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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: Highlands and Islands

Case ref: **202106175**

NHS Organisation: Western Isles NHS Board

Subject: Patient Safety/ handling of whistleblowing concern/ speak up culture

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 my investigation.

Executive summary

1. The complainant (C) complained to the INWO about Western Isles NHS Board (the Board). C was involved in a whistleblowing investigation carried out by the Board under the National Whistleblowing Standards.
2. The complaint I investigated[1] about the Board is that there was:
   - 2.1. Unreasonable failure to remove ligature points from hospitals. **(upheld)**
   - 2.2. Unreasonable failure to provide an ongoing Cognitive Behavioural Therapy (CBT) service or respond to concerns raised about the lack of provision. **(not upheld)**
   - 2.3. Unreasonable failure to assess and mitigate the risk of suicides through the use of suicide prevention strategies. **(not upheld)**
   - 2.4. Unreasonable failure to take appropriate review and learning action in response to a suicide. **(not upheld)**
   - 2.5. Unreasonable failure to consider and/ or act on learning and improvement recommendations from incident investigations. **(upheld)**
   - 2.6. Failure to handle concerns in line with the National Whistleblowing Standards. **(upheld)**

[1] The INWO discontinued investigation into a further point complaint for jurisdictional reasons. It is not relevant to this investigation. I refer to it for completeness.

2.7. Failure to create and maintain a culture that values and acts on concerns raised by staff. (**not 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, names in the report have been pseudonymised, and gender-specific pronouns and titles removed.

Approach

The investigation

1. INWO is the final stage of the process for those raising whistleblowing concerns about the NHS in Scotland. INWO has a remit to consider complaints from whistleblowers about how their concerns have been handled and the actions taken in respect of those concerns.[2]

2. 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 potential impact on patient safety.

3. In order to investigate C's complaint, I

   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

   3.3. obtained comments and documentary evidence from the Board

   3.4. reviewed relevant guidance

   3.5. sought information from the General Medical Council (GMC)

   3.6. obtained professional advice from a relevant adviser

   3.7. conducted a confidential survey of staff, and

   3.8. took evidence from witnesses through interview.

4. Evidence was assessed and analysed. From that, findings were made, and a decision with recommendations to address the findings taken. This report and supporting appendixes provide a summary of the evidence upon which I relied, my findings and recommendations, and my decision. 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.

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

Presentation of evidence and analysis

6. The evidence upon which I have relied 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 investigation means that not all of these appendices are published. Nor is it appropriate for people within the Board, to have sight of them, other than those who need to know. This document includes a Summary of documents that make up the full INWO report, including a list of the appendices and the restrictions relating to their publication and sharing.

Findings and decision

Point 2.1 Unreasonable failure to remove ligature points from hospitals (upheld)

8. Background to the complaint is set out in private Appendix B.

9. The key issues considered under this element of the complaint were C's concerns that

   9.1. the Board failed to act on concerns raised by C about ligature points, and

   9.2. there was a delay in addressing risks of ligature points in hospital wards

10. In summary, the Board's position was

    10.1. there was an existing risk assessment in place prior to C raising concerns about ligature points in 2021.

    10.2. following the external whistleblowing investigation in March 2022, a new risk assessment and action plan were developed with input from the external investigators. Progress has been made against the action plan to address the risks identified.

    10.3. the Board partially upheld C's complaint and recognised that more work should have been done, with more urgency. An apology was included in the letter to C.

11. To test and consider this, my investigation considered the evidence summarised in public Appendix A, and discussed in private Appendix B. I considered written correspondence provided by the Board and C, the Board's complaint file and the Board's ligature point action plan. I also sought independent professional advice.

Findings

12. My investigation found that there were delays progressing improvement works related to ligature point risks in the years preceding C's concerns. A number of these risks had been identified by the Board through risk assessment as early as 2017.

13. Following C’s whistleblowing concerns, a site visit conducted by the external whistleblowing investigators identified a large number of additional ligature points presenting significant risks.

14. I recognise that the Board responded to the whistleblowing investigation by putting in place an action plan to address the ligature points identified by the external whistleblowing investigators. I also note that the Board used the policies and information supplied by the external investigators to begin development on a new policy on ligature points. This was an appropriate response. However, despite early progress following the conclusion of the whistleblowing investigation, there have subsequently been significant delays in completing all the remaining works identified on the action plan.

15. The adviser noted that urgent action should have been taken when C first voiced their concerns. They also noted that the Board’s risk register did not accurately reflect the significance of the risks that ligature points caused at the time C raised concerns. They noted risks posed by a lack of anti-ligature risk assessment training for ward staff or for the safety team responsible for risk assessments. The Adviser did not think it was possible to have confidence that all ligature point risks had been identified and mitigated. I accept that advice.

Decision on point 2.1

16. I have considered whether there has been an unreasonable failure by the Board to remove ligature points from hospitals.

17. I consider the Board failed to take reasonable and timely steps to address the risk of ligature points up to and after the point at which C began to raise concerns with managers within the Board. This is supported by the Board’s whistleblowing investigation. I consider that the Board failed to make reasonable attempts to engage with the specific risks C was raising about ligature points.

18. In light of the findings from the external whistleblowing investigation, including the significant number of ligature points previously not identified or addressed by the Board, I agree with C that the Board should have fully upheld the complaint.

19. I am also of the view that, despite early progress immediately following the whistleblowing report, the Board failed to make significant and meaningful progress in addressing the outstanding actions identified on the ligature action plan. This is of significant concern, given the risks involved and the concerns raised by the external investigators. There has been ample time since then for the Board to take the necessary action, and I have not been provided with sufficient justification for the delay in resolving these risks since the ligature point action plan was produced in March 2022. It also makes me question the Boards commitment to the Standards and their willingness to listen to and support people raising concerns (a requirement of the Standards).

20. The external investigators identified a large number of ligature point risks that had not been picked up on previous risk assessments, suggesting that there were gaps in the knowledge of those conducting the assessments. They offered to provide this training. However, the Board confirmed that no formal training had taken place for relevant staff. This potentially leaves the Board poorly placed to identify and act on future ligature point risks. More significantly, it potentially puts patients at risk, if safety issues go undetected.

21. To be clear, I am not critical of the actions of the individuals, but of the lack of action by the Board to ensure that its staff are trained and have the skills and knowledge they need to carry out effective risk assessments.

22. For the reasons outlined above, I have significant concerns that there are ongoing risks, and that appropriate action has not been taken in relation to the points that have been identified in the action plan.

23. **I uphold this element of the complaint** and have made recommendations aimed at ensuring any existing risks are mitigated without delay. I have also received assurance from the Board that until the recommended works take place additional mitigations have been introduced.

24. Thank you to C for raising these concerns. I acknowledge that it took significant effort and perseverance. I encourage the Board to reflect on this comment and how they promote a speak up culture that welcomes and listens to concerns.

Point 2.2. Unreasonable failure to provide an ongoing CBT service or respond to concerns raised about the lack of provision (not upheld)

25. C's concerns under this element of the complaint are set out in private Appendix B. The concerns relate to a form of treatment called Cognitive Behavioural Therapy (CBT). This is a talking therapy that can help people manage their problems by changing the way they think or behave.

26. In summary, C's complaint relates to

    26.1. the level of CBT service provision by the Board, and

    26.2. concerns about the Board's inaction in improving CBT provision.

27. In summary, the Board's position was

    27.1. after investigation through the whistleblowing process, the impression is of an improving picture, with some continuing resource/ recruitment challenges and a new head of service pulling together the psychological therapies picture into a position that will work best for both governance and the benefit of all those needing psychological therapies in the Western Isles.

28. To test and consider this, my investigation considered the evidence summarised in public Appendix A and discussed in private Appendix B. I reviewed detailed information on CBT/ psychology resources at the time the concerns were raised

and looked at the evolving chronology of service provision prior to the whistleblower complaining to INWO. I also sought independent professional advice.

Findings

29. With a view to providing context, I note the Adviser highlighted shortages of trained Cognitive Behaviour Therapists throughout Scotland, particularly those trained in Clinical Psychology. The Adviser noted shortages tend to be more acute in rural areas with low population density, long travel times and relatively small services.

30. Having considered evidence provided by the Board, the Adviser was of the view that, historically there may have been gaps in Clinical Psychology and CBT provision resulting in long waiting times. However, the Adviser considered the Board recognised this and were putting in place an effective approach to service improvement.

31. The Adviser agreed with the whistleblowing investigator's view that the Board's position with regard to CBT and Psychological Therapy Services was improving. They told me that it was evident that the waiting time for CBT, although still long, has improved. They noted that the Board had recruited staff and had an active focus and approach which the adviser considered to be appropriate and reasonable.

32. I accept this advice.

Decision on point 2.2

33. I have considered whether there was unreasonable failure to provide an ongoing CBT service or respond to concerns raised about the lack of provision.

34. I recognise the challenges in CBT provision across Scotland and particularly in rural and remote areas.

35. From the evidence and advice I have seen, I consider that the Board was taking reasonable steps to improve CBT services, noting the difficult context. I also recognise C's point that they were part of these discussions. I have no reason to doubt these discussions were at times robust and there were different views about what could be achieved and in what time frame. Ultimately, however, this does not transform my view that reasonable steps were taken by the Board.

36. For the reasons outlined above, I **do not uphold** this element of the complaint.

Point 2.3. Unreasonable failure to assess and mitigate the risk of suicides through the use of suicide prevention strategies (not upheld)

37. The background to this element of the complaint is set out in private Appendix B.

38. The key issues considered under this point were C's concerns that

38.1. planned actions for suicide prevention were not being enacted, and

38.2. escalation routes for the Multi Agency Suicide Prevention Group did not work in practice.

39. In summary, the Board's position was

39.1. the Board's external investigators did not uphold C's concerns

39.2. the investigators concluded that the Western Isles had a well evidenced, credible, and deliverable Suicide Prevention Action Plan which demonstrated how they were following National Guidelines. The investigators said that the action plan showed a realistic understanding and data driven assessment of progress against actions. They found that there was substantial evidence that NHS Western Isles were delivering against the plan, and

39.3. the investigators also referred to the Prevention Group (and subgroups) that meets four times per year. They indicated that in their view, the group was linked appropriately to child and adult protection, as well as having a direct link to the Chief Officers Group for rapid escalation if required.

40. To test and consider this, my investigation considered the evidence summarised in public Appendix A and discussed in private Appendix B. I considered written correspondence provided by the Board and the C, the Board's complaint file, and what witnesses told me. I also took independent professional advice.

Findings

41. The Adviser told me that the Board's approach was consistent with the expectations and principles within the Scottish Government's Suicide Prevention Plan: Every Life Matters (2018); and that the approach taken by the Board to suicide prevention was appropriate and reasonable.

42. The Adviser highlighted active and ongoing work to expand and progress the suicide prevention actions identified by the Prevention Group and through community engagement. I accept this advice.

43. In terms of escalation, the Board were able to point to examples where the Prevention Group were alerted to a suicide and quickly responded using the mechanisms available to them (not just through escalation). I heard that numbers of cases were relatively small, and it was unusual that there would be a need to escalate. I did not see or hear evidence to suggest that there were issues with escalation or that the Prevention Group were frustrated in their efforts to respond appropriately to suicides of which they were aware.

Decision on point 2.3

44. I have considered whether there was an unreasonable failure to assess and mitigate the risk of suicide through the use of suicide prevention strategies.

45. Based on the evidence available, I consider reasonable steps have been, and continue to be, taken by the Board to assess and mitigate the risk of suicide. In making this finding, it is important to acknowledge that C had a role in contributing to the development of the systems that are in place and appear to be working well. I also recognise the dedicated work being done by others in the Board in this area. All of this is to be commended.

46. For the reasons outlined above, **I do not uphold** this element of the complaint.

Point 2.4. Unreasonable failure to take appropriate review and learning action in response to a suicide (not upheld)

47. C complained about the Board's failure to appropriately investigate and learn from a suicide. C accepted the Board's position (outlined below) that it did not currently review deaths by suicide unless the person was under the care of mental health services. However, C drew attention to section 16 of the General Medical Council (GMC)'s guide to Good Medical Practice, particularly part G. C questioned whether the case should have been referred to the GMC by the Responsible Officer (RO) in order to support learning, training, and improvement.

48. In summary, the Board's position was

    48.1. services in the Western Isles only review deaths by suicide known to Mental Health services. The external investigators agreed that this is not unusual. Action 10 of Every Life Matters is seeking to develop appropriate reviews into all deaths by suicide, but there are currently only a few NHS and Local Authority pilot sites in Scotland, as methodology is being explored; the Western Isles is not one of those pilot sites, and

    48.2. in the circumstances of the case, the Board were not aware of an obligation for the RO to contact the GMC.

49. To test and consider this element of the complaint, my investigation considered the evidence summarised in public Appendix A and discussed in private Appendix B. I considered written correspondence provided by the Board and C, the Board's complaint file, and information and guidance from the GMC.

Findings

50. INWO's role is not to review the fitness to practise of doctors, which is the remit of the GMC. Nor was it in the scope of my investigation to look at the actions of an independent medical provider. In looking at the guidance above, I took account of the expectations outlined in the GMC guidance to better understand the context to C's complaint, and review whether the decisions by the Board could be considered reasonable in the circumstances.

51. It is important to note that I did not ask the GMC to formally review or comment on the specifics of this case or the actions of any staff members at the Board. The

investigation sought general information from the GMC about the role and responsibilities of the RO within a health board.

52. ROs have discretion to determine whether or not to refer a doctor to the GMC if they are made aware of concerns. Decisions would be made on a case-by-case basis and informed by the experience of the RO, and dialogue with their Employer Liaison Adviser (ELA) contact at the GMC in some cases. Most often, action taken by the GMC would relate to a pattern of unprofessional behaviour rather than a single incident related to clinical performance.

53. There are examples of serious concerns where a referral would almost certainly be required, including violence, sexual misconduct, serious dishonesty, gross negligence, or recklessness about a risk of serious harm to a patient. Beyond this, I heard that there is a level of judgement to be exercised when determining if referral is necessary, and that the level of ELA support requested by the RO varies by Board and by situation.

Decision on point 2.4

54. I have considered whether there was an unreasonable failure by the Board to take appropriate review and learning action in response to a suicide. In particular, I have considered C's concerns that there should have been a referral made to the GMC to support learning, training, and improvement.

55. I have obtained and reviewed information from C, the Board and from the GMC.

56. I acknowledge that there is latitude given to ROs to decide if and when a referral to the GMC is necessary bearing in mind the circumstances of the case, local knowledge, and relevant guidance. I also recognise that action taken by the GMC is normally the result of a pattern of behaviour rather than a specific incident. I am sympathetic to C's view that the circumstances should have led to a referral. In light of my understanding of the support and advice available from the ELA on borderline cases, it is possible that a conversation between the RO and the ELA might have been warranted; and that a local investigation could have strengthened decision making by the RO. However, I have seen no evidence to suggest that this was a requirement for the RO in the circumstances and so consider it reasonable that the Board took a discretionary view.

57. I also note the Board's view that there would not normally be a review of deaths by suicide not known to mental health teams. C accepted this position, as do I.

58. I **do not uphold** this element of the complaint. As a good practice measure, I suggest that the Board review the GMC's *'principles of a good investigation'* and consider assessing their procedures for investigating concerns about doctors against these principles.

Point 2.5. Unreasonable failure to consider and/ or act on learning and improvement recommendations from incident investigations (upheld)

59. The background to this complaint is set out in private Appendix B.

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

    60.1. recommendations C made following their investigation into a Datix incident, and a patient complaint had not been implemented, and

    60.2. this showed a failure to engage with learning opportunities that could prevent harm in the future.

61. In summary, the Board's position was

    61.1. C's recommendations were not considered proportionate to the incidents/ complaints and went beyond the scope of the investigation

    61.2. in one of the examples, C's recommendations related more to the complaints handling process and the use of Datix than focusing on the complaint raised, and

    61.3. appropriate action had been taken to address the risk of harm identified through the patient complaint.

62. To test and consider this, my investigation considered the evidence summarised in public Appendix A and discussed in private Appendix B. I considered written correspondence provided by the Board and the complainant, the Board's whistleblowing complaint file, and supporting evidence including the relevant complaint and Datix records and wider complaint and incident data from the Mental Health Service within the Board.

Findings

<u>Complaints and investigation data</u>

63. The data indicated a good number of investigations were completed, which demonstrates an open approach to improvement. There was a wide spread of recommendations with no concerning clusters to suggest that action and learning was lacking in particular areas.

64. There are appropriate processes in place to investigate, identify and action learning and improvement recommendations within the Board.

<u>Response to C's recommendations</u>

65. In one case it was not clear from the Board's records that the full list of C's recommendations were appropriately considered, and those decisions recorded. While I agree that some of the recommendations related to the use of Datix and the complaints process, there were six further recommendations that did not. I

have seen nothing to indicate that recommendations related to HR processes were referred to that department or considered by them.

66. It is possible that C’s investigation went beyond it’s intended scope. However, the findings indicate the potential for service improvement and safeguarding of patients that does not appear to have been explored by the Board. I do not consider it is reasonable to ignore these findings on the basis that the investigation was originally intended to be smaller in scope.

67. If the Board had reviewed the findings and recommendations and reached a decision that the recommendations were disproportionate, I would have expected to see an audit trail for this. There would also have been potential to explore alternative steps or modifications that could have been implemented to provide a more proportionate response to the learning opportunities identified in C’s report.

Decision on point 2.5

68. I have considered whether there was an unreasonable failure by the Board to consider and/ or act on learning and improvement recommendations from incident investigations.

69. I have seen evidence that at a high level there are reasonable and robust processes in place to handle patient complaints and incidents recorded on Datix. More specifically, I have reviewed the information available in relation to the two examples identified by C. I consider that in one example the Board have been unable to provide sufficient evidence to demonstrate that the learning and improvement points recommended by C were fully and fairly considered.

70. I accept that this one example may not be typical of every instance but given the seriousness of learning to inform patient safety, I am content to make a decision based on this level of information. For this reason, and on balance, **I uphold** this element of the complaint and have made a recommendation.

Point 2.6. Failure to handle concerns in line with the National Whistleblowing Standards (upheld)

71. C complained that they had been told that the Western Isles had no whistleblowing procedure and were signposted to Once for Scotland guidance. C said that they had repeatedly attempted to raise concerns, but these had either been dismissed, or action had been taken to exclude C from meetings and discourage C from raising concerns in meetings (including through the use of conduct proceedings).

72. C recognised that there was a national policy but could not find information on how to raise a whistleblowing concern locally. C said they were signposted to the grievance process by HR. They used this to raise their concerns about patient safety risks, as well as other concerns appropriate for the grievance process.

73. C said that they contacted the INWO for advice when they failed to access the process locally and the risks were still outstanding. C complained that it was only

after the INWO initiated a monitored referral back to the Board that their concerns were considered.[3]

74. C also questioned why they had not been spoken to by the Board's investigators.

75. In summary, the Board's position was

    75.1. C raised concerns verbally at meetings about

        75.1.1. ligature points

        75.1.2. employee wellbeing and turnover, and

        75.1.3. a Datix incident

    75.2. as C had not raised these concerns with their manager under business as usual arrangements the concerns would not have been investigated under the National Whistleblowing Standards (the Standards)

    75.3. there was a soft launch of the Standards in April 2021 and information was made available to employees. There was no evidence of anyone signposting C to the incorrect procedure, and

    75.4. one update to C took longer than 20 working days but the Board said this was not intentional and resulted from unforeseen circumstances.

76. To test and consider this, my investigation considered the evidence summarised in public Appendix A and discussed in private Appendix B. I considered written correspondence provided by the Board and C, the Board's complaint file and the requirements of the National Whistleblowing Standards.

Findings

77. Following a monitored referral from the INWO, the Board took C's concerns seriously and moved quickly to identify appropriate external professionals to investigate C's concerns. From the documentation available, it is evident that the investigators looked into the concerns thoroughly and produced a detailed report for the Board outlining their conclusions. These conclusions were well-considered, and evidence based.

78. Investigators did not speak with C; this would have been good practice to ensure that they fully understood the concerns that C was raising, and to provide reassurance to C that they were being listened to.

79. The Board's stage 2 response clearly outlined the concerns raised by C and responded to each one in turn. The response included the findings and conclusions of the investigation and clearly indicated whether each concern was upheld or not upheld. They included an apology where a complaint was partially

[3] A full explanation INWO's monitored referral process can be found here: *https://inwo.spso.org.uk/monitored-referrals*

upheld. This was good practice and is in line with the requirements of the Standards.

80. C attempted to raise concerns about various issues directly with line managers, as well as at meetings (particularly the patient safety risks of ligature points). For this reason, I do not accept the Board's position that business as usual (BAU) processes had not been utilised by C. BAU processes can include a wide range of forums where staff have the opportunity to discuss and highlight issues around service delivery and patient safety as part of everyday processes, including meetings.

81. It is not possible to determine conclusively, from the evidence available, whether C was signposted correctly to the whistleblowing process or directed to the grievance process. I have no reason to doubt C's statement that they were advised to raise their concerns within a grievance submission, and they did so.

82. I have seen no evidence to suggest that the Board sought to review the grievance documentation to separate out whistleblowing concerns from grievance concerns. C does not appear to have been signposted to the Standards after they raised concerns in their grievance documentation. For this reason, I understand why C chose to contact the INWO for advice and guidance.

Decision on point 2.6

83. I have considered whether the Board failed to handle C's concerns in line with the Standards.

84. I have seen evidence of good practice by the Board in how the concerns were handled once the monitored referral was received from the INWO. The stage 2 response and the investigation report were thorough and well explained. It would have been good practice for the investigators to have met with C to discuss the concerns and I have included feedback to the Board on this point.

85. Despite the positive steps the Board took to investigate the concerns after the INWO's intervention, I have seen evidence to suggest that C was attempting to raise concerns before that point, through both BAU routes and the grievance process. I have seen nothing to indicate that C's concerns were considered or extracted from the grievance process prior to contact with the INWO. It is my view that the Board could have done more to recognise and thank C for their efforts to raise legitimate safety concerns about ligature points in the months before contacting the INWO, and enabled access to the Standards.

86. The challenges C experienced in accessing the Standards may reflect wider delays to the Board implementing the Standards, which would have made it difficult for anyone to access the Standards at that time.

87. For the reasons above, **I uphold** this element of the complaint.

Point 2.7. Failure to create and maintain a culture that values and acts on concerns raised by staff (not upheld)

88. C complained about the speak up culture within NHS Western Isles. They cited examples from their experience of working within the Board, including

    88.1. instances of staff saying they were unwilling to co-operate with incident investigations due to fear of reprisal

    88.2. an awareness of staff leaving posts as a result of bullying behaviour

    88.3. failure to respond to or act on concerns raised by staff (including through business as usual arrangements), and

    88.4. discouraging staff from raising concerns.

89. In summary, the Board's position was

    89.1. staff who had been involved in HR investigations reported that they had no concerns or fears of reprisal for taking part. They said that they felt well supported and, although the process could be stressful, they had no fear of repercussions

    89.2. HR data on bullying and harassment did not suggest an excess number of bullying concerns raised. Investigations took place for any allegations raised, and

    89.3. there was no pattern of conduct investigations arising after staff raised concerns about patient safety.

90. To test and consider this, my investigation considered the evidence summarised in public Appendix A and discussed in private Appendix B. I considered evidence provided by the Board on their whistleblowing arrangements, and work done to promote speaking up in the Board. I also considered evidence from C, the Board's complaint file, interview statements and data gathered by the INWO through a survey.

Findings

91. Speak up arrangements and the Board's Confidential Contacts have been creatively promoted, and information is available to staff through the intranet. It is notable that this promotional work took place after C raised concerns.

92. The INWO's survey went to 41 members of staff and received 17 fully completed responses (41%). The results suggest that staff know how to speak up and are aware of the Board's Confidential Contacts. This indicates that the Board have done a good job of raising awareness of their speak up arrangements after C originally raised their concerns.

93. The results for the rest of the survey indicated a relatively balanced split between those answering positively and those answering negatively on the majority of

questions about staff's confidence in the process. Although the results must be viewed with caution given the response rate, there is an indication that a proportion of staff lack confidence in some aspect of the process, including

93.1. that action would be taken to address concerns raised

93.2. that concerns would be considered objectively or fairly, and

93.3. that there would be no adverse consequences from speaking up.

94. There were a small number of comments on the survey, highlighting the feeling that some of the issues around speaking up come from the fact that Western Isles is a small regional board. This view was also reflected in the interviews, where my team heard about some of the unique challenges for a Board with a small island community. These included difficulties around maintaining confidentiality, the potential to be labelled a troublemaker, and the perception that people just do not like to complain. They also heard that the visibility of senior leaders could be improved on the smaller islands.

95. Beyond these comments, nothing from the interviews with staff or through the small number of comments in our survey suggested a significant cultural issue around speaking up within the Board.

Decision on point 2.7

96. I have considered whether the has been a failure by the Board to create and maintain a culture that values and acts on concerns raised by staff.

97. I have considered the views of staff and the Board's efforts to promote their whistleblowing arrangements. I recognise the challenges boards face in creating a safe and trusted whistleblowing culture, particularly in the early days of a new process. Some of the doubts expressed by staff through interview and the survey are indicative of the challenges and time it can take to bring about cultural change. I encourage the Board to reflect on the survey data as one source of intelligence in combination with other sources of feedback and data (e.g. the data from the speak up questions included in iMatter and through their annual whistleblowing report).

98. I recognise that at the time that C raised their concerns much of this work had not started, and during my investigation, work on this was ongoing. To a greater extent it will always be a work in progress in the context of listening to staff feedback, promoting learning, and developing processes and procedures. Despite the challenges faced, I have seen evidence that the Board have been successful to this point in their efforts to spread awareness of the process. I did not see or hear significant evidence from staff to conclude that there is a cultural issue around speaking up within the Board.

99. For the reasons outlined above, I **do not uphold** this element of the complaint. Nevertheless, I encourage the Board to build on this to achieve continuous

improvement in this area. I also caveat this with recognising and acknowledging C’s perspective and experience at the time they raised concerns.

Additional Comments and Feedback

100. I was pleased to see that the Board’s stage 2 response letter was detailed, thorough and clearly explained the conclusions and findings for each of the concerns raised. The letter clearly met the requirements of the Standards and represented good practice.

101. I note that C was not spoken to by the investigators during the Board’s external investigation. It is good practice to have a conversation with a whistleblower at the outset of an investigation to ensure that there is a shared understanding of the concerns being raised, and to establish the scope of the investigation. It also demonstrates that the Whistleblower is being listened to and their concerns are being taken seriously.

     I suggest that this is included as a standard consideration at the start of any investigations in the future and encourage the Board to think about how to build this into their procedures.

102. Thank you on behalf of my team. My investigation was helped by the co-operation of C, the witnesses who were interviewed, and the Board’s liaison officer. I commend them for their assistance and their constructive and thoughtful engagement with the process.

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 needs to see
1.	Under complaint point 2.6 I found that the Board failed to handle C's concerns in line with the Standards.	Apologise to C for (i) failing to recognise C's legitimate attempts to raise patient safety concerns about ligature points (ii) failing to direct C to the whistleblowing procedure when they raised patient safety concerns through the grievance process 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 was given to C. By: 24 August 2024

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

Rec. No	What I found	Outcome needed	What INWO needs to see
2.	Under complaint point 2.1 I found that relevant staff have not received formal training on anti-ligature point risk assessment.	Anyone completing or contributing to ligature risk assessments for the Board should be fully trained to identify ligature points in psychiatric settings.	Evidence that training has been completed for relevant staff and systems for contracting/ commissioning such services include the requirement. By: 24 November 2024
3.	Under complaint point 2.1 I found that there have been significant delays in completing the works identified on the ligature point action plan/ risk assessment.	(a) Mitigating works already identified as being necessary to address ligature risk, on risk assessments/ action plans should be completed without delay. (b) Risk assessments for all sites should be regularly reviewed and updated, with risk ratings and mitigating actions included for each risk. Risk management systems should ensure actions are monitored to ensure completion is timely, noted and signed-off.	(a) Evidence that demonstrates that the ligature action plan has been completed. (b) Evidence of a policy and/ or procedure (with supporting relevant documentation) that demonstrates how ligature risk will be actively assessed, the frequency of such assessment and how actions identified will be monitored and reported. By: 24 October 2024

Rec. No	What I found	Outcome needed	What INWO needs to see
4.	Under complaint point 2.5 I found that there was no record of the reasons for a decision to disregard recommendations from a complaint investigation.	All recommendations arising from investigations should be carefully considered. Where recommendations are adopted, they should be appropriately monitored. Where recommendations are not adopted, or where alternative actions have been taken to address the failings identified in the report, the reasons should be clearly documented and shared with the investigator.	Evidence that the Board have reflected on this finding and identified where improvements are needed to their process, what actions are needed and how learning will be shared. By: 24 September 2024

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 needs to see
5.	Under complaint 2.6 I found that C was not signposted to the whistleblowing procedure after they raised patient safety concerns within the grievance process.	Officers involved in handling HR and/ or whistleblowing submissions must understand the difference between whistleblowing concerns and issues suitable for HR procedures. They should be able to discuss the different processes with the person raising the concerns and signpost or refer the person to the correct procedure. This may mean that some elements of a submission are separated out and the concerns dealt with through parallel processes.	(a) Evidence that this finding has been shared with relevant staff for reflection and learning. (b) Evidence that learning is reflected in the Board's guidance, training, or information resources available for staff handling HR and/or whistleblowing concerns By: 24 September 2024

Summary of documents that make up the full INWO report

Document Name	Description	• Restrictions at draft stage	Restrictions at final stage
Summary Report on complaint about the Board Reference: 202106175	Anonymised/ pseudonymised summary of complaint investigation and findings	• Complainant • CEO • Whistleblowing Lead (Report must not be shared wider until final.)	None Published in full
Appendix A: High level summary of evidence relating to all points	Summary of the evidence considered in this case	• Complainant • CEO • Whistleblowing Lead (Appendix must not be shared wider until final.)	None Published in full
Appendix B: Detailed consideration of the complaints	Detailed discussion of the point/ s considered within the complaint	• Complainant • CEO • Whistleblowing Lead (Appendix must not be shared wider until final.)	• Complainant • CEO • Whistleblowing Lead • Chair • Whistleblowing Champion (Appendix must not be shared wider.)
Appendix C: INWO Speak Up Survey Data	Overview of survey results	• Complainant • CEO • Whistleblowing Lead (Appendix must not be shared wider until final.)	• Complainant • CEO • Whistleblowing Lead • Chair • Whistleblowing Champion (Appendix must not be shared wider.)

Appendix A: High level summary of evidence (public)

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

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

This is a public document and there are no restrictions on sharing it (once published)

Document Name	Description	Restrictions at draft stage	Restrictions at final stage
Appendix A: High level summary of evidence relating to all points	Public summary of evidence	• Complainant • CEO • Whistleblowing Lead (Appendix must not be shared wider until final)	None Published in full with summary report

The complaint I investigated is

(following the numbering in summary report)

2.1. Unreasonable failure to remove ligature points from hospitals.

2.2. Unreasonable failure to provide an ongoing CBT service or respond to concerns raised about the lack of provision.

2.3. Unreasonable failure to assess and mitigate the risk of suicides through the use of suicide prevention strategies.

2.4. Unreasonable failure to take appropriate review and learning action in response to a suicide.

2.5. Unreasonable failure to consider and/or act on learning and improvement recommendations from incident investigations.

2.6. Failure to handle concerns in line with the National Whistleblowing Standards.

2.7. Failure to create and maintain a culture that values and acts on concerns raised by staff.

Description	**Relevant to**						
	2.1	2.2	2.3	2.4	2.5	2.6	2.7
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
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.							

Description	Relevant to						
	2.1	2.2	2.3	2.4	2.5	2.6	2.7
(i) Notes from information gathering phone calls and meetings	Yes	Yes	Yes	Yes	Yes	Yes	Yes
The Board's Stage 2 report and complaint file a) We sought and obtained the Board's complaint file. This material included:							
i. The Board's Stage 2 final report dated 16 June 2022. ii. The full report from the external investigators iii. Correspondence with C	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Additional evidence provided by the Board We made a number of detailed enquiries of the Board. We sought and obtained their comments on matters considered relevant to the investigation and any supporting evidence. Key items of evidence are listed below. The list is not exhaustive.							
(i) Responses to INWO's enquiries	Yes	Yes	Yes	Yes	Yes	Yes	Yes
(ii) Relevant Datix records	Yes		Yes		Yes		
(iii) Ligature points SBAR and adverse event documentation	Yes						
(iv) Ligature point risk assessment and action plan	Yes						
(v) Relevant HR records	Yes						
(vi) Patient complaint report, findings and response letter					Yes		
(vii) Preventing Suicide – Community Response Plan and related materials			Yes				
(viii) Psychological Services staff provision and service developments		Yes					
(ix) NHS Model Complaints Handling Procedure and supporting documentation					Yes		

Description	Relevant to						
	2.1	2.2	2.3	2.4	2.5	2.6	2.7
(x) Mental Health Services complaints and Datix incident investigation data for 2021/22 and 2022/23					Yes		
(xi) Framework for Adverse Event Reporting, Management and Learning					Yes		
(xii) Speak Up Week materials							Yes
(xiii) Whistleblowing policy and employee guide						Yes	Yes
5. Applicable guidance i. Good Medical Practice (GMC) ii. Good Practice in prescribing and managing medicines and devices (GMC) iii. The Medical Profession (Responsible Officers) Regulations 2010 (and amendments)				Yes			
6. Information provided by the GMC i. Welcome leaflet for Responsible Officers ii. Overview of regulations for Responsible Officers across the UK iii. Guidance on assessing the seriousness of concerns relating to self-prescribing, or prescribing to those in close personal relationships with doctors iv. Principles of a good investigation				Yes			
7. INWO Speak Up Survey data. (Details provided in private Appendix C)							Yes
8. Evidence obtained through witness interviews			Yes				Yes
9. Independent professional advice	Yes	Yes	Yes		Yes		