INDEPENDENT
NATIONAL
WHISTLEBLOWING
OFFICER

People Centred | Improvement Focused

The Scottish Public Services
Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Report of the Independent National Whistleblowing Officer

Overview

Scottish Parliament Region: Glasgow

Case ref: 202306732

NHS Organisation: Glasgow City Health and Social Care Partnership

Subject: Patient safety

This is the report of the Independent National Whistleblowing Officer (INWO) on a whistleblowing complaint about 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 my investigation.

Executive summary

1. The complainant (C) complained to the INWO about Glasgow City Health and Social Care Partnership (the HSCP), following the investigation of a whistleblowing concern raised with NHS Greater Glasgow and Clyde under the National Whistleblowing Standards. The complaint concerned changes to specialist GP services for people experiencing homelessness in Glasgow.
2. The complaint I have investigated is:
   - 2.1. The HSCP unreasonably failed to follow a meaningful process of engagement and consultation with staff involved in the delivery of the GP service prior to the decision to reduce the service. (upheld)
   - 2.2. The HSCP unreasonably failed to undertake meaningful stakeholder consultation prior to the decision to reduce specialist GP service provision for people experiencing homelessness. (upheld)

2.3. The HSCP unreasonably failed to perform a full and timely assessment of risk and equalities impact prior to the decision to reduce specialist GP service provision for people experiencing homelessness. (upheld)

2.4. The HSCP unreasonably failed to take action to address the long term risks associated with the reduction in specialist GP service provision. (upheld)

3. As a result of my findings, the HSCP 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[1].

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 the potential impact on a particularly vulnerable patient population.

6. In order to investigate C's complaint, I and my officers:

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

    6.2. obtained and reviewed the NHS Greater Glasgow and Clyde's (the Board) stage 2 report and full complaint file, including notes from interviews with key staff members

    6.3. obtained comments and documentary evidence from the Board and HSCP

    6.4. reviewed relevant guidance, and

    6.5. obtained professional advice from an adviser with relevant experience.

7. Evidence was assessed and analysed and from that, findings and recommendations made, and a decision taken. This report, and supporting appendices, provide a

[1] *The Scottish Public Services Ombudsman Act 2002, section 6A*

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 A.

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

9. I have focused my investigation on the time period covering the first announcement to staff in March 2022 that a practice was planned to close, the eventual closure of the practice in April 2023, and the activities undertaken by the HSCP following the closure (including the whistleblowing investigation undertaken by NHS Greater Glasgow and Clyde). I recognise that there was a wider review of the Homeless Health Service in 2018—2020 which initially included the GP service; and I accept that there was a subsequent agreement that the review of the GP service would be handled separately. For this reason, I consider it appropriate to focus on the actions taken by the HSCP during this GP service review period.

10. It is also important to note that my investigation was not an assessment of the strategic rationale behind the HSCP's service re-design.

Presentation of evidence and analysis

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

12. 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 and the HSCP, to have sight of them, other than those who need to know. This document includes a ***Error! Reference source not found.***, including a list of the appendices and the restrictions relating to their publication and sharing.

Complaint background

13. The HSCP undertook a detailed review of their Homelessness Health Service in 2019. At the time the service consisted of various specialist teams each of which operated separately and delivered a range of medical, health and social interventions, including a 2c GP practice (a GP practice run by a health board rather than the GPs themselves). The GP provision was initially included in the review but

during the course of the review, an understanding was reached that the GP service would be considered through a separate process.

14. The main review resulted in a decision to move to a Complex Needs Model that would focus on people at the highest risk of premature mortality due to non-engagement with mainstream services. The new model would bring the separate services from across the Homelessness Health Service together, to form a single inter-disciplinary team. There was a delay in implementing the model due to the impact of the pandemic.

15. In March 2022, the HSCP wrote to staff to confirm plans to move to the new inter-disciplinary model, which included plans to close the specific GP practice. They informed staff that the practice would cease to accept new patients from 1 May 2022 and would close completely on 4 October 2022. After concerns were raised about the practice not being part of the concluded review, the HSCP agreed to begin a process of consultation and engagement with the aim of reviewing the current model of GP provision, considering its challenges, and seeking a way forward.

16. The HSCP organised three workshops with the GPs working at the practice. The workshops, named as ‘Homeless GP Re-design Workshops’, took place on the 6 February, 23 February and 23 March 2023. At the third workshop, an announcement was made that the funding had reduced, and the practice would close on 31 March 2023 (one week later).

17. With the closure of the practice, the GP staffing within the new Complex Needs Service was changed from 1.4 whole time equivalent staff (WTE) to 0.2 WTE, although at the time of my report, the 0.2 WTE GP sessions had not yet been allocated to a GP. At the point of closure, the practice had 167 registered patients and dealt with a larger number of patients on a temporary basis, with annual patient contacts at approximately 600. The additional patient contacts came from ‘temporary residents’ or ‘non-registered patients’ who also accessed the practice.

Whistleblowing Concerns

18. C raised a whistleblowing concern with the Board about the process followed by the HSCP, including concerns about:

    18.1. the apparent haste with which the decision to close the practice was made and a lack of transparency around the decision making,

    18.2. the degree of communication and stakeholder engagement, and

    18.3. whether the appropriate risk assessments and equality impact assessments (EQIA) were completed.

19. The Board undertook an investigation at stage 2 of their whistleblowing procedure and concluded that the concerns were not upheld. In their response to C, they said that there was a high level of engagement and partnership representation across the process of the 2019 review. The investigation also established that, to date, there had been no complaints escalated, no Datix reports (Datix is a reporting system used for staff to report incidents and risks) or Serious Adverse Event Reviews (SAERs) commissioned as a result of the new model of service.

Complaint to the INWO

20. C complained to the INWO that the investigation had focused on the original 2019 review, rather than the process followed to close the GP practice, which had been separated from the 2019 review before it concluded. As part of the complaint, C escalated their concerns about stakeholder engagement, consultation, impact assessments and risk assessment because they were dissatisfied with the response.

Findings and decision

Point 2.1 The HSCP unreasonably failed to follow a meaningful process of engagement and consultation with staff involved in the delivery of the GP service prior to the decision to reduce the service. (upheld)

Point 2.2 The HSCP unreasonably failed to undertake meaningful stakeholder consultation prior to the decision to reduce specialist GP service provision for people experiencing homelessness. (upheld)

21. I have considered these elements of the complaint together as they both relate to the HSCP's process of engagement and consultation. It is important to recognise that the

focus of the complaint was the impact on a vulnerable patient group and not the impact on staff (i.e. changes to staff contracts). It is not within my remit to consider contractual or HR issues and it was not C's intention to raise them through the whistleblowing process.

Complaint to INWO

22. The key issues considered under these elements of the complaint were C's concerns that:

22.1. the communication between the three scheduled workshops was inconsistent and there did not appear to be a shared understanding of the process being followed, for example:

22.1.1. staff believed that the workshops were the beginning stages of the review process, whereas the HSCP appeared to have reached a decision before the conclusion of the third workshop.

22.1.2. staff were asked to comment on a new Standard Operating Procedure (SOP) that would outline the process for the review. The SOP was never finalised and was not followed.

22.1.3. staff were informed during the second workshop that there was a stand-still budget available. However, by the third workshop (1 month later on 23 March 2023) the budget had reduced considerably.

22.2. the decision to close the practice appeared to have been taken very quickly between workshops two and three, leaving only one week between the decision and the closure date.

22.3. the decision to close the practice was not informed by a proper consideration of the views and concerns raised by staff during the workshops.

22.4. relevant stakeholders were neither consulted nor informed ahead of the change to the service.

22.5. the Board's investigation focused too heavily on the process followed during the 2019 review, despite an acknowledgement that the GP service review was to be continued separately.

The Board and HSCPs' position

23. In summary, the Board and HSCPs' position in the stage 2 response was that:

23.1. the 2019 service review had terms of reference that included guidance about communication, outcome monitoring, and a timetable for meetings. The review was linked closely to the Homeless Health Service Strategy. Funding was available, and the review was not focussed on financial cuts. The aim of the review was to contemporise the service and make the best use of the budget available.

23.2. to accommodate concerns from GPs it was agreed that the wider service review and recommendations would conclude. The new model would be implemented with the exception of GP provision, which would be considered with continued GP engagement; resulting in the three workshops in February and March 2023.

23.3. the first two workshops for the GPs (in February 2023) focussed on the current model and how this could be modernised. It was agreed that the third workshop (March 2023) would focus on the GP homeless service model options.

23.4. the budgeted figure presented at the second workshop was accurate, but not ring-fenced. Between the second and third workshops, the figure was impacted by financial governance and saving requirements.

23.5. during the 2019 review, and workshops, there had been significant input from HR, Organisational Development, staff side representatives and Finance.

23.6. the issues raised in the workshops were discussed at the 3 April 2023 Staff Partnership Forum (SPF), noting the concerns of GPs.

23.7. there was a recommendation from a previous whistleblowing investigation to develop an SOP for the ongoing reviews with the GP service at the HSCP. However, it was established that the SOP was unnecessary due to the strong Organisational Development and HR governance processes already in place. The approach adopted was via Change Management with the support of HR, which was considered appropriate.

23.8. an EQIA had been started with a view to concluding at the end of June 2023.

23.9. there was ongoing stakeholder engagement from August 2019. The engagement included those with lived experience, deep end practice[2] and the third sector, alongside guidance from HR.

24. To test and consider these aspects of the complaint, my investigation considered the evidence summarised in public Appendix A and discussed in private Appendix B.

Findings – complaint points 2.1 and 2.2

25. I took into account written correspondence and evidence provided by the Board, the HSCP and the complainant, the complaint file from the Board including witness interviews, and relevant policies and procedures. I also sought independent professional advice (which I accepted). I set out my detailed consideration of this advice and the background to the complaint in private in Appendix B. My key findings are set out below.

26. My findings in relation to stakeholder engagement suggest that the HSCP focused on staff engagement, rather than focusing on external engagement. Where I have looked at staff engagement in this report, it is in relation to the consultation that took place linked to service delivery and patient impact, rather than anything linked to any member of staff's employment situation. Although this is important as there was an obvious impact on staff in the service change we are discussing, this was not the focus of the complaint made to me and so has not formed part of my investigation.

27. The HSCP organised three workshops with GPs at the practice. The stated aim of the workshops was:

27.1. to collaborate on the design of an access service for General Practice, and

27.2. to establish trust and approaches to joint planning for services, including by

27.2.1. partners sharing their aspirations for a future model,

27.2.2. identifying options through discussion and suggestions, and

27.2.3. identifying areas of challenge in reshaping services.

[2] The University of Glasgow's Scottish Deep End project explains the term 'deep end' as follows: 'General Practitioners at the Deep End work in general practices serving the 100 most deprived populations in Scotland, based on the proportion of patients on the practice list with postcodes in the most deprived 15% of Scottish datazones.'

28. The HSCP agreed to restart the review of the GP service in March 2022. The workshops with staff took place in February and March 2023, eleven months later. The third workshop appears to have taken place after a decision had effectively been made about the future of the service (as a result the funding available) and only a week before the closure took place.

29. I have seen a copy of the SOP that was shared with staff for comment. I have also reviewed the comments the staff put forward, which focused on the need for external stakeholder engagement to measure the potential impact on patients.

30. The SOP was abandoned by the HSCP after internal advice indicated that it was unnecessary. It is not clear whether this change was communicated to staff who expected their feedback on the document to form part of the process that followed. I have not seen anything to suggest that the comments from staff, including the suggestions around stakeholder engagement, were addressed. It also appears that there was confusion around the status of the SOP internally, as a management update to the Staff Partnership Forum in April 2023 (after the practice closure) noted that an SOP had been developed to outline the organisational change principles.

31. Staff involved in the workshops were given one week's notice of the closure, which caught them off guard. Based on the evidence I have reviewed, it is evident that they believed the workshops were intended to initiate the redesign process. This belief was supported by the stated goals of the staff engagement workshops and the sudden shift in direction between the second and third workshops.

32. The fact that the workshops were planned and delivered demonstrates to me that the HSCP started with good intentions and sought to achieve positive engagement and a collaborative approach to the service design. However, by the third workshop, there no longer appeared to be an attempt to continue the review, and the notes suggest that session was dedicated to explaining the decision that was being taken to close the practice.

33. It is evident from witness testimony that the change in financial position was pivotal to the decision that was made to close the practice in 2023, but I have seen nothing that documents and outlines the final decision making process by senior management.

34. I acknowledge the HSCP's position that the proposal put forward by staff for an alternative model was not feasible due to the costs involved. However, I have not been convinced that any further consideration was given to exploring an alternative beyond the HSCP's preferred option. Once the budget position was confirmed, it appears that the HSCP moved to take a unilateral decision on the shape of the service.

35. I agree with C that by the end of the staff engagement workshops it was difficult to take the view that it was a meaningful process. The final decision was rushed and rolled out hastily, apparently as a result of the change to the financial position, rather than in the context of the output of the workshops.

36. The advice I received, and that I accept, is that I should expect to have seen external stakeholder engagement in advance of a closure of a practice. This engagement would have provided valuable insight into the challenges around the impact of the service change and helped the HSCP to develop strategies to mitigate these and plan for the transition. The adviser suggested engagement with:

    36.1. homeless patients,

    36.2. healthcare providers,

    36.3. support services, and

    36.4. mainstream GP services.

37. Despite the feedback from staff recommending this similar external engagement, I have seen no evidence to demonstrate that there was any consultation with external stakeholders about the potential of the practice closing. Indeed, I have seen evidence that a range of stakeholders including representatives of GP practices, the third sector and other services, expressed their shock and concern at the announcement.

38. While I recognise that there was stakeholder engagement during the 2019 review, I have accepted that the GP service was being reviewed separately and I would have expected to see further engagement around the change to GP provision.

39. The HSCP told me that they engaged with stakeholders who made direct contact after the practice closed and responded to their concerns; and that they offered to investigate any specific examples but nothing was raised.

Decision - complaint point 2.1

40. The point of complaint I have investigated is that the HSCP unreasonably failed to follow a meaningful process of engagement and consultation with staff involved in the delivery of the GP service prior to the decision to reduce the service, particularly in relation to the service for patients experiencing homelessness.

41. In making my decision, I recognise the significant financial pressures facing HSCPs and health services at that time (and going forward). I accept that the HSCP were in a difficult position where savings had to be found. I also accept that the HSCP organised and participated in the early workshops in good faith with an open mind about the future shape of the service.

42. However, the evidence leads me to the view, that the focus was on organisational development and the future role of staff. Although this certainly has an extremely important role in the service change process, I have not seen evidence to suggest that there was sufficient engagement with staff feedback around stakeholder engagement, risk and patient impact. My findings are that the staff engagement process was cut short and had little to no impact on the final outcome, which appeared to be a reaction to the financial position.

43. For these reasons it does not appear to have been an entirely meaningful process.

44. On balance, I **uphold** point 2.1 of this complaint.

Decision - complaint point 2.2

45. The point I have investigated is that the HSCP unreasonably failed to undertake meaningful stakeholder consultation prior to the decision to reduce specialist GP service provision for people experiencing homelessness.

46. Despite engagement during the whole service review in 2019, I have seen no evidence that external stakeholders were consulted about the closure of the practice or the reduction of the GP service in the months between the start of the review in March 2022 and the closure of the practice during April and May 2023.

47. On balance, I **uphold** complaint point 2.2 and I have made a recommendation set out later in this report.

Point 2.3 The HSCP unreasonably failed to perform a full and timely assessment of risk and equalities impact prior to the decision to reduce specialist GP service provision for people experiencing homelessness. (upheld)

Point 2.4 The HSCP unreasonably failed to take action to address the long term risks associated with the reduction in specialist GP service provision. (upheld)

48. I have grouped these elements of the complaint together as they both relate to the HSCP's approach to risk assessment.

49. The key issues considered under these elements of the complaint were C's concerns that the HSCP did not follow the proper process before taking a decision to close the GP practice. Including that:

    49.1. no equalities impact assessment (EQIA) was completed,

    49.2. the impact on other stakeholder groups was not considered,

    49.3. the short time between the decision and the closure of the practice did not allow for an appropriate level of risk assessment,

    49.4. there was no time for supportive communication with patients and handover by the existing GPs, and

    49.5. there remains potential for significant and ongoing negative impact on access to primary care for people experiencing homelessness.

50. In summary, the Board's position within their stage 2 response was that:

    50.1. after the HSCP's decision was made to proceed with the new service model there was a rapid risk assessment directed by the Clinical Director, service management and senior nurses to support all patients held in the GP caseload.

    50.2. approximately 160 patients were considered within the risk assessment. It confirmed 20% had no recent contact and/ or no longer in the Health Board area as a significant number of these patient had their own GP elsewhere. With the assistance of GP Practitioner Services, the remaining patient cohort were assigned a GP, and the Clinical Director personally managed all the cases that were categorised as 'red' in terms of risk.

50.3. all the appropriate databases were updated, and pharmacies were contacted by phone with updates on individual patients. This process took around six weeks to conclude.

50.4. an early review was completed for benchmarking, and follow up methodology was agreed by the Strategic Oversight Group. A first year review had been commissioned, which would include the scrutiny of 50 cases, and the outcome of this would be widely published.

50.5. to date, there had been no complaints, escalated, DATIX/ risks or Significant Adverse Event Reviews commissioned as a result of the new model of service.

50.6. given the level of scrutiny across both the risk assessment, EQIA and benchmarking exercise the Stage 2 Investigating Officer was satisfied that the appropriate level of governance has been followed with oversight from the relevant governance groups, and the Chief Officer and Chief Finance Officer.

51. In answer to further my enquiries, the Board and HSCP added that:

51.1. the EQIA report was substantially complete with three months of the closure.

51.2. the complex needs report was completed and made available to staff in July 2024.

51.3. the HSCP has engaged with stakeholders who raised concerns after the closure was announced, including an offer to investigate any specific examples of concerns. No examples have been provided.

51.4. the original risk assessment of patient needs, which took place when the practice was closed, confirmed that those who were at higher risk were already being case managed by the complex needs service. The audit of registrations some five months later showed that registration had been maintained.

51.5. the HSCP have listened to stakeholders and are enhancing the complex needs service to improve communication and support between GP practices, and others, and the complex needs service. This is so that support is based on universal services with the degree of additional support being adjusted in proportion to the degree of need identified.

51.6. The HSCP also informed me that there had been no intention for the first year review to include scrutiny of any patient cases. They explained that the reference to 'the scrutiny of 50 cases' in the Board's stage 2 response was a reference to the audit, although this was not subsequently included in the review.

52. To test and consider these aspects of the complaint, the INWO's investigation considered the evidence summarised in public Appendix A and discussed in private Appendix B.

Findings – complaint points 2.3 and 2.4

53. I took into account written correspondence and evidence provided by the Board, the HSCP and the complainant, the complaint file from the Board including witness interviews. I also reviewed relevant policies and procedures, including guidance from the Equality and Human Rights Commission (EHRC) and the Scottish Government. I also sought independent professional advice. I set out my detailed consideration of this advice and relevant guidance in private in Appendix B. My key findings are set out below:

Impact assessment

54. The HSCP is subject to specific duties, both linked to the Equalities Act 2010[3]. These duties are:

54.1. The Public Sector Equality Duty, and

54.2. The Fairer Scotland Duty.

55. In summary, the Public Sector Equality Duty (specific duties) include a requirement to:

55.1. assess impact.

55.2. consider relevant evidence.

55.3. take account of the results of the assessment in the development of the policy/ practice.

[3] Equality Act 2010, *https://www.legislation.gov.uk/ukpga/2010/15/contents*

55.4. publish the results of the assessment.

55.5. make arrangements to review policy and practice (and revise where necessary).

56. The Fairer Scotland Duty places a responsibility on public bodies to, in summary, actively consider how they can reduce inequalities of outcome caused by socio-economic disadvantage when making strategic decisions.[4]

57. The Equality and Human Rights Commission's guide to Assessing Impact and the Equality Duty explains that 'Assessing impact is not an end in itself but should be an integral part of policy development and decision-making. […] This means the assessment process must happen before a policy is decided. The assessment cannot be retrospective, or undertaken near the end of the process, but should instead be integral to the earliest stage of the development of proposed policies or practices, and in the revision of existing policies or practices.'[5]

58. I reviewed Glasgow City HSCP's EQIA template, which is well-structured and thorough. It prompts staff completing the assessment to actively consider human rights factors, socio-economic disadvantage and the Fairer Scotland Duty in addition to equalities impact. Their guidance for staff says that:

58.1. 'Equality Impact Assessment should be an early integrated consideration in any planning process. It should be used to sense check whether proceeding with a decision or policy implementation might have unintended consequences for protected characteristic groups .

59. The EQIA for the change to the GP service was completed within three months of the practice closure. It included a comprehensive assessment of equalities impact, human rights impact and socio-economic status. Mitigating actions focused on ongoing review, monitoring, stakeholder engagement and a planned needs assessment.

60. There appears to have been a common understanding that there was requirement to complete an EQIA within three months of the decision being taken. There is reference to this in interview notes and the investigation report from a previous

[4] *The Fairer Scotland Duty Guidance for Public Bodies*, Scottish Government

[5] *Assessing Impact and the Public Sector Equality Duty: A guide for public authorities in Scotland*, Equality and Human Rights Commission

whistleblowing concern that was raised in 2022. This is firmly at odds with the expectations outlined in the Equality and Human Rights Commission's guide quoted at paragraph 57 above.

61. I asked for the adviser's view on the EQIA that was completed. They provided reassurance that, in their view, the EQIA was of a good standard. They said that although there were areas that could be further strengthened, the assessment covered most of the relevant risks and mitigations expected in such a process.

62. However, they also told me that the EQIA relied, in part, on the information gathered during the previous service review, rather than using stakeholder data from the year the GP service was being reviewed. They explained that the use of data from the review in 2018—20, particularly in light of significant changes in the environment, such as the pandemic, may not have provided a fully accurate or reasonable view of the current situation. They told me that the population in question was likely to be transient, meaning that the circumstances and needs of those affected could have shifted considerably since the original review took place.

63. I noted that a Health Needs Assessment[6] was discussed in the first workshop with staff and, according to the minutes, managers agreed that this should be procured. I asked for information on this and was told by the HSCP that it was not completed at the time of the service review and there was no requirement for an assessment to be undertaken prior to the re-design of the service.

64. The HSCP confirmed that, at the time of my report, they were currently in the process of commissioning an assessment in line with NICE guidance from 2022. The HSCP also acknowledged that it would be helpful to include an assessment of this type with any future service changes.

[6] According to a glossary of terms provided by the National Institute for Health and Care Excellent (NICE), a Health Needs Assessment is 'a systematic process used by NHS organisations and local authorities to assess the health problems facing a population. This includes determining whether certain groups appear more prone to illness than others and pinpointing any inequalities in terms of service provision. It results in an agreed list of priorities to improve healthcare in a particular area'.

Risks and barriers

Advice

65. The adviser explained a number of specific challenges that those experiencing homelessness might face in accessing healthcare. These included:

65.1. difficulty with access, including navigating appointment systems, receiving appointment reminders or test results.

65.2. scheduling systems or opening hours vary and may not accommodate the unpredictable nature of the lifestyles of those experiencing homelessness, who may have more immediate or urgent needs.

65.3. lack of information on how to access GP services for those who are transient of newly homeless.

65.4. potential for negative experiences with mainstream services because of the risk of stigmatisation.

65.5. fear of facing judgement related to their situation or their health conditions. This could be due to a lack of experience or training within mainstream GP on the areas specific to the needs of those experiencing homelessness, including cultural competency, mental health and trauma-informed care.

65.6. individuals may only seek acute care and help in emergencies, rather than preventative or routine care because of the need to prioritise their concerns about their living situation. This may in time worsen health outcomes for those who experience homelessness.

66. The adviser told me that people experiencing homelessness can suffer disproportionate levels of complex medical conditions including chronic disorders, mental health complications, and substance use concerns.[7] These medical problems require adequate, integrated, and long-term treatment, which can be challenging to obtain for the above reasons.

67. I accept this advice.

[7] *Multimorbidity and emergency department visits by a homeless population: a database study in specialist general practice | British Journal of General Practice*

Impact on mainstream GP services and transfer of care

68. One of the issues C raised was that there was a failure to consider the wider risks of the change to the service, including the impact on mainstream GP services and other health services, including emergency departments in hospitals. All patients registered with the Homelessness GP service were moved to local GP practices.

Advice

69. I asked the adviser to comment on the potential impact on the mainstream GP services. They outlined a number of issues including:

    69.1. new patients with increased complexities could mean increased pressure on appointment and other resource availability in mainstream GP practices.

    69.2. practices might not be ready to accommodate the volume or intensity of care that homeless persons require. Many of these patients will likely have chronic conditions, mental illnesses, and substance use disorders.

    69.3. mainstream general practitioners may lack specialised training and experience in managing the complex health needs of those who are homeless, leaving potential for gaps in care.

    69.4. those experiencing homelessness may fall out of the system because mainstream practices are geared toward more stable patient populations and might not have flexible systems to support challenges such as a lack of permanent address, identification and documentation.

70. The adviser suggested that because of the potential impact, it would have been reasonable to expect that these (and other) issues would be carefully considered and documented in any decision making process. This would allow for any actual risks to be mitigated.

71. I accept this advice.

Approach to risk assessment and mitigation

72. The HSCP provided evidence of a rapid risk assessment that took place in March 2023, after the decision was taken to close the practice. The assessment involved a review of the practice caseload by a team of staff. All registered patients were

reviewed and assigned a rating using a Red, Amber, Green (RAG) System, which determined the follow up action required.

73. I noted that this risk assessment was undertaken quickly, in the short period between the decision to close the practice and the actual closure. I sought to understand whether the risk assessment completed by the HSCP appeared to be a reasonable short-term approach to mitigating the immediate risks involved in the imminent closure of the practice.

Advice

74. I asked the adviser if there would have been sufficient time for the HSCP to identify and address potential risks associated with a service change that involved a reduction to the GP service.

75. The adviser told me that the period of time between the start of the review of the GP service in Spring 2022 and the practice closure in April 2023, would have allowed adequate time to review the impact of this kind of proposed change.

76. They also outlined numerous good practice activities that they would have expected to see, including:

    76.1. impact assessment,

    76.2. stakeholder engagement,

    76.3. detailed risk assessment and planning. The risk assessment should focus on health outcomes, access to care, continuity of care and the impact on vulnerable groups,

    76.4. consultation,

    76.5. training/ information for mainstream GPs

    76.6. patient communication and support, and

    76.7. cross-service co-ordination e.g. with local hospitals, social services and homelessness support organisations.

77. Overall, the adviser told me that the rapid risk assessment demonstrated a good foundation for identifying and mitigating the immediate risks of service reduction.

They also told me that the approach could have been strengthened and improved with:

77.1. broader stakeholder engagement.

77.2. consideration of the impact on mainstream GP services.

77.3. longer-term monitoring and evaluation.

77.4. better communication and support of patients, including those with more complex needs.

78. The adviser emphasised the importance of risk assessment and planning being a prospective rather than a retrospective exercise.

79. I asked if the adviser would expect the GPs who had been providing the care within the practice to have been involved in the transfer of patient care. The adviser told me that this would not necessarily need to happen. Medical records should be created and maintained in such a way that should allow care to be continued, even for the most complex patients.

80. I accept this advice.

Ongoing monitoring

81. The stage 2 response to C's whistleblowing concern engaged with C's questions about risk assessment and assurance around safe service provision and continuous access for the patient population. In addition to the rapid risk assessment above, their response explained that there was a commitment to service delivery and a huge amount of scrutiny to ensure that the new model was fit for purpose. The response referred to a few pieces of work linked to this assurance including:

81.1. an audit performed in 2023, and

81.2. a plan to commission a first year review.

82. I received a copy of an audit of registrations, which was completed in August 2023. It captured the number of patients registered with the practice at the end of March 2023, as well as their registration status five months following the closure.

83. I requested and received a copy of the first year review which was shared with staff in July 2024. I was told that the report set out the stakeholder engagement relating to GP provision. The review did not look at individual cases.

84. The scope of the paper was:

84.1. to engage with a range of stakeholders from primary, community and complex need service to establish the best use of the GP and pharmacist resource in support of people experiencing homelessness and complexity.

84.2. to make recommendations on use of these resources to the Assistant Chief Officer (ACO) Public Protection, Clinical Director, and the Chief Officer on the basis of the engagement.

85. In terms of stakeholder engagement, the report gathered perspectives from:

85.1. a GP, with expertise in the subject area,

85.2. a lead pharmacist,

85.3. a representative from the Glasgow and Clyde Local Medical Committee (LMC),

85.4. an Assistant Chief Officer for HSCP, and

85.5. a General Manager supporting the Complex Needs Service.

86. The report made recommendations to develop the roles to further support the Complex Needs Service and wider community services.

87. The review and recommendations were made within the confines of the reduced financial situation, and the assumption that the multidisciplinary approach within the Complex Needs Service would continue.

Advice

88. I shared both documents with the adviser and asked if the two processes appeared to constitute a reasonable approach to measuring and addressing risks resulting from the service change. The adviser told me that neither document appeared designed to address the risks that they had outlined previously (at paragraph 65 and sub-paragraphs).

89. I asked the adviser for their view on the reasonableness of the HSCP's overall approach to risk assessment. The adviser acknowledged the size of the practice, and they told me that closing a practice of any size requires a structured prospective approach with a clear process that reviews and captures all the associated risks, mitigates these risks and subsequently measures outcomes to ensure no adverse impacts. They told me that they could not see evidence of this.

90. I accept this advice.

Decision - complaint point 2.3

91. The complaint I have investigated is that the HSCP unreasonably failed to perform a full and timely assessment of risk and equalities impact prior to the decision to reduce specialist GP service provision for people experiencing homelessness.

92. The EQIA covering the closure of the practice was only completed in the months following the decision to close it. Both the HSCP's own internal guidance and national guidance say that the EQIA should be an early part of the decision making process. It should not be retrospective. The adviser echoed this.

93. This leads me to conclude that HSCP's duties were not given due regard before the decision about services was made. I am surprised that this was not identified by the Board during their own handling of the whistleblowing concern.

94. This strongly suggests there is a need for more staff training to ensure that decision makers and staff involved in service change are aware of the organisation's responsibilities.

95. In relation to risk assessment, it appears that the only documented risk assessment that took place was completed after the decision was taken to close the practice. This was only a matter of days before the practice closed. Although this risk assessment did inform mitigation of the immediate challenges and risks posed by the imminent closure, there does not appear to be evidence of any thorough or systematic consideration of the risks prior to the decision.

96. On balance, I find that there is sufficient evidence, to **uphold** point 2.3 of this complaint and I have made a recommendation.

Decision - complaint point 2.4

97. The point I have investigated is that the HSCP unreasonably failed to take action to address the long term risks associated with the reduction in specialist GP service provision, particularly in relation to those experiencing homelessness.

98. I have considered the follow up action taken by the HSCP, including the audit of registrations and the one-year service review, which appeared smaller in scope than the stage 2 response suggested it would be.

99. I have received advice that neither review appeared designed to engage with the potential risks to patients associated with the reduction in the GP service. Nor did they measure the impact on patients and other services after the practice closed. The adviser would have expected to see more longer term monitoring and evaluation in place. I accept this advice.

100. I recognise that there are plans in development to complete a Health Needs Assessment but, at the time of writing, this was yet to be fully scoped. I have also noted that the question of a Health Needs Assessment was raised by GPs in February 2023 and managers at the time agreed that one would need to be procured, so there has been a considerable delay in progressing that work.

101. On balance, I find that there is sufficient evidence to **uphold** point 2.4 of this complaint and I have made a recommendation.

102. After I shared a copy of my draft report with the HSCP they informed me that there was more work planned to evaluate the Complex Needs Service, including work to establish a review of the service in partnership with the University of Strathclyde. I welcome this commitment.

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 is asking the HSCP to improve their improve the way they do things:

Rec. No	What I found	Outcome needed	What INWO needs to see
1.	Under point 2.2 I found: External stakeholders were not consulted about the closure of the practice or the reduction of the GP service between the start of the GP service review and the closure of the practice.	The HSCP ensure the principles in their Participation and Engagement Strategy are being met in practice.	Evidence that the HSCP have: (i) systems and processes in place to support decision making on whether and to what extent consultation is required when a change is proposed (ii) ensured there are tools or mechanisms in place to support appropriate and timely stakeholder engagement (iii) reviewed their guidance and the training needs for all relevant staff to ensure achievement of the outcomes needed. By: 23 June 2025

Rec. No	What I found	Outcome needed	What INWO needs to see
2.	Under point 2.3 I found: The HSCP did not give due regard to the Public Sector Equality Duty before the decision about the GP service was made.	Decision makers should be aware of their responsibilities under the Equalities Act 2010 and the need to complete timely equalities impact assessments.	Evidence that the HSCP have: (i) reviewed the training needs for all relevant staff to ensure achievement of the outcomes needed (ii) shared the findings of my investigation with relevant staff in a supportive manner for reflection and learning (iii) Governance arrangements are in place to ensure that the Duty and supporting policy are followed when proposing a service change. By: 23 June 2025
3.	Under point 2.4 I found: The HSCP's reviews did not engage with the potential risks to patients. Nor did the reviews measure the impact on patients and other services after the practice closed.	The HSCP seeks to fully understand the impact of the service closure on patient health. The ongoing health needs of those experiencing homelessness are understood and services adjusted as required.	(i) Evidence that a health needs assessment has been fully scoped and a plan is in place to complete the assessment (with definitive timescales) By: 8 weeks after the final decision is published (ii) Evidence that the health needs assessment has been completed. By: 28 October 2025

Additional Comments and Feedback

104. My investigation was helped by the co-operation of C and the Board's liaison officer. I am grateful to everyone involved for their assistance and their constructive and thoughtful engagement with the process.

105. The advice I received and accepted suggested that the EQIA could be improved with further detailed support for vulnerable subgroups, including appropriate strategies for particularly sub-groups experiencing vulnerability, such as older adults, pregnant women, and transgender people. Incorporating engagement from stakeholder groups and patients would be best practice.

Summary of documents that make up the final full INWO report

Document Name	Description	Published/private
Summary Report Reference: 202306732	Anonymised/ pseudonymised summary of complaint investigation and findings	Published
Appendix A: High level summary of evidence relating to all points	Summary of the evidence considered in this case	Published with the summary report
Private Appendix B: Detailed consideration of evidence	Detailed discussion of the complaint background and the professional advice received	Private

Appendix A
High level summary of evidence (public)

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 [once published].**

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

Description	Relevant to:			
	2.1	2.2	2.3	2.4
1. *National Whistleblowing Standards* The National Whistleblowing Standards set out how the Independent National Whistleblowing Officer (INWO) expects all NHS service providers to handle concerns that are raised with them and which meet the definition of a 'whistleblowing concern'. The Standards are available at https://inwo.spso.org.uk/national-whistleblowing-standards	Yes	Yes	Yes	Yes
2. *Complaint and documents provided by C*				
i. C's concerns submitted to the Board	Yes	Yes	Yes	Yes
ii. C's complaint to INWO				
iii. Agendas and minutes from relevant meetings				
iv. Email correspondence	Yes	Yes		
3. *The Board's Stage 2 report and complaint file* The Board's complaint file, which included:				
i. The Board's Stage 2 final report	Yes	Yes	Yes	Yes
ii. Correspondence relating to the concern	Yes	Yes	Yes	Yes
iii. Meeting notes with C	Yes	Yes	Yes	Yes
iv. Witness meeting notes	Yes	Yes	Yes	Yes
v. Homelessness Health Review – Terms of Reference 2018	Yes	Yes	Yes	Yes
vi. Workshop slides	Yes	Yes	Yes	Yes
vii. Relevant correspondence	Yes			
viii. Staff Partnership Forum paper – 3 April 2023	Yes	Yes	Yes	Yes
ix. Staff brief	Yes			
x. Meeting minutes	Yes	Yes	Yes	Yes

Description	Relevant to:			
	2.1	2.2	2.3	2.4
Additional evidence provided by the Board and HSCP We made a number of detailed enquiries of the Board. We sought and obtained their comments on matters considered relevant to the investigation and any supporting evidence. Key items of evidence are listed below. The list is not exhaustive.				
i. Equality Impact Assessment Guide			Yes	
ii. NHS Greater Glasgow and Clyde Equality Impact Assessment Template			Yes	
iii. Details of a linked whistleblowing investigation	Yes	Yes	Yes	
iv. NHS Greater Glasgow and Clyde Stakeholder Communication and Engagement Strategy	Yes	Yes	Yes	
v. Glasgow City Integrated Joint Board Participation and Engagement Strategy	Yes	Yes	Yes	
vi. Complex Needs Report (One-year review) and accompanying paper for Senior Management Team (SMT)			Yes	Yes
vii. GP service caseload review protocol			Yes	Yes
viii. Registration audit			Yes	Yes
ix. Service proposal from staff	Yes			
x. A linked whistleblowing investigation report	Yes	Yes	Yes	Yes
xi. Overview of current service				Yes
4. Assessing Impact and the Public Sector Equality Duty: A guide for public authorities in Scotland (Equalities and Human Rights Commission)		Yes	Yes	
5. The Fairer Scotland Duty Guidance for Public Bodies (Scottish Government)		Yes	Yes	
6. Glasgow City Health and Social Care Partnership – Equalities Mainstream Report 2020—2024			Yes	
7. Independent professional advice	Yes	Yes	Yes	Yes