INWO report

Case: **202205180, Lothian NHS Board**
Subject: Hospitals\Patient safety

Summary

C raised concerns in relation to the quality and safety of patient care within one of the Board's departments. The Board undertook an investigation under the National Whistleblowing Standards. In their Investigation Report, the Board substantially upheld C's concerns, and identified a series of recommendations to address them.

The recommendations were translated into an initial action plan. Discussion between the Board representative and C established that the action plan did not fully address the concerns raised and a revised action plan was requested. Over the following months, C became concerned about the responsiveness of the Board, the sufficiency of action being undertaken, the level of detail, and the timeliness of progress in addressing the identified issues. C raised a complaint with INWO because they considered the situation was continuing to deteriorate, raising safety issues for patients and staff. While recognising systemic pressures, C considered more could be done to adapt to these conditions and tangible action could reduce these impacts.

It was evident that the validity and degree of C's ongoing concerns about quality and safety of care were not in dispute. Rather, the complaint centred on the actions that the Board were taking to address the long term and short-term issues identified (i.e. whether they are a reasonable response to the difficult circumstances facing the service), and the timescale in which they were being progressed.

INWO considered the information provided by the Board including their complaint investigation file, iterations of action plans and other relevant information. Enquiries were made of the Board and C to understand their views and explore what actions might ameliorate the situation.

INWO held a meeting with representatives of the Board, C and the Board's confidential contact. There was a constructive and open discussion of the outstanding issues.

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INWO recognised C's exemplary dedication to improving the quality and safety of patient care, within the challenging circumstances of the service, and their determination in pursuing these over a considerable period.

INWO recognised the Board's open acknowledgement of issues, recognition of the difficult and prolonged process for C, and commitment to learning and improvement from the whistleblowing process.

Following the meeting, there was agreement on the key learning points from the case and actions to be taken forward. In particular:

- there was open acknowledgement from the Board that there had not been enough progress in taking action following the whistleblowing concerns raised.
- there was a missed opportunity to take specific action to address issues C had highlighted in the months since the stage 2 investigation.
- in that context, there was acknowledgement from the Board that there was relevant learning to improve the approach to identifying, monitoring, and implementing the actions arising from whistleblowing investigations.
- there was also a learning point for the Board about ongoing communication, particularly with whistleblowers.

The Board committed to take specific action in respect of the concerns raised through the whistleblowing process. Details of the specific action were further identified in collaboration with C.

The Board have made progress in implementing the actions identified. Circumstances in the service show signs of improving and there is a positive dialogue between the Board and C about the service.

As all parties agreed to specific and deliverable action that would resolve the complaint, our decision in this case was to discontinue the investigation, subject to monitoring of the actions agreed.

*Note: When this case was originally published on 16 August 2023, the case reference number stated was 202205108. This was incorrect, and should have read **202205180**. This was down to human error, and we apologise for any inconvenience that this has caused.*

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