Ashford and St. Peter's Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS			
Date of meeting	11 September 2025	**Agenda Item**	5.2
Author(s)	Anu Sehdev, Membership and Engagement Manager	**Confidential**	NO
Exec Sponsor	n/a	**Date submitted**	4.9.25
Title of paper	Patient Experience Group Report		
Presented by	Michael Smith, Lead and Public Governor for Woking and Guildford		
Committee(s) where paper has been discussed previously and outcome of discussion:			
Strategic Objective(s)			

Quality of Care	**x**	**People**		**Modern Healthcare**		**Digital**		**Collaborate**	

Executive Summary

The minutes of the meeting of the Patient Experience Group held on 16 July 2025 are attached.

Matters discussed in the meetings included:

- Integrated Performance Report – Patient Experience
- Feedback from Patient Panel meeting
- Feedback from the Learning from Patient Experience meeting
- Feedback from Group members on recent visits and meetings
- Feedback from members to Governors relating to Patient Experience
- Update on the Patient Portal

In addition on 16 July the Group heard from the newly appointed Patient Safety Partners.

Recommendation	For: Decision ☐ Discussion ☐ Information ☒
Key issues: State impact/implications and mitigation	
Quality, safety & patient impact	
Employee	
Other stakeholder(s)	
Equality, diversity & inclusion	
Finance	

Legal	
Risk(s) Identified (include link to Corporate Risk Register / Strategic (Board Assurance Framework) Risks:	

Ashford and St. Peter's Hospitals
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Council of Governors

Minutes of the Patient Experience Group
16th July 2025
14:00 – 16:00 hours

Via MS Teams

PRESENT:	Andy Brown	Staff Governor, Volunteers
	Heather Hall	Public Governor, Runnymede, Surrey Heath, Windsor and Maidenhead
	Karen Howkins	Public Governor, Spelthorne
Chair	Michael Smith	Public Governor, Woking and Guildford
	Denis Wright	Public Governor, Runnymede, Surrey Heath, Windsor and Maidenhead
IN ATTENDANCE:		
PEG-26/25 only	Jenni Davidson	Mortality Improvement Lead and Interim Head of Patient Safety
PEG-26/25 only	Diane Dodsworth	Patient Safety Partner
	Jay Dungeni	Chief Nursing Officer
	Jacqui Rees	Associate Director of Quality
PEG-26/25 only	Declan Slattery	Patient Safety Partner
NOTES:	Anu Sehdev	Membership and Engagement Manager
APOLOGIES:	Sue Doran	Appointed Governor, Spelthorne Borough Council
	Shirley Holmes	Public Governor, Woking and Guildford
	Chad Lake	Public Governor, Spelthorne
	Ann Ooms	Public Governor, Elmbridge
	Anthony Tweh	Public Governor, Hounslow, Kingston-upon-Thames, Richmond-upon-Thames and Rest of England

Minute **Action**

PEG-25/25 **Apologies**

As noted above.

PEG-26/25 **Patient Safety Partners**

The Mortality Improvement Lead and Interim Head of Patient Safety (MIL) provided an overview of the NHS Patient Safety Strategy, launched in 2019, which aimed to support staff and services in sharing safety insights and improving patient safety across the organisation. She explained that the updated Safety Incident Response Framework, known as PSIRF, had been adopted by all NHS providers in April of the previous year. It focused on compassionate engagement, systems-based learning, proportionate responses and data-driven oversight. The biggest change was that the Trust was able to sign off its own patient safety investigations.

The MIL highlighted the shift from levels of harm to recognising harm caused and considering psychological harm. The framework allowed for flexibility in choosing appropriate methodologies for responding to incidents. She described the move

from root cause analysis to a systems-based approach, considering multiple factors and interactions within the system, including tools, technology, organisational structures, and external environments. The MIL emphasised the importance of compassionate engagement and involvement of those affected by safety incidents, including staff, patients, and families.

The Trust was involving patients and families in safety investigations from the beginning, collaborating on questions and terms of reference, and allowing them to review and comment on findings and safety actions.

The MIL introduced the two patient safety partners. The Patient Safety Partner was a new role within the NHS, committed to being open and transparent about safety processes and governance. They supported the review and analysis of safety data, training, improvement projects, and engagement.

Declan Slattery shared his background in corporate HR and talent management, joining the NHS in December of the previous year. He was now working full-time with the clinical practice education team for maternity and contributing to patient safety initiatives.

Diane Dodsworth introduced herself as a retired lead nurse with extensive experience in intensive care. She joined as a patient safety partner in August of the previous year and is focused on patient engagement and the deteriorating patient.

Both Declan and Diane worked 15 hours a month in the role.

Diane described her involvement in weekly executive review meetings and patient safety incident investigations, acting as the voice of the patient and ensuring their concerns are heard.

Declan discussed the development of patient and staff surveys to understand the impact of safety incidents and gather feedback for process enhancement. The goal was to create trend analysis and drive actions for improvement. He also acknowledged the challenges in implementing surveys, including survey fatigue and the sensitivity of individuals involved in safety incidents, so the surveys aimed to gather feedback in a gentle and empathetic manner. He highlighted the importance of understanding the impact of safety incidents on staff and gathering their feedback to improve the patient safety framework.

It was queried how the role fit into the NHS jigsaw, particularly in relation to the PALS office and patient complaints. It was advised that most patient safety incidents were reported by staff, but some are identified through patient complaints or other services.

Approximately 20 to 30 incidents were reported per day, of which around 60% were safety incidents. Different methods were used to investigate these incidents. It was confirmed that patients should be informed of any incident they were involved in and offered the opportunity to be part of the investigation. The Trust was working towards involving every patient in every incident investigation. Diane clarified that the patient safety partner surveys focused on the most serious incidents, with around 8 to 10 per month. Declan added that the goal was to gather data and insights to shape patient safety work in the future. The CNO emphasised

the importance of patient experience alongside patient safety and clinical effectiveness.

In response to the query about the process for data-driven learning and action plans it was explained that the Trust used data from incidents, complaints, risks, audits and learning from deaths to develop local patient safety plans and prioritise resources. The governance structure for sharing information and learning from incidents was described with reports going through the Safety and Quality committee, quality of care, and Trust Board. The Trust also collaborated with external agencies and partners.

In response to the query on the follow-up process to ensure learning was implemented, the MIL confirmed that the Trust had test of effectiveness in place, aligned with clinical effectiveness and internal audit processes. The CNO added that the Trust was reviewing its governance arrangements to identify areas for improvement and ensure effectiveness. The Trust was seeking external support to strengthen its processes and avoid self-assessment biases.

The Group thanked the patient safety partners and the Mortuary Improvement Lead for providing information on their role and the work they did. The patient safety partners suggested they attend a future meeting when they were further into their work. **AS**

PEG-27/25 Minutes of the Previous Meeting

The minutes of the meeting held on 16th April 2025 were agreed as a correct record.

PEG-28/25 Matters Arising

None.

REGULAR ITEMS

PEG-29/25 Feedback from Patient Panel meeting

Two meetings had taken place with one where the Chair of the Patient Panel provided feedback on the work she had been involved with in relation to patient flow and the second the panel being asked to take part in a survey for Occupational Therapy and Physiotherapy. The Chief Nursing Officer and Chief Medical Officer had attended. It was agreed to pass on information to one of the Governors who was interested in becoming a member of the Patient Panel. **AB**

PEG-30/25 Learning from Patient Experience

One meeting had taken place where reports from divisions had been received.

PEG-31/25 My Care Patient Portal

The meeting due to take place had been postponed.

One Governor's experience of the portal had been good, especially since he had the NHS app as well. He had found all the information was there for him to access.

Issues relating to the delay in the user being able to change their appointments and the logging in process being lengthy were raised.

PEG-32/25 Integrated Performance Report - Quality Pages on Patient Experience

The Associate Director of Quality advised that the complaints performance had reduced due to the change in the process. Responses had been re-written to ensure they were compassionate and resolved all the issues raised. Complainants had been kept informed during the delays and more face to face meetings had taken place. The backlog had now reduced. Divisions were held more accountable for responses.

The PALS performance remained steady and the themes coming out related to appointment queries and delays and receiving results. Discharge documents and processes were being improved. Staff were being trained on how to respond to complaints. It was agreed to arrange for the lead in discharge to present the progress and improvements in the discharge process to the Group at a future meeting. **JR**

The Friends and Family Test (FFT) target had been increased to 20% and was currently at 17%. Increasing the feedback in the Emergency Department was being focused on with a kiosk about to be installed there. QR codes were also being used in areas as well as patients being followed up after their visit. The Trust was also exploring alternative ways to gather feedback and improve response rates.

In response to how many questions were on the FFT it was advised that there was only one mandatory question with follow up questions should the patient wish to provide more feedback.

Concern was raised on the numbers of patients having a long wait after the decision to admit as detailed on page 35 of the report. The graph highlighted those waiting more than 12 hours after the decision to admit had been made had risen sharply during October 2024 to 385. The CNO advised that capacity issues often led to long waits involving corridor care. This was a similar picture nationally but it was agreed to take this back to the performance team. **JD**

FEEDBACK

PEG-33/25 Feedback from Group members on recent visits and meetings

None.

PEG-34/25 Feedback from members/public to Governors relating to Patient Experience

Concerns relating to the discharge process and the delay in receiving a urology appointment were raised and it was agreed to discuss in detail after the meeting. **JR&KH**

A further concern relating to the lack of occupational therapy assessment and respite care was raised and it was agreed to discuss in detail after the meeting. **JR&HH**

Issues relating to the fitting of pacemakers was raised and again it was agreed to look into this after the meeting. **JR&KH**

Although now resolved, patients attending the Dermatology photo hub had been provided with incorrect information as to its location. The photo hub had now moved to Woking Community Diagnostic Centre.

It was queried whether the Trust had a policy on how staff should introduce themselves as it was noted that although a name would be given, their position was not always included. The CNO agreed it was important to maintain professional standards in customer care and he would be looking to improve interactions between staff and patients.

PEG-35/25 Any Other Business

The lack of recycling in the cafés at St Peter's Hospital was raised and it was agreed the CNO would look into this. **JD**

PEG-36/25 Date of Next Meeting

Wednesday 3rd September 2025, 2-4pm

Meeting Date	Minute Ref	Topic	Action	Lead	Due Date	Update	Completed
16.07.25	**PEG-26/25**	**Patient Safety Partners**	Invite the Patient Safety Partners to a future PEG meeting.	AS	2026	TBA	
16.07.25	**PEG-29/25**	**Patient Panel Feedback**	Share information with HH on how to become a Patient Panel member.	AB	ASAP	Complete	✔
16.07.25	**PEG-32/25**	**Integrated Performance Report - Quality Pages on Patient Experience**	Arrange for discharge lead to attend a future meeting.	JR	ASAP	Cherry Jordan invited to September meeting.	✔
16.07.25	**PEG-32/25**	**Integrated Performance Report - Quality Pages on Patient Experience**	Query the long wait after decision to admit; especially the spike in October 2024, with the performance team.	JD	ASAP		
16.07.25	**PEG-34/25**	**Feedback from members/public to Governors relating to Patient Experience**	Discuss detail around discharge issues and urology appointment delay.	JR&KH	ASAP	JR made an initial call but this is yet to be followed up.	
16.07.25	**PEG-34/25**	**Feedback from members/public to Governors relating to Patient Experience**	Discuss detail on the case where there was a lack of occupational therapy input and respite care.	JR&HH	ASAP		
16.07.25	**PEG-34/25**	**Feedback from members/public to Governors relating to Patient Experience**	Discuss detail around the issues relating to pacemaker fitting.	JR&KH	ASAP	JR made an initial call but this is yet to be followed up.	
16.07.25	**PEG-35/25**	**Any Other Business**	Look into recycling options at the St Peter's café.	JD	ASAP	The Director of Estates and Facilities advise that the catering team is working with our logistics department and waste company to identify the best solution. The issue currently is that people put the wrong waste in to recycling bins	✔

						which means the whole lot goes for incineration and the Trust is charged more.	