INDEPENDENT
NATIONAL
WHISTLEBLOWING
OFFICER

People Centred | Improvement Focused

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

Case ref: 202102821

NHS Organisation: National Services Scotland (NSS)

Subject: National Contact Centre at NHS National Services Scotland (NCC)

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

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

Executive summary

1. The complainant (C) complained to the INWO in July 2021 about NHS National Services Scotland (NSS). C worked in the National Contact Centre (NCC). (Background information about NCC can be found in public Appendix B.)
2. The complaint I have investigated is:
   - 2.1. staff did not have sufficient training and access to sufficient information to support them to provide correct information to the public. (*upheld*)
   - 2.2. NSS failed to handle the concern in line with the National Whistleblowing Standards. (*upheld*)
   - 2.3. NSS failed to protect the whistleblower from detriment associated with speaking up. (*not upheld*)
3. C also complained about an internal recruitment process which was outwith my remit, so I did not consider this matter further.
4. As a result of my findings, NSS 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.
5. My investigation also identified a number of areas of good practice, which have 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. Some information must be kept confidential because the Act says that, generally, reports of investigations should not name or identify individuals. In this context, within the report and appendices, names have been pseudonymised, and gender-specific pronouns and titles removed.

Parties with whom the report and its appendices may be shared with are set out in detail here: *Summary of documents that make up the full INWO report and restrictions on publication.*

Approach

The investigation

6. In order to investigate C's complaint, INWO:

   6.1. obtained and reviewed the NSS internal whistleblowing investigation file,

   6.2. took evidence from C in written format, by telephone and through interview,

   6.3. took evidence from other witnesses through interview,

   6.4. reviewed policies, reports and other documents provided by NSS, and

   6.5. considered an audit of 40 cases carried out by NSS and Public Health Scotland (PHS) relating to clinical risk from changes to exposure dates over a four-week period in summer 2021.

7. We assessed and analysed the evidence and, from that, I made findings and a decision with recommendations. This report and supporting appendices provide a summary of the evidence upon which I relied, and my findings and recommendations.

8. C and NSS were given an opportunity to comment on a draft of this report.

Presentation of evidence and analysis

9. The evidence upon which I have relied in making my findings, decision and recommendations is summarised in a series of appendices, some published, others kept private.

10. The requirement for confidentiality, and the need to protect the identity of C and others involved in the investigation, means that not all of these appendices are published. Only C and a limited number of staff at NSS will receive the private appendices. 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

Head of complaint 2.1 – staff did not have sufficient training and access to sufficient information to support them to provide correct information to the public

11. Key issues considered under this head of complaint were:

    11.1. whether or not staff had sufficient time and resources to manage their training and knowledge in the live environment,

    11.2. the process for communicating service updates to staff and the recording of these,

    11.3. the impact of staff rotation and shift patterns on the quality of the service provided,

    11.4. whether or not appropriate quality assurance processes were in place to ensure correct information was being given to the public[1], and

    11.5. whether or not the method for calculating exposure and isolation dates was reliable[2].

12. The focus of the investigation was the situation prior to 2 June 2021, when C first raised concerns with NSS. There have been changes since June 2021 in working practice, information sharing, training and quality assurance and I refer to these later and in my feedback at the end of the report.

13. NSS's position was that none of the issues summarised in paragraph 2 above was substantiated by their own investigation of the concerns raised. (NSS's responses to C's complaints are summarised in public Appendix A.)

14. To test and consider this, our investigation also considered the following evidence (summarised in public Appendix A and private Appendix D):

    14.1. NSS's whistleblowing investigation file, emails, a report of a rapid research exercise carried out in NCC in June 2021, NCC's training and improvement plan, call scripts and other documents in relation to NCC's training and quality assurance,

    14.2. an audit of 40 cases carried out by NSS and PHS, and

    14.3. interview testimony from C and six other witnesses.

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[1] This was raised by C during the investigation

[2] This was raised by C through the NSS whistleblowing mailbox on 11 June 2021

2.1 Findings

Training

15. C raised a whistleblowing concern by emailing the NSS whistleblowing mailbox on 2 June 2021, saying that insufficient training meant that contact tracing staff were calling the public with incorrect and outdated advice.

16. NSS began an immediate investigation into C’s claims. They also commissioned a rapid research exercise from an external provider, who surveyed 159 NCC staff in mid-June 2021, followed by smaller focus groups.

17. Evidence from witness interviews, the internal rapid research, and the internal whistleblowing investigation confirms that some staff felt they did not have sufficient time and resources to manage their training and knowledge in the live environment[3] at the time that C raised their whistleblowing concern. It was apparent that the requirement for NCC to move staff between different services (in response to surges in demand) contributed to the time and resource pressure reported by staff.

Communication and recording of updates

18. During the course of the pandemic, there were regular changes to Scottish Government health policy. Any new information was fed into NCC, and scripts and guidance were updated accordingly. Changes were often made to scripts after the daily close of business, and updates were communicated to staff in twice-daily briefings, through the Case Management System, and various MS Teams channels and chats corresponding to the different services NCC provided.

19. In the whistleblowing concern of 2 June 2021, C said that there were no permanent records of the latest information, there was a lack of communication from team leaders and team managers, and that they were unable to find information to update themselves following two weeks of annual leave.

20. NCC had already recognised there were issues with the management of information prior to C raising their concern. An NCC training improvement plan, developed between February and June 2021, noted that information was spread across multiple channels and there was ‘no single source of truth’. The plan proposed centralising information on MS SharePoint to make it easier to find. This had not been done by the time that C spoke up.

21. Evidence from the rapid research and NCC training improvement plan confirms that there were recognised problems with the communication of service updates to staff and the recording of these. These problems were exacerbated by the necessity to rotate staff between different services.

[3] The ‘live environment’ means staff handling calls with the public.

Rotation of staff and shift patterns

22. NSS explained that rotation of staff had not been anticipated at the outset. However, during early 2021 the role of NCC expanded from contact tracing into other services, such as vaccine support. At this time, there was a need to move staff between different telephone lines in order to manage surges in demand. The co-ordination and movement of staff between the services was planned by an Operational Resourcing Planning Team, which met weekly and on an ad-hoc basis, as needed by events.

23. When C raised their concern, they said that NCC staff were being moved between services on a daily basis. C also noted that when staff were moved they 'don't know where to look, who to go to and what is happening.'

24. Evidence shows that, by the time C spoke up, NCC had recognised there were problems arising from the movement of staff between services, and had developed a proposal in response, called 'A/B skills'. The A/B skills approach limited the number of services a staff member could be expected to work on, but this had not been implemented by June 2021. Rotation between services was still a cause of stress and anxiety for contact tracing staff at the time that C raised their concern.

25. Documented information about the impact of shift patterns on the quality of the service provided was limited. Witnesses told us they felt the shift patterns were an additional complication which hindered consistent delivery of information about updates to all staff.

Quality assurance

26. C contacted the whistleblowing mailbox on 11 June 2021 to say that work going through the quality control process was 'appalling'. Witnesses told us that the risks to the public from the contact tracing process were mitigated by a basic quality control process referred to as a 'review'. At the end of the contact tracing process, a review was normally carried out on all contact tracing cases by a contact tracing practitioner. The review checked that the case had been handled appropriately and the correct information had been recorded and escalated if necessary.

27. In a response to my office, NSS said that, during surges, the number of cases reviewed was limited by the availability of quality control staff. When call demand was very high, a proportionate approach had to be taken to prioritise higher risk cases (cases where there were complex settings like healthcare, travel, prisons etc.), and a sample was taken of the 'low risk' cases. We were told by a witness that 1 in 10 low risk cases were looked at in June 2021.

28. It is clear from the evidence considered that there was a quality assurance process in place that would normally have caught errors in the contact tracing process. However, the process was not being applied to every case in June 2021. I go on to

consider this in the context of the main risks to the public from incorrect exposure and isolation dates.

<u>Exposure and isolation dates</u>

29. See public Appendix C for background information about exposure and isolation dates. C did not explicitly raise concerns about exposure and isolation dates in their whistleblowing concern raised via the NSS whistleblowing mailbox on 2 June 2021, although C did say, 'The last thing a family requires is being told the incorrect information, on testing, isolation, support etc.'

30. C explicitly raised concerns in an email of 11 June 2021, saying that there was new evidence of the public getting incorrect isolation advice and incorrect exposure dates to positive COVID-19 cases, and again with whistleblowing staff at NSS on 2 July 2021, after receiving the stage 2 response from them. C said that problems were still continuing and contact tracing staff were having to 're-call contacts for wrong exposure dates and other matters'.

31. The early references were not picked up and investigated by the internal investigator. After the email on 2 July 2021, NSS responded to C by handling this, and an anonymous concern disclosed to the media, as a new anonymous concern (see paragraph 46 below for further context). Their investigation took the form of a joint audit with PHS, looking into the reasons for changes in exposure dates in a sample of 40 cases and the possible clinical impacts of these changes.

32. The auditor found that 91 percent of cases complied with the protocols (i.e. the call scripts) set by PHS. Of the nine percent of cases that did not conform, the auditor said 'the reason for non-conformance could be attributed to a lack of clarity in the work notes explaining the reason for the exposure date change, rather than an error with the date itself'. The report concluded that 'the method for calculating exposure and isolation dates has been reliable'.

33. The NSS/ PHS audit found that a relatively high number of exposure dates were changed by a quality control or supervisor check (25.5 percent across all cases, and 36 percent for cases that went through contact tracing). This corroborates C's concerns about incorrect exposure and isolation dates being given to members of the public in the initial stages, and the reliance that was placed on quality control and checking to ultimately achieve compliance with the protocols. However, as outlined above, the quality control process was not being fully applied to all contact tracing cases during the surge period in June 2021.

34. If errors were not picked up by the quality control process then there was a risk that contacts isolated when they did not need to, or did not isolate for the required period of time, or did not isolate.

35. I recognise that NCC understood the issues surrounding isolation and exposure dates and tried to manage it. A witness told us that there was a constant focus on

symptoms, exposure and isolation dates from inception, including throughout the period covered by the investigation. It had always been part of the training, and additional ad-hoc training materials were shared with staff in December 2020.

36. NSS provided my office with call scripts from June 2021, which had clear guidance for symptom onset, isolation and exposure dates. NSS also shared a readiness quiz, which all newly onboarded contact tracers completed before 'going live' in June 2021; this covered COVID-19 symptoms, symptom onset dates, isolation periods for contacts and exposure dates.

37. Despite these measures, there is reason to believe that there were greater risks of callers receiving incorrect information about exposure and isolation dates at the time that C raised their concern (June 2021 and prior to that date). This was because of reduced quality control, rotation of staff, difficulties in communicating updates and some staff being unable to access relevant training in the live environment.

2.1 Decision

38. The head of complaint I have investigated is that NCC staff did not have sufficient training and access to sufficient information to enable them to provide correct information to the public. This concerned the specific period prior to, and at the time of the concern being raised in June 2021.

39. Evidence shows that, at that time:

    39.1. some staff were unable to find the time and resources to manage their training and knowledge in the live environment,

    39.2. there were issues with how updates were shared and recorded,

    39.3. there was a requirement to move staff between different NCC services in response to an expansion of functions, and a surge in cases, and

    39.4. the normal controls in place to minimise and rectify errors were not fully applied, or as effective as they could have been.

40. My view is that it is more likely than not that these conditions resulted in an increased risk of incorrect information being given to members of the public.

41. On balance, I find that there is sufficient evidence to uphold this head of complaint, on the basis that some staff did not have sufficient training and access to sufficient information to enable them to provide correct information to the public. In making this decision, it should be remembered that the complaint relates to a specific point in time. I recognise the multiple challenges that C and NCC colleagues were facing, and their hard work to deliver the service through these challenges. Especially when the organisation was growing and responding to a rapid surge in COVID-19 case numbers.

42. Although I have upheld this head of complaint, I have not made any recommendation associated with my findings as NCC rectified the issues in the following months (for more information see paragraph 96 below).

Head of complaint 2.2 – NSS failed to handle the concern in line with the National Whistleblowing Standards

43. C's complaint to the INWO raised a number of concerns about the way NSS had handled their whistleblowing concern, in particular that:

    43.1. they had been given inaccurate information about accessing the whistleblowing process by an HR representative,

    43.2. the quality of the stage 2 response was poor, and

    43.3. the identities of witnesses involved in the investigation were inappropriately disclosed to a senior manager (who had been involved in the matters C raised in their whistleblowing concern), and to other witnesses.

44. NSS's position was that, as C had lost faith in NSS management and policies, they decided to handle all the concerns under the Standards even though parts of it did not meet the whistleblowing definition[4]. They sought to identify quickly if there was any risk of incorrect public health advice being given. NSS appointed an experienced investigator who was independent from the service to investigate the position in June 2021. NSS also, concurrently, researched staff training and awareness of the latest advice.

45. NSS summarised C's concern in a single, complex statement which related to multiple risk factors and issues:

    45.1. 'There is insufficient training and knowledge management within NCC for employees, which means contact tracers and contacting practitioners are not confident and calling the public with incorrect advice'

46. The scope of NSS's investigation was shared with C, who was invited to comment on it. The investigator met with C and considered the evidence C submitted. A detailed investigation report was prepared and C was informed of the outcome in the stage 2 outcome letter. C was not satisfied with this and identified (what NSS believed to be) a further concern in relation to the recording of exposure dates. NSS asked C to raise this as a concern under the Standards; however, C did not reply so NSS handled this as an anonymous concern.

47. NSS shared witness names with senior managers for the purposes of providing staff support to witnesses during the investigation. This was in line with their whistleblowing investigations policy and practice. NSS considered that staff

[4] C also raised concerns about recruitment and bullying and harassment. The latter concerns did not form part of INWO's investigation.

involved in the stage 2 concern process fulfilled their roles in terms of the Standards and in line with NSS processes.

48. NSS latterly realised that their initial interpretation of the Standards (including the roles and responsibilities for those involved in the process) was not what was intended by the Standards. NSS explained they were already in the process of recruiting more confidential contacts and they envisaged that this would help achieve separation between this role and executive leadership.

2.2 Findings

49. Section 6A of the Act sets out the INWO's powers and duties in relation to whistleblowing complaints. The provisions of 6A are wide-ranging and include ensuring compliance with a model complaints handling procedure for whistleblowers' complaints. They also state that a whistleblower is entitled to have a complaint handled in accordance with that procedure.

50. While C identified some particular issues, I would not expect them (at that point) to have known or been aware of every aspect of the Standards and the procedure for handling whistleblowing concerns. I would, however, expect NSS to ensure compliance with, and to have handled C's concern in accordance with, the Standards. In view of this, I have considered NSS's handling of the whistleblowing concern in the broad context of the Standards. This includes how they managed the concern.

51. I took into account NSS's whistleblowing standard operating procedure and what witnesses told me (referred to in public Appendix A and private Appendix E).

<u>Information about accessing the process</u>

52. C complained that, during a meeting with a colleague and an HR representative, they were informed that the whistleblowing process should not be used for urgent issues, and these matters should instead be raised with HR.

53. It is clear from the evidence considered that there was a misunderstanding. However, I consider it is less likely than not that C was misinformed about how to raise a whistleblowing concern. It is also notable that, by the time of the meeting which was the subject of C's allegation, C had already raised a concern under NSS's whistleblowing procedure. This suggests that any misunderstanding did not impact on C's ability to access the whistleblowing procedure.

<u>Quality of investigation and response</u>

54. C's concerns about the quality of the investigation were about the impartiality of NSS's investigation. C felt that the conclusions were based on opinions rather than facts. I also considered whether NSS's investigation addressed all the issues C raised.

55. I have identified no evidence to support C’s concerns about the investigation not being impartial or evidence based. I am satisfied that a suitably impartial investigating officer was appointed to conduct the investigation. I am also satisfied that NSS’s findings summarised in their stage 2 response (and more fully in the investigation report) were informed by the evidence they gathered.

56. The Standards state that an investigation should aim to establish all the facts relating to the points raised in the whistleblowing concern. An investigation should be thorough, in proportion to the seriousness of the concern and impartial, so that the organisation can identify any problems and consider what improvements can be made.

57. NSS told us that, following their investigation, C raised a new concern about ‘exposure dates’. However, there is evidence that C mentioned this in an email to a member of staff supporting the investigation on 11 June 2021. C repeated concerns that the public had been given wrong exposure dates and incorrect isolation advice in the meeting with the investigator on 23 June 2021. Unfortunately, the scope of the investigation was not expanded to include this key concern during the initial investigation. Although, at the point that NSS identified that this concern remained outstanding, they undertook to investigate it quickly.

58. NSS’s investigation included consideration of ‘Rotation of staff within NCC’. The investigator noted that the investigation did not allow time to develop a detailed understanding of the differences and overlap between staff roles. They expressed uncertainty about the basis of the decisions about rotation, although they acknowledged that it was a business need. When asked why they did not consider extending to the timescale to enable a more detailed investigation (as allowed for under the Standards), NSS explained it was not considered necessary as they were conducting the rapid research exercise and the investigation performed (up to that point) had not found evidence to support the concerns.

59. While I acknowledge NSS’s explanation, I am not persuaded that the investigation report supports their position fully. In particular, I see that the investigator recognised that there was merit to the concerns about rotation of staff and made a recommendation relating to this.

60. In relation to the stage 2 response, C believed that it contradicted itself in places and questioned why NSS were minded to make improvements, if they had identified no failings in respect of the concerns raised.

61. The basis for NSS’s decision to not uphold C’s concern about the service provision was that they considered there was no evidence of adverse outcomes as a result of the issues raised (i.e. no evidence of the public receiving incorrect advice). My findings on this (set out under head of complaint 2.1) indicate that there are reasons to doubt this conclusion.

62. I see that, although NSS's investigation did not uphold C's concern, it identified learning and improvement actions and made recommendations in relation to training, staff rotation and gathering feedback from staff. This appears contradictory in the way presented and I can understand why C was dissatisfied with NSS's stage 2 response.

63. At the end of the stage 2 investigation it was a matter for NSS to make the decision they considered appropriate. I recognise that there may be occasions where an organisation does not uphold a complaint, but in investigating it, identifies opportunities for learning and improvement. In such situations, it is good practice to ensure that the complaint outcome is communicated in a way which supports the whistleblower, and demonstrates they have been listened to and their concerns taken seriously. This is an important part of building and maintaining confidence in speaking up.

64. NSS could have achieved this by breaking down the concern into separate parts at the outset and making findings on each element, rather than reaching a single decision on a complex statement involving multiple issues.

<u>Confidentiality</u>

65. C's complaint was that a senior manager (implicated in their concern) received the names and contact details of the witnesses involved. C understood that the senior manager had contacted the witnesses by email, prior to them being interviewed by the internal investigator. C also raised concerns that the witnesses had been added to a chat on the MS Teams platform and so each knew the identity of the others. C told us that as a result they did not feel safe.

66. A fundamental duty and principle within the Standards is that the procedure is 'supportive to people who raise a concern and all staff involved in the procedure'. To do this, confidentiality must be maintained. Paragraph 58 of Part 2 (of the Standards) states: 'Confidentiality refers to the requirement not to disclose information about the person raising a concern, unless the law says that it can or must be disclosed. This includes anyone else involved in the process, such as other witnesses.'

67. NSS actively shared names and contact details of witnesses in order to facilitate support for the individuals. While I recognise this was well-intentioned and done in good faith, I am not persuaded that this was a necessary and proportionate means of enabling witnesses to access support in the event that they need it. NSS's approach had the effect of disempowering the witnesses by denying them any choice about whether and with whom their identity (as a person associated with a whistleblowing concern) should be disclosed. A witness may decide they do not need support and, in this circumstance, their identity would be shared unnecessarily.

68. NSS upheld C's allegations about the confidentiality of witnesses, but in view of what happened in this case, I can understand why C lost confidence in the process. Regardless of the intention, the fact that witness details were disclosed would have damaged C's trust in the impartiality and confidentiality of the process. Furthermore, both the disclosure of the witness details to the senior manager and adding the witnesses to an MS Teams channel increased the risk of others identifying C as the whistleblower.

NSS's management of the concern and investigation

69. NSS's investigation included consideration of concerns about recruitment, and bullying and harassment. NSS have acknowledged that not all of C's concerns met the whistleblowing definition, but they handled them under the whistleblowing investigation in order to offer C reassurance that they were taking the matter seriously.

70. I recognise NSS's well-meant intention, but there are good reasons to handle concerns that do not meet the definition under alternative procedures, such as Human Resources policies. This is because these are often better placed to achieve outcomes for the person raising the concern (or others involved). In this case, NSS might have achieved more had they instead investigated concerns about staff rotation.

71. A number of officers were involved in the handling of C's concerns. One officer, in particular, was closely involved in a number of activities, including having the first conversation with C; assessing the eligibility of the concerns; commissioning an investigation; arranging support for other witnesses; checking in with C during the process; and writing to C with the stage 2 outcome.

72. Part 4 of the Standards includes a summary of the roles of NHS staff involved in handling whistleblowing concerns. A clear distinction is drawn between the responsibilities of Executive Directors and Confidential Contacts (or 'Whistleblowing Ambassadors' as they are called by some organisations). Under the Standards, a director (or their delegate) is responsible for managing whistleblowing concerns and signing-off stage 2 decision letters. A confidential contact should be independent of normal management structures (for the purposes of this role) and have the capacity and expertise to be an initial point of contact for staff from across the organisation (or their part of the organisation) who want to raise concerns.

73. NSS's approach at the time of the concern did not reflect the roles outlined in the Standards and NSS acknowledged this during our investigation. There was, however, no evidence that NSS's approach in this case resulted in a conflict that adversely impacted on the handling of the concern or the investigation outcome.

74. NSS's communication with C throughout the process was supportive and reactive to the concerns they raised about detriment. That said, greater separation of the roles

as intended in the Standards would, in my view, have resulted in a perception of greater independence and impartiality.

2.2 Decision

75. In summary, I consider that some aspects of NSS's handling of C's whistleblowing concern were compliant with the Standards and demonstrated good practice. I am satisfied that the investigation (to the extent it was performed) was impartial and evidence based.

76. I was unable to conclude that C was given incorrect information about accessing the whistleblowing procedure. While it was regrettable that NSS did not identify C's concern about the risks relating to wrong exposure dates and incorrect isolation advice earlier, there was not a significant delay before this concern was identified and investigated as an anonymous concern.

77. I have also identified areas where NSS were not compliant with the Standards, and where they can continue to make improvements and build upon the learning they have already taken from this case. This includes:

    77.1. the structure of the roles of those involved did not reflect those outlined in the Standards,

    77.2. extending the remit of the investigation to include issues that did not meet the whistleblowing definition, and

    77.3. witnesses were not afforded sufficient confidentiality.

78. The latter error increased the risk of C being identified as the whistleblower and damaged their confidence in the process.

79. While I am unable to conclude that NSS's stage 2 response was unsupported by their evidence and findings, I consider that NSS could have communicated the outcome in a way which supported C to feel that they had been listened to and that they were right to speak up.

80. In making my decision, I recognise that NSS's implementation of the Standards was in its early stages at the time. I acknowledge that they have made changes and developed their approach since then. On balance, and in view of the issues with a number of aspects of the handling of the concern (particularly confidentiality), I uphold this head of complaint and make recommendations.

Head of complaint 2.3 – NSS failed to protect the whistleblower from detriment associated with speaking up

81. I have considered whether C experienced detriment because NSS failed to take appropriate measures to protect C for raising a whistleblowing concern.

82. The evidence is summarised in private Appendix F. Due to the sensitive nature of the evidence, I have decided that all of the detail must remain confidential, as to disclose it risks identifying C and other staff.

83. C and a restricted group of staff at NSS are aware of the evidence and my findings on this head of complaint. A confidential draft was shared with them during my investigation.

2.3 Decision

84. Based on the evidence provided by NSS and interview with C, the head of complaint that NSS failed to protect the whistleblower from detriment associated with speaking up is not upheld.

Recommendations

Learning from complaints
The Independent National Whistleblowing Officer expects all organisations to learn from complaints. The findings of this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation.

85. I accept the risks to service users and staff identified in my decision have largely been mitigated through NCC's continuous improvement work from, and since, that time, and my recommendations reflect that position.

What we are asking NHS National Services Scotland to do for C

Rec. No	What we found	What the organisation should do	What we need to see
1.	Under head of complaint 2.2, we found that witnesses were not afforded sufficient confidentiality, which increased the risk of C being identified as the whistleblower and damaged their confidence in the process.	Apologise to C for the issues with the confidential handling of witnesses' personal data and the impact this had on C. 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. By: 21 September 2022

What we are asking NHS National Services Scotland to do to improve their compliance with the Whistleblowing Standards

Rec. No	What we found	Outcome needed	What we need to see
2.	Under head of complaint 2.2, we found that NSS investigated concerns raised by C that did not meet the whistleblowing definition.	Concerns handled under the National Whistleblowing Standards must meet the definition set out in the *National Whistleblowing Standards*. If there are other concerns that do not meet this definition NSS should consider whether there is an alternative process and inform and advise the person raising the concern.	Evidence that the findings of my investigation have been fed back to the staff involved in handling the concern, in a supportive manner, for reflection and learning. Evidence that this learning is reflected in NSS whistleblowing guidance, training and information resources. By: 21 September 2022
3.	Under head of complaint 2.2, we found that witnesses were not afforded sufficient confidentiality, which increased the risk of C being identified as the whistleblower and damaged their confidence in the process.	Confidentiality must be maintained as far as possible in all aspects of the procedure for raising concerns. Whistleblowers and other staff should be aware of the measures being taken to maintain confidentiality so they can be confident 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.	Evidence that NSS have reviewed their approach to enabling witnesses to access support to ensure that disclosure of personal data is minimised and respects the rights of individuals to choose whom their personal data is shared with. By: 19 October 2022
4.	Under head of complaint 2.2, we found that NSS's approach in	NSS whistleblowing procedures should be compliant with the Standards, so that	Evidence that NSS have reviewed their whistleblowing

Rec. No	What we found	Outcome needed	What we need to see
	relation to structure of roles (at the time of the concern) did not mirror the structure of the roles outlined in the Standards.	officers involved in handling whistleblowing concerns can discharge their roles in accordance with the responsibilities set out in Part 4 of the Standards.	procedure in light of the findings of this investigation. By: 19 October 2022

Additional comments and feedback

86. In the spirit of sharing and learning, I have drawn on my investigation to provide feedback for NSS, including identifying good practice, which I encourage them to reflect on and action.

87. I also encourage other Boards to reflect on their own approach in the context of this case.

Whistleblowing concerns handling

88. Aspects of NSS's handling of C's whistleblowing concern were of a high standard and demonstrated good practice. In particular, I note that the communication with C throughout the process was supportive and reactive to the concerns C raised about detriment. I encourage NSS to share this feedback with the staff involved in handling C's concerns.

89. NSS did not identify C's concern about the risks relating to wrong exposure dates and incorrect isolation advice as early as they could have, but when they did there was no significant delay before this concern was identified and investigated as an anonymous concern. I encourage NSS (and other Boards) to reflect what steps could be taken to:

    89.1. communicate with whistleblowers to ensure that issues are identified from the outset, and

    89.2. identify and action as early as possible new elements of concern that emerge once an investigation has started.

90. How the outcome of an investigation (of a whistleblowing concern) is communicated, is important in providing assurance that concerns have been taken seriously and the whistleblower listened to. This helps to build trust and confidence in the process and in speaking up. Communication of outcomes can be challenging as the organisation may not be able to share all its evidence, or may not be upholding some or all of the matters raised.

91. I encourage NSS to reflect on how they could have supported C to feel that they had been listened to and that they were right to speak up. One approach that might have been helpful was to break down the concern into separate parts rather than trying to encapsulate all of the issues in a single (and quite complex) statement. This would then have enabled NSS to provide C with the reassurance that they had been listened to.

Response to INWO investigation

92. NSS were co-operative and communicated well with my office, and were professional and courteous throughout the process. NSS were transparent and provided helpful and comprehensive information in response to enquiries.

93. We also found witnesses to be helpful and willing to share their experiences.

Good practice

94. Points of good practice to note from this case included:

- NSS had kept all records relating to their own investigation and were able to share them on request,
- the whistleblowing function in NSS was separate from HR, which allowed for there to be sufficient independence between the HR and whistleblowing processes needed to respond to C's concerns, and
- NSS took C's concerns seriously at every stage and were responsive to the potential for detriment.

95. Even though NSS did not uphold C's concerns, they were willing to learn and improve. For example, NSS responded to the initial whistleblowing concern with an action plan, managed by appropriately senior staff which has delivered improvement for NCC.

96. Since February 2021, NSS have made the following improvements:

- February 2021: onboarding training for new staff was taken in-house and improved by the internal training team, to make it more applicable to the role.
- June 2021: the first cohorts to receive the improved training were also supported by an 'academy' as they moved into the live environment. This provided a more supported start for new staff and enabled NCC to gauge what further training was required for each individual.
- July 2021: a new quality control process (QC2) and skills matrix were introduced. These processes worked together to enable more objective measurement of staff strengths and identify training needs. For example, the QC2 process identified an issue in relation to how callers were verified on the vaccination service. A targeted training course significantly reduced the error rate in subsequent cases selected by the quality control process.
- July 2021: around the end of July 2021, NCC implemented an approach called 'A/B skills'. This limited the number of services each staff member was expected to provide (i.e. maintain knowledge about) to two, enabling staff to develop more expertise in their chosen areas.

- Summer of 2021: QC2 was rolled out across all services apart from contact tracing.
- Summer of 2021: NCC created training websites for each service which included workshops, quizzes and online learning materials which supported staff to consolidate their knowledge. Online information sources and updates were centralised onto MS SharePoint or equivalent. All the staff interviewed in November 2021 knew where to look for supporting information that they might need to speak to the public.

Summary of documents that make up the full INWO report and restrictions on publication

Document Name	Description	Restrictions at final stage
Summary Report on complaint about NHS National Services for Scotland Reference: 202102821	Anonymised/ pseudonymised summary of complaint investigation and findings	None Published in full
Public Appendix A: High level summary of evidence relating all points	Anonymised/ pseudonymised summary of evidence	None Published in full with Summary Report
Public Appendix B: Background to NCC	General overview of NCC	None Published in full with Summary Report
Public Appendix C: Calculation of exposure and isolation dates	Background information about exposure and isolation dates	None Published in full with Summary Report
Private Appendix D: Confidential summary of evidence for 2.1	Pseudonymised summary of evidence, anonymised as far as possible	**Restricted to**: • Complainant (whistleblower) • INWO Liaison Officer • NSS CEO • NSS Chair of the Board • NSS Whistleblowing Champion • NSS internal investigator • NSS Head of HR • NSS Whistleblowing Ambassador • NSS director responsible for NCC • PHS CEO • NSS/PHS staff with oversight of the audit of 40 cases

Document Name	Description	Restrictions at final stage
Private Appendix E: Confidential summary of evidence for 2.2	Pseudonymised summary of evidence, anonymised as far as possible	**Restricted to**: • Complainant (whistleblower) • INWO Liaison Officer • NSS CEO • NSS Chair of the Board • NSS Whistleblowing Champion • NSS internal investigator • NSS Head of HR • NSS Whistleblowing Ambassador • The staff involved in sharing the witness names
Private Appendix F: Confidential Summary of evidence and analysis for 2.3	Anonymised/ pseudonymised summary of complaint investigation and findings	**Restricted to**: • Complainant (whistleblower) • INWO Liaison Officer • NSS CEO • NSS Head of HR • NSS Whistleblowing Ambassador • Complainant’s line manager

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. **It 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 all points	Anonymised/ pseudonymised summary of evidence	None Published in full with Summary Report

2. Please note this evidence is supported by further detailed evidence, which has been listed in separate, unpublished appendices, as it cannot be shared for reasons of confidentiality.

3. 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.

Description	**Relevant to:**		
	2.1 Staff did not have sufficient training and access to sufficient information to support them to provide correct information to the public	2.2 NSS failed to handle the concern in line with the National Whistleblowing Standards	2.3 NSS failed to protect the whistleblower from detriment associated with speaking up
National Whistleblowing Standards	Yes	Yes	Yes
Complaint and documents provided by C	Yes	Yes	Yes
Interview testimony from C	Yes	Yes	Yes
Interview testimony from other witnesses	Yes	Yes	
NSS's response to our enquiries. Across various responses NSS said:			
(i) they considered that NCC staff were provided with time and resources to manage their training and knowledge at induction and in the live environment on an ongoing basis.	Yes		
(ii) there was a process for communicating service updates to staff and the recording of these.	Yes		

Description	Relevant to:		
	2.1 Staff did not have sufficient training and access to sufficient information to support them to provide correct information to the public	2.2 NSS failed to handle the concern in line with the National Whistleblowing Standards	2.3 NSS failed to protect the whistleblower from detriment associated with speaking up
(iii) the quality indicators for the service were good indicating that rotation and shift patterns were not having an impact on the quality of service provided.	Yes		
(iv) they found no indication or evidence of incorrect advice being given to the public.	Yes		
(v) they conducted an audit with Public Health Scotland (PHS) into changes to exposure dates for contacts and the possible clinical impact of these changes. The results indicated that the policy and process defined by PHS was being followed, and therefore there was no concern that dates had been incorrectly assessed.	Yes		
(vi) while parts of the whistleblower's concern did not meet the whistleblowing definition, because C had lost faith in NSS management and policies, NSS decided to handle all the concerns under the Standards		Yes	
(vii) on receipt of the concern, they sought to identify quickly if there was any risk of incorrect public health advice being given. NSS also commenced research work into staff training and awareness of the latest advice whilst		Yes	

Description	Relevant to:		
	2.1 Staff did not have sufficient training and access to sufficient information to support them to provide correct information to the public	2.2 NSS failed to handle the concern in line with the National Whistleblowing Standards	2.3 NSS failed to protect the whistleblower from detriment associated with speaking up
concurrently investigating the concerns raised. An experienced investigator who was independent from the service received the commission for investigation. (viii) the scope of the investigation was shared with C and they were invited to comment on this. The investigator met with C and considered the evidence C submitted. A detailed investigation report was prepared and C was informed of the outcome in the stage 2 outcome letter. C expressed dissatisfaction in response to this and identified (what NSS believed to be) a new concern in relation to the recording of exposure dates. NSS asked C to raise this as a concern under the Standards; however, C did not reply and so NSS handled this as an anonymous concern		Yes	
(ix) in relation to the confidentiality of the witnesses, NSS said that witness names were shared with senior managers for the purposes of providing staff support to witnesses during the investigation. They said this was in line with their whistleblowing investigations policy and practice in supporting staff that were being interviewed as witnesses in investigations.		Yes	

Description	Relevant to:		
	2.1 Staff did not have sufficient training and access to sufficient information to support them to provide correct information to the public	2.2 NSS failed to handle the concern in line with the National Whistleblowing Standards	2.3 NSS failed to protect the whistleblower from detriment associated with speaking up
(x) NSS considered that staff involved in the stage 2 concern process fulfilled their roles in terms of the Standards and in line with NSS processes. However, NSS latterly realised that their initial interpretation of the Standards was not what was intended. NSS explained they were already in the process of recruiting more confidential contacts and this would help achieve separation between this role and executive leadership		Yes	
NSS's internal complaint file which included:			
(i) email correspondence between C and NSS whistleblowing staff, and	Yes	Yes	Yes
(ii) copies of emails between C and the investigator, notes from witness interviews and the full investigation report from the original internal NSS whistleblowing investigation.	Yes	Yes	Yes
A rapid research exercise carried out in the NCC in mid-June 2021 with 159 staff, which focused on the service within the previous three months.	Yes		

Description	Relevant to:		
	2.1 Staff did not have sufficient training and access to sufficient information to support them to provide correct information to the public	2.2 NSS failed to handle the concern in line with the National Whistleblowing Standards	2.3 NSS failed to protect the whistleblower from detriment associated with speaking up
NCC's training improvement plan, which was developed between February and June 2021 and delivered during the summer months of 2021.	Yes		
Documents provided by NCC about their training and quality assurance processes up to 1 October 2021.	Yes		
An audit of 40 cases carried out by NSS and PHS relating to clinical risk from changes to exposure dates over a 4 week period.	Yes		
Correspondence and notes of a meeting between C and management in the period running up to and including their involvement in whistleblowing, and related correspondence between management and HR.			Yes
NHSScotland Workforce Policies Investigations Process			Yes
NHSScotland Workforce Policies Investigation Commissioned by NSS			Yes
Evidence relevant to the calculation of exposure and isolation dates			
(i) protocols (i.e. scripts for call handlers)	Yes		
(ii) documents from NSS	Yes		

Description	Relevant to:		
	2.1 Staff did not have sufficient training and access to sufficient information to support them to provide correct information to the public	2.2 NSS failed to handle the concern in line with the National Whistleblowing Standards	2.3 NSS failed to protect the whistleblower from detriment associated with speaking up
(iii) readiness checks (i.e. tests for new call handlers)	Yes		
(iv) interview testimony from witnesses	Yes		
(v) emails and interview testimony from C	Yes		
NSS's whistleblowing standard operating procedure			
(i) generally		Yes	Yes
(ii) specifically, NSS WB procedures states the following about provision of support (for whistleblowers and other involved)		Yes	
• Speak to SBU director (or designated other if concern is about the director) related to where the WB case has arisen regarding the commission and agree contact in SBU for support of staff who are witnesses.		Yes	
• Investigating manager writes to the witnesses using NSS WB template letters, ensuring HR, SBU Director and team manager (where appropriate) are aware this is happening to provide support.		Yes	
Other whistleblowers. A whistleblower contacted STV 2 July 2021 saying:			

Description	Relevant to:		
	2.1 Staff did not have sufficient training and access to sufficient information to support them to provide correct information to the public	2.2 NSS failed to handle the concern in line with the National Whistleblowing Standards	2.3 NSS failed to protect the whistleblower from detriment associated with speaking up
(i) 'In the last few weeks, it's been quite a stressful environment to be part of, a lot of the staff there are really overworked. The people who are working there are being moved around various phonelines throughout the day.'	Yes		
(ii) 'At points, they receive training, for example, contact training or tracing or vaccine enquiry, and then they're not put on that phone line for three weeks, so when it comes to then working on the line they've not been able to use their training, they don't know what they're doing. They'll be told in the morning 'you're on this phoneline' and then an hour later they might get moved somewhere else.'	Yes		
(iii) 'People are coming out of training and going straight on to do contact tracing calls that are not done to the standard that they should be, not done within the time that they should be, which is putting people at risk especially contacts of index cases – they are still going about their daily business because nobody has been in touch with them.'	Yes		
In response to our findings in the draft report NSS provided the following new information:			

Description	Relevant to:		
	2.1 Staff did not have sufficient training and access to sufficient information to support them to provide correct information to the public	2.2 NSS failed to handle the concern in line with the National Whistleblowing Standards	2.3 NSS failed to protect the whistleblower from detriment associated with speaking up
(i) Over the 2 years since Test & Protect has been operated, communication has been made over a number of channels, including by NCC call handlers, to 2.3 million people infected with COVID-19 and 3.2 million of their contacts. The number of adverse events and complaints reported by NCC is very small (in hundreds) in comparison, to these volumes. The NCC management team believe that this shows that the system of training, and other controls, together have been successful in mitigating the risk of incorrect public health advice being given to within the level which is acceptable given the nature of the pandemic.	Yes		
(ii) In addition, NCC would advise that Public Health Scotland and Scottish Government jointly commissioned three separate rounds of independent research into citizen compliance with isolation guidance. This research was not provided during previous NSS evidence submission to INWO. However, with INWO's conclusion in respect of incorrect public health information/advice, NCC would wish that these research studies are considered. The research studies were designed to test public understanding and compliance with isolation	Yes		

Description	Relevant to:		
	2.1 Staff did not have sufficient training and access to sufficient information to support them to provide correct information to the public	2.2 NSS failed to handle the concern in line with the National Whistleblowing Standards	2.3 NSS failed to protect the whistleblower from detriment associated with speaking up
guidance which had been provided, whatever the source (e.g. digitally, NCC agent, NHS Health Board Health Protection Team). Although the purpose was to assess public compliance, the research process required testing what the citizen believed the rules were at the time of their interaction with Test & Protect and therefore that would have included what they had been told by NCC (or others providing advice e.g. NHS Board Health Protection Teams). There was no evidence 4 from this research that showed incorrect advice had been given by any of the research respondents. (3)			
(iii) There was a balance to be struck, particularly in times of surge when Scottish Government policy and Public Health Scotland guidance were changing, between the amount resource allocated to training and the urgency of mobilising resources to be able to respond to increased demand. Throughout the pandemic, an approach of balancing risks has had to be taken, this requires to be taken account of.	Yes		
(iv)There is a permanent record of historic guidance held by PHS, and in terms of contact tracing notification of changes, scripts, knowledge base articles, content of SMS messages etc held in	Yes		

Description	Relevant to:		
	2.1 Staff did not have sufficient training and access to sufficient information to support them to provide correct information to the public	2.2 NSS failed to handle the concern in line with the National Whistleblowing Standards	2.3 NSS failed to protect the whistleblower from detriment associated with speaking up
the CMS quality system. Staff can access previous versions by accessing the current version clicking the appropriate link and are able to access historic versions of information.			
(v) The required isolation period has varied over the course of the pandemic from 14 to 10 to 5 days. Each reduction has been based on improved information about the virus and how it progresses in individuals. The virus does not progress uniformly in all 5 patients; some could be non-infectious sooner than others, some could potentially remain infectious after the 14/10/5 day period, so whatever the isolation period advised at any time point was, there were other factors which would apply to ending isolation. The advice provided would have been to continue to isolate after the recommended isolation period if you had a fever since that would indicate continuing infectiousness. For those index cases with no symptoms then the risk of transmission is lower in any respect, so if isolation period dates had changed by e.g. a day shorter then that would not necessarily increase the risk of transmission. For contacts the 14/10/5 had margins of variation built in so that if the date changed by a day or two (as the audit shows to be the case)	Yes		

Description	Relevant to:		
	2.1 Staff did not have sufficient training and access to sufficient information to support them to provide correct information to the public	2.2 NSS failed to handle the concern in line with the National Whistleblowing Standards	2.3 NSS failed to protect the whistleblower from detriment associated with speaking up
then the risk of having a different initial exposure date was mitigated.			

Appendix B
Background to the National Contact Centre

1. **This 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 NCC	General overview of NCC	None Published in full with Summary Report

2. National Contact Centre (NCC) commenced contact tracing on 22 June 2020. Its function was to deliver a vital new information service during the COVID-19 pandemic, responding swiftly to ongoing changes in public health guidance and government policy as the situation evolved.

3. Setting up the service involved recruiting and training large numbers of staff working from home. NCC contact tracers and contact tracing practitioners were a mixture of core and bank staff drawn from a wide variety of backgrounds. NCC also used external suppliers (contractors) to boost capacity.

4. Staff were deployed over more than 100 shift patterns. They were not expected to have clinical knowledge or experience, but were dependent on 'onboarding' training to learn and develop the relevant knowledge. Staff used call scripts provided by Public Health Scotland (PHS) containing information and guidance. They also received daily briefings and updates through online systems such as MS Teams.

5. Onboarding training was delivered by PHS in conjunction with NHS Education for Scotland (NES) until February 2021 from when it was taken in-house and developed by NCC to be more job specific. The first intake of staff to receive the in-house onboarding joined NCC in June 2021.

6. From contact tracing, NCC's work expanded to include:

   6.1. border monitoring: outbound surveillance calls to travellers recently arrived in Scotland from red and amber countries,

   6.2. inbound calls: people calling in response to a missed call or to query information they have received,

   6.3. vaccination support: rescheduling, registration and general enquiries,

   6.4. testing support: Providing LFT testing kit support for schools, prisons, social care, Scottish police service and Scottish fire and rescue service, and

   6.5. COVID-19 status: handling requests for vaccination certificates from callers who could not obtain these online, and confirmation of testing status.

7. Each new service required additional training and guidance to be developed, often at speed; for example, the vaccination service had to be developed within 10 days.

8. New staff learnt about contact tracing first as part of the onboarding and, as they became more confident and competent, they received training to provide other services. NCC say that no member of staff has been expected to provide advice to the public without having first received relevant training.

9. An Operational Resource Planning Team (OPRT) was set up in February 2021 to forecast and plan where resources needed to be allocated, taking into account staff training and experience. At the time, NCC staff were expected to be flexible and willing to be moved into any of NCC's services, as long as they had received the appropriate

training. Staff were informed through a shift update the night before about area where they were working. This could change at short notice; sometimes mid-shift, for example, in response to an escalation in calls following a Scottish Government announcement.

10. In May/ June 2021 there was a surge in COVID-19 cases. The contact tracing workload grew quickly, so further staff were moved in from other services. From mid-June 2021, new contact tracing staff were joining the live environment at the rate of about 70 per week.

Appendix C:
Calculation of exposure and isolation dates

1. **This not a confidential document and there are no restrictions on sharing it [once published].**

Document Name	Description	Restrictions at final stage
Appendix C: Calculation of exposure and isolation dates	Background information about exposure and isolation dates	None Published in full with Summary Report

2. This appendix sets out information in relation to calculating exposure and isolation dates.

Process overview

3. This information was relevant at the time C spoke up, and remained consistent during the evidence gathering stage of the INWO investigation.

4. The process of defining isolation dates involved a conversation between contact tracing staff and the COVID-19 positive person about the person's symptoms (if any) and symptom onset dates.

5. Contact tracing staff could only take account of 'cardinal symptoms'. These cardinal symptoms were consistent from the start of contact tracing. They were:

    5.1. a new continuous cough

    5.2. high temperature, and

    5.3. a loss or change to sense of smell or taste.

6. If the person did not have the cardinal symptoms, then the first positive test date was used as a proxy for the symptom onset date.

7. At the time, it was understood that a positive case would be infectious from two days prior to the symptom onset date to 10 days after. These were the **isolation dates**.

8. If new information came to light at a later date, symptom onset dates were updated, and this could have had a knock on effect on the person's isolation dates. Similarly, if a case with an asymptomatic positive test result had started to show symptoms by the time they were contacted, they would have been instructed to reset the isolation dates to when the symptoms started.

9. The isolation advice given to any contacts was dependent on the index case's symptom onset date and the date when contacts were last exposed to the index, i.e. the exposure date (the index case is the first identified case in a chain of infection).

10. Contacts were further broken down into household and non-household contacts, each of which had their own isolation guidance (household contacts were required to isolate from the index case's symptom onset date, non-household contacts from when they were last exposed to them). Whichever date was used, this was recorded as the **exposure date**.

11. It was not unexpected for a contact's exposure dates to change if new information came to light. For example, the contact may have had a different recollection of the last exposure date or may have believed that they were not a contact at all. These and other scenarios would have changed the advice given to the contact on the period of their isolation.

Opportunities for error

12. The INWO investigation learned of a number of situations where symptom onset, isolation and exposure dates could be captured inaccurately. For example:

    12.1. members of the public were not always able to remember exactly when they first became ill. The system onset date could be changed later if they recalled more accurate details.

    12.2. some members of the public were unable to say for sure whether they had the cardinal symptoms; for example, they were feeling hot, but were unsure if this was a high temperature. This required educated estimation from the contact tracing staff.

13. Staff were also operating in a complex and continually changing environment that was complicated by:

    13.1. press reports about new symptoms associated with emerging COVID-19 variants;

    13.2. the complexity of some of the situations presented to them;

    13.3. having to work remotely, managing phone call, scripts and guidance.

14. This could result in situations like:

    14.1. incorrectly recording the start of the infectious period as the symptom onset date, with a knock on effect on the exposure and isolation dates for household contacts, and

    14.2. applying the wrong household status to contacts and giving incorrect isolation advice as a result.