The Scottish Government
Riaghaltas na h-Alba

Consultation on proposals for the introduction of the role of an Independent National (Whistleblowing) Officer (INO): Analysis of responses

HEALTH AND SOCIAL CARE

social research

Consultation on proposals for the introduction of the role of an Independent National (Whistleblowing) Officer (INO): Analysis of responses

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1. Executive Summary

The Scottish Government and NHSScotland are committed to ensuring that all NHS employees in Scotland are encouraged, supported and confident in raising any concerns they may have about patient safety, behaviours which may lead to harm, or malpractice in the NHS. In Scotland, measures are in place or in development to support this commitment, for example, the NHSScotland Confidential Alert Line; training sessions for key NHS staff; removal of the routine inclusion of confidentiality clauses and derogatory statement clauses from settlement agreements; and guidance for NHSScotland staff and employers on the appropriate use of confidentiality clauses and derogatory statement clauses in settlement agreements.

The Freedom to Speak Up Review in England, chaired by Sir Robert Francis QC[1], highlighted a number of practical actions which the Scottish Government considered will further enhance and add value to the existing measures. One particular gap was oversight of how an NHSScotland body deals with concerns raised and a mechanism for external review of how concerns have been handled at a local level.

Scottish Ministers propose to establish the role of Independent National (Whistleblowing) Officer (INO) to provide the external review function and sought views on the role and remit of the INO in a consultation paper[2] published on 17 November 2015. 58 responses to the consultation were received, 31 from organisations and 27 from individuals. A summary of views from the consultation follows. The views are those of the respondents to this consultation and may not necessarily represent the views of a wider population.

Role of the INO

Most of those who provided a view considered that the role of the INO should be to consider complaints about the application of the local whistleblowing process, including examination of the decision-making and outcomes of the whistleblowing complaint. This was viewed as a holistic approach to examining complaints which would contribute to the effectiveness of the role, instil confidence in complainants, build trust and provide independence and impartial scrutiny.

Principles and process for raising concerns with the INO

Most respondents agreed with the principles and process for raising concerns with the INO proposed in the consultation. In particular, the emphasis on the INO being the final stage in the process was welcomed as helping to avoid duplication or undermining local effort and processes.

Views were mixed on the proposed bar on historic cases with most in agreement but supporting an element of discretion, depending on circumstances.

[1] www.gov.uk/government/publications/sir-robert-francis-freedom-to-speak-up-review

[2] http://www.gov.scot/Publications/2015/11/5123

A minority of those who responded considered that the INO should have more explicit powers to investigate cases at an earlier stage in exceptional circumstances, prior to the local investigation being completed. More flexibility was also called for in relation to involvement of the INO in individual employment matters in some instances. More guidance was requested on what "exceptional circumstances" should constitute.

Most of those who provided a view agreed with the proposed INO whistleblowing complaint criteria which were perceived as clear, fair and sensible but could be strengthened by the provision of examples.

A shared concern amongst several respondents was that undue emphasis was placed in the proposals on the whistleblower having to prove their case for INO involvement.

Prescribed powers of the INO

Most respondents agreed that consideration should be given to the INO having prescribed powers as without these they considered that the INO's effectiveness would be curtailed. A common view was that prescribed powers would provide the INO with credibility and would generate respect. A minority view was that sufficient powers already exist, for example the Partnership Information Network (PIN) Policy for NHSScotland.

Most of those providing a view agreed that the INO should have powers both to compel a public body to provide evidence and to enforce recommendations, as one of these without the other would be illogical. A minority view was that the INO should not have enforcement powers as existing legislation and accountability mechanisms should suffice.

A range of potential additional powers were suggested including to compel all NHSScotland bodies to put in place recommendations if these are generalisable to all; being able to refer issues to other regulators as appropriate; and levying fines and other sanctions against employers.

Options for hosting the INO role

Most of those expressing a clear preference considered that the INO should be hosted within the Scottish Public Service Ombudsman (SPSO); a minority of respondents favoured hosting the INO within the Healthcare Improvement Scotland (HIS). Respondents were against creating the INO as a new public body largely on grounds of cost.

The main reason for recommending the SPSO as the host was its independence from health and social care bodies and its impression of impartiality. The SPSO was also viewed as straddling the entire public sector including both health and social care sectors.

Those in favour of hosting the INO within HIS argued that the HIS and the INO roles were aligned in scrutiny functions with HIS already handling whistleblowing complaints. HIS was perceived as already well known to NHS staff.

Health and social care integration

Most respondents who provided a view agreed that employees of adult health and social care services, who are not employed by NHSScotland, should have access to the INO. The main arguments in favour were that this makes sense in terms of reflecting the joint working which will result from the Public Bodies (Joint Working) (Scotland) Act 2014; and that this would provide parity and consistency across staff working in these different disciplines.

The main argument against expanding access to the INO for employees of adult health and social care services was that the Integration Joint Board (IJB) does not employ staff, with staff remaining under their previous employer who will have organisational whistleblowing arrangements and protocol already in place.

Questions were raised over expanding access to the INO to independent sector organisations who provide commissioned services; students and trainees across the services within the IJBs; employees of children's health and social care services; and volunteers within these services.

INO title

A general view was that the INO title should reflect the INO purpose and be readily understood. The title most frequently recommended for the INO was "Independent National Whistleblowing Officer for NHSScotland". Another potential title which was commonly proposed was, "NHSScotland's Whistleblowing Ombudsman".

There were differences of opinion over whether "whistleblowing" should feature in the title, with some respondents perceiving this to have negative connotations whilst others considered it brought clarity of purpose. Some respondents recommended that the word "independent" feature in the title.

A common view was that a reference to "health and social care" should be inserted into the INO title should the role encompass staff not employed by NHSScotland who deliver health and social care services in Scotland.

Any other comments

A few main themes emerged within additional comments made by respondents.

Respondents considered that for the INO to be effective and credible, the Scottish Government and relevant Boards needed to display clear support for and commitment to the role.

Calls were made for further clarity over roles and relationships including the links between the INO and the non-executive whistleblowing champions; the relationship with existing whistleblowing initiatives; and with existing professional regulators.

Some respondents recommended that terminology be refreshed to ensure the INO is presented in a positive light, for example, by replacing reference to “complaints” with “concerns”. Others proposed that a formal review process be established to support the introduction of the INO role.

2. Introduction

The Scottish Government and NHSScotland are committed to ensuring that all NHS employees in Scotland are encouraged, supported and confident in raising any concerns they may have about patient safety, behaviours which may lead to harm, or malpractice in the NHS.

Such reporting is known as whistleblowing or "making a protected disclosure" or "qualifying disclosure". The Employment Rights Act 1996, amended by the Public Interest Disclosure Act (PIDA) 1998 protect workers who make a disclosure in the public interest from detriment.

The NHSScotland Staff Governance Standard requires employers to ensure that it is safe and acceptable to speak up about wrongdoing or malpractice and all NHSScotland Boards are required to have in place a local whistleblowing policy based on a national model[3] "Implementing & Reviewing Whistleblowing Arrangements in NHSScotland" PIN Policy. The policy, developed in partnership between employers, Staffside representatives and the Scottish Government, provides a minimum standard which must be adhered to.

The Scottish Government wishes to support an ongoing honest and open reporting culture in the NHS in Scotland and has in place, or in development, measures to support the whistleblowing policy and Standard. These include the NHSScotland Confidential Alert Line; training sessions for key NHS staff; removal of the routine inclusion of confidentiality clauses and derogatory statement clauses from settlement agreements; and guidance for NHSScotland staff and employers on the appropriate use of confidentiality clauses and derogatory statement clauses in settlement agreements.

Despite such measures, however, concerns remain about the way in which whistleblowing cases are handled with some staff remaining reticent about reporting concerns.

In England, The Freedom to Speak Up Review was established in 2014, chaired by Sir Robert Francis QC, aimed at providing advice and recommendations for an open and honest reporting culture in NHS England in which NHS staff can feel it is safe to raise concerns, confident that they will be listened to and have their concerns acted upon. The Review was comprehensive, based on widescale consultation with NHS Staff and relevant organisations and produced five themes identifying the need for: culture change; improved handling of cases; measures to support good practice; particular measures for vulnerable groups; and extending the legal protection for whistleblowers.

Whilst in Scotland various aspects of the recommendations were already in place, the Review highlighted a number of practical actions which the Scottish Government considered will further enhance and add value to the existing and

[3] www.gov.scot/publications/2011/12/06141807/0

developing national policies of NHSScotland. One particular gap identified was for oversight of how an NHS body deals with concerns raised by staff and the merit of having a mechanism for external review of how concerns have been handled at local level.

Key recomendations of Scottish Ministers following the Review were to develop and establish the role of Independent National (Whistleblowing) Officer (INO) to provide this external review function and offer advice and guidance to NHSScotland organisations on good practice on handling concerns; and to introduce non-executive "whistleblowing champions" in each NHSScotland Board whose role will include oversight and assurance at local level in addition to helping to ensure that internal Board mechanisms are working effectively to support whistleblowing arrangements and staff raising concerns. This role was introduced in each Board at the end of 2015.

The Scottish Government wishes to seek wider views on its proposals for the INO role and remit, in particular its functions and powers, but also on practical and logistical issues such as the INO host location and the process for considering complaints. With the integration of Health and Social Care on the wider agenda, views on the role of the INO in relation to the Social Care sector are also sought.

On 17 November 2015 the Scottish Government published a consultation paper to seek views on these matters with views invited by 10 February 2016.

Consultation responses

The Scottish Government received 58 written responses to the consultation. Table 2.1 overleaf shows the distribution of responses by category of respondent. A full list of the organisations which responded is in the Annex. The respondent category applied to each response was agreed with the Scottish Government policy team.

53% of responses were submitted by organisations; 47% were from individuals. The largest category of respondent amongst organisations was NHSScotland Territorial and Special Boards comprising 16% of all respondents.

All individual responses and most of the organisation responses were submitted via the online system, Citizen Space, established for consultation responses. Others were submitted in emails and were attached to the online system by the Scottish Government to create one complete database of responses for publication.

Table 2.1: Distribution of responses by category of respondent

Category	No. of respondents	% of all respondents
NHSScotland Territorial and Special Boards	9	16
Professional Body/Staffside Representatives	8	14
Regulatory/Scrutiny Bodies	3	5
Other Public Bodies	3	5
Local Authorities	2	3
Legal Bodies	2	3
Others	4	7
Total organisations	**31**	**53**
Individual respondents	**27**	**47**
Grand total of individuals and organisations	**58**	**100**

Analysis of responses

The analysis of responses is presented in the following seven chapters which follow the order of the topics raised in the consultation paper. 14 questions were posed by the consultation inviting a mix of closed and open responses. The analysis of responses to these is based on the views of those who responded to the consultation which are not necessarily representative of the wider population and cannot be extrapolated further.

Throughout the report quotes taken directly from responses have been used to illustrate specific points. These were selected on the basis that they enhance the analysis by emphasising specific points succinctly. Quotes from a range of sectors were chosen where the respondents have given permission for their respective response to be made public. Where respondents have requested confidentiality, the content of their response has been examined and taken into account in the findings, but is not reported explicitly in the text of the report so as to conceal the identity of the respondent.

3. Role of the INO

Background

The Scottish Government proposes that the INO role should involve three main areas when investigating whistleblowing complaints. These are summarised in three key questions: Has the local whistleblowing policy been followed correctly? Is the Board's decision and resultant outcome reasonable? Has the person/people who raised the complaint been treated fairly?

The Scottish Government is clear that the INO must add value and not duplicate or interfere with the role of any existing body. In addition, the role of the INO cannot impinge on an individual's contractual arangements as governed by the Employment Rights Act 1996, including claims of detriment suffered by the whistleblower, as this remains the exclusive jurisdiction of the Employment Tribunal.

Against this background, the Scottish Government considers there to be two options on the types of complaints which the INO could investigate. Under Option 1 the INO would consider the application of the whistleblowing process only, examining whether the processes outlined in the relevant Health Board's local whistleblowing policy had been properly followed. Under Option 2 the INO would investigate the process but also examine how the Board came to its decision and the subsequent outcome.

Question 1: What should the role of the INO be?

Option 1: To consider complaints about the application of the local whistleblowing process only.

Option 2: To consider complaints about the application of the local whistleblowing process, including examination on the decision-making and outcomes of the whistleblowing complaint.

54 respondents addressed this question. Of these, a majority of 47 respondents supported Option 2; four respondents supported Option 1; one respondent considered neither of these options to be appropriate; and two respondents provided commentary only without indicating their preference.

Recurring views in support of Option 2

The most common rationale given in support of Option 2 was that this provided **a holistic approach to examining complaints, carrying weight, increasing likely effectiveness of the INO role** and avoiding what was perceived as the overly narrow focus of Option 1. Comments included:

> "Our view is that this would create a robust framework" (NHS Education for Scotland).

> "We favour option 2. It is important that the INO has powers which are as robust as possible" (Royal College of Nursing Scotland).

> "Opting for Option 1 and limiting to the process of "whistleblowing" will create an impression of the postholder working with both hands and feet tied behind their back and merely scrutinising "process" rather than the whole of the complaint" (Individual).

> "Limiting its powers to reviewing procedure would materially reduce its effectiveness" (Thompsons Solicitors and Solicitor Advocates).

Another recurring view in favour of Option 2 was that this remit for the INO would **instil confidence in complainants** that the INO would deal with their complaint thoroughly and transparently. Option 2 was envisaged as helping to **build trust** in the INO role as an effective element in the whistleblowing framework. Examples of comments included:

> "Option 2 would give the opportunity to have the decision substituted or overturned. Without this power, the INO may be considered to be ineffectual which may result in frustration on behalf of the public and a lack of confidence or trust in the role. It may also result in a lack of respect for the role on the behalf of organisations" (NHS National Services Scotland).

> "View it as a further means of helping bring confidence to those wishing to raise concerns, as well as providing an important element of external review and assurance that genuine concerns are being treated seriously and investigated appropriately" (General Pharmaceutical Council).

> "It adds a level of external scrutiny to the NHS Board's process and therefore will provide additional assurance to the whistleblower" (NHS Greater Glasgow & Clyde).

A third repeated argument in favour of Option 2 was that this **would provide independence and an impartial scrutiny** of cases. One respondent remarked:

> "The person must be outwith any health board member or employee and be autonomous, someone any member employee can seek out as an impartial listener and able to consider complaints. They must be able to examine the decision and outcome...." (Individual).

Other views in support of Option 2

A range of other views in support of Option 2 were provided, each by only a few respondents:

- Option 2 remit will ensure the INO adds value and does not simply duplicate the respective roles of existing professional bodies.
- The remit will provide closure on cases, benefitting ultimately the NHS and the whistleblower.
- Avoids giving out an air of legitimacy to procedurally correct but otherwise poor employer decisions.
- The scrutiny function provides an added layer of protection, provides a safety net for whistleblowers.
- Enables lessons to be learned from the examination of the decision-making process.
- Prevents the INO role being simply a tick-box exercise:

“Reviewing the handling of concerns can be very paper based and a tick box matching of policy rather than the actual facts and outcomes to the worker or to the patient/environment/issue” (Individual);

“Though whether an organisation has followed the whistleblowing policy or not is important, focusing the role exclusively on this may result in the process resembling a tick box exercise, rather than a thorough investigation” (Public Concern at Work).

- In-keeping with usual grievance investigative procedural roles.
- Minimises whistleblower frustration over outcome:

“The early experience of Ombudsmen in Scotland was that restricting their remit to process issues alone added to the frustration felt by complainants when a high proportion of complaints were ruled out of remit or when the Ombudsman's report dealt only with the way things had been handled, not the substance of the complaint” (Royal College of Physicians of Edinburgh).

Views in support of Option 1

Amongst the small minority of respondents who supported Option 1 a number of arguments emerged. A few considered that **the outcome is a decision for the relevant organisation to take and should not be re-visited by the INO**. It was remarked that outcomes may be based on several factors only some of which the INO and whistleblower may know about. One respondent posed the question, who is to say that the decision of the INO is the correct one? A few expressed concern over the scale of the task set out under Option 2, one respondent stating:

> “I'm not clear what Option 2 means by "examination" of decision making and outcome. To do this effectively would require access and scrutiny to all

information - effectively reviewing the decision and outcome and I don't think this is workable, achievable or realistic" (Individual).

View supporting neither Option

One respondent called for a wider remit to include impact on the whistleblower's employment:

> "....given (that) concerns about the impact on their employment is often raised by and a key issue for whistleblowers, any investigating body that cannot consider the whole response of the organisation being investigated to the allegation will come up against restrictions which will limit its effectiveness" (SPSO).

4. Principles and process for raising concerns with the INO

Background

The Scottish Government considers it important to have in place principles to determine the process for raising concerns with the INO. It is proposed that each complaint must comply with each of the following principles:

- **the INO should add value and complement the work of existing regulatory or scrutiny bodies;**
- **the INO should not consider historic cases (it is recommended that under normal practice the INO should consider only cases brought to its attention within 12 months of the conclusion of a case investigated by a Health Board);**
- **the INO would not normally consider cases that have yet to be investigated by the Health Board, or are still under local investigation (although there may be exceptional circumstances which may require INO involvement at an earlier stage);**
- **the INO would not investigate or make assessments on employment matters, or issues relating to an individual's terms and conditions, or contract of employment;**
- **a member of staff would need to have raised a concern that met set criteria for their concern to be valid for consideration by the INO. The criteria include setting out reasons for referring the complaint to the INO and why the complaint is of public interest.**

Question 2: Do you agree with the principles and process for raising concerns with the INO?

51 respondents addressed this question. Of these, a majority of 43 respondents stated that they agreed with the proposed principles and process for raising concerns with the INO. Six individual respondents disagreed; one legal body expressed partial agreement; and one regulatory/scrutiny body provided commentary only. A few respondents qualified their support stating that the principles and process for raising concerns should be subject to regular review and refinement.

Supportive comments

General views were that the proposed process did not appear overly burdensome; the principles and process corresponded to PIN policy[4] and legislation; the flow chart outlined in the consultation document to illustrate the process of raising concerns was simple and a valuable tool; and that what was proposed would help to avoid duplication of roles. One respondent called for:

> "...the criteria ....to be written in an accessible, clear format and published widely so all potential users of the service are aware of the INO's remit" (General Medical Council).

Several respondents welcomed specifically what they saw as the emphasis on INO being the **final stage in the process** rather than potentially duplicating existing functions. The term "last resort" was used by a few to describe how they envisaged the INO fitting in to the existing framework:

> "....this remains a final independent channel with powers to ask for re-investigation in part or whole" (Individual).

Another respondent highlighted what they perceived to be the benefits of the **proposed bar on historic cases**:

> "We....agree with the principle of not considering historic cases as there needs to be a clear starting point from when cases might be investigated. It would be too easy for the role to be bogged down trying to investigate old complaints which should be closed" (Guild of Healthcare Pharmacists).

Others, however, were more circumspect, agreeing in general with the proposed bar on historic cases, but supporting a degree of discretion in certain circumstances:

> "....the principle that 'the INO should not consider historic cases' may be a little restrictive and historic cases may form a necessary part of a current review" (Law Society of Scotland).

One individual commented that historic cases could be important in enabling linkages to be made between one region or sector and another.

A few respondents recommended shortening the time period during which cases require to be brought to the attention of the INO following the conclusion of the respective Health Board investigation. A maximum of six months was suggested rather than the 12 months proposed. This was seen as consistent with current Care Inspectorate and SPSO practice and would ensure that urgent matters are dealt with promptly.

[4] http://www.staffgovernance.scot.nhs.uk/partnership/partnership-information-network

The British Medical Association (BMA) Scotland supported the five principles for raising concerns but considered that they were not particularly patient/health focused and that consideration could be given to more tailored principles in line with the Public Interest Disclosure Act (PIDA) 1998.

Concerns regarding the proposals

One repeated recommendation amongst those opposing aspects of the proposals was that the INO should have more explicit powers to **investigate cases at an earlier stage**, prior to the local investigation being completed. A few respondents shared the concern that some Health Boards may not apply up-to-date policy or may apply processes incorrectly, necessitating earlier intervention by the INO:

> "Dealing with whistleblowing requires an element of flexibility. In some cases it would be of no use for a whistleblower to exhaust internal processes within a Board that has a clear history of poor practice and mistreatment of whistleblowers" (Public Concern at Work).

A few respondents requested **greater clarity** on issues such as when a whistleblower should approach the INO and what "exceptional circumstances" might entail.

Another proposed principle challenged by a few respondents was that the INO would not investigate or make **assessments on employment matters**, or issues relating to an individual's terms and conditions or contract of employment. Again, some flexibility was called for so as to enable investigation by the INO in certain circumstances or at least have powers to intervene in order to refer investigation to another body.

Finally, one respondent expressed concern that allowing the INO to consider some exceptional cases at an earlier stage, could have:

> "....the potential to interfere with the Boards autonomy and /or may compromise the outcome" (Healthcare Improvement Scotland).

Question 2a: Do you feel that there should be any additional principles or changes to the process for raising concerns with the INO?

50 respondents addressed this question, with 25 of them stating that there should be additional principles or changes to the process for raising concerns with the INO and the remainder content with what was proposed.

A few respondents simply referred to their response to question 2; some made a general recommendation for the principles and process to be reviewed regularly in order to fine tune as the role of INO evolves.

Comments regarding the proposed principles

Regarding the first proposed principle that the INO should add value and complement the work of existing regulatory or scrutiny bodies, one view was that a separate principle should focus on sharing intelligence with the Boards and other regulators:

> "Our experience shows that gathering and sharing intelligence plays an important role in identifying and managing risk. In its role in providing national leadership on issues relating to concerns raised by NHS workers, the INO could identify themes and trends about concerns raised and share these with the Boards and other regulators such as the GMC" (General Medical Council).

Another proposed additional principle was that of fairness and equality to reflect the different communication and support needs which whistleblowers may have and to ensure they are not discriminated against on account of this.

Proposed principle three relates to cases not yet investigated by the Health Board or still under local investigation. Two respondents called for more guidance on what exceptional circumstances may encompass and the process by which the INO will be involved at this stage. One individual perceived the PIN policy to be dated with key aspects missing and proposed that amendments are made. A professional body suggested that the INO should use guidance issued by trade unions and professional organisations and should also consult with staffside organisations when assessing whether providers have followed correct protocol.

The fourth proposed principle refers to employment matters being outwith the scope of the INO. Two respondents from the legal sector recommended that the INO should be able to receive requests from the Employment Tribunal to submit written opinions or give live evidence to live cases. One individual suggested that the INO provide an advisory role outwith the employment system, to advise potential whistleblowers on whether to proceed.

One professional body called for a further principle relating to finality of case which made clear that no further appeals would be permitted.

Comments regarding the flowchart

One individual respondent called for the title of the flowchart in the consultation document to be amended to, "Concern raised by NHSScotland staff member and private care members". A few others commented that the flowchart assumes that the source of the complaint will always be an employee, whereas they envisaged complaints emerging from independent contractor colleagues such as GPs and dentists or patients, volunteers and other members of the public.

One individual recommended the addition of a final stage in the process whereby final decisions are sent to the appropriate regulators to ensure that organisations' general culture is monitored over time. An NHS respondent considered that a

Health Board's final letter to the whistleblower should include contact details of the INO, their remit and the timeframe for handling cases.

Other comments

Two respondents (professional body and other body) identified an additional training role for the INO post. Both envisaged the INO sharing good practice and lessons learned based on their investigation of cases, viewing this as enhancing the investigative role and improving its effectiveness.

Question 2b: Do you agree with the proposed INO whistleblowing complaint criteria?

52 respondents addressed this question with 44 agreeing and eight respondents across four different sectors disagreeing.

Supportive comments

Common views were that the proposed INO whistleblowing complaint criteria were clear, fair and sensible. A few respondents requested that they be subject to review. One respondent considered that the criteria would enable spurious claims to be filtered out:

> "The criteria suggested will ensure that only genuine claims are brought forward and not claims where an individual is just unhappy with the outcome of the investigation into their complaint" (NHS Lothian).

A few respondents suggested that the criteria could be strengthened by providing examples to help make their meaning clear. NHS Education for Scotland requested more information on the processes and principles to which the INO would adhere in determining which cases to investigate. The Royal College of Physicians of Edinburgh considered that it might be helpful to cross-reference the criteria as applied to the Ombudsman and to clarify the limits of discretion.

Concerns regarding the proposals

The most frequently raised concern was that the proposal placed **undue emphasis on the whistleblower having to prove their case** for INO involvement, using criteria set out in legal language which may discourage them from pursuing a legitimate complaint. A recurring view was that support should be available for whistleblowers in this position, for example local advocacy:

> "This duty on the whistleblower to gather all the relevant information and then prove it is correct may deter some people from going to the INO" (BMA Scotland).

> "We would suggest that too prescriptive or technical an approach will discourage individuals" (Law Society of Scotland).

> "We would suggest that the INO should develop a standard pro forma and allow for appropriate third party representation which would assist accessibility" (UNISON).

Very few respondents raised any other substantive concerns. One individual respondent perceived the criteria as currently framed to risk critical information being suppressed and recommended widening the criteria to include cases where the whistleblower *anticipates* failure in their employer's investigation process, provided the complainant can evidence some basis for their fears.

NHS National Services Scotland commented that for the NHS, the criterion around miscarriage of justice may be difficult to apply.

Public Concern at Work expressed specific concern regarding the proposed use of the PIDA list of wrongdoing, which they considered was generic and not specific to the health sector and risked excluding issues which are in the public interest but do not meet the legal PIDA criteria.

Question 2c: Do you feel that there should be any additional complaint criteria?

Very few respondents proposed any additional complaint criteria.

The BMA Scotland proposed that consideration could be given to including an option to review ongoing decisions that are taking a long time to resolve, as there may be a perception that issues are being inappropriately kept under local review for too long. The General Medical Council suggested including a question about whether the person making a complaint has raised their concerns with another body in order to alert the INO to sources of additional evidence that may be relevant to the case. One individual recommended that the whistleblower should be required to give information about timescales of the investigation to date and give full information on the investigation carried out by the Board along with the outcome.

A few respondents suggested items to add to the PIDA list: financial impropriety; breach by the organisation of professional codes of conduct; and some consideration to complex cases where multiple complaint criteria are identified.

5. Prescribed powers of the INO

Background

The Scottish Government considers that the INO should have the ability to provide independent challenge and oversight for the most complex of whistleblowing cases for it to be publicly credible. It is also felt that for the role of INO to be effective, and perceived in that way, it needs to be able to ensure that Boards take forward any recommended actions that it makes, and have the ability to follow-up on and enforce recommendations when required.

It is suggested that the INO role be further strengthened to include:

- **Giving the INO power, where necessary, to compel a public body to provide evidence to the INO to allow it to reach a decision and make appropriate recommendations.**
- **Giving the INO sufficient power to ensure that the recommendations it makes are acted upon and, where necessary, to enforce the recommendations if required.**

Question 3: Do you agree that consideration should be given to the INO having prescribed powers?

Question 3a: If yes, do you think that these powers should be:

To compel a public body to provide evidence only?

To enforce recommendations only?

Both?

Views on whether consideration should be given to the INO having prescribed powers

Of the 52 respondents who addressed the issue, 49 agreed that consideration should be given to the INO having prescribed powers and three did not agree.

The most common reason given in support of considering prescribed powers was that without these the INO would be ineffective and "toothless":

> "To ensure that the role of INO is effective in its aims, it is essential that there should be prescribed powers. This will be the only way that proposals and recommendations which are deemed necessary are definitely implemented. The overall aim is always to improve patient safety and care, and having prescribed powers is essential for this" (Individual).

Another common view was that prescribed powers would provide the INO with credibility and generate respect:

> "Without any prescribed powers, the role of the INO is likely to be disregarded and bypassed by both Boards and Staff" (Royal College of Physicians of Edinburgh).

Other reasons to support prescribed powers were provided each by one or two respondents:

- To equip the INO with insight.
- To encourage people to speak up.
- To fill gaps in existing policies and mechanisms.
- To reflect the national significance of cases coming before the INO.

A few respondents emphasised that any prescribed powers should not duplicate or undermine existing regulatory and quality assurance frameworks.

The view amongst the minority who did not agree with considering prescribed powers for the INO was that sufficient powers already exist elsewhere, for example, the PIN Policy for Scotland could be used as the vehicle for requiring evidence to be provided to the INO.

Views on what these powers should be

Of the 48 respondents who addressed the issue, 44 considered that the INO should have powers to compel a public body to provide evidence and also to enforce recommendations and four argued only for powers to compel public bodies to provide evidence.

A recurring view was that it would be illogical to have one of these powers without the other as both were seen as contributing to the effectiveness of the role of the INO.

The shared view amongst the four respondents who supported INO powers to compel a public body to provide evidence only was that a range of existing legislation and accountability mechanisms already exist and there is no need for what was seen as an additional and unnecessary layer of accountability. The notion of trust and building good relations between the INO and local organisations with their existing processes was highlighted as important, with enforcement perceived as a last resort and something best left to the appropriate scrutiny and regulatory bodies:

> "The priority will be for the INO to build positive and constructive relationships with Boards, and for Boards to be seen as fully and voluntarily co-operating with any cases" (Healthcare Improvement Scotland).

Suggestions for other powers for the INO

The consultation invited suggestions for other powers for the INO which produced the following:

- To refer issues to other regulators as appropriate.
- To compel other relevant agencies to engage fully with them whilst investigating cases.
- To compel all NHSScotland bodies to put in place recommendations if these are generalisable and have wider applicability.
- To levy fines against employers as appropriate.
- To sanction employees who make vexatious claims.
- To request that evidence be provided under oath.
- To publish the outcome of investigations and actions resulting.
- To compel organisations to provide evidence to show that they have complied with appropriate processes.

6. Options for hosting the INO role

Background

The Scottish Government considers that where the INO is hosted is fundamental to the credibility and ultimately the success of the role. The independence and impartial nature of the role are viewed as vitally important. The Scottish Government has considered various options for hosting the role bearing in mind factors such as costs, likely volume of cases, staffing considerations, legislative requirements and access to specialist advice.

Three key options emerged:

- **Option 1: INO hosted within NHSScotland – Healthcare Improvement Scotland (HIS)**
- **Option 2: INO hosted within existing external organisation – Scottish Public Services Ombudsman (SPSO)**
- **Option 3: INO created as a new Public Body**

Question 4: Where should the INO role be hosted?

Of the 47 respondents who provided a clear preference, a majority of 36 respondents considered that the INO should be hosted within the SPSO. 11 recommended hosting the INO within HIS, eight of these being individual respondents, the remaining three being professional or other public bodies. None suggested creating the INO as a new public body which was viewed as a costly and unnecessary option.

Only one further option, Audit Scotland, was proposed by one individual as being an independent organisation appropriate for hosting the INO role.

Views for and against Option 1: INO role hosted within HIS

Amongst the minority of respondents who supported the INO role being hosted within HIS the following benefits were identified:

- HIS role fits with the INO role regarding service improvement and scrutiny functions.
- HIS already deals with whistleblowing complaints and therefore taking on the wider INO role will be more straightforward than if another body takes this on.
- HIS is already well known to NHS staff.

The most common argument against hosting the INO role within HIS was that HIS is not viewed as independent by NHSScotland staff and conflicts of interest may arise or be seen to arise.

Another recurring argument against the HIS as host to the INO role was that HIS focuses on healthcare issues but the Integration Joint Board arrangements would require it to broaden its focus to wider care issues which may compromise its core functions.

Views for and against Option 2: INO role hosted within SPSO

This was the more popular option amongst those who responded, with the primary argument in favour being the independence of the SPSO from health and social care bodies and also the perception and impression of impartiality (from care bodies and from the Scottish Government) which it generates:

> "Whilst there are arguments that could be made for hosting the INO within HIS, we think that it would be better placed within the SPSO as it then is visibly independent of the NHS and Scottish Government. This independence could be important in avoiding allegations of NHS or government interference which might be raised if there was a contentious judgement and it was hosted within HIS" (Guild of Healthcare Pharmacists).

A few respondents highlighted the advantage of the SPSO already spanning the entire public sector, including both health and social care sectors. The Scottish Social Services Council commented:

> "We note that the SPSO currently has a role as the final stage in investigating complaints from service users and note that their remit extends beyond health boards to include some care providers who provide services on behalf of the NHS and also to local authorities who provide and commission social care services."

Other arguments in favour of hosting the INO role within the SPSO were that the SPSO already has relevant expertise and experience; this will be the most cost-effective option; and this is the option which will reduce risk of duplication the most.

7. Health and social care integration

Background

The proposals in the consultation paper relate entirely to employees of NHSScotland, however the Scottish Government recognises that as integrating adult health and social care services is one of their top priorities there will be an expectation that the services of the INO should be accessible to those staff who deliver health and social care services in Scotland.

Consideration is being given to widening the scope of the role of the INO so that it can be accessed by employees of the social care sector.

Question 5: Do you think employees of adult health and social care services, who are not employed by NHSScotland, should have access to the INO?

50 respondents addressed this question, with a majority of 37 agreeing that employees of adult health and social care services, who are not employed by NHSScotland, should have access to the INO, and 13 disagreeing. Most respondent sectors were represented in both categories, reflecting diverging views across the board on this topic.

Nine respondents proposed that the extension of the INO to cover employees of social care services should be undertaken incrementally, informed by evaluation of the initial roll-out within the NHS sector. A few suggested further consultation prior to taking what they considered to be the next step

> "It may be appropriate to proceed with an NHS focus initially so that the appropriate analysis and broader stakeholder consultation can take place" (Healthcare Improvement Scotland).

Views in favour of expanding access to the INO

Two main arguments prevailed in favour of expanding access to the INO for employees of adult health and social care services, who are not employed by NHSScotland.

Firstly, many respondents across four respondent categories argued that expanding access in this way makes sense in terms of **reflecting the joint working** which will result from the Public Bodies (Joint Working) (Scotland) Act 2014. It was felt that this would support joint risk-taking across sectors, holistic working arrangements, situations of concern which straddle health and social care provision, and a shared learning culture in which staff from different disciplines have the opportunity to observe and learn from each other at work.

Secondly, a common view again across four respondent categories was that access to the INO for those not employed by NHSScotland but working in adult health and social care services would provide **parity across staff**, with all treated the same and given the same protection. In this way a two-tier system would be avoided and consistency engendered:

> "To provide a fair and consistent referral route for whistleblowing outcomes is important to give to all staff in health and social care" (NHS Borders).

> "Every opportunity should be given to give all staff in the IJB's the same processes to use. Why would different processes be given or a process only given to some in a team, if working side by side, if related to health" (Individual).

A variety of other rationales supporting the expansion of access to the INO were provided by a small number of respondents:

- In keeping with a patient-centred approach.
- Will ensure that the joint bodies are working to the same rigour and standards as the NHS.
- Otherwise opportunities for service improvement could be missed.
- Otherwise a negative signal is given out about the Scottish Government's commitment to the integration agenda.
- INO may be required especially during the integration process if problems arise with implementing revised policies and responsibilities.

Views against expanding access to the INO

The main argument against expanding access to the INO for employees was that the Integration Joint Board (IJB) does not employ staff, with staff remaining under their previous employer who will have whistleblowing arrangements and protocol already in place. Attempts to expand access to the INO could cut across these. One respondent remarked that there has not been a review of adult social care whistleblowing procedures and therefore it is not yet known if the INO is required within this sector.

Two respondents including the Care Inspectorate highlighted specifically that the Care Inspectorate is recognised as the body to investigate whistleblowing complaints in care services:

> "Replication of existing arrangements, or any confusion about terms of reference, would be undesirable and should be avoided" (Care Inspectorate).

Two further respondents opposed expansion on the grounds that the INO caseload could become unmanageable and should not proceed unless properly resourced.

One respondent suggested that a separate consultation examine the issues prior to a decision being made.

Queries raised

A few respondents raised queries about the scope of the proposed expansion to the INO remit. These revolved around the possibility of expanding access further to include:

- Independent sector organisations who provide commissioned services.
- Students and trainees across the services within the IJBs.
- Employees of children's health and social care services.
- Volunteers within the services.

Healthcare Improvement Scotland remarked:

> "The general assumption for many Boards is that they will operate similar policies for volunteers as for staff where relevant, but the policies themselves often do not refer explicitly to volunteers, nor have they been designed with them specifically in mind."

Question 5a: If yes, which IJB services should be covered?

28 respondents addressed this topic. By far the most common response (22 mentions) was to recommend that "all" services are covered. A few respondents urged that independent and voluntary sector providers of services commissioned by adult health and social care services should be included. Other recommendations mentioned by only one or two respondents were for services in care/nursing homes to be covered; the inclusion of care services at home; services in day hospitals; primary care services such as clinics and GP practices; and integrated and shared services directly sourced from acute Health Boards.

Question 5b: If yes to Q5 do you have a view on how employees who have access to the INO could be defined?

22 respondents provided responses to this question. Two of these respondents did not provide a definition, but highlighted what they considered to be the importance of defining clearly which employees will have INO access. Another recommended that the word "employees" in the question suggested an exclusion of voluntary workers, which in their view should not be the case.

Others made the following recommendations:

- All public sector employees.

- Anyone employed by, or commissioned to work under, the jurisdiction of the health and social care partnership, that is, within the remit of the IJB.

- Any employee with a direct or indirect link to NHS/social care in Scotland.

- Any worker from an organisation regulated by a health systems' regulator (e.g. Health Improvement Service).

- Any employee who in respect of their duties is involved in the direct care of an individual or in a position to witness direct care of individuals involved in direct patient care services.

- By reference to the employees' profession e.g. health or social care worker.

8. INO title

Background

The Scottish Government considers it important to give the INO a clear title that signposts its functions to staff. Various suggestions have been made for the role.

If the role is to be extended to those staff not employed by NHSScotland who deliver health and social care services then the title will need to reflect these circumstances.

Question 6: What do you feel would be an appropriate title for the INO in Scotland?

42 respondents addressed this question with most proposing an appropriate title for the INO in Scotland and others providing their view on words and phrases which they considered should be included in or excluded from the title. Overall there was an emphasis on ensuring the title reflected the purpose of the INO role and was readily understood.

The most frequently nominated title for the INO in Scotland was "Independent National Whistleblowing Officer for NHSScotland" with 14 respondents across five different respondent categories identifying this as their preferred title. The second most favoured title was, "NHSScotland's Whistleblowing Ombudsman". Table 8.1 summarises proposals for the title which received more than one nomination.

Table 8.1: Summary of proposals for an appropriate title for the INO in Scotland

Category	No. of respondents
Independent National Whistleblowing Officer for NHSScotland	14
NHSScotland's Whistleblowing Ombudsman	7
NHSScotland's Independent National Officer	4
Independent National Officer	2
Scotland's Health and Social Care Whistleblowing Ombudsman	2

Contrasting views emerged on whether or not the word "whistleblowing" should be in the title. Whereas a few respondents considered it to have negative connotations, others welcomed the word as promoting clarity of purpose. A few respondents supported explicitly the word "independent" in the title, with

“Ombudsman” also seen as having merit in terms of promoting confidence in the investigation process.

Question 6a: What do you feel would be an appropriate title for the INO in Scotland if the role also covered staff not employed by NHSScotland who deliver health and social care services in Scotland?

37 respondents addressed this question with 11 identifying their response to question 6 as their preferred title, largely where their previous suggestion had not referred specifically to NHSScotland.

12 respondents recommended inserting some reference to “health and social care” into the title for the INO if the role covered staff not employed by NHSScotland but who deliver health and social care services. Two respondents suggested dropping the reference to “NHSScotland” from their previous proposal for the INO title.

A few respondents proposed that the word “Guardian” be included in the INO title, including Public Concern at Work which suggested: “NHSScotland Whistleblowing Guardian (Health and Social Care)” or “Scotland’s Whistleblowing Guardian for Health and Social Care” amongst its proposals for the title.

Two new proposals made in response to this question were: “Scotland’s Concerns Ombudsman (Reporting & Enforcement)” (Individual respondent); and “Independent Investigatory Officer Health and Social Care” (Royal College of Midwives Scotland).

9. Any other comments?

Question 7: Do you have any other comments to make on the proposals for the introduction of the role of INO?

Four main themes emerged from additional comments made by respondents.

1. Much support was expressed for the proposals but a recurring view was that for the INO role to be effective and credible there required to be clear support and commitment shown by the Scottish Government and relevant Boards. Respondents emphasised the importance of the INO being seen as independent with appropriate powers and adequate resourcing.

2. Several respondents sought further clarity over roles and relationships. The need to avoid duplication with other roles and systems was re-iterated with a few respondents requesting that greater emphasis be placed on utilising local resolution mechanisms before resorting to the INO.

Calls were made for the establishment of very clear role expectations and boundaries for the INO with these easy to understand for service users, carers and the wider public.

More detail was requested on the relationship and links between the INO and the non-executive whistleblowing champions; with existing arrangements such as PIDA and the NHSScotland Confidential Alert Line; and with existing professional regulators.

3. A further theme was that of ensuring that whistleblowing is presented in a positive and constructive light. Suggestions were made for changing terminology to enable this, for example, replacing “complaints” with “concerns”, which some considered would also help to differentiate more clearly between private matters and public issues.

4. A few respondents recommended elements of review and evaluation processes to support the introduction of the INO role. Lessons learned from England and consistency between England and Scotland were suggested by one respondent; the establishment of a formal review framework by another; and impact assessments to support implementation were also proposed.

Annex: List of Respondents

NHSScotland Territorial and Special Boards

NHS Ayrshire and Arran
NHS Borders
NHS Education for Scotland
NHS Greater Glasgow and Clyde
Healthcare Improvement Scotland
NHSScotland
NHS Lothian
NHS National Services Scotland
Scottish Ambulance Service

Professional Body/Staffside Representatives

BMA Scotland
General Medical Council
General Pharmaceutical Council
Guild of Healthcare Pharmacists
Royal College of Midwives Scotland
Royal College of Nursing Scotland
Royal College of Physicians of Edinburgh
UNISON

Regulatory/Scrutiny Bodies

Care Inspectorate
Health and Safety Executive
Professional Standards Authority for Health and Social care

Other Public Bodies

East Ayrshire Health and Social Care Partnership
Scottish Public Services Ombudsman
Scottish Social Services Council

Local Authorities

Glasgow City Council
Perth and Kinross Council

Legal Bodies

Law Society of Scotland
Thompsons Solicitors and Solicitor Advocates

Other Organisations

Action for a Safe and Accountable People's NHS
NHS Grampian Area Medical Committee
NHS Tayside Whistleblowing Policy Group
Public Concern at Work

Individuals

27 individuals

How to access background or source data

☐The responses to this consultation are available via the Scottish Government consultation hub https://consult.scotland.gov.uk/

social research

The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

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