Item 9

NHS Highland

Meeting:	**Board Meeting**
Meeting date:	**30 July 2024**
Title:	**Annual Whistleblowing Report 2023-2024**
Responsible Executive/Non-Executive:	**Gareth Adkins, Director of People and Culture**
Report Author:	**Gareth Adkins, Director of People and Culture**

1 Purpose

This is presented to Board for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement
- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

This report relates to the following Strategic Outcome(s)

Start Well		Thrive Well		Stay Well		Anchor Well	
Grow Well	X	Listen Well	X	Nurture Well	x	Plan Well	X
Care Well		Live Well		Respond Well		Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well		Progress well					

2 Report summary

2.1 Situation

Appendix 1 includes our 3rd Annual Whistleblowing Report covering 2023-2024 for approval by Board. The report has been considered by EDG, Area Partnership Forum, Staff Governance and Clinical Governance Committees.

2.2 Background

The whistleblowing standards were introduced in April 2021 and include a requirement for every NHS board to produce quarterly reports and an annual report. The annual report summarises activity including nationally agreed Key Performance Indicators and also provides an overview of the learning outcomes from cases concluded during the year.

The annual report must be submitted to the Independent National Whistleblowing Officer (INWO) within 3 months of the end of the financial year. Where it is not possible to meet this timescale the report should be submitted as close to the deadline as possible and INWO informed of the reason for any delay.

2.3 Assessment

Appendix 1 includes our 3rd Annual Whistleblowing Report which will be submitted to INWO following board approval at the end of July 2024. It has not been possible to submit this report within 3 month's of the end of the financial year due to governance cycle of the board. INWO will be kept informed of the expected submission date.

The key points from the report are summarised below.

- There have again been a small number of cases raised during 2023-2024.
- We continue to manage around 200 contacts via our confidential contacts service (provided by the Guardian Service) and this may be one reason why the number of formal whistleblowing concerns remains low.
- INWO did not uphold any complaints in relation to findings of investigations but did identify required improvements in processes, which we have progressed through our whistleblowing and speaking up action plan.
- We do know that further work to improve the timeliness of our processes has been required and we have made efforts to do this. Yet, whistleblowing cases are often complex and completing within the 20 working days for stage 2 remains challenging. We remain committed to progressing investigations as quickly as possible but also on the quality of the investigation and working with individuals to attempt to meet their expectations in terms of outcomes from investigations.
- There is learning from the small number of upheld cases outlined in this report but caution is required in interpreting the wider implications of the outcomes of these cases. (Further detail is provided within the report)
- We have considered the need for tracking actions arising from upheld concerns and concluded these are best managed within the appropriate governance arrangements. However, we will introduce a review period to ensure that actions have been progressed.

2.3.1 Quality/ Patient Care

The whistleblowing process primarily focuses on resolving individual issues including concerns related to the quality of care.

The annual report provides some insight into areas for improvement but given the limited number of cases caution is required when interpreting the findings of these cases. However, the findings do align with issues the board is aware of and the organisational priorities for the board for quality of care.

2.3.2 Workforce

The annual report demonstrates transparency in reporting our implementation of the whistleblowing standards and supports our commitment to encouraging staff to speak up and raise concerns.

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

The main risk identified from the annual report is the timeliness of our investigations and challenges associated with meeting the 20 working days standard. However, we are committed to ensuring that thorough investigations are completed and actions progress to address any risks identified this includes addressing any immediate risks to the organisation at the start of an investigation where this is required.

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

The annual report was considered and approved by the following groups prior to board approval:

- Executive Director's Group
- Area Partnership Forum
- Staff Governance Committee
- Clinical Governance Committee

2.4 Recommendation

This report proposes the following level of assurance:

Substantial	X	Moderate	
Limited		None	

The Board is asked to approve substantial assurance based on the content and format of the annual whistleblowing report demonstrating compliance with our reporting requirements under the standards.

3 List of appendices

The following appendices are included with this report:

Appendix 1 – Annual Whistleblowing Report 2023-2024

Annual Whistleblowing Report 2023-2024

1 Introduction

This is our 3rd annual report and provides a valuable opportunity to pause and reflect on the progress to date with our approach to speaking up and whistleblowing.

This report provides an overview of NHS Highland's whistleblowing cases received and progressed during 2023-2024 including the key performance indicators used to benchmark the whistleblowing standards across NHS Scotland.

NHS Highland is committed to effective implementation of the standards, supporting staff to speak up and acting where required to improve how we work with our staff to deliver health and care services. This report includes a summary of the findings from the concerns investigated as well as Independent National Whistleblowing Officer (INWO) reviews of some of our cases. We also have also included details of changes and improvements resulting from these findings.

2 KPI 1: Learnings, Changes and Improvements as a result of considering Whistleblowing concerns

Our learning from whistleblowing concerns in 2023-2024 can be drawn from two elements; concerns upheld by NHS Highland and recommendations from INWO reviews. In this section we outline the findings from both these areas and the changes and improvements we have planned and implemented during 2023-2024.

2.1 Upheld Concerns

2 whistleblowing cases were investigated and upheld by NHS Highland. Whilst it is not within the scope of the annual report to detail the individual actions from these cases it is possible to draw some general conclusions and themes from the 2 cases as follows:

- Availability of permanently appointed workforce is an ongoing area of concern for staff in relation to the challenges of managing day to day staffing with supplementary staffing
- Use of supplementary staffing impacts on team morale and well-being due to lack of continuity and extra workload involved in managing temporary workforce
- Staff feel that supplementary staffing impacts on the quality of care they are able to provide
- Staff feel that there is not enough regular communication between management including clinical and care professionals and staff in relation to workforce challenges
- Staff may not be clear on the day to day processes for managing workforce availability, service demands/delivery and raising concerns
- Staff may not be clear on the short, medium and long term plans to address workforce availability
- The demands placed on health and care services can exceed the planned capacity to respond resulting in impacts on staff health and wellbeing including concerns related to their ability to provide safe care in these circumstances
- Demand pressures can result in service users being cared for in a setting or location that was not designed for the needs of the service users and sometimes by staff without regular experience of the needs of service users
- Staff may not feel supported or be aware of how to raise clinical and safety concerns on a day to day basis through operational and professional management
- Staff may not feel supported or be aware of how to raise clinical and safety concerns through clinical governance processes

2.2 INWO case review

INWO concluded the review of 3 cases during 2023-2024, all of which completed as whistleblowing concerns during 2022-2023.

One case was a complaint in relation to a concern NHS Highland decided was not eligible for consideration under the standards. INWO did not uphold this complaint as they concluded that the concern did not meet the public interest element of the standards.

2 cases were progressed and final decisions provided by INWO and can be summarised as follows:

Case A

The complaint investigation by INWO was comprised of two elements as follows:

1. Whether the Board has appropriately investigated the clinical issues identified. (Including if they should be taking further action to ensure these issues are appropriately considered.)
2. Whether the Board has followed the appropriate process under the Standards in handling the whistleblowing concerns.

INWO did not uphold the complaints in relation to the outcome of the investigation, i.e. the original concerns were not upheld.

INWO did uphold concerns with the process as follows:

- the Board did not have a clear audit trail to show confidentiality was fully and appropriately discussed with the individual;
- there was a missed update; and
- it is not clear that the support provided to C fully complied with the Standards (for example, delays and sporadic engagement).

Case B

The complaint investigation by INWO was comprised of two elements as follows:

- the Board failed to ensure that there were appropriate systems in place so that waiting lists were managed and reported in accordance with guidance.
- the Board failed to handle the whistleblowing concern in line with the National Whistleblowing Standards.

INWO did not uphold the complaints in relation to the outcome of the investigation, i.e. the original concerns were not upheld.

INWO did uphold concerns with the process as follows:

- potential risks of inadvertently exposing the identity of the complainant
- delays in the handling of the concern and issues with communication

Summary

Both these cases and NHS Highland's experience of implementing the whistleblowing standards demonstrate that there is further improvement required in relation to the whistleblowing procedure and processes to ensure a confidential and a timely investigation is undertaken. It is re-assuring to note that the findings of the original investigations were upheld which indicates they have been completed in a thorough and appropriate manner, even though the complainants were not satisfied with the outcome.

2.3 Changes and Improvements

Tracking actions

The number of whistleblowing cases remains small and the priority remains addressing the specific issues raised and where upheld ensuring appropriate actions are agreed and followed through. One theme that has remained a question for the board is the extent to which action tracking is required following agreement of a local action plan with the whistleblower.

Reviewing the two cases investigated upheld during 2023-2024 it appears that continuing to regularly monitor the agreed actions within the whistleblowing administrative processes and associated resources would not be pragmatic or achievable. This is largely due to the diversity of the actions and the accountability for delivering the actions sitting within other governance and management structures.

However, it may be beneficial to agree a set review period for each case to review the actions and the degree to which action plans have been completed within the relevant management and governance processes.

Organisational priorities

The dataset from whistleblowing concerns is small so caution is required if attempting to interpret the data to inform wider organisational priorities for changes and improvements. However, the themes outlined in section 1.1 do align with issues and risks NHS Highland is aware of through its governance and management structures including:

- Workforce availability
- System and service pressures
- Managing demand, performance, quality and safety within available resources within our clinical governance governance framework
- Risk management and escalation including clinical and care risks within our clinical governance governance framework
- Communication and involvement of staff in workforce management, risk management and clinical governance

These themes align well with NHS Highland's organisational priorities which include:

Health and Care Staffing Act Programme

This programme is overseeing work across the organisation to strengthen:

- Workforce planning to ensure we have appropriate staffing in place to deliver our services
- Real time staffing processes to manage day to day workforce challenges, service demands and risk management
- Risk management and escalation to address short, medium and longer term challenges associated with workforce availability and safe, effective service delivery

Developing Our Quality Framework

We are engaging with our staff and working with our clinical and care leaders to agree a new approach to quality and our quality framework. This includes supporting our staff to:

- create and maintain a culture where it is safe to speak up and raise concerns about clinical and care safety and quality
- engage with our existing clinical and care governance framework to ensure concerns are captured and improvement plans are developed and delivered
- define what quality means to them and work together to deliver a high quality service within the resources available

Strategic transformation

Our strategy includes a focus on sustainability and ensuring we can deliver safe, high quality services to our population with the resources we have available to us. We know that this will require ongoing work to redesign and transform our services and develop new workforce models to deliver new models of care.

Improving the Whistleblowing Procedures and processes.

NHS Highland Board members and the executive team completed a review of our whistleblowing procedures during the Autumn of 2023, reflecting on the first 2 years since implementation of the standards. We considered what had worked well and what could be improved and this offered the opportunity for:

- our non-executive whistleblowing champion to share their experiences to date, their reflections and suggestions for further improvement
- the board to review the contents and recommendations within the second annual whistleblowing report

An action plan was developed and delivered during the latter half of 2023-2024 to address the issues outlined above and improve our overall processes. These actions included:

- The Director of People and Culture, Medical Director and Nurse Director forming a triage group to:
    - review whistleblowing cases (given that the majority of concerns raised were related to clinical or care governance and quality)
    - decide on redirection to business as usual processes such as clinical governance policies and processes or HR policies and processes including allocation of an investigating officer where appropriate
    - allocation of an appropriate executive lead to support cases agreed as proceeding to whistleblowing stage 1 or stage 2
    - allocation of investigating officer to support stage 1 or stage 2 cases
    - Refinement of our administration and support processes. This will provide coordination and oversight of all stages of the process and ensure a consistency with our responses and record keeping
    - Ensure a robust process is in place for tracking and monitoring actions. This would provide assurance on recommendations and actions being progressed and completed
    - Establish a bank of investigating officers with appropriate training to support whistleblowing standards and other complimentary investigatory processes, e.g. HR processes, complaints.

All of these actions have been completed to date with the exception of a process for reviewing and monitoring actions.

As outlined above, it has been proposed that actions resulting from whistleblowing concerns and investigations should not be directly retained within the whistleblowing management and governance but passed to the most appropriate governance route for monitoring, e.g. clinical governance, operational management teams or HR processes. The focus of whistleblowing governance should be ensuring that final reports include clear arrangements for monitoring and oversight of the actions arising from individual cases. However, it is also proposed that a review date is agreed for each case within the whistleblowing process to review case reports and associated actions with relevant parties to provide assurance they have been progressed and completed.

3 KPI 2 - Experiences of all those involved in the whistleblowing procedure

The number of whistleblowing cases raised and concluded each year remains small and the key information we have available to us to assess experience is feedback from:

- Individuals involved in the process
- INWO case reviews

Individual Feedback

Feedback from the 2 cases concluded this year is limited but in both cases the whistleblowers were satisfied with outcome of the process and the findings (both sets of concerns were upheld by NHS Highland).

INWO case reviews

The 3 INWO case reviews referred to above indicate that these individuals were dissatisfied where:

- they did not agree with the original consideration of eligibility or the outcomes of the investigation
- and/or they were dissatisfied with the process

It is understandable that some individuals will be dissatisfied with the outcomes of an investigation and where INWO uphold these concerns we will act. In 2023-2024 INWO did not uphold any outcome aspects of investigations but did highlight issues with our processes. We acknowledge the issues that have been raised and that these will impact on the experience of the individual whistleblowers. The action plan outlined above is a direct result of reflecting on the need for improvements and we aim to further improve our processes and the experience of whistleblowers.

4 KPI 3: Levels of staff perceptions, awareness and training

We continue to promote how staff can speak up through a range of different mechanisms including the formal whistleblowing policy and standards. Our confidential contacts service provided by the Guardian Service is also widely promoted throughout the organisation. This service is accessed by over 200 staff per annum for advice and support including support to access the whistleblowing procedure.

Whilst we know people actively seek out both the Guardian Service and access the whistleblowing procedures when they have concerns they wish to raise we are also aware that general awareness of the standards, and to some extent the Guardian Service, remains variable. Consequently, we continue to focus on raising awareness through a range of mechnanisms.

Speak Up Week
From the 2nd to the 6th October 2023, NHS Highland actively participated in the National Speak Up Week, led by the INWO.

Our Guardians, who act as our Whistleblowing Confidential Contacts, travelled extensively across the Board area promoting Speaking Up and the Whistleblowing Standards. There were also a series of local and national resources, press releases and social media postings shared. Our executive team also participated in sessions across the organisation, engaging with staff to raise awareness and support speaking up.

Non-Executive Whistleblowing Champion visits
In addition to the Speak Up week events, our Non-Executive Whistleblowing Champion carries out regular visits throughout the year to key locations and sites across the Board area and listening to colleagues and reporting back on his experiences and insights.

Induction and training
All new staff attend a 'Welcome to NHS Highland Induction' event, a half day online session where all new colleagues are updated on a range of information about NHS Highland, our services, our strategy, our values and our leadership. This includes how to raise concerns, Speaking up, the Guardian Service and the Whistleblowing Standards to ensure from the start of their career with us, colleagues know how to have their concerns heard and addressed.

We continue to signpost the online learning to colleagues, that is available on TURAS whenever we are talking about Speaking Up and Whistleblowing. We also signpost investigating managers to this, at the start of any new concern, to ensure they are up to date.

We are currently identifying around 40 managers to undertake further training on conducting an investigation which will support them to undertake whistleblowing investigations as well as other investigations such as those related to workforce policies. We will also ensure these managers receive refresher training on the standards.

5 KPI 4: Total Number of Concerns Received

During the period 1st April 2023 to 31st March 2024, NHS Highland received 5 whistleblowing concerns, of these 1 was received in quarter one, 1 received in quarter two and 3 received in quarter four.

NHS Highland received 2 monitored referrals in July 2023 from INWO requesting a review of two cases linked to the same location and associated services. These cases related to a range of issues raised via a collective grievance during 2022 including workforce and staffing, patient safety and quality of care as well as issues that were deemed to be more appropriate for NHS Scotland workforce policies. At the time an investigation was also underway by National Education Scotland (NES) under the whistleblowing standards and NHS Highland worked with NES to investigate and also address the issues arising from this investigation. In parallel workforce policies and procedures were followed to address the issues relevant to for NHS Scotland workforce policies. The whistleblowing case opened by NES resulted in an action plan that was monitored and reported back to NHS Highland and NES and concluded in October 2023, demonstrating significant improvements in staffing arrangements and quality of care. However, INWO requested a review of the original concerns from 2022 as they had received two complaints that indicated these concerns had not been resolved.

The two cases were reviewed and it was established that the concerns included issues dated back to 2021 and given the length of time that had passed and the ongoing improvement work underway NHS Highland deemed these concerns not eligible under the standards due to the time that had passed. However, we did offer to meet with the individuals to discuss any ongoing and current concerns they had. At the conclusion of this reporting period NHS Highland has not received any further contact from either individual to arrange a meeting to discuss the concerns they had raised with INWO.

One further concern was received in October 2023 and related to a concern that had been raised via the Guardian Service confidential contacts service in July 2022. The original concern was related to quality of care issues and was not deemed to be a whistleblowing concern at the time as the individual was content with the response that was provided by management outlining improvement work underway to address the issues raised. However, in October 2023 the individual was concerned that there were ongoing issues with quality of care that had not been resolved. The whistleblowing executive lead worked with the individual and with management to review the current situation in relation to the concerns being raised. It was agreed that further action was required to address the concerns being raised and the whistleblower was provided with further assurance under 'business as usual' processes that an updated action plan had been agreed. At this stage the individual still had

concerns but agreed a further meeting with the whistleblowing executive lead in February 2024 would be appropriate to review progress against the action plan. In February 2024 it was agreed that due to ongoing concerns of the individual that this would now be treated as a whistleblowing concern. The case remained open at the end of the reporting period.

In summary, 8 concerns were received during 2023-2024 with 6 progressing to investigation under the standards. The category of the concerns were:

- Patient Safety & Quality (6)
- Fraud (1)
- Changing or falsifying information (0)
- Breaking Legal Obligation (0)
- Abusing Authority (1)

2 cases were investigated and closed during 2023-204 and 4 remain open at the end of the year and under investigation.

6 KPI 5: Concerns closed at stage 1 and stage 2 of the whistleblowing procedure as a percentage of all concerns closed

2 cases were closed during 2023-2024, both were stage 2 concerns representing 100% of all concerns closed.

7 KPI 6: Concerns upheld, partially upheld, and not upheld at each stage of the whistleblowing procedure as a percentage of all concerns closed in full at each stage

Of the 2 concerns closed in 2023-2024 both were upheld representing 100% of all concerns closed.

8 KPI 7: The average time in working days for a full response to concerns at each stage of the whistleblowing procedure

The 2 concerns closed were stage 2 concerns and took 33 and 148 days to complete representing an average of 91 days (13 weeks).

9 KPI 8: The number and percentage of concerns at each stage which were closed in full within the set timescales of 5 and 20 working days

There were no stage 1 concerns raised in this period

None of the stage 2 concerns raised within this period were within the 20 working days standard.

We recognise that the average and maximum times of these cases exceed significantly the 20 working days for stage 2 concerns within the standards. We are continuing to focus on reducing the time to investigate and report on concerns and would note the following challenges:

- **Investigating officer capacity** – workload pressures continue to make it challenging for investigators to accommodate the work required to undertake an investigation including liaising and meeting with witnesses, collating and analysing data and providing the final reports
- **Coordinating and meeting with whistleblowers and witnesses** – All cases raised this year have involved multiple witnesses and it takes time to coordinate and arrange meetings that are mutually agreeable to both the investigator and the witnesses. This is exacerbated by the large geographical spread of NHS Highland and the logistics of meeting individuals which often requires face to face meetings.

- **Analysing information and data including report writing –** The amount of information generated in each case is significant and takes time to synthesise and draw conclusions from as well as develop proposed actions to address any concerns that are upheld
- **Finalising reports** – good practice includes meeting with whistleblowers to finalise the report.

Whilst we are endeavouring to improve our processes it is also important to ensure that the desired outcomes for the whistleblower are important and we should continue to include a focus on the quality of the investigation and the final report.

10 KPI 9: The number of concerns at stage 1 where an extension was authorised as a percentage of all concerns at stage 1

There were no stage 1 concerns raised in this period

11 KPI 10: The number of concerns at stage 2 where an extension was authorised as a percentage of all concerns at stage 2

There 2 concerns resolved at stage, 100% of these had extensions granted.

12 Reporting processes

Quarterly Reporting

NHS Highland Executive WB Lead presents the quarterly Whistleblowing reports to the following formal governance committees:

- NHS Highland Board
- NHS Highland Staff Governance Committee
- NHS Highland Area Partnership Forum

The reports are also discussed at the Executive Directors Group and Senior Leadership Teams.

All efforts are made to ensure that reporting is timely and prompt, however, it has to be noted that meetings of governance committees are bi-monthly and so often there will be some lag. However, all committees are given time and space to scrutinise the reports and discuss.

In addition, there is dynamic discussion and reporting via the Executive Lead into the Executive Directors Group as well as to specific leaders, to ensure the any urgent matters are rapidly addressed.

2023 / 2024 reporting

Quarter	Period covered	Area Partnership Forum	Staff Governance Committee	NHS Highland Board
Q1 22-23	1 April – 30 June 2023	18 August 2023	6 September 2023	26 Sept 2023
Q2 22-23	1 July – 30 September 2023	20 Oct 2023	8 November 2023	28 Nov 2023
Q3 22-23	1 October – 31 December 2023	16 February 2024	16 January 2024	30 January 2024
Q4 22-23	1 January - 31 March 2024	19 April 2024	7 May 2024	28 May 2024
Annual Report 22-23	1 April 2023 - 31 March 2024	21 June 2024	9 July 2024	30 July 2024

13 Summary

There have again been a small number of whistleblowing concerns raised during 2023-2024 which we have managed through the whistleblowing standards. It may helpful to note that we also have a confidential contacts service which has received over 200 contacts from staff during the year. The purpose of this service is to provide confidential advice and support on a wide range of issues. Staff contact the service for support including in relation to inter-personal issues at work and concerns around service delivery and quality. These are not categorised as whistleblowing concerns but may be one reason why we have a low number of formal cases raised as the confidential contacts service provides a safe, confidential way of providing advice to staff and resolving issues without the need for formal processes.

There is learning from the small number of cases outlined in this report but caution is required in interpreting the wider implications of the outcomes of these cases. As outlined in our report we have reviewed the outcomes in relation to wider improvement work underway across the organisation and this provides assurance that there is alignment between the two.

We do know that further work to improve the timeliness of our processes has been required and we have made efforts to do this. Yet, whistleblowing cases are often complex and completing within the 20 working days for stage 2 remains challenging. We remain committed to progressing investigations as quickly as possible but also on the quality of the investigation and working with individuals to attempt to meet their expectations in terms of outcomes from investigations.

NHS Highland is committed to the whistleblowing standards and we will continue to refine our approach and support staff to speak up with confidence.