INDEPENDENT
NATIONAL
WHISTLEBLOWING
OFFICER

People Centred | Improvement Focused

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: **202202429**

NHS Organisation: Greater Glasgow and Clyde NHS Board

Subject: Assessment of patients / Handling of whistleblowing concern

This is the report of the Independent National Whistleblowing Officer (INWO) on a whistleblowing complaint about the handling of a whistleblowing concern. It is published in terms of section 15(1) of the Scottish Public Services Ombudsman Act 2002 which sets out the INWO's role and powers. There is more information about this here: *https://inwo.spso.org.uk/*

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

Executive summary

1. The complainant (C) complained to the INWO about Greater Glasgow and Clyde NHS Board (the Board). C raised concerns about the Board's gender identity services, which the Board investigated under the National Whistleblowing Standards. C was dissatisfied with the Board's response and complained to the INWO.
2. The complaint I have investigated is:
   - 2.1. The Board's Young People's Gender Identity Service does not carry out assessments that are clinically appropriate and patient-centred. (*not upheld*)
   - 2.2. The Board failed to investigate and appropriately respond to the concern raised in accordance with the Standards. (*not upheld*)
3. In making my decision, I recognised the complex and evolving nature of medicine in this field. I also recognised the considerable steps the Board has taken to provide a robust process for assessments. While the complaints were not upheld, my investigation recognised the significant pressures and challenges facing the service, and the impact on service delivery, such as waiting times. I recognise the Board has been open about these challenges and efforts to address these issues are ongoing.
4. My investigation identified areas of good practice by the Board, as well as areas of potential improvement, 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 she is able. The INWO cannot make public every detail of her report. This is because some information must be kept confidential because the Act says that, generally, reports of investigations should not name or identify individuals. In this context in the report names have been pseudonymised, and gender-specific pronouns and titles removed.

Approach

The investigation

5. INWO is the final stage of the process for those raising whistleblowing concerns about the NHS in Scotland. INWO has a remit to consider complaints from whistleblowers about how their concerns have been handled and the actions taken in respect of those concerns.[1]

6. For something to be whistleblowing, it must be in the public interest, rather than primarily concerned with a personal employment situation. In this case, I was satisfied that there was a public interest in C's concerns given potential impacts to patients using the service.

7. I am mindful that the provision of gender identity services is an area that has attracted significant public attention and socio-political debate within the community. It is also clear that this is a relatively new and evolving area of medicine, and there is ongoing difference of view among clinicians as to assessment and treatment. It is not the role of my office to adjudicate between different clinical and theoretical approaches.

8. Similarly, it is important to emphasise that my decision is concerned only with whether the actions of the Board are in accordance with reasonable clinical and administrative practice as currently accepted, including national guidelines. It does not take a view on particular social and political debates in the community, and to do so would be out with my remit.

9. It is also important to note my role centres on a complaint and the Board's actions in respect of this. I do not have a 'roving commission' or general powers of enquiry and our investigation needs to remain referable to the concerns raised, which are grounded in particular experience over a specific period of time. It is not within my remit to provide the role undertaken by, for example, the Cass Review. [2]

10. In order to investigate C's complaint, I:

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

[2] The Independent Review of Gender Identity Services for Children and Young People (The Cass Review) was commissioned in 2020 to examine services in England and a final report is anticipated at the end of 2023.

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

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

10.3. obtained comments and documentary evidence from the Board, including the service's Standard Operating Procedure (SOP)

10.4. reviewed relevant guidance, articles and reports

10.5. obtained professional advice from an adviser, who is a clinician with knowledge of the area, and

10.6. took evidence through enquiries and interview.

11. Evidence was assessed and analysed and from that, findings and recommendations made, and a decision taken. This report and supporting appendixes provide a summary of the evidence upon which I relied, and my findings. A high level summary of the evidence considered is provided in public Appendix A.

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

Presentation of evidence and analysis

13. The evidence upon which I have relied in making my findings and decision is summarised in a public appendix. This evidence is further discussed and analysed in private Appendix B.

14. 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. This document includes a *Summary of documents that make up the full INWO report*, including a list of the appendices and the restrictions relating to their publication and sharing.

Findings and decision

Point 2.1 The Board's Young People's Gender Identity Service does not carry out assessments that are clinically appropriate and patient-centred

15. C's concerns under this complaint are enumerated in private Appendix B, but in summary, relate to the assessment of individuals in the service. In particular, C highlighted concerns about the impact of overly affirmative socio-political views on clinicians within the service as influencing decisions on assessment and treatment. C highlighted a number of clinical cases of concern. C also drew my attention to articles and other material in support of this.

16. C's concerns were subject to a stage 2 investigation under the Standards. In summary, the Board's position was:

16.1. the Board took the concerns seriously, recognised the complexity of the case and commissioned a thorough independent review, which engaged with the concerns through review of documentation, relevant guidance, and obtaining interview evidence.

16.2. while acknowledging the difficult context for the service, the investigation did not consider there was evidence of an overly affirmative approach impacting on assessments in the service.

16.3. recognising the challenges for the service, the Board emphasised actions they had taken including putting in place new guidance to provide structure for assessments (since mid-2021) and working arrangements to improve services and ensure against potential risks. They highlighted ongoing monitoring and oversight of risks for the service.

16.4. alongside the independent review, the Board undertook an internal clinical review of specific cases within the service in respect of which concerns had been raised. The clinical review did not identify any failings in assessments or clear evidence of risks to patients.

17. To test and consider what the Board has done, the INWO's investigation considered the evidence summarised in public Appendix A and discussed in more detail in private Appendix B.

2.1 Findings

18. My key findings are summarised below. With a view to conciseness, and in order to protect the privacy of all parties to the investigation, I have limited the level of detail.

<u>The Board's investigations</u>

19. The Board carried out two investigations following the concerns. As further detailed under point 2.2., I consider these represented a robust and thorough consideration of the points raised.

<u>Findings on the applicable guidance</u>

20. The Board highlighted their actions in formalising and developing guidance to support assessments for the service (since mid-2021). I carefully reviewed the SOP guidance and other relevant documents. I sought comments from C and the Board's officers. I obtained independent advice from a professional adviser (the Adviser) on the guidance.

21. I noted requirements in the SOP guidance designed to ensure robust and structured assessments, including surrounding the number of appointments, the separation of different treatment options, and review by more than one clinician.

22. The professional advice I obtained, and accepted, indicated the guidance was appropriate and in accord with national guidance, and sensitive to current

developments.[3] It indicated the guidance is patient and individual centred, and that it appropriately supports clinicians to engage with the complexities of cases, such as the presence of mental health conditions. The advice noted the evolving nature of gender identity medicine and approaches, and the ongoing need to keep guidance updated to reflect ongoing developments in the field.

23. Noting the above, I have concluded that the Board has robust and appropriate guidance to support assessments of patients, and this is consistent with national requirements.

Findings on other action taken

24. In respect of the level of clinical debate and openness to discussion, the Board provided details of other action to support assessments in the wake of the concerns. These include MDT arrangements, ongoing learning, and fostering of discussion for staff. The Board also highlighted governance and risk management arrangements.

25. I noted broader ongoing work involving the National Gender Identity Healthcare Reference Group;[4] and Healthcare Improvement Scotland work on Standards for gender identity healthcare services for adults and young people[5].

26. I have reviewed details of the steps the Board have taken and made enquiries to assist my understanding of these. Again, I sought professional advice to assist my understanding. The advice was that the Board's steps were reasonable. I accepted this advice.

27. Taking into account the professional advice I have received, I am of the view the Board has in place appropriate structures to support assessments within the service.

Findings on clinical cases

28. The Board have given details of how they reviewed and assessed specific clinical instances highlighted in the concerns. They noted that the cases were prior to the introduction of their new SOP, and as such some of these would be handled differently under current practice. However, the review did not identify specific failures or ongoing risks to patients.

29. Having reviewed this documentation, and obtained independent advice on it, I have concluded there was appropriate review and consideration by the Board.

[3] Scottish Government, *Scottish Gender Reassignment Protocol* CEL 26 (2012); The Royal College of Psychiatrists, *Good practice guidelines for the assessment and treatment of adults with gender dysphoria* CR181 (2013) (as it relates to young persons); and WPATH, *Standards of Care for Transgender and Gender Diverse People* Version 8 (2022).

[4] *National Gender Identity Healthcare Reference Group - gov.scot (www.gov.scot)*

[5] *Standards for gender identity healthcare services for adults and young people (healthcareimprovementscotland.org)*

Findings on the service generally

30. I sought and obtained details of the service, with a view to understanding the context of work and whether there was any evidence suggestive of problems with assessments and treatments.

31. The material highlighted a difficult context of increased patient numbers over recent years and limited staffing resources. The service has recognised these publicly. The service also recognised limitations on data collection, and there is current work to provide improved IT systems to support this.

32. While I consider it appropriate to recognise the above, I have not found evidence from this material suggestive of a systemic problem in assessments. A low number of patients are referred to endocrinology for puberty blockers or hormone therapy. The Board has not identified complaints or incidents suggestive of problems.

2.1 Decision

33. The complaint I have investigated is that the Board's service does not carry out assessments that are clinically appropriate and patient-centred.

34. In making my decision, I again recognise the challenging context for the service, and those providing it, and the evolving nature of practice in the field. In this regard, I am mindful that drawing conclusions about the service is not a straightforward matter, and necessarily somewhat indefinite.

35. As with any complaint investigation, my starting point has been the concerns brought to the Board and the investigations they have undertaken. I say more about this at point 2.2. However, these collectively indicate appropriate investigation by experienced clinicians, and that reasonable measures are in place to support assessments in the service.

36. The Board has (since mid-2021) put in place an SOP to support assessments of patients. I recognise that reasonable clinicians may have different views over aspects of the guidance; however, my focus is on whether it is within accepted practice, rather than the best possible. I also recognise the iterative nature of guidance and that there will be a need for ongoing revisions (to reflect national work and further results of the Cass Review). While acknowledging these unavoidable limitations, based on the advice I have received, I have concluded the SOP provides robust and appropriate guidance to ensure assessments are clinically appropriate and patient-centred in accordance with national requirements.

37. I have previously summarised key service improvement actions taken forward by the Board in respect of the service. I have also sought and accepted advice on this. I have concluded that the Board has undertaken appropriate steps to improve the service and support assessments in the service.

38. The concerns highlighted a number of clinical cases. I have considered whether the Board took appropriate action to examine these and address any risks. I have summarised previously the results of the Board's review. Having considered details of this, and tested their views with the Adviser, I consider the Board acted appropriately.

39. I have also outlined my enquiries about the broader work of the service. I do not consider this points to or is suggestive of failures in assessments being carried out by the Board.

40. In light of the various findings I have highlighted, I find that there is sufficient evidence, on balance, to conclude that the Board has taken appropriate action to ensure assessments are being undertaken in a clinically reasonable and patient centred fashion. In that regard, I do **not uphold** point 2.1 of this complaint.

41. In making my decision, I note that the Board's investigations and other scrutiny work produced multiple actions and recommendations. A number of these have no indicative timescale. The Board noted current pressures as impacting on these. While mindful of these challenges, I have highlighted to the Board to ensure action planning to ensure delivery of recommendations following whistleblowing concerns.

Point 2.2. The Board failed to investigate and appropriately respond to the concern raised in accordance with the Standards.

42. The key issues considered under this point of the complaint were C's concerns that:

    42.1. the Board had not thoroughly investigated the concerns, and

    42.2. the findings and recommendations were not based on a robust consideration of the available evidence.

43. In summary, the Board's position was that the concerns were taken seriously and subject to an appropriate and thorough investigation.

44. To test and consider this, the INWO's investigation considered the evidence summarised in public Appendix A and discussed in private Appendix B. I also considered the Board's concerns handling based on the expectations set out in the Standards more broadly.

2.2 Findings

45. Section 6A of the Act sets out the INWO's powers and duties in relation to whistleblowing complaints. This is wide-ranging and includes ensuring compliance with a model complaints handling procedure for whistleblowers' complaints – the National Whistleblowing Standards. It also states that a whistleblower is entitled to have a complaint handled in accordance with that procedure.

46. While C identified some particular issues, I would not expect them to know every aspect of the Standards. I would, however, expect the Board to ensure compliance with, and to have handled C's concern in accordance with, the Standards. It is, therefore, appropriate that I consider the Board's handling of the whistleblowing concern beyond C's specific complaints.

47. My key findings are set out below and are limited in detail to protect the privacy of all parties to the investigation. In summary:

    47.1. the Board's overall approach to investigating the complaint appears to be appropriate, proportionate and consistent with the Whistleblowing Standards.

    47.2. the early communications with C appear to have been supportive and positive, with the Board engaging constructively with C to take forward the concerns in the most appropriate way. There was an early meeting and correspondence with C to clarify and confirm the concerns.

    47.3. it is clear that the Board recognised the seriousness of the concerns raised and the potential risks to patient safety, and I consider they took appropriate action in conducting an internal review of clinical safety as an interim measure.

    47.4. on reflection, it may have been helpful for more details of the report to be provided to C. The executive summary given to C was quite brief, with scant details of the sources of information reviewed (beyond staff interviews) or the process adopted (for example, interview structure and questions), and some confusing statements about the reasons for the decision.

2.2 Decision

48. The complaint I have investigated is that the Board failed to investigate and appropriately respond to the concern raised in accordance with the Standards.

49. In light of the various issues I have highlighted, I consider the Board's investigation was, on the whole, appropriate. In view of this, I do **not uphold** point 2.2 of this complaint.

Additional Comments and Feedback

50. As noted in the report, there were elements of good practice in the Board's local investigations, including sourcing independent advice and interviewing staff, and carrying out a parallel clinical review. There may have been scope to communicate the level of investigation and findings to C.

51. The Board's investigations and other scrutiny work produced multiple actions and recommendations. A number of these have no indicative timescale. The Board noted current pressures as impacting on these. While mindful of these challenges, I have highlighted to the Board the need to ensure action planning to ensure delivery of recommendations following whistleblowing concerns.

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

53. It should be noted by the Board that the Standards place a continuing obligation on NHS organisations to provide support and protect those involved in a whistleblowing concern from detriment.

Summary of documents that make up the full INWO report

Document Name	Description	• Restrictions at draft stage	Restrictions at final stage
Summary Report on complaint about the Board Reference: 202202429	Anonymised/ pseudonymised summary of complaint investigation and findings	• Complainant • CEO • Whistleblowing Lead • Head of Corporate Governance and Administration (Report must not be shared wider until final.)	None Published in full
Appendix A: High level summary of evidence relating to all points	Summary of the evidence considered in this case.	• Complainant • CEO • Whistleblowing Lead • Head of Corporate Governance and Administration (Report must not be shared wider until final.)	None Published in full
Appendix B: Confidential discussion of complaints 1 & 2	Detailed discussion of the points considered within complaints 1 & 2.	• Complainant • CEO • Whistleblowing Lead • Head of Corporate Governance and Administration (Appendix must not be shared wider until final.)	• Complainant • CEO • Whistleblowing Lead • Head of Corporate Governance and Administration • Chair • Whistleblowing Champion (Appendix must not be shared wider.)

Appendix A

High level summary of evidence (public)

1. This Appendix contains a high level summary of the evidence considered during the investigation, and to which elements of the complaint it was relevant.

2. The findings in the summary report reflect how this evidence was used. The purpose in listing it here, is to assure the complainant and others involved that a wide range of evidence was sought and considered.

3. **It is not a confidential document and there are no restrictions on sharing it.**

Document Name	Description	Restrictions at draft stage	Restrictions at final stage
Appendix A: High level summary of evidence relating to all points	Summary of the evidence considered in this case.	• Complainant • CEO • Whistleblowing Lead • Head of Corporate Governance and Administration (Report must not be shared wider until final.)	None Published in full with summary report

Description	Relevant to:	
	2.1 The Board's Young People's Gender Identity Service does not carry out assessments that are clinically appropriate and patient-centred.	2.2 The Board failed to investigate and appropriately respond to the concern raised in accordance with the Standards.
1. *National Whistleblowing Standards* The National Whistleblowing Standards set out how the Independent National Whistleblowing Officer (INWO) expects all NHS service providers to handle concerns that are raised with them and which meet the definition of a 'whistleblowing concern'. The Standards are available at National Whistleblowing Standards | INWO (spso.org.uk).	Yes	Yes
2. *Complaint and documents provided by C* The starting point for our investigation was C's concerns submitted to the Board and their complaint to INWO. We also reviewed other relevant material provided by C as summarised below. i. C's complaint form submitted to INWO ii. C's SBAR document provided to the Board iii. Media and academic material provided to INWO and the Board	Yes	Yes
3. *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 report dated (May 2022). ii. Emails between C and the Board's officers regarding the investigation. iii. Internal documents considered by the Board's investigator, including the Board's Standard Operating Procedure (SOP). iv. Interview evidence obtained during the course of the Board's investigation with C, and current and former officers of the Board.	Yes	Yes

Description	Relevant to:	
	2.1 The Board's Young People's Gender Identity Service does not carry out assessments that are clinically appropriate and patient-centred.	2.2 The Board failed to investigate and appropriately respond to the concern raised in accordance with the Standards.
4. *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. i. Responses to INWO's enquiries. ii. The Board's internal clinical review (March 2022). iii. Other relevant internal documents. iv. Figures on the work of the service.	Yes	
5. Applicable guidance, including: i. *Scottish* Government, *Scottish Gender Reassignment Protocol* CEL 26 (2012). ii. The Royal College of Psychiatrists, *Good practice guidelines for the assessment and treatment of adults with gender dysphoria* CR181 (2013). iii. WPATH, *Standards of Care for Transgender and Gender Diverse People Version* 8 (2022).	Yes	
6. Public material produced by the Board's service	Yes	

Description	Relevant to:	
	2.1 The Board's Young People's Gender Identity Service does not carry out assessments that are clinically appropriate and patient-centred.	2.2 The Board failed to investigate and appropriately respond to the concern raised in accordance with the Standards.
7. Relevant reports and articles: i. Stephanie McCallion et al., 'An appraisal of current service delivery and future models of care for young people with gender dysphoria', *European Journal of Paediatrics* (2021) 180: 2969–2976 ii. Stephen B. Levine and E. Abbruzzese, 'Current Concerns About Gender-Affirming Therapy in Adolescents', *Current Sexual Health Reports* (2023) 15:113–123. iii. *Independent review of gender identity services for children and young people: Interim report* (February 2022) iv. Care Quality Commission, *The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report* (2021)	Yes	
8. Independent professional advice	Yes	Yes
9. Interview evidence obtained from the Board	Yes	