Ashford and St. Peter's Hospitals
NHS Foundation Trust

Report title:	Draft Quality Account Priorities 2026/27		
Report to:	**Public Council of Governors**		
Date of meeting:	Tuesday, 03 March 2026	**Agenda item:**	9.1
Report summary:	*This paper was previously presented to the Governors' Patient Experience Group for comments/feedback on 16 February 2026.* The Trust's draft Quality Account priorities for 2026/27 are presented to support early engagement with Governors as key stakeholders in the finalisation of the priorities. The paper sets out the draft overarching improvement priorities, the measures of success by which progress will be assessed. It also presents the rationale for selecting these priorities, and the behavioural changes required to deliver sustainable improvement (which is a new approach at ASPH). The draft priorities are aligned with the ICB's emerging system quality metrics and the Trust's strategic quality objectives. This year, the Trust has deliberately engaged Governors at a formative stage to strengthen transparency, enhance stakeholder involvement, and ensure that the priorities appropriately reflect the needs and expectations of the local communities served. This engagement is intended to provide assurance to the Council of Governors that the draft priorities have been considered in detail, that opportunities for constructive challenge and contribution have been provided, and that feedback has been captured and reflected as appropriate. At this stage, end-of-year data will be included for documentation and audit purposes. Falls data will be added once the 2025/26 financial year has concluded.		
Recommendation:	The Governors are asked to note the proposals and provide any further comments, observations and suggestions to inform refinement prior to finalisation.		
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Purpose of report:	**For Noting** ☒	**For Decision** ☐	**For Assurance** ☒

Assurance level:	**Significant** ☐ High level of confidence / evidence in delivery	**Acceptable** ☒ General confidence / evidence in delivery	**Partial** ☐ Some confidence / evidence in delivery	**No Assurance** ☐ No confidence / evidence in delivery

Link to Strategic Objectives:	Quality of Care -
Link to CQC Domains:	All CQC domains

Link to BAF risk:	SR4: There is a risk of failure to embed a culture of continuous improvement, and to deliver safe and effective care, impacting our ability to consistently deliver sustainable improvements
	SR4.1: The inability to effectively capture and act upon the patient voice, leading to missed opportunities to improve service quality, patient care, and experience...
Potential impact on stakeholders:	Quality priorities support improvement in patient care and experience and align with national and local objectives.
Next steps	Share with wider stakeholders

	Improvement Priority	Measure of Success	Rationale/behaviour change required/data source	Behavioural Metrics (Monthly/Quarterly)
Patient Safety	Strengthen the identification and escalation of adult patients at risk of deterioration using a Trust wide PIER approach (Prevention, Identification, Escalation, Response).	*Baseline (2025/26)* The PWQ had not been implemented previously. *Trajectory 2026/27* Introduce the Patient Wellness Questionnaire (PWQ) to be completed and recorded, with appropriate escalation Trust wide Q1 2026/27 60% of inpatients (excluding ITU will have daily PWQ by Q3 90% of inpatients by Q4 (excluding ITU) to have a daily PWQ completed and recorded, with appropriate escalation.	Aligns with PSIRF and the Trust Safety Priorities (deterioration likely to remain a safety priority for 2026-2028) and Martha's Rule mandatory implementation by 2026/27 **Behaviour Change Required** 1. Consistent daily safety routines: All ward staff integrate PWQ completion as a non-negotiable component of daily care. 2. Move from task-completion to clinical curiosity: Staff interpret changes in patient-reported wellness as meaningful triggers for clinical review rather than "another form to complete." 3. Escalate early, not late: Clinical teams adopt a "safe to escalate" mindset, following PIER steps reliably even when staffing is stretched. 4. Interdisciplinary communication: Nurses, doctors, AHPs, and site practitioners close the loop on escalation by confirming actions taken and documenting clear response plans.	**1. PWQ compliance reported at Trust Level. To be monitored at the department level.** **2. Sample audit of 5 patients per ward who triggered PWQ scoring to identify whether the appropriate escalation pathway was followed** **3. Sample audit of 5 patients per ward on compliance with the Early Warning Score (EWS) and deteriorating patient policy** **4. Sample audit of escalation phone call documentation from patients, family members, or staff (Marthers Rule). See also Audit 3 above.**

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Strengthen learning from patient safety events by embedding meaningful patient and family engagement throughout the Patient Safety Incident Response Framework (PSIRF)	*Baseline 2025/26* 58% of patients and/or family received formal feedback within 10 days of closure of moderate or above harm incidents. *Trajectory for 2026/27* Achieve a 25% increase in formal feedback, raising performance to 73% of relevant incidents by Q4 2026/27 All divisions are to demonstrate bimonthly improvement with no area below 50% by Q3.	Involving those affected by an incident enhances learning accuracy and aligns with national expectations for patient involvement in safety. Providing timely and precise feedback ensures families receive closure, supports healing, and improves organisational learning and accountability. **Behaviour Change Required** 1. Default to involvement: Divisions adopt an "opt-out" rather than "opt-in" approach to patient/family engagement for moderate harm and above. 2. Timeliness becomes a shared responsibility: Clinical and governance teams treat feedback timelines as part of the safety response rather than an administrative task. 3. Improve the quality of conversations: Staff use trauma-informed approaches to ensure communication is empathetic, jargon-free, and transparent. 4. Learn in public: Staff demonstrate the impact of patient involvement at Huddles, Grand Rounds, and divisional governance meetings to normalise this as core practice.	1. **95% compliance with the initial written duty of candour (DoC) recorded on Datix, with a letter uploaded (Datix % completion reported via the safety dashboard**. 2. **50 % DoC letter completion and uploaded to the system by Q3 and 73% by Q4** 3. **Sample audit of learning responses against the established good practice tool, with 75% assessed as showing good evidence of clear and easy to read report** **75% of patients surveyed following a PSIRF learning response agree or strongly agree they were treated with respect and compassion** 4. **75% of reporters receive feedback following incident closure via the Datix system** **75% of staff surveyed following a PSIRF learning response agree or strongly agree they were engaged in the learning response and received feedback**
As part of the Trust Harms Free Care (HFC) Strategy, reduce the number of inpatient falls by 10%	*Baseline 2025/26* The Trust rate of inpatient falls per 1000 bed days (this includes ED falls)	This target priority has been retained as it was not met in 2025/26. The target is to reduce inpatient falls, with an implementation plan from the outset that includes milestones and escalations when milestones are at risk. The HFC team validates data from Datix.	1. **Compliance audit of falls risk assessments in line with Trust policy. 95% falls risk assessments are completed within 4 hours of the decision to admit and thereafter x2 weekly**

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		Trajectory 2026/27 Achieve a 10% reduction in all inpatient falls by Q4 2026/27 Achieve a 10% reduction in ED/CAU falls by Q4 2026/27 Month on Month improvement expected from Q2 onwards No ward to show deterioration from baseline for two consecutive months	**Behaviour Change Required** 1. Reliable completion of risk assessments and care planning: Staff complete falls risk assessments within 4 hours of admission as part of the safety bundle. 2. Embed proactive mobility culture: Wards adopt Eat, Drink, Dress, Move (EDDM) principles as standard, with teams actively supporting patients to mobilise, hydrate, and maintain strength. (excluding ED) 3. Stop normalising "expected" falls: Teams shift from seeing falls as inevitable in older patients to treating every fall as preventable.	**95% lying and standing blood pressures (Bp) taken** **2. Sample Audit of the number of patients meeting EDDM standards.75% of eligible inpatients meet the standards on a given day across the Trust.** **3. Sample snapshot audit of acuity and dependency data, against staffing fill rates, with a target of 85% planned vs actual fill rate, triangulated with patient falls.**
Patient Experience	Increase the volume of feedback we receive via our viewpoint patient feedback platform and the percentage of Friends and Family Test (FFT) positive responses.	*Baseline 2025/26* Trust wide response Rate 15.2% (with variation between departments) The Trust's positive response rates were 82% and remain below the national benchmarks of 95% *Trajectory 2026/27* By Q4 2026/27, achieve an overall Friends and Family Test	This target priority has been retained as it was not met in 2025/2026. FFT is a key source of real-time patient experience data. Increasing the response rate ensures feedback reflects the diversity of patients using our services, enabling teams to identify themes, address concerns quickly, and celebrate areas of excellent practice. A 20% response rate aligns the Trust with national expectations and strengthens our approach to continuous improvement. **Behaviour Change Required**	**1. Develop and engage wards/departments in FFT league tables to drive a 20% increase in FFT response rates.** **2. Divisions to identify where response rates are lowest, e.g. mental health patients and undertake focused outreach, such as bedside engagement.** **3. Weekly matron review of FFT comments with thematic analysis and submission of an actionable improvement report via Datix, addressing emerging themes, with timescales for completion.**

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	(FFT) response rate of 20% across all eligible services, with no division falling below 15% by Q3. Increase positive FFT responses by 10% compared with the 2025/26 outturn. Strengthen qualitative analysis of both positive and negative feedback to identify themes and drive targeted service improvements.	Active invitation to give feedback: 1. Link to daily practice: Asking for feedback is part of the discharge and appointment-closing routines. Staff ask every eligible patient for feedback and explain its purpose. 2. Reduce inequality in feedback: Staff facilitate feedback for patients with communication needs, language barriers, or digital exclusion. 3. Local action cycles: Teams follow a "you said, we did" approach. Wards review FFT comments weekly and agree on 1–2 actionable improvements to show patients their feedback is valued. Shift from a defensive to a learning culture: Staff treat poor feedback as an opportunity to improve, not as criticism.	Reported via the divisional governance framework, to DCNs, and QCC via the learning from patient experience group.
In 2025/26, the Trust will improve the timeliness, quality, and compassion of all complaint responses, ensuring that all complainants receive a clear, empathetic, and person-centred explanation of their concerns. All complaint processes will be aligned with the PHSO Complaints Standards, which focus on early	*Baseline 2025/26* The Trust's overall compliance with the standard of 95% compliance responses completed within 28 days is poor *Trajectory for 2026/27* 95% of complaint responses delivered within the 28-day standard	This target priority has been retained as it was not met in 2025/2026. Timely, compassionate and well-structured complaint responses are essential to maintaining trust and demonstrating accountability. Aligning complaint handling to PHSO Standards ensures a consistent approach across the Trust. **Behaviour Change Required** 1. Divisions take ownership: Complaint responses are seen as part of safe governance outputs rather than solely a	**1. Divisional dashboards/reports include** Monthly performance on timeliness, quality, and backlog and the percentage of responses authored or co-authored by clinical teams rather than corporate teams. *(will need to be added to the current dashboards in Datix)* 2. **PHSO Standards** Sample quality audits against PHSO Standards with scoring for tone, clarity and empathy.

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	resolution, meaningful engagement, and the delivery of responses within the Trust's agreed 25-day standard.	Divisions meet their agreed backlog reduction trajectories by Q2 and sustain improvement throughout 2026/27. 75% of reviewed responses meet PHSO quality indicators for clarity, fairness, tone, and completeness by Q4. 5% of complaint responses to be independently reviewed by patient representatives in Q1–Q2, increasing to 10% by Q4, to strengthen compassion, clarity, and patient voice.	Patient experience or administrative function. 2. Empathy and learning become standard: Responses use clear, sensitive language, avoiding defensive or technical phrasing. Responses describe what the Trust has learned and what will change as a result. Consistent quality checks: Divisions adopt internal peer review and respond to feedback from patient representatives. 3. Resolve early where possible: Staff use proactive phone calls and meetings to avoid escalations and reduce response times. Timeliness is delivered through workflow processes.	Feedback from patient representatives reviewing responses (themes tracked). Reduction in reopened complaints due to poor clarity. Evidence of Divisional quality checks performed (QA checklist) in 100% of cases Responses returned to Divisions for redrafting. 3. **Early engagement and / reolution** Staff routinely (100%) phone complainants early to clarify concerns, agree on outcomes, and explore early resolution. 100% of complaints with documented early contact within 3 working days. 10% Increase in cases resolved through early resolution (tracked monthly). Reduced time from receipt to "case clarified and agreed."

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	Increase the number of adult inpatient discharges before midday to improve patient flow through the hospital and enable the elimination of Corridor Care.	*Baseline (2025/26)* The average (mean) adult inpatient discharges (excluding same day admissions) before midday is 15.2% *Trajectory 2026/27* The average (mean) adult inpatient discharges (excluding same day admissions) before midday o be 33%	Improving earlier in the day discharges is part of the Improving Flow Programme Ward Processes workstream and includes the following projects/ behaviour change: 1. Improve the effectiveness of the daily board round on adult in-patient wards to facilitate discharge planning in accordance with the Board Round SOP 2. To improve consistent use of targeted discharge dates (TDD) within the Millenium digital whiteboard 3. To optimise use of the Discharge Lounge 4. To improve discharge planning through increased pre-booked hospital transport journeys 5. To improve discharge planning through earlier completion of discharge summaries and TTO preparation for adult inpatients (excluding same day admissions)	1. **≥50% compliance with board round SOP** Source of information: Weekly Matrons/Heads of nursing audits 2. **Use of Target Discharge Dates on the digital whiteboards** 3. **Increased utilisation of the discharge lounge; % of days ≥20 adult inpatients were transferred to the discharge lounge** 4. **Number of prebooked vs on the day hospital transport bookings** 5. **Hospital discharge delays due to TTO completion. % of discharge summaries and TTOs completed the day before the TDD**
Clinical	To implement a Trust-wide Medicines Intelligence and Learning Framework that strengthens reporting culture, improves prescribing and administration reliability through EPMA optimisation, stabilises storage compliance, and achieves a minimum 5% reduction in	*Baseline (2025/26)* To confirmed 2025/26 baseline. *Trajectory 2026/27* Achieve a minimum 5% reduction in the rate of validated avoidable moderate-or-greater harm medicines incidents per 1,000 bed days by March 2027	Avoidable medicine incidents, including prescribing errors, administration delays or dosing errors, and storage non-compliance (controlled drugs, fridge items, liquid medicines), represent a preventable risk to patient safety and experience. Recent audit findings indicate that non-compliance with medicines standards is underreported in Datix, limiting organisational learning and reducing confidence in our risk intelligence. Without robust intelligence, the	1. **Intelligence and Reporting culture** ≥20% increase in near-miss reporting/1000 bed days (demonstrating improved safety culture) 95% of moderate+ medicines harm incidents are reviewed in SWARMs within 72 hours 100% of divisions conduct monthly medicines review at HFC (or equivalent)

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validated moderate-or-greater avoidable medicines harm per 1,000 bed days by March 2027.		Trust cannot reliably detect emerging themes or demonstrate harm reduction. This priority focuses first on strengthening the reliability of reporting and learning systems, while targeting defined high-risk processes that contribute most to avoidable harm. 1. Intelligence & Reporting Culture stabilisation and as a precursor to harm reduction by Q2 2. Prescribing & Administration Reliability through clinically led and agreed digital EPMA optimisation by Q2 (alerts, flagging, automated safety checks and decision support) 3. Storage Standards compliance stabilisation programme to improve compliance with medicine storage standards through clear traceability of prescriber and administrator actions 4. Strengthen Governance Clarity through explicit accountability	Q3: Trust-wide Medicines Safety Dashboard live and reported to S&Q **2. Prescribing & Administration Reliability** 50% reduction in cumulative 24-hour dose errors (e.g. paracetamol) 30% reduction in administration delays exceeding the agreed time threshold 95% compliance with barcode scanning (if available via EPMA) **3. Storage Standards** ≥95% compliance with: Controlled Drugs storage standards, fridge temperature monitoring, Liquid medicines: dating and discard standards 100% action plan completion within 30 days of failed audit **4. Strengthen Governance** By Q3, establish monthly medicines reviews via HFC meetings, Realtime divisional dashboards from EPMA system audits, Medicines Governance Group deep dive activity Bi-monthly triangulated report to S&Q and Annual medicines safety report to QCC

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Improving the timely and accurate communication in Discharge Letters at the point of discharge for patients from inpatient wards.	*Snapshot Baseline 2025/26 (2-8 February 2026)* Discharge summary started: **87%** Key Discharge Detail completed: **81%** Person Completing Record completed: **86%** Planned Actions completed: **83%** Clinical Summary completed **85%** Sent within 24 Hours: **78%** *Trajectory for 2026/27* Discharge summary started: **100%** Key Discharge Detail completed: **95%** Person Completing Record completed: **95%** Planned Actions completed: **95%** Clinical Summary completed **95%** Sent within 24 Hours: **95%** The Overall Aim is that 100% discharge summaries should be sent to primary care for patients who are discharged from the Trust *N.B Deceased patients (GP notified by Medical Examiner's Office), Inter-hospital Transfers will be excluded.*	Providing timely information to Primary Care and the patient at the point of discharge/transfer of care is fundamental to supporting ongoing care and treatment by other providers, including Primary Care and Community and Social Care. Evidence from research and HSSIB safety investigations indicates that incomplete discharge summary documentation poses a significant and avoidable risk to patients and to primary care interfaces. In 2025/26, 30 low or no-harm incidents were reported at our hospital that were directly related to the provision of discharge information. **Behaviour Change Required** 1. Inpatient Discharge Letters started at the point of admission 2. Inter-disciplinary contributions to the discharge letter for the patient during the patient's admission 3. Review and streamlining of the content and workflows for the inpatient Discharge Letters (This will need to be developed across the Group) 4. Co-Created Workflows and Standard Operating Procedure for the Completion and Sending of Discharge Letters	All Matrices are made available at Ward\Unit Level by Month to Divisional Leadership **1. Problem List. (collecting baseline data)** 100% of patients will have the problem list completed at admission and updated throughout the admission. Ensuring there is at least one for this visit **2. Clinical Summary** 95% of patients will have a clinical summary completed on discharge **3. Planned and Requested Actions** 95% of patients will have a summary provided of any a. Planned care and treatment at the trust b. Instructions for the Patient\Carers c. Follow-up with the patient's GP d. Any other follow-up planned with other providers **4. Person Completing Record** 95% of patients will have the name of the discharging member of the medical team completed (Typically the Hospital Resident but can be any member of the Medical Team) **5. Key Discharge Detail completed:** 95% patient will have key discharge details completed by the discharging nursing team

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		5. Embedding of the adherence to the Discharge Letter Standard Operating Procedures 6. Visualisation within the Ward and CAT Room (Subject to FDP Optica Implementation Summer 2026) Development and Utilisation of g training and user adoption activities developed and undertaken as an MDT. Ongoing monitoring and actions to be organisation-led within divisions, and local development plans to be developed to deliver against the Trajectory targets	

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Reduce total 12-hour waits in the Emergency Department by 7.2% from the 2025/26 baseline and sustain performance within the 10% NHSE tolerance level by Q4.	*Baseline 2025/26* The Trust reported an overall 12-hour wait of 17.2% in the ED in 2025/26. *Trajectory for 2026/27* Achieve a 7.2% reduction in total 12-hour waits from the 2025/2026 baseline by Q2. Sustain compliance with the 10% NHSE tolerance level by Q4 2025/2026.	There is published evidence to suggest that mortality at 30 days increases significantly in relation to the length of wait in the ED >12 hours. **Behaviour Change Required** 1. Accelerate decision-making: Senior clinical decision-maker presence earlier in the pathway. 2. Increased use of Same Day Emergency Care (SDEC) 3. Faster, more coordinated diagnostic turnaround times 4. Speciality teams respond promptly to ED referrals	**1. Senior clinical decision-maker review within 60 minutes** for ≥80% of non-ambulatory attendances. Time from arrival to initial senior decision tracked weekly (median and 90th centile). Proportion of ED patients with definitive disposition decision made within 3 hours. **2. Increase in SDEC utilisation by 10% from baseline**. Percentage of eligible patients streamed to SDEC within 2 hours of arrival. **Number of ambulatory-appropriate patients remaining >6 hours in ED. **3.** (a)**Radiology turnaround time for urgent ED imaging** (mean and 90th centile; target: improved trajectory each quarter). (b) % of ED bloods with results within 60–90 minutes. (c) Reduction in diagnostic-related delays identified in 12-hour breach reviews. **4. 80% of speciality referrals were seen within 60 minutes (tracked by speciality).** Reduction in repeated referrals or multiple senior opinions per patient. Time from ED referral to speciality decision is recorded weekly.