INDEPENDENT
NATIONAL
WHISTLEBLOWING
OFFICER

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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: Lothian

Case ref: **202301159**

NHS Organisation: **Lothian NHS Board**

Subject: **Management practice**

This is the report of the Independent National Whistleblowing Officer's (INWO) investigation of a 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 the investigation.

Executive summary

1. The complainant (C) complained to the INWO about Lothian NHS Board (the Board). C was involved in a whistleblowing investigation carried out by the Board under the National Whistleblowing Standards.
2. The complaint I have investigated is
   - 2.1. the Board failed to take a reasonably patient centred approach to managing reductions in waiting times in a service (**upheld**)
   - 2.2. the Board failed to reasonably engage with clinical staff in a service about new measures to reduce waiting times (**upheld**)
   - 2.3. the Board failed to handle the whistleblower's concern in accordance with the Standards (**upheld**)
3. To address 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 National Whistleblowing Standards.

Publication

5. In the interests of transparency and sharing learning to drive improvement, I make public the details of findings and conclusions as far as I am able. I cannot make public every detail of my report. 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 this report names have been pseudonymised, and gender-specific pronouns and titles removed.

Approach

The investigation

6. 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 at the local level.

7. For something to be whistleblowing, it must be in the public interest, rather than primarily concerned with a personal employment situation. I was satisfied that there was a public interest in C's concerns given the potential for wider risks to patients, and to staff wellbeing which in turn could impact upon patients.

4. In order to investigate C's complaint, I

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

    4.2. obtained and reviewed the Board's Stage 2 report and complaint file

    4.3. obtained comments and documentary evidence from the Board

    4.4. considered evidence provided by witnesses, and

    4.5. obtained professional advice from an adviser with relevant professional experience (the Adviser).

5. Evidence was assessed and analysed, and from that, findings made, and a decision taken including recommendations to address my findings. This report and supporting appendices provide a summary of the evidence upon which I relied,

and my findings and recommendations. A high-level summary of the evidence considered is set out in Appendix A.

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

Presentation of evidence and analysis

7. This report provides a summary of the evidence I considered, my findings and my recommendations. It is supported by a series of appendices; both public and private, which set out detailed analysis and decision making.

8. The requirement for confidentiality and need to protect the identity of C and others involved in the investigation means that not all of these appendices are published, nor is it appropriate for people within the Board to have sight of them, other than those who need to know.

9. A summary of documents that make up the full report can be found at the end of the report, along with information about whether these are published or remain private.

Findings and decision

Point 2.1 The Board failed to take a reasonably patient centred approach to managing reductions in waiting times in a service

10. This element of the complaint is about changes that were made to how patients engaged with the service and how the service responded to patients who did not attend a scheduled appointment for treatment.

11. By way of background, it is important to note I recognise that the service was under considerable pressure from both senior management and the Scottish Government to improve performance in relation to long waiting times. The context for these changes was an improvement plan developed to address and reduce waiting times and waiting lists in the service.

12. C raised concerns with the Board that

    12.1. a new procedure for patients who did not attend (DNA) their appointment may have alienated patients

12.2. a new patient focused booking (PFB) system created barriers for some patients, and

12.3. the service was very short staffed, but staff were being told to increase workloads, which was affecting staff retention.

13. In their stage 2 response to C, the Board did not uphold the concerns relating to the DNA procedure and PFB; however, it did uphold the concerns about staffing, noting the impact on staff morale. It also found that there should have been better communication about the new DNA procedure and PFB.

Investigation

14. Under this element of the complaint, I investigated

14.1. whether there was reasonable consideration given to the risks to the patient group before implementing a new DNA standard operating procedure (SOP)

14.2. whether reasonable consideration was given to the risks of patients disengaging from the waiting list under the PFB system, and

14.3. whether there was adequate consultation with patients prior to making the changes.

15. In summary, the Board's position was

15.1. individual assessments were carried out by clinicians before employing the DNA procedure

15.2. when patients were triaged, any patient unlikely to be able to use PFB would be offered an appointment directly with a clinician

15.3. there were few complaints about the new booking system

15.4. there was no requirement to consult with patients as the changes were implemented as part of a mainstream Scottish Government Policy, and

15.5. these were not new policies, so no Risk Assessment and/ or Equality Impact Assessments were undertaken prior to launch within the service.

16. To test and consider this, my INWO investigation considered correspondence provided by the Board and the complainant, the complaint file from the Board,

information from witnesses, Scottish Government guidance, and the views of a professional adviser (the Adviser).

Findings

17. Due to the risk of identifying individuals I have set out my detailed consideration of the specific issues raised by C in private Appendix B. My key findings are set out below.

Issue 14.1: whether reasonable consideration was given to the risks to patients before implementing a new DNA SOP

18. C complained that a DNA SOP introduced for a short period in 2022 required clinicians to discharge patients who did not arrive for a return appointment (return appointments are regular scheduled patient treatment sessions). Previously, if a patient did not arrive for their appointment, a clinician would make the decision about whether to discharge them or to offer another appointment. C was concerned that patients discharged under the new SOP would feel alienated and would view the service negatively.

19. The Board did not uphold this concern and appears to have misunderstood the point C was making. The stage 2 response conflates C's concerns about the DNA SOP with another initiative that had been tried in C's workplace (see complaint point 2.3).

20. I considered the SOP in question, and I noted that there was no written guidance concerning returning patients. However, a process flow diagram in the document confirmed C's complaint that patients who did not attend a return appointment were to be automatically discharged, and the patient and GP notified.

21. The Adviser noted that the SOP did not mention the Board's duty of care to people referred to them, even if they did not attend. They noted the Board had a duty of care to review the person's needs and risks before discharging them. They also noted the resource waste if a patient had to go through the system again to continue their treatment.

22. I understand that the SOP was changed several months later to include clinical discretion and consideration of the patient's needs, and whether it would be

appropriate to offer another appointment to a return patient who failed to attend an appointment. This indicates to me that there was a recognition by the Board that the procedure had been flawed.

23. I find that the Board did not carry out a reasonable assessment of the risks to patients from the DNA SOP implemented for a short period in 2022.

Issue 14.2: whether reasonable consideration was given to the risks of patients disengaging from waiting list because of the requirement to 'opt in' twice under PFB

24. PFB was a way of managing patient appointments. It worked as follows

    24.1. when patients reached the top of a waiting list, a letter was sent to them to invite them to make contact for an appointment

    24.2. if the patient called, they spoke to an administrator who could offer various appointment times to suit the patient

    24.3. if the patient did not make contact, a reminder letter was sent after seven days, then

    24.4. if the patient failed to make contact, they were removed from the waiting list and notified in writing (14 days after the first contact letter).

25. There were some clear advantages to the system

    25.1. PFB allowed patients to arrange an appointment at a time that was more suitable for them[1], and

    25.2. for the Board, PFB was understood to help create good appointments that patients were more likely to keep. It also allowed the Board to move patients on the waiting list through the system more quickly if other patients did not respond to the invitation to make an appointment.

26. PFB was introduced into this service in 2022. In this service, patients had to opt-in twice using the PFB system to receive treatment. The path to treatment followed this pattern

    26.1. following referral, the patient was added to a waiting list for an assessment

[1] C noted that prior to PFB clinicians had been flexible to offer appointments at times that suited patients.

26.2. when they were near the top of the waiting list, the patient was invited to make an assessment appointment

26.3. following assessment, the patient was put on a waiting list for treatment

26.4. when they reached the top of the treatment list, they were invited to opt-in again for their first treatment session, then

26.5. after the first treatment appointment, clinicians would arrange further sessions with the patient, based on their own diary and availability, and not through PFB.[2]

27. C's concern was that having to opt in twice was a barrier to treatment for patients and went against access policies. The Board's response was that the PFB was recognised nationally and within the Board, and as a way of managing waiting lists. The Board believed PFB was flexible, and it aligned to the Board's access policy. The Board did not uphold C's concern but said that the communications about the new process could have been better and should have involved all relevant stakeholders.

28. To be clear, C's complaint was not about PFB in its entirety. C recognised that PFB worked for assessment appointments. The main issue they had was the requirement for a second opt-in to receive treatment.

29. C and other witnesses told the INWO that the nature of the service's work was unpredictable. Patients had varying capacity to engage at the point they were opting-in to receive treatment. Patients in these situations required more flexibility than the PFB system could offer.

30. The Adviser noted that it was not clear why patients had to opt-in twice. They also noted that the Board had not consulted with patients, nor carried out public patient involvement work to solicit their views on the process. They identified that this would have been good practice. I accept this advice.

31. I acknowledge the advantages of PFB for patients and for Boards. I recognise that the Board were under considerable pressure to manage their waiting lists and that

[2] The PFB slots were fixed times in the clinician's diary, so they could not offer these times to patients for subsequent treatment sessions.

PFB gave them more control and created greater predictability around patients accessing the system. I also acknowledge that PFB is the Scottish Government's preferred approach to patient booking.

32. However, it is not clear why the Board required patients to opt-in twice for treatment and why they did not seek patient views on this. Whether policy or not, the Board should have ensured that the system did not create additional barriers for patients.

33. I find that on this issue, the Board did not give reasonable consideration to C's concerns about the risks of patients disengaging from the waiting list, because of the requirement to opt-in twice to receive treatment under PFB.

Issue 14.3: whether there was adequate consultation with patients prior to making changes to the way they accessed the service

34. This issue has largely been considered already. Essentially, the Board did not carry out any consultation with patients. Nor did it consider carrying out a risk assessment or an Equalities Impact Assessment (EQIA).

35. The Board said that there was no requirement to consult because the changes were implemented as part of a mainstreamed Scottish Government Policy. Also, they noted that individual patient assessments were undertaken to determine if PFB was unsuitable for specific patients[3].

36. I had concerns about this view so sought expert advice. The Adviser did not support the Board's view. They said that the Board should have carried out a local EQIA. They also referred to Scottish Government guidance that said that patient public involvement was a priority when planning changes to the booking system, and that this should be done at each service change, not at national level.

37. I accept the Adviser's view. I consider that the Board should have consulted with patients to understand their perspective on the changes.

[3] In which case alternative arrangements would be made.

Decision

38. The point I have investigated is that the Board failed to take a reasonably patient centred approach to managing reductions in waiting times in a service.

39. In making my decision I recognise the pressures on the service. Given the context, I understand why the changes were made, and recognise the benefits to the Board and patients. I do not underestimate the impact this had on waiting times, which enabled more patients on the waiting list to be seen quickly.

40. However, I am critical that the Board did not consult patient groups for their views at any stage and introduced a system that potentially created barriers to access for some patients. Nor did it consider carrying out a risk assessment or a local EQIA.

41. On balance, I uphold this element of C's complaint. I have made a recommendation to address this, set out later in this report with other recommendations.

Point 2.2 The Board failed to engage reasonably with clinical staff in a service about new measures to reduce waiting times

42. This part of the complaint is about the Board's engagement with staff, particularly around PFB.

43. During the investigation it became apparent that when witnesses talked about PFB, it was often not just about the booking system itself. PFB was introduced around the same time as several different initiatives to reduce waiting times, and these impacted on how PFB was experienced by staff. These included

    43.1. a matrix to determine how many treatment sessions a clinician should have with a patient; patients were assigned a level of severity of illness according to the matrix which corresponded with a target duration of treatment

    43.2. standardising the number of weekly appointments during which clinicians were expected to see patients (pro-rated for part time staff)

    43.3. increases in staff caseloads, in order to reduce waiting times

    43.4. automatic and regular allocation of new patients to clinicians, via PFB, regardless of whether they had discharged a previous patient, or not, and

43.5. detailed monitoring of job plans and performance in one to one meetings with staff and at a management level.

Investigation

44. Under this element of the complaint, I investigated whether

44.1. the Board's approach to managing waiting lists allowed sufficient discretion to clinicians to extend patient treatment where necessary

44.2. the Board had adequately consulted with staff before implementing changes to manage waiting times, and

44.3. the Board adequately considered feedback from staff about the changes.

45. The Board's response to my investigation was that there was no requirement on them to consult with staff, but there was regular engagement and consideration given to the limited feedback the Board received.

46. To test this, my investigation considered correspondence provided by the Board and the complainant, the Board's complaint file, information from witnesses, Scottish Government guidance, and the views of the Adviser.

Findings

47. I have set out my detailed consideration of the specific issues raised by C in private Appendix C. My key findings are set out below.

Issue 44.1: Whether the approach to managing waiting lists allowed sufficient discretion to clinicians to extend patient treatment where necessary

48. C complained to the INWO that staff lost autonomy over their workload, experienced high workloads, and were at risk of burnout through the implementation of PFB in the service. C said that the Board's approach to managing waiting times incentivised discharging patients as quickly as possible to avoid becoming overwhelmed or burnt out.

49. Interviews with witnesses corroborated this view and the following issues were identified as creating additional pressures for clinicians

49.1. patients triaged according to the matrix took longer to respond to treatment than the number of sessions allocated

49.2. new patients were added to their caseloads via PFB, regardless of whether previous patients had been discharged or not, and

49.3. in one to one meetings with managers there was considerable monitoring of caseloads to ensure that there was a sufficient throughput of patients to meet targets

50. The Board reported that there was flexibility for clinicians

50.1. to offer additional sessions to patients where it was clinically necessary, and

50.2. to request a temporary break from taking new patients via PFB.

51. In relation to these points, witnesses said

51.1. having to justify the variation to line managers was an inhibiting factor in requesting additional sessions, and

51.2. PFB appointments were booked six weeks in advance, so there was still a six-week lag of new patients for the clinician to see. Therefore, the system was not flexible enough to respond quickly when clinicians were experiencing high workloads and burn out.

52. Therefore, while I recognise that there was some flexibility, I consider that, realistically, the approach to managing waiting lists inhibited clinicians' discretion to apply their professional judgement to extend patient treatment where necessary.

Issue 44.2: Whether the Board adequately consulted with staff before implementing changes to manage waiting times

53. C complained to the INWO that there was no consultation with staff prior to introducing changes to the way patients accessed the service. C carried out their own research on PFB and early in the process shared several documents designed to help staff with implementation, and to provide feedback to senior managers. C said their work on this was ignored.

54. The Board's stage 2 report acknowledged that frontline staff had not been involved in the changes, that there were staff attrition and morale issues in C's workplace, and that staff had not had to follow these procedures before. The report

acknowledged the difficulties of aligning PFB with job plans (a clinician's agreed duties, responsibilities, and objectives). The report agreed with the service's implementation of PFB, but noted that communications should have been better.

55. When asked, the Board said they did not do any consultation or change management processes with staff prior to implementation, because these were existing Board and Scottish Government policies in use elsewhere.

56. The Adviser said that it is good practice to engage with staff, whether changes are government or local policy. They identified that the changes would have caused staff to worry and that some staff would cope better than others. But the Board did not consult with staff and therefore did not identify if they had any concerns.

57. The Adviser also said that one of the concerns for staff would be their lack of involvement in clinical decisions concerning discharge of their patients. This was inconsistent with professional codes of conduct, and so would have created ongoing concerns for clinicians.

58. I accept this advice.

59. In conclusion, it is important to note that the changes were not simply a new SOP for DNA returning patients and a new system for arranging patient appointments, that aligned with local or national policies. Changes made by the Board also impacted on the duration of sessions with patients, the workload of clinicians (and their control over it) and created additional and intense monitoring around the throughput of patients.

60. While I acknowledge the context, I find that the Board did not adequately or reasonably engage with staff before implementing significant changes, that undoubtedly impacted on the wellbeing of some staff. I accept that the Board took the view that it was government policy/ guidelines, but consultation would have given staff an early opportunity to make their views known and to contribute to the implementation.

Issue 44.3: Whether the Board adequately considered feedback from staff about the changes

61. The Board's stage 2 report noted C had raised concerns on numerous occasions about staffing, but had been ignored. C complained to the INWO that their concerns about the changes were repeatedly dismissed, ignored or they had been placated with justifications.

62. Witnesses told the INWO that their views were not valued, and some had a constant sense of failing or that they were not working hard enough. They described being able to speak-up and raise concerns with their immediate line managers; some described being protected by them. However, they felt that feedback reached a certain level within the service and was not taken any further forward.

63. Despite the significant changes, there was no evaluation undertaken by the Board, as part of the normal change cycle. The Adviser commented that this would have been good practice, a point I strongly agree with.

64. I consider that the Board did not adequately consider feedback from staff about the changes, nor did it actively seek feedback on the changes through an evaluation process.

Decision

65. I recognise that the Board were under pressure to address the significant (and growing) waiting lists and that the changes involved policies and procedures in use in other parts of the Board and nationally.

66. I also recognise that the changes made by the Board led to increased workloads, a reduction in autonomy, pressure to discharge patients, and potentially stressful interactions with line managers focused on caseloads; all under the umbrella of PFB. Witnesses felt overwhelmed, burnt out and some reported a constant feeling of failing. This is identified from the evidence, and the advice upon which I accepted and relied.

67. I consider that it would have been reasonable for the Board to have engaged more, and more meaningfully, with the staff concerned, before, during and after the changes were implemented.

68. I uphold this element of C's complaint that the Board failed to engage reasonably with clinical staff about new measures to reduce waiting times. I have made recommendations to the Board, set out later in this report.

Point 2.3 The Board failed to handle the whistleblower's concern in accordance with the Standards

69. This point of C's complaint to the INWO raised the following concern handling issues

69.1. whether the investigation considered all the issues raised, and

69.2. whether the Board's stage 2 investigation response minimised alleged poor behaviours C and colleagues reported and focused on the recipient's perceptions, rather than the events that took place.

70. My detailed consideration of these issues can be found in private appendix D.

Investigation

71. In my assessment of these matters, I considered C's complaint, and the Board's case file, correspondence, and stage 2 response and report.

Findings

Issue 69.1: whether the investigation considered all the issues raised, and whether there was sufficient information gathering at the start of the investigation

72. C complained to the INWO that the Board's response to their concern about the DNA SOP (see complaint point 2.1) addressed another topic that was not relevant to this concern.

73. I considered the Board's stage 2 response and report, and the interviews carried out as part of the local investigation. I can see that considerable attention was given to a different matter and that C's concern about the DNA SOP was viewed through this lens.

74. This lack of focus on the DNA SOP meant that the Board did not closely consider changes made to the SOP which supported C's concern. I am also critical that

witnesses to the local investigation were not asked to comment about the DNA SOP and were invited to comment on other matters.

75. I consider that this misunderstanding came about because there were no meetings with C before the investigation interview, and as a result opportunities to ensure a clear understanding (and potential for resolution) of C's concerns were missed.

76. Annex A of part three of the Standards says

76.1. "It is important to understand exactly what concern the person is raising. It may be necessary to ask for more information to get a full picture. When you receive a concern, remember that the person who raised it may be nervous about doing so. Make sure they have enough time and privacy to explain their concern fully. It can also be stressful to speak about a concern, so if you have a meeting you may need to take breaks or have more than one meeting."[4]

77. Paragraph 53 of part three of the Standards says

77.1. "At the end of the investigation, the organisation must give the person who raised the concern a full and considered response, setting out its findings and conclusions, and how it reached these. It must also provide evidence that it has taken the concern seriously and investigated it thoroughly.[5]

78. I find that the Board did not adequately consider all the issues raised by C because of inadequate information gathering at the initial stages. The stage 2 response undermined C's confidence in the investigation and was a contributing factor to their complaint to the INWO.

Issue 69.2: whether the Board's stage 2 investigation response minimised alleged poor behaviours C and colleagues reported and focused on the recipient's perceptions, rather than the events that took place

79. Given the risks of identifying the individuals concerned, this issue is considered in depth under private Appendix D.

[4] *https://inwo.spso.org.uk/sites/inwo/files/Standards/NationalWhistleblowingStandardsPart03-TwoStageProcedure.pdf* Annex A

[5] *https://inwo.spso.org.uk/sites/inwo/files/Standards/NationalWhistleblowingStandardsPart03-TwoStageProcedure.pdf* para 53

80. Paragraph 58 of part three of the Standards says that

80.1. "The quality of the investigation and the final (and any interim) report is very important. The report should:

80.1.1. be clear and easy to understand, and written in a way that is non-confrontational and focuses on the people involved;"[6]

81. I find that the author(s) of the Board's stage 2 response had difficulties in finding language that was supportive of several parties and that ensured that everyone's rights were respected. I urge the Board to reflect on this experience and in future to be mindful of how different audiences might perceive the language used in responses to whistleblowers.

Decision

82. I uphold this element of the complaint that the Board failed to handle C's concern in accordance with the Standards, resulting in an insufficiently thorough investigation of the DNA SOP. This also takes into account issues discussed in private Appendix D. I have made recommendations to address this, summarised later in my report.

Additional Comments and Feedback

83. My investigation was helped by the co-operation of C, the witnesses who were interviewed, 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.

[6] *https://inwo.spso.org.uk/sites/inwo/files/Standards/NationalWhistleblowingStandardsPart03-TwoStageProcedure.pdf* para 58

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 the INWO is asking the Board to do for C

Rec. No	What the INWO found	Outcome needed	What the INWO needs to see
1.	Under complaint points 2.2, and 2.3, I found • the Board disregarded early attempts from C to raise concerns, and provide feedback, about the impact of measures to reduce waiting times on staff and patients • the Board did not adequately consider all the issues raised by C because of inadequate information gathering at the initial stages, and • the stage 2 response undermined C's confidence in the investigation.	Apologise to C for these failings. The apology should meet the standards set out in the SPSO guidelines on apology available at *www.spso.org.uk/information-leaflets*	A copy of a letter or other record confirming an apology was given to C. By: 20 November 2024

What the INWO is asking the Board to do for patients

Rec. No	What the INWO found	Outcome needed	What the INWO needs to see
2.	Under complaint point 2.1 I found • the board did not carry out a reasonable assessment of the risks to patients from the DNA SOP implemented for a short period in 2022.	The Board meets their duty of care to consider the clinical needs of all their patients, including those who do not arrive for their appointments.	Evidence the Board has carried out a review of the patients impacted and that any risks to those patients have been identified and managed. (Please see private appendix B for relevant dates). By: 15 January 2025

What the INWO is asking the Board to do for staff working in the service

Rec. No	What the INWO found	Outcome needed	What the INWO needs to see
3.	Under complaint point 2.2 I found: • the approach to managing waiting lists inhibited clinicians' discretion to extend patient treatment where necessary • the Board did not adequately or reasonably engage with staff before implementing significant changes, that impacted on the wellbeing of some staff, and • the Board did not adequately consider feedback from staff about the changes.	There is meaningful communication with the staff group that (i) acknowledges the findings of the INWO's investigation (ii) outlines and invites comment on the steps planned for learning and improvement, and (iii) offers support to anyone affected by the changes.	Evidence the Board has engaged with staff in relation to these points. By: 15 January 2025

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

Rec. No	What the INWO found	Outcome needed	What INWO needs to see
4.	Under complaint point 2.1 I found • the Board did not give reasonable consideration to the risks of patients disengaging from the waiting list, because of the requirement to opt-in twice to receive treatment under PFB, and • the Board did not consider whether a local EQIA was warranted prior to implementing PFB and the DNA SOP.	Patients are involved in changes that impact on the way they access NHS services (particularly patients who are more likely to be identified as vulnerable).	Evidence the Board has systems in place that will ensure appropriate patient involvement in future. Evidence that the Board has considered whether a retrospective local EQIA should be carried out regarding the changes made to this service, and the reasons for its decision. By: 12 March 2025

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

Rec. No	What the INWO found	Outcome needed	What the INWO need to see
5.	Under complaint point 2.3 I found • the Board's investigation did not adequately consider all the issues raised • there was inadequate information gathering at the initial stages of the investigation, and • the language of the stage 2 response could have been more appropriate to C.	The Board complies with National Whistleblowing Standards	Evidence that the Board have reflected on the findings in this decision notice and identified where process and practice improvements are needed, the actions to address this, and how learning will be shared. By: 18 December 2024

Summary of documents that make up the final full INWO report

Document Name	Description	Published/private
Summary Report Reference: 202301159	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: Confidential discussion of complaint point 2.1	Detailed discussion of the investigation into point 2.1	Private
Private Appendix C: Confidential discussion of complaint point 2.2	Detailed discussion of the investigation into point 2.2	Private
Private Appendix D: Confidential discussion of complaint point 2.3	Detailed discussion of the Board's handling of the concern	Private

Appendix A
Summary of evidence considered

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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.

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

3. Points of complaint (these follow the numbering in the summary report and private appendices)

3.1 The Board failed to take a reasonably patient centred approach to managing reductions in waiting times in a service

3.2 The Board failed to reasonably engage with clinical staff in a service about new measures to reduce waiting times

3.3 The Board failed to handle the whistleblower's concern in accordance with the Standards

Description	**Relevant to:**		
	3.1 The Board failed to take a reasonably patient centred approach to managing reductions in waiting times in a service	3.2 The Board failed to reasonably engage with clinical staff in a service about new measures to reduce waiting times	3.3 The Board failed to handle the whistleblower's concern in accordance with the Standards
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 (spso.org.uk).	Yes	Yes	Yes
Complaint and documents provided by C C's concerns submitted to the Board, their complaint to the INWO, and information from C as summarised below.	Yes	Yes	Yes

Description	Relevant to:		
	3.1 The Board failed to take a reasonably patient centred approach to managing reductions in waiting times in a service	3.2 The Board failed to reasonably engage with clinical staff in a service about new measures to reduce waiting times	3.3 The Board failed to handle the whistleblower's concern in accordance with the Standards
i. A summary of C's concerns about Patient Focused Booking (PFB)	Yes	Yes	
The Board's Stage 2 report and complaint file We sought and obtained the Board's complaint file. This material included:	Yes	Yes	Yes
i. The Board's Stage 2 response dated 9 March 2023	Yes	Yes	Yes
ii. C's response to the stage 2 letter		Yes	Yes
iii. The post investigation action plan	Yes	Yes	Yes
iv. A letter to staff about the outcomes of the investigation		Yes	Yes
v. Copies of correspondence between the Board and C	Yes	Yes	Yes
vi. Copies of correspondence between the Investigating Officers and C	Yes	Yes	Yes
vii. Interview transcripts	Yes	Yes	Yes
viii. iMatter survey results		Yes	
ix. Copies of correspondence between the Investigating Officers and managers	Yes	Yes	Yes

Description	Relevant to:		
	3.1 The Board failed to take a reasonably patient centred approach to managing reductions in waiting times in a service	3.2 The Board failed to reasonably engage with clinical staff in a service about new measures to reduce waiting times	3.3 The Board failed to handle the whistleblower's concern in accordance with the Standards
x. Various Standard Operating Procedures (SOPs) for Did Not Attend/Could Not Attend (DNA/CNA) patients	Yes	Yes	Yes
xi. The Board's Local Access Policy	Yes	Yes	Yes
xii. A Scottish Government Letter	Yes	Yes	
xiii. Effective patient booking for NHSScotland 2012 document	Yes	Yes	
xiv. A document of PFB assessment removals	Yes	Yes	
xv. Review of a model for reducing waiting times	Yes	Yes	Yes
Additional evidence provided by the Board listed below			
i. Planned care improvement programme – published 2007	Yes	Yes	
ii. Further DNA and CNA SOPs	Yes	Yes	Yes
iii. The Board's Scheduled Care SOP	Yes	Yes	
iv. Patient Focused Booking publication by NHSScotland	Yes	Yes	

Description	Relevant to:		
	3.1 The Board failed to take a reasonably patient centred approach to managing reductions in waiting times in a service	3.2 The Board failed to reasonably engage with clinical staff in a service about new measures to reduce waiting times	3.3 The Board failed to handle the whistleblower's concern in accordance with the Standards
v. The Board's PFB summary, process flow and TRAK procedure	Yes	Yes	
vi. Data of patient complaints about PFB and the DNA SOP	Yes	Yes	
vii. Interview testimony and other information from staff.	Yes	Yes	Yes
viii. Relevant Board recovery and development plan	Yes	Yes	
ix. PFB letter templates	Yes	Yes	
NHSScotland documents i. NHSScotland Waiting Time Guidance (CEL33, August 2012) ii. Patient Focussed Booking Implementation Guide (2006) ISBN: 0-7559-5047-X	Yes	Yes	
Expert professional advice on complaint points 2.1 and 2.2	Yes	Yes	