NHS

Lincolnshire Community and Hospitals NHS Group

United Lincolnshire Teaching Hospitals NHS Trust Quality Account 2025-2026

Glossary of Abbreviations

AAA	Abdominal Aortic Aneurysm
BAUS	The British Association of Urological Surgeons
CDC	Community Diagnostic Centres
CEG	Clinical Effectiveness Group
CMP	Case Mix Programme
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CT	Computerised Tomography
DSPT	Data Security and Protection Toolkit
DTI	Deep Tissue Injury
ED	Emergency Department
EDI	Equality Diversity and Inclusion
EPR	Electronic Patient Record
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
ICB	Integrated Care Board
ICU	Intensive Care Unit
ICNARC	Intensive Care National Audit and Research Centre
IPC	Infection Prevention and Control
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
ME	Medical Examiner
MINAP	Myocardial Infarction National Audit Programme
M&M	Mortality & Morbidity Meeting
MOG	Mortality Oversight Group
MRI	Magnetic Resonance Imaging
NACEL	National Audit of Care at the End of Life
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
NVR	National Vascular Registry
OBD	Occupied Bed Days
O-G	Oesophago-Gastric
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
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

SHMI	Standardised Hospital-Level Mortality Indicator
SHOT	Serious Hazards of Transfusion
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
VAS	Visual Analog Scale
VTE	Venous Thromboembolism
7DS	Seven Day Services

Contents

Part 1: Chief Executive Statement

Welcome to the United Lincolnshire Teaching Hospitals NHS Trust (ULTH) Quality Account for 2025-2026. This report sets out how we are working to ensure that the care we provide across our hospitals is safe, effective and centred on the needs of our patients and communities.

Every day, our colleagues deliver care to thousands of people across Lincolnshire. We would like to begin by recognising the dedication, professionalism and compassion shown by our staff, often in the face of significant and sustained pressure across the NHS. Their commitment ensures that patients and their families receive care that is not only clinically effective, but also delivered with dignity, kindness and respect.

Over the past year, we have continued to focus on improving the safety, experience and outcomes of the services we provide. This includes strengthening our approach to patient safety and learning, improving the way we respond to feedback and concerns, and supporting clinical teams to lead quality improvement across our hospitals. We have also continued to develop new models of care that ensure patients are seen more quickly by the right teams, helping to reduce delays and improve the overall patient experience.

A key milestone during the year has been the continued development of the Lincolnshire Community Health Services Group (LCHG), which brings together United Lincolnshire Hospitals NHS Trust (ULTH) and Lincolnshire Community Health Services NHS Trust (LCHS). This partnership represents an important step in strengthening collaboration across our organisations, enabling us to work more closely together to improve care for patients and create more joined-up services across hospital and community settings.

By working together as a Group, we are better able to share expertise, develop our workforce, and design services that reflect the needs of our population. This approach supports the wider ambition of the NHS to deliver care closer to home, improve prevention and early intervention, and ensure services are sustainable for the future.

Other achievements over the past year have included:

- Continued success with our ward accreditation programme, recognising the wards and departments that demonstrate consistently high standards of patient care and evidence of their improvement journey, measured through a variety of metrics.
- Undertaken significant transformation of acute stroke care across Lincolnshire via the Clinically Led Workforce and Activity Redesign (CLEAR) Programme.
- Gained full approval and began the development of a new Community Diagnostic Centre (CDC) in Boston.

- Developed a £4million extension to the existing Community Diagnostic Centre (CDC) in Lincoln to deliver more planned care, including some elective orthopaedic clinics.
- The Lincolnshire Bowel Cancer Screening Team became the first nationally to introduce the lowered threshold for home-testing kits to support earlier detection of potential signs of bowel cancer.
- The Group Community Tuberculosis (TB) team were invited to attend the National Tuberculosis Summit to showcase their improvement programme. As part of the service redesign, an online consultation pilot has been implemented, offering video appointments as an additional option for TB consultations. Early outcomes from these changes include improved patient access, reduced travel time, and greater flexibility in how patients receive care.
- As part of the East Midlands Neuro-Oncology Service, which supports patients across the region with brain tumours, ULTH was awarded the prestigious Tessa Jowell Centre of Excellence status.
- Began the implementation of the Electronic Patient Record (EPR).
- Opened the first phase of the new Emergency Department (ED) at Pilgrim Hospital, Boston.

Quality improvement remains central to everything we do. This Quality Account highlights the progress we have made, the areas where further improvement is needed, and the priorities we are focusing on in the year ahead. We remain committed to listening to our patients, carers, staff and partners, ensuring their voices help shape how we deliver and improve services.

As we look ahead, our focus remains clear: to continue improving the safety, effectiveness and experience of care, while working collaboratively across our Group and the wider Lincolnshire system to deliver high-quality services for the communities we serve.

Professor Karen Dunderdale,

Chief Executive

Part 2: Deciding our Quality Priorities for 2026-2027

To determine our quality priorities, we have consulted with a range of stakeholders, including the Quality Committee (QC). The QC, on behalf of the Trust Board, formally approves the priorities, and progress against these is monitored through regular reporting throughout the year.

We have ensured that our quality priorities are aligned with the Group Strategy and reflect both national requirements and local areas of risk and opportunity. In developing these priorities, we have reviewed progress made against last year's objectives to identify areas where improvement has been achieved and where further focus is still required.

As these priorities remain central to delivering high-quality, safe, and effective care, the Trust has agreed to continue with the same priorities for 2026–27. This approach will ensure that improvements are not only achieved but are also sustained and fully embedded across the organisation, particularly in areas where longer-term change is required.

The following priorities have therefore been identified for continued focus for the Group in 2026–27, aligned to the Group Strategy 2025–2030. These priorities are intentionally maintained over multiple years to support meaningful, system-wide improvement, enhance patient safety, and deliver better patient experience and outcomes.

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 at the heart of everything we do. We have continued this priority from 2025–26 as ensuring patients are safe remains fundamental to delivering high-quality healthcare. Our approach aligns with the National Patient Safety Strategy and the Patient Safety Incident Response Framework (PSIRF), which support a culture of openness, transparency and continuous learning.

We regularly review trends in incidents and patient feedback to identify areas where care can be improved. By working collaboratively across teams, we aim to strengthen our safety culture, learn from what goes wrong, and make meaningful improvements that enhance patient outcomes and experience.

Throughout 2025–26, we have continued embedding PSIRF across the organisation, focusing on:

- Learning from patterns and themes in incidents, not just individual events
- Strengthening governance and oversight of patient safety
- Sharing learning across services and care groups
- Moving from reactive responses to incidents towards system-wide improvement

We have also continued to improve how we review incidents, focusing on understanding the underlying causes and ensuring that learning leads to real changes in practice.

While most reported incidents result in no or low harm, we recognise the importance of continuing to reduce all levels of harm, particularly the most serious outcomes through a continued commitment to open reporting and learning.

What will success look like?

- A reduction in the number and proportion of incidents causing harm.
- Clear evidence that learning from incidents leads to safer care and better patient outcomes.

How will we monitor progress?

- Quarterly reports to the Quality Committee, highlighting trends and key risks.
- Tracking improvements against identified themes and actions.
- Ongoing review through PSIRF processes to ensure learning is embedded into practice.

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 maintaining clean environments, is essential to ensure that people receive safe and effective care. Preventing infection is everyone's responsibility and must be part of everyday practice across all services.

As an acute Trust, we are required to comply with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections ("The Hygiene Code"). This sets out 10 key standards that the Care Quality Commission (CQC) uses to assess how well organisations prevent and control infections.

Whilst the Trust demonstrates strong compliance overall, we recognise that there are areas where we do not yet fully meet best practice, particularly relating to infrastructure, environment and capacity. These areas can directly impact patient safety and experience and therefore remain a priority for improvement. This continues to be a key focus for the Trust, carried forward from our 2025–26 priorities, reflecting our ongoing commitment to strengthening IPC standards and delivering sustained improvement.

Our Current Status:

The Trust continues to demonstrate a strong level of compliance with national IPC standards, with systems in place to meet all 10 required criteria:

- Fully compliant: Criteria 1, 3, 4, 5, 8, 9 and 10
- Partially compliant: Criteria 2, 6 and 7

10 IPC Criteria

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.

Within these partially compliant areas, most requirements are being met; however, some challenges remain, including:

- Ageing estate and infrastructure
- Limited availability of single rooms for isolation
- Decontamination processes and healthcare waste classification
- Workforce-related gaps such as Personal Protective Equipment (PPE) training and fit testing
- Estates-related risks including waste management and decontamination processes

These gaps are well understood, risk assessed, and actively managed, with clear action plans in place and oversight at Board level. Improvement work is ongoing and prioritised based on patient safety risk.

What will success look like?

- Demonstrable improvement in areas currently partially compliant.
- Reduced risk of infection and improved patient safety and experience.
- Evidence that improvements are sustained and embedded into everyday practice.

How will we monitor progress?

- Monthly reporting to the Quality Committee, including IPC performance and compliance.

- Monitoring of action plans and improvement programmes, with focus on areas off track.
- Ongoing Board-level oversight of key risks and mitigations.
- Regular audit, surveillance, and review processes to ensure continuous improvement.

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 central to everything we do. We recognise that high-quality care is not defined solely by clinical outcomes, but also by how well we meet the physical, emotional and personal needs of our patients and their families. Every person who uses our services should feel valued, respected and supported throughout their care.

Improving patient experience remains a key priority for the Trust. This focus is being continued into 2026–27, building on the progress and learning from 2025–26 to drive further improvement.

Our Current Status:

Top three themes of complaints during 2025-2026.

Complaint Categories	Number Received	% of overall complaints
Clinical treatment	636	35.87%
Communication	437	24.65%
Appointments	186	10.49%

The Trust received 87.53% positive responses through the Friends and Family Test (49,817 positive responses out of 56,911 total responses).

Top three themes' Friends & Family Themes

- Waiting Times.
- Communication.
- Clinical treatment.

These themes are consistent across multiple sources of feedback and indicate key areas where patients experience challenges.

What will success look like?

Success will be demonstrated through a sustained reduction in the top areas of patient feedback, communication, clinical treatment, and waiting times/appointments as measured through both complaints and FFT data, evidencing continued improvement during 2026–27.

How will we monitor progress?

Progress will continue to be monitored through quarterly reports to the Quality Committee. These reports will highlight performance against key measures, track delivery of improvement actions, and identify any areas that are off track, including the actions and mitigations in place to address them as we continue this priority into 2026–27.

Looking Back: Progress made since publication of 2024-25 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. **Maximise safety of patients in our care, through learning from incidents and reducing incidents causing harm.**
2. **Identify areas where services do not meet best practice requirements and deliver demonstratable improvement in those areas.**
3. **Focus on improving the top three patient feedback themes: Communication, Appointments and Clinical Practice.**

Introduction

The Quality Account for 2024–25 outlined the Trust's proposed quality improvement priorities for the year ahead (2025–26). These priorities were identified through engagement with patients, the public, staff, and external stakeholders. During 2025–26, we have monitored progress against these priority ambitions through our established governance framework. As these priorities remain fundamental to improving patient experience, safety, and outcomes, they will be carried forward into 2026–27 to ensure continued focus, delivery, and embedding across the Trust.

Trust performance

This section provides detail on how the Trust has performed against the three priority ambitions. Results relate to the period 01 April 2025 - 31 March 2026 or the nearest period available.

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

We said we would:

- Strengthen our patient safety culture in line with the National Patient Safety Strategy and PSIRF.
- Improve how we learn from incidents, focusing on system-wide learning and continuous improvement.
- Reduce the number and proportion of incidents resulting in moderate and severe harm, including those resulting in death.
- Use data and trend analysis to identify areas of risk and drive targeted improvements.

Our incident data shows a varied but overall improving trend, particularly in relation to the most serious outcomes.

There has been a reduction in deaths and a slight reduction in severe harm, indicating progress in reducing the most serious outcomes for patients.

The slight increase in moderate harm incidents is considered to reflect a more open reporting culture and improved identification of harm, rather than a deterioration in care, supporting stronger organisational learning.

The quarterly triangulated patient safety report demonstrates that, across 2025-26 it shows that we are listening to our patients, families and staff, and using this information to improve care. By bringing together data from incidents, complaints, patient feedback, safeguarding and learning reviews, we have identified the main areas where patients experience problems: long waits in Emergency Departments, delays in treatment or diagnosis, medication issues, falls, pressure ulcers, and communication. These themes appear consistently across different services, meaning they are important priorities for improvement. Work is already underway to address these issues, including improving patient flow through Emergency Departments, ensuring patients receive the right medication at the right time, reducing preventable harm such as falls and pressure ulcers, and improving how we communicate with patients and their families. While some improvements are already showing positive results, we recognise that we need to go further. Our focus is to better understand why these issues happen and to ensure that learning leads to real, measurable improvements in patient safety, experience and outcomes.

Data Source: Datix

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

Work has continued to embed the Patient Safety Incident Response Framework (PSIRF), and as a result, this will remain a key priority for 2026–27. This includes a continued focus on learning from patterns and themes in incidents rather than isolated events, ensuring that lessons are shared more widely across services. We are also strengthening how safety is overseen and monitored, improving how information is used to support safer care, and encouraging teams to work together to share learning. Overall, the approach is shifting from reacting to individual incidents towards making lasting, system-wide improvements that better protect patients and improve their experience of care.

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

We said we would:

1. **Systems to manage and monitor infection prevention and control**

The organisation has systems in place to prevent and control infections, supported by leadership, governance structures and regular reporting. There is a well-established approach to identifying risks, learning from incidents and improving practice, including through the implementation of the Patient Safety Incident Response Framework (PSIRF). Fully compliant.

2. **Clean and safe environment**

Overall, the organisation provides a clean and appropriate environment that supports infection prevention. However, there are some areas where further improvement is required, mainly related to aging infrastructure, maintenance pressures, waste management, and decontamination processes. These risks are recognised, monitored at Board level, and are supported by action plans and prioritised investment. Partially complaint.

3. **Safe use of antibiotics (antimicrobial stewardship)**

There are systems in place to ensure antibiotics are used safely and appropriately. This helps improve patient outcomes and reduce the risk of antibiotic resistance. Monitoring, audit programmes and clear leadership oversight support continuous improvement in prescribing practices. Fully compliant.

4. **Providing information to patients and the public**

Patients, families and carers are given clear and accessible information about infections and how they are prevented and managed. Information is available in a range of formats and is regularly reviewed to ensure it is accurate, up to date and easy to understand, supporting patients to be involved in their care. Fully compliant.

5. **Early identification and treatment of infection**

Patients are assessed promptly for signs of infection, with systems in place to ensure early identification and timely treatment. This reduces the risk of infections spreading and supports safe and effective care throughout a patient's journey. Fully compliant.

6. **Staff responsibilities and training**

Staff are trained and supported to understand their responsibilities in preventing and controlling infections. There is good compliance with training, although some areas require improvement, including specialist Personal Protective Equipment (PPE) training and fit testing, which are being actively addressed. Partially complaint.

7. **Isolation and infection control facilities**

Appropriate isolation procedures are in place to manage infectious patients safely. However, there are challenges related to limited availability of single rooms and high bed occupancy, which can impact optimal patient placement. Risk-based approaches are in place to ensure patient safety is maintained. Partially complaint.

8. **Access to laboratory and diagnostic services**

There is access to laboratory and diagnostic support, ensuring timely testing and identification of infections. Services meet national standards, enabling rapid response to infection risks and supporting effective patient care. Fully compliant.

9. **Infection prevention policies and procedures**

Comprehensive policies and procedures are in place and widely followed across the organisation. These support consistent practice in managing infections and outbreaks, with regular monitoring and strong engagement from clinical teams. Fully compliant.

10. **Staff health and wellbeing in relation to infection control**

There are systems in place to protect staff health, including risk assessments, occupational health support, and vaccination programmes. These measures help reduce the risk of infection transmission and ensure staff are supported to work safely. Fully compliant.

Data Source: Infection Prevention & Control Team

What we need to do to achieve our success measures?

Safe patient care remains a fundamental priority, and while good progress has been made, there is a continued need to embed and sustain improvements. The organisation is

fully compliant with the majority of Infection Prevention and Control standards, demonstrating strong systems and governance in place; however, a small number of areas remain partially compliant, particularly relating to environment, infrastructure, and decontamination processes. These challenges are recognised and are being actively managed through structured improvement plans and Board oversight. Alongside this, continued focus is required to reduce incidents causing harm and ensure that learning from incidents is consistently translated into meaningful improvements in patient outcomes. As such, this priority will be carried forward into 2026–27 to maintain momentum, strengthen patient safety culture, and deliver sustained, system-wide improvements.

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

We said we would:

Analysis of complaints and Friends and Family Test (FFT) data show some notable changes between 2024–25 and 2025–26.

In 2025–26, clinical treatment has become the most prominent complaint theme, increasing from 31% in 2024–25 to 35.87%. This indicates a growing focus from patients on the quality and delivery of care. Communication, while still a significant theme, has reduced proportionally from 32% to 24.65%, although it remains a key area for improvement. Complaints relating to appointments have increased from 7% to 10.49%, reflecting ongoing challenges around access and timeliness of services.

Patient feedback through the FFT remains positive overall; however, there has been a slight reduction in positive responses, from 89.84% in 2024–25 to 87.53% in 2025–26. The main themes identified through FFT, waiting times, communication, and clinical treatment closely align with complaint data, providing a consistent picture of where improvements are needed.

In response to this feedback, the Trust has taken a number of actions during 2025–26. There has been a continued focus on improving communication with patients and their families, including reinforcing expectations for clear, timely and compassionate communication across services. Work has also been undertaken to improve patient flow, waiting times, and access to services, particularly in areas experiencing high demand.

The development of the Patient Services Hub will support improvements in how patients access services and receive information. The Hub provides a central point of contact for patients, helping to streamline appointment management, improve coordination, and ensure patients receive timely updates regarding their care. This will contribute to improving consistency in communication and a more responsive service experience.

To address concerns relating to clinical treatment, services have strengthened clinical oversight, audit, and learning from incidents and complaints, ensuring that feedback is used to drive improvements in care quality and patient outcomes. Additionally, efforts have

been made to improve appointment management processes, including better coordination and clearer communication with patients regarding delays or changes.

While progress has been made, the data highlights that further work is required. The Trust will continue to focus on these key themes during 2026–27, ensuring that learning from patient feedback, supported by initiatives such as the Patient Hub, leads to meaningful and sustained improvements in patient experience.

Data Source: DATIX and FFT

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

To achieve a sustained reduction in the key patient experience themes of communication, clinical treatment, and waiting times, the Trust recognises that further coordinated action is required during 2026–27. This will include strengthening collaboration with Complaints and PALS teams to ensure that learning from feedback is consistently reviewed, triangulated with incident and FFT data, and translated into measurable improvements in practice.

The Trust will continue to work with the Communication Faculty to enhance staff skills in delivering clear, timely and compassionate communication, with a focus on actively listening to patients and managing expectations.

There will be an increased emphasis on responding to real-time patient feedback so that concerns can be identified and addressed more quickly at a local level.

In addition, further work will be undertaken to improve patient flow, appointment management and access to services, helping to reduce waiting times and improve overall experience.

Clinical teams will continue to strengthen learning from complaints, incidents and audits to improve the quality and consistency of care. This will be supported by embedding a culture of continuous improvement through PSIRF, ensuring that learning leads to meaningful and sustained changes in practice.

By increasing staff engagement and ownership of patient experience data, and continuing to work collaboratively across the Group, the Trust aims to deliver measurable improvements and a more positive experience for patients and their families.

Statement of Assurance

Review of services

During 2025-26, the United Lincolnshire Teaching Hospitals NHS Trust (ULTH) provided and/or subcontracted 69 relevant health services.

The ULTH has reviewed all the data available to them on the quality of care in 69 of these relevant health services.

The income generated by the NHS services reviewed in 2025-26 represents 93% of the total income generated from the provision of NHS services by the ULTH for 2025-26.

Participation in Clinical Audits

During 2025-26, 60 national clinical audits and 6 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 2025-26, 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 2023 (MBRRACE-UK)	Yes	January 2023 - December 2023 Published May 2025	No case ascertainment reported
State of Nation Confidential Enquiry into Maternal Deaths from hypertensive disorder, cardiac disease, mental health-related causes, homicide and accidents 2021-23 (MBRRACE –UK)	Yes	Published September 2025	No case ascertainment reported
State of Nation National Maternity & Perinatal Audit (NMPA)	Yes	2023 Report published September 2025	Data completeness each category between 94-100 except: smoking at delivery 43 and Breast milk at discharge 0
Induction of Labour Snapshot Audit (NMPA)	Yes	2023 Report published November 2025	IOL rate 41.3%, Caesarean birth following IOL 31%, Apgar score <7 at 5 mins following IOL: 1.47%
Neonatal Intensive and Special care (NNAP)	Yes	1st January – 31st December 2024 Report Published October 2025	Lincoln Hospital received Positive outlier in ROP screening 2024 measure.

National Audits	ULTH Participation	Reporting Period	Number and % Required
			Pilgrim Hospital received outlier at ALERT level (2 or more standard deviations below expected performance) for the audit measure: two years follow up 25%, national 77.9% and breast milk by day 2, 29.2%, national 66.8%
Children			
National Children's & Young People Asthma Audit (NRAP)	Yes	April 2023- March 2024 Catching our Breath Report published June 2025	Case ascertainment LCH 54 of 65 (83.1%), PHB 37 of 55 (67.3%)
Diabetes (RCPH National Paediatric Diabetes Audit) Type 2 Diabetes – spotlight audit 2023/24	Yes	1st April 2023- 31st March 2024 Published April 2025	There is currently no unit level report for the Type 2 Spotlight Audit
National Paediatric Diabetes Audit (NPDA) report on care and outcomes 2024/25	Yes	2023-2024 published March 2026	LCH 173, PHB 134, GK 87
National Epilepsy 12 Audit	Yes	1 Dec 2022 - 30 November 2023 Round 4 Cohort 6 Report published July 2025	31/31 (100%)
Acute Care			
National Emergency Laparotomy Audit (NELA) – Laparotomy	Yes	1 April 2025 – 31 December 2025 Report published monthly	LCH 98 PHB 100

National Audits	ULTH Participation	Reporting Period	Number and % Required
National Emergency Laparotomy Audit (NELA) – No Laparotomy	Yes	1 April 2025 – 31 December 2025 Report published monthly	LCH 16 PHB 12
Cardiac Arrest (National Cardiac Arrest Audit) ICNARC	Yes	April 2023 to March 2024	Lincoln 111 Pilgrim 51 No case ascertainment
Case Mix Programme (CMP) Intensive Care National Audit & Research Centre (ICNARC)	Yes	1 April 2025 - 31 December 2025 Report published quarterly	LCH 357 PHB 347 Case ascertainment is not reported
Royal College of Emergency Medicine (RCEM) QIPS c) Mental Health (Self Harm) (Year 3)	Yes	1 January 2025 – 31 December 25 Awaiting report	To be confirmed
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	18th June 2026 24hr snapshot	LCH 47 PHB 40
National Audit of Care End at the End of Life (NACEL)	Yes	January – December 2024 Organisation audit, staff survey, bereaved relatives/carers survey. Published Aug 2025	PHB 120 LCH 135 GDH 45
Royal College of Emergency Medicine (RCEM) QIPS b) Care of Older People (Year 3)	Yes	1 January 2025 – 31 December 25 Awaiting report	To be confirmed
Royal College of Emergency Medicine (RCEM) QIPS d)Time Critical Medications (Year 2)	Yes	1 January 2025 – 31 December 25 Awaiting report	To be confirmed

National Audits	ULTH Participation	Reporting Period	Number and % Required
Long Term Conditions			
Diabetes (National Adult Diabetes Audit)	Yes	1 January 2025 - 31 March 2025. 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	2024-25 published November 2025	Case ascertainment is not recorded. Data collected via the HES (Hospital Episode Statistic). Reported national level only
National Diabetes in Pregnancy Audit	Yes	1st January 2025 - 31 December 2025. Awaiting report (deadline 26 Feb 2026)	LCH 14 PHB 10 Case ascertainment is not reported
UK Parkinson's	Yes	1 May – 31 Oct 2025	LCH 23 PHB 20 GK 30
National Diabetic Foot Audit (NDFA)	Yes	1 Jan 2025 – 31 March 2026. Awaiting report	Case ascertainment is not reported
National Early Inflammatory Arthritis (NEIAA)	Yes	1 April 2024 - 31March 2025 Report published October 2025	79 Case ascertainment is not reported
National Adult Asthma Audit (NRAP)	Yes	April 2023- March 2024	Case ascertainment

National Audits	ULTH Participation	Reporting Period	Number and % Required
		Catching our Breath Report published June 2025	LCH 62 of 130 (47.7%) PHB 74 of 135 (54.8%) GDH 29 of 60 (48.3%)
Chronic Obstructive Pulmonary Disease (COPD) NRAP	Yes	April 2023- March 2024 Catching our Breath Report published June 2025	LCH 330 of 605 (54.5%) PHB 450 of 795 (56.6%) GDH 93 of 205 (45.4%)
National Audit Dementia R6	Yes	Next data collection due January 2027	Awaited
National Chronic Kidney Disease Renal Registry	Yes	Report published links to ICB data	Case ascertainment is not reported
National Renal Registry Acute Kidney Injury	Yes	Report published links to ICB data	Case ascertainment is not reported
National Diabetes Audit Integrated Specialist Services and Structure Survey	Yes	Annual submission, November 2025 Report awaited	Not applicable refers to the organisation of service
BAUS British audit Of the investigatiOn and referral of woMen with rEcurrent uRinary trAct infectioN using recent Guidance (BOOMERANG)	Yes	17 November 2025 – 30 November 2025 Report due to be published August 2026	Case ascertainment is not yet reported
Elective Procedures			
Cardiac Arrhythmia (NICOR)	Yes	April 2024 – 31 March 2025 2025 report published December 25	Case ascertainment is not reported.
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Yes	1 April 2024 - 31 March 2025 2025 report published December 25	Case ascertainment is not reported.

National Audits	ULTH Participation	Reporting Period	Number and % Required
National Vascular Registry (NVR)	Yes	1 January 2024 - 31 December 2024 Report published November 2025	28 Elective infrarenal AAA repairs, Case ascertainment >85% 29 Carotid endarterectomy, Case ascertainment 70-85% 215 Lower limb angioplasty/stenting, Case ascertainment >85% 24 Lower limb surgical revascularisation, Case ascertainment 30-39% 11 Major lower limb amputation, Case ascertainment 30-39%
National Joint Registry (Hip, Knee, Ankle, Elbow and Shoulder Replacements)	Yes	1 January 2024 - 31 December 2024 Report published November 2025	GDH 746 LCH 245 PHB 243 Case ascertainment is not reported
National Ophthalmology Database (NOD): Age-related Macular Degeneration Audit	Yes	1 April 2023 - 31 March 2024 Report due to be published March 2026	Case ascertainment is not yet reported
National Ophthalmology Database (NOD): Cataract Audit	Yes	1 April 2023 - 31 March 2024 Report published July 2025	1336 Case ascertainment 99.8%

National Audits	ULTH Participation	Reporting Period	Number and % Required
Breast and Cosmetic Implant Registry	Yes	January – December 2024	LCH 45 patients, 50 operations PHB 10 patients, 10 operations
Cardiovascular Disease			
Stroke Care (National Sentinel Audit of Stroke) SSNAP	Yes	1 April 2025 – 31st March 2026 Report awaited	To be confirmed
Acute Myocardial Infarction & Other Acute Coronary Syndrome (MINAP)	Yes	1 April 2024 - 31 March 2025 2025 report published in December 2025	Case ascertainment is not reported
Heart Failure	Yes	1 April 2024 - 31 March 2025	Case ascertainment not reported
Cancer			
National Prostate Cancer Audit (NPCA)	Yes	1st September 2021 - 31st March 2024 Report published October 2025	666 (Case ascertainment not reported)
National Audit of Primary Breast Cancer (NAoPri)	Yes	1st Jan 2020 – 31st Dec 2022 Report published September 2025	1207 (Case ascertainment not reported)
National Audit of Metastatic Breast Cancer (NAoME)	Yes	1st Jan 2020 – 31st Dec 2022 Report published September 2025	205 (Case ascertainment not reported)
National Lung Cancer Audit (NLCA)	Yes	1st January 2024 - 31st December 2024 Report published March 2026	465 (Case ascertainment not reported)

National Audits	ULTH Participation	Reporting Period	Number and % Required
National Bowel Cancer Audit (NBoCA)	Yes	1st January 2024 - 31st December 2023 Report published October 2025	420 (Case ascertainment not reported)
National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	1st January 2022 – 31st December 2023 Report published September 2025	276 (Case ascertainment not reported)
National Kidney Cancer Audit (NKCA)	Yes	1st January 2020 – 31st December 2022 Report published September 2025	286 (Case ascertainment not reported)
National Non-Hodgkin Lymphoma Audit (NNHLA)	Yes	1st January 2022 – 31st December 2022 Report published September 2025	220 (Case ascertainment not reported)
National Ovarian Cancer Audit (NOCA)	Yes	1 January 2022 - 31 December 2023 Report published September 2025	52
National Pancreatic Cancer Audit (NPaCA)	Yes	1st January 2021 – 31st December 2022 Report published September 2025	173 (Case ascertainment not reported)
BAUS Evaluating the Management Pathway for Suspected Testicular Cancer (EMPAST) Referrals and Compliance with Standard Care Practices	Yes	1 April 2023 - 31 March 2024 Report due to be published November 2026	GDH 4 LCH 8 PHB 2 Case ascertainment is not reported
Trauma			

National Audits	ULTH Participation	Reporting Period	Number and % Required
Fracture Liaison Service Database (FLS-DB)	No	1 January 2024 – 31 December 2024 Report published January 2026	Case ascertainment 0% ULTH received an outlier notification for non-participation. Work is currently underway to establish a Fracture Liaison Service.
National Hip Fracture Database (NHFD)	Yes	1 January 2024 - 31 December 2024 Report published September 2025	LCH 467 (105%) PHB 395 (90%)
National Audit Inpatient Falls (NAIF)	Yes	1 January 2024 - 31 December 2024. Report published October 2025	11 Case ascertainment not reported
National Major Trauma Registry (NMTR)	Yes	1 January 2025 - 31 December 2025 Report expected to be published in 2026	LCH 467 PHB 462 Case ascertainment not reported
Blood Transfusion			
National Comparative Audit of Blood Transfusion - 2025 National Comparative Audit of NICE Quality Standard QS138	Yes	1st July 2025 – 31st September 2025	LCH 43 cases PHB 8 cases
National Comparative Audit of Blood Transfusion - 2025 Audit of Compliance with Major Haemorrhage Protocols	Yes	1st April 2025 – 31st June 2025	LCH 14 cases PHB 13 cases
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	1st April 2025 – 31st March 2026	LCH 14 reports PHB 6 reports GDH 0 reports

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

During 2025-26 hospitals were eligible to enter data in up to 4 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			
Acute Illness in Patients with a Learning Disability	Yes	Clinical Questionnaire Organisational Questionnaire Report due Summer 2026	6/11 (55%) 100% completed/submitted
Pleural Procedures	Yes	Clinical Questionnaire Organisational Questionnaire	13/16 (81%) 100% completed
Stabilisation of the Critically Ill Child	Yes	Clinical Questionnaire Organisational Questionnaire	7/8 (88%) 100% completed/submitted
Rib Fractures	Yes	Clinical Questionnaire Organisational Questionnaire	Study underway Study underway

The reports of 4 national clinical audits were reviewed by the provider in 2025-26 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 Emergency Laparotomy Audit (NELA)	• Lincoln achieved a case ascertainment rate of 72.2%, comparable to the national average (72.5%), while Pilgrim showed significant improvement, increasing to 92.8% (a 17.1% rise from Year 9). • Adjusted 30-day mortality was 12.2% at Lincoln and 14.5% at Pilgrim, (8.1% nationally). Pilgrim received an alert for exceeding the upper control limit. • Compliance with preoperative risk assessment was below national levels (Lincoln 64.9%, Pilgrim 53.5%) and both sites fell below best practice CT reporting standards (Lincoln 3.8%, Pilgrim 9.1%). • Targeted education and daily handover prompts were introduced to strengthen engagement with NELA requirements and support consistent documentation. • A mandatory requirement was introduced for recording the NELA mortality risk score at the point of booking emergency bowel surgery (excluding CEPOD 1 cases). • Monthly case-ascertainment checks and direct clinician follow-up were established to improve the completeness of case submission and antibiotic data. • A draft acute abdomen/laparotomy bundle incorporating NELA best practice standards was produced and presented at governance forums and revisions are now underway ahead of Trustwide implementation. • NELA performance is now reviewed quarterly at Surgery Clinical Governance, ensuring regular oversight of outcomes, actions and compliance with national standards.

National Neonatal Audit Programme (NNAP)	July 2025:
	• Pilgrim Hospital received outlier at ALERT level (2 or more standard deviations below expected performance) for the audit measure:
	  ○ Two-year follow-up rates were 25%, compared to a national rate of 77.9%. This lower rate is attributable to families moving out of the area, which impacts our ability to complete follow-up.
	  ○ Breastfeeding rates by day 2 were 29.2%, compared to a national rate of 66.8%. We recognise that a range of clinical and personal factors influence a mother's choice or ability to breastfeed. To support families, the Trust has appointed dedicated breastfeeding midwives who provide advice, guidance, and practical support to mothers to help improve breastfeeding outcomes.
	• Lincoln Hospital received Positive outlier in Retinopathy of Prematurity (ROP) screening 2024 measure.

National Cardiac Arrest Audit 2025	• Lincoln Hospital Return of Spontaneous Circulation (ROSC) for inpatient ward performance for more than 20 minutes achieved 62% against expected 52% target. • Lincoln inpatient wards ROSC achieved 62% against expected 47%. • Lincoln site achieved 24.3% for survival to discharge against expected 23% target. • Lincoln inpatient wards achieved 22% for survival to discharge against expected 16.5% target. • Pilgrim hospital's rate of cardiac arrest per 1000s hospital is mid-point good performance.

National Audit	Headline Results and Actions Taken
National Kidney Cancer Audit (NKCA)	ULHT's performance in the 8 key Performance Indicators is compared with the national mean below: **Performance Indicator 1:** Percentage of people with kidney cancer with the data completeness measure recorded for MDT meeting: National 82% ULHT 92% **Performance Indicator 2:** Percentage of people with kidney cancer consented for a clinical trial: National 1% ULHT 1% **Performance Indicator 3:** Percentage of people with a small renal mass (≤4cm) who have a biopsy: National 20% ULHT 29% (Note: Increase from 23% in 2024 Report) **Performance Indicator 4:** Percentage of people with a T3+ and/ or 10cm+ and/or N1 and M0 RC who had a radical nephrectomy within 31 days of diagnosis: National 68% ULHT 67% (Note: Decrease from 73% in 2024 Report) **Performance Indicator 5:** Percentage of people with T1b-3NxM0 RCC who have surgery 1 month prior and 12 months following diagnosis: National 78% ULHT 79% (Note: Decrease from 84% in 2024 Report) **Performance Indicator 6:** Percentage of people with T1aN0M0 RCC who undergo nephron sparing treatment 1 month prior and 12 months following diagnosis: National 69% ULHT 41% (Note: Increase from 27% in 2024 Report) **Performance Indicator 7:** Percentage of people with metastatic RCC receiving initial SACT within 12 months of diagnosis: National 49% ULHT 56% (Note: Increase from 47% in 2024 Report) **Performance Indicator 8:** Percentage of people with kidney cancer who die within 30 days of SACT treatment: National 3% ULHT 0%

Local Clinical Audit

The reports of 5 local clinical audits were reviewed by the provider in 2025-26 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
Re-audit: 4AT (Delirium screening tool) Assessment for Neck of Femur (NOF) Patients	**Orthopaedics** • Audit undertaken in response to observed low compliance with new National Hip Fracture Database (NHFD) guidance requiring 4AT delirium assessment on first presentation and post-operatively. • First-cycle findings showed 69% fully completed 4AT assessments on arrival and 34% partially completed, indicating limited awareness of the new screening requirement. • 4AT forms were often completed but not consistently stored in patient notes, affecting continuity of assessment. • Actions included raising staff awareness of the updated NHFD standard via teaching sessions and ensuring 4AT forms were placed within patient notes at admission. • Second cycle demonstrated improvement with 79% pre-operative 4AT completion. • Further action included sending a reminder to all orthopaedic doctors to complete 4AT pre- and post-operatively and file assessments correctly in patient notes.
Re-Audit: Antibiotic prescription compliance as per trust guideline	**Acute Medicine** • The re-audit outcomes evidenced a considerable improvement compared to the outcomes within the 1st cycle. • Following the first audit, outcomes were shared in the Trust Teaching Sessions. Posters were also created and displayed in clinical areas along with training provided to emphasise the use of the guideline during ward handovers. • On review of each cycle, we can breakdown the improvement in compliance. • Antibiotics were prescribed relevant to the diagnosis for 136 out of 150 patients (90.67%) in first cycle and 150 out of 150 (100%) in second cycle. • Stat doses were given for 105 out of 150 patients (70%) in first cycle and 123 out of 150 patients (82%) in second cycle. • Renal dose adjustments were eligible for 21 patients which were done for 18 patients(85.7%) in first audit while it was eligible for 25 patients in second cycle and adjustment done for 22 patients (88%). • Overall, Antibiotic prescribed accurately for 93 out of 150 patients (62%) in first cycle and 121 out of 150 (81%) in second cycle. Comparing the first and second cycle, a significant improvement of all the parameters was noticed while prescribing antibiotic as per the trust guideline.
Care of Obstetric Women with BMI >45	**Obstetric & Gynaecology** • Proportion of pregnant women who have a record of maternal height, weight and BMI in their maternity records 100%. • Proportion of women with class III obesity who had an antenatal anaesthetic review 100%, PHB 75% LCH 37%. • Proportion of women with class I obesity or greater at booking, plus two other risk factors for Venous Thrombus Embolism (VTE), who had pharmacological thromboprophylaxis prescribe antenatally 100%, PHB 100 % LCH 98%. • All women were on growth scan pathways 100%. • All women were offered Global Trigger Tool (GTT) at booking and 28 weeks. • 100% of women in Pilgrim had blood pressure charting, 26% in Lincoln. • VTE assessment 100% in Lincoln and Pilgrim. • Increase documentation of Anaesthetic clinic assessment. • Increase awareness to staff of fortnightly blood pressure for women with BMI 30.

	• Increase documentation of prescribing of Aspirin.
Cancer Holistic Needs Assessment - Exploring Quality of Electronic Data input - "Cheque"	• The ULTH Personalisation Team sought to assure and strengthen the quality of personalisation within Holistic Needs Assessments (HNAs) and care planning, ensuring that each assessment and plan is person-centred, individualised, and responsive to what matters most to the individual. • An audit of 50 patient records from each tumour site was undertaken (total 568 patients reviewed) to assess whether a HNA had been offered/completed and whether these were completed in-line with best practice. 367 patients were offered HNA with 304 patients receiving a care plan. The audit results showed variation in uptake of best practice documentation on HNA Care plans across tumour-site teams. Where concerns were highlighted, the care plan contained personalised details in 87% of cases. • As a result of the audit the following service improvements are in progress: • Clarification of Roles and Responsibilities - Clear responsibility for HNA and care plan completion across CNS and Cancer Care Coordinators (CCCs) now defined. Promotion of shared ownership of care planning and ensuring staff understand when escalation or referral is required based on identified needs. • Improved Workforce Confidence and Capability – Providing targeted training to support meaningful HNA conversations and person-centred care planning using the SOP. Sharing best practice from high-performing teams to improve consistency, supported by supervision, peer support, and Personalisation Team coaching and recognition through values in action certificates. • Embedding of SOPs and Standardisation - Ensuring HNA and care planning SOPs are visible, accessible, and routinely referenced. Aligning documentation templates with SOP expectations to reduce variation and duplication. Ongoing: • The personalisation team routinely monitor HNA and care plan completion rates, through annual audit and monthly database metrics. By analysing data trends the team will continue to support targeted action plans rather than a one-size-fits-all approach to ensure greater compliance and outcomes for ULTH. • A 2026-27 Audit will highlight new areas to focus and has been curated following lessons learned around auditing.

Participation in Clinical Research

NHS England has set a clear ambition for research to be embedded as a core component of everyday NHS care, recognising that patients treated in research active organisations experience better outcomes, improved care experiences and lower mortality.

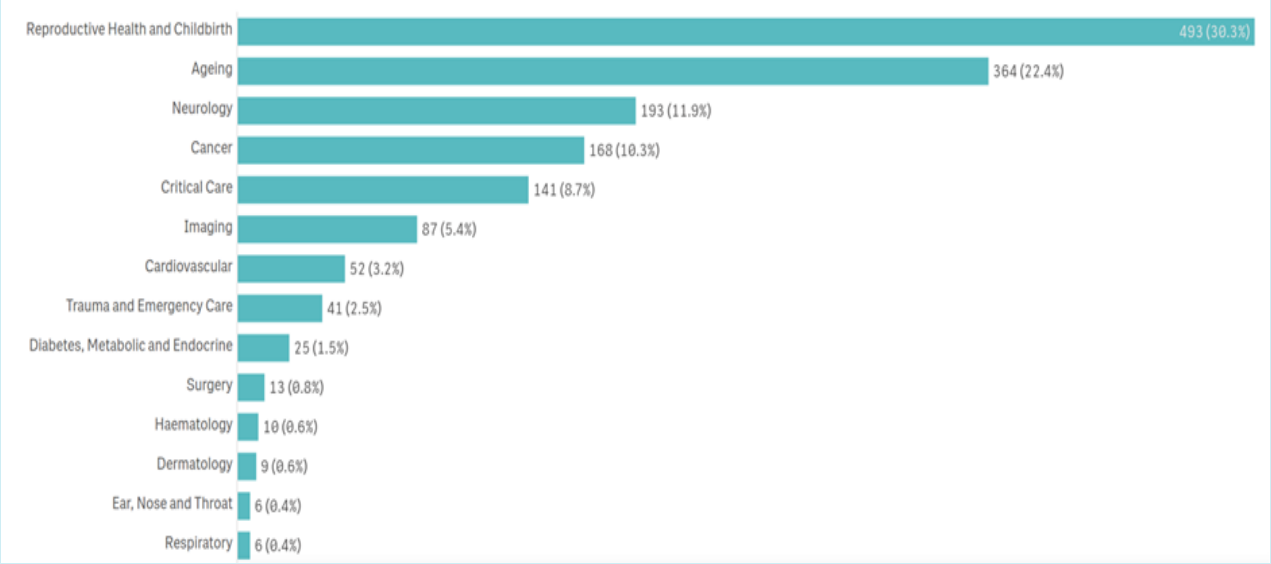
Nationally, the NHS aspires to be the best place in the world to undertake research for patient benefit, while supporting workforce development, accelerating innovation and contributing to the long-term sustainability of the health and care system. In line with this ambition, United Lincolnshire Teaching Hospitals NHS Trust (ULTH) is committed to enabling high quality, inclusive research that improves care today and advances health outcomes for our communities in the future.

Patient Participation in Research

In 2025-26, ULTH demonstrated its continued commitment to research through active participation in clinical studies across a wide range of disease areas and specialties.

For studies adopted on the National Institute for Health and Care Research (NIHR) Research Delivery Network Portfolio:

- 32 new studies were approved and opened within the Trust.
- A total of 89 studies were open to recruitment during the year.
- 71 studies successfully recruited participants in year.
- 1626 patients were recruited to NIHR Portfolio studies 1 April 2025 & 31 March 2026.



This level of activity highlights ULTH's emerging research infrastructure and its commitment to providing patients with opportunities to participate in high quality clinical research that may improve outcomes and care experiences. ULTH remains committed to enhancing its capacity, capability and culture of clinical research development and delivery. Our Research and Innovation Department has a strong record of patient recruitment, collaborative working as well as early signs of emerging research development activity.

The two Research Departments across the Lincolnshire Community & Hospitals Group are about to launch their new Group strategy for Research to demonstrate its commitment to improving the quality of care and contributing to wider health improvement, through research.

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 quality incentive schemes 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.

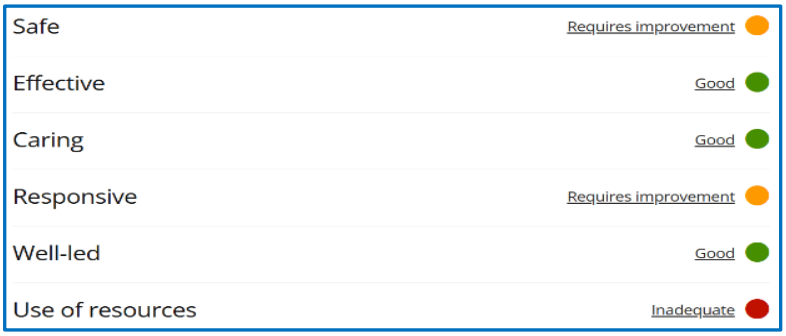
The United Lincolnshire Teaching Hospitals (ULTH) NHS Trust is required to register with the CQC, and its current registration status is registered. The Trust has no conditions on its registration.

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 2025-26.

CQC undertook unannounced visits to Medical Wards in Boston Pilgrim Hospital in January 2026 and Medical and Surgical Wards to assess End of Life Care delivery at Grantham Hospital during March 2026. The Trust is currently awaiting the final reports.

The current overall CQC rating for ULTH is requires improvement.



Data Quality

NHS Number and General Medical Practice Code Validity

United Lincolnshire Teaching Hospitals Trust submitted records during the year to the Secondary Uses Service for inclusion in Hospital Episode Statistics (HES) for Admitted & Outpatient activity (for the period April 2025 to February 2026 at the Month 11 inclusion date) and Accident & Emergency Care (for the period March 2025 to mid-March 2026). The percentage of records in the published data:

- Which included the patient's valid NHS number was:
  - 99.93% for Admitted Patient Care (National 99.7%)
  - 99.98% for Outpatient Care (National 99.8%)
  - 99.61% for Accident & Emergency care (National 98.5%)

- Which included the patient's valid General Medical Practice Code was:
  - 99.91% for Admitted Patient Care (National 99.8%)
  - 99.89% for Outpatient Care (National 99.6%)
  - 99.94% for Accident & Emergency Care (National 99.0%)

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.

ULTH's 2025-26 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' in all of the 110 mandatory areas required. The Trust developed an improvement plan which it is working to deliver 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 4 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.

Another audit will be commissioned for later in 2026 to refresh the above and also update on progress against recommendations made.

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 came 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.
- Further work has been undertaken to refine the format and content of the Board Integrated Performance Report and Board Committee Performance Reports (for Quality, Finance, Workforce and Integration Committees). This has included combining metrics into 6 pillars that have an aggregate score similar to the National Oversight Framework methodology, with key metrics that are scoring poorly for escalation and review.
- Work was paused on the application of the Data Quality Kite Mark. This will re-start in early 2026-27 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 is ongoing to implement NerveCentre EPR as a replacement for a number of systems including Careflow PAS and WebV.
- The Clinical Coding department continues to work closely with the 4 Clinical Care Groups 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. This is expected to commence in the first quarter of 2026-27.
- 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 Care Groups in the Trust. Consideration is being given towards the implementation and exploitation of the Federated Data Platform (FDP) where appropriate.

Learning From Deaths

The Lincolnshire Medical Examiners reviews all the Trust's 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 Care Group has an embedded mortality review process to undertake reviews on any death to identify learning. The Mortality Oversight Group (MOG) Meeting 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 (CEG), which upwardly reports to Quality Committee.

Measure	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Comments
Number of patients that have died within ULTH	539	504	602	649	During 2025-26, 2294 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	539	504	602	649	By March 2025, 2388 case record reviews and investigations have been carried out in relation to 2294of deaths included above. In 402 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, 116 cases were also discussed within the Governance Meetings.

Number/percentage of deaths that escalated with problems in care	1	2	1	1	5 deaths representing 0.2% of the patient deaths during the reporting period are 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:

Case record reviews and investigations into deaths have provided valuable insight into both good practice and areas where care can be strengthened. Overall, reviews have highlighted that many patients received compassionate and appropriate care; however, recurring learning themes have been identified to support quality improvement and reduce avoidable harm.

Early Recognition and Escalation

A key area of learning relates to early recognition and escalation of clinical deterioration. In several cases, signs of deterioration were not always identified or escalated promptly, particularly in patients with complex or multiple co-morbidities. This has reinforced the importance of consistent use of physiological monitoring tools, timely escalation in line with escalation policies, and early senior clinical involvement.

Communication & Documentation

Communication and documentation emerged as another recurring theme. Reviews identified occasions where clinical decision-making was not clearly documented, or where information was not effectively shared between teams during handovers or transfers of care. Improved documentation and structured handover processes have been identified as essential to ensure continuity and safety of care.

Care Planning

Learning has also been identified in relation to care planning and individualised decision-making. In some cases, opportunities for earlier discussions around treatment escalation, ceilings of care, and end-of-life planning may have supported more

person-centred care. This has reinforced the need for timely and sensitive advance care planning conversations involving patients, families, and multidisciplinary teams.

Investigations highlighted the importance of multidisciplinary working, particularly for patients with complex needs. Where care was well coordinated across medical, nursing, therapy, and specialist teams, outcomes and experiences were more positive.

Medication

Medication management and adherence to clinical guidelines were also identified as learning points in a small number of cases, including issues relating to prescribing, monitoring, or timely review of medications in acutely unwell patients.

Importantly, reviews consistently demonstrated the value of family engagement and communication. Families reported more positive experiences where they were kept informed, involved in decisions, and given opportunities to ask questions. Learning has focused on supporting staff to communicate openly, particularly following a death.

Description of actions that ULTH have taken in 2025-26 and proposes to take forward in consequence of what the ULTH has learnt.

During 2025–26, ULTH has taken action in response to learning identified through case record reviews, Structured Judgement Reviews (SJRs), and patient safety investigations relating to deaths.

Actions taken during 2025–26 have focused on strengthening the early recognition and escalation of deteriorating patients, improving communication and documentation, and supporting person-centred decision-making. This has included reinforcing the consistent use of physiological monitoring and escalation tools through targeted training, clinical communication, and assurance via governance forums. Learning has been shared at specialty, Care Group, and Trust-wide meetings to support system-wide improvement. In addition, the Trust continues to progress towards the implementation of electronic patient records, which is expected to further enhance documentation quality, information accessibility, and continuity of care.

ULTH has strengthened documentation standards and handover processes, emphasising the importance of clear clinical reasoning, effective multidisciplinary communication, and continuity of care, particularly during transitions between teams and care settings. Where learning identified gaps, these have been addressed through feedback to services, local action plans, and incorporation into education and induction programmes.

In response to learning related to treatment escalation planning and end-of-life care, the Trust has continued to promote timely and sensitive discussions with patients and families. A dedicated Palliative and End of Life (PEOL) Group provides oversight and support to improve practice, share learning, and promote consistent standards across the organisation. Actions have included reinforcing expectations around documenting treatment escalation decisions and ensuring plans are regularly reviewed and effectively communicated across teams.

Learning from investigations has also informed multidisciplinary working, with actions taken to encourage earlier senior clinical involvement and improved coordination of care for patients with complex needs. Initiatives such as Call to Concern have been embedded to empower staff and families to escalate concerns about patient deterioration. Learning themes continue to be shared through morbidity and mortality meetings, safety briefings, and clinical governance structures.

Family engagement and communication following a death have remained a priority in 2025–26 supported by the appointment of a Family Liaison Officer within the Patient safety Team. The Trust has continued to support staff to communicate openly and compassionately with families through duty of candour processes, bereavement support, and learning feedback mechanisms. Communication approaches have been further strengthened through initiatives such as Hear It Your Way, which promotes personalised communication based on individual patient and family needs and preferences.

Together, these actions demonstrate ULTH’s ongoing commitment to learning from deaths, improving patient safety, enhancing communication, and delivering high-quality, compassionate, and person-centred care.

Assessment of the impact of actions which were taken by ULTH during 2025-26.

Overall, the actions taken during 2025–26 have contributed to:

Improved safety culture and confidence in escalation

Clearer documentation and handover practices

More consistent and person-centred end-of-life care

Stronger multidisciplinary collaboration

Improved communication and engagement with families

While continued monitoring and assurance are required to demonstrate sustained impact and measurable outcome improvement, these actions provide a strong foundation for ongoing learning, quality improvement, and the Trust's commitment to learning from deaths.

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	62	17	8	7	94 case record reviews and investigations completed after 31 March 2025, 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	4	0	0	0	4 representing 4.3% of the patient deaths during 1 April 2025 - 31 March 2026 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 2025-26 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:

ULTH has reviewed the NHS Digital data relating to the percentage of patient deaths coded with palliative care at diagnosis or specialty level and considers it to be appropriately described. Mortality data is monitored monthly, sourced from an externally validated provider, and reviewed by the Learning from Deaths team against agreed key lines of enquiry, with established governance and reporting arrangements in place.

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

Strengthening the early identification and coding of palliative and end-of-life care, supported by improved documentation, targeted staff education, and ongoing oversight through established governance arrangements.

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	2021-2022	2023-2024	2024-2025
ULTH EQ:5D index Hip Replacement surgery (L) Low, (H) High	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	Pre Op (L) -0.349 (H) 0.796 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) -0.319 (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	Pre Op (L) -0.239 (H) 1.0 Post Op (L) -0.181 (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	2021-2022	2023-2024	2024-2025
ULTH VAS index Hip Replacement surgery - (L) Low, (H) High	Pre Op (L) 0 (H) 90 Post Op (L) 45 (H) 100	Pre Op (L) 3 (H) 100 Post Op (L) 13 (H) 100	Pre Op (L) 0 (H) 99 Post Op (L) 40 (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) 29 (H) 95 Post Op (L) 35 (H) 93	Pre Op (L) 8 (H) 100 Post Op (L) 15 (H) 100	Pre Op (L) 0 (H) 100 Post Op (L) 13 (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	2021-2022	2023-2024	2024-25
ULTH Oxford hip surgery score (L) Low, (H) High	L – 3 H - 48	L – 3 H - 48	L – 0 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 – 4 H - 46	L – 5 H - 48	L – 1.0 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, 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:

Enhancing pre-operative information and shared decision-making, optimising peri-operative and rehabilitation pathways, and routinely using PROMs data alongside clinical outcomes to drive service improvement.

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	2022-2023	2023-2024	2024-2025
ULTH readmitted within 30 days: 0-15	12.4%	14.7%	11.9%
*National Average: 0-15	12.8%	12.4%	12.5%
Best(B) / Worse(W) National Performance: 0-15	B - 3.7% W - 302.9	B - 1.6% W - 69.1%	B – 1.2% W – 139.5%

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	2022-2023	2023-2024	2024-2025
ULTH readmitted within 30 days: 16+	11.4	12.3	12.9
National Average: 16+	14.4	13.1	13.2
Best(B) / Worse(W) National Performance: 16+	B - 2.5 W - 46.8	B - 1.7 W - 99.6	B – 0.6 W – 120.8

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

The information is derived from nationally defined and consistently applied data definitions, providing a reliable measure of unplanned readmissions within 30 days of discharge. The data is subject to regular review through established clinical and governance processes, enabling the Trust to identify trends, understand contributory factors, and act where required to improve patient care and discharge processes.

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

Strengthening discharge planning and communication, enhancing medicines optimisation and patient information at discharge, supporting timely follow-up and community services, and using readmission data to identify themes and target improvement actions.

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:

Patient experience information relating to the Trust's responsiveness to personal needs is routinely collected through national patient surveys, local feedback mechanisms, and compliments and complaints. This data is reviewed through established governance arrangements and is used to understand patient experience, identify themes, and inform service improvement. The Trust monitors trends over time and triangulates this information with other quality and safety data to provide assurance regarding responsiveness to individual patient needs.

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

Strengthening personalised care through improved communication, continued use of patient feedback to drive service improvement, supporting staff to respond to individual needs, and maintaining oversight through established patient experience and governance arrangements.

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	2023	2024	2025
ULTH Strongly agree (SA) /Agreed (A)	44.3%	48.96%	43.04%
National Average Strongly agree (SA) /Agreed(A)	63.3%	61.5%	60.83%
Best(B) / Worse(W) National Performance	88.8% (B) 44.3% (W)	89.59% (B) 39.72% (W)	88.41% (B) 34.73% (W)

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

Information on whether patients would recommend the Trust as a provider of care is routinely collected through the Friends and Family Test (FFT), which provides consistent and nationally recognised patient feedback. The data is reviewed regularly through established patient experience and governance arrangements and is used to monitor trends, identify areas of good practice, and highlight opportunities for improvement. Feedback is triangulated with other sources of patient experience information to provide assurance regarding the quality of care delivered.

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

Strengthening compassionate, patient-centred care, actively using Friends and Family Test feedback to identify areas for improvement, sharing learning and best practice with staff, and maintaining oversight through established patient experience and governance arrangements.

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	Oct 2025	Nov 2025	Dec 2025
ULTH ED / National Avg/ Best(B)-Worst(W)	ULHT – 72% National – 77% 96% (B) 22% (W)	ULHT – 74% National – 77% 100% (B) 57% (W)	ULHT – 67% National – 78% 100% (B) 53% (W)
ULTH Inpatients/National Avg/ Best(B)-Worst(W)	ULHT – 88% National – 95% 100% (B) 63% (W)	ULHT – 90% National – 95% 100% (B) 76% (W)	ULHT – 89% National – 95% 100% (B) 76% (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:

Information on whether patients would recommend the Trust is collected through the Friends and Family Test (FFT), a nationally recognised and consistent measure of patient experience. The data is routinely monitored and reviewed through established patient experience and governance arrangements, and is triangulated with other feedback sources, including surveys, complaints, and compliments, to provide assurance regarding the quality of care delivered.

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

Continuing to strengthen compassionate, patient-centred care, actively using FFT feedback to identify and address areas for improvement, sharing learning and good practice with clinical teams, and maintaining oversight through established governance and patient experience processes.

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 2025	November 2025	December 2025
ULTH %	92.54%	91.96%	91.91%
National Avg %	91.62%	92.14%	92.37%

Best(B) / Worst(W) National Performance %	(B) 100% / (W) 0%	(B) 100% / (W) 0%	(B) 100% / (W) 0%

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

VTE risk assessment data is routinely collected using nationally mandated definitions and submission processes, providing a reliable measure of compliance. Performance is monitored regularly within the Trust and reviewed through established clinical and governance arrangements to ensure accuracy, oversight, and assurance.

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

Reinforcing compliance with VTE risk assessment requirements at admission, supporting staff education and awareness, improving documentation through electronic patient records, and maintaining regular monitoring and feedback through governance processes.

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	2022-2023	2023-2024	2024-2025
ULTH	25.09	33.25	39.18
National Avg	43.91	46.76	52.96
Best(B)-Worst(W) National Performance	(B) 0 / (W) 133.64	(B) 0 / (W) 131.2	(B) 2.68 (W) 125.25

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

The data is sourced from NHS Digital using nationally agreed definitions and reporting processes and is routinely compared with internal surveillance data to ensure accuracy and consistency. Performance is monitored through established infection prevention and control (IPC) governance arrangements, providing assurance and enabling the identification of trends and areas for improvement.

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

Continuing to strengthen infection prevention and control practices, promoting compliance with antimicrobial stewardship and isolation policies, ensuring timely identification and management of cases, and maintaining regular monitoring, review, and feedback through IPC and Trust governance structures.

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:

Patient Safety Incident data is collected and submitted using nationally agreed definitions and reporting requirements and is routinely monitored to provide assurance. Reporting is actively encouraged across the Trust, supporting an open and transparent safety culture. The data is reviewed through established patient safety, Learning from Deaths, and governance arrangements to identify trends, themes, and learning, including incidents resulting in severe harm or death.

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

Continuing to promote a strong reporting culture, strengthening investigation and learning processes, sharing learning and outcomes with clinical teams, and monitoring themes and actions through patient safety and Trust governance structures to reduce avoidable harm.

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)

The Patient Safety Incident Response Framework (PSIRF) is underpinned by four key principles:

- Compassionate engagement and involvement of patients, families and staff affected by patient safety incidents.
- The use of a range of system-based approaches to learning from incidents.
- Considered and proportionate responses to patient safety incidents.
- Supportive oversight, with a clear focus on learning and improvement rather than blame.

PSIRF is now fully embedded within the organisation. Our approach to incident management has shifted towards learning and improvement, reducing duplication and promoting a positive patient safety culture. There is a strong emphasis on compassionate and meaningful engagement with all those affected by patient safety incidents, including patients, families and staff.

Completion of the transition to PSIRF has strengthened our understanding of the impact of systems and human factors on patient safety incidents. Investigations now focus on understanding what happened and why, rather than who was involved, supporting the development of a just, learning and improvement-focused culture.

Not all serious patient safety events will require a Patient Safety Incident Investigation (PSII). A range of alternative and proportionate learning responses is now available,

including After Action Reviews, Multi-Disciplinary Team Reviews and clinical audit. These approaches enable timely, meaningful learning while ensuring that the response to incidents is appropriate to the level of risk and harm.

Under PSIRF, there is also enhanced support and involvement for staff and others affected by patient safety incidents, recognising the importance of psychological safety and staff wellbeing in delivering safe, high-quality care.

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur when the relevant preventative measures are in place. Historically, Never Events have been defined as incidents that are wholly preventable because strong systemic protective barriers exist at a national level and should be implemented by all healthcare providers.

During 2024-25, NHS England commissioned a review of the Never Events framework. This review concluded that future approaches should:

- Place greater emphasis on learning and improvement rather than strict definitions linked to the perceived strength of barriers.
- Reflect patient safety events of greatest concern to patients and the NHS.
- Better include patient safety events across all sectors and settings, including mental health and primary care.
- Align with the Patient Safety Incident Response Framework (PSIRF), supporting proportionate learning and response.
- Promote a just culture in which staff feel confident to report incidents and near misses.
- Target resources towards activities with the greatest potential for safety improvement.
- Better recognise the inherent complexity of healthcare delivery.

The Trust supports this evolving national approach and remains committed to the identification, reporting and robust investigation of Never Events, ensuring that learning is shared and actions are embedded to reduce the risk of recurrence.

Never Events reported April 2025 - March 2026

During the reporting period, the Trust recorded one Never Event:

- Patient administered the wrong blood transfusion.

A Patient Safety Incident Investigation was undertaken in line with PSIRF principles. Key learning identified included:

- Human factors influence, including time of day, workforce pressures, and operational demand.
- Equipment-related issues, impacting safe checking and administration processes.

As a result of the investigation, the Trust has:

- Strengthened existing policies and clinical guidelines relating to blood transfusion safety.
- Reinforced human factors awareness within clinical teams.
- Reviewed and addressed equipment reliability and availability.
- Shared learning across services to support organisational-wide improvement.

The Trust continues to focus on learning, system improvement and staff engagement to enhance patient safety and reduce the likelihood of recurrence.

Safety Culture

An Interim Head of Organisational Culture was appointed to lead the relaunch of the Lincolnshire Community and Hospitals Group (LCHG) Way. This refreshed approach will incorporate organisational culture principles aligned to key Patient Safety workstreams, providing further opportunities to embed the Just Culture/Being Fair Tool across the Group.

This work will enable the Group to bring together and consider all safety culture intelligence collected both locally and nationally, developing a single, overarching workstream focused on supporting a positive safety culture. This will help ensure that staff feel confident and psychologically safe to raise concerns, and that patients feel safe when accessing our services.

National Oversight Framework

NHS England has introduced the new NHS National Oversight Framework, which provides a consistent national approach to assessing the performance of NHS trusts. The framework comprises 22 key metrics across six domains, which together determine an organisation’s segment rating, ranging from Segment 1 (highest level of oversight) to Segment 5.

The results are published quarterly and presented in a national league table, providing a clear and accessible overview of organisational performance. This enables our partners, peer organisations, regulators and, importantly, our patients and the public to understand how we are performing against critical measures such as access to services, patient safety, and standards of care. The Trust has been rated Segment 4 in the latest results (quarter 3) moving up 16 places in the national league table for acute trusts during the quarter. This improvement reflects enhanced performance across several priority areas, including:

- Access to urgent and emergency care.
- Timeliness of cancer pathways.
- Strengthened infection prevention and control measures.

While the Trust remains in Segment 4, the improved trajectory demonstrates the positive impact of targeted improvement actions and continued focus on patient safety and access.

Patient stories

At Group Board Meetings, patient stories are presented to provide insight into patient experience and learning. Following each Board meeting, these patient stories are shared with staff via digital newsletters, alongside other key organisational updates. Patient stories are also presented to the Patient Experience Group as part of divisional assurance reporting, supporting ongoing oversight, reflection and improvement.

Bereavement care in Emergency Departments

The Board heard from a mother, who bravely shared her experience following the death of her nine-day-old daughter at Lincoln County Hospital. She spoke with honesty and courage about her experience and about the significant work she has undertaken since, using her story to help improve care for other families experiencing bereavement across Lincolnshire's hospitals.

She described how her and her family had to say goodbye in a busy resuscitation department, and the emotional impact this environment had at an incredibly distressing time. Following this experience, she has worked in partnership with the hospital to help redesign bereavement support within Emergency Departments. Through her ideas, insight and feedback, purpose-built family rooms were developed to provide a calm, private and supportive space for bereaved relatives. These rooms allow families time to process difficult news, spend time together and say goodbye to loved ones with dignity. As a direct result of this work, two new family rooms are now in place within the Emergency Departments at Lincoln County Hospital and Pilgrim Hospital, Boston. The rooms are well used and thoughtfully equipped with appropriate seating, lighting and facilities to help

families feel safe, supported and comfortable during some of the most difficult moments of their lives.

This story demonstrated the powerful impact of learning from lived experience, meaningful co-production with families, and the lasting improvements that can be achieved through compassionate partnership working.

Improving patient experience in the Intensive Care Unit (ICU), Lincoln County Hospital

The Board heard how colleagues working in the Intensive Care Unit (ICU) at Lincoln County Hospital have introduced meaningful improvements to enhance patient and family experience. Heather Baker, Advanced Clinical Care Practitioner, and Rebecca Cook, ICU Sister, recognised the psychological and emotional impact that receiving care in ICU can have. Time spent in ICU can be traumatic for patients and their families, with some patients reporting memory gaps following periods of sedation, which can make recovery and adjustment particularly challenging. In response to patient feedback, the team introduced two key initiatives:

- Patient diaries, introduced in January 2024, which allow healthcare professionals and family members to record notes during a patient's ICU stay. These diaries help patients to fill memory gaps by documenting recovery progress and significant moments that would matter to the individual, such as visits from loved ones or even the results of their favourite football team.
- An ICU support group for former patients, which has been running every three months since September 2023. Importantly, the group meets outside of a hospital setting, helping to avoid triggering further trauma that may be associated with returning to a clinical environment.

As part of the story, John and his wife Christine shared their experience. John described collapsing following a cardiac arrest and subsequently being admitted to ICU. Both John and Christine now attend the support group and spoke about how it has helped them to normalise their experiences, share their struggles, and connect with others who have been through similar circumstances.

While the improvement ideas were relatively simple, the Board heard how they have had a profound impact on patient experience. Both initiatives were developed directly in response to listening to patient feedback, demonstrating the value of co-production and compassionate innovation in care delivery. The team also shared plans to spread this

learning more widely across the Group. The story can be viewed at www.youtube.com/watch?v=bI73EXN1r6o

Call for Concern – Martha's Rule

NHS Trusts in England have worked to implement 'Call for Concern', an initiative which forms a key part of 'Martha's Rule' in reference to Martha who was a 13-year-old who tragically died in 2021 with sepsis. Martha's parents raised concerns that her condition was deteriorating but these were not acted upon.

Call for Concern is a component part of Martha's Rule and is designed to ensure we learn from this case by proactively offering a service that allows patients, families, and their carers to contact a specialist team for immediate, impartial, assessment of any concerns they may have about the worsening clinical condition to robustly detect deterioration.

Within the Trust, the Call for Concern service is coordinated by the Critical Care Outreach Team at Pilgrim Hospital Boston and Lincoln County Hospital, which specialises in the care of people who are very unwell and whose condition may be worsening. The team are available 24 hours a day, seven days a week to support the ward teams by assessing and reviewing patients, as well as offering advice to nurses and doctors on how to manage the patient's condition. This service is available for both adult and children in-patient services and will also be shortly rolled out at Grantham Hospital.

The initiative is signposted to patients, families, carers and staff throughout the Trust's hospitals and guidance is available in the form of patient information. The team is established to support when there are concerns of significant changes in a patient's condition and these concerns have not been satisfactorily addressed with the ward team.

Other feedback or general questions or concerns, not related to deterioration in clinical condition, is supported through ward teams or the Patient Advice and Liaison Service (PALS) being available to listen and support.

To ensure the Call for Concern process is effective and remains a key facet of the Trust's work to improve patient experience and safety, monthly updates and key data indicators are presented to the Trust's Deteriorating Patient Group which upwardly reports to the Patient Safety Group. This reporting mechanism enables the Quality Committee, a sub-committee of the Group Board to remain sighted and to provide assurance to Board. Learning is also shared within Care Group specific Clinical Governance meetings.

In addition, data from the Trust is routinely shared with NHS England alongside regular meetings with regional and NHS England teams to ensure the process is compliant with national standards and support if needed.

Aspiring Physiotherapy

The Talent Academy successfully delivered its first Aspiring Physiotherapy event on Thursday 10 and Friday 11 April at Lincoln County Hospital. Young people aged 14 to 18 from across Lincolnshire who were successful in securing a place attended this two-day programme. Participants took part in supervised clinical skills sessions and attended engaging presentations from experienced physiotherapy professionals, providing valuable insight into physiotherapy careers and supporting future workforce development.

Community Diagnostic Centre Development - Boston

During the summer, the Trust submitted plans for the development of a new Community Diagnostic Centre (CDC) in Boston, located on the site of the former Boston United football ground and that the proposal has now been granted full planning permission.
The new £24.9 million purpose-built facility will significantly increase local diagnostic capacity and improve access to timely investigations for the population of Boston and surrounding areas. The centre will provide a range of diagnostic services, including:

- X-ray
- Computerised Tomography (CT) Scans
- Magnetic Resonance Imaging (MRI)
- General medical ultrasound

In line with our established Community Diagnostic Centres in Grantham, Lincoln and Skegness, the Boston CDC will also provide opportunities to explore the co-location of additional community-based clinical services. This will support integrated care delivery and contribute to improved patient experience by reducing the need to travel to acute hospital sites.
This development represents a key investment in modern diagnostic infrastructure and supports the Trust's ambition to improve early diagnosis, reduce waiting times, and deliver care closer to home.

Seven-Day Services

The Seven-Day Hospital Services (7DS) programme was established to support acute providers to deliver consistently high-quality care and improved outcomes for patients admitted as emergencies, regardless of the day of the week.

The Trust is committed to providing equitable access to high-quality care 24 hours a day, seven days a week. As part of this commitment, the Trust continues to participate in the national seven-day services audits, which assess performance against the four nationally

defined 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 has a number of workstreams focused on improving patient flow and reducing unwarranted variation in care delivery. While many services currently operate on a seven-day basis, some areas continue to demonstrate variation between weekday and weekend provision. There is, however, strong clinical leadership and commitment across Care Groups to further develop seven-day working.

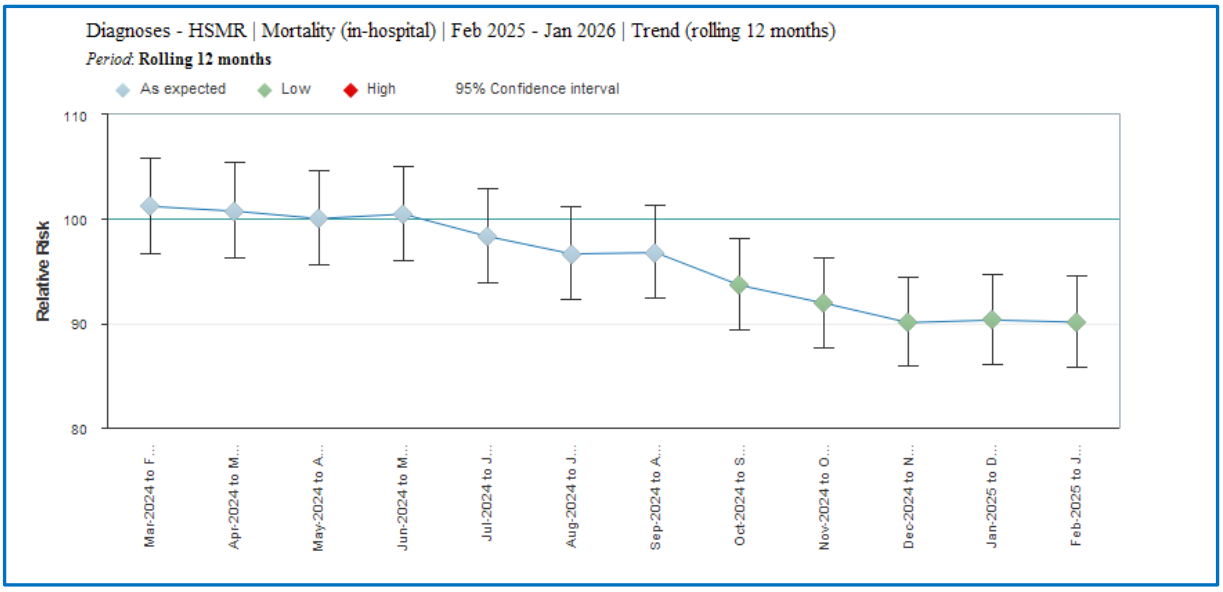
The establishment of the Group with Lincolnshire Community Health Services (LCHS) provides additional opportunities to strengthen patient pathways, enhance integration across acute and community services, and support further progress towards consistent seven-day service delivery.

HSMR/SHMI

HSMR

The Hospital Standardised Mortality Ratio (HSMR) is a nationally recognised indicator of healthcare quality. It compares the number of observed in-hospital deaths with the number that would be statistically expected, taking account of factors such as patient age, diagnosis, and comorbidities.

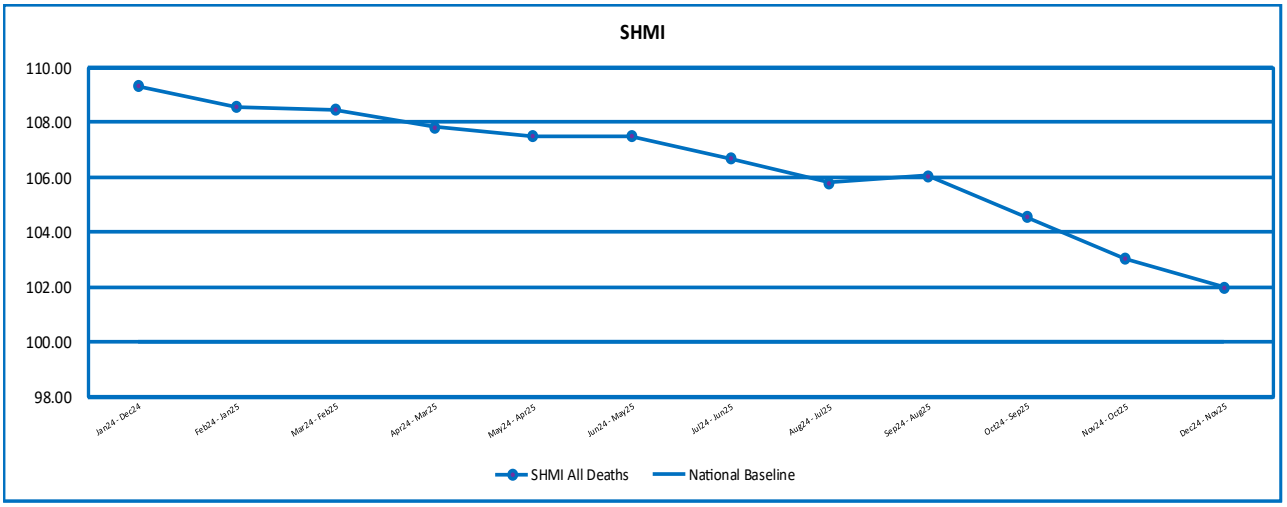
At the time of writing, the most recent rolling 12-month HSMR for the Trust relates to the January 2025 to December 2025 Dr Foster report. The Trust's HSMR for this period is 90.01, placing it within the 'Low' banding, indicating that mortality is lower than expected.



SHMI

The Summary Hospital-level Mortality Indicator (SHMI) is a national mortality measure that includes deaths occurring in hospital and within 30 days of discharge. The indicator is adjusted for a range of patient-level factors and is benchmarked against the national average, which is set at 100. A score below 100 represents lower-than-average mortality, while a score above 100 is within the expected range unless identified as an outlier.

The Trust's SHMI for the period December 2024 to November 2025 (noting a six-month national reporting lag) is 102.03, which is classified as 'As expected'. It is recognised that SHMI is not designed to enable direct comparison of mortality outcomes between NHS Trusts, but rather to support internal trend analysis and assurance.



Mortality Oversight (MOG) Group

The Mortality Oversight Group (MOG) meets monthly and provides Trust-wide oversight of all mortality review processes. This includes the Learning from Deaths framework and other mortality review activities undertaken across Care Groups.

The Group plays a key role in promoting a positive learning culture, supporting the identification, sharing and dissemination of learning arising from mortality reviews, in line with the Trust's Learning from Deaths policy. Monthly mortality review outputs and targeted actions from Care Groups are considered in detail, alongside progress against agreed improvement plans.

Over the past year, significant focus has been placed on strengthening the role of MOG to enhance its oversight of the end-to-end mortality review process across the Trust. The Group is also responsible for monitoring key mortality indicators, including HSMR and SHMI, and for identifying and escalating any emerging concerns.

Assurance and learning from the MOG are formally reported through a quarterly report to the Clinical Effectiveness Group, with onward escalation to the Quality Committee and Trust Board. MOG also provides a valued forum for shared learning, reflection, and challenge, supporting continuous improvement in the quality and safety of care.

Patient Falls

Falls prevention remains a key patient safety priority for the Trust. Our aim is to reduce avoidable inpatient falls and associated harm through sustained quality improvement and collaborative working across the Group and wider system.

Falls continue to be among the most frequently reported patient safety incidents in NHS hospitals, particularly affecting older patients with frailty, reduced mobility and complex needs. Nationally, around 30–50% of falls result in injury, reinforcing the importance of effective prevention and timely intervention.

During 2025-26, the Trust recorded an increase in overall falls; however, levels remain below those seen in 2022-23 and there has been no associated rise in harm. This is reassuring given increasing admissions, higher occupancy and greater patient acuity. Reducing falls and minimising harm remain priority quality and safety objectives.

The Trust target for falls resulting in moderate, severe or fatal harm is 0.19 per 1,000 occupied bed days (OBD). Performance has remained below this target for 34 of the last 36 months, with no sustained periods of deterioration. Despite rising occupied bed days,

increases in activity have not been associated with increased harm, demonstrating the effectiveness of improvement actions in mitigating risk.

Key Achievements

- The Falls Prevention Steering Group provides monthly multidisciplinary oversight and reports to the Patient Safety Group, with patient stories used to support learning.
- Falls prevention assurance is embedded within the Quality Accreditation Programme, supported by ward-level audits and executive oversight.
- Over 370 Harm Free Care certificates have been awarded, recognising sustained periods without patient falls.
- The Focus on Falls initiative has expanded, offering targeted support and practical recommendations for areas with higher fall rates.
- Education has been enhanced through bite-sized learning sessions delivered during handovers and safety huddles.
- The Falls Ambassador programme has been strengthened with clearer role expectations and regular collaborative huddles.
- The Continence Pathway has been updated to reflect the link between toileting needs and falls.
- Digital and sensor-based technologies are being explored, with pilot sites identified in higher-risk areas.
- Falls resources on the Trust intranet have been redesigned into a single, accessible hub.

Priorities for 2026-27

- Continue to reduce avoidable falls and associated harm.
- Further develop the Focus on Falls support offer and Falls Ambassador programme.
- Strengthen education and awareness of deconditioning and safe mobility.
- Explore digital and technological solutions to support falls prevention.
- Increase integration of falls improvement work across the Group and system.

Pressure Ulcers

Pressure ulcer prevention remains a key patient safety priority for the Trust. Our aim is to reduce hospital-acquired pressure ulcers through sustained quality improvement, supported by education, training and increased staff and patient awareness.

During 2025-26, the overall number of hospital-acquired pressure ulcers increased for the first time in four years. This increase has occurred alongside rising admissions and a higher proportion of patients with complex needs and increased vulnerability to skin damage. Despite this, pressure ulcer prevention remains a core focus for the Trust.

The total number of Category 3 and 4 pressure ulcers, representing the most severe harm, achieved the Trust's threshold targets. While the threshold for Category 2 pressure ulcers was exceeded, rates per 1,000 bed days demonstrated predominantly common cause variation with reduced variability. This indicates that preventative measures are effectively limiting the severity of harm.

The Trust continues to monitor Deep Tissue Injuries (DTIs) and Moisture Associated Skin Damage (MASD). DTI numbers have remained stable over the last four years. However, an increase in patients admitted with pre-existing MASD reflects growing patient vulnerability and has contributed to a rise in hospital-acquired MASD incidents. Thematic reviews have informed targeted improvement actions to address this risk.

Key Achievements:

- Skin integrity assurance is embedded within the Quality Accreditation Programme, supported by weekly ward reviews, Matron audits and monthly executive oversight.
- Harm Free Care certificates continue to recognise excellence, with 28 clinical areas achieving one year pressure ulcer harm-free care, including areas achieving two and three consecutive years.
- The Skin Integrity Group meets monthly, providing multidisciplinary oversight, accountability and shared learning informed by patient stories.
- A successful Tissue Viability Month and Group Stop the Pressure Day Conference supported staff engagement, learning and system-wide collaboration.
- Mandatory Tissue Viability eLearning was strengthened in line with national best practice.
- The Tissue Viability Ambassador programme expanded to 95 ambassadors, with evidence of reduced pressure ulcer incidents in areas supported by ambassadors.
- Monthly Pressure Ulcer Prevention Bulletins continue to share targeted learning based on incident trends.
- System-wide collaboration has continued, including regional improvement programmes and alignment of wound care practice through an updated Group Wound Formulary.
- Patient-facing national pressure ulcer prevention leaflets have been embedded to support shared responsibility for skin care.
- Improvements have been made to medical device use, emergency department standards and MASD prevention, including the introduction of a new skin wash.

Priorities for 2026-27

- Continue quality improvement to reduce hospital-acquired pressure ulcers.
- Improve digital support for tissue viability, including clinical photography.
- Strengthen joint improvement work across the Group and system.
- Deliver system-wide educational webinars for professionals and communities, including end-of-life skin integrity care.
- Align daily skin assessments regionally and transition from the Waterlow tool to PURPOSE T.

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:

	2023-24	2024-25	2025-26
New complaints received	1044	1273	1775

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
- Appointments

Examples of learning from complaints:

End of Life Care and Clinical Decision Making

Learning from this case reinforced the importance of timely, consistent and patient-centred decision making in end-of-life care, particularly regarding symptom control and the use of syringe drivers. Actions taken include sharing the patient story at a multidisciplinary meeting, providing additional staff training on appropriate initiation of syringe drivers, and reinforcing expectations for timely, compassionate decision making.

Medication Delays

Delays in medication administration were identified as causing unnecessary distress. Actions include improving handover processes, monitoring time-critical medications at ward level, and reinforcing escalation expectations if delays are anticipated.

End of Life Discussions and Compassion

Learning highlighted the importance of timely, sensitive end of life discussions and compassionate care. Actions include ward-based reflection on creating protected time for conversations and reinforcing expectations around reassurance, respect and calm environments.

Diagnostic Imaging and Specialist Review

Learning was identified following a delay in acting on the results of a specialist radiology report. In response, a number of actions have been implemented, including ensuring that all out-of-hours paediatric scans are reviewed by a specialist neuro-radiologist and that clinical decisions are based on formal specialist reports.

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 2025-26 PALS dealt with 10,033 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.

Equality Diversity and Inclusion

United Lincolnshire Teaching Hospitals NHS Trust, as part of Lincolnshire Community and Hospitals NHS Group (LCHG), is committed to promoting Equality, Diversity and Inclusion (EDI) across all protected characteristics set out in the Equality Act 2010. The Trust has a range of policies and procedures in place to support this commitment, with Equality Impact Assessments used as the primary mechanism to ensure legislative requirements are met when developing policies, practices and services.

EDI activity is overseen through the Group EDI Group, chaired by the Deputy Director of People and comprising key stakeholders from across LCHG. From a governance perspective, the group reports to the Trust Board via the People Committee.

During 2025/26, the Trust met all statutory and contractual EDI requirements, including:

- Publication of the EDI Annual Report and Equality Objectives
- Publication of Gender Pay Gap, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data, reports and action plans
- Completion of the NHS Equality Delivery System (EDS)
- Ongoing delivery of the NHS EDI Improvement Plan and associated High Impact Actions
- Implementation of the NHS Sexual Safety Charter

All publications are available on the Trust website.

Staff networks and engagement

The Trust continues to value its established Staff Networks, which support colleagues from diverse backgrounds and positively influence patient care. Each network is supported by executive sponsorship. In 2025, ULTH and LCHS staff networks formally aligned to become LCHG-wide Staff Networks, reflecting the Group structure. Current networks include:

- Armed Forces
- Carers
- MAPLE (Mental and Physical Lived Experience)
- Men’s
- PRIDE+

- REACH (Race, Ethnicity and Cultural Heritage)
- Women's

Networks meet regularly and deliver annual programmes of activity, using both face-to-face and virtual approaches. Key highlights are included in the EDI Annual Report.

The Trust maintains strong national and regional links through engagement with NHS England and NHS Employers. During 2025-26, progress continued with the Group Reverse Mentoring Programme, alongside a bespoke Board EDI Development Programme delivered in partnership with external providers. Board members hold both individual and collective EDI objectives aligned to the NHS EDI Improvement Plan. Further progress has been made towards a single Group-wide EDI function, ensuring consistent and joined-up delivery across LCHG. While statutory reporting continues separately for each legal entity, data is reviewed at Group level, with shared action plans developed to drive improvement across the system.

Freedom to Speak Up

The Trust has met its contractual requirement to appoint a Freedom to Speak Up Guardian (FTSUG) since 2016. In 2021, a full-time Guardian was appointed, demonstrating the Trust's commitment to listening to staff and ensuring concerns are raised and addressed safely and effectively. The FTSUG has lead responsibility for overseeing the appropriate handling of concerns and for providing assurance to the Board on the effectiveness of local speaking up arrangements.

The Trust has embedded the national NHS Freedom to Speak Up Policy within its local Voicing Your Concerns policy, clearly setting out how staff can raise concerns, the support available, and the process to be followed. The policy includes explicit protections against detriment or disadvantage, providing reassurance that staff who speak up in good faith will be supported. Feedback is routinely sought following the closure of cases to ensure actions have been taken and to identify learning and service improvement opportunities.

A dedicated database and dashboard have been developed to support oversight and learning. These capture key intelligence including case numbers, themes, staff groups and protected characteristics. Follow-up activity continues for up to 12 months after case closure to identify any potential detriment or disadvantage. An anonymous reporting tool is available via the Trust intranet, alongside multiple opportunities for staff engagement, including drop-in sessions that cover weekday, twilight and weekend shifts across all sites. The FTSUG also supports a regular virtual drop-in session with the Group Chair and Maternity Safety Champion.

Speaking Up training is now included as core learning for all staff, with Freedom to Speak Up covered at corporate induction. Board members, including Executive and Non-Executive Directors, have completed dedicated FTSU development and follow-up training, and the Non-Executive Director Champion has undertaken National Guardians Office development. The Board self-assessment Reflection and Planning Tool were completed as part of a Board development session. Any gaps identified will be addressed through agreed actions across the Trust. The assessment is undertaken on a biennial basis, with the next review scheduled for 2026.

Guardians of Safe Working

The Guardian of Safe Working Hours (GoSW) continues to play a vital role in ensuring patient safety by safeguarding doctors in training from working excessive hours and supporting a culture of openness, protection and prevention. Operating independently from the Trust's operational management, the Guardian is responsible for upholding the safeguards within the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. This includes ensuring compliance with safe working hours, intervening where exceptions occur, and providing assurance to the Trust Board that working patterns remain safe, sustainable and well governed. The Guardian is supported by the Guardian of Safe Working Officer, enabling robust oversight of reporting processes and timely escalation of concerns.

Exception Reporting – System Strengthening and 2026 Developments
From 04 February 2026, the Trust implemented a series of national reforms to exception reporting, introduced by NHS Employers as part of the updated 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. NHS Employers issued formal guidance to all organisations, requiring full adoption of the new processes by this date.

These reforms stem from the national framework agreement and updated 2016 TCS (Version 13), which outline substantial changes to the governance, reporting routes, accountability structures and financial safeguards associated with exception reporting. Throughout 2026, the Trust has strengthened its internal processes to ensure full compliance with these national requirements. Key developments include:

- Improved accessibility and clarity.
- Strengthened feedback and closure mechanisms.
- Enhanced monitoring and earlier theme identification.

These improvements, driven by NHS Employers and embedded into the updated 2016 Terms and Conditions of Service, ensure that exception reporting continues to act as a core mechanism for maintaining safe working hours, protecting doctors' wellbeing, and supporting a high-quality training environment.

Resident Doctor Forums and Engagement

The office of the Guardian continues to hold regular Resident Doctor Forums. These forums remain well attended and provide an open, psychologically safe space. Matters raised at the forums are escalated to senior management, resulting in timely actions and improved responsiveness. In addition, issues discussed within the forums are reviewed at the regular Resident Doctors' Committee meeting. The Guardian's Office now attends Resident Doctors' teaching sessions to deliver updates on exception reporting processes, contractual requirements and any changes to national guidance. These sessions support increased awareness, promote accurate reporting and strengthen understanding of exception reporting processes across all doctor groups.

Reporting to the Trust

The Guardian provides both quarterly and annual reports to the People and Organisational Development Committee. These reports include:

- The number of exception reports submitted.
- Trends by specialty, grade, location and issue type.
- Data relating to working hours, rota patterns, education and immediate safety concerns.
- Emerging themes and recommended actions.

These insights are used to drive continuous improvement within the Trust.

The Guardian's Office provides quarterly and annual reports which are presented at the People and OD Committee meetings and MSNF.

Support for Locally Employed Doctors (LEDs)

The Guardian's Office has maintained and strengthened its commitment to ensuring Locally Employed Doctors receive the same level of support as doctors in training.

LEDs now submit exception reports using the same Allocate system as postgraduate (deanery) trainees, ensuring consistency, equity and a unified reporting experience across all doctor groups. For governance and monitoring purposes, LED data is separated within Allocate, allowing clear reporting lines, accurate analysis and appropriate escalation routes for both trainee and LED groups. This approach ensures that LEDs benefit from the same

protections and safeguards, while enabling the Trust to monitor themes and respond to concerns effectively and efficiently.

Medical Workforce Programme

The remit of the Medical Workforce Programme for 2025/26 was to focus on reviewing temporary spend, best practice in rostering and the move to digitalisation of medical rotas. To support this a Medical Temporary Staffing Solutions Group was established which reviewed each specialty on a rolling programme. The Programme has been further refined for 2026/27 to build on the work already undertaken with the introduction of a new Temporary Spend Operational Group which will meet fortnightly initially to review and plan temporary spend with the Care Groups. It will also have a focus on how we can review and manage rotas more effectively and to sure appropriate contractual compliance, and wellbeing.

The Medical Workforce Team continues to work with Care Groups to prioritise quality improvements in developing rosters that comply with best practice and guidelines. Local guidance has been developed to support both the creation of new rotas and the management of rotas on an ongoing basis.

To support the digitalisation of medical rotas the Trust uses a platform called HealthMedics. All Resident Doctors are now on HealthMedics for the requesting and approval of leave which provides the doctors more flexibility in viewing leave records remotely and making leave requests. 70% of Resident Doctors are now on HealthMedics for the purpose of shift-based rostering. There is an ongoing implementation plan to move the remaining 30% of Resident Doctors on to the digital platform which will eliminate the need for spreadsheets. This is a significant step towards standardisation across the Trust and supports the achievement of national objectives.

In addition, the Trust has implemented the new national Exception Reporting Reforms on time with effect from 4th February 2026. The reforms provide a clear process for the management of both educational exception reports and hours exception reporting along with enhanced provision for access to data and confidentiality requirements.

Nationally a Ten Point Plan was introduced for Resident Doctors which covers required improvements for all Trusts to implement and measure against including such things as

payroll errors, the creation of Peer Leads, improved management of annual leave and improved facilities. The Trust has been acknowledged as an exemplar in this area with presentations delivered externally to highlight our approach and progress. This work will continue to be monitored and reported to Trust Board.

The Trust has a dedicated team within the Chief Medical Officer (CMO) who support Resident Doctors by ensuring that their rotas and pay are correct and that they have the correct work schedules. The Team have previously consistently delivered 99- 100% compliance for the issuing of work schedules in accordance with the Code of Practice.

Annex 1: Stakeholder Comments

NHS Lincolnshire Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

NHS Lincolnshire Integrated Care Board (ICB) welcomes the opportunity to review and comment on United Lincolnshire Teaching Hospitals (the Trust) Annual Quality Account 2025/26.

The three priorities identified for 2025/2026 had been aligned to those within Lincolnshire Community & Hospital Group Strategy. These priorities were:

- 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 commissioners commend the Trust on their achievements. Specific highlights of achievements include:

- The evolvement of the PSIRF approach with patterns and themes of incidents being considered and cross-organisation learning used to improve broader organisational ways of working rather than in isolation
- The triangulation of information relating to incidents, complaints, patient feedback, safeguarding and learning review to respond to areas where services are not achieving best practice
- The positive steps being taken towards improving patient flow with the intention to reduce Emergency Department waiting times
- Continued focus on infection prevention and control standards, utilising PSIRF to learn from incidents and work completed in relation to antimicrobial stewardship
- Collaborative work on falls prevention and pressure ulcer reduction with the Trust actively involved with system and regional falls prevention meetings ensuring learning is shared and acted upon

Looking forward to the coming year, following consultation with a range of stakeholders including the Quality Committee, the same key priorities have been identified for 2026/27 as they remain central to delivering high-quality, safe and effective care. The ICB acknowledges that further improvement is required in some areas, and this approach will ensure continued focus on a strengthened patient safety culture where improvements are not only achieved but are also sustained and fully embedded across the organisation.

The current CQC rating for the Trust is Requires Improvement which was awarded in February 2022 following an unannounced inspection in October 2021. The ICB note that that the CQC carried out short notice announced inspections of the medicine assessment service group at Pilgrim Hospital in January 2026 and End of Life services at Grantham Hospital in March 2026. The ICB welcomes the action taken based on the initial feedback received while the Trust awaits the final reports.

The commissioners would like to thank United Lincolnshire Teaching Hospitals, who have continued to work closely with partners in the Lincolnshire Health System to ensure patients' needs are met.

NHS Lincolnshire Integrated Care Board looks forward to working with the Trust over the coming year to further improve the quality of services available for our population, to deliver better outcomes and optimal patient experience.

Yours sincerely,

Rebecca Neno
Director of Quality, Safety and Improvement

ULTH Quality Account Statement

Healthwatch Lincolnshire values the positive and constructive relationship we continue to have with United Lincolnshire Teaching Hospitals NHS Trust (ULTH). We welcome the Trust's commitment to engaging with patients, carers, staff and stakeholders to identify areas for improvement and to ensure that patient experience remains central to the delivery of healthcare services across Lincolnshire.

We recognise the scale of the challenges facing acute hospital services nationally and acknowledge the considerable efforts being made by the Trust to improve quality, patient safety and patient experience whilst responding to increasing demand. We particularly welcome the Trust's continued focus on learning from incidents, responding to patient feedback and embedding a culture of continuous improvement.

Looking Back – Quality Priorities for 2025/2026

Healthwatch Lincolnshire welcomes the progress made against the Trust's three quality priorities during 2025/26 and supports the decision to continue these priorities into 2026/27 to ensure improvements become fully embedded across the organisation.

We particularly highlight:

- The continued implementation of the Patient Safety Incident Response Framework (PSIRF), promoting a stronger learning culture focused on identifying patterns, themes and system-wide improvements rather than isolated incidents.
- The Trust's use of triangulated patient safety reporting, bringing together information from incidents, complaints, patient feedback, safeguarding concerns and learning reviews to identify recurring themes and opportunities for improvement.
- The focus on reducing serious patient harm, alongside efforts to improve learning from incidents and strengthen organisational safety culture.
- The Trust's commitment to research and innovation, including recruiting more than 1,600 patients into research studies during the year and increasing opportunities for Lincolnshire residents to participate in research that may improve care and outcomes.

Priorities and Challenges for the Forthcoming Year

Healthwatch Lincolnshire supports the Trust's decision to continue its three quality priorities for 2026/27:

- Maximising patient safety through learning from incidents and reducing harm.
- Delivering improvement in areas that do not fully meet best practice requirements.
- Improving the key themes identified through patient feedback, particularly communication, appointments and clinical treatment.

We also support the Trust's commitment to improving communication with patients and families, strengthening learning from complaints and feedback, and responding more effectively to concerns in real time. These are areas that Healthwatch Lincolnshire continues to hear about regularly from local people and where improvements can have a significant impact on patient experience.

We recognise that the Trust continues to face challenges relating to demand, infrastructure, infection prevention requirements and maintaining timely access to services.

Themes and Trends in Feedback from the Last 12 Months

Over the past year, Healthwatch Lincolnshire has continued to hear feedback from patients, carers and families accessing hospital services across Lincolnshire. Whilst many people tell us about compassionate staff and positive experiences of care, several recurring themes continue to emerge.

Access to Services and Waiting Times

Access remains one of the most significant concerns raised with Healthwatch Lincolnshire. People continue to tell us about long waits for appointments, diagnostic tests, treatment and emergency care. Delays can create uncertainty and anxiety for patients and families, particularly where communication regarding waiting times is limited. It is therefore encouraging to see waiting times identified as one of the Trust's key improvement priorities.

Communication

Communication remains one of the most common themes raised through Healthwatch Lincolnshire feedback. Patients frequently tell us they would like clearer information about their care, treatment options, appointments, discharge arrangements and any delays they may experience.

Clinical Care and Patient Experience

We continue to hear that patients value being treated with dignity, respect and compassion. However, some people report concerns regarding consistency of care, involvement in decision-making and understanding what to expect from their treatment.

Coordination of Care

We continue to hear about the importance of coordinated care across departments and services, particularly for people with complex needs or multiple appointments. Patients often tell us that better communication between teams and clearer information sharing would improve their overall experience and confidence in the care they receive. The development of the Patient Services Hub and wider work to improve coordination and patient flow has the potential to resolve this issues and concerns.

Healthwatch Lincolnshire remains committed to working collaboratively with ULTH to ensure that the experiences and views of patients, carers and communities continue to inform service development and quality improvement. We look forward to seeing the impact of the Trust's ongoing work to improve patient safety, patient experience and clinical outcomes for people across Lincolnshire.

Health Scrutiny Committee for Lincolnshire Statement on the *Quality Account* for 2025/26 of the United Lincolnshire Teaching Hospitals NHS Trust

Introduction

The Health Scrutiny Committee for Lincolnshire is the statutory body through which elected councillors scrutinise the work of NHS organisations. The Committee welcomes the opportunity to review the draft *Quality Account* for 2025/26 and recognises the Trust's continued commitment to transparency and improvement. The Committee values its role as a critical friend and offers the following comments to support further strengthening of the document.

Progress on Priorities for Improvement for 2025/26

The Committee recognises that the Trust has made progress against its stated priorities and understands the rationale for carrying these forward into 2026/27. Improvements in learning from incidents and the further embedding of the Patient Safety Incident Response Framework are particularly welcome.

However, the Committee also notes that a number of recurring challenges remain. These include long waits in Emergency Departments, delays in diagnosis and treatment, medication issues, falls, pressure ulcers and communication. The Committee is particularly concerned that delays between the decision to admit, and allocation of a bed continue to impact patient flow and experience and would welcome greater clarity on improvement actions in this area.

Falls increased overall during 2025/26, and hospital-acquired pressure ulcers rose for the first time in four years, albeit with severe harm thresholds maintained. Given the recognised increase in patient vulnerability, including within community settings, the Committee would welcome clearer evidence of how the Trust is working with system partners to prevent harm earlier and mitigate risks across the whole pathway. In relation to pressure ulcers, the Committee would welcome further assurance on the reasons for the increase in hospital-acquired cases and clearer actions to reduce significant harm, including prevention at the point of admission and continuity of care into the community.

The Committee recognises the rationale for focusing on infection prevention and control as Priority 2 and notes the reported compliance with the majority of Hygiene Code criteria. However, the remaining areas of partial compliance relate to important operational issues,

including estate condition, isolation capacity, and workforce training, which will need ongoing focus. The increase in C. difficile rates, though still below the national average, reinforces the importance of maintaining improvement momentum.

With regard to patient experience, the Committee notes a mixed picture. The Friends and Family Test (FFT) remains largely positive, but the positive response rate has fallen from 89.84% to 87.53%, and complaints have risen markedly from 1,273 to 1,775.

While the document highlights key themes, the Committee considers that waiting times, identified as a prominent issue in patient feedback, are not sufficiently reflected in the narrative and should be more clearly acknowledged and addressed.

Priorities for 2026/27

The Committee accepts the Trust's decision to carry forward the same three priorities into 2026/27, recognising that they remain relevant to patient safety, quality and experience. However, the Committee considers that the priorities would be strengthened by clearer ambition, measurable targets and a more explicit link to current performance challenges and patient concerns.

- **Priority 1**

The Committee welcomes the focus on reducing incidents causing harm and strengthening organisational learning. However, it notes that success measures lack clear quantified targets and trajectories and would welcome more specific outcome measures, including an explicit ambition to eliminate never events.

- **Priority 2**

The Committee recognises the progress in infection prevention and control, but notes that some data underpinning performance appears historic and would benefit from more up-to-date reporting to strengthen assurance.

- **Priority 3**

The Committee welcomes the Trust's continued focus on communication, appointments and clinical practice. However, the Committee considers that waiting times, consistently highlighted in both complaints and FFT feedback, should be more prominently reflected within this priority as a key driver of patient experience.

The Committee also notes areas of concern within maternity and neonatal services, including breastfeeding outcomes and audit findings, and would expect these to be more clearly reflected within priorities and improvement actions for 2026/27.

Data, Metrics and Assurance

The Committee considers that one of the main weaknesses of the document is uneven use of data and assurance. Several sections rely on historic data (including data from 2018–2021) or datasets with limited completeness, which reduces the ability to provide a current and robust picture of performance.

For example, some domains only present data up to 2020, and audit sections frequently report “no case ascertainment” or limited submission rates. The Committee recommends that future *Quality Accounts* prioritise the inclusion of the most recent available data, alongside clear explanations where this is not possible.

The Committee also notes that response rates for patient surveys are not consistently reported. Without this context, it is difficult to assess the strength and representativeness of the findings. The Committee would therefore welcome inclusion of response rates and an explanation of how feedback is used to shape priorities and improvement actions.

In addition, the Committee would welcome greater transparency in relation to cancer performance data, including clearer presentation of activity levels and outcomes, to support meaningful scrutiny.

Presentation of the Document

The Committee recognises the challenges of balancing statutory requirements with accessibility. However, the document remains lengthy and at times difficult to navigate. The Committee recommends clearer summaries, improved data visualisation, and consistent presentation of metrics to support readability and public understanding.

Engagement with the Health Scrutiny Committee for Lincolnshire

During 2025-26, engagement with the Health Scrutiny Committee for Lincolnshire has continued, with various representatives of the Trust attending Committee meetings and submitting comments and statements for the Committee’s benefit. We look forward to continued engagement with the Trust's managers, and where appropriate clinicians, in the coming year.

Conclusion

The Committee welcomes the opportunity to comment on the draft *Quality Account* and recognises progress and transparency. However, it considers that the document would be strengthened by clearer focus on measurable outcomes, benchmarking and delivery. The Committee looks forward to continued engagement and assurance of demonstrable,

measurable improvements in safety, experience and quality across both hospital and community pathways.

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.

We acknowledge the Committee's comments in relation to the use of data within the Quality Account and we will ensure that we incorporate this where appropriate to enhance clarity going forward.

Thank you for highlighting the committee's view on patient priorities for 2026/2027 which we acknowledge and will ensure these will be reported through our established reporting processes to ensure effective oversight and progress.

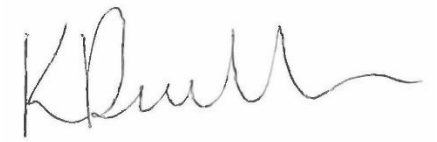
Annex 2: Statement of Directors' Responsibilities

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:

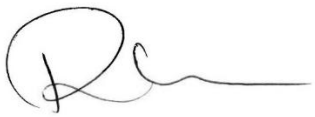
- The Quality Account presents a balanced picture of the Trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included 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



Rebecca Brown

Group Chair