INWO decision report

Case: **202310886, Scottish Ambulance Service**

Subject: **Patient safety**

Summary

C raised concern about Scottish Ambulance Service's (SAS) decision to introduce a process that changed the way the organisation managed a small proportion of emergency calls. The process meant that some emergency calls relating to chest pain or breathing difficulty would have a remote consultation with an Urgent Care Practitioner before an ambulance was dispatched. C believed that handling these types of calls using the new process could result in unnecessary delays and could cause harm to patients.

SAS investigated C's concerns at stage 2 of the procedure within the National Whistleblowing Standards (the Standards). The investigation concluded that the process did not result in a higher level of risk to patients overall. However, the investigation recognised the challenges of measuring harm in a complex system. In view of their findings, SAS made recommendations to improve their outcome measurement systems and communication with Urgent Care Practitioners who carry out the remote consultations.

C remained concerned about the risk of harm and the thoroughness of the analysis carried out by SAS. Our investigation involved reviewing SAS's investigation findings and interviewing staff. We concluded that SAS were aware of the balance of risk in using the new process, based on the evidence available at the time. We also noted that SAS had made progress with developing the way they measure outcomes. However, it was unclear whether the recommendations they made had been fully completed. On balance, we did not uphold this aspect of C's complaint.

C was also unhappy with how SAS had handled their concerns. We reviewed whether SAS's handling of the concern was in line with the requirements of the Standards. We identified learning and areas for improvement for SAS in relation to:

- the handling of C's concerns before they raised a formal concern under the whistleblowing procedure,
- managing delays in the investigation process,
- the implementation of recommendations, and
- maintaining confidentiality.

We upheld this part of C's complaint and made a number of recommendations.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C in relation to the handling of their concerns prior to raising a formal concern andthe approach to investigating C's concern which was not effective at protecting their identity. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets

In relation to compliance with the Standards, we recommended:

- Confidentiality must be maintained in line with the Standards in all aspects of the procedure for raising concerns. It is important that all aspects of confidentiality are discussed when the person first raises the concern. Among other things, the discussion should cover:
    - who the concern will be shared with and why;
    - if there is a high risk that their identity could become clear to others, are there ways of reducing that risk; and
    - what action could be taken to limit the number of people who are made aware of the concern, while still taking appropriate action.
- Investigations will often identify changes that are needed to provide services more safely and efficiently, or improve governance arrangements (how the organisation is managed and held accountable for its actions).

Actions must be appropriately planned making sure that relevant parties are kept informed of changes. The organisation should be able to clearly demonstrate that recommendations have been implemented.

- Staff involved in whistleblowing investigations should seek to avoid delays where possible. Those with a responsibility for managing investigations should ensure that participants are clear about their responsibility to provide information in a timely manner.
- The procedure for handling concerns should be supportive to people who raise a concern and all staff involved in the procedure.