

INWO decision report



Case: 202409126, Tayside NHS Board

Subject: Complaint handling

Decision: Some upheld

Summary

C raised concerns with the Board about delays in addressing concerns about service provision, workforce sustainability and culture and behaviours within a service. The Board investigated the concerns under the NHS whistleblowing procedure. The Board partially upheld C's concerns and made recommendations for improvement.

C was dissatisfied with the Board's investigation and complained to the INWO. C disagreed with the outcome of the investigation and had concerns about its thoroughness. We reviewed the Board's investigation and spoke with several witnesses. We found that some aspects of the Board's investigation and decision making were reasonable. However, we concluded that the number of interviews carried out by the Board was not sufficient to provide a reliable perspective on some of C's concerns. We also found that there were factors that the Board could have investigated further to understand how they had contributed to the delay in addressing concerns. On balance, we upheld C's complaint.

C was unhappy with the time it took for the Board to investigate their concerns and complete the recommendations. We found that there were significant delays in the early stages of the Board's handling of the concerns. While there were some factors that made the process more complicated, we found that the delay was unreasonable, and the communication was not effective at keeping C updated. In relation to the recommendations, we found that there were some delays, but that the Board kept C updated. We identified one recommendation that appeared to be partially complete, and we asked the Board to provide further evidence regarding this. We upheld this part of C's complaint.

Finally, C felt that they had been treated unfairly because of speaking up. We gathered evidence about the reasons for the decision that affected C and we considered the circumstances leading up to this decision. We found that what happened was not a

form of victimisation or unfair treatment because C spoke up. We did not uphold this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to the complainant for:
 - not carrying out sufficient interviews
 - implying that they were the main cause of the delay in the organisation addressing the concerns
 - the delays in the early stages of the handling of the concern
 - not keeping them informed in the early stages of the handling of the concern.

The apology should meet the standards set out in the SPSO guidelines on apology available at www.spsso.org.uk/information-leaflets.

What we said should change to put things right in future:

- The Board should be assured that:
 - There are effective systems in place to triangulate and act on concerns.
 - Staff have confidence to use organisational procedures to raise concerns.

In relation to compliance with the Standards, we recommended:

- An investigation under the Standards must focus on the practices or procedures that are unsafe or inappropriate. It must focus on patient safety, safe working practices and good governance; it must be fair, robust and proportionate to the risks identified. It must aim to handle and provide a full response to all the issues involved in the whistleblowing concern that has been raised. The Board must ensure that there are not prolonged delays that impact access to the whistleblowing procedure and the timely resolution of concerns.