NHS

Lincolnshire Community and Hospitals NHS Group

United Lincolnshire Teaching Hospitals NHS Trust Quality Account 2024-25

Glossary of Abbreviations

AAA	Abdominal Aortic Aneurysm
BAU	Business As Usual
BAUS	The British Association of Urological Surgeons
BTS	British Thoracic Society
CBU	Clinical Business Unit
CDC	Community Diagnostic Centres
CDOP	Child Death Overview Panel
CMP	Case Mix Programme
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus disease caused by the SARS-CoV-2virus
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CT	Computerised Tomography
DCIQ	Internal Reporting System
DTA	Decision to Admit
DKA	Diabetic Ketoacidosis
DSPT	Data Security and Protection Toolkit
DTI	Deep Tissue Injury
ED	Emergency Department
EDI	Equality Diversity and Inclusion
EPR	Electronic Patient Record
ePMA	Electronic Prescribing and Medicines Administration
FaCTs	Falls Current Themes
FPSG	Falls Prevention Steering Group
FFT	Friends and Family Test

FTSUG	Freedom to Speak Up Guardian
GDH	Grantham and District Hospital
GSF	Gold Standards Framework
HES	Hospital Episode Statistics
HSMR	Hospital Standardised Mortality Ratio
IBD	Inflammatory Bowel Disease
ICB	Integrated Care Board
ICU	Intensive Care Unit
ICNARC	Intensive Care National Audit and Research Centre
JBDS	Joint British Diabetes Societies
KPI	Key Performance Indicator
LCH	Lincoln County Hospital
LCHG	Lincolnshire Community Hospital Group
LCHS	Lincolnshire Community Health Services NHS Trust
LEDs	Locally Employed Doctors
MASD	Moisture Related Skin Damage
MAP	Mean Arterial Pressure
ME	Medical Examiner
MINAP	Myocardial Infarction National Audit Programme
M&M	Mortality & Morbidity Meeting
MorALS	Mortality Assurance and Learning Strategy Group
MRI	Magnetic Resonance Imaging
NACEL	National Audit of Care at the End of Life
NAIF	National Audit of Inpatient Falls
NAoME	National Audit of Metastatic Breast Cancer
NAoPri	National Audit of Primary Breast Cancer
NBoCA	National Bowel Cancer Audit

NDFA	National Diabetic Foot Audit
NCEPOD	National Confidential Enquiry into Patient Outcomes and Death
NEIAA	National Early Inflammatory Arthritis Audit
NELA	National Emergency Laparotomy Audit
NHFD	National Hip Fracture Database
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NICOR	National Institute for Cardiovascular Outcomes Research
NIHR	National Institute for Health Research
NJR	National Joint Registry
NKCA	National Kidney Cancer Audit
NLCA	National Lung Cancer Audit
NMTR	National Major Trauma Registry
NNAP	National Neonatal Audit Programme
NNHLA	National Non-Hodgkin Lymphoma Audit
NOCA	National Ovarian Cancer Audit
NOD	National Ophthalmology Database
NOGCA	National Oesophago-Gastric Cancer Audit
NPaCA	National Prostate Cancer Audit
NRAP	National Respiratory Audit Programme
NVD	National Vascular Database
NVR	National Vascular Registry
OBD	Occupied Bed Days
O-G	Oesophago-Gastric
OSCE	Objective Structured Clinical Examination

PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
PE	Pulmonary Embolism
PEOL	Palliative End of Life
PRM	Performance Review Meetings
PHB	Pilgrim Hospital Boston
PHSO	Parliamentary and Health Service Ombudsman
PMRT	Perinatal Mortality Reporting Tool
PROMs	Performance Reported Outcome Measures
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Investigation Response Framework
QC	Quality Committee
RCEM	Royal College of Emergency Medicine
RCPCH	Royal College of Paediatrics and Child Health
SJR	Structured Judgement Review
SUDIC	Sudden Unexpected Death in Childhood
SHMI	Standardised Hospital-Level Mortality Indicator
SHOT	Serious Hazards of Transfusion
SIG	Skin Integrity Group
SSNAP	Sentinel Stroke National Audit Programme
SUS	Secondary Uses Service
TCS	Terms and Conditions of Service
TVN	Tissue Viability Nurse
ULTH	United Lincolnshire Teaching Hospitals NHS Trust
UTC	Urgent Treatment Centre
VA	Visual Acuity

VAS	Visual Analog Scale
VBAC	Vaginal Birth after Caesarean
VTE	Venous Thromboembolism
YCWCC	You Care; We Care to Call
7DS	Seven Day Services

Contents

Part 1: Chief Executive's Statement

Welcome to the Quality Account for United Lincolnshire Teaching Hospitals NHS Trust (ULTH) for 2024/25. This document provides an overview of all the activity that has been taking place within our hospitals over the past year, with a focus on improving the quality of care that we provide to our patients.

This year has seen the organisation come together as a Group with Lincolnshire Community Health Services NHS Trust (LCHS), which has enabled us to focus more than ever before on improving our services together for the benefit of the residents of Lincolnshire.

We are already seeing benefits in terms of more streamlined, effective and efficient services that are easier for patients to understand and access. There are examples of fantastic Group working across our services, which have reduced bureaucracy and put the patient at the heart of the design of our services.

During the year, we also received the fantastic news that we were successful in our application for teaching hospital status. This is awarded by the Secretary of State for Health and Social Care, and will not only benefit our patients, but will further enhance our ability to attract top-tier talent to our hospitals, the Group, and the wider NHS in Lincolnshire.

However, this past year has not been without its challenges. We have continued to experience increased pressure on our Emergency Departments and continued challenges around cutting our waiting lists, as well as the impact of a spike in respiratory viruses and norovirus during the winter season, which affected both our staff and our services. We have also faced a number of estates issues such as water and power outages.

In spite of these, there is much to be proud of and celebrate when it comes to improvements in quality and delivering the best possible care to our patients.

This includes examples of improved performance in a number of national standards, notably including huge progress made in reducing ambulance handover times in our Emergency Departments, which has freed up ambulance service colleagues to serve our communities. We were also proud to have been moved out of the ‘tiering’ programme for elective and diagnostics by the NHS National Elective Recovery and Diagnostics Programme.

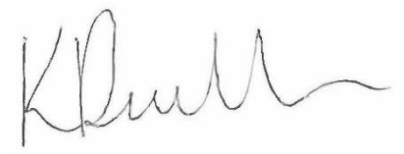
Other achievements over the past year have included:

- Construction of the first phase of the multi-million-pound Emergency Department at Pilgrim Hospital, Boston is almost complete.

- Opening of two new Community Diagnostic Centres in Skegness and Lincoln, at a cost of £38 million.
- Recruiting hundreds of patients to a wide range of clinical trials and studies.
- Starting work on the build of a £19 million new Endoscopy Unit at Lincoln County Hospital.
- Numerous national award wins for individuals and teams across the Trust.
- Continued to assess and recognise clinical areas as part of our ambitious Diamond Award in Quality Accreditation programme.
- Rollout of 'Martha's Rule' Call For Concern service at both Lincoln and Boston hospitals, offering patients, their families, and carers 24-hour access to a rapid review if they have concerns about a person's deteriorating condition.
- Opening of a new hub to support the wellbeing of care partners and provide practical advice and guidance at Pilgrim Hospital, Boston.
- Approval to procure an electronic patient record (EPR) which will transform how we manage patient records.
- Finished the implementation of a digital solution for Electronic Prescribing and Medicines Administration (ePMA).
- The expansion of the United Lincolnshire Hospitals Charity, which supports our staff and patients.

We also continue to involve our patients in discussions and decision making in the Trust, with our Patient Panel taking part in regular discussions about the development and improvement of services, as well as the delivery of broader public engagement activities around the development and delivery of specific services and service specifications.

Over the next year we will continue with our focus on moving more of our services closer to the people that need them, improving quality of care for our patients and making sure that people are seen and treated in the right place, at the right time, by the most appropriate healthcare professional as part of Lincolnshire Community and Hospitals NHS Group.



Professor Karen Dunderdale,

Chief Executive

Part 2: Deciding our Quality Priorities for 2025-26

To determine our quality priorities, we have consulted with several stakeholders including our Quality Committee (QC). The QC on behalf of the Trust Board approve the priorities and there will be regular reports on progress to QC throughout the year.

We have ensured that our quality priorities are aligned to the Group strategy. We have considered our progress throughout the year against last year's priorities to help decide which priorities need an ongoing focus within this year's Quality Account.

The following priorities have been identified for particular focus for the Group in 2025-26 from the Group Strategy 2025-2030. These priorities are extended over the coming years to ensure they are fully embedded within our organisation. Each of the priorities have been selected, as they are a key component of the patient experience.

Priority 1 – Maximise safety of patients in our care, through learning from incidents and reducing incidents causing harm.

Why have we selected this Priority?

Safe patient care is the foundation of high-quality healthcare. Our strategy aligns with requirements of the National Patient Safety Strategy and the National Patient Safety Incident Response Framework (PSIRF), promoting a culture of openness, learning, and continuous improvement. We have looked at trends in our incident reporting over time and are working collaboratively to identify solutions, while promoting a strong organisational safety culture. We are driven to deliver the best possible care and health outcomes. We want to ensure our services remain safe and embed strong processes to learn from practise.

Our Current Status:

The number of incidents causing moderate or severe harm in 2024-2025:
Moderate = 163
Severe = 49
Death = 21

What will success look like?

Percentage of incidents causing moderate or severe harm will be reduced.

How will we monitor progress?

Quarterly reports will be presented at the Quality Committee which will focus on highlighting progress and key actions/mitigations for off track actions.

Priority 2 – Identify areas where services do not meet best practice requirements and deliver demonstratable improvement in those areas.

Why have we selected this Priority?

Good infection prevention and control (IPC), including cleanliness, is essential to ensure that people who use health and adult social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone. Good management and organisational processes are crucial to make sure that high standards of IPC (including cleanliness) are developed and maintained.

As an acute Trust we must adhere to the Health and Social Care 2008: code of practice on the prevention and control of infections and related guidance. This is otherwise known as the “Hygiene Code.” These are the 10 criteria against which the CQC will judge a registered provider on how it complies with the IPC (including cleanliness) requirements, which are set out in the regulations.

Our Current Status:

The Trust will need to demonstrate adherence to the following 10 criteria, currently, we are compliant in all apart from 4 partially compliant areas within criteria 2.

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2. The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3. Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4. The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.
5. That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7. The provision or ability to secure adequate isolation facilities.
8. The ability to secure adequate access to laboratory support as appropriate.
9. That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.
10. That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

What will success look like?

Improvement of adherence to National Infection Prevention Control (IPC) standards.

How will we monitor progress?

Quarterly reports will be presented at the Quality Committee which will focus on highlighting progress and key actions/mitigations for off track actions.

Priority 3 - Focus on improving the top three patient feedback themes; Communication, Appointments and Clinical Practice.

Why have we selected this Priority?

Patient experience is at the heart of everything we do. We understand that care is more than just clinical outcomes, it's about meeting the physical, emotional, and personal needs of our patients and their families. Every person who uses our services should feel valued, respected, and well cared for. We know that patient experience is critical to both individual patients and their families and goes well beyond the health outcomes of their care.

Our Current Status:

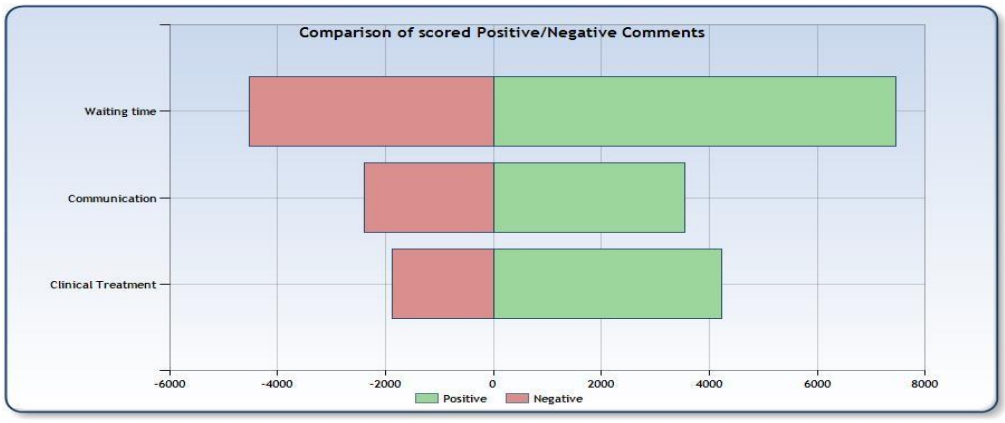
Top three themes of complaints during 2024-2025.

Complaint Categories	Number Received	% of overall complaints
Communication	408	32%
Clinical treatment	395	31%
Appointments	84	7%

The Trust received 89.84% Positive (54022 'Positive' Responses / 60134 Total Responses) from the FFT.

Top three themes' Friends & family Themes

- Waiting Times
- Communication
- Clinical treatment



What will success look like?

Reduction in the top three patient feedback themes, through complaints and Friends & Family Test.

How will we monitor progress?

Quarterly reports will be presented at the Quality Committee which will focus on highlighting progress and key actions/mitigations for off track actions.

Looking Back: Progress made since publication of 2023-24 Quality Account

This section of the Quality Account presents in summary the Trust's progress since the publication of last year's account against the identified improvement priorities.

These were:

1. **End of Life Care**
2. **Hear it Your Way**
3. **Diabetes Pathway**

Introduction

The Quality Account for 2023-24 outlined the Trust's proposed quality improvements for the year ahead (2024-25). These priorities were identified following engagement with patients, the public, staff and external stakeholders. During the year 2024-25 we have been monitoring our progress against these priority ambitions through our governance framework. The priorities that we have not carried forward will become 'business as usual' and we will have defined work streams to enable the Trust to deliver on the improvements not achieved in 2024-25.

Trust performance

This section provides detail on how the Trust has performed against the three priority ambitions. Results relate to the period 01 April 2024 - 31 March 2025 or the nearest period available. Mechanisms of measurement vary by priority and by the availability of national benchmark.

Priority 1: End of Life Care

We said we would:

Have a task and finish group who will review the standards and processes across the system to improve timely recognition and identification of people in their last year of life.

ULTH have supported the review of the Lincolnshire strategy, which highlights the need for system wide approach to improving recognition and identification of patients in their last year of life. Promotion of identification tools recommended by NICE have been achieved through education events and tools are available to each department in their Palliative & End of Life (PEOL) Folders. Work has commenced on exploring appropriate tools to support clinicians, which links community to hospital. Exploration of Gold Standards Framework (GSF) implementation in ULTH commenced linking with the GSF team. Working with Stroke team to trial use of identification tool on admission.

Have an education programme for end-of-life care rolled out across the Trust.

Fundamentals of PEOL education delivered through PEOL Champions forum, Ward ready programme and Dying Matters month. ULTH is a key partner in developing an Education Strategy for PEOL across Lincolnshire, which will support core education across the system. Staff from the Trust have been involved in the development of ReSPECT podcasts. Once the education strategy is published (later this year), we will be able to roll out the updated education framework across the Group. Standard definitions for Palliative and End of Life Care have been developed and are awaiting final approval through organisations to improve understanding and reduce risk of patient harm due to lack of clarity across providers. One example is that as we start to work together as organisations, we are able to share more patient information to inform clinical decision making. There is a risk that different definitions may impact on clinical decision making. This has been noted when patients have been identified as end-of-life by GP and then attend ED. GP definition is that they are in the last year and still appropriate for escalation. ED definition is that the person was in the last days/weeks and that they person should not be for escalation therefore delaying appropriate treatment due to lack of clarity in clinical picture.

Review End-of-life documentation across the Lincolnshire system and standardised as appropriate.

The review of policy is completed and documentation for Five Priorities of Care was updated. This is part of Lincolnshire system wide approach and covers partner organisations. Integrated care approach taken and was completed in April.

Capture End-of-life care within the Trust's Quality Accreditation programme.

Mapping of framework completed and recognition that the accreditation framework already supports majority of end-of-life care. Framework adapted to support elements of end-of-life care and being trialled at hospice in the hospital; this includes personalised care approaches to nutrition and hydration and falls risk and appropriate monitoring of syringe drivers. This will inform review of the current accreditation tools going forward.

Increase the number of staff responding to the staff survey within the annual NACEL survey to increase the staff voice in the care of end-of-life patients.

In 2022, there were15 respondents therefore the Trust required 30 respondents to meet target. In 2024 (not run in 2023) there were over 100 respondents so target overachieved. This was through promotion by palliative champions and teams across ULTH at multiple events / forums / communications.

Raise awareness of the shared end of life strategy across Lincolnshire and map progress through PEOL.

The strategy has been published. ULTH have collaborated with partner organisations as part of core palliative leadership system group to develop a socialisation plan. This is commencing in ULTH and will be presented at Quality Committee in May 2025. ULTH staff are also supporting socialisation of strategy in other organisations / areas as per plan.

Data Source: Palliative and End of Life Care Lead Nurse

What more do we need to do to achieve our success measures?

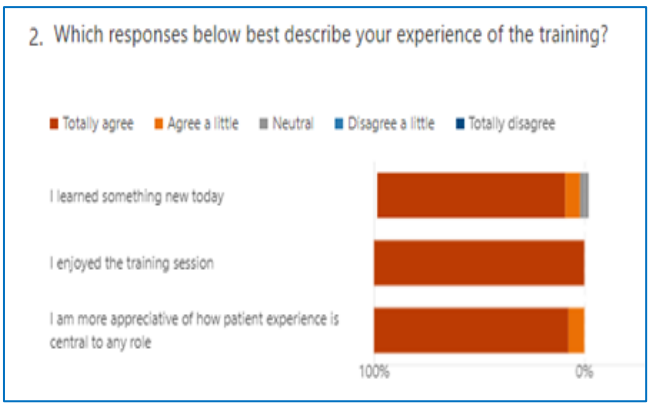
This work is ongoing and continuing into 2025-26.

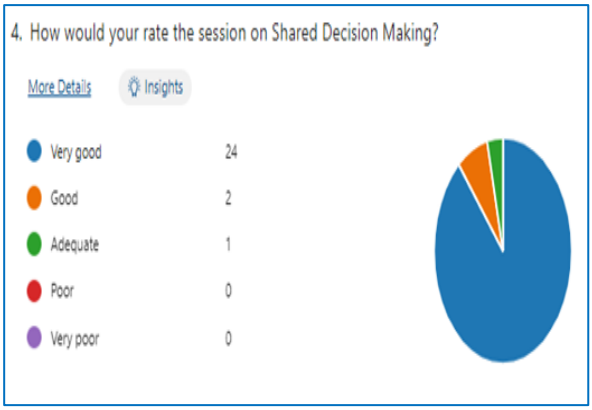
Priority 2: Hear It Your Way

We said we would:

Develop a Hear it Your Way Faculty within the Trust.

HIYW is an OSCE (Objective Structured Clinical Examination) type-training programme for staff that consists of a practical assessment designed to assess the skill, performance and competence of all staff in a range of communication skills. Scenarios from genuine complaints were designed that have patient actors in role and staff go to each 'station' and are observed with how they handle the situation. The observers are not 'scoring' staff rather they use a reflective approach, and ratings are designed from observations themes that are then used as general feedback. Three full day training sessions have been held during the year with 20 attendees at each and feedback has been excellent.





Data Source: Patient Experience Team

What we need to do to achieve our success measures?

There are mores sessions scheduled for 2025-2026 and discussions with LCHS colleagues who are keen to participate.

Priority 3: Diabetes Pathway

We said we would:

Getting the Basics Right – Digital Transformation

Within the Trusts antenatal clinics, the diabetes specialist nurses are inputting into the maternity medway system. The Trust are using Advice & Guidance to its fullest potential in both Endocrinology and Lipidology, which uses an integrated care portal which is used system wide.

Defining Service Models

A business case has been developed to increase the number of Diabetic Specialist Nurses. The Team provides a community multi-disciplinary team to support the community Diabetic Specialist Nurses.

Improving Quality & Safety

Business cases have been submitted for an expansion of the Diabetic Specialist Nurses workforce to meet national benchmarking requirements; plus new business cases have been submitted to initiate an endocrine specialist nursing workforce and a secondary care lipid specialist nurse workforce.

The clinical governance leads receive monthly reports in diabetes/insulin related incidents within the hospital. We also have a Diabetic Ketoacidosis (DKA) task & finish group and have a new pathway for patients who develop DKA whilst in hospital.

Service Development for Lipid Specialist Nurse Service

A business case has been submitted to the Integrated Care Board (ICB) from the ICB Programme Manager for lipidology nurse specialists that sit within the community setting, with input to and from secondary care.

Sustainable and Multi-professional Workforce

The Clinical Business Unit has undertaken a review of what is required to provide and develop the existing service we have, benchmarking against the Joint British Diabetes Societies workforce calculator (national), our current inpatient Diabetic Specialist Nurse workforce is only around 30% where it should be against nationally recommended guidance. For outpatient care we have predicted what proportion of current consultant delivered services could be changed to nurse led services.

Data Source: Endocrinology Department

What more do we need to do to achieve our success measures?

There are ongoing workstreams with our System Partners to improve the service we provide for our patients.

Statement of Assurance

Review of services

During 2024-25, the United Lincolnshire Teaching Hospitals NHS Trust (ULTH) provided and/or subcontracted 71 relevant health services.

The ULTH has reviewed all the data available to them on the quality of care in 71 of these relevant health services.

The income generated by the NHS services reviewed in 2024-25 represents 93% of the total income generated from the provision of NHS services by the ULTH for 2024-25.

Participation in Clinical Audits

During 2024-25, 58 national clinical audits and 8 national confidential enquiries covered relevant health services that ULTH provides.

During that period, ULTH participated in 100% of national clinical audits and 100% national confidential enquiries, which it was eligible to participate in.

The national clinical audits and National Confidential Enquiries that ULTH participated in, and for which data collection was completed during 2024-25, are listed below alongside 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.

National Audits	ULTH Participation	Reporting Period	Number and % Required
Peri and Neonatal			
State of Nation report UK Perinatal Deaths for babies born in 2022 (MBRRACE-UK)	Yes	January 2022 - December 2022 Published July 2024	No case ascertainment reported
Perinatal Confidential Enquiry (MBRRACE –UK) : The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death	Yes	Published December 2024	No case ascertainment reported
Saving Lives Improving Mothers Care	Yes	2020-2022 Report published October 2024	No case ascertainment reported
Neonatal Intensive and Special care (NNAP)	Yes	1st January – 31st December 2023 Report Published October 2024	LCH 64 PHB 28
Children			
National Children's & Young People Asthma Audit (NRAP)	Yes	2022- 2023 Breathing Well Report published August 2024	LCH 42 of 40 (105%), PHB 38 (63.3%)
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	1st April 2023- 31st March 2024 Published March 2025	LCH 164 PHB 122 GK 80

National Audits	ULTH Participation	Reporting Period	Number and % Required
National Epilepsy 12 Audit	Yes	1 Dec 2021 - 30 November 2022 Round 4 Cohort 5 Report published October 2024	168/169 (99%)
Acute Care			
National Emergency Laparotomy Audit (NELA) – Laparotomy	Yes	1 April 2024 - 30 November 2024 Report published monthly	LCH 103 PHB 81
National Emergency Laparotomy Audit (NELA) – No Laparotomy	Yes	1 April 2024 - 30 November 2024 Report published monthly	LCH 9 PHB 8
Cardiac Arrest (National Cardiac Arrest Audit) ICNARC	Yes	Awaiting report	To be confirmed
Case Mix Programme (CMP) Intensive Care National Audit & Research Centre (ICNARC)	Yes	1 April 2024 - 31 December 2024 Report published quarterly	LCH 386 PHB 314 Case ascertainment is not reported
Royal College of Emergency Medicine (RCEM) QIPS c) Mental Health (Self Harm) (Year 2)	Yes	October 2022 - October 2023 Report published August 2024	LCH 276 (104%) PHB 308 (116%)
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Awaiting report	To be confirmed
National Audit of Care End at the End of Life (NACEL)	Yes	January – December 2024 Organisation audit, staff survey, bereaved relatives/carers survey. Real-time reporting available	PHB 120 LCH 135 GDH 45

National Audits	ULTH Participation	Reporting Period	Number and % Required
Royal College of Emergency Medicine (RCEM) QIPS b) Care of Older People (Year 2)	Yes	October 2022 - October 2023 Report published August 2024	LCH 304 (115%) PHB 313 (118%)
Royal College of Emergency Medicine (RCEM) QIPS d)Time Critical Medications (Year 1)	Yes	October 2022 - October 2023 Report published August 2024	LCH 322 (101%) PHB 377 (119%)
British Thoracic Society (BTS) Respiratory Support (RSU)	Yes	1 February 2021- 31 May 2023 Report published July 2023	Not applicable this is an organisation of service audit
Long Term Conditions			
Diabetes (National Adult Diabetes Audit)	Yes	1 January 2023 - 31 March 2024. Report published links to ICB data	Case ascertainment is not reported (data is linked to local CCG/ICB)
Diabetes (National Adult Diabetes Inpatient /Survey/ Audit HARMs)	Yes	Awaiting report	Case ascertainment is not recorded
National Gestational Diabetes Mellitus Audit	Yes	Awaiting report	Case ascertainment is not recorded. Data collected via the Maternity Services dataset (MDS)
National Diabetes in Pregnancy Audit	Yes	1t January 2024 - 31 December 2024. Awaiting report	LCH 31 PHB 26 Case ascertainment is not reported
National Diabetic Foot Audit (NDFA)	Yes	1 Jan 2024 – 31 March 2025. Awaiting report	LCH TBC PHB TBC Case ascertainment is not reported

National Audits	ULTH Participation	Reporting Period	Number and % Required
National IBD Registry Ulcerative Colitis & Crohn's Disease	Yes	2023 - 2024 Summary reports	Data submission quarterly
National Early Inflammatory Arthritis (NEIAA)	Yes	1 April 2023 - 31March 2024 Report published October 2024	44 Case ascertainment is not reported
National Adult Asthma Audit (NRAP)	Yes	2022 - 2023 Breathing Well Report published August 2024	LCH 74(59.2%) PHB 78 (57.8%) GDH 26 (57.8%)
Chronic Obstructive Pulmonary Disease (COPD) NRAP	Yes	2022 - 2023 Breathing Well Report published August 2024	LCH 412 (68.7%) PHB 513 (76%) GDH 83 (44.9%)
National Audit Dementia R6	Yes	August 2023 – January 2024.Report published December 2024	LCH 42 PBH 45
National Chronic Kidney Disease Renal Registry	Yes	Report awaited	To be confirmed
National Renal Registry Acute Kidney Injury	Yes	Data up to 31 December 2022 Report published December 2023	Case ascertainment is not reported
National Diabetes Audit Integrated Specialist Services and Structure Survey	Yes	Annual submission, November 2024 Report awaited	Not applicable refers to the organisation of service
Elective Procedures			
BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Yes	1 April 2024 - 31 April 2024 Report published December 2024	LCH 10 Case ascertainment is not reported

National Audits	ULTH Participation	Reporting Period	Number and % Required
Cardiac Arrhythmia (NICOR)	Yes	April 2022 – 31 March 2023 2024 report published April 2024	Case ascertainment is not reported
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Yes	1 April 2022 - 31 March 2023 2024 report published April 2024	864 Case ascertainment is not reported
National Vascular Registry (NVR)	Yes	1 January 2023 - 31 December 2023 Report published November 2024	19 Elective infrarenal AAA repairs Case ascertainment >85% 46 Carotid endarterectomy Case ascertainment >85% 192 Lower limb angioplasty/stenting, Case ascertainment >85% 32 Lower limb surgical revascularisation, Case ascertainment 40-49% 28 Major lower limb amputation, Case ascertainment 50-59%
National Joint Registry (Hip, Knee, Ankle, Elbow and Shoulder Replacements)	Yes	1 January 2023 - 31 December 2023 Report published September 2024	GDH 801 LCH 227 PHB 93 Case ascertainment is not reported

National Audits	ULTH Participation	Reporting Period	Number and % Required
National Ophthalmology Database (NOD): Age-related Macular Degeneration Audit	Yes	1 April 2023 - 31 March 2024 Report due to be published February/March 2026	Case ascertainment is not yet reported
National Ophthalmology Database (NOD): Cataract Audit	Yes	1 April 2022 - 31 March 2023 Report published May 2024	1512 (98.9%)
Cardiovascular Disease			
Stroke Care (National Sentinel Audit of Stroke) SSNAP	Yes	1 April 2023 – 31st March 2024 Report published November 2024.	Total = 908 (90%+)
Acute Myocardial Infarction & Other Acute Coronary Syndrome (MINAP)	Yes	1 April 2022 - 31 March 2023 2024 report published in April 2024	LCH 937 Case ascertainment Stringent (94.93%) Non-stringent (94.08%) PHB 178 Case ascertainment Stringent (291.8%) Non-stringent (237.33%)
Heart Failure	Yes	1 April 2022 - 31 March 2023 2024 report published in April 2024	LCH 438 PHB 412 GDH 93 Trust overall submitted cases is 943 No % is available
Cancer			
National Prostate Cancer Audit (NPCA)	Yes	1st January 2019 – 31st December 2023 Report published January 2025	455 (100%) Not available in data tables – NPCA emailed

National Audits	ULTH Participation	Reporting Period	Number and % Required
National Audit of Primary Breast Cancer (NAoPri)	Yes	2019 - 2021 Report published October 2024	1254
National Audit of Metastatic Breast Cancer (NAoME)	Yes	2019 - 2021 Report published October 2024	161
National Lung Cancer Audit (NLCA)	Yes	1 January 2022 – 31 December 2022 Report published April 2023	408
National Bowel Cancer Audit (NBoCA)	Yes	1 April 2022 and 31March 2023 Report published January 2025	466
National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	1 April 2021 and 31 March 2023 Report published January 2025	261
National Kidney Cancer Audit (NKCA)	Yes	1 January 2019 - 31 December 2021 Report published September 2024	282
National Non-Hodgkin Lymphoma Audit (NNHLA)	Yes	1 January 2020 - 31 December 2021 Report published September 2024	169
National Ovarian Cancer Audit (NOCA)	Yes	1 January 2021 - 31 December 2021 Report published September 2024	52

National Audits	ULTH Participation	Reporting Period	Number and % Required
National Pancreatic Cancer Audit (NPaCA)	Yes	1 January 2020 - 31 December 2021 Report published September 2024	192
BAUS Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Yes	1 April 2024 - 31 May 2024 Report due to be published June 2025	GDH 1 LCH 3 PHB 1
Trauma			
National Hip Fracture Database (NHFD)	Yes	1 January 2023 – 31 December 2023 Report published September 2024	LCH 453 (101.1%) PHB 437 (99.8%)
National Audit Inpatient Falls (NAIF)	Yes	1 January 2024 - 31 December 2024. Report due to be published Oct 2025	LCH – to be confirmed PHB - to be confirmed
National Major Trauma Registry (NMTR)	Yes	1 January 2024 - 31 December 2024 Report expected to be published in 2026	LCH 98 PHB 336 Data submission commenced in April 2024
BAUS Penile Fracture Audit	Yes	1 April 2022 - 31 March 2024 Report due to be published June 2025	LCH 1
Blood Transfusion			
National Comparative Audit Blood Transfusion - 2024 Bedside Transfusion Audit	Yes	A sample of up to 40 patients being transfused in the months of March and April 2024	LCH 27 PHB 11

National Audits	ULTH Participation	Reporting Period	Number and % Required
National Comparative Audit of Blood Transfusion (NICE Quality Standard QS138)	Yes	Data collection to completed December 2024	Results awaited
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	1 April 2024 – 31 March 2025	LCH 11 PHB 6 GDH 1

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

During 2024-25 hospitals were eligible to enter data in up to 8 NCEPOD studies. Below is a summary of those studies in which ULTH participated. Studies for which ULTH were exempt are not listed. Action plans are developed for any areas not achieving the recommended standards.

National	ULTH Participation	Reporting Period	Number and % Required
Confidential Enquiries			
End of Life	Yes	Organisational Questionnaire Clinical Questionnaire Report published November 2024	- 5/12 42%
Acute Limb Ischaemia	Yes	Organisational Questionnaire Clinical Questionnaire	Full study not yet closed
Emergency (non-elective) procedures in children and young people	Yes	Organisational Questionnaire Clinical Questionnaire	100% completed/submitted Full study not yet closed
Hypernatremia	Yes	Organisational Questionnaire	-

National	ULTH Participation	Reporting Period	Number and % Required
		Clinical Questionnaire	0/2 0%
Hyponatraemia	Yes	Organisational Questionnaire Clinical Questionnaire	- 3/7 43%
ICU Rehabilitation	Yes	Organisational Questionnaire Clinical Questionnaire	Grantham:16% completed/submitted Lincoln: 26% completed/submitted Pilgrim 20% completed/submitted 3/11 27%
Blood Sodium	Yes	Organisational Questionnaire Clinical Questionnaire	100% completed/submitted -
Juvenile Idiopathic Arthritis Study	Yes	Organisational Questionnaire Clinical Questionnaire Report published February 2025	100% completed/submitted -

The reports of 7 national clinical audits were reviewed by the provider in 2024-25 and ULTH intends to take the following actions to improve the quality of healthcare provided (see tables below).

Descriptions of outcomes and improvements from a sample of the national audits:

National Audit	Headline Results and Actions Taken
National Ophthalmology Database (NOD) Audit	• Cataract procedures performed during 2022-2023 • ULTH submitted 1512 eligible operations to the NOD Audit, which is an estimated 98.9% case ascertainment, an increase from 94.9% in the 2021 audit year. • The 1512 eligible operations were performed by 23 surgeons.

National Audit	Headline Results and Actions Taken
	• 89.2% of cases had recorded preoperative Visual Acuity (VA) data, which is an increase from 86.8% in 2021, and is above the national average of 86.5%. • 68.1% of cases had recorded postoperative VA data, which is an increase from 61.2% in 2021. This is below the national average of 69.0%. • The adjusted PCR rate for ULTH is 0.94%, above the overall for all centres of 0.61% but within the 95% confidence interval
National Neonatal Audit Programme (NNAP)	• July 2024: Provisional notification of positive outlier for National Neonatal Audit Programme (NNAP) 2022 measures • Pilgrim Hospital has been identified as Outstanding for the audit measure Retinopathy of prematurity screening • The result of interest for this measure is 100%. The national average result was 78.4%
MINAP (heart attack and Ischaemic heart disease)	• Door To Balloon - 85% compliant (above national 70%) with STEMI heart attacks undergoing primary PCI within 90 minutes. • Above national target for NSTEMI patients undergoing angiogram before discharge within 72hrs at 61% compliant. • NSTEMI Patients admitted to cardiology ward compliant and above national target at 85%
National Kidney Cancer Audit (NKCA)	• 282 patients diagnosed between 2019 and 2021 • 23% of people with a small renal mass (≤4cm) have a biopsy (national 20%) • 73% of people with a T3+ and/ or 10cm+ and/or N1 and M0 RC had a radical nephrectomy within 31 days of diagnosis (national 69%) • 0% of people with kidney cancer die within 30 days of SACT treatment (national 3%)
National Prostate Cancer Audit (NPCA)	• Review of outcome data continues with the Multidisciplinary Team (MDT) lead total number of cases submitted 346 • The National Cancer Audit Collaborating Centre (NATCAN) is in place to capture Trust data via the existing data sets collected nationally
National Oesophago-Gastric Cancer Audit (NOGCA)	• 261 patients diagnosed between 1st April 2021 and 31st March 2023 • 75% of patients diagnosed within 28 days of referral (national 73%) • 0% of people with stage 4 disease died within 30 days of starting SACT (national 5%)
National Non-Hodgkin Lymphoma Audit (NNHLA)	• 169 patients diagnosed in 2020 (86 high grade and 83 low grade) and 188 in 2021 (96 high grade and 91 low grade) • Overall one-year survival for both high and low grade lymphoma is better than the national average

Local Clinical Audit

The reports of 4 local clinical audits were reviewed by the provider in 2024-25 and ULTH intends to take the following actions to improve the quality of healthcare provided: (see tables below):

The local audit plan is linked to National Institute for Health and Clinical Excellence (NICE), CQC, Best practice and key priorities for the Trust.

Examples of actions taken locally:

Local Audit	Actions - Improvements
Managing AKI in Post-Operative Femur Fracture and other Orthopaedic Patients	**Orthopaedics** • Low compliance with local Guidelines for Management of Acute Kidney Injury (AKI) in first cycle of audit for femur fracture patients: 20% adherence to AKI bundle checklist. • Following first cycle interventions included education of junior doctors and nurses around the AKI bundle and management of post femur fractures, creation of a proforma and educational posters displayed in the resource room. • The re-audit highlighted significant improvement from 20% adherence in the AKI bundle to 100% adherence. There was 100% documentation of pre and post operative fluid status, 100% documentation of bloods on day 1 or day 2 and 100% of medications reviewed.
Subarachnoid haemorrhage caused by a ruptured aneurysm: diagnosis and management Re-audit	**Accident and Emergency** • The re-audit outcomes evidenced a considerable improvement compared to the outcomes within the 1st cycle. • Following the first audit, it was identified that it would be beneficial to deliver training in order to re-educate staff on the management plan of Subarachnoid Haemorrhages. • Red flags documentation improved from 45% in 1st cycle to 85% in 2nd cycle • Medical admission reduced by 20%, from 87% in 1st cycle to 67% in 2nd cycle • CT scan to be done with 6 hours of headache onset also improved from 4% to 50% in 2nd cycle
Facing the future – RCPCH Standard Re-audit	**Paediatrics** • At least two medical handovers every 24 hours are led by a consultant paediatrician. Morning (100%), evening (71.4%)

	• Every child with an acute medical problem who is referred for a paediatric opinion is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged. • Throughout all the hours they are open, paediatric assessment units have access to the opinion of a consultant paediatrician. • The extension of consultant presence in the PAU to 21:00 during weekdays in Lincoln. (achieved in Pilgrim) • To make the clinical team including all doctors and nurses aware of this standard. This can be achieved by email and poster. Discussed in the consultants' meeting recommending the consultant to see the newly admitted patients after attending the evening handover.
Vaginal Birth after Caesarean (VBAC)	**Obstetric & Gynaecology** • PHB - Good compliance (100%) to 5 out of 6 standards. Rate of successful VBAC consistent with national standards. To improve on documentation of discussion and use of VBAC checklist. • Rate of successful VBAC consistent with national standard (61.5% in PHB vs 60.7% in NMPA) • Good compliance (100%) to 5/6 suggested auditable topics in GTG • 100% senior involvement in induction/augmentation of labour • New checklist being prepared/created. To inform and encourage incoming doctors the use of VBAC checklist

Participation in Clinical Research

ULTH remains committed to enhancing its capacity, capability and culture of clinical research development and delivery, as it prepares to transform into a University Teaching Hospital. Our Research and Innovation Department has a strong record of patient recruitment, as well as collaborative working. 2024-25 has seen a healthy growth in research delivery performance.

The number of patients receiving relevant health services provided or sub-contracted by ULTH in 2024-25, that were recruited to participate in research approved by a research ethics committee, and into National Institute for Health Research (NIHR) portfolio research, is 2946. These participants were recruited through 74 studies from 29 research specialties including: Ageing, Anaesthesia, Cancer, Cardiovascular Disease, Children, Critical Care, Dermatology, Diabetes, Gastroenterology, Genetics, Haematology, Musculoskeletal Disorders, Neurological Disorders, Renal Disorders, Reproductive Health & Childbirth, Stroke, Surgery, and Trauma & Emergency Care.

In 2024-25, the Trust has approved 51 new portfolio studies. (51 in 2023-24, 38 in 2022-23).

The two Research Departments across the Lincolnshire Community & Hospitals Group are developing a new Group strategy for Research to demonstrate its commitment to improving the quality of care and contributing to wider health improvement, through research. The Group is also linking in as an active partner of the Lincolnshire Integrated Care Board research leaders' group.

The Trust continues to play a significant role in improving patient care and in developing new and innovative drugs, treatment, and services. Research evidence shows that research active hospitals improve patient care and outcomes. Due to the increased number of commercial and non-commercial trials, Lincolnshire patients are benefitting by being given more opportunities to receive the latest medications and treatment options. The Trust has implemented the findings of trials, which has helped the Trust in improving patient care, as well as achieving cost savings. As the system continues to develop, it is hoped that even more benefits from research will be realised across the county.

Use of the Commissioning for Quality and Innovation (CQUIN) Framework

The 2025-26 CQUIN scheme has been paused nationally while a wider review of incentives for quality is undertaken.

Care Quality Commission (CQC) Statements

The Care Quality Commission (CQC) are the regulators of quality standards within all NHS Trusts. They monitor our standard of care through assessments, patient feedback, and other external sources of information.

The Trust is required to register with the CQC, and its current registration status is registered. The Trust has no conditions on its registration.

ULTH has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC has not taken enforcement action against ULTH during 2024-25.

CQC undertook unannounced visits to Emergency Departments in Lincoln and Boston in October 2024 and November 2024 respectively. The Trust is awaiting the final report but is acting on initial feedback from CQC.

The current CQC rating for ULTH is requires improvement.

	Safe	Effective	Caring	Responsive	Well-led	Overall
County Hospital Louth	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Lincoln County Hospital	Requires Improvement →← Feb 2022	Good ↑ Feb 2022	Good →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022
Pilgrim Hospital	Requires Improvement ↑ Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022	Requires Improvement →← Feb 2022
Grantham and District Hospital	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Overall trust	Requires Improvement →← Feb 2022	Good ↑ Feb 2022	Good →← Feb 2022	Requires Improvement →← Feb 2022	Good ↑ Feb 2022	Requires Improvement →← Feb 2022

Data Quality

NHS Number and General Medical Practice Code Validity

United Lincolnshire Hospitals Trust submitted records during April 2024 to January 2025 at the Month 10 inclusion date to the Secondary Uses Service (SUS) for inclusion in Hospital Episode Statistics (HES), which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS number was:
  - 99.90% for admitted patient care (National performance 99.7%)
  - 99.97% for outpatient care (National 99.7%)
  - 99.67% for accident and emergency care (National 98.2%)

- Which included the patient's valid General Medical Practice Code was:
  - 99.97% for admitted patient care (National performance 99.4%)
  - 99.97% for outpatient care (National 99.3%)
  - 99.96% for accident and emergency care (National 99.2%)

Data Security and Protection Toolkit (DSPT)

The Data Security and Protection Toolkit (DSPT) is an annual online self-assessment tool via NHS England that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. As data security standards evolve, the requirements of the DSPT are reviewed and updated to ensure they are aligned with current best practice. Organisations with access to NHS patient data must therefore review and submit their annual assessment each year before the deadline.

All organisations that have access to NHS patient information must provide assurances that they have the proper measures in place to ensure that this information is kept safe and secure. Completion of the DSPT is therefore a contractual requirement specified in the NHS England Standard Conditions contract and it remains Department of Health and Social Care policy that all bodies that process NHS patient information for whatever purpose provide assurances via the DSPT.

Completion of the DSPT is also necessary for organisations, which use national systems such as NHSmail and the e-referral service.

ULTH's 2024-25 DSPT was submitted as 'approaching standards. An approaching Standards' assessment indicates that the Trust have demonstrated good progress but have not fully reached 'Standards Met'. The Trust develop and deliver to an improvement plan for those areas where work was identified as being needed and delivery of this is monitored through National Health Service England (NHSE).

Clinical Coding

ULTH commissioned an external provider to undertake a Clinical Coding audit in September 2024, as part of the Data Security & Protection Toolkit requirements, as well as ensuring internal processes are working as expected. Overall, the standard of Clinical Coding was rated as excellent, with Primary Diagnosis scoring a 94.5% accuracy rate, and Secondary Diagnosis scoring a 96.01% accuracy rate. Primary procedural coding scored 98.85% accuracy, with secondary procedure coding scoring 95.42%.

There were four key recommendations that came out of the audit, which the Head of Clinical Coding is leading on to ensure learnings and training are rolled out to the rest of the team.

Data Quality

Data Quality is an important element of safe, quality care at acute sites and is a continuing focus for improvement. United Lincolnshire Teaching Hospitals NHS Trust will be taking the following actions to improve data quality:

- An annual review of the main Key Performance Indicators (KPIs) that are reported to the Trust Board and Board Committees, including the addition of new metrics linked to a refresh of the Performance Review Meetings (PRM) that are undertaken for each Clinical Division. This will come into effect from January 2025. This involves understanding the metric itself, how it is calculated and assurance around underlying robustness of the metric, data source and collation/publishing.
- Work was paused on the application of the Data Quality Kite Mark. This will re-start in early 2025/26 and will alert end users to 4 indicators: Timeliness, Completeness, Validation and Process. Further work will ensure that all metrics are assigned a kite mark, and those assigned already are reviewed and updated as required.

- Work was completed to upgrade to the latest version of Careflow PAS (formerly known as Medway). We are also assessing the upgrades made available by the system supplier to enable our submissions to NHS England continue to be compliant to CDSv6.3 and ECDSv4
- The Clinical Coding department continues to work closely with the 4 Clinical Divisions and underlying Specialty Business Units; we are looking at what improvements can be made, including internal audit and training, and improved engagement with the Divisions.
- As part of the Group work bringing together United Lincolnshire Teaching Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust, the structure of the Information Services team is being reviewed to ensure we support the needs of the Group.
- We have adopted Microsoft PowerBI as the preferred visualisation tool for the Trust. Ongoing development of the data warehouse, coupled with PowerBI, will enable more timely reporting of information and assist with data quality reporting throughout the Divisions in the Trust.

Learning From Deaths

The Lincolnshire Medical Examiners review all deaths. The role includes reviewing medical records and liaising with bereaved relatives to assess whether the care provided was appropriate. Any death where a concern has been raised by the Medical Examiner is escalated for further review.

The Trust has an embedded process to screen, review and investigate inpatient deaths. Each Division has an embedded mortality review process to undertake reviews on any death to identify learning. The Mortality Meeting (MorALS) provides Executive-led scrutiny of mortality surveillance to ensure the Trust is driving quality improvement by using a systematic approach to mortality review and learning from death. The Group reports monthly to the Clinical Effectiveness Group.

Measure	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Comments
Number of patients that have died within ULTH	608	619	675	671	During 2024-25, 2573 of ULTH patients died. This line indicates the number of deaths which occurred in each quarter of that reporting period
Number of deaths that have had a case record review/investigation	608	619	675	631	By March 2024, 2533 case record reviews and investigations have been carried out in relation to 2494 of deaths included above. In 778 of cases a death was subjected to both a case record review and an investigation. This measure illustrates the number of deaths in each quarter for which a case record review or an investigation was carried out. In addition, 52 cases were also discussed within the Governance Meetings.
Number/percentage of deaths that	6	3	3	0	12 deaths representing 0.5% of the patient deaths during the reporting period are

escalated with problems in care					judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been used for all cases that have been graded a 3.

Summary of what ULTH has learnt from case record reviews and investigations conducted in relation to deaths

Circa 94% of the mortality reviews that were undertaken at the Trust identify that the death was unavoidable. The Trust objective is to learn from these cases of good care, as evidence suggests most care delivered in hospitals is of good or excellent quality, and as such, shared learning at M&M meetings from the review of high-quality care is key.

The Trust uses the Royal College of Physician's National Mortality Case Record Review Programme methodology known as the Structured Judgement Review (SJR). The Trust recognises that learning from the care given to patients in their final days of life enables us to understand where we have provided good care but also where there are opportunities for learning and improvement. It is vital to recognise that acknowledging the care given to patients at such a difficult time will improve the standard of care for all patients.

Other methodology and review tools are also used across the Trust regarding Learning from Deaths than may be more appropriate, such as:

Infant/child deaths may utilise alternative mortality reviews, such as:

- Sudden Unexpected Death in Childhood (SUDIC);
- Perinatal Mortality Reporting Tool (PMRT); or,
- Child Death Overview Panel (CDOP).

SACT 30-Day Mortality Reviews are completed for patient who die 30-days post-Systemic Anti-Cancer Therapy, even if an SJR has been completed previously.

Mortality and Morbidity meetings; where case reviews can be shared and learning from thematic analyses that related to concerns in care delivery.

Learning from Deaths allows for those identified concerns in care to be reviewed and discussed, and where possible, assist in opportunities to create service delivery improvements.

Learning identified from mortality reviews:

Documentation issues:

The Trust works with paper clinical records and there are concerns highlighted over loose notes and poor adherence to Trust policy when it comes to filing.

Several SJRs have highlighted poorly completed documentation in specific areas such as medications and fluid balance management.

End of Life:

The was a need for improvement in recognising the deteriorating patient and ensuring that End of Life discussion are held as soon as possible.

Delays within our Emergency Department (ED):

Patients were noted to have been within our ED for over 12-hours.

Issues with patients who have received a Decision to Admit (DTA) from ED, who were unable to be transferred to a ward within a timely manner due to bedspaces. This highlights the Trust discharge processes and how the flow within the Trust's Inpatients impacts the ED, increasing waiting times.

There was learning identified around transitional care patients from Children and Young Peoples services moving into adult care, whereby ownership could not be established due to the child's age.

Communication:

A highlighted issue at the Trust is our communications with families and carers in regard to issues access information about their loved ones on the wards, and the need to improve on difficult conversations and having these at the appropriate time; as well as ensuring these are accurately documented.

Fluid balance management:

This has been highlighted throughout our SJRs, whether this be poorly completed charts or where patients are not hydrated enough.

The review of 10 patients' death through an SJR process identified that these were more likely than not due to problems in care as such these cases were reviewed under our PSIRF criteria and approved as an individual PSII's.

ULTH reviews the Dr Foster system provided by Telstra Health UK, by completing monthly reviews on the Hospital Standardised Mortality Ratio (HSMR) data, which is reported to the Trust's Mortality Group (MorALS).

The Trust utilises this information to review the HSMR Diagnosis Group alerts and take a proactive response in providing thematic analyses and instigating in-depth case note reviews.

Description of actions that ULTH have taken in 2024-25 and proposes to take forward in consequence of what the ULTH has learnt.

Concerning the issues with documentation, audits have been included within the Quality Assurance Assessments completed by the Quality Matrons, which have a specific section that now reviews patient documentation; not only within the paper case notes but within some electronic records such as ePMA, which is used for prescribing medication.

Several specialties are completing audits around end-of-life care, to review the current practice and identify improvements. This is being completed alongside liaising with the Specialist Palliative Care Team to understand the wider impacts of end-of-life care.

We are working closer with our partner organisation LCHS and building relationships when it comes to end-of-life care delivery. With LCHS now attending many of our meetings to share insights and learning.

Delays in ED have been reviewed centrally by the Trust, with most of the cases highlighted by mortality review already being investigated by the department die to stringent national KPI's which they monitor.

Several projects have been completed across the reporting period to look to improve both discharge from hospital and improving patient flow from our ED departments in conjunction with the ICB and partner organisations.

New policies and pathways are being created with larger discussions between the Family Health and Medicine divisions around transitional care patients from Children and Young Peoples services moving into adult care.

New processes have been put in place to improve the communication with families and specifically when they try to call the wards via the telephone.

Discussions with the families are now documented more in the notes, as a result of discussions within Governance meetings. An understanding of documenting as much as possible will help when a case is reviewed by the Medical Examiner, or in the result of further investigations or complaints.

A 'Hear it Your Way' faculty has been launched with a number of sessions run; This looks to teach staff how to navigate challenging conversations with confidence and empathy and

master techniques for clear and concise communication, reducing the risk of errors and misunderstandings. Explore the importance of active listening and nonverbal cues in building strong patient clinician relationships.

Some of the wards are trialling new methods of providing hydration to patients with the jugs that have different coloured lids so it can be monitored more simplistically. The aims are to improve on patient hydration and reduce the need for IV fluids, which could come at a cost saving.

M&M meetings:

Newsletters and briefings are being issued that identify key learning issues and actions. This enables them to be sent to all staff within the relevant area and not only the people who can attend a meeting, ensure dissemination of shared learning.

The Learning from Deaths team has completed more thematic reviews on unavoidable deaths that had some element of suboptimal care that did not impact on the outcome. This enables the Trust to review themes and trends across department from cases where an individual review would not have identified a theme or improvements needed.

The Trust has moved all mortality information and not just SJRs into the DCIQ system making it a one stop for all mortality cases bring together SUDIC, PRMT, SACT, M&M and SJRs into one platform: with wider oversight of all learning from deaths in one system.

The Trust has continued to run the Mortality Masterclasses and opened these up to our partner organisation LCHS.

The Trust will be moving to Group working within 2025-26, and to be proactive the two Learning from Deaths teams have been working more collaboratively to review patients and share learning experiences.

Assessment of the impact of actions which were taken by ULTH during 2024 - 25.

Moving all the Learning from Death cases to DCIQ has enabled the Trust to support a larger number of timely reviews of patient deaths that meet the criteria defined within our Learning from Deaths Mortality Review policy.

The Trust reviewed the current Mortality and Morbidity (M&M) meetings. Positive engagement with the newer M&M processes, leading to the implementation of some CBU lead M&M's, taking wider discussion from multi-disciplinary specialists, highlighting concerns and sharing reviews and learning in a larger group rather than in silo by specialty.

Mortality Masterclasses that were run by the Learning from Deaths team in conjunction with the Medical Examiners service allowed for wider shared learning of process and procedures relating to patient deaths. It also allowed the Trust to explain some of the national metric such as HSMR and SHMI and how their work can impact these.

We are continuing to improve the clinical governance processes around Learning from Deaths and ensuring that we triangulate with other teams e.g. patient safety, complaints, and audit to optimise learning opportunities.

Due to shared working with our partner organisation LCHS, the Learning from Deaths teams are collaborating more frequently and looking to align processes. There is going to be new Mortality Oversight Group, with attendees from both organisations to look at Mortality, shared learning and insights, aligning these to Trust priorities alongside a new Group Learning from Deaths Mortality Review Policy.

United Lincolnshire Teaching Hospitals NHS Trust have been using a grading of avoidability since January 2016. The review grading is outlined below:

- Grade 0 - Unavoidable Death, No Suboptimal Care
- Grade 1 - Unavoidable Death, Suboptimal care, but different management would not have made a difference to the outcome
- Grade 2 - Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)
- Grade 3 - Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)

Measure	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Comments
Number of reviews/ investigations completed which took place before the start of the reporting period	82	16	2	1	101 case record reviews and investigations completed after 31 March 2024, which related to deaths, which took place before the start of the reporting period.
Number/Percentage of deaths that are judged likely not to be problems in care	1	0	0	0	1 representing 1% of the patient deaths during 1 April 2024 - 31 March 2025 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Reporting Against Core Indicators

The tables below show the Trust's latest performance for 2024/25 and the last two financial years for a selection of indicators for patient safety, clinical effectiveness and patient experience. The following data relating to national reporting requirements in the Quality Account are provided by NHS Digital. NHS Digital provide data for 15 mandatory indicators, based upon the recommendations by the National Quality Board. The last two previous reporting periods available on NHS Digital for ULTH are to be reported within the Quality Account.

Domain 1: Preventing people from dying prematurely.

The data made available to the Trust by NHS Digital with regard to:

- The value and banding of the Summary Hospital-level Mortality Indicator (SHMI) for the Trust for the reporting period

Description	Dec 2021 – Nov 2022	Dec 2022 – Nov 2023	Dec 2023 – Nov 2024
ULTH SHMI / Band	1.0267 / 2	1.0325	1.0999 / 2
National Average	0.9997	1.0033	1.0031
Best(B) / Worse(W) National Performance	0.7173 (B) / 1.2219 (W)	0.9578 (B) / 1.2564 (W)	0.7016 (B) / 1.2849 (W)

The data made available to the Trust by NHS Digital with regard to:

- The percentage of patient deaths with palliative care coded at either diagnoses or speciality level for the Trust for the reporting period

Description	Dec 2021 – Nov2022	Dec 2022 – Nov-2023	Dec 2023 – Nov 2024
ULTH%	33%	32%	32%
National Average %	40%	42%	44%
Best(B) / Worse(W) National Performance %	66% (B) / 13% (W)	66% (B) / 16% (W)	66% (B) / 17% (W)

ULTH considers that this data is as described for the following reasons:

Information relating to mortality is monitored monthly and used to drive improvements.

The mortality data is provided by an external source (Dr Foster).

The data is reviewed by the Learning from Deaths team, interrogated in line with the key lines of enquiry identified by the team and has reporting and governance arrangements in place.

ULTH intends to take the following actions to improve this indicator and so the quality of its services by:

Continually reviewing our mortality processes and reviewing our data.

Learning from deaths team continue to monitor palliative care coding against national best practice in order to ensure the number of expected deaths is accurately recorded.

Domain 3: Helping people to recover from episodes of ill health or following injury.

The data made available by NHS Digital with regard to:

- The Trust's patient reported outcome measures scores for Total/Primary Hip replacement surgery & Knee replacement surgery-EQ:5D Index

Description	2020-2021	2021-2022	2023-2024
ULTH EQ:5D index Hip Replacement surgery (L) Low, (H) High	Pre Op (L) -0.484 (H) 0.796 Post Op (L) –0.264 (H) 1.0	Pre Op (L) -0.319 (H) 0.796 Post Op (L) 0.186 (H) 1.0	Pre Op (L) -0.248 (H) 0.814 Post Op (L) -0.239 (H) 1.0
National Avg EQ:5D index Hip Replacement surgery (L) Low, (H) High	Pre Op (L) -0.594 (H) 1.0 Post Op (L) -0.594 (H) 1.0	Pre Op (L) -0.594 (H) 1.0 Post Op (L) -0.594 (H) 1.0	Pre Op (L) -0.594 (H) 1.0 Post Op (L) -0.594 (H) 1.0
ULTH EQ:5D index Knee Replacement surgery (L) Low, (H) High	Pre Op (L) -0.074 (H) 0.796 Post Op (L) 0.516 (H) 1.0	Pre Op (L) -0.319 (H) 0.76 Post Op (L) -0.016 (H) 1.0	Pre Op (L) -0.239 (H) 0.796 Post Op (L) -0.239 (H) 1.0
National Avg EQ:5D index Knee Replacement surgery (L) Low, (H) High	Pre Op (L) -0.594 (H) 1.0 Post Op (L) -0.594 (H) 1.0	Pre Op (L) -0.594 (H) 1.0 Post Op (L) -0.594 (H) 1.0	Pre Op (L) -0.594 (H) 1.0 Post Op (L) -0.594 (H) 1.0

The data made available by NHS Digital with regard to the Trust's patient reported outcome measures scores for:

- Total/Primary Hip replacement surgery & Knee replacement surgery-VAS Index

Description	2020-2021	2021-2022	2023-2024
ULTH VAS index Hip Replacement surgery - (L) Low, (H) High	Pre Op (L) 25 (H) 95 Post Op (L) 51 (H) 95	Pre Op (L) 0 (H) 90 Post Op (L) 45 (H) 100	Pre Op (L) 3 (H) 100 Post Op (L) 13 (H) 100
National Avg VAS index Hip Replacement surgery - (L) Low, (H) High	Pre Op (L) 0 (H) 100 Post Op (L) 0 (H) 100	Pre Op (L) 0 (H) 100 Post Op (L) 0 (H) 100	Pre Op (L) 0 (H) 100 Post Op (L) 0 (H) 100
ULTH VAS index Knee Replacement surgery - (L) Low, (H) High	Pre Op (L) 40 (H) 85 Post Op (L) 35 (H) 99	Pre Op (L) 29 (H) 95 Post Op (L) 35 (H) 93	Pre Op (L) 8 (H) 100 Post Op (L) 15 (H) 100
National Avg VAS index Knee Replacement surgery - (L) Low, (H) High	Pre Op (L) 0 (H) 100 Post Op (L 0 (H) 100	Pre Op (L) 0 (H) 100 Post Op (L 0 (H) 100	Pre Op (L) 0 (H) 100 Post Op (L 0 (H) 100

The data made available by NHS Digital with regard to the Trust's patient reported outcome measures scores for:

- Total/Primary Hip replacement surgery and Knee Replacement Surgery-Oxford Score

Description	2020-2021	2021-2022	2023-2024
ULTH Oxford hip surgery score (L) Low, (H) High	L – 3 H - 48	L – 3 H - 48	L – 3 H - 48
National Avg Oxford Hip surgery score (L) Low, (H) High	L – 0 H - 48 (Actual High and low)	L – 0 H - 48 (Actual High and low)	L – 0 H – 48 (Actual High and low)
ULTH Oxford Knee surgery score (L) Low, (H) High	L – 5 H - 48	L – 4 H - 46	L – 5 H - 48

National Avg Oxford Knee surgery score (L) Low, (H) High	L – 0 H - 48	L – 0 H - 48	L – 0 H - 48

ULTH considers that this data is as described for the following reasons:

Patients undergoing elective inpatient surgery for a hip or knee replacement, funded by the English NHS are asked to complete a voluntary questionnaire before and after their operations to assess improvement in health as perceived by the patient themselves. The data is taken from NHS Digital PROMS data set.

ULTH intends to take the following actions to improve PROMS outcomes and so the quality of its services by:

We are continuing to focus on improving participation rates.

The Orthopaedic Team will review the data quarterly to ensure good participationn rates and any identify actions if any areas are below the required benchmark.

The data made available to the Trust by NHS Digital with regard to:

- The percentage of patients aged (i) 0 to 15 readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the trust during the reporting period (emergency readmissions)

Description	2021-2022	2022-2023	2023-2024
ULTH readmitted within 30 days: 0-15	12.9%	12.4%	14.7%
*National Average: 0-15	12.5%	12.8%	12.4%
Best(B) / Worse(W) National Performance: 0-15	B - 3.3% W - 46.9%	B - 3.7% W - 302.9	B - 1.6% W - 69.1%

The data made available to the Trust by NHS Digital with regard to:

- The percentage of patients aged (ii) 16 or over readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the trust during the reporting period (emergency readmissions)

Description	2021-2022	2022-2023	2023-2024
ULTH readmitted within 30 days: 16+	11.9	11.4	12.3
National Average: 16+	14.7	14.4	13.1
Best(B) / Worse(W) National Performance: 16+	B - 2.1 W -142.0	B - 2.5 W - 46.8	B - 1.7 W - 99.6

ULTH considers that this data is as described for the following reasons:

The data is taken from the Trust's Patient Administration System (Careflow).

The data is consistent with Dr Foster's standardised ratios for re-admissions.

ULTH intends to take the following actions to improve this indicator and so the quality of its services by:

Working to ensure we treat and discharge patients appropriately, so they do not require an unplanned readmission. Working with partners in the system to address long-standing pressures around demand, capacity and patient flow and working closely with system partners to ensure safe discharge practice.

Domain 4: Ensuring people have a positive experience of care.

The data made available by NHS Digital with regard to the:

- Trust's responsiveness to the personal needs of its patients during the reporting period

Description	2018-2019	2019-2020
ULTH	64.6	61.3
National Average	67.2	67.1
Best(B) / Worse(W) National Performance	B – 85.0 W – 58.9	B – 84.2 W – 59.5

*Latest data available

ULTH considers that this data is as described for the following reasons:

The data is provided by the national survey contractor.

ULTH intends to take the following actions to improve this indicator and so the quality of its services by:

Continuing to collect real-time feedback from patients as part of its inpatient survey, working to increase the FFT response rate this year and expanding the work of the Patient Experience Team.

The data made available by NHS Digital with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period:

- Who would recommend the Trust as a provider of care to their family and friends

Description	2022	2023	2024
ULTH Strongly agree(SA) /Agreed (A)	42.7%	44.3%	48.96%
National Average Strongly agree(SA) /Agreed(A)	61.9%	63.3%	61.5%
Best(B) / Worse(W) National Performance	86.4% (B) 39.2% (W)	88.8% (B) 44.3% (W)	89.59% (B) 39.72% (W)

ULTH considers that this data is as described for the following reasons:

The data has been sourced from NHS Digital and compared to published survey results.

ULTH intends to take the following actions to improve this indicator and so the quality of its services by:

Continuing to encourage participation in this survey and by developing local action plans and responses to the feedback received.

The data made available to the Trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2):

- Patients who would recommend the Trust to family and friends: % recommended

Description	Nov 2024	Dec 2024	Jan 2025
ULTH ED / National Avg/ Best(B)-Worst(W)	ULHT – 73% National – 77% 100% (B) 36% (W)	ULHT – 70% National – 76% 95% (B) 13% (W)	ULHT – 73% National – 80% 97% (B) 56% (W)
ULTH Inpatients/National Avg/ Best(B)-Worst(W)	ULHT 90% National – 95% 100% (B) 75% (W)	ULHT – 89% National – 94% 100% (B) 72% (W)	ULHT – 90% National – 95% 100% (B) 72% (W)
ULTH Maternity /National Avg/ Best(B)-Worst(W)	No Responses recorded	No Responses recorded	No Responses recorded

ULTH considers that this data is as described for the following reasons:

The data has been sourced from NHS Digital and compared to published survey results.

ULTH intends to take the following actions to improve this indicator and so the quality of its services by:

Improving our communication and keeping our patients informed and updated on their care and treatment.

Domain 5: Treating and caring for people in a safe environment and protecting from avoidable harm.

The data made available to the Trust by NHS Digital with regard to the:

- Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

Description	October 2024	November 2024	December 2024
ULTH %	97.85%	97.68%	97.36%
National Avg %	90.19%	90.34%	89.69%
Best(B) / Worst(W) National Performance %	(B) 100% / (W) 13.73%	(B) 99.96% / (W) 14.50%	(B) 100% / (W) 12.65%

ULTH considers that this data is as described for the following reasons:

The data has been sourced from NHS Digital and compared to internal data.

ULTH intends to take the following actions to improve this indicator and so the quality of its services by:

Continuing with our VTE programme aims to reduce preventable harm to our patients by promoting timely and accurate VTE risk assessment and ensuring thromboprophylaxis is prescribed accurately and administered effectively when required.

Provide VTE risk assessment data to clinical areas.

A VTE Nurse Specialist has been appointed.

The data made available to the Trust by NHS Digital with regard to:

- The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reported period.
-

Description	2021-2022	2022-2023	2023-2024
ULTH	24.60	25.08	30.95
National Avg	43.73	43.58	46.67

Best(B)-Worst(W) National Performance	(B) 0 / (W) 138.38	(B) 0 / (W) 133.64	(B) 0 / (W) 131.2

ULTH considers that this data is as described for the following reasons:

The data has been sourced from NHS Digital and compared to internal data.

ULTH intends to take the following actions to improve this indicator and so the quality of its services by:

Focusing on improving hand hygiene; adopting national and local campaigns including visual prompts.

Training staff on infection prevention and hand hygiene; focusing on high standards of cleanliness, screening of emergency and elective patients and focusing on effective antibiotic stewardship and ensuring that patients are effectively isolated and monitoring and feeding back on cases where inappropriate prescribing is a possible contributory factor.

The data made available to the Trust by NHS Digital with regard to:

- The number and, where available, rate of Patient Safety Incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death

Description	Oct 2018 - Mar 2019	Apr 2019 - Sep 2019	Oct 2019 - Mar 2020
ULTH %	(T) 27.9% (SD) 0.21%	(T) 28.3% (SD) 0.11%	(T) 27.5% (SD) 0.13%
National Avg %	(T) 47.0% (SD) 0.15%	(T) 51.3% (SD) 0.15%	(T) 51.5% (SD) 0.15%
ULTH Total No of Incidents (T) / Severe or Death (SD)	(T) 6,291 / (SD) 47	(T) 6,413 / (SD) 25	(T) 5,914 / (SD) 28

*Latest data available

ULTH considers that this data is as described for the following reasons:

The data has been sourced from NHS Digital and compared to internal data.

ULTH intends to take the following actions to improve this indicator and so the quality of its services by:

Providing staff training in incident reporting and risk management.

Undertaking comprehensive investigations and utilising varying forums for learning such as huddles and Trust Communications and Safety Bulletins.

Part 3: Review Quality Performance

Patient Safety

The safety of our patients is central to everything we want to achieve as a provider of healthcare. We are committed to continuously improving the safety of our services and will focus on avoiding and preventing harm to patients from the care, treatment and support that is intended to help them. We will do this by successfully implementing proactive patient safety improvement programmes and by working to better understand and improve our safety culture. We recognise the importance of a culture where staff are comfortable to report when things go wrong, and we work hard to ensure that the appropriate support for staff is available in an effective, efficient, and timely way.

We will also continue to conduct thorough investigations and analyse when things go wrong, identifying and sharing learning, and making improvements to prevent or reduce the risk of a recurrence. We will be open and honest with patients and their families when they have been subject to a patient safety incident and will strive to eliminate avoidable harm as a consequence of care we have provided.

Patient Safety Incident Response Framework (PSIRF)

Last year we reported how we had launched the NHSE PSIRF which replaced the national serious incident framework. This year we have completed our transition and collaborated with our ICB to develop a PSIRF plan and policy to underpin the change.

PSIRF set out a new direction for how the NHS responds to patient safety incidents, focusing on effective learning and improvement, compassionate engagement and embedding a patient safety culture.

Completing our transition has meant there is now greater focus on understanding the impact of systems and human factors in our patient safety incidents and we have greater understanding in the “what” not the “who” in investigations to support a just and learning culture. Not all serious events will lead to a Patient Safety Incident Investigation (PSII) – other tools will be available such as After-Action Reviews, clinical audit or Mortality & Morbidity (M&M) meetings, and greater support and involvement is being provided for those involved in patient safety incidents.

Never Events

Never Events are serious, largely preventable, safety incidents that should not occur if the available preventative measures are implemented. The Trust is committed to identifying, reporting and investigating never events, and ensuring that learning is shared across the organisations, and actions are taken and embedded to reduce the risk of recurrence.

From April 2024 – March 2025 the Trust had three never events:

1. Wrong sided femoral nerve block
2. Retained swab
3. Wrong mole removal

Two of three Never Event investigations have been completed, and the following learning has been identified:

Femoral Nerve Block Incident:

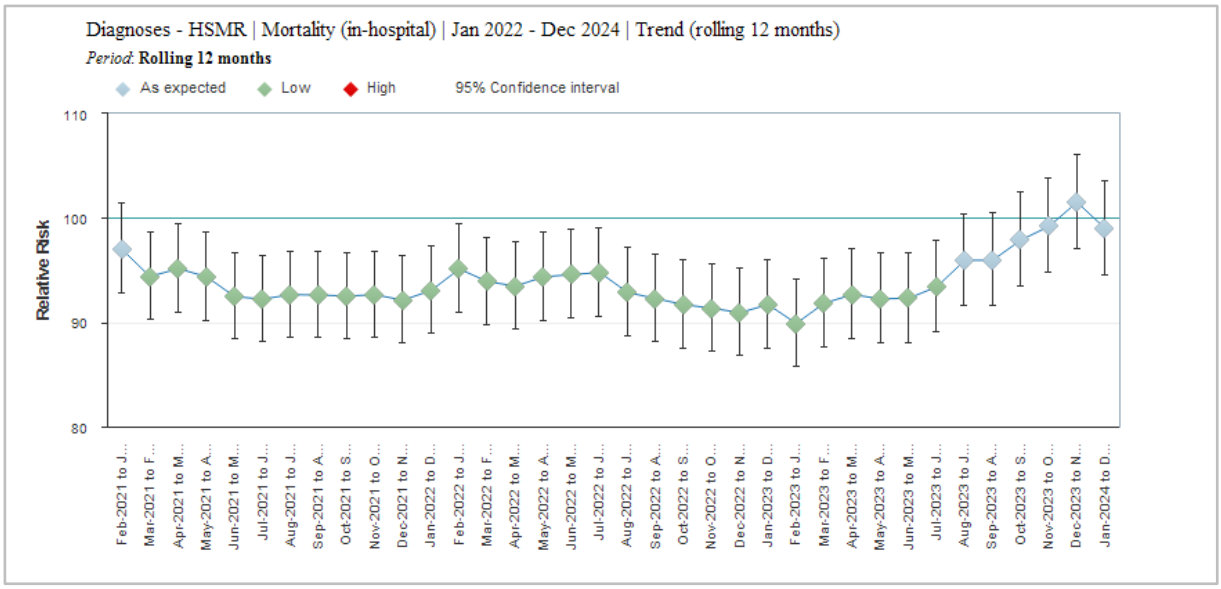
- Distractions within the anaesthetic room
- Workplace pressure and its impact on staff
- Stop Before You Block equipment availability
- Stop Before You Block staff training
- Human Factors Training

Retained Swab Incident

- Policy and Process related to item counting during surgery.
- Staff changeover due to an extended surgery and complications arising
- Consideration of theatre lists for complex gallbladder cases.
- Converting from laparoscopic to an open procedure during the operation.
- Protocol for a patient that has a significant bleed during the operation.
- Requirement for a debrief following surgery

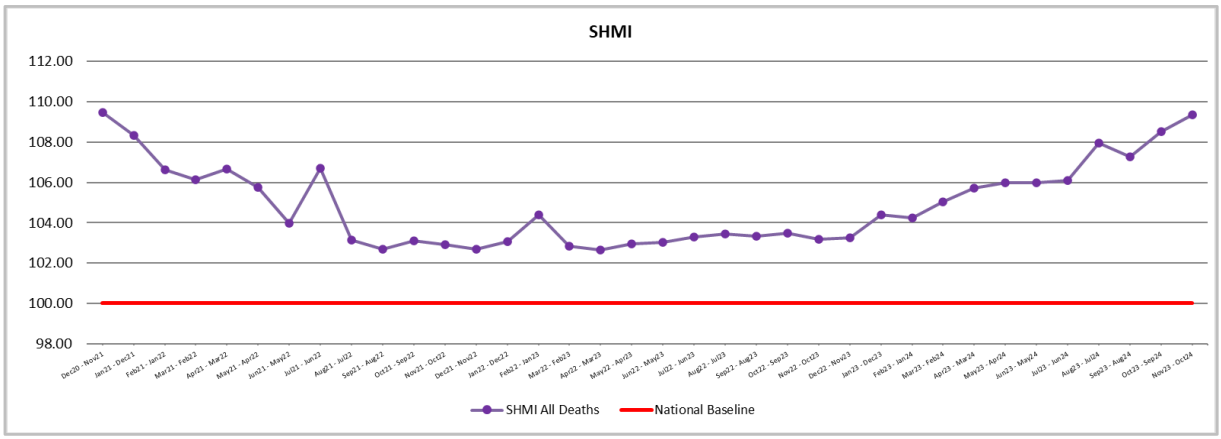
HSMR/SHMI

HSMR is an indicator of healthcare quality that measures the ratio of observed deaths to expected deaths, and whether the number of deaths in hospital is higher or lower than would be expected. At the time of writing the latest 12 month rolling HSMR for the Trust relates to the January 2024 – December 2024 Dr Foster report. HSMR for the rolling 12-months is 98.98, which places the Trust in the ‘As Expected’ banding.



SHMI

The Summary Hospital Level Mortality Indicator (SHMI) is a mortality measure that takes account of a number of factors, including a patient's condition. It includes patients who have died while having treatment in hospital or within 30 days of being discharged from hospital. The SHMI score is measured against the NHS average, which is 100, a score below 100 denotes a lower-than-average mortality rate. It is recognised that SHMI cannot be used to directly compare mortality outcomes between Trusts. The Trusts SHMI from November 2023 – October 2024 (there is a 6-month data lag) is 109.53 which is 'As expected'.



Mortality Assurance (MorALS) Group

The Mortality Assurance Learning Strategy (MorALS) Group meet every month and has oversight of the activities of all mortality review processes across the Trust, including the activities of Learning from Deaths and promoting the learning from mortality reviews. The meeting provides an opportunity to discuss any issues arising and to help support the development of learning culture in the organisation in line with our Learning from Deaths

policy. The monthly outputs from the Divisions are described in this meeting and the targeted areas for improvement reviewed. The development of this group into something that has greater oversight of the Trust-wide mortality review process has been the focus of our energies. It is also responsible for ensuring the Trust has oversight of the key mortality measures for the Trust and reporting on any concerns arising, which it does via a monthly report to the Clinical Effectiveness Group, which upwardly reports to Quality Committee and Trust Board.

Call for CONCERN

Call for Concern enables patients, families, and carers to call for urgent help and advice if they are concerned that a patient's deteriorating condition is not being adequately recognised by Ward teams. This initiative acknowledges that relatives/carers/friends often possess the ability to recognise 'soft signs' of patient deterioration before it becomes apparent to staff.

The service is coordinated by the Critical Care Outreach Team who support the Ward teams by assessing and reviewing patients as well as offering advice on how to manage the patient's condition. The team will ensure an appropriate care plan is in place for the patient.

The pilot was launched on the Lincoln County Hospital site in December 2024 and on the Pilgrim Hospital site in February 2025 and includes all adult

Care Partner Hub

The Care Partner Hub is a joint venture between the Trust and Carers First which aims to improve the quality of life of care partners, including young carers, those caring for someone at the end of their life or with dementia and those that have been bereaved.

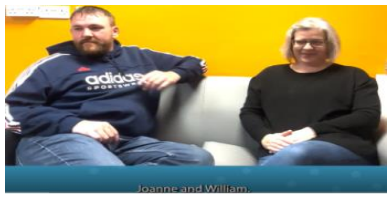
Volunteers from ULTH and Carers First offer a wide range of services and comprehensive local resources, including carers assessment referrals and support, carers awareness training for professionals, and information, advice, and signposting, in addition to being a friendly space for a chat with people that understand.

The Care Partner Hub is part of the Trusts commitment to recognising the invaluable role of carers as experts, and the hub will raise awareness of the Trust's Care Partner Badge Scheme, which helps recognise the role of care partners within hospitals to give them greater flexibility to stay outside of visiting hours and inclusion in care, admittance and discharge discussions if they choose to be.

Patient stories

Each month a digital patient story is presented to Trust Board, and these are all now available to all staff within our Patient Story Library on the intranet. Patient stories are also presented to Patient Experience Group as part of divisional assurance reports and clinical business units and governance groups have a story to start their meetings.

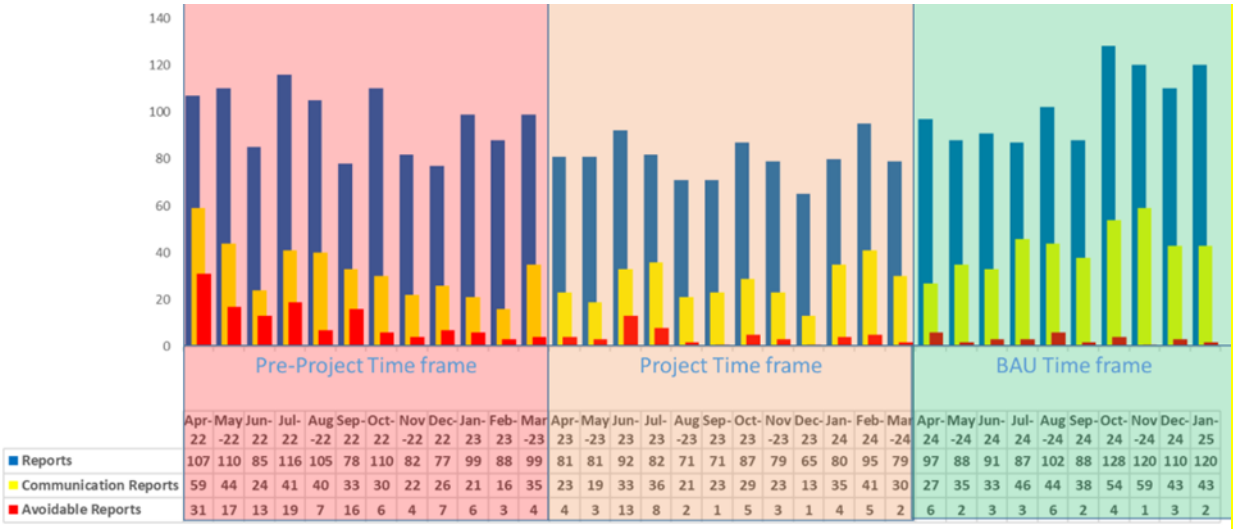
The following are example stories shared at Trust Board during 2024-2025

William's story William who is part of the Deaf community in Lincolnshire and tells of his poor experiences being Deaf when accessing hospital services.  https://youtu.be/WTjFnUNDqls	**Ethan's story** This story told by Ethan's mum Celia, who talks about the amazing work done by the Complex Needs Rapid Response Respiratory Service in Lincolnshire.  https://www.youtube.com/watch?v=7wp3NycE3Tk
Phillips Kitten Scanner is the purr-fect way to help children prepare for hospital scans	**Young Carers** This film featured three Lincolnshire Young Carers stories, and we hear how being a Young

The story follows the heart-warming experience of Phoebe, a young patient at our hospital who recently underwent an MRI after having a session using the new Kitten scanner.  https://youtu.be/fJQ5C2DsbVk	Carer affects their family life and describes some of the barriers and challenges they face when accessing our healthcare services.  https://youtu.be/0LEHw1LaNN8

You Care; We Care to Call (YCWCC)

In April 2023, the Trust launched the YCWCC project aimed to ensure we proactively keep relatives up to date with important information without them having challenges of getting through to the right person on the ward. We knew that staff were busy, and phone calls were being missed or not answered as our families were telling us this. Many patients were able to update families themselves or had family members coming in to visit but there were also a large number who were so unwell or vulnerable that families understandably would call to see how they were doing. The principle is to first confirm who needs an update phone call, when and how frequently, what information needs to be shared and to establish the best person to make that call. This not only reduced phone traffic but also, most importantly, communicated more effectively with families. The project was included in the 2023-2024 Integrated Improvement Plan with a target to roll out across 38 wards and reduce avoidable complaints by 50%. Both these targets were achieved and exceeded. An avoidable complaint is one that had a proactive YCWCC call been made then that complaint could have been avoided. The measure is determined by reviewing all complaints and PALS concerns against this criterion. YCWCC has continued to be monitored - the graph below shows the period prior to the initiative being launched, the project year itself and this last year under ‘business as usual’ (BAU). Communication complaints and PALS concerns overall are back to around the 2022-23 level (having dropped while the project was ongoing and being focussed on heavily in 2023-24) what we can see is that the numbers of avoidable complaints are still under control and haven't increased again following the move to BAU.



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Reports	107	110	85	116	105	78	110	82	77	99	88	99	81	81	92	82	71	71	87	79	65	80	95	79	97	88	91	87	102	88	128	120	110	120
Communication Reports	59	44	24	41	40	33	30	22	26	21	16	35	23	19	33	36	21	23	29	23	13	35	41	30	27	35	33	46	44	38	54	59	43	43
Avoidable Reports	31	17	13	19	7	16	6	4	7	6	3	4	4	3	13	8	2	1	5	3	1	4	5	2	6	2	3	3	6	2	4	1	3	2

Patient Information

Work to review all our existing patient information started in 2023, continued during 2024 and the backlog was finally completed in the summer enabling a move to ‘business as usual’. By December 2024 601 leaflets had been reviewed, 455 of these were approved and have been published with the remaining either being redirected to a Trusted Source provider or no longer being needed. The approval group meets virtually when new leaflets are submitted or existing ones due for review and can turn around approvals much quicker.

There are two repositories: the internal intranet and external website. Some information is published in both but there are some pieces that require being discussed with patients on receipt and some also have space for individual information to be written in – for this reason these are not placed on the external website. Over a recent 90-day period there were 4,869 visits to view or download information from the internal repository and the most traffic was via desktop computer at 98.7%.

The external website Patient Information Library allows patients to directly access and download information. These are grouped under 48 headings such as Audiology, Gastroenterology, Head and Neck and Physiotherapy. As the external website has the ‘ReciteMe’ functionality these can then be viewed in multiple languages and formats. Over the same recent 90-day period the public website library had 645 visits showing that our public are accessing it.

Sensory Aids

The sensory aids are being offered to help soothe dementia patients during their stay within the Trust. The Precious Petzzz, are life-like animals, the cats purr and they all simulate breathing as they sit on the beds and laps of patients. The designs include spaniel and border collie puppies, as well as a variety of cats. All come with their own bed. United Lincolnshire Hospitals Charity has funded these sensory dog and cat aids which will soon be available at Lincoln, Grantham and Pilgrim hospitals.

Access to Diagnostic Testing

Over the past few years, we have been working to make accessing these tests easier and more convenient through the development of Lincolnshire's Community Diagnostic Centre (CDC) programme. Each CDC has been designed to consider what the local community needs. CDCs are facilities in the community, away from busy hospitals, where you can access tests such as MRI, CT and non-obstetric ultrasound scans, X-rays or blood tests.

In March 2024, Grantham's CDC, underwent a £5million expansion to include state-of-the-art CT and MRI scanners. In November 2024, a new Skegness CDC opened, and a new Lincoln CDC opened in December 2024.

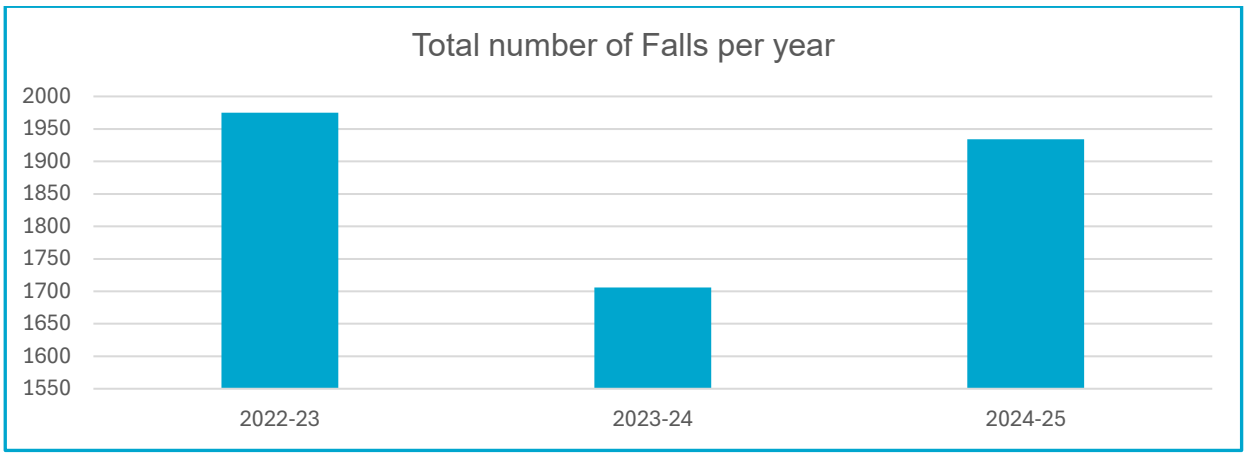
Patient Falls

Falls prevention continues to be a key patient safety focus for the organisation. The Trust aims to reduce our rate of avoidable falls and continue our quality improvement journey through collaborative working across the organisation and with our system partners.

Falls amongst inpatients has historically been the most frequently reported safety incident in NHS hospitals with 50% of patients over 80 estimated to fall at least once a year, and 30% of over 65's. Approximately 30-50% of falls result in some form of injury and fractures occur in 1 to 3% of incidents.

Our annual falls numbers have shown an increase during 2024 however, they remain below the levels seen in 2022-23 and we have not seen an associated increase in the level of harm. Taking into consideration a continued rise in admissions and increase in the number of patients admitted with complex care needs that increases their risk of falling; this still demonstrates an encouraging position. Reducing the number of patients who fall in our care and reducing the risk of harm associated with a fall are key quality and safety issues and a priority for improvement for the Trust.

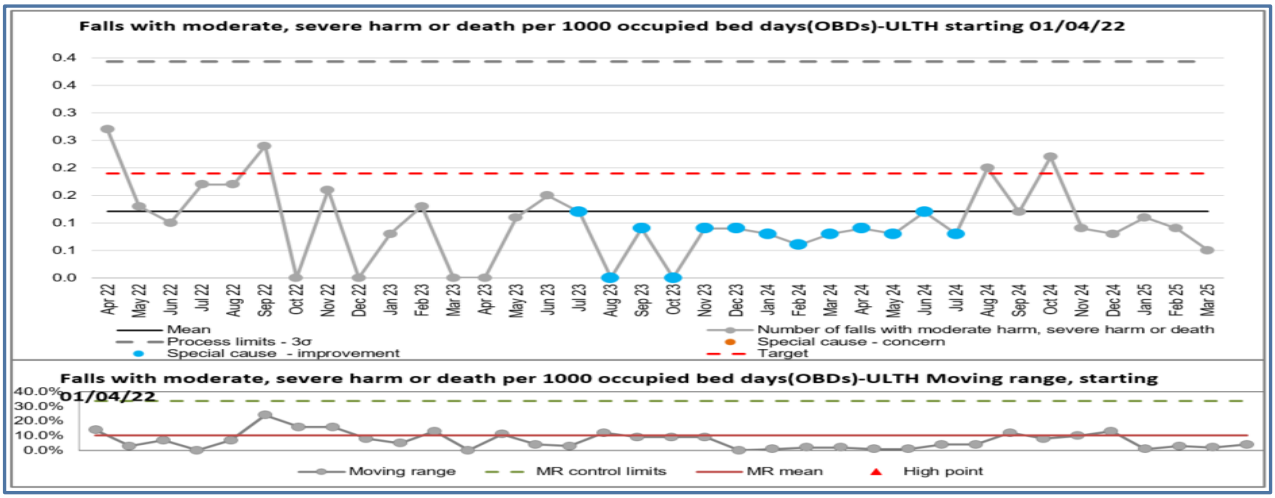
Annual falls performance 2022-2025



Reducing avoidable harm from patient falls

Falls incidents can result in psychological and physical harm, also having a substantial financial impact to the NHS. Falls resulting in harm are more likely to occur in acute Trusts like ours. These incidents may affect patient confidence, and the resulting injuries could mean a longer stay in hospital. In some cases, following a fall, a patient cannot be discharged to their usual place of residence, which is a significant life change. Moving to a Group model has seen acute and community care partners increasingly work together to share data, experiences and learning to support each other to reduce avoidable patient falls.

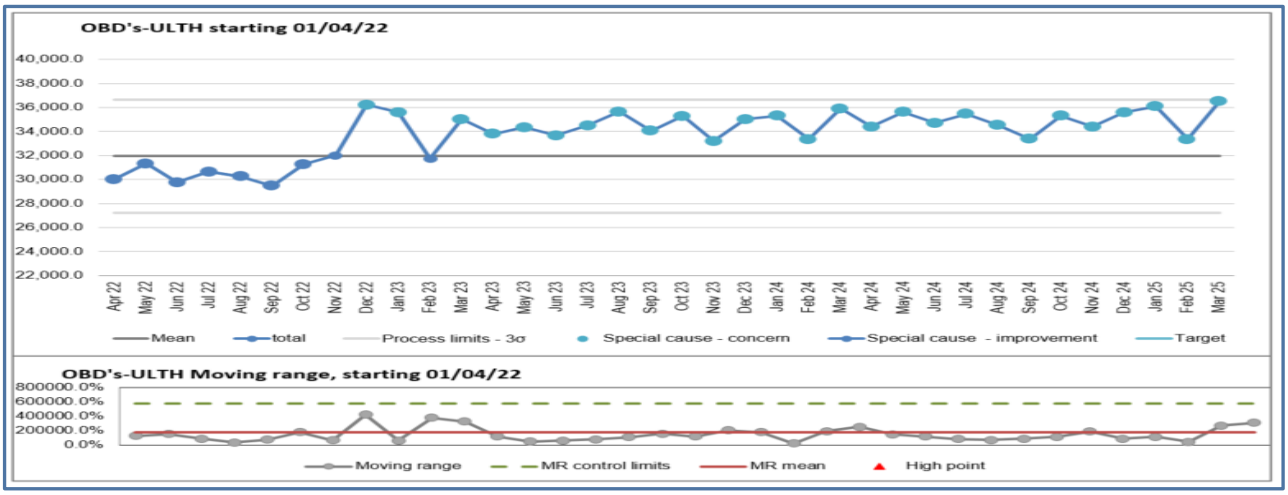
Falls resulting in moderate harm, severe harm or fatal per 1000 bed days April 2022 – March 2025



The Trust target for falls resulting in moderate, severe harm and death is 0.19. The Trust has been below this target for thirty-two of the thirty-six months shown in the above chart. The pattern for the data detailed above is different from the pattern in which our occupied bed days (OBD) rate has changed over the same time-period.

Falls data continues to show some variation over the previous 3 years, however the number of occasions where the Trust have failed to achieve the target has not increased. As demonstrated in the chart below, the number of occupied bed days have shown an upward trend although the months with the highest OBD's do not have correlating peaks of falls resulting in level 3 harm or above; demonstrating that the ongoing improvement actions in place across the organisation to mitigate and prevent falls, are continuing to limit the severity of harm and are positively impacting on the safety of our patients.

Occupied bed days April 2022-March 2025



Key Achievements

- The Falls Prevention Steering Group (FPSG) continues to meet monthly and has been developing into a Group meeting across LCHG. The group has a multidisciplinary membership and provides oversight, monitoring and accountability of the ongoing improvement work around falls prevention. Patient stories are regularly shared at FPSG to ensure wider learning and prompt person focused improvement ideas.
- Falls prevention documentation and care is reviewed in the weekly Ward/Department Leader's assurance and monthly Matrons audits as a component of the Quality Accreditation Programme. The monthly Quality Metrics review meeting chaired by the Deputy Director/Assistant Director of Nursing monitors ward and departments' performance relating to falls.
- Representatives from the clinical and quality teams continue to be actively involved in system wide and regional falls prevention meetings where local and national data and initiatives are shared and acted upon.

- Monthly lessons learned and educational Falls Prevention Bulletin's continue to be produced and shared with our clinical teams to improve staff knowledge regarding falls prevention.
- Falls ambassador huddles recommenced in 2024, giving a platform for staff to share and discuss new initiatives, share lessons learnt and provide peer support for any areas experiencing challenges in falls prevention.
- We continue to produce and share our quarterly newsletter to provide staff with an oversight of current national and local priority topics, share and celebrate team's improvement initiatives, and provide dates for up-and-coming Trust events relating to falls prevention.
- We held a successful falls prevention awareness study day during national Falls Awareness week in September 2024. Following positive feedback on the day a series of quarterly study days are being established. We also facilitated two falls prevention 'Focus on Fundamentals' months in August 2024 and February 2025. These included a range of activities and use of Trust social media sites and communications channels to maximise awareness for all staff, celebrate successes and share improvement ideas.
- The Quality Matron team have collaborated with the University of Lincoln and have started to deliver a falls prevention educational session to second year Student Nurses.
- We have introduced Falls FaCTs (Falls Current Themes) delivered as short drop-in sessions each month which are open to all staff.
- 'Baywatch' a method to ensure staff are consistently present and visible in ward bay areas has been reinvigorated, with particular focus in those areas experiencing a higher number of falls. Clinical areas have used this as an opportunity to introduce improvement initiatives; examples are the use of yellow lanyards to indicate the staff member with responsibility for Baywatch at a given time and the introduction of additional patient stations to support staff to stay in the area to undertake their work. This supports the increased the visibility of patients who are vulnerable to falling.
- Divisional falls focus groups are now established and support a multidisciplinary approach to reviewing falls incidents and sharing learning.
- The B.I.G Question was developed with the aim of encouraging all staff at the end of every patient contact to ask 'Before I Go' to check if there is anything else the patient needs. This was developed in response to an increase in patients falling following interventions such as clinical observations or medication rounds.

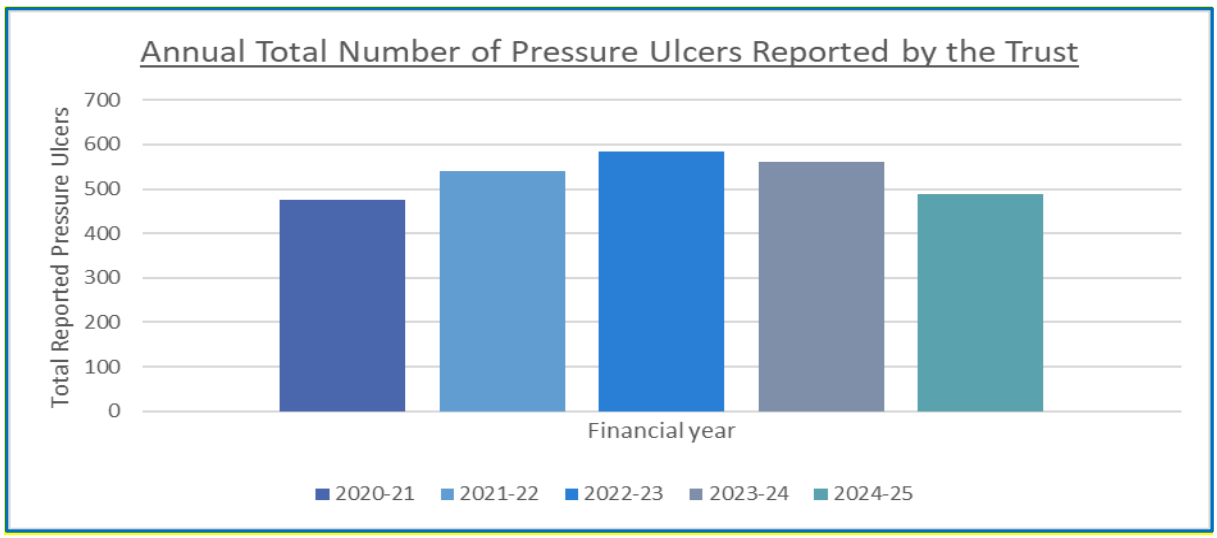
- As part of the Quality Accreditation programme Harm Free certificates continue to be awarded to those areas who have periods with no falls incidents. This year we have celebrated 30 areas achieving a year of providing falls harm free care.
- Representatives from our quality, patient safety and patient safety partner teams have been collaborating to develop several human factors based educational falls videos. These demonstrate a variety of scenarios that may result in a patient fall and discussion points to get staff thinking about how these could be approached differently.
- The falls improvement online teams channel has more than doubled its membership; providing a central point for staff to access and share educational resources, updates and improvement projects.

Aims for 2025/26

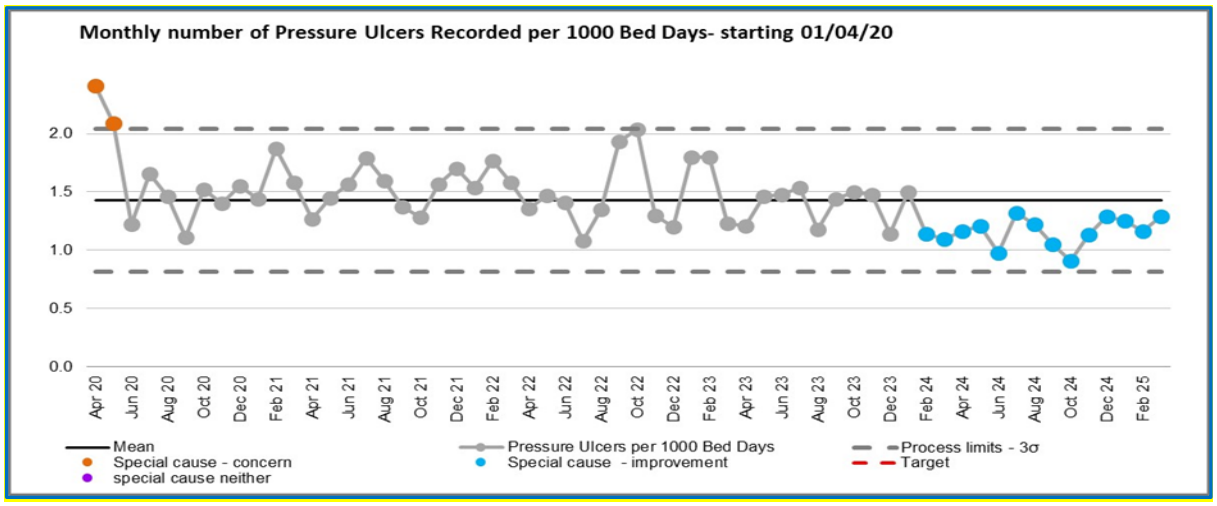
- Continue with our quality improvement work and focus on reducing avoidable falls across the organisation.
- Continue to develop the Falls Ambassador program to drive understanding and ownership of improvement activities at a local level.
- Review and build on existing falls prevention education and training offer.
- Develop the work focused on raising awareness of deconditioning and embed the culture of reducing deconditioning and promoting safer mobility in all clinical areas.
- Continue to explore opportunities for implementing digital and technological solutions to aid in the prevention of falls.
- Continue to create opportunities to integrate joint processes and improvement initiatives across the Group and System.

Pressure Ulcers

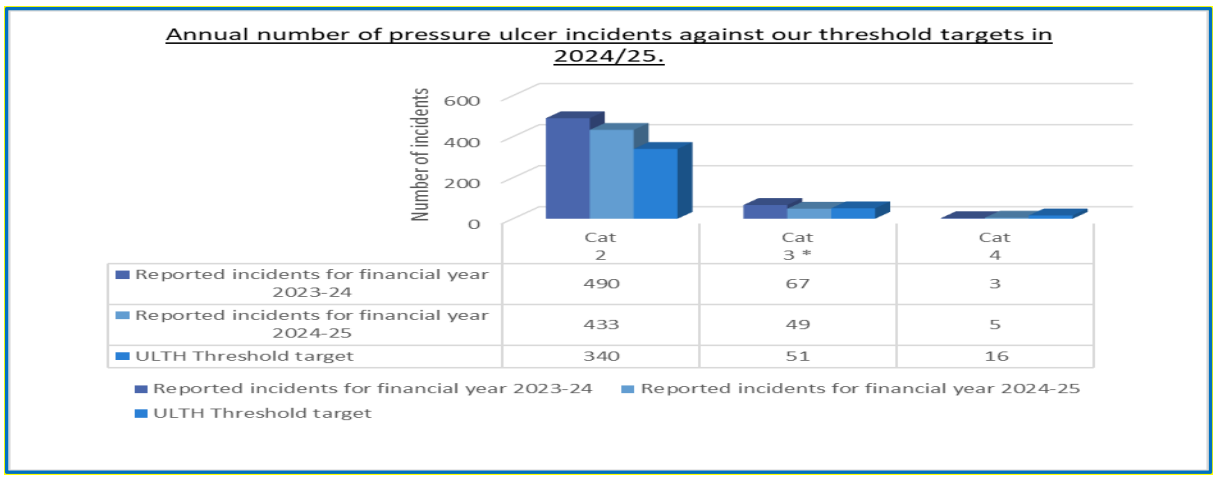
Pressure ulcer prevention remains a key priority for the organisation. The Trust aims to reduce our rates for hospital acquired pressure ulcers through quality improvement work and continues to focus on education, training, staff and patient awareness. Throughout 2024-25, the overall number of hospital acquired pressure ulcers has continued to decrease. This progress, especially in the context of a continued rise in admissions and increase in the number of patients admitted with complex care needs and additional vulnerabilities placing them at an increased risk of developing skin damage, is a positive position. Pressure ulcer prevention continues to be a patient safety priority and area of focus for the Trust.



Note: Total number of pressure ulcers recorded includes categories 2, 3, 4, and Unstageable combined.



This year the total number of category 3 and 4 pressure ulcer incidents that represent the most severe levels of harm achieved our ambition against the threshold targets the Trust had set. Whilst the threshold set for our category 2 pressure ulcers was exceeded, the total number reported this year has fallen by 11.6% compared to the previous year. This demonstrates that the preventative and supportive measures in place are having a positive effect on reducing the number and severity of patient harm from hospital acquired pressure ulcers.



*Since April 2024, Category 3 pressure ulcer numbers were reclassified to include those pressure ulcers previously known as unstageable. For ease of reporting the number of category 3 incidents from 2023-2024 include pressure ulcers that would have been previously classified as Category 3 or Unstageable.

The Trust continues to monitor Deep Tissue Injuries (DTI's) and Moisture Related Skin Damage (MASD) incidents and highlight those patients who are at an increased risk and vulnerable to further skin damage. Thematic reviews undertaken have enabled us to implement focused improvement actions in efforts to reduce the number of patients who experience this type of skin damage whilst in our care. Our annual number of hospital acquired Deep Tissue Injuries (DTI's) over the last three years has remained relatively consistent. Whilst the number of hospital acquired MASD incidents has seen an upward trend over the last year, this picture is reflective of a comparative increase in patients who are presenting with MASD when they arrive at our hospitals, demonstrating the increased vulnerability of patients within the communities we serve.

Key Achievements:

- Skin Integrity documentation and care is reviewed in the weekly Ward/department Leader's assurance and monthly Matrons audits as a component of the Quality Accreditation Programme. The monthly Quality Metrics review meeting chaired by the Deputy Director/Assistant Director of Nursing monitors ward and departments' performance relating to pressure ulcers.
- As part of the Quality Accreditation programme Harm Free certificates continue to be awarded to those areas who have periods with no pressure ulcer related incidents. This year we have celebrated 17 areas achieving a year of providing pressure ulcer harm free care, and an impressive 8 areas achieving 2 years harm free care.

- In line with the National Wound Care Strategy Programme recommendations for best practice, the Trust continues to review and adapt its guidance and practice relating to pressure ulcer prevention and management.
- The Skin Integrity Group (SIG) continues to meet monthly and has now developed into a Group meeting. The group has a multidisciplinary membership and provides oversight, monitoring and accountability of the ongoing improvement work around prevention of pressure ulcers. Patient stories are regularly shared at SIG to ensure wider learning and prompt improvement ideas.
- We had a successful 'Focus on Fundamentals' Tissue Viability month in November 2024. This included events to promote "International Stop the Pressure Day", use of social media and Trust communications to promote the activities, celebrating success and encouraging staff to have a conversation about skin integrity. This year the first Group Stop the Pressure Day Conference was facilitated for skin integrity ambassadors and clinical staff across both ULTH and LCHS joined by colleagues from across the Lincolnshire System. The day included interactive sessions and workshops on the key themes that have been identified from incidents and are focus areas to improve upon.
- Mandatory Tissue Viability E-learning training for all staff was implemented in 2021. This year we have consistently maintained a Trust compliance level of >90%.
- The Tissue Viability Ambassador programme, aimed to develop confidence, knowledge and skills in skin integrity care within our clinical teams, continues to be an effective resource in reducing our skin integrity incidents. We currently have 30 ambassadors trained with a number of other staff members booked in to complete their training. In those areas who have a Tissue Viability Ambassador there has been some reduction in pressure ulcer incidents observed.
- Monthly educational Pressure Ulcer Prevention Bulletin's continue to be produced and shared throughout the Trust to our clinical teams to improve staff knowledge regarding pressure ulcer prevention. The content of the bulletins are based upon the Trusts current risks and incident themes.
- Representatives from the Tissue Viability and Quality teams continue to participate in a system wide pressure ulcer improvement programme of work. Sharing learning from our patients and staff perspective.
- Our quarterly newsletter called "Tissue Viability Matters" continues to be produced and shared to provide staff with an oversight of current national and local priority

topics, share and celebrate team's improvement initiatives, and provide dates for up-and-coming Trust events relating to Tissue Viability.

- We upgraded our dynamic air mattress and cushion fleet supported by a programme of training and education. Feedback since the equipment has been updated has been very positive.
- The Tissue Viability team (TVN) and Quality Matron have created an annual programme of Tissue Viability Matters Improvement and Learning forums to deliver face to face training and educational updates to clinical staff. The forums are conducted bimonthly at each of the main hospital sites, with the content delivery based upon current national and local priorities.
- The Trust have implemented the use of nationally created pressure ulcer prevention leaflets designed to support both patients and relatives/care partners in understanding the risks of pressure ulcer development and what practical steps they could take to reduce their individual risks.
- Continue to support personal care packs for patients awaiting admission to ward areas, allowing them to independently manage their hygiene needs as required during this time to support the prevention of moisture associated skin damage.
- The TVN have streamlined and updated our MASD pathway making the process easier for staff to manage this type of skin damage.
- The TVN team have supported the review of different respiratory devices with the aim of reducing device related skin integrity incidents whilst maintaining the effectiveness of the device required.
- Face to face teaching sessions regarding medical devices have been delivered by the TVN team, the Quality Matron and external company representatives regarding best practice use to limit the risk of skin integrity harms.

Aims for 25/26

- Continue with our quality improvement work and focus on reducing pressure ulcers across the organisation.
- Continue working towards an ambition to eliminate all Category 4 pressure ulcers.
- Update the Trusts skin integrity documentation with the introduction of Purpose T Risk assessments.

- Continue to work collaboratively with the Digital Team on improving electronic resources relating to tissue viability and pressure ulcer prevention including clinical photography.
- Continue to create opportunities to integrate joint processes and improvement initiatives across the Group and System.

Complaints

Complaints and enquiries are a key source of feedback for the Trust and informs us about our patients' views regarding the quality of services and care provided which enables us to examine our services and make improvements. All formal complaints received are responded to appropriately on an individual basis and are fully investigated through the Trust's complaints procedure.

The Trust ensures that complainants have the option to have their concerns dealt with informally or formally, via the NHS Complaints Procedure. All complaints, whether formal or informal, are monitored to identify if there are any trends and to provide a consistent approach for patients, carers and the public.

Each complaint is treated individually. Although the issue raised may be similar to others, the circumstances are often different for the individual concerned. The Trust aims to respond to complaints within 25, 35 or 50 working days, dependent on the complexity and nature of the complaint, and the number of issues raised. If the timescale cannot be achieved, the complainant is informed of when they may expect their response. A quarterly report is produced and presented the Patient Experience and Involvement Group and Quality Committee.

Number of complaints received:

	2022-23	2023-24	2024-25
New complaints received	835	1044	1273

The Trust has seen an increase in the number of complaints year on year. Reviews have been completed to identify if any themes are increasing.

The following themes were identified from the complaints received:

- Clinical Treatment
- Communication
- Discharge
- Appointments

Examples of learning from complaints:

Complaint received regarding a patient where family members were not informed about their loved ones ward moves which caused distress to the family and hindered effective communication during their transition of care. As a result, a new section has been added to the handover sheet from January 2025, requiring documentation of family notification. The discharging ward must confirm that they have contacted the family, and the receiving ward must ensure that this information is updated and recorded.

The Trust received a complaint regarding a patient that was inappropriately discharged home via a taxi without adequate consideration of their mobility and care needs. This resulted in the patient being placed at risk during their journey and arrival at their home. A discharge risk assessment form has been devised. This will be completed for all patients awaiting transport home by taxi. This form will verify the patient's mobility and whether additional assistance or supervision is required during transport and once they return home. If a patient does require further assistance, then alternate arrangements would be made.

The Trust have received complaints regarding the completion of electronic Discharge Documents (eDD). The feedback is that there have been inaccuracies, and they are not being completed correctly. As a result, the Complaint Facilitator for the General Surgery division will be undertaking ward level training sessions to feedback and reinforce the importance of these documents being correctly completed in conjunction with junior doctor training sessions.

Patient Advice and Liaison Service (PALS)

PALS is a core service that provides timely and appropriate access to help, advice, and information to the users of the service. PALS also facilitate self-advocacy and will assist with discussions and negotiations between service users and representative of the Trust.

During 2024-25 PALS dealt with 7397 contacts were from patients, families, and carers where support and investigation has been provided by the PALS team to enable resolution of their concerns in a timely manner. The resolution of these concerns by the PALS team has enabled the patient, families, and carers to obtain the answers they require, therefore, reducing the number being escalated to a formal complaint.

PALS collate all comments, concerns and suggestions made and share this feedback directly with services and departments or by the patient experience feedback mechanisms available throughout the hospital.

Themes identified from PALS:

- Being unable to get hold of appointment services or department secretaries despite leaving messages patients are not being called back.
- Delay in letter being received.
- Delay in appointments.

Improvements:

- Lost property – The policy is now in place on wards, and they are following the correct process and investigation when a concern has been raised about a patient's private property going missing.
- Business Units are provided with a monthly report of PALS. We have seen improved ownership of the cases which has prompted quicker responses and support.
- Call for Concern – PALS have been able to provide the contact for this which had enabled families to speak with someone when they are unsure of the clinical information given to them.
- The Task and Improvement Group within ED Pilgrim continues to make positive improvements.

Seven-Day Services

The seven-day hospital services (7DS) programme was developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

The Trust is committed to delivering high-quality services that ensure equity of access for all patients 24 hours a day, seven days a week. The Trust has been participating in the national audits for seven-day hospital services against the four clinical priority standards:

Priority Clinical Standards	• Standard 2: Time to Consultant Review • Standard 5: Diagnostics • Standard 6: Consultant Directed Interventions • Standard 8: On-going Daily Consultant Directed Review

Standard 2	Standard 5	Standard 6	Standard 8
All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital	Access to Consultant-directed Diagnostics within one hour if critical, 12 hours if urgent and 24 hours for non-urgent patients	Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols	Patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours

The Trust currently has multiple work-streams dedicated to the delivery of improved patient flow through the organisation. Whilst many services are delivered on a seven-day basis, in other services there remains a differential between weekdays and weekends. There is however clear clinical commitment to move towards seven-day services within our Divisions. The Trust has become a Group with LCHS which will also help improve patient pathways and seven day working.

Equality Diversity and Inclusion

United Lincolnshire Teaching Hospitals NHS Trust, as part of Lincolnshire Community and Hospitals NHS Group (LCHG), fully embraces Equality, Diversity, and Inclusion (EDI) across all protected characteristics of the Equality Act 2010. The Trust has a range of policies and procedures to support this. The Equality Impact Assessment is the primary mechanism to demonstrate the meeting of the legislative requirements that underpin the Trust's practice, policy, and service developments. All EDI business is managed and monitored through the EDI Group which is led by the Deputy Director of People and comprises key stakeholders from across LCHG. From a governance perspective the EDI Group reports upwardly to the Trust Board through the People Committee.

During 2024-2025, the Trust met all its statutory and contractual Equality, Diversity and Inclusion duties, these include:

- Publication of the Equality, Diversity and Inclusion Annual Report
- Publication of Equality Objectives
- Publication of the Gender Pay Gap data, report and action plan
- Publication of the Workforce Race Equality Standard data, report and action plan
- Publication of the Workforce Disability Equality Standard data, report and action plan
- Completion and publication of the NHS Equality Delivery System
- Completion and publication of the NHS Equality Diversity and Inclusion Improvement Plan and the associated High Impact Actions

All these reports are published on the Trust website: Equality, diversity and inclusion - United Lincolnshire Hospitals

The Trust has a range of Staff Networks to support staff from a diverse range of backgrounds and impact positively on the delivery of patient services. Each of the staff networks has designated leads and is supported by a sponsor from the executive team. The current staff networks are:

- Armed Forces Network
- Carers' Network
- MAPLE (Mental and Physical Lived Experience) Network
- Men's Network
- PRIDE+ Network
- REACH (Race, Ethnicity and Cultural Heritage) Network
- Women's Network

All the networks meet regularly and have annual plans to ensure meaningful and supportive events are scheduled throughout the year. These events take place using a range of delivery options from face-to-face events to utilising the virtual platform / webinars.

Highlights from each of the networks are contained in the Equality, Diversity and Inclusion Annual Report.

The Trust has strong links nationally and regionally, working closely with NHS Employers and NHS England. This has been supported by technology, accessing webinars, and being involved in discussions both regionally and nationally. The EDI Team continues to

roll out the Cultural Intelligence programme within the Trust and now across LCHG. The Cultural Intelligence programme equips leaders to lead their teams and services inclusively.

All EDI work in the Trust is currently being joined up across the Lincolnshire Hospitals and Community NHS Group and we are starting to work as a unified team across the Group.

Freedom to Speak Up

Since 2016, the Trust has complied with the NHS contract requirement to appoint a Freedom to Speak Up Guardian (FTSUG). In 2021, the Trust appointed a full time Freedom to Speak Up Guardian to demonstrate their commitment to supporting and listening to staff who speak up. The Trust Freedom to Speak Up Guardian has lead responsibility to ensure that the appropriate handling of concerns is in place and the effectiveness of the local systems is considered by the Board.

The Trust has incorporated the new national NHSE/I Freedom to Speak Up policy into it's local 'Voicing your concerns' policy, which describes the different ways to speak up and who to speak up to, the process and an appendix, which provides assurance to staff that anyone speaking up with genuine reason should not suffer detriment/disadvantageous behaviour and the process to follow. To complete the Speak Up process, feedback questions are asked to gain assurance that actions have been taken or questions answered and to highlight any potential service improvements/learning.

A database and dashboard have been produced for intelligence, to capture metrics, including number of cases, thematic information, who is speaking up and protected characteristics. The database will measure all open cases, feedback, and follow up from closure of a case over a twelve-month period to establish any detriment/disadvantageous behaviour.

Drop-in sessions, twilight and weekend shifts have been organised to capture staff across all sites, covering day and night staff and weekend workers. The FTSUG attends a virtual drop-in session with Rebecca Brown, Deputy Chair, Non-Executive Director, Maternity Safety Champion.

Speak Up training has been approved as core learning and is now included for all staff. Listen Up training is being sent to all managers to complete, by the FTSUG and will be reviewed for core learning. The Chair, Chief Executive, Directors, and Non-Executive Directors attended the FTSU board development session (Follow up module).

The Board self-assessment (reflection and planning tool) has been completed at a Board development session and any gaps will be actioned across the Group.

How does the Trust support staff to speak up:

- Voicing Your Concerns Policy
- Freedom to Speak Up Guardian
- Freedom to Speak Up Champions from across different staff groups and staff networks, who have been engaged to promote speaking up and signpost to the appropriate person or relevant policy
- The commitment of the Board to champion the importance of speaking up
- The Board receives a quarterly report on speaking up and has completed the speaking up self-assessment (Reflection and Planning Tool)
- The board have completed a board development session on FTSU follow up training
- The Non-Executive Champion for FTSU completed the National Guardians Office training development session
- The Freedom to Speak Up Guardian meets monthly with the Group Chief Executive, Group Trust Chair and Non-Executive Champion for Speaking Up, FTSUG also has direct access to the board, if needed.
- Mandatory Speak Up training is Core Learning for all staff and FTSU is discussed at all new starter's induction
- Virtual drop-in session held with the Deputy Chair/Non-Executive Director / FTSUG for neonates & maternity
- There are promotional materials which includes posters / pens and post it notes with FTSUG / Champions contact details
- FTSU intranet page
- Promotes through Chief Executive / Directors blogs
- Information is included within the Communications round up
- Information on contacting FTSUG on the Trust internal incident reporting tool (Datix)
- Promotional events across the wider organisation

What should staff do if they have a concern?

- Approach their line manager or senior divisional manager or any appropriate manager
- Contact anyone named in the 'Voicing Your Concerns Policy'
- Contact the Freedom to Speak Up Guardian through the dedicated confidential email address ulth.freedomtospeakguardian21@nhs.net telephone number 07471110490, via Teams or in writing
- Contact a Freedom to Speak Up Champion

- Contact the Non-Executive Director for Freedom to Speak Up
- Contact the National Guardians Office

Guardians of Safe Working

The Guardian of Safe Working will support safe care for patients through protection and prevention measures to stop doctors working excessive hours. The Guardian of Safe Working oversees the exception reporting process and has the power to levy financial penalties where safe working hours are breached. The role sits independently from the management structure, and the Guardian is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and / or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that doctors' working hours are safe. The Guardian has a permanent 0.6 WTE administrative post to support them in this role.

The Office of the Guardian continues to hold regular Resident Doctors Forum meetings on a two monthly basis and doctors have felt comfortable to raise issues at these meetings, which have been escalated further and addressed by senior management. The Guardian also continues to hold Educational / Clinical Supervisors' training / update sessions over Teams. These are well attended and have received excellent feedback. The training sessions are held twice a year (March / April and September / October). The purpose of these sessions is to increase awareness of exception reporting, support the Clinical / Educational Supervisors in the reporting mechanism and give supervisors opportunity to feedback on issues they may have.

The Guardian reports quarterly and annually to the People and Organisational Development Committee meeting. The reports contain the number of exception reports submitted per quarter, split by speciality, grades of doctors and the issue, such as working hours, work pattern, educational issues and immediate safety concerns. Common themes are documented, which can then be used to improve the experience of the Resident Doctors within the Trust. Resident Doctors are continually encouraged to submit exception reports, to help identify where rotas and working patterns differ from those described in the doctor's individual work schedule. The Trust is committed to supporting Resident Doctors who raise exception reports and ensuring that they are confident to raise issues where necessary.

The Guardian’s Office has continued its commitment to ensure that the Locally Employed Doctors (LEDs) working within the Trust are supported in the same way as the Resident Doctors. The Guardian’s Office is pleased to report that all the LEDs are now allocated a Clinical Supervisor to support them and be able to exception report through the Allocate system. The Trust is working towards streamlining their contracts of employment. The Guardian’s Office is aware that it is a nation-wide issue and hopes that an appropriate solution will be drawn soon.

Annex 1: Stakeholder Comments

NHS Lincolnshire Integrated Care Board (ICB) welcomes the opportunity to review and comment on the United Lincolnshire Teaching Hospitals NHS Trust (the Trust) Annual Quality Account 2024/25.

The Quality Account provides a comprehensive summary of the Trust's key quality improvement priorities which were:

- End of life care
- Hear It Your Way
- Diabetes pathway

The ICB acknowledges the challenges faced with achieving all elements of the Diabetes Pathway and recognises the ongoing work in this area, and they commend the Trust on the work achieved relating to End of life care and Hear It Your way.

The Trust have developed and successfully rolled out an education programme for end-of-life care with Palliative and End of Life (PEOL) Champions supporting this work. The ICB thank the Trust for supporting the review and development of the Lincolnshire PEOL Strategy which has been finalised and is being socialised across the system.

A Hear It Your Way faculty was achieved with successful roll out of training sessions which have received excellent feedback. The ICB notes the commitment into 2025/26 for more sessions to be scheduled and to be expanded to colleagues from Lincolnshire Community Health Services under The Group model.

The ICB recognises the scale of work that was required to apply for teaching hospital status and was delighted when this was awarded by the Secretary of State for Health and Social care during 2024/25. This will be of benefit to patients as well as enhancing the Trusts' ability to attract highly skilled professionals to the organisation and into Lincolnshire.

In addition, the Quality Account highlights numerous achievements in 2024/25 including:

- The Trust moved into the Group model with Lincolnshire Community Health Services and the ICB welcomes the strengthening of ways of working which provides opportunity for collaborative approaches to patient care.
- Roll out of Martha's rule across Lincoln County and Pilgrim Hospitals – the "Call for concern" initiative acknowledges that families and carers may identify changes or a deterioration in a patient's condition before they become apparent to staff
- Falls prevention continues to be a focus of patient safety and, whilst the number of falls has increased, there has not been an associated increase in the level of harm. The Trust is actively involved with system and regional falls prevention meetings ensuring learning is shared and acted upon
- The Trust has achieved a reduction in the overall number of hospital acquired pressure ulcers and pressure ulcer prevention continues to be an area of focus. The Skin Integrity Group provides an opportunity for a multi-disciplinary approach to learning and oversight of improvement activities. Wider education is provided in multiple formats ensuring staff across the Trust are aware of latest developments improving patient outcomes

The ICB recognises that this year has not been without its challenges with increased pressure continuing within the Emergency Departments (ED) and increasing demand on hospital services generally. The ICB acknowledges the Trust's commitment to improve patient experience and the work it has undertaken to reduce ambulance handover times in ED, supporting ambulance service colleagues to serve the communities.

The current CQC rating for ULTH is Requires Improvement which was awarded in February 2022 following an unannounced inspection in October 2021. The ICB note that the CQC conducted unannounced visits into Lincoln County and Pilgrim Emergency Departments, October and November 2024 respectively and that the Trust await the final report. The ICB welcomes the action being taken based on the initial feedback received while the Trust await the final report.

Looking ahead into 2025/26 the ICB notes the Trust has aligned their priorities to those in the Group Strategy and are:

- Maximise safety of patients in our care, through learning from incidents and reducing incidents causing harm
- Identify areas where services do not meet best practice requirements and deliver demonstrable improvement in those areas
- Focus on improving the top three patient feedback themes: communication, appointments and clinical practice

The ICB welcomes these as priorities for the coming year noting the continued learning from incidents through the implementation of PSIRF; the Trust's current position in relation to infection prevention and control and the importance of getting this right for good patient experience; and the utilisation of themes from patient feedback as identified in 2024/25's Quality Account.

The ICB would like to thank United Lincolnshire Teaching Hospitals NHS Trust for their commitment and dedication working with Lincolnshire Health System to ensure patient's needs are met.

Yours sincerely,

Vanessa Wort
Associate Chief Nurse
NHS Lincolnshire Integrated Care Board

Healthwatch Lincolnshire Quality Account Statement 2025

United Lincolnshire Teaching Hospitals NHS Trust (ULTH)

Healthwatch Lincolnshire welcomes the opportunity to respond to ULTH's Quality Account 2024/25 and values the Trust's continued commitment to transparency, service improvement, and meaningful engagement with patients and communities. We also note with interest ULTH's recent transition to Teaching Hospital status and its strengthened collaboration with Lincolnshire Community Health Services NHS Trust as part of the Lincolnshire Community and Hospitals Group. We hope this joint working leads to improved coordination and continuity for patients.

Looking Back – Progress on 2023/24 Priorities

We commend the Trust's efforts over the past year to address its three priority areas: end-of-life care, communication, and diabetes services.

- We particularly welcome the focus on **end-of-life care**, including the education and engagement of staff, system-wide strategy development, and improved documentation processes. Increasing NACEL survey responses and supporting alignment across settings demonstrates positive progress.
- The **Hear It Your Way** programme is an innovative training approach to improving communication, and we are encouraged to see good staff feedback and a commitment to continued roll-out.
- Despite ongoing challenges, progress has also been made in the **diabetes pathway**, including digital improvements, pathway reviews, and quality governance. However, we note that key developments remain contingent on business case approvals and funding.

These efforts reflect responsiveness to feedback and learning, but we note the need for consistency in embedding changes across the Trust.

Priorities and Challenges for 2025/26

Healthwatch Lincolnshire supports the Trust's three Quality Priorities for the coming year:

1. **Maximising patient safety** through learning from incidents, this is rightly identified as a foundational priority. Reducing the number of incidents causing moderate or severe harm, alongside alignment with the Patient Safety Incident Response Framework (PSIRF), is a positive and necessary focus.
2. **Improving compliance with best practice**, especially around infection prevention and control (IPC) and hygiene standards. This is essential given the clinical risks involved and public concern around cleanliness in hospitals. We support the Trust's commitment to meeting the CQC's "Hygiene Code" requirements and hope to see the Trust move from partial to full compliance.
3. **Addressing top themes from patient feedback**, including communication, appointments, and clinical care. Healthwatch Lincolnshire recognises these as consistent issues in public feedback we have received. Efforts to reduce complaints and improve Friends and Family Test (FFT) scores in these areas will be key indicators of success.

We appreciate that these priorities are clearly aligned to what matters to patients and hope the Trust ensures tangible impact and communication back to the public about changes made.

Themes from Public Feedback

Our insight over the past year continues to reflect recurring issues that patients and families face when accessing hospital services:

- **Communication**: As acknowledged by the Trust, patients often report unclear or delayed communication about appointments, treatment plans, and clinical updates. This contributes to anxiety and confusion. While initiatives such as 'Hear It Your Way' and Call for Concern show promise, these must translate into consistent frontline practice.
- **Waiting Times and Access to Services**: Feedback often highlights long waits for diagnostics, outpatient appointments, and procedures. The development of new diagnostic centres is welcome, and we would encourage further public updates on their impact.

- **Transfers of Care and Discharge**: Issues around delayed discharges and coordination between hospital and community services persist. We urge ULTH to work closely with LCHS and the ICB to ensure safe and timely transitions.

Final Comments

Healthwatch Lincolnshire appreciates ULTH's ongoing engagement with system partners and patient voice, including the Trust's use of a Patient Panel and broader engagement forums and welcome further opportunity to work with Healthwatch to provide patient experience insight.

Health Scrutiny Committee for Lincolnshire Statement on the *Quality Account* for 2024/25 of the United Lincolnshire Teaching Hospitals NHS Trust

The Committee is grateful to the Trust for sharing a copy of its draft quality account.

Presentation of the Document

The Committee recognises that there is a balance between making the document accessible to the public and meeting all the requirements of the regulations. In future, the Committee suggests an overview of the Trust's services be included, for example, providing information on headline activities and service volumes, such as accident and emergency attendances, at each hospital. This would give the public a feel for the extent and locality of the services provided by the Trust.

Prescribed content does not assist the flow of the document. However, where information has to be included because it is a prescribed requirement, the Committee suggests there could be a brief explanation to assist the understanding of the lay reader. The Committee welcomes the inclusion of patient stories in the document.

Quality of Care – Trust's Priorities for Improvement

The Committee's View of Patient Priorities

The Committee would like to record its own views on what it sees as most important for patients and the public:

- improving access to all NHS services, by reducing waiting lists and waiting times, and providing equality of access to services
- providing seamless care between different NHS and other services, including from children's services to adult services

- providing high-quality safe services as locally as possible, to avoid unnecessary travel
- making sure patients are signposted to the appropriate service at the first point of contact, so as to avoid as much as possible onward transfer to other hospitals or services.

Many of these aspirations are reflected in national, local and the Trust's strategies.

Selecting the Trust's Priorities for Improvement for 2025/26

The Committee accepts that the Trust's priorities have been developed by reference to patient safety incidents and patient feedback, with three dominant themes in (communication, appointments, clinical practice). This demonstrates how patients and the public have been involved in the development of the document.

Specific Comments on the Trust's Priorities for Improvement for 2025/26

The Committee believes that *Priority One (Maximising Patient Safety)* should be intrinsic to the Trust's daily operations and would like to see how this priority will deliver shift changes in practice and benefits to patients, so that its adoption goes beyond what ought to be a 'business as usual' approach.

The Committee believes *that Priority Two (Improvement in Services not Meeting Best Practice)* is too broad and as a result risks lacking focus, with potential overlaps into *Priority One*. The Committee would like to see a list of measurable actions in support of the priority.

The Committee would like to see *Priority Three (Improvement of Patient Feedback Themes: Communication, Appointments and Clinical Practice)* broadened so that it is not solely focused on complaints, but could include other patient data on waiting times, re-admission rates, and ambulance handover times.

Progress on Priorities for Improvement for 2024/25

Although there has been progress with all three priorities for 2024/25, the Committee's preference is for a clear summary, with an indication, using red, amber or green, whether

each action in support of a priority had been met. The Committee would not wish to see the progress made on these priorities lost, because they are not being carried forward into 2025/26.

Achievements During 2024/25

The Committee welcomes all the achievements, listed in the Chief Executive's statement, which include completion of the first phase of the new emergency department at Pilgrim Hospital, Boston; opening two Community Diagnostic Centres in Lincoln and Skegness; and starting construction of the new endoscopy unit at Lincoln County Hospital. Achievements also include procurement of an electronic patient record system, which will represent a significant improvement, when paper records are replaced. The Committee supports all developments improving the quality of care provided to patients and recommends that the achievements fully outline all these benefits.

Engagement with the Health Scrutiny Committee for Lincolnshire

During 2024-25, engagement with the Health Scrutiny Committee for Lincolnshire has continued, with various representatives of the Trust attending five of the ten meetings of the Committee during the year. We look forward to continued engagement with the Trust's managers, and where appropriate clinicians, in the coming year. The Committee will be giving consideration to adding the following topics to its work programme in the coming year:

- Stroke Services
- Maternity Services
- Patient Discharge Arrangements

Conclusion

The Committee is grateful for the opportunity to make a statement on the draft Quality Account. The Committee looks forward to the Trust's progress, not only with its three priorities, but also with national priorities in the coming year and will continue to engage the Trust at its meetings.

Trust Comments

Thank you for your comments. We recognise the importance of ensuring our Quality Account remains clear while also meeting public reporting requirements and regulatory standards. We also recognise the value of including key headline activities such as emergency attendances to give the public a clearer understanding of the locality and services provided by the Trust.

A brief explanation along prescribed content can support better understanding and improve accessibility to a wider audience. We will look to incorporate this where appropriate to enhance clarity going forward.

Thank you for highlighting the committee's view on patient priorities for 2025/2026 which we acknowledge and will ensure these will be reported through our established reporting processes.

Regarding the 2024/2025 quality priorities, we can confirm that these will continue to be monitored through our governance processes to ensure effective oversight and progress.

Annex 2: Statement of Directors' Responsibilities

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011, 2012 and 2017 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

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;
- 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 included 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, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

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

Professor Karen Dunderdale

Chief Executive Officer

Elaine Baylis

Chair, Trust Board