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: North East Scotland

Case ref: **202101686**

NHS Organisation: **Tayside NHS Board**

Subject: **Working from home during COVID-19**

This is the report of the Independent National Whistleblowing Officer (INWO) on a whistleblowing complaint about compliance with national guidance on working from home during the COVID-19 pandemic. 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 confidential appendixes, it is a full and fair summary of the investigation.

Executive summary

1. The complainant (C) complained to the INWO about Tayside NHS Board (the Board). C had a non-clinical role with the Board, which they normally performed at one of the Board's hospital sites.
2. The complaint I have investigated is:
   - 2.1. the Board unreasonably failed to comply with the Scottish Government guidance on working from home during the COVID-19 pandemic. (*upheld*)
   - 2.2. the Board unreasonably failed to handle C's whistleblowing concern in accordance 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

5. 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 the status of the guidance as a measure in the response to the COVID-19 pandemic, and the potential for non-compliance to impact on staff and patient safety.

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

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

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

   6.3. obtained comments and documentary evidence from the Board

   6.4. reviewed national policy and guidance, including:

      6.4.1. DL (2020) 8: Staff Wellbeing And Support: Employers Duty Of Care During COVID-19 Pandemic (14 April 2020)

      6.4.2. DL (2021) 05: Stay at Home Regulations: Working From Home (2 February 2021)

   6.5. obtained information to assist our understanding of the context and purpose of the above from the Scottish Government

   6.6. took evidence from witnesses through interview, and

   6.7. obtained professional HR advice to inform our understanding of the issues.

7. 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 Appendix A.

8. C and the organisation 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 appendixes, some disclosed, others kept private. Where necessary for confidentiality, these appendixes also include analysis of the evidence.

10. The requirement for confidentiality, and need to protect the identity of C and others involved in the investigation means that not all of these appendixes are published, nor is it appropriate for those 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 appendixes and the restrictions relating to their publication and sharing.

Findings and decision

Point 2.1 The Board unreasonably failed to comply with the Scottish Government guidance on working from home during the pandemic

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

    11.1. the Board did not comply with specific guidance, most notably DL (2021) 05

    11.2. the Board's working from home arrangements were not a reasonable response to supporting critical areas of the Board's work, and

    11.3. the Board failed to carry out adequate risk assessments to support their decisions on working from home arrangements.

12. C's concerns arose in the context of the 'second wave' of the COVID-19 pandemic (the end of 2020 and early 2021). The investigation has focused on the period immediately before and after DL (2021) 05 (2 February 2021) and the introduction of the Board's hybrid working arrangements (March 2021); however, as many of the Board's decisions date to earlier in the COVID-19 pandemic it has been necessary to refer to these as background.

13. C's concerns were subject to a stage 2 investigation under the Standards (April-June 2021).[1] In summary, the Board's position was:

    13.1. At the outset of the pandemic, the Board recognised the significant challenge this situation posed and placed the organisation in business critical mode. Gold Command, the Board's most senior decision-making body, took the decision to designate all staff as key workers who would report for work as usual while applying the recognised COVID-19 safety measures contained in Scottish Government guidance.

[1] *National Whistleblowing Standards | INWO (spso.org.uk)*

13.2. Throughout the pandemic, staff were required to be deployed to support a number of critical areas of work. Services across the organisation had to make assessments of operational delivery on a regular basis and deployment of staff was done responsively and often at short notice.

13.3. The Board considered fully and took appropriate action in relation to national guidance including the DL (2020) 8 (14 April 2020) and DL (2021) 05 (2 February 2021).

13.4. Following DL (2021) 05, the Board put in place arrangements to facilitate a hybrid model, which commenced in March 2021.

13.5. These arrangements ensured an on-site presence to meet the demands of key service needs while allowing staff to work from home or be agile regarding their working arrangements in an equitable way. This model was established in partnership with staff and staff side representatives.

13.6. Confirmation was obtained that the Board was responding appropriately and acting in line with regulations and directions following the issue of DL (2021) 05.

14. To test and consider this, the INWO's investigation considered the evidence summarised in public Appendix A and private Appendix B. The focus has been the situation in C's particular work area. As is inevitable in a large organisation, the INWO is aware of local variation across the Board regarding working from home arrangements.

2.1 Findings

Applicable guidance

15. I reviewed guidance documents and statements of policy issued throughout the course of the COVID-19 pandemic.

16. I noted various statements during the course of 2020:

16.1. FAQs for Health and Social Care Workers released by the Scottish Government on 30 March 2020 advised: 'As it stands, if you are able to perform your job from home you should do this – this is part of the Scottish and UK Government's measures to prevent the transmission of COVID-19.'

16.2. DL (2020) 08 (noted above) refers to the need for NHS Scotland Boards 'to be proactive in protecting employees and supporting them to feel safe and secure', including listening to concerns and responding appropriately.

16.3. Coronavirus (COVID-19): guidance for homeworking (23 July 2020), directed at employers generally, states: 'Organisations should make every reasonable effort to make working from home the default position. Where a worker can perform their work from home, they should continue to do so.'

17. C placed particular emphasis on compliance with DL (2021) 05. I note that DL (2021) 05 was issued on 2 February 2021 in the context of heightened concerns about a 'second wave' of COVID-19 infections. I note:

17.1. the statement that 'for NHS Scotland staff, anyone who is able to work from home, must do so' (paragraph 2), and

17.2. a number of 'considerations' are detailed, including the recognition that some roles cannot be performed at home, the need to respond to service requirements, the relevance of individual circumstances, and the relevance of IT services, and infrastructure.

18. I have concluded that DL (2021) 05 was intended to reiterate and reinforce current policy, which was that staff should work from home where possible. This would be subject to meeting critical needs, and IT infrastructure. However, the default would be working from home, with an expectation that Boards would make reasonable efforts to address barriers (e.g. through hybrid working). The fact that all staff had been designated as 'key workers' (at an early stage in the pandemic), should not have been a barrier to putting in place working from home arrangements (where appropriate). The expectation would be a person-centred approach to these decisions on a case by case basis. There would be an expectation for ongoing risk assessment to ensure office arrangements minimised the potential for COVID-19 infections.

<u>Findings on the situation pre-March 2021</u>

19. The investigation reviewed the Board's complaint file and obtained relevant documents in relation to the concerns. The INWO also obtained HR advice to inform our understanding of the case, and took evidence from C and other witnesses through interview. These enquiries were undertaken confidentially; in order to preserve this confidentiality, it is appropriate to only summarise the key findings.

20. The information obtained from the Board and interviews, indicated the default was office working for all employees until March 2021 (when hybrid arrangements were implemented), with some limited working from home to enable social distancing.

21. Regarding the work being performed by C's business area in the months immediately before March 2021, the INWO found evidence that there were limited business tasks which needed to be performed in the office. (I note that the situation at the beginning of the pandemic was different.)

22. The INWO was aware of internal documentation that showed IT capacity had been expanded since the advent of the pandemic. In the interviews, we enquired as to the level of IT infrastructure and resources available for staff at the time. The investigation found that most of those interviewed had laptops and connectivity around six months before the implementation of the hybrid arrangements

(September 2020). On the basis of this evidence, IT infrastructure does not appear to have been an obstacle by January 2021 at the latest.

23. Evidence from interview showed that by the end of 2020 concerns were being actively and widely raised by staff in C's work area about the position on working from home. The INWO heard there was a high level of concern and anxiety among staff at this time about compliance with national policy, the contrasting position with other NHS organisations, and concerns about the health and safety of staff and patients. Among some, there was a perception that requests to work from home would be refused.

24. The INWO sought evidence from the Board as to what happened with the concerns in C's work area; however evidence they were addressed and responded to was not forthcoming.

Findings on the situation post-March 2021

25. The INWO reviewed documentation surrounding the hybrid arrangements implemented in March 2021. We also took evidence of staff members who were actively involved in development of the hybrid arrangements.

26. The investigation found that staff involved felt empowered to make a decision as to the minimum office presence required, noting they did so based on their general assessments of what would be required to support the Board's operations.

27. Enquiries were made during interviews as to the impact of the hybrid arrangements. The information obtained indicated that the implementation of hybrid arrangements in March 2021 significantly reduced the number of staff in the office.

28. The INWO found staff were generally positive about the impact of the hybrid arrangements as having dramatically reduced footfall within the office premises. The INWO did not get the impression that this had impaired any business functions.

29. The INWO explored the concern that the hybrid arrangements required an excessive number of staff to attend the office:

    29.1. the picture that emerged from interviews was that staff typically attended the office to perform work that could have been performed at home.

    29.2. while staff offered some examples of exigent work that was required to be conducted on site, it appears many of these occurred relatively infrequently.

    29.3. there were some activities where there was no clear view as to whether they needed to be performed in person/ in the office.

    29.4. it was noted staff were allowed to attend the office over and above the rota. There does not appear to have been a formal process surrounding this.

2.1 Decision

30. The complaint I investigated is that the Board unreasonably failed to comply with the Scottish Government guidance on working from home during the pandemic. Given the introduction of DL (2021) 05 in February 2021, and the implementation of hybrid arrangements in March 2021, I will reflect on its application both before and after this time.

31. In making my decision, I recognise an element of discretion for NHS organisations in how to implement broadly framed national policy and guidance. I also acknowledge the significant pressures facing NHS organisations during the course of the pandemic, and that decisions need to be assessed in this context. It is also important to note that my decision is concerned only with the complaint made to me and its specific context. It does not relate to ongoing discussion in the community as to the respective benefits and drawbacks of home/ hybrid working.

<u>The situation pre-March 2021</u>

32. I have first considered the situation prior to the March 2021 hybrid arrangements.

33. Having reviewed the relevant guidance, and taken into account the explanatory statements of the Scottish Government, I consider there was already an expectation that NHS organisations would be enabling work from home arrangements for staff prior to DL (2021) 05 with a view to reducing infections among staff, patients and the public generally. I consider this should have received additional importance given the increasingly grave circumstances of the pandemic in the months prior to March 2021.

34. It is apparent that in C's team, the default was office working up until the commencement of hybrid arrangements in March 2021, with the exception of some very limited working from home when office capacity exceeded the capacity to meet social distancing requirements. It was only with increasing concerns in the context of the 'second wave' of COVID-19, government statements around January 2021, and ultimately DL (2021) 05 that the Board apparently recognised the need to take action on this issue.

35. The policy on working from home was subject to the need to deliver critical services. In that regard, the Board's submissions emphasised the need for an on-site presence to deliver critical services and to be available to be redeployed. While it is clear such work occurred, and was particularly prominent at a very early stage in the pandemic, the evidence obtained through interviews does not suggest this constituted a significant volume of work in the few months prior to DL (2021) 05. Staff (as covered by this complaint; not all NHS Tayside staff) appear to have been mostly performing business as usual roles from their desks, often using remote working technology. I consider that working from home would have been a viable option for much of this work.

36. I am mindful that one potential obstacle to putting working from home arrangements in place would be IT infrastructure. From the evidence available, it appears there were sufficient IT resources in place to enable working from home. In particular, interview evidence suggests that a significant number of staff had laptops and remote connectivity by September 2020.

37. I note that feedback from interviews suggested there was significant concern and anxiety among staff about the working environment in the lead up to DL (2021) 05. The staff interviewed could not see the rationale for their continued presence in the office based on business need, and were concerned about the potential impact on clinical staff and patients given their physical location at a hospital site. A number of staff expressed the view that they did not feel trusted. They felt their concerns about this were being dismissed, and that they had no clear option to raise them further.

38. Taking all this into account, I consider the Board situation prior to the implementation of the hybrid arrangements in early 2021 was contrary to applicable guidance and national policy.

<u>The situation post-March 2021</u>

39. I turn to C's concerns about the hybrid working arrangements which were developed following DL (2021) 05, and commenced in March 2021.

40. I recognise the strong terms of DL (2021) 05 that 'anyone who is able to work from home, must do so'. However, I also note the range of 'considerations' for NHS organisations to take into account, shaped by the compelling policy need not to frustrate NHS operations. In this regard, I am mindful there is some scope for reasonable minds to differ as to what that minimum would be to meet service, and the need for caution in making finely balanced assessments about the level of office presence necessary to support vital operations.

41. There is sufficient evidence that some on-site services were critical. In this context, I consider that the working group that developed the arrangements, did so with broad discretion from senior management, and reached their conclusions based on professional judgments of the officers involved. I did not find evidence that the group felt fettered to offer any particular arrangement or formula. Inevitably their deliberations comprehended some ballpark assessments of what would be needed, and these were necessarily made with an eye to possibilities rather than certainties. It is clear that the hybrid arrangements drastically reduced footfall, and thus substantially delivered on the policy objective of DL (2021) 05.

42. I considered carefully the concern that hybrid arrangements overestimated the amount of employees needed in the office and thus did not put into effect the terms of DL (2021) 05. The INWO found some evidence from the interviews supporting this view, namely that staff felt their attendance was often to perform

work that might have been performed at home. Staff could attend outwith the rota, and while this may well have been entirely appropriate in many cases, there does not appear to have been any checks to ensure business need. The focus appears to have been on facilitating people to be in the office, where that was their preference, rather than supporting and enabling people to be at home whenever possible.

43. Taking all this into account, I can understand the concerns of C that not all staff who could work from home were doing so, and it is important to underscore my view that C raised legitimate concerns in the public interest. Yet while I have sympathy for the view that this was not strictly consistent with DL (2021) 05, I consider the Board had followed a reasonable process to formulate its response relying on the professional judgement of their officers. In that regard, the arrangements developed in early 2021 were, on balance, a reasonable response to the guidance.

Conclusion

44. On the basis of my concerns about the period before March 2021, I find that there is sufficient evidence to **uphold** point 2.1 of the complaint.

Point 2.2. The Board unreasonably failed to handle C's whistleblowing concern in accordance with the National Whistleblowing Standards

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

45.1. there was not a proper acknowledgement of the concerns raised

45.2. the Board did not appoint a person to investigate timeously

45.3. the Board did not address failings in the procedure once C had raised them

45.4. the Board did not progress the investigation

45.5. the Board did not offer support to the whistleblower

45.6. the Board appointed a person who was not empowered to make a decision on the findings of an investigation, and

45.7. the Board did not properly investigate the whistleblowing concern.

46. Some of the concerns raised with me had already been raised by C during the Board's investigation; others were raised with me following the conclusion of the internal investigation. The Board did not respond to the concerns raised with them in their response.

47. When C first raised concerns the Board quickly reviewed them and sought to determine which aspects were appropriate for the whistleblowing procedure and which aspects were for alternative HR processes. This review was carried out by

members of the HR team assigned to investigate concerns raised under the grievance procedure. Following consultation with C, all aspects of the complaint, which amounted to a list of 64 questions, were referred for investigation under the whistleblowing policy. At the same time this review was taking place, NHS Tayside appointed a senior member of staff, experienced in investigations, to consider the whistleblowing concerns. The list of questions that had been raised by C and reviewed by the HR department were not shared with the Investigating Officer (IO).

48. The Board sent a formal acknowledgement letter 14 days after the concerns were originally submitted, asking C to submit details of their concerns to the investigator. In response, C raised further concerns about the progress and handling of the investigation. The Board extended the timescale of the investigation after 23 days, because the IO had not received the details of the concern directly from C. C responded to the extension notification, providing the original list of questions and raising further concerns about the delay and the requirement to provide information more than once.

49. On receipt of the document from C, a meeting was quickly arranged to discuss the issues raised. At the meeting, it was agreed that the concerns would be summarised under three headings:

    49.1. 'NHS Tayside's non-application of guidance and statutory requirements of the Scottish Government Stay at Home Regulations: Working From Home DL (2021) 05'.

    49.2. 'C's request to work from home', and

    49.3. 'The standard of alternative accommodation offered'.

50. Notes of the meeting were shared with C for comment and the investigation proceeded quickly from that point.

2.2 Findings

51. 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.

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

53. In considering this aspect of C's complaint, I took into account email correspondence provided by NHS Tayside and the complainant, the complaint file

from NHS Tayside and what witnesses told me (public Appendix A and private Appendix B refer). I have set out my detailed consideration of complaints handling in private Appendix C. My key findings are set out below.

Acknowledgement of the concerns raised

54. It is clear that there was a significant delay in formally acknowledging the concerns raised: 14 days compared to 3 days required by the Standards. While I have not seen evidence that the delay in sending the acknowledgement was a result of inaction by the Board or deliberate, my view is that these delays were avoidable.

Procedural failings and the progress of the investigation

55. Once the investigator received C's concerns it appears the investigation progressed quickly. However, I consider that there was a failing by the Board to progress the investigation between the time the investigator was assigned and the point the investigation started. The delays appear to have been the result of miscommunication within the Board, rather than an intention to delay matters. The responsibility for the delay was unreasonably placed on C who was required to resubmit information prior to the commencement of the investigation.

56. I am of the view that there were too many officers involved in the handling of C's concerns, and I am concerned by the failure to talk to C about who would need to know their identity before their name was shared with these officers.

Support for the whistleblower

57. I have found the Board could have been more proactive in offering support to C. While some options (including mediation) were canvassed, I have found there was some confusion about how this might work, which was compounded by communication issues. Adjustments to C's working arrangements were eventually implemented. However, this did not reflect supportive engagement, but occurred in the context of increasingly strained communication between C and the Board.

Investigation of the concerns raised

58. I recognise there were positive aspects of the Board's investigation. It is clear that the concerns were treated seriously by the Board's investigator. The IO was sensitive to the need to protect the confidentiality of the whistleblower. Evidence, including through interviews, highlighted the importance placed on welcoming the potential for learning from concerns.

59. I consider there could have been more clarity on the scope of the investigation, and for there to have been a shared understanding between C and the Board on how this would be handled. This is particularly important in cases, such as this one, where aspects of the complaint could have been addressed through alternative procedures. I recognise that this resulted in delays in a number of matters being progressed for C. A significant number of C's original concerns

were never addressed by the Board, either through whistleblowing or any other route.

60. I would note that where a Board receives a concern that includes a large number of separate points, it is a reasonable approach to summarise those concerns under a smaller number of specific points or headings to ensure all points are taken into account. Furthermore, where appropriate, boards should list as separate points issues that are not covered by the Standards. A clear decision should be given in respect of these specific points, and the whistleblower signposted to the INWO as these types of decisions can be complained about to me.

61. In my view the investigator acted quickly to progress the investigation. However, in the response provided to the whistleblower there were a number of statements that relied on evidence that was not tested or confirmed during the investigation, particularly when the information came from senior members of staff. This leads me to the conclusion that the investigation could have been more thorough and the evidence could have been viewed with a more critical eye.

Appointment of the investigator (timescales and capacity to make decisions)

62. I am satisfied that an officer with appropriate independence was identified to investigate C's concerns and that they had the authority to address the majority of the points raised by C. However, I would note my comments about the scope of the investigation (above). These have left me with the impression that the IO was placed in a challenging position with regards to their authority to challenge the approach broadly established by Gold Command. In that context, I have reservations as to whether the IO would have been empowered to recommend a significant change of approach should they have identified grounds to do so.

2.2 *Decision*

63. The complaint I have investigated is that the Board unreasonably failed to handle C's whistleblowing concern in accordance with the National Whistleblowing Standards.

64. In summary, I have found that some aspects of Tayside NHS Board's handling of C's whistleblowing concerns were compliant with the Standards and demonstrated good practice. I am satisfied that the investigation itself (to the extent that it was performed) was handled sensitively and, once started, progressed promptly.

65. I have also identified areas where Tayside NHS Board were not compliant with the Standards and where they can make improvements and take learning from this case. This includes:

65.1. delays to the progression of the investigation

65.2. a limited consideration and exploration of C's support needs

65.3. not addressing (or re-directing) all of the concerns raised by C, and

65.4. limited testing of the evidence gathered during the investigation.

66. In making my decision, I recognise that the Board's implementation of the Standards was in its early stages and that some of the delays and miscommunication were likely to have been the result of the organisation finding its feet with a new procedure. On balance, and in light of the various issues I have highlighted (and the impact this had on C), I find that there is sufficient evidence to **uphold** this complaint.

Additional Comments and Feedback

67. While my decisions in respect of the complaint outlined above relates to a particular period of time, I am mindful that the Board and C have an ongoing relationship, and that this has been impacted through the whistleblowing process.

68. During the course of the investigation, C approached INWO with concerns about the support they were receiving and aspects of their treatment at work so we made enquiries about this with the Board. I recognise that additional support arrangements were subsequently put in place; however, I would note C's difficult experience and the time taken for these arrangements to be established. I would stress the need to move forward beyond the concerns in a sensitive and supportive manner, including maintaining an open dialogue with C into the future.

69. It should also be noted by the Board that the Standards place a continuing obligation on NHS organisations to provide support and protect whistleblowers (and others involved in a whistleblowing concern) from detriment.

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.

70. I accept the risks to staff and the public generally identified in my decision have largely been mitigated by the implementation of hybrid arrangements, and the abatement of the pandemic, and my recommendations reflect that position.

What INWO are 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 did not comply with guidance on working from home in the pandemic. Under 2.2 I found there were shortcomings in handling C's whistleblowing concerns.	Acknowledge to C that the Board did not comply with national policy on working from home in the pandemic. Acknowledge that C raised legitimate concerns about the above in the public interest. Apologise to C for the shortcomings in handling the whistleblowing concern. The apology should meet the standards set out in the SPSO guidelines on apology available at *www.spso.org.uk/information-leaflets*	A copy of a letter or other record confirming an apology and acknowledgement were given to C. By: 23 January 2023

Rec. No	What INWO found	Outcome needed	What INWO need to see
2.	Under 2.1 and 2.2 I found the circumstances in which C and others found themselves has resulted in a breakdown of relationships within the work area.	Restored working relationships. It is open to the Board as to their approach, but this might, for example, include mediation or other restorative action.	Evidence that the Board is actively working with C in a structured and planned way, including how the INWO will be kept informed of progress. By: 21 February 2023

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

Rec. No	What I found	Outcome needed	What INWO need to see
3.	Under 2.1 I found the Board did not comply with guidance on working from home in the pandemic. Under 2.2 I found there were shortcomings in handling C's whistleblowing concerns.	Learning is identified from this case and actioned appropriately.	Evidence that the Board has identified and actioned (or plans to action) learning. By: 21 March 2023

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

Rec. No	What INWO found	Outcome needed	What INWO need to see
4.	Under 2.2 I found there was confusion surrounding support options available, and a situation which left C feeling unsupported and isolated.	Staff can raise concerns in a safe environment.	Evidence that the Board has developed and implemented guidance on how support will be provided to whistleblowers, drawing on the learning from this case. (The Board may find it helpful to draw on C's own experience and insight into this). By: 21 March 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: 202101686	Anonymised/ pseudonymised summary of complaint investigation and findings	None Published in full
Appendix A: High level summary of evidence relating all points	Anonymised/ pseudonymised summary of evidence	None Published in full with Summary Report
Appendix B: Confidential Summary of Evidence	Anonymised/ pseudonymised summary of evidence	• Complainant (whistleblower) • CEO • internal investigator • Director of HR • Whistleblowing Lead • Chair • Whistleblowing Champion (Appendix must not be shared wider.)
Appendix C: Detailed consideration of 2.2	Anonymised/ pseudonymised summary of investigation findings and conclusions	• Complainant (whistleblower) • CEO • internal investigator • Director of HR • Whistleblowing Lead • Chair • Whistleblowing Champion (Appendix must not be shared wider.)

Appendix A
High level summary of evidence for complaint (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. Please note this evidence is supported by further detailed evidence, which has been listed in a separate, unpublished Appendixes, as it cannot be shared for reasons of confidentiality.
3. **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

2.1 The Board unreasonably failed to comply with the Scottish Government guidance on working from home during the pandemic.

For clarity this has been divided into:

(i) the situation prior to March 2021 (before the hybrid arrangements were implemented) and

(ii) the situation post March 2021 (after the hybrid arrangements were implemented).

2.2. The Board unreasonably failed to handle C's whistleblowing concern in accordance with the National Whistleblowing Standards.

Description	**Relevant to**		
	2.1(i)	2.1(ii)	2.2
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	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 letter of concerns to the Board and associated documentation including a list of questions submitted to the Board.	Yes	Yes	Yes
(ii) C's correspondence with INWO detailing their concerns. a) C's substantive concern was that working practices were in contradiction to government guidance regarding the control of Covid-19. Specifically, C said it was possible and had been	Yes	Yes	Yes

Description	Relevant to		
	2.1(i)	2.1(ii)	2.2
possible for some time for a number of staff within NHS Tayside to work from home; however, the Board had insisted that everyone attends the office site. b) C also detailed concerns about complaint handling.			
(iii) Further documents and emails submitted to support C's views about their concerns.	Yes	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 22 June 2021. This included consideration of: a) whether the Board complied with Scottish Government guidance on working from home in the pandemic b) C's request to work from home, and c) the standard of alternative accommodation offered by the Board.	Yes	Yes	Yes
(i) records of interviews undertaken by the Board's investigator during the course of their investigation.	Yes	Yes	Yes
(ii) emails and other documents relevant to the whistleblowing process.			Yes
4. *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) Board communications to staff at an early stage of the pandemic	Yes	Yes	
(ii) the Board's comments on critical work on-site	Yes	Yes	

Description	Relevant to		
	2.1(i)	2.1(ii)	2.2
(iii) documents concerning the Board's decision-making	Yes	Yes	
(iv) the Board's report on IT infrastructure (January 2021)	Yes	Yes	
(v) the Board's communications to staff (January 2021)	Yes	Yes	
(vi) the Board's internal guidance on hybrid arrangements		Yes	
(vii) the Board's update to staff on new home-working arrangements		Yes	
(viii) the proposal for hybrid working arrangements within C's work area		Yes	
(ix) an internal review conducted of the hybrid arrangements		Yes	
(x) records of the Board's interactions with the Scottish Government concerning compliance with national policy and guidance		Yes	
5. *National policy and guidance on working from home during the Covid-19 pandemic* We reviewed statements of national policy and guidance below for what it says about working from home during the pandemic.			
(i) Coronavirus (Covid-19): National Arrangements for NHS Scotland Staff DL (2020)/5 13 March 2020	Yes	Yes	
(ii) Publication of National Guidance for NHS Scotland Staff and Managers on Coronavirus DL (2020) 30 March 2020	Yes	Yes	
(iii) DL(2020)08 - Staff wellbeing and support: employers' duty of care during COVID-19 pandemic (scot.nhs.uk)	Yes	Yes	
(iv) Coronavirus (COVID-19): guidance for homeworking (23 Jul 2020)	Yes	Yes	
(v) Coronavirus (COVID-19): additional measures - 8 October 2020 - gov.scot (www.gov.scot)	Yes	Yes	

Description	Relevant to		
	2.1(i)	2.1(ii)	2.2
(vi) Covid-19-guidance-for-staff-and-managers-on-coronavirus-141021.pdf (scot.nhs.uk) (28 October 2020)	Yes	Yes	
(vii) *Partnership-working-arrangements-during-covid19-v20-17-november-2020.pdf (scot.nhs.uk)* 17 November 2020	Yes	Yes	
(viii) Coronavirus (COVID-19) update: First Minister's statement - 4 January 2021	Yes	Yes	
(ix) *Stay at Home Regulations: Working from Home DL (2021) 05 2 February 2021*		Yes	
6. *Explanations of the context and purpose of national policy from the Scottish Government* We made enquiries of the Scottish Government to assist our investigation			
(i) National policy and guidance: We made enquiries to understand the context and purpose for the applicable national policy and guidance.	Yes		
(ii) Assurance and oversight provided: We made enquiries as to the Board's interactions with the Scottish Government in respect of the national policy and guidance.	Yes		

Description	Relevant to		
	2.1(i)	2.1(ii)	2.2
7. *Interview evidence from C* We interviewed C in order to understand their position on the concerns raised with the Board and their experience of the whistleblowing process.	Yes		Yes
8. *Interview evidence from other witnesses* We interviewed witnesses from a list of staff provided by the Board, including the Board's investigator. As noted in the summary report, the interviews were conducted with an expectation they would be confidential. In that regard, we have provided a general summary, and not included identifying personal details.			
(i) Regarding the situation pre-March 2021, we obtained evidence on: a) the experience of interviewees with office/home working in the months prior to the hybrid arrangements b) IT infrastructure and connectivity c) the type of work being carried out in the office d) the working from home application process, and e) whether staff had concerns with the situation.	Yes		
(ii) Regarding the situation post-March 2021, we obtained evidence on: a) the development of the hybrid arrangements b) the impact for staff of the hybrid arrangements, and c) the type of work carried out in the office under hybrid arrangements.		Yes	

Description	Relevant to		
	2.1(i)	2.1(ii)	2.2
9. Professional HR advice We sought and obtained advice from a professional HR adviser (the Adviser) to understand what it was reasonable to expect in the circumstances of this case. The Adviser reviewed the interview evidence and other relevant evidence and information obtained. We have used the HR advice to inform the decision outlined in the Summary Report; however, decisions on the complaint ultimately rest with the INWO.			
(iii) Regarding the situation pre-March 2021, the Adviser provided comments on: a) the Board's IT resources b) whether the evidence suggested a need for work to be carried out within the office as opposed to from home c) the Board's working from home arrangements d) the culture surrounding home working, and e) the level of consultation with staff.	Yes		
(iv) Regarding the situation post-March 2021, the Adviser provided comments on: a) the hybrid arrangements put in place b) the level of flexibility in the arrangements c) whether the hybrid arrangements broadly complied with applicable national policy and guidance d) the level of review following the guidance e) other practices surrounding working from home within C's work area.		Yes	