Apr	18	5	8	20	51
May	20	5	9	17	51
Jun	14	3	8	32	57
Jul	22	5	2	27	56
Total	74	18	27	96	215

- **Stable:** Patients in the stable phase have their symptoms and concerns well-managed, and their care plan is functioning effectively. No urgent interventions or changes in the care plan are needed.
- **Unstable:** This phase indicates the need for a change in the care plan or a potentially urgent intervention. It may involve new or rapidly worsening symptoms, or unexpected changes in the patient's condition or their family's situation.
- **Deteriorating:** Patients in the deteriorating phase experience gradual and expected deterioration of their condition. While not an emergency, their symptoms and concerns require regular review and assessment.
- **Dying:** This phase signifies that the patient is expected to die within a short period, typically days or weeks. Care focuses on managing symptoms and providing comfort and support.

The SPCT proactively supports advance care planning discussions, including recording a patient's preferred place of care and death and whether this is achieved. Where appropriate, this is uploaded into the Pan-London Universal Care Plan (UCP), so it is visible to all urgent and emergency care staff. In Q1 of 2025/26, approximately 54 palliative care patients had a UCP updated or created by the SPCT.

Quality and Performance Indicators

The SPCT participates in the National Audit of Care at the End of Life (NACEL) on behalf of the Trust. The audit runs continuously across the year and we submit data quarterly. Along with case note reviews, there are quality surveys available to bereaved carers and an overview of the hospital looking at data including workforce, training, 7-day service provision and numbers of inpatient neds. The table below shows our key performance indicators, which are comparable to our local peer trusts.

No	Key Indicator	Submission (n)	Submission (%)	Peer Group (n)	Peer Group (%)	Country (n)	Country (%)	Sample (n)	Sample (%)
1	Deaths expected during final admission	80	92.5%	2,627	87.1%	17,028	84.1%	17,669	83.8%

No	Key Indicator	Submission (n)	Submission (%)	Peer Group (n)	Peer Group (%)	Country (n)	Country (%)	Sample (n)	Sample (%)
2	Hydration discussion documented	79	91.1%	2,557	70.9%	16,635	62.6%	17,262	62.3%
3	Anticipatory medication prescribed	78	94.9%	2,469	89.4%	16,261	88.0%	16,876	88.0%
4	Emotional/psychological needs assessed	79	96.2%	2,583	87.9%	16,760	84.4%	17,399	84.0%
5	Overall care rated excellent or good	0	-	859	73.2%	5,593	74.3%	5,726	74.6%
6	Face-to-face specialist palliative care available	1	0.0%	31	48.4%	172	66.9%	179	67.0%
7	Sensitive communication with bereaved	0	-	855	82.9%	5,619	83.3%	5,753	83.5%
8	Individualised end-of-life care plan	74	89.2%	2,271	83.2%	14,259	84.9%	14,714	84.7%
9	Ethnicity documented	80	83.8%	2,625	89.9%	16,995	89.2%	17,628	88.3%

The hospital is currently undergoing the NACEL 2026 audit. This will include a staff reported measure.

We have continued to run highly praised study days for nursing and AHP staff in the Trust on palliative care and communication skills. We also contribute to medical and nursing induction programmes and in regular rolling teaching to Healthcare Support Workers (HCSWs), student midwives and others. We have also taught ITU, Emergency Department, Pharmacy, Care of elderly physicians and Respiratory teams over the last year. One of our experienced band 7 Clinical Nurse Specialists has retired in early 2025, and we have now recruited to her part time position.

Learning from Deaths

During 2025/26, there were 378 inpatient deaths at the Trust (this figure excludes patients who died in the emergency department) with the following distribution seen across the year:

Quarter 1	81
Quarter 2	102
Quarter 3	101
Quarter 4	94

Our latest SHMI is 0.87 (November 2024 - October 2025). This result is in band 2 which means that we continue to lie in the as expected range for our mortality outcomes. The Hospital Standardised Mortality Ratio (HSMR) is 81.51(January 2025 - December 2025).

Oversight

The Trust has an embedded process to screen, review and investigate inpatient deaths. The Mortality Review Group (MRG) has oversight and reports to the Quality Governance Committee and Quality Assurance Committee. From HED (Healthcare Evaluation Data- our external reviewer) our SHMI, HSMR (Hospital Standardised Mortality Ratio) have all been slowly falling and are within the expected range. There have been no disease specific mortality alerts. Our overall number of actual deaths has decreased. Our elective coding has improved. There remains some concern regarding the impact of late discharge summaries on our non-elective coding. There is a monthly audit of discharge summaries, and the distribution list is being reviewed and updated. There is a 3 monthly Learning from Death report. Acknowledging that this is a relatively long report, a brief summary of important events to learn from is generated and shared with the mortality and quality leads to hopefully improve awareness and learning from death.

Reviews

26 out of 378 deaths for the year were identified as meeting the criteria for a structured judgement review. Of the 26 identified deaths, 20 structured judgement reviews have been completed so far.

The table below shows the number of case record reviews by quarter and the number of deaths judged more likely than not to have been due to problems in care:

	Quarter 1 2025/26	**Quarter 2 2025/26**	**Quarter 3 2025/26**	**Quarter 4 2025/26**
Number of structured judgement reviews (requested and completed)	5 requested and 5 completed	8 requested and 6 completed	10 requested and 9 completed	3 requested and 0 completed
Number of deaths judged probably avoidable (more than 50:50)	1	0	0	0

Additionally, one death was reviewed via a PSII. A patient was given feed via a misplaced nasogastric tube into the lung. This is a never event leading to death, and it was therefore felt a more in-depth investigation was needed. A Coronial outcome is also awaited.

The Trust received two Prevention of Future Deaths (PFD) notices in 2025/26.

One was in response to the death of a young child in ED and related to expectations regarding the requirement for the need of observations to be completed, reviewed and documented. This is now documented within Careflow, our electronic medical record. This requirement has been disseminated at medical ED and surgical induction for all patients (adults and paediatrics). On discharge in a checklist on Careflow, doctors need to confirm when filling in the ED clerking: time and date of observations; a discharge checklist including a requirement for repeat observations within the last hour prior to discharge, with any abnormal observation at any time being repeated within 1 hour. There is an ongoing audit of this is occurring. There has been an improvement in nursing staffing and allocation to enable improved observations to occur.

Another PFD was issued in regard to the care that was delivered by the Whittington Health community team to a patient who subsequently died as an inpatient at another Trust. A response was submitted to HM Coroner which includes a Quality Improvement Project (QIP) in ED regarding adherence to our Pressure Ulcer (PU) Prevention and Management Policy. In the community ensuring patients have daily visits allocated individually, timely referral to TVN (Tissue Viability Nurse) and that learning should be shared regarding the development of PUs. An increase in support and training for staff involved in writing statements and attending the coroner's court, and ongoing audit and training regarding Duty of Candour has occurred as recommended by the Coroner.

In addition, there was a PFD issued to NHSE and the Department of Health and Social Care (DHSC) regarding a frail patient who was admitted and subsequently died at the Whittington Health. They were admitted via ED where they remained while waiting for an inpatient bed and there were concerns regarding overcrowding in the ED. However, the coroner felt that overcrowding was a problem not just at the Whittington, but also at other acute trusts, and so the PFD was issued to NHSE and DHSC rather than the Whittington.

Summary of themes, learning and actions from Structured Judgement Reviews

From the deaths reviewed in 2025/26, the key themes, learning and actions were:

In many reviews there was clear evidence of good standards of care including the involvement of the resuscitation team, medical, nursing and surgical teams, palliative care, MHLT (mental health liaison team) and MDTs (multi-disciplinary teams). There was evidence of good end of life care (EOLC) for patients in many reviews.

Learning themes identified were:

- Ensuring that patients have appropriate treatment escalation plans communicated clearly to them and their families at all times.
- Patients who re-present with medical problems after discharge from the ED, should be either reviewed by a senior doctor in ED or referred to the appropriate medical team.
- Referrals to Critical Care should be done promptly. No assumptions should be made that a referral has taken place, and communication regarding escalation should be documented.

- There was the death of one patient with a gynaecological cancer where imminent death was not recognised. A departmental update was organised regarding TEPs (treatment escalation plans) and ensuring good EOLC.

- Consistent monitoring needs to occur for all patients, but vigilance is required regarding respiratory rate monitoring for patients receiving opioids.

- Ensuring patients with a swallowing disturbance have SALT (Speech and Language Therapy) signs at their bedhead and that these are checked by all staff involved in providing nutrition for patients.

- To obtain early advice from ENT (Ear Nose and Throat) in patients presenting with nose bleeds and low platelet counts

- Ensure appropriate forms and containers are used for samples from operating theatres. An update to Bluespier (Operating Theatres IT system) regarding sample collection and form generation is occurring and will be included in the operating theatre sign out process.

- Falls:
    - Patients at high risk of falls require close monitoring, especially if they have had a recent fall. Baywatch needs to be maintained at all times for those at risk. Staffing challenges and redeployment can compromise observation and supervision, increasing falls risk.
    - Falls retrievals should follow protocols, using a HoverJack or other appropriate equipment, and involve the Trauma Team.
    - The Falls Lead and Ward Manager should be notified as soon as possible after a significant fall for oversight and leadership. Falls training remains important to ensure they are managed appropriately.

- National guidance is that patients with chest pain should be triaged within 15 minutes.

- Vigilance is required with radiology reports and reviews. There were 2 fractures missed initially in patients who had SJRs. REALM (Radiology Events and Learning Meetings) are mandated by the Royal College of Radiologists and missed radiological abnormalities are discussed at these meetings.

Learning from SJRs on patients with a serious mental illness (SMI) were:

- There was evidence of good care in the majority of patients.

- A patient with a significant psychiatric history was appropriately flagged to the safeguarding team on admission. The patient's care was complex as they were refusing medical interventions, and their level of capacity was fluctuant.

- Early involvement of the mental health liaison team, family and potentially palliative care were recognised to be important in cases and occurred in the majority. However, in two cases this was involvement felt by the reviewers to be late.

- Two patients were in distress when first seen by the palliative care team, and the learning is that both medical and nursing staff need to ensure that treatment is administered promptly.

- In more than one patient with SMI, reports highlighted the support given to relatives. However, accuracy of contact details for relatives on admission is always important and was flagged as absent in two reviews delaying their subsequent contact and involvement.

- When patients are admitted if they have previously been an inpatient, the medication history section on Careflow will pull through from their previous hospital admission. This section therefore needs review and updating on admission to reflect the up-to-date medications. This will be flagged on the Careflow clerking proforma.

Learning Disabilities (LD) and Autism

A patient with learning difficulties arrived at the hospital peri arrest and subsequently had a cardiac arrest. The reviewer noted that Advance Life Support (ALS) protocols were managed well and according to the Resuscitation Council guidance.

A man with LD was supported by the LD nurse throughout his stay. It was identified that he had an underlying malignancy. He had an 8 day wait for an inpatient nephrostomy which presents concerns regarding the length of wait and organisation around this. However, his cause of death was an unrelated catastrophic intracranial haemorrhage. He was correctly referred to the organ donation team but did not meet the criteria. The urology team are reviewing his care in relation to the delays around organising a nephrostomy for him.

There were no patients identified with a diagnosis of autism who died who had an SJR. There have been reminders communicated to the Medical Examiner team, and departmental Morbidity and Mortality leads to try and ensure that patients with autism should have an SJR. These would then be shared with the Learning from lives and deaths of people with learning disability and autistic people (LeDeR) team.

Maternal deaths

There were no maternal deaths

Neonatal deaths

There was one neonatal death in the first three quarters of 2025 to 2026. The baby subsequently went home after birth at the Whittington, was discharged from midwifery care at day 14, and then returned to ED at 17 days old in cardiac arrest. The coroner’s postmortem (PM) states SUDI (unexplained - sudden unexpected death of infancy). Sadly, all attempts at resuscitation were unsuccessful. The main learning points were around the use of interpreters and staff not following a plan made by the safeguarding team for further support to be offered to the family. Neither of these points were thought to have contributed to the death.

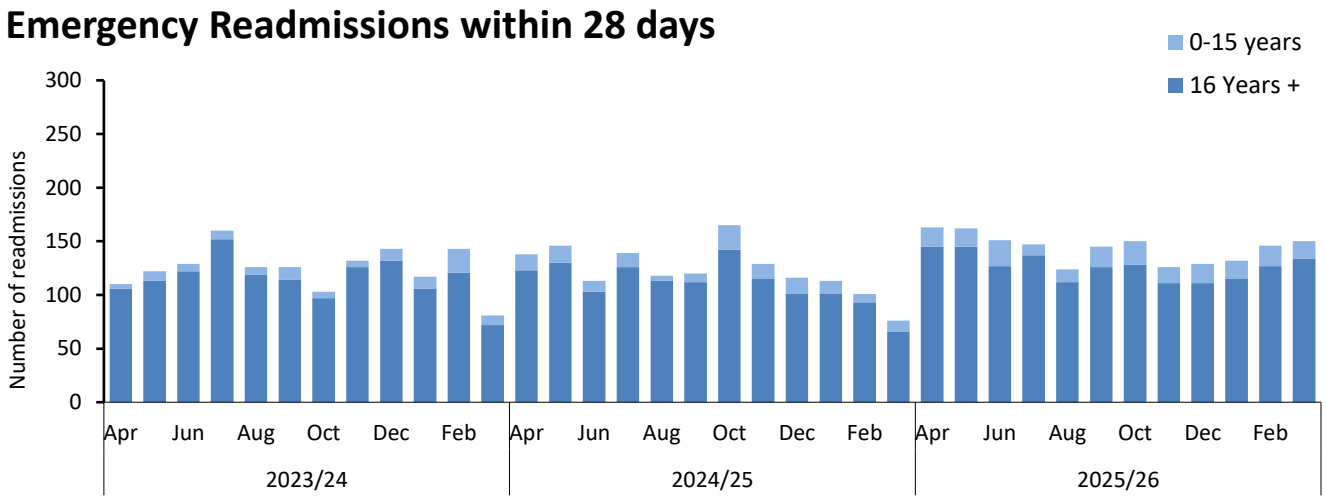
Paediatric deaths

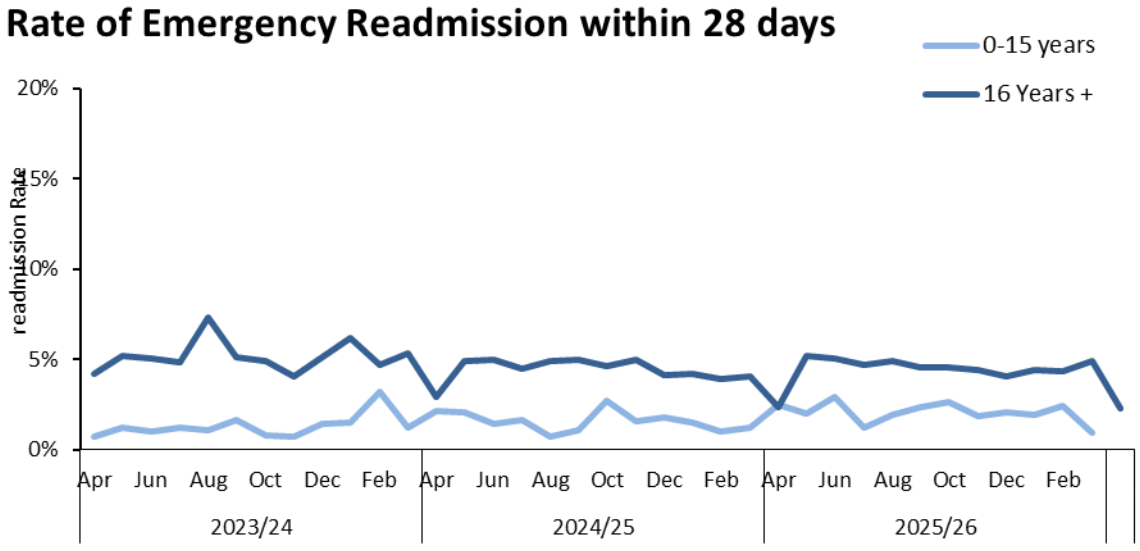
There was one paediatric death in the first three quarters of the year 2025 to 2026. A 17-year-old with a learning disability and complex social circumstances who had been in care for the last few years died. Palliative care were involved for relapsed acute lymphoblastic leukaemia. and they were admitted to Ifor ward for end-of-life care. Attempts were made to transfer the patient to a hospice (Noah's Ark) to be in an appropriate environment with his mother, but due to lack of nursing capacity, this was not possible.

Percentage of patients 0-15 and 16+ readmitted within 28 days of discharge

The Whittington Health NHS Trust considers that this data is as described because it has been produced specifically in line with stated requirements, reviewed thoroughly and compared closely to the metric that is used for routine board and departmental monitoring of readmissions.

*Data is reported against the month of discharge of the emergency readmission





*Data excludes patients between 0 and 4 years at time of admission or re-admission. Cancer and Maternity admissions and readmissions are excluded. Patients who discharged themselves are also excluded.

The data table that informs the graphs above can be found in Appendix 2

The Trust's Responsiveness to the Personal Needs of its Patients

Learning from National Patient Surveys 2025 - 2026

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

- Children and young people: fieldwork July - October 2024, publication March 2025 (TBC)
- Maternity: fieldwork April - June 2025, publication 10 December 2025
- National Adult inpatient 2024: fieldwork January - April 2025, publication September 2025

Adult Inpatient Survey 2025

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 SMS.

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.

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? ……
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	1Thinking 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 include 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
- Complaints

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

Overall Experience

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

Comparisons with other 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 - Question	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 - Question	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

- **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)

Staff Friends and Family Tests

Listening to Our Staff

This is the 15th year that Whittington Health, as an Integrated Care Organisation (ICO), has participated in the National NHS Staff Survey, and the eighth year in which all eligible staff were invited to give their views. The survey continues to be delivered independently by the Picker Institute to ensure confidentiality and robust benchmarking against comparable organisations in the Acute and Acute & Community Trust grouping

The 2025 National Staff Survey was open between September and November 2025 and was mandatory for all NHS trusts in England. Staff directly employed by Whittington Health as of 1 September 2025 were eligible to participate. Whittington Health is benchmarked against 121 Acute and Acute & Community Trusts nationally.

This Quality Report summarises the key findings from the 2025 Staff Survey, highlights progress against last year's improvement priorities and identifies areas of continued focus to support staff experience, engagement, and retention.

A total of 2,493 staff from 5,432 eligible employees completed the survey, producing a 46% response rate. This represents a 1% increase from 2024 and is just 1% below the benchmark group median of 47%, reflecting continued improvement in staff engagement with the survey process.

Response rate trends and respondent demographics (including occupational group, age, ethnicity, and protected characteristics) demonstrate good representation across the organisation

In the 2025 NHS Staff Survey, we ranked first on the overall positive score league table among all Acute and Acute Community Trusts that completed the survey with Picker, improving on our twelfth position in 2024. This represents a significant improvement in relative performance. Compared with peers, Whittington Health experienced more positive movement and fewer declines across measures, which has resulted in this top-ranking position

Staff Engagement Indicator

Whittington Health achieved a staff engagement score of 7.06, which is above the Picker benchmark average of 6.74, and continues a steady upward trend since 2021.

Staff engagement is measured on a 0–10 scale and is composed of three elements:

- Advocacy – recommending the organisation as a place to work or receive care

- Motivation – enthusiasm and willingness to go the extra mile
- Involvement – ability to contribute to improvements at work

This sustained improvement reflects a strengthening culture of staff voice and commitment across the organisation.

Staff Morale Indicator

The staff morale score for 2025 is 6.04, exceeding the benchmark average of 5.84 and representing Whittington Health's highest morale score to date since the indicator was introduced.

Morale is informed by staff perceptions of:

- Work pressures
- Stressors
- Thinking about leaving the organisation

The improvement in morale aligns with targeted Trust-wide actions over recent years focusing on wellbeing, retention, and work–life balance.

Whittington Health – overall results – Themes

In 2025, Whittington Health scored above average across all seven People Promise elements, as well as for staff engagement and morale – a significant improvement on previous years.

The largest year-on-year improvements were seen in:

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

All People Promise themes have improved consistently since 2021, demonstrating the cumulative impact of sustained organisational focus.

Most improved scores

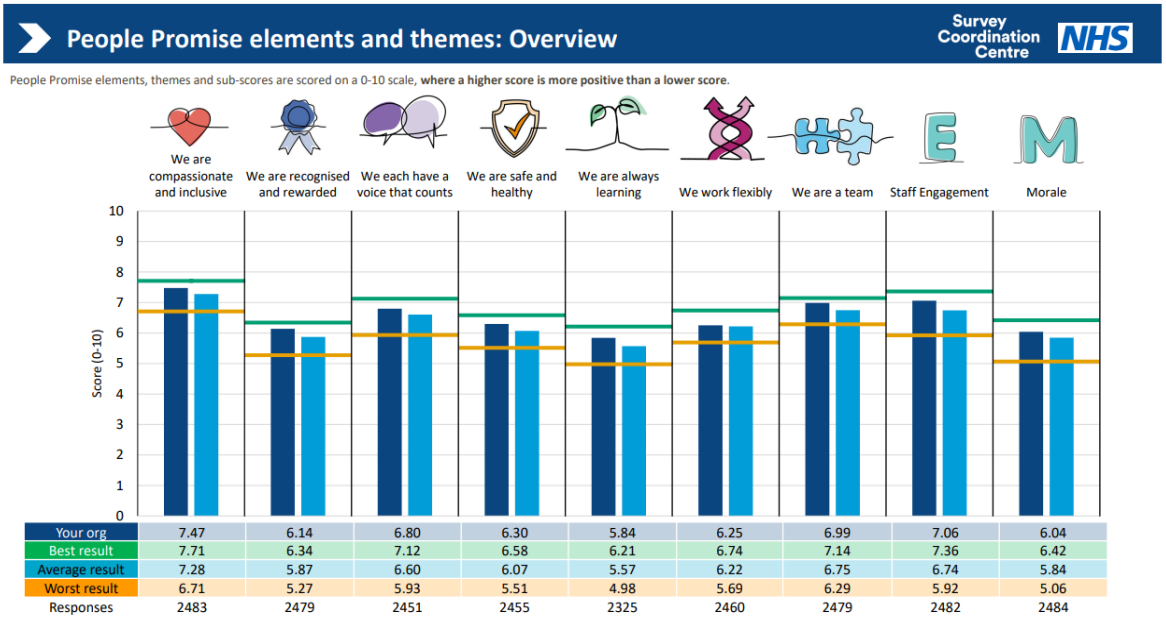
The five most improved scores compare 2025 results with those from 2024. Continued organisational focus on making reasonable adjustments as a Trust-wide priority has had a positive impact. In addition, actions taken following the 2022 Staff Survey deep-dive into access to adequate materials, supplies, and equipment, alongside staff feedback from focus groups and Trust-wide listening events, have contributed to these improvements.

The table below highlights the top five areas of improvement in 2025 compared to 2024.

Most improved scores	Org 2025	Org 2024
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	69%	63%
q3i. Enough staff at organisation to do my job properly	40%	35%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	48%	43%
q22. I can eat nutritious and affordable food at work	59%	54%
q3h. Have adequate materials, supplies and equipment to do my work	58%	53%

Most declined scores

The five most declined scores compare 2025 results with those from 2024. There is a perceived decline in staff satisfaction within the theme of career development, reflected across four of the lowest-scoring questions. Previous listening events indicate that time pressures limit access to training, managers may be perceived as a barrier, and there are fewer opportunities for stretch activities such as shadowing and mentoring.



In addition, there has been a 1% decline in responses to Q18 ('not seen any errors, near misses or incidents that could harm staff, patients or service users'), which requires further attention.

The table below shows the bottom five most declined scores for 2025 in comparison to 2024

Most declined scores	Org 2025	Org 2024
q24b. There are opportunities for me to develop my career in this organisation	52%	56%
q24c. Have opportunities to improve my knowledge and skills	70%	72%
q24a. Organisation offers me challenging work	65%	66%
q18. Not seen any errors/near misses/incidents that could have hurt staff/patients/service users	69%	70%
q3c. Opportunities to show initiative frequently in my role	76%	76%

Highest and lowest ranking scores

The top five scores offer a comparison to other acute and acute community trusts that used Picker for the survey. It highlights the areas where we are performing better than our benchmark organisations. These findings show that there is a clear patient-centred culture where staff feel valued for their work and contribution. There is strong staff advocacy in recommending Whittington Health as a place to work, and we rank as the 5th highest in London for this result. Staff are confident in the organisations responses in actioning concerns raised, which demonstrates a positive safety culture. Staff are also more positive than the benchmark organisations about having enough staff to do their job properly.

The table below shows the top 5 scores for the organisation compared to other acute and acute community trusts.

Top 5 scores vs Organisation Average	Org	Picker Avg
q25c. Would recommend organisation as place to work	68%	56%
q25b. Organisation acts on concerns raised by patients/service users	77%	67%
q4b. Satisfied with extent organisation values my work	52%	42%
q25a. Care of patients/service users is organisation's top priority	79%	70%
q3i. Enough staff at organisation to do my job properly	40%	31%

The bottom five scores offer a comparison against other acute and acute community trusts that used Picker for the survey. The question on "q31b Disability: organisation made reasonable adjustment(s) to enable me to carry out work" also featured in our most improved scores with a 6% increase since

2024, showing that good progress is being made in this area, although it features in our bottom five score too. In addition, “q10c Don’t work additional unpaid hours per week for this organisation, over and above contracted hours”, also features in the improved scores showing that improvements are being made, however we are still low compared to our benchmark organisations. The lower scores around “organisation offers me challenging work” connect with a continued need to focus on career development and progression.

The table below shows the bottom 5 scores for the organisation compared to other acute and acute community trusts.

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	69%	73%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	48%	52%
q24a. Organisation offers me challenging work	65%	67%
q14b. Not experienced harassment, bullying or abuse from managers	89%	91%
q13d. Last experience of physical violence reported	72%	73%

Performance against 2024 priorities and improvements made.

Following the Staff Survey findings of 2024, four Trust-wide improvement areas were identified; career development, wellbeing, disabilities and reasonable adjustments, and civility and respect. Each priority had executive sponsorship, a trust wide listening event and clear action plans to support improvement.

High impact interventions include, but are not limited to;

Career development	Wellbeing	Disabilities and reasonable adjustments	Civility and respect
New appraisal paperwork designed to support meaningful conversations. New manager's passport developed to support managers in their roles including career conversations. B2-7 BME Career Development Programme run London Wide	Early intervention for staff exposed to traumatic events. Wellbeing Champions Staff Engagement Roadshows: Bringing wellbeing services directly to teams. On-site Physical Activity: Subsidised classes	Toolkit created for Ableism and Disablism to educate staff. Using communication channels to promote existing reasonable adjustments pathway. New sickness policy e-learning module on Manager's passport.	Facilitated conversation training launched to divisions Civility and respect policy launched Mediation service open to all teams Internal and external coaching and mentoring offer for all staff.

Equalities Indicators from the Staff Survey

The Workforce Race Equality Standard (WDES) is an NHS framework designed to measure and improve race equality for staff working in NHS organisations. This year, we have seen improvements in all four of the questions related to race with reducing the difference of experience reported between global majority and white staff. For example, the difference with the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public is 3.8%, compared to last year which was 5.3%.

The Workforce Disability Equality Standard (WDES) is the NHS framework that measures and improves the experiences of disabled staff across NHS organisations. There has been a year-on-year improvement in seven out of the eight questions for WDES There has been significant effort put into improving reasonable adjustments which is showing positive results. However, there has been an increase in staff experiencing harassment, bullying or abuse from managers in the last 12 months.

A comprehensive Inclusion action plan continues to be developed and implemented which encompasses recruitment, eliminating pay gaps with respect to race, disability and gender, addressing health inequalities within workforce, induction, and onboarding of internationally recruited staff and eliminating conditions and environment in which bullying and harassment may occur.

Summary and Recommendations

The 2025 National Staff Survey shows that Whittington Health has achieved its strongest performance to date and has demonstrated steady improvements in staff engagement, morale, and all seven People Promise elements. However, challenges remain around career development, bullying and harassment, and reasonable adjustments.

Leaders from divisions have been offered group coaching to provide them with dedicated time to reflect and interpret their staff survey results and build a sustainable action plan. In addition, all leaders are encouraged to make their own action plans based on team results.

The Trust-wide priorities are to maintain focus on, career development, reasonable adjustments, and civility and respect. This will be supported by local listening events, targeted interventions for lower-performing divisions, and Trust-wide listening activities

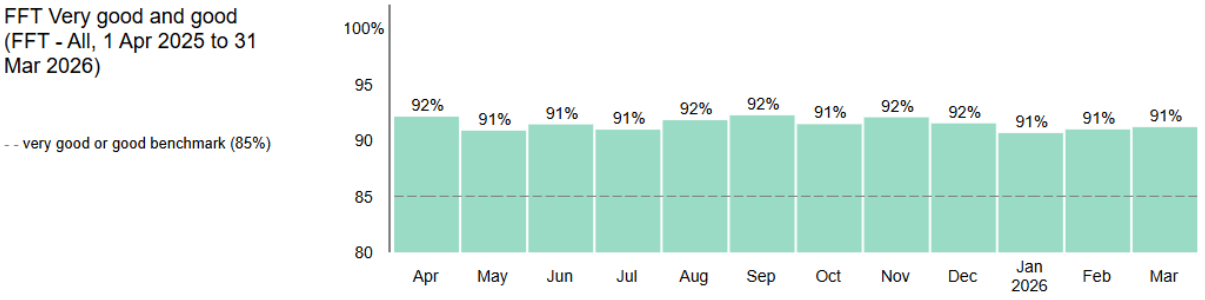
Patient Feedback: Friends and Family Tests

Friends & Family Test (FFT) 2025-2026

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

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

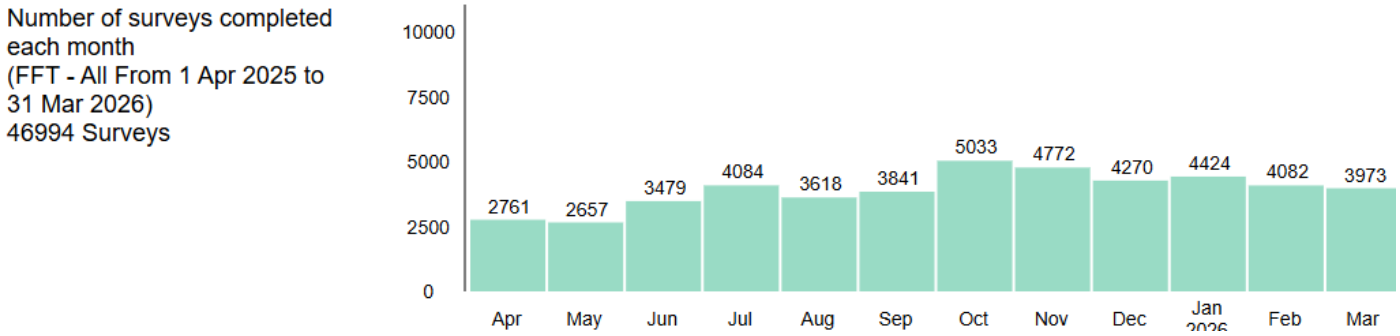
The graph below illustrates our monthly performance for “very good” and “good” ratings compared with the NHS 85% benchmark. It shows a consistently strong performance, with the Trust exceeding the national benchmark every month throughout the year.



Performance against the NHS benchmark by month 2025 - 2026

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

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



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

Work continues across the Patient Experience and Voluntary Services team to promote and increase Friends and Family Test (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.

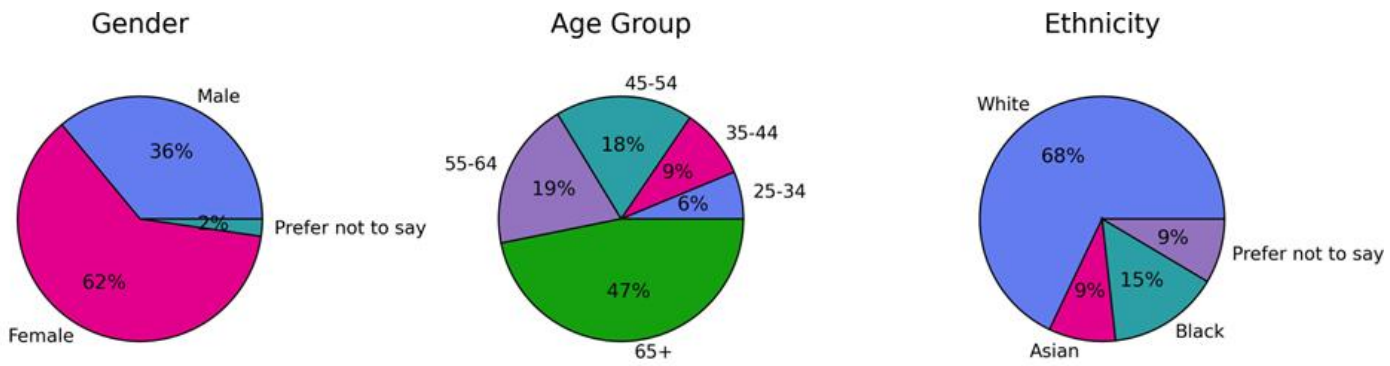
This work includes the ongoing collection of handwritten postcard feedback, which is uploaded into the electronic reporting system to ensure every patient voice is captured. Volunteers also provide valuable face-to-face FFT support across outpatient areas, maternity, and imaging, helping to improve accessibility 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:

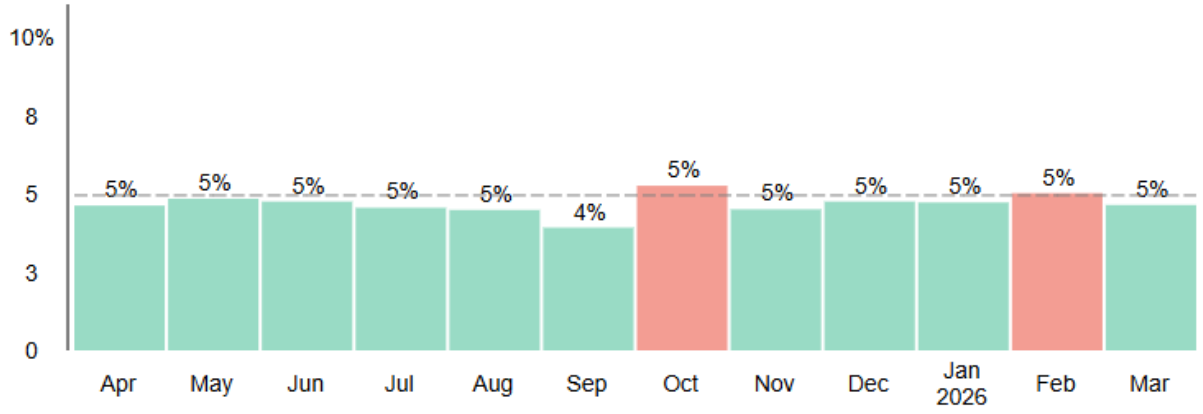
- SMS/text 28,297 and increase of 18,461 responses on 2024-2025
- Smartphone app/tablet/kiosk before or at point of discharge or at appointment 3,788responses, a reduction of 229 responses on 2024 - 2025
- Paper/postcards at the point of discharge 7, 584 responses
- Online survey after discharge/appointment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

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

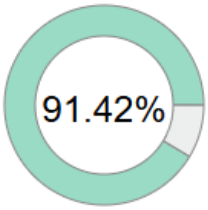
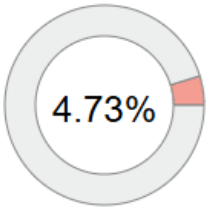
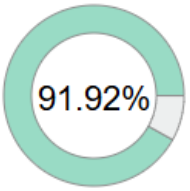
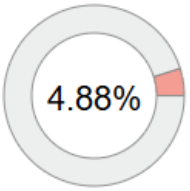
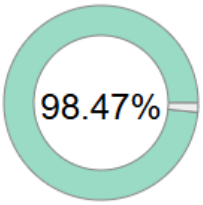
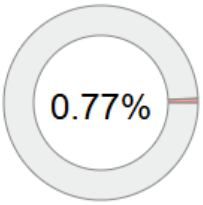
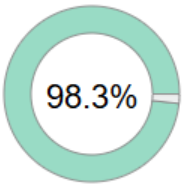
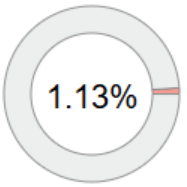
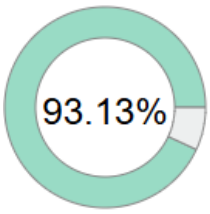
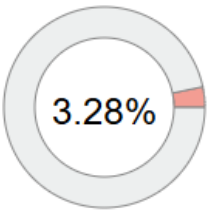
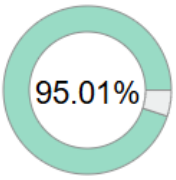
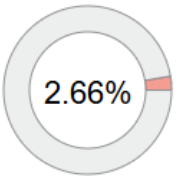
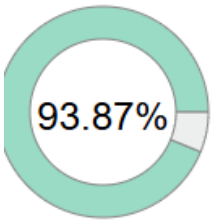
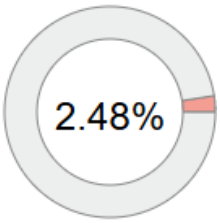
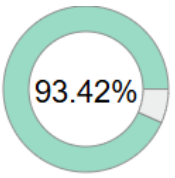
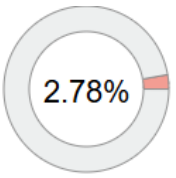
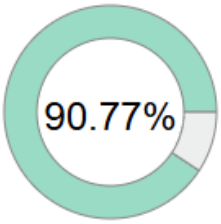
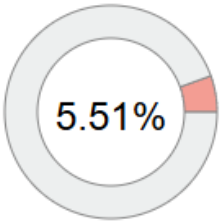
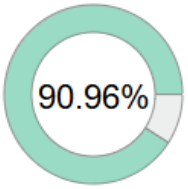
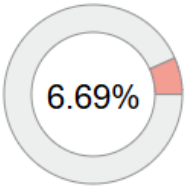
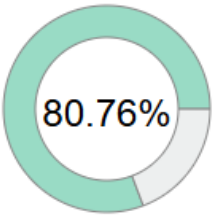
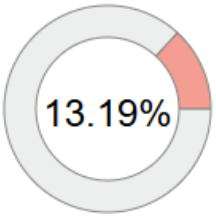
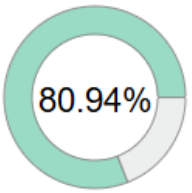
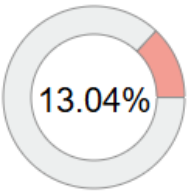
The demographic profile of our FFT respondents highlights several areas for improvement in how we gather and act on patient feedback. Men remain significantly under-represented in our survey returns, which risks creating a gender imbalance in our understanding of patient experience and indicates the need for more targeted approaches to increase male participation. In addition, because older adults make up the majority of respondents, their feedback disproportionately shapes our overall results, reinforcing the importance of prioritising improvements in the services they use most frequently, particularly outpatient care, inpatient wards, and frailty-related pathways, however, this also indicates that a more targeted approach to obtaining feedback from younger patients important, as not to exclude their opinions. We also see clear under-representation from ethnic communities, which means we may not be fully hearing the experiences of groups who already face known inequalities in healthcare access and outcomes. Addressing this will require more inclusive feedback methods, wider use of interpreters and translated materials, greater volunteer support, and targeted outreach through trusted community networks to ensure we are capturing the voices of all patient groups across our diverse local population.



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



Poor and very poor responses for all FFTs

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

Patient Experience & Engagement Strategy 2026–2030 – Summary

Ensure clear, compassionate, and consistent communication across all patient interactions. Complaints, Friends and Family Test (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.

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

Venous Thromboembolism (VTE)

Every year, thousands of people in the UK develop a blood clot within a vein. This is known as a venous thromboembolism (VTE) and is a serious, potentially fatal, medical condition. The Trust policy requires all admitted patients to be individually risk assessed and have appropriate thromboprophylaxis prescribed and administered.

In the last financial year (April 2025 – March 2026), the Trust VTE Risk assessment (RA) compliance has continued to average above 95% overall, as per the National Standards. The Trust monthly VTE risk assessment compliance has been consistently above 95%. The team continue to work with areas

that fall below this target such as Obstetrics and Gynaecology to ensure these are being completed in line with national guidance and accurate data collection. Continuous education and training and working with teams to ensure we are meeting the national standard monthly is provided. The VTE prevention team at the Whittington received a special commendation from Thrombosis UK on for the work achieved in this area.

The following actions have been taken:

- Continuous close co-operation between the VTE pharmacist and Information Technology (IT) to ensure continuation and monitoring of mandatory VTE risk assessment completion on the Careflow clinical noting system.
- Education and training sessions to nurses, health care assistants, doctors, and pharmacists to ensure teams are completing VTE risk assessments (VTE RA) for all admitted patients.
- Introducing the implementation of the electronic VTE RA in the paediatric patient cohort
- Engaging with gynaecology to increase VTE RA in this patient population, leading to improvement in compliance to 90% for the first time.
- Re-introduction of the Thrombosis Committee, which now meets quarterly. The committee reviews Datix reports, HAT cases, and RCAs, and provides a structured forum for progressing updates to thrombosis-related policies and guidelines.
- Weekly MDT meeting with the haematology and cardiology consultants, anticoagulation team and VTE pharmacist to follow up complex patients who need bridging plans or haematology reviews.
- An additional haematology consultant with an interest in thrombosis and haemostasis (substantive) has been appointed.
- Introduction of a VTE risk-assessment process within Virtual Ward -an assessment that was not previously in place- with the aim of ensuring appropriate patient review and reducing and ultimately eliminating VTE events in this setting.
- Work has started on creation of a new ‘Bridging Service’ for patients undergoing surgery whilst on anticoagulation.

Root Cause Analysis:

Root cause analysis represents an educational tool for healthcare professionals on VTE thromboprophylaxis. The VTE pharmacist and the haematology team are working together to ensure we continue to collect and analyse data to ensure we meet trust standards.

- A report system is in place to provide data on Hospital Acquired Thrombosis (HAT) which occurred annually in the Trust.
- Serious Incidents management (Datix) and co-operation with the Patient Safety Pharmacist and Patient Safety Group leads to help increase awareness of incidents occurring related to anticoagulation.

The team continues to work towards an application as VTE Exemplar Centre.

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 (NIPCM), 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 (NCL ICB), UK Health Security Agency (UKHSA), and NHS England.

Healthcare Associated Infections (HCAI)

Management of Healthcare-associated infections (HCAIs) remain 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 (BSI)

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 4 cases, exceeding the trajectory of 3. Although numbers remain small, this highlights the need for continued vigilance, particularly in relation to environmental sources and water safety systems.

Table 1: Blood-stream Infections for the year 2025-26

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

*Hospital Onset – Hospital Associated

Clostridioides difficile Infections (CDI)

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

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

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

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

Acute Respiratory Infections (ARI)

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 (PPE), 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 (SSI)

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 remain 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: SSI Surveillance – Neck of Femur for the year 2025-26

Quarter	No. of Procedures	SSI Cases Reported	Rate
Qtr 1 (Apr – Jun 2025)	44	0	0%
Qtr 2 (Jul – Sep 2025)	39	0	0%
Qtr 3 (Oct – Dec 2025)	55	1	2%

Note: *SSI surveillance for Qtr 4 (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.

Antimicrobial Stewardship (AMS) Strategy 2025–2027

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 IPC, microbiology, pharmacy, and clinical teams. The AMS programme remains a critical enabler in reducing HCAIs, particularly C. difficile infections and Gram-negative bloodstream infections, and provides ongoing assurance that antimicrobial use within the Trust is safe, effective, and aligned to national standards.

Neonatal Unit Outbreak – *Enterobacter hormaechei* Colonisation

During 2025–26, the Trust continued to manage a complex and protracted outbreak of Enterobacter hormaechei colonisation within the Neonatal Intensive Care Unit (NICU) and Special Care Baby Unit (SCBU). The outbreak, initially identified in August 2024, demonstrated 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 UKHSA. Enhanced environmental decontamination, including hydrogen peroxide vapour (HPV), 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 challenge 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 has strengthened its oversight of water safety through:

- Active participation in Water Safety Group meetings and escalation of risks where assurance is limited
- 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 Project

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 Safety Incidents

The Trust has been operating under the Patient Safety Incident Response Framework (PSIRF) since April 2024, 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.

Since the implementation of LFPSE (Learning from Patient Safety Events) in November 2023, person harm changed and is now recorded as physical and psychological harm. The data below is based on all levels of physical harm caused to the patient and there is no differential between death caused or not caused by the incident; all 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	2023/2024	2024/2025	2025/2026	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 Patient Safety Incident Response Plan (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:

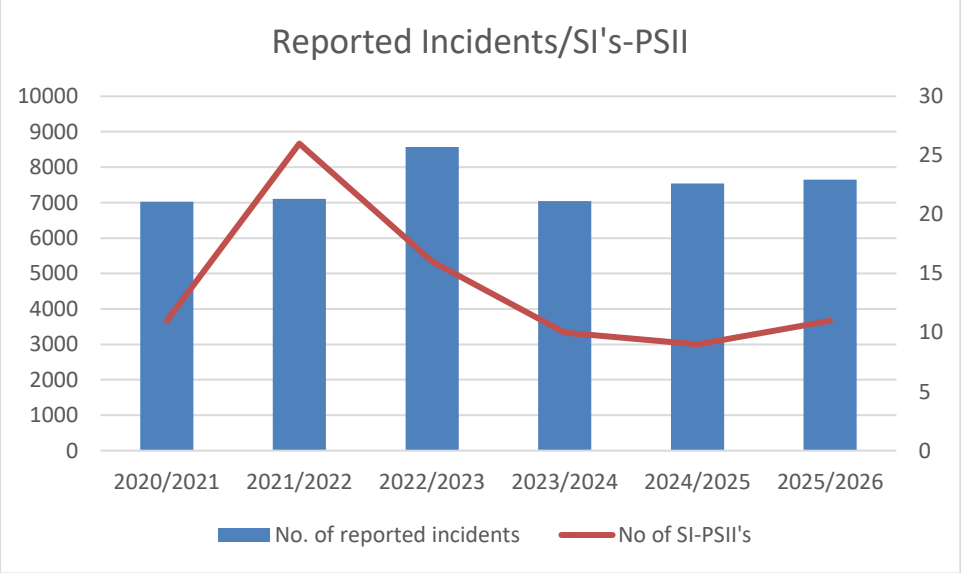
- Early identification of patient safety risks
- Consistent decision-making regarding learning responses and follow-up actions
- Timely escalation of significant events to services leads, divisional triumvirates, or quality governance structures
- Assurance that appropriate initial actions have been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

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

Under the PSIRF the Trust is no longer required to declare serious incidents based on predefined thresholds however there are a number of mandated incidents where a Patient Safety Incident

Investigation (PSII) must be completed. Where it is felt there is new learning and improvement the Trust utilises the most appropriate learning response tool. The Trust has improvement plans and workstreams in place in relation to pressure related skin damage, falls and medication safety. This ensures the Trust can focus more time and resource on learning and improving.
During 2025/26 there were 11 PSIIs requested. As illustrated in the graph below, the number of PSIIs declared as a proportion of all patient safety incidents has remained similar since the implementation of PSIRF. This is a positive trend, indicative of an open, transparent safety culture where reporting of incidents is encouraged, with a higher volume of incidents which are near misses or low harm incidents.

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



To follow the Patient Safety Incident Response Framework (PSIRF), Whittington Health focus on identifying the whole system issues and take a human factors approach. WISH have supported the use of a variety of learning response tools, such as After-Action Reviews, Situational, what's happening, Action, Risks, Mitigation - 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

1) Emergency & Integrated Medicine (EIM) Division – Misplaced naso- gastric tubes
   Description: A naso-gastric tube found to be in the left lung

2) – Acute Patient Access, clinical Support Services & Women's Health (ACW) Division – Retained foreign object post-procedure
Description: Retained Swab post spontaneous Vaginal Delivery (SVD)

Both have been investigated via Patient Safety Incident Investigations (PSII) as per the national guidance.

Maternity and Newborn Safety Investigations (MNSI) and Perinatal Mortality Review Tool (PMRT) Update - Reporting period: 1 April 2025 – 31 March 2026

1. Maternity and Newborn Safety Investigations (MNSI)

The Maternity and Newborn Safety Investigations (MNSI) programme is part of the national strategy to improve maternity safety across NHS England. Established in 2018 within the Healthcare Safety Investigation Branch, the programme is now hosted by the Care Quality Commission. NHS trusts are required to refer all incidents that meet MNSI criteria, including those previously defined within the Each Baby Counts programme and maternal deaths meeting MNSI thresholds.
MNSI investigations take a systems-based approach, reviewing clinical care alongside workplace environment, organisational factors and safety culture.

Activity and outcomes

Between 1 April 2025 and 31 March 2026, two incidents were referred to MNSI. Both involved intrapartum stillbirths at term.

Case 1: Intrapartum stillbirth at 41+2 weeks gestation
The MNSI investigation has concluded and identified two Safety Recommendations and two Safety Prompts.

Safety Recommendations
Electronic booking systems: The Trust is recommended to review the electronic maternity booking system and staff training to ensure accurate pathway allocation and appropriate adjustments to care plans from booking.

Informed decision-making for post-dates pregnancy: The Trust is recommended to support staff to undertake and clearly document comprehensive discussions on the risks and benefits of induction of labour versus continuation of pregnancy beyond 41 weeks, enabling informed maternal choice.

Safety Prompts

Raised BMI screening

- Consistency of staff awareness of guideline updates
- Ease of access to clinical guidelines
- Access to training aligned with Saving Babies' Lives
- Use of interpreting services
- Systems to ensure consistent provision of key pregnancy information
- Improvements to support equitable communication
- Tools and training to address ethnicity-related health inequalities

An action plan addressing all recommendations and prompts has been developed and is being monitored.

Case 2: Intrapartum stillbirth at 39+1 weeks gestation
The MNSI investigation is still being investigated. An internal rapid action review has been completed, identifying the following key learning:

- Fetal ultrasound and cardiotocography do not predict or prevent stillbirth in cases of Intrahepatic Cholestasis of Pregnancy (ICP).
- Service users with ICP and additional co-morbidities (e.g. gestational diabetes) may be at increased risk, which should be explicitly considered during counselling and shared decision-making about timing of birth.

2. Perinatal Mortality Review Tool (PMRT)
Use of the PMRT is a mandatory requirement under Safety Action 1 of the Maternity Incentive Scheme. PMRT enables structured, multidisciplinary reviews of all stillbirths, neonatal deaths and relevant post-neonatal deaths, with a focus on learning and service improvement.

April – June 2025
Three cases met PMRT eligibility:

- Early neonatal death (preterm) following cord prolapse in a mother booked at a neighbouring Trust and conveyed to Whittington by LAS – no care or service delivery issues identified.
- Two preterm intrauterine deaths, one associated with severe growth restriction and chromosomal abnormality – care reviewed and found to be in line with guidance.

July – September 2025
Four stillbirths and one neonatal death met PMRT eligibility:

- Two preterm stillbirths (including abnormal placentation)
- One intrapartum stillbirth at term (also reviewed by MNSI)
- One neonatal death at three days of age following discharge

Learning and improvement actions were identified and embedded, except for the recommendation to review the electronic maternity booking system. This links to two recognised risks on the Trust risk register:

- Hybrid maternity records across digital and paper systems (Risk score: 20)
- Out-of-date maternity EPR with no agreed replacement until Spring 2028 (Risk score: 15)

To mitigate risk and support future digital transformation, a clinically-led 3-month Task & Finish Group is proposed for Private Board approval.
The neonatal death is being reviewed under the PSII framework, led by Children and Young People's Services. The PMRT review will follow completion of the PSII and coroner's inquest.

October – December 2025
Two stillbirths and one neonatal death met eligibility:
Learning identified a lack of a clear pathway for women who attend triage and leave prior to full assessment. Local guidance is being developed and incorporated into the maternity triage guideline. It also identified the lack of a defined pathway for pregnancies conceived via IVF, evidence review and benchmarking with neighbouring units are underway.
The neonatal death at 17 days was attributed to Sudden Unexplained Death in Infancy (SUDI). Care was aligned with guidance, however the panel identified issues with care that have not contributed to the outcome:

- Failure to follow a safeguarding support plan
- Inconsistent access to interpreters
- Initial lack of a clear keyworker (subsequently addressed)

Concerns were also raised regarding coroner communication and family experience; this was acknowledged despite being outside the panel's direct remit.

January – March 2026

Five cases met PMRT eligibility (four stillbirths, one neonatal death). One stillbirth also met MNSI criteria and is under investigation.

- Two PMRT reviews completed:

Antepartum loss at 22+1 weeks: learning focused on assessment of English fluency and interpreter provision. A language assessment proforma and interpreter card were launched in March 2026.
Antepartum stillbirth at 37+4 weeks with trisomy 18: care aligned with guidance, no concerns identified.

- Outstanding reviews:

Antepartum stillbirth at 38 weeks scheduled for April 2026
Neonatal death at 30 weeks associated with placenta praevia and massive APH scheduled for May 2026
All is within national reporting timeframes. Rapid action reviews have been completed for outstanding cases and confirmed care in line with guidelines.

A consistent theme across PMRT reviews is the inability to provide bereaved families with appropriate, sound-proofed or separate spaces, due to estate limitations. This risk is recorded on the Trust risk register and has been escalated through maternity safety champions.

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 incidents had Duty of Candour requirements fulfilled and seven are outstanding which are reviewed by the Risk Managers.

Central Alerting System (CAS) Alerts

Patient safety alerts are issued via the CAS, which is a web-based cascading system for issuing alerts, important public health messages and other safety information and guidance to the NHS and other organisations. The Trust uses a cascade system to ensure that all relevant staff are informed of any alerts that affect their areas.

From the period of 2025/2026 One CAS alert remains partially unresolved and is being managed through the risk register, Bed Rail Risks Working Group, Medical Devices Committee and Patient Safety Group.

Safety alert: NatPSA/2023/010/MHRA issued on the 30th of August 2023

Description: The MHRA continues to receive reports of deaths and serious injuries from entrapment or falls relating to medical beds, bed rails (also known as bed safety rails), trolleys, bariatric beds, lateral turning devices and bed grab handles (also known as bed levers or bed sticks). Chest or neck entrapment in bed rails is currently listed (number 11; 2018) as a 'Never Event' according to the NHS

Freedom to Speak Up

This report provides an overview of Freedom to Speak Up (FTSU) activity from April 2025 to March 2026. Over this twelve-month period, 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 show 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 3 concerns submitted anonymously over the entire year: 2 in the first half and 1 in the second half. This highlights staff confidence to speak up openly. The Speak Up Champion Network currently comprises 44 Champions, with over half from a Black and Asian Minority Ethnic (BAME) background. Concerns received show that bullying and harassment remain a significant theme. At the same time, for the first 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 BAME staff raising concerns, reflecting the Trust's commitment to removing barriers for all staff groups.

Data received by Quarters: 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 BAME.

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, Finance, and IT. 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.

Guardian for safe working hours – (GoSWH)

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
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 are typically seen. The reasons for this are multifactorial but over the last year there have been more exception reports from historically lower reporting specialities such as paediatrics and psychiatry.

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

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

The tenure of the current GoSWH is due to end on 23rd April 2026 and a successor has been appointed.

Part 3: Review of Quality Performance

This section provides details on the progress the Trust is making with the Quality Account priorities 2024-2025.

During 2024/25, Whittington Health continued to focus on delivering safe, compassionate and person-centred care, while improving access, tackling health inequalities and developing services in response to population need. Evidence from national surveys, Friends and Family Test (FFT), PLACE assessments, complaints, and engagement activity demonstrates strong performance in several core areas, alongside clear learning and actions where further improvement is required.

Priority 1 Ensuring Safe, Compassionate and Person-Centred Care

Clear, compassionate communication and meaningful engagement are essential to patient safety, shared decision-making and positive experience, particularly for patients who are anxious, unwell or vulnerable.

Patient experience remained a key strength for the Trust during 2024/25. Results from the National Adult Inpatient Survey 2024 showed the Trust performed particularly well in areas relating to communication, dignity and discharge. Patients consistently reported receiving clear information about medicines, being well informed during ward moves, being supported to rest at night, and being given appropriate guidance following discharge. Family and carers were also frequently involved in discharge discussions, supporting safer transitions of care.

Progress was made against priorities to promote kindness, compassion and respectful communication. A suite of “What Matters to Me” patient quotes and posters has been developed to support staff education and cultural change, with rollout planned. FFT scores exceeded the NHS benchmark of 85% consistently across the Trust, with performance reported through established governance routes, including PEG, QGC and QAC.

Learning from complaints continued to be shared through Patient Experience and governance reports.

Priority 2 Improving the Trust Environment to Enhance Patient Experience

Poor physical, sensory and digital environments can contribute to poor patient experience.

The Trust made significant progress in improving the physical environment, supported by strong results from the 2025 PLACE assessments. Improvements were seen across all domains, including cleanliness, food, privacy and dignity, condition and maintenance, and dementia-friendly and disability-friendly environments, with several areas demonstrating marked year-on-year improvement.

PLACE feedback is now a standing item on the Patient Experience Group agenda, strengthening assurance and oversight. Work to reduce ligature risks progressed throughout the year, with audits completed across high-risk areas and mitigation actions in place, including estates improvements, staff training and enhanced observation where required. Oversight is maintained through established governance arrangements.

Priority 3 Reducing Health Inequalities and Improving Access

Complex information, digital exclusion and poor navigation disproportionately affect people with learning disabilities, sensory impairments and language barriers.

Reducing health inequalities and improving navigability of services remained a core priority. The Trust continued to deliver engagement and listening activity with seldom-heard groups, including targeted listening events with community groups and outpatient populations. Qualitative feedback is now incorporated into governance reporting to support triangulation and learning.

Access to diagnostics was strengthened through the Wood Green Community Diagnostic Centre, with data demonstrating that a significant proportion of attendees are from the most deprived local populations, supporting earlier diagnosis and improved equity of access.

Outpatient transformation work progressed, with pilots to centralise booking extended to Rheumatology and Neurology. Early indicators demonstrate positive impacts on patient access, utilisation of capacity, and reductions in cancellations and DNAs.

While progress was made in several areas, challenges remain with long waits in services including ASD/ADHD, MSK, stroke rehabilitation and talking therapies. Work is ongoing to address these pressures through redesign and productivity initiatives.

Priority 4 Developing Services to Meet Population Need
Services must adapt to rising demand, complexity and changing expectations while ensuring patients can self-manage, access care early and avoid avoidable hospital visits.

The Trust continued to expand and embed new models of care to support admission avoidance, early discharge and community-based provision. The Virtual Ward operated at an 18-bed capacity, supporting timely discharge and reducing unnecessary hospital stays. Rapid Response services are well embedded across both boroughs and continue to support admission avoidance.

New community services, including Pain Management and Falls Prevention in Haringey, were fully launched during the year and experienced high demand. Progress was also made in Neurology and Stroke pathways, although pressures remain in Musculoskeletal (MSK) and talking therapies due to workforce and capacity constraints.

In maternity services, key actions addressed inequalities and patient experience, including the relaunch of the online interpreter app, implementation of interpreter cards co-produced with the MNVP, and introduction of the Capital Midwife Anti-Racism Framework. Leadership and governance arrangements were strengthened through the Start Well programme, with clear programme leadership and defined workstreams in place.

Summary

Overall, performance during 2024/25 demonstrates sustained strengths in patient experience, communication and compassion, supported by strong Friends and Family Test (FFT) results, improved Patient – Led Assessments of the Care Environment (PLACE) scores and positive national survey feedback. Tangible progress has been made in improving environments, expanding

community services and addressing inequalities, while acknowledging ongoing challenges in access, waiting times and demonstrating learning from complaints.

The assurance gained from 2024/25 directly informs and shapes the Trust's Quality Account priorities for 2025/26, ensuring continued focus on what matters most to patients, carers and communities.

Part 4: Other Information

Local Performance Indicators

Goal	*Standard/benchmark*	*Whittington performance*						
		2025/26	***2024/25***	***23/24***	***22/23***	***21/22***	*20/21*	*19/20*
ED 4-hour waits	*95% to be seen in 4 hours*	*71.6%*	*70.9%*	***65.30%***	***68.40%***	***78.30%***	*87.4%*	*83.8%*
RTT 18 Week Waits: Incomplete Pathways	*92% of patients to be waiting within 18 weeks*	*71.4%*	*64.9%*	***66.2%***	***67.8%***	***74.4%***	*65.6%*	*92.1%*
RTT patients waiting 52 weeks	*No patients to wait more than 52 weeks for treatment*	*76*	*4028*	***8007***	***6182***	***7093***	*11094*	*2*
Waits for diagnostic tests	*99% waiting less than 6 weeks*	*82.8%*	*94.4%*	***86.9%***	***85.9%***	***94.1%***	*72.1%*	*99.3%*
Cancer: Urgent referral to first visit	*93% seen within 14 days*	*Data not available*	*Data not available*	**51.8%**	**45.8%**	**74.8%**	94.6%	94.8%
Cancer: Diagnosis to first treatment	*96% treated within 31 days*	*98.6%*	*94.7%*	**93.4%**	**90.2%**	**95.3%**	98.1%	98.8%
Cancer: Urgent referral to first treatment	*85% treated within 62 days*	*80.9%*	*66.3%*	**63.3%**	**48.2%**	**61.1%**	73.8%	84.0%
Improved Access to Psychological Therapies (IAPT)	*75% of referrals treated within 6 weeks*	*93.8%*	*93.2%*	**93.2%**	**92.8%**	**91.4%**	93.8%	95.1%

Summary Hospital-Level Mortality Indicator (SHMI)

The most recent data available (published 9 April 2026) covers the period December 2024 to November 2025.

Whittington Trust SHMI score:	0.86	Compared to 0.97 reported for October 2023 to September 2024
Lowest National Score	0.70	Chelsea and Westminster Hospital NHS Foundation Trust

Highest National Score	1.33	Chesterfield Royal Hospital NHS Foundation Trust

The full data from the SHMI reporting period can be seen below, the score gives Whittington Health NHS Trust an as expected SHMI.

Provider Spells	Observed Deaths	Expected Deaths	SHMI Value
24,845	530	615	0.86

The SHMI represents a comparison against a standardised National Average. The 'national average' therefore is a standardised 1.0 and values significantly below 1.0 indicate a lower-than-expected number of mortalities (and vice versa for values significantly above).

Annex 1: Statements from external stakeholders

Joint Health Overview and Scrutiny Committee for North Central London feedback – TBC following completion

Commissioner feedback

NHS
West and North London

22 May 2026

West and North London ICB 15 Marylebone Road

London NW1 5JD 0203 198 9743

NHS West and North London Integrated Care Board Statement Whittington Health NHS Trust

North Central London Integrated Care Board (NCL ICB) has worked closely with Whittington Health NHS Trust throughout 2025/26, taking a pragmatic approach regarding assurance of commissioned services throughout the year; obtained through regular discussions with key staff within the Trust, along with review of papers for the Trust's Quality and Safety Committee.

We are acutely aware that you are currently operating in an environment of unprecedented pressure. Whether it is managing the complexities of evolving patient needs, navigating resource constraints, or maintaining the highest standards of safety amidst rising demand, the challenging circumstances you face daily do not go unnoticed. Despite these hurdles, your commitment to delivering high-quality, safe care remains unwavering. It is your expertise and resilience that ensure our patients receive the dignity and treatment they deserve.

We confirm that we have reviewed the information contained within the draft Quality Account (provided to the newly formed West and North London ICB in May 2026). The document received complies with the required content, as set out by the Department of Health and Social Care. Where the information is not yet available a place holder has been inserted.

The report describes the Trust's achievements, priorities, and performance in delivering safe, effective, equitable and compassionate care.

Throughout 2025/26, the Trust have embedded the Patient Safety Incident Response Framework (PSIRF), with a focus on medication safety and early recognition of the deteriorating patient.

We commend the Trust for achieving zero MRSA bloodstream, driving down other infection rates and championing antimicrobial stewardship.

The 2025 National Staff Survey results mark the Trusts strongest performance to date. It is encouraging to see these improvements across staff engagement and morale. Nonetheless, challenges remain regarding career development, workplace adjustments, alongside bullying and harassment. We are supportive of the on-going work undertaken by the Trust to listen to and support staff.

The ICB are supportive of the priorities for 2026/27 and look forward to working collaboratively with you.

Yours sincerely,

Jennifer Roye Chief Nurse Officer

NHS West and North London ICS

Healthwatch Islington

Healthwatch Islington welcomes the opportunity to comment on Whittington Health's Quality Account 2025/26. We are pleased to see the Trust's continued commitment to delivering safe, compassionate and person-centred care across both acute and community settings.

We particularly welcome the emphasis in the 2026/27 priorities on reducing health inequalities by making services easier to access, understand and navigate, especially for people who experience poorer outcomes or additional barriers to care. This is consistent with the insight we hear from local residents, where clear communication, accessible information and support to move through services remain central to people's experience of care.

We also welcome the focus on timely, joined-up care, safe discharge, patient flow and strengthening community-based models. These are important areas for local people and will require continued collaboration across the system, including with voluntary and community sector partners.

Healthwatch Islington values its ongoing relationship with Whittington Health and looks forward to continuing to work together to ensure that the voices and experiences of Islington residents, particularly those who are less often heard, inform service improvement and the development of responsive, safe and inclusive care.

Best wishes

Laura

Laura Saksena (she/her)
Chief Executive
healthwatch Islington

How to provide feedback

If you would like to comment on our Quality Account or have suggestions for future content, please contact us either:

By writing to:
The Communications Department,
Whittington Health,
Magdala Avenue,
London. N19 5NF

By telephone:
020 7288 5983

By email:
communications.whitthealth@nhs.net

Publication:

The Whittington Health NHS Trust 2025/26 Quality Account will be published on the Trust website by the 30th June 2026. A copy is also sent electronically to NHS England as per national requirements.

https://www.nhs.uk/pages/home.aspx

Accessible in other formats:

This document can be made available in other languages or formats, such as Braille or Large Print.

Please call **020 7288 3131** to request a copy.

Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance in the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amended Regulations 2011.

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

The Quality Account presents a balanced picture of the Trust's performance over the period covered, in particular, the assurance relating to consistency of the Quality Report with internal and external sources of information including:

- Board minutes.
- Papers relating to the Quality Account reported to the Board.
- Feedback from Health Watch.
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009.
- the latest national patient survey.
- the latest national staff survey.
- feedback from Commissioners.
- the annual governance statement; and
- CQC Intelligent Monitoring reports.

The performance information reported in the Quality Account is reliable and accurate. There are proper internal controls over the collection and reporting of the measures of performance reported in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.

The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and The Quality Account has been prepared in accordance with the Department of Health guidance.

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

Baroness Neuberger DBE
Chair

Selina Douglas
Chief Executive Officer

Appendix 1: National Mandatory and Non-Mandatory Audits 2025/2026

Title	Management Body	Participated in 2025/2026	If completed, number of records submitted (as total or % if requirement set)
British audit of the investigatiOn and referral of woMen with rEcurrent uRinary trAct infectioN using recent Guidance (BOOMERANG)	The British Association of Urological Surgeons	**x**	Non-participation due to resident doctor industrial action and high number of flu cases in the hospital.
Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	The British Association of Urological Surgeons	✓	Data submitted: 12 cases
Breast and Cosmetic Implant Registry	NHS England	✓	Data submitted: 48 Cases
British Spine Registry	British Spine Registry	✓	Data submitted: 163 cases
Case Mix Programme (CMP)	Intensive Care National Audit & Research Centre (ICNARC)	✓	Data submitted: 503 cases
LeDeR - Learning from Lives and Deaths of People with a Learning Disability and Autistic People	NHS England	✓	Data submitted: 5 cases
National Acute Kidney Injury Audit	UK Kidney Association	✓	Data submitted: 4394 cases
National Audit of Care at the End of Life	NHS Benchmarking Network	✓	Data submitted: 80 cases
National Bariatric Surgery Registry (NBSR)	British Obesity and Metabolic Surgery Society	✓	Data submitted: 80 cases
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre (ICNARC)/Resuscitation Council UK (RCUK)	✓	Data submitted: 39 cases

Title	Management Body	Participated in 2025/2026	If completed, number of records submitted (as total or % if requirement set)
National Child Mortality Database (NCMD)	University of Bristol	✓	Review of published reports
National Clinical Audit of Seizures and Epilepsies for Children and Young People	Royal College of Paediatrics and Child Health	✓	Data submitted: 32 cases
2025 Major Haemorrhage Audit	NHS Blood and Transplant	✓	Data submitted: 18 cases
National Early Inflammatory Arthritis Audit	British Society for Rheumatology	✓	Data submitted: 33 cases
National Emergency Laparotomy Audit	Royal College of Anaesthetists	✓	Data submitted: 100 cases
National Emergency Laparotomy Audit - No Lap	Royal College of Anaesthetists	✓	Data submitted: 4 cases
National Audit of Inpatient Falls	Royal College of Physicians	✓	Data submitted: 4 cases
National Hip Fracture Database	Royal College of Physicians	✓	Data submitted: 165 cases
National Joint Registry	Healthcare Quality Improvement Partnership	✓	Data submitted: 117 cases
National Major Trauma Registry Network	Outcomes & Registries Programme, NHS England	✓	Data submitted: 461 cases
National Maternity and Perinatal Audit	Royal College of Obstetrics and Gynaecology	✓	Data submitted: 2515 cases
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health	✓	Data submitted: 361 cases
National Obesity Audit	NHS England	✓	Community Data: 459 cases Inpatient Data: 80 cases
National Perinatal Mortality Review Tool (PMRT)	University of Oxford	✓	Data submitted: 13 cases

Title	Management Body	Participated in 2025/2026	If completed, number of records submitted (as total or % if requirement set)
Perioperative Quality Improvement Programme (PQIP)	Royal College of Anaesthetists	✓	Consented and enrolled on the study: 45 cases Consented and did not have surgery: 4 cases Consented and later declined participation: 5 cases Consented and surgery later cancelled/reschedule:9 cases Approached but declined: 9 cases Identified as not suitable for study: 20 cases Requires interpreter: 16 cases
Sentinel Stroke National Audit Programme (SSNAP)	King's College London	✓	Total: 214 cases - Islington: 70 cases, Haringey: 144 cases.
UK Parkinson's Audit	Parkinson's UK	✓	Data submitted: 93 cases: elderly care 28 cases, neurology 21 cases, Community Adult OT 4 cases, Community Adult Physio 12 cases, Community Adult SLT 16 cases, Pharmacy 12 cases.

Maternal, Newborn and Infant Clinical Outcome Review Programme data on 14 cases were submitted to MBRRACE-UK who allocate to the appropriate work stream		
Title of Audit	**Management Body**	**If completed, number of records submitted (as total or % if requirement set)**
Maternal morbidity confidential enquiry - annual topic based serious maternal morbidity	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	Ongoing (1 case)
Maternal mortality confidential enquiries	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	Ongoing (0 cases)
Maternal mortality surveillance	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	Ongoing (0 cases)
Perinatal mortality and serious morbidity confidential enquiry	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	Ongoing (0 cases)
Perinatal Mortality Surveillance	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	Ongoing (13 cases)

Mental Health Clinical Outcome Review Programme			
Title of Audit	**Management Body**	**Participated in 2025/2026**	**If completed, number of records submitted (as total or % if requirement set)**

Suicide and Homicide	National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) - University of Manchester	✓	If cases identified to WH then participate - none to date

Child Health Clinical Outcome Review Programme			
Title of Audit	**Management Body**	**Participated in 2025/2026**	**If completed, number of records submitted (as total or % if requirement set)**
Emergency surgery in children and young people	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	Submitted Cases: Anaesthetic: 5/5 Surgery: 4/5 Transfer: 1/1
Stabilisation of the critically ill child	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	5/5 cases submitted

Medical and Surgical Clinical Outcome Review Programme			
Title of Audit	**Management Body**	**Participated in 2025/2026**	**If completed, number of records submitted (as total or % if requirement set)**
Managing acute illness people with learning disability	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	6/6 cases submitted

Pleural Procedures	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	6/8 cases submitted
Rib Fractures	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	Study launched in Jan 2026 with data collection underway

National Respiratory Audit programme			
Title of Audit	**Management Body**	**Participated in 2025/2026**	**If completed, number of records submitted (as total or % if requirement set)**
Asthma Secondary Care	Royal College of Physicians of London	✓	Data submitted: 109 cases
Children and Young People Asthma	Royal College of Physicians of London	✓	Data submitted: 147 cases
COPD Secondary Care	Royal College of Physicians of London	✓	Data submitted: 105 cases
Pulmonary Rehabilitation	Royal College of Physicians of London	✓	Data submitted: 187 cases

National Cardiac Audit programme

Title of Audit	Management Body	Participated in 2025/2026	If completed, number of records submitted (as total or % if requirement set)
Myocardial Ischaemia National Audit Programme (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)	✓	Data submitted: 50 cases
National Heart Failure Audit (NHFA)	National Institute for Cardiovascular Outcomes Research (NICOR)	✓	Data submitted: 101 cases
National Audit of Cardiac Rehabilitation	University of York	✓	Data submitted: 310 cases

National Cancer Audit Collaborating Centre (NATCAN)			
Title of Audit	**Management Body**	**Participated in 2025/2026**	**If completed, number of records submitted (as total or % if requirement set)**
Breast Cancer, Metastatic (NAoMe)	Royal College of Surgeons of England	✓	Data submitted: 13 cases
Breast Cancer, Primary (NAoPri)	Royal College of Surgeons of England	✓	Data submitted: 162 cases
Kidney Cancer (NKCA)	Royal College of Surgeons of England	✓	Data submitted: 59 cases

Title of Audit	Management Body	Participated in 2025/2026	If completed, number of records submitted (as total or % if requirement set)
National Bowel Cancer Audit (NBOCA)	Royal College of Surgeons of England	✓	Data submitted: 59 cases
National Lung Cancer Audit (NLCA)	Royal College of Surgeons of England	✓	Data submitted: 110 cases
National Oesophagogastric Cancer Audit (NOGCA)	Royal College of Surgeons of England	✓	Data submitted: 16 cases
National Prostate Cancer Audit (NPCA)	Royal College of Surgeons of England	✓	Data submitted: 137 cases
Non-Hodgkin Lymphoma (NNHLA)	Royal College of Surgeons of England	✓	Data submitted: 3 cases
Ovarian Cancer (NOCA)	Royal College of Surgeons of England	✓	Data submitted: 12 cases
Pancreatic Cancer (NPaCA)	Royal College of Surgeons of England	✓	Data submitted: 16 cases

National Diabetes Audits			
Title of Audit	**Management Body**	**Participated in 2025/2026**	**If completed, number of records submitted (as**

			total or % if requirement set)
Diabetes (Adult - national core) to include Diabetes Prevention Programme (DPP) Audit and Transition (Adolescents and Young Adults) and Young Type 2 Audit	NHS Digital	✓	Data submitted: 1054 cases
National Diabetes Foot Care Audit (NDFA)	NHS Digital	✓	Data submitted: 142 cases
National Diabetes Inpatient Safety Audit (NDISA)	NHS Digital	✓	Data submitted: 5 cases
National Pregnancy in Diabetes Audit (NPID)	NHS Digital	✓	Data submitted: 14 cases
National Paediatric Diabetes Audit to include Transition (Adolescents and Young Adults) and Young Type 2 Audit	Royal College of Paediatrics and Child Health	✓	Data submitted: 125 cases

Royal College of Emergency Medicine			
Title of Audit	**Management Body**	**Participated in 2025/2026**	**If completed, number of records submitted (as total or % if requirement set)**
Care of Older People (Year 3)	The Royal College of Emergency Medicine	✓	Data submitted: 261 cases
Mental Health (Self Harm) (Year 3)	The Royal College of Emergency Medicine	✓	Data submitted: 237 cases
Time Critical Medications (TCM) (Year 2)	The Royal College of Emergency Medicine	✓	Data submitted: 253 cases

Adolescent Mental Health (Year 1)	The Royal College of Emergency Medicine	✓	Study commenced 1 Jan 2026 for data submission by 31 Dec 2026
Care of Older People (Year 4)	The Royal College of Emergency Medicine	✓	Study commenced 1 Jan 2026 for data submission by 31 Dec 2026
Time Critical Medications (TCM) (Year 3)	The Royal College of Emergency Medicine	✓	Study commenced 1 Jan 2026 for data submission by 31 Dec 2026

Appendix 2: Non-mandatory national audits 2025/2026

Project Title	Management Body	Status
Appendicitis Global Outcomes study (Alligator Study)	NIHR Global health research unit	Data submitted
National Audit of Surgical Management of Miscarriage	University College London Hospitals	Data submitted
Trainee Research Intensive Care network project: A na7onal audit Measuring AN7microbial prescribing and resistance in Cri7cal Care Units in the United Kingdom (TRIC-MAN)	Liverpool School of Tropical Medicine	Data submitted
Society for Acute Medicine Benchmarking Audit (SAMBA)	Society for Acute Medicine	Data submitted
ATOMM -audit of thromboprophylaxis in newly diagnosed myeloma	Myeloma UK, HaemStar, Anticoagulation for Thrombosis Prevention in Multiple Myeloma	Data submitted
A Study of the Role of Sentinel Node Biopsy during Completion Mastectomy for Ductal Carcinoma in Situ.	Association of Breast Surgery / NICE guidance / North West Breast Trainee Research Collaborative	Data submitted
Greener GIRFT guide for elective primary total hip replacement snapshot audit	Getting it Right First Time (GIRFT)	Data submitted
2025 National Comparative Audit of the NICE QS138	NHS Blood & Transplant, Dept of Health	Data submitted

Project Title	Management Body	Status
United Kingdom Obstetric Surveillance System – national audits of rare conditions of pregnancy	UKOSS National Perinatal Epidemiology Unit	on target
Neonatal Baby Friendly Accreditation	United Nations Children's Fund	on target
Mandatory Surveillance of Healthcare Associated Infections	Public Health England	on target
Surgical Site Infection Surveillance Service	Public Health England	on target
National study of HIV in Pregnancy and Childhood (NSHPC)	NSHPC now (Integrated Screening Outcomes Surveillance Service)	on target
NHS Digital Tobacco Dependence national data collection	NHS Digital	on target
National Gestational Diabetes Audit	NHS England	on target
Implementation of Hybrid Closed Loop technologies	NHS Digital	on target
NAP8: Major complications of regional anaesthesia and other perioperative nerve injuries	Royal College of Anaesthetists	on target
Tranexamic Acid In Major Surgery (TXAIMS) project	NICE guidelines, University College Hospitals NHS Foundation Trust and supported by PLAN (Pan-London Perioperative Audit & Research Network)	on target
PANDORA - acute PAncreatitis National auDit Of pRActice	ASGBI. AUGIS	on target
Trust-wide adherence to national GIRFT surgical guidelines on post-operative antibiotic prescribing in paediatric appendicitis: multi-centre multi-cycle audit of clinical practice	National GIRFT guidance	on target
Potential Donor Audit	National Potential Donor Audit	on target
TULIPS Study: Treatment of asymptomatic Urinary tract (Lower) Infection in Pregnancy Screening	UK National Screening Committee, NICE	on target

Appendix 2: Percentage of patients 0–15 and 16+ readmitted within 28 days data

Year and Month		0-15 years			16 Years +		
		Readmissions	Discharges	Readmission rate	Readmissions	Discharges	Readmission rate
2019/20	Apr	7	639	1.1%	205	2913	7.0%
	May	2	688	0.3%	163	2791	5.8%
	Jun	9	629	1.4%	143	2899	4.9%
	Jul	6	664	0.9%	167	2860	5.8%
	Aug	6	601	1.0%	179	2582	6.9%
	Sep	3	615	0.5%	177	2556	6.9%
	Oct	9	669	1.3%	187	2842	6.6%
	Nov	5	675	0.7%	166	2780	6.0%
	Dec	7	645	1.1%	157	2532	6.2%
	Jan	7	621	1.1%	169	2703	6.3%
	Feb	4	607	0.7%	151	2616	5.8%
	Mar	3	525	0.6%	117	1977	5.9%
2020/21	Apr	1	308	0.3%	96	967	9.9%
	May	2	387	0.5%	109	1220	8.9%
	Jun	6	447	1.3%	137	1748	7.8%
	Jul	3	547	0.5%	171	2296	7.4%
	Aug	3	570	0.5%	160	2042	7.8%
	Sep	6	630	1.0%	140	2302	6.1%
	Oct	7	715	1.0%	165	2353	7.0%
	Nov	7	683	1.0%	193	2383	8.1%
	Dec	10	674	1.5%	183	2322	7.9%
	Jan	13	599	2.2%	156	1853	8.4%
	Feb	8	632	1.3%	153	1922	8.0%
	Mar	14	875	1.6%	110	2442	4.5%
2021/22	Apr	4	573	0.7%	111	2132	5.2%
	May	5	595	0.8%	111	2134	5.2%
	Jun	14	1549	0.9%	167	4476	3.7%
	Jul	10	805	1.2%	213	2476	8.6%
	Aug	8	704	1.1%	164	2464	6.7%
	Sep	3	762	0.4%	209	2657	7.9%
	Oct	2	722	0.3%	162	2583	6.3%
	Nov	4	670	0.6%	140	2431	5.8%
	Dec	11	684	1.6%	132	2521	5.2%
	Jan	10	790	1.3%	111	2329	4.8%
	Feb	6	765	0.8%	128	2392	5.4%
	Mar	5	639	0.8%	113	2049	5.5%
20	Apr	1	645	0.2%	151	2104	7.2%

Year and Month		0-15 years			16 Years +		
		Readmissions	Discharges	Readmission rate	Readmissions	Discharges	Readmission rate
	May	13	728	1.8%	150	2337	6.4%
	Jun	3	725	0.4%	123	2321	5.3%
	Jul	12	687	1.7%	138	2339	5.9%
	Aug	5	649	0.8%	130	2267	5.7%
	Sep	9	683	1.3%	99	2405	4.1%
	Oct	2	748	0.3%	118	2386	4.9%
	Nov	14	761	1.8%	103	2473	4.2%
	Dec	5	699	0.7%	106	2099	5.1%
	Jan	20	767	2.6%	99	2392	4.1%
	Feb	12	673	1.8%	70	2117	3.3%
	Mar	9	720	1.3%	95	2254	4.2%
2023/24	Apr	4	583	0.7%	106	2040	5.2%
	May	9	734	1.2%	113	2247	5.0%
	Jun	7	689	1.0%	122	2522	4.8%
	Jul	8	668	1.2%	152	2073	7.3%
	Aug	7	637	1.1%	119	2337	5.1%
	Sep	12	728	1.6%	114	2320	4.9%
	Oct	6	748	0.8%	97	2408	4.0%
	Nov	6	836	0.7%	126	2475	5.1%
	Dec	11	758	1.5%	132	2136	6.2%
	Jan	11	735	1.5%	106	2259	4.7%
	Feb	22	683	3.2%	121	2280	5.3%
	Mar	9	740	1.2%	72	2490	2.9%
2024/25	Apr	15	697	2.2%	123	2500	4.9%
	May	16	766	2.1%	130	2634	4.9%
	Jun	10	709	1.4%	103	2307	4.5%
	Jul	13	809	1.6%	126	2577	4.9%
	Aug	5	711	0.7%	113	2268	5.0%
	Sep	8	743	1.1%	112	2435	4.6%
	Oct	23	861	2.7%	142	2859	5.0%
	Nov	14	895	1.6%	115	2807	4.1%
	Dec	15	842	1.8%	101	2408	4.2%
	Jan	12	800	1.5%	101	2600	3.9%
	Feb	8	796	1.0%	93	2295	4.1%
	Mar	10	837	1.2%	66	2827	2.3%
2025/26	Apr	18	729	2.5%	145	2807	5.2%
	May	17	843	2.0%	145	2860	5.1%
	Jun	24	824	2.9%	127	2719	4.7%
	Jul	10	839	1.2%	137	2807	4.9%
	Aug	12	634	1.9%	112	2463	4.5%

Year and Month		0-15 years			16 Years +		
		Readmissions	Discharges	Readmission rate	Readmissions	Discharges	Readmission rate
	Sep	19	820	2.3%	126	2773	4.5%
	Oct	22	838	2.6%	128	2916	4.4%
	Nov	15	824	1.8%	111	2725	4.1%
	Dec	18	877	2.1%	111	2531	4.4%
	Jan	17	877	1.9%	115	2662	4.3%
	Feb	19	796	2.4%	127	2583	4.9%
	Mar	16	1670	1.0%	134	5833	2.3%

NHS
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Quality Account

2025/26

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