People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

INWO
Bridgeside House
99 McDonald Road
Edinburgh
EH7 4NS

Tel **0800 008 6112**
Web **www.inwo.org.uk**

Report of the Independent National Whistleblowing Officer

Overview

Scottish Parliament Region: North East Scotland

Case ref: 202310423

NHS Organisation: Grampian NHS Board

Subject: Patient Safety/Handling of whistleblowing concern

This is the report of the Independent National Whistleblowing Officer (INWO) on the outcome of an investigation of a whistleblowing complaint about patient safety and the handling of a whistleblowing concern. It is published in terms of section 15(1) of the Scottish Public Services Ombudsman Act 2002 which sets out the INWO's role and powers. There is more information about this here: https://inwo.spso.org.uk/

Supported by the public and confidential appendices, it is a full and fair summary of the investigation.

Executive summary

1. The complainant (C) complained to the INWO about Grampian NHS Board (the Board). C raised concerns about the lack of service planning, compliance with National Service Standards and the relocation of the service's advice line. These concerns were investigated under the National Whistleblowing Standards. However, C was dissatisfied with the Board's response and complained to the INWO.

2. The complaint I have investigated is:

   2.1. the Board failed to adequately plan for a specific service at Dr Gray's Hospital. **(upheld)**

   2.2. the Board failed to ensure the service was being delivered in line with National Service Standards. **(upheld)**

2.3. the Board failed to ensure an adequate advice line service for patients using the specific service at Dr Gray's Hospital. **(upheld)**

3. As a result of my findings, the Board have been asked to implement a number of recommendations, and to consider and reflect on other feedback.

Publication

In the interests of transparency and sharing learning to drive improvement, the INWO makes public the details of findings and conclusions as far as she is able. The INWO cannot make public every detail of her report. This is because some information must be kept confidential because the Act says that, generally, reports of investigations should not name or identify individuals. In this context in the report names have been pseudonymised, and gender-specific pronouns and titles removed.

Approach

The investigation

4. The INWO is the final stage of the process for those raising whistleblowing concerns about the NHS in Scotland. The INWO has a remit to consider complaints from whistleblowers about how their concerns have been handled and the actions taken in respect of those concerns.

5. For something to be whistleblowing, it must be in the public interest, rather than primarily concerned with a personal employment situation. In this case, I was satisfied that there was a public interest in C's concerns given potential impacts to patients using the service.

6. In order to investigate C's complaint, the INWO:

   6.1. took evidence from C in written format and by telephone

   6.2. obtained and reviewed the Board's Stage 2 report and investigation file

   6.3. obtained comments and documentary evidence from the Board

   6.4. reviewed relevant guidance, and

   6.5. obtained professional advice from an adviser who is a clinician with knowledge and experience within the service specialism.

7. Evidence was analysed, assessed and weighed, and from that, findings and recommendations made, and a decision taken. This report and supporting appendices provide a summary of the evidence upon which I relied, and my findings and recommendations. A high-level summary of the evidence considered is provided in public Appendix B.

8. C and the Board were given an opportunity to comment on a draft of this report.

Presentation of evidence and analysis

9. The evidence upon which I have relied in making my findings, decision and recommendations is summarised in a series of appendices. These appendices also include analysis of the evidence.

10. The requirement for confidentiality and need to protect the identity of C and others involved in the investigation means that not all of these appendices are published, nor is it appropriate for people within the Board, to have sight of them, other than those who need to know. This document includes a Summary of documents that make up the full INWO report, including a list of the appendices and the restrictions relating to their publication and sharing.

Background

11. C works in a service at Dr Gray's Hospital (DGH). After raising concerns through business as usual routes for several years about service provision and planning, they raised a whistleblowing concern in 2023. Their overall concern was that the service was unsustainable due to a lack of service planning over a number of years. The concern was investigated under the Standards.

12. In their Stage 2 response, the Board acknowledged that the service was unsustainable and was on the hospital's risk register. However, they explained to C that planning for a Pan Grampian service (regional) was underway and the delivery of the service would be considered as the plan was developed and options for joint working explored.

Findings and decision

Point 2.1 The Board failed to adequately plan for the service at DGH

13. C was concerned that the Board's response to their whistleblowing concerns lacked detail in terms of timescales, risk assessment and evidence of any progress made toward a Pan Grampian plan for the service.

14. Concerned that the lack of a current service plan posed a risk to patient safety and that no consideration had been given to the impact a Grampian wide service would have on staff and patients in terms of patient care and access to local services, C complained to the INWO.

15. The key issues considered under this complaint were C's concerns that:

    15.1. the Board's response had not provided adequate detail of the proposed Pan Grampian Plan for the service.

15.2. there was no indication of timescales for the implementation of the Pan Grampian Plan or of any progress made on the development of the plan.

15.3. the lack of service planning and capacity within the service had impacted staff access to training and supervision.

15.4. there was no evidence of local consultation having taken place when developing a Pan Grampian Plan.

15.5. the Board's response had not provided evidence of any risk assessment carried out when deciding to move services to Aberdeen Royal Infirmary (ARI) or when incorporating the current service into the Pan Grampian Plan.

16. In response to my investigation, the Board provided:

16.1. a copy of the complaint file, including the investigation report and summaries of staff interviews

16.2. a copy of the Service Plan for 2019—2020

16.3. and a copy of the Proposal Paper for the service, dated May 2024

17. The Board's position was:

17.1. The service at DGH is unsustainable due to there only being a single specialist Consultant, recruitment difficulties, capacity and facilities. The Board hoped that joint working across the region would equalise waiting times and provide an equitable service for all patients. Waiting times at DGH are longer than at ARI and a Pan Grampian Service would redress the balance.

17.2. The service had not been reduced and patients were not at risk, as joint working arrangements were in place at other hospitals. The Board advised that further development of these services would be required and would be taken forward when developing the Pan Grampian service.

17.3. A training needs analysis would be carried out and training and supervision arrangements would be included in the Pan Grampian Plan.

17.4. Full engagement and consultation with all staff groups and stakeholders would occur as the Board worked through a service redesign plan.

18. To test and consider this, the INWO's investigation considered the evidence discussed in private Appendix A.

2.1 Findings

19. I took into account written correspondence provided by the Board and the complainant, the complaint file from the Board and sought the advice of an independent clinical adviser (the Adviser), with further details provided in public Appendix B. I have set out my detailed consideration of the specific issues raised by C in private Appendix A. My key findings are set out below:

20. Having reviewed the Board's Stage 2 response to C's concerns, I found attempts were made to reassure C that the concerns raised would be addressed and potentially resolved through the development of a Pan Grampian Plan for the service. However, minimal detail was provided in terms of what the plan entailed, of progress made to date and of timescales for implementation. This led C to believe that the Board had not taken their concerns seriously, and they were doubtful about the future of the service.

21. I note and accept the Adviser's comments regarding the lack of risk assessment carried out when changes were made to the Service, the absence of a risk-based approach in the Board's proposal for a Pan Grampian Service, and the lack of consultation with staff and patients prior to changes being made. I found that the Board missed a number of opportunities to further assess patient risk when C's concerns were investigated through the whistleblowing process; and the Stage 2 response does not provide any evidence that risk to patients had been considered by the Board.

22. I also found no evidence that the Board had considered whether an Equalities Impact Assessment (EQIA) was required when planning for the Pan Grampian Service.

23. I acknowledge the Board's position that staff training and supervision would be considered as part of the Pan Grampian Plan; however I also note and accept the Adviser's comment that these needs should be reviewed without waiting for the service plan. I therefore found the Board's response to C's concerns about training and supervision to be insufficient, as an immediate and detailed plan was required.

24. I also note and accept the Adviser’s concern that the Board’s proposal for a Pan Grampian Service appeared to be in its infancy, having been presented in May 2024. Given that the fragility of the service had been known for a number of years, I would have expected the Board to be able to show that this work is being prioritised and supported in the form of a fully developed and detailed service plan. I found this not to be the case.

2.1 Decision

25. The point of complaint I have investigated is that the Board failed to adequately plan for the service. This included consideration of the Board’s response to C’s whistleblowing concerns, the current service plan, the detail within the proposed Pan Grampian Service Plan, evidence of progress made toward its’ implementation and the level of risk assessment carried out by the Board.

26. In making my decision, I recognise the significant pressures facing NHS organisations in terms of service planning and acknowledge that the planning focus shifted in response to the COVID-19 pandemic. I also note and accept the Board’s position that, due to the unsustainability of the service in its current form, their intention is to explore opportunities for joint working across the region and for services to be delivered in larger, more adequately resourced settings.

27. However, given the fragility of this service locally and its inclusion on the hospital’s risk register, I have found no evidence that the Board have prioritised planning for these changes. I have found that minimal progress has been made toward developing a plan and no meaningful consultation on the future of the service has happened. The proposal paper provided by the Board in response to this investigation lacks detail, there are no clear timescales and no evidence of risk assessment.

28. In light of the various issues, I **uphold** the complaint that the Board failed to adequately plan for the service.

Point 2.2. The Board failed to ensure the service was being delivered in line with National Service Standards

29. C raised a concern with the Board that the service was not being delivered in line with National Service Standards[1].

30. The key issues considered under this complaint were C's concerns that:

30.1. there was no regular review or oversight of patients undergoing specialist therapies.

30.2. Multi-Disciplinary Team meetings (MDT's) were being held at ARI, 70 miles away. C stated the service had not been invited to attend MDT's and, due to the patient population, C was concerned that the time available to discuss local patients would be limited.

31. In response to my investigation, the Board provided:

31.1. a copy of the complaint file which included the investigation report and a summary of staff interviews

31.2. a copy of the Service Plan for 2019-2020

31.3. a Proposal Paper for the service, dated May 2024, and

31.4. a copy of the Secondary Care Hub Guidance 2024

32. In summary, the Board's position was:

32.1. The service is being delivered in accordance with National Service Standards however, infrastructure and capacity at DGH is limited to deliver all pathways locally.

32.2. There are challenges regarding the delivery of the specialist therapy which will be addressed as part of the Pan Grampian service planning process.

32.3. There had been no local MDT's taking place, however, the Consultant now links in with a Pan Grampian MDT. This allows for new and repeat requests

[1] There are a number of National Service Standards applicable to the delivery of these services, which are detailed in private Appendix A and public Appendix B.

to be looked at and also allows access to Grampian wide resources to even up waiting lists. MDT arrangements will form part of the Pan Grampian Plan.

33. To test and consider this, the INWO's investigation considered the evidence summarised in public Appendix B and discussed in private Appendix A.

2.2 Findings

34. The National Service Standards relevant to this complaint, make clear the importance of regular review, in particular for patients undergoing specialist therapies, regular MDT meetings to discuss patients and the prompt availability of specialist MDT care for patients.

35. Having reviewed the Stage 2 response issued to C with regard to their concerns about the service not being delivered in line with the National Service Standards, I found the Board's response to be insufficient. It is not enough to simply state that the Standards are being met. I would have expected the Board to have provided evidence as to how each of the relevant Standards are being delivered. Where standards cannot be met at DGH, I would have expected greater detail on how these standards would be delivered by a Pan Grampian Service Plan. However, as I found under point 2.1 of this complaint, planning for this has been insufficient and from the information provided by the Board, it remains unclear how the service at DGH and the Pan Grampian Service will deliver a service in line with the relevant National Standards.

36. Due to the lack of information provided by the Board when asked to provide further detail around the delivery of the specialist therapy, I noted the Adviser was unable to determine whether National Service Standards are being met. It was unclear to the Adviser how patients from the local area were assessed and monitored and opinions varied among staff interviewed as to whether Service Standards were being met.

37. I note and accept the Adviser's comment that it is unclear from the information provided by the Board how involved staff at DGH are in terms of clinical decision making for their patients, and whether there is fair and proportionate representation of this group of patients being discussed at MDT.

38. I found that while clinicians at DGH may be able to attend the Grampian wide MDT meetings, regular attendance may not be possible due to lack of capacity and there is no formal process in place to ensure either attendance or inclusion of local patients in MDT discussions. Greater detail in the Board's response regarding MDT arrangements could have provided reassurance to C that their service would be included at a Pan Grampian level and the risk to patients would be mitigated by regular review at MDT meetings.

39. I acknowledge and accept that the service at DGH is unsustainable and that achieving National Service Standards may be difficult due to infrastructure, resources and capacity; hence the need for a Pan Grampian Service. However, I found the Board's proposal for a Pan Grampian Service lacked detail in terms of how it would meet each of the standards set for the service. As per point 2.1, it is vital that the Board prioritises the development and implementation of the Pan Grampian Plan and this must include consideration of how a Grampian wide service meets the relevant National Service Standards.

2.2 Decision

40. The point of complaint I have investigated is that the Board failed to ensure the service was being delivered in line with National Service Standards. This included consideration of the positions of both C and the Board and advice from the Adviser.

41. It is disappointing that the Board's response to C's concerns about National Service Standards not being met lacked detail. This was an opportunity for the Board to reassure C that their concerns were being taken seriously, to acknowledge that due to the unsustainability of the service at DGH there were difficulties in meeting National Service Standards, and to detail how the relevant standards would be delivered via a Pan Grampian Service.

42. However, the information provided by the Board did not provide reassurance or clarity as to whether the service at DGH is being delivered in line with National Service Standards or how a Pan Grampian Service will achieve this. On this basis, I **uphold** C's complaint that the Board failed to ensure the service was being delivered in line with National Service Standards

Point 2.3. The Board failed to ensure an adequate advice line service for patients

43. C raised a concern with the Board about the provision of the advice line for patients at DGH. The advice line allowed local patients and GPs to call for advice but the service was now provided from ARI, over 70 miles away.

44. The key issues I considered under this complaint were C's concerns that:

44.1. a local advice line was particularly vital due to the geography of the area, with many of the patients on medication which requires regular review

44.2. with the closure of the advice line, patients no longer had access to a local service, and

44.3. when the advice line closed, patients were left unaware of the support options available to them.

45. In response to my investigation, the Board provided:

45.1. a copy of the complaint file which included the investigation report and a summary of staff interviews

45.2. a copy of the Service Plan for 2019—2020, and

45.3. a Proposal Paper for the service, dated May 2024

46. In summary, the Board's position was:

46.1. the advice line is now managed from ARI by specialist nurses and the team aims to respond within 48 hours

46.2. along with the advice line, support for local patients is provided through a number of pathways and the local Consultant can email colleagues from ARI for support and,

46.3. there are plans to improve the helpline to increase efficiency and ensure patients have access to the support they need.

47. To test and consider this, my investigation considered the evidence summarised in public Appendix B, and discussed in private Appendix A.

2.3 Findings

48. Having reviewed the Stage 2 response to C's concern about the provision of the advice line, I found the Board's response to be insufficient in terms of detail, risk assessment and consideration of how patients from DGH are managed once they contact the advice line.

49. I note and accept the Adviser's comments that without an adequate risk assessment, and formal arrangement to ensure the attendance of local clinicians at MDT meetings, the provision of the advice line in its current form is not in the best interests of patients from DGH. Communication is key to patient management and decisions made without the local clinical team being involved risk information being lost.

50. Having reviewed the Board's Proposal Paper for the Pan Grampian Service, I found minimal detail relating to the advice line. I also found that there has been a lack of clear communication to patients about the changes and the support available to them and no formalisation of the relationship between both hospitals to ensure a closer working relationship. The plan did not make clear whether patients from DGH are under the care of the local team or colleagues from ARI. The plan also lacks clarity regarding who is responsible for the care of a patient from DGH when they contact the advice line. Overall, I found the information provided by the Board in relation to how the current advice line functions to be insufficient.

2.3 Decision

51. The complaint point I investigated is whether the Board failed to ensure an adequate advice line service for patients. This included consideration of the positions of both C and the Board and advice from the Adviser.

52. I found the Board's decision to move the advice line to ARI to be reasonable. The service had been stopped locally, due to capacity and by moving the advice line, the Board ensured contact with local patients could be maintained.

53. I recognise that the Pan Grampian Plan for the service is in its infancy and as the plan progresses, the Board should be able to better evidence the delivery of the advice line. However, I am not reassured that the evidence provided by the Board

in response to C’s complaint and to this investigation demonstrates that the advice line in its current form is in the best interests of local patients. I found no evidence of a risk assessment being carried out when the decision was taken to move the advice line and found the details around how the care of patients is managed once they do contact the advice line to be minimal.

54. I find therefore that there is sufficient evidence, on balance, to **uphold** C’s complaint that the Board failed to ensure an adequate advice line service for patients.

Recommendations

Learning from complaints

The Independent National Whistleblowing Officer expects all organisations to learn from complaints. The learning should be shared with those responsible for whistleblowing as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation.

What INWO are asking the Board to do to improve the way they do things:

Rec. No	What I found	Outcome needed	What INWO need to see
1.	Under 2.1 I found The Board failed to adequately plan for a specific service at DGH In particular I found • a lack of priority in developing a Pan Grampian Plan for the Service, despite the unsustainability of the service at DGH and its inclusion on the hospital's risk register. • The Pan Grampian Plan to be at an early stage, with no detail	The Board develops and implements a Pan Grampian Service Plan. This should include: • Securing and defining organisational support from the Board to assist the service in the planning process. • A plan for improved communication with the team at DGH who should be involved in the development of the Pan Grampian Service Plan. • A clear consultation plan with staff at DGH and its patient population.	A plan which evidences the actions and timescales to prioritise, develop, and implement a risk-based Pan Grampian Service Plan, reflecting the findings in this report. By: **16 April 2025**

Rec. No	What I found	Outcome needed	What INWO need to see
	around timescales, risk assessment, service delivery and consultation with staff and patients.	• A gap analysis using the National Service Standards as a benchmark and then risk assessment of current arrangements to inform target areas for priority work. • Training and staff supervision with an immediate focus on review of staff access to appraisals, training and CPD to deliver safe patient services in line with standards and guidance. • How communications between the teams at DGH and the ARI will be improved and how they will work in a more integrated way with their respective views being listened to.	

Rec. No	What I found	Outcome needed	What INWO need to see
2.	Under 2.2 I found: The Board failed to ensure the Service was delivered in line with National Service Standards. In particular I found: • a lack of detail around how the service in its current form and in the proposed Pan Grampian Plan meets the National Service Standards. • The current MDT arrangements in terms of meetings, patient care, and review to be unclear. • Uncertainty around whether specialist therapies are being delivered in line with the National Service Standards.	The Pan Grampian Plan should deliver a service which meets the requirements and standards set out in the National Service Standards.	Evidence that the Pan Grampian Plan for the Service details how National Service Standards are being met across each of the specialisms, or that there is a clear timetable for this set out in the action plan. By: **16 April 2025**

Rec. No	What I found	Outcome needed	What INWO need to see
3.	Under 2.3 I found The Board failed to ensure an adequate advice line service for patients using the specific service at DGH. In particular I found: • A lack of risk assessment when the decision was taken to move the advice line service to Aberdeen. • A lack of clarity regarding the ongoing management of patients from DGH who call the advice line.	Patient's at DGH should have access to an adequate advice line that meets National Service Standards. This should be based on • risk assessment of the decision to move the advice line from DGH to ARI • consideration of any accessibility issues for the patient population in Moray • clarity regarding MDT arrangements and how patients from Moray who call the advice line are managed.	Evidence that the findings of this investigation have been incorporated into the Pan Grampian Plan as it relates to the provision of the advice line. By: **16 April 2025**

Feedback for the Board

Whistleblowing concerns handling

1. C complained to INWO about the Board's handling of their concern, stating that there was failing with communication, updates, timescales and a failure to recognise the impact the whistleblowing process had on C. I note from the Stage 2 response and through further correspondence provided to INWO that the Board acknowledged and accepted these failings and offered to apologise to C. I also note the actions already taken by the Board to improve their concerns handling and evidence of good practice in terms of regular meetings with C and extra support provided to help C return to work. Due to their acknowledgement of the failings with concerns handling, the offer of an apology and the actions taken to address and improve the process, I did not investigate this aspect of C's complaint.

Response to INWO investigation

2. Whilst I am reassured that the Board have made improvements regarding their handling of whistleblowing concerns in terms of dealing with complainants, I have identified issues with the Board's response to this investigation. The Board's handling of my request for information caused delay to our investigation. Although I appreciated the efforts to inform me about a separate external review, this should not have prevented the Board from providing me with the information I had requested. This caused unnecessary delay with the potential to create further concern to the whistleblower.

Appendix B[2]: High level summary of evidence

1. This Appendix contains a high level summary of the evidence considered during the investigation, and to which elements of the complaint it was relevant.
2. The findings in the summary report reflect how this evidence was used. The purpose in listing it here, is to assure the complainant and others involved that a wide range of evidence was sought and considered.
3. **This appendix is not a confidential document and there are no restrictions on sharing it.**

Document Name	Description	Restrictions at draft stage	Restrictions at final stage
Appendix B: High level summary of evidence relating to all points	Summary of the evidence considered in this case.	• Complainant • CEO • Internal investigator • Whistleblowing Lead (Appendix must not be shared wider until final)	None

[2] Appendix A is private and not for publication

The complaint I investigated is: (following the numbering in summary report)

2.1. The Board failed to adequately plan for a specific service at Dr Gray's Hospital (DGH).

2.2. The Board failed to ensure the Service was being delivered in line with National Service Standards

2.3. The Board failed to ensure an adequate advice line for patients using the specific service at DGH.

Description	Relevant to:		
	2.1	2.2	2.3
1. Complaint and documents provided by C This included C's concerns submitted to the Board and their complaint to INWO. I also reviewed other relevant material provided by C during phone calls and meetings	Yes	Yes	Yes
2. The Board's Stage 2 report and complaint file I sought and obtained the Board's complaint file. This material included:			
i. Correspondence between C and the Board	Yes	Yes	Yes
ii. The Stage 2 response, dated 17 August 2023	Yes	Yes	Yes
iii. The Board's investigation documents, including investigation plan, interview summaries and investigation report	Yes	Yes	Yes
3. ***Additional evidence provided by the Board*** This included			
i. Response to INWO 19 June 2024	Yes	Yes	Yes
ii. Pan Grampian relevant Service Proposal	Yes	Yes	Yes
iii. Relevant Service Plan 2019—2020	Yes	Yes	Yes
iv. Other relevant NHS Grampian service information	Yes	Yes	No
4. Applicable guidance This included three specific sets of guidance relevant to the service area	Yes	Yes	No
5. Independent Professional Advice	Yes	Yes	Yes