NHS Shetland

Meeting:	**Shetland NHs Board**
Meeting date:	**28th April 2026**
Title:	**Quality Report**
Agenda reference:	**Board Paper 2026/27/01**
Responsible Executive/Non-Executive:	**Prof Kathleen Carolan, Director of Nursing & Acute Services**
Report Author:	**Michelle Hankin, Clinical Governance and Risk Team Leader and Carolyn Hand, Head of Corporate Services**

1 Purpose

This is presented to the Board/Committee for:

- Awareness/Discussion

This report relates to:

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

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

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

2 Report summary

2.1 Situation

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

2.2 Background

The report includes:

- A summary of the work undertaken to date in response to the 'quality ambitions' described in the Strategy;
- Our performance against a range of quality indicators (locally determined, national collaborative and national patient safety measures)
- When available, feedback gathered from patients and carers – along with improvement plans. This report has a specific focus on feedback. 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 April 2026
Appendix 2 Quality Scorecard April 2026
Appendix 3 Complaints and Feedback Report Q3 2025-26

APPENDIX 1 PROGRESS ON LOCAL QUALITY STRATEGY IMPLEMENTATION

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

DEEP DIVE INTO THE QUALITY SCORCARD

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

In summary, the data in this scorecard highlights the following:

Summary of Performance Indicator Activity (46 KPIs):				
2025/2026	No target set/ Suspended activity/ awaiting update			
Q3	**8**	**9**	**3**	**26**
	4 KPIs national activity suspended (NA-IC-23, NA-IC-24, NA-IC-25, NA-IC-30) CH-MH-05 People with diagnosed dementia who take up the offer of post diagnostic support (rolling 12 months) 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-53 NA-HC-66 NA-HC-69 NA-HC-79 NA-HC-80 NA-IC-01 NA-IC-02 NA-IC-13 Measures will remain on red until the target has been met	NA-HC-26 % of people who say they were involved as much as they wanted to be in communication, transitions, handovers about them (aggregated) NA-HC-09 All Falls rate (per 1000 occupied bed days) NA-IC-10 Aggregated Compliance with Catheter Associated Urinary Tract Infection (CAUTI) Insertion Bundle	Detailed in the Quality Score Card (Appendix 1)

Q2 2025/26	7	10	1	24
Q1 2025/26	12	8	2	19
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.
  Performance is above the set target and the measure remains on green.

- **Patient Experience Outcome Measures** – During Q3 performance against 6 patient experience measures surpassed the set target of 90%. However performance against the measure NA-HC-26, *the percentage of people who say they were involved as much as they wanted to be in communication, transitions, handovers about them* fell during Q3 from 100% to 80%, the target identified for this measure is 90%. All patient feedback is discussed at the relevant governance group (Medical Governance and Surgical Audit) on a monthly basis. Following discussion at these platforms, clinicians agreed to be more mindful of including the patient in their care discussion as part of the daily ward round. Performance in Q4 has returned to the previous 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. There is no target identified for this measure, there was 1 PPH in Q3 which was reported via the Datix system and is currently being reviewed by the maternity team.

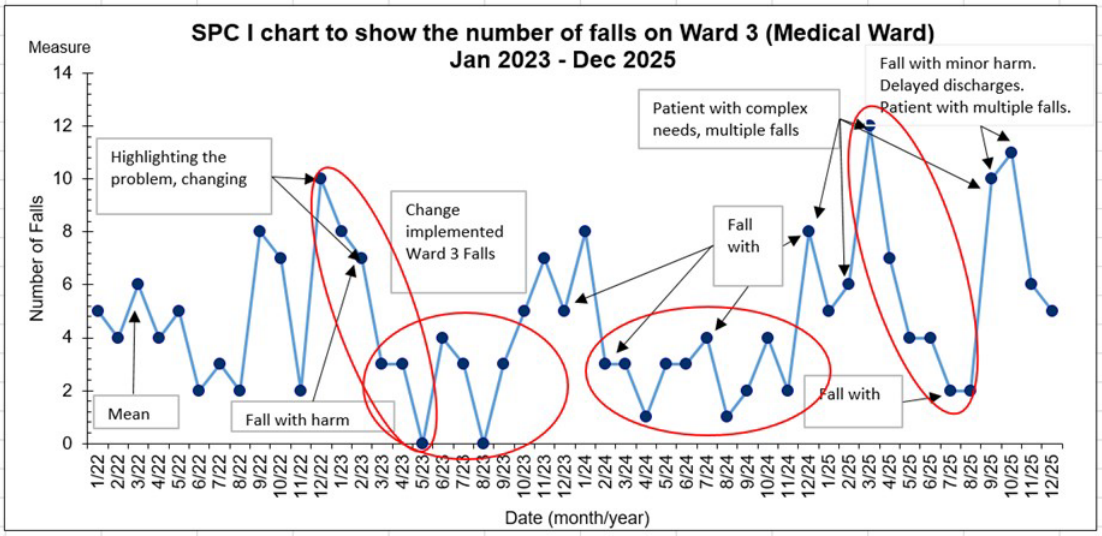
Service and Quality Improvement measures (noted by topic below):

- **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 Q3 2025/26.

- **Falls** – During Q3 there is a decrease in the number of falls per occupied 1000 occupied bed days. However we have seen an increase in the number of falls from 20 in Q2 to 31 in Q3. However inpatient care during Q3 was extremely busy, and

the high occupancy levels have resulted in the decrease in all falls rate observed in Q3.

The SPC chart below, shows the number of falls on Ward 3 (Medical Ward) from



January 2022 to December 2025), this data is included in the quarterly data return to the SPSP:

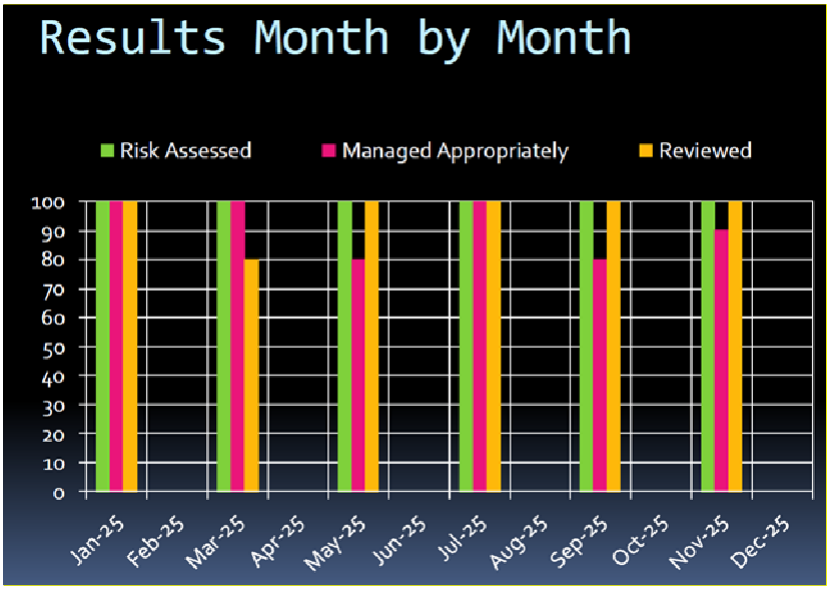
The graph above highlights a reduction in falls data from March 2025 until December 2025, Q3 was a busy period with several delayed discharges. There were 22 falls, including 3 falls with harm during October and November. All falls reported during Q3 were recorded on the Datix electronic adverse event management system. One patient with complex health needs had multiple falls. Post falls assessments were completed for all of these patients.

Pressure ulcers – There was one hospital acquired pressure ulcers reported in Q3 this was reported on the electronic adverse event system and is currently being reviewed by the Senior Charge Nurse (SCN). Performance indicator NA-HC-53 the number of 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. The DVT data is summarized as follows:

DVT Audit Results in 2025

	Jan 25	Mar 25	May 25	July 25	Sep 25	Nov 25
Risk Assessed NA-HC-71	100%	80%	100%	100%	100%	100%
Managed appropriately NA-HC-72	100%	100%	80%	100%	80%	90%
Evidence of review NA-HC-73	100%	80%	100%	100%	100%	100%
Discussed with patient NA-HC-74	20%	0%	10%	30%	30%	0%



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

  NA-IC-01 the number of days between Catheter Associated Urinary Tract Infections (CAUTI) developed in acute care, during Q3 there was one CAUTI infections identified, the Infection Control Team and ward Senior Charge Nurse reviewed this case and the measure will remain on red until the performance target of 300 days have been achieved across both inpatient areas.

  NA-IC-02 the catheter usage rate was at its highest in Q2 2025/2026 (24.44%) there was a slight reduction in Q3 (20.75%), the Infection Control Team continue to monitor this measure and the performance indicator will remain on red until the target of 15% is achieved.

  NA-IC-10 during Q3 we observe a decrease in the compliance with Catheter Associated Urinary Tract Infection (CAUTI) Insertion Bundle, from 93.33% in Q2 to 81.25% in Q3.

  NA-IC-13 during Q3 we observe a decrease in compliance with Catheter Associated Urinary Tract Infection (CAUTI) maintenance bundle, from 100% in Q2 to 61.54% in Q3. The performance target is 95%.

  The Infection Control Team continue to monitor both performance indicators **NA-IC-10** and **NA-IC-13** and provide support and education to the clinical areas as required.

- **Clinical Governance Leadership Walkrounds** – During Q3, there were three Leadership Walkrounds scheduled, these were to the Community Nursing Team at Lerwick Health Centre, the Specialist Nurses at the Gilbert Bain Hospital, and the Vaccination Centre at Grantfield in Lerwick. A more detailed Leadership Walkround report is presented at the Operational Clinical Governance Group (OCGG), Joint Governance Group (JGG) and Clinical Governance Committee (CGC).

- **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 Q3 we observe a slight reduction in the frequency of completed NEWs charts, from 87.5% in Q2 to 77.5% in Q3, reduction in compliance has been escalated to the ward SCNs at the point of identification. Performance regarding the accuracy of observations completed on the NEWS charts has increased slightly during Q3 to 87.5%.

- **Thematic learning** – During Q3 there were 200 adverse events reported, this is a slight decrease from the previous quarter of 213. The total number of adverse events closed this quarter is 128 compared to 85 in the previous quarter.

The data below provides an overview of the 'live' adverse events in the Datix system:

	Q2 24/25	Q3 24/25 (as of 09/02/2025)	Q4 24/25	Q1 25/ 26 (As of 21/07/2025)	Q2 25/26 (As of 30/09/2025)	Q3 25/26 (As of 02/02/2026
In the holding are/ waiting to be reviewed	150	174	183	230	281	285
Being Reviewed	219	242	234	242	276	266
Awaiting Final Approval	18	53	69	65	89	197
TOTAL number adverse events 'live' in the system	**387**	**469**	**486**	**537**	**646**	**748**
					Heads of Service have been asked to review and catch up with investigations following the winter where we have had a period of governance lite in place.	

The report includes an overview of the thematic analysis of Lessons Learnt for October – December 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 Q3 all inpatient feedback for both wards against both performance measures: *how would you rate your hospital experience? (Excellent/Good)* and *did you received the care/support that you expected and needed (% of those that answered 'Yes')* was 100% for every month in Q3. 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. Teams were congratulated on their performance at the relevant monthly governance meetings.
- **Q3 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)** – an overview of the H@H dashboard is included as part of the QSC providing an overview of activity and outcomes in the service. 111 patients have been referred to the service with 95 patients being accepted by the service. Common admission categories include:

  - Acute Older Adult/ Frailty
  - Respiratory
  - Outpatient Parenteral Antibiotic Therapy (OPAT)
  - Heart Failure
  - Administration of Intravenous medicines such as Zolendronic Acid (bisphosphonate treatment used to strengthen bones and treat osteoporosis).

- **Student Feedback (QMPLE)** – During Q3, 8 student nurses provided placement feedback. Approximately 75% of students were very satisfied with their learning experience, this is a slight decrease from 80% in Q2. All students identified they received more than 28 days advanced notice of their placement in Shetland, this is an increase compared to the 80% in Q2, all students had an assigned mentor. All the students acknowledged they witnessed person centred care in the practice environments. 2 students required reasonable adjustments which they felt were fully met. Overall feedback comments highlighted the variety of placement settings, the student opportunities available and the positive support they received.

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 Q3 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.

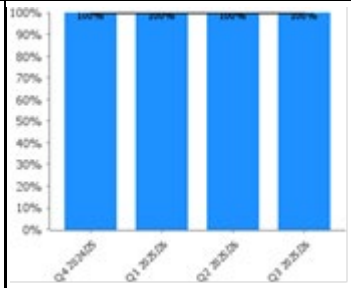
The report shows that complaint numbers are relatively small owing to the size of the Board and trend analysis is less possible because of this. Low numbers can also skew performance statistics, however the narrative for the more significant Stage 2 complaints allows Board and Committee Members the ability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

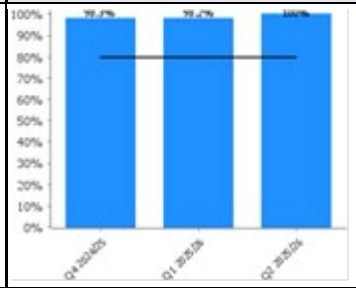
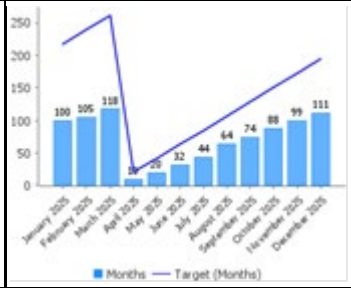
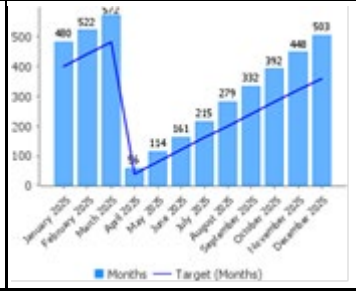
In line with the national Complaint Handling Procedure and in areas identified as examples of good practice by the Scottish Public Services Ombudsman, there are capacity challenges within the system to allow for reviews to be prioritised. There also remains significant capacity challenges for complaint investigators.

BOARD – April 2026
(Data reflects period to end of February 2026)

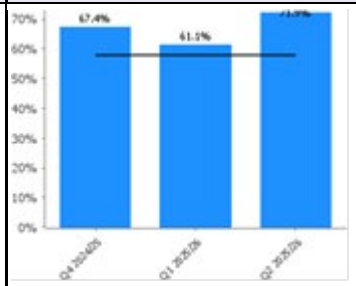
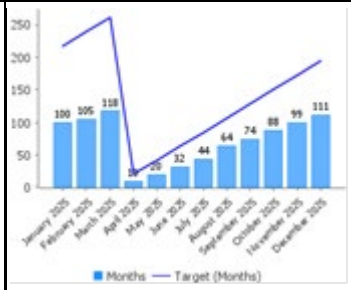
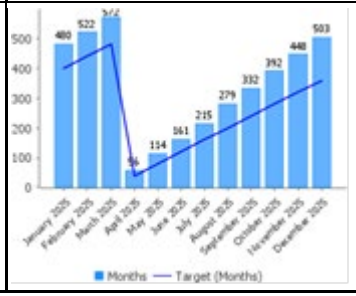
Quality Scorecard - BOARD

Title
CHSC Performance

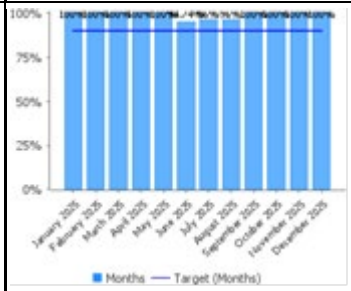
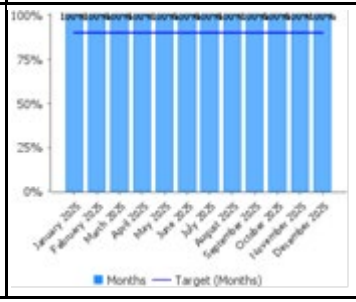
Performance Indicators	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
CH-MH-03 All people newly diagnosed with dementia will be offered a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan	Measured Quarterly			100%	100%	100%		100%		

Performance Indicators	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
CH-MH-05 People with diagnosed dementia who take up the offer of post diagnostic support (rolling 12 months)	Measured Quarterly			98.2%	100%					**Awaiting Q3 Data**
PH-HI-03 Sustain and embed Alcohol Brief Interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.	88	99	111	32	74	111	🛑	195		
PH-HI-03a Number of FAST alcohol screenings	392	448	503	161	332	503	✅	360		

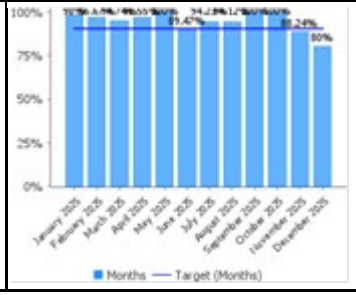
Title
Health Improvement

Performance Indicators	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 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			61.1%	71.9%			58%		Q3 data will be available end March 2026.
PH-HI-03 Sustain and embed Alcohol Brief Interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.	88	99	111	32	74	111		195		Measure will remain on red until target of 261 is achieved.
PH-HI-03a Number of FAST alcohol screenings	392	448	503	161	332	503		360		

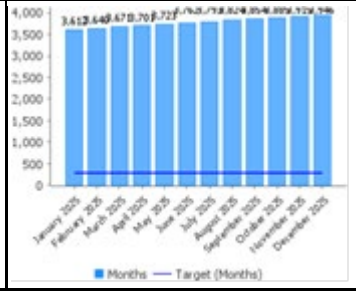
Title
Patient Experience Outcome Measures

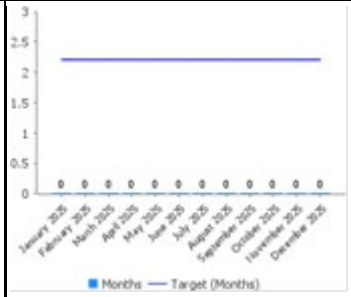
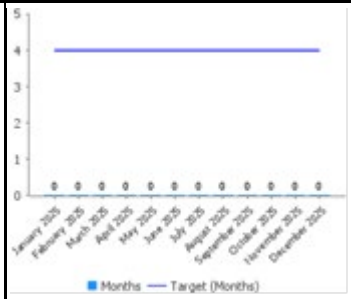
Performance Indicators	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-01 % who say they had a positive care experience overall (aggregated)	100%	100%	92.9%	89.5%	100%	92.9%		90%		
NA-HC-04 % of people who say they got the outcome (or care support) they expected and needed (aggregated)	100%	100%	100%	94.74%	100%	100%		90%		
NA-HC-14 What matters to you - % of people who say we took account of the things that were important to them whilst they were in hospital (aggregated)	100%	100%	100%	100%	100%	100%		90%		

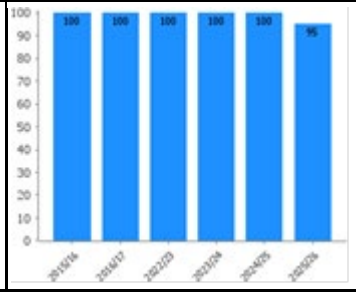
Performance Indicators	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-17 What matters to you % of people who say we took account of the people who were important to them and how much they wanted to be involved in care/treatment (aggregated)	100%	100%	92.86%	93.75%	100%	92.86%		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)	98.25%	100%	98.15%	92.11%	100%	98.15%		90%		
NA-HC-23 What matters to you % of people who say that staff took account of their personal needs and preferences (aggregated)	100%	100%	92.59%	100%	100%	92.59%		90%		

Performance Indicators	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 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)	100%	88.24%	80%	89.47%	100%	80%		90%		

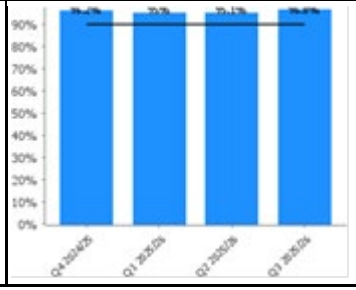
Title
Patient Safety Programme - Maternity & Children Work stream

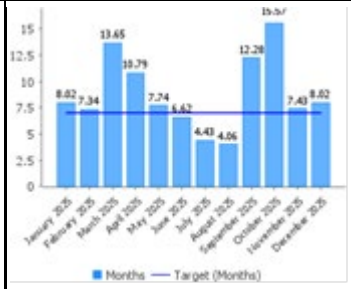
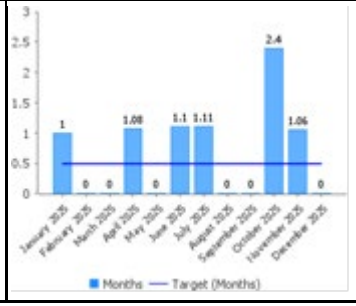
Performance Indicators	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-CF-07 Days between stillbirths	3,885	3,915	3,946	3,762	3,852	3,946		300		

Performance Indicators	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 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	0	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	The last piece of feedback received via Care Opinion was in July 2025. Wonderful Antenatal Care | Care Opinion									

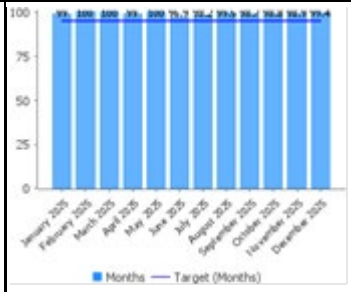
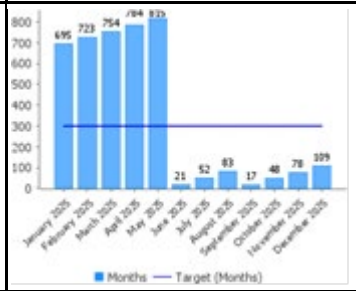
Performance Indicators	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-58 % compliance with the newborn screening bundle	Measured Quarterly			100%	95%			100%		**Awaiting Q3 Data.**

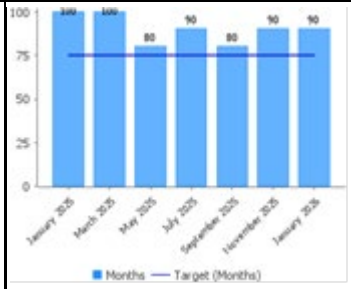
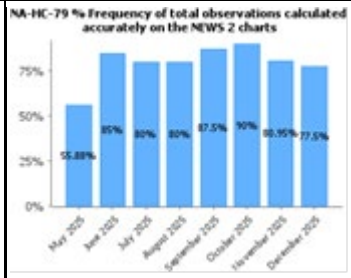
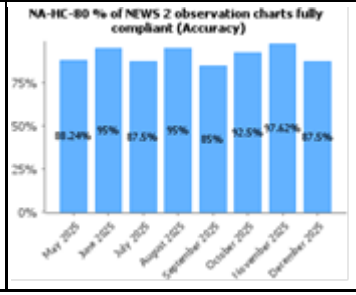
Title
Service & Quality Improvement Programmes - Measurement & Performance

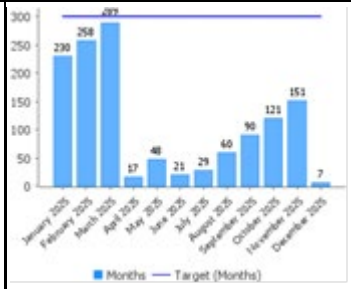
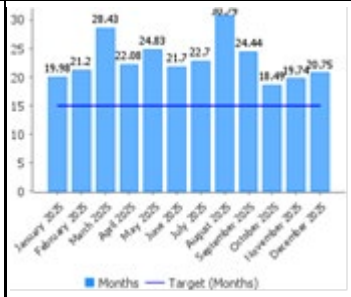
Performance Indicators	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
CE-IC-01 Cleaning Specification Audit Compliance	Not measured for Months			95%	95.1%	96.8%		90%		

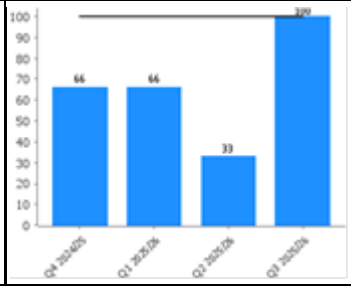
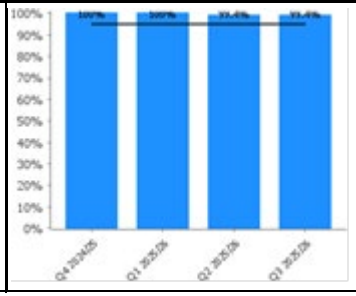
Performance Indicators	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-08 Days between Cardiac Arrests	592	622	653	469	561	653		300		
NA-HC-09 All Falls rate (per 1000 occupied bed days)	15.57	7.43	8.02	6.62	12.28	8.02		7		During Q3 there is a decrease in the number of falls per occupied 1000 occupied bed days. N.B. we observe an increase in the number of falls from 20 in Q2 to 31 in Q3. However inpatient care during Q3 was extremely busy, the high occupancy levels have resulted in the decrease in all falls rate observed in Q3.
NA-HC-10 Falls with harm rate (per 1000 occupied bed days)	2.4	1.06	0	1.1	0	0		0.5		

Performance Indicators	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 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)	48	10	41	1	17	10		300		Measure will remain on red until target of 300 days reached across both inpatient areas.
NA-HC-54 Pressure Ulcer Rate (grades 2-4)	0	1.06	0	2.21	2.05	0		0		

Performance Indicators	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 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).	98.8	98.9	99.4	96.9	98.7	99.4		95		
NA-HC-66 Pressure ulcer - days between pressure ulcers developed on Ward 1.	48	78	109	21	17	109		300		Measure will remain on red until 300 days is achieved.
NA-HC-69 Pressure ulcers - days between pressure ulcers on Ward 3	87	10	41	1	56	41		300		Measure will remain on red until 300 days is achieved.

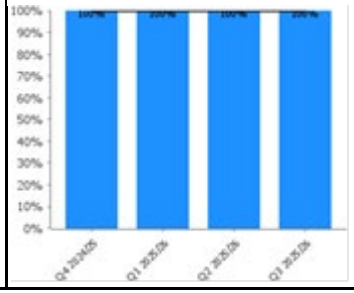
Performance Indicators	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-72 % of patients who had the correct pharmacological/mechanical thromboprophylaxis administered		90%		80%	80%	90%		75%		
NA-HC-79 % of total observations calculated on the NEWS 2 charts (Frequency)	90%	80.95%	77.5%	85%	87.5%	77.5%		95%		
NA-HC-80 % of NEWS 2 observation charts fully compliant (Accuracy)	92.5%	97.62%	87.5%	95%	85%	87.5%		95%		

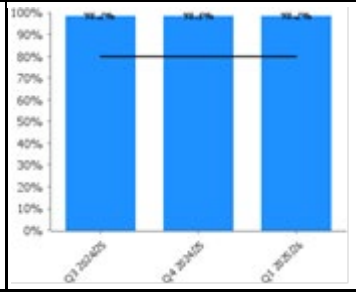
Performance Indicators	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 2025/26	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-IC-01 Days between Catheter Associated Urinary Tract Infection (CAUTI) developed in acute care	121	151	7	21	90	7		300		Measure will remain on red until target of 300 days reached across both inpatient areas.
NA-IC-02 Catheter Usage Rate	18.49	19.74	20.75	21.7	24.44	20.75		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	100%	93.75%	81.25%	80%	93.33%	81.25%		95%		

Performance Indicators	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 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	86.96%	77.27%	61.54%	88.46%	100%	61.54%		95%		
NA-IC-20 % of Patient Safety Conversations Completed (3 expected each quarter)	Measured Quarterly			66%	33%	100%		100%		
NA-IC-22 Hand Hygiene Audit Compliance	Measured Quarterly			100%	99.4%	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	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 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	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 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	Oct 2025	Nov 2025	Dec 2025	Q1 2024/25	Q2 2025/26	Q3 2025/26	Q3 2025/26	Q3 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			98.2%	100%			80%		**Awaiting Q3 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: October – December 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	0	2	199		**Oct 25**	2	9	3	Small graze on right arm / Left leg abrasion
Nov 25	0	4	229		**Nov 25**	1	5	21	Back abrasion
Dec 25	0	3	260		**Dec 25**	0	5	52	
Total	**2**	**27**			**Total**	**5**	**69**		

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	0	0	48			**Oct 25**	0	0	87		
Nov 25	0	0	78			**Nov 25**	1	1	10		
Dec 25	0	0	109			**Dec 25**	0	2	41		
Total	**3**	**4**				**Total**	**4**	**12**			

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	84	327	0	0%	26%	Oct	65	479	0	0%	14%
Nov	119	449	0	0%	27%	Nov	61	463	0	0%	13%
Dec	90	472	0	0%	19%	Dec	114	511	1	1%	22%
Total	1049	3930	0	0	26%	Total	1104	5192	4	0.16%	21%

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?**
October - December 2025	3	1 x Being Reviewed 2 x Finally Approved			3 inpatient falls on the medical ward during this period, all are reported via the Datix system. Datix 11385: Unavoidable fall resulting in a graze to arm. Falls assessments were completed on admission and deemed 'low risk', post falls bundle completed. Datix 11408: abrasion to leg, the incident is currently being reviewed by the SCN. Datix 11428: Unavoidable fall resulting in very small graze to back. Appropriate care given and the patient was placed appropriately (in the most appropriate room). Post falls bundle was completed and patient received a full medical review.
HOSPITAL ACQUIRED PRESSURE ULCERS					
Date	**No. of Patients**	**Avoidable/ Unavoidable**	**Appropriate Care Given?**	**Debrief Conducted?**	**Learning Points?**
October – December 2025	1	Being Reviewed by SCN.			Reported on the Datix system Dx11456. Currently being reviewed by the SCN.

Excellence in Care (EiC) Data:

Excellence in Care - Submission Report

NHS Shetland

Period from: September 2024 - August 2025
Extract date: 30 September 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 September 2024 - August 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

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

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

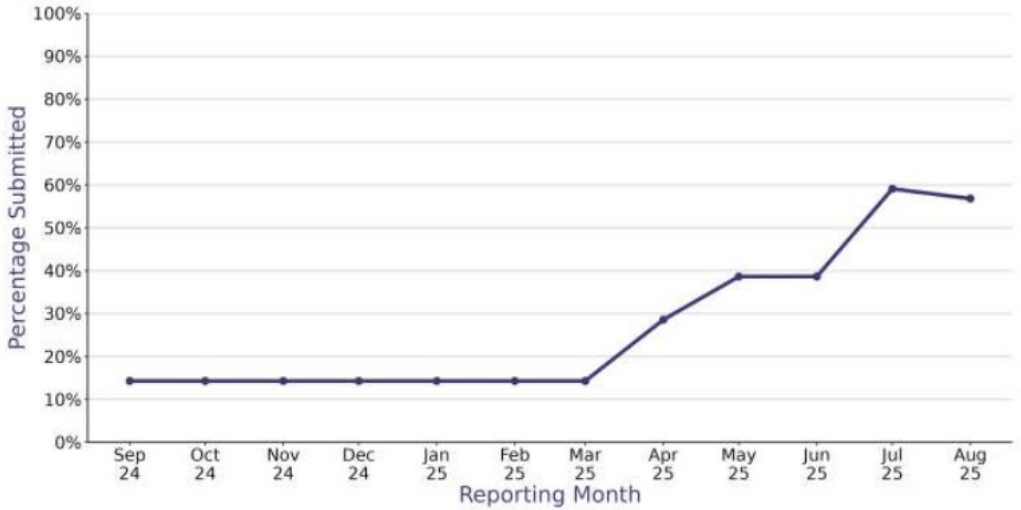


Table 2: Quarterly submission rates (%) in NHS Shetland

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

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

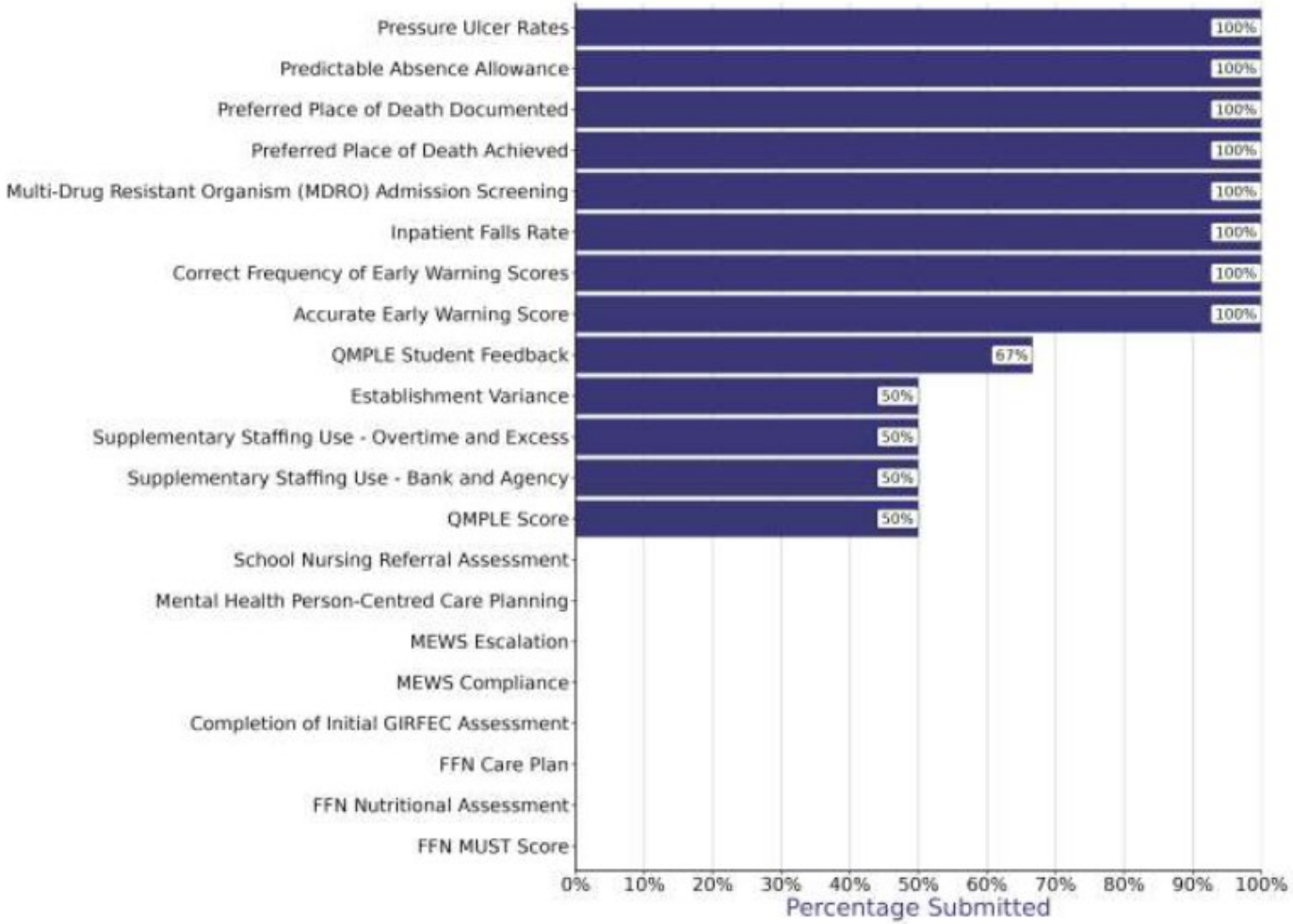


Table 3: Quarterly submission rates (%) by measure in NHS Shetland

Measure Name	Jul-Sep 2024	Oct-Dec 2024	Jan-Mar 2025	Apr-Jun 2025
Accurate Early Warning Score	0%	0%	0%	67%
Completion of Initial GIRFEC Assessment	N/A	N/A	N/A	0%
Correct Frequency of Early Warning Scores	0%	0%	0%	67%
Establishment Variance	0%	0%	0%	0%
FFN Care Plan	0%	0%	0%	0%
FFN MUST Score	0%	0%	0%	0%
FFN Nutritional Assessment	0%	0%	0%	0%
Inpatient Falls Rate	0%	0%	0%	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%	0%
Predictable Absence Allowance	100%	100%	100%	100%
Preferred Place of Death Achieved	0%	0%	0%	100%
Preferred Place of Death Documented	0%	0%	0%	100%
Pressure Ulcer Rates	0%	0%	0%	100%
QMPLE Score	33%	44%	56%	67%
QMPLE Student Feedback	83%	72%	89%	67%
School Nursing Referral Assessment	N/A	N/A	N/A	100%

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

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.

Figure 3: Submission rates (%) by partial measure in the latest month (August 2025) in NHS Shetland

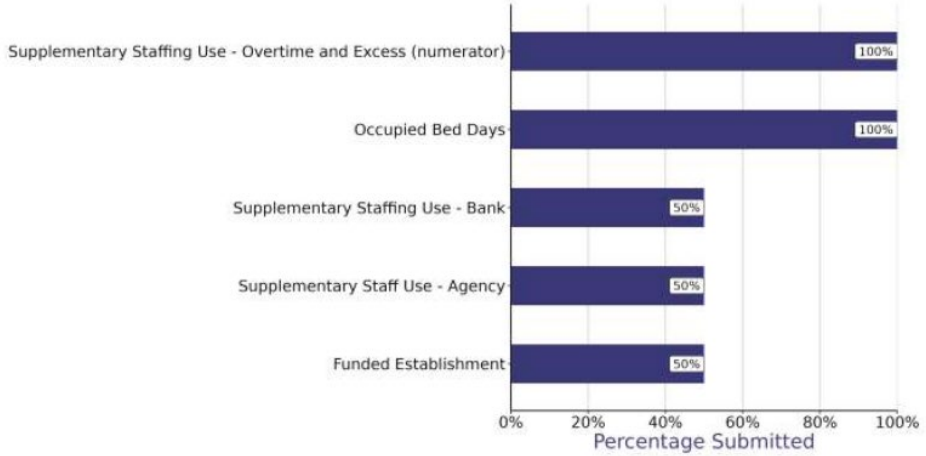
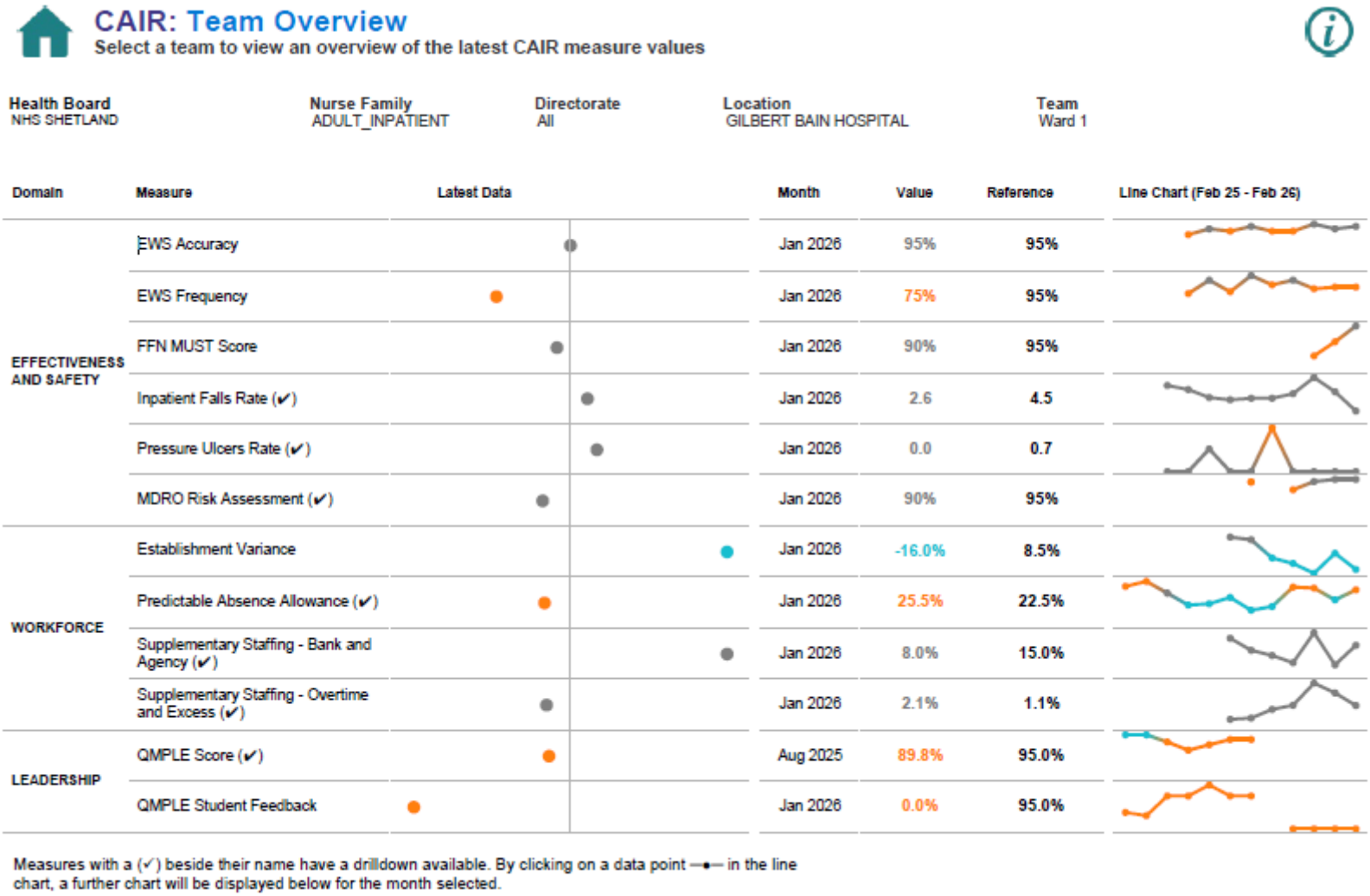


Table 4: Quarterly submission rates (%) by partial measure in NHS Shetland

Measure Name	Jul-Sep 2024	Oct-Dec 2024	Jan-Mar 2025	Apr-Jun 2025
Funded Establishment	0%	0%	0%	0%
Occupied Bed Days	0%	0%	0%	100%
Supplementary Staff Use - Agency	0%	0%	0%	0%
Supplementary Staffing Use - Bank	0%	0%	0%	0%
Supplementary Staffing Use - Overtime and Excess (numerator)	100%	100%	100%	100%

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 (Feb 25 - Feb 26)
EFFECTIVENESS AND SAFETY	EWS Accuracy		Jan 2026	95%	95%	
	EWS Frequency		Jan 2026	75%	95%	
	FFN MUST Score		Jan 2026	90%	95%	
	Inpatient Falls Rate (✔)		Jan 2026	2.6	4.5	
	Pressure Ulcers Rate (✔)		Jan 2026	0.0	0.7	
	MDRO Risk Assessment (✔)		Jan 2026	90%	95%	
WORKFORCE	Establishment Variance		Jan 2026	-16.0%	8.5%	
	Predictable Absence Allowance (✔)		Jan 2026	25.5%	22.5%	
	Supplementary Staffing - Bank and Agency (✔)		Jan 2026	8.0%	15.0%	
	Supplementary Staffing - Overtime and Excess (✔)		Jan 2026	2.1%	1.1%	
LEADERSHIP	QMPLE Score (✔)		Aug 2025	89.8%	95.0%	
	QMPLE Student Feedback		Jan 2026	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 3 Medical Ward:

CAIR: Team Overview

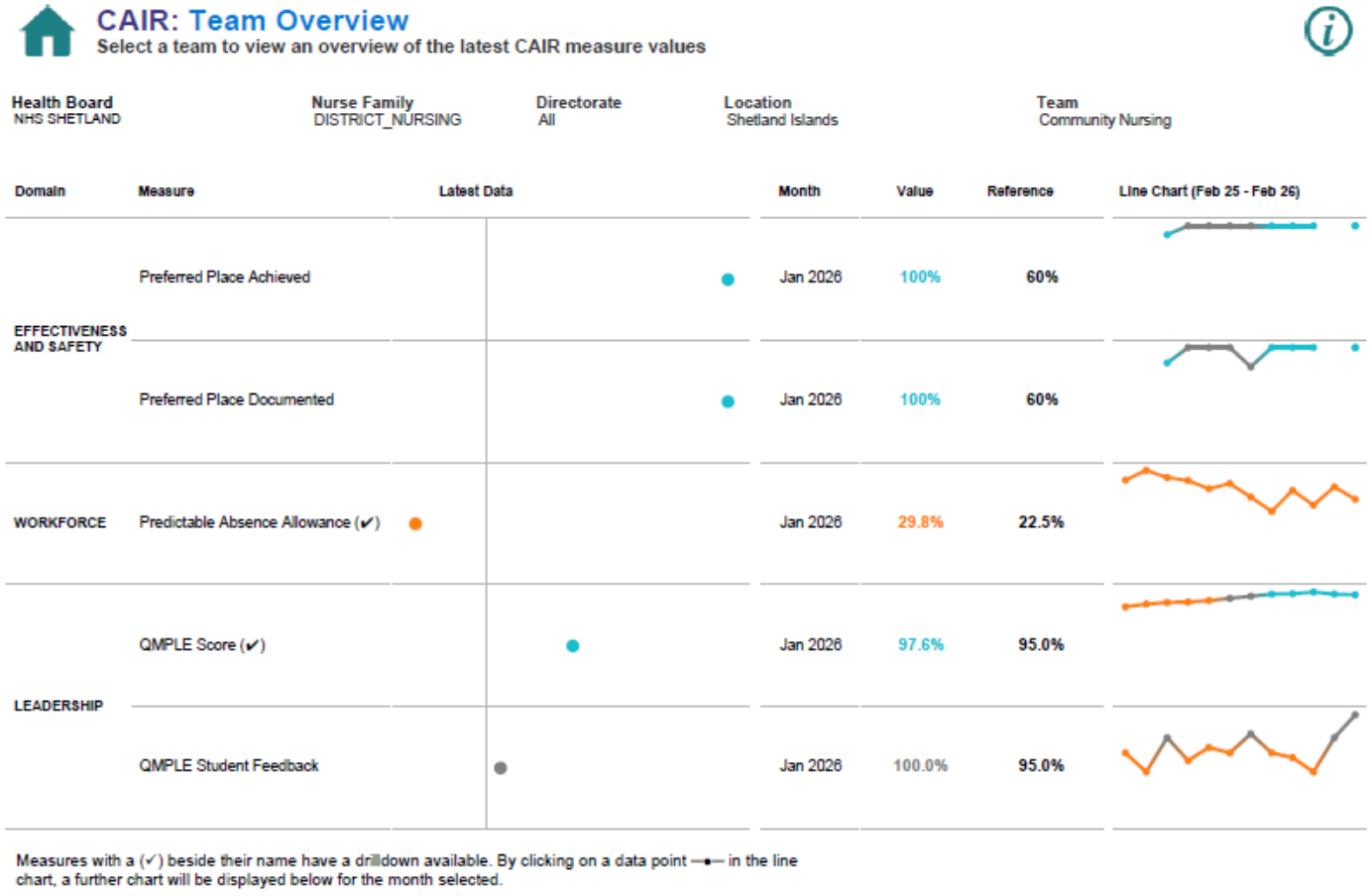
Select a team to view an overview of the latest CAIR measure values

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 (Feb 25 - Feb 26)
EFFECTIVENESS AND SAFETY	EWS Accuracy		Jan 2026	90%	95%	
	EWS Frequency		Jan 2026	80%	95%	
	FFN MUST Score		Jan 2026	65%	95%	
	Inpatient Falls Rate (✔)		Jan 2026	9.7	4.5	
	Pressure Ulcers Rate (✔)		Jan 2026	1.9	0.7	
	MDRO Risk Assessment (✔)		Jan 2026	100%	95%	
WORKFORCE	Establishment Variance		Jan 2026	-6.7%	8.5%	
	Predictable Absence Allowance (✔)		Jan 2026	26.3%	22.5%	
	Supplementary Staffing - Bank and Agency (✔)		Jan 2026	17.7%	15.0%	
	Supplementary Staffing - Overtime and Excess (✔)		Jan 2026	0.6%	1.1%	
LEADERSHIP	QMPLE Score (✔)		Jan 2026	100.0%	95.0%	
	QMPLE Student Feedback		Jan 2026	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 – 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 (Feb 25 - Feb 26)
EFFECTIVENESS AND SAFETY	Preferred Place Achieved	●	Jan 2026	100%	60%	
	Preferred Place Documented	●	Jan 2026	100%	60%	
WORKFORCE	Predictable Absence Allowance (✔)	●	Jan 2026	29.8%	22.5%	
LEADERSHIP	QMPLE Score (✔)	●	Jan 2026	97.6%	95.0%	
	QMPLE Student Feedback	●	Jan 2026	100.0%	95.0%	

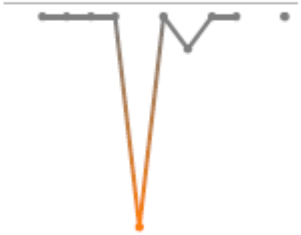
Measures with a (✓) beside their name have a drilldown available. By clicking on a data point —●— in the line chart, a further chart will be displayed below for the month selected.

Excellence in Care Measures – 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 (Feb 25 - Feb 26)
EFFECTIVENESS AND SAFETY	School Nursing Referral Assessment (✔)		Jan 2026	100.0%	90.0%	
WORKFORCE	Predictable Absence Allowance (✔)		Jan 2026	21.8%	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: October – December 2025

Thematic analysis of Lessons Learnt:

Q3 Total Data: 200 Adverse Events Reported: 8 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
October 2025	**72**	**2 Extreme (11363, 11364)** **2 Major (11355, 11387)** **4 Moderate (11388, 11342, 11413, 11402)**	**2** **11383** **11387**

Adverse event theme (11383) – Level 3 Review: Communication: Reviewed by Consultant Physician
Primary diagnosis was omitted from the discharge letter.

Learning identified:

- Resident doctors to be reminded of the importance of completing discharge letters accurately.
- Consultants to apply greater attention to detail when reviewing and signing off discharge letters
- Findings to be presented and discussed at Medical Governance meeting.

Adverse event theme (11387) – Level 3 Review: Clinical assessment: Reviewed by Associate Medical Director for Primary Care
Patient with heart disease attended for routine cardiology follow-up. Consultant noticed GP had stopped some of their heart-failure medication. Patient had experienced deterioration with significant oedema and weight gain. They were later treated with higher doses of alternative medications, which caused side effects highlighting possible issues with the advice and management provided in primary care.

Learning identified:

- Earlier and clearer communication between primary and secondary care.
- Better shared IT systems to support information flow and awareness of comorbidities.

November 2025	**64**	**6 Extreme (11450, 11461, 11475, 11429, 11423, 11469)** **0 Major** **6 Moderate (11416, 11430, 11467, 11439, 11415, 11473)**	**3** **11439** **11441** **11445**

Adverse event theme (11439) – Level 3 Review: Obstetrics: Reviewed by Senior Charge Midwife

Patient had Postpartum Haemorrhage (PPH) following spontaneous vaginal birth.

Learning identified:

- Syntometrine should be used in the active management of the third stage of labour.
- Drug supplies should be checked at every shift handover.
- The PPH proforma should be used consistently.
- A 2222 call should be considered early, especially overnight when reduced staffing.
- Labour room buzzers must be checked every morning (now included in the SHCSW checklist).
- Clocks in labour rooms should be positioned so all staff, including the scribe, can clearly see them to support accurate timing of incident and management.

Adverse event theme (11441) – Level 3 Review: Confidentiality: Reviewed by Radiographer

Medical imaging reports for patients registered at various Health Centres were all sent to one Health Centre.

Learning identified:

- Staff involved reminded to be careful and double check reports before they are sent out.

Adverse event theme (11445) – Level 3 Review: Medication: Reviewed by Clinical Team Lead

A patient with complex healthcare needs had a sputum sample taken during pre-assessment with the result being sent to an Advanced Nurse Practitioner (ANP) to prescribe an Antibiotic. Relevant antibiotic prescribed according to sensitivities, but consideration not given to patient's poor kidney function, so the dose was not adjusted accordingly.

Learning identified:

- High workload contributed to the clinician not checking renal function, highlighting the importance of seeking support from colleagues when under pressure to ensure safe prescribing.
- The clinician has reflected on the incident, recognised the missed renal function check and will routinely use resources such as the renal drugs database to support safe prescribing in future.

December 2025	**64**	**3 Extreme (11538, 11526, 11541)** **2 Major (11508, 11481)** **4 Moderate (11544, 11484, 11522, 11510)**	**2** **11485** **11499**
Adverse event theme (11485) – Level 3 Review: Communication: Reviewed by the Medical Director Poor communication between primary and secondary care when referring a patient for in-patient alcohol detox. Escalation of emails then occurred to senior managers. Admission took place 3 days later with no issues. **Learning identified:** • Need to improve information flow to GP's regarding the involvement of Substance Use and Recovery Team's involvement in individual patient's care. • Standardise approach for admission to GBH for detoxification requests. • Raise awareness re evidence-based approach to addiction.			
Adverse event theme (11499) – Level 3 Review: Sharps: Reviewed by the Cardiac Specialist Nurse Needle stick injury **Learning identified:** • Staff member to ensure sharps bin is available nearer to patient in the delivery of future clinical tasks • Member of staff has reflected on their practice and updated knowledge of local policies and procedures.			

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	100%	100%	100%	100%
Nov-25	100%	100%	100%	100%
Dec-25	91%	100%	100%	100%
Average for the year	**97%**	**82%**	**99%**	**90%**

Ward 1						
Person Centred Measure description	**MD01 (NA-HC-16)** % of people who say that we took account of the things that were important to them. Aim 90%	**MD02 (NA-HC-19)** % of people who say that we took account of the people who were important to them and how much they wanted to be involved in care/treatment. Aim 90%	**MD03 (NA-HC-22)** % of people who say that they have all the information they needed to help them make decisions about their care/treatment. Aim 90%	**MD04 (NA-HC-25)** % of people who say that staff took account of their personal needs and preferences Aim 90%	**MD05 (NA-HC-28)** % of people who say they were involved as much as they wanted to be in communication/ transitions/ handovers about them Aim 90%	**Number of responses**
Jan-25	100%	100%	98%	100%	98%	**20**
Feb-25	100%	100%	97%	94%	94%	**9**
Mar-25	100%	100%	95%	94%	94%	**19**
Apr-25	100%	100%	100%	100%	100%	**14**
May-25	100%	100%	100%	100%	100%	**5**
Jun-25	100%	90%	88%	100%	85%	**13**
Jul-25	100%	100%	100%	100%	100%	**20**
Aug-25	100%	100%	96%	97%	95%	**19**
Sep-25	100%	100%	98%	100%	100%	**9**
Oct-25	100%	100%	98%	100%	100%	**23**
Nov-25	100%	100%	100%	100%	88%	**8**
Dec-25	100%	91%	98%	90%	75%	**13**
Average for year	**100%**	**98%**	**97%**	**98%**	**94%**	**14**

Ward 3						
Person Centred Measure description	**MD01 (NA-HC-15)** % of people who say that we took account of the things that were important to them. Aim 90%	**MD02 (NA-HC-18)** % of people who say that we took account of the people who were important to them and how much they wanted to be involved in care/treatment. Aim 90%	**MD03 (NA-HC-21)** % of people who say that they have all the information they needed to help them make decisions about their care/treatment. Aim 90%	**MD04 (NA-HC-24)** % of people who say that staff took account of their personal needs and preferences Aim 90%	**MD05 (NA-HC-27)** % of people who say they were involved as much as they wanted to be in communication/ transitions/ handovers about them Aim 90%	**Number of responses**
Jan-24	100%	100%	100%	100%	100%	**5**
Feb-24	100%	100%	100%	100%	100%	**6**
Mar-24	100%	100%	100%	100%	100%	**2**
Apr-24	100%	0%	50%	50%	50%	**1**
May-24	100%	100%	100%	100%	100%	**4**
Jun-24	100%	100%	100%	100%	100%	**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	100%	100%	100%	100%	100%	**6**
Nov-24	100%	0%	100%	100%	100%	**1**
Dec-24	100%	100%	100%	100%	100%	**3**
Average for year	**92%**	**75%**	**87%**	**83%**	**85%**	**4**

WARD 1 INPATIENT SURVEY – PATIENT COMMENTS – October / 2025
I felt very well looked after.
Pharmacy seemed a bit slow, but overall good treatment supplied.
Excellent treatment from the set so!
Excellent staff, very helpful and caring, very thankful for their care.
The nurses were all fantastic, amazing and wonderful! They are a great team!
The staff were very professional & take excellent care of me. Thank you.
The staff were amazing and the ward was really clean. I had excellent care and was looked after really well. Thank you!
Additional guidance given by all staff particularly helpful to aid and improve future life. Thank you to all for an amazing stay after the shock of first realising I had a major problem.
My stay on Ward 1 was very well looked after, always there to lend an ear when uncomfortable. Only ups no downs. Well done Ward 1.

WARD 3 INPATIENT SURVEY - PATIENT COMMENTS – October / 2025
No comments provided on the inpatient survey.

WARD 1 INPATIENT SURVEY – PATIENT COMMENTS – November / 2025
Everyone was very nice & accommodating. Thank you for a private room so I could take care and b/feed my baby. You're all working so hard, thank you very much, it's very much appreciated.
All good, no complaints.
Great staff that can pick up on the vibe!
They are all worth their weight in gold. Very dedicated, caring. Couldn't fault them on any issue.

WARD 3 INPATIENT SURVEY - PATIENT COMMENTS – November / 2025
Everyone has been very kind, thank you.

WARD 1 INPATIENT SURVEY – PATIENT COMMENTS – Dec / 2025
Long wait for getting drugs on day of leaving place of treatment.
Two bowel preps in one day after other. Plenvu isn't as good as the stuff used last time. I got it done when 52 so 4 years ago, 2022.
Everyone has been so caring and kind - I've been very well looked after. Thank you.
Fabulous care - the best staff <3

WARD 3 INPATIENT SURVEY - PATIENT COMMENTS – Dec / 2025
From Fraserburgh myself. This hospital was amazing. Staff and food is awesome. Big shout to you all. Amazing job. Cheers.
Comments on this form are about ward 3 staff and A&E on this visit. When I came to A&E on Monday 22nd I was not helped at all and the actions there could have avoided my illness getting worse.

Q3 NHS Shetland Care Opinion Feedback:

Area	Story Title	Care Opinion Link
Lerwick Health Centre	“Very convenient to be offered appointment on a Saturday"	https://www.careopinion.org.uk/1404856
Gilbert Bain Hospital/ Accident & Emergency	"The team provided exceptional care"	https://www.careopinion.org.uk/1411474

An overview of Care Opinion Feedback received:

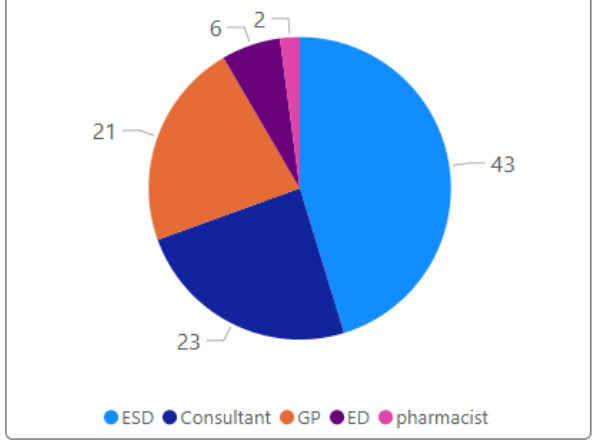
	Q3 2024/2025 (Feedback first included as part of the Quality Score Card)	Q4 2024/2025	Q1 2025/2026	Q2 2025/2026	Q3 2025/2026
Number of Care Opinion Feedback received	5	3	4	1	2

Hospital at Home: H@H - As of 27th February 2026:

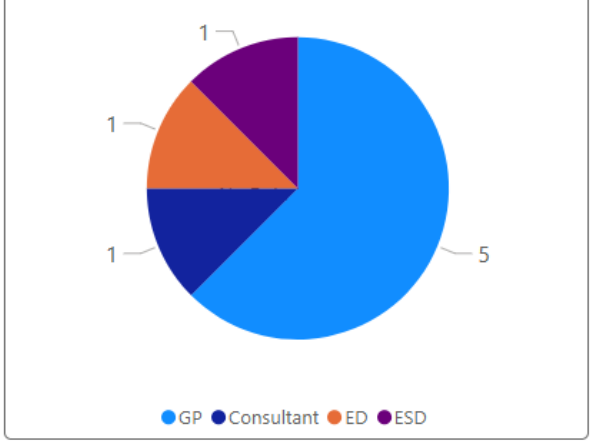
Hospital at Home Dashboard - To Date Summary (Dec 23 - Today)

Total Number of Referrals:	Number of Patients Accepted:	Number of Patients Rejected:	Number of Patients Whose Care Ended:	Total Bed Days:	Median LoS:	Average Age:
111	95	8	95	988	7	75

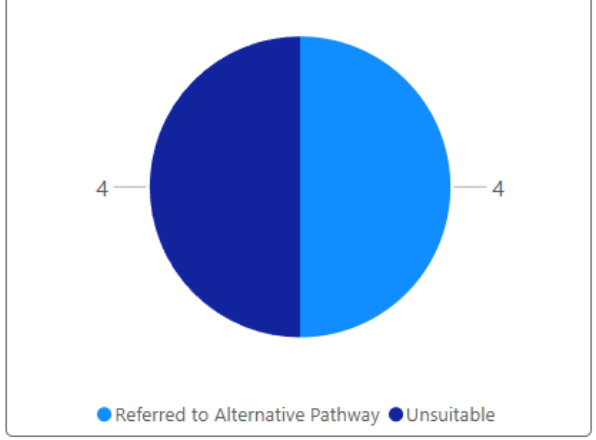
Admitted Referral Sources



Rejected Referral Sources

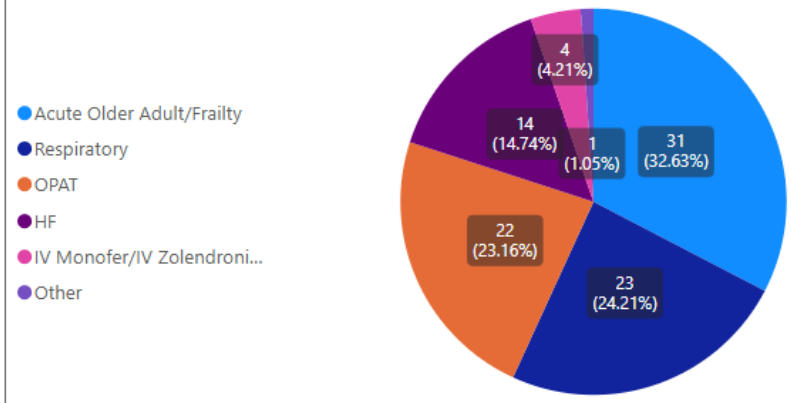


Rejected Referral Reasons

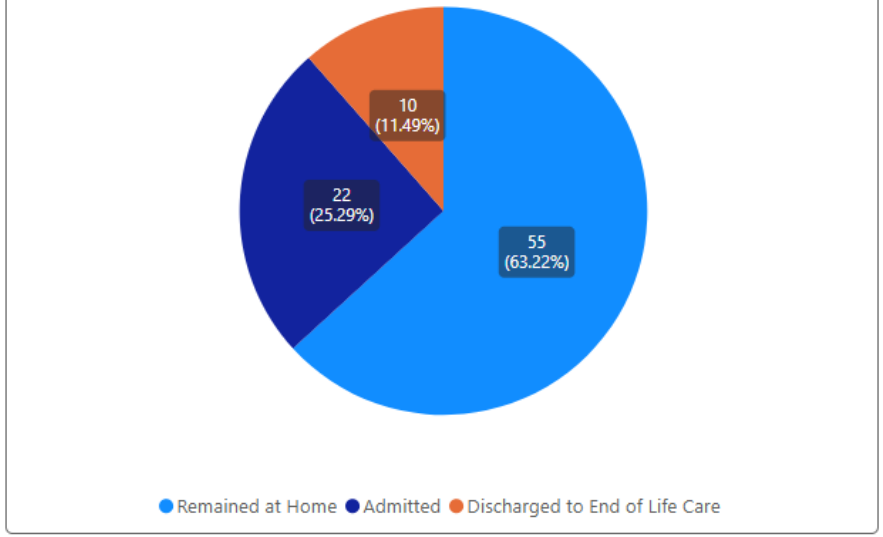


Hospital at Home Dashboard

Admission Category



30 Day Outcome

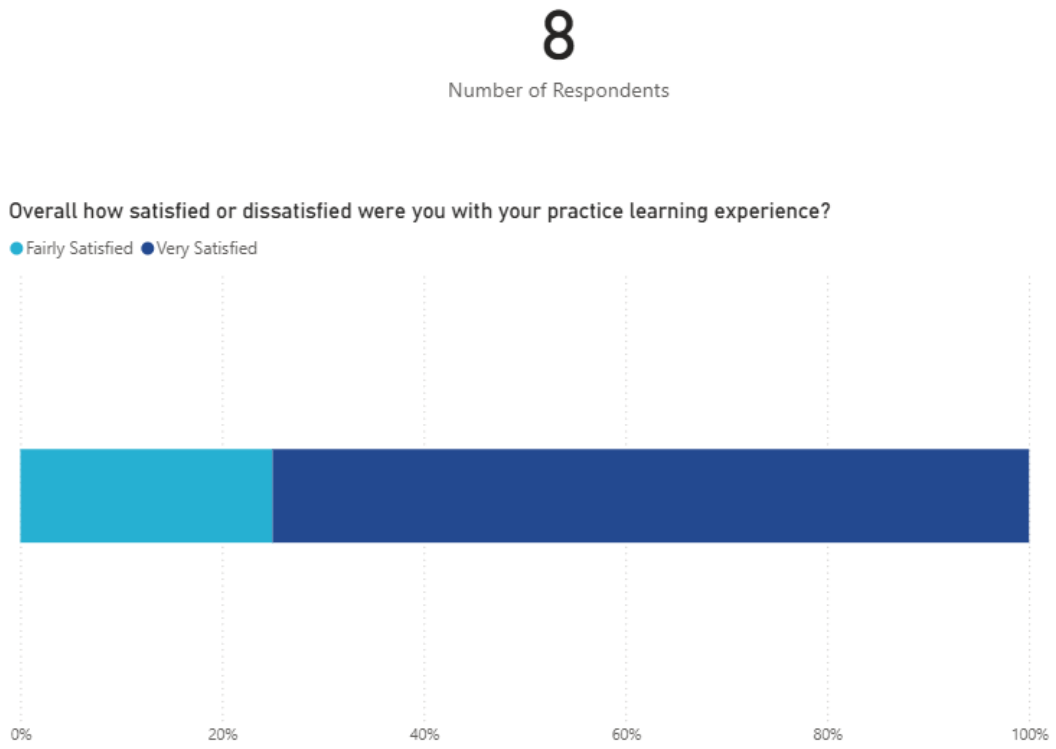


Current Stats:

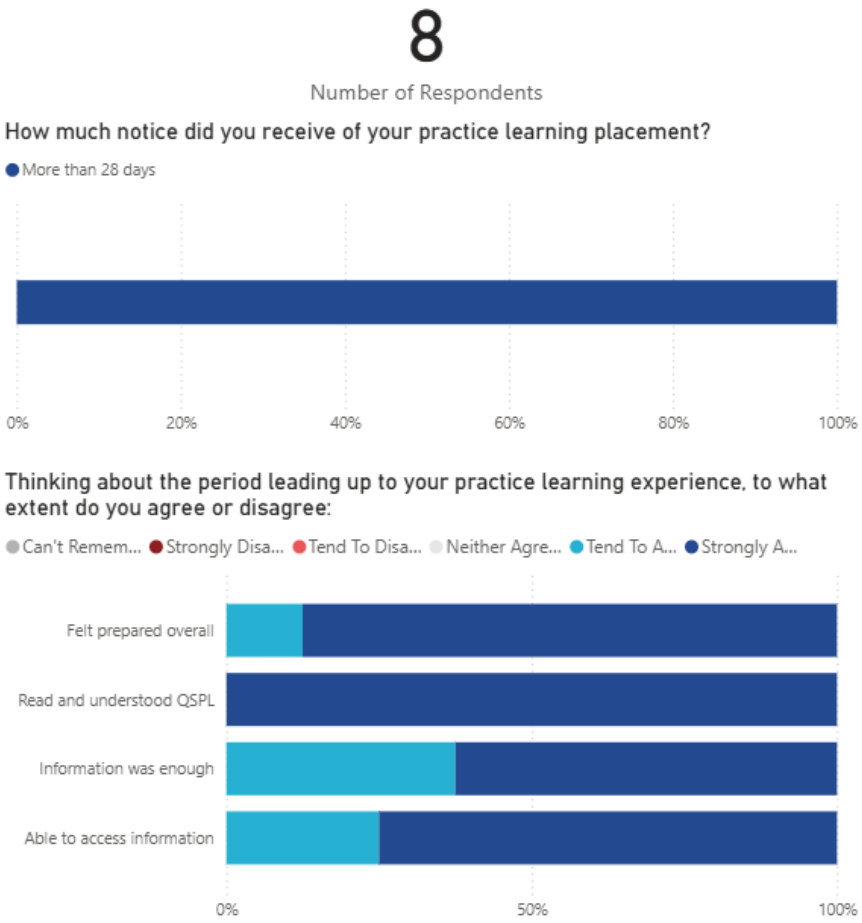
75	988	7	10.5
Average Age	Total Bed Days	Median LoS	Average LoS

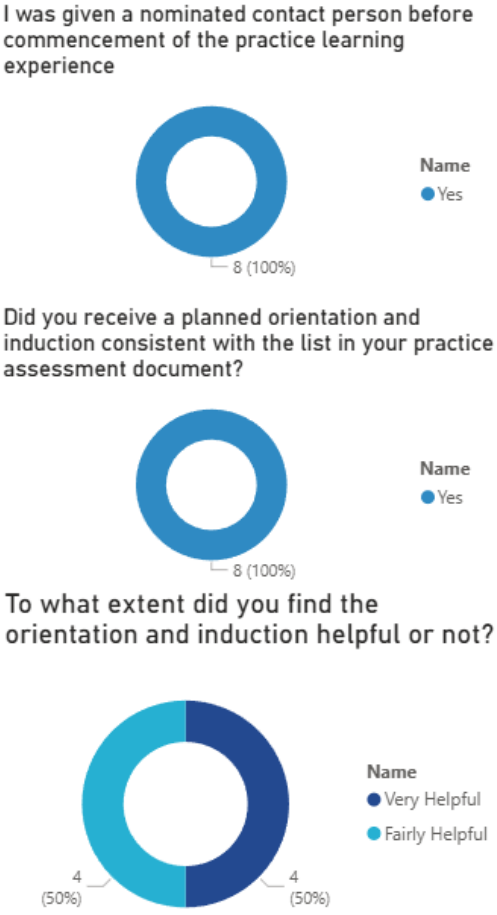
Appendix F: Quality Management of the Practice Learning Environment (QMPLE)
Q3 1st October – 31st December 2025
Overall Satisfaction:

Student Feedback Overview:

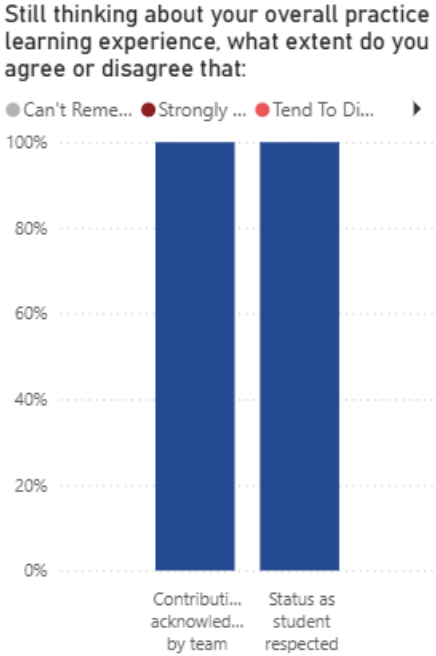


Preparation for Practice Learning:

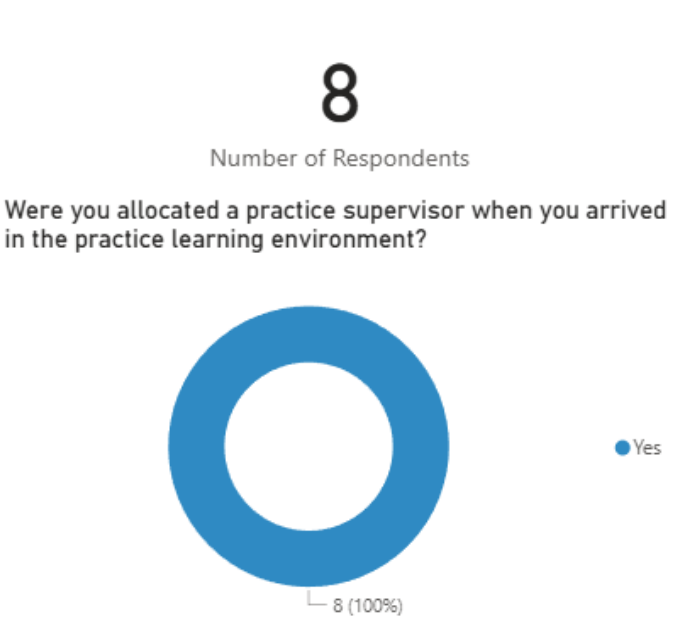


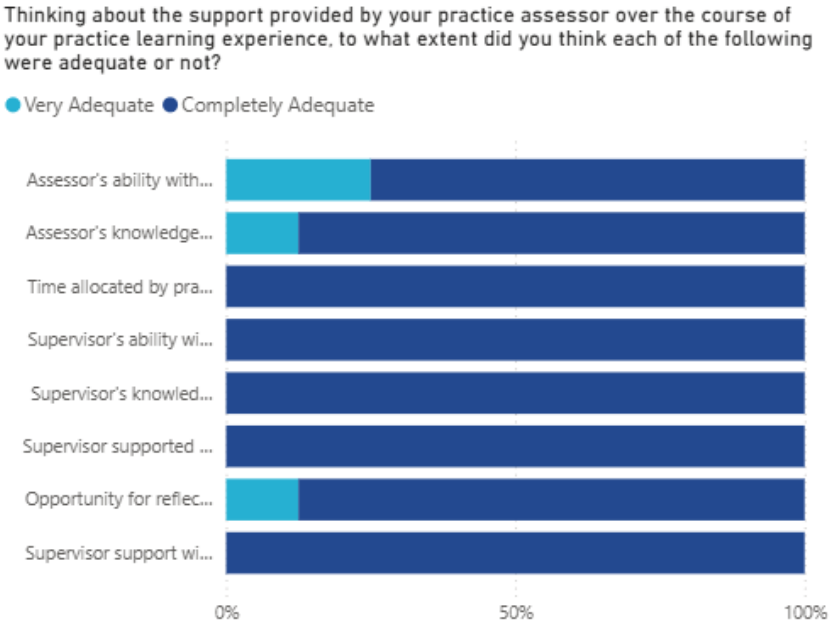


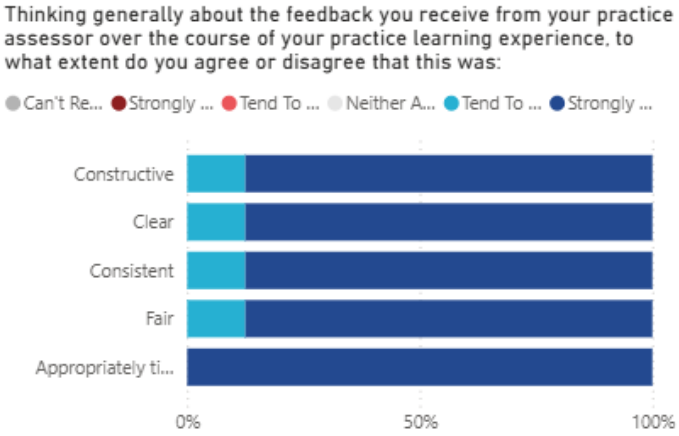
Learning Environment:

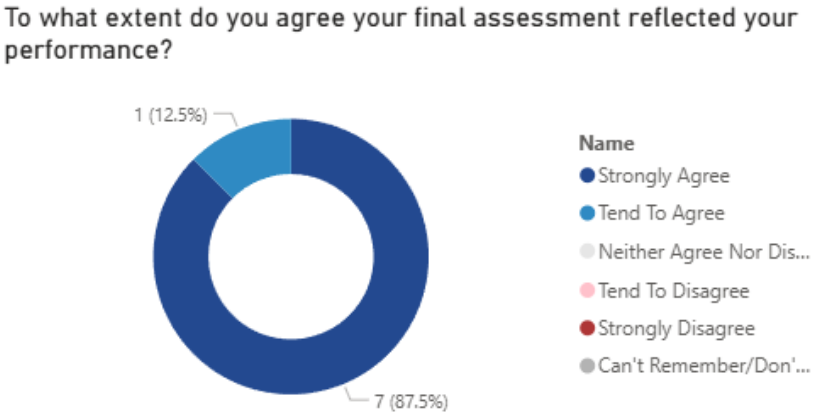


Practice support:

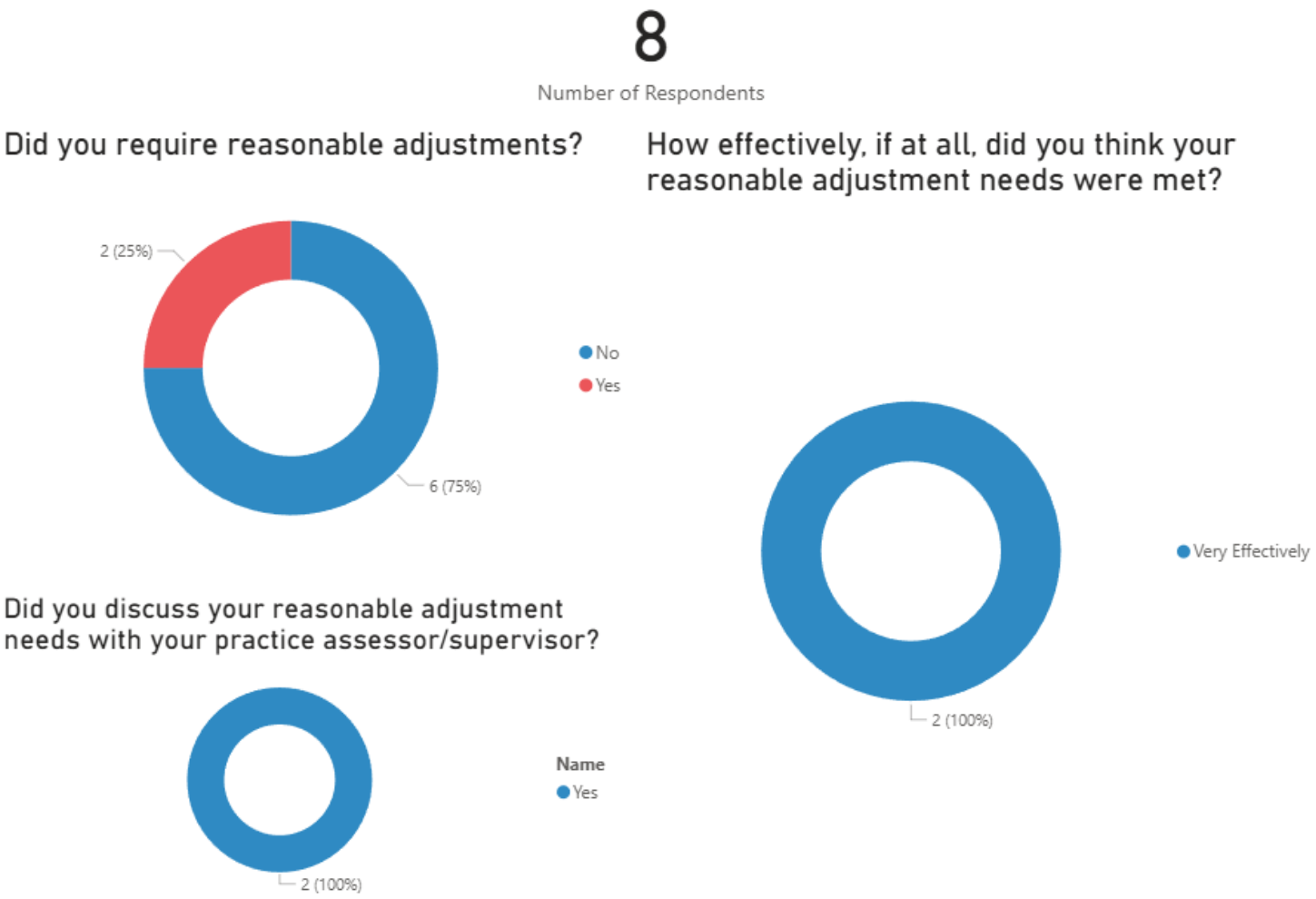








Additional Support Needs:



Student feedback Overview –particularly good:

8

Number of Respondents

Search all responses...

Search

Response	Learning Environment	Learning Centre
All staff were really supportive during my placement. Making sure I was able to see different things and have opportunities to be involved in the resus team and getting to theatres. The staff encouraged me and helped me build my confidence and feel as a part of the team.	Accident and Emergency	Gilbert Bain Hospital
I got the opportunity to do so much. Learning about all the different types of wound care has been really interesting. I've really enjoyed being in the community!	Brae Community	Shetland Community
Being able to experience nursing on a rural island both in the hospital and out in the community.	Child Health	Gilbert Bain Hospital
The team in daysurgery have been really supportive and the range of procedures and skills has been really good.	Day Surgery Unit	Gilbert Bain Hospital
I got to learn and practice a range of different skills which helped build confidence and greater my skill set.	Lerwick Practice Nurses	Shetland Community
I was treated like part of the team and felt really welcomed.	Levenwick Community	Shetland Community
Every member of staff was very welcoming and supported me throughout the placement.	Out Patients Department	Gilbert Bain Hospital
I was made to feel incredibly welcome and part of the team. Staff were willing to help and actively encourage me to expand my learning and enhance my practice. I cannot fault a moment of my placement on Ward 3.	Ward 3	Gilbert Bain Hospital

Student feedback – improved experience:

8

Number of Respondents

Search all responses...

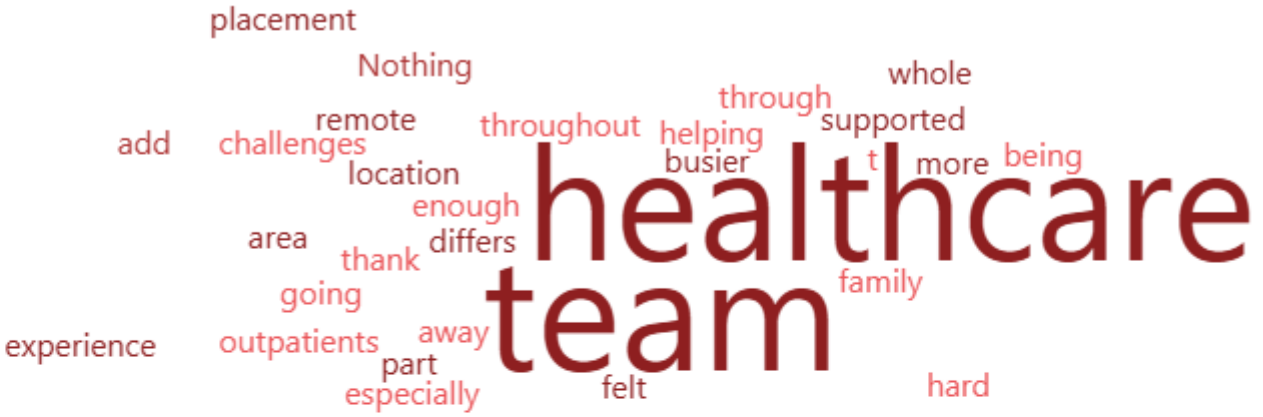
Search

Response	Learning Environment	Learning Centre
I cannot think of anything that could of improved my learning experience.	Day Surgery Unit	Gilbert Bain Hospital
unsure.	Lerwick Practice Nurses	Shetland Community
There wasn't really anything bad about my placement it was just unfortunate that the community nursing teams in Shetland at the moment are short staffed but despite this i was still welcomed warmly at every base i visited.	Levenwick Community	Shetland Community
Had I been able to take bloods and cannulate I would have been able to be even more involved in the care of patients.	Ward 3	Gilbert Bain Hospital

Additional Comments:

8

Number of Respondents



Search all responses...

Search

Response	Learning Environment	Learning Centre
I felt supported and a part of the team my whole placement. I was able to experience healthcare in a more remote area and how it differs to healthcare in a busier location	Accident and Emergency	Gilbert Bain Hospital
Nothing else to add	Day Surgery Unit	Gilbert Bain Hospital
The team at outpatients , can't thank them enough for helping me throughout all the challenges I was going through especially how hard it was to being away from my family.	Out Patients Department	Gilbert Bain Hospital

NHS Shetland Feedback Monitoring Report 2025_26 Quarter 3

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 October to December 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 64 pieces of feedback in Quarter 3 of 2025/26 (1 October 2025 – 31 December 2025). For clarity these figures include all salaried GP practices (note this is 9 of 10 practices in Shetland for the purposes of Quarter 3 reporting):

	01.10.25 – 31.12.25		01.07.25 – 30.09.25 (previous quarter)	
Feedback Type	**Number**	**%**	**Number**	**%**
Compliments	8	12.5	2	4
Concerns	31	48.4	24	48
Complaints	25	39.1	24	48
Totals:	**64**		**50**	

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

	01.10.25 – 31.12.25		01.07.25 – 30.09.25 (previous quarter)	
Service	**Number**	**%**	**Number**	**%**
Directorate of Acute and Specialist Services	9	36	12	50
Directorate of CH&SC	14	56	10	42
Acute and community	-	-	-	-
Other (e.g. PH, Patient Travel)	2	8	2	8
Totals:	**25**		**24**	

Key highlights

- The introduction of a new reporting system through 2026 will reduce capacity initially but has the potential to be extremely beneficial in the longer term, allowing focussed feedback and complaint reporting in departmental areas, and streamlining general report writing.
- Performance regarding the length of time to respond to Stage 1 complaints has marginally improved from the last quarter, with 12 of the 19 Stage 1 complaints handled within five working days. Responding to Stage 2 complaints within 20 working days remains challenging, with no 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 has been followed up with a local focussed training session, however there is more to do to build confidence in this area. A second cohort of staff will receive training in March.
- 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, with the possibility that it may be handled solely by a partner Board.

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	01.10.25 – 31.12.25	01.07.25 – 30.09.25 (previous quarter)
Number of complaints closed at Stage One as % of all complaints closed	79.2% (19 of 24)	61% (14 of 23)
Number of complaints closed at Stage Two as % of all complaints closed	16.6% (4 of 24)	39% (9 of 23)
Number of complaints closed at Stage Two after escalation as % of all complaints closed	4.2% (1 of 24)	0% (0 of 23)

*S2 complaints reduce from 5 to 4 for reporting purposes as one Stage 2 complaint from December 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	01.10.25 – 31.12.25	01.07.25 – 30.09.25 (previous quarter)
Number of complaints upheld at Stage One as % of all complaints closed at Stage One	52.6% (10 of 19)	29% (4 of 14)
Number complaints upheld at Stage Two as % of complaints closed at Stage Two	25% (1 of 4)	11% (1 of 9)
Number escalated complaints upheld at Stage Two as % of escalated complaints closed at Stage Two	0% (0 of 1)	n/a

Partially Upheld

Description	01.10.25 – 31.12.25	01.07.25 – 30.09.25 (previous quarter)
Number of complaints partially upheld at Stage One as % of complaints closed at Stage One	36.9% (7 of 19)	57% (8 of 14)
Number complaints partially upheld at Stage Two as % of complaints closed at Stage Two	75% (3 of 4)	67% (6 of 9)
Number escalated complaints partially upheld at Stage Two as % of escalated complaints closed at Stage Two	100% (1 of 1)	n/a

Not Upheld

Description	01.10.25 – 31.12.25	01.07.25 – 30.09.25 (previous quarter)
Number complaints not upheld at Stage One as % of complaints closed at Stage One	10.5% (2 of 19)	14% (2 of 14)
Number complaints not upheld at Stage Two as % of complaints closed at Stage Two	0% (0 of 4)	22% (2 of 9)
Number escalated complaints not upheld at Stage Two as % of escalated complaints closed at Stage Two	0% (0 of 1)	n/a

3 The average time in working days for a full response to complaints at each stage			
Description	**01.10.25 – 31.12.25**	**01.07.25 – 30.09.25 (previous quarter)**	**Target**
Average time in working days to respond to complaints at Stage One	8	9.6	5 wkg days
Average time in working days to respond to complaints at Stage Two	53.3	43.3	20 wkg days
Average time in working days to respond to complaints after escalation	44	-	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	**01.10.25 – 31.12.25**	**01.07.25 – 30.09.25 (previous quarter)**	**Target**
Number complaints closed at Stage One within 5 working days as % of Stage One complaints	63.2% (12 of 19)	42.9% (6 of 14)	80%
Number complaints closed at Stage Two within 20 working days as % of Stage Two complaints	0% (0 of 4)	11% (1 of 9)	80%
Number escalated complaints closed within 20 working days as % of escalated Stage Two complaints	0% (0 of 1)	-	80%

5 The number and percentage of complaints at each stage where an extension to the 5 or 20 working day timeline has been authorised.		
Description	**01.10.25 – 31.12.25**	**01.07.25 – 30.09.25 (previous quarter)**
% of complaints at Stage One where extension was authorised	36.8%	57.1%
% of complaints at Stage Two where extension was authorised	100%	89%
% of escalated complaints where extension was authorised	100%	-

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.

We realise there is a need to plan increased communication regarding complaint handling and drop in session availability for support.

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 is being followed up at a local level, as it is apparent more training in this area is required.

The Stage 1 complaint reporting process is being modernised and will be re-communicated for 2026/27.

Stage 2 complaints received 1 April 2025 to 30 December 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	Part upheld	• Apology for discharge and the way the patient was sent home. • Explanation provided that the patient was receiving the correct treatment and that admission symptoms had settled, hence the discharge, however the communication could have been better regarding the patient's state.
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
19	Attitude of staff member and subsequent related matters	Admin	No	Staff unavailability	Part upheld	• Learning points identified regarding the interaction and subsequent complaint handling • Explanation given as to why further advice and action was taken • Review of application of policy across directorates to be requested
20	Difficult consultation and referral not actioned	GP	No	Marginally over due to final sign off	Part upheld	• Delay offering appointment was due to low staffing. • Email not sent to another department due to confusion between clinicians, however it was explained it would not have expedited treatment as this was prioritised on clinical need.

						• Apology offered for upset caused, and meeting offered.
21	Treatment decisions affecting end of life care and a lack of transparency of information	AHP and nursing	No		Upheld	• Staff reminded about the importance of documenting discussions in the relevant clinical notes • Formal criteria and assessment documentation to be developed for accessing specific equipment requested • Departmental waiting list to be reviewed to lower the risk of individuals with deteriorating health not having their needs met • Review of clinical pathway • Apology given for the lack of transparency regarding decision making and without the intended outcome
22	Poor experience in appointment for family member	Consultant	No	Marginally delayed	Part upheld	• Apology given for experience, with reflection and an explanation of matters discussed. • Mediation offered, and an appointment with an alternative consultant
23	Delayed cancer diagnosis	GP	No	Investigating manager needed more time	Part upheld	• Investigation did not identify evidence of a significant delay in diagnosis • Service improvement for vague symptoms/Rapid Cancer Diagnosis Service (RCDS) pathway to be taken forward through the Cancer Leads group to try and streamline the diagnostic process in this area
24	Medical error and inappropriate patient placement	Medical/Community	No		Open	

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