

INWO decision report



Case: 202406209, Forth Valley NHS Board

Subject: Policy/ admin

Decision: Fully upheld

Summary

C raised a concern about extra patients being seen within a service, which circumvented the normal route for patient referral and waiting list management. C believed this may have resulted in patients being seen out of date order. The Board responded to C's concern at stage 2 of the whistleblowing procedure under the National Whistleblowing Standards (the Standards). The Board did not uphold C's concerns and concluded that the extra patients did not interfere with the management of patients on the waiting list. However, the Board identified a number of recommendations for learning and improvement.

C was not satisfied with the response they received from the Board. C felt that the Board's investigation did not address key aspects of their concerns. They also believed that the Board's recommendations were insufficient.

Following a complaint from C, we reviewed the Board's investigation and decision making. As part of our investigation, we obtained independent advice to inform our assessment. We noted that the Board's investigation did not conclusively rule out the possibility that patients were seen out of date order. However, the evidence suggested that the impact of this (if it happened) was unlikely to be significant.

In view of the evidence gathered by the Board and the improvement actions identified, we considered that there were grounds for the Board to uphold C's main concerns. We noted this would have provided C with greater assurance about the fairness and transparency of the Board's investigation.

We reviewed the Board's recommendations for learning and improvement, and we found the actions had been planned and appeared reasonable. A number of the actions were still in progress at the time of our investigation. As they had not been completed, we were unable to confirm that there were sufficient processes in place to ensure that referrals are managed in a fair and consistent way.

We also reviewed how the Board handled C's concerns against the requirements of the Standards. C was also unhappy with the time taken for the Board to complete their investigation and felt that an adequate explanation for the delay had not been given.

We found that, given the extent of the investigation carried out, it was reasonable for the Board to extend the timescale. However, we found some evidence that suggested that there may be opportunities to further improve investigation timescales. We provided feedback to the Board about this.

In relation to communication, we found that the Board missed an update to C on one occasion. Otherwise, the Board provided updates in line with the expectations of the procedure.

Finally, we considered the quality of the Board's final response to C's concerns. We found that the response letter could have been more open about the evidence considered and did not include the level of information that would offer C assurance that their concerns had been fully and fairly investigated.

We upheld C's complaints and made recommendations.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the findings regarding the Board's investigation and their handling of C's concerns. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spsso.org.uk/information-leaflets.

What we said should change to put things right in future:

- The Board has identified and managed the risks relating to staff treating family, friends, colleagues or others known to them.
- There are robust processes in place to ensure that patient referrals (regardless of the source) and the waiting list are managed in a fair and consistent way. Staff are clear about the expectations and process for handling referrals and managing the waiting list. In line with Paragraph 22, Part 3, of the Standards, the Board should consider whether (1) wider learning is needed across other departments following the investigation;

and (2) the improvements would be beneficial to other NHS organisations across Scotland. If so, it should share them with national organisations or clinical groups to take forward as appropriate.

In relation to compliance with the Standards, we recommended:

- The investigation must focus on the practices or procedures that are unsafe or inappropriate. It must focus on patient safety, safe working practices and good governance; it must be fair, robust and proportionate to the risks identified. It must aim to handle and provide a full response to all the issues involved in the whistleblowing concern that has been raised. If the organisation needs to extend the time limit, it must tell the person raising the concern when they can expect a full response within the first 20 working days (and then at least every 20 working days after that).