Board Paper 2021/22/36

Shetland NHS Board

Meeting:	Shetland NHS Board		
Paper Title:	Quality Report – Update on Progress		
Date:	12 October 2021		
Author:	Kathleen Carolan	**Job Title:**	Director of Nursing & Acute Services
Executive Lead:	Kathleen Carolan	**Job Title:**	Director of Nursing & Acute Services

Decision / Action required by meeting:

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.

High Level Summary:

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

Key Issues for attention of meeting:

Noting the good performance as shown in the report

Corporate Priorities and Strategic Aims:

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.

Implications : *Identify any issues or aspects of the report that have implications under the following headings*

Service Users, Patients and Communities:	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
Human Resources and Organisational Development:	The focus of this report is on evidencing effective training and role development to deliver care, professionalism and behaviours which support person centred care
Equality, Diversity and Human Rights:	EQIA is not required.
Partnership Working	Quality standards and assessment of impact applies in all NHS settings.
Legal:	

Finance:	Quality standards and the delivery of them is part of the standard budgeting process and are funded via our general financial allocation.	
Assets and Property:	Nil	
Environmental:	A Strategic Environmental Impact Assessment is not required or has been completed.	
Risk 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.	
Policy and Delegated Authority:	Delegated authority for the governance arrangements that underpin quality and safety measures sit with the Clinical Governance Committee (and the associated governance structure)	
Previously considered by:	Data in this report is also shared with the Joint Governance Group will meet in November 2021	

"Exempt / private" item	*Public document*

PROGRESS ON LOCAL QUALITY STRATEGY IMPLEMENTATION
PROGRESS ON THE DEVELOPMENT OF A PATIENT EXPERIENCE FRAMEWORK

The Board supported a formal proposal to develop an approach (or framework) that would enable us to bring together the various systems that are in place to gather patient experiences and feedback so that we can demonstrate clearly how feedback is being used to improve patient care.

Progress continues and since August 2021 the following actions have been taken:

- There continues to be regular interactions via social media and with the local media during the pandemic to make sure that people in our wider community and patients know how to access our services and know how services have changed in order to meet new requirements as a result of COVID 19. This has included films, radio interviews, podcasts, articles in local news media and live streaming information sessions on social media, facilitated by the Chief Executive.

- The Clinical and Care Strategy sits within a wider programme of strategic planning and is the first phase of the capital planning process to develop a strategic assessment (SA) for the re-provision of the Gilbert Bain Hospital which will be undertaken during 2021-22. The clinical and care models will be used to help build a 'case for change' that supports the need to look at our built environment as well as our clinical and care pathways. This second phase to develop the SA is underway and due to be completed by January 2022. Three workshops have been held to date, to explore the views of professionals. As part of this work we will be undertaking a specific engagement exercise to gather views from patients and the wider public.

- As part of the work to develop early intervention and prevention support for people in Shetland, the Shetland Early Action Programme Board (SEAP) has commissioned an evaluation of the second year of the programme which includes detailed feedback from families that have accessed support in the last 12 months. The feedback clearly illustrates that family support and empowerment provides a sustained, positive impact on people's lives. A more detailed overview of the evaluation findings will also be provided at Board/IJB seminars later in the year.

- SEAP has also commissioned a project to review our current application of technology and how we use it to support families in Shetland. Some of the early findings are that there is untapped potential in the use of technology, signposting to services and appropriately sharing information in order to provide early support for families. The project will include specific engagement exercises to gather views from families and professionals and sessions to explore case studies and solutions to some of the barriers identified/emerging.

- Partnership working that is aligned to the Children's Joint Plan includes reviewing the way in which we provide neuro-developmental care across services in Shetland and developing a whole system approach in the way we provide services for young people and their families. We have three workshops planned between October 2021 and January 2022 to collectively review and develop the diagnostic pathway for young people with a neuro-developmental condition. Again, this work involves families in helping to identify gaps in services and shaping new pathways for assessment and ongoing support.

DELIVERING QUALITY CARE AND SUPPORTING STAFF DURING THE PANDEMIC

Staff wellbeing

The Staff Governance Committee (SGC) is supporting a comprehensive programme of staff health and wellbeing activities. This includes specific approaches for effective and inclusive debriefs following significant traumatic events e.g. unexpected patient death (using Schwartz rounds and TRiM). We are also encouraging teams to undertake learning reviews following all complex adverse events to share learning and opportunities for improvement. The themes and lessons learnt from this work are shown in Appendix A.

To help create some consistency in our approach for undertaking learning reviews, we are in the process of developing a set of principles that can be applied to an adverse event to determine if a learning review would be beneficial.

The SGC is also supporting training opportunities aimed at building resilience and wellness and this ranges from accessing fitness classes to coaching time with Educational Psychologists. The implementation of this programme is being overseen by the SGC and the Area Partnership Forum (APF).

We are in the process of preparing for a further wave of imatters survey feedback from health and social care staff. Action plans will be completed by November 2021.

POGRESS ON LOCAL QUALITY STRATEGY IMPLEMENTATION FOR INFORMATION AND NOTING

Our focus over 18 months has been to ensure that we maintain safe and effective care in all settings during the initial phase of the pandemic and through into more recent months where we have remobilised services. We remain on an emergency footing given the significant pressures that Health Boards and Health and Social Care Partnerships (H&SCPs) are experiencing, particularly the increase in urgent care.

As we start to remobilise, we are aware of the impact of the pandemic across the whole system, with a rise in the number of people accessing emergency care via GP Practices and the Emergency Department (ED) as well as waiting lists for planned care, particularly for complex treatments that are provided in specialist centres. In response to this, we have prepared the fourth iteration of the remobilisation plan which was submitted to Scottish Government at the end of September 2021, this reflects the extended period of recovery needed and the ongoing impact on elective care, mental health services and urgent care. In conjunction with the development of this operational plan, we are also preparing our winter planning arrangements. Taking into account the challenges of managing pandemic related pressures alongside the expected winter pressures, we will consider escalation plans to reflect anticipated issues with the demands placed on teams e.g. service continuity plans for staff self-isolation due to COVID etc. The operational winter plan will be received by the Health Board and the IJB by December 2021.

The programme of care assurance to support care services in the community in Shetland is ongoing and has helped us to reduce risks associated with care delivery. The emergency arrangements for Health Board oversight of the infection control and clinical care of residents will remain in place until the end of 2021-22. The next phase of assurance visits are due to commence in October 2021. As restrictions start to lift, the focus of the care assurance work is starting to become less reactive and focus on longer term improvement goals. We are currently reviewing our care home assurance and oversight arrangements to reflect the current challenges in respect of winter planning and the increased demand for community care (which is reflected in H&SCP across Scotland).

We have continued to work on the restructuring of the clinical and care governance framework for NHS Shetland and the Integration Joint Board (IJB). The revised structure and terms of reference were received and approved by the NHS Shetland Board in June 2021 and is on the agenda again in October 2021 to reflect further refinements to the Committee structure. Work is now ongoing to implement a revised Clinical Governance Committee to assure the Board and the IJB on the performance and quality of NHS services. To support this assurance role an operational clinical governance group will be established in October 2021, which will be made up of the chairs of all of the NHS governance groups. The IJB is developing the assurance arrangements for local authority services via existing governance structures.

Similarly, we are in the latter stages of reviewing the governance structure and agreeing the partnership priorities for the Shetland Children's Partnership (SCP). This review will run until November 2021 and is aimed at identifying the strategic aims and outcomes for the SCP, in line with the Children's Joint Plan for Shetland and streamlining the partnership landscape.

We will be hosting our annual celebrating excellence event in December 2021 which is an opportunity for staff to showcase the improvement work that they have undertaken individually or as a team during 2021. We are in the early stages of developing the programme for the event which is open to all staff.

As noted in the HAI report, Healthcare Improvement Scotland (HIS) undertook an unannounced inspection at the Gilbert Bain Hospital to review our infection control and COVID management arrangements. As part of our infection control governance arrangements we have an ongoing programme of environmental audits and we have also asked patients about their experience of infection control procedures, information and support whilst in Hospital. Lay members also participated in gathering feedback from patients. The results are positive and are shown in Appendix C. The HIS report will be published in early October 2021.

Teams continue to implement quality improvement programme and releasing time to care approaches. This work is being reported through the excellence in care, care assurance framework and data for assurance is shown in the Quality dashboard in Appendix A. Other examples of quality improvement work include the development of an improvement plan for primary care services as well as a programme of work to implement digital records. Appendix B includes the themes and management of feedback and complaints between April and June 2021 (the second quarter was included in the annual report received by the Board in August 2021).

Quality Report - Board

Generated on: 17 September 2021

Health Improvement

	Months			Quarters			Icon	Target	
Code & Description	June 2021	July 2021	August 2021	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q1 2021/22	Q1 2021/22	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			62.8%	60.4%	61.9%		58%	Exceeding national target of 50% and local target of 58%. National data for 2019-20 shows us at 64.6% - the best performing Board in Scotland and well above the national average (43.9%).
PH-HI-03 Sustain and embed Alcohol Brief Interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.	7	7	7	15	20	7		63	The Shetland Health Survey, which is due to report in October 2021, will help understanding of the level of harmful and hazardous drinking in Shetland and allow the setting of a realistic target for completed ABIs.
PH-HI-03a Number of FAST alcohol screenings	138	182	229	348	482	138		120	

Patient Experience Outcome Measures

	Months			Quarters			Icon	Target	
Code & Description	June 2021	July 2021	August 2021	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q1 2021/22	Q1 2021/22	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%	97%	100%	100%	100%		90%	

Code & Description	Months			Quarters			Icon	Target	Latest Note
	June 2021	July 2021	August 2021	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q1 2021/22	Q1 2021/22	
	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)	95.83%	100%	100%	100%	100%	95.83%		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%	96.6%	100%	99%	100%		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%	93.75%	92.31%	88.89%	93.33%	100%		90%	
NA-HC-20 What matters to you % of people who say that they have all the information they needed to help them make decisions about their care/treatment (aggregated)	97.92%	98.19%	96.92%	95.96%	98.53%	97.92%		90%	
NA-HC-23 What matters to you % of people who say that staff took account of their personal needs and preferences (aggregated)	97.87%	100%	93.65%	95.83%	100%	97.87%		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)	97.92%	93.02%	95.06%	94%	95.52%	97.92%		90%	

Patient Safety Programme - Maternity & Children Workstream

Code & Description	Months			Quarters			Icon	Target	Latest Note
	June 2021	July 2021	August 2021	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q1 2021/22	Q1 2021/22	
	Value	Value	Value	Value	Value	Value	Status	Target	
NA-CF-07 Days between stillbirths	1,401	1,432	1,463	1,220	1,310	1,401		300	
NA-CF-09 Rate of neonatal deaths (per 1,000 live births)	0	0	0	0	0	0		2.21	
NA-CF-15 Rate of stillbirths (per 1,000 births)	0	0	0	0	0	0		4	
NA-CF-16 % of women satisfied with the care they received									Currently reviewing the questionnaire and collation process.

Service & Quality Improvement Programmes - Measurement & Performance

Code & Description	Months			Quarters			Icon	Target	Latest Note
	June 2021	July 2021	August 2021	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q1 2021/22	Q1 2021/22	
	Value	Value	Value	Value	Value	Value	Status	Target	
NA-HC-08 Days between Cardiac Arrests	23			197	287	23		300	Patient had a cardiac arrest in Hospital - patient survived
NA-HC-09 All Falls rate (per 1000 occupied bed days)	1.82	8.6		2.93	2.86	1.82		7	
NA-HC-10 Falls with harm rate (per 1000 occupied bed days)	0	1.43	0	1.46	0	0		0.5	

	Months			Quarters			Icon	Target	
Code & Description	June 2021	July 2021	August 2021	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q1 2021/22	Q1 2021/22	Latest Note
	Value	Value	Value	Value	Value	Value	Status	Target	
NA-HC-53 Days between a hospital acquired Pressure Ulcer (grades 2-4)	8	39	70	2	40	8		300	Tissue Viability Nurse now in post leading educational sessions and route cause analysis using the 'Red Day' Tool which supports investigation of pressure ulcers. Tissue viability group are now exploring a new risk assessment tool entitled PURPOSE T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool). Educational sessions are now also being run by the Tissue Viability Nurse for care home and care at home teams via MS Teams.
NA-HC-54 Pressure Ulcer Rate (grades 2-4)	5.45	0	0	1.46	0	5.45		0	
NA-HC-59 % of patients discharged from acute care without any of the combined specified harms	97.1			99.4	98	97.1		95	
NA-HC-72 % of patients who had the correct pharmacological/mechanical thromboprophylaxis administered	100	90		100	100	100		75	
NA-HC-79 % of total observations calculated accurately on the NEWS 2 charts	95.32%	96.22%	93.46%	87.86%	92.33%	95.51%		95%	
NA-HC-80 % of NEWS 2 observation charts fully compliant (Accuracy)	64.29%	70.97%	57.5%	49.53%	52.1%	66.67%		75%	Ward senior charge nurses or nurse in charge continue with spot checks of observation charts. Results are discussed at ward meetings and additional training provided where necessary. Chief Nurse conducting care assurance visits/audits twice monthly to assist SCNs/teams with quality improvement priorities.
NA-IC-20 % of Patient Safety Conversations Completed (3 expected each quarter)	Measured quarterly								We have an expression of interest from one department and we are in the process of arranging a date for the visit.
NA-IC-23 Percentage of cases where an infection is identified post Caesarean section	Measured quarterly								Note: Surgical Site Infection Surveillance suspended due to COVID-19.

Code & Description	Months			Quarters			Icon	Target	Latest Note
	June 2021	July 2021	August 2021	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q1 2021/22	Q1 2021/22	
	Value	Value	Value	Value	Value	Value	Status	Target	
NA-IC-24 Percentage of cases developing an infection post hip fracture	Measured quarterly								Note: Surgical Site Infection Surveillance suspended due to COVID-19.
NA-IC-25 Percentage of cases where an infection is identified post Large Bowel operation	Measured quarterly								Note: Surgical Site Infection Surveillance suspended due to COVID-19.
NA-IC-30 Surgical Site Infection Surveillance (Caesarean section, hip fracture & large bowel procedures)	Measured quarterly								Note: Surgical Site Infection Surveillance suspended due to COVID-19.

Treatment

Code & Description	Months			Quarters			Icon	Target	Latest Note
	June 2021	July 2021	August 2021	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q1 2021/22	Q1 2021/22	
	Value	Value	Value	Value	Value	Value	Status	Target	
CH-MH-03 All people newly diagnosed with dementia will be offered a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan	100%	100%	100%	100%	100%	100%		100%	This is not currently being measured as a target at national level. We *offer* the link worker to everyone newly diagnosed and therefore we meet the target (understandably, not everyone wants to take up the offer). See CH-MH-04 for details of our balancing measure.
CH-MH-04 People with diagnosed dementia who take up the offer of post diagnostic support (i.e. have an active Post Diagnosis Support status)	Measured quarterly			38.2%	27.9%				Note: this is a local measure showing the number of people with an active PDS Status as a percentage of those diagnosed with dementia who take up the offer of post diagnostic support - 39 of 140 cases. This measure was revised for year 2019-20.
MD-HC-01 Quarterly Hospital Standardised Mortality Ratios (HSMR)	Measured quarterly			0.92	0.9				Latest available provisional national data. Rate remains consistently well within expected levels. Next data due Nov 21.

APPENDIX A – Overview of falls and pressure ulcer incidence up to August 2021

Falls in Secondary Care

WARD 1 NA-HC-60 Total number of falls				
Date	Fall with injury NA-HC-62	Fall - no injury	Days Between	Injury
B/Fwd			22	
Jan-21	1	1	5	2 minor lacerations on leg
Feb-21	0	2	33	
Mar-21	0	0	64	
Apr-21	0	1	94	
May-21	0	1	125	
Jun-21	0	0	155	
Jul-21	0	2	186	
Aug-21	0	2	217	
Sep-21			247	
Oct-21			278	
Nov-21			308	
Dec-21			339	
Total	**1**	**9**		

WARD 3 NA-HC-61 Total number of falls				
Date	Fall with injury NA-HC-63	Fall - no injury	Days Between	Injury
B/Fwd			143	
Jan-21	0	0	174	
Feb-21	2	2	8	1 - graze to head 1 - broken hip
Mar-21	0	2	39	
Apr-21	1	4	20	Minor cut to elbow
May-21	1	5	24	Minor injury - small bump to head with slight bruise
Jun-21	0	1	54	
Jul-21	1	3	6	Black eye
Aug-21	0	7	37	
Sep-21			67	
Oct-21			98	
Nov-21			128	
Dec-21			159	
Total	**5**	**24**		

Pressure Ulcers in Secondary Care

WARD 1

Date	Total number of sores aquired while on 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	Comments
B/Fwd			200			
Jan-21	0	0	231			
Feb-21	2	2	9	Grade 2 Grade 2 Grade 3 Grade 3	On Ward On Ward Home - on admission Ward 3 - on admission	Ward 3 - on admission was originally admitted to Ward 3 from the community with the PU
Mar-21	0	1	40	Grade 2	Community	On Admission to the ward
Apr-21	0	1	70	Grade 2	Outwith Shetland	On Admission to the ward
May-21	0	3	101	Grade 2 Grade 2 Deep tissue injury	Community Outwith Shetland Outwith Shetland	All on admission to the ward
Jun-21	2	0	8	Grade 2 Grade 2	On Ward On Ward	Same patient
Jul-21	0	2	39	Grade 3 Grade 2	Community x 2	On Admission to the ward
Aug-21	0	2	70	Ungradeable Grade 2	Community Outwith Shetland	Deep tissue injury On admission to Ward x 2
Sep-21			100			
Oct-21			131			
Nov-21			161			
Dec-21			192			
Total	**4**	**11**				

WARD 3

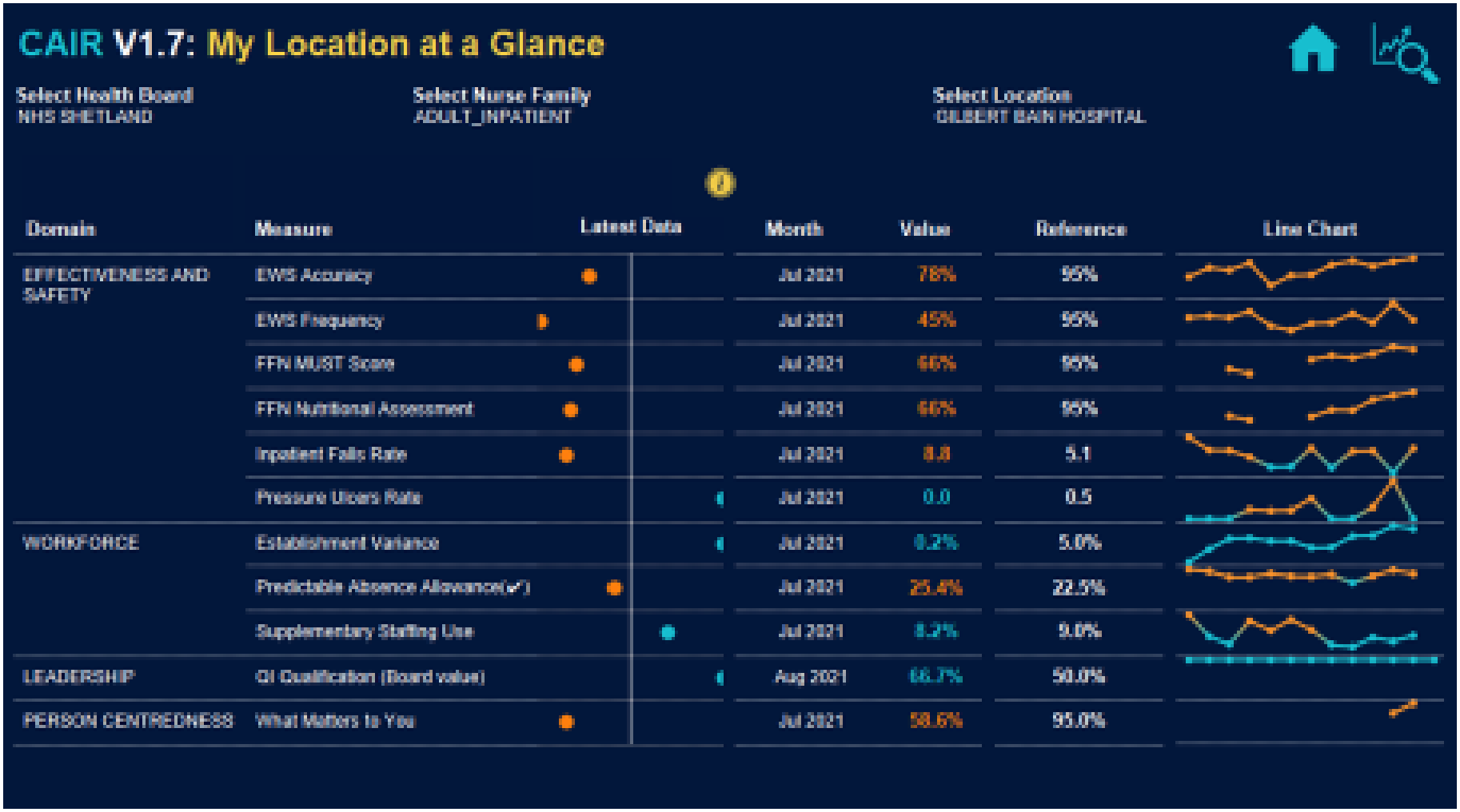
Date	Total number of sores aquired while on ward (NA-HC-67)	Number present on admission (NA-HC-68)	Number of days between a new PU being identified (NA-HC-69)	Grade	Origin	Comments
B/Fwd			2			
Jan-21	1	1	29	Grade 2 Grade 3	On the ward Outwith Shetland	
Feb-21	0	1	57	Grade 3	In the community	
Mar-21	0	6	88	Grade 4 x 2 Grade 3 Grade 2 x 2 Grade 2	All in the community	All on admission to ward
Apr-21	0	3	118	Grade 2 Ungradeable Grade 2	All in the community	All on admission to ward
May-21	2	0	17	Grade 2 x 2	On the Ward	
Jun-21	1	0	13	Grade 2	On the Ward	
Jul-21	0	1	44	Grade 3	In the community	On admission to ward
Aug-21	0	0	75			
Sep-21			105			
Oct-21			136			
Nov-21			166			
Dec-21			197			
Total	**4**	**12**				

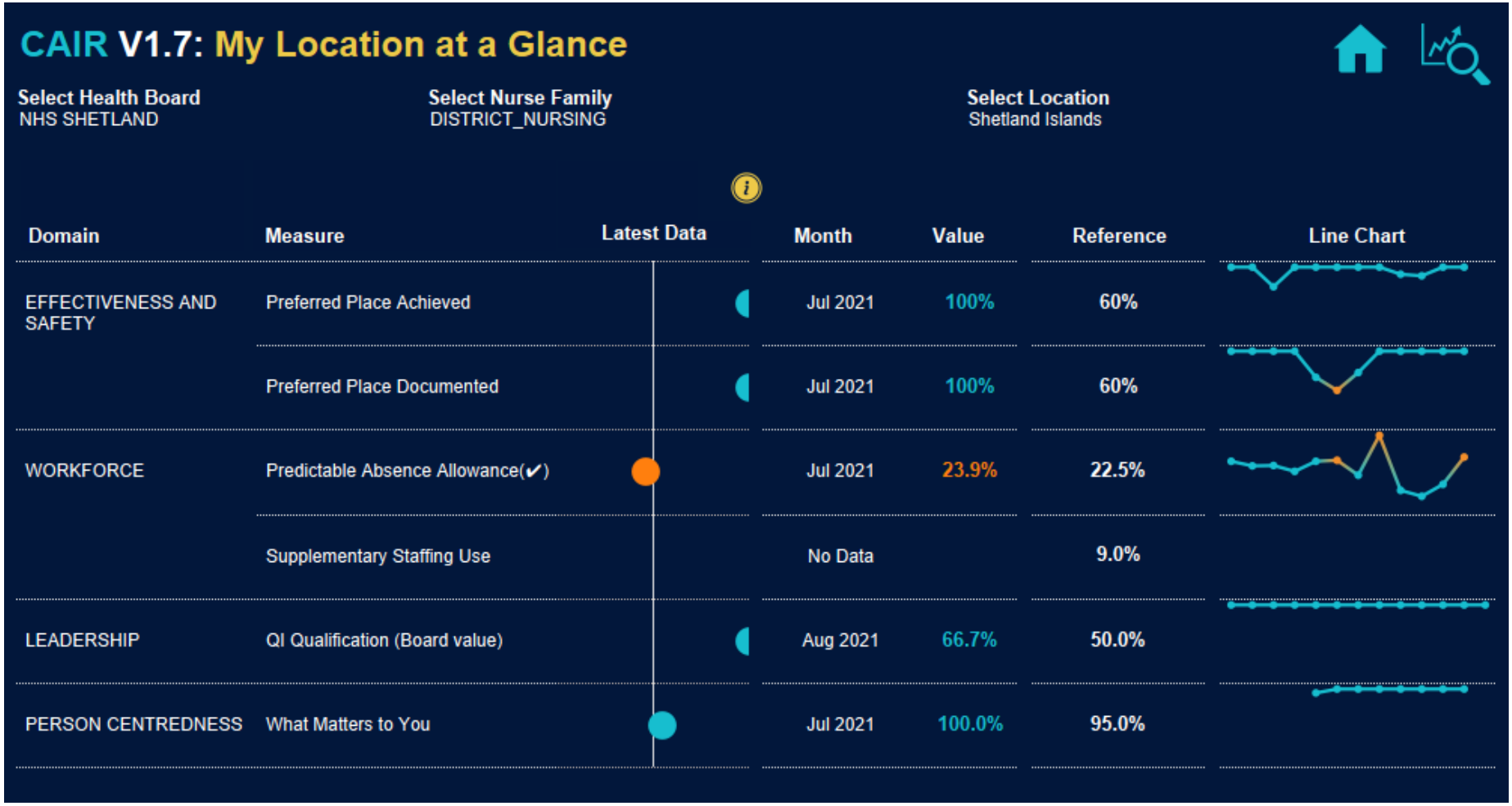
APPENDIX B – Learning points from the investigation of patients that have had a fall with harm and patients who developed pressures ulcers in Hospital in Appendix A.

FALLS					
Date	**No. of Patients**	**Avoidable/ Unavoidable**	**Appropriate Care Given?**	**Debrief Conducted?**	**Learning Points?**
June to August 2021	1	Avoidable	Yes	N/A	Assessments reviewed and care plans updated, risks mitigated where possible, remaining risks reasonable to ensure re-ablement of patient

PRESSURE ULCERS					
Date	**No. of Patients**	**Avoidable/ Unavoidable**	**Appropriate Care Given?**	**Debrief Conducted?**	**Learning Points?**
June to August 2021	3	Avoidable	No	NA	The patients who developed pressure sores were all recorded in June and were reported in the last quality report

Screenshots from the Excellence in Care Dashboard




CAIR V1.7: My Location at a Glance
Select Health Board
NHS SHETLAND
Select Nurse Family
DISTRICT_NURSING
Select Location
Shetland Islands
Domain
Measure
Latest Data
Month
Value
Reference
Line Chart
EFFECTIVENESS AND SAFETY
Preferred Place Achieved
Jul 2021
100%
60%
Preferred Place Documented
Jul 2021
100%
60%
WORKFORCE
Predictable Absence Allowance(✔)
Jul 2021
23.9%
22.5%
Supplementary Staffing Use
No Data
9.0%
LEADERSHIP
QI Qualification (Board value)
Aug 2021
66.7%
50.0%
PERSON CENTREDNESS
What Matters to You
Jul 2021
100.0%
95.0%

Appendix C – Thematic Learning from Debrief Discussions July-August 2021

Month	Number of Adverse Events Reported	Number of Category 1 Reported	Number of Moderate, Major and Extreme Events Reported	Number of Debriefs Completed or to be Completed	Thematic Learning
July 21	62	1	Extreme – 1 Major - 0 Moderate - 9	1	Adverse Event theme (8062) – Failure to follow policy / process • **Patient safety** – Caring for patient who presented on several occasions with concerns. Failure to follow process was compounded by the IT system and the methods used to record patient interactions within the system and clinical staff not being fully cognisant of the available functionality. Other mitigating factors included not adhering to the safer staffing guidelines and the department escalation policy. The Organisational Duty of Candour was applied. An improvement plan is in development to address the issues identified with a debrief to be held once confirmed
Aug 21	77	0	Extreme – 0 Major – 1 Moderate – 4	1	Adverse event theme (8142): delay in post-operative physiotherapy • **Patient safety** – pandemic resulted in the closure of the department without a business continuity plan in place to support, so we need to understand the steps to take and have a clear plan in place should this happen again. Actions include the need for clear documentation of next steps and ensure clinician discharges after making clinically reasoned decision. Also need to be more aware of the significant impact of staff well-being on ability to make clinical decisions and have appropriate measures in place for senior support
Total	**139**	**1**	**Extreme = 1 Major = 1 Moderate = 13**	**2**	

NHS Shetland Feedback Monitoring Report 2021_22 Q1

Since April 2017 all NHS Boards in Scotland have been required to further monitor patient feedback and to report performance against a suite of high level indicators determined by the Scottish Public Services Ombudsman (SPSO). This report outlines NHS Shetland's performance against these indicators for the period April to June 2021 (Q1).

Further detail, including the actions taken as a result of each Stage 2 complaint from 1 April 2021 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 at a subsequent iteration of the report). All Stage 2 complaint learning from 2020/21 was included in the Feedback and Complaints Annual Report presented to the Board in August 2021.

A summary of cases taken to the Scottish Public Services Ombudsman from April 2019 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.

Summary

- Corporate Services recorded 51 pieces of feedback in Quarter 1 of 2021_22 (1 April 20201 – 30 June 2021):

	01.04.21 – 30.06.21		01.01.21 – 31.03.21 (previous quarter)	
Feedback Type	**Number**	**%**	**Number**	**%**
Compliments	4	8	6	13
Concerns	29	57	27	57
Complaints	18	35	14	30
Totals:	**51**		**47**	

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

	01.04.21 – 30.06.21		01.01.21 – 31.03.21 (previous quarter)	
Service	**Number**	**%**	**Number**	**%**
Directorate of Acute and Specialist Services	9	50	6	42.9
Directorate of Community Health and Social Care	8	44	6	42.9
Acute and community	1	6	1	7.1
Corporate	-	-	0	-
Other	-	-	0	-
Withdrawn	-	-	1	7.1
Totals:	**18**		**14**	

Key highlights

- Complaint numbers are increasing to more typical levels, and in particular there is increased feedback regarding waiting times for non-urgent, but significantly life improving operations, access to dental and mental health services. These pressure areas are not unique to Shetland.
- We have liaised with SPSO regarding two complaints referred to them and have been advised within recent weeks that neither will be taken forward for a full investigation, as the Board's responses and actions were found to be reasonable on each occasion.
- ISD no longer collates complaint performance data on a quarterly basis. As NHS Bodies already publish annual reports covering complaints, we are asked instead to include complaints information covering nine Key Performance Indicators (KPIs).

  A standardised reporting template regarding the key performance indicators has been agreed with complaints officers and the Scottish Government.
- Compliance with complaint returns from Family Health Service providers remains minimal and for those areas that do submit the numbers of complaints recorded are negligible. This will continue to be picked up through professional leads.
- Complainant experience in relation to the complaints service provided for Stage 1 and Stage 2 complaints will be included on an annual basis given the low numbers involved.

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	01.04.21 – 30.06.21	01.01.21 – 31.03.21 (previous quarter)
Number of complaints closed at Stage One as % of all complaints	55.6% (10 of 18)	38.5% (5 of 13)
Number of complaints closed at Stage Two as % of all complaints	38.8% (7 of 18)	53.8% (7 of 13)
Number of complaints closed at Stage Two after escalation as % of all complaints	5.6% (1 of 18)	7.7% (1 of 13)

NB One Stage 1 complaint withdrawn in Quarter 3 and one Stage 2 complaint withdrawn in Q4 so not included in these figures

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

Upheld

Description	01.04.21 – 30.06.21	01.01.21 – 31.03.21 (previous quarter)
Number of complaints upheld at Stage One as % of all complaints closed at Stage One	80% (8 of 10)	60% (3 of 5)
Number complaints upheld at Stage Two as % of complaints closed at Stage Two	14.3% (1 of 7)	37.5% (3 of 8)
Number escalated complaints upheld at Stage Two as % of escalated complaints closed at Stage Two	0% (0 of 1)	12.5% (1 of 8)

Partially Upheld

Description	01.04.21 – 30.06.21	01.01.21 – 31.03.21 (previous quarter)
Number of complaints partially upheld at Stage One as % of complaints closed at Stage One	20% (2 of 10)	40% (2 of 5)
Number complaints partially upheld at Stage Two as % of complaints closed at Stage Two	71.4% (5 of 7)	25% (2 of 8)
Number escalated complaints partially upheld at Stage Two as % of escalated complaints closed at Stage Two	100% (1 of 1)	-

Not Upheld

Description	01.04.21 – 30.06.21	01.01.21 – 31.03.21 (previous quarter)
Number complaints not upheld at Stage One as % of complaints closed at Stage One	0% (0 of 10)	-
Number complaints not upheld at Stage Two as % of complaints closed at Stage Two	14.3% (1 of 7)	25% (2 of 8)
Number escalated complaints not upheld at Stage Two as % of escalated complaints closed at Stage Two	0% (0 of 1)	-

3 The average time in working days for a full response to complaints at each stage			
Description	**01.04.21 – 30.06.21**	**01.01.21 – 31.03.21 (previous quarter)**	**Target**
Average time in working days to respond to complaints at Stage One	5.3	6	5 wkg days
Average time in working days to respond to complaints at Stage Two	30	27.7	20 wkg days
Average time in working days to respond to complaints after escalation	12	37	20 wkg days

*Response times for Stage 2 complaints remain significantly impacted upon by capacity due to the Covid-19 Pandemic.

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	**01.04.21 – 30.06.21**	**01.01.21 – 31.03.21 (previous quarter)**	**Target**
Number complaints closed at Stage One within 5 working days as % of Stage One complaints	80% (8 of 10)	40% (2 of 5)	80%
Number complaints closed at Stage Two within 20 working days as % of Stage Two complaints	28.57 (2 of 7)	43% (3 of 7)	80%
Number escalated complaints closed within 20 working days as % of escalated Stage Two complaints	100% (1 of 1)	0% (0 of 1)	80%

5 The number and percentage of complaints at each stage where an extension to the 5 or 20 working day timeline has been authorised.		
Description		**01.01.21 – 31.03.21 (previous quarter)**
% of complaints at Stage One where extension was authorised	20% (2 of 10)	60% (3 of 5)
% of complaints at Stage Two where extension was authorised	71.43% (5 of 7)	57% (4 of 7)
% of escalated complaints where extension was authorised	0% (0 of 1)	100% (1 of 1)

Learning from complaints

For Quarter 1 noted above, restrictions resulting from the Covid-19 Pandemic have contributed to concerns being raised about potential waiting times. Restrictions aimed at lowering footfall in clinical settings have also contributed to some communication difficulties.

Staff Awareness and Training

Staff are provided with key information on feedback and complaint handling at each induction session. Staff attending mandatory refresher training are given an update sheet on feedback and complaints. The Feedback and Complaints Officer is continuing to speak with departments to try and empower more people to feel confident to handle a Stage 1 complaint or signpost effectively to the appropriate support. Reminders have been put in staff briefings.

A management bundle on feedback and complaints has been developed for delivery by the Feedback and Complaints Officer. Staff are also 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 2021 to 30 June 2021

	Summary	Staff Group(s)	<= 20 wkg days	If not, why	Outcome	Findings/Actions
1	Treatment and care in the hospital	Medical and nursing	N	Availability of key personnel	Part upheld	• Diagnosis and treatment considered reasonable given the medical background the patient presented with. • Learning points identified with aspects of the nursing care.
2	Lack of care following injury, and concerns about treatment thereafter	Medical	N	Delay in final statement	Part upheld	• No evidence found to support that the clinical team had acted inappropriately in terms of treatment, however it was recognised the complainant had found certain aspects of their hospital stay unprofessional and an apology was provided for this.
3	Repeated failure to listen to patient and family about diagnosis	Medical	Y		Part upheld	• No evidence to suggest the miscommunication had any influence on the treatment plan, however the medical team recognised they could have resolved the patient's concerns earlier and apologised for the frustration this had caused. • Meeting with patient and family about this matter and ongoing health concerns.
4	Concerns about treatment over a number of years and failure to listen to patient about pain levels	Medical and AHP	N	Delay in a statement and capacity to conclude investigation	Part upheld	• Concluded that the medical team had made an effort to listen and all recognised the pain experienced was causing disability, however despite best intentions they had not managed to effectively manage pain. • Primary Care team to reflect on learning where there are multiple teams and clinicians involved as to how to create the best person-centred approach and consistency of messaging.
5	Care provided following falls	Medical and Social Care	N	Broad investigation across two organisations	Upheld	• Communication failures identified, which had they been avoided may have resulted in a better outcome for the patient. • Review of medical status of patients within health and care services to ensure the information provided is

						sufficient to enable the most appropriate care for the needs of the individual.
6	Staff attitude (escalated from Stage 1)	Admin	Y		Part upheld	• Recognised interaction was not positive for either party. • Apologies offered for the delay in getting answers about family member care resulting from the pandemic, and explanation provided about next steps. • Consideration of recording calls if and when the functionality becomes available to the department.
7	Concern prescription is incorrect and patient is not being listened to due to racial prejudice	Medical	Y		Part upheld	• Medication was correct but the patient's wish for two lower doses had not been explained. • No evidence found to support patient's view of racial prejudice. • As a newly registered patient a telephone consultation would have been beneficial given the medication required. • Medication review to be carried out.
8	Lack of treatment following injury	AHP	N	Complexity of response including input from a number of external clinicians	Not upheld	• Wording of discharge letter clarified with author and further explained to family. • Professionals meeting to be held to enable a holistic discussion of ongoing care needs. • Recommendation to adopt a case specific professional group for patients discharged to NHS Shetland in order to provide an early opportunity for all those involved in an individual's care to fully discuss discharge advice and ongoing care requirements.

Cases escalated to the Scottish Public Services Ombudsman from 1 April 2019 to 15 September 2021

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 2019/20								
21.10.19	2018_19_24	201902265	Unreasonable attempt to continue procedure and should have been stopped sooner	09.06.20	Upheld	1. Letter of apology for the failings identified by 10.08.20 2. Evidence that this matter has been fed back to relevant medical staff in a supportive manner that encourages learning by 09.10.20 3. Evidence that the junior doctor included this case in their appraisal by 10.08.20	File submitted 07.11.19 Letter of apology sent to family Evidence sent to SPSO for all three actions 10.08.20	Considered closed by SPSO
09.01.20	2019_20_16	201908764	GP attitude during consultation	09.01.20	Will not take forward	None		Closed
Notified 2020/21								
12.08.20	2018_19_18	201907983	Complication following surgical procedure	07.01.21	Will not take forward	None	Additional information submitted for consideration	Closed
02.03.21	2019_20_08	202007880	Care provided following off island procedure	26.08.21	Will not take forward	Has determined the Board's responses to be reasonable and no significant issues overlooked.	Files submitted for review	Closed
Notified 2021/22								
30.04.21	2020_21_18	202008807	Care provided by CMHT	07.07.21	Will not take forward	Response reasonable based on the advice received.	Files submitted for review	Closed

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

Hospital Cleanliness Survey – May 2021

Background

The first Hospital Cleanliness Survey was carried out in 2016. The intention is to carry out the survey on a yearly basis to assess patients and visitors perception of the cleanliness of the hospital and Infection Prevention and Control measures in place.

Results are fed back at ward level through 'you said, we did' posters and to relevant stakeholders including at Board level through the Control of Infection Committee.

Aims

- To gather feedback from patients/relatives/visitors about their experience of the cleanliness of the hospital
- To identify areas for improvement
- To understand peoples' concerns with regard to the risk of infection while in hospital
- To improve the infection control measures across the hospital

Timescale

This was undertaken for three weeks at the end of March/beginning of April.

Methodology

Questionnaires were given to each of the hospital areas and staff were asked to pass on to patients/relatives/visitors to complete and return to reception in an envelope provided.

A new section was added to the questionnaire which focussed on questions relating to COVID-19 and the changes that have taken place within the hospital as a result.

Auditor

The survey was undertaken by the Infection Control Nurses: Linda Turner and Michelle Wilkinson.

Sample size:

Please see the table below showing the number of questionnaires provided to each area and the number of responses received:

Hospital Location	Questionnaires on the Ward/Unit	Responses Received	Response Rate
Ward 1	30	25	83%
Ward 3	30	14	47%
Maternity	20	6	30%
Renal	10	8*	100%
Day Surgery	30	29	97%

* Please note that there were only 8 patients requiring dialysis at the time of the survey

Results

In each of the tables below, the denominator (the total number of applicable responses) is given for each area (N=) – please note that the numbers of any 'Not applicable' responses or questions not answered have been removed from the denominator.

Q1. Are you a:

	Ward 1 (N=25)	Ward 3 (N=14)	Maternity (N=6)	Renal (N=8)	Day Surgery (N=29)
Patient	22 (88%)	13 (93%)	6 (100%)	8 (100%)	29 (100%)
Relative	3 (12%)	1 (7%)	0	0	0
Visitor	0	0	0	0	0
Not answered	0	0	0	0	0

Q2 (a). Have you received/seen any information about preventing infections?

	Ward 1 (N=25)	Ward 3 (N=14)	Maternity (N=6)	Renal (N=8)	Day Surgery (N=29)
Yes	21 (84%)	12 (86%)	4 (67%)	6 (75%)	27 (93%)
No	2 (8%)	1 (7%)	2 (33%)	2 (25%)	1 (3%)
Unsure	2 (8%)	1 (7%)	0	0	1 (3%)
Not answered	0	0	0	0	0

Q2 (b). If yes, please, tick all that apply

	Ward 1 (N=25)	Ward 3 (N=12)	Maternity (N=3)	Renal (N=6)	Day Surgery (N=27)
Coming to hospital leaflet	9 (36%)	3 (25%)	0	1 (17%)	18 (67%)
Hand hygiene poster	15 (60%)	10 (83%)	3 (100%)	5 (83%)	18 (67%)
Patient information folder	8 (32%)	4 (33%)	1 (33%)	1 (17%)	11 (41%)
Infection Control notice board	12 (48%)	6 (50%)	1 (33%)	4 (67%)	9 (33%)
Other	2 (8%)	2 (17%)	1 (33%)	0	0
Not applicable	0	2	2	2	1
Not answered	0	0	1	0	1

Comments related to Q2b		
1	Ward 1	I was a transfer in from Aberdeen
2	Ward 1	Wearing a face mask
3	Ward 3	COVID Info
4	Ward 3	Information on wearing a face mask
5	Maternity	Been spoken to

Q3. Have you observed staff cleaning their hands?

	Ward 1 (N=25)	Ward 3 (N=14)	Maternity (N=6)	Renal (N=8)	Day Surgery (N=27)
Always	21 (84%)	12 (86%)	5 (83%)	7 (88%)	23 (85%)
Most of the time	4 (16%)	1 (7%)	1 (17%)	1 (13%)	2 (7%)
Sometimes	0	1 (7%)	0	0	1 (4%)
Rarely	0	0	0	0	1 (4%)
Never	0	0	0	0	0
Not applicable	0	0	0	0	0
Not answered	0	0	0	0	2

Comments related to Q3		
1	Ward 1	The staff are always cleaning their hands, I am not clear how they have skin still on their hands!
2	Ward 1	Haven't always been watching
3	Ward 1	Very clean
4	DSU/Ronas	Not at the moment but I have just got here, I am sure I will see though later

Q4. Do you have the opportunity to clean your hands?

	Ward 1 (N=25)	Ward 3 (N=14)	Maternity (N=6)	Renal (N=7)	Day Surgery (N=29)
Always	23 (92%)	13 (93%)	6 (100%)	7 (100%)	26 (90%)
Most of the time	0	0	0	0	3 (10%)

	Ward 1 (N=25)	Ward 3 (N=14)	Maternity (N=6)	Renal (N=7)	Day Surgery (N=29)
Sometimes	2 (8%)	1 (7%)	0	0	0
Rarely	0	0	0	0	0
Never	0	0	0	0	0
Not applicable	0	0	0	0	0
Not answered	0	0	0	1	0

Comments related to Q4		
1	Ward 1	Very clean
2	Ward 1	Staff excellent
3	Renal	On entering and exiting

Q5. Is the ward/department clean?

	Ward 1 (N=24)	Ward 3 (N=14)	Maternity (N=6)	Renal (N=7)	Day Surgery (N=28)
Always	21 (88%)	12 (86%)	6 (100%)	6 (86%)	27 (96%)
Most of the time	2 (8%)	2 (14%)	0	1 (14%)	1 (4%)
Sometimes	1 (4%)	0	0	0	0
Rarely	0	0	0	0	0
Never	0	0	0	0	0
Not applicable	0	0	0	0	0
Not answered	1	0	0	1	1

Comments related to Q5		
1	Ward 1	Spotless

Q6. Do you think equipment is clean and in good condition?

	Ward 1 (N=24)	Ward 3 (N=14)	Maternity (N=6)	Renal (N=8)	Day Surgery (N=28)
Always	21 (88%)	12 (86%)	6 (100%)	6 (75%)	27 (96%)
Most of the time	2 (8%)	2 (14%)	0	2 (25%)	1 (4%)
Sometimes	1 (4%)	0	0	0	0
Rarely	0	0	0	0	0
Never	0	0	0	0	0
Not applicable	0	0	0	0	0
Not answered	1	0	0	0	1

Comments related to Q6		
1	Ward 1	Immaculate

Q7. If you have a concern about infection control, would you feel comfortable speaking to a member of staff about it?

	Ward 1 (N=24)	Ward 3 (N=14)	Maternity (N=6)	Renal (N=8)	Day Surgery (N=28)
Yes	23 (96%)	13 (93%)	6 (100%)	8 (100%)	27 (96%)
No	1 (4%)	0	0	0	1 (4%)
Unsure	0	1 (7%)	0	0	0
Not applicable	0	0	0	0	0
Not answered	1	0	0	0	1

Comments related to Q7		
1	DSU/Ronas	On admission staff went through hygiene etc. in relation to COVID

ADDITIONAL QUESTIONS RELATED TO COVID-19

Q8. Have you received guidance on how to perform good hand hygiene and safe mask wearing?

	Ward 1 (N=24)	Ward 3 (N=14)	Maternity (N=5)	Renal (N=8)	Day Surgery (N=28)
Yes	22 (92%)	12 (86%)	3 (60%)	7 (88%)	25 (89%)
No	2 (8%)	2 (14%)	2 (40%)	1 (13%)	3 (11%)
Not applicable	0	0	0	0	0
Not answered	1	0	1	0	1

Q9. Do you feel safe being in/visiting the hospital during the COVID-19 pandemic?

	Ward 1 (N=23)	Ward 3 (N=14)	Maternity (N=6)	Renal (N=8)	Day Surgery (N=28)
Yes	23 (100%)	14 (100%)	6 (100%)	8 (100%)	28 (100%)
No	0	0	0	0	0
Not applicable	0	0	0	0	0
Not answered	2	0	0	0	1

Q10. Do you think the infection control measures put in place are adequate?

	Ward 1 (N=24)	Ward 3 (N=14)	Maternity (N=5)	Renal (N=8)	Day Surgery (N=27)
Yes	24 (100%)	14 (100%)	5 (100%)	7 (88%)	27 (100%)
No	0	0	0	0	0
Unsure	0	0	0	1 (13%)	0
Not applicable	0	0	0	0	0
Not answered	1	0	1	0	2

Q11. Do you think there is enough signage relating to COVID-19 throughout the hospital?

	Ward 1 (N=23)	Ward 3 (N=14)	Maternity (N=6)	Renal (N=8)	Day Surgery (N=27)
Yes	23 (100%)	14 (100%)	6 (100%)	8 (100%)	26 (96%)
No	0	0	0	0	1 (4%)
Not applicable	1	0	0	0	0
Not answered	1	0	0	0	2

Comments related to Q11		
1	Ward 1	Do not know about the signage - I was a transfer in from Aberdeen

Q12. Feel free to leave any further comments in the box below:

Further Comments		
1	Ward 1	Staff very pleasant and helpful
2	Ward 1	Good
3	Ward 1	Good
4	Ward 1	Pillows and sheets not comfortable or in good condition
5	Renal	Staff are exemplary and diligent
6	Renal	All staff are very professional and always follow procedures and policies
7	Renal	Well done NHS Shetland!
8	DSU/Ronas	I am a member of staff so didn't need further information about preventing infections/guidance on how to perform good hand hygiene and safe mask wearing
9	DSU/Ronas	Spot on
10	DSU/Ronas	Hospital very clean
11	DSU/Ronas	Felt very safe

Conclusion

A high percentage of respondents gave positive responses in this year's survey, this was particularly encouraging in times of the COVID 19 pandemic.

The number of respondents were lower than last year in some areas and there were less comments generally. This will be reviewed with an aim to improve the response in future surveys.

The results will be shared with stakeholders and at ward level through 'you said, we did' posters.

Recommendations

- To repeat the survey again in 2021/2022
- Evaluate the format of the survey following this year's survey
- Feedback to results to staff and the importance of encouraging patients and visitors to complete survey

Action Plan

Action	Person(s) Responsible	Update	Target Date
To feedback the results at the SCN meeting and encourage the sharing of results with the staff	Linda Turner (LT) Michelle Wilkinson (MW)	Completed 16/09/2021	19/08/2021
To produce 'You said, we did' feedback posters displaying the results	Fiona Morgan	Completed 16/09/2021	13/08/2021
Update the Infection Control folders by the bedside	Ward staff with support from LT and MW		31/10/2021
Remind staff to inform patients about the Infection Control information available to them	Linda Turner Michelle Wilkinson	Completed 19/08/2021	19/08/2021
Continue to monitor the integrity of pillows and sheets weekly	Ward staff & During ICT environmental audits		Ongoing

Action	Person(s) Responsible	Update	Target Date
Run education sessions on the format and importance of audit and surveillance	Covered by LT & MW at SCN meetings, link nurse meetings and at ward level		On going
To review the questions on the questionnaire before running the survey again	Linda Turner, Michelle Wilkinson, Fiona Morgan, Camille Brizell and Lay member of the public		31/01/2021