# NHS Shetland

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| **Meeting:** | **Shetland NHS Board** |
| **Meeting date:** | **26 June 2025** |
| **Agenda reference:** | **Board Paper 2025/26/18** |
| **Title:** | **Quality Report** |
| **Responsible Executive/Non-Executive:** | **Prof Kathleen Carolan, Director of Nursing & Acute Services** |
| **Report Author:** | **Prof Kathleen Carolan, Director of Nursing & Acute Services** |

## 1 Purpose

**This is presented to the Board/Committee for:**

- Awareness/Discussion

**This report relates to:**

- Government policy/directives and how we are implementing them locally
- An overview of our person centred care improvement programmes

**This aligns to the following NHSScotland quality ambition(s):**

The quality standards and clinical/care governance arrangements are most closely aligned to our corporate objectives to improve and protect the health of the people of Shetland and to provide high quality, effective and safe services.

## 2 Report summary

## 2.1 Situation

The Board is asked to note the progress made to date with the delivery of the action plan and other associated work which focuses on effectiveness, patient safety and service standards/care quality.

## 2.2 Background

The report includes:

- A summary of the work undertaken to date in response to the 'quality ambitions' described in the Strategy;
- Our performance against a range of quality indicators (locally determined, national collaborative and national patient safety measures)
- When available, feedback gathered from patients and carers – along with improvement plans. This report has a specific focus on feedback.

## 2.3 Assessment

The report provides a general overview of the person centred care improvement work that is taking place across the Board, particularly in support of managing pressures, recovery and embedding new ways of working as described in the clinical and care strategy. It includes data measures, set out in a quality score card format with a more detailed analysis where there have been exceptions or deviation from the agreed national standards. When available, a written report summarising patient feedback and actions arising from those comments will be included. A patient story will also be included in the context of the quality report, when speakers are available to share their experiences. Feedback monitoring quarterly updates are also a standard component of the quality report content.

The Quality Report does not include any specific exceptions or deviations from the agreed national standards that need to be highlighted to the Board, that do not already have risk assessments and mitigations in place to support them.

### 2.3.1 Quality/ Patient Care

The focus of the quality scorecard is on evidencing safe practice and providing assurance to service users, patients and communities that services are safe and effective.

### 2.3.2 Workforce

The focus of this report is on evidencing effective training and role development to deliver care, professionalism and behaviours which support person centred care.

### 2.3.3 Financial

Quality standards and the delivery of them is part of the standard budgeting process and are funded via our general financial allocation.

### 2.3.4 Risk Assessment/Management

The quality agenda focuses on reducing risks associated with the delivery of health and care services. The adverse event policy also applies to HAI related events.

### 2.3.5 Equality and Diversity, including health inequalities

EQIA is not required.

### 2.3.6 Other impacts

### 2.3.7 Communication, involvement, engagement and consultation

### 2.3.8 Route to the Meeting

Delegated authority for the governance arrangements that underpin quality and safety measures sit with the Clinical Governance Committee (and the associated governance structure).
The data included in this report have been received by CGC in bespoke reports provided by Michelle Hankin, Clinical Governance and Risk Team Leader and Carolyn Hand, Head of Corporate Services.

## 2.4 Recommendation

Awareness – for Board members

# 3 List of appendices

The following appendices are included with this report:

Appendix 1 Quality Report June 2025
Appendix 2 Quality Scorecard June 2025
Appendix 3 Complaints and Feedback Report Q4 2024-2025

## APPENDIX 1 PROGRESS ON LOCAL QUALITY STRATEGY IMPLEMENTATION

In this report, there is a focus on providing some interpretation of the data, set out in the quality score card and the most recent feedback and complaints report.

### DEEP DIVE INTO THE QUALITY SCORCARD

The quality scorecard is shown as Appendix 2. In summary, the data in this scorecard highlights the following:

| **Summary of Performance Indicator Activity (41 KPIs):** | | | | |
|---|---|---|---|---|
| **2024/2025** | No target set/ Suspended activity | 🛑 | ⚠️ | ✅ |
| **Q4** | **10** | **7** | **0** | **24** |
| | 4 KPIs national activity suspended (NA-IC-23, NA-IC-24, NA-IC-25, NA-IC-30)<br><br>NA-HC-79 & NA-HC-80 EiC data collection to resume in Q1 2025/26<br><br>1 KPI (MD-HC-01) awaiting national update<br><br>NA-CF-16 women satisfied with the care they receive – Care Opinion is now being used<br><br>MD-HC-01 calculated following national data release<br><br>NA-HC-72 DVT audit data awaiting clinician review | NA-IC-01, NA-IC-02, NA-IC-13, NA-IC-20 Catheter Usage Rate, CAUTI<br><br>PH-HI-03, NA-HC-09, NA-HC-10, NA-HC-53, NA-HC-69, Measures will remain on red until the target has been met | | Detailed in the Quality Score Card (Appendix 1) |
| **Q3** | 8 | 7 | 0 | 26 |
| **Q2** | 8 | 8 | 0 | 24 |
| **Q1** | 7 | 6 | 0 | 28 |

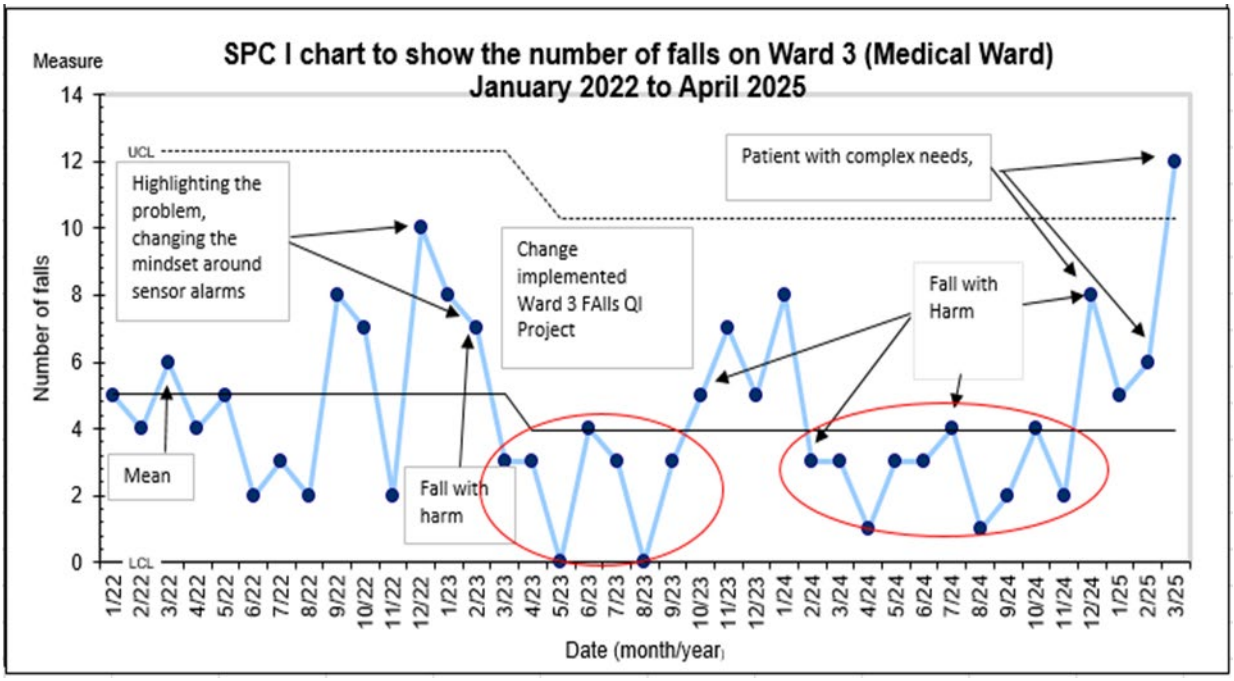
- **Health Improvement Measures:**

PH-HI-03 & PH-HI-03a - A steady increase in Alcohol Brief Interventions (ABIs) were recorded over the last 12 months (2023/2024). Data is reset every April, to enable cumulative data collection for the new financial year (2024/2025). This measure will remain on red until the set target has been achieved. 2024/2025 data in all quarters to date reflect the upwards trend observed in the previous year.

- **Patient Experience Outcome Measures** – all 7 patient experience measures in Q2, Q3 achieved 100% compliance. During Q4 performance dips slightly ranging from 96-100%, however performance remains above the target of 90% for all these measures, this could reflect the system challenges encountered in Q4.
- **Patient Safety Programme – Maternity and Children**:
  There were no still births or neonatal deaths this quarter and the number of days between stillbirths continues to increase. All new-borns in Q4 received the new-born screening bundle assessments. From Q2 2023/2024 Care Opinion is being used to ask patients to provide feedback regarding their care experience. All women receive information on Care Opinion in their discharge pack, however, there has been no feedback received via Care Opinion since March 2024. There was no Care Opinion feedback received for maternity in Q4.

**Service and Quality Improvement measures (noted by topic below):**

- **Cardiac Arrests** – cardiac arrest data continues to be reported as part of the Scottish Patient Safety Programme (SPSP). There were no reportable cardiac arrests in Q2, Q3 and Q4.
- **Falls** – During Q4 there was a significant increase in the number of inpatient falls, which occurred on the medical ward, reflecting the complex patient care needs these individuals have. There were twelve falls in March 2025, two of these patients had multiple falls. Adverse events reporting was completed for all these incidents and the SCN is currently reviewing these falls. The Health & Safety Team have also reviewed these incidents as 'Topic Specialists', all patients received the appropriate falls assessments and nursing interventions. All of these falls have been included in the Scottish Patient Safety Programme quarterly data return. The increase in falls is reflected in the Q4 Quality Score Card performance indicators, NA-HC-09 All Falls rate (per 1000 occupied bed days) and NA-HC-10 Falls with harm rate (per 1000 occupied bed days), these measures will remain on red until the target of 300 days is reached across both inpatient areas. During Q4 there was one fall with harm (small superficial laceration to head caused by the patient's glasses), the fall was reported via the adverse event system and reviewed by the Senior Charge Nurse. Appropriate care and actions were taken at the time of the fall, falls assessments were completed upon patient admission.




Considering the SPC chart above, in Q4 we observe a significant increase in falls, this reflects the number of inpatients with complex needs who are having multiple falls. It is important to acknowledge that there will always be patients with complex needs who have multiple co-morbidities which will increase their risk of a fall. Case review and regular risk assessment plays an important part in the management of this group of patients. Following discussion with the clinical team, the patients who having multiple falls are receiving specialist input from Grampian.

- **Pressure ulcers** – There was one Hospital Acquired Pressure Ulcer reported for Q4 2024/2025, this was classified as unavoidable. Following review by the Senior Charge Nurse, all appropriate care was implemented. The pressure ulcer was reported via the adverse event Datix system. The Red Day Review was completed by the Senior Charge Nurse and Tissue Viability Nurse which identified that the patient had multiple co-morbidities, all appropriate nursing assessments had been completed within four hours of admission and the pressure ulcer was unavoidable. Audit Measure NA-HC-69 the number of days between pressure ulcers developed on Ward 3 and NA-HC-53 the days between hospital acquired pressure ulcers will remain on red until the target of 300 days is reached.
- **DVT Audit** – The DVT audit is carried out every second month, with the performance being reported via the Quality Score Card (NA-HC-72). This measure considers the percentage of patients who had the correct pharmacological/mechanical thromboprophylaxis administered, performance against this measure has improved from Q3 2023/2024 (40%) to Q1 2024/2025 (80%), performance is now above the identified target of 75%, achieving 100% in Q3.

Following the review (December 2024) and subsequent changes to the Hepma system to enable data collection via the Hepma system for performance indicators NA-HC-73 and NA-HC-74, it is anticipated that performance against these indicators will improve. The new Clinical Governance Facilitators completed the December 2024 DVT audit, in February 2025, this is awaiting lead Clinician Review.

**DVT Audit 2024 Result overview:**

| | Feb 2024 | April 2024 | June 2024 | August 2024 | October 2024 | December 2024 |
|---|---|---|---|---|---|---|
| **Risk Assessed**<br>**NA-HC-71** | 100% | 90% | 100% | 90% | 100% | Awaiting Lead Clinician Review |
| **Managed appropriately**<br>**NA-HC-72** | 60% | 0% | 100% | 0% | 100% | |
| **Evidence of review**<br>**NA-HC-73** | 50% | 60% | 38% | 10% | 40% | |
| **Discussed with patient**<br>**NA-HC-74** | 80% | 0% | 0% | 0% | 0% | |

- **Catheter Associated Urinary Tract Infection (CAUTI):**

  **NA-IC-01** the number of days between Catheter Associated Urinary Tract Infection (CAUTI) developed in acute care, will remain on red until the performance target of 300 days have been achieved across both inpatient areas. Current Q4 performance is 289 days.

  **NA-IC-02** catheter usage rates continues to increase, with Q4 usage rate increasing to 28.43%, compared to 20.27% in Q3. The Infection Control Team will continue to monitor this measure. The increase observed throughout 2024/2025 may reflect the regular theatre scheduling of weekly gynaecology and urology lists and the increase in the number of surgical procedures which require post-operative catheterisation.

  **NA-IC-10** during Q4 we have observed a decrease in the compliance with Catheter Associated Urinary Tract Infection (CAUTI) Insertion Bundle, from 84.62% in Q3 to 72.22% in Q4. The Infection Control Team who continue to monitor and provide support and education to the clinical areas.

  **NA-IC-13** during Q4 we observe a decrease in compliance with Catheter Associated Urinary Tract Infection (CAUTI) maintenance bundle, from 84% in Q3 to 51.85% in Q4. Conversations with the Infection Control Team, identify that compliance with insertion and maintenance bundles has been frequently raised with clinical teams at the time of audit completion. The teams acknowledge that performance requires improvement, however the

current winter and workforce pressures (bed capacity, agency use, lengthened inpatient stays etc) have provided additional challenges.

One of the main reason for low compliance in terms of catheter insertion is the lack of clarity or poor documentation which does not specify the reason 'why the catheter was inserted'.

If the reason for insertion is not recorded then the catheter can often be classed as a long term catheter. The Infection Control Team continue to offer training and support to teams. In March 2025 additional training resources (appendix 2) were recirculated to raise awareness around catheter care. CAUTI compliance is identified for discussion at the Infection Control Meeting on the 22nd April 2025.

- **Clinical Governance Leadership Walkrounds** – During Q4, three were three Leadership Walkrounds scheduled to Medical Imaging, (GBH), Medical Physics (GBH) and the Vaccination Centre. Unfortunately the visit to the Vaccination Centre was cancelled due to system pressures across the organisation. The Clinical Governance Team, are exploring possible dates to reschedule this visit. Details of these Leadership Walkround visits is provided in Q4 Leadership Walkround Report and reflected in Q4 Quality Score Card data.
- **Excellence in Care (EiC) NEWS & CAIR Dashboard reports** – CAIR Dashboard reports from December 2023 onwards are not currently available, as due to Clinical Governance Team vacancies this data has not been collected. The Clinical Governance Team are pleased to announce following successful recruitment, the new Clinical Governance Support Manager has now commenced in post and Excellence in Care training has been scheduled for 18th April 2025, following this the collection of Excellence in Care data collection will recommence.

- **Thematic learning** – 199 adverse events were reported in Q4 and 7 debriefs were held.

| | Q1 2024/25 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 |
|---|---|---|---|---|
| **Number of adverse events** | **190** | **205** | **200** | **199** |
| **Number of debriefs held** | **3** | **12** | **6** | **7** |
| **Number of Extreme Adverse Events -** | **2** | **4** | **1** | **7** |
| All Adverse Events categorised as ‘extreme’ were related to death notification reporting and have been discussed via the weekly Clinical Risk Advisory Team (CRAT) Meeting. | | | | |
| **Number of Major Adverse Events** | **0** | **0** | **1** Related to an inpatient fall | **0** |
| **Number of Moderate Adverse Events** | **11** | **6** | **5** | **9** |

The scorecard also provides an overview of the thematic analysis of Lessons Learnt for January – March 2025. All the adverse events categorised as ‘extreme’ are related to

death notification reporting, and have been discussed and reviewed via the weekly Clinical Risk Advisory Team (CRAT) meeting and via monthly governance meetings.

- **Inpatient Experience** – 98% of patients in this quarter on Ward 1 and 100% of Ward 3 patients' said they had a positive care experience. 100% of Ward 1 and Ward 3 patients and 100% agreed they received the care and support they expected or needed. Inpatient survey feedback shared by patients identified the excellent level of care they received, highlighting the appreciation of care delivered and the support and caring nature exhibited by staff. One individual highlighted that they felt the doctor spoke to them in a dismissive way. Other patients shared concerns regarding discharge planning (waiting for drugs and transport). Monthly patient feedback is now being regularly shared at the monthly Medical Governance and Surgical Audit meetings, this assists in reviewing and implementing any improvements or changes in a timely manner with the whole multidisciplinary team. Feedback shared within this quarter also acknowledged the pressures the teams are working under.
- **Q4 Care Opinion Feedback** – has been included in the Quality Score Card Appendix to share organisational feedback and organisational responses to the feedback shared. Care Opinion feedback is also being shared at the relevant monthly governance meetings.
- **Surgical Site Infection Surveillance** – this national workstream continues to be suspended, there is no confirmed position regarding the timeframe for surgical site infection surveillance to be re-established.
- **Student Feedback (QMPLE)** – Student feedback generally continues to be positive. 12 nursing students completed feedback for Q4. 75% of students were very satisfied with their placement experiences. The majority of students received more than 28 days advanced notice of their placement in Shetland and were assigned a practice supervisor when they arrived in the practice environment. Students valued the learning environment, and opportunities to practice practical nursing skills, they felt their placements provided a good range of learning opportunities.

  However, it is noted that some students felt that practice experiences could have been better, identifying that information provided, achievement of learning outcomes, and respect for student status could be improved. Considering this feedback, time pressures and busy placement environments reflect the increased workforce pressures currently being experienced by the whole organisation. The organisation values any feedback received and utilises this to improve the learning/clinical environment, we would like to thank the students for their time and effort whilst they have been upon clinical placements in Shetland, and for their honesty when providing QMPLE feedback. All student feedback is reviewed by the Practice Education Team, who have provided the following comment;

  "Students are offered many opportunities to discuss any concerns and issues, however there is a national trend occurring where students are choosing to leave negative feedback on QMPLE after leaving placement, which due to the anonymity of the feedback we cannot discuss with the student to investigate further with them. Along with our partners Robert Gordon University (RGU), NHS Grampian and NHS Orkney, we are looking to improve guidance to students on the options for giving feedback and raising concerns, this work is already in progress.

Negative feedback has been reviewed by RGU and senior management, actions have been identified which have been agreed locally with the teams involved, the practice education team will support the completion of these actions."

## COMPLAINTS AND FEEDBACK

The complaints and feedback report for Q4 2024-25 is shown as Appendix 3. The Patient Rights (Scotland) Act 2011 and associated Regulations place a duty on all Boards to receive, log and respond to complaints, with an emphasis on supporting individual complainants and also taking forward organisational learning. There is a requirement for complaint handling data to be brought to the attention of NHS Boards. A national Model Complaint Handling Procedure was implemented by all NHS Scotland Boards in April 2017 and this introduced nine key performance indicators for compliance to be measured against.

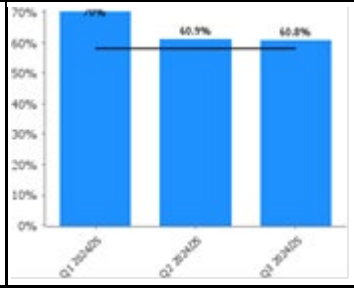
The report shows that complaint numbers are relatively small owing to the size of the Board and trend analysis is less possible because of this. Low numbers can also skew performance statistics, however the narrative for the more significant Stage 2 complaints allows Board and Committee Members the ability to seek clarity and additional assurance as required.

# BOARD

**Generated on:** 28 May 2025 14:37

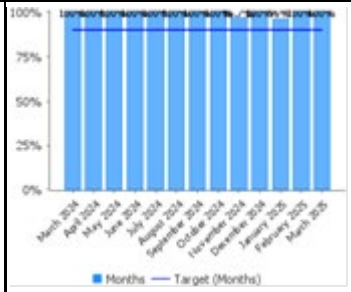
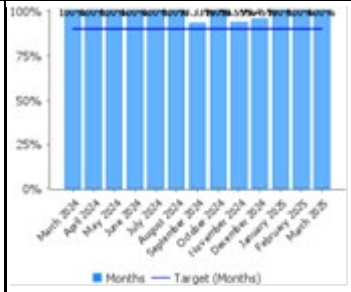
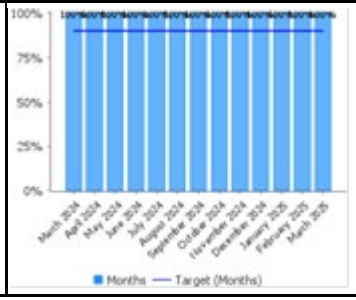
# Quality Scorecard - BOARD

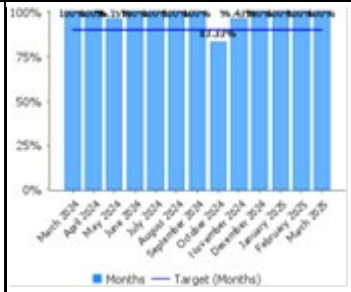
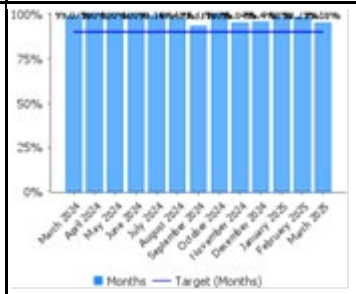
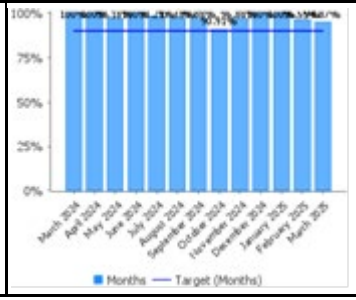
| Title |
| --- |
| Health Improvement |

| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| NA-HI-01 Percentage Uptake of Breastfeeding at 6-8 Weeks (exclusively breastfed plus mixed breast and formula) (Rolling annual total by quarter) | Measured Quarterly | | | 60.9% | 60.8% | | | 58% |  | **Q4 data will be available end May 2025** |

| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
|---|---|---|---|---|---|---|---|---|---|---|
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| PH-HI-03 Sustain and embed Alcohol Brief Interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings. | 100 | 105 | 118 | 53 | 86 | 100 |  | 261 |  | Measure will remain on red until target of 261 is achieved. |
| PH-HI-03a Number of FAST alcohol screenings | 480 | 522 | 572 | 255 | 398 | 572 |  | 400 |  | |

| Title |
| --- |
| Patient Experience Outcome Measures |

| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| NA-HC-01 % who say they had a positive care experience overall (aggregated) | 96% | 100% | 100% | 100% | 100% | 100% |  | 90% |  | |
| NA-HC-04 % of people who say they got the outcome (or care support) they expected and needed (aggregated) | 100% | 100% | 100% | 93.33% | 95.45% | 100% |  | 90% |  | |
| NA-HC-14 What matters to you - % of people who say we took account of the things that were important to them whilst they were in hospital (aggregated) | 100% | 100% | 100% | 100% | 100% | 100% |  | 90% |  | |

| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
|---|---|---|---|---|---|---|---|---|---|---|
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| NA-HC-17 What matters to you % of people who say we took account of the people who were important to them and how much they wanted to be involved in care/treatment (aggregated) | 100% | 100% | 100% | 100% | 100% | 100% |  | 90% |  | |
| NA-HC-20 What matters to you % of people who say that they have all the information they needed to help them make decisions about their care/treatment (aggregated) | 98% | 98.21% | 95.1% | 93.33% | 95.4% | 98.21% |  | 90% |  | |
| NA-HC-23 What matters to you % of people who say that staff took account of their personal needs and preferences (aggregated) | 100% | 96.55% | 94.87% | 96.88% | 100% | 96.55% |  | 90% |  | |

| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
|---|---|---|---|---|---|---|---|---|---|---|
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| NA-HC-26 % of people who say they were involved as much as they wanted to be in communication, transitions, handovers about them (aggregated) | 96.67% | 96.67% | 94.74% | 90.63% | 89.13% | 96.67% |  | 90% |  | |

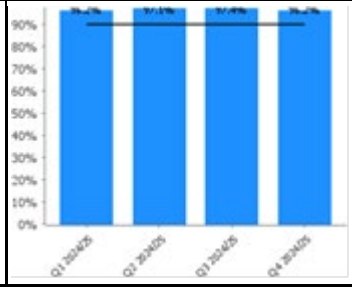
| Title |
|---|
| **Patient Safety Programme - Maternity & Children Work stream** |

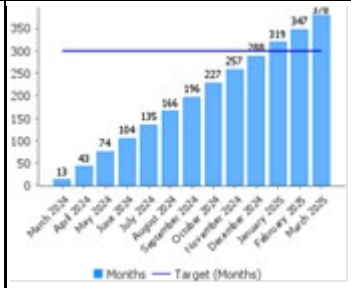
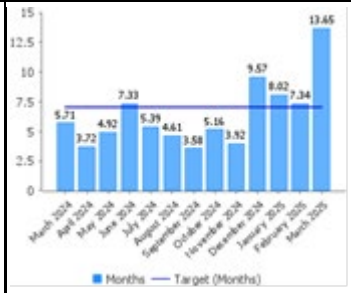
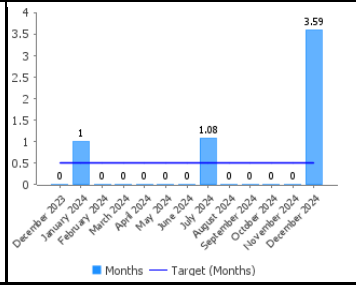
| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
|---|---|---|---|---|---|---|---|---|---|---|
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| NA-CF-07 Days between stillbirths | 3,612 | 3,640 | 3,671 | 3,489 | 3,581 | 3,671 |  | 300 |  | |

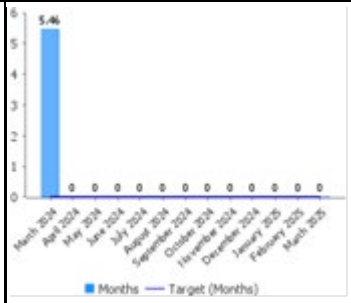
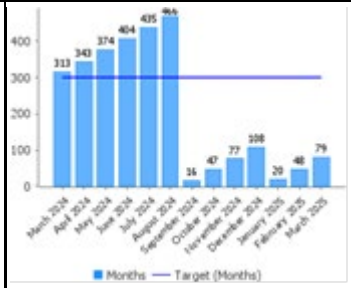
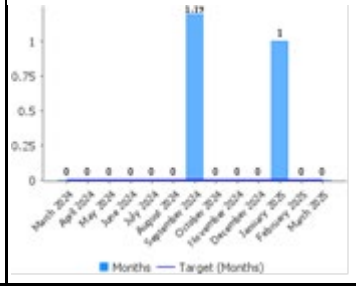
| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
|---|---|---|---|---|---|---|---|---|---|---|
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| NA-CF-09 Rate of neonatal deaths (per 1,000 live births) | 0 | 0 | 0 | 0 | 0 | 0 |  | 2.21 |  | |
| NA-CF-15 Rate of stillbirths (per 1,000 births) | 0 | 0 | 0 | 0 | 0 | 0 |  | 4 |  | |
| NA-CF-16 % of women satisfied with the care they received | From Q2 2023/2024 Care Opinion is used to ask patients to provide feedback regarding their care experience. All women receive Care Opinion feedback information in their discharge pack. There has been no feedback received via Care Opinion since March 2024. | | | | | | | | | |

| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
|---|---|---|---|---|---|---|---|---|---|---|
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| NA-HC-58 % compliance with the newborn screening bundle | Measured Quarterly | | | 100 | 100 | 100 |  | 100 |  | |

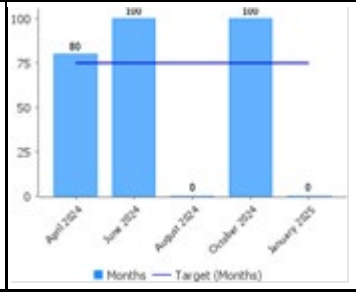
| Title |
|---|
| Service & Quality Improvement Programmes - Measurement & Performance |

| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
|---|---|---|---|---|---|---|---|---|---|---|
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| CE-IC-01 Cleaning Specification Audit Compliance | Measured Quarterly | | | 97.1% | 97.6% | 96.2% |  | 90% |  | |

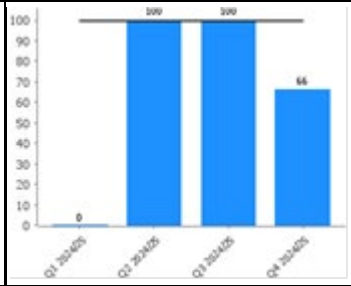
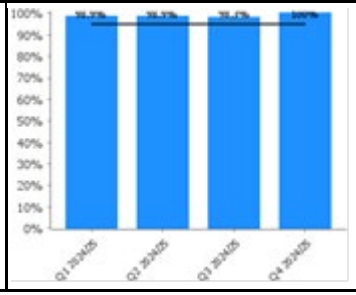
| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
|---|---|---|---|---|---|---|---|---|---|---|
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| NA-HC-08 Days between Cardiac Arrests | 319 | 347 | 378 | 196 | 288 | 378 |  | 300 |  | |
| NA-HC-09 All Falls rate (per 1000 occupied bed days) | 8.02 | 7.34 | 13.65 | 3.58 | 9.57 | 13.65 |  | 7 |  | During Q3 & Q4 there was an increase in the number of inpatient falls reflecting the complex needs of patients, who are presenting with multi comorbidities. During Q4 there was three patients who had multiple falls associated with the conditions they presented to hospital with. |
| NA-HC-10 Falls with harm rate (per 1000 occupied bed days) | 1 | 0 | 0 | 0 | 3.59 | 0 |  | 0.5 |  | |

| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
|---|---|---|---|---|---|---|---|---|---|---|
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| NA-HC-13 Crash call rate per 1000 discharges (number of crash calls/total number of deaths + live discharges x 1000) | 0 | 0 | 0 | 0 | 0 | 0 | ✅ | 0 |  | |
| NA-HC-53 Days between a hospital acquired Pressure Ulcer (grades 2-4) | 20 | 48 | 79 | 16 | 108 | 79 | 🛑 | 300 |  | Measure will remain on red until target of 300 days reached across both inpatient areas. |
| NA-HC-54 Pressure Ulcer Rate (grades 2-4) | 1 | 0 | 0 | 1.19 | 0 | 0 | ✅ | 0 |  | |

| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
|---|---|---|---|---|---|---|---|---|---|---|
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| NA-HC-59 % of patients discharged from acute care without any of the combined specified harms | 99 | 100 | 100 | 99.4 | 98.2 | 100 |  | 95 |  | |
| NA-HC-66 Pressure ulcer - days between pressure ulcers developed on Ward 1. | 695 | 723 | 754 | 572 | 664 | 754 |  | 300 |  | |
| NA-HC-69 Pressure ulcers - days between pressure ulcers on Ward 3 | 20 | 48 | 79 | 16 | 108 | 79 |  | 300 |  | Measure will remain on red until 300 days is achieved. |

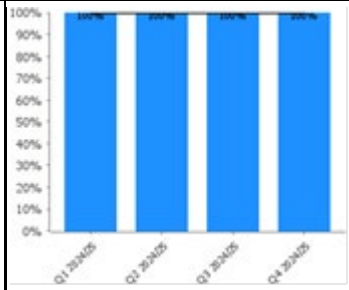
| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
|---|---|---|---|---|---|---|---|---|---|---|
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| NA-HC-72 % of patients who had the correct pharmacological/mechanical thromboprophylaxis administered | 0 | | 0 | 0 | 100 | | | 75 |  | **December 2024 data was audited in February 2025. Currently being reviewed by the Lead Clinician.** |
| NA-HC-79 % of total observations calculated accurately on the NEWS 2 charts | Due to Clinical Governance Team vacancies, Excellence in Care (EiC) data has not been updated since December 2023. Following successful recruitment, data will recommence April 2025. | | | | | | | | | |
| NA-HC-80 % of NEWS 2 observation charts fully compliant (Accuracy) | Due to Clinical Governance Team vacancies, Excellence in Care (EiC) data has not been updated since December 2023. Following successful recruitment, data will recommence April 2025. | | | | | | | | | |
| NA-IC-01 Days between Catheter Associated Urinary Tract Infection (CAUTI) developed in acute care | 230 | 258 | 289 | 107 | 199 | 289 |  | 300 |  | Measure will remain on red until target of 300 days reached across both inpatient areas. |

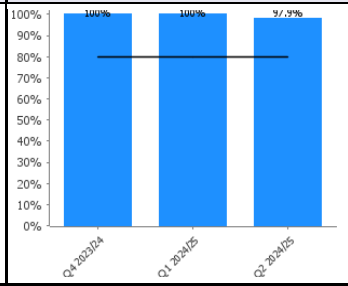
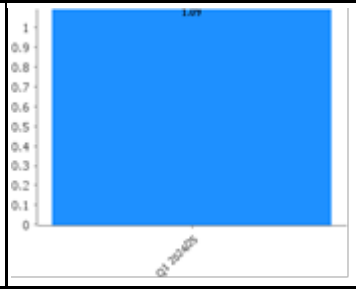
| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
|---|---|---|---|---|---|---|---|---|---|---|
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| NA-IC-02 Catheter Usage Rate | 19.98 | 21.2 | 28.43 | 21.47 | 20.27 | 28.43 | | 15 |  | The Infection Control Team will continue to monitor this measure. |
| NA-IC-10 Aggregated Compliance with Catheter Associated Urinary Tract Infection (CAUTI) Insertion Bundle | 87.5% | 82.35% | 72.22% | 75% | 84.62% | 72.22% | | 95% |  | |
| NA-IC-13 Aggregated Compliance with the Catheter Associated Urinary Tract Infection (CAUTI) maintenance bundle | 87.5% | 64.71% | 51.85% | 73.08% | 84% | 51.85% | | 95% |  | |

| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
|---|---|---|---|---|---|---|---|---|---|---|
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| NA-IC-20 % of Patient Safety Conversations Completed (3 expected each quarter) | Measured Quarterly | | | 100 | 100 | 66 | | 100 |  | 2 out of 3 scheduled Leadership Walkrounds were carried out during Q4. The Leadership walkround to the Vaccination Centre was postponed due to system pressures across the organisation. |
| NA-IC-22 Hand Hygiene Audit Compliance | Measured Quarterly | | | 98.9% | 98.3% | 100% | | 95% |  | |
| NA-IC-23 Percentage of cases where an infection is identified post Caesarean section | Measured Quarterly | | | Surgical Site Infection Surveillance activity remains suspended, there is no national updated regarding when this will be recommenced. | | | | | | |
| NA-IC-24 Percentage of cases developing an infection post hip fracture | Measured Quarterly | | | Surgical Site Infection Surveillance activity remains suspended, there is no national updated regarding when this will be recommenced. | | | | | | |
| NA-IC-25 Percentage of cases where an infection is identified post Large Bowel operation | Measured Quarterly | | | Surgical Site Infection Surveillance activity remains suspended, there is no national updated regarding when this will be recommenced. | | | | | | |

| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
|---|---|---|---|---|---|---|---|---|---|---|
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| NA-IC-30 Surgical Site Infection Surveillance (Caesarean section, hip fracture & large bowel procedures) | Measured Quarterly | | | Surgical Site Infection Surveillance activity remains suspended, there is no national updated regarding when this will be recommenced. | | | | | | |

## Treatment

| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
|---|---|---|---|---|---|---|---|---|---|---|
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| CH-MH-03 All people newly diagnosed with dementia will be offered a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan | 100% | 100% | 100% | 100% | 100% | 100% | | 100% |  | |

| Performance Indicators | January 2025 | February 2025 | March 2025 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q4 2024/25 | Q4 2024/25 | Trend Chart | Latest Note |
|---|---|---|---|---|---|---|---|---|---|---|
| | Value | Value | Value | Value | Value | Value | Status | Target | | |
| CH-MH-05 People with diagnosed dementia who take up the offer of post diagnostic support (rolling 12 months) | Measured Quarterly | | | 97.9% | 98.2% | |  | 80% |  | **Awaiting Q4 data** |
| MD-HC-01 Quarterly Hospital Standardised Mortality Ratios (HSMR) | Measured Quarterly | | | 1.09 | | | | |  | Calculated following national data release. |

**APPENDIX A – Overview of falls and pressure ulcer incidence between January – March 2024**

| Falls in Secondary Care | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| WARD 1 NA-HC-60 Total number of falls | | | | | WARD 3 NA-HC-61 Total number of falls | | | | |
| Date | Fall with injury NA-HC-62 | Fall – no injury | Number Days Between (falls with injury) | Injury | Date | Fall with injury NA-HC-63 | Fall – no injury | Number Days Between (falls with injury) | Injury |
| B/Fwd | 0 | 18 | 390 | | B/Fwd | 3 | 5 | 2 | |
| **Jan 25** | 1 | 2 | 21 | Laceration to head | **Jan 25** | 0 | 5 | 33 | |
| **Feb 25** | 0 | 1 | 49 | | **Feb 25** | 0 | 6 | 61 | |
| **Mar 25** | 0 | 2 | 80 | | **Mar 25** | 0 | 12 | 92 | |
| **Apr 25** | | | | | **Apr 25** | | | | |
| **May 25** | | | | | **May 25** | | | | |
| **Jun 25** | | | | | **Jun 25** | | | | |
| **July 25** | | | | | **July 25** | | | | |
| **Aug 25** | | | | | **Aug 25** | | | | |
| **Sept 25** | | | | | **Sept 25** | | | | |
| **Oct 25** | | | | | **Oct 25** | | | | |
| **Nov 25** | | | | | **Nov 25** | | | | |
| **Dec 25** | | | | | **Dec 25** | | | | |
| **Total** | **1** | **5** | | | **Total** | **0** | **23** | | |

| Pressure Ulcers in Secondary Care | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| WARD 1 | | | | | | WARD 3 | | | | | |
| **Date** | **Total number of pressure ulcers acquired while on the ward (NA-HC-64)** | **Number present on admission (NA-HC-65)** | **Number of days between a new PU being identified (NA-HC-66)** | **Grade** | **Origin** | **Date** | **Total number of pressure ulcers acquired while on the ward (NA-HC-64)** | **Number present on admission (NA-HC-65)** | **Number of days between a new PU being identified (NA-HC-66)** | **Grade** | **Origin** |
| B/Fwd | 0 | 0 | 664 | | | B/Fwd | 1 | 7 | 108 | | |
| **Jan 25** | 0 | 0 | 695 | | | **Jan 25** | 1 | 1 | 20 | | |
| **Feb 25** | 0 | 0 | 723 | | | **Feb 25** | 0 | 0 | 48 | | |
| **Mar 25** | 0 | 1 | 754 | | | **Mar 25** | 0 | 0 | 79 | | |
| **Apr 25** | | | | | | **Apr 25** | | | | | |
| **May 25** | | | | | | **May 25** | | | | | |
| **June 25** | | | | | | **Jun 25** | | | | | |
| **July 25** | | | | | | **July 25** | | | | | |
| **Aug 25** | | | | | | **Aug 25** | | | | | |
| **Sept 25** | | | | | | **Sept 25** | | | | | |
| **Oct 25** | | | | | | **Oct 25** | | | | | |
| **Nov 25** | | | | | | **Nov 25** | | | | | |
| **Dec 25** | | | | | | **Dec 25** | | | | | |
| **Total** | **0** | **1** | | | | **Total** | **1** | **1** | | | |

## APPENDIX B – Learning points from the investigation of patients that have had a fall with harm and patients who developed pressures ulcers in Hospital in Appendix A

| FALLS WITH HARM | | | | | |
|---|---|---|---|---|---|
| **Date** | **No. of Patients** | **Avoidable/ Unavoidable** | **Appropriate Care Given?** | **Debrief Conducted?** | **Learning Points?** |
| January – March 2025 | 1 | Unavoidable | Yes | Reviewed by SCN | During Q4 there was one fall with harm (small superficial laceration to head caused by the patient's glasses), the fall was reported via the adverse event system (Datix 10716). Appropriate care and actions were taken at the time of the fall, falls assessments were completed upon patient admission. |
| **HOSPITAL ACQUIRED PRESSURE ULCERS** | | | | | |
| **Date** | **No. of Patients** | **Avoidable/ Unavoidable** | **Appropriate Care Given?** | **Debrief Conducted?** | **Learning Points?** |
| January – March 2025 | 1 | Unavoidable | Yes | Review conducted by SCN and TVN | Following review by the Senior Charge Nurse, all appropriate care was implemented. The pressure ulcer was reported via the adverse event Datix system (incident number 10720). The Red Day Review was completed by the Senior Charge Nurse and Tissue Viability Nurse which identified that the patient had multiple co-morbidities, all appropriate nursing assessments had been completed within four hours of admission, and the pressure ulcer was unavoidable. |

**Appendix C Thematic analysis of Lessons Learnt: January – March 2025**

| **Q4 Total Data: 199 Adverse Events Reported: 7 Debriefs held.**<br>**N.B. All Adverse Events categorised as 'extreme' were related to death notification reporting and have been discussed via the weekly Clinical Risk Advisory Team (CRAT) Meeting and/or via monthly governance meetings.** | | | |
|---|---|---|---|
| **Month** | **No. of Adverse Events Reported** | **Moderate, Major and Extreme Events Reported** | **No. of Debriefs Completed** |
| **January 2025** | **75** | **7 Extreme (10727, 10728, 10736, 10737 10748, 10759, 10769)**<br>**0 Major**<br>**9 Moderate (10705, 10721, 10722, 10723, 10732, 10740, 10755, 10761, 10764)** | **4** |

**Adverse event theme (10721) – Level 2 Review: Clinical Event: Review completed by Senior Midwife.**

Patient had prolonged labour. When conducting patient review, (CTG applied), fetal heart showed prolonged bradycardia. 2222 called initiated. Decision made for emergency Category 1 caesarean section under general anaesthetic. Baby needed resuscitation and respiratory support. SCOTSTAR was contacted, baby stabilized, retrieved and transferred to Tertiary unit.

**Learning identified:**

**What was the issue:**

- Lack of clarity around degree of urgency and no decision made about category of caesarean section with the result receptionist was unable to clarify whether Category 1 or 2 call.

**What went well:**

- Woman prepared for theatre whilst awaiting consultant obstetrician
- Theatre was opened and set up by A&E staff
- 2nd anaesthetist available for the baby

**If anything, what could we improve on:**

- Midwives can call a category 1 caesarean section if the consultant obstetrician is not in the department
- Midwives to ensure if requesting the Health Care Worker (HCW) to put out the 2222 call that they communicate to reception the category of the call to be requested. Once the 2222 call has been actioned, the HCW should report back to the Midwife, confirm this has been completed.
- Clear concise information to reception - avoids any delays in appropriate personnel being informed of classification of emergency, this also informs the consultant anaesthetist that a second anaesthetist may be required
- Consultant surgeon to be called as may be required to complete surgical procedure if Consultant obstetrician required to assist with neonatal resuscitation

- To be clear when communicating with partner that if the midwives are involved with resuscitation of baby, then best place for him/her is in maternity department
- If possible a second midwife to theatre to assist with resuscitation - especially for category 1 section
- Consider timing of transfer to maternity once baby is stable - enables theatre to be readied in case of clinical needs and whether a second team may be required
- Locum consultants Induction to include neonatal resuscitation and stabilisation training
- Managing the role as a sole worker

**What have we learnt:**

- Initial phone call following SRM advise should be given as per guideline
- On admission following SRM then temperature should be documented
- If request made to review of a CTG, this should be documented as a peer review and documented appropriately including ongoing management.
- Latent phase of labour guideline - Monitoring the Fetal Heart every 30 minutes for 4 hours post morphine administration is advised in the latent phase.
- 2222 call for Category 1 section should be made by midwife if Consultant is not in the department.
- Ensure member of staff requesting the receptionist to put out call is clear and concise to avoid delays in appropriate staff being notified
- Minimal notes from midwifery team including APGARS following birth of baby

**Lessons Learnt Shared:**

Following debrief with team involved there was an action plan completed, Midwives now aware that it is within their remit to call a Category 1 section if consultant is not in department. Discussion about the impact of unclear communications with the midwives and health care worker.

Mother and baby are doing well.

**Adverse event theme (10705) – Level 3 Review: Clinical Event: Reviewed by Consultant Anaesthetist.**

Patient reported pain in one of their teeth post operatively, and subsequently required to have tooth removed and replaced at substantial cost. Highly likely that the tooth was damaged during intubation. No documentation at the time of surgery regarding any dental damage or pain experienced.

**Learning identified:** The patient was involved throughout the review process and has received an apology. Discussed with Medical Director, following a detailed review by the Consultant Anaesthetists and Director of Dentistry, this does not meet the threshold for Duty of Candour, as this is an accepted risk associated with the procedure. As a good will gesture the NHS has reimbursed patient for private dental treatment, however NHS services could have provided the treatment if aware of the issue at the time.

**Adverse event theme (10754) – Level 3 review: Treatment, procedure: Reviewed by Clinical Lead.**

Central Decontamination Unit contacted Service manager, to inform that an instrument recorded as having been used on a patient, had exceeded its sterilisation expiry date.

**Learning identified:**

- Importance of regularly checking/rotating stock, especially prior to use.
- To ensure equipment that is not used frequently is regularly checked for their sterilisation status.
- Once issue identified team reacted quickly to highlight issue at team meeting/huddle.
- Patient informed of incident, and confirmed no harm sustained.

**Adverse event theme (10778) – Level 3 review: Clinical Event: Review completed by Senior Midwife.**

Woman receiving medical management of miscarriage in Northern Star room in Maternity.

-Heavy blood loss throughout day, not all volumes of blood loss recorded so estimated blood loss (EBL) difficult to establish during later emergency.

-Woman became symptomatic of blood loss, had vasovagal - emergency buzzer pulled for help and reviewed by consultant.

-Second vasovagal episode after an hour, unable to call for help as other staff member in labour rooms.

-PPH ?1.2ltr estimated blood loss

-Transferred to theatre for ongoing treatment.

**Learning identified:**

- Use of bedpans to measure blood loss from admission
- Fluid balance chart to document blood loss
- Weigh pads and incontinence pads if required
- Ensure blood loss during any procedure is measured and documented
- Recognition of deteriorating patient
- No clock in room
- No immediate access to PPE
- Unable to access emergency trolley as patient in labour
- No scales for weighing
- checklist and MEWS chart not scanned into Badgernet (available in miscarriage folder)
- Review of work load and potential need for additional staff

**Improvement: Range of improvements made including**

- Pack is now available in bereavement room with fluid balance charts, MEWS.
- Clock is now in room.
- Scales have been ordered for sluice.

<table>
<tr><td colspan="4">
<ul>
<li>PPE unit has been ordered has arrived.</li>
<li>In house training for staff members – questionnaire sent to staff and to be returned by 28/02/2025 to ensure sessions are relevant.</li>
</ul>
</td></tr>
<tr><td>February 2025</td><td>50</td><td>1 Extreme (10826)<br>1 Major (10828)<br>5 Moderate(10787, 10795, 10813, 10822, 10834)</td><td>1</td></tr>
<tr><td colspan="4">Adverse event theme (10632) – Level 3 Review: Test Results: Reviewed by Advanced Practice Lead.<br>Incorrect patient ID label attached to sample pot. When the result was communicated to the health centre, they identified that this patient had not provided this type of specimen, highlighting that the incorrect patient label had been used. The correct patient contacted, asked to attend the health centre, explanation given and repeat sample obtained.<br>Learning identified:<ul><li>Staff member did not confirm patient details when sample request pot handed out.</li><li>The sample had good clinical detail which allowed identification of correct patient.</li><li>Once error identified both the laboratory and patient were contacted promptly to rectify situation.</li><li>Staff member reflected on their practice. Re-iterated the need to ensure patient details are confirmed.</li><li>Lessons Learnt shared across the wider Community Nursing Team.</li></ul></td></tr>
<tr><td>March 2025</td><td>74</td><td>0 Extreme<br>0 Major<br>9 Moderate (10848, 10851, 10856, 10860, 10870, 10896, 10908, 10909, 10911)</td><td>1</td></tr>
<tr><td colspan="4">Adverse event theme (10585) – Level 3 Review: Other: Reviewed by the Medical Records and Reception Manager.<br>A letter was not franked before being sent in the Royal Mail. The patient refused to accept the letter.<br>Learning identified:<ul><li>The patient did not miss their appointment.</li><li>Franking machine manufacturer was contacted to arrange a service.</li><li>Staff were reminded to check all letters have been franked before handing over to Royal Mail.</li><li>Gilbert Bain Reception records updated accordingly.</li><li>All team members are now aware of the need for regular equipment maintenance as per service contract.</li><li>Learning shared with the Reception/Medical Records Team.</li></ul></td></tr>
</table>

## Appendix D:
## Medical and Surgical Unit, Inpatient patient experience survey feedback results:

| Reporting period | CE01 - Overall, how would you rate your hospital experience? (Excellent/Good) | | CE02 - You received the care/support that you expected and needed (% of those that answered 'Yes') | |
|---|---|---|---|---|
| | Ward 1 NA-HC-03 | Ward 3 NA-HC-02 | Ward 1 NA-HC-06 | Ward 3 NA-HC-05 |
| Jan-25 | 95% | 100% | 100% | 100% |
| Feb-25 | 100% | 100% | 100% | 100% |
| Mar-25 | 100% | 100% | 100% | 100% |
| Apr-25 | | | | |
| May-25 | | | | |
| Jun-25 | | | | |
| Jul-25 | | | | |
| Aug-25 | | | | |
| Sep-25 | | | | |
| Oct-25 | | | | |
| Nov-25 | | | | |
| Dec-25 | | | | |
| **Average** | **98%** | **100%** | **100%** | **100%** |

| Ward 1 | | | | | | |
|---|---|---|---|---|---|---|
| **Person Centred Measure description** | **MD01 (NA-HC-16)** | **MD02 (NA-HC-19)** | **MD03 (NA-HC-22)** | **MD04 (NA-HC-25)** | **MD05 (NA-HC-28)** | **Number of responses** |
| | % of people who say that we took account of the things that were important to them.<br>Aim 90% | % of people who say that we took account of the people who were important to them and how much they wanted to be involved in care/treatment.<br>Aim 90% | % of people who say that they have all the information they needed to help them make decisions about their care/treatment.<br>Aim 90% | % of people who say that staff took account of their personal needs and preferences<br>Aim 90% | % of people who say they were involved as much as they wanted to be in communication/ transitions/ handovers about them<br>Aim 90% | |
| Jan-25 | 100% | 100% | 98% | 100% | 98% | **20** |
| Feb-25 | 100% | 100% | 97% | 94% | 94% | **9** |
| Mar-25 | 100% | 100% | 95% | 94% | 94% | **19** |
| Apr-25 | | | | | | |
| May-25 | | | | | | |
| Jun-25 | | | | | | |
| Jul-25 | | | | | | |
| Aug-25 | | | | | | |
| Sep-25 | | | | | | |
| Oct-25 | | | | | | |
| Nov-25 | | | | | | |
| Dec-25 | | | | | | |
| **Average for year** | **100%** | **100%** | **97%** | **95%** | **95%** | **48** |

| Ward 3 | | | | | | |
|---|---|---|---|---|---|---|
| **Person Centred Measure description** | **MD01 (NA-HC-15)** | **MD02 (NA-HC-18)** | **MD03 (NA-HC-21)** | **MD04 (NA-HC-24)** | **MD05 (NA-HC-27)** | **Number of responses** |
| | % of people who say that we took account of the things that were important to them. Aim 90% | % of people who say that we took account of the people who were important to them and how much they wanted to be involved in care/treatment. Aim 90% | % of people who say that they have all the information they needed to help them make decisions about their care/treatment. Aim 90% | % of people who say that staff took account of their personal needs and preferences Aim 90% | % of people who say they were involved as much as they wanted to be in communication/ transitions/ handovers about them Aim 90% | |
| Jan-24 | 100% | 100% | 100% | 100% | 100% | |
| Feb-24 | 100% | 100% | 100% | 100% | 100% | |
| Mar-24 | 100% | 100% | 100% | 100% | 100% | |
| Apr-24 | | | | | | |
| May-24 | | | | | | |
| Jun-24 | | | | | | |
| Jul-24 | | | | | | |
| Aug-24 | | | | | | |
| Sep-24 | | | | | | |
| Oct-24 | | | | | | |
| Nov-24 | | | | | | |
| Dec-24 | | | | | | |
| **Average for year** | **100%** | **100%** | **100%** | **100%** | **100%** | |

| WARD 1 INPATIENT SURVEY – PATIENT COMMENTS – Jan / 2025 |
| --- |
| My unexpected hospital stay was made more bearable because of the excellent care I received from all the staff/doctors/nurses involved in my care. Thank you to everyone. |
| Doctor talked over me, not giving me chance to explain details or ask questions - felt very dismissed. Discharged in the same pain I was in when admitted. With no offer for follow up to see what underlying cause may be |
| Every member of staff were amazing, very friendly and very helpful. Always checking up on me and making sure I was ok. |
| Went above and beyond. Washing clothes because from mainland. Couldn't be more helpful. |
| The level of care received had been outstanding. I was given full information of the start of every phase of my treatment, by all staff concerned. There was rarely, if ever, any conflicting information provided which assured clarity at all times. Given the resource demands currently affecting the NHS, the standard of care has been tremendous, with respect and dignity shown, a major component of my experience. Thank you, sincerely, thank you. |
| I observed during my short stay in Ward 1 that all staff went beyond their duties to do their very best for all their patients. I appreciated the care and attention I received and observed that all patients were given the same. Thanks to all. |
| Excellent care and attention at all times, been admitted twice in 3 weeks, thank you to all staff. |
| Was looked after very well. Much better treatment than I would have received if I was in a hospital at home. Thank you very much. |
| All hospital staff worked well together and made you feel at ease and feel you were being looked after by professionals. |
| Staff brilliant, food lovely, no complaints! |
| I can't fault the service given while in hospital. The staff were all excellent and attended all my needs. |
| All GBH staff have been brilliant, both in theatre and Ward 1. We are so lucky in Shetland. |
| The nursing team were fantastic - they are a credit to the service. Nursing staff and doctors made sure I was aware of what was being done around my treatment. Thank you. |
| Staff were exceptional. |
| I had excellent care by all the staff - thank you! |

| WARD 3 INPATIENT SURVEY - PATIENT COMMENTS – Jan / 2025 |
| --- |
| Staff were excellent in every way. |
| Staff have been excellent - caring for patients & family. Staff well lead and worked well as a team. Most difficult area was 16 week wait for bed in community!!. |
| Thanks |

| WARD 1 INPATIENT SURVEY – PATIENT COMMENTS – Feb / 2025 |
| --- |
| The nurses did a great job looking after me |
| Overall treatment good. Especially my care workers were excellent. Just need more of them as they are an asset in helping the nurses. Could do with more on nights. |

| WARD 3 INPATIENT SURVEY - PATIENT COMMENTS – Feb / 2025 |
| --- |
| Very impressed with all the care. |
| Thank you all for taking great care of me. |
| Canna fault any o them, saved me life |

| WARD 1 INPATIENT SURVEY – PATIENT COMMENTS – Mar / 2025 |
| --- |
| My nurse was amazing - as were all the staff that looked after me. Thank you! |
| Need a hand rail in room 10 toilet.<br><br>Having been really poorly you don't always remember everything or have it correct in your head, it would have been nice to have had a small chat from someone after my cancelled procedure to explain that my consultant was a locum and to advise who was now in charge of my care. Also things such as 'this is how this works' 'this is the person to speak with should you have any concerns your forthcoming discharge' instead of someone to say 'you will be going home tomorrow' as that came as a shock. Maybe that's a task that could be performed with the help of the ward volunteers as staff are very busy. |
| Thank you! |
| Very difficult to find a time to sleep during the day if you had no sleep at night. |
| The only thing I was unhappy with is I had to spend an extra night in hospital when my antibiotics finished at lunchtime so could have gone home. I was told right from the start I would get patient transport home and was told yesterday that we couldn't get it. |
| Amazing staff who are very hard working and under paid. Thanks for everything! |
| Some of the nurses went way above the call of duty. |
| Thanks to all the staff. |
| The issues lie with Fife NHS. The staff here struggling as they did not have all my old records. This hospital was great, thanks. |
| Staff are amazing as they are working under such pressure. Not enough nurses to spread the load. Our government needs to invest in the NHS. My nurses are top marks. |
| Could do with a TV. |

| WARD 3 INPATIENT SURVEY - PATIENT COMMENTS – Mar / 2025 |
| --- |
| Staff were excellent in every way. |
| Staff have been excellent - caring for patients & family. Staff well lead and worked well as a team. Most difficult area was 16 week wait for bed in community!!. |
| Thanks |

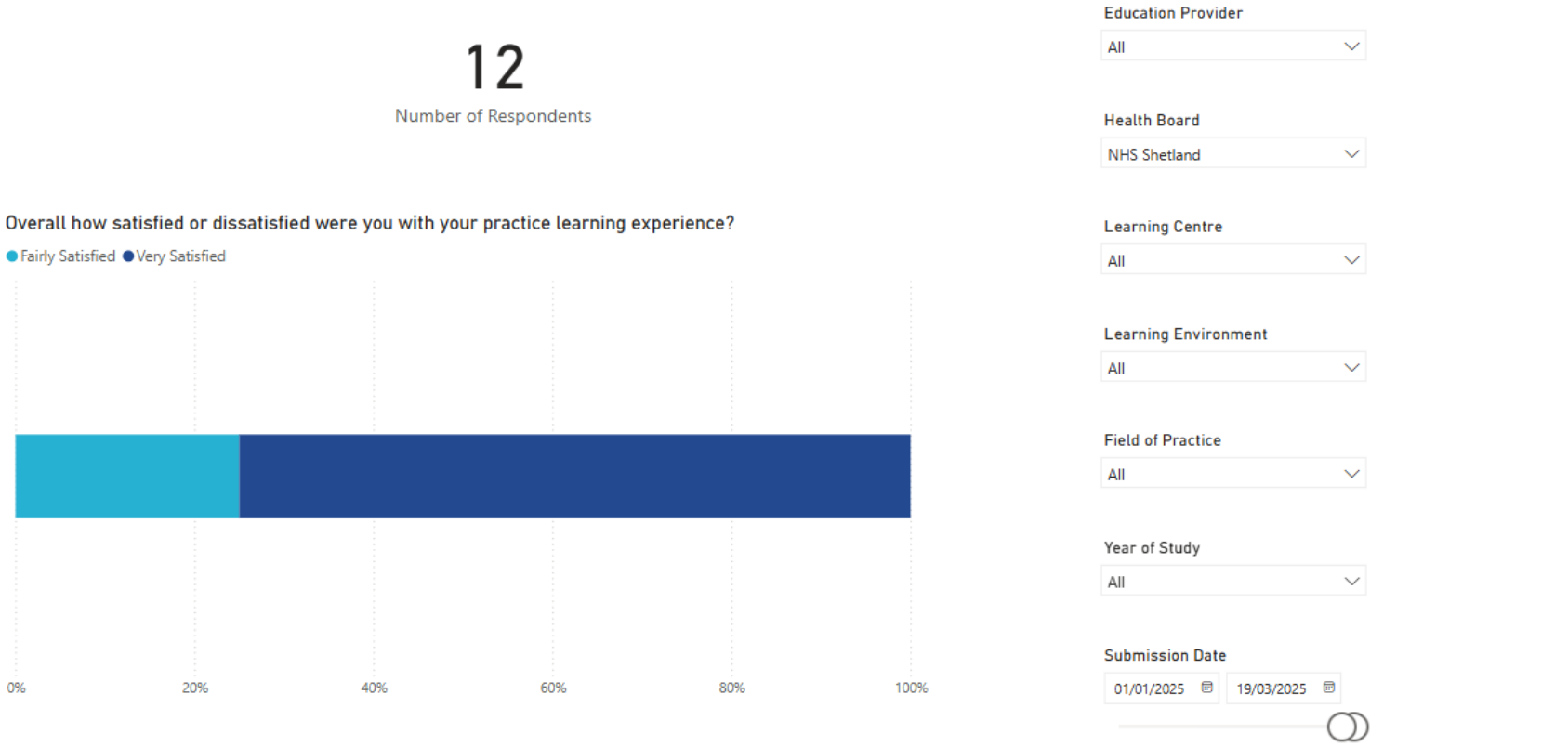
**Q4 NHS Shetland Care Opinion Feedback:**

| Area | Feedback | Response |
|---|---|---|
| GBH Gynaecology | I had to get an ultrasound, there was a problem with my period and I got the ultrasound and when I got there the ultrasound nurse suggested they might have to do an internal exam and I immediately started to shake and get scared. I was trying not to cry but I also needed to know what was going on and reluctantly I agreed to do it but the nurse, I think could tell there was something wrong and I eventually admitted it, I felt ashamed and guilty but she went above and beyond for me, finding out a way we could find out and diagnose my PCOS without the internal exam and I can't ever forget how comfortable she made me.<br><br>She made me feel like I wasn't a freak or a victim and did it all on a friendly and professional way. I can't thank her enough for how she made me feel. I hope she knows what a difference nurses like her make people's lives. | Thank you for taking the time to post your kind comments about your recent ultrasound experience. We are glad to hear that staff member was able to make you comfortable with her friendly and professional approach to your care.<br><br>It is always good for us to receive feedback and is very much appreciated by our staff. We have shared the post with the team. |
| General Practice in Shetland | My island games training was interrupted with knee pain. I couldn't run or cycle and I was quite doom and gloom about it all.<br><br>Scalloway First Contact Physio was very helpful and knowledgeable, she got my confidence back and I will be able to train again soon. It all happened in only 4 weeks.<br><br>Thank you so much. | Thank you for taking the time to post your kind comments about attending First Contact Physio in. We are glad to hear that you have got your confidence back and hope your training for the Island Games goes well.<br><br>It is always good for us to receive feedback and is very much appreciated by our staff. We have shared the post with the team. |

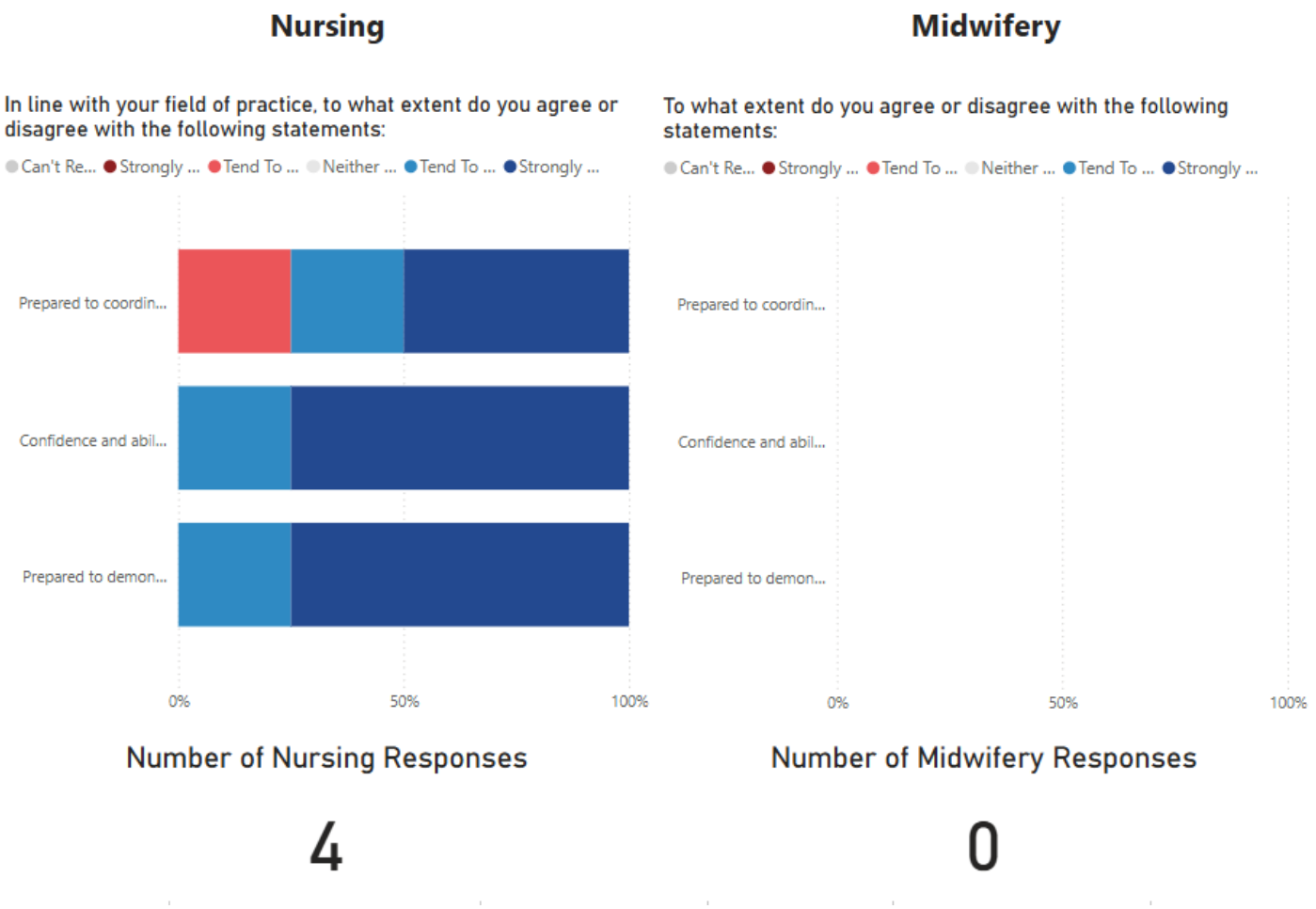
| | | |
|---|---|---|
| Shetland Community Services | I had my annual flu vaccination at the new vaccination centre in Lerwick - I had to take my little boy and Julie was so lovely and accommodating and he felt very welcome.<br><br>Whole experience was quick, easy and supportive, with helpful and welcoming receptionist too. | Thank you for taking the time to post your kind comments about attending the new vaccination centre in Lerwick where you were seen by Julie, and for sharing how it was such a positive experience for you and your young son. It is always good for us to receive feedback and is very much appreciated by our staff. We have shared the post with the team. |

**Appendix E: Quality Management of the Practice Learning Environment (QMPLE)**
**Q4 January - March 2025**
**Overall Satisfaction:**

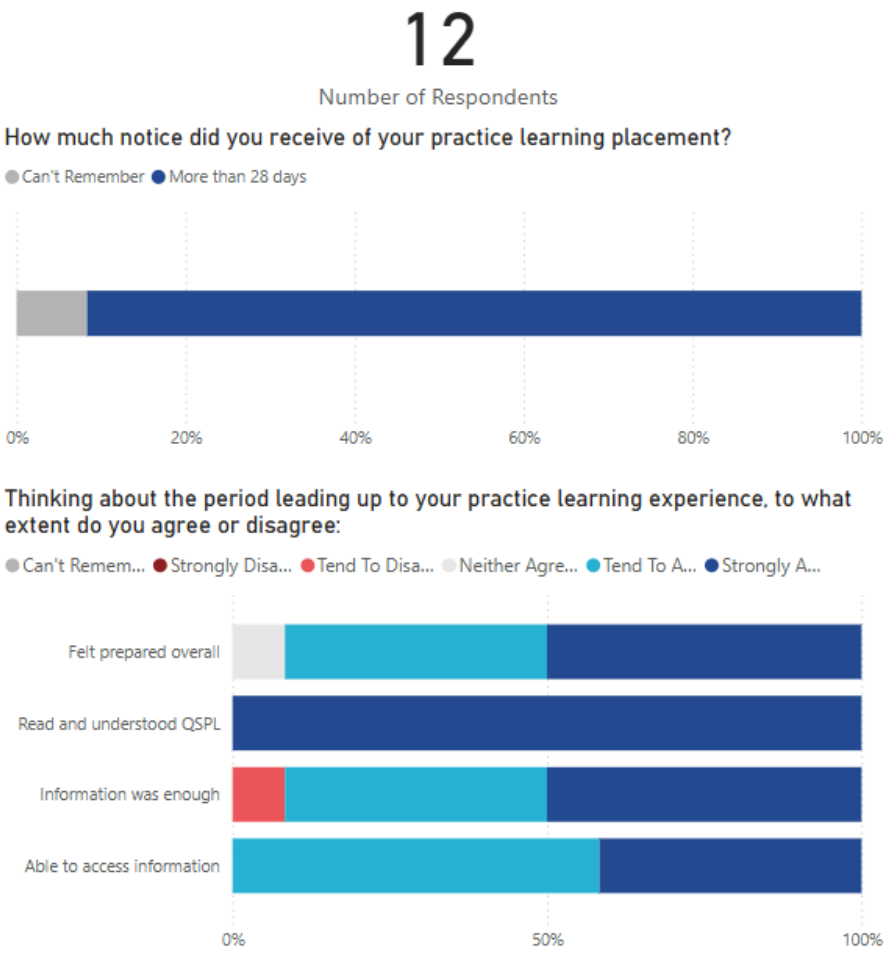
**Student Feedback Overview:**

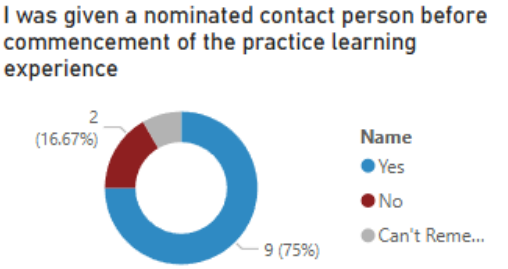


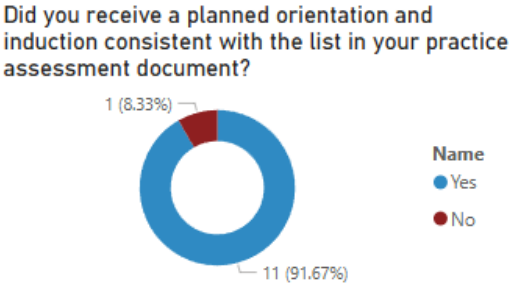
**Performance Management:**

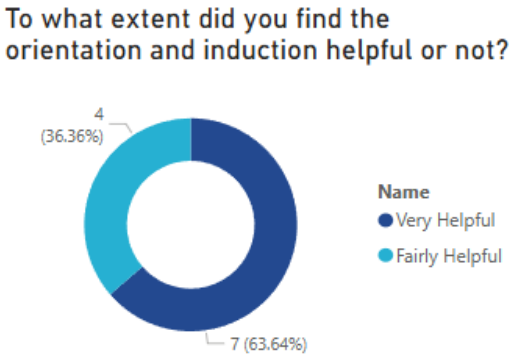


**Preparation for Practice Learning:**

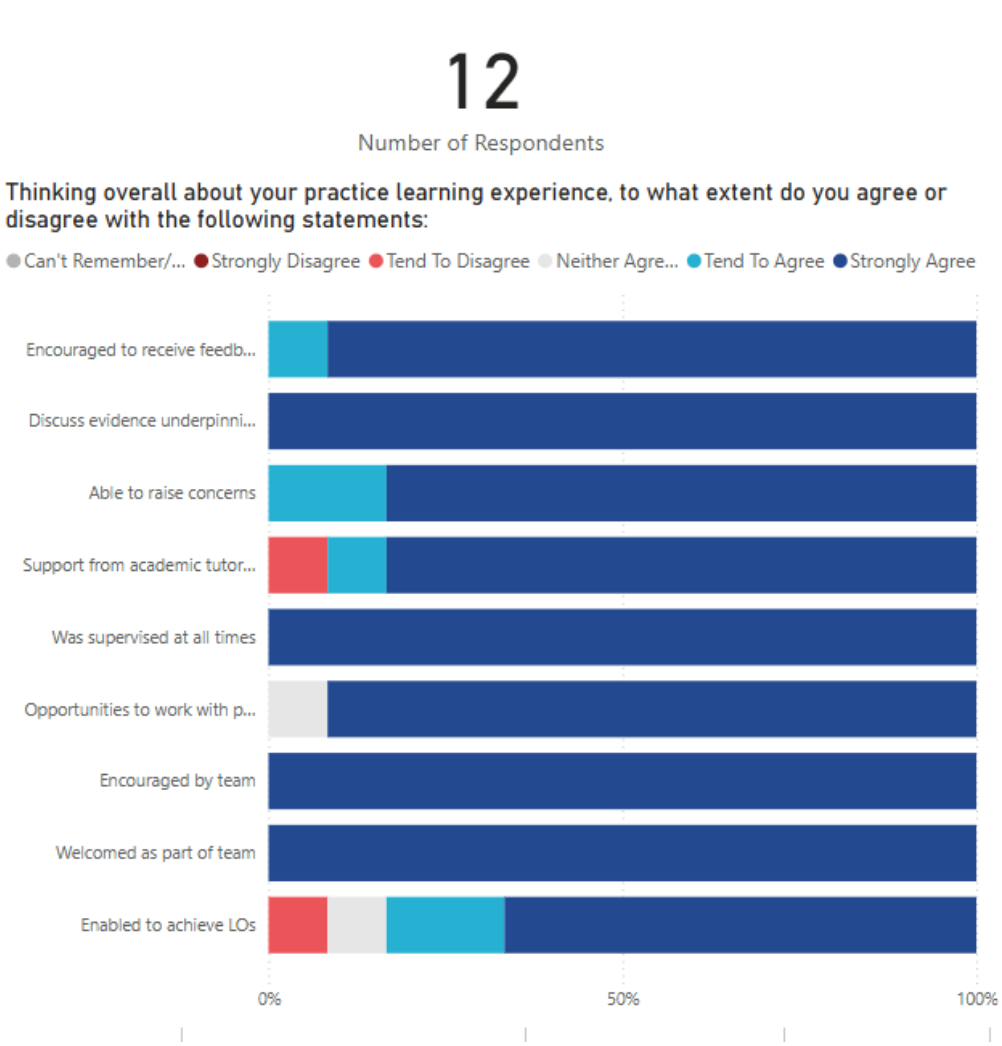


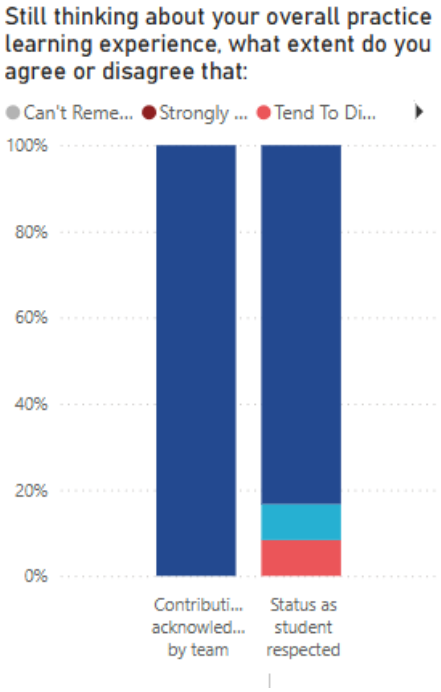



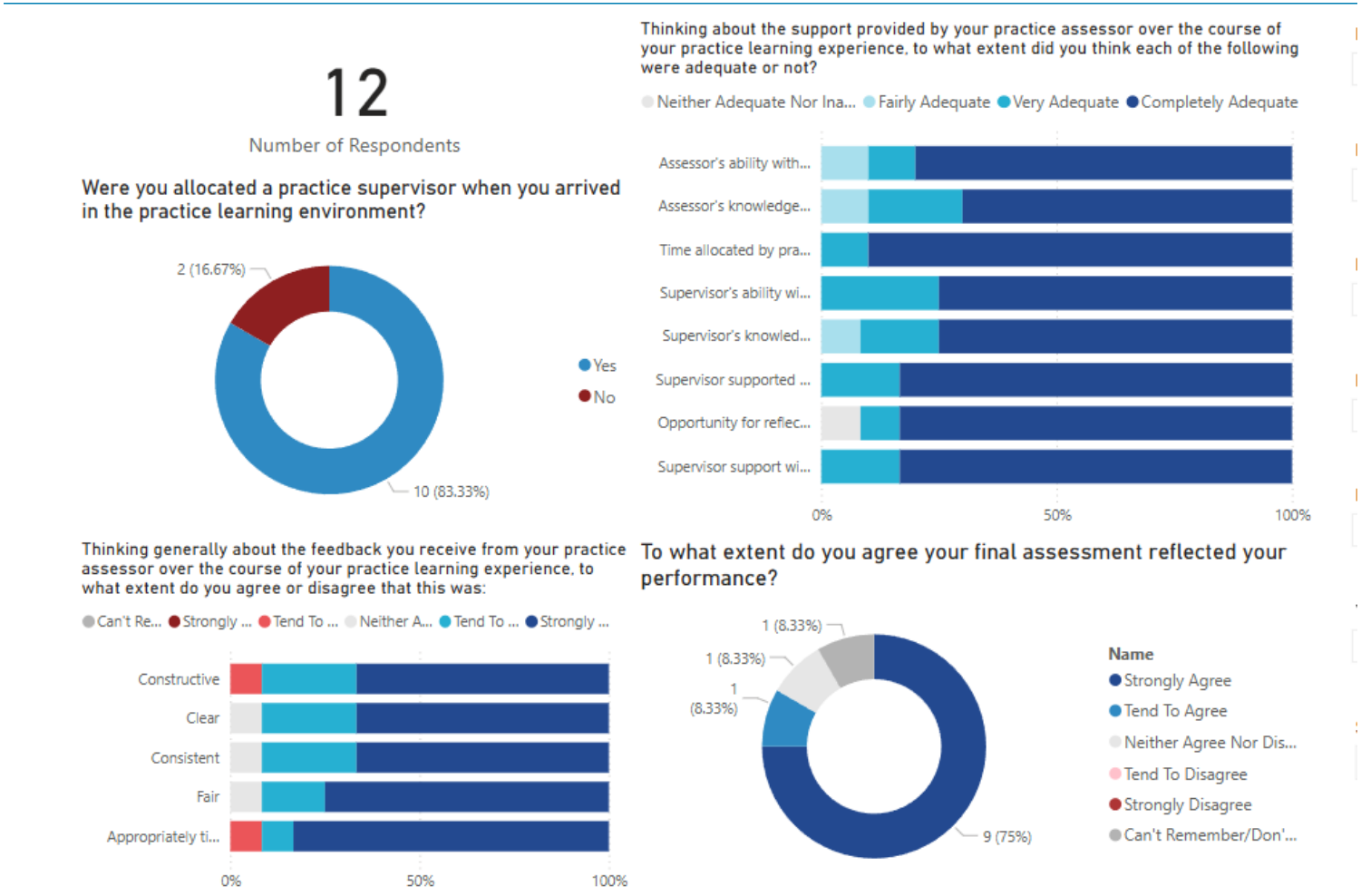
**Learning Environment:**



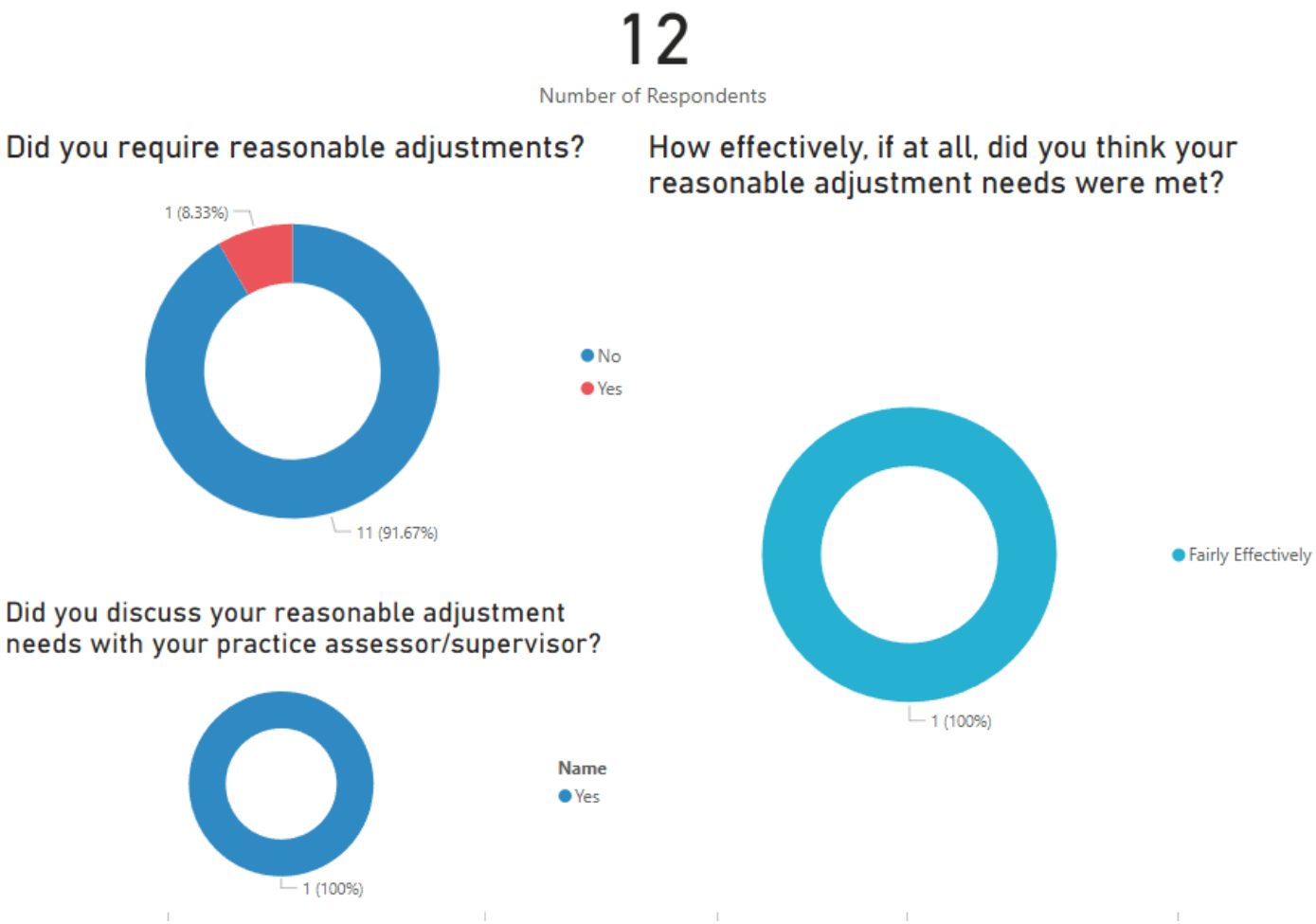




**Practice support:**



**Additional Support Needs:**



**Student feedback Overview –particularly good:**

12

Number of Respondents


**Search all responses...**

Search

| Response | Learning Environment | Learning Centre |
|---|---|---|
| I have been given a lot of chances to practice my practical skills and work on my note taking technique. I have had lots of experience with diabetic patients and insulin support.<br><br>Lots of catheter care including flushes and full catheter changes.<br><br>They have also supported me in attending any additional learning opportunities that are available. | Brae Community | Shetland Community |
| The staff have been amazing and really helping my confidence to grow. They have been so patient with me and really got me involved while working to within my limitations. I've had some great spoke days and opportunities to work in different parts of the health service. | Brae Community | Shetland Community |
| I found the whole experience of day surgery to be a fantastic one, with being first ever placement and time in a health care workplace it was the perfect way to bed you in slowly and have the ability to learn the fundamentals of being a nurse. That along with being involved with excellent staff and with being in Shetland having more opportunity for spokes and person centred care i found the whole time there one of great value and experience. | Day Surgery Unit | Gilbert Bain Hospital |
| There were a good range of learning opportunities which meant there was the opportunity to practice a good range of skills. The staff were excellent role models and made me feel comfortable and included. | Day Surgery Unit | Gilbert Bain Hospital |

| | | |
|---|---|---|
| All of the nurses and HCAs are great teachers. They were all very patient with me and ensured that I understood what they were talking about before we moved onto the next task. The team were also good at finding a balance between pushing me out of my comfort zone, but also making sure I wasn't too uncomfortable at the same time. They have been very welcoming and I feel I settled quickly into my placement because of that. I am also very grateful that they encouraged me to gain experience in other departments, as well as their own. | Lerwick Community | Shetland Community |
| All staff were helpful and supportive in allowing me to meet my objectives | Maternity ward | Gilbert Bain Hospital |
| The staff at Shetland Maternity were really friendly and encouraging. They had a range of learning opportunities and skills not only out on community but also on the ward, they also offered inter-proffesional experiences. I had a really benifical placement here that I thouroghly enjoyed. | Maternity ward | Gilbert Bain Hospital |
| I was given so many opportunities to improve on my skills and learn new procedures. I was very supported throughout my whole placement. | Scalloway Health Centre | Shetland Community |
| Everyone was extremely welcoming and it made me feel comfortable to ask any question in regards to my learning | Specialist Nurses | Gilbert Bain Hospital |
| The care provided to all patients from the staff in ward one was of a high standard. The staff were all willing to answer my questions and I felt supported in learning new skills. I was welcomed and felt valued as a<br>member of their team. | Ward 1 and HDU | Gilbert Bain Hospital |
| The diverse range of learning opportunities and spokes available. Staff are really nice and helpful and supportive. | Ward 3 | Gilbert Bain Hospital |
| The staff were all very friendly. I was able to gain a good understanding of rural healthcare. Due to the size of the hospital there was a range of different age groups and conditions in the ward making it a more fulfilling placement. My mentor was very helpful in taking me around her day with her on the ward and letting me getting involved where I could. Anyone was happy to answer any questions I had. I feel I have gained confidence and knowledge from this placement. | Ward 3 | Gilbert Bain Hospital |

**Student feedback – improved experience:**

12

Number of Respondents


| Response | Learning Environment | Learning Centre |
|---|---|---|
| Having more staff. Although the staff have been amazing in supporting me on this placement. It is not fair on students or the staff when they are working with such reduced numbers to be taking on a student especially considering the journey it takes to get to the placement area. | Brae Community | Shetland Community |
| Not to much just slightly difficult with one full time member of staff and only one other that is part time | Brae Community | Shetland Community |
| Having had a few days to reflect, I think that it would have been better if the PA or PS had identified the skills that were available during the practice learning experience but which were not signed off at the mid-point because they seemed difficult for me to do such as cannulation and infusion pumps so we had all been MUCH MORE focused on finding ways of ensuring I achieved them, rather than just doing them - I hope that makes sense. | Day Surgery Unit | Gilbert Bain Hospital |
| The only thing that day surgery might not provide is enough opportunity to get proveniences and skills ticked off as much as other places. | Day Surgery Unit | Gilbert Bain Hospital |

| | | |
|---|---|---|
| As much as I felt welcome when I arrived, it was really daunting coming up to Shetland as I knew very little about my placement. I had tried to make contact numerous times, to numerous people, in various forms, before I arrived. It was only the week prior to my arrival that I managed to get in contact with the team, and the nurse who answered the call didn't actually know I was coming to them. I know this might not have been their fault - but there was some lack of communication somewhere which was disappointing. A lot of the staff members and their contacts that were listed weren't even part of the team anymore. It just felt as though the team weren't ready to have a student. I think the welcome pack on QMPLE needs to be updated as there was lots of staffing changes just before I started, this would probably solve the issue.<br><br>The working environment could sometimes be very toxic. Multiple nurses would slag off other nurses to me about each other and would complain about each others clinical decisions. I don't mind letting people vent to me, and to be honest I have probably vented to some of the nurses as well if I haven't been happy in situations. But I think there was a huge lack of professionalism in that aspect, especially with the senior and managerial nurses. Some days it could be a very draining environment, but I know the nurses are just extremely overworked due to understaffing. I just believe that it doesn't take much to hold back on your feelings, especially with a student who isn't a permanent member of the team. | Lerwick Community | Shetland Community |
| Nothing. Everything was great. | Maternity ward | Gilbert Bain Hospital |
| Nothing I can think of, I feel everything in this placement was very good. | Scalloway Health Centre | Shetland Community |
| Absolutely nothing | Specialist Nurses | Gilbert Bain Hospital |
| I did not get the opportunity to see much HDU care but this couldn't be helped as there was no patients requiring this level of care whilst I was on shift. | Ward 1 and HDU | Gilbert Bain Hospital |
| unsure. | Ward 3 | Gilbert Bain Hospital |

**Additional Comments:**

12

Number of Respondents


**Search all responses...**

Search

| Response | Learning Environment | Learning Centre |
|---|---|---|
| I have really enjoyed this placement. The staff in the community team and within the GP practice have been so welcoming and accommodating. I feel very lucky to have had this experience as my first placement. | Brae Community | Shetland Community |
| Really really enjoyed this placement. I really feel part of the team here | Brae Community | Shetland Community |
| Very well run place the day surgery at Gilbert Bain hospital. | Day Surgery Unit | Gilbert Bain Hospital |
| I am very thankful for all the opportunities I have been given, I feel more confident with my skill and procedures and just communication with patients in general. This placement has set me up well for being able to build on my skills for my next placement. | Scalloway Health Centre | Shetland Community |
| This placement helped me gain a better understanding from what I had learnt about conditions such as heart failure, diabetes, cancer and stroke | Specialist Nurses | Gilbert Bain Hospital |
| I have had an enjoyable experience in Ward One and have been well supported throughout. The feedback I have received has been helpful and I have reflected and developed my learning going forward. | Ward 1 and HDU | Gilbert Bain Hospital |
| Thank you so much. | Ward 3 | Gilbert Bain Hospital |

**NHS Shetland Feedback Monitoring Report 2024_25 Quarter 4**

All NHS Boards in Scotland are required to monitor patient feedback and to receive and consider performance information against a suite of high level indicators as determined by the Scottish Public Services Ombudsman (SPSO). A standardised reporting template regarding the key performance indicators has been agreed with complaints officers and the Scottish Government. This report outlines NHS Shetland's performance against these indicators for the period January to March 2025 (Quarter 4).

Further detail, including the actions taken as a result of each Stage 2 complaint from 1 April 2024 is provided (this allows an overview of types of complaints in year and also for any open complaints at the point of reporting to be completed in a subsequent iteration of the report). All Stage 2 complaint learning from 2023/24 is included in the Feedback and Complaints Annual Report: https://www.nhsshetland.scot/downloads/file/1780/24-25-28-annual-feedback-and-complaints-report-2023-24

A summary of cases taken to the Scottish Public Services Ombudsman from April 2021 onwards is included at the end of this report, allowing oversight of the number and progress of these and also the compliance with any learning outcomes that are recommended following SPSO investigation.

In liaison with the clinical directors who handle the investigation of the majority of complaints received, the Feedback and Complaints team is considering ways in which assurance can be provided to the meeting regarding whether actions have been concluded and the sharing of organisational learning. Since January there is now a new member of the Feedback and Complaints team which is increasing resilience in the service, and director time is being sought to refresh the focus on this important area of work.

Summary

- Corporate Services recorded 60 pieces of feedback in Quarter 4 of 2024/25 (1 January 2025 – 31 March 2025). For clarity these figures include all salaried GP practices (note this is 9 of 10 practices in Shetland for the purposes of Quarter 4 reporting):

| | 01.01.25 – 31.03.25 | | 01.10.24 – 31.12.24 (previous quarter) | |
|---|---|---|---|---|
| **Feedback Type** | **Number** | **%** | **Number** | **%** |
| Compliments | 5 | 8.3 | 8 | 12.9 |
| Concerns | 29 | 48.3 | 28 | 45.2 |
| Complaints | 26 | 43.4 | 26 | 41.9 |
| **Totals:** | **60** | | **62** | |

- The Stage 1 and Stage 2 complaints received related to the following directorates:

| | 01.01.25 – 31.03.25 | | 01.10.24 – 31.12.24 (previous quarter) | |
|---|---|---|---|---|
| **Service** | **Number** | **%** | **Number** | **%** |
| Directorate of Acute and Specialist Services | 10 | 38.5 | 9 | 34.6 |
| Directorate of CH&SC | 12 | 46.2 | 11 | 42.3 |
| Acute and community | 3 | 11.5 | 1 | 3.8 |
| Other (e.g. PH, Patient Travel) | 1 | 3.8 | 5 | 19.3 |
| **Totals:** | **26** | | **26** | |

## Key highlights

- There is now additional capacity in the Feedback and Complaints Service with the recent addition of an Assistant Feedback and Complaints Officer. Induction and training is continuing.
- Performance regarding length of time to respond to Stage 1 complaints has marginally decreased from the last quarter. Responding to Stage 2 complaints within 20 working days remains challenging, with only one Stage 2 complaint meeting the target. The average response time of closed Stage 2 complaints has decreased, but a number still remain open at the point of writing.

  Stage 2 complaints are often complex and some require input from other Boards and partner organisations which can further elongate the response time. There is also a capacity issue with complaint investigators. Consideration is being given to sourcing investigation training for a wider group of staff in support of handling adverse events, HR and complaint investigations.
- Complaint returns from Family Health Service providers are being sought on an annual basis and for those areas that do submit returns the numbers of complaints recorded are low. This will continue to be picked up as a reporting requirement through professional leads.
- A new case was submitted to SPSO in the time period, with the outcome noted.
- The one litigation case previously reported regarding a delayed diagnosis remains in an early stage of information gathering.

## Complaints Performance

**Definitions**:
**Stage One** – complaints closed at Stage One Frontline Resolution;
**Stage Two (direct)** – complaints that by-passed Stage One and went directly to Stage Two Investigation (e.g. complex complaints);
**Stage Two Escalated** – complaints which were dealt with at Stage One and were subsequently escalated to Stage Two investigation (e.g. because the complainant remained dissatisfied)

**1 Complaints closed *(responded to)* at Stage One and Stage Two as a percentage of all complaints closed.**

| Description | 01.01.25 – 31.03.25 | 01.10.24 – 31.12.24 (previous quarter) |
|---|---|---|
| Number of complaints closed at Stage One as % of all complaints | 73% (16 of 22*) | 68% (17 of 25) |
| Number of complaints closed at Stage Two as % of all complaints | 23% (5 of 22) | 16% (4 of 25) |
| Number of complaints closed at Stage Two after escalation as % of all complaints | 4% (1 of 22) | 16% (4 of 25) |

***Four Stage 2 complaints remain open at the time of report writing and are therefore not included in the figures**

**2 The number of complaints upheld/partially upheld/not upheld at each stage as a percentage of complaints closed *(responded to)* in full at each stage.**

**Upheld**

| Description | 01.01.25 – 31.03.25 | 01.10.24 – 31.12.24 (previous quarter) |
|---|---|---|
| Number of complaints upheld at Stage One as % of all complaints closed at Stage One | 43.75% (7 of 16) | 53% (9 of 17) |
| Number complaints upheld at Stage Two as % of complaints closed at Stage Two | 20% (1 of 5) | 0% (0 of 4) |
| Number escalated complaints upheld at Stage Two as % of escalated complaints closed at Stage Two | 0% (0 of 1) | 25% (1 of 4) |

**Partially Upheld**

| Description | 01.01.25 – 31.03.25 | 01.10.24 – 31.12.24 (previous quarter) |
|---|---|---|
| Number of complaints partially upheld at Stage One as % of complaints closed at Stage One | 43.75% (7 of 16) | 23.5% (4 of 17) |
| Number complaints partially upheld at Stage Two as % of complaints closed at Stage Two | 60% (3 of 5) | 100% (4 of 4) |
| Number escalated complaints partially upheld at Stage Two as % of escalated complaints closed at Stage Two | 0% (0 of 1) | 50% (2 of 4) |

**Not Upheld**

| Description | 01.01.25 – 31.03.25 | 01.10.24 – 31.12.24 (previous quarter) |
|---|---|---|
| Number complaints not upheld at Stage One as % of complaints closed at Stage One | 12.5% (2 of 16) | 23.5% (4 of 17) |
| Number complaints not upheld at Stage Two as % of complaints closed at Stage Two | 20% (1 of 5) | 0% (0 of 4) |
| Number escalated complaints not upheld at Stage Two as % of escalated complaints closed at Stage Two | 100% (1 of 1) | 25% (1 of 4) |

| 3 The average time in working days for a full response to complaints at each stage | | | |
|---|---|---|---|
| **Description** | **01.01.25 – 31.03.25** | **01.10.24 – 31.12.24 (previous quarter)** | **Target** |
| Average time in working days to respond to complaints at Stage One | 6.25 | 5.3 | 5 wkg days |
| Average time in working days to respond to complaints at Stage Two | 29.6 | 49.3 | 20 wkg days |
| Average time in working days to respond to complaints after escalation | 30 | 43.5 | 20 wkg days |

| 4 The number and percentage of complaints at each stage which were closed *(responded to)* in full within the set timescales of 5 and 20 working days | | | |
|---|---|---|---|
| **Description** | **01.01.25 – 31.03.25** | **01.10.24 – 31.12.24 (previous quarter)** | **Target** |
| Number complaints closed at Stage One within 5 working days as % of Stage One complaints | 56.25% (9 of 16) | 47% (8 of 17) | 80% |
| Number complaints closed at Stage Two within 20 working days as % of Stage Two complaints | 20% (1 of 5) | 0% (0 of 4) | 80% |
| Number escalated complaints closed within 20 working days as % of escalated Stage Two complaints | 0% (0 of 1) | 25% (1 of 4) | 80% |

| 5 The number and percentage of complaints at each stage where an extension to the 5 or 20 working day timeline has been authorised. | | |
|---|---|---|
| **Description** | **01.01.25 – 31.03.25** | **01.10.24 – 31.12.24 (previous quarter)** |
| % of complaints at Stage One where extension was authorised | 43.75% | 53% |
| % of complaints at Stage Two where extension was authorised | 80% | 100% |
| % of escalated complaints where extension was authorised | 100% | 75% |

## Staff Awareness and Training

The Feedback and Complaints Officer is available to speak to individuals or departments to try and empower more people to feel confident to handle a Stage 1 complaint or signpost effectively to the appropriate support, or to handle a complaint investigation at Stage 2.

There is a renewed organisational push on mandatory training (for which there is a Feedback and Complaints eLearning module). A more detailed management bundle on feedback and complaints has been developed for delivery by the Feedback and Complaints Officer as required – in Quarter 3 this was delivered to senior managers across two areas. It is intended to offer some quarterly drop in complaints sessions for staff which can be tailored to their needs.

Staff are able to access excellent national e-learning resources regarding feedback and complaint handling, including investigation skills, through TURAS Learn.

Stage 2 complaints received 1 April 2024 to 31 March 2024

| | Summary | Staff Group(s) | <= 20 wkg days | If not, why | Outcome | Findings/Actions |
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| 1 | Care and staff attitude | Maternity | N | Delay with investigation | Partly upheld | • Apology given that communication could have been better<br>• All clinics now in the system and reviewed weekly so absences will be identified and appointments covered<br>• A commitment made to timely communication when home visits are not possible<br>• Sensitive information to be on the system as an alert rather than through a long narrative in clinical notes |
| 2 | Delay in diagnosis/treatment | GP | N | Delay with investigation | Upheld | • Full apology given<br>• Radiologist request for follow up missed two years prior. Duty of Candour triggered as complainant has had pain for the intervening time period which is likely associated |
| 3 | Lack of support and unwanted outcome | Mental health | N | Delay with investigation | Partly upheld | • Actions taken were found to be appropriate, however communication could have been better, for which an apology was given |
| 4 | Failure to diagnose/staff attitude | A&E | Y | | Partly upheld | • Treatment found to be appropriate at the time, however apology given for perceived attitude and communication issues |
| 5 | Assessment outcome | Mental health | N | Delay due to annual leave | Partly upheld | • The assessment was found to be carried out professionally in a comprehensive and appropriate manner and in line with SIGN Guidelines. Complainant however entitled to a second opinion, which had already been considered as a viable option at the time of the assessment but not yet followed up. This will be organised with Consultant Psychiatrist in Shetland. |

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| 6 | Delay to diagnosis and treatment | A&E | N | Complex investigation | Partly upheld | • Every clinician involved in care had acted appropriately and with the patient's best interests in mind. There was no evidence the patient had not received the correct treatment for each stage of their illness, as was presented to the staff examining them.<br>• Apologies offered for the way the family had felt and clinicians involved asked to reflect on the experience reported. |
| 7 | Staff attitude | GP | N | Delay due to annual leave | Upheld | • Clinician has reflected on the consultations and events that took place during calls and apologised for the distress caused. Both parties realised the consultations did not go as well as would have been desired.<br>• Medical record amended. |
| 8 | Lack of treatment and care | Acute/medical | N | Delay due to annual leave | Not upheld | • No evidence that the diagnosis was overlooked, that there was a misdiagnosis or a lack of investigation. However, clinicians are generalist and therefore will arrange a notes review from specialist Consultant. |
| 9 | Equipment and adaptation delays | AHP | N | Complex investigation | Upheld | • Poor communication and uncertainty about who to make contact with in the team.<br>• Poor record keeping of actions and what had been reviewed.<br>• Request for clear communication to explain closing an episode of care, to confirm the plan and who would be responsible. |
| 10 | Unacceptable delays in treatment | Dental | N | Delay due to annual leave | Part upheld | • Much of the delay and problems were unavoidable, given the restrictions on the service and the specific challenges of the care provided. Acknowledged the impact on the patient's health and wellbeing.<br>• Apologies given that communication was not strong enough, especially in relation to the treatment provided, the referrals and the impact on the timeframe of care. |

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| 11 | Inappropriate sharing of information | Mental Health | N | Annual leave and capacity issues | Not upheld | • Apologies offered for misunderstanding of the term MDT (multi-disciplinary team meeting). No evidence found that information had been shared wider than was appropriate. |
| 12 | Not initially admitted despite acute pain | A&E | N | Annual leave and capacity issues | Part upheld | • Medical team trying their best to determine the cause of pain, however had the treatment plan been referred to earlier a short stay on the ward for analgesia and physio rather than a prolonged stay in A&E might have been preferable.<br>• Apology offered that complainant felt they were not being listened to. |
| 13 | Poor communication between GP and A&E, lack of care for family member, staff attitude | A&E | N | Capacity issues of investigating manager and investigation contributors | Upheld | • Initial assessment was likely due to test results but second visit concluded that a scan would have been helpful as treatment may have started sooner.<br>• Apologues offered for this, and for the miscommunication and poor communication experienced when discharged. Proper planning and support should have been provided.<br>• Planned this year to organise a multi-professional training session to focus on raising awareness of trauma in older people |
| 14 | Treatment and poor communication | Medical | N | Meeting arranged with complaint investigator and key clinician | Part upheld | • Apologies offered for poor communication<br>• Arranged further diagnostic test and commitment to maintain consistent contact with patient |
| 15 | Medication regime | Mental Health | Y | | Not upheld | • Explanation for why a request had been declined<br>• Service offered to meet complainant and explain |
| 16 | Treatment and staff attitude | A&E/Medical | N | Capacity of investigating manager | Part upheld | • No shortcomings found in assessment followed<br>• Sincere apology offered for poor communication – member of staff to reflect on the feedback during the appraisal process |

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| 17 | Lack of treatment and communication | Medical | N | Capacity of investigating manager | Part upheld | • No evidence found to suggest local medical team had delayed ARI surgery, which had been considered earlier but there were other health concerns.<br>• Agreed that communication between patient and two Boards could have been better and apologised patient felt left in the dark and unsure when to seek medical advice as no worsening advice had been offered |
| 18 | Delay in treatment and poor communication | Medical | N | Response delayed by staff in sign off process | Upheld | • Noted there was a need to consider another source of infection in children with fever and mild respiratory symptoms. Further teaching put in place.<br>• Failure in process identified as paper copy of results not received. Training to be provided |
| 19 | Treatment and staff attitude | Medical | N | Capacity of investigating manager | Part upheld | • Apologies given for the way the family member was treated and for the poor communication.<br>• Agreed to follow up with update when more information known |
| 20 | Failure to follow process/incorrect treatment | Primary Care | N | Additional time required by investigating manager | Part upheld | • Escalated from S1 response as the action committed to had not been followed.<br>• Apology given that some admin staff had not been made aware of the necessary actions following the S1 complaint<br>• Follow up training session organised for the team |
| 21 | Home adaptations not in place one year on | Community | N | Repeat holding letters sent | Fully upheld | • Communication issues identified, and a lack of clear process.<br>• Records not complete so reassessment required.<br>• Sincere apologies for the investigation delays and the matter still not resolved – a commitment to work with SIC to progress. |
| 22 | Unacceptable communication regarding travel for treatment | Finance | N | Internal verification process | Part upheld | • Explained local policy currently more flexible than any other NHS Board, and meets with SG criteria. Shared information to be documented separately and patient asked to notify in advance of any health conditions to be mindful of |

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| | | | | | | • Policy due for review with public engagement<br>• Review of care plan advised |
| 23 | Feels symptoms are being ignored and not seen holistically, pain not under control | Medical | Y | | Fully upheld | • Admin error meant appointment had been sent to NHS Grampian by mistake<br>• Diagnostic report delayed but consultant to follow up<br>• Pain medication amended in the meantime |
| 24 | Feels support is lacking for friend needing services | Mental Health | N | Internal verification process | Part upheld | • Evidence of significant number of contacts/appointments with acknowledgment they had not always felt helpful/been attended<br>• New CPN to be allocated following review with Consultant Psychiatrist<br>• Care plan to be completed with patient and CPN |
| 25 | Failure to perform a diagnostic test, lack of basic nursing care and unsafe discharge | Acute/medical | N | Complex and has needed additional information after drafting response | Open | |
| 26 | Misdiagnosis of injury and then lengthy delays waiting for scans. Issue with referral | Acute | N | More time required | Part upheld | • Explanation provided as to why the scan was done locally, treatment management given and reasons as to why there were delays to certain processes<br>• Consultant/patient recollection of discussions not consistent<br>• Apology given for delay in scan time as service transitioned |
| 27 | Staff attitude toward patient – lacking understanding of dementia, felt staff cared more about having an empty bed, delay in death certificate | Acute/medical | N | More time required | | |
| 28 | Behaviour of nursing staff on ward | Acute nursing | N | | Not upheld | • Toaster bags to be purchased and more information about specific food intolerances to be made available<br>• Perspective of staff member very much at odds but no previous concerns raised regarding this individual. Difficult to resolve without a witness to interactions |

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| 29 | Staff attitude/treatment | Acute nursing | N | More time required | Not upheld | • Appropriate procedures followed by staff with regard to disability<br>• Explanation given of why certain actions were taken, and apology offered for how the complainant felt |
| 30 | Concerns about end of life care | Acute/Community | N | More time required | | |
| 31 | Appropriateness of care/place of residence | Community | N | More time required | | |
| 32 | GP advised attendance at A&E – complainant felt was dismissed, untreated but subsequently did need care | Medical | N | More time required | Part upheld | • Both clinical evaluations found to be good – senior consultant briefed on symptoms<br>• Safety netting advice provided<br>• Member of staff to reflect on communication |

Cases escalated to the Scottish Public Services Ombudsman from 1 April 2021 to May 2025

| Date notified with SPSO | Our complaint ref | SPSO ref | Area of complaint | Date of SPSO outcome | SPSO outcome | SPSO recommendations | Action update | Board/SPSO status |
|---|---|---|---|---|---|---|---|---|
| **Notified 2021/22** | | | | | | | | |
| 30.04.21 | 2020_21_18 | 202008807 | Care provided by CMHT | 07.07.21 | Will not take forward | Response reasonable based on the advice received. | Files submitted for review | Closed |
| **Notified 20222/23** | | | | | | | | |
| 30.11.22 | 2021_22_24 | 202111117 | Potential long Covid treatment | 30.11.22 | Will not take forward | None | | Closed |
| **Notified 2023/24** | | | | | | | | |
| 05.04.23 | 2021_22_08 | 202200363 | Provision of physiotherapy | 05.04.23 | Will not take forward | None – advised timed out | | Closed |
| 22.02.24 | 2022_23_18 | 202302219 | Cancer care waits and communication | 25.03.24 | | Seeking early resolution by requesting a meeting takes place | Written to patient offering meeting – not heard back to date | |
| 11.03.24 | 23_24_02 | 20230680 | Dental care | 01.05.24 | Will not take forward | The Board's investigation found to be thorough and response supported by evidence | Sent complaint file and clinical records | Closed |
| **Notified 2024/25** | | | | | | | | |
| 18.07.24 | 22_23_23 | 202402135 | Delay in diagnosis for broken hip | 18.07.24 | Will not take forward | Cannot achieve outcomes sought. Advice given regarding legal action | | Closed |
| 20.03.25 | 24_25_22 | 20249992 | Failure to follow correct process in diagnosis of UTIs, failure to evidence learning | 30.04.25 | Will not take forward | Response to complaint appeared reasonable, explanation provided as to why there was a different position. Accepted failings and taken the kind of action expected | | Closed |

**Key:**
Grey – no investigation undertaken nor recommendations requested by SPSO
Green – completed response and actions
Amber – completed response but further action to be taken at the point of update
No colour – open case