INWO decision report

Case: **202210733, Highland NHS Board**
Subject: Hospitals \ Quality of care

Summary

C worked as a locum in one of the Board's services. C raised concerns about a colleague's practice with their regulator. C later raised similar concerns under the National Whistleblowing Standards (the Standards). The concerns were investigated under stage 2 of the process. Given the still ongoing regulatory procedure, the Board took the approach of carrying out a service review. At the end of the process the findings were shared with C through verbal and written feedback. The feedback did not state whether the concerns were upheld or not, and there was no reference to the INWO as the review stage of the process. C was dissatisfied with the Board's response and brought a complaint to the INWO.

We considered whether the Board had reasonably considered the risks to patients from the concerns C raised, and the Board's handling of the concern. We found that the ongoing regulatory process and the Board's decision to carry out a service review meant that the whistleblowing process was not followed as laid down by the Standards. The service review approach also did not directly address the risks that C raised. There were other issues with the investigation including confidentiality not being respected, delays in updates to C, possible earlier missed opportunities to recognise that C was whistleblowing, and the written response to C.

Our decision in this case was to uphold C's complaints. We gave advice to the Board on how to manage future complaints of this nature, made recommendations for the Board to improve their concern handling, to apologise to C and to carry out a review of specific patient feedback. We also gave feedback to the Board on ensuring the case file is accessible to the INWO liaison officer, in case of enquiries from the INWO. Finally, we noted that the Board has identified further work it needs to do to minimise risks of patient harm in this service and we asked to be kept up to date on this.

Recommendations

What we asked the organisation to do in this case:

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

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

- For there to be an independent review of the seven Datix concerns to ensure that any risk to patients is identified and managed and to demonstrate a reflective learning process.
- Patients of the service need to be assured that the service that they receive is safe and that the Board are committed to minimising any potential harms.

In relation to complaints handling, we recommended:

- That processes are in place to ensure that whistleblowing investigations meet the requirements of the Standards, and take full account of the risks raised.