NHS Shetland

Meeting:	Board
Meeting date:	22 September 2026
Agenda reference:	Board Paper 2026/27/29
Title:	Quality Scorecard Report Q1 2026/2027
Responsible Executive/Non-Executive:	Kathleen Carolan, Director of Nursing and Acute & Specialist Services
Report Author:	Michelle Hankin, Clinical Governance and Risk Team Leader Carolyn Hand, Head of Corporate Services

1 Purpose

This report is presented to the Board/ Committee for:

- Discussion and Awareness

This report relates to:

- Government policy/directive
- An overview of our person centred care improvement programmes

This aligns to the following NHS Scotland 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.

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.

2.4 Recommendation

Awareness – for Board members

3 List of appendices

The following appendices are included with this report:

- Appendix 1 Quality Report September 2026
- Appendix 2 Quality Scorecard September 2026
- Appendix 3 Complaints and Feedback Report Q1 2026-27

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 (41 KPIs):				
2026/2027	**No target set/ Suspended activity/ awaiting update**			
Q1 2026/2027	**7**	**10**	**1**	**23**
	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 Post-Partum Haemorrhage (PPH)	PH-HI-03 NA-HC-08 NA-HC-09 NA-HC-53 NA-HC-66 NA-HC-69 NA-HC-80 NA-IC-01 NA-IC-02 NA-IC-20 Measures will remain on red until the target has been met	NA-IC-13	Detailed in the Quality Score Card (Appendix 1)
Q4 2025/26	8	11	3	20
Q3 2025/26	8	9	3	26
Q2 2025/26	7	10	1	24
Q1 2025/26	12	8	2	19

- **Health Improvement Measures:**

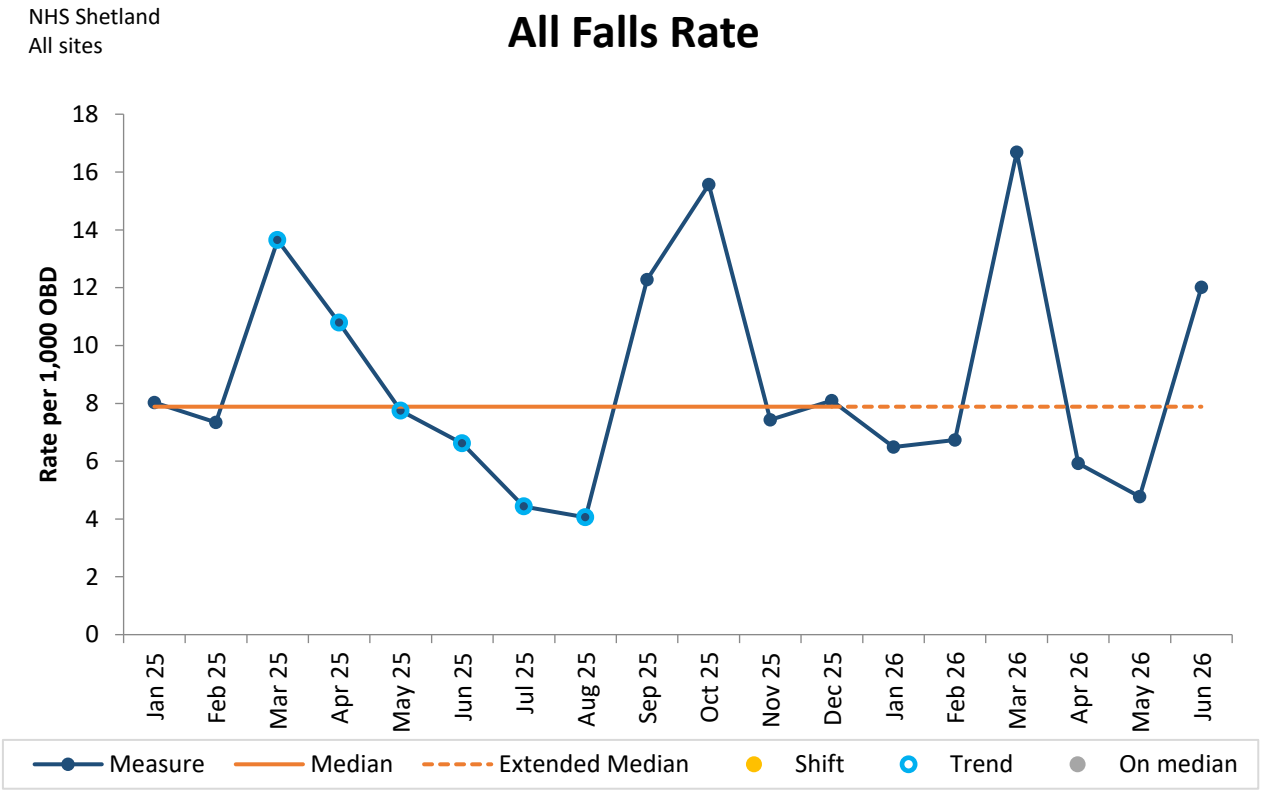
  PH-HI-03 & PH-HI-03a – Data is reset every April, to enable cumulative data collection for the new financial year. This measure has steadily increased since the annual reset. PH-HI-03a Performance is above the set target and the measure remains on green.
- **Patient Experience Outcome Measures** – During Q1 performance against all 7 patient experience measures surpassed the set target of 90%. All patient feedback is discussed at the relevant governance group (Medical Governance and Surgical Audit) on a monthly basis.

- **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.

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 was no reportable cardiac arrest in Q1 2026/27.
- **Falls** – During Q1 the all falls rate per 1000 occupied bed days reduced slightly from 16.69% in Q4 to 12.01%. During Q1 there were three falls with harm across both inpatient wards, the post falls bundle was completed for all patients and nursing and medical reviews were carried out. The performance target for measure NA-HC-10 Falls with harm rate (per 1000 occupied bed days) was achieved in Q1.

The SPC chart below, shows the Scottish Patient Safety Programme [SPSP] All Falls Rate from January 2025 to June 2026):



The SPSP all-site falls rate demonstrates expected variation around a median of 7.8 falls per 1,000 occupied bed days. A period of sustained improvement was observed between May and August 2025, with six consecutive months below the median, indicating a significant reduction in falls. While several isolated spikes occurred during the reporting period, including peaks in October 2025 and March 2026, these were not sustained and were related to a few complex patients who had complex conditions. These spikes were followed by a return towards expected levels. Overall, there is no evidence of a sustained deterioration in performance; however, the increased variability observed since September 2025 warrants ongoing monitoring and exploration of factors contributing to periods of higher falls activity.

Pressure ulcers – There were two hospital acquired pressure ulcers reported in Q1 these were reported on the electronic adverse event system, this is a reduction compared to the three hospital acquired pressure ulcers reported in Q4. Both of these incidents were reviewed by the Senior Charge Nurse (SCN) and the Tissue Viability Nurse, appropriate care was delivered. 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 summarised below:

DVT Audit Results 2025-2026:

	Jan 25	Mar 25	May 25	July 25	Sep 25	Nov 25	Jan 26	May 26
Risk Assessed NA-HC-71	100%	80%	100%	100%	100%	100%	100%	100%
Managed appropriately NA-HC-72	100%	100%	80%	100%	80%	90%	90%	100%
Evidence of review NA-HC-73	100%	80%	100%	100%	100%	100%	100%	100%
Discussed with patient NA-HC-74	20%	0%	10%	30%	30%	0%	20%	40%

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

  NA-IC-01 during Q1 there was one CAUTI infection identified, this incident was reviewed by the Infection Control Team. This 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 for Q1 2026/2027 (21.03%) was comparative to performance in Q4 2025/2026 (21.05%), 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 Q1 compliance with Catheter Associated Urinary Tract Infection (CAUTI) Insertion Bundle has achieved the set performance target.

  NA-IC-13 performance during Q1 2026/20207 (85%) remains comparative to Q4 2025/2026 (82.61%).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 Q1, there were no Leadership Walkrounds scheduled, this has provided the opportunity for the clinical governance team to prioritise other activities whilst the team experience workforce challenges. It

also provides the opportunity to review the walkround questions and align these to common themes such as:

- Risk management
- Cultural Transformation
- Closing the loop
- 'Just Culture' promotion
- Performance monitoring
- Patient Safety
- Quality

A new schedule of Leadership Walkrounds have been created commencing in October 2026.

- **Excellence in Care (EiC) NEWS & CAIR Dashboard reports** – During Q1 we observe an increase in the frequency of completed NEWs charts, from 77.5% in Q4 to 95% in Q1, the performance target is 95%. Performance regarding the accuracy of observations completed on the NEWS charts has increased from 70% in Q4 to 85%. Excellence in Care data performance is highlighted to the ward Senior Charge Nurses at the point of collection, so that teams can be reminded of the importance of accurate documentation.

  Submission performance has remained relatively stable at 68% during the final six months of the reporting period, with 21 of 22 measures maintaining or improving their submission rate compared to the previous month**.** Performance remains strong across a number of clinical effectiveness and patient safety measures, with 100% submission rates achieved for measures including Early Warning Scores, Falls, Pressure Ulcers, MDRO Risk Assessment, Nutritional Screening (MUST), MEWS Compliance and Escalation, School Nursing Referral Assessment, and Preferred Place of Death recording and achievement. Several measures also demonstrated improvement, notably the palliative care measures which increased from 0% to 100% in May. Overall, the report demonstrates improvement in data submissions and strong performance across key patient safety indicators.

- **Adverse Events** – The data below provides an overview of the 'live' adverse events in the Datix system:

	Q1 25/ 26 (As of 21/07/2025)	**Q2 25/26 (As of 30/09/2025)**	**Q3 25/26 (As of 02/02/2026**	**Q4 25/26 (As of 03/04/2026)**	**Q1 26/27 (As of 26/06/2026)**
In the holding are/ waiting to be reviewed	230	281	285	341	310
Being Reviewed	242	276	266	290	278
Awaiting Final Approval	65	89	197	214	332

TOTAL number adverse events 'live' in the system	**537**	**646**	**748**	**845**	**920**

Inpatient Experience – During Q1 inpatient feedback for Ward 1 (surgical) for 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 of Q1, this replicates Q4 performance levels..

Ward 3 (medical ward) achieved scores between 50-100% performances against both of these measures.

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.

- **Q1 Care Opinion Feedback** – has been included in the Quality Score Card Appendix to share organisational feedback and organisational responses to the feedback shared. Care Opinion feedback is also being shared at the relevant monthly governance meetings.

- **Surgical Site Infection Surveillance** – this national workstream continues to be suspended, there is no confirmed position regarding the timeframe for surgical site infection surveillance to be re-established.

- **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. 155 patients have been referred to the service with 139 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 Q1, 8 student nurses provided placement feedback. 62% of students were very satisfied with their learning experience, this is a decrease from 100% in Q4, and the remaining 38% of students were fairly satisfied with their placement experiences. 100% of students identified they received more than 28 days advanced notice of their placement in Shetland, this is an increase in performance

compared to 75% in Q4, all students had an assigned mentor. Overall feedback comments highlighted the variety of placement settings, the availability of practical learning opportunities and the positive support they received. Student comments related to improved experiences identified that placements could be enhanced through better planning and increased availability of student resources.

COMPLAINTS AND FEEDBACK

All NHS Boards in Scotland are required to monitor patient feedback and to receive performance reports against a suite of high level indicators determined by the Scottish Public Services Ombudsman (SPSO). The complaints and feedback report for Q1 2026-27 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.

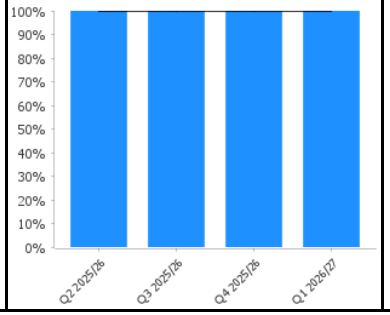
In line with the national Complaint Handling Procedure and in areas identified as examples of good practice by the Scottish Public Services Ombudsman, there are capacity challenges within the system to allow for reviews to be prioritised. There also remains significant capacity challenges for complaint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

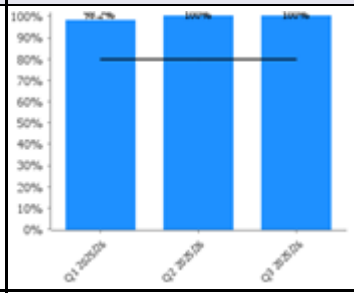
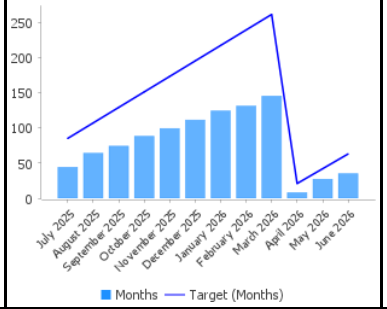
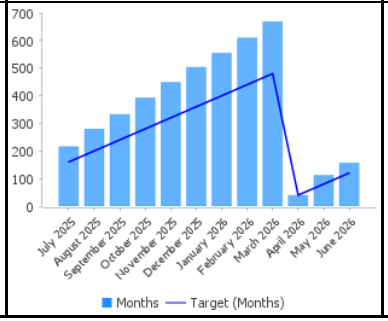
APPENDIX 2
BOARD

Generated on: 4 September 2026

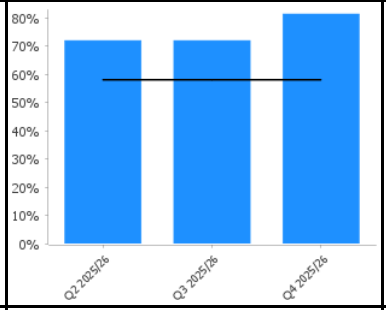
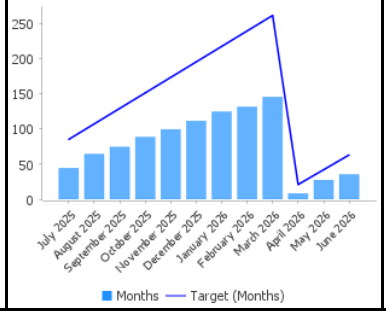
Quality Scorecard - BOARD

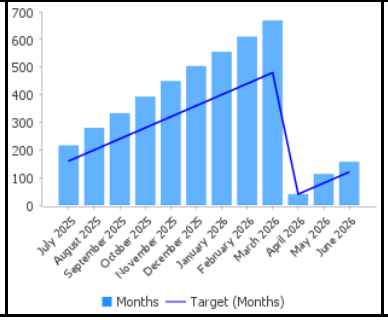
Title
CHSC Performance

Performance Indicators	April 2026	May 2026	June 2026	Q3 2025/26	Q4 2026/27	Q1 2026/27	Q1 2026/27	Q1 2026/27	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	April 2026	May 2026	June 2026	Q3 2025/26	Q4 2026/27	Q1 2026/27	Q1 2026/27	Q1 2026/27	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			100%	100%					**Awaiting 2025/26 Q4 Data and 2026/27 Q1 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.	8	27	35	111	145	35		63		
PH-HI-03a Number of FAST alcohol screenings	39	112	156	503	668	156		120		

Title
Health Improvement

Performance Indicators	April 2026	May 2026	June 2026	Q3 2025/26	Q4 2026/27	Q1 2026/27	Q1 2026/27	Q1 2026/27	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			71.9%	81.25%			58%		**Awaiting Q1 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.	8	27	35	111	145	35		63		Measure will remain on red until target of 261 is achieved.

Performance Indicators	April 2026	May 2026	June 2026	Q3 2025/26	Q4 2026/27	Q1 2026/27	Q1 2026/27	Q1 2026/27	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
PH-HI-03a Number of FAST alcohol screenings	39	112	156	503	668	156		120		

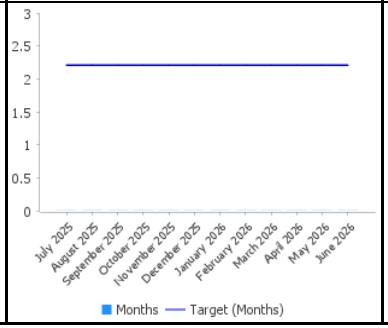
Title
Patient Experience Outcome Measures

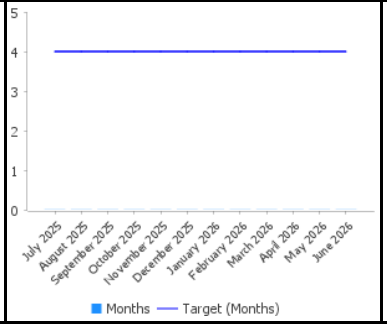
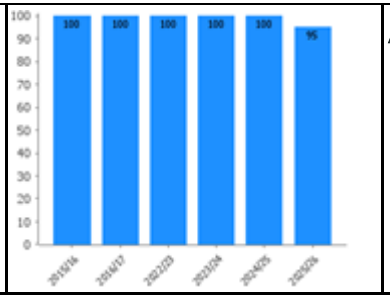
Performance Indicators	April 2026	May 2026	June 2026	Q3 2025/26	Q4 2026/27	Q1 2026/27	Q1 2026/27	Q1 2026/27	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-01 % who say they had a positive care experience overall (aggregated)	94.4%	89.5%	100%	92.9%	100%	100%		90%		

Performance Indicators	April 2026	May 2026	June 2026	Q3 2025/26	Q4 2026/27	Q1 2026/27	Q1 2026/27	Q1 2026/27	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-04 % of people who say they got the outcome (or care support) they expected and needed (aggregated)	94.44%	94.44%	100%	100%	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)	94.1%	100%	100%	100%	100%	98%		90%		
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%	88.24%	100%	92.86%	92.86%	100%		90%		

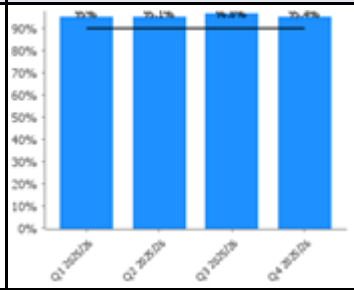
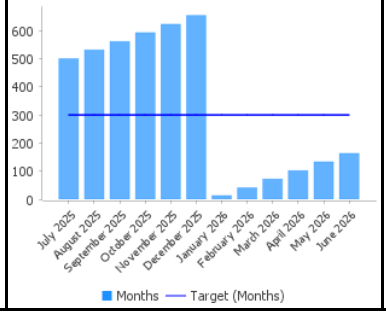
Performance Indicators	April 2026	May 2026	June 2026	Q3 2025/26	Q4 2026/27	Q1 2026/27	Q1 2026/27	Q1 2026/27	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-20 What matters to you % of people who say that they have all the information they needed to help them make decisions about their care/treatment (aggregated)	97.22%	97.37%	100%	98.15%	100%	100%		90%		
NA-HC-23 What matters to you % of people who say that staff took account of their personal needs and preferences (aggregated)	93.33%	96.97%	100%	92.59%	100%	100%		90%		
NA-HC-26 % of people who say they were involved as much as they wanted to be in communication, transitions, handovers about them (aggregated)	91.67%	100%	100%	80%	100%	100%		90%		

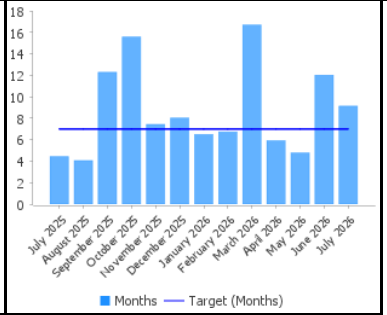
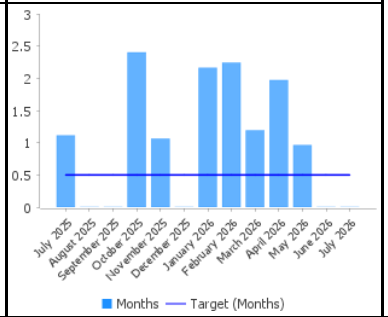
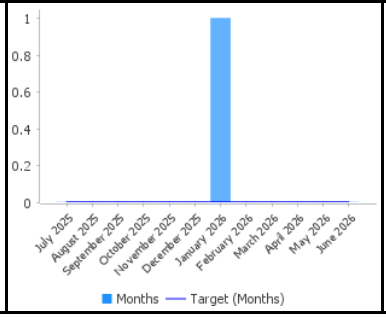
Title
Patient Safety Programme - Maternity & Children Work stream

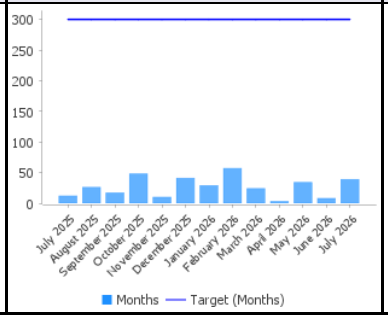
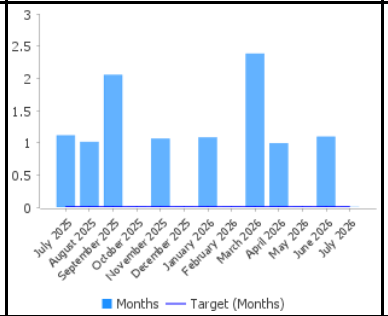
Performance Indicators	April 2026	May 2026	June 2026	Q3 2025/26	Q4 2026/27	Q1 2025/26	Q1 2026/27	Q1 2026/27	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-CF-07 Days between stillbirths	4066	4097	4127	3946	4036	4127		300		
NA-CF-09 Rate of neonatal deaths (per 1,000 live births)	0	0	0	0	0	0		2.21		

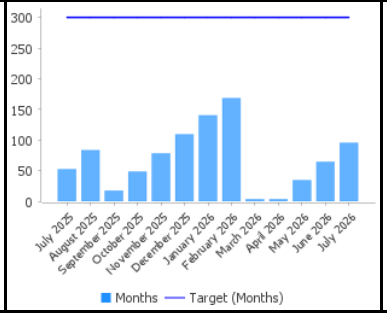
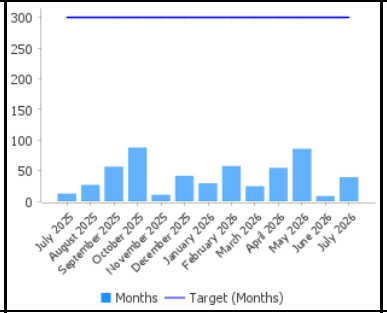
Performance Indicators	April 2026	May 2026	June 2026	Q3 2025/26	Q4 2026/27	Q1 2025/26	Q1 2026/27	Q1 2026/27	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-CF-15 Rate of stillbirths (per 1,000 births)	0	0	0	0	0	0		4		
Post-Partum Haemorrhage (PPH) over 1.5L	0	0	0	0	0	0	No Target Set			Reflects the data collected for the National Maternity and Perinatal Audit (NMPA). (Data submitted as part of the SPSP programme)
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 Care Opinion cards with NHS logo and QR codes are being issued to help encourage feedback on local services via this national platform									
NA-HC-58 % compliance with the newborn screening bundle	Measured Quarterly	95%					100%			**Awaiting Q4 & Q1 Data.**

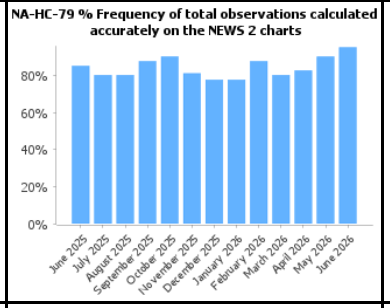
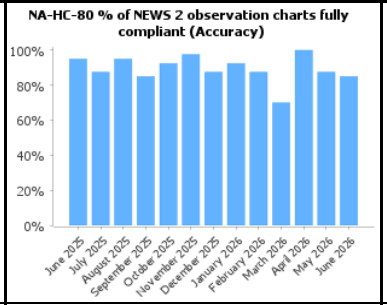
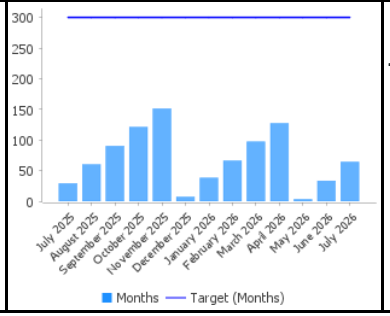
Title
Service & Quality Improvement Programmes - Measurement & Performance

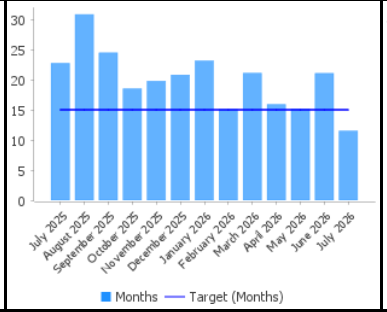
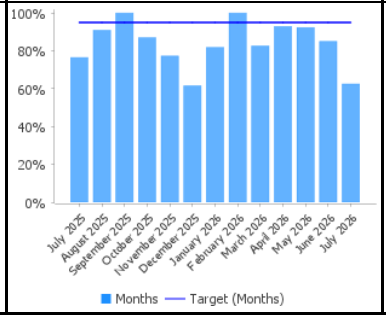
Performance Indicators	April 2026	May 2026	June 2026	Q3 2025/26	Q4 2026/27	Q1 2026/27	Q1 2026/27	Q1 2026/27	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
CE-IC-01 Cleaning Specification Audit Compliance	Measured Quarterly			96.8%	95.4%			90%		**Awaiting Q1 Data**
NA-HC-08 Days between Cardiac Arrests	102	133	163	653	72	163		300		**Measure will remain on red until target of 300 is achieved.**

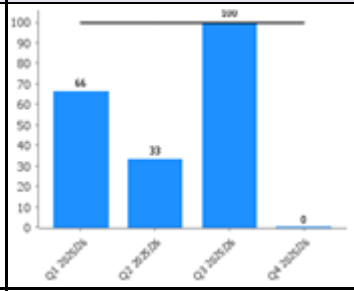
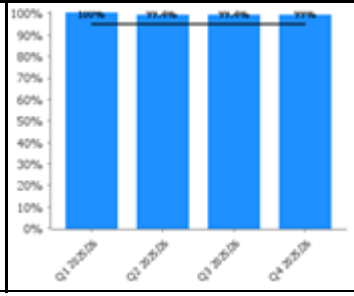
Performance Indicators	April 2026	May 2026	June 2026	Q3 2025/26	Q4 2026/27	Q1 2026/27	Q1 2026/27	Q1 2026/27	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-09 All Falls rate (per 1000 occupied bed days)	5.92	4.78	12.01	8.02	16.69	12.01		7		**Measure will remain on red until target of 300 is achieved.**
NA-HC-10 Falls with harm rate (per 1000 occupied bed days)	1.97	0.96	0	0	1.19	0		0.5		
NA-HC-13 Crash call rate per 1000 discharges (number of crash calls/total number of deaths + live discharges x 1000)	0	0	0	0	0	0		0		

Performance Indicators	April 2026	May 2026	June 2026	Q3 2025/26	Q4 2026/27	Q1 2026/27	Q1 2026/27	Q1 2026/27	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-53 Days between a hospital acquired Pressure Ulcer (grades 2-4)	3	34	8	41	24	8		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)	0.99	0	1.09	0	2.38	1.09		0		
NA-HC-59 % of patients discharged from acute care without any of the combined specified harms (SPSI).	98%	98%	99%	99.4	98.46	99%		95		

Performance Indicators	April 2026	May 2026	June 2026	Q3 2025/26	Q4 2026/27	Q1 2026/27	Q1 2026/27	Q1 2026/27	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-66 Pressure ulcer - days between pressure ulcers developed on Ward 1.	3	34	64	109	3	64		300		**Measure will remain on red until 300 days is achieved.**
NA-HC-69 Pressure ulcers - days between pressure ulcers on Ward 3	54	85	8	41	24	8		300		**Measure will remain on red until 300 days is achieved.**
NA-HC-72 % of patients who had the correct pharmacological/mechanical thromboprophylaxis administered				90	90	100		75		

Performance Indicators	April 2026	May 2026	June 2026	Q3 2025/26	Q4 2026/27	Q1 2026/27	Q1 2026/27	Q1 2026/27	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-HC-79 % of total observations calculated on the NEWS 2 charts (Frequency)	82.5%	90%	95%	87.5%	77.5%	95%		95%		
NA-HC-80 % of NEWS 2 observation charts fully compliant (Accuracy)	100%	87.5%	85%	87.5%	70%	85%		95%		
NA-IC-01 Days between Catheter Associated Urinary Tract Infection (CAUTI) developed in acute care	127	3	33	7	97	33		300		**Measure will remain on red until target of 300 days reached across both inpatient areas.**

Performance Indicators	April 2026	May 2026	June 2026	Q3 2025/26	Q4 2026/27	Q1 2026/27	Q1 2026/27	Q1 2026/27	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-IC-02 Catheter Usage Rate	15.88	15.12	21.03	20.75	21.05	21.03		15		The Infection Control Team continue to monitor this measure.
NA-IC-10 Aggregated Compliance with Catheter Associated Urinary Tract Infection (CAUTI) Insertion Bundle	85.71%	90%	90%	81.25%	81.25%	90%		95%		
NA-IC-13 Aggregated Compliance with the Catheter Associated Urinary Tract Infection (CAUTI) maintenance bundle	92.86%	92.31%	85%	61.54%	82.61%	85%		95%		The Infection Control Team will continue to monitor this measure.

Performance Indicators	April 2026	May 2026	June 2026	Q3 2025/26	Q4 2026/27	Q1 2026/27	Q1 2026/27	Q1 2026/27	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-IC-20 % of Patient Safety Conversations Completed (3 expected each quarter)	Measured Quarterly			100	0	0		100		The Leadership Walkrounds have been re-established with the first visit scheduled for October 2026.
NA-IC-22 Hand Hygiene Audit Compliance	Measured Quarterly			99.4%	99 %			95%		**Awaiting Q1 Data**
NA-IC-23 Percentage of cases where an infection is identified post Caesarean section	Measured Quarterly			Surgical Site Infection Surveillance activity remains suspended, there is no national updated regarding when this will be recommenced.						
NA-IC-24 Percentage of cases developing an infection post hip fracture	Measured Quarterly			Surgical Site Infection Surveillance activity remains suspended, there is no national updated regarding when this will be recommenced.						
NA-IC-25 Percentage of cases where an infection is identified post Large Bowel operation	Measured Quarterly			Surgical Site Infection Surveillance activity remains suspended, there is no national updated regarding when this will be recommenced.						

Performance Indicators	April 2026	May 2026	June 2026	Q3 2025/26	Q4 2026/27	Q1 2026/27	Q1 2026/27	Q1 2026/27	Trend Chart	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target		
NA-IC-30 Surgical Site Infection Surveillance (Caesarean section, hip fracture & large bowel procedures)	Measured Quarterly			Surgical Site Infection Surveillance activity remains suspended, there is no national updated regarding when this will be recommenced.						

APPENDIX A – Overview of falls and pressure ulcer incidence between: April – June 2026

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			260		B/Fwd			52	
Jan 26	0	1	291		**Jan 26**	2	3	14	Small graze on right forearm / Bruise on left elbow and skin flap on left knee
Feb 26	0	1	379		**Feb 26**	2	3	1	Head incision / Face laceration
Mar 26	0	4	410		**Mar 26**	1	9	9	Wound to left elbow
Apr 26	1	1	22	Back abrasion	**Apr 26**	1	3	8	Left arm bruise/swelling
May 26	0	1	53		**May 26**	1	3	0	Left arm laceration
Jun 26	0	7	83		**Jun 26**	0	4	30	
July 26	0	3	114		**July 26**	0	5	61	
Aug 26					**Aug 26**				
Sept 26					**Sept 26**				
Oct 26					**Oct 26**				
Nov 26					**Nov 26**				
Dec 26					**Dec 26**				
Total	**1**	**18**			**Total**	**7**	**30**		

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			109			B/Fwd			41		
Jan 26	0	0	140			**Jan 26**	1	0	29		
Feb 26	0	0	168			**Feb 26**	0	1	57		
Mar 26	1	0	3			**Mar 26**	1	4	24		
Apr 26	1	0	3			**Apr 26**	0	1	54		
May 26	0	3	34			**May 26**	0	1	85		
June 26	0	0	64			**Jun 26**	1	0	8		
July 26	0	2	95			**July 26**	0	0	39		
Aug 26						**Aug 26**					
Sept 26						**Sept 26**					
Oct 26						**Oct 26**					
Nov 26						**Nov 26**					
Dec 26						**Dec 26**					
Total	**2**	**5**				**Total**	**3**	**7**			

CAUTIs in Secondary Care											
WARD 1						WARD 3					
Month 2026	Total Number of Urinary Catheters	Total Number of Inpatients	Total Number of CAUTIs	CAUTI Rate (per catheter days) NA-IC-09	Usage rate	Month 2026	Total Number of Urinary Catheters	Total Number of Inpatients	Total Number of CAUTIs	CAUTI Rate (per catheter days) NA-IC-09	Usage rate
Jan	69	403	0	0%	17%	Jan	143	514	0	0%	28%
Feb	76	396	0	0%	19%	Feb	58	495	0	0%	12%
Mar	93	322	0	0%	29%	Mar	79	495	0	0%	16%
Apr	87	414	0	0%	21%	Apr	67	556	0	0%	12%
May	65	442	0	0%	15%	May	87	563	1	1%	15%
June	100	379	0	0%	26%	Jun	83	491	0	0%	17%
July	56	391	0	0%	14%	July	38	427	0	0%	9%
Aug						Aug					
Sept						Sept					
Oct						Oct					
Nov						Nov					
Dec						Dec					
Total	546	2747	0			Total	555	3541	1		

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

FALLS WITH HARM					
Date	**No. of Patients**	**Avoidable/ Unavoidable**	**Appropriate Care Given?**	**Debrief Conducted?**	**Learning Points?**
April - June 2026	1	Unavoidable – all appropriate care was delivered. Laceration to arm. Family member was present when this individual fell.			This incident was reviewed by the Senior charge Nurse [SCN], all appropriate care was delivered and the relevant nursing assessments were completed. This patient had a higher risk of falls and the nursing team and family were supporting the individual to remain mobile to maintain independence and prevent deconditioning.
HOSPITAL ACQUIRED PRESSURE ULCERS					
Date	**No. of Patients**	**Avoidable/ Unavoidable**	**Appropriate Care Given?**	**Debrief Conducted?**	**Learning Points?**
April - June 2026	2	Appropriate Care Delivered in both incidents. A. Complex patient who had multiple core morbidities which contributed to poor health outcomes. B. Unavoidable – patient was in multi-organ failure and fell at home. This individual received all appropriate pressure area and end of life care.			Both Incidents were reviewed by the SCN and Tissue Viability Nurse. Review of both of these incidents identified the need to improve nursing documentation related to pressure area care, this is being progressed by the SCN and Tissue Viability Nurse.

Excellence in Care (EiC) Data:

Excellence in Care - Submission Report

NHS Shetland

Period from: July 2025 - June 2026
Extract date: 04 August 2026
Contact: phs.excellenceincare@phs.scot

Background

The submission report presents data on the submission rates for Excellence in Care measures that have been submitted to the CAIR dashboard. The submission report is a snapshot of a point in time, and the full methodology can be found in the notes section below.

This report contains a range of metrics to help health boards understand their submission rates and the key points from this report are available in the summary bullet points. We also provide breakdowns including by inpatient and community settings, by specific measure, and we also provide information on the number of CAIR users within your health board. The report is also supported by the Data Overview dashboard on CAIR, which can be used to investigate team-level submission rates.

This report aims to support health boards hoping to monitor and increase their submission rates. If you have any questions about the content or data, please reach out to the team.

Summary

- The latest submission rate across NHS Shetland is 68%, which is the same as the previous month.
- 20 out of 22 measures have the same or a higher submission rate than last month.
- There are currently 5 CAIR users and 4 have accessed the dashboard in the past eight weeks.

Overall submission rates, NHS Shetland

Figure 1: Monthly submission rates, July 2025 - June 2026

The below chart shows the monthly submission rates in NHS Shetland. The solid purple line shows the overall submission rate, and the dotted magenta and blue lines show the submission rates in community and inpatient teams, respectively.

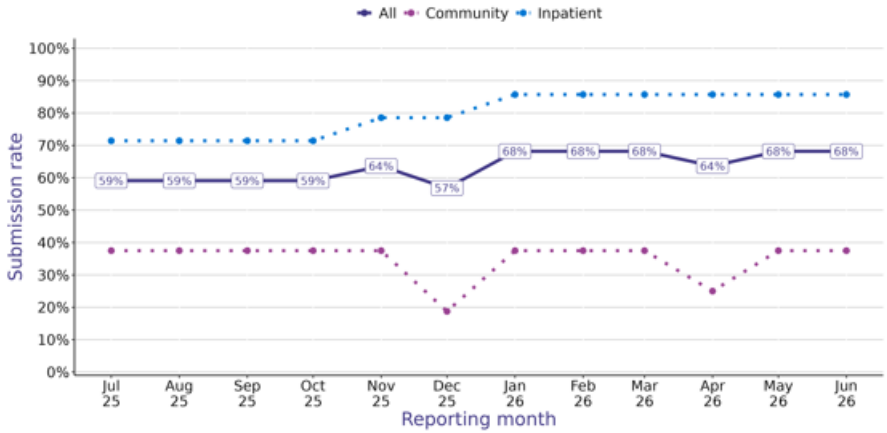


Table 1: Monthly submission rates, July 2025 - June 2026

Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26
59%	59%	59%	59%	64%	57%	68%	68%	68%	64%	68%	68%

Submission rates by measure domain, Shetland

The below tables breakdown each measure's submission rate. For each measure, the table provides the submission rate in the latest month, the change since the previous month, and the average and trend of the latest six months. The tables are grouped by measure domain. These tables can be used to track submission rates over time at a measure level, and identify any unexpected dips. When the latest submission rate is 85% or greater, it will be highlighted in purple.

Partial measures are for any submissions for measures that are calculated across multiple submissions or sources. To learn more about partial measures, please see the Notes section.

Table 2: Effectiveness and Safety measures, January 2026 - June 2026

Measure	Latest month (Jun 26)	Change since previous month (May 26)	6-month average incl. Jun 26	Latest 6-month trend
Accurate Early Warning Score	100%	0% →	100%	
Completion of Initial GIRFEC Assessment	0%	0% →	0%	
Correct Frequency of Early Warning Scores	100%	0% →	100%	
FFN Care Plan	0%	0% →	0%	
FFN MUST Score	100%	0% →	100%	
FFN Nutritional Assessment	0%	0% →	0%	
Inpatient Falls Rate	100%	0% →	100%	
MEWS Compliance	100%	0% →	100%	
MEWS Escalation	100%	0% →	100%	
Mental Health Person-Centred Care Planning	0%	0% →	0%	
Multi-Drug Resistant Organism (MDRO) Admission Screening	100%	0% →	100%	
Preferred Place of Death Achieved	100%	0% →	83%	
Preferred Place of Death Documented	100%	0% →	83%	
Pressure Ulcer Rates	100%	0% →	100%	
School Nursing Referral Assessment	100%	0% →	100%	

Table 3: Leadership measures, January 2026 - June 2026

Measure	Latest month (Jun 26)	Change since previous month (May 26)	6-month average incl. Jun 26	Latest 6-month trend
QMPLE Score	33%	-17% ↓	56%	
QMPLE Student Feedback	50%	-17% ↓	70%	

Table 4: Workforce measures, January 2026 - June 2026

Measure	Latest month (Jun 26)	Change since previous month (May 26)	6-month average incl. Jun 26	Latest 6-month trend
Establishment Variance	50%	0% →	50%	
Predictable Absence Allowance	100%	0% →	100%	
Supplementary Staffing Use - Bank and Agency	50%	0% →	50%	
Supplementary Staffing Use - Overtime and Excess	50%	0% →	50%	

Table 5: Partial measures, January 2026 - June 2026

Measure	Latest month (Jun 26)	Change since previous month (May 26)	6-month average incl. Jun 26	Latest 6-month trend
Funded Establishment	50%	0% →	50%	
Occupied Bed Days	100%	0% →	100%	
Supplementary Staff Use - Agency	50%	0% →	50%	
Supplementary Staffing Use - Bank	50%	0% →	50%	
Supplementary Staffing Use - Overtime and Excess (numerator)	100%	0% →	100%	

CAIR user data analysis

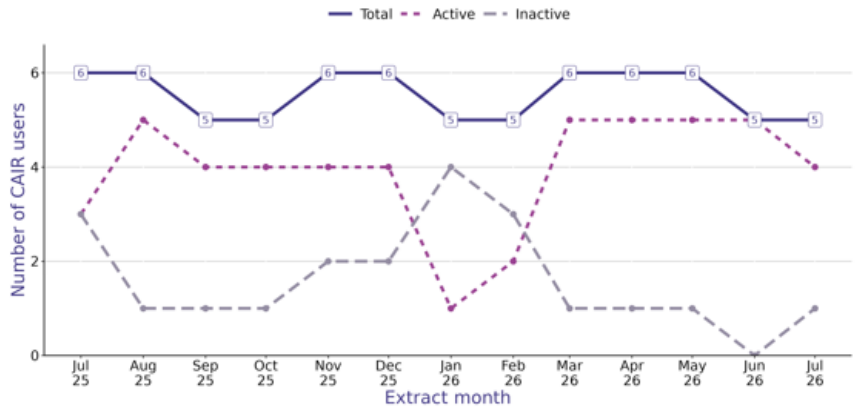
This section outlines analytics involving health board users and how recently they have accessed the CAIR dashboard. The most recent snapshot of CAIR users was taken on 28 July 2026 and is presented in the below table. CAIR users are defined as anyone who has current access to the CAIR dashboard, requested and approved through the **User Access System**.

Table 6: Number of CAIR users based on activity category in NHS Shetland

Last login category	Number of users
0-4 Weeks	2
4-8 Weeks	2
Over 8 Weeks	0
No Login	1
Total	**5**

Figure 2: CAIR Users overview by last login category across NHS Shetland

This chart shows the total number and activity breakdown of CAIR users over the past year. Active users have logged in to the CAIR dashboard within the last eight weeks.



Further information

The CAIR Data Overview can be used to investigate your submission rates further. This dashboard provides a further breakdown of submission information in all teams, to support Health Boards to identify any non-submissions. The day after we produce the submission reports, the Data Overview will be updated with the latest complete month of data.

Notes

Overall methodology

Submission rates are calculated by counting the number of teams per month and measure who have submitted data, dividing this by the number who were expected to submit data. Expected submissions are based on nurse families that are linked to the nationally agreed measures within the CAIR Dashboard. Overall measure submission rates are calculated from the total number of submissions expected and submitted for complete measures.

The teams and associated nurse and midwifery families are based on the information provided by Health Boards in their reference files. All closed locations and teams that have been notified to PHS are excluded, based on data within the Health Board reference file.

The cells in the tables are highlighted in dark purple-gray when a submission rate of 85% or higher has been achieved. 85% has been set as a good target or indicator of high completeness.

Partial measures

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. Partial measure submission do not directly contribute to the overall submission rate; the full measure must be submitted.

Partial measures or those that require more than one submission 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 report and table due to the submission rules in place. When a team has submitted occupied bed days and does not submit the number of falls or pressure ulcers, CAIR will automatically assume the missing submission is a zero (except for in Ayrshire and Arran and Borders). This process was set up due to local systems not registering or downloading a "0" fall or pressure ulcer.

Specific measure notes

Some measures are treated differently in the methodology to calculate submission rates, please see below for more information:

- QMPLE Score and QMPLE Student Feedback - as some teams may not have had a student nurse in each rolling three month period, these measures have been excluded from the overall submission rates. The submission rates for QMPLE Score are often lower than QMPLE Student Feedback due to both true zeroes (so when no students completed their feedback survey within the period) or due to delays with the scores being input into the system.
- Mental Health Care Planning - this measure is currently under review, and is therefore excluded from the overall submission rate.
- Multidrug-Resistant Organisms (MDRO) Screen Risk Assessment - this measure is only appropriate for admitting wards, therefore should not be expected from all Adult Inpatient teams. Given we cannot accurately record the number of teams that should be expected to submit this measure, it has been excluded from the overall submission rate.
- Secure Environment Admission Screening Completion - for prisons, this data is still being sourced nationally and therefore is currently excluded from the submission reports entirely.
- Omitted Medicines - Doses and Patients - these measures are only relevant to non-HEPMA Health Boards, therefore have been excluded from the submission reports entirely.
- Occupied Bed Days - when a team has submitted occupied bed days and does not submit the number of falls or pressure ulcers, CAIR will automatically assume the missing submission is a zero (except for in Ayrshire and Arran and Borders). This process was set up due to local systems not registering or downloading a "0" fall or pressure ulcer.

Exclusions

Health Boards have been invited to provide a file that identifies teams who should not submit data for specific measures they are "expected" to, based on Nurse Family. This report has incorporated this new methodology, which should see a more accurate and increased completeness in measures where teams are excluded. To learn more about exclusion criteria, please get in touch with the Excellence in Care mailbox.

Excluded teams will be removed from both "expected" and "submitted" measures for the time period provided in the look-up file. Table 7 below details the number of excluded teams per measure in the latest month.

Table 7: Number of excluded teams per measure in NHS Shetland

There are currently no excluded teams in the latest month of data.

Excellence in Care Measures – Ward 1 Surgical Ward:

Latest CAIR measures - Ward 1, GILBERT BAIN HOSPITAL

Domain	Measure	Latest month	Measure value	Reference value	Trend (latest 12 months)	Click icon to view drilldown chart below
EFFECTIVENESS AND SAFETY	EWS Accuracy	Jun 2026	75.0%	95.0%		
	EWS Frequency	Jun 2026	90.0%	95.0%		
	FFN MUST Score	Jun 2026	50.0%	95.0%		
	Inpatient Falls Rate	Jun 2026	17.3	4.6		
	MDRO Risk Assessment	Jun 2026	60.0%	95.0%		
	Pressure Ulcers Rate	Jun 2026	0.0	0.7		
WORKFORCE	Establishment Variance	Jun 2026	-14.8%	6.4%		
	Predictable Absence Allowance	Jul 2026	24.2%	22.5%		
	Supplementary Staffing - Bank and Agency	Jun 2026	5.2%	15.0%		
	Supplementary Staffing - Overtime and Excess	Jun 2026	2.6%	0.7%		
LEADERSHIP	QMPLE Score	Aug 2026	95.8%	95.0%		
	QMPLE Student Feedback	Aug 2026	100.0%	95.0%		

Excellence in Care Measures – Ward 3 Medical Ward:

Latest CAIR measures - Ward 3, GILBERT BAIN HOSPITAL

Domain	Measure	Latest month	Measure value	Reference value	Trend (latest 12 months)	Click icon to view drilldown chart below
EFFECTIVENESS AND SAFETY	EWS Accuracy	Jun 2026	95.0%	95.0%		
	EWS Frequency	Jun 2026	100.0%	95.0%		
	FFN MUST Score	Jun 2026	60.0%	95.0%		
	Inpatient Falls Rate	Jun 2026	7.9	4.6		
	MDRO Risk Assessment	Jun 2026	90.0%	95.0%		
	Pressure Ulcers Rate	Jun 2026	2.0	0.7		
WORKFORCE	Establishment Variance	Jun 2026	-13.8%	6.4%		
	Predictable Absence Allowance	Jul 2026	28.5%	22.5%		
	Supplementary Staffing - Bank and Agency	Jun 2026	15.2%	15.0%		
	Supplementary Staffing - Overtime and Excess	Jun 2026	0.9%	0.7%		
LEADERSHIP	QMPLE Score	Aug 2026	98.6%	95.0%		
	QMPLE Student Feedback	Aug 2026	75.0%	95.0%		

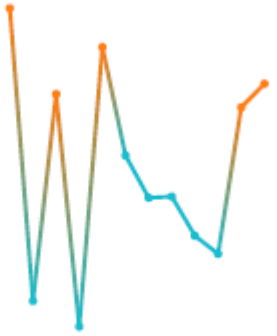
Excellence in Care Measures – Community Nursing:

Latest CAIR measures - Community Nursing, Shetland Islands

Domain	Measure	Latest month	Measure value	Reference value	Trend (latest 12 months)	Click icon to view drilldown chart below
EFFECTIVENESS AND SAFETY	Preferred Place Achieved	Jun 2026	66.7%	60.0%		
	Preferred Place Documented	Jun 2026	75.0%	60.0%		
WORKFORCE	Predictable Absence Allowance	Jul 2026	31.6%	22.5%		
LEADERSHIP	QMPLE Score	Aug 2026	100.0%	95.0%		
	QMPLE Student Feedback	Aug 2026	50.0%	95.0%		

Excellence in Care Measures – School Nursing:

Latest CAIR measures - Children Young people, Shetland Islands

Domain	Measure	Latest month	Measure value	Reference value	Trend (latest 12 months)	Click icon to view drilldown chart below
EFFECTIVENESS AND SAFETY	School Nursing Referral Assessment	Jun 2026	92.3%	90.0%		
WORKFORCE	Predictable Absence Allowance	Jul 2026	27.3%	22.5%		

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-26	100%	100%	100%	100%
Feb-26	100%	0%	100%	0%
Mar-26	100%	100%	100%	100%
Apr-26	100%	80%	100%	80%
May-26	100%	50%	100%	67%
Jun-26	100%	100%	100%	100%
Jul-26	94%	100%	94%	100%
Aug-26				
Sep-26				
Oct-26				
Nov-26				
Dec-26				
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-26	100%	100%	96%	100%	100%	**13**
Feb-26	100%	95%	100%	97%	100%	**21**
Mar-26	100%	90%	100%	100%	100%	**11**
Apr-26	100%	100%	100%	92%	100%	**13**
May-26	100%	93%	100%	100%	100%	**15**
Jun-26	100%	100%	100%	100%	100%	**12**
Jul-26	94%	100%	95%	88%	91%	**16**
Aug-26						
Sep-26						
Oct-26						
Nov-26						
Dec-26						
Average	**99%**	**97%**	**99%**	**97%**	**99%**	

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-26	100%	100%	100%	100%	100%	**3**
Feb-26	0%	0%	0%	0%	0%	**0**
Mar-26	100%	100%	100%	100%	100%	**4**
Apr-26	80%	100%	90%	100%	70%	**5**
May-26	50%	67%	88%	80%	100%	**1**
Jun-26	100%	100%	100%	100%	100%	**4**
Jul-26	100%	100%	100%	100%	88%	**0**
Aug-26						
Sep-26						
Oct-26						
Nov-26						
Dec-26						
Average						

WARD 1 INPATIENT SURVEY – PATIENT COMMENTS – April / 2026
From A&E to Ward 1 and day surgery treated me with the utmost respect and kindness, extremely professional in all areas and when I was feeling worried and even a little scared, they were always there with a kind word which made a HUGE difference to my experience. I would like to call out two people in particular Staff Nurse Michael in Ward 1 and Nurse Practitioner Leah in A&E. Without their expert care and warmth of heart, I don't know what I would have done!
Thank you all for your care & help.
Whole experience was good, food, care, and attention of staff was excellent.
Would love more choice for foods suitable for diabetics (e.g. appropriate yoghurts and soups) and biscuits.
The most helpful staff I could have wish for.
I felt that I received an excellent level of care and attention from everybody involved from initially the paramedics and then all concerned at GB Hospital.
Angels, all of you. Thank you.
Once again I don't have a single complaint. Every single member of staff went above and beyond especially staff nurse Michael. He is a very skilled nurse and always very kind. He made my unpleasant experience so much more bearable and I am extremely grateful. Thank you all!
Arrived in emergency ambulance about 00:50 on Friday night, Sat morning – and yet not a time anyone would want to turn up in emergency, I felt A&E staff were monitoring me effectively and when my condition worsened, the staff produced the necessary doctor. Impressed also by surgeon's calm approach to me, even though he must have been on call. In the ward, the staff of all sorts were amazing and clearly working well as a team and hard as individuals. Aftercare arrangements re appointment re stitches very helpful. But also a good bunch.
Pain relief needs to be more regimented. When a patient screams for pain relief it is already too late. He has the pain, which can then take another hour to get back under control. Pain relief before pain re-appears - please.

WARD 3 INPATIENT SURVEY - PATIENT COMMENTS – April / 2026
Day staff were very good, didn't feel listened by night staff.
Staff very professional – took time to explain – always sought permission pre intervention. Food (had lunch – cottage pie) was really nice. No concerns or complaints.

WARD 1 INPATIENT SURVEY – PATIENT COMMENTS – MAY / 2026
Well-staffed and overall pleased with my treatment by staff nurses doctors who I will thank for the excellent treatment I received.
Excellent staff at all levels. Very well cured for special mention to Eric and John.
Ever since moving to Shetland and the time I have spent in this hospital for various problems my care from all doctors, nurses, auxiliary staff has been first class. I cannot thank everyone though.
Excellent care.
Thanks for everything.
All staff excellent. Thank you all.
Everyone was fantastic - we can't thank you enough!
The staff were very very good at looking after me and took time to explain any questions I had. Thank you.
Brill! Thank you.
Lack of tea, coffee etc. in forenoon & afternoon in Ward as staff are too busy
A+ from start to finish.
Everybody warm & friendly. Also good patient interaction!

WARD 3 INPATIENT SURVEY - PATIENT COMMENTS – MAY / 2026
Staff on the floor doing everything in their power but the constant beeping through the night, with no options provided a sanctuary rooms, greenery, reflection spaces, craft cupboards to aid recovery for patients. That side of things has been very poor and I have had to bring materials in from home from family and have been made to feel I needed to hide such items until medical team saw I was suffering from Chronic anxiety based on my previous mental health history, which in my view is irrelevant and I have plenty of evidence to prove my competence working in a similar environment, just using different binders, etc.
The staff were lovely. The building is a bit tired, noisy at night. General noise also constant machines beeping.

WARD 1 INPATIENT SURVEY – PATIENT COMMENTS – JUNE / 2026
Suggest if you really want feedback you might design a different kind of form/questions or method. I have had few hours of sleep and gall bladder removed yesterday. Almost don't know my name.
I was very pleased with my treatment during my stay.
I had the best care in the hands Pinki Singh and the care after that was excellent.
Honestly I can't thank you all enough. The service was the best I've had for the treatment. I've been in and out at least 20x over past 5 years and was most in-depth treatment received. Thank again. You were all amazing.
Everybody was very good and I thank them all.

WARD 3 INPATIENT SURVEY - PATIENT COMMENTS – JUNE / 2026
Very pleasant staff and good care. Doctors are brilliant and kind. Good team of people.

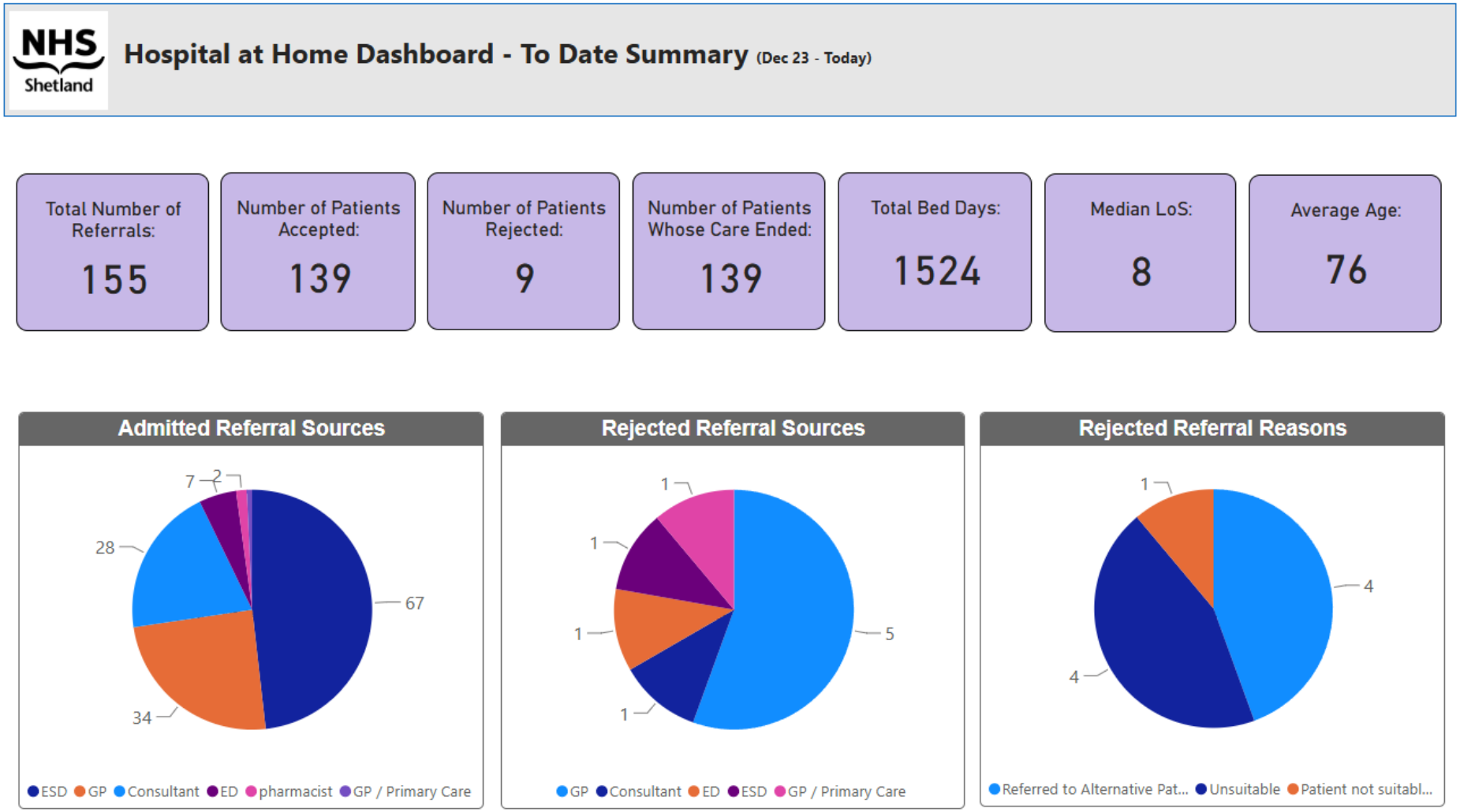
Q1 2026/27 NHS Shetland Care Opinion Feedback:

Area	Story Title	Care Opinion Link
Gilbert Bain Hospital/ Accident & Emergency	“Accident and Emergency”	https://www.careopinion.org.uk/1450975
General Practices in Shetland	“Took time to listen”	https://www.careopinion.org.uk/1450052
Gilbert Bain Hospital/ Accident & Emergency and NHS 24/ NHS 24 (111 service)	“My visit to hospital”	https://www.careopinion.org.uk/1447518
Gilbert Bain Hospital/ day Surgery	“First class care”	https://www.careopinion.org.uk/1447107
Lerwick Health Centre	“Compassionate perimenopause care”	https://www.careopinion.org.uk/1444982
Lerwick Health Centre	“Difficult to make appointments”	https://www.careopinion.org.uk/1442996
General Practices in Shetland	“Great treatment in a time of need”	https://www.careopinion.org.uk/1441510
Lerwick Health Centre	"Difficult to access services"	https://www.careopinion.org.uk/1428492

An overview of Care Opinion Feedback received:

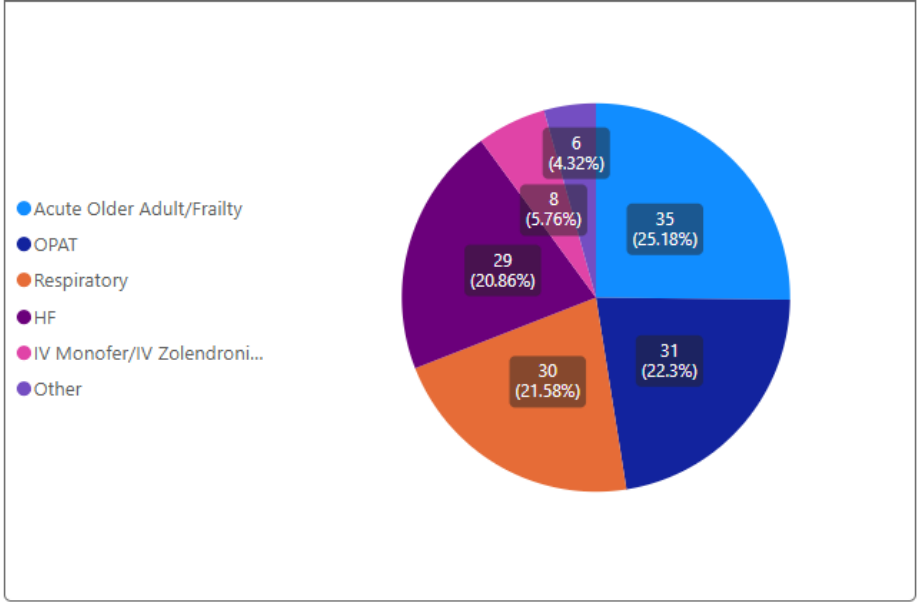
	Q3 2024/2025 (Feedback first included as part of the Quality Score Card)	**Q4 2024/2025**	**Q1 2025/2026**	**Q2 2025/2026**	**Q3 2025/2026**	**Q4 2025/2026**	**Q1 2026/2027**
Number of Care Opinion Feedback received	5	3	4	1	2	4	8

Hospital at Home: H@H - As of 26th August 2026:

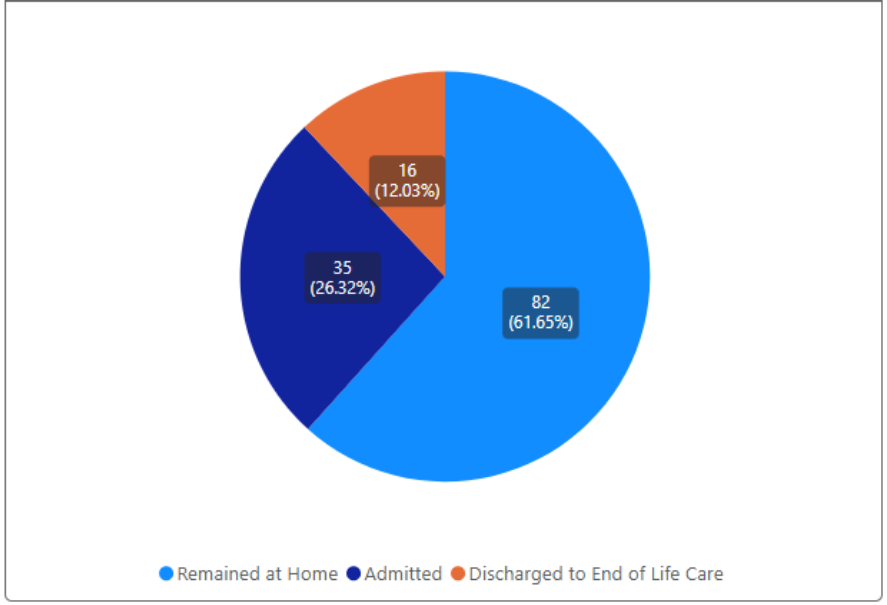


Hospital at Home Dashboard

Admission Category



30 Day Outcome



Current Stats:

76	1524	8	11.2
Average Age	Total Bed Days	Median LoS	Average LoS

Filter by Admission Date:

Admission Date

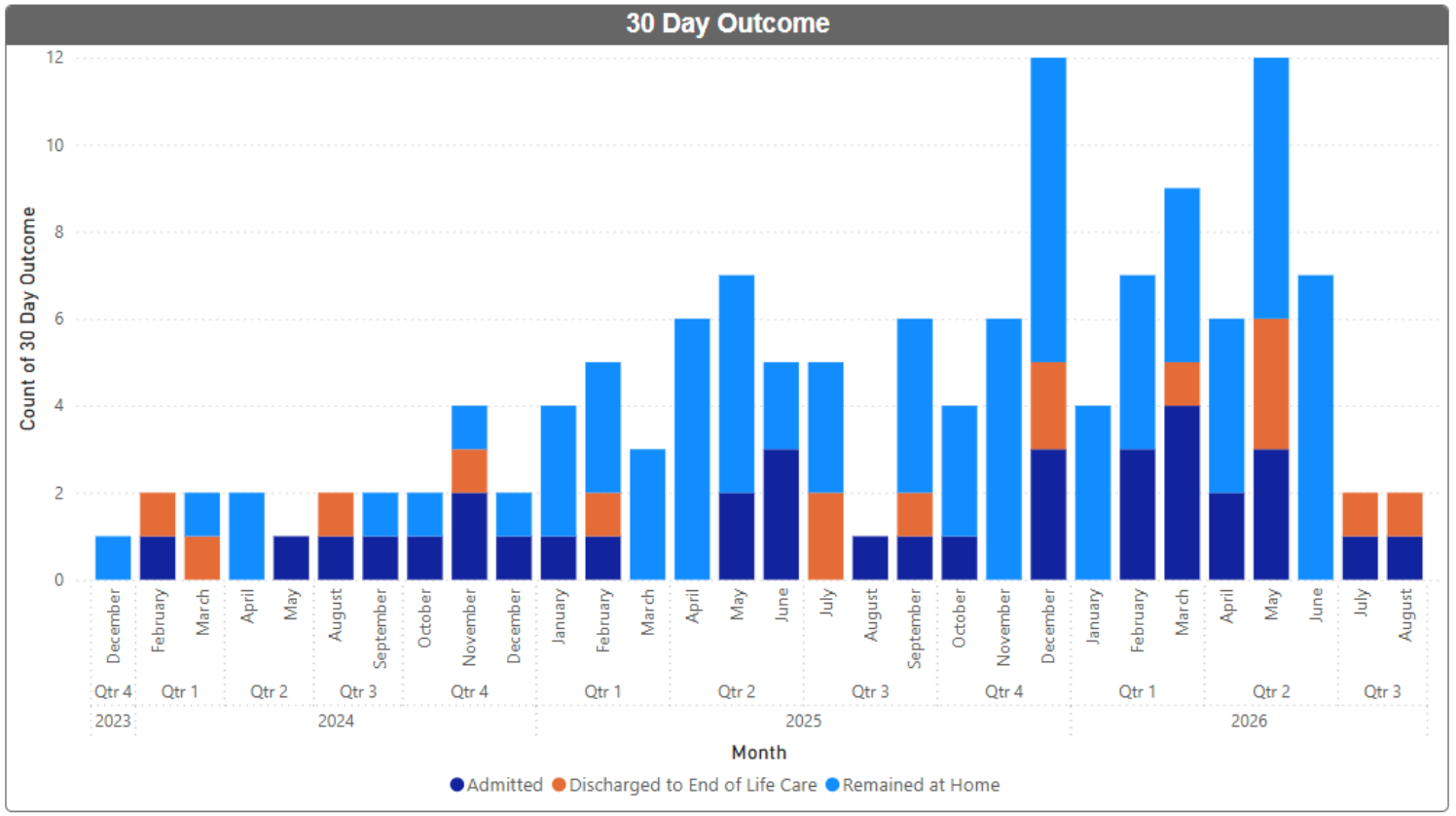
08/12/2023 24/08/2026

Hospital at Home Dashboard - 30 Day Outcome

Filter by Admission Date:

Admission Date

08/12/2023 24/08/2026

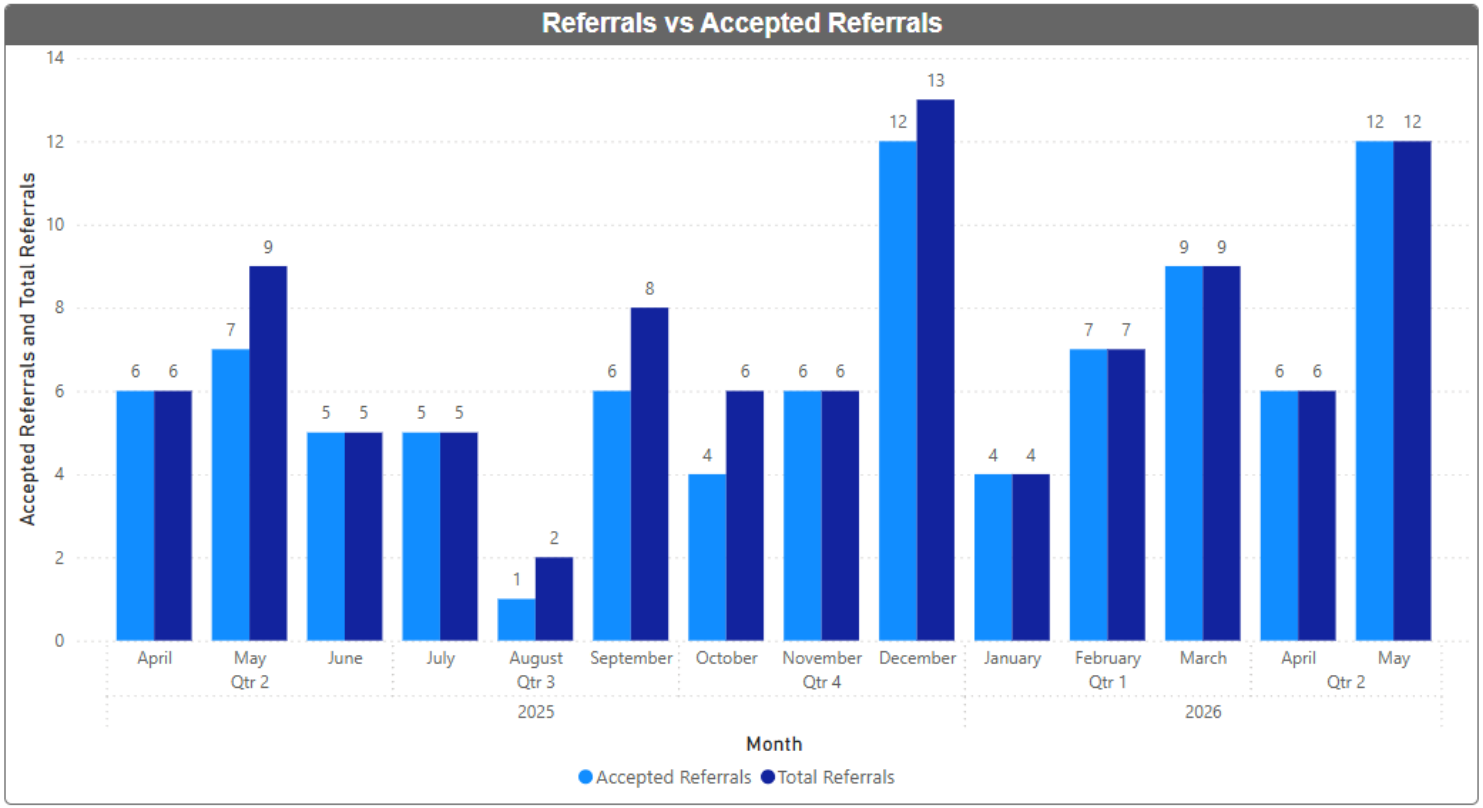


Hospital at Home Dashboard - Referrals vs Accepted Referrals

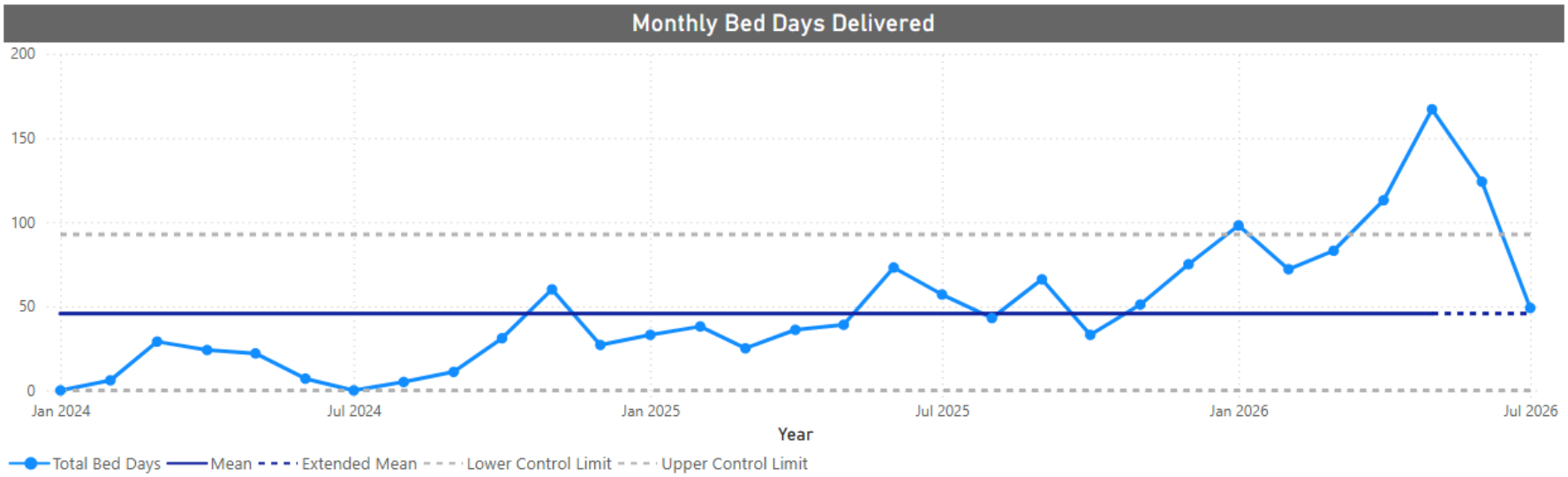
Filter by Admission Date:

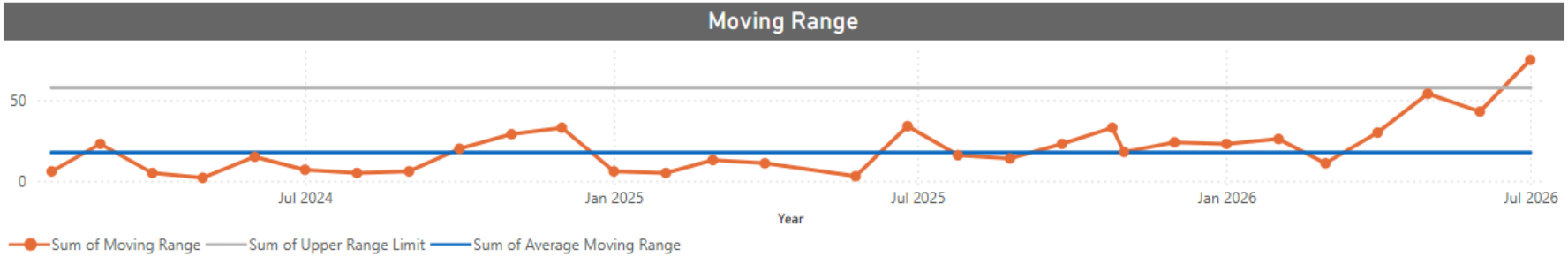
Admission Date

01/04/2025 31/05/2026



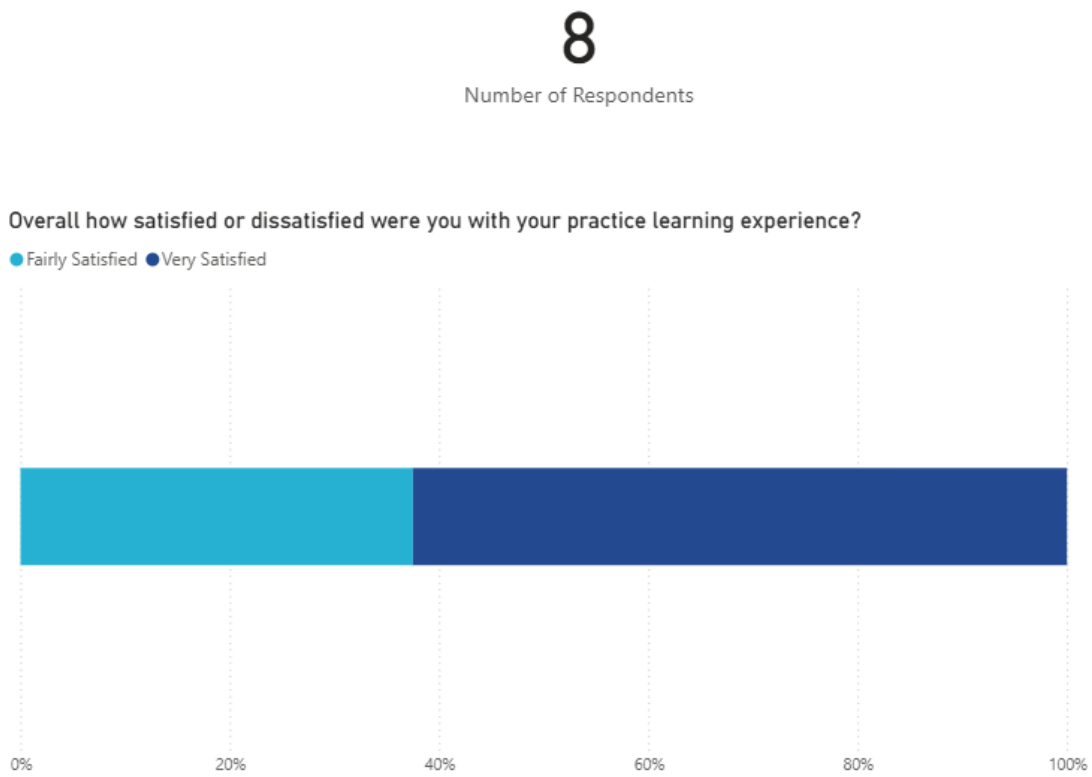
Hospital at Home Dashboard - XmR Chart



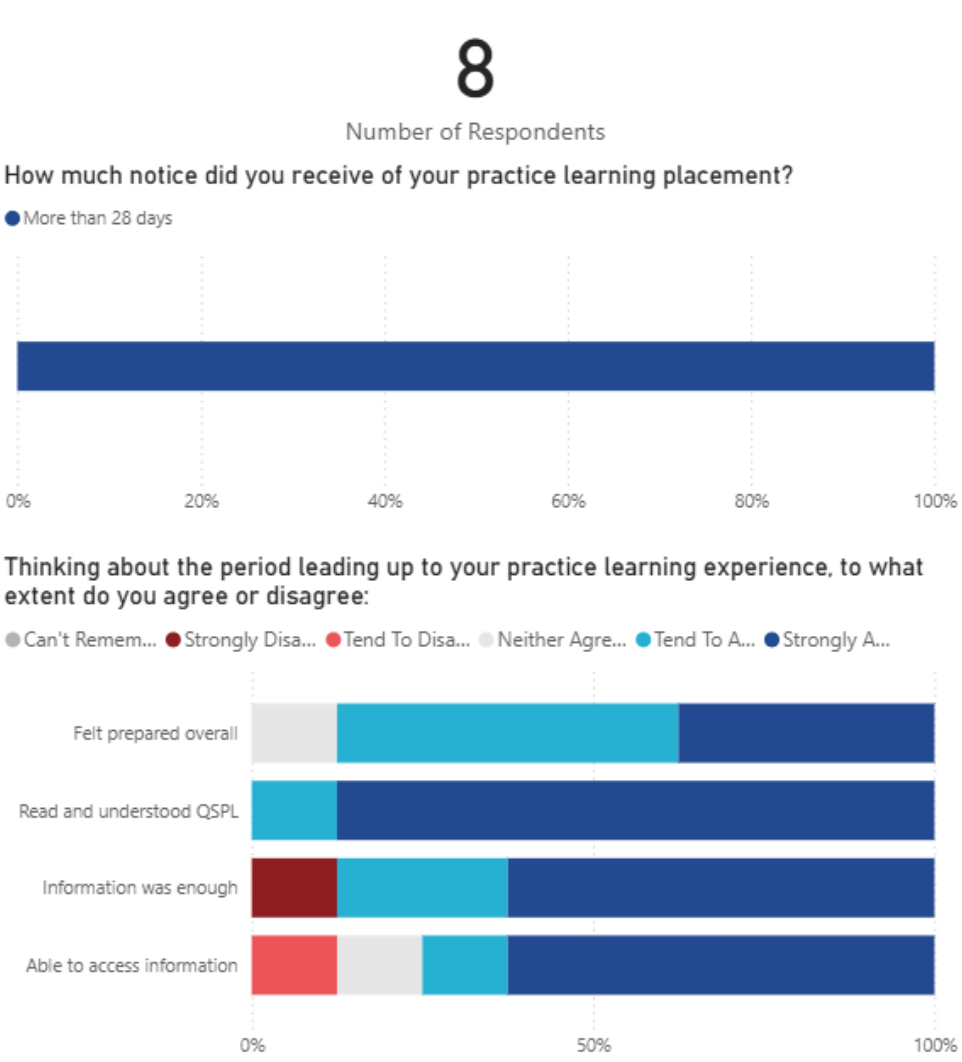


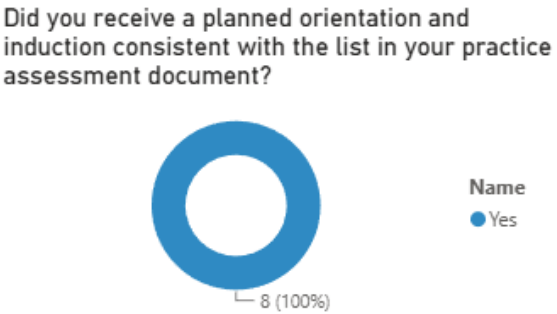
Appendix F: Quality Management of the Practice Learning Environment (QMPLE)
Q1 1st April– 30th June 2026
Overall Satisfaction:

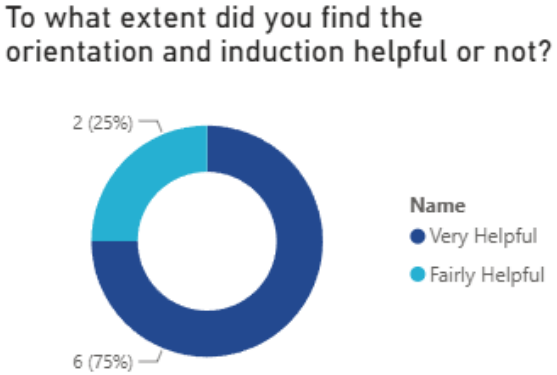
Student Feedback Overview:



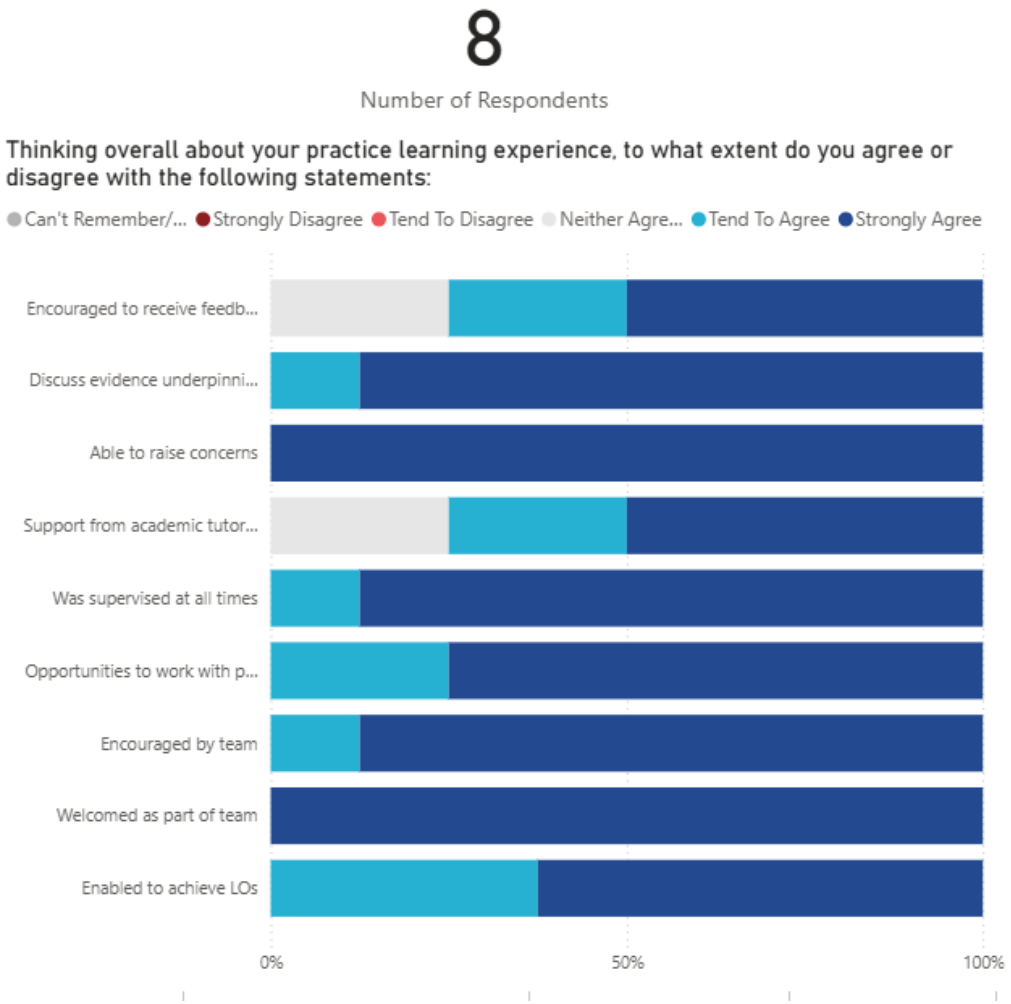
Preparation for Practice Learning:

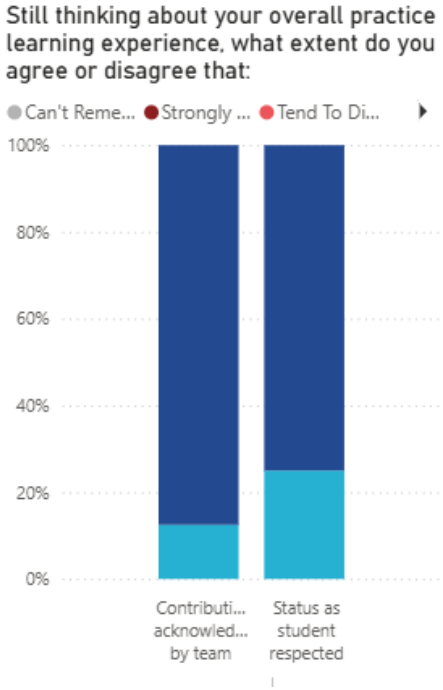




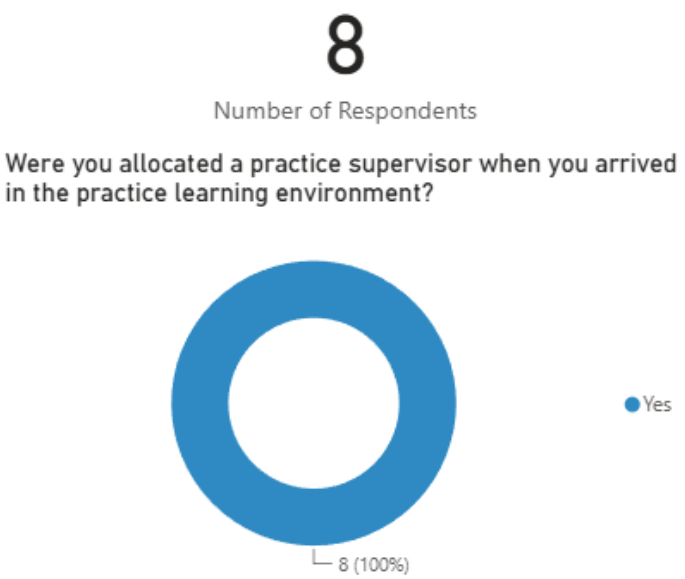


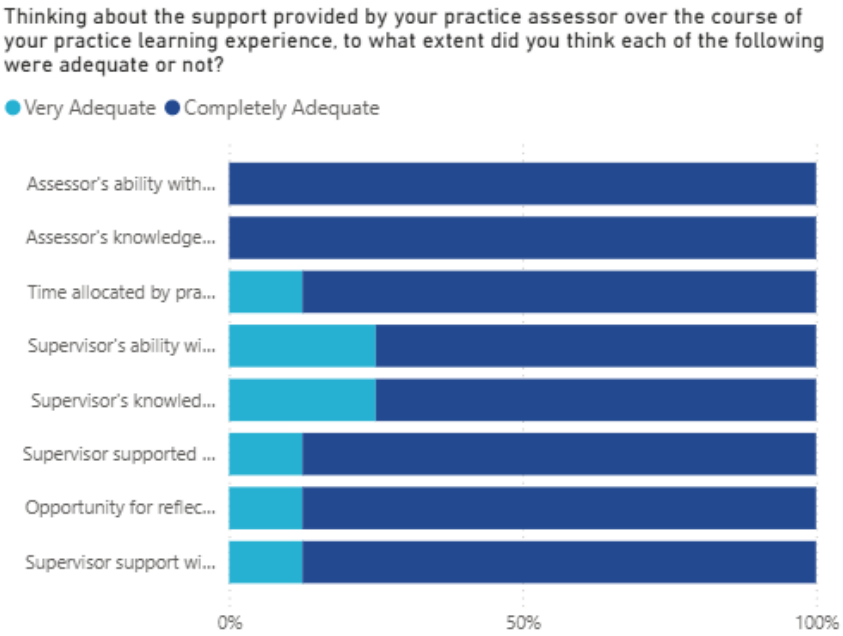
Learning Environment:

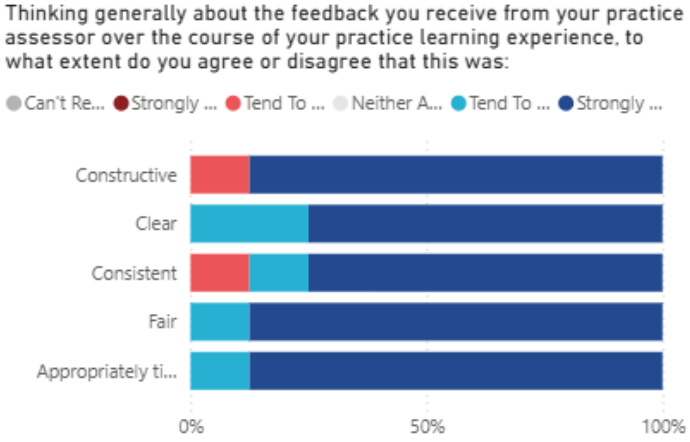


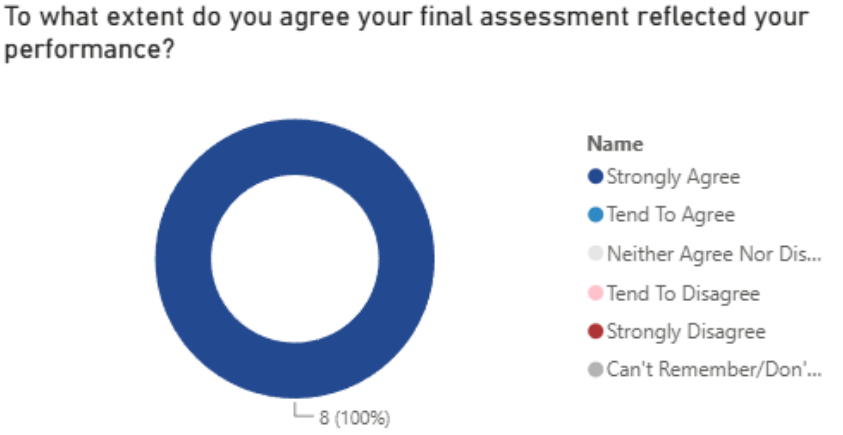


Practice support:

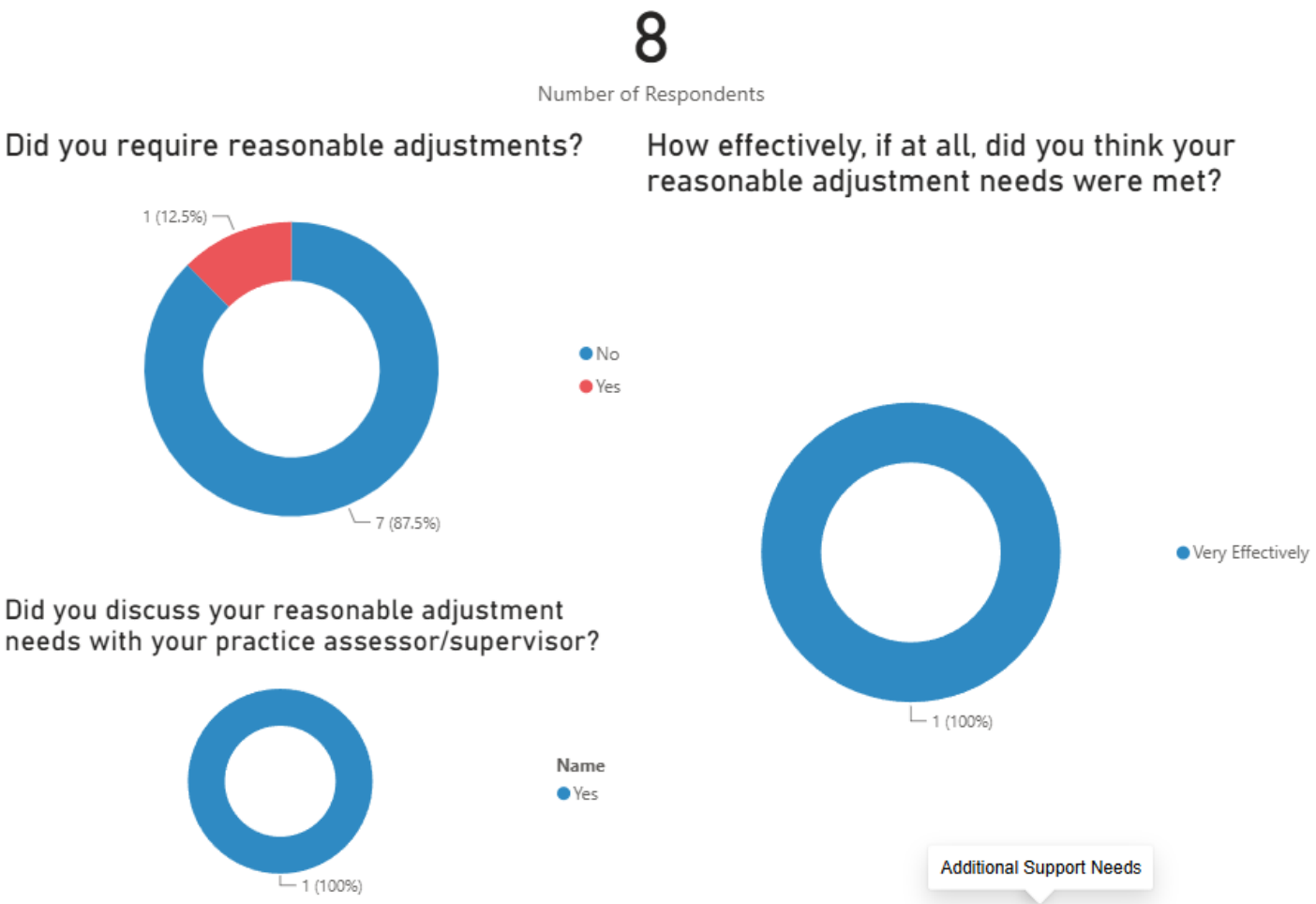








Additional Support Needs



Student feedback Overview –particularly good:

8

Number of Respondents

Search all responses...

Search

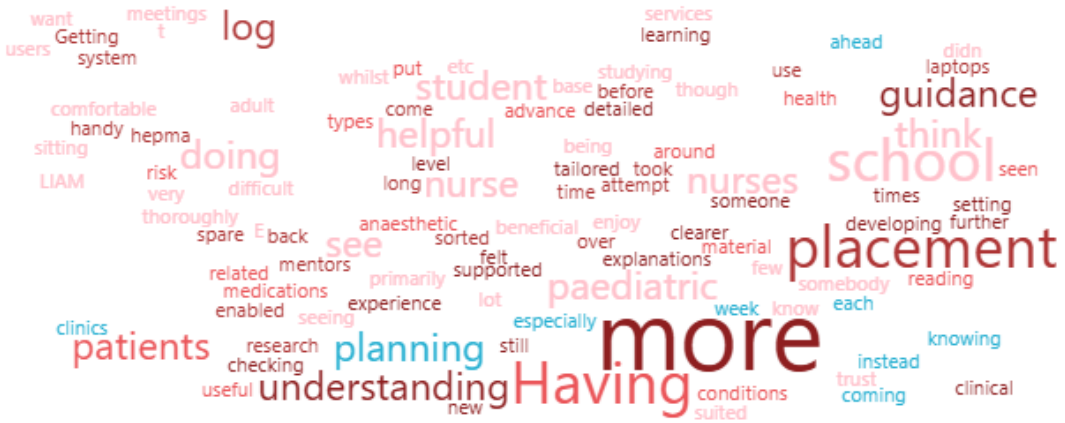
Response	Learning Environment	Learning Centre
I have really enjoyed this placement. I have felt fully supported all the way through and i've had the opportunity to learn so much.	Accident and Emergency	Gilbert Bain Hospital
The staff were all very friendly, Being in a small island community i was able to deal with all sorts of medical conditions and was able to care for adults and children. The range of clinics was also interesting.	Out Patients Department	Gilbert Bain Hospital
The department gave me a good opportunity to develop my ability to apply good communication skills by taking part in health assessments gaining a comprehensive picture of patients medical history, along with learning the impacts and risks involving having a anaesthetic.	Pre Op Assessment, Outpatients, Gilbert Bain Hospital	Gilbert Bain Hospital
I found to every helpful to understand what services are offered to children and young people in Shetland and in turn help with any children that present to A+E, I know what services would suit their needs. The team was very helpful at including me and explaining everything that we were doing. It gave me a deeper understanding into a range of conditions, diseases and what support is offered to the children who have long term illnesses that they live with. It was a helpful placement to learn more about the background of patients and have an insight into their lives and their reasoning for why they're receiving support.	School Nursing	Gilbert Bain Hospital
In theatre I got given the opportunity to be involved in so much in both scrub and anaesthetics, learning valuable skills and knowledge I am able to carry into all aspects of my nursing career. The staff were all very welcoming, encouraging, and very good at teaching enabling the best learning experience possible as a student.	Theatre	Gilbert Bain Hospital

My practice supervisor has been really supportive and has allowed me to enter my leadership placements with greater autonomy. She has always been there in the background if I need her. She has ensured I feel competent in the tasks I am undertaking beforehand, and if I have not felt competent at any time, she has taken the time to go through everything with me and show me the ropes. I have thoroughly enjoyed stepping up in my role during the final year of my degree and being given the chance to do so.	Ward 1 and HDU	Gilbert Bain Hospital
I had a very positive experience on Ward 3 and I found it to be an excellent first placement to have as someone with no prior clinical experience. The ward offers a wide variety of medical conditions and patient presentations, which provided valuable learning opportunities and exposure to experiences I would not have come across elsewhere. All staff were incredibly approachable and patient, which helped me feel welcomed and supported. I felt able to ask questions, develop my skills and gradually build my confidence within the practice area.	Ward 3	Gilbert Bain Hospital
I really enjoyed that all staff members were keen and happy to have me for the day and everyone works slightly differently so it was nice to see how they all provided the same care in different approaches. At handover every morning the nurse in charge made sure I had a nurse to be with and that was very helpful and I appreciate in the first few weeks as I didn't know the nurses well enough to ask.	Ward 3	Gilbert Bain Hospital

Student feedback – improved experience:

8

Number of Respondents



Search all responses...

Search

Response	Learning Environment	Learning Centre
More planning would be helpful especially planning ahead to what clinics the student will do each week instead of coming in and not knowing what you are doing.	Out Patients Department	Gilbert Bain Hospital
Having in advance some useful reading material / guidance, around types of medications and health related conditions that can be seen to put patients at risk of having an anaesthetic	Pre Op Assessment, Outpatients, Gilbert Bain Hospital	Gilbert Bain Hospital
I think that the placement was helpful to me as my base is A+E where we see paediatric patients, but being primarily with the school nurses would have been more suited to somebody studying to be a paediatric nurse rather as adult. It was also difficult for me to see a lot of what the school nurses do as a few of the services users were only comfortable seeing the school nurse they know and trust and didn't want a student sitting in whilst having meetings, doing LIAM, etc. I do think this placement was very beneficial to me though and I did thoroughly enjoy it.	School Nursing	Gilbert Bain Hospital
At times, I felt that explanations could have been clearer or more tailored to my level of experience. As someone new to a clinical setting, I was still developing my understanding and more detailed guidance or checking of my understanding would have further supported my learning	Ward 3	Gilbert Bain Hospital
Getting a log in for the system would have been handy. My mentors did attempt to get this sorted however it took so long to come back that placement was over before I got a log in. This would have enabled me to use hepma more and do some research on the laptops in spare time.	Ward 3	Gilbert Bain Hospital

Additional Comments:

8

Number of Respondents

Search all responses...

Search

Response	Learning Environment	Learning Centre
I fell an out patients department is more suited for a 1st year to gain basic knowledge and confidence. I don't feel being 2nd year or 3rd year these placements would benefit students as there is many things you cant do to have you ready for qualifying.	Out Patients Department	Gilbert Bain Hospital
Working within an island pre-op department compared to a large hospital in the mainland gave the opportunity to spend more time with the patient then you would generally see in the mainland. This was great to see, as I felt this promoted good patient care, the department worked well, and the staff were very supportive in making sure I had a good placement with many additional learning opportunities.	Pre Op Assessment, Outpatients, Gilbert Bain Hospital	Gilbert Bain Hospital
It was good to be able to do spoke days relating to my placement and get a grasp of the multidisciplinary team that supports Shetland's paediatric patients and their families.	School Nursing	Gilbert Bain Hospital
I have had an amazing time as a student in Ward One, and I would like to thank my supervisor for her support and highlight that she has done an amazing job with her first-ever student; any student she has in the future will be lucky to have her! Everyone has been so welcoming, and I have loved working with you all. Thank you.	Ward 1 and HDU	Gilbert Bain Hospital
I have nothing further to add but I would just like to thank everyone on Ward 3 for making my placement so enjoyable!	Ward 3	Gilbert Bain Hospital

NHS Shetland Feedback Monitoring Report 2026_27 Quarter 1

All NHS Boards in Scotland are required to monitor patient feedback and to receive and consider performance information against a suite of high level indicators as determined by the Scottish Public Services Ombudsman (SPSO). A standardised reporting template regarding the key performance indicators has been agreed with complaints officers and the Scottish Government. This report outlines NHS Shetland's performance against these indicators for the period April to June 2026 (Quarter 1).

Further detail, including the actions taken as a result of each Stage 2 complaint from 1 April 2026 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). The majority of Stage 2 complaint learning from 2025/26 is included in the Feedback and Complaints Annual Report going to the September Board meeting. The outcome of four open complaints from Quarter 4 of 2025/26 will be included in a future quarterly report.

A summary of cases taken to the Scottish Public Services Ombudsman from April 2024 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.

Despite an ask to consider ways in which further assurance can be provided to the meeting regarding whether actions have been concluded and if there is a need to share organisational learning, due to the high number of complaints in the system and investigator capacity it has not proved possible to progress this to date.

Summary

- Corporate Services recorded 49 pieces of feedback in Quarter 1 of 2026/27 (1 April 2026 – 30 June 2026). For clarity these figures include all salaried GP practices (note this is 9 of 10 practices in Shetland for the purposes of Quarter 1 reporting):

	01.04.26 – 30.06.26		01.01.26 – 31.03.26 (previous quarter)	
Feedback Type	**Number**	**%**	**Number**	**%**
Compliments	13	26.5	7	8
Concerns	13	26.5	31	35
Complaints	23	47	51	57
Totals:	**49**		**89**	

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

	01.04.26 – 30.06.26		01.01.26 – 31.03.26 (previous quarter)	
Service	**Number**	**%**	**Number**	**%**
Directorate of Acute and Specialist Services	6	26	20	39.2
Directorate of CH&SC	15	65	19	37.3
Acute and community	0	0	3	5.9
Other (e.g. PH, Patient Travel)	2	9	9	17.6
Totals:	**23**		**51**	

Key highlights

- 49 pieces of feedback is a 45% decrease from the previous quarter. This has been helpful in allowing more time to continue addressing the high volume of complaints from Quarter 4.
- Two of 5 Stage 2 complaints from Quarter 1 remain open in August 2026. The key performance indicator data at 1 – 4 below does not reflect the open complaints.
- Three Stage 2 complaints remain open from Quarter 4 at the time of report writing. The longest open has received a sixth holding letter.
- Performance regarding the length of time to respond to Stage 1 complaints has improved from the last quarter, with 11 of 16 closed Stage 1 complaints handled within five working days. Responding to Stage 2 complaints within 20 working days remains challenging, however two Stage 2 complaints were responded to on time.
- Each new Stage 2 complaint must be summarised into heads of complaint and formally acknowledged within three days of receipt. This can be a lengthy process, sometimes exacerbated by complainants using AI to draft correspondence. This can take far longer to distil the outcome/s the complainant is seeking, and also manage expectation as best as possible at this early stage.
- The introduction of a new reporting system is impacting on capacity within Feedback and Complaints, with a requirement to develop and implement the feedback, complaints and claims modules with the software developers. Longer term this has the potential to be extremely beneficial, allowing focussed feedback and complaint reporting in departmental areas, and streamlining general report writing. We also anticipate implementing a Stage 1 reporting process for staff to input straight on to the system.
- 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 likelihood that it will 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	01.04.26 – 30.06.26	01.01.26 – 31.03.26 (previous quarter)
Number of complaints closed at Stage One as % of all complaints closed	84% (16 of 19)	73.7% (28 of 38)
Number of complaints closed at Stage Two as % of all complaints closed	11% (2 of 19)	18.4% (7 of 38)
Number of complaints closed at Stage Two after escalation as % of all complaints closed	5% (1 of 19)	7.9% (3 of 38)

*S1 complaints reduce from 18 to 16 with 2 still open, and S2 complaints (including escalated complaints) reduce from 5 to 3 with 2 Stage 2 complaints from Quarter 1 remaining open at the time of report writing

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

Upheld

Description	01.04.26 – 30.06.26	01.01.26 – 31.03.26 (previous quarter)
Number of complaints upheld at Stage One as % of all complaints closed at Stage One	31% (5 of 16)	42.9% (12 of 28)
Number complaints upheld at Stage Two as % of complaints closed at Stage Two	0% (0 of 2)	0% (0 of 7)
Number escalated complaints upheld at Stage Two as % of escalated complaints closed at Stage Two	0% (0 of 1)	33.3% (1 of 3)

Partially Upheld

Description	01.04.26 – 30.06.26	01.01.26 – 31.03.26 (previous quarter)
Number of complaints partially upheld at Stage One as % of complaints closed at Stage One	38% (6 of 16)	46.4% (13 of 28)
Number complaints partially upheld at Stage Two as % of complaints closed at Stage Two	100% (2 of 2)	100% (7 of 7)
Number escalated complaints partially upheld at Stage Two as % of escalated complaints closed at Stage Two	100% (1 of 1)	66.7% (2 of 3)

Not Upheld

Description	01.04.26 – 30.06.26	01.01.26 – 31.03.26 (previous quarter)
Number complaints not upheld at Stage One as % of complaints closed at Stage One	31% (5 of 16)	10.7% (3 of 28)
Number complaints not upheld at Stage Two as % of complaints closed at Stage Two	0% (0 of 2)	0% (0 of 7)
Number escalated complaints not upheld at Stage Two as % of escalated complaints closed at Stage Two	0% (0 of 1)	0% (0 of 3)

3 The average time in working days for a full response to complaints at each stage			
Description	**01.04.26 – 30.06.26**	**01.01.26 – 31.03.26 (previous quarter)**	**Target**
Average time in working days to respond to complaints at Stage One	6.4	9.5	5 wkg days
Average time in working days to respond to complaints at Stage Two	29.5	47	20 wkg days
Average time in working days to respond to complaints after escalation	20	45	20 wkg days

4 The number and percentage of complaints at each stage which were closed *(responded to)* in full within the set timescales of 5 and 20 working days			
Description	**01.04.26 – 30.06.26**	**01.01.26 – 31.03.26 (previous quarter)**	**Target**
Number complaints closed at Stage One within 5 working days as % of Stage One complaints	69% (11 of 16)	53% (15 of 28)	80%
Number complaints closed at Stage Two within 20 working days as % of Stage Two complaints	50% (1 of 2)	0% (0 of 7)	80%
Number escalated complaints closed within 20 working days as % of escalated Stage Two complaints	100% (1 of 1)	0% (0 of 7)	80%

5 The number and percentage of complaints at each stage where an extension to the 5 or 20 working day timeline has been authorised.		
Description		**01.01.26 – 31.03.26 (previous quarter)**
% of complaints at Stage One where extension was authorised	31%	46%
% of complaints at Stage Two where extension was authorised	50%	100%
% 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/signpost effectively to the appropriate support, or to handle a complaint investigation at Stage 2.

After two cohorts of staff undertaking SPSO Investigation training it has become apparent there is a need to plan increased communication regarding complaint handling and to schedule in some regular drop-in sessions for additional support. A training plan has been discussed and is being developed.

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

Stage 2 complaints received 1 April 2026 to 30 June 2026

	Summary	Staff Group(s)	<= 20 wkg days	If not, why	Outcome	Findings/Actions
1	Lack of treatment and care	Dentist	N	Additional time for verification	Part upheld	• No evidence of clinical care failure, but acknowledged patient experience did not meet expectations regarding communication, understanding of needs and support. • Apology offered, and transferred to different dentist.
2	Inappropriate prescribing without consent	Medical	N	More time required for investigation	Open	
3	Inadequate care, unmanaged pain and delayed investigation	Maternity/GP	Y		Part upheld	• Investigation found appropriate clinical assessments and investigations, however it was acknowledged that the complainant felt their concerns were not always heard. • Case to be discussed at a clinical governance meeting.
4	Falsified medical records and lack of transparency	GP	N	Complexity of progressing investigation	Open	
5	Failure to respond to urgent request	Health Centre	Y		Part upheld	• Patient not informed that the request had been closed after clinical review, which caused distress. Practice asked to improve communication when requests are closed following ED attendance.

Cases escalated to the Scottish Public Services Ombudsman from 1 April 2024 to August 2026

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 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