NHS Shetland

Meeting:	**Shetland NHS Board**
Meeting date:	**23rd September 2025**
Title:	**Quality Report**
Paper reference:	**Board Paper 2025/26/26**
Responsible Executive/Non-Executive:	**Prof Kathleen Carolan, Director of Nursing & Acute Services**
Report Author:	**Michelle Hankin, Clinical Governance and Risk Team Leader and Carolyn Hand, Head of Corporate 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 September 2025
Appendix 2 Quality Scorecard September 2025
Appendix 3 Complaints and Feedback Report Q1 2025-26

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):				
2025/2026	No target set/ Suspended activity/ awaiting update	🛑	⚠	✅
Q1	**12**	**8**	**2**	**19**
	4 KPIs national activity suspended (NA-IC-23, NA-IC-24, NA-IC-25, NA-IC-30) NA-CF-16 women satisfied with the care they receive – Care Opinion is now being used MD-HC-01 calculated following national data release Awaiting update: NA-HI-01, PH-HI-03, PH-HI-03a, CE-IC-01, NA-IC-22, CH-MH-05	NA-HC-10 NA-HC-53 NA-HC-66 NA-HC-69 NA-HC-79 NA-IC-01 NA-IC-02 NA-IC-20 Measures will remain on red until the target has been met	NA-HC-54 NA-IC-10	Detailed in the Quality Score Card (Appendix 1)
Q4 24/25	10	7	0	24
Q3 24/25	8	7	0	26
Q2 24/25	8	8	0	24
Q1 24/25	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. We await Q1 data.

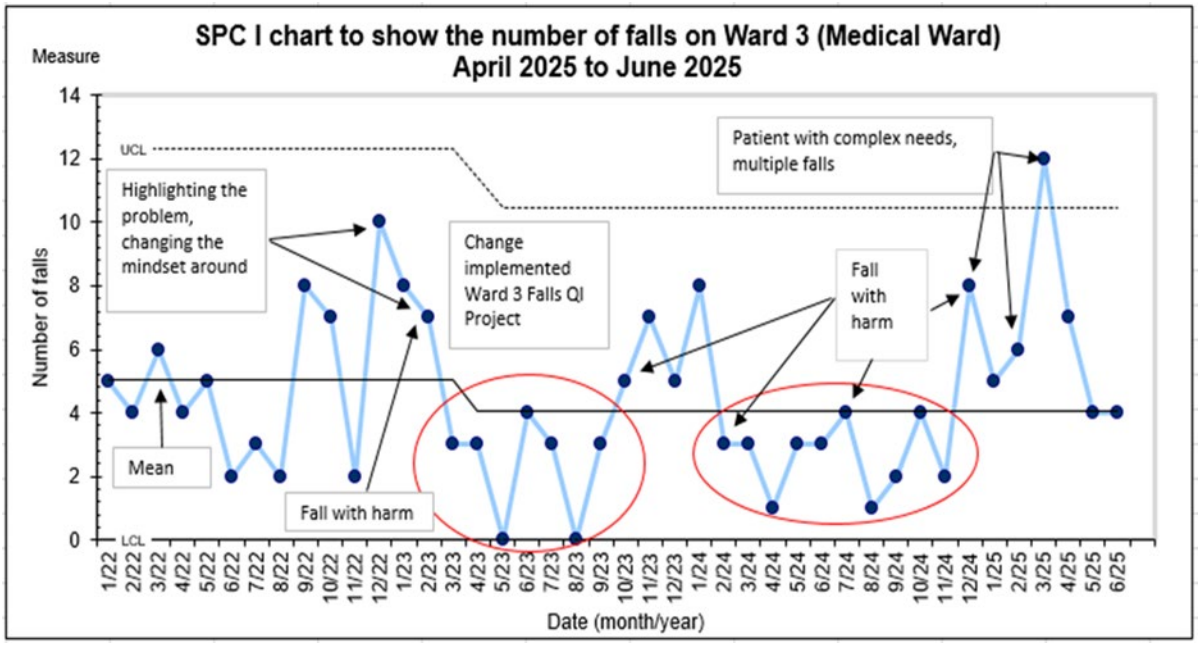
- **Patient Experience Outcome Measures** –During Q1 performance against all 7 patient experience measures met the set target of 90%.

- **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 Q1 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, there was no feedback received via Care Opinion in Q1. However, there is one Maternity Care Opinion feedback received in Q2 (July 2025).

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 Q1 2025/26.

- **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. During Q1 we start to observe a reduction in the number of falls, from 23 in Q4 to 15 in Q1 2025/26. This reflects a similar reduction in the number of falls observed in spring/summer 2022, 2023 and 2024.



Pressure ulcers – There were two Hospital Acquired Pressure Ulcers reported for Q1 2025/2026 (one upon each inpatient ward), both of these were classified as unavoidable. Following review by the Infection Control Nurse, all appropriate care was implemented. Both of these pressure ulcers were via the adverse event Datix system (incident number 11077 and 11125). Datix 11077, the Red Day Review was completed by the Tissue Viability Nurse, the review identified this patient already had a pre-existing pressure ulcer,

all preventative measures were therefore already in place. Datix 11125, the Red Day Review was completed by the Tissue Viability Nurse which identified that the patient had multiple co-morbidities, all appropriate nursing assessments had been completed and all preventable measures were in place, the pressure ulcer was unavoidable. The Senior Charge Nurses (SCNs) for both inpatient wards, are currently reviewing these incidents and will update the adverse event system upon completion. Audit Measure NA-HC-69 the number of days between pressure ulcers developed on Ward 3, NA-HC-66 the number of days between pressure ulcers developed on Ward 1, 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. An overview of the DVT audit results from February 2024 is provided below:

	Feb 2024	**April 2024**	**June 2024**	**Aug 2024**	**Oct 2024**	**Jan 2025**	**March 2025**	**May 2025**
Risk Assessed NA-HC-71	100%	90%	100%	90%	100%	100%	100%	100%
Managed appropriately NA-HC-72	60%	0%	100%	0%	100%	100%	100%	80%
Evidence of review NA-HC-73	50%	60%	38%	10%	40%	100%	80%	100%
Discussed with patient NA-HC-74	80%	0%	0%	0%	0%	20%	0%	10%

Reviewing the DVT audit results, since October 2024, all surgical patients are being risk assessed, and the majority of patients (80-100%) are being managed appropriately and have evidence of review recorded via HEPMA or in the patient's notes. Performance regarding recording the DVT discussions with patients remains low (0-20%), this reflects that these conversations are not routinely being recorded on the HEPMA system. This was discussed at July's surgical audit meeting, where the team were congratulated on their improvements and encouraged and reminded to tick the box in HEPMA to provide the required evidence to support the patient discussion audit measure.

- **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. During Q1 there were two CAUTI infections identified on Ward 3, reflecting this the current Q1 performance is 21 days. The Infection

Control Team are working closely with the ward area to review and support good infection control practices.

NA-IC-02 during Q1 catheter usage rates start to decrease, from 28.43% in Q4 to 21.7% in Q1. The target set is 15%, the infection Control Team continue to monitor this measure.

NA-IC-10 during Q1 we have observed an increase in the compliance with Catheter Associated Urinary Tract Infection (CAUTI) Insertion Bundle, from 72.22% in Q4 to 80% in Q1. The Infection Control Team who continue to monitor and provide support and education to the clinical areas.

NA-IC-13 during Q1 we observe an increase in compliance with Catheter Associated Urinary Tract Infection (CAUTI) maintenance bundle, from 51.85% in Q4 to 88.46% in Q1. The performance target is 95%. 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 the winter and workforce pressures have provided additional challenges which has impacted upon patient care delivery.

- **Clinical Governance Leadership Walkrounds** – During Q1, there were three Leadership Walkrounds scheduled to Mental Health, Estates and Facilities (at the old fish market, Lerwick) and the Walls Health Centre. These visits continue to be received enthusiastically by the visiting team, feedback received continues to be positive with increased appreciation and value of the Walkrounds from the visiting areas. A more detailed Leadership Walkround report is created and presented at the Operational Clinical Governance Group (OCGG), Joint Governance Group (JGG) and Clinical Governance Committee (CGC). Leadership Walkround data is included in the Quarterly Quality Score Card report which is presented at CGC and at the NHS Board meeting.

- **Excellence in Care (EiC) NEWS & CAIR Dashboard reports** – CAIR Dashboard reports from December 2023 to April 2025 are not available, due to Clinical Governance Team vacancies this data has not been collected. Data collection was resumed in May 2025 following successful recruitment to the new Clinical Governance Support Manager post. During May 2025 only part of a data submission was possible, reflecting the need for the post holder to complete EiC training. There are two EiC performance indicators identified on the Quality Score Card; NA-HC-79 focuses upon the percentage NEWS 2 observation charts where the correct frequency of observations have been completed and NA-HC-80 focuses upon the percentage of NEWS 2 observation charts where the correct accuracy is recorded. For both measures the target set is 95%. During Q1 we have achieved the 95% target in accuracy however we have only achieved 85% in frequency. EiC and NEWS training is planned to be delivered to both inpatients wards in Q2, this we assist in raising awareness of the EiC programme and completion of the NEWS charts.

- **Thematic learning** – 211 adverse events were reported in Q1 and 6 debriefs were held.

	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
Number of adverse events	**190**	**205**	**200**	**199**	**211**
Number of debriefs held	**3**	**12**	**6**	**7**	**6**
Number of Major Adverse Events	**0**	**0**	**1** Related to an inpatient fall where patient sustained a hip fracture (Please see the 'Falls' section of this report)	**0**	**2**
Number of Moderate Adverse Events	**11**	**6**	**5**	**9**	**15**

The report also provides an overview of the thematic analysis of Lessons Learnt for April – June 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** – between 85%-100% of patients in this quarter on Ward 1 and 100% of Ward 3 patients' said they had a positive care experience. 92%-100% of Ward 1 and 100% of Ward 3 patients 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. Patient feedback comments were generally very positive and expressed thanks for the care they had received. One patient was particularly grateful for supporting the family dog to visit whilst they were in hospital. However, one individual highlighted they were moved around the ward several time, which was upsetting for the individual. In response to this the ward was experiencing system pressures at this time and patient placement needed to be reviewed upon several occasions to accommodate patients with increased monitoring needs, for infection control purposes and to support patients at high risk of falls.

  The teams involved in these decisions acknowledge that better communication with the individual being moved, may have improved their understanding of the situation and requirement for being moved. 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.

- **Q1 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)** – During Q1, 11 student nurses provided placement feedback. 72.73% of student were very satisfied with their learning experience, this is a slight decrease from 75% in Q4. Only 63.64% of students identified they received more than 28 days advanced notice of their placement in Shetland. The majority of students valued the learning environment, and opportunities to practice practical nursing skills, they felt their placements provided a good range of learning opportunities.

  91% of students strongly agreed that practice learning environment were able to evidence underpinning care. 82% of students strongly agreed they were able to raise concerns, 9% of students tended to agree that they could raise concerns and 9% of students tended to disagree regarding their ability to raise concerns. The promotion of speak up week (September 2025) may help raise the profile of raising concerns and elevate confidence associated with this.

  Overall feedback comments highlighted the friendliness of staff and the variety of learning opportunities available. Improved experience feedback, highlighted the challenges regarding the 46 mile daily commute for community placements and the quality of NHS accommodation. Allocation of practice time between specialisms and protected time for students and supervisors was also highlighted. One student commented upon the lack of support from the Practice Education Facilitator (PEF) team, suggesting that there may need for additional capacity in the team to support questions and use of the ePad which is used to completed placement documentation.

  All student feedback is reviewed by the Practice Education Team, who support students in their placements in Shetland. The Practice Education Team shared the following comment in Q4:

  "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

All NHS Boards in Scotland are required to monitor patient feedback and to receive performance reports against a suite of high level indicators determined by the Scottish Public Services Ombudsman (SPSO). The complaints and feedback report for Q1 2025-26 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.

The key highlights of the report are:

- 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 the length of time to respond to Stage 1 complaints has marginally decreased from the last quarter, however nine of the 13 Stage 1 complaints were handled within five working days. Responding to Stage 2 complaints within 20 working days remains challenging, with three out of eight Stage 2 complaint investigations meeting the target.

  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. A wider group of staff will receive additional SPSO investigation training 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.
- One litigation case previously reported regarding a delayed diagnosis remains in an early stage of information gathering.

CGC

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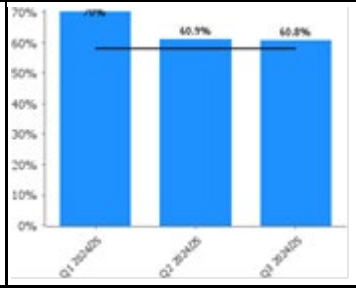
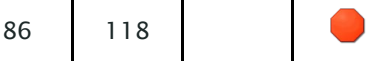
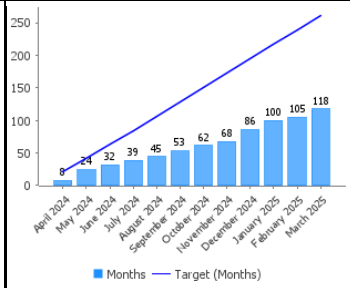
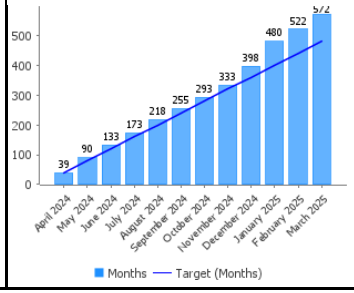
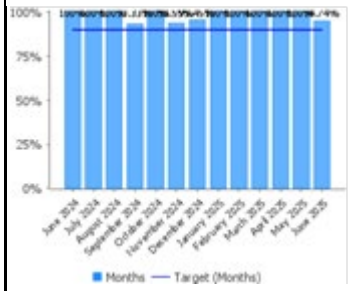
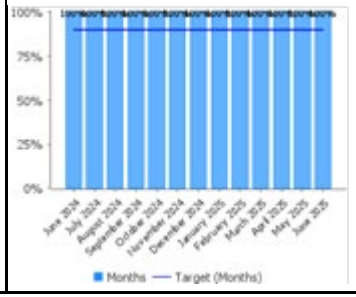
Quality Scorecard - BOARD

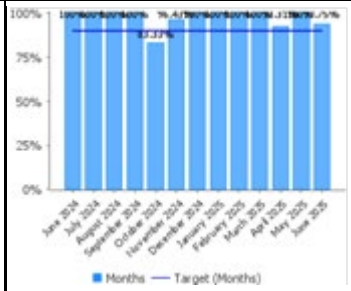
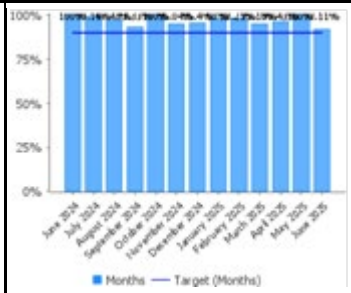
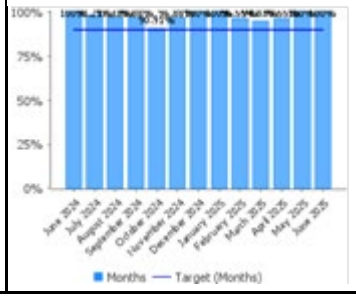
Title
Health Improvement

Performance Indicators	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	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			60.8%				58%		**Awaiting Q4 data.** **Q1 data will be available end August 2025.**

Performance Indicators	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	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.				86	118					Measure will remain on red until target of 261 is achieved. **Awaiting Q1 data.**
PH-HI-03a Number of FAST alcohol screenings				398	572			400		**Awaiting Q1 data.**

Title
Patient Experience Outcome Measures

Performance Indicators	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	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)	93.3%	100%	89.5%	100%	100%	89.5%		90%		
NA-HC-04 % of people who say they got the outcome (or care support) they expected and needed (aggregated)	100%	100%	94.74%	95.45%	100%	94.74%		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%		

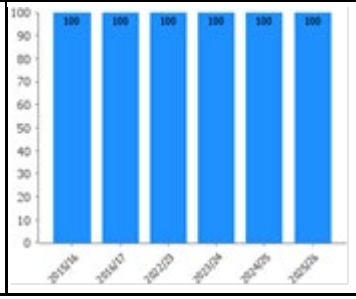
Performance Indicators	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-17 What matters to you % of people who say we took account of the people who were important to them and how much they wanted to be involved in care/treatment (aggregated)	92.31%	100%	93.75%	100%	100%	93.75%		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)	96.43%	100%	92.11%	95.4%	95.18%	92.11%		90%		
NA-HC-23 What matters to you % of people who say that staff took account of their personal needs and preferences (aggregated)	96.55%	100%	100%	100%	94.87%	100%		90%		

Performance Indicators	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	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)	96.55%	100%	89.47%	89.13%	94.74%	89.47%		90%		

Title
Patient Safety Programme - Maternity & Children Work stream

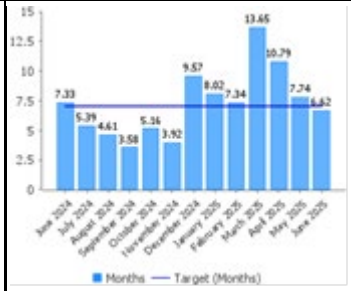
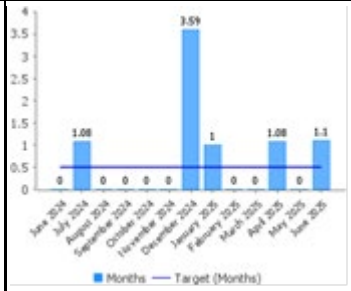
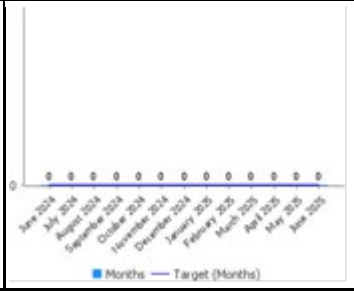
Performance Indicators	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-CF-07 Days between stillbirths	3,701	3,732	3,762	3,581	3,671	3,762		300		

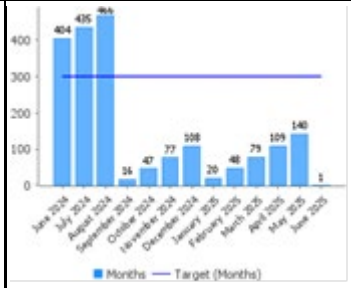
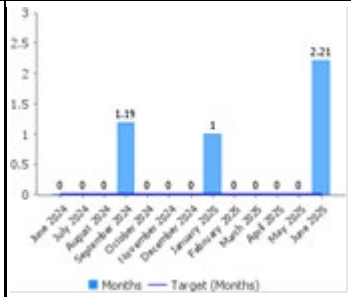
Performance Indicators	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-CF-09 Rate of neonatal deaths (per 1,000 live births)	0	0	0	0	0	0		2.21		
NA-CF-15 Rate of stillbirths (per 1,000 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 one piece of feedback received via Care Opinion in July 2025 which was very positive regarding care received. Wonderful Antenatal Care | Care Opinion									

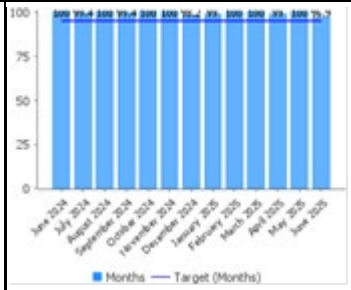
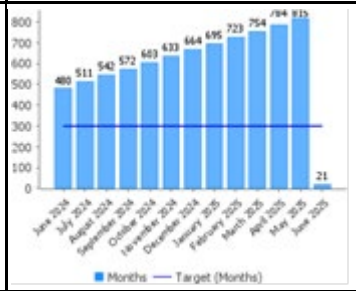
Performance Indicators	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-58 % compliance with the newborn screening bundle	Measured Quarterly			100	100	100		100		

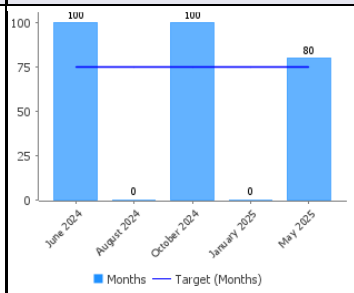
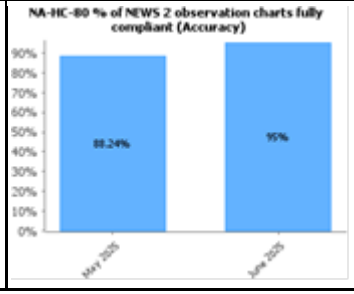
Title
Service & Quality Improvement Programmes - Measurement & Performance

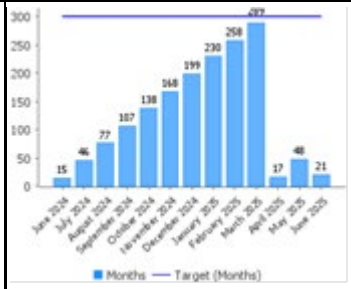
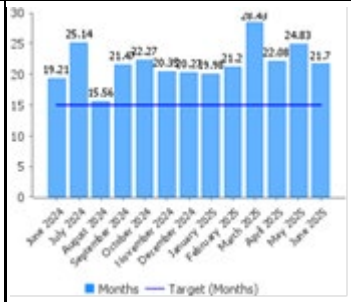
Performance Indicators	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
CE-IC-01 Cleaning Specification Audit Compliance	Measured Quarterly			97.4%	96.2%			90%		**Awaiting Q1 data.**
NA-HC-08 Days between Cardiac Arrests	408	439	469	288	378	469		300		

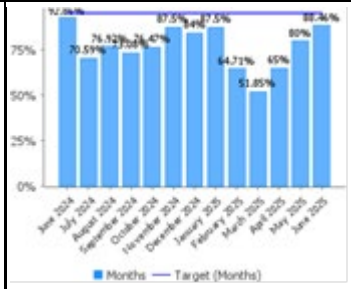
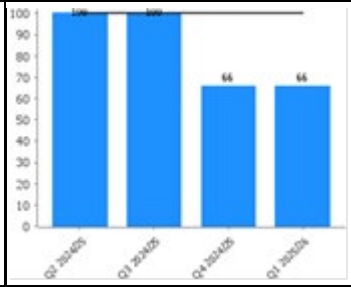
Performance Indicators	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-09 All Falls rate (per 1000 occupied bed days)	10.79	7.74	6.62	9.57	13.65	6.62		7		During Q1 we start to observe a reduction in the number of falls, from 23 in Q4 to 15 in Q1. This reflects a similar reduction in the number of falls observed in spring/summer 2022, 2023 and 2024.
NA-HC-10 Falls with harm rate (per 1000 occupied bed days)	1.08	0	1.1	3.59	0	1.1		0.5		There were two inpatient falls with harm during Q1(one upon each inpatient ward), these have been reviewed by the SCNs and identified as unavoidable falls, all the appropriate nursing assessments and interventions had been completed.
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		

Performance Indicators	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-53 Days between a hospital acquired Pressure Ulcer (grades 2-4)	109	140	1	108	79	1		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)	0	0	2.21	0	0	2.21		0		During Q1 there were two hospital acquired pressure ulcers (one upon each inpatient ward). These have both been reviewed by the tissue viability nurse and identified as unavoidable, reflecting the patient's deterioration in condition/ pre-existing health conditions. All appropriate intervention and nursing care was implemented. The ward SCNs are currently reviewing these incidents and will update the adverse event system, upon completion.

Performance Indicators	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	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%	96.9%	98.2	100	96.9%	✅	95		
NA-HC-66 Pressure ulcer - days between pressure ulcers developed on Ward 1.	784	815	21	664	754	21	🛑	300		Measure will remain on red until 300 days is achieved.
NA-HC-69 Pressure ulcers - days between pressure ulcers on Ward 3	109	140	1	108	79	1	🛑	300		Measure will remain on red until 300 days is achieved.

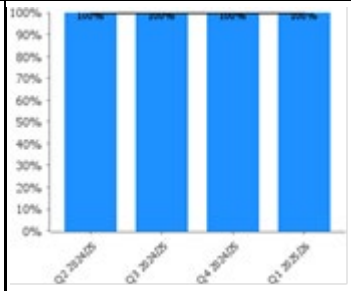
Performance Indicators	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-72 % of patients who had the correct pharmacological/mechanical thromboprophylaxis administered	N/A	80%	N/A	100%	N/A	80%		75%		Next DVT audit is scheduled for July 2025
NA-HC-79 % of total observations calculated on the NEWS 2 charts (Frequency)	N/A	56%	85%	N/A	N/A	85%		95%		Excellence in Care (EiC) data collection recommenced in May 2025. Only partial data collection occurred in May.
NA-HC-80 % of NEWS 2 observation charts fully compliant (Accuracy)	N/A	88.23%	95%	N/A	N/A	95%		95%		Excellence in Care (EiC) data collection recommenced in May 2025. Only partial data collection occurred in May.

Performance Indicators	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-IC-01 Days between Catheter Associated Urinary Tract Infection (CAUTI) developed in acute care	17	48	21	199	289	21		300		Measure will remain on red until target of 300 days reached across both inpatient areas.
NA-IC-02 Catheter Usage Rate	22.08	24.83	21.7	20.27	28.43	21.7		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	64.71%	100%	80%	84.62%	72.22%	80%		95%		

Performance Indicators	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-IC-13 Aggregated Compliance with the Catheter Associated Urinary Tract Infection (CAUTI) maintenance bundle	65%	80%	88.46%	84%	51.85%	88.46%		95%		
NA-IC-20 % of Patient Safety Conversations Completed (3 expected each quarter)	Measured Quarterly			100	66	66		100		2 out of 3 scheduled Leadership Walkrounds were carried out during Q4. The Leadership walkround to the Walls Health Centre was cancelled by the visiting area.
NA-IC-22 Hand Hygiene Audit Compliance	Measured Quarterly			98.3%	100%			95%		**Awaiting Q1 data.**
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	Measured Quarterly			Surgical Site Infection Surveillance activity remains suspended, there is no national updated regarding when this will be recommenced.						

Performance Indicators	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
identified post Large Bowel operation										
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	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	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	April 2025	May 2025	June 2025	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q1 2025/26	Q1 2025/26	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			98.2%	93.8%			80%		**Awaiting Q1 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: April – June 2025

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	1	2	15	Skin tear to elbow	**Apr 25**	0	7	122	
May 25	0	3	46		**May 25**	0	4	153	
Jun 25	0	2	76		**Jun 25**	1	3	9	Laceration to head
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	**2**	**12**			**Total**	**1**	**37**		

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	0	0	784			**Apr 25**	0	0	109		
May 25	0	1	815			**May 25**	0	1	140		
June 25	1	0	21			**Jun 25**	1	3	1		
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**			

CAUTIs in Secondary Care											
WARD 1						WARD 3					
Month 2025	Total Number of Urinary Catheters	Total Number of Inpatients	Total Number of CAUTIs	CAUTI Rate (per catheter days) NA-IC-09	Usage rate	Month 2025	Total Number of Urinary Catheters	Total Number of Inpatients	Total Number of CAUTIs	CAUTI Rate (per catheter days) NA-IC-09	Usage rate
Jan	68	359	0	0%	19%	Jan	122	592	0	0%	21%
Feb	82	396	0	0%	21%	Feb	113	524	0	0%	22%
Mar	128	417	0	0%	31%	Mar	158	589	0	0%	27%
Apr	120	397	0	0%	30%	Apr	80	509	1	1%	16%
May	148	440	0	0%	34%	May	73	450	0	0%	16%
June	91	382	0	0%	24%	Jun	100	498	1	1%	20%
July						July					
Aug						Aug					
Sept						Sept					
Oct						Oct					
Nov						Nov					
Dec						Dec					
Total	637	2391	0			Total	646	3162	2		

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?**
April – June 2025	2	Unavoidable	Yes	Reviewed by SCN	During Q1 there were two falls with harm (one in each inpatient ward). (Dx 10950, skin tear to an elbow, and Dx 11108, laceration to head) Both falls were reviewed by the Senior Charge Nurse for each ward and were deemed to be unavoidable. Post falls bundles were completed for both patients.
HOSPITAL ACQUIRED PRESSURE ULCERS					
Date	**No. of Patients**	**Avoidable/ Unavoidable**	**Appropriate Care Given?**	**Debrief Conducted?**	**Learning Points?**
April – June 2025	2	Unavoidable	Yes	Review conducted by TVN. SCN currently reviewing.	During Q1 there were two hospital acquired pressure ulcers (one in each inpatient ward). (Dx 11077 & Dx 11125 has been reviewed by the tissue viability nurse, the red day review has been completed and were Unavoidable pressure ulcers). Currently the SCNs for each ward are reviewing both adverse events.

Excellence in Care (EiC) Data:

Excellence in Care - Submission Report

NHS Shetland

Period from: July 2024 - June 2025
Extract date: 29 July 2025
Contact: **phs.excellenceincare@phs.scot**

Background

This submission report presents data on the submission rates for the nationally agreed measures in the **CAIR dashboard**. To allow health boards to complete their data submissions, the report presents data for the time period July 2024 - June 2025.

To ensure that Health Boards can get the most out of the CAIR dashboard, a high data completeness across measures and teams is very important. A higher completeness is essential for robust evaluation of the standard of healthcare. Therefore, this submission report is a valuable tool in assessing how your Health Board is performing in terms of data completeness.

Overall submission rates

Table 1: Monthly submission rates (%) in NHS Shetland

Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
12%	12%	12%	12%	12%	12%	12%	14%	14%	29%	39%	36%

Figure 1: Monthly submission rates (%) in NHS Shetland

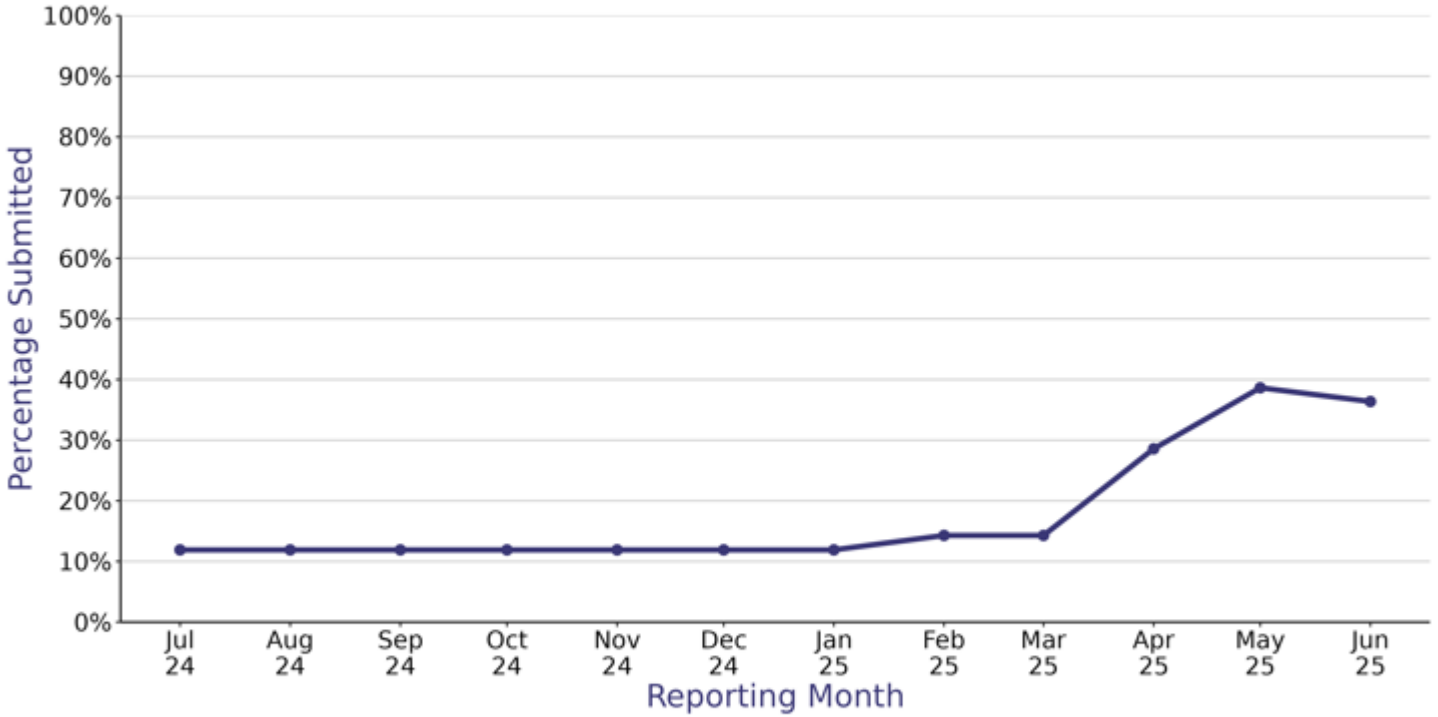


Figure 2: Submission rates (%) by measure in the latest month (June 2025) in NHS Shetland

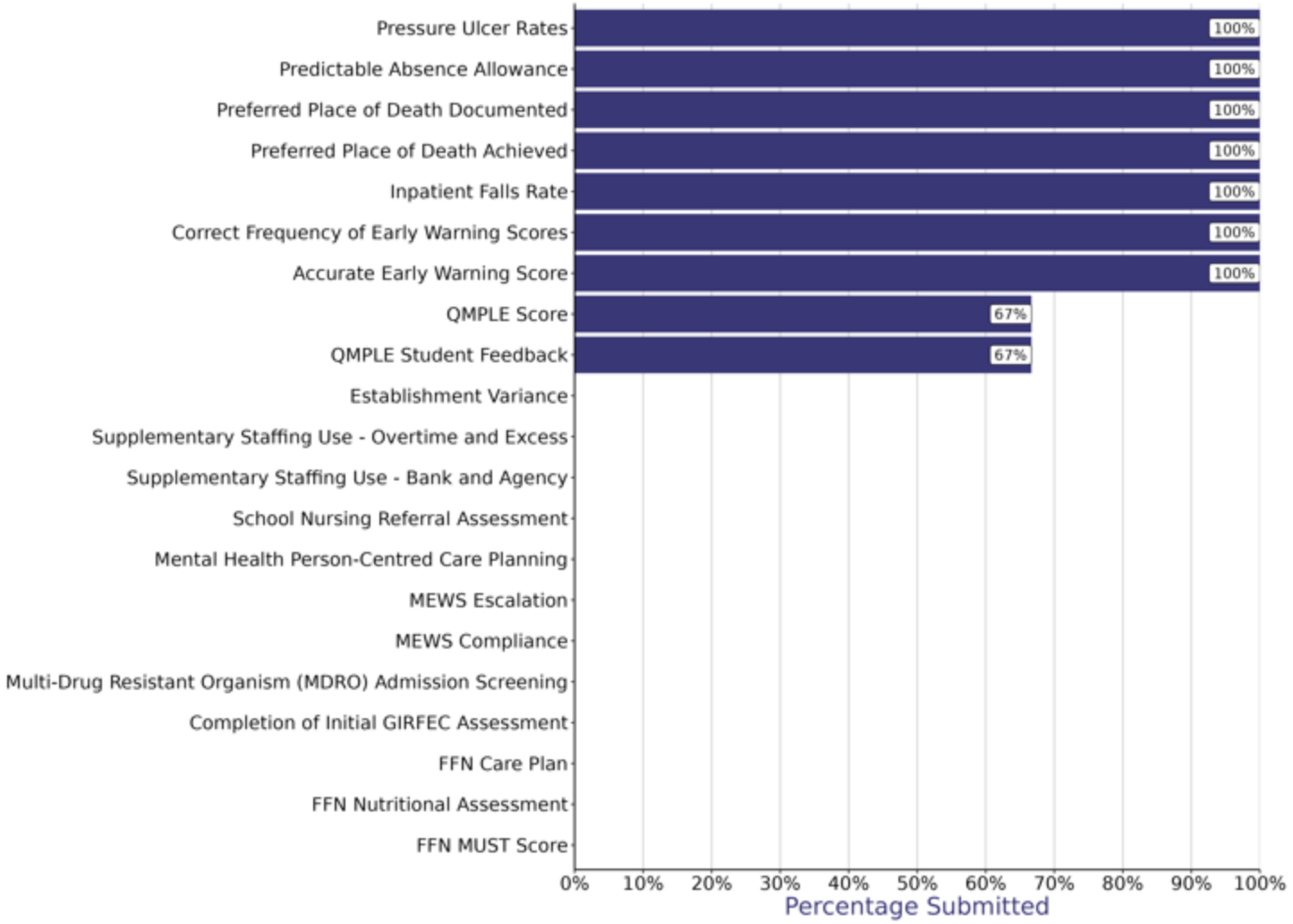
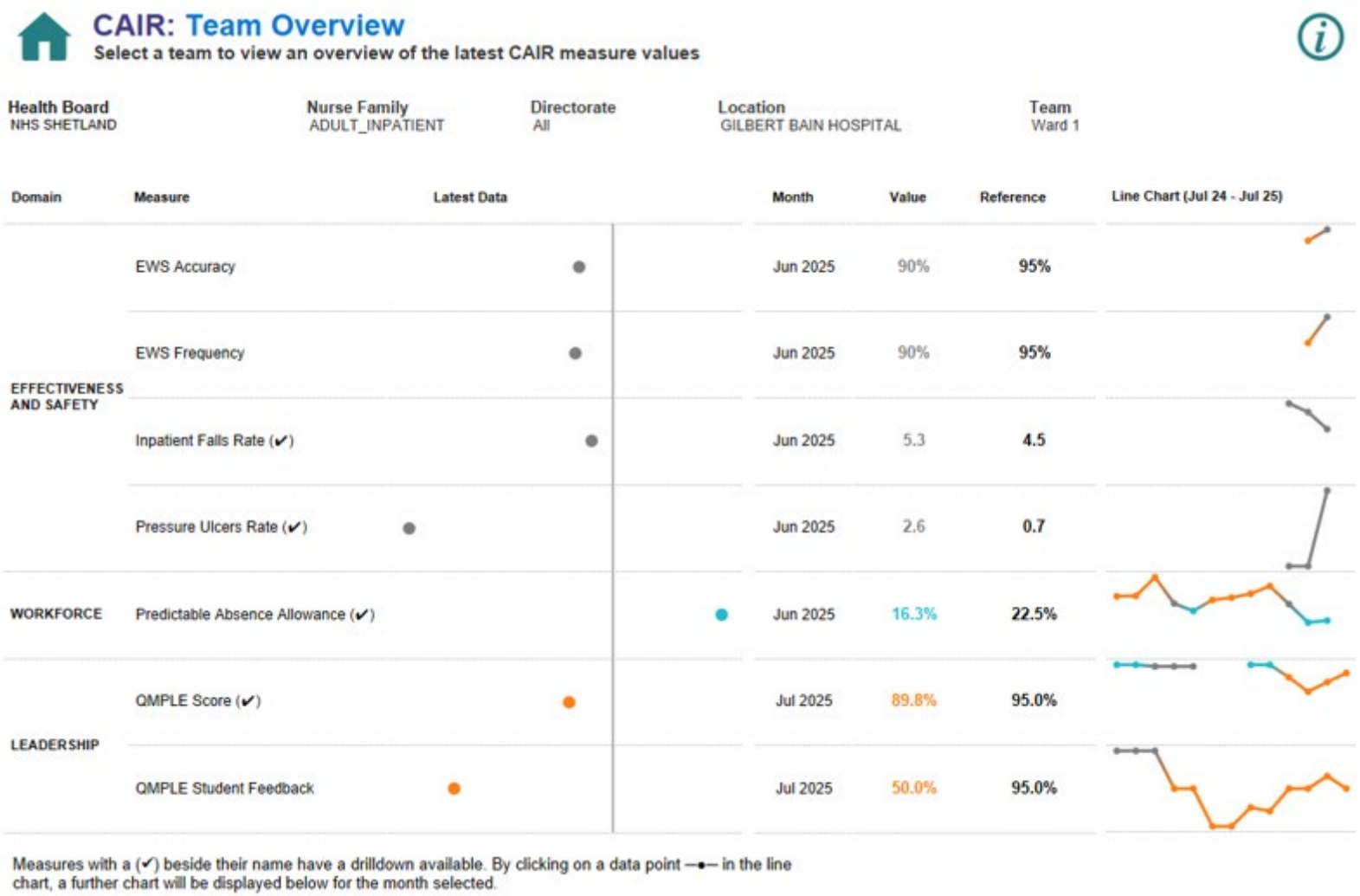


Table 2: Quarterly submission rates (%) in NHS Shetland

Quarter	Percentage
Jul-Sep 2024	12%

Quarter	Percentage
Oct-Dec 2024	12%
Jan-Mar 2025	13%
Apr-Jun 2025	35%

Excellence in Care Measures – Ward 1 Surgical Ward:



CAIR: Team Overview

Select a team to view an overview of the latest CAIR measure values

Health Board	Nurse Family	Directorate	Location	Team
NHS SHETLAND	ADULT_INPATIENT	All	GILBERT BAIN HOSPITAL	Ward 1

Domain	Measure	Latest Data	Month	Value	Reference	Line Chart (Jul 24 - Jul 25)
EFFECTIVENESS AND SAFETY	EWS Accuracy		Jun 2025	90%	95%	
	EWS Frequency		Jun 2025	90%	95%	
	Inpatient Falls Rate (✔)		Jun 2025	5.3	4.5	
	Pressure Ulcers Rate (✔)		Jun 2025	2.6	0.7	
WORKFORCE	Predictable Absence Allowance (✔)		Jun 2025	16.3%	22.5%	
LEADERSHIP	QMPLE Score (✔)		Jul 2025	89.8%	95.0%	
	QMPLE Student Feedback		Jul 2025	50.0%	95.0%	

Measures with a (✔) beside their name have a drilldown available. By clicking on a data point —●— in the line chart, a further chart will be displayed below for the month selected.

Excellence in Care Measures – Ward 1 Surgical Ward: Drilldown:

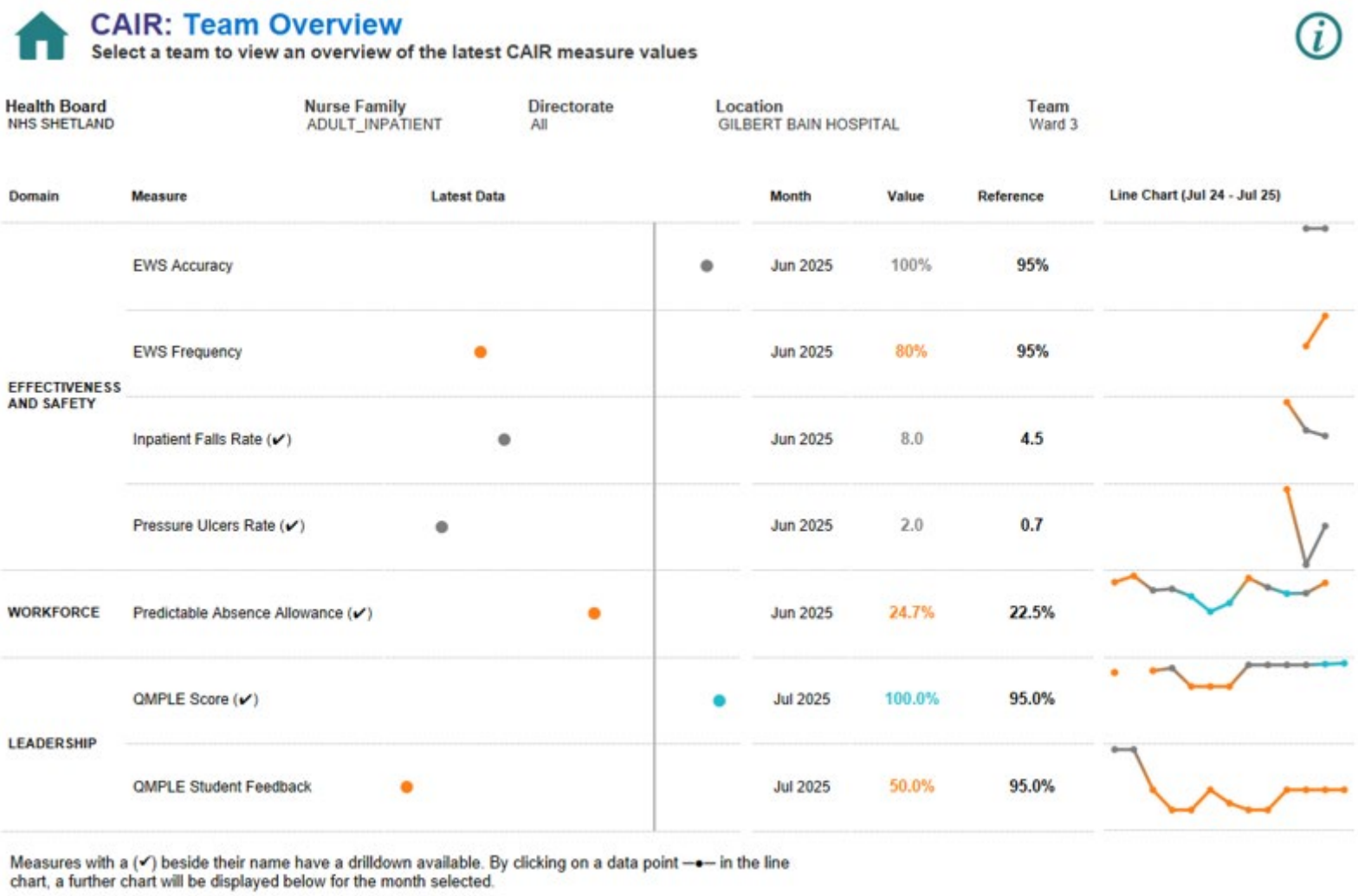
CAIR: Team Level drilldown

A drilldown of the monthly CAIR measure submissions at team level

Health Board	Location Name	Sub Location Name	Measure	Month	Measure status
NHS SHETLAND	Gilbert Bain Hospital	Ward 1	Multiple values	Multiple values	All

Measure Name	Location N..	Location Code	Sub Location Name	Month	Measure status	
EWS Accuracy	Gilbert Bain Hospital	Z102H	Ward 1	Apr 2025	Not submitted	
				May 2025	Less desirable	78%
				Jun 2025	Within expected range	90%
EWS Frequency	Gilbert Bain Hospital	Z102H	Ward 1	Apr 2025	Not submitted	
				May 2025	Less desirable	61%
				Jun 2025	Within expected range	90%
Inpatient Falls Rate	Gilbert Bain Hospital	Z102H	Ward 1	Apr 2025	Within expected range	7.7
				May 2025	Within expected range	6.9
				Jun 2025	Within expected range	5.3
Pressure Ulcers Rate	Gilbert Bain Hospital	Z102H	Ward 1	Apr 2025	Within expected range	0.0
				May 2025	Within expected range	0.0
				Jun 2025	Within expected range	2.6

Excellence in Care Measures – Ward 3 Medical Ward:



CAIR: Team Overview

Select a team to view an overview of the latest CAIR measure values

Health Board	Nurse Family	Directorate	Location	Team
NHS SHETLAND	ADULT_INPATIENT	All	GILBERT BAIN HOSPITAL	Ward 3

Domain	Measure	Latest Data	Month	Value	Reference	Line Chart (Jul 24 - Jul 25)
EFFECTIVENESS AND SAFETY	EWS Accuracy		Jun 2025	100%	95%	
	EWS Frequency		Jun 2025	80%	95%	
	Inpatient Falls Rate (✔)		Jun 2025	8.0	4.5	
	Pressure Ulcers Rate (✔)		Jun 2025	2.0	0.7	
WORKFORCE	Predictable Absence Allowance (✔)		Jun 2025	24.7%	22.5%	
LEADERSHIP	QMPLE Score (✔)		Jul 2025	100.0%	95.0%	
	QMPLE Student Feedback		Jul 2025	50.0%	95.0%	

Measures with a (✔) beside their name have a drilldown available. By clicking on a data point —●— in the line chart, a further chart will be displayed below for the month selected.

Excellence in Care Measures – Ward 3 Medical Ward: Drill Down:

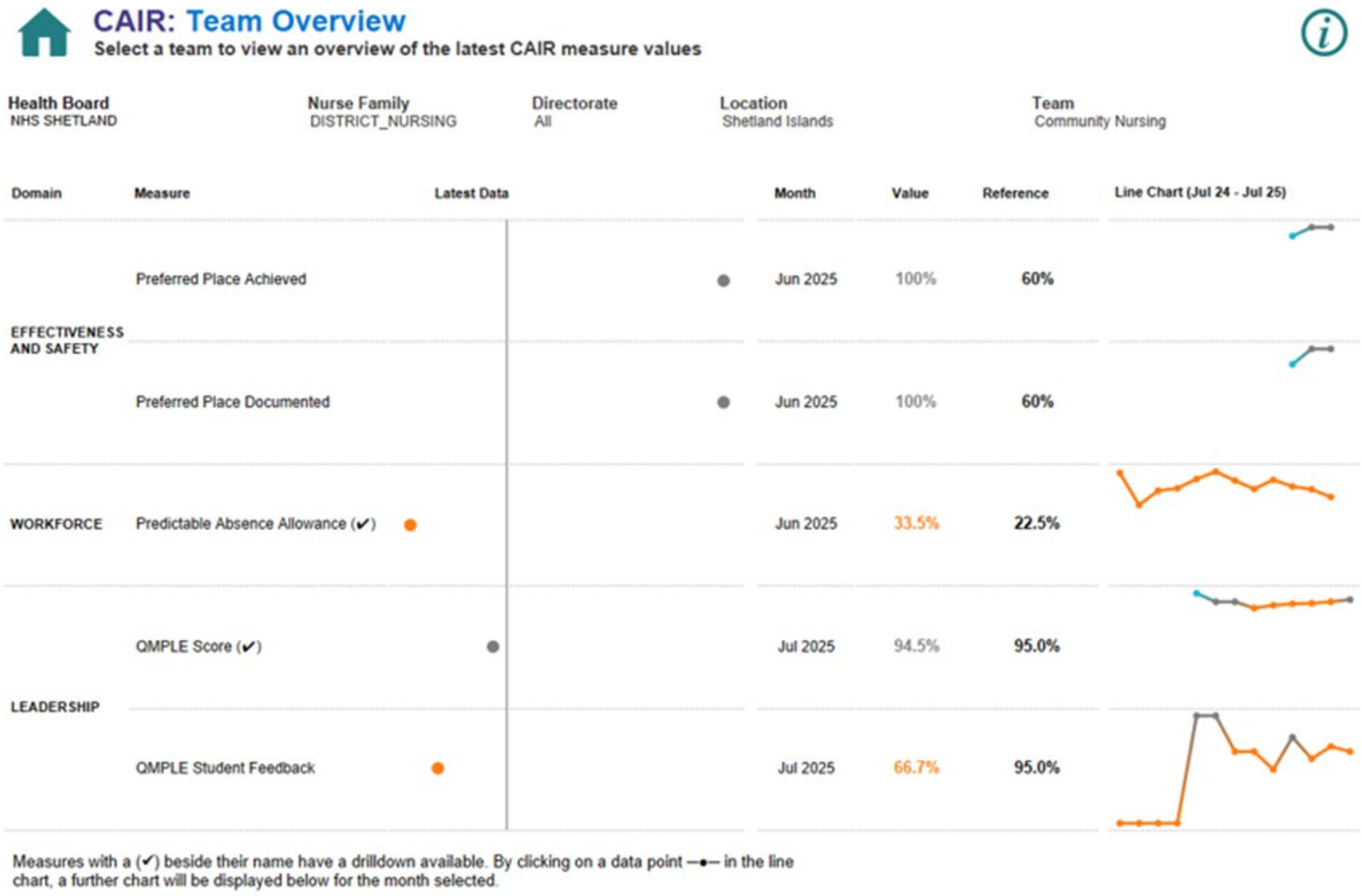
CAIR: Team Level drilldown

A drilldown of the monthly CAIR measure submissions at team level

Health Board	Location Name	Sub Location Name	Measure	Month	Measure status
NHS SHETLAND	Gilbert Bain Hospital	Ward 3	Multiple values	Multiple values	All

Measure Name	Location N..	Location Code	Sub Location Name	Month	Measure status	
EWS Accuracy	Gilbert Bain Hospital	Z102H	Ward 3	Apr 2025	Not submitted	
				May 2025	Within expected range	100%
				Jun 2025	Within expected range	100%
EWS Frequency	Gilbert Bain Hospital	Z102H	Ward 3	Apr 2025	Not submitted	
				May 2025	Less desirable	50%
				Jun 2025	Less desirable	80%
Inpatient Falls Rate	Gilbert Bain Hospital	Z102H	Ward 3	Apr 2025	Less desirable	13.6
				May 2025	Within expected range	8.9
				Jun 2025	Within expected range	8.0
Pressure Ulcers Rate	Gilbert Bain Hospital	Z102H	Ward 3	Apr 2025	Less desirable	3.9
				May 2025	Within expected range	0.0
				Jun 2025	Within expected range	2.0

Excellence in Care Measures – Community Nursing:



CAIR: Team Overview

Select a team to view an overview of the latest CAIR measure values

Health Board	Nurse Family	Directorate	Location	Team
NHS SHETLAND	DISTRICT_NURSING	All	Shetland Islands	Community Nursing

Domain	Measure	Latest Data	Month	Value	Reference	Line Chart (Jul 24 - Jul 25)
EFFECTIVENESS AND SAFETY	Preferred Place Achieved		Jun 2025	100%	60%	
	Preferred Place Documented		Jun 2025	100%	60%	
WORKFORCE	Predictable Absence Allowance (✔)		Jun 2025	33.5%	22.5%	
LEADERSHIP	QMPLE Score (✔)		Jul 2025	94.5%	95.0%	
	QMPLE Student Feedback		Jul 2025	66.7%	95.0%	

Measures with a (✔) beside their name have a drilldown available. By clicking on a data point —●— in the line chart, a further chart will be displayed below for the month selected.

Excellence in Care Measures – Community Nursing Drilldown:

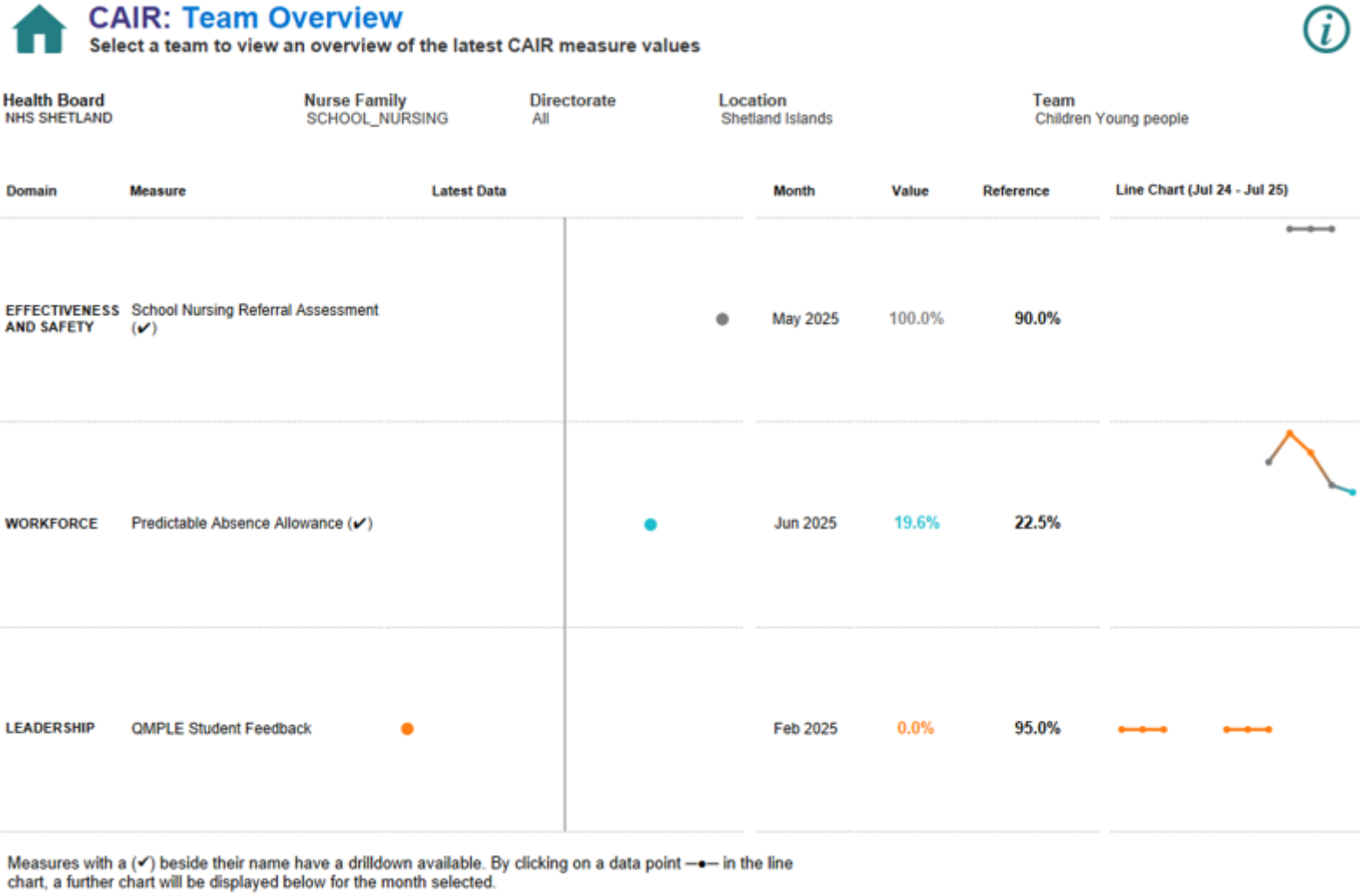
CAIR: Team Level drilldown

A drilldown of the monthly CAIR measure submissions at team level

Health Board	Location Name	Sub Location Name	Measure	Month	Measure status
NHS SHETLAND	Shetland Islands	All	Multiple values	Multiple values	All

Measure Name	Location N..	Location Code	Sub Location Name	Month	Measure status	
Preferred Place Achieved	Shetland Islands	S37000026	Community Nursing	Apr 2025	More desirable	92%
				May 2025	Within expected range	100%
				Jun 2025	Within expected range	100%
Preferred Place Documented	Shetland Islands	S37000026	Community Nursing	Apr 2025	More desirable	87%
				May 2025	Within expected range	100%
				Jun 2025	Within expected range	100%

Excellence in Care Measures – School Nursing:



CAIR: Team Overview

Select a team to view an overview of the latest CAIR measure values

Health Board	Nurse Family	Directorate	Location	Team
NHS SHETLAND	SCHOOL_NURSING	All	Shetland Islands	Children Young people

Domain	Measure	Latest Data	Month	Value	Reference	Line Chart (Jul 24 - Jul 25)
EFFECTIVENESS AND SAFETY	School Nursing Referral Assessment (✔)		May 2025	100.0%	90.0%	
WORKFORCE	Predictable Absence Allowance (✔)		Jun 2025	19.6%	22.5%	
LEADERSHIP	QMPLE Student Feedback		Feb 2025	0.0%	95.0%	

Measures with a (✔) beside their name have a drilldown available. By clicking on a data point —•— in the line chart, a further chart will be displayed below for the month selected.

Appendix D Thematic analysis of Lessons Learnt: April – June 2025

Q1 Total Data: 211 Adverse Events Reported: 6 Debriefs held. **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**
April 2025	**68**	**1 Extreme (10957)** **1 Major (10955)** **3 Moderate (10976, 10921, 10965)**	**0**
N/A			
May 2025	**73**	**5 Extreme (10998, 11047, 11048, 11049, 11014)** **0 Major** **4 Moderate (11017, 11028, 11029, 11034)**	**3** **11028** **11001** **10999**

Adverse event theme (11028) – Level 3 Review: Medical Device: Reviewed by Health Records and Clinical Coding Manager
An appointment letter was not franked, resulting in patient being asked to pay a £5 postage fee. The patient declined which meant they missed their appointment. The patient's appointment was rebooked as soon as team made aware of mistake.
Learning identified:

- The incident showed the need for a digital appointment notification system to reduce reliance on physical mail.
- Staff have been reminded to double check that all letters have been correctly franked before handing to Royal Mail.

Adverse event theme (11001) – Level 3 Review: Medication: Reviewed by Associate Medical Director for Primary Care
GP practice initially declined to issue a prescription for a high risk off-license medication for a CAMHS patient. When reviewed, it was found that the GPs made this decision as the request was for an antipsychotic drug for a non-psychotic indication in a young person. The primary care team felt concerned about this approach and did not feel they could safely take on this risk without a documented shared care agreement. The CAMHS consultant does not work on island and is unable to prescribe remotely. It was agreed that an emergency prescription was provided for 1 week although this was not communicated to the CAMHS team. On island CAMHS nurse now able to prescribe medication and continues to do so until handed to primary care.
Learning identified:

- A productive meeting was held between CAMHS and health centre where the two teams had the opportunity to share issues, perspectives and concerns.
- Two prescribing agreement documents were shared.

- CAMHS and the lead pharmacist will work together to develop a shared care prescribing agreement, that will allow primary care to take prescribing responsibilities for this patient and other similar cases.
- The incident highlights the importance of clear communication with patients to make sure they understand their care plan, follow up arrangements, where to collect their medication and that they are kept informed with any changes.
- The value of specialist nurse prescribers within the service has been recognised.

Adverse event theme (10999) – Level 3 Review: Confidentiality: Reviewed by Occupational Health Manager
A medical report request was incorrectly sent to the wrong health centre. The person who had made the request had submitted two separate requests for two different health centres but both were mistakenly sent to the same practice.
Learning identified:

- This incident highlighted gaps in staff knowledge regarding data protection. As a result, a development session held with the Information Governance team.
- Staff were reminded of the importance of due diligence, accuracy and attention to detail when processing requests.

June 2025	**74**	**7 Extreme (11065, 11081, 11084, 11091, 11096, 11105, 11068)** **1 Major (11100)** **8 Moderate (11099, 11064, 11089, 11082, 11088, 11093, 11111, 11120)**	**3** **11086** **11059** **11059**

Adverse event theme (11086) – Level 3 Review: Medication: Reviewed by Clinical Team Lead (Community)
An incorrect dose of an antibiotic was administered to a patient during a particularly busy and complex round of visits at a local residential home. As a result, the patient received twice the intended dose of the medication.
Learning identified:

- The clinician involved has reflected on this incident and several provisions have been put in place to prevent reoccurrence.
- Additional clinical supervision has been implemented to provide support.
- The clinician has been reminded of the importance of taking a moment to carefully review prescriptions before printing, especially during busy or stressful periods.
- Emphasis has been placed on the need for a cautious approach to prescribing, with the understanding that pharmacy teams may not always notice errors prior to dispensing.

Adverse event theme (11059) – Level 3 Review: Communication: Reviewed by Clinical Nurse Manager – Mental Health
Threatening and aggressive behaviour from patient family member towards Mental Health member of staff. Lack of clear communication within mental health team triggered reaction from relative.
Learning identified:

- That there will be shared knowledge across mental health service teams re any safety issues in households.
- Going forward all staff reminded that all incidents of verbal abuse towards staff should be reported via Datix.

Adverse event theme (11094) – Level 3 Review: Investigations (scans / x-ray / specimens): Reviewed by Associate Medical Director (Acute)

Patient with multiple comorbidities being treated for ongoing cardiac and respiratory illnesses, deteriorated over a few days, palliative care was provided. When the team reviewed this death and the echocardiogram (ECHO) images as part of the medical governance mortality and morbidity (M&M) review; the cause of death on the death certificate was inaccurate, however this would not have changed the management of the patient or the patient outcome. The family had no concerns about the care the patient received. Following a conversation with the death certification service advice was given, that the cause of death on the death certificate needs only to be changed if it was felt to be important by a family member or interested party. Both cardiac physiologists are aware of the review. There was a discussion with senior colleagues prior to discussion with the family to reflect the sensitive nature of the conversation going to be had with the family.

Learning identified:

- Good medical ward governance and review of the case.
- The need for an ECHO verification process, which is currently being developed.

Appendix E:
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	100%	0%	100%	100%
May-25	100%	100%	100%	100%
Jun-25	85%	100%	92%	100%
Jul-25				
Aug-25				
Sep-25				
Oct-25				
Nov-25				
Dec-25				
Average for the year				

Ward 1						
Person Centred Measure description	**MD01 (NA-HC-16)** % of people who say that we took account of the things that were important to them. Aim 90%	**MD02 (NA-HC-19)** % 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%	**MD03 (NA-HC-22)** % of people who say that they have all the information they needed to help them make decisions about their care/treatment. Aim 90%	**MD04 (NA-HC-25)** % of people who say that staff took account of their personal needs and preferences Aim 90%	**MD05 (NA-HC-28)** % of people who say they were involved as much as they wanted to be in communication/ transitions/ handovers about them Aim 90%	**Number of responses**
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	100%	100%	100%	100%	100%	**14**
May-25	100%	100%	100%	100%	100%	**5**
Jun-25	100%	90%	88%	100%	85%	**13**
Jul-25						
Aug-25						
Sep-25						
Oct-25						
Nov-25						
Dec-25						
Average for year						

Ward 3						
Person Centred Measure description	**MD01 (NA-HC-15)** % of people who say that we took account of the things that were important to them. Aim 90%	**MD02 (NA-HC-18)** % 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%	**MD03 (NA-HC-21)** % of people who say that they have all the information they needed to help them make decisions about their care/treatment. Aim 90%	**MD04 (NA-HC-24)** % of people who say that staff took account of their personal needs and preferences Aim 90%	**MD05 (NA-HC-27)** % of people who say they were involved as much as they wanted to be in communication/ transitions/ handovers about them Aim 90%	**Number of responses**
Jan-24	100%	100%	100%	100%	100%	**5**
Feb-24	100%	100%	100%	100%	100%	**6**
Mar-24	100%	100%	100%	100%	100%	**2**
Apr-24	100%	0%	50%	50%	50%	**1**
May-24	100%	100%	100%	100%	100%	**4**
Jun-24	100%	100%	100%	100%	100%	
Jul-24						
Aug-24						
Sep-24						
Oct-24						
Nov-24						
Dec-24						
Average for year						

WARD 1 INPATIENT SURVEY – PATIENT COMMENTS – Apr / 2025
Ward 1 staff were always so helpful and caring in all they did for me. Thank you very much for all you do.
Staff deserve wage increase about 25% at least.
Thank you.
Obviously I didn't want to be here. But the care was brilliant.
All the staff were excellent. Thank you very much.
Friendly staff
Could not fault the staff on anything.

WARD 3 INPATIENT SURVEY - PATIENT COMMENTS – Apr / 2025
I had many moves – perhaps 10/12 times, and I felt it was absolutely ridiculous, very unsettling and very inappropriate as I was extremely mixed up.

WARD 1 INPATIENT SURVEY – PATIENT COMMENTS – May / 2025
Exceptional Staff
Fantastic care from start to finish. Both myself and my son (the patient) felt well looked after at such a worrying and stressful time. A massive thank you to everyone!
Thanks ☺
Very well cared for, thank you!

WARD 3 INPATIENT SURVEY - PATIENT COMMENTS – May / 2025
I was very well cared for and the outcome is testimony to this.
All staff at all times were helpful and respective. Medical staff, DRs & consultants took time to explain & answer questions. A very positive experience when I needed it!

WARD 1 INPATIENT SURVEY – PATIENT COMMENTS – June / 2025
Everyone has done a good job.
This hospital was extremely friendly and helpful. They were accommodating to our entire family. The quality of care was excellent. Thank you for everything.
Great nurses.

WARD 3 INPATIENT SURVEY - PATIENT COMMENTS – May / 2025
My care team were excellent and all deserve a pay rise and are worth their weight in gold.
I have been well cared for both in A&E and ward 3 by all the staff. Very grateful!
During my hospitalisation my daughter visited with her dog Pablo. I found these short visits to be both comforting and uplifting. I understand that dogs are not appropriate in an acute setting but may these be a way to accommodate therapy dogs in a common area for those inpatients who would like to participate. I think that this small thing would bring comfort to those who miss their pets.

Q1 NHS Shetland Care Opinion Feedback:

Area	Feedback	Response
GBH Gynaecology	Bladder prolapse: “I recently saw a gynaecologist. It was awful and the examination has hurt my insides. I am in my 70s and felt like I was treated with contempt and no thought for my age. The gynaecologist put me on an awful chair which at my age was very hard to take.” First reply: I'm really sorry to read about your recent experience following your appointment with the gynaecologist. We would never wish for anyone to feel the way you describe. If you would like to share more information and allow us to investigate this more thoroughly, then please contact me at shet.feedbackandcomplaints@nhs.scot “I have a blood disorder that can't be accurately diagnosed. I feel my care has been predjudiced because of this. I was told that I couldn't have an operation because of the blood disorder. I was amazed to learn this was from a freelance staff member gynaecologist based elsewhere in the UK! I thought I would surely have been seen from someone from Aberdeen Royal Infirmary. I will never go through an experience like that ever again.”	Thank you for taking the time to leave us your feedback after your recent visit to the gynaecology service at Gilbert Bain. I’m really sorry to read about your experience and I want to reiterate what was said previously in that we don’t want anyone to feel the way you describe. I can answer part of your feedback. The chair we use is a special chair for women having gynae examinations and procedures. While it is not the most comfortable chair, it does allow the person performing the examination and/or procedure to put the patient in the correct position. Previously, we had a couch with static legs rests. For this couch the patient’s legs needed to be manually lifted into the leg rests. For patients who have mobility issues, have had joint replacements, they were often unable to tolerate lifting the legs into the required position, however with this chair, the legs do not need to be manually lifted and are instead gently raised to the required level or a level that can be tolerated. As the chair is purpose built, it is used for all our patients and is generally well tolerated, even by those who are older and may have struggled with the previous couch. It would be helpful to us, for learning purposes, if we could understand and be able to investigate your concerns more thoroughly. In order to do this, I would need more information, if you would you be willing to share your contact details with shet.feedbackandcomplaints@nhs.scot

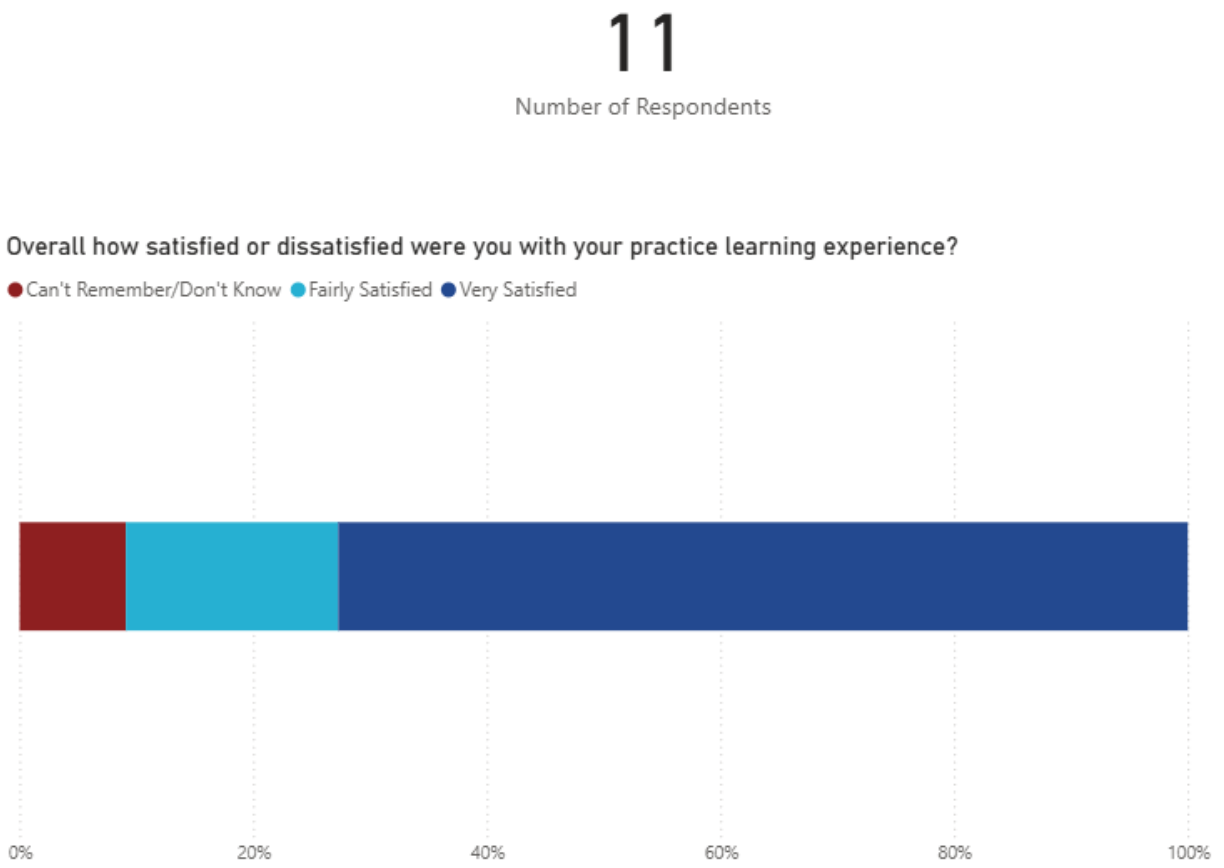
GBH Medical Imaging	Left Waiting: “I had an appointment for a CT scan, I was told to report to the X-ray Department, which I did. Nobody there when I arrived so I rang the bell. Despite hearing plenty voices and joking in an office nearby, still nobody came. I sat down and waited, a lady came by and looked at me but didn’t ask who I was or was I being dealt with. It took another 10 minutes for them to notice I’d arrived only to be told to go to CT and wait there. In the CT waiting area I was handed a gown and told to get ready, no door closed, very little privacy and other patients coming and going. It didn’t feel great. I feel quite let down by the service in this department overall.”	I'm really sorry to read about your recent experience following your appointment with Medical Imaging. We would never wish for anyone to feel the way you describe. If you would like to share more information and speak with us directly, then please do not hesitate to contact me at shet.feedbackandcomplaints@nhs.scot
Lerwick Health Centre	Asthma review: “My daughter had an asthma review today and I just wanted to mention how brilliant Kat was at explaining things clearly. She was really friendly and approachable for her as a fairly shy 13 year old, listening well to how things are for her at the moment and finding the right treatment pathway for her that is going to make it easier for her to manage her asthma symptoms and ensure she can live life to the fullest being the active girl she loves to be unhindered by her asthma. I am so impressed with Kat's knowledge and professional abilities but also her patient care was exemplary. Thanks Kat.”	Thank you very much for taking the time to post your lovely feedback about your daughter’s recent asthma appointment with Kat. It is so helpful to hear feedback about our services and I will share your feedback directly with Kat.
GBH Ward 1 (Surgical)	End of Life Care in the Gilbert Bain Hospital:	Thank you for your feedback regarding End of Life care at Gilbert Bain Hospital, please accept my sincere condolences to you and your family for the loss of your uncle. It is heart-warming to hear that staff were able to provide him with so much peace and comfort during his final days.

	Thank you to all the clinicians, nurses and other staff on Ward 1 who cared for my Uncle for an extended period prior to his passing. The majority of his family live on the mainland and it was comforting to know that he was being given the best possible care towards the end of his life. My mum was able to travel to Shetland and visit him on a few occasions, including on the day he passed away. On the final day, she found him being treated with dignity and respect, having been moved to a bright airy side room off the main ward, with a clean, comfortable bed and sun shining in the window. We thank you for making his passing as peaceful as possible. The only difficulty my mum, as next of kin, sometimes encountered over the past couple of months was receiving clear and regular updates on his condition, which impacted her and the wider family's ability to make travel plans. While the nursing staff on the ward were as helpful as they could be when she called, I feel it would be useful for a next of kin (particularly those who do not live in Shetland) to be provided with a single point of contact who is able, with the patients consent, to share clinical information, expected next steps for their care etc.	I am very sorry to hear the communication from the ward was not as regular or clear as it could have been, and how this impacted your family's ability to make travel plans so they could visit. I will forward your suggestion for a single point of contact for next of kin's to the relevant directorate for consideration. Thank you again for leaving your valuable feedback so that we can continue to improve our services for all our patients and their loved ones. Reply: Thank you for your reply and condolences. I would very much like to hear the outcome of the consideration of my suggestion by the relevant Directorate. An update on this platform would, therefore, be much appreciated. Response: I have received the following response from the directorate: This is on the agenda for the next team meeting on the ward, where it will be asked that the nurse in charge of the ward be the single point of contact in these circumstances, recognising what a difficult time it is for friends and family. I hope this update was helpful. Reply/acknowledgement:

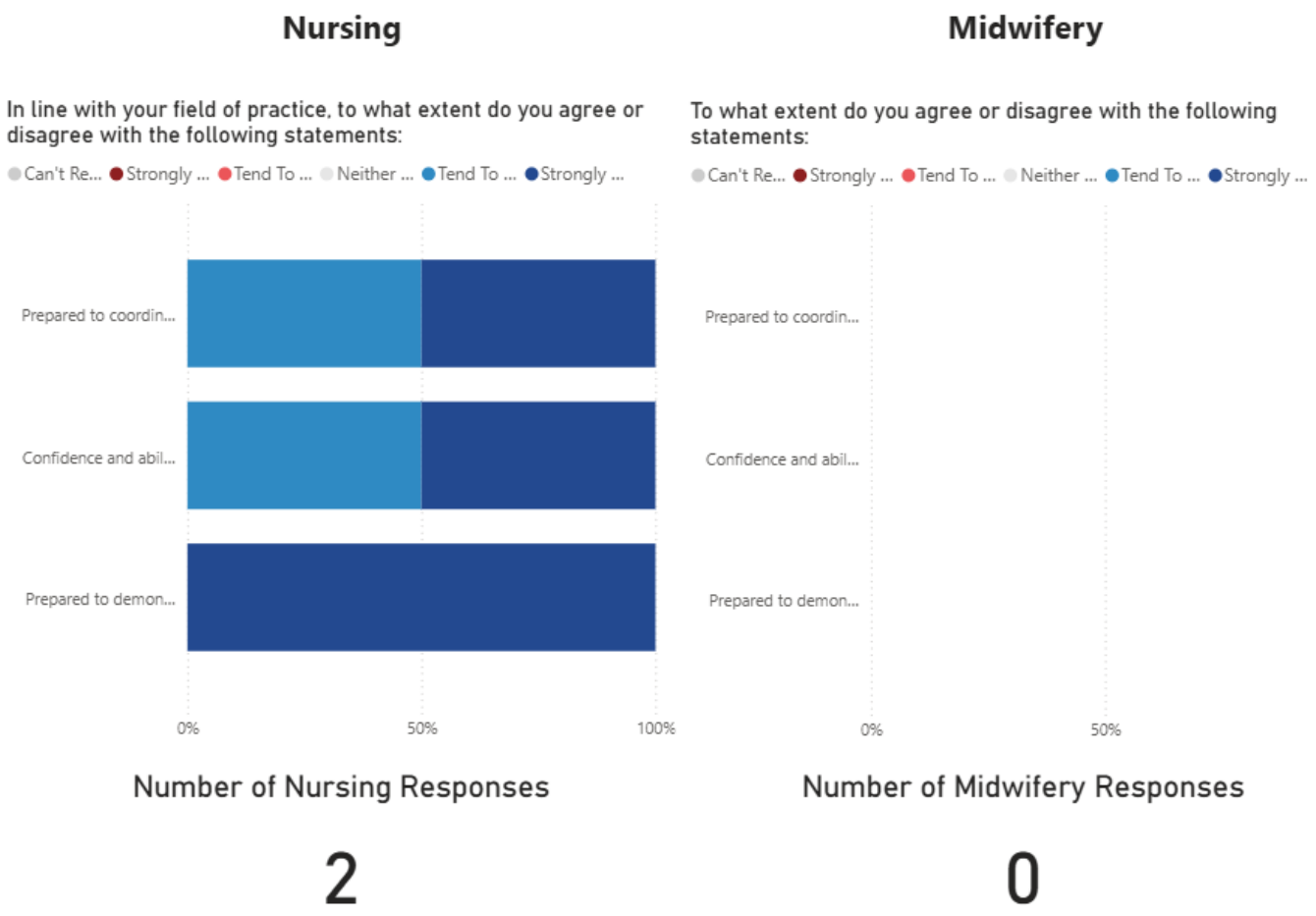
	Many thanks again for making a difficult time for my family that little bit easier.	Thanks so much for your prompt update. It is heartening to learn that my feedback may benefit patients and their families in the future.

Appendix F: Quality Management of the Practice Learning Environment (QMPLE)
Q1 April - 18 June 2025
Overall Satisfaction:

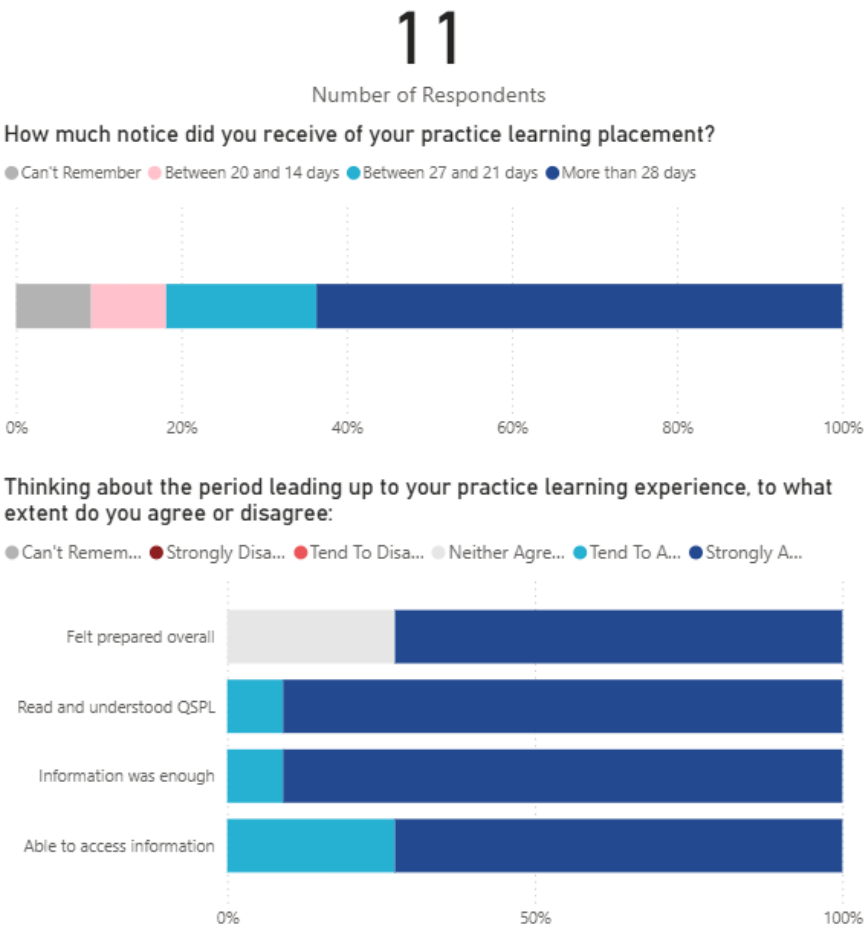
Student Feedback Overview:

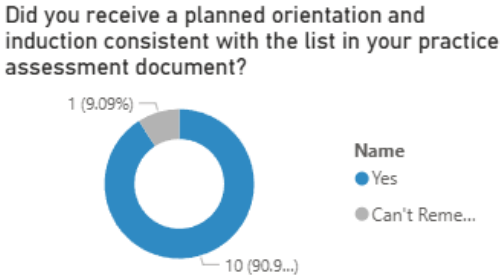


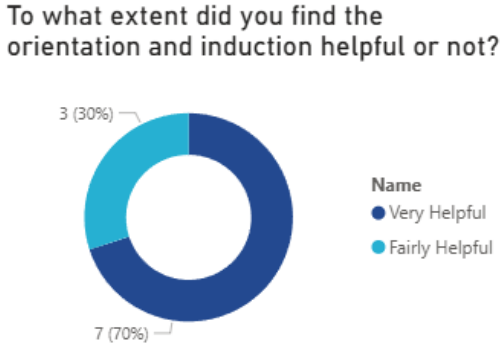
Performance Management:



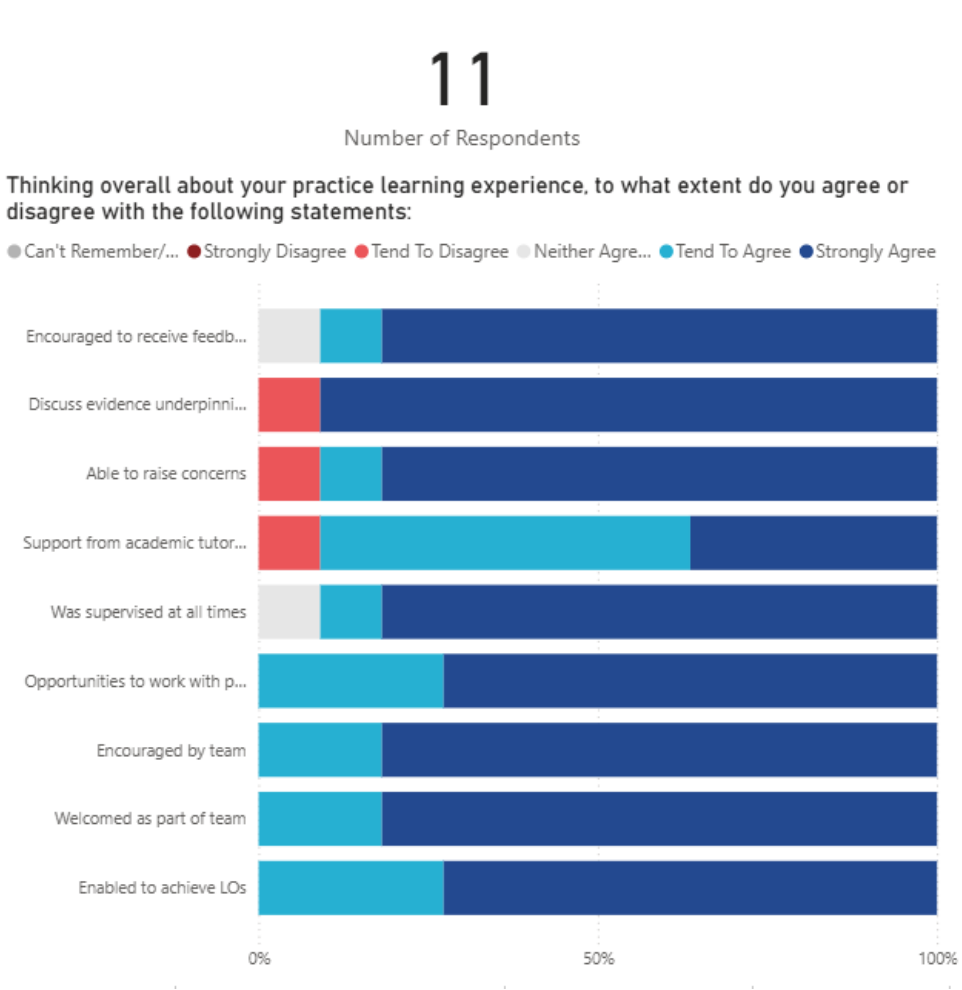
Preparation for Practice Learning:

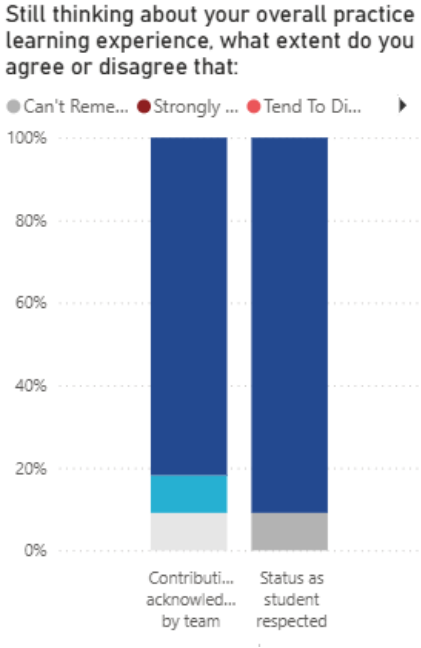




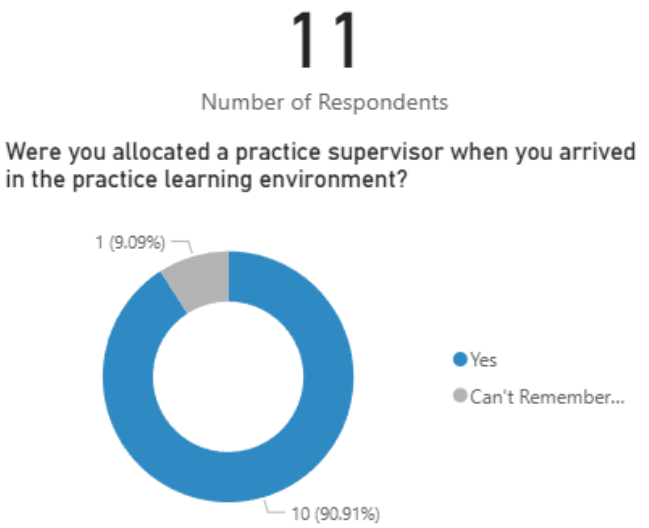


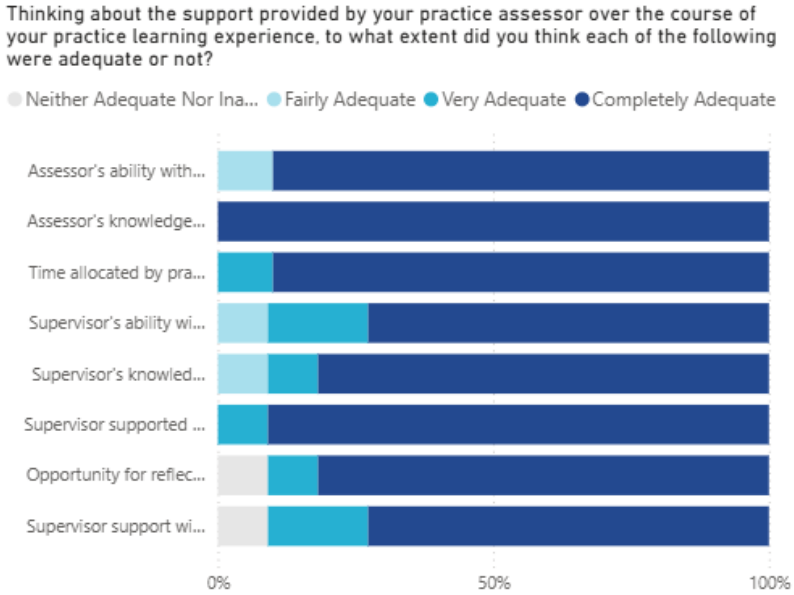
Learning Environment:

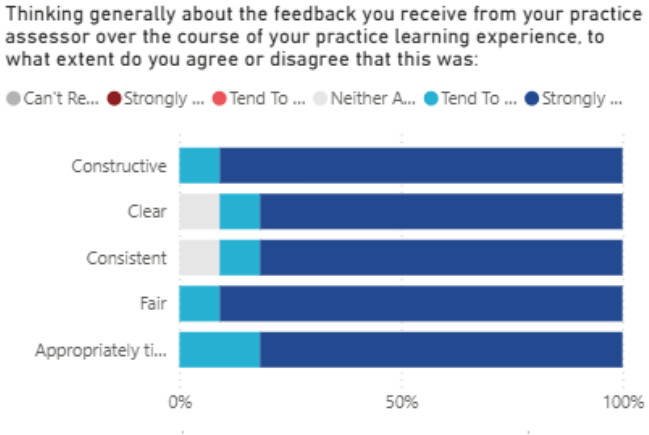


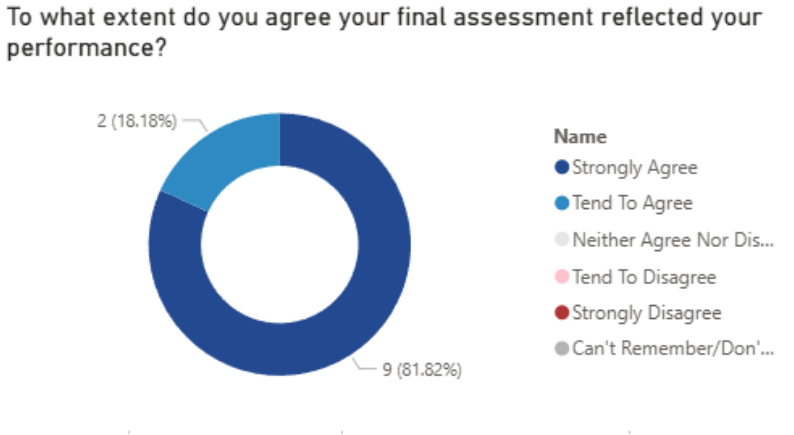


Practice support:

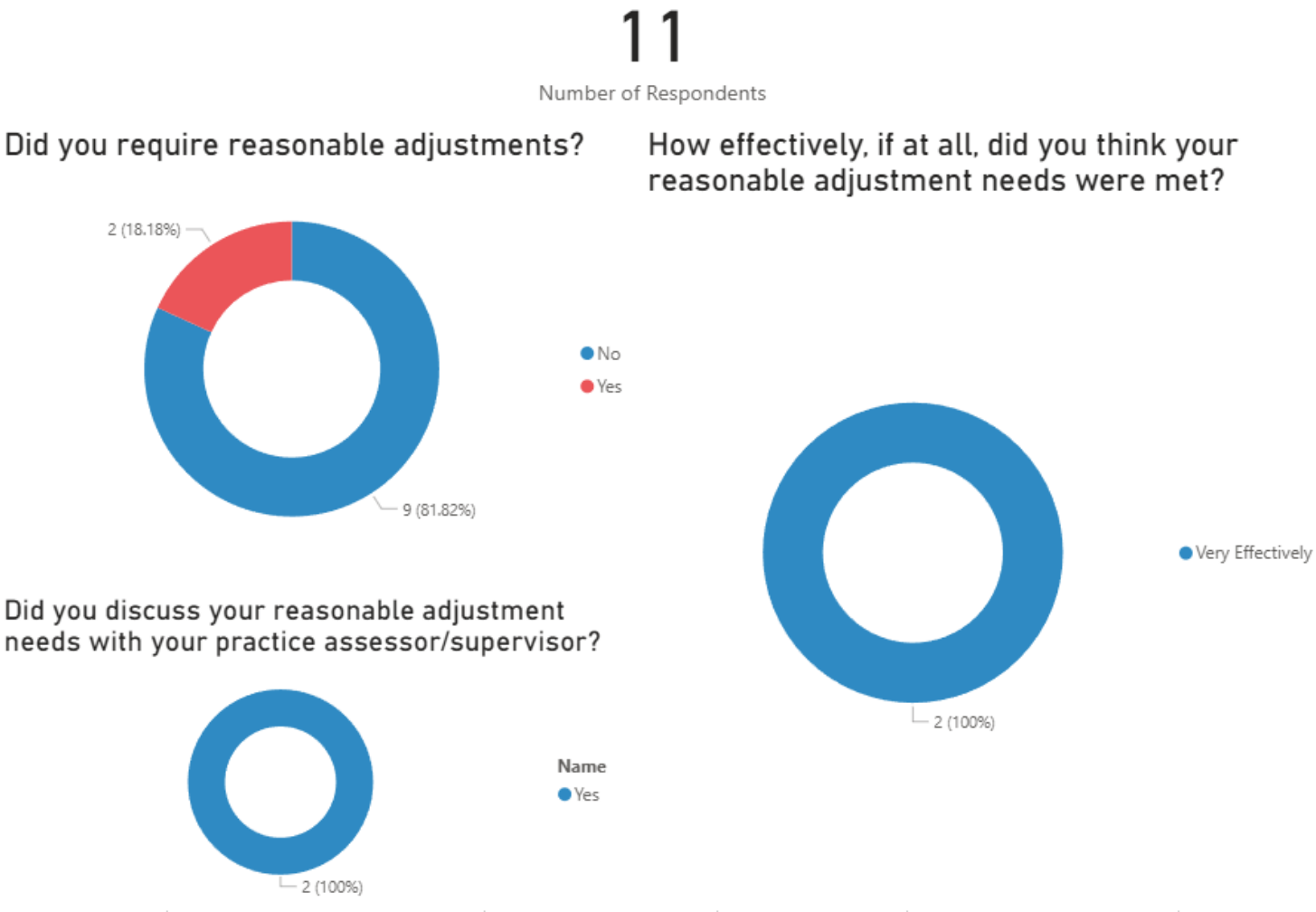








Additional Support Needs:



Student feedback Overview –particularly good:

11

Number of Respondents

Response	Learning Environment	Learning Centre
This was a fantastic learning environment to promote leadership and provide many opportunities to demonstrate independence.	Accident and Emergency	Gilbert Bain Hospital
I enjoyed the community setting as it helps build and maintain a rapport with patients and benefits patients from having the same nurses going in, in some cases everyday or multiple times a week. I have seen and heard a change in my vocabulary about wounds for example as most patients in the community I was based in was wound care, diabetic care and catheter care. I also enjoyed getting to know my assessor and supervisor in car journeys to patient houses and getting some knowledge of what to expect going to a patient and what was expected of me so I am not going in completely blind not knowing anything about their history or what is to be treated on the day.	Brae Community	Shetland Community
All the staff at my placement area were really welcoming, friendly and supported me all through out placement. I also got to achieve a lot of placement as i got the opportunity to do a wide range of things everyday both in the clinical setting and community.	Child Health	Gilbert Bain Hospital
The day surgery team welcomed me into their team and made me feel valued. They helped me gain valuable nursing skills, such as canulation, catheterisation and making up IV's. I appreciate their encouragement and ongoing support. I was able to go through to the theatre, where the staff explained everything that was happening. All in all, this placement has been a great experience. Thank you!	Day Surgery Unit	Gilbert Bain Hospital
the whole team was so welcoming from day one, i was never treated as another pair of hands, and everyone was happy to take me for a spoke	Lerwick Practice Nurses	Shetland Community

Welcoming, friendly team who truly work together for the good of the unit each other and the women they serve. Able to see a wide range of fields including antenatal, triage, baby loss, intrapartum, postnatal ward and home visits, breastfeeding support, tongue-tie clinic	Maternity ward	Gilbert Bain Hospital
Being in the out patients department has been really good for me to gain a lot of independence in my nursing. I have been able to take bloods, obs, ECG's and run clinics on my own for the Drs and consultants. The staff in outpatients have been able to help me learn new things, experience things that I may not see in other departments. I have also been able to go out on spoke days to several different areas of interest along with going on spokes to different departments that lead to areas of my pad being able to be signed off.	Pre Op Assessment, Outpatients, Gilbert Bain Hospital	Gilbert Bain Hospital
Great place to develop independence in your learning, good place to learn about infection control, co-morbidities, risk assessing complex needs and building interpersonal relationships with both patients, families and multidisciplinary teams.	Renal Unit	Gilbert Bain Hospital
The range and depth of details in equipment, drugs, procedures was immense. It's a rich environment full of lots of opportunity to learn specialist skills. The team work really well together under incredible pressures and managed the environment effectively for best patient outcomes.	Theatre	Gilbert Bain Hospital
The staff were very friendly and quickly made me feel part of their team. I had opportunities to be involved in delivering care. My accessor and various other nursing staff were great at involving me in caring for patients. The team leader made sure that I knew about training session available which helped my learning.	Ward 1 and HDU	Gilbert Bain Hospital
The way the majority of the staff on the ward included me and were open to showing me things to expand my learning	Ward 3	Gilbert Bain Hospital

Student feedback – improved experience:

11

Number of Respondents

Search all responses...

Search

Response	Learning Environment	Learning Centre
I would have loved to stay longer, I had a brilliant time.	Accident and Emergency	Gilbert Bain Hospital
I feel that I struggled with the commute out to the community setting I was based in as it was 46 miles roundtrip 5 days a week. I know there is not accommodation near Brae for students but I feel after doing a 8.5 hr shift everyday to then have 30-40 min commute each way takes a lot of energy out of someone. I would have appreciated more consistency from the PEF as well. It would have been beneficial as well as after the initial meeting, there was no interim and final feedback meetings.	Brae Community	Shetland Community
i don't think anything could	Lerwick Practice Nurses	Shetland Community
NHS accommodation is unclean and not acceptable for any professional whether it be staff or student. Ensuite facilities would also be appreciated. I cannot fault anything about the actual learning experience at the Gilbert Bain. I would love to return. Keep being you!	Maternity ward	Gilbert Bain Hospital
I think that RGU and OU should look into timings of placements as I was on placement at the same time as an OU student, the staff in outpatients were really good at giving us both such good experiences but I think that sometimes this area is too small to have more than one student in it at a time.	Pre Op Assessment, Outpatients, Gilbert Bain Hospital	Gilbert Bain Hospital

I believe that if I hadn't read so much about dialysis before coming on placement, I could have spaced out my learning more effectively throughout the placement. Since it's such a specialised area I felt that there's only so much I could read before it became too specialised to were it wouldn't be relevant to my general learning experience unless I was planning to go into renal. It seemed that I had my placement when there wasn't as many patients as before so there was opportunity to self direct my learning with additional reading, so come week 6 I felt like I had ran out of things to familiarise myself with. However this is a reflection of my over-preparedness not the placement area. When I felt that I had read as much as was necessary there were plenty of spokes opportunities for me to organise to utilise the quieter hours.	Renal Unit	Gilbert Bain Hospital
The weighting of scrub time vs anaesthetic time could be altered. I found scrub to be a little be debilitating in that there was not much that I as a student could do unsupervised to develop my independence. Finding protected time for students and supervisors to communicate would be really helpful to bring up any issues and plan goals. Especially with the introduction of the ePad which needs computers to document. I would have benefitted from a 30min session of devoted and protected student administration time per week in collaboration with my assessors / supervisors to set learning goal and make sure things were getting signed off as we went along. I understand in the busy environment it's difficult to find protected and uninterrupted time. I felt unstructured at times and like I was a burden for needing to take someone off the floor to look at my ePad. This environment doesn't work well with the ePad as its so difficult to document learning in real time. Setting weekly targets of things to sign off would have helped me a little with maintaining motivation. I didn't feel very supported at all from the PEF team, Maybe there needs to be a full time member to support the students here. I needed support with questions about the ePad and there didn't seem to be anyone available to answer the queries of myself or the theatre team despite emailing, calling and leaving teams messages requesting support.	Theatre	Gilbert Bain Hospital
Unfortunately as this was not a full placement and I was on reduced hours, this made it difficult for both the team and myself to allocate with accessor/supervisors, however the department managed extremely well with the limited time due to my phased return.	Ward 1 and HDU	Gilbert Bain Hospital

Additional Comments:

11

Number of Respondents

Search all responses...

Search

Response	Learning Environment	Learning Centre
This PLE is brilliant for stage 3 students. I would highly recommend it to other students. The staff are welcoming and promote learning opportunities.	Accident and Emergency	Gilbert Bain Hospital
i was able to practice skills more then once, which really benefitted my learning and i really improved on a variety of skills	Lerwick Practice Nurses	Shetland Community
I think that a lot of the staff here were really accommodating to me coming here as a student and really helped me to become confident in myself whilst also teaching me tips and tricks that they have learned. I think that some of the AP staff specifically really push for student to learn and take as much away from this placement as possible and the SCN should be really proud of them.	Pre Op Assessment, Outpatients, Gilbert Bain Hospital	Gilbert Bain Hospital
I feel this would be a good placement for first years specifically as it's a good place for building rapport with patients especially for someone who is possibly younger from school with no experience in healthcare. A great place to build confidence and due to the nature of the hospital there's plenty opportunities to build skills in other areas through spokes - another way of building confidence by directing your own learning. I do wonder if it would be better as a 6 week placement rather than an 8 week one but nonetheless there's ways of filling in the gaps by taking a proactive approach which I know the renal team will be a accommodating for	Renal Unit	Gilbert Bain Hospital
Overall my time in Shetland has been enjoyable and I received good learning from my experience. The team have been pleasant and welcoming and have tried their best to slow down a past faced environment to give me learning to take away with me. I'm grateful for the opportunity to see a different side of nursing.	Theatre	Gilbert Bain Hospital
My accessor was very friendly and helpful, she took the time to explain any questions I had and made sure that I was involved with her allocated patients. There is so much to learn on the surgical ward and it is managed efficiently and professionally.	Ward 1 and HDU	Gilbert Bain Hospital

NHS Shetland Feedback Monitoring Report 2025_26 Quarter 1

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 April to June 2025 (Quarter 1).

Further detail, including the actions taken as a result of each Stage 2 complaint from 1 April 2025 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 2024/25 will be included in the Feedback and Complaints Annual Report.

A summary of cases taken to the Scottish Public Services Ombudsman from April 2022 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 42 pieces of feedback in Quarter 1 of 2025/26 (1 April 2025 – 30 June 2025). For clarity these figures include all salaried GP practices (note this is 9 of 10 practices in Shetland for the purposes of Quarter 1 reporting):

	01.04.25 – 30.06.25		01.01.25 – 31.03.25 (previous quarter)	
Feedback Type	**Number**	**%**	**Number**	**%**
Compliments	6	14.3	5	8.3
Concerns	15	35.7	29	48.3
Complaints	21	50	26	43.4
Totals:	**42**		**60**	

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

	01.04.25 – 30.06.25		01.01.25 – 31.03.25 (previous quarter)	
Service	**Number**	**%**	**Number**	**%**
Directorate of Acute and Specialist Services	5	23.8	10	38.5
Directorate of CH&SC	11	52.4	12	46.2
Acute and community	1	4.8	3	11.5
Other (e.g. PH, Patient Travel)	4	19	1	3.8
Totals:	**21**		**26**	

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	01.04.25 – 30.06.25	01.01.25 – 31.03.25 (previous quarter)
Number of complaints closed at Stage One as % of all complaints	61.9% (13 of 21)	73% (16 of 22*)
Number of complaints closed at Stage Two as % of all complaints	33.3% (7 of 21)	23% (5 of 22)
Number of complaints closed at Stage Two after escalation as % of all complaints	4.8% (1 of 21)	4% (1 of 22)

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	01.04.25 – 30.06.25	01.01.25 – 31.03.25 (previous quarter)
Number of complaints upheld at Stage One as % of all complaints closed at Stage One	61.5% (8 of 13)	43.75% (7 of 16)
Number complaints upheld at Stage Two as % of complaints closed at Stage Two	14.3% (1 of 7)	20% (1 of 5)
Number escalated complaints upheld at Stage Two as % of escalated complaints closed at Stage Two	0% (0 of 1)	0% (0 of 1)

Partially Upheld

Description	01.04.25 – 30.06.25	01.01.25 – 31.03.25 (previous quarter)
Number of complaints partially upheld at Stage One as % of complaints closed at Stage One	30.8% (4 of 13)	43.75% (7 of 16)
Number complaints partially upheld at Stage Two as % of complaints closed at Stage Two	57.1% (4 of 7)	60% (3 of 5)
Number escalated complaints partially upheld at Stage Two as % of escalated complaints closed at Stage Two	100% (1 of 1)	0% (0 of 1)

Not Upheld

Description	01.04.25 – 30.06.25	01.01.25 – 31.03.25 (previous quarter)
Number complaints not upheld at Stage One as % of complaints closed at Stage One	7.7% (1 of 13)	12.5% (2 of 16)
Number complaints not upheld at Stage Two as % of complaints closed at Stage Two	28.6% (2 of 7)	20% (1 of 5)
Number escalated complaints not upheld at Stage Two as % of escalated complaints closed at Stage Two	0% (0 of 1)	100% (1 of 1)

3 The average time in working days for a full response to complaints at each stage

Description	01.04.25 – 30.06.25	01.01.25 – 31.03.25 (previous quarter)	Target
Average time in working days to respond to complaints at Stage One	8	6.25	5 wkg days
Average time in working days to respond to complaints at Stage Two	36	29.6	20 wkg days
Average time in working days to respond to complaints after escalation	14	30	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	**01.04.25 – 30.06.25**	**01.01.25 – 31.03.25 (previous quarter)**	**Target**
Number complaints closed at Stage One within 5 working days as % of Stage One complaints	69.2% (9 of 13)	56.25% (9 of 16)	80%
Number complaints closed at Stage Two within 20 working days as % of Stage Two complaints	28.6% (2 of 7)	20% (1 of 5)	80%
Number escalated complaints closed within 20 working days as % of escalated Stage Two complaints	100% (1 of 1)	0% (0 of 1)	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	**01.04.25 – 30.06.25**	**01.01.25 – 31.03.25 (previous quarter)**
% of complaints at Stage One where extension was authorised	30.8%	43.75%
% of complaints at Stage Two where extension was authorised	71.4%	80%
% of escalated complaints where extension was authorised	-	100%

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). 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. There is also an intention for a cohort of staff to undertake SPSO investigation training to support investigation handling across a number of areas (e.g. complaints, HR processes, clinical incidents).

Stage 2 complaints received 1 April 2025 to 30 June 2025

	Summary	Staff Group(s)	<= 20 wkg days	If not, why	Outcome	Findings/Actions
1	Issues linked with neighbouring Board occupied properties	Estates and Facilities	No	Investigation not able to be completed in time	Not upheld	• Explanation offered for actions taken and apology offered for distress caused
2	Misdiagnosis despite complainant suggesting what it might be	Medical	No	More time required for investigation	Not upheld	• No evidence to suggest a missed diagnosis in care – more likely, given the absence of key symptoms, there were other related issues causing pain • Meeting offered with Medical Director to go through notes
3	Delay in diagnosis and communication issues prior to family member's death	Medical	No	More time required for investigation as multiple reports required	Part upheld	• Explanation provided by treating clinicians about decision making • Apologies offered that there was a feeling neither the patient nor their family were listened to • Learning Event Analysis recommended • Facilitated meeting with family offered
4	Recent medical operations and ongoing patient care	Medical	No	Phone meeting with complainant prior to concluding investigation report	Part upheld	• Treatment found to be appropriate however clinical documentation needed improving to ensure accuracy and clarity throughout patient care • Apology offered for shortcomings with medical records
5	Staff attitude and being asked to leave when clearly unwell	Nursing	Yes		Part upheld	• Clinical care appropriate for self-limiting issue • Apology offered that communication did not feel sympathetic or caring
6	Care provided to family member by NHS staff	Medical and nursing	No	More time required for investigation	Part upheld	• No evidence of actual harm between treatment but apology given that action could have been taken sooner • Clinicians involved had reflected on communication

						• Situation was considered and addressed at the point of the complaint being received, despite the delay in a written response
7	ESC Miscommunication about escort approval and reimbursement of accommodation costs	Nursing, Patient Travel	Yes		Part upheld	• Could not evidence that the complainant had been made aware • Review of Patient Travel Escort leaflet and undertaking further communication with staff • Acknowledged communications on both sides were challenging, and reminded of need for respectful communication • Reimbursement provided
8	Follow up care and treatment for family member	Medical	Yes		Upheld – Duty of Candour process triggered	• Apology offered that family member did not receive any follow up care or treatment as expected and for the Board's involvement in what could have otherwise been a potentially preventable emergency situation • Failed process and poor communication • Learning includes improved admin processes and tracking

Cases escalated to the Scottish Public Services Ombudsman from 1 April 2021 to August 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 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	Closed
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