NHS Shetland

Meeting:	Shetland NHS Board
Meeting date:	16 December 2025
Agenda reference:	Board Paper 25/26/43
Title:	Quality Report
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, Corporate Services Manager

1 Purpose

This is presented to the Board 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 ambitions:

- 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. On this occasion, the report includes the UNICEF assessment of baby friendly services at NHS Shetland.

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 December 2025
- Appendix 2 Quality Scorecard November 2025
- Appendix 3 Complaints and Feedback Report Q2 2025-26
- Appendix 4 UNICEF Gold assessment report - NHS Shetland 2025

APPENDIX 1 PROGRESS ON LOCAL QUALITY STRATEGY IMPLEMENTATION

In this report, there is a focus on providing some interpretation of the data, set out in the quality score card and the most recent feedback and complaints report. It also includes a report (shown as Appendix 4), which sets out an independent evaluation of our baby friendly care in Shetland, produced by UNICEF in September 2025. This review includes feedback from a wide range of stakeholders including women who have recently had a baby and experienced maternity care in Shetland.

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 (42 KPIs):				
2025/2026	No target set/ Suspended activity/ awaiting update			
Q2	**7**	**10**	**1**	**24**
	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 Post-Partum Haemorrhage (PPH)	PH-HI-03 NA-HC-09 NA-HC-53 NA-HC-66 NA-HC-69 NA-HC-79 NA-HC-80 NA-IC-01 NA-IC-02 NA-IC-20 Measures will remain on red until the target has been met	NA-HC-54	Detailed in the Quality Score Card (Appendix 1)
Q1	**12**	**8**	**2**	**19**

2025/26				
Q4 2024/25	**10**	**7**	**0**	**24**
Q3 2024/25	8	7	0	26
Q2 2024/25	8	8	0	24
Q1 2024/25	7	6	0	28

- **Health Improvement Measures:**

  PH-HI-03 & PH-HI-03a – Data is reset every April, to enable cumulative data collection for the new financial year. This measure has steadily increased since the annual reset and will remain on red until the set target has been achieved. Relevant teams are encouraged and invited to complete alcohol brief intervention training.

- **Patient Experience Outcome Measures** – During Q2 performance against all 7 patient experience measures surpassed the set target of 90% and achieved 100%.
- **Patient Safety Programme – Maternity and Children**:

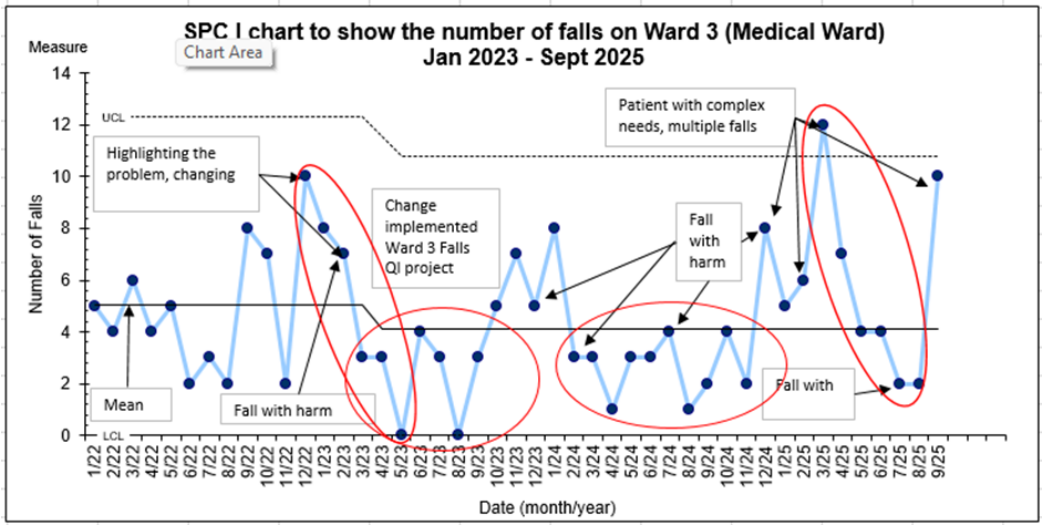
  There were no still births or neonatal deaths this quarter and the number of days between stillbirths continues to increase.

  The number of Post-Partum Haemorrhage (PPH) cases in Shetland has been included in the Quality Score Card from this quarter, this correlates to the National Maternity and Perinatal Audit (NMPA) and provides oversight regarding the number of women having PPHs in Shetland. PPH is a bleed following giving birth which is greater than 500mls. The Royal College of Obstetricians and Gynaecologists (2016) have developed a patient information leaflet which explains what a PPH is and identifies risk factors which may contribute to the likelihood of a PPH occurring. RCOG Heavy bleed after birth (postpartum haemorrhage) (2016)

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

- **Cardiac Arrests** – cardiac arrest data continues to be reported as part of the Scottish Patient Safety Programme (SPSP). There were no reportable cardiac arrests in Q2 2025/26.

- **Falls** – During Q2 there was an increase in the number of inpatient falls from 15 in Q1 to 20 in Q2. The majority of these falls occurred on the medical ward (14 falls). A couple of individuals had multiple falls which reflected their complex patient care needs of these individuals. Adverse events reporting was completed for all these incidents and the SCN is currently reviewing these falls. The Health & Safety Team have also been invited to review these incidents as 'Topic Specialists'.



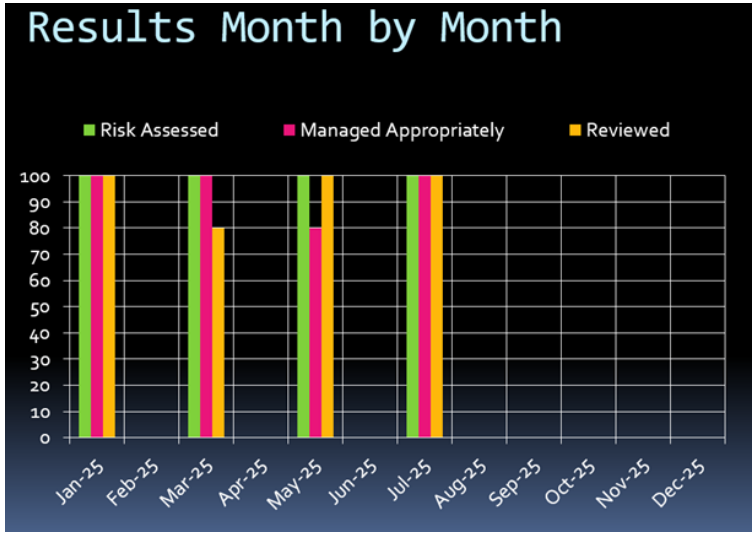
Pressure ulcers – There were four Hospital Acquired Pressure Ulcers reported for Q2 (two upon each inpatient ward), this is an increase compared to the previous quarter when there were two incidence of hospital acquired pressure ulcers. Currently these cases are being reviewed by the Senior Charge Nurses and Tissue Viability Nurse, an update following the review and analysis of these cases will be shared in Q3 Quality Score Card report. All of these pressure ulcers were reported via the adverse event Datix system. 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). Performance reporting and discussion is a standing meeting agenda item at the monthly Surgical Audit meetings, a summary of the

2024/2025, the team were congratulated in the September Surgical Audit meeting for the improvement made regarding DVT care. The DVT data is summarised below:

DVT Audit Results 2024/2025:

	Feb 2024	April 2024	June 2024	Aug 2024	Oct 2024	Jan 2025	March 2025	May 2025	July 2025	Sept 2025	Dec 2025
Risk Assessed NA-HC-71	100%	90%	100%	90%	100%	100%	80%	100%	100%	100%	Audit to be carried out Dec 2025
Managed appropriately NA-HC-72	60%	0%	100%	0%	100%	100%	100%	80%	100%	80%	
Evidence of review NA-HC-73	50%	60%	38%	10%	40%	100%	80%	100%	100%	100%	
Discussed with patient NA-HC-74	80%	0%	0%	0%	0%	20%	0%	10%	30%	30%	



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

  NA-IC-01 the number of days between Catheter Associated Urinary Tract Infections (CAUTI) developed in acute care, will remain on red until the performance target of 300 days have been achieved across both inpatient areas. During Q2 there were no CAUTI infections identified, the Infection Control Team continue to work 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 Q2 we continue to observe the increase in the compliance with Catheter Associated Urinary Tract Infection (CAUTI) Insertion Bundle, from 72.22% in Q4 to 93% in Q2. The Infection Control Team continue to monitor and provide support and education to the clinical areas.

  NA-IC-13 during Q2 we continue to observe the increase in compliance with Catheter Associated Urinary Tract Infection (CAUTI) maintenance bundle, from 51.85% in Q4 to 100% in Q2. The performance target is 95%. This is a positive achievement for both inpatient wards and the infection control team, and reflects their ongoing work to minimise the risk of CAUTI.

- **Clinical Governance Leadership Walkrounds** – During Q2, there were three Leadership Walkrounds scheduled to Montfield Dental, Yell and Unst Health Centres. The visits to Yell and Unst Health Centres unfortunately had to be cancelled due to other commitments which the executive member of the visiting team had.

  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** –There are two EiC performance indicators identified on the Quality Score Card; NA-HC-79 which 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 Q2 we observe a reduction in the accuracy of completed NEWs charts, from 95% in Q1 to 85% in Q2, this reduction in compliance has been escalated to the ward SCNs at the point of identification. EiC and NEWS training is planned to be delivered to both inpatients wards, thus assisting in raising awareness of the EiC programme and the importance of completion of the NEWS charts. Performance regarding the frequency of observations completed on the NEWS charts has increased slightly during Q2 to 87.5%.

- **Thematic learning** – 281 adverse events were reported in Q2 and 3 debriefs were held.

	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26
Number of adverse events	**190**	**205**	**200**	**199**	**211**	**281**
Number of debriefs held	**3**	**12**	**6**	**7**	**6**	**3**
Number of Extreme Adverse Events -	**2**	**4**	**1**	**7**	**13**	**4**
All Adverse Events categorised as ‘extreme’ were related to death notification reporting and have been discussed via the weekly Clinical Risk Advisory Team (CRAT) Meeting.						
Number of Major Adverse Events	**0**	**0**	**1**	**0**	**2**	**5**

			Related to an inpatient fall where patient sustained a hip fracture (Please see the 'Falls' section of this report)			
Number of Moderate Adverse Events	**11**	**6**	**5**	**9**	**15**	**13**

Appendix C provides an overview of the thematic analysis of Lessons Learnt for July – September 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** – During Q2 no inpatient feedback forms were received for Ward 3 during September 2025, the SCN is unsure regarding why no patients completed the experience surveys, the ward will continue to promote the survey to all patients. However, over this quarter between 95-100% of patients on Ward 1 and between 80-100% of Ward 3 patients' said they had a positive care experience. 94%-100% of Ward 1 and 80-100% 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. Patient feedback comments were generally very positive and expressed thanks for the care they had received and appreciation of the service provided.

  A couple of feedback comments highlighted poorer communication between the patients and Doctors; patient feedback is shared at both Surgical Audit and Medical Governance, discussion generated at these governance meetings highlighted the recent challenges experienced on both wards (complex patients and a busier ward environment), teams acknowledged that this should not detract from the interaction with patients and they would be more mindful of this in the future. The nursing teams will continue to support patients following consultant discussions to ensure patients understand the care they are receiving and any questions they may have are answered.

- **Q2 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.
- **Hospital at Home (H@H)** – Hospital at Home data is a new addition to the Quality Score Card (QSC), the team were enthusiastic following discussions at Joint Governance Group (JGG) regarding establishing the service to provide oversight of their service at regular intervals throughout the year. The information provided in appendix 1 page 42 and 43 provides an overview of data collected since Dec 2023 to the 20/11/2025. Going forward the data presented will be presented in the QSC on a quarterly basis. The team have created a dashboard which collates this data, as well as providing the figures regarding referrals, patients treated by the H@H team, the data is then explored further and helps provide an understanding of the reasons for admission, the rejection of case referrals and the patient outcome at 30 days. This data provides a useful overview of activity and outcomes in the service.

- **Student Feedback (QMPLE)** – During Q2, 11 student nurses provided placement feedback. 80% of students were very satisfied with their learning experience, this is an increase from 72% in Q1. 80% of students identified they received more than 28 days advanced notice of their placement in Shetland, this is an increase compared to the 63% in Q1. 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. There was noticeable improvement regarding practice support, all students were allocated a practice supervisor when they arrived in Shetland. 90% of students considered that completely adequate support was provided (this is an increase from 55% in Q1) with all students strongly agreeing with the final performance assessment completed.

  Overall feedback comments highlighted the variety of placement settings and the student opportunities available. Seven students left additional comments which highlighted there was nothing which could improve their placement experience.

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 Q2 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 going well. The introduction of a new reporting system in 2026 is anticipated to reduce capacity initially but has the potential to be extremely beneficial in the longer term, allowing focussed feedback and complaint reporting in departmental areas.
- Performance regarding the length of time to respond to Stage 1 complaints has decreased from the last quarter, with 6 of the 14 Stage 1 complaints handled within five working days. Responding to Stage 2 complaints within 20 working days remains challenging, with one out of nine 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 first group of staff have received SPSO investigation training which will be followed up with a local focussed training session on 18th December 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 is ongoing.

NHS Shetland Feedback Monitoring Report 2025_26 Quarter 2

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 July to September 2025 (Quarter 2).

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 is 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. There 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 50 pieces of feedback in Quarter 2 of 2025/26 (1 July 2025 – 30 September 2025). For clarity these figures include all salaried GP practices (note this is 9 of 10 practices in Shetland for the purposes of Quarter 2 reporting):

	01.07.25 – 30.09.25		01.04.25 – 30.06.25 (previous quarter)	
Feedback Type	**Number**	**%**	**Number**	**%**
Compliments	2	4	6	14.3
Concerns	24	48	15	35.7
Complaints	24	48	21	50
Totals:	**50**		**42**	

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

	01.07.25 – 30.09.25		01.04.25 – 30.06.25 (previous quarter)	
Service	**Number**	**%**	**Number**	**%**
Directorate of Acute and Specialist Services	12	50	5	23.8
Directorate of CH&SC	10	42	11	52.4
Acute and community	-	-	1	4.8
Other (e.g. PH, Patient Travel)	2	8	4	19
Totals:	**24**		**21**	

Key highlights

- There is now additional capacity in the Feedback and Complaints Service with the recent addition of an Assistant Feedback and Complaints Officer. Induction and training is going well. The introduction of a new reporting system in 2026 is anticipated to reduce capacity initially but has the potential to be extremely beneficial in the longer term, allowing focussed feedback and complaint reporting in departmental areas.
- Performance regarding the length of time to respond to Stage 1 complaints has decreased from the last quarter, with 6 of the 14 Stage 1 complaints handled within five working days. Responding to Stage 2 complaints within 20 working days remains challenging, with one out of nine 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 first group of staff have received SPSO investigation training which will be followed up with a local focussed training session on 18th December 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 is ongoing.

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	01.07.25 – 30.09.25	01.04.25 – 30.06.25 (previous quarter)
Number of complaints closed at Stage One as % of all complaints closed	61% (14 of 23)	61.9% (13 of 21)
Number of complaints closed at Stage Two as % of all complaints closed*	39% (9 of 23)	33.3% (7 of 21)
Number of complaints closed at Stage Two after escalation as % of all complaints closed	0% (0 of 23)	4.8% (1 of 21)
*One Stage 2 complaint from August remains open at present		

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	01.07.25 – 30.09.25	01.04.25 – 30.06.25 (previous quarter)
Number of complaints upheld at Stage One as % of all complaints closed at Stage One	29% (4 of 14)	61.5% (8 of 13)
Number complaints upheld at Stage Two as % of complaints closed at Stage Two	11% (1 of 9)	14.3% (1 of 7)
Number escalated complaints upheld at Stage Two as % of escalated complaints closed at Stage Two	n/a	0% (0 of 1)

Partially Upheld

Description	01.07.25 – 30.09.25	01.04.25 – 30.06.25 (previous quarter)
Number of complaints partially upheld at Stage One as % of complaints closed at Stage One	57% (8 of 14)	30.8% (4 of 13)
Number complaints partially upheld at Stage Two as % of complaints closed at Stage Two	67% (6 of 9)	57.1% (4 of 7)
Number escalated complaints partially upheld at Stage Two as % of escalated complaints closed at Stage Two	n/a	100% (1 of 1)

Not Upheld

Description	01.07.25 – 30.09.25	01.04.25 – 30.06.25 (previous quarter)
Number complaints not upheld at Stage One as % of complaints closed at Stage One	14% (2 of 14)	7.7% (1 of 13)
Number complaints not upheld at Stage Two as % of complaints closed at Stage Two	22% (2 of 9)	28.6% (2 of 7)
Number escalated complaints not upheld at Stage Two as % of escalated complaints closed at Stage Two	n/a	0% (0 of 1)

3 The average time in working days for a full response to complaints at each stage			
Description	**01.07.25 – 30.09.25**	**01.04.25 – 30.06.25 (previous quarter)**	**Target**
Average time in working days to respond to complaints at Stage One	9.6	8	5 wkg days
Average time in working days to respond to complaints at Stage Two	43.3	36	20 wkg days
Average time in working days to respond to complaints after escalation	-	14	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	**01.07.25 – 30.09.25**	**01.04.25 – 30.06.25 (previous quarter)**	**Target**
Number complaints closed at Stage One within 5 working days as % of Stage One complaints	42.9% (6 of 14)	69.2% (9 of 13)	80%
Number complaints closed at Stage Two within 20 working days as % of Stage Two complaints	11% (1 of 9)	28.6% (2 of 7)	80%
Number escalated complaints closed within 20 working days as % of escalated Stage Two complaints	-	100% (1 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	**01.07.25 – 30.09.25**	**01.04.25 – 30.06.25 (previous quarter)**
% of complaints at Stage One where extension was authorised	57.1%	30.8%
% of complaints at Stage Two where extension was authorised	89%	71.4%
% of escalated complaints where extension was authorised	-	-

Staff Awareness and Training

Feedback and Complaints staff are 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. More will be done to encourage staff to get in touch if they are uncertain about how to proceed.

There is a renewed organisational push on mandatory training (for which there is a Feedback and Complaints eLearning module).

Staff are able to access excellent national e-learning resources regarding feedback and complaint handling, including investigation skills, through TURAS Learn. SPSO investigation training is being provided to a number of staff to support investigation handling across a number of areas (e.g. complaints, HR processes, clinical incidents). This will be followed up at a local level.

The Stage 1 complaint reporting process is being modernised and will be re-communicated in the new year.

Stage 2 complaints received 1 April 2025 to 30 September 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
9	Delay in diagnosis over a three-year period	Medical	No	More time required for investigation	Part upheld	• Timeline of events outlining clinical treatment used to explain patient pathway • Acknowledged these were not specific to rare cancers • Apologies offered to complainant and a learning outcome review undertaken as an opportunity to learn from this • Signposting to various organisations for additional support
10	Inappropriate prescription for family member	Medical	No	Marginally missed 20 days	Not upheld	• Age of family member meant they could consent or decline treatment • Second opinion declined by patient • Additional information about guidelines shared
11	Lack of communication and follow up diagnosis/diagnostics	Primary Care	No	More time required	Part upheld	• Earliest indication of diagnosis was from correspondence in 2006, however unfortunately a mistake had led to discharge from clinic

						• Treatment stood down in pandemic so further support was missed • Diagnosis now given and plan to see patient again for a follow up appointment
12	Family member discharged from hospital in poor condition	Acute nursing	No	More time required	Open	
13	Family member's treatment and care in A&E	A&E	No	More time required	Part upheld	• Work undertaken with CPN and wider multidisciplinary team to develop a plan for future presentations • Failings from this episode shared to identify learning opportunities • Communication could have been improved • Changes made to the triage process to ensure there are no patients waiting in the department that the clinical team is not fully aware of
14	Concern about family member's death and communication surrounding this	Acute nursing	Yes		Part upheld	• Apologies offered for the way the situation had unfolded • Confirmed that family were immediately notified of the patient's death • Learning for the team from the family's experience
15	Lack of support or treatment	GP	No	More time required	Part upheld	• Apologies for delay in care – additional prompts to be implemented on GP IT systems to prevent further issues • Explanation of treatment pathways available and why a referral had been rejected • Apology for lack of follow up after medication prescribed • Review appointment booked
16	Poor procedure experience and confidentiality concerns	Acute nursing	No	More time required for verification	Part upheld	• Procedure outcome had been within normal limits, however there was some good learning for the nurse involved • Standard Operating Procedure reviewed, observation in practice and written reflection by nurse involved

17	Lack of support following test result	Maternity	No	More time required for verification	Fully upheld	• Apology offered for areas where staff had fallen short in the care received • Training to be given and a leaflet created to inform patients about additional support available • Spiritual Care Lead to support by developing a pathway for patients who experience loss • Meeting offered
18	Lack of urgency and support for diagnosis	Medical/Physio	No	More time required	Not upheld	• Apologies for delay in treatment – explanation of pathway followed and why it was clinically correct • If details of worsening symptoms had been explained, referral would have been resubmitted with more urgency • Following up with partner Board regarding surgical prioritisation

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

The UK Committee for UNICEF (UNICEF UK) Baby Friendly Initiative

Gold assessment report

NHS Shetland, Maternity and Health Visitor services

on 27 August 2025

unicef.org.uk/babyfriendly/

The United Kingdom Committee for UNICEF (UNICEF UK),
Registered Charity No. 1072612 (England & Wales), SC043677 (Scotland).
1 Westfield Ave, London E20 1HZ.

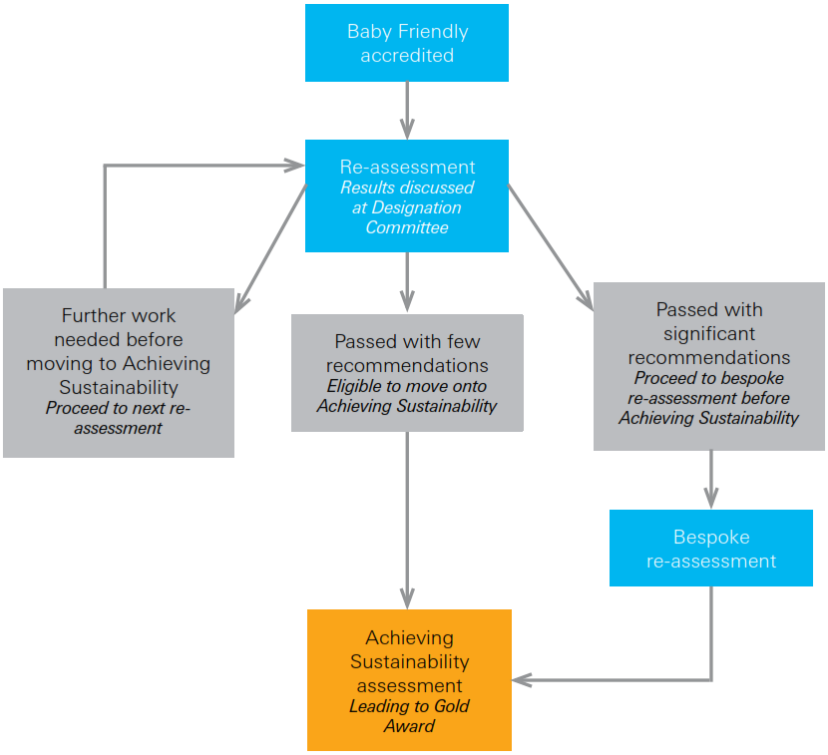
Contents

Background

Baby Friendly accreditation is based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centres services. These are designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development. Facilities implement the standards in stages over a number of years and are externally assessed by UNICEF UK at each stage. When all the stages are passed, they are accredited as Baby Friendly. The initial accreditation lasts for two years; after this, re-assessments take place on a regular basis to ensure that the standards are being maintained and to explore how the service is building on the good work it has already done.

After successful re-assessment the services are eligible to be assessed against the Achieving Sustainability standards, which if passed, lead to a Gold award. Gold services will no longer have to undergo large external re-assessments to maintain their accreditation but rather will be re-validated via the annual submission of a portfolio and three-yearly re-validation meetings with an external assessor. Re-assessment costs will be replaced with an annual licence fee.

Introducing any significant change into a large organisation requires a great deal of effort, and it then takes time for changes to become embedded into everyday practice. These Achieving Sustainability standards are designed to help with this longer-term implementation. They do not describe the direct clinical care of babies, their mothers, and families, but rather they are an organisational roadmap for how to implement the standards in a way that is both effective in the short term and sustainable over time.



Achieving Sustainability standards

THEME 1: LEADERSHIP

Develop a leadership team that promotes the Baby Friendly standards

- There is a named Baby Friendly lead/team with sufficient knowledge, skills and hours to meet their objectives
- There is a mechanism for the Baby Friendly lead/team to remain up-to-date with their education and skills
- A Baby Friendly Guardian with sufficient seniority and engagement is in post
- The leadership structures support proportionate responsibility and accountability
- All relevant managers are educated to support the maintenance of the standards.

THEME 2: CULTURE

Foster an organisational culture that protects the Baby Friendly standards

- There is support for ongoing staff learning
- There are mechanisms in place to support a positive culture, such as staff recognition schemes, mechanisms for staff to feedback concerns and systems to enable parents' and families' feedback to be heard and acted upon.

THEME 3: MONITORING

Construct robust monitoring processes to support the Baby Friendly standards

Mechanisms exist to ensure that:

- Baby Friendly audits are carried out regularly according to service needs
- All relevant data is available and is accessed
- Data is analysed effectively and collectively to give an overall picture
- Action plans are developed in response to findings
- Relevant data is routinely reported to the leadership team
- Relevant data is routinely reported to UNICEF UK.

THEME 4: PROGRESSION

Continue to develop the service in order to sustain the Baby Friendly standards

- The service demonstrates innovation and progress
- There is evidence to demonstrate that outcomes have improved
- The needs of babies, their mothers and families are met through effective integrated working.

Assessment result

We found that NHS Shetland Maternity and Health Visitor services has met most standards for the Gold Award.

NHS Shetland, Maternity and Health Visiting service is commended for their submission and the progress made with embedding and developing care related to the Baby Friendly standards.

A comprehensive portfolio of evidence was submitted for this Achieving Sustainability assessment. Interviews were completed with the Infant Feeding Lead, Head of Service and Baby Friendly Guardian. There are clear leadership structures and support across the service, a positive culture as evidence by feedback from staff and families, robust monitoring and evidence of planned service improvement.

However, as outlined below, one question in the staff culture survey was 79% and was almost met. The assessment team asks the Designation Committee to consider this report and what actions are required before the Gold Award can be made.

Janet Dalzell
3 September 2025

Supporting documents

The following list details the documents reviewed as part of this assessment.

Document number	Document title
D1	D1 1.1 Shetland - Leadership - Infant Feeding Coordinator role
D2	D2 1.1 Shetland - Leadership -Band 6 - Integrated Midwife (updated June 2013) JD
D3	D3 1.1 Shetland - Leadership -Band 7 - Clinical Team Leader (Health Visiting) updated March 2024 JD
D4	D4 1.1 Shetland - Leadership - Band 7 - Senior Charge Midwife (updated November 2014) JD
D5	D5 1.1 Shetland - Leadership - Band 8a Child Health Clinical Nurse Manager - 2022 JD
D6	D6 1.1 Shetland - Leadership -Band 8b- Chief Midwife JD
D7	D7 1.1 Shetland - Leadership - Deputy Director of Acute Services JD
D8	D8 1.1 Shetland - Leadership - Director of Nursing and Acute Services JD
D9	D9 1.2 Shetland - Leadership - Leadership Team Organogram
D10	D10 1.3 Shetland - Baby Friendly Guardian - Kathleen Carolan profile
D11	D11 1.3 Shetland - Baby Friendly Guardian - Kathleen Carolan statement
D12	D12 2.1 Shetland - Culture - Ongoing staff training -Infant Feeding Update Day
D13	D13 2.1 Shetland - Culture - Staff training- Collation of training evaluation forms
D14	D14 2.2 Shetland - Positive Culture Greatix
D15	D15 2.2 Shetland - Positive culture - Greatix
D16	D16 2.2 Shetland - Positive culture - TS email from Infant Feeding Lead
D17	D17 2.2 Shetland - Positive culture - Maternity meeting agenda
D18	D18 2.2 Shetland - Collation Staff Questionnaire HV confidence satisfaction 311024
D19	D19 2.2 Shetland - Collation Staff Questionnaire MW confidence satisfaction 311024
D20	D20 2.2 Shetland - Collation Staff Questionnaire HCA confidence satisfaction 311024
D21	D21 2.2 Shetland - Infant Feeding Lead Support provided to Maternity & Health Visiting Staff Audit results
D22	D22 2.2 Shetland - Positive culture -Minutes of Health Visitor Team Meeting 100924
D23	D23 2.2 Shetland - Positive culture - iMatters MaternityTeam Report 2025
D24	D24 2.2 Shetland -Positive Culture HV imatters Team Report 2025
D25	D25 2.2 Shetland - Positive culture - Excellence in Care awards 2024 - Lynn Ritch & Hannah McCluskey
D26	D26 2.2 Shetland - Positive culture - Care Opinion - SK
D27	D27 2.2 Shetland - Positive culture -Maternity Voices minutes 050625
D28	D28 2.2 Shetland - Culture - Risk Management Feedback
D29	D29 2.3 Shetland - Culture of kindness - Card 1
D30	D30 2.3 Shetland -Culture of kindness - Card 2
D31	D31 2.3 Shetland - Culture of kindness - Card 3
D32	D32 2.3 Shetland -Culture of kindness- Card 4

D33	D33 3 Shetland -Monitoring -Annual-audit-form-maternity Shetland April 24 - March 2025
D34	D34 3 Shetland -Monitoring- Annual-audit-form-community-Shetland April 24 - March 25
D35	D35 3 Shetland- Monitoring – Postnatal Questionnaire
D36	D36 2.3 Shetland -Feedback from attendees at Peer Support Drop-in group
D37	D37 2.2 Culture Shetland- Infant Feeding Lead Specialist Support Service Mothers satisfaction audit - Results
D38	D38 2.2 Culture - Shetland -Tongue tie service audit April 24 - March 25 Word doc
D39	D39 3. Shetland- Monitoring -PHS HEYS dashboard HV 1st visit & 6-8week review
D40	D40 3. Monitoring -Shetland April 24 - March 25 Health Visitor First Visit Heyes data
D41	D41 3. Monitoring -Shetland April 24 - March 25 6-8w Heyes data
D42	D42 3. Monitoring - Copy of Breastfeeding_Report_Card_NHS_Shetland 180325 progress
D43	D43 3. Shetland-Monitoring - FINAL Q4 2024 2025 Quality Score Card Report to Board
D44	D44 3. Shetland - Monitoring - Q4 Appendix 1 CGC QSC V0.1 Quality Scorecard to Board 280525
D45	D45 2.2 Shetland - Positive culture - 2024 RCM Conference presentation - Janice Irvine
D46	D46 4 Shetland - Progression- Integrated Working -Health Improvement Update meeting July 25
D47	D47 4.1 & 4.2 Shetland - Progression -Report-template-for-improvements - Peer Support
D48	D48 4. Shetland - Progression -Report-template-for-improvements Infant feeding sessions 36weeks
D49	D49 4.1 Shetland - Progression - Report-template-for-improvements - Early antenatal class
D50	D50 4.1 Shetland - Progression - Report-template-for-improvements - Infant Feeding Healthcare support worker
D51	D51 4.1 & 4.2 Shetland - Progression - Report-template-for-improvements Lynn Ritch
D52	D52 4.1 & 4.2 Shetland - Progression - Report template for improvements - BFFS
D53	D53 4.1 & 4.2 Shetland -Progression - Report template for improvements - BFFS -Early Learning Scheme
D54	D54 4.1 & 4.2 Shetland -Progression - SUDI Lead
D55	D55 4.1 Shetland - Progression - Report-template-for-improvements UNICEF ANCC
D56	D56 4 Shetland - Progression - Baby Friendly Steering Group meeting August 24
D57	D57 4 Shetland - Progression- Baby Friendly Steering Group meeting June 25

The results in detail: Criteria to be met for the Gold Award

This report explains how each of the four standards have been met. Each section details:

- the documents submitted
- whether each of the criteria have been met
- key achievements
- what is needed should additional evidence be required before the Gold Award can be made (requirements)
- recommendations which we will expect to be addressed in advance of the first annual review.
- suggestions which we believe may further enhance sustainability and are therefore presented for consideration.

Theme 1 – Leadership

Criteria	Met	Almost met	Partially met	Not met	Action needed
Theme 1: Leadership					
1. There is a named Baby Friendly lead/team with sufficient knowledge, skills and hours to meet their objectives.	✓				
2. There is a mechanism for the Baby Friendly lead/team to remain up-to-date with their education and skills.	✓				
3. A Baby Friendly Guardian with sufficient seniority and engagement is in post.	✓				
4. The leadership structures support proportionate responsibility and accountability.	✓				
5. All relevant managers are educated to support the maintenance of the standards.	✓				

We found that the following is working well:

- The Infant Feeding Lead maintains and monitors the implementation of the UNICEF UK Baby Friendly Initiative standards across maternity and health visiting services.
- The Infant Feeding Lead is supported to maintain their knowledge and skills to ensure they can meet the learning outcomes of staff to support local families.
- The Infant Feeding Lead provides a specialist support service which was evaluated positively by service users with appropriate action planning for improvement.

- The Baby Friendly Guardian advocates at a senior level offering support and guidance to the Infant Feeding Lead.
- All internal audit results are reported to the Child Health Forum, Children's Planning Forum and to NHS Shetland Board.
- All managers have completed the UNICEF UK BFI leader programme.
- We recommend that you provide audit training to other members of the team which can include midwives, health visitors and health care assistants to increase capacity for the Infant Feeding Lead to progress other workplans.

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Theme 2 – Culture

Theme 2: Culture					
6. There is support for ongoing staff learning.	✓				
7. There are mechanisms in place to support a positive culture, such as staff recognition schemes, mechanisms for staff to feedback concerns.	✓				
8. Systems to enable parents' and families' feedback to be heard and acted upon.	✓				
Staff survey responses		✓			

We found that the following is working well:

- Annual updates are provided to staff and internal audit results are used to inform discussions with staff to build confidence in managing conversations with pregnant women and new mothers. By the end of September 2025 all staff will have attended a session.
- NHS Shetland provide Greatix awards to staff identified by staff or patients as proving exceptional support and care.
- NHS Shetland Celebrating Excellence in Care Awards is an annual celebration of some of the best improvement work undertaken by teams. The person-centred care award for antenatal education classes by a Health Visitor was included to highlight staff recognition.
- Infant feeding is discussed at the Health Visitor team meetings.
- Staff confidence questionnaire feedback has been utilised to develop learning and education content with these updated sessions evaluating positively.
- The Infant Feeding Lead provides positive feedback to staff on an individual basis based on feedback from mothers. Several examples were included in the portfolio which demonstrated a culture of kindness across the services.
- Care Opinion feedback is used to seek feedback from families.

Staff culture audit

77% of staff (23/30) completed the Baby Friendly staff culture audit. The survey link was sent to all staff, and this included 9 health visitors and 21 midwives. The respondents included 6 health visitors, 11 midwives, 3 health/maternity care assistants and 2 obstetric medical staff.
Question 6. '*If you voiced ideas, do you think you would be listened to?,*' was almost met at 79%.

Question	Standard	Response	
1. How valued is Baby Friendly within your service?	80% Very valued	Very valued	83%
		Somewhat valued	17%
		Not very valued	0%
		Not at all valued	0%
2. How motivated do you feel to implement the Baby Friendly standards?	80% Most of the time	Most of the time	96%
		Some of the time	4%
		Occasionally	0%
		Not at all	0%
3. Do you feel there is an opportunity for you to raise concerns about how the service provides Baby Friendly care?	80% Yes	Yes	100%
		No	0%
4. If you raised concerns, do you think that positive action would be taken?	80% Probably	Probably (high chance of happening)	83%
		Maybe (equal chance of happening)	13%
		Not at all (low chance of happening)	4%
5. If you had ideas about how to further improve care for parents and babies, is there a way in which you can voice your ideas?	80% Yes	Yes	100%
		No	0%
6. If you voiced ideas, do you think you would be listened to?	80% Probably	Probably (high chance of happening)	79%
		Maybe (equal chance of happening)	17%
		Not at all (low chance of happening)	4%
7. Do you feel that there is a culture of kindness between staff of all grades?	80% Nearly/Most	Nearly all the time	70%
		Most of the time	17%
		Some of the time	13%
		Occasionally or not at all	0%
8. Do you feel that there is a culture of kindness towards women and families?	80% Nearly/Most	Nearly all the time	96%
		Most of the time	4%
		Some of the time	0%
		Occasionally or not at all	0%

Overall, the responses to the staff culture survey were extremely positive and included the following comments:

- *"I think the culture here is very well supported and driven by the highly professional Infant Feeding Lead midwife that we have in our Health Board. The difference that she makes to staff and families is monumental."*
- *"I feel we are all very supportive of the mothers and each other."*

- *"Staff very positive about breastfeeding & Baby Friendly in general. A number of changes occurring just now which are unsettling for staff."*

Written comments in relation to Question 6: '*If you voiced ideas, do you think you would be listened to?'* included:

- *"The cultural problems within the unit are being addressed but this will take a long time and will not be an easy fix."*
- *"Definitely by Infant Feeding Lead, but she may be restricted by Chief midwife & maternity senior MW or child health lead in what she can do."*
- *"The planned future changes of our services will now be taken into account before making any changes."*

The maternity unit building will be having planned repairs which may have resulted in some of the free text comments. We recommend that you develop an action plan to increase the percentage of staff responding that this would probably happen *"If you voiced ideas, do you think you would be listened to?".*

Theme 3 – Monitoring

Criteria	Met	Almost met	Partially met	Not met	Action needed
Theme 3: Monitoring					
9. Baby Friendly audits are carried out regularly according to service needs.	✓				
10. All relevant data is available and is accessed.	✓				
11. Data is analysed effectively and collectively to give an overall picture.	✓				
12. Action plans are developed in response to findings.	✓				
13. Relevant data is routinely reported to the leadership team.	✓				
14. Relevant data is routinely reported to UNICEF UK.	✓				

We found that the following is working well:

- Annual internal audit results all met above 80%.
- Public Health Scotland Infant Feeding Dashboard, Breastfeeding Report card data are used to target interventions and support.
- Scottish Government Breastfeeding Project identified antenatal and early postnatal support as service improvement need.

We found the following recommendations to augment this high-quality submission:

- The assessment team were impressed by your use of Public Health Scotland infant feeding data and the Scottish Government Breastfeeding project. We recommend that you continue to utilize this data to monitor the Scottish Government stretch aim.

Theme 4 – Progression

Criteria	Met	Almost met	Partially met	Not met	Action needed
Theme 4: Progression					
15. The service demonstrates innovation and progress	✓				
16. There is evidence of improved outcomes	✓				
17. There is evidence of integrated working.	✓				

We found that the following is working well:
The evidence portfolio included information on the following:

- NHS Shetland Breastfeeding Peer Support
- Promoting the importance of bonding and attachment for first time parents
- Breastfeeding Friendly Scotland Scheme
- Antenatal Colostrum Collection
- SUDI Pathway

We recommend that you provide evaluation reports on the above projects and planned projects, at your 2-year revalidation:

- NHS Shetland Breastfeeding Peer Support
- Promoting the importance of bonding and attachment for first time parents
- Breastfeeding Friendly Scotland Scheme
- Antenatal Colostrum Collection
- SUDI Pathway
- Breastfeeding Friendly Scotland Early Learning scheme
- Antenatal Infant Feeding sessions

Breastfeeding trends

The following data has been provided by the service (2023-2024 report card):

Feeding type	Age/stage collected	Year (Gold)
		2025
Exclusive breastfeeding	Initiation	**85%**
	HVFV	**58%**
	6-8 weeks	**51%**
Partial breastfeeding		
	HVFV	**19%**
	6-8 weeks	**17%**
Formula feeding	Initiation	**15%**
	HVFV	**42%**
	6-8 weeks	**49%**

Summary of what is required.

Actions that are required are mandatory if the criteria for the Gold Award are to be met in full. If any requirements are made, these are listed below.
The Designation Committee will be asked to consider what additional evidence is required. Further requirements may be made in the future in relation to any changes made and in light of practice found.

1. Evidence of an increase in staff responses to Question 6. *"If you voiced ideas, do you think you would be listened to?".*

How we recommend you achieve and maintain the standards

Recommended actions are those that have proven valuable in supporting the implementation of the standards to maintain core Baby Friendly standards or will address any weaker areas. In some cases, implementation (or not) of these recommendations is likely to make a significant difference to sustainability and thus to the ability of the facility to maintain and progress the Baby Friendly standards. The recommendations made by the assessment team are listed in this report. Further recommendations may be made in the future in relation to any changes made, and in light of practice found or current research evidence.
Actions taken to address the recommendations will be considered at the time of the subsequent annual review.

Culture

- We recommend that you develop an action plan to increase the percentage responding that this would probably happen *"If you voiced ideas, do you think you would be listened to?".*

Monitoring

- The assessment team were impressed by your use of Public Health Scotland infant feeding data and the Scottish Government Breastfeeding project. We recommend that you continue to utilize this data to monitor the Scottish Government stretch aim.
- Currently the Infant Feeding Lead completes all of the internal audits. We recommend that you provide audit training to other members of the team which can include midwives, health visitors and health care assistants to increase capacity for the Infant Feeding Lead to progress other workplans.

Progression

We recommend that you provide evaluation reports on progression at your 2-year revalidation:

- NHS Shetland Breastfeeding Peer Support
- Promoting the importance of bonding and attachment for first time parents
- Breastfeeding Friendly Scotland Scheme
- Antenatal Colostrum Collection
- SUDI Pathway
- Breastfeeding Friendly Scotland Early Learning scheme
- Antenatal Infant Feeding sessions

Any additional advisory comments

Advisory suggestions relate to areas where we feel some change would be beneficial or could readily be achieved. They are offered purely as advice and do not affect designation of the service as Baby Friendly, either now or in the future (unless the assessment criteria nationally are changed, in which case prior notice would be given).

1. We advise that future staff culture surveys are sent separately to maternity and health visitor services which will enable differentiation between the comments from staff and the services.

Foundation standards

As part of the changes made to standards from January 2025, services are requested to consider how they would plan to implement changes to strengthen the foundation standards. If your next assessment is after June 2026, this will be required rather than advisory criteria.

	The service implementation is:		
	In place	**Planning**	**Recommended**
A Baby Friendly Lead with the knowledge skills and capacity to implement the standards	✓		
A strategy group or equivalent	✓		
A Guardian who sits on or with access to the Trust Board	✓		
Relevant data sharing agreements Maternity to Community Neonatal to Maternity and Community Handover process	✓		
Annual mandatory training updates	✓		
Relevant quality assurance of training for commissioned service staff	✓		
Consideration of local population needs	✓		
Evidence of co-design of services, resources.	✓		

Comments

- The foundation standards are met in full.

What happens next?

- The Designation Committee will consider this report, and you will be informed by letter of what is required. It is most likely that further evidence will be needed. Plans should be made for this to occur by **November 2025**.

Background information

Baby Friendly accreditation history	Full accreditation awarded December 2014. Re-accredited February 2017, September 2020, August 2024
Births per year	166 April 2024 – March 2025 92 women delivered in Shetland, 69 in Aberdeen and 5 in other Scottish locations.
Facilities	9 Health Visitors 10 Health Centres
Local demographics	The Shetland Islands are a remote and rural location. Ferry journeys are required to get to the outer Shetland islands from mainland Shetland. Our closest tertiary hospital is Aberdeen Maternity Hospital which is 220 miles away. Transfers are via air ambulance, routine flights, or overnight ferry.

Appendix: UNICEF UK Baby Friendly Initiative

The Baby Friendly Initiative is improving healthcare for babies, their mothers, parents and families in the UK as part of a wider global partnership between the World Health Organization (WHO) and UNICEF. We enable public services to better support families with feeding and developing close and loving relationships so that all babies get the best possible start in life. Introduced to the UK in 1994, the Baby Friendly accreditation programme is recognised and recommended in numerous government and policy documents across all four UK nations, including the National Institute for Health and Care Excellence guidance.

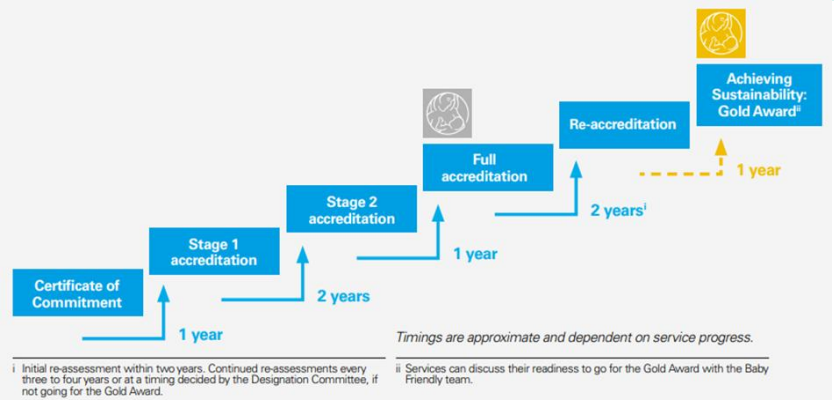
The programme supports maternity, neonatal, community and hospital-based children's services to transform their care and works with universities to ensure that newly qualified midwives and health visitors have the strong foundation of knowledge needed to support families. Services which implement the Baby Friendly standards receive the prestigious Baby Friendly award, a nationally recognised mark of quality care. The programme supports services by:

- Setting standards which provide a roadmap for sustainable improvements
- Providing training and personalised support to help services implement the standards
- Assessing progress by measuring the skills and knowledge of health professionals, and interviewing mothers to hear about their personal experiences of care.

Initial accreditation as a Baby Friendly facility takes place in three stages:

- Stage 1 of the assessment procedure is designed to ensure that the necessary policies, guidelines, information and mechanisms are in place to allow health care providers to implement the Baby Friendly standards effectively.
- Stage 2 involves the assessment of staff knowledge and skills.
- Stage 3 assesses the implementation of the Baby Friendly standards in the care of pregnant women and new mothers.
- Re-assessment takes place after two years with the aim of ensuring that the standards are maintained. Ongoing assessment is carried out every three years with the same goal of ensuring the maintenance of standards.

The work of the Baby Friendly Initiative within the UK is overseen by the Designation Committee, a panel of impartial experts in the field of breastfeeding and neonatal care including representatives from paediatrics, neonatal, midwifery and health visiting, voluntary organisations and mother support groups as well as representatives from Baby Friendly accredited facilities. The findings from all assessments are reviewed by the Designation Committee in order to ensure consistency and fairness.

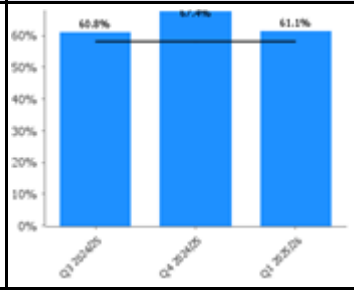


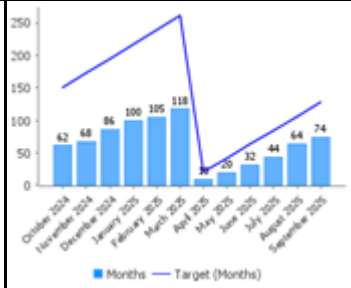
Board

Generated on: 14 November 2025

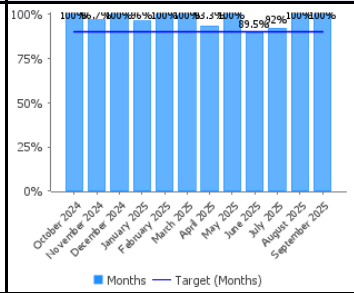
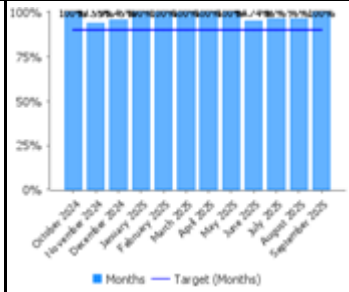
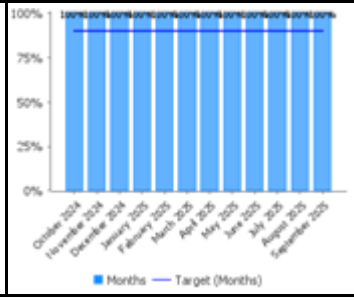
Quality Scorecard – NHS Board

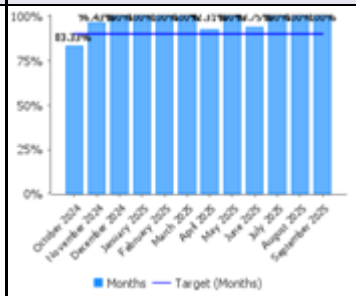
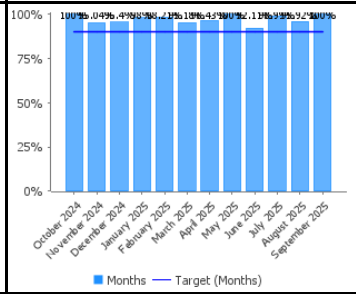
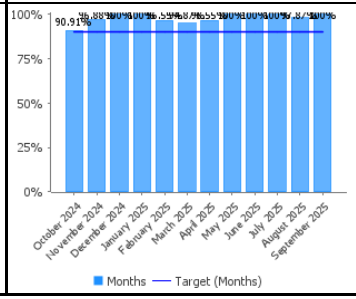
Title
Health Improvement

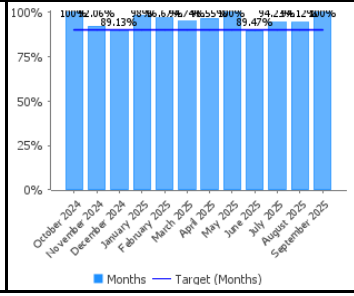
Performance Indicators	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HI-01 Percentage Uptake of Breastfeeding at 6-8 Weeks (exclusively breastfed plus mixed breast and formula) (Rolling annual total by quarter)	Measured Quarterly			67.44%	61.11%			58%		Q2 data will be available end November 2025.

Performance Indicators	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 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.	44	64	74	118	32	74		129		Measure will remain on red until target of 261 is achieved.
PH-HI-03a Number of FAST alcohol screenings	215	279	332	572	161	332		240		

Title
Patient Experience Outcome Measures

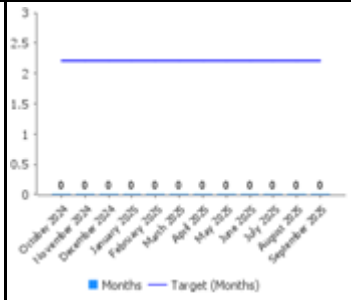
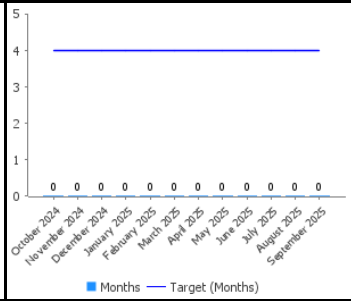
Performance Indicators	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-01 % who say they had a positive care experience overall (aggregated)	92%	100%	100%	100%	89.5%	100%		90%		
NA-HC-04 % of people who say they got the outcome (or care support) they expected and needed (aggregated)	96%	96%	100%	100%	94.74%	96%		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%		

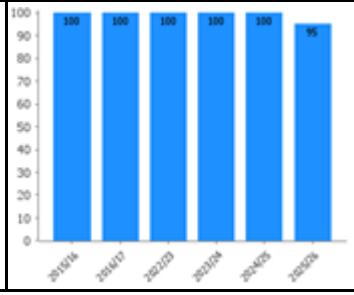
Performance Indicators	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-17 What matters to you % of people who say we took account of the people who were important to them and how much they wanted to be involved in care/treatment (aggregated)	100%	100%	100%	100%	93.75%	100%		90%		
NA-HC-20 What matters to you % of people who say that they have all the information they needed to help them make decisions about their care/treatment (aggregated)	98.99%	95.92%	100%	95.18%	92.11%	100%		90%		
NA-HC-23 What matters to you % of people who say that staff took account of their personal needs and preferences (aggregated)	100%	97.87%	100%	94.87%	100%	100%		90%		

Performance Indicators	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 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)	94.23%	94.12%	100%	94.74%	89.47%	100%		90%		

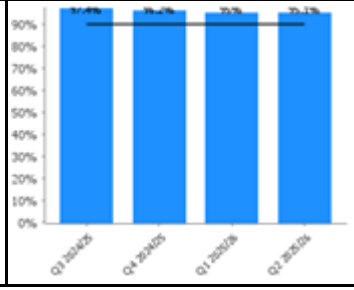
Title
Patient Safety Programme - Maternity & Children Work stream

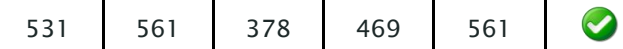
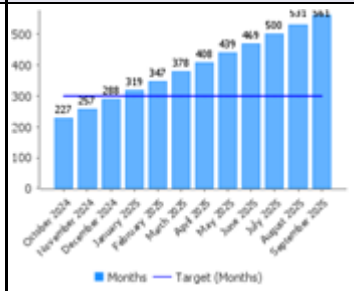
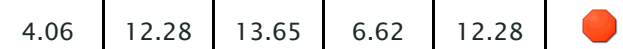
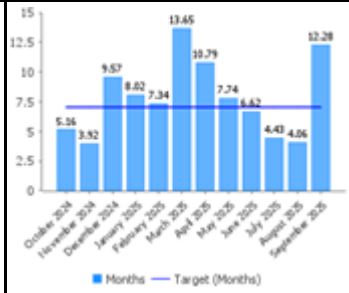
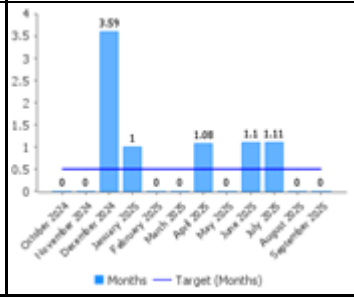
Performance Indicators	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-CF-07 Days between stillbirths	3,793	3,824	3,854	3,671	3,762	3,852		300		

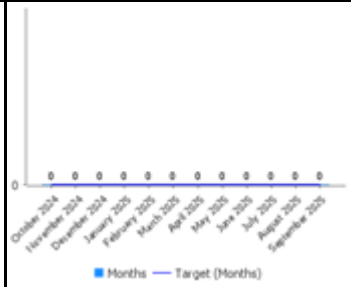
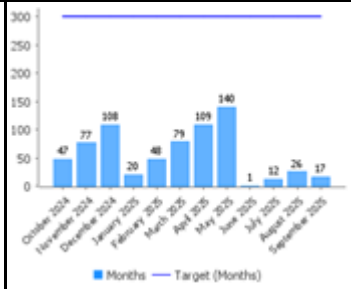
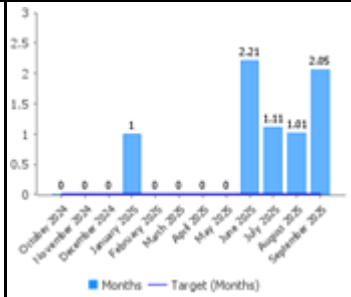
Performance Indicators	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-CF-09 Rate of neonatal deaths (per 1,000 live births)	0	0	0	0	0	0		2.21		
NA-CF-15 Rate of stillbirths (per 1,000 births)	0	0	0	0	0	0		4		
Post-Partum Haemorrhage (PPH)	0	0	1	1	1	1	No Target Set			Reflects the data collected for the National Maternity and Perinatal Audit (NMPA).
NA-CF-16 % of women satisfied with the care they received	There has been one piece of feedback received via Care Opinion in July 2025 which was very positive regarding care received. The department continues to receive lots of thank you cards and direct messages of thanks. Wonderful Antenatal Care | Care Opinion									

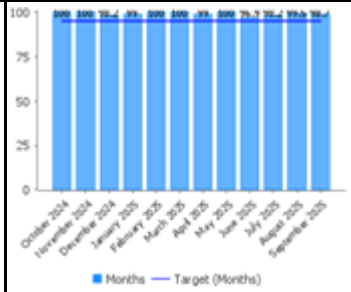
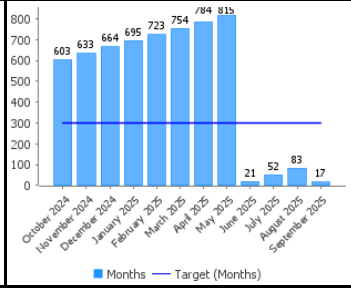
Performance Indicators	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-58 % compliance with the newborn screening bundle	Measured Quarterly			100%	100%	95%		100%		

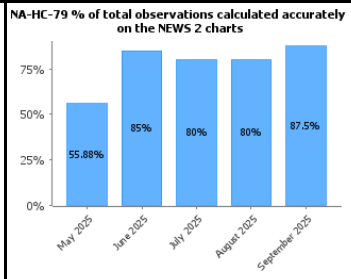
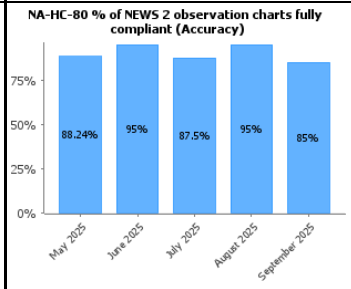
Title
Service & Quality Improvement Programmes - Measurement & Performance

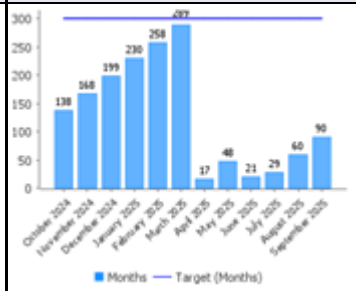
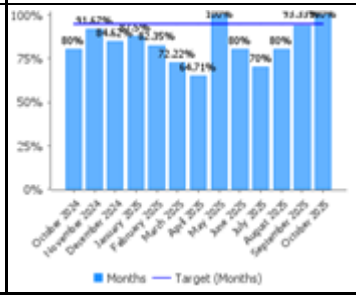
Performance Indicators	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
CE-IC-01 Cleaning Specification Audit Compliance	Measured Quarterly			96.2%	95%	95.1%		90%		

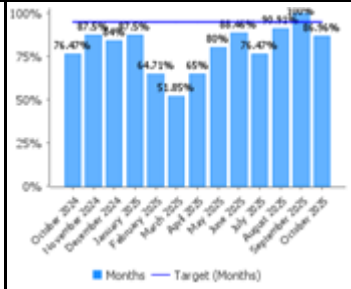
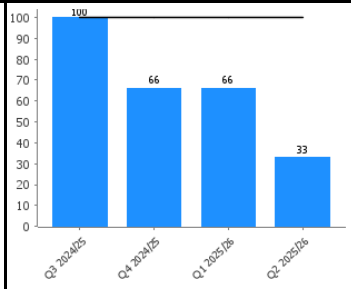
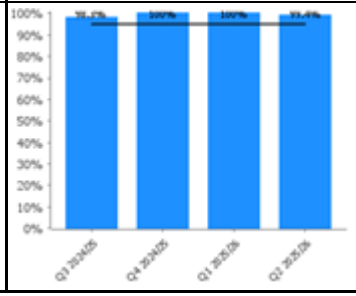
Performance Indicators	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-08 Days between Cardiac Arrests	500	531	561	378	469	561		300		
NA-HC-09 All Falls rate (per 1000 occupied bed days)	4.43	4.06	12.28	13.65	6.62	12.28		7		During Q2 there is an increase in the number of falls, from 15 in Q1 to 20, a number of these falls were associated with a couple of individuals who had complex care needs.
NA-HC-10 Falls with harm rate (per 1000 occupied bed days)	1.11	0	0	0	1.1	1.1		0.5		There was one inpatient fall with harm during Q2 which is being reviewed by the SCN.

Performance Indicators	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-13 Crash call rate per 1000 discharges (number of crash calls/total number of deaths + live discharges x 1000)	0	0	0	0	0	0		0		
NA-HC-53 Days between a hospital acquired Pressure Ulcer (grades 2-4)	12	26	17	79	1	17		300		Measure will remain on red until target of 300 days reached across both inpatient areas.
NA-HC-54 Pressure Ulcer Rate (grades 2-4)	1.11	1.01	2.05	0	2.21	2.05		0		During Q2 there were four hospital acquired pressure ulcers (two upon each inpatient ward). These are currently being reviewed by the SCNs and tissue viability nurse, following review the analysis will be included in Q3 Quality Score Card. All these pressure ulcers were reported via the Datix Adverse Event System

Performance Indicators	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 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 (SPSI).	98.2%	99.5%	98.7%	100	69.6%	98.7%		95		
NA-HC-66 Pressure ulcer - days between pressure ulcers developed on Ward 1.	52	83	17	754	21	17		300		Measure will remain on red until 300 days is achieved.
NA-HC-69 Pressure ulcers - days between pressure ulcers on Ward 3	12	26	56	79	1	56		300		Measure will remain on red until 300 days is achieved.

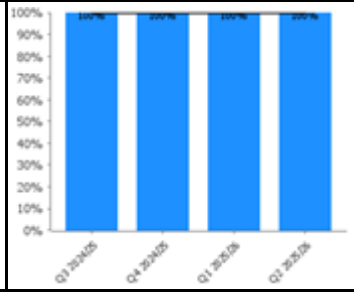
Performance Indicators	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-72 % of patients who had the correct pharmacological/mechanical thromboprophylaxis administered	90%		80%	100%	80%	80%		75%		Next DVT audit is scheduled for December 2025
NA-HC-79 % of total observations calculated on the NEWS 2 charts (Frequency)	80%	80%	87.5%	No data available	85%	87.5%		95%		Excellence in Care (EiC) data collection recommenced in May 2025. Ward training is being supported by the Clinical Governance Support Manager and the Resuscitation Practice Education Officer.
NA-HC-80 % of NEWS 2 observation charts fully compliant (Accuracy)	87.5%	95%	85%	No data available	95%	85%		95%		Excellence in Care (EiC) data collection recommenced in May 2025. Ward training is being supported by the Clinical Governance Support Manager and the Resuscitation Practice Education Officer.

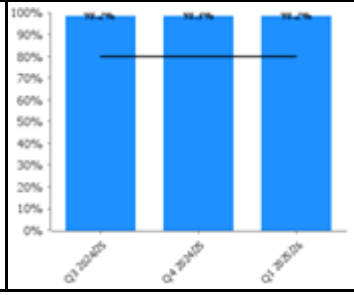
Performance Indicators	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-IC-01 Days between Catheter Associated Urinary Tract Infection (CAUTI) developed in acute care	29	60	90	289	21	90	🛑	300		Measure will remain on red until target of 300 days reached across both inpatient areas.
NA-IC-02 Catheter Usage Rate	22.7	30.79	24.44	28.43	21.7	24.44	🛑	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	70%	80%	93.33%	72.22%	80%	93.33%	✅	95%		

Performance Indicators	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 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	76.47%	90.91%	100%	51.85%	88.46%	100%		95%		
NA-IC-20 % of Patient Safety Conversations Completed (3 expected each quarter)	Measured Quarterly			66%	66%	33%		100		1 out of 3 scheduled Leadership Walkrounds were carried out during Q2. The Leadership walkround to the Yell & Unst Health Centre unfortunately had to be cancelled due to other pressing commitments for the executive visiting team member.
NA-IC-22 Hand Hygiene Audit Compliance	Measured Quarterly			100%	100%	99.4%		95%		
NA-IC-23 Percentage of cases where an infection is identified post Caesarean section	Measured Quarterly			Surgical Site Infection Surveillance activity remains suspended, there is no national updated regarding when this will be recommenced.						

Performance Indicators	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-IC-24 Percentage of cases developing an infection post hip fracture	Measured Quarterly			Surgical Site Infection Surveillance activity remains suspended, there is no national updated regarding when this will be recommenced.						
NA-IC-25 Percentage of cases where an infection is identified post Large Bowel operation	Measured Quarterly			Surgical Site Infection Surveillance activity remains suspended, there is no national updated regarding when this will be recommenced.						
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	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 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,	100%	100%	100%	100%	100%	100%		100%		

Performance Indicators	July 2025	August 2025	September 2025	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q2 2025/26	Q2 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
including the building of a person-centred support plan										
CH-MH-05 People with diagnosed dementia who take up the offer of post diagnostic support (rolling 12 months)	Measured Quarterly			98.3%	98.2%			80%		**Awaiting Q2 data.**
MD-HC-01 Quarterly Hospital Standardised Mortality Ratios (HSMR)	**Calculated following national data release.**									

APPENDIX A – Overview of falls and pressure ulcer incidence between: July – September 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	0	2	107		**July 25**	1	1	22	Back was abraded
Aug 25	0	2	138		**Aug 25**	0	2	53	
Sept 25	0	2	168		**Sept 25**	0	10	83	
Oct 25					**Oct 25**				
Nov 25					**Nov 25**				
Dec 25					**Dec 25**				
Total	**2**	**18**			**Total**	**2**	**50**		

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	0	1	52			**July 25**	1	2	12		
Aug 25	0	1	83			**Aug 25**	1	1	26		
Sept 25	2	0	17			**Sept 25**	0	1	56		
Oct 25						**Oct 25**					
Nov 25						**Nov 25**					
Dec 25						**Dec 25**					
Total	**3**	**4**				**Total**	**4**	**9**			

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	76	415	0	0%	18%	July	121	453	1	1%	27%
Aug	129	403	0	0%	32%	Aug	166	555	0	0%	30%
Sept	123	394	0	0%	31%	Sept	106	543	0	0%	20%
Oct						Oct					
Nov						Nov					
Dec						Dec					
Total	1049	3930	0			Total	1104	5192	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?**
July - September 2025	1	Being Reviewed			1 fall on the medical ward resulted in back abrasion, this is currently being reviewed by the SCN. The analysis will be shared in Q3 via the QSC
HOSPITAL ACQUIRED PRESSURE ULCERS					
Date	**No. of Patients**	**Avoidable/ Unavoidable**	**Appropriate Care Given?**	**Debrief Conducted?**	**Learning Points?**
July – September 2025	4	Being Reviewed			2 patients with pressure ulcers were identified on the medical ward and 2 on the surgical ward, all are currently being reviewed by the SCNs and the tissue viability nurse. The analysis will be shared in Q3 via the QSC. All pressure ulcers were reported via the Datix Adverse Event System.

Excellence in Care (EiC) Data:

Excellence in Care - Submission Report

NHS Shetland

Period from: October 2024 - September 2025

Extract date: 27 October 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 October 2024 - September 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

Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
14%	14%	14%	14%	14%	14%	29%	39%	39%	59%	59%	57%

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

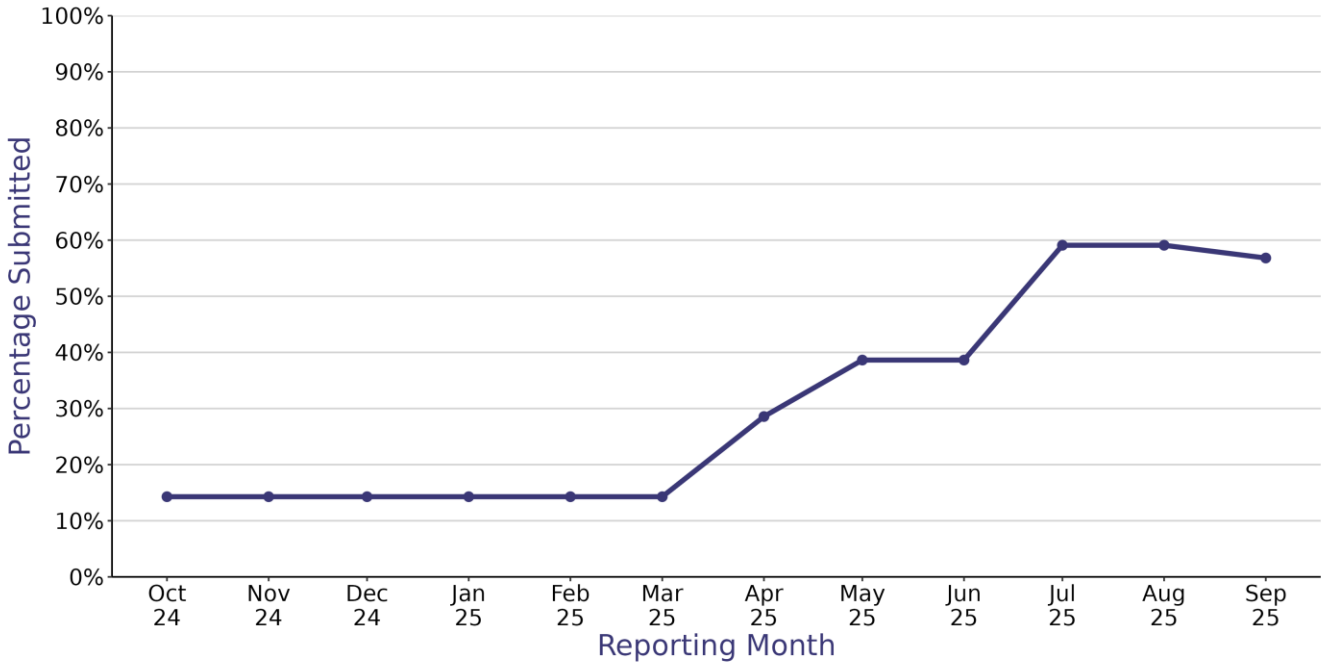


Figure 2: Submission rates (%) by measure in the latest month (September 2025) in NHS Shetland

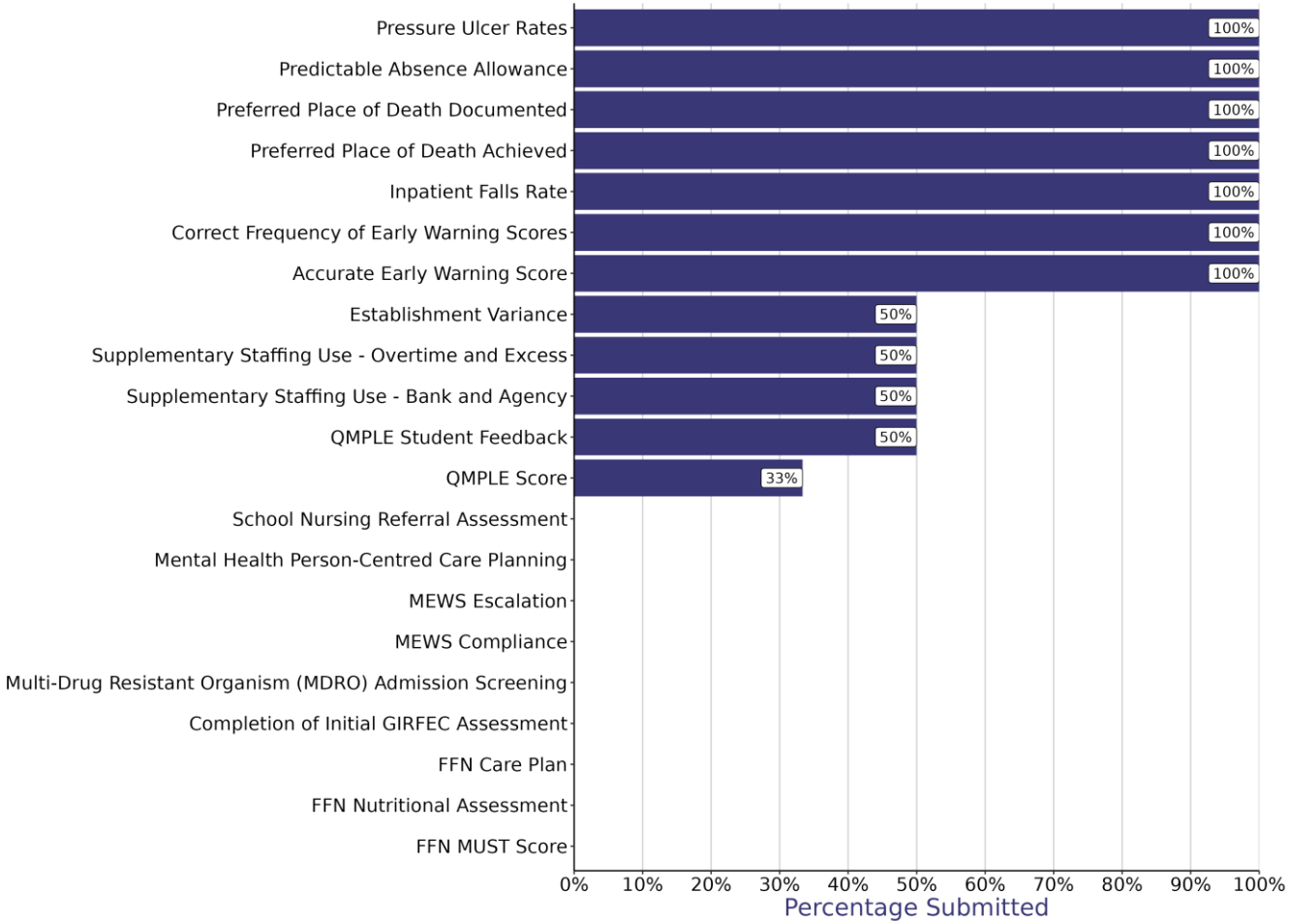


Table 2: Quarterly submission rates (%) in NHS Shetland

Quarter	Percentage
Oct-Dec 2024	14%
Jan-Mar 2025	14%
Apr-Jun 2025	35%
Jul-Sep 2025	58%

Table 3: Quarterly submission rates (%) by measure in NHS Shetland

Measure Name	Oct-Dec 2024	Jan-Mar 2025	Apr-Jun 2025	Jul-Sep 2025
Accurate Early Warning Score	0%	0%	67%	100%
Completion of Initial GIRFEC Assessment	N/A	N/A	0%	0%
Correct Frequency of Early Warning Scores	0%	0%	67%	100%
Establishment Variance	0%	0%	0%	50%
FFN Care Plan	0%	0%	0%	0%
FFN MUST Score	0%	0%	0%	0%
FFN Nutritional Assessment	0%	0%	0%	0%

Measure Name	Oct-Dec 2024	Jan-Mar 2025	Apr-Jun 2025	Jul-Sep 2025
Inpatient Falls Rate	0%	0%	100%	100%
MEWS Compliance	0%	0%	0%	0%
MEWS Escalation	0%	0%	0%	0%
Mental Health Person-Centred Care Planning	0%	0%	0%	0%
Multi-Drug Resistant Organism (MDRO) Admission Screening	0%	0%	0%	33%
Predictable Absence Allowance	100%	100%	100%	100%
Preferred Place of Death Achieved	0%	0%	100%	100%
Preferred Place of Death Documented	0%	0%	100%	100%
Pressure Ulcer Rates	0%	0%	100%	100%
QMPLE Score	44%	56%	67%	50%
QMPLE Student Feedback	72%	89%	67%	61%
School Nursing Referral Assessment	N/A	N/A	100%	67%
Supplementary Staffing Use - Bank and Agency	0%	0%	0%	50%

Measure Name	Oct-Dec 2024	Jan-Mar 2025	Apr-Jun 2025	Jul-Sep 2025
Supplementary Staffing Use - Overtime and Excess	0%	0%	0%	50%

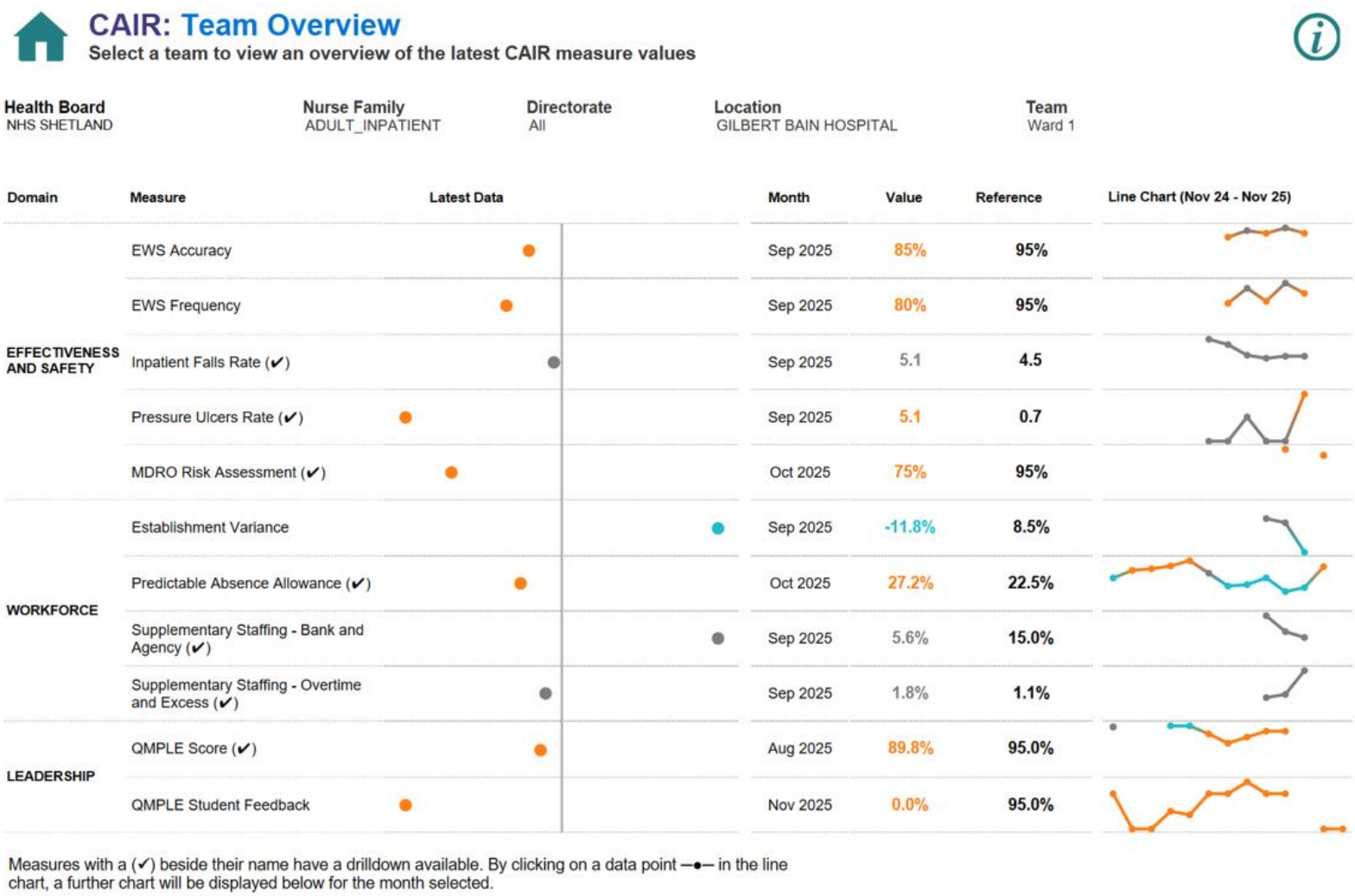
Partial measure submission rates

Some measures are composed of submissions of data from two or more data sources, rather than a single submission. These submissions often come from multiple data sources. For these measures to display on the dashboard and to be considered a submission, a submission must be made for all composite parts. This section will display data completeness for partial measures. The measures with more than one submission required are:

- Inpatient Falls Rate: Submission for Occupied Bed Days and Number of Falls* required
- Pressure Ulcers Rate: Submission for Occupied Bed Days and Number of Pressure Ulcers* required
- Establishment Variance: Submission for Funded Establishment and valid roster in reference files for SSTS data required
- Supplementary Staffing Use - Overtime and Excess: Submission for Funded Establishment and valid roster in reference files for SSTS data required.
- Supplementary Staffing Use - Bank and Agency: Submission for Funded Establishment, number of Bank hours, and number of Agency hours required

*The number of falls and pressure ulcers submissions are not displayed in the below chart and table due to the submission rules in place. Please see the notes for more information.

Excellence in Care Measures – Ward 1 Surgical Ward:



CAIR: Team Overview

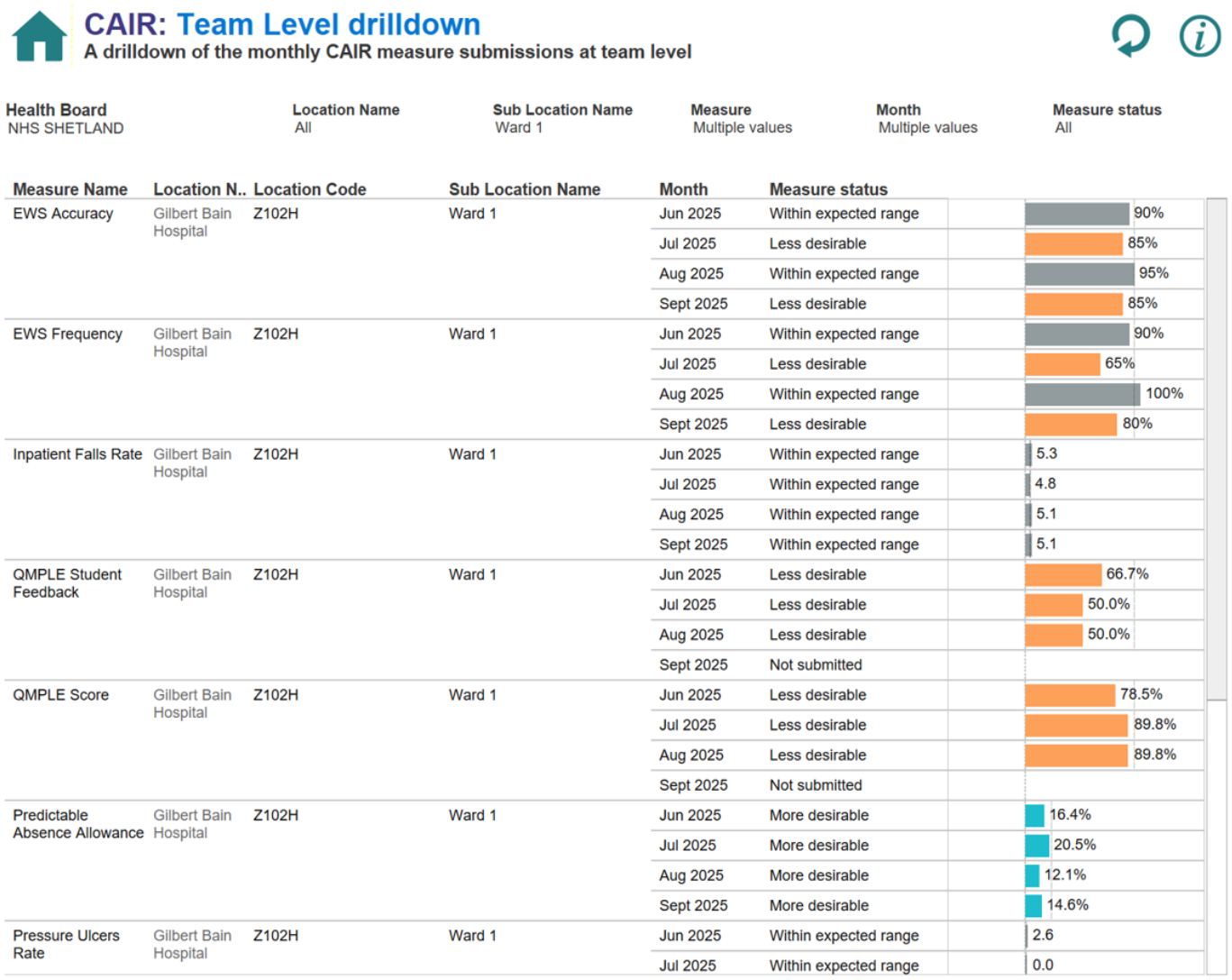
Select a team to view an overview of the latest CAIR measure values

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 (Nov 24 - Nov 25)
EFFECTIVENESS AND SAFETY	EWS Accuracy		Sep 2025	85%	95%	
	EWS Frequency		Sep 2025	80%	95%	
	Inpatient Falls Rate (✔)		Sep 2025	5.1	4.5	
	Pressure Ulcers Rate (✔)		Sep 2025	5.1	0.7	
	MDRO Risk Assessment (✔)		Oct 2025	75%	95%	
WORKFORCE	Establishment Variance		Sep 2025	-11.8%	8.5%	
	Predictable Absence Allowance (✔)		Oct 2025	27.2%	22.5%	
	Supplementary Staffing - Bank and Agency (✔)		Sep 2025	5.6%	15.0%	
	Supplementary Staffing - Overtime and Excess (✔)		Sep 2025	1.8%	1.1%	
LEADERSHIP	QMPLE Score (✔)		Aug 2025	89.8%	95.0%	
	QMPLE Student Feedback		Nov 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.

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



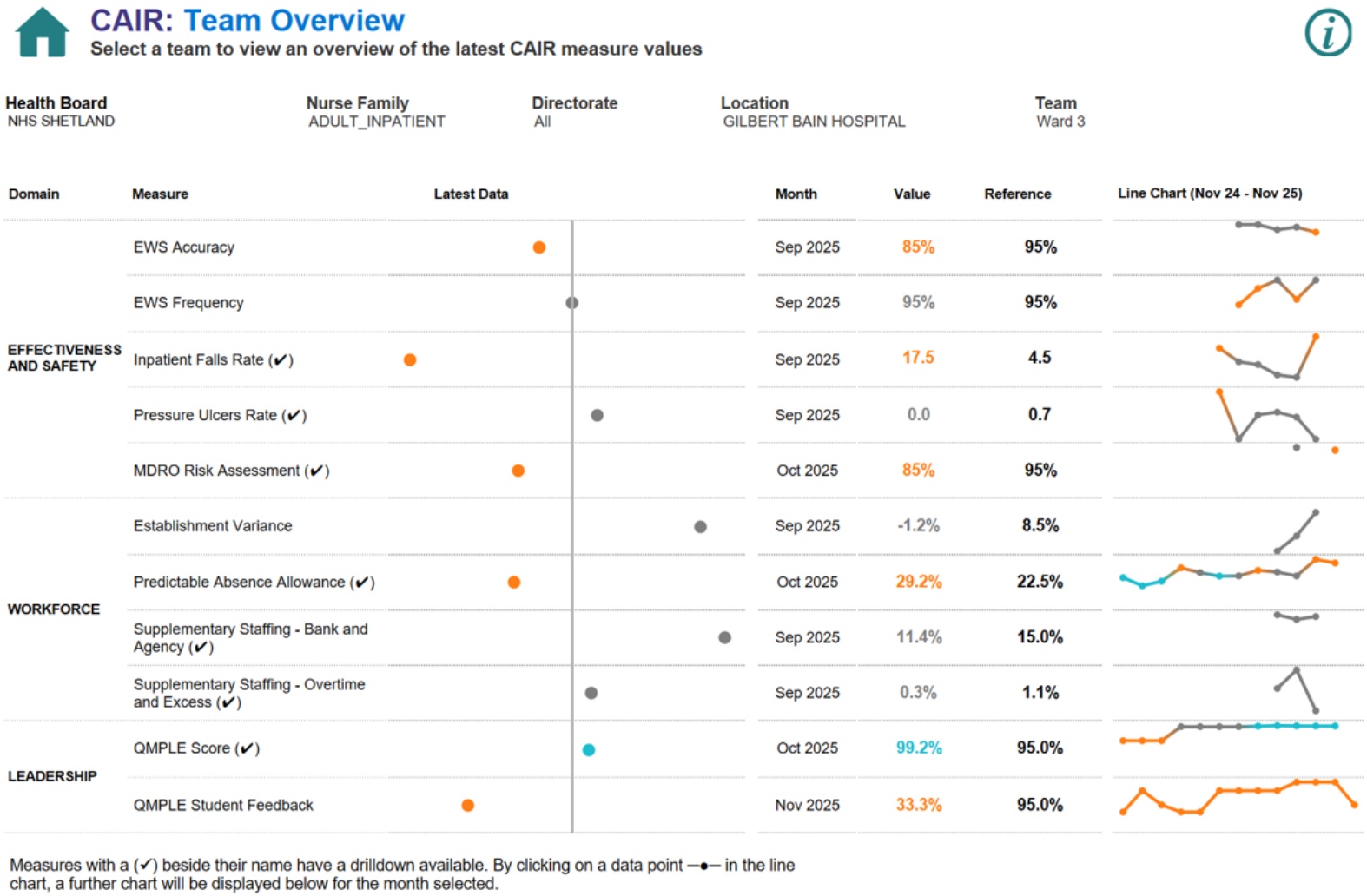
CAIR: Team Level drilldown

A drilldown of the monthly CAIR measure submissions at team level

Health Board	Location Name	Sub Location Name	Measure	Month	Measure status
NHS SHETLAND	All	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	Jun 2025	Within expected range	90%
				Jul 2025	Less desirable	85%
				Aug 2025	Within expected range	95%
				Sept 2025	Less desirable	85%
EWS Frequency	Gilbert Bain Hospital	Z102H	Ward 1	Jun 2025	Within expected range	90%
				Jul 2025	Less desirable	65%
				Aug 2025	Within expected range	100%
				Sept 2025	Less desirable	80%
Inpatient Falls Rate	Gilbert Bain Hospital	Z102H	Ward 1	Jun 2025	Within expected range	5.3
				Jul 2025	Within expected range	4.8
				Aug 2025	Within expected range	5.1
				Sept 2025	Within expected range	5.1
QMPLE Student Feedback	Gilbert Bain Hospital	Z102H	Ward 1	Jun 2025	Less desirable	66.7%
				Jul 2025	Less desirable	50.0%
				Aug 2025	Less desirable	50.0%
				Sept 2025	Not submitted	
QMPLE Score	Gilbert Bain Hospital	Z102H	Ward 1	Jun 2025	Less desirable	78.5%
				Jul 2025	Less desirable	89.8%
				Aug 2025	Less desirable	89.8%
				Sept 2025	Not submitted	
Predictable Absence Allowance	Gilbert Bain Hospital	Z102H	Ward 1	Jun 2025	More desirable	16.4%
				Jul 2025	More desirable	20.5%
				Aug 2025	More desirable	12.1%
				Sept 2025	More desirable	14.6%
Pressure Ulcers Rate	Gilbert Bain Hospital	Z102H	Ward 1	Jun 2025	Within expected range	2.6
				Jul 2025	Within expected range	0.0

Excellence in Care Measures – Ward 3 Medical Ward:



CAIR: Team Overview

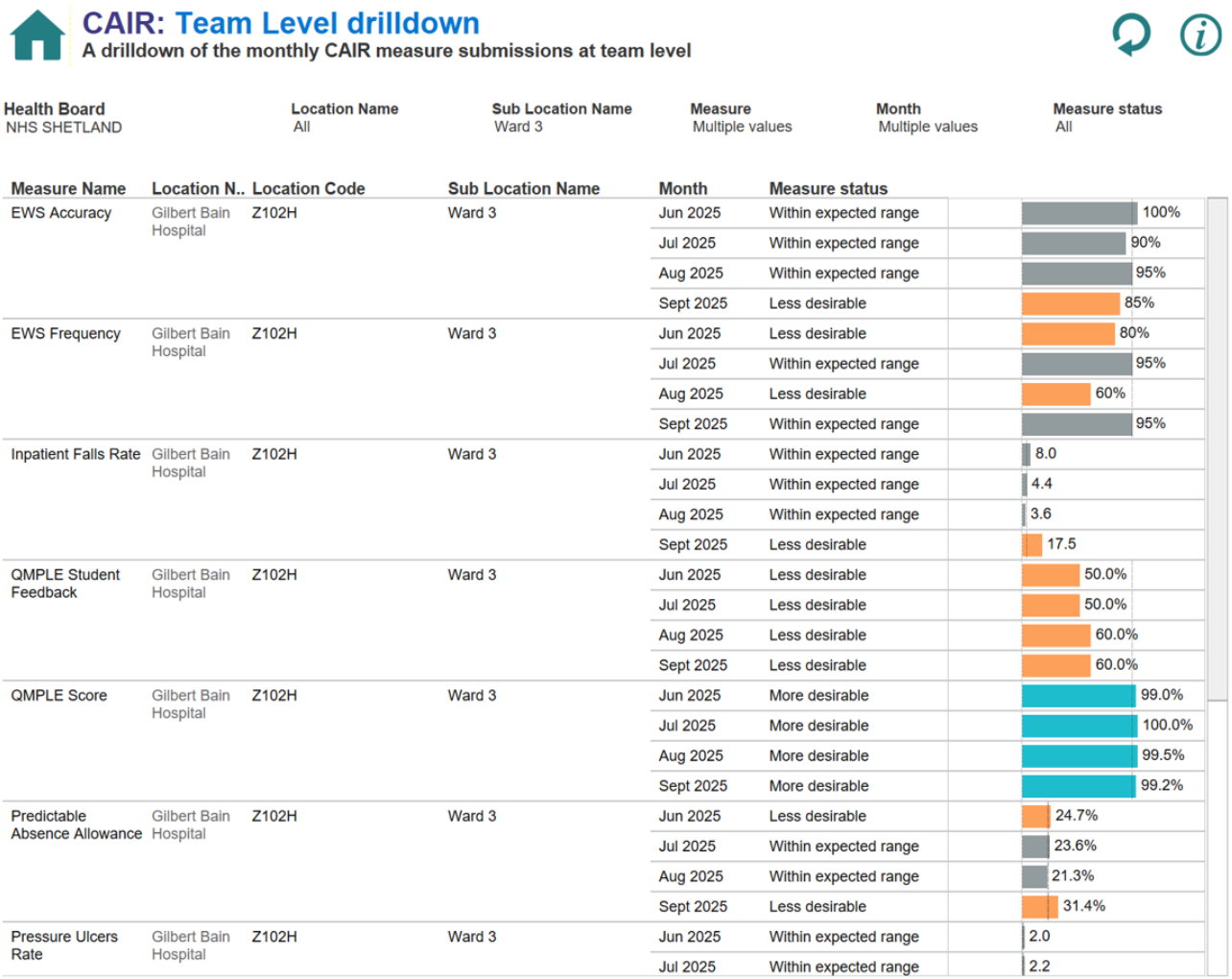
Select a team to view an overview of the latest CAIR measure values

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 (Nov 24 - Nov 25)
EFFECTIVENESS AND SAFETY	EWS Accuracy		Sep 2025	85%	95%	
	EWS Frequency		Sep 2025	95%	95%	
	Inpatient Falls Rate (✔)		Sep 2025	17.5	4.5	
	Pressure Ulcers Rate (✔)		Sep 2025	0.0	0.7	
	MDRO Risk Assessment (✔)		Oct 2025	85%	95%	
WORKFORCE	Establishment Variance		Sep 2025	-1.2%	8.5%	
	Predictable Absence Allowance (✔)		Oct 2025	29.2%	22.5%	
	Supplementary Staffing - Bank and Agency (✔)		Sep 2025	11.4%	15.0%	
	Supplementary Staffing - Overtime and Excess (✔)		Sep 2025	0.3%	1.1%	
LEADERSHIP	QMPLE Score (✔)		Oct 2025	99.2%	95.0%	
	QMPLE Student Feedback		Nov 2025	33.3%	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:



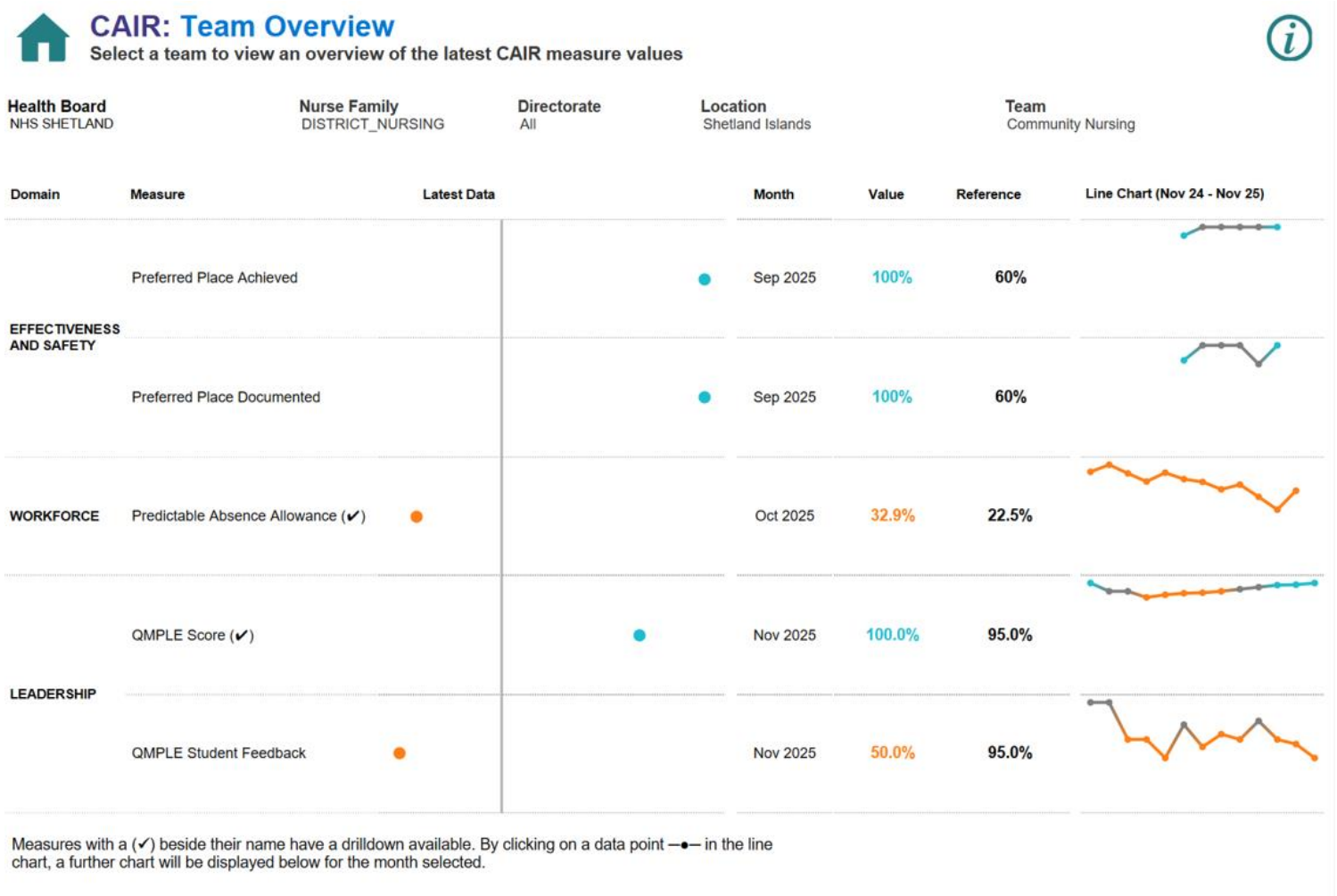
CAIR: Team Level drilldown

A drilldown of the monthly CAIR measure submissions at team level

Health Board	Location Name	Sub Location Name	Measure	Month	Measure status
NHS SHETLAND	All	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	Jun 2025	Within expected range	100%
				Jul 2025	Within expected range	90%
				Aug 2025	Within expected range	95%
				Sept 2025	Less desirable	85%
EWS Frequency	Gilbert Bain Hospital	Z102H	Ward 3	Jun 2025	Less desirable	80%
				Jul 2025	Within expected range	95%
				Aug 2025	Less desirable	60%
				Sept 2025	Within expected range	95%
Inpatient Falls Rate	Gilbert Bain Hospital	Z102H	Ward 3	Jun 2025	Within expected range	8.0
				Jul 2025	Within expected range	4.4
				Aug 2025	Within expected range	3.6
				Sept 2025	Less desirable	17.5
QMPLE Student Feedback	Gilbert Bain Hospital	Z102H	Ward 3	Jun 2025	Less desirable	50.0%
				Jul 2025	Less desirable	50.0%
				Aug 2025	Less desirable	60.0%
				Sept 2025	Less desirable	60.0%
QMPLE Score	Gilbert Bain Hospital	Z102H	Ward 3	Jun 2025	More desirable	99.0%
				Jul 2025	More desirable	100.0%
				Aug 2025	More desirable	99.5%
				Sept 2025	More desirable	99.2%
Predictable Absence Allowance	Gilbert Bain Hospital	Z102H	Ward 3	Jun 2025	Less desirable	24.7%
				Jul 2025	Within expected range	23.6%
				Aug 2025	Within expected range	21.3%
				Sept 2025	Less desirable	31.4%
Pressure Ulcers Rate	Gilbert Bain Hospital	Z102H	Ward 3	Jun 2025	Within expected range	2.0
				Jul 2025	Within expected range	2.2

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 (Nov 24 - Nov 25)
EFFECTIVENESS AND SAFETY	Preferred Place Achieved	●	Sep 2025	100%	60%	
	Preferred Place Documented	●	Sep 2025	100%	60%	
WORKFORCE	Predictable Absence Allowance (✔)	●	Oct 2025	32.9%	22.5%	
LEADERSHIP	QMPLE Score (✔)	●	Nov 2025	100.0%	95.0%	
	QMPLE Student Feedback	●	Nov 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 – 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	All	Community Nursing	Multiple values	Multiple values	All

Measure Name	Location N..	Location Code	Sub Location Name	Month	Measure status	
QMPLE Student Feedback	Shetland Islands	S37000026	Community Nursing	Jun 2025	Less desirable	71.4%
				Jul 2025	Less desirable	66.7%
				Aug 2025	Within expected range	83.3%
				Sept 2025	Less desirable	66.7%
QMPLE Score	Shetland Islands	S37000026	Community Nursing	Jun 2025	Less desirable	92.6%
				Jul 2025	Within expected range	94.5%
				Aug 2025	Within expected range	96.3%
				Sept 2025	More desirable	98.2%
Preferred Place Achieved	Shetland Islands	S37000026	Community Nursing	Jun 2025	Within expected range	100%
				Jul 2025	Within expected range	100%
				Aug 2025	Within expected range	100%
				Sept 2025	More desirable	100%
Preferred Place Documented	Shetland Islands	S37000026	Community Nursing	Jun 2025	Within expected range	100%
				Jul 2025	Within expected range	100%
				Aug 2025	Within expected range	83%
				Sept 2025	More desirable	100%
Predictable Absence Allowance	Shetland Islands	S37000026	Community Nursing	Jun 2025	Less desirable	33.5%
				Jul 2025	Less desirable	35.3%
				Aug 2025	Less desirable	30.6%
				Sept 2025	Less desirable	25.6%

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 (Nov 24 - Nov 25)
EFFECTIVENESS AND SAFETY	School Nursing Referral Assessment (✔)		Aug 2025	100.0%	90.0%	
WORKFORCE	Predictable Absence Allowance (✔)		Oct 2025	15.8%	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: July – September 2025

Q2 Total Data: 213 Adverse Events Reported: 5 Debriefs held. **N.B. All Adverse Events reported categorised as 'extreme' were related to the centralised 'unexpected death' notification, which reports into Clinical Governance. These reports will then have been discussed via the weekly Clinical Risk Advisory Team (CRAT) Meeting and/or via relevant monthly governance meetings.**			
Month	**Total No. of Adverse Events Reported**	**Moderate, Major and Extreme Events Reported**	**No. of Debriefs Completed**
July 2025	**68**	**1 Extreme (11129)** **1 Major (11175)** **6 Moderate (11151, 11132, 11182, 11195 11181, 11163)**	**3** **11176** **11175** **111753**

Adverse event theme (11176) – Level 3 Review: Obstetrics: Reviewed by Risk Management Midwife
Reviewing neonatal retrieval arrangements due to a delay in transfer
Learning identified:

- Good quality documentation by all staff, including consultants.
- Use SBAR and assign a scribe during neonatal emergencies to support communication and record-keeping.
- Utilise existing systems (e.g. 2222 call, BadgerNet, SCOTSTAR) promptly to avoid delays in care.
- Consultant obstetrician leads all maternity care, including neonates, and must document key decisions.
- Keep documentation and delivery packs stocked and accessible in key clinical areas.
- Explore digital tools (e.g. GoodSAM) to enhance emergency response and coordination.
- Improve staff coordination and early escalation to reduce risk and improve outcomes.

Adverse event theme (11175) – Level 3 Review: Access / admission: Reviewed by Associate Medical Director for Primary Care
Patient requiring specialist dementia care, difficulties in ensuring the patient was able to access an appropriate care setting
Learning identified:

- Highlighted difficulties in managing patients with complex dementia.
- Working group being set up by dementia nurse specialist with involvement from psychiatrists, dementia team, social work and GPs to review situations like this and what the options are for how best to manage patients with complex needs in Shetland.

<table>
<tr><td colspan="4">Adverse event theme (11153) – Level 3 Review: Test results and reports: Reviewed by Practice Manager
Delay in following in patient test results in primary care
Learning identified:
Ensure that all patients present at reception desk to check in
Need to ask/confirm patients details (name and date of birth etc) before taking blood.</td></tr>
<tr><td>August 2025</td><td>78</td><td>2 Extreme (11218, 11233)
2 Major (11199, 11230)
5 Moderate (11231, 11273, 11244, 11246, 11202)</td><td>1
11205</td></tr>
<tr><td colspan="4">Adverse event theme (11205) – Level 3 Review: Clinical Event: Reviewed by the Resuscitation Officer and discussed at Anaesthetic Governance Group and Surgical Audit.

Discussed with Medical Director, case to be further considered at CRAT meeting.</td></tr>
<tr><td>September 2025</td><td>67</td><td>1 Extreme (11304)
2 Major (11291, 11287)
2 Moderate (11334, 11298)</td><td>0</td></tr>
<tr><td colspan="4">N/A</td></tr>
</table>

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	95%	80%	100%	80%
Aug-25	100%	100%	94%	100%
Sep-25	100%	no forms returned	100%	no forms returned
Oct-25				
Nov-25				
Dec-25				
Average for the year				

Ward 1						
Person Centred Measure description	**MD01 (NA-HC-16)**	**MD02 (NA-HC-19)**	**MD03 (NA-HC-22)**	**MD04 (NA-HC-25)**	**MD05 (NA-HC-28)**	**Number of responses**
	% of people who say that we took account of the things that were important to them. Aim 90%	% of people who say that we took account of the people who were important to them and how much they wanted to be involved in care/treatment. Aim 90%	% of people who say that they have all the information they needed to help them make decisions about their care/treatment. Aim 90%	% of people who say that staff took account of their personal needs and preferences Aim 90%	% of people who say they were involved as much as they wanted to be in communication/ transitions/ handovers about them Aim 90%	
Jan-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	100%	100%	100%	100%	100%	**20**
Aug-25	100%	100%	96%	97%	95%	**19**
Sep-25	100%	100%	98%	100%	100%	**9**
Oct-25						
Nov-25						
Dec-25						
Average for year						

Ward 3						
Person Centred Measure description	**MD01 (NA-HC-15)**	**MD02 (NA-HC-18)**	**MD03 (NA-HC-21)**	**MD04 (NA-HC-24)**	**MD05 (NA-HC-27)**	**Number of responses**
	% of people who say that we took account of the things that were important to them. Aim 90%	% of people who say that we took account of the people who were important to them and how much they wanted to be involved in care/treatment. Aim 90%	% of people who say that they have all the information they needed to help them make decisions about their care/treatment. Aim 90%	% of people who say that staff took account of their personal needs and preferences Aim 90%	% of people who say they were involved as much as they wanted to be in communication/ transitions/ handovers about them Aim 90%	
Jan-24	100%	100%	100%	100%	100%	**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%	**6**
Jul-24	100%	100%	95%	100%	75%	**6**
Aug-24	100%	100%	96%	100%	93%	**7**
Sep-24	0%	0%	0%	0%	0%	**0 No feedback received**
Oct-24						
Nov-24						
Dec-24						
Average for year						

WARD 1 INPATIENT SURVEY – PATIENT COMMENTS – July / 2025
Lovely staff.
Being poorly is no fun, but the staff made you felt as one of the family. Everyone was so kind, polite.
My care couldn't have been better.
Thanks for everything
Excellent from everybody first class all nurses particularly helpful under some quite messy circumstance.
Staff on Ward 1 was extremely kind, caring, listening and taking time for any questions or extra care you need.
All staff could not have been more helpful.
On the whole very good.
All staff really helpful and all cheery and happy very uplifting
Thank you. Well done to everyone.
Thanks!

WARD 3 INPATIENT SURVEY - PATIENT COMMENTS – July / 2025
I felt totally confident that I would be appropriately cared for.
The staff in ward 3 are fabulous. Nothing too much bother.
10/10
Main consultant did not listen to me or take my feelings into account.
Time spent at GBH was a mixture with so much going on and in bed 3 it was dreadful to hear about yourself being discussed by doctors and nurses and to overhear conversation about priorities the individual who had to decide what to do with much difficulties.

WARD 1 INPATIENT SURVEY – PATIENT COMMENTS – August / 2025
No suggestions, only thanks!
Good to see teamwork. Everyone pulling their weight. Thank you!
A few doctors were not as good at communicating as we needed. One doctor is particular was brilliant! Nurses all lovely and we'll miss them!
I wasn't offered any breakfast and water for the first 12 hours.
Thanks for your care.
The staff were excellent. Every single one. Thank you so much for my care.
Very friendly helpful staff felt very well cared for.
Very appreciative of everyone's fabulous care. You all do an amazing job <3
If this was TripAdvisor you would get 5 stars.
Very good care by all staff. From A&E to the ward. Very professional at all times.
Thank you.

WARD 3 INPATIENT SURVEY - PATIENT COMMENTS – August / 2025
Happily surprised at the quality and level of care provided in what many considered a remote location like Shetland. We felt cared for! Zero stress. Loved the experience!
I received excellent care throughout my stay. Staff were all kind and caring. Thank you to all of them.
Appreciate the care & treatment from staff, including all staff making us feel welcome.
If you were lucky enough to get a building to match your staff's ability, the GBH would be some hospital!

WARD 1 INPATIENT SURVEY – PATIENT COMMENTS – September / 2025
I have written a thank you for the Shetland Times to publish.
My 3 days in hospital went well from having surgery through to recovery in ward 1. I can only say that all staff rated 10/10 for kindness and help given. I would also rate the food highly too.
An emergency admission is always worrying but staff (all staff) did everything they could to care for and reassure me. I felt listened to and all staff asked me about and involved me in all aspects of my care. I have nothing but praise and thanks.
Excellent care by staff but more staff needed to help staff already in place.
10/10. Would break my leg again to come back.

WARD 3 INPATIENT SURVEY - PATIENT COMMENTS – September / 2025
No inpatient survey in September 2025

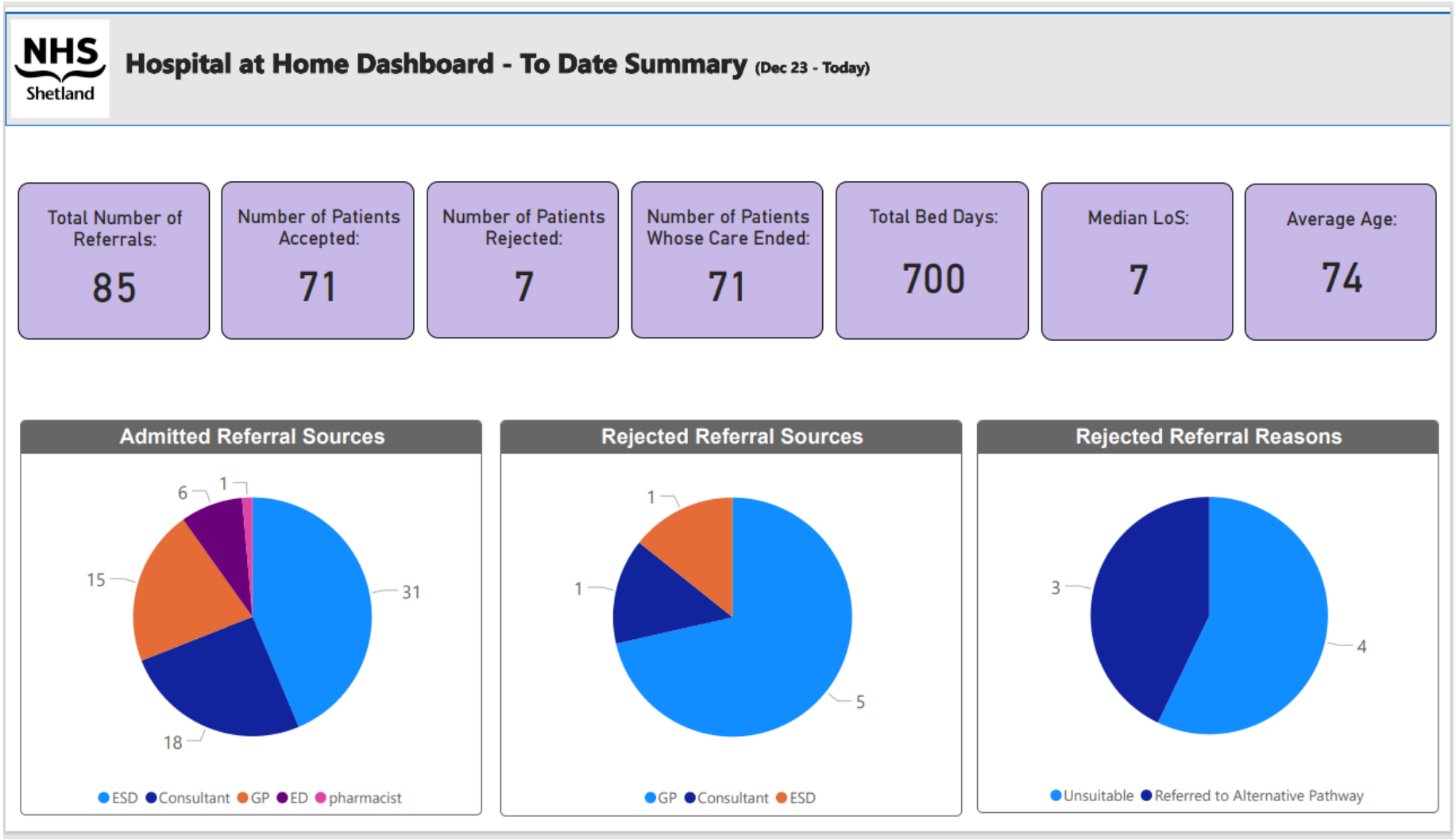
Q2 NHS Shetland Care Opinion Feedback:

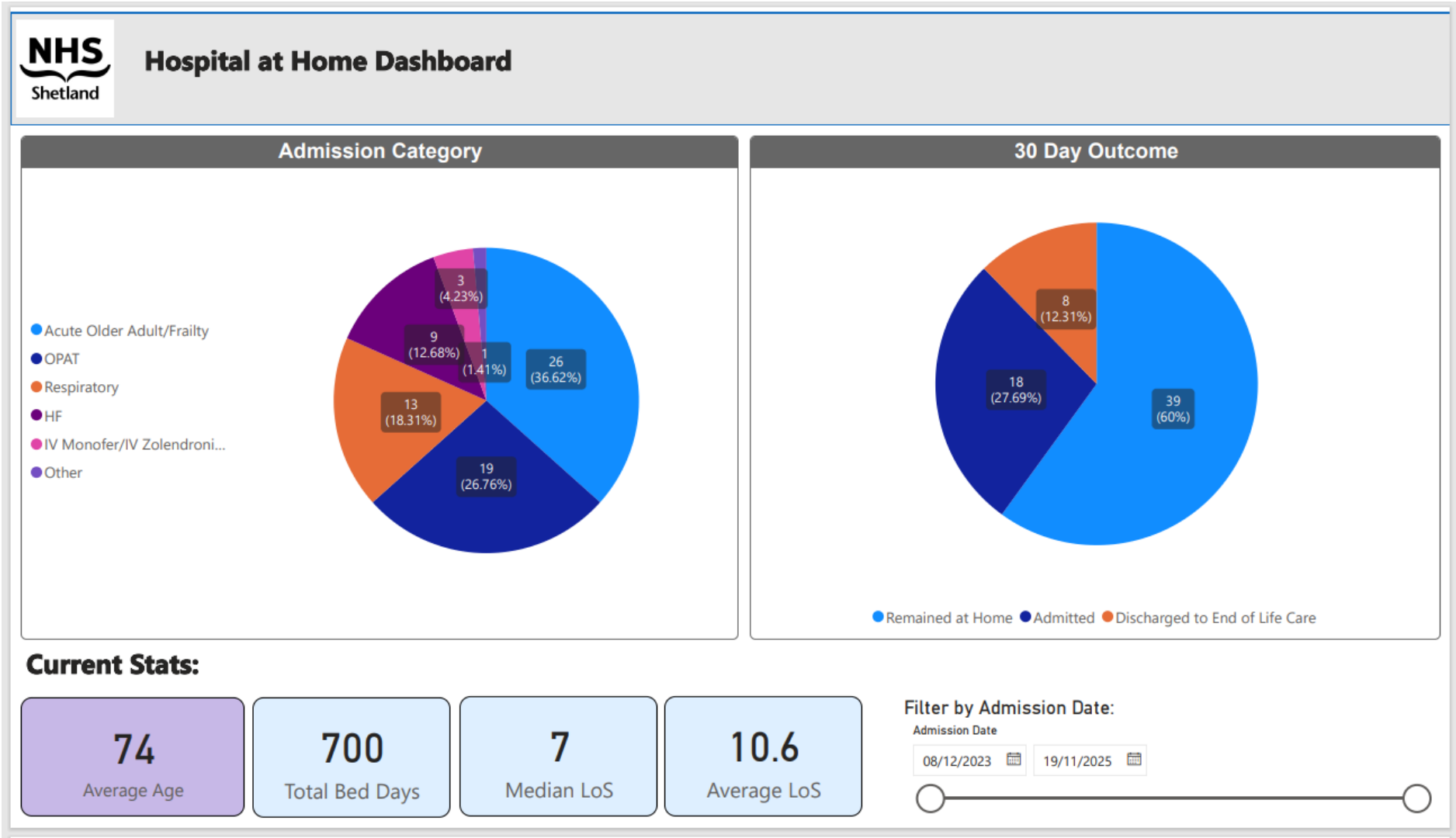
Area	Story Title	Care Opinion Link
Ward 3	“We appreciated all the support Nanny had”	We appreciate all the support Nanny had | Care Opinion

An overview of Care Opinion Feedback received:

	Q3 2024/2025 (Feedback first included as part of the Quality Score Card)	Q4 2024/2025	Q1 2025/2026	Q2 2025/2026
Number of Care Opinion Feedback received	5	3	4	1

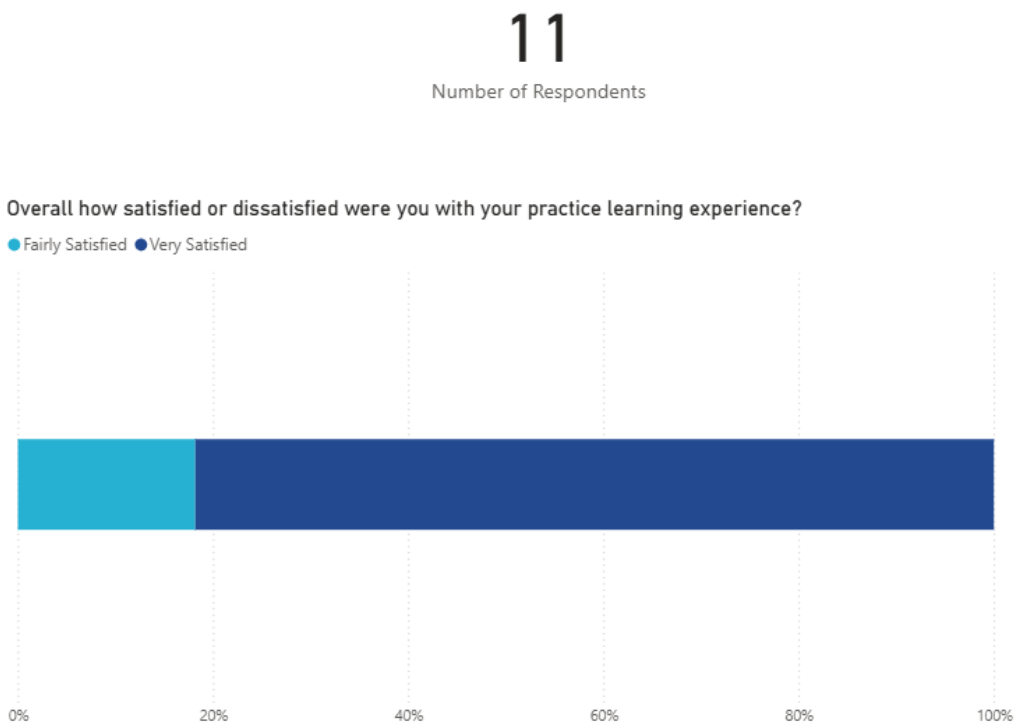
Hospital at Home: H@H



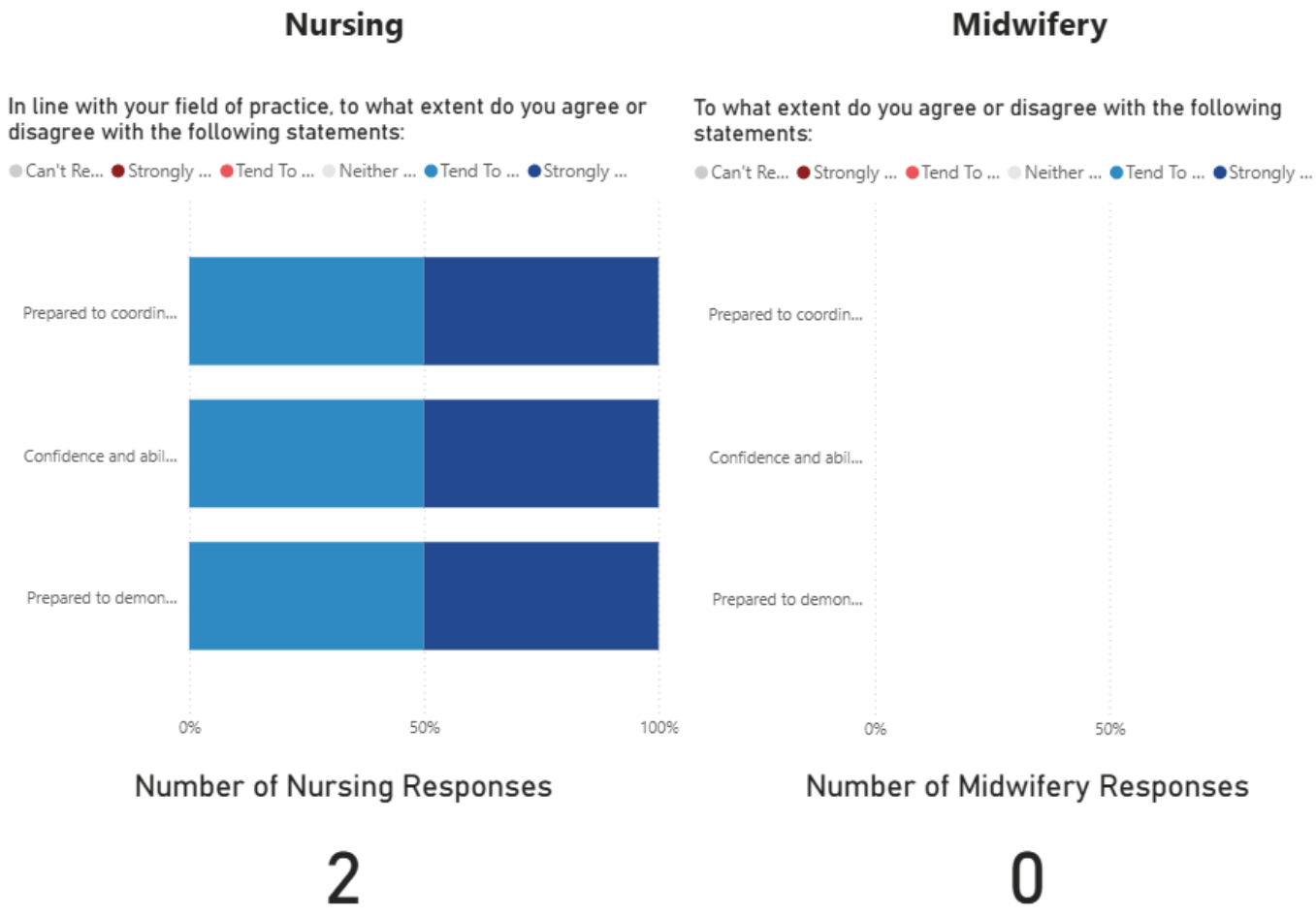

NHS
Shetland
Hospital at Home Dashboard
Admission Category
Acute Older Adult/Frailty
OPAT
Respiratory
HF
IV Monofer/IV Zolendroni...
Other
26
(36.62%)
19
(26.76%)
13
(18.31%)
9
(12.68%)
1
(1.41%)
3
(4.23%)
30 Day Outcome
39
(60%)
18
(27.69%)
8
(12.31%)
Remained at Home
Admitted
Discharged to End of Life Care
Current Stats:
74
Average Age
700
Total Bed Days
7
Median LoS
10.6
Average LoS
Filter by Admission Date:
Admission Date
08/12/2023
19/11/2025

Appendix F: Quality Management of the Practice Learning Environment (QMPLE)
Q2 1st July – 25th September 2025
Overall Satisfaction:

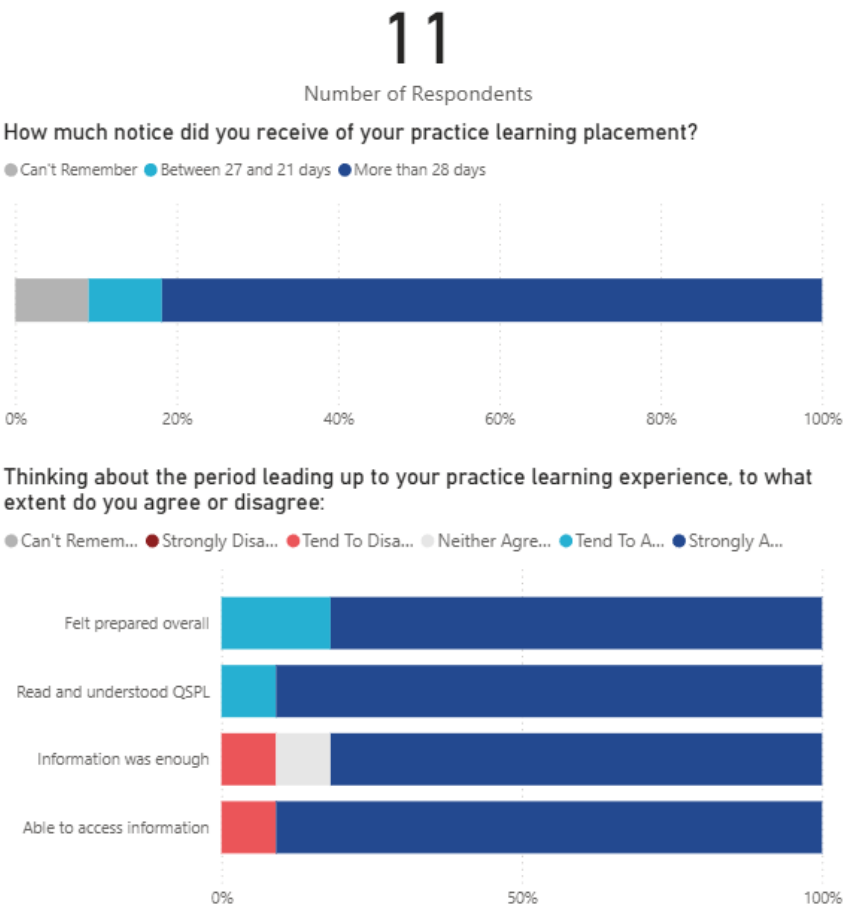
Student Feedback Overview:

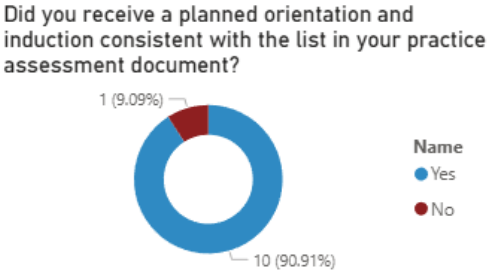


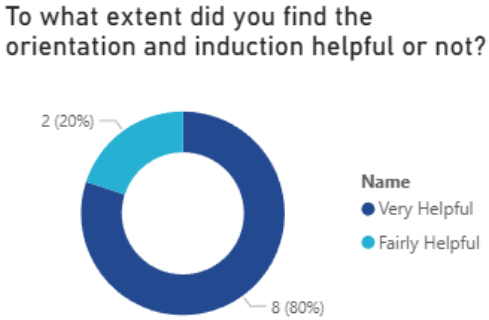
Performance Management:



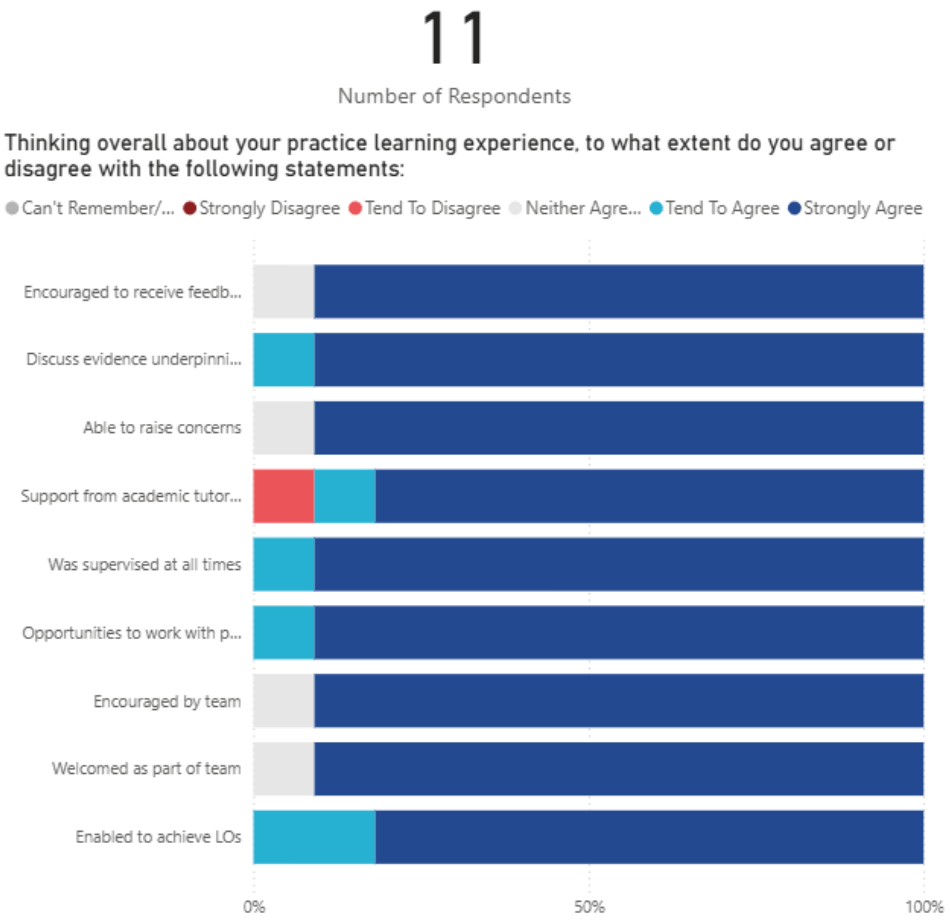
Preparation for Practice Learning:

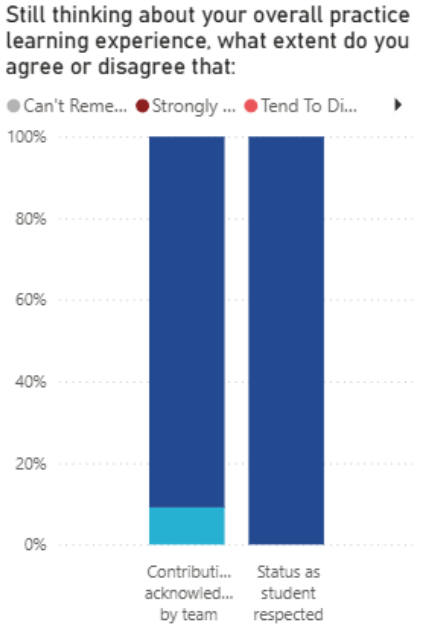




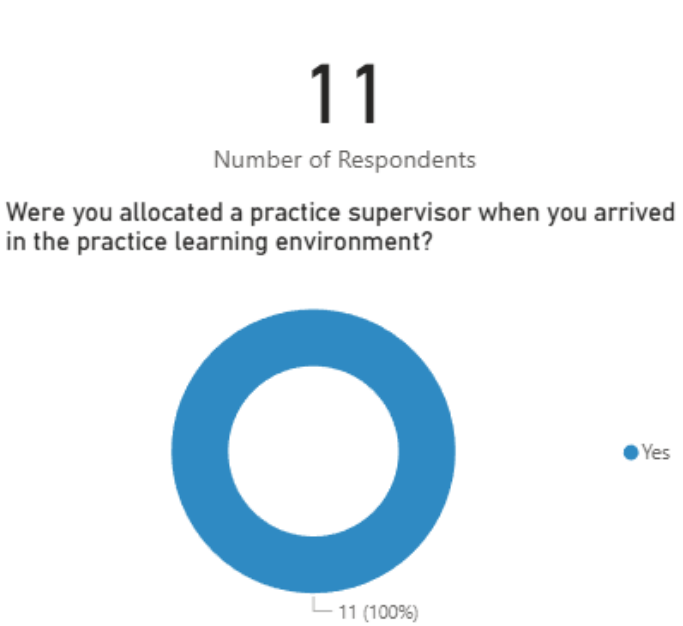


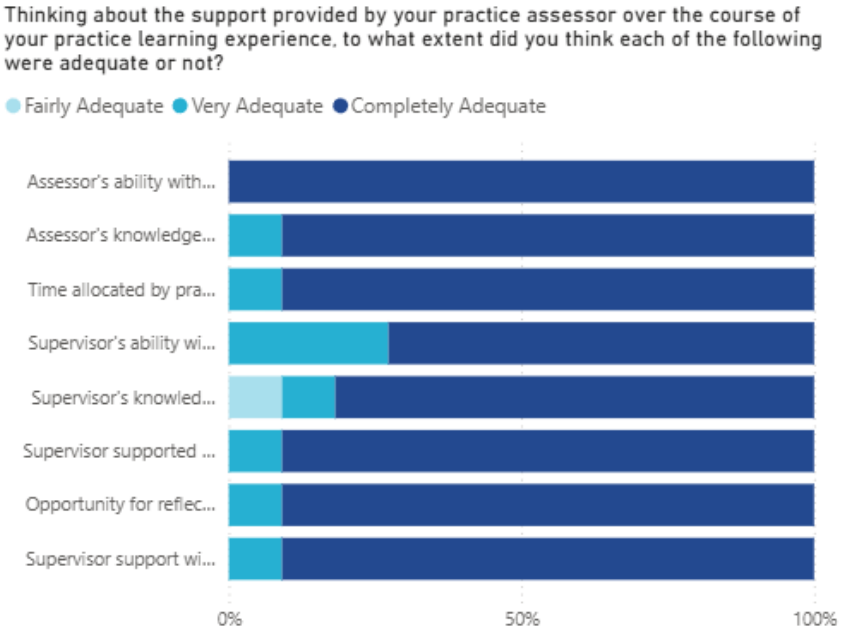
Learning Environment:

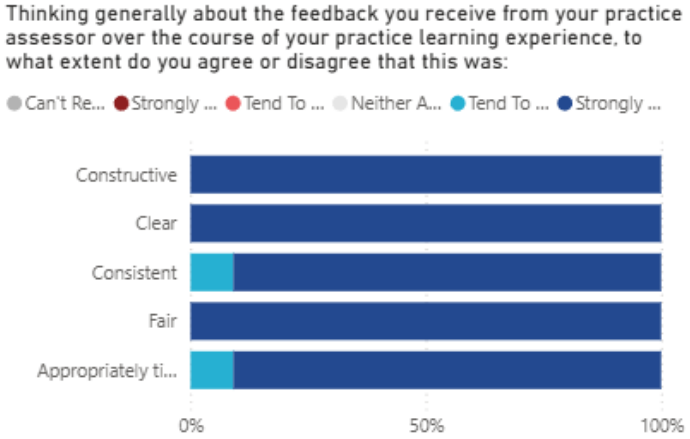


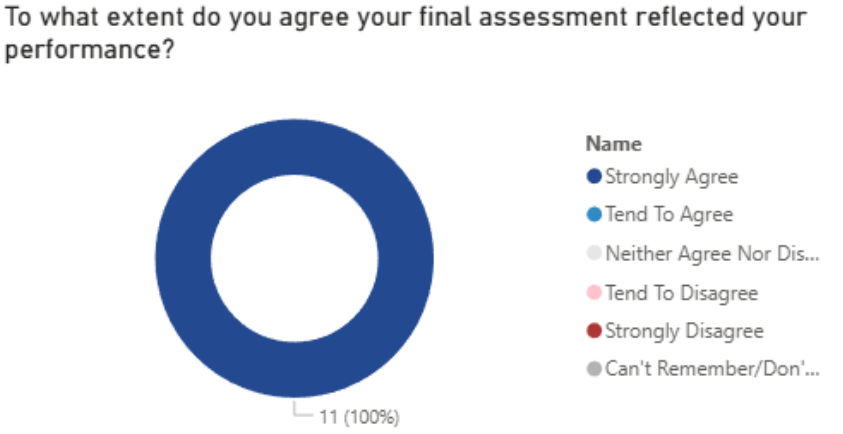


Practice support:







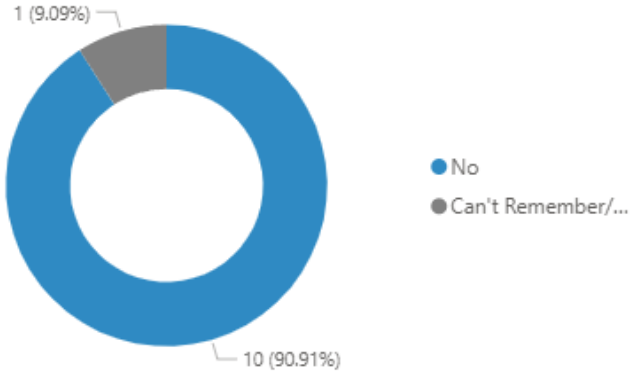


Additional Support Needs:

11

Number of Respondents

Did you require reasonable adjustments?



How effectively, if at all, did you think your reasonable adjustment needs were met?

Did you discuss your reasonable adjustment needs with your practice assessor/supervisor?

Student feedback Overview –particularly good:

11

Number of Respondents

Search all responses...

Search

Response	Learning Environment	Learning Centre
I liked how varied the day was, no 2 patients where the same even if they arrived into the department with the same symptoms as someone else. Every patient was unique.	Accident and Emergency	Gilbert Bain Hospital
I felt that my experience was really consolidated in this placement	Child Health	Gilbert Bain Hospital
I have really enjoyed this placement! I got the opportunity to do and observe so much. Learning about all the different infusions and biologics have been so interesting. Can't thank the staff in day surgery enough!	Day Surgery Unit	Gilbert Bain Hospital
This was a great practice learning experience for stage 3 as I was able to provide care for patients both independently and with support of team members.	Lerwick Community	Shetland Community
Experiencing community for the first time and getting the opportunity to spend time with patients of a different age group	Levenwick Community	Shetland Community
My ple at the outpatients department at GBH was really good. The variety of clinics and visiting consultants provided lots of opportunities to learn and to practice practical skills. Couldn't imagine a more supportive environment. Every one there is lovely. I had a great placement.	Out Patients Department	Gilbert Bain Hospital

The staff in the outpatient department at Gilbert Bain bent over backwards to get some very niche and difficult to find skills and proficiencies signed off for me in my final placement. I felt totally supported throughout my placement, 100% part of the team and I felt that my skills, thoughts, and feelings were all valued. I felt like I was challenged at the right times, trusted by all the staff and left to gain independence and work as a qualified professional where appropriate. The team were consistently understaffed and yet managed to cancel no clinics, which is a testament to them and their hard work, while continuing to support each other and any students in the department. I really can't fault anything about this placement, and whichever student is lucky enough to be allocated this department next, has truly struck gold.	Pre Op Assessment, Outpatients, Gilbert Bain Hospital	Gilbert Bain Hospital
The team are brilliant at Scalloway Community Nursing - they were very patient and accommodating of a 1st year student. They made sure i had plenty of learning opportunities, varying from wound care to catheter care. There was a lot of regular patients on the caseload so it gave a good opportunity to be able to build a relationship and build confidence when completing procedures - such as catheter flushes. I was also able to complete my venepuncture training. Definitely a positive placement experience	Scalloway Health Centre	Shetland Community
All the staff informed me of anything new happening, if there was an admission they would get me to do it for learning, this also helped me understand the patients needs and more about the condition they were admitted with. All the doctors and nurses explained everything is amazing detail to help me understand things better. There was never a wrong answer.	Ward 3	Gilbert Bain Hospital
I enjoyed the variety that was on offer	Ward 3	Gilbert Bain Hospital
In this environment I was able to learn so much due to the complete range of different patients the ward has and the staff went above and beyond to get me involved allowing me to learn and gain confidence in so many new skills. I have had the best time here.	Ward 3	Gilbert Bain Hospital

Student feedback – improved experience:

11

Number of Respondents

Search all responses...

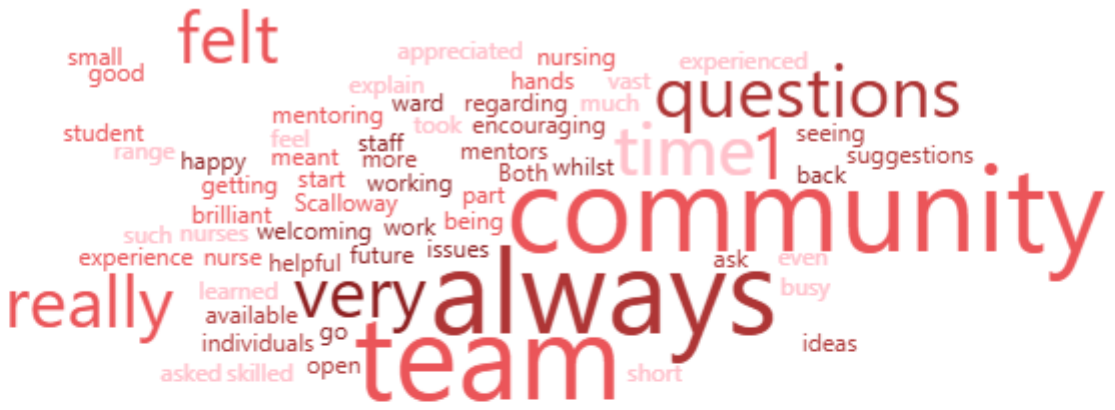
Search

Response	Learning Environment	Learning Centre
Nothing, everyone was very aware I was there to learn and pointed me in the correct direction if there was a patient in that I could learn from.	Accident and Emergency	Gilbert Bain Hospital
If it had been busier that would have been beneficial to me	Child Health	Gilbert Bain Hospital
Nothing I can think of, The entire team was extremely supportive and great at welcoming me into their department.	Lerwick Community	Shetland Community
Nothing, I loved it!	Levenwick Community	Shetland Community
There is nothing I would change about this placement, in an ideal world, staffing levels could be improved - however I felt that this offered me the opportunities to run clinics independently and take the lead, as well as gain experience juggling tasks and prioritising workload, while being supported entirely by the team around me.	Pre Op Assessment, Outpatients, Gilbert Bain Hospital	Gilbert Bain Hospital
It would have been nice to go in knowing exactly who my mentors were from the start. this seemed to take a week to be put in place even though it was known i was coming some time before I had arrived.	Ward 3	Gilbert Bain Hospital
There is nothing that would have improved my PLE.	Ward 3	Gilbert Bain Hospital

Additional Comments:

11

Number of Respondents



Search all responses...

Search

Response	Learning Environment	Learning Centre
Both my mentors could not have been more helpful and encouraging. They were open to any ideas and suggestions I had and always available for me to ask any questions regarding individuals we were seeing	Child Health	Gilbert Bain Hospital
The community team has a vast range of skilled and experienced nurses that always took the time to explain any questions I asked even if they were busy, which I really appreciated as I feel I have learned so much in such a short time.	Lerwick Community	Shetland Community
Scalloway community nursing is a small team which i felt was really good for a student nurse, it felt like i was part of the team from the start. being in the community meant it was always 1 to 1 mentoring which was brilliant for getting hands on experience	Scalloway Health Centre	Shetland Community
All the staff were very welcoming. I had no issues whilst working on the ward and would be very happy to go back and work for them in the future.	Ward 3	Gilbert Bain Hospital