Ashford and St. Peter's Hospitals NHS Foundation Trust

Report title:	2025/26 Annual Quality Account (Draft for External Circulation)		
Report to:	**Public Council of Governors**		
Date of meeting:	Tuesday, 02 June 2026	**Agenda item:**	8.1
Report summary:	The Trust's 2025/26 Annual Quality Account is on track for publication by 30 June 2026 in line with the timelines set by the Department of Health and Social Care. The format follows the standard guidance set for NHS providers by the National Quality Board and includes all the required statutory sections (1–3). The quality priorities for 2026/27, which were shared with the Council of Governors in March 2026, have been included in the draft Quality Account. As part of the stakeholder engagement process extensive work has been carried out to optimise the use of our digital solutions to monitor the behaviours that affect patient safety, effectiveness and experience, whilst focusing on the improvement objective within each priority. A statement of engagement (section 4) has been gratefully received from the Chair Governor of the Patient Experience Group and the Lead Governor. As part of the continuous engagement process the latest draft is attached. The remaining statements of engagement from the ICB, Healthwatch and the Surrey County Council are due back by 27 May 2026. The final Quality Account will be available on the Trust's public website following reviews within internal governance structures and final approval by the Trust Board.		
Recommendation:	To note		
Report lead:	Jay Dungeni, Chief Nursing Officer		
Report author:	Jacqui Rees, Associate Director of Quality, Yvonne Jones, Head of Clinical Effectiveness		

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
Potential impact on stakeholders:	Timely dissemination of a high-quality, accurate Quality Account is needed to satisfy NHSE requirements.
Next steps	As per the agreed timeline, key events:

	- 27 May 2026 Incorporation of stakeholder statements in section 4 and any suggested edits/amendments - 2 June 2026 Final sign off by TEB meeting - 18 June 2026 Final sign off at QCC - 26 June 2026 Final Sign off by Trust Board Executives at the Audit and Risk Committee
Appendices:	

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Annual Quality Account - 31 March 2026

Contents

Introduction 4
Part 1: 5
Statement on quality from the Group Chief Executive 5
Part 2: 10
Priorities for improvement and statements of assurance from the Board 10
2.1 Priorities for improvement 10
2.1.1 Priorities for improvement for 2026/2027 10
Discontinued priorities 11
2.2 Statements of assurance from the Board 14
Participation in national audits and national confidential enquiries 15
National Clinical Audits Reviewed 18
Local Clinical Audits Reviewed 21
Participation in clinical research 22
Commissioning for quality and innovation (CQUIN) payment framework 24
Care Quality Commission (CQC) registration 25
Special Reviews Undertaken by the CQC under Section 48 of the Health and Social Care Act 2008 25
Healthcare Data Submitted to Secondary Uses Service (SUS) 28
Information Governance - Data Security and Protection Toolkit Submission 28
Learning from Deaths 29
2.3 Performance against Core Indicators 31
Domain 1: Preventing people from dying prematurely 31
Domain 3: Helping people to recover from episodes of ill health or following injury 32
Domain 4: Ensuring that people have a positive experience of care 33
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm 39
3.1 Overview of the quality of care against 2025/2026 priorities 44
3.1.1 2025/2026 Rationale for indicator changes 46
3.1.2 Rotas of doctors and dentists in training 46
3.2 Performance against NHS improvement indicators 47
3.3 Other highlighted areas of achievement 50
Academic publications 50
Improvement Partnership Update 58
..... 60
3.4 Glossary 61
Part 4 – Statements on the engagement process for the development of the Quality Accounts 63
Ashford and St Peter's Hospitals NHS Foundation Trust 64
Chair Governor Patient Experience Group 64

Healthwatch Surrey 66
NHS Surrey Heartlands Integrated Care System (ICS) Commissioner Statement 67
Surrey County Council Statement 68

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Introduction

This Quality Account is an annual report to improve public accountability about the quality of healthcare services that our foundation trust delivers and our plans for improvement.

The contents of the report are set out in the NHS Act 2009, the Quality Accounts Regulations, and annual guidance from NHS England. Quality improvements are set out in 3 core categories of patient safety, clinical effectiveness, and patient experience. The report summarises our performance against the quality priorities and objectives we set at the start of 2025/2026 and what we plan to achieve during 2026/2027. It summarises feedback on where we have made progress, where challenges remain, and how feedback from patients and stakeholders has shaped our priorities for the year ahead. Feedback from our Governors and the NHS Surrey Heartlands Integrated Care Board (ICB) on our performance and future plans is also incorporated into the report.

We know that not every patient experience is positive, and where care falls below the standards we expect, we are committed to listening, learning and improving.

Your feedback
If you have any comments or suggestions regarding this Quality Account, including accessibility issues or requests for other formats, we welcome your feedback. Please contact Mr Jay Dungeni, Chief Nursing Officer, through our Patient Experience Team's advice and liaison service by email: asp-tr.patient.advice@nhs.net or by telephone: 01932 723553.

Part 1:

Statement on quality from the Group Chief Executive

Delivering Outstanding Care Through Innovation, Compassion and Excellence

A year of progress, innovation and improvement: 2025/26

This has been a year of sustained delivery, learning and continued commitment from our staff across Ashford and St Peter's Hospitals NHS Foundation Trust. During a period of sustained demand across the NHS, our staff, volunteers and partners have continued to provide compassionate care while improving safety, modernising services and enhancing the experience of patients and families.

Over the year, the Trust delivered care to more than 410,000 residents across North West Surrey and neighbouring areas while maintaining a strong focus on quality improvement, safety and service transformation.

I would like to thank every member of staff, volunteer, governor, member and partner organisation for the professionalism, resilience and dedication they have shown throughout the year.

Across our hospitals and community services, we have delivered meaningful improvements in quality, safety and access to care.

Spring 2025 – building strong foundations

The year began with a clear focus on service development, prevention, and patient empowerment, laying strong foundations for improvement.

We expanded and enhanced key services, including the introduction of a one-stop Audiology Tinnitus pathway, reducing the number of separate appointments required, thereby improving access, reducing delays, and enabling patients to better manage their condition. The implementation of the mediSIGHT electronic medical record system in Ophthalmology marked a significant step forward in digital transformation, strengthening patient safety and data quality.

Our commitment to safety remained central across 2025/26. Trust-wide campaigns such as World Hand Hygiene Day and Insulin Safety Week supported high standards of clinical practice and reduced the risk of avoidable harm.

Clinical innovation was also evident, with:

- Our Endoscopy team introducing biodegradable stents, improving patient experience, reducing the need for repeat procedures and improving recovery for patients
- Our Computed Tomography (CT) service received a national quality award, reflecting major improvements in diagnostic accuracy and turnaround performance

Our Neonatal Intensive Care Unit (NICU) achieved the prestigious Level 3 Baby Friendly Award, recognising exceptional support for families and excellence in infant care, as evidenced by consistent positive feedback from parents.

At the same time, ASPH strengthened its role as a contributor to national and international learning, presenting work on improvement, frailty, and clinical pathways at leading conferences.

Summer 2025 – Improving flow, safety and clinical pathways

Through the summer months, the trust accelerated work on patient flow, harm reduction and pathway redesign, delivering tangible improvements in both operational performance and patient outcomes.

A Rapid Process Improvement Week brought together multidisciplinary teams and patient representatives to redesign the medical pathway, identifying key actions to reduce delays, improve continuity of care and support timely discharge.

Across our wards, teams continued to deliver excellent safety outcomes, and this period also saw:

- Multiple wards achieving zero avoidable pressure ulcers and zero falls over sustained reporting periods, demonstrating a strong and embedded safety culture
- The launch of day-case hysterectomy pathways, improving recovery times and reducing length of stay from overnight admission to same day discharge in line with national best practice
- International recognition of our frailty services, with the Senior Adults Medical Service (SAMS) team presenting the impact of the Older Person's Assessment Unit (OPAU)

These achievements reflect a continued focus on safe, efficient, and evidence-based care, delivered through strong teamwork and innovation.

Autumn 2025 – National recognition for quality and compassionate care

Autumn marked a period of significant external recognition and validation of quality across the trust.

We were proud to maintain an overall 'Good' rating following inspection by the Care Quality Commission (CQC), with maternity services also rated 'Good'. This reflected strong leadership, compassionate care, and a culture of inclusion and teamwork.

Our commitment to safety and continuous improvement was further demonstrated through:

- Trust-wide engagement in infection prevention campaigns, embedding consistent, high-quality practice
- Our Medical Examiner Service, strengthening transparency, learning from deaths, and support for bereaved families

Many teams also received regional and national recognition:

- The colorectal nursing team won the Patient Safety Improvement Award at the Nursing Times Awards for a transformational, nurse-led pathway redesign
- Our Neonatal Unit is recognised for excellent outcomes through the National Neonatal Audit Programme
- Dr Shirish Prabhudesai, Consultant Radiologist, was elected to a national professional committee, reflecting the growing reputation of ASPH services

Internally, teams continued to excel, with wards achieving accreditation and recognition for quality improvement and patient safety.

Winter 2026 – Innovation, integration and future-focused care

Winter showcased the trust's ability to deliver innovative, integrated and future-ready models of care.

We became the first trust in Surrey to deliver Level 2 paediatric high dependency care locally, a major step forward in improving access for children and families while reducing the need for transfers to tertiary specialist centres.
Working in partnership with ambulance services, we also successfully piloted a community-based Falls Pathway that enabled rapid assessment and mobile imaging in patients' homes. This avoided unnecessary hospital

attendances, improved patient experience, and demonstrated clear benefits and joined up care across the wider health system.

These developments highlight our commitment to:

- Care closer to home
- Integrated system working
- Reducing pressure on acute services while improving outcomes

Other awards, achievement and a culture of excellence

Our staff and services have received national and international recognition, reflecting a strong culture of excellence across the organisation.

Highlights include:

- Mr Mohamed Rashad was awarded Educator of the Year 2025, recognising his global impact on medical education and commitment to patient safety
- National awards for innovation, safety and pathway redesign across multiple specialities
- Sustained harm-free care achievements across wards, demonstrating vigilance and commitment to patient safety
- Gold Standards Framework[1] accreditation for end-of-life care on Aspen and Cherry wards, recognising high-quality, compassionate care

These achievements are a testament to the dedication, expertise and compassion of our teams.

Chief Executive's reflection – Building our future through the Group Model

This has been a year of strong delivery and shared achievement. From national awards and international presentations to measurable improvements in safety, effectiveness and patient experience, our teams have consistently demonstrated what it means to deliver high-quality, compassionate care.

What stands out most is not just what has been achieved, but how it has been achieved, through collaboration, professionalism, and an unwavering commitment to putting patients first.

We have also made strong progress in developing the Group Model with Royal Surrey Hospital, bringing our two organisations together around four shared priorities: outpatients, patient flow, productivity and neighbourhood health.

By aligning leadership, expertise and support functions, we have created a focused programme of improvement that is already translating into practical benefits for patients. This includes redesigning outpatient pathways, improving discharge processes, making better use of theatres and clinic capacity, and developing innovative neighbourhood services such as community diabetes hubs.

Our approach has been to focus on a smaller number of high-impact priorities and deliver them well. By learning from each organisation's strengths and working collaboratively, we are building a stronger and more sustainable future for our services.

[1] See https://www.goldstandardsframework.org.uk/

While we are proud of the progress made this year, we know there is more to do. Some patients still wait too long for care, some experiences remain inconsistent, and we must continue to improve access, responsiveness and reliability.

Our priorities for 2026/27 will remain clear: safer care, better outcomes and a better experience for every patient. I remain grateful to our patients, carers, governors, members, partners and staff whose support, challenge and feedback help us improve every day.

Louise Stead
Group Chief Executive
June 2026

Learning
Disability
Champion

Part 2:

Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

Section 2.1.1 describes priority areas for improvement in the quality of relevant health services that the trust intends to provide or sub-contract in 2026/27 and outlines why these measures were chosen based on our strategic direction, national aims, and review of our existing improvement programmes. The Quality of Care Strategic Objective will remain to:

> *"Grow and develop as a place of learning, underpinned by a culture and mind-set of continuous improvement that reduces harm and improves patient experience".*

2.1.1 Priorities for improvement for 2026/2027

Governors, Surrey County Council, Surrey Heartlands ICB, and staff stakeholders were consulted on our proposed priorities for the next year, which were approved by the Trust Board on 3 June 2026. Patient Panel representatives and Governors provided patient and public perspectives to inform these priorities. Data on these priorities is collated monthly. Assurance will be provided through bimonthly oversight by the Trust Board, with focused updates to stakeholders and Governors. The Quality Account Regulations require the Trust to set at least three improvement objectives for each of the core quality categories of patient safety, clinical effectiveness, and patient experience.

This year, the trust undertook a comprehensive review and refresh of the way its quality priorities are described. Each priority is supported by defined behavioural expectations and supporting metrics to enable delivery of the agreed targets. The priorities are further underpinned by a quarterly trajectory, providing oversight and assurance that progress towards the year-end objectives will remain on track.

The quality priorities proposed were informed by reviewing progress against the 2025/26 priorities and the themes highlighted from:

- Internal and external assessments
- Local and national audit
- National Priorities
- Triangulation of incidents, risks, and claims
- Analysis of complaints and patient feedback

Discontinued priorities

Each year, we renew our quality improvement priorities, considering our strategic aim and reflecting on what we have achieved and what we must do next to ensure we grow as a learning organisation. Many of the 2025/26 priorities will continue, although some of them are no longer standalone priorities due to the refresh. For example, regular recording of lying and standing blood pressure is now a behavioural metric linked to achieving the overarching priority of reducing falls. Achievement against the 2025/26 priorities is outlined in detail in Section 3.1.

2026/27 Quality Account improvement priorities

Patient Safety			
	Improvement Priority	Measure(s) of Success	Rationale and Behavioural Expectations
1	**Strengthen the identification and escalation of adult patients at risk of deterioration using a trust-wide PIER approach (Prevention, Identification, Escalation, Response).**	• Introduce the Patient Wellness Questionnaire (PWQ) to be completed and recorded, with appropriate escalation Trust wide in 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	This priority aligns with PSIRF, the Patient Safety Incident Response Framework[2], and supports Martha's Rule[3] mandatory implementation by 2026/27. Deteriorating patients will remain a safety priority until at least 2028. • PWQ completion is routine daily care • Changes in patient-reported wellness trigger clinical review • Early escalation follows policy • Clear multidisciplinary communication and documented response plans
2	**Strengthen learning from patient safety events by embedding meaningful patient and family engagement throughout the Patient Safety Incident Response Framework (PSIRF)**	• 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 patients and families after incidents improves learning, meets expectations, and supports healing through timely, compassionate feedback. • Make involvement the default for moderate harm and above • Treat timely feedback as a core safety responsibility • Communicate clearly, empathetically, and transparently • governance meetings to normalise this as a core practice
3	**As part of the trust Harms Free Care (HFC) Strategy, reduce the number of inpatient falls**	• 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	Inpatient falls are a key indicator of care quality and are largely preventable. This priority is retained with a focus on reducing falls through a clear plan, milestones, and escalation. • Consistent risk assessment and care planning • Proactive mobility culture using Eat, Drink, Dress, Move (EDDM) principles (excluding ED) • Shift from accepting falls as inevitable to treating all falls as preventable

[2] See NHS England » Patient Safety Incident Response Framework

[3] See NHS England » Martha's Rule

Clinical Effectiveness			
	Improvement Priority	Measure(s) of Success	Rationale and Behavioural Expectations
4	To implement a trust-wide Medicines Intelligence and Learning Framework that strengthens reporting culture, improves prescribing and administration reliability through electronic prescribing optimisation, stabilises storage compliance.	• 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 medicines incidents are a preventable safety risk. This priority focuses on improving reporting and learning while addressing high-risk processes that have potential to cause most harm. • Strengthen reporting and near-miss learning • Improve prescribing and administration through optimised e-prescribing • Improve medicines storage compliance with clear audit traceability • Strengthen divisional accountability and governance
5	Improving the timely and accurate communication in discharge letters at the point of discharge for patients from inpatient wards.	• The overall aim is that 100% discharge summaries should be sent to primary care for patients who are discharged from the Trust • Discharge summary started on admission: 100% • Key discharge detail completed: 95% • Person completing record completed: 95% • Planned actions completed: 95% • Clinical Summary completed 95% • Sent within 24 Hours: 95%	Timely, accurate discharge information is essential for safe ongoing care. Evidence shows that incomplete discharge summaries pose a preventable risk to patients and to primary care interfaces. • Start discharge letters at admission • Enable multidisciplinary input during admission • Streamline discharge letter content and workflows (Group-wide) • Co-create standard workflows and standard operating procedures (SOPs) • Embed consistent adherence to discharge letter standards
6	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.	• Achieve a 7.2% reduction in total 12-hour waits from the 2025/26 baseline by Q2 • Sustain compliance with the 10% NHSE tolerance level by Q4 2025/26	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. • Accelerated decision-making: Senior clinical decision-maker presence earlier in the pathway • Increased use of Same Day Emergency Care (SDEC) with patients streamed within 2 hours of arrival • Faster, more coordinated diagnostic turnaround times to prevent 12-hour breaches • Speciality teams respond promptly to ED referrals to review patients within 60 minutes

Patient Experience			
	Improvement Priority	Measure(s) of Success	Rationale and Behavioural Expectations
7	**Increase the volume of feedback we receive via our viewpoint patient feedback platform and the percentage of Friends and Family Test (FFT) positive responses.**	• By Q4 2026/27, achieve an overall Friends and Family Test (FFT) response rate of 20% across all eligible services • 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	This target priority has been retained as it was not met in 2025/26. FFT provides real-time patient feedback. Increasing response rates ensures more representative insight, faster action on concerns, and recognition of good practice. A 20% response rate meets national expectations and supports improvement. • Make obtaining FFT feedback part of routine discharge and appointment closure • Support feedback from patients with additional needs and prevent digital exclusion • Teams review FFT feedback weekly, using "you said, we did" actions to show impact and that feedback is valued
8	**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[4], which focus on early resolution, meaningful engagement, and the delivery of responses within the Trust's agreed standard.**	• 95% of complaint responses delivered within the 28-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	This priority is retained as the 2025/26 target was not met. Timely, compassionate responses to complaints are essential for trust, accountability, and alignment with PHSO Standards. • Divisions' own complaint responses as part of safe governance • Responses are empathetic, clear, avoid defensive language and are focused on learning and change • Consistent quality checks through peer review and patient representative feedback • Early resolution through proactive calls and meetings
9	**Increase the number of adult inpatient discharges before midday to improve patient flow through the hospital and enable the elimination of corridor care**	• On average, 33% of adult inpatient discharges (excluding same-day admissions) should occur before midday	Improving the rate of earlier discharges is part of the ward processes workstream of the Trust-wide Improving Flow Programme. • More effective daily board rounds aligned to the Board Round SOP • Consistent use of Targeted Discharge Dates (TDD) on the Millennium digital whiteboard • Optimised use of the Discharge Lounge • Increased pre-booked hospital transport • Earlier completion of discharge summaries and take-home medications for adult inpatients (excluding same-day admissions)

[4] See NHS Complaint Standards | Parliamentary and Health Service Ombudsman (PHSO)

2.2 Statements of assurance from the Board

The Board is responsible for ensuring that the trust maintains and continuously improves the quality of healthcare services it provides.

The following statements of assurance comply with the statutory requirements set out in the National Health Service (Quality Accounts) Regulations, as amended in 2018 and 2026.

The Board receives regular assurance on quality through:

- integrated quality and performance reporting
- patient safety intelligence
- complaints and patient experience themes
- workforce indicators
- clinical audit and effectiveness reporting
- mortality and learning from death reviews
- risk management reporting
- external regulatory and accreditation feedback

This enables the Board to monitor performance, identify emerging risks and oversee improvement action.

Scope of services

From 1 April 2025 to 31 March 2026, Ashford and St Peter's Hospitals NHS Foundation Trust provided and/or subcontracted 8 categories of relevant health services.

- Surgical procedures
- Medical treatments
- Accident and emergency
- Diagnostics and screening
- Maternity and neonatal
- Termination of pregnancy
- Cancer services
- Therapies and rehabilitation

Ashford and St Peter's Hospitals NHS Foundation Trust has reviewed the available data on the quality of care for 100% of these relevant health services. The income generated by the relevant health services reviewed in the 12 months ending 31 March 2026 represents 100% of the total income generated from the provision of relevant health services by Ashford and St Peter's Hospitals NHS Foundation Trust for the 12-month period ended 31 March 2026.

Participation in national audits and national confidential enquiries

In total, the trust took part in 47 of the 48 national audit workstreams to which it was eligible, as specified in the NHS England Quality Accounts list 2025/26. The Trust participated in all the relevant National Confidential Enquiries (NCEPOD). These 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. Many audits are completed in arrears, and in some cases, the latest available figures are for quarter three (October to December 2025). For audits where data submission is not yet complete, the number of cases submitted is listed as ongoing, and the Trust will continue to submit data until the deadline.

The National Data Opt-Out (NDO) applies to some national audits as it gives patients the right to choose whether their personal data is used for any reason other than direct care. Therefore, in the following table, the percentage of cases submitted includes only eligible patients, not those with NDO on record or those who have withheld consent for a particular study.

N.B. A glossary in section 3.4 provides brief explanations of the medical conditions covered in these audit lists.

Table 1: National clinical audits and national confidential enquiries

National Clinical audits and national confidential enquiries with the participation rate	Percentage of cases submitted
BAUS BOOMERANG (British audit of the investigation and referral of women with recurrent urinary tract infection using recent Guidance The British Association of Urological Surgeons (BAUS)	No patients identified
BAUS EMPAST (Evaluating the Management Pathway for Suspected Testicular Cancer Referrals) The British Association of Urological Surgeons (BAUS)	100%
Breast and Cosmetic Implant Registry NHS England	100%
British Spine Registry British Spine Registry	100%
Case Mix Programme **Intensive Care National Audit and Research Centre (ICNARC) Case MixProgramme (CMP).** Refer to https://www.icnarc.org/Our-Audit/Audits/Cmp/About	100%
Child Health Clinical Outcome Review Programme National Confidential Enquiry into Patient Outcome and Death (NCEPOD) NCEPOD https://www.ncepod.org.uk/transition.html	100%
Elective Surgery (National PROMS Programme) Total hip replacement and total knee replacement NHS Digital	174 Hip 228 Knee[5]
Emergency Medicine QIPs Adolescent Mental Health, Care of Older People, Time critical Medications Royal College of Emergency Medicine	Ongoing
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People Royal College of Paediatrics and Child Health	100% Cohort 7 2026 Submitting Cohort 8 due to close Jan 2027

[5] It is not possible to calculate percentage compliance for this programme at this time.

National Clinical audits and national confidential enquiries with the participation rate	Percentage of cases submitted
Falls and Fragility Fracture Audit Programme (FFFAP) - Fracture Liaison Service Database (FLS-DB) Royal College of Physicians (RCP)	100%
Falls and Fragility Fracture Audit Programme (FFFAP) - National Audit of Inpatient Falls Royal College of Physicians (RCP)	100%
Falls and Fragility Fracture Audit Programme (FFFAP) - National Hip Fracture Database Royal College of Physicians (RCP)	100%
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR) NHS England	100%
Maternal, Newborn and Infants Clinical Outcome Review Programme Refer to www.npeu.ox.ac.uk/mbrrace-uk National Confidential Enquiry into Patient Outcome and Death. University of Oxford / MBRRACEUK collaborative	100%
Medical and Surgical Clinical Outcome Review Programme National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Ongoing[6]
National Adult Diabetes Audit – National Adult Diabetes Inpatient Safety Audit (NDISA) NHS England	100%
National Adult Diabetes Audit – National Diabetes Foot Care Audit NHS England	100%
National Adult Diabetes Audit – National Pregnancy in Diabetes Audit NHS England	100%
National Adult Diabetes Audit – National Diabetes Core Audit NHS England	100%
National Adult Diabetes Audit – Transition (Adolescents and Young Adults) and Young Type 2 Audit NHS England	Only every three years, last completed 2024
National Adult Diabetes Audit – Gestational Diabetes Audit NHS England	Ongoing, expected 100%
National Audit of Cardiac Rehabilitation (NACR) University of York http://www.cardiacrehabilitation.org.uk/	100%
National Audit of Care at the End of Life (NACEL) Refer to: NHS Benchmarking Network http://www.nhsbenchmarking.nhs.uk/nacel	100%
National Audit of Dementia (NAD) Royal College of Psychiatrists https://www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-audit-of-dementia	100%
National Bariatric Surgery Registry British Obesity & Metabolic Surgery Society	100%
National Cancer Audit Collaborating Centre – NATCAN Royal College of Surgeons of England (RCS)	Data submitted by RSH[7]

[6] At the time of this report 15/16 questionnaires and case records for pleural procedures study have been submitted and 9/12 questionnaires and case records for rib fracture study have been submitted.

[7] Royal Surrey Hospital (RSH) has a specialist cancer centre that provides cancer care to Ashford and St Peter's Hospitals patients.

National Clinical audits and national confidential enquiries with the participation rate	Percentage of cases submitted
National Cardiac Arrest Audit (NCAA) Intensive Care National Audit & Research Centre (ICNARC)	100%
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit (NHFA) National Institute for Cardiovascular Outcomes Research (NICOR) hosted at NHS Arden and Greater East Midlands CSU https://www.nicor.org.uk/	100%
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management (CRM) National Institute for Cardiovascular Outcomes Research (NICOR) hosted at NHS Arden and Greater East Midlands CSU https://www.nicor.org.uk/	100%
National Cardiac Audit Programme (NCAP) – Myocardial Ischaemia National Audit Project (MINAP) National Institute for Cardiovascular Outcomes Research (NICOR) hosted at NHS Arden and Greater East Midlands CSU https://www.nicor.org.uk/	100%
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Intervention (NAPCI) National Institute for Cardiovascular Outcomes Research (NICOR) hosted at NHS Arden and Greater East Midlands CSU https://www.nicor.org.uk/	100%
National Child Mortality Database (NCMD) University of Bristol	100%
National Comparative Audit of Blood Transfusion: 2025 Major Haemorrhage Audit NHS Blood and Transplant	100%
National Early Inflammatory Arthritis Audit (NEIAA) British Society of Rheumatology	100%
National Emergency Laparotomy Audit (NELA) Royal College of Anaesthetists	100%
National Joint Registry Data National Joint Registry data collection on hip, knee, ankle, elbow, and shoulder joint replacements. Refer to www.njrcentre.org.uk	Predicted 100%[8]
National Major Trauma Registry NHS England **Note: Previously named Trauma Audit Research Network (TARN)**	76%[9]
National Maternity and Perinatal Audit (NMPA) Royal College of Obstetrics and Gynaecology	100%
National Neonatal Audit Programme (NNAP) Royal College of Paediatrics and Child Health	100%
National Obesity Audit NHS England	100%
National Ophthalmology Database (NOD) Audit – National Cataract Audit The Royal College of Ophthalmologists (RCOphth)	MDOR only[10]

[8] All data quality work has been completed and currently indicating 100% compliance however this is yet to be confirmed by NJR.

[9] Position at February 2026 dataset, deadline is July 2026. There have been delays in submitting data due to staffing shortages and the adjustment to the new submission system. The team is working hard to address these issues and enhance efficiency to return to achieving 100% submission.

10 NOD feeds into the national Medical Device Outcome Registry. Currently the Trust submits details of implanted devices from ophthalmology procedures directly into MDOR. This is a key safety factor should a product be recalled. However, NOD also captures a wider range of patient outcomes. The Trust is taking steps to be able to obtain the full range of patient outcome data needed for participation in NOD audit in future years.

National Clinical audits and national confidential enquiries with the participation rate	Percentage of cases submitted
National Paediatric Diabetes Audit (NPDA) Royal College of Paediatrics and Child Health http://npda-results.rcpch.ac.uk/unit-data.aspx	100%
National Respiratory Audit Programme (NRAP) COPD Secondary Care Royal College of Physicians **Note: Previously named National Asthma and COPD Audit Programme (NACAP)**	100%
National Respiratory Audit Programme (NRAP) Adult Asthma Secondary Care Royal College of Physicians	100%
National Respiratory Audit Programme (NRAP) Children and Young People's Asthma Secondary Care Royal College of Physicians	100%
Perioperative Quality Improvement Programme (PQIP) Royal college of Anaesthetists. https://pqip.org.uk/	Ongoing
Sentinel Stroke National Audit Programme Kings College London (CKL) Sentinel Stroke National Audit Programme (SSNAP). Refer to www.strokeaudit.org	100%
UK Parkinson's Audit Parkinson's UK	60%[11]

National Clinical Audits Reviewed

The reports of 39 national clinical audit workstreams were reviewed by Ashford and St Peter's Hospitals NHS Foundation Trust in the 12 months ending 31 March 2026, and the trust intends to take the following actions to improve the quality of healthcare provided, as outlined in Table 02 below. Note that not all the national audit reports were available during the 2025/26 period, but some audits produce multiple reports. A selection of our results with improvement work is shown below. All national audit reports were reviewed for key recommendations, discussed at the trust's Clinical Effectiveness Committee, and disseminated for review and action plan formulation at the relevant speciality clinical governance meeting.

[11] The data collection/submission occurred during a period of unexpected staffing pressures within the Parkinson's team; it was not possible to submit all cases whilst maintaining patient facing services. In previous years the Trust has submitted 100% of cases and intends to participate fully in 2026/27

Table 2: Selection of improvement actions from national clinical audits and NCEPOD reports

National clinical audits reviewed with improvement actions

NCEPOD study: Rehabilitation Following Critical Illness. The initial self-assessment against the recommendations was completed. The Trust performs well in ensuring that comprehensive, holistic assessments of patients' needs are met and discussed at regular multidisciplinary meetings. Other recommendations regarding rehabilitation staff are partially met, as there is no rehabilitation provision on weekends, and core roles are not ring-fenced for ITU, which could mean staff are required to support wards during Trust pressures. Improving seven-day services remains a Trust aim. Unmet recommendations around having a named lead for patients across the hospital and into the community will be discussed and taken forward with the Kent, Surrey and Sussex Critical Care Network.

National Care at the End of Life (NACEL). One of the key recommendations was around regional leadership. Whilst this action is above Trust level, the Trust's Clinical Lead for End of Life Care has worked to drive a number of regional projects, including a mini prescribing formulary to support GPs. The palliative care team at the Trust works proactively with community resources to deliver cohesive end-of-life care. An area that the Trust are not currently meeting is for out of hours palliative service. This is challenging due to the current financial constraints within the NHS; however, options are being explored. Areas where the Trust performs well include teaching, and two of the hospital's wards have achieved Gold Standards Framework (GSF) accreditation.

MBRRACE-UK The Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK) report for 2024 deaths was published in March 2026. The report includes all babies born at the Trust who sadly died during the 2024 calendar year, irrespective of place of death. Births under 24 weeks' gestation and terminations of pregnancy are excluded.

Key findings:

- The stabilised and adjusted stillbirth rate was in line with the average for similar Trusts and Health Boards.
- The stabilised and adjusted neonatal mortality rate was more than 15% lower than the average for similar organisations.
- The stabilised and adjusted extended perinatal mortality rate was lower than the average for similar Trusts and Health Boards.
- There was full compliance with reporting requirements and the Statutory Duty of Candour.
- The Perinatal Mortality Review Tool (PMRT) was completed for all cases, supporting assessment of care and identification of improvements to reduce future risk.

In August 2025, a perinatal MDT review of the 2024 deaths was undertaken, including review of demographics, PMRT panel quality and outcomes, progress against previously identified improvement actions, and compliance with Saving Babies' Lives standards. All actions arising from this review have been completed, including targeted measures to reduce disparities in outcomes for those living in the most deprived areas.

National Lung Cancer Audit. The respiratory team at Ashford and St Peter's Hospitals works with the Cancer Alliance to provide this care, with most treatment undertaken at the Royal Surrey Hospital, St George's Hospital and University College London Hospitals. This ensures that ASPH patients have adequate access to surgical treatments and sufficient capacity. The Trust is working with the Cancer Alliance on a recommendation to increase access to systemic anti-cancer therapy for patients with a specific stage and type of lung cancer. There can be delays in transferring patients to Oncologists due to the Alliance's 62-day capacity. The team at ASPH has asked for improved data to be provided for their multidisciplinary team meetings so they can better understand the nature of any delays and work to reduce any factors under their control. Some test results are taking longer to arrive than the target time. This is a national problem, and although the Trust is performing better than most others, it is still not ideal for the patient. The Cancer Alliance reports that they are working towards improving these results.

National Child Mortality Database – Child Death due to Asthma or Anaphylaxis. Key doctors and specialist nurses have completed the National Capabilities Framework training for professionals who care for children and young people with asthma; however, some staff within the wider team still need to complete it. There is a recommendation that asthma nurses offer home visits following a paediatric intensive care admission. At present, the ASPH team does not have the capacity to perform home visits, so referrals are made to the Royal Berkshire Hospital. An asthma clinic is being implemented at Woking Community Diagnostic Centre to aid accessibility to services.

National clinical audits reviewed with improvement actions continued.

Sentinel Stroke National Audit Programme (SSNAP) During 2025/26, the Trust's SSNAP performance continued to face challenges, including achieving the four-hour arrival to Stroke Unit target and sustaining 90% Stroke Unit stay. These challenges were largely driven by system pressures, including high acuity and increased volumes of stroke admissions, ongoing ring-fenced bed occupancy, non-stroke outliers, overseas patients, infection-related isolation requirements, reduced resident medical cover, and the absence of overnight and weekend specialist staffing, all of which impacted timely discharge flow.

To address these challenges and improve SSNAP outcomes, a number of targeted improvement actions are underway, including approval and implementation planning of pre-hospital video triage in collaboration with SECAmb, the local ambulance service, and work with Radiology to administer thrombolysis within the CT area to reduce door-to-needle times[12], and the launch of a Quality Improvement programme spanning the Emergency Department and Stroke Services.

Workforce sustainability remains a priority, with the recruitment of two Specialist Stroke Doctors, ongoing recruitment of stroke consultants and leadership, and the development of new middle-grade roles to strengthen clinical cover and service resilience.

In 2025/26, we had two external reviews from the ISDN (Integrated Stroke Delivery Network); the hyperacute peer review took place in February 2026, and the ISDN Rehabilitation Roadshow for NW Surrey was carried out in September 2025. They identified strong teamwork within the hyperacute stroke pathway, with the stroke team, ED team, and radiology working closely together to achieve the best outcomes for their patients. The Rehabilitation Roadshow report highlighted the passion, motivation and expertise of the ASPH teams involved.

An official report for the hyperacute peer review has recently been shared, and the teams are working through this to identify strategies and recommendations to support quality improvement for 2026/27.

Saving babies' lives. Work is progressing well with implementing the latest saving babies' lives elements (v 3.2 issued June 2025)

In February 2026, the Local Maternity and Neonatal System (LMNS) conducted an assurance visit to review the local self-assessment. This confirmed full compliance with elements 2-6 and partial compliance with element 1. The elements with full compliance are: Foetal growth restriction, reduced foetal movements, foetal monitoring in labour, preterm birth, and diabetes. The remaining element, smoking in pregnancy, was found to be 80% implemented.

There are monthly saving babies' lives oversight meetings where smart actions are reviewed for progress, which include the planned actions to meet the targets for supporting the cessation of smoking during pregnancy.

National Cancer Audit Collaborating Centre – NATCAN Services within the Diagnostics, Therapeutics and Cancer Division contributed data and clinical engagement to a number of national clinical audits and publications coordinated through NATCAN

- National Oesophago-Gastric Cancer Audit (NOGCA) – supporting evaluation of care for patients with upper gastrointestinal cancers
- National Prostate Cancer Audit (NPCA) – contributing to assessment of diagnosis, treatment and outcomes in prostate cancer
- National Bowel Cancer Audit (NBoCA) – informing improvements in colorectal cancer pathways and outcomes
- National Lung Cancer Audit (NLCA) – supporting national reporting on lung cancer diagnosis, staging and access to treatment

Participation in these programmes enables benchmarking, identification of variation, and implementation of evidence-based improvements across cancer pathways. Findings are reviewed through specialty governance structures and contribute to ongoing quality improvement within the organisation.

[12] The is the time from arrival to administration of a drug to clear blood clots. For more information on the measures see https://www.strokeaudit.org/SupportFiles/Documents/Dataset-changes-2024/Dataset-changes-2024-webinar-4-inpatient-scoring.aspx

Local Clinical Audits Reviewed

The reports of 85 local clinical audits and evaluations were formally reviewed by the trust in the 12 months ending 31 March 2026. Examples of findings and actions to improve the quality of healthcare provided are shown in Table 3 below. Learning from audits is shared in educational meetings and learning publications. Key areas of learning from local audits that are relevant to other areas of the trust are also discussed in the Clinical Effectiveness Committee meeting to aid dissemination and Trust-wide learning.

Table 3: Improvement actions from local audits and patient surveys

Examples of Local clinical audit with improvement actions for 2025/2026
Quality Improvement project to assess if it would be safe to avoid tissue sampling in ultrasound benign breast lesions in women less than 30 years of age. Records of 131 women were audited to compare ultrasound scan results with subsequent biopsy results. It was found that ultrasound classification of lesions meant that benign (non-cancerous) lesions were reliably detected, so a tissue biopsy could be avoided in this group of patients, sparing them the procedure and the stress of waiting for results. No lesions suspected to be benign on ultrasound were found to be cancerous on biopsy. Patients where there was any suspicion of cancer would continue having a biopsy. With the breast surgeons' agreement, this new pathway will be adopted, and the audit will be repeated in a year.
Documentation of patient weight. Accurate patient weight is essential for medication prescribing, monitoring fluid balance, and assessing nutrition. Use of estimated weight had been increasing. Audit results showed that compliance varied across the hospital, but in the ED, only 1/3 of patients had their weight measured. Recommendations were to increase the availability of equipment to accommodate all patient types and to allow easier weighing when transferring patients from stretchers to beds. Weight measurement would be a required element of the triage assessment.
A two-cycle audit improving delirium recognition. The 4AT is a rapid, two-minute bedside tool used to screen for delirium and cognitive impairment. An initial audit showed that of 40 patients admitted to geriatric wards in one month, only nine patients had documented 4AT scores on admission. Actions were taken to improve teaching and promote 4AT during ward rounds and handover. In the repeat audit, 74 patient records were examined, of which 53 had a 4AT score. The documentation rate improved from 22.5% to 71.62%, a significant increase that also improved early identification of delirium, likely to reduce overall complications. Plan to ensure delirium, and 4AT is on quarterly teaching sessions, and to reaudit in one year.
Prostate cancer biopsy turnaround times. The aim of this audit was to assess performance against the Royal College of Pathologists' guidance and the national prostate cancer audit (80% of cases must be reported within seven calendar days, and 90% within 10 calendar days). After an initial audit, recommendations were implemented, such as prioritising prostate biopsies, better secretarial support and standardising the number of biopsies taken to ensure uniformity. The percentage of biopsies reported within seven days improved from 68% to 74%. Although the average turnaround time was six days, the target of reporting 80% of cases within seven days was not met. The percentage of cases taking more than 10 days to report decreased from 12% to 8%. Following the implementation of recommendations, the target of reporting within 10 days was met, with 92% of all cases reported within that timeframe. For cases outside the turnaround time, the majority (65%) required additional testing, a key factor contributing to delays in meeting the target. Future work will focus on reducing the impact of this.
Enhancing cataract surgery efficiency. This audit looked at cancellation rates for cataract surgery. An initial audit showed that 15.5% of procedures were cancelled on the day of surgery. This was due to a number of reasons, including patients not attending, having high blood pressure, high blood sugar, or being unwell. Recommendations put in place included enhanced communication with patients, improved testing of blood glucose levels at pre-operative assessment, and the introduction of new pathways and guidelines. At reaudit, the number of cancellations had nearly halved to 7.96%. Reducing cancellations on the day improves patient experience and promotes efficient use of resources to aid in cutting waiting lists.
The impact of pre-endoscopy team huddles on patient safety This is an ongoing piece of work led by Clinical Endoscopist examining complication and readmission rates following colonoscopy. This initiative supports improved team communication, situational awareness and adherence to safety standards within high-volume diagnostic service.

Participation in clinical research

In the last 12 months ending 31 March 2025, we recruited over 3,200 patients receiving relevant health services to participate in clinical research approved by the NHS Research Ethics Committee and the Health Research Authority.

Clinical research's impact on improving the standard of care for patients is invaluable and truly benefits future generations. Hospitals that actively participate in research have been shown to have better patient outcomes, including lower mortality rates.

Our research portfolio comprises both academic and commercial studies, giving our patients the opportunity to participate and potentially benefit from research.

Table 4: Patients recruited to participate in approved research by year

	2022/23	2023/24	2024/25	2025/26
Number of patients	1,652	2,722	3,799	3,298

Some of our important trials over the last year are:
Full Title: A randomised controlled trial of regular MRI scans compared to standard care in patients with prostate cancer managed using active surveillance
Short Title: IP9 – ATLAS (Approaches to Long-Term Active Surveillance)
Study Acronym: Atlas Study
Principal Investigator at ASPH: Dr Nimalan Arumainayagam, Consultant Urologist

Brief Study Description: Some men with prostate cancer have a slow-growing form of the disease that doesn't need treatment straight away. Instead, doctors monitor the cancer closely through a process called active surveillance. This usually involves regular blood tests (PSA tests) and physical examinations to check for any changes.

This study is examining whether having regular MRI scans in addition to these usual checks can help detect changes in the cancer earlier. By comparing patients who have the standard monitoring with those who also have MRI scans, researchers hope to find the safest and most effective way for the NHS to keep track of prostate cancer over the long term.

Recruitment Status: Open to recruitment- 11 patients recruited to date [11 patients recruited between April 2025 and January 2026].

Full Title: A multicentre, randomised controlled, non-inferiority trial, comparing surfactant administration by supraglottic airway compared to endotracheal catheter in preterm infants (the SURFSUP Trial).
Short Title: Surfactant Administration by Supraglottic Airway (SURFSUP Trial)
Study Acronym: SURFSUP Trial
Principal Investigator at ASPH: Dr Peter Reynolds, Consultant Neonatal Paediatrician

Brief Study Description: Premature babies (born before 37 weeks) often have underdeveloped lungs and may need help with their breathing due to a condition called respiratory distress syndrome. Some of these babies need a medicine called surfactant, which helps their lungs work more effectively.

The research project compares two different ways to administer surfactant to premature babies. Both methods are currently used at the Children's Hospital in Glasgow, and the study aims to determine which approach is best and safest for the babies.

Recruitment Status: Open to recruitment –10 patients recruited from April 2025 to January 2026.

Full Title: PAN Alimentary Cancer Exhaled Breath Analysis (PANACEA)
Short Title/ Study Acronym: PANACEA.

Principal Investigator at ASPH: Mr Philip Bearn, Consultant

Brief Study Description: More than 44,000 people in the UK die each year from cancers of the digestive system, such as cancer of the oesophagus, stomach, pancreas, liver, or bowel. These cancers can be difficult to detect early because their symptoms are often similar to those of less serious conditions.

This study is testing a simple breath test that could help GPs identify signs of these cancers sooner. Patients will provide breath samples before having their usual investigations, such as camera tests or scans. The samples will be analysed to look for molecules that may indicate cancer. Over 8,000 patients will take part to help determine how accurate and practical this breath test could be for use in the NHS. Early detection could improve survival and treatment outcomes.

Recruitment Status: Open to recruitment- 17 patients recruited from April 2025 to February 2026.

Full Title: Clinical and cost-effectiveness of a maternity quality improvement programme to reduce excess bleeding and need for transfusion after childbirth: the Obstetric Bleeding Study UK (OBS UK) Stepped Wedge Cluster Randomised Trial.
Short Title/ Study Acronym: Obstetric Bleeding Study UK (OBS UK)
Principal Investigator at ASPH: Dr Justin Hews, Consultant Anaesthetist

Brief Study Description: Heavy bleeding during or after birth is the most common complication of childbirth. The OBS UK team has developed a new approach, known as the OBS care bundle, to help manage this more effectively. Early results from a small project were promising, so researchers are now carrying out a larger study across the UK.

As part of the study, they want to understand how bleeding is currently managed and how women (and where possible, their birth partners) experienced their care. This will help show whether the OBS care bundle improves outcomes and experiences for women during childbirth.

Recruitment Status: Open to recruitment – 5222 patients recruited to date. [3181 patients recruited from April 2024 to March 2025, and 2289 patients recruited from April 2025 to January 2026].

Full Title: Graduated compression stocking as an adjunct to extended duration pharmacological thromboprophylaxis for venous thromboembolism prevention
Short Title/ Study Acronym: Grace Trial
Principal Investigator at ASPH: Mr Abdullah Jibawi, Consultant Vascular Surgeon

Brief Study Description: Blood clots in the legs or lungs sometimes develop after people have been in hospital, especially after surgery. These clots can cause pain, swelling, or even become life-threatening if they travel to the lungs. Patients are usually given blood thinning medication to reduce this risk, and some hospitals also provide compression stockings.

However, it is unclear whether wearing stockings after leaving hospital offers extra protection for patients already taking blood thinners. This study aims to find out whether adding compression stockings to standard treatment helps prevent blood clots after surgery. The results will help guide best practice across the NHS.

Recruitment Status: Open to Recruitment- 23 Patients Recruited from April 2025 to February 2026.

More details of clinical studies in the Trust can be found on our website: www.asph.nhs.uk/research-current

Commissioning for quality and innovation (CQUIN) payment framework

The commissioning for quality and innovation (CQUIN) quality incentive scheme remained paused for the 2025/26 financial year.

Care Quality Commission (CQC) registration

The trust remained registered with the Care Quality Commission during the reporting period. Where inspections identified areas requiring improvement, action plans were implemented and monitored through established governance processes.

In March 2025, the Care Quality Commission carried out an unannounced focused inspection of maternity services at Ashford and St Peter's Hospitals NHS Foundation Trust as part of the national re-inspection programme. The service rating was raised from Inadequate to Good, and the 2023 Section 29a Warning Notice was lifted. However, the inspection identified a remaining breach of Regulation 12 (Safe Care and Treatment) relating to the completion of daily emergency equipment checks. In response, the service introduced a new digital system for safety checks in October 2025, enabling electronic completion and real-time monitoring. Work continues to ensure consistent compliance across the service.

The Inspection Report can be accessed on the CQC website here: St Peter's Hospital - Care Quality Commission

In March 2024, the Care Quality Commission carried out an unannounced inspection of Medical Services at the St Peter's Hospital site. The CQC later published the report in July 2025, confirming that the service had maintained its overall rating of Good.

The inspection identified a breach of Regulation 12 (Safe Care and Treatment) relating to gaps between planned and actual nursing staffing levels, with some patient harms potentially linked to reduced staffing and skill mix. The trust has since implemented a range of actions to strengthen safe staffing and governance. These include enhanced daily oversight processes, improved rostering practices, regular reviews of staffing and patient acuity, and strengthened clinical risk management. Recruitment efforts have significantly reduced vacancies, particularly among healthcare support workers, and work is ongoing to minimise reliance on agency staffing. Adjustments to skill mix and enhanced care provision have also supported improvements in patient safety. Collectively, these measures have strengthened staffing resilience, oversight, and the safety of care provided.

The Inspection Report can be accessed on the CQC website here: St Peter's Hospital - Care Quality Commission

All trust ratings are summarised by site and core service in Table 5 below.

The trust ensures continuous and impartial oversight of its regulated activities through the Regulatory, External Visits and Accreditation Group (REVAG), which provides assurance on compliance, monitors external standards, and oversees action plans from inspections and audits. This approach promotes early risk identification, sustained regulatory readiness, and a culture of continuous improvement to safeguard quality and patient safety.

Special Reviews Undertaken by the CQC under Section 48 of the Health and Social Care Act 2008

Ashford and St Peter's Hospitals NHS Foundation Trust has not participated in any special reviews by the Care Quality Commission during the 12-month period ending 31 March 2026.

Table 5: CQC Ratings

	Safe	Effective	Caring	Responsive	Well-led Provider Rating	Overall Quality Rating	Date of last inspection
Trust by key question	Requires Improvement	Good	Good	Good	Good	Good	
ST PETERS HOSPITAL(SPH)							
Urgent and Emergency Services	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement	2018
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good	2024
Surgery	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement	2021
Critical Care	Good	Good	Outstanding	Good	Outstanding	Outstanding	2018
Maternity	Requires Improvement	Good	Good	Good	Good	Good	2025
Services for Children and Young People	Good	Good	Good	Good	Good	Good	2018
End of Life Care	Good	Good	Good	Good	Good	Good	2015
Outpatients	Good	Insufficient Evidence to Rate	Good	Good	Good	Good	2015
SPH Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement	
ASHFORD HOSPITAL (AH)							
Medical care (including older people's care)	Requires Improvement	Good	Good	Good	Good	Good	2015
Surgery	Good	Good	Good	Good	Good	Good	2021
Outpatients	Requires Improvement	Insufficient Evidence to Rate	Good	Good	Requires Improvement	Requires Improvement	2018
AH Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement	

Healthcare Data Submitted to Secondary Uses Service (SUS)

Ashford and St Peter's Hospitals NHS Foundation Trust recognise the importance of high-quality information to patient care, decision-making and statutory reporting.

The trust continued to submit required datasets and maintained oversight of data quality, completeness and information governance standards. We submitted records during the 12-month period to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the M11 data[13]. The table below presents a comparison of the completeness of trust data for patient NHS numbers and consultant GMC codes submitted to SUS. The trust continues to demonstrate a high level of compliance with this standard.

Table 9: Completeness of data submitted to Secondary Uses Service (SUS)

Completeness of data submitted to secondary uses service (SUS) (%)	2023/2024	2024/2025	2025/2026
Admitted patient care	99.8	99.8	99.8
Outpatient care	99.9	100	100
Accident and emergency care	99.2	99.2	99.3

Information Governance - Data Security and Protection Toolkit Submission

The Data Security and Protection Toolkit (DSPT) is an annual mandated submission. The toolkit is provided by NHS England in accordance with the National Data Guardian's (NDG) 10 data security standards. The toolkit enables organisations to measure their compliance against legislation and central guidance. The trust uses the toolkit to identify areas of full compliance, partial compliance, and non-compliance.

Data security and protection assessment 2025/2026

An external audit commenced in February 2026. The trust will make a full and comprehensive submission for the year 2025/26 and expects to achieve a status of "Standards Met" on 30 June 2026.

[13] The Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

Learning from Deaths

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This section sets out how the trust has implemented the national "Learning from Deaths" framework, as required by NHS England. We are committed to learning effectively from deaths in our care and to continuously improving the quality and safety of the services we provide.

We track mortality using national indicators, including the Summary Hospital-level Mortality Indicator (SHMI). The trust's rolling average SHMI is 0.8730, which is lower than our regional peers and within the expected range when compared against trusts nationally.

Adult deaths in our care

There were 1092 adult in-hospital deaths across our hospitals in 2025/2026. All non-coronial deaths were reviewed by the Medical Examiners Service.

Table 10: Cases reviewed under Learning from Deaths framework

	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26	Total
Number of deaths	251	243	279	319	1092
Number of deaths of patients with a learning disability or autism	≤5	≤5	≤5	≤5	12
Number of cases identified for structured judgement review	12	6	7	26	51
Number of cases identified for a patient safety review	≤5	≤5	7	8	20
Percentage of deaths deemed more likely than not to have been due to problems in care	0.4%	0%	0.7%*	0.9%*	0.5*

* Estimated, as some cases remain under investigation

The trust Learning from Deaths Policy was updated in Quarter 3 and revised the criteria for a structured judgement review to include all cases referred to the HM Coroner that were not the subject of an inquest or medical examiner scrutiny. This reflects the increase in cases identified for a structured judgement review in Quarter 4. Additionally, the amended policy directs that all medical examiner concerns be reviewed under the Patient Safety Incident Response Framework, reflecting the increased number of cases identified for patient safety review in Quarter 4.

Of the cases reviewed using the SJR methodology, all have been graded as adequate, good or excellent care.

All cases where there are concerns that the patient's death may have been related to care or service delivery issues are reviewed under PSIRF to facilitate a comprehensive and systems-based approach to the review of care. There were 21 deaths meeting these criteria which were reviewed under PSIRF, with 15 completed and confirming that care and service delivery issues did not contribute to the patient's death. The remaining six cases either identified care and service delivery issues that did directly contribute to the patient's death or remain under investigation at the time of publication.

Themes identified included treatment delays, delayed recognition and escalation of deterioration, and communication issues. These are being addressed through Trust wide safety programmes, including:

- Improving the recognition and response to deteriorating patients, and enhancing the hospital at night programme
- Introduction of electronic consenting for surgical procedures to enhance communication

Focus on vulnerable groups

There were 12 deaths of patients with a learning disability or autism, and all were referred for a LeDeR[14] review. An additional 13 cases were identified for a structured judgement review following the deaths of patients with a severe mental health condition (N.B. all deaths were related to physical health issues). All reviews completed for these two patient groups have graded overall care as adequate or above, with 86% of those grading it as good or excellent.

The trust receives completed LeDeR reviews and has acted based on learning identified, including:

- Participation in the implementation of the Reasonable Adjustments Digital Flag to ensure accurate information sharing and highlighting of individual needs across the health system
- The implementation of Martha's Rule, as reflected in our 26/27 Quality Priorities
- The rolling out of end-of-life care study days focused on the monitoring and management of end-of-life symptoms, and the development of an end-of-life Care guideline

Completion of outstanding structured judgment reviews from 2024/2025

There were 31 cases from 2024/25 rolled over into 2025/26. All have been completed with 26 cases being initially graded as adequate, good or excellent care during their stage 1 SJR. The remaining five cases progressed to a stage 2 SJR which was completed. None of these cases were judged as probably avoidable (more than 50:50), strongly avoidably, or definitely avoidable.

Child and neonatal deaths in our care

There were 16 neonatal deaths and fewer than five child deaths. All deaths were reviewed using national tools, including the Perinatal Mortality Review Tool (PMRT), Mothers and Babies: Reducing Risk through Audits and Community Engagement (MBRRACE), and the Child Death Overview Panel (CDOP), to ensure ongoing learning and improvement.

2026/2027 Focus

Through 2026/27 we will be:

- Augmenting our mortality reporting to improve our ability to identify and learn across all specialities, taking into consideration patient demographics and health inequalities
- Introducing speciality level reporting into the Learning from Deaths meeting
- Standardising mortality and morbidity meetings across specialities
- Continuing to embed and align learning from deaths with the Patient Safety Incident Response Framework

[14] Learning from lives and death of people with a learning disability and Autistic people see NHS England » Learning from lives and deaths – people with a learning disability and autistic people (LeDeR)

2.3 Performance against Core Indicators

This section summarises how Ashford and St Peter's Hospitals NHS Foundation Trust performed during 2025/26 against the NHS Outcomes Framework domains as listed below[15]

Domain 1: Preventing people from dying prematurely

1. Summary hospital-level mortality indicator (SHMI)

The SHMI banding for a trust[16] is the ratio between the actual number of patients who die[17], considering the characteristics of the patients treated and the number expected to die based on average England figures. Table 12 below shows the trust's mortality banding as 2, which is as expected. COVID-19 activity has been excluded from the SHMI. The SHMI is not designed for this type of pandemic activity, and the statistical modelling used to calculate it may be less robust if such activity were included. SHMI statistics are published six months in arrears; the data below was the latest available at the time of writing this report.

Table 11: SHMI mortality data

Summary hospital-level mortality indicator (SHMI)	Oct 2022-Sept 2023	Oct 2023 - Sept 2024	Oct 2024 - Sept 2025
Trust score	0.8905	0.9836	0.8730
Trust banding	2	2	2
National benchmark score	1.0	1.0	1.0
Lowest score nationally (most favourable)	0.677	0.6968	0.7194
Highest score nationally (least favourable)	1.2293	1.3094	1.3183

As the SHMI does not adjust for palliative care provision, a further indicator is needed. The 'palliative care indicator' measures deaths occurring under palliative care conditions for each provider reported in the SHMI using the indicator of the percentage of deaths per palliative care coding. The trust tracks above average in specialist palliative care coding, which may reflect factors such as a dedicated Palliative Care Ward, improved coding accuracy following the introduction of Millennium ePR in May 2022, and local hospice availability.

Table 12: Palliative care coding rate

Palliative care rate (%)	Oct 2022-Sept 2023	Oct 2023 - Sept 2024	Oct 2024 - Sept 2025
Trust score	53	56	56
National benchmark	41	44	44
Lowest score nationally	15	17	17
Highest score nationally	66	67	69

Ashford and St Peter's Hospitals NHS Foundation Trust consider that this data is as described for the following reasons: mortality data is monitored quarterly by the Trust Board, coding checks occur, and the clinical coding service is a regional centre of excellence accredited by the HSCIC Clinical Classifications Service (CCS). The trust will continue to take every opportunity afforded by clinical advances and best care, and by learning from mortality and patient safety data, to strive towards an improved SHMI score and banding. The combined Mortality Committee and End of Life Care Group maximise learning and improvement opportunities.

[15] Refer to https://digital.nhs.uk/data-and-information/publications/ci-hub/nhs-outcomes-framework for information on the NHS Outcomes Framework and the 5 domains.

[16] SHMI banding 1 reflects higher than expected deaths; banding 2 is as expected and banding 3 is lower than expected.

[17] Deaths are those in non-specialist acute hospitals or in the 30 days following discharge per Hospital Episode Statistics.

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

2. Patient reported outcome measures

Patient reported outcome measures (PROMs)[18] indicate a patient's health status or health-related quality of life from the patient's perspective, for the procedures specified by the PROMS national programme. This information is gathered from a questionnaire that patients are invited to complete before surgery and six months after surgery. Pre-operative assessment teams encourage participation in the questionnaire.

The indicator used is the EQ-5D index case mix adjusted health gain, where a higher value represents a better score. This data is released in arrears due to the inclusion of feedback from patients 6 months after surgery; the latest data available is for 2024/25.

Table 13: Patient reported outcome measures hip and knee replacement

	Hip replacement - primary			Knee replacement - primary		
Period	**2022/2023**	**2023/2024**	**2024/2025**	**2022/2023**	**2023/2024**	**2024/2025**
Trust	0.443	0.477	0.487	0.330	0.285	0.304
National	0.460	0.458	0.451	0.333	0.323	0.320
Lowest	0.362	0.352	0.268	0.241	0.231	0.231
Highest	0.548	0.581	0.544	0.412	0.405	0.497

Ashford and St Peter's Hospitals NHS Foundation Trust consider that this data is as described for the following reasons: The trust contracts the management of the PROMS programme to the external provider IQVIA and holds regular meetings that include reporting on data quality and assurance. The trust is satisfied with PROMS participation rates and intends to take no further action regarding data completeness. Patient outcomes are discussed at speciality level, with data investigated in more detail to inform improvement actions if required.

3. Emergency Readmission to Hospital within 30 days of discharge[19]

This national indicator, clarified for 2025/2026, is 'The data made available to the NHS trust or NHS foundation trust by NHS Digital with regard to the percentage of patients aged

- (i) 0 to 15; and
- (ii) 16 or over

readmitted to a hospital that forms part of the trust within 30 days of being discharged from a hospital that forms part of the trust during the reporting period.'

The most recent data available at the time of this report is for 2024/25.

Table 14: 30 Day emergency (non-elective) readmissions[20]

Patient Age	**0-15**			**≥16**		
Period	**2022/23**	**2023/24**	**2024/25**	**2022/23**	**2023/24**	**2024/25**
Trust	8.4%	7.4%	12.7%	18.0%	11.4%	11.5%
National	12.8%	13.2%	13.0%	14.4%	15.1%	14.9%
Lowest	3.7%	1.6%	1.2%	2.5%	1.7%	0.6%
Highest	302.9%	69.1%	48.1%	46.8%	99.6%	40.3%

[18] See https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms for more information

[19] In previous Quality Account documents the Trust has reported on admissions within 28 days of discharge as per Quality Account detailed requirements. However the national figure and guidance on the NHS Digital website states 30-day readmissions, hence data has been updated See https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts The most recently published data available covers 2024/2025.

[20] Readmissions for prior years re-stated owing to continued data refresh as cases are coded. The dataset above is on the same basis to ensure consistency of information.

Ashford and St Peter's Hospitals NHS Foundation Trust consider that this data is as described for the following reason: checks on the completion and accuracy of coding are performed before upload. The trust benchmarks well nationally but intends to take the following actions to further improve this rate and, in turn, the quality of its services: continued focus on safe discharge and improvement programmes for urgent and emergency care.

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

4. Responsiveness to the personal needs of patients - experience of inpatient care

This metric is the trust score for responsiveness to patients' personal needs during the reporting period. The indicator value is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals and is part of the NHS Outcomes Framework. Following the merger of NHS Digital and NHS England on 1 February 2023, the future presentation of the NHS Outcomes Framework indicators was reviewed, and whilst certain metrics have recommenced as of February 2025, this workstream does not currently have any available data [21]. Therefore, as the required national data is not currently available, in its place, the trust provides a summary of key findings from the most recently available Adult Inpatient Survey 2024. These results show that the trust continues to deliver strong interpersonal care and responsiveness in meeting fundamental personal needs such as eating, drinking, hygiene, privacy, and compassionate interactions. However, the survey also highlights areas requiring improvement, many of which relate to personalised communication, comfort, and involvement in care. The 2024 survey demonstrates that patients consistently experience high-quality personal care, kindness, dignity, and support with basic needs, but there is a need for continued improvement in communication, discharge involvement, dietary responsiveness, and nighttime patient comfort.

Inpatient Survey Report 2024

The trust response rate was 40%, slightly below the national response rate of 41%. Patients rated the overall experience of care as 79%; 99% were treated with respect and dignity, and 98% had confidence and trust in doctors. Ashford and St Peter's Hospitals NHS Foundation Trust ranked 49th in the country for overall positive score when compared to other organisations which ran the Adult Inpatient Survey 2024 with Picker.

Of the 63 questions asked in the 2024 survey, 45 received positive scores. The results from the survey demonstrate that strong areas are:

- Helping patients with eating
- Waiting time experience on the ward once admitted
- Cleanliness
- Drinks
- Respect and Dignity

The lowest across compared with the Picker average is:

- Waiting for admission
- Quality of information whilst on a waiting list
- Staff explanations of ward changes at night
- Patient involvement in decisions about discharge and who to contact if worried post discharge
- Staff taking account of the patient's dietary needs

[21] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework

Results for Ashford and St Peter's Hospitals NHS Foundation Trust

Top 5 scores vs Picker Average	Trust	Picker Avg
Q14. Got enough help from staff to eat meals	90%	86%
Q7. How long waited before been admitted onto a ward	93%	90%
Q11. Room or ward very or fairly clean	97%	97%
Q16. Got enough to drink	94%	94%
Q47. Treated with respect and dignity overall	99%	98%

Bottom 5 scores vs Picker Average	Trust	Picker Avg
Q2. Did not mind waiting as long as did for admission	46%	58%
Q4. Quality of information given while on waiting list to be admitted was very or fairly good	69%	79%
Q10. Staff explained reasons for changing wards at night	71%	80%
Q35. Felt involved in decisions about discharge from hospital	66%	73%
Q31_5. Hospital staff took into account dietary needs (Excluding respondents who answered using a smartphone)	72%	79%

Work to address the bottom five scores is as follows.

Waiting for admission: The trust is implementing further measures to reduce delays for patients awaiting an emergency admission bed. Acknowledging that some patients continue to experience extended waits, departments are asked to prioritise proactive, transparent communication throughout the admission process. Teams are expected to provide regular, timely updates to patients and their families, so they feel informed and supported while waiting.

To help improve overall admission and discharge (hospital flow), the trust is expanding its Improving Hospital Flow Programme, with a renewed focus on accelerating the safe and effective discharge of both medically fit and complex patients. This work aims to ensure that acute bed capacity is used efficiently, reducing the time patients spend waiting for an inpatient bed.

In addition, the trust has enhanced its educational offerings by introducing biweekly 'Discharge 101' virtual training sessions, which now cover a broader range of topics essential to staff confidence in planning and coordinating timely discharges. These sessions support improved discharge practice across clinical areas, contributing to a more reliable and responsive admission pathway.

Quality of information while on a waiting list: The trust continues to improve the quality of information provided to patients on waiting lists, building on the introduction of the Waiting Well initiative. Waiting Well is designed to identify and support patients who may be at risk of harm while awaiting an appointment, diagnostic test, follow-up, or planned procedure, including those on surveillance waiting lists.

The initiative is underpinned by seven core principles, which together provide a comprehensive safety net for patients. A key element of this approach is proactive patient contact. Patients on waiting lists are routinely contacted to assess any changes in symptoms or condition, enabling timely clinical triage and reprioritisation where required, and helping to reduce the risk of harm while waiting. This process ensures patients whose condition has deteriorated can be seen more quickly, while also identifying cases where symptoms may have improved, and clinical input is no longer required.

Patients are kept informed about expected timescales and are actively tracked through to their appointment, helping to improve transparency and manage expectations. Clear written information, including Waiting Well leaflets, continues to support patients by explaining what to expect, how to seek help if their condition changes, and where to obtain further advice.

Active waiting list validation and review are now embedded as part of business as usual, contributing to improved oversight of waiting times and enhanced communication with patients. The trust continues to refine this approach in response to patient feedback and operational learning, with the aim of ensuring patients feel informed, reassured and supported throughout their time on a waiting list.

Moving wards at night: To support patient recovery and minimise disruption to patients and their wellbeing, every effort is made to avoid moving patients at night. The trust recognises that sleep and rest are vital to recovery, and every effort is therefore made to avoid moving patients overnight. However, during periods of

high demand for inpatient beds, nighttime transfers may be unavoidable to ensure patient safety, appropriate clinical placement, or manage hospital capacity. Where transfers are necessary, staff are expected to explain the reason for the move in advance wherever possible, offer reassurance, and take steps to minimise disruption and anxiety. Clinical teams emphasise the importance of clear communication, particularly for patients who may feel vulnerable, confused, or distressed by ward changes at night. Nighttime movement is carefully considered clinically to ensure site safety, kept to a minimum, and clinical areas remain responsible for ensuring that relatives are informed of any ward changes and for providing a clear explanation for the transfer. The trust continues to review bed management processes and patient feedback to reduce avoidable nighttime moves and improve the patient experience when transfers are required.

Patients feeling involved in decisions about discharge from hospital: The trust recognises that meaningful involvement in discharge decisions is essential to patient confidence, safety and continuity of care. Communication with patients and their families is a focus, ensuring that discharge planning begins early in the hospital stay and that patients receive clear information about their condition, ongoing care needs, and what to expect following discharge. Staff involve patients as active partners in decision making, taking into account individual circumstances and support needs, to help ensure that patients feel informed, prepared and supported when leaving the hospital.

Staff taking account of patients' dietary needs: ASPH recognises that meeting patients' dietary needs is a core part of delivering safe, personalised and compassionate care. Positive scores were observed for helping patients with meals and providing patients with drinks. Areas for improvement included food provision, such as menu choices, service flexibility, and the mealtime environment. In response, the trust implemented actions to improve the overall quality and consistency of food provision across sites. A revised inpatient menu was introduced, supported by feedback from the Patient-Led Assessments of the Care Environment (PLACE), along with updated cooking and food service protocols.

The trust has a nutrition steering group that focuses on ensuring patients' nutritional needs are met, and experiences are optimised, including for patients at risk of malnutrition, those with longer lengths of stay, and those requiring specialist or texture-modified diets.

Ward teams are supported in seeking timely dietetic advice and escalating concerns when patients are unable to tolerate food or have limited nutritional intake. Clinical teams are also supported to ensure patients who require assistance with eating and drinking receive appropriate help, including the use of recognised visual prompts and protected mealtime principles, with increasing flexibility in meal provision for patients who miss meals due to procedures, investigations or feeling unwell.

5. Staff who would recommend the trust to their family or friends

This indicator measures 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. The data is from the National NHS Staff Survey, which is gathered during quarter 3 of each financial year. It is measured as the percentage of staff who either agreed or strongly agreed with the following statement: 'If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.'

5,278 staff members were eligible to participate in the staff survey in 2025, of which 2,225 (42%) completed the survey. This was a response rate of 42%, a decline compared to the previous year (51%) and below the national average for acute and acute community trusts (48%)

Table 15: Staff who would recommend the trust to family and friends

	2023	2024	2025
Trust	60.4%	62.6%	63.7%
National Average	63.3%	61.6%	60.8%
Highest Score	88.8%	89.6%	88.4%
Worst Score	44.3%	39.7%	34.7%

Ashford and St Peter's Hospitals NHS Foundation Trust consider that this data is as described for the following reasons: the trust contracts the administration of the national surveys to Picker who provide quality assurance on the process. The trust has improved and benchmarks well nationally but intends to take the following actions to further improve this rate and, in turn, the quality of its services: the trust undertakes additional quarterly pulse surveys to enable it to respond to any changing trends. There is a comprehensive range of wellbeing support for staff.

Staff wellbeing and engagement 2025/2026

National Stress Awareness Month – April 2025

During Stress Awareness Month (April 2025), the trust delivered a wide range of initiatives to support staff mental health and wellbeing. Practical guidance was provided through Age UK advisory sessions on future planning, alongside communications from Pastoral Care and Wellbeing Support, which offered tips for managing stress and information on accessing services, including the Employee Assistance Programme (EAP), which provides counselling and advice. Weekly trust-wide updates helped maintain awareness and encouraged proactive engagement with available support.

Staff were also offered creative and social wellbeing opportunities, including free art and knitting sessions led by the Healing Arts Manager and Volunteer Team. The Men's Health Network hosted a dedicated event focusing on stress and depression among men, fostering open discussions about mental health.

National Walking Month – May 2025 – 'Walk This May' initiative

In recognition of National Walking Month in May 2025, this annual event encourages people to embrace walking as a simple and effective way to improve their health and well-being. There are many benefits to walking and physical exercise, including positive impacts on physical and emotional wellbeing. We had 30 teams across the organisation join this initiative, with the top three teams who walked the most miles receiving a Just Eat Gift Voucher to celebrate as a team.

Health and Wellbeing Day – November 2025

The trust held its first Health and Wellbeing Day on Wednesday 5 November 2025, dedicated to promoting staff wellbeing across all aspects of health. The event was well attended, with over 140 colleagues representing 44 departments across the trust. It provided a comprehensive overview of the trust's wellbeing offer, with teams from across the trust, including:

Initiatives supporting physical, emotional, social, and financial wellbeing

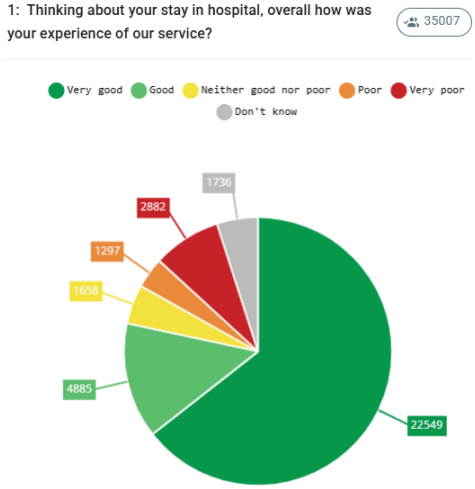
- Promotion of 'Vivup', an employee benefits platform that helps employees save money, access support services, and use workplace perks
- Engagement with Equality, Diversity and Inclusion (EDI), 'Here 4 You' Champions, and Freedom to Speak Up teams
- Updates on the trust's violence reduction and sexual safety commitments
- Information from Occupational Health and the Bicycle User Group promoting active travel.
- Mini Health Checks and flu vaccinations provided by Occupational Health

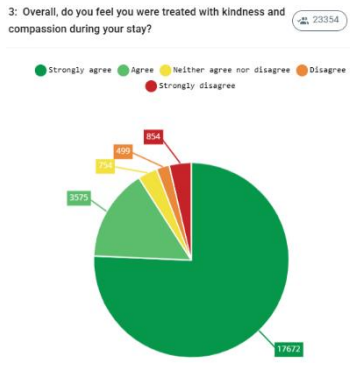
Feedback from attendees was positive, highlighting strong staff engagement and awareness of available wellbeing resources. Plans are in development to make this an annual event.

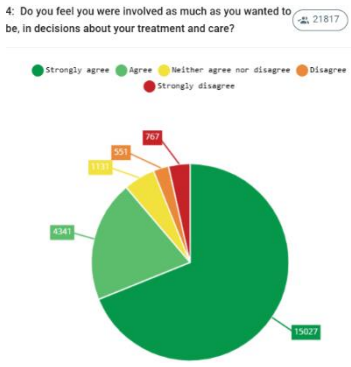
6. Friends and Family Test (FFT)

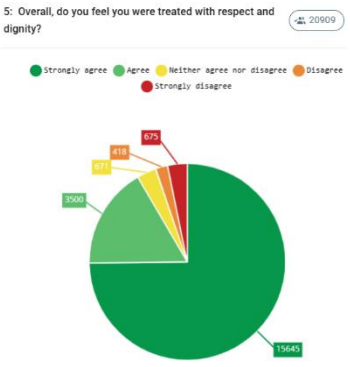
The mandatory question for trusts to measure satisfaction was set in April 2020 by NHS England as 'Overall, how was your experience of our service?' The results for 2025/26 are shown below, 83% of inpatients reported a positive experience[22] giving a score of 'good' or 'very good'.

The charts below show the responses to the trust's strategic questions for inpatients from April 2025 to March 2026. In this reporting period, 94% of patients said they were treated with compassion, 94% said they were involved in decisions about their care and treatment, and 95% said they were treated with respect and dignity.









Ashford and St Peter's Hospitals NHS Foundation Trust consider that this data is as described for the following reasons: The trust uses the electronic feedback system Viewpoint to routinely collect patient feedback, which is then analysed and used for reporting, quality monitoring and improvement purposes. The trust continues to receive and monitor patient feedback through the Learning from Patient Experience Group. Staff feedback is monitored through the People Committee. These forums provide regular oversight of emerging themes, trends and areas for improvement. Action plans in response to feedback are developed, reviewed, and monitored through the relevant committee or group to ensure improvements are implemented and learning is embedded across the organisation.

[22] The number of responses to each question is the number encircled at the end of the question wording.

In the year, there has been continued progress in strengthening patient experience across the trust. Patient, carer and family feedback has been increasingly embedded across services, drawing on complaints, PALS, compliments and wider patient experience data to inform discussions and decision-making. There has been a growing emphasis on using lived experience to support learning and improvement, alongside a sustained commitment to early resolution in complaint management, helping to address concerns promptly and prevent escalation where possible. The quality of responses has continued to improve, with greater consistency in empathetic, kind and open communication that demonstrates action focused learning. In parallel, there has been stronger alignment between concerns and complaints processes, and patient safety systems, supporting a more integrated and holistic approach to learning from experience.

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

7. Patients admitted to the hospital who were risk assessed for venous thromboembolism.

This measure shows the percentage of patients aged 16 years and older at the time of hospital admission who underwent a risk assessment for venous thromboembolism (VTE) during the reporting period. VTE risk assessment data collection is a national quality KPI (Key Performance Indicator) under the NHS Standard Contract, with a target achievement of 95%.

Table 16: VTE risk assessment showing the % risk assessed

Percentage risk assessed for VTE	Apr to Jun 2024	Jul to Sep 2024	Oct to Dec 2024	Jan to Mar 2025	Apr to Jun 2025	Jul to Sep 2025	Oct to Dec 2025	Jan to Mar 2026
Trust	98.77%	97.96%	98.53%	98.35%	98.68%	97.2%	97.59%	95.57%
National	89%	89%	90%	91%	91%	91%	92%	*

* Data not available at time of report

Ashford and St Peter's Hospitals NHS Foundation Trust consider that this data is as described for the following reasons: independent checks on accuracy and completeness are performed before upload to the national portal. The trust continues to exceed the national benchmark.

8. Clostridiodes Difficile Infection

Clostridioides difficile Cases are apportioned to this trust from the following two categories: Hospital Onset Healthcare Associated (HOHA) which is when the specimen date is three days or more after current admission date (where day of admission is day one), or Community Onset Healthcare Associated (COHA) where cases are not categorised as HOHA and patient most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day one is the specimen date).

Each year, the nationally determined threshold is based on the trust's performance in the previous year. Following the achievement of the 2024/25 threshold, the 2025/26 threshold was lowered to 29. The total number of cases for 2025/26 was 46, exceeding the threshold. All cases were reviewed, and it was confirmed that 43 of these were unavoidable.

Table 17: Clostridioides difficile infection

Clostridiodes difficile	Target	2023/24	Target	2024/25	Target	2025/26
Trust- cases per year	17	35	38	32	29	46
Infection rate per 100,000 bed days		14.60		13.51		*
National average bed days		18.82		23.29		*
Lowest score nationally bed days – most favourable		0		1.78		*
Highest score nationally bed days – least favourable		56.65		80.96		*

* Data not available at time of report

Ashford and St Peter's Hospitals NHS Foundation Trust consider that this data is as described for the following reasons: independent checks on accuracy and completeness are performed before upload to the national portal. The trust will continue to take action to improve this rate and so the quality of its services by advancing our quality improvement priorities to reduce healthcare-associated infections.

It is worth noting that Clostridioides difficile is known to be an antibiotic associated infection. Taking this into account, most cases were assessed as being unavoidable, as they occurred in patients receiving antibiotics which were clinically indicated and prescribed in line with the trust's prescribing guidelines. Only a small number of cases resulted from incorrect prescribing that was not in line with the prescribing guidelines. This learning was

rolled out to clinical teams during PSIRF swarms in the affected areas, along with more widespread training for medical staff. Other lessons to emerge from Clostridioides difficile cases included early sample collection, early patient isolation based on symptoms of diarrhoea, and sufficient stool sample collection to aid timely diagnosis. Whilst this learning was not the cause of the Clostridioides difficile cases seen, it was nevertheless Important learning to improve patient management and patient experience and has been translated into clear actions through PSIRF swarm reviews, mandatory induction and refresher training, ward-based tea trolley coaching, and the IPC link nurse programme. These measures are being used to strengthen day-to-day practice, improve consistency of care, enhance staff awareness, and provide ongoing assurance that high standards of infection prevention, communication, and patient-centred care are sustained.

Assurance around Infection Prevention and Control in line with national recommendations[23] is through the IPC Board Assurance Framework and the annual Director of Infection Prevention and Control (DIPC) report, which includes associated risks and actions to address them by designating key quality improvement priorities. The IPC Board Assurance Framework is included as a standing agenda item at the Control of Infection Committee, including actions to address those areas with partial or inadequate assurance. The trust's Quality of Care Committee and Trust Board also receive regular IPC reports.

See section 3.1 for further details of performance against the NHS standard contract targets and our Quality Account priority for IPC.

9. Rate of patient safety incidents and percentage resulting in severe harm or death

The trust moved to using the Patient Safety Incident Response Framework (PSIRF) in 2024 and has now come to the end of its first Patient Safety Incident Response Plan Timeframe. A refreshed plan, based on the trust's current safety incident data, intelligence, and local risks, will be published in Q1 2026/27. The adoption of PSIRF has enabled us to focus on proportionate responses to safety incidents and continuous improvement across the complex system in which we deliver care, whilst ensuring that patients, families and staff remain at the centre of compassionate engagement through investigations.

Over 87% of trust staff have completed the national Level 1 Patient Safety Syllabus training. Over 40 staff have completed specialist learning response lead and engagement lead training under PSIRF. This places the trust in a good position to identify, report and respond to patient safety incidents.

Table 18: Patient Safety Events

Patient Safety Events	2023/24*	2024/25*	2025/26*
Total number of events reported	7,651	7,493	6474
Number of events where the patient safety incident contributed to the death	≤5 (0.04%)	≤5 (0.01%)	7** (0.11%)
Number of events where the patient safety incident contributed to severe harm	52 (0.68%)	34 (0.45%)	36** (0.56%)

* LFPSE local data

** Unvalidated, as some incidents remain under investigation

[23] Board Assurance of compliance against the Health and Social Care Act 2008: code of practice on the prevention and control of infections
Implementation and monitoring of the National IPC manual : NHS England » National infection prevention and control
Implementation and monitoring of the National Standards of Healthcare cleanliness 2021 : B0271-national-standards-of-healthcare-cleanliness-2021.pdf (england.nhs.uk)

Ashford and St Peter's Hospitals NHS Foundation Trust consider that this data is as described for the following reasons: From 2023/2024 onwards, the trust implemented LFPSE reporting. Whilst we do not have official statistical publications, we analysed the data internally and scrutinised it at our trust committees.
The trust will continue to take action to improve this reporting rate and the quality of its services by advancing our quality improvement priorities and continuing to implement the National Patient Safety Strategy, including the Patient Safety Incident Response Framework (PSIRF), local safety priorities, and National Safety Improvement Programmes.

The trust's overall reporting rate for 2025/26 has reduced. It is unclear why this is the case; however, it is likely due to several factors, including the introduction of mandatory fields in the Learning from Patient Safety Events system, which increased the reporting burden, and significant periods of operational challenge throughout 2025/26. To support reporting, several actions are being undertaken by the trust, including:

- Review and refresh of the incident reporting form, including reducing mandatory fields where possible
- Co-design of incident reporting forms with staff and speciality groups to ensure data capture is proportional and relevant to the incident type being reported
- Continued rollout of Level 1 safety syllabus training for all staff, which includes recognising and reporting safety incidents.

We expect all staff to report patient safety incidents and near misses promptly, and we actively encourage patients and families to raise concerns and to ask staff whether an incident has been or should be reported. This helps ensure issues are recognised early, investigated appropriately, and used as opportunities for learning and improvement.

Patient Safety Incident Investigations (PSIIs) and Thematic Reviews

As part of the trust Safety Priorities, 13 patient safety incident investigations were commenced in 2025/26 under the following national and local priority themes

- Death thought more likely than not due to problems in care
- National Screening Programme Incident
- Incidents meeting a Never Event criteria
- Failure to recognise or escalate a deteriorating patient
- Emerging risks and trends or incidents of significant concern

The PSIIs that remain open are on course for completion in early 2026/27. The three completed PSIIs identified learning and safety actions, which included:

- Clinician understanding of the impact unconscious bias has on their decision making and communication with patients and families. This is to be a key theme in our 2026/27 patient safety conference
- Reviewing previous imaging can help identify interval changes and provide important clinical context, supporting accurate interpretation and reporting of findings. A patient safety alert was shared with radiologists, setting clear expectations to review prior imaging where available, carefully assess the density of fluid collections, and adopt a systematic approach that considers serious conditions are appropriately excluded rather than assumed absent, 'rule out rather than rule in'.
- The need for and development of a failsafe process for Newborn Infant Physical Examinations (NIPE) to ensure infants with risk factors for Developmental Dysplasia of the Hip (DDH) are identified appropriately. This is now in place
- A clear pathway for NIPE practitioners to follow when identifying infants with risk factors for DDH. This is now in place

A thematic review of nutrition and hydration related incidents was undertaken during 2025/26 and is scheduled for publication in Q1 2026/27. The review identified several opportunities to strengthen practice, quality of care and patient experience, with a focused improvement programme to be delivered during 2026/27, including:

- Enhanced usability of the electronic patient record to support complete assessment of nutritional status and the request of specialised diets
- Improved e-learning and facilitation of face-to-face training on the assessment and management of nutrition and hydration for staff
- Capital investment of a range of weighing scales, stadiometers to measure height, and specialist feeding equipment

Never events

Less than five never events were reported in 2025/26, and all remain under investigation. Themes from the never events include wrong site surgery, retained foreign objects and implantation of an incorrect prosthesis. One incident has been reviewed as a Patient Safety Incident Investigation, and three have been reviewed using the After Action Review[24] methodology. Immediate actions taken following these never events include:

- Implementation of a written compatibility reference chart for prostheses within theatres
- A trust-wide programme to refresh and improve local safety checking processes to ensure the National Safety Standards for Invasive Procedures are met

The patients involved experienced no harm or only minor harm; however, all incidents are taken seriously, regardless of outcome, as each provides an important opportunity to learn, improve practice, and reduce the risk of recurrence.

Focus for 2026/2027

The trust aims to build on the implementation of PSIRF over the past two years and further embed the framework across the organisation. To support this, we will:

- Increase the number of patient safety specialists within the organisation
- Roll out further patient safety training for staff
- Enhance our processes to engage patients, families and staff with learning responses
- Consider expanding our mandatory patient safety training to include the Level 2 Patient Safety Syllabus for clinical staff

[24] A structured debriefing tool which is part of the PSIRF toolkit, used for rapid learning rather than intensive investigation.

Part 3: Other Information

3.1 Overview of the quality of care against 2025/2026 priorities

Priority 1 Patient Safety - learning from errors and reducing avoidable harm and in-hospital infection		
1.1	Achieve and/or exceed the Infection Prevention and Control (IPC) NHS Contract standards thresholds for 2025/26.	The targets for e coli bloodstream infections, Pseudomonas and Klebsiella were met. The Clostridioides difficile and MRSA thresholds were missed. Of the Clostridioides difficile cases, only three of the 46 cases were assessed as being avoidable. There were four cases of MRSA, three of which were assessed as being avoidable.
1.2	90% of learning responses are completed within the timescales set in the Patient Safety Policy/Plan 2025/26.	This priority was not met. On reflection, following the implementation of PSIRF, the trust's self-imposed timescales for completing learning responses have not provided staff with adequate time to produce thorough responses. The timescales were also not aligned with national PSIRF guidance. Therefore, as part of the updated trust Patient Safety Incident Response Plan for 2026-2028, these timescales will be aligned with the national guidance. By extending the expected timeframe for completion, quality learning responses with meaningful engagement of those affected and involved should be achieved. To support this and ensure that learning responses are completed in a timely manner, the trust is introducing a new patient safety governance meeting starting in May 2026 to monitor and strengthen oversight of learning response completion.
1.3	95% compliance with lying and standing blood pressure measurements for eligible patients in all ward areas.	Inpatient falls are a key indicator of care quality and are largely preventable. Measurement of lying and standing blood pressures detects postural hypotension[25], a known risk factor for inpatient falls. The overall trust average compliance is 84.7%, with monthly compliance ranging from 77.7% to 94.4%. The trust has taken a number of actions, including bi-monthly Multi-Disciplinary Team Harms Free Grand Rounds to share learning and discuss challenges and actions related to harms, and targeted training in areas with lower compliance with lying and standing blood pressure measurements.
1.4	A 10% reduction in Category 3[26] and above pressure ulcers, including unstageable, based on 2024/25 outturn.	The upper tolerance for hospital acquired category 3 and above pressure ulcers for 2025/26 was 29. A reduction from the previous year was achieved, but the target was narrowly missed, with the final number at 30. Actions included staff training, a focus on improving pain management to enable patients to mobilise more comfortably, and a review of dressing availability.

[25] Postural hypotension is a drop in blood pressure when moving from sitting to standing. This can cause dizziness or fainting.

[26] A category 3 pressure ulcer involves full thickness skin loss, an unstageable pressure ulcer involves full thickness skin loss, but it is not yet clear if there is further deeper tissue loss as the base of the wound is not currently visible due to the presence of dead tissue. As this becomes visible in due course it will be assigned to a category.

Priority 2 Clinical Effectiveness – learning from deaths and addressing episodes of poor care		
2.1	5% increase in patients prescribed chemical thromboprophylaxis[27] (CTP) within 14 hours of admission in the first six months of 2025/26 from a baseline of 73%, with a subsequent 5% increase in the following six months.	Prescribing of chemical thromboprophylaxis within 14 hours of admission remains consistently above the target, meeting and surpassing the incremental improvement trajectory for 2025/26. Sustained performance reflects the successful embedding of improvement actions, including visual dosing guidance, optimised electronic prescribing workflows, and routine VTE and CTP review at board rounds and safety huddles. The focus is now on sustaining current performance, with monitoring through audits and continued oversight by the trust Thrombosis Committee and the Safety and Quality Committee.
2.2	Using an experience-based co-design model previously used in maternity, establish a focused patient information programme to ensure patients admitted to surgery will have been informed of the reason for having a VTE risk assessment, how to reduce personal risk of VTE and what to do if they develop signs of VTE.	Work to deliver this priority has been focused on scoping and alignment to support effective delivery. Implementation of the experience-based co-design approach, previously used in maternity services, required adaptation for patients admitted for surgery and engagement across multiple clinical teams. This work ensured the model could then be applied effectively. The next phase is focusing on co-designing patient information that clearly explains the purpose of VTE risk assessment, actions patients can take to reduce their individual risk, and what to do if signs or symptoms of VTE develop. This work will be aligned with existing patient safety and thrombosis prevention initiatives to support consistency and sustainability.
2.3	95% of all deaths of babies, suitable for review using the Perinatal Mortality Review Tool (PMRT), have been started within two months of each death (including homebirths), and 60% of PMRT reports are published within six months.	This measure is part of the Maternity Improvement programme. Both targets have been met. This process is embedded and monitored as part of business as usual.

Priority 3 Patient Experience – our learning culture is reducing harm to improve patient experience		
3.1	Develop and establish trust best practice complaint handling training, including remedy, and equitable experience for vulnerable groups.	This priority was achieved through training designed to improve the patient experience during the complaints process and to empower staff to proactively resolve concerns raised by patients at the time of the event. This priority was established in 2024/25 and continued in 2025/26 with a focus on compassion and empathy in responses to achieve earlier resolution, embedding the training and reaching more staff. Work on response quality will continue in the 2026/27 priorities.

[27] Drugs designed to prevent blood clots forming in the veins in patients with reduced mobility

Priority 3 Patient Experience – our learning culture is reducing harm to improve patient experience		
3.2	To achieve a 20% Friends and Family Test (FFT) response rate of all eligible patients.	This measure was continued due to the importance of gaining patient feedback to inform our learning and service development, building on the previous target of 15% achieved in 2024/25. During 2025/26, it was not possible to improve the response rate to reach the target, with average performance remaining around 15%. Increasing the number of responses is an aim that will continue into 2026/27.
3.3	To achieve a 10% increase in positive FFT responses from 2024/25 outturn.	This was a new priority aimed at increasing the number of positive responses for Maternity, ED, inpatients, and outpatients. The target was set at 89%, but the average achieved was 81%. Although positive feedback increased in several areas, overall performance remained inconsistent due to low response rates.
3.4	Reduce the number of incidents, complaints and PALS concerns related to patient discharge by 20% from 2024/25 out-turn.	This was a continuation of the previous priority. The target was no more than 20 PALS concerns per month, but the average was 25. Although this measure is not continuing as a standalone priority, it is linked to the wider work on improving discharges outlined in the 2026/27 priorities.

3.1.1 2025/2026 Rationale for indicator changes

There have been no indicator changes during 2025/26 from the previously stated forward priorities (for 2025/26) in the Quality Account report dated June 2025.

3.1.2 Rotas of doctors and dentists in training

The 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training requires the Quality Account to summarise our annual report on rota gaps. The Guardian of Safe Working (GoSW) quarterly report for quarter 2 (Q2) 2025/26 is the latest available data at the time of writing this Quality Account; the annual report is not due to the Trust Board until July 2026.

In Q2, there were no non-compliant rotas. Locum shifts (rota gaps), and in particular unfilled locum shifts, are an important metric, as they provide a measure of workload intensity and patient safety. Unfilled shifts mean that a reduced medical workforce will be required to deliver the same level of clinical care.
The two specialities with the greatest demand for locum shifts are Medicine (21% of all shifts) and Emergency Medicine (19% of all shifts). Emergency Medicine managed to fill all its locum shifts. Within Medicine, 18% of locum shifts were unfilled.

3.2 Performance against NHS improvement indicators

The trust delivered strong performance against the NHS England 2025/26 Priorities and Operational Planning Guidance, with the majority of indicators exceeding national averages for acute trusts, highlighting the trust's continued commitment to high-quality care and system-wide improvement.

Table 19: NHS operational delivery priorities

	Apr-25	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-26	Feb	Mar	25/26 Monthly Average	National Target	National Average
RTT Waiting List	59,337	57,389	55,345	55,874	55,232	55,850	54,384	51962	51,310	50,621	49,638	50,932	53,990		
RTT Waiting List >52 weeks	783	847	863	977	1,089	1,017	1001	662	621	710	621	599	814		
RTT Waiting List >65 weeks	23	30	32	57	82	86	60	10	1	37	32	13	39	0	
RTT Incomplete Pathway	57.5%	59.0%	60.0%	57.5%	57.2%	58.0%	58.9%	59.0%	58.9%	58.8%	60.6%	61.9%	58.9%		61.1%
%Cancer - Faster Diagnosis Standard	80.5%	76.5%	77.3%	77.6%	75.7%	73.0%	78.7%	78.4%	81.8%	75.0%	83.0%	84.2%	Mar=84.2%	> 80%	75.6%
%Cancer - Combined 31Day	94.3%	99.4%	96.7%	98.5%	98.8%	99.0%	98.5%	98.8%	97.1%	96.7%	97.3%	97.1%	97.7%	> 96%	91.6%
%Cancer - Combined 62 Day	82.6%	80.6%	80.9%	82.4%	84.8%	88.3%	86.6%	81.8%	81.9%	81.6%	84.1%	82.7%	Mar=82.7%	> 75%	69.0%
A&E Performance - All Types	74.7%	75.9%	76.1%	75.6%	75.3%	76.1%	74.9%	76.4%	73.8%	72.4%	73.6%	78.4%	Mar=78.4%	> 78.3%	77.0%
%Ambulance Waits >45 mins	4.7%	3.8%	6.4%	6.5%	5.7%	6.6%	8.4%	5.8%	8.5%	9.4%	11.9%	6.7%	7.0%	0	
6 Week Diagnostic Performance	87.6%	85.2%	88.5%	92.2%	91.7%	93.8%	92.7%	90.2%	85.9%	85.7%	89.2%	82.9%	88.8%		77.4%

The ***Referral to Treatment Time (RTT) Incomplete Pathway***[28] measures the percentage of patient pathways within 18 weeks for those patients waiting for treatment at the end of each month.

The trust faced challenges in delivering the 18-week Referral to Treatment (RTT) standard during 2025/26, principally driven by the delay in opening four new inpatient theatres and the closure of one day-surgery theatre following ventilation and electrical failures. These infrastructure issues constrained elective surgical capacity across Orthopaedics, Ophthalmology, and Specialist Surgery throughout the year.

The trust's year-end RTT position was 61.9% at the end of March 2026. The number of patients waiting longer than 65 weeks fluctuated during the year, falling to just one patient in Q3, effectively achieving the zero target, before rising to 30 by March 2026. This compares to 13 at the end of 2024/25. Overall, the year-end RTT performance of 61.9% was below the target of 66.3% set out in the trust plan at the start of the year, but it compares favourably with the national average. The trust also provided mutual aid for long waiting orthopaedic patients from local providers, consistent with its commitment to system-wide collaboration.

Recovery actions implemented during the year included the undertaking of weekend theatre lists, increased outsourcing to independent sector providers in Q4, and additional outpatient clinics. The opening of the four new theatres in December and January was critical to improving RTT recovery, and the trust remains committed to delivering against its agreed trajectories into 2026/27, supported by the Improving Flow and Productivity transformation portfolios established under the Group Transformation Programme.

[28] Further information can be found at https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2025-26/

Cancer performance remained resilient throughout 2025/26, with the trust successfully maintaining delivery against key national cancer waiting time standards despite sustained demand and operational challenges, including workforce pressures in diagnostic services and some capacity constraints in imaging and endoscopy[29].

The trust exceeded the Cancer Faster Diagnosis Standard (FDS) of 80% in March 2026, reporting 84.2%. The trust also comfortably exceeded the 62-Day Combined Treatment Standard target of 75% in March 2026, reporting 82.7%. Multiple weekly PTL meetings actively manage cancer pathways, supported by the regional Cancer Alliance.

A patient should be admitted, transferred, or discharged ***within four hours of arrival at the Accident and Emergency Department (ED)***. Performance includes Walk-in Centres that align with the agreed NHS England criteria[30]

The trust achieved the national four-hour ED standard of 78.3% in March 2026, reporting 78.4%. ED attendances remained high throughout the year, with approximately 1,600 more attendances than in 2024/25. The trust successfully implemented the 'Your Next Patient' initiative, designed to decongest the Emergency Department early in the morning. Other interventions contributing to performance throughout the year included the opening of the new Ambulatory Care Centre, the seven-day opening of the Older Persons' Assessment Unit, and the expansion of the opening hours of our Same Day Emergency Care unit. The trust continues to experience challenges relating to patients requiring inpatient admission from the Emergency Department. An Improving Flow transformation portfolio has been established under the Group Transformation Programme to address flow challenges in a structured and sustained way.

A patient's ***initial diagnostic test or procedure should be completed within six weeks*** of the first referral[31]. This national indicator measures performance across a bundle of 15 diagnostic tests.

No national target was set for DM01 diagnostic performance in 2025/26. The trust's performance in delivering diagnostic tests within six weeks ranged from 87.1% in Q1 to 92.6% in Q2, closing the year at 85.9% in Q4. Throughout the year, the trust performed considerably above the England average of 77.4%, reflecting sustained delivery despite operational pressures. Performance was lower than the 94.3% achieved in 2024/25, with the decline primarily attributable to unplanned workforce shortages in sonography (ultrasound), ongoing national recruitment challenges for some diagnostic staff, such as cardiac physiology, and demand above in-house capacity within our endoscopy services. Recovery actions included additional weekend diagnostic lists, the opening of an additional MRI scanner at the Woking site operating on a six-day basis, and Board-approved investment in new endoscopy equipment. The trust remains focused on improving performance for the coming year.

[29] See https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/monthly-data-and-summaries/2025-26-monthly-cancer-waiting-times-statistics/

[30] See https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2025-26/

[31] See https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/monthly-diagnostics-data-2025-26/

Divisional Patient Tracking List (PTL) meetings to manage elective waiting lists are held weekly and chaired by relevant service managers to identify key pathway delays and ensure patients are managed according to clinical priority. A summary of performance, along with the identification of risks, is presented to the trust Performance Meeting, chaired by the Director of Performance and Deputy Chief Operating Officer, on a weekly basis. Trust-wide performance is reviewed within the bi-monthly Quality of Care Committee and Finance and Performance Committee before being presented to the Trust Board for further scrutiny. A revised Group governance structure has been implemented during the year, with the introduction of a new Performance Management Committee, chaired by the Chief Operating Officer, to oversee the delivery of constitutional access and operational performance.

Overall, for 2025/26, the trust achieved the key standards for ED four-hour performance, Cancer FDS, and Cancer 62-day target, and delivered diagnostic performance considerably above the England average throughout the year. The trust remains committed to improving patient experience and safety as it builds on this foundation into 2026/27.

3.3 Other highlighted areas of achievement

Academic publications

Published work

On an annual basis, the Ashford and St Peter's Hospitals Knowledge Service Team produces a report that shows how many papers authored by Ashford and St Peter's Hospitals are indexed in healthcare databases by searching Medline, CINAHL, and Embase. The search is performed by the Knowledge Service Lead at Ashford and St Peter's Hospitals NHS Foundation Trust. The search is limited to the institutional field or the author affiliation field.

For the year April 2025 to March 2026, there were 95 authored papers. The breakdown of the publications is as follows:

On the next few pages, please find the publication bibliographic details for all the papers. The Ashford and St Peter's Hospitals' authors are emboldened.

There are 64 Open Access items, and these are denoted by the Open Access symbol

Articles

1. **Lisk R, Yeong K, Watters H,** Fry CH**, Han TS**. Influences of Pre-fracture Mobility and Early Mobility on Healthcare Outcome Measures in Older Patients Undergoing Hip Fracture Surgery. Calcified Tissue International. 117(1):12, 2026 Jan 23. doi: 10.1007/s00223-025-01475-6

2. Bhakar R, Chakrapani AS, Shaik A, Alexander A, Murugesan T, **Anbazhagan PK**, Ghent D. Short-Term Functional Outcomes in Patients Undergoing Primary Total Knee Arthroplasty According to Their Body Mass Index. Cureus. 18(1):e101269, 2026 Jan. doi: 10.7759/cureus.101269

3. Khalafallah M.A., Hassan A.A., Badawy S.G., Waleed M., Abouelmaati D., **Imam M.A**. Coding vs. Culture: How Artificial Intelligence is Transforming Bone, Joint, Skin, and Soft Tissue Infection Management? Current Infectious Disease Reports. 28(1) (no pagination), Article Number: 2 2026 Jan doi: 10.1007/s11908-025-00873-z

4. Gallagher K, MacLennan S, Bhatt N, et al. [*INVESTIGATORS* include **Arumainayagam N., Maqboul F., Agrawal S.**] RESECT: A Randomised Controlled Trial of Audit and Feedback in Non-muscle-invasive Bladder Cancer Surgery. European Urology. 2025 Dec 10. doi:10.1016/j.eururo.2025.09.4174

5. COVIDTrach Collaborator **Gill, P**. The COVIDTrach prospective cohort study on outcomes in 1982 tracheostomised COVID-19 patients during the first and second UK pandemic waves. Scientific Reports. 15(1):23013, 2025 Jul 02. doi: 10.1038/s41598-025-93391-w

6. Sharma R, Ahad A, Khan MA, **Akter S**, Yousuf R, Haque MM, Salam MM, Salam A. Bacterial Profile and Antimicrobial Susceptibility Patterns in Diabetic Foot Ulcers: A Cross-Sectional Study in Bangladesh. Cureus. 17(12):e99212, 2025 Dec. doi: 10.7759/cureus.99212

7. Ken-Dror G, Chua V, **Sharma P**. Traumatic injuries in polo players. Postgraduate Medical Journal. 2025 Nov 20. doi: 10.1093/postmj/qgaf200

8. Yin S, **Ghatora K, Teodoro T,** Edwards M, Yogarajah M, **Coebergh J**. Functional Neurological Disorder, Sleep, and Dreaming: A Large Online Questionnaire-Based Study. Journal of Neuropsychiatry & Clinical Neurosciences. appineuropsych20250092, 2025 Nov 17. doi: 10.1176/appi.neuropsych.20250092

9. Lehn A, Hoeritzauer I, McLoughlin C, Stone J, Zahir SF, **Coebergh J**, Leavy Y, Morton A, Palmer D. The Impact of Pregnancy on Functional Neurological Disorder (FND). European Journal of Neurology. 32(11):e70413, 2025 Nov. doi: 10.1111/ene.70413

10. Gonzalez-Herrero B, **Coebergh J**, Pagonabarraga J, Morgante F, Deeley Q, Edwards MJ. Structured clinical diagnostic assessment reveals autism spectrum disorder in adults with functional neurological disorder. Scientific Reports. 15(1):40423, 2025 Nov 18. doi:10.1038/s41598-025-20508-6

11. Lau TM, **Coebergh JA**. Intercostal Muscle Wasting Is the Clue to a Diagnosis of Diabetic Thoracic Radiculopathy. Neurology. 105(9):e214290, 2025 Nov 11. doi: 10.1212/WNL.0000000000214290

12. Nightingale K, Stephenson J, Sivaprakasam R, Brown T, Inston N, Hamsho A, Ravanan R, Nicholson M, Asderakis A, Browne S, Hunter J, Marson LP, Connor KL, Kelleher M, Sutherland A, Norton W, Maple H, Calder F, Dor FJMF, Barlow A, Wijetunga I, Youngs R, Falconer S, Boardman V, Smith MW, Bagul A, Sharma H, Mehra S, Moinuddin Z, Campbell T, van Dellen D, Rogers A, Burnapp L, **Haq K**, Yates J, Sinha S, Malik S, Saif I, Gibbs P, Khan K, Harvitkar R, Shrestha B, Ghazanfar A, Siddiky A, Motallebzadeh R, Moneke M, Bhatia K, Augustine T. The Variation in Practice of the Living Donor Kidney Transplant Pathway in the UK: Results of a National Survey. Transplant International. 38:15341, 2025. doi: 10.3389/ti.2025.15341

13. **Kalogeropoulos A, Tekie T**, Hassan A, Dimock R, **Imam M, Narvani AA**. Combined Arthroscopic Assisted Lower Trapezius Tendon Transfer and Achilles Tendon Allograft plus Superior Capsular Reconstruction using Long Head Biceps Autograft for Massive Irreparable Rotator Cuff Posterosuperior Tears: The 'Pull-Over' Technique. Arthroscopy Techniques. 14(11):103891, 2025 Nov. doi: 10.1016/j.eats.2025.103891

14. **Kataria R**, Kadal KK, Shanmugam S, Setya P. A Comparative Study on the Efficacy, Safety and Cost Effectiveness of Gabapentin and Pregabalin in the Treatment of Neuropathic Pain. Cureus. 17(11):e95916, 2025 Nov. doi: 10.7759/cureus.95916

15. **Habib M**, Khalil K, Tayyab Z, Atiq H, Usman M, Khattak S, Syed A. Oncological Outcomes of Immature Ovarian Teratoma: A 15-Year Report From a Cancer Center. Cureus. 17(11):e95934, 2025 Nov. doi: 10.7759/cureus.95934

16. Adebisi YA, Ngoma C, Campagna D, Ceriello A, Alshahrani NZ, Misra A, Basit A, **Russo C,** Battelino T, Somasundaram N, Jalaludin MY, Le Dinh P, Saisho Y, Walicka M, Tomaselli V, Cantone G, Moser O, Polosa R. Differential associations between smoking, e-cigarette use, and diabetes prevalence. Diabetes & Metabolic Syndrome. 19(10):103331, 2025 Oct. doi: 10.1016/j.dsx.2025.103331

17. **Rashid Z, Wales E, Scott A**. Chronic Ulcerative Lesion with Peristomal Involvement: A Diagnostic Challenge. Clinical & Experimental Dermatology. 2025 Oct 25. doi: 10.1093/ced/llaf474

18. Yousaf J, Sakina S, **Saeed A**, Aftab M, Khattak MI, Elrefae A, Qandeel M, Hameed A. Dermatological Manifestations of Smoking-Induced Oxidative Stress and Inflammation: A Multifaceted Analysis of Cutaneous Aging and Disease Progression. Cureus. 17(10):e94147, 2025 Oct. doi: 10.7759/cureus.94147

19. Milad M, Almanasra M, Al-Khazaleh M, **Gabriel A**, Sriranganathan S. Evaluating the Impact of Age and Sex on Survival in Localised Anterior Uveal Melanoma Undergoing Eye-Preserving Interventions Within a Surveillance, Epidemiology, and End Results (SEER) Cohort. Cureus. 17(10):e93835, 2025 Oct. doi: 10.7759/cureus.93835

20. Kantyka C, **Wanigasekara R, Ponnusamy V,** Heath PT, Clarke P. Current antibiotic and prophylactic antifungal drug policies in UK neonatal intensive care units: a national survey. JAC-antimicrobial Resistance. 7(5):dlaf194, 2025 Oct. doi: 10.1093/jacamr/dlaf194

21. **Vindya A, Gangadharaswamy Nagabhushan SB**. A Retrospective Audit of the Timescales Involved in the Diagnosis and Management of Soft Tissue Knee Injuries at a Single National Health Service Trust: A Quality Service Improvement and Redesign Project. Cureus. 17(10):e94641, 2025 Oct. doi: 10.7759/cureus.94641

22. **Santani B,** De S, **Vergara-Jalandoni D, George A, Manipol V, Sardar U, Upreti R, Unnithan A.** Preoperative Prediction of Chronic Post-surgical Pain Risk After Total Knee Arthroplasty: Insights From a Single-Center Case-Control Study. Cureus. 17(10):e93815, 2025 Oct. doi:10.7759/cureus.93815

23. **Solomon J, Ameer A, Chopda V, Lisk R, Yeong K, Acharya J, Robin J**, Fry CH, **Han TS**. Impact of Care Delivered in Nondesignated Areas on Older Patients Admitted With Hip Fractures: A Quality Improvement Initiative. Journal of Evaluation in Clinical Practice. 31(6):e70276, 2025 Sep. doi: 10.1111/jep.70276

24. **Imam MA**, Elgebaly A, Zumla A, Kolvekar S, Ahmed R, Zumla A. Transforming the NHS through AI-driven solutions: a new era of digital health. Postgraduate Medical Journal. 101(1199):777-778, 2025 Aug 17. doi: 10.1093/postmj/qgaf023

25. **Wanigasekara R., Dunn E., Ponnusamy V**. A model for the successful implementation of BAPM NSQI 3: Parental partnership in care. Infant 2025 21(4): 93-98

26. **Ormond M,** Fitzpatrick D. Gender parity in sports medicine; Present imperative not future aspiration. BMJ Open Sport and Exercise Medicine. 11(3) (no pagination), 2025. Article Number: e002657 doi: 10.1136/bmjsem-2025-002657

27. Zeng A, **Steinke J**, Bocse HF, De Pastena M. Dr. LLM Will See You Now: The Ability of ChatGPT to Provide Geographically Tailored Colorectal Cancer Screening and Surveillance Recommendations. Journal of Clinical Medicine. 14(14), 2025 Jul 18. doi: 10.3390/jcm14145101

28. **Eleftheriadou A, Collins C, Kannapiran D, Antara F, Elhammadi M, Janardanan S, Mikail M, Arumainayagam N, Carbin DD.** Diagnostic precision, safety, and patient experience of the freehand transperineal prostate biopsy technique under local anesthesia - A single-center experience. Indian Journal of Urology. 41(3):183-189, 2025 Jul-Sep. doi: 10.4103/iju.iju_423_24

29. Ng CPY, Light A, Eleftheriou C, Hug O, Richardson E, Gill-Taylor T, Shamsuddin A, Abboudi H, **Agrawal S**. Long-term outcome of transurethral laser ablation for recurrent non-muscle invasive bladder cancer: An EORTC risk-matched study. BJUI Compass. 6(7): e70052, 2025 Jul. doi: 10.1002/bco2.70052

30. **Buksh MM, Al Samaraee A**. Benign Choledochal Cyst Management in Adults: General Surgeons' Perspective in a Non-Tertiary Centre. Cureus. 17(7): e89161, 2025 Jul. doi: 10.7759/cureus.89161

31. Fishley WG, Baldock T, Hilley AJ, Morrison R, Baker P, Townshend D, I**mam M, Antonios T, Shahid Z, Luck J,** Kent J, Crowther I, Mazur K, Barwick T, Al-Musawi H, Adesina TS, Dhinsa B, Garcia SMA, Maatough A, Kantak AP, Lal A, Shammeseldin E, Jane Madeley N, Warwick C, Paterson A, Gould A, Brown R, Stamatpoulos A, Boddu K, Chrastek D, Gopinath P, Giannoudis P, Rizwi H, Asaju A, Ellacott M, Samaullah A, Heidari A, Ditta A, Bhattia C, Griffiths A, Guiot L, Townshend D, Rohman A, Kovarik P, Koc T, Hardie J, Al-Kharouf K, Chakravarthy J, Neo C, Gray M, Shaw C, Angel C, Francis D, Barrie A, Diamond O, Gilmore C, Mercer R, Aldridge S, Zaheen H, Elamin D, Baker P, Nagalingam P, Irvine S, Onwuekwe CV, Dowen D, Alder G, Duffy P, Morrison R, Elgendy M, Vaughan P, Chauhan V, Selvakumar C, Barrow J, Allport J, Yadav AK. The Fracture Ankle Implant Review (FAIR) study: a national multicentre retrospective review of practice in implant choice, fixation methods, and outcomes in fixation of the fibula in ankle fractures. Bone & Joint Open. 6(7):841-849, 2025 Jul 18. doi: 10.1302/2633-1462.67.BJO-2025-0009.R1

32. **Carr CP**, Cawley P. Family integrated care-a BAPM framework for practice. Archives of Disease in Childhood Education & Practice. 2025 Jul 28. doi: 10.1136/archdischild-2024-328179

33. **Imam M**, Hassan A, **Peake C, Mitsiou K, Fozo ZA, Antonios T, Khoriati AA, Narvani A**. The Triple Anatomical Technique for Acromioclavicular Joint Reconstruction: A True Anatomical Reconstruction Technique Using Synthetic Ligaments With Acromioclavicular Ligament Reconstruction. Arthroscopy Techniques. 14(7):103595, 2025 Jul. doi: 10.1016/j.eats.2025.103595

34. **Coebergh JA**, McDowell S, van Woerkom TCAM, Koopman JP, Mulder JL, Smink FRE, Blom JD, de Bruijn SFTM. Auditory agnosia for environmental sounds in Alzheimer's disease: Effects on daily life. IBRO Neuroscience Reports. 18:142-147, 2025 Jun. doi: 10.1016/j.ibneur.2025.01.006

35. Arachchige N, Dharmasiri R, Weerathunga A, Senanayake S**, Janage N**, Muthugala R. Genomic and demographic characterization of SARS-CoV-2 infections within early Omicron cluster, Western Sri Lanka. World Journal of Virology. 14(2):106108, 2025 Jun 25. doi: 10.5501/wjv.v14.i2.106108

36. Fluck D, **Jackson E,** Llamas-Montoya A, **Chana AS, Kelly K, Jones GI, Rees JN, Tudose J, Jones Y, Finch JS, Davison J, Ruse J, Jones C, Robin J,** Fry CH, **Han TS.** Health Status And Delays In Referral-To-Treatment Waiting Times for Elective Admissions of Adults From Deprived Areas And Ethnic Minority Backgrounds: A Study of Healthcare Inequalities. Journal of Racial & Ethnic Health Disparities. 2025 Jun 18. doi: 10.1007/s40615-025-02515-5

37. Bass EJ, Rawlins F, Shah T, Klimowska-Nassar N, Sasikaran T, Jadav P, Cullen E, Szigeti M, Fiorentino F, Sydes MR, Winkler M, **Arumainayagam N**, Pope A, Sokhi H, Nasseri M, Ahmed HU. Prostate Pathway Embedded Comparative Trial: Outcomes from the Pilot Phase of the Imperial Prostate 3-PROState Pathway Embedded Comparative Trial. European Urology Focus. 2025 Jun 04. doi: 10.1016/j.euf.2025.05.007

38. **Beeton I, Acharya J, Kesin Meric B, Hobden J, Ali T, Han TS**. Comparisons of risk factors and outcomes between abdominal aortic aneurysm and peripheral arterial disease: a case-control study. American Journal of Medicine Open. 13:100087, 2025 Jun. doi: 10.1016/j.ajmo.2025.100087

39. **Yamamoto A**. Ethics and a democratic ethos in practice. British Journal of Healthcare Assistants. 19 (5) (pp 108-109), 2025 May. doi: 10.12968/bjha.2025.19.5.108

40. Nagy V, Poole L, **Banting E**, Satherley RM. An interpretative phenomenological analysis of lived experiences and psychological processes in internalized weight stigma. British Journal of Health Psychology. 30(2):e12804, 2025 May. doi: 10.1111/bjhp.12804

41. **Han TS**, Hannemann A, Arffman R, Friedrich N, Ittermann T, Wilkening R, Piltonen T, Fry CH, Crujeiras AB, Casanueva FF. The relationship between hypoprolactinemia and cardiometabolic health in women. European Journal of Endocrinology. 192(5):662-670, 2025 Apr 30. doi: 10.1093/ejendo/lvaf101

42. **Eleftheriadou A, Aljoe J, Deacon M, Iyer V, Arumainayagam N**. Rethinking routine histological analysis of transurethral resection of the prostate tissue samples: cost, relevance, and patient impact. BJU International. 135(5):741-742, 2025 May. doi: 10.1111/bju.16649

43. **Horwell E,** Freer-Smith C, Hong HA, **Bearn P**, Cutting SM. Bacillus velezensis inhibits azoxymethane/dextran sulphate sodium induced colitis associated colorectal cancer via the small molecule HeLM. Journal of Gastrointestinal Oncology. 16(2):470-484, 2025 Apr 30. doi: 10.21037/jgo-24-610

44. **Imam MA**, Hutton C. A simple trick for supinated hand positioning during hand surgery. Annals of the Royal College of Surgeons of England. 2025 Apr 08. doi: 10.1308/rcsann.2024.0118

45. **Carbin DD**, Antonoglou G, Harmouche C, Abou Chedid W. Clipless robot-assisted Retzius-sparing radical prostatectomy: a study on its safety profile and outcomes. Journal of Robotic Surgery. 19(1):141, 2025 Apr 09. doi: 10.1007/s11701-025-02321-5

46. **Shrewsbury JV, Hampal R, Beeton I, Baltabaeva A.** Multimodality cardiac imaging in an adult patient with unrepaired tetralogy of Fallot. BMJ Case Reports. 18(4), 2025 Apr 06. doi: 10.1136/bcr-2024-263494

47. International Network for Evaluation of Outcomes (iNeo) Investigators. (**Neonatal Research Team**). Outcomes of Preterm Infants Born at 22 to 23 Weeks' Gestation in 11 International Neonatal Networks. JAMA Pediatrics. 179(11):1183-1193, 2025 Nov 01. doi: 10.1001/jamapediatrics.2025.2958

48. iNEO Investigators. (**Neonatal Research team**). Transfusion Practices in 12 Neonatal Networks: Are We Closer to Adopting a Restrictive Transfusion Approach? Neonatology. 122(5):561-569, 2025. doi: 10.1159/000546612

49. International Network for Evaluation of Outcomes (iNeo) of Neonates Investigators. (**Neonatal Research team**). Birth weight and head circumference for 22-29 weeks gestation neonates from an international cohort. Archives of Disease in Childhood Fetal & Neonatal Edition. 110(4):401-408, 2025 Jun 19. doi: 10.1136/archdischild-2024-327845

50. **Kaba RA,** Rajkumar C, Mattace-Raso F. Guideline commentary on the ESC/EACTS 2024 guidelines for atrial fibrillation: a focus on managing AF in the older population. Age Ageing. 2026 Jan 3;55(1):afag002. doi: 10.1093/ageing/afag002

51. **Lisk R, Yeong K, Fluck D, Robin J**, Fry CH, **Han TS**. Etiological factors and clinical outcomes in extracapsular and intracapsular hip fractures among older adults: sex-specific analysis. *Physical Medicine and Rehabilitation* 2025; 17: 793-803. doi: 10.1002/pmrj.13326.

52. Davey C, Newman E, Hare J, **Fluck D, Han TS**. Risk of Instagram dieting trends on eating behaviour and body satisfaction in women of different age and body mass index. *Journal of Technology in Behavioral Science* 2025; 10:586-595. DOI: 10.1007/s41347-024-00464-0.

53. Ken-Dror G, Sureshkumar P, **Han TS**, Sharma SD, Sylaja PN, Khan FY, Prasad K, **Sharma P**; BRAINS collaborators. Ischemic heart disease among South Asians with ischaemic stroke in three countries across two continents: the BRAINS study. *Annals of Epidemiology* 2025;103:48-54. DOI: 10.1016/j.annepidem.2025.02.006

54. **Acharya J, Lisk R, Mahmood R, Manzoor A, Young F, Gill M, Yeong K, Kelly K, Robin J**, Fluck D, Fry CH, **Han TS.** Frailty and delirium: a fatal combination in older adults. *Archives of Gerontology and Geriatrics Plus*. 2025; 2:100180. doi: 10.1016/j.aggp.2025.100180

Editorials

55. **Narvani A.A., Imam M.A**. Long Head of Biceps: From Nuisance to Ally. Archives of Bone and Joint Surgery. 13(11) (pp 673-675), 2025 Nov. doi: 10.22038/ABJS.2025.91837.4159

56. **Hawkins JP**. Bad medicine and bad law. BMJ supportive & palliative care. 15(6):722-724, 2025 Oct 27. doi: 10.1136/spcare-2025-005575

Reviews

57. Leong IL, Ng TH, Sen K, Burchill E, Costello H, Badenoch JB, **Coebergh J,** McCutcheon RA, Nair A, Browning M, Huys QJM, Lewis G, Lees A, David AS, Rogers JP. Reduced striatal dopamine transmission as a transdiagnostic substrate of psychomotor retardation. Brain. 149(1):18-36, 2026 Jan 08. doi: 10.1093/brain/awaf335

58. **Russo C,** Walicka M, Cohen G, Bellanca CM, Geraci G, Caponnetto P, Noviello DE, Chianetta R, George J, Sammut R, Franek E, Polosa R. Addressing the dual challenge: Managing smoking cessation in patients with diabetes. World Journal of Diabetes. 16(12):105241, 2025 Dec 15. doi: 10.4239/wjd.v16.i12.105241

59. Akram N, Karimaghaei D, Mattoo S, **Selvarajan DP**, Radha S. Computer Vision Applications in Spinal Orthopaedics: A Scoping Review of Imaging-Based Algorithms for Diagnosis, Measurement, and Surgical Planning. Cureus. 17(12):e98486, 2025 Dec. doi: 10.7759/cureus.98486

60. **Anbazhagan PK**, Boyapati HPN, Syeda STH, Saravanan A, Payidiparty D. Pancreatitis Unveiled: Linking Pathogenesis, Organ Failure, and Emerging Predictive Biomarkers. Cureus. 17(12): e98838, 2025 Dec. doi: 10.7759/cureus.98838

61. **Sooranahalli Nabh Y,** Rayapati AD, **Hamid A**. Artificial Intelligence in Acute Neuroimaging Pathways: Diagnostic Accuracy, Workflow Performance, and Clinical Outcomes Across CT and MRI in Stroke and Trauma. Cureus. 17(12):e98312, 2025 Dec. doi: 10.7759/cureus.98312

62. George V, Pillai MH, Jacob V, Mp R, **Vasant A**, Adnan H. Comparing the Long-Term Effectiveness of Sodium-Glucose Cotransporter 2 Inhibitors Versus Mineralocorticoid Receptor Antagonists as Add-On Therapies in the Management of Heart Failure: A Systematic Review. Cureus. 17(11):e96616, 2025 Nov. doi: 10.7759/cureus.96616

63. Hwang R, Paley M, Bull D, Omrani O, **Vergara-Jalandoni D**, Egbury G. A Systematic Review and Meta-Analysis on the Impact of Peer-Made MCQ Question-Bank Usage on Summative Assessments in Medical Education. Journal of Advances in Medical Education & Professionalism. 13(4):259-269, 2025 Oct. doi: 10.30476/jamp.2025.104780.2084

64. Abbott TEF, **Watson SL**, Begum S, Dias P, Haviland JS, Glasbey J, Ismail L, Love S, Pearse RM. Platform trials-an emerging methodology for perioperative medicine: a narrative review. Perioperative Medicine. 14(1):67, 2025 Jul 04. doi: 10.1186/s13741-025-00543-7

65. Khalafallah MA, Shehata AR, Sharf Eldeen MM, Abdelbaset HH, Harfoush AH, Mohamed A, Osman AS, **Kalogeropoulos A**, Waleed M, **Narvani A, Imam MA**. Optimizing lateralization and distalization shoulder angles in shoulder arthroplasty: A systematic review of functional outcomes and complication. Shoulder And Elbow. 17585732251351864, 2025 Jun 25. doi: 10.1177/17585732251351864

66. Vitus ES, **Mann S**, Lees CW, Jess T, Elmahdi R. A Systematic Review and Meta-Analysis: Adverse Inflammatory Bowel Disease Outcomes Following Acute COVID-19. Gastro Hep Advances. 4(3):100581, 2025. doi: 10.1016/j.gastha.2024.10.021

67. **Elbakry Abdelmahdy NE**, Abd Alnour Suliman ET, Osman Mohmed FM, Ali Elamin NS, Hamza Yousif BA, Ahmmed NAM. Diagnostic Performance of Neural Network-Based Artificial Intelligence in the Detection and Classification of Pediatric Astrocytoma: A Systematic Review. Cureus. 17(5):e83543, 2025 May. doi: 10.7759/cureus.83543

68. **Ashfield S**, Ojha U. Cardiometabolic Dysregulation and Heart Failure. Reviews in Cardiovascular Medicine. 26(5):38504, 2025 May. doi: 10.31083/RCM38504

69. Boyapati HPN, Syeda STH, Saravanan A, Payidiparty D, **Anbazhagan PK**. Cracking the Code of Colorectal Cancer Screening: An Overview With a Focus on Current and Emerging Screening Methods. Cureus. 17(5):e84724, 2025 May. doi: 10.7759/cureus.84724

70. Khalafallah MA, Mohamed MI, Farrag MM, Bishara HA, Muir D, **Narvani A**, Calvo E, **Imam MA**. Partial repair versus superior capsule reconstruction in managing massive rotator cuff tears. A meta-analysis of the current evidence. Shoulder And Elbow. 17585732251345137, 2025 May 29. doi: 10.1177/17585732251345137

71. Motiwala ZY, Desai A, Bisht R, Lathkar S, Misra S, **Carbin DD**. Telesurgery: current status and strategies for latency reduction. Journal of Robotic Surgery. 19(1):153, 2025 Apr 12. doi: 10.1007/s11701-025-02333-1

72. Ken-Dror G, Khanna T, Hills E, Lepert L, Mughal S, Han TS, Sharma P. Mendelian randomization assessing causal relationship between fibrinogen levels and ischemic stroke. Journal of Stroke and Cerebrovascular Diseases 2025; 34:108199. doi: 10.1016/j.jstrokecerebrovasdis.2024.108199

Randomised controlled trial

73. Lateral Versus Modified Tilted Supine Position of Patients Undergoing Peritrochanteric Fracture Fixation By Dynamic Hip Screw: A Randomized Controlled Trial. Sallam A., **Imam M**., Mokhtar M., Abdelaty A.A. Techniques in Orthopaedics. (no pagination), 2025. Article Number: 10.1097/BTO.0000000000000719 doi: 10.1097/BTO.0000000000000719

Meta-analysis

74. Salih A, Sutaria A, Montaser Z, Magar TP, **El Ashal G**, Zaghloul S, Tom AJ, Ahmad M, Creta A, Ali H, Barra S, Farkowski M, Cappato R, Providencia R. Fibrosis-Guided Ablation in Patients With Atrial Fibrillation: A Meta-Analysis of Randomized Controlled Trials. Journal of Cardiovascular Electrophysiology. 36(8):2025-2040, 2025 Aug. doi: 10.1111/jce.16723

75. **Arbis A,** Rafay A, Namgoong C, Yoon JH, Ashrafian H, Fehervari M, **Humadi S**. The impact of bariatric surgery on maternal and neonatal health: a systematic review and meta-analysis. Surgery for Obesity & Related Diseases. 21(8):901-920, 2025 08. doi: 10.1016/j.soard.2025.03.005

76. Urgesi, E., Mukhtar, I., Ahmed, O., Behr, E., Momin, A, **Kaba, RA**. Safety of Transdiaphragmatic and Subxiphoid Mediastinal Access in Hybrid Convergent Atrial Fibrillation Ablation: A Systematic Review and Meta-Analysis. Journal of Atrial Fibrillation & Electrophysiology September 2025, Volume 18, Issue 2.

Multicentre Studies

77. Fluck A, **Fry CH**, Affley B, **Kakar P, Sharma P,** Jones GI, Rees JN, Tudose J, Jones Y, Finch JS, Davison J, Bull E, Robin J, **Fluck D**, Han TS. Evaluation of mediators of seasonal variation in fatal strokes: a multicentre registry-based cohort study. Journal of Stroke & Cerebrovascular Diseases. 34(8):108360, 2025 Aug. doi: 10.1016/j.jstrokecerebrovasdis.2025.108360

78. **Thiagamoorthy G**, Dua A, Araklitis G, Mohamed-Ahmed R, Bansal J, Karim F, Davis C, Cartwright R, Khullar V, Khunda A, Srikrishna S, Robinson D, Cardozo L. Post-Operative Pain After Pelvic Organ Prolapse Surgery (POPPOP): A Double Blind Randomised Multicentre Study to Assess the Effect of Local Anaesthesia During Vaginal Hysterectomy. BJOG: An International Journal of Obstetrics & Gynaecology. 132(9):1212-1219, 2025 Aug. doi: 10.1111/1471-0528.18162

79. *INVESTIGATORS include* **Evans, A., Morris, R**. The KNEE study: A prospective multicentre observational study of 459 fractures around the knee in older patients. Injury. 56(7):112362, 2025 Jul. doi: 10.1016/j.injury.2025.112362

80. Emanuel S, Field BC, Joy M, Fan X, Williams J, **Kaba RA**, Lip GYH, de Lusignan S. Disparities in the care and direct-acting oral anticoagulant (DOAC) management in atrial fibrillation (AF) and chronic kidney disease (CKD) in English primary care between 2018 and 2022: primary care sentinel network database study. Open Heart. 12(1), 2025 May 21. doi: 10.1136/openhrt-2024-002923

81. iNeo Neonatal Network. (**Neonatal Research team**). International Variation and Trends of Intraventricular Hemorrhage in Very Preterm Infants. Neonatology. 122(5):570-585, 2025. doi: 10.1159/000546714

Observational Studies

82. **Ojha U**, Marshall DC, Hammond-Haley M, Salciccioli JD, Shalhoub J, Hartley A. Percutaneous coronary intervention, coronary artery bypass grafting and mortality from acute myocardial infarction in EU15+ countries, 2006-2020: a secondary analysis of the OECD database. BMJ Open. 15(12):e106838, 2025 Dec 03. doi: 10.1136/bmjopen-2025-106838

83. Fairbairn TA, Mullen L, Nicol E, Lip GYH, Schmitt M, Shaw M, Tidbury L, Kemp I, Crooks J, Burnside G, **Sharma S,** Chauhan A, Liew C, Waidyanatha S, Iyenger S, Beale A, Sunderji I, Greenwood JP, Motwani M, Reid A, Beattie A, Carter J, Haworth P, Bellenger N, Hudson B, Rodrigues J, Watson O, Venugopal V, Bull R, O'Kane P, Deshpande A, McCann GP, Duckett S, Mansoubi H, Parish V, Sehmi J, Rogers C, Mullen S, Weir-McCalL J. Implementation of a national AI technology program on cardiovascular outcomes and the health system. Nature Medicine. 31(6):1903-1910, 2025 Jun. doi: 10.1038/s41591-025-03620-y

Practice Guideline

84. Wood MJ, **Al-Jabri T**, Mirdad RS, Alqahtani YS, Rambani R, Giannoudis PV. Cement-in-cement revision of the cemented femoral stem as a treatment for periprosthetic fracture around a total hip arthroplasty: an up-to-date review. Injury. 57(2):112932, 2025 Dec 04. doi: 10.1016/j.injury.2025.112932

Case Reports

85. **Gabriel A**, Dimitry RS, Milad M, Kelada M, Papastavrou K. A Case of Bilateral Macular Phototoxicity and the Role of Multimodal Imaging. Cureus. 17(12):e99791, 2025 Dec. doi: 10.7759/cureus.99791

86. **Das A**, Khetan A, Bera D, Bag K. ICD-associated R-wave double counting in ARVC: A mechanistic approach to troubleshooting inappropriate shocks. Indian Pacing & Electrophysiology Journal. 25(6):458-462, 2025 Nov-Dec. doi: 10.1016/j.ipej.2025.11.002

87. Sermaxhaj F, **Latifaj B**, Sermaxhaj B, Sopjani M. Malignant Melanoma of the Middle Ear: Case Report. Ear, Nose, & Throat Journal. 104(2_suppl):42S-45S, 2025 Nov. doi: 10.1177/01455613231169454

88. **Antara FR, Vasant A**. Caecal Volvulus in Pregnancy: A Rare Cause of Intestinal Obstruction and a Diagnostic Dilemma. Cureus. 17(11):e97241, 2025 Nov. doi: 10.7759/cureus.97241

89. **Antara FR**, **Kataria R**. Anterior Urethral Metastasis of Prostate Cancer Presenting With Minimal Prostate-Specific Antigen (PSA) Elevation. Cureus. 17(11):e96979, 2025 Nov. doi: 10.7759/cureus.96979

90. Misra S, Motiwala ZY, Mulla A, Chinnathambi J, **Carbin DD**. Vanishing clear cell carcinoma of the kidney presenting with skin metastases - a case report. Ecancermedicalscience. 19:1959, 2025. doi: 10.3332/ecancer.2025.1959

91. **Abuelhassan A**. Ovarian Torsion in Patients With Polycystic Ovary Syndrome Without Ovulation Induction or an Adnexal Mass: A Report of Two Cases. Cureus. 17(7):e88608, 2025 Jul. doi: 10.7759/cureus.88608

Letters

92. **Smutna T**. Government plans to tackle childhood obesity must follow Unicef's guidance. BMJ. 391:r2542, 2025 Dec 04. doi: 10.1136/bmj.r2542

93. **Arbis A**, Fehervari M, **Humadi S**. Letter to editor regarding comments by Dr. Veldi et al. for manuscript 'the impact of bariatric surgery on maternal and neonatal health: a systematic review and meta-analysis'. Surgery for Obesity & Related Diseases. 21(10):1171-1173, 2025 Oct. doi: 10.1016/j.soard.2025.07.006

94. Ranque B, Garner P, Allenbach Y, Hupin D, David AS, Wade D, Sharpe M, Garcin B, Little P, Tinazzi M, Fink P, Hamilton W, Peto T, Lemogne C, Wyller VBB, Chalder T, **Coebergh J**. Reply: Muscle abnormalities in Long COVID. Nature communications. 16(1):1490, 2025 Feb 11. doi: 10.1038/s41467-025-56430-8

PrePrint

95. Zhao X., Yu C., Adamson A., Zhao A., Zhou H., **Sharma P.**, Wang T. Selective vulnerability of cerebral vasculature to NOTCH3 variants in small vessel disease and rescue by phosphodiesterase-5 inhibitor. bioRxiv. (no pagination), 2025 Jun 2025 doi: 10.1101/2025.05.30.656914

Improvement Partnership Update

Improving Flow Programme

The Improving Flow Programme commenced in March 2025 with the aim to optimise patient flow through our hospitals; reducing delays and ensuring high quality care delivered in the right place, at the right time, by the right person.

The programme is made up of five workstreams, see below, that cover the whole patient journey and each have spent time this year identifying key projects that will make the most significant impact on achieving the overall goals of the programme; to reduce average length of stay for adult inpatients, to reduce the time spent waiting in the emergency department after a decision to admit has been made and to eliminate 'corridor care'.

Neighbourhoods	Front Door	Ward Processes	Flow: Patient Pathway	Discharge
Aim: To optimise the use of alternatives to attending the emergency department and hospital admission	Aim: To ensure access to Same Day Emergency Care (SDEC) alternatives to hospital admission and where admission is required minimise waiting in the ED.	Aim: To promote discharge from hospital with minimal delays once the person is medically well and able to return home.	Aim: To ensure the admitted pathway is efficient and ensures people get to the right place to be seen by the right professional at the right time.	Aim: Working closely with system partners to optimise the discharge process for people requiring additional support when leaving hospital.

Achievements/highlights

Neighbourhoods – offering a weekend frailty service within the ED has enabled more timely delivery of out of hospital care for some of our most vulnerable patients. Trials of Urgent Community Response (UCR) teams being on site at St Peter's Hospital and working more closely with the SECAmb ambulance service have shown promising results.

7-day Frailty Service has improved access to **specialised care** during weekends **enabling timely discharges**

ED chairs improved environment and increased use of ED chairs has supported more **timely access to patient care**

Front door – improved use of 'ED Chairs' has improved flow through the ED and redirection to SDEC continues to support a reduction in the number of hospital admissions.

Ward processes – multiprofessional teams have been involved in mapping day-to-day processes and identifying opportunities to reduce delays and duplication. The digital team has supported the development and implementation of a digital 'whiteboard' patient management system, which is being embedded into ward practice. Enhanced discharge lounge provision and promotion of its use by all inpatient areas have resulted in patients leaving ward areas earlier in the day, freeing up beds for patients being admitted as emergencies.

Ward-level Digital Whiteboard is now live to facilitate **consistent information sharing** for patient care

RPIW
- Reduce intervention delays
- Improve assessment areas and short-stay use
- Reduced duplication
- Consistent MDT approach

Patient pathway – A Rapid Process Improvement Week (RPIW) was held in June 2025. Patient stories and experiences underpinned the work, mapping the current emergency admission pathway and, with the multidisciplinary team, creating an 'ideal state'. The week's output informed subsequent work to address the issues identified: reducing delays to tests, investigations and specialist review; improving the use of assessment and short-stay areas; reducing duplication in documentation; and ensuring a consistent multidisciplinary team approach to discharge planning.

Discharge - a new tool to collect important information needed to inform discharge planning has been created, tested, and is now available as part of the electronic patient record (ePR). The 'Help to Get Home' form reduces duplication and ensures all information is held in one place.

Next Steps

The ASPH Improving Flow Programme is continuing and will be a critical part of delivering the Group Transformation Programme for 2026/2027, of which Improving Flow is one of the four priority pillars. There will be a renewed focus on valuing the time of our patients and staff, whilst continuing to work with a continuous quality improvement approach, building improvement capacity and capability within our teams.

3.4 Glossary

AAA abdominal aortic aneurysm is a swelling in the abdominal aorta, the main blood vessel in the abdomen. No symptoms are usually caused, except during rupture, which can be fatal.
Age Related Macular Degeneration a degenerative process affecting the macula of the retina that occurs in older adults and results in impairment or loss of central vision
CAUTI, catheter-associated urinary tract infection, is the most commonly reported hospital-acquired infection.
Clinical audit involves reviewing clinical practice against evidence-based standards to improve the quality of patient care and treatment.
Confidential enquiries (NCEPOD) are national enquiries which investigate clinical standards and decisions in specificcircumstances to inform and improve clinical practice.
Clostridiodes difficile bacteria can cause a bowel infection in patients who have taken antibiotics.
CQUIN framework enables healthcare commissioners to reward excellence by linking a proportion of a service provider's income to the achievement of a quality improvement goal (NHS Institute for Innovation and Improvement, www.institute.nhs.uk).
Duty of candour is being open and honest when moderate or severe harm affects patients.
Escherichia coli is the most common cause of UTIs; gastrointestinal infections and bacteraemia can also occur.
GIRFT is the national Get it Right First-Time programme, which incorporates operational and service improvement through a QI approach.
ICB Integrated Care Board (formerly Clinical Commissioning Group CCG), which is the statutory body for planning and commissioning localhealth care services.
ICS Integrated Care System: ICSs are partnerships between different organisations (such as hospitals, local authorities, GPs, and social care providers) that work together to improve health and care for people in a specific area.
Ilizarov frame: A type of external fixation used in orthopaedic surgery for fractures or to lengthen and reshape deformed bones. The technique utilises wires inserted through bones fixed to a series of rings encircling the limb.
Intertrochanteric fractures of the femur occur betweenthe bony protrusions (trochanters) on the femur.
Juvenile Idiopathic Arthritis is a chronic inflammatory condition affecting children under 16, causing joint pain, swelling, and stiffness
Klebsiella bacteria are common causes of bloodstream infections in adults.
KPI key performance indicator.
Laparotomy a procedure involving an incision to the abdomen, commonly for bowel or gynaecology surgery.
Medication reconciliations confirm a patient's medications as taken just before the hospital admission.
MRSA meticillin/methicillin-resistant Staphylococcus aureus bacteria are resistant to several widely used antibiotics and are the main cause of bacteraemia.
MSSA meticillin-sensitive Staphylococcus aureus bacteria are sensitive to the more commonly used antibiotics.
NSTEMI, non-ST-segment elevation myocardial infarction, is a type of heart attack.
PCI percutaneous coronary intervention opens narrowed or blocked blood vessels in the heart using a stent.
Percutaneous nephrolithotomy minimally invasive procedure to remove kidney stone(s).
Primary Coronary Intervention, also known as angioplasty, is a procedure used to treat narrowed coronary arteries. It is sometimes used as an emergency treatment for patients who have had a heart attack.
Pseudomonas bacteria commonly cause bloodstream infections in adults.
Sepsis 6 care bundle comprises 6 assessments to monitor sepsis (blood cultures, blood tests, urine output monitoring, oxygen, intravenous fluids, and antibiotics).
SJR Structured judgement review uses a standardisedtool to review mortalities in hospital, enabling identification of potential areas for improvement.
STEMI ST-segment elevation myocardial infarction is themost serious type of heart attack.

Testicular Torsion occurs when the testicle rotates cutting off blood supply, emergency surgery is needed to prevent permanent damage
Varicocele an abnormal enlargement of a vein in the scrotum
Venous thromboembolism (VTE) is when a blood clot forms in a vein.

Part 4 – Statements on the engagement process for the development of the Quality Accounts

The trust recognises that high-quality healthcare is shaped not only by clinical expertise and operational performance, but also by meaningful engagement with patients, carers, staff, governors, partners and local communities.

This Quality Account has been informed through discussion, challenge and feedback from a range of stakeholders. Their views help ensure our priorities reflect what matters most to the people we serve.

The trust is grateful to all individuals and organisations who contributed to the development of this report.

4.1 Engagement with patients, carers and the public

Throughout 2025/26, Ashford and St Peter's Hospitals NHS Foundation Trust sought feedback from patients, carers and members of the public through a range of channels, including:

- Friends and Family Test responses
- Complaints, compliments and concerns
- Patient surveys
- Patient representatives and participation forums
- Patient Advice and Liaison contacts
- Service-specific engagement exercises
- Community and stakeholder events
- Direct feedback to clinical teams

This feedback has helped shape improvement priorities for 2026/27, particularly in relation to:

- Communication during delays and waiting times
- Involvement in discharge planning
- Timely complaint responses
- Access to services
- Clearer information for patients and families
- Compassionate and person-centred care

The trust remains committed to widening participation and ensuring that seldom heard groups are better represented in future engagement activities.

Ashford and St Peter's Hospitals NHS Foundation Trust
Chair Governor Patient Experience Group

The Patient Experience Group (PEG) of the Council of Governors comprises Governors appointed by the Council to assist that body in achieving its functions in relation to patient experience in the Trust. The Group makes a report to each meeting of the Council. I have been a member of this Group for 6 years and was elected Chair in November 2024.

The Patient Experience Group considers a detailed Quality Report at each of its meetings. This report (which is also considered by the ASPH's Quality of Care Committee) covers:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

The Group is given the opportunity to discuss the data relating to those items with a senior manager from the Trust: usually the Chief Nurse or Deputy Chief Nurse, Associate Director of Quality or Head of Patient Experience and Involvement, all of whom are, usually, in attendance at the PEG Meetings. For the year 2025/26, two of our four meetings have been held remotely with benefits to time management and carbon reduction as well as minimising unnecessary visits to hospital sites. The other two meetings were face to face allowing governors to visit a specific area at each hospital site.

Discussions this year have focused on:

- Patient Safety
- Patient Flow and Discharge
- Patient Feedback and Complaint Handling
- Annual Quality Account

Governors have been particularly interested to hear about the changes being introduced as part of the Patient Flow and Discharge Project. We are hopeful that this work will result in all areas of the hospital working as efficiently and safely as possible and enhance patient experience.

For our first face to face meeting during this reporting period Governors enjoyed a tour of the Eye Unit at Ashford Hospital. The tour was led by Dorothy Adjorolo, Matron for Specialist Surgery. Governors were particularly impressed by the new spacious state of the art Ophthalmology Theatres and range of services offered to our patients. During our visit governors also had the opportunity to meet and speak to front line staff.

At our second face to face meeting on 18 May we were very pleased to welcome Ellen Bull, Deputy Chief Nurse and Claire Atkinson, Deputy Head of Patient Experience. Ellen explained the rationale behind the statutory Annual Quality Account. Committee members raised some points where clarity might be enhanced which were noted and the Account was welcomed by Governors. Claire presented the Patient Experience section of Integrated Performance Report.

The concluding item on the agenda was a visit to the staff restaurant and kitchen. We were welcomed by Eimear Jordan, Facilities Support Services Manager for Housekeeping and Catering. Cleaning of the kitchen after a very busy lunch service was just being completed and it was pristine. Eimear explained the challenges presented by serving some 600 – 700 main meals daily from such a small kitchen and the value of close team working to achieve this. She also explained the complexities of patient meal provision and the efforts made to enhance the quality and variety of what was on offer to patients.

It is envisaged that we will have a mix of face to face and virtual meetings over the next cycle.

Other events and special celebratory days attended by some members of the group relating to patient experience included:

- Staff Awards Ceremony
- Annual Members Meeting
- Schwartz Rounds
- Quality Improvement Event
- Place Inspections at both hospital sites

Governors, and particularly those who are members of the Patient Experience Group of the Council of Governors, have appreciated the opportunities given to receive full papers from, attend and fully participate in the Quality Account Assurance Group.

Patient Experience Group Governors, particularly, do see this as an important extension of their role, beyond their regular meetings. The Trust also holds regular Learning from Patient Experience Meetings and Patient Panel Meetings. Key points from these meetings are fed back to the Patient Experience Group by one of the Governors who is a member of both groups. We are pleased to see the Trust's continued focus on quality and patient experience and to be able to observe positive progress in several areas.

Patient Experience Group meetings have continued to give a strong emphasis on participation by everyone who attends. Data being circulated in advance and front-line clinical team members attending to speak about the "work behind the data" has been appreciated.

The Governors also note, favourably, the further improvements that have been made in the accessibility and clarity of the material provided. This continuous improvement approach to reporting aids in rapid understanding of the data. It has also facilitated richer discussion of the subject matter, giving Governors, Board members and other people using the documents the opportunity to facilitate greater improvements to the patient experience.

The Governors look forward to further continuous development and improvement of the services provided in the Trust over the coming year. They also appreciate the efforts to maintain and improve standards despite the continuing pressure faced by the Trust and its staff.

Shirley Holmes
Public Governor & Chair of the Patient Experience Group of the Council of Governors

Michael Smith,
Lead Governor
May 2026

Healthwatch Surrey

Healthwatch Surrey
xx 2026

NHS Surrey Heartlands Integrated Care System (ICS) Commissioner Statement

Clare Stone
ICS Director of Multi-Professional Leadership and Chief Nursing Officer
NHS Surrey Heartlands Integrated Care System (ICS)
xx 2026

Surrey County Council Statement

Adults and Health Select Committee
Surrey County Council
xx 2026

2025/2026 Statement of Directors' responsibilities in respect of the Quality Report

This Quality Account reflects not only the trust's performance during 2025/26, but also the views, expectations and experiences of the people we serve and those we work alongside.

The trust remains committed to listening, learning and improving through open partnership with patients, staff, governors, local communities and system partners.

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 Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS foundation trust Reporting Manual and supporting guidance.
- Detailed requirements for Quality Reports
- The content of the Quality Report is not inconsistent with internal and external sources of information, including:
  - Board minutes and papers for the period 1 April 2025 to 31 March 2026
  - Papers relating to quality reported to the Board over the period 1 April 2025 to 31 March 2026
  - Feedback from commissioners dated x 2026
  - Feedback from governors dated May 2026
  - Feedback from local Healthwatch organisation dated x June 2026
  - Feedback from Surrey County Council Adults and Health Select Committee dated x June 2026
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, updated 2025
  - The 2024 national inpatient survey
  - The 2025 national staff survey
  - CQC inspection report dated March 2025

- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, 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 Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

NHS providers are not currently expected to obtain assurance from their external auditor on their quality account/quality report.

The Directors are confident in the quality of the services we provide across our service portfolio and that, for the majority of our quality and performance targets, we meet the standards expected by and acceptable to our regulator and commissioners. Further, the information in this Quality Account is provided by our data management and quality improvement systems and, to the best of our knowledge, is accurate and provides a true reflection of our organisation.

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

Joss Bigmore
Chair
June 2026

Louise Stead
Group Chief Executive
June 2026