THE STATE HOSPITALS BOARD FOR SCOTLAND

WHISTLEBLOWING ANNUAL REPORT

1 April 2021 – 31 March 2022

1. INTRODUCTION

The SPSO (Scottish Public Services Ombudsman) developed a model procedure for handling whistleblowing concerns raised by staff and others delivering NHS services and this was formally published on 1 April 2021. The Independent National Whistleblowing Office (INWO) provides a mechanism for external review of how a Health Board, primary care or independent provider has handled a whistleblowing case. For NHS Scotland staff, these form a 'Once for Scotland' approach to Whistleblowing.

The SPSO worked with NHS National Education Scotland (NES) on the development of training materials, and these are now available to all staff through the TURAS Learn Website. There are two training modules: one for raising general staff awareness of whistleblowing, and a more detailed programme for managers or others who may receive concerns. This provides additional support and guidance on best practice, should a concern be raised through the policy.

In addition to this, the Scottish Government revised and promoted the role of the Whistleblowing Champion as a formal Non-Executive member of each NHS Board. Their role is to ensure that the systems are in place to enable staff to raise concerns, and that the culture of the organisation supports the full application of these systems, by valuing staff concerns. Brian Moore, (Chair) held the position of the Non-Executive Whistleblowing Champion until his appointment as Chair in July 2021. Unfortunately, this post remains vacant whilst we await the conclusion to the formal recruitment process conducted by the Scottish Government. Until this position is formally in place, it has been agreed that staff will be able to raise concerns with any of the Non-Executive Directors.

The Executive Lead remains the Director of Workforce. However once the Non-Executive position has been filled, this will be reviewed in line with the Standards recommendations.

2. IMPLEMENTATION AND REVIEWS

The State Hospital fully launched the Whistleblowing Standards and the National Policy in April 2021. A soft launch had also been undertaken in February 2021.

In advance of the formal launch of the Standards, a special Staff Bulletin was made available to all staff providing details of the new Standards, the role of the INWO, how to raise any concerns, and information relating to the Training available.

In terms of the Training, to date the current levels of training as at:

Introduction for all Staff – 448
Managers Training – 28

This information is provided to Operational Management Team, Corporate Management Team, Staff Governance and the Board. Ongoing work will continue to improve these figures with a dedicated communication plan to ensure that information is regularly sent to all Staff regarding their access to this Policy and Standard.

All Whistleblowing Complaints are recorded locally via the DATIX system and then updated as and when the case is investigated and concluded.

Currently the Board has two Confidential Contacts, however, work is taking place with the other National Boards on a possible shared resource to ensure complete confidentiality is in place for anyone raising a concern. It is hoped that more Staff will come forward to undertake the Confidential Contact training and therefore strengthen the pool of resource. However, it should be noted that as a small Board whilst this remains a challenge, we have been able to source and resource additional provision as and when required with support from other Health Boards.

Work continues on the development of a culture which fully promotes openness and transparency in its daily reporting. A development session has taken place with the Joint Staff Side with a full Partnership session to take place later in the year. Developing and building relationships with the Trade Unions has had significant improvements in joint working and this will continue to be undertaken – in full partnership. There is certainly has been a strengthening of the work over the past several months and the Partnership Forum and HR and Wellbeing Groups will continue with the excellent progress made to date.

The Corporate Management Team leads development of leadership throughout the organisation, and has undertaken a comprehensive review of organisational governance to support this. This has included re-visiting the learning from the Sturrock and Strang reports (published in 2019) and how this may apply to the hospital as we enter a new landscape of learning to live with Covid-19. In addition, the Workforce Directorate are developing Leadership Programmes and a Developing Manager Programme which will help support new and future and leaders in the organisation. Our Induction Programme is also under review with a view to ensuring that all staff feel fully included from their first day in the organisation, with a proposed follow up to this to “check-in” with them three months after they commence employment.

To ensure the Board are completely updated on the Standard and roll out, the INWO will attend a Board Development day in September 2022. This will ensure they are fully aware of the Standard and Policy.

3. WHISTLEBLOWING REPORTING

A key requirement of the revised standards is notification of case incidence to the Board and Staff Governance Committee.

Throughout 2021/22 a report updating the position on Whistleblowing has been produced and presented to the Board on the following dates:

15 April 2021	-	Introduction to Standard and Process
26 August 2021	-	Quarter 1 Update
23 December 2021	-	Quarter 2 Update
24 February 2022	-	Quarter 3 Update

The report has also been presented to the Staff Governance Committee and the dates this was on the agenda were:

20 May 2021
19 August 2021
18 November 2021
17 February 2022

4. WHISTLEBLOWING CASES 2021/22

In 2021/22 there was a total of two cases raised within The State Hospital under Whistleblowing.

Case 1 - investigated internally at Stage 2 and the individual who raised the concern has had formal feedback, with a follow up in writing.
Unfortunately, this case was concluded outwith the 20-day target which was due to sick leave. However, this was rectified and feedback was given as quickly as possible thereafter.

Case 2 – due to the complex nature of this complaint the investigation was conducted by a Team external to the Board. This again, was completed at Stage 2 level and feedback has been given to the individual who raised the concern along with a follow up in writing. Unfortunately, this case was not concluded within the 20-day target and was due to a number of factors outwith the control of the Investigation Team. The reasons for the delay included the complex nature of the investigation, the number of witnesses to be interviewed and sickness.

The next stage for both cases is they have the opportunity to request a review via the INWO. To date, no notification has been received that this has been requested.

5. LEARNING AND ACTIONS

As well as the outcomes, recommendations have been made in each of the cases and these are being actioned, with updates being provided at Board and Staff Governance. These include:

- Review of Recruitment Processes;
- Work on building key relationships to ensure openness and transparency;
- Further communications on the Whistleblowing Standards and Training;
- Development of more Confidential Contacts;
- Recruitment to the Non-Executive Whistleblowing Lead;
- Development of an internal Operating Procedure providing clarity on the process followed when dealing with any concerns;
- Additional support sources, not only for those who are raising the concerns but for anyone who may become involved (i.e. witnesses)
- Development of a Communication Plan aimed at raising awareness of the Standards;
- Development of a Culture where complaints and concerns are encouraged and welcomed.

6. QUALITY AND PATIENT CARE

Whistleblowing is an important Policy and process for staff, students and volunteers to enable them to speak up about any concerns they may have in the organisation with respect to quality and safety in patient care. The information in this report has no direct impact on patient care, except in those circumstances when the whistleblowing process is used to highlight patient safety concerns or other quality matters in the organisation. Any recommendations or actions that come out of future whistleblowing cases will help to improve quality of The State Hospital services and patient care.

7. CONCLUSION

During 2021/22 there were two Cases raised under Whistleblowing, both of which were investigated and feedback given to the Complainants.

Action which have come out of this will continue to be worked on and updates will be given at Corporate Management Team, Staff Governance Committee and the Board.

Work continues to improve the support given to Staff and development will take place on the systems and processes used to encourage feedback on any issues.

Brian Moore
Chair
On behalf of the State Hospitals Board for Scotland