NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NHS
Humber Health
Partnership

QUALITY ACCOUNTS 2025/26

United by Compassion:
Driven by Excellence

Working in partnership:
Hull University Teaching Hospitals NHS Trust
Northern Lincolnshire and Goole NHS Foundation Trust

Contents

Part 1: Introducing our Quality Account

1.1 Group Chief Executive Statement

Welcome to the quality account for Northern Lincolnshire and Goole NHS Foundation Trust.

This report provides an open and transparent overview of the quality of care we deliver as part of the NHS Humber Health Partnership, highlighting both our achievements and the areas where we must continue to improve for the benefit of our patients, families and staff.

The past year has continued to present significant challenges across the NHS, with sustained pressure on urgent and emergency services, workforce capacity and patient demand. Despite this, I am proud of the commitment, compassion and professionalism demonstrated by our staff, who continue to deliver high quality care in often complex and demanding circumstances.

Throughout 2025/26, we have maintained a clear focus on our core quality priorities: keeping patients safe, delivering effective and timely care, and ensuring that every patient is treated with kindness, dignity and respect. This report outlines the progress we have made against our key priorities, including improvements in end of life care, earlier recognition of deteriorating patients and sepsis, medication safety, and the application of the Mental Capacity Act.

We have also continued to strengthen our patient safety culture. Increased reporting of patient safety incidents, alongside a reduction in the proportion that result in harm, reflects a more open and learning focused environment. We are committed to embedding the Patient Safety Incident Response Framework and ensuring that learning from incidents and mortality reviews leads to meaningful, sustained improvement.

Listening to our patients, families and staff remains central to how we improve services. Feedback from the Friends and Family Test, national surveys and complaints continues to shape our priorities. While overall patient feedback remains positive, we recognise that improvements are still required in areas such as communication, care delivery and the care environment, and targeted work is underway to address these themes.

We recognise that there is more to do. Our current Care Quality Commission rating of “Requires Improvement” reinforces the importance of maintaining momentum in our improvement journey. We remain fully committed to working collaboratively across the Group and with our system partners to address these challenges and deliver consistently high standards of care.

As we look ahead to 2026/27, our focus will remain on reducing harm, improving outcomes and addressing unwarranted variation. This includes a continued focus on sepsis, infection prevention, safer surgery, insulin safety and reducing deconditioning, alongside strengthening patient experience and workforce engagement.

Finally, I would like to thank our staff, volunteers and partners for their continued dedication, and our patients and communities for their valuable feedback and support.

Signed Declaration; It is important that our Quality Report is accurate and presents an honest picture of our care. We seek to foster an open and transparent culture so we can understand where improvements are needed. As Group Chief Executive of Northern Lincolnshire and Goole NHS Foundation Trust, I can confirm that the information used and published in the Quality Report is, to the best of my knowledge, accurate and complete.

Lynn Simpson,

Group Chief Executive

1.2 About Us

Northern Lincolnshire and Goole NHS Foundation Trust (referred to as 'the Trust' throughout this report) consists of three hospitals and community services in North Lincolnshire. The Trust employs 8,787 staff and provides acute hospital services and community services to a population of more than 450,000 people across North and North East Lincolnshire and East Riding of Yorkshire and has approximately 750 beds across three hospitals. The site locations are:

- Diana, Princess of Wales Hospital in Grimsby (also referred to as DPoW),
- Scunthorpe General Hospital located in Scunthorpe (also referred to as SGH),
- Goole & District Hospital (also referred to as GDH), and
- Community services in North Lincolnshire.

The Trust was originally established as a combined hospital Trust on April 1 2001, and achieved Foundation Status on May 1 2007. It was formed by the merger of North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospitals NHS Trust and operates all NHS hospitals in Scunthorpe, Grimsby and Goole. In April 2011 the Trust became a combined hospital and community services Trust (for North Lincolnshire). As a result of this the name of the Trust, while illustrating the geographical spread of the organisation, was changed during 2013 to Northern Lincolnshire and Goole NHS Foundation Trust to reflect that the Trust did not just operate hospitals in the region.

The Trust is now part of a Group – NHS Humber Health Partnership – as we work more closely with our colleagues at Hull University Teaching Hospitals NHS Trust.

The Group manages five main hospitals sites: Hull Royal Infirmary, Grimsby Diana Princess of Wales Hospital, Scunthorpe General Hospital, Castle Hill Hospital and Goole Hospital. It provides a wide range of community services across North and North East Lincolnshire, including district nursing, physiotherapy, psychology, podiatry and specialist dental services.

NHS Humber Health Partnership employs over 19,000 staff, sees more than 1,000,000 patients each year and has a budget of £1.4bn.

2025/2026
A YEAR IN NUMBERS

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Figures from 1 April 2025 to 31 March 2026 where available. Emergency department figures include Urgent Treatment Centre attendances. Diagnostic activity is based on DM01 data which include 15 different diagnostic tests

1.3 What our Patients said in 2025/26

The Trusts have continued to work with Healthcare Communications to collect Friends and Family Test (FFT) feedback from patients and relatives. In June 2026, the HUTH element of the contract ended, and from July 2026 FFT data for HUTH has been collected in-house. As a result, responses via text message reduced following the cessation of this service. During 2025/26, Humber Health Partnership (HHP) received 52,995 FFT responses, representing a significant increase compared to 23,000 responses in 2024/25. The Partnership is grateful to patients and families who took the time to provide feedback to support service improvement.

At Northern Lincolnshire and Goole NHS Foundation Trust (NLaG), the externally commissioned FFT service has continued and remains aligned to the Group structure. Patients and relatives are able to provide feedback through multiple channels, including SMS text messaging, interactive voice messages (IVM), a webpage, QR codes and paper forms. Volunteers are available to support patients who may not have access to a smart device, using iPads or paper forms to improve accessibility and response rates.

FFT processes at HUTH have been redeveloped to improve data submissions and strengthen feedback loops to ward and service areas, enabling tangible improvements in patient experience. Updated materials, including posters and paper forms, are now available across patient areas. Handheld electronic tablets are being piloted with volunteer support, including access to translated surveys in other languages, to enable a wider range of patients to participate.

Overall response rates remain broadly consistent with the previous year, and the Trust continues to achieve an overall FFT rating of 4.5 out of 5, with some improvement noted. While the volume of negative feedback has reduced, further work is required to drive sustained improvements in patient experience.

Feedback themes identified during the year are set out below. The most frequently reported areas for improvement relate to staff attitude, implementation of care, the care environment, patient mood or emotional wellbeing, and communication.

Top 5 positive themes	Top 5 negative themes
Staff attitude	Staff attitude
Implementation of care	Waiting time
Environment	Environment
Patient mood/feeling	Implementation of care
Communication	Communication

Whilst we have received fewer negative elements of feedback, with over half of our responding patients taking the time to provide positive feedback, there is significant work for us to drive forward and improve our experience for patients.

1.4 Patient Surveys

The national survey programme provides a year-on-year review of person-centred validated questions and responses. This data allows the Trust to monitor internal progress and benchmarking. During 2024/25 the Trust implemented a comprehensive action plan based on the 2024 national surveys of which the headlines are detailed below.

Children and Young People Survey

A total of 98 questions were asked to people that had a child as a day case or inpatient at the Trust, 68 of which were positively scored. The sample was taken between March and May 2024 and published in May 2025. The survey results demonstrate that the Trust performs broadly in line with comparable organisations overall, with positive scores achieved in 68 of the 98 survey questions. However, 9 questions were rated as significantly worse than the national comparator, highlighting specific areas for targeted improvement.

1250	1226	13%	19%	NA
Invited to complete the survey	Eligible at the end of survey	Completed the survey (154)	Average response rate for similar organisations	Your previous response rate

97%	P44. Parent felt child was looked after in hospital
97%	P46. Parent or carer was treated with dignity and respect by the staff
81%	P48. Parent's overall rating of their child's experience in hospital (being 7/10 or more)

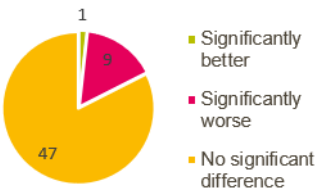


*Chart shows the number of questions that are better, worse, or show no significant difference

Top 5 scores vs Picker Average	Trust	Picker Avg
P29. Parent felt there was hospital food available for their child outside of mealtime	80%	67%
P28. Parent felt there was enough hospital food choices for their child	83%	77%
P4. Child was not bothered whilst they were in the waiting area	55%	50%
P42. Parent was informed whom to contact if worried about their child when at home	93%	90%
P31. Parent had sufficient access to food in the hospital	88%	86%

Bottom 5 scores vs Picker Average	Trust	Picker Avg
P20. Parent felt that staff played with their child	38%	62%
C8. Child felt staff did everything they could to help manage any pain	75%	94%
C17. Child felt the staff took time to listen to their fears and worries	80%	92%
C25. Staff informed the child whom to talk to if they had any worries when they got home	78%	89%
C13. Child felt the staff talked to them in a way they understood	86%	96%

Care Groups develop local plans for improvement and progress will be measured in our monthly performance meetings.

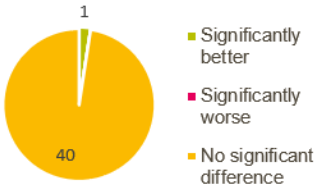
Inpatient Survey

A total of 63 questions were asked to people that had hospital admissions at the Trust, 45 of which were positively scored. The sample was taken November 2024 and published September 2025. Survey results indicate stability in performance, with no areas demonstrating a statistically significant deterioration compared to historical data. Overall, the Trust performed broadly in line with peer organisations, although two questions were identified as significantly below the national comparator. These areas have been prioritised for further review and improvement.

1250	1180	40%	41%	44%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (470)	Average response rate for similar organisations	Your previous response rate

82%	Q48. Rated overall experience as 7/10 or more
99%	Q47. Treated with respect and dignity overall
97%	Q18. Had confidence and trust in the doctors

Historical comparison*



Comparison with average*

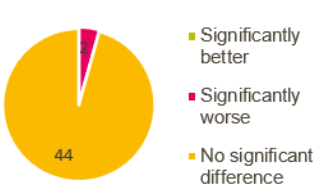


*Chart shows the number of questions that are better, worse, or show no significant difference

Top 5 scores vs Picker Average	Trust	Picker Avg
Q10. Staff explained reasons for changing wards at night	87%	80%
Q31_1. Hospital staff took into account language needs (Excluding respondents who answered using a smartphone)	88%	83%
Q15. Able to get food outside of meal times	79%	76%
Q14. Got enough help from staff to eat meals	89%	86%
Q33. Information given about the risks and benefits of continuing treatment on a virtual ward	85%	82%

Bottom 5 scores vs Picker Average	Trust	Picker Avg
Q2. Did not mind waiting as long as did for admission	51%	58%
Q35. Felt involved in decisions about discharge from hospital	68%	73%
Q43. Staff told patient who to contact if worried after discharge	72%	76%
Q31_2. Hospital staff took into account cultural needs (Excluding respondents who answered using a smartphone)	74%	79%
Q39. Given information about what they should or should not do after leaving hospital	76%	79%

Most improved scores	Trust 2024	Trust 2023
Q15. Able to get food outside of meal times	79%	67%
Q37. Staff discussed need for additional equipment or home adaptation after discharge	84%	77%
Q4. Quality of information given while on waiting list to be admitted was very or fairly good	75%	69%
Q36. Staff involved family or carers in discussions about leaving the hospital	59%	53%
Q44. Staff discussed need for further health or social care services after discharge	79%	73%

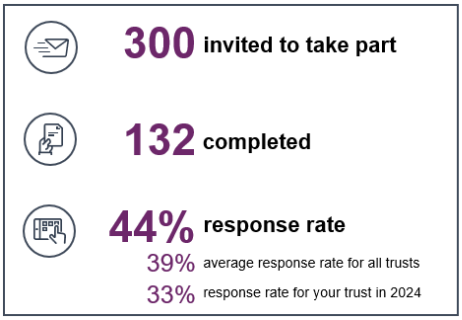
Most declined scores	Trust 2024	Trust 2023
Q34. Enough information given about care and treatment while on a virtual ward	86%	89%
Q35. Felt involved in decisions about discharge from hospital	68%	71%
Q24. Staff did not contradict each other about care and treatment	63%	65%
Q26. Right amount of information given on condition or treatment	78%	80%
Q17. Doctors answered questions in a way patient could understand	94%	96%

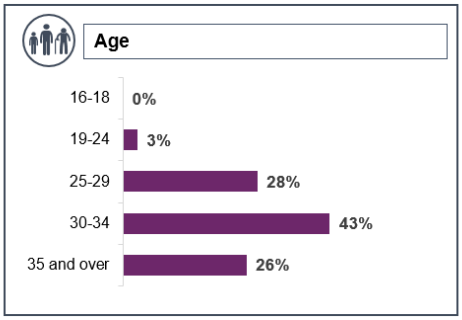
Care Groups develop local plans for improvement and progress will be measured in our monthly performance meetings.

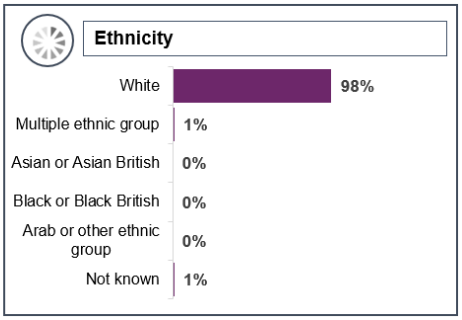
Maternity Survey

An alternative provider was used to gather the Maternity data and therefore data is presented differently.

A total of 57 questions were asked to people that gave birth at the Trust. The sample was taken February 2025 and published in December 2025. Results show that there were no statistically significant differences for many questions where historical comparisons were available, and that the Trust performed broadly in line with other organisations across most areas. However, four questions were identified as significantly worse, indicating specific areas for targeted improvement.

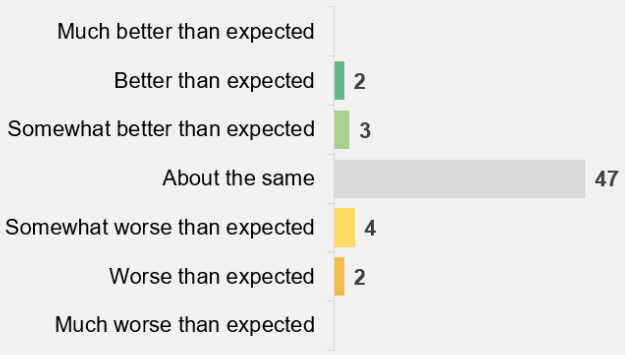






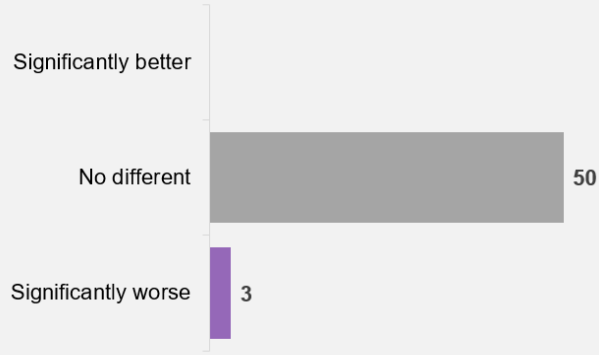
Comparison with other trusts

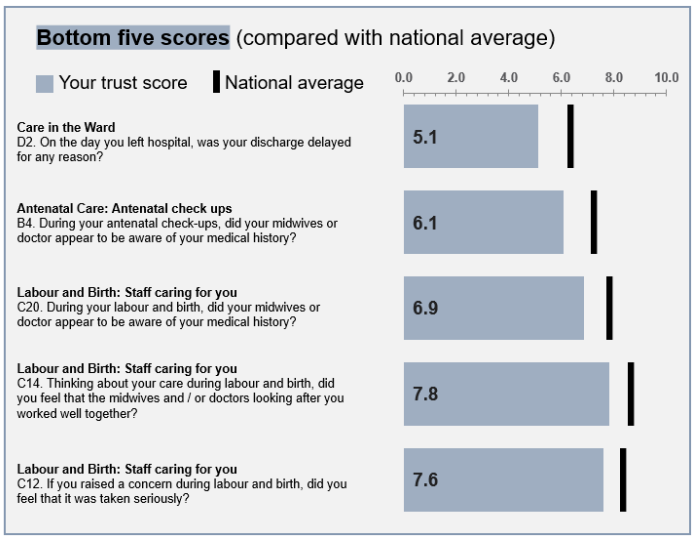
The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2025 vs 2024.





Care Groups develop local plans for improvement and progress will be measured in our monthly performance meetings.

1.5 Celebrating Success and Innovation

The Trust had yet another difficult year in 2025/26, much like many NHS providers nationwide. Even though the Trust has faced many challenges, staff members continue to rise to the occasion, as seen by the numerous instances of incredible successes and accomplishments they have made during the year. The NHS Humber Health Partnership also hosts annual staff awards known as Golden Stars. Below are a few of this year's accomplishments:

Queens Nurse - A Community Nursing Matron has received a top honour in recognition of her commitment to our patients. Laura Inglis has been awarded the title of Queen's Nurse. This is a formal recognition by the Queen's Institute of Community Nursing (QICN) that she's part of a professional network of nurses committed to delivering and leading outstanding care in the community.

Applicants face a rigorous application and assessment process where they must demonstrate their knowledge and expertise. They underwent a rigorous application process to demonstrate their expertise. The title offers access to various professional opportunities and networks.

Patients with endometriosis to benefit from national accolade – Patients with endometriosis across the region continue to benefit from nationally recognised specialist services. Endometriosis centres at Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) have been successfully re-accredited by the British Society of Gynaecological Endoscopy (BSGE), confirming the continued delivery of high-quality care. Endometriosis is a complex condition which can cause severe pelvic pain and other significant symptoms, and surgery for deep endometriosis should only be provided in accredited specialist centres.

Pioneering AI technology assists in identifying fractures - Northern Lincolnshire and Goole NHS Foundation Trust is one of a handful of NHS trusts taking part in the two-year NHS England pilot scheme, which will launch later this month, Pioneering new AI technology is being introduced to assist in identifying possible broken bones and dislocations in emergency patients. Our Emergency Department and Radiography teams will be using the cloud-based software as an additional tool to assist our expert teams, highlighting the presence of possible fractures, dislocations, and joint effusions.

The trial will have some exceptions, and we will not be using the technology for patients under the age of two, or for inpatient and outpatient clinics. In addition, we will not use it for chest, spine, skull, facial, or soft tissue imaging, regardless of the age of the patient. The final diagnosis will always be made by one of our expert clinicians.

Practice Development Nurses win national award - Patricia McKenna and Michael Sanni from NLaG won a HSJ Patient Safety Award for a staff wellbeing initiative supporting internationally educated nurses. The award recognises collaborative work by the Practice Development Team to improve psychological safety and help international nurses transition into the NHS and UK life.

Speaking about winning the award, Patricia said: "We are truly honoured to receive this award. What began as a passion project has grown through the dedication and collaboration of colleagues across departments and from diverse backgrounds. This recognition is not just a milestone, it's a springboard for us to drive meaningful change throughout the NHS. Above all, we extend our deepest gratitude to our internationally educated colleagues, whose sacrifices and contributions continue to enrich and strengthen our NHS."

JAG Accreditation - The Endoscopy team at Diana, Princess of Wales Hospital has successfully achieved re-accreditation following its annual Joint Advisory Group (JAG) review. The service passed the assessment with positive feedback and has been accredited for a further year. JAG accreditation provides independent assurance to staff, patients and the public that the endoscopy service continues to meet high standards of quality and safety, reflecting the commitment and hard work of the whole team

BFI Gold Award - Northern Lincolnshire and Goole NHS Foundation Trust (NLAG), in collaboration with health visiting teams in North and North East Lincolnshire, has achieved the Baby Friendly Initiative (BFI) Gold Award, run by international charity UNICEF.

Following 16 years of commitment and dedication to supporting parents and their babies, ensuring families across the area receive the highest quality care, midwives and health visitors in Grimsby, Scunthorpe, and Goole have achieved the prestigious international award for their breastfeeding and infant feeding programme.

Part 2: Priorities for Improvement

2.1 Quality Priorities 2025/26

End of Life:

Background

The End-of-Life Care Quality Priority is vital for ensuring that patients receive personalised palliative and end-of-life care, allowing patients to have a dignified and peaceful death. This initiative supports the delivery of Key Quality Priorities and aligns with national NHS recommendations. The focus is on improving health outcomes and reducing inequalities by providing high-quality care to patients.

A number of key workstreams were identified to support and drive improvements for the End-of-Life Quality Priority including comfort observations and recognition of the dying patient.

Key Achievements in 2025/26

Comfort observations: improve the End-of-Life care that is delivered

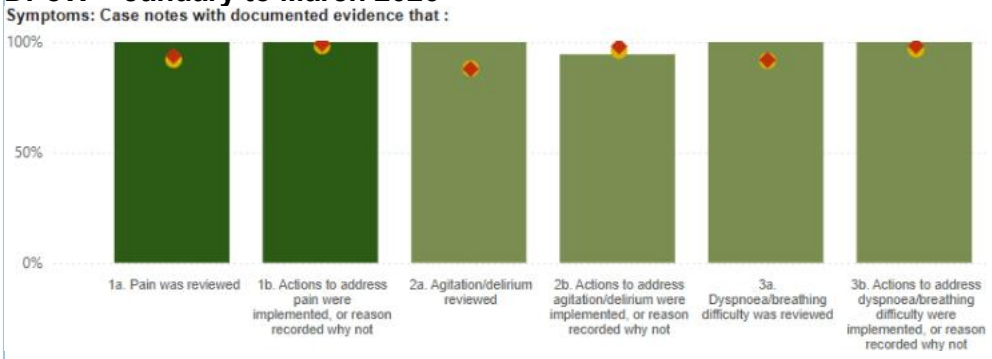
- A new Comfort Observations approach was introduced to improve how staff regularly check and respond to pain, agitation or distress, and breathing difficulties for patients in the last days of life.
- Comfort Observations were rolled out across all hospital sites, using different models to reflect local needs, with full implementation completed by March 2026.
- Standard guidance was developed to support consistent use of Comfort Observations, with a strong focus on dignity, comfort, and personalised care.
- Digital recording of Comfort Observations was built into existing clinical systems to make it easier for staff to record checks and actions in real time.
- Staff engagement was supported through link nurses and specialist palliative care teams, helping teams understand why Comfort Observations matter and how to use them well.
- Use of Comfort Observations improved the reliability of symptom review and documentation for patients at the end of life, aligned to national audit standards.
- The workstream helped teams identify comfort needs earlier and act more consistently, supporting better day-to-day care for dying patients.
- Feedback from wards was positive, with teams reporting clearer prompts to review comfort and take appropriate action.
- Ongoing audit arrangements are now in place to monitor quality and sustain improvements as part of routine practice.

The graphs below show how each symptom (pain, agitation/delirium, and dyspnoea/breathing difficulties) were reviewed and actions were implemented: **DPoW – January to December 2025**	• Benchmarking against acute and regional peer averages shows variation in performance across sites. • Comfort Observations at DPoW are consistently at or above benchmark levels. • Performance at SGH was lower during 2025 but showed

improvement in early 2026.

- Overall, the data indicates improving practice, with further work needed to increase consistency across all sites.
- Comfort Observations will be reviewed regularly to improve consistency, quality and implementation of actions, in line with the SOP.

DPoW – January to March 2026



SGH – January to December 2025

SGH – January to March 2026

Key:

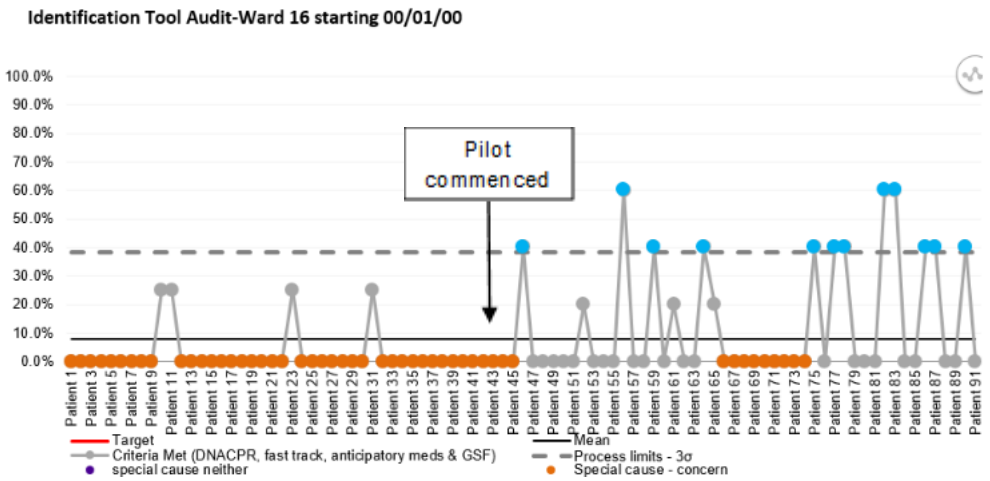
Sample (%) is average of all data for the **Acute site type**

Peer group (%) is average of the data in the **Acute site type** in **the North East & Yorkshir**

Recognition of the dying patient - Improve the recognition and escalation of patients in the last days of life

- Work was taken forward to improve how quickly and consistently patients in the last days of life are recognised by clinical teams.

- A structured approach to recognising dying patients was developed and tested on wards, to support earlier, clearer decision-making .
- The workstream brought together signs of deterioration, clinical judgement and existing care planning tools into one clearer process for staff.
- Pilot wards reported improved confidence in recognising when patients were dying and starting appropriate end-of-life care earlier.
- Earlier recognition supported more timely comfort-focused care, including symptom control and personalised care planning.
- The work aligned recognition of the dying patient with other end-of-life improvements, including Comfort Observations, to improve continuity of care.
- Specialist palliative care teams and ward staff worked together to support testing, learning and local ownership of the approach.
- Learning from the pilots informed plans for wider roll-out and embedding recognition into routine practice.
- Ongoing review through audit and governance reporting has been put in place to support sustained improvement

Recognition of the dying patient in last weeks/months/year of life	
The graph below shows the initial pilot and first PDSA cycle audit data from Ward 16:  	• There is an ongoing pilot on Ward 16 to use the Gold Standard Framework (GSF) and other tools to support the earlier identification of End-of-Life patients.

Moving Forward

Looking ahead, achievements for the End-of-Life Quality Priority will be integrated into standard operations and will continue to support ongoing improvements – moving towards business as usual. Comfort Observations will be regularly reviewed to enhance their frequency, quality, and the implementation of actions, ensuring alignment with the SOP. Oversight will be maintained through bi-monthly End-of-Life Committee meetings. Additionally, the expansion of the End-of-Life Identification Tool pilot will facilitate earlier identification of patients approaching end-of-life, enabling timely initiation of the End-of-Life Pathway with all necessary support provided and clearly communicated.

Deteriorating Patient and Sepsis:

Background

This quality priority is about spotting when a patient is becoming more unwell and responding quickly, including recognising and treating sepsis. Sepsis is a life-threatening reaction to infection that can damage the body's organs. Early recognition and prompt treatment can save lives and reduce harm.

To support this work, we focused on: staff training, introducing Martha's Rule (a way for patients and families to raise urgent concerns), reducing infections linked to urinary catheters, and improving how we screen for and treat sepsis.

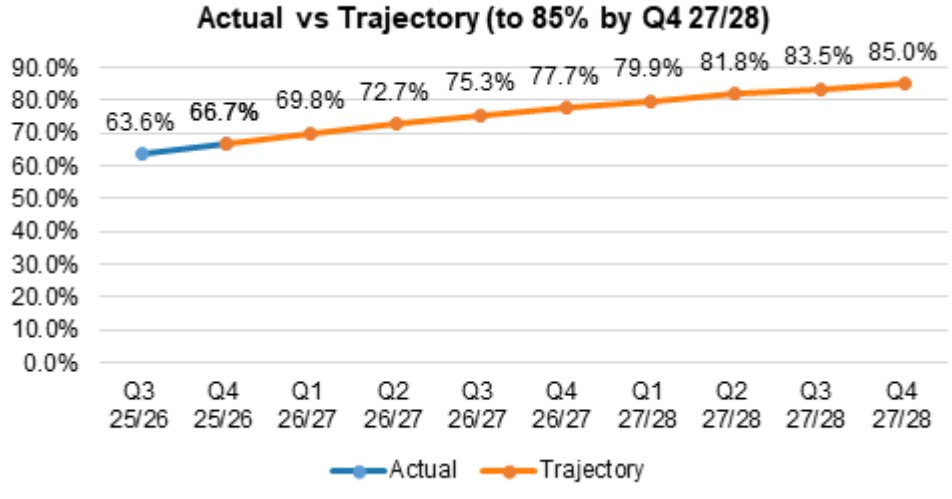
Key Achievements in 2025/26

Education and training: consistent training on sepsis and deterioration

- We introduced one education programme for sepsis and deteriorating patients across the Group, to reduce differences between sites and services.
- We created role-specific training, so staff receive learning that matches what they do in practice.
- Core training on sepsis and deterioration was made mandatory, with the same expectations across the organisation.
- We used a "train the trainer" approach so teams can deliver training locally and staff can access it more easily.
- Training was built around real clinical risks, focusing on early recognition, escalation and timely response when patients deteriorate.
- We set up oversight arrangements and regular reporting to monitor progress and address gaps.
- Training records and reporting were improved so we can see completion levels more clearly and follow up where uptake is low.
- Staff are increasingly trained to the same standard, supporting more consistent and reliable care for patients across the Group.
- This work has established a consistent approach that we will continue to build on as part of our wider patient safety work.

Group compliance of 85% for completion of ATHENS training.

The graph below shows actual versus trajectory completion rates for the training module (ATHENS) on sepsis and deteriorating patients:



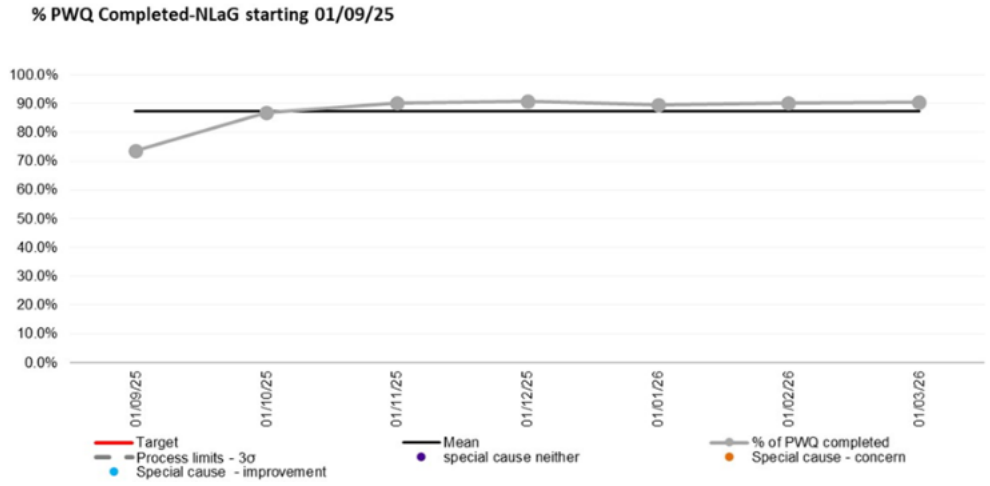
- By the end of 25/26, **66.7%** of staff had completed the training.
- A three-year plan is in place to reach and sustain an **85%** training completion rate by April 2028.
- The Trust will continue to monitor compliance rates to ensure the target of **85%** is met.

Martha's Rule: helping patients and families raise concerns quickly

- We introduced Martha's Rule, so patients, families and carers have a clear way to raise urgent concerns if a patient seems to be getting worse in hospital and feel their concerns are not being listened to or acted upon.
- The Patient Wellness Questionnaire (PWQ) is now used on all wards to help staff check how patients are feeling each day and identify concerns earlier.
- Staff feedback suggests the questionnaire fits with day-to-day ward routines and supports earlier conversations and opportunities for escalation when a patient may be deteriorating.
- Clear escalation routes were agreed so concerns raised by patients or families are reviewed promptly by the right clinical teams.
- We developed a Group-wide standard operating procedure to support consistent and safe use of Martha's Rule.
- We have started to co-produce patient information leaflets and ward posters to explain Martha's Rule in clear, accessible language, with lots of communication made available to staff to raise awareness around Martha's Rule.
- We started developing a dashboard to help monitor how often the PWQ is completed, what actions are taken when concerns are raised and identify themes for improvement or further training.
- Training and awareness sessions supported staff confidence and understanding.
- Overall, this work strengthens how we listen to and act on concerns about deterioration, supporting safer care for patients.

Completion rate of daily PWQs

The graph below shows our PWQ completion rate over time:



- All inpatients should have a PWQ completed each day whilst in hospital.
- The average completion rate is **87%**, indicating that the process is being embedded into everyday routine.
- The PWQ completion rate will continue to be monitored to ensure correct processes are followed.

Infection Reduction: reducing catheter-associated infections

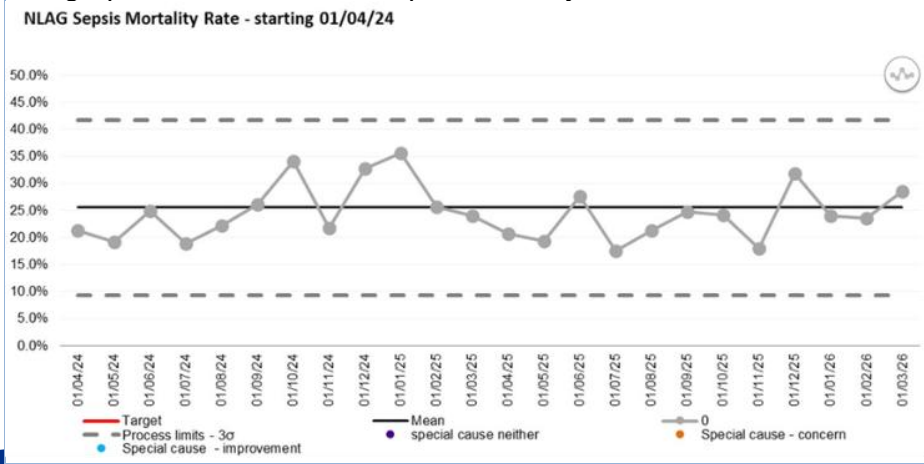
- We focused on reducing infections linked to urinary catheters, which can cause harm and may contribute to deterioration or sepsis.
- We agreed an improvement plan with clear aims, measures and actions across hospital and community care.
- We improved how we collect and report data so catheter-related infections can be identified more reliably and acted on earlier.
- We reviewed why catheters are used, how they are cared for, and how quickly they are removed, to reduce unnecessary catheter use.
- We started aligning policies and clinical guidance across services to reduce variation and improve consistency of care.

- Multi-professional groups were set up to focus on staff training, catheter care standards and safer discharge arrangements.
- Education materials were updated so staff have clearer, more consistent guidance on safe catheter care.
- We began work to standardise catheter equipment and take-home supplies, helping to reduce confusion when care transfers between settings.
- We strengthened links between acute and community teams to support safer handovers and continuity of care after discharge.

Reduction in the number of infections associated with (coded) catheter procedures	
The graph below shows the percentage of infections associated with catheter use over time: 	• The average rate of catheter related infections is **11.9%**. • The foundations laid during 25/26 will further enable improvements and ensure any improvements made will sustain over time. • We will continue to monitor data and use the information to identify further opportunities for improvement.

Sepsis: Improving screening and timely treatment

- We introduced standard tools and pathways to help staff recognise possible sepsis and know what action to take next.
- We developed new databases to provide more reliable and more automated information on screening, treatment and outcomes at ward and site level.
- We progressed work to better understand outcomes from sepsis, including data on how common it is and how it affects mortality, to target improvement and support learning from deaths.
- We delivered targeted ward-based teaching in response to audits and staff feedback, to improve confidence in recognising and treating suspected sepsis.
- We strengthened learning from patient safety incidents by involving the Sepsis Team in investigations and improvement actions.
- Work continues to improve digital prompts and documentation so clinicians consider sepsis earlier and we can monitor care more accurately.

Sepsis Mortality Rates	
The graph below shows the Sepsis Mortality Rate: 	• Since April 2024, the Trust's sepsis mortality rate has remained broadly in line with the long-term average of **25%**. • Overall, the data indicates a stable position. • The Trust continues to monitor sepsis outcomes closely as part of its ongoing focus on patient safety and quality improvement.

Moving Forward

Going forward, we will further develop the progress achieved by integrating training, catheter-care and Martha's Rule into daily care practices and standard business operations. We remain committed to assisting wards and services in applying these methods consistently, enabling them to become established components of safe care and routine procedures.

Quality Priority Aims for 2026/27

In 2026/27, we will uphold our commitment to quality by continuing the sepsis screening workstream as part of the 2026/27 Quality Accounts. Our efforts will remain concentrated on ensuring timely sepsis screening and treatment with the aim of enhancing patient safety and improving outcomes.

Medication Safety:

Background

Medication safety is about making sure medicines are used as safely and effectively as possible. This includes preventing avoidable errors and harm, supporting staff to learn from incidents, and using antibiotics appropriately.

In 2025/26 we focused on three areas: ensuring adult patients are weighed so weight-based medicines can be prescribed safely; switching suitable patients from intravenous (IV) to oral antibiotics in a timely way; and improving insulin safety.

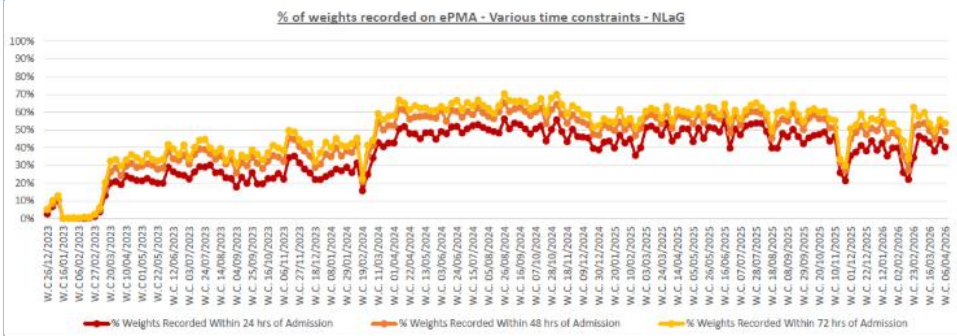
Key Achievements in 2025/26

Weighing patients: safer prescribing of weight-based medicines

- We worked to ensure adult patients are weighed promptly so medicines that depend on weight can be prescribed and given safely.
- We improved digital links between systems so recorded weights can flow into electronic medication charts, reducing manual entry and the risk of error.
- This helped staff record weights more reliably at the point of care.
- By 2025/26, performance improved, with around nine in ten adult inpatients having a weight recorded during their admission.
- Some services improved quickly once the digital changes went live.
- Progress was monitored through routine medication safety reporting.
- As recording became more stable, the work moved into routine monitoring to help sustain safe practice.
- These changes support safer prescribing of weight-based medicines.

Weights recorded in electronic Prescribing and Medicines Administration (ePMA)

The graph below shows the percentage of weights recorded in the ePMA system within 24, 48 and 78 hours of admission:

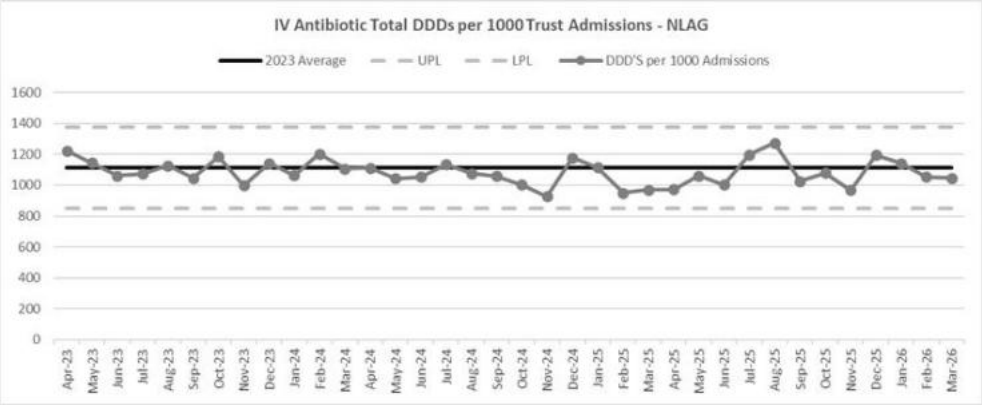


- Timely recording of patient weights on ePMA improved significantly in early 2025.
- Overall, the data demonstrates a sustained improvement in timely weight recording supporting safer prescribing and medicines optimisation.
- Performance continues to be monitored as part of the Trust's ongoing patient safety and digital medicines initiatives.

Switching from IV to oral antibiotics: reducing unnecessary IV use

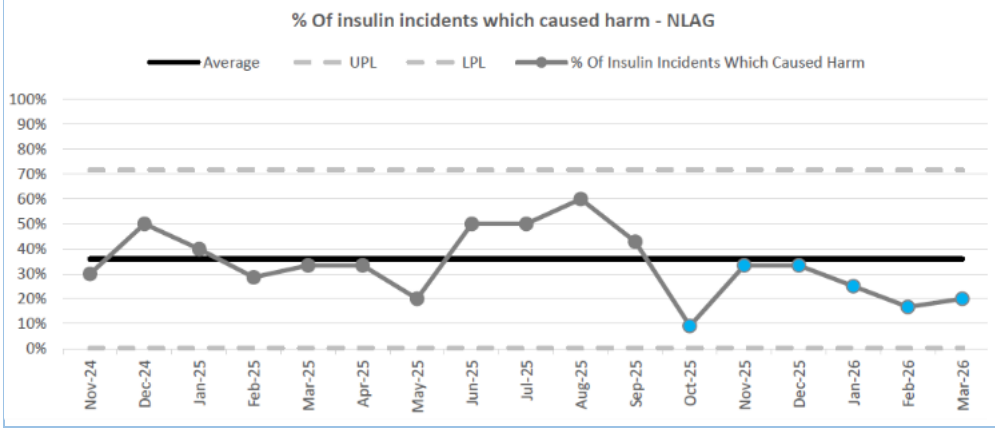
- We worked to switch suitable patients from intravenous (IV) to oral antibiotics sooner, where clinically appropriate.
- A multi-professional group (pharmacy, nursing and medical teams) agreed priorities and supported consistent practice.

- We developed clear clinical messages to support timely review, aligning with existing safety communications.
- Training materials were refreshed and simplified so they can be used easily in ward briefings and team discussions.
- Pharmacy teams played a stronger role in prompting IV-to-oral review during ward rounds and medicines reviews.
- Updates were shared through established staff channels to maximise reach.
- This work supports safer antibiotic use by reducing unnecessary time on IV treatment.

IV antibiotic use measured as Defined Daily Doses (DDDs) per 1,000 admissions	
The graph shows the number of defined daily doses per one thousand admissions for IV antibiotics:  	• IV antibiotic use remains above target averaging around 1,035 DDDs per 1,000 admissions. • This measure has not yet improved as work continues to align processes. • To support a sustained reduction, an SOP for switching from IV to oral antibiotics is being developed and is awaiting approval.

Insulin safety: reducing insulin-related harm

- We made insulin safety a key focus because insulin is a high-risk medicine and mistakes can cause serious harm.
- After an early pause due to pharmacy capacity pressures, we restarted the work with clear oversight.
- We reviewed insulin risks and the main causes of insulin errors and set out a clear improvement plan.
- Incorrect insulin-related equipment was identified and removed from wards to reduce the risk of errors
- We introduced hypoglycaemia treatment boxes (“hypo boxes”) on wards to support faster and safer treatment of low blood sugar.
- We began developing a consistent approach to insulin safety training across hospital sites.
- We agreed clear aims to reduce insulin-related harm and to eliminate insulin-related “Never Events” (serious incidents that should not happen).
- We strengthened awareness through planned activity linked to national Insulin Safety Week (May) and Hypoglycaemia Awareness Week (November).
- This work set the foundations for further improvement in 2026/27, with a focus on safer insulin use, the right equipment, staff learning, and a positive culture of reporting and learning from incidents.

Insulin incidents reported causing harm	
The graph below shows the percentage of insulin reported incidents that had caused harm over time:  	• There is a notable reduction in the number of incidents causing harm between October 2025 and March 2026. • This indicates an improving and more stable position in insulin medicines safety with continued monitoring in place.

Moving Forward

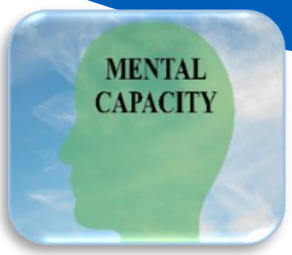
Moving forward, we will continue to advance the integration of patient weighing and IV-to-oral antibiotic transition into routine care processes and standard operational protocols. Our ongoing commitment is to support wards and services in implementing these practices consistently, ensuring they become integral to safe care and established procedures.

Quality Priority Aims for 2026/27

In 2026/27, we will continue to prioritise quality by advancing the insulin safety workstream as part of our 2026/27 Quality Accounts. Our approach will remain focused on the following key areas:

- Increasing staff awareness of safe insulin prescribing and administration through the introduction of a targeted training package and engagement with teams across the Group.
- Ensuring wards and departments are equipped with the appropriate tools for insulin administration to minimise avoidable incidents.
- Supporting safer insulin practices during Insulin Safety Week (May) and Hypoglycaemia Awareness Week (November), in alignment with national campaigns.
- Developing a decision support algorithm for community teams to maintain high standards of insulin safety for patients at home and in community settings.
- Encouraging staff to report any insulin-related incidents to foster a just and transparent reporting culture throughout the Group.

Mental Capacity:



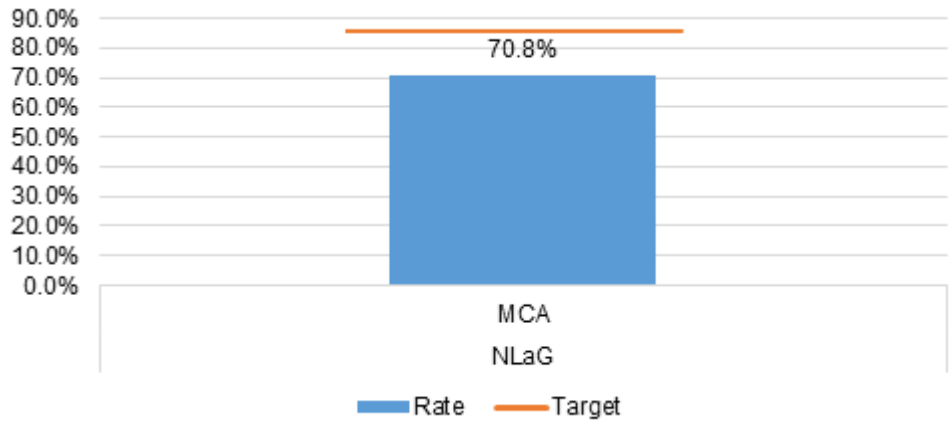
Background

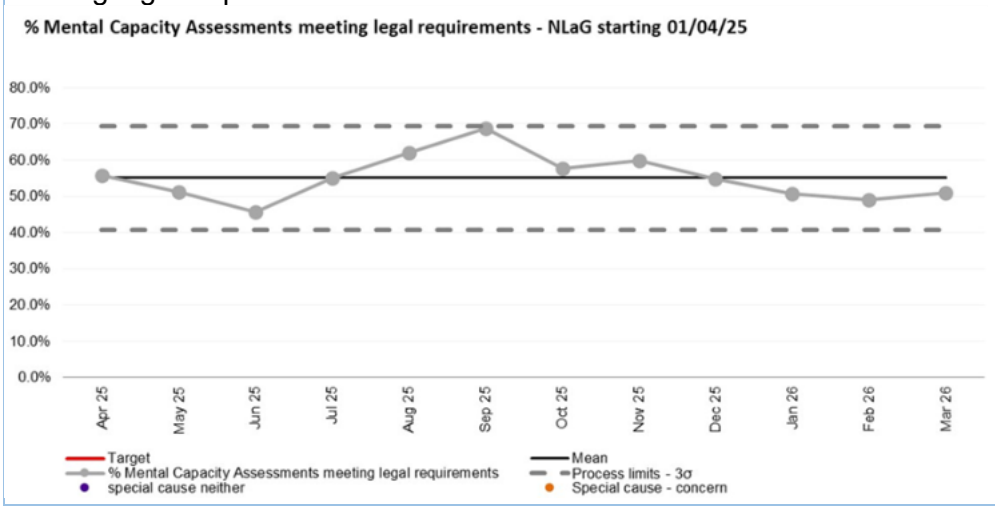
All patients should be involved in health care decisions, aligning with the Mental Capacity Act (2005). If a patient has impaired decision-making capacity, reasonable adjustments must enable patients to make decisions. For those lacking capacity, health professionals must document assessments and follow the best interests process, balancing patient wishes and professional actions.

Key Achievements in 2025/26

Training and education: improve the quality of mental capacity assessment and best interest documentation

- A single, unified Mental Capacity Act training programme was developed across the Humber Health Partnership, reducing variation and setting clear expectations for staff.
- The training focuses on how to apply the law in practice, not just theory, helping staff make and record clear, lawful decisions in real clinical situations.
- A train-the-trainer approach was introduced, building local expertise and enabling learning to be delivered closer to clinical teams.
- Bite-size, case-based learning materials are being developed to improve confidence, particularly around what to write and how to evidence decisions.
- The programme recognises that mental capacity assessment is everyone's responsibility, challenging the view that it is role-specific.
- Training content is being designed to support different roles and settings, including therapy teams and staff working with people who have communication difficulties.
- Workshops and focus groups helped identify common myths and gaps, shaping training to address real risks seen in audits and incidents.
- A proportionate approach to measuring impact was agreed, using audits, feedback and confidence checks rather than relying on training completion rates alone.

Compliance rate for staff identified as required to complete MCA training	
The graph below shows the compliance for mandatory training on the Mental Capacity Act:  	• The 85% compliance rate for staff completing MCA training has not been achieved, however, plans are in place to move the training onto an e-learning platform to enable staff to complete the training more readily. • Compliance rates will continue to be monitored through the appropriate governance routes.

Mental Capacity Assessments meeting legal requirements	
The graph below shows the percentage of mental capacity assessments meeting legal requirements:  	• The percentage of Mental Capacity Assessments meeting legal requirements has stayed broadly the same over time. • Overall, performance has been stable. • A target for compliance with the process is to be confirmed. • Continued development of the train-the-trainer approach to support application of the MCA in practice.

Moving Forward

Moving forward, the accomplishments related to the Mental Capacity Quality Priority will be incorporated into routine operations, ensuring ongoing improvement and continued progress in assessment quality and application of the Mental Capacity Act through the Mental Capacity Leads as standard practice.
This objective will be achieved by expanding the train-the-trainer programme from its pilot phase to a full-scale rollout and implementation throughout the Group.

2.1.1 Quality Priorities 2026/27

Sepsis – prevention, identification and treatment:

Background

SHMI for Septicaemia is higher than expected for both Trusts meaning there are more than expected deaths with this condition. We aim to improve reliability in recognising and treating patients presenting/admitted with infections at the earliest opportunities to reduce harm. Prevent infection and recognise development of sepsis for inpatients.

Key Aims in 2026/27

- SHMI for sepsis reduction of 20%.
- Reduced number of deaths from sepsis by 10%

Infection Control Alert Organism rate reduction for Clostridium difficile, MRSA BSI and E.Coli BSI:

Background

National benchmarking shows higher rates and National Outcomes Framework scores for Clostridium difficile and blood stream infections for MRSA and E.Coli. We aim to reduce hospital acquired infections for Clostridium difficile cases, MRSA Blood Stream Infections and E.Coli Blood Stream Infections.

Key Aims in 2026/27

Improve the National Outcomes Framework scores for each infection from 2025/26 rates and working towards Quartile 1 benchmarking rather than Quartile 3 or 4.

Ensuring Safer Surgery and Interventions:

Background

There have been 19 Never Events identified since HHP commenced in April 2024. The majority relate to surgery and interventions. Both Trusts were jointly 6th nationally for number of Never Events cases in April – September 2025. We aim to improve reliability in all surgical and clinical interventions, reducing never events.

Key Aims in 2026/27

- Reduce the number of never events in a 12 month rolling period.

Safe care for patients prescribed insulin:

Background

Insulin safe practice has been identified as a theme nationally and locally, with HSSIB reports and PSII and AAR proportional learning responses. We aim to reduce harm caused to patients who are treated with insulin, in respect of prescribing, administration and monitoring the effect of treatment.

Key Aims in 2026/27

- Reduced incidents of harm to patients.

Preventing deconditioning:

Background

Patients with longer length of stay carry additional risks of harm associated with hospital care and loss of independence. This can be impacted by their reduced mobility when unwell or recovering from illness, nutrition, hydration and delays to discharge, including NCTR. We aim to reduce harm from deconditioning as a consequence of hospitalisation.

Key Aims in 2026/27

Reducing:

- Length of stay (non-elective)
- Length of stay (elective)
- Malnutrition/ excessive weight loss incidence
- Acute Kidney Injury
- Patient falls (per 1000 bed days)
- Pressure Ulcers (per 1000 bed days)

2.2 Performance against other Quality and Safety Indicators

2.2.1 Performance Against Key National Priorities

Performance against indicators that form the Oversight Framework (not already reported on within this document) are shown as follows for 2025/26.

Indicator	Quarter 1 25/26 (Percentage)			Quarter 2 25/26 (Percentage)			Quarter 3 25/26 (Percentage)			Quarter 4 25/26 (Percentage)			Target	Full year average
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	59.6%	60.8%	60.8%	59.9%	59.1%	59.3%	59.7%	59.5%	59.2%	58.3%	59.5%	61.4%	**92%**	59.8%
A&E: Maximum waiting time of four hours from arrival to admission/transfer/ discharge	69.3%	70.5%	71.0%	74.2%	74.1%	70.6%	69.8%	67.1%	65.3%	66.2%	74.4%	71.6%	**78%**	70.3%
All cancers: 62- day wait for first treatment from referral/screening	52.3%	48.2%	52.5%	58.8%	71.7%	59.1%	67.2%	70.4%	66.1%	62.1%	63.3%	74.2%	**85%**	62.2%
Maximum 6-week wait for diagnostic procedures	35.2%	35.1%	33.6%	35.1%	38.8%	35.9%	38.4%	41.6%	46.5%	46.5%	37.2%	29.9%	**1.0%**	37.8%

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2.2.2 NHS Staff Survey Results

Results of the 2025 Staff Survey for NLAG

All NHS trusts are required to survey their workforce annually using the National Staff Survey. A total of 124 questions were asked in the 2025 survey, of these, 110 can be compared to 2024 and 101 can be positively scored. The NHS England benchmark reports are themed in line with the seven NHS People Promise areas.

The National Staff Survey ran between September and December 2025. Picker is commissioned by 50 Acute and Acute Community Trusts organisations to run their National Staff survey, including HUTH.

NLAG's **completion rate** was maintained at 42% (3281 staff responded compared to 3230 last year).

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.05	5.73	6.39	6.05	5.37	6.05	6.51	6.46	5.80
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	3272	3273	3251	3248	3053	3253	3273	3275	3274

The National Staff Survey measures organisations against key themes, seven of which are based on the national People Promise indicators. Each indicator is a score out of 10.

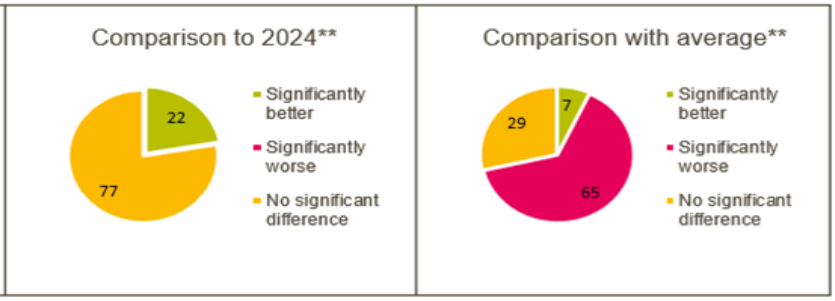
NLaG has improved across many elements of the People Promise,

People Promise elements	2024 score	2024 respondents	2025 score	2025 respondents	Statistically significant change?
We are compassionate and inclusive	7.00	3213	7.05	3272	Not significant
We are recognised and rewarded	5.56	3214	5.73	3273	Significantly higher
We each have a voice that counts	6.35	3185	6.39	3251	Not significant
We are safe and healthy	5.93	3175	6.05	3248	Significantly higher
We are always learning	5.27	3015	5.37	3053	Not significant
We work flexibly	5.75	3193	6.05	3253	Significantly higher
We are a team	6.40	3204	6.51	3273	Significantly higher
Themes					
Staff Engagement	6.43	3215	6.46	3275	Not significant
Morale	5.64	3214	5.80	3274	Significantly higher

The table below shows comparison scores for NLAG in 2025.

7856	7793	42%	48%	42%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (3281)	Average response rate for similar organisations	Your previous response rate

48%	q25c. Would recommend organisation as place to work
49%	q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation
60%	q25a. Care of patients/service users is organisation's top priority



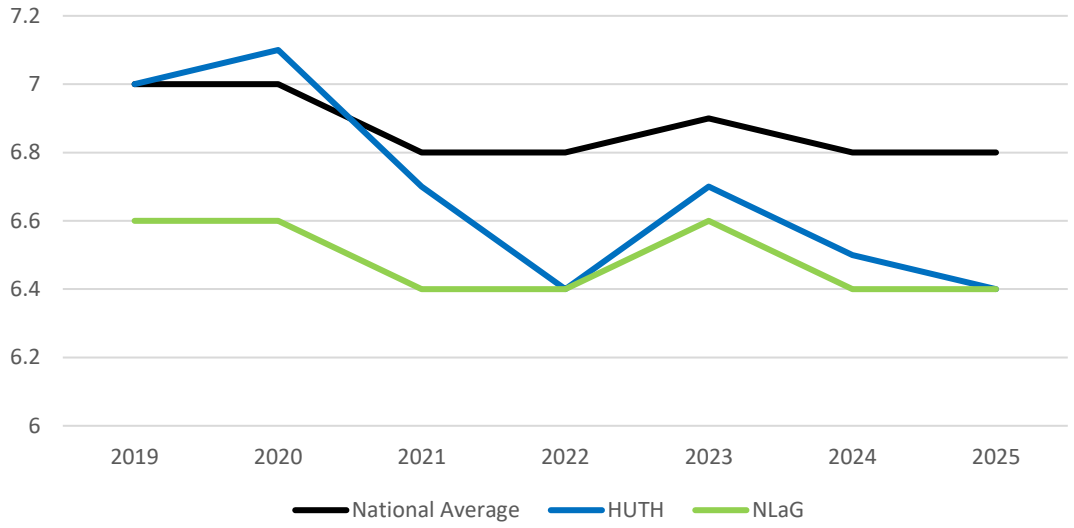
*Bank worker survey results are presented via separate reports for those organisations who took part
**Chart shows the number of questions that are better, worse, or show no significant difference

Staff Engagement

One of the key measures in the National Staff Survey is that of staff engagement, which is seen as a strong indicator of cultural health in an organisation. NLAG has maintained staff engagement in the 2025 survey.

Our Group People Strategy 2025-2028 deals with the basics of enabling a solid psychologically safe environment, whilst pushing the boundaries and practicalities of what a positive and healthy staff experience should look and feel like. The partnership has focused on the key element of our People Strategy – Putting People First. This has been our byline for improving the culture of our group and creating a working environment where everyone is supported to deliver high quality care and services as well as generate ideas for improvement and deliver on those ideas.

A chart showing staff engagement trend data for the past seven years is below.



NLAG maintained a score of 6.47 in 2024 to a score of 6.4 in 2025. Whilst this remains below the national average, the Trust is seeking through its improvement journey to return ahead of national average as it was prior to the pandemic.

Care Groups and Directorates have been asked to develop local plans for improvement and progress is measured in our monthly performance meetings. A set of corporate actions have been developed to address issues in the key areas – Communication, Health and Wellbeing, Reward and Recognition and Essential (CARE) needs. The below table provides an overview of the actions that have been developed.

Putting People First	Key Themes	Actions
Communication	**Staff engagement**	Managing change well, involving people in decisions about them, intra-departmental communication, raising concerns, Just Learning Culture/accepted responsibility, staff networks, team meetings, FTSU, Bridget, ATCE
Action	**Health and wellbeing**	Managers proactively checking in – daily activity, staff support services, wellbeing events and activities, physio4staff, coaching, mentoring, mediation, Occupational Health, support with challenging events work/personal
Recognition	**Reward and recognition**	Long service, Golden Stars, Shining Lights, national awards, King's honours, training and development, progression, talent development, appraisal, lottery and events, staff benefits
Essentials	**Foundations**	Staff rest areas, parking, hot and healthy food provision, IT and digital inclusion, work/life balance, flexible working, working environments

2.2.3 Freedom to Speak Up

Freedom to Speak Up (FTSU) is core to the delivery of the People Strategy, supporting the development of our culture at NLaG and reinforcing the values and behaviours. FTSU processes are in place to support patient safety and improve staff experience and provides an additional route to raise workplace concerns in a confidential manner. Freedom to speak up supports the NHS People Promise which states:

"We all feel safe and confident when expressing our views. If something concerns us, we speak up, knowing we will be listened to and supported. Our teams are safe spaces where we can work through issues that are worrying us. If we find a better way of doing something, we share it. We use our voices to shape our roles, workplace, the NHS, and our communities, to improve the health and care of the nation. We take the time to really listen – beyond the words – to understand the hopes and fears that lie beneath them. We help one another through challenges, during times of change, and to make the most of new opportunities".

The Freedom to Speak Up Guardian (FTSUG) role at NLAG is undertaken by the Head of Freedom to Speak Up, Liz Houchin and the role is supported by both an Executive Sponsor and a Non-Executive Director sponsor. The FTSUG attends and reports directly to the Group Trusts Boards-in-Common (held in public), and various committees and includes presenting a high level summary of the types of concerns being raised through this role, any learning and the proactive activities undertaken by the FTSUG to promote and raise awareness of speaking up.

As a result of continued engagement and promotion during 2025/26, the number of concerns raised to the FTSUG to date is 388 which makes the Trust an above average reporter when compared nationally.

2.2.4 Duty of Candour

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires healthcare providers to respond to patient safety incidents that result in moderate or severe harm or death. This includes informing people about the incident, providing reasonable support and providing truthful information and a timely apology.

The CQC assessed the Trust most recently in December 2022 against the Duty of Candour requirements. The CQC found that staff understood Duty of Candour and were aware of their responsibilities under the Duty of candour requirements.

When a notifiable safety incident is reported, there is a Trust expectation that:

- Verbal apology is provided within 10 working days of being reported,
- Written apology is provided within 10 working days of being reported,
- Where further enquiries or investigations are needed, their outcomes are shared within 10 working days of being completed.

Compliance is managed and monitored through the Trust's local risk management reporting system and is an integral part of the reporting and subsequent incident management process.

The quarter four figures for duty of candour demonstrates 100% completed for the Trust. During 2025/26 a significant amount of work has been undertaken to improve the timeliness of duty of candour and this will continue into 2026/27.

2.2.5 Guardian of Safe Working

The Exception Reporting process was introduced under the 2016 Terms and Conditions of Service for Doctors and Dentists in Training. Its purpose is to ensure that instances of overtime working, changes to working patterns, insufficient service support, and missed educational opportunities are formally recorded for both doctors in training and locally employed doctors.

We are now in the tenth year of the 2016 national contract for doctors in training which aimed to encourage stronger safeguards to prevent doctors working excessive hours. The changes to the Terms and Conditions of service came into effect in February 2026 and were adopted across the group following a trial period starting in October 2025. This mostly changed the way exception reports are submitted and handled, giving greater safeguards to resident doctors regarding confidentiality.

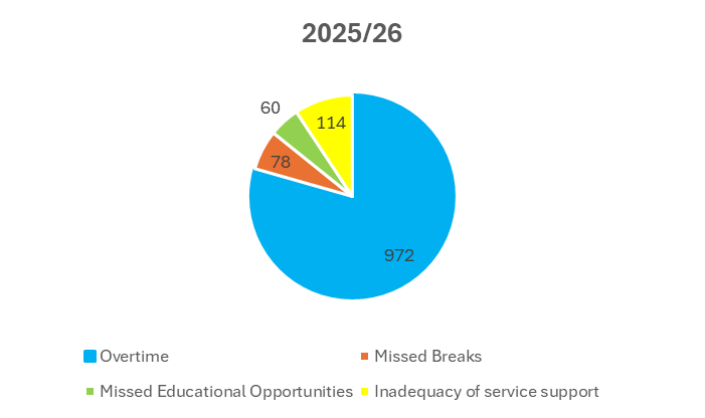
Exception reporting is a valuable instrument that provides up to date information regarding pressure points in the system. It ensures safe working hours and improves the morale of doctors in training, the quality of medical training and patient safety. It is also the agreed contractual mechanism for ensuring that trainees are paid for all work done.

The safety of patients is a paramount concern for the NHS and for us as a Trust. Staff fatigue is a hazard to both patients and staff. The safeguards for working hours of doctors in training are outlined in the terms and conditions of service (TCS) and are designed to ensure that this risk is mitigated, and that this mitigation is assured.

The Trust continues to achieve a high fill rate for doctors in training, exceeding 90%. This has had a positive impact on rota resilience, compliance with working hour requirements, and access to educational and training opportunities.

Number of deanery appointed doctors and dentists in training currently in post at Northern Lincolnshire and Goole NHS Trust: **339.5**

- Establishment: **375**
- Vacancies: **35.5**
- Fill rate: **90.5%**



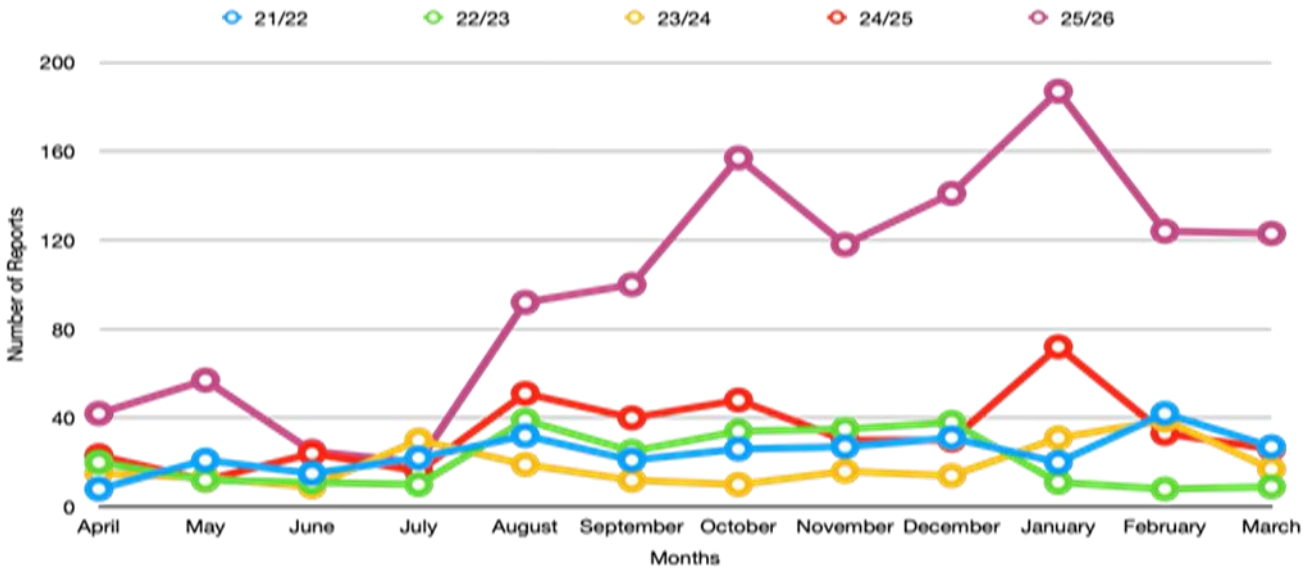
Of the 1,224 exception reports submitted during the reporting period, 24 were identified as breaches of the rota rules outlined within the Terms and Conditions of Service. These breaches resulted in fines totalling £3382.90 being issued to departments for safe working violations.

Responsibility for rota design and coordination currently sits within the Medical Staffing team. This provides robust oversight of rota development and ensures compliance with the Terms and Conditions of Service set out in the Resident Doctors Contract. The effectiveness of this oversight is reflected in the relatively low number of rota breaches recorded during the year.

Care Group:	Total fines levied:
Family Services	£2262.51
Specialist Medicine	£100.76
Digestive Diseases	£31.77
Acute and Emergency Medicine	£696.66
Head and Neck	£291.20
Total	**£3382.90**

Work to review the rotas of doctors at all grades has been ongoing, led by the Medical Directors. Information provided by the guardian of safe working contributes to this. There is a dedicated resident doctors forum which runs every month and is attended my many senior managers in addition to resident doctor representatives. Attendance at this forum has improved throughout the year, reflective of the good engagement with the resident doctors.

Figure 1- Comparison of reports received over the past five years



2.3 Statements of Assurance from the Board

2.3.1 Review of Services

During 2025/26 the Northern Lincolnshire and Goole NHS Foundation Trust provided and/or subcontracted 7 relevant health services. The 7 services are taken from the Trust's standard contract with the ICB as the "categories of service which the Provider is commissioned to provide under this contract". These are:

- A&E Services
- Acute Services
- Cancer Services
- Community Services
- Diagnostic, Screening and/or Pathology Services
- End of Life Care Services
- Urgent Treatment Centre Services

The Trust has reviewed all the data available to them on the quality of care in 7 of these relevant health and care services.

The income generated by the relevant health services reviewed in 2025/26 represents 100% of the total income generated from the provision of relevant health and care services for 2025/26.

2.3.2 Clinical Audits and National Confidential Enquiries

Participation

During 2025/26, 55 national clinical audits and 4 national confidential enquiries covered relevant health services that Northern Lincolnshire and Goole NHS Foundation Trust provide.

During that period Northern Lincolnshire and Goole NHS Foundation Trust participated in 96% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Northern Lincolnshire and Goole NHS Foundation Trust were eligible and/ or 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

National Audit Programme	Participated	% of Cases Submitted
BAUS - British audit Of the investigation and referral of women with recurrent urinary tract infection using recent Guidance (BOOMERANG)	✓	100%
BAUS - Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	✓	100%
Breast and Cosmetic Implant Registry	✓	100%
Case Mix Programme (CMP)	✓	100%
Emergency Medicine QIPs: Care of Older People	✓	100%
Emergency Medicine QIPs: Mental Health Self Harm	✓	100%
Emergency Medicine QIPs: Time Critical Medications	✓	100%
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	✓	100%
Fracture Liaison Service Database (FLS-DB)	✓	24%
National Audit of Inpatient Falls (NAIF)	✓	100%
National Hip Fracture Database (NHFD)	✓	100%
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	✓	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	✓	100%
National Diabetes Core Audit	✓	100%
National Diabetes Footcare Audit (NDFA)	✓	100%

National Audit Programme	Participated	% of Cases Submitted
National Diabetes Inpatient Safety Audit (NDISA)	✓	100%
National Pregnancy in Diabetes Audit (NPID)	✓	100%
Gestational Diabetes Audit	✓	100%
National Audit of Cardiac Rehabilitation	✓	100%
National Audit of Care at the End of Life (NACEL)	✓	100%
National Audit of Dementia (NAD)	Data collection paused Nationally for 2025/26	Data collection paused Nationally for 2025/26
National Audit of Metastatic Breast Cancer (NAoMe)	✓	100%
National Audit of Primary Breast Cancer (NAoPri)	✓	100%
National Bowel Cancer Audit (NBOCA)	✓	100%
National Kidney Cancer Audit (NKCA)	✓	100%
National Lung Cancer Audit (NLCA)	✓	100%
National Non-Hodgkin Lymphoma Audit (NNHLA)	✓	100%
National Oesophago-Gastric Cancer Audit (NOGCA)	✓	100%
National Ovarian Cancer Audit (NOCA)	✓	100%
National Pancreatic Cancer Audit (NPaCA)	✓	100%
National Prostate Cancer Audit (NPCA)	✓	100%
National Cardiac Arrest Audit (NCAA)	✓	100%
National Heart Failure Audit (NHFA)	✓	100%
National Audit of Cardiac Rhythm Management (NACRM)	✓	100%
Myocardial Ischaemia National Audit Project (MINAP)	✓	100%
National Audit of Percutaneous Coronary Intervention (NAPCI)	✓	100%
National Child Mortality Database (NCMD)	✓	100%
National Comparative Audit of Blood Transfusion: 2025 Major Haemorrhage Audit	✓	100%
National Early Inflammatory Arthritis Audit (NEIAA)	✓	100%

National Audit Programme	Participated	% of Cases Submitted
National Emergency Laparotomy Audit (NELA) - Laparotomy	✓	Data unavailable
National Emergency Laparotomy Audit (NELA) - No Laparotomy	X	0%[1]
National Joint Registry	✓	100%
National Major Trauma Registry	✓	100%
National Maternity and Perinatal Audit (NMPA)	✓	100%
National Neonatal Audit Programme (NNAP)	✓	100%
National Ophthalmology Database (NOD): Age-related Macular Degeneration Audit	X	Did not participate[2]
National Ophthalmology Database (NOD): Cataract Audit	X	Did not participate[2]
National Paediatric Diabetes Audit (NPDA)	✓	100%
National Perinatal Mortality Review Tool (PMRT)	✓	100%
NRAP: COPD Secondary Care	✓	64%
NRAP: Adult Asthma Secondary Care	✓	100%
NRAP: Children and Young People's Asthma Secondary Care	✓	100%
Perioperative Quality Improvement Programme (PQIP	✓	100%
Sentinel Stroke National Audit Programme (SSNAP)	✓	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	✓	100%
UK Parkinson's Audit	✓	100%

National Confidential Enquires (NCEPOD)

National Confidential Enquires	Participated	% of Cases Submitted
Acute illness in people with a learning disability	✓	100%
Stabilisation of the critically ill child	✓	100%
Pleural Procedures	✓	100%
Rib Fractures	✓	100%

[1]Note: It is not possible to identify cases retrospectively as the cases for inclusion do not undergo any procedure to help identify them, which makes submitting to the audit challenging. There is not an agreed process to identify cases prospectively.

[2] Note: The Trust did not participate in the National Ophthalmology Database Audit as this is not a mandated audit under NCAPOP and data collection is expected to be via an automated Electronic Patient Record System such as Medisoft that the Trust does not have. Therefore, it was agreed through the Trust's Clinical Effectiveness Group not to participate in the audit as diverting clinical resources to collect the vast amount of data required manually would be an adverse risk to the quality of the service. Instead, it was agreed that a local audit project of cataract surgery covering the key standards would be undertaken in its place to allow some level of benchmarking in comparison to the published national audit data.

National Clinical Audits Actions

The reports of 18 national clinical audits were reviewed by the provider in 2025/26 and Northern Lincolnshire & Goole Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

National Audit	Summary of some actions taken
National Emergency Laparotomy Audit 2023	• Anaesthetists contacted via email to highlight the need to be in theatre for high-risk cases and the issue highlighted to Governance. • Cases that were deceased during the period to be identified and reviewed for possible learning • Surgeons to change practice to include pre-operative mortality risk on the operation notes so it is easily found, to increase the rate at which it is found and submitted to the audit. • Surgical Project Lead to write to Radiologists to request they amend their practice to just give a brief report on WebV to show they have discussed the case with the surgeons.
BAUS IDUNC Audit	• Discuss the importance of having a risk stratified approach at the Urology MDT meeting and encourage it to happen going forward.
BAUS Nephrostomy Audit	• Audit Lead to review the 5 cases in the audit to determine the cause of the delay from their diagnosis to their nephrostomy.
National Kidney Cancer Audit 2024	• Email cancer manager and highlight concerns around data accuracy to improve the data completeness for tumour size and TNM staging.
National Prostate Cancer Audit 2024	• Email cancer manager and highlight concerns around data accuracy to improve the data completeness for performance status, gleason score and TNM staging.
National Joint Registry 2024	• Contact to be made with the pre-assessment nurses and trauma coordinators and encourage them to complete the NJR consent form with the patients when they consent for surgery. Also ask them to fill in the patient's BMI on the NJR form. • Remind consultants to monitor their individual NJR compliance.
National Fracture Liaison Service Database (FLS-DB) 2024	• Continue with current practice as above the national average for KPI10 • Fracture Liaison nurse to ensure the data is submitted in a timely manner. KPI10 is above national average • Fracture Liaison nurse to signpost patients to the resources available • Fracture Liaison nurse to ensure the request for the DX scans are in a timely manner • Fracture Liaison nurse to signpost patients to the resources available • Ensure the data collection and input is in a timely manner
Perinatal Mortality Review Tool (PMRT) 23/24	• Discuss at board the potential provision for admin support for PMRT • All cases are reviewed using PMRT. Regular meetings and recommendations to Health Partnership board • Separate PMRT action plans in place and monitored

National Audit	Summary of some actions taken
	• All relevant staff to ensure they have up to date training for PMRT and usage of parent engagement materials • To ensure PMRT reviews have external representation
MBRRACE-UK (Perinatal Confidential Enquiry) Perinatal care of recent migrant women with language barrier 2022 state of national report	• Healthcare professionals should be given training on specific social, religious and psychological needs of women who are recent migrants, asylum seekers or refugees.
MBRRACE-UK Saving Lives Improving Mothers care Maternal Morbidity Confidential Enquiries – 2020/2022 data	• DCG218 to be amended to include a clear pathway. • DCG336 to be updated and amended. • Review existing training and implementation of further training required.
RCEM Care of Older People	• Rockwood frailty screening tool added to Emergency Departments Electronic Patient Management system and made mandatory for all patients aged 65 and above. • 4AT delirium screening tool added to Emergency Departments Electronic Patient Management system and made mandatory for all patients aged 75 and above. • Electronic Nursing documentation rollout on Emergency Departments Electronic Patient Management system – includes Falls risk assessments & Post fall care plan.
RCEM Time Critical Medications	• Implementation of consultant led front rapid assessment model for walk in patients, reducing time to triage & providing earlier opportunities to identify patients on time critical medications. • Work collaboratively with East Midlands Ambulance Service to improve identification of Time Critical Medications at the earliest possible point in patient pathway.
RCEM Mental Health (Self Harm)	• Priority Triage System in place with additional Mental Health assessment document (WQN-1507 Management of Adults with Mental Health Presentations v2.2) containing TAG (Threshold Assessment Grid) to assess risk of further self-harm and categorize into a low, medium, high-risk level with traffic light system which indicates list of actions and regularity of observations. • Nursing Safety checklists added to Emergency Departments Electronic Patient Management system. This will aid retrospective evidence on continuous patient monitoring for patients at heightened risk of further self harm.
National Audit of Percutaneous Coronary Intervention (NAPCI)	• HHP pathway for PCI procedures updated. All NLAG procedures to be undertaken at DPOW. Complex PCIs to be undertaken at CHH.
Sentinel Stroke National Audit Programme (SSNAP) - 2023/2024	• Recruit to the Assistant Stroke Data Collector vacancy. • Increase the establishment of the Speech and Language Therapy team to support with the swallowing assessments. • Improve MDT working by having a dedicated clinician to prioritise the new patients that require a review.
National Audit of Care at the End of Life (NACEL) - 2024	• Implement a new version of the care in the last days of life document. • Workstream to be introduced to identify when patients are in the last year of their lives and that Advanced Care Planning is undertaken on those identified. • QI to be added to the agenda for new starters during care camp to encourage staff to undertake QI work.

National Audit	Summary of some actions taken
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People – Cohort 6	• A questionnaire to be sent to cohort 6 and cohort 7 patients to address the mental health provision (Cohort 8 to be completed prospectively). • Review processes and ensure MRI is requested as urgent.

Local Clinical Audits Actions

The reports of 27 local clinical audits were reviewed by the provider in 2025/26 and Northern Lincolnshire & Goole NHS Foundation Trust intends to take the following sample of actions to improve the quality of healthcare provided.

Local Audit	Summary of some actions taken
Audit of Guideline Adherence in Upper GI Bleed Management	• Organised departmental teaching regarding management of Upper Gi Bleeding
Strabismus Surgery Audit	• AS-20 QoL questionnaire to be used to measure patient satisfaction with service, to begin use pre and post operatively. • Only patients that attend a pre-operative assessment to be given a TCI (To Come In) date.
Adherence to Radiological Guidelines for Bedside and Radiographic CXR Confirmation of NG Tube Placement in ITU - Are We Getting It Right? (SGH)	• Presentation delivered providing education to staff on trust guidelines. Reaudit this topic over the next few months to see if we can result in a meaningful improvement in clinical practice
An audit on day case surgery at Goole	• Email to be sent to senior members in the team including the audit lead, T&O general manager and clinical lead for elective procedures to highlight the audit results and inform them of suggested recommendations.
Anaesthetic assessment for Obstetric patients with BMI >40 (SGH)	• Re-audit with larger sample covering longer time frame. • Present the results at an audit meeting.
Antibiotic prophylaxis in DPOW theatres	• Surgical practice and guidance often differ. The NLaG surgical prophylaxis guidance is planned to be reviewed soon, after which the second audit cycle can be conducted.
Audit to check ventilator settings in SGH ICU (SGH)	• Further ad hoc teaching on this to be implemented by ICU nurse trainers for new staff
Documentation of Nasogastric Tube Position (DPOW)	• Continue to try to gain clarification from Trust managers regarding achieving competency in confirming NG tube placement from radiological images. • The development of an online form with the WebV team to improve the standard of documentation.
Prospective Audit of Blood Transfusion Sample Collection and Labelling in the Accident & Emergency Unit in DPOW, Grimsby	• Discuss with the transfusion managers to explore upcoming training sessions for staff in the A&E department and the possibility of implementing continuous training sessions. • Meet with the transfusion managers to explore ways of liaising with Emergency Department staff to provide individualised feedback to healthcare staff involved in blood sampling. Additionally, I will discuss with the clinical educator in the ED the possibility of increasing education and awareness around correct sampling and labelling practices to reduce errors.
Readmission to ITU at DPOW	• To contribute as a team member to formulate and submit a proposal to the Trust for a pilot project on patient rehabilitation following critical care discharge.

Local Audit	Summary of some actions taken
Review of Ortho-Geriatric Assessment Proforma Compliance with Updated Clinical Guidelines. (SGH)	• To address the gaps identified in the old ortho-geriatric proforma, a revised new version will be developed with structured prompts for cognitive assessment, frailty, falls risk, nutrition, delirium screening, MDT involvement, medication review, rehabilitation, and discharge planning. The new proforma will be aligned with BOAST, NICE, and local trauma guidelines. • Staff training sessions will be conducted to ensure correct completion. • Compliance will be monitored through re audits, with feedback provided to the team to drive continuous improvement.
Time interval from flexible cystoscopy an transurethral resection of bladder tumour (TURBT)	• Improve the cystoscopy documentation of tumour morphology and stratification the risk, based on this morphology. Share this information at the audit meeting with colleagues.
To assess Sedation hold in Ventilated patients (SGH)	• To add the sedation hold option in the ICU daily assessment chart
Unplanned admissions of Orthopaedics patients from day care surgery (DPOW)	• Regular review of the unplanned admissions and re-audit
C Section category target times	• Presentation of recommendations at Gynae forum meeting, as well as a poster in the O&G department with audit results and reminders of target times. • Gynae forum meeting reminding all staff the importance of correct documentation standards and reminder how to input C section details into BadgerNET system.
Electronic discharge summary Gynaecology	• Share findings and ensure medical team are aware that attention should be taken when submitting EDS • Spot check of submitted EDS to identify areas missing. • Inform the actual F1, F2 and ST1 trainees separately in DPoW and SGH to incompletely documented points in the EDS, ensure this is included in the induction about the importance of the accuracy of EDS, and show them the critical standards that needs improvement. • Investigate together with the F1, F2, ST1 actual team. Can they/we see any explanation for the missing/inconsistency of those standards in the EDS and their suggestions for improvements in the future. The form of this would be: a. send the standards that we plan to discuss b. to allocate about 1 hour for discussion c. to summarise the conclusion, d. inform from the conclusion for the F1, F2, ST1+ to reach improvement.
Seven Day Services in Gynaecology	• Re-audit sample to be requested and reviewed when required. • Ensure handovers are reviewed as part of the re-audit and virtual views are counted.
Spot check WHO Checklist Audit	• Midwifery Staff on the Labour Ward to be made aware of the need to document on Badgernet rather than completing a paper version. • E-mail results to Labour Ward Lead Consultants to discuss non-compliance with medical staff covering the labour ward. • E-mail copy of results to Maternity Matron and CDS Ward Manager at SGH and Labour Ward Managers at DPOW. • Non-compliant cases with blank sections on Badgernet / in the case notes to be discussed with individual Midwives (SGH). • Midwifery staff on the Labour Ward to be made aware of the need to document on Badgernet rather than completing a paper version.
Maternity Anaesthetic Reviews in Badgernet	• Escalate to Anaesthetic Clinical Lead, re-iterating the importance of the need to complete Badgernet documentation.

Local Audit	Summary of some actions taken
O2 Prescribing in the Emergency Department	• Named O2 champions on a daily basis • Laminated poster to push the quality of full completion of prescription chart (posters up in Ambulance Handover, RAT, and Zone B near board rounds) • Communicate requirements to Emergency Department's WhatsApp group to raise awareness • Added to 2026/27 audit programme for at least 2 cycles depending on performance
Audit of PEWs in the Emergency Department	• Clinical Educators provided time on the PEN corridor to work alongside the PEN team to build knowledge and including focused work on PEWs charts • Results fed back to clinical educators on both sides, Clinical Educators added PEWS to their training days and increased the time spent on PEWs, mock pews charts were completed and each point was discussed in detail to improve quality of completion/documentation.
Audit of Paediatric Record Keeping in the Emergency Department	• Discussed with Paediatric Clinical lead, Audit Lead and at Paediatrics Governance, agreed as the paediatric doctors use web V they can either document in Symphony ED notes, or continue to use web V, however if they use Web V this needs to be printed to be with Symphony notes for scanning to ensure a true picture of clinical care whilst in the Emergency Department. • Returning PEN Nurse manager to look to adapt the Trauma booklet to enable accurate recording of those present during resus add to actions log for group-wide Audit meeting to monitor ensuring no duplication of workstreams with QI team • Fed back documentation standards specifically RCP designation/grade to all PEN team and highlighted to ED staff on training courses • Add separate audit on care rounds for children and adults ensuring PEWs/NEWS is taken to account along with length of stay in ED to ensure required observations are taking place in expected timescales
Assessing quality of facial bone examinations against set criteria	• Presentation of audit findings to radiographers during team brief • A display poster showing the proper positioning for facial bones xray • Re-audit after one year
Reporting Urgent Findings /Results to Wards Audit	• The integration between WebV and diagnostic systems is being tested and in the future will be piloted. Eventually it will be rolled out to all areas and will mean that urgent results are given a 'push' notification to the relevant clinicians and if there is no acknowledgement of the results being reviewed it will automatically be escalated by the system. • Review whether the data collected for the audit can include the ward that has to be contacted, so that potential patterns can be identified if it the same ward or wards than cannot be contacted.
JAG GI Bleed Audit	• Review of cases that were admitted to hospital with acute upper gastrointestinal bleeding who were haemodynamically stable but were not given an endoscopy within 24 hours of admission, and those who were not haemodynamically stable but were not given an endoscopy within 2 hours of admission.
SEPSIS Pathway Audit	• Sepsis Nurse to attend an audit meeting to demonstrate how documentation can affect the coding of cases. • New group wide deteriorating patient policy currently being written to include that all children need to be screened on admission.
Learning Disability Improvement standards 2024	• Develop an audit to monitor rates of DNACPR decisions in patients with a learning disability. • Explore data available to allow monitor and oversight of emergency re-admission rates in children, young people, and adults with a learning disability.

Local Audit	Summary of some actions taken
	• Discuss with the Trust membership office the process for someone with lived experience becoming a governor and/or being involved in any Trust board sub-committees. • Discuss with workforce lead re development of new roles in learning disability.

2.3.3 Clinical Research

Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) in 2025/26 that were recruited during that period to participate in research approved by a research ethics committee or Health Research Authority was 1,657* (as at 17/04/2026).

Clinical Research Network – National Institute Health Research portfolio

The 2025-26 Annual Report highlights areas of success and notable outcomes in line with the 3 core pillars of our Humber Health Partnership (HHP) Group Research and Innovation Strategy.

Key points to note are:

- Recruited over 1,650 participants to NIHR Portfolio research across 28 studies – ranked 15th for volume in Yorkshire)
- Recruited 5 participants across 3 new commercial studies since 1st April 2025.
- Delivered feedback from 26 research participants as part of the annual NIHR Participant Research Experience Survey (PRES).
- NLaG is expected to adhere to the government expectation of supporting trial setup within 150 days (if sponsor) or within 90 days of site selection (hosted studies) to first participant consented (as measured as median days). The baseline position for NLaG in 2025-26 was 61.5 days (for those studies that recruited the first participant).
- Humber Health Partnership HHP (HUTH and NlaG) continues to support research delivery activities to over 700 projects at any one time (over 100 at NLaG).
- HHP provides a range of research study opportunities across 27 research active specialties (16 active at NLaG).
- Staff development opportunities in research have been supported across a range of staff groups and disciplines (PhDs, fellowships, internships).
- Academic and commercial partnerships remain strong and are expanding, attracting funding, recognition and highlighting areas of research excellence.
- HHP has produced over 720 publications from the HUTH and NLaG in 2025/26 (Medline and Embase) – 95 from NLaG.
- The Innovation pipeline is emerging in HHP with a number of early-stage discussions on projects that we will aim to pursue in 2026/27 with support from our partner Innovation Hub – Medipex.
- The Humber Alliance for Health and Care Innovation has been established and infrastructure developed with the appointment of a designated Programme Manager.

In 2025-26 the Group leadership and management model is stimulating increased research awareness and appetite amongst our staff. It is anticipated that this will increase the volume of our research activity overall. This can then stimulate an upsurge in research income for reinvestment and growth. In turn, this will enhance opportunities for more of our patients to take part in research and benefit from the adoption of innovative healthcare delivery.

The impact some of our strategic initiatives has delivered in 2025-26 is seen by recognition of the growing number of staff across professional groups and levels being recognised internally and externally, nationally and internationally for endeavours in research and innovation activities.

Furthermore, our research and innovation activities continue to drive highly successful academic, commercial and network collaborations that seek to address population health and healthcare access inequalities. In turn, this is yielding ever-increasing opportunities for our patients, carers and staff to take part in ground-breaking research. We have seen another year of the tireless efforts of all staff (research and non-research) in ensuring all possible opportunities to participate have been made available for our patients, staff and carers.

Research Activity Performance Summary

The following tables detail the research activity performance as of 17th April 2026:

FY by Trust
Recruitment in FY2526

Trust	Large Observational (1)	Observational (3.5)	Large Interventional (Individual)	Interventional (11*)	Commercial (0)	Total Recruitment
Total	**35,826**	**13,724**	**37,641**	**11,882**	**1,721**	**100,794**
Bradford Teaching Hospital...	10,914	1,050	1,108	1,002	119	14,193
Hull University Teaching Ho...	2,514	946	8,379	993	154	12,986
Leeds Teaching Hospitals N...	3,528	2,804	2,502	3,124	793	12,751
Mid Yorkshire Teaching NH...	3,435	144	6,789	507	63	10,938
Sheffield Teaching Hospital...	293	3,108	5,079	1,813	212	10,505
York and Scarborough Teac...	2,636	173	1,827	716	61	5,413
NIHR RDN: Yorkshire and ...	3,030	705	516	792	189	5,232
Humber Teaching NHS Fou...	3,755	170	805	110	0	4,840
The Rotherham NHS Foun...	254	92	2,832	195	0	3,373
Calderdale and Huddersfiel...	20	50	2,905	241	38	3,254
Harrogate and District NHS ...	864	221	1,638	98	11	2,832
Doncaster and Bassetlaw T...	2,028	248	66	116	14	2,472
Barnsley Hospital NHS Fou...	52	33	1,676	114	7	1,882
Airedale NHS Foundation T...	27	182	1,311	275	0	1,795
Northern Lincolnshire and ...	1,372	8	148	124	5	1,657
Other	0	661	19	500	0	1,180
Leeds Community Healthca...	0	788	0	214	5	1,007
South West Yorkshire Partn...	130	538	0	128	0	796
Sheffield Children's NHS Fo...	99	329	0	246	39	713
Primary Care	702	0	0	1	0	703
Rotherham Doncaster and ...	95	299	0	258	8	660
Leeds and York Partnership...	25	380	0	76	0	481
Bradford District Care NHS ...	36	372	0	58	2	468
Yorkshire Ambulance Servic...	0	315	41	65	0	421
Sheffield Health Partnershi...	17	108	0	45	1	171
NIHR CRN: Yorkshire and ...	0	0	0	71	0	71

Trust	Recruitment FY2526	Target	YTD Target (Mar)	Recruitment against YTD Target (Mar)	Weighted Recruitment
Northern Lincolnshire and ...	1,657	1,000	1,000	166%	4252

Celebrating Research Success in 2025-26

There are a number of notable initiatives and achievements that are currently supporting the delivery of research and innovation activities across the NHS Humber Health Partnership:

We will build the infrastructure to deliver excellent clinical research and innovation.

Research and Innovation Strategy: Work has continued to implement the Group R&I Strategy with a particular focus on supporting the uptake of research and innovation opportunities for staff across

professional groups (Clinical, Nursing, Midwifery and Allied Health Professionals), building collaborations with academia, industry and regional and national research and innovation networks.

Our attention has also centered on building an infrastructure platform from which to grow our innovation ambition and this annual report outlines the progress made in 2025-26.

New NMAHP Research Strategy launched: The new Nursing, Midwifery and Allied Health Professional (NMAHP) Research Strategy 2026–2029 was launched in late 2025. The strategy strengthens pathways for NMAHP colleagues to engage in, develop and lead research, ensuring research becomes an embedded part of everyday practice across Humber Health Partnership. It outlines priorities across building a research aware workforce, enabling research active staff and strengthening research leadership.

This strategy is an invitation to every colleague, no matter their role, to be part of a thriving research culture that can advance our professions, empower our patients, and build a healthier future for our communities.

A significant number of NMAHP initiatives were launched in 2025-26 including:

NMAHP Research and Innovation Strategy Group – to steer colleagues on the direction of the strategy and progress and to ensure all voices are heard and considered in shaping future workstreams and initiatives.

SORT Tool & Baseline Engagement Work: The NHS England Self-Assessment of Organisational Readiness Tool (SORT) has been completed and provides a baseline measure of current research activities and personnel.

Research Workforce Survey has been distributed to gather data on staff levels of research interest and experience.

Enhanced PDR – Integration of Research: The 4 Clinical Pillars of Practice (Clinical, Education, Leadership, and Research) are being embedded into the appraisal process. The RDI Matron has developed notes and guidance for both appraisers and appraisees within the HHP draft appraisal guide.

Research Training & Education: The ‘Support, Deliver, Lead’ (SDL) Training Pathway has been fully developed and tested.

Research Champions Initiative: Over 80 research-active clinical areas have been identified across the Group. Managers in these areas are being contacted to nominate a ‘Research Champion’. The Research Champion role will operate as a link role, mirroring existing link models in other domains.

Newly Qualified Staff Engagement: Research Awareness Training has been incorporated into the ‘Keep In Touch’ days for all newly qualified nurses since September 2025. A dedicated training package has been developed

NLaG and HUTH research delivery integration: 2025/26 has involved ensuring activities across NLaG are focused on generating income, where possible. Emergency Department (ED), Hepatology and Gastroenterology, reproductive health, paediatrics and Clinical Trials Pharmacy Teams have continued to work on plans to integrate research delivery and support services across the Group. These areas have provided peer support and are now routinely assessing new studies to open at all hospital sites where possible.

Aligned Digital Sponsorship Request Process: In 2025-26 we implemented a digital Group study sponsorship request process which is ensuing a consistent approach across the Group. This has already stimulated more ‘in-house’ research projects being submitted from NLaG staff. The standardised approach builds in a risk assessment of the research governance and oversight processes required and helps the Quality Assurance Team to allocate proportionate and pragmatic monitoring plans.

Aligned Digital Study Setup Process: The use of the Monday.com (MDC) platform in HHP to conduct study set-up reviews has continued to see a 40% improvement in study approvals timelines. Furthermore, the feedback from both commercial and non-commercial study sponsors has been overwhelmingly positive. NLaG implemented this platform from 1st April 2025.

Streamlining Clinical Trial Set-Up: As announced by the Prime Minister in April 2025, the UK government is committed to reducing the time it takes to get a clinical trial set up from over 250 days, down to 150 days, by March 2026. This commitment is a headline action of the Life Sciences Sector Plan and is reinforced in the 10 Year Health Plan for England.

The 150-day metric measures the time taken in calendar days for a single study **from application for regulatory approval through to recruitment of first study participant**.

It is important to note that uncertainties and discrepancies in definition and interpretation of these metrics is still being discussed across the R&D community, regulatory bodies and networks, making it difficult to use current data for purposes of our HHP baseline position and our position relative to other providers. This is further compounded by factors outside of the control of R&D Offices (i.e. the time taken for external partners to allow recruitment activities to commence) as well as variances in study complexity and volume.

With the caveats above, current data for 2025-26 shows **NLaG has a median days of 61.5 days** (against a target of 90) from site approval to recruitment of the first participant).

From April 2026, the RDN's funding model in England will allocate 20% of delivery funding towards achieving a set of KPIs focused on reducing study-set up time and improving study delivery and driving growth. Delivery organisations that have met the 90-day target described above between 1 April 2025 and 31 December 2025 will receive performance-based recognition in their funding allocation for 26/27. Further performance-based recognition will be built into future funding cycles. Core RDN funding for 2026-27 (based on 2025-26 performance data) for HUTH has been confirmed as £2.3m representing an increase of around £300k. NLaG Core funding for 2026-27 is £522k, representing a slight reduction of around £50k compared to 2025-26.

NIHR funding: HHP will soon benefit from two NIHR funded mobile research units, due to arrive in April 2026. This investment stems from an earlier national NIHR programme designed to strengthen research capacity across the NHS, including the introduction of mobile units to widen access to studies and support participation within our communities.

Following confirmation of funding, extensive planning and coordination across both Trusts has been underway in 2025 to progress the procurement and ensure the units will be ready for deployment as soon as they arrive.

These mobile units will support research delivery across both Trusts within HHP, helping us take studies closer to participants and strengthening our joint research capability.

2. We will align our research and innovation efforts to the big challenges facing our population

Cancer Vaccine Launch Pad (CVLP) update: In 2025/26 HUTH and NLaG continued to support the NHS Cancer Vaccine Launch Pad (CVLP). CVLP is a platform that will speed up access to personalised cancer vaccine clinical trials for people diagnosed with cancer. It will also accelerate the development of cancer vaccines as a form of cancer treatment. Through the CVLP, eligible people with cancer who are receiving treatment in the NHS in England can join a cancer vaccine clinical trial.

HHP is the current joint top recruiter to the BNT113-01 Head and Neck Cancer Vaccine study with 4 enrolled and 4 referred.

In 2025/26 we continued to support 6 cancer vaccine trials in collaboration with pharmaceutical company BioNTech as part of the CVLP across lung, breast and colorectal tumour sites and endometrial and head and neck cancer. We continue to establish a Humber and North Yorkshire Cancer Alliance footprint to accept patient referrals from neighbouring Trusts, including York, Scarborough and NLaG under the CVLP arrangements.

Paediatric research team (NLaG): Scunthorpe General Hospital has reached a major research milestone by recruiting the 7,000th baby worldwide into an international neonatal study.

The neoGASTRIC trial, running across the UK and Australia, is a large, multi-centre clinical trial investigating whether avoiding routine measurement of gastric residual volumes in preterm babies can help them reach full milk feeds more quickly, without increasing harm. The findings have the potential to change national and international neonatal feeding guidance, influencing care for thousands of babies in the future.

Scunthorpe General Hospital, which is a small Level 2 neonatal unit, opened to the trial in December 2024 with an initial recruitment target of 15 babies (approximately one to two per month). Since opening, the unit has more than doubled this target, successfully recruiting 32 babies to date.

This achievement is particularly notable due to the high level of staff engagement across Scunthorpe's Neonatal Intensive Care Unit (NICU), with 17 nurses and four doctors trained to recruit and randomise babies.

Diana, Princess of Wales Hospital in Grimsby has also contributed to the trial. With the same recruitment target, the unit has recruited 49 babies so far, with six nurses trained to recruit and randomise.

BaBi study: The 'Born and Bred in' family wellbeing cohort study has recruited over 1,680 participants at NLaG. The BaBi study has received such a positive response from local families and looks at both maternal health and children's health in their early years. A Group-wide approach to utilising the data generated from this study will be implemented with partners in the integrated care system (ICS) so that we can build up a much clearer picture of people's lives and answer questions that may help to improve health, care and services through research and planning.

3. We will equip our people to innovate and transform:

The Humber Alliance for Health and Care Innovation: As part of the HHP R&I Strategy focussed on 'challenge-led innovation', the Humber Alliance for Health and Care Innovation is an emerging collaborative structure between the Humber Health Partnership, the University of Hull, Hull York Medical School, and the Humber and North Yorkshire NHS Integrated Care Board. The Alliance, led by HHP, aims to support and enable innovation activity across the Group and wider region.

During the year, the Research, Development, and Innovation (RDI) Department recruited a Programme Manager, who took up post in November 2025. The role has been established to support the delivery of existing innovation projects within respiratory medicine and to develop frameworks that will enable future growth in innovation activity.

Work has begun to develop a clear identity for the Alliance, formalising workflows, and strengthening partnerships so that innovation becomes fully embedded in health and care delivery across the Humber region. Streamlined data, governance and contractual processes will increase the region's capacity for innovation, moving it beyond reliance on individual expertise and towards an established operational model where the necessary infrastructure and support are accessible across disciplines and care settings.

Medipex Service Level Agreement and Group Intellectual Property Rights Policy: Working with our local NHS Innovation Hub, Medipex, we secured a revised Service Level Agreement ensuring colleagues at

NLaG will have access to membership benefits of expert advice and hands-on support to individuals and teams that are developing novel healthcare interventions designed to deliver patient benefit.

Medipex's experienced multi-disciplinary team can help innovators assess, develop and commercialise their ideas. To complement this provision, we have also aligned HUTH and NLaG Intellectual Property policies into a harmonised single Group policy.

Network partnerships: 2025-26 has seen the start of new relationships as a Group:

Y&H Regional Research Delivery Networks (RRDN) – main funding route, hosted by Leeds Teaching Hospitals NHS Trust proving core funding for research delivery, contingency funding to increase research delivery capacity in our support services as well as strategic funding in year.

Health Improvement Yorkshire and Humber – supporting the adoption of innovation and strategic development – now routinely part of communications within HHP linking up innovators and companies wishing to test and deploy innovations within our Group.

Humber and North Yorkshire Innovation, Research and Improvement System – representing the Groups in Innovation and Research Communities of Practice – focussing on large cohort study delivery (BaBi) and the utilisation of Secure Data Environments (SDE).

Humber and North Yorkshire Cancer Alliance – supporting the uptake of cancer vaccine study roll-out across a number of tumour sites and establishing as a lead for patient referrals across York, Scarborough, Harrogate and NLaG. HHP is represented on the steering group and has been awarded several funding awards through this alliance in 2025.

Publications: Between April 2025 and March 2026 there has been 728 publications from the HUTH and NLaG search of Medline and Embase.

Two of the NLaG Senior CT MRI radiographers, Franklin Ogwudu and Godfrey Akpaniwo, recognised the challenging experience faced by patients with hearing loss or impairment who are unable to receive reassurance or instructions from the radiography staff when undergoing CT or MRI procedures. They conducted a qualitative research study to understand radiographers' perspectives of this situation with the aim of creating guidance for radiography staff and have published their findings in the journal 'Radiography'.

Group Research Events: On 20 May 2025, we proudly celebrated International Clinical Trials Day, with research teams from across HUTH and NLaG coming together to showcase the outstanding work being carried out across the group. It was a fantastic opportunity to highlight the vital role research plays in advancing patient care and innovation. The day provided an opportunity to meet our clinical trials teams, attend facility tours, information stands for diabetes, weight management and paediatric research, body composition screening and the launch of the 'Friends of ADEM (Academic Diabetes, Endocrinology and Metabolism)' community group.

In June and July 2025, HHP proactively supported the 'Be Part of Research' annual campaign led by the National Institute for Health and Care Research. It seeks to raise awareness of the important role health and care research plays, as well as drive participation in research studies.

Be Part of Research is an NIHR flagship initiative that makes it easier for more people to participate in health and care research, supporting recruitment activity across the sector.

The campaign aims to:

- Encourage more people to volunteer and participate, or get involved in research
- Significantly increase the number of people signed up to the Be Part of Research service, including more people from underrepresented groups.

2.3.4 What others say about the Trust: Care Quality Commission

Statement of compliance with the Care Quality Commission

Northern Lincolnshire and Goole NHS Foundation Trust is registered with the Care Quality Commission (CQC) for a range of regulated activities delivered across three Trust-managed locations. The Trust has undergone trust-wide CQC inspections in **2019** and **2022**, and a service-level inspection of maternity services at the Goole Midwifery Led Unit in **2023**. During **2025/26**, further service-level inspections were undertaken by the CQC in relation to **Urgent and Emergency Care**, **End of Life Care**, and **Outpatients at Goole**. At the time of publication, the reports for these inspections had not been published and the Trust continues to engage proactively with the CQC in anticipation of the reports.

The Care Quality Commission has not taken enforcement action against the Trust during 2025/26. The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reported period.

Care Quality Commission (CQC) ratings grid for the Trust:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Trustwide	**Requires Improvement** ↑ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Good** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022
Diana Princess of Wales Hospital	**Requires Improvement** ↑ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Good** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022
Goole District Hospital	**Good** ↑ Feb 2024	**Good** ↔ Nov 2022	**Good** ↔ Nov 2022	**Good** ↑ Nov 2022	**Requires Improvement** ↔ Feb 2024	**Good** ↑ Nov 2022
Scunthorpe General Hospital	**Requires Improvement** ↑ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Good** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022
Overall Trust	**Requires Improvement** ↑ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Good** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022

Following the trust-wide inspection carried out in **June and July 2022**, with the report published in **December 2022**, the Trust was rated as **'Requires Improvement' overall**. The Trust received a rating of **'Good'** for the **'Caring'** domain and for **Goole District Hospital overall**. The domains of **'Safe'**, **'Effective'**, **'Responsive'** and **'Well-led'** were rated as **'Requires Improvement'**.

A focused inspection of maternity services at the Goole Midwifery Led Unit was undertaken in **November 2023**. This inspection did not result in a change to the Trust's existing ratings and supported the Trust in retaining the **'Good'** overall rating for **Goole District Hospital**. NLAG CQC Reports

The Trust continues to have engagement meetings with the CQC and provides them with regular updates on progress with the plan along with supporting evidence.

2.3.5 Information on Quality of Data

Northern Lincolnshire and Goole NHS Foundation Trust submitted records during 2025/26 (as of March 2026) to the Secondary Users service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data (as of March 2026):

Which included the patient's valid NHS Number was:

- **96.73%** for admitted patient care.
- **99.96%** for outpatient care.
- **99.24%** for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:

- **100%** for admitted patient care.
- **100%** for outpatient care.
- **100%** for accident and emergency care.

2.3.6 Information Governance

Data Security & Protection Toolkit

The Information Governance Data Security and Protection Toolkit (DSP Toolkit) is part of the Department of Health's commitment to ensuring the highest standards of information governance. It allows organisations to measure their compliance against legislation and central guidance and helps identify any areas of partial or non-compliance.

It remains Department of Health policy that all organisations that process NHS patient information provides assurance via the IG Toolkit and is fundamental to the secure usage, sharing, transfer, storage and destruction of data both within the organisation and between external organisations. The Information Governance Assurance Statement is a required element of the DSP Toolkit and is re-affirmed by the annual submission to demonstrate that the organisation has robust and effective systems in place to meet statutory obligations on data protection and data security. The submission deadline for the 2025/26 DSP Toolkit Assessment is 30th June 2026 and updates can be accessed via the NHS Digital website: https://www.dsptoolkit.nhs.uk/OrganisationSearch/RJL

The current status for Northern Lincolnshire and Goole NHS Foundation Trust following submission of the 2024/25 DSP toolkit is **Approaching Standards**.

2.3.7 Payment by Results Clinical Coding Audit

Clinical Coding Audit

The Coding Department operates as a shared service across the Humber Health Partnership, and each Trust within the group has an individual audit produced for the Data Security and Protection Toolkit.

A programme of internal speciality and individual coder audits have been conducted by the Group's NHS England approved auditors throughout 2025/26. A sample of audited FCEs (Finished Consultant Episodes) for each Trust has been taken and summarised below.

Percentage Correct			
Primary Diagnosis	**Secondary Diagnosis**	**Primary Procedure**	**Secondary Procedure**
90.61%	88.4%	88.24%	88.2%

Department Priorities 25/26

Priority	Level	Progress Update	Status
Maintain data quality standards	High	Coder audits and spot checks have, on average, attained DSPT level of attainment score for Standards met. Coding depth remains on par with previous years.	Partially complete
Have a robust internal training programme for new starters.	High	One new starter has completed foundation training this year and is progressing through the next stages of their career pathways.	On-going.
Improve performance related to local and national deadlines	High	Seeking out efficiencies in day-to-day practices and processes. On-going recruitment strategy.	On-going
Raise recruitment and retention rates of qualified and experienced clinical coders.	High	Coding structures and recruitment and retention strategies continually under assessment and review.	On-going
Standardise Coding Department's policies, documentation and training and support materials across the Group.	Moderate	Group wide shared platform created for all Department's polices, documentation and training materials.	Complete
Expand current RPA solution to include Chemotherapy day case episodes.	Moderate	Work in progress, some system constraints encountered.	On-going.

2.3.8 Learning from Deaths

During 2025/2026, **1,431** of Northern Lincolnshire & Goole NHS Foundation Trust's patients died in hospital as an inpatient. In addition to this, 268 deaths occurred in ED or were dead on arrival and there were 12 still births. The inpatient deaths comprised of the following number of deaths which occurred in each quarter of that reporting period:

- **359** in the first quarter
- **312** in the second quarter
- **388** in the third quarter
- **373** in the fourth quarter

As at the 1st April 2026, 1,617 have been reviewed by the Medical Examiners, 110 had a Structured Judgement Review (SJR) and 8 were subject to a Patient Safety Incident Investigation (PSII). There were no cases which were subjected to both an SJR and a PSII. The number of deaths in each quarter for which an SJR or a PSII was carried out (as of 1st April 2026) was:

- 21 in the first quarter
- 32 in the second quarter
- 33 in the third quarter
- 32 in the fourth quarter

A Patient Safety Incident Investigation (PSII) does not assess the avoidability of death.

There was 13 case record reviews, and 7 investigation completed after 2024/2025 which related to deaths which took place before the start of the reporting period.

Summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the deaths identified during 2025/26

And,

Description of the actions which the Trust has taken and those proposed to be taken as a consequence of what has been learnt during 2025/26

And,

An assessment of the impact of the actions taken by the Trust during 2025/26:

Following on from the success of the introduction of the Medical Examiner Service, the service became statutory from 09/09/2024. The team now reviews all non-coronal in hospital deaths, and community deaths for North and North East Lincolnshire. The team has full establishment with 4.3 whole time equivalent (WTE) Medical Examiners comprising of 10 Medical Examiners and 4.3 full time equivalent Medical Examiner Officers. This is an invaluable service that oversees and scrutinises the quality of care for patients who die. The benefits of the service for families or carers are likely to be the most impactful as the service provides clarity, dissipates doubts, and helps to alleviate negative thoughts and experiences the families or carers may be experiencing.

Providing a voice to the bereaved at this most difficult of times is critically important and rewarding. It allows them to make significant improvements in what happens after death, including identifying areas for improvement as well as highlighting good practice. The service ensures a correct and accurate cause of death is registered and appropriate deaths are referred to the coroner.

Representatives from the Medical Examiners attend the Trust's Mortality Improvement Group quarterly for triangulation of learning.

The Trust is committed to continuously learning from deaths to improve the quality of the following learning themes that have been identified in 2025/26:

- Lack of early recognition of commencing End of Life care pathway.
- Quality/Legibility of Medical/Nursing Documentation.

Actions implemented to address areas for improvement include:

- Introduction of End-of-Life Mortality and Morbidity (M&M) meeting.
- Introduction of a Group wide, monthly, Humber Health Partnership Mortality Improvement Group (MIG) meeting.
- Recognition of End of Life and care planning are included in mandatory training for nursing staff delivered by the specialist team at NLAG with different options of training delivery offered to improve compliance, including face to face, virtual training and targeted sessions.
- The End-of-Life team at NLAG have commenced training for student nurses.

A Groupwide Sepsis improvement plan has also been developed, which provides a comprehensive list of actions designed to improve the care given to patients with sepsis. These actions include:

- Implementing and embedding a unified Group Sepsis Guideline across services.
- Enforce mandatory sepsis e-learning, including inclusion within staff induction
- Establishing and operating a new Sepsis Task & Finish Group under enhanced senior oversight
- Improving sepsis screening compliance, with a focus on high-risk patients and early identification
- Reviewing the current sepsis screening tool against the National Tool to simplify and improve usability
- Developing and launching ward-level Sepsis QI dashboards to monitor screening compliance, time-to-antibiotics and reliability of escalation and response
- Strengthening data quality and reporting through a new Sepsis QI BI dashboard to reduce reliance on manual reviews
- Reinforcing compliance with 1-hour sepsis treatment protocols, including timely antibiotic administration
- Improving repeat observation and monitoring reliability, particularly for patients with NEWS 5–6
- Using staff feedback, questionnaires, and data to identify and test new PDSA cycles for sepsis improvement
- Defining and confirming Sepsis outcome, process, and balancing measures to support ongoing monitoring and assurance

2.3.9 Reporting Against Core Indicators: NHS Digital

Since 2012/13 Northern Lincolnshire and Goole NHS Foundation Trust has been required to report on performance against a core set of indicators using data made available by NHS Digital. The core set of indicators are prescribed in the NHS Outcomes Framework (NHS OF) developed by the Department of Health and Social Care to monitor the health outcomes of adults and children in England. The framework provides an overview of how NHS Trusts are performing and uses comparative data against the national average and other NHS organisations with the lowest and highest scores.

The Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described because performance information is consistently gathered and data quality assurance checks made as described in the next section.

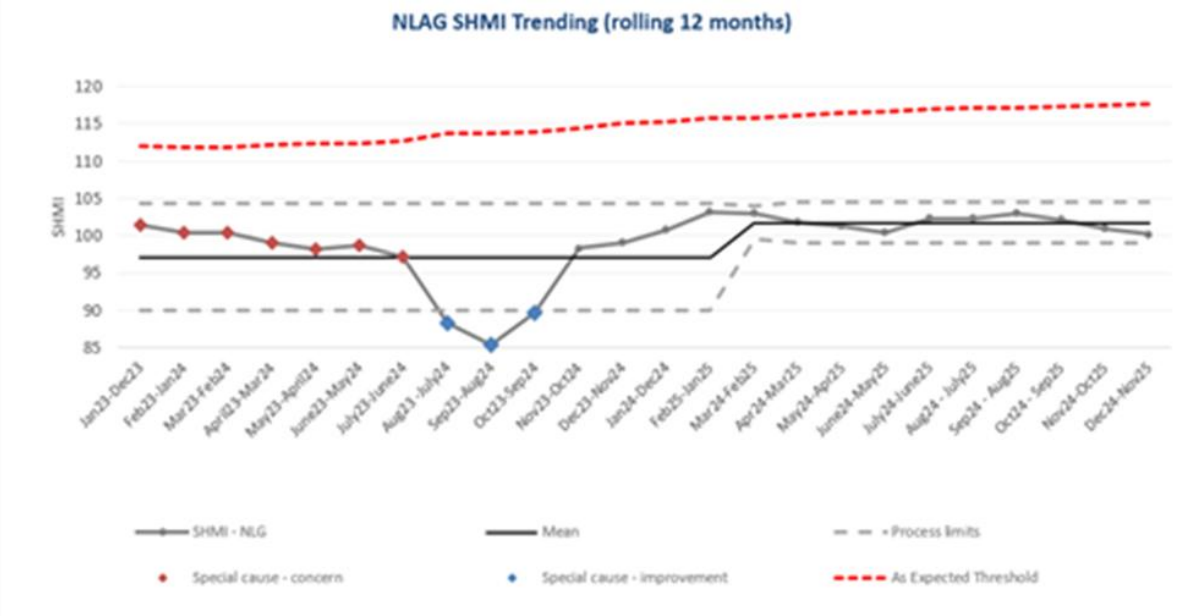
Domain 1 – Preventing people from dying prematurely.

Summary Hospital Mortality Indicator (SHMI)

The table below details performance against the Summary Hospital-level Mortality Indicator (SHMI):

Indictor	Trust Value Jan – Dec 2024	Trust Value Jan – Dec 2025	National Average	National Highest	National lowest
The value of the SHMI for the Trust for the reporting period*	1.00	0.99	1.00	1.33	0.71
The banding of the SHMI for the Trust for the reporting period*	2 (as expected)	2 (as expected)	2 (as expected)	1 (higher than expected)	3 (lower than expected)
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period*	27%	32%	44%	69%	17%

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of- interest/hospital-care/quality-accounts). * Reporting period January 2025 to December 2025



- The above chart illustrates the Trust's performance against the Summary Hospital Mortality Indicator (SHMI). The SHMI is a Standardised Mortality Ratio (SMR). SHMI is the only SMR to include deaths out-of-hospital (within 30 days of hospital discharge). The SHMI is a measure of observed deaths compared with 'expected deaths', derived statistically from the recording and coding of patient risk factors.

- NHS Digital Guidance on SHMI interpretation states that the difference between the number of observed deaths and the number of expected deaths cannot be interpreted as 'avoidable deaths.' The 'expected' number of deaths is not an actual count but is a statistical construct which estimates the number of deaths that may be expected based on the average England figures and the risk characteristics of the Trust's patients. The SHMI is therefore not a direct measure of quality of care.

- The Trust, as demonstrated in the chart above, has maintained its SHMI value resulting in the Trust being categorised as having mortality that is 'as expected'. *The rolling 12-month SHMI value for the Trust for the period January 2025 – December 2025 was 0.9989.

- Palliative care coding is a group of codes used by hospital coding teams to reflect palliative care treatment of a patient during their hospital stay. There are strict rules that govern the use of such codes to only those patients seen and managed by a specialist palliative care team.

- The SHMI does not exclude or make any adjustments for palliative care. Other Standardised Mortality Ratios (SMRs) like the Hospital Standardised Mortality Ratio (HSMR) adjust for palliative care.

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

- The Trust experienced data quality issues over a 7 month period during April 2024 – October 2024 with the submission of incomplete data sets. The missing data has been resubmitted via the SUS data warehouse, and the information was refreshed within the Trust's mortality information system CHKS. However, in the publicly available dashboards NHS England release, this information has not been corrected yet.

Therefore, the NHS England SHMI data for the Trust should be interpreted with caution as it is not accurate due to historical data quality issues that are yet to be updated by the National team.

- The Trust continues with the processes to improve the quality and accuracy of the data that underpins statistical mortality calculations like the SHMI and improving the consistency of the learning from deaths programme of work.
- Data continues to highlight the difference between hospital sites with SGH having higher levels of palliative care coding than DPoW. This reflects the disparity of consultant-led Palliative care provision between both hospitals.
- Planned increase in consultant capacity has progressed. Currently, two General Practitioners (GPs) are undergoing an induction period to support within the North Lincolnshire community. Plans for the future include increased visibility of palliative care consultant at DPoW.

The Trust has taken the following actions to improve the indicator and percentage in indicators a and b, and so the quality of its services by:

- Clinician led coding validation sessions have been reinstated in 2025/26, currently focusing on infection related SHMI Diagnosis Groups.
- The Trust is taking a pro-active approach to monitoring outcome risk of death for each SHMI diagnosis group and undertakes deep dive work with case reviews to learn from any early warning indicators to prevent future outlier alerts.
- Quality of care assessments, undertaken via the Structured judgement Review methodology, in key areas where SHMI/HSMR/RAMI is higher than the mean value for seven consecutive months.
- A full assessment of how the Trust learns from mortality and morbidity at a Specialty level, allowing for full gap analysis and identification of replicable excellent practices.
- Development of a fully digital SJR training package, accessible via the online portal.
- Development of a regular Learning from Deaths Poster that is shared across the Trust.
- The Clinical Coding team receives a monthly palliative care extract from the WebTV Team. This is used to code patients who received specialist palliative care.

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

Patient Reported Outcome Measures (PROMS)

The table below details performance against the Patient Reported Outcome Measures (PROMs):

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

a) Hip replacement surgery

b) Knee replacement surgery

c) Varicose vein surgery (Not applicable as no longer performed by the Trust)

The PROMs is a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. The table shows the adjusted health gain reported by the patient reported using the EQ-5D index, following their surgery. EQ-5D index collates responses given in 5 broad areas (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression) and combines them into a single value. The single value scores for the EQ-5D index range are from -0.594 (worse possible health) to 1.0 (full health). As participation is voluntary, patients can choose not to participate in PROMs.

Type of surgery	Sample time frame	Trust adjusted average health gain	National average	National highest	National lowest
Hip replacement (Primary)	April 2023 – March 2024	0.440	0.458	0.581	0.352
	April 2024 – March 2025	0.402	0.451	0.544	0.268
Knee replacement (Primary)	April 2023 – March 2024	0.316	0.323	0.405	0.231
	April 2024 – March 2025	0.311	0.320	0.497	0.231

Source: NHS Digital Quality Account Indicators Portal, Primary data used, EQ-5D Index used (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

NHS digital has stated that the April 2024-March 2025 data has been released as management information, rather than as an official statistic and whilst investigations continue, the findings should be treated with caution.

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

Patient-reported outcomes following primary knee replacement surgery are within the statistically calculated confidence intervals for EQ-5D measures. Patient-reported outcomes following primary hip replacement surgery are outside the statistically calculated 95% control limit but within the 99.8% control limit for EQ-5D measures.

The Trust has taken the following actions to improve these outcome scores, and so the quality of its services by:

- A summary report will be compiled and discussed with the clinical lead to generate an action plan to improve the outcome scores.
- The summary report will be presented at the Patient Safety Learning Group and also the Quality and Safety Committee-in-Common.

Patients readmitted to a hospital within 30 days of being discharged

The table below details performance against the Readmission rate into hospital within 30 days of discharge:

Prescribed Information	Trust (April 2024 to March 2025)	Trust (April 2025 to February 2026)	National average	National Highest	National Lowest
The percentage of patients aged 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*	14.82%	14.91%	9.56%	20.52%	0.41%
The percentage of patients aged 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*	9.60%	9.88%	7.13%	18.86%	0.21%

Source: CHKS https://icompare.chks.co.uk/ : GIRFT – Readmissions within 30 days (April 25 – Feb 26)

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust is above the England average for readmissions

Northern Lincolnshire and Goole NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services:

- The Trust continues to monitor its readmission rates on a monthly basis (from locally available data) and compares these to the national rates in order to benchmark our performance.
- The Trust works with GIRFT across five workstreams, including one that focuses on readmission reasons and identifying improvements.
- Patient flow and discharge workstreams continue in order to achieve national targets with a full Patient Flow Campaign being embedded throughout the organisation. This incorporates all aspects of patient flow and discharge involving a programme of back to basics a fundamental aspect of planning discharge from admission which will improve discharge planning, improve patient experience and reduce incidents around discharge safety.
- Discharge lounge's now have substantive teams and good leadership within the departments and open until 10pm 7 days a week.
- Weekly No Criteria Reside director meeting in place to review adult patients with complex care needs, supported by Northern Lincolnshire system partners.

Domain 4 – Ensuring people have a positive experience of care

Responsiveness to the Personal needs of patients

Humber Health Partnership
Humber Health Partnership is committed to ensuring that people have a positive experience of care, delivered with compassion, dignity and respect and shaped by what matters most to our patients, families and carers.

Understanding patient experience
The Group uses a range of intelligence to understand how well it is meeting the personal needs of patients, including their involvement in decisions, emotional support, privacy, medicines information and clarity about who to contact following discharge.
The most recently published National Inpatient Survey data (2024), released in June 2025, demonstrates strong performance across key patient experience indicators. The Group however does not rely solely on national benchmarking to understand patient experience.

		Historical					External	
		2020	2021	2022	2023	2024	Average	Trust
Q46	Treated with kindness and compassion	-	-	-	98%	99%	98%	99%
Q47	Treated with respect and dignity overall	98%	98%	99%	98%	99%	98%	99%
Q48	Rated overall experience as 7/10 or more	82%	85%	81%	82%	82%	83%	82%

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of- interest/hospital-care/quality-accounts).

Real-time and locally collected feedback forms the cornerstone of our assurance and improvement activity. This includes:

- Group review and action planning of all surveys from the National Survey programme, supporting alignment to all national patient experience questions
- Friends and Family Test (FFT) feedback collected across wards and services
- Direct feedback received through PALS, complaints, compliments and concerns
- Development of a new quality assurance tool for wards, services and departments which will include patient experience

These sources are triangulated to provide a more comprehensive and timely understanding of patient experience and emerging themes.

Learning from feedback and complaints

The Group places strong emphasis on learning from patient and family feedback. PALS and complaints services provide person-centred responses, alongside clear signposting and timely resolution wherever possible. Continued work to improve complaint pathways has supported responses and learning outcomes. Themes identified from complaints, PALS concerns, FFT and surveys are reviewed regularly and shared with clinical and operational teams to support service level improvements. Learning is also escalated through clinical governance structures to ensure organisational oversight and assurance.

Board Stories & the Lived Experience

Patient stories and lived experiences are shared at Board level to support oversight of the current and ongoing pressures within services. Patient stories are also presented at the Patient Experience Learning Meeting and Care Group Governance meetings, Ensuring that the patient voice is heard and responded to by both the Executive team and wider staff groups.

Improving involvement, communication and support

Feedback continues to highlight the importance of compassionate communication, feeling listened to and being supported by people who matter most during times of illness. In response, the Group has embedded a number of initiatives to improve experience, including:

- Flexible visiting arrangements, recognising the positive impact of family presence
- The ongoing development of a care partner, enabling patients to identify people who can support them during their hospital stay
- Continued focus on staff engagement, recognising the link between staff experience and patient experience

The Group recognises that access to emotional support and trusted individuals can have a significant impact on patient wellbeing and recovery.

Using feedback to improve care in 2026–27

During 2026–27, the Group will continue to strengthen how patient experience data is used to drive improvement by:

- Enhancing triangulation of feedback across FFT, surveys, PALS and complaints
- Supporting services to use local feedback to inform quality improvement initiatives
- Embedding learning into Care Group and Group-wide governance
- Ensuring patient experience insight informs service redesign, Quality Improvement programmes and assurance processes

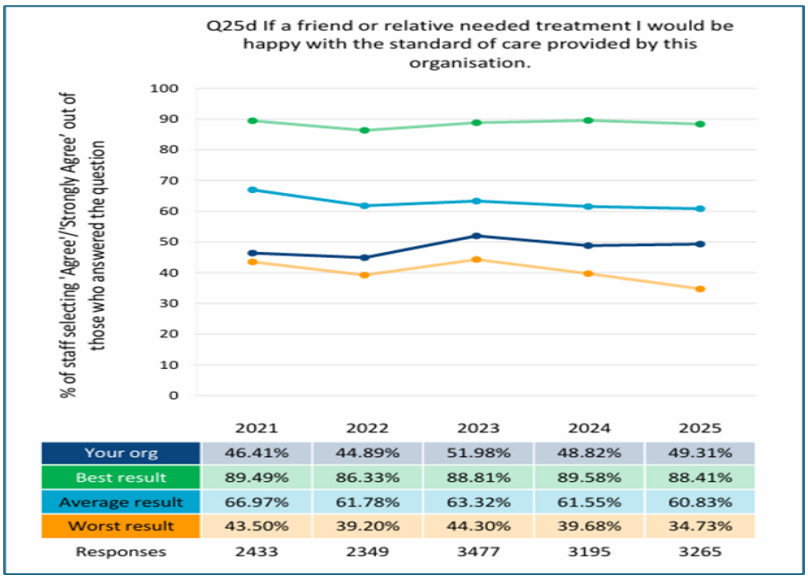
The Group remains committed to listening to patients and families, acting on what they tell us, and using that learning to continuously improve the quality, safety and care patients receive.

Staff recommending Trust as a provider to friends and family

The table and graph below, from the National Staff Survey 2025, detail performance against the Friends and Family Test for staff – would staff recommend the Trust as a provider of care to their family and friends:

Prescribed Information	2024	2025	National Average	National highest	National lowest
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 or friends*	48.82%	49.31%	60.83%	88.41%	34.73%

*Most recent staff survey data – 2025 (Source: (Source: https://cms.nhsstaffsurveys.com/app/reports/2025/RJL-benchmark-2025.pdf)



Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- The data is collected from our staff as part of the latest National Staff Survey.

Northern Lincolnshire and Goole NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services:

- The Group has developed and launched its Group People Strategy 2025-2028.
- The Group has identified 4 key actions to focus on corporately and within care groups.
- The work will be monitored through the Workforce, Education and Culture Committee in Common.

Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

Risk assessed for Venous Thromboembolism (VTE)

The national compliance rate target for VTE risk assessed within 16 hours of admission to hospital is **95%.**

The following table demonstrates the compliance rates for the NLaG each quarter during the reporting period alongside comparative data both regionally and nationally:

% of patients risk assessed for VTE within 16 hours of admission*	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
NLAG	93.9%	93.2%	91.2%	93.4%
North East and Yorkshire Average	88.4%	89.4%	89.2%	89%
National Average	91%	91.6%	91.6%	92%
National Highest	99.7%	100%	99.9%	99.8%
National Lowest	14.5%	15.4%	14.9%	15.1%

*Source: Statistics » VTE risk assessment 2025/26

Northern Lincolnshire and Goole Foundation NHS Trust considers that this data is as described for the following reasons:

- Following clarification in the calculation rates from NHS England, the average compliance rate for NLaG over 25/26 is **93%** but remains higher than the national average of **91.5%** and the regional average of **89%**.

Northern Lincolnshire and Goole Foundation NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services:

- Implemented the national requirement for VTE risk assessment to be completed within 14 hours of admission, in line with NICE guidance, and updated Trust reporting arrangements accordingly.
- Enhanced business intelligence reporting, including ward-level dashboards and corrected cohorting logic, to allow targeted support in areas with lower compliance.

Northern Lincolnshire and Goole Foundation NHS Trust intends to take the following actions to further improve the VTE compliance rate:

- Continue to strengthen real-time monitoring and escalation arrangements to support earlier identification and response where VTE assessments are overdue.
- Sustain and refine targeted improvement support for services with lower compliance, informed by regular performance reporting and SPC analysis.
- Maintain strong clinical and executive oversight through established governance forums to support sustained compliance with the national 95% standard.

Clostridium Difficile infection reported within the Trust

The table below details performance against the C. Difficile infection rate, per 100,000 bed days:

Prescribed Information	2024/25	2025/26	National Average (England)	National Highest	National Lowest
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 reporting period*	6.34	11.67	Not published	42.15	7.47

(Source- Most recent data published by https://publicview.health/Auth/MetricDetail/RJL/19 Feb 25 - Jan 26 Metric - C.difficile cases per 100k bed days (Hospital Onset))

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

There has been a national and regional increase in the rates of c.difficile, which is also reflected in the Trust rates.

Northern Lincolnshire and Goole NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services:

- Enhanced environmental cleaning protocols including terminal cleaning and equipment decontamination, including daily environmental cleaning with a sporicidal disinfectant to reduce environmental contamination.
- Review of screening policy for C. difficile at admission to identify colonised patients early, including diagnostic stewardship to ensure appropriate testing and reduce false positives or unnecessary tests.
- Robust antimicrobial stewardship to minimise unnecessary antibiotic exposure, aligned to the revised antimicrobial formulary.
- Appropriate use of barriers to cross infection including handwashing, bare below the elbow, personal protective equipment, isolation protocols, environmental and equipment containment controls.
- Monitoring of effectiveness of barriers, including hand hygiene through audit.· Ensuring all patients receive the assistance needed for daily patient bathing or hygiene support with soap and water to reduce skin contamination.
- Interprofessional collaboration and accountability processes to ensure consistent implementation of prevention measures.
- Infrastructure and systems to support CDI prevention, including rapid communication of test results and isolation protocols.
- Oversight of process and controls by the Strategic Infection Reduction Committee.

Patient safety incidents

The table below details performance against the number of patient safety incidents reported and the level of harm:

Time period	Trust number of patient safety incidents reported	Trust rate of patient safety incidents reported per 1,000 bed days	Trust number of patient safety incidents reported involving severe harm or death	Trust rate of patient safety incidents reported involving severe harm or death per 1,000 bed days	Percentage of safety incidents that resulted in severe harm or death
April 2023 – March 2024	19,627	82.29	33	0.14	0.17%
April 2024 – March 2025	17,624	84.03	23	0.10	0.13%
April 2025 – March 2026	18,908	71.42	29	0.11	0.15%

Source: The data in the table has been calculated internally by the Trust.

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

- Incident reporting data from April 2025 to March 2026 aligns with expected patterns, with no significant fluctuations compared with previous years.

The Trust has taken the following actions to improve this number and/or rate, and so the quality of its services by:

- The Trust has successfully implemented the national NHS platform - Learning from Patient Safety Events (LfPSE) and has maintained a positive reporting culture since transition.
- The Trust continues to monitor incident rates locally and actively promotes and encourages staff to report all incidents including near misses as part of an open and transparent culture designed to support learning and improvement, recognising that high levels of reporting indicate a high level of safety awareness. This is particularly so when the high level of reporting is for no/low harm or near miss incidents. 98% of patient safety incidents reported in each of the timeframes shown in the table were in this category of harm levels.
- The central incident team provide routine and ad hoc training on reporting and managing incidents on the Trust's local risk management system. Incident reporting is promoted at various forums including nurse preceptorship and doctor inductions.
- Incidents are reviewed daily (Monday to Friday) by the central incident team and the Care Group quality governance teams. Each Care Group also carries out a weekly review to ensure prompt action and effective follow-up. This regular oversight supports early identification of emerging risks and helps capture learning that can drive improvements and be shared across teams. Incidents with potential harm are also reviewed and escalated at the daily groupwide safety huddle, attended by Care Group Nurse Directors and key stakeholders such as the Safeguarding and Falls teams, to ensure prompt action and oversight.
- The Trust analyses data for understanding of key themes, sharing learning opportunities and for informing quality improvement activities.
- The Patient Safety Incident Response Framework (PSIRF) has been successfully implemented across the organisation with the Trust's response to patient safety incidents focussing on effective learning and improvement, compassionate engagement, and embedding a patient safety culture.
- A range of proportionate learning responses are used to respond to patient safety incidents, focusing on areas where improvement will have the greatest impact as outlined in the Trust's Patient Safety

- Investigation Response Plan. Findings from these reviews are used to identify themes and trends across the organisation for learning and improvement purposes.
- The Trust oversees the identification and management of incident investigations weekly at the Learning Response Panel ensuring that the appropriate learning response is undertaken in line with the PSIRF and Patient Safety Incident Response Framework Policy and Plan.
- Completed learning responses including Patient Safety Incident Investigations (PSIIs) are presented at the PSIRF Oversight Group to ensure they are conducted to the highest standard, that there has been effective engagement with patients, families and staff, and the safety actions will lead to improvements.
- Learning is shared via relevant improvement groups as well as via speciality and Care Group governance meetings.

ANNEXES

This section includes:

Annex 1: Stakeholder Feedback

This section includes:

- Statement from NHS Humber and North Yorkshire Integrated Care Board (ICB)
- Joint Statement from Healthwatch North Lincolnshire, Healthwatch North East Lincolnshire and Healthwatch East Riding of Yorkshire
- Statement from local council overview and scrutiny committees (OSC)
- Statement from the Trust's Council of Governors
- Trust response to Stakeholder Statement

Statements from Key Stakeholders

Statement from NHS Humber and North Yorkshire Integrated Care Board (ICB)

The NHS Humber and North Yorkshire Integrated Care Board (ICB) welcomes the opportunity to review the 2025/26 Quality Account for Northern Lincolnshire and Goole NHS Foundation Trust. We would like to take this opportunity to thank all staff for their continued dedication and commitment to improving quality, patient safety and the experience of those who use its services.

The ICB acknowledges this has been another challenging year, with significant operational pressures particularly across urgent and emergency care, and over the winter period. We recognise the challenges relating to infection prevention and control, patient flow and pressures in the Emergency Department. We acknowledge the work of the Trust and regular assurances provided to the Quality Improvement Group as the Trust progresses its improvement journey.

Humber and North Yorkshire ICB acknowledge the commitment of the Trust in working to achieve its 2025/26 quality priorities, included end of life care, the deteriorating patient, sepsis, medication safety, and the application of the Mental Capacity Act. We are pleased to hear about how the Trust will ensure improvement is informed by patients, families and staff. The Trust continues to actively engage with people using the services and in seeking to improve, shape priorities and enhance its responsiveness to feedback.

We note the ambitions and momentum in this improvement journey and plans to improve upon the Trusts current Care Quality Commission rating which is currently "requires improvement".

Humber and North Yorkshire ICB support the Trust's 2026/27 priorities, which appropriately reflect both provider and system priorities, including sepsis improvement and reduction in mortality. We also wish to highlight the aims for 2026/27 in relation to infection prevention and control, including reductions in Clostridium Difficile and bloodstream infections and the strengthened focus on reducing catheter-associated infections. We note the further work in the development of improvement plans and enhanced data collection through the Humber Health Partnership Group Infection Reduction Committee. The ICB looks forward to seeing the delivery of sustained reductions in healthcare-associated infections over the next year.

The ICB further looks on with interest to hear of the progress made across the coming year as the Trust embarks on the Safer Surgery priorities with the ambition of reducing Never Events. We welcome hearing more on these priorities over the coming months and as we prepare for Winter 2026/27 and the implementation of plans in reducing and to eradicate the use of Corridor Care and Temporary Escalation Spaces.

We acknowledge the Trust's progress in implementing the Patient Safety Incident Response Framework (PSIRF), including the use of proportionate learning responses, strengthened oversight arrangements and continued high levels of incident reporting; reflecting a growing safety culture. We look forward to hearing more on the impact of learning, on reducing repeated harm and the priorities within the Patient Safety Incident Response Plan. We are particularly interested to learn how these are aligned to the Trust's 2026/27 quality priorities; supporting clear links between PSIRF insights and quality improvement priorities and timely implementation of learning and safety actions in evidencing sustained improvement.

We welcome the Trust's continued commitment to improving services for children and young people and in the continual training to staff in supporting this. It is positive to note that the Children and Young People Survey has been prominently highlighted from the outset; demonstrating clear recognition of the importance of children and young people experiences of the Trust. We note the audit and improvement work in particular, the inclusion of children within the deteriorating patient policy for sepsis screening on admission

and that the Paediatric Early Warning Score (PEWS) audits which form part of the Trust's programme of local audits. We recognise that the Trust is a key partner in local area arrangements for children and young people with Special Educational Needs and Disabilities (SEND) and contribute to the strategic improvement plans.

We note the good integration of maternity and neonatal oversight in the Account, including the National Neonatal Audit Programme participation and the information relating to the work and achievements of the Paediatric Research Team. We particularly note the neoGASTRIC Trial and further applaud the Trust on the clear high level of staff engagement, a critical factor in the success of the Programme.

The ICB would like to congratulate the Trust on the number of notable achievements, including an Health Service Journal Patient Safety Award for staff wellbeing initiatives, the achievement of national accreditations including the British Society of Gynaecological Endoscopy, Joint Advisory Group and performance in clinical research and innovation, including pioneering Artificial Intelligence technology to identify fractures.

The ICB would also like to formally congratulate the Trust on being awarded the Baby Friendly Initiative (BFI) Gold Award, delivered by UNICEF. This represents a significant achievement and reflects a strong organisational commitment to promoting and supporting breastfeeding, with well-established benefits for the health and wellbeing of both babies and mothers.

The Humber and North Yorkshire Integrated Care Board confirm, to the best of our knowledge, the 2025/26 Quality Account is an accurate reflection of the quality of care delivered by North Lincolnshire and Goole NHS Foundation Trust.

The ICB remains committed to working in partnership with Northern Lincolnshire and Goole NHS Foundation Trust and the wider Humber Health Partnership to support delivery of sustainable improvements in quality, safety and patient experience, and to ensure patients across Humber and North Yorkshire receive consistently high standards of care. We look forward to seeing the progress and impact of the Trust's Quality Priorities during 2026/27.

Joint Statement from Healthwatch North Lincolnshire, Healthwatch North East Lincolnshire and Healthwatch East Riding of Yorkshire

Healthwatch North Lincolnshire, Healthwatch North East Lincolnshire and Healthwatch East Riding of Yorkshire welcome the opportunity to make a statement on the Quality Account for Northern Lincolnshire and Goole NHS Foundation Trust and have agreed to provide a joint statement.

Areas of success and innovation detailed with the Quality Accounts are a welcome addition to the account. This supports patient accessibility to information and assists public understanding of the trust's achievements.

The quality account highlights various methods in which the trust obtains patient feedback, including: the Friends and Family Test (FFT), children and young people survey, inpatient survey and the maternity survey (three of these being part of the national survey programme).

It was noticed that for the children and young people's survey most of the areas receiving lower than average scores related to communication between staff and the child or young person whilst most of the positives were around meals/access to food. Indeed, many of the areas receiving a lower score on the inpatient survey were also connected to communication between staff and patients. Worryingly, for the maternity survey some of the areas that received lower scores were around staff caring for patients during labour and birth. Sadly, the report does not explain what measures will be put in place to try and improve these areas.

Healthwatch welcomes the work done on improving end of life care including the recognition of the dying patient and comfort observations. The work Healthwatch North Lincolnshire and Healthwatch North East Lincolnshire did on End-of-life care in 2022/23 highlighted possible areas for consideration including Recommendation 5: Hospital processes should be reviewed to make sure that patients who are receiving end of life care are identified and treated with sensitivity and kept comfortable in all departments not just those caring for the patient's terminal illness. This includes being provided with a place to rest and something to eat/drink if needed.

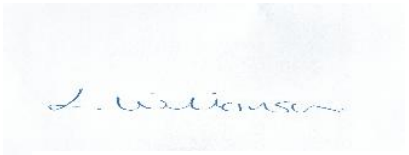
Interestingly, when Healthwatch carried out the investigation the Bluebell model was in use, however, there was no reference to this in the 2025/26 Quality Accounts. Also, the accounts state that the trust will introduce an end-of-life Mortality and Morbidity meeting as an action to address areas for improvement. Previously a multi-agency meeting took place, the Northern Lincolnshire End-of-Life Care Steering Group, again no mention of this group is made within the Quality Accounts or whether the new group supersedes the Steering Group.

Other quality priority areas for 25/26 have been worked on by the trust and actions have been taken to improve. Healthwatch teams also note the priorities for 26/27, and the actions intended from the national and local clinical audits.

It was disappointing to see that patients are waiting longer than the national priorities targets especially for 18 week waits from referral to treatment, (patients on an incomplete pathway) and people waiting for their first treatment for cancer from referral/screening. It was also disappointing to note that reported readmission rates are higher than the national average.

The report refers to continued work to improve complaint pathways that have supported responses and learning The report also states that the PALS and complaints services 'provide person-centered responses, alongside clear signposting and timely resolution wherever possible'. Unfortunately, over the year, people have reported to local Healthwatch that they have struggled to get through to PALS or receive timely communication, something Healthwatch is now looking into.

Jen Allen
Delivery Manager
Healthwatch North Lincolnshire



Lucy Wilkinson
Delivery Manager
Healthwatch North East Lincolnshire

Becky Volans
Transition and development Lead – Health, Hull CVS
For Healthwatch East Riding

Statement from Lincolnshire Council overview and scrutiny committees (OSC)

Health Scrutiny Committee for Lincolnshire Statement on the Quality Account for 2025/26 of the Northern Lincolnshire and Goole NHS Foundation Trust

Introduction

The Health Scrutiny Committee for Lincolnshire is the statutory body through which elected councillors scrutinise the work of NHS bodies and other organisations in relation to healthcare services and health outcomes for Lincolnshire residents. Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) covers a wider geographical area that extends beyond the county. The Committee recognises the important role it plays in providing services to Lincolnshire residents and is therefore pleased to act as a critical friend in reviewing the draft Quality Account for 2025/26, acknowledging the Trust's commitment to transparent reporting and continuous quality improvement.

The Committee welcomes the report's openness and candour in recognising and highlighting areas of challenge, providing a credible basis for scrutiny. The breadth of information and clear presentation of statistics across services is also noted positively.

Progress in 2025/2026

The Committee notes progress in end-of-life care, including the rollout of Comfort Observations and improved recognition of patients in the last days of life. These developments align with the Committee's view that compassion, dignity and communication are central to good care.

Progress in deterioration and sepsis is also acknowledged, particularly the introduction of mandatory training, role-specific learning, Martha's Rule and improved daily Patient Wellness Questionnaires. However, the Committee notes that Mental Capacity Act training compliance remains below the Trust's target at 70.8%, which appears low given the availability of online training. The Committee would welcome further understanding of the barriers to achieving higher compliance, the potential impact on patient care and safeguarding, and how this is being addressed especially as it is a legal requirement that appears not being met.

In medicines safety, improvements in recording patient weights in electronic prescribing systems (ePMA) appear to support safer prescribing. However, the Committee notes that the IV-to-oral antibiotic work has not yet achieved the intended reduction and that insulin safety initiatives, while positive, are still in early stages of embedding.

The Committee also considers that the continued emphasis on patient safety is appropriate, particularly in light of the reported number of Never Events and would welcome assurance that this focus is being matched by strong preventative action, learning and consistent practice across services.

National Priorities

The Committee recognises the considerable operational pressures the Trust continues to face, including challenges in meeting national standards for elective care, urgent care and cancer pathways.

As a constructive observation, the Committee considers that there is an opportunity to more closely align these operational pressures with the Trust's quality priorities. Waiting times (elective surgery, diagnostics, A&E) and access delays are not solely operational issues; they are also directly linked to patient experience, safety and outcomes.

The Committee would therefore welcome clearer articulation of improvement plans, milestones and timescales, demonstrating how the Trust intends to address the quality impact of delays and how progress will be monitored.

Priorities for 2026/2027

The Committee notes that the proposed 2026–27 priorities are sensible and reflect areas of recognised risk, however, notes its concerns that some priorities are not yet fully embedded.

The Committee would welcome clearer delivery plans, measurable milestones and demonstrable outcomes to show sustained improvement over time, particularly in areas such as sepsis, medicines safety and deconditioning.

It is positive that patient experience and workforce engagement remain priorities. However, the committee believes that emphasis on the stated 2026/27 priorities should not detract from the Trust from striving to improve these three specific areas:

- While cancer services are referenced within audit programmes, they are not explicitly reflected within the stated priorities for 2026/27. Given the national importance of cancer performance and outcomes, the Committee would welcome clarification on how improvement in cancer services, in particular meeting the Cancer Faster Diagnosis Standard, will be addressed and monitored going forward.

- The committee is also conscious that Maternity services are also an area of concern nationally and would suggest that the trust endeavours to improve the response rate for its Maternity surveys to ensure that they are fully representative – and in particular capture data from demographic groups with known national evidence of inequalities in maternity outcomes

- The Committee also notes a general lack of emphasis on identifying and reducing health inequalities across the population served by the Trust and would welcome comment on this in future Quality Accounts.

Engagement with the Committee

The Committee welcomes the constructive engagement it has had with the Trust over the past year and looks forward to building on this positive working relationship.

Data Quality and Accuracy

The Committee notes the explanation provided regarding data quality issues affecting submissions between April 2024 and October 2024.

While the Committee welcomes the transparency with which this has been reported, it emphasises the importance of ensuring data used for Quality Accounts is robust, timely and reliable. The Committee would welcome reassurance on how data quality processes have been strengthened to prevent recurrence, and how reporting timelines are being managed to ensure accuracy at the point of publication.

Presentation and Use of Data

The Committee welcomes the range of statistical information included in the report. While the volume of data is helpful, benchmarking could be strengthened further by more clearly comparing performance against best practice and high-performing organisations, rather than relying on general comparisons.

The Committee notes that, although comprehensive, the Quality Account is not always easy to navigate for a general audience. Dense narrative, technical language and complex charts can obscure key messages, and clearer structure and signposting would improve accessibility and readability. In addition, the Committee notes that some visual elements are difficult to interpret and would encourage improvements to accessibility and clarity of presentation.

Conclusion

The Committee welcomes the Trust’s commitment to transparency, quality improvement and patient safety.

Overall, the report provides a clear and honest account of performance. As improvement progresses, greater focus on measurable impact and alignment with system pressures would be beneficial. The Committee thanks the Trust for its constructive engagement and looks forward to strengthening this relationship.

Statement from North Lincolnshire Council overview and scrutiny committees (OSC)

North Lincolnshire Council's Health, Integration and Performance Scrutiny Panel welcomes the opportunity to comment on Northern Lincolnshire & Goole (NLG) NHS Trust's 2025-26 Quality Account. NLG is a key partner, providing critical services to residents of North Lincolnshire, and we have built a valuable and mutually respectful relationship over many years.

The scrutiny panel intends to invite senior Trust representatives to a number of meetings throughout 2026/7 to discuss the priorities and performance as outlined within the Quality Account document, as well as other issues of relevance.

It is with some regret that the panel reiterate that our views, repeatedly stated within our Quality Account comments over more than a decade, remain unchanged. NLG consistently performs poorly when compared to their peers, and against national targets, and unfortunately the Trust has shown a marked inability to improve over many years. We therefore welcome the recent intervention by NHS England into NHS Humber Health Partnership, by moving into Segment 5 of the National Oversight Framework. We hope that this can lead to genuine improvements for patients and residents, and we will be working with regional colleagues to seek discussions with the Trust and the wider Partnership as to progress.

To highlight some of our specific concerns, and as set out in our comments to accompany the 24/25 Quality Account, we share the Trust’s concerns regarding local performance on all of the indicators in section 2.2.1. In particular, performance against the 18-week Referral To Treatment (RTT) target remains consistently and significantly below expectations, and almost unchanged in the last twelve months. Other key indicators on 62-day wait for cancer treatment and A&E 4-hour waits are also significantly underperforming and very similar to the previous year’s data. We also note a deeply troubling deterioration of 6-week waits for diagnostics, from 18.6% last year, to 37.8% in the current account, far beyond the national target of 1%. Again, we intend to raise these concerns in-person with Trust leaders in due course.

Many other indicators described in the Account are also of concern, including paediatric sepsis, palliative coding, readmission rates, and a worrying disparity of care for end of life patients between Scunthorpe General Hospital and Diane Princess of Wales Hospital throughout 2025. We would hope to see improvements on all of the above in 26/27.

As in previous years, we would also like to record our serious concerns regarding the recent 2025 staff survey. In particular, we are alarmed to see that the responses to question Q25c “I would recommend my organisation as a place to work” and Q25d "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation” remain below 50%, with almost no improvement from last year. As the Trust would expect, we find this deeply worrying, and we will be seeking urgent discussions with Trust representatives.

The Scrutiny Panel would wish to make it very clear that our concerns about local performance in no way diminished our support for the thousands of committed and professional staff and volunteers who work across the Trust. As elected councillors, we regularly hear from residents of examples of wonderful care received in the hospital sites or in the community. In addition, specialist staff across the council regularly report excellent working relationships with NLG colleagues. Naturally, we are concerned that the Trust’s poor performance and reputation is unfairly impacting upon their morale.

Finally, as previously, we note the progress in developing proposals for the future of Goole and District Hospital. Many North Lincolnshire residents use the site for elective care or rehabilitation, so we will look forward to engaging in discussions with both the Trust and the ICB in the coming months to discuss further, in order to better understand the impact of any proposals on patients, and also the likely impact on NLG's staff, performance against the Trust's indicators, and on local health inequalities.

Cllr J Kennedy

Chair – North Lincolnshire Council's Health and Care Integration and Performance Scrutiny Panel.

Statement from the Trust's Council of Governors

The Council of Governors is pleased to have been given the opportunity to comment on the Trust's Quality Account for 2025/26 which we commend for its accessibility in terms of both content and design. Whilst we recognise the efforts of NLaG staff at all levels and in all settings to deliver safe high-quality services, we have been disturbed by some significant quality challenges that have arisen. In particular, the number of Never Events recorded in the early part of the year did not reflect well on the safety culture of the organisation. We are pleased that the concerted efforts that have been made to address these issues appear to have started to bear fruit.

Throughout the year governors continued to seek robust assurance regarding the quality and safety of all hospital and community services provided by the Trust in the context of our duty to hold Non-Executive Directors (NEDs) to account for the performance of the Trust Board. We received regular reports at Council of Governors meetings on progress in implementing the Trust's quality priorities. We were represented at meetings of the Quality & Safety Committees-in-Common in an observer capacity and NED chairs made themselves available to brief governors on committee highlights and to answer our searching questions.

Governors are pleased to see that progress that has been made against some of the Trust's 2025/26 quality priorities and we have been consulted regarding the choice of the priorities for 2026/27. We accept that in determining quality priorities it is necessary to select areas in which metrics are readily available to chart progress against targets set. Unfortunately, this requirement has precluded the selection of what governors believe to be the biggest single area of quality failure – poor communication both internally and with patients/carers. Our engagement activities with patients, carers and Foundation Trust members consistently reveal examples of poor patient experience that could easily be prevented by improved communication. We will continue to highlight feedback we receive in this regard.

Trust response to Stakeholder Statement

The Trust would like to thank all stakeholders for their considered feedback on our Quality Account for 2025/26.

The Trust welcomes and values the feedback provided by our key stakeholders in relation to this Quality Account. We are encouraged that our continued focus on patient safety, quality improvement and a strengthening learning culture has been recognised, alongside our sustained commitment to priority areas including end of life care, medication safety and mental capacity.

We acknowledge the areas for improvement highlighted, particularly in relation to performance against national standards and staff experience. In response, we are progressing a range of targeted actions through our Group People Strategy and quality improvement programmes, with a continued emphasis on improving engagement, communication and outcomes for patients.

We remain committed to working collaboratively with our partners across the Humber Health Partnership to deliver measurable improvements in quality, safety and patient experience over the coming year

Annex 2: Statement of Directors' Responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS England has issued guidance to NHS trust boards on the form and content of the annual quality accounts (which incorporate the above legal requirements) and on the arrangements that NHS Trust boards should put in place to support the data quality for the preparation of the quality report.

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

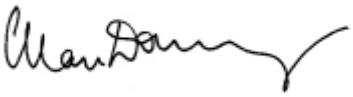
- The content of the Quality Account meets the requirements set out in the supporting guidance published by NHS England for 2025/26
- The content of the Quality Account is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2025 to March 2026
    - Papers relating to quality reported to the board over the period April 2025 to March 2026
    - Feedback from commissioners
    - Feedback from Local Healthwatch organisations
    - Feedback from Overview and Scrutiny Committees
    - Latest national inpatient survey 2025
    - Latest national urgent and emergency care survey 2025
    - Latest national child and young people survey 2025
    - Latest national staff survey 2025
    - CQC inspection report published December 2022 and November 2023

- The Quality Account presents a balanced picture of the NHS Trust's performance over the period covered.
- The performance information reported in the quality account is routinely quality checked to ensure it 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 routinely quality checked to ensure it is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.

- The Quality Account has been prepared in accordance with NHS England's supporting guidance and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account.

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

By order of the Board

Group Chair:		**Date:**	29/06/26
Group Chief Executive		**Date**	29/06/26

Annex 3

This section includes:

Abbreviations and Definitions

The below table is a list of abbreviations and definitions used throughout the Quality Accounts:

Abbreviation	Definition
AAR	After Action Review forms part of the Patient Safety Incident Response Framework.
AMaT	Audit Management and Tracking System used across the group to manage clinical audit, ward/area audit, QI, service evaluation, inspections and NICE compliance.
Audit	Audit is a process of assessing compliance with standards and specific criteria that help to provide assurance that policies, procedures and guidelines are followed. They generate opportunities to take action to improve practice.
Care Groups	Clinical Services are managed through sixteen Care Groups that operate across HHP. The Care Groups are: Acute and Emergency Medicine and Major Trauma (North) and Acute and Emergency Medicine (South), Family Services, Pathology Network, Neuroscience Specialist Care, Specialist Medicine, Community, Frailty and Therapy, Specialist Surgery, Site Management and Discharge, Cancer Network, Digestive Diseases, Head and Neck, Theatres, Anaesthetics and Critical Care, Cardiovascular Care, Specialist Cancer and Support Services and Patient Services. These Care Groups are headed by a triumvirate consisting of a Chief of Service, Director of Nursing and an Operations Director.
CAS	The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.
CHCP	City Healthcare Partnership Community Interest Company, operates in the Hull and East Riding area providing some health services.
CHH	Castle Hill Hospital.
Clinical Audit	This is the same process as Audit but focused on clinical care activities and supports assurance and improvement of clinical care.
Clinical Research	Clinical research is a branch of medical science that determines the safety and effectiveness of medication, diagnostic products, devices and treatment regimes. These may be used for prevention, treatment, diagnosis or relieving symptoms of a disease.
CQC	Care Quality Commission (CQC) regulates and monitors the Trust's standards of quality and Safety.
Data Quality	Ensuring that the data used by the organisation is accurate, timely and informative.
DPOW	Diana, Princess of Wales Hospital in Grimsby.
Duty Of Candour	Involves explaining and apologising for what happened to patients who have been harmed or involved in an incident as a result of their healthcare treatment.
ED	The Emergency Department (ED) assesses and treats people with serious injuries and those in need of emergency treatment. Its open 24 hours a day, 365 days of the year.
Engagement	This is the use of all resources available to us to work with staff, patients and visitors to gain knowledge and understanding to help develop patient pathways and raise staff morale. It also means involving all key stakeholders in every step of the process to help us provide high quality care.
ePMA	Electronic Prescribing and Medicines Administration.
Friends and Family Test	The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.
GDH	Goole & District Hospital.
Health and Wellbeing Boards	Health and wellbeing boards are statutory bodies whose role is to promote integrated working among local providers of healthcare and social care.

Abbreviation	Definition
Healthwatch	Healthwatch is an independent national champion for people who use health and social care services.
HUTH	Hull University Teaching Hospitals is a Group member alongside Northern Lincolnshire and Goole NHS Foundation Trust in the NHS Humber Health Partnership.
HRI	Hull Royal Infirmary Hospital.
ICB	Integrated Care Board.
LFPSE	Learn from Patient Safety Events is a national patient safety incident reporting system, with a direct connection form the organisations incident reporting system.
Lorenzo	Patient administration system across the partnership and electronic patient record at HUTH.
National Patient Safety Agency Alerts	NHS England and the UKHSA issue safety notices through the Central Alerting System which relevant organisations use to review and update patient safety control measures. This is monitored for timely completion.
Near Miss	A Near Miss is an incident that had the potential to cause harm, loss or injury but was prevented. These include cyber, clinical and non-clinical incidents that did not lead to harm, loss or injury, disclosure or misuse of confidential data but had the potential to do so.
NerveCentre	An electronic patient record system which provides the electronic capture of patient information, via handheld devices, at the bedside, enabling timely and accurate data collection at HUTH.
Never Event	These are defined as 'serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.
NEWS2	National Early Warning Score (NEWS) is based on a simple scoring system in which a score is allocated to six physiological measurements already taken in hospitals – respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness. NEWS2 is the latest version of the National Early Warning Score (NEWS), first produced in 2012 and updated in December 2017, which advocates a system to standardise the assessment and response to acute illness.
NHS	National Health Service.
NHS England	NHS England acts as a direct commissioner for healthcare services, and as the leader, partner and enabler of the NHS commissioning system.
NHSI	NHS Improvement (NHSI) is a non-departmental body in England, responsible for overseeing the National Health Service's foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.
NICE	The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to health and social care organisations to ensure the service provided is safe, effective and efficient.
NIHR	The National Institute for Health Research commissions and funds research in the NHS and in social care.
NLAG	Northern Lincolnshire and Goole NHS Foundation Trust is a Group member alongside Hull University Teaching Hospitals in the NHS Humber Health Partnership.
NMC	The Nursing and Midwifery Council (NMC) are the professional regulator for nurses and midwives in the UK, and nursing associates in England.
PSII	A Patient Safety Incident Investigation (PSII) is a structured investigation carried out when a patient safety incident (or near miss) indicates significant risk or opportunity for learning. Its purpose is to understand what happened, explore why it happened, identify how systems and processes contributed and drive improvements to prevent recurrence
PSIRF	Patient Safety and Incident Response Framework.
QIP	Quality Improvement Plan/Project (QIP) - The purpose of this plan is to define, at a high level; the overall continuing quality improvement journey the Trust is making and the improvement goals that the trust will work towards over the next 12 months. The plan includes all of the MUST DO and SHOULD DO recommendations in the CQC Quality Reports and detailed plans are

Abbreviation	Definition
	being developed for each project/work area. However, the plan is broader than those actions and includes longer-term pieces of work that the trust is pursuing to improve overall quality and responsiveness across the organisation, for example in relation to Quality Accounts.
RCEM	The Royal College of Emergency Medicine (RCEM) is an independent professional association of emergency physicians in the United Kingdom which sets standards of training and administers examinations for emergency medicine in the United Kingdom and Ireland.
ReSPECT	A Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) provides a summary for a person's clinical care and treatment in a future emergency in which they do not have capacity to make or express choices.
Sepsis	Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs, with the immune system going into overdrive.
SGH	Scunthorpe General Hospital.
SHMI	Standardised Hospital Mortality Indictor - is a hospital-level indicator which measures whether mortality associated with hospitalisation was in line with expectations.
Stakeholders	People and organisations that have a vested interest in the organisation functions and delivers services. This can include partner organisations, regulatory organisations, and patient and public representative groups.
SystmOne	An electronic patient record system.
Tissue viability	Tissue viability is a speciality that primarily considers all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and all forms of leg ulceration.
Trust Board	The Trust's Board of Directors, made up of Executive and Non-Executive Directors.
Ulysses	Ulysses is the Group wide incident reporting system.
VTE	Venous thromboembolism (VTE) is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis, DVT) and travels in the circulation, lodging in the lungs (known as pulmonary embolism, PE).
WEB-V	The WebV system is a clinical portal and electronic patient record used at Northern Lincolnshire and Goole NHS Foundation Trust.

How to provide feedback

We would like to hear your views on our Quality Account

The Quality Account gives the Trust the opportunity to tell you about the quality of services we deliver to our patients. We would like your views to help shape our report so that it contains information, which is meaningful to you and reflects, in part, the aspects of quality that matters most to you.

If you have any feedback regarding the Quality Account, please e-mail your comments to:

hyp-tr.quality.accounts@nhs.net

However, if you prefer pen and paper, your comments are welcome at the following address:

The Compliance Team

Quality Governance and Assurance Department
Medical Education Centre

Hull Royal Infirmary

Anlaby Road

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HU3 2JZ

Other formats

This document can also be made available in various languages and different formats including Braille, audio tape and large print.

For more information, you can contact Rebecca Thompson:

Call: (01482) 674828

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