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

Scottish Parliament Region: Mid Scotland and Fife

Case ref: 202206116

NHS Organisation: NHS Forth Valley

Subject: **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 NHS Forth Valley (the Board). C was involved in a whistleblowing investigation carried out by the Board under the National Whistleblowing Standards.
2. The complaint I have investigated is:
   2.1. The Board unreasonably failed to handle C's concerns in line with the National Whistleblowing Standards (*upheld*)
3. As a result of my findings, the Board have been asked to implement a number of recommendations and consider and reflect on other feedback, particularly in relation to compliance with the National Whistleblowing Standards.
4. My investigation also identified a number of areas of good practice by the Board, 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

1. The 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 at local level.

2. In this case, C brought a complaint to the INWO about the handling of their concern and also escalated their original concerns, which they felt had not been addressed. On review of the complaint and the investigation file from the Board, I decided to focus my investigation on the handling of the whistleblowing concern and refer the original issues back to the Board for further consideration. I will explain the reasons for this more fully in the report below.

3. In order to investigate C's complaint about the handling of their concerns, the INWO

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

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

   3.3. obtained comments from the Board.

4. 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 and recommendations. A high level summary of the evidence considered is provided in public Appendix A.

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

Presentation of evidence and analysis

6. The evidence upon which I have relied in making my findings, decision and recommendations is summarised in a series of public and private appendices. These appendices also include analysis of the evidence.

7. The requirement for confidentiality, and need to protect the identity of C and others involved in the Board's investigation means that not all of these appendices are published, nor is it appropriate for all people within the Board, to have sight of them, only 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 unreasonably failed to handle C's concerns in line with the National Whistleblowing Standards (upheld)

2.1 Background

8. With support, C submitted concerns in writing to the Board and grouped them into three main headings with considerable narrative detail under each.

9. The Board appointed an independent external investigator to consider C's concerns. In their stage 2 response, they partially upheld C's concerns and outlined a list of recommendations.

10. C complained to the INWO about the handling of their concerns by the Board and sought an independent review of the original whistleblowing concerns raised, which they said had not been addressed. In broad terms, C's original concerns focused on the risk of harm to staff and patients resulting from serious issues they had with leadership, governance and culture at the Board.

11. In order to undertake a full assessment of the complaint and determine the scope of my investigation, I reviewed the Board's investigation report and the complaint from C. I agreed with C that it was difficult to understand how the investigation and the recommendations addressed the specific concerns raised.

12. For this reason, I decided to focus my consideration of this complaint on the handling of C's concerns and refer the original issues back to the Board. I will expand on this decision further below.

13. To assess the Board's handling of the case, my investigation considered the evidence provided by C and the Board (summarised in public Appendix A and discussed in private Appendix B). It considered this against the expectations set out in the Standards.

14. The key issues considered under this complaint were C's concerns that

    14.1. the Board's response did not provide assurance that the concerns had been taken seriously

    14.2. the stage 2 response lacked detail about the decision making, findings and conclusions

    14.3. the investigation focused on existing or ongoing reviews rather than C's specific concerns

    14.4. the suggestion that C had agreed that this approach would address the issues, and

    14.5. the response failed to identify how the investigation addressed concerns related to senior staff.

15. In summary, the Board's position was that

    15.1. the concern was taken seriously and an external investigator was commissioned to ensure an impartial review

    15.2. the response letter reflected the understanding of the external investigator that C was confident that the concerns would be addressed if there was a focus on the following reviews or action plans

        15.2.1. Emergency Department Review (August 2021)

        15.2.2. Healthcare Improvement Scotland (HIS) safe delivery of care inspection reports for Forth Valley Royal Hospital (April and September 2022)

        15.2.3. actions taken by the board in relation to the Scottish Government Stage 4 Escalation process (in progress at the time of the investigation)

15.3. the Board made efforts to double check this position with the external investigator before sending the stage 2 response to C, and

15.4. the majority of the recommendations made by the external investigator were fulfilled by the Stage 4 Escalation Improvement Plan that was submitted to the Scottish Government.

2.1 Findings

16. 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 Standards. It also states that a whistleblower is entitled to have a complaint handled in accordance with that procedure.

17. 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.

18. I have found that some aspects of the Board's handling of the whistleblowing concerns were compliant with the Standards and demonstrated good practice. In particular

18.1. the acknowledgement letter was informative and met the timescale in the Standards

18.2. the Board considered the best way to investigate a concern involving senior figures and appointed an external investigator

18.3. the investigator met with C to discuss their concerns at the outset of the investigation, and

18.4. the Board issued their stage 2 response within the timescales outlined in the Standards and included signposting to the INWO.

19. I have also identified areas where the Board were not complaint with the Standards and where they can make improvements and take learning from this case. In particular

19.1. the Board did not retain the notes from the initial meeting between the C and the investigator on the complaint file

19.2. the limited scope and methodology of the investigation resulted from a misunderstanding between the investigator and C, with no written agreement to ensure shared understanding

19.3. neither the stage 2 response nor the investigation report addressed each of the issues raised and demonstrated how each element had been fully and fairly investigated

19.4. the stage 2 response did not set out the conclusions alongside an explanation of how these were reached

19.5. the stage 2 response letter indicated the overall outcome was that the concerns were partially upheld but did not clearly explain which of C's 3 separate concerns had been upheld or not upheld

19.6. the stage 2 response did not provide detail of the actions that were being taken to address the recommendations, nor explain how the actions would fulfil the recommendations, and

19.7. the Board did not clearly outline which specific aspects of C's concerns were considered unsuitable for the whistleblowing process and signpost to the INWO to review the decision.

20. Importantly, I have found that the Board's stage 2 response and investigation report failed to demonstrate clearly how the investigation, findings and recommendations addressed the details of the concerns originally raised by C. There is no written agreement between the investigator and C that the concerns would be addressed by a focus on the existing reviews and action plans, and there is disagreement on whether or not this was understood and agreed by both parties. The investigation was subsequently significantly limited in scope and there was little information available to include in the stage 2 response letter.

21. Similarly, I have found that although the stage 2 response indicated the Board's position that the actions required by the recommendations were covered by the Stage 4 Escalation Plan to the Scottish Government, there is not sufficient information to explain how these action plans fulfil the recommendations or to identify which action on the plan relates to each of the recommendations made.

2.1 Decision

22. The complaint I have investigated is that the Board unreasonably failed to handle C's concerns in line with the National Whistleblowing Standards.

23. In making my decision, I recognise that the landscape within which these concerns were raised was cluttered and that the original concerns appeared to have aspects in common with recent and current reviews taking place, as well as the Scottish Government's stage 4 escalation process, for which an action plan was in development. There is potential that a combination of these reviews and the resulting action plans may indeed address some or all of the original concerns raised by C. However, I have not seen evidence to adequately explain how the Board consider that the action plans address both C's upheld concerns and/ or the recommendations made by the external investigator.

24. For this reason, I have decided that the original issues raised by C are yet to be fully considered by the Board and I am therefore referring the concerns back to the Board through a recommendation in this report. I have not considered the specifics of the original concerns as part of this investigation and so, for the avoidance of doubt, C has the right to return to my office at the conclusion of the Board's work on my recommendation, if they remain dissatisfied with the outcome.

25. In light of the various issues I have highlighted, I find that there is sufficient evidence to **uphold** this complaint.

Additional Comments and Feedback

26. The complainant was supported throughout the whistleblowing process by a Confidential Contact at the Board. I have had extremely positive feedback from the complainant on the quality of the support and advice offered by the Confidential Contact and wanted to take the opportunity to acknowledge the excellent work being done by those in the role within the Board.

27. My investigation was helped by the co-operation of the Board's Liaison Officer and Whistleblowing Lead. I am grateful to them for their assistance and their constructive and thoughtful engagement with the process. During my review of the complaint, my team met with the Whistleblowing Lead and found them to be both open and committed to getting the process right. This included an acceptance that they may need to look again at the concerns. This attitude reflected well on the Board.

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

Recommendations

Learning from complaints

The Independent National Whistleblowing Officer expects all organisations to learn from complaints. The learning should be shared with those responsible for whistleblowing as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation.

What INWO is asking the Board to do for C

Rec. No	What INWO found	Outcome needed	What INWO need to see
1.	Under 2.1 I found • The Board failed to demonstrate that each of C's concerns had been fully and fairly investigated, or to keep adequate records, and to explain what element(s) of the concerns were not covered by the Standards. • The Board failed to include detail of their proposed actions and did not clearly explain how the actions would address the concerns or recommendations.	The Board must evidence an effective investigation that clearly links the findings and recommendations to the concerns raised by the Whistleblower. C should receive a final response that meets the requirement of the Standards: • *At the end of the investigation, the organisation must give the person who raised the concern a full and considered response, setting out its findings and conclusions, and how it reached these. It must also provide evidence that it has taken the concern seriously and investigated it thoroughly. It must include the conclusions of the investigation and information about any action it has taken or plans to take as a result of the concern, both to deal with the current situation and*	A copy of the response letter that meets the requirements of the Standards. By: Under the timescales outlined in the National Whistleblowing Standards – 20 working days, or if the investigation requires more time, updates at 20 working day intervals with accompanying evidence that progress is being made.

Rec. No	What INWO found	Outcome needed	What INWO need to see
		to avoid it from happening again in the future (part 3, paragraph 52) If, following a detailed review of C's concerns, the Board decide that aspects are not suitable for the whistleblowing procedure, they should record full and accurate details of the decision and ensure that C fully understands these reasons.	

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

2.	Under 2.1 I found • there were shortcomings in the handling of the concerns in accordance with the Standards.	The Board must carefully consider the findings in this report and put in place measures that ensure processes are in place, in line with the Standards, in relation to • how new concerns are reviewed to establish suitability for the whistleblowing process • record keeping • process for drafting and signing off stage 2 reports.	Evidence that the Board have reflected on the findings in this report and identified good practice, where improvements are needed to their process, what actions are needed and how learning will be shared. Action plan by: 12 October 2023 Implementation by: 30 November 2023

Summary of documents that make up the full INWO report

Document Name	Description	Restrictions at final stage
Summary Report on complaint about the Board Reference: 202206116	Anonymised/ pseudonymised summary of complaint investigation and findings	None Published in full
Appendix A: High level summary of evidence relating to all points	Summary of the evidence considered in this case.	None Published in full with summary report
Appendix B: Confidential discussion of complaint point 2.1	Detailed discussion of the point/s considered within complaint 2.1	• Complainant • CEO • Whistleblowing Executive Lead • INWO Liaison Officer • Chair • Whistleblowing Champion • External investigator (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 range of evidence was sought and considered.

3. **This is a public 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 to all points	Anonymised summary of the evidence considered in this case.	None Published in full with summary report

Description	Relevant to:
	2.1 The Board unreasonably failed to handle C's concerns in line with the National Whistleblowing 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
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 full complaint to the Board outlining the concerns in detail	Yes
ii. C's correspondence with INWO detailing their concerns	Yes
iii. Notes from conversations with C by phone	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 23 December 2022. This included information on and reference to the: a) three areas of concern raised by C b) recommendations made by the external investigator c) Stage 4 Escalation Improvement Plan	Yes
ii. The external investigator's final report and supporting evidence including: a) documents related to the Emergency Department review (August 2021), including recommendations, risk register, action plans, minutes from working groups and Board meetings b) Healthcare Improvement Scotland safe delivery of care inspection report (April 2022) c) iMatter reports d) Stage 4 Escalation Improvement Plan	Yes

Description	Relevant to:
	2.1 The Board unreasonably failed to handle C's concerns in line with the National Whistleblowing Standards
e) records of the Executive team mandatory learning	
iii. Correspondence including between: a) The Board and C b) The Board and the external investigator c) The external investigator and C d) The external investigator and third parties named in the concerns	Yes
4. Additional comment provided by the Board We sought additional comment from the Board on matters considered relevant to the investigation and any supporting evidence. This took the form of:	Yes
i. Written comments/clarification on the evidence available	Yes
ii. A meeting with the Board	Yes