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: Glasgow

Case ref: **202411198**

NHS Organisation: Greater Glasgow and Clyde NHS Board

Subject: Staffing and workload

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

Executive summary

1. The complainants (Cs) complained to the INWO about Greater Glasgow and Clyde Board (the Board). The Board had carried out a whistleblowing investigation into their concerns under the National Whistleblowing Standards.

2. The complaint I have investigated is:

    2.1. The Board did not ensure there were appropriate staffing levels in the maternity unit at Queen Elizabeth University Hospital (QEUH) (**upheld**)

    2.2. The Board did not appropriately manage patient demand for the maternity unit at QEUH (**upheld**)

    2.3. The Board did not appropriately manage patient journeys through the QEUH maternity unit (**upheld**)

2.4. The Board did not ensure there was appropriate out of hours support arrangements for staff in the maternity unit **(upheld)**

2.5. The Board did not handle the whistleblowing concerns in line with the National Whistleblowing Standards (the Standards) **(upheld)**

3. In considering the Board's compliance with the Standards, my investigation reviewed the Board's own whistleblowing investigation, including the recommendations it identified, how these were overseen and implemented, the governance arrangements in place, and how the Board provided updates to Cs throughout the process.

4. As a result of my findings, the Board have been asked to implement a number of recommendations and consider and reflect on other feedback, particularly in relation to compliance with the Standards.

5. My investigation also identified a number of areas of good practice by the Board, which has been included in my 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 they are able. The INWO cannot make public every detail of his 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

6. Cs raised multiple concerns about patient and staff safety in the maternity unit at QEUH, under the Board's whistleblowing process in June 2024. This followed earlier concerns raised under business-as-usual in February 2024.

7. The Board's investigation finished in October 2024. The investigation partially upheld or upheld most of the concerns and made a series of recommendations.

8. The INWO received a complaint from Cs on 10 March 2025 because the Board's stage 2 whistleblowing report recommendation due dates had passed without actions being completed. Cs also had ongoing concerns about patient and staff safety issues, including

   8.1. unsafe staffing levels

   8.2. high workloads

   8.3. delays of more than 48 hours to access the maternity unit's labour ward, and

   8.4. lack of management support.

9. They also complained that during the Board's investigation their identities had not been sufficiently protected and they had not been interviewed individually. In addition, they said that communication about progress on the Board's recommendations had been poor following the investigation.

10. 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 Cs' concerns given the potential impact on patient and staff safety.

11. My investigation has focused on the period up to when Cs complained to INWO and whether sufficient action has been taken to address their concerns.

12. In order to investigate Cs' complaint, the INWO

    12.1. took evidence from Cs in writing, telephone and in online meetings

    12.2. reviewed the Board's stage 2 report and complaint file

    12.3. reviewed comments and documentary evidence from the Board, given in writing and in online meetings

    12.4. obtained independent professional advice, and

    12.5. interviewed witnesses.

13. This report and supporting appendixes provide a summary of the evidence I relied on, and my findings and recommendations. A high-level summary of the evidence considered is provided in *Appendix A*.

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

15. In their comments on the draft report the Board explicitly referenced their "desire to maintain open and constructive dialogue with the whistleblowers and to involve them, where appropriate, in the improvement / investment work that follows." We welcome this approach.

Presentation of evidence and analysis

16. This document includes a summary of documents that make up the full INWO report, including a list of the appendices.

Findings and decisions on complaints 2.1-2.5

Point 2.1 - The Board did not ensure there were appropriate staffing levels in the maternity unit at QEUH

17. This complaint considers whether midwifery staffing levels were appropriate at the time that Cs complained to the INWO. A background to the maternity unit and midwifery staffing structure can be found in *Appendix B*.

18. Cs complained that short staffing was directly affecting patient care, patient outcomes and prolonging patient journeys through the maternity unit.

19. Cs told INWO that

    19.1. the funded staffing establishment[1] in the maternity unit had not changed since 2014

    19.2. since 2014, there had been an increase in the acuity[2] of maternity patients, who require more staff care to look after them

    19.3. a midwifery staffing tool exercise carried out in November 2023 had shown the unit at QEUH to be short staffed by 17.2 whole time equivalent (WTE) midwives

    19.4. the midwifery skills mix[3] had been a challenge, because experienced midwives were not replaced like for like when they retired

    19.5. staffing and workload issues made it difficult for new midwives to attain competencies which impacted on retention of both new midwives and those training them

---

[1] The funded establishment is the approved budgeted number of staff a board is resourced to employ to provide a service. The funded establishment was set by the Board when the maternity unit moved into their current building in 2014.

[2] Severity of illness. More patients have complications such as obesity, diabetes or cardiac issues than in 2014.

[3] The balance of midwives at different grades, with different levels of experience.

19.6. there was a heavy reliance on a relatively small group of experienced band six midwives to look after high-risk patients, and this impacted on their wellbeing and retention

19.7. sickness was high, and

19.8. there was insufficient bank staff cover.

20. In interviews Cs said that when staffing was poor

20.1. mistakes happened

20.2. care was not achieved

20.3. there were delays for patients

20.4. activities like medicine rounds were delayed

20.5. breastfeeding was not as well supported

20.6. discharges were delayed and

20.7. it was hard for staff to take breaks leaving them physically exhausted.

21. The Board's stage 2 investigation partially upheld staffing concerns. The investigation report noted that the Board did not have a process for translating the outcome of staffing tool exercises into more staff.

22. During our investigation, the Board provided updates in writing and in meetings as follows

22.1. In April 2025, they told INWO they had

22.1.1. carried out a December 2024 midwifery staffing tool exercise[4] that indicated a need for a further 15.1 (WTE) midwives at QEUH

[4] In line with the Health and Care (Staffing) (Scotland) Act (2019)

22.1.2. recruited additional midwives in February 2025, above the funded number of posts (the funded establishment) in the QEUH maternity unit

22.1.3. agreed an increase in staffing to cover a new way of doing triage (Birmingham Symptom-specific Obstetric Triage System – BSOTS)[5]

22.1.4. been actively monitoring vacancies, bank use, leave, sickness and absence rates, and

22.1.5. appointed a clinical skills midwife to help inexperienced midwives to develop their skills.

22.2. In June 2025, they told us

22.2.1. they had been carrying out interviews for a campaign to recruit newly qualified midwives (NQMs) to join in September 2025, and

22.2.2. they planned to cover all outstanding vacancies, 50% of maternity leave, and additional staffing to implement BSOTS

22.3. In August 2025, they said

22.3.1. a process for translating the findings of staffing tools into increased staff was still being finalised

22.3.2. they acknowledged staff had not seen the benefit of previous staffing tool exercises

22.3.3. there were some known issues with the midwifery staffing tool and a new version had been developed and tested by the Board in July 2025, and

22.3.4. summer months were particularly difficult in terms of staffing due to a seasonal increase in births, staff attrition, reduced bank staff availability and annual leave.

---

[5] The Board told INWO that if the right staff were at the front of the process, i.e. triage, then this would ensure better flow through the system.

22.4. In November 2025, the Board told the INWO

22.4.1. they now had resources in place to support teams to comply with the Health and Care (Staffing) (Scotland) Act (2019)[6]

22.4.2. they had successfully recruited most of the staff they had planned to in September 2025, with some staff due to start in January 2026

22.4.3. they recognised staffing was still a critical risk

22.4.4. they had identified further areas where staffing could be improved and were planning additional recruitment in 2026

22.4.5. some service redesign and system change was likely (e.g. an outpatient approach to induction of labour, elaborated on later)[7], and

22.4.6. a further midwifery staffing tool exercise is to be carried out in summer 2026 as part of their ongoing monitoring of staffing.

23. The Board also described how it managed staffing risks

23.1. a ‘safe to start’ assessment[8] takes place at the beginning of each shift and a Red, Amber, Grey or Green (RAGG) status is allocated for each unit[9]

23.2. this information is shared and acted upon through several internal huddles and at least one cross-site huddle per day, i.e. with the Board’s other 2 maternity units

---

[6] The Act came into effect in April 2024. The Act aims to support strong, evidence-based decisions about staffing and how services are designed and delivered. The Act does not set rules about how many staff there must be, what skills they must have, or what the minimum staffing levels should be. It also does not stop organisations from trying new and innovative ways of delivering care.

[7] The Board’s comments on the draft report stated, “Alongside workforce strengthening, NHSGGC is committed to modernising our maternity services through the redesign of key clinical pathways, including Caesarean Birth and Induction of Labour. We strongly advocate consistent clinical leadership and meaningful patient and family engagement in shaping and embedding these improvements.”

[8] This takes account of staffing, patient acuity and bed occupancy.

[9] Red = no capacity, not enough staff or poor skill mix – help required

Orange = almost at capacity and poor skill mix

Grey = acceptable levels of patients and staff

Green = the unit has additional staff and can support (however Cs told INWO this can change within hours)

23.3. where there are serious issues, possible mitigations include (where appropriate)

23.3.1. moving staff around units to prioritise areas like the labour ward[10]

23.3.2. diverting patients to other units, and

23.3.3. moving midwives between maternity units.[11]

23.4. The Board also takes account of DATIX reports and reporting through other governance processes to monitor staffing issues. They told the INWO they had fostered a culture within QEUH where staff felt able to raise risks on DATIX, including staffing. Staffing and safety were also discussed at each maternity governance meeting.

24. In interviews we were told that the increase in staffing in September 2025 had made a difference; however, as these were NQMs this brought its own challenges in terms of skills mix.

2.1 Findings

25. I took account of written correspondence provided by the Board and the complainants, the complaint file from the Board, what witnesses told me in meetings and interviews, and took advice from a professional adviser.

26. I consider some of the causes of the staffing issues below and the advice given by the professional adviser.

<u>Demographic change</u>

27. Both Cs and the Board agreed there has been an increase in rates of obesity, diabetes, preterm birth and planned caesarean section births amongst maternity patients, since 2014. The Board serves an area where there are persistent health inequalities. They reported a significant increase in women living in deprivation or

---

[10] Patients in active labour normally receive one-to-one care. In other wards the staff to patient ratio can vary, however if staff are moved to the labour ward, this can leave other areas short. Cs described some wards on some shifts having 2 staff to 20 patients, instead of 3 staff to 18 patients.

[11] This is considered a last resort given that the transferring midwife will not be familiar with the unit and this action may cause more problems than it resolves from a human factors perspective.

from the global majority, who have higher risks of poorer outcomes. With more complications, more activity is required to care for patients, and more staffing is needed than was the case when the establishment was set in 2014.

Staffing tool findings and processes

28. Under the *Health and Care (Staffing) (Scotland) Act 2019*, NHS Scotland services must be appropriately staffed. Healthcare Improvement Scotland has made a suite of staffing tools available to help NHS Scotland services plan the number of staff they need. These tools support Boards to identify whether staffing levels are safe and sufficient to meet patient need[12].

29. Midwifery staffing tool exercises were carried out by the Board in November 2023, December 2024 and July 2025, all of which supported the need for an increase in staffing beyond the funded establishment. A lack of action to address the findings of these exercises was a key frustration for Cs, as they saw the outcomes as a clear reflection of the staffing difficulties they were experiencing from day to day.

30. Until as recently as August 2025, we were told by the Board that a process for translating the outcomes of staffing tools into increased staffing had not yet been finalised, and this contributed to the delay.

31. Apart from the staffing tools, there were also other signals of staffing concerns which could have prompted action, for example, staff DATIX reporting, management reporting, whistleblowing concerns and adverse events. It was clear to the INWO that the Board had required significant evidence before agreeing to fund the increase in staffing in September 2025.

32. I understand that the Board has not yet updated the 2014 funded establishment in line with recent recruitment and therefore the current establishment is still short on the outcomes from the previous midwifery staffing tool exercises.

---

[12] For more information see *Health and Care (Staffing) (Scotland) Act 2019 – The Common Staffing Method and Staffing Level Tool*

Sickness and maternity leave

33. Both Cs and the Board told us that there were high levels of sickness in some parts of the unit. In interviews it was acknowledged that some of this was due to work related stress, however it was difficult for the Board to know the extent of this, as stress could present itself across a variety of illnesses.

34. In addition, there were high levels of maternity leave in some of the unit's wards. The Board's policy is to provide 50% cover for maternity leave, and this left some areas of the unit short of staff.

35. This policy is likely to have had a greater impact on maternity services than other areas, because

    35.1. a higher proportion of the workforce are younger women, and

    35.2. there is very little cover for unfilled shifts from bank, especially in the summer months.

Introduction of new and specialist roles

36. From the information given to us by both Cs and Board new ways of working were implemented without a corresponding increase in staffing. For example, we were told there was no additional staffing provided for

    36.1. Newborn and Infant Physical Examination (NIPE) screening, to assess babies for specific health conditions, and

    36.2. the QEUH becoming a specialist Neonatal Intensive Care Unit (NICU) for extremely premature babies[13] under the Scottish Government's Best Start neonatal model, which is in the process of being implemented.

[13] The unit is one of three national Neonatal Intensive Care Units (NICUs) and provides specialist care of babies born at less than 27 weeks gestation, babies under 800 grams at birth, and babies requiring complex life support e.g. cardiac or surgery. QEUH has been receiving all preterm neonatal transfers from Dumfries and Galloway, Ayrshire and Arran and the Royal Alexandra Hospital.

37. We were told by the Board that additional staffing for NIPE has now been agreed and the staffing requirements for Best Start have been scoped. However, these additional workstreams have added to staffing pressures in the meantime.

The national picture

38. The INWO was told that nationally it is difficult to recruit experienced midwives. The Board has tended to focus its biggest annual recruitment on the late summer months when trainee midwives complete their courses.

39. High numbers of NQMs affect the skills mix in the unit. The NQMs need to be given supervision and support to gain experience.

40. The Board told the INWO that they had been doing this through skills midwives (a new role) supporting the NQMs. They said they had also been improving staff retention by providing more opportunities than there had been previously, for example project midwife opportunities.

Professional advice

41. The professional adviser told us that when staffing levels do not match clinical acuity, patient-safety risks increase, including potential for

    41.1. delay in recognising when a mother or baby are deteriorating

    41.2. lack of one-to-one intrapartum[14] care

    41.3. medication errors, and

    41.4. omissions in essential care, and/or

    41.5. a poorer patient experience.

42. They considered that the recent evidence provided by the Board showed a more favourable staffing position relative to the 2014 funded establishment. However, they thought that more frequent use of staffing tools would strengthen evidence of impact

[14] Period from the onset of true labour until after the delivery of the placenta.

of the recent changes made and support the governance oversight of the staffing risks.

43. The adviser said that it was unreasonable that the Board had not finalised a procedure for translating the findings of the staffing tools into increased funding for staff until the November 2025 update, given that the Health and Care (Staffing) (Scotland) Act (2019) came into effect in April 2024.

44. They noted that further service-design opportunities existed to release midwifery capacity, mainly around the use of midwives in theatres (the Board have a recommendation from their own investigation to look at this, which is still in progress).

2.1 Decision

45. The complaint I have investigated is that the Board did not ensure there were appropriate staffing levels in the maternity unit at QEUH.

46. In making my decision, I recognise that the midwifery staffing issues are multi-factorial and that the Board have acknowledged staffing remains a critical risk. I also acknowledge the increase in midwifery staffing at QEUH, since September 2025, as well as the Boards plans to recruit further staff in 2026.

47. However, it was unreasonable that the Board did not have policies and procedures in place to support the outcomes of staffing tool exercises for at least a year and a half after the Health and Care (Staffing) (Scotland) Act 2019 came into force in April 2024.

48. Staffing tool exercises carried out at the end of 2023 and 2024 indicated the need for an increase in staff, however the Board failed to act on these in a timely manner. The Board could have also considered other data such as management reporting, adverse events, DATIX reports and whistleblowing concerns as warning signs that action was required.

49. The delays had a significant impact on Cs and their trust in the Board. Short staffing and high workload impacted on staff retention and sickness. It also reduced the quality of care for patients on some occasions, which will have had consequences for their physical and mental health too.

50. Some of the Board’s other policies and procedures also contributed to the staffing issues. For example, the policy of covering 50% of maternity leave is likely to have had a more significant impact on maternity than on other areas.

51. Finally, I note that there has not yet been an update to the funded establishment for maternity services in line with recent recruitment, i.e. it still reflects the 2014 position.

52. Given the various issues I have highlighted, which remain ongoing despite concerted efforts to improve the situation, I have decided to uphold complaint 2.1 and I have made recommendations.

Point 2.2. The Board did not appropriately manage patient demand for the maternity unit at QEUH

53. This complaint considers whether sufficient measures were taken to balance workloads across the Board’s three maternity units.[15]

54. Cs told the INWO that the midwives at QEUH experienced high workloads, that were difficult to manage. They said

    54.1. demand for planned induction of labour and caesarean birth often exceeded the preplanned slots available at QEUH, and additional patients had to be incorporated into the labour ward workload out of hours

    54.2. the unit had to manage and prioritise unplanned demand from patients arriving in spontaneous labour including some patients that had never contacted the unit before, and

    54.3. they also received unplanned demand of a specialist nature as the unit is one of three centres in Scotland that receives extremely pre-term women[16] and babies from other areas under the Scottish Government’s Best Start arrangements.

55. Cs described some of the other reasons for the high workload as being

---

[15] QEUH, Princess Royal Maternity Hospital (PRM), Royal Alexandra Maternity Unit

[16] Extremely preterm women may be sent to the QEUH as a precaution. They may be monitored in the labour ward if it is likely that they will give birth prematurely.

55.1. the increased acuity of patients

55.2. staffing issues as discussed under complaint 2.1

55.3. increased numbers of planned caesareans and inductions of labour either through patient choice or because of a medical decision

55.4. patients choosing to bypass other units to have their babies at QEUH, and

55.5. a patient focused visiting policy that allowed partners to stay over, making QEUH more attractive than the other two units.

56. The Board acknowledged and partially upheld workload issues in their stage 2 response.

57. Across information requests, meetings and interviews the Board told INWO

57.1. there was at least one cross-site huddle per day to provide opportunities for units to support each other and to arrange diverts where necessary

57.2. the maternity unit's location and ability to carry out ongoing high-level care and various specialist interventions for babies, made QEUH a natural venue for specialist work

57.3. the numbers of patients had not actually increased in recent years, but the acuity and activity required to look after patients had

57.4. there had been an increase in inductions of labour as part of a strategy to reduce the numbers of still births, and

57.5. the numbers of planned caesareans had also increased through maternal choice with those giving birth by caesarean section exceeding the number of vaginal births for the first time in 2024.

58. To address the issues raised by Cs the Board told the INWO they had

58.1. implemented a postcode project which had been redirecting patients from selected postcodes towards other units[17]

58.2. they revised the visiting policy at QEUH in July 2025 to limit the circumstances in which partners could stay over, and

58.3. set up a women and children's workforce planning group to focus on the development of a dashboard to enhance workload visibility.

2.2 Findings

59. I considered written correspondence provided by the Board and Cs, the complaint file and information requests from the Board and what witnesses told me. My findings are set out below.

60. The maternity unit at QEUH has multiple demands placed on it, some of which are different to the Board's other units, for example the QEUH's specialist work. We were told by both Cs and the Board that planned capacity (slots) for caesarean births and inductions can be exceeded, before other unplanned demands are considered.

61. As already discussed under 2.1 patient acuity has increased, as has the activity required to look after patients. Staffing issues have also placed a greater demand on the remaining staff. Delays in accessing the labour ward and theatres have also increased the risks of complications, which can cause patients to stay for longer.

62. Patient choice has also been a factor. Patients can choose where they give birth and by what procedure. If, as increasingly happens, a patient chooses to give birth via a caesarean section, then any subsequent births will be by caesarean section as well, so the additional workload will continue for future births.

63. The unit has a specialist role in accepting extremely premature babies, and for foetal medicine, including cardiac and surgery. This brings in women and/or babies from other units in the area and from outside the area. This is often unplanned and Cs told

[17] Particularly to the PRM. PRM is a similar sized unit to the QEUH. In 2022 there were 570 more births at QEUH. From November 2024 to November 2025 this had reduced to 134 births, with PRM correspondingly busier than before.

me that because of the QEUH's specialist role there is pressure to find room for these patients, even when the unit is full.

64. I recognise that the Board monitors the workload across the units daily, and there is guidance for moving staff and an escalation policy that allows for patients to be diverted to other units. However, this only works if the other units have capacity.

65. The Board have tried several initiatives to help improve matters at QEUH and to distribute the workload across the units. Cs acknowledged

    65.1. the changes to the visiting policy have improved the security of the unit and reduced tensions, and

    65.2. the postcode project had shifted some numbers away from QEUH.

66. However, neither of these changes have made a significant difference to the workload at QEUH. In the meantime, staff at other units have reported increased workloads.

67. In mitigation, I recognise that

    67.1. the postcode project has further phases to run, so this may improve matters in the future

    67.2. other initiatives being tried by the Board are likely to improve patient flow which may in turn improve capacity across all the units (I discuss these in the next section), and

    67.3. the improvement in the staffing situation across the maternity units will have had a beneficial impact, in that there are now more midwives to share the workload, providing that staffing keeps up with attrition.

68. However, there is also a risk that the efforts to move workload from QEUH may eventually result in other units feeling workload pressure.

2.2 Decision

69. The complaint I have investigated is that the Board did not appropriately manage patient demand for the maternity unit at QEUH.

70. In making my decision I recognise that this issue has been complicated by patient acuity and activity, staffing, patient choice and QEUH's specialist role.

71. The Board have attempted to move demand to other units, but in light of the various issues I have highlighted, I find that there is sufficient evidence to uphold point 2.2 of this complaint and I have made recommendations.

Point 2.3. The Board did not appropriately manage patient journeys through the QEUH maternity unit

72. In their complaint, Cs told us that pre-booked patients were regularly waiting between 48 and 72 hours to access the labour ward for induction of labour and that delays had led to frustration and inappropriate behaviour from patients and birthing partners.

73. Cs told INWO that

    73.1. patient access to the labour ward and theatre was prioritised according to medical need

    73.2. the picture was further complicated by patients spontaneously arriving in active labour who had a higher priority than patients waiting to be induced

    73.3. senior midwives had responsibility for prioritising patients, and

    73.4. there was a lack of support from the multi-disciplinary team (MDT) to manage prioritisation of delayed patients.

74. Cs told INWO the risks of delaying patients for induction of labour were sepsis and more complicated births. They said that if patients gave birth outside of the labour ward (due to lack of capacity), other areas were not equipped to provide some types of pain relief or deal with complications like haemorrhages. This could affect patient outcomes, and lead to prolonged stays requiring additional observations.

75. In interviews Cs were also concerned by the limited capacity of the labour ward which has twelve rooms. They described a recent situation where multiple patients at risk of very premature birth, were being monitored in the labour ward at the same

time,[18] and this had reduced the capacity for pre-booked patients which then had to be managed.

76. Cs also complained that daily huddles were ineffective for resolving flow and capacity issues, and that often the status quo had to be accepted. They were also concerned there was a lack of management visibility in the maternity unit when there were issues.

77. The Board's investigation at stage 2 of the process partly upheld Cs' concerns noting

77.1. the MDT's approach to delays, was to view these as service issues and this put greater pressure on midwives

77.2. when there was no capacity in theatre or labour ward it fell to the midwives to decide whom to delay and to explain this to the patient, and

77.3. it felt to the midwives that they were carrying the risk of this alone.

78. Across information requests and interviews the Board acknowledged

78.1. that patient flow was an ongoing issue

78.2. delays, compounded by high vacancy and sickness absence rates had led to suboptimal care and poor experiences for patients and families

78.3. the lists for inductions of labour and planned caesareans could exceed the planned slots available

78.4. the numbers of slots available for inductions and planned caesareans had not changed despite an increase in demand for them, and

[18] As discussed under complaint 2.2 this is a precaution for extremely preterm patients who are at risk of giving birth, given that they are likely to give birth very quickly.

78.5. that senior midwives were expected to prioritise patients for the labour ward and theatre (with obstetric input), and that this role could feel particularly exposed, especially out of hours[19].

79. To mitigate flow issues the Board said

79.1. daily internal huddles took place which looked at

79.1.1. how many inductions of labour were waiting

79.1.2. delayed access to the labour ward, and

79.1.3. the risks for individual patients, for example cardiac women.

79.2. the implementation of BSOTS would help relieve pressure in all areas

79.3. they had started improving flow meetings with the MDT to improve booking of planned caesarean births

79.4. a new approach to managing inductions had started in June 2025, focusing on out-patient inductions for low-risk women, to reduce ante-natal bed occupancy

79.5. they had started a unit MDT huddle at 11am every day to discuss pressures and make decisions, and there were good working relationships between midwives and obstetricians on the unit

79.6. an additional theatre had been identified to address the daily planned caesarean operating list, and

79.7. the Board had put on additional out of hours and public holiday lists to try and create capacity.

[19] In their comments on the draft report the Board told the INWO, “We are clear, and our clinical leaders and senior managers have confirmed, that midwives are not left to make unilateral decisions on the prioritisation of patients for labour ward or theatre. This is, and must remain, a shared multidisciplinary-team (MDT) responsibility, supported by robust, evidence-based criteria and involving consultant obstetric input for final decisions on medical complexity. We fully acknowledge the concerns raised by the whistleblowers that this shared accountability was not always felt in practice, and we are therefore committed to introducing clearer fail-safes, escalation pathways and real-time senior obstetric availability so that every member of the team feels supported and able to access medical decision makers promptly.”

80. Regarding the professional risks to midwives, the Board told the INWO

    80.1. that support was available from obstetrics colleagues,[20] and

    80.2. if co-ordinators escalated safety concerns when they occurred, the Board was responsible for anything of consequence that followed.

81. In interviews the Board disagreed that there was no management visibility. Some managers had acted down, for example to cover staff illness and this had been appreciated by staff. They said senior management also carried out monthly visits; this translated into one visit per quarter to each unit. The INWO was told staff engagement with the visits had increased over time, including amongst junior staff. There were also six weekly meetings between senior managers and Cs.

2.3 Findings

82. I considered written correspondence provided by the Board and Cs, the complaint file from the Board, what witnesses told me and professional advice. My findings are set out below.

83. I did not find any disagreement between the parties that there were issues with patient flow through the unit and that there had been significant delays to access the labour ward and theatres.

84. It was also clear that a significant responsibility was placed on senior midwives to prioritise patients, and that the risks associated with this were not fully shared by the MDT.

85. I found it difficult to balance the competing perspectives on the issue of management visibility. Better identification may make it more obvious when senior managers are visiting the unit, especially when it is busy.

86. While the Board has been taking various actions to address capacity and flow, many of the initiatives are at an early stage. There was not always agreement between Cs

[20] Cs told the INWO that the co-ordinators received medical advice from the obstetricians, however it was not considered part of the obstetrician's role to support prioritisation.

and the Board about the effectiveness of the actions, and I briefly consider some of these issues below.

Birmingham Symptom-specific Obstetric Triage System (BSOTS)

87. BSOTS is a nationally recognised model for maternity triage that enhances prioritisation of unscheduled maternity attendances, i.e. women presenting with unexpected complications or concerns. As well as aiming to triage patients who arrive within 15 minutes of arrival, BSOTS also provides a central point for all calls coming into the unit, thus reducing the call demand on other areas. Once this is fully implemented, the Board expects that BSOTS will help to improve patient flow through the unit.

88. Cs expressed concerns about the staffing being below the minimum recommended in the model in the implementation of BSOTS to date. The Board told us that the implementation had been affected by staff sickness, with only a few weekly shifts being fully staffed according to the model. The Board recruited additional staffing for this project in September 2025 which should help to address the staffing concerns. It is too early to say what impact this project is likely to have on patient flow.

Outpatient approach to inductions of labour

89. The Board told INWO a new approach to inductions has been tried since June 2025 involving the insertion of a balloon (Cooks balloon), as an alternative to prostaglandins (a pharmacological process to induce labour which requires patients to stay on the ward). Once the balloon is in place the patient can go home while it takes effect, returning later to access the labour ward and give birth. This potentially reduces bed occupancy in the ante-natal ward. At the time of reporting the balloon had been used in around 40% of induction of labour cases.

90. Cs were concerned that some QEUH patients were not suitable for this initiative. Also, in early trials, Cs and the Board reported that patients called back to the unit to give birth were caught up again in the delays and prioritisation, limiting the effectiveness of the approach.

91. In interviews, the Board said that the procedure was effective for most patients that wanted it. The INWO was told the procedure required a pro-active approach to call women back in for labour. I understand the Board now has plans to separate out this stream of work with dedicated staff, so that patients with the balloon can access the labour ward more quickly. At this stage it is not clear how effective this will be in increasing bed capacity and reducing delays.

Huddles and MDT huddle

92. In addition to safe to start huddles, the Board started a daily MDT huddle in January 2025 to enhance MDT communication around pressures or key decisions needing to be made[21]. Cs were sceptical of their effectiveness at resolving issues, particularly around flow and capacity.

93. Those involved in leading the huddles considered them to be effective, and an opportunity to check progress throughout the day. They also noted that sometimes the flow and capacity issues were not possible to resolve due to difficult circumstances across all the units.

Out of hours and holiday lists

94. Out-of-hours and holiday theatre lists were tried to reduce pressure on planned caesarean section slots during normal working hours. These lists did not have the intended impact because there were not enough midwives available to support them. Consultants covering these lists received a financial enhancement, but this was not available to midwives.

Professional advice

95. The professional adviser reported that several recent maternity inspections in Scotland and reviews in the rest of the UK had highlighted concerns around long waiting times for induction of labour and increased clinical risks due to increasing acuity.

[21] Those invited include anaesthetics, neonatology, obstetrics and midwifery, as well as the unit Senior Charge Midwives and Lead Midwife.

96. From the information provided by the Board, the professional adviser was not clear on what changes had been made to MDT working following the Board's own whistleblowing investigation report.

97. They said that clinical prioritisation should be an MDT approach, and that prioritising patients should be jointly led by an obstetrician to ensure all risks are identified and that the decisions made are appropriate.

98. They noted that plans to increase staffing for community services should also impact on hospital flow, and in turn have a positive impact on inpatient bed capacity.

99. The adviser recommended reviewing the huddles and the effectiveness of these, including MDT input.

2.3 Decision

100. The complaint I have investigated is that the Board did not appropriately manage patient journeys through the QEUH maternity unit.

101. I acknowledge the complexity of the system, and I recognise there are multiple factors that are likely to have impacted on patient flow, including those discussed under previous complaints.

102. I recognise the Board has proposals to address patient flow issues, and that most of the Board's work is at an early stage.

103. The Board's investigation identified problems with the MDT taking joint responsibility for patient prioritisation and recommended that this be reviewed. This does not appear to have been fully effective, and advice provided to me highlighted that midwives require greater support to prioritise patients.

104. In addition, it is not clear that huddles have consistently resolved capacity and flow issues. While I recognise that some of these challenges may not have straightforward solutions, this reinforces the need for additional measures to improve flow and create capacity where possible.

105. I therefore uphold this complaint, as more work needs to be done to improve patient flow, to ensure that huddles are effective and that midwives are appropriately

supported by the MDT to prioritise waiting patients. I have made recommendations around reviewing the effectiveness of huddles and the process for prioritisation of patients.

106. I have not made additional recommendations on capacity because this is already included within a recommendation from the Board's investigation that is still outstanding. However, I have made a recommendation on the governance arrangements and timely actions required to implement recommendations from local whistleblowing investigations.

Point 2.4. The Board did not ensure there was appropriate out of hours support arrangements for staff in the maternity unit

107. Cs complained to INWO that

107.1. out of hours cross-site huddles only took place if one unit was at a red RAGG status

107.2. out of hours huddles were not effective to resolve issues, as there were no senior managers in attendance

107.3. capacity issues were not addressed during the day, when more managers were available

107.4. the out of hours escalation arrangements were ineffective because they were not specific to maternity services, and

107.5. an informal arrangement for staff to contact more senior managers at times of escalation was ineffective because staff felt reticent to use it.

108. Across evidence requests and interviews the Board said that

108.1. they had carried out a consultation with senior midwives about the out of hours huddles and this had influenced the decision not to go ahead unless one of the units was at a red RAGG status

108.2. senior managers had attended the out of hours huddle on their own time, on an ad-hoc basis

108.3. they acknowledged that there were issues that were not resolved during working hours and a proposed new role would potentially reduce the number of issues for out of hours staff

108.4. some of the senior maternity managers were on the acute services out of hours rota

108.5. it was not possible to have a separate maternity out of hours rota given the small number of managers

108.6. a separate rota would also have a knock-on effect on the acute services rota if managers were withdrawn, and

108.7. informal support was available from senior managers when units were under pressure, but this was not guaranteed.

2.4 Findings

109. I considered written correspondence provided by the Board and Cs, the complaint file from the Board, what witnesses told me and took professional advice. I have set out my consideration of the issues raised by Cs below.

110. Out of hours huddles only take place when one unit is at a red RAGG status and help is required. Senior managers do not normally attend the meeting, therefore those on the call are the same staffing band. If there is no-one with seniority in the meeting, decision making is likely to be more difficult, as there is no-one with an independent view of the situation across all the units.

111. I reviewed the escalation process. I was told that senior maternity managers are included in the acute out of hours rota for 4 out of 14 shifts. However, much of the duty rota is covered by managers who do not have any maternity experience, which can limit the support available during escalations.

112. I found that informal arrangements were not sufficient as staff were less likely to engage when they needed support, creating further risks.

113. I consider that staff should have access to senior maternity management support when it is needed, given the professional risks and the implications for patient and staff safety.

Professional advice

114. As noted already, the professional adviser recommended reviewing the effectiveness of the huddles. They also recommended reviewing whether there should be an additional huddle at the end of normal working hours to address issues that would otherwise be passed to out of hours colleagues.

115. They considered the current escalation process to be reasonable; however, they felt it could be enhanced, for example, with triggers for staff to know when to move to the next stage of escalation.

116. They said it could be unreasonable to expect a small group of managers to cover a full out of hours rota for maternity. They also noted that separate maternity on call arrangements could have a negative impact on the visibility of maternity services as part of system wide decision making, during the Board's out of hours service.

117. Instead, they said that the Board should assess the knowledge gap for all on call managers on the acute services rota and equip them to better support maternity services with escalations.

118. In addition, they recommended replacing the current informal arrangements with a formal arrangement, with specific triggers for when a dedicated midwifery on call system would be required - for example, times of increased acuity, major incident and increased dependency.[22]

2.4 Decision

119. The complaint I have investigated is that the Board did not ensure there was appropriate out of hours support arrangements for staff in the maternity unit.

[22] It is less likely that this will be needed if the managers on the acute out of hours rota are suitably trained to provide support.

120. In making my decision I recognise that there is a small senior management group in maternity services and this limits the options available for out of hours support for midwives. However, it is also not reasonable for staff in the unit to be unable to access meaningful out of hours support when they need it.

121. I have therefore upheld complaint 2.4 as I consider it reasonable for the Board to improve the out of hours support and escalation arrangements and I have made recommendations accordingly.

Point 2.5 The Board did not handle the whistleblowing concerns in line with the National Whistleblowing Standards (the Standards)

122. The key issues considered under this complaint were whether

    122.1. the Board sufficiently protected the identities of the complainants

    122.2. the Board interviewed all relevant staff involved in the concern, and

    122.3. the communication with the complainants following the stage 2 response was appropriate.

123. The INWO also has a role to consider how concerns are handled in line with the Standards. One of the areas of concern for the INWO was

    123.1. the length of time taken for the Board's own investigation recommendations to be actioned.

2.5 Findings

124. I took account of written correspondence provided by the Board and the complainant, the complaint file from the Board and what witnesses told me. My key findings are set out below.

Whether the Board sufficiently protected the identities of the complainants

125. The complainants said that in the latter stages of the Board's investigation their identities were discussed by consultants, who were clearly aware they had whistleblown. Cs contacted the Board's whistleblowing team and investigator to advise them of this.

126. The INWO was told by the Board that Cs had initially raised their concerns in a meeting with managers, prior to whistleblowing. Therefore, some of the managers interviewed as part of the investigation had a prior knowledge of who the whistleblowers were. Nevertheless, the Investigating Officer had emphasised to those that they spoke to that the process was confidential, and they had obligations to protect Cs against detrimental treatment.

127. The whistleblowing team asked Cs for further information about the breach of confidentiality; however, they said that the information provided by Cs was not specific enough to directly address the matter with any individual(s).

128. Part 2 paragraph 60 of the Standards says that "Confidentiality must be maintained as far as possible in all aspects of the procedure for raising concerns. Staff need to know that their identity will not be shared with anyone other than the people they have agreed can know it, unless the law says that it can or must be. The name of the person raising the concern must not be routinely or automatically shared at any point, either during the investigation or afterwards. There are, however, times when information about the person raising a concern will become clear to others, or when it will be necessary to share this information in order to put things right or continue with an investigation."

129. In this case, I recognise that the circumstances of how the concerns were raised may have led to Cs' identities being shared. To appropriately manage situations like this, I would remind the Board to ensure that they discuss confidentiality with whistleblowers and ways of reducing the risk of their identities being shared (paragraph 62, part 2 of the Standards).

Whether the Board interviewed all relevant staff involved in the concern

130. Cs complained to INWO that they were not interviewed as part of the Board's investigation process and therefore that the process had felt one sided.

131. From the Board's case file, it is apparent that Cs raised this as an issue by email at the same time as the confidentiality concerns above.

132. The Board responded that the investigation was nearly completed but they would welcome any further evidence Cs felt was necessary to the investigation. The investigation was completed shortly afterwards without interviews taking place.

133. In interviews the INWO was told by the Board that

    133.1. the normal approach of the Board where more than one person raises a concern was to see them together, however people can see the investigator individually after the initial discussion

    133.2. Cs were spoken to in a group setting at the outset of the investigation

    133.3. the issues of concern were summarised and shared with Cs for approval

    133.4. in this case Cs had made changes to the issues under investigation, and therefore it was felt there was a common understanding

    133.5. the investigator had chosen to interview people with responsibility for the issues of concern to be assured that they were aware of them and were taking appropriate steps, and

    133.6. that on reflection, a better explanation to Cs of the Board's approach to interviewing a group of staff raising concerns would have been beneficial.

134. I accept the Board's explanation for why Cs were not individually interviewed. However, I can also understand why Cs were disappointed not to be interviewed.

135. Paragraph 49.2 of part 3 of the Standards says that investigators must "give everyone involved the right to be heard."

136. I consider that Cs were given a right to be heard at the outset of the investigation and were offered an opportunity to provide evidence at the end stage of the investigation. While I recognise Cs' concerns about the impact the lack of individual interviews with them may have had on the report, I do not consider that the approach significantly impacted on the fairness of the final outcome, as the investigation partially or fully upheld the majority of their concerns.

137. I have provided feedback that a better explanation of the Board's approach to interviewing a group of complainants would be helpful.

Whether the communication with the complainants following the stage 2 response was appropriate

138. Cs reported to INWO that there had been a meeting with the Board after they received the stage 2 response. However, by the time they complained to the INWO, they said that deadlines for recommendations had passed without comment from the Board.

139. The Board told INWO that regular meetings had been arranged for Cs to meet with managers to ensure there was open communication about progress. However, engagement by Cs had been limited at meetings in early 2025.

140. Cs responded that they were being asked to attend the meetings on their own time, and meetings were scheduled for times that conflicted with caring responsibilities.

141. Paragraph 21 of part 3 of the Standard says, “Concerns raised at stages 1 and 2 of this procedure 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). Any improvements must be appropriately planned, making sure that everyone concerned is kept informed of changes.”

142. I consider that it is the Board’s responsibility to agree with whistleblowers, how changes and actions from recommendations will be communicated and how often. Failure to do so can result in whistleblowers being concerned that the Board does not intend to implement the recommendations and can result in a complaint to the INWO.

143. In this case, I consider that the Board did not do enough to communicate with Cs about the recommendations following the Board’s investigation.

The length of time taken for the Board’s investigation recommendations to be actioned

144. Following on from the concern above, the INWO requested an update on the progress of the recommendations from the Board’s investigation. The recommendations were

shared with Cs in October 2024 (Cs complained to the INWO five months later in March 2025) and of these, at the November 2025 update

144.1. seven had been completed (of which six were completed after the deadline)

144.2. six were still in progress after the deadline, and

144.3. one had not been taken forward.

145. In interviews the INWO was told by different parties that the reasons for the recommendations not being carried forward in a timely manner were respectively staffing and workload, and money.

146. Some actions were also contingent on other parts of the Board being able to prioritise the needs of the maternity service. For example, capital spending is required to bring a theatre previously used by another service up to standard for the maternity unit.

147. The INWO was told that actions had been taken where there was no contingency or funding issues. For example, the visiting policy at QEUH had been fairly quickly revised in response to concerns by both patients and staff.

148. It is not clear that those responsible for implementing the Board's investigation recommendations had the resources needed to deliver them. Governance oversight does not appear to have been sufficient to ensure actions were completed within expected timescales. This raises concerns about whether the executive team and the Board had clear visibility of progress and were able to support improvement effectively. While recommendations remain outstanding, there is an ongoing risk that the underlying issues persist; the Board should evidence proportionate interim controls and risk management until full implementation is achieved.

149. Paragraph 2 of part 4 of the Standards says, "Board members need to show interest and enthusiasm for issues that arise through concerns raised by staff, and in particular, to support the learning and improvements that stem from them. They also need to ensure that the arrangements in place act to promote trust between staff and the board in raising concerns."

150. Paragraphs 19 and 20 of part 5 of the Standards discusses the role of senior management review in the process, “Concerns must be analysed for trend information to ensure service failures are identified and appropriate action is taken. Quarterly reporting to senior management helps to identify how services could be improved or internal policies and procedures updated. Where appropriate, this review must also consider any recommendations made by the INWO in relation to the investigation of NHS whistleblowing concerns.

    The outcomes of these reviews should be reported via the organisation’s governance structure to the NHS board for review by its members, or equivalent governing body.”

151. In this case, the Board was slow to progress its own recommendations and the associated learning and improvement. The delays affected how the system functioned and contributed to a loss of trust in the Board’s ability to address concerns in a timely way.

152. Until recommendations are completed, the Board should demonstrate how ongoing risks are assessed, monitored and controlled, including clear ownership, timescales and escalation routes within the governance framework.

153. I consider that the Board has been slow to supporting the learning and improvement from this case. The delays in acting have also negatively impacted on Cs trust in the Board to resolve concerns.

2.5 Decision

154. The complaint I have investigated is that the Board did not handle the whistleblowing concerns in line with the National Whistleblowing Standards (the Standards).

155. For Cs, I recognise their concerns about their identities potentially being shared more widely and I acknowledge their concerns at not being individually interviewed. However, I do not consider these were deliberate failings to follow the Standards by the Board. I have provided feedback for the Board to make improvements on these issues.

156. I find the delays in addressing the recommendations within the timescales recommended in the Board’s investigation report and the lack of ongoing

communication about progress to be of greater concern. To build confidence in the whistleblowing process the Board needs to be more responsive to its own whistleblowing investigation findings. Failure to do so, as in this case, has resulted in a complaint to the INWO.

157. I find that there is sufficient evidence to uphold point 2.5 of this complaint and I have made recommendations.

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 for Cs

Rec. No	What INWO found	Outcome needed	What INWO need to see
1.	Under heads of complaint 2.1 to 2.5 I found • the Board could have acted sooner to address serious staffing concerns • midwives were not sufficiently supported by the MDT to prioritise waiting patients	Apologise to Cs for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	A copy or record of the apology including (where relevant) • an expression of empathy • an acceptance of what has gone wrong • an acceptance of responsibility • an acknowledgement of the effect the problems have had for Cs

Rec. No	What INWO found	Outcome needed	What INWO need to see
	• midwives were not given an appropriate level of support during escalations out of hours • the Board did not effectively communicate with Cs about progress on the recommendations from its own whistleblowing investigation • the Board significantly delayed addressing its own whistleblowing investigation recommendations.		• an explanation of why the problem occurred • a description of anything that is being done to put matters right/to avoid the problem happening in the future. By: 18 April 2026

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
2.	Under 2.1 I found • there were delays in recognising the risks being highlighted by staffing tools and other data available to the Board, about the midwifery staffing levels • the Board's maternity cover policy continues to create staffing shortfalls • recent changes in staffing have not been consolidated under the funded establishment	The Board should ensure that maternity units are safely staffed to provide appropriate patient care.	Evidence that appropriate governance and risk arrangements for safe staffing levels at all of the boards maternity units are in place. This should include • governance and risk-register oversight of midwifery staffing • systems that triangulate data from staffing tools, cross-site huddles, management reports, DATIX and whistleblowing to support decisions on safe staffing • use of the staffing tool at a frequency that provides assurance to staff and the Board • assessment of risks created by the Board's 50% maternity leave cover policy • confirmation of the appropriate funded establishment for midwifery staffing Appropriate evidence may include reports, briefings, decision maker minutes, action plans, risk assessments, and risk registers. The Board should also consider benchmarking with other similar Boards. By: 18 July 2026

Rec. No	What I found	Outcome needed	What INWO need to see
3.	Under 2.2 I found • the Board did not appropriately manage patient demand for the maternity unit at QEUH.	The Board should ensure that there is sufficient maternity capacity to meet current and future demand.	Evidence that appropriate governance and risk arrangements for maternity capacity are in place. This should include • governance and risk-register oversight of capacity issues • analysis of whether current capacity remains sufficient in light of increased acuity and the introduction of specialist roles not anticipated in 2014 • assessment of risks to other units becoming overwhelmed due to patient transfers under the postcode project Appropriate evidence may include reports, briefings, decision-maker minutes, action plans, risk assessments and risk registers. By: 18 July 2026

Rec. No	What I found	Outcome needed	What INWO need to see
4.	Under 2.3 I found • huddles were not always effective to resolve issues • more work is required to ensure that midwives are supported to prioritise patients waiting for the labour ward or theatre.	The Board should ensure huddles are effective in managing issues and that patient prioritisation is consistently supported by the MDT.	Evidence that appropriate governance and processes are in place to support safe prioritisation of patients waiting for labour ward or theatre. This should include • review and assurance of effective multidisciplinary decision-making at huddles • a clear, consistent prioritisation process, including obstetric support for midwives responsible for prioritising patients Appropriate evidence may include reports, briefings, minutes from decision-making meetings and staff meetings, policies and standard operating procedures. By: 18 June 2026

Rec. No	What I found	Outcome needed	What INWO need to see
5.	Under 2.4 I found • escalation arrangements for out of hours were inadequate	The Board should ensure that there are formal and adequate out of hours escalation routes.	Evidence that appropriate governance and escalation arrangements for out-of-hours decision-making are in place. This should include • review of out-of-hours huddle effectiveness and steps taken to strengthen decision-making • review of whether an additional huddle is needed at the end of normal working hours • an updated escalation policy with defined trigger points for each escalation stage • training or information for managers on the out of hours acute services duty rota to support maternity escalation • a formalised procedure for when a dedicated midwifery on-call system is needed, based on clear trigger points Appropriate evidence may include reports, briefings, minutes of relevant meetings, staff meeting minutes, training materials, and policies or standard operating procedures. By: 18 June 2026

What INWO are asking the Board to do to improve their compliance with the Whistleblowing Standards

Rec. No	What INWO found	Outcome needed	What INWO need to see
6.	Under 2.5 I found • the Board's communications with Cs about progress made on its whistleblowing investigation recommendations was inadequate. • The Board did not implement its own recommendations, or support the associated learning and improvement, in a timely way.	The Board should agree how it will communicate with Cs and the frequency of communication about recommendations following an investigation. The Board should ensure there is effective governance in place to oversee the implementation of recommendations arising from whistleblowing investigations. If recommendation deadlines are not being met, the Board should update whistleblowers on anticipated timescales and the reasons for this. The Board should ensure that it follows the Standards and supports	Evidence that appropriate governance and oversight arrangements are in place to manage whistleblowing recommendations and communication with whistleblowers. This should include • governance and risk arrangements showing who is responsible for managing whistleblowing recommendations and how the executive is updated • an agreed communication plan with Cs covering updates on recommendations from both the previous and current investigations • an action plan with timescales and responsible owners for outstanding recommendations from the Board's own investigation

Rec. No	What INWO found	Outcome needed	What INWO need to see
		the learning and improvement from upheld whistleblowing concerns.	• changes to whistleblowing processes that strengthen governance oversight and promote timely learning and improvement Appropriate evidence may include meeting minutes, correspondence, reflective learning reviews, reports, briefings, and relevant policies or standard operating procedure. By: 18 June 2026

Feedback for the Board

General

158. My investigation was helped by the co-operation of the witnesses who were interviewed, Cs and the Board's liaison officer. I am grateful to all of them for their assistance and their constructive and thoughtful engagement with the process.

159. It is evident that trust between Cs and the Board has been affected during this process. The Board should consider how it can support the restoration of trust, for example through organisational development support.

160. I remind the Board that they have an ongoing obligation to protect Cs from detriment relating to speaking up.

Whistleblowing concerns handling

161. Under complaint 2.5 the Board should consider

    161.1. how it ensures confidentiality is managed with a group of whistleblowers, and how this is discussed at the start of the investigation, and

    161.2. how it provides information about options for interviews where there is a group of whistleblowers

Summary of documents that make up the full INWO report

Document Name	Description	Published/private
Summary Report Reference: 202411198	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
Appendix B: Background	Background to the maternity unit and staffing structure	Published with the summary report

Appendix A: 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 complainants 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 final stage
Appendix A: High level summary of evidence relating to all points	Summary of the evidence considered in this case.	None Published in full with summary report

Description	Relevant to complaint:
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 *National Whistleblowing Standards | INWO*	2.5
1. *Complaint and documents provided by Cs* The starting point for our investigation was Cs’ concerns submitted to the Board and their complaint to INWO.	All
2. *The Board’s stage 2 report and complaint file* We sought and obtained the Board’s complaint file. This material included: i. The Board’s stage 2 final investigation report dated 23 October 2024 ii. Copies of correspondence between Cs and the Board iii. Copies of correspondence related to the investigation iv. Interview transcripts v. SAERS and complaints data vi. Meeting summaries and presentations vii. Copy of an action plan	All
3. *Additional evidence provided by the Board* 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.	2.1 – 2.4
i. Safe to start reports ii. Situation, Background, Assessment, Recommendation report	2.1 – 2.4

Description	Relevant to complaint:
iii. Escalation policy iv. Good practice guide for movement of midwives v. Copies of surveys vi. Births, diverts and staff movements vii. Communications relating to visiting changes	
4. Interview testimony from key personnel involved in the investigation	All
5. Professional advice	2.1 -2.4

Appendix B: Background and context to the complaint

1. This appendix provides a background to the complaint made to INWO.

2. **This appendix is not a confidential document and there are no restrictions on sharing it once published.**

Document Name	Description	Restrictions at final stage
Appendix B: Background to the complaint	Context to the complaint	None Published in full with summary report

The structure of maternity services at the Board

3. There are three maternity units under the Board at Queen Elizabeth University Hospital (QEUH), Royal Alexandra Hospital and Princess Royal Maternity Hospital (PRM). The unit complained about (QEUH) is the busiest by numbers of babies born (5,218 births from 1 November 2024 to 1 November 2025). QEUH and PRM have similar capacities; since May 2024 the Board has been working to redirect births from QEUH, mainly to PRM.

4. The maternity unit at QEUH includes

   4.1. triage

   4.2. labour ward

   4.3. theatre

   4.4. antenatal, gynaecology and postnatal wards

   4.5. neonatal unit

   4.6. Early Pregnancy Assessment Service (EPAS) and clinics (during normal working hours).

Staffing

5. By increasing seniority, the QEUH midwifery staffing structure is as follows

   5.1. Band 5 newly qualified midwives who are developing their training and skills

   5.2. Band 6 midwives, who are more experienced, although they may be developing specific skills if they have come from other settings (e.g. community)

   5.3. Band 7 Charge Midwives – there are two charge midwives per shift, one co-ordinates the labour ward, the other co-ordinates the unit, especially out of hours

   5.4. Each ward has a band 7 Senior Charge Midwife, who may also take turns co-ordinating during normal working hours

   5.5. A Lead Midwife, and

   5.6. The Director of Midwifery

6. To provide an appropriate and safe level of care to patients requires a good skills mix of bands on each shift. The band 7 co-ordinating the unit is generally responsible for ensuring the staffing is as safe as possible and matched to the acuity of the patients. If necessary, they will move midwives around the unit to support other areas, particular to cover the labour ward where 1:1 care is provided.

7. QEUH is unique in having midwives also working in theatre, for example doing scrubbing and suturing. In other health boards this work is done by scrub nurses.